

ALASKA LEGISLATURE COMMITTEE FILES 1983-1984 86/2

2375 SHESS SB 510 - SB 517

2175

CORF - AG opinion on ATC, do qualify as a
CORF by Medicare. ATC offers services not
covered under Medicaid - state cannot
cover social worker/psychological services.

Colmatten Dr. Vicki Nelson - chiro.
freedom of choice of providers.

Arca Marcia Wakeland - PT Eagle River

Arca Lisa Brooks - P.T.

Sadotna Monica Lofgren - P.T.; on Board
against broadening referrals.

Arca Susan Hutchinson - PT
different philosophies.

Kim Busch - 3347

1. Transferring people from hosp. ~~and~~ ^{to} nursing home.
2. ATC - Comp. outpt. rehab. ~~unit~~ ^{facility}.

Presp. Reimb.

CORF

3 spec. services

- soc. & psych services

CORF - as def. under Fed Medicare Regulations.

3.

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: HB 712
 Title: "An Act relating to the pro-
 vision of chiropractic & CORF services under Medicaid"
 sponsor: _____
 Requestor: House & Labor & Commerce Committee
 Date of Request: 4/10/84

FISCAL DETAIL

Agency Affected: DHSS - D1A
 Program Category Affected: Medicaid
 BRU, Program or Subprogram(s) Affected: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		44.0	25.9	28.0	30.2	32.6
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS		809.3	1117.9	1206.5	1302.2	1405.5
800 MISCELLANEOUS						
TOTAL OPERATING		853.3	1143.8	1234.5	1332.4	1438.1
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		426.6	571.9	617.2	666.2	719.0
FEDERAL FUNDS		426.7	571.9	617.3	666.2	719.1
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

See Attached

ANALYSIS: Attach a separate page for analysis

Prepared By: Jeffrey Hubbard
 Division: Medical Assistance

JCC
 Phone: 465-3355
 Date: 7/12/84

Approved by Commissioner: Robert Loden Smith
 Agency: Department of Health & Social Services

Date: 4/17/84

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

Cost Analysis
CORF Services

	<u>FY85</u>	<u>FY86</u>
A. # of Total Annual Recipients (FY83)	2058	10,516
B. # of Recipients Needing Rehabilitation	253 Annually	368 Annually
C. Psych Evaluation (\$172 per evaluation C = \$172 (b)) Limit Once Annually	\$43,516	\$63,296
D. Social Work (80% of B for 30 Hours annually at \$72/hour or 2160 per recipient)	\$437,184	\$635,040
E. Psychology Services (50% (b) for 15 hours annually at \$92/hr or \$1,380 per recipient)	<u>\$174,570</u>	<u>\$253,920</u>
Subtotal	\$655,270	\$952,256
F. FY85 our Admin with B recipients at \$2.80 per claim and 5.7 claims/recipient	<u>\$4,037</u>	<u>\$5,873</u>
Yearly Cost	\$659,307	\$958,129
G. Enrollment, AMPS Modification for MARS, SURS and PBA	<u>\$20,000</u>	<u>\$20,000</u>
Total Operating	\$679,307	\$978,129
FY85 General Fund 50%	\$349,304	\$489,064
Federal 50%	\$349,304	\$489,065

The chief impact of this bill would be a) the expansion of providers who can be reimbursed by Medicaid for psychological services; and b) the inclusion of social services as a covered service in an outpatient clinic; and c) the increase in administrative costs for surveillance and utilization review.

FY85 costs were computed by estimating the cost of psychological and social services rendered at Alaska Treatment Center, which is the only certified CORF, for all medicaid recipients treated there (253 recipients). Psychological services consist of a 2 hour evaluation for all recipients followed by an average of 15 hours of therapy for 50% of the recipients. Social services are budgeted for 80% of the recipients for an average of 30 hours per recipient.

While Alaska currently has only one CORF, in FY86 it is expected the number of CORF's will be expanded. Especially given the proposed expansion by Humana and Providence Hospitals of inpatient rehabilitation beds of 15 each. These two facilities handle significant numbers of medicaid patients and referrals from all around the State. It is estimated that 3.5% would make use of the "new" CORF services.

Cost Analysis for Chiropractic Services

Contractual

Chiropractors will need to be added to the Alaska Medical Payments System (AMPS). The contractual costs include the following: provider manuals, training, a new claims form, tables included in the system for chiropractic services, computer programming, computer reports, the addition of collocation codes, the provision of notice to providers, provider relations, and a computer system test.

Grants/Claims

These figures were adjusted by an inflation factor of 7.5%. This is the average percent increase experienced during the past two years in chiropractic services. These costs are for only manual manipulation of the spine and the x-rays necessary for diagnosis. Again, these are the only chiropractic services for which federal reimbursement is available. The federal match for Medicaid is 50%.

We did not develop a fiscal note for the full range of chiropractic services included in SB 510. We used the following formula to develop our cost estimates:

$$\left(\frac{\# \text{Recipients}}{\text{Month}} \times \frac{\# \text{Services}}{\text{Month}} \times \frac{\text{Cost/Service}}{\text{Month}} + \frac{\# \text{Recipients}}{\text{mth}} \times \frac{\# \text{X-Rays}}{\text{Month}} \times \frac{\text{Cost/X-Ray}}{\text{Month}} \right) \times 12 \text{mths}$$
$$[50 \times \$30 \times 2] + [\$65 \times 50 \times 3] \times 12 = \$154.0 + 1 \text{ time Administrative Cost } \$20 = \$174.00$$

Assumption #1:

Alaska's ratio of recipients to eligibles is similar to the ratio of recipients to eligibles in Idaho.

Idaho averaged 75 chiropractic recipients and 30,000 eligibles per month. Therefore we would average 50 chiropractic recipients out of 20,000 eligibles per month.

Assumption #2:

Services would be limited to 2 visits per month per recipient.

Assumption #3:

X-rays would be limited to three x-rays per month per recipient.

Assumption #4:

Manual manipulation of the spine costs \$30. An x-ray costs \$65.55.

Position Paper
House Bill No. 712

"An act relating to provision of services under the Medical Assistance program."

I. Background

This bill would modify the Medicaid program to 1) add chiropractic services and 2) expand reimbursable services offered by a Comprehensive Outpatient Rehabilitative Facility (CORF). (A 1984 Attorney General's opinion stated CORF could participate in Medicaid for those services already added by the Legislature.)

II. Need for Chiropractic Services

Currently, 29 states recognize the value of chiropractic services by including them in their Medicaid program. In addition, the major private insurance programs also include chiropractic coverage. Generally, chiropractors and advocates of their services contend that chiropractic services are an alternative to other, potentially more costly medical treatments.

The chiropractic services should be limited to the two services for which we can claim federal financial participation. Specifically, these are manual manipulation of the spine and the x-rays necessary for this treatment. The Department would support this addition to the Medicaid program with this limited definition. Added FY85 costs is anticipated to be \$174.0 of which \$87.0 is State funds.

III. Need for Comprehensive Outpatient Rehabilitation Facility Services

Alaska's Medicaid program already provides coverage for most of the 13 services that can be provided by a CORF. Services covered include physician services, physical therapy, occupational therapy, prosthetic devices, orthotic devices and nursing care.

The services that are not currently covered but which would be added under this bill are:

1. Social services performed by a social worker with a B.A. who has had one year of experience in a health care setting.
2. Psychological services performed by a psychologist with a master's degree.
3. Drugs and biologicals which are currently reimbursed under the General Relief Medical Assistance Program.
4. Home environment evaluations for the purpose of assessing the potential impact of the home situation on the rehabilitation goals.

POSITION PAPER/Department of Health & Social Services

The Department does not support adding these additional services to Medicaid. Psychological services are already available under Medicaid if provided as inpatient hospital services, through a community mental health clinic, or by a physician. Addition of psychological and social worker services is not recommended as the FY85 added costs are expected to be \$679.3 of which \$339.6 is State funds.

Recommended By: Rod Betit
Rod Betit, Director
Division of Medical Assistance

Date: 4/12/84

Approved By: _____
Robert London Smith, Ph.D.
Commissioner
Department of Health & Social
Services

Date: _____

Position Paper
CSSB No. 510

"An act relating to provision of services under the Medical Assistance program."

I. Background

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Rod Betit, Director
Division of Medical Assistance

Date: 4/12/84

Approved By: Robert London Smith
Robert London Smith, Ph.D.
Commissioner
Department of Health & Social
Services

Date: 4/17/84

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Includes both chiropractic
and CORF services as
proposed in bill.

Revision Date: _____

REQUEST

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12/1/83

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MEMORANDUM

State of Alaska

TO: William O'Connor
Executive Director
Alaska Treatment Center

272-0586

DATE: February 17, 1984

FILE NO:

TELEPHONE NO:

FROM: Robert G. Ogden, Chief
Medical Assistance

SUBJECT: Reimbursement of a CORF
Under Medicaid

As you know, for some time we have been waiting for an Attorney General's interpretation of what CORF services are to be reimbursed under the Alaska Medicaid program, and how to handle what seems to me to be a conflict in statutes; i.e., AS 47.07.070 and AS 47.07.030.

As you will note in the attached opinion, Medicaid will set rates prospectively for those services included in AS 47.07.030, but may not pay for services not included in AS 47.07.030.

As you know, we have set Alaska Treatment Center's rates at 100 percent of charges for services covered by Medicaid.

I hope this opinion is of important reference.

RGO:hp

attachment

cc: Rod Betit

MEMORANDUM

State of Alaska ⁶⁰¹

TO: Hon. Robert London Smith, Ph.D
Commissioner
Department of Health and
Social Services

DATE: January 1984

FILE NO: 366-405-B3

TELEPHONE NO: 465-3603

FROM: Norman C. Gorsuch
Attorney General

SUBJECT: CORF'S Expansion
Services Under
AS 47.07.030

RECEIVED
JAN 30 1984

MEDICAL REVIEW
SECTION

By: Elizabeth L. Shaw
Assistant Attorney General
Human Services - Juneau

You have asked whether a Comprehensive Outpatient Rehabilitation Facility may be included in the prospective rate determinations of the Medicaid Rate Commission.

We believe that those functions of a CORF which are reimbursable under Medicaid fall under the provisions of prospective rate determination but those functions which are not reimbursable may not be included in determining the prospective rate.

Discussion

As "rehabilitation facility" is not defined in statute or regulation, the Department needs to use a reasonable standard in determining what is a rehabilitation facility. ^{1/} At this time it does not appear to be unreasonable to assume that a CORF is a rehabilitation facility. That assumption does not mean that all the services provided in a rehabilitation facility may be reimbursed under Medicaid.

AS 47.07.070 provides in part:

The commission shall determine prospectively the rate of payment to a health facility under this chapter and AS 47.25.120 -- 47.25.300 based on a fair rate for reasonable costs incurred by the facility. The commission shall by regulation list the factors it considers in making its rate determinations under this section....

^{1/} We suggest that the Department, either through regulations or statute, inform the public of that definition.

AS 47.07.900 defines a health care facility to include:

... a hospital skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic. 2/

Although the Medicaid Rate Commission may set prospective rates for a health care facility, which includes a rehabilitation facility, it does not have the authority to determine a rate for services which may not be reimbursed under Medicaid. Merely because a health care facility provides a service does not mean that that service is a medical service which is approved for payment.

AS 47.07.030 provides:

MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, nurse midwife, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, physical therapy, occupational therapy, prosthetic devices and medical supplies, long-term care noninstitutional services, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature.

2/ One may argue that the language of AS 47.07.900(5) does not contain an exhaustive list of facilities which may participate in the prospective rate scheme. The term "includes" generally is interpreted to mean "includes but is not limited to."

Hon. Robert London Smith, Ph.D.
Commissioner
366-405-83

January 18, 1984
Page 3

Some of those services listed in AS 47.07.030 are provided in a CORF. A CORF, however, is also required by federal regulation to provide services such as social work services and psychological services, which are not covered under AS 47.07.030. 3/

In summary, a CORF may be considered a rehabilitation facility as it provides a range of medical rehabilitation services. As a health facility a rehabilitation facility is eligible for prospective rate determinations for those services reimbursable under Medicaid.

ELS:bap

3/ Services of a social worker or psychologist are currently reimbursed if provided in a community mental health clinic, a general hospital or a psychiatric hospital. This office has received no information which would make us believe that the CORF is a general medical or psychiatric hospital. See 7 AAC 43.130(b).

ANCHORAGE CENTER FOR CHIROPRACTIC, INC.
KENNETH O. KETZ, D.C., AND ASSOCIATES
3128 SEWARD HIGHWAY
ANCHORAGE, ALASKA 99503
PHONE 274-7621

To date there are twenty-eight states which have chiropractic care covered in their medicaid programs, and one state pending.

They are as follows:

- | | |
|---------------|--------------------------|
| 1. Arkansas | 15. New Hampshire |
| 2. California | 16. New Nersey |
| 3. Kentucky | 17. North Carolina |
| 4. Idaho | 18. North Dakota |
| 5. Illinois | 19. Ohio |
| 6. Indiana | 20. Oregon |
| 7. Iowa | 21. Pennsylvania |
| 8. Kansas | 22. South Carolina |
| 9. Louisiana | 23. South Dakota |
| 10. Maine | 24. Texas |
| 11. Michigan | 25. Utah |
| 12. Minnesota | 26. Washington |
| 13. Nebraska | 27. West Virginia |
| 14. Nevada | 28. Wisconson |
| | * 29. New York - Pending |

More information will be forwarded to you as I receive and segregate it.

