Industrial Commission of Arizona

Arizona Physicians' and Pharmaceutical Fee Schedule
(Effective October 1, 2015 through September 30, 2016)

Summary of Commission Action

by

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I. REVIEW OF ISSUES AND PUBLIC COMMENTS RECEIVED

A. Updated Values and Adoption of Deletions, Additions, General Guidelines, Identifiers, and Modifiers of the CPT®-4.

In the March 2, 2015, report staff recommended that the values for all codes be updated based on the methodology previously approved by the Commission. While there were comments received as to the Commission's methodology, which are discussed below, no comments were received with respect to the proposed values for the codes.

Although the Commission is not permitted to include in its fee schedule the descriptors associated with five-digit *CPT*® codes, staff recommended that the Commission adopt by reference the deletions, additions, terminology changes, general guidelines, identifiers, and modifiers of the 2014 and 2015 *CPT*® codes to ensure that the 2015/2016 Fee Schedule is current and reflects the latest changes to those editions of the *CPT*®-4. To the extent that a conflict may exist between the adopted portions of the *CPT*®-4 and a code or guideline unique to Arizona, the Arizona code or guideline would control.

U.S. HealthWorks (USHW) submitted comments in support of this recommendation. Additionally, an analysis of the impact of the proposed changes was provided by the National Council on Compensation Insurance ("NCCI"), which estimated that the proposed changes would result in an overall increase in Arizona workers' compensation system costs of +1.1%.

B. Methodology to Determine the Values of Codes Under Review.

The Commission surveys the workers' compensation fee schedules from the states of Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah, and Washington and uses the following methodology to calculate the reimbursement values for the codes under review:

a. Current Arizona values between the 75th and 100th percentile of the states surveyed are not adjusted;
b. Current Arizona values over the 100th percentile of the states surveyed are reduced to the 100th percentile; and
c. Current Arizona values below the 75th percentile are increased to the 75th percentile subject to the following: Increases shall be capped at 25%, unless and except as necessary to bring a current value up to the 50th percentile.

The foregoing methodology does not apply to following:

a. If the survey sample size is less than four, then the code may be identified as RNE (Relativity Not Established)[1] or BR (By Report)[2], except if it involves the

[1] RELATIVITY NOT ESTABLISHED (RNE) in the value column indicates a new or infrequently performed service for which sufficient data has not been collected to allow the assignment of a reimbursement value based on unit relativity. Additional information about the RNE designation is contained in the Fee Schedule introduction.

professional component ("PC") of a value in which case the PC value may be based on the current ICA PC to Total Value ratio;
b. Codes specific to Arizona, the value of which may be determined through the hearing process; and
c. Codes otherwise designated as BR.

In response to an ongoing interest from the community to evaluate this issue and recommendations made last year from a Director's advisory committee that were adopted by the Commission, several changes were implemented, which were reflected in this year's staff report:

- Replacing the four year cycle of review, all codes were reviewed this year. This task was performed by Commission staff rather than an outside vendor as considered last year. To facilitate this process, the form of reporting the codes and values was changed to mirror how this information is presented commercially, as well as by other states. This included identifying codes that are "not covered" because they had not previously been adopted by the Commission (e.g. maternity codes, pediatric codes, etc.). This also included identifying, where applicable, the technical component of a value ("TC"). As part of this process, and to improve the clarity of the information presented, *CPT*® codes that contain explanatory language specific to Arizona continued to be preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx.

- The Fee Schedule was updated to the 2015 *CPT*® (which became effective January 1, 2015). Because last year's fee schedule adopted changes to the 2013 *CPT*®, updating this year's Fee Schedule to the most recent *CPT*® edition required review of both the 2014 and 2015 editions of the *CPT*®.

- The review date of the Fee Schedules of other jurisdictions was changed to January 31, 2015.

The Commission requested feedback on the changes that were implemented.

Summary of Public Comments Received

Arizona Medical Association ("ArMA"): ArMA supports a review of all codes annually and maintaining the seven state comparison methodology. ArMA opposes tying physician fees to AHCCS or Medicare Fee Schedules noting that physician fees need to be at appropriate levels so as to encourage qualified clinicians to remain available to injured workers.

Arizona Self-Insurers Association ("ASIA"): ASIA continues to supports the recommendations of the methodology committee including a transition toward an

[2] BY REPORT (BR) in the value column indicates that the value of the service is to be determined "by report" because the service is too unusual or variable to be assigned a reimbursement value based unit relativity. Additional information about the BR designation is contained in the Fee Schedule introduction.

