ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE
FREQUENTLY ASKED QUESTIONS
(Revised October 2019)

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

Since 1925, when the Arizona Legislature passed the state's first Workers' Compensation Act, the Commission has administered Arizona's workers' compensation program. Under A.R.S. § 23908(B), the Commission is required to "fix a schedule of fees to be charged to physicians, physical therapists or occupational therapists attending injured employees and . . . for prescription medicines required to treat an injured employee" and to "annually review the schedule of fees." Under § 23-908(B), the schedule of fees may include "other reimbursement guidelines for medications dispensed in settings that are not accessible to the general public."

Laws 2018, Chapter 101, Senate Bill 1111, § 3 specifically directed the Commission to "review information and data, consult with physician, employee and business and industry stakeholders and hold at least one public hearing in considering whether to adopt additional reimbursement guidelines for medications dispensed in settings that are not accessible to the general public." The Commission and agency staff diligently completed all requirements contained in the 2018 session law during its annual review of the fee schedule, including by holding an initial public hearing on August 23, 2018.

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

The proposed 2019/2020 Fee Schedule is based upon the following two-step methodology to compute reimbursement values for all applicable service codes:

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

a. Utilize applicable RVUs from the 2019 MPFS or BUs from the *2019 Anesthesia Base Units from 2019 CPT®-4.* The 2019 MPFS was the preliminary source for assigning and updating RVUs for all service codes.

b. Utilize applicable RVUs from OPTUM 360's 2019 publication *The Essential RBRVS*.

This method was used to assign and update RVUs for all "gap" codes not included in the 2019 MPFS.

c. Utilize applicable RVUs from OWCP's *Fee Schedule Effective October 15, 2018*. This method was used to assign and update RVUs for codes that could not be assigned using the first two methods.

d. Utilize applicable RVUs from the *2019 Clinical Diagnostic Laboratory Fee Schedule*. This method was used to update RVUs for most pathology and laboratory service codes.

e. Utilize a back-filling approach to assign RVUs for any service codes that have a current rate but could not be assigned RVUs using the above methods. This method involved backing into overall RVUs by dividing the current rate for a service code by the applicable current conversion factor.

STEP 2: Once RVUs were assigned to all service codes, reimbursement rates were calculated by multiplying the applicable RVU by the Arizona-specific conversion factor. Staff proposes that the 2019/2020 Fee Schedule continue using a multiple conversion factor model, consisting of one conversion factor for Anesthesia Services, one for Surgery and Radiology, and a third for all remaining service categories (including E & M, Pathology and Laboratory, Physical Medicine, General Medicine, and Special Services).

The three conversion factors for the 2019/2020 Fee Schedule are:

RBRVS Conversion Factors	
Surgery/Radiology	$82.38
All Other	$64.63
Anesthesia	$61.00

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

Note: Additionally:

a. The 2019/2020 Fee Schedule uses CMS's surgical global periods.

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

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

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

b. The 2019/2020 Fee Schedule assigns 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 2019/2020 Fee Schedule does not incorporate a geographic adjustment factor ("GAF"), but instead uses the Arizona-specific conversion factor to adjust payment for the state. It should be noted that CMS utilizes one GAF for the entire State of Arizona.

d. The 2019 Fee Schedule has been updated to incorporate by reference the 2019 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT*® codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

e. The proposed 2019/2020 Fee Schedule applies a 25% Stop Loss Cap to any service codes whose reimbursement values incurred a decrease of greater than 25% due to the transition to a RBRVS-based system.

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

The Commission reviews all of the codes on an annual basis.

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

Annual updates to the Fee Schedule become effective October 1st of each year. The public is afforded an opportunity to participate in the process. In spring of each year, the Commission provides an analysis of issues along with staff recommendations for the next year Fee Schedule in a Staff Proposal and Recommendations Report that is posted on the Industrial Commission website. This document is intended to serve as a foundational document for public comment and future discussions that may arise during the public hearing process.

Following the posting of a Notice of Hearing on the Commission's website, a public hearing is held to receive public comment. Written comments are welcomed in advance of the public hearing. Thereafter, at a duly noticed public meeting, the Commission will take official action on the Fee Schedule, which will be incorporated in the Fee Schedule to become effective October 1st of that year.

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

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

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

Under A.R.S. § 23-908(B), the Commission is required to establish a schedule of fees to be charged by physicians, physical therapists or occupational therapists attending injured employees, and for prescription medicines required to treat an injured employee.
For purposes of the Fee Schedule, the term "physician" includes chiropractors and naturopaths. Fees for certain products, supplies, and services are not included in the Fee Schedule. This includes fees for ambulance services, durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office. If a product, supply, or services are not included in the Fee Schedule, there will not be a code for those items in the Fee Schedule.

7. What is the appropriate fee for products, supplies or services, not covered under the Fee Schedule? Is it "usual, customary, and reasonable (UCR)"?

If a product, supply, or service is not covered under the Arizona Fee Schedule, then the Commission has no jurisdiction to set a fee or resolve a fee dispute related to the service. Additionally, while the obligation of a payer under the Arizona Workers' Compensation Act is to provide medical benefits that are reasonably required, neither the Arizona Workers' Compensation Act, A.R.S. § 23-901 *et seq.,* nor the Arizona Physicians' Fee Schedule make reference to the phrase "usual, customary and reasonable." You may wish to consult an attorney for further assistance regarding this issue.

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

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

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

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

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

The Fee Schedule applies to fees charged by covered entities attending employees that are entitled to receive workers' compensation benefits under the Arizona Workers' Compensation Act. Nothing in this Fee Schedule precludes a physician 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

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

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

12. Does the Fee Schedule apply to fees charged by Physical Therapy Assistants?

The Fee Schedule applies to Physical Therapist and *not* to Physical Therapy Assistants.

