

Industrial Commission of Arizona



Final Staff Proposal
for
2022/2023 Arizona Physicians' and Pharmaceutical Fee Schedule

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	<u>Page</u>
I. Introduction	2
II. Final Proposal Regarding the 2022/2023 Physicians' and Pharmaceutical Fee Schedule.....	3
A. Adoption of Updates to Relative Value Units and Reimbursement Values	3
B. Designation of Medi-Span [®] to Determine Average Wholesale Price	5
C. Adoption of Deletions, Additions, General Guidelines, and Identifiers of the CPT [®]	5

The accompanying file contains the following tables, which are referenced in this report:

RBRVS Fee Schedule 2022 (all codes)

Anesthesia Codes and Anesthesia Conversion Factor (00100–01999)

Surgery Codes (10021–69990)

Radiology Codes (70010–79999)

Pathology/Laboratory Codes (80047–89398)

Medicine Codes (90281–96999)

Physical Medicine Codes (97010–98969)

Special Services Codes (99000-99607)

Evaluation and Management Codes (99201–99499)

Category III Codes (0019T–0436T)

D. Amendments to the Introduction.....	5
E. Amendments to the Surgery Guidelines.....	6
F. Amendments to the Physical Medicine and Rehabilitation Guidelines.....	6
G. Update to the Service Description of Code AZ099	6

I. INTRODUCTION.

The information contained in this final report is based on a review of various resources, including the following: (1) *CY 2022 Medicare Physician Fee Schedule* (“MPFS”), a RBRVS-based reimbursement fee schedule used by Centers of Medicare & Medicaid Services (“CMS”); (2) OPTUM 360’s 2022 publication *The Essential RBRVS*; (3) Office of Workers’ Compensation Programs (“OWCP”) Fee Schedule Effective October 1, 2021; (4) *2022 Anesthesia Base Units as listed in CPT®*, a schedule of base units used by CMS to compute allowable amounts for anesthesia services; (5) *2022 Clinical Diagnostic Laboratory Fee Schedule*, a fee schedule maintained by CMS that identifies state-specific rates for pathology and laboratory services; and, (6) *Physicians as Assistants at Surgery: 2020 Update*.

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

Note: The Commission is not permitted to include descriptors associated with five-digit CPT® codes in its Fee Schedule.

II. FINAL PROPOSAL REGARDING THE 2022/2023 PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE.

A. Adoption of Updates to Relative Value Units and Reimbursement Values.

Staff proposes adoption of the service codes, RVUs, and reimbursement values contained in Tables 1 through 9, found on the MRO webpage .

The Staff Proposal is based upon continued use of a RBRVS reimbursement system, in which reimbursement values are calculated by multiplying “resources required to perform a service or RVUs” by a dollar value conversion factor (“CF”). The proposed 2022/2023 Fee Schedule is based upon the following two-step methodology to compute reimbursement values for all applicable service codes:

STEP 1: Establishing 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 2022 MPFS or BUs from the *2022 Anesthesia Base Units from 2022 CPT®*. The 2022 MPFS was the preliminary source for assigning and updating RVUs for all service codes.
- b. Utilize applicable RVUs from OPTUM 360’s 2022 publication *The Essential RBRVS*. This method was used to assign and update RVUs for all “gap” codes not included in the 2022 MPFS.

Please note, the Commission is not permitted to publish the RVUs assigned to “gap” codes contained in the 2022 edition of *The Essential RBRVS* by OPTUM 360.

- c. Utilize applicable RVUs from OWCP’s *Fee Schedule Effective October 1, 2021*. 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 *2022 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 appropriate Arizona-specific conversion factor. Staff proposes that the 2022/2023 Fee Schedule continue using a multiple conversion factor model, consisting of one conversion factor for Anesthesia Services, a second for

Surgery/Radiology, and a third for all remaining service categories (including E & M, Pathology and Laboratory, Physical Medicine and Rehabilitation, General Medicine, and Special Services).

The three proposed conversion factors for the 2022/2023 Fee Schedule are:

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

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, Bundled², Not Covered or RNE³.

Note: Additionally:

- a. The proposed 2022/2023 Fee Schedule continues to use CMS’s surgical global periods.
- b. The proposed 2022/2023 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 proposed 2022/2023 Fee Schedule does not incorporate a geographic adjustment factor (“GAF”), 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. All CPT® codes that contain explanatory language specific to Arizona will continue to be 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.

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 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. Continued Designation of Medi-Span as the Publication for Purposes of Determining Average Wholesale Price.

Staff proposes that Medi-Span[®] continue to be used for determining Average Wholesale Price (“AWP”) in the 2022/2023 Fee Schedule.