Sincerely,

Francis L. Corbin D.C.

F. L. (Butch) Corbin, D.C.

FLC/dh

ANCHORAGE CENTER FOR CHIROPRACTIC, INC.
KENNETH O. KETZ, D.C., AND ASSOCIATES
3128 SEWARD HIGHWAY
ANCHORAGE, ALASKA 99503
PHONE 274-7621

To date there are a total of thirty-four states which have an insurance equality act, they are as follows:

- | | |
|-------------------|--------------------|
| 1. Arkansas | 18. Nevada |
| 2. California | 19. New Hampshire |
| 3. Colorado | 20. New Mexico |
| 4. Connecticut | 21. New York |
| 5. Delaware | 22. North Carolina |
| 6. Florida | 23. Ohio |
| 7. Illinois | 24. Oklahoma |
| 8. Indiana | 25. Pennsylvania |
| 9. Kansas | 26. Rhode Island |
| 10. Louisiana | 27. South Dakota |
| 11. Maryland | 28. Utah |
| 12. Massachusetts | 29. Virginia |
| 13. Michigan | 30. Washington |
| 14. Minnesota | 31. West Virginia |
| 15. Missouri | 32. Wisconsin |
| 16. Montana | 33. Wyoming |
| 17. Nebraska | 34. New Jersey |

I'm still in the process of combining more information on insurance equality, when I have more I'll forward it on to you.

Sincerely,

Francis L. Corbin D.C.

F.L. (Butch) Corbin, D.C.

Note

pect to payments under section 1396b of s title for calendar q rters commencing er Dec. 31, 1973, see section 13(d) of Pub. 93-233, set out as an Effective Date of 73 Amendment note under section 1396a of s title.

Legislative History. For legislative history purpose of Pub.L. 89-97, see 1965 U.S. de Cong. and Adm.News, p. 1943 See, o, Pub.L. 93-233, 1973 U.S.Code Cong. l Adm.News, p. 3177.

Practice Manual

tion, see § 13904.

Regulations

- 41 seq.
- see 45 CFR 19.1 et seq.
- es, see 42 CFR 441.1 et seq.
- 1 et seq.

Workers and Disability Insurance

Disabled, see 20 CFR 416.101 et seq., set

Amendments

- 9 Social Security and Public Welfare 126
- 8 United States § 122

Provisions

Eligibility

one may directly apply for medical aid out first applying for a category of public ource. Perez v. Layme, D.C.N.Y.1976, 1 Supp. 1340, supplemented 422 F.Supp.

though persons eligible for Aid to Fam- with Dependent Children are automati- eligible for medicaid, persons who do nally for welfare assistance may never- still qualify for medicaid. 11.

order for person to qualify for medicaid, person must be eligible, and to be eligible son must qualify under a state plan n agrees with all the statutes and regula- promulgated under this chapter. Flat- Health Center v. Flathead County, 598 P.2d 1111, 183 Mont. 211

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1)-provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, ex-

cept that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter:

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (11) and (12) of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to—

(i) all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this

42 § 1396c

Note 8

mination would have on them, patients were entitled to a pretermination evidentiary hearing which would be governed by Department regulations providing for a hearing with respect to suspension, reduction, discontinuance, or termination of assistance to medicaid recipients. *Id.*

9. Findings

On reassessment of medicaid reimbursement given State, Social Rehabilitation Service Administrator's findings that sample of physicians' claims was not biased, that pricing of sample claims was accurately and consistently done by qualified medicare clerk, that medicare data used in pricing sample claims were consistent and that Medicare data necessary to screen physicians' claims were available to State, were not arbitrary and capricious. *State of Ga. By and Through Dept. of Human Resources v. Califano, D.C.Ga.1977, 446 F.Supp. 404.*

PUBLIC HEALTH AND WELFARE

10. Injunction

Plaintiff was entitled to a preliminary injunction requiring the Secretary to commence proceedings to prevent the Commonwealth of Massachusetts from enforcing medicaid rule which violated this subchapter and, until such proceedings were completed, to withhold from the Commonwealth all federal contributions for medicaid payments to persons other than supplemental security income recipients unless, within 30 days, the invalid regulation was amended. *Robinson v. Pratt, D.C.Mass. 1980, 497 F.Supp. 116.*

11. Mandamus

Ordering of holding of compliance hearing by Secretary to determine whether state is complying with approved medicaid plan was not within mandamus power of the district court. *Arthur C. Logan Memorial Hospital v. Tona, D.C.N.Y.1977, 441 F.Supp. 26.*

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, N, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter.

10. Injunction

Plaintiff was entitled to a preliminary injunction requiring the Secretary to commence proceedings to prevent the Commonwealth of Massachusetts from enforcing medicaid rule which violated this subchapter and, until such proceedings were completed, to withhold from the Commonwealth all federal contributions for medicaid payments to persons other than supplemental security income recipients unless, within 30 days, the invalid regulation was amended. *Robinson v. Pratt*, D.C.Mass. 1980, 497 F.Supp. 116.

11. Mandamus

Ordering of holding of compliance hearing by Secretary to determine whether state is complying with approved medicaid plan was not within mandamus power of the district court. *Arthur C. Logan Memorial Hospital v. Tona*, D.C.N.Y. 1977, 441 F.Supp. 26.

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter, or

(viii) pregnant women,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2)(A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (I) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (I) of this section) and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older¹ (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

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Medical assistance

means payment of part or all of the cost of (if provided in or after the third month beneficiary makes application for assistance) for physicians' or dentists' services, at the option (other than individuals with respect to whom benefits are not being paid under subchapter I, subchapter IV, and with respect to whom benefits are not being paid under subchapter

or, at the option of the State, under the age 21 may choose,

section 606(b)(1) of this title with whom a person is (or would, if needy, be) a dependent child under subchapter IV of this chapter,

later,

to States eligible to participate in the State plan program established under subchapter XVI of this chapter.

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1396a(a)(3)(A) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in subsection (m) of this section) which he is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not he is under the supervision of, or associated with, a physician or other health care provider; and

(18) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

For purposes of clauses² (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under subchapter I, X, XIV, or XVI of this chapter), and such person is determined, under such a State plan, to be essential to the well being of such individual.

**(b) Federal medical assistance percentage; State percentage;
Indian health care percentage**

The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal

§ 436.1002 FFP for services.

(a) FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided, except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability.

[42 FR 45218, Sept. 29, 1978, as amended at 44 FR 17940, Mar. 23, 1979]

§ 436.1003 Recipients overcoming certain conditions of eligibility.

FFP is available for a temporary period specified in the State plan in expenditures for services provided to recipients who are overcoming certain eligibility conditions, including blindness, disability, continued absence or incapacity of a parent, or unemployment of a parent.

[45 FR 24000, Apr. 11, 1980]

§ 436.1004 Institutionalized individuals.

(a) Except as provided in paragraph (b) of this section, FFP is not available in expenditures for services provided to—

(1) Individuals who are inmates of public institutions as defined in § 435.1009; or

(2) Individuals under age 65 who are patients in an institution for tuberculosis or mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under § 440.160 of this subchapter.

(b) FFP is available in expenditures for services provided to eligible individuals during the month in which they become inmates of a public institution or patients in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under § 440.160 of this subchapter is

considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.

§ 436.1005 Definitions relating to institutional status.

For purposes of FFP, the definitions in § 435.1009 of this subchapter apply to this part.

PART 440—SERVICES: GENERAL PROVISIONS

Subpart A—Definitions

- Sec.
- 440.1 Basis and purpose.
- 440.2 Specific definitions; definitions of services for FFP purposes.
- 440.10 Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases.
- 440.20 Outpatient hospital services and rural health clinic services.
- 440.30 Other laboratory and X-ray services.
- 440.40 Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases), EPSDT, and family planning services and supplies.
- 440.50 Physicians' services.
- 440.60 Medical or other remedial care provided by licensed practitioners.
- 440.70 Home health services.
- 440.80 Private duty nursing services.
- 440.90 Clinic services.
- 440.100 Dental services.
- 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- 440.120 Prescribed drugs, dentures, prosthetic devices, and eyeglasses.
- 440.130 Diagnostic, screening, preventive, and rehabilitative services.
- 440.140 Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases.
- 440.150 Intermediate care facility services, other than in institutions for tuberculosis or mental diseases.
- 440.160 Inpatient psychiatric services for individuals under age 21.
- 440.165 Nurse-midwife services.
- 440.170 Any other medical or remedial care recognized under State law and specified by the Secretary.
- 440.180 Home or community-based services.

Sec.

Subpart B—Requirements and Limits Applicable to All Services

- 440.200 Basis, purpose, and scope.
- 440.210 Required services for the categorically needy.
- 440.220 Required services for the medically needy.
- 440.230 Sufficiency of amount, duration, and scope.
- 440.240 Comparability of services for groups.
- 440.250 Limits on comparability of services.
- 440.260 Methods and standards to assure quality of services.
- 440.270 Religious objections.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

SOURCE: 43 FR 45224, Sept. 29, 1978, unless otherwise noted.

Subpart A—Definitions

§ 440.1 Basis and purpose.

This subpart interprets section 1905(a) of the Act, which lists the services included in the term "medical assistance," sections 1905 (c), (d), (f)-(i), (j), and (m), which define some of those services, and section 1915(c), which lists as "medical assistance" certain home and community-based services provided under waivers under that section to individuals who would otherwise require institutionalization. It also implements sec. 1902(a)(43) with respect to laboratory services (see also §§ 447.10 and 447.342 for related provisions on laboratory services), and implements section 1913 of the Act with respect to "swing-bed" services (see related provisions in §§ 405.1041 and 447.280 of this chapter).

[47 FR 31532, July 20, 1982]

§ 440.2 Specific definitions; definitions of services for FFP purposes.

(a) *Specific definitions.* "Outpatient" means a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, which is not providing him with room and board and professional services on a continuous 24-hour-a-day basis.

"Patient" means an individual who is receiving needed professional services that are directed by a licensed

practitioner of the healing arts toward the maintenance, improvement, or protection of health, or lessening of illness, disability, or pain. (See also § 435.1009 of this subchapter for definitions relating to institutional care.)

(b) *Definitions of services for FFP purposes.* Except as limited in Part 441, FFP is available in expenditures under the State plan for medical or remedial care and services as defined in this subpart.

§ 440.16 Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases.

(a) "Inpatient hospital services" means services that—

(1) Are ordinarily furnished in a hospital for the care and treatment of inpatients;

(2) Except in the case of nurse-midwife services, as specified in § 440.165, are furnished under the direction of a physician or dentist; and

(3) Are furnished in an institution that—

(i) Is maintained primarily for the care and treatment of patients with disorders other than tuberculosis or mental diseases;

(ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

(iii) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare; and

(iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 405.1035 of this chapter, unless a waiver has been granted by the Secretary.

(b) Inpatient hospital services do not include SNF and ICF services furnished by a hospital with a swing-bed approval.

[47 FR 21050, May 17, 1982, as amended at 47 FR 31532, July 20, 1982]

§ 440.20 Outpatient hospital services and rural health clinic services.

(a) "Outpatient hospital services" means preventive, diagnostic, thera-

peutic, rehabilitative, or palliative services that—

- (1) Are furnished to outpatients;
- (2) Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist; and
- (3) Are furnished by an institution that—

(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

(ii) Except in the case of medical supervision of nurse-midwife services, as specified in § 440.165, meets the requirements for participation in Medicare.

(b) *Rural health clinic services.* If nurse practitioners or physician assistants (as defined in § 481.1 of this chapter) are not prohibited by State law from furnishing primary health care, "rural health clinic services" means the following services when furnished by a rural health clinic that has been certified in accordance with Part 481 of this chapter.

(1) Services furnished by a physician within the scope of practice of his profession under State law, if the physician performs the services in the clinic or the services are furnished away from the clinic and the physician has an agreement with the clinic providing that he will be paid by it for such services.

(2) Services furnished by a physician assistant, nurse practitioner, nurse midwife or other specialized nurse practitioner (as defined in §§ 405.2401 and 481.2 of this chapter) if the services are furnished in accordance with the requirements specified in § 405.2414(a) of this chapter.

(3) Services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner. (See §§ 405.2413 and 405.2415 of this chapter for the criteria for determining whether services and supplies are included under this paragraph.)

(4) Part-time or intermittent visiting nurse care and related medical supplies (other than drugs and biologicals) if:

(i) The clinic is located in an area in which the Secretary has determined that there is a shortage of home health agencies (see § 405.2417 of this chapter);

(ii) The services are furnished by a registered nurse or licensed practical nurse or a licensed vocational nurse employed by, or otherwise compensated for the services by, the clinic;

(iii) The services are furnished under a written plan of treatment that is established and reviewed at least every 60 days by a supervising physician of the clinic or that is established by a physician, physician assistant, nurse practitioner, nurse midwife, or specialized nurse practitioner and reviewed and approved at least every 60 days by a supervising physician of the clinic; and

(iv) The services are furnished to a homebound recipient. For purposes of visiting nurse care, a "homebound" recipient means one who is permanently or temporarily confined to his place of residence because of a medical or health condition. He may be considered homebound if he leaves the place of residence infrequently. For this purpose, "place of residence" does not include a hospital or a skilled nursing facility.

