Industrial Commission of Arizona

Staff Proposal and Request for Public Comment

for

2025/2026 Arizona Physicians' and Pharmaceutical Fee Schedule

Medical Resource Office

Phone (602) 542-4308 / Fax (602) 542-4797

mro@azica.gov

I. INTRODUCTION.

The information contained in this report is based on a review of various resources, including the following: (1) The 2025 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology associated with the incorporated codes; (2) The 2025 Healthcare Common Procedure Coding System (HCPCS) codes that include procedures, supplies, products, and services published by the Centers for Medicare & Medicaid Services (CMS), (3) 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 (ASA); (4) The *2025 Clinical Diagnostic Laboratory Fee Schedule,* CMS Clinical Laboratory Fee Schedule; (5) The *National Correct Coding Initiative Edits,* CMS; (6) *Physicians as Assistants at Surgery: 2023 Update*; (7) Surgical global periods published by CMS, 2025 Update, (8) *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* was published by the American Psychiatric Association in March 2022, (9) ICD-10 Version: 2019: International Statistical Classification of Diseases and Related Health Problems 10th Revision published by the World Health Organization (WHO), and (10) FAIR Health data, copyright 2025, FAIR Health, Inc.

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

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 2025/2026 Physicians' and Pharmaceutical Fee Schedule ("2025/2026 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 2025/2026 PHYSICIANS AND PHARMACEUTICAL FEE SCHEDULE.

A. Adoption of Updates to Relative Value Units and Reimbursement Values Assigned to CPT® Codes.

Staff proposes adoption of the service codes, Relative Value Units (RVUs), Anesthesia Base Units (BUs), and reimbursement values contained in Tables 1 through 8, published with the staff proposal. These tables provide the reimbursement values assigned to Anesthesia, Surgery, Radiology, Pathology, Medicine, Physical Medicine and Rehabilitation, Evaluation and Management, and Category III services.

The Staff Proposal is based upon the continued use of a resource-based relative value scale (RBRVS) reimbursement system for Tables 1 through 8 in which reimbursement values are calculated by multiplying "resources required to perform a service (RVUs or BUs)" by a dollar value conversion factor ("CF"). The proposed 2025/2026 Fee Schedule is based upon the following two-step methodology to compute reimbursement values for all applicable service codes:

STEP 1: Establishing RVUs or BUs for each service code. This was done using one of the five methods below:

a. Utilize applicable RVUs from the 2025 MPFS or BUs from the *2025 Anesthesia Base Units from 2025 CPT®*. The 2025 MPFS is the preliminary source for assigning and updating RVUs for all service codes.

b. Utilize applicable RVUs from the *2025 Clinical Diagnostic Laboratory Fee Schedule*. This method was used to update RVUs for most pathology and laboratory service codes.

c. Utilize applicable RVUs from FAIR Health data. This method was used to assign and update RVUs for "gap" codes not included in the 2025 MPFS.

d. 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 and BUs were assigned to all service codes, reimbursement rates were calculated by multiplying the applicable RVU or BU by the appropriate Arizona-specific conversion factor. Staff proposes that the 2025/2026 Fee Schedule continue using a multiple conversion factor model, consisting of one conversion factor for Anesthesia Services, a second

for Surgery services, a third for Radiology Services, and a fourth for all remaining service categories (including Pathology and Laboratory, Medicine, Physical Medicine and Rehabilitation, and Evaluation & Management).

The four proposed conversion factors for the 2025/2026 Fee Schedule are:

RBRVS Conversion Factors	
Anesthesia	$61.00
Surgery	$72.00
Radiology	$70.00
All Other Services	$68.00

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

Note: Additionally:

a. The proposed 2025/2026 Fee Schedule continues to incorporate by reference CMS's surgical global periods.

b. The proposed 2025/2026 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 2025/2026 Fee Schedule does not incorporate a geographic adjustment factor ("GAF") for codes that are valued utilizing RVUs, but instead uses the Arizona-specific

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

conversion factor to adjust payment for the state. CMS utilizes one GAF for the entire State of Arizona.

d. Codes unique to Arizona and not otherwise found in the CPT® publication or HCPCS codes are preceded by an "AZ" identifier and numbered in the following format: AZxxx.

