

ARIZONA PHYSICIANS' AND PHARMACEUTICAL
FEE SCHEDULE
2020/2021



Adopted by
The Industrial Commission of Arizona

Contact Medical Resource Office
Phone (602) 542-4308 / Fax (602) 542-4797
mro@azica.gov

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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). 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, 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 monthly 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 2020 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[®]-4 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.

- a. The Commission has also adopted by reference: 1) 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 <https://www.asahq.org>; 2) The *1995 and 1997 Documentation Guidelines for Evaluation and Management Services*, Centers for Medicare and Medicaid Services (CMS) <https://www.cms.gov>; 3) The *2020 Clinical Diagnostic Laboratory Fee Schedule*, Centers for Medicare and Medicaid Services (CMS) Clinical Laboratory fee Schedule <https://www.cms.gov>; 4) The *National Correct Coding Initiative Edits*, CMS; <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>; 5) *20 Optum 360 The Essential RBRVS* <https://www.optum360.com/>; and 6) *Physicians as Assistants at Surgery: 2018 Update* <https://www.facs.org/>. The RBRVS based fee schedule adopts surgical global periods published by CMS.

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 or any other entity or organization.

A. GENERAL GUIDANCE

1. Reimbursements and billing associated with Pharmaceuticals are found in the Pharmaceutical Fee Schedule Section of this document.
2. This Fee Schedule establishes the fees that can be charged by healthcare providers for services performed for injured workers under the Arizona's workers' compensation law.
3. 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.
4. Routine progress and routine final reports filed by the attending healthcare provider do not ordinarily command a fee.
5. Payment will be made for only one professional visit in any one day except when the submitted report clearly demonstrates the need for the additional visit and fee.
6. Fees for hospital, office, or home visits, subsequent to the initial visit, are not to be added to coded surgical procedures performed in the same day.
7. Routine office treatment principally by injection of drugs, other than antibiotics, requires authorization by the carrier or self-insured employer for each series of 10 after the first series of 10.
8. 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.
9. 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.
10. An attending healthcare provider may submit a claim for consultant's fee only when such service is requested by carrier or self-insured employer.
11. Missed individual appointments for consultants, without prior notification, will be compensated at 50% of consultation fee.
12. No fees may be charged for services not personally rendered by the healthcare provider, unless otherwise specified.

13. The Commission will investigate an injured workers' 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.
14. As authorized under A.A.C. R20-5-128, the 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.

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 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 days from the date the claim is accepted, if the billing is received before the date of acceptance, or within thirty 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 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 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;
 - e. A provision that A.R.S. § 23-1062.01 does not apply to written contracts entered into between medical 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. "Reasonable justification" to deny a bill does not include that the payment/billing policies of another private or public entities (publications) do not allow it unless the publication has been adopted by reference in the Fee Schedule.
 6. Excluding bundling and unbundling issues, it is not the Commission's intent to restrict an insurance carrier's, self-insured employers or third party processing service's ability to address issues not addressed by the Fee Schedule. This includes evaluating unlisted procedures, establishment of values for unlisted procedures, establishment of values for codes that are listed as "BR" or "RNE", new CPT[®] codes that have not been adopted by the Industrial Commission, or issues outside the jurisdiction of the Fee Schedule, such as hospital billings.
 7. 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).

8. Treating physicians shall submit a narrative that justifies the billing of a level 4 or 5 E & M service.
9. The Commission has adopted by reference the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. Medical billings shall be prepared and reviewed consistent with how these guidelines are used and interpreted by CMS. Additionally, payers are required to disclose the guideline utilized in their Explanation of Reviews (or other similar document).
10. 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:
 - 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.
11. 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. A 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. If a payer fails to provide evidence that it is entitled to pay a contracted rate, then the payer shall be required to make payment as provided in this Fee Schedule.
12. Billing for Pharmaceuticals is found in the Pharmaceutical Fee Schedule Section of this document.