(c) *Other ambulatory services furnished by a rural health clinic.* If the State plan covers rural health clinic services, other ambulatory services means ambulatory services other than rural health clinic services, as defined in paragraph (b) of this section, that are otherwise included in the plan and meet specific State plan requirements for furnishing those services. Other ambulatory services furnished by a rural health clinic are not subject to the physician supervision requirements specified in § 481.8(b) of this chapter, unless required by State law or the State plan.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 21050, May 17, 1982]

§ 440.30 Other laboratory and X-ray services.

"Other laboratory and X-ray services" means professional and technical laboratory and radiological services—

(a) Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law or ordered and billed by a physician but provided by an independent laboratory;

(b) Provided in an office or similar facility other than a hospital outpatient department or clinic; and

(c) Provided by a laboratory that meets the requirements for participation in Medicare.

[46 FR 42672, Aug. 24, 1981]

§ 440.40 Skilled nursing facility services for individuals age 21 or older (other than services in an institution for tuberculosis or mental diseases), EPSDT, and family planning services and supplies.

(a) *Skilled nursing facility services.* (1) "Skilled nursing facility services for individuals age 21 or older, other than services in an institution for tuberculosis or mental diseases," means services that are—

(i) Needed on a daily basis and required to be provided on an inpatient basis under §§ 405.127, 405.128, and 405.128a of this chapter;

(ii) Provided by (A) a facility or distinct part of a facility that is certified to meet the requirements for participation under Subpart C of Part 442 of this subchapter, as evidenced by a valid agreement between the Medicaid agency and the facility for providing skilled nursing facility services and making payments for services under the plan; or (B) if specified in the State plan, a swing-bed hospital that has an approval from HCFA to furnish skilled nursing facility services in the Medicare program; and

(iii) Ordered by and provided under the direction of a physician.

(2) Skilled nursing facility services includes services provided by any facility located on an Indian reservation and certified by the Secretary as meeting the requirements of Subpart K of Part 405 of this chapter.

(b) *EPSDT.* "Early and periodic screening and diagnosis and treatment" means—

(1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and

(2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. (See Subpart B of Part 441 of this subchapter.)

(c) *Family planning services and supplies for individuals of child-bearing age.* [Reserved]

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

§ 440.50 Physicians' services.

"Physicians' services," whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services provided—

(a) Within the scope of practice of medicine or osteopathy as defined by State law; and

(b) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

§ 440.60 Medical or other remedial care provided by licensed practitioners.

(a) "Medical care or any other type remedial care provided by licensed practitioners" means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law.

(b) *Chiropractors' services* include only services that—

(1) Are provided by a chiropractor who is licensed by the State and meets standards issued by the Secretary under § 405.232b of this chapter; and

(2) Consists of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

§ 440.70 Home health services.

(a) "Home health services" means the services in paragraph (b) of this section that are provided to a recipient—

(1) At his place of residence, as specified in paragraph (c) of this section; and

(2) On his physician's orders as part of a written plan of care that the physician reviews every 60 days.

(b) Home health services include the following services and items. Those listed in paragraphs (b) (1), (2) and (3) of this section are required services; those in paragraph (b)(4) of this section are optional.

(1) Nursing service, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency as defined in paragraph (d) of this section, or if there is no agency in the area, a registered nurse who—

(i) Is currently licensed to practice in the State;

(ii) Receives written orders from the patient's physician;

(iii) Documents the care and services provided; and

(iv) Has had orientation to acceptable clinical and administrative record-keeping from a health department nurse.

(2) Home health aide service provided by a home health agency.

(3) Medical supplies, equipment, and appliances suitable for use in the home, and

(4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services. (See § 441.15 of this subchapter.)

(c) A recipient's place of residence, for home health services, does not include a hospital, skilled nursing facility, or intermediate care facility except for home health services in an intermediate care facility that are not required to be provided by the facility under Subparts F and G of Part 442 of this subchapter. For example, a registered nurse may provide short-term care for a recipient in an intermediate care facility during an acute illness to avoid the recipient's transfer to a skilled nursing facility.

(d) "Home health agency" means a public or private agency or organization, or part of an agency or organization, that meets requirements for participation in Medicare.

(e) A "facility licensed by the State to provide medical rehabilitation services" means a facility that—

(1) Provides therapy services for the primary purpose of assisting in the re-

habilitation of disabled individuals through an integrated program of—

(i) Medical evaluation and services; and

(ii) Psychological, social, or vocational evaluation and services; and

(2) Is operated under competent medical supervision either—

(i) In connection with a hospital; or

(ii) As a facility in which all medical and related health services are prescribed by or under the direction of individuals licensed to practice medicine or surgery in the State.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980]

§ 440.80 Private duty nursing services.

"Private duty nursing services" means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility, and that are provided—

(a) By a registered nurse or a licensed practical nurse;

(b) Under the direction of the recipient's physician; and

(c) To a recipient in his own home or in a hospital or skilled nursing facility.

§ 440.90 Clinic services.

"Clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that—

(a) Are provided to outpatients;

(b) Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

(c) Except in the case of nurse-midwife services, as specified in § 440.165, are furnished by or under the direction of a physician or dentist.

[47 FR 21050, May 17, 1982]

§ 440.100 Dental services.

(a) "Dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of—

(1) The teeth and associated structures of the oral cavity; and

(2) Disease, injury, or impairment that may affect the oral or general health of the recipient.

(b) "Dentist" means an individual licensed to practice dentistry or dental surgery.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980]

§ 440.110 Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(a) *Physical therapy.* (1) "Physical therapy" means services prescribed by a physician and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

(2) A "qualified physical therapist" is an individual who is—

(i) A graduate of a program of physical therapy approved by both the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent; and

(ii) Where applicable, licensed by the State.

(b) *Occupational therapy.* (1) "Occupational therapy" means services prescribed by a physician and provided to a recipient by or under the direction of a qualified occupational therapist. It includes any necessary supplies and equipment.

(2) A "qualified occupation therapist" is an individual who is—

(i) Registered by the American Occupational Therapy Association; or

(ii) A graduate of a program in occupational therapy approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

(c) *Services for individuals with speech, hearing, and language disorders.* (1) "Services for individuals with speech, hearing, and language disorders" means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician. It includes any necessary supplies and equipment.

(2) A "speech pathologist or audiologist" is an individual who—

(i) Has a certificate of clinical competence from the American Speech and Hearing Association;

(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

[43 FR 45224, Sept. 29, 1978, as amended at 45 FR 24888, Apr. 11, 1980]

§ 440.120 Prescribed drugs, dentures, prosthetic devices, and eyeglasses.

(a) "Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are—

(1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law;

(2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

(3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

(b) "Dentures" are artificial structures made by or under the direction of a dentist to replace a full or partial set of teeth.

(c) "Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to—

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

(d) "Eyeglasses" means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist.

§ 440.130 Diagnostic, screening, preventive, and rehabilitative services.

(a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

(b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

(c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to—

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

(d) "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

§ 440.140 Inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases.

(a) *Inpatient hospital services.* (1) "Inpatient hospital services for individuals age 65 or older in institutions for tuberculosis or mental diseases" means services provided under the direction of a physician for the care and treatment of recipients in—

(i) An institution for tuberculosis that meets the requirements under

Medicare, § 405.1036 of this chapter; and

(ii) An institution for mental diseases that meets the requirements under Medicare, §§ 405.1035 and 405.1036 of this chapter, except the requirements for admission reviews under § 405.1035(f) of this chapter, or utilization review under § 405.1035 of this chapter if the institution has been granted a waiver under section 1903(i)(4) and Subpart II of Part 456 of this subchapter.

(2) "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical care, nursing care, and related services.

(3) "Institution for tuberculosis" means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with tuberculosis, including medical attention, nursing care, and related services.

(b) *Skilled nursing facility services.* "Skilled nursing facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases" means skilled nursing facility services as defined in § 440.40 that are provided in institutions for tuberculosis or mental diseases, as defined in paragraph (a) of this section.

(c) *Intermediate care facility services.* "Intermediate care facility services for individuals age 65 or older in institutions for tuberculosis or mental diseases" means intermediate care facility services as defined in § 440.150 of this subpart, that are provided to recipients who are—

(1) Determined under §§ 456.360-456.372 of this subchapter to be in need of services; and

(2) In institutions for tuberculosis and mental diseases, as defined in paragraph (a) of this section.

§ 440.150 Intermediate care facility services, other than in institutions for tuberculosis or mental diseases.

(a) "Intermediate care facility services, other than in an institution for tuberculosis or mental diseases" means services provided in a facility that—

(1) Fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services that—

(i) Are above the level of room and board; and

(ii) Can be made available only through institutional facilities;

(2) Has been certified to meet the requirements of Subpart C of Part 442 of this subchapter as evidenced by a valid agreement between the Medicaid agency and the facility for providing intermediate care facility services and making payments for services under the plan; and

(3) Meets the conditions of Subpart E of Part 442 of this subchapter.

(b) "Intermediate care facility services" include services—

(1) Considered appropriate by the State and provided by a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass.; or

(2) Provided by a facility located on an Indian reservation that—

(i) Furnishes, on a regular basis, health-related services; and

(ii) Is certified by the Secretary to meet the standards in Subpart E of Part 442 of this subchapter.

(c) "Intermediate care facility services" may include services in an institution for the mentally retarded or persons with related conditions if—

(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;

(2) The institution meets the standards in Subpart E of Part 442 of this subchapter; and

(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as defined in § 435.1009.

(d) "Intermediate care facility services" may include services provided in a distinct part of a facility other than an intermediate care facility if the distinct part—

(i) Meets all requirements for an intermediate care facility;

(2) Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;

(3) Consists of all beds and related facilities in the unit;

(4) Houses all recipients for whom payment is being made for intermediate care facility services, except as provided in paragraph (e) of this section;

(5) Is clearly identified; and

(6) Is approved in writing by the survey agency.

(e) If a State includes as intermediate care facility services those services provided by a distinct part of a facility other than an intermediate care facility, it may not require transfer of a recipient within or between facilities if, in the opinion of the attending physician, it might be harmful to the physical or mental health of the recipient.

(f) Intermediate care facility services may include services provided in a swing-bed hospital that has an approval to furnish intermediate care services.

[43 FR 45224, Sept. 29, 1978, as amended at 47 FR 31532, July 20, 1982]

§ 440.160 Inpatient psychiatric services for individuals under age 21.

"Inpatient psychiatric services for individuals under age 21" means services that—

(a) Are provided under the direction of a physician;

(b) Are provided in a facility or program accredited by the Joint Commission on Accreditation of Hospitals; and

(c) Meet the requirements in Subpart D of Part 441.

§ 440.165 Nurse-midwife service.

(a) "Nurse-midwife services" means services that—

(1) Are concerned with management of the care of mothers and newborns throughout the maternity cycle;

(2) Are furnished by a nurse-midwife within the scope of practice authorized by State law or regulation and, in the case of inpatient or outpatient hospital services or clinic services, are furnished by or under the direction of a nurse-midwife to the extent permitted by the facility; and

(3) Unless required by State law or regulations or a facility, are reimbursed.

bursed without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider. (See § 441.21 of this chapter for provisions on independent provider agreements for nurse-midwives.)

(b) "Nurse-midwife" means a registered professional nurse who meets the following requirements:

(1) Is currently licensed to practice in the State as a registered professional nurse.

(2) Is legally authorized under State law or regulations to practice as a nurse-midwife.

(3) Except as provided in paragraph (b)(4) of this section, has completed a program of study and clinical experience for nurse-midwives, as specified by the State.

(4) If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, meets one of the following conditions:

(i) Is currently certified as a nurse-midwife by the American College of Nurse-Midwives.

(ii) Has satisfactorily completed a formal educational program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives.

(iii) Has successfully completed a formal educational program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and was practicing as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976 to July 16, 1982.

(c) "Maternity cycle" means a period limited to—

- (1) Pregnancy;
- (2) Labor;
- (3) Birth; and
- (4) The immediate postpartum period, not to exceed six weeks.

[47 FR 21050, May 17, 1982; 47 FR 23448, May 20, 1982]

§ 440.170 Any other medical care or remedial care recognized under State law and specified by the Secretary.

(a) *Transportation.* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient.

(2) Transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency. If other arrangements are made to assure transportation under § 431.53 of this subchapter, FFP is available as an administrative cost.

(3) "Travel expenses" include—

(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

(ii) The cost of meals and lodging en route to and from medical care, and while receiving medical care; and

(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the recipient's family, salary.

(b) *Services of Christian Science nurses.* "Services of Christian Science nurses" mean services provided by nurses who are listed and certified by the First Church of Christ, Scientist, Boston, Mass., if—

(1) The services have been requested by the recipient; and

(2) The services are provided—

(i) By or under the supervision of a Christian Science visiting nurse organization listed and certified by the First Church of Christ, Scientist, Boston, Mass.; or

(ii) As private duty services to a recipient in his own home or in a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Mass., if the recipient requires individual and continuous care beyond that available from a visiting nurse or that routinely provided by the nursing staff of the sanatorium.

