



1949 HOUSE LABOR & COMMERCE

date proposed and the director replaces the board as the person giving notice of the selected date.

Section 20 amends AS 23.30.041(q) to replace the board with the division as the agency receiving filed waivers of rehabilitation benefits and serving notices of the waivers. The amendment also replaces the board with the director as the agency prescribing or approving the form of such waivers.

Section 21 amends AS 23.30.080(d) regarding proceedings to obtain stop work orders against uninsured employers. The amendment provides that the board may issue a stop work order at the request of the director. The amendment clarifies the role of the director. Unlike the original SB 130 language, it does not specifically characterize the procedure for the director's request as being pursuant to the board's petition process (provided by regulation at 8 AAC 45.050).

Section 22 amends AS 23.30.080 by creating three new statutory provisions relating to penalties against uninsured employers and stop orders. New subsec. (e) authorizes the director to issue a stop order after an investigation by a department officer reveals substantial evidence that the employer is not insured or has no self-insurance certificate. The director must dissolve the stop order on receipt of proof of insurance or a self-insurance certificate. In addition, the director may petition the board to assess a civil penalty if the employer fails to obey the stop order.

New subsec. (f) authorizes the division to petition the board for a civil penalty of up to \$1,000 per day of employment per uninsured employee. New subsec. (g) permits the director to declare an employer in default if the employer fails to pay a civil penalty under subsec. (d) (failing to comply with a board stop work order, \$1000 per day), subsec. (e) (failing to comply with a director stop work order, \$1000 per day), or subsec. (f) (failing to insure employee, \$1,000 per employee per day), within seven days of the date ordered. Upon filing a certified copy of the penalty order and a declaration of default with the clerk of the superior court, the court shall enter judgment for default. The attorney general, as requested by the director, shall take appropriate action to collect on the default judgment, and a writ of execution may be issued on the judgment. The person against whom the judgment is issued may seek court review of the judgment as allowed by the civil rules.

Section 23 creates a new section, AS 23.30.082, establishing a workers compensation benefits guaranty fund to assist injured employees of uninsured employers. The fund is established in the general fund, comprised of the civil penalties paid under AS 23.30.080, income earned by investment, money deposited in the fund by the department, and appropriations to the fund. The fund may be used to pay claims, expenses of the fund, and legal expenses. The reference to

“legal expenses” in subsec. (a) is intended to refer to the legal expenses of the fund, not those of the claimant against the fund. The Department of Revenue shall inform the division of the fund balance and interest income. Subsec. (c) provides for injured employees to file a claim against the fund and preserves the rights of the fund to defend claims. Subsec. (d) provides that the fund is subrogated to all rights of the employee, and is assigned all rights of the employee against the uninsured employer to the extent of payment by the fund. Money collected shall be paid to the fund. Claims will be paid in the order made against the fund. Finally, the division is authorized to contract for adjustment of claims against the fund.

Section 24 amends AS 23.30.095(c) to add provisions relating to palliative care or treatment which involves continuing and multiple treatments of a similar nature. After the employee’s condition is medically stable, (defined at current statute AS 23.30.396(21)), is not payable unless the attending physician certifies that the palliative care is necessary to allow the employee to continue employment or participation in a reemployment benefits plan. This section does not apply with the treatment is needed for chronic debilitating pain. The choice of the word “debilitating” was intended to convey something greater in degree than “intractable.”

Section 25 amends AS 23.30.095(j) to reassign from board to the commissioner authority to appoint a medical services review committee or contract with organizations to assist and advise the department and the board in matters respecting medical care under the workers’ compensation act.

Section 26 amends AS 23.30.095 to add three new subsections. The first, subsec. (n) requires pharmacists to dispense generic medication where a generic is available and the attending physician does not provide written justification of medical necessity for the brand name product. This subsection also requires the department to establish a preferred drug list for use under this subsection, but also allowing attending physicians to depart from the list when medical necessity justifies departure. The department shall make a regulation for the process to establish medical necessity. The change from “prescribing physician” in the original text of SB 130 to “attending physician” reinforces the role of the attending physician in continuously monitoring and participating in treatment of the employee.

The second new subsection, (o), for purposes of determining what medical treatment or services the employer is liable for under AS 23.30.095(a), establishes a rebuttable presumption of correctness of the recommended treatment guidelines of the American College of Occupational and Environmental Medicine in effect at the time treatment is provided. For injuries not covered by the guidelines, the board may adopt other scientific, evidence-based guidelines generally recognized by the national medical

community. The requirement in the original SB 130 that the presumption be rebutted by "a preponderance of scientific evidence" is deleted.

The third new subsection (p), added in an earlier committee substitute, allows the presumption created in subsec. (o) to be rebutted by a certified (i.e., upon oath) written statement by the employee's physician describing the variance in treatment and setting out the basis for the physician's conclusion that the variance is reasonably required by the nature of the injury or the process of recovery. This statement would eliminate the "presumption of correctness" of the national guidelines and probably raise the presumption in AS 23.30.120(a) that a claim for the disputed treatment is compensable. In resolving any continuing dispute, the board would be required to address the matter on the evidence, in the same process it presently uses.

Section 27 creates a new statutory section, AS 23.30.097,⁷ dealing with payment of medical benefits. This section provides that all fees and charges for medical treatment or services under the act are subject to board regulation and that an employee may not be required to pay a fee or charge covered by the workers' compensation act. The fee or charge may not exceed the lesser of the usual, customary, and reasonable fee in effect on December 15, 2003, or the payment negotiated by an employer under the preferred provider process. Provision is made to allow employers or groups of employers to negotiate with physicians to establish preferred provider lists and fees for services, but the selection of a physician on the list is voluntary and an employee must be so advised. No attempt to influence treatment or rating decisions may be made when negotiating the list. Selection of a physician for inclusion on the list does not affect the employer's right to choose an independent medical examiner. Subsec. (d) of this provision parallels former AS 23.30.095(l), repealed in sec. 50 of this legislation, and provides that payment of bills for medical treatment must be made within 30 days after the date that the employer receives the bill or a completed report as required by AS 23.30.095(c), whichever is later. Subsec. (e) of this provision duplicates former AS 23.30.095(m), repealed in sec. 50, relating to payment of pharmacy and travel charges, and reimbursement of third party payers such as health insurers.

Section 28 amends AS 23.30.100(b) to require that the notice of an injury or death given under the workers' compensation act contain a consent by the employee to release medical records of treatment of the injury or death to the employer's adjuster and the board. This "release" is limited solely to records of treatment of the reported injury or medical records of the death, and does not replace the consent to release information contained in AS 23.30.107. The intent of this

⁷ An amendment repeals this section on June 30, 2007. See sec. 51 of this amended committee substitute.

amendment is to speed the process of payment of medical expenses by allowing adjusters to immediately request treatment records for the reported injury and encourage physicians to comply with AS 23.30.095(c) by making reports of treatment to the employer and the board.

Section 29 amends AS 23.30.107(b) to add the division as the agency where workers' compensation files are maintained. The amendment also adds the division as an agency that may release records as provided by the statute.

Section 30 amends AS 23.30.107 by adding a new subsection that prohibits the division from assembling or providing information contained in individual workers' compensation files for commercial purposes outside the scope of the workers' compensation act. The intent of this provision is to prevent "mining" of division records for commercial purposes, such as investment solicitations, credit agencies, and the like. Currently the act makes it a misdemeanor to solicit employment for a lawyer or oneself in respect to a compensation claim. *See* AS 23.30.260(2). Although that statute prohibits certain solicitation activities, it does not clearly provide the division authority to decline to produce information for commercial endeavors. This new section clarifies the division's ability refuse to assist in illegal conduct and provides guidance to the division. This section is not intended to prohibit disclosure of, for example, public record information regarding a specific claim to a newspaper reporter, an insurer seeking the names of employers who are uninsured for purposes of soliciting contracts to provide workers' compensation insurance (as employer coverage status is not in respect of a claim), or an investigator for a law firm representing an injured worker asking, pursuant to a valid discovery order or other authorized discovery process, for information regarding other claims that are relevant to an on-going claim for compensation. This provision does not alter other subsections providing that medical and vocational reemployment records in a claim are not public records.

Section 31 repeals and reenacts AS 23.30.122, relating to determinations of the credibility of witnesses. As provided by the former statute, the board has the sole power to determine credibility of witnesses, but the amendment removes language relating to the conclusiveness of the board's findings regarding the weight of the evidence.

Section 32 repeals and reenacts AS 23.30.125 relating to review of compensation orders. It replaces superior court review of board decisions with commission review of compensation orders. The amendment sets a date on which compensation orders are final unless review is undertaken. It makes explicit that the commission has the power to review board decisions and orders, and that orders may not be suspended, reconsidered or set aside except through the commission process. This amendment also creates a provision for stays of

orders pending appeal. It requires a party seeking a stay to produce evidence of irreparable damage. If a party seeks a stay of continuing periodic compensation payments, the party seeking the stay must demonstrate that the appeal is likely to be decided adversely to the compensation recipient. The commission may allow a hearing on the stay on three days notice to the parties in interest.

Section 33 creates three new statutory provisions relating to commission review of board decisions, commission procedure on appeal, commission authority to review and judicial review of commission proceedings. The first new statute, AS 23.30.127, establishes the basic procedure for appeal to the commission. This provision allows the director to intervene in an appeal. If a party does not have legal representation and the order appealed concerns an unsettled question of law, the director may file an appeal to obtain a ruling. The intent is that the director would not represent the party, but, in order to insure that the unsettled issue of law of importance to the system is fully examined, would be able to exercise discretion to file an appeal. This provision sets a 30-day period for appeal of a compensation order or a director decision. It describes the documents that must be filed with the commission to initiate an appeal and a cross-appeal. It authorizes the commission to charge a fee up to \$100 for filing appeals and cross appeals, but exempts the state and political subdivisions of the state from the filing fee. It authorizes the commission to require an appellant to pay costs of preparing a transcript and preparing the record on appeal. Cross appellants and intervenors may be required to share in the costs. This provision grants the commission general authority to make rules and orders for the prompt fair and just disposition of appeals and authorizes the commission to require written briefs.

The second new statutory provision, AS 23.30.128, establishes the commission's authority to review and act on appeals. The commission hears appeals in panels of three members, the chair, and one citizen member representing employees, and one citizen member representing employers. The panel decision is the decision of the commission. The commission may review all exercises of discretion, factual findings, and legal conclusions below, but board findings regarding the credibility of a witness who appeared in the hearing is binding on the commission. Findings of fact will not be set aside if supported by substantial evidence in light of the whole record. If not set aside, the board's findings are conclusive. This standard is a change from the original provision in SB 130. This statute provides that the commission review will be on the record, except that briefs and argument shall be allowed. The exception is that the commission may receive evidence in applications for a stay of a decision by the board, attorney fees and costs of appeal, waiver of fees for indigent appellants, and dismissal of appeals for failure to prosecute

or settlement. This provision also gives the commission wide discretion to act on appeal. The commission may expedite appeals. It may affirm, reverse or modify a decision; remand matters it determines were improperly or insufficiently developed, or remand for further action without relinquishing jurisdiction. The commission members who heard an appeal must decide whether to grant reconsideration. The commission may reconsider its decisions on specific grounds listed in subsection (f): misapplication or failure to apply directly controlling law; overlooking or misconceiving a material fact; misunderstanding a material question in the case presented on appeal; or, applying law that has subsequently changed. AS 44.62 does not apply to proceedings of the commission. This provision balances shorter time for appeal and reconsideration (30 days) with sufficient time for collegial consideration of the merits of the appeal before a commission decision (90 days). This provision sets out clearly when a decision of the commission is final, to avoid confusion as to dates of finality.

The third new statutory provision, AS 23.30.129, exempts the commission from the grant of superior court jurisdiction over judicial appeals of administrative agency decisions contained in AS 44.62.590 and states that commission orders may not be otherwise appealed to the superior court. The purpose of this provision is to eliminate appeal to the superior court, and to provide that decisions of the commission may be appealed directly to the Supreme Court. This provision withdraws workers' compensation appeals from the jurisdiction of the superior court, which the legislature may do by law. See, Art. IV, Sec. 1 of the Alaska Constitution, see also AS 22.10.020(d). It does not encroach on the judicial power reserved to the courts under Art. IV, Sec. 15, because incidental effects of substantive change do not trigger Art. IV, Sec. 15 requirements. See, *Wienegardner v. Greater Anchorage Borough Bd. Of Equalization*, 534 P.2d 541, 547 n. 18 (Alaska 1975). This provision does not affect the right to seek declaratory judgment in superior court on matters affecting workers' compensation law, as, for example, to declare a regulation invalid or to require coverage under an insurance contract. This provision also establishes the standard of review for commission decisions.

Section 34 creates a new statutory provision, AS 23.30.175(b)(5), which "caps" compensation paid to non-resident recipients at the compensation rate the recipient would receive if residing in Alaska. The effect of the amendment is to allow compensation rates paid to a non-resident to decrease by cost of living adjustments for the recipient's area of residence, but caps any increase due to a cost of living adjustment in the recipient's area of residence so that the recipient's compensation rate does not exceed what the recipient would receive in Alaska.

Section 35 amends AS 23.30.175(c) to transfer the authority to provide cost of living comparisons from the board to the department and to replace annual redeterminations of cost of living comparisons with redeterminations every three years.

Section 36 amends AS 23.30.205(e) to replace the commissioner with the director for receipt of notice of award or adjudication respecting the second injury fund.

Section 37 adds a new section providing for coordination of certain disability benefits and workers' compensation payments for temporary total disability, permanent total disability, and reemployment compensation. For employees benefiting under AS 39.35 or AS 14.75, the employer's liability for total disability compensation under AS 23.30.180 or AS 23.30.185 is limited to the lesser of the difference between the employee's spendable weekly wages and the disability benefits the employee payable to the employee under AS 14.25.130, or AS 39.35.400 or 39.35.410 or the maximum compensation rate. The intent is that the combined workers' compensation and disability benefit should not exceed the employee's after tax wages, and that an "off-set" is allowed for disability benefits against workers' compensation payments. The employee whose workers' compensation and disability benefit, combined, do not exceed his or her spendable weekly wages should continue to receive the workers' compensation to which the employee is otherwise entitled. For employees who are not receiving total disability compensation, but who are receiving benefits under AS 23.30.041(k), the employer's liability is limited to the lesser of the combination of the AS 23.30.041(k) benefit and disability benefits up to 80 percent of the employee's spendable wages or 105 percent of the state average weekly wage (i.e. AS 23.30.041(k) benefit). Thus, the disability benefit is off-set against the employer's liability for AS 23.30.041(k) benefits. Similar provisions are also included for employees who are eligible for disability benefits from an employer-contributed union or group insurance plan or welfare trust, if the benefit from the plan or trust does not make an off-set for workers' compensation benefits paid to the employee. The purpose of this provision is to eliminate the circumstance of employees receiving employer-funded disability benefits and workers' compensation, tax free, that together exceed what they would have received, after taxes, had they not been injured. This section does not limit the employee's benefits on account of private disability insurance or group disability insurance procured through other means (such as membership in trade or professional organizations) than those specified in this provision. This provision does not apply to death benefits.

Section 38 amends AS 23.30.240 to include members of limited liability companies in the catch line and replace the director of the division of workers' compensation for the commissioner as the person approving executive officer waivers.

Section 39 amends AS 23.30.240 to add a new subsection providing that members of limited liability companies are not employees, except at the affirmative election of the company, which must specify the member for the period of coverage. When the coverage lapses, the specified member's inclusion as an employee also lapses and must be affirmatively renewed by the company to continue.

Section 40 creates a new section, AS 23.30.249, relating to fraudulent acts or false or misleading statements in workers' compensation. Provisions for administrative reimbursement for benefits obtained through fraudulent acts or false or misleading statements, currently in AS 23.30.250(b), are moved to this section, and the standard of proof of fraudulent acts or false or misleading statements is clarified. In this amended committee substitute additional language was added to confirm that a person may be required to reimburse money paid to a provider, such as a physician or vocational rehabilitation specialist. The form of the statute conforms to modern usage, without other change in meaning.

This section also provides civil immunity for a person who furnishes information regarding fraud in good faith to law enforcement officials, the division, the division of insurance in the Department of Commerce, Community and Economic Development, or an insurer or risk manager of a self-insured employer. The immunity is not extended to those whose liability is the result of reckless, willful or intentional misconduct. In addition, an insurer, adjuster, or risk manager is required to report information about suspected fraud to the director, and is immune from civil liability for making such a report. The provision grants the director authority to investigate reports of fraud, and, if the director finds credible evidence of fraud, to refer the facts to a prosecutor and to the affected insurer. If the fraud was perpetrated against the division, the director may seek an order of forfeiture against the person, precluding the person from future benefits. The director's investigations are made confidential, unless a court directs public inspection. The director is given power to obtain information outside the state, through other state's officials, and to cooperate with officials outside the state. Definitions are provided of "fraudulent acts", which include actions by persons other than an employee.

