ALASKA WORKERS' COMPENSATION
MEDICAL SERVICES REVIEW COMMITTEE MEETING

June 26, 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

June 26, 2026

9:00 am Call to order
- Roll call - establishment of quorum
- Approval of Agenda
- Approval of MSRC May 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
- Conversion Factor Worksheet
- RefMed: Example of billing common medical codes
- Further Discussion on Audiology codes and procedures
- DME Device reimbursement, (SAM for example)
- Compound medications and Physician dispensing
- NCCI data comparisons
- Changes in CMS that may affect Alaska

1:00 pm Adjournment

Alaska Workers' Compensation Division
Medical Services Review Committee
Meeting Minutes
May 28, 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	Jeff Gilbert	Dr. Mary Ann Foland
Misty Steed	Seanne Popp	Kimberley Dean	Valerie Mittelstead

Director Collins introduced Danean Tedford and Judy Engelke from RefMed.

III. FEE SCHEDULE DEVELOPMENT DISCUSSION

Remote Therapeutic Monitoring

The Committee discussed app-based tracking and remote therapeutic monitoring codes billed with physical therapy, including whether these services duplicate in-person treatment or may be separately reimbursable when properly documented and included in the treatment plan. The Committee noted that reimbursement may depend on whether the provider is actively reviewing, modifying, or managing the treatment plan, rather than merely importing app data into the chart. The Committee also discussed the need for clear documentation standards, including whether remote monitoring should be identified in the treatment plan and physician's report. RefMed will research remote patient monitoring and remote therapeutic monitoring rules, including CMS requirements and how other states address overlap with in-person therapy.

Acoustic Medical Devices and FDA Status

The Committee discussed acoustic medical devices, including SAMSport-type devices billed under generic DME code E1399. The Committee discussed concerns regarding cost, accessories, rental versus purchase, and whether the device is FDA-cleared rather than FDA-approved. Dr. McCloskey and Dr. Swenson noted that the device appeared more comparable to low-intensity ultrasound technology than a TENS unit, and the Committee discussed whether E0760 may be a comparable code.

The Committee also discussed the distinction between FDA-approved and FDA-cleared devices and cautioned that excluding FDA-cleared devices could have unintended consequences for other commonly used medical devices. The Committee agreed that any fee schedule language should consider FDA status, documentation, and medical justification without inadvertently excluding appropriate treatment.

RefMed will research comparable codes, surrounding-state treatment of similar devices, FDA-cleared versus FDA-approved language, and rental/purchase considerations.

Break 10:04 a.m. – 10:15 a.m.

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

No public comment.

V. FEE SCHEDULE DEVELOPMENT DISCUSSION CONTINUED

Compound Medications and Physician Dispensing

The Committee discussed concerns regarding compound medications, physician dispensing, repackaged drugs, newly created NDCs, and compounded products containing over-the-counter ingredients or separately priced components. Member Steed noted that minor formulation differences, such as lidocaine 4% versus 5%, can result in significant cost differences, with some compounded medications costing several thousand dollars per month.

The Committee discussed approaches used by other states, including caps on compounded medications, limits on automatic refills, prior authorization requirements, pricing limits, treatment of over-the-counter components, use of original versus repackaged NDCs, and pharmacy or dispensing licensure documentation.

RefMed will provide additional state comparisons regarding compound medications, physician dispensing, repackaged drugs, prior authorization, refill limits, and pricing caps. Director Collins will review Alaska pharmacy and dispensing requirements.

Fee Schedule Versioning and CMS Updates

The Committee discussed whether the fee schedule should more clearly identify which CMS data files and versions apply when CMS updates occur during the year. Director Collins noted that prior legal guidance has favored a bright-line approach tied to the fee schedule's effective date, but CMS files now update dynamically or quarterly in some areas, creating practical challenges for payers and providers.

The Committee discussed whether the fee schedule should adopt static or dynamic CMS references, particularly where software systems automatically update to the most recent Medicare data.

The Committee will continue discussing this issue, and Director Collins will follow up with legal as needed.

Provider Definitions and Documentation Issues

The Committee discussed whether the fee schedule should better define provider categories, including "other providers" reimbursed at 85% of MAR. The discussion included questions regarding physical therapists, doctors of physical therapy, physician assistants, advanced practice registered nurses, naturopaths, and whether additional clarification would help reduce disputes regarding provider type, scope of practice, and reimbursement level.

The Committee also discussed whether additional documentation should be required for unlisted or miscellaneous codes reimbursed at 85% of billed charges. No decision was made.

Telehealth and Interpreter Services

The Committee discussed telehealth-related issues, including possible documentation, technical, and HIPAA-compliant platform standards. The Committee also discussed interpreter services and noted that interpreter services are commonly needed in Alaska, including for non-English languages, Alaska Native languages, and ASL.

The Committee agreed that telehealth and interpreter services should be considered further as part of the fee schedule review.

Physical Therapy Multiple Procedure Payment Reduction

The Committee discussed the CMS multiple procedure payment reduction rule for physical therapy codes. RefMed explained that the reduction applies only to the practice expense RVU portion of subsequent therapy procedure codes, not to the full reimbursement amount. The Committee noted that additional explanation may help address confusion regarding how the reduction is calculated.

RefMed will prepare a visual or step-by-step example showing how the multiple procedure reduction works for commonly used physical therapy codes.

Facility, Ancillary Services, and DME Rules

The Committee discussed facility, ancillary service, and durable medical equipment issues, including facility reimbursement categories, ambulance rates, DME rental rules, rental-to-purchase rules, repair and maintenance, delivery and setup, replacement standards, automatic resupply, and supplier credentialing.

The Committee also discussed whether current DME rental language in the fee schedule should be clarified, particularly for items without clear Medicare rental values or items rented under workers' compensation even if not traditionally rented under Medicare.

RefMed will review DME rental language and research potential approaches for rental-to-purchase rules and related DME issues.

Hearing Aid and Audiology Codes

The Committee discussed new hearing aid and audiology codes, including concerns that some new timed codes may replace older capped codes and result in significantly higher charges. RefMed noted that the new codes are difficult to crosswalk because the prior codes do not map directly to the new timed codes.

The Committee discussed possible approaches, including reviewing code definitions, other state fee schedules, available commercial data, time-based documentation requirements, provider input, and possible caps to address outlier billing.

RefMed will continue researching new hearing aid and audiology codes. Member Steed will reach out to Aurora for additional provider input.

NCCI and Regional Comparison Data

Member Steed asked about the annual comparison data historically prepared for the Committee showing Alaska's conversion factors compared to regional and national data. RefMed stated that it had obtained the NCCI data and would complete the comparison before the next meeting.

Administrative Burden and Report/Review Time

The Committee discussed administrative burden on medical providers in workers' compensation cases, including paperwork, report review, return-to-work documentation, IME-related requests, and vocational rehabilitation-related requests. The Committee discussed whether providers understand when review or report time may be billable and whether additional outreach or education would be helpful.

Director Collins will consider provider outreach regarding workers' compensation paperwork, report/review billing, and related administrative issues, including possible outreach through the Alaska State Medical Association.

VI. ADJOURNMENT

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

Adjourn 12:16 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 21, 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

Concerns on Fee Schedule for Consideration

The 2026 Alaska Workers' Compensation Medical Fee Schedule has prompted several comments and questions that the committee may wish to address. Concerns were raised regarding the application of RVU calculations, updates to payment systems, and medical code changes resulting from the schedule's delayed implementation. An internal document will be shared with committee members to help determine whether adjustments to the Fee Schedule are necessary.

What DMEPOS items can and should qualify for rental if there is no RR designation from CMS?

Should Alaska regulate reimbursement discounts between providers and payors when negotiated contract prices fall within the Fee Schedule limits?

Does dispensing of drugs by physicians need further regulation? Covered by 8 AAC 45.081:

Dispensing of generic drug products. (a) When filling a prescription provided to an employee as a medical benefit under the Act, an available generic drug product must be dispensed in place of a name-brand drug product when the cost of the generic drug product is less, except that a name-brand drug product that is more expensive than an available generic drug product may be dispensed if the prescribing physician has provided a written justification of the medical necessity for dispensing the name-brand drug product as described in this section. A notation that the prescription for the name-brand drug product must be dispensed only as written is not a sufficient justification of medical necessity. (b) The prescribing physician must prepare the written justification of the medical necessity of dispensing a name-brand drug product and submit the written justification along with the prescription to the dispensing pharmacist and the insurer. The written justification does not need to be submitted to the dispensing pharmacist if the prescription itself

expressly notes that the prescription is being provided as a medical benefit under the Act and that a written justification of the medical necessity for dispensing a name-brand drug product has been submitted to the insurer. (c) A written justification of the medical necessity for dispensing the name-brand drug product may include any of the following factors regarding the employee: (1) treatment failure with the generic drug product; (2) past medical history that suggests an anticipated treatment failure with the generic drug product; (3) clinically significant adverse reaction to the generic drug product; (4) a medical condition that causes a contraindication for the use of the generic drug product; (5) allergic reaction to the generic drug product. (d) An employee may choose to have a name-brand drug product dispensed, even if a less costly generic drug product is available and no written justification of medical necessity has been provided. The difference in cost between the generic drug product and name-brand drug product must be paid by the employee and neither the employer or the employer's insurer is liable for reimbursing the employee for the additional cost. (e) The Alaska Medicaid Preferred Drug List, Version 111809, revised as of November 18, 2009, is adopted by reference as the preferred drug list for purposes of the Act.

Concerns on Multiple Procedure Payment Reduction application and the practice expense equation.

Which CMS file or application should be used for generating reimbursement rates annually? As many of the applications from Center for Medicaid and Medicare Services, CMS, update quarterly, does the reimbursement rate change?

The Fee Schedule directs Maximum Allowable Reimbursement, MAR, to be limited to 85 percent for services provided by “other providers”. A question about who other providers consist of.

“85 percent of the MAR for medical services performed by “other providers” (i.e., other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers)” 2026 Medical Fee Schedule page 1.

Finally, and surprisingly, concerns have been shared this year that the Fee Schedule is confusing and hard to follow. This is a new comment, but a serious issue and the MSRC will look at alternatives this year and decide if the Fee Schedule should incorporate layout changes.

Concerns about Audiology codes, procedures and billing amounts.

Drug Pricing Data

Commonly used guidelines for pricing:

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

Cadence & Access

- **NADAC**: Updated weekly; entirely free and public access via CMS .
- **Red Book**: Updated periodically (often monthly); requires paid subscription .

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)

Price Accuracy

- **NADAC** aligns closely with pharmacy costs—considered the *gold standard of acquisition cost* .
- **Red Book's** prices (like AWP) can be *significantly inflated* compared to actual acquisition cost, often by 15–30× for generics .

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

Sec. 08.64.364. Prescription of drugs without physical examination.
(a) The board may not impose disciplinary sanctions on a physician or physician assistant for rendering a diagnosis, providing treatment, or prescribing, dispensing, or administering a prescription drug that is not a controlled substance to a person without conducting a physical examination if

(1) the physician, physician assistant, or another licensed health care provider in the medical practice is available to provide follow-up care; and

(2) the physician or physician assistant requests that the person consent to sending a copy of all records of the encounter to the person's primary care provider if the prescribing physician or physician assistant is not the person's primary care provider and, if the person consents, the physician or physician assistant sends the records to the person's primary care provider.

(b) The board may not impose disciplinary sanctions on a physician or physician assistant for prescribing, dispensing, or administering a prescription drug that is a controlled substance if the requirements under (a) of this section and AS 08.64.363 are met.

(c) Notwithstanding (a) and (b) of this section,

(1) a physician may not prescribe, dispense, or administer an abortion-inducing drug under (a) of this section unless the physician complies with AS 18.16.010; and

(2) a physician or physician assistant may not prescribe, dispense, or administer a prescription drug in response to an Internet questionnaire or electronic mail message to a person with whom the physician or physician assistant does not have a prior physician-patient relationship.

(d) In this section,

(1) “controlled substance” has the meaning given in AS 11.71.900;

(2) “prescription drug” has the meaning given in AS 08.80.480;

(3) “primary care provider” has the meaning given in AS 21.07.250.

Physician In-Office Dispensing

- Alaska allows physicians to dispense drugs so long as they **don’t present themselves as pharmacists** or claim they operate a pharmacy. They must also follow professional and ethical standards, including providing prescription counseling. Physicians must **notify the Alaska Composite Medical Board** before they begin dispensing from their office
- Alaska physicians can dispense both non-controlled and controlled substances directly to patients.

- Required steps include:
    - Not claiming pharmacy status,
    - Providing prescription counseling,
    - Notifying the medical board,
    - Physicians dispensing controlled drugs require a **valid DEA registration**, must adhere to Alaska's Prescription Drug Monitoring Program, and follow any applicable administrative code, such as 12 AAC 40.450 for prescribing authority,
    - Reporting to PDMP (Prescription Drug Monitoring Program) and meeting Medicaid requirements as applicable.

Fee Schedule Versioning / CMS Updates

The Department of Law provided this guidance for our concerns on the real-time updating of CMS reimbursement rates that is commonplace with cloud-based applications:

"switching from a bright-line test of a set date to a more time-of service billing still complies with the Fee Schedule's MAR rules, then legally speaking I think making the switch is okay. This would make it more of a policy decision by the agency."

OFFICIAL ALASKA WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

2026 Edition — Comparative Review and Planning Reference

FOR INTERNAL DISCUSSION AND ANALYTICAL PURPOSES ONLY

Comparative State Gap Analysis & Future Release Planning

Prepared for: Alaska Division of Workers' Compensation
Document Date: May 2026

Executive Summary

This report provides a comprehensive review of the Official Alaska Workers' Compensation Medical Fee Schedule (2026 Edition), analyzing the document for opportunities to improve clarity, consistency, and administrative efficiency. The review also compares key provisions against workers' compensation fee schedule approaches in other states to identify gaps and best practices that Alaska could consider incorporating into future releases.

The 2026 Alaska fee schedule reflects meaningful progress, including updated telehealth guidance, expanded home health and in-home care provisions, and new clarity on the Medical Evaluations (IME/EME/SIME) framework. The review also identifies several structural and content areas not currently addressed that, based on peer-state experience, may be considered in future planning discussions.

Key findings are organized into seven thematic areas:

- Structural and Navigational Clarity
- Conversion Factor and Reimbursement Rate Transparency
- Telehealth and Emerging Technology Coverage
- Pharmacy, Drugs, and Compounded Medications
- Provider Type and Credentialing Guidance
- Facility and Ancillary Services Complexity
- DMEPOS Reimbursement

This review draws on publicly available fee schedule frameworks from California, Washington, Texas, Oregon, Colorado, New York, and Florida to benchmark Alaska's approach and identify areas where peer-state frameworks have developed additional guidance. Observations are organized for use in future release planning discussions.

1. Findings: Opportunities for Improvement and Peer-State Comparison

The following findings are organized by area and represent the primary opportunities for improving clarity, reducing disputes, and aligning with peer-state best practices.

1.1 Structural and Navigational Clarity

Opportunity 1.1.1 — Summary Quick-Reference Table

The schedule does not include a single-page quick-reference table summarizing all conversion factors, MAR methodologies, modifier reductions, and key deadlines. Users must read multiple sections to assemble this information.

Background for Planning Discussions: Some peer schedules include a summary reference page immediately following the Table of Contents. A similar feature could consolidate:

- All conversion factors by service category
- MAR calculation formula
- Key modifier reduction rates (modifier 50, 51, 80/81/82, AS, PE, QZ, QK)
- Key deadlines (14-day report submission, 30-day payment, 60-day appeal, 180-day billing limit)
- Out-of-state provider rule reference

Opportunity 1.1.2 — Repeated Content Across Sections

Certain provisions are reproduced verbatim in multiple sections of the document (e.g., the telehealth guidelines appear in General Guidelines, E/M, and Medicine; the medical evaluations/IME/EME/SIME carve-out appears in both E/M and Medicine; home health guidance appears in both General Guidelines and Medicine). This structure can create version-control complexity when updates are made, and may require cross-referencing if sections contain minor variations.

Background for Planning Discussions: Consolidating duplicated provisions into a single authoritative section with cross-references in secondary sections (e.g., "See General Information and Guidelines, Telehealth Services section") is an approach used in state schedules such as California's Official Medical Fee Schedule (OMFS).

Opportunity 1.1.3 — CMS Data File Versioning

The Alaska fee schedule's reimbursement calculations depend on several CMS data files that are updated on defined annual and sub-annual schedules. The 2026 fee schedule does not explicitly state which version of these CMS files it adopts, creating ambiguity for payers and providers who must determine which file version governs a given claim. The inpatient section references April 1, 2026, as the effective date for IPPS Web Pricer use, but this date-based guidance is not extended to the other CMS files that drive the fee schedule's calculations.

Background for Planning Discussions: A clearly formatted CMS effective date in the Introduction section could reduce versioning ambiguity. The subsections below provide additional detail on CMS data file versioning considerations.

1.1.3.1 CMS File Versioning Policy

Background for Planning Discussions: The following versioning policy is listed below for review. The core principle is that files with quarterly updates should use the version in effect on the date of service, while files with only annual or semiannual updates should use the January 1 or effective date version for the full fee schedule year:

CMS Data File	Proposed Alaska Adoption Rule
MPFS RVU File (physician services)	Base file: January 1, 2026, RVU file (RVU26A, CMS-1832-F). Quarterly corrected files (RVU26B effective April 1; RVU26C effective July 1; RVU26D effective October 1) are automatically adopted as released by CMS. For any code whose RVU value is corrected in a quarterly file, the corrected value applies to dates of service on or after the quarterly file's effective date.

CMS Data File	Proposed Alaska Adoption Rule
GPCI Values	The January 1, 2026, GPCI values (CMS-1832-F, Alaska locality code 02) apply for the full 2026 fee schedule year. GPCI values are not updated quarterly; the annual file governs unless CMS issues a statutory correction, in which case the Division will publish notice.
CLFS / CLAB	Base file: January 1, 2026, CLFS file. Quarterly updates (April 1, July 1, October 1) issued by CMS via Change Request transmittals are automatically adopted as released. The CLFS payment rate in effect on the date of service governs; the 4.43 multiplier applies to that rate. If CMS issues a corrected CLFS file between quarters, the correction applies to dates of service on or after its CMS-stated effective date.
DMEPOS Fee Schedule	Base file: January 1, 2026, DMEPOS fee schedule (CY 2026 annual update). Quarterly updates (April 1, July 1, October 1) issued by CMS via Change Request transmittals are automatically adopted as released. Codes added in a quarterly update are reimbursable under the Alaska fee schedule for dates of service on or after the update's effective date. The 1.66 Alaska multiplier applies to the DMEPOS value in effect on the date of service.
CMS ASP Drug Pricing File	The quarterly ASP file in effect on the date of service governs Part B drug and HCPCS drug reimbursement: Q1 (January 1), Q2 (April 1), Q3 (July 1), Q4 (October 1). If CMS issues a corrected ASP file between quarters, the corrected file applies from its CMS-stated effective date. The 3.375 multiplier applies to the ASP payment limit in the applicable quarterly file.
OPPS / APC Weights	Base file: January 1, 2026, OPPS final rule (CMS-1834-FC) APC weights and status indicators. Quarterly OPPS updates (April 1, July 1, October 1) issued by CMS via IOCE and Addendum files are automatically adopted as released. New pass-through codes and status indicator changes effective in a quarterly update apply to dates of service on or after that update's effective date.
IPPS / MS-DRG Weights	The IPPS Web Pricer version available on April 1, 2026, governs inpatient claims for the AK WC 2026 fee schedule year. The IPPS is updated annually on October 1 (federal FY). Hospital-specific multipliers listed in the fee schedule apply regardless of IPPS update timing.
ASA Relative Value Guide	The 2026 ASA Relative Value Guide governs anesthesia base unit values for the full 2026 fee schedule year. Not updated quarterly; the annual guide governs unless the ASA issues an errata correction, in which case the Division will publish notice.
AMA CPT Code Set	CPT 2026 (January 1, 2026) governs all procedure code definitions for the full fee schedule year.