B. Adoption of Healthcare Common Procedure Coding System Codes and Assigned Reimbursement Values.

Staff proposes adoption of the service codes and reimbursement values contained in Table 9, published with the staff proposal. This table provides the reimbursement values assigned to Healthcare Common Procedure Coding System (HCPCS) codes that include procedures, supplies, products, and services.

The Staff Proposal is based upon the reimbursement values published by CMS in the January 2025 DMEPOS file and maintains separate values for rural and nonrural areas. The methodology utilized by CMS to designate rural and nonrural areas was incorporated as well. HCPCS codes that did not have a reimbursement value in the DMEPOS, were assigned a reimbursement value using FAIR Health data.

These values are then multiplied by an Arizona conversion factor to produce the reimbursement values listed in the table.

The proposed HCPCS conversion factor for the 2025/2026 Fee Schedule is 1.4.

Note: J-codes and S-codes are not assigned reimbursement values. J-codes describe administered medications. Medication will continue to be reimbursed according to the Pharmaceutical Fee Schedule Guidelines. Reimbursement for many Home Healthcare Services shall be negotiated between the payer and provider.

C. Adoption of Reimbursement Values for Arizona Specific Codes.

Staff proposes adoption of the Arizona Specific Codes and reimbursement values contained in Table 10, published with the staff proposal. This table provides the reimbursement values assigned to codes unique to Arizona and not otherwise found in the CPT® publication or HCPCS codes.

D. 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 2025/2026 Fee Schedule.

E. Adoption of Deletions, Additions, General Guidelines, and Identifiers of the CPT®.

The proposed 2025/2026 Fee Schedule is based upon staff review of deletions and additions to CPT®. The proposed 2025/2026 Fee Schedule is intended to conform to changes that have taken place in the 2025 edition of CPT®.

Note: Proposed amendments to the Fee Schedule Guidelines as described in Sections II(F) – (N) of the Staff Proposal are reflected in Exhibit A, attached.

F. Amendments to the Introduction Guidelines.

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

Introduction Section

Add The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) and ICD-10 Version: 2019 to the list of resources that are incorporated by reference.

Section A

Add subsection A(15) that provides guidance for the resources healthcare providers should use when establishing an ICD-10 code. Additional guidance is provided for the resources mental health providers should use when establishing a diagnosis for injured workers.

15. Healthcare providers shall use the appropriate International Statistical Classification of Disease and Related Health Problems (ICD-10 code(s)) published by the World Health Organization (WHO) to classify and code all diseases, signs, and symptoms, abnormal findings, social circumstances, and external causes of injury and/or disease. Mental health providers shall reference the most recent published version of the Diagnostic and Statistical Manual of Mental Disorder (DSM) published by the American Psychiatric Association to define and classify mental disorders when establishing the appropriate ICD-10 code(s).

Section K

Add the following acronyms,

APA	American Psychological Association
A.R.S.	Arizona Revised Statute

AZ	Arizona
DSM	Diagnostic and Statistical Manual of Mental Disorder
FDA	Food and Drug Administration
HBIG	Hepatitis B Immune Globulin
HIV	Human Immunodeficiency Virus
NDC	National Drug Code
NF	Non-Facility
ODG	Official Disability Guidelines
OSHA	Occupational Safety and Health Association
PC	Professional Component
PFS	Pharmaceutical Fee Schedule
POS	Place of Service
RNE	Relativity Not Established
TC	Technical Component
TPA	Third-Party Administrator
WHO	World Health Organization

G. <u>Amendments to the Physical Medicine and Rehabilitation Guidelines.</u>

Staff proposes to update the language in the guidelines to add clarification to reimbursement practices.

H. <u>Amendments to the Evaluation and Management Guidelines.</u>

Staff proposes to update the language in the guidelines to correspond with the updates to the Evaluation and Management Guidelines in the 2025 CPT®.

