Industrial Commission of Arizona

Amended Staff Proposal and Request for Public Comment

2020/2021 Arizona Physicians' and Pharmaceutical Fee Schedule

Medical Resource Office
Phone (602) 542-4308 / Fax (602) 542-4797
mro@azica.gov

Page

I. Introduction 2

II. Proposals and Request for Public Comment Regarding the 2020/2021 Physicians' and Pharmaceutical Fee Schedule 3

A. Adoption of Updates to Relative Value Units and Reimbursement Values 3

B. Continued Designation of Medi-Span as the Publication for Purposes of Determining Average Wholesale Price……. 5

C. Adoption of Deletions, Additions, General Guidelines, and Identifiers of the CPT®-4 5

The accompanying Excel file contains the following tables, which are referenced in this report:

RBRVS Fee Schedule 2020 (all codes)
Anesthesia Codes and Anesthesia Conversion Factor (00100–01999)
Surgery Codes (10021–69990)
Radiology Codes (70010–79999)
Pathology/Laboratory Codes (80047–89398)
Medicine Codes (90281–96999)
Physical Medicine Codes (97010–98969)
Special Services Codes (99000-99607)
Evaluation and Management Codes (99201–99499)
Category III Codes (0019T–0436T)

D. Revisions to the Fee Schedule Guidelines 5

E. Inclusion of Four Healthcare Common Procedure Coding System (HCPCS) Approved by the Commission on March 26, 2020 5

F. Change to the Description of Special Services Code AZ099-005 6

G. Adoption of Billing Standards for Time-Based Services 6

F. Amendments to the Pharmaceutical Fee Schedule Guidelines 6

I. INTRODUCTION.

The information contained in this *Amended* Staff Proposal is based on a review of various resources, including the following: (1) *CY 2020 Medicare Physician Fee Schedule* ("MPFS"), a RBRVS-based reimbursement fee schedule used by Centers of Medicare & Medicaid Services ("CMS"); (2) OPTUM 360's 2020 publication *The Essential RBRVS*; (3) Office of Workers' Compensation Programs ("OWCP") Fee Schedule Effective October 1, 2019; (4) *2020 Anesthesia Base Units as listed in CPT®-4*, a schedule of base units used by CMS to compute allowable amounts for anesthesia services; (5) *2020 Clinical Diagnostic Laboratory Fee Schedule*, a fee schedule maintained by CMS that identifies state-specific rates for pathology and laboratory services; and (6) *Physicians as Assistants at Surgery: 2018 Update*.

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

This *Amended* Staff Proposal is preliminary and intended to serve as a proposal for public comment and future discussion during the public hearing process. Following the public hearing, staff of the Industrial Commission of Arizona (the "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 2020/2021 Physicians' and Pharmaceutical Fee Schedule ("2020/2021 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 2020/2021 PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE.

A. Adoption of Updates to Relative Value Units and Reimbursement Values.

Staff proposes adoption of the service codes, relative value units ("RVUs"), and reimbursement values contained in Tables 1 through 10, found in the accompanying Excel file.

The proposal is based upon continued use of a RBRVS reimbursement system, in which reimbursement values are calculated by multiplying "resources required to perform a service or RVUs" by a dollar value conversion factor ("CF"). The proposed 2020/2021 Fee Schedule is based upon the following two-step methodology to compute reimbursement values for all applicable service codes:

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

a. Utilize applicable RVUs from the 2020 MPFS or BUs from the *2020 Anesthesia Base Units from 2020 CPT®-4*. The 2020 MPFS was the preliminary source for assigning and updating RVUs for all service codes.

b. Utilize applicable RVUs from OPTUM 360's 2020 publication *The Essential RBRVS*. This method was used to assign and update RVUs for all "gap" codes not included in the 2020 MPFS.

c. Utilize applicable RVUs from OWCP's *Fee Schedule Effective October 1, 2019*. This method was used to assign and update RVUs for codes that could not be assigned using the first two methods.

d. Utilize applicable RVUs from the *2020 Clinical Diagnostic Laboratory Fee Schedule*. This method was used to update RVUs for most pathology and laboratory service codes.

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

STEP 2: Once RVUs were assigned to all service codes, reimbursement rates were calculated by multiplying the applicable RVU by the Arizona-specific conversion factor. Staff proposes that the 2020/2021 Fee Schedule continue using a multiple conversion factor model, consisting of one conversion factor for Anesthesia Services, one for Surgery and Radiology, and a third for all remaining service categories (including E & M, Pathology and Laboratory, Physical Medicine, General Medicine, and Special Services).

The three proposed conversion factors for the 2020/2021 Fee Schedule are the same as the conversion factors used in the 2019/2020 Fee Schedule and are as follows:

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

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

Note: Additionally:

a. The proposed 2020/2021 Fee Schedule continues to use CMS's surgical global periods.

b. The proposed 2020/2021 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 2020/2021 Fee Schedule does not incorporate a geographic adjustment factor ("GAF"), but instead uses the Arizona-specific conversion factor to adjust payment for the state. It should be noted that CMS utilizes one GAF for the entire State of Arizona.

d. All *CPT*® codes that contain explanatory language specific to Arizona will continue to be preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®*-4* are preceded by an "AZ" identifier and numbered in the following format: AZ0xx-xxx.

e. The proposed 2020/2021 Fee Schedule applies a Stop Loss Cap to any service codes whose reimbursement values have decreased more than 50% since Arizona's transition to a RBRVS-based system.

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

B. 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 2020/2021 Fee Schedule.

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

The proposed 2020/2021 Fee Schedule is based upon staff review of deletions and additions to CPT®-4. The proposed 2020/2021 Fee Schedule is intended to conform to changes that have taken place in the 2020 edition of CPT®-4.

D. Revisions to the Fee Schedule Guidelines.

Staff proposes to update the Fee Schedule Guidelines to clarify the definition and usage of the terms "physician" and "healthcare provider." The term "healthcare provider" is used when referring to licensed professionals whose scope of practice allows them to legally provide services to injured workers. The term "physician" is used when referring to a specific subset of healthcare providers who may provide and bill evaluation and management services pursuant their respective scope of practice and Arizona law. The proposed redline changes to the Fee Schedule Guidelines are attached as Exhibit A.