Section 41 amends AS 23.30.250, relating to criminal and civil penalties for fraudulent acts or false or misleading statements, and administrative restitution. The amended committee substitute deletes the improvements provided by adding definitions and modernizing the language of subsec. (a) provided in the original SB 130 text. However, the amendments in this section provide additional clarification as to the persons subject to the civil and criminal actions in subsec. (a).

Section 42 amends AS 23.30.250(b) by repealing the current content of that statute, which is now substantially contained in AS 23.30.249(a), enacted in sec. 40 of this legislation, and reenacting it as a provision for allowing awards of compensatory damages. An amendment clarified the application of the provision to civil actions only and eliminated any suggestion of unconstitutional impairment of the right to trial by jury. The amendment also deleted an allowance of punitive damages.

Section 43 amends AS 23.30.260 to add a new subsec. (b) that provides that an attorney may charge up to \$300 for one-time only consultation with a claimant. This provision gives statutory authority for a regulation that presently exists allowing such fees.

Section 44 amends AS 23.30.395(17) to add a limitation on the definition of "injury" covered by the workers' compensation act. The amendment provides that, in cases in which the claimed injury is an aggravation, acceleration, or combination with a preexisting condition, the injury is not within the act unless the employment is "the major contributing cause" of the disability or need for medical treatment. The use of "the major contributing cause" is intended to reflect that as between two causes, the employment and a preexisting cause, the employment must be greater than the other preexisting cause. This is a change from current law, developed through Supreme Court decisions, that a covered injury includes aggravation, acceleration, or combination with a preexisting condition if the employment is "a substantial factor" in bringing about the disability. Thus, the current law requires, in a claim of aggravation of a preexisting condition, the employer to produce evidence that the other causes were the *exclusive* cause of the aggravated condition or evidence to *eliminate* the employment as a causal factor among others. This provision would, to some extent, reverse *DeYonge v. NANA/Marriott*, 1 P.3d 90 (Alaska 2000)⁸ and its predecessors. In addition,

⁸ Ms. DeYonge was hired in 1992 as a housekeeper on the North Slope. In March 1995, she told her supervisor her knees hurt, and she took leave from work due to knee pain several weeks later. She had had problems with her knees since the 1970's. Her physician and the employer's physician agreed she had degenerative conditions in her knees. The Board relied on the employer's physician, who stated her condition was not caused by her job. Her duties would have been a factor in increasing her symptoms, but not necessarily in either causing or making her condition progress any more rapidly. He felt that the impairment was not necessarily caused by her work as opposed to being merely pointed out by her work. The court held this opinion was insufficient to deny medical benefits and temporary total disability because "we only require that the employment cause a temporary increase in symptoms". *DeYonge v. NANA/Marriott*, 1 P.3d 90, 97 (Alaska 2000). The court also rejected the employer's argument that Ms.

the use of the disjunctive "or" reflects an intent that this rule be applied separately to the need for medical treatment and disability: the employment may be the major contributing factor in bringing about a need for medical treatment, but not be a major contributing factor in the disability or *vice versa*. This provision also coordinates with current AS 23.30.190(c), requiring reduction of permanent impairment compensation ratings by the permanent impairment that existed before the compensable injury.

Section 45 amends AS 23.30.395 to add new subsections defining attending physician, the director, department, commission commissioner, and division.

Section 46 amends AS 37.05.146(c) to include the workers' compensation benefit guaranty fund in the list of accounts within the general fund.

Section 47 amends AS 39.25.110 to include the chair of the commission in the exempt service.

Section 48 amends AS 39.25.120(c)(14) to remove a reference to the board and substitute the division as the employer of the rehabilitation administrator.

Section 49 amends AS 39.50.200(b)(31) to add the commissioner

Section 50 repeals AS 23.30.095(f), 23.30.095(l) and 23.30.095(m). The complete provisions of AS 23.30.095(l) and 23.30.095(m), and portions of AS 23.30.095(f), are now contained in new statutory section AS 23.30.097 (see sec. 27).

Section 51 repeals AS 23.30.097, enacted in sec. 27 of this legislation, effective June 30, 2007. All provisions regarding time for payment and regulation of the cost of medical treatment are included in this section.

Section 52 creates a new provision of uncodified law establishing a legislative task force on workers compensation, requiring a review of workers' compensation and insurance reform measures in other states, analysis of proposals for reform in Alaska, review of current benefits, costs, and compliance, and such other issues as the task force determines. The task force includes 11 members representative of the legislature and various "stakeholders" in the workers compensation system. The task force is directed to provide a report and

DeYonge's other activities caused the symptoms because the employer did not produce evidence the other activities were the *exclusive* cause of the aggravated condition or to *eliminate* the employment as a causal factor among others. *Id.* Under this legislation, Ms. DeYonge would still have the benefit of a presumption of compensability. However, instead of the employer having to eliminate employment as a substantial factor among others, the employer could overcome the presumption by evidence the employment was not "the major contributing cause."

proposed legislation to the president of the senate and speaker of the house of representatives by December 1, 2005.

- Section 53** creates a new provision of uncodified law that provides that the cap on rates paid to out of state claimants shall apply only to injuries occurring after the effective date of the provision establishing the cap.
- Section 54** creates a new provision of uncodified law setting the initial terms of the commission to achieve staggered terms as provided in AS 39.05.055.
- Section 55** creates a new provision of uncodified law permitting the director to lend staff temporarily to the commission for a period of six months after the effective date of the provision creating the commission.
- Section 56** creates a new provision of uncodified law that provides for continuation of effect notwithstanding a transfer of function from the board to the director or the institution of the commission as an appellate body for workers' compensation appeals. This provision also continues in force all regulations, orders, decisions, or certificates issued by the board until revoked, modified or vacated under the provisions of this bill; and continues in effect all contracts, rights, liabilities or obligations.
- Section 57** creates a new provision of uncodified law permitting the director of insurance in the Department of Community and Economic Development and Department of Labor and Workforce Development to proceed to adopt necessary regulations to implement this bill, but not before the effective date of the bill. It also permits the commission to adopt emergency regulations to implement this legislation.
- Section 58** creates a new provision of uncodified law directing the commissioner to appoint a medical services review committee pursuant to AS 23.30.095(j), as amended by this act, to make a study of provision of medical treatment and services, and the cost of such benefits, and to report its findings to the commissioner and the legislature to by the end of the first week of the Twenty-fifth Alaska State Legislature. This reflects a change from the original deadline of March 1, 2007.
- Section 59** provides that the "cap" on compensation paid to out-of-state recipients applies only to persons injured after the effective date of the section establishing the "cap."
- Section 60** provides an effective date of September 1, 2005, for the insurance provisions (secs. 1-4 of this bill), the cap on benefits paid out-of-state recipients, (sec. 34 of this bill), and the directive to appoint the medical services review committee, (sec. 58 of this bill).
- Section 61** provides an effective date of August 1, 2005 for all other provisions of the act.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

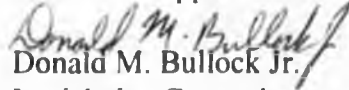
State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

May 5, 2005

SUBJECT: Date in Sec. 76 of HCS CSSB 130(L&C)
(Work Order No. 24-GS1112\S)

TO: Representative Tom Anderson
Attn: Josh Applebee

FROM: 
Donald M. Bullock Jr.
Legislative Counsel

Enclosed is the bill referred to above that includes the nine conceptual amendments added in your committee.

Please look at the date in sec. 76(b) of the bill. The date in version "L" was May 15, 2006. I changed the date in this version to December 1, 2005 to have the recommendations given to the task force approximately six weeks before the task force delivers its report to the legislature before the second session begins.

If this is not acceptable, please change the date in the next committee.

If I may be of further assistance, please advise.

DMB:lmb
05-172.lmb

Enclosure

Summary Comparison of CSSB 130(FIN) am and Draft HCS 5/1/05

The reforms in HB 180/SB 130 are aimed at lessening the threat to jobs and benefits caused by insurance premiums increasing at intolerable rates. The reforms are consistent with the oft-stated legislative intent of ensuring the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to their employers. The reforms address six major areas:

PROTECTING WORKERS' BENEFITS AND JOBS

Draft HCS CSSB 130(FIN) am

Sec. 25	Sec. 22	Empower the Division Director to immediately shut down an employer upon completion of an investigation confirming lack of required insurance. (Page 18)
Sec. 25	Sec. 22	Empower the Board to fine uninsured employers up to \$1,000/day/employee. (Pages 18-19)
Sec. 26	Sec. 23	Establish a Benefits Guaranty Fund to receive fines assessed against uninsured employers. Permit the Fund to use those fines to pay benefits to injured workers whose employers were uninsured and fail to pay. Authorize the Fund to pursue reimbursement from the uninsured employer. (Pages 19-20)
NO ?	Sec. 2	Protect benefits payments from an insurer's insolvency by requiring in-state deposits to back the insurer's loss reserves. (Page 3)
Sec. 1	Sec. 3	Release the deposits to the Alaska Insurance Guaranty Association, upon the insurer's insolvency, for payment of benefits to injured workers. (Pages 3-4)
Sec. 66	Sec. 52	Implement a thorough review of the workers' compensation system and potential reforms through appointment of a legislative task force. Task force report, including reform recommendations, due by December 1, 2005. (Pages 38-39)

Thirteen member task force (adds rep of AK Chiropractic Society and a rehabilitation specialist), report with recommendations due before December 1, 2006. Legislative administrative support staff to be appointed.

Summary Comparison of CSSB 130(FIN) am and Draft HCS 5/1/05

ADDITIONAL PROVISIONS IN DRAFT HCS

- Sec. 6 Board may authorize Commissioner's representatives to hear procedural, discovery, and stipulated matters without a Board hearing panel. (Pages 3-4)
- Sec. 24 Director may order suspected uninsured employer to stop work without investigation. (Page 12)
- DC* Sec. 31 Establishes a "medical rehabilitation caseworker" to assist injured worker in securing medical treatment. Board may appoint one at party's request at any time and must appoint after 60 days treatment. Board must develop list, appoint by rotation, notify parties, develop and enforce quality, effectiveness, and impartiality standards, receive written reports every 30 days. Caseworker may not interfere with treatment. (Pages 15-17) Sec. 61 "Caseworker" must be a registered nurse, certified rehabilitation counselor, or "equivalent" in Board regulation. (Page 31)
- ✓ Sec. 41 Persons owed compensation without a Board order also will receive any penalties for late payment. (Page 23)
- ✓ Sec. 42 Persons owed compensation under a Board order also will receive any penalties for late payment. (Page 23)
- ✓ Sec. 49 Employer need not make retroactive compensation rate adjustments if annual recalculation of state average weekly wage (due 12/1) done between 1/1 and 4/1 of following year. (Page 25)
- ✓ Sec. 51 Second Injury Fund phased out. (Like SB 130/HB 180). (Page 26)
- ✓ Sec. 52 Compensation rate calculations changed for: all workers paid by hour/day/output; workers in exclusively seasonal or temporary employment paid weekly or monthly, and minors, apprentices, and trainees. Changes are departures from Model Act provisions adopted in 1995 (with Ad Hoc Committee agreement to address Supreme Court invalidation of prior provisions) that were recently affirmed by Supreme Court. (Pages 26-28)
- Sec. 60 Division must establish anti-fraud section with not less than two full-time investigators, sufficient staff support, and a publicized, toll-free report number. (Page 31)
- Sec. 64 Attorney General must designate not less than one half attorney position for fraud prosecutions. (Page 32)

Amendments to HCS CSSB 130()
24-GS1112L

Conceptual Amendments 1 – 9

#1 – Rep. Kott

Page 4, Line 7 {insert from Y.A version page 5, line 22-23}

(n) The board may by regulation delegate authority to the director to assist the board in administering and enforcing this chapter.

#2 – Rep. Crawford

Page 12, Line 7 {see attached Amendment L.1 amended}

#3 – Rep. Kott

Page 16, Line 1 – Page 17, Line 26 Delete Section 31 in its entirety

#4 – Kott

See attached amendment as amended

#5 – Kott

See attached amendment

#6 – Kott

Page 36, Line 31

Delete: May 15, 2006 Insert: September 30, 2005

#7 – Kott – Withdrawn

New #7 – Kott

Page 35, Line 14

Delete: December 1, 2006

Insert: Prior to the first day of the start of the 2nd session of the 24th Alaska State Legislature.

#8 – Kott

Page 35, Line 15

Delete: 2007 Insert: 2006

#9 – Rokeberg

Page 7, Line 31

{insert from Y.A version Pg 12, Ln 31 –Pg 13, Ln 19
see attached}

24-GS1112V.1
Bullock
5/4/05

Concettual
AMENDMENT #2

OFFERED IN THE HOUSE

BY REPRESENTATIVE CRAWFORD

TO: HCS CSSB 130(), Draft Version "L"

1 Page 12, following line 7:

2 Insert a new bill section to read:

3 ****Sec. 24 AS 23.30.075 is amended by adding a new subsection to read:**

4 (c) An employer who fails to properly classify an employee for the purpose of
5 obtaining workers' compensation insurance or to furnish proof to the division of the
6 employer's financial ability to pay compensation directly fails to comply with the
7 requirements in (a) of this section."

Knowingly

8
9 ~~Renumber the following bill sections accordingly.~~

10
11 Page 33, line 29:

12 ~~Delete "sec. 60"~~

13 ~~Insert "sec. 61"~~

14
15 Page 35, line 22:

16 ~~Delete "sec. 47"~~

17 ~~Insert "sec. 48"~~

18
19 Page 35, line 23:

20 ~~Delete "sec. 47"~~

21 ~~Insert "sec. 48"~~

22
23 Page 36, line 19

CONCEPTUAL AMENDMENT #4

OFFERED IN THE HOUSE LABOR AND COMMERCE COMMITTEE

BY REPRESENTATIVE KOTT

TO: CSSB 130 Version L

Page 34, Line 6;
Delete, "and insurance"

Page 34, Lines 8-9;
Delete, "an analysis and assessment of proposals for workers' compensation and workers' compensation liability insurance reform in Alaska;
(3)"

Page 34, Line 10;
Delete, "benefits and"
Insert, "medical"

Page 34, Line 13;
Delete, "(4) a review of compliance with current Alaska workers' compensation laws;"
Insert, "(3) a review of the ACOM guidelines and effect in other states;"

Page 34, Line 14;
Delete, "(5)"
Insert, "(4)"

— medical guidelines including

Page 34, Line 16;
Insert, "(6) review of current Alaska, and other states', vocational rehabilitation, and return to work programs."

Page 34, Line 16;
Delete, "(6)"
Insert, "(7)"

CONCEPTUAL AMENDMENT #5

OFFERED IN THE HOUSE LABOR AND COMMERCE COMMITTEE

BY REPRESENTATIVE Kott

TO: CSSB 130 Version L

Page 35, Line 12;

Insert, "(4) The Task Force on Workers' Compensation shall contract with a consultant specializing in workers' compensation issues for the purpose of researching information and conducting a comparative analysis from other states on topics listed in section (a). Such information shall be presented to the Task Force on or before September 1, 2005.

Renumber subsections accordingly

AS 23.30.041 (c) is repealed & 24-GS112Y.A.
re-enacted to read!

(c) An employee and an employer may stipulate to the employee's eligibility for reemployment benefits at any time. If an employee suffers a compensable injury and, as a result of the injury, the employee is totally unable, for 45 consecutive days, to return to the employee's employment at the time of injury, the administrator shall notify the employee of the employee's rights under this section within 14 days after the 45th day. If the employee is totally unable to return to the employee's employment for 60 consecutive days as a result of the injury, the employee or employer may request an eligibility evaluation. The administrator may approve the request if the employee's injury may permanently preclude the employee's return to the employee's occupation at the time of the injury. If the employee is totally unable to return to the employee's employment at the time of the injury for 90 consecutive days as a result of the injury, the administrator shall, without a request, order an eligibility evaluation unless a stipulation of eligibility was submitted. If the administrator approves a request or orders an evaluation, the administrator shall, on a rotating and geographic basis, select a rehabilitation specialist from the list maintained under (b)(6) of this section to perform the eligibility evaluation. [the person that employs a rehabilitation specialist selected by the administrator to perform an eligibility evaluation under this subsection is performing any other work on the same workers' compensation claim involving the injured employee, the administrator shall select a different rehabilitation specialist.

(on
Amended
H9

* Sec. 14. AS 23.30.041(f) is amended to read:

- (f) An employee is not eligible for reemployment benefits if
 - (1) the employer offers employment within the employee's predicted post-injury physical capacities at a wage equivalent to at least the state minimum wage under AS 23.10.065 or 75 percent of the worker's gross hourly wages at the time of injury, whichever is greater, and the employer prepares the employee to be employable in other jobs that exist in the labor market;
 - (2) the employee previously declined the development of a reemployment benefits plan under (g) of this section, received a job dislocation benefit under (g)(2) of this section, and returned to work in the same or similar occupation in terms of physical demands required of the employee at the time of the previous injury;

PASSE 4-3

24-GS11120X L
Bullock
5/3/05

CONCEPTUAL
AMENDMENT #2

OFFERED IN THE HOUSE

BY REPRESENTATIVE CRAWFORD

TO: HCS CSSE 130(), Draft Version "X" L

1 Page 12, following line 5:

2 Insert a new bill section to read:

3 **** Sec. 24. AS 23.30.075 is amended by adding a new subsection to read:**

4 (c) An employer who fails to properly classify an employee for the purpose of
5 obtaining workers' compensation insurance or to furnish proof to the division of the
6 employer's financial ability to pay compensation directly fails to comply with the
7 requirements in (a) of this section."

