ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE MEETING

July 17, 2026

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
Telephone 977-853-5247 ID 867 2796 5944
Zoom Conference https://us02web.zoom.us/j/86727965944

AGENDA

July 17, 2026

9:00 am Call to order
- Roll call - establishment of quorum
- Approval of Agenda
- Approval of MSRC June Meeting Minutes

9:50 am Break

10:15 am Public Comment Period

11:15 am Break

11:30 pm Overview/Discussion of MSRC Fee Schedule Issues
- NCCI data comparisons
- Further Discussion on Audiology codes and procedures
- Remote therapy documentation
- PT MPPR section update
- DME Device reimbursement, (SAM for example)
- DME Device for rental reimbursement
- Compound medications and Physician dispensing
- Conversion Factor Worksheet

1:00 pm Adjournment

Alaska Workers' Compensation Division
Medical Services Review Committee
Meeting Minutes
June 26, 2026

I. CALL TO ORDER

Director Charles Collins called the meeting to order at 9:04 a.m. in Juneau, Alaska. Participation was available via Zoom videoconference.

II. ROLL CALL

The following members were present, constituting a quorum:

Dr. Alan Swenson	Dr. Mason McCloskey	Dr. Mary Ann Foland	Misty Steed
Seanne Popp	Kimberley Dean	Valerie Mittelstead	

Member Jeff Gilbert was excused. Director Collins introduced Danean Tedford and Judy Engelke from RefMed.

III. APPROVAL OF MAY 28, 2026 MEETING MINUTES

Member Mittlestead moved to approve the May 28, 2026 minutes; Member Steed seconded. The motion passed unanimously.

IV. FEE SCHEDULE DEVELOPMENT DISCUSSION

Fee Schedule Updates and CMS Dynamic Pricing

Director Collins updated the Committee on follow-up with the Department of Law regarding CMS pricing updates that occur during the year. He explained that legal guidance indicated the Division may treat use of updated CMS pricing as a policy decision and does not need to expressly address the issue in the fee schedule. Director Collins noted the practical difficulty for payers and providers when billing software updates dynamically and cannot easily be reset to a prior CMS pricing date.

The Committee discussed whether silence in the fee schedule may continue to result in clarification questions, particularly following the January-to-April transition in the current fee schedule. Director Collins noted that the Division has not identified disputes filed solely because of CMS price changes during the year.

Physician Dispensing, Repackaged Drugs, and Topical Medications

The Committee discussed physician-dispensed medications, repackaged drugs, compounded medications, and high-cost topical medications. RefMed explained that other states have addressed physician dispensing and repackaged drugs in their fee schedules, including language requiring use of the original NDC for repackaged drugs.

The Committee discussed concerns with high-cost topical creams, including instances where over-the-counter products or minor formulation changes resulted in charges of hundreds or thousands of dollars. The Committee also discussed patient safety concerns, including whether patients receive adequate counseling when medications are dispensed in a physician's office rather than by a pharmacy.

The Committee reviewed examples from other states, including Georgia, Colorado, Arizona, South Carolina, Florida, and Idaho. RefMed explained that Georgia adopted specific caps for topical and topical compound medications, including three categories of topical codes and a 30-day maximum supply. Mr. Fowler, Director of Regulatory Affairs with MyMatrix, stated during public comment and discussion that caps have been one of the more effective approaches used by other states to control topical medication costs and that Georgia and South Carolina have seen significant cost reductions without known access-to-care issues.

The Committee generally supported further development of fee schedule language to address topical and topical compound medications, including possible caps. Members also discussed whether Alaska should require original NDC information for repackaged drugs and whether additional limits should apply to physician dispensing, while ensuring that access to care is not unintentionally limited in urgent care or rural settings.

RefMed will research proposed language addressing topical and topical compound medication caps, physician dispensing, repackaged drugs, and original NDC requirements. Director Collins will also review applicable Alaska statutes and regulations regarding physician dispensing and repackaging.

Break 10:10 a.m. – 10:15 a.m.

V. PUBLIC COMMENT PERIOD 10:15 AM - 11:15 AM

Adam Fowler, Director of Regulatory Affairs with MyMatrixx

- Stated that MyMatrixx is willing to provide additional information on pharmaceutical fee schedule language, other states' approaches, and what has or has not worked well in other jurisdictions.

Debbie Ryan, Alaska Chiropractic Society

- Stated that providers have experienced reductions in reimbursement over time while business costs, staffing costs, and other expenses have increased. Commented that some providers and DME suppliers may stop offering certain services or products if reimbursement is not adequate.

VI. FEE SCHEDULE DEVELOPMENT DISCUSSION CONTINUED

NCCI and Regional Comparison Data

The Committee reviewed NCCI data and conversion factor information, including year-over-year changes and comparison data. RefMed discussed changes affecting surgery codes, including CMS changes that reduced certain practice RVUs and affected Alaska reimbursement calculations because Alaska's conversion factor remained static.

The Committee discussed whether reductions in certain surgery codes may affect provider participation in the workers' compensation system. Dr. Swenson stated that he had spoken with providers and that practices are experiencing increased overhead, staffing, and benefit costs. He expressed concern that if workers' compensation reimbursement moves too close to Medicare or Medicaid reimbursement levels, some providers may reconsider whether they can continue accepting workers' compensation patients.

RefMed and Director Collins will provide additional comparison information, including Alaska's reimbursement relative to other states and national benchmarks. Dr. Swenson will

continue seeking provider input regarding whether current reimbursement levels are affecting access to care.

Physical Therapy Multiple Procedure Payment Reduction

RefMed reviewed a worksheet explaining the multiple procedure payment reduction for physical therapy codes and explained that the reduction applies to the practice expense portion of subsequent therapy procedure codes, rather than to the entire reimbursement amount.

The Committee discussed questions received regarding the multiple procedure payment reduction and whether additional explanation in the fee schedule would help providers, payers, and bill reviewers understand how the reduction is calculated. Ms. Engelke explained that the multiple procedure reduction is intended to account for overlapping practice expenses when multiple therapy procedures are performed on the same date of service.

The Committee also discussed provider concerns that time-based therapy services may not experience reduced costs in the same way as other multiple procedure services. Dr. Swenson stated that therapy providers have expressed concern that the cost of delivering 45 to 60 minutes of care may not decrease simply because multiple time-based codes are billed. The Committee discussed the need to balance consistency with CMS-based billing logic against provider concerns regarding actual costs. RefMed will prepare possible fee schedule language or an example showing how the multiple procedure payment reduction is calculated for physical therapy codes.