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

No, see answer to question five (5). The Industrial Commission does not regulate or set reimbursement rates for inpatient hospital services, outpatient hospital services or ambulatory surgical center (ASC) services.

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

A physician is not entitled to be reimbursed for supplies and materials normally necessary to perform the service. A physician may charge for other supplies and materials using code 99070. A physician may use an applicable Medicare Healthcare Common Procedure Coding System (HCPCS) code in lieu of code 99070 if the HCPCS code more accurately describes the materials and supplies provided by the physician. The Industrial Commission only establishes RVUs and reimbursement rates for HCPCS codes G0480-G0483. Examples of those items that are and are not reimbursable are listed below. Documentation showing actual costs (i.e.manufacturer's current* invoice) associated with providing supplies and materials plus fifteen percent (15%) to cover overhead costs will be adequate justification for payment. This provision does not apply to retail operations involving drugs or supplies. Administration of drugs to patients in a clinical setting covered under code 99070. Prescription drugs provided to patients as a part of the overall treatment regimen but outside of the clinical setting are not included under this code.

*current = within one year of the date of service

Examples of supplies that are not separately reimbursable:

- Applied hot or cold packs
- Eye patches, injections, or debridement trays
- Steristrips
- Needles
- Syringes
- Eye/ear trays
- Drapes
- Sterile gloves
- Applied eye wash or eye drops
- Creams (massage)
- Fluorescein
- Ultrasound pads and gel
- Tissues
- Urine collection kits
- Gauze
- Cotton balls/fluff
- Sterile water
- Band-Aids® and dressings for simple wound occlusion
- Head sheets
- Aspiration trays
- Tape for dressing

Examples of material and supplies that are generally reimbursable include:

- Cast and strapping materials
- Sterile trays for laceration repair and more complex surgeries
- Applied dressings beyond simple wound occlusion
- Taping supplies for sprains
- Iontophoresis electrodes
- Reusable patient-specific electrodes
- Dispensed items, including canes, braces, slings, ACE wraps, TENS electrodes, crutches, splints, back splints, back support, dressings, hot or cold packs

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

No, see answer to question five (5).

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

No.

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

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

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

The PFS includes reimbursement guidelines for dispensing fees under Section VIII.

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 medical practitioner.

1. If a prescription medication is dispensed by a medical practitioner or in a pharmacy not accessible to the general public pursuant to Section VII (A), (B), or (C), 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 medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.
2. If a prescription or OTC medication is administered by a medical practitioner, a dispensing fee is not permitted.

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

Yes. 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. R20-51301(H). Medical practitioners are encouraged to consult the ODG Formulary before dispensing or prescribing medications to injured employees.

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

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

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

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

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

Yes, the reimbursement guidelines may be found under Section V in the current PFS. Medical providers should reference the Official Disability Guidelines (ODG) treatment guidelines and Appendix A Drug Formulary when prescribing compound medications. A pharmaceutical bill submitted for a compound medication must identify each reimbursable component ingredient, the applicable NDC of each reimbursable component ingredient, the corresponding quantity of each component ingredient, and the calculated reimbursement value of each component ingredient.
Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed.

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

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

22. Can medical practitioners dispense medications to injured employees?

Yes. A pharmaceutical bill submitted for a medication administered by a medical practitioner must comply with billing procedures outlined in Sections III, IV, and V 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 that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if all of the following apply:

1. The prescription medication is dispensed by a medical practitioner to the injured employee within seven (7) days of the date of the industrial injury;

2. The prescription medication is limited to no more than a one-time, ten-day supply;

3. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.

An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if all of the following apply:

1. 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 medical practitioner;

2. The injured employee cannot reasonably acquire the prescription medication from an online or mail order pharmacy accessible to the general public; and

3. The prescription medication conforms to dosages and formulations which are commercially available in pharmacies accessible to the general public.

An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if the dispensing of a prescription medication for an individual claim and specified duration has been preapproved 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 preapprove the dispensing of prescription medications under this subsection.

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

No. Average wholesale price shall be determined on from pricing published in a nationally recognized pharmaceutical publication designated by the Commission. The Commission has selected Medi-Span for the 2019/2020 PFS.

An entity responsible for payment of prescription drugs may select the following as an alternative to the foregoing if the selection is made no later than October 1st of each year. This selection shall be communicated in writing to the Commission and remain in effect until the following October 1. AWP shall be determined on the date a drug is dispensed from pricing published in the most

recent issue, as updated quarterly, of the publication designated by the Commission. For purposes of this paragraph, quarterly means the first day of the month on January, April, July, and October.

24. Where can I find Medi-Span?

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

25. What is the Average Wholesale Price?

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

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

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

27. Does the Fee Schedule cover Telemedicine services?

Yes. Telemedicine services in Arizona should be billed using codes listed in Appendix P which may be found in the AMA Current Procedural Terminology (CPT), and should be billed with modifier -95.

Telemedicine services should be paid at the non-facility RVU rate unless the provider is billing an originating site fee which would then warrant those Telemedicine services being paid at the facility RVU rates.

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

No preauthorization is required under the Act to ensure payment for reasonably required medical treatment or services. While preauthorization is not required under the Act, a provider may seek preauthorization.

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

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

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

Yes. Billing code AZ099-005 under the Special Services section is to be used for completion of workers' compensation insurance forms (e.g. return-to-work status, work restrictions, supportive care recommendations), not to exceed more than one billing in a thirty (30) day period. The form should be attached to a report.