

S C F A R I Z O N A ' S

MEDPRO

NEWS & INFORMATION FOR MEDICAL PROVIDERS



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New drug law

A new Arizona law will introduce a change in procedures related to workers' compensation coverage of some prescriptions.

The 49th Arizona Legislature took action on a variety of workers' compensation-related legislation, ranging from technical corrections and statutory housekeeping, to substantive laws impacting medical

treatment and earning capacity determinations.

The Omnibus Workers' Compensation bill (Senate Bill 1262) passed the Arizona Senate and House of Representatives unanimously and was signed by Gov. Jan Brewer on July 13. The legislation dealt with workers' compensation rate filing, policyholder fraud, loss of earning capacity determi-

nations and narcotic use.

The portion relevant to narcotic use adds Arizona Revised Statute 23-1062.02, which allows carriers to hold doctors accountable when they prescribe Class 2 narcotics for purposes other than those approved by the Food and Drug Administration.

Upon request by a claims adjuster, doctors are

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New Drug Law *continued*

required to submit detailed reports justifying the continued prescription of the narcotic. Adjuster requests may require the patient to submit to drug tests and explain how the drug usage has resulted in an improvement in function, among other things.

The intent of the law is to obtain better control over the indiscriminate prescription of medications by some physicians, which has resulted in addictions and fraud. The inappropriate prescription of such drugs along with the diversion of the drugs to illegal street sales contribute significant costs to the workers' compensation system, costs that ultimately impact Arizona employers by way of higher insurance premiums.

Briefly, the new statute says that an interested party – in the case of SCF Arizona, the payer – can ask the prescribing physician of Class 2 narcotics for the following:

- Justification of use of the controlled substance
- A treatment plan that describes the physician's monitoring of said substance
- A medication contract
- Drug testing (done at payer's expense)
- Documentation that the regimen is providing relief demonstrated by increased function.

Failure to comply with all requests allows the payer to suspend payment for the prescribing physician's services until the physician complies with the requests.



GETTING TO KNOW YOU Kent McCray, Medical Review supervisor, is a lifelong Phoenix native – “one of the few,” he says. McCray has worked at SCF nine

years and in his current position six months. He would like medical providers to know that he and his co-workers are focused on processing bills as quickly and accurately as possible. He finds the work environment at SCF challenging and gives careful attention to the details of workers' compensation law. McCray is pursuing a master's in business administration. When time allows, he enjoys playing the drums.

PARTICIPATING IN SCF ARIZONA'S PREFERRED CONNECTION NETWORK

Using the PCN: Arizona employers may direct an injured worker to a designated medical provider on a one-time basis. Patients usually will continue to see that provider for the duration of their care. Employers can find a PCN provider by visiting www.scfaz.com/pcn.

For billing questions, e-mail SCF's Medical Review/Provider Inquiry Team at providerinquiry@scfaz.com.

JUST THE FACTS

DOWNLOAD SCF'S RETURN TO WORK/STAY AT WORK MANUAL AT WWW.SCFAZ.COM. CLICK "SAFETY & PREVENTION," "RETURN TO WORK."

Glossary

Permanent impairment:

A permanent impairment is a limitation that is the direct result of a workplace injury. Examples include limited movement of a limb or finger. The evaluation of the extent of this limitation is called an impairment rating. It is the percentage of impairment using the current AMA standards.

Supportive care:

An example of supportive care for maintenance of a stationary status includes one to two office visits a year or an annual office visit for monitoring and prescribing of anti-inflammatory medications. Supportive care is different than active care. Active care status requires that the injured worker be seen at least once a month by the treating physician. Active care is rendered while the injured worker's condition has not reached maximum medical improvement.

Case closed

A physician's discharge of a patient with a workers' compensation claim should be as clear as possible to ensure the most efficient management of the claim.

A patient is discharged from active treatment when the provider does not expect the patient's condition will improve beyond the current status. When this happens, the physician's monthly report lets the SCF claims adjuster know an injured worker's condition has stabilized. It's preferred that the provider's report clearly indicate this condition by including one

of the following statements:

- The patient is being discharged from further active treatment.
- The patient has reached Maximum Medical Improvement.
- The patient is stationary.

Stating the information in one of the above ways provides stronger closure of the claim.

Notes that are ambiguous include "return as needed," the abbreviation "PRN," "return if pain persists" and "patient returned to Date of Injury occupation."

The patient's discharge also must

address two questions:

- Is the provider recommending supportive care such as annual office visits necessary to maintain the patient at his or her current status?
- Does the patient have permanent impairment?

An impairment rating must be included with the discharge of a patient with a permanent impairment. The Sixth Edition of the *American Medical Association Guidelines* contains specific impairment ratings and guidance on assessing a limitation.

THE INDUSTRIAL COMMISSION OF ARIZONA HOLDS WEEKLY MEETINGS THAT ARE OPEN TO THE GENERAL PUBLIC. TO VIEW MEETING AGENDAS, VISIT WWW.ICA.STATE.AZ.US AND CLICK ON "AGENDA." THE FIVE-MEMBER COMMISSION ESTABLISHES THE ANNUAL PHYSICIAN'S FEE SCHEDULE.

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Q&A

Q Can providers bill for a "consultation" if the initial visit was initiated by the patient, a family member or the employer?

A No, for the visit to be classified as a "consultation" the written request for a consultation must be made by a physician or other appropriate source. If additional requests for an opinion or advice regarding the same or a new problem is received from

another physician or other appropriate source, and documented in the medical record, the provider may bill for a consultation.

For a consultation, use Current Procedural Terminology codes 99241-99245.

A visit initiated by the patient, a family member or the employer should be billed as an office visit. For a new patient, use CPT codes 99201 - 99205. For an established patient, use CPT codes 99211 - 99215.

Q Are "transfer of care" and "referral" the same service?

A Yes, a referral is the transfer of the total or specific care of a patient from one physician to another. It is not a consultation. The physician accepting a patient on a referral basis will be managing a portion of or all the patient's care.

LOOK INSIDE

AT A GLANCE

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