Unlawfully
~~*Flagrantly*~~

Con. #3 Kott Adopt
UK

Delete Sect 31 in its entirety

~~Con #4 CRAWFORD~~

Con #6 Kott
AS 36 LW 31 Sept 30, 2005
Strike me!

Con Amend # 7
Page 37 Line 4-5

Kott
w/d

Del May 17, 2006
INS Spt 30, 2005

Page 35 Line 14 #7
BCI Dec
Change Date to Jan 1, 2006
prior to 1st day of start
2nd session at 24th legs

Pg 35 Line 15 #8 Kott
Terminate on ~~2006~~ 2006

See Attached #9 Rokeberg
adopted u/c

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION



Rev. 6/98

Central Microfilm Services
Department of Education & Early Development
State of Alaska

PAGES 4-3

24-GS11120X L
Bullock
5/3/05

CONCEPTUAL
AMENDMENT #2

OFFERED IN THE HOUSE

BY REPRESENTATIVE CRAWFORD

TO: HCS CSSB 130(), Draft Version "X" L

1 Page 12, following line 5:

2 Insert a new bill section to read:

3 **** Sec. 24. AS 23.30.075 is amended by adding a new subsection to read:**

4 (c) An employer who fails to properly classify an employee for the purpose of
5 obtaining workers' compensation insurance or to furnish proof to the division of the
6 employer's financial ability to pay compensation directly fails to comply with the
7 requirements in (a) of this section."

Knowingly
Flagrantly

Con. #3 Kott Adopt
UK

Delete Sect 31 in its Entirety

~~Con #4 CRAWFORD~~

Con #6 Kott
Pg 36 LW 31 Sept 30, 2005
Strike may.

Con Amend # 7
Page 37 Line 4-5

Kott
w/d

Del May 17, 2006
INS Spt 30, 2005

Page 35 Line 14 #7
BCI Dec
~~Change Date to Jan 1, 2006~~
prior to 1st day of 1st start
2nd session at 24th legs

Pg 35 Line 15 #8 Kott
Terminate on ~~2006~~ 2006

See Attached #9 Rokeberg
adopted u/c

Con Amend # 7
Page 37 Line 4-5

Kott
w/d

Del May 17, 2006
INS Sept 30, 2005

Page 35 Line 14 #7
BCI Dec
Change Date to Jan 1, 2006
prior to 1st day of start
2nd session of 24th leg

Pg 35 Line 15 #8 Kott
Terminate on ~~2006~~ 2006

See Attached #9 Rokeberg
adopted 4/c

CONCEL. AM. 8

PG. 35

LINE 15

DELETE 2007

INSERT 2006

ADOPTED

CONC.
AM. 9

SEC. ~~MAN~~

23.30.041 (c)

LINE 30

ADOPTED

MAR-29-04 03:59P

AM. 9

P. 09

WORK DRAFT

WORK DRAFT

24-GS11120

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

employers, employees, attorneys, training providers, and rehabilitation specialists of the reemployment program established in this subsection.

Sec. 14. AS 23.30.041(c) is repealed and reenacted to read:

(c) An employee and an employer may stipulate to the employee's eligibility for reemployment benefits at any time. If an employee suffers a compensable injury and, as a result of the injury, the employee is totally unable, for 45 consecutive days, to return to the employee's employment at the time of injury, the administrator shall notify the employee of the employee's rights under this section within 14 days after the 45th day. If the employee is totally unable to return to the employee's employment for 60 consecutive days as a result of the injury, the employee or employer may request an eligibility evaluation. The administrator may approve the request if the employee's injury may permanently preclude the employee's return to the employee's occupation at the time of the injury. ~~If the employee is totally unable to return to the employee's employment at the time of the injury for 90 consecutive days as a result of the injury,~~ the administrator shall, without a request, order an eligibility evaluation unless a stipulation of eligibility was submitted. If the administrator approves a request or orders an evaluation, the administrator shall, on a rotating and geographic basis, select a rehabilitation specialist from the list maintained under (b)(6) of this section to perform the eligibility evaluation.

Sec. 15. AS 23.30.041(f) is amended to read:

(f) An employee is not eligible for reemployment benefits if

(1) the employer offers employment within the employee's predicted post-injury physical capacities at a wage equivalent to at least the state minimum wage under AS 23.10.065 or 75 percent of the worker's gross hourly wages at the time of injury, whichever is greater, and the employer prepares the employee to be employable in other jobs that exist in the labor market;

(2) the employee previously declined the development of a reemployment benefits plan under (g) of this section, received a job dislocation benefit under (g)(2) of this section, and returned to work in the same or similar occupation in terms of physical demands required of the employee at the time of the previous injury;

SALE

1 (c) An employee and an employer may stipulate to the employee's eligibility
 2 for reemployment benefits at any time. If an employee suffers a compensable injury
 3 and, as a result of the injury, the employee is totally unable, for 45 consecutive days,
 4 to return to the employee's employment at the time of injury, the administrator shall
 5 notify the employee of the employee's rights under this section within 14 days after the
 6 45th day. If the employee is totally unable to return to the employee's employment for
 7 60 consecutive days as a result of the injury, the employee or employer may request an
 8 eligibility evaluation. The administrator may approve the request if the employee's
 9 injury may permanently preclude the employee's return to the employee's occupation
 10 at the time of the injury. If the employee is totally unable to return to the employee's
 11 employment at the time of the injury for 90 consecutive days as a result of the injury,
 12 the administrator shall, without a request, order an eligibility evaluation unless a
 13 stipulation of eligibility was submitted. If the administrator approves a request or
 14 orders an evaluation, the administrator shall, on a rotating and geographic basis, select
 15 a rehabilitation specialist from the list maintained under (b)(6) of this section to
 16 perform the eligibility evaluation. [If the person that employs a rehabilitation specialist
 17 selected by the administrator to perform an eligibility evaluation under this subsection
 18 is performing any other work on the same workers' compensation claim involving the
 19 injured employee, the administrator shall select a different rehabilitation specialist.]

20 * Sec. 14. AS 23.30.041(f) is amended to read:

- 21 (f) An employee is not eligible for reemployment benefits if
- 22 (1) the employer offers employment within the employee's predicted
 23 post-injury physical capacities at a wage equivalent to at least the state minimum wage
 24 under AS 23.10.065 or 75 percent of the worker's gross hourly wages at the time of
 25 injury, whichever is greater, and the employment prepares the employee to be
 26 employable in other jobs that exist in the labor market;
- 27 (2) the employee previously declined the development of a
 28 reemployment benefits plan under (g) of this section, received a job dislocation
 29 benefit under (g)(2) of this section, and returned to work in the same or similar
 30 occupation in terms of physical demands required of the employee at the time of
 31 the previous injury;

1 **(3)** the employee has been previously rehabilitated in a former
 2 worker's compensation claim and returned to work in the same or similar occupation
 3 in terms of physical demands required of the employee at the time of the previous
 4 injury; or

5 **(4)** [(3)] at the time of medical stability, no permanent impairment is
 6 identified or expected.

7 * Sec. 15. AS 23.30.041(g) is amended to read:

8 (g) Within **30** [15] days after the employee receives the administrator's
 9 notification of eligibility for benefits, an employee [WHO DESIRES TO USE THESE
 10 BENEFITS] shall give written notice under oath, on a form provided by the
 11 division, to the administrator and the employer of the employee's election to
 12 either use the reemployment benefits or to accept a job dislocation benefit under
 13 (2) of this subsection. The following apply to an election under this subsection:

14 **(1) an employee who elects to use the reemployment benefits also**
 15 **shall notify the** employer of the employee's selection of a rehabilitation specialist who
 16 shall provide a complete reemployment benefits plan; **failure** [. FAILURE] to give
 17 notice **of selection of a rehabilitation specialist** required by this **paragraph**
 18 [SUBSECTION] constitutes noncooperation under (n) of this section; **if** [. IF] the
 19 employer disagrees with the employee's choice of rehabilitation specialist to develop
 20 the plan and the disagreement cannot be resolved, then the administrator shall assign a
 21 rehabilitation specialist; **the** [. THE] employer and employee each have one right of
 22 refusal of a rehabilitation specialist;

23 **(2) an employee who elects to accept a job dislocation benefit in**
 24 **place of reemployment benefits and who has been given a permanent partial**
 25 **impairment rating by a physician shall be paid**

26 **(A) \$5,000 if the employee's permanent partial impairment**
 27 **rating is greater than zero and less than 15 percent;**

28 **(B) \$8,000 if the employee's permanent partial impairment**
 29 **rating is 15 percent or greater but less than 30 percent; or**

30 **(C) \$13,500 if the employee's permanent partial**
 31 **impairment rating is 30 percent or greater;**

CONCEPTUAL AMENDMENT

4

OFFERED IN THE HOUSE LABOR AND COMMERCE COMMITTEE
BY REPRESENTATIVE

KOTT

TO: CSSB 130

Page 34, Line 6;
Delete, "and insurance"

Page 34, Lines 8-9;
Delete, "an analysis and assessment of proposals for workers' compensation and workers' compensation liability insurance reform in Alaska;
(3)"

Page 34, Line 10;
Delete, "benefits and"
Insert, "medical"

Page 34, Line 13;
Delete, "(4) a review of compliance with current Alaska workers' compensation laws;"
Insert, "(3) a review of the ACOM guidelines and effect in other states;"

Page 34, Line 14;
Delete, "(5)"
Insert, "(4)"

medical guidelines including

Page 34, Line 16;
Insert, "(6) review of current Alaska, and other states', vocational rehabilitation and return to work programs."

Page 34, Line 16;
Delete, "(6)"
Insert, "(7)"

ADOPTED

CONCEPTUAL AMENDMENT

5

OFFERED IN THE HOUSE LABOR AND COMMERCE COMMITTEE
BY REPRESENTATIVE

KOTI

TO: CSSB 130

Page 35, Line 12;

Insert, "(4) The Task Force on Workers' Compensation shall contract with a consultant specializing in workers' compensation issues for the purpose of researching information and conducting a comparative analysis from other states on topics listed in section (a). Such information shall be presented to the Task Force on or before September 1, 2005.

Renumber subsections accordingly

ADOPTED

CONCEPT. AM. 6

PG. 36

LINE 31

INSERT SEP. 30, 2005
DELETE MAY 15, 2006

ADOPTED

CONC. AM. 7
ADOPTED LINE 14
PG 35
DELETE DEC. 1,
2006
INSERT PRIOR
TO THE FIRST
OF CONVENTION
THE OF THE
29 2006

Conceptual

#1 Kott

Page 4 Line 7

insert from Y.A version
from Pg 5 LN 22-23

(N) The board may by regulation delegate Authority
to the director to Assist the board in administering &
enforcing this chapter.

#2 CRAWFORD

Page 12 Line 7 see Attached

#3 Kott

Delete Sect 31

page 16 line 1 - Pg 17 Line 26

#4 Kott

see Attached

#5 Kott

#6 Kott

Pg 36 line 31

Delete May 15, 2006

insert Sept 30, 2005

#7 Kott

with drawn

~~Pg 37~~

NEW

#~~8~~ 7 Kott

Pg 35 LN 14

Del Doc. 1, 2006
INS Prior to first
day of start of 2nd Session
of 24th Legislature

Kott

#8

Page 35 Line ~~15~~¹⁵ Delete 200~~0~~⁷
JMS 2006

#9

Rokeberg See Attached
insert language from Y.A version

Page 12 Line 31 - Page 13 Line 19
~~19~~

1 members each sitting for the third judicial district, and one panel of three members
 2 that may sit in any judicial district. Each panel must include the commissioner of
 3 labor and workforce development or a hearing officer designated to represent [THE
 4 DESIGNATED REPRESENTATIVE OF] the commissioner, a representative of
 5 industry, and a representative of labor. The latter two members of each panel shall be
 6 appointed by the governor and are subject to confirmation by a majority of the
 7 members of the legislature in joint session. The board shall by regulation provide
 8 procedures to avoid conflicts and the appearance of impropriety in hearings.

9 * Sec. 7. AS 23.30.005(b) is amended to read:

10 (b) The commissioner shall act as chair [CHAIRMAN] and executive officer
 11 of the board and chair [CHAIRMAN] of each panel. The commissioner may
 12 designate a representative to act for the commissioner as chair and executive
 13 officer of the board. The commissioner may designate hearing officers to serve as
 14 chairs of panels for hearing claims [IF THE COMMISSIONER DESIGNATES A
 15 REPRESENTATIVE TO ACT FOR THE COMMISSIONER, THE
 16 REPRESENTATIVE SHALL SERVE IN THAT CAPACITY ON THE BOARD
 17 AND ON EACH PANEL].

18 * Sec. 8. AS 23.30.005 is amended by adding new subsections to read:

19 (m) The department may, in its discretion, contract with a nonprofit
 20 organization to provide information services and legal representation to employees in
 21 proceedings under this chapter.

22 (n) The board may by regulation delegate authority to the director to assist the
 23 board in administering and enforcing this chapter.

24 * Sec. 9. AS 23.30 is amended by adding new sections to read:

25 **Sec. 23.30.007. Workers' Compensation Appeals Commission.** (a) There
 26 is established in the Department of Labor and Workforce Development the Workers'
 27 Compensation Appeals Commission. The commission has jurisdiction to hear appeals
 28 from final decisions and orders of the board under this chapter. Jurisdiction of the
 29 commission is limited to administrative appeals arising under this chapter.

30 (b) The commission consists of five members appointed by the governor and
 31 confirmed by a majority of the members of the legislature in joint session. The

1 members shall be appointed as follows:

2 (1) a member appointed as chair who meets the requirements of (c)(2)
3 of this section;

4 (2) two members who, because of their employment or affiliations,
5 may be classified as a representative of employees covered by this chapter;

6 (3) two members who, because of their employment or affiliations,
7 may be classified as a representative of employers covered by this chapter.

8 (c) To be eligible for appointment under this section

9 (1) the member must

10 (A) be a citizen of the United States;

11 (B) be a resident of the state for the five years preceding the
12 appointment; and

13 (C) have not been convicted of either a

14 (i) felony; or

15 (ii) misdemeanor related to workers' compensation;

16 (2) the chair must

17 (A) meet the criteria specified in (1) of this subsection;

18 (B) be licensed to practice law in this state and be a member in
19 good standing with the Alaska Bar Association; and

20 (C) have engaged in the active practice of law for at least five
21 years with experience in workers' compensation in this state.

22 (d) A member may act and receive compensation under this section from the
23 date of appointment until confirmation or rejection by the legislature.

24 (e) The term of service on the commission is five years. A member may be
25 reappointed so long as the reappointment complies with the provisions of this section.

26 (f) The chair of the commission is in the exempt service under AS 39.25.110
27 and shall receive a monthly salary that is not less than Step A nor more than Step F of
28 Range 27 of the salary schedule in AS 39.27.011(a) for Anchorage, Alaska.

29 (g) A vacancy arising in the commission shall be filled by appointment by the
30 governor and confirmed by a majority of the members of the legislature in joint
31 session. Except as provided in AS 39.05.080(4), an appointee selected to fill a

24-GS1120X L
Bullock
5/3/05

CONCEPTUAL
AMENDMENT 2

OFFERED IN THE HOUSE

BY REPRESENTATIVE CRAWFORD

TO: HCS CSSB 130(), Draft Version "X" L

1 Page 12, following line 5:

2 Insert a new bill section to read:

3 **KNOWINGLY**
PROGNOTH
4 **** Sec. 24. AS 23.30.075 is amended by adding a new subsection to read:**

5 (c) An employer who fails to properly classify an employee for the purpose of
6 obtaining workers' compensation insurance or to furnish proof to the division of the
7 employer's financial ability to pay compensation directly fails to comply with the
8 requirements in (a) of this section."

N III
Y IIII

ADOPTED

CONCEPTUAL AM #3 KOTI

ADOPTED

DELETE
SEC. 31

24-LS0637R.1
Craver
5/3/05

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE ANDERSON

TO: HCS CSSB 141(FIN)

1 Page 67, line 30, following "AS 39.35.095 - 39.35.680":

2 Insert "However, AS 39.35.095 - 39.35.680 apply to a peace officer or fire fighter first
3 hired on or after July 1, 2005."

4
5 Page 84, line 30, following "AS 39.35.940.":

6 Insert "AS 39.35.700 - 39.35.990 do not apply to a peace officer or fire fighter first
7 hired on or after July 1, 2005. Under AS 39.35.095, AS 39.35.095 - 39.35.680 apply to those
8 members."

