Medical Data Report

For the state of

ARIZONA

September 2020

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Introduction

Medical costs have been growing over the last 30 years. Today, in many states, close to 60% of workers compensation benefits are attributed to medical costs. Managing the cost and delivery of medical care is one of the major concerns facing workers compensation 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 underlie the financial soundness of the workers compensation system. When making comparisons to the region and countrywide (CW), it is important to note that some states in this report do not have a fee schedule.

Knowing how payments for different services contribute to 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, Prosthetics, Orthotics and Supplies (DMEPOS)
- Other

The report drills down into these categories to show which 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.

The data contained in this report represents medical transactions for Service Year 2019 (medical services delivered from January 1, 2019, to December 31, 2019), 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 over the most recent three years for which NCCI is the rating or 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 an insurance group are required to report, regardless of whether they write less than 1% of the market share in the state.

For the state of Arizona in Service Year 2019, the reported number of transactions was more than 1,503,300, with more than $316,895,400 paid, for more than 68,200 claims. This represents data from 93% of the workers compensation premium written, which includes experience for large-deductible policies. Bulk payments and lump-sum settlements are not required to be reported. Also, self-insured data is not included.

Unless otherwise noted, the source for all data in this report is:

- NCCI's Medical Data Call, Service Year 2019
- 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

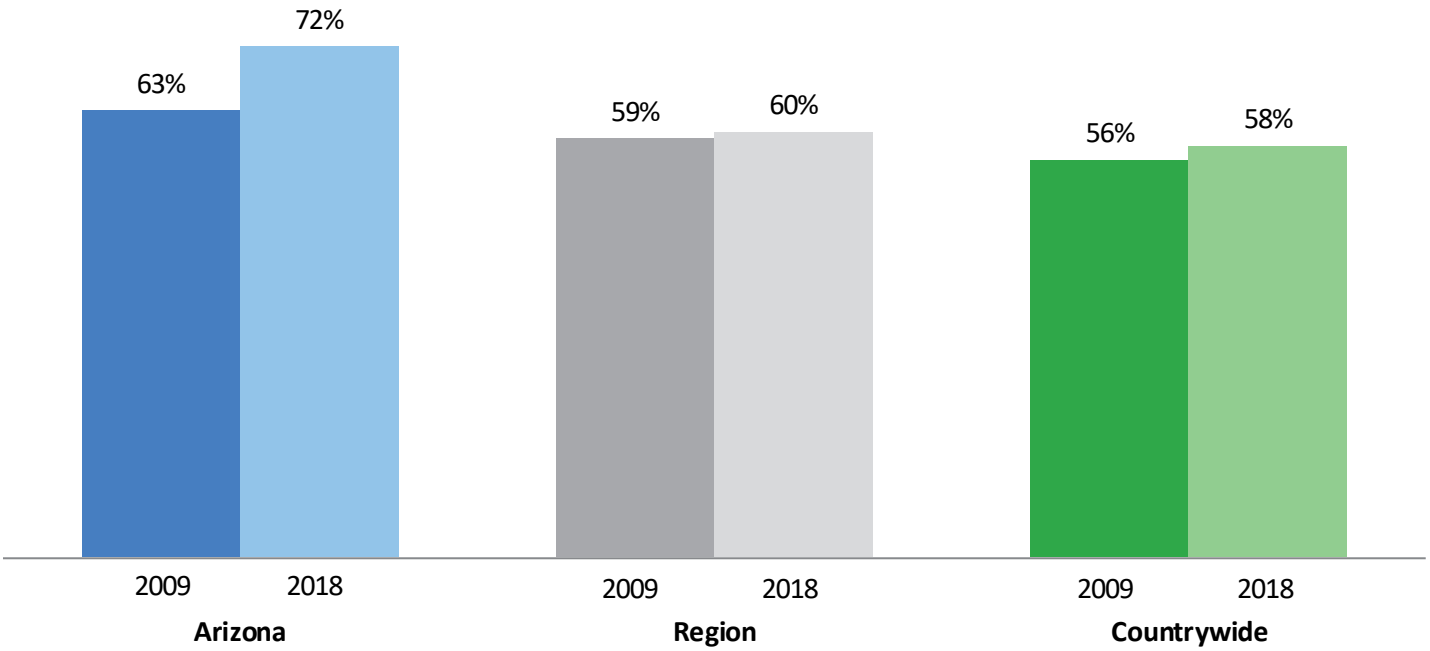
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

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

Chart 1 displays the medical percentage of total benefit costs for Arizona, the region, and countrywide for Accident Years 2009 and 2018.

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.