(c) *Services in Christian Science sanatoriums.* "Services in Christian Science sanatoriums" means services

provided in Christian Science sanatoriums that are operated by, or listed and certified by, the First Church of Christ, Scientist, Boston, Mass.

(d) *Skilled nursing facility services for individuals under age 21.* "Skilled nursing facility services for individuals under 21" means those services specified in § 440.40 that are provided to recipients under 21 years of age.

(e) *Emergency hospital services.* "Emergency hospital services" means services that—

(1) Are necessary to prevent the death or serious impairment of the health of a recipient; and

(2) Because of the threat to the life or health of the recipient necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet—

(i) The conditions for participation under Medicare; or

(ii) The definitions of inpatient or outpatient hospital services under §§ 440.10 and 440.20.

(f) *Personal care services in a recipient's home.* Unless defined differently by a State agency for purposes of a waiver granted under Part 441, Subpart G of this chapter, "personal care services in a recipient's home" means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is—

(1) Qualified to provide the services;

(2) Supervised by a registered nurse; and

(3) Not a member of the recipient's family.

[43 FR 45224, Sept. 20, 1978, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 46540, Oct. 1, 1981]

§ 440.180 Home or community-based services.

(a) "Home or community-based services" means services that are furnished under a waiver granted under the provisions of Part 441, Subpart G of this subchapter. The services may consist of any of the following services as defined by the agency (but not including room and board except as specifically provided for in paragraph (b) of this section):

- (1) Case management services;

- (2) Homemaker services;
- (3) Home health aide services;
- (4) Personal care services;
- (5) Adult day health services;
- (6) Habilitation services;
- (7) Respite care services;
- (8) Other services requested by the Medicaid agency and approved by HCFA as cost-effective.

(b) FFP for home community-based services described in paragraph (a) of this section is not available in expenditures for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence. For purposes of this provision, "board" means three meals a day or any other full nutritional regimen and does not include meals provided as part of a program of adult day health services.

[46 FR 46540, Oct. 1, 1981]

Subpart B—Requirements and Limits Applicable to All Services

§ 440.200 Basis, purpose, and scope.

(a) This subpart implements—

(1) Section 1902(a)(10), regarding comparability of services for groups of recipients, and the amount, duration, and scope of services described in section 1905(e) of the Act that the State plan must provide for recipients;

(2) Section 1902(a)(22)(D), which provides for standards and methods to assure quality of services;

(3) Section 1907 on observance of religious beliefs; and

(4) Section 1915 on exceptions to section 1902(a)(10) and waivers of other requirements of section 1902 of the Act.

(b) The requirements and limits of this subpart apply for all services defined in Subpart A of this part.

[46 FR 46528, Oct. 1, 1981]

§ 440.210 Required services for the categorically needy.

A State plan must specify that, as a minimum, categorically needy recipients are provided the services as specified in §§ 440.10 through 440.50, 440.70, and (to the extent nurse-mid-

wives are authorized to practice under State law or regulation) 440.165.

147 FR 21050, May 17, 1982]

§ 440.220 Required services for the medically needy.

A State plan that includes the medically needy must specify that the medically needy are provided, as a minimum, the following services:

(a) Prenatal care and delivery services for pregnant women.

(b) Ambulatory services, as defined in the State plan, for—

- (1) Individuals under age 18; and
- (2) Individuals entitled to institutional services.

(c) Home health services (§ 440.70) to any individual entitled to skilled nursing facility services.

(d) If the State plan includes services in an institution for mental diseases (§ 440.140 or § 440.160) or in an intermediate care facility for the mentally retarded (§ 440.150(c)) for any group of medically needy, either of the following sets of services to each of the medically needy groups:

(1) The services contained in §§ 440.10 through 440.50 and (to the extent nurse-midwives are authorized to practice under State law or regulation) 440.165; or

(2) The services contained in any seven of the sections in §§ 440.10 through 440.165.

146 FR 47992, Sept. 30, 1981; 46 FR 54744, Nov. 4, 1981, as amended at 47 FR 21050, May 17, 1982]

§ 440.230 Sufficiency of amount, duration, and scope.

(a) The plan must specify the amount, duration, and scope of each service that it provides for—

- (1) The categorically needy; and
- (2) Each covered group of medically needy.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

146 FR 47993, Sept. 30, 1981]

§ 440.240 Comparability of services for groups.

Except as limited in § 440.250—

(a) The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient; and

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group:

- (1) The categorically needy.
- (2) A covered medically needy group.

146 FR 47993, Sept. 30, 1981]

§ 440.250 Limits on comparability of services.

(a) Skilled nursing facility services (§ 440.40(a)) may be limited to recipients age 21 or older.

(b) Early and periodic screening, diagnosis, and treatment (§ 440.40(b)) must be limited to recipients under age 21.

(c) Family planning services and supplies must be limited to recipients of childbearing age, including minors who can be considered sexually active and who desire the services and supplies.

(d) If covered under the plan, services to recipients in institutions for tuberculosis or mental diseases (§ 440.140) must be limited to those age 65 or older.

(e) If covered under the plan, inpatient psychiatric services (§ 440.160) must be limited to recipients under age 22 as specified in § 441.151(e) of this subchapter.

(f) If Medicare benefits under Part B of title XVIII are made available to recipients through a buy-in agreement or payment of premiums, or part or all of the deductibles, cost sharing or similar charges, they may be limited to recipients who are covered by the agreement or payment.

(g) If services in addition to those offered under the plan are made available under a contract between the agency or political subdivision and an organization providing comprehensive health services, those additional services may be limited to recipients who reside in the geographic area served by the contracting organization and who elect to receive services from it.

(h) Ambulatory services for the medically needy (§ 440.220(b)) may be limited to—

- (1) Individuals under age 18; and
- (2) Individuals entitled to institutional services.

(i) Services provided under an exception to requirements allowed under § 431.54 may be limited as provided under that exception.

(j) If HCFA has approved a waiver of Medicaid requirements under § 431.55, services may be limited as provided by the waiver.

(k) If the agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide home or community-based services under § 440.180, the services provided under the waiver need not be comparable for all individuals within a group.

143 FR 45224, Sept. 29, 1976, as amended at 45 FR 24889, Apr. 11, 1980; 46 FR 48541, Oct. 1, 1981]

§ 440.260 Methods and standards to assure quality of services.

The plan must include a description of methods and standards used to assure that services are of high quality.

§ 440.270 Religious objections.

(a) Except as specified in paragraph (b) of this section, the agency may not require any individual to undergo any medical service, diagnosis, or treatment or to accept any other health service provided under the plan if the individual objects, or in the case of a child, a parent or guardian objects, on religious grounds.

(b) If a physical examination is necessary to establish eligibility based on disability or blindness, the agency may not find an individual eligible for Medicaid unless he undergoes the examination.

PART 44.—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

Sec.
441.1 Purpose.

Subpart A—General Provisions

- 441.10 Basis.
- 441.11 Continuation of FFP for institutional services.
- 441.12 Inpatient hospital tests.
- 441.13 Prohibitions on FFP: Institutionalized individuals.
- 441.15 Home health services.
- 441.20 Family planning services.
- 441.21 Nurse-midwife services.
- 441.25 Prohibition on FFP for certain prescribed drugs.
- 441.30 Optometric services.
- 441.40 End-stage renal disease.

Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21

- 441.50 Basis and purpose.
- 441.51 Definitions.

STATE PLAN REQUIREMENTS

- 441.55 Basic requirement.
- 441.56 Required services.
- 441.57 Discretionary services.
- 441.58 Periodicity schedule.
- 441.59 Administration.
- 441.60 Identifying, informing, and referring eligible recipients to title V services.
- 441.61 Maximum utilization of existing services.
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PENALTY FOR FAILURE TO PROVIDE EPSDT SERVICES

- 441.70 Imposition of penalty.
- 441.71 Application of penalty.
- 441.75 Informing a family of availability of EPSDT services.
- 441.80 Providing for EPSDT services.
- 441.85 Referral for services not in the State plan.
- 441.90 Documentation.

Subpart C—Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

- 441.100 Basis and purpose.
- 441.101 State plan requirements.
- 441.102 Plan of care for institutionalized recipients.
- 441.103 Alternate plans of care.
- 441.105 Methods of administration.
- 441.106 Comprehensive mental health program.

S B

514

FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: SB 514
 Title: "...married persons' rights in a family home."
 Sponsor: Sen. Rules, Code Rev. Comm.
 Requestor: Sen. Judiciary
 Date of Request: 3/13/84

FISCAL DETAIL

Agency Affected: Department of Law
 Program Category Affected: General Government
 Program or Subprogram(s) Affected: Legal Services Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: Richard I. Pegues Phone: 465-3672
 Division: Administrative Services Division Date: 3-13-84
 Approved by Commissioner: Richard I. Pegues/for Date: 3-13-84
 Agency: Department of Law

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

This bill was requested by the Code Revision Commission to remove certain anachronisms and would repeal certain statutory provisions that cause uncertainty in titles to Alaska real property. The protections afforded a widow by the right of dower are now afforded by various options under the Uniform Probate Code, as are the protections afforded a widower under the related "curtesy" right. This bill would repeal some of the protections once afforded a married person under common law dower and curtesy. Because the bill only deals with private property rights, it will not have a fiscal impact on state government operations.

ALASKA CODE REVISION COMMISSION
COMMENTARY TO ACCOMPANY BILL RELATING TO
MARRIED PERSONS' RIGHTS IN A FAMILY HOME

58514

This bill would remove certain anachronisms and would repeal certain statutory provisions that cause uncertainty in titles to Alaska real property. The principal provisions to be repealed are AS 34.15.010(b), (c) and (d), subsections that deal with conveyances of "the family home or homestead".

The other two sections to be repealed by the bill deal with dower, a common law concept that has not been recognized in Alaska in its pure form since 1900 (Bechtol v. Bechtol, 2 Alaska 397 (1905)). Its altered, statutory form was removed from Alaska law in 1963 (sec. 30, ch. 38, SLA 1963). The protections once afforded a widow by the right of dower are now afforded by various options under the Uniform Probate Code adopted in Alaska in 1972, as are the protections afforded a widower under the related "curtesy" right. The official comment to the Uniform Probate Code includes:

"The provisions of this Code replace the common law concepts of dower and curtesy and their statutory counterparts."

The main subjects of this bill, AS 34.15.010(b), (c) and (d), are subsections enacted over a period of time, apparently in a patchwork effort to approach some of the protections once afforded a married person under common law dower and curtesy.

Common law dower was a life estate given a widow in one-third of the lands her husband owned at any time during the marriage. Her husband could not transfer away her right. But Alaska's statutory dower only applied to real property owned by the husband at the husband's death. Common law curtesy was similar to dower but was a right given a husband in lands of his wife. In its statutory form (sec. 482, Compiled Laws of Alaska 1913, since repealed) it applied only to lands owned by the wife at the wife's death.

To compensate for the lesser protection afforded in the statutory forms of dower and curtesy, the legislature required the signature of both spouses on every deed to "a family home or homestead" (ch. 107, SLA 1933; now AS 34.15.010(b)).

Unless both spouses' names appear on the title

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documents, a purchaser down the chain of title usually will have no way of knowing whether a predecessor was married and usually will have no way of knowing whether real property was a married couple's "home or homestead". Therefore, the 1953 legislature (ch. 145, SLA 1953) engrafted further provisions on the statute in an effort to clear titles clouded by what now is AS 34.15.010(b).

The confused and contradictory state of these subsections of AS 34.15.010 can best be shown by setting them out in full:

(b) In a deed or conveyance of the family home or homestead by a married man or a married woman, the husband and wife shall join in the deed or conveyance.

(c) The requirement that a spouse of a married person join in a deed or conveyance of the family home or homestead does not create a proprietary right, title or interest in the spouse not otherwise vested in the spouse.

(d) Failure of the spouse to join in the deed or conveyance does not affect the validity of the deed or conveyance, unless the spouse appears on the title. The deed or conveyance is sufficient in law to convey the legal title to the premises described in it from the grantor to the grantee when the deed or conveyance is otherwise sufficient, and (1) no suit is filed in a court of record in the judicial district in which the land is located within one year from the date of recording of the deed or conveyance by the spouse who failed to join in the deed or conveyance to have the deed or conveyance set aside, altered, changed, or reformed, or (2) the spouse whose interest in the property is affected does not file, within one year in the office of the recorder for the recording district where the property is situated, a notice of his interest in the property.

Inconsistencies in the subsections make them extremely difficult to interpret. All that is clear is that there are title problems whenever only one person is record owner of real property, and that person conveys an interest in the property by a document that does not show whether he or she is a single person. At best, the title is clouded during the year of limbo provided under AS 34.15.010(c) and (d).

By proposing this bill, the code revision commission is suggesting (1) that any worthwhile purpose there may be in

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retaining AS 34.15.010(b), (c) and (d) in the law is far outweighed by the uncertainty in land titles the subsections cause, and (2) that the options afforded a married person under the Uniform Probate Code provide adequate protection.

AS 09.45.480(a)(1) relates to determining value of an "estate in dower". AS 09.45.720 relates to "actions to recover possession by a tenant in dower". The sections should be repealed because the dower right no longer exists in Alaska, as noted above.

