Industrial Commission of Arizona

Staff Proposal and Request for Public Comment
for
2019/2020 Arizona Physicians' and Pharmaceutical Fee Schedule

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I. INTRODUCTION.

The information contained in this report is based on a review of various resources, including the following: (1) *CY 2019 Medicare Physician Fee Schedule* ("MPFS"), a RBRVS-based reimbursement fee schedule used by Centers of Medicare & Medicaid Services ("CMS"); (2) OPTUM 360's 2019 publication *The Essential RBRVS*; (3) Office of Workers' Compensation Programs ("OWCP") Fee Schedule Effective October 15, 2018; (4) *2019 Anesthesia Base Units as listed in CPT®-4,* a schedule of base units used by CMS to compute allowable amounts for anesthesia services; (5) *2019 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: 2018 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.

It is important to note that this report is preliminary and intended to serve as a proposal for public comment and future discussion during the public hearing process. Following the public hearing process, staff of the Industrial Commission of Arizona ("Commission") will provide supplemental information to the Commission, including a summary of public comments received and staff recommendations. The Commission, at a later duly-noticed public meeting, will take formal action to adopt a 2019/2020 Physicians' and Pharmaceutical Fee Schedule ("2019/2020 Fee Schedule").

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

II. PROPOSALS AND REQUEST FOR PUBLIC COMMENT REGARDING THE 2019/2020 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 10, found in the accompanying Excel file.

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

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

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

b. Utilize applicable RVUs from OPTUM 360's 2019 publication *The Essential RBRVS*.
This method was used to assign and update RVUs for all "gap" codes not included in the 2019 MPFS.

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

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

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

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

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

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

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

Note: Additionally:

a. The proposed 2019/2020 Fee Schedule continues to use CMS's surgical global periods.

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

d. 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®-4* are preceded by an "AZ" identifier and numbered in the following format: AZ0xx-xxx.

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

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

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

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

B. Adoption of four HCPCS Level II G codes for definitive drug testing, G0480 – G0483.

Current coding for drug testing relies on a structure of "screening" (also known as "presumptive" testing), followed by "confirmation" testing to confirm the results of the screening tests and quantitative or "definitive" testing that identifies the specific drug and quantity.

The Clinical Diagnostic Laboratory Fee Schedule, a fee schedule maintained by CMS, introduced four HCPCS Level II G codes for definitive testing, G0480-G0483, in 2016. These codes are selected based upon the number of drug classes screened. Staff proposes that the Commission adopt HCPCS Level II G codes for definitive drug testing. Only one of the four HCPCS Level II G codes for may be billed per patient, per day. The number of definitive classes tested, including metabolites if performed, will determine the appropriate definitive testing HCPCS G code to bill.

C. 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 2019/2020 Fee Schedule.

D. Adoption of Deletions, Additions, General Guidelines, and Identifiers of the CPT®-4.

The proposed 2019/2020 Fee Schedule is based upon staff review of deletions and additions to CPT®-4. The proposed 2019/2020 Fee Schedule is intended to conform to changes that have taken place in the 2019 edition of CPT®-4.

E. Revisions to the Pharmaceutical Fee Schedule Guidelines.

Staff proposes to revise and update the Pharmaceutical Fee Schedule Guidelines, consistent with SB1111, to include billing and reimbursement guidelines for prescription medications, repackaged medications, compound medications, physician-administered medications, physician-dispensed medication, and over-the-counter medications. The full text of the proposed revisions are attached.

PROPOSED

PHARMACEUTICAL FEE SCHEDULE

I. GENERAL PROVISIONS AND APPLICABILITY OF THE PHARMACEUTICAL FEE SCHEDULE.

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

B. Medications are not reimbursable unless "reasonably required" at the time of injury or during the period of disability. See A.R.S. § 23-1062(A); A.A.C. R20-5-1303(A). The Industrial Commission of Arizona has adopted the Official Disability Guidelines (ODG), including ODG's Drug Formulary Appendix A (ODG Formulary), as the standard reference for evidence-based medicine used in treating injured employees within the context of Arizona's workers' compensation system. Effective October 1, 2018, ODG applies to all body parts and conditions. See A.A.C. R20-5-1301(B), (E). ODG is to be used as a tool to support clinical decision making and quality health care delivery to injured employees. The ODG Formulary sets forth pharmaceutical guidelines that are generally considered reasonable and are presumed correct if the guidelines provide recommendations related to a particular medication. See A.A.C. R20-5-1301(H). Medical practitioners are encouraged to consult the ODG Formulary before dispensing or prescribing medications to injured employees.