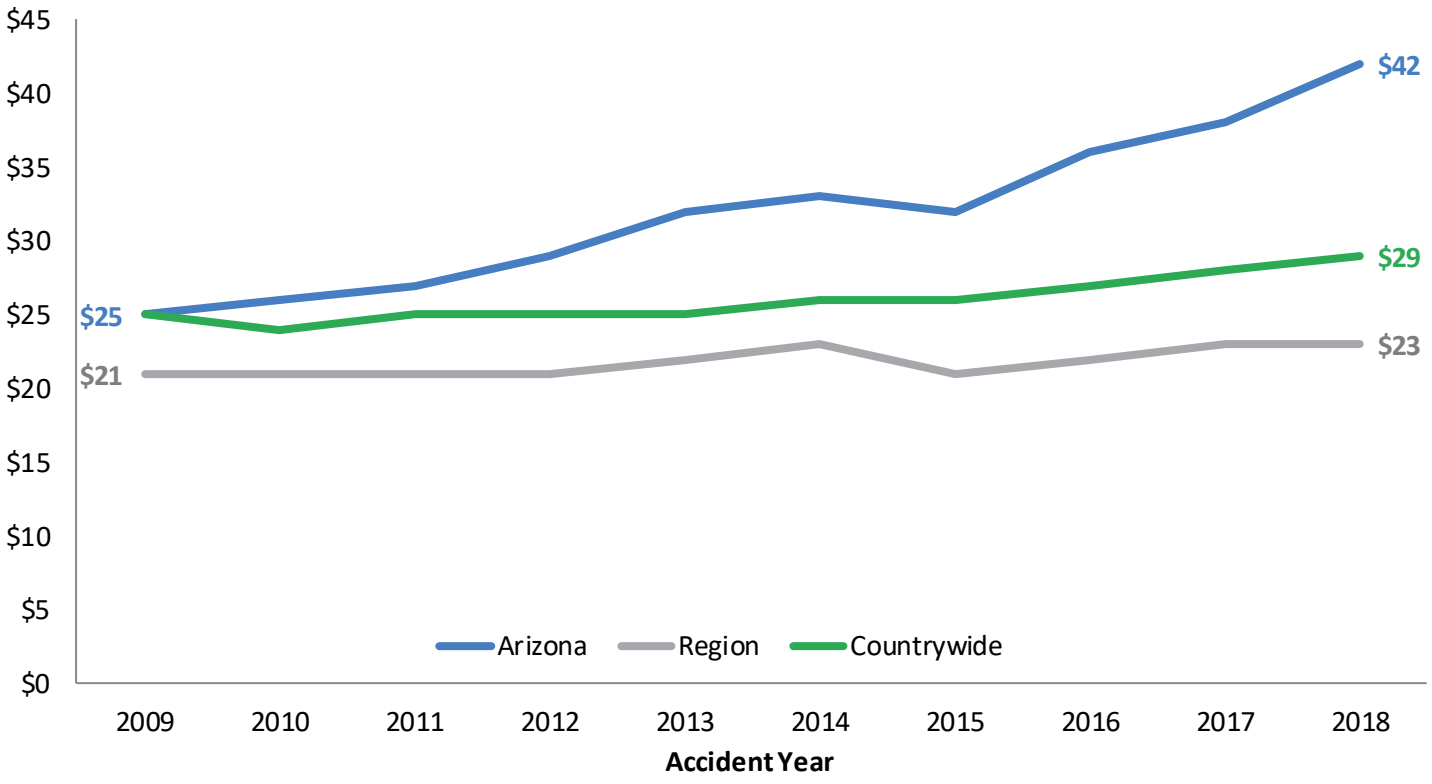
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging about 2% from Accident Years 2009 to 2018; this has increased at a similar rate as the United States Personal Healthcare Spending per capita. [1] Chart 2 displays the historical overall medical 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 AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, and WV.

[1] **State of the Line Report, *Annual Issues Symposium***, May 2020, www.ncci.com/Articles/Documents/AIS2020-SOTL-Presentation.pdf.

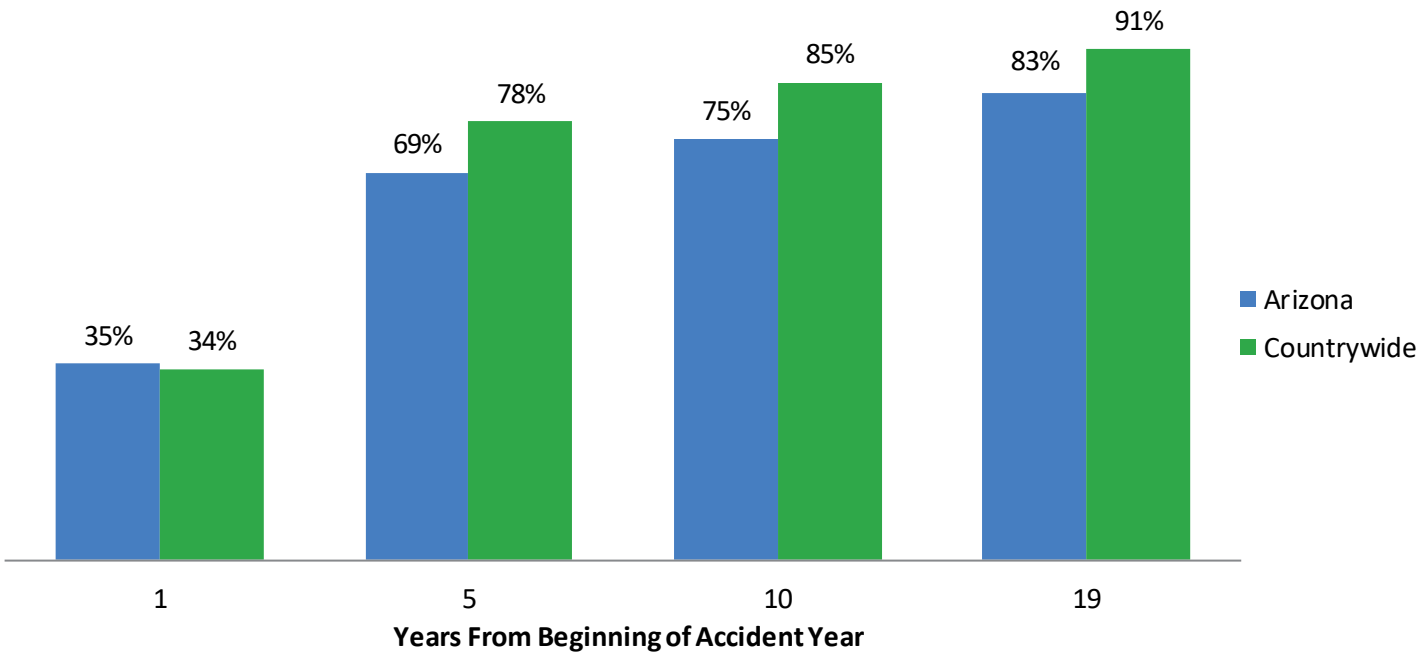
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. NCCI research has found that it is likely that about 10% of the cost of medical benefits for workplace injuries that occur this year will be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

