Medical Data Report

For the state of

ARIZONA

September 2018

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

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

Introduction

Medical costs have 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 the pricing of proposed state legislation, assessing impacts of changes to medical fee schedules, and conducting research.

This publication is a data source for regulators and others who are interested in the driving forces behind 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 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.

Unless otherwise noted, the source for all data in this report is NCCI's Medical Data Call, Service Year 2017. Region includes data from the following states: AK, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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

Table of Contents

Medical Cost Statistics 5
Medical Share of Total Benefit Costs by Accident Year 5
Overall Medical Average Cost per Lost Time Claim (in 000s) 6
Percentage of Medical Paid by Claim Maturity 7
Distribution of Medical Payments for Arizona 8
Physicians 9
Physician Payments as a Percentage of Medicare 9
Distribution of Medical Payments for Physicians 10
Distribution of Physician Payments by AMA Service Category for Arizona 11
Top 10 Surgery Procedure Codes by Amount Paid 13
Top 10 Surgery Procedure Codes by Transaction Counts 14
Top 10 Radiology Procedure Codes by Amount Paid 15
Top 10 Radiology Procedure Codes by Transaction Counts 16
Average Amount Paid per Transaction by Modifier Code for Arizona 17
Top 10 Physical and General Medicine Procedure Codes by Amount Paid 18
Top 10 Physical and General Medicine Procedure Codes by Transaction Counts 19
Top 10 Evaluation and Management Procedure Codes by Amount Paid 20
Top 10 Evaluation and Management Procedure Codes by Transaction Counts 21
Office or Other Outpatient Visit for the Evaluation and Management of a New Patient for Arizona 22
Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient for Arizona 23
Time Until First Treatment for Major Surgery (in Days) 24
Time Until First Treatment for Radiology (in Days) 24
Time Until First Treatment for Physical and General Medicine (in Days) 25
Time Until First Treatment for Initial Evaluation and Management Visit (in Days) 25
Hospital Inpatient 26
Hospital Inpatient Payments as a Percentage of Medicare 26
Distribution of Medical Payments for Hospital Inpatient 27
Average Inpatient Amount Paid per Stay for Hospital Inpatient Services 28
Average Inpatient Amount Paid per Day for Hospital Inpatient Services 28
Average Number of Inpatient Stays per 1,000 Active Claims 29
Length of Stay for Hospital Inpatient Services 29
Time Until First Treatment for Hospital Inpatient Stays (in Days) 30
Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services 31

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services 32
Hospital Outpatient 33
Hospital Outpatient Payments as a Percentage of Medicare 33
Distribution of Medical Payments for Hospital Outpatient 34
Average Amount Paid per Surgical Visit for Hospital Outpatient Services 35
Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims 35
Average Amount Paid per Nonsurgical Visit for Hospital Outpatient Services 36
Average Number of Nonsurgical Hospital Outpatient Visits per 1,000 Active Claims 36
Time Until First Treatment for Outpatient Visits (in Days) 37
Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services 38
Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services 39
Top 10 Nonsurgery Procedure Codes by Amount Paid for Hospital Outpatient Services 40
Average Amount Paid per Emergency Room Visit 41
Average Number of Emergency Room Visits per 1,000 Active Claims 41
Emergency Room Payments by Procedure Code for Arizona 42
Emergency Room Transactions by Procedure Code for Arizona 43
Ambulatory Surgical Centers 44
ASC Payments as a Percentage of Medicare 44
Distribution of Medical Payments for ASC 45
Average Amount Paid per Visit for ASC Services 46
Average Number of ASC Visits per 1,000 Active Claims 46
Time Until First Treatment for ASC Visits (in Days) 47
Top 10 Diagnosis Groups by Amount Paid for ASC Services 48
Top 10 Surgery Procedure Codes by Amount Paid for ASC Services 49
Prescription Drugs 50
Distribution of Medical Payments for Drugs 50
Distribution of Prescription Drug Payments by CSA Schedule 51
Top 10 Workers Compensation Drugs by Amount Paid 52
Top 10 Workers Compensation Drugs by Prescription Counts 53
Distribution of Drugs by Brand Name and Generic 54
Distribution of Drugs by Pharmacy and Nonpharmacy 55
Durable Medical Equipment, Supplies and Implants 56
Distribution of Medical Payments for DME, Supplies and Implants 56
Distribution of Payments DME, Supplies and Implants 57
Top Five DME HCPCS Codes by Amount Paid 58

Top Five Supplies Other Than DME HCPCS Codes by Amount Paid 59
Top Five Implants/Orthotics and Prosthetics HCPCS Codes by Amount Paid 60
Diagnosis Group and Body System 61
Top Body Systems by Amount Paid for Dates of Injury in 2016 62
Top Diagnosis Groups by Amount Paid for Dates of Injury in 2016 62
Comparison of Selected Results by Year 63
Glossary 67
Appendix 69

Medical Cost Statistics

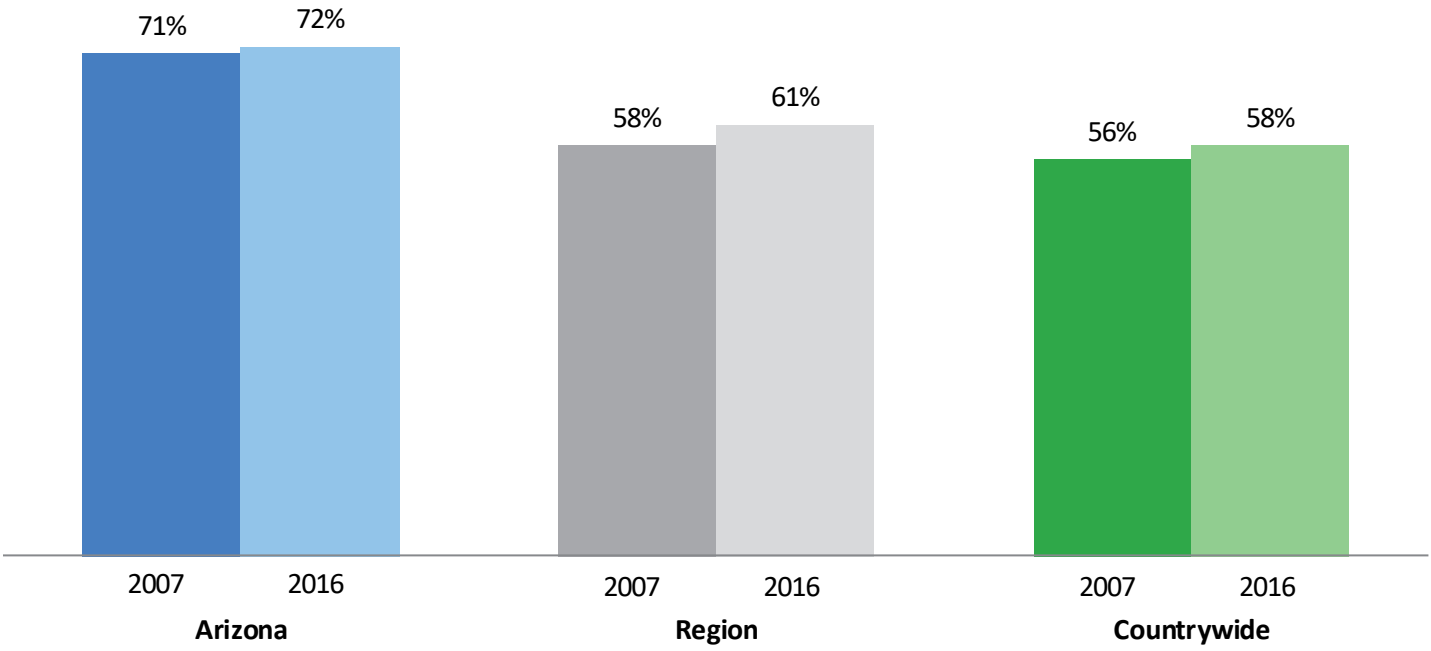
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

Of the two, medical benefits resulting from a work-related injury or disease are the leading cost drivers for workers compensation claims on a countrywide basis. Because this is a relative measure and benefits for both indemnity and medical may vary from state to state, the 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, the region, and countrywide for Accident Years (AY) 2007 and 2016.

Chart 1

Medical Share of Total Benefit Costs by Accident Year



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

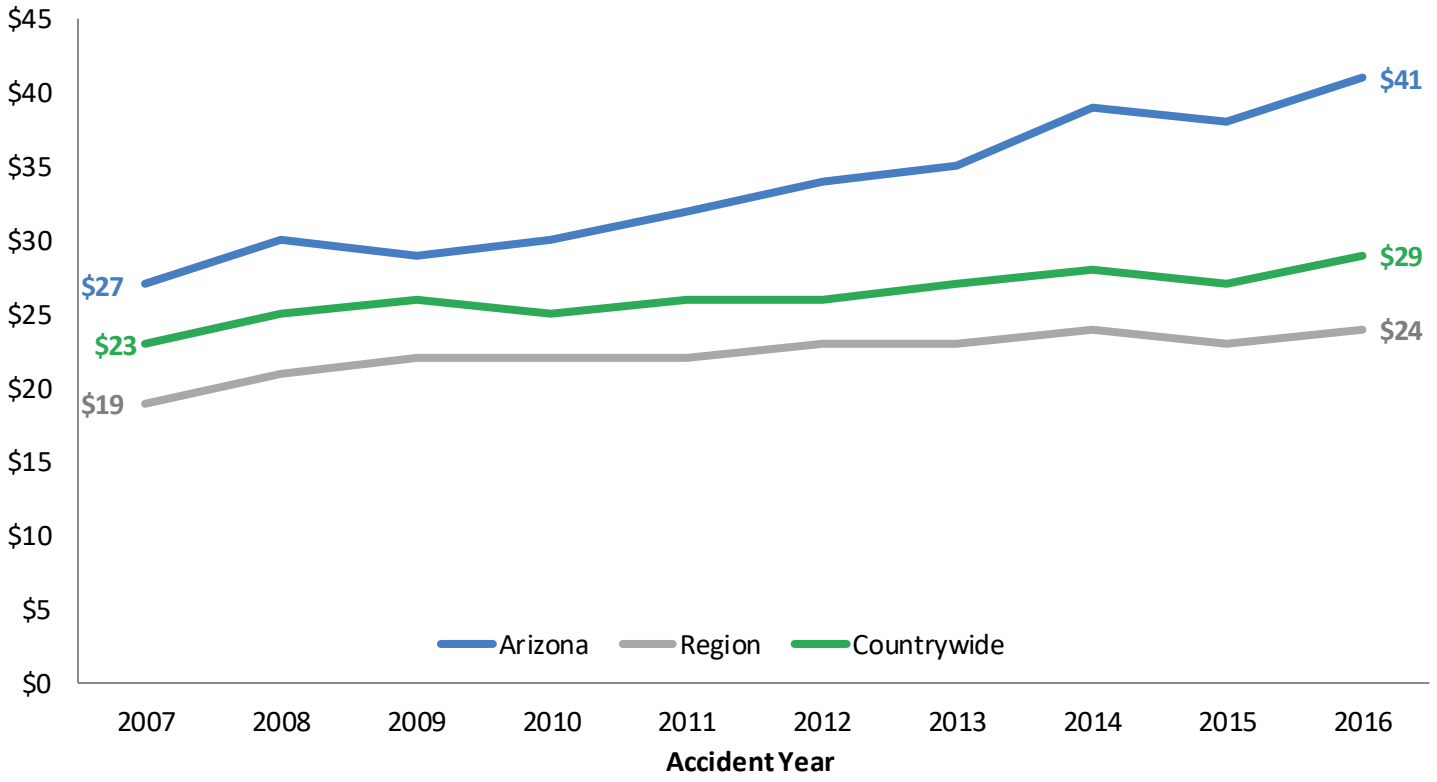
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging 3% from Accident Years 2007 to 2016; this has tracked annual growth for the United States Personal Healthcare Spending per capita.[1] Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for Arizona, the region, and countrywide.

Medical losses are at historical benefit levels and historical dollar values—meaning that no adjustment for inflation or changes in benefits has been made. Since the data is aggregated for 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 regional and countrywide average for each individual accident year and allows for the comparison of the growth in average medical costs.

Chart 2

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



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

[1] **State of the Line Report, *Annual Issues Symposium***, May 2018, www.ncci.com/Articles/Documents/AIS2018-SOTL-Presentation.pdf.

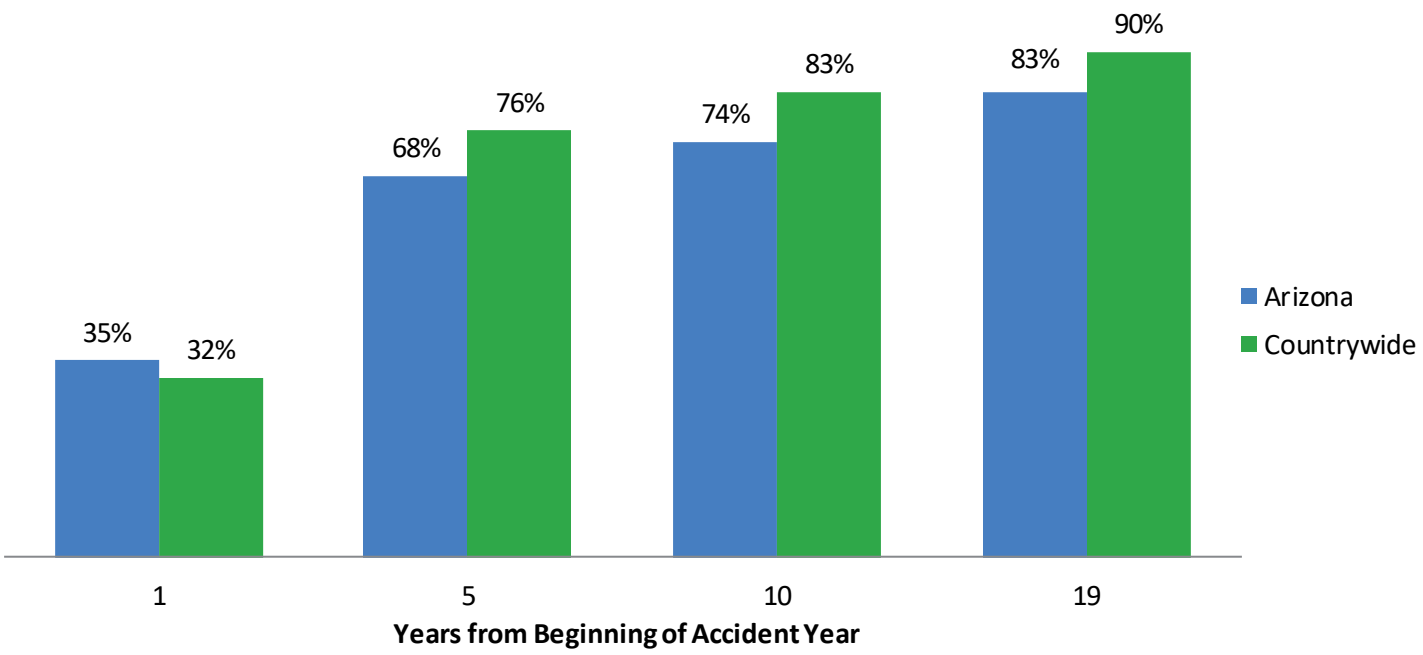
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. Recent NCCI research has found that it is likely that more than 10% of the cost of medical benefits for workplace injuries that occur this year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

Chart 3

Percentage of Medical Paid by Claim Maturity



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

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

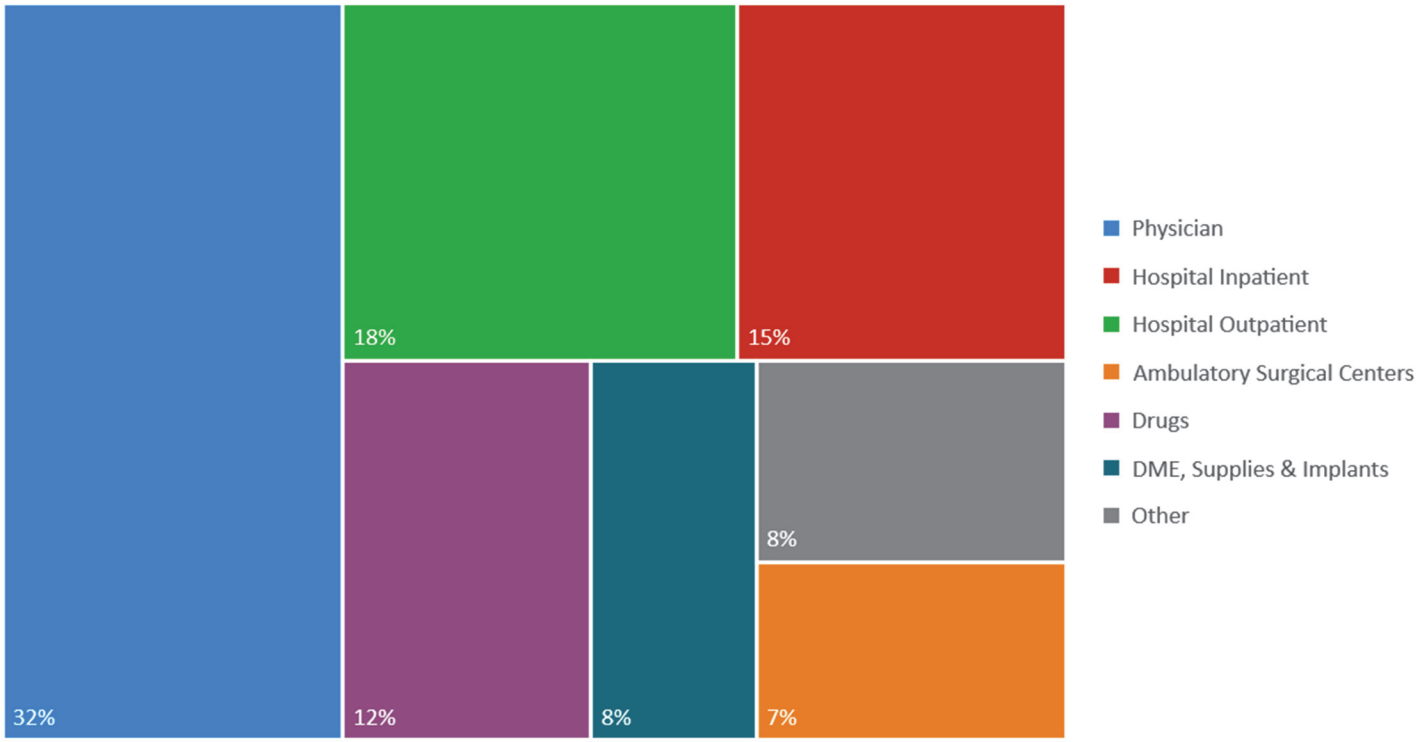
Payments are categorized as Drugs; Durable Medical Equipment (DME), Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the 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 displays the distribution of medical payments by type of service.

Chart 4

Distribution of Medical Payments for Arizona



Physicians

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 chart below shows the average percentage of Medicare schedule reimbursement[2] amounts for physician payments by category for Arizona, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the four categories listed in the chart.

Chart 5

Physician Payments as a Percentage of Medicare

Physician Service Category	Arizona	Region	Countrywide
Surgery	217%	214%	275%
Radiology	215%	228%	236%
General and Physical Medicine	133%	130%	131%
Evaluation and Management	140%	147%	141%
All Physician Services	**155%**	**156%**	**167%**

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

Chart 6 displays the percentage of medical payments for physician services for Arizona, the region, and countrywide.

