Medical Data Report

For the state of

ARIZONA

September 2023

NCCI's **Medical Data Report** and its content are intended to be used as a reference tool and for informational purposes only. No further use, dissemination, sale, assignment, reproduction, preparation of derivative works, or other disposition of this report or any part thereof may be made without the prior written consent of NCCI.

NCCI's **Medical Data Report** is provided "as is" and includes data and information available at the time of publication only. NCCI makes no representations or warranties relating to this report, including any express, statutory, or implied warranties including the implied warranty of merchantability and fitness for a particular purpose. Additionally, NCCI does not assume any responsibility for your use of, and for any and all results derived or obtained through, the report. No employee or agent of NCCI or its affiliates is authorized to make any warranties of any kind regarding this report. Any and all results, conclusions, analyses, or decisions developed or derived from, on account of, or through your use of the report are yours; NCCI does not endorse, approve, or otherwise acquiesce in your actions, results, analyses, or decisions, nor shall NCCI or other contributors to the **Medical Data Report** have any liability thereto**.**

Introduction

Medical costs have been growing over the last 30 years. Today, in many states, close to 60% of workers compensation benefits are attributed to medical costs. Managing the cost and delivery of medical care is one of the major concerns facing workers compensation (WC) stakeholders now and in the foreseeable future. The availability of medical data on WC claims is essential for the pricing of proposed state legislation and assessing impacts of changes to fee schedules.

This publication is a data source for regulators and others who are interested in the driving forces behind changing medical costs in WC claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that underlie the financial soundness of the WC system. When making comparisons to the region and countrywide (CW), it is important to note that some states in this report do not have a fee schedule.

Knowing how payments for different services contribute to WC medical benefit costs provides insight into the growth of medical benefits. This report illustrates the breakdown of services by category, namely:

- Physician
- Hospital Outpatient
- Hospital Inpatient
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Other

The report drills down into these categories to show which procedures represent the greatest share of payments.

There is one important caveat: Information in this report may not coincide with an analysis of a medical fee schedule change performed in the future. An analysis of a medical fee schedule change requires evaluation of the specific procedures covered by the fee schedule, which may be different from how payments are categorized in this report.

The data contained in this report represents medical transactions for Service Year 2022 (medical services delivered from January 1, 2022, to December 31, 2022), except where otherwise noted. WC insurance carriers must report paid medical transactions if, over the most recent three years, they write at least 1% of the market share in any one state for which NCCI is the rating or advisory organization. Once a carrier meets the eligibility criteria, it is required to report for all applicable states in which it writes WC insurance. All carriers within an insurance group are required to report.

No data adjustments have been made for the reporting of COVID-19-related claims.

For Arizona in Service Year 2022, the reported number of transactions was more than 1,388,100, with more than $294,760,300 paid, for more than 63,300 claims. This represents data from 94% of the workers compensation premium written, which includes experience for large-deductible policies. Bulk payments and lump-sum settlements are not required to be reported. Also, self-insured data is not included.

Unless otherwise noted, the source for all data in this report is NCCI's Medical Data Call, Service Year 2022.

Also:

- Region includes data from the following states: AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT.
- Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV
- Texas data is included for Service Year 2020 and beyond

Additional information regarding the data underlying this report is available in the Appendix.

Table of Contents

Medical Cost Statistics

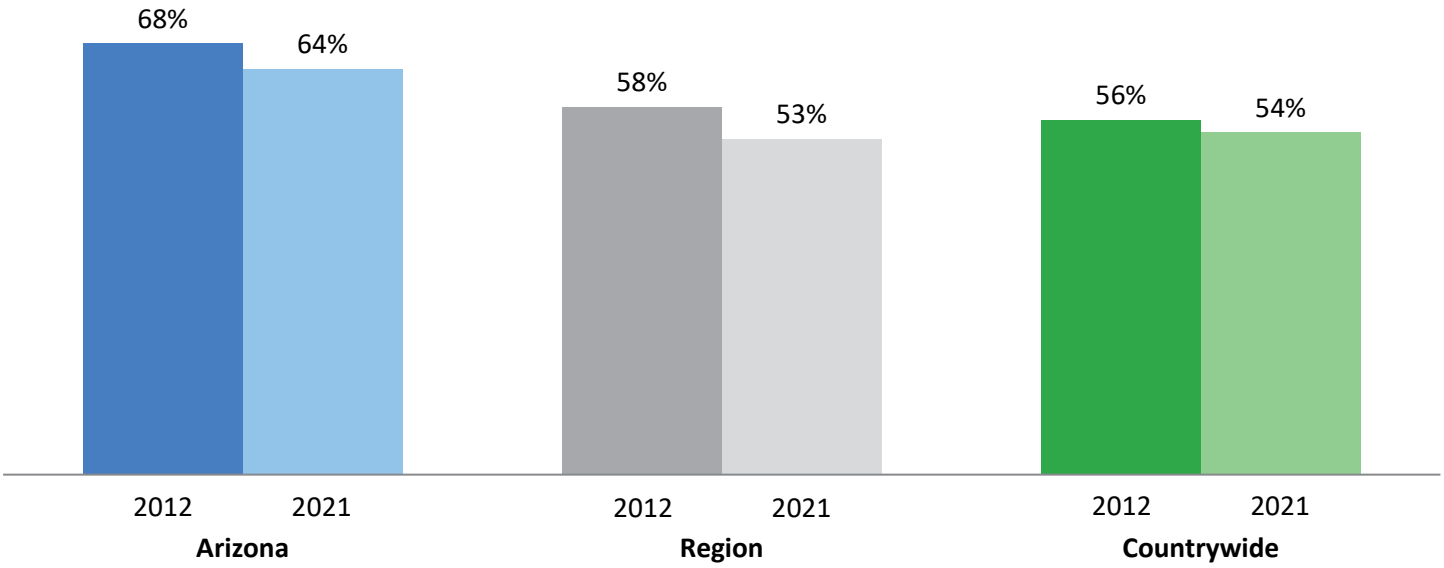
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

Of the two, medical benefits resulting from a work-related injury or disease are the leading cost drivers for workers compensation claims on a countrywide basis. Because this is a relative measure and benefits for both indemnity and medical may vary from state to state, the share of medical benefit costs may vary across states. In particular, the medical share in a state may be large because the indemnity benefits are relatively less prominent.

Chart 1 displays the medical percentage of total benefit costs for Arizona, the region, and countrywide for Accident Years 2012 and 2021.

Chart 1

Medical Share of Total Benefit Costs by Accident Year



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

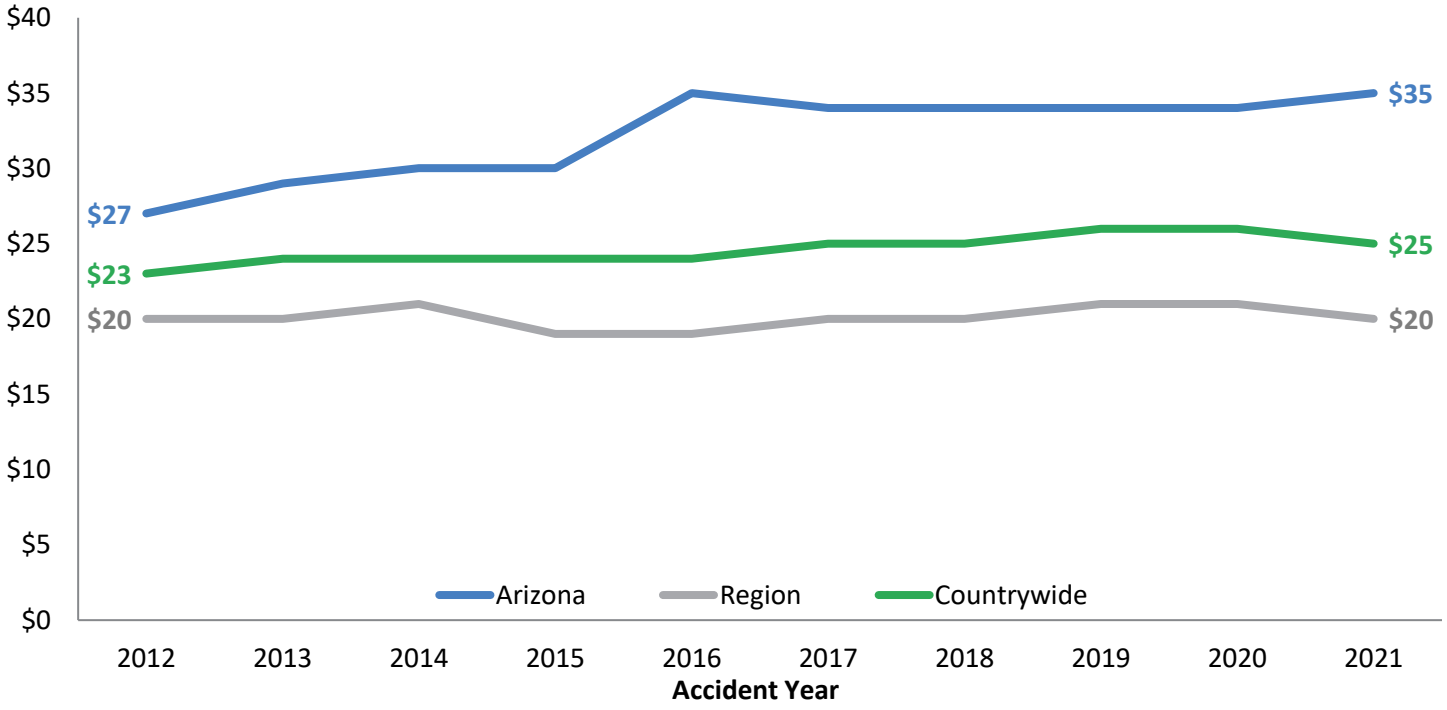
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging about 1% from Accident Years 2012 to 2021; this has increased at a slightly lower rate than the United States Personal Healthcare Spending per capita.[1] Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for Arizona, the region, and countrywide.

Medical losses are at historical benefit levels and historical dollar values—meaning that no adjustment for inflation or changes in benefits has been made. Since the data is aggregated for medical losses of lost-time claims by accident year, the results shown in this chart provide a high-level perspective of the average medical cost per case.

This chart illustrates how Arizona compares to the regional and countrywide average for each individual accident year and allows for the comparison of the growth in average medical costs.

Chart 2

Overall Medical Average Cost per Lost-Time Claim (in 000s)



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

[1] **State of the Line Report, *Annual Issues Symposium***, May 2022, www.ncci.com/Articles/Pages/AIS2022-SOTL-Presentation.pdf

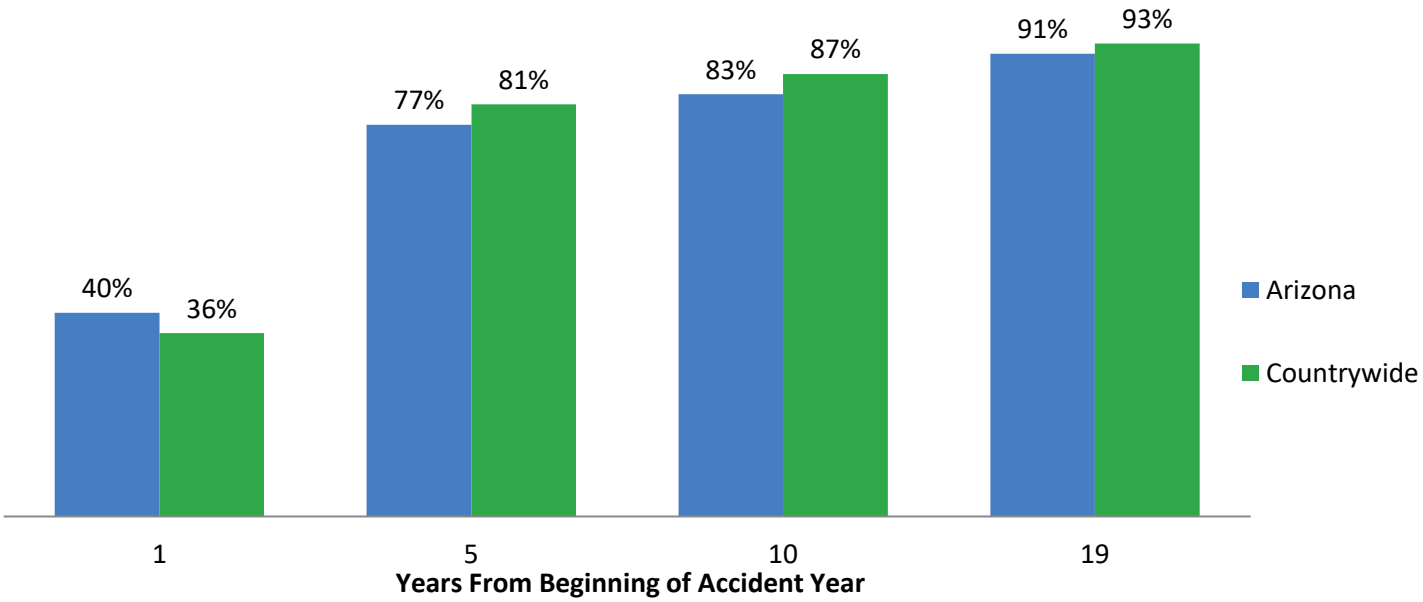
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. NCCI research has found that it is likely that about 10% of the cost of medical benefits for workplace injuries that occur this year will be for services provided more than two decades into the future.

A key determinant driving payment patterns for medical services is the effectiveness of dispute resolution processes, settlement practices, and statutory provisions for medical benefits. An aging workforce and continued changes in rules for Medicare set-asides have created a shifting environment for the settlement of claims and, particularly, medical benefits.

Chart 3 shows the percentage of medical benefits paid (including medical settlements) at different claim maturities for Arizona and countrywide.

Chart 3

Percentage of Medical Paid by Claim Maturity



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, and VT.

Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits.

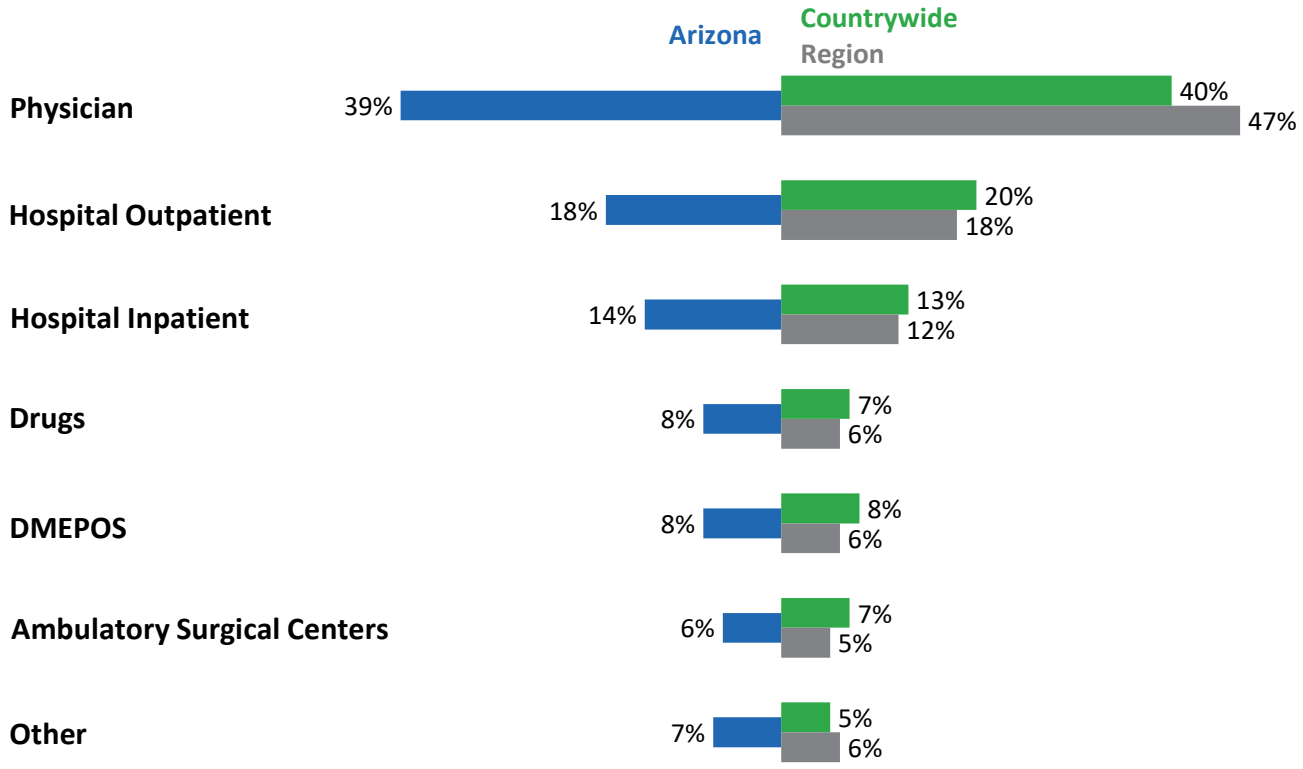
Payments categorized as Drugs; DME, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services) are based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed. For the remaining categories—Physicians, Hospital Outpatient, Hospital Inpatient, and Ambulatory Surgical Centers (ASC)—NCCI relies on a combination of:

- Provider taxonomy code—identifies the type of provider that billed for, and is being paid for, a medical service
- Procedure code—alphanumeric code used to identify procedures performed by medical professionals
- Place of services—alphanumeric code used to identify places where procedures were performed (e.g., physician's office or ambulatory surgical center)

Chart 4 displays the distribution of medical payments by type of service.

Chart 4

Distribution of Medical Payments



Physicians

In the 1970s, fewer than a dozen states had physician fee schedules in place. In the 1990s, several states established such schedules. Today, few states remain without a physician fee schedule. Recent changes in the schedules indicate greater attention to provisions that often seek to balance cost containment with service provider availability. NCCI's most recent study, "The Impact of Fee Schedule Updates on Physician Payments" (December 2018), shows that:

- Approximately 80% of any change in the maximum allowable reimbursement (MAR) for a physician service will be realized as a change in prices paid
- Most of the impact of a MAR change on prices paid is realized within one year from the date of a fee schedule change

One measure of workers compensation medical costs is a comparison of current payments to the Medicare rates adjusted for your state.