In addition, in the Introduction section of the Fee Schedule, statutory language was added to reinforce the timelines and expectations established by A.R.S. § 23-1062.01. Additionally, the Introduction was updated to require payers to provide valid contracts to healthcare providers when billing disputes over negotiated fees with healthcare providers arise. Lastly, the Introduction was updated to reflect that a current invoice for materials and supplies is one which is dated within one year of the billed date.

E. Inclusion of Four Healthcare Common Procedure Coding System (HCPCS) Approved by the Commission on March 26, 2020.

Staff proposes to continue adoption of HCPCS codes G2010, G2012, U0001, and U0002 in the 2020/2021 Fee Schedule. The codes were initially approved and adopted by the Commission on March 26, 2020 in response to the spread of COVID-19. Codes G2010 and G2012 are used to bill for Virtual Check-ins provided by appropriately-licensed physicians. Codes U0001 and U0002 are used to bill for laboratory testing to detect a COVID-19 infection.

The codes were added to the Evaluation and Management and Pathology and Laboratory sections. *See Exhibit A.*

F. Change in the Description of Special Services Code AZ099-005.

The current definition for Special Services Code AZ099-005 is:

> Completion of workers' compensation insurance forms (i.e. return-to-work status, work restrictions, supportive care restrictions), not to exceed more than one billing in a thirty (30) day period. Form must be attached to report.

As a result of questions and concerns shared by stakeholders, staff proposes to modify the definition for Code AZ099-005 (as follows) to add clarity as to when a provider can charge for completion of workers' compensation forms:

> Completion of workers' compensation insurance forms (*i.e.* return-to-work status, work restrictions, supportive care restrictions) which are requested or required either by the Commission, the applicable payer (insurance , self-insured employer, or the Special Fund of the Commission), or a third-party administrator of the applicable payer, not to exceed more than one billing in a thirty (30) day period. The applicable form must be attached to the billing.

G. Adoption of Billing Standards for Time-Based Services.

Staff proposes to add language to the Physical Medicine section of the Fee Schedule which adds clarity regarding billing practices for time-based services. Currently, healthcare providers may bill for time-based services using either the AMA guidelines or CMS guidelines. Establishing a single standard by adopting the CMS guidelines will ensure that all healthcare providers and applicable payers have consistency when billing and reimbursing time-based services. Staff recommends the adoption of the CMS guidelines as the standard for billing for time-based services, as it aligns with the Commission's adoption by reference of the National Correct Coding Edits by CMS. *See Exhibit A.*

E. Amendments to the Pharmaceutical Fee Schedule Guidelines.

Staff proposes to amend the Pharmaceutical Fee Schedule Guidelines, as follows:

Section II(L)
"Pharmacy accessible to the general public" means a pharmacy that is readily accessible and provides pharmaceutical services (including prescription medication services) to all segments of the general public without restricting services to a defined or exclusive group of consumers, including but not limited to consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner.

Section II(M)
"Pharmacy not accessible to the general public" means a pharmacy that provides pharmaceutical services (including prescription medication services) only to a defined or exclusive group of consumers, including but not limited to consumers who have access to ~~pharmaceutical~~ services ~~(including prescription medication services)~~ because they are treated by or have an affiliation with

a specific entity or medical practitioner. "Pharmacy not accessible to the general public" does not include a hospital pharmacy.

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

1. The prescription medication is dispensed by a medical practitioner or pharmacy not accessible to the general public to the injured employee within seven days of the date of the industrial injury;
2. The prescription medication is limited to no more than a one-time, ten-day supply;
3. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.

New Section VII(D) (Re-letter existing subsections D-G in Section VII to be E-H)
An insurance carrier, self-insured employer, or the Special Fund of the Commission is responsible for the payment of prescription medications that are dispensed by a pharmacy not accessible to the general public if all of the following apply:

1. The prescription medication was dispensed to an injured employee whose workers' compensation claim was initially denied by the carrier, self-insured employer, or the Special Fund of the Commission;
2. The injured employee protested the claim denial by filing a timely request for hearing;
3. The workers' compensation claim was either: (a) subsequently accepted by the carrier, self-insured employer, or the Special Fund of the Commission; or (b) the claim was found to be compensable by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court;
4. The prescription medication was dispensed during the time period between: (a) the initial claim denial and (b) the subsequent acceptance of the claim or the compensability determination by the Commission's Administrative Law Judge Division, the Arizona Court of Appeals, or the Arizona Supreme Court; and
5. The prescription medication conforms to dosages and formulations that are commercially available in pharmacies accessible to the general public.

The proposed amendments are intended to: (1) clarify the definitions of "Pharmacy Accessible to the General Public" and "Pharmacy Not Accessible to the General Public"; (2) correct the inadvertent omission of "Pharmacy Not Accessible to the General Public" in Section VII(A)(1); and (3) add a new, narrow exception to Section VII that will make it easier for injured workers' whose claims have been denied to receive prescription medication services during the period of a compensability protest.

Exhibit A

ARIZONA PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE 2020/2021

Adopted by
The Industrial Commission of Arizona

Contact Medical Resource Office
Phone (602) 542-4308 / Fax (602) 542-4797
mro@azica.gov