I. <u>Amendments to the HCPCS Guidelines.</u>

Staff proposes to update the language in the guidelines to add clarification to reimbursement.

Exhibit A

ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE

2024~~4~~5/2025~~5~~6

Adopted by The Industrial Commission of Arizona

Medical Resource Office
Phone (602) 542-4308 / Fax (602) 542-4797

mro@azica.gov

Effective May 1, 2025

2025/2026 ARIZONA PHYSICIANS' & PHARMACEUTICAL FEE SCHEDULE TABLE OF CONTENTS

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 anesthesiologists, 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 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 following:

1. The 2025 Edition of the American Medical Association's *Current Procedural Terminology* (CPT®) publication, including the general guidelines, identifiers, modifiers, and terminology associated with the incorporated codes

2. The 2025 Healthcare Common Procedure Coding System (HCPCS) codes that include procedures, supplies, products, and services published by the Centers for Medicare & Medicaid Services (CMS).

3. 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 (ASA) https://www.asahq.org.

4. The *2025 Clinical Diagnostic Laboratory Fee Schedule,* CMS Clinical Laboratory Fee Schedule ~~https://www.cms.gov/~~ https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/files.

5. The *National Correct Coding Initiative Edits,* CMS; https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual ~~https://www.cms.gov/ncci-medicare/medicare-ncci-policy-manual~~

6. Physicians as Assistants at Surgery: 2023 Update ~~https://www.facs.org/for-medical-professionals/practice-management/coding-and-billing/physicians-as-assistants-at-surgery-report/~~ https://www.facs.org/media/gp3ny4ps/2023-update-physicians-as-assistants-at-surgery.pdf

7. Surgical global periods published by CMS, 2025 Update

8. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)* was published by the American Psychiatric Association in March 2022; https://www.psychiatry.org/Psychiatrists/Practice/DSM

9. ICD-10 Version: 2019: International Statistical Classification of Diseases and Related Health Problems 10th Revision published by the World Health Organization (WHO); https://icd.who.int/browse10/2019/en

10. FAIR Health data, copyright 2025, FAIR Health, Inc.

Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx. To the extent that a conflict may exist between an incorporated portion of the CPT® publication or HCPCS codes and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier, or modifier shall control.

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, the American Society of Anesthesiologists, the Centers for Medicare and Medicaid Services, or any other entity or organization.

A. GENERAL GUIDANCE

1. Reimbursements and billing associated with Pharmaceuticals are found in the Pharmaceutical Fee Schedule Section and HCPCS Guidelines of this document.

2. A CPT code shall be billed when a CPT code exists that accurately describes the service provided. If no CPT code exists that accurately describes the service, a HCPCS code shall be billed. A miscellaneous or unlisted code shall not be used when a specific CPT or HCPCS code exists that describes the service. Reimbursement values for unlisted codes are By Report and the bill must be accompanied by documentation to support the amount billed. Exceptions apply to the following services for which HCPCS codes should be used in place of CPT codes:

    - Drug testing: CPT codes 80320-80377 may not be used to bill for drug testing. HCPCS codes G0480 - G0483 shall be used for definitive drug testing.

3. 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 for services performed by healthcare providers to injured workers under Arizona's workers' compensation law.

4. 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.

5. Routine progress and routine final reports filed by the attending healthcare provider do not ordinarily command a fee.

6. Payment will be made for only one professional visit in any one (1) day except when the submitted report clearly demonstrates the need for the additional visit and fee.

7. 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.

8. Routine office treatment principally by injection of drugs, other than antibiotics, requires authorization by the carrier or self-insured employer for each series of ten (10) after the first series of ten (10).

9. 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.

10. 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.

11. Missed individual appointments for consultants, without prior notification, will be compensated at 50% of the consultation fee.