C. Adoption of Deletions, Additions, General Guidelines, and Identifiers of the CPT[®].

The proposed 2022/2023 Fee Schedule is based upon staff review of deletions and additions to CPT[®]. The proposed 2022/2023 Fee Schedule is intended to conform to changes that have taken place in the 2022 edition of CPT[®].

Note: Proposed amendments to the Fee Schedule as described in Paragraphs II(D) – (G) of the Staff Proposal are reflected in Exhibit A, attached.

D. Amendments to the Introduction.

Staff proposes to amend the Introduction section of the Fee Schedule, as follows:

Section A(2)

Update the language to clarify that the Fee Schedule establishes maximum reimbursement values for services performed by healthcare providers to injured workers under Arizona workers’ compensation law.

Section I

Add the following new section (I) to provide guidance on reimbursing healthcare providers who testify at hearing.

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 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 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.

Section J(4)

Update the language to clarify that healthcare providers who charge for supplies should do so in accordance with the guidance in Section J. Add language to clarify that the documentation and

reimbursement guidance does not apply in settings outside of the healthcare provider's office (*e.g.*, hospitals, ambulatory surgery centers, and durable medical equipment providers).

E. Amendments to the Surgery Guidelines.

Staff proposes to add modifiers “82” and “AS” and language that clarifies who should use modifier “AS”. Staff also proposes to increase the reimbursement value for minimum assistant surgeons (modifier 81) to sixteen percent of the listed reimbursement value of the surgical procedure.

Δ-82 Assistant Surgeon (when qualified resident surgeon not available): These services are valued at sixteen percent (16%) of the listed value of the surgical procedure(s).

Δ-AS Use the modifier AS for assistant at surgery services, when services are provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). These services are valued at fourteen percent (14%) of the listed value of the surgical procedure(s).

NOTE: A Medical Doctor or Doctor of Osteopathic Medicine should not submit the AS modifier. This modifier is only valid for use by a PA, NP, and CNS when billing under their own provider number

F. Amendments to the Physical Medicine and Rehabilitation Guidelines.

Staff proposes to update the language in the Physical Medicine and Rehabilitation Guidelines section to clarify that the time spent performing time-based modalities are included when determining the total treatment time and the total number of units that may be billed during a single visit. The time spent performing time-based modalities has no impact on the requirement for prior approval from the payer when exceeding four units of therapeutic procedures.

G. Update to the Service Description of Code AZ099.

Staff proposes to update the service description of code AZ099, based on the proposed changes to the witness fees, as follows:

AZ099 Expert testimony at hearing, for the initial hour (or any portion thereof), prorated for each additional 20 minute increment (or any portion thereof).

Exhibit A

ARIZONA PHYSICIANS' AND PHARMACEUTICAL
FEE SCHEDULE
2022/2023



Adopted by
The Industrial Commission of Arizona

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Effective October 1, 2022 through September 30, 2023

2022/2023 ARIZONA PHYSICIANS' & PHARMACEUTICAL FEE SCHEDULE

TABLE OF CONTENTS

	<u>Page</u>
Introduction	1
A. General Guidance	2
B. Payment and Review of Billings	3
C. Reimbursement of Mid-Level Providers	6
D. Directed Care and Use of Networks	6
E. Treatment of Industrial Injuries and Diseases	7
F. Reopening of Claims	9
G. No-Insurance Claims	10
H. Consultations	10
I. <u>Witness Fees</u>	<u>XX</u>
I.J. Definitions of Select Unit Values	10
I.K. List of Acronyms	12
Pharmaceutical Fee Schedule	14
I. General Provisions and Applicability of Pharmaceutical Fee Schedule	14
II. Definitions	15
III. General Guidelines for Billing and Reimbursement of Prescription Medications	17
IV. Billing and Reimbursement for Repackaged Medications	18
V. Billing and Reimbursement for Compound Medications	19
VI. Billing and Reimbursement for Medications Administered by a Medical Practitioner	19
VII. Reimbursement for Medications Dispensed by a Medical Practitioner or in a Pharmacy Not Accessible to the General Public	20
VIII. Dispensing Fee	21
IX. Additional Billing Guidelines	22
X. Severability Clause.	22
Anesthesia Guidelines	23
Anesthesia Codes	25
Surgery Guidelines	30
Surgery Codes	33
Radiology Guidelines	133
Radiology Codes	136
Pathology and Laboratory Guidelines	168
Pathology and Laboratory Codes.....	170
Medicine Guidelines	200
Medicine Codes	201
Physical Medicine and Rehabilitation Guidelines	225
Physical Medicine Codes	231
Special Services Guidelines	233
Special Services Codes	234
Evaluation and Management Guidelines	237
Evaluation and Management Codes	257
Category III Guidelines	261
Category III Codes	262

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 anesthetologists, 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 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, 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 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.