Effective October 1, 2020 through September 30, 2021

2020/2021 ARIZONA PHYSICIANS' & PHARMACEUTICAL FEE SCHEDULE

TABLE OF CONTENTS

		Page
Introduction		1
A.	General Guidance	2
B.	Payment and Review of Billings	3
C.	Reimbursement of Mid-Level Providers	5
D.	Directed Care and Use of Networks	6
E.	Treatment of Industrial Injuries and Diseases	7
F.	Reopening of Claims	9
G.	No-Insurance Claims	9
H.	Consultations	10
I.	Definitions of Select Unit Values	10
J.	List of Acronyms	12
Pharmaceutical Fee Schedule		13
I.	General Provisions and Applicability of Pharmaceutical Fee Schedule	13
II.	Definitions	14
III.	General Guidelines for Billing and Reimbursement of Prescription Medications	15
IV.	Billing and Reimbursement for Repackaged Medications	16
V.	Billing and Reimbursement for Compound Medications	17
VI.	Billing and Reimbursement for Medications Administered by a Medical Practitioner	17
VII.	Reimbursement for Medications Dispensed by a Medical Practitioner or in a Pharmacy Not Accessible to the General Public	18
VIII.	Dispensing Fee	19
IX.	Additional Billing Guidelines	19
X.	Severability Clause.	20
Anesthesia Guidelines		21
Anesthesia Codes		23
Surgery Guidelines		30
Surgery Codes		33
Radiology Guidelines		175
Radiology Codes		178
Pathology and Laboratory Guidelines		225
Pathology and Laboratory Codes		227
Medicine Guidelines		268
Medicine Codes		269
Physical Medicine Guidelines		302
Physical Medicine Codes		304
Special Services Guidelines		307
Special Services Codes		308
Evaluation and Management Guidelines		311
Evaluation and Management Codes		322
Category III Guidelines		327
Category III Codes		328

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 ~~physicians, physical therapists, and occupational therapists~~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 "physicians" in the Fee Schedule is intended to include physical therapists, occupational therapists, certified registered nurse anesthetists, physician assistants and nurse practitioners. See also the definition of "physician" found on page 7 of this introduction. Physicians 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 monthly filing of reports and bills for payment, and the use of forms prescribed are essential to timely and correct payment for a physician's services and can be vital in the award of benefits to the injured worker and their dependents.~~

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 monthly 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 2020 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule CPT®-4 codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in CPT®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

a. The Commission has also adopted by reference: 1) 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 https://www.asahq.org*; 2*) The *1995 and 1997 Documentation Guidelines for*

Evaluation and Management Services, Centers for Medicare and Medicaid Services (CMS) https://www.cms.gov; 3) The *2020 Clinical Diagnostic Laboratory Fee Schedule,* Centers for Medicare and Medicaid Services (CMS) Clinical Laboratory fee Schedule https://www.cms.gov; 4) The *National Correct Coding Initiative Edits,* CMS; https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html; 5) *20 Optum 360 The Essential* RBRVS https://www.optum360.com/; and 6) Physicians as Assistants at Surgery: 2018 Update https://www.facs.org/. The RBRVS based fee schedule adopts surgical global periods published by CMS.

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 or any other entity or organization.

A. GENERAL GUIDANCE

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

2. This Fee Schedule establishes the fees that can be charged by ~~physicians~~ healthcare providers for services performed for injured workers under the Arizona's workers' compensation law.

3. If a ~~physician~~ 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.

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

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

6. Fees for hospital, office, or home visits, subsequent to the initial visit, are not to be added to coded surgical procedures performed in the same day.

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

8. 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 ~~physician~~ healthcare provider within a reasonable period of time to facilitate processing of the claim.

9. The Commission requests that carriers notify attending ~~physicians~~ 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 ~~physician~~ healthcare provider of that approval.

10. An attending ~~physician~~ healthcare provider may submit a claim for consultant's fee only when such service is requested by carrier or self-insured employer.

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

12. No fees may be charged for services not personally rendered by the ~~physician~~healthcare provider, unless otherwise specified.

13. The Commission will investigate an injured workers' 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 ~~physician~~ 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.

14. 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.

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 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 ~~physician~~ 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 days from the date the claim is accepted, if the billing is received before the date of acceptance, or within thirty days from the date of the receipt of the billing if the billing is received after the date of ~~injury~~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 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 health-care provider is due. *See* A.R.S. § 23-1062.01.

To ensure timely 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 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. "Reasonable justification" to deny a bill does not include that the payment/billing policies of another private or public entities (publications) do not allow it unless the publication has been adopted by reference in the Fee Schedule.

6. Excluding bundling and unbundling issues, it is not the Commission's intent to restrict an insurance carrier's, self-insured employers or third party processing service's ability to address issues not addressed by the Fee Schedule. This includes evaluating unlisted procedures, establishment of values for unlisted procedures, establishment of values for codes that are listed as "BR" or "RNE", new CPT® codes that have not been adopted

by the Industrial Commission, or issues outside the jurisdiction of the Fee Schedule, such as hospital billings.

7. ~~Physicians~~ 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 ~~physician~~ healthcare provider shall ensure that their patients' medical files include the information required by A.R.S. § 32-1401.2. The ~~medical~~ 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).

8. Treating physicians shall submit a narrative that justifies the billing of a level 4 or 5 E & M service.

9. The Commission has adopted by reference the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. Medical billings shall be prepared and reviewed consistent with how these guidelines are used and interpreted by CMS. Additionally, payers are required to disclose the guideline utilized in their Explanation of Reviews (or other similar document).

10. A payer's Explanation of Review (or other similar document) shall contain sufficient information to allow the ~~physician~~ 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 ~~physician~~ 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 ~~physician~~healthcare provider;

    f. The amount of any reduction due to a written contract with the ~~physician~~healthcare provider; and

    g. The amount of payment.

11. Nothing in this Fee Schedule precludes a ~~physician~~ 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 ~~physician's~~ 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.

12. Billing for Pharmaceuticals is found in the Pharmaceutical Fee Schedule Section of this document.

C. REIMBURSEMENT OF MID-LEVEL PROVIDERS

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

2. 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:

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

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

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

   d. 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.

3. 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 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.

4. 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 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 health-care networks.

Actions or conduct that impair or limit the right of an employee to choose their medical 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 ~~physician~~ healthcare provider ~~(or other provider)~~ that is "in the network;"
- A claimant is told that care from a "non-network" ~~physician~~ healthcare provider ~~(or other provider)~~ is not authorized;
- A "network" ~~physician~~ healthcare provider ~~(or other provider)~~ is told that referrals are required to be made to another "network" ~~physician~~ healthcare provider~~(or other provider)~~;
- A "network" ~~physician~~ healthcare provider ~~(or other provider)~~ is told that they may not recommend a "non-network" healthcare provider to a patient;
- A "non-network" ~~physician~~ healthcare provider ~~(or other 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] 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, reasonable required at the time of the injury, and during the period of disability. Such benefits shall be termed 'medical, surgical and hospital benefits.'"

