ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE
FREQUENTLY ASKED QUESTIONS
(Rev. January 14, 2022)

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 Industrial Commission of Arizona (the "Commission") has administered Arizona's workers' compensation program. Under A.R.S. § 23-908(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."

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

The 2021/2022 Fee Schedule is based upon the following two-step methodology to compute reimbursement values for all applicable service codes:

STEP 1: Relative Value Units ("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 2021 Medicare Physician Fee Schedule ("MPFS") or BUs from the *2021 Anesthesia Base Units from 2021 CPT®*. The 2021 MPFS was the preliminary source for assigning and updating RVUs for all service codes.

b. Utilize applicable RVUs from OPTUM 360's 2021 publication *The Essential RBRVS*.

Methods (c) through (e) are used to assign and update RVUs for all "gap" codes not included in the 2021 MPFS.

c. Utilize applicable RVUs from OWCP's *Fee Schedule Effective October 15, 2020*. 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 *2021 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. The 2021/2022 Fee Schedule continues to use 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 2021/2022 Fee Schedule are:

RBRVS Conversion Factors	
Surgery/Radiology	$70.00
All Other	$65.00
Anesthesia	$61.00

Note: The above-described methodology does not apply to service codes that could not be assigned an 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 2021/2022 Fee Schedule uses CMS's surgical global periods.

b. The 2021/2022 Fee Schedule assigns RVUs to consultation services, recognizing the functional importance of these services.

c. The 2021/2022 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 2021/2022 Fee Schedule has been updated to incorporate by reference the 2021 Edition of the American Medical Association's *Current Procedural Terminology*, Fourth Edition (CPT®), 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®* are preceded by an AZ identifier and numbered in the following format: AZxxx. To the extent that a conflict may exist between

[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.

an adopted portion of the CPT® and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier, or modifier shall control.

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

The Commission reviews the codes on an annual basis.

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

Generally, 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 the 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 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 "healthcare provider" is used when referring to licensed professionals whose scope of practice allows them to legally provide services to injured workers. The term "physician" is used when referring to a specific subset of healthcare providers who may provide and bill evaluation and management services pursuant their respective scope of practice and Arizona law. Fees for certain products, supplies, and services are not regulated in the Fee Schedule, including fees for ambulance services, durable medical equipment, prosthetics, orthotics, and supplies when provided outside a physician's office. Products, supplies, and services not included in the Fee Schedule will not have a code or reimbursement value in the Fee Schedule.

7. What is the appropriate fee for products, supplies or services (other than ambulance 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 formally 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' and Pharmaceutical Fee Schedule reference 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 current 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 current 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 services. A payer who claims that fees are governed by a separate contract is required to provide a copy of the contract to the provider in the event of a dispute over fees.

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

Yes, 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. Under A.R.S. § 23-1071(A), an employee may not leave the state for a period exceeding two weeks while the necessity of having medical treatment continues without the written approval of the Commission.

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 Therapists, but *not* to Physical Therapy Assistants.

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

No. The Commission does not currently regulate or set reimbursement rates for inpatient hospital services, outpatient hospital services, or ambulatory surgical center ("ASC") services. *See* Question 6, above.

14. Does the Fee Schedule apply to fees charged by ambulance service providers?

No. *See* Question 6, above. Although the Fee Schedule does not apply to ambulance service providers, service fees for ambulance transportation are set and mandated by the Arizona Department of Health Services through its Arizona Ground Ambulance Service Rate Schedule. *See* A.R.S. § 36-2239(D), which 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.

15. 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 a medical service. A physician may, however, 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. However, the Commission only establishes RVUs and reimbursement values for HCPCS codes G0480-G0483, U0001-U0002, G2010 and G2012. Examples of supplies and materials that are and are not reimbursable are listed below. A current invoice dated within one year of the billed date showing actual costs 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, including, but not limited to: hospitals, ambulatory surgery centers, ambulance service providers, and durable medical equipment providers. Drugs administered or dispensed to patients in a clinical setting may be billed using code 99070 and are subject to the current Pharmaceutical Fee Schedule Guidelines. Prescription drugs provided to patients as part of the overall treatment regimen but outside of the clinical setting are not included under code 99070.