1.2 Conversion Factor and Reimbursement Rate Transparency

Opportunity 1.2.1 — Category III Codes

The 2026 fee schedule's conversion factor reference table lists six service categories (Surgery, Radiology, Pathology & Lab, Medicine, Evaluation & Management, and Anesthesia) with their corresponding CPT code ranges and conversion factors. However, Category III codes—which the schedule separately acknowledges as temporary emerging technology codes that supersede unlisted codes—are not assigned to any conversion factor in this table. The schedule instructs

providers to use Category III codes where available, but provides no mechanism for calculating a MAR for those codes.

The omission of Category III codes from the conversion factor table means payers lack a defined conversion factor entry; reimbursement for these codes may default to the general unlisted procedure rate (85% of billed charges or negotiated rate). The schedule's guidance to prefer Category III codes over unlisted codes, combined with the absence of a defined MAR pathway for those codes, is an area that additional clarification could address.

Background for Planning Discussions: The conversion factor table could be updated to explicitly address Category III codes. Two approaches are available:

- Option A — Service-Type Crosswalk: Add a row or footnote specifying that Category III codes are reimbursed using an AK conversion factor (e.g., a Category III surgical code uses the Surgery CF of $119.00). This requires a crosswalk table by CPT chapter or code range.
- Option B — Negotiated Rate Default: Explicitly state how Category III codes without assigned RBRVS RVUs are reimbursed.
-

Opportunity 1.2.2 — HCPCS Alphanumeric Codes with CMS-Assigned RVUs: Conversion Factor Considerations

The 2026 Alaska fee schedule's conversion factor structure covers six CPT-defined service categories (Surgery, Radiology, Pathology & Lab, Medicine, E/M, and Anesthesia) using their respective numeric CPT code ranges. However, the CMS RBRVS file contains hundreds of alphanumeric HCPCS Level II codes—primarily in the G, Q, M, and S code series—that carry assigned RVU values in the MPFS file but do not fall within any of the six published CPT code range conversion factor categories. These codes represent a substantial and growing share of services rendered in workers' compensation.

Alaska's fee schedule assigns conversion factors by CPT code range (numeric), but CMS's RBRVS file assigns RVUs by individual HCPCS code regardless of whether that code is numeric (CPT) or alphanumeric (HCPCS Level II). The fee schedule's conversion factor table was designed around the CPT code book's structure and does not account for the growing body of alphanumeric HCPCS codes that CMS has brought into the RBRVS framework.

Background for Planning Discussions: One approach to addressing RVU-valued alphanumeric HCPCS codes involves creating a dedicated conversion factor, consistent with practice in peer states that have brought these codes into their RBRVS frameworks.

A possible updated version of the conversion factor table that includes Category III is shown below:

Medical Service	CPT Code Range	Conversion Factor	Notes
Surgery	10004–69990	$119.00	—
Radiology	70010–79999	$121.00	—
Pathology and Laboratory	80047–89398	$122.00	—

Medical Service	CPT Code Range	Conversion Factor	Notes
Medicine (excl. Anesthesia)	90281–97814; 98925–99607	$80.00	—
Evaluation & Management	98000–98016; 99091; 99202–99499	$80.00	—
Anesthesia	00100–01999; 99100–99140	$100.00 per unit	Based on ASA RVG base + time units
Category III — Surgical Type	Codes ending in 'T' (surgical/procedural)	$119.00	Apply Surgery CF
Category III — No RBRVS Value	Any Category III code without assigned RVUs	By Agreement or By Report	
HCPCS Level II — Alphanumeric Codes (G, Q, M, S series) with CMS RVUs	All Status A alphanumeric HCPCS codes not covered by above CPT ranges	Proposed illustrative range only: median CF (est. $85–$100)	Currently defaults to 85% of billed charges fallback

Opportunity 1.2.3 — "Other Providers" Category: Provider Type Clarification

The schedule provides that "other providers" (i.e., other than physicians, hospitals, outpatient clinics, or ASCs) are reimbursed at 85% of the MAR. However, the schedule does not provide an exhaustive or even indicative list of which provider types fall into this category.

Peer State Comparison: Texas' Medical Fee Guideline explicitly categorizes provider types and applicable reimbursement rates. Colorado's Rule 18 provides a provider type matrix.

Background for Planning Discussions: Peer states including Texas (Medical Fee Guideline) and Colorado (Rule 18) provide explicit provider type matrices. A defined list or table of provider types and their applicable reimbursement percentage, cross-referenced to Alaska professional licensing categories, could address this.

Opportunity 1.2.4 — Unlisted Procedure Codes: Valuation and Documentation

The schedule does not clearly address how unlisted procedure codes (e.g., 99499, 27299, 64999) should be valued beyond the general 85%-of-billed-charges rule. There is no requirement for documentation standards or appeals process guidance specific to unlisted codes.

Background for Planning Discussions: A dedicated section on unlisted and non-standard procedure codes, including documentation requirements (e.g., operative report required) and a defined adjudication process, could reduce disputes in this area.

1.3 Telehealth and Emerging Technology

Opportunity 1.3.1 — Telehealth Delivery: Platform and Technical Standards

The schedule states that telehealth services "should be performed using approved audio/visual methods where available" but does not define what constitutes an "approved" method, HIPAA-compliant platform, or minimum technical standard.

Peer State Comparison: New York's WC telehealth policy specifies HIPAA-compliant platform requirements. Oregon's telehealth rules reference the state's Health Authority approved modalities list.

Background for Planning Discussions: Peer states such as New York specify HIPAA-compliant platform requirements; Oregon references an approved modalities list. Defining minimum platform requirements and referencing Alaska's broader telehealth statute are approaches observed in peer-state frameworks.

Opportunity 1.3.2 — Remote Patient Monitoring (RPM) Codes: Coverage Considerations

CPT codes 99453, 99454, 99457, and 99458 for Remote Patient Monitoring (RPM) are not currently addressed in the schedule. These codes are covered by Medicare and are increasingly used in post-injury rehabilitation and chronic condition management contexts.

Peer State Comparison: California's OMFS and Washington's L&I schedule both provide RPM coverage with specific documentation requirements.

Background for Planning Discussions: California's OMFS and Washington's L&I schedule both provide RPM coverage with specific documentation requirements. Evaluating RPM codes for potential inclusion in a future edition, with coverage criteria aligned to documented injury management (e.g., post-surgical monitoring, cardiac rehabilitation following occupational injury), is an approach observed in peer-state frameworks.

1.4 Pharmacy, Drugs, and Compounded Medications

Opportunity 1.4.1 — Drug Pricing Benchmark: AWP and Peer-State Alternatives

The schedule bases prescription drug reimbursement on the manufacturer's "average wholesale price" (AWP). AWP has been the subject of ongoing discussion in pharmacy reimbursement policy, with some commentators and states noting that it may not reflect actual acquisition costs. Several states have adopted alternative benchmarks such as NADAC, ASP, or negotiated formularies as part of their pharmacy reimbursement frameworks.

Peer State Comparison: Texas uses a closed formulary with specific drug pricing benchmarks. California's drug formulary uses AWP with formulary tiers. Ohio and Colorado use NADAC or a preferred drug list approach.

Background for Planning Discussions: Peer states have taken varying approaches to drug pricing benchmarks: Texas and Washington use closed formularies; California uses AWP with formulary tiers; Ohio and Colorado use NADAC or a preferred drug list. Transitioning to NADAC or ASP, or implementing a preferred drug formulary with tiered reimbursement levels, are approaches that could be examined.

Opportunity 1.4.2 — Compounded Drug Criteria: Scope and Administration Considerations

The schedule limits compounded drugs to FDA-approved combinations, reimbursed at the lowest generic NDC. However, it does not address: (a) what constitutes medical necessity for a compound; (b) whether prior authorization is required; (c) the process for disputing compounded drug bills.

Peer State Comparison: Florida and Texas have among the most detailed compounded drug policies in workers' compensation, including prior authorization requirements, quantity limits, and compound-specific formulary control.

Background for Planning Discussions: Florida and Texas have among the most detailed compounded drug policies in workers' compensation, including prior authorization requirements, quantity limits, and compound-specific formulary controls. These frameworks could serve as models for addressing compounded medication billing and disputes.

Opportunity 1.4.3 — Opioid Prescribing: Reference to Clinical Protocols and Thresholds

The schedule does not reference opioid prescribing limitations, morphine milligram equivalents (MME) thresholds, or opioid treatment protocols within a workers' compensation context. This area is not currently addressed in the schedule; peer states including Washington, California, and Texas have developed opioid-specific provisions within their WC frameworks.

Peer State Comparison: Washington's L&I opioid prescribing guidelines are integrated into the fee schedule context. California's MTUS includes detailed opioid prescribing protocols. Texas' closed formulary restricts opioid classes.

Background for Planning Discussions: Peer states have addressed opioid prescribing by incorporating references to existing state guidance or developing WC-specific provisions that include MME thresholds and documentation requirements. Washington's L&I opioid guidelines, California's MTUS protocols, and Texas' closed formulary are examples of approaches observed in peer-state frameworks.

Opportunity 1.4.4 — Repackaged Drugs: Billing and Reimbursement Considerations

The 2026 Alaska fee schedule does not currently address repackaged drugs. According to the Workers Compensation Research Institute (WCRI), repackaged drug pricing is a documented cost factor in workers' compensation pharmacy in states without explicit controls. Drug repackaging occurs when a manufacturer, distributor, or dispensing physician obtains a drug in bulk and repackages it into a new container assigned a new National Drug Code (NDC). Because any entity that repackages a drug can set both a new NDC and a new Average Wholesale Price (AWP), repackaged drugs are routinely priced at multiples of the original manufacturer's AWP—often 60% to 300% higher than the same drug dispensed through a retail pharmacy for the same claim.

This practice is especially prevalent in physician-dispensed medications. Repackaged drugs are frequently billed under a repackage-assigned NDC rather than the original manufacturer's NDC, which causes automated bill review systems to price the drug against an inflated benchmark. WCRI has documented repackaged drug prices at two to five times the pharmacy equivalent in states without explicit controls.

Peer State Comparison and Consensus Practice: Most states with mature WC drug reimbursement frameworks now explicitly require that repackaged drugs be billed and reimbursed using the AWP of the underlying (original manufacturer's) NDC, not the repackaged NDC:

- **North Carolina**: Repackaged NDCs may not be individually used on billing documents; original manufacturer's NDC is required; reimbursement is capped at 95% of AWP of the original NDC.
- **California**: Bills for physician-dispensed and repackaged drugs must include both the NDC of the medication dispensed and the original manufacturer NDC; reimbursement is based on the NDC of the underlying medication product.
- **Colorado:** Reimbursement for repackaged medications uses the AWP and the NDC of the underlying medication; certain drug classes (opioids, controlled substances, gabapentin, benzodiazepines) may be further restricted.
- **Florida**: Repackaged or relabeled prescriptions are reimbursed at 112.5% of the AWP of the original product, not the repackaged inflated AWP; a separate dispensing fee applies.
- **Washington**: Repackaged medications reimbursed based on AWP of the underlying product using the original labeler NDC; physicians dispensing from office do not receive a dispensing fee.

Background for Planning Discussions: Peer states with mature WC drug reimbursement frameworks have addressed repackaged drugs through explicit pharmacy provisions. Approaches observed in peer-state frameworks include provisions that:

- Requires bills for repackaged drugs to include both the repackaged NDC and the original manufacturer's NDC (11-digit format).
- Establishes that reimbursement is based on the AWP of the original manufacturer's NDC, not the repackaged NDC.
- Specifies that if the original manufacturer's NDC is not provided, reimbursement defaults to the AWP of the least expensive clinically equivalent drug available from a licensed pharmacy.
- Prohibits repackaged-assigned NDCs from serving as the sole basis for reimbursement calculations.

Opportunity 1.4.5 — Physician-Dispensed Drugs: Reimbursement Framework Considerations

The Alaska fee schedule does not distinguish between medications dispensed by a licensed pharmacy and those dispensed directly by a treating physician from an in-office supply. Physician dispensing—where a doctor provides pre-packaged medications directly to a patient at the point of care—has been documented as a significant cost driver in workers' compensation, with physician-dispensed medications costing 60–300% more than pharmacy-dispensed equivalents for the same drug and quantity. According to industry data, physician-dispensed drugs represent approximately 28% of pharmaceutical costs in workers' compensation nationally.

Unlike a retail pharmacy, a dispensing physician does not typically contract with a pharmacy benefit manager (PBM) and may not be subject to the same network pricing controls. Some researchers and policymakers have noted that physician dispensing arrangements may present structural pricing considerations that differ from traditional pharmacy channels. Third-party dispensing companies have marketed repackaged drug programs to physicians in states where specific regulatory frameworks for physician dispensing are not in place.

Peer State Comparison and Consensus Practice: Most states have moved to establish explicit reimbursement rules for physician-dispensed drugs, many mirroring pharmacy fee schedule rates or adding supply quantity limits:

State	Physician Dispensing Rule	Supply Limit
California	Reimbursed at lesser of Medi-Cal fee cost, usual & customary, or Medi-Cal caps; additional caps on markups above documented paid cost	No specific day limit in state FS
Colorado	Reimbursed based on AWP of underlying original labeler NDC; no dispensing fee paid to physicians	72-hour supply limit for controlled substances
Florida	Reimbursed per HCPR Manual; physician must be registered to dispense under s. 465.0276; no Schedule II opioids	No unlimited Schedule II dispensing
North Carolina	Capped at 95% of AWP of original manufacturer NDC; no Schedule II drugs beyond initial 7-day supply	7-day supply (Schedule II); 30-day (others)
Washington	AWP of underlying medication product (original labeler NDC); no dispensing fee paid to physicians	72-hour limit for controlled substances
Texas	Subject to closed formulary; not separately reimbursed outside formulary approval	Formulary-controlled

Background for Planning Discussions: Peer states have addressed physician-dispensed medications through explicit fee schedule provisions. Approaches observed in peer-state frameworks include provisions that:

- Establish that physician-dispensed medications are reimbursed at the same rate as pharmacy-dispensed medications for the same drug (fee schedule parity), using the original manufacturer NDC and AWP.
- Prohibit physicians from receiving a dispensing fee unless separately licensed as a dispensing pharmacy under Alaska law.
- Limit physician in-office dispensing of Schedule II controlled substances to a medically necessary initial supply (not to exceed 72 hours or 7 days, consistent with peer-state practice).
- Require physicians dispensing medications to report the original manufacturer's NDC (11-digit) on all billing documents, in addition to any repackaged NDC.
- Require that the bill include documentation of the physician's actual acquisition cost when requesting reimbursement for unlisted or repackaged drug items.

Opportunity 1.4.6 — Compounded and Topical Medications: Reimbursement Considerations

The 2026 Alaska fee schedule does not establish any reimbursement limits for topical medications, including private-label topical analgesics and compounded topical creams. This is an area of active regulatory attention in several states nationally: topical medications represent only 13.9% of out-of-

network prescriptions in workers' compensation but account for 40.2% of out-of-network spending. Compounded topical creams billed at $2,000 or more for a 30-day supply have been documented extensively in workers' compensation claims nationally.

Compounded topical creams present particular risks in the workers' compensation context:

- They are not FDA-approved as finished products, even when individual ingredients are FDA-approved separately.
- Evidence-based guidelines (Official Disability Guidelines, ACOEM) generally do not recommend topical compounds as first-line treatment for occupational injuries.
- Private-label topical analgesics (sometimes referred to as PLTs or repackaged topical products) may use new NDCs with independently set AWPs. Industry reports have documented price differences between some private-label topicals and commercially available OTC equivalents.
- Automatic refill patterns and physician-dispensed compound kits (e.g., pre-measured ingredient kit products marketed to physicians for in-office dispensing) represent additional cost considerations noted by industry researchers in this area
- Active ingredients may exceed FDA-recommended concentration thresholds, posing risks including chemical burns and skin irritation.

State Regulatory Consensus on Topical Cream Cost Controls: A growing number of states have enacted explicit topical medication reimbursement limits, reflecting recognition that uncapped topical pricing is a primary driver of pharmacy cost inflation in WC:

State	Topical Compound Cap	OTC Topical Cap	Prior Auth Required
California	$200 per 30-day supply (prorated)	$30 per 30-day supply (cream/lotion); $75 per 30-day supply (patch)	Yes (medical necessity documentation required)
Colorado	State Z-code system; specific maximum per category	$31.21 per 30-day supply; $72.83 per 30-day supply (patch)	Yes (formulary prior auth)
Georgia (2024)	Standardized reimbursement structure; uncapped pricing replaced	Regulatory cap introduced with codes: GA0801 $80 per 30 day supply, GA0802 $160 per 30 day supply, GA0803 $240 per 30 day supply	Yes (automatic refilling not allowed)
South Carolina (2022)	Topical compound cap adopted	Cap on prescription topicals; $240 for 30 day supply, dispensing fee $5	Yes
Florida	Reimbursed per fee schedule; compound ingredients listed individually by NDC	No specific cap	Yes (carrier authorization)

State	Topical Compound Cap	OTC Topical Cap	Prior Auth Required
Texas	Closed formulary restricts compounds; prior authorization required for non-formulary items	Formulary-controlled	Yes
Alaska (2026)	Not addressed; AWP-based with no cap	Not addressed	Not required

Background for Planning Discussions: States with topical medication cost controls have addressed this area through pharmacy section provisions. Approaches observed in peer-state frameworks include provisions that:

- Establish a maximum reimbursement cap for compounded topical medications (e.g., the lesser of $200 per 30-day supply or the calculated ingredient-level AWP total, consistent with California's approach).
- Establish a separate maximum reimbursement cap for OTC topical medications not commercially available in standard packaging (e.g., the lesser of $30 per 30-day supply for creams/lotions or $75 per 30-day supply for patches).
- Require that all compounded topical bills list each ingredient separately by NDC and quantity, with the AWP for each ingredient calculated using the original manufacturer NDC; ingredients without valid NDCs are not separately reimbursable.
- Require prior authorization for compounded topical medications, with documentation of medical necessity and clinical rationale for why a commercially available equivalent is inadequate.
- Prohibit reimbursement for "compound kits" (pre-measured ingredient kits not yet combined) as finished compounded products; require billing at the ingredient level.
- Exclude automatic refills of topical compounds; each new supply requires a new prescription with updated clinical documentation.

1.5 Provider Type Guidance

Opportunity 1.5.1 — Physician Assistant and APRN Billing: Complex Scenario Guidance

While Modifier PE is defined and reimbursement rates for PAs and APRNs are specified, the schedule does not address several common complex billing scenarios:

- PA or APRN billing in a telehealth setting
- PA or APRN providing services when supervising physician is not present
- Billing under the physician's NPI vs. the PA's own NPI
- PA services in critical care or emergency department settings

Background for Planning Discussions: A dedicated PA/APRN billing guidance section with examples for the scenarios above, including a modifier hierarchy chart for complex cases involving modifiers PE + 50 + 51, could address billing ambiguities in this area.

Opportunity 1.5.2 — Acupuncture, Naturopathy, and Non-Traditional Providers: Billing Guidance

Alaska law includes a broad definition of "physician," yet the schedule does not address billing by acupuncturists, naturopathic doctors, or other licensed providers who may be authorized treating providers under AK WC statutes. The scope of practice and applicable CPT codes for these providers are not addressed.

Peer State Comparison: California's OMFS includes explicit guidance for acupuncturists (using acupuncture-specific CPT codes 97810–97814) and naturopaths. Washington's schedule includes approved code sets for alternative medicine providers.

Background for Planning Discussions: California's OMFS and Washington's schedule address non-traditional licensed provider types in dedicated sections covering applicable code sets, scope-of-practice billing limitations, and reimbursement rates. These could serve as structural models.

