HCPCS GUIDELINES

Information regarding the incorporation of HCPCS codes is found in the Introduction to the Fee Schedule.

HCPCS codes are five-character codes with a leading alpha-character followed by four numeric digits.

The following Commission guidelines are provided in addition to the Center for Medicare & Medicaid Services' (CMS) HCPCS codes and descriptions and represent additional guidance from the Commission relative to services unique or uniquely utilized in Workers' Compensation. To the extent that a conflict may exist between an incorporated HCPCS code and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier, or modifier shall control. Codes that contain explanatory language specific to Arizona are preceded by Δ in this Fee Schedule. Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx.

HCPCS codes in this section are used to bill for services, equipment, and supplies including:

- Medical and surgical supplies
- Durable medical equipment
- Physician-administered drugs
- Prosthetics and orthotics
- Vision and hearing supplies

In this section, any reference to Durable Medical Equipment (DME) includes reimbursable supplies, prosthetics, and orthotics.

A. REIMBURSEMENT

1. Materials and supplies normally necessary to perform a service, such as needles and syringes, ultrasound pads and gel, band-aids, and dressings are considered part of a healthcare provider's overhead and are not separately reimbursable. Please see Section J of the Introduction Guidelines to the Fee Schedule for more examples of non-reimbursable supplies and materials.

2. This section of the fee schedule includes maximum reimbursement amounts for DME, services, and procedures billed with HCPCS codes.

3. DME dispensed by a healthcare provider to the patient ancillary to an office visit shall be reimbursed at the lesser of the provider's billed charge or the value listed in the fee schedule.

4. DME may be reimbursed differently based on whether the zip code where the materials are provided are classified by CMS as rural or nonrural. The fee schedule includes different rates for rural and nonrural zip codes where applicable. The zip codes included on the list below shall be reimbursed based on the fees in the "Rural" column in the fee schedule. All other zip codes shall be reimbursed based on the "Nonrural" fee.

Rural Zip Codes

85135	85371	85542	85621	85920	85936	86034	86511
85192	85390	85543	85623	85922	85937	86039	86512
85320	85501	85544	85624	85923	85938	86042	86514
85321	85502	85545	85628	85924	85939	86043	86515
85325	85530	85546	85631	85925	85940	86047	86520
85328	85531	85547	85634	85926	85941	86054	86535
85334	85532	85548	85637	85927	85942	86502	86538
85341	85533	85550	85640	85928	86025	86503	86540
85344	85534	85551	85646	85929	86028	86504	86544
85346	85535	85552	85648	85930	86029	86505	86545
85348	85536	85553	85901	85932	86030	86506	86547
85357	85539	85554	85902	85933	86031	86507	86556
85358	85540	85611	85911	85934	86032	86508	
85359	85541	85618	85912	85935	86033	86510	

5. DME shipped to the patient shall be reimbursed based on the location of the patient when determining if the fees for rural or nonrural zip codes apply.

6. HCPCS codes describing physician-administered drugs and biologicals including, chemotherapy and immunosuppressive drugs, inhalation solutions and other miscellaneous drugs and solutions shall be used when billing for these products. Please refer to the Pharmaceutical Fee Schedule for billing and reimbursement information for prescription and over-the-counter drugs, including those that are described by HCPCS codes.

7. DME items that are listed as By Report, have no listed value, or are not included in the fee schedule, shall be reimbursed at 140% of the actual cost. The DME provider shall include a copy of the original invoice for each item. No additional reimbursement for shipping or delivery shall be provided. If the DME was procured from an intermediary entity (e.g., wholesaler) and not the original manufacturer, the provider must disclose any rebates, reductions, discounts, or relationship with that intermediary entity and the impact on the original manufacturer's cost of that item. Reimbursement may also be based on a predetermined agreement between the provider and the payer.

8. Services that are listed as By Report, have no listed value, or are not included in the fee schedule, shall be reimbursed based on a predetermined agreement between the provider and the payer.

9. Reimbursement for DME shall not be less than the actual cost of an item. Specialized (*e.g.,* bariatric) equipment may have an actual cost that is greater than the reimbursement value listed in the Fee Schedule. The DME provider must demonstrate the actual cost of the DME is greater than the listed reimbursement value by presenting a copy of the original invoice for that item. The reimbursement value for the item shall be based on a predetermined agreement between the DME provider and the payer. When the DME was procured from an intermediary entity

(*e.g.,* wholesaler) and not the original manufacturer, the provider must disclose any rebates, reductions, discounts, or relationship with that intermediary entity and the impact on the original manufacturer's cost of that item.

10. Home Health Care – please see the Home Health Care Fee Schedule Guidelines.

B. MODIFIERS

1. As appropriate, durable medical equipment, should be billed with the following modifiers:

    a. NU – indicates the purchase of new equipment.

    b. UE – indicates the purchase of used equipment.

    c. RR – indicates that the equipment is being rented. Rental periods shall be considered monthly unless defined differently in the code description.

        i. The maximum rental period is 13 months. After 13 months, the equipment shall be considered purchased.

    Note: Not all durable medical equipment will have modifiers. For example, certain supplies are low cost and therefore will not have used or rental options; other codes may have "rental" or "used" included in the code description.

C. BILLING

1. Providers of orthotics and prostheses may bill for fitting, training, and management using CPT® codes 97760-97763.

2. DME and Implantable devices shall be billed separately from facility and professional service fees only if they are not considered bundled with the primary service code.

3. Certain DME may be rented. Determination to purchase or rent DME shall be based on CMS Medicare guidelines in effect on the date the patient takes possession of the DME.

4. Materials, supplies, and equipment billed with a miscellaneous code (e.g., E1399 – durable medical equipment, miscellaneous) shall include the brand name and model number of the DME being supplied when available.

5. Actual shipping or delivery costs necessary to transit DME to the injured worker may be billed except those DME items described in Subsection (A)(7). Documentation demonstrating the cost of shipping shall be included with the invoice.