Chart 6

Distribution of Medical Payments for Physicians

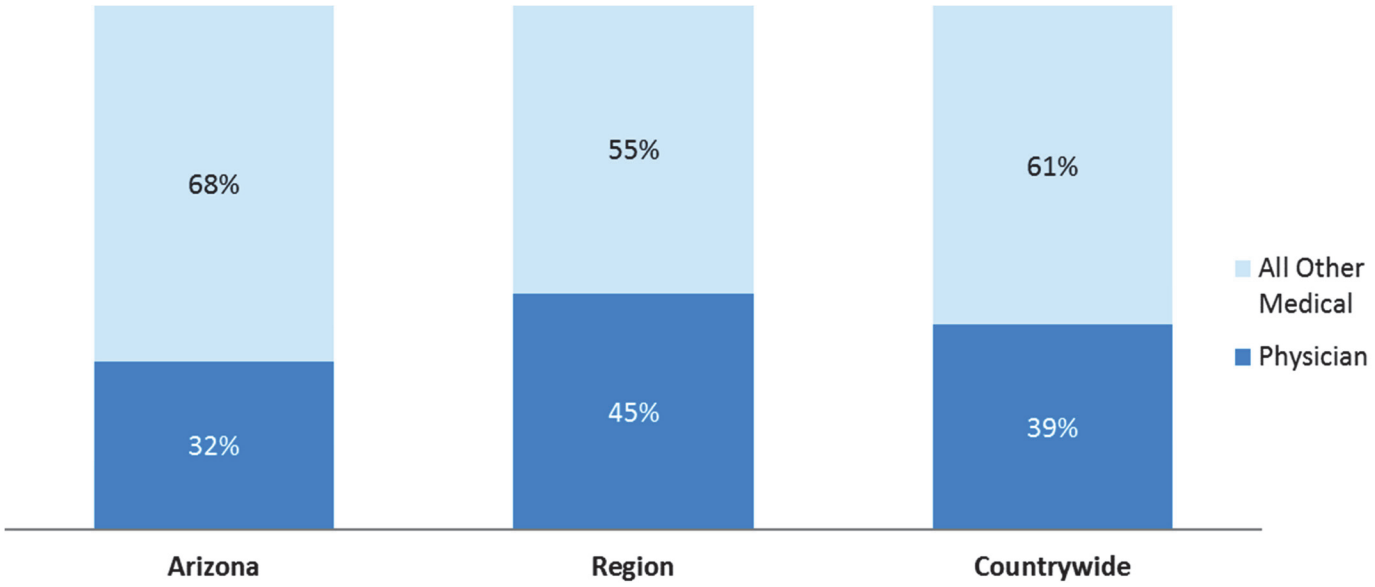
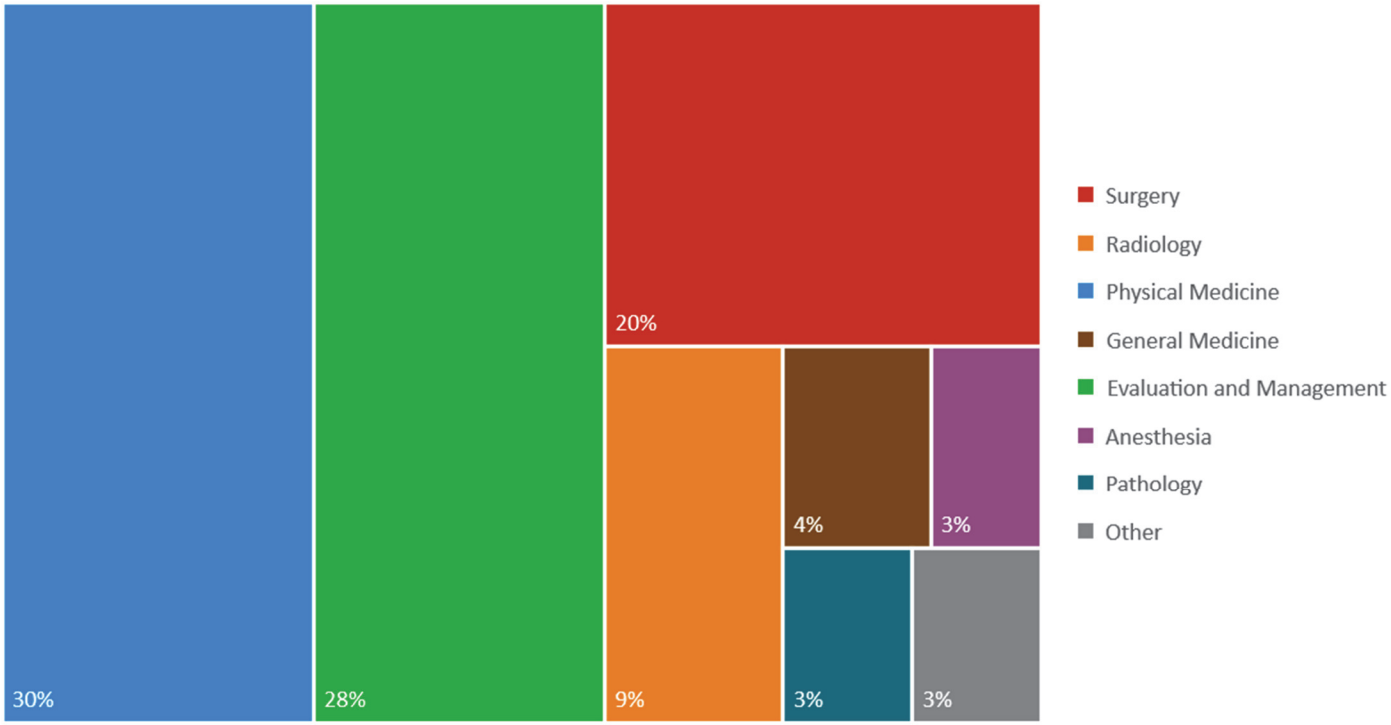


Chart 7 shows the distribution of physician payments by service category. Service categories are defined by the American Medical Association (AMA). Services involving office visits and consultations are included in the Evaluation and Management category. The Other category includes any codes not included 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 7

Distribution of Physician Payments by AMA Service Category for Arizona



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 8 through 16 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 is displayed in the corresponding table below each chart.

The charts also include the average amount paid per transaction (PPT) 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, and quantity/units, 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.

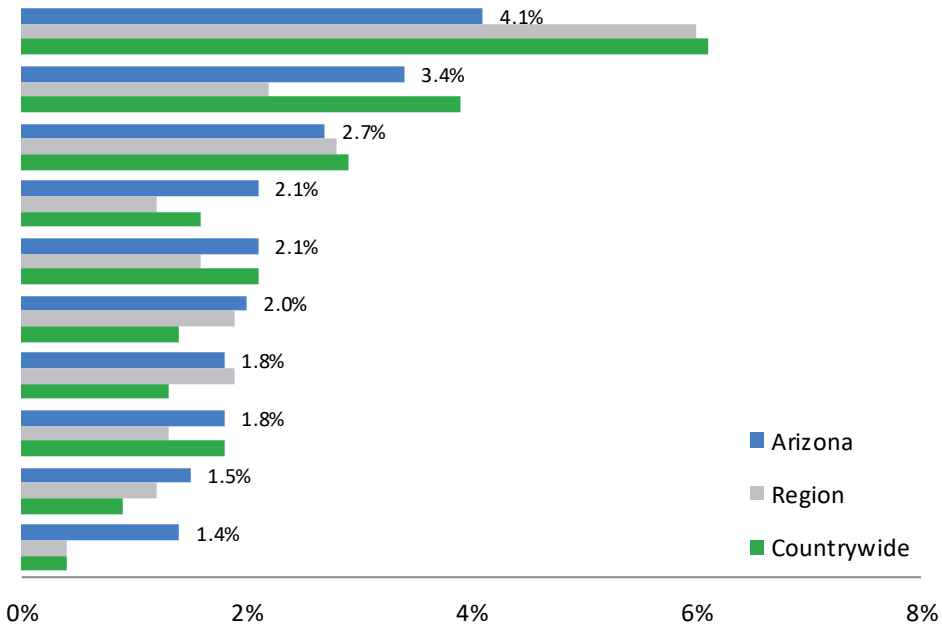
Results from NCCI's study, "The Price Impact of Physician Fee Schedules" (April 2014), show that the influence of fee schedules is quite different between the high-volume Evaluation and Management (E&M) service category and the small-volume Surgery category. For Surgery, many workers compensation payments 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 2017 are, on average, 217% of Medicare scheduled reimbursement amounts, compared to 214% in the region and 275% countrywide. Payments for these services comprise 20% of physician payments, compared to 19% in the region and 25% countrywide.

Chart 8

Top 10 Surgery Procedure Codes by Amount Paid

	Average PPT			
Code	**AZ**	**Region**	**CW**	**Paid Share**
29827	$1,421	$1,684	$2,095	4.1%
29826	$1,038	$475	$1,020	3.4%
29881	$1,414	$1,116	$1,525	2.7%
63047	$2,655	$1,784	$2,570	2.1%
29823	$950	$692	$1,065	2.1%
12001	$176	$155	$180	2.0%
29888	$1,975	$1,781	$2,186	1.8%
64483	$381	$354	$540	1.8%
20680	$777	$733	$857	1.5%
11012	$1,161	$710	$851	1.4%

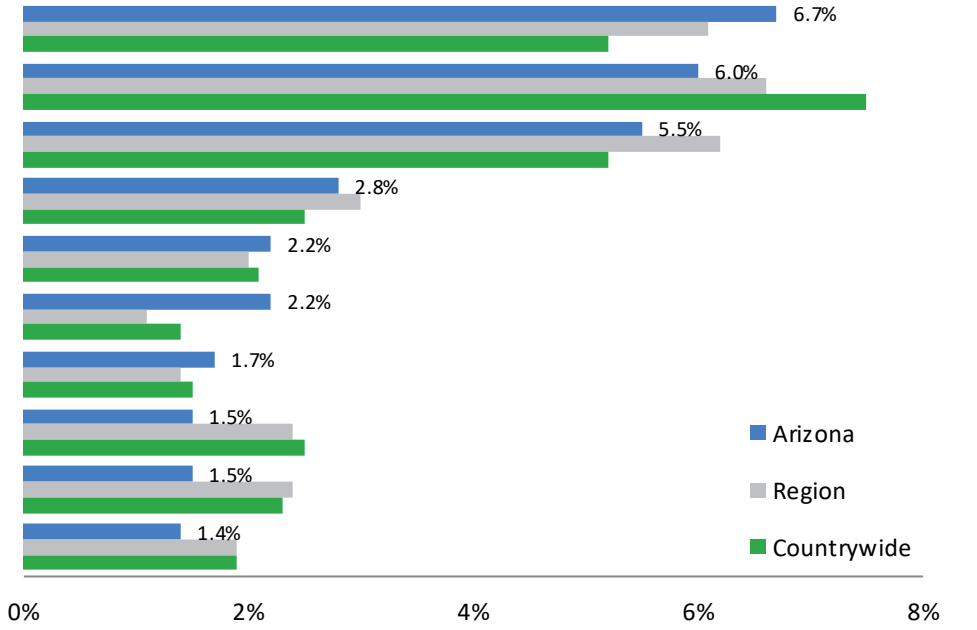


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
63047	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
29823	Arthroscopy, shoulder, surgical; debridement extensive
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
11012	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

Chart 9

Top 10 Surgery Procedure Codes by Transaction Counts

Code	Average PPT AZ	Region	CW
36415	$12	$11	$11
20610	$112	$125	$128
12001	$176	$155	$180
12002	$223	$194	$209
64483	$381	$354	$540
29125	$113	$116	$117
20550	$89	$106	$106
29826	$1,038	$475	$1,020
64415	$263	$171	$289
29827	$1,421	$1,684	$2,095



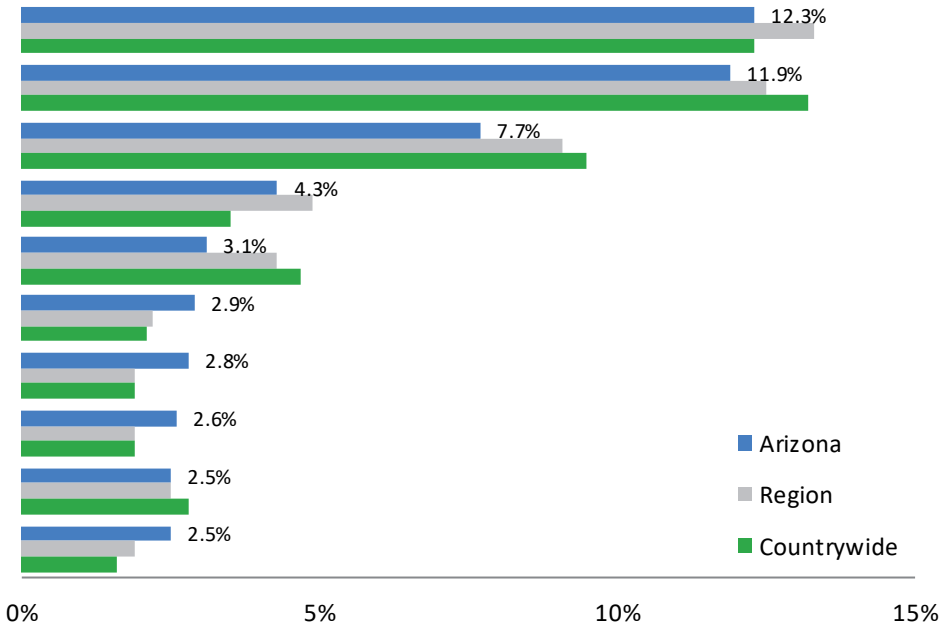
Code	Description
36415	Collection of venous blood by venipuncture
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities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

In Arizona, physician payments for radiology services provided in 2017 are, on average, 215% of Medicare scheduled reimbursement amounts, compared to 228% in the region and 236% countrywide. Payments for these services comprise 9% of physician payments, compared to 8% in the region and 9% countrywide.

Chart 10

Top 10 Radiology Procedure Codes by Amount Paid

	Average PPT		
Code	**AZ**	**Region**	**CW**
73721	$511	$441	$499
73221	$499	$445	$505
72148	$488	$427	$481
73222	$722	$559	$639
72141	$480	$423	$478
73110	$66	$56	$60
73140	$61	$47	$50
73630	$51	$49	$51
73030	$53	$51	$57
73562	$65	$58	$61

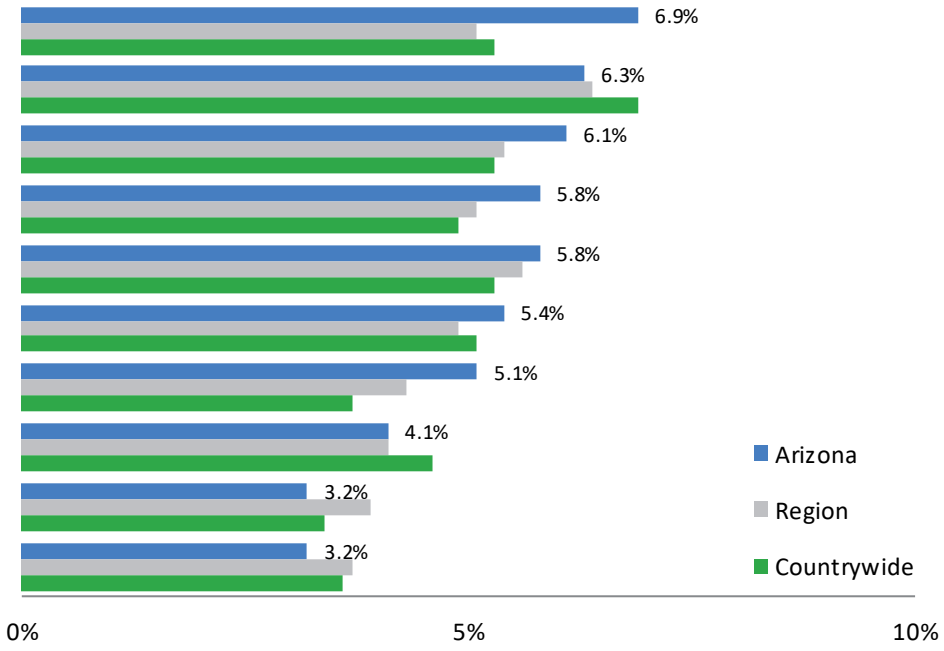


Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
73110	Radiologic examination, wrist; complete minimum of 3 views
73140	Radiologic examination, finger(s); minimum of 2 views
73630	Radiologic examination, foot; complete minimum of 3 views
73030	Radiologic examination, shoulder; complete minimum of 2 views
73562	Radiologic examination, knee; 3 views

Chart 11

Top 10 Radiology Procedure Codes by Transaction Counts

Code	Average PPT AZ	Region	CW
73630	$51	$49	$51
73030	$53	$51	$57
73140	$61	$47	$50
73110	$66	$56	$60
73610	$56	$51	$54
73130	$55	$47	$51
73562	$65	$58	$61
72100	$64	$64	$63
73721	$511	$441	$499
73221	$499	$445	$505



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

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 is typically reported along with the CPT code. These modifiers may be “26” for the professional component or “TC” for the technical component. In Arizona, 1% of radiology payments are reported with a TC modifier, 8% of payments are reported with a 26 modifier, and 91% of payments are reported with no TC or 26 modifier.

Chart 12 shows the average payment for the identified top 10 radiology procedures, by amount paid, in Arizona.

Chart 12

Average Amount Paid per Transaction by Modifier Code for Arizona

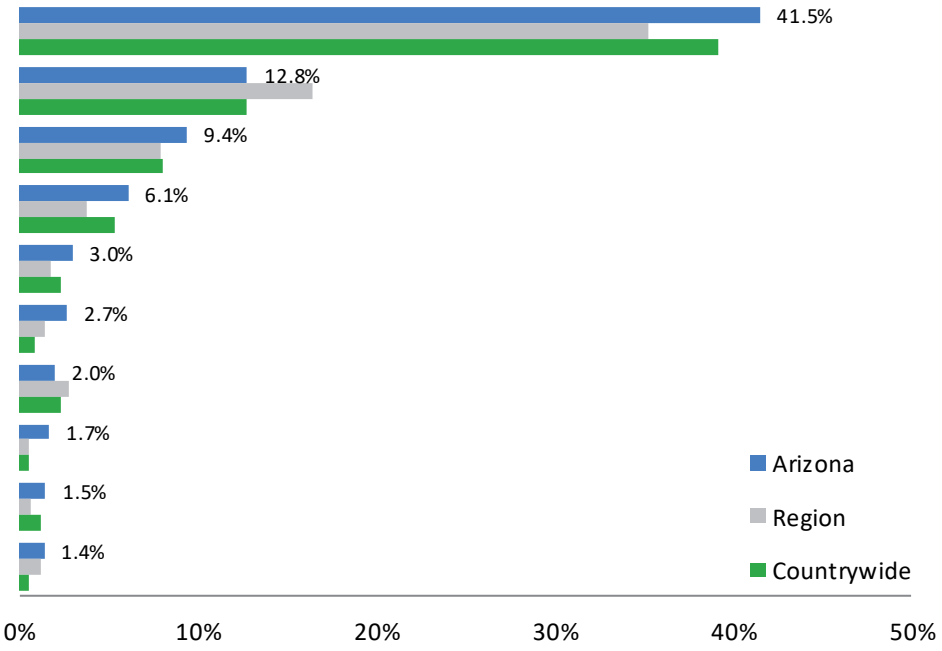
Code	No TC or 26 Modifier	Professional	Technical
73721	$543	$138	$769
73221	$538	$138	$1,456
72148	$549	$138	$723
73222	$760	$136	$419
72141	$537	$137	$5,779
73110	$72	$16	$44
73140	$67	$12	$41
73630	$54	$17	$58
73030	$59	$18	$37
73562	$72	$17	$54

In Arizona, physician payments for physical and general medicine services provided in 2017 are, on average, 133% of Medicare scheduled reimbursement amounts, compared to 130% in the region and 131% countrywide. Payments for these services comprise 34% of physician payments, compared to 34% in the region and 34% countrywide.

Chart 13

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

Code	Average PPT AZ	Region	CW
97110	$68	$74	$76
97140	$47	$52	$47
97530	$58	$74	$57
97112	$48	$50	$49
97014	$23	$21	$23
97001	$107	$96	$92
99199	$102	$234	$192
97535	$52	$47	$44
97010	$10	$8	$16
90837	$191	$181	$159

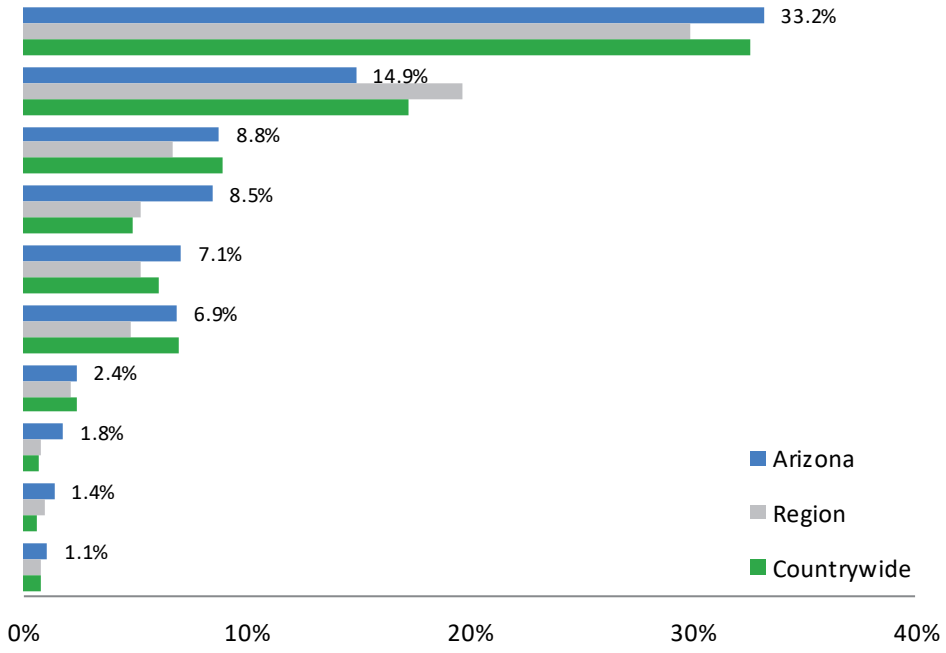


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97001	Physical therapy evaluation
99199	Unlisted special service procedure or report
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
97010	Application of a modality to 1 or more areas; hot or cold packs
90837	Psychotherapy, 60 minutes with patient

Chart 14

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

Code	Average PPT AZ	Region	CW
97110	$68	$74	$76
97140	$47	$52	$47
97530	$58	$74	$57
97010	$10	$8	$16
97014	$23	$21	$23
97112	$48	$50	$49
97035	$15	$18	$22
97535	$52	$47	$44
97001	$107	$96	$92
99199	$102	$234	$192



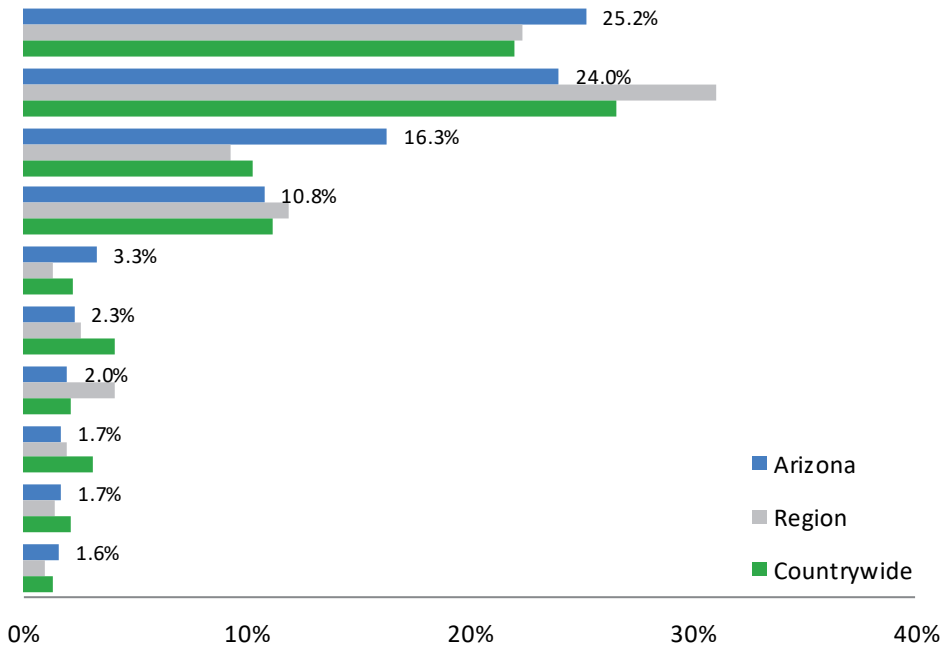
Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97010	Application of a modality to 1 or more areas; hot or cold packs
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97035	Application of a modality to 1 or more areas; ultrasound each 15 minutes
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
97001	Physical therapy evaluation
99199	Unlisted special service procedure or report

In Arizona, physician payments for evaluation and management services provided in 2017 are, on average, 140% of Medicare scheduled reimbursement amounts, compared to 147% in the region and 141% countrywide. Payments for these services comprise 28% of physician payments, compared to 28% in the region and 23% countrywide.