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

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

Chart 3

Percentage of Medical Paid by Claim Maturity



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

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

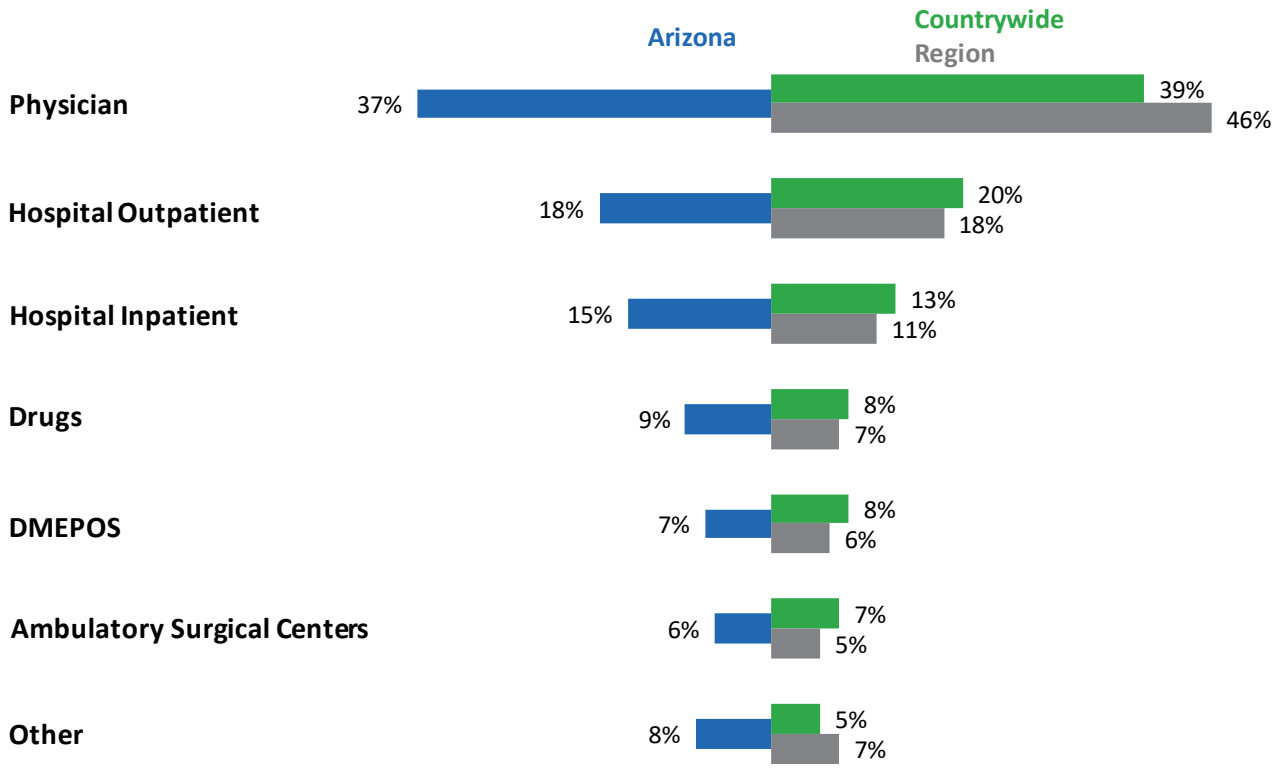
Payments are categorized as Drugs; DME, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed. For the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

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

Chart 4

Distribution of Medical Payments



Physicians

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

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

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

The chart below shows the average percentage of Medicare schedule reimbursement[2] amounts for physician payments by category for Arizona, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the five categories listed in the chart, and the state comparison reflects Medicare's geographic adjustments. In Arizona, 89% of "all physician services" payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