RBRVS-based Fee Schedule, noting that an RBRVS based methodology is not the same as Medicare fees, but rather starts with the same baseline to which various state-specific multipliers are applied.

CopperPoint: CopperPoint supports reviewing all codes annually and moving the review date to January to include the most current CPT codes. CopperPoint continues to support moving to an RBRVS based system. CopperPoint also supports the adoption of an Arizona specific identifier.

Dr. Mark Greenfield: Dr. Greenfield explains that he does not support an RBRVS system, and that under such a system it will be harder to find physicians willing to treat injured workers. He explains that treating injured workers is much more demanding than treating the average group health patient or Medicare patient where the focus is not on return to function or return to work. Dr. Greenfield explains that moving to an RBRVS based system will impact the availability of qualified physicians who are willing to treat injured workers.

MBI Industrial Medicine: MBI expresses concern that the seven state mix may find some states that are not as progressive as Arizona, and part of the progression of occupational medicine and workers' compensation in Arizona has been a Fee Schedule that has been adopted for Arizona. Transition to an RBRVS based system may result in difficulties finding appropriate care for injured workers, which could extend the duration of care.

Property Casualty Insurers ("PCI"): PCI supports moving to an RBRVS based system stating this methodology has created fairness and stability in medical pricing and reimbursements.

Jeffrey D. Scott, M.D., Palo Brea Pain & Rehabilitation: Dr. Scott supports the comments of ArMA noting that moving to a Medicare Fee Schedule and/or guidelines is not appropriate because the Medicare model is designed to establish policy and payment practices related to the aging population not the working population, and standardization as the best practice is not valid when you are dealing with people's health. The ArMA comments on keeping current qualified clinicians available to injured workers are important and Dr. Scott explains that any discussion of moving to a Medicare based system needs to consider reduced access to care issues and preventing further injury to workers. He also explains the burdens on physicians to justify care, and how bills and supporting documentation that fully justify time and complexity are down coded. He states that physicians are providing care to patients and questions whether any analysis has been done regarding the efforts of physicians to get properly paid.

U.S. HealthWorks (USHW): USHW supports the methodology that the Commission used to determine the value of the codes reviewed for the 2015/2016 fee update. USHW also supports the annual review of all codes, moving the review date to January 1st of the current year, and moving forward with the RBRVS based feasibility study. This would allow for equitable fees based on the Relative Values for each CPT service and still allow for the incorporation of State specific conversion factors and ground rules governing how the Fee Schedule is administered. *USHW* also supports the adoption of an Arizona specific identifier.

C. Adoption of National Correct Coding Initiative Edits as published by the Centers for Medicare and Medicaid Services.

The Commission received questions in the past regarding the applicability of the National Correct Coding Initiative Edits ("CCI Edits) to bills processed under the Arizona Fee Schedule. Because the CCI edits had not been adopted by the Commission, some payers expressed an interest in having this issue considered.

According to information provided on the Centers for Medicare and Medicaid Services' ("CMS") webpage for The National Correct Coding Initiative Edits, the CMS developed the CCI Edits to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's *CPT*® Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Additional information about the CCI Edits is found at http://www.cms.gov/NationalCorrectCodInitEd

Summary of Public Comments Received

CopperPoint: CopperPoint supports the adoption of National Correct Coding Initiative Edits as published by CMS.

PCI: PCI supports the adoption of National Correct Coding Initiative Edits as published by CMS.

USHW: USHW supports the adoption of National Correct Coding Initiative Edits as published by CMS.

D. Reimbursement for Participation in Peer Review as Described in the Evidence Based Treatment Guideline Process Approved by the Commission on December 18, 2014.

On December 18, 2014, the Commission adopted the recommendations of an advisory committee regarding the implementation of a process for the use of evidence based treatment guidelines. The process, which has not yet been implemented, includes a provision that allows a provider to bill a payer for time spent participating in an independent peer review described in the Administrative Review Section of this process. See Section III(K) of the process draft which can be viewed in its entirety at: http://www.ica.state.az.us/PublicNotices/DIRECTOR_EBM_Dir_Adv_Comm_on_EBM_Treatment_Guidelines_final_draft.pdf

The Commission welcomed public comment on whether an existing *CPT*® code (or codes) could be used (with, if necessary, Arizona specific language adopted to address the peer review provision found in the treatment guideline document described above) or whether an Arizona specific code should be adopted. Additionally, the Commission welcomed public comment on the reimbursement value that should be adopted for the corresponding code.

