

ICA Mailing list

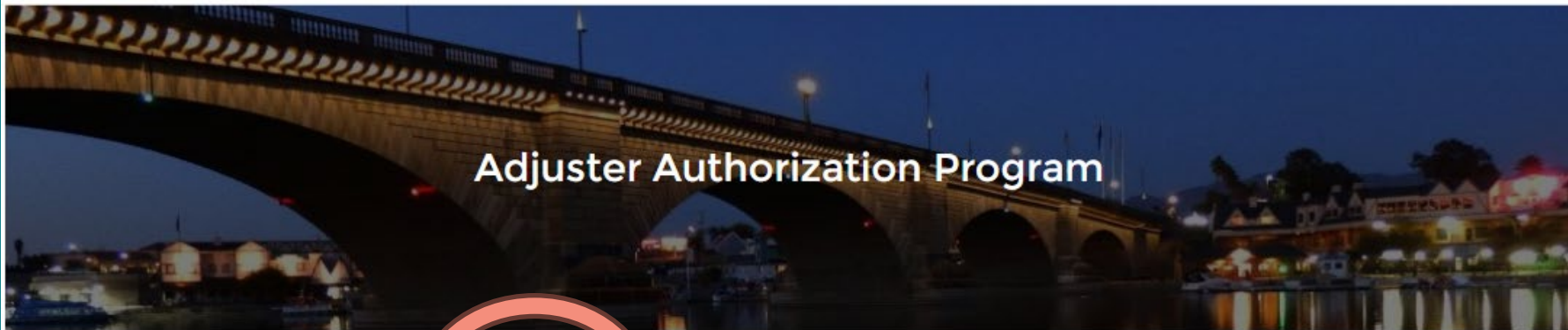


- Stay connected and find out What's New! Scan and Get registered for current news about the Industrial Commission of Arizona.

Current 2025 Claims Seminar Manual



- Scan and Download the current
- 2025 ICA Claims Seminar Manual



Adjuster Authorization Program

Program Information Internet Based Training **Class Registration**

To enroll in upcoming class webinar, click Upcoming Classes below.

Technical Requirements

The ICA uses the Google Suite; and webinars are conducted with Google Meets. The transition to G Suite may require participants to have a Google Account. Before the registering for a class, please confirm with your IT department that you are able to:

- Achieve connectivity to our resources such as the Google Meet. Install or use Google Chrome as it is the preferred browser.

If you experience problems after the above steps have been followed, feel free to contact the Commission at the number and/or email toward the bottom of this page.



**Adjuster Authorization?
Log into Community Account &
Register in 'Class Registration**

Celebrating 100 Years

INDUSTRIAL COMMISSION OF
ARIZONA

Medical Resource Office



About Me



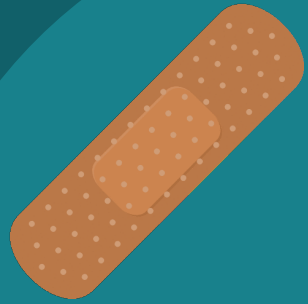
Valerie Ruiz MPH, RDH, PMP

The Program Manager of the MRO Division ICA. With more than two decades of experience in healthcare, she brings a wealth of clinical expertise and program management acumen to her role. Valerie holds a Master of Public Health (MPH), is a Registered Dental Hygienist (RDH), and maintains her Project Management Professional (PMP) certification.



Agenda

- **Initial Injury**
 - **Directing Care**
- **Ongoing Treatment**
 - **Documentation**
- **Fee Schedule**
 - **Payments**
- **Release from Active Care**



Initial Injury

A.R.S. § 23-908 (A)

Medical treatment does not include: onetime, short-term treatment by nonmedical staff that requires little technology or training to administer, including treatment of minor scratches, cuts, burns and splinters and other issues that ordinarily do not require medical care



Directing Care A.R.S. § 23-908(F)

An employer can direct an injured employee to a physician of the employer's choice for a one-time evaluation. Following that visit, the injured worker may return to that physician or pursue treatment with a physician of his/her choice.