C. REIMBURSEMENT OF MID-LEVEL PROVIDERS

1. Certified Registered Nurse Anesthetists (“CRNA’s”) are reimbursed at 85% of the fee schedule.
2. 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:
 - a. The Physician Assistant and Nurse Practitioner must work under the direct supervision of an appropriately licensed physician,
 - b. The Physician must initially see that patient and establish a plan of care for that patient (“treatment plan”),
 - c. Subsequent service provided by the Physician Assistant and Nurse Practitioner must be a part of the documented treatment plan, and
 - d. 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.
3. 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 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.
4. 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(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 medical providers, while employees of all other

employers do (including public 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 health-care networks.

Actions or conduct that impair or limit the right of an employee to choose their medical 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;
- 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. Only physicians and surgeons licensed in the State of Arizona are permitted to treat injured or disabled employees under the jurisdiction of the Commission, unless others are specifically authorized.
2. 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-

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, upon 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, reasonable required at the time of the injury, and during the period of disability. Such benefits shall be termed 'medical, surgical and hospital benefits.'"

1070. Employers described in A.R.S. § 23-1070, excluding the State or Political Subdivisions thereof, are allowed to direct medical care.

3. 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 the Title 20, Chapter 5, Article 1 of the Arizona Administrative Code, which can be obtained at: http://apps.azsos.gov/public_services/Title_20/20-05.pdf
4. 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.
5. 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.
6. 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.
7. If the patient refuses to submit to medical examination or to cooperate with the healthcare provider's treatments, the carrier or self-insured employer should be notified.
8. If an employee is capable of some form of gainful employment, it is proper for the healthcare provider to release 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.
9. 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.

10. 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.

11. Once an exposure to 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 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.

12. 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.
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 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 for the average private patient. In difficult problems and in 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. 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 establishment of a relativity. “RNE” items are clearly definable and not inherently variable as are BR procedures. A report may be necessary.
3. **SERVICE “SV” ITEMS:** “SV” in the value column indicates the value is to be calculated as the sum of the various services rendered (e.g., office, home, nursing home or hospital visits, consultation or detention, etc.), according to the ground rules covering those services. Identify by using the code number of the “SV” item. The Value is established by identifying each individual service, listing the code number and its value.
4. **MATERIALS AND SUPPLIES:** A healthcare provider is not entitled to be reimbursed for supplies and materials normally necessary to perform the service. A healthcare provider may charge for other supplies and materials using code 99070². A healthcare provider may use an applicable HCPCS code in lieu of code 99070 if the HCPCS code

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more accurately describes the materials and supplies provided by the healthcare provider; however, the Commission has **not** adopted the RVUs for HCPCS codes. Examples of those items that are and are not reimbursable are listed below. Documentation showing actual costs (i.e. manufacturer's invoice dated within one year of the billed date) 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 is 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.

Examples of supplies that are usually not separately reimbursable include:

- 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
- Sterile trays for laceration repair and more complex surgeries
- Tape for dressings

Examples of material and supplies that are generally reimbursable include:

- Cast and strapping materials
- 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 support
 Dressings
 Hot or cold packs

5. “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 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.

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.

J. LIST OF ACRONYMS

AMA	American Medical Association
AS	Assistant Surgeon
AWP	Average Wholesale Price
BR	By Report
CCI	Current Coding Initiative (National)
CF	Conversion Factor
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
DME	Durable Medical Equipment
E/M	Evaluation and management services
FCE	Functional Capacity Evaluation
FUD	Follow-up day(s)
HCPCS	Healthcare Common Procedure Coding System
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IME	Independent medical examination
MPFS	Medicare physician fee schedule

MRI	Magnetic resonance imaging
NCCI	(see CCI)
NP	Nurse practitioner
OTC	Over-the-counter
PA	Physician assistant
RBRVS	Resource based relative value scale
RVU	Relative value unit