ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE
FREQUENTLY ASKED QUESTIONS
(Revision of December 2015)

1. What is the authority under which the schedule of fees is set?

Since 1925, when the Arizona Legislature passed the State's first Workers' Compensation Act ("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 physicians, physical therapists, and occupational therapists attending injured employees. See A.R.S. § 23-908(B). The Arizona Legislature amended A.R.S. § 23-908 in 2004 to include the setting of fees for prescription medicines required to treat an injured employee.

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

The Commission surveys the workers' compensation fee schedules from the states of Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah, and Washington and uses the following methodology to calculate the reimbursement values for the codes under review:

a. Current Arizona values between the 75th and 100th percentile of the states surveyed will not be adjusted;
b. Current Arizona values over the 100th percentile of the states surveyed will be reduced to the 100th percentile; and
c. Current Arizona values below the 75th percentile will be increased to the 75th percentile subject to the following: Increases shall be capped at 25%, unless and except as necessary to bring a current value up to the 50th percentile.

The foregoing methodology does not apply to the following:

a. If the survey sample size is less than four, then the code may be identified as RNE (Relative Value Not Established) or BR (By Report), except if it involves the PC (Professional Component) of a value in which case the PC value may be based on the current ICA PC to Total Value ratio;
b. Codes specific to Arizona, the value of which may be determined through the hearing process; and
c. Codes otherwise designated as BR.

Regarding the formula to calculate the associated percentiles, the Commission uses the percentile formula in Microsoft® Excel®.

The following changes have been adopted by the Commission and implemented in the 2015/2016 Fee Schedule:

a. Replacing the four-year cycle of review, all codes were reviewed this year. The form of reporting the codes and values was changed to mirror how this information is presented commercially, as well as by other states. This included identifying codes

that are "not covered" because they had not previously been adopted by the Commission (*e.g.*, maternity codes, pediatric codes, etc.). This also included identifying, where applicable, the TC (Technical Component) of a value. As part of this process, and to improve the clarity of the information presented, *CPT*® codes that contain explanatory language specific to Arizona continued 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.

b. The Fee Schedule was updated to the 2015 *CPT*-4® (which became effective January 1, 2015). The Commission adopted the reference deletions, additions, terminology changes, general guidelines, identifiers, and modifiers of the 2014 and 2015 CPT® codes to ensure that the 2015/2016 Fee Schedule is current and reflects the latest changes to those editions of the *CPT*®-4. 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 would take precedence.

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

The Commission reviews all of the codes on an annual basis. The review date of the Fee Schedule of other jurisdictions for the Arizona 2016 Fee Schedule is January 31, 2016.

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

Annual updates to the Fee Schedule become effective October 1st of each year. The public is afforded an opportunity to participate in the process. In early spring of each year, the Commission provides an analysis of issues along with staff recommendations for the fee schedule (to be effective the following October 1st). This document is posted on the Commission's website and is intended to serve as a foundational document for public comment and future discussions that may arise during the public hearing process. Following the posting of a Notice of Hearing on the Commission's website, a public hearing is held to receive public comment. Written comments are welcomed in advance of the public hearing. Thereafter, at a later duly noticed public meeting, the Commission will take official action on the Fee Schedule. This action will be incorporated into the Fee Schedule to become effective October 1st of that year.

5. What fees are covered under the Arizona Fee Schedule?

Under A.R.S. § 23-908(B), the Commission is required to establish a schedule of fees to be charged by physicians and physical therapists or occupational therapists attending injured employees. The Commission is also required to establish a schedule of fees for prescription medicines required to treat an injured employee.

For purposes of the Fee Schedule, the term "physician" includes chiropractors and naturopaths.

Fees for certain products, supplies, and services are not included in the Fee Schedule. This includes fees for ambulance services, durable medical equipment, prosthetics,

orthotics, and supplies when used outside a physician's office. If a product, supply, or services are not included in the Fee Schedule, there will not be a code for those items in the Fee Schedule (*e.g.*, codes from Medicare's Healthcare Common Procedure Coding System, HCPCS).

6. What is the appropriate fee for products, supplies, or services not covered under the Fee Schedule? Is it "usual, customary, and reasonable (UCR)"?

If a product, supply, or service is not covered under the Arizona Fee Schedule, then the Commission has no jurisdiction to set a fee or resolve a fee dispute related to the service. Additionally, while the obligation of a payer under the Arizona Workers' Compensation Act is to provide medical benefits that are reasonably required, neither the Arizona Workers' Compensation Act, A.R.S. § 23-901 *et seq.*, nor the Arizona Physicians' Fee Schedule make reference to the phrase "usual, customary and reasonable." You may wish to consult an attorney for further assistance regarding this issue.

7. May a provider bill for services using a code that has not been adopted by the Commission?

A provider is not precluded from billing for a service for which there is no corresponding code in the current Fee Schedule. But, for such a service, since there is no reimbursement value set forth in the Fee Schedule, reimbursement for the service performed is subject to negotiation between the parties. See Section (B)(4) of the Fee Schedule Introduction. As an alternative to billing under a code that has not yet been adopted, some providers will use an otherwise applicable code or an "unlisted service or procedure" code in the current fee schedule.