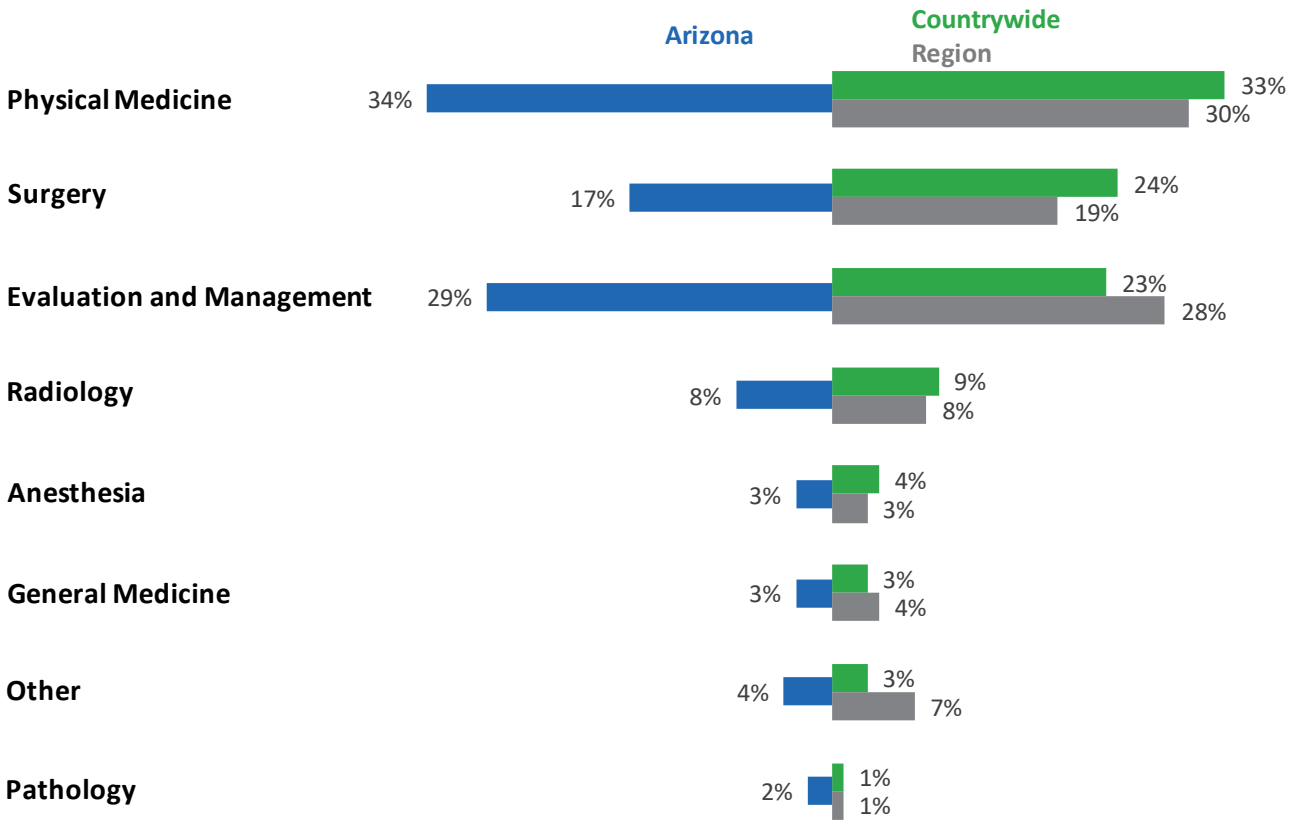
Physician Service Category	Arizona	Region	Countrywide
General and Physical Medicine	145%	134%	132%
Surgery	208%	215%	270%
Evaluation and Management	153%	153%	143%
Radiology	202%	221%	228%
Anesthesia	251%	254%	305%
All Physician Services	**163%**	**160%**	**168%**

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

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

Chart 6

Distribution of Physician Payments by AMA Service Category



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

Physicians typically use current 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. The charts below display the top 10 procedure codes reported by physicians for the following service categories: anesthesia, surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code is displayed in the corresponding table below each chart.

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

The Top 10 charts rank the procedure codes for each service category 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.

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

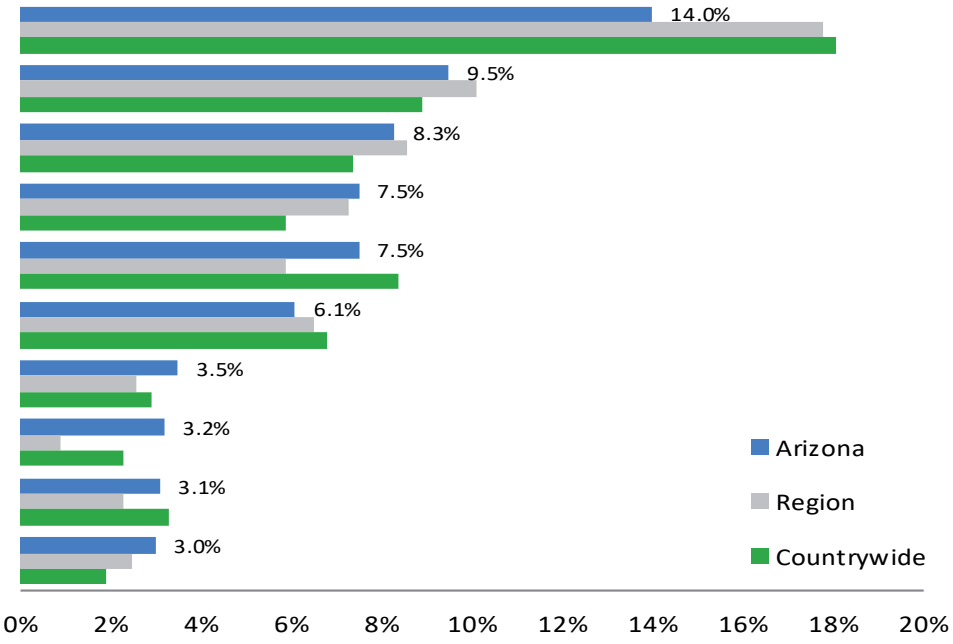
[3] Lipton, B. [Channel NCCI]. (2019, May 23). *Work Comp vs. Group Health-- The Price We Pay* [Video File]. Retrieved from https:/youtu.be/fb3tnbQoMSY.

In Arizona, physician payments for anesthesia services provided in 2019 are, on average, 251% of Medicare-scheduled reimbursement amounts, compared to 254% in the region and 305% countrywide. Payments for these services comprise 3% of physician payments, compared to 3% in the region and 4% countrywide.