~~1. The term "physician" in relation to workers' compensation cases includes the following: doctors of medicine, doctors of osteopathy, doctors of chiropractic, doctors of naturopathic medicine, certified registered nurse anesthesiologists, physician assistants and nurse practitioners.~~

~~2.~~1. Only physicians and surgeons licensed in the State of Arizona are permitted to treat injured or disabled employees under the jurisdiction of the Commission, unless others are specifically authorized.

~~3.~~2. An employee who sustains an injury arising out of, or in the course of, employment is entitled, under Arizona law, to select a ~~physician~~ 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.

~~4.~~3. The attending ~~physician's~~ 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 ~~physician~~ healthcare provider in processing the required reports. Rules addressing the completion of these forms are found in the Title 20, 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

~~5.~~4. The Commission, the employer and the insurance carrier may, at any time, designate a ~~physician~~ healthcare provider or ~~physicians~~ healthcare providers to examine an employee. Additionally, upon application of the employer, employee, or insurance carrier, the Commission may order a change of ~~physician~~ 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.

~~6.~~5. 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.

~~7.~~6. 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.

~~8.~~7. If the patient refuses to submit to medical examination or to cooperate with the ~~physician's~~ healthcare provider's treatments, the carrier or self-insured employer should be notified.

~~9.~~8. If an employee is capable of some form of gainful employment, it is proper for the ~~physician~~ 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 ~~physician's~~ healthcare provider's judgment in such matters is extremely important.

~~10.~~9. If the employee no longer requires active medical care for the industrial injury and is discharged from treatment, the ~~physician~~ 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.

~~11.~~10. When a ~~physician~~ healthcare provider discharges a claimant from treatment, the ~~physician~~ 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.

~~12.~~11. Once an exposure to 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 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.

~~13.~~12. 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 ~~physician's~~ 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 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 ~~physician~~ 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 for the average private patient. In difficult problems and in 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. 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 establishment of a relativity. "RNE" items are clearly definable and not inherently variable as are BR procedures. A report may be necessary.

3. SERVICE "SV" ITEMS: "SV" in the value column indicates the value is to be calculated as the sum of the various services rendered (e.g., office, home, nursing home or hospital visits, consultation or detention, etc.), according to the ground rules covering those services. Identify by using the code number of the "SV" item. The Value is established by identifying each individual service, listing the code number and its value.

4. MATERIALS AND SUPPLIES: A ~~physician~~ healthcare provider is not entitled to be reimbursed for supplies and materials normally necessary to perform the service. A ~~physician~~ healthcare provider may charge for other supplies and materials using code 99070[2]. A ~~physician~~ healthcare provider may use an applicable HCPCS code in lieu of code 99070 if the HCPCS code more accurately describes the materials and supplies provided by the ~~physician~~healthcare provider; however, the Commission has **not** adopted the RVUs for HCPCS codes. Examples of those items that are and are not reimbursable are listed below. Documentation showing actual costs (i.e. manufacturer's ~~current~~ invoice dated within one year of the billed date) associated with providing supplies and materials plus fifteen percent (15%) to cover overhead costs will be adequate justification for payment. This provision does not apply to retail operations involving drugs or supplies. Administration of drugs to patients in a clinical setting is covered under code 99070. Prescription drugs provided to patients as a part of the overall treatment regimen but outside of the clinical setting are not included under this code.

   Examples of supplies that are usually not separately reimbursable include:

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

[2] CPT only copyright 2020 American Medical Association. All rights reserved.

Head sheets
Aspiration trays
Sterile trays for laceration repair and more complex surgeries
Tape for dressings

Examples of material and supplies that are generally reimbursable include:

Cast and strapping materials
Applied dressings beyond simple wound occlusion
Taping supplies for sprains
Iontophoresis electrodes
Reusable patient specific electrodes
Dispensed items, including:
- Canes
- Braces
- Slings
- Ace wraps
- TENS electrodes
- Crutches
- Splints
- Back support
- Dressings
- Hot or cold packs

5. "Modifiers: A two-digit (numeric or alpha) sequence that provides the means by which the reporting ~~physician~~ healthcare provider can specify that a procedure performed has been altered under 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.

J. LIST OF ACRONYMS

AMA	American Medical Association
AS	Assistant Surgeon
AWP	Average Wholesale Price
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
E/M	Evaluation and management services
FCE	Functional Capacity Evaluation
FUD	Follow-up day(s)
HCPCS	Healthcare Common Procedure Coding System
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)
NP	Nurse practitioner
OTC	Over-the-counter
PA	Physician assistant
RBRVS	Resource based relative value scale
RVU	Relative value unit

SURGERY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2020 Editions of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT®* codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT®*-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx.

The Commission has also adopted by reference: 1) The *1995 and 1997 Documentation Guidelines for Evaluation and Management Services,* Centers for Medicare and Medicaid Services (CMS) https://www.cms.gov; 2) *2020 Optum 360 The Essential RBRVS https://www.optum360.com/;* 3) The *National Correct Coding Initiative Edits,* CMS https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html; and, 4) Physicians as Assistants at Surgery Update 2018 https://www.facs.org. The RBRVS-based fee schedule adopts surgical global periods published by CMS. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for surgical services. To the extent that a conflict may exist between CMS, an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. MATERIALS AND SUPPLIES: A ~~physician~~ healthcare provider may charge for materials and supplies as described in subsection (I) (4) of the Introduction Section of the Physician's Fee Schedule (pages 11-12).

B. MULTIPLE PROCEDURES: It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. However, the primary procedure code is the code that determines the follow-up days when a surgery has multiple procedures. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated "add-on" codes.

C. SPECIAL REPORT: A typical request for more detailed information from an insurance carrier regarding a billing does not constitute a "special report", which is defined in the CPT® book.