12. The Commission will investigate an injured worker's 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 and no reductions are justified unless specified by the Fee Schedule. The performance of telehealth services is governed by Arizona Revised Statutes, Title 36, Chapter 36. Bills for telehealth services shall include modifier -95 and place of service (POS) code according to the incorporated AMA/CMS guidelines. Reimbursement for telehealth services shall be based on the non-facility (NF) rate regardless of the POS code.

15. Healthcare providers shall use the appropriate International Statistical Classification of Disease and Related Health Problems (ICD-10 code(s)) published by the World Health Organization (WHO) to classify and code all diseases, signs, and symptoms, abnormal findings, social circumstances, and external causes of injury and/or disease. Mental health providers shall reference the most recent published version of the Diagnostic and Statistical

Manual of Mental Disorder (DSM) published by the American Psychiatric Association to define and classify mental disorders when establishing the appropriate ICD-10 code(s).

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 twenty-four (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 (30) days from the date the claim is accepted, if the billing is received before the date of acceptance, or within thirty (30) 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 (30) 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 and accurate 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 healthcare ~~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. Healthcare ~~care~~ providers shall bill the code that most accurately describes the service performed. If an insurance carrier, self-insured employer, or claims processing representative determines that the documentation submitted does not support the procedure code billed, the payment to the healthcare ~~care~~ provider may be appropriately adjusted based on Fee Schedule reimbursement values. *See* A.R.S. § 23-1062.01. The payer shall provide documentation justifying the adjustment and clearly outline the process a healthcare ~~care~~ provider may follow to appeal the determination. Payers shall not downcode medical billings under the Arizona Physicians' & Pharmaceutical Fee Schedule. Downcoding is defined as a payer changing a code in a payment remittance to a code at a lower service level than was billed by the healthcare provider. As applicable, the health care provider may resubmit the bill with documentation that addresses the reason for the adjustment.

6. "Reasonable justification" to deny a bill does not include the payment/billing policies of other private or public entities (publications) unless the publication has been incorporated by reference in the Fee Schedule.

7. Excluding bundling and unbundling issues, it is not the Commission's intent to restrict an insurance carrier's, self-insured employer's, or third party processing service's ability to address issues not addressed by the Fee Schedule. This includes evaluating unlisted procedures, establishing values for unlisted procedures, establishing values for codes that are listed as "BR" or "RNE", or new CPT® codes that have not been incorporated by the Industrial Commission, or managing issues outside the jurisdiction of the Fee Schedule, such as hospital billings.

8. 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).

9. Treating physicians shall submit a narrative that justifies the billing of a level four (4) or five (5) E/M service.

10. The Commission has incorporated by reference the Centers for Medicare and Medicaid Services, Evaluation and Management Services Guide, and the most current American Medical Association, Evaluation and Management Code and Guideline Changes. Medical billings shall be prepared and reviewed consistent with how these guidelines are used and interpreted by CMS. Additionally, payers are required to disclose any additional guideline(s) utilized in their Explanation of Reviews (or other similar document.

11. 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.

12. 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.

13. Billing and reimbursement guidelines for Pharmaceuticals are found in the Pharmaceutical Fee Schedule Section of this document.

14. 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 MEDICAL PROVIDERS

1. Certified Registered Nurse Anesthetists ("CRNAs") are reimbursed at 85% of the fee schedule.

   a. 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:

   b. The Physician Assistant and Nurse Practitioner must work under the direct supervision of an appropriately licensed physician,

   c. The Physician must initially see that patient and establish a plan of care for that patient ("treatment plan"),

   d. Subsequent service provided by the Physician Assistant and Nurse Practitioner must be a part of the documented treatment plan, and

   e. 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.

2. 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 of 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.

3. 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~~ healthcare 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 healthcare networks.

Actions or conduct that impair or limit the right of an employee to choose their ~~medical~~ healthcare 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. 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. § 23-1070. Employers described in A.R.S. § 23-1070, excluding the State or Political Subdivisions thereof, are allowed to direct medical care.

2. 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 Title 20,

[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, reasonably required at the time of the injury, and during the period of disability. Such benefits shall be termed 'medical, surgical and hospital benefits.'"