Chart 7

Top 10 Anesthesia Procedure Codes by Amount Paid

	Average PPU[4]		
Code	**AZ**	**Region**	**CW**
01630	$83	$94	$93
01400	$93	$97	$96
01830	$75	$85	$80
01480	$73	$77	$76
00670	$99	$112	$112
01810	$78	$91	$89
00400	$82	$83	$80
01992	$72	$89	$99
01936	$87	$127	$116
00840	$130	$101	$104



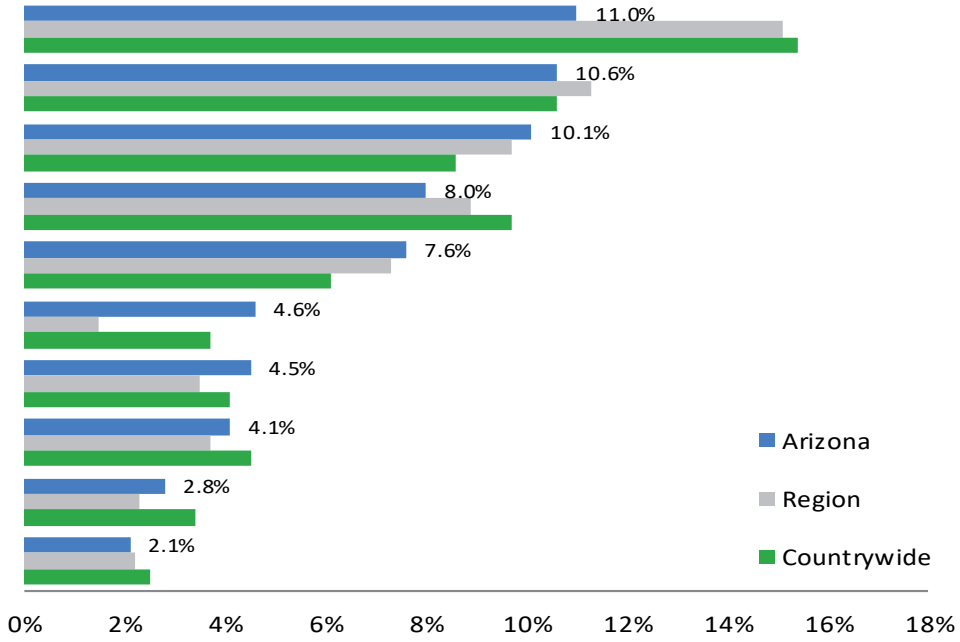
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified

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

Chart 8

Top 10 Anesthesia Procedure Codes by Transaction Counts

Code	Average PPU AZ	Region	CW
01630	$83	$94	$93
01400	$93	$97	$96
01830	$75	$85	$80
01810	$78	$91	$89
01480	$73	$77	$76
01992	$72	$89	$99
00400	$82	$83	$80
01936	$87	$127	$116
00670	$99	$112	$112
01710	$76	$85	$83



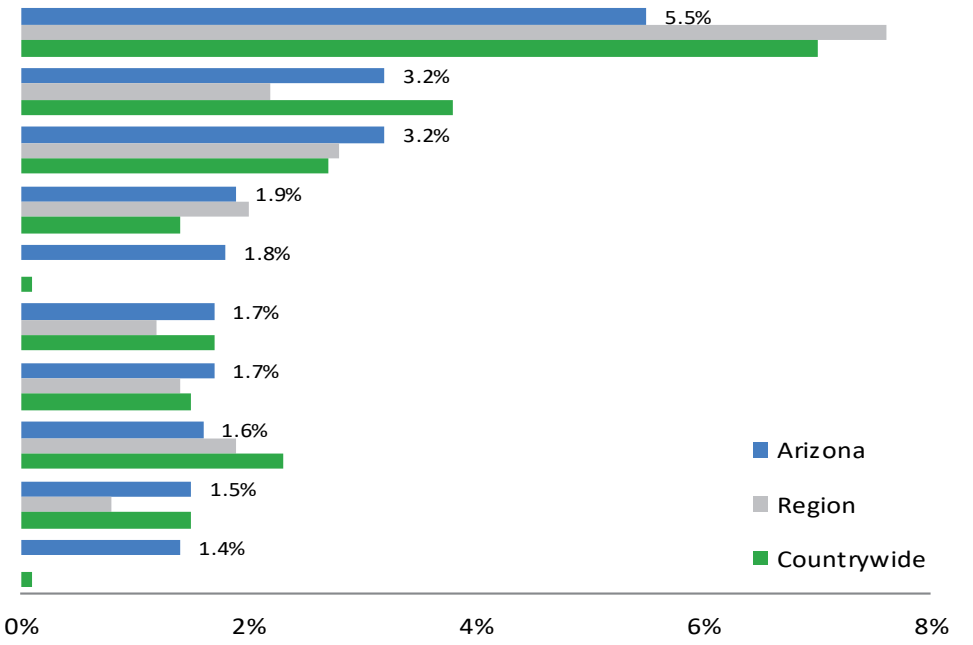
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified

In Arizona, physician payments for surgery services provided in 2019 are, on average, 208% of Medicare-scheduled reimbursement amounts, compared to 215% in the region and 270% countrywide. Payments for these services comprise 17% of physician payments, compared to 19% in the region and 24% countrywide.