8. May a provider covered by the Fee Schedule negotiate a fee that is different from that in the Fee Schedule?

Yes. Nothing in the Fee Schedule precludes an entity covered under the Fee Schedule from entering into a separate contract that addresses fees for service.

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

The Fee Schedule applies to fees charged by covered entities attending employees that are entitled to receive workers' compensation benefits under the Arizona Workers' Compensation Act.

10. Does the Fee Schedule apply to fees charged by chiropractors and naturopaths?

Yes.

11. Does the Fee Schedule apply to fees charged by nurse practitioners, physician assistants, or certified nurse anesthetists?

Yes. Certified Registered Nurse Anesthetists are reimbursed at 85% of the Fee Schedule. 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 made at 100% of the Fee Schedule. See Section C of the Introduction, Reimbursement of Mid-Level Providers for additional information.

12. Does the Fee Schedule apply to fees charged by Physical Therapy Assistants?

The Fee Schedule applies to Physical Therapists and *not* Physical Therapy Assistants. Please see answers to questions 5 and 6.

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

No. See also answers to questions 5 and 6.

14. Does the Fee Schedule apply to charges for materials and supplies used in the physician's office?

A physician is not entitled to be reimbursed for supplies and materials normally necessary to perform the service. A physician may charge for other supplies and materials using code 99070. A physician 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 physician. Examples of those items that are and are not reimbursable are listed below. Documentation showing actual costs associated with providing supplies and materials plus fifteen percent (15%) to cover overhead costs will be adequate justification for payment. This provision does not apply to retail operations involving drugs or supplies. Administration of drugs to patients in a clinical setting is covered under code 99070. Prescription drugs provided to patients as a part of the overall treatment regimen but outside of the clinical setting are not included under this code.

Examples of supplies that are not separately reimbursable:

Applied hot or cold packs
Eye patches, injections, or debridement trays
Steristrips
Needles
Syringes
Eye/ear trays
Drapes
Sterile gloves
Applied eye wash or eye drops
Creams (massage)
Fluorescein
Ultrasound pads and gel
Tissues
Urine collection kits
Gauze
Cotton balls/fluff
Sterile water

Band-Aids® and dressings for simple wound occlusion
Head sheets
Aspiration trays
Tape for dressing

Examples of material and supplies that are generally reimbursable include:

Cast and strapping materials
Sterile trays for laceration repair and more complex surgeries
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.

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

No. See also answers to questions 5 and 6.

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

No.

17. Does the Pharmaceutical Fee Schedule permit a Payer to choose the publication source for determining Average Wholesale Price?

No. Average wholesale price shall be determined from pricing published in a nationally recognized pharmaceutical publication designated by the Commission. The Commission has selected Medi-Span®.

18. What publication is required to be used for purposes of determining Average Wholesale Price?

Average wholesale price 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. The Commission has selected Medi-Span®.

An entity responsible for payment of prescription drugs may select the following as an alternative to the foregoing if the selection is made no later than October 1st of each year. This selection shall be communicated in writing to the Commission and remain in effect until the following October 1st: AWP shall be determined on the date a drug is dispensed from pricing published in the most recent issue, as updated quarterly, of the publication designated by the Commission. For purposes of this paragraph, quarterly means the first day of the month on January, April, July, and October.

19. Does the Pharmaceutical Fee Schedule apply to repackaged medicines dispensed by a physician?

The Fee Schedule applies to the dispensing of prescription drugs, regardless of whether the drug is dispensed by a retail establishment or by a physician. The reimbursement rate is based on a discount from AWP plus a dispensing fee. The dispensing fee does not apply to an OTC medication that is not dispensed pursuant to a prescription order.

20. What is the Average Wholesale Price for repackaged drugs?

For purposes of the Fee Schedule, "average wholesale price" is the average wholesale price (AWP) established by a wholesaler who sells that brand name or generic drug to a pharmacy. For a repackaged or compounded drug, this would be the AWP of the underlying drug product used in the repackaging or compounding. If information pertaining to the original labeler of the underlying drug product is not provided or unknown, then discretion is vested in the payer to select the AWP to use (as published in Medi-Span®) when making payment for the repackaged or compounded drug. Stated another way, the NDC number upon which reimbursement is based is not the NDC of the repackager. Instead, reimbursement is based upon the underlying drug product from the original labeler.

21. I am a physician and I have been subpoenaed to provide telephonic court testimony. How do I bill for my services?

If the physician wishes to submit an invoice, the invoice must be sent to the Industrial Commission's Administrative Law Judge Division. The address of this Division is located on the subpoena that the physician received. The physician is entitled to bill under code 99099 (expert testimony) at a rate of $110 per hour. The invoice must include the name of the injured worker and the date that the physician provided testimony.