Remote Therapeutic Monitoring

The Committee discussed whether remote therapeutic monitoring and related codes, including app-based or device-based tracking used in connection with physical therapy or rehabilitation, should be reimbursable, whether they may duplicate existing treatment or documentation, and whether they should be subject to specific documentation requirements.

The Committee discussed concerns regarding limited documentation, patient-reported data, general activity tracking that may not relate to the injury, and potential future billing for apps, setup fees, software, or reports.

Dr. Swenson stated that remote monitoring may have value and could reduce some treatment costs when used appropriately, but also noted that the codes could become a significant cost driver if not controlled. Member Dean stated that medical necessity should be documented and approved by the treating physician of record or surgeon, particularly when physical therapy treatment plans or changes in treatment are involved.

The Committee discussed possible approaches, including noncoverage, caps, specific reimbursement values, and documentation guardrails. RefMed will research other state approaches and possible language addressing documentation, medical necessity, device requirements, relationship to the treatment plan, and reimbursement limits.

Acoustic Medical Devices and Miscellaneous DME

The Committee discussed acoustic medical devices, including SAMSport-type devices billed under miscellaneous DME code E1399. RefMed reviewed whether E0760 may be a comparable code and noted that the device is similar in some respects but is not an exact match because the function and intended use differ.

The Committee discussed whether the fee schedule should include language allowing use of a comparable code or requiring reimbursement based on the manufacturer or supplier invoice plus the applicable percentage.

The Committee generally agreed that any approach should avoid allowing unsupported billed charges for miscellaneous devices while still allowing appropriate reimbursement when documentation and cost information support the device. RefMed will continue researching possible language regarding comparable codes, invoices, and reimbursement of miscellaneous DME.

DME Rental Rules

The Committee discussed DME rental rules, including whether rental payments should be limited so that total rental reimbursement does not exceed the purchase price. Members also discussed how to define purchase price, whether supplies or batteries may be separately rented, and whether rental language should apply to DME items that do not have a specific rental modifier.

The Committee discussed concerns regarding automatic resupply, unnecessary continued rentals, and whether components required for equipment to function should be included in the rental of the equipment. The Committee generally supported clarifying that DME rental should not exceed the applicable purchase price and that the purchase price should be based on the lower of billed charges or the manufacturer/supplier invoice plus the applicable percentage.

RefMed will draft possible clarifying language regarding DME rentals, purchase-price limits, and related supply or component issues.

Hearing Aid and Audiology Codes

The Committee discussed new hearing aid and audiology codes, including possible crosswalks from prior codes, values used by other payers, and whether certain services should remain bundled with hearing aid dispensing, evaluation, fitting, or follow-up services.

The Committee discussed whether new timed codes should be separately reimbursed or bundled when they are part of the initial hearing aid purchase, fitting, or verification process. Members noted that the fee schedule previously bundled related testing, dispensing, evaluation, fitting, accessories, and supplies into the hearing aid reimbursement methodology to address outlier billing.

The Committee discussed several new hearing aid measurement, verification, fitting, and post-fitting follow-up codes. Members generally supported maintaining bundled treatment where the service is part of the initial hearing aid process, while considering whether certain post-fitting or maintenance-related services should be separately reimbursable when appropriate.

RefMed will continue updating the hearing aid and audiology code table using the Committee's discussion, including proposed crosswalks, bundled codes, and possible values for separately reimbursable codes.

Hospital Sections and Future Fee Schedule Work

RefMed noted that additional work remains on the hospital sections, including outpatient status indicators and inpatient wage index information. The Committee discussed questions regarding whether CMS updates that occur after fee schedule preparation should be recognized if they are not specifically listed in the fee schedule.

Director Collins noted that this issue relates to the broader discussion regarding static versus dynamic CMS references and stated that the Division will continue considering whether additional language is needed or whether the fee schedule should remain silent and address issues as they arise.

VII. ADJOURNMENT

Member Steed moved to adjourn; Member Dean seconded. The motion passed unanimously.

Adjourn 1:51 p.m.

ALASKA DEPARTMENT OF LABOR
& WORKFORCE DEVELOPMENT

Workers' Compensation Medical Services Review Committee

Medical Services Review Committee Members

Charles Collins, Chair
Alan Swenson, MD
Mason McCloskey, DC
Mary Ann Foland, MD
Jeff Gilbert
Misty Steed
Seanne Popp
Valerie Mittelstead
Kimberley Dean

Schedule for 2026

The Medical Services Review Committee (MSRC) meeting dates for 2026 are as follows:

The committee will begin the year with a virtual Zoom meeting on **May 28 at 9:00 a.m.** Additional Zoom meetings are scheduled for **June 26 at 9:00 a.m.** and **July 17 at 9:00 a.m.**

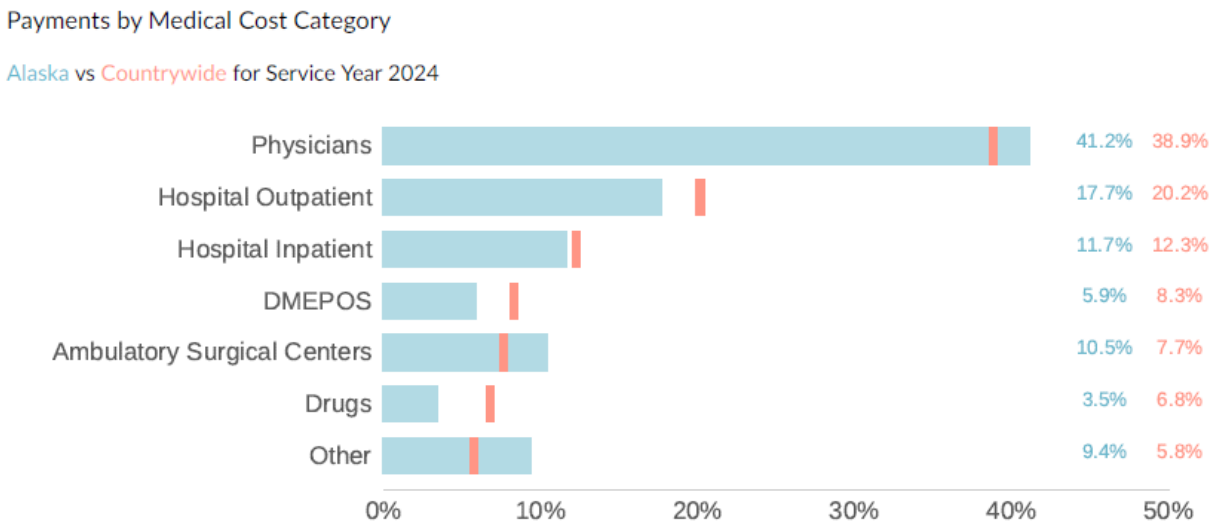
The meeting on **August 7 at 9:00 a.m.** will be held ~~**in person**~~ at the Eagle Street building. All meetings will also be available via Zoom, and a quorum is required for each meeting. Public comments will be accepted at every meeting and will be included in the official minutes.