D. MODIFIERS: Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code, which may be reported in either of two ways.

The modifier may be reported by a two-digit number placed after the usual procedure number from which it is separated by a hyphen. Or the modifier may be reported by a separate five-digit code that is used in addition to the procedure code. If more than one modifier is used, the "Multiple Modifiers" code placed first after the procedure code indicates that one or more additional modifier codes will follow.

Modifiers either unique to Arizona or containing explanatory language specific to Arizona are as follows:

Δ-22 Increased Procedural Services: Use of this modifier will result in a twenty-five percent (25%) increase in the listed value for the listed procedure.

Δ-25 Separately Identifiable Evaluation and Management Service by same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service. It may be necessary 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 above and beyond the other service provided or beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). As such, different diagnoses are not required for reporting of the E/M services on the same date. The circumstance may reported by adding modifier 25 to the appropriate level of E/M service.

Δ-47 Anesthesia by Surgeon: The value shall be fifty percent (50%) of the calculated American Society of Anesthesiologists Relative Value Guide value.

Δ-50 Bilateral Procedure: Unless otherwise identified in the listings, when bilateral procedures which add significant time or complexity to patient care are provided at the same operative session, identify and value the first or major procedure as listed. Identify the secondary or lesser procedure(s) by adding this modifier '-50' to the usual procedure number(s) and value at fifty percent (50%) of the listed value(s). If, however, the procedures are independently complex and involve different parts of the body, including digits, the bilateral procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

Δ-51 Multiple Procedures: When multiple procedures are performed during the same operative session*, the procedures should be valued at the appropriate percent of its listed value, as shown below:

100% (full value) for the first or major procedure
50% for the second and multiple procedure(s)
Sixth and subsequent procedures – by report

*Multiple Procedure Guidelines do not apply to codes specifically identified as "Add-on/Additional Procedures, Global indicator"*ZZZ"*.

The major or primary procedure is defined as the procedure with the highest value and is the code that determines the follow-up days when a surgery has multiple procedures. The second procedure is the procedure with the next highest value, the third the next highest value and so on. **

**If, however, the procedures are independently complex such as digits, tendons, nerves or artery repair, the multiple procedure rule would not apply. In such cases, independent procedures would be billed at one hundred percent (100%) of their listed value.

Δ–57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may identified by adding modifier 57 to the appropriate level of E/M service.

Δ-62 Two Surgeons: By prior agreement, the total value of services performed by two surgeons working together as primary surgeons may be apportioned in relation to the responsibility and work done, provided the patient is made aware of the fee distribution according to medical ethics. If no apportionment listed, the fee should be split evenly between the co-surgeons. The total value may be increased by twenty-five percent (25%) in lieu of the usual assistant's charge. Under these circumstances the services of each surgeon should be identified by adding this modifier '-62' to the joint procedure number(s) and valued as agreed upon. (Usual charges for surgical assistance may be warranted if still another physician is required as part of the surgical team.) The value of the procedure should be 125 percent of the customary value listed. Payment of 125% of the maximum allowable would be divided between the participating surgeons.

Two Surgeons – When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on codes(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported with modifier -62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

Δ-80 Assistant Surgeons: These services are valued at twenty percent (20%) of the listed value of the surgical procedure(s).

– OR –

Δ-81 Minimum Assistant Surgeons: These services are valued at ten percent (10%) of the listed value of the surgical procedure(s).

RADIOLOGY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2020 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT®* codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT®*-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. Additional information regarding publications (e.g. CMS Guidelines) adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to CMS and CPT® guidelines, and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. GENERAL GUIDELINES

1. Values include usual contrast media, equipment and materials. An additional charge may be warranted when special surgical trays and materials are provided by the ~~physician~~healthcare provider.

2. Values include consultation and written reports to the referring ~~physician~~healthcare provider.

3. X-ray findings and attending ~~physician's~~ healthcare provider's written order for x-rays must be included with statement for x-ray services. Bills unsupported by findings will not be paid.

4. X-rays should be taken, reported, and be properly marked for identification and orientation in accordance with the accepted standard of radiologic practice in the State of Arizona.

B. MODIFIERS

Modifiers identify circumstances that alter or enhance the description of the service. For radiology codes, two modifiers affect the assigned unit value and are listed in *The Essential RBRVS.* However, other modifiers may be required for correct reporting of service. See CMS and the 2020 CPT®-4 publications for additional information on modifiers. Listed radiology modifiers affect the unit values as follows:

1. Total: When no modifier is listed, the unit value represents the global value of the procedure. The five-digit code is used to represent a global service inclusive of professional and technical value of providing that service. The following sections, provide additional definitions for each component.

2. Professional: Modifier 26 is used to designate professional services. The professional component includes examination of the patient, when indicated, performance and/or supervision of the procedure, interpretation and written report of the examination, and consultation with referring ~~physicians~~healthcare providers.

3. Technical: Modifier TC is used to designate the technical value of providing the service. The technical component includes personnel, materials, space, equipment, and other allocated facility overhead normally included in providing the service. Note that modifier TC is not CPT® compatible.

C. REFERENCE TO RELATIVE VALUES

Two patterns of billing currently prevail in radiology. A total charge for the radiology service, to include both professional fees and technical costs, is made by radiologists working in offices, clinics and, under some circumstances, in hospital x-ray departments.

In a majority of voluntary hospital radiology departments, the radiologist submits a separate statement to the patient for his professional services. The hospital charges for use of the department facilities and the services of its employees. This pattern is similar to the charges made by the hospital for the use of delivery rooms or surgical suites. Such charges are entirely separate from the fees charged by obstetricians and surgeons. In most separate radiology billing situations, the total will approximate the amount billed singly by the radiologist in their office or billed singly by the hospital.

The two separate scales in Radiology Relative Values have been devised for use in radiology and are not coordinated with scales for services in other branches of medicine such as surgery, medicine or pathology. The two scales are compatible only within themselves. Within each of the two separate headings, the total dollar value and the PC or professional components dollar value, where appropriate, can be used. Some procedures are noted as a "BR" value or "By Report". This usage is intended to indicate that circumstances involving a given patient procedure may require much more than the average amount of time and effort to perform and thus a value would be unique and could not be anticipated or established. When such added involvement is claimed, a written explanation will usually be required as an addendum to the bill.

