Industrial Commission of Arizona

Staff Recommendation

for

2026/2027 Arizona Physicians' and Pharmaceutical Fee Schedule

Medical Resource

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An additional file published on the Medical Resource Webpage contains the following tables, which are referenced in this report:

1. Anesthesia Codes and Anesthesia Conversion Factor (00100–99140)
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I. INTRODUCTION.

The information contained in this report is based on a review of various resources, including the following: (1) The 2026 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology associated with the incorporated codes; (2) The 2026 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); (4) The *2026 Clinical Diagnostic Laboratory Fee Schedule,* CMS Clinical Laboratory Fee Schedule; (5) The *National Correct Coding Initiative Edits,* CMS; (6) *Physicians as Assistants at Surgery: 2023 Update*; (7) Surgical global periods published by CMS, 2026 Update, (8) *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* was published by the American Psychiatric Association in March 2022, (9) ICD-10 Version: 2019: International Statistical Classification of Diseases and Related Health Problems 10th Revision published by the World Health Organization (WHO), (10) FAIR Health data, copyright 2026, FAIR Health, Inc. and (11) Current Dental Terminology© 2026 American Dental Association. All rights reserved.

This document includes the methodology for setting values of new and existing codes for Anesthesia, Surgery, Radiology, Pathology/Laboratory, Medicine, Physical Medicine, Evaluation and Management, Category III, HCPCS, and Dental Codes.

The Commission, will take formal action to adopt a 2026/2027 Physicians' and Pharmaceutical Fee Schedule ("2026/2027 Fee Schedule").

Note: The Commission is not permitted to include descriptors associated with five-digit CPT® codes or five-digit CDT© codes, nor is it permitted to publicly publish the CDT© codes. All rights reserved within this Fee Schedule.

II. STAFF RECOMMENDATIONS REGARDING THE 2026/2027 PHYSICIANS AND PHARMACEUTICAL FEE SCHEDULE.

A. Adoption of Updates to Relative Value Units, Base Units, and Reimbursement Values Assigned to CPT ® Codes.

Staff recommends the adoption of the service codes, Relative Value Units (RVUs), Anesthesia Base Units (BUs), and reimbursement values contained in Tables 1 through 8, published with the staff recommendation. These tables provide the reimbursement values assigned to Anesthesia, Surgery, Radiology, Pathology, Medicine, Physical Medicine and Rehabilitation, Evaluation and Management, and Category III services.

The Staff Recommendation is based upon the continued use of a resource-based relative value scale (RBRVS) reimbursement system for Tables 1 through 8 in which reimbursement values are calculated by multiplying "resources required to perform a service (RVUs or BUs)" by a dollar value conversion factor ("CF"). The recommended 2026/2027 Fee Schedule is based upon the following three-step methodology to assign reimbursement values for all applicable service codes:

STEP 1: Establishing RVUs or BUs for each service code. This was done using one of the two methods below:

a. Utilize applicable RVUs from the 2026 MPFS or BUs from the *2026 Anesthesia Base Units from 2026 CPT®*. The 2026 MPFS is the preliminary source for assigning and updating RVUs for all service codes.

b. Utilize applicable RVUs from the *2026 Clinical Diagnostic Laboratory Fee Schedule*. This method was used to update RVUs for most pathology and laboratory service codes.

STEP 2: Once RVUs and BUs were assigned to all service codes, reimbursement rates were calculated by multiplying the applicable RVU or BU by the appropriate Arizona-specific conversion factor. Staff recommends that the 2026/2027 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 2026/2027 Fee Schedule are:

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 certain service codes that could not be assigned a RVU using the two methods stated earlier. Service codes of this nature, which are not GAP codes, are identified as By Report (BR)[1], Bundled[2], and Not Established (RNE)[3].

STEP 3: Assign reimbursement values to GAP codes using FAIR Health data.

Note: Additionally:

a. The recommendation for the 2026/2027 Fee Schedule continues to incorporate by reference CMS's surgical global periods.

b. The recommendation for the 2026/2027 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 recommendation for the 2026/2027 Fee Schedule does not incorporate a geographic adjustment factor ("GAF") for codes that are valued utilizing RVUs, but instead uses the Arizona-specific conversion factor to adjust payment for the state. CMS utilizes one GAF for the entire State of Arizona.

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

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

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

Staff recommends the adoption of the service codes and reimbursement values contained in Table 9, published with the staff recommendation. This table provides the reimbursement values assigned to Healthcare Common Procedure Coding System (HCPCS) codes that include procedures, supplies, products, and services.

The Staff Recommendation is based upon the reimbursement values published by CMS in the January 2026 DMEPOS file and maintains 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 the reimbursement values listed in the table.

The recommendation for the HCPCS conversion factor for the 2026/2027 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. Adoption of Current Dental Terminology Codes and Assigned Reimbursement Values.

Staff recommends the adoption of the service codes and reimbursement values contained in Table 11. This table provides the reimbursement values assigned to Current Dental Terminology (CDT©) codes that describe dental procedures.

The Staff Recommendation is based upon reimbursement values from FAIR Health data reflecting the 70th percentile of billed charges for millions of dental services provided in Arizona during a recent 12-month period.

The recommended reimbursement values in the Dental Fee Schedule are equal to the 70th percentile of billed charges.

Note: The licensing agreement between the Industrial Commission of Arizona and the American Dental Association (ADA) does not allow public display of the CDT© codes contained in Table 11. Stakeholders may request a copy of the table by filling out a webform in the 2026 CDT© codes section https://www.azica.gov/arizona-physicians-fee-schedule-year-selector.

D. Adoption of Reimbursement Values for Arizona Specific Codes.

Staff recommends the adoption of the Arizona Specific Codes and reimbursement values contained in Table 10, published with the staff recommendation. This table provides the reimbursement values assigned to codes unique to Arizona and not otherwise found in the CPT® publication, CDT© publication, or HCPCS codes.

E. 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 2026/2027 Fee Schedule.

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

The recommendation for the 2026/2027 Fee Schedule is based upon staff review of deletions and additions to CPT®. The recommendation for the 2026/2027 Fee Schedule is intended to conform to changes that have taken place in the 2026 edition of CPT®.

Note: Recommended amendments to the Fee Schedule Guidelines as described in Sections II(F)– (I) of the Staff Recommendation are reflected in Exhibit A, attached.

G. Amendments to the Introduction Guidelines.

Staff recommends to amend the Introduction Guidelines of the Fee Schedule as follows:

Introduction Section

Add Dental Guidelines and Current Dental Terminology (CDT©) Codes to 2026/2027 Arizona Physicians' & Pharmaceutical Fee Schedule Table of Contents.

Add the sentence to the Introduction's first paragraph. In 2025, the Act was amended to include the setting of fees for durable medical equipment (DME) and dental care required to treat an injured employee.

Add to the Introduction second paragraph, second sentence, “doctors of dental surgery, doctors of medical dentistry” to incorporate the Dental Fee Schedule and Guidelines.

Add Current Dental Terminology © 2026 American Dental Association. All rights reserved to the list of resources that are incorporated by reference.

Add to the first paragraph, first sentence under the reference section, or the CDT© publication.

Add to the second paragraph, first sentence under the reference section, the American Dental Association.

Section A

Add subsection A(3) that provides guidance for the resources healthcare providers should use when billing a CDT© code.

3. A CDT© code shall be billed when a CDT© code exists that accurately describes the service provided. If no CDT© code exists that accurately describes the service, reimbursement shall be By Report. The bill from the Dentist must be accompanied by supporting documentation and the amount billed.

Add the word “maximum” to the first sentence of A(13) that provides the allowance for the reproduction of medical records for workers’ compensation clerical costs for reproducing documents.

Section B

Add the following to B(12) to provide guidance on disputes for contract reimbursement.

12. If a dispute regarding the existence of a contract occurs, the payer shall demonstrate that it is entitled to pay the contracted rate by providing a valid copy of the governing contract to the healthcare provider within 30 days of receipt of the provider’s appeal. If a payer fails to provide evidence that it is entitled to pay a contracted rate, within 30 days of receipt of the provider’s appeal, then the payer shall be required to make payment as provided in this Fee Schedule.