9
10 Page 96, line 12 - 14:

11 Delete all material and insert:

12 "(1) the member has at least 30 years of membership service; or"

13
14 Page 96, line 30, through page 97, line 1:

15 Delete all material and insert:

16 "(1) a member with at least 30 years of membership service and who
17 retires directly from the plan;"

18
19 Page 100, line 9:

20 Delete "(j)"

21 Insert "(h)"

22
23 Page 101, lines 12 - 22:

24-LS0637R.1

1 Delete all material.

2

3 Reletter the following subsections accordingly.

4

5 Page 103, lines 1 - 6:

6 Delete "The monthly survivor's pension in (b) of this section for survivors of
7 employees who were not peace officers or fire fighters is 40 percent of the employee's
8 monthly compensation in the month in which the employee dies. The monthly survivor's
9 pension in (b) of this section for survivors of employees who were peace officers or fire
10 fighters is 50 percent of the monthly compensation in the month in which the employee dies."

11 Insert "The monthly survivor's pension in (b) of this section for survivors of
12 employees is 40 percent of the employee's monthly compensation in the month in which the
13 employee dies."

24-GS11121X L
Bullock
5/3/05

CONCEPTUAL
AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE CRAWFORD

TO: HCS CSSB 130(), Draft Version "X" L

1 Page 12, following line 5:

2 Insert a new bill section to read:

3 **** Sec. 24. AS 23.30.075 is amended by adding a new subsection to read:**

4 (c) An employer who fails to properly classify an employee for the purpose of
5 obtaining workers' compensation insurance or to furnish proof to the division of the
6 employer's financial ability to pay compensation directly fails to comply with the
7 requirements in (a) of this section."

24-GS1112VX L
Bullock
5/3/05

CONCEPTUAL
AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE CRAWFORD

TO: HCS CSSB 130(), Draft Version "X" L

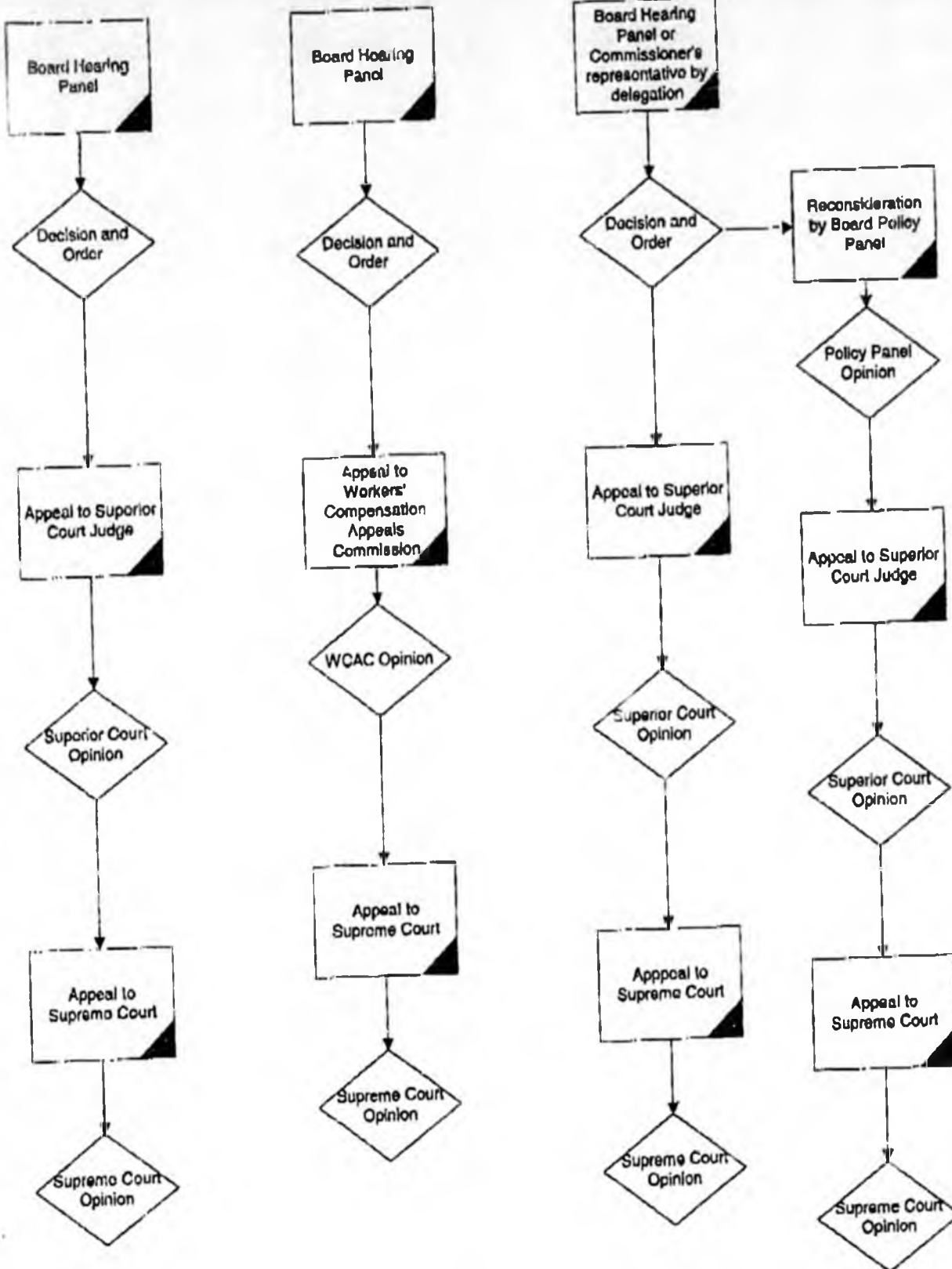
1 Page 12, following line 5:

2 Insert a new bill section to read:

3 **** Sec. 24. AS 23.30.075 is amended by adding a new subsection to read:**

4 (c) An employer who fails to properly classify an employee for the purpose of
5 obtaining workers' compensation insurance or to furnish proof to the division of the
6 employer's financial ability to pay compensation directly fails to comply with the
7 requirements in (a) of this section."
8

Comparison of AWCA, HB 180, Ad Hoc Committee recommendations



Current System

HB 180

Ad Hoc Committee

Topical Comparison of Governor's 2005 Workers' Compensation Reform Bill and Ad Hoc Committee Bill

HB 180

Protecting Rights of Employees and Employers

- Division may petition Board to order uninsured employer to stop work.
- After investigation Department representative may request Director to order uninsured employer to stop work.
- Board may assess fines up to \$1,000/day/employee against uninsured employer and Director may seek enforcement of fines in Court.
- Workers' Compensation Benefits Guaranty Fund established to receive uninsured employer fines.
- Injured worker may seek payment from Fund when uninsured employer fails to pay benefits.
- Broadened Board-level anti-fraud provisions.
- Improved criminal anti-fraud provisions.
- Limited Liability Company members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy.
- Coordination of disability and workers' compensation benefits.

Fairness to Alaska Resident Workers

- Non-resident compensation may not exceed that paid to Alaska residents.
- COLA studies every three years

Modernizing Return to Work Incentives

- Second Injury Fund wind down, no new claims accepted after September 1, 2005.
- All current claims continue to be paid, SIF closed out when Commissioner certifies to Lt. Governor that all SIF claims paid off.

Ad Hoc Bill

Protecting Rights of Employees and Employers

- Division may petition Board to order uninsured employer to stop work.
- After investigation Department representative may request Director to order uninsured employer to stop work.
- Board may assess fines up to \$1,000/day/employee against uninsured employer and Director may seek enforcement of fines in Court.
- No provision.
- No provision.
- Broadened Board-level anti-fraud provisions.
- Improved criminal anti-fraud provisions.
- Limited Liability Company members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy.
- No provision.

Fairness to Alaska Resident Workers

- Non-resident compensation may not exceed that paid to Alaska residents.
- COLA studies every three years.

Modernizing Return to Work Incentives

- Second Injury Fund wind down, no new claims accepted after July 1, 2005.
- All current claims continue to be paid, SIF closed out when all existing SIF claims paid off.

Topical Comparison of Governor's 2005 Workers' Compensation Reform Bill and Ad Hoc Committee Bill

Balancing Privacy and Discovery Rights

- Injury report must include release for medical records for the injury or death.
- Medical/rehabilitation records confidential when held by Division or Appeals Commission.
- Division may not assemble or provide individual records for commercial purposes.

Insurance Improvements

- In-state deposits to collateralize insurers' loss costs.
- Insurance Director may release deposits to Guaranty Association if insurer becomes insolvent.
- Reciprocal insurers exempt from assigned risk pool obligation.

Speeding and Improving Dispute Resolution

- DOL&WD may contract with non-profit organizations to provide information/representation to employees.
- Mandate use of "hearing officer."
- Mandate Board conflict of interest regulations.
- Board credibility findings must be supported by specific findings.
- Settlement forms prescribed by Director, filed with Division.
- Most settlement agreements effective upon filing.
- Claimants who are minors, incompetent, or not represented by Alaska-licensed attorney must have settlement agreements approved by Board.
- One-time attorney consultation fee up to \$300 payable without Board approval.

Balancing Privacy and Discovery Rights

- No provision.
- Medical/rehabilitation records confidential when held by Board.
- Individually identifiable information not public records.

Insurance Improvements

- In-state deposits equal basic capital/required surplus.
- Insurance Director may request release of deposits to Guaranty Association if insurer becomes insolvent.
- No provision.

Speeding and Improving Dispute Resolution

- No provision.
- Add three Board hearing panels.
- No provision.
- No provision.
- No provision.
- Limited issues heard by designated representative alone.
- No provision.
- No provision.
- All claimants must have settlement agreements approved by Board.
- One-time attorney consultation fee up to \$300 payable without Board approval.

Topical Comparison of Governor's 2005 Workers' Compensation Reform Bill and Ad Hoc Committee Bill

Reemployment Benefits Improvements

- Director hires Reemployment Benefits Administrator (RBA) and authorizes staffing.
- Parties may stipulate to injured worker's reemployment benefits eligibility.
- 45 continuous days off work require RBA to inform worker of rights.
- After 60 continuous days off worker or employer may request benefits eligibility evaluation.
- After 90 continuous days off RBA must order evaluation absent an eligibility stipulation.
- Worker ineligible for reemployment benefits if previously declined reemployment benefits, received cash job dislocation benefit, and then returned to work in occupation having physical demands similar to those at time of injury job.
- Within 15 days after determination of eligibility, worker must elect to use reemployment benefits or decline them and accept cash job dislocation benefit of \$5,000 (0-14% PPI), \$8,000 (15-29% PPI), or \$13,500 (30% or greater PPI).
- Director picks date for implementing use of new SCODRDOT within 90-days already required by Act.
- Director prescribes reemployment benefits waiver form then filed with and served by Division.

Controlling Health Benefits Costs

- Commissioner required to appoint medical services review committee.
- Medical services review committee report to Commissioner no later than March 1, 2007.
- Require use of generic drugs unless brand medically justified.

Reemployment Benefits Improvements

- Director hires Reemployment Benefits Administrator (RBA) and authorizes staffing.
- Parties may stipulate to injured worker's reemployment benefits eligibility.
- No provision.
- §041(k) compensation paid during reemployment process.
- ~~No~~ provision.
- Wages earned offset during reemployment process.
- No provision.
- PPD/PPI lump sum offset before §041(k) compensation paid.
- No provision.
- No provision.
- Director picks date for implementing use of new SCODRDOT within 90-days already required by Act.
- No provision.
- Revised remunerative employability rate calculation.

Controlling Health Benefits Costs

- Director may appoint medical services review committee.
- No provision.
- Require use of generic drugs unless brand medically justified.

Topical Comparison of Governor's 2005 Workers' Compensation Reform Bill and Ad Hoc Committee Bill

- Department required to establish a preferred drug list.
- American College of Occupational and Environmental Medicine (ACOEM) medical treatment guidelines adopted.
- Treatment under guidelines presumed correct subject to rebuttal by preponderance of scientific evidence.
- Board must adopt other recognized national guidelines for injuries not covered by ACOEM guidelines.
- Medical fee payments may not exceed lesser of usual, customary and reasonable (UCR) rate effective December 15, 1999 or any rate negotiated by the employer.
- Employer may establish a preferred provider list but worker not required to use listed providers and list must clearly so state.
- Employers may negotiate rates with providers.
- A worker still may not be required to pay a fee or charge for treatment provided under Act.

Appeal Process Improvements

- Workers' Compensation Appeals Commission established, decisions are legal precedent.
- Director may appeal if party unrepresented and unsettled question of law.
- Appeals generally based on written record and arguments without new evidence.
- Evidence allowed on stays, attorney's fees/costs, fee waivers, dismissal for failure to prosecute or settlement of appeal.
- Review de novo of legal conclusions and factual findings.
- Commission decision due within 90 days of record closure.
- Decisions appealable to Supreme Court, factual findings reviewed for substantial evidence.

- Advisory Committee helps adopt preferred drug list.
- No provision.
- No provision.
- No provision.
- Worker finds billing discrepancy, gets 25% of recovery.
- Medical fee payments may not exceed lesser of usual, customary and reasonable (UCR) calculated annually, rate paid by general public, or employer-negotiated rate.
- Employer may establish a preferred provider list but worker not required to use listed providers and list must clearly so state.
- Employers may negotiate rates with providers.
- A worker still may not be required to pay a fee or charge for treatment provided under Act.

Appeal Process Improvements

- Policy Panel established within Workers' Compensation Board, decisions are legal precedent.
- No provision.
- No provision.
- No provision.
- Policy Panel reconsiders hearing panel decisions. Hearing panel decisions may still be appealed to Superior Court.
- Review de novo only legal conclusions not factual findings.
- Panel decision due 90 days after hearing panel decision.
- Decisions appealable to Superior Court, factual findings reviewed for substantial evidence, then Supreme Court.

Topical Comparison of Governor's 2005 Workers' Compensation Reform Bill and Ad Hoc Committee Bill

Administrative Improvements

- Board may delegate its administrative authority to Director by regulation.

Administrative Improvements

- Numerous administrative provisions for notices, claims, reports, and similar documents to be filed with, retained by, or served by the Workers' Compensation Board redelegated to the Director, Division, or Department.

Compensation Rate Methodology

- Compensation rate calculation methods revised for workers paid by day/hour/output, seasonal/temporary work, and minors/apprentices/trainees.

HB 180

Ad Hoc Proposal

	Sec 1: Provides legislative intent to reform Workers' Compensation and to reduce overall cost of Workers' Compensation premiums.	Sec 1: Provides legislative intent to reform Workers' Compensation, give affected parties a voice on the AK Insurance Guaranty Association and reduce overall cost of Workers' Compensation premiums.
21.09.090(e) & (f)	Sec 2: Establishes an in-state deposit, for all insurers of workers' compensation in the state, to collateralize insurers' loss costs	Sec. 2: Establishes an in-state deposit equal to basic capital or required surplus for all insurers of workers' compensation in the state. Allows the Director of Insurance to release those deposits to Guaranty Association if insurer becomes insolvent.
21.24.130(f)	Sec. 3: Insurance Director may release deposits to Guaranty Association if insurer becomes insolvent	
21.39.155(a)	Sec. 4: Exempts all reciprocal insurers from assigned risk pool participation	
21.24.130(d)		Sec. 3: Exempts deposits, subject to the Guaranty Association, from requirement to yield assets to insolvent insurer's conservator.
21.80.050(a)		Sec. 4: Expands Insurance Guaranty Association board membership from 2 public members and 2-7 insurer members to 9 members – 4 representing insurers, 2 each representing labor and employers and 1 member representing licensees.
23.05.067(a)	Sec. 5: Service fee, delete reference to Second Injury Fund (SIF) contributions	Sec. 5: Service fee, refer to Division rather than Board
23.30.001	Sec. 6: Intent language, workers' compensation provisions.	
23.30.005(a)	Sec. 7: Replace designated representative with "hearing officer," mandate Board conflict of interest regulations.	Sec. 6: Adds three additional hearing panels to the Workers' Compensation Board.
23.30.005(b)	Sec. 8: Commissioner's representative chairs full Board meetings, hearing officers chair hearing panels	
23.30.005(f)		Sec. 7: Clarifies Panel quorum acts as full board 'on claims heard'
23.30.005(h)		Sec. 8: Allows department to adopt regulations to allow procedural, discovery, and stipulated matters to be heard by Commissioner's representative instead of Board hearing panel.
23.30.005(m) & (n)	Sec. 9: DOL&WD may contract with non-profit to provide information/representation to employees, Board may delegate its authority to Director	

P. 07

FAX NO. 9074652700

MAR-30-2005 WED 12:20 PM Commissioner Labor

HB 180

Ad Hoc Proposal

P. 08
FAX NO. 9074652700
MAR-30-2005 WED 12:20 PM Commissioner Labor

23.30.007 - 009	Sec. 10: Create Workers' Compensation Appeals Commission. 5 members to be appointed by Governor, approved by Legislature; members must be Alaskan attorneys with at least 5 years of Alaskan workers' compensation experience. Members will receive \$200 per day. Appeals Commission will hear workers' compensation appeals in lieu of the Superior Court.	
23.30.012	Sec. 11: Settlement forms prescribed by Director, filed with Division, some agreements not effective upon filing. Claimants who are minors, incompetent, or not represented by Alaska-licensed attorney must have settlement agreements approved by Board	
23.30.015	Sec. 12: (e) Distribution of third-party recovery, delete SIF contributions reference	Sec. 9: (j) Notice of third-party lawsuit filed with Division rather than Board
23.30.025(a)		Sec. 10: Insurer policy form filed with Division rather than Board
23.30.030(5)		Sec. 11: Insurer policy cancellation notice filed with Division rather than Board.
23.30.040(a)		Sec. 12: Second Injury Fund (SIF) administered by Director rather than Board
23.30.040(d)		Sec. 13: Again, transfers authority from Board to Director for refunding SIF payments
23.30.041(a)	Sec. 13: Has Director hire Reemployment Benefits Administrator (RBA) and authorize staffing rather than Board	Sec. 14: Allows Director to hire Reemployment Benefits Administrator (RBA) and authorize staffing rather than the Board.
23.30.041(c)	Sec. 14: Parties may stipulate to injured worker's reemployment benefits eligibility. After 45 continuous days off work requires RBA to inform worker of rights. After 60 continuous days off either worker or employer may request benefits eligibility evaluation. After 90 continuous days off work RBA must order an evaluation absent an eligibility stipulation.	Sec. 15: Allows employer and employee to stipulate to injured worker's eligibility for reemployment benefits.
23.30.041(f)	Sec. 15: Adds wording stating worker is ineligible for reemployment benefits if previously declined reemployment benefits, received cash job dislocation benefit and then returned to work in occupation having physical demands similar to those at time of previous injury.	