ALASKA CODE REVISION COMMISSION

SB 511-575



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EXECUTIVE SECRETARY
BILLY G. BERRIER

March 1, 1984

Senator Bill Ray, Chairman
Alaska Legislative Council
Pouch V, State Capitol
Juneau, Alaska 99811

- RE: (1) a bill relating to principal and income of trusts;
(2) a bill relating to administration of decedents' estates;
(3) a bill relating to renunciation of rights in decedents' estates;
(4) a bill relating to married persons' rights in a family home; and
(5) a bill relating to the uniform disposition of certain property rights at death

Dear Senator Ray:

Pursuant to AS 24.20, the Alaska Code Revision Commission has prepared the enclosed bills and respectfully asks that they be introduced in the legislature.

They are technical bills the commission has been working on with the probate committee of the Alaska Bar Association. They relate generally to rights at death and to property arrangements that usually have their inception in death.

At its last meeting, the Legislative Council agreed to introduce the bills.

One of the bills, the bill on disposition of certain property rights at death, was previously in the legislature but received little notice. It is revived at the request of the probate committee of the Alaska Bar Association, and that

erty in question is admitted by the parties or ascertained by the court to be existing at the time of the order of sale, and the person entitled to that estate is a party to the action, the estate may be first set off out of a part of the property and a sale made of that part, subject to the unsold estate of that tenant in that part. But, if in the judgment of the court a due regard to the interest of all the parties requires the sale of that estate also, the sale may be ordered. (§ 22.20 ch 101 SLA 1962)

Sec. 09.45.460. Compensation for sale of estate for life or years. A person entitled to an estate for life or years in an undivided part of the property, whose estate has been sold, is entitled to receive a sum as reasonable satisfaction for the estate, the sum being based on principles of law applicable to annuities. The person so entitled shall consent to accept the sum for his estate by an instrument duly acknowledged or proved in the same manner as deeds for the purpose of record and filed with the clerk of court. (§ 22.21 ch 101 SLA 1962)

Sec. 09.45.470. Determination of value of estate for life or years sold without consent. If the consent is not given as provided in § 460 of this chapter, before the report of sale, the court shall determine what proportion of the proceeds of the sale, after deducting expenses, is a just and reasonable sum to be invested for the benefit of the person entitled to the estate for life or years, and shall order the sum to be deposited in court for investment. (§ 22.22 ch 101 SLA 1962)

Sec. 09.45.480. Rules for determining value. (a) The proportion of the proceeds of the sale to be invested as provided in § 470 of this chapter shall be determined as follows.

(1) If an estate in dower is included in the order of sale, its proportion shall be one-third of the proceeds of the sale of the property, or of the sale of the undivided share in the property on which the claim of dower existed.

(2) If an estate for life or years be included in the order of sale, its proportion shall be the whole proceeds of the sale of the property, or of the sale of the undivided share in which that estate may be.

(b) In all cases, the proportion of the expenses of the proceeding shall be deducted from the proceeds of the sale. (§ 22.23 ch 101 SLA 1962)

Sec. 09.45.490. Protection of unknown tenants. If the persons entitled to the estate for life or years are unknown, the court shall provide for the protection of their rights in a similar manner, as far as possible, as if they were known and had appeared. (§ 22.24 ch 101 SLA 1962)

judgment and granting him a new trial upon the payment of the costs of the action. (§ 25.08 ch 101 SLA 1962)

Sec. 09.45.710. Possession when new trial granted. If the judgment is set aside and a new trial granted as provided in § 700 of this chapter, after the plaintiff has taken possession of the property, he shall remain in possession. But if judgment is given for the defendant in the new trial, the defendant is entitled to restitution by execution as if he were plaintiff. (§ 25.09 ch 101 SLA 1962)

Sec. 09.45.720. Actions to recover possession by tenant in dower. In an action to recover the possession of real property by a tenant in dower or his successor in interest, execution on the judgment may not issue until admeasurement of dower. If the dower has not been admeasured before the commencement of the action, the dower may be admeasured after entry of the judgment, as follows.

(1) Upon motion of either party, the court shall conduct proceedings to admeasure the dower out of the real property recovered in the action in the manner provided in actions for partition unless it appears probable that a partition of the property would prejudice the interests of the other owners. If the court finds that a partition would prejudice the interests of the other owners, it shall deny the motion. The plaintiff shall then proceed for partition or sale of the real property by independent action in the manner provided in actions for partition.

(2) At any time after the confirmation of the report of the referees, the plaintiff may have execution for the delivery of the possession of the property according to the admeasurement and for the damages recovered. (§ 25.10 ch 101 SLA 1962)

Article 7. Trespass.

Section

730. Trespass by cutting or injuring trees or shrubs

Sec. 09.45.730. Trespass by cutting or injuring trees or shrubs. A person who cuts down, girdles, or otherwise injures or carries off a tree, timber, or shrub on the land of another person or on the street or highway in front of a person's house, or of a village, town, or city lot, or cultivated grounds, or on the commons or public grounds of a village, town, or city, or on the street or highway in front of them, without lawful authority, is liable to the owner of that land, or to the village, town, or city for treble the amount of damages which may be assessed in a civil action. However, if the trespass was casual or involuntary, or the defendant had probable cause to believe that the land on which the trespass was committed was his own or that of the person in whose service or by whose direction the act was done, or where the timber was taken from unenclosed woodland for the purpose of repairing a pub-

Title 9
Code of Civil Procedure

and deliver a quitclaim deed to the former owner of the property. (§ 4 ch 17 SLA 1957; am § 2 ch 179 SLA 1959)

Sec. 34.10.220. Repurchase by record owner or assigns. (a) The record owner at the time of the entry of the order of foreclosure or his assigns may, at any time before sale of the foreclosed property by the state, repurchase the property and the property shall be resold by the state to the former record owner, or his assigns, for the full amount applicable to the property under the judgment and decree, with interest at the rate of eight per cent a year from the date of entry of the judgment and decree of foreclosure to the date of repurchase, together with other charges imposed on the property.

(b) No right of repurchase attaches to property, after the termination of the redemption period, which has been sold by the state or which is held by the state for and devoted to a public purpose authorized by law and upon which improvements have been constructed in accordance with the public purpose. (§ 5 ch 17 SLA 1957; added by § 4 ch 179 SLA 1959)

Sec. 34.10.230. Definitions. In this chapter (1) "department" means the Department of Natural Resources;

(2) "real property" includes patented land and other land in which the owner has a fee simple title. (§ 7 ch 135 SLA 1955)

Sec. 34.10.240. Short title. This chapter may be cited as the Land Registration Law. (§ 1 ch 134 SLA 1953)

Chapter 15. Conveyances.

Article

1. Form and Effect (§§ 34.15.010 — 34.15.140)
2. Acknowledgment and Proof (§§ 34.15.150 — 34.15.250)
3. Recording (§§ 34.15.260 — 34.15.350)

Article 1. Form and Effect.

Section	Section
10. Manner of executing conveyances	90. Covenant not implied in mortgage
20. [Repealed]	100. Conveyance of lands held adversely
30. Form of warranty deed	110. Conveyances construed as creating tenancy in common
40. Form of quitclaim deed	120. Remedy of tenant in common
50. Effect of quitclaim	130. Joint tenancy abolished
60. Passage of fee	140. Tenancy by the entirety
70. Passage of grantor's entire estate	
80. Covenants not implied	

Sec. 34.15.010. Manner of executing conveyances. (a) A conveyance of land, or of an estate or interest in land, may be made by deed, signed and sealed by the person from whom the estate or interest is intended to pass, who is of lawful age, or by his lawful agent or attorney, and acknowledged or proved, and recorded as directed in this chapter, without any other act or ceremony whatever.

Title 31
Oil and Gas

Title 32
Partnership

Title 33
Probation, Prisons,
and Prisoners

Title 34
Property

(b) In a deed or conveyance of the family home or homestead by a married man or a married woman, the husband and wife shall join in the deed or conveyance.

(c) The requirement that a spouse of a married person join in a deed or conveyance of the family home or homestead does not create a proprietary right, title or interest in the spouse not otherwise vested in the spouse.

(d) Failure of the spouse to join in the deed or conveyance does not affect the validity of the deed or conveyance, unless the spouse appears on the title. The deed or conveyance is sufficient in law to convey the legal title to the premises described in it from the grantor to the grantee when the deed or conveyance is otherwise sufficient, and (1) no suit is filed in a court of record in the judicial district in which the land is located within one year from the date of recording of the deed or conveyance by the spouse who failed to join in the deed or conveyance to have the deed or conveyance set aside, altered, changed, or reformed, or (2) the spouse whose interest in the property is affected does not file, within one year in the office of the recorder for the recording district where the property is situated, a notice of his interest in the property. (§ 22-3-1 ACLA 1949; am § 1 ch 145 SLA 1953)

This section authorizes the conveyance of land without recitation or proof of consideration. *Halleck v. Halleck*, 216 Ore. 23, 337 P.2d 330 (1959), construing the Oregon statute.

Construction of deeds. — A deed must be construed according to its legal construction, effect, and operation apparent on its face, or with the aid of any such evidence as is admissible by the rules of law to explain it. *Valdez Bank v. Von Gunther*, 3 Alaska 657 (1909).

And reformation thereof. — Courts of equity will reform deeds made to carry into effect contracts and agreements, according to their original intentions, notwithstanding any defect in the execution of the instrument adopted. *Valdez Bank v. Von Gunther*, 3 Alaska 657 (1909).

Conveyance may be valid between parties without being properly executed and recorded. — An instrument in writing, signed by the parties, may serve as one step in the conveyance of real estate, although it is neither witnessed, acknowledged, or recorded. Such an instrument, containing apt words to convey, when made, signed, and delivered to the grantee, and followed by acts constituting estoppel, becomes sufficient, as between grantor and grantee, to convey the legal title. *Morency v. Floyd*, 2 Alaska 194 (1904).

As between the parties themselves, a conveyance is good without record.

Wooldridge v. Williams, 5 Alaska 149 (1914).

As to validity of conveyances without two witnesses, see AS 34.15.150. As to validity of unrecorded instruments, see AS 34.15.290. — Ed. Note.

Or may be treated as contract to convey. — A document purporting to be a deed conveying land, unwitnessed and unrecorded, is ineffective as a conveyance under this section and AS 34.15.150, although it is valid as a contract to convey. *Whitehead v. Foxlund*, 13 Alaska 726, 105 F. Supp. 966 (D. Alas. 1952).

But action may not be maintained on defectively executed lease. — Where a statute requires a lease for a term of years to be under seal, witnessed, acknowledged, or recorded, to be valid, an action of covenant, on a lease not executed with these formalities, cannot be maintained, though the lessees enter under the lease. *Rolando v. Zesch*, 7 Alaska 437 (1926).

A homestead interest under this section is not a restriction on alienation and only as it regards rights to occupancy will it be treated as such. *Spracher v. Spracher*, 17 Alaska 698 (1958).

It is only a right to occupancy. — The homestead right was created to protect the family from total loss of its abode due to judgments and executions on unsatisfied debts. It was not enacted, as this section clearly states, to create any new right, title or interest other than the right of occupancy in property used as a

Public Buildings, Works,
and Improvements

Title 35
Public Contracts

Title 37
Public Finance

S

B

515

Joe

March 21

SB 514-515

Matthew Black - Probate Committee / Bar Assoc.

SB 514 -

Bar Assoc. would like to study
full more closely. (don't have a position
cloud in title of property for
one sp. if spouses name is not in
title.

Protection in statute for
surviving spouse.

Should not affect tenancy by
entirety - must be stated in deed -
both names. Title companies require
both names in title.

SB 515

has been before legislature before
important for probate purposes.
community property interest
recognized if: 1) domiciled outside
state (comm prop) and moved to
Alaska 2) have bought w/ proceeds
of community property.
could affect IRS action

Will clarify the common law in practice
in Alaska.

Apply to assets when community
property records are retained as proof.

Dice Regan - Code Rev. Comm

36 514

Bill would clarify title problems when titles to real property do not indicate marital status.

OK. law an anachronism

34,15,010 (C) (D) put in law when state had dower rights so a wife could claim interest in a family home. Present, no substance or basis to set aside deed.

If (b) is retained, title problems stay w/o a limitation period.

on other side, the interest of the spouse may be served by maintaining 34,15,010

FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: SB 515
 Title: "...disposition of certain property rights at death."
 Sponsor: Sen. Rules/Code Rev. Comm.
 Requestor: Sen. Judiciary
 Date of Request: 3/13/84

FISCAL DETAIL

Agency Affected: Department of Law
 Program Category Affected: General Government
 RU, Program or Subprogram(s) Affected: Legal Services Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: Richard I. Pegues, Director Phone: 465-3672
 Division: Administrative Services Division Date: 3-13-84
 Approved by Commissioner: Norman C. Gorsuch Date: 3-13-84
 Agency: Department of Law

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

This bill was requested to prescribe the rights, at death, of a married person who has community property acquired prior to a change in domicile to Alaska, or which is traceable to community property, where the spouses have not indicated an intention that their community rights be severed.

The Act codifies what the Code Revision Commission believes is now common law in Alaska. The Act should help eliminate the necessity of stating that common law through litigation, thus saving private parties some litigation expense and reducing court costs. Because the bill deals only with private estate interests, it will not have a fiscal impact on state government operations, other than slightly reducing crowded court calendars.