A joint **AWCB/MSRC** meeting will be held **in person on August 28, 2026**, at the same location. Committee recommendations will be presented during this session.

Meeting Location:
Department of Labor and Workforce Development
3301 Eagle Street, Suite 208
Anchorage, AK 99503

NCCI Cost Comparisons

This information is provided annually from National Council on Compensation Insurance, NCCI, as a resource to monitor aggregated medical data reported by market insurance companies in the states NCCI represents. This data does not include self-insured entities, such as the State of Alaska, in those markets.



The payment distribution by cost category in Alaska is generally consistent with national trends. Physician costs in Alaska are modestly higher than the countrywide average, which is expected given the state's rural geography and the unique challenges associated with delivering healthcare across dispersed populations.

Ambulatory Surgery Centers (ASCs) in Alaska have continued to demonstrate strong performance and provide cost-effective, high-quality services for the workers' compensation system.

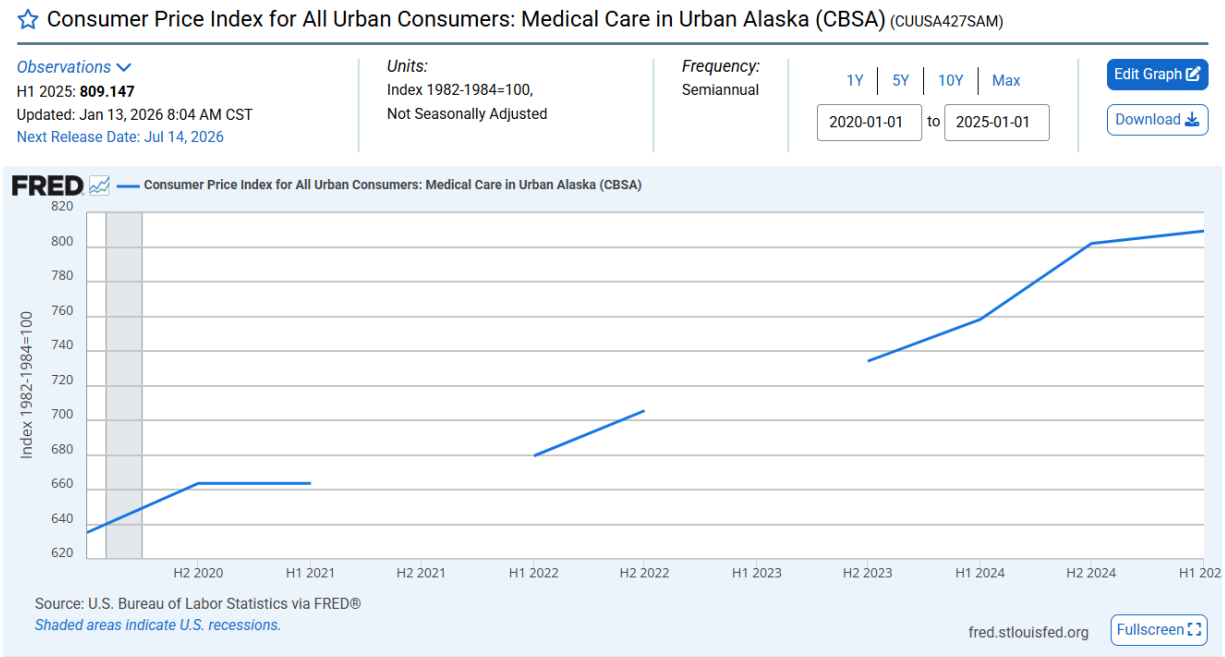
Physician Payments as a Percentage of Medicare

Service Year 2024

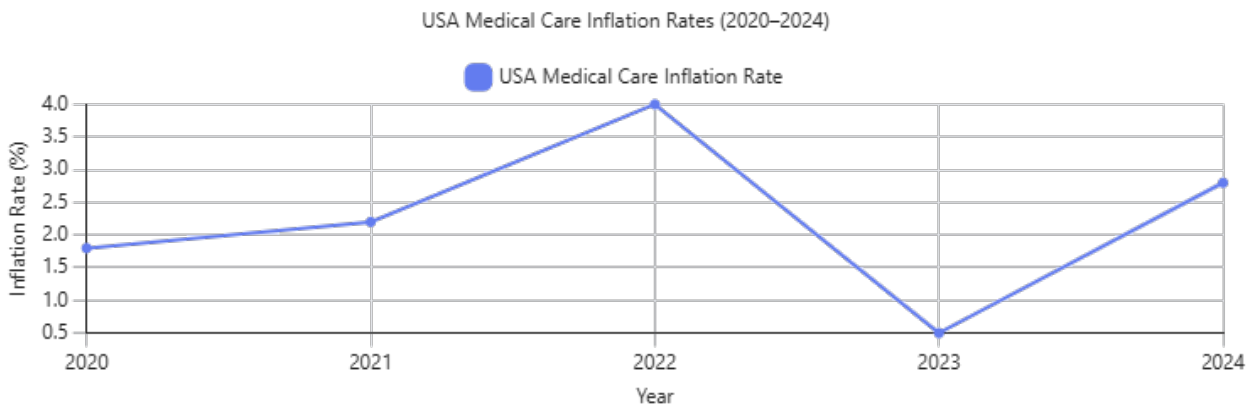
Physician Service Category	Alaska	Countrywide
Anesthesia	298%	316%
Evaluation and Management	189%	148%
Physical and General Medicine	167%	142%
Surgery	275%	258%
Radiology	322%	236%
All Physician Services	**205%**	**169%**

Inflation Data

The U.S. Bureau of Labor Statistics reports that from 2020 through 2024 the Consumer Price Index, CPI, rose 22.9% nationwide. Alaska average weekly wages, the figure workers' compensation benefits are adjusted to, over the same period rose 17.52%. Notably, the Alaska CPI only rose 6.3% during that time.