Section K

Add the following acronyms,

A.A.C.	Arizona Administrative Code
ASA	American Society of Anesthesiologists
CBC	Complete Blood Count

CDT©	Current Dental Terminology
CNS	Clinical Nurse Specialist
ED	Emergency Department
EHR	Electronic Health Record
GPI	Generic Product Identifier
ICU	Intensive Care Unit
MDM	Medical Decision Making
NCM	Nurse Case Manager
OT	Occupational Therapist
OTA	Occupational Therapy Assistant
PT	Physical Therapist
PTA	Physical Therapist Assistant
QHP	Qualified Healthcare Provider

H. <u>Amendments to the Pharmaceutical Guidelines.</u>

Staff recommends adding A(4) to provide guidance on general provisions and applicability of the Pharmaceutical Fee Schedule.

4. If more than one drug manufacturing company produces a medication that is prescribed to reasonably treat an injured worker, whenever possible, pharmacies should seek to procure the medication with the lowest AWP.

Staff recommends updating E(6)(a) reimbursement amount to two hundred and forty dollars ($240.00) for a 30-day supply of topical compound medication in the guidelines to incorporate inflation into reimbursement practices.

Staff recommends adding to section G, and over-the-counter (OTC), to provide guidance on the reimbursement for medication dispensed by a healthcare provider or in a pharmacy not accessible to the general public.

I. Amendments to the Physical Medicine and Rehabilitation Guidelines.

Staff recommends adding section A to the guidelines to provide guidance for NCCI edits.

A. Payers shall review the documentation from healthcare providers before denying any service(s) described by billing codes in this section due to NCCI edits. Except when specified by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(K)(1), documentation by healthcare providers supporting medically reasonable services that are performed separately to the same area may prevail and supersede NCCI edits for billing codes in this section. Payer denials for services described by CPT® codes in this section shall not be based solely on NCCI edits when documentation accompanies the healthcare provider's invoice.

Staff recommends adding section B to the guidelines to provide guidance on reimbursement.

B. Except when specified by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(K)(1), payers shall not reduce the Fee Schedule reimbursement for services provided by a physical therapy assistant (PTA).

J. Addition of the Dental Guidelines.

Staff recommends the addition of the Dental Guidelines.

Exhibit A

ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE

2026/2027

Recommendation

Adopted by The Industrial Commission of Arizona
Medical Resource Office
Phone (602) 542-4308 / Fax (602) 542-4797

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Effective May 1, 2026

2026/2027 ARIZONA PHYSICIANS' & PHARMACEUTICAL FEE SCHEDULE TABLE OF CONTENTS

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INTRODUCTION

Since 1925, when the Arizona Legislature passed the state's first Workers' Compensation Act ("Act"), the Industrial Commission of Arizona ("Commission") has administered the workers' compensation laws of that Act. The Act includes the authority of the Commission to set a schedule of fees to be charged by healthcare providers attending injured employees (also referred to in this document as "injured worker" or "claimant." A.R.S. § 23-908(B). In 2004, the Act was amended to include the setting of fees for prescription medicines required to treat an injured employee. A.R.S. § 23-908(C). In 2025, the Act was amended to include the setting of fees for durable medical equipment (DME) and dental care required to treat an injured employee. A.R.S. § 23-908(B).This fee schedule is referred to as the Arizona Physicians' and Pharmaceutical Fee Schedule (Fee Schedule).

Any reference to "healthcare providers" in the Fee Schedule is intended to include all licensed professionals whose scope of practice allows them to legally provide services to injured workers. Any reference to "physician" in relation to workers' compensation cases includes the following: doctors of medicine, doctors of osteopathy, doctors of podiatric medicine, doctors of chiropractic, doctors of naturopathic medicine, doctors of dental surgery, doctors of medical dentistry, certified registered nurse anesthesiologists, physician assistants and nurse practitioners. Healthcare providers treating employees under industrial coverage are entitled by law to charge according to the schedule of fees adopted by the Commission. Accurate calculation of fees based upon this schedule, the filing of reports and bills for payment, and the use of forms prescribed are essential to timely and correct payment for a provider's services and can be vital in the award of benefits to the injured worker and their dependents.

This Fee Schedule has been updated to incorporate by reference the following:

1. The 2026 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology associated with the incorporated codes

2. The 2026 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. The 2026 *Clinical Diagnostic Laboratory Fee Schedule,* CMS Clinical Laboratory Fee Schedule; https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/files

5. The *National Correct Coding Initiative Edits,* CMS;
~~https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual~~
https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual

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

7. Surgical global periods published by CMS, 2026 Update

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8. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* was published by the American Psychiatric Association in March 2022; https://www.psychiatry.org/Psychiatrists/Practice/DSM

9. ICD-10 Version: 2019: International Statistical Classification of Diseases and Related Health Problems 10th Revision published by the World Health Organization (WHO); https://icd.who.int/browse10/2019/en

10. FAIR Health data, copyright 2026, FAIR Health, Inc.

11. Current Dental Terminology, © 2026 American Dental Association. All rights reserved.

Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx. To the extent that a conflict may exist between an incorporated portion of the CPT® publication ~~or~~ HCPCS codes, or the CDT © publication and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier, or modifier shall control.

Except as otherwise noted, unit values assigned to the service codes listed in this document are the product of the Industrial Commission of Arizona and are not associated in any way with the American Medical Association, the American Society of Anesthesiologists, the Centers for Medicare and Medicaid Services, the American Dental Association, or any other entity or organization.

A. GENERAL GUIDANCE

1. Reimbursements and billing associated with Pharmaceuticals are found in the Pharmaceutical Fee Schedule Section and HCPCS Guidelines of this document.

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.

3. A CDT © code shall be billed when a CDT© code exists that accurately describes the service provided. If no CDT© code exists that accurately describes the service, reimbursement shall be By Report. The bill from the Dentist must be accompanied by supporting documentation and the amount billed.

4. Except when governed by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(K~~J~~)(1), this Fee Schedule establishes the maximum reimbursement values for services performed by healthcare providers to injured workers under Arizona's workers' compensation law.

5. If a healthcare provider or insurance carrier is referring an injured worker to a medical specialist for evaluation and/or treatment, the medical specialist's diagnosis becomes the foundational diagnosis for billing purposes.

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6. Routine progress and routine final reports filed by the attending healthcare provider do not ordinarily command a fee. Payment will be made for only one professional visit in any one (1) day except when the submitted report clearly demonstrates the need for the additional visit and fee.

7. Fees for hospital, office, or home visits, subsequent to the initial visit, are not to be added to coded surgical procedures performed on the same day.

8. Routine office treatment principally by injection of drugs, other than antibiotics, requires authorization by the carrier or self-insured employer for each series of ten (10) after the first series of ten (10).

9. Except in emergencies, a carrier must be given notice regarding a consultation and the consultant must provide his/her report to the carrier and the attending healthcare provider within a reasonable period of time to facilitate processing of the claim.

10. The Commission requests that carriers notify attending healthcare providers at the same time the claimant is notified that their claim is closed with or without supportive care. If a claim is approved for reopening, the carrier should also notify the attending healthcare provider of that approval.

11. Missed individual appointments for consultations, without prior notification, will be compensated at 50% of the consultation fee.

12. The Commission will investigate an injured worker's complaint of bad faith/unfair claims processing practices, and if appropriate, impose penalties under A.R.S. § 23-930, in those circumstances where a "peer to peer" review was not conducted by a healthcare provider with appropriate skill, training, and knowledge or where the individual performing the "peer to peer" review was not licensed. The Commission will also investigate an injured workers' complaint of bad faith/unfair claims processing practice, and if appropriate, impose penalties under A.R.S. § 23-930, for a denial of treatment based on the failure of the treating doctor to participate in a "peer to peer" review, when the treating doctor has not been given reasonable time or opportunity to participate in the "peer to peer" review.

13. As authorized under A.A.C. R20-5-128, the maximum fee for the reproduction of medical records for workers' compensation purposes shall be 25¢ per page and $10.00 per hour per person for reasonable clerical costs associated with locating and reproducing the documents.

14. Reimbursement values for telehealth services are governed by the Fee Schedule and no reductions are justified unless specified by the Fee Schedule. The performance of telehealth services is governed by Arizona Revised Statutes, Title 36, Chapter 36. Bills for telehealth services shall include modifier -95 and place of service (POS) code according to the incorporated AMA/CMS guidelines. Reimbursement for telehealth services shall be based on the non-facility (NF) rate regardless of the POS code.