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
Sterile trays for laceration repair and more complex surgeries

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 splints, back support, dressings, hot or cold packs.

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

No. *See* Question 6, above.

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

No. An independent medical exam is not a covered service in the Fee Schedule.

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

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

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

Section VIII of the current Pharmaceutical Fee Schedule states the guidelines for dispensing fees.

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

Yes. *See* Section I(B) of the current Pharmaceutical Fee Schedule. Medical, surgical, and hospital benefits 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 Commission has adopted the Official Disability Guidelines (ODG), published by MCG Health, 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). Medical practitioners are encouraged to consult the ODG Formulary before dispensing or prescribing medications to injured employees.

Complementary access to the ODG Drug Formulary Appendix A is available on the Medical Resource Office (MRO) home page or through this link: https://www.odgbymcg.com/state-formulary. Injured workers without representation may contact the MRO via email at MRO@azica.gov to make arrangements to access ODG at the Commission.

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

The Pharmaceutical Fee Schedule 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. *See* Section IV of the current Pharmaceutical Fee Schedule.

Reimbursement for repackaged medication shall be based on the current Pharmaceutical Fee Schedule reimbursement methodology contained in Section III of the Pharmaceutical Fee Schedule, 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.

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

Yes, the reimbursement guidelines may be found under Section V in the current Pharmaceutical Fee Schedule. 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.

23. Can medical practitioners dispense medications to injured employees?

Nothing in the Pharmaceutical Fee Schedule prohibits medical practitioner from dispensing medications to injured employees. The Pharmaceutical Fee Schedule does, however, include reimbursement guidelines regarding when a medical practitioner may be reimbursed for medications dispensed to injured employees. These guidelines can be found in Section VII of the current Pharmaceutical Fee Schedule.

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

No. Average wholesale price must be determined from pricing published in a nationally recognized pharmaceutical publication designated by the Commission. The Commission has selected Medi-Span® for the 2021/2022 Pharmaceutical Fee Schedule.

25. Where can I find Medi-Span®?

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

26. 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.

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

The 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.

Additionally, the Commission adopted HCPCS codes G2010, G2012, U0001, and U0002 in the 2020/2021 Fee Schedule. The codes were initially approved and adopted by the Commission on March 26, 2020, in response to the spread of COVID-19. Codes G2010 and G2012 are used to bill for Virtual Check-ins provided by appropriately-licensed physicians. Codes U0001 and U0002 are used to bill for laboratory testing to detect a COVID-19 infection.

28. Does the Fee Schedule cover Telemedicine services?

Yes. Reimbursement values for telehealth services are governed by the Fee Schedule. The performance of telehealth services is governed by Arizona Revised Statutes, Title 36, Chapter 36.

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

Preauthorization is not required under the Act to ensure payment for reasonably required medical treatment or services. *See* R20-5-1303 (A). While preauthorization is not required under the Act, a provider may seek preauthorization.

A provider should submit a request for preauthorization in writing to the adjustor using Section I (Provider Request for Preauthorization) of the form approved by the Commission under R20-5-106(A)(12). A provider should 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. The form can be found here.

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

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

Yes. Billing code AZ005 under the Special Services section is to be used for completion of workers' compensation insurance forms (i.e., return-to-work status, work restrictions, supportive care restrictions) which are requested or required either by the Commission, the applicable payer (insurance, self-insured employer, or the Special Fund of the Commission), or a third-party administrator of the applicable payer, not to exceed more than one billing in a thirty (30) day period. The applicable form must be attached to the billing.

31. Which billing standard should providers and payers follow for time-based services?

The Commission has designated the use of the CMS guidelines as the billing standard for providers and payers. This designation aligns with the Commission's adoption by reference of the National Correct Coding Edits by CMS.