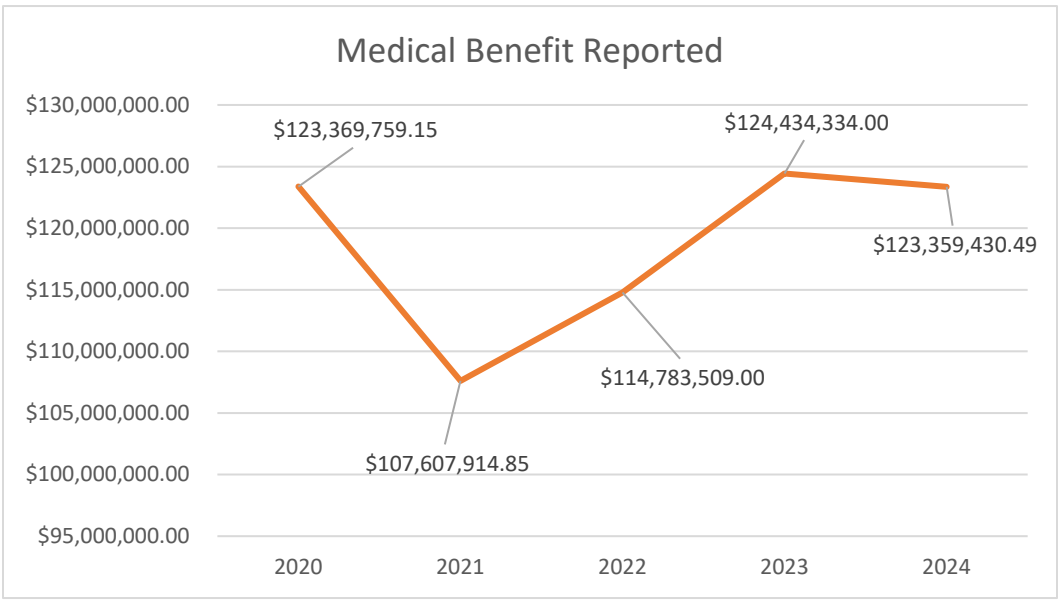
Graph from the Federal Reserve Bank of St Louis charting medical care in Alaska. In comparison, the nationwide medical care inflation graph tells a different story.



Here's a comparison of medical care CPI inflation between Anchorage, AK (H2-to-H2) and U.S. national averages (12-month annual changes)

Region / Period	2020–2024 Increase
Anchorage, AK (H2 2020 → H2 2024)	**+20.8%**
U.S. National (end-2020 → end-2024)	**+11.4%**

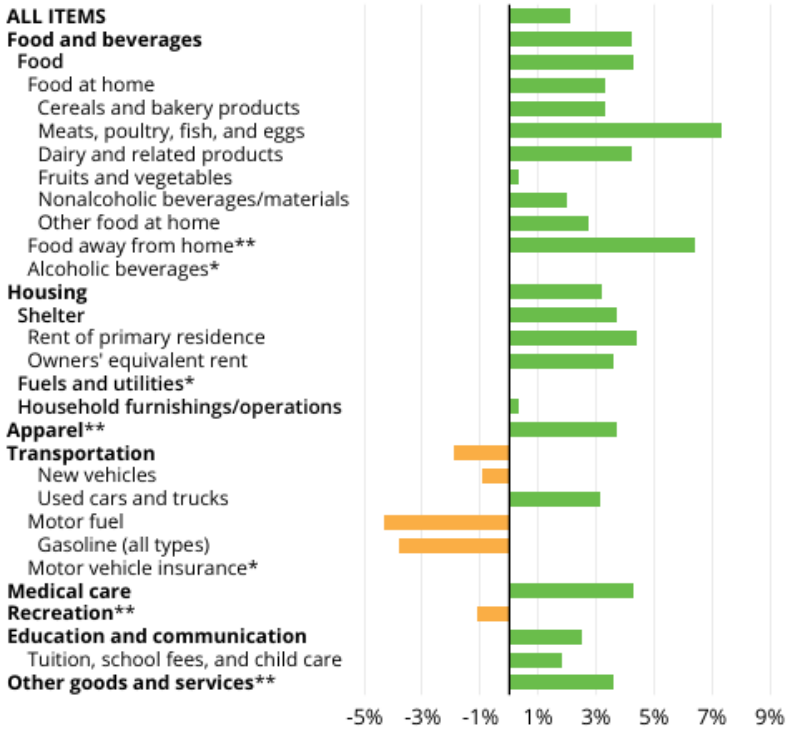
Anchorage experienced a notably larger rise in medical costs, which was ~ 9.4 percentage points higher than the national average over the same period.



Work Document
Medical Services Review Committee
July 17, 2026

Exerts from the Department of Labor and Workforce Development's Research and Analysis unit highlight the issue in Alaska. This month's Trends article on "The Cost of Living" shows continued inflationary pressure on healthcare costs.

Urban Alaska inflation by category in 2025



Health care costs jumped 4.3 percent. Medical care inflation has exceeded 2.4 percent in all of the last eight years. It is also the only major category that has never shown annual price decreases in the 50 years it has been tracked in Alaska.

*Categories weren't reported for 2025. **Annual average not provided by BLS. Estimated values calculated using simple average of all 2025 bimonthly index values provided.

