



Medical Data Report

For the state of:

ARIZONA

September 2017



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Introduction

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

This publication is a data source for regulators and others who are interested in the driving forces behind the increasing medical costs in workers compensation 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 threaten the financial soundness of the workers compensation system.

Knowing how payments for different services contribute to workers compensation 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 (DME), Supplies, and Implants
- Other

Next, the report drills down into these categories to show which particular procedures represent the greatest share of payments and which are performed the most.

Additionally, this report provides detail on payments for prescription drugs, including which drugs are being prescribed the most and which ones represent the greatest share of drug payments, as well as information on repackaged drugs and controlled substances.

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.

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



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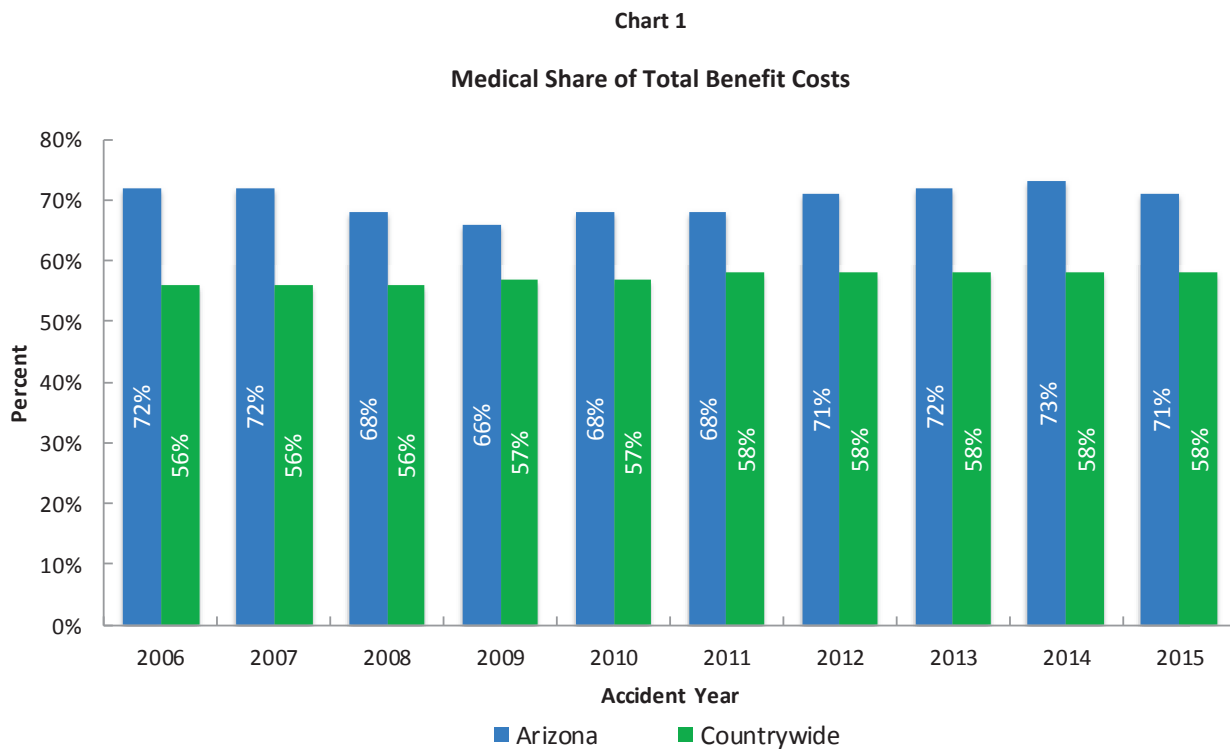
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Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

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 local share of medical benefit costs may vary. 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 and the countrywide average for the past 10 accident years.

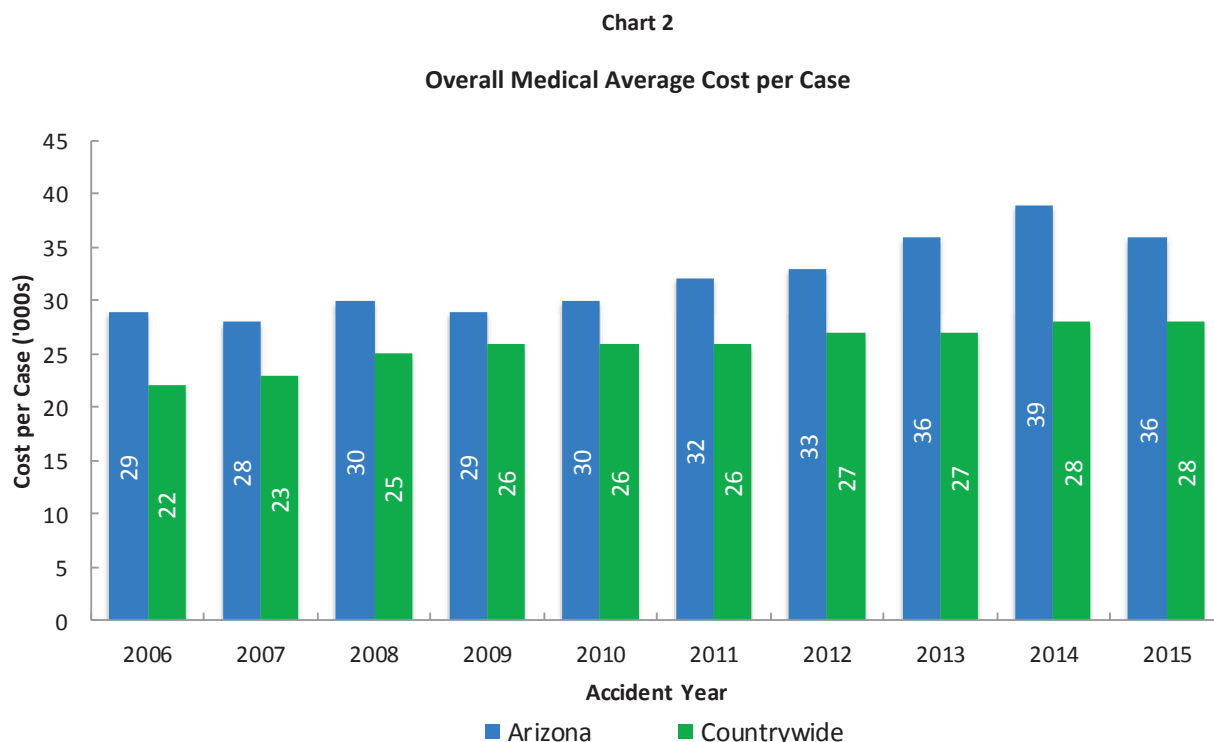


Source: NCCI Calendar-Accident Year Call for Compensation Experience. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

After a decade of medical cost inflation at an annual rate of 6%, the countrywide overall medical average cost per claim has seen more moderate increases, averaging 1% from 2009 to 2015; this is markedly less than the observed 3% annual growth for 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 both Arizona and the countrywide average.

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 all medical losses 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 countrywide average for each individual accident year and allows for the comparison of the growth in average medical costs.



Source: NCCI Calendar-Accident Year Call for Compensation Experience. Losses and claim counts are developed to ultimate. Medical-only claim counts and losses are excluded. Countrywide includes data for the following states: 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.

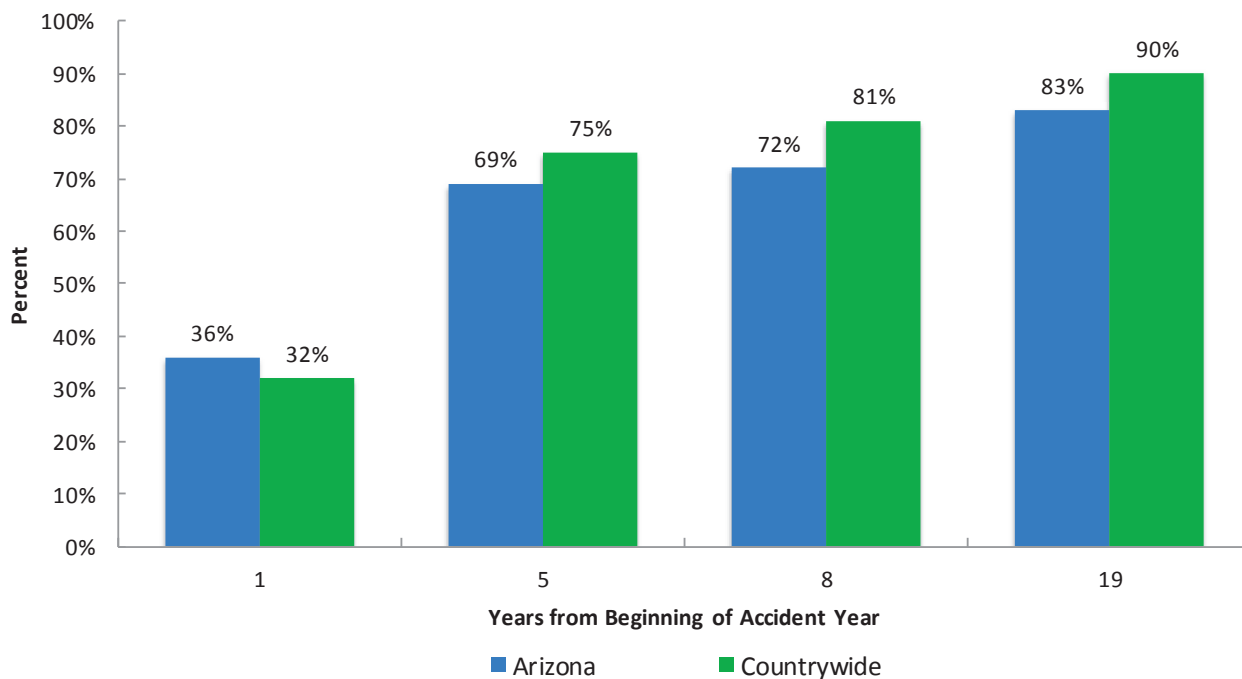
¹ Medical Cost Trends Then and Now, www.ncci.com/Articles/Documents/II_AIS2017-Lipton.pdf.

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. Recent NCCI research has found that it is likely that more than 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 the countrywide average.

Chart 3
Percentage of Medical Paid by Claim Maturity



Source: NCCI Calendar-Accident Year Call for Compensation Experience. Countrywide includes data for the following states: 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, UT, VA, and VT.

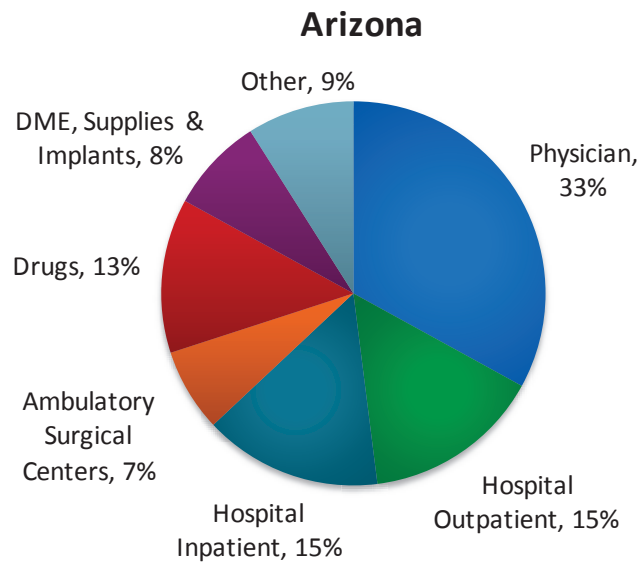
Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits.

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

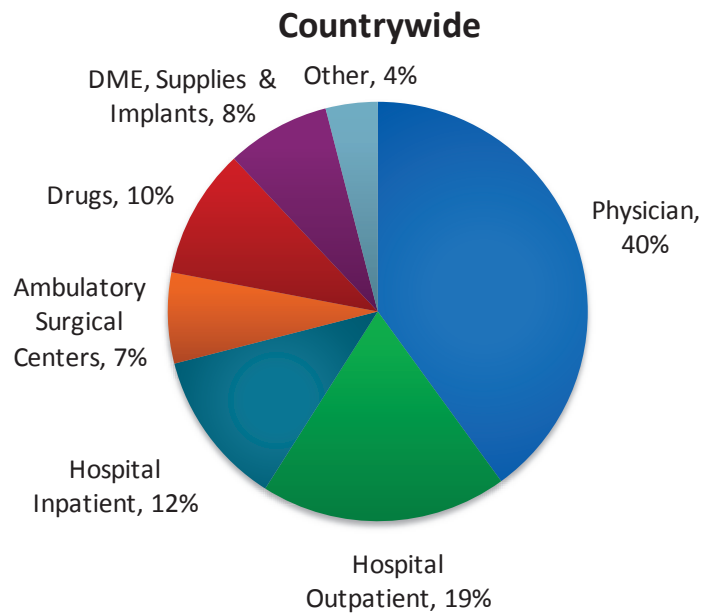
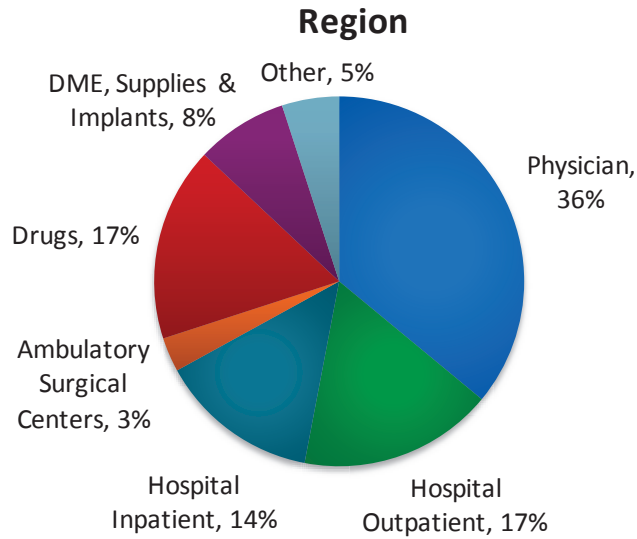
Payments are categorized as Drugs; Durable Medical Equipment (DME), Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the 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; see Glossary
- 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, ambulatory surgical center)

Chart 4
Distribution of Medical Payments



Distribution of Medical Payments (cont'd)



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.



Results from NCCI’s study, [“The Price Impact of Physician Fee Schedules”](#) (April 2014), show that the median workers compensation price for a physician service is always at, or very near, the maximum allowable reimbursement (MAR) amount set by the fee schedule. 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.

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

The table below shows the average percentage of Medicare schedule reimbursement amounts for physician payments, by category, for Arizona, the region, and countrywide.

Payments Percentage of Medicare	AZ	Region	Countrywide
Surgery	197%	148%	228%
Radiology	215%	229%	243%
Medicine	128%	111%	129%
Evaluation and Management	138%	132%	139%
All Physician Services	149%	134%	160%

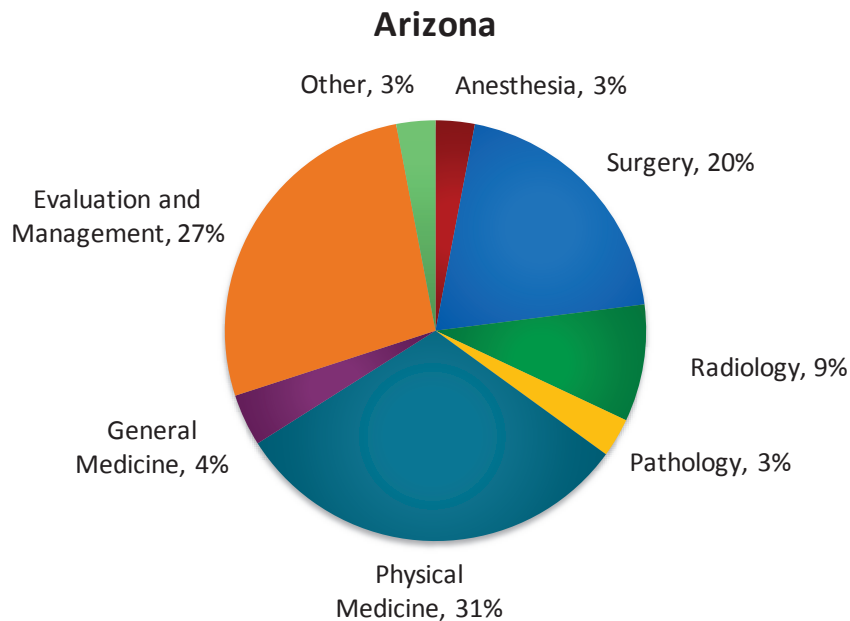
Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Chart 5 shows the distribution of physician payments by service category. Service categories are defined by the American Medical Association (AMA). Services involving office visits and consultations are included in the Evaluation and Management category. The Other category includes any codes not included in the AMA service categories, such as state-defined codes.

Since many states' medical fee schedule payment levels vary by service categories, an analysis of physician payments provides insights into the effectiveness of the fee schedule. For example, if the share of payments is high for a particular category compared to other states, a driver of the higher share could be higher maximum payment levels for that service category provided in the fee schedule.

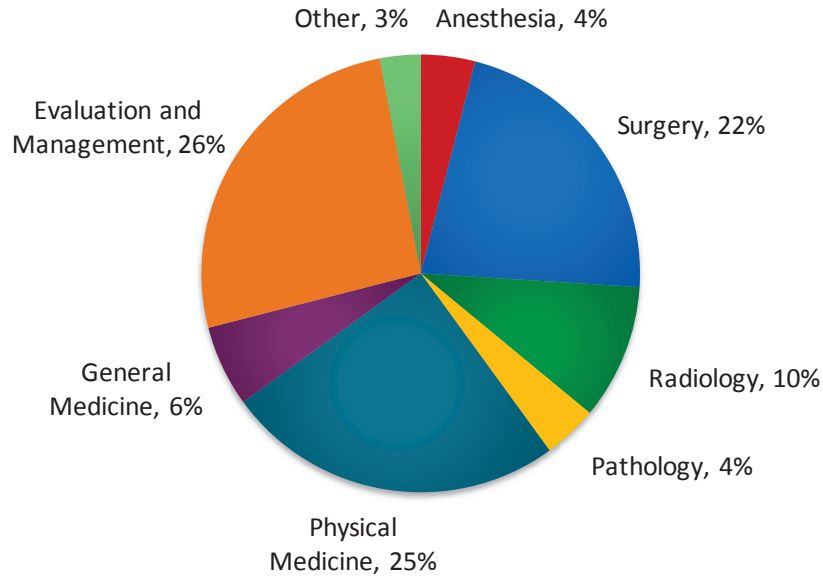
Chart 5

Distribution of Physician Payments by AMA Service Category

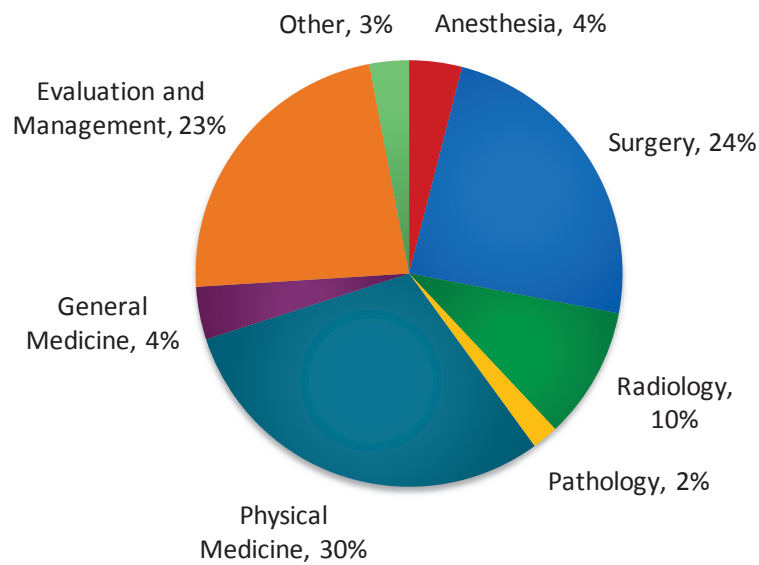


Distribution of Physician Payments by AMA Service Category (cont'd)

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Physicians typically use current procedure 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. Charts 6 through 14 display the top 10 procedure codes reported by physicians for the following service categories: surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code, including the percentage of payments that the procedure code represents in Arizona, is displayed in the corresponding table below each chart.

The charts also include the average amount paid per transaction for these codes in Arizona, in the region, and across the country. The average amount paid per transaction 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, quantity/units, and others may need to be considered when evaluating average payments per service.

The Top 10 charts rank the procedure codes for each service category using two different methods. The first method ranks procedure codes by total payments. 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.