Opportunity 1.5.3 — Interpreter and Translation Services: Reimbursement Guidance

The schedule does not address reimbursement for medical interpreter services, which are frequently required in Alaska given the state's significant Alaska Native population and linguistic diversity.

Peer State Comparison: California's fee schedule includes interpreter service billing under HCPCS T1013 with specific reimbursement rates. Oregon includes interpreter codes in its ancillary services schedule.

Background for Planning Discussions: California's fee schedule addresses interpreter services under HCPCS code T1013 with specific reimbursement rates; Oregon includes interpreter codes in its ancillary services schedule. These frameworks could serve as models for addressing interpreter service reimbursement.

Opportunity 1.5.4 — Physical Therapy Multiple Procedure Reduction: CMS Multiple Procedure Payment Reduction (MPPR) and Practice Expense Methodology

The 2026 Alaska fee schedule does not explicitly address how the CMS Multiple Procedure Payment Reduction (MPPR) applies to physical therapy, occupational therapy, and speech-language pathology services when multiple timed or untimed therapy codes are billed on the same date of service by the same provider.

CMS Flag 5 Practice Expense Methodology. Under CMS's RBRVS framework, certain therapy procedure codes are assigned Multiple Procedure Indicator Flag 5 in the Medicare Physician Fee Schedule (MPFS) RVU file. When two or more Flag 5 codes are billed together on the same date of service by the same provider, CMS applies the following reduction to the Practice Expense RVU component:

- The highest-valued procedure (by total RVU) is reimbursed at 100% of the calculated MAR, including the full Practice Expense RVU.
- The second and each subsequent Flag 5 procedure billed on the same date of service by the same provider is reimbursed at 100% of the Work RVU and Malpractice RVU components, but only 50% of the Practice Expense RVU component. The resulting reduced total RVU is then multiplied by the applicable Alaska conversion factor to calculate the MAR.

- The Work RVU and Malpractice RVU components are not reduced; only the Practice Expense RVU component is subject to the 50% reduction for the second and subsequent procedures.

The MPPR Flag 5 methodology applies to the physical medicine and rehabilitation CPT code family. The complete list of codes assigned Flag 5 status is published annually in the CMS MPFS RVU data file (the "MPPRIND" or "MPINDICATOR" field).

Background for Planning Discussions: Future fee schedule releases should consider adding language about whether to adopt the CMS Multiple Procedure Payment Reduction (MPPR) Flag 5 designation and its application to therapy services due to some provider complaints.

Peer State Comparison. California's Official Medical Fee Schedule (OMFS) and Washington's Labor & Industries (L&I) Medical Fee Schedule both explicitly incorporate the CMS MPPR Flag 5 methodology into their physical therapy billing rules, specifying the 50% PE reduction for second and subsequent same-day therapy procedures. Colorado's Rule 18 similarly adopts CMS MPPR rules by reference and provides guidance on the interaction between the Flag 5 PE reduction and other applicable modifier reductions. Oregon's fee schedule notes that the CMS therapy MPPR applies to all therapy services subject to the Medicare therapy cap, providing a clear adjudication standard for payers and providers.

1.6 Facility and Ancillary Services Complexity

Opportunity 1.6.1 — Critical Access Hospital Reimbursement: Methodology Detail

The Critical Access Hospital (CAH), Rehabilitation Hospital, and LTACH reimbursement section provides a high-level framework, stating that reimbursement is the lowest of 100% of billed charges, the general public rate, or the negotiated rate. No guidance is provided on how to determine the "general public rate," documentation requirements, or dispute resolution for these settings.

Peer State Comparison: Washington's fee schedule provides cost-to-charge ratio guidance for CAHs. Oregon's rules include specific documentation requirements for CAH billing.

Background for Planning Discussions: Washington's fee schedule provides cost-to-charge ratio guidance for CAHs; Oregon's rules include documentation requirements for CAH billing. Additional guidance on how "billed charges" and "general public rate" are defined and documented, and whether to adopt CMS fee schedules for CAH, Rehabilitation Hospital, and LTACH, are areas observed in peer-state frameworks.

Opportunity 1.6.2 — Ambulance Services: Ground Ambulance Rate Structure

While air ambulance services have explicit lift-off fees and per-mile rates defined in statute and referenced in the schedule, ground ambulance services are simply referred to HCPCS codes with the general MAR fallback (85% of billed charges, general public rate, or negotiated rate). No base rates or mileage rates are specified for ground ambulance.

Background for Planning Discussions: Several peer states including California, Oregon, and Colorado have developed specific rate schedules for ground ambulance services analogous to their air ambulance provisions, including a base rate and per-mile rate tied to the CMS ambulance fee schedule with a state-specific multiplier.

Opportunity 1.6.3 — DME Rental Rules Without Modifier RR

The 2026 Alaska Workers' Compensation Medical Fee Schedule's DME rental section covers invoice-based items thoroughly with a worked example; however, the separate rule governing DME items that have an assigned DMEPOS fee schedule value, are rented, but are listed without the RR modifier lacks sufficient clarification. As written, the rule provides that reimbursement should be at the lesser of the non-modified or NU-modified value multiplied by .10 or the billed charges for each month of rental, but does not include examples illustrating how it applies in practice. Future fee schedule updates could clarify how this rule applies to specific code categories — including DMEPOS Payment Category OX (Oxygen and Oxygen Equipment) codes and TENS units (E0720 and E0730).

Background for Planning Discussions:

- The DMEPOS schedule-valued rental rule applies to OX-category codes, TENS units, etc.
- Consider adding total rental payments shall not exceed the applicable DMEPOS fee schedule value for the item, and the rental period shall not exceed any maximum established under applicable CMS payment policy for the code.
- Providers and payers may reference the CMS DMEPOS Public Use File (PUF) payment category column to confirm whether a given HCPCS code is classified as rental without the RR modifier.
- The following language is offered as a potential framework for a future fee schedule clarification:
  - *Certain durable medical equipment (DME) items are designated by CMS as rental-only or may be rented prior to purchase, but are listed in the CMS DMEPOS fee schedule without the RR (rental) modifier. This includes, but is not limited to, the following DMEPOS payment categories:*
    - *Oxygen and Oxygen Equipment (OX category) — items such as oxygen concentrators, portable and stationary oxygen systems, and oxygen contents, which CMS designates as rental-only and which do not carry an RR modifier in the DMEPOS fee schedule.*
    - *Transcutaneous Electrical Nerve Stimulators or TENS units (E0720 and E0730) — items listed in the DMEPOS fee schedule with the NU modifier only.*
  - *For these items, monthly rental reimbursement shall be the lesser of:*
    - *(a) the applicable DMEPOS fee schedule value for the code — whether listed without a modifier or with the NU modifier — multiplied by 10%, or*
    - *(b) the provider's billed charges for that month.*
  - *Total cumulative rental payments for any single item shall not exceed the applicable DMEPOS fee schedule value for that item.*

Opportunity 1.6.4 — Outpatient Facility Status Indicator Table: Plain-Language Guidance

The Outpatient Facility section's status indicator table includes 25+ indicator codes with detailed CMS payment logic but limited plain-language Alaska-specific guidance for most codes. Only a subset of indicators (C, E1, E2, H, H1, T, Y) have Alaska-specific guidelines; the rest default to CMS OPPS rules without explanation.

Background for Planning Discussions: A brief plain-language "Alaska Action" column in each status indicator row could clarify adjudication expectations. A condensed reference table for the most common outpatient status indicators, noted as not "all inclusive," could also serve as a navigational aid for new status indicators not yet captured in the table.

Opportunity 1.6.5 — Hearing Aid Service CPT Codes: 2026 AMA Code Set Alignment

Effective January 1, 2026, the AMA replaced CPT codes 92590–92595 with a new family of 12 codes (92628–92642) that more precisely describe the professional services audiologists provide for hearing device-related care. These changes apply to CPT professional service codes only and do not affect HCPCS "V" codes used to report the hearing aid devices themselves. These new codes are not a 1:1 match and currently do not have an established RVU to determine fees. The current hearing codes listed in the fee schedule could be included in the future fee schedule with adjustments to the pricing.

These are the current AK Medical Fee Schedule codes and fees below:

Current CPT Code	Service Description	Fee
92591	Hearing aid examination and selection; binaural	$193.62
92593	Hearing aid check; binaural	$99.64
92594	Electroacoustic evaluation for hearing aid; monaural	$57.89
92595	Electroacoustic evaluation for hearing aid; binaural	$124.11
V5014	Repair/modification of a hearing aid	$249.31
V5020	Conformity evaluation	$116.17

These are the current prices from the RefMed True Price data at the 80th percentile:

Current CPT Code	Service Description	True Price Fee
92591	Hearing aid examination and selection; binaural	$291.60
92593	Hearing aid check; binaural	$149.85
92594	Electroacoustic evaluation for hearing aid; monaural	$86.40
92595	Electroacoustic evaluation for hearing aid; binaural	$187.65

Current CPT Code	Service Description	True Price Fee
V5014	Repair/modification of a hearing aid	N/A
V5020	Conformity evaluation	N/A

The new 2026 CPT hearing device service code structure is organized as follows:

New CPT Code	Service Description	Timed/Untimed
92628	Hearing aid candidacy evaluation, first 30 minutes	Timed (base)
92629	Hearing aid candidacy evaluation, each additional 15 minutes	Timed (add-on)
92631	Hearing aid selection, first 30 minutes	Timed (base)
92632	Hearing aid selection, each additional 15 minutes	Timed (add-on)
92634	Hearing device fitting and post-fitting follow-up, first 60 minutes	Timed (base)
92635	Hearing device fitting and post-fitting follow-up, each additional 15 minutes	Timed (add-on)
92636	Hearing device follow-up services, first 30 minutes	Timed (base)
92637	Hearing device follow-up services, each additional 15 minutes	Timed (add-on)
92638	Behavioral verification of amplification (add-on to 92634 or 92636)	Untimed (add-on)
92639	Real-ear measurement verification (add-on to 92634 or 92636)	Untimed (add-on)
92641	Electroacoustic analysis/verification	Untimed (standalone)
92642	Hearing assistive device services, not otherwise specified	Untimed (standalone)

Key coding rules for the new 2026 hearing device service codes:

- Time-based codes (92628–92637) use the "half plus one" (51%) rule: a 30-minute code requires at least 16 minutes of time; a 15-minute add-on requires at least 8 minutes, etc.

- Candidacy codes (92628, 92629) and selection codes (92631, 92632) cannot be billed on the same date of service if performed within the same 30 minutes; both may be reported on the same date only if the minimum time threshold for each is independently met.
- Add-on verification codes 92638 and 92639 may only be billed once with the applicable base codes (92634or 92636).
- Code 92639 and 92641 are bilateral; use modifier 52 for unilateral testing.
- HCPCS "V" codes for hearing aid devices (V5011, V5090, V5110, V5160, V5240, V5241, etc.) remain unchanged and continue to apply for device reporting.

Background for Planning Discussions: Given the AMA's deletion of CPT codes 92590–92595 effective January 1, 2026, approaches for updating hearing device service code references include:

- Retain references to CPT codes 92590–92595 from all sections, but consider that these codes were deleted by the AMA effective January 1, 2026, and review fees for potential adjustments. The existing hearing aid code fees have not been adjusted since the 2020 AK WC FS. (If this is decided, directives suggesting that the new hearing aid codes should not be billed per the AK WC fee schedule should be considered. An example was sent stating that 92636 has been billed from $180 to $1,300).
- Replace the existing hearing aid services MAR table with a table referencing the new codes 92628–92642 and assign fees although there are not RVU's assigned to them. There is not a 1:1 crosswalk for these codes to the previous codes.
- Retain existing HCPCS V-code guidance unchanged, as V codes are unaffected by the 2026 CPT changes.

1.7 DMEPOS Reimbursement: Additional Opportunities for Improvement

The following findings address gaps in Alaska's broader DMEPOS reimbursement framework beyond the rental and hearing aid issues addressed above. These are areas where peer states have developed explicit policies that could serve as reference points for future planning discussions.

Opportunity 1.7.1 — Prior Authorization Requirements for DME

Alaska does not have a PA process for high-cost or complex DME. Under the current framework, power wheelchairs, complex rehabilitation technology (CRT), custom prosthetics, and advanced orthotics are processed without a specified prior authorization step. Several peer states have implemented PA requirements for these categories.

Peer State Comparison: New York maintains a WC DME fee schedule with an explicit PAR-required column; Washington L&I requires PA for power mobility and complex orthotics; Colorado requires PA for all continuous rental items.

Background for Planning Discussions: Peer states such as New York, Washington, and Colorado maintain PA-required DME lists as part of their fee schedules. These frameworks typically address power mobility devices, CRT, custom prosthetics and orthotics, and high-cost items. A fee schedule appendix approach is one model that could be examined.

Opportunity 1.7.2 — Medical Necessity Documentation Standards for DME

No documentation standard exists for establishing medical necessity for a DME item. There is no requirement for a written physician order, HCPCS code specification, diagnosis linkage, or expected duration of need. Colorado requires a face-to-face (F2F) physician encounter within 6 months of ordering continuous rental items; Texas and New York require treating physician orders with clinical documentation tied to evidence-based guidelines.

Background for Planning Discussions: States such as Colorado, Texas, and New York require a written physician order for all DME specifying the HCPCS code, diagnosis code, and expected duration of need; PA-required items in those states also require a signed clinical summary documenting medical necessity. These approaches could serve as models.

Opportunity 1.7.3 — Repair and Maintenance of DME

The schedule contains no rules on DME repair billing, repair cost caps, or routine maintenance. Common questions left unanswered include: which HCPCS codes apply to repairs (K0739, L4205, A9900); whether repair reimbursement is capped at replacement cost; whether routine servicing is separately billable; and whether PA is required. Oregon explicitly caps repair at replacement cost, excludes routine servicing from separate reimbursement, and prohibits maintenance payments for rented items. Washington requires PA for repairs when similar new equipment would require PA.

Background for Planning Discussions: Oregon caps repair reimbursement at replacement cost, excludes routine maintenance from separate reimbursement, and prohibits maintenance payments for rented items; Washington requires PA for repairs when similar new equipment would require PA. These peer-state frameworks could serve as models for addressing DME repair and maintenance.

Opportunity 1.7.4 — Delivery and Setup Costs

The schedule does not state whether delivery, shipping, setup, fitting, and adjustments are included in the DMEPOS rate or separately billable. The absence of explicit guidance on whether these costs are included in the DMEPOS rate can contribute to billing and adjudication inconsistencies, an issue noted in peer-state policy discussions. New York and Oregon both explicitly state these costs are bundled into the DMEPOS schedule value. New York provides a PA pathway (A9901) for documented unusual delivery circumstances.

Background for Planning Discussions: New York and Oregon explicitly state that delivery, shipping, setup, standard fitting, and adjustments are bundled into the DMEPOS schedule value and are not separately reimbursable. New York also provides a pathway (A9901) for documented unusual delivery circumstances. These approaches could be examined as structural models.

Opportunity 1.7.5 — Replacement and Useful Life Standards

There is no minimum useful life standard, no documentation requirement for early replacement, and no guidance on how irreparable damage or loss is handled. Oregon establishes a 5-year minimum useful life (calculated from delivery date) and distinguishes irreparable wear from accidental damage. Colorado aligns its replacement standards with CMS DMEPOS guidelines.

Background for Planning Discussions: Oregon establishes a 5-year minimum useful life standard (calculated from delivery date) and distinguishes irreparable wear from accidental damage; Colorado aligns its replacement standards with CMS DMEPOS guidelines. These frameworks could serve as models for addressing replacement and useful life standards.

Opportunity 1.7.6 — Rental-to-Purchase Conversion Rules

Alaska's rental pricing rules do not establish a maximum rental period, a conversion-to-ownership threshold, or a cap on cumulative rental payments relative to purchase price. Without these rules, 10% monthly rental payments could continue indefinitely with no conversion or cost ceiling. Texas and California adopt CMS DMEPOS payment category conversion rules by reference (capped rental: 13 months; oxygen/OX: 36 months).

Background for Planning Discussions: Texas and California adopt CMS DMEPOS payment category conversion rules by reference, including capped rental periods (13 months for standard items; 36 months for oxygen/OX category). These frameworks include provisions under which cumulative rental payments do not exceed the purchase price equivalent, and may require a cost-effectiveness evaluation for long-term rentals.

Opportunity 1.7.7 — Prosthetics and Orthotics-Specific Guidance

P&O items are treated with no provisions for custom fabrication, fitting and modification billing, component replacement intervals, or repair of prosthetic devices. New York's WC DME schedule includes PAR-required designations for complex P&O. Oregon has specific P&O replacement schedules. California requires PA and detailed documentation for custom P&O items.

Background for Planning Discussions: New York's WC DME schedule includes PA-required designations for complex P&O; Oregon has specific P&O replacement schedules; California requires PA and detailed documentation for custom P&O items. These peer-state frameworks addressing prefabricated vs. custom-fabricated device reimbursement, fitting and adjustment bundling, component replacement intervals, and repair could serve as structural models.

Opportunity 1.7.8 — Guidance on Custom DME and Modifications

Custom-fabricated DME not listed in the DMEPOS schedule falls under the invoice plus 20% fallback, but there is no documentation requirement for clinical justification of a custom vs. standard device or for modifications to standard equipment. Oregon and New York both require clinical documentation for custom items and modifications.

Background for Planning Discussions: Oregon and New York both require clinical documentation for custom items and modifications. Peer-state approaches observed in this area include a signed physician statement justifying a custom device over a commercially available equivalent, submitted with the invoice; modifications to standard DME are typically billed with appropriate HCPCS modification codes.

Opportunity 1.7.9 — Used and Refurbished Equipment: UE Modifier

The UE modifier is listed but the schedule provides no guidance on when used equipment is appropriate, how it is priced, or what condition standards apply. Colorado requires PA and a "like new" condition attestation from the supplier for all used/refurbished equipment. Washington requires a warranty check and PA.

Background for Planning Discussions: Colorado requires PA and a "like new" condition is required. PA is required for used items above a defined cost threshold.

Opportunity 1.7.10 — Automatic DME Resupply

The schedule does not prohibit automatic resupply of DME consumables (e.g., CPAP supplies, ostomy supplies, wound care materials) on a predetermined schedule without a new active order (except for TENS electrodes/supplies). Automatic delivery programs are a documented cost driver and compliance risk in DMEPOS billing. Oregon explicitly prohibits automatic delivery without a current order and requires documentation of continued medical need for each resupply.

Background for Planning Discussions: Oregon explicitly prohibits automatic delivery without a current order and requires documentation of continued medical need for each resupply. This approach could be examined as a model for addressing automatic resupply of DME consumables.

Opportunity 1.7.11 — DME Supplier Credentialing Requirements

There is no requirement that DME suppliers billing under Alaska WC be enrolled as authorized WC providers or meet any credentialing standard. New York requires Medicaid licensing within 6 months of registration. Washington requires L&I provider enrollment.

Background for Planning Discussions: New York requires Medicaid licensing within 6 months of WC registration; Washington requires L&I provider enrollment. Peer-state frameworks typically include DME supplier enrollment requirements aligned with applicable business licensing and CMS DMEPOS supplier standards (42 CFR Part 424, Subpart F).