Chart 9

Top 10 Surgery Procedure Codes by Amount Paid

	Average PPT		
Code	**AZ**	**Region**	**CW**
29827	$1,516	$1,876	$2,107
29826	$839	$472	$959
29881	$1,380	$1,156	$1,498
12001	$160	$163	$180
14302	$2,779	$1,260	$2,009
64483	$383	$376	$559
20610	$135	$125	$131
29823	$656	$721	$1,001
63047	$1,873	$1,628	$2,544
24346	$2,355	$1,257	$2,550

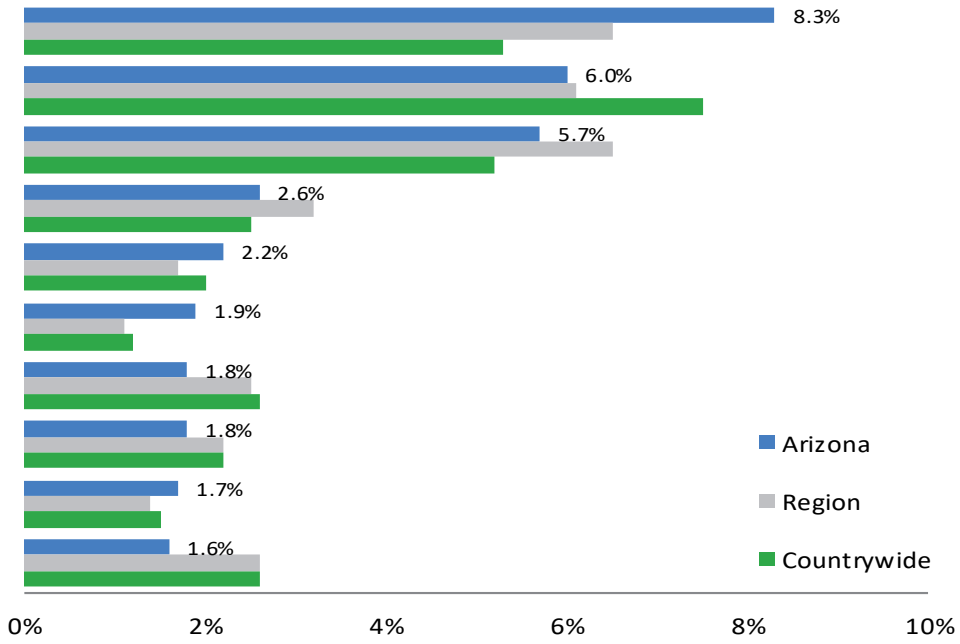


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
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
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
29823	Arthroscopy, shoulder, surgical; debridement extensive
63047	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root), single vertebral segment; lumbar
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)

Chart 10

Top 10 Surgery Procedure Codes by Transaction Counts

Code	Average PPT AZ	Region	CW
36415	$10	$12	$11
20610	$135	$125	$131
12001	$160	$163	$180
12002	$198	$199	$212
64483	$383	$376	$559
29125	$136	$123	$118
29826	$839	$472	$959
29827	$1,516	$1,876	$2,107
20550	$102	$105	$108
64415	$175	$177	$285

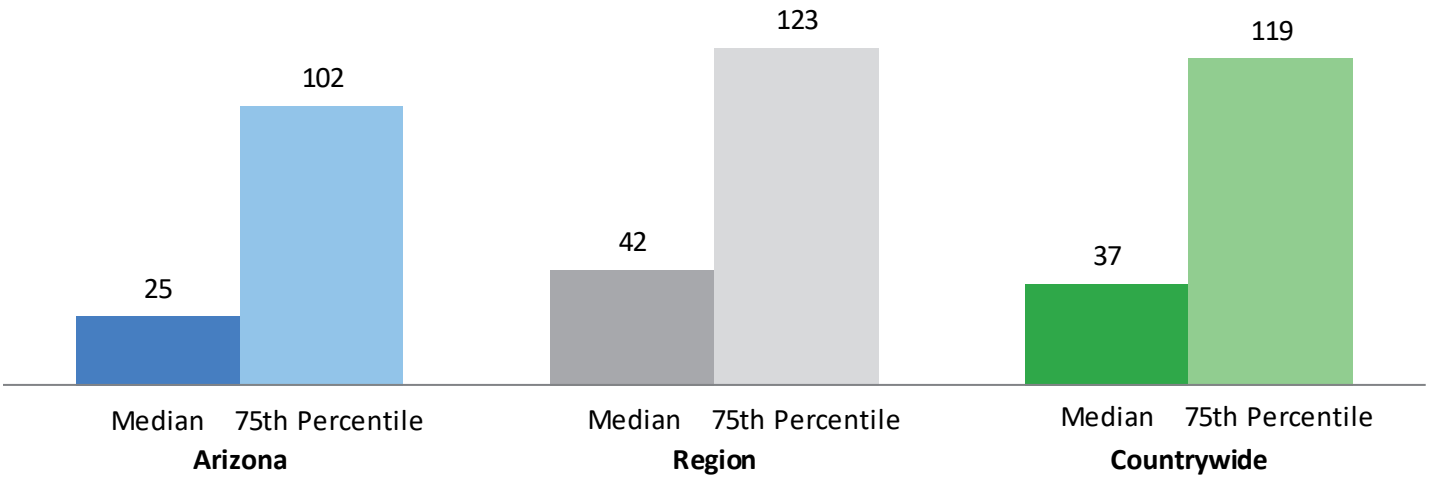


Code	Description
36415	Collection of venous blood by venipuncture
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (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
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release when performed
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
20550	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)
64415	Injection, anesthetic agent; brachial plexus, single

Chart 11 shows the median and 75th percentile[5] time until first treatment for major surgery for Arizona, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop such as an occupational disease, which may extend the time between the date a work-related injury or disease is reported and the first medical treatment takes place.

Chart 11

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



Source: NCCI's Medical Data Call for Accident Year 2018 and Service Years 2018 and 2019.

