Alaska Workers' Compensation Division
Medical Services Review Committee
Meeting Minutes
July 17, 2026

I. CALL TO ORDER

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

II. ROLL CALL

The following members were present, constituting a quorum:

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

Member Mittelstead arrived after roll call.

III. APPROVAL OF AGENDA

Member Foland moved to approve the agenda; Member Steed seconded. The motion passed unanimously.

IV. APPROVAL OF JUNE 26, 2026 MEETING MINUTES

Member Foland moved to approve the June 26, 2026 minutes; Member Steed seconded. The motion passed unanimously.

V. FEE SCHEDULE DEVELOPMENT DISCUSSION

Medical Cost and Utilization Data

The Committee reviewed general information concerning retail drug pricing, physician dispensing, and the most frequently reported medical procedure codes. Director Collins noted that Alaska does not regulate pharmacy retail prices. The utilization data showed that physical and occupational therapy services remain among the most frequently reported services, while certain durable medical equipment services occurred relatively infrequently.

Repackaged Drugs

Ms. Tedford presented proposed language addressing reimbursement for repackaged drugs. She explained that the current fee schedule does not clearly require submission of the drug's original National Drug Code.

The Committee agreed that the fee schedule should require the original NDC and calculate reimbursement using the original manufacturer's NDC and average wholesale price. No separate repackaging, relabeling, or handling fee would be payable.

Physician-Dispensed Drugs

The Committee reviewed proposed language addressing medications dispensed from a physician's office. Ms. Tedford noted that AS 23.30.097 refers specifically to physician dispensing, although other practitioners may dispense medications while working under a physician's supervision.

The Committee distinguished ordinary physician-dispensed medications from topical and compounded medications. Ordinary medications dispensed by a physician would be reimbursed using the original NDC calculation in the same manner as a pharmacy-dispensed medication, but without a separate dispensing, compounding, or handling fee.

The Committee agreed that the physician-dispensing provision should cross-reference the separate requirements and caps applicable when the physician-dispensed medication is a topical or topical compounded drug. Members stated that the cross-reference is necessary to prevent an argument that a physician-dispensed topical medication is exempt from the applicable topical drug caps.

Topical and Compounded Medications

The Committee reviewed the existing term "compounded and/or mixed drugs." The Committee discussed whether the term might refer to medications added to intravenous solutions or other combination products, but no clear or consistently recognized definition was identified. The Committee directed RefMed to revise the terminology throughout the applicable sections so that the fee schedule consistently distinguishes:

1. Topical drugs;
2. Topical compounded drugs; and
3. Non-topical compounded drugs.

References to "mixed drugs" will be revised or removed as necessary to maintain consistent terminology. Non-topical compounded medications will be addressed separately from the caps developed for topical and topical compounded drugs.

The Committee supported the proposed tiered reimbursement caps for topical and topical compounded medications and agreed to retain an overall maximum reimbursement of $240 for any single prescription. The capped amount will include any applicable dispensing fee, and no separate dispensing fee may be added to the capped reimbursement.

The proposed language also stated that compounded topical medications would require prior authorization. Member Dean explained that workers' compensation adjusters do not generally provide prior authorization and cannot direct an injured worker's medical care. Members agreed to remove the prior-authorization requirement while retaining language allowing review for medical necessity.

The Committee discussed compounded products that contain over-the-counter ingredients or closely resemble an available over-the-counter product. Participants noted that a minor change in concentration may technically make a product a customized prescription, but the provider should still be able to establish why the compounded product is medically necessary instead of an available lower-cost alternative.

The Committee agreed to retain language providing that reimbursement will be based on the lesser of the applicable cap, the equivalent average wholesale price, or an available lower-cost therapeutic or over-the-counter equivalent. Medical necessity may be reviewed when a compounded product differs only slightly from an available lower-cost product.

Remote Therapy Monitoring

Ms. Tedford reviewed the remote therapy monitoring codes, existing Alaska fee schedule values, and documentation requirements. She explained that the applicable device-supply codes are based on the number of monitoring days during a calendar month and that only one of the applicable codes should be billed within a 30-day period. The Committee supported

adding language to clarify this limitation and reduce the potential for overlapping or improper billing.

Ms. Tedford advised that CMS has proposed replacing certain remote therapy monitoring codes with new G-codes in 2027. Because the proposed codes may not have an established Alaska conversion factor, the Committee deferred a final decision on how replacement codes should be valued. RefMed will consolidate the remote therapy monitoring provisions under a separate heading in the Medicine section, include appropriate cross-references, and present revised language for further review.

Break 10:10 a.m. – 10:15 a.m.

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

No public comment.

VII. FEE SCHEDULE DEVELOPMENT DISCUSSION CONTINUED

Remote Therapy Monitoring Continued

The Committee discussed whether remote monitoring should be billed in addition to regular in-person physical therapy. Members recognized that remote monitoring could improve access to care, particularly for injured workers in rural communities, but expressed concern about duplicative reimbursement when it is added to frequent in-person treatment without a clearly documented need. Members agreed that the medical record should support the service, including the monitoring performed and how the information was used in the treatment plan.