- 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 *2022 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) *2022 Optum360 The Essential RBRVS* <https://www.optum360.com/>; and 6) *Physicians as Assistants at Surgery: 2020 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. Except when governed by a separate contract or network that governs fees pursuant to A.R.S. § 23-908(J)(1), This Fee Schedule establishes the maximum reimbursement values~~fees that can be charged by healthcare providers~~ for services performed by healthcare providers to~~for~~ injured workers under 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 on 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. Missed individual appointments for consultants, without prior notification, will be compensated at 50% of consultation fee.
11. No fees may be charged for services not personally rendered by the healthcare provider, unless otherwise specified.
12. 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.

13. 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.
14. Reimbursement values for telehealth services are governed by the Fee Schedule. Performance of telehealth services are governed by Arizona Revised Statutes, Title 36, Chapter 36.

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 other 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.
13. 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(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 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 complex cases 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. 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 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 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 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 [in accordance with this subsection](#). A healthcare provider may use an applicable HCPCS code in lieu of code 99070 if the HCPCS code 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) associated with providing supplies and materials plus fifteen percent (15%) to cover overhead costs and is adequate justification for payment only when the documentation is dated within one year of the billed date. This provision does not apply to retail operations [or locations not maintained by a healthcare provider’s office, including, but not limited to: hospitals, ambulatory surgery centers, ambulance service providers, and durable medical equipment providers](#)~~involving drugs or supplies~~. Drugs that are administered to patients in a clinical setting are covered under code 99070 and reimbursed according to the Pharmaceutical Fee Schedule Guidelines. 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

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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 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.

KJ. 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

PROPOSAL

SURGERY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Editions of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, 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.

The Commission has also adopted by reference: 1) *The 1995 and 1997 Documentation Guidelines for Evaluation and Management Services*, Centers for Medicare and Medicaid Services (CMS) <https://www.cms.gov>; 2) *2022 Optum 360 The Essential RBRVS* <https://www.optum360.com/>; 3) *The National Correct Coding Initiative Edits*, CMS <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>; and, 4) *Physicians as Assistants at Surgery: 2020 Update* <https://www.facs.org>. The RBRVS-based fee schedule adopts surgical global periods published by CMS. 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 surgical services. To the extent that a conflict may exist between CMS, 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.

- A. **MATERIALS AND SUPPLIES:** A healthcare provider may charge for materials and supplies as described in subsection (I)(4) of the Introduction Section of the Physician's Fee Schedule.
- B. **MULTIPLE PROCEDURES:** It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).
Note: This modifier should not be appended to designated "add-on" codes.
- C. **SPECIAL REPORT:** A typical request for more detailed information from an insurance carrier regarding a billing does not constitute a "special report", which is defined in the CPT® book.
- D. **MODIFIERS:** Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways. The modifier may be reported by a two-digit number placed after the usual procedure number from which it is separated by a hyphen. Or the modifier may be reported by a separate five-digit code that is used in addition to the procedure code. If more than one

modifier is used, the “Multiple Modifiers” code placed first after the procedure code indicates that one or more additional modifier codes will follow.

Modifiers either unique to Arizona or containing explanatory language specific to Arizona are as follows:

Δ-22 Increased Procedural Services: Use of this modifier will result in a twenty-five percent (25%) increase in the listed value for the listed procedure.

Δ-25 Separately Identifiable Evaluation and Management Service by the same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). As such, different diagnoses are not required for reporting of the E/M services on the same date. The circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Δ-47 Anesthesia by Surgeon: The value shall be fifty percent (50%) of the calculated American Society of Anesthesiologists Relative Value Guide value.

Δ-50 Bilateral Procedure: Unless otherwise identified in the listings, when bilateral procedures which add significant time or complexity to patient care are provided at the same operative session, identify and value the first or major procedure as listed. Identify the secondary or lesser procedure(s) by adding this modifier 50 to the usual procedure number(s) and value at fifty percent (50%) of the listed value(s). If, however, the procedures are independently complex and involve different parts of the body, including digits, the bilateral procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

Δ-51 Multiple Procedures: When multiple procedures are performed during the same operative session*, the procedures should be valued at the appropriate percent of its listed value, as shown below:

100% (full value) for the first or major procedure

50% for the second and multiple procedure(s)

Sixth and subsequent procedures – by report

*Multiple Procedure Guidelines do not apply to codes specifically identified as “Add-on/Additional Procedures, Global indicator ZZZ”.

The major or primary procedure is defined as the procedure with the highest value and is the code that determines the follow-up days when a surgery has multiple procedures. The second procedure is the procedure with the next highest value, the third the next highest value, and so

on. If, however, the procedures are independently complex such as digits, tendons, nerves or artery repair, the multiple procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

When performing multiple procedures with different global period values during the same operative session, the global period value for the session is the largest global period value.