Chart 15

Top 10 Evaluation and Management Procedure Codes by Amount Paid

	Average PPT		
Code	**AZ**	**Region**	**CW**
99214	$144	$153	$141
99213	$102	$109	$99
99204	$230	$227	$214
99203	$147	$162	$148
99455	$251	$536	$197
99284	$235	$222	$280
99456	$1,471	$1,191	$905
99283	$152	$130	$181
99285	$340	$332	$400
99244	$302	$291	$270

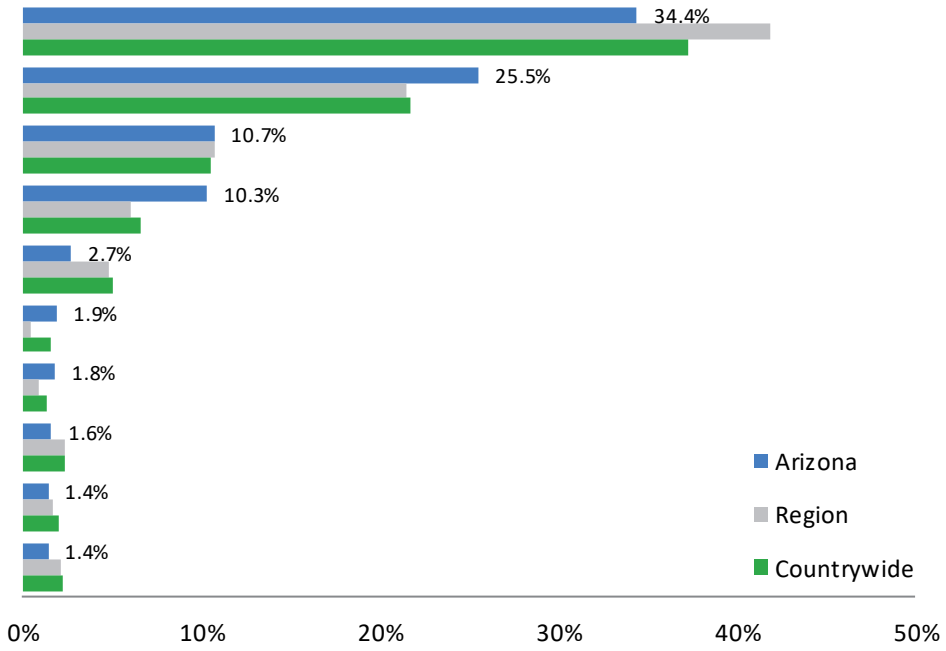


Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient 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.
99204	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	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	Work related or medical disability examination by the treating physician.
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.
99456	Work related or medical disability examination by other than the treating physician.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99244	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.

Chart 16

Top 10 Evaluation and Management Procedure Codes by Transaction Counts

Code	Average PPT AZ	Region	CW
99213	$102	$109	$99
99214	$144	$153	$141
99203	$147	$162	$148
99204	$230	$227	$214
99212	$60	$68	$65
99455	$251	$536	$197
99232	$86	$125	$101
99283	$152	$130	$181
99284	$235	$222	$280
99202	$101	$118	$105



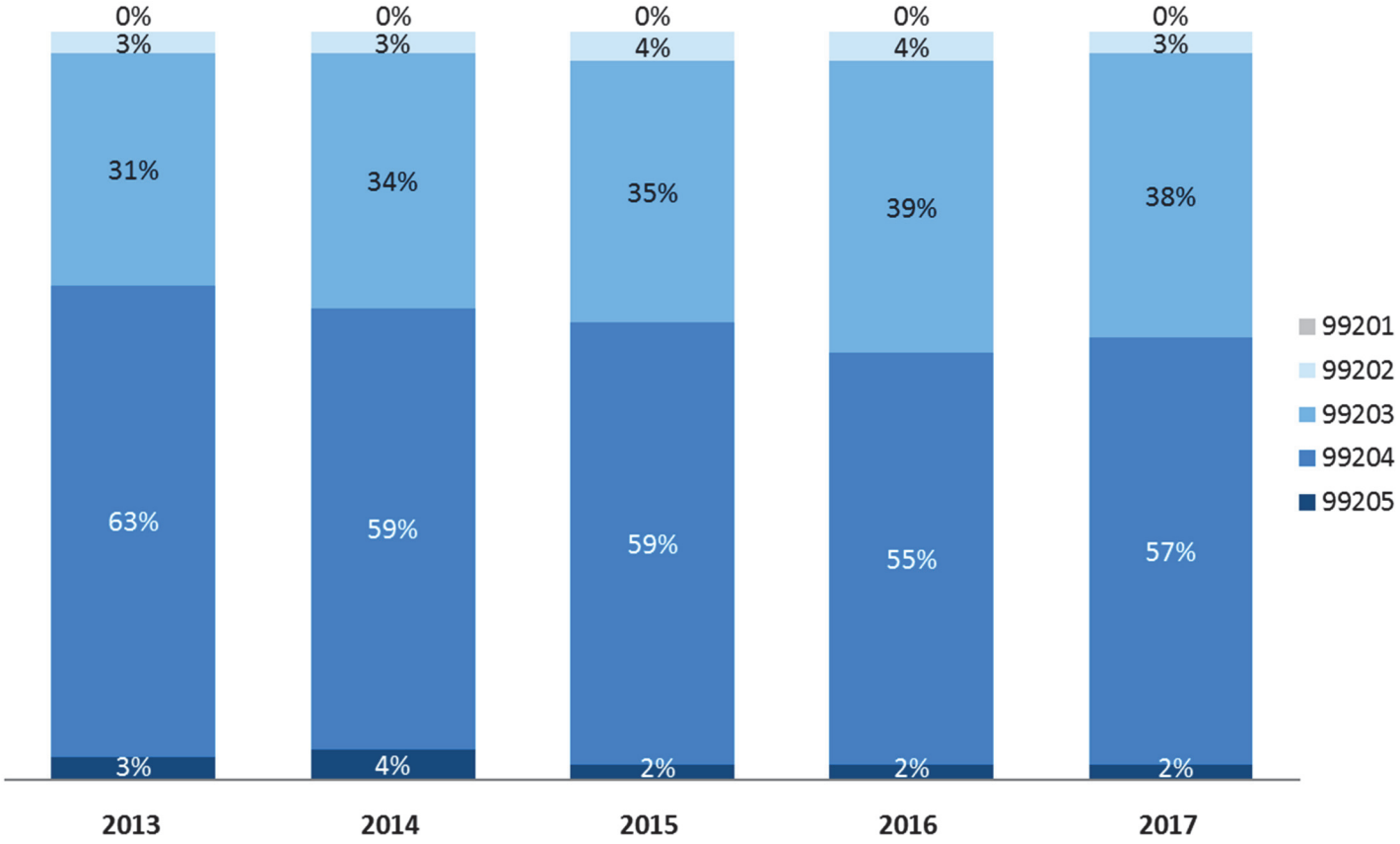
Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit 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	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	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	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	Work related or medical disability examination by the treating physician.
99232	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.
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.
99202	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.

Evaluation and Management services consist largely of office or outpatient visits for a new patient 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 17 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction.

Chart 17

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



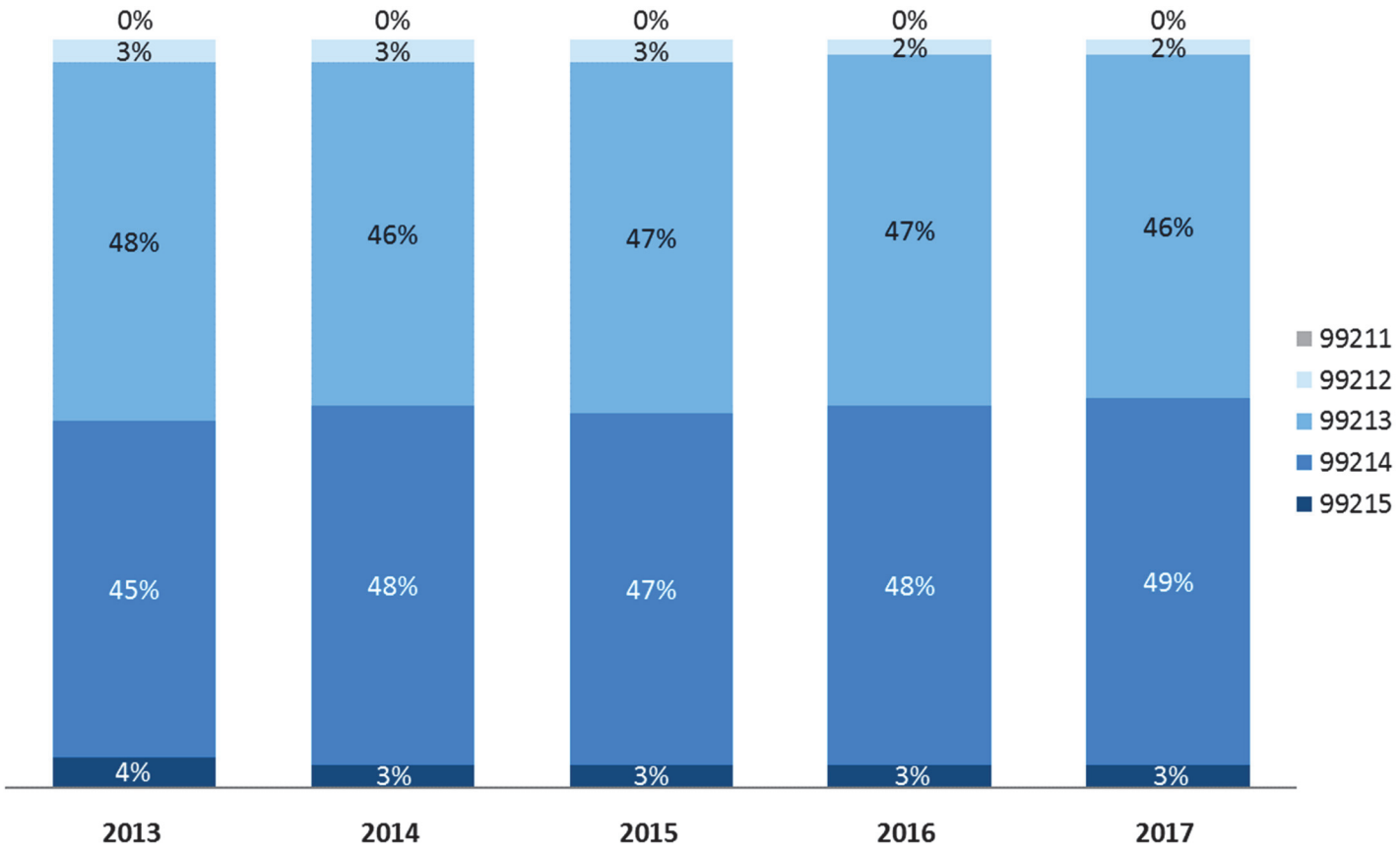
Source: NCCI's Medical Data Call, Service Years 2013 to 2017.

		Average PPT				
Code	**Severity/Time**	**2013**	**2014**	**2015**	**2016**	**2017**
99201	Low to Moderate; 10 minutes with patient	$48	$52	$53	$60	$63
99202	Low to Moderate; 20 minutes with patient	$78	$89	$92	$98	$101
99203	Moderate; 30 minutes with patient	$113	$131	$133	$143	$147
99204	Moderate to High; 45 minutes with patient	$162	$188	$194	$221	$230
99205	Moderate to High; 60 minutes with patient	$204	$236	$242	$262	$258

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 18 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction.

Chart 18

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



Source: NCCI's Medical Data Call, Service Years 2013 to 2017.

		Average PPT				
Code	**Severity/Time**	**2013**	**2014**	**2015**	**2016**	**2017**
99211	Low to Moderate; 5 minutes with patient	$27	$30	$32	$33	$29
99212	Low to Moderate; 10 minutes with patient	$48	$54	$56	$59	$60
99213	Moderate; 15 minutes with patient	$74	$85	$87	$98	$102
99214	Moderate to High; 25 minutes with patient	$108	$123	$127	$140	$144
99215	Moderate to High; 40 minutes with patient	$150	$168	$177	$192	$197

One measure of the availability of medical services is time until first treatment. Time to treatment (TTT) is measured by the number of days between date of injury and the date on which the worker first received medical services. Charts 19 through 22 show the median and 75th percentile[3] TTT by physician service category for Arizona, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop, such as an occupational disease, that may extend the time between the date a work-related injury or disease is reported to a workers compensation insurer and the first medical treatment an insurer is responsible for.

Chart 19

Time Until First Treatment for Major Surgery[4] (in Days)

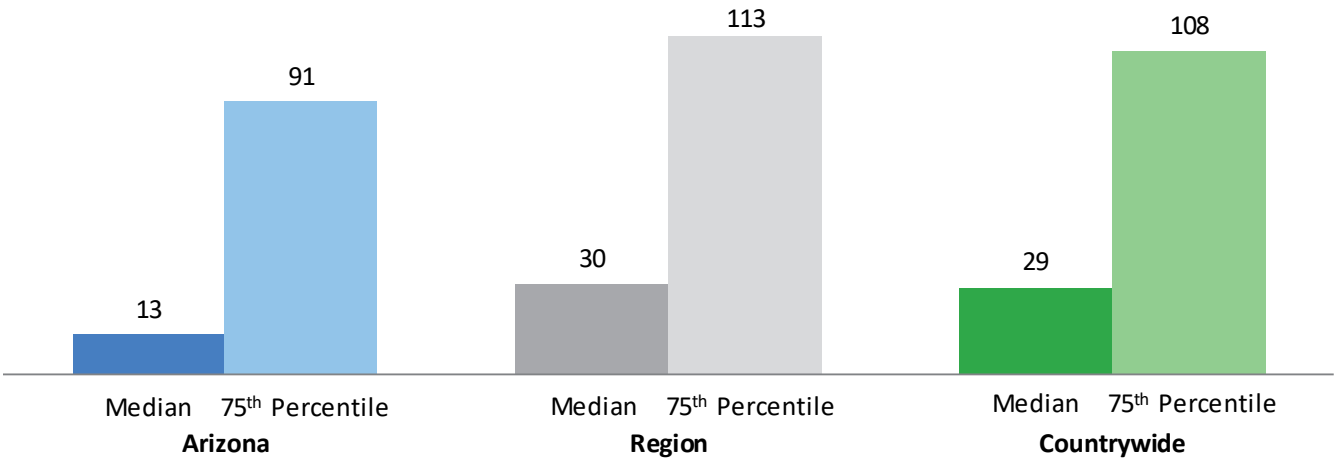
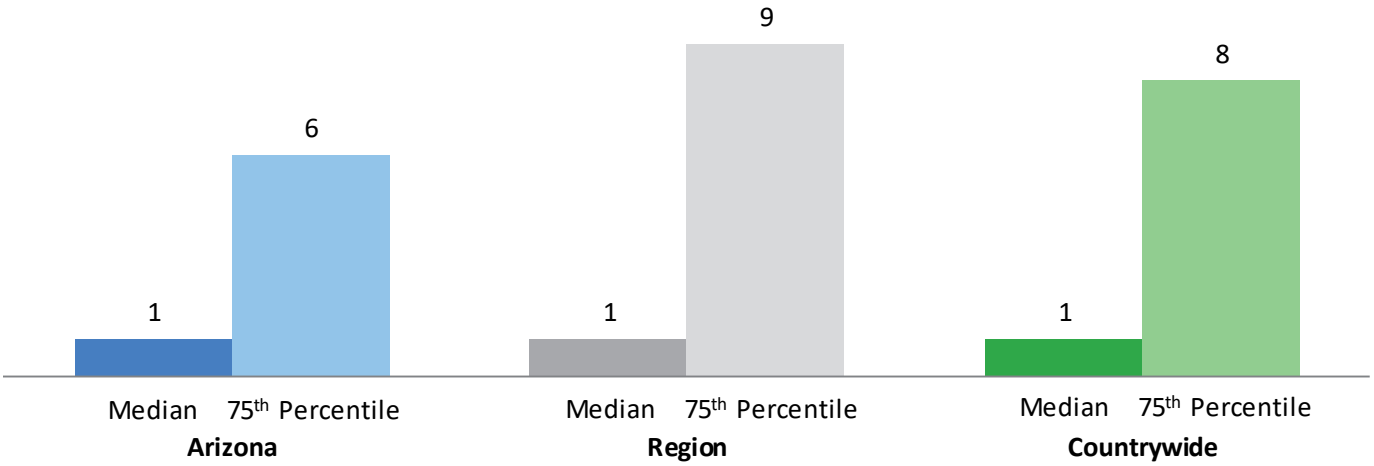


Chart 20

Time Until First Treatment for Radiology (in Days)



Source: NCCI's Medical Data Call for Accident Year 2016 and Service Years 2016 and 2017.

[3] The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 19 indicates that out of 100 claimants, 75 will receive major surgical treatment within 91 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

[4] A surgical service is defined as "major surgery" or "minor surgery" within the surgical category as defined by the AMA.

Chart 21

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

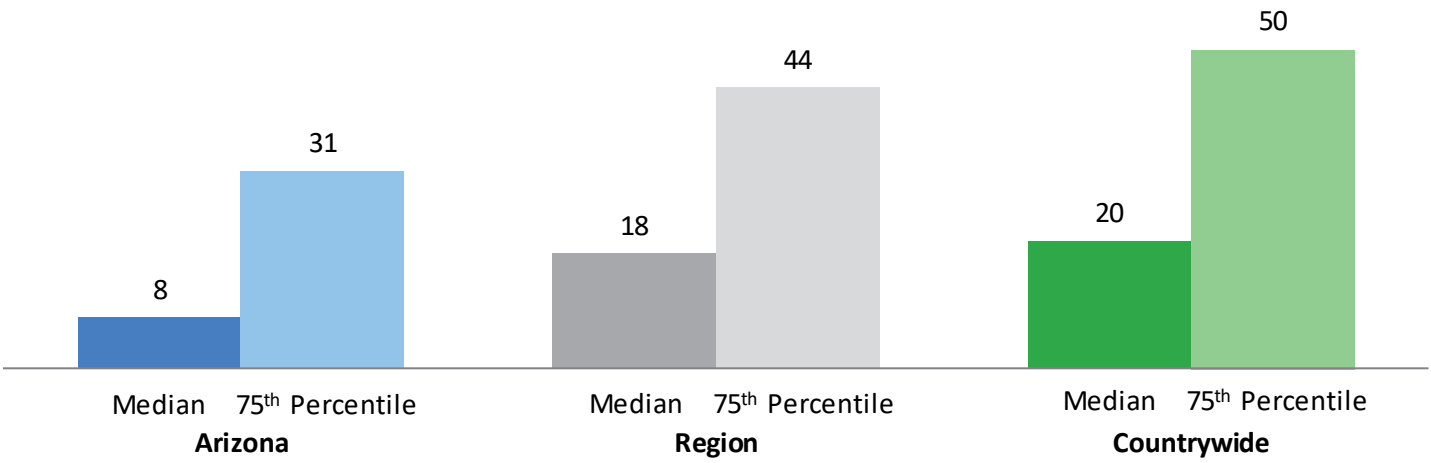
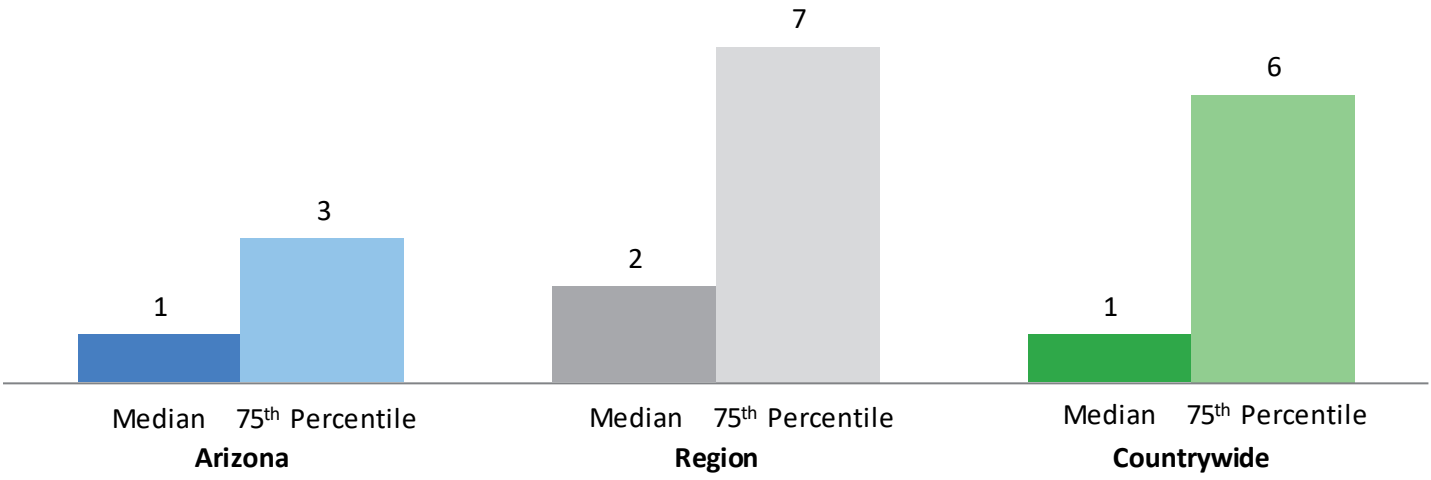


Chart 22

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



Source: NCCI's Medical Data Call for Accident Year 2016 and Service Years 2016 and 2017.