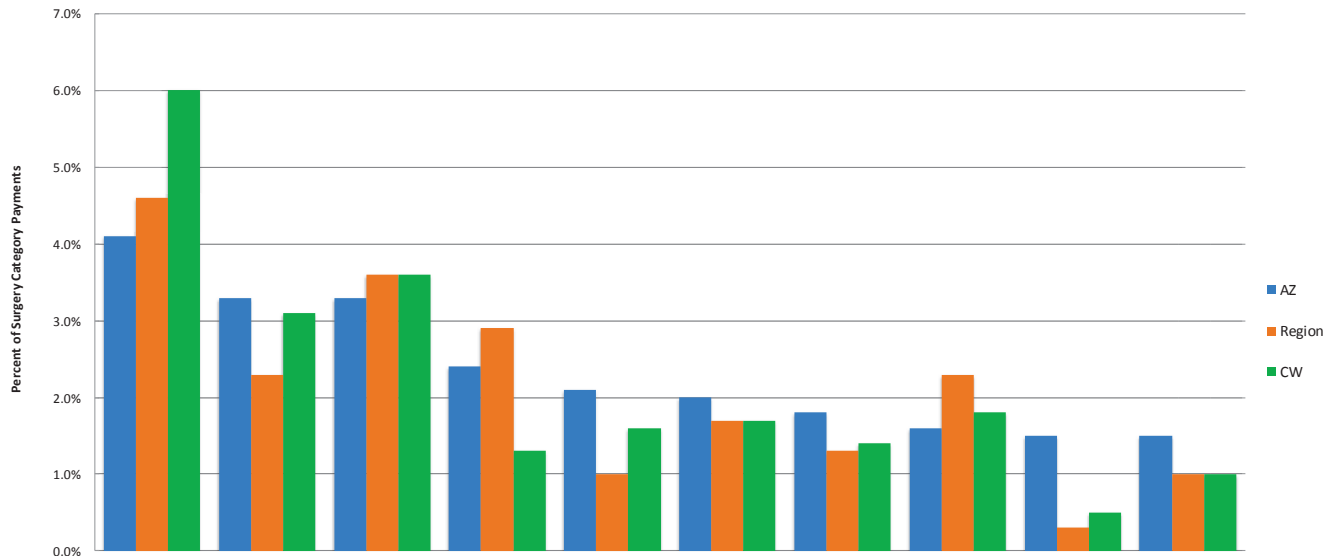
The second method ranks procedure codes by total count of transactions. The procedure code with the highest total transaction count is ranked first, the procedure code with the second highest total transaction count is ranked second, and so on. This method reveals the most frequently used procedures.

Results from NCCI's study, [“The Price Impact of Physician Fee Schedules”](#) (April 2014), show that the influence of fee schedules is quite different between the high-volume Evaluation and Management (E&M) service category and the small-volume Surgery category. For Surgery, many workers compensation payments are well below the MAR but are considerably above group health payments. In contrast, for E&M, workers compensation payments are closer to the MAR than those for Surgery and are more in line with those for group health.

In Arizona, physician payments for surgery services provided in 2016 are, on average, 197% of Medicare scheduled reimbursement amounts.

Chart 6

Top 10 Surgery Procedure Codes by Amount Paid for Arizona



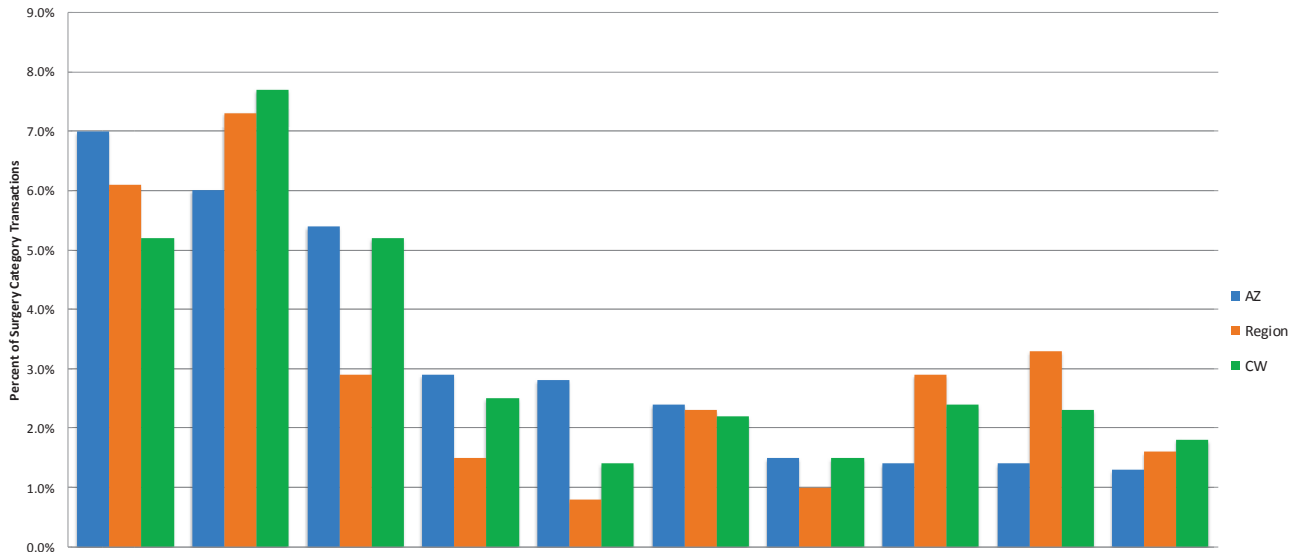
Procedure Code	AZ	Reg	CW
29827	\$1,482	\$1,551	\$1,092
29881	\$1,221	\$776	\$549
29826	\$2,718	\$1,433	\$1,996
63047	\$182	\$146	\$179
12001	\$375	\$329	\$467
64483	\$2,144	\$1,445	\$2,165
29888	\$1,087	\$634	\$1,047
29823	\$1,116	\$676	\$810
11012	\$777	\$623	\$804
20680			

Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
29827	4.1%	Arthroscopy shoulder surgical; with rotator cuff repair
29881	3.3%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29826	3.3%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
63047	2.4%	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root[s] [e.g., spinal or lateral recess stenosis]) single vertebral segment; lumbar
12001	2.1%	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	2.0%	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
29888	1.8%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29823	1.6%	Arthroscopy shoulder surgical; debridement extensive
11012	1.5%	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (e.g., excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone
20680	1.5%	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)

Chart 7

Top 10 Surgery Procedure Codes by Transaction Counts for Arizona



Procedure Code	AZ	Reg	CW
36415	\$12	\$9	\$13
20610	\$112	\$81	\$124
12001	\$182	\$146	\$179
12002	\$234	\$163	\$209
29125	\$105	\$77	\$113
64483	\$375	\$329	\$467
20550	\$84	\$67	\$106
29826	\$1,092	\$549	\$895
64415	\$275	\$164	\$270
29827	\$1,482	\$1,221	\$1,993

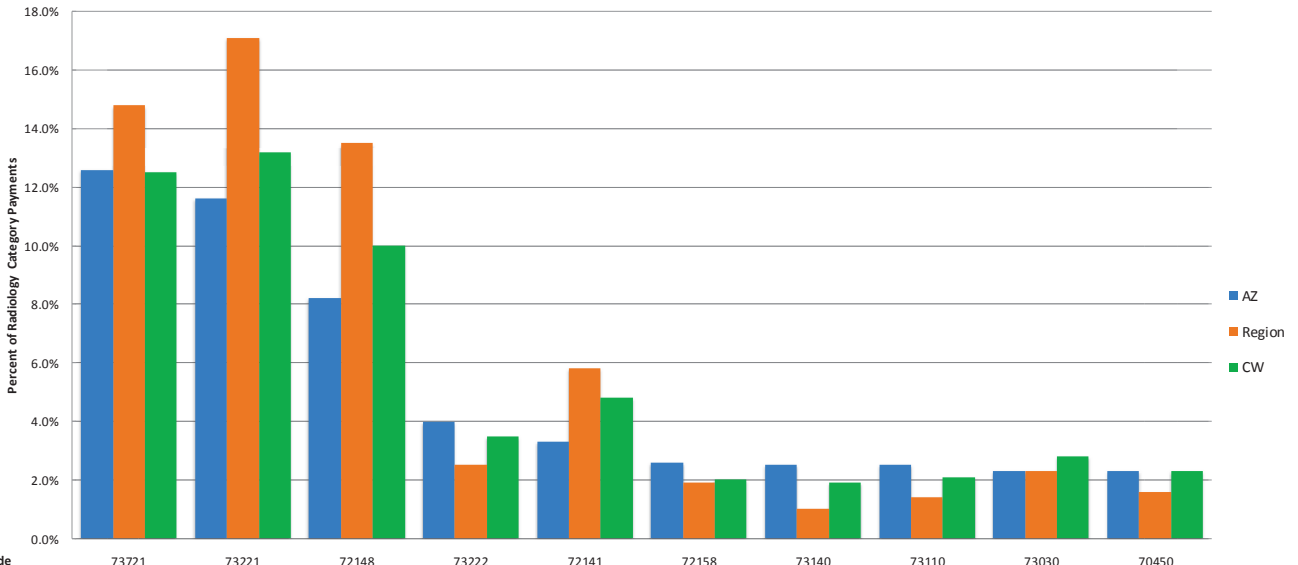
Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
36415	7.0%	Collection of venous blood by venipuncture
20610	6.0%	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
12001	5.4%	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
12002	2.9%	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
29125	2.8%	Application of short arm splint (forearm to hand); static
64483	2.4%	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
20550	1.5%	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)
29826	1.4%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
64415	1.4%	Injection, anesthetic agent; brachial plexus, single
29827	1.3%	Arthroscopy shoulder surgical; with rotator cuff repair

In Arizona, physician payments for radiology services provided in 2016 are, on average, 215% of Medicare scheduled reimbursement amounts.

Chart 8

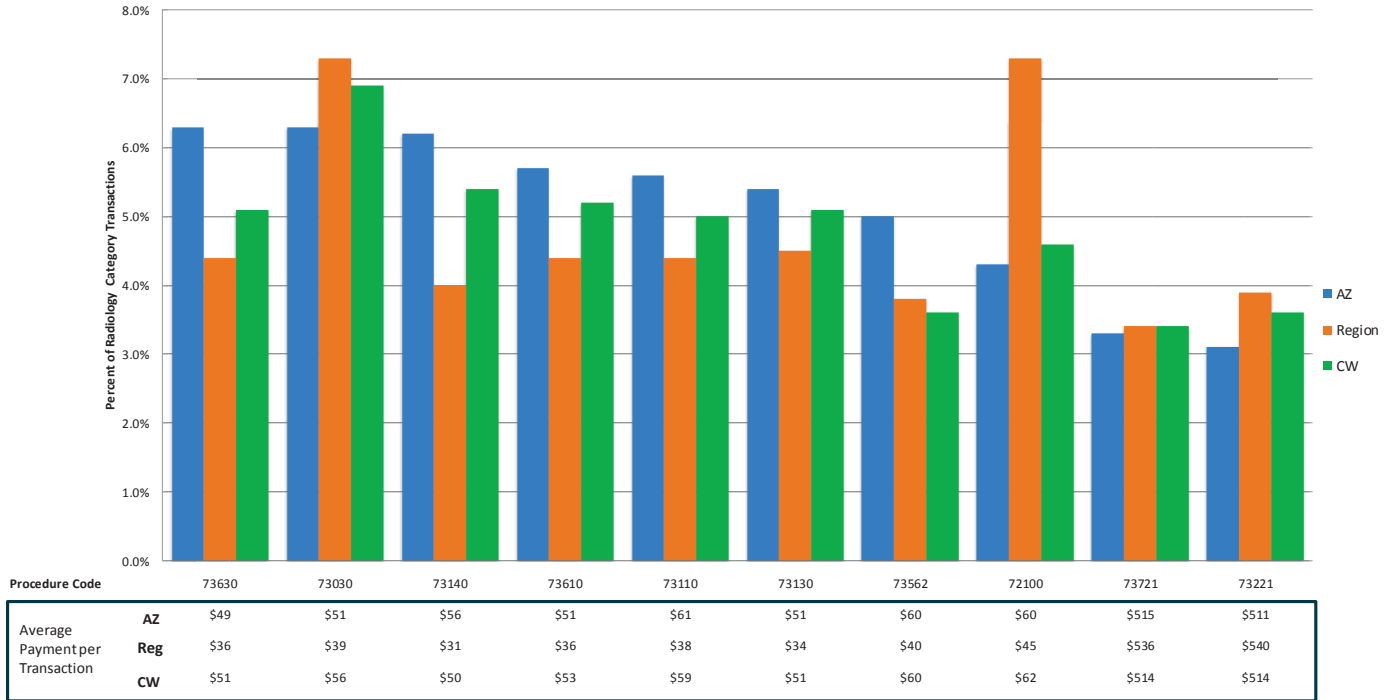
Top 10 Radiology Procedure Codes by Amount Paid for Arizona



Procedure Code	AZ	Reg	CW
73721	\$515	\$536	\$514
73221	\$511	\$540	\$514
72148	\$494	\$524	\$495
73222	\$739	\$581	\$651
72141	\$505	\$503	\$500
72158	\$755	\$754	\$736
73140	\$56	\$31	\$50
73110	\$61	\$38	\$59
73030	\$51	\$39	\$56
70450	\$183	\$136	\$164

Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
73721	12.6%	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
73221	11.6%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)
72148	8.2%	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
73222	4.0%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; with contrast material(s)
72141	3.3%	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material
72158	2.6%	Magnetic resonance (e.g., proton) imaging spinal canal and contents without contrast material followed by contrast material(s) and further sequences; lumbar
73140	2.5%	Radiologic examination finger(s) minimum of 2 views
73110	2.5%	Radiologic examination wrist; complete minimum of 3 views
73030	2.3%	Radiologic examination shoulder; complete minimum of 2 views
70450	2.3%	Computed tomography head or brain; without contrast material

Chart 9
Top 10 Radiology Procedure Codes by Transaction Counts for Arizona


Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

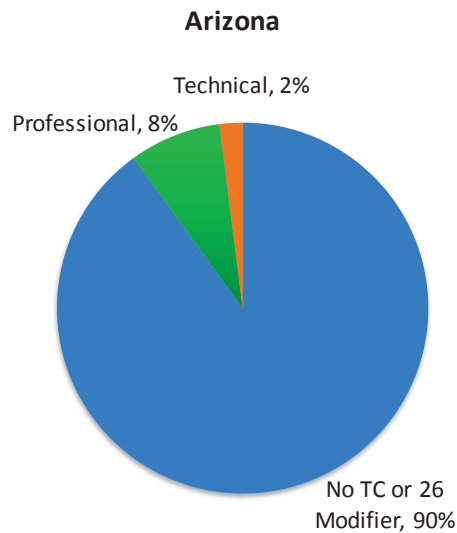
Code	% in AZ	Description
73630	6.3%	Radiologic examination foot; complete minimum of 3 views
73030	6.3%	Radiologic examination shoulder; complete minimum of 2 views
73140	6.2%	Radiologic examination finger(s) minimum of 2 views
73610	5.7%	Radiologic examination ankle; complete minimum of 3 views
73110	5.6%	Radiologic examination wrist; complete minimum of 3 views
73130	5.4%	Radiologic examination hand; minimum of 3 views
73562	5.0%	Radiologic examination knee; 3 views
72100	4.3%	Radiologic examination spine lumbosacral; 2 or 3 views
73721	3.3%	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
73221	3.1%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)

Radiology procedures consist of two components. There is a technical component, which is the performance of the examination, and a professional component for the interpretation of the results. Radiology services may be billed for the entire procedure, or they may be billed separately for each component. If billed by component, a modifier should be reported along with the CPT code. These modifiers may be “26” for the professional component or “TC” for the technical component.

Chart 10 shows the distribution of radiology payments by component for the latest service year and the breakdown for the identified top 10 radiology procedures, by paid amount, in the state.

Chart 10

Distribution of Radiology Payments by Modifier Code for Arizona



Source: NCCI Medical Data Call, Service Year 2016.

Average Paid Amount per Transaction by Modifier Code for Arizona

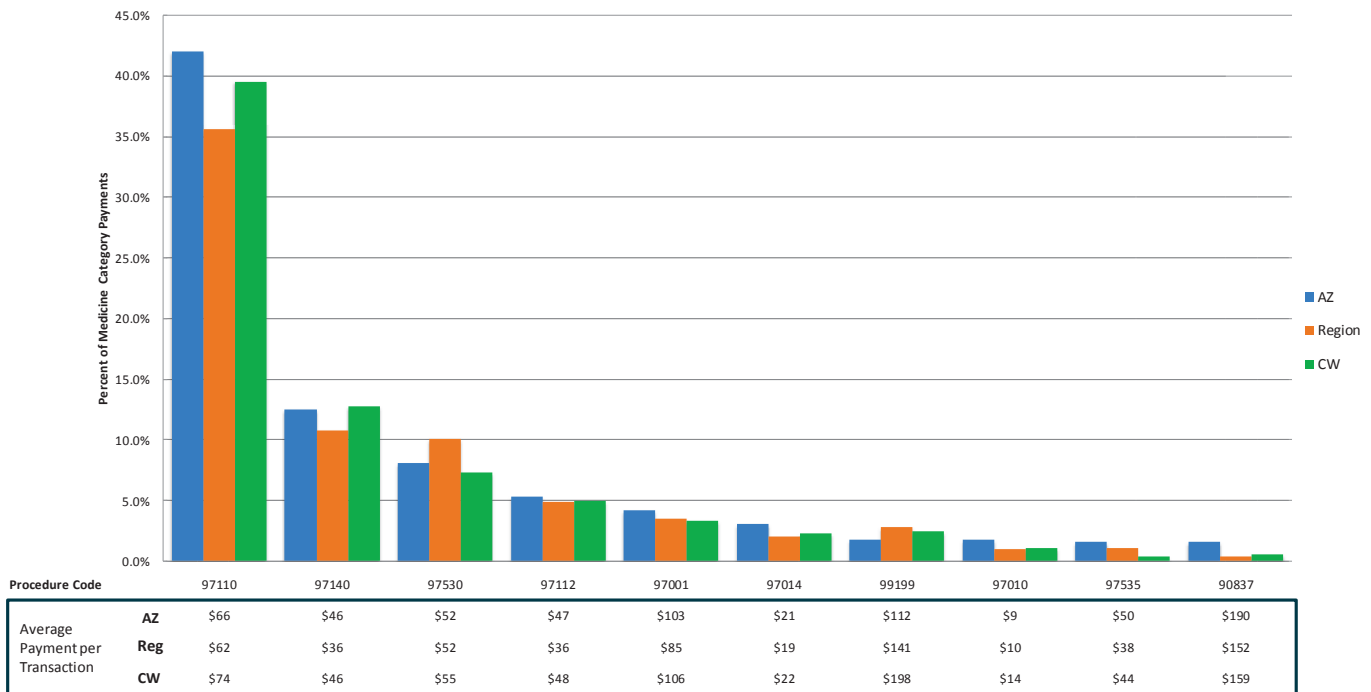
Code	No TC or 26 Modifier	Professional	Technical
73721	\$546	\$145	\$804
73221	\$550	\$149	\$498
72148	\$555	\$141	\$614
73222	\$780	\$164	\$678
72141	\$581	\$143	\$686
72158	\$833	\$259	\$668
73140	\$61	\$12	\$44
73110	\$67	\$16	\$40
73030	\$56	\$17	\$44
70450	\$538	\$78	\$1,026



In Arizona, physician payments for physical and general medicine services provided in 2016 are, on average, 128% of Medicare scheduled reimbursement amounts.