15. Healthcare providers shall use the appropriate International Statistical Classification of Diseases and Related Health Problems (ICD-10 code(s)) published by the World Health Organization (WHO) to classify and code all diseases, signs, and symptoms, abnormal findings, social circumstances, and external causes of injury and/or

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disease. Mental health providers shall reference the most recent published version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) published by the American Psychiatric Association to define and classify mental disorders when establishing the appropriate ICD-10 code(s).

B. PAYMENT AND REVIEW OF BILLINGS

1. Under Arizona workers' compensation law, an insurance carrier, self-insured employer, or their representative is not responsible for payment of a billing for medical, surgical, and hospital benefits that the insurance carrier, employer, or representative received more than twenty-four (24) months from the date that the medical service was rendered, or from the date on which the provider knew or should have known that the service was rendered, whichever occurs later. A subsequent billing or corrective billing does not restart the limitations period. *See* A.R.S.§ 23-1062.01.

2. It is incumbent upon the insurance carrier, self-insured employer, and third party processing service to inform all parties, including the Commission, regarding changes in addresses for bill processing locations.

3. Under Arizona workers' compensation law, a healthcare provider is entitled to timely payment for services rendered. An insurance carrier, self-insured employer, or claims processing representative shall make a determination whether to deny or pay a medical bill on an accepted claim, in whole or in part, including the decision as to the amount to pay, within thirty (30) days from the date the claim is accepted, if the billing is received before the date of acceptance, or within thirty (30) days from the date of the receipt of the billing if the billing is received after the date of acceptance. All billing denials shall be based on reasonable justification. The insurance carrier, self-insured employer, or claims processing representative shall pay the approved portion of the billing within thirty (30) days after the determination for payment is made. If the billing is not paid within the applicable time period, the insurance carrier, self-insured employer, or claims processing representative shall pay interest to the health provider on the billing at a rate that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the healthcare provider is due. *See* A.R.S. § 23-1062.01.

   To ensure timely and accurate payment of a medical billing, a billing must contain the information required under A.R.S. § 23- 1062.01. A billing must contain at least the following information: Correct demographic patient information including claim number, if known; Correct provider information, including name, address, telephone number, and federal taxpayer identification number; Appropriate medical coding with dollar amounts and units clearly stated with all descriptions and dates of services clearly printed; and legible medical reports required for each date of service if the billing is for direct treatment of the injured worker.

4. Payment of a workers' compensation medical billing is governed by A.R.S. § 23-1062.01, which includes:

   a. Timeframes for processing and payment of medical bills;

   b. Criteria for billing denials;

   c. A provision that the injured worker is not responsible for payment of any portion of a medical bill on an accepted claim or payment of any portion of a medical billing that is being disputed;

   d. A provision that the insurance carrier or self-insured employer may establish an internal system for resolving payment disputes;

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e. A provision that A.R.S. § 23-1062.01 does not apply to written contracts entered into between healthcare providers and insurance carriers and self-insured employers or their representatives that specify payment periods or contractual remedies for untimely payments; and

f. A provision that the Industrial Commission does not have jurisdiction over contract disputes between the parties.

5. Healthcare 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 healthcare 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 healthcare 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.

6. "Reasonable justification" to deny a bill does not include the payment/billing policies of other private or public entities (publications) unless the publication has been incorporated by reference in the Fee Schedule.

7. Excluding bundling and unbundling issues, it is not the Commission's intent to restrict an insurance carrier's, self-insured employer's, or third party processing service's ability to address issues not addressed by the Fee Schedule. This includes evaluating unlisted procedures, establishing values for unlisted procedures, establishing values for codes that are listed as "BR" or "RNE", or new CPT® codes that have not been incorporated by the Industrial Commission, or managing issues outside the jurisdiction of the Fee Schedule, such as hospital billings.

8. Healthcare providers shall provide legible medical documentation and reports that are sufficient for insurance carriers/self-insured employers to determine if treatment is being directed towards injuries sustained in an industrial accident or incident. The healthcare provider shall ensure that their patients' medical files include the information required by A.R.S. § 32-1401(2). The healthcare provider is not required to provide copies of documents or reports that they did not author and that are not in their possession *(i.e.,* Employers' First Report of Injury).

9. Treating physicians shall submit a narrative that justifies the billing of a level four (4) or five (5) E/M service.

10. The Commission has incorporated by reference the Centers for Medicare and Medicaid Services, Evaluation and Management Services Guide, and the most current American Medical Association, Evaluation and Management Code and Guideline Changes. Medical billings shall be prepared and reviewed consistent with how these guidelines are used and interpreted by CMS. Additionally, payers are required to disclose any additional guideline(s) utilized in their Explanation of Reviews (or other similar document).

11. A payer's Explanation of Review (or other similar document) shall contain sufficient information to allow the healthcare provider to determine whether the amount of payment is correct and whom to contact regarding any questions related to the payment. Information in the Explanation of Review (or other similar document) shall include the following:

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a. The name of the injured worker;

b. The name of the payer and the name of the third party administrator ("TPA"), if applicable;

c. If applicable, the name, telephone number, and address of all entities that reviewed the medical billing on behalf of the payer;

d. If applicable, the name, telephone number, and address of the party that has a written contract signed by the healthcare provider that allows the contracting party or other third party to access and pay rates that are different from those provided under this Fee Schedule;

e. The amount billed by the healthcare provider;

f. The amount of any reduction due to a written contract with the healthcare provider; and

g. The amount of payment.

12. Nothing in this Fee Schedule precludes a healthcare provider from entering into a separate contract that governs fees. In this instance, reimbursement shall be made according to the applicable contracted charge. In the absence of a separate contract that governs a healthcare provider's fees, reimbursement shall be made according to this Fee Schedule. If a dispute regarding the existence of a contract occurs, the payer shall demonstrate that it is entitled to pay the contracted rate ~~in the event of a dispute~~ by providing a valid copy of the governing contract to the healthcare provider within 30 days of receipt of the provider's appeal. If a payer fails to provide evidence that it is entitled to pay a contracted rate, within 30 days of receipt of the provider's appeal, then the payer shall be required to make payment as provided in this Fee Schedule.

13. Billing and reimbursement guidelines for Pharmaceuticals are found in the Pharmaceutical Fee Schedule Section of this document.

14. The Fee Schedule does not apply to ambulance service providers. Service fees for ground ambulance transportation are set and mandated by the Arizona Department of Health Services through its Arizona Ground Ambulance Service Rate Schedule. A.R.S. § 36-2239~~1401~~(D) 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.

C. REIMBURSEMENT OF MID-LEVEL MEDICAL PROVIDERS

1. Certified Registered Nurse Anesthetists ("CRNAs") are reimbursed at 85% of the fee schedule.

a. Physician Assistants and Nurse Practitioners are reimbursed at 85% of the fee schedule, ***except*** if services are provided "incident to" a physician's professional services. In that instance, reimbursement is required to be at 100% of the fee schedule. The following criteria are identified as establishing the "incident to" exception:

b. The Physician Assistant and Nurse Practitioner must work under the direct supervision of an appropriately licensed physician,

c. The Physician must initially see that patient and establish a plan of care for that patient ("treatment plan"),

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d. Subsequent service provided by the Physician Assistant and Nurse Practitioner must be a part of the documented treatment plan, and

e. The Physician must always be involved in the patient's treatment plan and see the patient often enough to demonstrate that the Physician is actively participating in and managing the patient's care.

15. For purposes of the Fee Schedule, the Commission recognizes that direct supervision of a Physician Assistant or Nurse Practitioner by a Physician can be accomplished through the use of modern technology and telecommunications (telemedicine) and may not require the on-site presence of the Physician when the Physician Assistant or Nurse Practitioner sees the patient. In all instances, however, and regardless of the extent to which telemedicine is used, the Physician must actively participate in and manage the patient's care if services provided by a Physician Assistant or Nurse Practitioner are billed at 100% of the fee schedule under the "incident to" exception.

16. It is the responsibility of the Physician to document if the services provided by a Physician Assistant and Nurse Practitioner are "incident to" the Physician's professional service. If either the incident to criteria is not met, or the documentation submitted fails to support the "incident to" criteria, the reimbursement should be made at 85% of the fee schedule.

