PATHOLOGY AND LABORATORY GUIDELINES

The general guidelines and modifiers found in the 2012 CPT®-4 were adopted by reference by the Industrial Commission and are applicable when utilizing Arizona's Physicians' Fee Schedule. The Pathology Guidelines adopted by reference may be found in the *Current Procedural Terminology®, Fourth Edition ("CPT® book")* published by the AMA. The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between the adopted portions of the CPT®-4 and a code or guideline unique to Arizona, the Arizona code or guideline shall control.

1. For purposes of this Fee Schedule, reimbursement for Codes 80100, 80101, and 80104 is subject to the following:

    a. A provider is entitled to reimbursement under code 80100 for drug testing that is performed using complex chromatographic instruments. Additionally, a payer is only required to pay for one unit of service per patient encounter regardless of the number of drug classes tested.

    b. A provider is entitled to reimbursement under code 80101 for complex chemistry analyzers that involve a distinct analysis per drug class. A payer is not required to reimburse under this code for testing methods such as drug test kits, dipsticks, cups, cassettes, and cards that are interpreted either visually, with the assistance of a scanner, or are read utilizing a device outside the instrumented laboratory setting (i.e., non-instrumented devices).

    c. A provider is entitled to reimbursement under code 80104 for drug testing that is performed using a drug test kit. This includes testing methods such as dipsticks, cups, cassettes, and cards that are interpreted visually, with the assistance of a scanner, or are read utilizing a device outside the instrumented laboratory setting (i.e., non-instrumented devices). This also includes a drug test kit that is described as using an "immunochromatographic method." A payer is only required to pay for one unit of service per patient encounter regardless of the number of drug classes tested.

2. A provider seeking reimbursement for "point of care" drug testing must submit to the payer written documentation establishing:

    a. That the testing is medically necessary and reasonably required;

    b. The type of drug testing utilized; and

c. The provider's interpretation of the "point of care" testing.

For purposes of this section, "point of care" testing is testing that is performed at or near the site of patient care (i.e. the physician's office).

3. In the text of the Fee Schedule, we utilize * and ** to denote "add-on" codes and those codes that are exempt from the multiple procedure rule.

a. * Denotes Add-on Codes

(List separately in addition to code for primary procedure)

Note: This code is an add-on procedure and as such is valued appropriately. Multiple procedure guidelines for reduction of value are not applicable.

b. ** Denotes Codes Exempt from Modifier "-51"

Note: Multiple procedure guidelines for reduction of value are not applicable for this code.