Hospital Inpatient

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

Hospital inpatient fee schedules in workers compensation 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, 39% 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, the region, 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 chart below shows the average percentage of Medicare schedule reimbursement amounts for hospital inpatient payments for Arizona, the region, and countrywide.

Chart 23

Hospital Inpatient Payments as a Percentage of Medicare

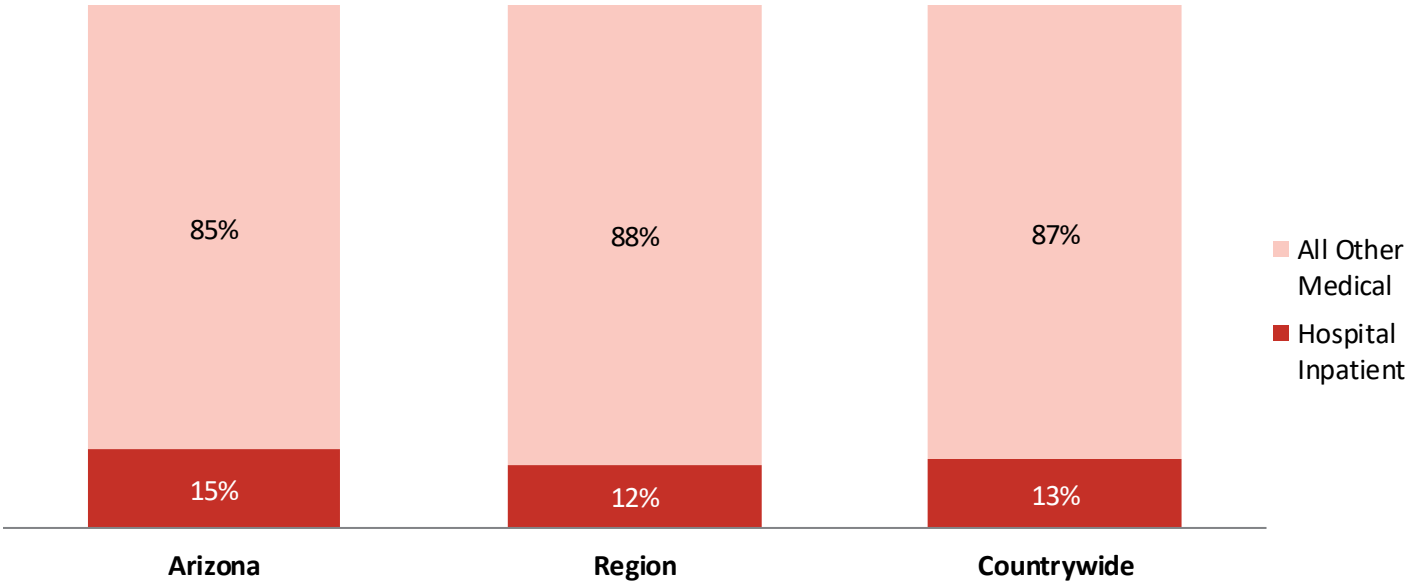
Medical Cost Category	Arizona	Region	Countrywide
Hospital Inpatient	244%	161%	191%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AK, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Chart 24 displays the percentage of medical payments for hospital inpatient services for Arizona, the region, and countrywide.

Chart 24

Distribution of Medical Payments for Hospital Inpatient



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 25 displays the average amount paid per stay for hospital inpatient services, while Chart 26 displays the average amount paid per day for hospital inpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 25

Average Inpatient Amount Paid per Stay for Hospital Inpatient Services

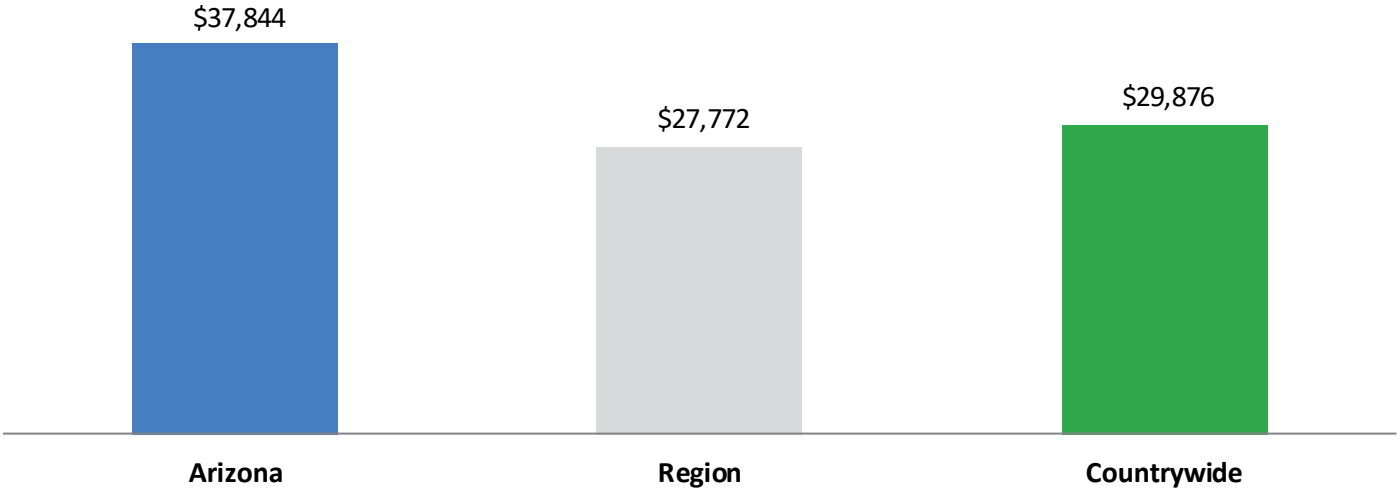


Chart 26

Average Inpatient Amount Paid per Day for Hospital Inpatient Services

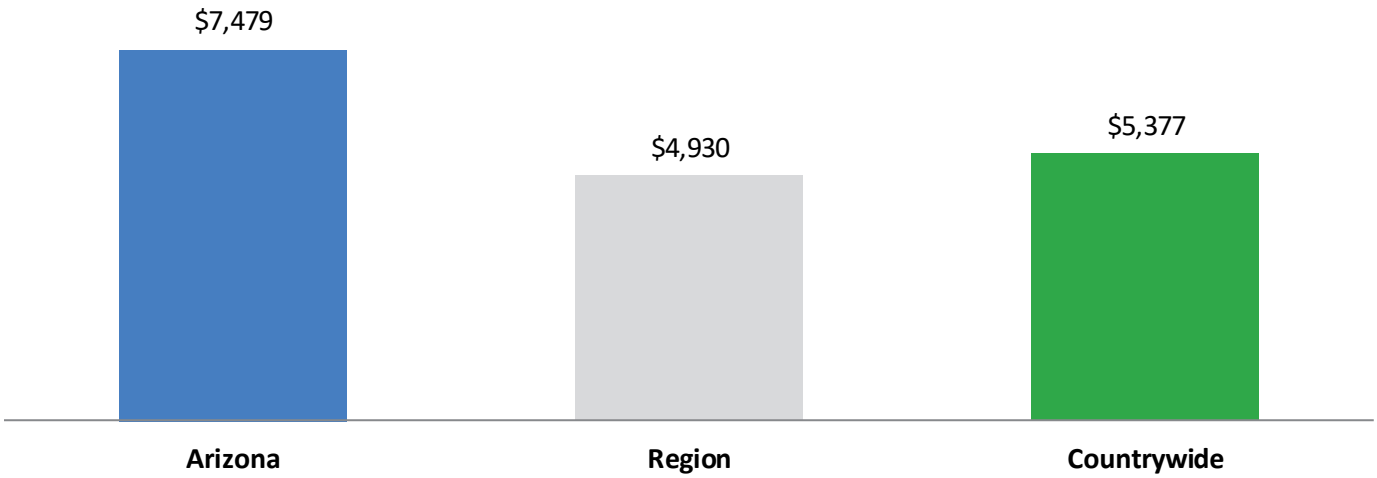


Chart 27 displays the average number of hospital inpatient stays per 1,000 active claims in 2017 for Arizona, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 28 displays the average and median length of stay for hospital inpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 27

Average Number of Inpatient Stays per 1,000 Active Claims

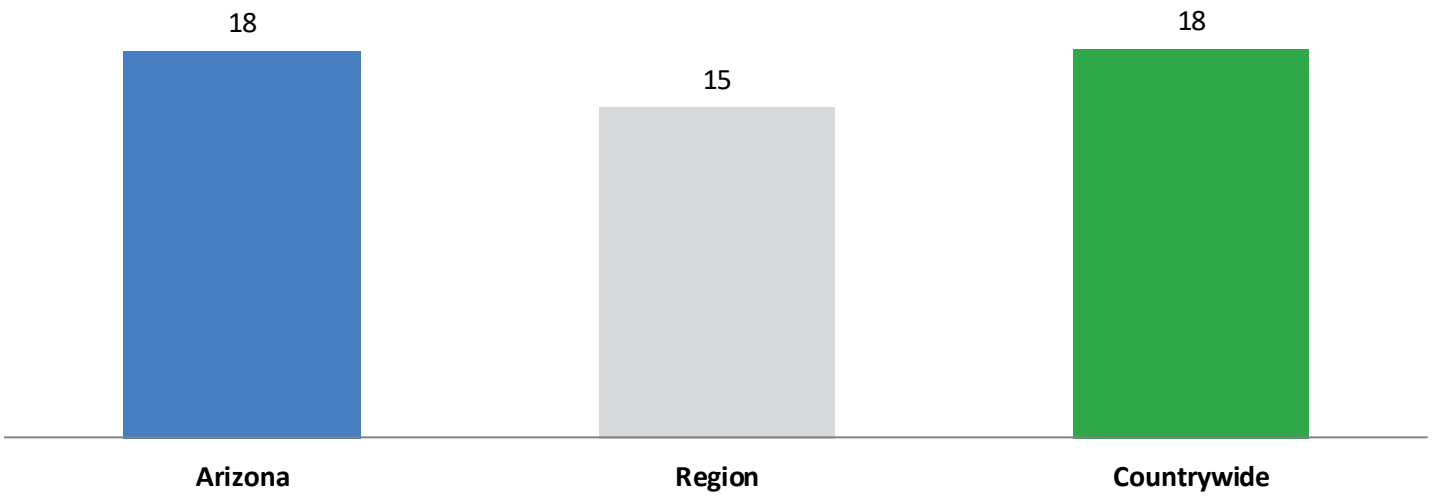


Chart 28

Length of Stay for Hospital Inpatient Services

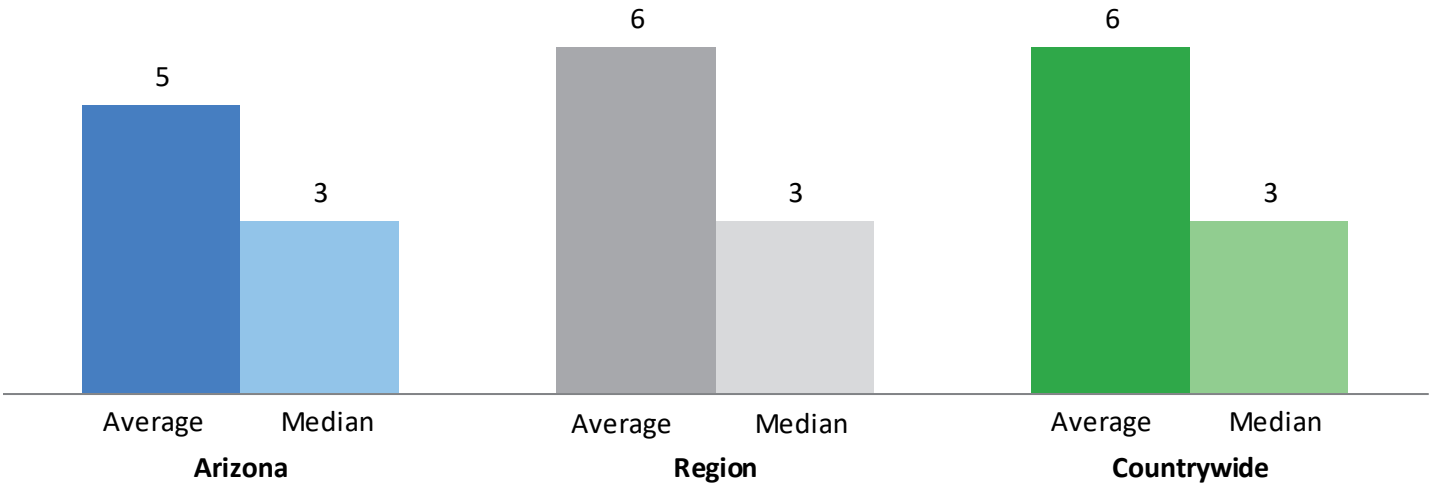
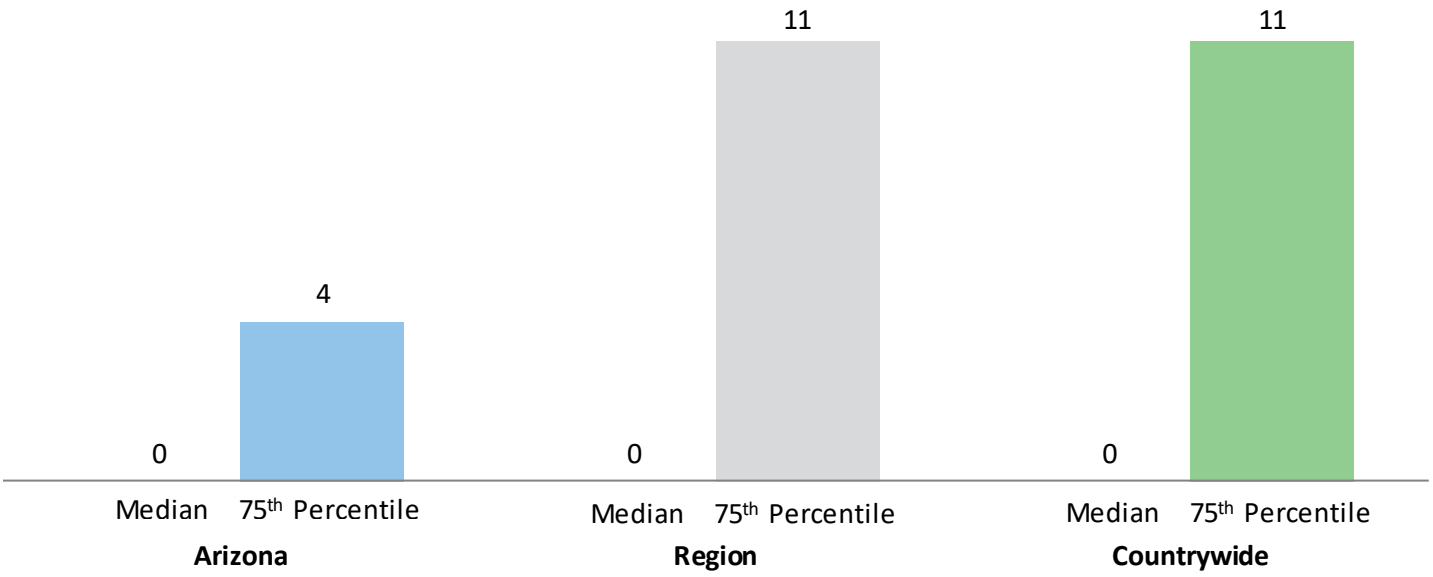


Chart 29 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Arizona, the region, and countrywide.

Chart 29

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



Source: NCCI's Medical Data Call for Accident Year 2016 and Service Years 2016 and 2017.

Charts 30 and 31 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient services, revealing the most prevalent types of hospital inpatient stays. Diagnosis group and body system are identified for each visit based on ICD-10 (International Classification of Diseases) code. The diagnosis groups and DRG codes are ranked based on total payments in Arizona. A brief description of each DRG code is displayed in the table below chart 31.

Chart 30

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

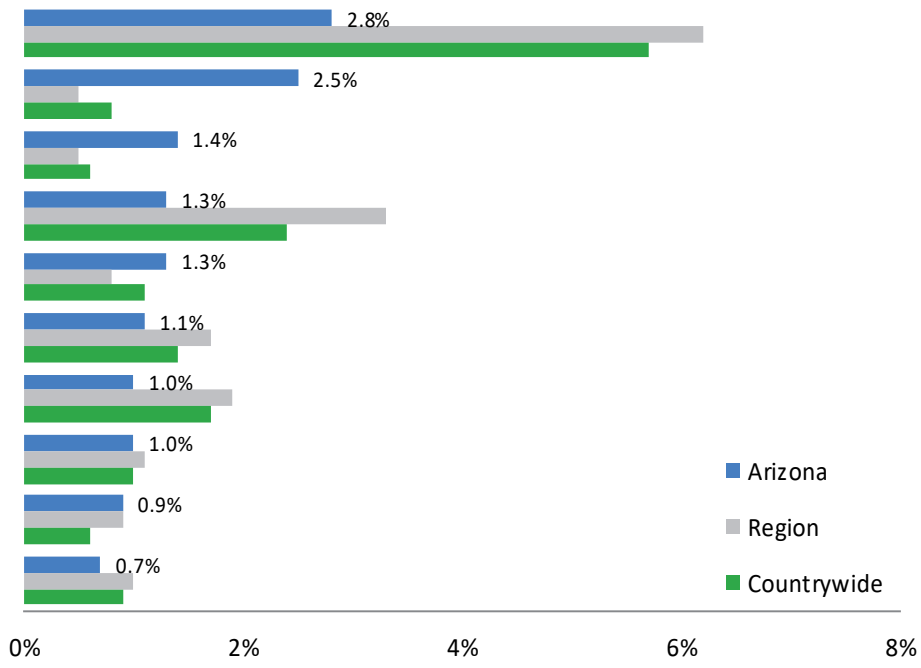
Diagnosis Group	Paid Share	Median Amount Paid per Stay		
		Arizona	Region	Countrywide
Lumbar spine degeneration	7.8%	$43,623	$32,276	$30,504
Intracranial injury	7.2%	$27,375	$20,150	$21,210
Fracture of lower leg, including ankle	6.0%	$25,641	$17,523	$18,514
Hip/pelvis fracture/major trauma	4.8%	$22,905	$19,903	$19,257
Lumbosacral intervertebral disc disorders	3.9%	$41,630	$20,021	$25,084
Fracture of rib(s), sternum and thoracic spine	3.5%	$32,790	$16,169	$16,118
Complications of internal orthopedic prosthetic devices, implants and grafts	3.3%	$26,582	$21,891	$21,011
Knee degenerative/overuse injuries	2.8%	$18,888	$18,770	$18,562
Fracture of skull and facial bones	2.4%	$35,033	$19,825	$20,885
Fracture of forearm	2.2%	$26,369	$17,085	$19,044

Source: NCCI's Medical Data Call for Service Years 2016 and 2017

Chart 31

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services

Code	Median Paid per Stay AZ	Region	CW
460	$48,542	$40,692	$38,742
928	$195,828	$77,817	$70,680
464	$63,684	$36,474	$38,252
470	$28,218	$21,084	$21,232
493	$47,527	$24,009	$25,376
003	$253,668	$198,389	$221,808
494	$22,923	$17,567	$18,532
958	$125,832	$47,626	$62,060
482	$32,286	$16,984	$18,317
455	$68,154	$63,173	$50,942



Code	Description
460	Spinal fusion except cervical without major complications or comorbidities
928	Full thickness burn with skin graft or inhalation injury with complications or comorbidities/major complications or comorbidities
464	Wound debridement and skin graft except hand for musculo-connective tissue disorders with complications or comorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
493	Lower extremity and humerus procedures except hip, foot, femur with complications or comorbidities
003	Extracorporeal membrane oxygenation (ECMO) or tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth, and neck with major operating room
494	Lower extremity and humerus procedures except hip, foot, femur without complications or comorbidities/major complications or comorbidities
958	Other operation room procedures for multiple significant trauma with complications or comorbidities
482	Hip and femur procedures except major joint without complications or comorbidities/major complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities

Source: NCCI's Medical Data Call for Service Years 2016 and 2017

Hospital Outpatient

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

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

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

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 because 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 chart below shows the average percentage of Medicare schedule reimbursement amounts for hospital outpatient payments for Arizona, the region, and countrywide.