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

3. 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.

4. 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.

5. 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.

6. If the patient refuses to submit to a medical examination or to cooperate with the healthcare provider's treatments, the carrier or self-insured employer should be notified.

7. 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.

8. 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.

9. 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.

Additional guidance on appropriate billing and reimbursement for impairment evaluations is found in the Evaluation and Management Section of this document.

10. Once an exposure to a 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 the 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.

11. 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 fifteen (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 the average private patient. In complex cases and 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 twenty (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 twenty (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 the establishment of relativity. "RNE" items are clearly definable and not inherently variable as are BR procedures. A report may be necessary.

3. MATERIALS AND SUPPLIES: A healthcare provider is not entitled to be reimbursed for supplies and materials normally necessary to perform a billable service. Examples of those items that are not reimbursable are listed below. Billing and reimbursement guidelines for materials and supplies that are reimbursable are found in the HCPCS Section of the Fee Schedule.

Drugs that are administered to patients in a clinical setting shall be billed using the appropriate HCPCS code and reimbursed according to the Pharmaceutical Fee Schedule Guidelines. The provisions in this subsection do not apply to hospitals, ambulatory surgery centers, and ambulance service providers.

Examples of supplies that are usually not separately reimbursable include:

Applied hot or cold packs
Eye patches, injections, or debridement trays
Steri-strips
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 Tape for dressings

4. 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.

K. LIST OF ACRONYMS

AMA	American Medical Association
APA	American Psychological Association
A.R.S.	Arizona Revised Statute
AS	Assistant Surgeon
AWP	Average Wholesale Price
AZ	Arizona
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
DSM	Diagnostic and Statistical Manual of Mental Disorder
E/M	Evaluation and management services
FCE	Functional Capacity Evaluation
FDA	Food and Drug Administration
FUD	Follow-up day(s)
HBIG	Hepatitis B Immune Globulin
HCPCS	Healthcare Common Procedure Coding System
HIV	Human Immunodeficiency Virus
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)
NDC	National Drug Code
NF	Non-Facility
NP	Nurse Practitioner
ODG	Official Disability Guidelines
OSHA	Occupational Safety and Health Association
OTC	Over-the-counter
PA	Physician Assistant
PC	Professional Component
PFS	Pharmaceutical Fee Schedule
POS	Place of Service
RBRVS	Resource Based Relative Value Scale
RNE	Relativity Not Established
RVU	Relative value unit
TC	Technical Component
TPA	Third Party Administrator

Information regarding publications incorporated by reference is found in the Introduction Section 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 incorporated portion of the CPT® and a code, guideline, identifier, or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control. Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx.

General requirements on 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 (2) 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 (3) modalities or more than three (3) units of a time-based modality or any combination of time-based and untimed modalities equaling three (3) 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 (4) 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). **The amount of time spent performing each specific procedure or modality provided to the patient is not required to be documented in the treatment notes** (*see* Section G)**.**

   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 (modality, untimed code)
97014 1 unit at 50% of value (modality, untimed code)
97035 1 unit at 50% of value (modality, 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 (4) 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 (4) 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). Reimbursement for therapeutic procedures in excess of the maximum, without prior approval, shall not affect reimbursement for therapeutic procedures performed within the allowed maximum.

D. The values for the codes in this section include the time and work of the healthcare 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 and managed in accordance with the HCPCS Section of this Fee Schedule.

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 eight (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 eight (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 (2) units should be billed. Please refer to the table below, which outlines how to bill for up to four (4) 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 seven (7) minutes or less on the same day as another service also represented by a 15-minute timed code performed for seven (7) minutes or less, and the total time of these two services is eight (8) minutes or greater, the provider may bill one (1) unit of service that was performed for the most minutes. The same logic is applied if three (3) or more different services are performed on the same day for seven (7) minutes or less.