The chart below shows the average percentage of Medicare schedule reimbursement[2] amounts for physician payments by category for Arizona, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the categories listed in the chart, and the state comparison reflects Medicare's geographic adjustments. In Arizona, 92% of "all physician services" payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

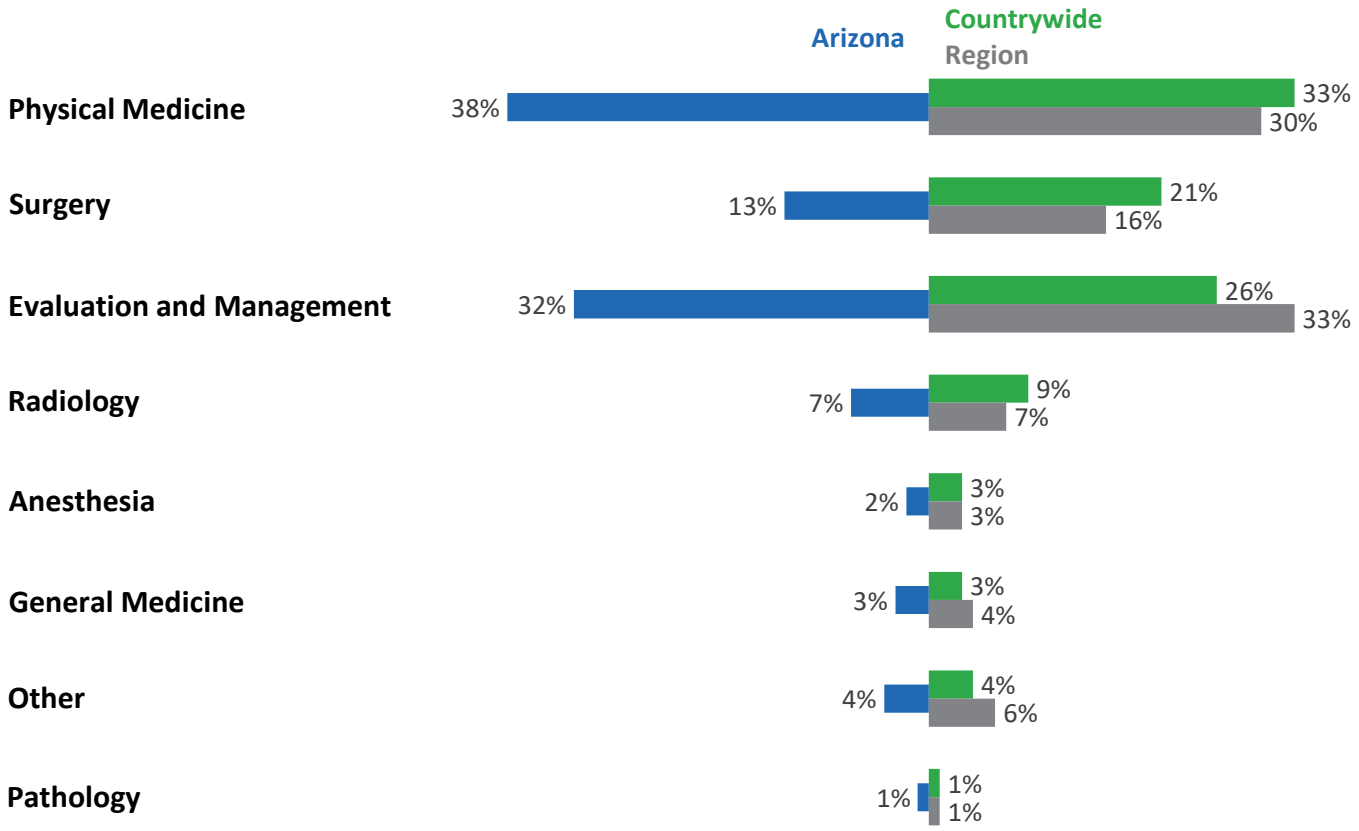
Physician Service Category	Arizona	Region	Countrywide
General and Physical Medicine	159%	140%	133%
Surgery	189%	217%	250%
Evaluation and Management	162%	154%	137%
Radiology	192%	203%	219%
Anesthesia	253%	269%	290%
All Physician Services	**167%**	**161%**	**160%**

[2] The calculation for Surgery takes into account Medicare's endoscopic procedures reimbursement rules.

Chart 6 displays the distribution of physician payments by service category for Arizona, the region, and countrywide.

Chart 6

Distribution of Physician Payments by AMA Service Category



In 2019, NCCI conducted a review of physician costs in workers compensation as compared to group health (GH). Results[3] show that WC physician costs are 77% higher than GH in general, with variation across states ranging from 0% to 200%. The difference in costs for physician services is due to both prices and utilization of services. Most notably, physical medicine services in WC are almost three times the costs of physical medicine services in GH, largely due to the number of services provided.

Physicians typically use current procedural terminology (CPT) codes to identify the services that they provide to claimants. These codes are specific and provide detailed information on what service was performed. The charts below display the top 10 procedure codes reported by physicians for the following service categories: anesthesia, surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code is displayed in the corresponding table below each chart.

Except for anesthesia codes and physical & general medicine codes, the charts also include the average amount paid per transaction (PPT) for these codes in Arizona, in the region, and countrywide. The average PPT is calculated by taking the total payments for the procedure code and dividing by the number of transactions for the procedure code. Other fields, such as the secondary paid procedure code, modifier, diagnosis code, place of service, and quantity/units, may need to be considered when evaluating average payments per service. The charts for the top 10 anesthesia codes and physical & general medicine codes include the average amount paid per unit (PPU) for the codes in Arizona, in the region, and countrywide. The PPU is calculated by taking the total payments for the procedure code and dividing by the number of units for the procedure code. For these codes, a unit is typically a measurement of time (15-minute increment, 30-minute increment, 1-hour increment, etc.) but can also be one transaction. The procedure code description will indicate the unit measurement.

The Top 10 charts rank the procedure codes for each service category. Procedure codes are sorted from highest total payments to lowest total payments. The procedure code with the highest amount paid is ranked first, the procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows those procedures that represent the highest percentage share of payments.

Additional charts show time until first treatment. Time to initial treatment (TTT) is a measure of the availability of medical services and is measured by the number of days between the date of injury and the date on which the worker first received medical services.

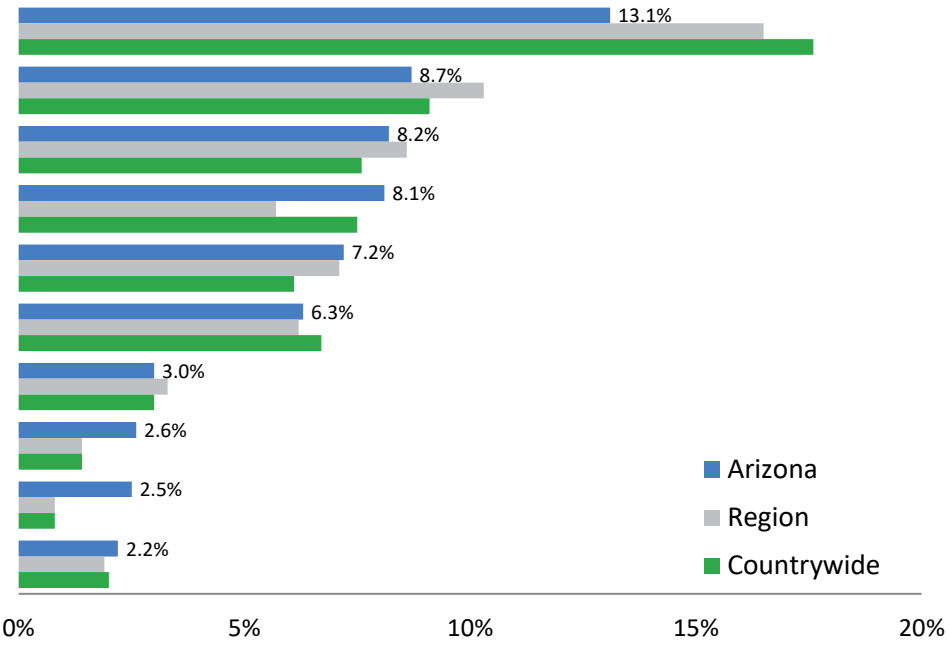
[3] Lipton, Barry, *Work Comp vs. Group Health—The Price We Pay* (Channel NCCI, video file), May 23, 2019, www.youtube/fb3tnbQoMSY

In Arizona, physician payments for anesthesia services provided in 2022 are, on average, 253% of Medicare-scheduled reimbursement amounts, compared to 269% in the region and 290% countrywide. Payments for these services comprise 2% of physician payments, compared to 3% in the region and 3% countrywide.

Chart 7

Top 10 Anesthesia Procedure Codes by Amount Paid

Code	Average PPU[4] AZ	Region	CW
01630	$83	$86	$84
01400	$92	$90	$88
01830	$78	$75	$72
00670	$107	$105	$96
01480	$66	$71	$67
01810	$79	$84	$86
00400	$92	$72	$74
01740	$66	$74	$70
01938	$91	$81	$82
01992	$59	$87	$83



Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified
01938	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position

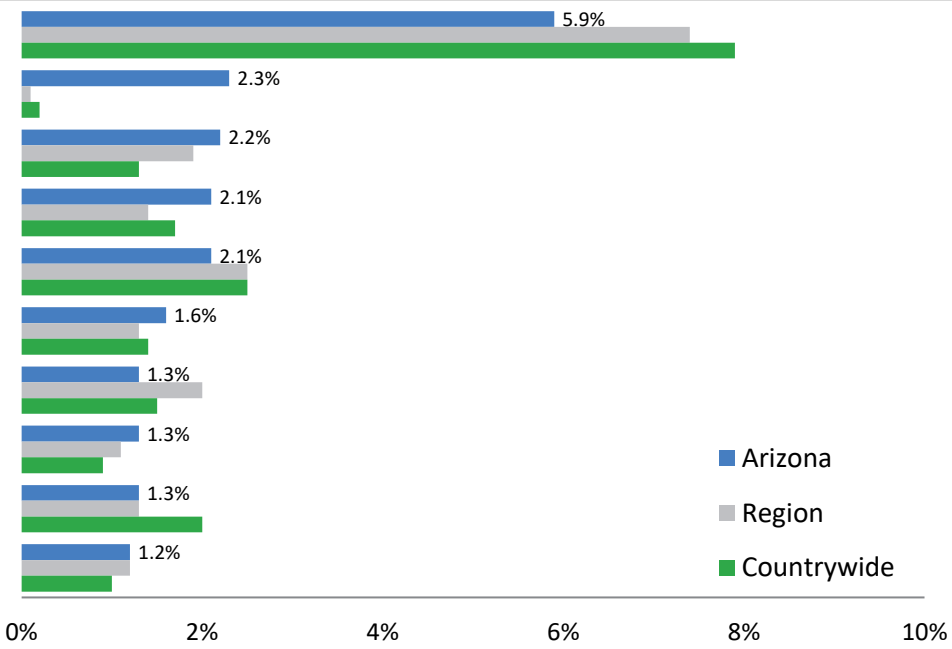
[4] A unit is an increment of 15 minutes unless otherwise defined in the description.

In Arizona, physician payments for surgery services provided in 2022 are, on average, 189% of Medicare-scheduled reimbursement amounts, compared to 217% in the region and 250% countrywide. Payments for these services comprise 13% of physician payments, compared to 16% in the region and 21% countrywide.

Chart 8

Top 10 Surgery Procedure Codes by Amount Paid

Code	Average PPT AZ	Region	CW
29827	$1,567	$1,820	$2,113
24346	$3,012	$2,594	$3,131
12001	$147	$165	$166
64483	$388	$455	$538
29881	$908	$1,073	$1,352
20610	$114	$123	$124
29888	$1,308	$1,776	$2,013
25609	$1,659	$1,968	$1,958
29823	$541	$629	$966
20680	$653	$732	$829

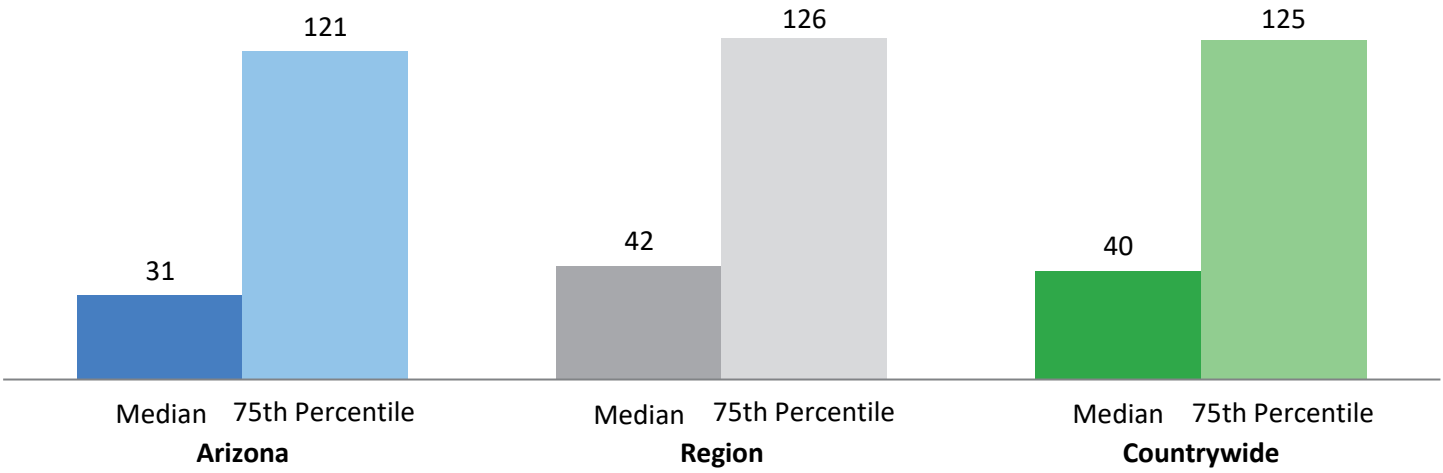


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
29823	Arthroscopy, shoulder, surgical; debridement, extensive
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)

Chart 9 shows the median and 75th percentile[5] time until first treatment for major surgery for Arizona, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop such as an occupational disease, which may extend the time between the date a work-related injury or disease is reported and the first medical treatment takes place.

Chart 9

Time Until First Treatment for Major Surgery[6] (in Days)



Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

[5] The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 9 indicates that out of 100 claimants, 75 will receive a major surgery within 121 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

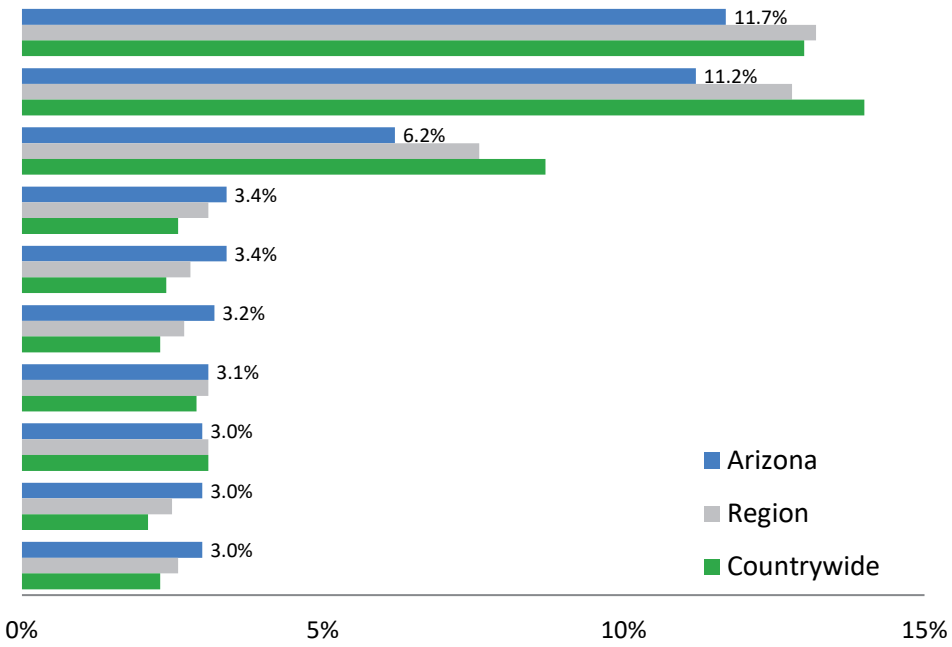
[6] A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, or the procedure involves spine/spinal cord neurostimulators.

In Arizona, physician payments for radiology services provided in 2022 are, on average, 192% of Medicare-scheduled reimbursement amounts, compared to 203% in the region and 219% countrywide. Payments for these services comprise 7% of physician payments, compared to 7% in the region and 9% countrywide.

Chart 10

Top 10 Radiology Procedure Codes by Amount Paid

Code	Average PPT AZ	Region	CW	Paid Share
73721	$397	$398	$456	11.7%
73221	$395	$398	$462	11.2%
72148	$364	$387	$450	6.2%
73610	$60	$57	$57	3.4%
73110	$70	$63	$62	3.4%
73630	$56	$55	$54	3.2%
73222	$601	$531	$615	3.1%
73030	$56	$56	$58	3.0%
73140	$65	$56	$55	3.0%
73130	$62	$55	$54	3.0%

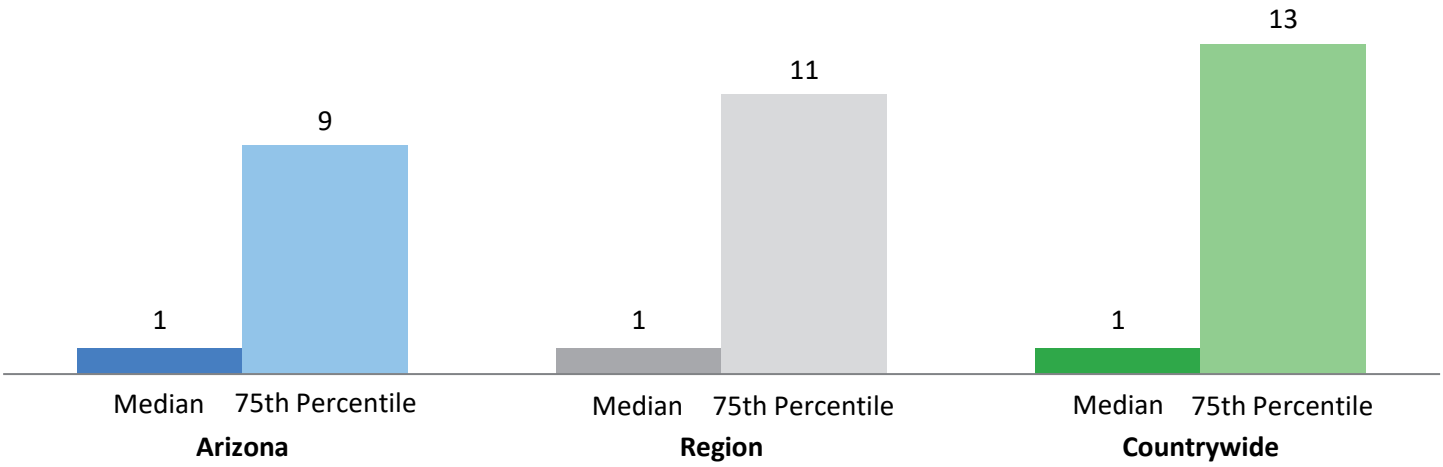


Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
73610	Radiologic examination, ankle; complete minimum of 3 views
73110	Radiologic examination, wrist; complete minimum of 3 views
73630	Radiologic examination, foot; complete minimum of 3 views
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
73030	Radiologic examination, shoulder; complete minimum of 2 views
73140	Radiologic examination, finger(s); minimum of 2 views
73130	Radiologic examination, hand; minimum of 3 views

Chart 11 shows the median and 75th percentile time until first treatment for radiology procedures for Arizona, the region, and countrywide.

Chart 11

Time Until First Treatment for Radiology (in Days)



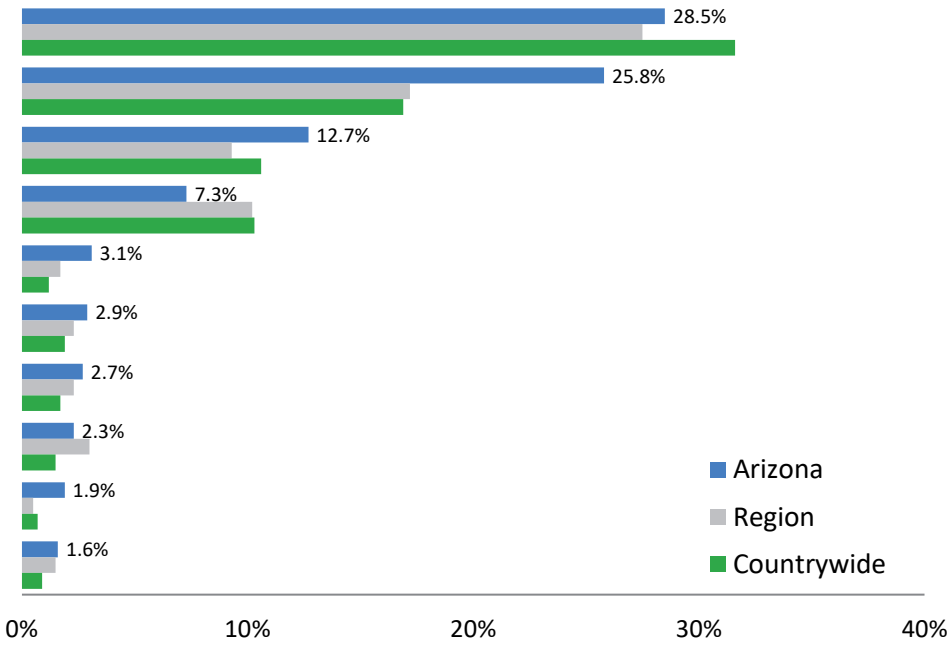
Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

In Arizona, physician payments for physical and general medicine services provided in 2022 are, on average, 159% of Medicare-scheduled reimbursement amounts, compared to 140% in the region and 133% countrywide. Payments for these services comprise 41% of physician payments, compared to 34% in the region and 36% countrywide.