HB 180

Ad Hoc Proposal

P. 09

FAX NO. 9074652700

MAR-30-2005 WED 12:20 PM Commissioner Labor

23.30.041(g)	Sec. 16: Adds new language stating: within 15 days after determination of eligibility, worker must elect to use reemployment benefits or decline them and accept cash job dislocation benefit of \$5,000 (0-14% PPI), \$8,000 (15-29% PPI), or \$13,500 (30% or greater PPI)	
23.30.041(j)	Sec. 17: Syntax change.	
23.30.410(k)		Sec. 16: §041(k) compensation paid, and wages earned offset, during reemployment process. Lump sum PPD and PPI payments considered before §041 compensation paid
23.30.041(p)	Sec. 18: Gives authority to DOLWD to pick date for implementing use of new SCODRDOT within time frame required by law (formerly Board).	Sec. 17: Allows Director, rather than Board, to pick and announce date for implementing use of new SCODRDOT within the time frame required by law.
23.30.041(q)	Sec. 19: Director prescribes reemployment benefits waiver form then filed with and served by Division.	
23.30.041(r)		Sec. 18: Revises method for calculating remunerative employability rate
23.30.065		Sec. 19: Allows for Injury report requirements to be set by Division rather than Board.
23.30.070(a)		Sec. 20: Allows Injury report to be filed with Division rather than Board.
23.30.070(b)		Sec. 21: Allows additional reports to be filed with the Division and prescribed by Director rather than Board.
23.30.070(d)		Sec. 22: Allows reports to be mailed to Division rather than Board.
23.30.075		Sec. 23: Allows self-insurance documentation to be provided to Division and for the Division to provide self-insurance certificates rather than Board.
23.30.080(d)	Sec. 20: Division may petition Board to order uninsured employer to stop work	Sec. 24: Division may petition Board to order uninsured employer to stop work (formerly Board issued stop order)
23.30.080	Sec. 21: After investigation Department representative may request Director to order uninsured employer to stop work. Director can dissolve stop order upon evidence insurance has been secured, or petition Board to assess penalty. Board may assess fines up to \$1,000/day/ee against uninsured employer and Director may seek enforcement of fines in Court.	Sec. 25: After investigation Department representative may request Director to order uninsured employer to stop work. Director can dissolve stop order upon evidence insurance has been secured, or petition Board to assess penalty. Board may assess fines up to \$1,000/day/ee against uninsured employer and Division may seek enforcement of fines in Court.

HB 180

Ad Hoc Proposal

P. 10

FAX NO. 9074652700

MAR-30-2005 WED 12:21 PM Commissioner Labor

23.30.082	Sec. 22: Workers' Compensation Benefits Guaranty Fund established, worker may seek payment from Fund when uninsured employer fails to pay benefits	
23.30.085(a)		Sec. 26: Amends to allow Proof of insurance to be filed with Division in form prescribed by Director rather than Board
23.30.095(h)		Sec. 27: Allows Medical reports to be filed with Division rather than Board
23.30.095(j)	Sec. 23: Commissioner required to appoint medical services review committee. Report is due no later than March 1, 2007.	Sec. 28: Allows Medical services review committee to be appointed by Director rather than Board
23.30.095(i)		Sec. 29: Requires use of generic drugs unless brand medically justified
23.30.095(m)		Sec. 30: Establishes Medical policy advisory committee (consisting of 4 Board members, 2 medical professionals & WC director). Committee will assist Division to establish/administer preferred drug list, educate providers about Act, and administer return to work program
23.30.095	Sec. 24: New section requires use of generic drugs unless brand name is medically justified; Department is required to establish a preferred drug list. Sets the American College of Occupational and Environmental Medicine (ACOEM) medical treatment guidelines as the allowed treatment of injuries or illness. Treatment under these guidelines presumed correct subject to rebuttal by preponderance of scientific evidence. Board must adopt other recognized national guidelines for injuries not covered by ACOEM guidelines	
23.30.097	Sec. 25: Adds new section which states medical fee payments may not exceed lesser of usual, customary and reasonable (UCR) rate effective December 15, 1999 or any rate negotiated by the employer. Employer may establish a preferred provider list but worker not required to use listed providers and list must clearly so state. Employers may negotiate rates with providers, an employee may not be required to pay a fee or charge for treatment provided	Sec. 31: Medical fee payments regulated by Board, may not exceed lesser of annual usual, customary and reasonable (UCR) rate, charge to general public, or employer-negotiated rate. Opens law to allow employer to establish a preferred provider list, or to negotiate rates with providers. If employer uses a preferred provider list, worker is not required to use list. Other employee rights regarding obtaining treatment and use of providers remain. Requires copies of bills must be sent to employees. Employees finding billing errors are entitled to a 25% fee if discrepancy found is more than \$100 (less if insurer pursues repayment) and insurer did not note discrepancy.

HB 180

Ad Hoc Proposal

P. 11

FAX NO. 9074652700

MAR-30-2005 WED 12:21 PM Commissioner Labor

23.30.100(a)		Sec. 32: Allows for Notice of injury to be sent to Division rather than Board.
23.30.100(b)	Sec. 26: Adds authority for Injury report to include a release of medical records for the injury or death.	
23.30.100(c)		Sec. 33: Allows for Notice of injury to be submitted to Division office rather than Board
23.30.107	Sec. 27: Extends confidentiality of Medical/rehabilitation records to those held by Division or Commission.	Sec. 34: Allows for Discovery petitions to be filed with Division rather than Board. Expands confidentiality of division records to include individually identifiable information.
23.30.107	Sec. 28: Prohibits Division from assembling or providing individual records for commercial purposes	
23.30.122	Sec. 29: Gives Board sole power to determine credibility of witness testimony. Requires Board's determination of credibility must be supported by specific findings.	
23.30.125	Sec. 30: Effective date of Board decision, may be appealed to WC Appeals Commission, procedures for stay	
23.30.127	Sec. 31: Sets out procedures for appeals to WCA Commission. Allows Director to appeal if party is unrepresented and there is an unsettled question of law, appeal procedures, filing and transcript fees. Commission hearing panel composition, review de novo of legal conclusions and factual findings. Appeals generally based on written record and arguments without new evidence, evidence allowed on stays, attorney's fees/costs, fee waivers, dismissal for failure to prosecute or settlement of appeal. Commission decision due within 90 days of record closure, decisions appealable to Supreme Court, factual findings reviewed for substantial evidence	Sec. 35: Establishes a Workers' Compensation Board Policy Panel and defines procedures to reconsider hearing panel legal decisions using substitution of judgment standard. The Panel may not reconsider factual findings. Its opinions are binding legal precedent unless reversed by Supreme Court. Board hearing panels may still reconsider their own decisions.
23.30.140		Sec. 36: Allows Director to seek guardianship rather than Board
23.30.145		Sec. 37: Syntax change
23.30.155(a)		Sec. 38: Allows Director to prescribe controversy notice rather than Board.
23.30.155(c)		Sec. 39: Allows Director to prescribe compensation reports and for those reports to be filed with Division (formerly both directed by Board).

HB 180

Ad Hoc Proposal

P. 12

FAX NO. 9074652700

MAR-30-2005 WED 12:21 PM Commissioner Labor

23.30.155(d)		Sec. 40: Allows controversion notice to be filed with Division rather than Board; syntax change in attorney's fee provision.
23.30.155(e)		Sec. 41: Clarifies additional compensation "penalty" is payable to person owed compensation without an award rather than employee.
23.30.155(f)		Sec. 42: Clarifies additional compensation "penalty" is payable to person owed compensation under an award rather than employee
23.30.155(i)		Sec. 43: Allows Division to require deposit to secure payment rather than Board
23.30.155(k)		Sec. 44: Allows benefits receipts to be inspected by Director rather than Board.
23.30.155(m)		Sec. 45: Allows Annual reports to be filed on form prescribed by Director and filed with Division, rather than Board. Amends t allow penalty notification by Director rather than Commissioner.
23.30.155(o)		Sec. 46: Allows Director, rather than the Board to notify Division of Insurance of unfair or frivolous controversions.
23.30.175(b)	Sec. 32: Adds language restricting the maximum Non-resident compensation to that paid to Alaska residents.	Sec. 47: Adds language restricting the maximum Non-resident compensation to that paid to Alaska residents.
23.30.175(c)	Sec. 33: Allows for COLA studies every three years rather than annually.	Sec. 48: Allows for COLA studies every three years rather than annually.
23.30.180(a)		Sec. 49: Syntax change
23.30.190(d)		Sec. 50: Allows Director rather than Board to pick and announce date for implementing use of new AMA Guides (rating permanent impairment) within 90-day period allowed by law.
23.30.200(b)		Sec. 51: Syntax change
23.30.205(e)	Sec. 34: Allows SIF notifications to go to Director rather than Commissioner.	Sec. 53: Allows SIF notifications to go to Director rather than Commissioner
23.30.205(f)		Sec. 54: SIF claim notifications to Director rather than Commissioner
23.30.205	Sec. 35: SIF wind down, no new claims may be filed after September 1, 2005 or accepted after July 1, 2006	Sec. 52: SIF wind down, no new claims may be filed after July 1, 2005. Payments will be made on previously filed claims until SIF liabilities for claim are extinguished.

HB 180

Ad Hoc Proposal

P. 13

FAX NO. 9074652700

MAR-30-2005 WED 12:21 PM Commissioner Labor

23.30.220(a)		Sec. 55: Amends methods for compensation rate calculations for workers paid by day/hour/output, seasonal/temporary work, and for minors/apprentices/trainees
23.30.224	Sec. 36: Allows for coordination of employer sponsored disability and workers' compensation benefits	
23.30.240	Sec. 37: Allows Corporate officer waivers to be approved by Director (was Commissioner)	Sec. 56: Allows Corporate officer waivers to be approved by Director (was Commissioner). LLC members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy
23.30.240(b)	Sec. 38: Limited Liability Company (LLC) members not required to be covered but LLC may choose to include them in its workers' compensation liability insurance policy.	
23.30.247(c)	Sec. 39: Delete reference to SIF on employment questionnaires	
23.30.249	Sec. 40: Broadens Board-level anti-fraud provisions. Allows director to investigate fraudulent claims.	
23.30.250	Sec. 41: Improves criminal anti-fraud provisions	Sec. 57: Criminal anti-fraud provision broadened, Board-level anti-fraud provisions expanded to include providers, civil liabilities under both provisions include compensatory damages, punitive damages, and attorney's fees
23.30.260	Sec. 42: (b) One-time attorney consultation fee up to \$300 payable without Board approval	Sec. 58 & 59: Syntax change in unauthorized attorney's fee and solicitation provisions (b) (new) Allows one-time attorney consultation fee up to \$300 payable without Board approval
23.30.395	Sec. 43: Adds definitions for Commissioner, Department, Director and Division	Sec. 60: Adds definitions for Director and Division
37.05.146(c)	Sec. 44: Includes Workers' Compensation Benefits Guaranty Fund in Program Receipts list	
39.25.110	Sec. 45: Places Commission chair in exempt service	
39.25.120	Sec. 46: RBA continues in partially exempt service	Sec. 61: RBA continues in partially exempt service
39.50.200	Sec. 47: Requires Appeals Commission members to file financial disclosure forms	
Section 48	Repeals 23.30.095(f), 23.20.095(l), 23.30.095(m)	
Section 49	Repeals (delayed) 23.30.015(c), 23.30.040, 23.30.205, 23.30.395(27), 37.05.146(c)(12).	
Section 50	Sec. 32 (23.30.175(b) amendment) applicable to injuries on/after effective date	Sec. 62: Sec. 32 (23.30.175(b) amendment) applicable to injuries on/after effective date

HB 180

Ad Hoc Proposal

P. 14

FAX NO. 9074652700

Section 51	Transition, initial Commission members get staggered appointments under AS 39.05.055	Sec. 63: Transition, initial Commission members get staggered appointments
Section 52	Transition, Division staff may be assigned to Commission for six months	
Section 53	Transition, ongoing activities continued and completed, determinations remain in effect	
Section 54	Transition, DOL&WD, DCCED, and Commission regulations	
Section 55	Transfer of SIF balance upon final repeal	
Section 56	Transition, medical services review committee report to Commissioner no later than March 1, 2007.	
Section 57	Sec. 54(a) (regulations) effective immediately under AS 01.10.070(c).	
Section 58	Sec. 1-4, 32, 56 effective September 1, 2005	
Section 59	Sec. 5, 12, 39, 49, 55 (SIF) effective upon Commissioner certification to Lt. Governor that all SIF claims paid off	
Section 60	Except as provided in Sec. 57-59, Act effective August 1, 2005	Sec. 64: Act takes effect July 1, 2005

MAR-30-2005 WED 12:21 PM Commissioner Labor

Senate Bill & House Bill 130 and 180

My testimony is that the Alaska Injured Workers Alliance does not support these bills for a number of reasons.

Medical Costs:

Asking for a roll back of rates will only lead to a bigger shortage of physicians available to treat injured workers. We are also not addressing the problems with the fee schedule. According to Engenix (the fee schedule holder) they have only sold approximately 2,000 fee schedules for the state of Alaska. Some of the health care providers that we surveyed a. hold a fee schedule and b. regularly have their bills reduced below the rates set out in the fee schedule. This would mean that globally if insurance review audit companies are reducing the payments, there is no clear idea of how much each company is saving on medical costs. What it does reveal to us is that medical costs are already being cut. It also tells us that not only are insurance companies saving money, but they are providing little information on what those savings may be. We also have no enforcement of the current fee schedule. It would appear that there is more cost shifting here than enforcement of the current fee schedule. We need reliable data and information to address the medical costs.

Medical Benefits:

We do not believe that a preferred provider list or a drug list would be appropriate for workers compensation. This further limits care and drugs injured workers could potentially receive. Insurance companies now have control over what they are willing to pay for. The current law does not provide for pre-authorization of services, and pushing list of providers and drugs would further complicate an already complex process. Equally, injured employees would like to suggest that employers be held to a IME provider list. Injured Workers would like to see only one doctor at a time unless a referral is provided. Right now injured workers are subjected to doctor panels paid for by employers.

Adjudication:

We do not feel that the proposed legislation would better serve injured workers or employers. There is currently no education process to explain how they should participate in the adjudication process. Complex changes as proposed will in our view increase appeals, and the time delay appears to be about the same. Additionally we do not feel that an over-panel should have authority to set precedence over the superior and supreme courts. The balance must be restored to the impartial process to create a fair chance for all parties. We feel that giving a lot of power to an unbalanced board or division is wrong.

Retraining Benefits:

We believe that a clear re-training process that provides results for injured workers would be of greater benefit than that of the proposed bill. Injured workers know little or nothing about retraining and this will add more red tape and confusion to a complex part of benefits available to injured workers. Workers need to understand and not guess about the benefits that they need.

Overall:

We know that all personnel in the division have little or no training on the complex hearings process, the Workers Compensation Act, and little or no medical training. Yet, they must make complex decisions based on information that is available to them. We need to encourage training for all staff, make benefits more clear and base rate increases on tangible, factual data. We do not need to make sacrifices for the sake of expediency, but need to make informed changes based on facts. We have little or no information on the complex mess on medical costs, rehabilitation retraining benefits and know that the hearings process is far from impartial. We don't want to jump in to a series of changes that make the process more complex and harder than the last time.

