ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE
FREQUENTLY ASKED QUESTIONS
(Rev. December 26, 2023)

1. What is the authority under which the schedule of fees is set?

Since 1925, when the Arizona Legislature passed the state's first Workers' Compensation Act, the Industrial Commission of Arizona (the "Commission") has administered Arizona's workers' compensation program. Under A.R.S. § 23-908(B), the Commission is required to "fix a schedule of fees to be charged to physicians, physical therapists or occupational therapists attending injured employees and . . . for prescription medicines required to treat an injured employee" and to "annually review the schedule of fees." Under § 23-908(B), the schedule of fees may include "other reimbursement guidelines for medications dispensed in settings that are not accessible to the general public."

2. What is the methodology used by the Commission to establish its schedule of fees?

The 2023/2024 Fee Schedule is based upon the following methodology to compute reimbursement values for all applicable service codes:

STEP 1: Assign Relative Value Units ("RVUs") or Anesthesia Base Units ("BUs") to each CPT® code. Assign a base rural and non-rural reimbursement value to each HCPCS code. This was done using one of the methods below:

a. Utilize applicable RVUs and BUs from the 2023 Medicare Physician Fee Schedule ("MPFS") . The 2023 MPFS was the preliminary source for assigning and updating RVUs and BUs for CPT® codes.

b. Utilize applicable BUs from the 2023 Anesthesia Base Units from the 2023 CPT® publication.

c. Utilize applicable RVUs from the 2023 Clinical Diagnostic Laboratory Fee Schedule. This method was used to update RVUs for most pathology and laboratory CPT® codes.

d. Utilize applicable reimbursement values from the most current (based on date the Fee Schedule proposal is published) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule File to assign and update the base reimbursement values for HCPCS codes.

e. Utilize applicable RVUs and BUs from FAIR Health data. This method was used to assign and update RVUs and BUs for "gap" CPT® codes not included in the 2023 MPFS.

f. Utilize a back-filling approach to assign RVUs for any service codes that have a current rate but could not be assigned RVUs using the above methods. This method involved

backing into overall RVUs by dividing the current rate for a service code by the applicable current conversion factor.

STEP 2: Once RVUs, BUs, and base reimbursement values were assigned to all service codes, reimbursement rates were calculated by multiplying the applicable RVU, BU, or base reimbursement value by the Arizona-specific conversion factor. The 2023/2024 Fee Schedule continues to use a multiple conversion factor model, consisting of one conversion factor for Anesthesia Services, a second for Surgery Services, a third for Radiology Services, a fourth for all remaining service categories (including E & M, Pathology and Laboratory, Physical Medicine, and General Medicine), and a fifth for HCPCS Services.

The conversion factors for the 2023/2024 Fee Schedule are:

Conversion Factors	
Anesthesia	$61.00
Surgery	$72.00
Radiology	$70.00
All Other Services	$68.00
HCPCS	1.4

Note: The above-described methodology does not apply to service codes that could not be assigned an RVU, BU, or base reimbursement value using the methods stated earlier. Service codes of this nature are identified as By Report (BR)[1], Bundled[2], Not Covered or Relativity Not Established (RNE)[3].

Note: Additionally:

a. The 2023/2024 Fee Schedule assigns RVUs to consultation services, recognizing the functional importance of these services. These codes observe the bundling principles used by CMS.

b. The 2023/2024 Fee Schedule does not incorporate a geographic adjustment factor ("GAF"), but instead uses the Arizona-specific conversion factor to adjust payment for the state. It should be noted that CMS utilizes one GAF for the entire State of Arizona.

c. The 2023/2024 Fee Schedule has been updated to incorporate by reference the following:

[1] 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.

[2] BUNDLED there are a number of services/supplies that are covered under Medicare and have codes, but they are services for which Medicare bundles payment into the payment for other related services. If carrier receive a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment should be denied by the carrier.

[3] RELATIVITY NOT ESTABLISHED "RNE" in value column indicates new or infrequently performed services for which sufficient data has not been collected to allow establishment of a relativity. RNE items are clearly definable and not inherently variable as are BR procedures. A report may be necessary.

1. The 2023 Edition of the American Medical Association's *Current Procedural Terminology Publication* (CPT®), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes.