D. DIRECTED CARE AND USE OF NETWORKS

The Arizona Workers' Compensation Act only permits private self-insured employers to direct medical care. A.R.S. § 23-1070(F~~A~~); See also *Southwest Gas Corp. v. Industrial Commission of Arizona*, 200 Ariz. 292, 25 P.3d 1164 (2001).

This limitation on the scope of directed care means that employees of private self-insured employers do not have an unrestricted right to choose their own healthcare providers, while employees of all other employers do (includingpublic self-insured employers).[1] Notwithstanding an employee's right to choose, many workers' compensation insurance carriers ("carriers") and public self-insured employers ("employers") have taken advantage of "networks" to reduce their costs. This is done by either creating their own network of "preferred providers" or by contracting with a third party to access private healthcare networks.

Actions or conduct that impair or limit the right of an employee to choose their healthcare provider may rise to the level of bad faith and/or unfair claims processing practices under A.R.S. § 23-930. The Commission will investigate a complaint of bad faith/unfair claims processing practices, and if appropriate, impose penalties under A.R.S. § 23-930, in those circumstances where a carrier, employer, or TPA has engaged in conduct that results in directing a claimant to a "network" provider. The following are examples of conduct that the Commission would consider appropriate for investigation under A.R.S. § 23-930.

- A claimant is told that they must see a healthcare provider that is "in the network;"
- A claimant is told that care from a "non-network" healthcare provider is not authorized;

[1] It should be noted that the law governing directed care is not limited to "medical doctors," but instead applies to medical, surgical, and hospital benefits. *See* A.R.S. § 23-1070. The phrase, "medical, surgical, and hospital benefits" is defined in A.R.S. § 23- 1062(A), which states: "Promptly, on notice to the employer, every injured employee shall receive medical, surgical and hospital benefits or other treatment, nursing, medicine, surgical supplies, crutches and other apparatus, including artificial members, reasonably required at the time of the injury, and during the period of disability. Such benefits shall be termed "medical, surgical and hospital benefits".

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- A “network” healthcare provider is told that referrals are required to be made to another “network” healthcare provider
- A “network” healthcare provider is told that they may not recommend a “non-network” healthcare provider to a patient;
- A “non-network” healthcare provider is told that care will only be authorized if provided by a “network” provider; and
- A “non-network” healthcare provider is told that reimbursement will be made according to “network” discounts.

E. TREATMENT OF INDUSTRIAL INJURIES AND DISEASES

1. An employee who sustains an injury arising out of, or in the course of, employment is entitled, under Arizona law, to select a healthcare provider of his/her own choice unless that employee is employed by a private self-insured employer as described in A.R.S. § 23-1070. Employers described in A.R.S. § 23-1070, excluding the State or Political Subdivisions thereof, are allowed to direct medical care.

2. The attending healthcare provider’s promptness and professional exactness in the completion and filing of workers’ compensation forms are extremely important to the employee being treated. The injured or disabled employee’s claim to medical benefits and compensation can rest on the conscientious attention of the healthcare provider in processing the required reports. Rules addressing the completion of these forms are found in Title 20, Chapter 5, Article 1 of the Arizona Administrative Code, which can be obtained at: https://apps.azsos.gov/public_services/CodeTOC.htm#ID20

3. The Commission, the employer, and the insurance carrier may, at any time, designate a healthcare provider or healthcare providers to examine an employee. Additionally, upon application of the employer, employee, or insurance carrier, the Commission may order a change of healthcare provider or a change of conditions of treatment when there are reasonable grounds or a belief that the employee’s health or progress can thus be improved.

4. A claimant may not change doctors without the written authorization of the insurance carrier, the Commission, or the attending physician. A claimant may not transfer from one hospital to another without the written authorization of the insurance carrier or the Commission. If the patient’s employment requires leaving the locale in which he/she is receiving treatment, the attending physician should arrange for continued treatment and notify the carrier of such arrangement. It is the responsibility of the physician or the hospital to which a patient has transferred to ascertain whether such a change has been authorized.

5. Treatment of conditions unrelated to the injuries sustained in the industrial accident may be denied as unauthorized if the treatment seems directed principally toward the non-industrial condition or if the treatment does not seem necessary for the patient’s physical rehabilitation from the industrial injury.

6. If the patient refuses to submit to a medical examination or to cooperate with the healthcare provider’s treatments, the carrier or self-insured employer should be notified.

7. If an employee is capable of some form of gainful employment, it is proper for the healthcare provider to release

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the employee to light work and make a specific report to the carrier or self-insured employer as to the date of such release. It can be to the employee's economic advantage to be released to light work since he/she can receive compensation based on 66 2/3% of the difference between one's earnings and one's established wage. On the other hand, it would not be to the employee's economic advantage to be released to light work if, in fact, the employee is not capable of performing such work. The healthcare provider's judgment in such matters is extremely important.

8. If the employee no longer requires active medical care for the industrial injury and is discharged from treatment, the healthcare provider is required to provide a signed report with the date of discharge to the carrier or self-insured employer, even if, as a private patient, the employee may require further medical care for conditions unrelated to the industrial accident. This final report and discharge date are necessary for closing the claim file.

9. When a healthcare provider discharges a claimant from treatment, the healthcare provider shall determine whether the employee has suffered any impairment of function, or disfigurement about the head or face, including injury to or loss of teeth, and include this information in the final signed report provided to the carrier or self-insured employer. The Rules of Procedure Before the Industrial Commission of Arizona require that any rating of the percentage of functional impairment should be made in accordance with the standards of evaluation published in the most recent edition of the American Medical Association Guides to the Evaluation of Permanent Impairment. Additional guidance on appropriate billing and reimbursement for impairment evaluations is found in the Evaluation and Management Section of this document.

10. Once an exposure to a blood-borne pathogen occurs, the workers' compensation insurance carrier/self-insured employer is responsible for payment of the accepted treatment protocol which includes the HBIG vaccination (Hepatitis B Immune Globulin), and, if necessary, the three (3) Hepatitis B vaccinations.

    When a work-related incident occurs that may have exposed an employee to Hepatitis, the insurance carrier/self-insured employer is responsible for paying for the testing and/or treatment of Hepatitis B or C. As to the treatment of HIV, if a bona fide claim exists under A.R.S. § 23-1043.02, then the insurance carrier/self-insured employer is responsible for paying for the treatment.

11. It is the employer's responsibility, in accordance with existing OSHA standards, to pay for HIV testing. The insurance carrier may seek reimbursement from the employer for the costs associated with providing the series of three (3) Hepatitis B vaccinations if the employer failed to provide them in violation of federal and state laws.

F. REOPENING OF CLAIMS

1. Whether or not the employee has suffered a permanent disability, on a claim that has been previously accepted, the claim may be reopened on the basis of a new, additional, or previously undiscovered disability or condition, but:

    a. The claimant should use the form of petition prescribed by the Commission;

    b. The petition must be personally signed by the worker or his authorized representative and must be filed at any office of the Industrial Commission of Arizona;

    c. The petition, in order to be considered, must be accompanied by the healthcare provider's medical report.

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2. If the claim is reopened, the payment for such reasonable and necessary medical, hospital and laboratory work expenses shall be paid by the insurance carrier if such expenses are incurred within fifteen (15) days of the filing of the petition to reopen.

3. No monetary compensation is payable for any period prior to the date of filing of the petition to reopen. Surgical benefits are not payable for any period prior to the date of filing of a petition to reopen, except that surgical benefits are payable for a period prior to the date of filing not to exceed seven (7) days if a bona fide medical emergency precludes the employee from filing a petition to reopen prior to the surgery. Other information relative to reopening rights may be found at A.R.S. § 23-1061(H).

4. If a claim is approved for reopening, the carrier must notify the attending healthcare provider of that approval.

G. NO-INSURANCE CLAIMS

"No-Insurance" claims are workers' compensation claims involving injuries to employees of employers who do not have workers' compensation insurance coverage as required by Arizona law. In such cases, all claims and reports are to be addressed to the No-Insurance Section of the Special Fund of the Industrial Commission of Arizona.

H. CONSULTATIONS

Workers' compensation cases can present additional medical and legal problems that justify consultation sooner and more frequently than the average private patient. In complex cases and cases requiring an estimate of general or unscheduled disability, consultation with specialists in the appropriate field may be requested by any interested party. The Industrial Commission continues to recognize the necessity for consultations in workers' compensation and establishes relative value units and rates for consultation codes.