Legal council will not become more available until defense cost is fully reported. Plaintiff attorneys are making approximately .50 on the dollar while defense attorneys get dollar for dollar what they bill for. Why not drop defense costs to match that of injured workers to contain costs?

Insurance Premiums should be frozen until we can figure the mess out so that employers are not overcharged for insurance products.

Hiring advocates in theory is a good thing but who would want the job. Legal Services is a non-profit and the Alaska Pro-Bono programs are not geared for workers' compensation. At minimum, it could potentially take up to two years for them to get the nuances of the program as well as procedures and practices. We urge you to not pass this bill. The bill could create an even bigger mess than we currently have.

Thank you
Barbara Williams
Alaska Injured Workers Alliance
P. O. Box 101093
Anchorage, Alaska 99510

Research Contributions
Alaska Legislative Audit 07-4601-00

Alaska Hearing Officers Manual for Administrative Hearings

Richard Fineburg Report 1-21-1980

Survey Anchorage, Mat-Su Healthcare providers

Survey: Engenix

Survey: Concerta, Bunch and Associates, Corvell, AIG Claims Services

Your immediate response is greatly appreciated



Preferred Medical Claim Solutions L.L.C.

Assignment Letter Agreement

Regina

Date: November 22, 2004 Client: Risk and Benefit Management Services
 Provider: Community Chiropractic Clinic
 Phone #: (907) 222-2100 Fax #: (907) 222-2131
 Attn: Office Manager E-mail: _____

Patient Name	Patient ID#	Dates of Service	Total Billed	Allowable Amount	Adjusted Amount
		11/15/2004			

2090

This Assignment Letter Agreement ("Agreement") outlines Provider's (You or Your) willingness to accept the following terms relating to the above claim:

- 1) You agree to accept the Adjusted Amount on the above claim.
- 2) In consideration, You will receive payment of Adjusted Amount, less patient co-pay, co-insurance and deductible amounts within 12-15 working days, from the date this document is received in the office of PMCS.
- 3) You agree not to balance bill the payor, administrator, and/or patient for the difference between the Allowable Amount and the Adjusted Amount in accordance with the terms of the agreement.
- 4) You assign to PMCS or its assigns all sums due from the payor for the above referenced claim only and authorize PMCS to deposit checks or instruments received in payment of the assigned claim.
- 5) You agree that if payments due to PMCS under this Agreement are inadvertently forwarded to You by payor, such payment will immediately be sent to PMCS.
- 6) If for any reason any claim is deemed ineligible or benefits were improperly determined, upon written notice, you agree that any payments made by PMCS under this agreement for any claim will be immediately reimbursed to PMCS.

Please sign below and return a faxed copy to my attention at 877-768-1969.

Upon receipt of this executed document, this claim will be processed and a check with Explanation of Payment (E.O.P.) will be forwarded to your patient accounts department at the address shown on the original claim.

I have the authority to accept the provisions outlined in this agreement; and further provide PMCS the assurance that proceeds associated with this claim have not been previously assigned to any other individual or organization.

Signature

Date

Printed Name

E-Mail

Thank you for your time and consideration. We look forward to working with you in the near future.

If you have any questions, please contact me toll free at 877-768-1968.

Sincerely,

Christopher Simmon

Christopher Simmon
Regional Claims Manager

<p>PMCS OFFICE USE</p> <p>Payment must be received by:</p> <p>/ /</p>
--

Confirmation # 1018449



Preferred Medical Claim Solutions L.L.C.

Assignment Letter Agreement

Date: November 22, 2004 Client: Risk and Benefit Management Services
 Provider: Community Chiropractic Clinic
 Phone #: (907) 222-2100 Fax #: (907) 222-2131
 Attn: Office Manager E-mail: _____

Patient Name	Patient ID#	Dates of Service	Total Billed	Allowable Amount	Adjusted Amount

This Assignment Letter Agreement ("Agreement") outlines Provider's (You or Your) willingness to accept the following terms relating to the above claim:

- 1) You agree to accept the Adjusted Amount on the above claim.
- 2) In consideration, You will receive payment of Adjusted Amount, less patient co-pay, co-insurance and deductible amounts within 12-15 working days, from the date this document is received in the office of PMCS.
- 3) You agree not to balance bill the payor, administrator, and/or patient for the difference between the Allowable Amount and the Adjusted Amount in accordance with the terms of the agreement.
- 4) You assign to PMCS or its assigns all sums due from the payor for the above referenced claim only and authorize PMCS to deposit checks or instruments received in payment of the assigned claim.
- 5) You agree that if payments due to PMCS under this Agreement are inadvertently forwarded to You by payor, such payment will immediately be sent to PMCS.
- 6) If for any reason any claim is deemed ineligible or benefits were improperly determined, upon written notice, you agree that any payments made by PMCS under this agreement for any claim will be immediately reimbursed to PMCS.

Please sign below and return a faxed copy to my attention at 877-768-1969.

Upon receipt of this executed document, this claim will be processed and a check with Explanation of Payment (E.O.P.) will be forwarded to your patient accounts department at the address shown on the original claim.

I have the authority to accept the provisions outlined in this agreement; and further provide PMCS the assurance that proceeds associated with this claim have not been previously assigned to any other individual or organization.

Signature

Date

Printed Name

E-Mail

Thank you for your time and consideration. We look forward to working with you in the near future.

If you have any questions, please contact me toll free at 877-768-1968.

Sincerely,

Christopher Simmon
Regional Claims Manager

<p>PMCS OFFICE USE Payment must be received by: / /</p>
--

Confirmation # 1018467

Your immediate response is greatly appreciated



Preferred Medical Claim Solutions L.L.C.

Assignment Letter Agreement

Date: November 22, 2004 Client: Risk and Benefit Management Services
 Provider: Community Chiropractic Clinic
 Phone #: (907) 222-2100 Fax #: (907) 222-2131
 Attn: Office Manager E-mail: _____

Patient Name	Patient ID#	Dates of Service	Total Billed	Allowable Amount	Adjusted Amount
			\$124.00	\$124.00	\$99.20

This Assignment Letter Agreement ("Agreement") outlines Provider's (You or Your) willingness to accept the following terms relating to the above claim:

- 1) You agree to accept the Adjusted Amount on the above claim.
- 2) In consideration, You will receive payment of Adjusted Amount, less patient co-pay, co-insurance and deductible amounts within 12-15 working days, from the date this document is received in the office of PMCS.
- 3) You agree not to balance bill the payor, administrator, and/or patient for the difference between the Allowable Amount and the Adjusted Amount in accordance with the terms of the agreement.
- 4) You assign to PMCS or its assigns all sums due from the payor for the above referenced claim only and authorize PMCS to deposit checks or instruments received in payment of the assigned claim.
- 5) You agree that if payments due to PMCS under this Agreement are inadvertently forwarded to You by payor, such payment will immediately be sent to PMCS.
- 6) If for any reason any claim is deemed ineligible or benefits were improperly determined, upon written notice, you agree that any payments made by PMCS under this agreement for any claim will be immediately reimbursed to PMCS.

Please sign below and return a faxed copy to my attention at 877-768-1969.

Upon receipt of this executed document, this claim will be processed and a check with Explanation of Payment (E.O.P.) will be forwarded to your patient accounts department at the address shown on the original claim.

I have the authority to accept the provisions outlined in this agreement; and further provide PMCS the assurance that proceeds associated with this claim have not been previously assigned to any other individual or organization.

Signature

Date

Printed Name

E-Mail

Thank you for your time and consideration. We look forward to working with you in the near future.

If you have any questions, please contact me toll free at 877-768-1968.

Sincerely,

Christopher Simmon
Regional Claims Manager

PMCS OFFICE USE
Payment must be received by:
/ /

Confirmation # 1018490



Preferred Medical Claim Solutions L.L.C.

Date: November 22, 2004
Provider: Community Chiropractic Clinic
Phone #: (907) 222-100

Attn: Office Manager
TIN #: 43-1979448
Fax #: (907) 222-2131

This agreement is between Preferred Medical Claim Solutions LLC ("PMCS") and the Provider TIN listed above and becomes effective upon execution by the parties.

This Agreement shall continue in effect for a period of one (1) year from the date of execution and will automatically renew successive one (1) year terms. Either party may terminate this agreement without cause by providing thirty (30) days written notice to the other party.

PMCS and Provider enter into this agreement under the following terms and conditions:

- 1) You agree to accept 80% of the Allowed Amount as the Adjusted Billed Charges on all claims processed by PMCS.
- 2) In consideration, You will receive payment of Adjusted Billed Charges, less patient co-pay, co-insurance and deductible amounts within 7-10 working days from the date the claim is received by PMCS.
- 3) You agree not to balance bill the payor, administrator, and/or patient for the difference between the Allowed Amount and the Adjusted Billed Charges in accordance with the terms of the agreement.
- 4) You assign to PMCS or its assigns all sums due on all claims processed by PMCS and authorizes PMCS to deposit checks or instruments received in payment of those claims.
- 5) You agree that if payments due to PMCS under this Agreement are inadvertently forwarded to You by payor, such payment will immediately be sent to PMCS.
- 6) If for any reason any claim is deemed ineligible or benefits were improperly determined, upon written notice, you agree that any payments made by PMCS under this agreement for any claim will be immediately reimbursed to PMCS.

Please sign below and fax to 877-768-1969 or call us at 877-768-1968.

Upon receipt of this Agreement by the parties, all open and future claims will be processed in accordance with this Agreement and payment, along with an Explanation of Payment (E.O.P.), will be forwarded to your patient accounts department at the address shown on the claim.

I have the authority to accept the provisions outlined in this agreement; and further provide PMCS the assurance that proceeds associated with this claim have not been previously assigned to any other individual or organization.

Signature

Date

Printed Name

E-Mail

Thank you for your time and consideration. We look forward to working with you in the near future.

Sincerely,

Christopher Simmon
Regional Claims Manager

CORVEL

Explanation of Review

Employer: ██████████
Patient: ██████████
 Anchorage, AK 99508

Business Unit: Fred Meyer 11 (Div 701)
 1000 E Northern Lgts
 Anchorage, AK 99508

Phone: 629-19-1978
Patient DOB: 10/26/1972

LOB: Workers' Compensation
Site/Bill #: 21/56885 - 1
Reprice: AK, 39618
Billed Date: 01/27/2005
Business Rcvd: 02/08/2005
MBR Rcvd: 02/16/2005
Date of Audit: 02/18/2005
DOS From - To: 10/20/2004 - 10/22/2004

Providence Alaska Medical Center
 PO Box 34503
 Seattle, WA 98124-1503

Network:	Treating Physician: BRECHT STEPHEN	Claim #: 200410189990001NE
Network Branch:	Referring Physician:	Processor Initials: CC
Contract:	Patient Control #: 4293012170000	Claim Rep.: XNULL
Provider Tax Id: 92-0016429	RX Number:	DOI: 10/19/2004
Postmark Date: 02/15/05		

Bill Comments

Payment to follow under separate cover.

Date	Code	Units	POS	Bill Charges	Reduction	Network Reduction	Allowe Fee
				TOS	DXR		Fee
10/19/2004	270 MED-SUR SUPPLIES			\$48.00	\$48.00	\$0.00	\$0.00
	110 IV saline lock		21				
10/19/2004	270 MED-SUR SUPPLIES			\$14.00	\$14.00	\$0.00	\$0.00
	110 bandage ace		21				
10/19/2004	460 PULMONARY FUNC			\$55.00	\$55.00	\$0.00	\$0.00
	110 pulse ox		21				
10/20/2004	270 MED-SUR SUPPLIES			\$10.00	\$10.00	\$0.00	\$0.00
	110 padding		21				
10/20/2004	270 MED-SUR SUPPLIES			\$67.00	\$67.00	\$0.00	\$0.00
	11C tourniquet		21				
10/20/2004	278 SUPPLY/IMPLANTS	1		\$85.00	\$48.50	\$0.00	\$16.50
	532 screw cortex 3.5 28mm 204		21				
10/20/2004	278 SUPPLY/IMPLANTS	1		\$85.00	\$48.10	\$0.00	\$16.90
	532 screw cortex 3.5 34mm 204		21				

fe	Code	Units	POS	Bill Charges	TOS	Reduction	DXR	Network Reduction	Allowe Fee
1/20/2004	278 532	SUPPLY/IMPLANTS	1	21	\$65.00	\$46.10		\$0.00	\$18.9
		screw tortex 204 832							
1/20/2004	278 532	SUPPLY/IMPLANTS	1	21	\$362.00	\$258.20		\$0.00	\$103.8
		screw locking 3.5 12mm 21							
3/20/2004	278 532	SUPPLY/IMPLANTS	1	21	\$362.00	\$258.20		\$0.00	\$103.8
		screw locking 3.5 40mm 21							
6/20/2004	278 532	SUPPLY/IMPLANTS	1	21	\$854.00	\$548.80		\$0.00	\$305.2
		plate lcp l oblique rt 3h							
6/20/2004	270 110	MED-SUR SUPPLIES	1	21	\$32.00	\$32.00		\$0.00	\$0.0
		cast PCA							
10/20/2004	270 110	MED-SUR SUPPLIES	1	21	\$9.00	\$9.00		\$0.00	\$0.0
		tubing							
10/20/2004	270 110	MED-SUR SUPPLIES	1	21	\$38.00	\$38.00		\$0.00	\$0.0
		blanket							
10/20/2004	270 110	MED-SUR SUPPLIES	1	21	\$70.00	\$70.00		\$0.00	\$0.0
		oxygen supplies							
10/20/2004	270 110	MED-SUR SUPPLIES	1	21	\$22.00	\$22.00		\$0.00	\$0.0
		gu irrigation							
10/20/2004	270 110	MED-SUR SUPPLIES	1	21	\$40.00	\$40.00		\$0.00	\$0.0
		ice grip							
10/20/2004	272 110	STERILE SUPPLY	1	21	\$19.00	\$19.00		\$0.00	\$0.0
		drape							
10/20/2004	272 110	STERILE SUPPLY	1	21	\$10.00	\$10.00		\$0.00	\$0.0
		needle counter							
10/20/2004	272 110	STERILE SUPPLY	1	21	\$19.00	\$19.00		\$0.00	\$0.0
		stockinette							
10/20/2004	272 110	STERILE SUPPLY	1	21	\$80.00	\$80.00		\$0.00	\$0.0
		turn over supplies							
10/20/2004	272 110	STERILE SUPPLY	1	21	\$495.00	\$495.00		\$0.00	\$0.0
		Instruments							
10/20/2004	272 110	STERILE SUPPLY	1	21	\$53.00	\$53.00		\$0.00	\$0.0
		hair hugger							
10/20/2004	272 110	STERILE SUPPLY	1	21	\$59.00	\$59.00		\$0.00	\$0.0
		bovie							

Code	Units	POS	Bill Charges	TOS	Reduction	DXR	Network Reduction	Allowed Fees
'2004	272 110	21	\$85.00		\$85.00		\$0.00	\$0.00
	synthes sm fragment							
/2004	272 110	21	\$47.00		\$47.00		\$0.00	\$0.00
	STERILE SUPPLY							
	light handle cover							
1/2004	272 110	21	\$22.00		\$22.00		\$0.00	\$0.00
	STERILE SUPPLY							
	padding							
3/2004	272 110	21	\$22.00		\$22.00		\$0.00	\$0.00
	STERILE SUPPLY							
	padding							
0/2004	272 110	21	\$32.00		\$32.00		\$0.00	\$0.00
	STERILE SUPPLY							
	bandage							
0/2004	272 110	21	\$53.00		\$53.00		\$0.00	\$0.00
	STERILE SUPPLY							
	kit trocar							
10/2004	272 110	21	\$34.00		\$34.00		\$0.00	\$0.00
	STERILE SUPPLY							
	bandage							
20/2004	272 110	21	\$10.00		\$10.00		\$0.00	\$0.00
	STERILE SUPPLY							
	protector ulnar nerve							
20/2004	272 110	21	\$20.00		\$20.00		\$0.00	\$0.00
	STERILE SUPPLY							
	protector ulna nerve							
20/2004	272 110	21	\$45.00		\$45.00		\$0.00	\$0.00
	STERILE SUPPLY							
	suture							
'20/2004	272 110	21	\$14.00		\$14.00		\$0.00	\$0.00
	STERILE SUPPLY							
	electrodes							
120/2004	272 110	21	\$10.00		\$10.00		\$0.00	\$0.00
	STERILE SUPPLY							
	towel							
120/2004	272 110	21	\$109.00		\$109.00		\$0.00	\$0.00
	STERILE SUPPLY							
	cuff							
1/20/2004	272 110	21	\$10.00		\$10.00		\$0.00	\$0.00
	STERILE SUPPLY							
	suture							
3/20/2004	272 110	21	\$10.00		\$10.00		\$0.00	\$0.00
	STERILE SUPPLY							
	suture							
0/20/2004	272 110	21	\$10.00		\$10.00		\$0.00	\$0.00
	STERILE SUPPLY							
	glove							
0/20/2004	272 110	21	\$10.00		\$10.00		\$0.00	\$0.00
	STERILE SUPPLY							
	glove							