2. The 2023 Healthcare Common Procedure Coding System (HCPCS) codes that include procedures, supplies, products, and services published by the Centers for Medicare & Medicaid Services ("CMS").

3. The unit values and guidance for consultative, diagnostic and therapeutic services published in the most recent edition of *Relative Value Guide,* American Society of Anesthesiologists (ASA) https://www.asahq.org.

4. American Medical Association, Evaluation and Management Code and Guideline Changes, https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf and the Guidelines for Evaluation and Management Services in the current version of CPT®.

5. The *2023 Clinical Diagnostic Laboratory Fee Schedule,* CMS Clinical Laboratory fee Schedule https://www.cms.gov.

6. The *National Correct Coding Initiative Edits,* CMS; https://www.cms.gov/ncci-medicare/medicare-ncci-policy-manual.

7. Physicians as Assistants at Surgery: 2023 Update https://www.facs.org/media/gp3ny4ps/2023-update-physicians-as-assistants-at-surgery.pdf

8. Surgical global periods published by CMS,

9. FAIR Health data, copyright 2023, FAIR Health, Inc.

d. Codes that are unique to Arizona and not otherwise found in CPT® or HCPCS are preceded by an AZ identifier and numbered in the following format: AZxxx. To the extent that a conflict may exist between an adopted portion of the CPT® publication, HCPCS Guidelines, and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier, or modifier shall control.

3. How often is the Arizona Fee Schedule reviewed by the Commission?

The Commission reviews the Fee Schedule on an annual basis.

4. When does the annual review of the Fee Schedule take place? Is there an opportunity to participate in the review process?

Generally, annual updates to the Fee Schedule become effective May 1st of each year. The public is afforded an opportunity to participate in the process. In the beginning of each year, the Commission provides an analysis of issues along with staff recommendations for the Fee Schedule

update in a Staff Proposal and Recommendations report that is posted on the Commission website. This document is intended to serve as a foundational document for public comment and future discussions that may arise during the public hearing process.

Stakeholders are invited to participate in the annual informal stakeholder meeting. A.R.S. § 23-908(C) directs the Commission to hold at least one meeting after the Staff Proposal and Recommendations report is published and prior to the public hearing. Following the posting of a Notice of Hearing on the Commission's website, a public hearing is held to receive public comment. Written comments are welcomed in advance and until the end of the week following the public hearing. Thereafter, at a duly noticed public meeting, the Commission will take official action on the Fee Schedule, which will be incorporated in the Fee Schedule to become effective May 1st of that year.

5. Where may I find the most recent fee schedule?

The Arizona Physicians' and Pharmaceutical Fee Schedule is available at https://www.azica.gov/arizona-physicians-fee-schedule-year-selector

6. What fees are covered under the Arizona Physicians' and Pharmaceutical Fee Schedule?

Under A.R.S. § 23-908(B), the Commission is required to establish "a schedule of fees to be charged by physicians, physical therapists or occupational therapists attending injured employees", and "for prescription medicines required to treat an injured employee".

For purposes of the Fee Schedule, the term "healthcare provider" is used when referring to licensed professionals whose scope of practice allows them to legally provide services to injured workers. Fees for certain products, supplies, and services are regulated in the Fee Schedule, including fees for durable medical equipment ("DME"), prosthetics, orthotics, and supplies

7. May a provider bill for services using a code that has not been adopted by the Commission?

A provider is not precluded from billing for a service for which there is no corresponding code in the current Fee Schedule. But, for such a code, since there is no reimbursement value set forth in the Fee Schedule, reimbursement for the service performed is subject to negotiation between the parties. *See* Section (B)(6) of the current Fee Schedule Introduction. As an alternate to billing under a code that has not yet been adopted, some providers will use an "unlisted service or procedure" code in the current Fee Schedule.

8. May a provider covered by the Fee Schedule negotiate a fee that is different than the Fee Schedule?

Yes, see Section (B)(11) of the current Fee Schedule Introduction. Nothing in the Fee Schedule precludes an entity covered under the Fee Schedule from entering into a separate contract that

addresses fees for services. A payer who claims that fees are governed by a separate contract is required to provide a copy of the contract to the provider in the event of a dispute over fees.

