On March 7, 2024, the Commission held its annual Fee Schedule Public Hearing. Oral and written public comments were received in response to the Staff Proposal and Request for Public Comment for the 2024/2025 Arizona Physicians' and Pharmaceutical Fee Schedule (Staff Proposal). The written comments have been posted on the Medical Resource Office website, available at: https://www.azica.gov/fee-schedule-public-comments-2024.

In addition to oral comments made during the public hearings, written comments were received from Mitchell.

Following careful review and consideration of all public comments, staff recommends the Commission adopt the following changes/updates to the 2024/2025 Fee Schedule:

A. <u>Adoption of Updated Relative Value Units (RVUs) and Reimbursement Values</u>.

Staff recommends adoption of the service codes, relative value units (RVUs), and reimbursement values contained in Tables 1 through 8, available at: https://www.azica.gov/fee-schedule-public-comments-2024.

The recommendation is based upon continued use of a RBRVS reimbursement system, in which reimbursement values are calculated by multiplying "resources required to perform a service" or RVUs by a dollar value conversion factor (CF). The recommended 2024/2025 Fee Schedule is based upon the following two-step methodology to compute reimbursement values for all applicable service codes:

STEP 1: Establishing RVUs or Anesthesia Base Units (BUs) for each service code. This was done using one of the four methods below:

a) Utilize applicable RVUs from the 2024 Medicare Physician Fee Schedule (MPFS) or BUs from the 2024 Anesthesia Base Units from 2024 CPT®. The 2024 MPFS was the preliminary source for assigning and updating RVUs for service codes.

b) Utilize applicable RVUs from the 2024 Clinical Diagnostic Laboratory Fee Schedule. This method was used to update RVUs for most pathology and laboratory service codes.

c) Utilize applicable RVUs from FAIR Health data. This method was used to assign and update RVUs for "gap" codes not included in the 2024 MPFS.

d) 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 were assigned to all service codes, reimbursement rates were calculated by multiplying the applicable RVU by the Arizona-specific conversion factor. Staff recommends that the 2024/2025 Fee Schedule continue using a multiple conversion factor model, consisting of one conversion factor for Anesthesia Services, a second for Surgery Services, a third for Radiology Services, and a fourth for all remaining service categories (including Pathology and Laboratory, Medicine, Physical Medicine and Rehabilitation, and Evaluation & Management).

The four recommended conversion factors for the 2024/2025 Fee Schedule are as follows:

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

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

Note: Additionally:

a) The recommended 2024/2025 Fee Schedule continues to incorporate by reference CMS's surgical global periods.

b) The recommended 2024/2025 Fee Schedule continues to assign RVUs to consultation services, recognizing the functional importance of these services. However, these consultation service codes observe the bundling principles used by CMS to avoid excessive reimbursement rates.

c) The recommended 2024/2025 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.
d) Codes unique to Arizona and not otherwise found in CPT® publication or HCPCS codes are preceded by an "AZ" identifier and numbered in the following format: AZxxx.

B. Adoption of Healthcare Common Procedure Coding System Codes and Assigned Reimbursement Values.

Staff recommends adoption of the service codes and reimbursement values contained in Table 9, found at: https://www.azica.gov/fee-schedule-public-comments-2024. This table provides the reimbursement values assigned to Healthcare Common Procedure Coding System (HCPCS) codes that includes procedures, supplies, products, and services.

The recommendations are based upon the reimbursement values published by CMS in the January 2024 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule (DMEPOS) and maintaining separate values for rural and nonrural areas. The methodology utilized by CMS to designate rural and nonrural areas was incorporated as well. HCPCS codes that did not have a reimbursement value in the DMEPOS, were assigned a reimbursement value using FAIR Health data.

These values are then multiplied by an Arizona conversion factor to produce a reimbursement value that establishes and maintains access to care, including procedures, supplies, products, and services for injured workers.

The recommended HCPCS conversion factor for the 2024/2025 Fee Schedule is 1.4.

Note: J-codes and S-codes are not assigned reimbursement values. J-codes describe administered medications. Medication will continue to be reimbursed according to the Pharmaceutical Fee Schedule Guidelines. Reimbursement for many Home Healthcare Services shall be negotiated between the payer and provider.

C. Continuation of Reimbursement Values for Arizona Specific Codes.

Staff recommends the continued use of the Arizona Specific Codes and reimbursement values contained in Table 10, found at: https://www.azica.gov/fee-schedule-public-comments-2024. This table provides the reimbursement values assigned to codes unique to Arizona and not otherwise found in the CPT® publication or HCPCS codes.

D. Continued Designation of Medi-Span® as the Publication for Purposes of Determining Average Wholesale Price.

Staff recommends that Medi-Span® continue to be used for determining Average Wholesale Price ("AWP") in the 2024/2025 Fee Schedule.

E. Adoption of Deletions, Additions, General Guidelines, and Identifiers of the CPT®

The recommended 2024/2025 Fee Schedule is based upon staff review of deletions and additions to the 2024 edition of CPT®. The recommended 2024/2025 Fee Schedule is intended to conform to changes that have taken place in the 2024 edition of CPT®.