Chart 32

Hospital Outpatient Payments as a Percentage of Medicare

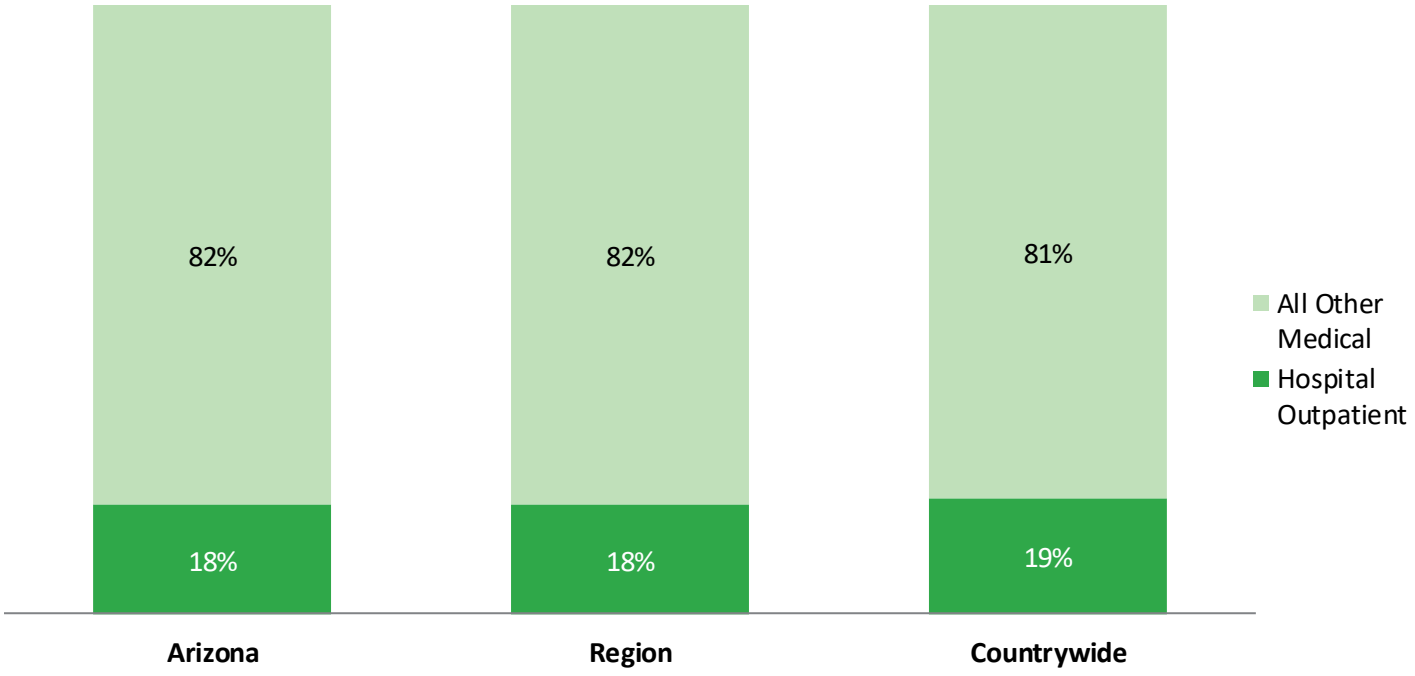
Medical Cost Category	Arizona	Region	Countrywide
Hospital Outpatient	352%	188%	256%

Source: NCCI’s Medical Data Call for Service Year 2017. Region includes AK, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Chart 33 displays percentage of medical payments for hospital outpatient services for Arizona, the region, and countrywide.

Chart 33

Distribution of Medical Payments for Hospital Outpatient



Surgical services represent 53% of hospital outpatient payments in Arizona. Chart 34 displays the average amount paid per visit for hospital outpatient surgical services, while Chart 35 displays the average number of visits per year per 1,000 active claims for hospital outpatient surgical 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 Surgical Visit for Hospital Outpatient Services

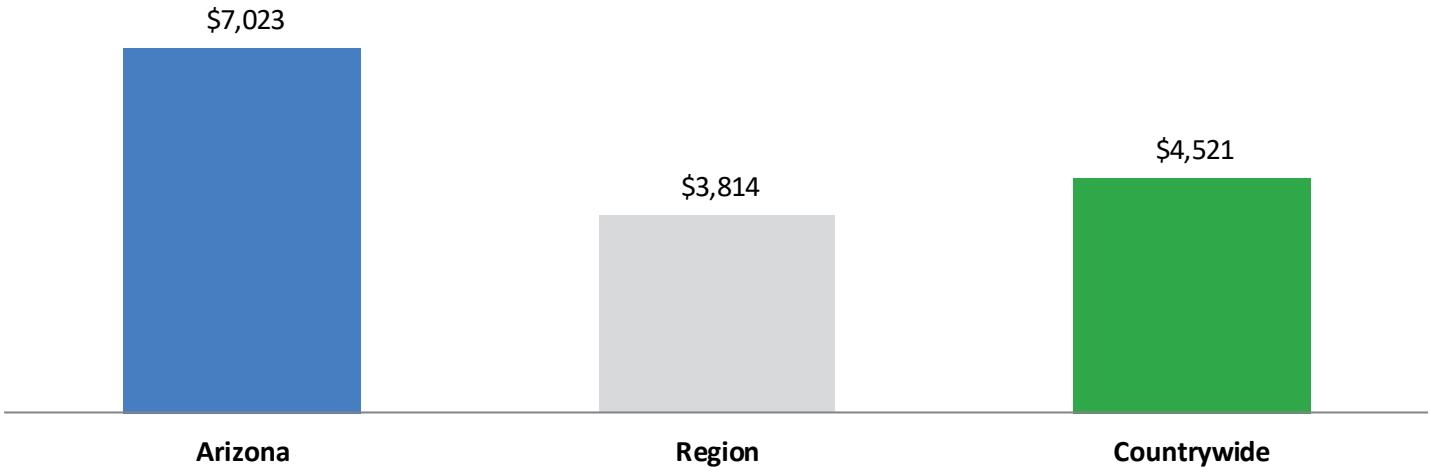
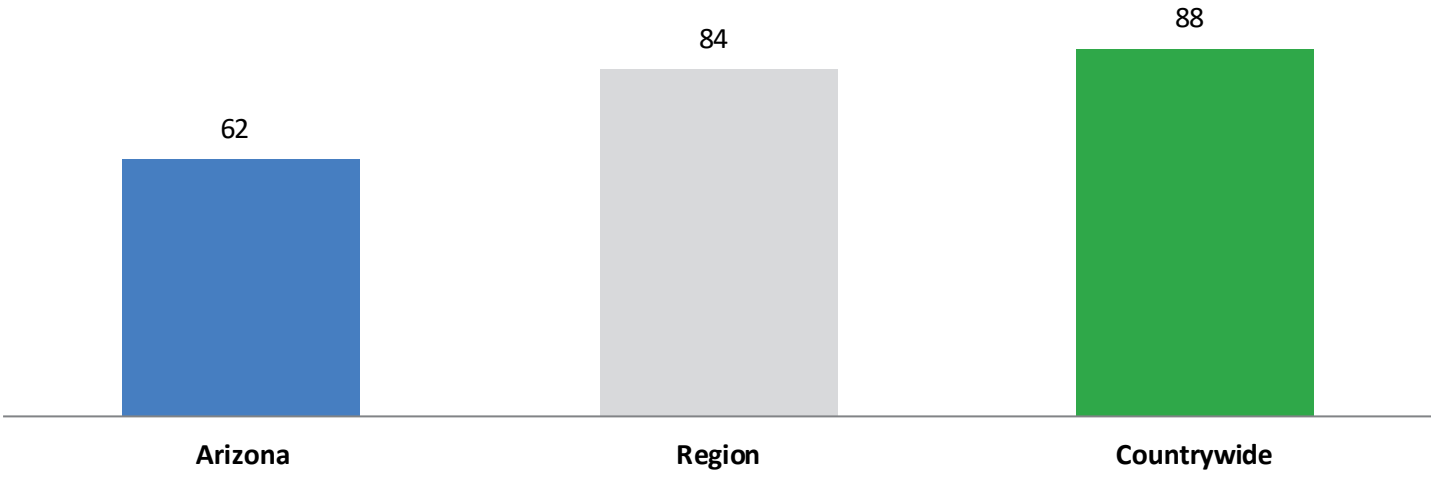


Chart 35

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



Nonsurgical services (such as physical therapy) represent 47% of hospital outpatient payments in Arizona. Chart 36 displays the average amount paid per visit for hospital outpatient nonsurgical services, while Chart 37 displays the average number of visits per year per 1,000 active claims for hospital outpatient nonsurgical services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 36

Average Amount Paid per Nonsurgical Visit for Hospital Outpatient Services

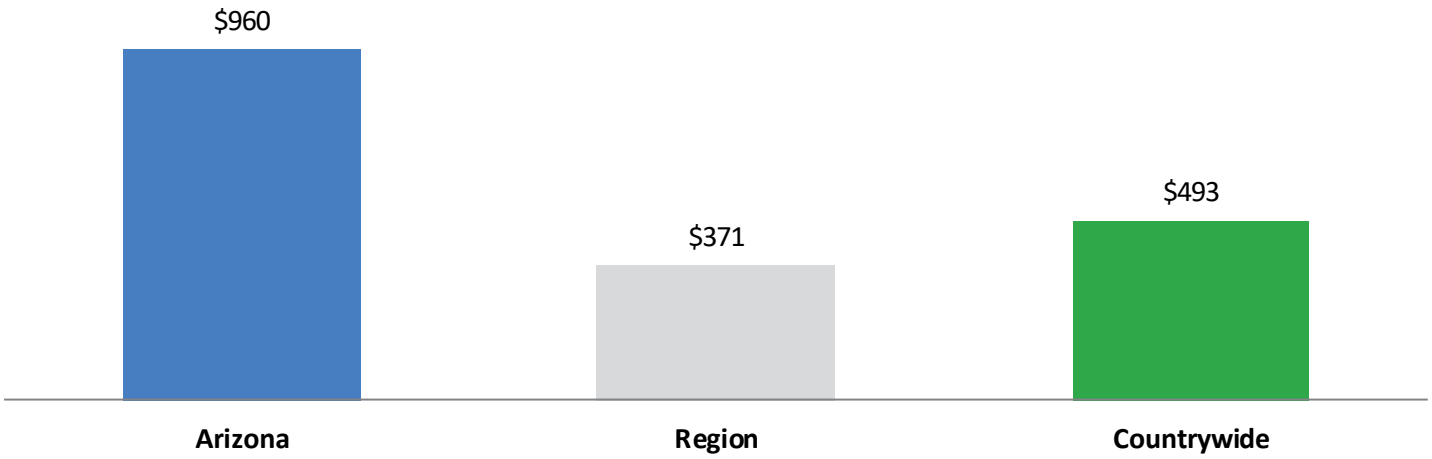


Chart 37

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

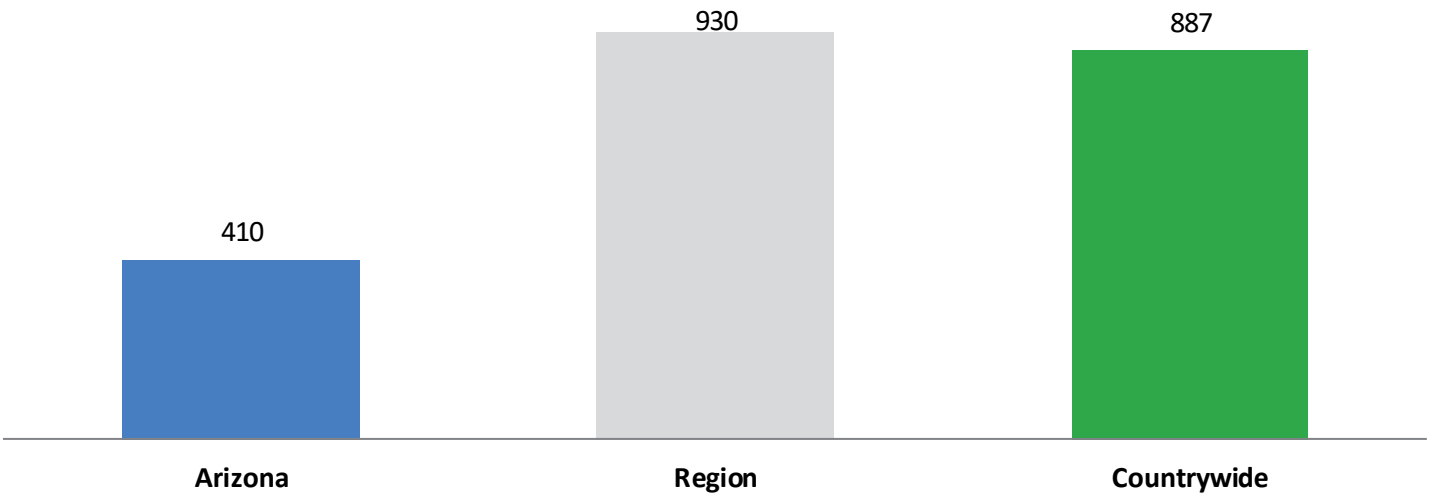
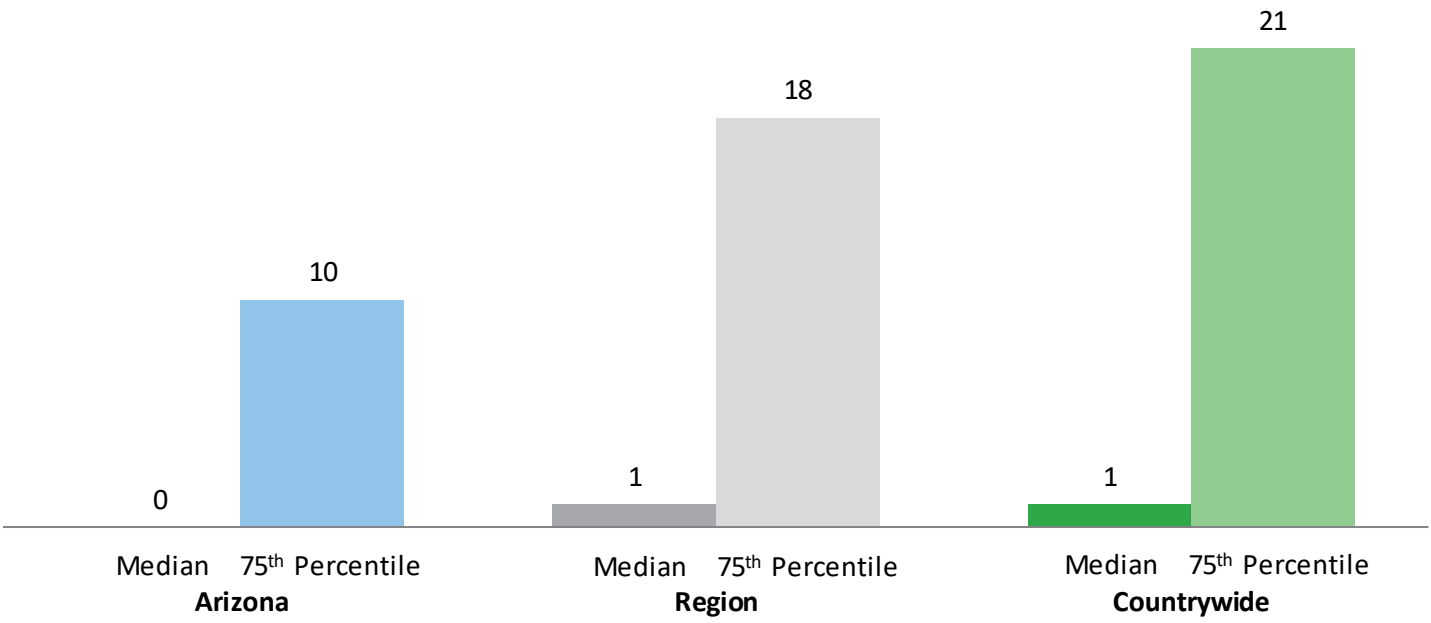


Chart 38 shows the median and 75th percentile time until first treatment for outpatient visits, other than emergency room visits, for Arizona, the region, and countrywide.

Chart 38

Time Until First Treatment for Outpatient Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2016 and Service Years 2016 and 2017.

Chart 39 displays the median amount paid per visit for outpatient services in Arizona, the region, and countrywide for the top 10 diagnosis groups in Arizona. The diagnosis groups are ranked based on total payments in Arizona.

Chart 39

Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services

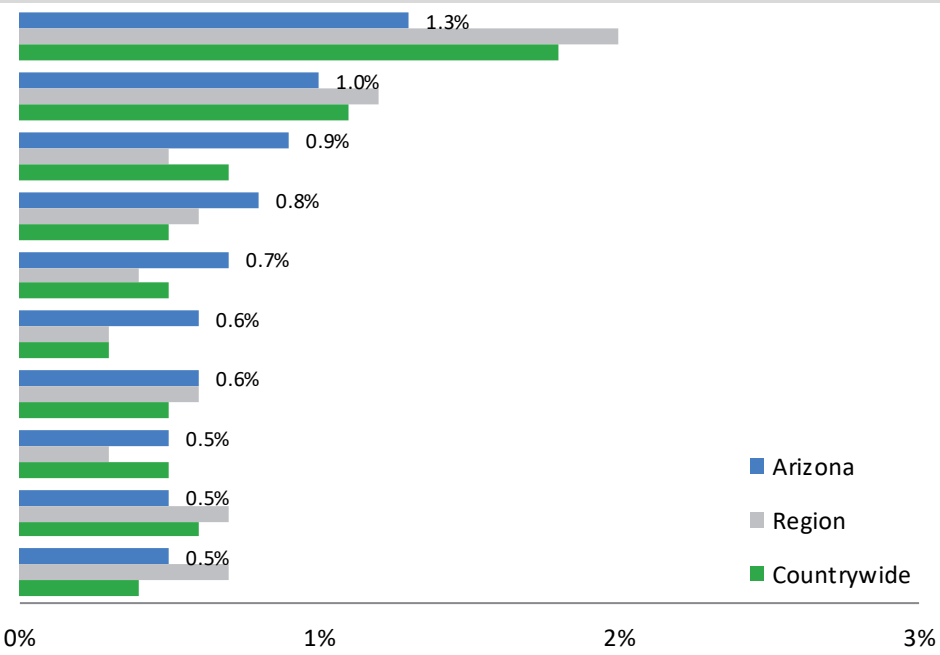
Diagnosis Group	Paid Share	Median Amount Paid Per Visit		
		Arizona	Region	Countrywide
Rotator cuff tear	4.3%	$325	$163	$204
Open wound of wrist, hand and fingers	4.2%	$772	$443	$507
Fracture of forearm	4.0%	$478	$165	$248
Fracture of lower leg, including ankle	3.4%	$411	$163	$224
Fracture at wrist and hand level	2.9%	$608	$180	$292
Intracranial injury	2.7%	$293	$256	$357
Neck pain	2.2%	$419	$170	$239
Other and unspecified injuries of head	2.2%	$1,910	$586	$853
Other joint disorder, not elsewhere classified	2.2%	$266	$158	$183
Fracture of foot and toe, except ankle	2.2%	$688	$209	$293

Charts 40 and 41 display the average amount paid per visit for outpatient services in Arizona, the region, and countrywide for the top 10 surgery CPT and nonsurgery CPT codes in Arizona. In 2017, 63% of Hospital Outpatient costs were reported with a CPT code. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the table below.