[5] The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 11 indicates that out of 100 claimants, 75 will receive a major surgery within 102 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

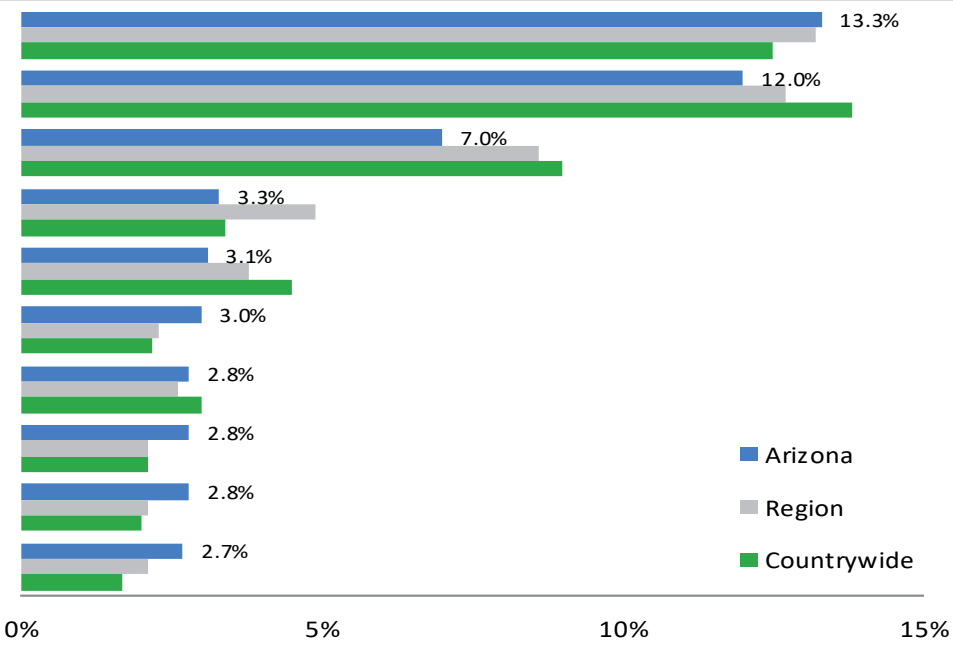
[6] A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it has a global follow up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection.

In Arizona, physician payments for radiology services provided in 2019 are, on average, 202% of Medicare-scheduled reimbursement amounts, compared to 221% in the region and 228% countrywide. Payments for these services comprise 8% of physician payments, compared to 8% in the region and 9% countrywide.

Chart 12

Top 10 Radiology Procedure Codes by Amount Paid

	Average PPT			
Code	**AZ**	**Region**	**CW**	**Paid Share**
73721	$491	$429	$487	
73221	$476	$428	$496	
72148	$457	$424	$473	
73222	$587	$539	$620	
72141	$454	$417	$467	
73110	$68	$56	$60	
73030	$56	$51	$58	
73630	$52	$50	$52	
73140	$63	$49	$52	
73562	$67	$59	$62	

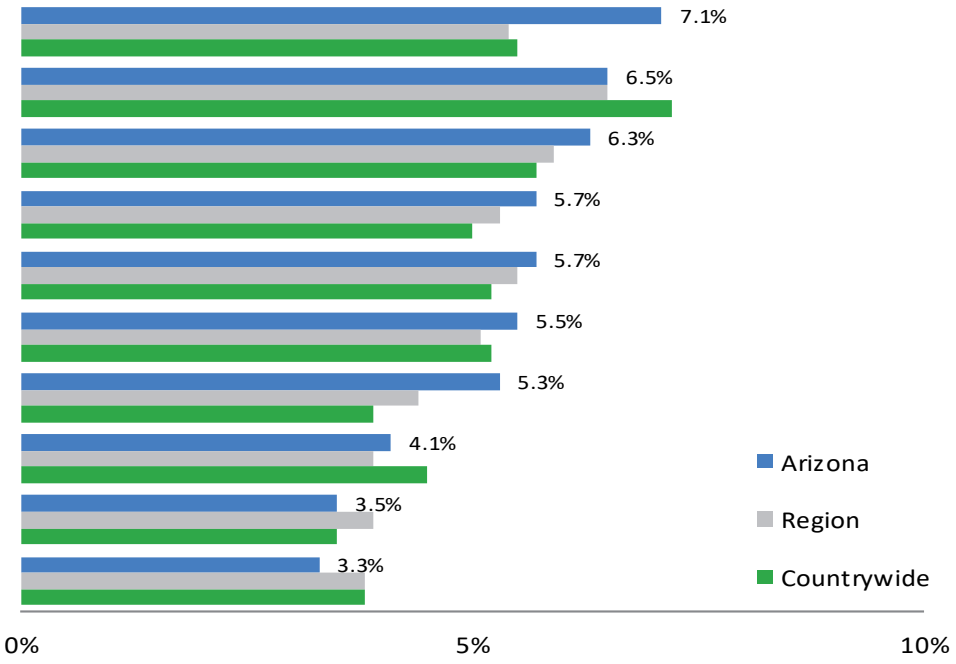


Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents,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

Chart 13

Top 10 Radiology Procedure Codes by Transaction Counts

Code	Average PPT AZ	Region	CW
73630	$52	$50	$52
73030	$56	$51	$58
73610	$56	$51	$55
73110	$68	$56	$60
73140	$63	$49	$52
73130	$60	$49	$52
73562	$67	$59	$62
72100	$69	$65	$64
73721	$491	$429	$487
73221	$476	$428	$496