Summary of Public Comments Received

ArMA: ArMA urges caution in this arena of treatment guidelines. It is far more complicated to fit patients to guidelines and not disturb the best quality outcomes, then to implement across the board guidelines for patients. There are times when adhering to a preordained treatment protocol is not in the patients' best interests. If evidence based guidelines are formally adopted, then there must be an administratively simple and medically competent mechanism to establish an allowable variance.

ASIA: ASIA supports the comments made by PCI on this subject. Additionally, it would be important to allow the treatment guideline process to be fully completed before a decision is made on reimbursement.

CopperPoint: CPT codes 99446-99440 appear to be the most appropriate codes for reimbursement of physician time for participation in the peer review process as outlined in the treatment guideline process.

PCI: PCI expresses concern that this will increase the cost of medical review and reward outlier medical providers who regularly refuse to follow evidence based medicine, noting that compliance with adopted evidence based treatment guidelines is more effectively achieved by removing this financial incentive to pursue inappropriate medical care.

USHW: USHW supports the recommendation for implementation of the process for payment of a peer to peer review and recommends an Arizona specific code be adopted and the fee calculated according to the work value of each service. For example, other states utilize a time-based methodology with a relative value assigned to each 15 minutes of time spent in all aspects of the evaluation. USHW also recommends that a ground rule governing the requirements for use of the code(s) be incorporated into the Fee Schedule.

E. Designation of Medi-Span as the Publication for Purposes of Determining Average Wholesale Price.

Medi-Span® is the publication currently used for determining average wholesale price ("AWP") under the Pharmaceutical Fee Schedule. Staff recommended continued use of this publication.

Summary of Public Comments Received

ASIA: ASIA supports continued use of Medi-Span as the publication for determining AWP under the Pharmaceutical Fee Schedule.

CopperPoint: CopperPoint supports the continued utilization of Medi-Span as the source of determination of AWP.

Coventry Healthcare: Coventry supports continued use of Medi-Span.

Healthesystems: Healthesystems supports continued use of MediSpan as the data source for AWP data.

Helios (formerly Progressive Medical and PMSI): Helios supports maintaining Medi-Span as the publication used for determining AWP under the Pharmaceutical Fee Schedule.

PCI: PCI supports continued use of Medi-Span as the publication for determining AWP under the Pharmaceutical Fee Schedule.

USHW: USHW supports the designation of Medi-Span as the single source for determining AWP for payment purposes.

F. Adoption of Add-On and Modifier "-51" Exempt Codes.

The Commission has historically identified Add-On and Modifier "51" Exempt Codes in the Arizona Fee Schedule through the use of asterisks. One asterisk denotes add-on codes, while two asterisks denotes modifier 51 exempt codes. This information is contained in the *CPT*® adopted by the Commission and staff questions whether it needs to be separately stated in the Arizona Fee Schedule unless it is required with respect to an Arizona specific code. Staff recommended that this designation be discontinued in the Arizona Fee Schedule as it is unnecessary.

Summary of Public Comments Received

CopperPoint: CopperPoint supports staff's recommendations.

PCI: PCI supports staff's recommendation.

USHW: USHW supports staff's recommendations.

G. Pharmacy Dispensing Fee for Over the Counter Medications.

Last year *U.S. HealthWorks* recommended that the Pharmacy Fee Schedule be changed to eliminate a dispensing fee for over the counter ("OTC") medications. At that time, the Commission took no action on the recommendation and advised that the issue would be considered this year to allow for public comment. The Commission requested public comment on this recommendation, along with any studies or practices that are validated and accepted in the industry with respect to dispensing fees for over the counter medications.

Summary of Public Comments Received

ASIA: ASIA supports the comments made by PCI, USHW, and CopperPoint.

CopperPoint: CopperPoint agrees with U.S. HealthWorks' recommendation to eliminate a dispensing fee for OTC medications.

Coventry Healthcare: Coventry supports the removal of the dispensing fee for OTC medications. Coventry also recommends that the Commission consider removing a dispensing fee in relation to prescriber dispensed medications for the reason that prescribers are not making the preparations regarding pharmaceuticals, which is what the dispensing fee is traditionally meant to stand behind.