Chart 40

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

Code	Average PPT AZ	Region	CW
29827	$6,455	$4,748	$4,824
29881	$5,053	$3,268	$3,939
29826	$4,025	$1,748	$2,234
20680	$5,195	$2,624	$3,332
29823	$6,729	$2,447	$3,056
25609	$11,985	$5,485	$6,201
49505	$9,055	$3,783	$4,520
64721	$4,913	$2,085	$2,635
49650	$7,875	$5,045	$6,092
23430	$4,977	$4,359	$4,026

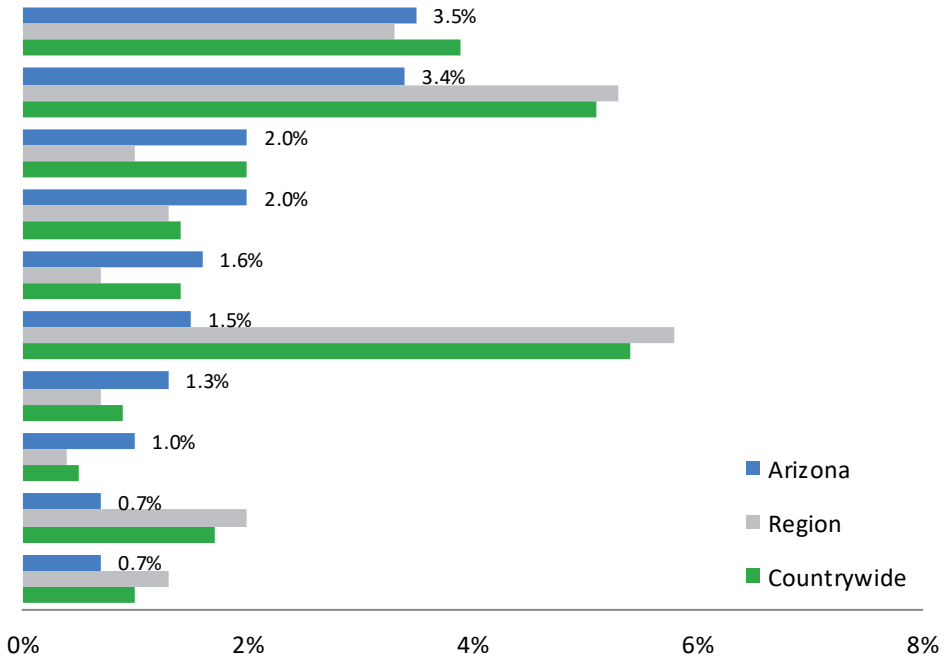


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release when performed
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
29823	Arthroscopy, shoulder, surgical; debridement extensive
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
49505	Repair initial inguinal hernia, age 5 years or older; reducible
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
49650	Laparoscopy, surgical; repair initial inguinal hernia
23430	Tenodesis of long tendon of biceps

Chart 41

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

Code	Average PPT AZ	Region	CW
99284	$936	$600	$695
99283	$560	$372	$441
70450	$1,315	$391	$834
99285	$1,527	$916	$1,057
72125	$1,746	$484	$1,009
97110	$164	$95	$122
74177	$2,893	$924	$1,762
G0378	$1,576	$753	$1,093
97140	$127	$62	$85
99282	$325	$223	$258



Code	Description
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.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
70450	Computed tomography (CT) head or brain; without contrast material
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
72125	Computed tomography (CT), cervical spine; without contrast material
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
74177	Computed tomography (CT), abdomen and pelvis; with contrast material
G0378	Hospital observation service, per hour
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
99282	Emergency department visit. Usually the presenting problem(s) are of low to moderate severity.

In Arizona, 21% of the payments associated with facilities (ASC, hospital outpatient, and hospital inpatient) are for emergency room payments, compared to 18% countrywide.

Chart 42 displays the average amount paid per visit for emergency room services for Arizona, the region, and countrywide. The average amount paid 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 43 displays the number of visits per year per 1,000 active claims for emergency room services for Arizona, as well as for the region and countrywide.

Chart 42

Average Amount Paid per Emergency Room Visit

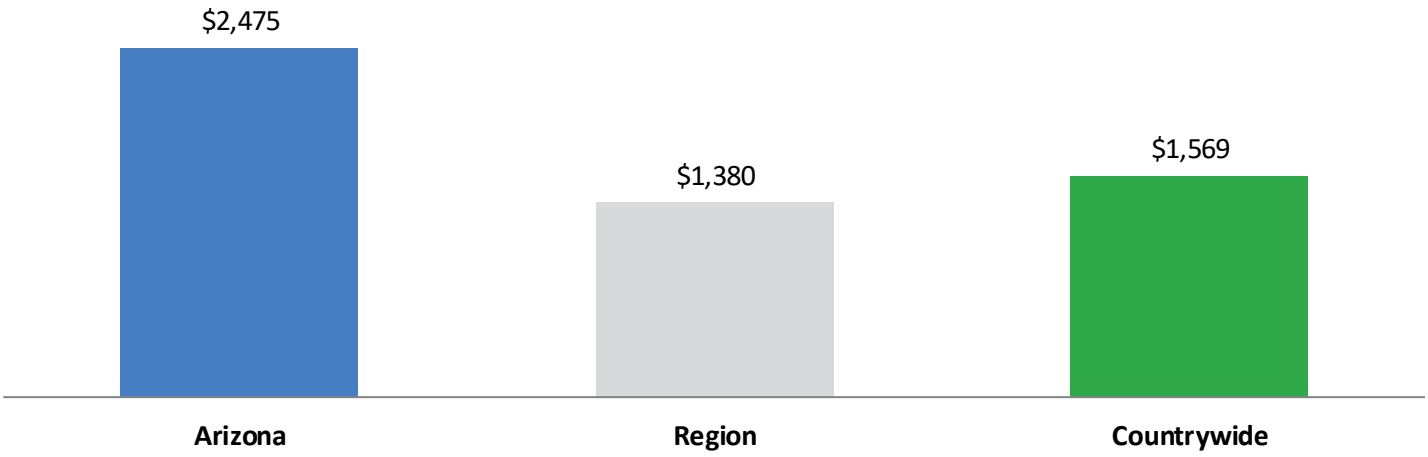


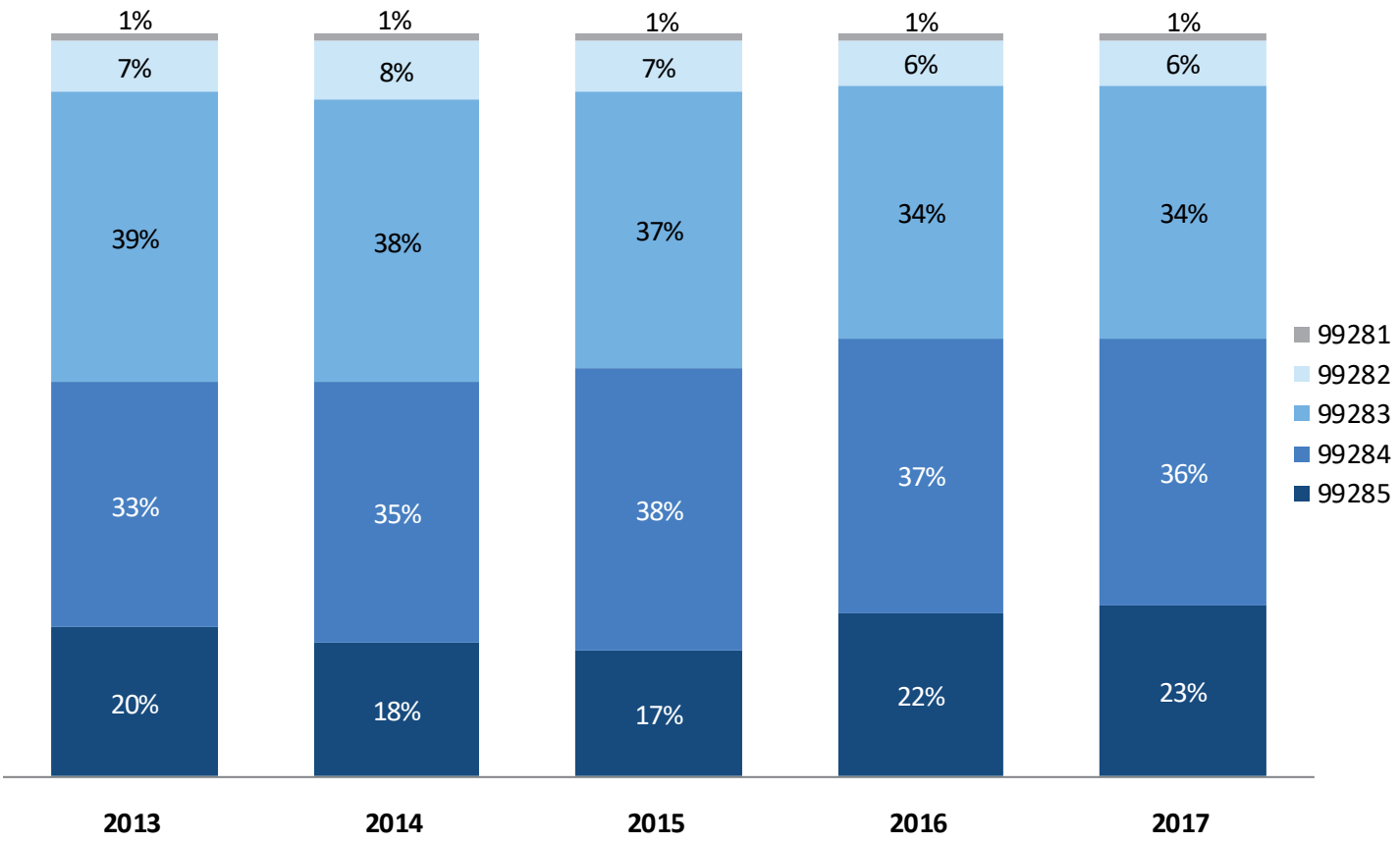
Chart 43

Average Number of Emergency Room Visits per 1,000 Active Claims

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

Chart 44

Emergency Room Payments by Procedure Code for Arizona



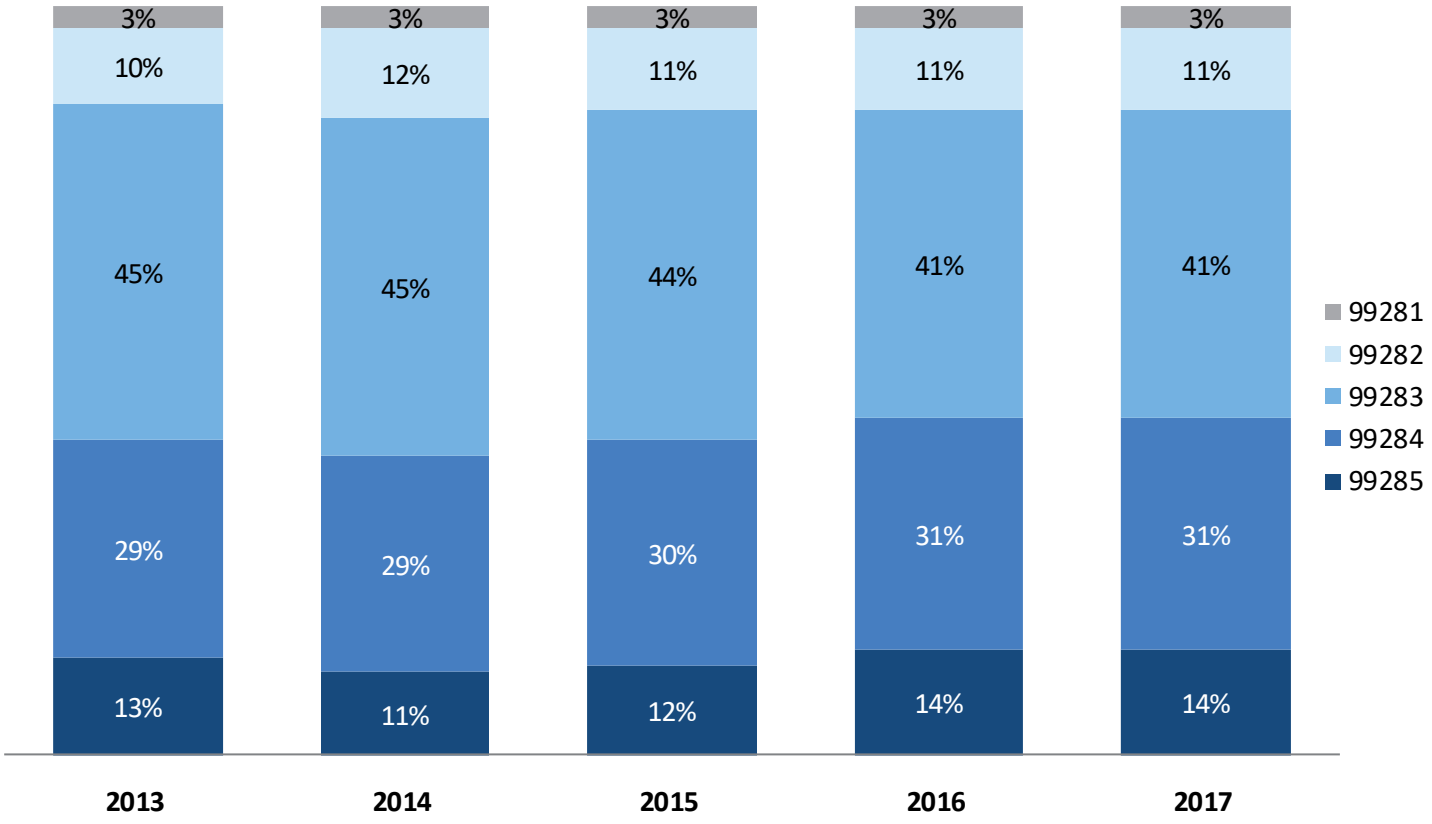
Source: NCCI's Medical Data Call, Service Years 2013 to 2017.

		Average PPT				
Code	Severity	2013	2014	2015	2016	2017
99281	Minor	$145	$151	$172	$194	$178
99282	Low to moderate	$208	$239	$240	$250	$270
99283	Moderate	$267	$287	$311	$341	$359
99284	High	$354	$413	$453	$497	$528
99285	High and immediately life-threatening	$483	$535	$549	$689	$739

Chart 45 shows a five-year snapshot of experience for each procedure type per service year.

Chart 45

Emergency Room Transactions by Procedure Code for Arizona



Source: NCCI's Medical Data Call, Service Years 2013 to 2017.

Code	Severity
99281	Minor
99282	Low to moderate
99283	Moderate
99284	High
99285	High and immediately life-threatening

Ambulatory Surgical Centers

Ambulatory surgical centers 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 chart below shows the average percentage of Medicare schedule reimbursement amounts for ASC payments for Arizona, the region, and countrywide.

Chart 46

ASC Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Ambulatory Surgical Center	308%	208%	285%

Source: NCCI's Medical Data Call for Service Year 2017. Region includes AK, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Chart 47 displays percentage of medical payments for ASC services for Arizona, the region, and countrywide.

Chart 47

Distribution of Medical Payments for ASC

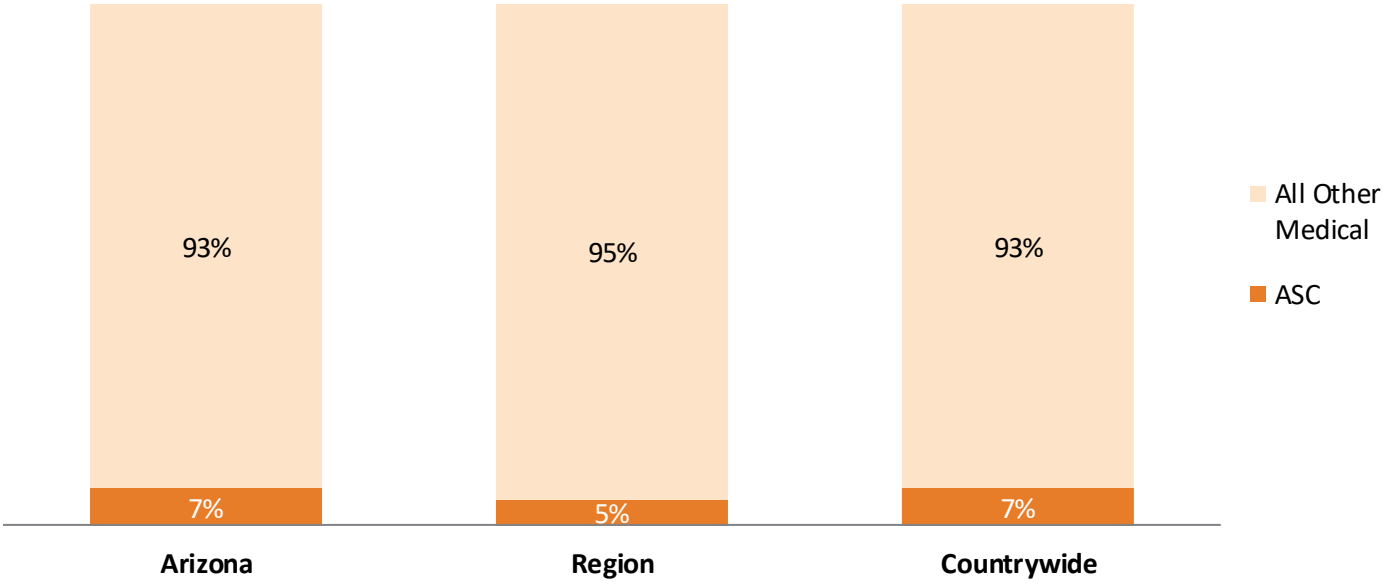


Chart 48 displays the average amount paid per visit for ASC services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions. Chart 49 displays the number of ASC visits per year per 1,000 active claims for Arizona, the region, and countrywide.

Chart 48

Average Amount Paid per Visit for ASC Services

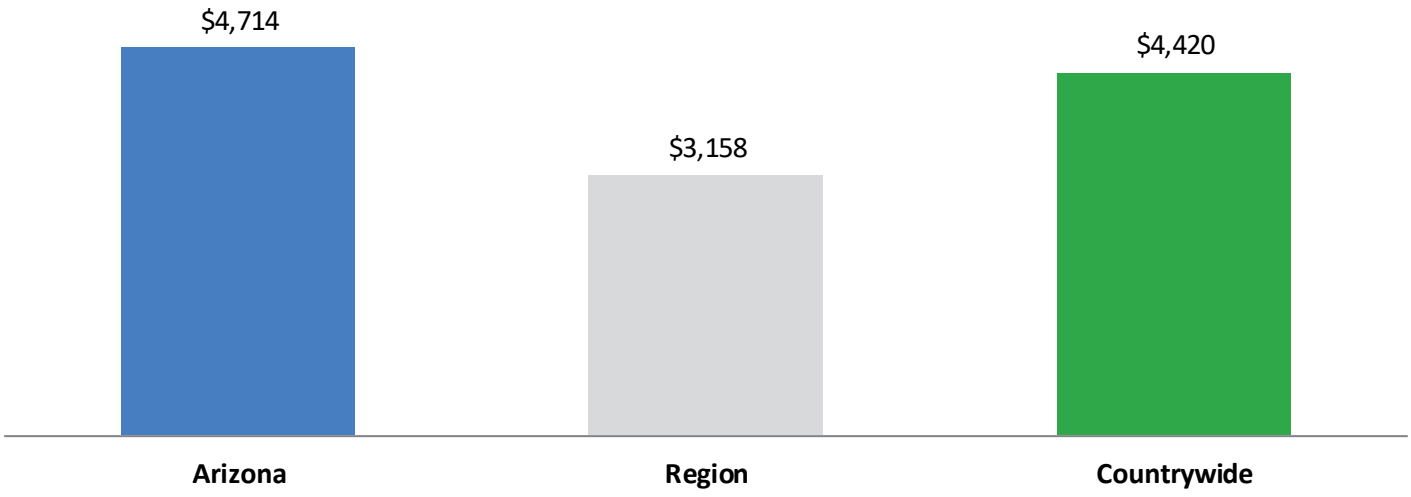


Chart 49

Average Number of ASC Visits per 1,000 Active Claims

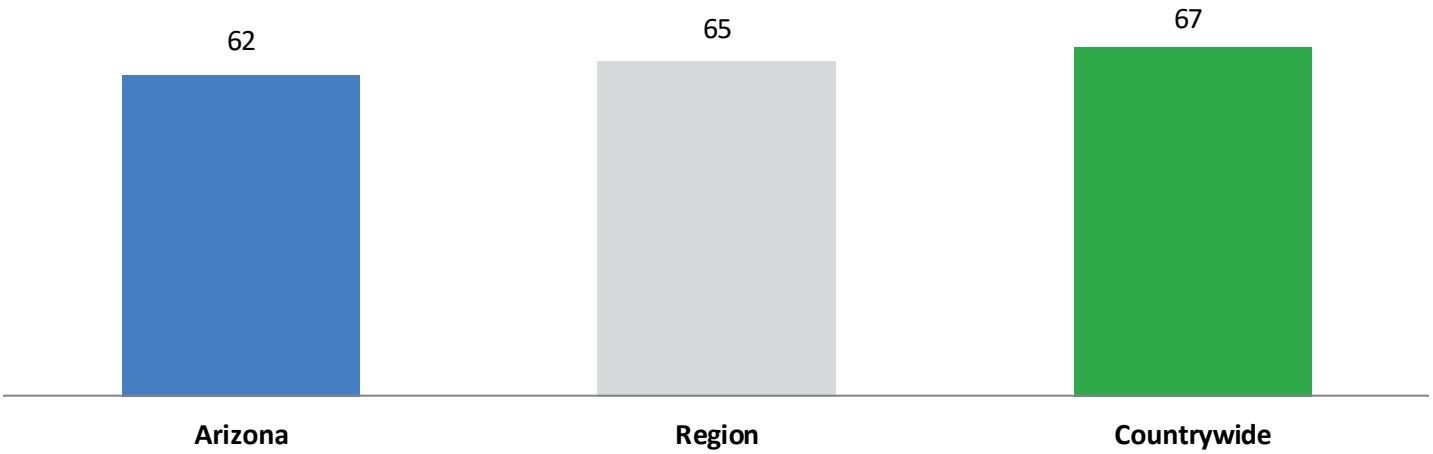
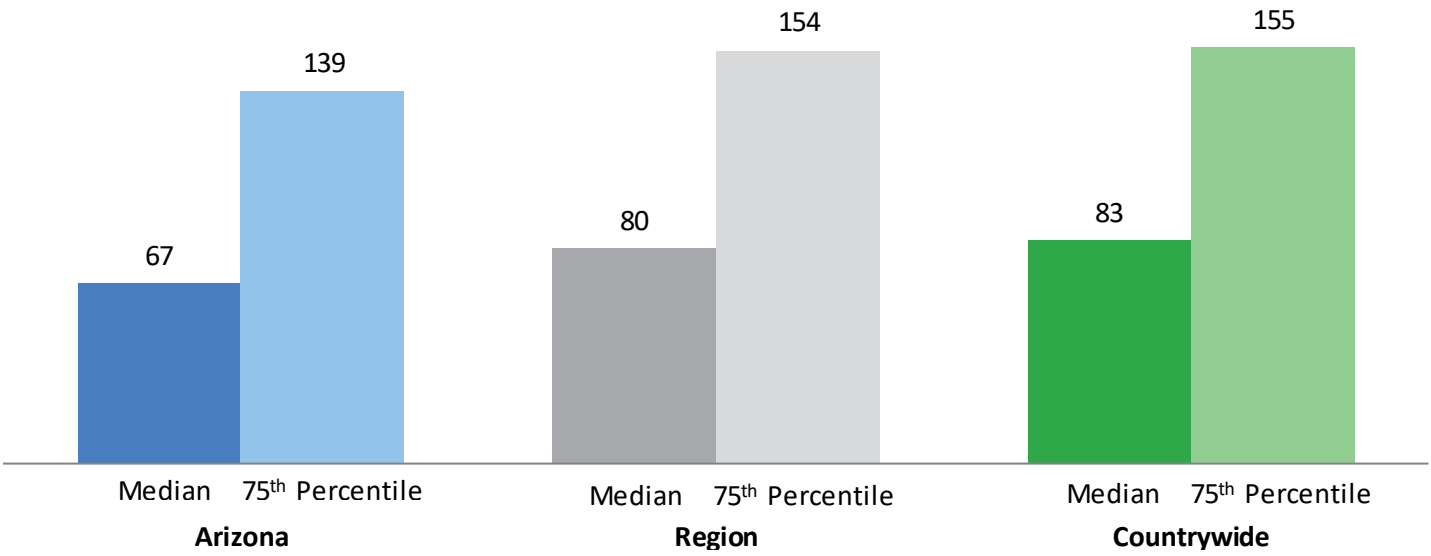


Chart 50 shows the median and 75th percentile time until first treatment for ASC visits for Arizona, the region, and countrywide.