Source: U.S. Department of Labor, Bureau of Labor Statistics, CPI-U for Urban Alaska

How costs for upper-income households compared by city in 2025

	Total	Groceries	Housing	Utilities	Transp	Health	Misc
Category's weight in total index	100%	15%	28%	8%	9%	5%	35%
Survey average of 257 cities	100.0	100.0	100.0	100.0	100.0	100.0	100.0
West							
San Jose CA	184.1	110.3	330.4	143.4	137.0	107.3	121.6
Honolulu HI	183.9	131.4	299.0	194.1	141.5	127.8	122.5
Orange County CA	163.8	108.3	275.0	122.4	138.6	93.6	117.7
San Francisco CA	163.7	115.4	254.0	150.1	141.8	124.3	120.6
San Diego CA	147.4	112.3	209.5	149.3	143.1	99.6	116.0
Seattle WA	144.6	110.9	203.6	100.6	134.8	120.2	124.8
Juneau AK	**131.7**	**128.4**	**138.0**	**144.3**	**120.0**	**139.5**	**126.5**
Anchorage AK	**125.5**	**123.7**	**133.5**	**111.8**	**118.8**	**142.7**	**122.0**
Lake Havasu City AZ	124.5	99.9	173.7	117.2	94.4	88.8	106.8
Sacramento CA	123.8	104.9	137.5	164.1	134.5	106.3	109.8
Fairbanks AK	**122.9**	**123.0**	**99.4**	**213.4**	**121.7**	**135.4**	**119.3**
Bellingham WA	122.7	106.6	138.7	106.0	121.8	105.1	122.8
Portland OR	116.3	107.8	135.8	98.1	126.2	117.9	104.6
Denver CO	110.0	101.9	120.2	87.3	98.8	119.1	112.1
Phoenix AZ	105.3	102.6	112.3	106.4	109.2	95.8	100.5
Salt Lake City UT	104.9	97.5	120.2	85.0	106.3	93.2	101.2
Boise ID	103.2	102.5	105.4	73.0	107.2	105.0	108.0
Billings MT	97.1	103.1	92.8	81.8	105.2	111.2	97.9
Albuquerque NM	96.8	97.7	90.5	84.8	94.4	108.0	104.0
Las Vegas NV	95.6	102.9	102.7	92.5	113.3	87.7	83.5
Laramie WY	92.9	98.0	82.2	96.1	90.0	92.6	100.0

Drug Pricing Data

Alaska does **not regulate pharmacy retail pricing** in the private market, including prices for repackaged drugs. Pharmacies are free to set their own prices.

Data Basis & Transparency

Feature	NADAC	Red Book
Data Source	Real acquisition invoices from pharmacies	Manufacturer-supplied list and reference prices
Transparency	Fully public, CMS methodology available	Proprietary pricing; methodology not fully transparent

Typical Uses

- **NADAC**:
    - Benchmarking pharmacy acquisition costs
    - Medicaid reimbursement modeling
    - Transparent cost analysis
- **Red Book**:
    - Contracting and pricing guides for payers and PBMs
    - Clinical decision support, drug compendium data
    - Legacy pricing references (like AWP)

Summary

- Use **NADAC** when you need a **public, accurate, weekly** benchmark of what pharmacies actually pay—ideal for cost analysis, Medicaid reimbursement, and transparency efforts.
- Use **Red Book** when you require a **comprehensive, commercial drug database** with list prices, clinical data, and payer contract references—especially in contexts involving PBM pricing, clinical support systems, or legacy AWP-based contracts.

Physician Dispensing in Alaska

Alaska regulations **do permit** the dispensing of repackaged or prepackaged drugs, but under specific conditions overseen by licensed pharmacists:

Pre-packaged Drugs for Practitioner Use

Under **12 AAC 52.590**, pharmacies may **prepackage** medications (e.g., unit-doses) for prescribing practitioners, provided:

- A **pharmacist supervises** the prepackaging
- Packages are **child-resistant**
- Labels include:
    1. Pharmacy name, address, phone
    2. Drug name, strength, quantity
    3. Lot number and expiration date
    4. Safety/cautionary statements
    5. Pharmacist's initials

Alaska does not set retail price caps for pharmacies in the private market. However, **Medicaid** imposes legally defined limits on *reimbursement* and *dispensing fees* for covered outpatient drugs.

Dispensing Fee Limits

Under **7 AAC 145.410**, Alaska Medicaid pays a capped dispensing fee for each covered outpatient drug, with the amount depending on the type and location of the pharmacy:

- **$15.03** – Nontribal pharmacy on the road system
- **$26.94** – Nontribal pharmacy off the road system
- **$28.21** – Tribal pharmacy
- **$16.58** – Tribal or nontribal **mediset** pharmacy
- **$10.76** – Out-of-state pharmacy
- Compounded drugs receive the same applicable dispensing fee

Medicaid will reimburse **the lesser of** the assigned dispensing fee or the provider's submitted fee. If a pharmacy fails to supply required cost documentation when requested, the state may reduce its reimbursement to **$3.45** and impose sanctions.

Medicaid establishes ingredient reimbursement based on **NADAC**, **wholesale acquisition cost (WAC) + 1%**, or **usual and customary (U&C)** price—depending on drug type and availability.

Top Procedure Codes by Taxonomy from NCCI Data 2024

Here are the **top-used procedure codes for each provider taxonomy**, based on the highest number of **transactions** in the NCCI dataset. (Analysis performed programmatically.)

Physical Therapist
- **Code:** 97110
- **Transactions:** 2,816
- This is the most frequently billed code by Physical Therapists.

Orthopedic Surgery
- **Code:** 97110
- **Transactions:** 1,227
- Orthopedic Surgery providers most often bill this PT therapeutic exercise code.

Chiropractor
- **Code:** 97012
- **Transactions:** 440
- Mechanical traction appears as the most-used code for chiropractors.

Clinic/Center
- **Code:** 97140
- **Transactions:** 359
- Manual therapy (97140) is the highest-volume code in clinic/center settings.

General Practice
- **Code:** 97110
- **Transactions:** 355
- Therapeutic exercise (97110) is the most frequently used code in general practice.

Massage Therapist
- **Code:** 97140
- **Transactions:** 102
- Manual therapy (97140) is the most commonly used procedure code.

Occupational Therapist
- **Code:** 97530
- **Transactions:** 323
- Therapeutic activities (97530) is the most-used OT code.

Occupational Therapy Assistant
- **Code:** 97530
- **Transactions:** 202
- OTAs also bill therapeutic activities most often.

Prosthetic/Orthotic Supplier

- **Code:** 97799
- **Transactions:** 1
- Only one line item appears, so this is automatically the top.

Durable Medical Equipment & Medical Supplies

- **Code:** 97760
- **Transactions:** 11
- Orthotic management and training are the most frequent.

Neuromusculoskeletal Medicine & OMM

- **Code:** 97597
- **Transactions:** 19
- Active wound care management is the highest-volume.

Physical Medicine & Rehabilitation

- **Code:** 97110
- **Transactions:** 17
- Therapeutic exercise again appears as most-used.