Healthesystems: Healthesystems explains that there are several different ways injured workers can obtain non-prescription or OTC medications: from a physicians' office at the time they are seen for their work injury; off the shelf from a retail store; and from a pharmacist in a pharmacy setting. Because there are different methods of obtaining these medications, Healthesystems recommends the Commission consider the source of the OTC in determining whether a dispense fee is allowable. When workers obtain OTC medications from a physician's office or off the shelf at a retailer, then no dispense fee should be payable since these types of transactions do not involve a pharmacist's time, expertise or intervention. However, when an injured worker goes to the pharmacy counter to obtain an OTC medication, more often than not the pharmacist is performing work for which he or she would be entitled to a dispense fee. For these reasons, Healthesystems recommends allowing dispense fees for OTC medications, but only when a pharmacist was involved in the dispensing of the OTC medication. Healthesystems recommends the Commission consider disallowing dispense fees to physicians for any type of medications dispensed, both OTC and prescription drugs. Physicians are compensated for their services at the time of the office visit within their professional billing codes (Evaluation and Management CPT).

MBI Industrial Medicine: MBI does not support the removal of a dispensing fee for OTC medications explaining that it covers the liability of a physician associated with dispensing that medication. When a physician hands a particular medication to a patient, they have to take time to explain the usage and to make sure that it is not contraindicated for the patient. If a patient gets an OTC medication from a pharmacy, the dispensing fee may not apply, but in a physician's office, MBI thinks that it does.

PCI: PCI agrees with U.S. HealthWorks that the Pharmacy Fee Schedule should be changed to eliminate a dispensing fee for OTC medications noting that most states do not allow a dispensing fee for OTC medications.

Jeffrey D. Scott, M.D., Palo Brea Pain & Rehabilitation: Dr. Scott objects to eliminating the dispensing fee for physicians stating that there is a misunderstanding of the office process. He explains that the assertion that a physician has already been paid for the medication review is not valid noting that carriers consistently down code evaluation and management services provided by the physician. He explains that there is a large amount of case management that a physician performs in workers' compensation that they do not get paid for, and that the code for pharmacy management has been deleted. He describes those services which includes evaluation management and medication management (drug screening and monitoring, treatment and future planning).

USHW: USHW maintains its position from last year that the dispensing fee for OTC medications be eliminated noting that the vast majority of current state workers' compensation Fee Schedules that allow physician dispensing allow a dispense fee for

prescription strength medications, but not for OTC medications. In addition, USHW encourages the Commission to maintain the dispensing fee when the medication dispensed is a prescription strength dose. Several states, including California, Florida, Illinois and Wisconsin currently utilize this methodology to compensate physicians for the work involved in managing the patient's prescription drugs.

H. Billing for Pharmaceuticals.

Last year the Commission declined to take action on requiring standardized billing for pharmaceuticals and advised that it would continue its review, which would include consideration of providing direction on how to bill for pharmaceuticals dispensed by a physician. Specific to this issue, *Helios* recommended that physician billing for pharmaceuticals include both the repackaged national drug code (NDC) and the original manufacturer NDC. If the Commission was not going to adopt a universal billing form (which the Commission declined to do last year), then *Helios* recommended that the reporting of this multiple NDC information be done as follows: The original manufacturer NDC should be reported first, followed by the repackaged NDC. If a physician uses the CMS 1500 form (which is typically used by physicians), then this information could be provided, in that order, in the shaded upper portion of the service line(s) of that form (fields 24(a) through 24(g)). In addition to requesting public comment on this issue, the Commission also sought public comment on whether, without mandating the use of a specific form, other information should be required when billing for a pharmaceutical, such as ingredient-level billing of compound drugs.

Summary of Public Comments Received

ASIA: ASIA supports the comments made by PCI, USHW, and CopperPoint noting that physician dispensing has been a longstanding concern of ASIA. Members have seen instances where physicians have dispensed medication from their offices, but used a third party biller so that it appears that the prescription was not dispensed out of the office. Additionally, the forms often used for such dispensing, Health Insurance Claims Form or HICFA, are traditionally used for professional services and not pharmacy. Claims for pharmacy and professional services are routed to different bill review services. When pharmacy claims are submitted using HICFA, this can create a host of problems for payers, not the least of which is cost.

