# MEDICINE GUIDELINES

This 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. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. 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.

A. MATERIALS SUPPLIED BY PHYSICIAN: A physician may charge for materials and supplies as described in subsection (I)(4) of the Introduction Section of the Physician's Fee Schedule (pages 10 - 11).

B. COMPLIANCE WITH THE AMERICAN'S WITH DISABILITIES ACT: Code 99199 can be used to bill for the services of an interpreter when they are used to comply with the provisions of "The American's With Disabilities Act", i.e. interpreters for the hearing impaired.

C. ADD-ON CODES: Some of the listed procedures are commonly carried out in addition to the primary procedure performed. All add-on codes found in the CPT codebook are exempt from the multiple procedure concept. They are exempt from the use of modifier -51.

D. SEPARATE PROCEDURES: Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term " separate procedure". The codes designated as a "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

   When a procedure or service is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier -59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure.

E. BUNDLED CODES: Indicates that the service is always bundled in a payment for another service. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (e.g., a telephone call from a hospital nurse regarding the care of a patient).