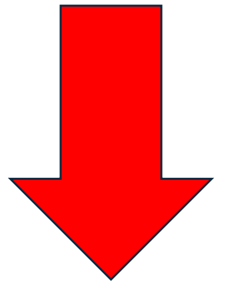
There are exceptions to this rule

Directing Care

Self-insured employer that has complied with the requirements of A.R.S. § 23-1070(F)



INDUSTRIAL COMMISSION OF
ARIZONA



List of Authorized Self-Insurers as of January 1, 2025

Self-Insurer Identification #	Self-Insurer Name (Company subsidiaries included but not listed)	Date of Authorization	Direct Medical Care?
SI00096	ABF Freight, Inc.	1/1/1980	✓
SI00232	Albertson's Companies, LLC (acquired Safeway, Inc. Safeway was self-insured since 1/1/1977)	9/1/2015	✓
SI00238	American Furniture Warehouse Co., Inc.	7/1/2019	
SI00176	Arizona Counties Insurance Pool	7/1/1994	
SI00198	Arizona Municipal Risk Retention Pool	7/1/1997	
SI00100	Arizona, State of (pursuant to A.R.S. §23-962)	7/1/1983	
SI00259	Banner Health	1/1/1995	✓
SI00177	BH Automotive LLC	4/1/1994	✓
SI00227	Central Arizona Water Conservation District (CAP)	1/1/2011	
SI00064	Chevron, U.S.A., Inc.	8/9/1996	
SI00236	City of Avondale	1/1/2018	
SI00215	City of Chandler	1/1/2003	
SI00175	City of Glendale	7/1/1994	
SI00094	City of Mesa	7/1/1982	
SI00225	City of Peoria	7/1/2009	
SI00216	City of Phoenix	4/1/2003	
SI00028	City of Scottsdale	7/1/1978	
SI00017	City of Tempe	7/1/1980	
SI00021	City of Tucson	7/8/1979	
SI00184	City of Yuma	10/1/1995	
SI00239	Concrete Reinforcements, Inc. (CRI)	2/1/2019	✓
SI00139	CostCo Wholesale Corporation	2/1/1991	✓
SI00228	DG Retail, LLC dba Dollar General	9/1/2011	
SI00068	Dignity Health	12/1/1991	✓
SI00132	Dole Food Company, Inc.	7/1/1989	
SI00008	Empire Southwest, LLC	4/1/1981	
SI00122	Federal Express Corporation dba FedEx Express, Inc. (Includes FedEx Ground Package System eff 4/1/2024)	1/15/1988	

Ongoing Treatment A.R.S. § 23-1062



“...shall receive [medical, surgical, and hospital benefits or other treatment...***reasonably required*** [emphasis added] at the time of the injury, and during the period of disability.”

Legible Medical Reports

A.R.S. § 23-908 (A)

“...full and complete report of every known injury to the employee arising out of or in the course of employment and resulting in loss of life or injury.”



Documentation A.R.S. § 23-1062.01

- ✓ Correct patient information
- ✓ Correct provider information
- ✓ Appropriate medical coding – values and units
- ✓ Date and dates of service
- ✓ Legible medical reports are required

The image shows a standard Health Insurance Claim Form (1500) with various fields for patient, provider, and insurance information. The form is titled "HEALTH INSURANCE CLAIM FORM" and includes sections for patient information, provider information, insurance details, and a table for medical services. The form is partially filled out with red text and checkboxes.