Chart 12

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

	Average PPU			
Code	**AZ**	**Region**	**CW**	**Paid Share**
97110	$47	$42	$40	28.5%
97530	$61	$53	$46	25.8%
97112	$53	$47	$42	12.7%
97140	$40	$40	$37	7.3%
97164	$107	$99	$85	3.1%
97161	$166	$146	$134	2.9%
97162	$169	$143	$139	2.7%
97799	$295	$136	$200	2.3%
97535	$56	$53	$44	1.9%
90837	$248	$216	$189	1.6%

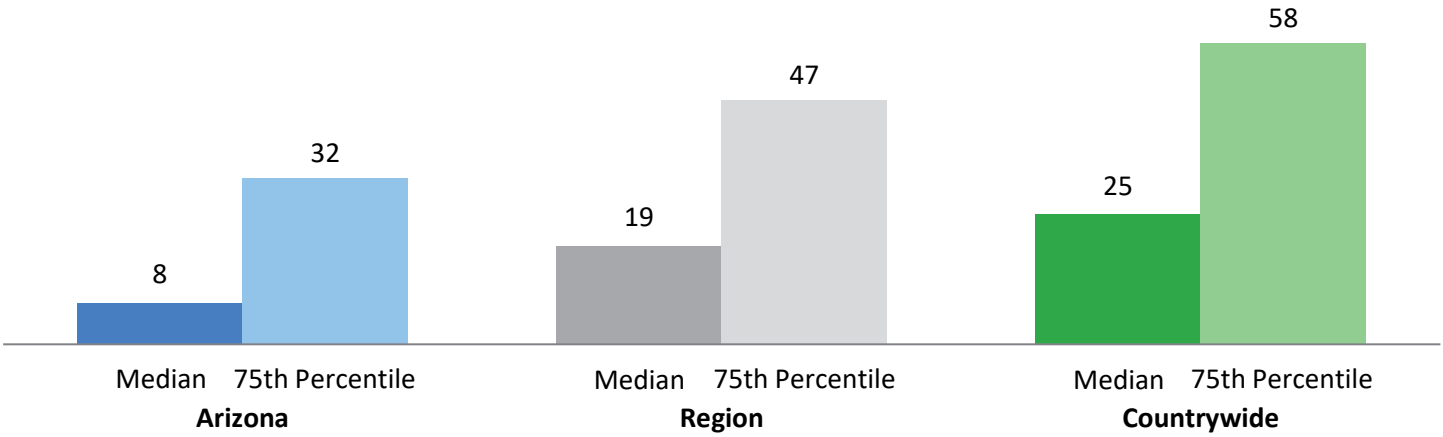


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97164	Re-evaluation of physical therapy and established plan of care; 20 minutes face-to-face with patient and/or family
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
97162	Physical therapy evaluation of moderate complexity; typically, 30 minutes are spent with the patient and/or family
97799	Unlisted physical medicine/rehabilitation service or procedure
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
90837	Psychotherapy, 60 minutes with patient

Chart 13 shows the median and 75th percentile time until first treatment for physical and general medicine procedures for Arizona, the region, and countrywide.

Chart 13

Time Until First Treatment for Physical and General Medicine (in Days)



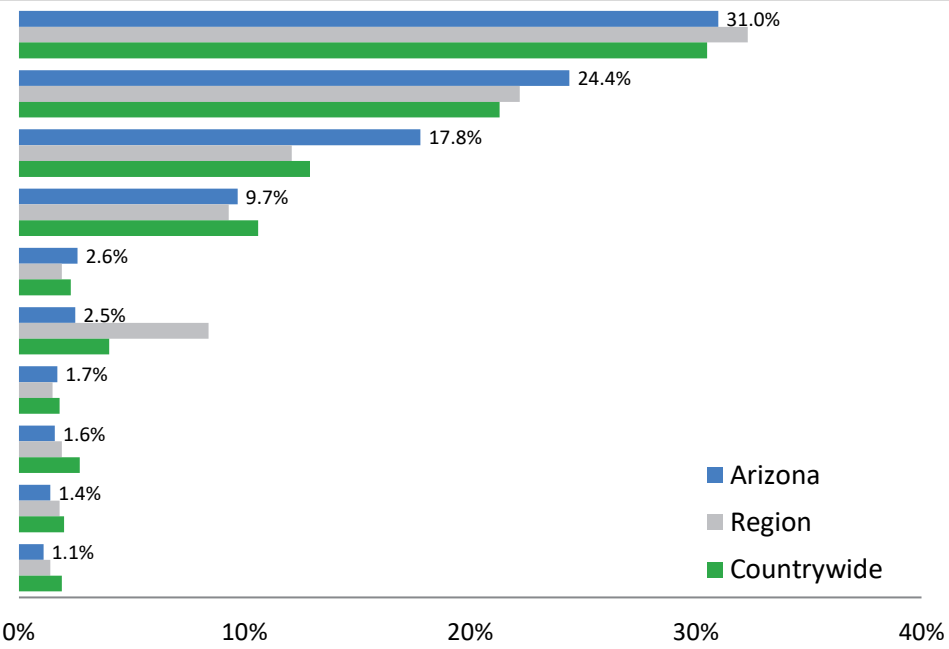
Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

In Arizona, physician payments for evaluation and management services provided in 2022 are, on average, 162% of Medicare-scheduled reimbursement amounts, compared to 154% in the region and 137% countrywide. Payments for these services comprise 32% of physician payments, compared to 33% in the region and 26% countrywide.

Chart 14

Top 10 Evaluation and Management Procedure Codes by Amount Paid

Code	Average PPT AZ	Region	CW
99213	$144	$138	$118
99214	$201	$196	$166
99204	$271	$261	$234
99203	$176	$175	$156
99455	$321	$210	$190
99456	$2,225	$628	$707
99212	$89	$85	$73
99284	$247	$255	$264
99215	$271	$275	$220
99283	$172	$167	$179

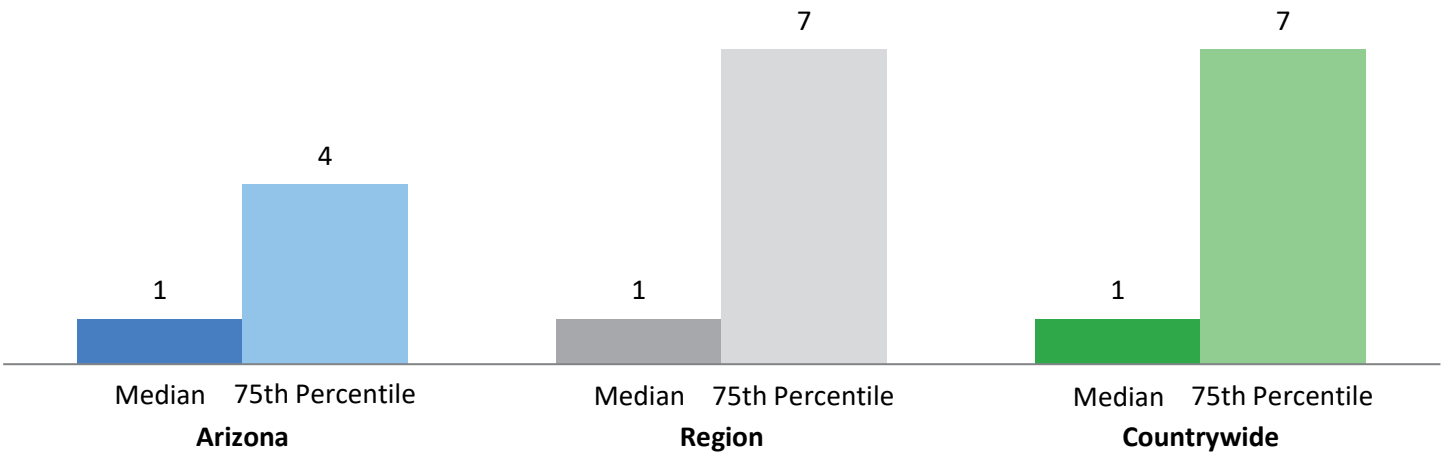


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.
99455	Work related or medical disability examination by the treating physician.
99456	Work related or medical disability examination by other than the treating physician.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a high level of medical decision making. 40-54 minutes of total time is spent on the date of the encounter.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.

Chart 15 shows the median and 75th percentile time until first treatment for evaluation and management procedures for Arizona, the region, and countrywide.

Chart 15

Time Until First Treatment for Evaluation and Management (in Days)



Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

Hospital Inpatient

Payments attributed to facilities represent hospital inpatient services, hospital outpatient services, and ambulatory surgical center services. General healthcare trends may be the primary driver of the cost distribution; however, the fee schedule may also play a role. In many states, the fee schedule varies by type of facility, which may help explain differences observed between states.

Hospital inpatient fee schedules in workers compensation vary across jurisdictions. Some states have fee schedules based on a group of facility services related to the hospital admission, such as a Medicare Severity Diagnosis-Related Group (MS-DRG or DRG for short); others are on a per-diem basis, with some variation on the per-diem amount by type of admission. Other states have provisions for the reimbursement to be a certain percentage of hospital charges. Several states remain without any regulation today.

A hospital inpatient stay is typically reported with one of two types of codes: DRG code or revenue code. Data reporters are instructed to report the code that is consistent with how the reimbursement was determined.

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In Arizona, 42% of hospital inpatient payments are reported with a DRG code.

Comparisons by procedure code for inpatient costs should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide. Some measures for hospital inpatient services include the average cost of an inpatient stay, the average length of stay, or the average cost per day.

Unless otherwise stated, the inpatient results are based on inpatient stays with a discharge date in 2022.

A measure of workers compensation hospital inpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital inpatient payments for Arizona, the region, and countrywide, based on hospital episodes that are reported with a DRG code.

Chart 16

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Hospital Inpatient	277%	159%	199%

Source: NCCI's Medical Data Call for inpatient stays discharged in Calendar Year 2022. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

The distribution of medical payments for hospital inpatient is 14% for Arizona, 12% for the region, and 13% for countrywide. One comparative measure of inpatient service costs is the average payment per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting, for a specific diagnosis. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

Chart 17 displays the average amount paid per stay for hospital inpatient services, while Chart 18 displays the average amount paid per day for hospital inpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 17

Average Amount Paid per Stay for Hospital Inpatient Services

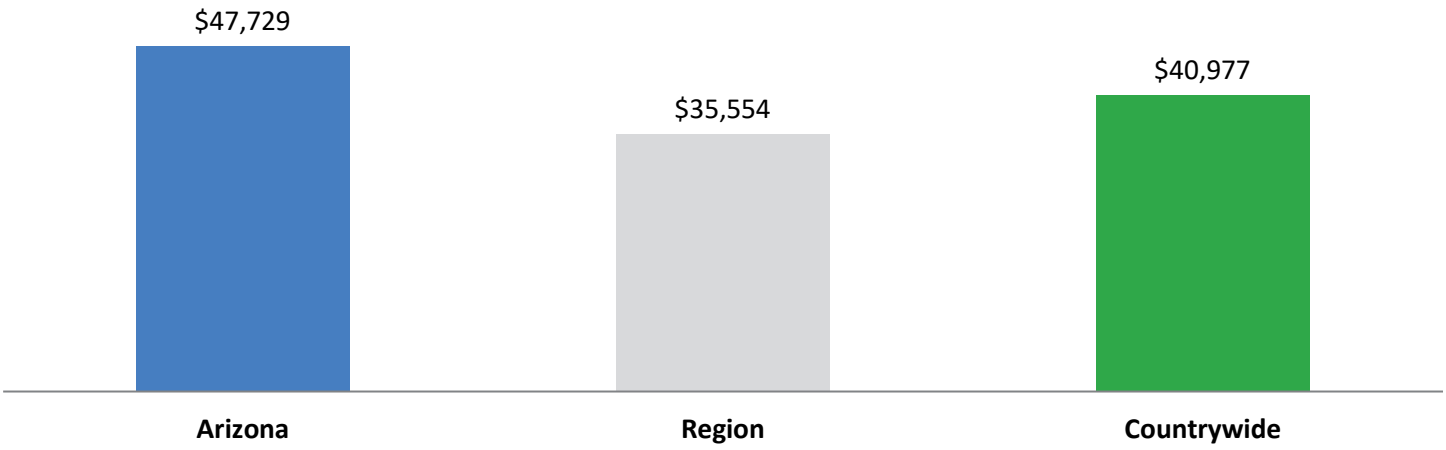


Chart 18

Average Amount Paid per Day for Hospital Inpatient Services

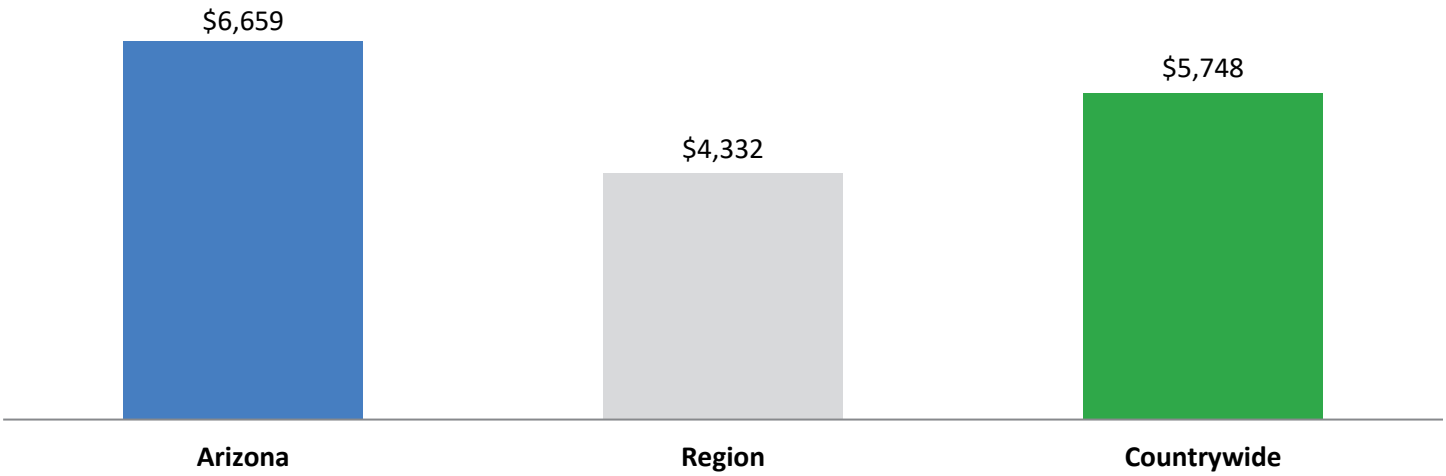


Chart 19 displays the average number of hospital inpatient stays per 1,000 active claims in 2022 for Arizona, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 20 displays the average and median length of stay for hospital inpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 19

Average Number of Inpatient Stays per 1,000 Active Claims

Chart 20

Length of Stay for Hospital Inpatient Services (in Days)

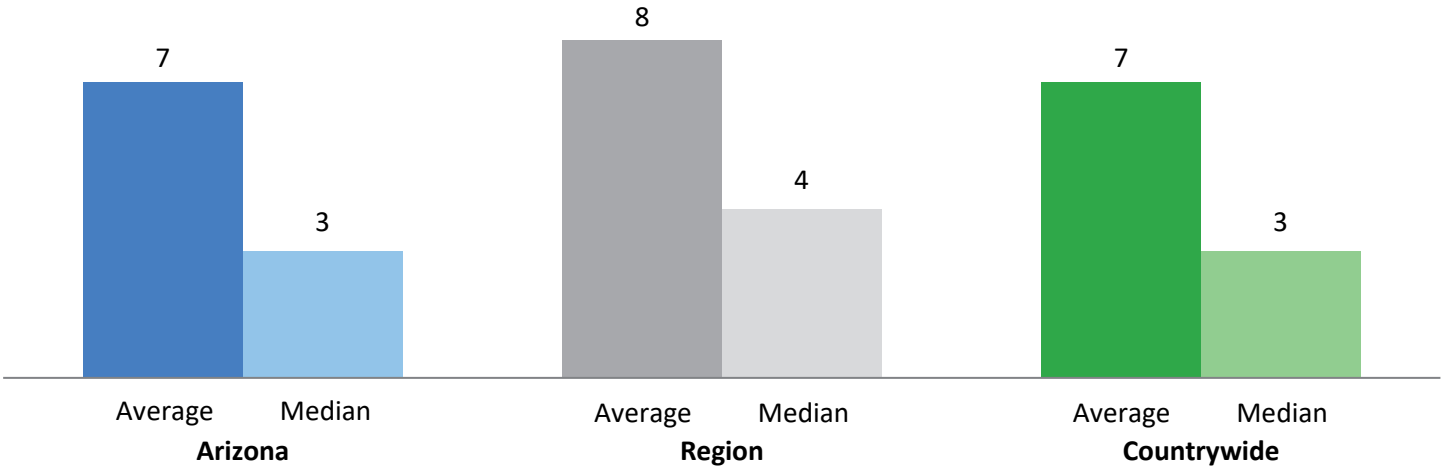
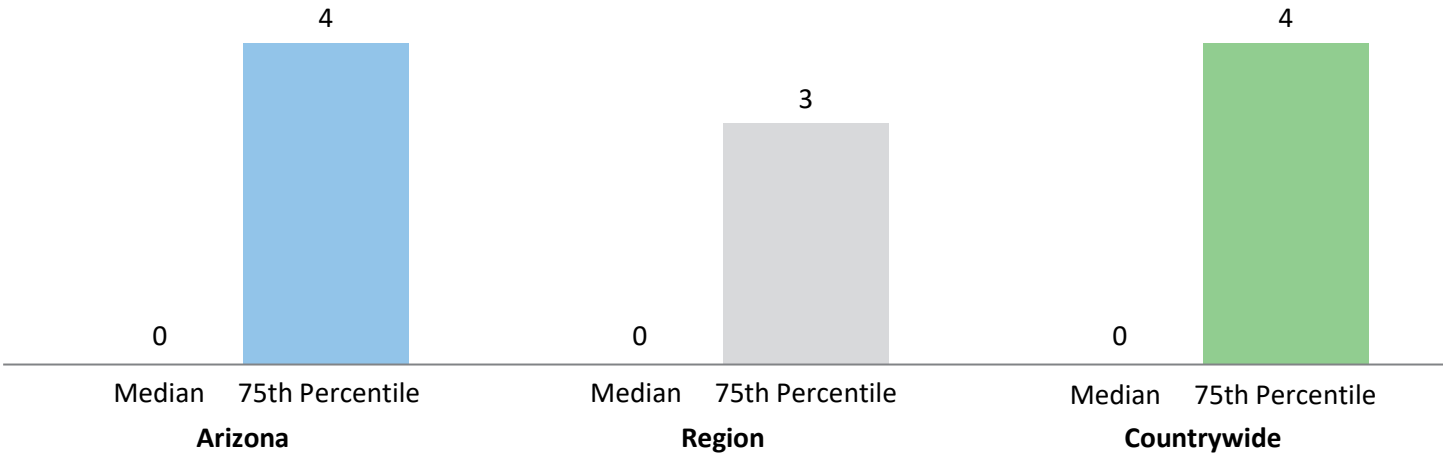


Chart 21 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Arizona, the region, and countrywide.

Chart 21

Time Until First Treatment for Hospital Inpatient Stays (in Days)



Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

Charts 22 and 23 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient stays. A diagnosis group is identified for each stay based on an ICD-10 (International Classification of Diseases) code. The diagnosis groups and DRG codes are ranked based on total payments for hospital inpatient services in Arizona. A brief description of each DRG code is displayed in the table below chart 23. The information is based on inpatient stays with a discharge date in 2021 or 2022.