9. Does the Fee Schedule apply to services provided by out-of-state providers?

Yes, the Fee Schedule applies to fees charged by covered entities attending employees that are entitled to receive workers' compensation benefits under the Arizona Workers' Compensation Act. Under A.R.S. § 23-1071(A), an employee may not leave the state for a period exceeding two weeks while the necessity of having medical treatment continues without the written approval of the Commission.

10. Does the Fee Schedule apply to fees charged by chiropractors and naturopaths?

Yes, "physician" means a licensed physician or other licensed practitioner of the healing arts. (*See* R20-5-102).

11. Does the Fee Schedule apply to fees charged by hospitals or outpatient surgery facilities?

No. The Commission does not currently regulate or set reimbursement rates for inpatient hospital services, outpatient hospital services, or ambulatory surgical center ("ASC") services. *See* Question 6, above.

12. Does the Fee Schedule apply to fees charged by ambulance service providers?

No. *See* Question 6, above. Although the Fee Schedule does not apply to ambulance service providers, service fees for ambulance transportation are set and mandated by the Arizona Department of Health Services through its Arizona Ground Ambulance Service Rate Schedule. *See* A.R.S. § 36-2239(D), which states "an ambulance service shall not charge, demand or collect any remuneration for any service greater or less than or different from the rate or charge determined and fixed by the department as the rate or charge for that service." Service fees published in the Arizona Ground Ambulance Service Rate Schedule are applicable in the workers' compensation setting. *See* Section (B)(13) of the current Fee Schedule Introduction.

13. Does the Fee Schedule apply to charges for materials and supplies used in the physician's office?

A healthcare provider is not entitled to be reimbursed for supplies and materials normally necessary to perform a billable service. Examples of those items that are not reimbursable are listed below. Billing and reimbursement guidelines for materials and supplies that are reimbursable are found in the HCPCS Section of the Fee Schedule.

Examples of supplies that are not separately reimbursable:

Applied hot or cold packs
Eye patches, injections, or debridement trays
Steristrips

Needles
Syringes
Eye/ear trays
Drapes
Sterile gloves
Applied eye wash or eye drops
Creams (massage)
Fluorescein
Ultrasound pads and gel
Tissues
Urine collection kits
Gauze
Cotton balls/fluff
Sterile water
Band-Aids® and dressings for simple wound occlusion
Head sheets
Aspiration trays
Tape for dressing
Sterile trays for laceration repair and more complex surgeries

14. Does the Fee Schedule apply to charges for durable medical equipment, prosthetics, orthotic supplies, or surgical implants?

The HCPCS Section of the Fee Schedule does not apply to hospital and ASC settings. Healthcare providers in clinical settings and DME providers shall use the applicable HCPCS code when submitting invoices for DME, prosthetics, orthotic supplies, or surgical implants in settings external to hospital and ASC facilities. Reimbursement shall be made based on the guidance provided in the HCPCS Guidelines.

15. Does the Fee Schedule apply to fees charged for independent medical examinations?

No. An independent medical exam is not a covered service in the Fee Schedule.

16. What medications are covered under the Pharmaceutical Fee Schedule?

The current Pharmaceutical Fee Schedule applies to prescription and over-the-counter (OTC) medications reasonably required to treat an injured employee, whether dispensed or administered by a pharmacy (including online or mail order pharmacies) or by a medical practitioner.

17. Does the Pharmaceutical Fee Schedule include a dispensing fee? If so, what is the dispensing fee?

Section VIII of the current Pharmaceutical Fee Schedule states the guidelines for dispensing fees.

18. Should medical practitioners consider the Official Disability Guidelines when treating injured employees, including prescribing of medications?

Yes. *See* Section I(B) of the current Pharmaceutical Fee Schedule. Medical, surgical, and hospital benefits are not reimbursable unless "reasonably required" at the time of injury or during the period of disability. *See* A.R.S. § 23-1062(A); A.A.C. R20-5-1303(A). The Commission has adopted the Official Disability Guidelines (ODG), published by MCG, including ODG's Drug Formulary Appendix A (ODG Formulary), as the standard reference for evidence-based medicine used in treating injured employees within the context of Arizona's workers' compensation system. Effective October 1, 2018, ODG applies to all body parts and conditions. *See* A.A.C. R20-5-1301(B), (E). ODG is to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The ODG Formulary sets forth pharmaceutical guidelines that are generally considered reasonable and are presumed correct if the guidelines provide recommendations related to a particular medication. *See* A.A.C. R20-5-1301(H). Medical practitioners are encouraged to consult the ODG Formulary before dispensing or prescribing medications to injured employees.