Chart 11

Top 10 Physical and General Medicine Procedure Codes by Amount Paid for Arizona

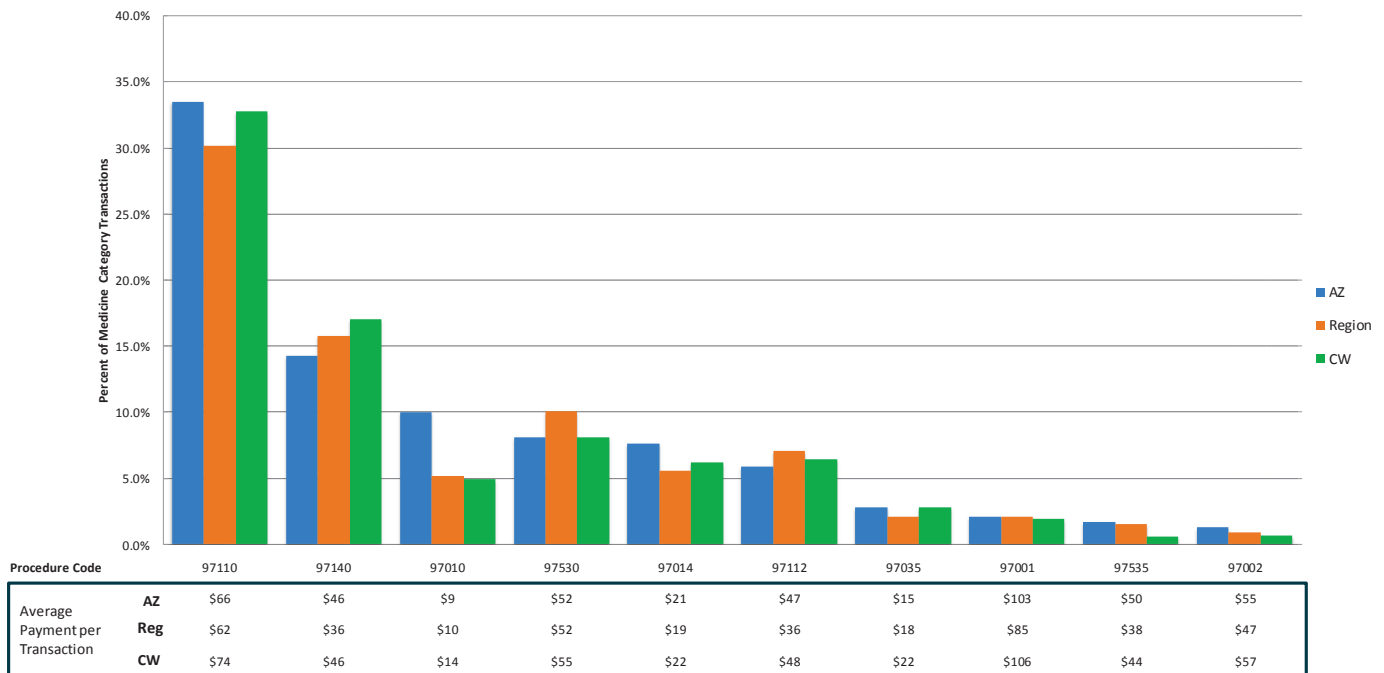


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Code	% in AZ	Description
97110	42.0%	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	12.5%	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
97530	8.1%	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	5.3%	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
97001	4.2%	Physical therapy evaluation
97014	3.1%	Application of a modality to 1 or more areas; electrical stimulation (unattended)
99199	1.8%	Unlisted special service procedure or report
97010	1.8%	Application of a modality to 1 or more areas; hot or cold packs
97535	1.6%	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
90837	1.6%	Psychotherapy, 60 minutes with patient

Chart 12

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

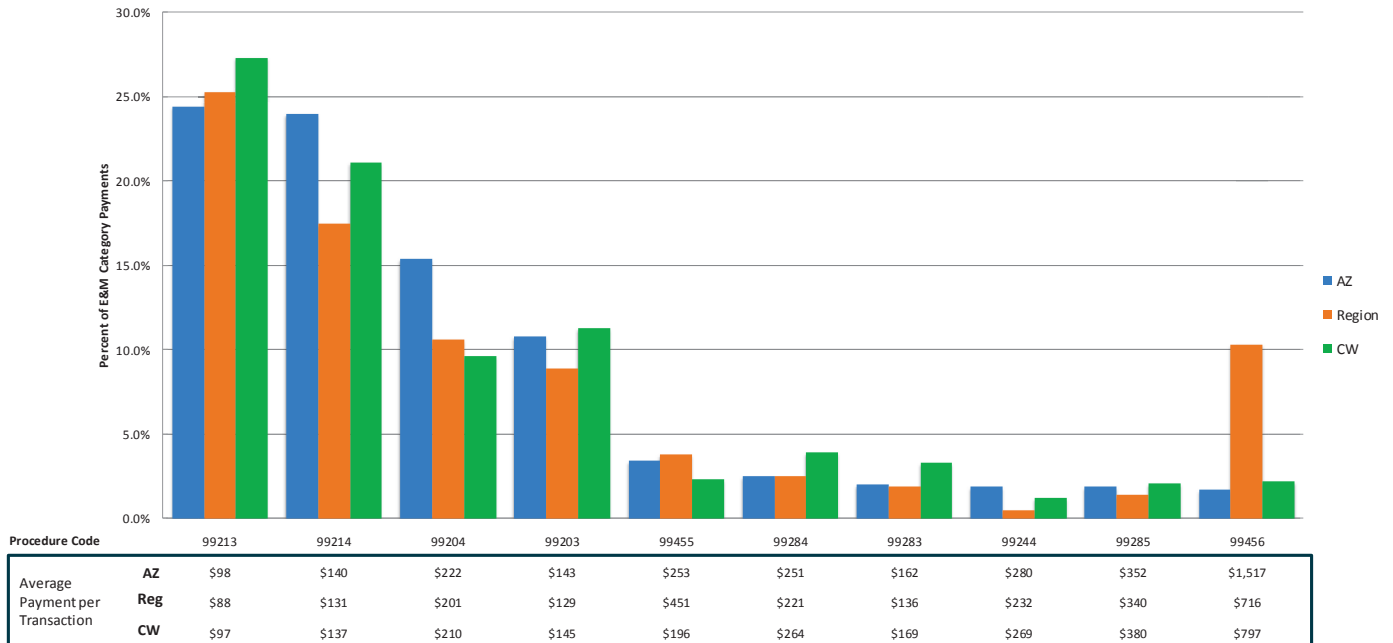
Code	% in AZ	Description
97110	33.5%	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	14.3%	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
97010	10.0%	Application of a modality to 1 or more areas; hot or cold packs
97530	8.1%	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97014	7.6%	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97112	5.9%	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
97035	2.8%	Application of a modality to 1 or more areas; ultrasound each 15 minutes
97001	2.1%	Physical therapy evaluation
97535	1.7%	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97002	1.3%	Physical therapy re-evaluation



In Arizona, physician payments for evaluation and management services provided in 2016 are, on average, 138% of Medicare scheduled reimbursement amounts.

Chart 13

Top 10 Evaluation and Management Procedure Codes by Amount Paid for Arizona

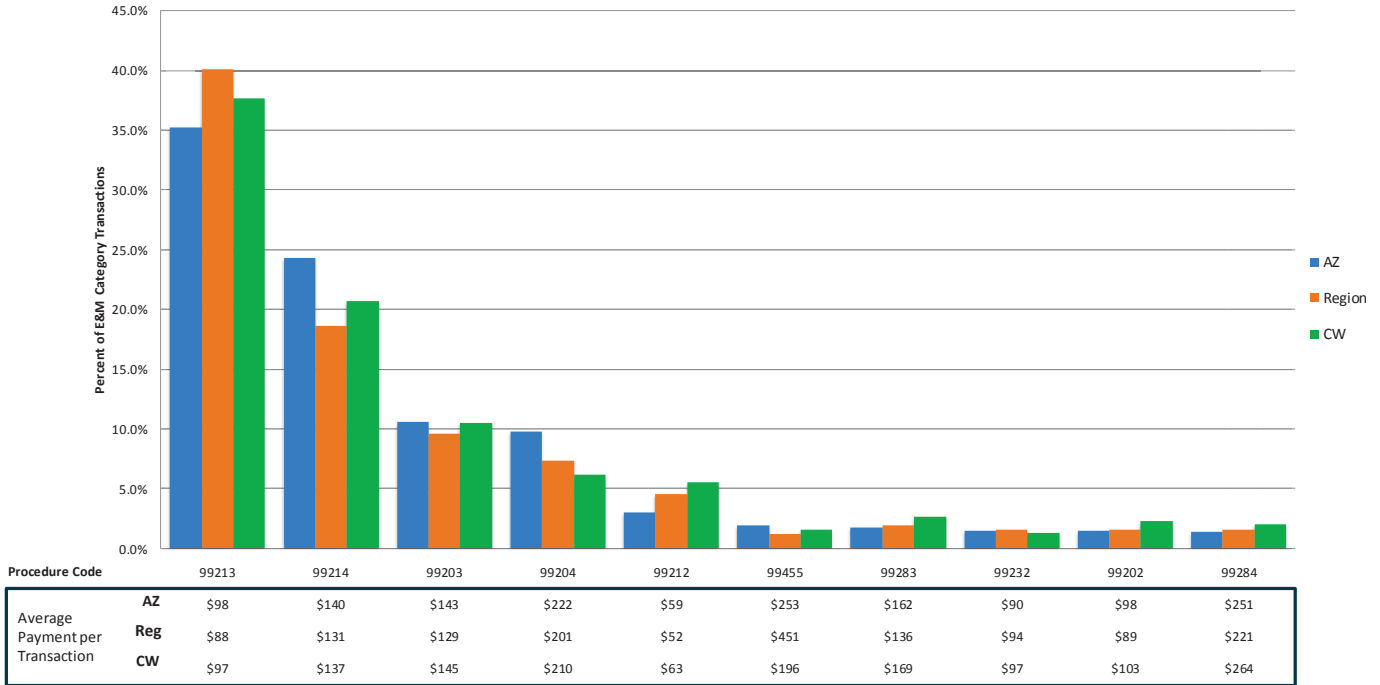


Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
99213	24.4%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	24.0%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99204	15.4%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99203	10.8%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99455	3.4%	Work related or medical disability examination by the treating physician.
99284	2.5%	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.
99283	2.0%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99244	1.9%	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99285	1.9%	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99456	1.7%	Work related or medical disability examination by other than the treating physician.

Chart 14

Top 10 Evaluation and Management Procedure Codes by Transaction Counts for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

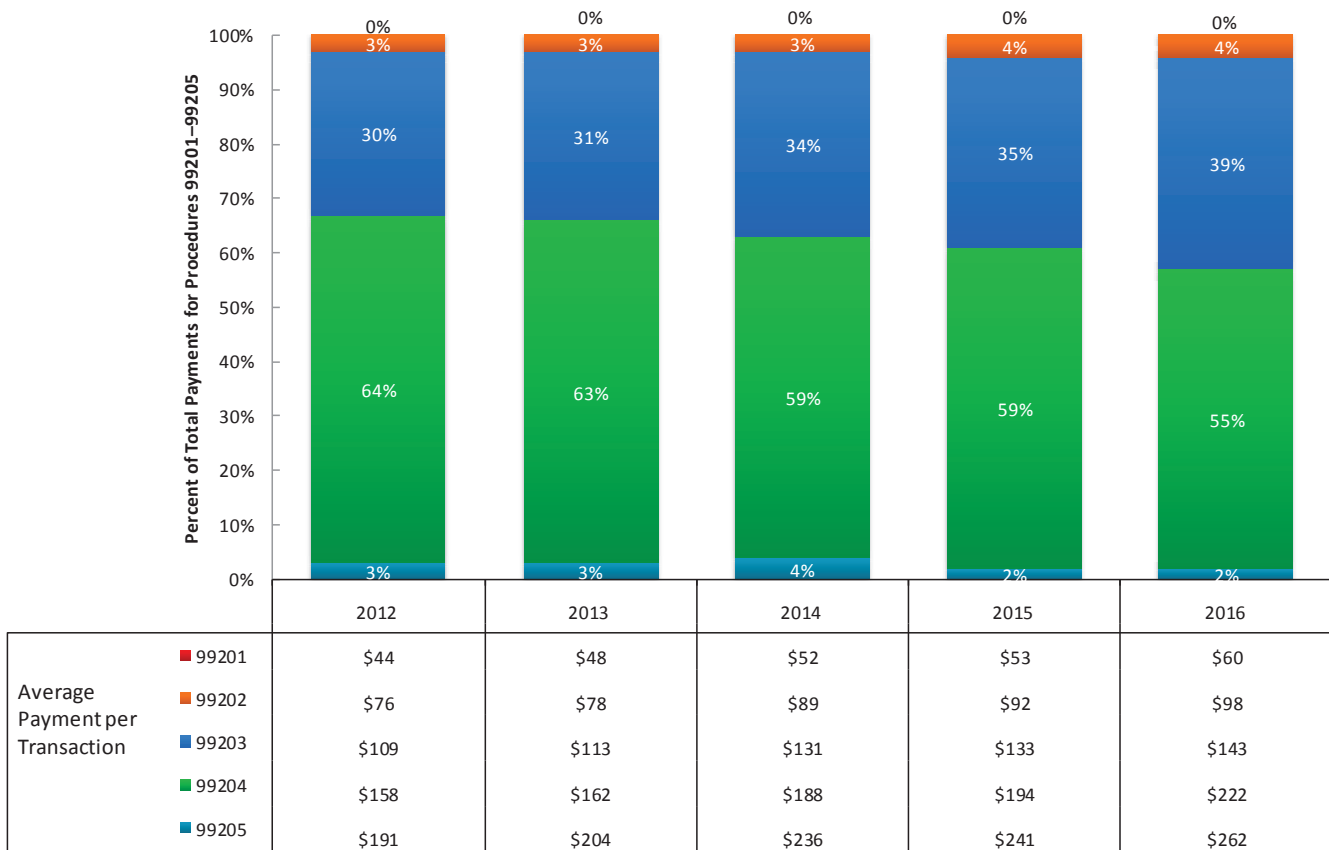
Code	% in AZ	Description
99213	35.2%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	24.3%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99203	10.6%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	9.8%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99212	3.0%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99455	1.9%	Work related or medical disability examination by the treating physician.
99283	1.7%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99232	1.5%	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99202	1.5%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99284	1.4%	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.

Evaluation and Management services consist largely of office or outpatient visits for new patients or an established patient.

There are five periods of time spent with a *new* patient, ranging from 10 minutes for Procedure Code 99201 to 60 minutes for Procedure Code 99205. Chart 15 shows a five-year snapshot of experience for each procedure type and the average payment per transaction.

Chart 15

Office or Other Outpatient Visit for the Evaluation and Management of a New Patient for Arizona



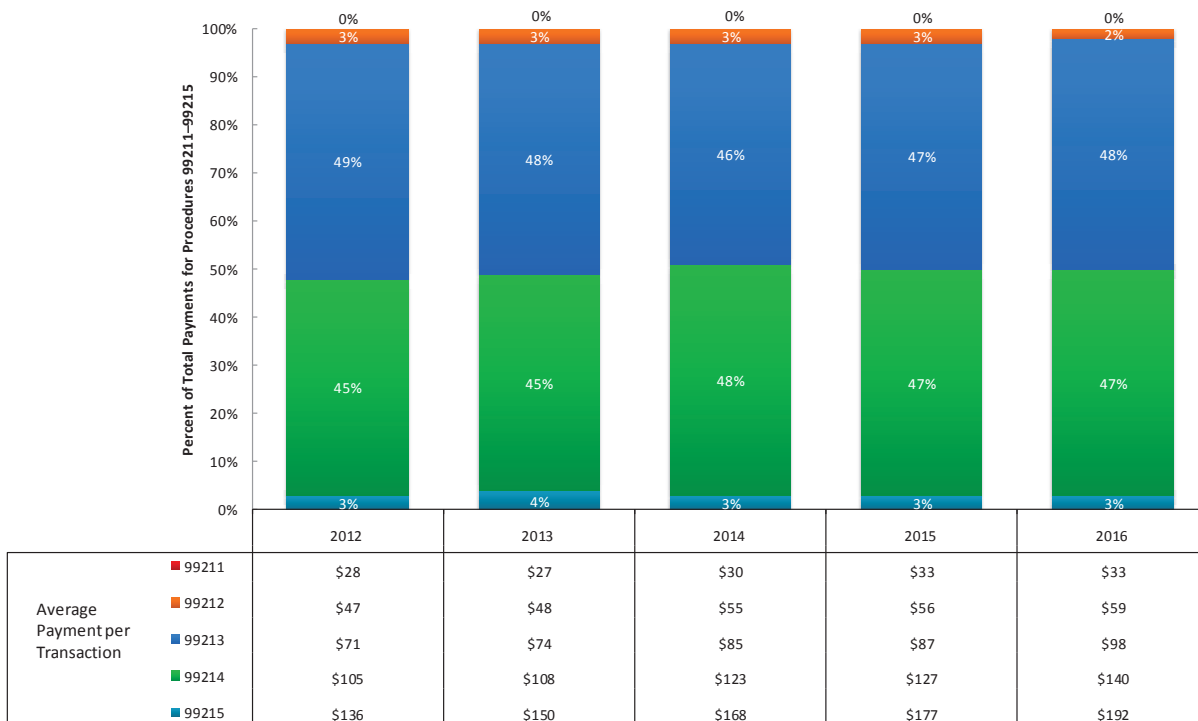
Source: NCCI Medical Data Call, Service Year 2016.

Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient, for problems of low to moderate severity. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, for problems of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, for problems of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, for problems of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient, for problems of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Similarly, for *established* patients, there are five periods of time spent with the patient, ranging from five minutes for Procedure Code 99211 to 40 minutes for Procedure Code 99215. Chart 16 shows a five-year snapshot of experience for each procedure type and the average payment per transaction.

Chart 16

Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient for Arizona



Source: NCCI Medical Data Call, Service Year 2016.

Code	Description
99211	Office or other outpatient visit for the evaluation and management of an established patient for problem(s) that are minimal. Typically 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient for problem(s) that are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient for problem(s) that are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient for problem(s) that are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient for problem(s) that are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.



Payments attributed to facilities represent inpatient hospital services, outpatient hospital services, and ambulatory surgical center services. Payments are mapped to these categories based on a combination of data elements reported for each transaction, including:

- Taxonomy code
- Procedure code
- Place of service

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 were mostly established in the last decade. Several states remain without such regulation today. Unlike physician fee schedules, hospital inpatient fee schedules vary a great deal. Some are based on Medicare, others reflect a discount off the charge master established by the hospitals, and yet others are based on per diem rates.

A hospital inpatient stay is typically reported with one of two types of codes: a diagnosis related group (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, 36% of hospital inpatient payments are reported with a DRG code.

Due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, regional and countrywide, comparisons by procedure code for inpatient costs should be interpreted with caution. 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.

A measure of workers compensation hospital inpatient costs is a comparison of current payments to the Medicare rates. The table below shows the average percentage of Medicare schedule reimbursement amounts for hospital inpatient payments for Arizona, the region, and countrywide.

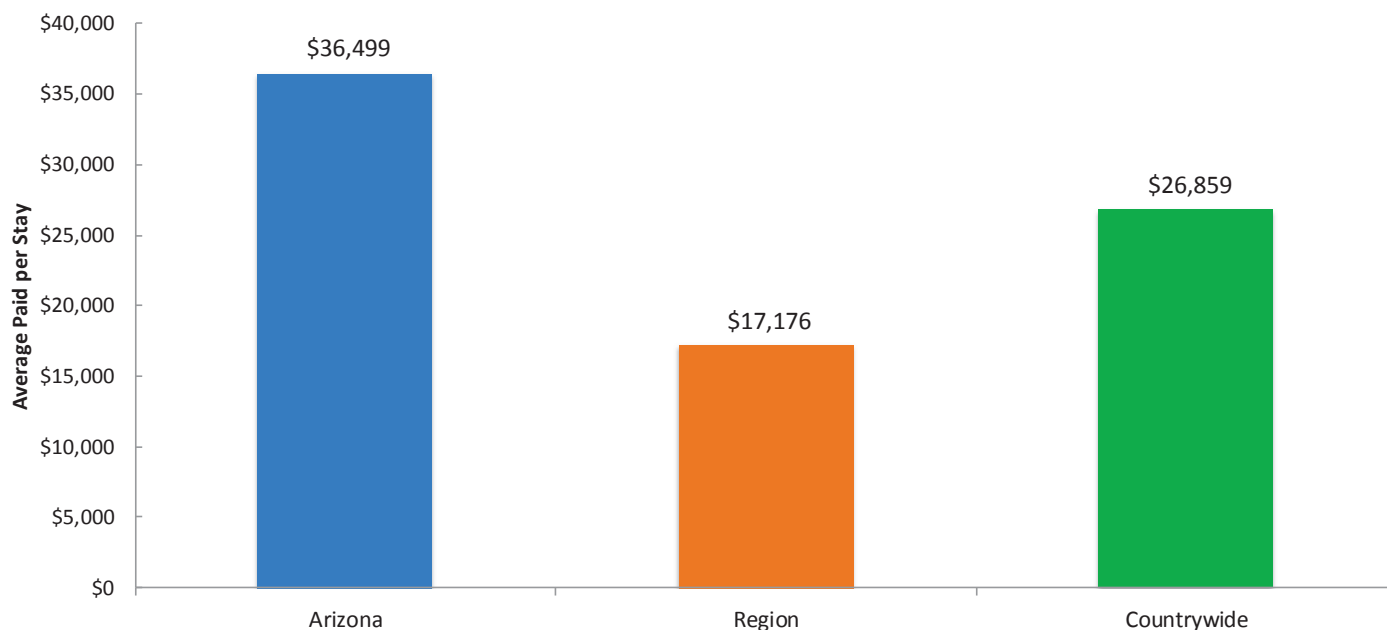
Medical Cost Category	AZ	Region	Countrywide
Hospital Inpatient	251%	137%	201%

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 paid amount per 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.