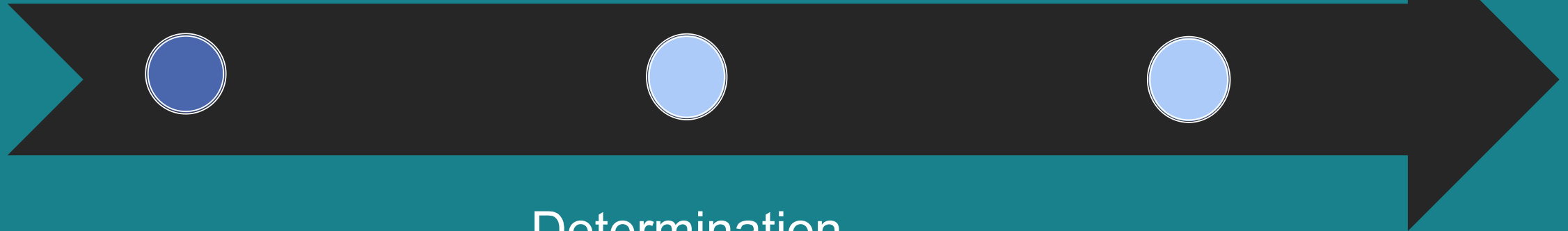
Reimbursement Timeline

A.R.S. § 23-1062.01



Invoice
Received

Payment 30 days
following determination



Determination

30 days following receipt or
acceptance of claim

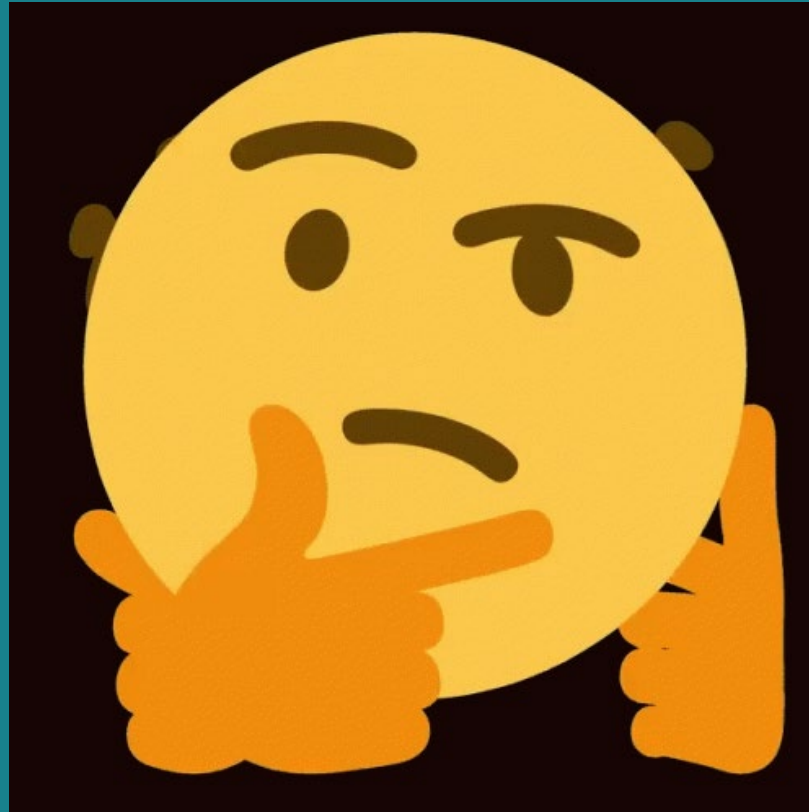


Fee Schedule

A.R.S. § 23-908(B)

“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.”

What's New in the 2025/2026 Fee Schedule?



Introduction

NEW

Added to Resources:

- The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)
- ICD-10 Version 2019

Section A(15) pg. 5

- Added additional guidance for mental health providers when establishing a diagnosis for injured workers In intro section A(15)



Physical Medicine & Rehabilitation

Addition to the bottom of C:

Reimbursement for therapeutic procedures in excess of the maximum, without prior approval, shall not affect reimbursement for therapeutic procedures performed within the allowed maximum.

NEW!

HCPCS Guidelines

DME items that are listed By Report, no listed value, or not included in FS:

- Shall be reimbursed at 140% of cost
- DME provider must include copy of original invoice
- Provider must disclose any rebates, reductions, discounts or relationship
- Reimbursement may also be predetermined agreement between the provider and payer



HCPCS Guidelines



A(8) was newly added to Reimbursement

Services that are listed as By Report, have no listed value, or are not included in the fee schedule, shall be reimbursed based on a predetermined agreement between the provider and the payer.

C(5) was added to Billing

Actual shipping or delivery costs necessary to transit DME to the injured worker may be billed *except those DME items described in Subsection (A)(7)*. Documentation demonstrating the cost of shipping shall be included with the invoice.

Misunderstood Sections of Fee Schedule

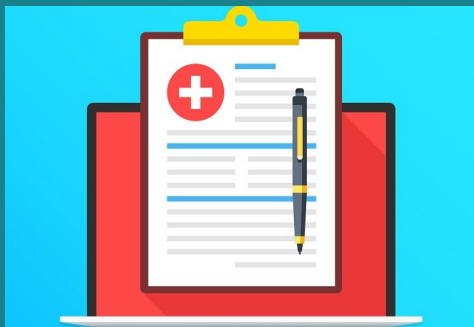


Ground Ambulance Services

A.R.S. § 36-2239



Arizona Specific Codes-AZ003/AZ004



Arizona Specific Codes-AZ005



Pharmaceutical Fee Schedule

A.R.S. § 32-1963.01(L)

Whenever possible:

- (1) medical practitioners should prescribe less costly drugs; and
- (2) pharmacies and medical practitioners (under Section VII) should dispense generic drugs with lower AWP values;
- (3) medical practitioners (under Section VI) should administer generic drugs with lower AWP values.