Complementary access to the ODG Drug Formulary Appendix A is available on the Medical Resource Office (MRO) home page or through this link: https://www.odgbymcg.com/state-formulary. Injured workers without representation may contact the MRO via email at MRO@azica.gov to make arrangements to access ODG at the Commission.

19. Does the Pharmaceutical Fee Schedule apply to repackaged medications dispensed by a physician?

The Pharmaceutical Fee Schedule applies to the dispensing of prescription drugs, regardless of whether the drug is dispensed by a retail establishment or by a physician. A pharmaceutical bill submitted for a repackaged medication must identify the NDC of the repackaged medication, the NDC of the original manufacturer registered with the U.S. FDA, the quantity dispensed, and the reimbursement value of the repackaged medication. Under no circumstances shall the reimbursement value of a repackaged medication be based upon an NDC other than the original manufacturer's NDC. A repackaged NDC shall not be used for calculating the reimbursement value of a repackaged medication and shall not be considered the original manufacturer's NDC. *See* Section IV of the current Pharmaceutical Fee Schedule.

Reimbursement for repackaged medication shall be based on the current Pharmaceutical Fee Schedule reimbursement methodology contained in Section III of the Pharmaceutical Fee Schedule, utilizing the NDC(s) and corresponding AWP(s) of the original manufacturer(s).

Any component of a co-pack drug product for which there is no NDC shall not be reimbursed.

20. Does the Pharmaceutical Fee Schedule apply to compound medications?

Yes, the reimbursement guidelines may be found under Section V in the current Pharmaceutical Fee Schedule. Medical providers should reference the Official Disability Guidelines (ODG) treatment guidelines and Appendix A Drug Formulary when prescribing compound medications.

A pharmaceutical bill submitted for a compound medication must identify each reimbursable component ingredient, the applicable NDC of each reimbursable component ingredient, the corresponding quantity of each component ingredient, and the calculated reimbursement value of each component ingredient.

Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed.

Any component ingredient in a topical compound medication that is not FDA approved for topical use shall not be reimbursed.

The maximum reimbursement value for a topical compound medication shall be the lesser of: (1) two hundred ($200) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days); or (2) the reimbursement value of the compound medication calculated under this section.

21. Can medical practitioners dispense medications to injured employees?

Nothing in the Pharmaceutical Fee Schedule prohibits medical practitioner from dispensing medications to injured employees. The Pharmaceutical Fee Schedule does, however, include reimbursement guidelines regarding when a medical practitioner may be reimbursed for medications dispensed to injured employees. These guidelines can be found in Section VII of the current Pharmaceutical Fee Schedule.

22. Does the Pharmaceutical Fee Schedule permit a payer to choose the publication source for determining average wholesale price (AWP)?

No. Average wholesale price must be determined from pricing published in a nationally recognized pharmaceutical publication designated by the Commission. The Commission has selected Medi-Span® for the 2023/2024 Pharmaceutical Fee Schedule.

23. Where can I find Medi-Span®?

Medi-Span® is an online subscription and may be found at: https://www.wolterskluwercdi.com/price-rx/.

24. What is the Average Wholesale Price?

"Average Wholesale Price" or "AWP" means the wholesale price charged on a specific commodity that is assigned by the drug manufacturer and is listed in a nationally-recognized drug pricing file.

25. Does the Fee Schedule include Medicare's Healthcare Common Procedure Coding System (HCPCS) codes?

The Commission adopted the use of sections A, E, K, L, and V of the HCPCS codes in the 2023 Fee Schedule update. These codes and their assigned reimbursement values became effective on October 1, 2023. These codes should be used to bill for products, supplies, and services not included in the CPT® codes.

The Fee Schedule uses HCPCS codes G0480 – G0483 for definitive drug testing. Definitive drug testing is done to confirm the results of the screening (also known as "presumptive" testing) and identifies specific drugs and quantity of the drugs. CPT® codes 80320 -80377 do not have RVUs or reimbursement rates, as HCPCS G0480-G0483 should be used when billing for definitive drug testing.