Code	Units	POS	Bill Charges	TOS	Reduction	DXR	Network Reduction	Allowed Fees
10/2004 272	STERILE SUPPLY		\$34.00		\$34.00		\$0.00	\$0.00
110	suture	21						
10/2004 279	SUPPLY/OTHER		\$81.00		\$81.00		\$0.00	\$0.00
110	pump pcs daily	21						
10/2004 120	ROOM-BOARD/SEMI		\$10,518.26		\$0.00		\$0.00	\$10,518.26
520		2						
11/2004 279	SUPPLY/OTHER		\$81.00		\$81.00		\$0.00	\$0.00
110	pump PCA daily	21						
11/2004 290	MED EQUIP/DURAB		\$83.00		\$83.00		\$0.00	\$0.00
110	crutches	21						
Totals for Bill: 56885			\$14,213.26		\$3,125.90		\$0.00	\$11,087.36

Bill for Bill: 56885

\$11,087.36

Item Reason Codes and Descriptions

Service included in primary procedure allowance

520 Inpatient Surgical Per Diem Allowance

Allowed at Cost + 20% Markup

If provider bill has been processed according to Alaska Workers' Compensation Act and designated fee schedule. An employee may not be required to pay a fee or charge for medical treatment or service. Title 23, Chapter 30, Sec. 23.30.095(f)

ICD9 Diagnosis

ICD9 Procedure

- 86.0 CLOSED FRACTURE OF CALCANEUS(Admit Dx)
- 86.25 CLOSED FRACTURE OF METATARSAL BONE
- 86.22 CLOSED FRACTURE NAVICULAR BONE FOOT
- 86.0 OTH MX&ILL-DEFINED CLOS FX LOW LIMB
- 86.1 NONDEPENDENT TOBACCO USE DISORDER

79.37 OP PEDUC W/INT FIX-TARS-METATARS

Q Information:

G : 225 - Foot procs

92 DRG : 225 - Foot procs

Questions regarding this bill may be sent to:

Toll free: () -

Phone: (907) 274-2785

Fax: (907) 274-7583

MedCheck Corporation - MedCheck

35 S Bragaw St

Ste 525

Anchorage, AK 99508-3489

Claim Summary to Date

Date Range: 10/19/2004 - 02/03/2005

Amount Billed on Claim: \$20,976.03

Allowed Fee on Claim: \$18,821.92

Total Bills for Claim: 15

APPROVED BY: 0818-229

PROVIDENCE ALASKA MED CTR
P O BOX 34603
SEATTLE WA 981241603
4266873800

3 PATIENT CONTROL NO.
429301217

RECEIVED
FEB 16 2005
MEDICAL CHECK ALASKA

6 PED. TAX NO. 920016429
8 STATEMENT COVER PERIOD FROM 102004 TO 102204
7 COV. D. 002

12 PATIENT NAME [REDACTED] 13 PATIENT ADDRESS [REDACTED]

14 BIRTHDATE 10251972 15 SEX M 16 AGE M 17 DATE OF ADMISSION 102004 18 TIME 00 19 TYPE 1 20 DRG 7 21 DR 11 22 BYAT 01 23 MEDICAL RECORD NO. C 595384

37 OCCURRENCE CODE 04 38 DATE 101904 35 OCCURRENCE CODE 35 36 DATE 102104

FRED MEYER CLAIMS WC
ATTN ANGELA WHITE
13401 OLD GLENN HWY
EAGLE RIVER, AK 99577

39 CODE 01 40 VALUE CODES AMOUNT 1052 00 45 21 00

42 REV. CD.	43 DESCRIPTION	44 HCPCRATES	45 SERV. DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0120	ROOM & BOARD	1157.00		2	2314.00		
0250	PHARMACY			35	921.74		
0270	MED-SURG SUPPLIES			14	501.00		
0272	STERILE SUPPLY			33	1448.00		
0278	SUPPLY/IMPLANTS			6	1773.00		
0279	SUPPLY/OTHER			2	162.00		
0290	MED EQUIP/DURAB			1	83.00		
0300	LABORATORY			4	239.00		
0320	DX X-RAY			3	987.00		
0359	CT SCAN/OTHER			1	981.00		
0360	OR SERVICES			1	2297.56		
070	ANESTHESIA			142	894.60		
0420	PHYSICAL THERAPY			1	170.00		
0460	EMERGENCY ROOM			1	852.00		
0460	PULMONARY FUNCTION			1	55.00		
0636	DRUGS/DETAIL			6	197.66		
0710	RECOVERY ROOM			70	330.70		
0001	TOTAL CHARGES				14213.26		

50 PAYER FRED MEYER CLAIMS WC 51 PROVIDER NO 920016429 54 PRIOR PAYMENTS Y Y 55 NET AMOUNT DUE 14213.26 56 225 394001

DUE FROM PATIENT

58 INSURED'S NAME [REDACTED] 59 CERT. NO. 20041018990 61 GROUP NAME [REDACTED] 62 INSURANCE GROUP NO. [REDACTED]

RECEIVED
FEB 08 2005

63 TREATMENT AUTHORIZATION CODES 1 64 EMPLOYER NAME FRED MEYER 65 EMPLOYER LOCATION Fred Meyer Claims Dept.

67 PRIN. DIAG. CD 8250 68 CODE 82525 69 DRG 82522 70 CODE 8270 71 CODE 3051 72 CODE 73 CODE 74 CODE 75 CODE 76 ADM. DIAG. CD 8250 77 E-CODE E8493 78 225

78 P.C. 9 7937 80 DATE 102004 81 OTHER PROCEDURE CODE 82 ATTENDING PHYS. ID 84178 BRECHT J STEPHEN 83 OTHER PHYS. ID 84178 BRECHT J STEPHEN

3/11/05 pay me

85 PROVIDER REPRESENTATIVE XDH 86 DATE 01/27/01

Patient Account Transmittal



Sent Via Facsimile on: Jan 18, 2005
This claim will close on Jan 18, 2005.

**PRIORITY
HANDLING PLEASE
FOURTH REQUEST**

PLEASE DELIVER TO:

BILLING MANAGER
COMMUNITY CHIOPRA

550 EAST TUDOR ROAD
ANCHORAGE, AK 99503

TELEPHONE: (907) 222-2100

FACSIMILE: (907) 222-2131

NCN Claim No.: 1037721

NCN Return Fax: (866) 307-4991

PATIE [REDACTED]

BIRTHDATE [REDACTED]

PT ACCOUNT NO: [REDACTED]

STATEMENT PERIOD: 12/29/2004 - 12/29/2004

PAYOR: ECOM - NATIONAL RURAL ELECTRIC
4301 WILSON BLVD
ARLINGTON, VA 22203

National Care Network (NCN) is a nationally recognized leader in the area of Bill Review and Payment Validation Services. We have been retained by ECOM - National Rural Electric Cooperative Associa to perform our services on the above-referenced claim.

To accelerate the processing of this claim, we are communicating via our Automated Claims Evaluation Process. This claim has not been flagged with coding compliance or excessive pricing issues that would require an Account Manager review at this time. However, the claim value is outside the parameters of the standard allowable amount for your geographic region. Due to this inconsistency, we are asking you to agree to the adjusted price listed below as payment in full for the services rendered on the above date(s) of service.

BILLED CHARGES

\$62 00

ALLOWED CHARGES

\$49 60

ADJUSTMENT

\$12 40

By signing below, COMMUNITY CHIROPRA agrees that the charges for the above-mentioned date(s) of service have been accepted as \$49.60 and that the patient will not be balance-billed for the remaining \$12.40. Any coinsurance, deductible or policy limitations that may be applied to this claim are the patient's responsibility. Any late charges will be subject to the same adjustment percentage as agreed to above. Payment will be processed within 10 business days of receipt of the signed agreement.

To ensure timely processing of this claim, please fax the signed document to (866) 307-4991. If you have any questions or need additional information, please contact David Horton at (800) 499-9708 ext 128. We appreciate your cooperation.

AUTHORIZED SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **TITLE:** _____

Payment of benefits, if any, is subject to the terms and provisions of the patient's policy. This letter does not guarantee payment by ECOM - National Rural Electric Cooperative Associa. NCN bears no financial responsibility for any payments due. If this claim is not eligible for benefits or has not been processed within the specified time frame, no discount will be applied.

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.

Patient Account Transmittal



Sent Via Facsimile on: Jan 14, 2005
This claim will close on: Jan 18, 2005.

**PRIORITY
HANDLING PLEASE
THIRD REQUEST**

PLEASE DELIVER TO:

PATIENT

BILLING MANAGER
COMMUNITY CHIROPRA

550 EAST TUDOR ROAD
ANCHORAGE, AK 99503

TELEPHONE: (907) 222-2100
FACSIMILE: (907) 222-2131

NCN Claim No.: 1037716
NCN Return Fax: (866) 307-4991

BIRTHDATE

PT ACCOUNT NO:

STATEMENT PERIOD: 12/21/2004 - 12/21/2004

PAYOR: ECOM - NATIONAL RURAL ELECTRIC
4301 WILSON BLVD
ARLINGTON, VA 22203

National Care Network (NCN) is a nationally recognized leader in the area of Bill Review and Payment Validation Services. We have been retained by ECOM - National Rural Electric Cooperative Associa to perform our services on the above-referenced claim.

To accelerate the processing of this claim, we are communicating via our Automated Claims Evaluation Process. This claim has not been flagged with coding compliance or excessive pricing issues that would require an Account Manager review at this time. However, the claim value is outside the parameters of the standard allowable amount for your geographic region. Due to this inconsistency, we are asking you to agree to the adjusted price listed below as payment in full for the services rendered on the above date(s) of service:

BILLED CHARGES	ALLOWED CHARGES	ADJUSTMENT
\$62.00	\$49.60	\$12.40

By signing below, COMMUNITY CHIROPRA agrees that the charges for the above-mentioned date(s) of service have been accepted as \$49.60 and that the patient will not be balance-billed for the remaining \$12.40. Any coinsurance, deductible or policy limitations that may be applied to this claim are the patient's responsibility. Any late charges will be subject to the same adjustment percentage as agreed to above. Payment will be processed within 10 business days of receipt of the signed agreement.

To ensure timely processing of this claim, please fax the signed document to (806) 307-4991. If you have any questions or need additional information, please contact David Horton at (800) 459-9708 ext 128. We appreciate your cooperation.

AUTHORIZED SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ TITLE: _____

Payment of benefits, if any, is subject to the terms and provisions of the patient's policy. This letter does not guarantee payment by ECOM - National Rural Electric Cooperative Associa. NCN bears no financial responsibility for any payments due. If this claim is not eligible for benefits or has not been processed within the specified time frame, no discount will be applied.

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.

Patient Account Transmittal



Sent Via Facsimile on: Jan 14, 2005
 This claim will close on Jan 18, 2005.

**PRIORITY
 HANDLING PLEASE
 THIRD REQUEST**

PLEASE DELIVER TO:

BILLING MANAGER
 COMMUNITY CHIROPRA

550 EAST TUDOR ROAD
 ANCHORAGE, AK 99503

TELEPHONE: (907) 222-2100
 FACSIMILE: (907) 222-2131

NCN Claim No.: 1037715
 NCN Return Fax: (866) 307-4991

PATIENT: [REDACTED]

BIRTHDATE: [REDACTED]

PT ACCOUNT NO: [REDACTED]

STATEMENT PERIOD: 12/16/2004 - 12/16/2004

PAYOR: ECOM - NATIONAL RURAL ELECTRIC
 4301 WILSON BLVD
 ARLINGTON, VA 22203

National Care Network (NCN) is a nationally recognized leader in the area of Bill Review and Payment Validation Services. We have been retained by ECOM - National Rural Electric Cooperative Associa to perform our services on the above-referenced claim.

To accelerate the processing of this claim, we are communicating via our Automated Claims Evaluation Process. This claim has not been flagged with coding compliance or excessive pricing issues that would require an Account Manager review at this time. However, the claim value is outside the parameters of the standard allowable amount for your geographic region. Due to this inconsistency, we are asking you to agree to the adjusted price listed below as payment in full for the services rendered on the above date(s) of service:

BILLED CHARGES	ALLOWED CHARGES	ADJUSTMENT
\$62.00	\$49.60	\$12.40

By signing below, COMMUNITY CHIROPRA agrees that the charges for the above-mentioned date(s) of service have been accepted as \$49.60 and that the patient will not be balance-billed for the remaining \$12.40. Any coinsurance, deductible or policy limitations that may be applied to this claim are the patient's responsibility. Any late charges will be subject to the same adjustment percentage as agreed to above. Payment will be processed within 10 business days of receipt of the signed agreement.

To ensure timely processing of this claim, please fax the signed document to (866) 307-4991. If you have any questions or need additional information, please contact David Horton at (800) 499-9708 ext 128. We appreciate your cooperation.

AUTHORIZED SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ TITLE: _____

Payment of benefits, if any, is subject to the terms and provisions of the patient's policy. This letter does not guarantee payment by ECOM - National Rural Electric Cooperative Associa. NCN bears no financial responsibility for any payments due. If this claim is not eligible for benefits or has not been processed within the specified time frame, no discount will be applied.

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.

Patient Account Transmittal



Sent Via Facsimile on: Jan 14, 2005
This claim will close on Jan 18, 2005.

**PRIORITY
HANDLING PLEASE
THIRD REQUEST**

PLEASE DELIVER TO:

BILLING MANAGER
COMMUNITY CHIROPRA

550 EAST TUDOR ROAD
ANCHORAGE, AK 99503

TELEPHONE: (907) 222-2100

FACSIMILE: (907) 222-2131

NCN Claim No.: 1037721

NCN Return Fax: (866) 307-4991

PATIENT

BIRTHDATE

PT ACCOUNT NO:

STATEMENT PERIOD:

PAYOR: ECOM - NATIONAL RURAL ELECTRIC
4301 WILSON BLVD
ARLINGTON, VA 22203

National Care Network (NCN) is a nationally recognized leader in the area of Bill Review and Payment Validation Services. We have been retained by ECOM - National Rural Electric Cooperative Associa to perform our services on the above-referenced claim.

To accelerate the processing of this claim, we are communicating via our Automated Claims Evaluation Process. This claim has not been flagged with coding compliance or excessive pricing issues that would require an Account Manager review at this time. However, the claim value is outside the parameters of the standard allowable amount for your geographic region. Due to this inconsistency, we are asking you to agree to the adjusted price listed below as payment in full for the services rendered on the above date(s) of service.

BILLED CHARGES

\$62.00

ALLOWED CHARGES

\$49.60

ADJUSTMENT

\$12.40

By signing below, COMMUNITY CHIROPRA agrees that the charges for the above-mentioned date(s) of service have been accepted as \$49.60 and that the patient will not be balance-billed for the remaining \$12.40. Any coinsurance, deductible or policy limitations that may be applied to this claim are the patient's responsibility. Any late charges will be subject to the same adjustment percentage as agreed to above. Payment will be processed within 10 business days of receipt of the signed agreement.

To ensure timely processing of this claim, please fax the signed document to (866) 307-4991. If you have any questions or need additional information, please contact David Horton at (800) 499-9708 ext 128. We appreciate your cooperation.

AUTHORIZED SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

TITLE: _____

Payment of benefits, if any, is subject to the terms and provisions of the patient's policy. This letter does not guarantee payment by ECOM - National Rural Electric Cooperative Associa. NCN bears no financial responsibility for any payments due. If this claim is not eligible for benefits or has not been processed within the specified time frame, no discount will be applied.

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.

1037721 - CSV

Patient Account Transmittal



Sent Via Facsimile on: Jan 12, 2005
 This claim will close on Jan 18, 2005.

**PRIORITY
 HANDLING PLEASE
 SECOND REQUEST**

PLEASE DELIVER TO:

**BILLING MANAGER
 COMMUNITY CHIROPRA**

550 EAST TUDOR ROAD
 ANCHORAGE, AK 99503

TELEPHONE: (907) 222-2100
FACSIMILE: (907) 222-2131

NCN Claim No.: 1037716
NCN Return Fax: (866) 307-4991

PATIENT: [REDACTED]

BIRTHDATE: [REDACTED]

PT ACCOUNT NO.: [REDACTED]
STATEMENT PERIOD: 12/21/2004 - 12/21/2004

PAYOR: ECOM - NATIONAL RURAL ELECTRIC
 4301 WILSON BLVD
 ARLINGTON, VA 22203

National Care Network (NCN) is a nationally recognized leader in the area of Bill Review and Payment Validation Services. We have been retained by ECOM - National Rural Electric Cooperative Associa to perform our services on the above-referenced claim.