Pharmaceutical Fee Schedule Dispensed vs. Administered



ODG Drug Formulary

Home / Divisions / Medical Resource Office



Treatment Guidelines Information

[Flowcharts for Preauthorization, Reconsideration and Administrative Peer Review >](#)

[Treatment Guidelines Administrative Rules \(Article 13\) >](#)

[Medical Resource Office \(MRO\) Portal >](#)

[Medical Treatment Preauthorization Form >](#)

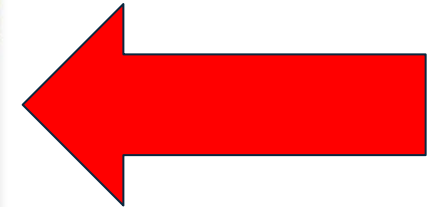


Official Disability Guidelines

[Official Disability Guidelines Information \(ODG\) >](#)

[ODG Drug Formulary >](#)

[ODG by MCG Homepage >](#)



ODG Drug Formulary

Formulary Opioid MED Calculator Drug Formulary - Appendix A

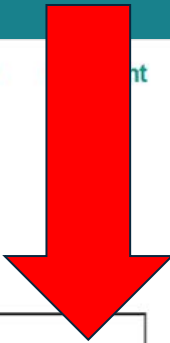
Drug Formulary (Appendix A)

Complimentary State Formulary Access

Show entries

Filter

Opioids	Tramadol	Ultram		Yes	Y
Opioids	Tramadol ER	Ultram ER		Yes	Y
Opioids	Tramadol ER, biphasic	ConZip/Ryzolt		No	N
Opioids	Tramadol/Acetaminophen	Ultracet		Yes	Y
Opioids	Ziconotide	Prialt	Morphine pump	No	N
Oral corticosteroids	Methylprednisolone	Medrol		Yes	Y
Oral corticosteroids	Prednisone	Prednisone		Yes	Y

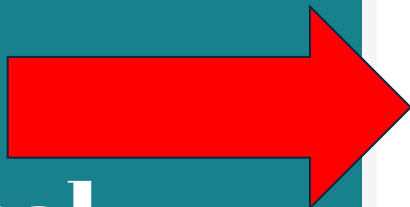


Treatment Guidelines

SECTION	 CODES	 GUIDELINES
Introduction		2025-2026 Fee Schedule Introduction (PDF)
Pharmaceutical Fee Schedule		2025-2026 Pharmaceutical Fee Schedule Guidelines (PDF)
Anesthesia CPT® 00100-01996 & 99100-99140	2025 Fee Schedule Anesthesia Codes (PDF)	2025-2026 Fee Schedule Anesthesia Guidelines (PDF)
Surgery CPT® 10004 – 69990	2025 Fee Schedule Surgery Codes (PDF)	2025-2026 Fee Schedule Surgery Guidelines (PDF)
Radiology CPT® 70010 - 79999	2025 Fee Schedule Radiology Codes (PDF)	2025-2026 Fee Schedule Radiology Guidelines (PDF)
Pathology/Laboratory CPT® 80047 – 89398 & G0480 – G0659	2025 Fee Schedule Pathology and Lab Codes (PDF)	2025-2026 Fee Schedule Pathology Guidelines (PDF)
Medicine CPT® 90281 – 96999 & 99000 – 99607	2025 Fee Schedule Medicine Codes (PDF)	2025-2026 Fee Schedule Medicine Guidelines (PDF)



MRO 1.1 Medical Treatment Preauthorization Form



INDUSTRIAL COMMISSION OF ARIZONA

MEDICAL TREATMENT PREAUTHORIZATION FORM

*Instructions for using this form are available [HERE](#)