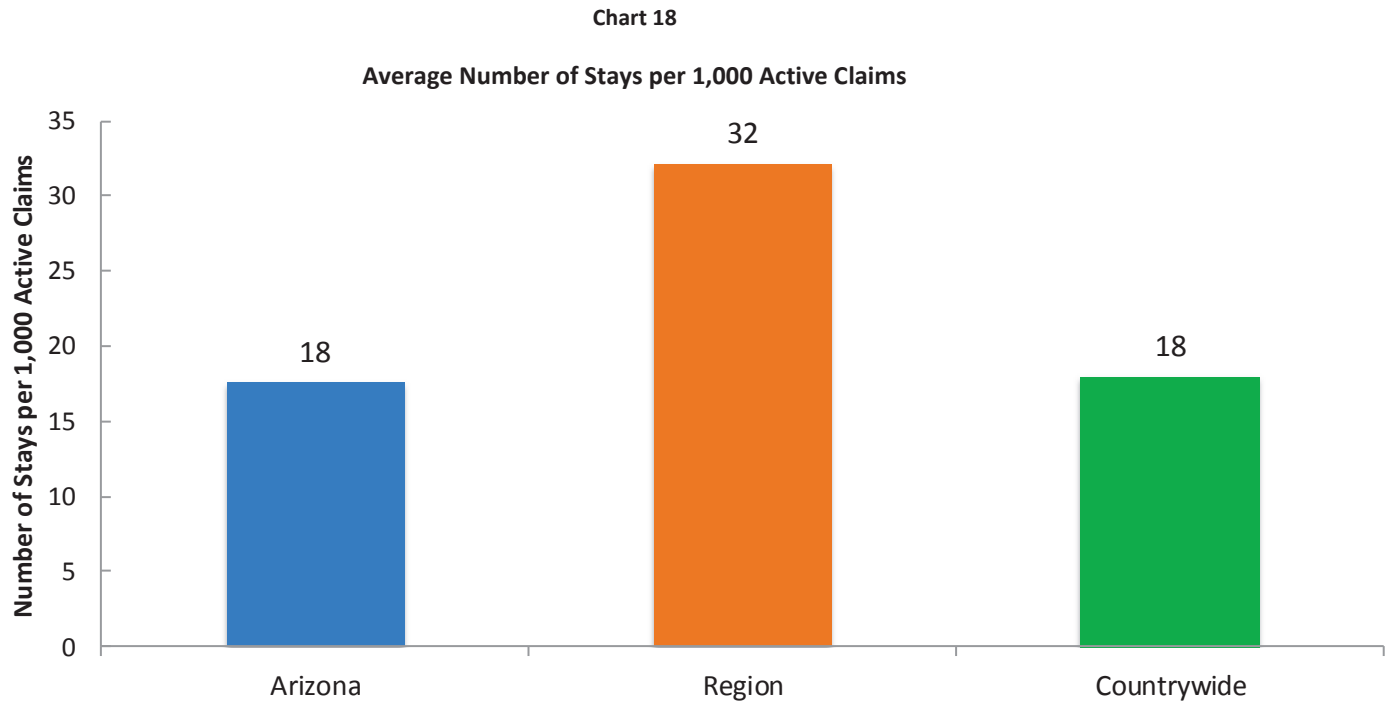
Chart 17

Average Paid Amount per Stay for Hospital Inpatient Services



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

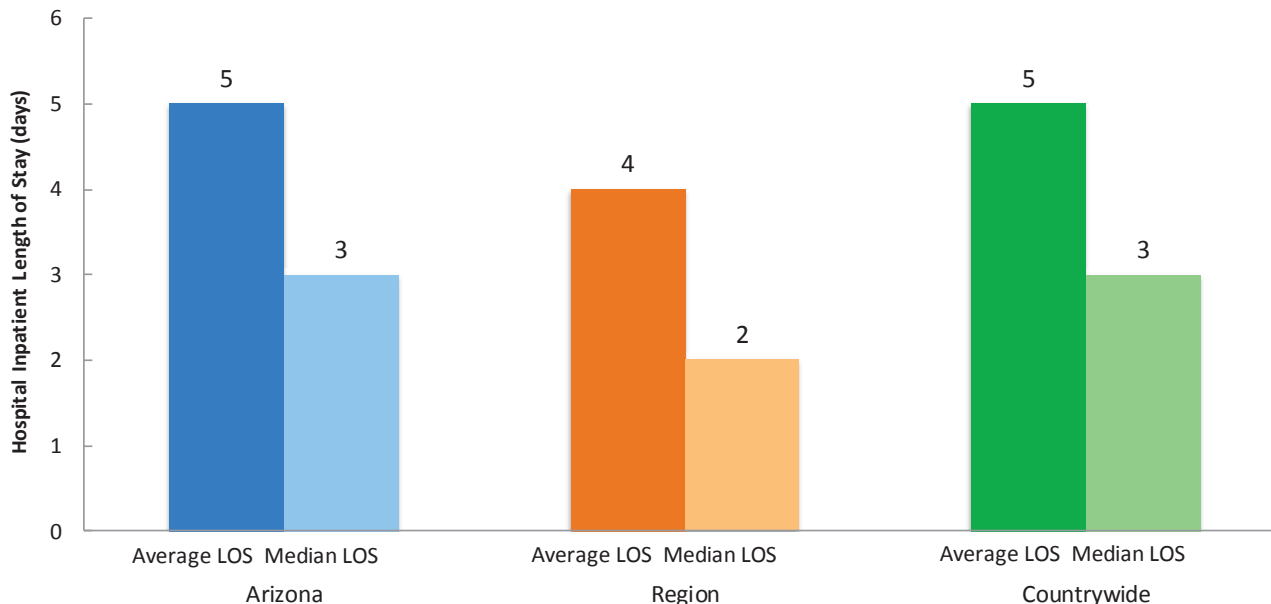
Chart 18 displays the average number of stays for hospital inpatient services per 1,000 active claims in 2016 for Arizona, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Chart 19 displays the average and median² length of stay (LOS) 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
Inpatient Length of Stay for Hospital Inpatient Services



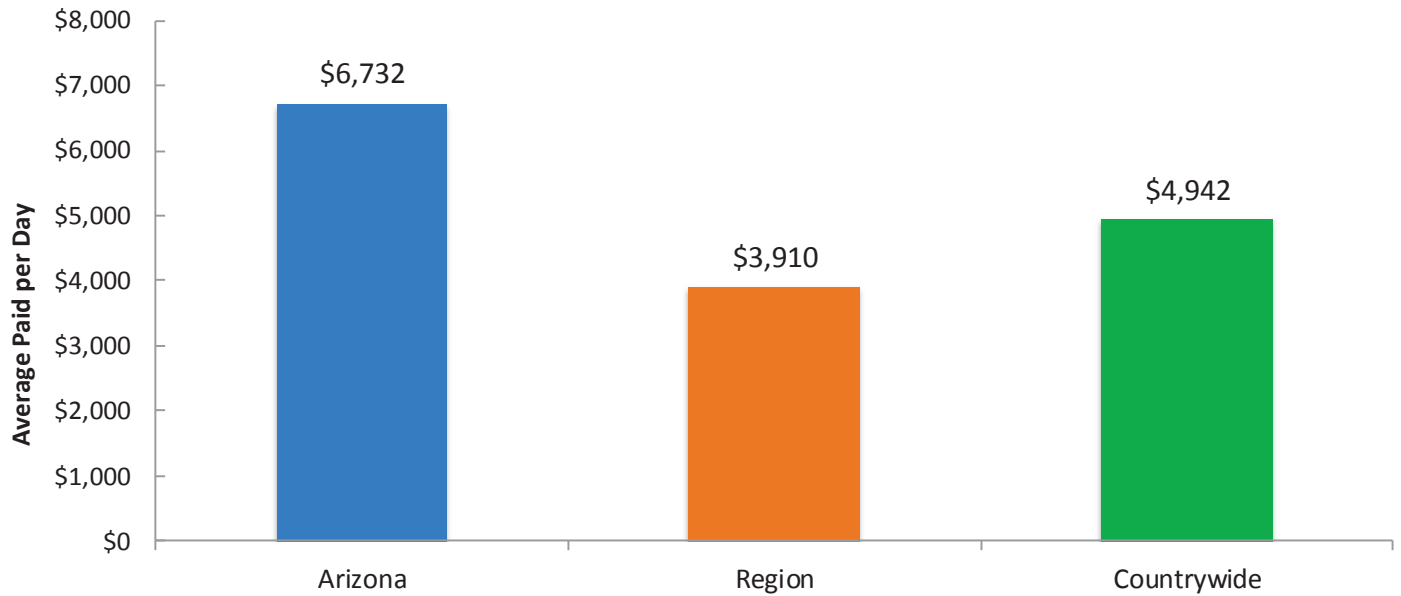
Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

² The median LOS is the LOS where one-half of all LOS values is higher and one-half is lower. This statistic is less affected by extremely low or extremely high values.

Chart 20 displays the average paid amount 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 20

Average Paid Amount per Day for Hospital Inpatient Services

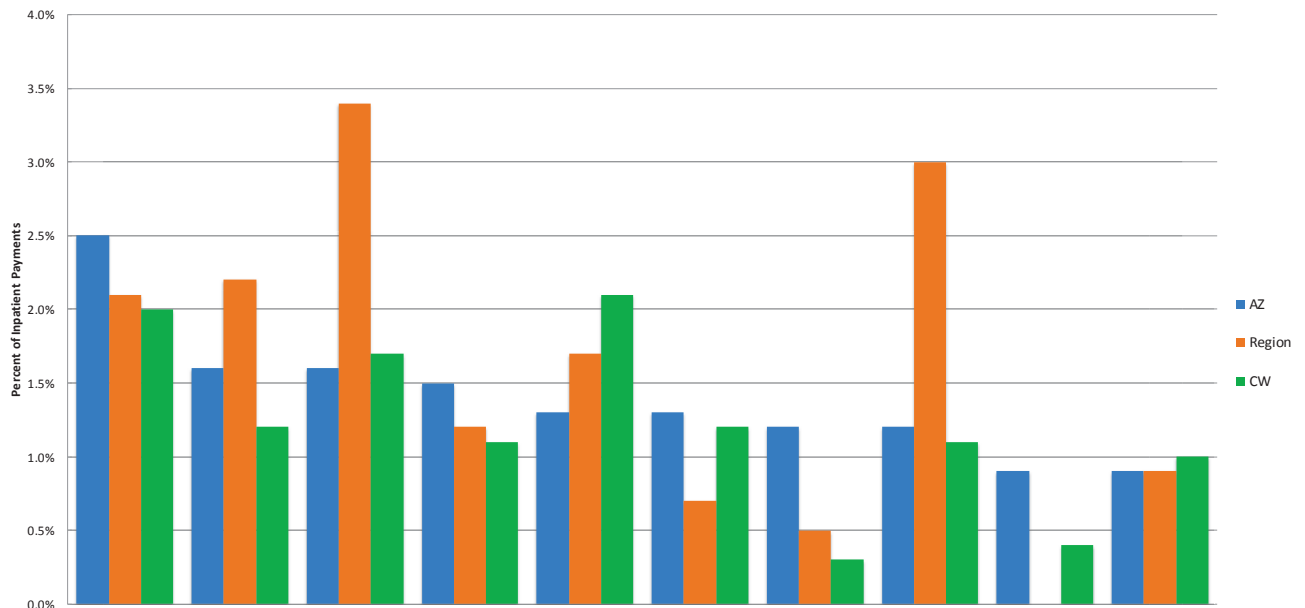


Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Charts 21 and 22 display the top 10 diagnoses and top 10 DRG codes for hospital inpatient services, revealing the most prevalent types of hospital inpatient stays. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the tables below the charts.

Chart 21

Top 10 Diagnoses by Amount Paid for Hospital Inpatient Services for Arizona



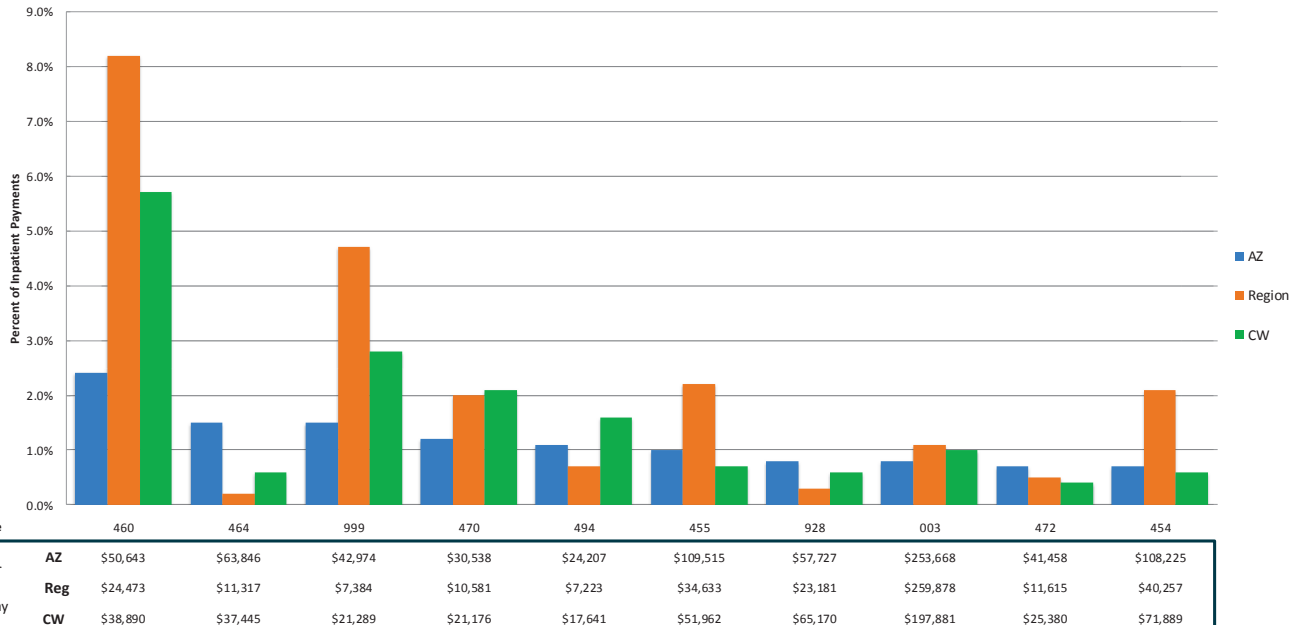
Diagnosis Code		M48.06	M51.16	M51.2	M17.9	Z51.89	A41.9	M47.26	M51.3	S06.890A	T81.4XXA
Median Payment per Hospital Inpatient Stay	AZ	\$31,329	\$43,350	\$29,216	\$22,422	\$14,763	\$23,261	\$57,354	\$53,814	\$31,711	\$21,273
	Reg	\$10,273	\$13,113	\$12,454	\$9,853	\$5,347	\$8,454	\$25,046	\$20,704	\$14,273	\$4,829
	CW	\$24,313	\$24,081	\$19,011	\$17,689	\$14,844	\$14,820	\$31,115	\$30,740	\$17,174	\$13,790

Source: NCCI Medical Data Call, Service Years 2015 and 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
M48.06	2.5%	Spinal stenosis, lumbar region
M51.16	1.6%	Intervertebral disc disorders with radiculopathy, lumbar region
M51.2	1.6%	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M17.9	1.5%	Osteoarthritis of knee, unspecified
Z51.89	1.3%	Encounter for other specified aftercare
A41.9	1.3%	Sepsis, unspecified organism
M47.26	1.2%	Other spondylosis with radiculopathy, lumbar region
M51.3	1.2%	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
S06.890A	0.9%	Other specified intracranial injury without loss of consciousness, initial encounter
T81.4XXA	0.9%	Infection following a procedure, initial encounter

Chart 22

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services for Arizona



Source: NCCI Medical Data Call, Service Years 2015 and 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
460	2.4%	Spinal fusion except cervical without major complications or comorbidities
464	1.5%	Wound debridement and skin graft except hand for musculo-connective tissue disorders with complications or comorbidities
999	1.5%	Ungroupable
470	1.2%	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
494	1.1%	Lower extremity and humerus procedures, except hip, foot, and femur, without complications or comorbidities/major complications or comorbidities
455	1.0%	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
928	0.8%	Full thickness burn with skin graft or inhalation injury with complications or comorbidities/major complications or comorbidities
003	0.8%	Extracorporeal membrane oxygenation (ECMO) or tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth, and neck with major operating room
472	0.7%	Cervical spinal fusion with complications or comorbidities
454	0.7%	Combined anterior/posterior spinal fusion with complications or comorbidities



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 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.

Due to these differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide, comparisons by procedure code for outpatient benefits should be interpreted with caution. 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. A surgical visit includes at least one surgical service, while a nonsurgical visit does not. A surgical service is defined as “major surgery” or “minor surgery” within the surgical category defined by the AMA. In this section, we provide measures of hospital outpatient payments that take into account the type of visit, since the level of reimbursement varies considerably by type of visit.

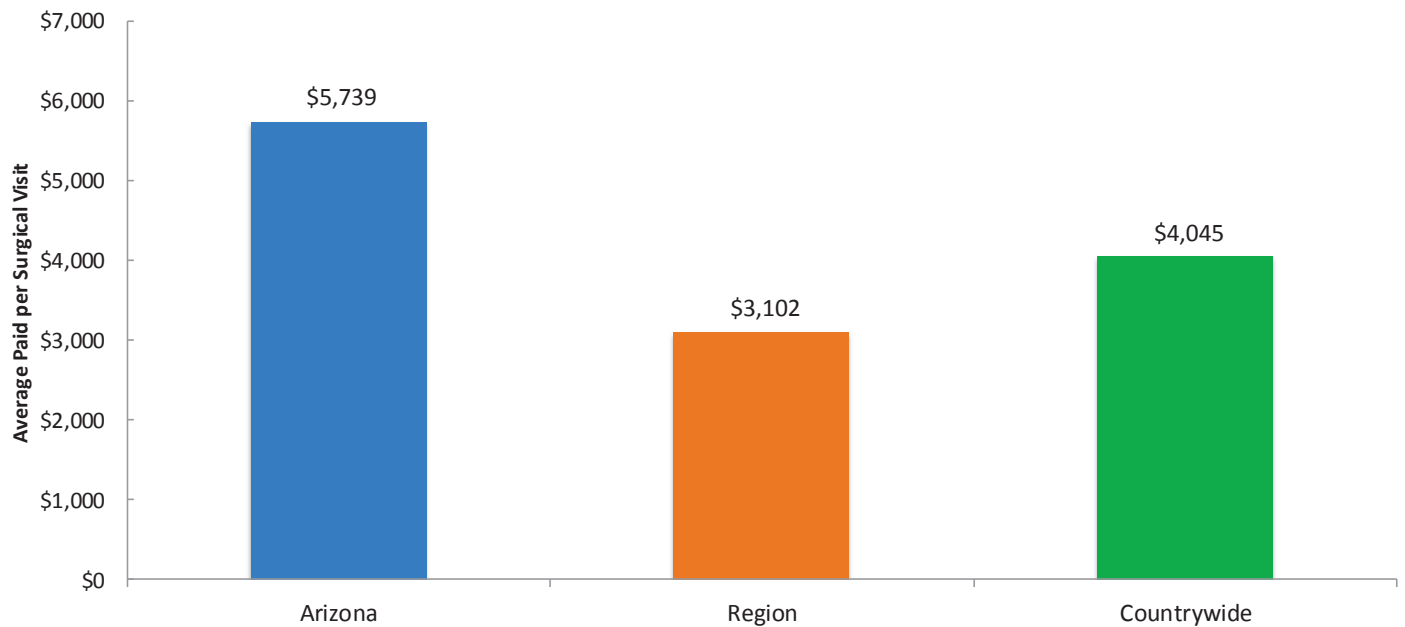
One measure of workers compensation hospital outpatient costs is a comparison of current payments to the Medicare rates. The table below shows the average percentage of Medicare schedule reimbursement amounts for hospital outpatient payments for Arizona, the region, and countrywide.

Medical Cost Category	AZ	Region	Countrywide
Hospital Outpatient	249%	136%	192%

Chart 23 displays the average paid amount per visit for hospital outpatient surgical services for Arizona, the region, and countrywide. Surgical services represent 49% of hospital outpatient payments in Arizona. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

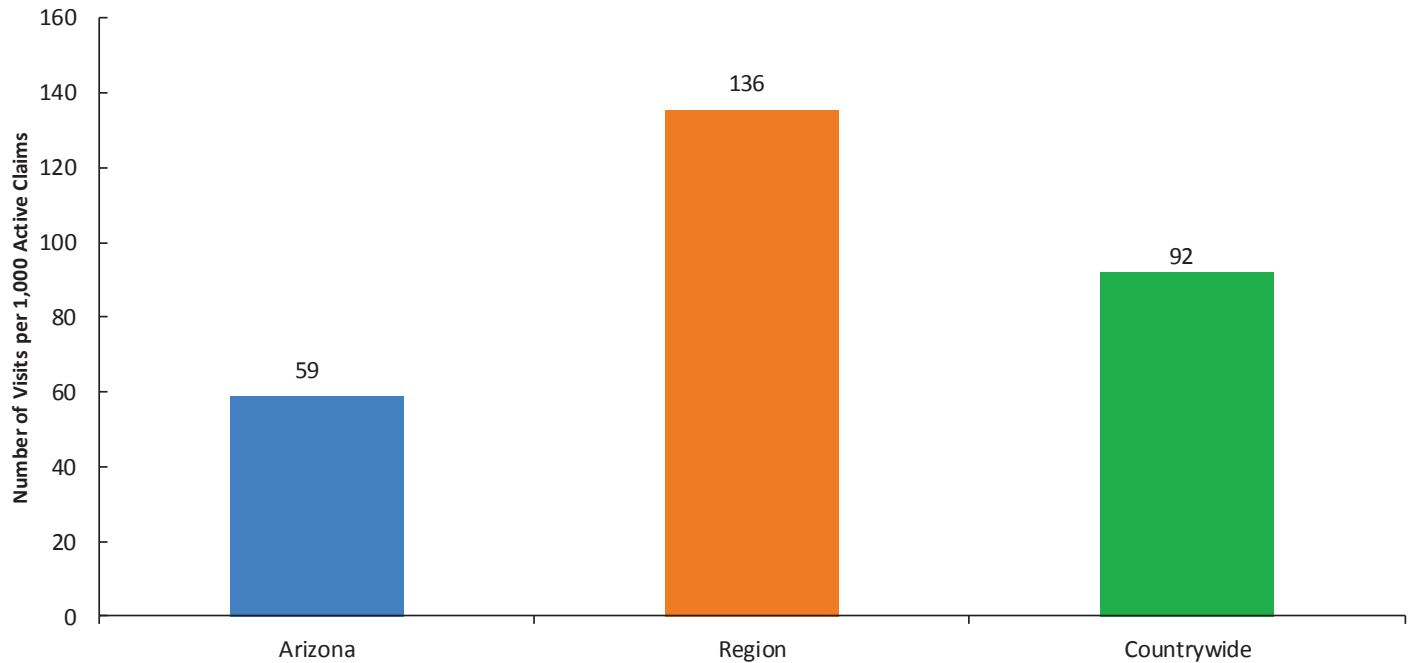
Chart 23

Average Paid Amount per Surgical Visit for Hospital Outpatient Services



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Chart 24 displays the number of visits per year per 1,000 active claims for hospital outpatient surgical services for Arizona, as well as the average visits per year per 1,000 active claims for 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.