The expectation, based on the work values assigned to these codes, is that a healthcare 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 healthcare 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 of 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 eight (8) minutes, one (1) unit is billed for 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 (1) unit is appropriate for each. Two (2) 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 (3) units to be billed. Since the time for each service is the same, the healthcare provider can choose which code to bill for two (2) units and which code to bill for one (1) 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 two (2) units. The remaining three (3) minutes is added to the seven (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 (1) 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 (3) units would be billed.

F. A work hardening program is limited to 6 1/2 hours per day, not to exceed a six (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 (2) 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 unnecessarily 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 is straightforward. Modalities are utilized as a sub-element of the overall 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.

Information regarding publications incorporated by reference is found in the Introduction of the Fee Schedule.

The evaluation and management guidelines incorporated by reference may be found in the CPT® published by the AMA and is reprinted, in part, below with permission. To the extent that a conflict may exist between an incorporated portion of the CPT® publication or HCPCS code and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control. Codes that are unique to Arizona are preceded by an AZ identifier and numbered in the following format: AZxxx.

Documentation and review of records, when required, is inclusive to the performance of the appropriate E/M service. A health care provider shall only be reimbursed for time that is not accounted for in the E/M service code by billing prolonged services codes 99415, 99416, 99417, or 99418. Proper documentation must justify the use of these codes and accompany the invoice.

Impairment Examinations

Impairment examinations shall be billed using CPT® 99455, work related or medical disability examination by the treating physician, or CPT® 99456, work related or medical disability examination by other than the treating physician. Physicians may bill one unit of these codes for the initial hour and an additional unit for each 30-minute increment after the initial hour. Each 30 minute increment commences the minute following the end of the previous time interval. The physician shall include documentation that demonstrates the complexity of the case and the time spent on the service to justify billing each additional unit. Reimbursement for CPT® codes 99455 and 99456 shall be made at 100% of the listed reimbursement value for the initial unit and then 50% of the listed reimbursement value for each additional unit.

Example:
A physician spends 72 minutes performing a work related disability examination on a patient they previously treated.

The physician would bill two units of 99455 and be reimbursed at 1.5 times the listed reimbursement value for CPT® 99455.

Remote Monitoring

One HCPCS code is included in this section of the 2025/2026 Fee Schedule for remote monitoring: G2010 – Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion.

A. CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES.

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, (*e.g.*, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

Initial and Subsequent Services

Some categories apply to both new and established patients (e.g., hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance when a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Split or Shared Visits

Physician(s) and other qualified health care professionals(s) (QHP[s]) may act as a team in providing care for the patient, working together during a single E/M service. The split or shared visits guidelines are applied to determine which professional may report the service. If the physician or other QHP performs a substantive portion of the encounter, the physician or other QHP may report the service. If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service. For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician'(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP.

Multiple Evaluation and Management Services on the Same Date

The following guidelines apply to services that a patient may receive for hospital inpatient care, observation care, or nursing facility care. For instructions regarding transitions to these settings from the office or outpatient, home or residence, or emergency department setting, see guidelines for Hospital Inpatient and Observation Care Services or Nursing Facility Services.

A patient may receive E/M services in more than one setting on a calendar date. A patient may also have more than one visit in the same setting on a calendar date. The guidelines for multiple E/M services on the same date address circumstances in which the patient has received multiple visits or services from the same physician or other QHP or another physician or QHP of the exact same specialty and subspecialty who belongs to the same group practice.

Per day: The hospital inpatient and observation care services and the nursing facility services are "per day" services. When multiple visits occur over the course of a single calendar date in the same setting, a single service is reported. When using MDM for code level selection, use the aggregated MDM over the course of the calendar date. When using time for code level selection, sum the time over the course of the day using the guidelines for reporting time.