I. WITNESS FEES

1. Insurance providers, self-insured employers, and the Special Fund of the Commission are responsible for paying $150.00 for the first hour of testimony (or any portion thereof) and $50.00 for each twenty (20) minute increment following the initial hour (or any portion thereof) to a healthcare provider who testifies at hearing at their request.

2. The Commission is responsible for paying $150.00 for the first hour of testimony (or any portion thereof) and $50.00 for each twenty (20) minute increment following the initial hour (or any portion thereof) to a healthcare provider who testifies at hearing on request of a workers' compensation claimant.

J. DEFINITIONS OF SELECT UNIT VALUES

1. BY REPORT "BR" ITEMS: "BR" in the value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a unit relativity. Pertinent information concerning the nature, intent, and need for the procedure or service, the time, the skill and equipment necessary, etc., is to be furnished. A detailed clinical record is not necessary.

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

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3. MATERIALS AND SUPPLIES: 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.

   Drugs that are administered to patients in a clinical setting shall be billed using the appropriate HCPCS code and reimbursed according to the Pharmaceutical Fee Schedule Guidelines. The provisions in this subsection do not apply to hospitals, ambulatory surgery centers, and ambulance service providers.

   Examples of supplies that are usually not separately reimbursable include:

   Applied hot or cold packs
   Eye patches, injections, or debridement
   trays Steri-strips
   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
   Sterile trays for laceration repair and more complex surgeries, Tape for dressings

4. MODIFIERS: A two-digit (numeric or alpha) sequence that provides the means by which the reporting healthcare provider can specify that a procedure performed has been altered under a special circumstance. This allows defining the modifying circumstance of the service or procedure without creating a separate procedure or listing.

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Modifier Examples

Professional Component (PC): Certain procedures are a combination of a physician, or Professional component and a technical component. When modifier 26 is added to an appropriate code, a PC allowable amount will be paid.*Technical Component (TC):* The TC component reflects the technical portion of the procedure code. When the technical component is provided by a healthcare provider other than the one providing the professional component, the healthcare provider bills for the technical component by adding modifier TC to the applicable code.

K. LIST OF ACRONYMS

A.A.C.	Arizona Administration Code
AMA	American MedicalAssociation
APA	American Psychological Association
A.R.S.	Arizona Revised Statute
AS	Assistant Surgeon
ASA	American Society of Anesthesiologists
AWP	Average Wholesale Price
AZ	Arizona
BR	By Report
CBC	Complete Blood Count
CCI	Current Coding Initiative (National)
CDT©	Current Dental Terminology
CF	Conversion Factor
CMS	Centers for Medicare & Medicaid Services
CNS	Clinical Nurse Specialist
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
DME	Durable Medical Equipment
DSM-5-TR	Diagnostic and Statistical Manual of Mental Disorders
ED	Emergency Department
EHR	Electronic Health Record
E/M	Evaluation and Management Services
FCE	Functional Capacity Evaluation
FDA	Food and Drug Administration
FUD	Follow-up day(s)
GPI	Generic Product Identifier
HBIG	Hepatitis B Immune Globulin
HCPCS	Healthcare Common Procedure Coding System
HIV	Human Immunodeficiency Virus
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ICU	Intensive Care Unit
IME	Independent Medical Examination

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MDM	Medical Decision Making
MPFS	Medicare Physician Fee Schedule
MRI	Magnetic Resonance Imaging
NCCI	(See CCI)
NCM	Nurse Case Manager
NDC	National Drug Code
NF	Non-Facility
NP	Nurse Practitioner
ODG	Official Disability Guidelines
OSHA	Occupational Safety and Health Association
OT	Occupational Therapist
OTA	Occupational Therapy Assistant
OTC	Over-the-Counter
PA	Physician Assistant
PC	Professional Component
PFS	Pharmaceutical Fee Schedule
POS	Place of Service
PT	Physical Therapist
PTA	Physical Therapist Assistant
QHP	Qualified Healthcare Provider
RBRVS	Resource-Based Relative Value Scale
RNE	Relativity Not Established
RVU	Relative Value Unit
TC	Technical Component
TPA	Third Party Administrator
WHO	World Health Organization

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PHARMACEUTICAL FEE SCHEDULE

A. GENERAL PROVISIONS AND APPLICABILITY OF THE PHARMACEUTICAL FEE SCHEDULE.

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

2. Medications 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 Industrial Commission of Arizona has adopted the Official Disability Guidelines (ODG), 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). Healthcare providers are encouraged to consult the ODG Formulary before dispensing, administering, or prescribing medications to injured employees.

3. Generic drugs must be dispensed or administered to injured employees when appropriate, consistent with A.R.S. § 32-1963.01(A)[1], (B), and (D) through (L)[2]. *See* A.R.S. § 23-908(C). For purposes of this subsection, the definitions in A.R.S. § 32- 1963.01(L) apply[3]. Whenever possible: (1) healthcare providers should prescribe less costly drugs; (2) pharmacies and healthcare providers (Section G) should dispense generic drugs with lower AWP values; and (3) healthcare providers (Section F) should administer generic drugs with lower AWP values.

4. If more than one drug manufacturing company produces a medication that is prescribed to reasonably treat an injured worker, whenever possible, pharmacies should seek to procure the medication with the lowest AWP.

[1] A.R.S. § 32-1963.01(A) states: "If a medical practitioner prescribes a brand name drug and does not indicate an intent to prevent substitution as prescribed in subsection E of this section, a pharmacist may fill the prescription with a generic equivalent drug."

[2] A.R.S. § 32-1963.01(E) states: "A prescription generated in this state must be dispensed as written only if the prescriber writes or clearly displays 'DAW', 'dispense as written', 'do not substitute' or 'medically necessary' or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form. A prescription from out of state or from agencies of the United States government must be dispensed as written only if the prescriber writes or clearly displays 'do not substitute', 'dispense as written' or 'medically necessary' or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form."

[3] A.R.S. § 32-1963.01(L) states, in part:

2. "Brand name drug" means a drug with a proprietary name assigned to it by the manufacturer or distributor.

5. "Generic equivalent" or "generically equivalent" means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects. Generic equivalent or generically equivalent does not include a drug that is listed by the United States food and drug administration as having unresolved bioequivalence concerns according to the administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

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B. DEFINITIONS.

1. “Administer” has the meaning set forth in A.R.S. 32-1901(1).
2. “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.
3. “Commercially available” means a drug product is widely available for purchase in pharmacies accessible to the general public, including in brick and mortar pharmacies accessible to the general public.
4. “Compound medication” means a pharmaceutical product created by virtue of mixing or combining drugs and/or components to meet the unique needs of an individual patient when the finished product does not recreate a commercially available product.
5. “Dispense” or “dispensing” means to deliver to an ultimate user by or pursuant to the lawful order of a healthcare provider, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare for that delivery. *See* A.R.S. § 32-1901(27).
6. “Drug” has the meaning set forth in A.R.S. § 32-1901(31).
7. “Hospital” means any institution for the care and treatment of the sick and injured that is approved and licensed as a hospital by the Arizona Department of Health Services. See A.R.S. § 32-1901(45).
8. “Healthcare provider” means any person who is permitted/licensed and authorized by law to use and prescribe prescription medications, acting within the scope of such authority, for the treatment of sick and injured human beings or for the diagnosis or prevention of sickness in human beings in the State of Arizona or any U.S. state, territory or district. *See* A.R.S. § 32-1901(56).
9. “Non-traditional strength” medication means a finished drug product in a strength (*i.e.,* dosage) that is not commercially available in pharmacies accessible to the general public.
10. “Over-the-counter medication” or “OTC medication” means a finished drug product, including label and container according to context, which does not require a prescription order.
11. “Pharmacy” has the meaning set forth in A.R.S. § 32-1901(74).
12. “Pharmacy accessible to the general public” means a pharmacy that is readily accessible and provides pharmaceutical services (including prescription medication services) to all segments of the general public without restricting services to a defined or exclusive group of consumers, including but not limited to consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner. This definition includes mail order pharmacies delivering pharmaceutical services to workers’ compensation claimants if both of the following apply

    a. The pharmacy does not limit or restrict access to claimants with an affiliation to a medical provider or other entity.
    b. Any healthcare provider or other entity referring a claimant to the pharmacy does not receive or accept any rebate, refund, commission, preference, or other consideration as compensation for the referral.