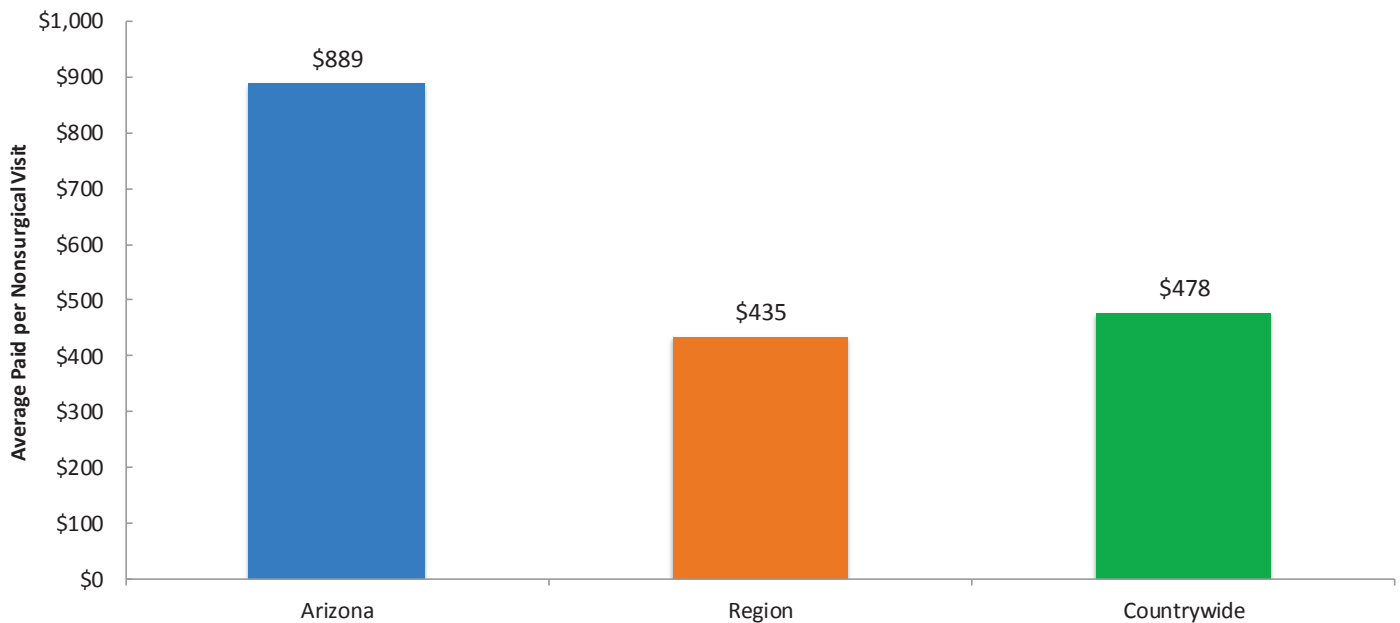
Chart 24**Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims**

Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Chart 25 displays the average paid amount per visit for hospital outpatient nonsurgical services (such as physical therapy) for Arizona, the region, and countrywide. Nonsurgical services represent 51% of hospital outpatient payments in Arizona. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 25

Average Paid Amount per Nonsurgical Visit for Hospital Outpatient Services

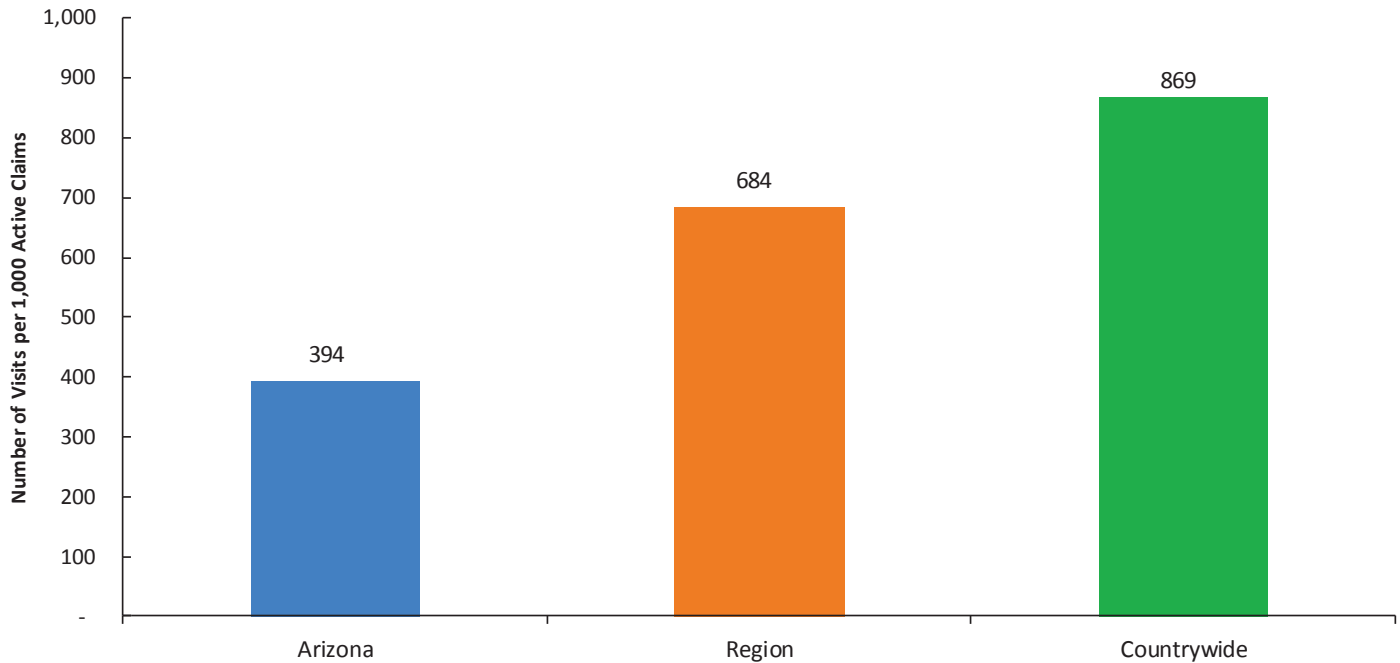


Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Chart 26 displays the number of visits per year per 1,000 active claims for hospital outpatient nonsurgical services for Arizona, as well as the average visits per year per 1,000 active claims for 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 26

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



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Chart 27 displays the average paid amount per visit for outpatient services in Arizona, the region, and countrywide for the top 10 diagnoses in Arizona. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the table below.

Chart 27
Top 10 Diagnoses by Amount Paid for Hospital Outpatient Services for Arizona

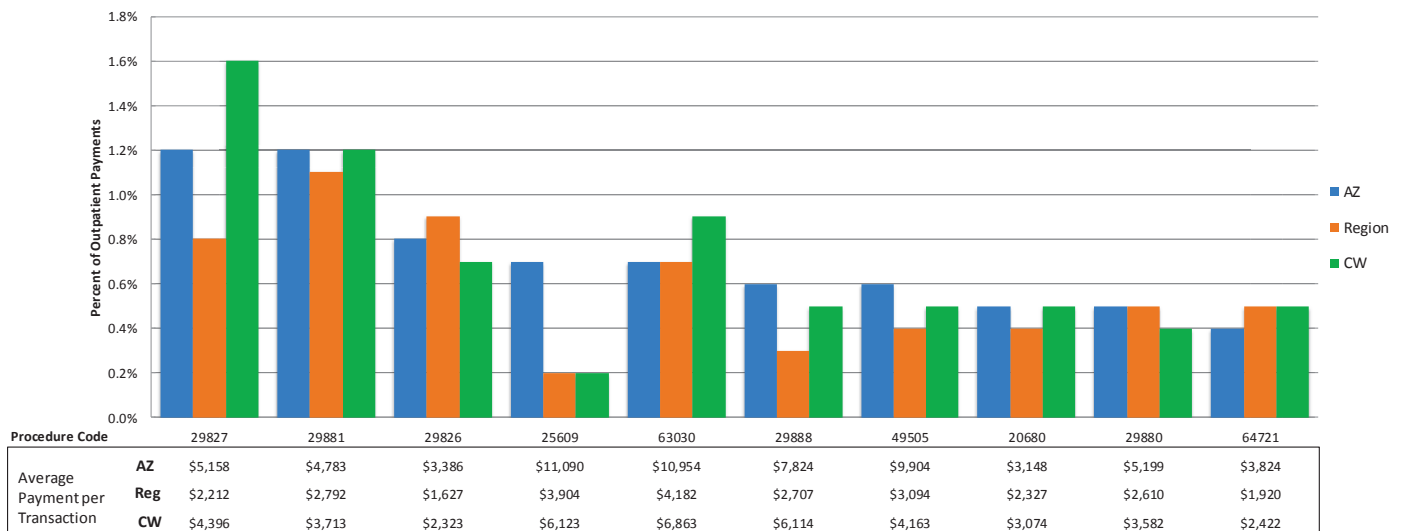

Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
S09.90XA	2.0%	Unspecified injury of head, initial encounter
M54.5	1.5%	Low back pain
K40.90	1.1%	Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
S16.1XXA	1.1%	Strain of muscle, fascia and tendon at neck level, initial encounter
T84.84XA	0.9%	Pain due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
S39.012A	0.9%	Strain of muscle, fascia and tendon of lower back, initial encounter
M51.16	0.8%	Intervertebral disc disorders with radiculopathy, lumbar region
S52.572A	0.7%	Other intraarticular fracture of lower end of left radius, initial encounter for closed fracture
M51.26	0.7%	Other intervertebral disc displacement, lumbar region
M75.101	0.6%	Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic

Charts 28 and 29 display the average paid amount per visit for outpatient services in Arizona, the region, and countrywide for the top 10 surgery CPT and nonsurgery CPT codes in Arizona. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the table below.

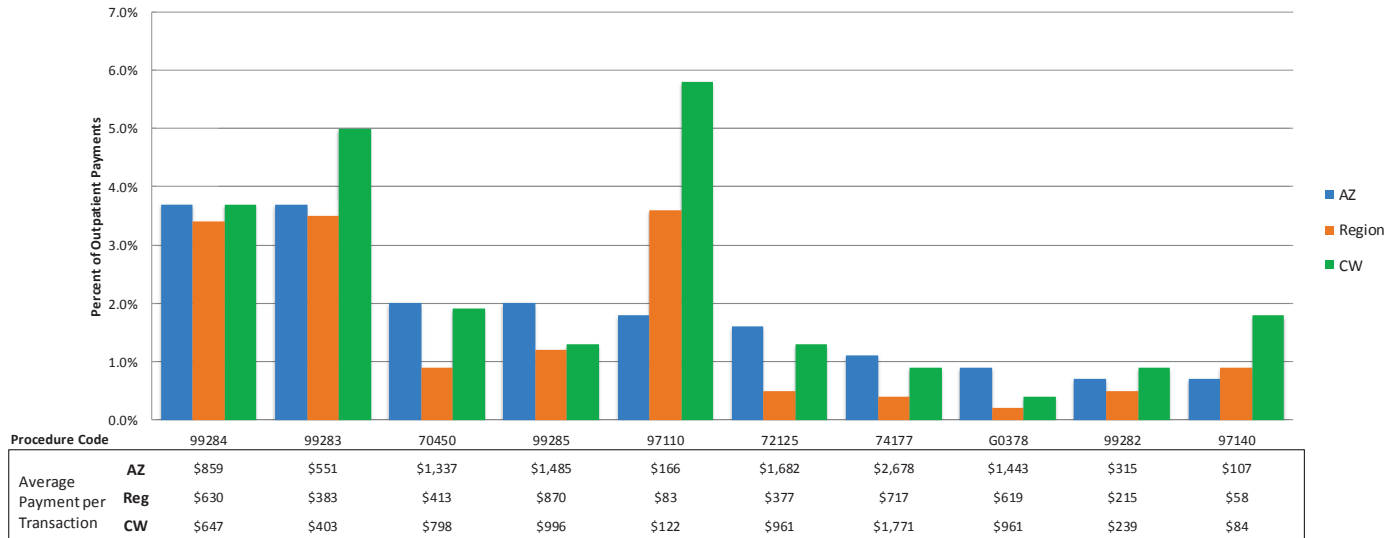
Chart 28

Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
29827	1.2%	Arthroscopy shoulder surgical; with rotator cuff repair
29881	1.2%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29826	0.8%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
25609	0.7%	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
63030	0.7%	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
29888	0.6%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
49505	0.6%	Repair initial inguinal hernia, age 5 years or older; reducible
20680	0.5%	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
29880	0.5%	Arthroscopy knee surgical; with meniscectomy (medial and lateral including any meniscal shaving) including debridement/shaving of articular cartilage
64721	0.4%	Neuroplasty and/or transposition; median nerve at carpal tunnel

Chart 29
Top 10 Nonsurgery Procedure Codes by Amount Paid for Hospital Outpatient Services for Arizona


Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

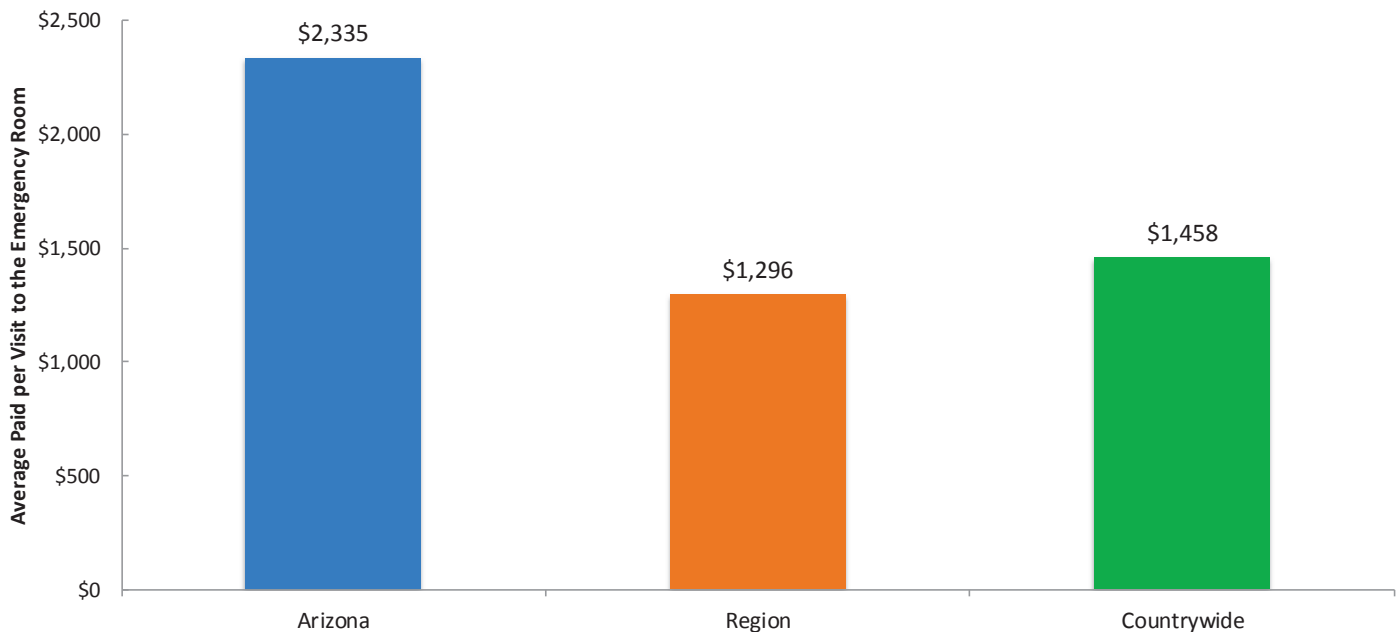
Code	% in AZ	Description
99284	3.7%	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99283	3.7%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
70450	2.0%	Computed tomography head or brain; without contrast material
99285	2.0%	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
97110	1.8%	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
72125	1.6%	Computed tomography (CT) cervical spine; without contrast material
74177	1.1%	Computed tomography, abdomen and pelvis; with contrast material(s)
G0378	0.9%	Hospital observation service, per hour
99282	0.7%	Emergency department visit. Usually the presenting problem(s) are of low to moderate severity.
97140	0.7%	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes

In Arizona, 20% of the payments associated with facilities (ASC, hospital outpatient, and hospital inpatient) are for emergency room payments, compared to 17% countrywide.

Chart 30 displays the average paid amount per visit for emergency room services for Arizona, the region, and countrywide. The average paid amount includes all payments for an emergency room visit such as payments for facility services, physician services, and drugs. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 30

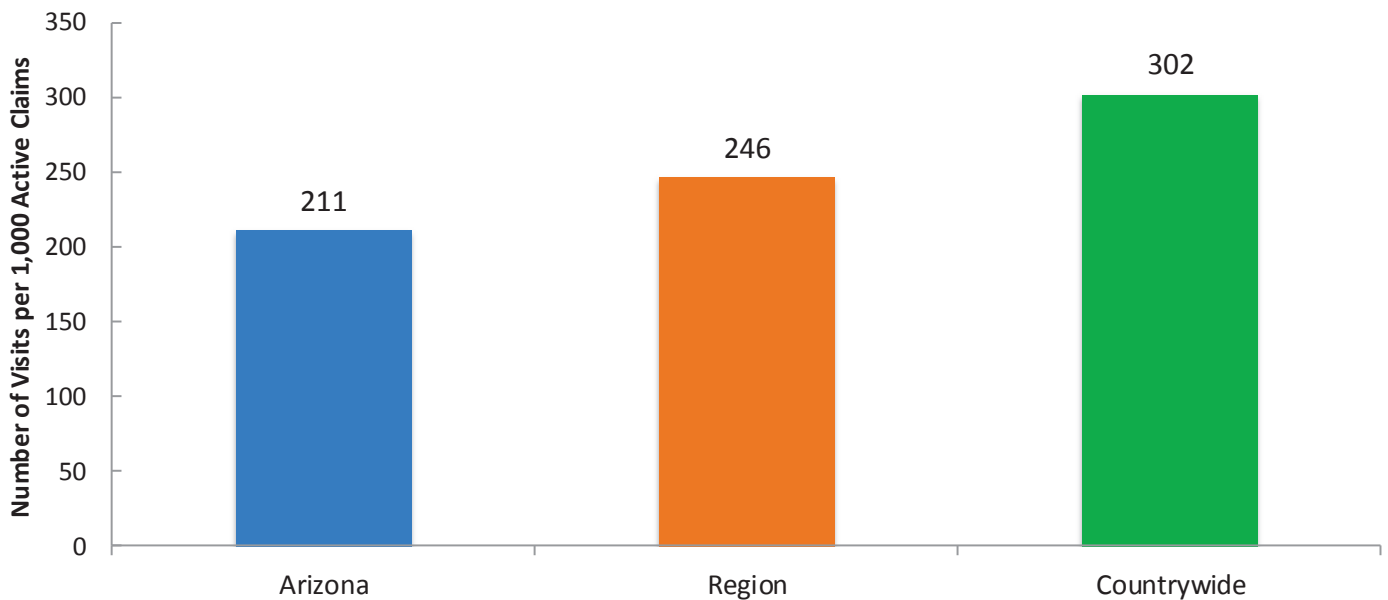
Average Amount Paid per Emergency Room Visit



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Chart 31 displays the number of visits per year per 1,000 active claims for emergency room services for Arizona, as well as the average visits per 1,000 active claims for 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 31
Average Number of Emergency Room Visits per 1,000 Active Claims

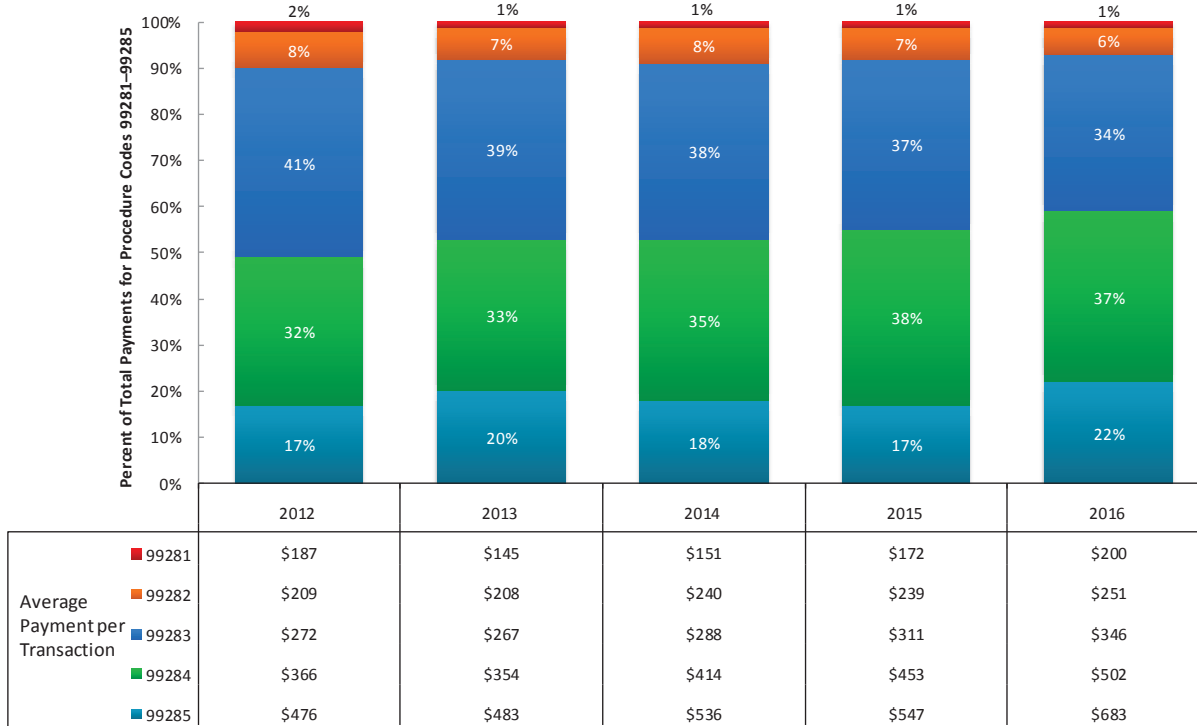


Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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. Chart 32 shows a five-year snapshot of experience for each procedure type and the average payment per transaction.