Multiple encounters in different settings or facilities: A patient may be seen and treated in different facilities (e.g., a hospital-to-hospital transfer). When more than one primary E/M service is reported and time is used to select the code level for either service, only the time spent providing that individual service may be allocated to the code level selected for reporting that service. No time may be counted twice when reporting more than one E/M service. Prolonged services are also based on the same allocation and their relationship to the primary service. The designation of the facility may be defined by licensure or regulation. Transfer from a hospital bed to a nursing facility bed in a hospital with nursing facility beds is considered as two services in two facilities because there is a discharge from one type of designation to another. An intra-facility transfer for a different level of care (e.g., from a routine unit to a critical care unit) does not constitute a new stay, nor does it constitute a transfer to a different facility.

Emergency department (ED) and services in other settings (same or different facilities): Time spent in an ED by a physician or other QHP who provides subsequent E/M services may be included in calculating total time on the date of the encounter when ED services are not reported and another E/M service is reported (e.g., hospital inpatient and observation care services).

Discharge services and services in other facilities: Each service may be reported separately as long as any time spent on the discharge service is not counted towards the total time of a subsequent service in which code level selection for the subsequent service is based on time. This includes any hospital inpatient or observation care services (including admission and discharge services) time (99234, 99235, 99236) because these services may be selected based on MDM or time. When these services are reported with another E/M service on the same calendar date, time related to the hospital inpatient or observation care service (including admission and discharge services) may not be used for code selection of the subsequent service.

Discharge Services and services in the same facility: If the patient is discharged and readmitted to the same facility on the same calendar date, report a subsequent care service instead of a discharge or initial service. For the purpose of E/M reporting, this is a single stay.

Discharge services and services in a different facility: If the patient is admitted to another facility, for the purpose of E/M reporting, this is considered a different stay. Discharge and initial services may be reported as long as time spent on the discharge service is not counted towards the total time of the subsequent service reported when code level selection is based on time.

Critical care services (including neonatal intensive care services and pediatric and neonatal critical care): Reporting guidelines for intensive and critical care services that are performed on the same calendar date as another E/M service are described in the service specific section guidelines.

Transitions between office or other outpatient, home or residence, or emergency department and hospital inpatient or observation or nursing facility: See the guidelines for Hospital Inpatient and Observation Care Services or Nursing Facility Services. If the patient is seen in two settings and only one service is reported, the total time on the date of the encounter of the aggregated MDM is used for determining the level of the single reported service. If prolonged services are reported, use the prolonged services code that is appropriate for the primary service reported, regardless of where the patient was located when the prolonged services time threshold was met. The choice of the primary service is at the discretion of the reporting physician or other QHP.

Services Reported Separately

Any specifically identifiable procedure or service (i.e., identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (e.g., tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level. The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. The physician or other qualified health care professional may need 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. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (e.g., by electronic health record [EHR] portal or questionnaire) that is

reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in the selection of the level of these E/M service codes.

B. LEVELS OF E/M SERVICES.

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**
2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are NOT interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting Level of Service Based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to CPT codes 99211 and 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- The number and complexity of problem(s) that are addressed during the encounter.

- The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented. Data are divided into three categories:
  1. Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
  2. Independent interpretation of tests (not separately reported).
  3. Discussion of management or test interpretation with an external physician or other qualified health care professional or appropriate source (not separately reported).

- The risk of complications and/or morbidity or mortality of patient management. This includes decisions made at the encounter, associated with diagnostic procedure(s), and treatment(s). This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family. For example, a decision about hospitalization includes considerations of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT® code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services. When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of outpatient E/M services.

The Levels of Medical Decision Making (MDM) table (Table 1) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (*i.e.*, straightforward, low, moderate, high) and the three elements of MDM (*i.e.*, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (e.g., transfer to ICU) applies to the hospitalized or observation care patient. See also the introductory guidelines of each code family section.

The elements listed in Table 1, Levels of Medical Decision Making, are defined in the guidelines for number and complexity of problems addressed at the encounter, amount and/or complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management.