C. Generic drugs must be dispensed to injured employees when appropriate, consistent with A.R.S. § 32-1963.01(A),[1] (B), and (D) through (L).[2] See A.R.S. § 23-908(C). For purposes of this subsection, the definitions in A.R.S. § 32-1963.01(L) apply.[3] As a cost reducing measure, medical practitioners should prescribe less costly drugs whenever possible.

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[1] A.R.S. § 32-1963.01(A) states: "If a medical practitioner prescribes a brand name drug and does not indicate an intent to prevent substitution as prescribed in subsection E of this section, a pharmacist may fill the prescription with a generic equivalent drug."

[2] A.R.S. § 32-1963.01(E) states: "A prescription generated in this state must be dispensed as written only if the prescriber writes or clearly displays 'DAW', 'dispense as written', 'do not substitute' or 'medically necessary' or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form. A prescription from out of state or from agencies of the United States government must be dispensed as written only if the prescriber writes or clearly displays 'do not substitute', 'dispense as written' or 'medically necessary' or any statement by the prescriber that clearly indicates an intent to prevent substitution on the face of the prescription form."

[3] A.R.S. § 32-1963.01(L) states, in part:

2. "Brand name drug" means a drug with a proprietary name assigned to it by the manufacturer or distributor.

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4. "Generic equivalent" or "generically equivalent" means a drug that has an identical amount of the same active chemical ingredients in the same dosage form, that meets applicable standards of strength, quality and purity according to the United States pharmacopeia or other nationally recognized compendium and that, if administered in the same amounts, will provide comparable therapeutic effects. Generic equivalent or generically equivalent does not include a drug that is listed by the United States food and drug administration as having unresolved bioequivalence concerns according to the administration's most recent publication of approved drug products with therapeutic equivalence evaluations.

II. DEFINITIONS.

A. “Administer” has the meaning set forth in A.R.S. 32-1901(1).

B. “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.

C. “Commercially available” means a drug product is widely available for purchase in pharmacies accessible to the general public and that are sold in substantial quantities in the commercial marketplace.

D. “Compound medication” means a pharmaceutical product created by a licensed pharmacist, or under the supervision of a licensed pharmacist, by virtue of mixing, combining, or altering drugs and/or components to meet the unique needs of an individual patient when the finished product does not recreate a commercially-available product.

E. “Dispense” or “dispensing” means to deliver to an ultimate user by or pursuant to the lawful order of a medical practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare for that delivery. See A.R.S. § 32-1901(27).

F. "Drug" has the meaning set forth in A.R.S. § 32-1901(31).

G. ”Hospital" means any institution for the care and treatment of the sick and injured that is approved and licensed as a hospital by: (1) the Arizona Department of Health Services; or (2) an equivalent regulatory agency in another U.S. state, territory, or district. See A.R.S. § 32-1901(42).

H. "Medical practitioner" means any person who is permitted/licensed and authorized by law to use and prescribe prescription medications, acting within the scope of such authority, for the treatment of sick and injured human beings or for the diagnosis or prevention of sickness in human beings in the State of Arizona or any U.S. state, territory or district. See A.R.S. § 32-1901(53).

I. “Non-traditional strength” medication means a finished drug product in a formulation that is not commercially available in pharmacies accessible to the general public.

J. “Over-the-counter medication” or “OTC medication” means a finished drug product, including label and container according to context, that does not require a prescription order.

K. "Pharmacy" has the meaning set forth in A.R.S. § 32-1901(71).

L. “Pharmacy accessible to the general public” means a pharmacy that is readily accessible and provides pharmaceutical services (including prescription medication services) to all segments of the general public without restricting

services to a defined or exclusive group of consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner.

M. “Pharmacy not accessible to the general public” means a pharmacy that provides services only to a defined or exclusive group of consumers who have access to pharmaceutical services (including prescription medication services) because they are treated by or have an affiliation with a specific entity or medical practitioner. “Pharmacy not accessible to the general public” does not include a hospital pharmacy.

N. “Prescription” means either a prescription order or a prescription medication. See A.R.S. § 32-1901(80).

O. "Prescription medication” means any drug, including label and container according to context, that is dispensed pursuant to a prescription order. See A.R.S. § 32-1901(81).