2. Comparative State Analysis

The following table summarizes how Alaska's key provisions compare to peer states with mature workers' compensation medical fee schedules:

Topic	Alaska (2026)	California	Washington	Texas	Oregon	Colorado
Drug Pricing Benchmark	AWP + dispensing fee	AWP + formulary tiers	Closed formulary	Closed formulary	NADAC-based	AWP + rules
Opioid Prescribing Limits	Not addressed	MTUS protocols	MME thresholds in L&I guidance	Formulary-controlled	ODG guidelines referenced	Rule 17 MME limits
Telehealth Platform Standards	Not defined	HIPAA-compliant required	Platform standards referenced	TDLR telehealth rules	OHA modalities list	Not detailed
RPM Codes (99453–99454, 99457–99458)	Not addressed	OMFS covered	L&I schedule covered	Not in formulary	Not addressed	Not addressed
Interpreter Services	Not addressed	T1013 covered	Covered with rates	Not addressed	Covered (ancillary)	Not addressed

Topic	Alaska (2026)	California	Washington	Texas	Oregon	Colorado
Acupuncture Billing	Not addressed	97810–97814 covered	Covered with guidance	Limited	Covered	Not addressed
CAH Methodology	Billed charges fallback	Cost-to-charge ratios	Detailed CAH rules	Not explicit	Documentation required	Negotiated
Ground Ambulance Rates	HCPCS + MAR fallback	AFS-based	Specific base/mileage	Specific rates	AFS-based	AFS-based
Compounded Drug PA Required	Not explicit	Yes (formulary)	Prior auth required	Prior auth required	Not explicit	Prior auth required
Change Summary Published	No	Yes (annual)	Yes (change memo)	Yes	Yes	Yes
Provider Type Matrix	Partial (85% rule)	Explicit table	Explicit table	Explicit table	Explicit	Rule 18 matrix
DME Prior Authorization	Not addressed	Yes — RFA process	Yes — L&I PA system	Rx required; ODG standard	Yes — listed items	Yes — continuous rentals
DME Medical Necessity Docs	Not specified	MTUS + RFA clinical docs	Med. necessity criteria apply	Physician order + ODG	Physician order required	F2F within 6 months (initial)
DME Repair & Maintenance	Not addressed	Partial guidance	PA if new item needs PA; warranty check required	Not detailed	Cap at replacement cost; no routine maintenance; no rented item repair	CRT repairs: no PA with modifier RB
DME Delivery & Setup	Not addressed	Bundled in rate	Bundled in rate	Not detailed	Explicitly bundled; shipping not covered	Not detailed
DME Replacement / Useful Life	Not addressed	Addressed in regs	Useful life standards apply	Not detailed	5-year minimum useful life	Addressed in DMEPOS manual
DME Rental-to-Purchase Conversion	Not addressed	CMS rules by reference	Cost-effectiveness evaluation required	CMS DMEPOS rules adopted	Duration-based standards	CMS categories by reference
Prosthetics & Orthotics Rules	Not addressed	PA for complex; physician-dispensed caps	Addressed in L&I policy	DMEPOS rules apply	Specific P&O replacement schedules	Addressed in DMEPOS manual
Custom DME & Modifications	Not addressed	Addressed	Not detailed	Not detailed	Addressed with documentation	Not detailed
Used / Refurbished DME	UE modifier listed; no rules	Not detailed	Warranty check; PA required	Not detailed	Safety/functionality docs required	PA required; "like new" attestation

Topic	Alaska (2026)	California	Washington	Texas	Oregon	Colorado
Automatic DME Resupply	Not addressed	Not detailed	Not detailed	Not detailed	Explicitly prohibited without active order	Not detailed
DME Supplier Credentialing	Not addressed	Licensing requirements apply	L&I enrollment required	Provider enrollment required	Not detailed	Provider enrollment required

Note: This table is based on publicly available fee schedule documents and guidance from the referenced states. Accuracy reflects the most recent available information as of the date of this review.

3. Additional Long-Term Opportunities

Beyond near-term clarifications, the following longer-term opportunities could position Alaska's workers' compensation medical fee schedule as a model for transparency and administrative efficiency:

3.1 Evidence-Based Treatment Guidelines Integration

The schedule references medical necessity and off-label use requirements but does not incorporate or cross-reference evidence-based treatment guidelines (e.g., Official Disability Guidelines / ODG, or state-specific MTUS equivalent). Washington and California have deeply integrated treatment guidelines into their workers' compensation frameworks, reducing disputes and improving clinical outcomes.

3.2 Formulary Development for Workers' Compensation

Alaska does not currently maintain a workers' compensation drug formulary. A closed or open formulary would provide a structured framework for drug coverage decisions, reduce inappropriate prescribing, and create a clearer basis for payment disputes. Texas' closed formulary, implemented in 2011, has been associated with significant reductions in opioid prescribing and drug costs in the workers' compensation system.

3.3 Behavioral Health and Mental Health Parity

The schedule does not address behavioral health services beyond a brief reference to psychiatric residential treatment centers under Nursing Facility E/M codes. Given the high rates of PTSD and mental health conditions among injured workers, explicit guidance on psychological and behavioral health CPT codes, provider types (licensed clinical psychologists, licensed clinical social workers), and reimbursement rates would address a meaningful coverage gap.

3.4 Rural and Remote Care Provisions

Alaska's unique geography creates significant access challenges for injured workers in rural and remote areas. The schedule could be enhanced to address: (a) explicit coverage for community health aide/practitioner (CHAP) services; (b) rural telehealth provisions that account for limited broadband access; and (c) enhanced reimbursement for providers serving remote communities, analogous to Medicare's Health Professional Shortage Area (HPSA) bonus payments.

Appendix: Reference Documents

The following publicly available documents were used as comparative references in this analysis. All state workers' compensation fee schedule references reflect the 2026 edition of each state's schedule, verified against current publications as of April 2026.

Alaska:

- Alaska Workers' Compensation Medical Fee Schedule, 2026 Edition (effective April 1, 2026), Alaska Division of Workers' Compensation — accessed at labor.alaska.gov/wc/

Peer State Fee Schedules (2026 Editions):

- California Official Medical Fee Schedule (OMFS), 2026 — Division of Workers' Compensation, California Department of Industrial Relations. Physician and Non-Physician Practitioner Services section effective March 1, 2026 (Administrative Director Update Order); DMEPOS section effective March 1, 2026 (Title 8 CCR §9789.60); Pathology/Clinical Laboratory section effective January 1, 2026 (Q1) and April 1, 2026 (Q2); Hospital Outpatient/ASC section effective April 1, 2026. Accessed at dir.ca.gov/dwc/omfs9904.htm
- Washington L&I Medical Fee Schedule and Billing Policies, effective July 1, 2025 (the current 2025–2026 fee schedule year, as Washington's schedule runs July 1–June 30) — Washington State Department of Labor & Industries. Accessed at lni.wa.gov/patient-care/billing-payments/fee-schedules-and-payment-policies/
- Texas Medical Fee Guideline, 2026 — Texas Department of Insurance, Division of Workers' Compensation. Conversion factors effective January 1, 2026 ($72.07 and $90.48, reflecting 2.7% MEI increase); professional fee schedule document dated January 15, 2026. 28 TAC Chapter 134. Accessed at tdi.texas.gov/wc/fee/
- Oregon Medical Fee and Payment Rules, OAR 436-009, 2026 Edition — Oregon Workers' Compensation Division. Temporary rules effective January 1, 2026 (Order No. 25-058) and permanent rules effective April 1, 2026 (Order No. 26-050) adopting CPT 2026 codes and ASA Relative Value Guide 2026. Accessed at wcd.oregon.gov/medical/pages/fee-schedules-forms.aspx
- Colorado Division of Workers' Compensation Rule 18 Medical Fee Schedule, 2026 — Colorado Department of Labor and Employment, Division of Workers' Compensation. Rule 18 and exhibits effective January 1, 2026 (adopted September 2025, posted October 2025). 2026 Medical Fee Schedule Excel file published by DOWC. 7 CCR 1101-3 Rule 18. Accessed at cdle.colorado.gov/dwc/medical-providers/fee-schedule-rule-18

- New York Workers' Compensation Board Durable Medical Equipment Fee Schedule, Fourth Edition (effective June 28, 2024; the current 2024 DME fee schedule) — New York State Workers' Compensation Board. Accessed at wcb.ny.gov

Federal Sources (CY 2026):

- CMS RBRVS Physician Fee Schedule RVU26A, CY 2026 Final Rule (CMS-1832-F) — Centers for Medicare & Medicaid Services, effective January 1, 2026
- CMS IPPS Final Rule FY 2026 — Centers for Medicare & Medicaid Services, effective October 1, 2025
- CMS DMEPOS Fee Schedule Public Use File (PUF), CY 2026 — Centers for Medicare & Medicaid Services
- AMA CPT 2026 Professional Edition — American Medical Association (includes 12 new hearing device service codes 92628–92642; deletion of 92590–92595, effective January 1, 2026)
- ASA Relative Value Guide 2026 — American Society of Anesthesiologists

Industry and Research Sources:

- Optum Workers' Compensation Pharmacy Resource Guide, March 2026 — Optum/UnitedHealth Group
- WCRI: Physician Dispensing In Workers' Comp: A Costly Loophole--And How to Close it — Workers Compensation Research Institute; Physician Dispensing in Workers' Comp: A Costly Loophole—and How to Close It | WCRI
- Enlyte: Workers' Compensation Pharmacy Legislative & Regulatory 2024 Recap; https://www.enlyte.com/insights/article/compliance/workers-compensation-pharmacy-legislative-and-regulatory-end-year-recap
- Healthesystems RxInformer: High Prices, High Impact: Drugs Driving Up Claim Costs in Workers' Comp; https://healthesystems.com/rxi-articles/high-prices-high-impact-meet-the-drugs-driving-up-claim-costs-in-workers-comp/
- ASHA: Audiology CPT and HCPCS Code Changes for 2026 — American Speech-Language-Hearing Association
- AAA: AMA Releases 2026 CPT Codebook with New Hearing Device Services Codes — American Academy of Audiology
- AMA History of Medicare Conversion Factors (CF History PDF) — American Medical Association

Alaska Statutes and Regulations Referenced:

- Alaska Statute AS 23.30 — Alaska Workers' Compensation Act
- Alaska Regulation 8 AAC 45.083 — Compensation and benefits; medical treatment
- Alaska Regulation 8 AAC 45.086 — Medical reports and treatment plans
- Alaska Regulation 8 AAC 45.900 — Definitions
- AS 47.05.270 — Telehealth definition
- AS 08.20.100 — Practice of Chiropractic

For State & MSRC Review Only

	2019 CF or Ratio	2020 CF or Ratio	2021 CF or Ratio	2022 CF or Ratio	2023 CF or Ratio	2024 CF or Ratio	2025 CF or Ratio	2025 Medicare Ratio	2026 CF or Ratio	2026 Medicare Ratio		File	2025		File	2026
ASP	3.375	3.375	3.375	3.375	3.375	3.375	3.375	3.38	3	3.38		cms rbrvs cf	32.3465	(jan)	cms rbrvs cf	33.4009
CLAB	6.33	4.43	4.43	4.43	4.43	4.43	4.43	4.43	4	4.43						
DME	1.84	1.84	1.75	1.75	1.75	1.75	1.66	1.66	2	1.66						
EM	80	80	80	80	80	80	80	2.47	80	2.40						
HCP	1	1	1	1	1	1	1	1.00	1	1.00						
Lab	135	122	122	122	122	122	122	3.77	122	3.65						
Med	80	80	80	80	80	80	80	2.47	80	2.40						
Rad	196	141	134	121	121	121	121	3.74	121	3.62						
Sur	165	132	125	119	119	119	119	3.68	119	3.56						
Ane	121.82	110	105	100	100	100	100	3.59	100	3.55		cms ane cf	27.86	(jan)	cms ane cf	28.15
ASC	221.79	177	168	168	168	168	168	1.88	168	1.84	asc to opps	cms opps cf	89.169	(jan)	cms opps cf	91.415
OPF	221.79	221.79	221.79	221.79	221.79	221.79	221.79	2.49	222	2.43	opps	cms ascpps cf	54.895	(jan)	cms ascpps cf	56.322
ASC (based on ASC)								3.06		2.98	asc to asc					
INP																
Providence Alaska Medical Center		2.38	2.38	2.38	2.38	2.38	2.38	2.38	2.38	2.38						
Mat-Su Regional Medical Center		1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84	1.84						
Bartlett Regional Hospital		1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79	1.79						
Fairbanks Memorial Hospital		1.48	1.48	1.48	1.48	1.48	1.48	1.48	1.48	1.48						
Alaska Regional Hospital		2.32	2.32	2.32	2.32	2.32	2.32	2.32	2.32	2.32						
Yukon Kuskokwim Delta Reg Hospital		2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63	2.63						
Central Peninsula General Hospital		1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38	1.38						
Alaska Native Medical Center		2.53	2.53	2.53	2.53	2.53	2.53	2.53	2.53	2.53						
Other		2.02	2.02	2.02	2.02	2.02	2.02	2.02	2.02	2.02						

CMS Multiple Procedure Payment Reduction (MPPR) — CPT 97530

Locality: Alaska (CMS Locality 01) · CY2026 · Non-facility

ASSUMPTIONS / INPUTS		*(blue = input)*
CPT Code	97530	*Therapeutic activities, each 15 min*
Conversion Factor (2026, non-QP)	$33.4009	*Source: CMS CY2026 PFS Final Rule (non-QP CF)*
PE payment % — highest-PE service	100%	*Service with highest PE RVU paid at 100%*
PE payment % — 2nd & subsequent	50%	*MPPR: PE reduced 50% (since 4/1/2013, all settings)*
97530 RVUs (non-facility, national)		
Work RVU	0.44	*Source: PPRRVU2026_Jul_nonQPP (CMS, rel. 5/20/2026)*
PE RVU (non-facility)	0.60	*Source: PPRRVU2026_Jul_nonQPP (CMS, rel. 5/20/2026)*
MP RVU	0.01	*Source: PPRRVU2026_Jul_nonQPP (CMS, rel. 5/20/2026)*
Alaska 2026 GPCIs (Addendum E)		
Work (PW) GPCI	1.500	*Source: GPCI2026.xlsx, Addendum E, AK Loc 01 (statutory 1.5 floor)*
PE GPCI	1.065	*Source: GPCI2026.xlsx, Addendum E, AK Loc 01*
MP GPCI	0.551	*Source: GPCI2026.xlsx, Addendum E, AK Loc 01*

CALCULATION — per 15-minute unit

Claim Line	CPT	PE pay %	Work $	PE $	MP $	Allowed $
Line 1 (full — highest PE)	97530	100%	$22.04	$21.34	$0.18	**$43.57**
Line 2 (MPPR — PE × 50%)	97530	50%	$22.04	$10.67	$0.18	**$32.90**

Total allowed — 2 units WITH MPPR	**$76.47**
Total allowed — 2 units, NO MPPR	$87.14
MPPR reduction ($)	$10.67
MPPR reduction (%)	12.2%

NOTES

- MPPR reduces ONLY the practice-expense (PE) component. Work and malpractice are always paid in full.
- The service/unit with the highest PE RVU is paid at 100% PE; every other unit or procedure that day gets PE × 50%.
- Applies to multiple UNITS as well as multiple procedures; order on the claim does not matter.
- Triggered on professional claims by the Multiple Procedure indicator = 5 in the MPFS database.
- https://www.cms.gov/medicare/coding-billing/therapy-services

97161

RVUs - Nonfacility

	National	Global(Locality)	26	TC
Work RVU:	1.54000	1.54000	n/a	n/a
PE RVU:	1.38000	1.38000	n/a	n/a
Malpractice RVU:	0.01000	0.01000	n/a	n/a
Total RVU:	2.93000	2.93000	n/a	n/a
Conversion Factor:	33.4009			

97161	126.43

MCR CF	AK MAC 0210201 AK		
33.4009	1st unit	2nd unit	3rd unit
97161	100%	MPPR	MPPR
Work	77.16	77.16	77.16
PE	49.09	24.54	24.54
MP	0.18	0.18	0.18
Total	126.43	101.88	101.88
			24.54 MPPR $
			19.41% MPPR %

97161	AK WC CF	AK 2026 WC FEE SCHEDULE		
	80.00	1st unit	2nd unit	3rd unit
	97161	100%	MPPR	MPPR
	Work	184.80	184.80	184.80
	PE	117.58	58.79	58.79
	MP	0.44	0.44	0.44
	Total	302.82	244.03	244.03
				58.79 MPPR $
				19.41% MPPR %

		W GPCI	PE GPCI	MP GPCI	W RVU	PE RVU	MP RVU	Mult	PT CODE	MCR	MCR MPPR	AK	AK MPPR
97110	37.31	1.5	1.065	0.551	0.45	0.41	0.01	5	97110	37.31	30.02	89.37	71.91
97161	126.43	1.5	1.065	0.551	1.54	1.38	0.01	5	97161	126.43	126.43	302.82	302.82
97530	43.57	1.5	1.065	0.551	0.44	0.6	0.01	5	97530	43.57	32.90	104.36	78.80
									ALL TOTAL	207.31	189.35	496.55	453.53
MCR CF	33.4009										0.913366		0.913362
AK CF	80.00										8.66%		8.66%

If all 3 of these codes were performed on the same date of service, one unit each, there would be an additional 8.66% reduction ($43.02) of the AK payment per the MPPR.

43.02

New 2026 Audiology CPT Codes — Multi-State Fee Schedule Comparison

Sources that publish payable rates. MA = Workers' Comp peer. Two AK WC projections: (I) multiplier method, (J) crosswalk method (see 'AK WC Crosswalk' tab).

CPT Code	Description	ID Medicaid (Apr–Jun 2026)	OR Medicaid (03/2026)	MA Workers' Comp (2026)	ME DHHS (MaineCare 1/1/26)	TX Medicaid (non-fac, adult 1/1/26)	Average (published payable)	AK WC Proj. (multiplier method)	AK WC Proj. (crosswalk method)	Recommended AK WC Fee
92628	Evaluation for hearing aid candidacy, first 30 min	$46.64	$43.26	BR	$49.63	Not listed	$46.51	$93.02	$93.02	**$93.02**
92629	Evaluation for hearing aid candidacy, each additional	$23.32	$21.63	BR	$29.83	Not listed	$24.93	$49.85	$49.85	**$49.85**
92631	Hearing aid selection service, first 30 min	$23.29	$43.26	$35.23	$47.71	Not listed	$37.37	$74.75	$74.75	**$74.75**
92632	Hearing aid selection service, each additional	$11.65	$21.63	$17.62	$29.70	Not listed	$20.15	$40.30	$40.30	**$40.30**
92634	Hearing aid fitting service, first 60 min	$0.00	$126.82	BR	$48.14	$116.54	$97.17	$194.33	$194.33	**$194.33**
92635	Hearing aid fitting service, each additional	$0.00	$31.71	BR	$24.54	$29.14	$28.46	$56.93	$56.93	**$56.93**
92636	Hearing aid post-fitting follow-up, first	$17.01	$34.05	$28.75	$31.35	$11.97	$24.63	$49.25	$49.25	**$49.25**
92637	Hearing aid post-fitting follow-up, each additional	$8.51	$17.03	$14.38	$20.19	$5.99	$13.22	$26.44	$26.44	**$26.44**
92638	Behavioral verification of amplification	$0.00	$59.20	BR	$35.32	$23.94	$39.49	$78.97	$78.97	**$78.97**
92639	Hearing-aid measurement / verification	$0.00	$59.20	BR	$35.33	$23.94	$39.49	$78.98	$78.98	**$78.98**
92641	Hearing device verification, electroacoustic analysis	$17.01	$30.27	$82.32	$32.59	$27.45	$37.93	$75.86	$57.89	**$82.32**
92642	Supplemental / assistive technology fitting service	$0.00	$31.71	BR	$29.60	Not listed	$30.66	$61.31	$61.31	**$61.31**
	Average across codes						**$36.67**	**$73.33**	**$71.84**	**$73.87**

ASSUMPTION → multiplier-method marku **2.00x**

Notes & methodology:

1. Source values are verbatim from each uploaded fee schedule (blue). MA Workers' Comp shaded peach.

2. Sources with no payable fee for these codes (AZ 'By Report', CA $0.00, NV not listed, WA non-covered) were removed at user request.

3. TX Medicaid = non-facility, adult (21+) office rate. TX prices only 92634–92639 & 92641; 92628/29/31/32/42 are 'Not listed'.

4. 'BR' (MA WC) = By Report. Average uses AVERAGEIF(>0), excluding BR / not-listed / $0.00 (incl. ID's bundled $0 codes).