The PC values do not include charges made by the hospital in which the procedure was accomplished. Such charges by the hospital cover the services of technologists and other helpers, the films, contrast media, radioactive agents, chemical and other materials, the use of the space and facilities of the x-ray department plus any other hospital costs. Most hospitals have derived their own schedule of charges of these items. The establishment of the hospital's charges is not properly the subject of this publication.

The separation of billing in no way implies a division of responsibility, but only a division of the charge. The radiologist is a physician performing a needed medical service for a patient, and he must retain full responsibility for his own activity and also full responsibility for the

supervision of technologists, the selection and maintenance of equipment, the control of radiation hazards and the general administration of the radiology department.

D. REVIEW OF DIAGNOSTIC STUDIES

No separate charge is warranted for prior studies reviewed in conjunction with a visit, consultation, record review, or other evaluation by ~~the medical provider or other medical personnel~~a healthcare provider; neither the professional component value modifier 26 nor the radiological consultation CPT® code 76140 is reimbursable. The review of diagnostic tests is included in the evaluation and management codes.

PATHOLOGY AND LABORATORY GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2020 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT®* codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT®*-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. The Industrial Commission has adopted the Clinical Laboratory Fee Schedule (CLAB) used by Medicare to reimburse the majority of pathology and laboratory services (see additional information regarding publications adopted by reference 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 unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

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

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

   2. The type of drug testing utilized; and

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

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

CPT® codes 80305-80307 are used for reporting presumptive drug class screening. Each code represents all drugs and drug classes performed by the respective methodology per date of service.

~~Providers~~ Healthcare providers performing validity testing on urine specimens utilized for drug testing shall not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

Definitive drug testing may be reported with HCPCS codes G0480 - G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this group of codes may be reported per date of service. Any request for quantitative or definitive testing requires documentation that qualifies necessity.

G0480 – Definitive drug testing 1 – 7 drug class(es) including metabolites(s) if performed

G0481 – Definitive drug testing 8 – 14 drug class(es) including metabolite(s) if performed

G0482 – Definitive drug testing 15 – 21 drug class(es) including metabolites(s) if performed

G0483 – Definitive drug testing 22 or more drug class(es), including metabolite(s) if performed.

U0001 – Laboratory testing for infection of SARS-CoV-2/2019-nCoV (COVID-19). Tests developed by the CDC.

U0002 – Laboratory testing for infection of SARS-CoV2/2019-nCoV (COVID-19). Non-CDC developed tests.

MEDICINE GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2020 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT®* codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT®*-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

A. MATERIALS SUPPLIED BY A ~~PHYSICIAN~~HEALTHCARE PROVIDER: A ~~physician~~ healthcare provider may charge for materials and supplies as described in subsection (I)(4) of the Introduction Section of the Physician's Fee Schedule (pages 10 - 11).

B. COMPLIANCE WITH THE AMERICAN'S WITH DISABILITIES ACT: Code 99199 can be used to bill for the services of an interpreter when they are used to comply with the provisions of "The American's With Disabilities Act", i.e. interpreters for the hearing impaired.

C. ADD-ON CODES: Some of the listed procedures are commonly carried out in addition to the primary procedure performed. All add-on codes found in the CPT® codebook are exempt from the multiple procedure concept. They are exempt from the use of modifier -51.

D. SEPARATE PROCEDURES: Some of the procedures or services listed in the CPT® codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term " separate procedure". The codes designated as a "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

   When a procedure or service is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier -59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure.

E. BUNDLED CODES: Indicates that the service is always bundled in a payment for another service. If these services are covered, payment for them is subsumed by the payment for

the services to which they are incident (e.g., a telephone call from a hospital nurse regarding the care of a patient).

PHYSICAL MEDICINE GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2020 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT®* codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT®*-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The following Commission guidelines are in addition to the CPT® guidelines and represent additional guidance from the Commission relative to unit values for these services. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

General requirements in 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 on PHYSICAL MEDICINE are defined or identified as follows:

A. During the course of physical medicine treatments, only one evaluation and management billing is allowed per week, except that the following evaluations are allowed once every two calendar weeks: 97164, 97168, and 97172. Additional billing for evaluation and management procedures may be allowed when specific additional services are warranted. Approval of the payer must be obtained prior to performing additional services.

   IT IS IMPORTANT TO NOTE THAT THESE LIMITATIONS DO *NOT* APPLY TO REFERRING ~~PHYSICIANS~~ HEALTHCARE PROVIDERS OR TO ~~PHYSICIANS~~ HEALTHCARE PROVIDERS WHO TREAT PATIENTS ONCE PER MONTH.

B. When multiple modalities (97010* through 97039) are performed, the first modality is reported as listed. The second modality is identified by adding modifier "-51" to the code number. The second and each subsequent modality should be valued at 50% of its listed value.

   100% - Full value for the first modality
   50% - For the second and additional modalities

   *97010 is bundled in the payment when a separate Physical Therapy Service is performed.

   Any more than 5 additional modalities or therapeutic procedures must have prior approval of the payer.

Example: During a visit a patient receives the following care: therapeutic exercise (97110) for 45 minutes, mechanical traction (97012) for 15 minutes, electrical stimulation (97014) for 15 minutes and moist heat (97010) for 15 minutes. Under the multiple procedure rule, you would bill 100% of the total value for (97110) therapeutic exercise ($56.23 x 3), 100% of the total value for (97012) mechanical traction ($27.79 x 1) and 50% of the total value for (97014) electrical stimulation ($26.50 x 50%) and 0% (zero percent) for moist heat (97010), for a total billing of $209.73. Moist heat (97010) is paid at 0% (zero percent) because it is bundled with the physical therapy service (therapeutic exercise, 97110).