58513

ALASKA CODE REVISION COMMISSION
COMMENTARY TO ACCOMPANY BILL ON
UNIFORM DISPOSITION OF CERTAIN PROPERTY RIGHTS AT DEATH ACT

The Act is intended to prescribe the rights, at death, of a married person who has community property acquired prior to a change in domicile to Alaska, or which is traceable to community property, where the spouses have not indicated an intention that their community rights be severed.

The Act codifies what the code revision commission believes is now the common law in Alaska. The Act is intended to eliminate the necessity of stating that common law through litigation.

AS 13.41.005 defines the property which is subject to disposition under chapter 41. Subsection (1) covers all personal property acquired by the spouses while domiciled in a community property state to the extent that property would have been treated as community property at the time of acquisition under the laws of that state and in which the spouses have expressed no intent to sever their community rights. Also included would be property which the spouses have agreed to treat as community property. Subsection (2) covers real property in the state (real property located in other states would be treated under the laws of those states) to the extent that it can be traced to a community source (e.g., was purchased with the proceeds of community property).

AS 13.41.010 establishes rebuttable presumptions intended to assist a court in applying the definitions of sec. 5. The presumptions are that (1) property acquired by a married person while domiciled in a community property state is and remains community property, and (2) property acquired by a married person while domiciled in a common law state, title to which included a right of survivorship, is not community property.

AS 13.41.015 requires that one-half of a deceased married person's property to which the chapter applies, i.e., community property or property traceable to it, becomes the property of the surviving spouse and is not subject to testamentary or intestate disposition. The other half is subject to the applicable manner of disposition. The one-half of the property to which the chapter applies is made not subject to the surviving spouse's elective share.

SBS13

AS 13.41.020 provides a method for the perfection, by means of a court order, of the title to property passing to the surviving spouse under the provisions of this chapter. It is intended to protect the personal representative from liability for failing to search the decedent's estate for property to which the chapter applies. The personal representative's duty may be reinstated by written demand of the surviving spouse or that spouse's successor in interest.

AS 13.41.025 provides a method whereby the personal representative, heir, or devisee may institute an action to perfect the surviving spouse's title to property to which the chapter applies. It is a corollary to sec. 20.

AS 13.41.030 protects purchasers and lenders taking a security interest, who acquire such interest for value, after the spouse's death, from liability to a person who appears to have title to property to which the chapter applies. It is intended to permit reliance upon apparent title and to facilitate both ascertainment of title and disposition of assets where adequate consideration is paid.

AS 13.41.035 merely states that the rights of creditors in property to which the chapter applies is not affected.

AS 13.41.040 makes clear that the rights of spouses to sever their community property interests or to create a form of ownership not subject to this chapter are in no way limited by the chapter.

AS 13.41.045 provides that the chapter does not authorize the testamentary disposition of property which is otherwise prevented from such disposition.

AS 13.41.050 and 13.41.055 provide for uniform construction and application and for citation for short title, respectively.

Nine states have adopted the 1971 uniform Act.

ALASKA CODE REVISION COMMISSION

SB 511-575



COMMISSIONERS
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JAMES L. BALDWIN - VICE CHAIRMAN
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L. S. KURTZ, JR.
JUDGE (RET.) THOMAS B. STEWART
FREDERIC E. BROWN

ALASKA STATE LEGISLATURE
POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 485-4878

EXECUTIVE SECRETARY
BILLY G. BERRIER

March 1, 1984

Senator Bill Ray, Chairman
Alaska Legislative Council
Pouch V, State Capitol
Juneau, Alaska 99811

- RE: (1) a bill relating to principal and income of trusts;
(2) a bill relating to administration of decedents' estates;
(3) a bill relating to renunciation of rights in decedents' estates;
(4) a bill relating to married persons' rights in a family home; and
(5) a bill relating to the uniform disposition of certain property rights at death.

Dear Senator Ray:

Pursuant to AS 24.20, the Alaska Code Revision Commission has prepared the enclosed bills and respectfully asks that they be introduced in the legislature.

They are technical bills the commission has been working on with the probate committee of the Alaska Bar Association. They relate generally to rights at death and to property arrangements that usually have their inception in death.

At its last meeting, the Legislative Council agreed to introduce the bills.

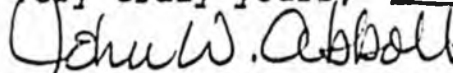
One of the bills, the bill on disposition of certain property rights at death, was previously in the legislature but received little notice. It is revived at the request of the probate committee of the Alaska Bar Association, and that

Senator Bill Ray, Chairman
March 1, 1984
Page 2

committee has advised the commission that it will actively support the bill.

A commentary on each bill is enclosed.

Very truly yours,



John W. Abbott, Chairman
Alaska Code Revision Commission

JWA:chw

Enclosures

cc: Hon. Bill Sheffield
Hon. Edmond W. Burke, Chief Justice
Myrton R. Charney, Executive Director
Legislative Affairs Agency

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B

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STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

February 29, 1984

SUBJECT: Sectional analysis of Work Order 13-1907

TO: Senator Dick Eliason
Chairman, Senate Labor & Commerce

FROM: Thomas A. Sofo *TAS*
Legislative Counsel

You have asked for a sectional analysis of Work Order 13-1907, a bill draft which makes amendments to the workers compensation law.

Section 1 This section merely decreases from 20 to 14 days the time within which a doctor or employee must notify the workers compensation board of the giving or receiving of medical treatment. Section 1 also standardizes the 14 day notice time limit for the first and subsequent medical treatments.

Section 2 Increases from 14 to 21 days the time within which the employer must file with the board a notice of controversion if the employer wishes to contest the right of the employee to workers compensation. The same section allows for the employer to also file a notice of controversion within seven days after a payment of compensation is due even after the employer has already begun the payment of compensation.

Section 3 Decreases from 14 to 7 days the time after which a 20 percent penalty is to be added to an unpaid installment of compensation.

Section 4 Immediate effective date.

TAS:ojb
J4/026

STATE OF ALASKA

Bill Sheffield, Governor

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

POUCH K - STATE CAPITOL
JUNEAU, ALASKA 99811
PHONE: (907) 465-3600

November 21, 1983

M E M O R A N D U M

TO: Honorable Bill Sheffield
Governor

Norman C. Gorsuch

FROM: Norman C. Gorsuch
Attorney General

RE: Attached bill on workers' compensation
Our file: 377-044-84

Attached is a bill, requested by the Department of Labor, amending the workers' compensation law. The bill coordinates the maximum time periods for filing of the physician's notice of treatment, for the employer's notice of controversion, and for commencement of compensation payments to an injured worker. This will enable an employer to make an informed decision of whether to pay or contest a workers' compensation claim.

A draft transmittal letter to the legislature is also attached.

NCG:LS:jca

cc w/enc.: Honorable James Robison
Commissioner
Department of Labaor

Under current law, an employer has 28 days to pay a compensation claim but only 14 days in which to controvert it. Ideally, the decision to pay a claim should be made after receipt of a physician's notice which verifies that the worker's injury is in fact work-related and that the worker is disabled. Under current law, however, a physician has 20 days to file the notice. This often results in employers controverting claims needlessly, and payments thus being unduly delayed.

The proposed legislation would require a physician's notice to be filed within 14 days of treatment instead of 20, would allow an employer 21 days instead of 14 to controvert a claim, and would shorten the time for payment from 28 to 21 days. These changes would enable an employer to make an informed decision on whether to pay or controvert a worker's compensation claim; they thus inure to the benefit of employers, workers, and insurers.



Scott Wetzel Services Incorporated

An Affiliate of The Home Group Inc

741 Sesame Street • Suite 1A • Anchorage, Alaska 99503

Phone (907) 561-1725

March 14, 1984

RECEIVED

MAR 19 1984

Josephson,

Senator Joe Josephson
Chairman
Health, Education and Social
Services Committee
Pouch V
Juneau, AK. 99811

Re: Senate Bill No. 517 "An Act relating to workers' compensation and providing for an effective date."

Dear Senator Josephson:

As a member of the insurance claims community, on behalf of our firm and the other firms in our industry, I would like to voice our opposition to enactment of the above bill, which will require one more reporting procedure and another penalty for an already much maligned industry.

I cannot begin to tell you the additional workload this will place on all our staffs; not so much so for having to pay medical bills within 14 days or pay a 20% penalty but due to the time and effort that will be spent in reporting to the Worker's Compensation Division, writing letters of explanation on why bills could not be paid in 14 days (i.e. such as; no physician's report received, no chart notes, claim has been controverted, no report of injury and hundreds of other reasons that occur daily that require we seek additional information before having to pay a bill that we may, or may not owe.)

This "cause celebre", i.e. - late payment of medical bills, has been grossly overrated, mainly by the chiropractic community and our firm was one that was singled out by the chiropractic community as a prime offender. Therefore, I did an in depth survey of all the chiropractors in our community and the results of this survey are attached hereto, along with my cover letter. You will note that the accusations were totally false and I now firmly believe that this is being used as a smokescreen by the chiropractic association in order to gain passage of Senate Bill No. 517.

I ask you to consider the added costs, which I can assure you will be monumental and weigh that against the small benefit, if any, that would be gained by passage of this bill. As in all businesses, the cost must eventually be passed on to the consumer and as you know, the cost of worker's compensation coverage is already very costly.

Thank you for your time and for your consideration of an issue that is very important to the insurance claims community.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Renee Murray". The signature is written in dark ink and is positioned above the typed name and title.

Renee Murray
Vice President

rm/ss

Encls.



Scott Wetzel Services Incorporated

An Affiliate of The Home Group, Inc

741 Sesame Street • Suite 1A • Anchorage, Alaska 99503

Phone: (907) 561-1725

March 9, 1984

TO WHOM IT MAY CONCERN:

Recently I have been told by several different and reliable sources that Scott Wetzel Services is really in trouble for late payment of chiropractic bills and that the chiropractors were really out to get us and we had "better clean up our act".

Since I have never been willing to accept generalized statements and innuendos and prefer dealing only in facts, I decided to research this problem personally.

I called approximately 80% of all the chiropractic clinics in Southcentral Alaska (including all of the larger and well known clinics) and I am attaching hereto the results of that survey.

The list of clients were provided to me by the individual chiropractic clinics and I researched each case to obtain the current status. You will find this list self explanatory, I believe.

It should be obvious to anyone who reviews these statistics that the chiropractic bills received in this office are not only being paid in a reasonable period of time, they are being paid in a very timely manner, with very few exceptions.

In fact, included in the packet attached, you will find a letter from the Ireland Clinic of Chiropractic, which was received in response to my request for a list of all accounts they currently have with SWS, which states, "We have no problem with timely payments from Scott Wetzel. You are the only insurance company which sends prompt payments." In view of the rumors "on the street", I found this statement to be astounding, as I'm sure you will.

I must admit that even I was surprised to find our situation as favorable as it is and in view of the many negative comments I have heard about our firm from several sources in the community, including the worker's compensation division, I must conclude that everyone assumed that the innuendos were fact.

Therefore, I wish it to be known by all interested parties that there is no truth in any of the rumors you have heard about Scott Wetzel Services and the chiropractic association and it would appear there is an effort to discredit our firm.

If this situation continues, we plan to take action appropriate to the damage it has caused to the reputation of this firm.

All of us in the insurance industry are having serious problems keeping on top of our bill payments since the Division of Worker's Compensation instituted the filing of so many forms, which carry huge penalties for late reporting. The time

we used to be able to use paying bills is now being used on a priority basis to file the reports required by the Worker's Compensation Division, because none of us can afford the huge penalties that are assessed for late reporting to the division; which added to the additional workload of approximately 25%, or more, created by the excessive reporting requirements, has caused all our overheads to skyrocket and profits to be decreased. I realize this is of absolutely no concern to the Worker's Compensation Division, but whether they are interested or not, private industry certainly should be because the bottom line is, someone has to pay the costs involved.

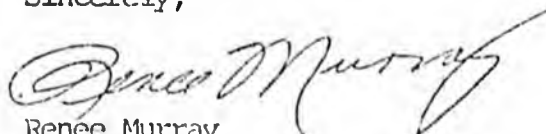
If the Worker's Compensation Division now starts imposing further penalties for late payment of medical bills, it can only create more havoc, more expense and once again, these costs will have to be borne by private industry and ultimately by the consumer.

The worker's compensation industry in Alaska presently has some very serious problems, mostly created by the state bureaucracy and we are doing the best we can with a very bad situation.

I certainly do not have the answers to these very serious problems, but I will be happy to work with any group that would like to address any of these issues and attempt to resolve these problems before we are all buried under a sea of forms, paperwork, penalties and red ink.

I feel that situation is critical and one we cannot afford to ignore further.

Sincerely,



Renee Murray
Vice President



IRELAND CLINIC OF CHIROPRACTIC

A Professional Corporation

541 WEST 36TH AVENUE • ANCHORAGE, ALASKA 99503-5899
(907) 561-1222 APPOINTMENTS • (907) 562-2734 BUSINESS

March 8, 1984

SCOTT WETZEL
SERVICES, INC.

Renee Murray
Scott Wetzel
741 Sesame Street
Suite 1A
Anchorage, Alaska 99503

ANCHORAGE, ALASKA

Dear Renee,

This letter is per your telephone request for a list of outstanding accounts that your company has with the Ireland Clinic as of March 2, 1984.