5. Column I (multiplier method): multi-state average x the editable markup (yellow cell).

6. Column J (crosswalk method): the recommended approach given NO RVUs exist yet for these new codes. It derives the AK WC markup from AK's own existing audiology codes and directly anchors 92641 (electroacoustic) to predecessor code 92594. See 'AK WC Crosswalk' tab.

7. Both projections are planning estimates, not official AK rates. Revisit once AK assigns RVUs / conversion factors to these codes.

8. Reasonableness review (added): established rates cross-checked vs the old AK fees, the MA WC peer, and internal time/add-on consistency. All twelve fees reviewed and accepted as FINAL (incl. 92634 magnitude and 92641 set to the WC peer). See AK WC Crosswalk Sections 4 & 5.

AK WC Crosswalk & Calibration — New 2026 Audiology Codes

No RVUs exist yet for the new 2026 codes, so a crosswalk from AK WC's existing audiology codes (combined with the multi-state Medicaid averages) is the available strategy.

Section 1 — Existing AK WC audiology codes used as calibration anchors

Old Code	Description	AK WC Fee	Comparison Schedule	Comparison Rate	Implied AK÷Comp	Notes
92591	Hearing aid exam & selection, binaural	$193.62	AZ Medicaid	$79.14	2.45x	*Professional predecessor; AZ is a low Medicaid payer so this ratio is likely overstated*
92593	Hearing aid check, binaural	$99.64	AZ Medicaid	$17.81	5.59x	*OUTLIER — AZ prices this very low; excluded from the blended multiplier*
92594	Electroacoustic evaluation, monaural	$57.89	—	—	—	*Direct $ anchor for new 92641 (per-device basis)*
92595	Electroacoustic evaluation, binaural	$124.11	—	—	—	*Bilateral electroacoustic eval (≈ 2× monaural)*
V5014	Hearing aid repair/modification	$249.31	OR Medicaid	$112.59	2.21x	*Device code — different pricing logic than professional codes*
V5014	Hearing aid repair/modification	$249.31	TX Medicaid (adult)	$229.76	1.09x	*Same code, TX denominator → 1.09×: shows how unstable the ratio is*
V5020	Conformity evaluation	$116.17	OR Medicaid	$118.40	0.98x	*AK WC ≈ Oregon Medicaid here (0.98×) for this device/verification code*

Section 2 — Crosswalk multiplier (applied to the multi-state average in main-sheet column J)

Blended multiplier candidates	1.68x
APPLIED crosswalk multiplier (editable):	**2.00x**
92641 DIRECT anchor (= old 92594 monaural electroacoustic):	**$57.89**

Section 3 — Old→New functional crosswalk map

New Code	New Service	Closest Old AK WC Code	Mapping Basis	Projection Method
92628	Hearing aid candidacy eval, first	92591 (exam & selection)	*Examination component of the old bundled exam/selection*	*Avg × multiplier*
92629	Hearing aid candidacy eval, addl	92591 (exam & selection)	*Add-on to the examination component*	*Avg × multiplier*
92631	Hearing aid selection, first	92591 (exam & selection)	*Selection component of the old bundled code*	*Avg × multiplier*
92632	Hearing aid selection, addl	92591 (exam & selection)	*Add-on to the selection component*	*Avg × multiplier*
92634	Hearing aid fitting, first	92591 (exam & selection)	*Fitting was bundled into the old exam/selection service*	*Avg × multiplier*
92635	Hearing aid fitting, addl	92591 (exam & selection)	*Add-on to fitting*	*Avg × multiplier*
92636	Post-fitting follow-up, first	92593 (hearing aid check)	*Follow-up/check of fitted device*	*Avg × multiplier*
92637	Post-fitting follow-up, addl	92593 (hearing aid check)	*Add-on to follow-up/check*	*Avg × multiplier*
92638	Behavioral verification of amplification	92595 / V5020	*Verification of fit/performance*	*Avg × multiplier*
92639	Hearing-aid measurement / verification	92595 (electroacoustic)	*Real-ear/probe-mic verification*	*Avg × multiplier*
92641	Hearing device electroacoustic verification	92594 (electroacoustic, monaural)	*Near 1:1 service match*	*DIRECT anchor = $57.89*
92642	Supplemental/assistive device fitting	V5020 (conformity eval)	*Closest device/verification analog*	*Avg × multiplier*

Section 4 — Reasonableness review (established AK WC fees cross-checked)

New Code	Recommended Fee	Cross-check	Assessment
92628	**$93.02**	Eval 30-min slice; ≈ 48% of old 92591 binaural bundle; $3.10/min	OK
92629	**$49.85**	Add-on = 54% of 92628 — standard add-on ratio	OK
92631	**$74.75**	2.1× MA WC peer ($35.23); $2.49/min	OK
92632	**$40.30**	2.3× MA WC peer; 54% of 92631	OK
92634	**$194.33**	60-min svc, $3.24/min (consistent) BUT no old AK anchor; ≈ entire old exam+sel bundle; top episode driver	Final
92635	**$56.93**	Add-on only 29% of 92634 vs ~54% elsewhere (large 60-min base)	Final
92636	**$49.25**	Unilateral OR bilateral, time-based (first 30 min) — one fee covers both ears, same scope as old binaural 92593 ($99.64 flat). 1.71× MA WC peer ($28.75). Markup alignment in Section 5.	OK (see Sec 5)
92637	**$26.44**	1.8× MA WC peer; 54% of 92636	OK
92638	**$78.97**	≈ 64% of old 92595 binaural electroacoustic eval	OK
92639	**$78.98**	≈ 92638; verification pair consistent	OK
92641	**$82.32**	Now pinned to MA WC peer $82.32 (the only real WC data point); was $57.89 crosswalk / $75.86 mult	Final
92642	**$61.31**	≈ 53% of old V5020 conformity eval ($116.17)	OK

Verdict: rates are internally consistent and supported by the multi-state Medicaid data and the old AK fees. Episode total (first units) approx $487 vs old binaural approx $417 (+17%), the expected unbundling effect. All twelve fees accepted as FINAL.

Section 5 — Coding-unit correction & AK WC markup alignment (92636)

Per the CPT descriptor, the new post-fitting follow-up code (92636) is reported per SESSION as 'unilateral or bilateral' and is TIME-based (first 30 min; add-on 92637 per each additional). It is NOT a per-ear code, so the earlier monaural-equivalent comparison is superseded. Its scope matches the old binaural check 92593 (both ears), but the old code was a single FLAT fee ($99.64) while the new code accrues by time. The two therefore align by service DURATION, not by a flat 1:1 comparison.

Follow-up duration	New AK fee (2× markup)	New-code Medicaid	Old AK 92593 (flat)	New ÷ Old	Markup needed to match old
30 min (92636 only)	**$49.25**	$24.63	$99.64	0.49×	**4.05×**
60 min (92636 + 1× 92637)	**$75.69**	$37.85	$99.64	0.76×	**2.63×**
90 min (92636 + 2× 92637)	**$102.13**	$51.07	$99.64	1.03×	**1.95×**

Conclusion: the 2× markup is well-aligned with AK's own historical valuation. Matching the old flat $99.64 would require a ~4× markup IF the service were only 30 min, but only ~2× at ~90 min. The extensive 92636 descriptor (fit confirmation, benefit/performance validation, sound-quality check, programming and device adjustments, connections, training, and assistive-device fitting) describes a lengthy bilateral session, so the realistic duration sits at the 60–90 min end — where the 2× markup reproduces the old AK fee. $49.25 is therefore defensible as the first-30-min rate; a full bilateral session reaches the old level via the 92637 add-on. No change to the 2× markup or to the 92636 fee is required.

ON LINE 91 BELOW HIGHLIGHTED IN GREEN

			2025 & 26 AK Fee	MAX/min	MIN/min	AVG/min
92591	2026	30-60 MIN	193.62	6.45	3.23	4.84

Could be up to 3 hr

		AVG/min		MIN/min		MAX & MIN/min	
92628	30 MIN	145.22	4.8405	96.81	3.23	193.62	6.45
92629	15 MIN	72.61		24.225	1.615	48.45	3.23
92629	15 MIN	72.61		48.45		48.45	3.23
TOTAL	1 HR	290.43		169.485		290.52	

			2025 & 26 AK Fee	MAX/min	MIN/min	AVG/min
92593	2026	15-30 MIN	99.64	6.64	3.32	4.98

		AVG/min		MIN/min		MAX & MIN/min	
92636	30 MIN	149.46	4.982	99.64	3.32	199.28	6.64
92637	15 MIN	37.365	2.491	24.90	1.66	49.80	3.32
92637	15 MIN	37.365		49.80		49.80	3.32
TOTAL	1 HR	224.19		174.34		298.88	

			2025 & 26 AK Fee	MAX/min	MIN/min	AVG/min
92594	2026	15-30 MIN	57.89	3.86	1.93	2.89

		AVG/min		MIN/min		MAX/MIN	
92641 **Monoaural**	Not timed	86.835	2.89	57.89	1.93	115.78	30

92594 Electroacoustic evaluation for hearing aid; monaural

01/01/2026 To report, see ([92639], [92641])

92641 Hearing device verification, electroacoustic analysis

ADD ON CODE:

92639 Hearing-aid measurement, verification with probe-microphone (List separately in addition to code for primary procedure) +

		AVG/min
92639	Add on	57.89

			2025 & 26 AK Fee	MAX/MIN	MIN/MIN
92595	2026	15-30 MIN	124.11	8.27	4.14

		92641 value
92641 **Binaural**	Not timed	$57.89 X2 $115.78

92595 Electroacoustic evaluation for hearing aid; binaural

01/01/2026 To report, see ([92639], [92641])

92641 Hearing device verification, electroacoustic analysis

ADD ON CODE:

92639 Hearing-aid measurement, verification with probe-microphone (List separately in addition to code for primary procedure)

Reimbursement Justification Memorandum

Fair & Reasonable Reimbursement of the SAM (Sustained Acoustic Medicine) Device under HCPCS E1399, Alaska Workers' Compensation

Subject device: ZetrOZ Systems sam® / sam-12 wearable ultrasonic diathermy unit (long duration low intensity therapeutic ultrasound)

Billed as: HCPCS E1399, Durable medical equipment, miscellaneous (unlisted / carrier priced; no national fee schedule value)

Jurisdiction: Alaska Workers' Compensation Medical Fee Schedule

Fee data: 2026 Alaska Workers' Compensation Medical Fee Schedule (AK WC FS); CMS DMEPOS Fee Schedule, April 2026 (Q2) update

Prepared: June 2026

Purpose

The SAM device has no dedicated HCPCS code and is billed under E1399, which carries no fee schedule value and must be priced by individual consideration. The aim is to show how the comparable code rules found in workers' compensation medical fee schedules can be applied to reimburse an unlisted item like the SAM device at a comparable code. This memo sets out a fair and reasonable basis for reimbursement under the Alaska Workers' Compensation (AK WC) fee schedule, identifies the comparable DME HCPCS codes that best describe the device, lists their current Alaska fee schedule values, ranks the available pricing approaches in order of preference, applies the federal comparability test to the E0760 crosswalk, presents a reference model and workflow drawn from the jurisdictions whose fee schedules expressly authorize valuing an unlisted code from a comparable code, and identifies a comparable code for the device's single use coupling patches (the consumable supply). It closes with a worked 8 week reimbursement example.

Device summary (coding relevant facts)

- Wearable, prescription only therapeutic ultrasound / ultrasonic diathermy device (FDA cleared diathermy modality).
- Operating parameters: 3 MHz continuous wave ultrasound, ~0.132 W/cm² intensity, up to 4 hours of low intensity delivery; patient applied via single use coupling bandages.
- Indicated for relief of pain, relief of muscle spasm, treatment of joint contracture, and local increase of circulation.
- Durable, reusable power controller and applicators (≈300 charge cycles / 1,500 applicator hours), supporting both purchase and rental treatment.

2. Comparable DME HCPCS codes:

Pref.	HCPCS	Descriptor	AK WC FS Purchase (NU)	AK WC FS Rental (RR/mo.)	Basis / match to SAM
1	**(none)**	Alaska invoice method, E1399 priced at 120% of manufacturer invoice	Invoice × 1.20	Invoice × 1.20 × 10%	AK's own stated rule for unlisted DME.
2	**E0760**	Osteogenesis stimulator, low intensity ultrasound, noninvasive	**$7,648.65**	**$764.86**	Strongest technology match: only DME code for a noninvasive, patient applied, prescription LOW INTENSITY ULTRASOUND emitter. Caveat: labeled for bone healing, not soft tissue/pain.

Values are 2026 Alaska Workers' Compensation fee schedule amounts (

Manufacturer list prices (samsport.com) vs. the E0760 comparable value

For context, the manufacturer's current retail prices are shown below against the E0760 comparable value. These are list/retail prices, not the acquisition invoice that Alaska's invoice × 1.20 method uses; they are provided to show that the E0760 crosswalk is a reasonable, in fact conservative, value.

SamSport product (samsport.com)	List price	Comparison to E0760
sam® 2.0 Device (device only)	**$8,715.00**	Exceeds the E0760 AK WC FS purchase value ($7,648.65) by ≈ $1,066 (≈ 14% higher); ≈ 1.9× the raw E0760 CMS DMEPOS rate for Alaska ($4,607.62).
sam® 2.0 8 Week Recovery Kit (device + 8 week consumables)	**$9,945.00**	Bundled device plus a full 8 week course of patches/gel; above E0760 because it includes consumables.
sam® x1 8 Week Recovery Kit	**$7,725.00**	Lower tier device kit; almost identical to the E0760 AK WC FS purchase value ($7,648.65).
sam® Advanced Gel Capture Patches (60 pc, UB-14-60W / 60T)	**$616.00**	Consumable supply (see Section 5); ≈ $10.27 per patch.
sam® Multi-Hour Coupling Gel	**$22.00**	Consumable coupling gel (the A4559 analog).

Read against these prices, E0760's AK WC FS value ($7,648.65) sits just below the device's retail price and almost exactly at the x1 kit price, so the E0760 crosswalk is a reasonable, conservative comparable, not an inflated one. The primary Alaska path (acquisition invoice × 1.20) would typically yield more than the E0760 value if acquisition cost approximates retail; use the actual invoice, since list price ≠ invoice.

3. Rationale

Alaska invoice method.

Reimburse the purchase at 120% of the manufacturer/acquisition invoice, or the rental at invoice × 1.20 × 10% per month. This is Alaska's own established methodology for unlisted DME (E1399), requires no analogy, and is the cleanest fair and reasonable basis. Attach a current ZetrOZ invoice.

E0760 as the corroborating crosswalk.

If a code based benchmark is requested, E0760 is the closest descriptor on the fee schedule because it is the only code for a noninvasive, prescription, patient applied low intensity ultrasound device, the same delivery technology as SAM. Use it to show the invoice based amount is reasonable. Disclose proactively that E0760's FDA labeled indication is bone healing rather than soft tissue/pain, so a payor cannot later claim the difference was concealed; the crosswalk is by device type, not by indication. See the factor by factor comparability analysis in Section 4.

4. Comparable code methodology: reference model and workflow for valuing E1399

Alaska prices E1399 by invoice (Sections 1–3) and does not have a comparable code rule of its own. The jurisdictions below are presented as a reference model, the federal rule and the state fee schedules whose own text expressly authorizes valuing an unlisted or no value code from a comparable or analogous code. The point is to show that the E0760 crosswalk follows a recognized, codified methodology, and to provide a defensible step by step workflow. These are illustrative methodology, not authority that governs an Alaska claim. Only jurisdictions that use comparable code / comparable item language are included; states that instead pay a percentage of the code's own DMEPOS value, use charge database or supplier survey benchmarks, or use invoice cost plus are omitted because they do not speak in comparable code terms.

Jurisdiction	Authority	Comparable code language / what the rule directs
Federal (CMS), basis for state DMEPOS	42 CFR §414.238(b); Medicare Claims Processing Manual Ch. 23 §60.3	Prices a new / no history code from "existing fee schedule amounts for comparable items," judged by physical, mechanical, and electrical components, function and intended use, and additional features.
California (DWC)	8 CCR §9789.12.4(c)	A "By Report" code is valued by reference to "the value assigned to a comparable procedure or analogous code," which should reflect a similar amount of resources. (DWC: payers "shall pay 'by report' services based on comparable procedures or analogous codes.")
Texas (DWC)	28 TAC §134.1	Where no fee guideline applies, "fair and reasonable" reimbursement must "ensure that similar procedures provided in similar circumstances receive similar reimbursement."
Minnesota (DLI)	Minn. R. 5221.0500, subp. 2(B)	If a max fee is not set by the schedule, liability is 85% of usual & customary or 85% of the "prevailing charge for similar treatment, articles, or supplies," whichever is lower.
Virginia (VWC)	Va. Code §65.2-605(B)(1), (E); 2026 MFS Ground Rules	Items the fee schedule does not address (including DME dispensed at retail) are limited to "such charges as prevail in the same community for similar treatment"; an unlisted fee scheduled item's maximum is set by the Commission, and unlisted services are billed "By Report."

Exact wording from each authority

Federal, 42 CFR §414.238(b) (Comparability):

> *"Fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history are established using existing fee schedule amounts for comparable items when items with existing fee schedule amounts are determined to be comparable to the new items and services based on a comparison of: Physical components; mechanical components; electrical components; function and intended use; and additional attributes and features."*

California, 8 CCR §9789.12.4(c):

> *"In determining the value of a By Report procedure, consideration may be given to the value assigned to a comparable procedure or analogous code. The comparable procedure or analogous code should reflect similar amount of resources, such as practice expense, time, complexity, expertise, etc. as required for the procedure performed."*

Texas, 28 TAC §134.1 (fair and reasonable):

> *"Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."*

Minnesota, Minn. R. 5221.0500, subp. 2(B):

> *"if the maximum fee for service, article, or supply is not limited by parts 5221.4005 to 5221.4070, the payer's liability for payment shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charge for similar treatment, articles, or supplies furnished to an injured person when paid for by the injured person, whichever is lower."*

Virginia, Va. Code §65.2-605(B)(1) and (E):

> *"[B.1] … shall be limited … to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person. … [E] The maximum pecuniary liability of the employer for a fee scheduled medical service that is not included in a Virginia fee schedule when it is provided shall be determined by the Commission."*

Applying the federal §414.238(b) comparability test to E0760 vs. SAM

These federal factors are the framework a payor or reviewer will use to judge the E0760 crosswalk. Applied to SAM, E0760 satisfies four of the five factor groups strongly; the divergence is confined to "function and intended use." (Note: §414.238 governs CMS setting a fee for a new code; here the factors are applied by analogy to support pricing the existing unlisted code E1399.)

§414.238(b) factor	E0760 (LIPUS osteogenesis stimulator)	SAM (sam-12)	Match
Physical components	Portable controller + transducer, skin coupling, battery; single patient home use	Portable controller + 1–2 applicators, coupling bandages, lithium ion battery; single patient home use	**Strong**
Mechanical components	Piezoelectric ultrasound transducer delivering acoustic energy through coupling to tissue	Same, piezoelectric ultrasound transducer(s) via coupling bandage	**Strong**
Electrical components	Battery powered low power driver for the transducer	Battery powered low power driver for the transducer(s)	**Strong**
Function & intended use	Emit therapeutic ultrasound; intended use = stimulate bone (fracture) healing; nonthermal, pulsed LIPUS (~1.5 MHz, ~30 mW/cm², ~20 min/day)	Emit therapeutic ultrasound; intended use = deep heating (diathermy) for pain/spasm/contracture/circulation; thermal, continuous wave (3 MHz, ~132 mW/cm², up to 4 hr./day)	**Partial**
Additional attributes & features	Rx only, FDA cleared, durable controller + disposable coupling, wearable, multiweek course	Rx only, FDA cleared, durable controller + disposable coupling, wearable, multiweek course	**Strong**

Verdict: under §414.238(b)'s holistic comparison (which does not require identity on every factor), E0760 is the strongest available on schedule comparable for SAM, a clear match on physical, mechanical, and electrical components and on the additional DME class attributes. The contestable prong is "function and intended use": both emit therapeutic ultrasound, but E0760 is nonthermal bone healing LIPUS while SAM is thermal soft tissue diathermy.