Nurse Practitioner

- **Code:** 97140
- **Transactions:** 6
- Manual therapy is most common.

Social Worker

- **Code:** 97110
- **Transactions:** 17
- This provider appears to use therapeutic exercise most often.

Student in Health Care Training Program

- **Code:** 97530
- **Transactions:** 4
- Therapeutic activities is the top code.

Military Health Care Provider

- **Code:** 97112
- **Transactions:** 7
- Neuromuscular reeducation is the most-used.

Acupuncturist

- **Code:** 97530
- **Transactions:** 14
- Therapeutic activities emerges as most-used despite being uncommon for acupuncture.

Physician Assistant

- **Code:** 97140
- **Transactions:** 18
- Manual therapy is most-used.

Top Medicine Codes by usage 2026 SY 2024				Alaska Conversion Factor
Codes 90281-99199				$80.00
CPT Code	Total Payments	Total Transactions	Cost Each	Description
97110	$ 2,021,963.98	18,246	$ 110.82	Therapeutic treatment to develop strength and range of motion.
97140	$ 1,367,853.36	13,519	$ 101.18	Manual therapy techniques
97530	$ 1,687,472.13	12,643	$ 133.47	Therapeutic activities functional improvement
97112	$ 1,003,819.70	9,452	$ 106.20	Therapeutic procedure reeducation of movement
99199	$ 755,979.37	5,975	$ 126.52	Unlisted / Miscellaneous
98941	$ 255,396.25	2,847	$ 89.71	Chiropractic manipulative treatment Spinal 3-4 regions
97014	$ 35,689.45	1,063	$ 33.57	Electrical Stimulation
98943	$ 68,227.70	1,060	$ 64.37	Chiropractic manipulative treatment extraspinal region
97035	$ 33,152.55	986	$ 33.62	Ultrasound Therapy
97545	$ 211,548.71	976	$ 216.75	2-hour session work hardening program

RECOMMENDATIONS TO THE MEDICAL SERVICES REVIEW COMMITTEE (MSRC)

Proposed Additions and Amendments to the 2026 Alaska Workers' Compensation Medical Fee Schedule

Prepared for the Alaska MSRC — Consolidated package of four recommendations, with target insertion points keyed to the published 2026 fee schedule (printed page numbers).

Overview

This document consolidates the Committee's finalized items into a single set of recommendations for the 2026 Alaska Workers' Compensation Medical Fee Schedule ("AK WC FS"). Each recommendation below identifies the exact location in the published schedule where the language or values should be inserted, using the schedule's printed page numbers. Proposed regulatory text is shown in italics; supporting fee values and documentation standards are shown in tables.

Summary of recommendations and insertion points

#	Recommendation	Insertion point	Fee-schedule section
1	Repackaged/relabeled drugs, physician-dispensed drugs, and topical & compound caps	Page 2	Introduction → Drugs and Pharmaceuticals
2	Remote Therapeutic Monitoring (RTM) — documentation requirements and code values	Pages 33–36	Medicine (new RTM subsection + fee values)
3	Durable Medical Equipment — rental cap and valued-items-without-RR language	Page 43	HCPCS Level II → Durable Medical Equipment
4	Audiology / hearing-aid CPT codes and MSRC-approved fees	Page 44	HCPCS Level II → Hearing Aid Services chart

Note on status: The drug/physician-dispensed language, RTM code values, DME language, and hearing-aid determinations were finalized by the Committee; the topical/compound cap language and the RTM documentation standards are added here so the full package can be adopted together.

Recommendation 1 — Repackaged/Relabeled Drugs, Physician-Dispensed Drugs, and Topical & Compound Caps

Insertion point: Page 2 of the 2026 AK WC FS, under *Introduction → Drugs and Pharmaceuticals*. Add the following as new lettered subsections. Per the Committee's direction, the topical/compound cap language is placed in this same drug section so all pharmacy reimbursement rules sit together.

(e) Repackaged or relabeled drugs

Reimbursement for a repackaged or relabeled drug may not exceed the current Alaska workers' compensation fee-schedule amount for the same drug and quantity, calculated on the original NDC (the manufacturer's average wholesale price). No separate repackaging, relabeling, or handling fee is payable.

(f) Physician-dispensed drugs

Reimbursement for a drug dispensed by a physician in the physician's office may not exceed the current Alaska workers' compensation fee-schedule amount for the same drug and quantity, calculated on the original NDC (the manufacturer's average wholesale price), and no separate dispensing, compounding, or handling fee is payable to the physician. The bill must include the original NDC, as required by AS 23.30.097(o). A physician-dispensed topical or compounded drug (topical creams, gels, ointments, lotions, patches, topical compounds, and over-the-counter products) is reimbursed at a lower-cost therapeutic equivalent when available, and reimbursement may not exceed the equivalent's average wholesale price.

(g) Topical and compounded drug caps

Proposed cap language (new), derived from a peer-state benchmark analysis:

Reimbursement for a topical or compounded drug — including topical creams, gels, ointments, lotions, patches, topical compounds, and over-the-counter products, whether physician-dispensed or pharmacy-dispensed — may not exceed the lesser of the applicable cap below or the Alaska workers' compensation fee-schedule (AWP-based) amount for the drug and quantity dispensed. Each 30-day cap is prorated to the exact number of days' supply or quantity dispensed:

- *(1) OTC or private-label topical cream, gel, ointment, or lotion — $30 per 30-day supply;*
- *(2) OTC or private-label topical patch — $70 per 30-day supply;*
- *(3) Compounded topical preparation — $240 per 30-day supply;*
- *(4) Dispensing fee — a single dispensing fee not to exceed $5 per prescription;*
- *(5) In no event may total reimbursement for any single topical or compounded prescription exceed $240.*

Compounded preparations must be billed at the ingredient level using each ingredient's original-manufacturer NDC; ingredients without a valid NDC, or that are not FDA-approved for topical use, are not reimbursed. Compounded topicals require prior authorization and documented medical necessity, and no automatic refills are permitted (each fill requires a new prescription). Where a lower-cost therapeutic or OTC equivalent is available, reimbursement may not exceed the lesser of the applicable cap or that equivalent's average wholesale price.