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13. "Pharmacy not accessible to the general public" means a pharmacy that provides pharmaceutical services (including prescription medication services) only to a defined or exclusive group of consumers, including but not limited to consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner. "Pharmacy not accessible to the general public" does not include a hospital pharmacy. This definition does not include mail order pharmacies delivering pharmaceutical services to workers' compensation claimants if both of the following apply:

    a. The pharmacy does not limit or restrict access to claimants with an affiliation to a medical provider or other entity.

    b. Any medical provider or other entity referring a claimant to the pharmacy does not receive or accept any rebate, refund, commission, preference, or other consideration as compensation for the referral.

14. "Prescription" means either a prescription order or a prescription medication. *See* A.R.S. § 32-1901(83).

15. "Prescription medication" means any drug, including label and container according to context, which is dispensed pursuant to a prescription order. *See* A.R.S. § 32-1901(84).

16. "Prescription order" shall have the meaning set forth in A.R.S. § 32-1901(87).

17. "Repackaged medication" means a finished drug product removed from the container in which it was distributed by the original manufacturer and placed into a different container without further manipulation of the drug. The term also includes the act of placing the contents of multiple containers of the same finished drug product into one container. The term also includes "co-pack drug" products which contain two or more separate finished medications that are contained in a single package or unit. The term does not include a drug that is manipulated in any other way, including if the drug is reconstituted, diluted, mixed, or combined with another ingredient.

18. "Therapeutically-similar" medication means a medication that is expected to produce a clinical effect comparable to the original product. Key considerations for determining the "most therapeutically-similar" medications are: (1) the similarity of the clinical effects; (2) the extent to which active ingredients overlap; (3) the similarity of the dosage profiles; and (4) the similarity of the mode of administration; and (5) the similarity of the intended strength.

19. "Traditional strength" medication means a finished drug product in a formulation that is commercially available in pharmacies accessible to the general public.

20. "Ultimate user" means a person who lawfully possesses a prescription medication for that person's own use or for the use of a member of that person's household. *See* A.R.S. § 32-1901(100).

C. GENERAL GUIDELINES FOR BILLING AND REIMBURSEMENT OF PRESCRIPTION MEDICATIONS.

1. Except as permitted in Sections F and G of the current PFS, an insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications only if all of the following apply:

    a. The prescription medication is dispensed by an individual who is currently licensed to practice the profession of pharmacy by either: (i) the Arizona State Board of Pharmacy; or (ii) an equivalent regulatory agency in another U.S. state, territory, or district; and

    b. The prescription medication is dispensed by a pharmacy accessible to the general public, including online or mail-order pharmacies that are accessible to the general public.

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2. Subject to Sections C(7), D, E, and F(2), reimbursement for prescription medications shall be based on the actual medication dispensed or administered, including a substituted medication that is dispensed or administered pursuant to A.R.S. § 32-1963.01.

3. Except as specified in Sections D and E of the current PFS, a pharmaceutical bill submitted for a prescription medication must include the National Drug Code (NDC) of the original manufacturer registered with the U.S. Food & Drug Administration (FDA), the quantity dispensed, and the reimbursement value of the medication. Under no circumstance shall an NDC other than the original manufacturer's NDC be used.

4. The reimbursement value for prescription medications shall be based on the current PFS reimbursement methodology in the absence of a contractual agreement between the pharmacy or healthcare provider and payer governing reimbursement. Network discounts may not be applied in the absence of a contractual agreement with the pharmacy or healthcare provider authorizing such discounts.

5. The reimbursement value for a prescription medication shall be determined on the date a drug is dispensed from pricing published in the most recent issue, as updated in the most recent update, of a nationally recognized pharmaceutical publication designated by the Commission. For purposes of determining AWP, the Commission has selected Medi-Span®.

6. The reimbursement value for a prescription medication shall be determined by reference to the original manufacturer's NDC and shall be calculated on a per unit basis as follows:

   a. Generic drugs:
      - (75% of AWP per unit) x (number of units dispensed).

   b. Brand name drugs:
      - (85% of AWP per unit) x (number of units dispensed).

7. Reimbursement for non-traditional strength prescription medications shall be calculated on a per unit basis, as of the date of dispensing or administering, based on the original manufacturer's NDC and corresponding AWP of the most therapeutically-similar traditional strength form of the same medication. Under no circumstance shall the NDC of the non-traditional strength medication be used.

8. The reimbursement value for OTC medications shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the OTC medication in settings where the medication is commercially available.

9. Subject to Section C(10), the reimbursement value for OTC medications that are not commercially available in pharmacies accessible to the general public shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the most therapeutically-similar OTC medication commercially available in pharmacies accessible to the general public. Under no circumstance shall the NDC or AWP of the non-commercially available OTC medication be used.

10. The reimbursement value for OTC medications that are not commercially available may not exceed:

    a. Thirty dollars ($30.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for a topical cream or lotion.

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b. Seventy-five dollars ($75.00) for a thirty-day supply (or a pro-rated amount if the supply is greater or less than thirty days) for topical patches.

D. BILLING AND REIMBURSEMENT FOR REPACKAGED MEDICATIONS.

1. 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.

2. If a pharmaceutical bill for a repackaged medication is submitted without the original manufacturer's NDC, the payer has the discretion to determine the appropriate NDC (and corresponding AWP) to use or, alternatively, may deny coverage until the appropriate NDC is furnished.

3. The reimbursement value for a repackaged medication shall be based on the current PFS reimbursement methodology contained in Section C of the PFS, utilizing the NDC(s) and corresponding AWP(s) of the original manufacturer(s).

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

E. BILLING AND REIMBURSEMENT FOR COMPOUND MEDICATIONS.

1. 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. All component ingredients of a compound medication must be billed on a single bill.

2. The reimbursement value for a compound medication shall be calculated at the component ingredient level. The reimbursement value for a compound medication shall be based on the sum of the reimbursement values of each component ingredient and the corresponding component ingredient's NDC, based on the current PFS reimbursement methodology set forth in Section C.

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

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

5. If any component ingredient in a compound medication is a repackaged medication, the reimbursement value for the repackaged medication ingredient shall be determined based on the current PFS reimbursement methodology set forth in Section C, using the AWP corresponding to the NDC of the original manufacturer. *See* Section D.

6. The maximum reimbursement value for a topical compound medication shall be the lesser of:

   a. Two hundred and forty dollars ($2~~0~~40.00) for a 30-day supply (or a pro-rated amount if the supply is greater or less than 30 days), or

   b. The reimbursement value of the compound medication as calculated under this section.

Recommendation

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F. BILLING AND REIMBURSEMENT FOR MEDICATIONS ADMINISTERED BY A HEALTHCARE PROVIDER.

1. A pharmaceutical bill submitted for a medication administered by a healthcare provider must comply with billing procedures outlined in Sections C, D, and E of the current PFS, as applicable.

2. The reimbursement value for a medication administered by a healthcare provider shall be based on the current PFS reimbursement methodology contained in Sections C, D, and E of the PFS, as applicable.

G. REIMBURSEMENT FOR MEDICATIONS DISPENSED BY A HEALTHCARE PROVIDER OR IN A PHARMACY NOT ACCESSIBLE TO THE GENERAL PUBLIC.[4,5]

1. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription and over-the-counter (OTC) medications that are dispensed by a healthcare provider or in a pharmacy not accessible to the general public if all of the following apply:

   a. The prescription and over-the-counter (OTC) medication is dispensed by a healthcare provider or a pharmacy not accessible to the general public to the injured employee within seven days of the date of the industrial injury;

   b. The prescription and over-the-counter (OTC) medication is limited to no more than a one-time, ten-day supply;

   c. The prescription and over-the-counter (OTC) medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.

2. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription and over-the-counter (OTC) medications that are dispensed by a healthcare provider or in a pharmacy not accessible to the general public if all of the following apply:

   a. The injured employee does not have access to a pharmacy accessible to the general public within 20 miles of the injured employee's home address, work address, or the address of the prescribing healthcare provider;

   b. The injured employee cannot reasonably acquire the prescription and over-the-counter (OTC) medication from an online or mail order pharmacy accessible to the general public; and

   c. The prescription and over-the-counter (OTC) medication conforms to dosages and formulations which are commercially available in pharmacies accessible to the general public.