The Committee also discussed whether exercise or tracking applications qualify under the remote therapy monitoring codes. RefMed explained that the existing codes appear to require a qualifying medical device that is supplied to the patient and transmits information to the provider. The Committee agreed that application-only programs would not be reimbursable under these codes and should be monitored for possible consideration in a future fee schedule cycle.

Durable Medical Equipment and Unlisted Devices

RefMed presented proposed language addressing durable medical equipment, supplies, and devices billed under unlisted or miscellaneous codes such as E1399 and CPT 99070. The Committee discussed concerns that these codes may be used as catch-all codes when a more specific code is available or to obtain reimbursement based on billed charges rather than the actual cost of the item.

The Committee agreed that providers should use a specific code when one exists. When no specific code is available, the provider must submit the original manufacturer or supplier invoice. Reimbursement will be based on the invoice amount plus 20 percent, and the general provision allowing reimbursement at 85 percent of billed charges will not apply. Members agreed that no reimbursement should be made when the required invoice is not provided.

The Committee supported using criteria-based language that applies to all unlisted or miscellaneous durable medical equipment, supplies, devices, and accessories rather than identifying only E1399. Members noted that this would prevent providers from avoiding the invoice requirement by selecting another unlisted code.

Durable Medical Equipment Rentals

RefMed presented proposed language providing that total rental reimbursement for an item may not exceed its purchase price. Once cumulative rental payments equal the purchase price, the item will be considered purchased and no additional rental reimbursement will be payable.

The Committee supported the proposed limitation. Members noted that the provision would prevent circumstances in which rental payments ultimately exceed the cost of purchasing the equipment.

The Committee also discussed products that are available only as rentals and may not have an identifiable purchase price. RefMed will clarify how the provision applies to rental-only products and to equipment that has an established purchase value but no separately listed rental rate.

Hearing Aids and Audiology Services

RefMed reviewed the hearing-aid provisions in light of changes to audiology procedure codes. The current fee schedule reimburses hearing aids at the manufacturer or supplier invoice amount plus a 30 percent markup. Director Collins explained that the higher markup was intended to compensate providers for related evaluations, testing, fitting, adjustments, repairs, and reprogramming that were included in the hearing-aid reimbursement rather than separately payable.

Ms. Engelke noted that changes to the audiology codes may now allow separate reimbursement for some services that were previously included in the markup. The Committee discussed whether retaining the 30 percent markup while also paying separately for those services could result in duplicative reimbursement.

Members also expressed concern that making evaluation and testing services nonpayable could leave an audiologist uncompensated when the provider performs the evaluation but the patient ultimately obtains hearing aids elsewhere. The Committee agreed that medically necessary evaluation and testing should remain reimbursable when hearing aids are not dispensed by the evaluating provider.

The Committee discussed limiting separately reimbursable hearing evaluations and testing to no more than once per year to prevent repeated testing or frequent follow-up billing. RefMed will revise the section to clarify which services are included in the hearing-aid markup, which services may be separately reimbursed, and how the provisions apply during the initial dispensing process.

The Committee also reviewed the existing provisions allowing replacement hearing aids generally once every four years when supported by appropriate medical evaluation and documentation. No final change to the 30 percent markup or replacement provisions was made pending review of the revised language.

Conversion Factors and Provider Reimbursement

Director Collins asked Dr. Swenson to report on provider concerns regarding the surgical conversion factor and recent federal reimbursement changes. Dr. Swenson stated that the primary concern was the cumulative effect of reimbursement reductions, increasing practice costs, administrative requirements, and the additional time required to manage workers' compensation cases.

Dr. Swenson reported that providers do not believe Alaska reimbursement has yet reached the point where accepting workers' compensation patients is financially impractical. However, providers are increasingly evaluating whether the administrative burden and reimbursement justify continued participation, particularly because many providers in other states have already limited or discontinued workers' compensation services.

Director Collins noted that the surgical conversion factor was reduced approximately three years earlier when Alaska reimbursement was substantially above countrywide levels. Current data showed that Alaska surgical reimbursement remained somewhat above the countrywide comparison but was much closer to the Committee's intended range. Members agreed that an additional reduction could negatively affect provider participation and injured-worker access to care.

The Committee agreed not to change the conversion factors for the 2027 fee schedule. The Committee will continue monitoring medical inflation, administrative costs, reimbursement comparisons, and provider participation during future fee schedule reviews.

Fee Schedule Organization and Cross-References

The Committee agreed to improve cross-references throughout the fee schedule so providers and payers can more easily locate applicable requirements. Multiple-procedure payment-reduction rules will remain in the Medicine section, with references added to the Physical Medicine and other applicable sections. Remote therapy monitoring will also be placed under a separate heading in the Medicine section, with appropriate cross-references.

Technical and Annual Fee Schedule Updates

Ms. Tedford summarized the remaining technical and annual revisions for the 2027 fee schedule, and provided a high-level overview of proposed CMS changes. The Committee noted that the federal proposals were not yet final and that changes to the federal conversion factor would not automatically change Alaska's established conversion factors.

Member Gilbert asked whether the hospital reimbursement multipliers should continue. Director Collins explained that the multipliers are based on Medicare classifications that account for differences among facilities, including the volume of uninsured or uncompensated care. The Committee agreed that the explanation supported retaining the current methodology, and no change was recommended.

VIII. ADJOURNMENT

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

Adjourn 1:32 p.m.