Chart 22

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

		Median Amount Paid per Stay		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Traumatic brain injury	7.9%	$35,004	$28,944	$28,469
Lumbar spine degeneration	7.0%	$76,820	$37,086	$38,869
Hip/pelvis fracture/major trauma	5.6%	$28,458	$21,319	$22,091
Tibia/fibula fracture	5.6%	$37,519	$22,730	$24,642
Complication from surgical device	4.3%	$47,013	$23,227	$24,272
Lumbosacral intervertebral disc disorders	4.0%	$72,982	$22,700	$31,275
Chest trauma major	3.6%	$36,391	$21,271	$21,822
Burn and corrosion, third degree, other than head, face, and neck	2.6%	$71,674	$60,080	$49,605
Complications of procedures, not elsewhere classified	2.4%	$46,332	$20,859	$21,505
Femur fracture	2.4%	$43,120	$22,970	$25,436

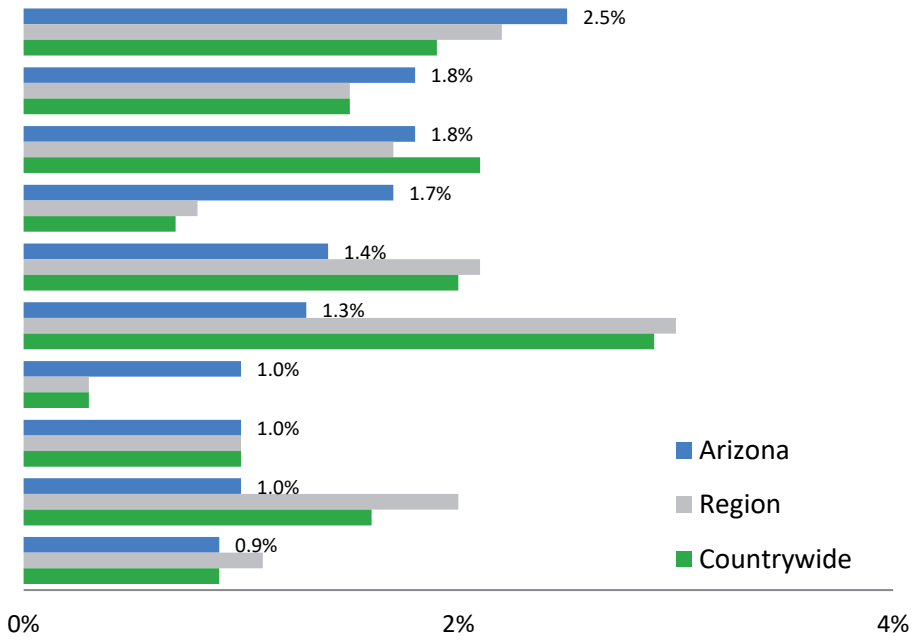
Source: NCCI's Medical Data Call for inpatient stays with a discharge date in Calendar Year 2021 or 2022.

Chart 23

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services

Code	Median Paid per Stay AZ	Region	CW
957	$181,203	$86,623	$100,255
454	$94,359	$56,650	$55,794
460	$75,102	$38,059	$39,061
464	$79,452	$36,930	$42,700
455	$100,045	$43,016	$44,399
003	$520,481	$228,767	$248,058
459	$191,205	$75,136	$77,234
481	$52,090	$22,818	$25,535
494	$38,972	$20,150	$21,367
906	$24,075	$21,329	$23,286

Paid Share



Code	Description
957	Other operation room procedures for multiple significant trauma with major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
460	Spinal fusion, except cervical, without major complications or comorbidities
464	Wound debridement and skin graft except hand for musculoskeletal system and connective tissue disorders with complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
003	Extracorporeal membrane oxygenation (ECMO) or tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth, and neck with major operating room
459	Spinal fusion, except cervical, with major complications or comorbidities
481	Hip and femur procedures except major joint with complications or comorbidities
494	Lower extremity and humerus procedures except hip, foot, and femur without complications or comorbidities/major complications or comorbidities
906	Hand procedures for injuries

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in 2021 or 2022. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.
Note: In Arizona, 42% of hospital inpatient payments are reported with a DRG code.

Hospital Outpatient

Hospital outpatient services are reported with several types of procedure codes. Data reporters are instructed to report the code that is consistent with the way the reimbursement was determined.

If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by current procedural terminology (CPT) or other healthcare common procedure coding system (HCPCS) codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Some payments are also reported by a specific ambulatory payment classification (APC) code. An APC code represents a group of services provided by the facility on an outpatient basis.

If the hospital outpatient fee schedule is based on a discount from charged amounts, then revenue codes may be the more prevalent code type. Revenue codes are very generic and do not provide much information about the specific services that were performed.

Comparisons by procedure code for outpatient benefits should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide. One comparative measure of outpatient service costs is the average cost per outpatient visit. A visit is defined as any service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claim may have more than one visit.

Hospital outpatient visits can vary in nature and the level of reimbursement varies considerably by type of visit. A service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services (CMS), or the procedure involves spine/spinal cord neurostimulators. A hospital outpatient visit could be the result of an emergency visit and those visits are shown separately. Nonemergency outpatient visits are shown separately for those with and without major surgery services; those without a major surgery service are referred to as “Other” outpatient visits.

The distribution of medical payments for hospital outpatient is 18% for Arizona, 18% for the region, and 20% for countrywide.

One measure of workers compensation hospital outpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital outpatient payments for Arizona, the region, and countrywide. In Arizona, 82% of hospital outpatient payments are included in the chart below.

Chart 24

Hospital Outpatient Payments as a Percentage of Medicare

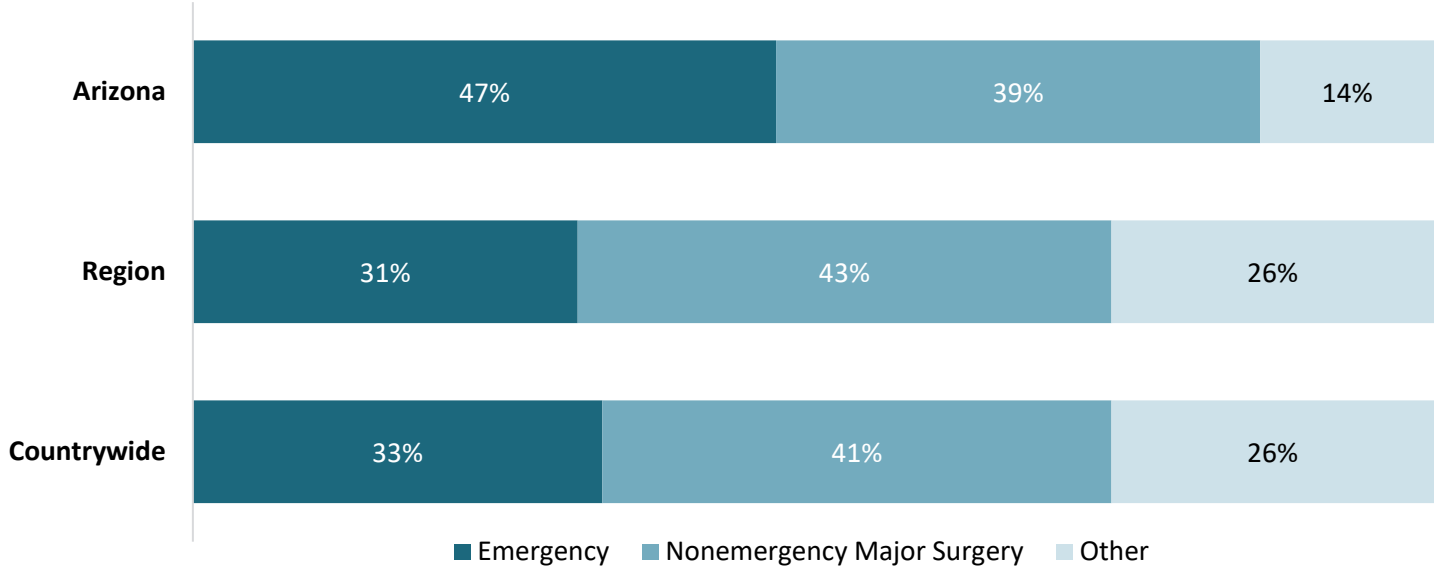
Medical Cost Category	Arizona	Region	Countrywide
Hospital Outpatient	330%	185%	231%

Source: NCCI’s Medical Data Call for Service Year 2022. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

Chart 25 displays the distribution of hospital outpatient payments by visit type for Arizona, the region, and countrywide.

Chart 25

Distribution of Payments for Outpatient Services by Hospital Outpatient Visit Type



Emergency hospital outpatient visits represent 47% of hospital outpatient payments in Arizona. Chart 26 displays the average amount paid per emergency visit for outpatient services, while Chart 27 displays the average number of emergency hospital outpatient visits per 1,000 active claims for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 26

Average Amount Paid for Hospital Outpatient Services per Emergency Visit

Chart 27

Average Number of Emergency Hospital Outpatient Visits per 1,000 Active Claims

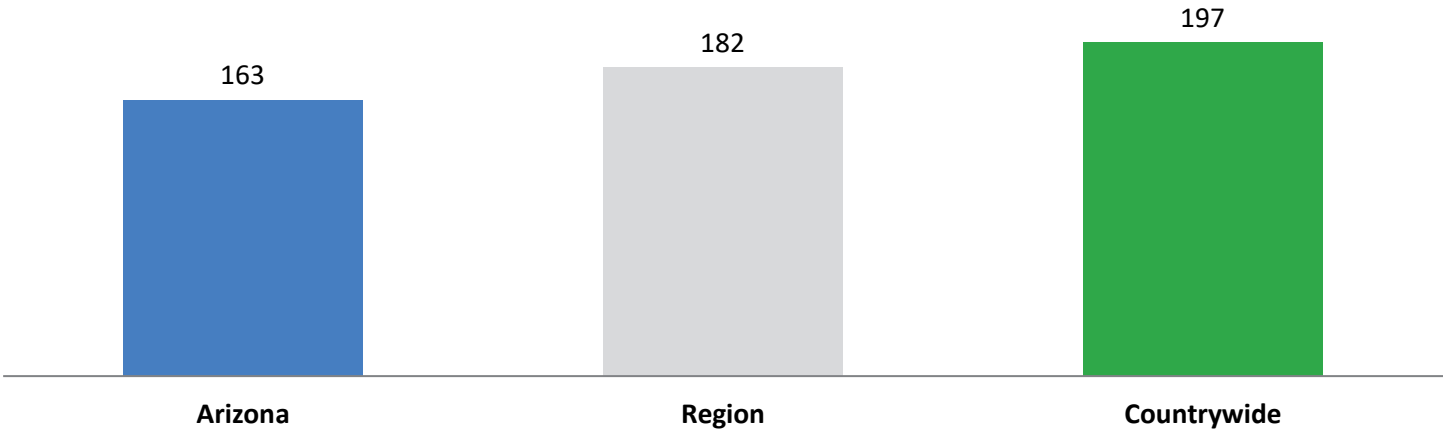


Chart 28 displays the top 10 diagnosis groups for emergency outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Arizona.

Chart 28

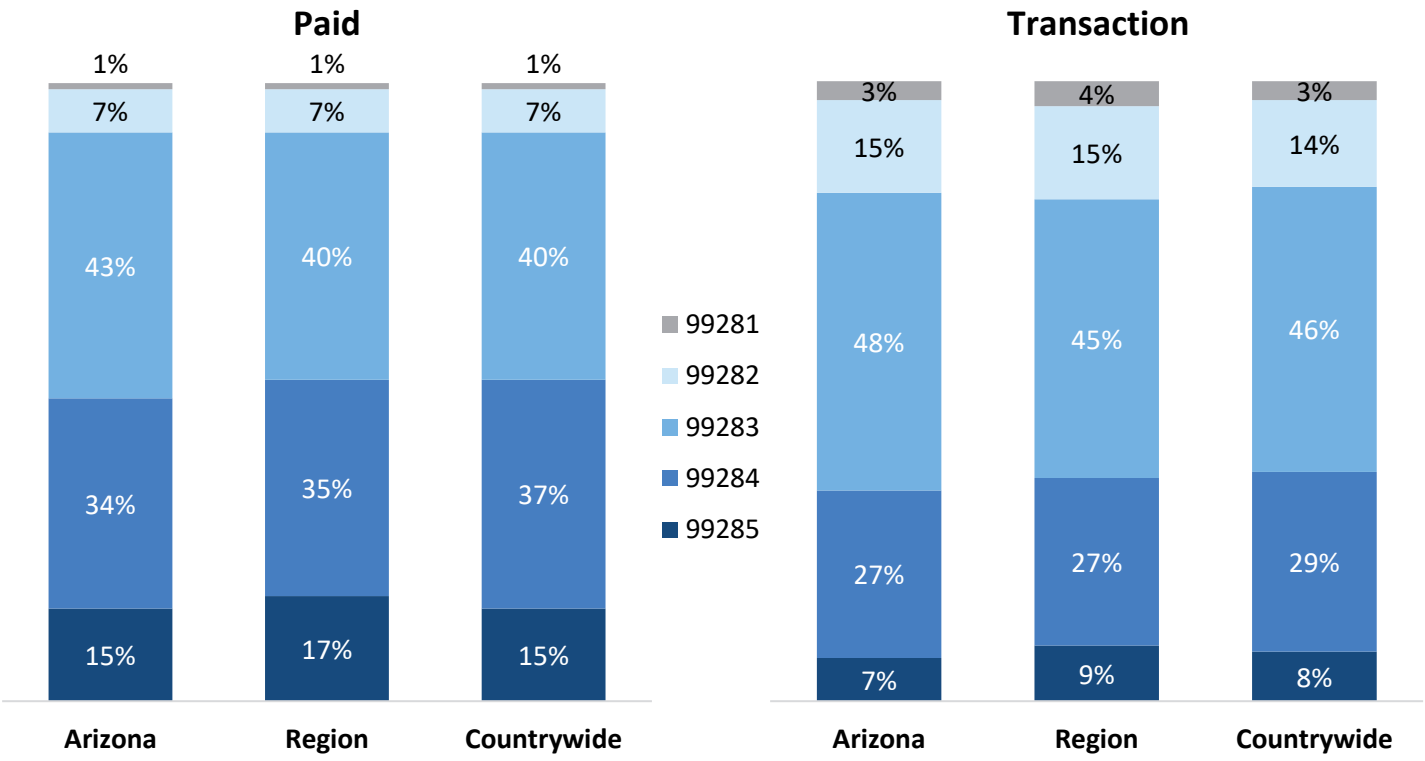
Top 10 Diagnosis Groups by Amount Paid for Emergency Hospital Outpatient Visits

		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Minor hand/wrist injuries	9.4%	$805	$648	$698
Hand/wrist fracture	6.1%	$1,470	$1,016	$1,087
Head injury not otherwise classified	5.8%	$1,647	$964	$1,125
Neck pain	4.4%	$2,480	$1,095	$1,214
Concussion/minor traumatic brain injury	4.1%	$1,622	$979	$1,089
Low back pain	4.0%	$1,168	$770	$827
Head/face wound	4.0%	$1,286	$903	$941
Minor ankle/foot injuries	2.9%	$1,000	$626	$697
Head injury minor	2.6%	$1,506	$895	$1,000
Upper back pain	2.6%	$1,482	$849	$950

For emergency room visits, there are five levels of severity, ranging from limited or minor problems reported with Procedure Code 99281 to life-threatening situations reported with Procedure Code 99285. About 79% of all emergency visits had outpatient services. Chart 29 shows the distribution of emergency room outpatient services by procedure code for both paid amount and transactions for Service Year 2022 as well as the average payment per transaction.

Chart 29

Distribution of Emergency Room Outpatient Services by Procedure Code



Emergency Room Outpatient Paid per Transaction by Procedure Code

		Average PPT		
Code	Severity	Arizona	Region	Countrywide
99281	Minor	$341	$168	$177
99282	Low to Moderate	$404	$274	$278
99283	Moderate	$675	$494	$492
99284	High	$979	$753	$749
99285	High and immediately life-threatening	$1,704	$1,187	$1,161

Nonemergency outpatient visits with major surgery services represent 39% of hospital outpatient payments in Arizona. Chart 30 displays the average amount paid per major surgery visit for outpatient services, while Chart 31 displays the average number of major surgery hospital outpatient visits per 1,000 active claims for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 30

Average Amount Paid for Hospital Outpatient Services per Nonemergency Major Surgery Visit

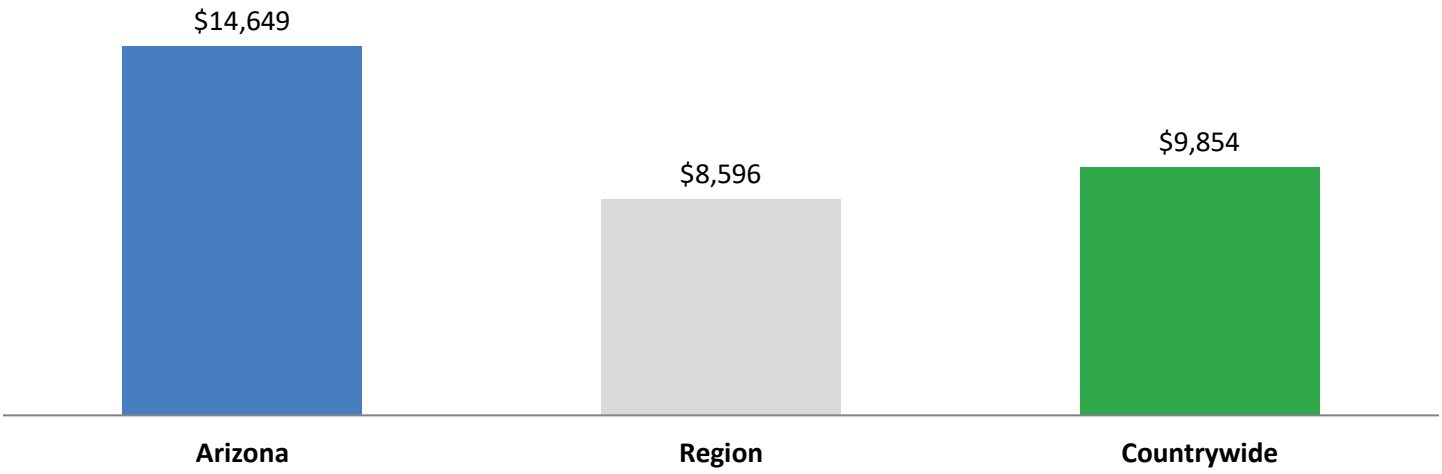


Chart 31

Average Number of Nonemergency Major Surgery Hospital Outpatient Visits per 1,000 Active Claims