Additionally, the Commission adopted HCPCS codes G2010 and G2012 in the 2020/2021 Fee Schedule. The codes were initially approved and adopted by the Commission on March 26, 2020, in response to the spread of COVID-19. Codes G2010 and G2012 are used to bill for Virtual Check-ins provided by appropriately-licensed physicians.

26. How should healthcare providers bill for administered medication?

Administered medications should be billed using the appropriate J code. The healthcare provider must include the NDC of the original manufacturer in accordance with Sections III and IV of the current Pharmaceutical Fee Schedule when submitting an invoice to a payer. Administered drugs are reimbursed based on the current Pharmaceutical Fee Schedule.

27. Does the Fee Schedule cover Telemedicine services?

Yes. Reimbursement values for telehealth services are governed by the Fee Schedule. The performance of telehealth services is governed by Arizona Revised Statutes, Title 36, Chapter 36. Bills for services performed via telehealth shall include the appropriate modifier and place of service code according to the incorporated AMA/CMS guidelines.

28. Is preauthorization required for medical treatment or services that are provided to injured employees?

Preauthorization is not required under the Act to ensure payment for reasonably required medical treatment or services. *See* R20-5-1303 (A). While preauthorization is not required under the Act, a provider may seek preauthorization.

A provider should submit a request for preauthorization in writing to the adjustor using Section I (Provider Request for Preauthorization) of the form approved by the Commission under R20-5-106(A)(12). A provider should attach documentation to a request for preauthorization that supports the medical necessity and appropriateness of the treatment or services requested, such as office notes and diagnostic reports. The form can be found here.

A medical provider may submit the request for preauthorization to the adjustor by mail, electronically, or by fax.

29. Are medical providers allowed to bill for completing “work” status forms?

Yes. Billing code AZ005 under the Special Services section is to be used for completion of workers’ compensation insurance forms (i.e., return-to-work status, work restrictions, supportive care restrictions) which are requested or required either by the Commission, the applicable payer (insurance, self-insured employer, or the Special Fund of the Commission), or a third-party administrator of the applicable payer, not to exceed more than one billing in a thirty (30) day period. The applicable form must be attached to the billing.

30. Which billing standard should providers and payers follow for time-based therapeutic procedures and modalities?

The Commission has designated the use of the CMS guidelines as the billing standard for providers and payers. This designation aligns with the Commission’s adoption by reference of the National Correct Coding Edits by CMS.

31. How are healthcare providers paid after providing testimony?

Healthcare providers who are requested to testify by claimants (the injured worker) are reimbursed by the Commission. The Commission will identify those providers and automatically provide reimbursement commensurate to the time spent providing testimony and in accordance with the established rate. *See* Special Services Section of the applicable Fee Schedule.

Healthcare providers who are requested to testify by insurance providers, self-insured employers, and the Special Fund of the Commission are reimbursed by the entity who made the request. The process for reimbursement should be determined by the involved parties.

32. When can a healthcare provider bill for AZ003 or AZ004 and what documentation does a provider need to submit when billing for those codes?

AZ003 and AZ004 were implemented to reimburse healthcare providers for their time spent interacting with a nurse case manager (NCM).

AZ003 may be billed if time is spent discussing a patient’s treatment plan or other related information with the NCM when they are present with the patient. This should not be billed if there is no interaction with the NCM who is present during the time that a service, which is billed using a separate CPT® code, is performed. The documentation must include:

- The name of the NCM
- The name of the organization the NCM is representing
- The purpose of the interaction

AZ004 may be billed if time is spent discussing a patient's treatment plan or other related information with the NCM when the patient is not present. The documentation must include:

- The name of the NCM
- The name of the organization the NCM is representing
- The purpose of the interaction

Healthcare providers should be reimbursed according to the current Fee Schedule when these services are performed and the documentation, as indicated above, is included with the invoice.

33. Will the Commission update the HCPCS reimbursement values when CMS produces a new file?

No, the Fee Schedule is updated annually. The reimbursement values are calculated based on the most current update available when the updated Fee Schedule staff proposal is published.

34. Is it necessary to include an invoice when billing DME?

An invoice is normally not needed when billing for DME if an appropriate HCPCS code describing the item is used. An invoice is required when the listed reimbursement value is less than the actual cost of the item to demonstrate the potential loss or if an unlisted code is appropriately used. *See* Section A(8) of the HCPCS Guidelines.