Table 1: Levels of Medical Decision Making (MDM)

Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	**Minimal** 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Low	**Low**
	• **2** or more self-limited or minor problems;
	or
	• **1** stable, chronic illness;
	or
	• **1** acute, uncomplicated illness or injury;
	or
	• **1** stable, acute illness;
	or
	• **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
		Limited
		(Must meet the requirements of at least 1 out of 2 categories)
		Category 1: Tests and documents
		• **Any combination of 2 from the following:**
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;\
		  • Ordering of each unique test*
		or
		Category 2: Assessment requiring an independent historian(s)
		(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
			Low risk or morbidity from additional diagnostic testing or treatment

Moderate	**Moderate**
	• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• **2** or more stable, chronic illnesses;
	or
	• **1** undiagnosed new problem with uncertain prognosis;
	or
	• **1** acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  • Review of prior external note(s) from each unique source*;
		  • Review of the result(s) of each unique test*;
		  • Ordering of each unique test*;
		  • Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician /other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health.

High	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Decision regarding parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of office or other outpatient services is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are unlikely to represent a highly morbid condition may "drive" MDM even when the

ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of management.

Definitions for the elements of MDM (see Table 1, Levels of Medical Decision Making) are:

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified healthcare provider reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified healthcare professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified healthcare professional, but the service is provided under the physician's or other qualified health care professional's supervision (see CPT codes 99211, 99281).

Self-limiting or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (*e.g.*, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation l level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for *self-limited or minor problem* or *acute, uncomplicated illness or injury.* Systemic symptoms may not be general but may be a single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with a risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, and acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

Amount and/or Complexity of Data to Be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: the process of using the data as part of the MDM. The data element itself may not be subject to analysis (*e.g.*, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they

are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (*e.g.*, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT® code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT® code set. When multiple results of the same unique test (*e.g.*, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT® codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC, without differential, and platelet count. A unique source is defined as a physician or other qualified healthcare professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all the materials from any unique source counts as one element toward MDM.

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: External records, communications, and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (*e.g.*, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be synchronous (*i.e.*, does not need to be in person), but it must be initiated and completed within a short time period (*e.g.*, within a day or two).

Independent historian(s): An individual (*e.g.*, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (*e.g.*, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history

does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretations: The interpretation of a test for which there is a CPT® code and an interpretation or report is customary. This does not apply when the physician or other healthcare professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test. A test that is ordered and independently interpreted may count both as a test ordered and interpreted.

Appropriate source: For the purpose of the discussion of management data element (see Table 1, levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (*e.g.*, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers. For the purpose of documents reviewed, documents from an appropriate source may be counted.

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified healthcare professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as *high, medium, low,* or *minimal* risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other health care professional as part of the reported encounter.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Surgery (minor or major, elective, emergency, procedure or patient risk):

Surgery - Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.

Surgery – Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of the procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (*e.g.*, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Surgery – Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia with the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Parenteral controlled substances: The level of risk is based on the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty and subspecialty and not simply based on the presence of an order for parenteral controlled substances.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (e.g., Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require

the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

Each service that may be reported using time for code level selection has a required time threshold. The concept of attaining a mid-point between levels does not apply. A full 15 minutes is required to report any unit of prolonged service codes 99417, and 99418.

Physician(s) and other qualified health care professional(s) may each provide a portion of the face-to-face and non-face-to-face work related to the service. When time is being used to select the appropriate level of services for which time-based reporting is allowed, the time personally spent by the physician(s) and other qualified health care professional(s) assessing and managing the patient and/or counseling, educating, communicating results to the patient/family/caregiver on the date of the encounter is summed to define total time. Only distinct time should be summed (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other qualified health care professional time includes the following activities, when performed:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Do not count time spent on the following:

- The performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

For split or shared visits, see the split or shared visits guidelines.

C. UNLISTED SERVICE

An E/M service may be provided that is not listed in this section of CPT® codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in item E. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

99429 Unlisted preventive medicine service
99499 Unlisted evaluation and management service

D. SPECIAL REPORT.

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

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. ~~Services and materials~~ DME items that are listed as By Report, ~~or~~ 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. ~~HCPCS codes representing professional services that are not listed in the fee schedule may be reimbursed 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. ~~8.~~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. ~~9.~~ 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.