Chart 32

Emergency Room Payments by Procedure Code for Arizona



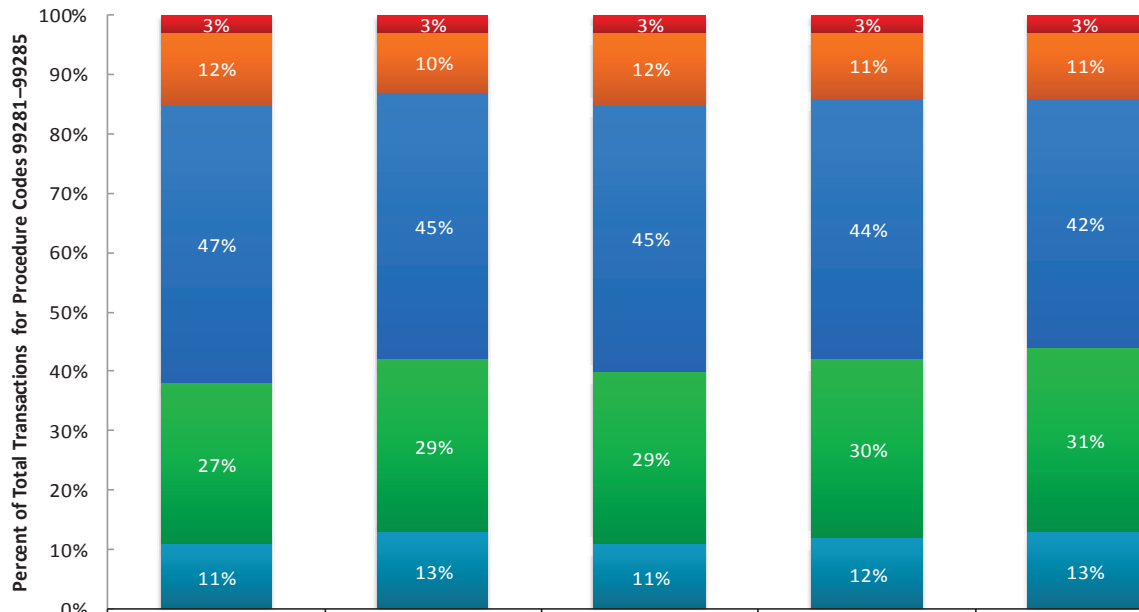
Source: NCCI Medical Data Call, Service Year 2016.

Code	Description
99281	Emergency department visit for the evaluation and management of a patient. Usually the presenting problem(s) are self limited or minor.
99282	Emergency department visit. Usually the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
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.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Chart 33 shows a five-year snapshot of experience for each procedure type and the number of transactions per service year.

Chart 33

Emergency Room Transactions by Procedure Code for Arizona



	2012	2013	2014	2015	2016
■ 99281 ■ 99282 ■ 99283 ■ 99284 ■ 99285	534	499	473	527	495
Total Transactions	2,297	7,974	7,705	8,027	7,061
	5,017	5,088	4,869	5,435	5,204
	1,986	2,209	1,941	2,115	2,254

Source: NCCI Medical Data Call, Service Year 2016.

Code	Description
99281	Emergency department visit for the evaluation and management of a patient. Usually the presenting problem(s) are self limited or minor.
99282	Emergency department visit. Usually the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
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.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.



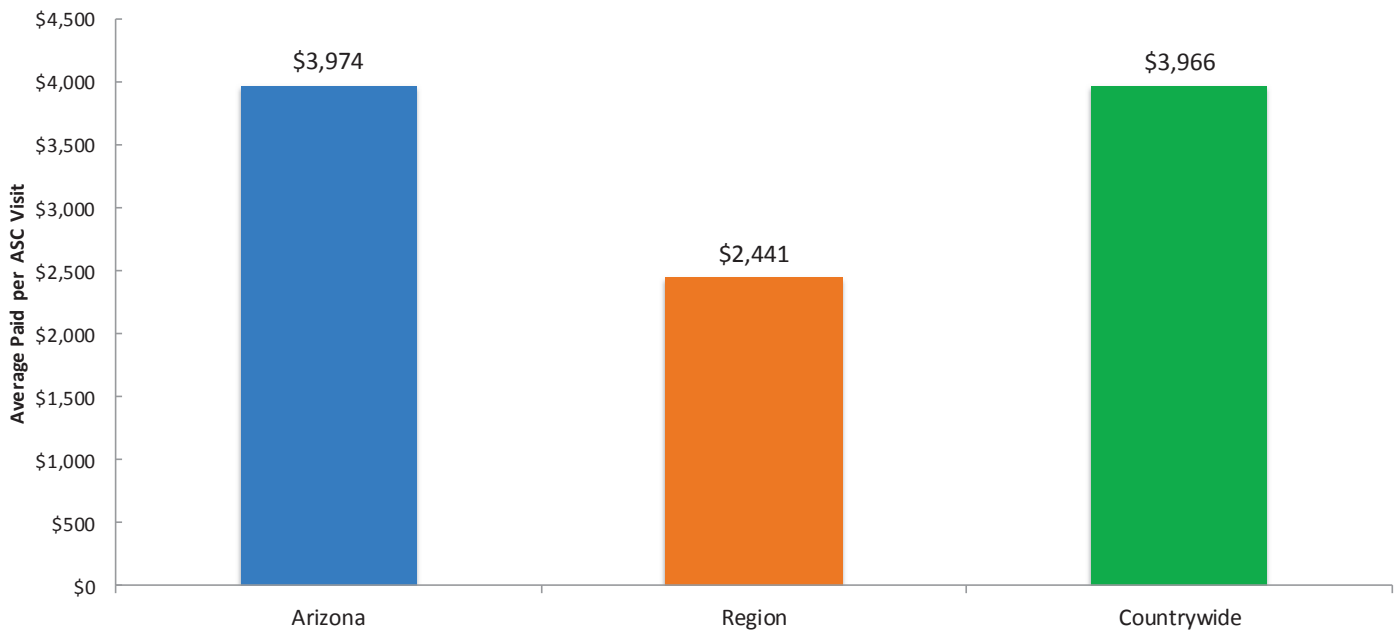
Ambulatory surgical centers (ASC) are often used as an alternative facility to hospitals for conducting outpatient surgeries. One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. The table below shows the average percentage of Medicare schedule reimbursement amounts for ASC payments for Arizona, the region, and countrywide.

Medical Cost Category	AZ	Region	Countrywide
Ambulatory Surgical Center	301%	203%	292%

Chart 34 displays the average paid amount per visit for ASC services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

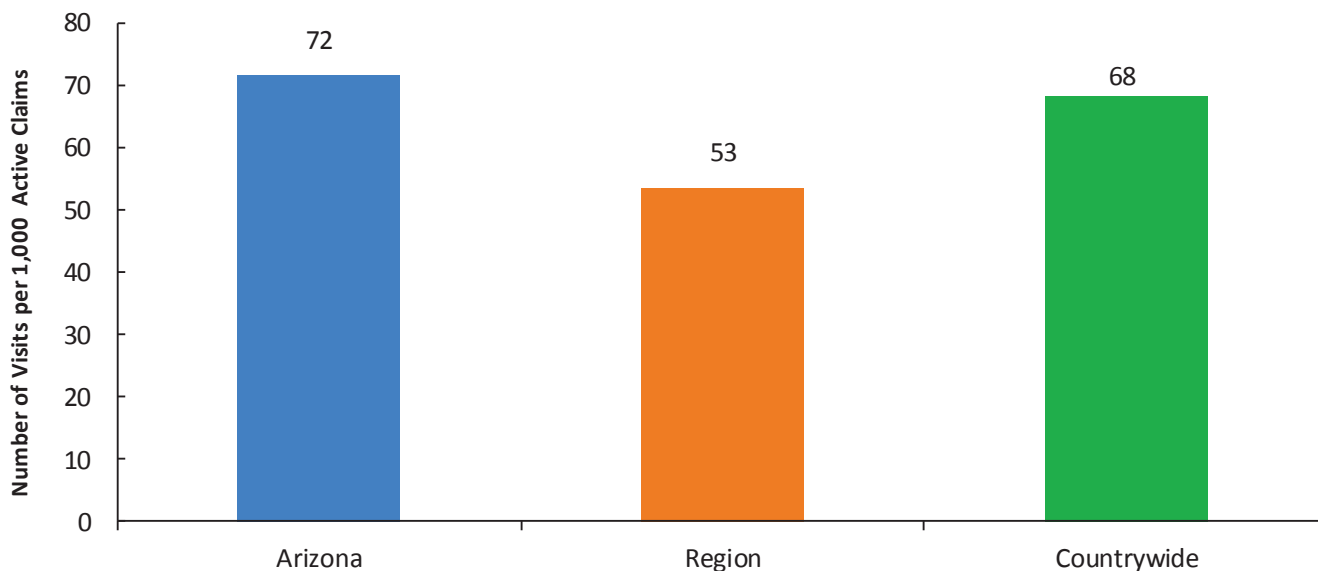
Chart 34

Average Amount Paid per Visit for ASC Services



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Chart 35 displays the number of ASC visits per year per 1,000 active claims for Arizona, as well as the average visits per 1,000 active claims for 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 35**Average Number of ASC Visits per 1,000 Active Claims**

Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.



Chart 36 displays the top 10 diagnoses for ASC visits. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the table below.

Chart 36

Top 10 Diagnoses by Amount Paid for ASC Services for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

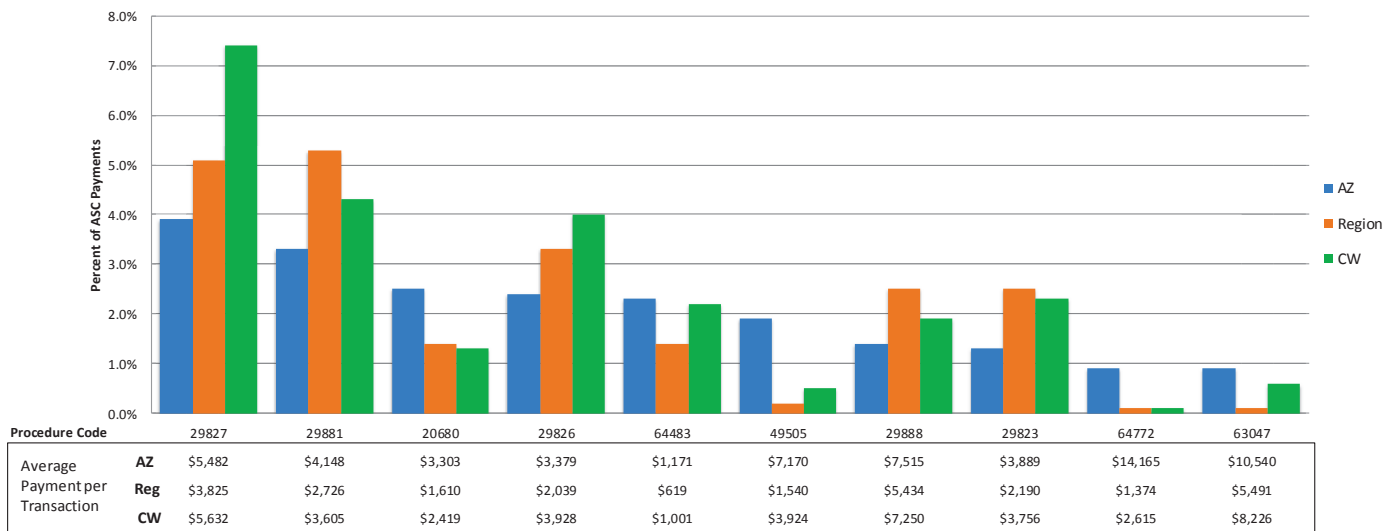
Code	% in AZ	Description
M54.16	3.5%	Radiculopathy, lumbar region
S46.011A	3.1%	Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter
K40.90	2.5%	Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
M47.816	2.4%	Spondylosis without myelopathy or radiculopathy, lumbar region
S46.012A	2.0%	Strain of muscle(s) and tendon(s) of the rotator cuff of left shoulder, initial encounter
M48.06	1.5%	Spinal stenosis, lumbar region
M54.5	1.3%	Low back pain
T14.90	1.3%	Injury, unspecified
M75.102	1.2%	Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic
M96.1	1.2%	Post laminectomy syndrome, not elsewhere classified

Typically, only surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes. The predominant revenue code reported for ASC services is code 0490—Ambulatory Surgical Care. In Arizona, code 0490 represents 95% of ASC payments reported by revenue codes.

Chart 37 displays the top 10 surgery CPT codes for ASC services. The procedure codes are ranked based on total payments in Arizona. A brief description of each procedure code is displayed in the table below.

Chart 37

Top 10 Surgery Procedure Codes by Amount Paid for ASC Services for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
29827	3.9%	Arthroscopy shoulder surgical; with rotator cuff repair
29881	3.3%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
20680	2.5%	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
29826	2.4%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
64483	2.3%	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
49505	1.9%	Repair initial inguinal hernia, age 5 years or older; reducible
29888	1.4%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29823	1.3%	Arthroscopy shoulder surgical; debridement extensive
64772	0.9%	Transection or avulsion of other spinal nerve, extradural
63047	0.9%	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root[s] [e.g., spinal or lateral recess stenosis]) single vertebral segment; lumbar



According to NCCI’s study, “Workers Compensation and Prescription Drugs: 2016 Update” (*Annual Issues Symposium*, May 2016), in 2014, the narcotics Oxycontin® and Oxycodone-Acetaminophen (commonly known as Percocet®) were among the most widely prescribed drugs in workers compensation.

Drugs are uniquely identified by a national drug code (NDC). Charts 38 through 43 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.

Chart 38 displays the shares of the payments of prescription medication for the top 10 workers compensation drugs and whether the drugs are generic (G) or brand name (B). This method of ranking shows which drugs have the highest percentage share of payments. Also included is the amount paid per unit (PPU). (See Glossary for the definition of *unit*.)

Chart 38
Top 10 Workers Compensation Drugs by Amount Paid for Arizona

Name of Drug	Type B/G	Category	% of Drug Payments	PPU Arizona	PPU Region	PPU Countrywide
Oxycontin®	B	Analgesics/Antipyretics	7.3%	\$9.25	\$8.12	\$8.43
Lyrica®	B	Miscellaneous Central Nervous System Agents	5.9%	\$6.27	\$6.13	\$6.24
Gabapentin	G	Anticonvulsants	3.8%	\$1.36	\$1.31	\$1.20
Oxycodone HCl	G	Analgesics/Antipyretics	3.1%	\$1.38	\$1.42	\$1.27
Celecoxib	G	Analgesics/Antipyretics	3.1%	\$5.27	\$5.36	\$5.14
Tramadol HCl	G	Analgesics/Antipyretics	3.1%	\$1.41	\$0.79	\$1.16
Duloxetine HCl	G	Psychotherapeutic Agents	2.7%	\$5.82	\$5.24	\$5.28
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	2.7%	\$1.65	\$2.05	\$1.76
Meloxicam	G	Analgesics/Antipyretics	2.4%	\$3.25	\$2.94	\$3.29
Lidocaine	G	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	2.2%	\$6.82	\$6.51	\$7.01

Top 10 Workers Compensation Drugs by Amount Paid for Countrywide

Name of Drug	Type B/G	Category	% of Drug Payments	PPU Arizona	PPU Region	PPU Countrywide
Lyrica®	B	Miscellaneous Central Nervous System Agents	7.0%	\$6.27	\$6.13	\$6.24
Oxycontin®	B	Analgesics/Antipyretics	4.4%	\$9.25	\$8.12	\$8.43
Gabapentin	G	Anticonvulsants	4.2%	\$1.36	\$1.31	\$1.20
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	3.7%	\$1.65	\$2.05	\$1.76
Meloxicam	G	Analgesics/Antipyretics	3.4%	\$3.25	\$2.94	\$3.29
Duloxetine HCl	G	Psychotherapeutic Agents	2.8%	\$5.82	\$5.24	\$5.28
Tramadol HCl	G	Analgesics/Antipyretics	2.7%	\$1.41	\$0.79	\$1.16
Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	2.5%	\$0.60	\$0.60	\$0.58
Lidocaine	G	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	2.3%	\$6.82	\$6.51	\$7.01
Celecoxib	G	Analgesics/Antipyretics	2.3%	\$5.27	\$5.36	\$5.14

Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.



Chart 39 displays the top 10 workers compensation drugs according to the number of prescriptions. This chart reveals the most frequently prescribed drugs and the amount PPU.

The results in this chart are based only on payments reported with an NDC.