C. Codes 97110 – 97150 and 97530 -97546 are not subject to the multiple procedure rule and shall be paid at 100% of their listed value. When performing therapeutic procedure(s), excluding work hardening (97545/97546) and Functional Capacity Evaluation 97750), a maximum of 60 minutes is allowed each day. Approval must be obtained by the payer prior to performing therapeutic procedures in excess of 60 minutes.

D. The values for codes in this section apply to provider's time, expertise and use of equipment. Medications and disposable electrodes used in these procedures should be considered supplies, code 99070, (see item 1, Guidelines for Medicine Section regarding billing for supplies).

E. Time-Based Physical Medicine Services are billed according to guidance provided by the Centers for Medicare and Medicaid Services (CMS). When only one service is provided in a day, healthcare providers should not bill for services performed for less than 8 minutes. For any single timed service provided in a day measured in 15-minute units, healthcare providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. Please refer to the following table which outlines the billing units for each time interval.

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

When more than one service represented by 15-minute timed codes is performed in a single day, the total number of minutes of service (as noted in the chart above) determines the number of timed units billed. If any 15-minute timed service that is performed for 7 minutes or less on the same day as another 15-minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater, then the provider may bill one unit for the service performed for the most minutes. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes. See example below.

During a visit, a patient receives the following care: therapeutic exercise (97110) for 45 minutes, manual therapy (97140) for 5 minutes, and therapeutic activities (97530) for 7 minutes. The provider would bill 3 units of therapeutic exercise (97110) and 1 unit of therapeutic activities (97530). Since the total time spent on therapeutic activities and manual therapy is greater than 8 minutes (7 minutes + 5 minutes = 12 minutes), one unit should be billed. The unit billed is for therapeutic activities (97530) since the time spent on that time-based service is greater than the time spent on manual therapy (97140).

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. The healthcare provider is also expected to include the duration (in minutes) for each time-based service in their documentation.

~~D.~~F. A work hardening program is limited to 6 1/2 hours per day, not to exceed a 6 week period of time.

~~E.~~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 weeks, it is at that time the ~~medical~~ healthcare provider should be required to address the success of the treatment protocol, i.e. improvements or lack of improvements regarding stamina, flexibility and strength.

It is not appropriate for the payer on a per billing basis to require a ~~medical~~ healthcare provider to provide unnecessary detailed documentation to justify payment. A ~~medical~~ 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 are straightforward. Modalities are utilized as a sub-element of the over-all 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 ~~medical~~ healthcare provider should provide documentation regarding changes in strength, stamina, and flexibility.

EVALUATION AND MANAGEMENT GUIDELINES

This Fee Schedule has been updated to incorporate by reference the 2020 Edition of the American Medical Association's *Physicians' Current Procedural Terminology*, Fourth Edition (CPT®-4), including the general guidelines, identifiers, modifiers, and terminology changes associated with the adopted codes. In this Fee Schedule *CPT®* codes that contain explanatory language specific to Arizona are preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT®*-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx. Additional information regarding publications adopted by reference is found in the Introduction of the Fee Schedule.

The evaluation and management guidelines adopted by reference may be found in the *Current Procedural Terminology®, Fourth Edition ("CPT® book")* published by the AMA and is reprinted, in part, below with permission. To the extent that a conflict may exist between an adopted portion of the CPT®-4 and a code, guideline, identifier or modifier unique to Arizona, then the Arizona code, guideline, identifier or modifier shall control.

On March 26, 2020 the Commission approved the adopted two HCPCS codes used for a Virtual check-in with physicians via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. Virtual check-ins are initiated by the patient and may be performed via multiple technology modalities including telephone, secure text messaging, email, or use of a patient portal. The two HCPCS codes are included in the 2020/2021 Fee Schedule.

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.

G2012 – Brief communication technology-based service, *e.g.*, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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; 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 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 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. This classification is important because the nature of work varies by type of service, place of service, and the patient's status.

   The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, e.g.,

office consultation. Third, the content of the service is defined, e.g. comprehensive history and comprehensive examination. (See "Levels of E/M Services" in 2020 AMA CPT® codebook, for details on the content of E/M services). Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified.

B. DEFINITIONS OF COMMONLY USED TERMS: Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties. E/M services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice.

- New and Established Patient: 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 my report evaluation and management services reported by a specific CPT® code(s). A new patient is one who has not received any professional services from the physician~~/qualified health care professional~~ or another physician~~/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~~/qualified health care professional~~ or another physician~~/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~~/qualified health care professional~~ is on call for or covering for another physician~~/qualified health care professional~~, the patient's encounter will be classified as it would have been by the physician~~/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 exact same subspecialties 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.

- Chief Complaint: A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words.

- Concurrent Care and Transfer of Care: Concurrent care is the provision of similar services (e.g., hospital visits) to the same patient by more than one physician ~~or other qualified health care professional~~ on the same day. When concurrent care is provided, no special reporting is required. Transfer of care is the process whereby a physician ~~or other qualified health care professional~~ who is providing management for some or all

of a patient's problems relinquishes this responsibility to another physician ~~or other qualified health care professional~~ who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician ~~or other qualified health care professional~~ transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician ~~or other qualified health care professional~~ who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

- Counseling: Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

  • Diagnostic results, impressions, and/or recommended diagnostic studies;
  • Prognosis;
  • Risks and benefits of management (treatment) options;
  • Instructions for management (treatment) and/or follow-up;
  • Importance of compliance with chosen management (treatment) options;
  • Risk factor reduction; and
  • Patient and family education.
  (For psychotherapy, see 90832-90834, 90836-90840)

- Family History: A review of medical events in the patient's family that includes significant information about:

  • The health status or cause of death of parents, siblings and children;
  • Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
  • Diseases of family members which may be hereditary or place the patient at risk.

- History of Present Illness: A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

- Levels of E/M Services: Within each category or subcategory of E/M service, 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.

  The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical

decision-making required to determine the need and/or location for appropriate care and treatment of the patient (e.g., office and other outpatient setting, emergency department, nursing facility). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians ~~or other qualified health care professionals~~.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- History;
- Examination;
- Medical decision making;
- Counseling;
- Coordination of care;
- Nature of presenting problem; and
- Time.