Established workflow for valuing E1399 via a comparable code

1. Confirm the item has no specific HCPCS code and no fee schedule value, it is billed under E1399 (unlisted, carrier priced/individual consideration).
2. Identify the comparable code using the §414.238(b) factors, physical, mechanical, and electrical components, function and intended use, and additional attributes/features. For SAM, this is E0760 (low intensity ultrasound), the only on schedule low intensity ultrasound emitter.
3. Establish the value from the comparable code's published fee schedule amount, here the 2026 AK WC FS amount for E0760 (NU $7,648.65; RR $764.86/mo.), and/or the payor's own stated method (Alaska invoice × 1.20).
4. Document the comparability analysis and disclose any factor divergence, for E0760, the bone healing vs. soft tissue intended use difference, in a By Report narrative, so the basis is transparent and cannot be characterized as concealed.
5. Submit the bill with the manufacturer invoice and the comparability memo; if the value is contested, cite the comparable code authorities (42 CFR §414.238(b); CA 8 CCR §9789.12.4(c); TX 28 TAC §134.1; MN R. 5221.0500; VA Va. Code §65.2-605) as recognized methodology supporting the amount.

Takeaway: pricing an unlisted code from a comparable code is recognized, codified methodology used both federally (§414.238(b)) and in state fee schedules (CA, TX, MN, VA). E0760 substantially satisfies the federal comparability factors for SAM, so it is a sound comparable. Apply the workflow above: lead with Alaska's invoice method and use the E0760 comparable to corroborate the amount, with the intended use difference disclosed.

5. Consumable supply: SAM Advanced Gel Capture coupling patches (UB-14-60W / UB-14-60T)

The SAM device requires a single use "Advanced Gel Capture" coupling patch (white UB-14-60W or skin tone UB-14-60T; 60 piece pack) to acoustically couple each applicator to the skin. Each patch is a disposable adhesive bandage with ultrasound coupling gel sealed inside (hypoallergenic, 3M adhesive). One patch is used per applicator per treatment session, so the patches are a recurring consumable across a multiweek course. List price is about $616 per 60 piece pack (≈ $10.27 per patch).

Like the device, the patches have no dedicated HCPCS code. The comparable code analysis is:

Code	Descriptor	Fee schedule status / value	Fit for the SAM coupling patch
A4559	Coupling gel or paste, for use with ultrasound device, per oz	On the DMEPOS jurisdiction list but "not separately payable" when incident to a physician's service (commonly bundled); nominal allowance (≈ $0.98/oz)	Closest match by FUNCTION (ultrasound coupling medium). Weak on form and value: it is loose gel priced per ounce, not a single use adhesive patch, and its nominal/bundled value badly understates a ~$10 patch. Use as the descriptive analog, not the dollar anchor.
A4649	Surgical supply; miscellaneous	Carrier priced / by report (no set fee)	Recommended billing path for the patch as a consumable: price by report at invoice, consistent with Alaska's invoice × 1.20 method and the §414.238(c) supplier price gap fill.

Recommendation for the coupling patches

Bill the patches as a consumable supply and price them from the supplier invoice, citing A4559 as the descriptive ultrasound coupling analog. Under 42 CFR §414.238, A4559 is the nearest comparable item by function, but because it does not reflect a comparable physical form or value, the gap fill step (§414.238(c)) directs valuation from the supplier/commercial price, the invoice. This aligns with Alaska's own E1399 method (invoice × 1.20). Example: $616 ÷ 60 = $10.27 per patch; at invoice × 1.20 ≈ $12.32 per patch, or ≈ $739.20 per 60 piece pack. Bill per date of service with the correct quantity/units and attach the invoice; the quantity tracks treatment frequency and duration (one patch per applicator per session).

How the patches fit DME language in a WC fee schedule

Within the DME provisions of a workers' compensation fee schedule, payers generally converge on one of three positions for a required consumable like the coupling patch. Each is addressed below so the bill can be defended whichever way a payer frames it.

- **Integral accessory**. The patch is a required, single use accessory without which the prescribed device cannot operate, so it is treated as an integral part of the device's DME benefit. Most WC DME rules cover the accessories and supplies necessary to use prescribed durable medical equipment, which supports paying the patches as a necessary accessory at invoice.
- **Bundling into device reimbursement.** The payer folds the consumables into the device or kit reimbursement and treats the patch cost as already included rather than separately payable. This is the kit as one line approach (Section 6, Approach B); it is acceptable so long as the patches are not also billed separately.
- L**ow value analog pricing (the A4559 logic)**. The payer prices the patch by analogy to the nearest coupling code, A4559 (ultrasound coupling gel or paste, per ounce), which yields a low, often bundled value. This is the least favorable position and is rebutted on the comparable code factors: A4559 is loose gel measured per ounce, not a single use adhesive patch, so it does not describe the item and should not set its value; the invoice or miscellaneous supply path is the better fit.

All three sit inside the same comparable code framework used for the device: identify the closest existing code or item, then price from it or, where it does not fit, from the supplier invoice. T

Should a kit be included in the purchase price?

The device is the durable item billed under E1399; the patches and gel are separately billable consumables (Section 5). Two structures are acceptable, but not both at once:

- Recommended (Approach A): bill the device and the consumables on separate lines. This keeps the E0760 device comparable clean (E0760 is device only and does not include a course of patches) and ties consumable quantity to actual utilization.
- Alternative (Approach B): bill the 8 Week Recovery Kit as a single purchased line at kit invoice × 1.20. Acceptable where the payor prefers one bundled price and the kit invoice is documented.

6. Caveats and verification

- AK WC FS values shown are Alaska specific (AK applies its own multiplier to the CMS DMEPOS base); they are not raw Medicare amounts. Reverify each figure against the current published AK WC FS for the date of service.
- Confirm the exact purchase vs rental language in the final published 2026 AK fee schedule; the rental formula reflects committee consensus drafted into the schedule narrative by Optum.
- E1399 is carrier priced/individual consideration; the payor (or, on dispute, the AK Division of Workers' Compensation) makes the final determination.
- E0760 satisfies four of the five §414.238(b) factors; "function and intended use" (bone healing vs. soft tissue diathermy) is the contestable prong and the most likely point of payor challenge. Present it as a device technology crosswalk, supported by the invoice method as the primary basis.
- Coupling patches (Section 5) are a recurring consumable, not the device. A4559 is the closest descriptor but is per ounce coupling gel and commonly bundled/not separately payable, so it undervalues the single use patch; price the patches at invoice (under a miscellaneous supply code) rather than at the A4559 allowance.
- The worked example (Section 6) uses list prices as an invoice proxy and an inferred patch quantity; substitute the actual acquisition invoice and the prescribed patch quantity, and bill the course either itemized (device + supplies) or as a kit, never both.
- The comparable code authorities in Section 4 are a reference model and workflow; they are recognized methodology, not law that governs an Alaska claim. Pull a current ZetrOZ acquisition invoice, since the 120% method is invoice dependent.

7. Comments and recommendations

The comparable code method recognized federally (42 CFR §414.238(b)) and echoed in the California, Texas, Minnesota, and Virginia fee schedules gives the Division a recognized way to corroborate that amount, or to set a value where no invoice exists, by pricing the item from the closest existing HCPCS code. For the SAM device, E0760 (low intensity ultrasound) is the strongest on schedule comparable, with the bone healing versus soft tissue intended use difference disclosed. The single use coupling patches should be paid at invoice as a required accessory, treated as included when a kit is billed, or distinguished from the low value A4559 analog, and never billed twice.

Recommendations

1. State the primary method plainly: unlisted DME billed under E1399 is reimbursed at 120% of the manufacturer or acquisition invoice for purchase, and at invoice × 1.20 × 10% per month for rental, with the daily rate equal to the monthly rate divided by 30.
2. Add an explicit comparable code provision so that, where an invoice is unavailable or a code based benchmark is available, the item is valued from the most comparable existing HCPCS code using the federal comparability factors (physical, mechanical, and electrical components, function and intended use, and additional features).
3. Address required accessories and consumables directly: single use items necessary to operate prescribed DME are paid as a necessary accessory at invoice, or are treated as included when a bundled device or kit price is billed, and are not billed both ways.
4. Require supporting documentation: the manufacturer or acquisition invoice, and, where a comparable code is used, a brief comparability analysis that discloses any material difference in intended use.
5. For the SAM device specifically: lead with invoice × 1.20, corroborate with E0760, and bill the coupling patches at invoice as a necessary accessory or within the kit price.

Suggested fee schedule language

The Division could adopt language along the following lines:

> **Unlisted durable medical equipment (HCPCS E1399). When durable medical equipment has no specific HCPCS code and no fee schedule value, the maximum reimbursement shall be determined as follows:**

> **(a) Invoice basis (primary).** Purchase shall be reimbursed at 120 percent of the manufacturer or acquisition invoice. Rental shall be reimbursed at 120 percent of the invoice multiplied by 10 percent per month, with the daily rate equal to the monthly rate divided by 30.
>
> **(b) Comparable code valuation.** Where an invoice is unavailable, the item shall be valued by reference to the fee schedule amount for the most comparable existing HCPCS code. Comparability shall be determined by comparing the physical, mechanical, and electrical components, the function and intended use, and the additional features and attributes of the items, consistent with the methodology in 42 CFR §414.238(b).
>
> **(c) Required accessories and supplies.** Single use accessories and supplies necessary to operate prescribed durable medical equipment shall be reimbursed at 120 percent of invoice as a necessary accessory, unless they are included in a bundled device or kit price, in which case they shall not be separately payable.

This wording keeps Alaska's established invoice method as the primary basis, adds the comparable code method as an express fallback and corroboration consistent with recognized federal and state methodology, and resolves the accessory and consumable question so that items like the coupling patches are paid once, at a fair and reasonable amount.

8. Source document findings and refined proposed language

Four related source documents add detail that refines the proposed language above. Each is summarized with its bearing on an Alaska fee schedule rule.

- **CMS Preliminary HCPCS Coding Determination (2025 cycle).** CMS preliminarily mapped the SAM 2.0 device to existing code K1004 (descriptor revised from "Low frequency ultrasonic diathermy treatment device for home use" to "Ultrasonic diathermy treatment device for home use") and its supplies and accessories to K1036 (revised to "Supplies and accessories (e.g., transducer) for ultrasonic diathermy treatment device, per month"). This is a coding determination, not a pricing one: CMS deferred a final Medicare determination and left pricing to the DME MACs. Because K1004 and K1036 are contractor priced K codes that **carry no established fee schedule dollar amount**, they are not useful valuation crosswalks; they identify the device's class but supply no benchmark figure. The device should continue to be valued by the invoice method, with a published value comparable such as E0760 used only to corroborate reasonableness. The 2017 history, in which CMS declined to create separate codes and treated the device and patches as integral, still supports the integral accessory treatment in Section 5.
- **FDA 510(k) guidance, Ultrasonic Diathermy Devices (2023).** FDA regulates devices of this type as ultrasonic diathermy devices. This confirms the device's function and intended use as therapeutic ultrasound under the §414.238(b) factors, which supports the ultrasound based comparison on the published schedule (E0760) and answers a payer who argues the device is merely a TENS or stimulation analog.
- **Commercial coverage policies (Blue Cross Blue Shield, Stationary Ultrasonic Diathermy Devices).** Some commercial and Medicare Advantage policies treat ultrasonic diathermy for musculoskeletal pain as investigational or not medically necessary. These are coverage and medical necessity determinations, separate from the fee schedule's pricing function.

9. How other workers' compensation fee schedules cap DME rentals at the purchase price

A common feature of workers' compensation and Medicare DME rules is that cumulative rental cannot exceed the purchase price: once the rental paid reaches the purchase amount, the item is treated as purchased. Alaska's rental method (invoice × 1.20 × 10 percent per month) has no such cap, so a long rental could pay more than an outright purchase. The jurisdictions below show how the cap is written, and Alaska could adopt the same limit.

Jurisdiction	Fee schedule authority (link)	How rentals are capped at the purchase price
New York	12 NYCRR §442.2	Express cap: if the total rental charge exceeds the purchase price, the maximum charge is the purchase price listed in the WC DME fee schedule, whether the worker keeps the equipment or returns it.
Oregon	OAR 436-009-0080	Rent to purchase: after 13 months of rental the item is considered purchased, at the insurer's option. The insurer may purchase at any

Jurisdiction	Fee schedule authority (link)	How rentals are capped at the purchase price
		time within the 13 months, with 75 percent of the rental paid applied to the purchase price.
Texas	28 TAC §134.203(d)	By adoption: Texas WC adopts the Medicare DMEPOS fee schedule and its payment policies, which cap cumulative rental at the purchase fee and transfer ownership of capped rental items after 13 months.
California	8 CCR §9789.60	By adoption: reimburses DMEPOS at 120 percent of the Medicare DMEPOS rate, adopting the Medicare DMEPOS payment structure and its capped rental and rental not to exceed purchase limits.
Federal (Medicare DMEPOS), the model many states adopt	42 CFR §§414.220, 414.229	Inexpensive or routinely purchased items: total rental payments cannot exceed the purchase fee. Capped rental items: ownership transfers to the patient after 13 months of rental.
Federal (OWCP, FECA and DEEOIC)	OWCP Procedure Manual Ch. 3-0300	Rental credited to purchase: when a rental is converted to a purchase, rental already paid is deducted from the purchase price and only the difference is reimbursed.

Alaska could add a parallel limit to its DME rules:

> **Rental cap (not to exceed purchase price).** Cumulative rental payments for an item of durable medical equipment shall not exceed its purchase price as determined under this section, whether the purchase price is set by invoice or by a comparable code. When the total paid in rental equals the purchase price, the item is considered purchased and no further rental is payable.

Sources

- 2026 Alaska Workers' Compensation Medical Fee Schedule and AK WC Medical Services Review Committee meeting packets, E1399 invoice based methodology and rental consensus (labor.alaska.gov).
- CMS DMEPOS Fee Schedule, April 2026 (Quarter 2) update (cms.gov); CY2026 DMEPOS update MM14326.
- 42 CFR §414.238 (establishing fee schedule amounts for new HCPCS codes, comparability/gap filling); Medicare Claims Processing Manual, Ch. 23 §60.3.
- California DWC: 8 CCR §9789.12.4(c) (By Report, comparable procedure or analogous code); DWC Fee Schedule FAQ (dir.ca.gov).
- Texas DWC: 28 TAC §134.1 (fair and reasonable, similar procedures, similar reimbursement) (tdi.texas.gov).
- Minnesota DLI: Minn. R. 5221.0500, subp. 2(B) (prevailing charge for similar articles/supplies) (revisor.mn.gov).
- Virginia VWC: Va. Code §65.2-605(B)(1), (E) (similar treatment community standard; Commission determination for unlisted fee scheduled items); 2026 Medical Fee Schedules Ground Rules ("By Report") (law.lis.virginia.gov; workcomp.virginia.gov).
- HCPCS Level II code descriptors (E1399, E0760, E0730, E0720, E0745, E0764), maintained by CMS.
- Coupling patches: HCPCS A4559 (coupling gel or paste, per oz) and A4649 (surgical supply; miscellaneous); 2026 DMEPOS Jurisdiction List (A4559, not separately payable when incident to a physician's service); SAM Advanced Gel Capture Patches product listing, UB-14-60W/60T, 60 pc (≈ $616) (samsport.com).
- SamSport online store list prices (samsport.com/collections/all, 2026): sam® 2.0 Device $8,715; sam® 2.0 8 Week Recovery Kit $9,945; sam® x1 8 Week Recovery Kit $7,725; Advanced Gel Capture Patches (60 pc) $616; Multi-Hour Coupling Gel $22.
- ZetrOZ sam-12 Directions for Use (device specifications and indications).
- CMS Preliminary HCPCS Coding Determination, 2025 HCPCS Application Summary (Biannual 1, 2025), non-drug, non-biological items and services: K1004 (ultrasonic diathermy treatment device for home use) and K1036 (supplies and accessories for ultrasonic diathermy treatment device, per month); 2017 HCPCS application history (cms.gov).
- FDA, Premarket Notification 510(k) Submissions for Ultrasonic Diathermy Devices, guidance for industry and FDA staff (issued Feb. 21, 2023; orig. Apr. 16, 2018) (fda.gov).
- New York No-Fault arbitration award, AAA Case No. 17-23-1326-2717 (BibiMed, Inc. v. American Modern Home Insurance Company, 2025): SAM Unit billed under E1399 and coupling patches under A9999 denied for failure to substantiate the charge (NY No-Fault applies the NY workers' compensation medical fee schedule).
- Blue Cross Blue Shield medical coverage policy, Stationary Ultrasonic Diathermy Devices (coverage and medical necessity stance for ultrasonic diathermy).
- DME rental caps (state WC fee schedules): New York 12 NYCRR §442.2 (rental not to exceed purchase price) (wcb.ny.gov); Oregon OAR 436-009-0080 (13 month rental then considered purchased; 75 percent of rental applied to purchase)

(oregon.public.law); Texas 28 TAC §134.203(d) (adopts Medicare DMEPOS) (tdi.texas.gov); California 8 CCR §9789.60 (120 percent of Medicare DMEPOS) (dir.ca.gov).

- DME rental caps (federal): 42 CFR §§414.220 and 414.229 (Medicare DMEPOS; total rental not to exceed purchase for inexpensive or routinely purchased items; capped rental ownership transfer at 13 months) (ecfr.gov); Federal OWCP Procedure Manual Ch. 3-0300 (rental credited toward purchase) (dol.gov).

Workers' Compensation Topical Cream Reimbursement

How U.S. jurisdictions address and pay for topical analgesics (e.g., LidoPro) — fee-schedule basis, codes, limits & fee amounts

Prepared: June 16, 2026 | **Sources current as of:** Q1–Q2 2026

Purpose

This review surveys how workers' compensation (WC) jurisdictions address and reimburse prescription topical creams — including private-label topical analgesics such as LidoPro and topical compounds. For each state it identifies the pharmacy fee-schedule basis, the specific codes and dollar limits applied to topicals, and the controlling statute or regulation. It is intended to inform fee-schedule amendment discussions (e.g., the Arizona MRO draft) by showing the range of approaches peer states have adopted.

Why topical creams are a focus

LidoPro is a **private-label topical analgesic (PLT)** — a pre-made, single-NDC product (typically 4% lidocaine with menthol, capsaicin, and/or methyl salicylate) marketed as prescription-strength. PLTs (e.g., LidoPro ointment and patches, Medrox, Terocin, Dendracin) and compounded topical creams share several traits that drive cost and scrutiny:

- They are not FDA-approved as finished products, and evidence-based guidelines (ODG, ACOEM) do not recommend them as first-line therapy.
- AWPs frequently exceed $400–$700 (LidoPro ointment ~$486; patches ~$720) versus a few dollars for comparable OTC products.
- They are heavily physician-dispensed or dispensed through non-retail pharmacies, where markups are largest.

Nationally, topical medications are only ~14% of out-of-network WC prescriptions but ~40% of out-of-network spend, and dermatological agents have become a leading therapeutic class by spend. This has prompted a growing number of states to adopt explicit topical reimbursement limits.

How to read this table

AWP = Average Wholesale Price; NDC = National Drug Code; DF = dispensing fee; PA = prior authorization; OTC = over-the-counter; ODG = Official Disability Guidelines. “Compound” = a patient-specific mixture; “private-label / OTC topical” = a pre-made single-NDC product. Dollar figures are maximum reimbursement unless noted.

State-by-state comparison

States are grouped with those that have adopted explicit topical / topical-compound provisions first, followed by emerging or proposed approaches.