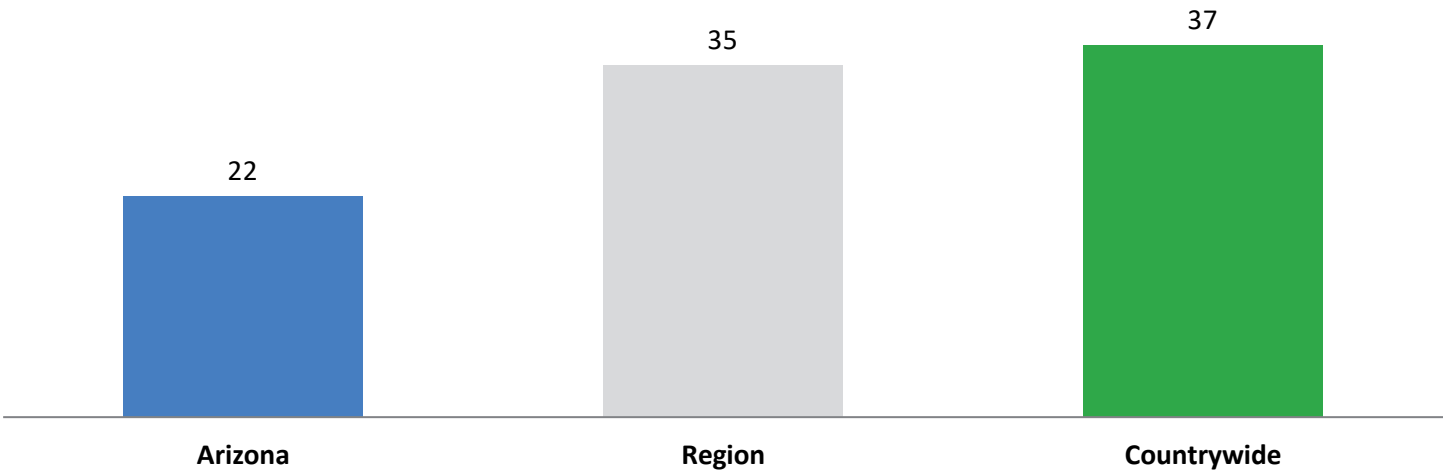
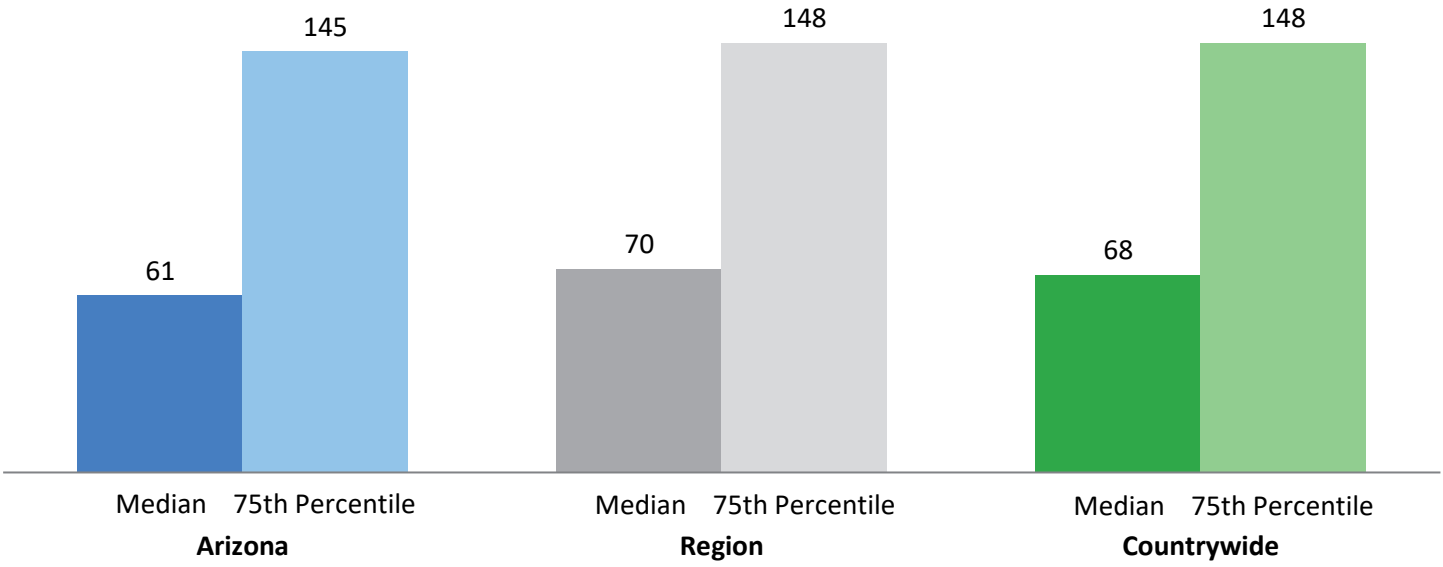


Chart 32 shows the median and 75th percentile time until first treatment for nonemergency major surgery outpatient visits for Arizona, the region, and countrywide.

Chart 32

Time Until First Treatment for Nonemergency Major Surgery Outpatient Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

Chart 33 displays the top 10 diagnosis groups for nonemergency major surgery outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Arizona.

Chart 33

Top 10 Diagnosis Groups by Amount Paid for Nonemergency Major Surgery Hospital Outpatient Visits

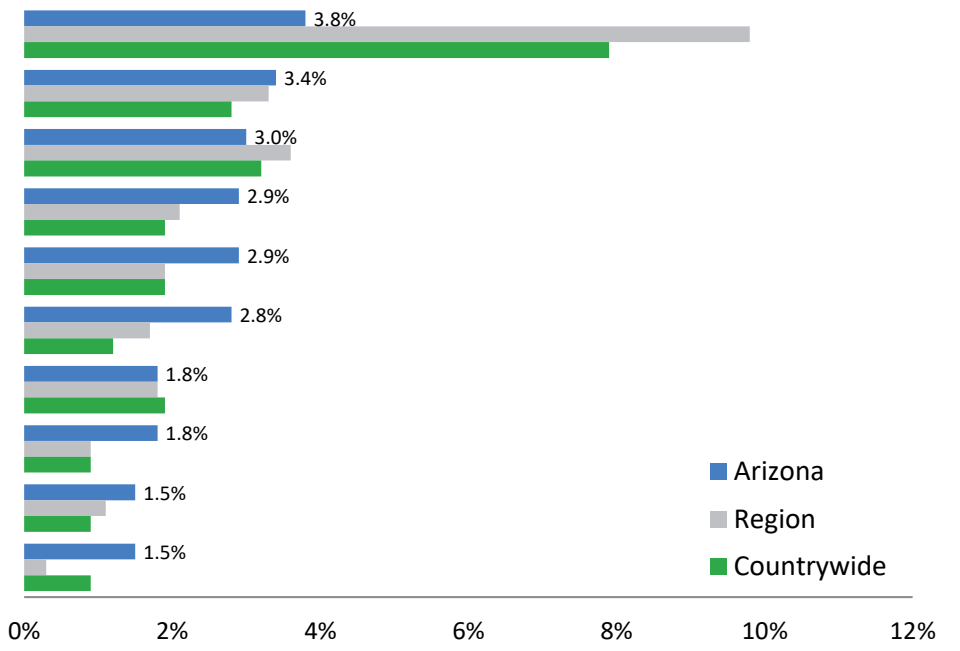
		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Rotator cuff tear	8.8%	$10,760	$10,650	$10,560
Hand/wrist fracture	7.9%	$9,249	$5,718	$6,090
Inguinal hernia	4.9%	$6,605	$7,991	$8,230
Knee degenerative/overuse injuries	4.3%	$20,543	$11,388	$11,123
Lumbar spine degeneration	3.8%	$28,964	$12,176	$12,133
Complication from surgical device	3.8%	$6,585	$4,749	$5,272
Knee internal derangement - meniscus injury	3.6%	$4,250	$5,310	$5,467
Heel/midfoot fracture	3.6%	$10,569	$10,567	$9,703
Tibia/fibula fracture	3.2%	$9,464	$10,788	$10,259
Ventrical incisional hernia	3.0%	$9,830	$6,324	$7,034

Charts 34 displays the average amount paid per nonemergency major surgery visit for outpatient services in Arizona, the region, and countrywide for the top 10 CPT codes in Arizona. The codes are ranked based on total outpatient payments in Arizona, where the code shown below is the code with the highest total paid on a nonemergency major surgery visit. In 2022, 83% of Hospital Outpatient costs were reported with a CPT code being the highest paid code. A brief description of each code is displayed in the table below.

Chart 34

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Nonemergency Major Surgery Visits

Code	Average Paid per Visit AZ	Region	CW
29827	$14,639	$10,722	$12,096
49650	$15,380	$9,056	$10,916
29881	$9,183	$5,576	$6,673
20680	$8,886	$5,327	$6,832
27447	$30,124	$16,632	$18,773
25609	$19,807	$11,182	$11,391
63030	$28,910	$11,344	$13,173
63047	$21,792	$11,040	$13,153
49505	$9,407	$6,336	$7,507
29826	$18,846	$11,388	$13,976



Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
49650	Laparoscopy, surgical; repair initial inguinal hernia
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
63047	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root), single vertebral segment; lumbar
49505	Repair initial inguinal hernia, age 5 years or older; reducible
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed

Nonemergency outpatient visits without a major surgery service, referred to as "Other" outpatient visits, represent 14% of hospital outpatient payments in Arizona. Chart 35 displays the average amount paid per other visit for hospital outpatient services, while Chart 36 displays the average number of other visits per 1,000 active claims for hospital outpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 35

Average Amount Paid for Hospital Outpatient Services per Other Outpatient Visit

Chart 36

Average Number of Other Hospital Outpatient Visits per 1,000 Active Claims

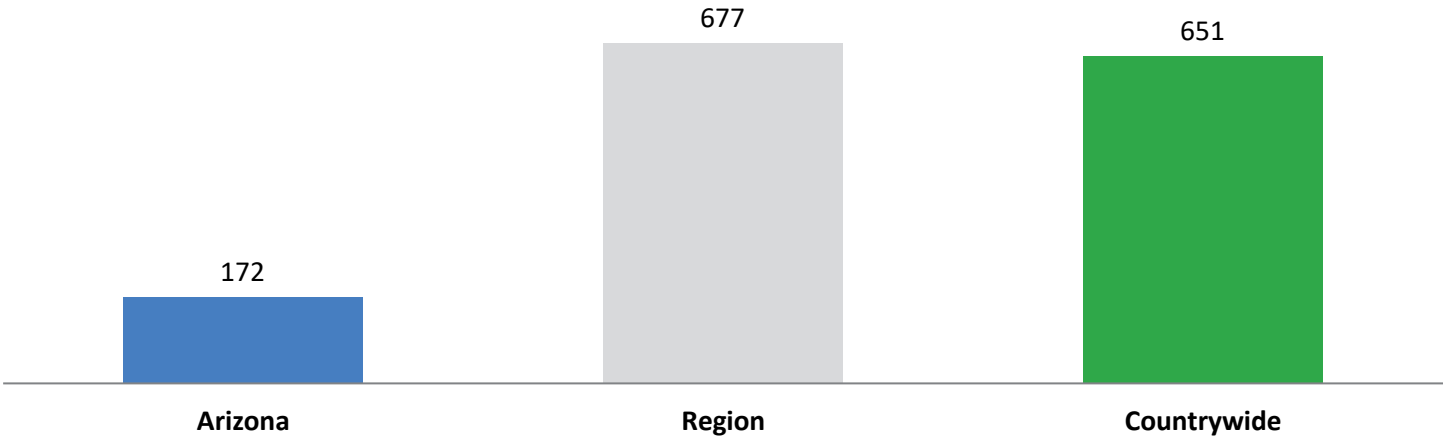
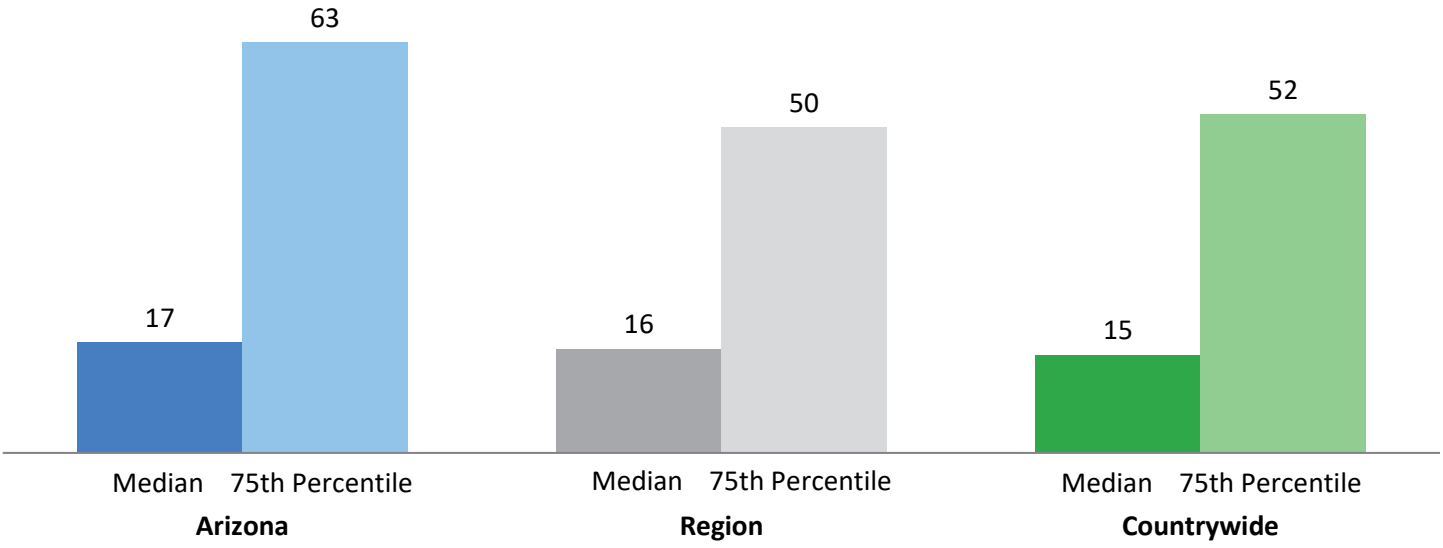


Chart 37 shows the median and 75th percentile time until first treatment for other outpatient visits for Arizona, the region, and countrywide.

Chart 37

Time Until First Treatment for Other Outpatient Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

Chart 38 displays the top 10 diagnosis groups for other outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Arizona.

Chart 38

Top 10 Diagnosis Groups by Amount Paid for Other Hospital Outpatient Visits

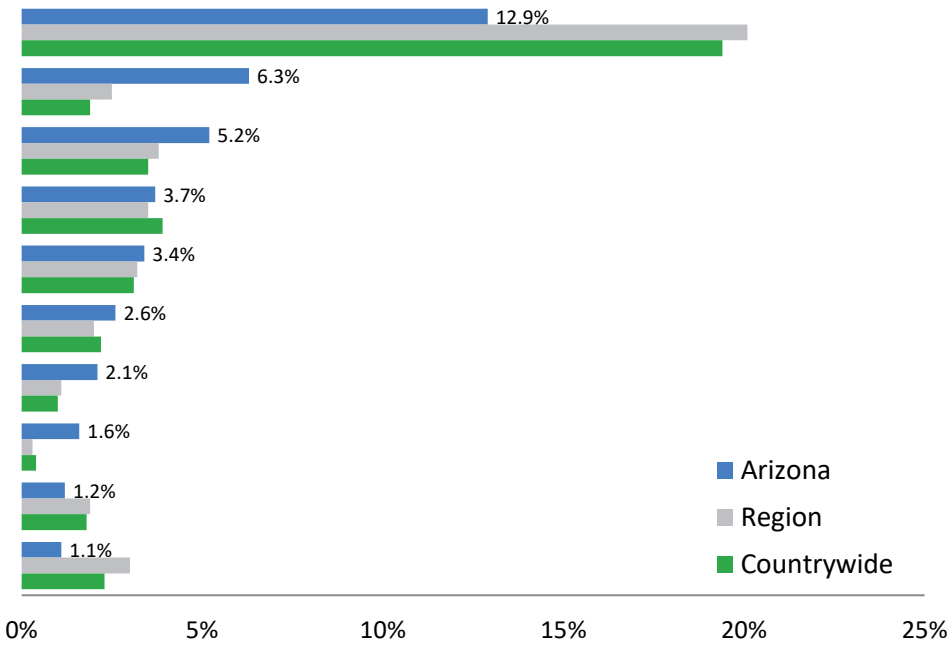
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Traumatic brain injury	6.2%	$388	$460	$345
Minor shoulder injury	4.1%	$203	$151	$161
Low back pain	3.5%	$238	$155	$166
Minor knee injury	3.5%	$232	$157	$169
Lumbar spine degeneration	3.3%	$510	$264	$353
Minor ankle/foot injuries	3.0%	$218	$154	$165
Hand/wrist fracture	2.9%	$337	$151	$161
Minor hand/wrist injuries	2.9%	$230	$141	$156
Rotator cuff tear	2.6%	$251	$154	$170
Lumbosacral intervertebral disc disorders	2.4%	$535	$223	$259

Chart 39 displays the average amount paid per other visit for outpatient services in Arizona, the region, and countrywide for the top 10 CPT codes in Arizona. The codes are ranked based on total outpatient payments in Arizona, where the code shown below is the code with the highest total paid on an "Other" outpatient visit. A brief description of each code is displayed in the table below.

Chart 39

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Other Visits

Code	Average Paid per Visit AZ	Region	CW
97110	$299	$152	$192
97799	$17,622	$3,049	$6,056
73721	$2,064	$718	$1,045
73221	$1,860	$725	$1,107
97140	$290	$147	$192
72148	$2,230	$746	$1,180
11042	$1,037	$775	$838
G0378	$2,302	$1,965	$1,953
73222	$3,743	$1,608	$2,273
97530	$278	$174	$222



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97799	Unlisted physical medicine/rehabilitation service or procedure
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
G0378	Hospital observation service, per hour
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Ambulatory Surgical Centers

An Ambulatory Surgical Center (ASC) is often used as an alternative facility to a hospital for conducting outpatient surgeries. The distribution of medical payments for ASCs is 6% for Arizona, 5% for the region, and 7% for countrywide.

Typically, surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes.

One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for ASC payments for Arizona, the region, and countrywide. In Arizona, 79% of ASC payments are included in the chart below.

Chart 40

ASC Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Ambulatory Surgical Center	223%	188%	247%

Source: NCCI's Medical Data Call for Service Year 2022. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

ASC visits with major surgery services represent 88% of ASC payments in Arizona. Other ASC visits typically include minor procedures, with injections for therapeutic or diagnostic purposes being the most common. Chart 41 displays the average amount paid per major surgery visit for ASC services, while Chart 42 displays the average number of major surgery ASC visits per 1,000 active claims for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 41