SECTION I – PROVIDER REQUEST FOR PREAUTHORIZATION (PROVIDER TO COMPLETE/SUBMIT TO PAYER)		
PATIENT/EMPLOYEE INFORMATION		
Name (Last, First, Middle): _____		
Date of Injury (MM/DD/YYYY): _____	Date of Birth (MM/DD/YYYY): _____	
Payer Claim No. _____	Social Security Number: ¹ _____	
PROVIDER INFORMATION		
Name: _____	Contact Name: _____	
Phone: _____	Specialty: _____	
Preferred Method of Contact: <input type="checkbox"/> E-mail <input type="checkbox"/> Fax	E-mail or Fax: _____	
PAYER INFORMATION (Self-Insured Employer, Insurance Carrier, Third-Party Administrator, or Special Fund)		
Name: _____	Contact Name: _____	
Diagnosis/ICD Code	Treatment/Services Requested <input type="checkbox"/> Urgent <input type="checkbox"/> Routine	CPT/NDC Code
<input type="checkbox"/> I have attached documentation to support the medical necessity and appropriateness of the treatment/services requested.		
Original sent to Payer via: <input type="checkbox"/> U.S. Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Fax	Requested Treatment/Services Supported by ODG? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Payer Mailing Address, Fax, or Email: _____		
Provider Signature: _____	Date Sent: _____	
SECTION II – PAYER DECISION ON REQUEST FOR PREAUTHORIZATION (Payer Decision supported by IME? <input type="checkbox"/> Yes <input type="checkbox"/> No)		
Preferred Method of Contact: <input type="checkbox"/> E-mail <input type="checkbox"/> Fax	E-mail or Fax: _____	
Date Req. for Preauthorization Received: _____	ICA Claim No.: _____	
Payer Response: <input type="checkbox"/> Approved <input type="checkbox"/> Partially Denied <input type="checkbox"/> Denied <input type="checkbox"/> Request for Preauthorization Incomplete <input type="checkbox"/> IME Requested		
<input type="checkbox"/> I have attached a statement of the approved treatment/services or, if not approved, the reasons supporting a denial/partial denial.		
<input type="checkbox"/> Original sent to Provider via Provider's Preferred Method of Contact (see above).	Copy to: <input type="checkbox"/> Employee <input type="checkbox"/> Employee's Attorney	
Payer Signature: _____	Date Sent: _____	



INDUSTRIAL COMMISSION OF ARIZONA

MEDICAL TREATMENT PREAUTHORIZATION FORM

*Instructions for using this form are available [HERE](#)

SECTION I – PROVIDER REQUEST FOR PREAUTHORIZATION (PROVIDER TO COMPLETE/SUBMIT TO PAYER)

PATIENT/EMPLOYEE INFORMATION

Name (Last, First, Middle):

Date of Injury (MM/DD/YYYY): Date of Birth (MM/DD/YYYY):

Payer Claim No. Social Security Number:^{*1}

PROVIDER INFORMATION

Name: Contact Name:

Phone: Specialty:

Preferred Method of Contact: E-mail Fax E-mail or Fax:

PAYER INFORMATION
(Self-Insured Employer, Insurance Carrier, Third-Party Administrator, or Special Fund)

Name: Contact Name:

Diagnosis/ICD Code	Treatment/Services Requested <input type="checkbox"/> Urgent <input type="checkbox"/> Routine	CPT/NDC Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

I have attached documentation to support the medical necessity and appropriateness of the treatment/services requested.

Original sent to Payer via: U.S. Mail E-mail Fax Requested Treatment/Services Supported by ODG? Yes No Unknown

Payer Mailing Address, Fax, or Email:

Provider Signature: Date Sent:

Provider Signature:		Date Sent:
SECTION II – PAYER DECISION ON REQUEST FOR PREAUTHORIZATION (Payer Decision supported by IME? <input type="checkbox"/> Yes <input type="checkbox"/> No)		
Preferred Method of Contact: <input type="checkbox"/> E-mail <input type="checkbox"/> Fax		E-mail or Fax:
Date Req. for Preauthorization Received:	ICA Claim No.:	
Payer Response: <input type="checkbox"/> Approved <input type="checkbox"/> Partially Denied <input type="checkbox"/> Denied <input type="checkbox"/> Request for Preauthorization Incomplete <input type="checkbox"/> IME Requested		
<input type="checkbox"/> I have attached a statement of the approved treatment/services or, if not approved, the reasons supporting a denial/partial denial.		
<input type="checkbox"/> Original sent to Provider via Provider's Preferred Method of Contact (see above).		Copy to: <input type="checkbox"/> Employee <input type="checkbox"/> Employee's Attorney
Payer Signature:		Date Sent:



7 Business Days

SECTION III – PROVIDER OR EMPLOYEE REQUEST FOR RECONSIDERATION OF PAYER DECISION

I have attached a statement of the reasons and justifications supporting the Request for Reconsideration.