We have no problems with timely payments from Scott Wetzel. You are the only insurance company which sends prompt payments. The only difficulty is with Thermography payments and as you are aware the board is in the process of making a decision on insurance payments and Thermography.

Per your request is the following information:

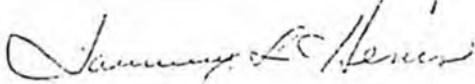
-#5004	Bernard, Andrew	Balance \$ 415.00	<i>No record of claim. Not reported to date</i>
#4846	Culp, Donald	Balance \$ 44.00	<i>Pd. in full 2/18/84</i>
#4076	Hatcher, Jerry	Balance \$ 375.00	<i>(over 120 \$375.00) Contracted</i>
#3667	Henry, Paul	<i>Ad. to date - 3566.00 Bal. 6231.00</i> Balance \$ 375.00	<i>(over 120 \$375.00) Contracted</i>
#4882	Jingco, Mario	Balance \$ 44.00	<i>Pd. in full. Bill added incorrectly</i>
-#4177	Linnell, Jodie	Balance \$ 198.00	<i>Pd. in full 11/23/83 - \$3626.00</i>
-#4942	Lyda, Edward	Balance \$ 154.00	<i>(over 30 \$154.00) No record of claim. Not reported</i>
-#3136	McKibben, Baird	Balance \$ 77.00	<i>(over 90 \$ 77.00) Contracted</i>
#4954	Medearis, Robert	Balance \$1864.00	<i>Pd. in full 2/17/84. These charges insured since 1/20/84. Not billed yet.</i>
#4897	Rodgers, Mike	Balance \$2124.00	<i>(over 30 \$873.00) correct Bill submitted. OK'd for payment.</i>
#4841	Stoltenberg, Edwin	Balance \$ 66.00	<i>Pd. in full 2/13/84</i>
#4815	Warren, Beulah	Balance \$ 335.00	<i>Pd. in full 2/15/84</i>
#4991	Wilder, Robert	Balance \$1537.00	<i>Pd. in full 3/7/84</i>

The balance shown is reflective of care to March 7, 1984. The comments in parenthesis is just the aging and amount overdue.

Please feel free to contact me if you should need any further information. Thank you.

Sincerely,

IRELAND CLINIC OF CHIROPRACTIC, A.P.C.



Tammy L. Henin
Assistant Business Director

TLH/clc

cc: Jacquelyn Mc Clintock
cc: Rebecca Reese
cc: W C C A Committee

SCOTT WETZEL
SERVICES, INC.

ANCHORAGE, AK.

As of 3/9/84

TURNAGAIN CHIROPRACTIC CLINIC

No outstanding accounts. One new patient and bill mailed 3/5/84.

COMMUNITY CHIROPRACTIC CLINIC - Dr. Adrian Barber

Only two accounts. None overdue.

Robert Gray vs. Municipality of Anchorage	\$33.00
Janet Lyons vs. Anchorage School District	\$33.00

PALMER CHIROPRACTIC CLINIC

Shirley Mendt	Last bill received 3/2/84	-	Paid 3/8/84
	Previous bill "	2/6/84	" 2/23/84

WEST CHIROPRACTIC - SOLDOTNA

Kimberley Rudge	Last bill received 3/2/84	Paid 3/8/84
	Previous bill "	2/7/84 " 2/23/84

TEAGUE CHIROPRACTIC CENTER

Dale Miller vs. Anchorage School District

	Last bill received 3/2/84	Paid 3/8/84
	Previous bill "	12/19/84 " 12/28/83
	" "	" 11/29/83 " 12/12/83

No other outstanding accounts

FAMILY CHIROPRACTIC CLINIC - ANCHORAGE

Did not return my phone call

KREMER CHIROPRACTIC CLINIC

Castleberry, James vs. Spenard Builders

CONTROVERTED

Blatchford, Sidney vs. Kodiak Oilfield Haulers

Bal. \$32.00

(This file was closed in Sept. and is being reopened for this new charge.)

No other accounts

DIMOND CHIROPRACTIC CLINIC

F. D. Schrenknegost. V.s. Municipality of Anchorage

Bill received 2/6/84

Paid 3/6/84

No other accounts

Dr. GODFREY

Siggi Hein vs. Municipality of Anch.

Bill received 2/6/84

Paid 2/21/84

Current billing received 3/6/84

Eugene Parmenter vs. Muni. of Anch.

Bill rec'd 9/29/83

Paid 10/2/83

Bill rec'd 2/3/84

" 3/6/84

No other outstanding accounts from either of the Dr.'s Godfrey

ALASKA CHIROPRACTIC CLINIC

Kevin Jones vs. Carr-Gottstein

Bill rec'd 3/5/84

Paid 3/8/84

Prev. " " 2/6/84

" 3/1/84

DR. CECIL McLEOD

Sam Turner vs. Muni. of Anchor

Bill rec'd 2/9/84

Paid 2/29/84

Current bill rec'd 3/5/84

Shannon Mays vs. Kodiak Oilfield

Bill rec'd 2/9/84

Overdue

John Alexander vs. St. of Ak.

Bill rec'd 1/25/84

Pd. 2/9/84

Current bill rec'd 2/29/84

DR. CECIL MC LEOD (CONTINUED)

T- J. (TED) JOHNSON VS. Muni of Anchor.	Bill rec'd 2/9/84	Pd. 3/6/84
	Prev. " " 1/11/84	" 2/11/84
Chris Smith vs. Muni of Anchorage	Unable to locate file	

IRELAND CLINIC OF CHIROPRACTIC

See Dr. Ireland's attached letter, which is self explanatory.

You will note there is one legitimate overdue bill. This was a clerical error on our part. The bill was put in the file without having been paid.

ANCHORAGE CENTER FOR CHIROPRACTIC

Barbara Agnew vs. St. of Ak.	- Kenneth O. Ketz, D. C.	
	Bill rec'd 2/6/84	Paid 2/27/84
	Current bill rec'd 3/1/84	
Diane Boyer, vs. AK Airlines	Paid to date - \$1169.00	
	Last bill rec'd 3/1/84	Paid 3/8/84
Gerald Conn. vs. Carr-Gottstein	Bill rec'd 2/9/84	Paid 3/9/84
	No bill rec'd for \$951.00 charge outstanding.	
Paul Denyer vs. Wien	Unable to locate file. Clinic indicates balance of \$1350.00.	
Eleanor Frisby vs. St. of Ak.	Paid to date - \$5087.00. Statement rec'd 3/6/84 shows balance of \$114.00 - not \$443.00 as indicated by clinic.	
Kirk Garoutte vs. Seaalaska	Paid \$2200.00 to date. Awaiting chart notes before payment of current bill of \$364.00.	
Ann Hill vs. Muni of Anchorage	Paid to date \$3265.00. \$430.00 bill rec'd 3/1.	
Mike Johnson vs. Wien	Bill rec'd 2/21/84. Payment overdue - \$650.00.	
Suzanne Kennell vs. Muni. of Anch.	CONTROVERTED.	
Harriet Kersick vs. St. of Ak.	Paid to date - \$1144.00	
	Bill rec'd 2/6/84	Pd. 3/6/84
	Bill rec'd 11/4/83	Pd. 11/11/83
	Bill rec'd 10/13/83	Pd. 10/19/83
David Meeks vs. Muni of Anch.	Paid to date \$2982.00. File closed.	
	Current bill of 114.00 received 3/6/84	
Melvin Main vs. Kodiak Oilfield	Bill re cd 3/1/84	Pd. 3/8/84
	Prev. bill rec'd 2/2/84	Pd. 2/9/84
	" " " 1/9/84	Pd. 1/13/84

ANCHORAGE CENTER FOR CHIROPRACTIC - Kenneth O. Ketz (continued)

Gerry Reed vs. State of Alaska - Injury of 6/5/78 - Unable to locate file.
 Mike Serra vs. Carr-Gottstein Bill for \$900.00 rec'd 3/6/84. No previous bills on this claim.
 Marvin Sexton vs. Wien Paid to date \$1786.00. \$785.00 bill outstanding and overdue for payment.
 Kitty Von Kreybig vs. St. of Ak. Bill rec'd 3/1/84 Pd. 3/8/84
 Charles Wellong, vs. Muni of Anch. Paid to date - \$1144.00. Further treatment
 CONTROVERTED

 CHERIER CHIROPRACTIC CLINIC

Darrel Painter vs. Safeway	Bill rec'd 3/5/84	Paid 3/8/84
	Prev. bill rec'd 12/19/83	" 12/28/83
	" bill rec'd 11/29/83	" 12/12/83

No other outstanding accounts

 KENT CHIROPRACTIC CLINIC

Joe Bard vs. Anchorage School Dist.	Bill rec'd 3/6/84	Paid 3/8/84
	Prev. bill rec'd 21/21/84	" 2/27/84

Gary Haase - Muni of Anchorage New claim. Bill sent to us 3/5/84 - not rec'd yet
 Eldon Hinckley vs. Anch. School Cost to date - \$1627.00. Treatment for Jan. not paid until 3/5/84.
 Christine Thomas vs. St. of Ak. New claim. Bill sent to us 3/5/84. No rec'd yet.

No other accounts



Scott Wetzel Services Incorporated

An Affiliate of The Home Group, Inc.

741 Sesame Street • Suite 1A • Anchorage, Alaska 99503

Phone: (907) 561-1725

September 26, 1983

Kenneth O. Ketz, D. C.
Anchorage Center for Chiropractic
3330 "C" Street
Anchorage, AK 99503

RE: Employer: STATE OF ALASKA
 Employee: KERKSICK, HARRIET A.
 Date of Injury: 7/4/83
 Claim Number: 1072

Dear Chiropractor Ketz:

Thank you for sending the code for diagnosis as used by Blue Cross-Blue Shield of Alaska and by your office. This code does not meet our requirements, however, as there are several different diagnosis for one code (i.e. for 839.20 there are 5; for 847.0 there are 3; for 839.2 there are 12 and for 847.1 there are 2 diagnosis--while for 839.08 there is no diagnosis shown). Although many of these diagnosis may be similar (i.e. sprain/strain), we require a more definite diagnosis.

I would also like to bring to your attention that we have requested chartnotes for services rendered 8/3 - 8/29/83 which have not as yet been supplied. We cannot pay for these services until we have received these chartnotes and a diagnosis. Thank you.

Sincerely,

SCOTT WETZEL SERVICES, INC.

Veryl Purbaugh
Medical Only Examiner

/vp



Scott Wetzel Services Incorporated

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741 Sesame Street • Suite 1A • Anchorage, Alaska 99503

Phone: (907) 561-1725

March 11, 1984

Douglas J. Mosher, D. C.
Ireland Clinic of Chiropractic
541 West 36th Avenue
Anchorage, AK. 99503

Re: Marion M. Jingco #4882
vs. Carr-Gottstein
D/Inj: 12/14/83
State Claim No. 328869

Dear Dr. Mosher:

In reviewing your statement on the above account, we note that on 12/15/83, the first day of treatment of Mr. Jingco, you incurred charges of \$427.00.

Included in this sum is a charge of \$111.00 for an intermediate history and exam. Will you please explain why this charge is so excessive; what this consisted of and provide us with a copy of the intermediate history.

In addition, you have charged you have charged \$244.00 for x-rays and another \$66.00 for actual treatment. Also, why are we being charged for a urinalysis for a back strain?

Your charges appear excessive and unreasonable and we would suggest you review your fee schedule and consider a reduction.

We are willing to pay any fair and reasonable charge, but this is ridiculous.

Very truly yours,

Renee Murray
Vice President

rm/ss

cc: Alaska Worker's Compensation Board
cc: Mario M. Jingco



Scott Wetzel Services Incorporated

An Affiliate of The Home Group, Inc.

741 Sesame Street • Suite 1A • Anchorage, Alaska 99503

Phone (907) 561-1725

March 9, 1984

Ireland Clinic of Chiropractic
541 West 36th Ave.
Anchorage, AK. 99503

Attn: Douglas J. Mosher, D. C.

Re: Robert Medearis vs.
Anchoorage School District

Dear Dr. Mosher:

In reviewing your statement on the above account, we note that on 1/24/84, the second day of your treatment of Mr. Medearis, you incurred charges of \$427.00.

Included in this sum is a charge of \$111.00 for and intermediate history and exam. Will you please explain why this charge is so excessive; what this consisted of and provide us with a copy of the intermediate history.

In addition, you have charged \$133.00 for "Full Spine A-P/Lat (Comprehensive) and another \$111.00 for Lumbosacral (Comprehensive).

I assume all of this is for x-rays. Please correct me if I am wrong, but assuming that to be the case, I consider \$243.00 for x-rays to be totally outrageous. These x-rays could be taken at any clinic or hospital in Anchorage for a much lesser charge and in the future, I would suggest you utilize other facilities if you cannot perform this service for a reasonable charge.

Perhaps this statement was in error. If so, please provide us with a corrected billing.

Very truly yours,

Renee Murray
Vice President

rm/s

cc: Robert L. Medearis
cc: Alaska Worker's Compensation Board

POSITION PAPER
Senate Bill No. 510

"An act related to provision of chiropractic services under the Medicaid program."