To accelerate the processing of this claim, we are communicating via our Automated Claims Evaluation Process. This claim has not been flagged with coding compliance or excessive pricing issues that would require an Account Manager review at this time. However, the claim value is outside the parameters of the standard allowable amount for your geographic region. Due to this inconsistency, we are asking you to agree to the adjusted price listed below as payment in full for the services rendered on the above date(s) of service:

BILLED CHARGES	ALLOWED CHARGES	ADJUSTMENT
\$2.00	\$49.60	\$12.40

By signing below, COMMUNITY CHIROPRA agrees that the charges for the above-mentioned date(s) of service have been accepted as \$49.60 and that the patient will not be balance-billed for the remaining \$12.40. Any coinsurance, deductible or policy limitations that may be applied to this claim are the patient's responsibility. Any late charges will be subject to the same adjustment percentage as agreed to above. Payment will be processed within 10 business days of receipt of the signed agreement.

To ensure timely processing of this claim, please fax the signed document to (866) 307-4991. If you have any questions or need additional information, please contact David Horton at (800) 499-9708 ext 128. We appreciate your cooperation.

AUTHORIZED SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **TITLE:** _____

Payment of benefits, if any, is subject to the terms and provisions of the patient's policy. This letter does not guarantee payment by ECOM - National Rural Electric Cooperative Associa. NCN bears no financial responsibility for any payments due. If this claim is not eligible for benefits or has not been processed within the specified time frame, no discount will be applied.

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.

Patient Account Transmittal



Sent Via Facsimile on: Jan 12, 2005
This claim will close on Jan 18, 2005.

**PRIORITY
HANDLING PLEASE
SECOND REQUEST**

PLEASE DELIVER TO:

BILLING MANAGER
COMMUNITY CHIROPRA

550 EAST TUDOR ROAD
ANCHORAGE, AK 99503

TELEPHONE: (907) 222-2100
FACSIMILE: (907) 222-2131

NCN Claim No.: 1037721
NCN Return Fax: (866) 307-4991

PATIENT: _____

BIRTHDATE: _____

PT ACCOUNT NO: _____ **D:** 12/29/2004 - 12/29/2004

STATEMENT PERIOD: 12/29/2004 - 12/29/2004

PAYOR: ECOM - NATIONAL RURAL ELECTRIC
4301 WILSON BLVD
ARLINGTON, VA 22203

National Care Network (NCN) is a nationally recognized leader in the area of Bill Review and Payment Validation Services. We have been retained by ECOM - National Rural Electric Cooperative Association to perform our services on the above-referenced claim.

To accelerate the processing of this claim, we are communicating via our Automated Claims Evaluation Process. This claim has not been flagged with coding compliance or excessive pricing issues that would require an Account Manager review at this time. However, the claim value is outside the parameters of the standard allowable amount for your geographic region. Due to this inconsistency, we are asking you to agree to the adjusted price listed below as payment in full for the services rendered on the above date(s) of service:

BILLED CHARGES

\$62.00

ALLOWED CHARGES

\$49.60

ADJUSTMENT

\$12.40

By signing below, COMMUNITY CHIROPRA agrees that the charges for the above-mentioned date(s) of service have been accepted as \$49.60 and that the patient will not be balance-billed for the remaining \$12.40. Any coinsurance, deductible or policy limitations that may be applied to this claim are the patient's responsibility. Any late charges will be subject to the same adjustment percentage as agreed to above. Payment will be processed within 10 business days of receipt of the signed agreement.

To ensure timely processing of this claim, please fax the signed document to (866) 307-4991. If you have any questions or need additional information, please contact David Horton at (800) 499-9708 ext 128. We appreciate your cooperation.

AUTHORIZED SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

TITLE: _____

Payment of benefits, if any, is subject to the terms and provisions of the patient's policy. This letter does not guarantee payment by ECOM - National Rural Electric Cooperative Association. NCN bears no financial responsibility for any payments due. If this claim is not eligible for benefits or has not been processed within the specified time frame, no discount will be applied.

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.

CONCENTRA INTEGRATED SERVICES INC
 5757 Phantom Drive
 Suite 125
 Hazelwood, MO 63042
 Phone: (800)491-8151

we

EXPLANATION OF REVIEW

Provider: BARBER, EDWARD L DC
 550 E TUDOR RD
 ANCHORAGE, AK 99503-7371

Process Date: 02/25/2005 Rec Dt: 01/24/2005
 Bill ID: 26011459-H-255-0
 Claim #: 42931
 DOI: 12/09/2004
 Ext Claim#: WCV411190001 Employer: BEKINSMOVING&
 Pol/Status: Adjuster:
 Ex/Acct ID: Unit:

Provider ID: #5277002
 Provider TIN: 431979448

Group: COMMUNITY CHIROPRACTIC CLINIC
 Group ID: #4082386
 Group TIN: 431979448
 Patient Account #: 2103132-2-3
 Network:
 Network Plan:
 Network Plan #:

Dates of Service: 01/14/2005 - 01/14/2005
 Batch #: SP157472 CMC Case#:
 Adjuster: B7 CPS Bill #:
 Conv Bill#: Other:

ICD-9 DX:
 847.0 NECK SPRAIN AND STRAIN
 724.2 LUMBAGO

Audit Account: VANLINER INSURANCE FENTON MO
 VANLINER INSURANCE CO
 PO BOX 26352
 FENTON, MO 63026
 Audit Account ID: 17507WC002
 Report Account: VANLINER INSURANCE
 Report Account ID: 17507WC001
 Control #: 1012774 Alt Code:
 Control #: 1012774 Alt Code:
 847.2 LUMBAR SPRAIN AND STRAIN
 723.1 CERVICALGIA

Submitted Code	Modifiers	Reimbursed Code(s)	Modifiers	Minutes /Units	Total Charges	Reductions Bill Review	Network	Other	Total Allowance
Date of Service: 01/14/2005									
98941		98940		71.55 <i>Fee Sch. - 11</i>	88.00	10.35			55.65
CHIROPRACTIC MANIPULATIVE TX, SPINAL 1-2 REGIONS							TOS: 1		
Explanation Codes*: 227, 663									

TOTAL CHARGES	\$	88.00
BILL REVIEW REDUCTION	\$	10.35
NETWORK REDUCTION	\$	0.00
OTHER REDUCTION	\$	0.00
TOTAL RECOMMENDED ALLOWANCE	\$	55.65

110.0/0/0/0/0/0/0/0/110

*EXPLANATION CODES

- 227 THE MANIPULATION CODE BILLED IS NOT APPROPRIATE FOR THE NUMBER OF BODY AREAS TREATED AS INDICATED BY THE DIAGNOSIS CODES. THEREFORE, THE CODE HAS BEEN CHANGED TO A MORE APPROPRIATE MANIPULATION CODE.
- 663 REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO STATE FEE SCHEDULE GUIDELINES

THIS ANALYSIS WAS PREPARED IN ACCORDANCE WITH THE RULES AND REGULATIONS SET FORTH IN THE SCHEDULE OF MEDICAL FEES ADOPTED BY THE STATE OF ALASKA'S WORKERS' COMPENSATION BOARD. UNLESS OTHERWISE STATED, ALL REDUCTIONS ARE DUE TO THE ACTUAL CHARGES EXCEEDING THE APPLICABLE STATE FEE SCHEDULE UNDER THE PROVISIONS OF AS 23.30.095(f). REGULATION AAC 45.082 (DX1) REQUIRES THAT THEY INSURANCE CARRIER NOTIFY THE EMPLOYEE AND THE MEDICAL PROVIDER IN WRITING THE REASON FOR NOT PAYING ALL OR PART OF A BILL. THE PROVIDER MAY NOT BILL FOR ANY UNPAID BALANCE OF CHARGES THAT EXCEED THE AMOUNT ALLOWABLE UNDER THE ALASKA WORKERS' COMPENSATION FEE SCHEDULE

If you have any questions regarding this analysis, please call (800) 491-8151 or send your bill and the analysis to: Concentra Integrated Svcs, 5757 Phantom Drive, Suite 125, Hazelwood, MO 63042.

Bunch & Associates, Inc.

WC

EXPLANATION OF BENEFITS

BILL ID: 2222-N-844880-0
 PROCESS DATE: 02/10/2008
 RECEIVED DATE: 02/01/2008
 DATE PAID:
 ADJUSTER: NELSON, RITA
 CHECK:
 CHECK DATE:

PROVIDER: RYAN, PETER
 860 E TUDOR RD
 ANCHORAGE, AK 99503

PATIENT:

PROVIDER TIN: 431978448
 GROUP: Community Chiropractic
 GROUP TIN: 431878448
 PATIENT ACCOUNT: 880374134

PATIENT ID:
 CLAIM: CE203122 C
 001 02/08/2008
 ACCOUNT ID: LOWES COMPANIES
 HIGHWAY 260 EAST
 NORTH WILKESBORO, NC 28658

NETWORK:
 NETWORK PLAN:
 NETWORK PLAN:

DATES OF SERVICE: 12/22/2004 - 12/22/2004
 ICD-9 DX:
 838 00 CLOSED DISLOCATION UNSPECIFIED CERVICAL VERTEBRA

DATE OF SERVICE	PS	CODE	MOD	SERVICE DESCRIPTION	DIAG NO	MIN/UNITS	CHARGES	REVIEW REDUCTION	NETWORK REDUCTION	OTHER REDUCTION	ALLOWANCE	EXPL CODE(S)
12/22/2004	11	98040		CHIROPRACTIC MANIPULATIVE T		1	82 00	0 36	0 00	0 00	86 66	227, 863
12/22/2004	11	97140	59	MANUAL THERAPY TECH 1/MORE		1	20 00	0 00	0 00	0 00	20 00	
12/22/2004	11	97140	59	MANUAL THERAPY TECH 1/MORE		1	20 00	0 00	0 00	0 00	20 00	
12/22/2004	11	97140	59	MANUAL THERAPY TECH 1/MORE		1	20 00	0 00	0 00	0 00	20 00	
12/22/2004	11	97140	59	MANUAL THERAPY TECH 1/MORE		1	20 00	0 00	0 00	0 00	20 00	

TOTAL CHARGES 142 00
 REVIEW REDUCTIONS 4 36
 NETWORK REDUCTIONS 0 00
 OTHER REDUCTIONS 0 00
 RECOMMENDED ALLOWANCE 135 66

227 THE MANIPULATION CODE BILLED IS NOT APPROPRIATE FOR THE NUMBER OF BODY AREAS TREATED AS INDICATED BY THE DIAGNOSIS CODES THEREFORE, THE CODE HAS BEEN CHANGED TO A MORE APPROPRIATE MANIPULATION CODE

863 REIMBURSEMENT HAS BEEN CALCULATED ACCORDING TO THE STATE FEE SCHEDULE GUIDELINES

Direct inquiries regarding the review to: Bunch & Associates, Inc P.O. BOX 32045, Lakeland, FL 33802-2045 Phone 888-453-4738

Unless otherwise noted, all reductions are due to standard coding guidelines and Relative and Actual Charge Data for similar services in the provider's geographic area.

Patient Account Transmittal



Sent Via Facsimile on: Jan 12, 2005
This claim will close on Jan 18, 2005.

**PRIORITY
HANDLING PLEASE
SECOND REQUEST**

PLEASE DELIVER TO:

**BILLING MANAGER
COMMUNITY CHIROPRA**

550 EAST TUDOR ROAD
ANCHORAGE, AK 99503

TELEPHONE: (907) 222-2100
FACSIMILE: (907) 222-2131

NCN Claim No.: 1037715
NCN Return Fax: (866) 307-4991

PATIENT

BIRTHDATE

PT ACCOUNT NUMBER

STATEMENT PERIOD:

PAYOR: ECOM - NATIONAL RURAL ELECTRIC
4301 WILSON BLVD
ARLINGTON, VA 22203

National Care Network (NCN) is a nationally recognized leader in the area of Bill Review and Payment Validation Services. We have been retained by ECOM - National Rural Electric Cooperative Associa to perform our services on the above-referenced claim.

To accelerate the processing of this claim, we are communicating via our Automated Claims Evaluation Process. This claim has not been flagged with coding compliance or excessive pricing issues that would require an Account Manager review at this time. However, the claim value is outside the parameters of the standard allowable amount for your geographic region. Due to this inconsistency, we are asking you to agree to the adjusted price listed below as payment in full for the services rendered on the above date(s) of service.

BILLED CHARGES

\$62.00

ALLOWED CHARGES

\$49.60

ADJUSTMENT

\$12.40

By signing below, COMMUNITY CHIROPRA agrees that the charges for the above-mentioned date(s) of service have been accepted as \$49.60 and that the patient will not be balance-billed for the remaining \$12.40. Any coinsurance, deductible or policy limitations that may be applied to this claim are the patient's responsibility. Any late charges will be subject to the same adjustment percentage as agreed to above. Payment will be processed within 10 business days of receipt of the signed agreement.

To ensure timely processing of this claim, please fax the signed document to (866) 307-4991. If you have any questions or need additional information, please contact David Horton at (800) 499-9708 ext 123. We appreciate your cooperation.

AUTHORIZED SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ TITLE: _____

Payment of benefits, if any, is subject to the terms and provisions of the patient's policy. This letter does not guarantee payment by ECOM - National Rural Electric Cooperative Associa. NCN bears no financial responsibility for any payments due. If this claim is not eligible for benefits or has not been processed within the specified time frame, no discount will be applied.

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.



Fax Transmission

Please respond by: 11/13/2004

**CLAIM MUST BE PROCESSED ASAP!
PLEASE SIGN AND RETURN TO FAX #: (817) 436 5339**

To: ACCOUNT MANAGER / (Patient Accounts Manager)
Fax #: (907) 562 4256
Phone #: (907) 562 5366
DATE: November 9, 2004
SUBJECT:
Payor:
PAGE (S): ...cluding cover sheet

Multiplan Reference #: 2004308 - 901 - 1476

UnitedHealthCare requested our Bill Review services on a claim for the above referenced patient/account. Our Bill Review process involves evaluation for compliance with recognized standards for Reasonable & Customary (R&C) pricing, coding and utilization.

In consideration of accelerated processing, prompt payment and reduction of patient liability on this claim, we are asking that **COMMUNITY CHIROPRACTIC** (Provider) agree to accept the adjusted price listed below as the full payment for services rendered on the following date(s):

Service Date(s)	Provider's List Price	Adjusted Price
10/19/2004 - 10/25/2004	\$573.00	\$401.10

Provider agrees not to bill patient (or financially responsible party) for the difference between the total charges (list price) and the adjusted price. Provider maintains the right to bill the patient (or financially responsible party) for non-covered items, and patient-responsible amounts per policy provisions, if applicable.

Provider agrees to accept the above, provided that payment is released within 10 business days from date of receipt of faxed signature.

Thank you for your willingness to work with us in this matter. If you have questions please immediately contact Laronica Clement at (817) 436 5162.

Provider's Signature

Date

Print Name

Title

Multiplan Corporation is not financially responsible for any payments due to the Provider. Payment of benefits, if any, is subject to the terms and conditions of the patient's policy. Therefore, this letter of agreement does not constitute, nor should it be construed as, a guarantee of benefit payment by the Payor.

NOTICE OF CONFIDENTIALITY: Information included in and/or attached to this fax transmission may be confidential. This fax transmission is intended for the addressee(s) only. Any unauthorized disclosure, reproduction, or distribution of and/or any unauthorized action taken in reliance on the information in this fax is prohibited. If you believe that you receive this fax transmission in error, please notify the sender by reply transmission and destroy the fax without copying or disclosing it.

Patient Account Transmittal

Sent Via Facsimile on: Nov 12, 2004

**PRIORITY
HANDLING PLEASE**

PLEASE DELIVER TO:

DEBBIE RYAN
 PETER A RYAN DC
 550 E TUDOR RD
 ANCHORAGE, AK 99503

SENT BY:

TAKIYAH DOUGLAS, ACCOUNT MANAGER
 THE NATIONAL CARE NETWORK
 2550 SW GRAPEVINE PKWY, SUITE 150
 GRAPEVINE, TEXAS 76051

RUSH!

TELEPHONE: (800) 499-9708 EXT: 168

FACSIMILE: (800) 622-7363

TELEPHONE: (907) 222-2100

FACSIMILE: (907) 222-2131

PAGE: 1 of 2

PATIENT:

PAYCR: BSC - FAIRBANKS NORTH STAR BOROUGH
 2815 SECOND AVE
 SEATTLE, WA 98124

BIRTH:

INSURED:

POLICY:

PT ACCOUNT NO:

ICN: 1003117

CTL NO: 0405290-

R1010

DATES OF SERVICE		POB	TOB	PROCEDURE	QTY	CHARGE	ALLOWED CHARGE	ADJUSTMENT
Begin	End							
10/4/2004	10/4/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/5/2004	10/5/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/6/2004	10/6/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/7/2004	10/7/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/8/2004	10/8/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/9/2004	10/9/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/11/2004	10/11/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/12/2004	10/12/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/13/2004	10/13/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
10/14/2004	10/14/2004	11	1 98941	CHIROPRACTIC MANIPULATIVE TX, SP	1	\$62.00	\$50.00	\$12.00
TOTAL:						\$620.00	\$500.00	\$120.00

This telecopy transmission may contain confidential information which is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby advised that any disclosure, copying, distribution, or taking of any action in reliance of the contents of this information is prohibited. If you have received this transmission in error, please notify us to arrange for the return of the documents. Thank you.