[4] Dispensing pursuant to Section G is subject to the Arizona Opioid Epidemic Act, which imposes statutory limits on the prescribing and dispensing of schedule II opioids. For more information about the Arizona Opioid Epidemic Act, please see the FAQs published by the Arizona State Board of Pharmacy, available at:
https://pharmacypmp.az.gov/sites/default/files/2022-03/Opioid%20Epidemic%20Act%20FAQs%20022819.pdf

[5] Section G sets forth reimbursement guidelines for medications dispensed in settings that are not accessible to the general public in Arizona's workers' compensation system and does not interfere with a medical practitioner's ability to dispense medications pursuant to A.R.S. § 32-1491 or seek payment from sources unrelated to workers' compensation.

Recommendation

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3. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription and over-the-counter (OTC) medications that are dispensed by a healthcare provider or in a pharmacy not accessible to the general public if the dispensing of a prescription and over-the-counter (OTC) medication for an individual claim and specified duration has been pre-approved in writing by the insurance carrier, self-insured employer, or the Special Fund of the Commission. Nothing in this section requires an insurance carrier, self-insured employer, or the Special Fund of the Commission to pre-approve the dispensing of prescription and over-the-counter (OTC) medications under this subsection.

4. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription and over-the-counter (OTC) medications that are dispensed by a pharmacy not accessible to the general public if all of the following apply:

   a. The prescription and over-the-counter (OTC) medication was dispensed to an injured employee whose workers' compensation claim was initially denied by the carrier, self-insured employer, or the Special Fund of the Commission;

   b. The injured employee protested the claim denial by filing a timely request for hearing;

   c. The workers' compensation claim was either: (a) subsequently accepted by the carrier, self-insured employer, or the Special Fund of the Commission; or (b) the claim was found to be compensable by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court;

   d. The prescription and over-the-counter (OTC) medication was dispensed during the time period between: (a) the initial claim denial and (b) the subsequent acceptance of the claim or the compensability determination by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court; and

   e. The prescription and over-the-counter (OTC) medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.

5. The guidelines in Section C(1) and this section do not apply to prescription and over-the-counter (OTC) medications dispensed during in-patient hospital care or upon discharge from in-patient hospital care.

6. Subject to the limitations in this section, medications that have been provided as free samples to a healthcare provider may be dispensed to an injured employee when appropriate, but are not reimbursable.

H. DISPENSING FEE.

1. If a prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars ($7.00) per prescription medication, repackaged medication, or compound medication may be charged. The dispensing fee does not apply to OTC medications that are not prescribed by a healthcare provider.

2. If a prescription medication is dispensed by a healthcare provider or in a pharmacy not accessible to the general public pursuant to Section G(1), (2), or (3), a dispensing fee of up to seven dollars ($7.00) per prescription medication, repackaged medication, or compound medication may be charged. If an OTC medication is dispensed by a healthcare provider or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.

Recommendation

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3. If a prescription or OTC medication is administered by a healthcare provider, a dispensing fee is not permitted.

I. ADDITIONAL BILLING GUIDELINES.

1. Paper billing by a physician:

   The following is an example of how to report both the repackaged NDC and original NDC on the CMS 1500 form using the shaded area of line 24. The information is reported in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code."

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H.	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N455289047590 UN30 ORIGN400025152531													N	G2	12345678901
10	01	05	10	01	05	11		J3490		A	500 00	30	N	NPI	0123456789

   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 (in the required order) separately or as an attachment to the CMS 1500 form.

2. Paper billing by non-physician entities.

   A non-physician entity using paper billing to bill for medications shall use the most recent version of the Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) adopted by the National Council for Prescription Drug Programs.

J. SEVERABILITY CLAUSE.

If any provision of the Pharmaceutical Fee Schedule or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application of the Pharmaceutical Fee Schedule which can be given effect without the invalid provisions or application, and to this end the provisions of this Pharmaceutical Fee Schedule are severable.

Recommendation

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PHYSICAL MEDICINE AND REHABILITATION GUIDELINES

Information regarding publications incorporated by reference is found in the Introduction Section of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to physical medicine and rehabilitation services. To the extent that a conflict may exist between an incorporated portion of the CPT® and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control. Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx.

General requirements on reporting services are found in the Introduction of the Fee Schedule. In addition to the definitions and commonalities preceding the coded medical procedures, several other requirements unique to this Section (Physical Medicine and Rehabilitation) are defined or identified as follows:

A. Payers shall review the documentation from healthcare providers before denying any service(s) described by billing codes in this section due to NCCI edits. Except when specified by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(K)(1), documentation by healthcare providers supporting medically reasonable services that are performed separately to the same area may prevail and supersede NCCI edits for billing codes in this section. Payer denials for services described by CPT codes in this section shall not be based solely on NCCI edits when documentation accompanies the healthcare provider's invoice.

B. Except when specified by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(K)(1), payers shall not reduce the Fee Schedule reimbursement for services provided by a physical therapist assistant (PTA) or occupational therapy assistant (OTA). Modifiers CQ and CO are not required when submitting an invoice for services provided by PTAs and OTAs.

C. Physical therapy (PT) evaluation codes (97161-97163) and occupational therapy (OT) evaluation codes (97165-97167) are billed at the initial visit and a re-evaluation code (97164 for PT, 97168 for OT) may be billed once every two (2) calendar weeks following an initial evaluation. Additional billing for PT and OT evaluation services may be allowed when specific additional services are warranted. Approval of the payer must be obtained prior to performing additional services. Criteria to select the appropriate evaluation and re-evaluation codes are outlined in the current CPT® publication.

   Note: These limitations do **not** apply to referring healthcare providers or to providers who treat patients once per month.

D. When multiple modalities (untimed 97012-97028 and/or time-based 97032-97036) are performed, the first modality (or the first unit of a time-based modality) is reported as listed. The second modality (or the second unit of a time-based modality) is identified by adding modifier -51 to the code number. The second and each subsequent modality (or unit(s) of a time-based modality) should be valued at fifty percent (50%) of its listed value.

   First modality reported or first unit of a time-based modality -100%
   Second, third, and additional approved modality or unit(s) - 50%

   Any more than three (3) modalities or more than three (3) units of a time-based modality or any combination of time-based and untimed modalities equaling three (3) billed units per body part being treated must have prior approval from the payer. The time a healthcare provider bills for a time-based modality (97032-97036) does not count towards the total timed therapeutic procedure maximum of four (4) units or 67 minutes. However, the time spent performing time-based modalities counts towards the total treatment time and should be used to determine the number of units a provider bills (*see* Section E and Example 5). **The amount of time spent performing each specific procedure or modality provided to the patient is not required to be documented in the treatment notes** (*see* Section G**).**

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Recommendation

Note: 97010 is a bundled service and not separately reportable.

Example:

During a visit, a patient receives the following services:
45 minutes therapeutic exercise 97110
15 minutes mechanical traction 97012
15 minutes unattended electrical stimulation 97014
10 minutes ultrasound 97035
15 minutes moist heat 97010 while receiving the electric stimulation

Under the multiple modality rule, the healthcare provider would bill:

97110	3 units at 100% of value (therapeutic procedure, timed code)
97012	1 unit at 100% of value (modality, untimed code)
97014	1 unit at 50% of value (modality, untimed code)
97035	1 unit at 50% of value (modality, timed code)

97010 is bundled into the above services and not paid as a separate service. The total time spent performing time-based codes (97110 and 97035) is 55 minutes and justifies billing four (4) units of time-based services (*see* Section E).

E. CPT® codes describing therapeutic procedures (97110-97150 and 97530-97546) are not subject to the multiple modality rule and shall be paid at 100% of their listed value. When performing therapeutic procedure(s), (excluding work hardening/conditioning, 97545-97546, and physical test or measures for functional capacity evaluation, 97750), a maximum of four (4) units or 67 minutes is allowed each day. Approval must be obtained from the payer prior to performing therapeutic procedures in excess of this maximum (*e.g.*, when multiple body parts are treated in a single visit). Reimbursement for therapeutic procedures in excess of the maximum, without prior approval, shall not affect reimbursement for therapeutic procedures performed within the allowed maximum.