- Δ-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.
- Δ-62 Two Surgeons: By prior agreement, the total value of services performed by two surgeons working together as primary surgeons may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. If no apportionment is listed, the fee should be split evenly between the co-surgeons. The total value may be increased by twenty-five percent (25%) in lieu of the usual assistant's charge. Under these circumstances, the services of each surgeon should be identified by adding this modifier 62 to the joint procedure number(s) and valued as agreed upon. (Usual charges for surgical assistance may be warranted if still another physician is required as part of the surgical team.) The value of the procedure should be 125 percent of the customary value listed. Payment of 125% of the maximum allowable would be divided between the participating surgeons.

Two Surgeons – When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80, 81, or ~~modifier~~ 82 added, as appropriate.

- Δ-80 Assistant Surgeon: These services are valued at twenty percent (20%) of the listed value of the surgical procedure(s).

~~OR~~

- Δ-81 Minimum Assistant Surgeon: These services are valued at sixteen percent (~~10~~6%) of the listed value of the surgical procedure(s).

Δ-82 Assistant Surgeon (when qualified resident surgeon not available): These services are valued at sixteen percent (16%) of the listed value of the surgical procedure(s).

Δ-AS Use the modifier AS for assistant at surgery services, when services are provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). These services are valued at fourteen percent (14%) of the listed value of the surgical procedure(s).

NOTE: A Medical Doctor or Doctor of Osteopathic Medicine should not submit the AS modifier. This modifier is only valid for use by a PA, NP, and CNS when billing under their own provider number

PROPOSAL

PHYSICAL MEDICINE AND REHABILITATION GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2022 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, 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. 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 physical medicine and rehabilitation services. To the extent that a conflict may exist between 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.

General requirements in 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. 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 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.

- B. 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 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 modalities or more than three units of a time-based modality or any combination of time-based and untimed modalities equaling three 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 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 \(see Section E and Example 5\).](#)

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 (untimed code)

97014 1 unit at 50% of value (untimed code)

97035 1 unit at 50% of value (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 units of time-based services \(see Section E\).](#)

- C. 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 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).
- D. The values for the codes in this section include the time and work of the 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, code 99070, (see Section A in the Medicine Guidelines and Subsection (I)(4) of the Fee Schedule Introduction regarding billing for supplies).
- E. 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 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 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 units should be billed. Please refer to the table below, which outlines how to bill for up to four units or 67 minutes, without payer approval.

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 7 minutes or less on the same day as another service also represented by a 15-minute timed code performed for 7 minutes or less, and the total time of these two services is 8 minutes or greater, the provider may bill one unit of service that was performed for the most minutes. The same logic is applied if three or more different services are performed on the same day for 7 minutes or less.

The expectation, based on the work values assigned to these codes, is that a 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 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 on how to count the appropriate number of minutes for the total therapy minutes provided:

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

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 8 minutes, one unit is billed of 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 unit is appropriate for each. Two 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 units to be billed. Since the time for each service is the same, the provider can choose which code to bill for two units and which code to bill for one 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 2 units. The remaining 3 minutes is added to the 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.

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 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 units would be billed.

- F. A work hardening program is limited to 6 1/2 hours per day, not to exceed a 6 week period of time.
- G. 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 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 unnecessary 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 are

straightforward. Modalities are utilized as a sub-element of the over-all 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.

PROPOSED

ARIZONA PHYSICIANS' FEE SCHEDULE
Special Service Codes 2022
Special Service Conversion Factor \$65.00

Code	Category	FY22 NF RVU	FY22 FAC RVU	FY22 NF RBRVS Rate	FY22 FAC RBRVS Rate
AZ028 00 When more than one patient seen, apportion mileage charge among total number of patients.	Special Service	0.00	0.00	BR	BR
AZ030 00 Mileage round-trip: each mile in excess of 8 miles of travel by physician.	Special Service	0.00	0.00	BR	BR
AZ031 00 Within large metropolitan areas a travel time basis may be appropriate. Code AZ031 00 would apply to Arizona's major metropolitan areas, to include Phoenix, Tucson, Flagstaff, Kingman and Yuma. This code would only be used when travel times are 45 minutes or more.	Special Service	0.00	0.00	BR	BR
AZ044 00 Services rendered in a night medical care facility: a charge in addition to the usual value of the procedure may be warranted.	Special Service	0.00	0.00	BR	BR
AZ099 00 Expert testimony at hearing. per hour. for the initial hour (or any portion thereof), prorated for each additional 20 minute increment (or any portion thereof).	Special Service	2.31	2.31	\$ 150.00	\$ 150.00