Cap values and derivation (peer-state benchmarks):

Category	Proposed cap	Derivation logic	Peer benchmark range
OTC / private-label topical cream or lotion	$30 / 30-day	Modal peer flat cap	AZ $30 · MS $30 · CO $31.21
OTC / private-label topical patch	$70 / 30-day	Modal peer flat cap	MS $70 · SC $70 · CO $72.83 · AZ $75
Compounded topical — single flat cap	$240 / 30-day	Modal peer flat cap (GA Cat III / SC ceiling)	GA/SC/AZ $240 · MS $300 · RI $500
Compounded topical — tiered alternative (Georgia model)	$80 / $160 / $240	Adopt GA category codes for administrability	GA0801 $80 / GA0802 $160 / GA0803 $240
Single dispensing fee	$5	Modal peer flat dispensing fee	SC $5 · MS $5 · AZ $7
Absolute per-Rx ceiling (any topical)	$240	No topical reimbursed above the compound cap	$240 (GA, SC)

Currently Alaska sets no topical or compound dollar cap — pharmacy is AWP-based (brand AWP + $5 / generic AWP + $10) with no specific compound guidance. These caps add a dollar ceiling on that basis. The Committee may adopt either the single $240 compound cap or the tiered Georgia alternative shown above.

Recommendation 2 — Remote Therapeutic Monitoring (RTM): Documentation Requirements and Code Values

Insertion point: Medicine section, pages 33–36 of the 2026 AK WC FS. RTM codes 98975–98986 fall within the Medicine section (immediately after the physical-medicine, telehealth, and manipulative-treatment codes). Add the documentation standards below as a new *Remote Therapeutic Monitoring* subsection of the Medicine guidelines, and add the RTM fee values to the Medicine fee listing.

RTM code values (Alaska WC fee schedule)

Code	Description	AK Non-Facility Fee	AK Facility Fee
98975	RTM initial set-up & patient education on equipment	$54.56	$54.56
98976	RTM device supply, respiratory system, 16–30 days	$132.50	$132.50
98977	RTM device supply, musculoskeletal system, 16–30 days	$130.80	$130.80
98978	RTM device supply, cognitive behavioral therapy, 16–30 days	$0.00*	$0.00*
98979	RTM treatment management, first 10 minutes	$77.68	$39.34
98980	RTM treatment management, first 20 minutes	$158.37	$85.95
98981	RTM treatment management, each additional 20 minutes	$125.64	$84.75
98984	RTM device supply, respiratory system, 2–15 days	$132.50	$132.50
98985	RTM device supply, musculoskeletal system, 2–15 days	$130.80	$130.80
98986	RTM device supply, cognitive behavioral therapy, 2–15 days	$0.00*	$0.00*

** Codes 98978 and 98986 (CBT device supply) are valued at $0.00, i.e., not separately payable under the Alaska WC fee schedule.*

RTM documentation requirements

The following documentation supports each RTM claim and reflects CMS and CPT rules for 2026 together with general compliance practice. The foundational items apply to every claim; the remainder are code-specific. For workers' compensation, each item must be tied to the compensable injury.

Category	Requirement	What must be documented	Applies to
Every claim	Patient consent	Obtained and documented before services begin; may be verbal but must be recorded; note the cost-sharing disclosure and that only one practitioner bills per period.	All
	Order and plan of care	Physician or qualified health professional order; when a therapist furnishes the service, under a therapy plan of care.	All
	Medical necessity	Tied to the specific condition; for workers' compensation, the compensable injury.	All
	FDA-defined device	Document that the device meets the FDA medical-device definition, what it is, and how it collects and transmits data (data may be self-reported).	All

Category	Requirement	What must be documented	Applies to
	Electronic transmission	Evidence the data was electronically collected and sent to a secure location for the billing practitioner's review and interpretation.	All
	Program selection	RTM and RPM are not billed in the same month; only one clinician bills per period.	All
Device-supply	Day-count log	A date-stamped log of the number of days data was collected or transmitted in the 30-day period. Proves the tier: 16–30 days supports 98976/98977; 2–15 days supports 98984/98985.	98976, 98977, 98984, 98985
	Subjective (patient-reported) input	Document the specific self-reported data (pain scores, function/mobility ratings, symptom reports, home-exercise and medication adherence), that it was entered by the patient through the FDA-defined device or app, and the dates of entry. Show how the practitioner reviewed and used it against the plan and the compensable injury.	98977, 98985 (and 98976 / 98984)
	30-day window	Document the 30-day period for each billed device code (billed per 30-day period, not per calendar month).	Device codes
	Device and dates	Identify the specific device or software supplied and the dates in use. No monthly time log is required for these codes.	Device codes
	One code per period	Only one device-supply code is billed per 30-day period. 98977 and 98985 are not additive and not a base-and-add-on pair (CY2026 final rule); select one based on days of data transmission.	98977, 98985
	Date of service	Report the device code once per 30-day period, using the last date of treatment (final data day) within that period as the date of service.	Device codes
Management	Monthly time log	A contemporaneous, itemized log of treatment-management minutes in the calendar month (98979 covers the first 10 minutes).	98979
	Real-time interaction	At least one real-time, synchronous, two-way interactive communication with the patient or caregiver per calendar month, with date and participants recorded. Audio qualifies; asynchronous review, texting, and email do not count.	98979
	Content of the work	Review of the monitoring data, assessment of adherence and therapeutic response, and any treatment or care-plan adjustments.	98979
With active PT	Segregated time	RTM management minutes documented as separate and distinct from the timed, one-on-one therapy minutes (97110, 97112, 97140, 97530). The same minute cannot count toward both.	98979
	Outside the session	A note that the RTM management activity occurred outside the in-person therapy session, so it is clearly additional to the billed therapy.	98979

Category	Requirement	What must be documented	Applies to
Modifiers	Therapy modifiers	GP, GO, or GN when furnished under a therapy plan of care by a PT, OT, or SLP.	All (therapist)
	PTA/OTA de minimis	CQ or CO when a PTA or OTA furnishes the service in whole or in part. Applies to 98975, 98979, 98980, 98981; not to device-supply codes.	98975, 98979, 98980, 98981
	Setup	For 98975, document the education and training on device setup and use, and what data to input, how, and how often.	98975
WC / Alaska	Compensable-injury tie	Explicit link to the compensable injury and documentation of medical necessity for the accepted condition.	All (WC)
	Alaska authorization	Capture any Alaska authorization the Board adopts, and identify the billing provider and payee correctly on the claim.	All (Alaska)
Retention	Records and audit	Maintain secure, contemporaneous, auditable records of device/software data, day-count logs, time logs, and interactive-communication notes for the applicable retention period.	All
Related (RPM)	RPM code ranges	RPM is a distinct family (physiologic data, not RTM therapy data) and cannot be billed with RTM in the same month. RPM: 99453 (setup), 99454 (device 16–30d), 99445 (device 2–15d, new 2026), 99457 (mgmt first 20 min), 99458 (each add'l 20 min), 99091 (data review); self-measured BP 99473/99474 is separate.	RPM family