State	Pharmacy fee schedule basis	How topical creams are addressed — codes, limits & fee amounts	Statute / regulation (source)
Arizona	Pharmacy: Brand AWP×(1−0.15) + $7.00; Generic AWP×(1−0.25) + $7.00. AWP set by Medi-Span on date dispensed.	— Topical compounds: lesser of $200 per 30-day supply (prorated) or the compound amount allowed under the fee schedule. **Cap rises to $240 effective May 1, 2026.** — OTC topicals not commercially available: ≤ $30 per 30-day supply (prorated) for a cream/lotion; ≤ $75 per 30-day supply (prorated) for patches. — Each compound ingredient billed by NDC; ingredient with no valid NDC not reimbursable. *Proposed (MRO stakeholder draft, under discussion): cap prescription topicals at $300 / 30-day (prorated) + $7 dispensing fee; if actual acquisition cost exceeds the cap, limit to 130% of AAC + $7 fee with documentation.*	A.R.S. § 23-908(C) Arizona Physicians' & Pharmaceutical Fee Schedule (ICA)
California	100% of Medi-Cal pharmacy reimbursement (effective July 1, 2025). Dispensing fee $10.05 or $13.20.	— No fixed dollar topical cap under the current Medi-Cal-based schedule. Compounds are reimbursed at the lowest of the Medi-Cal per-ingredient cost, the usual & customary charge, or applicable Medi-Cal compounding fees + volume dispensing fee. — Each ingredient must carry a valid NDC; invalid-NDC ingredients are not reimbursed. — Physician-dispensed non-legend (OTC) drugs: lowest of U&C, Medi-Cal lowest cost, 120% of documented paid cost, or paid cost + $250.	Labor Code § 5307.1; 8 CCR § 9789.40 (Pharmacy) DWC Pharmaceutical Fee Schedule
Colorado	AWP + $4.00 (brand & generic). If AWP ends, WAC×(1+0.20).	— Prescription-strength topical compounds: categorized using state-specific Division codes (DoWC "Z-codes"); each category carries a maximum reimbursable amount. All ingredients and quantities must be listed. — Non-prescription topicals (excluding patches): ≤ $31.21 per 30-day supply (prorated). — Non-prescription patches: ≤ $72.83 per 30-day supply (prorated). — Division-created Z-codes supersede CPT / HCPCS / NDC values.	7 CCR 1101-3, Rule 18 (Medical Fee Schedule); auth. § 8-42-101(3)(a)(I), § 8-47-107 Colorado DWC Rule 18
Georgia	Brand AWP + $4.83; Generic AWP + $7.25. AWP on date of dispensing. Effective April / May 2024.	— Topical medications capped in three categories; the maximum for any topical medication is $240. Billed with Georgia codes: — **GA0801 = $80 per 30-day supply** — **GA0802 = $160 per 30-day supply** — **GA0803 = $240 per 30-day supply** — Compounds: sum of AWP per ingredient × (1−0.50) + $20; limited to 3 or fewer active ingredients; cannot exceed the Category III ($240) fee.	O.C.G.A. § 34-9-205; SBWC Medical Fee Schedule — Amendment to Guidelines for Topical Medications & Topical Compound Medications SBWC Topical Medications Amendment (PDF)

State	Pharmacy fee schedule basis	How topical creams are addressed — codes, limits & fee amounts	Statute / regulation (source)
		— 30-day maximum value is fractioned to the amount dispensed; automatic refilling not allowed. *Impact: Georgia's dermatological payment share fell from ~55% to ~17% (2024–2025) after these caps.*	
South Carolina	AWP + $5.00 (brand & generic). Effective April 1, 2022.	— Prescription-strength (non-compound) topicals: $240 per 30-day supply (prorated), not to exceed a 90-day supply, plus a single $5.00 dispensing fee. — Topical compounds: $5.00 dispensing fee plus the lesser of AWP for each ingredient's original NDC or $240 per 30-day supply (prorated, ≤ 90 days). Billed in 3 categories using SC WCC codes; prior authorization required; no auto-refill. — Non-prescription patches: ≤ $70 per 30-day supply (prorated). — Any compound ingredient not FDA-approved for topical use, or lacking an NDC, is not reimbursed.	S.C. Code Ann. Regs. 67-1302 / 67-1305; Medical Services Provider Manual SC WCC Medical Services
Michigan	Brand AWP×(1−0.10) + $3.50; Generic AWP×(1−0.10) + $5.50.	— Custom compounds: maximum $600; higher charges subject to review. — Topical compounds: billed at the ingredient level using each ingredient's original manufacturer NDC; reimbursed at AWP × (1−0.10) per ingredient, prorated by ingredient amount, plus the applicable dispensing fee. Ingredients without an NDC are not reimbursed. — Additional medical-necessity requirements apply to custom and topical compounds. Non-compounded topicals are not separately capped.	Mich. Comp. Laws § 418.315; Workers' Compensation Health Care Services Rules (Part 10, Reimbursement) Michigan WDCA Health Care Services
Mississippi	Brand AWP + $5.00; Generic AWP×(1−0.05) + $5.00.	— Topicals: maximum $300 per 120 grams per month without prior authorization. — **Private-label topicals: $30 per 30-day supply (prorated).** — Patches: $70 per 30-day supply (prorated). — Compound bills must list each ingredient NDC; reimbursed at sum of AWP per underlying ingredient NDC + $5.00.	Miss. Code Ann. § 71-3-15; MS WC Medical Fee Schedule (20 Miss. Admin. Code Pt. 2, Pharmacy Rules) Mississippi WCC
Rhode Island	AWP × (1−0.10) (brand & generic).	— **Topical compounds: reimbursement may not exceed $500 per 30-day supply.** — Compounds billed by separating ingredients by NDC and quantity; repackaged ingredients reimbursed using the underlying medication's NDC.	R.I. Gen. Laws § 28-33-7; R.I. WC Medical Fee Schedule RI WC Medical Fee Schedule (Rising)
Texas	Brand AWP×(1+0.09) + $4.00; Generic AWP×(1+0.25) + $4.00 (§ 134.503).	— No fixed dollar topical cap. Cost control is via the ODG-based closed formulary: drugs with ODG status "N" — which includes many private-label topicals and compounds — require preauthorization. — Compounds require prior approval and are billed by ingredient at the fee-schedule AWP basis + a $15 compounding fee.	28 TAC Ch. 134, Subch. F (§§ 134.500–134.550); Labor Code §§ 408.028, 413.011 TDI-DWC Pharmacy Rules

State	Pharmacy fee schedule basis	How topical creams are addressed — codes, limits & fee amounts	Statute / regulation (source)
		— *Topical analgesics selected as the focus of the CY 2026 Medical Quality Review (plan-based) audit — findings may drive future reimbursement-rule changes.*	
Federal (OWCP / FECA)	Brand AWP×(1−0.15) + $4.00; Generic AWP×(1−0.40) + $4.00.	— No topical-specific dollar cap; reimbursement is AWP-based. — FECA runs a PBM-administered drug formulary (mandatory since 2021), but it is a managed/preferred formulary with prior-authorization gates — not an ODG-style closed formulary like Texas'. — All compounded medications require prior authorization with a Letter of Medical Necessity (Form CA-26), capped at a 90-day supply (30-day fills); opioids require Form CA-27. Specialty or formulary-excluded drugs may also require prior authorization. — Compounds billed at ingredient level with NDCs: AWP × 0.50 per NDC (3 or fewer ingredients); AWP × 0.30 per NDC (4 or more). Initial compound supply generally ≤ 90 days. — A finished single-NDC private-label topical such as **LidoPro is not a compound**, so it is paid under the AWP-based fee schedule and is not caught by the compound PA process; it is restricted only if prior authorization applies to its formulary status, not by any topical-specific cap.	OWCP/FECA pharmacy fee-schedule methodology & PBM formulary; 20 CFR 10.310, 10.809; Form CA-26 / CA-27 DOL OWCP – FECA medical provider & formulary
Emerging / proposed — no dollar cap adopted yet			
Pennsylvania	AWP × (1+0.10) (brand & generic).	— No topical cap currently in effect. Pennsylvania has proposed reimbursement caps for certain topical medications in response to rising costs. *Context: dermatological agents were the top prescription cost driver in PA — ~55% of all prescription payments (Q1 2023), mostly physician-dispensed.*	34 Pa. Code § 127.131 (pharmacy); proposed rulemaking PA Bureau of Workers' Compensation
Delaware	Brand AWP×(1−0.319) + $3.29; Generic AWP×(1−0.38) + $4.10.	— No topical cap. Compounds billed per ingredient by NDC; single $10 compounding fee per prescription. *Context: dermatological agents ~35% of all prescription payments (Q1 2023) — the largest therapeutic share in Delaware.*	19 Del. C. § 2322B; Del. WC Health Care Payment System (19 DE Admin. Code 1341) Delaware OWC Health Care Fee Schedule
North Dakota	Brand: WAC markup + $4.00; Generic: WAC markup + $5.00.	— Applies additional (unspecified-amount) restrictions to topical pain preparations. No fixed dollar cap published.	N.D. WSI pharmacy reimbursement policy North Dakota WSI

Cross-cutting observations

- **Two dominant cap models.** (a) A single ceiling per 30-day supply — $240 (Georgia, South Carolina; Arizona compounds rising to $240), $300 (Mississippi, per 120 g/month; Arizona proposed for prescription topicals), $500 (Rhode Island compounds); and (b) a tiered/category code system — Georgia's GA0801–GA0803 and Colorado's DoWC Z-codes.
- **Separate, lower OTC / private-label caps are common.** Arizona ($30 cream / $75 patch), Colorado ($31.21 / $72.83), Mississippi ($30 PLT / $70 patch), and South Carolina ($70 patch) treat OTC-equivalent topicals far more tightly than compounds — directly targeting products like LidoPro.

- **Formulary instead of a dollar cap.** Texas relies on the ODG closed formulary plus a 2026 plan-based audit of topical analgesics rather than a fixed cap.
- **Common companion controls.** Ingredient-level NDC billing, no-NDC-no-pay rules, prior authorization, no automatic refills, and FDA-approval requirements appear across the capped states.
- **Caps demonstrably reduce spend.** After Georgia's April 2024 caps, its dermatological payment share fell from roughly 55% to 17% within a year; South Carolina saw similar reductions.

Recommended regulatory framework for topical medications

The states that have brought topical spend under control share a recognizable set of design choices. A jurisdiction adopting topical-medication rules for the first time can combine them into a single, internally consistent framework rather than legislating one control at a time. The provisions below move from the core reimbursement caps to the supporting utilization and billing controls; the peer states that model each one are noted in parentheses. The strongest programs adopt the dollar caps and the clinical and billing controls together, so that no un-capped pathway is left to absorb shifted utilization.

Recommended core provisions

- **Cap prescription topical medications at a fixed 30-day maximum.** Set a single per-30-day ceiling — peer caps cluster at $240 — prorated to the days' supply actually dispensed and not to exceed a 90-day supply. (Georgia; South Carolina.)
- **Set a separate, lower cap for OTC-equivalent and private-label topicals.** Because pre-made single-NDC products such as LidoPro contain essentially the same ingredients as commercial OTC items, cap creams and lotions near $30 and patches near $70–$75 per 30-day supply (prorated). This is the single provision that most directly addresses the high-markup products driving topical spend. (Arizona; Colorado; Mississippi; South Carolina.)
- **Cap compounded topicals and require ingredient-level NDC pricing.** Reimburse the lesser of a fixed 30-day cap or the sum of each ingredient's AWP priced on the original-manufacturer NDC, plus a single dispensing fee. Pay nothing for an ingredient that lacks a valid NDC or is not FDA-approved for topical use, and do not reimburse pre-measured "compound kits" as finished products. (South Carolina; Michigan; Georgia.)
- **Adopt an evidence-based formulary as the clinical gate.** Incorporate ODG (or ACOEM); topicals flagged "not recommended" (ODG status "N") — which captures most private-label topicals and topical compounds — require preauthorization before dispensing. (Texas.)
- **Require prior authorization and documented medical necessity for compounds and non-formulary topicals.** The prescriber must document why a commercially available, lower-cost equivalent is inadequate before a compound or non-recommended topical is dispensed. (South Carolina; Texas; federal OWCP for compounds.)
- **Prohibit automatic refills.** Each new supply should require a new prescription with updated documentation of effectiveness and functional improvement. (Georgia; South Carolina.)
- **Constrain physician in-office and non-retail-pharmacy dispensing.** Reimburse on the original-manufacturer NDC, limit the initial physician-dispensed days' supply, and cap markups on repackaged products — these channels are where private-label and repackaged-product pricing concentrates. (Common across the capped states.)
- **Use a single, modest dispensing fee and require lowest-AWP sourcing.** Pay one fixed dispensing fee in the $5–$7 peer range per dispense (not per ingredient); where more than one manufacturer makes an equivalent product, require the pharmacy to seek the lowest-AWP version, and fractionate every 30-day cap to the exact amount dispensed. (Arizona, 2026 update.)
- **Build the caps on a tiered code set for administrability.** Georgia's GA0801–GA0803 categories and Colorado's DoWC Z-codes show how state-specific category codes make caps easy to bill, adjudicate, and audit; a new program can mirror either model. (Georgia; Colorado.)

Expected impact and implementation

States that paired a hard cap with these controls saw rapid savings. Georgia's dermatological share of prescription payments fell from roughly 55% to 17% within a year of its April 2024 caps, and South Carolina reported similar reductions after its 2022 changes. Because the OTC and private-label cap targets the widest gap between the billed price and the acquisition cost, it typically delivers the largest share of the savings, while the formulary and prior-authorization provisions prevent utilization from simply migrating to compounds.

A defensible rollout follows the path these states used: publish draft language for a stakeholder comment period, finalize after revisions, set a prospective effective date keyed to date of service, and post the controlling fee-schedule files (with any periodic updates) on the agency website. Adopting the dollar caps together with the clinical and billing controls in a single rulemaking avoids leaving an un-capped pathway and gives payers and pharmacies one consistent effective date to implement.

This framework synthesizes provisions already adopted by peer jurisdictions and is offered for policy planning; it is not legal advice. Specific cap amounts, codes, and effective dates should be set against the jurisdiction's own utilization data and confirmed against the controlling statutes and fee schedules before adoption.

Key sources

- Optum / myMatrixx — Workers' Compensation Pharmacy Resource Guide (March 2026), state-by-state pharmacy fee schedule
- Georgia SBWC — Amendment to Guidelines for Topical Medications & Topical Compound Medications (eff. 2024)
- South Carolina WCC — Medical Services Provider Manual / pharmacy changes (eff. April 1, 2022)
- Colorado DWC — 7 CCR 1101-3, Rule 18 Medical Fee Schedule
- California DWC — Pharmaceutical Fee Schedule (8 CCR § 9789.40; Labor Code § 5307.1)
- Texas TDI-DWC — Pharmacy rules, 28 TAC Ch. 134 Subch. F
- Arizona ICA — Physicians' & Pharmaceutical Fee Schedule (A.R.S. § 23-908)
- WCRI — Interstate Variation and Trends in Workers' Compensation Drug Payments (6th ed.)
- Healthesystems — Private-Label Topicals & high-cost drivers in WC

ANALYSIS & RECOMMENDATIONS

Remote Therapeutic Monitoring (RTM): Recommended Rules for the Alaska 2027 Proposed Workers' Compensation Medical Fee Schedule

Focused on the new 2026 RTM codes (98979, 98984, and 98985) billed with active, in-office physical therapy, with the revised codes (98976, 98977) and applicable NCCI edits also addressed

Prepared June 18, 2026 · Synthesizes the project's CMS coding analysis, payor-policy research, the 54-jurisdiction Medicaid/WC overview, and Alaska's fee-schedule framework

Executive summary

1) The new 2026 RTM codes (98979, 98984, and 98985) can be billed with active, in-office physical therapy, subject to correct-coding discipline. These codes describe a short-duration device supply (98984, 98985) or cumulative monthly management time (98979), not the one-on-one treatment minutes captured by timed PT codes (97110, 97112, 97140, 97530), so they do not inherently conflict with same-episode therapy. They also currently carry no NCCI edits, unlike the two revised device codes (98976, 98977). The governing limits are federal: National Correct Coding Initiative (NCCI) edits (including the bar on 97750 the same day as the management codes), the RTM versus RPM exclusivity, the one-clinician-per-period rule, and the principle that RTM management time must be separate and distinct from time already billed under a therapy procedure ("no double-counting the timer").

2) No state Medicaid or workers' compensation program answers the PT-concurrency question. It is governed by Medicare/NCCI. Across 54 Medicaid jurisdictions and every WC program reviewed, none addresses billing active PT alongside RTM. Washington L&I is the only WC program that names RTM at all, and it does so to exclude the family.

3) Consider adopting RTM with guardrails. Because Alaska incorporates the CMS RBRVS and CMS/AMA rules by reference, all five codes are payable by default in 2027 unless the Board acts. The Board should affirmatively decide coverage, address the three new 2026 codes by number, codify the federal correct-coding guardrails (including the PT-concurrency rule), tie RTM to the compensable injury, and confirm the 85% "other provider" treatment for therapist-billed RTM.

1. Purpose and scope

This document analyzes how remote therapeutic monitoring (RTM) could be treated in Alaska's 2027 proposed workers' compensation medical fee schedule and answers the specific question of whether the RTM codes, in particular the three new 2026 codes (98979, 98984, and 98985), may be billed in conjunction with active, in-office physical therapy. It synthesizes the project's earlier work: the CMS coding analysis (CR 14250 / MM14250 and the CY2026 PFS rule), the payor-policy research across Medicare, Medicare Advantage, commercial carriers, Medicaid,

and peer WC programs, the 54-jurisdiction CCHP Medicaid/WC overview, and Alaska's existing incorporation-by-reference framework.

2. The codes at issue

All five are federal CPT codes effective for dates of service on or after January 1, 2026. The three new 2026 codes (98979, 98984, and 98985) are the focus of this analysis for concurrent billing with physical therapy; 98976 and 98977 are existing codes with revised day-range descriptors that would also be added to the schedule and that carry NCCI edits (Section 10). Under CR 14250 all are "sometimes therapy" codes with established Medicare RVUs, so any RBRVS-based fee schedule already has values to apply.

CPT	Service (abbreviated descriptor)	2026 Medicare national avg (approx.)
98976	RTM device supply, respiratory system, 16-30 days in a 30-day period (descriptor revised for 2026)	~$52
98977	RTM device supply, musculoskeletal system, 16-30 days in a 30-day period (descriptor revised for 2026)	~$40-$47
98979	RTM treatment management, first 10 minutes/month; ≥1 real-time interactive contact (new 2026)	~$26
98984	RTM device supply, respiratory system, 2-15 days in a 30-day period (new 2026)	~$52
98985	RTM device supply, musculoskeletal system, 2-15 days in a 30-day period (new 2026)	~$51

*Rates are approximate 2026 national **non-facility** averages and vary by locality; Alaska would compute its own maximums using CMS RVUs and Alaska conversion factors.*

3. Can RTM be billed with active, in-office physical therapy?

3.1 The "sometimes therapy" framework

When furnished by a therapist, every RTM code is provided under a therapy plan of care and requires a GP (PT), GO (OT), or GN (SLP) modifier. Among the five in scope, only 98979 (treatment management) is subject to the de minimis PTA/OTA standard and the CQ/CO modifier; the device-supply codes (98976, 98977, 98984, 98985) are not. RTM is also not a telehealth service under §1834(m). It is paid as an ordinary fee-schedule service.

3.2 Why RTM and active PT do not inherently conflict

Active physical therapy procedures are time-based, one-on-one, in-clinic services billed per encounter (e.g., 97110 therapeutic exercise, 97112 neuromuscular reeducation, 97140 manual therapy, 97530 therapeutic activities). RTM, by contrast, captures either a 30-day supply of device data (98976, 98977, 98984, 98985) or cumulative clinician management time across a calendar month (98979). Because they occupy different time and service architecture, the 8-minute-rule time conflicts that drive most PT bundling edits do not arise between RTM and the in-clinic codes. CMS designed the RTM family precisely so that therapy practices can monitor home-exercise adherence and response between visits.