Average Amount Paid per Major Surgery Visit for ASC Services

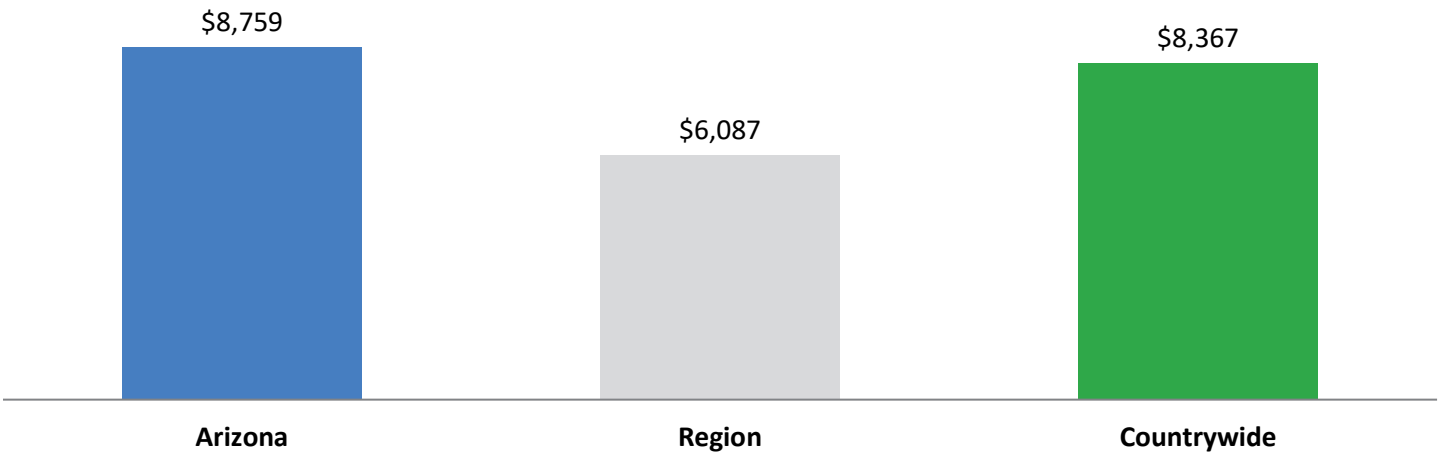


Chart 42

Average Number of ASC Major Surgery Visits per 1,000 Active Claims

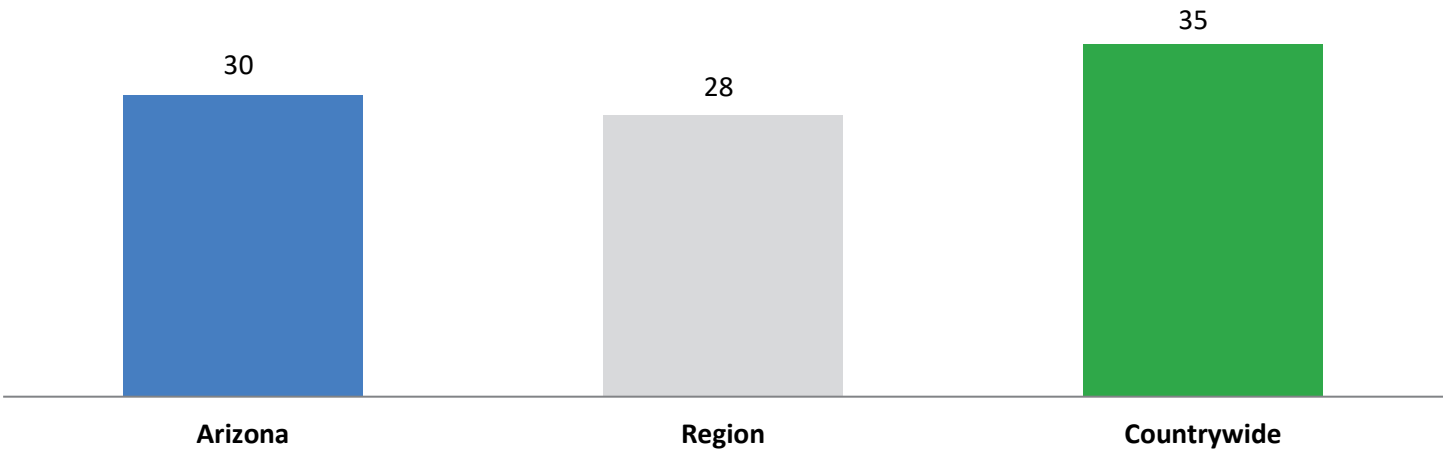
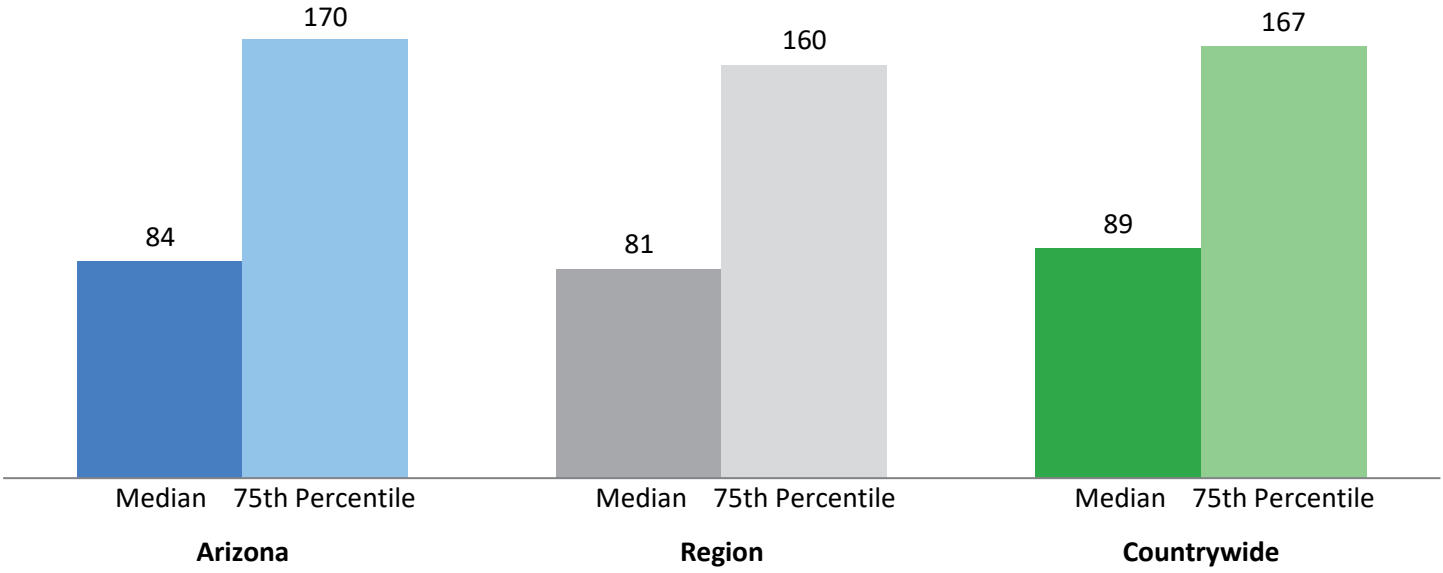


Chart 43 shows the median and 75th percentile time until first treatment for ASC major surgery visits for Arizona, the region, and countrywide.

Chart 43

Time Until First Treatment for ASC Major Surgery Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2021 and Service Years 2021 and 2022.

Chart 44 displays the top 10 diagnosis groups for ASC major surgery visits. The diagnosis groups are ranked based on total payments for ASC services in Arizona.

Chart 44

Top 10 Diagnosis Groups by Amount Paid for ASC Major Surgery Visits

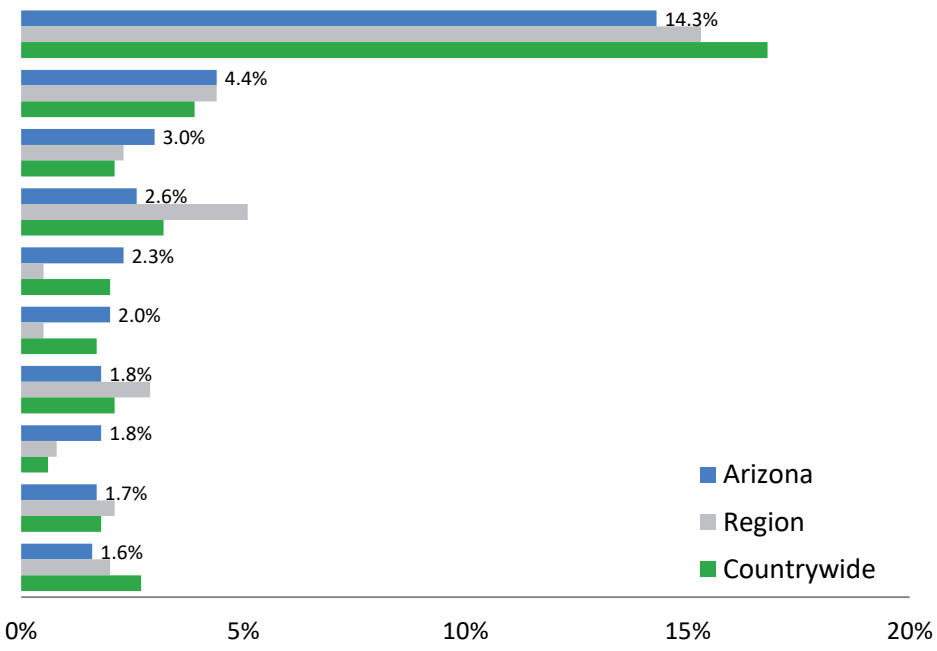
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Rotator cuff tear	19.4%	$10,489	$8,242	$10,245
Knee internal derangement - meniscus injury	7.5%	$3,698	$3,258	$4,201
Hand/wrist fracture	5.5%	$4,684	$4,201	$5,367
Minor shoulder injury	5.2%	$6,813	$7,433	$8,148
Inguinal hernia	3.1%	$6,074	$4,627	$5,013
Heel/midfoot fracture	3.1%	$6,960	$7,396	$8,224
Knee internal derangement - cruciate ligament tear	2.9%	$8,521	$8,162	$9,596
Chronic pain	2.6%	$20,918	$12,582	$14,256
Degenerative shoulder	2.3%	$6,714	$5,134	$7,851
Ventrical incisional hernia	2.2%	$5,917	$4,140	$4,627

Chart 45 displays the average amount paid per major surgery visit for ASC services in Arizona, the region, and countrywide for the top 10 CPT codes in Arizona. The codes are ranked based on total ASC payments in Arizona, where the code shown below is the code with the highest total paid on a major surgery visit. A brief description of each procedure code is displayed in the table beneath the chart. Chart 46 displays similar results for visits in an outpatient setting for the list of codes in Chart 45, if applicable.

Chart 45

Top 10 Procedure Codes by Amount Paid for ASC Services in Major Surgery Visits

Code	Average Paid per Visit AZ	Region	CW
29827	$12,993	$8,515	$12,445
29881	$4,815	$3,524	$4,600
63685	$38,218	$26,739	$37,627
29888	$14,268	$9,445	$11,331
29826	$12,615	$10,873	$15,859
22551	$27,462	$13,944	$26,071
24342	$6,371	$7,406	$7,559
28485	$17,615	$8,142	$10,543
29806	$12,218	$7,659	$9,715
29828	$18,794	$10,336	$13,241



Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; cervical below C2
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29828	Arthroscopy, shoulder, surgical; biceps tenodesis

Chart 46

Major Surgery Outpatient Visit Comparisons for Procedure Codes in Chart 45

Code	Average Paid per Visit in AZ ASC	Outpatient	Distribution of Major Surgery Visits in AZ in an ASC or Outpatient Setting
29827	$12,993	$14,639	77% / 23%
29881	$4,815	$9,183	69% / 31%
63685	$38,218	$14,548	87% / 13%
29888	$14,268	$17,435	72% / 28%
29826	$12,615	$18,846	66% / 34%
22551	$27,462	$31,361	67% / 33%
24342	$6,371	$18,026	81% / 19%
28485	$17,615	$14,454	53% / 47%
29806	$12,218	$19,912	88% / 12%
29828	$18,794	$14,448	67% / 33%

Prescription Drugs

The distribution of medical payments for drugs is 8% for Arizona, 6% for the region, and 7% for countrywide. Prescription drugs are uniquely identified by a national drug code (NDC). Charts 47 through 55 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

The Controlled Substances Act (CSA) was passed in 1970 to regulate the manufacture, distribution, possession, and use of certain drugs. There are five schedules, or groups of drugs, determined by varying qualifications, such as the drug's medical uses, if any, and its potential for abuse. For example, Schedule V drugs are defined as having the lowest potential for abuse, while Schedule I drugs are illegal at the federal level, mainly because they are defined as having no currently accepted medical uses and a high potential for abuse.

In Arizona, the share of claims observed in Service Year 2022 with at least one controlled substance was 6%. This compares to the region and countrywide shares of 7% and 8%, respectively. In 2022, Arizona spent $1.8M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 47 shows the distribution of prescription drug payments by CSA schedule in Arizona, the region, and countrywide.

Chart 47

Distribution of Prescription Drug Payments by CSA Schedule

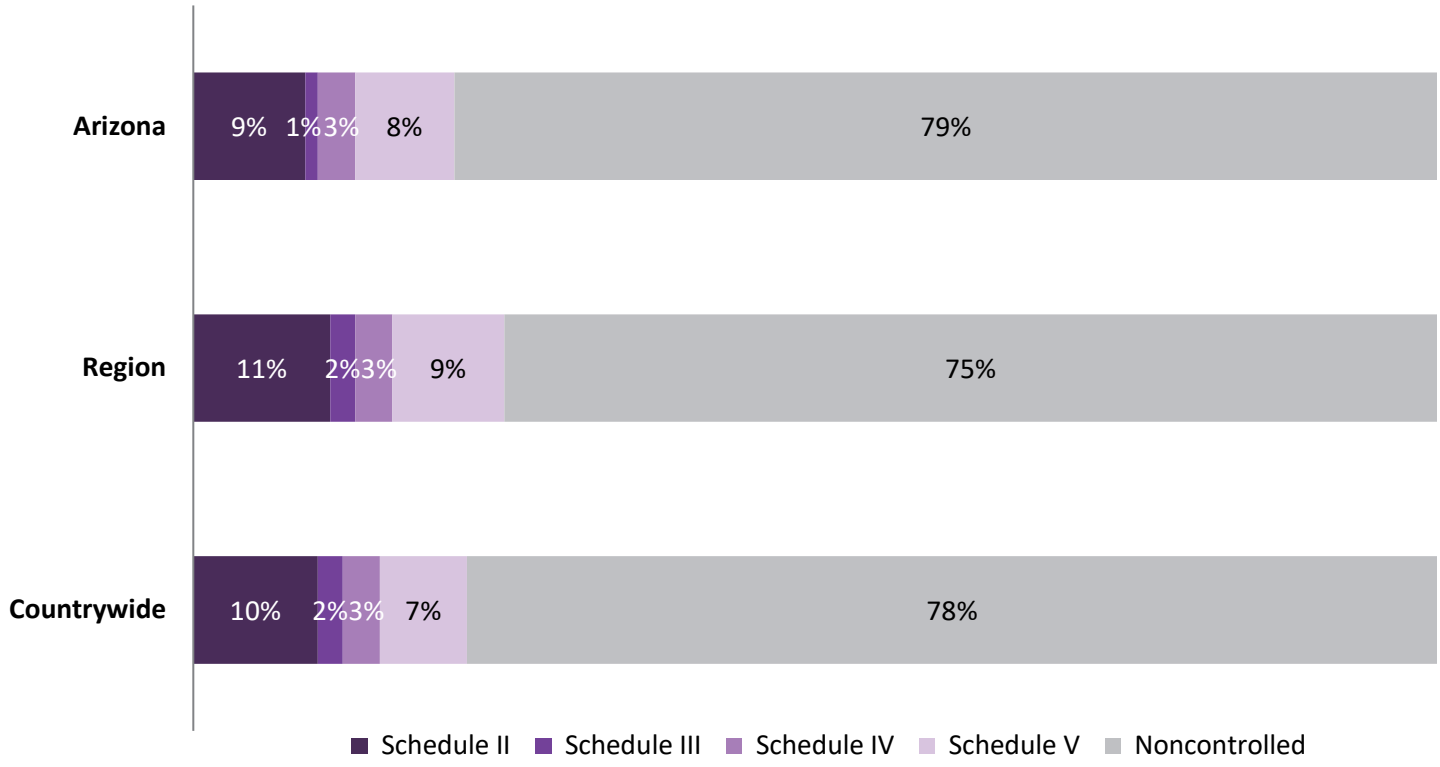


Chart 48 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Arizona. This chart also indicates whether the drugs are generic (G) or brand name (B) and whether the drugs are opioids (O) or non-opioids (N); for generic drugs, a commonly used brand name equivalent is also provided. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the average price per unit (PPU). (See the Glossary for the definition of *units*.)

Chart 48

Top 10 Workers Compensation Drugs by Amount Paid

Drug Name	Average PPU AZ	Average PPU Region	Average PPU CW	Arizona Paid Share
Diclofenac Sodium (NSAID)	$1.87	$1.10	$2.31	6.8%
Pregabalin	$4.86	$4.62	$4.66	6.6%
Lidopro Patch®	$36.19	$39.39	$43.93	6.4%
Diclofenac Sodium (3% Gel)	$8.48	$8.43	$10.07	5.7%
Lidocaine	$6.72	$6.06	$6.52	5.5%
Celecoxib	$4.48	$4.59	$5.41	3.7%
Duloxetine HCl	$5.17	$4.39	$4.37	3.6%
Gabapentin	$1.00	$0.90	$0.90	3.3%
Oxycontin®	$8.84	$9.56	$10.03	3.1%
Cyclobenzaprine HCl	$1.89	$1.11	$1.96	2.7%

Drug Name	B/G	Common Brand Name	O/N	Category	CSA Schedule	CW Rank
Diclofenac Sodium (NSAID)	G	Voltaren®	N	Analgesics/Antipyretics	None	2
Pregabalin	G	Lyrica®	N	Miscellaneous Central Nervous System Agents	V	1
Lidopro Patch®	B	N/A	N	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	13
Diclofenac Sodium (3% Gel)	G	Solaraze®	N	Skin/Mucous Membrane	None	10
Lidocaine	G	Lidoderm®	N	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	4
Celecoxib	G	Celebrex®	N	Analgesics/Antipyretics	None	3
Duloxetine HCl	G	Cymbalta®	N	Psychotherapeutic Agents	None	8
Gabapentin	G	Neurontin®	N	Anticonvulsants	None	5
Oxycontin®	B	N/A	O	Analgesics/Antipyretics	II	9
Cyclobenzaprine HCl	G	Flexeril®	N	Muscle Relaxants, Skeletal	None	7

Chart 49 displays the top 10 drugs used in workers compensation treatment, according to the number of prescriptions in Arizona. This chart reveals the most frequently prescribed drugs and the average PPU.

Chart 49

Top 10 Workers Compensation Drugs by Prescription Counts

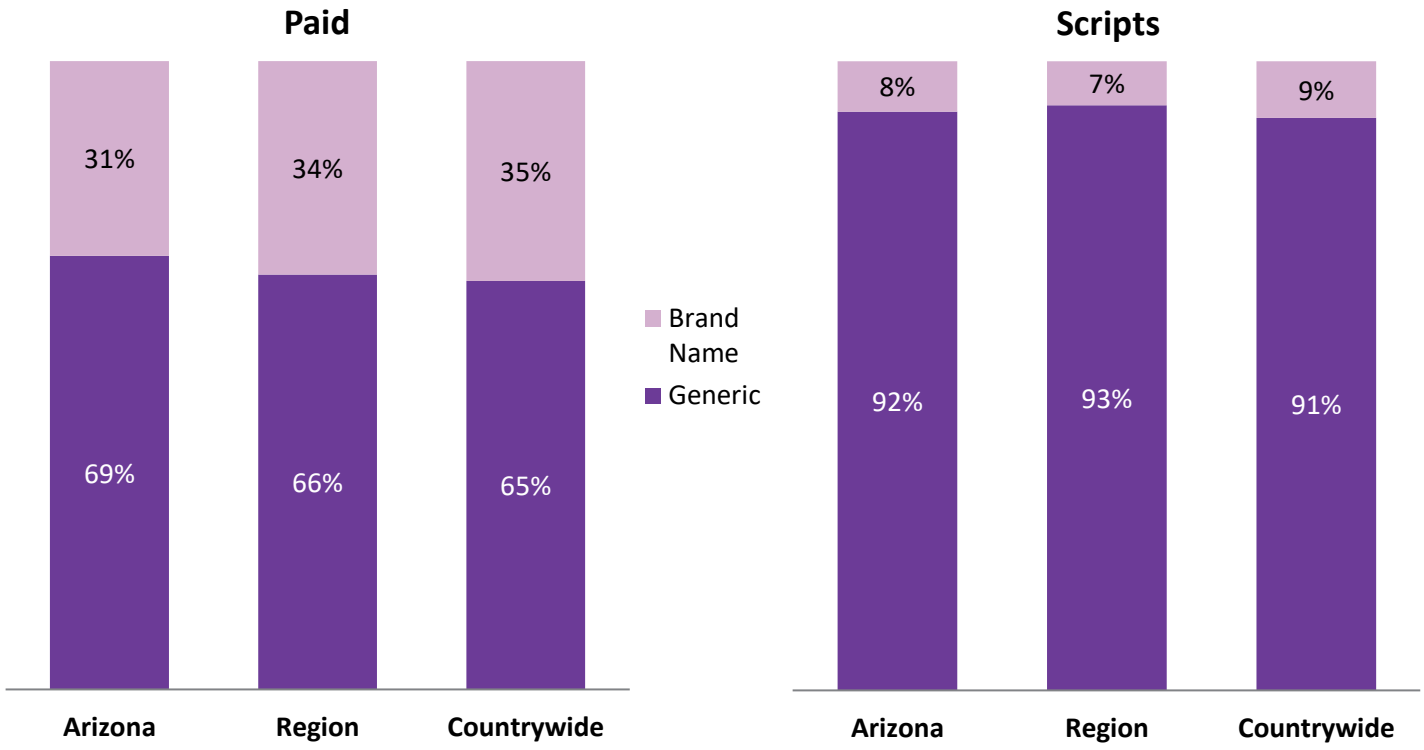
Drug Name	Average PPU AZ	Average PPU Region	Average PPU CW	Arizona Prescription Share
Ibuprofen	$0.43	$0.54	$0.48	6.9%
Diclofenac Sodium (NSAID)	$1.87	$1.10	$2.31	6.1%
Cyclobenzaprine HCl	$1.89	$1.11	$1.96	5.4%
Gabapentin	$1.00	$0.90	$0.90	4.7%
Naproxen	$0.94	$1.06	$1.01	4.0%
Hydrocodone Bitartrate-Acetaminophen	$0.47	$0.49	$0.47	3.6%
Tramadol HCl	$0.94	$0.67	$0.78	3.1%
Meloxicam	$2.63	$2.86	$3.06	2.9%
Celecoxib	$4.48	$4.59	$5.41	2.9%
Oxycodone HCl	$0.52	$0.60	$0.65	2.9%

Drug Name	B/G	Common Brand Name	O/N	Category	CSA Schedule	CW Rank
Ibuprofen	G	Advil®	N	Analgesics/Antipyretics	None	4
Diclofenac Sodium (NSAID)	G	Voltaren®	N	Analgesics/Antipyretics	None	6
Cyclobenzaprine HCl	G	Flexeril®	N	Muscle Relaxants, Skeletal	None	3
Gabapentin	G	Neurontin®	N	Anticonvulsants	None	1
Naproxen	G	Aleve®	N	Analgesics/Antipyretics	None	12
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	O	Analgesics/Antipyretics	II	2
Tramadol HCl	G	Ultram®	O	Analgesics/Antipyretics	IV	7
Meloxicam	G	Mobic®	N	Analgesics/Antipyretics	None	5
Celecoxib	G	Celebrex®	N	Analgesics/Antipyretics	None	9
Oxycodone HCl	G	Oxycontin®	O	Analgesics/Antipyretics	II	13

Chart 50 shows the distribution of prescription drugs by brand name and generic for Arizona, the region, and countrywide. The share between brand name and generic is displayed based on the prescription counts and the payments. Typically, a higher percentage of drugs is given in the generic form; however, higher costs occur when brand name drugs are prescribed. In many states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand name and generic drugs.