In summary: every RTM claim documents, before services begin, patient consent (may be verbal but must be recorded), a physician/QHP order (and a therapy plan of care when a therapist furnishes the service), medical necessity tied to the compensable injury, use of an FDA-defined device and how it collects/transmits data, and secure electronic transmission to the billing practitioner — with RTM and RPM never billed in the same month and only one clinician billing per period. Device-supply codes (98976, 98977, 98984, 98985) require a date-stamped day-count log proving the tier (16–30 days for 98976/98977; 2–15 days for 98984/98985); only one device-supply code is billed per 30-day period, and the date of service is the last treatment date in that period. The management code (98979) instead requires a monthly time log and at least one real-time, synchronous, two-way interaction (asynchronous review, texting, and email do not count). When RTM runs alongside active in-office PT, management minutes must be separate from the timed therapy minutes. Claims carry the correct modifiers (GP/GO/GN; CQ/CO for PTA/OTA on 98975, 98979, 98980, 98981 but not device codes) and are retained as secure, auditable records.

Recommendation 3 — Durable Medical Equipment (DME)

Insertion point: Page 43 of the 2026 AK WC FS, under *HCPCS Level II → Durable Medical Equipment*. Replace the existing DME paragraphs with the revised wording below (recommended additions are underlined in the source markup and described in the summary of changes).

Proposed revised wording

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are reported using HCPCS Level II codes. Reimbursement is the lower of the CMS DMEPOS fee schedule value for Alaska in effect at the time of treatment or service multiplied by 1.66 or billed charges. If no code identifies the supply, bill using the appropriate unlisted HCPCS code or CPT code 99070. An invoice is required and reimbursement shall be the lower of the submitted manufacturer/supplier's invoice plus 20 percent or billed charges. DME items without a code or unvalued (i.e., $0.00) in the DMEPOS fee schedule are still reported with the correct HCPCS code. An invoice is required for items without stated value and reimbursement shall be the lower of the submitted manufacturer/supplier's invoice plus 20 percent or billed charges. Rental items are reported with modifier RR. The monthly reimbursement is the value as calculated using the invoice multiplied by 0.10. Only those DME rental items calculated using the invoice may be reimbursed at a daily rate based on the monthly reimbursement divided by 30 (multiplied by 0.0333). In no event shall the total accumulated rental reimbursement for an item exceed its purchase price; when cumulative rental payments equal the purchase price, the item is considered purchased and no further rental is payable.

Some DME codes are listed in the DMEPOS fee schedule with a value but without a separate rental (RR) rate. Examples include, but are not limited to: E0720 and E0730 (TENS units) and codes in the oxygen and oxygen equipment (OX) category. When such an item is rented, the monthly reimbursement is the lesser of the billed charges or the code's DMEPOS purchase value multiplied by 0.10, for each month of rental. For this purpose, the purchase value is the amount listed for the code without a modifier or, where applicable, the amount listed under the NU modifier. This rental calculation applies only to reusable equipment; it does not apply to consumable, disposable, or single-use items, such as batteries and other expendable supplies, which are reimbursed as purchased items rather than rented. In no event shall the total accumulated rental reimbursement for an item exceed its purchase price; when cumulative rental payments equal the purchase price, the item is considered purchased and no further rental is payable.

Summary of recommended changes

- **Rental cap (invoice-based rentals):** added that total accumulated rental reimbursement may not exceed the purchase price, and that once cumulative rental equals the purchase price the item is considered purchased and no further rental is payable.
- Revision of the valued-items-rented-without-an-RR-rate paragraph for clarity, including:
    - Added examples of such codes: E0720 and E0730 (TENS units) and the oxygen and oxygen equipment (OX) category.
    - Defined "purchase value" as the amount listed for the code without a modifier or, where applicable, under the NU modifier (replacing "non-modified or modified with NU value").
    - Added the rental-not-to-exceed-purchase-price cap to this paragraph as well.
    - Added an exclusion for consumable, disposable, or single-use items (e.g., batteries, expendable supplies), reimbursed as purchased rather than rented.

Recommendation 4 — Audiology / Hearing-Aid Codes and Fees

Insertion point: Page 44 of the 2026 AK WC FS, in the *Hearing Aid Services* chart (HCPCS Level II section). Add the new 2026 audiology CPT codes to the existing page-44 chart alongside the current hearing-aid entries (e.g., V5014 and V5020, and 92591/92593), using the MSRC-approved fees below.

Committee action: of the twelve new 2026 CPT audiology codes reviewed, six are covered at the fees shown and six are non-covered. Covered fees total $585.

MSRC-approved audiology fees

CPT Code	Description	AK WC Fee (MSRC Approved)
92628	Evaluation for hearing aid candidacy, first 30 min	$195
92629	Evaluation for hearing aid candidacy, each additional	$50
92631	Hearing aid selection service, first 30 min	Non-Covered
92632	Hearing aid selection service, each additional	Non-Covered
92634	Hearing aid fitting service, first 60 min	Non-Covered
92635	Hearing aid fitting service, each additional	Non-Covered
92636	Hearing aid post-fitting follow-up, first	$150
92637	Hearing aid post-fitting follow-up, each additional	$50
92638	Behavioral verification of amplification	Non-Covered
92639	Hearing-aid measurement / verification	$70
92641	Hearing device verification, electroacoustic analysis	$70
92642	Supplemental / assistive technology fitting service	Non-Covered

Placement note: *The six covered codes (92628, 92629, 92636, 92637, 92639, 92641) should be added to the page-44 Hearing Aid Services chart in the same code/MAR format as the existing entries (e.g., V5014 $249.31 and V5020 $116.17). The six non-covered codes may be listed as non-covered for completeness or omitted per Committee preference.*

Prepared as a consolidated recommendation package for MSRC review and adoption into the 2026 Alaska Workers' Compensation Medical Fee Schedule. Page references correspond to the printed page numbers of the published 2026 schedule.