Chart 50

Time Until First Treatment for ASC Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2016 and Service Years 2016 and 2017.

Chart 51 displays the top 10 diagnosis groups for ASC visits. The diagnosis groups are ranked based on total payments in Arizona.

Chart 51

Top 10 Diagnosis Groups by Amount Paid for ASC Services

Diagnosis Group	Paid Share	Median Amount Paid per Visit		
		Arizona	Region	Countrywide
Rotator cuff tear	7.4%	$7,326	$6,463	$8,684
Knee internal derangement - meniscus injury	5.7%	$4,618	$3,034	$3,692
Lumbar spine degeneration	5.5%	$1,953	$1,276	$1,710
Other specific joint derangements	4.5%	$7,904	$4,281	$5,847
Other joint disorder, not elsewhere classified	4.3%	$5,297	$1,038	$2,589
Dorsalgia	4.3%	$1,001	$806	$1,172
Inguinal hernia	4.0%	$7,618	$4,854	$4,835
Fracture at wrist and hand level	3.2%	$3,732	$2,975	$3,694
Fracture of foot and toe, except ankle	3.1%	$7,967	$3,694	$4,679
Lumbosacral intervertebral disc disorders	2.9%	$1,234	$858	$1,264

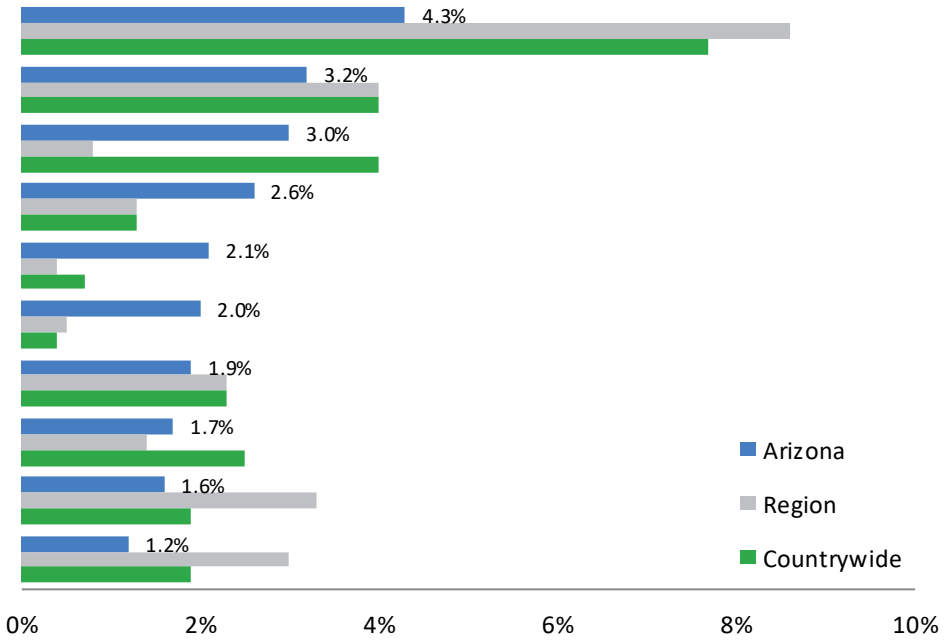
Typically, only surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes. The predominant revenue code reported for ASC services is code 0490—Ambulatory Surgical Care. In Arizona, code 0490 represents 93% of ASC payments reported by revenue codes.

Chart 52 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 52

Top 10 Surgery Procedure Codes by Amount Paid for ASC Services

Code	Average PPT AZ	Region	CW
29827	$5,933	$5,389	$5,987
29881	$4,481	$2,731	$3,709
29826	$3,939	$1,822	$3,963
20680	$4,162	$1,789	$2,664
63047	$18,926	$5,391	$8,811
49505	$7,862	$3,388	$4,225
64483	$1,058	$729	$1,089
29823	$3,907	$2,056	$3,526
29888	$6,129	$7,183	$7,162
23430	$5,288	$4,848	$4,831



Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release when performed
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
63047	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
49505	Repair initial inguinal hernia, age 5 years or older; reducible
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
29823	Arthroscopy, shoulder, surgical; debridement extensive
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23430	Tenodesis of long tendon of biceps

Prescription Drugs

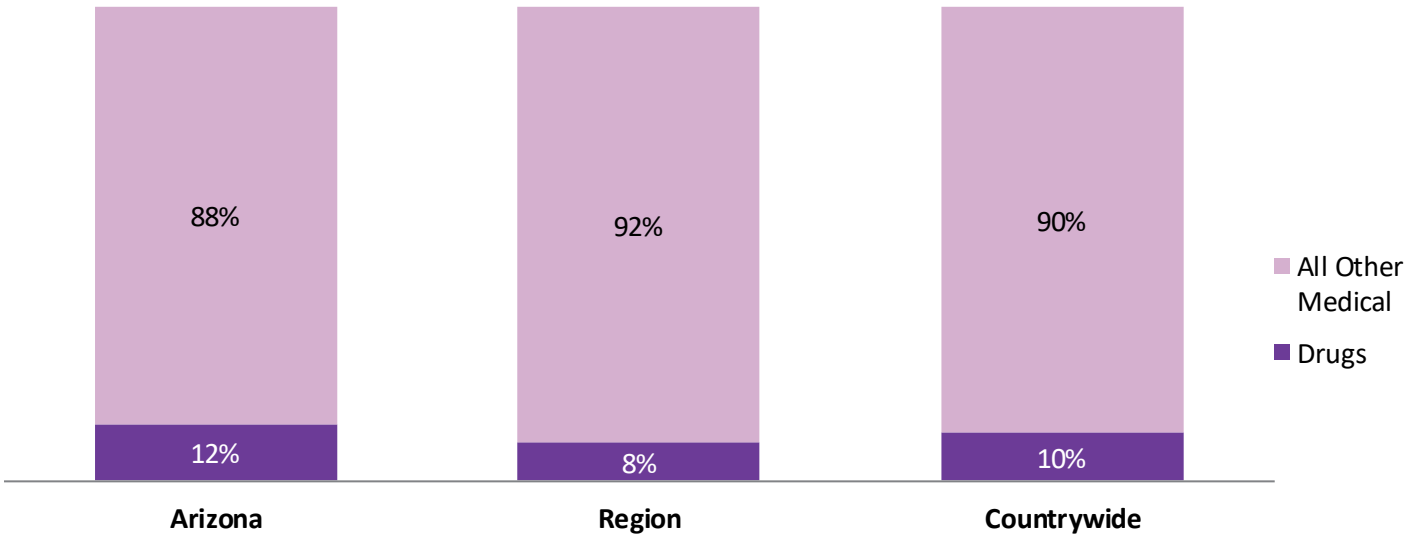
According to NCCI's research[5], the narcotics oxycodone and hydrocodone bitartrate-acetaminophen (commonly known as Oxycontin® and Vicodin®, respectively) were among the most widely prescribed drugs in workers compensation for Service Year 2016.

Drugs are uniquely identified by a national drug code (NDC). Charts 54 through 58 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 53 displays percentage of medical payments for drugs for Arizona, the region, and countrywide.

Chart 53

Distribution of Medical Payments for Drugs



[5] "Opioids–Killer Pain Relief", presented at ***Annual Issues Symposium***, May 2018

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

In Arizona, the share of claims observed in Service Year 2017 with at least one controlled substance was 15%. This compares to the region and countrywide shares of 15% and 14% , respectively. In 2017, Arizona spent $7.4M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 54 shows the distribution of prescription drug payments by CSA schedule in Arizona, the region and countrywide.

Chart 54

Distribution of Prescription Drug Payments by CSA Schedule

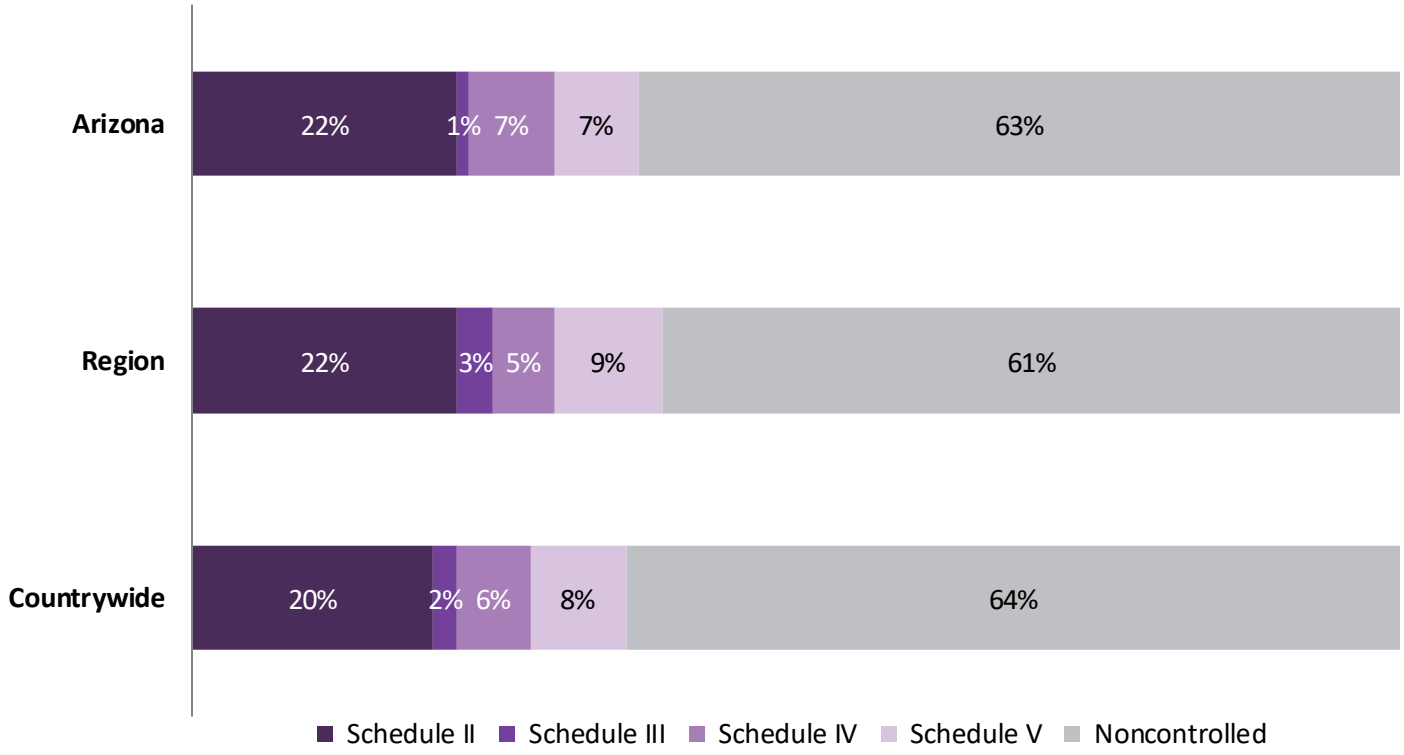


Chart 55 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Arizona. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also provided. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the average price per unit (PPU). (See Glossary for the definition of *unit*.)

Chart 55

Top 10 Workers Compensation Drugs by Amount Paid

Code	Average PPU AZ	Region	CW	Arizona Paid Share
Lyrica®	$7.15	$6.95	$7.10	7.0%
Oxycontin®	$9.61	$8.02	$8.84	6.7%
Gabapentin	$1.30	$1.01	$1.18	4.0%
Celecoxib	$4.99	$4.59	$5.09	3.3%
Duloxetine HCl	$5.73	$4.56	$5.18	3.0%
Lidocaine	$6.80	$6.07	$7.04	2.9%
Oxycodone HCl	$1.23	$1.00	$1.28	2.8%
Tramadol HCl	$1.25	$0.78	$1.14	2.6%
Oxycodone HCl-Acetaminophen	$1.61	$1.56	$1.70	2.5%
Meloxicam	$3.21	$2.88	$3.25	2.4%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Lyrica®	B	N/A	Miscellaneous Central Nervous System Agents	V	1
Oxycontin®	B	N/A	Analgesics/Antipyretics	II	2
Gabapentin	G	Neurontin®	Anticonvulsants	None	3
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	8
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	7
Lidocaine	G	Lidoderm®	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	6
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	10
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	9
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	4
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	5

Chart 56 displays the top 10 drugs used in workers compensation treatment, according to the number of prescriptions in Arizona. This chart reveals the most frequently prescribed drugs and the average PPU.

Chart 56

Top 10 Workers Compensation Drugs by Prescription Counts

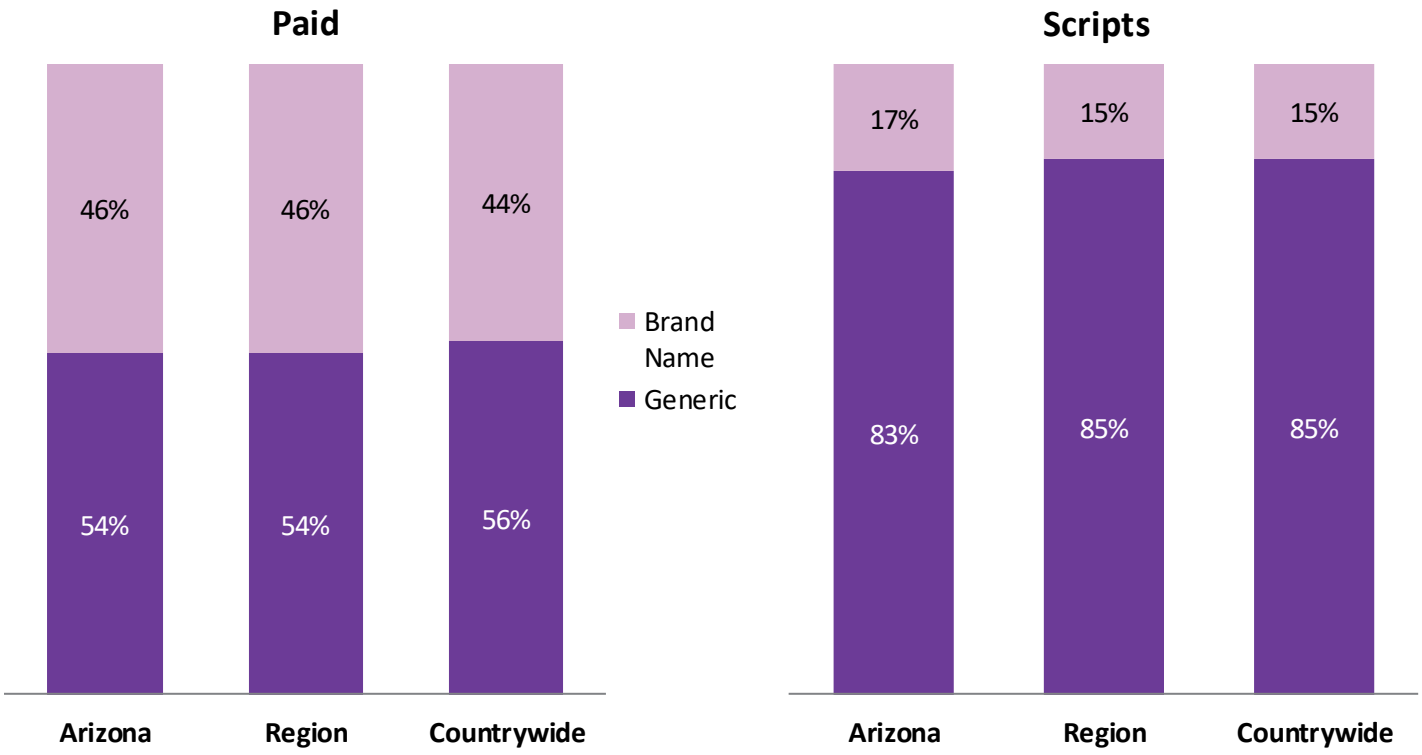
Drug Name	Average PPU AZ	Region	CW	Arizona Paid Share
Hydrocodone Bitartrate-Acetaminophen	$0.58	$0.55	$0.58	6.3%
Tramadol HCl	$1.25	$0.78	$1.14	4.4%
Gabapentin	$1.30	$1.01	$1.18	4.3%
Oxycodone HCl	$1.23	$1.00	$1.28	4.1%
Cyclobenzaprine HCl	$1.19	$0.96	$1.43	4.1%
Oxycodone HCl-Acetaminophen	$1.61	$1.56	$1.70	3.9%
Ibuprofen	$0.29	$0.47	$0.43	3.5%
Ibu®	$0.29	$0.27	$0.28	3.4%
Naproxen	$0.94	$0.88	$0.95	3.1%
Meloxicam	$3.21	$2.88	$3.25	2.5%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	4
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	8
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	5
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	7
Ibu®	B	N/A	Analgesics/Antipyretics	None	15
Naproxen	G	Aleve®	Analgesics/Antipyretics	None	9
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	6

Chart 57 shows the distribution of prescription drugs by brand name and generics for Arizona, the region, and countrywide. 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.

Chart 57

Distribution of Drugs by Brand Name and Generic

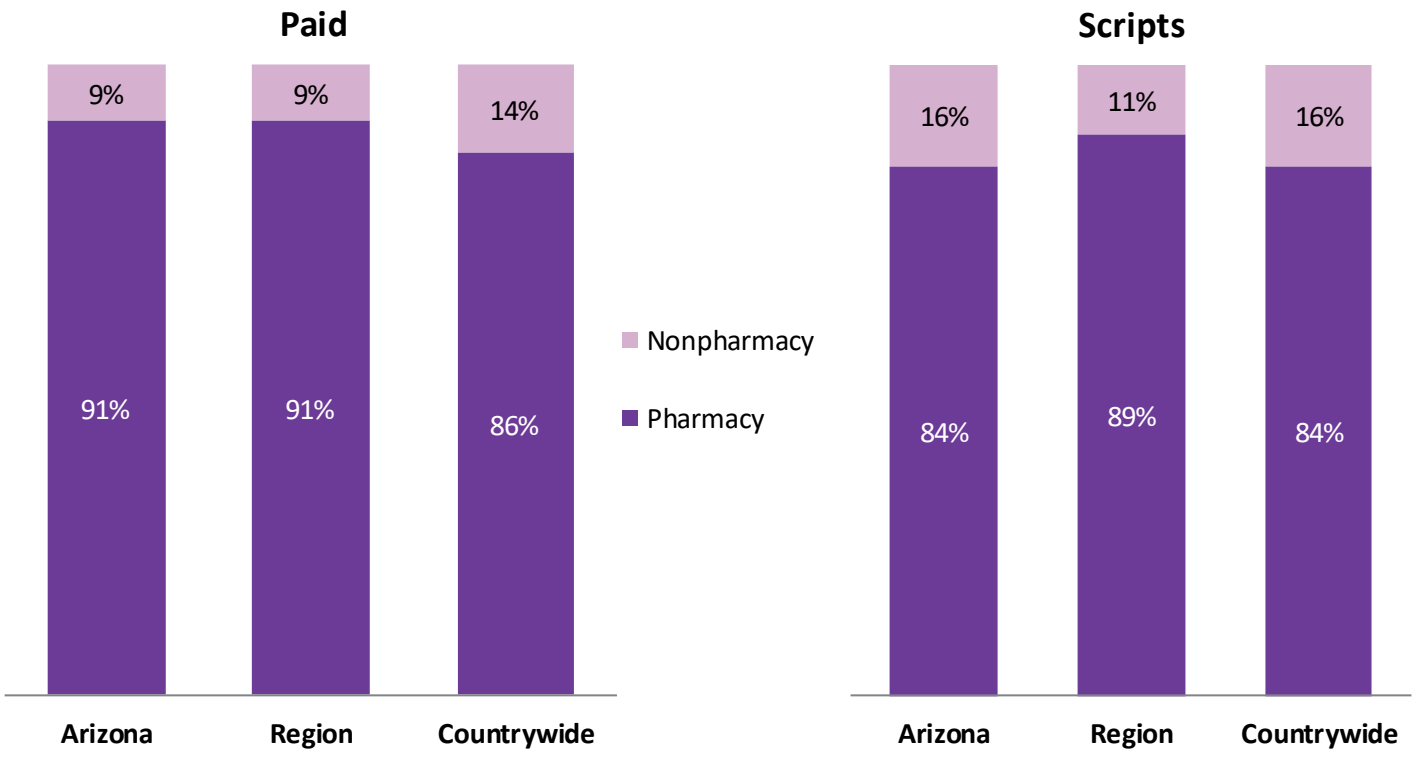


The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states limit or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight into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

Chart 58 shows the distribution of prescription drugs dispensed by pharmacies and nonpharmacies. The share between pharmacy-dispensed and nonpharmacy-dispensed is displayed, based on both prescription counts and payments, for Arizona, the region, and countrywide.