P. “Prescription order” shall have the meaning set forth in A.R.S. § 32-1901(84).

Q. “Repackaged medication” means a finished drug product removed from the container in which it was distributed by the original manufacturer and placed into a different container without further manipulation of the drug. The term also includes the act of placing the contents of multiple containers of the same finished drug product into one container. The term also includes “co-pack drug” products which contain two or more separate finished medications that are contained in a single package or unit. The term does not include a drug that is manipulated in any other way, including if the drug is reconstituted, diluted, mixed, or combined with another ingredient.

R. “Traditional strength” medication means a finished drug product in a formulation that is commercially available in pharmacies accessible to the general public.

S. "Ultimate user" means a person who lawfully possesses a prescription medication for that person's own use or for the use of a member of that person's household. See A.R.S. § 32-1901(95).

III. GENERAL GUIDELINES FOR BILLING AND REIMBURSEMENT OF PRESCRIPTION MEDICATIONS.

A. Except as permitted in Section VII of the current PFS, an insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications only if all of the following apply:

B. The prescription medication is dispensed by an individual who is currently licensed to practice the profession of pharmacy by either: (i) the Arizona State Board of Pharmacy; or (ii) an equivalent regulatory agency in another U.S. state, territory, or district; and

C. The prescription medication is dispensed by a pharmacy accessible to the general public, including online or mail-order pharmacies that are accessible to the general public.

D. Reimbursement for prescription medications shall be based on the actual medication dispensed, including a substituted medication that is dispensed pursuant to A.R.S. § 32-1963.01.

E. Except as specified in Sections IV and V of the current PFS, a pharmaceutical bill submitted for a prescription medication must include the National Drug Code (NDC) of the original manufacturer registered with the U.S. Food & Drug Administration (FDA), the quantity dispensed, and the reimbursement value of the medication. Under no circumstance shall an NDC other than the original manufacturer's NDC be used.

F. The reimbursement value for prescription medications shall be based on the current PFS methodology in the absence of a contractual agreement between the pharmacy or medical practitioner and payer governing reimbursement. Network discounts may not be applied in the absence of a contractual agreement with the pharmacy or medical practitioner authorizing such discounts.

G. The reimbursement value for a prescription medication shall be based on a discount from the applicable AWP, as determined by reference to the original manufacturer's NDC. AWP shall be determined on the date a drug is dispensed from pricing published in the most recent issue, as updated in the most recent update, of a nationally-recognized pharmaceutical publication designated by the Commission. For purposes of determining AWP, the Commission has selected Medi-span for the 2019/2020 PFS.

H. The reimbursement value for a prescription medication shall be calculated on a per unit basis based on the applicable AWP per unit and the following methodology:

I. Generic drugs: (85% of AWP per unit) x (number of units dispensed).

J. Brand name drugs: (85% of AWP per unit) x (number of units dispensed).

K. Reimbursement for non-traditional strength prescription medications shall be calculated on a per unit basis, as of the date of dispensing, based on the original manufacturer's NDC and corresponding AWP of the most similar traditional strength form of the same medication. Under no circumstance shall the NDC of the non-traditional strength medication be used.

IV. BILLING AND REIMBURSEMENT FOR REPACKAGED MEDICATIONS.

A. 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.

B. If a pharmaceutical bill for a repackaged medication is submitted without the original manufacturer's NDC, the payer has the discretion to determine the appropriate NDC (and corresponding AWP) to use or, alternatively, may deny coverage until the appropriate NDC is furnished.

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

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

V. BILLING AND REIMBURSEMENT FOR COMPOUND MEDICATIONS.

A. 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. All component ingredients of a compound medication must be billed on a single bill.

B. The reimbursement value for a compound medication shall be calculated at the component ingredient level. The reimbursement value for a compound medication shall be based on the sum of the reimbursement values of each component ingredient and the corresponding component ingredient's NDC, based on the current PFS reimbursement methodology set forth in Section III.

C. Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed.

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

E. If any component ingredient in a compound medication is a repackaged medication, the reimbursement value for the repackaged medication ingredient shall be determined based on the current PFS reimbursement methodology set forth in Section III, using the AWP corresponding to the NDC of the original manufacturer. See Section IV.

F. 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.

VI. BILLING AND REIMBURSEMENT FOR MEDICATIONS ADMINISTERED BY A MEDICAL PRACTITIONER.

A. A pharmaceutical bill submitted for a medication administered by a medical practitioner must comply with billing procedures outlined in Sections III, IV, and V of the current PFS, as applicable.