Chart 50

Distribution of Drugs by Brand Name and Generic

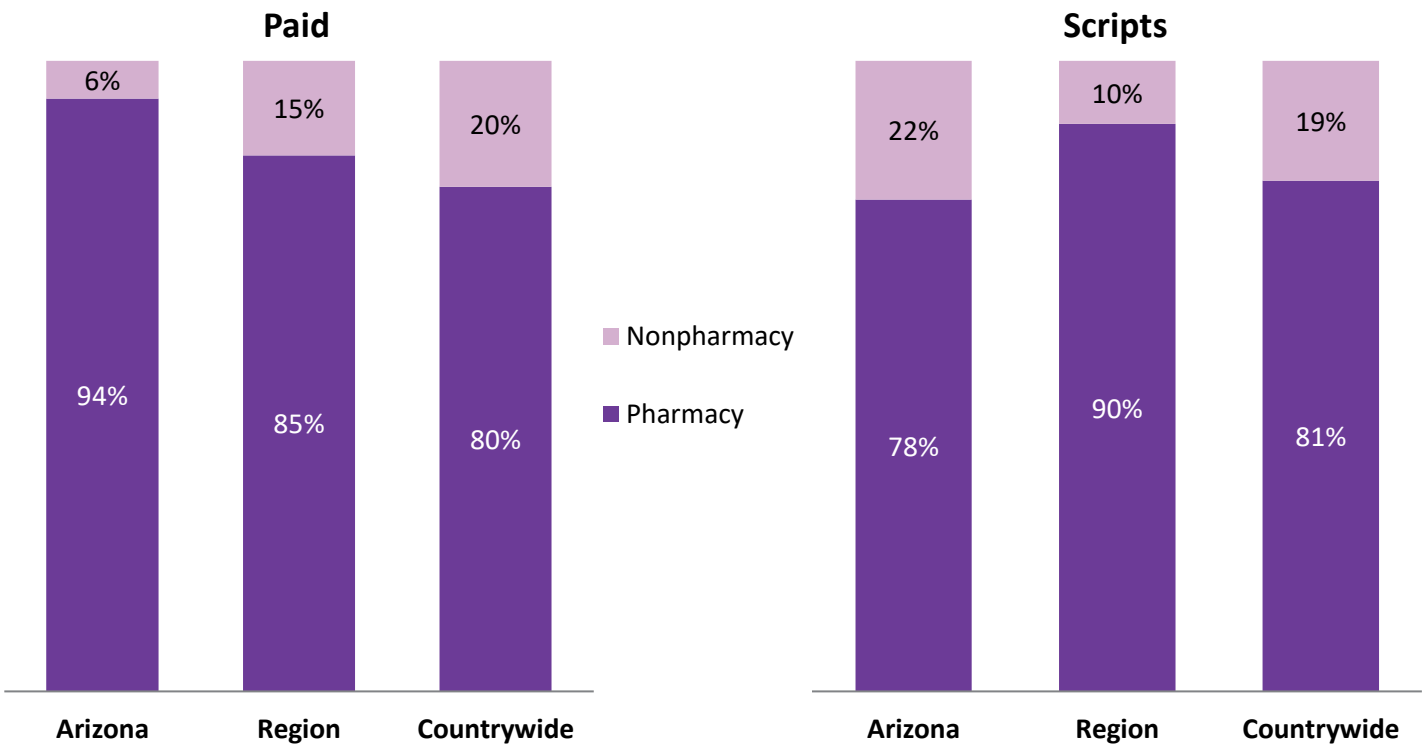


The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states limit or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight into the drivers of drug costs.

Chart 51 shows the distribution of prescription drugs dispensed by pharmacies and nonpharmacies. The share between pharmacy-dispensed and nonpharmacy-dispensed is displayed, based on both prescription counts and payments, for Arizona, the region, and countrywide.

Chart 51

Distribution of Drugs by Pharmacy and Nonpharmacy



There can be a multitude of medications prescribed during an injured worker's path to recovery from a workplace injury. Opioids are one type of drug used to treat moderate to severe pain—often when pain is chronic and troublesome. The opioid epidemic brought much needed awareness on the risks associated with opioid prescriptions.

Chart 52 shows the proportion of drug payments and prescription counts for opioids in Arizona, the region, and countrywide.

Chart 52

Distribution of Drugs by Opioid and Nonopioid

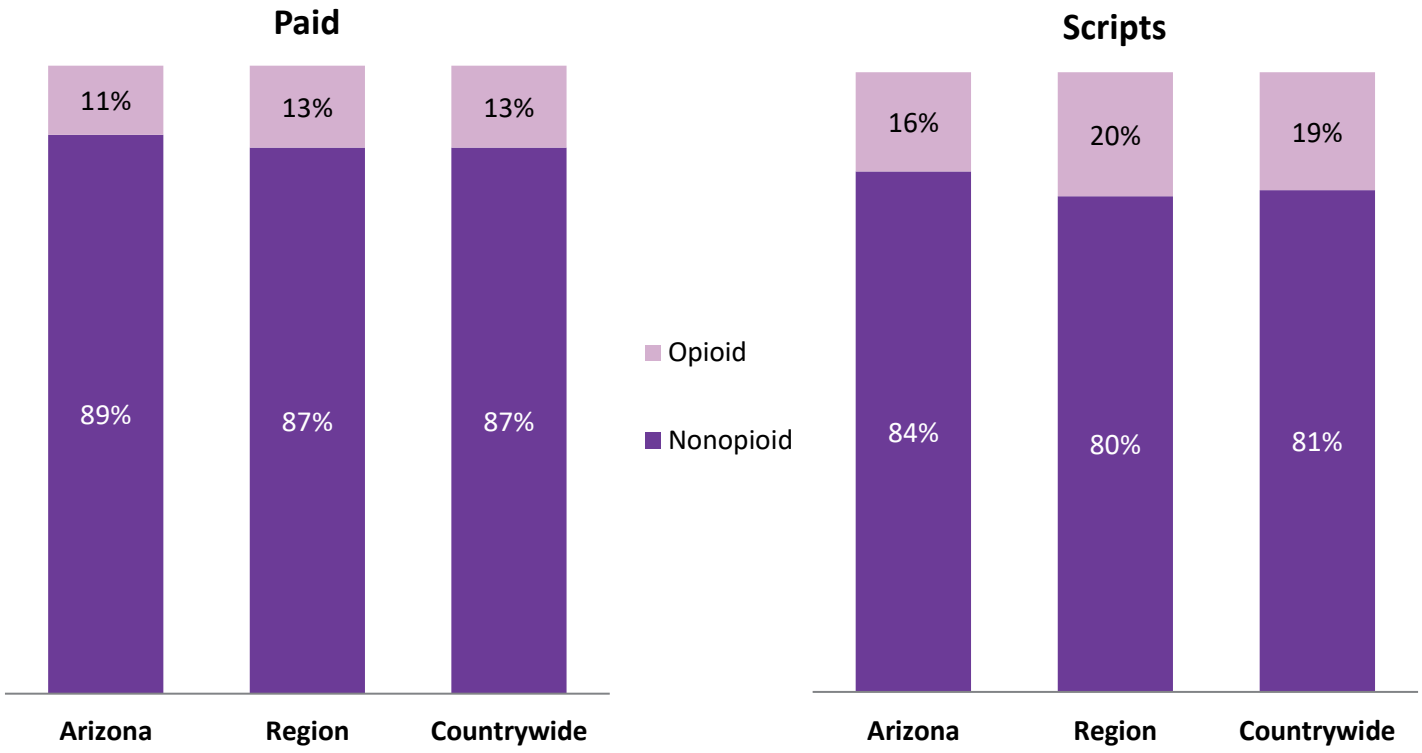
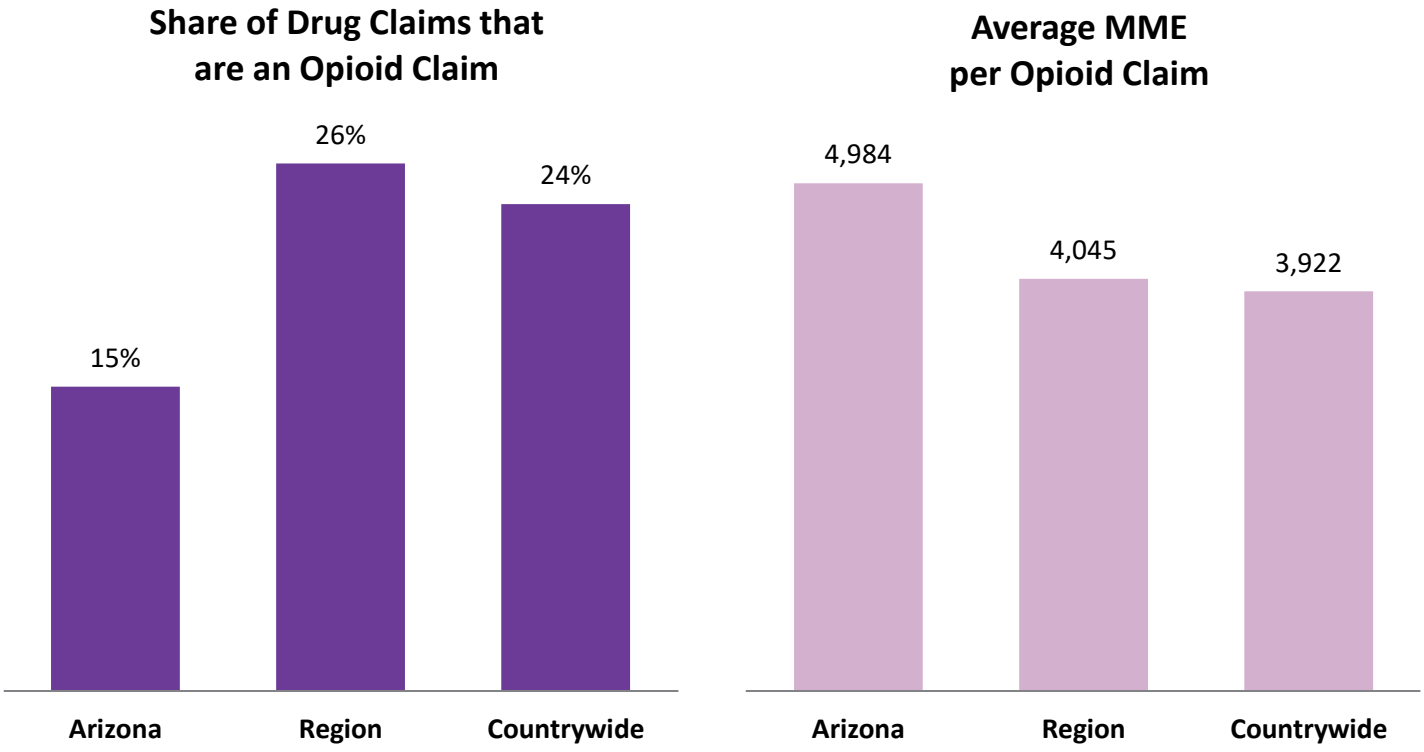


Chart 53 shows the share of claims with a prescription that also have an opioid prescription (an opioid claim), as well as the average Morphine Milligram Equivalents (MME) per opioid claim in Arizona, the region, and countrywide.

With respect to MME, the CDC[7] provides a way to convert daily—or hourly—doses of opioids to an equivalent daily dose of morphine by assigning a conversion factor to each type of drug, thus deriving the MME for any opioid prescription, based on the number of units (pills, for example) prescribed and the drug formulation.

Chart 53

Share of Opioid Claims and Average MME



[7] https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm#T1_down

Workers compensation insurance is considered to have a long tail of liability, meaning that injured workers continue to receive medical benefits over a long period of time, sometimes 30 years or more. Observing opioid claims by claim maturity provides insight into the long-lasting usage of opioid prescriptions and their prevalence among injured workers at various stages of their disability.

Chart 54 shows the distribution of opioid claims by claim maturity for Arizona, the region, and countrywide, where maturity is measured by the number of years from the date of injury. Chart 55 shows the share of MME by maturity.

Chart 54

Opioid Claim Distribution by Claim Maturity in Years

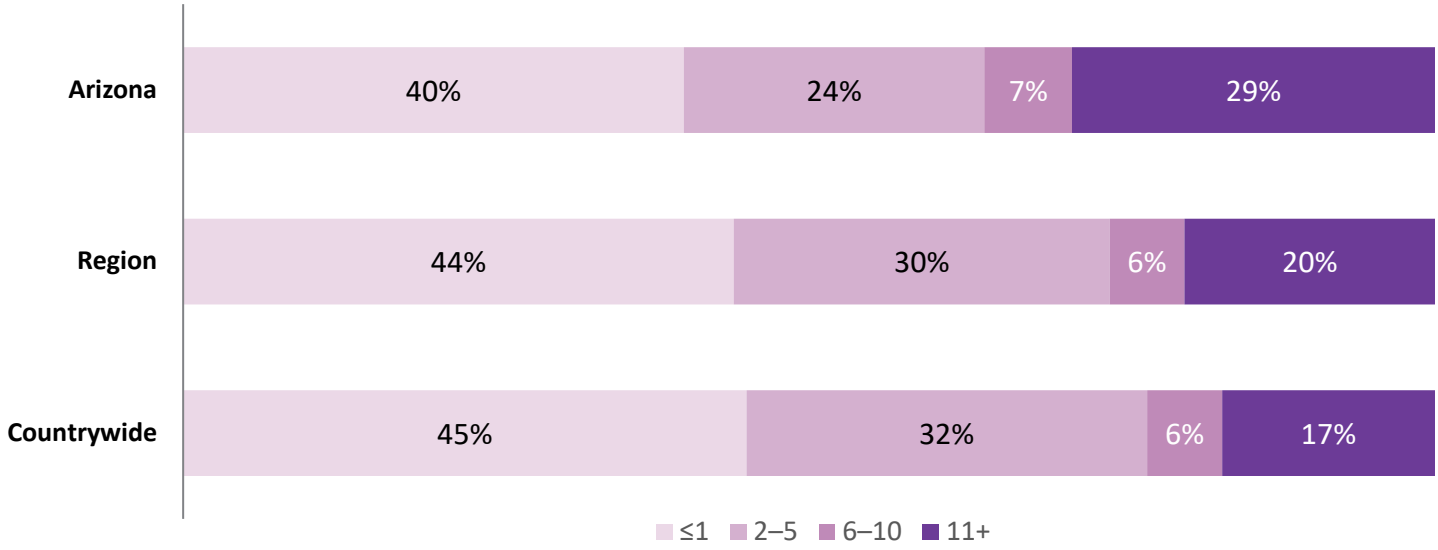
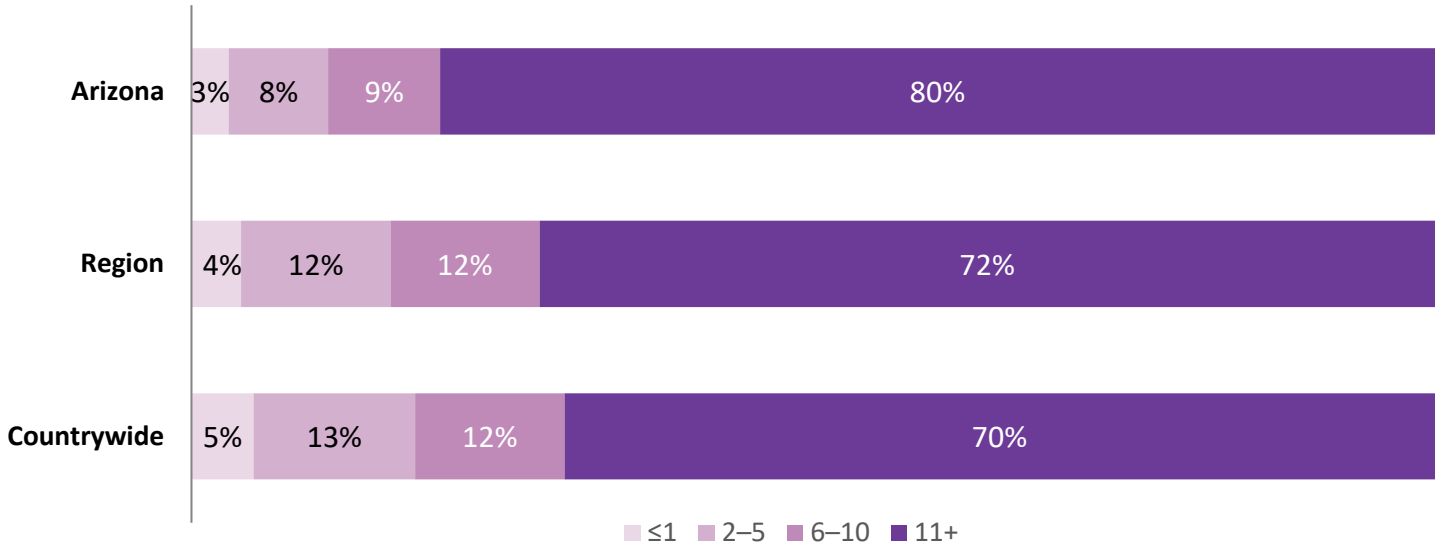


Chart 55

MME Share by Claim Maturity in Years



Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

The distribution of medical payments for DMEPOS is 8% for Arizona, 6% for the region, and 8% for countrywide.