Chart 58

Distribution of Drugs by Pharmacy and Nonpharmacy



Durable Medical Equipment, Supplies and Implants

Chart 59 displays the distribution of medical payments by type of service for Durable Medical Equipment (DME), supplies and implants for Arizona, the region, and countrywide.

Chart 59

Distribution of Medical Payments for DME, Supplies and Implants

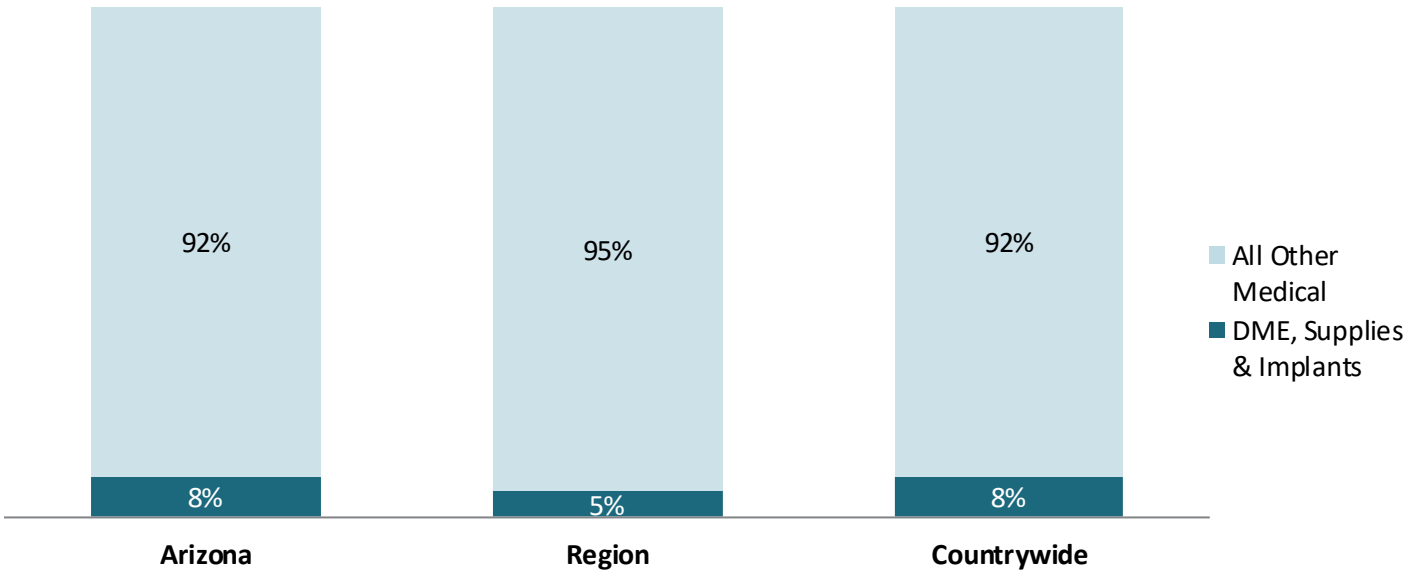


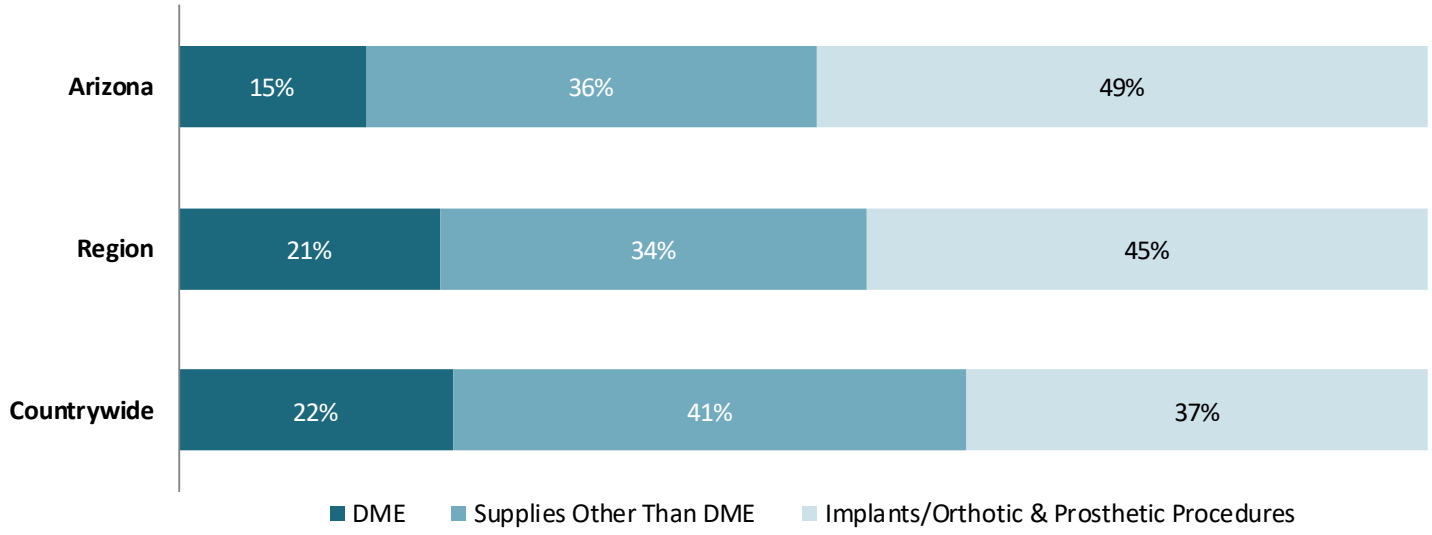
Chart 60 displays the distribution of payments among three separate categories:

- Durable Medical Equipment
- Supplies Other Than DME
- Implants/Orthotics and Prosthetics

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 60

Distribution of Payments DME, Supplies and Implants



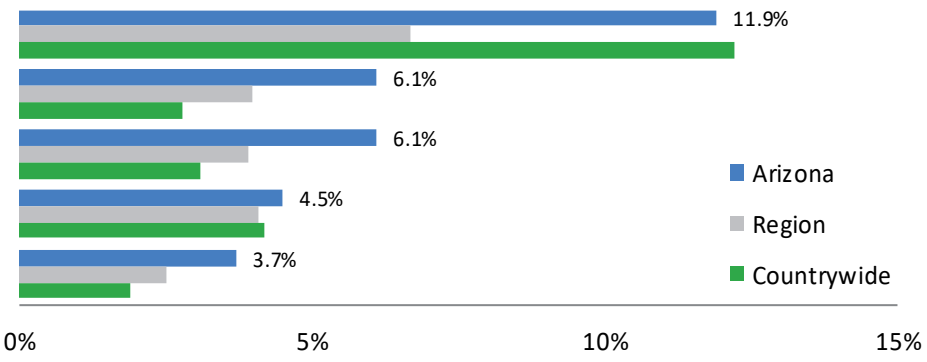
The most prevalent procedure code types reported for DMEs are Healthcare Common Procedure Coding System (HCPCS) codes. The predominant HCPCS code reported for DME is E1399—Durable Medical Equipment, Miscellaneous. In Arizona, code E1399 represents 29% of DME payments.

Chart 61 displays the top five HCPCS codes for DME other than code E1399. The codes are ranked based on total payments in Arizona. A brief description of each procedure code is displayed in the table below.

Chart 61

Top Five DME HCPCS Codes by Amount Paid

	Average PPT		
Code	**AZ**	**Region**	**CW**
E0676	$1,581	$1,300	$1,234
E0673	$537	$349	$400
E0747	$3,940	$3,581	$3,418
E0760	$3,800	$3,619	$3,569
E0218	$414	$283	$307



Code	Description
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified
E0673	Segmental gradient pressure pneumatic appliance, half leg
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive
E0218	Water circulating cold pad with pump

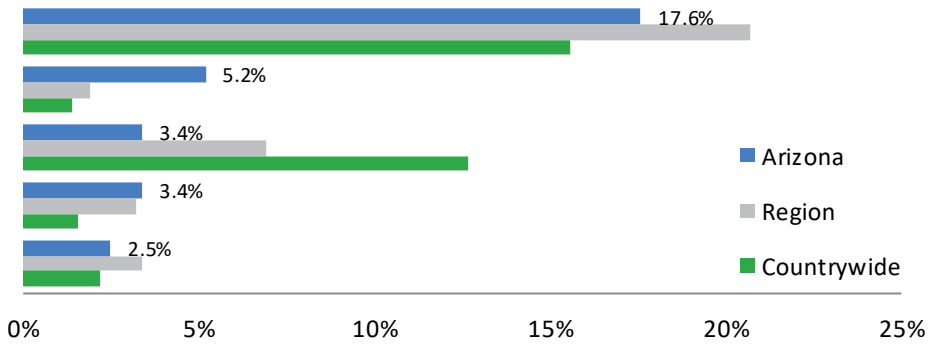
The most prevalent procedure code types reported for Supplies Other than DME are HCPCS codes and revenue codes. HCPCS codes represent 54% of Supplies other than DME payments, while revenue and other codes represent the other 46%.

Chart 62 displays the top five HCPCS codes for Supplies other than DME. The codes are ranked based on total payments in Arizona. A brief description of each procedure code is displayed in the table below.

Chart 62

Top Five Supplies Other Than DME HCPCS Codes by Amount Paid

Code	Average PPT AZ	Region	CW
C1713	$2,093	$1,408	$1,867
C1762	$10,062	$3,015	$3,603
99070	$30	$99	$221
A4353	$1,032	$1,264	$1,109
A4556	$63	$59	$62



Code	Description
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
C1762	Connective tissue, human (includes fascia lata)
99070	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	Intermittent urinary catheter, with insertion supplies
A4556	Electrodes (e.g., apnea monitor), per pair

The most prevalent procedure code types reported for Implants/Orthotics and Prosthetics are HCPCS codes and revenue codes. Revenue codes represent 58% of Implants/Orthotics and Prosthetics payments, while HCPCS codes represent 42%.

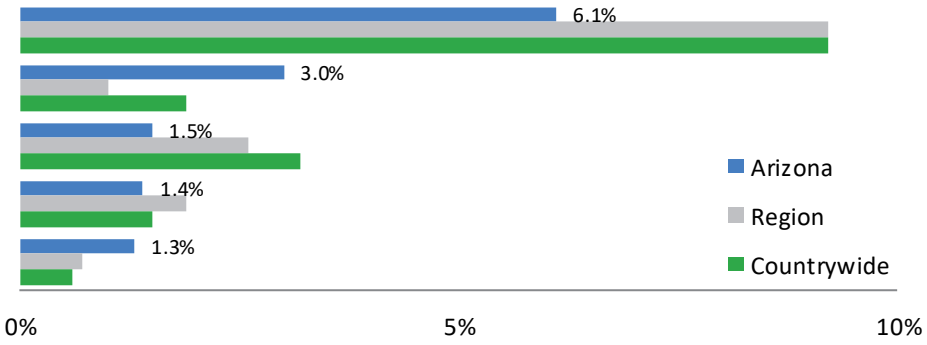
The predominant revenue code reported for Implants/Orthotics and Prosthetics is code 0278—medical/surgical supplies: other implants. In Arizona, payments for code 0278 represent 58% of Implants/Orthotics and Prosthetics payments.

Chart 63 displays the top five HCPCS codes for Implants/Orthotics and Prosthetics. The codes are ranked based on total payments in Arizona. A brief description of each HCPCS code is displayed in the table below.

Chart 63

Top Five Implants/Orthotics and Prosthetics HCPCS Codes by Amount Paid

Code	Average PPT AZ	Region	CW
L8699	$1,311	$1,360	$1,946
L5999	$13,708	$4,561	$10,087
L7499	$5,232	$6,532	$7,873
L4361	$308	$267	$260
L5856	$23,996	$22,695	$23,708



Code	Description
L8699	Prosthetic implant, not otherwise specified
L5999	Lower extremity prosthesis, not otherwise specified
L7499	Upper extremity prosthesis, not otherwise specified
L4361	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf
L5856	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type

Diagnosis Group and Body System

Charts 64 and 65 display the top 10 body systems and diagnosis groups, respectively. Body system and diagnosis group are identified for each claim based on ICD-10 (International Classification of Diseases) code. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 body systems and diagnosis groups are ranked by total claim payments for Arizona. This method of ranking shows which body systems and diagnosis groups have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2016, and December 31, 2016, and they include all reported services provided for those claims through December 31, 2017. 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 body systems and diagnosis groups.

Chart 64

Top Body Systems by Amount Paid for Dates of Injury in 2016

Body System	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Injury or Poisoning Not Otherwise Classified	38.7%	$3,018	$2,357	$2,759
Muscles	9.0%	$4,903	$4,509	$5,108
Knee	7.6%	$4,478	$4,298	$4,660
Shoulder	7.6%	$6,288	$7,165	$8,746
Hand/Wrist	7.0%	$2,496	$2,107	$2,531
Lumbar Spine	5.6%	$2,893	$3,434	$3,699
Neck	3.4%	$3,420	$3,918	$4,195
Ankle/Foot	3.2%	$1,630	$1,519	$1,677
Hip	2.6%	$9,142	$6,685	$7,534
Digestion	2.3%	$10,159	$7,586	$9,203

Chart 65

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2016

Diagnosis Group	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Low back pain	3.6%	$2,116	$2,509	$2,414
Open wound of wrist, hand and fingers	3.5%	$1,016	$860	$1,051
Fracture at wrist and hand level	3.3%	$7,527	$4,464	$5,254
Rotator cuff tear	3.2%	$14,360	$14,458	$19,053
Fracture of forearm	3.0%	$18,184	$12,240	$13,472
Fracture of lower leg, including ankle	2.8%	$19,572	$15,177	$17,920
Knee internal derangement - meniscus injury	2.8%	$13,868	$10,659	$13,042
Minor knee injury	2.8%	$2,098	$2,116	$2,269
Other joint disorder, not elsewhere classified	2.8%	$4,569	$4,548	$5,028
Minor hand/wrist injuries	2.6%	$1,287	$1,275	$1,348

Comparison of Selected Results by Year

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

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

Distribution of Medical Payments for Arizona (Chart 4)

Medical Category	2013	2014	2015	2016	2017
Physician	33%	32%	33%	33%	32%
Hospital Outpatient	13%	14%	14%	15%	18%
Hospital Inpatient	15%	14%	16%	16%	15%
ASC	5%	6%	6%	7%	7%
Drugs	13%	14%	14%	13%	12%
DME, Supplies, and Implants	8%	7%	7%	7%	8%
Other	13%	13%	10%	9%	8%

Distribution of Physician Payments by AMA Service Category for Arizona (Chart 7)

AMA Service Category	2013	2014	2015	2016	2017
Anesthesia	4%	3%	3%	3%	3%
Surgery	23%	22%	21%	20%	20%
Radiology	10%	10%	9%	9%	9%
Pathology	4%	3%	3%	3%	3%
Physical Medicine	27%	30%	31%	31%	30%
General Medicine	6%	4%	4%	4%	4%
Evaluation and Management	24%	26%	26%	27%	28%
Other	2%	2%	3%	3%	3%

Median Time Until First Treatment (in Days) (Charts 19–22, 29, 38, and 50)[6]

Medical Category	AY 2012	AY 2013	AY 2014	AY 2015	AY 2016
Physicians - Surgery	13	14	13	13	13
Physicians - Radiology	1	1	1	1	1
Physicians - Physical or Occupational Therapy	8	8	8	9	8
Physicians - Evaluation and Management	1	1	1	1	1
Hospital Inpatient	0	0	0	0	0
Hospital Outpatient	0	0	0	0	0
ASC	64	64	66	64	67

75th Percentile of Time Until First Treatment (in Days) (Charts 19–22, 29, 38, and 50)

Medical Category	AY 2012	AY 2013	AY 2014	AY 2015	AY 2016
Physicians - Surgery	84	86	90	90	91
Physicians - Radiology	5	5	6	6	6
Physicians - Physical or Occupational Therapy	28	27	28	29	31
Physicians - Evaluation and Management	3	3	3	3	3
Hospital Inpatient	11	5	7	4	4
Hospital Outpatient	5	7	7	6	10
ASC	140	132	134	138	139

Hospital Inpatient Statistics (Charts 25 and 27)

Hospital Inpatient Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Stay	$27,143	$29,354	$35,137	$37,386	$37,844
Number of Stays per 1,000 Active Claims	23	21	20	19	18

Distribution of Hospital Outpatient Payments by Surgery and Nonsurgery (Paragraphs preceding Charts 34 and 36)

Visit Type	2013	2014	2015	2016	2017
Surgery	45%	46%	49%	50%	53%
Nonsurgery	55%	54%	51%	50%	47%

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

Hospital Outpatient Surgery Statistics (Charts 34 and 35)

Hospital Outpatient Surgery Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Visit	$4,034	$4,705	$5,207	$5,948	$7,023
Number of Visits per 1,000 Active Claims	65	61	63	62	62

Hospital Outpatient Nonsurgery Statistics (Charts 36 and 37)

Hospital Outpatient Nonsurgery Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Visit	$735	$786	$840	$909	$960
Number of Visits per 1,000 Active Claims	429	422	413	411	410

Emergency Room Statistics (Charts 42 and 43)

Emergency Room Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Visit	$2,048	$2,040	$2,210	$2,418	$2,475
Number of Visits per 1,000 Active Claims	220	211	221	220	216

ASC Statistics (Charts 48 and 49)

ASC Statistics	2013	2014	2015	2016	2017
Average Amount Paid Per Visit	$3,236	$3,474	$3,813	$4,194	$4,714
Number of Visits per 1,000 Active Claims	72	72	74	72	62

Distribution of Prescription Drug Payments by CSA Schedule (Chart 54)

CSA Schedule	2013	2014	2015	2016	2017
Schedule II	27%	30%	27%	25%	22%
Schedule III	2%	2%	2%	1%	1%
Schedule IV	10%	9%	9%	8%	7%
Schedule V	5%	5%	5%	6%	7%
Non-Controlled	56%	54%	57%	60%	63%

Distribution of Drug Payments by Brand Name and Generic (Chart 57)

Type of Drug	2013	2014	2015	2016	2017
Brand Name	52%	48%	44%	46%	46%
Generic	48%	52%	56%	54%	54%

Distribution of Drug Payments by Pharmacy and Nonpharmacy (Chart 58)

Type of Provider	2013	2014	2015	2016	2017
Pharmacy	92%	92%	91%	91%	91%
Nonpharmacy	8%	8%	9%	9%	9%

Distribution of Payments by DME, Supplies, and Implants (Chart 60)

Category	2013	2014	2015	2016	2017
DME	17%	17%	16%	17%	15%
Supplies Other Than DME	35%	34%	35%	33%	36%
Implants/Orthotic and Prosthetic Procedures	48%	49%	49%	50%	49%

Glossary

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

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

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

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

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

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

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

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.

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

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.

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

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.

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

Transaction: A line item of a medical bill.

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

- For tablets, capsules, suppositories, nonfilled syringes, etc., *units* represent the actual number of the drug provided. For example, a bottle of 30 pills would have 30 units.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, the units are specified by the procedure code. For example, a cream is dispensed in a standard tube, which is defined as a single unit.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, the number of units is the amount provided in its standard unit of measurement (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 2017 (medical services delivered from January 1, 2017, to December 31, 2017), except where otherwise noted. Workers compensation 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 is required to report for all applicable states in which it writes workers compensation insurance, even if an individual state's market share is below the 1% 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 2017, the reported number of transactions was over 1,713,900, with more than $335,441,600 paid, for more than 69,500 claims. This represents 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, improve its accuracy and quality, and increase efficiency of computer systems.

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

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

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