B. The reimbursement value for a medication administered by a medical practitioner shall be based on the current PFS reimbursement methodology contained in Sections III, IV, and V of the PFS, as applicable.

VII. REIMBURSEMENT FOR MEDICATIONS DISPENSED BY A MEDICAL PRACTITIONER OR IN A PHARMACY NOT ACCESSIBLE TO THE GENERAL PUBLIC.[4]

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

1. The prescription medication is dispensed by a medical practitioner providing initial treatment to the injured employee following an industrial injury;
2. The prescription medication is limited to no more than a one-time, ten-day supply;
3. The prescription medication is dispensed within seven days from the date of the industrial injury; and
4. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.

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

1. The injured employee does not have access to a pharmacy accessible to the general public within 20 miles of the injured employee's home address, work address, or the address of the prescribing medical practitioner;
2. The injured employee cannot reasonably acquire the prescription medication from an online or mail order pharmacy accessible to the general public; and
3. The prescription medication conforms to dosages and formulations which are commercially available in pharmacies accessible to the general public.

C. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are

[4] Dispensing pursuant to Section VII is subject to the Arizona Opioid Epidemic Act, which imposes statutory limits on the prescribing and dispensing of schedule II opioids. For more information about the Arizona Opioid Epidemic Act, please see the FAQs published by the Arizona State Board of Pharmacy, available at https://drive.google.com/file/d/1JCIs8VwtdJ1T-DyGfJN3WWUm4KhDMXe-/view.

dispensed by a medical practitioner or in a pharmacy not accessible to the general public if all of the following apply:

1. The prescription medication is dispensed by a hospital medical practitioner upon discharge from in-patient care;
2. The prescription medication is limited to no more than a one-time, thirty-day supply; and
3. The prescription medication conforms to dosages and formulations which are commercially available in pharmacies accessible to the general public.

D. An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a medical practitioner or in a pharmacy not accessible to the general public if the dispensing of a prescription medication for an individual claim and specified duration has been preapproved in writing by the insurance carrier, self-insured employer, or the Special Fund of the Commission. Nothing in this Section requires an insurance carrier, self-insured employer, or the Special Fund of the Commission to preapprove the dispensing of prescription medications under this subsection.

E. The guidelines in this section do not apply to prescription medications dispensed during in-patient hospital care.

F. The reimbursement value for OTC medications dispensed by a medical practitioner or in a pharmacy not accessible to the general public shall be calculated on a per unit basis, as of the date of dispensing, based on the retail price (per unit) of the OTC medication in settings where the medication is commercially available.

G. Subject to the limitations in this section, medications that have been provided as free samples to a medical practitioner may be dispensed to an injured employee when appropriate, but are not reimbursable.

VIII. DISPENSING FEE.

A. If a prescription medication is dispensed by a pharmacy accessible to the general public pursuant to a prescription order, a dispensing fee of up to seven dollars ($7.00) per prescription medication, repackaged medication, or compound medication may be charged. The dispensing fee does not apply to OTC medications that are not prescribed by a medical practitioner.

B. If a prescription or OTC medication is dispensed by a medical practitioner or by a pharmacy not accessible to the general public, a dispensing fee is not permitted.

C. If a prescription or OTC medication is administered by a medical practitioner, a dispensing fee is not permitted.

IX. ADDITIONAL BILLING GUIDELINES.

PROPOSED

A. Paper billing by a medical practitioner:

The following is an example of how to report both the repackaged NDC and original NDC on the CMS 1500 form using the shaded area of line 24. The information is reported in the following order: qualifier (N4), NDC code, one space, unit/basis of measurement qualifier, quantity, one space, ORIG, qualifier (N4), NDC code."

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N455289047590 UN30 ORIGN400025152531													N	G2	12345678901
10	01	05	10	01	05	11		J3490		A	500	00 30	N	NPI	0123456789

If a physician does not bill using the CMS 1500 form, or is not able to include all the required information on the CMS 1500 form (due to software/system limitations), then the physician may provide the required information (in the required order) separately or as an attachment to the CMS 1500 form.

B. Paper billing by non-physician entities.

A non-physician entity using paper billing to bill for medications shall use the most recent version of the Workers' Compensation/Property & Casualty Universal claim Form (WC/PC UCF) adopted by the National Council for Prescription Drug Programs.