F. The values for the codes in this section include the time and work of the healthcare provider, the equipment required to provide the service, and the cost of the healthcare provider's liability insurance. Medications and disposable electrodes used in these procedures should be considered supplies and managed in accordance with the HCPCS Section of this Fee Schedule.

G. Time-Based Physical Medicine and Rehabilitation CPT® codes are billed according to guidance from the Centers for Medicare and Medicaid Services (CMS), as published in the Medicare Claims Processing Manual, Chapter 5, Section 20.2, C. Counting Minutes for Timed Codes in 15 Minute Units.

When only one service is provided in a day, healthcare providers should not bill for services provided for less than eight (8) minutes. For any single 15-minute timed CPT® code in the same day, healthcare providers bill a single 15-minute unit for treatment of greater than or equal to eight (8) minutes through and including 22 minutes. If the duration of a single procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, two (2) units should be billed. Please refer to the table below, which outlines how to bill for up to four (4) units or 67 minutes, without payer approval.

Recommendation

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Units	Number of Minutes
0	< 8 minutes
1	≥ 8 minutes and ≤ 22 minutes
2	≥ 23 minutes and ≤ 37 minutes
3	≥ 38 minutes and ≤ 52 minutes
4	≥ 53 minutes and ≤ 67 minutes

If additional therapeutic procedures and/or time-based modalities are approved by the payer, the pattern for determining time/units is continued.

When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service determines the number of timed units billed (as noted in the chart above). For any service represented by a 15-minute timed code that is performed for seven (7) minutes or less on the same day as another service also represented by a 15-minute timed code performed for seven (7) minutes or less, and the total time of these two services is eight (8) minutes or greater, the provider may bill one (1) unit of service that was performed for the most minutes. The same logic is applied if three (3) or more different services are performed on the same day for seven (7) minutes or less.

The expectation, based on the work values assigned to these codes, is that a healthcare provider's direct patient contact time for each unit will average 15 minutes in length. If more than one 15-minute timed CPT® code is billed during a single calendar day, the total number of units billed is constrained by the total treatment time for that day.

When documenting to support the billing of timed CPT® codes, the healthcare provider should **document the total number of timed minutes and the total time of the treatment provided that day.** Total treatment time includes the minutes for timed code treatment and untimed code treatment. Total treatment time does not include time for services that are not billable (*e.g.*, rest periods). **The amount of time for each specific intervention/modality provided to the patient is not required to be documented in the treatment note.**

It is important that the total number of timed treatment minutes support the billing of units on the invoice and that the total treatment time also reflects the services billed as untimed codes. The billing and the total timed code treatment minutes documented must be consistent. Additional guidance for documentation of timed codes is found in the CMS Benefit Policy Manual, Chapter 15, 220.3, E. Treatment Note

Examples of how to count the appropriate number of minutes for the total therapy minutes provide:

Example 1

During a visit, the patient receives the following services:
45 minutes therapeutic exercise 97110
5 minutes manual therapy 97140
7 minutes therapeutic activities 97530
Total Timed Codes: 57 minutes

Recommendation

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The healthcare provider would bill: 4 units
97110 3 units
97530 1 unit

Since the total time spent providing manual therapy and therapeutic exercises is greater than eight (8) minutes, one (1) unit is billed for the service which was performed for more time.

Example 2
During a visit, the patient receives the following services:
24 minutes neuromuscular reeducation 97112
23 minutes therapeutic exercise 97110
Total Timed Codes: 47 minutes

The healthcare provider would bill: 3 units
97112 2 units
97110 1 unit

Each service is provided for more than 15 minutes, so at least one (1) unit is appropriate for each. Two (2) units are billed for Neuromuscular reeducation since that service was performed for more time.

Example 3
During a visit, the patient receives the following services:
20 minutes therapeutic activities 97530
20 minutes therapeutic exercise 97110
Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units
97530 2 units
97110 1 unit

OR

97110 2 units
97530 1 unit

Each service was provided for 20 minutes, which would allow for one unit for each service. However, the total time of 40 minutes allows for three (3) units to be billed. Since the time for each service is the same, the healthcare provider can choose which code to bill for two (2) units and which code to bill for one (1) unit.

Example 4
During a visit, the patient receives the following services:
33 minutes therapeutic exercise 97110
7 minutes manual therapy 97140 Total Timed Codes: 40 minutes

The healthcare provider would bill: 3 units 97110 2 units
97140 1 unit

The first 30 minutes of therapeutic exercise is two (2) units. The remaining three (3) minutes is added to the seven (7) minutes of manual therapy and then is billed for one unit of manual therapy. The time for manual therapy is greater than the remaining time from the therapeutic exercise.

Recommendation

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Example 5
During a visit, the patient receives the following services:
18 minutes therapeutic exercise 97110
13 minutes manual therapy 97140
10 minutes gait training 97116
8 minutes ultrasound 97035 Total Timed Codes: 49 minutes

The healthcare provider would bill: 3 units 97110 1 unit
97140 1 unit
97116 1 unit

Bill the procedures that the most time was spent performing. One (1) unit each of 97110, 97140, and 97116. Although the ultrasound should be documented, it cannot be billed, as the healthcare provider is constrained by the total timed codes minutes. Since the total for the timed codes is 49 minutes, only three (3) units would be billed.

H. A work hardening program is limited to 6 1/2 hours per day, not to exceed a six (6) week period of time.

I. The payer has the right to require documentation to establish that a modality or therapeutic procedure was performed. Inasmuch as these Guidelines allow for re-evaluations to be performed every two (2) weeks, it is at that time the healthcare provider should address and document the status of the treatment protocol.

It is not appropriate for the payer on a per billing basis to require a healthcare provider to provide unnecessarily detailed documentation to justify payment. A healthcare provider is required to comply with A.R.S. § 23-1062.01 when submitting a bill. For example, the purpose of modalities like hot and cold packs, paraffin baths, and whirlpools is straightforward. Modalities are utilized as a sub-element of the overall treatment protocol to prepare the injured worker for therapy or to minimize the impact of the therapy on the injured worker. Other than a statement that certain modalities were performed, any additional documentation such as the purpose of the application of modalities, resulting flexibility or comfort is unnecessary. Additionally, listing the amount of weight an individual is lifting, repetitions, and sets is, again, unnecessary. During a re-evaluation visit, the healthcare provider should provide documentation regarding changes in strength, stamina, and flexibility.

Documentation of each treatment shall include the following elements:

- Date of treatment.
- Identification of each specific intervention/modality provided and billed, both timed and untimed services in a manner that it can be compared with the billing record to verify correct coding.
- Total timed code treatment minutes and total treatment time in minutes (the amount of time for each specific intervention/modality provided is not required).
- Signatures (written or electronic) and professional designation of the qualified healthcare provider who furnished or supervised the services provided.

Recommendation

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DENTAL GUIDELINES

Information regarding publications incorporated by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CDT© guidelines and represent additional guidance from the Commission relative to dental services. To the extent that a conflict may exist between an incorporated portion of the CDT© and a guideline or identifier unique to Arizona, then the Arizona guideline or identifier shall control.

General requirements on reporting services are found in the Introduction of the Fee Schedule. In addition to the definitions and commonalities preceding the coded procedures, several other requirements unique to this Section (Dental) are defined or identified as follows:

A. Dental practitioners shall include dentists, dental specialists, denturists, dental therapists, dental hygienists, hospitals, and dental clinics. Practitioners shall be licensed in the state where they practice. Services provided by dental therapists and dental hygienists shall be billed by the dentist or dental specialist, except when a dental hygienist is providing service under an affiliated practice agreement and the State dental practice act allows individual billing by the hygienist or other providers.

B. A CDT© code shall be billed when a CDT© code exists that accurately describes the service provided. If a code is not listed in the rate table, reimbursement shall be By Report, and the bill must be accompanied by documentation to support the amount billed.

C. Laboratory services such as crafting dental appliances, including but not limited to crowns and dentures, are bundled with the MAR for the associated dental procedure. No additional reimbursement shall be due for these services. Laboratory services do not include imaging such as radiographs or scans, which shall be reimbursed based on the MAR of the CDT© code or the billed amount, whichever is less.

D. Preexisting or underlying conditions shall be covered only when required to successfully complete treatment related to the compensable workers' compensation illness or injury.

E. Prophylaxis or routine preventive care shall not be reimbursed.

Recommendation

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