I have attached documentation to support the medical necessity and appropriateness of the treatment/services requested.

Original sent to Payer via Payer's Preferred Method of Contact (see Section II above).

Provider or Employee Signature:

Date Sent:

SECTION IV – PAYER DECISION ON REQUEST FOR RECONSIDERATION (Payer Decision supported by IME? Yes No)

Payer Response:

Approved Partially Denied Denied IME Requested

Date Req. for Reconsideration Received:

I have attached a statement of the approved treatment/services or, if not approved, the reasons supporting a denial/partial denial.

Original sent to Provider via Provider's Preferred Method of Contact (see above).

Copy to: Employee Employee's Attorney

Payer Signature:

Date Sent:

7 Business Days

SECTION V – PROVIDER OR EMPLOYEE REQUEST FOR ADMINISTRATIVE PEER REVIEW (SUBMIT TO ICA)

Reason for Request for Administrative Review:

Payer Non-Response Denial/Partial Denial of Requested Treatment/Services

I have attached copies of all relevant medical records and (if applicable) documentation related to Payer's non-response.

I have attached copies of all documentation and statements previously attached to Sections I-IV (above).

Original sent to ICA MRO via:

U.S. Mail (800 W. Washington St., Phoenix, AZ 85007) E-mail (MRO@azica.gov) Fax (602-542-4797)

Provider or Employee Signature:

Date Sent:

99% of all Peer Review requests are due to no response within 7 business days



Impairment Ratings R20-5-113(B)

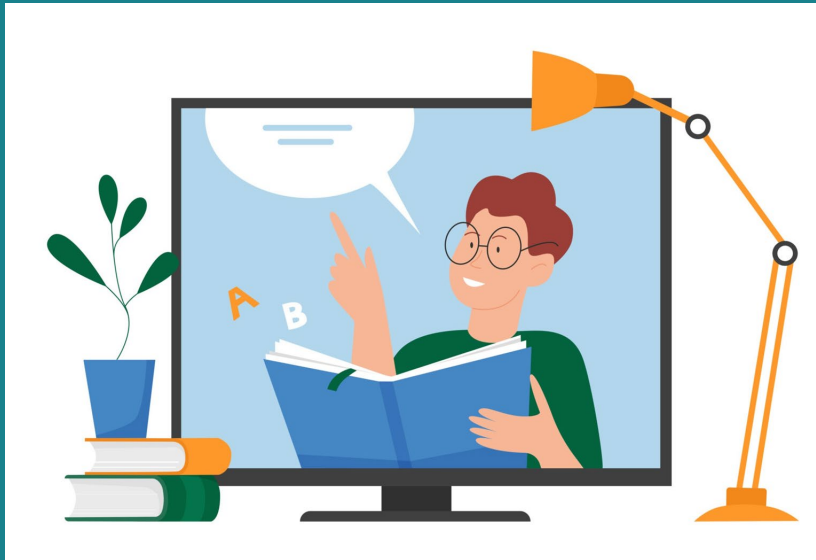
Shall determine whether the patient has sustained any impairment of function resulting from the industrial injury...

Shall provide a final signed report...that details the rating of impairment and the clinical findings that support the rating

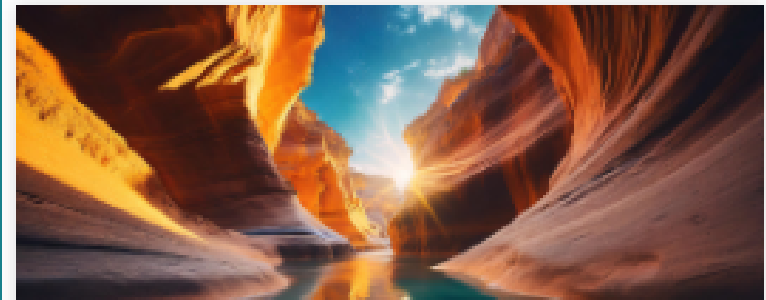
Informal Payment Dispute Resolution Program



Be On the Lookout



azica.gov



Sign up for News from
the Industrial
Commission of Arizona

[Click Here To Sign Up](#)

Big News for 2026 Fee Schedule



Dental Fee Schedule!!!!!!!!!!!!

Thank you

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