CopperPoint: CopperPoint understands the issues and potential benefits presented by those requesting the adoption of standardized billing form for pharmaceuticals. Processes that promote transparency and efficiency should be adopted regardless of the billing entity – physician or pharmacy. These should also include ingredient level billing detail for compound drugs.

Coventry Healthcare: Coventry supports the comments of PMSI and Healthesystems, supports the use of the NCPDP universal form, and the reporting of both NDC codes. Coventry explains that in the pharmacy world, the actual NDC associated with the medication being dispensed is required to be reported for health and safety concerns, and not having the additional national drug code for the lot that was actually dispensed can cause some health and safety risks within the industry.

Healthesystems: Healthesystems continues to recommend that the Commission adopt nationally recognized billing forms, such as the NCPDP WC – UCF form for medications dispensed by a pharmacist and the CMS-1500 for physician dispensed medications. Both forms have very specific guidance on how repackaged and compounded medications should be billed. In response to concerns from physicians and insurers nationwide, Healthesystems references the recent guidance published by the National Uniform Claim Committee, responsible for the maintenance of the CMS-1500 form.

Helios: Helios continues to recommend that the Commission adopt the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) for billing of pharmaceuticals. Helios believes doing so will provide greater clarity and standardization to the processing of pharmaceutical bills within the state's workers' compensation system and lead to a lower chance of billing and payment disputes. Helios also recommends that, if there was a concern with requiring physicians to use the WC/PC UCF in lieu of their more typically utilized CMS-1500 for dispensed pharmaceuticals, that the Commission adopt the instructions adopted by the National Uniform Claim Committee (NUCC), the organization controlling the CMS-1500, for how to bill both a repackaged and original manufacturer NDC on the CMS-1500 form. Those instructions call for listing the repackaged NDC first, followed by the original manufacturer NDC, along with appropriate qualifiers and units. Lastly, as a simple method of adopting those instructions without actually adopting the form itself, it may sufficient to just state that bills should include both NDCs without detailing which fields on a specific form to use. Helios also supports requiring ingredient-level billing of compounds noting that by their very nature, custom compounds are not assigned a single NDC; rather, each individual component ingredient in the compound typically has its own NDC. Billing and reimbursement based on component NDCs is now a pharmacy industry standard (supported by all the major standards billing forms/formats) and provides greater transparency and accuracy in the process.

National Council for Prescription Drug Programs ("NCPDP"): NCPDP recommends adoption of the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) for pharmacy paper billing and adoption of ingredient-level billing for compounds noting that the absence of standards permits a wide variety of billing forms and invoices to be used by providers requiring payers to implement multiple processing methodologies. NCPDP explains the advantages to using the WC/PC UCF, which includes that it accommodates reporting both the original manufacturer's and repackager's NDCs associated with a repackaged drug. NCPDP notes that for physicians submitting paper bills for dispensed repackaged medications, the National Uniform Claim Committee has adopted instructions for reporting both the repackaged NDC and the original NDC on the CMS 1500. NCPDP also describes the work of the IAIABC to advance the adoption of standards and explains why it supports the billing of compound medications at the ingredient level.

PCI: PCI supports the adoption of a standardized billing format of the billing of pharmaceuticals, including pharmaceuticals dispensed by a physician. In the absence of adoption of a universal billing form, PCI supports amendments to the Pharmaceutical Fee Schedule that would require the reporting of multiple NDC information when a

repackages drug has been dispensed. The original manufacturer NDC should be reported first followed by the repackaged NDC. If a CMS 1500 form is used for billing, then this information should be provided in fields 24(a) through 24(g). PCI also supports mandated ingredient level billing for compound drugs.

Jeffrey D. Scott, M.D., Palo Brea Pain & Rehabilitation: The inclusion of a policy defining forms for pharmaceutical dispensing can include the NCPDP WC-UCF, but it should also include the CMS-1500 instructions so physicians do not bare yet another dual system requirement or software purchase requirement.

USHW: USHW expresses concern that requiring both NDC numbers to be reported on the claim may produce an administrative burden for the provider. The challenge would not be around how the numbers would appear on the claim; this is very clearly delineated in the NUCC instructions for completion of the CMS 1500, but rather in how the physician billing systems would get it there. Most claims software currently utilized only has a field identifier for a single NDC number. Additionally, USHW does not feel that requiring an office-based physician to file an additional pharmacy form would be beneficial. This standard has only been utilized up to this point for pharmacy billing. This would place an undue burden on the physicians, as well as the payers, and could cause complications in electronic claims filing. Additionally, USHW requests clarification on the payment methodology being proposed for physician dispensed pharmaceuticals. If the reimbursement will continue to be based on the AWP of the original manufacturer NDC and not the re-packager NDC then the requirement to also list the re-packager NDC is redundant. USHW also supports ingredient level billing for compound drugs.