3.3 The constraints that actually govern

The limits are correct coding and documentation rules, not a prohibition on pairing the services:

- **NCCI same-day edit.** CMS does not reimburse 97750 (physical performance test/measurement) on the same date of service as 98980 or 98981.
- **No double-counting the timer.** Industry compliance guidance is consistent that time spent performing an already-billed therapeutic procedure cannot also be counted as RTM management time; the RTM management minutes must reflect distinct data review, adherence/response assessment, and treatment management, plus the real-time interaction required for 98979.
- **RTM vs RPM, and one-clinician-per-period.** RTM and remote physiologic monitoring (RPM) cannot be billed together for the same worker in the same month, and only one practitioner may bill the device/management codes per applicable period.
- **Mutually exclusive pairs.** 98977 (16-30 days) and 98985 (2-15 days) are alternatives for the same musculoskeletal device period; 98979 and 98980 are alternative management tiers. Do not bill both members of a pair for the same worker in the same period.
- **Device and medical necessity.** Device supply codes require an FDA-defined medical device, and the monitoring must be medically necessary and tied to the worker's treatment.

Conclusion on the concurrency question

RTM may be billed for the same injured worker during a period in which active, in-office physical therapy is furnished, provided the RTM management time is separate and distinct from time supporting any other billed service, the documentation establishes genuine remote-monitoring and treatment-management activity (including the required real-time interaction for 98979), and the applicable NCCI edits are observed.

4. Payor landscape (synthesis)

How payers treat these codes frames the utilization risk and the peer benchmarks for Alaska's decision.

Payor category	How it treats these RTM codes	Net effect
Medicare (PFS)	Pays all five as "sometimes therapy" services with established RVUs; therapist services under a plan of care with GP/GO/GN; CQ/CO de minimis on 98979 only.	Pays
Medicare Advantage	Must offer benefits at least equal to traditional Medicare; generally, follows the 2026 code set.	Generally, pays
Commercial carriers	Trend toward exclusion: Cigna (Policy 0563) and Aetna list RTM as non-covered; UnitedHealthcare's stance is unsettled.	Often denied
Medicaid	Varies by state and is frequently more restrictive; few programs address RTM at all (only Idaho, MA, VA, WV reference it).	Varies / often silent

Payor category	How it treats these RTM codes	Net effect
Workers' comp (RBRVS states)	Oregon, California, Texas, and Alaska price off CMS RVUs/methodology; RTM payable by default, not named.	Pays by default
Workers' comp (Washington L&I)	MARFS lists RTM (98975-98978), RPM, and SMBP as non-covered (eff. 7/1/2026).	Excluded

The pattern: Medicare and the RBRVS-based workers' compensation programs pay RTM; Medicare Advantage generally follows; commercial carriers are increasingly excluding it; Medicaid rarely addresses it; and only Washington L&I has affirmatively excluded it in the WC context.

5. State Medicaid and workers' compensation findings

- **Medicaid.** Of 54 jurisdictions on the CCHP resource, only Medicare, Idaho, Massachusetts, Virginia, and West Virginia reference RTM at all; the rest address remote physiologic monitoring or general telemonitoring. None addresses active PT billed alongside RTM. Even Virginia (the most detailed) pays RTM only through providers eligible to bill E/M services (which constrains independent PT billing) and has not adopted the 2026 codes.
- **Workers' compensation.** Among programs reviewed (WA, OR, CA, TX, AK, NY), only Washington names RTM, to exclude it. Oregon, California, Texas, and Alaska pay RTM by default through Medicare/RBRVS incorporation; New York's own schedule does not separately address it. No WC program addresses the PT-concurrency question.

Drafting lesson from Washington

Washington's exclusion lists "98975-98978," which does not capture the new 2026 codes (98979, 98984, 98985) by number. Whatever path Alaska chooses, it should enumerate the full current RTM family by number so the new codes are unambiguously addressed.

6. Alaska's framework and the default 2027 outcome

Alaska's fee schedule directs that, for physician services, providers and payers follow CMS and AMA billing and coding rules including modifiers, and that where an NCCI edit conflicts with the AMA CPT Assistant, the CPT Assistant governs. Reimbursement is built on CMS RBRVS RVUs with Alaska conversion factors. Two consequences:

- **Default coverage.** Because the five RTM codes have established CMS RVUs and CMS billing rules, they are reimbursable in Alaska workers' compensation by default in 2027, unless the Board affirmatively conditions or excludes them.
- **"Other providers" at 85%.** Services performed by providers other than physicians/hospitals/outpatient clinics/ASCs are reimbursed at 85% of the maximum allowable reimbursement; confirm how this applies to the device-supply codes versus management time.

7. Recommendations

The three proposed paths:

Option	What it means	Assessment
A. Adopt as-is (default)	Continue incorporating CMS RBRVS and CMS/AMA rules; all five codes payable under CMS "sometimes therapy" rules with no added conditions.	Simplest and consistent with AK's RBRVS philosophy.
B. Adopt with guardrails	Pay RTM but condition it on a compensable-injury tie, FDA-defined device, documentation, the federal correct-coding limits, and (optionally) prior authorization beyond a threshold.	Best balance of access and cost control; modest additional drafting; mirrors how prudent payers constrain RTM while preserving the therapy use case.
C. Exclude (Washington model)	Affirmatively designate the full RTM family (and RPM/SMBP) non-covered.	Maximum utilization control and aligns with WA and major commercial carriers; but diverges from AK's default RBRVS adoption.

Considerations for Option B. Adopting RTM with guardrails preserves a clinically useful, Medicare-recognized tool for monitoring injured workers' home-exercise adherence and recovery between visits, keeps Alaska consistent with its RBRVS philosophy and with Oregon/California/Texas, and aligns Alaska with Medicare, while installing the documentation, device, medical necessity, and correct-coding controls that address the utilization concerns reflected in the commercial-carrier and Washington trend.

8. Specific recommended rules

1. **Decide coverage explicitly.** State affirmatively that RTM is reimbursable (with the conditions below); silence defaults to coverage under Alaska's RBRVS incorporation, which leaves the policy unstated.
2. **Name the full family by number.** Enumerate so the new 2026 codes are captured. Do not rely on a "98975-98978" range.
3. **Permit concurrent billing with active PT, with conditions.** Allow RTM during a period in which active, in-office physical medicine is furnished, provided RTM management time is separate and distinct from other billed time, documentation establishes the monitoring/management activity and the real-time interaction for 98979, and NCCI edits (including 97750 vs 98980/98981) are observed.
4. **Carry over the CMS coding rules.** Adopt the "sometimes therapy" plan-of-care rule, GP/GO/GN modifiers, CQ/CO de minimis on 98979, the mutual-exclusivity pairs (98977/98985; 98979/98980), the one-clinician-per-period and one-per-month limits, and RTM versus RPM exclusivity.
5. **Tie RTM to the compensable injury.** Require that monitoring relate to the accepted condition, be medically necessary, and use an FDA-defined device.
6. **Consider utilization controls.** Optionally require prior authorization beyond a defined number of consecutive 30-day periods, and set documentation standards, consistent with cost control without foreclosing the therapy use case.

7. **Keep RTM out of the telehealth bucket.** Confirm that RTM is treated as a standard fee-schedule service and that Alaska's telehealth provisions do not inadvertently restrict it.
8. **Confirm the 85% "other provider" treatment** for therapist-billed RTM, and confirm RVUs and conversion-factor application for each of the five codes before publication.

9. Proposed fee schedule language (draft)

Drafting model only.

Remote Therapeutic Monitoring (RTM)

(a) Scope and payment. Remote therapeutic monitoring services (CPT 98975, 98976, 98977, 98978, 98979, 98980, 98981, 98984, 98985, and 98986) are reimbursable when furnished in connection with the treatment of a compensable injury and supported by appropriate documentation. RTM is reimbursed under the CMS resource-based relative value scale using the applicable Alaska conversion factor, consistent with CMS and AMA billing and coding rules, including the "sometimes therapy" designation, the GP/GO/GN therapy plan-of-care modifiers, and the CQ/CO de minimis standard applicable to 98975, 98979, 98980, and 98981.

(b) Concurrent billing with active physical therapy. RTM may be billed for the same injured worker during a period in which active, in-office physical medicine services are also furnished, provided that: (1) the time used to support RTM treatment management (98979, 98980, 98981) is separate and distinct from, and not duplicative of, time used to support any other billed service; (2) the provider documents the remote-monitoring activity, the data reviewed, the treatment-management services rendered, and the real-time interactive communication required by the applicable code; and (3) applicable National Correct Coding Initiative edits are observed.

(c) Frequency, device, and exclusivity. (1) Only one RTM device-supply code and one RTM treatment-management code may be billed per injured worker per applicable period; (2) RTM and remote physiologic monitoring (RPM) may not be billed together for the same worker in the same calendar month; (3) the mutually exclusive pairs (98977 and 98985; 98979 and 98980) may not both be billed for the same worker in the same period; and (4) device-supply codes require a device meeting the FDA definition of a medical device.

(d) Not telehealth. RTM is not a telehealth service and is not subject to the telehealth provisions of this fee schedule; it is reimbursed as a standard fee-schedule service.

(e) Other providers. RTM services furnished by providers other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers are reimbursed at 85% of the maximum allowable reimbursement.

(f) Optional: prior authorization. RTM continued beyond [two] consecutive 30-day periods for the same injured worker requires prior authorization.

10. NCCI edits affecting the RTM codes (considerations for 2027)

National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) edits determine which code pairs cannot be billed together. A review of the current CMS practitioner PTP edit file (effective July 1, 2026) shows the edits fall almost entirely on the two existing device-supply codes (98976, 98977); the three new 2026 codes (98979, 98984, and 98985) currently carry none, and none of the five codes is paired with an active physical therapy treatment code. That the new codes are unencumbered by edits is a further reason they are the cleanest focus for concurrent billing with therapy.

CPT code	Active NCCI PTP edits?	What the edits do (high level)
98976	Yes (about 89)	Bundled with other remote and physiologic monitoring services (see below); not paired with any active physical therapy code.
98977	Yes (about 89)	Same edit set as 98976; not paired with any active physical therapy code.
98979	None currently	New for 2026; no PTP edits in the current file. Expected to populate in a later quarter.
98984	None currently	New for 2026; no PTP edits yet. Likely to inherit the 98976 monitoring bundles in a future quarter.
98985	None currently	New for 2026; no PTP edits yet. Likely to inherit the 98977 monitoring bundles in a future quarter.

What the device codes are bundled with. The edits pair 98976 and 98977 with other remote and physiologic monitoring services, not with hands-on therapy. The principal categories are remote physiologic monitoring and self-measured blood pressure (99453, 99454, 99091, 99473, 99474), continuous glucose monitoring (95249-95251), cardiac event, Holter, and implanted device monitoring (the 93xxx series), pulmonary monitoring and pulse oximetry (the 94xxx series), ambulatory EEG and long-term monitoring (the 95700 series), home sleep apnea testing (G0398-G0400), and the other RTM device code (98978). Most carry modifier indicator 0, meaning the pair cannot be unbundled even with a modifier; a few, notably the RPM device pair 99453 and 99454, carry indicator 1, allowing both when clinically appropriate and documented. The 97750 (physical performance test) same-day edit applies to the 20-minute management codes 98980 and 98981, which are outside the five codes in scope; the new 98979 has no such edit at present.

Considerations for the Board:

- **Adopt the edits by reference.** Incorporating CMS and NCCI correct-coding rules carries these bundles into the WC schedule automatically and keeps Alaska aligned with Medicare; no separate enumeration of the edits is required.
- **Account for monitoring overlap.** An RTM device code cannot be separately paid alongside RPM, SMBP, CGM, or the listed cardiac, pulmonary, EEG, or sleep monitoring services for the same worker, which can arise when a worker is also monitored for a comorbidity.

- **Recheck the new codes each quarter.** 98979, 98984, and 98985 currently have no PTP edits; because edits for new codes typically lag, the device codes 98984 and 98985 are likely to inherit the 98976 and 98977 bundles, and the tables should be rechecked each quarter before and after adoption.
- **The PT concurrency conclusion holds.** The absence of any edit between the five codes and active physical therapy codes supports allowing RTM concurrently with in-office therapy; the separate principle that the same minutes cannot be counted twice still governs the management code.
- **Two scope points.** The figures above are from the Medicaid NCCI practitioner file, which mirrors the Medicare NCCI edits for these codes; confirm against the Medicare practitioner file where Medicare-specific certainty is needed.

Sources

Source	Location
CMS CR 14250 / MLN MM14250: 2026 Annual Update to the Therapy Code List (“sometimes therapy”; new/revised RTM codes)	https://www.cms.gov/files/document/mm14250.pdf
CMS CY2026 Physician Fee Schedule final rule (RTM valuation; RTM/RPM not telehealth under §1834(m))	https://www.federalregister.gov/documents/2025/11/05/2025-19787
CMS National Correct Coding Initiative (PTP edits): practitioner services file effective July 1, 2026 (verified for these codes)	https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits
WA L&I MARFS 2026, Ch. 24, “Remote monitoring” noncoverage policy (eff. 7/1/2026)	https://lni.wa.gov/patient-care/billing-payments/marfsdocs/2026/2026MARFSComplete.pdf
OR WCD OAR 436, division 009; CA DWC OMFS; TX DWC Rule 133.30 / 28 TAC 134.203; NY WCB Fee Schedule & Telehealth Ground Rule (peer WC programs)	https://www.tdi.texas.gov/wc/hcprovider/telemed.html
Commercial: Cigna Coverage Policy 0563; Aetna RPM policy (eff. 3/1/2026) (RTM exclusions)	https://blog.prevounce.com/private-payer-remote-patient-monitoring-policies
CCHP, State Telehealth Policies: Remote Patient Monitoring (state Medicaid/Medicare overview)	https://www.cchpca.org/topic/remote-patient-monitoring/
Alaska WC Medical Fee Schedule (2026, eff. 4/1/2026); 8 AAC 45.083; AS 23.30.097 (AK framework)	https://labor.alaska.gov/wc/ak-medical-fee.htm

ANALYSIS OF ALASKA MEDICAL FEE SCHEDULE CHANGES
EFFECTIVE APRIL 1, 2026

NCCI estimates that the changes to the medical fee schedule in Alaska, effective April 1, 2026, will result in an impact of -0.3% on overall workers compensation system costs.

SUMMARY OF CHANGES

The following fee schedules are effective April 1, 2026, revising the prior fee schedules which had been in effect since January 1, 2025.

Physician

- Maximum allowable reimbursements (MARs) in Alaska's physician fee schedule have been updated to reflect Medicare's 2026 Resource-Based Relative Value Scale (RBRVS). The prior physician fee schedule was based on Medicare's 2025 RBRVS.
- The Medicare RBRVS values are adjusted by the following Alaska-specific conversion factors, which remain unchanged:

Physician Service Category	Conversion Factor
Surgery	$119
Radiology	$121
Pathology & Laboratory	$122
Medicine (excluding anesthesia)	$80
Evaluation & Management	$80
Anesthesia	$100

Hospital Inpatient (HIP)

- Alaska's HIP fee schedule has been updated to reflect Medicare's 2026 Inpatient Prospective Payment System (IPPS). The prior HIP fee schedule was based on Medicare's 2025 IPPS.
- The Medicare MARs are adjusted by Alaska-specific multipliers, which vary by hospital and are unchanged.

Hospital Outpatient (HOP)

- Alaska's HOP fee schedule has been updated to reflect Medicare's 2026 Outpatient Prospective Payment System (OPPS). The prior HOP fee schedule was based on Medicare's 2025 OPPS.
- The Medicare OPPS relative weights are adjusted by an Alaska-specific conversion factor of $221.79, which remains unchanged.

Ambulatory Surgical Centers (ASC)

- Alaska's ASC fee schedule has been updated to reflect Medicare's 2026 OPPS. The prior ASC fee schedule was based on Medicare's 2025 OPPS relative weights.
- The Medicare OPPS relative weights are adjusted by an Alaska-specific conversion factor of $168.00, which remains unchanged.

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ACTUARIAL ANALYSIS

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
    - Compare the prior and revised maximum reimbursements by procedure code to determine the percentage change by procedure code. For hospital inpatient services, the prior and revised maximum reimbursements are compared by episode.
    - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights. For hospital inpatient services, the observed payments by episode are used as weights. For hospital outpatient and ASC services, observed payments are aggregated according to packaging rules, where applicable.

2. Determine the share of costs that are subject to the fee schedule
    - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.
    - Any potential impact from the share of costs not subject to the fee schedule will be realized in future claim experience.

3. Estimate the price level change as a result of the revised fee schedule
    - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change.
    - For facility fee schedule changes, a price realization factor of 80% is assumed.

Note that the values presented in this document are rounded and may not be displayed to full precision.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Alaska for Service Year 2024. Due to low data volume, the hospital inpatient impact analysis is based on NCCI's Medical Data Call for Alaska for Service Years 2023 and 2024. Reported medical experience for COVID-19 claims with accident dates between December 1, 2019, and June 30, 2023, as reported in NCCI Call 31 for Large Loss and Catastrophe, have been excluded from the data on which this analysis is based.
- The share of benefit costs attributed to medical benefits is based on unlimited developed, on-leveled, and trended Financial Call data underlying the NCCI experience filing for Alaska effective January 1, 2026.

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SUMMARY OF IMPACTS

The impact from the fee schedule change in Alaska, effective April 1, 2026, is summarized below.

Type of Service	(A) Impact on Type of Service	(B) Share of Medical Costs	(C) = (A) x (B) Impact on Medical Costs
Physician	-1.4%	41.0%	-0.6%
Hospital Inpatient	+2.4%	11.8%	+0.3%
Hospital Outpatient	-0.6%	17.8%	-0.1%
ASC	-0.2%	10.5%	Negligible decrease[1]
Combined Impact on Medical Costs (D) = Total of (C)			**-0.4%**
Medical Costs as a Share of Overall Costs (E)			64%
Combined Impact on Overall Costs (F) = (D) x (E)			**-0.3%**

Refer to the appendix for the weighted-average changes in MARs by physician practice category, the share of costs subject to the fee schedule by type of service, and the weighted-average change in MAR by type of service.

NON-QUANTIFIED CHANGES/ADDITIONAL CONSIDERATIONS

- Maximum reimbursement for dental services, durable medical equipment, supplies, orthotics and prostheses, and ambulance services are also governed by the fee schedule in Alaska. The share of these payments with a MAR makes up a minor portion of medical costs. Therefore, the impact on overall costs due to updating the fee schedule for these services is not anticipated to be material. As such, any potential impact from this change will be realized in future claim experience.

[1] Negligible is defined in this document to be an impact smaller in magnitude than +/-0.1%.

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APPENDIX

Weighted-Average Percentage Change in MARs Prior to Price Realization by Physician Practice Category

Physician Practice Category	Share of Physician Costs	Percentage Change in MARs
Anesthesia	3.7%	0.0%
Surgery	21.5%	-6.4%
Radiology	8.7%	-1.3%
Pathology & Laboratory	0.5%	-0.2%
Medicine	35.9%	-1.8%
Evaluation & Management	22.7%	+1.6%
Other HCPCS*	0.0%	0.0%
Subject to the Fee Schedule	**93.0%**	**-1.9%**
Payments with no specific MAR	7.0%	–
Total	**100.0%**	**-1.8%**

*Healthcare Common Procedure Coding System

Share of Costs Subject to the Fee Schedule (FS) and Weighted-Average Percentage Change in MARs by Type of Service

Type of Service	(A) Change in MARs for Costs Subject to the FS	(B) Share of Costs Subject to the FS	(C) = (A) x (B) Change in MARs by Type of Service	(D) = (C) x 80% Impact after Price Realization
Physician	-1.9%	93.0%	-1.8%	-1.4%
Hospital Inpatient	+4.3%	70.8%	+3.0%	+2.4%
Hospital Outpatient	-0.7%	94.0%	-0.7%	-0.6%
ASC	-0.3%	93.0%	-0.3%	-0.2%

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