Note: Recommended amendments to the Fee Schedule as described in Sections F – N of this memo are reflected in Exhibit A, attached.

F. Revisions to the Fee Schedule Guidelines

Staff recommends removing language referring to codes that are preceded by Δ in each of the Fee Schedule Guidelines. The codes and modifiers that were using this designation have been updated and use the standard language in adopted resources.

G. Amendments to the Introduction Guidelines.

Staff recommends amending the Introduction Guidelines of the Fee Schedule as follows:

Introduction Section

Remove the reference to the American Medical Association, Evaluation and Management Code and Guideline Changes. This document is no longer in publication.

Section A

Add Subsection A(2) that provides guidance on the codes health care providers should use when billing for services.

2. A CPT code shall be billed when a CPT code exists that accurately describes the service provided. If no CPT code exists that accurately describes the service, a HCPCS code shall be billed. A miscellaneous or unlisted code shall not be used when a specific CPT or HCPCS code exists that describes the service. Reimbursement values for unlisted codes are By Report and the bill must be accompanied by documentation to support the amount billed. Exceptions apply to the following services for which HCPCS codes should be used in place of CPT codes:

    - Drug testing: CPT codes 80320-80377 may not be used to bill for drug testing. HCPCS codes G0480 - G0483 shall be used for definitive drug testing.

Delete Subsection A(11).

Section B

Add Subsection B(5) that discusses adjusting reimbursement based on the documentation.

5. Health care providers shall bill the code that most accurately describes the service performed. If an insurance carrier, self-insured employer, or claims processing representative determines that the documentation submitted does not support the procedure code billed, the payment to the health care provider may be appropriately adjusted based on Fee Schedule reimbursement values. *See* A.R.S. § 23-1062.01. The payer shall provide documentation justifying the adjustment and clearly outline the process a health care provider may follow to appeal the determination. Payers shall not downcode medical billings under the Arizona Physicians' & Pharmaceutical Fee Schedule. Downcoding is defined as a payer changing a code in a payment remittance to a code at a lower service level than was billed by the healthcare provider. As applicable, the health care provider may resubmit the bill with documentation that addresses the reason for the adjustment.

Remove the links in Subsection B(9) and indicate the reference is the most current edition at the time the Fee Schedule is updated.

Section E

Remove Subsection E(1). Arizona statutes indicate who is permitted to treat injured workers.

Section J

Remove Subsection J(3). This designation is no longer used in the Fee Schedule.

H. Amendment to the Anesthesia Guidelines.

Staff recommends adding a note at the end of the guidelines to clarify billing practices.

> **Note:** Healthcare providers who provide additional services that are billed using CPT® codes 62320-62327 or 64400-64530 shall follow the Surgery Guidelines in this Fee Schedule.

I. Amendment to the Surgery Guidelines.

Staff recommends updating modifier "47" to clarify the manner in which it should be billed and reimbursed. Additional language was added that differs from the proposal after receiving a public comment that desired clarification on how frequently the code may be billed and the reference for reimbursement.

Staff recommends adding language to modifier "59" that clarifies how providers should bill for specific services that are reported on the same date of service as an anesthesia code.

> **Note:** If an epidural or peripheral nerve block injection (62320-62327 or 64400-64530) for postoperative pain management is reported separately on the same date of service as an anesthesia 0XXXX code, **modifier 59** shall be appended to the epidural or peripheral nerve block injection code (62320-62327 or 64400-64530) to indicate that it was administered for postoperative pain management. An epidural or peripheral nerve block injection (62320-62327 or 64400-64530) for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or postoperative pain management in patients receiving general anesthesia,

spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection as described above may be administered preoperatively, intraoperatively, or postoperatively.

J. Amendments to the Radiology Guidelines.

Staff recommends amending the language in Section C to clarify the meaning and use of the technical and professional components when they are billed separately.

K. Amendments to the Evaluation and Management Guidelines.

Staff recommends updating the language in the guidelines to correspond with the updates to the Evaluation and Management Guidelines in the 2024 CPT®.

L. Amendments to the HCPCS Guidelines.

Staff recommends removing language in Subsection A(3) that refers to Section J of the Introduction.

Staff recommends adding a note in Section B that clarifies the appropriate use and non-use of modifiers.

> **Note** that not all durable medical equipment will have modifiers. For example, certain supplies are low cost and therefore will not have used or rental options; other codes may have "rental" or "used" included in the code description.

M. Amendments to the Home Healthcare Guidelines.

Staff recommends adding guidelines that clarify how supplies are reimbursed and reinforce statutory guidance on billing and reimbursement for medical benefits.

5. Except when governed by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(J)(1), reasonably required supplies shall be reimbursed based on the HCPCS Guidelines. This includes supplies dispensed prior to the execution of an agreement and during times when preauthorization of services is in process.

6. Submission of invoices and reimbursement for invoices shall be made in accordance with A.R.S. § 23-1062.01 (See Section B of the Introduction).

N. Amendments to the Special Services Guidelines.

Staff recommends amending the title of this section to Arizona Specific Codes Guidelines.