The first three of these components (history, examination and medical decision making) are considered the key components in selecting a level of E/M services.

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered contributory factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other physicians, other health care professionals, or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in the following pages.

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

The actual performance and/or interpretation of diagnostic test/studies ordered during a patient encounter are not included in the levels of E/M services. Physician 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 physician's 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 with modifier 26 appended.

The physician ~~or other 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 above and beyond other

services provided or beyond the usual preservice and post service care associated with the procedure that was performed. 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.

- Nature of Presenting Problem: A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

  Minimal - A problem that may not require the presence of the physician ~~or other qualified health care professional~~, but service is provided under the physician's ~~or other qualified health care professional's~~ supervision.

  Self-limited or Minor - A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

  Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

  Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

  High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

- Past History: A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

  • Prior major illnesses and injuries;
  • Prior operations;
  • Prior hospitalizations;
  • Current medications;
  • Allergies (e.g., drug, food);
  • Age appropriate immunization status;
  • Age appropriate feeding/dietary status.

- Social History: An age appropriate review of past and current activities that includes significant information about:

  • Marital status and/or living arrangements;

• Current employment;
• Occupational history;
• Military history;
• Use of drugs, alcohol, and tobacco;
• Level of education;
• Sexual history;
• Other relevant social factors.

- System Review (Review of Systems): An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of CPT®, the following elements of a system review have been identified:

  • Constitutional symptoms (fever, weight loss, etc.);
  • Eyes;
  • Ears, nose, mouth, throat;
  • Cardiovascular;
  • Respiratory;
  • Gastrointestinal;
  • Genitourinary;
  • Musculoskeletal;
  • Integumentary (skin and/or breast);
  • Neurological;
  • Psychiatric;
  • Endocrine;
  • Hematologic/Lymphatic;
  • Allergic/Immunologic.

  The review of systems helps define the problem, clarify the differential diagnosis, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

- Time: The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of CPT®. The inclusion of time as an explicit factor beginning in CPT® 1992 is done to assist in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages and, therefore, represent a range of times which may be higher or lower depending on actual clinical circumstances.

  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. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

  Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services.

Since "work" is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians' estimates of their "work." It has been demonstrated that estimations of intraservice time (as explained below), both within and across specialties, is a variable that is predictive of the "work" of E/M services. This same research has shown there is a strong relationship between intraservice time and total time for E/M services. Intraservice time, rather than total time, was chosen for inclusion with the codes because of its relative ease of measurement and because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.

Intraservice times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit. When prolonged time occurs in either the office or the inpatient areas, the appropriate add-on code should be reported.

Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, performing an examination, and counseling the patient.

Time is also spent doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This non-face-to-face time for office services – also called pre- and post-encounter time – is not included in the time component described in the E/M codes. However, the pre- and post-non-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

Unit/floor time (hospital observation services, inpatient hospital care, initial inpatient hospital consultations, nursing facility): For reporting purposes, intraservice time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.

In the hospital, pre- and post-time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital.

This pre- and post-visit time is not included in the time component described in these codes. However, the pre- and post-work performed during the time spent off the floor or unit was included in calculating the total work of typical services in physician surveys.

Thus, the unit/floor time associated with the services described by any code is a valid proxy for the total work done before, during, and after the visit.

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 D. 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.

E. CLINICAL EXAMPLES: Clinical examples of the codes for E/M services are provided to assist in understanding the meaning of the descriptors and selecting the correct code. The clinical examples are listed in Appendix C. (*Appendix C of the CPT® has not been reprinted in this text.)* Each example was developed by the specialties shown.

The same problem, when seen by different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

F. INSTRUCTIONS FOR SELECTING A LEVEL OF E/M SERVICE:

- Review the Reporting Instructions for the Selected Category or Subcategory: Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicted, e.g., "Inpatient Hospital Care," special instructions will be presented preceding the levels of E/M services.

- Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory: The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

• History;

• Examination;
• Medical decision making;
• Counseling;
• Coordination of care;
• Nature of presenting problem;
• Time.

The first three of these components (ie, history, examination and medical decision making) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits which consist predominantly of counseling or coordination of care. (See instructions for selecting level of E/M Service).

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

- Determine the Extent of History Obtained: The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

  Problem Focused - Chief complaint; brief history of present illness or problem.

  Expanded Problem Focused - Chief complaint; brief history of present illness; problem pertinent system review.

  Detailed - Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient's problems.

  Comprehensive - Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.

  The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

- Determine the Extent of Examination Performed: The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

  Problem Focused - A limited examination of the affected body area or organ system.

Expanded Problem Focused - A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed - An extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive - A general multisystem examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.

For the purposes of these CPT® definitions, the following body areas are recognized:

- Head, including the face;
- Neck;
- Chest, including breasts and axilla;
- Abdomen;
- Genitalia, groin, buttocks;
- Back;
- Each extremity;

For the purposes of these CPT® definitions, the following organ systems are recognized:

- Eyes;
- Ears, nose, mouth, and throat;
- Cardiovascular;
- Respiratory;
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Skin;
- Neurologic;
- Psychiatric;
- Hematologic/Lymphatic/Immunologic.

- Determine the Complexity of Medical Decision Making: Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

  - The number of possible diagnoses and/or the number of management options that must be considered;
  - The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
  - The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Four types of medical decision making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision making, two of the three elements in the table following must be met or exceeded.

Table 1 – Complexity of Medical Decision Making

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
Minimal	Minimal or none	Minimal	Straightforward
Limited	Limited	Low	Low complexity
Multiple	Moderate	Moderate	Moderate complexity
Extensive	Extensive	High	High complexity

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

- Select the Appropriate Level of E/M Services Based on the Following:

  1. For the following categories/subcategories, **all of the key components** i.e., history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; emergency department services; initial nursing facility care; domiciliary care, new patient; and home, new patient.

  2. For the following categories/subcategories, **two of the three key components** (i.e., history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

  3. When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** shall be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.