I. Deletion of Pathology Codes 80100, 80101, and 80104.

The Pathology and Laboratory guidelines contained in the 2014 Arizona Fee Schedule contain criteria for reimbursement for Pathology codes 80100, 80101 and 80104. These three codes are deleted in the 2015 *CPT*®, which means that the language found in the Pathology and Laboratory guidelines will also be deleted. The Commission requested public comment of whether new language needs to be included in the Fee Schedule to replace the language that will be deleted.

Summary of Public Comments Received

CopperPoint: CopperPoint supports Commission action which is consistent with industry standards.

USHW: In order to maintain consistency with adoption of current year CPT coding USHW supports the deletion of these codes.

II. COMMISSION ACTION REGARDING 2015 CHANGES TO ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE

At its June 11, 2015, meeting, the Commission took action on the following issues. For more information regarding the discussion and action taken on these issues, please see the Commission minutes from that date, which are posted on the Commission's website at www.azica.gov.

A. Updated Values and Adoption of Deletions, Additions, General Guidelines, Identifiers, and Modifiers of the CPT®-4.

The Commission unanimously approved the adoption of the proposed values for all codes and adoption of the deletions, additions, general guidelines, identifiers, and modifiers of the CPT®-4. The adopted values, deletions, and additions are found in Tables 1 through 11 of the accompanying Excel file. This action conforms the Fee Schedule to changes that have taken place in the 2014 and 2015 editions of the *CPT*®-4. Additionally, although the Commission is not permitted to include in its fee schedule the descriptors associated with five-digit *CPT*® codes, the adoption of the proposed values for all codes is intended to adopt by reference the terminology changes associated with those codes.

B. Methodology to Determine the Values of Codes Under Review.

The Commission unanimously agreed that no action was required at this time. For informational purposes, a contract has been awarded to an outside consultant to perform a study to evaluate the impact of moving to an RBRVS based system. Subject to available finding, this study will be performed this year.

C. Adoption of National Correct Coding Initiative Edits as published by the Centers for Medicare and Medicaid Services.

The Commission unanimously approved the adoption of the National Correct Coding Initiative Edits as published by CMS.

D. Reimbursement for Participation in Peer Review as Described in the Evidence Based Treatment Guideline Process Approved by the Commission on December 18, 2014.

The Commission unanimously agreed to take no action at this time.

E. Designation of Medi-Span as the Publication for Purposes of Determining Average Wholesale Price.

The Commission unanimously approved the continued use of Medi-Span.

F. Adoption of Add-On and Modifier "-51" Exempt Codes.

The Commission unanimously approved to discontinue the use of asterisks to identify Add-On and Modifier "-51" Exempt Codes.

G. Pharmacy Dispensing Fee for Over the Counter Medications.

The Commission unanimously agreed to take no action at this time except to add language to the Fee Schedule to clarify that the dispensing fee does not apply to an OTC medication that is not dispensed pursuant to a prescription order.

H. Billing for Pharmaceuticals.

The Commission unanimously approved requiring that a billing for a physician dispensed repackaged drug include the NDC of the repackaged drug and the NDC of the original manufacturer, and that a billing for a compound drug include the NDC for each underlying ingredient used in the compound.

With respect to the form used for the paper billing of pharmaceuticals by a physician, the Commission unanimously approved requiring that a physician follow the instructions published by the National Uniform Claim Committee when using the CMS 1500 form to bill for physician dispensed medications. These instructions require the listing of the repackaged NDC first, followed by the original manufacturer NDC, along with appropriate qualifiers and units. If a physician does not bill using the CMS 1500 form, or is not able to include all the required information on the CMS 1500 form (due to software/system limitations), then the physician may provide the required information separately or as an attachment to the CMS 1500 form.

With respect to the form used for the paper billing of pharmaceuticals by non-physician entities (e.g. pharmacy, pharmacy benefit manager, etc.) the Commission unanimously approved requiring the use of the most recent version of the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF).

I. Deletion of Pathology Codes 80100, 80101, and 80104.

The Commission unanimously agreed to take no action.