Chart 39

Top 10 Workers Compensation Drugs by Prescription Counts for Arizona

Name of Drug	Type B/G	Category	% of Drug Prescriptions	PPU Arizona	PPU Region	PPU Countrywide
Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	7.2%	\$0.60	\$0.60	\$0.58
Tramadol HCl	G	Analgesics/Antipyretics	4.7%	\$1.41	\$0.79	\$1.16
Ibuprofen	G	Analgesics/Antipyretics	4.5%	\$0.33	\$0.46	\$0.45
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	4.3%	\$1.65	\$2.05	\$1.76
Cyclobenzaprine HCl	G	Muscle Relaxants, Skeletal	4.2%	\$1.12	\$0.92	\$1.30
Gabapentin	G	Anticonvulsants	4.1%	\$1.36	\$1.31	\$1.20
Oxycodone HCl	G	Analgesics/Antipyretics	4.1%	\$1.38	\$1.42	\$1.27
Naproxen	G	Analgesics/Antipyretics	2.6%	\$0.96	\$0.89	\$0.96
Meloxicam	G	Analgesics/Antipyretics	2.6%	\$3.25	\$2.94	\$3.29
Ibu®	B	Analgesics/Antipyretics	2.3%	\$0.31	\$0.25	\$0.29

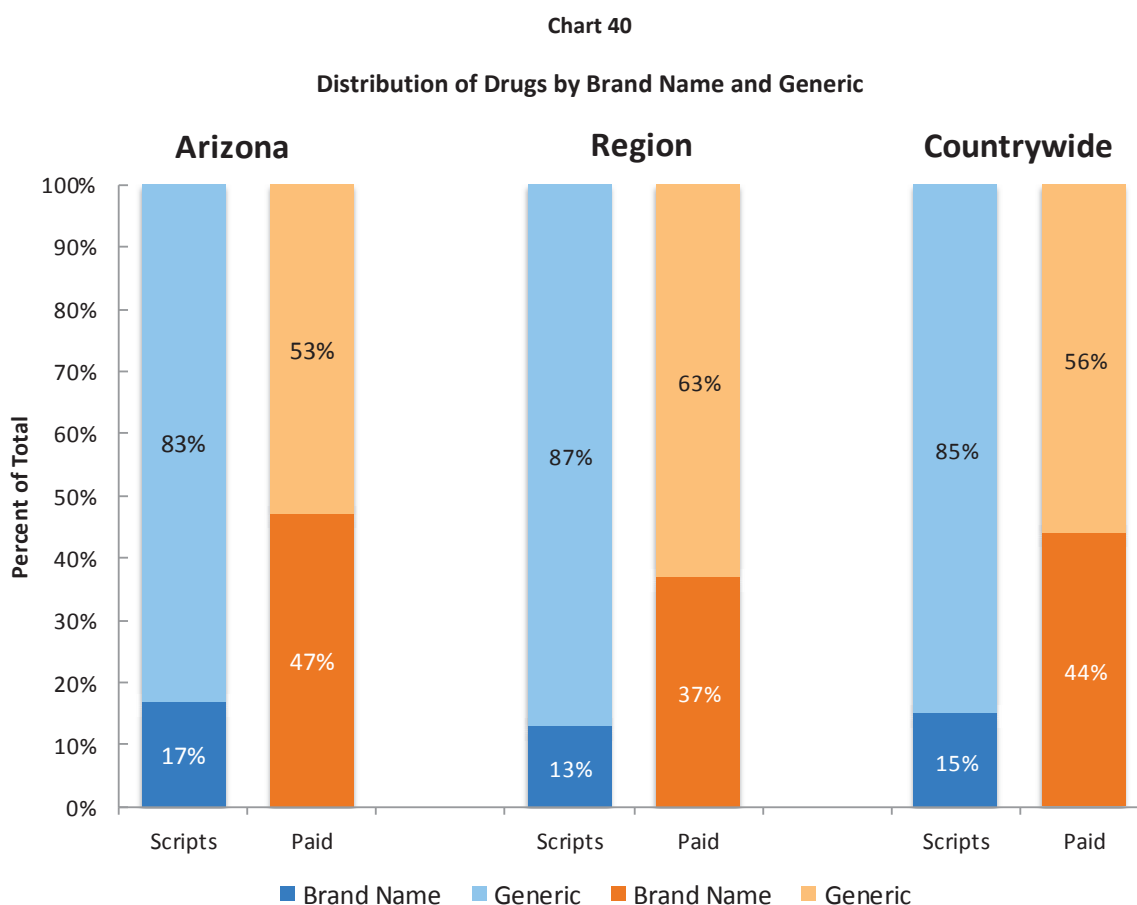
Top 10 Workers Compensation Drugs by Prescription Counts for Countrywide

Name of Drug	Type B/G	Category	% of Drug Prescriptions	PPU Arizona	PPU Region	PPU Countrywide
Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	9.7%	\$0.60	\$0.60	\$0.58
Tramadol HCl	G	Analgesics/Antipyretics	5.1%	\$1.41	\$0.79	\$1.16
Cyclobenzaprine HCl	G	Muscle Relaxants, Skeletal	5.0%	\$1.12	\$0.92	\$1.30
Gabapentin	G	Anticonvulsants	4.9%	\$1.36	\$1.31	\$1.20
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	4.7%	\$1.65	\$2.05	\$1.76
Meloxicam	G	Analgesics/Antipyretics	3.9%	\$3.25	\$2.94	\$3.29
Ibuprofen	G	Analgesics/Antipyretics	3.5%	\$0.33	\$0.46	\$0.45
Oxycodone HCl	G	Analgesics/Antipyretics	2.8%	\$1.38	\$1.42	\$1.27
Naproxen	G	Analgesics/Antipyretics	2.7%	\$0.96	\$0.89	\$0.96
Lyrica®	B	Miscellaneous Central Nervous System Agents	2.2%	\$6.27	\$6.13	\$6.24

Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

According to NCCI’s study, “Workers Compensation and Prescription Drugs: 2016 Update” (*Annual Issues Symposium*, May 2016), brand-name drug prices increased by 14% in 2014 while utilization was down 18%, resulting in a 7% decrease in brand-name drug payments.

Chart 40 shows the distribution of prescription drugs by brand name and generics for Arizona, the region, and the countrywide average. The share between brand name and generics 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 several states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand-name and generic drugs. The results in this chart are based only on transactions reported with an NDC.



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

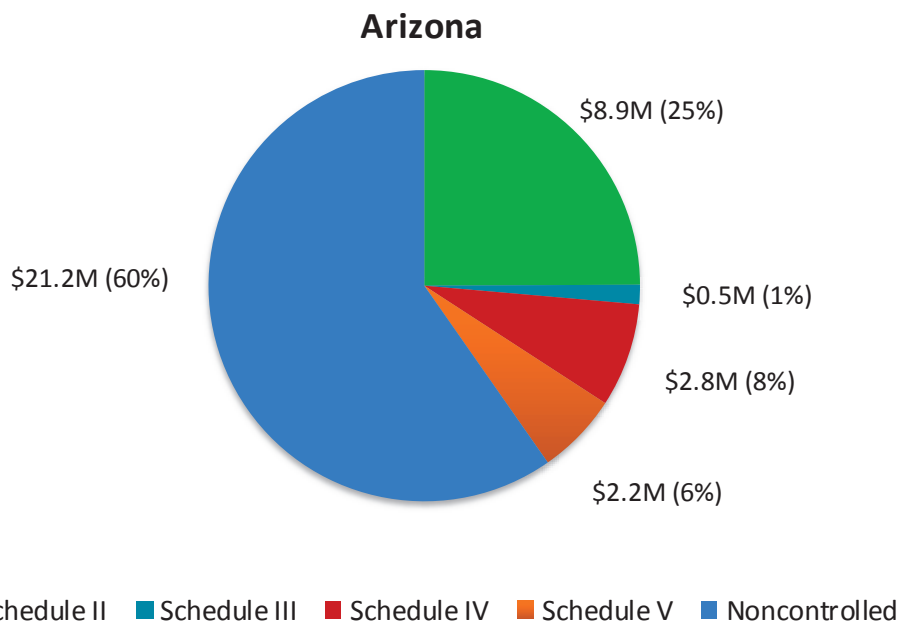
The Controlled Substance Act (CSA) was passed in 1970 to regulate the manufacture, distribution, possession, and use of certain drugs. There are five schedules, or groups, determined by varying qualifications, such as the drug’s medical uses, if any, and its potential for abuse. For example, Schedule V drugs have the lowest potential for abuse, while Schedule I drugs are illegal, mainly because they have no known medical uses.

The share of claims observed in Service Year 2016 with at least one controlled substance in Arizona is 19%. This compares to the region and countrywide shares of 24% and 16% respectively.

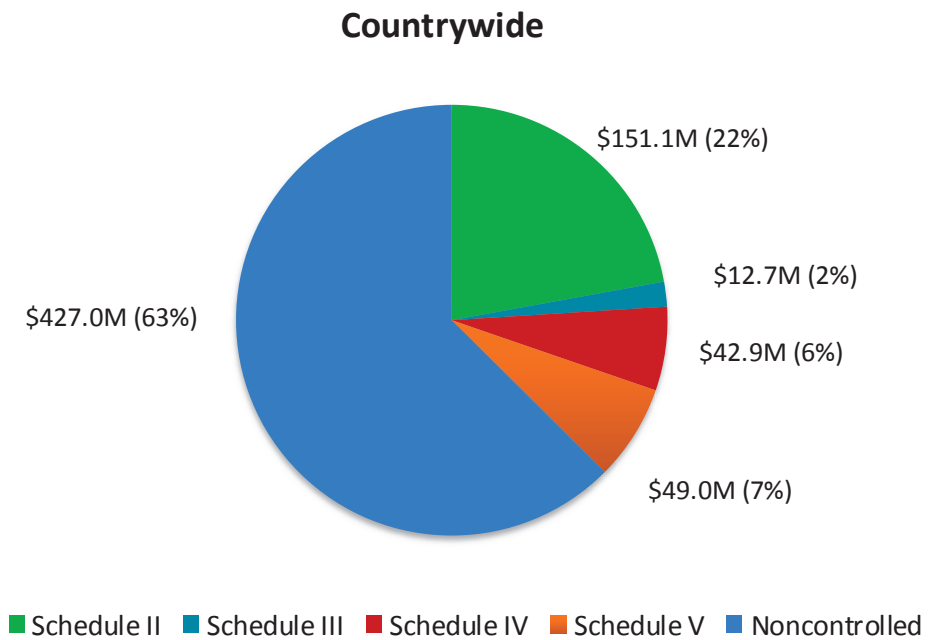
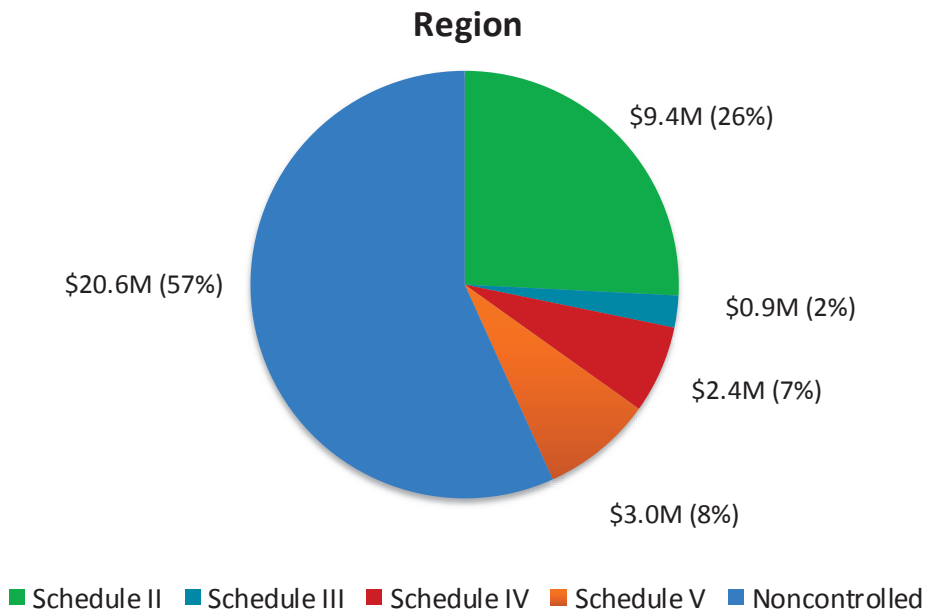
According to NCCI’s study, “Workers Compensation and Prescription Drugs: 2016 Update” (*Annual Issues Symposium*, May 2016), controlled substance prices increased 16% in 2014 while utilization was down 7%, resulting in an 8% increase in controlled substance payments countrywide. In 2016, Arizona spent \$9.4M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 41 shows the distribution of prescription drug payments in Arizona by CSA schedule (paid amounts shown in millions of dollars). The distributions for the region and countrywide are also shown.

Chart 41
Distribution of Prescription Drug Payments by CSA Schedule



Distribution of Prescription Drug Payments by CSA Schedule (cont'd)



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

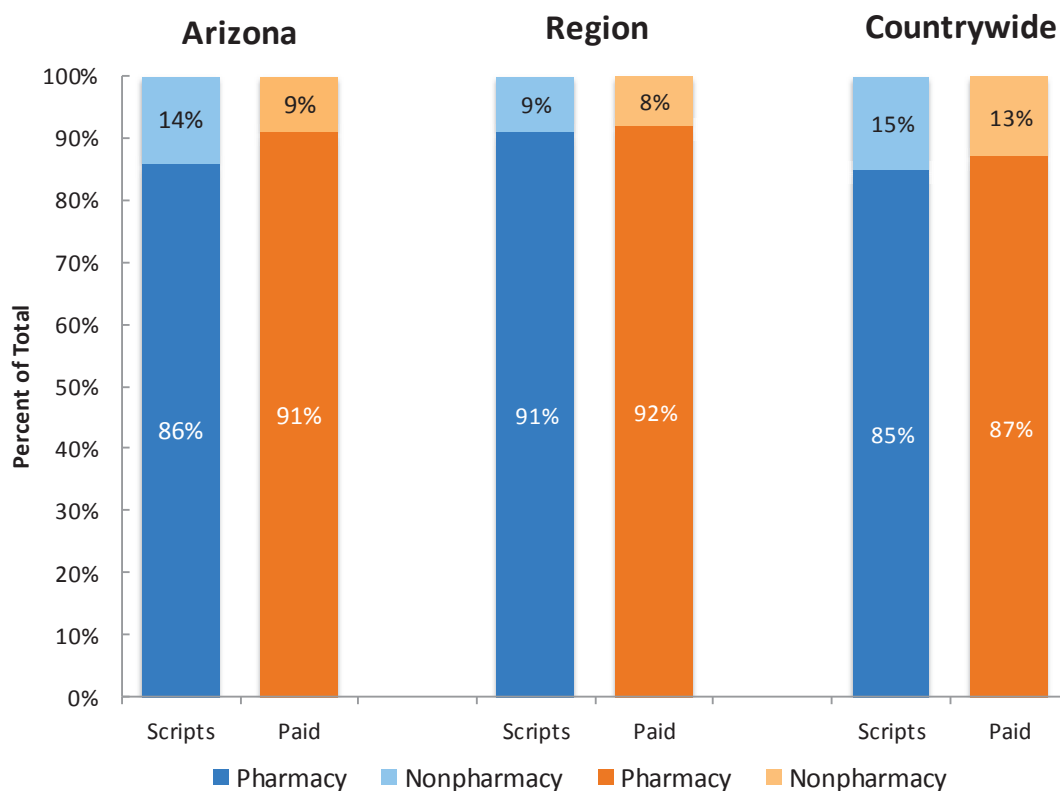
The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states place limits or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight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

According to NCCI’s study, “Workers Compensation and Prescription Drugs: 2016 Update” (*Annual Issues Symposium*, May 2016), physician-dispensed prescription drug prices and utilization increased 4% each in 2014, resulting in an 8% increase in physician-dispensed prescription drug payments countrywide.

Chart 42 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 the countrywide average. The results in this chart are based only on transactions reported with an NDC.

Chart 42

Distribution of Drugs by Pharmacy and Nonpharmacy by Scripts and Amount Paid



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

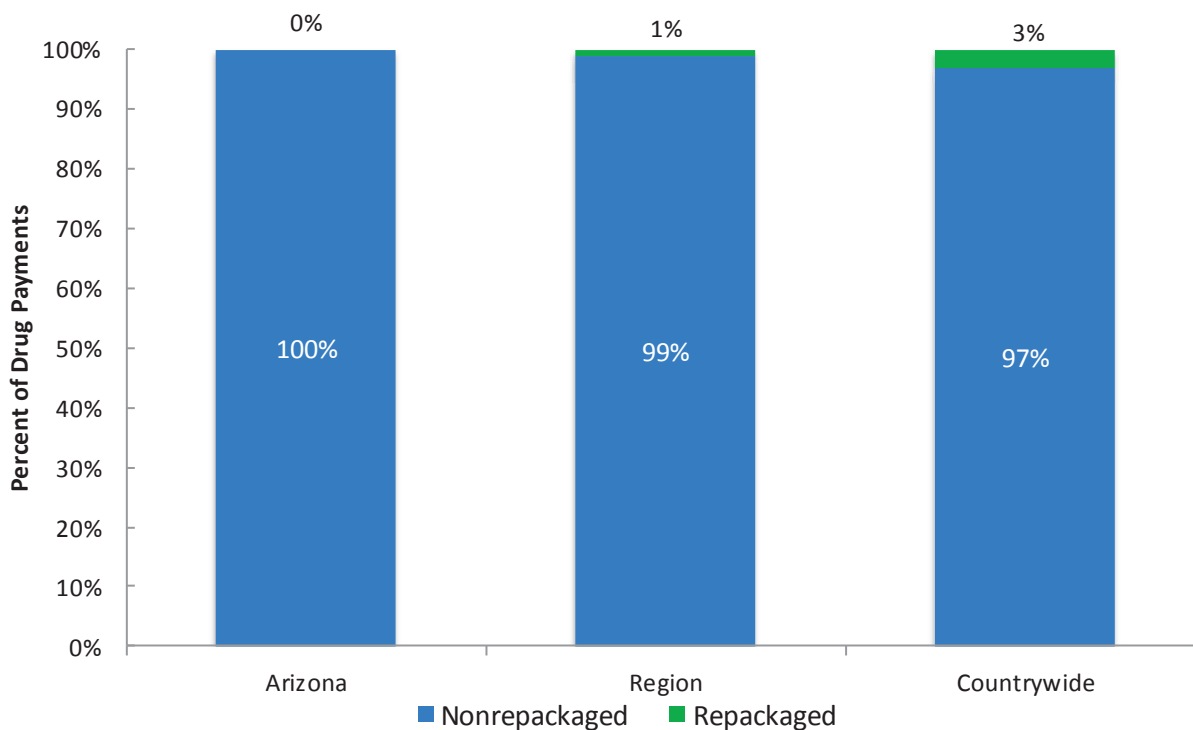
NDCs are specific not only to the product (including strength and formulation) and the package size but also to the labeler. Labelers are manufacturers, repackagers, and distributors.

Workers compensation drug fee schedules are typically based on Average Wholesale Price (AWP). Because each NDC comes with a unique AWP, any firm that repackages a drug can set both a new NDC and a new, possibly higher, AWP. As a result, workers compensation costs for repackaged drugs had grown out of proportion to the number of prescriptions written for repackaged drugs. Repackaged drugs now represent a small portion of overall drug payments because several states have implemented regulation on their reimbursement.

Chart 43 shows the distribution of payments for repackaged and nonrepackaged drugs. The results in this chart are based only on payments reported with an NDC.

Chart 43

Distribution of Drug Payments by Repackaged and Nonrepackaged



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Chart 44 displays the distribution of payments among three separate categories:

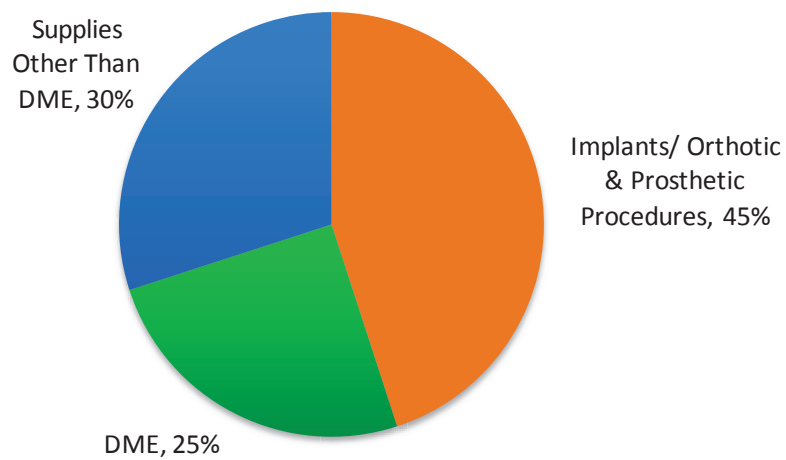
- Implants/Orthotic and Prosthetic Procedures
- Durable Medical Equipment (DME)
- Supplies Other Than DME

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 44

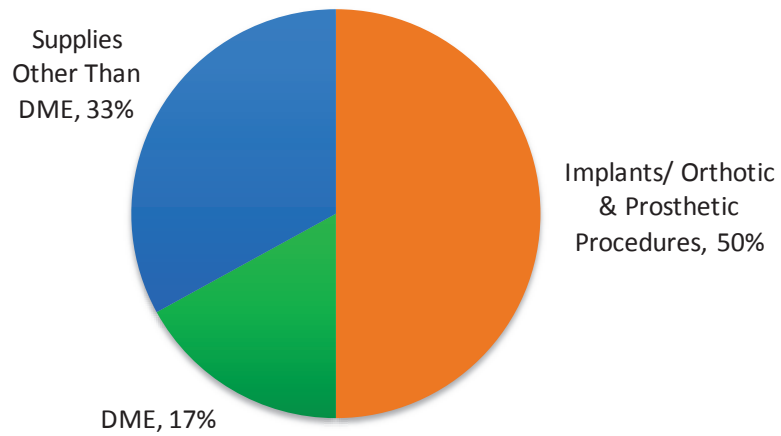
Distribution of Payments by DME, Supplies, and Implants

Arizona

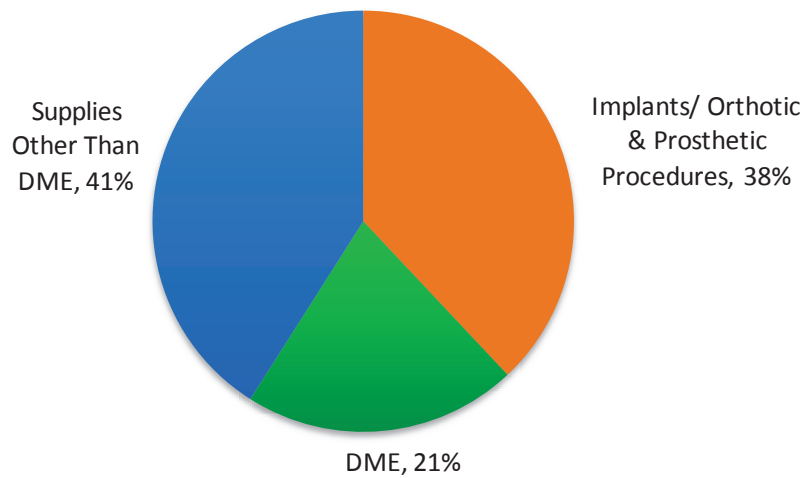


Distribution of Payments by DME, Supplies, and Implants (cont'd)