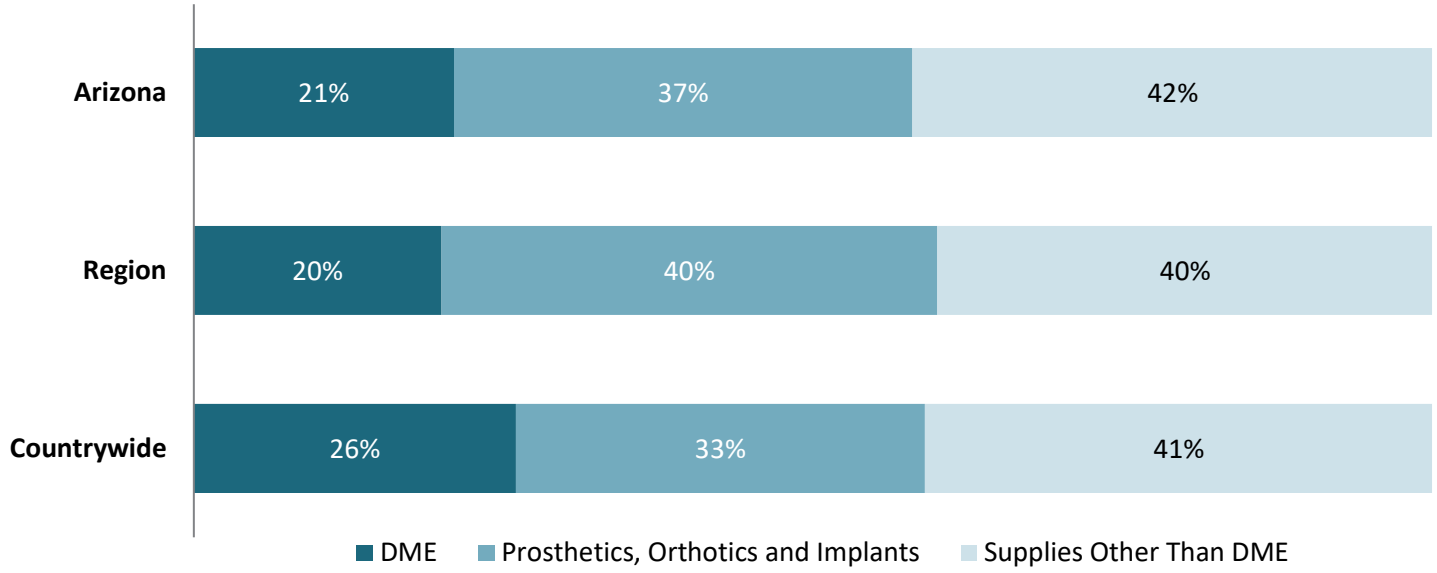
Chart 56 displays the distribution of payments among three separate DMEPOS categories:

- Durable Medical Equipment (DME)
- Prosthetics, Orthotics, and Implants
- Supplies Other Than DME

Payments are mapped to each of these categories based on the procedure code reported, regardless of who provides the service or where the service is performed.

Chart 56

Distribution of Payments by DMEPOS

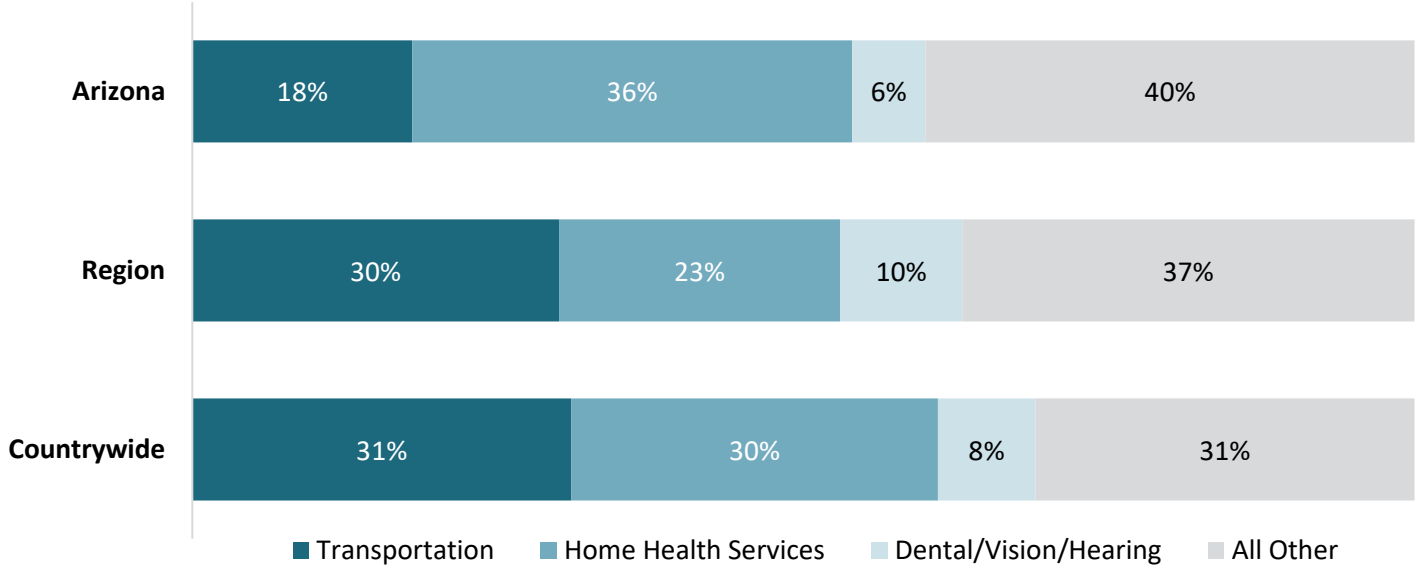


Other Medical Services

For Service Year 2022, other medical services represent 5% of total medical costs countrywide. Chart 57 shows the distribution of these services by four categories: transportation, home health services, dental/vision/hearing, and all other. The "All Other" category typically includes services that may have a missing, invalid, or unlisted procedure, in addition to some other valid services (e.g., payments for interpreters, vehicle modifications, etc.).

Chart 57

Distribution of Other Medical Services Payments



Diagnosis Group and Body System

Charts 58 and 59 display the top 10 body systems and diagnosis groups, respectively. A body system and diagnosis group are identified for each claim based on an ICD-10 code. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 body systems and diagnosis groups are ranked by total claim payments for Arizona. This method of ranking shows which body systems and diagnosis groups have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2021, and December 31, 2021, and they include all reported services provided for those claims through December 31, 2022.

Chart 58

Top Body Systems by Amount Paid for Dates of Injury in 2021

		Average Amount Paid Per Claim		
Body System	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Hand/wrist	15.8%	$2,899	$2,457	$2,814
Shoulder	13.0%	$7,440	$8,035	$9,684
Lumbar spine	11.7%	$4,601	$3,932	$4,532
Ankle/foot	8.4%	$3,731	$3,413	$3,719
Knee	8.1%	$5,167	$5,306	$5,684
Head	6.7%	$5,050	$3,540	$3,927
Leg	5.1%	$5,226	$5,323	$6,658
Neck	4.1%	$5,492	$4,917	$6,390
Chest/upper torso	3.6%	$4,661	$3,499	$3,783
Hip/pelvis	3.2%	$12,302	$10,272	$11,368

Chart 59

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2021

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Minor hand/wrist injuries	7.0%	$1,661	$1,368	$1,477
Minor shoulder injury	5.5%	$4,291	$4,597	$5,053
Low back pain	5.2%	$2,430	$2,664	$2,530
Rotator cuff tear	4.8%	$16,843	$18,270	$23,094
Hand/wrist fracture	4.7%	$9,359	$7,037	$7,732
Minor ankle/foot injuries	3.8%	$2,331	$2,064	$2,101
Minor knee injury	3.4%	$2,851	$2,629	$2,670
Traumatic brain injury	3.0%	$94,138	$66,958	$71,554
Neck pain	2.2%	$3,377	$3,499	$3,418
Hip/pelvis fracture/major trauma	2.2%	$55,307	$41,900	$47,280

Comparison of Selected Results by Year

The charts in this section provide a comparison of results for Arizona. These comparisons are over the latest five service years unless otherwise noted. Analysis in the growth of shares may provide additional insight into medical cost drivers above and beyond an analysis at a specific point in time.

Results in the charts below may vary compared to medical reports from previous years. This is due to a lag in reporting, as well as improved derivations affecting categories for certain charts.

Distribution of Medical Payments (Chart 4)

Medical Category	2018	2019	2020	2021	2022
Physician	37%	39%	38%	39%	39%
Hospital Outpatient	17%	17%	17%	18%	18%
Hospital Inpatient	15%	15%	16%	14%	14%
Drugs	11%	9%	9%	8%	8%
DMEPOS	7%	7%	7%	8%	8%
ASC	6%	6%	6%	6%	6%
Other	7%	7%	7%	7%	7%

Distribution of Physician Payments by AMA Service Category (Chart 6)

AMA Service Category	2018	2019	2020	2021	2022
Physical Medicine	35%	35%	38%	39%	38%
Surgery	16%	17%	15%	14%	13%
Evaluation and Management	29%	29%	28%	29%	32%
Radiology	8%	8%	8%	8%	7%
Anesthesia	3%	3%	3%	2%	2%
General Medicine	3%	3%	3%	3%	3%
Other	4%	3%	4%	4%	4%
Pathology	2%	2%	1%	1%	1%

Median Time Until First Treatment (in Days) (Charts 9, 11, 13, 15, 21, 32, 37, and 43)[8]

Medical Category	AY 2017	AY 2018	AY 2019	AY 2020	AY 2021
Physicians – Major Surgery	22	25	28	22	31
Physicians – Radiology	1	1	1	1	1
Physicians – Physical and General Medicine	10	9	9	8	8
Physicians – Evaluation and Management	1	1	1	1	1
Hospital Inpatient	0	0	0	0	0
Hospital Outpatient – Major Surgery	50	55	58	58	61
Hospital Outpatient – All Other	12	13	15	20	17
ASC – Major Surgery	66	70	78	79	84

75th Percentile of Time Until First Treatment (in Days) (Charts 9, 11, 13, 15, 21, 32, 37, and 43)[8]

Medical Category	AY 2017	AY 2018	AY 2019	AY 2020	AY 2021
Physicians – Major Surgery	98	101	102	111	121
Physicians – Radiology	7	7	8	8	9
Physicians – Physical and General Medicine	32	31	33	30	32
Physicians – Evaluation and Management	4	4	4	4	4
Hospital Inpatient	4	6	5	8	4
Hospital Outpatient – Major Surgery	128	126	139	149	145
Hospital Outpatient – All Other	47	49	52	68	63
ASC – Major Surgery	134	150	149	168	170

Hospital Inpatient Statistics (Charts 17 and 19)

	2018	2019	2020	2021	2022
Average Amount Paid Per Stay	$41,339	$43,917	$49,779	$49,217	$47,729
Number of Stays per 1,000 Active Claims	15	15	15	13	14

[8] In the charts displaying the distribution of time until first treatment, the data is organized by the year in which the injury occurred, rather than by service year, and includes services performed within 365 days of the date of injury.

Distribution of Hospital Outpatient Payments by Outpatient Visit Type (Chart 25)

Visit Type	2018	2019	2020	2021	2022
Emergency	46%	46%	45%	48%	47%
Nonemergency Major Surgery	37%	37%	37%	37%	39%
Other	17%	17%	18%	15%	14%

Emergency Hospital Outpatient Statistics (Charts 26 and 27)

	2018	2019	2020	2021	2022
Average Amount Paid Per Visit	$2,077	$2,216	$2,377	$2,450	$2,407
Number of Visits per 1,000 Active Claims	169	160	141	157	163

Emergency Room Outpatient Services Paid per Transaction (Chart 29)

Code	Severity	2018	2019	2020	2021	2022
99281	Minor	$222	$257	$255	$342	$341
99282	Low to moderate	$354	$358	$377	$378	$404
99283	Moderate	$610	$647	$654	$680	$675
99284	High	$936	$921	$949	$982	$979
99285	High and immediately life-threatening	$1,492	$1,501	$1,504	$1,632	$1,704

Nonemergency Major Surgery Hospital Outpatient Statistics (Charts 30 and 31)

	2018	2019	2020	2021	2022
Average Amount Paid Per Visit	$12,582	$13,341	$12,919	$14,281	$14,649
Number of Visits per 1,000 Active Claims	22	21	22	21	22

Other Hospital Outpatient Statistics (Charts 35 and 36)

	2018	2019	2020	2021	2022
Average Amount Paid Per Visit	$540	$613	$624	$658	$689
Number of Visits per 1,000 Active Claims	230	208	216	189	172

ASC Major Surgery Statistics (Charts 41 and 42)

	2018	2019	2020	2021	2022
Average Amount Paid Per Visit	$8,494	$8,183	$8,229	$8,192	$8,759
Number of Visits per 1,000 Active Claims	28	30	30	30	30

Distribution of Prescription Drug Payments by CSA Schedule (Chart 47)

CSA Schedule	2018	2019	2020	2021	2022
Schedule II	19%	14%	13%	11%	9%
Schedule III	1%	1%	1%	1%	1%
Schedule IV	6%	5%	4%	4%	3%
Schedule V	9%	8%	8%	9%	8%
Noncontrolled	65%	72%	74%	75%	79%

Distribution of Drug Payments by Brand Name and Generic (Chart 50)

Type of Drug	2018	2019	2020	2021	2022
Brand Name	45%	39%	31%	32%	31%
Generic	55%	61%	69%	68%	69%

Distribution of Drug Payments by Pharmacy and Nonpharmacy (Chart 51)

Type of Provider	2018	2019	2020	2021	2022
Pharmacy	86%	82%	95%	95%	94%
Nonpharmacy	14%	18%	5%	5%	6%

Distribution of Drug Payments by Opioid and Non-Opioid (Chart 52)

Drug Type	2018	2019	2020	2021	2022
Non-Opioid	78%	84%	85%	88%	89%
Opioid	22%	16%	15%	12%	11%

Share of Drug Claims that are Opioid Claims and the Average MME per Opioid Claim (Chart 53)

	2018	2019	2020	2021	2022
Opioid Claim Share	28%	23%	21%	18%	15%
Average MME per Opioid Claim	5,664	5,184	5,660	5,267	4,984

Distribution of Payments by DMEPOS (Chart 56)

Category	2018	2019	2020	2021	2022
DME	16%	18%	21%	20%	21%
Prosthetics, Orthotics and Implants	46%	44%	38%	39%	37%
Supplies Other Than DME	38%	38%	41%	41%	42%

Distribution of Payments by Other Medical Services (Chart 57)

Category	2018	2019	2020	2021	2022
Transportation	22%	22%	22%	21%	18%
Home Health Services	30%	29%	31%	33%	36%
Dental/Vision/Hearing	6%	6%	7%	6%	6%
All Other	42%	43%	40%	40%	40%

Glossary

75th Percentile: The point on a distribution that is higher than 75% of observations and lower than 25% of observations.

Accident Year: A loss accounting definition in which experience is summarized by the calendar year in which an accident occurred.

Ambulatory Payment Classification (APC): Unit of payment under Medicare's Outpatient Prospective Payment System (OPPS) for hospital outpatient services where individual services are grouped based on similar characteristics and similar costs.

Ambulatory Surgical Center (ASC): A state-licensed facility that is used mainly to perform outpatient surgery, has a staff of physicians, has continuous physician and nursing care, and does not provide for overnight stays. An ASC can bill for facility fees much like a hospital, but it generally has a separate fee schedule.

Controlled Substances: Drugs that are regulated by the Controlled Substances Act (CSA) of 1970. Each controlled substance is contained in one of five schedules based on its medical use(s) and its potential for abuse and addiction.

CPT Code Modifiers: Modifiers are codes added to a CPT code that further describe the procedure performed without changing the meaning of the original code.

Current Procedural Terminology (CPT): A numeric coding system maintained by the American Medical Association (AMA). The CPT coding system consists of five-digit codes that are primarily used to identify medical services and procedures performed by physicians and other healthcare professionals.

Diagnosis Groups: Based on ICD-10 codes; groups based on similar injuries and parts of body.

Diagnosis-Related Groups (DRG): A system of hospital payment classifications that groups patients with similar clinical problems who are expected to require similar amounts of hospital resources.

Drugs: Includes any data reported by a National Drug Code (NDC), which is referred to as a prescription drug. Also included are data for revenue codes, the Healthcare Common Procedure Coding System (HCPCS), and other state-specific codes that represent drugs.

Durable Medical Equipment (DME): Equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and is not generally useful to a person in the absence of an illness or injury.

Emergency Services: Services performed for patients requiring immediate attention.

Emergency Visit: A visit where emergency services are performed.

Healthcare Common Procedure Coding System (HCPCS): Alphanumeric codes that include mostly nonphysician items or services such as medical supplies, ambulatory services, prostheses, etc. These are items and services not covered by Current Procedural Terminology (CPT) procedures.

ICD-10 Codes: The *International Classification of Diseases, Tenth Revision,* is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the United States.

Hospital Inpatient Service: Services for a patient who is admitted to a hospital for treatment that requires at least one overnight stay (more than 24 hours in a hospital).

Hospital Inpatient Stay: A hospital admission of a patient requiring hospitalization of at least one 24-hour period.

Hospital Outpatient Service: Any type of medical or surgical care, performed at a hospital, that is not expected to result in an overnight hospital stay (less than 24 hours in a hospital).

International Statistical Classification of Diseases and Related Health Problems (ICD-10): A classification of diseases and other health problems based on a diagnosis maintained by the World Health Organization (WHO).

Length of Stay: The amount of time, in days, between admission to a hospital and discharge.

Major Surgery Visit: A visit in which at least one surgery procedure is performed based on the reported procedure code, and where the surgical procedure is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, or the procedure involves spine/spinal cord neurostimulators.

Medical Data Call: Captures transaction-level detail for medical billings that were processed on or after July 1, 2010. All medical transactions with the jurisdiction state in any applicable Medical Data Call state are reportable. This includes all workers compensation claims, including medical-only claims.

National Drug Code (NDC): A universal product identifier for human drugs in the United States. Each NDC code uniquely identifies a drug product based on key characteristics, such as the labeler (manufacturer/distributor), active ingredients, strength, dosage form, and package form.

Opioids: A class of drugs used to treat moderate to severe pain, particularly chronic intractable pain.

Other Outpatient Visit: A nonemergency outpatient visit where no major surgery services are performed.

Prescription: NCCI defines a “prescription” to be synonymous with a transaction. Therefore, a refill on a prescribed drug is considered a separate prescription.

(Paid) Procedure Code: A code from the jurisdiction-approved code table that identifies the procedure associated with the reimbursement. Examples include CPT code or revenue code.

Revenue Code: A numeric coding system used in hospital billings that provides broad classifications of the types of services provided. Some examples are emergency room, operating room, recovery room, room and board, and supplies.

Service Year: A loss accounting definition where experience is summarized by the calendar year in which a medical service was provided.

Taxonomy Code: A code that identifies the type of provider that billed for, and is being paid for, a medical service. Data reporters are instructed to use the provider taxonomy list of standard codes maintained by the National Uniform Claim Committee.

Time to Treatment (TTT): The amount of time, measured in days, between the date on which an accident occurs and the date on which the first medical service in a given category is provided.

Transaction: A line item of a medical bill.

Units: The number of units of service performed or the quantity of drugs dispensed. For Paid Procedure Codes related to medications, the quantity/units depend on the type of drug:

- For tablets, capsules, suppositories, nonfilled syringes, etc., *units* represent the actual number of the drug provided. For example, a bottle of 30 pills would have 30 units.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, the units are specified by the procedure code. For example, a cream is dispensed in a standard tube, which is defined as a single unit.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, the number of units is the amount provided in its standard unit of measurement, such as milliliters, grams, or ounces. For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as four units.

Visit: Any hospital outpatient or ASC service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claimant may have more than one visit.

Appendix

The data contained in this report is reported under the jurisdiction state—the state under whose workers compensation act the claimant's benefits are being paid. Medical transactions must continue to be reported until the transactions no longer occur (i.e., the claim is closed) or 30 years from the accident date. There are nearly 30 data elements reported.

Wherever possible, standard industry codes are used because they provide a clear definition of the data, improve its accuracy and quality, and increase efficiency of computer systems.

Carriers differ in their handling of medical data reporting. Some carriers retain all medical claims handling internally and submit the data themselves. Others use business partners for various aspects of medical claim handling, such as third party administrators or medical bill review vendors. It is possible for a carrier to authorize its vendor to report the data on its behalf. Some carriers may use a combination of direct reporting and vendors. Although data may have been provided by an authorized vendor on behalf of a carrier, the quality, timeliness, and completeness of the data is the responsibility of the carrier.

Before a medical data provider can send files, each submitter's electronic data file must pass certification testing. This ensures that all connections, data files, and systems are functioning and processing correctly. Each medical data provider within a reporting group is required to pass certification testing. If a medical data provider reports data for more than one reporting group, that data must be certified for each group.

For more information about the Medical Data Call, please refer to the ***Medical Data Call Reporting Guidebook*** on **ncci.com**.