I. Background

The Alaska Medicaid program was created by the Legislature in 1972 and sections in the statutes were created to list all categories of service and groups of eligibles. The original legislation created a program providing basic medical coverage for individuals eligible for cash payments under the Aid to Families with Dependent Children (AFDC) and Adult Public Assistance (APA) programs, individuals in long term care facilities, and children under the supervision of the Department in foster homes and private child-caring facilities.

Since 1972, the Legislature has amended the statutes several times to add new groups of eligibles or categories of service.

The new groups of eligibles added to AS 47.07.020 since 1972 have been institutionalized individuals for whom the State had previously paid all of their cost of care, needy children not in AFDC households, and pregnant women. By adding these groups to the Medicaid program, the State was able to receive federal funds to partially offset state funds.

The new categories of services added to AS 47.07.030 since 1972 have been fairly low cost services when compared to the total Medicaid program. Several of the new categories of service had the effect of permitting the State to receive federal funds to partially offset state funds being used to provide services.

The trend has clearly been toward maximizing federal financial participation in medical assistance.

II. Need for Chiropractic Services:

Currently, 29 states recognize the value of chiropractic services by including them in their Medicaid program. In addition, the major private insurance programs also include chiropractic coverage.

Generally, chiropractors and advocates of their services contend that chiropractic services are an alternative to other, potentially more costly medical treatments.

III. Effect of Senate Bill No. 510:

Section 1 of the bill amends AS 47.07.030 by adding chiropractic services as covered services under Medicaid.

Section 2 of the bill amends AS 47.07.035 by adding chiropractic services as the first services to be eliminated in the event of a funding shortfall in the Medicaid program.

Section 3 of the bill amends AS 47.07.900 by defining chiropractic as it is defined in AS 08.20.220.

AS 08.20.220 defines chiropractic as follows:

"Chiropractic is the science of locating and correcting interference with nerve energy transmission and expression within the human body, and the employment and practice of drugless therapeutics, including physiotherapy, hydrotherapy, mechanotherapy, phytotherapy, electrotherapy, chromotherapy, thermotherapy, thalmotherapy, correcting and orthopedic gymnastics, and dietetics which includes the use of foods and those biochemical tissue building products and cell salts found within the normal human body, without the use of drugs or surgery."

Regardless of what services chiropractors are licensed to perform according to the laws of individual states, the federal government will only provide reimbursement under Medicaid for manual manipulation of subluxation of the spine and x-rays. Therefore, if the State extends coverage to include the other services listed in SB 510, the State must provide 100 percent of the reimbursement for these services. Currently, many of these services such as laboratory tests are already provided under the Medicaid program through medical providers for whose services the state receives federal reimbursement.

Approximately 29 states cover chiropractic services as an option under Medicaid. Almost all of them limit reimbursement to manual manipulation of subluxation of the spine. As a necessary adjunct to this treatment, some states also cover x-rays necessary to identify the need for manual manipulation.

IV. The Department's Position:

The Department of Health and Social Services would support the addition of chiropractic services with a more limited definition than that currently contained in SB 510. Specifically, we would support coverage for manual manipulation of the spine and the x-rays services necessary to identify the need for this treatment. We believe that this would provide needy Alaskans with medical coverage that is comparable to that of their privately insured neighbors while minimizing the expenditure of state funds that are unmatched by federal dollars.

Recommended By: for Jim R. Poy
Rod Betit, Director
Division of Public Assistance

Date: 3/9/84

Approved By: Robert London Smith
Robert London Smith, Ph.D.
Commissioner
Department of Health & Social Services

Date: 3/19/84

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: SB #510
 Title: An Act related to provision of chiropractic services under the
 Sponsor: _____
 Requestor: Senate HESS Committee
 Date of Request: March 2, 1984

FISCAL DETAIL

Agency Affected: DHSS - DPA
 Program Category Affected: Medical Medicaid program. Assistance
 BRU, Program or Subprogram(s) Affected: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		20.0				
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS		154.0	165.6	178.0	191.4	205.8
800 MISCELLANEOUS						
TOTAL OPERATING		174.0	165.6	178.0	191.4	205.8
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		87.0	82.8	89.0	95.7	102.9
FEDERAL FUNDS		87.0	82.8	89.0	95.7	102.9
OTHER						
TOTAL		174.0	165.6	178.0	191.4	205.8

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

Funding for this service is not currently included in the Governor's budget. Therefore, additional funds would have to be appropriated.

ANALYSIS: Attach a separate page for analysis

Prepared By: Kim Busch Phone: 465-3347
 Division: Public Assistance Date: 3/19/84

Approved by Commissioner: [Signature] Date: 3/19/84
 Agency: Dept. of Health & Social Services

Distribution (by Agency preparing fiscal note):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

12/1/83

Analysis

Contractual

Chiropractors will need to be added to the Alaska Medical Payments System (AMPS). The contractual costs include the following: provider manuals, training, a new claims form, tables included in the system for chiropractic services, computer programming, computer reports, the addition of collocation codes, the provision of notice to providers, provider relations, and a computer system test.

Grants/Claims

These figures were adjusted by an inflation factor of 7.5%. This is the average percent increase experienced during the past two years in chiropractic services. These costs are for only manual manipulation of the spine and the x-rays necessary for diagnosis. Again, these are the only chiropractic services for which federal reimbursement is available. The federal match for Medicaid is 50%.

We did not develop a fiscal note for the full range of chiropractic services included in SB 510 as we did not have sufficient data to accurately determine the cost. This data is not available from other states primarily because the states that cover chiropractic services have limited the coverage to services for which federal reimbursement is available. We used the following formula to develop our cost estimates:

#Recipients X	#Services X	Cost Per Service +	#X-Rays X	Cost Per X-Ray X	12 Months
per/month	per/month	per/month	per/month		

$$50[(\$30 \times 2) + (\$65.55 \times 3)]12 = \$154.0$$

Assumption #1:

That the ratio of recipients to eligibles is similar to the ratio of recipients to eligibles in Idaho.

Idaho averaged 75 chiropractic recipients and 30,000 eligibles per month. We would average 50 chiropractic recipients out of 20,000 eligibles per month.

Assumption #2:

Services would be limited to 2 visits per month per recipient.

Assumption #3:

X-rays would be limited to three x-rays per month per recipient.

Assumption #4:

Manual manipulation of the spine costs \$30. An x-ray costs \$65.55.



AWCB
JUNEAU MAR 19 1984

Scott Wetzel Services Incorporated

An Affiliate of The Home Group Inc

741 Sesame Street • Suite 1A • Anchorage, Alaska 99503

Phone (907) 561-1725

March 15, 1984

Senator Joe Josephson
Chairman
Health, Education and Social
Services Committee
Pouch V
Juneau, AK. 99811

Re: Senate Bill No. 517 "An Act relating to worker's compensation and providing for an effective date".

Dear Senator Josephson:

Yesterday I wrote to you relative to my opposition to the above referred bill.

Last night I had the opportunity to meet with some of my constituents and also with the sponsors of the bill. I find that I interpreted this bill incorrectly and, in fact, it does not assess a penalty on medical bills as I had initially thought. Therefore, I am withdrawing my opposition to this bill.

In addition, the bill is going to be amended by the sponsors^{LO} to include a clause which will be most beneficial to the insurance claims community and at that point, it will have my full support.

I apologize for any confusion and misunderstanding that I have caused.

When you spoke before the Alaska Adjuster's Association recently, there was a discussion relative to the mandatory insurance bill which is being considered this session.

I am attaching hereto a letter which was printed in the Anchorage Times on 3/14/84. Mr. Clements is a very knowledgeable insurance man and I am in agreement with his comments. I believe he has some valid points which bear consideration.

Sincerely,

Renee Murray
Vice President

mr/ss

Enc.

Joe, Paul, Pappy

April 4, 1984

Senate HESS

SB 517 - (Workers' Compensation)

Jacquelyn McClintock - D.O.L. (Work. Comp. Division)

physician file 14 days instead of 20
~~#~~ Employers cut reverse time from ~~#4~~ to 21
time to pay 28 to 20 days.

Div of Insurance did an audit 6 mos.
ago. Don Koch found this to be a
major problem.

Does something for everyone.

Met with Ms. Murray - Scott Wetzel -
said she had misinterpreted the
bill. Has withdrawn opposition to bill

SB 510

ALASKA STATE SENATE

PATRICK RODEY
SENATOR

POUCH V
JUNEAU, ALASKA 99811
(907) 465-3793
(907) 475-3754



Senator Dick Eliason, Chair
Senate Labor & Commerce Committee
Capitol Building Room 417
Juneau, Alaska

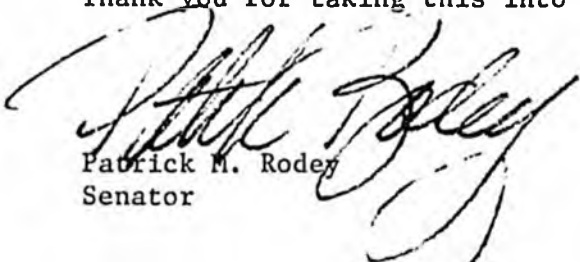
March 5, 1984

Dear Dick:

I would like to request that the Senate Labor & Commerce Committee introduce a proposed draft of the attached worker's compensation bill. I would be happy to sponsor this legislation but as you know the deadline for individual sponsors has passed.

Please keep this letter on file as proof that I specifically requested this legislation to be introduced through the committee.

Thank you for taking this into consideration.


Patrick M. Rodey
Senator

STATE OF ALASKA

DEPARTMENT OF LABOR

OFFICE OF THE COMMISSIONER

BILL SHEFFIELD, GOVERNOR

P.O. BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2700

January 18, 1984

The Honorable Patrick M. Rodey
Alaska State Senate
Pouch V
Juneau, AK 99811

Dear Senator Rodey:

Enclosed are the section-by-section analyses for the workers' compensation and unemployment insurance bills Commissioner Robison and I talked with you about yesterday.

Thanks for your help with this.

Sincerely,



Eileen Plate
Special Assistant

Enclosures

EP:gs
A:26

Section-By-Section Analysis

Section 1. This section requires the physician rendering treatment to file a medical report within 14 days following treatment instead of 20 days.

Section 2. This section extends the maximum time period for an employer to file a controversion from 14 days to 21 days from date of knowledge of the alleged injury or death, or, if payments have begun, within 7 days after an installment or compensation payable without an award is due.

Section 3. This section shortens the maximum time period for an employer to pay compensation to an injured worker from 28 days to 21 days.

Section 4. Provides for an effective date of July 1, 1984.

1 IN THE SENATE

BY THE RULES COMMITTEE
REQUEST OF THE GOVERNOR

2 SENATE BILL NO.

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 THIRTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to workers' compensation;
7 providing for an effective date."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 23.30.095(c) is amended to read:

10 (c) No claim for medical or surgical treatment is valid
11 enforceable [AS] against the employer unless, within 14 [20] d
12 following [THE FIRST] treatment [AND FOLLOWING THE TIME SET BY
13 BOARD FOR NOTICE OF SUBSEQUENT TREATMENTS], the physician giving
14 treatment or the employee receiving it furnishes to the employer
15 the board notice of the injury and treatment, preferably on a f
16 prescribed by the board. The board shall, however, excuse the fail
17 to furnish notice within 14 [20] days when it finds it to be in
18 interest of justice to do so, and it may, upon application by a pa
19 of interest, make an award for the reasonable value of the medical
20 surgical treatment so obtained by the employee.

21 * Sec. 2. AS 23.30.155(d) is amended to read:

22 (d) If the employer controverts the right to compensation
23 shall file with the board a notice of controversion on or before
24 21st [14th] day after he has knowledge of the alleged injury or death.
25 If the employer controverts the right to compensation after payment
26 have begun, he shall file with the board a notice of controversion
27 within seven days after [OR ON OR BEFORE] an installment of compen
28 sation payable without an award is due[, A NOTICE OF CONTROVERSION
29 A FORM PRESCRIBED BY THE BOARD].

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* Sec. 3. AS 23.30.155(e) is amended to read:

(e) If any installment of compensation payable without an award is not paid within seven [14] days after it becomes due, as provided in (b) of this section, there shall be added to the unpaid installment an amount equal to 20 percent of it. This additional amount [WHICH] shall be paid at the same time as, and in addition to, the installment, unless notice is filed under (d) of this section or unless the nonpayment is excused by the board after a showing by the employer that owing to conditions over which the employer [HE] had no control the installment could not be paid within the period prescribed for the payment.

* Sec. 4. This Act takes effect July 1, 1984.

D R A F T

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to workers' compensation. The bill brings into harmony the periods of time allowed for several related acts, and should result in a system in which claims are handled more efficiently.

Under current law, an employer has 28 days to pay a compensation claim but only 14 days in which to controvert it. Ideally, the decision to pay a claim should be "made after receipt of a physician's notice which verifies that the worker's injury is in fact work-related and that the worker is disabled. Under current law, however, a physician has 20 days to file the notice. This often results in employers controverting claims needlessly, and payments thus being unduly delayed.

The proposed legislation would require a physician's notice to be filed within 14 days of treatment instead of 20, would allow an employer 21 days instead of 14 to controvert a claim, and would shorten the time for payment from 28 to 21 days. These changes would enable an employer to make an informed decision on whether to pay or controvert a worker's compensation claim; they thus inure to the benefit of employers, workers, and insurers.

Sincerely,

Bill Sheffield
Governor