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

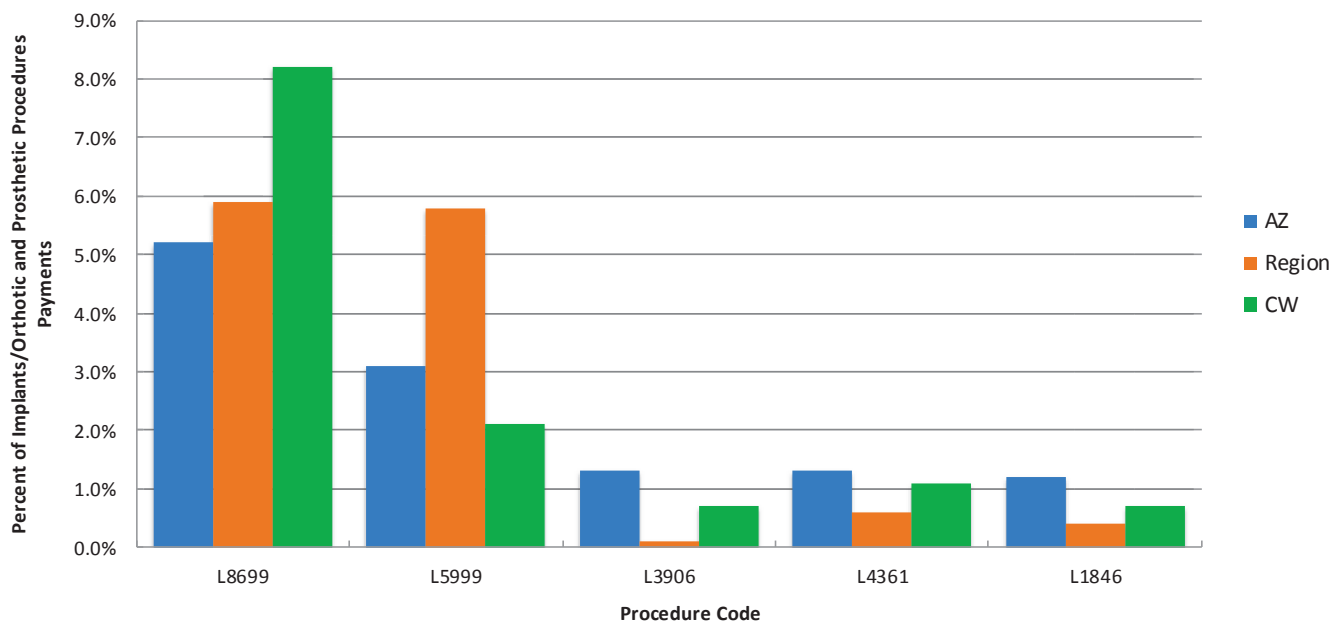
The most prevalent procedure code types reported for Implants/Orthotic and Prosthetic Procedures are HCPCS codes and revenue codes. Revenue codes represent 61% of Implants/Orthotic and Prosthetic Procedures payments, while HCPCS codes represent 39%.

The predominant revenue code reported for Implants/Orthotic and Prosthetic Procedures is code 0278— Medical/Surgical Supplies: Other implants. In Arizona, payments for code 0278 represent 60% of Implants/Orthotic and Prosthetic Procedures payments.

Chart 45 displays the top five HCPCS codes for Implants/Orthotic and Prosthetic Procedures. The procedure codes are ranked based on total payments in Arizona. A brief description of each HCPCS code is displayed in the table below.

Chart 45

Top Five Implants/Orthotic and Prosthetic Procedures Codes by Amount Paid for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

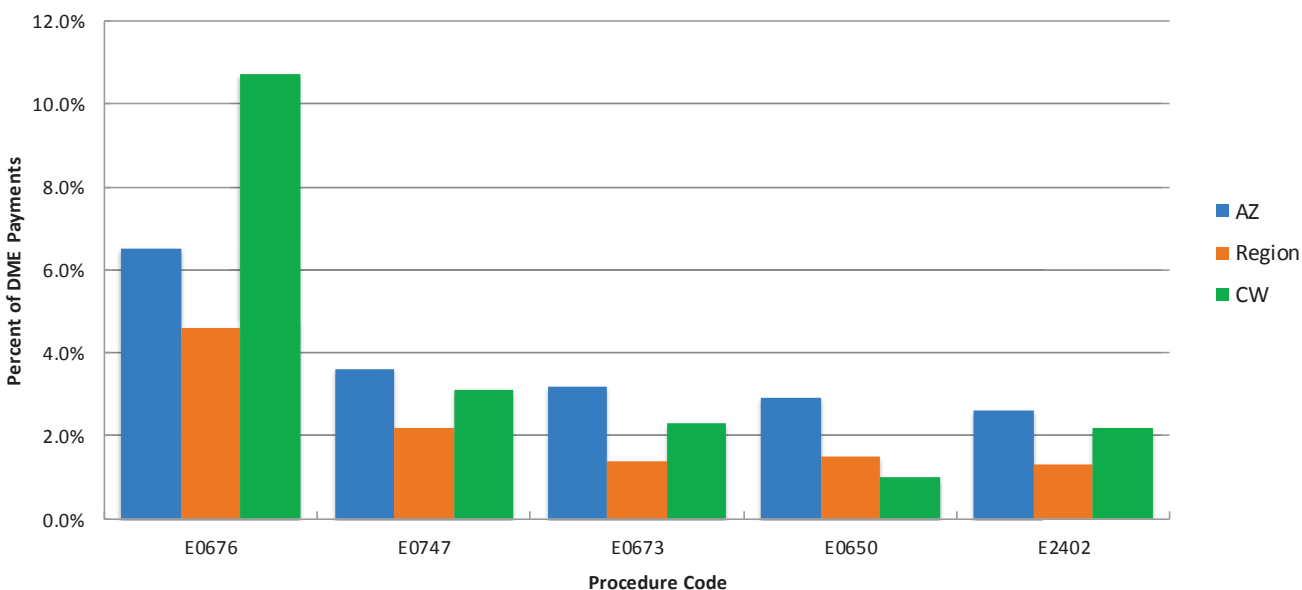
Code	% in AZ	Description
L8699	5.2%	Prosthetic implant, not otherwise specified
L5999	3.1%	Lower extremity prosthesis, not otherwise specified
L3906	1.3%	Wrist-hand orthosis (WHO), without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment
L4361	1.3%	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf
L1846	1.2%	Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated

The most prevalent procedure code types reported for DMEs are HCPCS codes. The predominant HCPCS code reported for DMEs is E1399—Durable Medical Equipment, Miscellaneous. In Arizona, code E1399 represents 53% of DME payments.

Chart 46 displays the top five procedure codes for DME other than code E1399. The procedure codes are ranked based on total payments in Arizona. A brief description of each procedure code is displayed in the table below.

Chart 46

Top Five DME Codes by Amount Paid for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

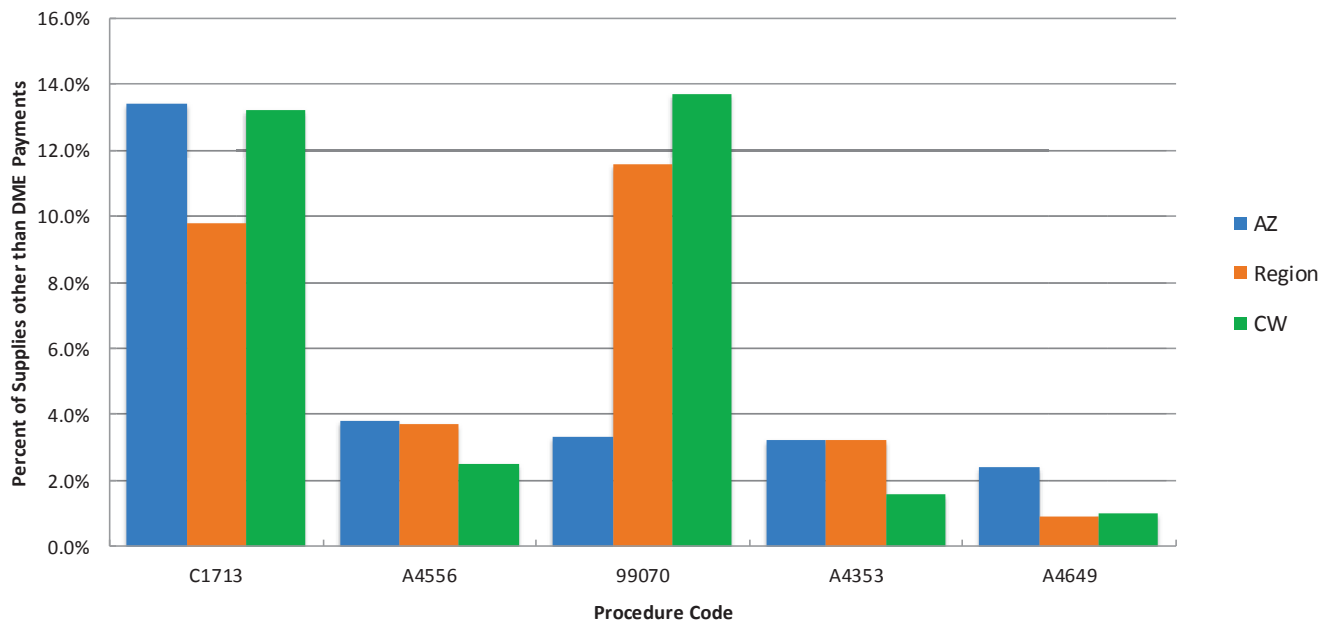
Code	% in AZ	Description
E0676	6.5%	Intermittent limb compression device (includes all accessories), not otherwise specified
E0747	3.6%	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
E0673	3.2%	Segmental gradient pressure pneumatic appliance, half leg
E0650	2.9%	Pneumatic compressor, nonsegmental home model
E2402	2.6%	Negative pressure wound therapy electrical pump, stationary or portable

The most prevalent procedure code types reported for Supplies other than DME are HCPCS codes and revenue codes. HCPCS codes represent 52% of Supplies other than DME payments, while revenue and other codes represent the other 48%.

Chart 47 displays the top five procedure codes for Supplies other than DME. The procedure codes are ranked based on total payments in Arizona. A brief description of each procedure code is displayed in the table below.

Chart 47

Top Five Supplies other than DME Codes by Amount Paid for Arizona



Source: NCCI Medical Data Call, Service Year 2016. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
C1713	13.4%	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
A4556	3.8%	Electrodes (e.g., apnea monitor), per pair
99070	3.3%	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered
A4353	3.2%	Intermittent urinary catheter, with insertion supplies
A4649	2.4%	Surgical supply; miscellaneous

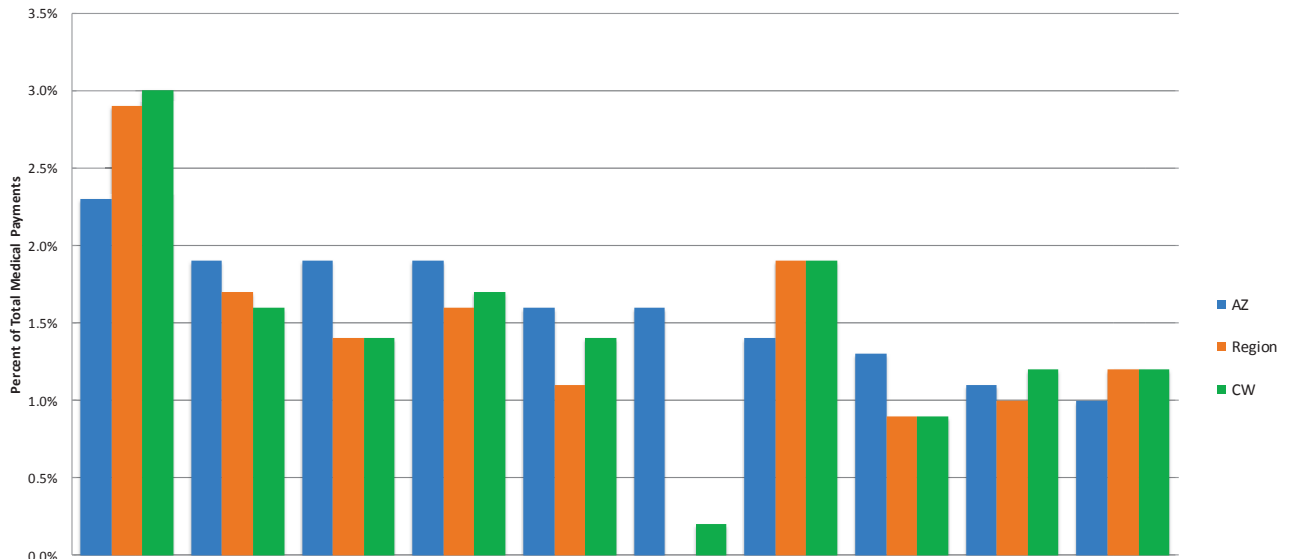


Chart 48 displays the top 10 diagnoses, identified by the ICD-10 (International Classification of Diseases) codes. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 diagnosis codes are ranked by total claim payments for Arizona. This method of ranking shows which diagnostic codes have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2015, and December 31, 2015, and they include all reported services provided for those claims through December 31, 2016. As these claims mature, the mix of ICD-10 codes may change, thus impacting the percentage share of payments for a specific code over time. This mix may also affect how costs per code in Arizona compare to countrywide costs. The state, region, and countrywide average payments per claim are also displayed for each diagnostic code. A brief description of each diagnostic code is displayed in the table below the chart.

Chart 48

Top 10 ICD-10 Codes by Amount Paid for Dates of Injury in 2015 for Arizona



Diagnosis Code	AZ	Reg	CW
M54.5	\$2,564	\$1,605	\$6,123
S33.5XXA	\$3,073	\$1,365	\$3,631
S62	\$2,453	\$4,963	\$2,562
T14.90	\$780	\$685	\$812
S61.209A	\$66,999	\$1,257	\$7,247
T21	\$17,161	\$11,745	\$18,185
S43.429A	\$9,934	\$5,478	\$8,231
K40.90	\$3,597	\$2,861	\$3,550
M54.2	\$2,790	\$2,431	\$2,753
M25.519			

Source: NCCI Medical Data Call, Dates of Injury in 2015. Region includes NM and OK. Countrywide includes data for 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, UT, VA, VT, WI, and WV.

Code	% in AZ	Description
M54.5	2.3%	Low back pain
S33.5XXA	1.9%	Sprain of ligaments of lumbar spine, initial encounter
S62	1.9%	Fracture at wrist and hand level
T14.90	1.9%	Injury, unspecified
S61.209A	1.6%	Unspecified open wound of unspecified finger without damage to nail, initial encounter
T21	1.6%	Burn and corrosion of trunk
S43.429A	1.4%	Sprain of unspecified rotator cuff capsule, initial encounter
K40.90	1.3%	Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
M54.2	1.1%	Cervicalgia
M25.519	1.0%	Pain in unspecified shoulder

Comparison of Selected Results by Service Year

The tables in this section provide a comparison of results for Arizona for the latest five service years. 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. The oldest data available from the Medical Data Call is for Service Year 2011 because this is the first full service year of data since the inception of the Call.

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 for Arizona (Chart 4)

Medical Category	2012	2013	2014	2015	2016
Physician	32%	34%	32%	33%	33%
Hospital Outpatient	13%	13%	14%	14%	15%
Hospital Inpatient	16%	15%	14%	16%	15%
ASC	5%	5%	6%	6%	7%
Drugs	14%	13%	14%	14%	13%
DME, Supplies, and Implants	10%	9%	8%	8%	8%
Other	10%	11%	12%	9%	9%

Distribution of Physician Payments by AMA Service Category for Arizona (Chart 5)

AMA Service Category	2012	2013	2014	2015	2016
Anesthesia	4%	4%	3%	3%	3%
Surgery	23%	23%	22%	21%	20%
Radiology	10%	10%	10%	9%	9%
Pathology	3%	4%	3%	3%	3%
Physical Medicine	29%	27%	30%	32%	31%
General Medicine	5%	6%	4%	4%	4%
Evaluation and Management	24%	24%	26%	25%	27%
Other	2%	2%	2%	3%	3%

**Hospital Inpatient Statistics for Arizona (Charts 17 and 18)**

Hospital Inpatient Statistics	2012	2013	2014	2015	2016
Average Payment Per Stay	\$26,356	\$26,480	\$29,173	\$33,887	\$36,499
Number of Stays per 1,000 Active Claims	23	23	20	20	18

Distribution of Hospital Outpatient Payments by Surgery and Nonsurgery for Arizona

Visit Type	2012	2013	2014	2015	2016
Surgery	45%	45%	46%	48%	49%
Nonsurgery	55%	55%	54%	52%	51%

Hospital Outpatient Surgery Statistics for Arizona (Charts 23 and 24)

Hospital Outpatient Surgery Statistics	2012	2013	2014	2015	2016
Average Payment Per Visit	\$3,840	\$3,989	\$4,654	\$5,134	\$5,739
Number of Visits per 1,000 Active Claims	66	65	61	62	59

Hospital Outpatient Nonsurgery Statistics for Arizona (Charts 25 and 26)

Hospital Outpatient Nonsurgery Statistics	2012	2013	2014	2015	2016
Average Payment Per Visit	\$701	\$732	\$785	\$839	\$889
Number of Visits per 1,000 Active Claims	442	429	420	410	394

Emergency Room Statistics for Arizona (Charts 30 and 31)

Emergency Room Statistics	2012	2013	2014	2015	2016
Average Payment Per Visit	\$1,826	\$2,045	\$2,035	\$2,201	\$2,335
Number of Visits per 1,000 Active Claims	233	220	211	220	211

**ASC Statistics for Arizona (Charts 34 and 35)**

ASC Statistics	2012	2013	2014	2015	2016
Average Payment Per Visit	\$3,047	\$3,182	\$3,385	\$3,748	\$3,974
Number of Visits per 1,000 Active Claims	69	72	72	74	72

Distribution of Drug Payments by Brand Name and Generic for Arizona (Chart 40)

Type of Drug	2012	2013	2014	2015	2016
Brand Name	53%	52%	48%	44%	47%
Generic	47%	48%	52%	56%	53%

Distribution of Drug Payments by Pharmacy and Nonpharmacy for Arizona (Chart 42)

Type of Provider	2012	2013	2014	2015	2016
Pharmacy	92%	92%	92%	91%	91%
Nonpharmacy	8%	8%	8%	9%	9%

Distribution of Drug Payments by Repackaged and Nonrepackaged for Arizona (Chart 43)

Type of Drug	2012	2013	2014	2015	2016
Repackaged	1%	1%	1%	0%	0%
Nonrepackaged	99%	99%	99%	100%	100%

Distribution of Payments by DME, Supplies, and Implants for Arizona (Chart 44)

Category	2012	2013	2014	2015	2016
Implants/Orthotic and Prosthetic Procedures	40%	40%	44%	45%	45%
DME	28%	30%	26%	24%	25%
Supplies Other Than DME	32%	30%	30%	31%	30%



Glossary

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 generally has a separate fee schedule.

Controlled Substance: Drugs that are regulated by the Controlled Substance 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 Procedure 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 Related Groups (DRG): A system of hospital payment classification 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). Also included are data for revenue codes, the Healthcare Common Procedure Code 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 Room Services: Services performed in a hospital for patients requiring immediate attention.

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 Procedure Terminology (CPT) procedures.

Inpatient Hospital 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).

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

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

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.

Outpatient Hospital 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).



(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.

Surgery Visit: A visit in which at least one surgery procedure is performed based on the reported procedure code.

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.

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* represents 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 (e.g., milliliters, grams, 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 represents medical transactions for Service Year 2016 (medical services delivered from January 1, 2016, to December 31, 2016), except where otherwise noted. Insurance carriers must report paid medical transactions if they write at least 1% of the market share in any one state for which NCCI is the advisory organization. Once a carrier meets the eligibility criteria, the carrier will be required to report for all applicable states in which it writes, even if an individual state's market share is below the threshold. All carriers within a group are required to report, regardless of whether they write less than 1% of the market share in the state.

The data 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.

For the state of Arizona in Service Year 2016, the reported number of transactions was more than 1,730,000, with more than \$328,595,400 paid, for more than 70,400 claims, representing data from 94% of the workers compensation premium written, which includes experience for large-deductible policies. Lump-sum settlements are not required to be reported. Also, self-insured data is not included.

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

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, medical bill review vendors, etc. 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 using 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.