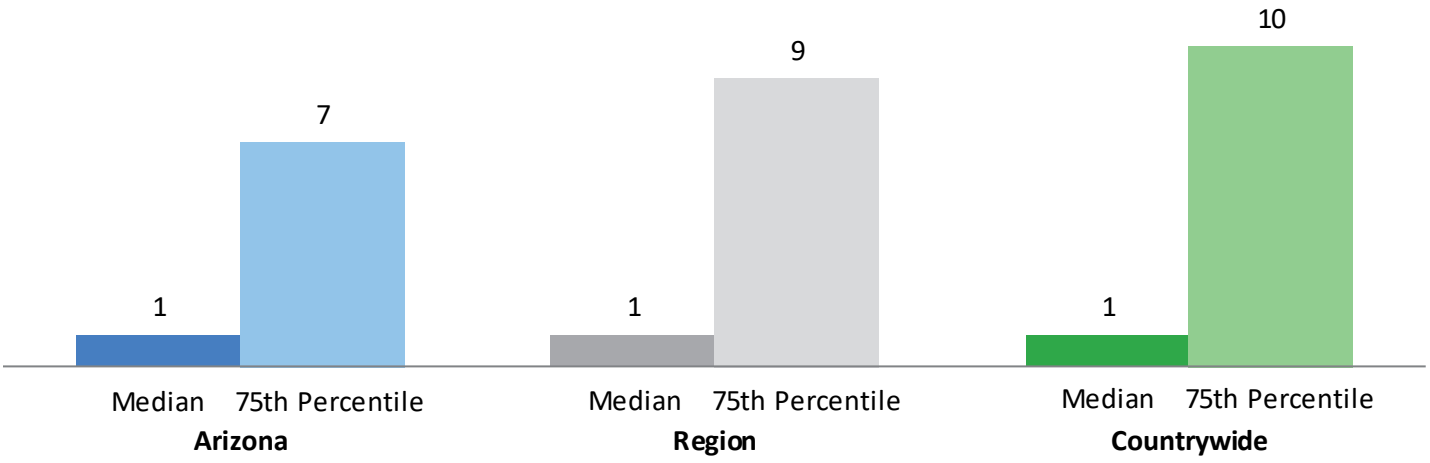


Code	Description
73630	Radiologic examination, foot; complete minimum of 3 views
73030	Radiologic examination, shoulder; complete minimum of 2 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73110	Radiologic examination, wrist; complete minimum of 3 views
73140	Radiologic examination, finger(s); minimum of 2 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

Chart 14 shows the median and 75th percentile time until first treatment for radiology procedures for Arizona, the region, and countrywide.

Chart 14

Time Until First Treatment for Radiology (in Days)



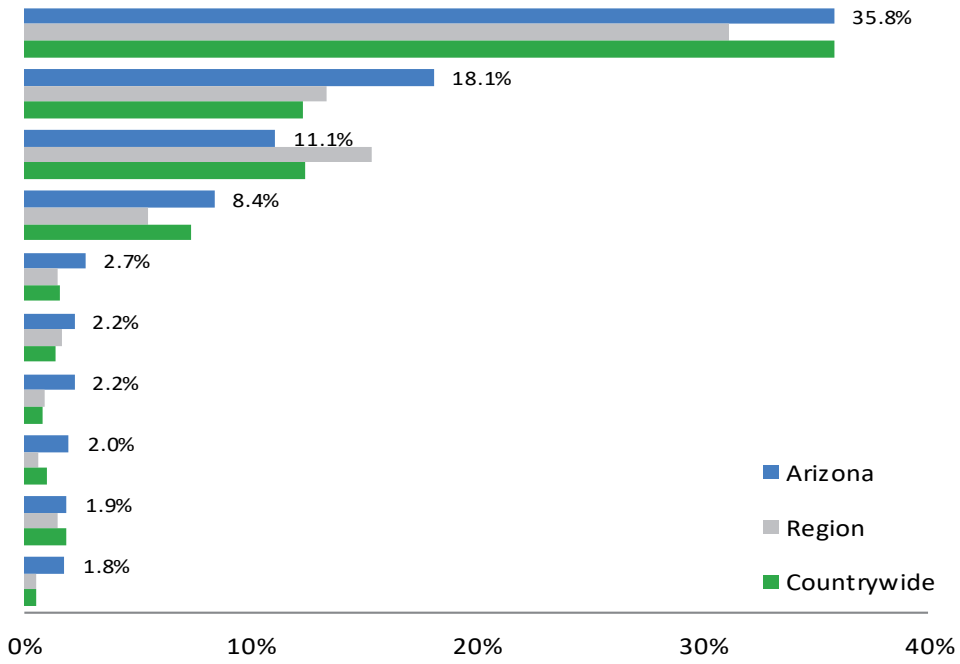
Source: NCCI's Medical Data Call for Accident Year 2018 and Service Years 2018 and 2019.

In Arizona, physician payments for physical and general medicine services provided in 2019 are, on average, 145% of Medicare-scheduled reimbursement amounts, compared to 134% in the region and 132% countrywide. Payments for these services comprise 37% of physician payments, compared to 34% in the region and 36% countrywide.

Chart 15

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

	Average PPU			
Code	AZ	Region	CW	Paid Share
97110	$46	$42	$42	
97530	$58	$53	$45	
97140	$39	$39	$38	
97112	$50	$44	$42	
97161	$133	$104	$118	
97162	$138	$109	$124	
97164	$85	$70	$73	
97799	$466	$267	$417	
97014	$22	$21	$23	
97535	$55	$48	$43	

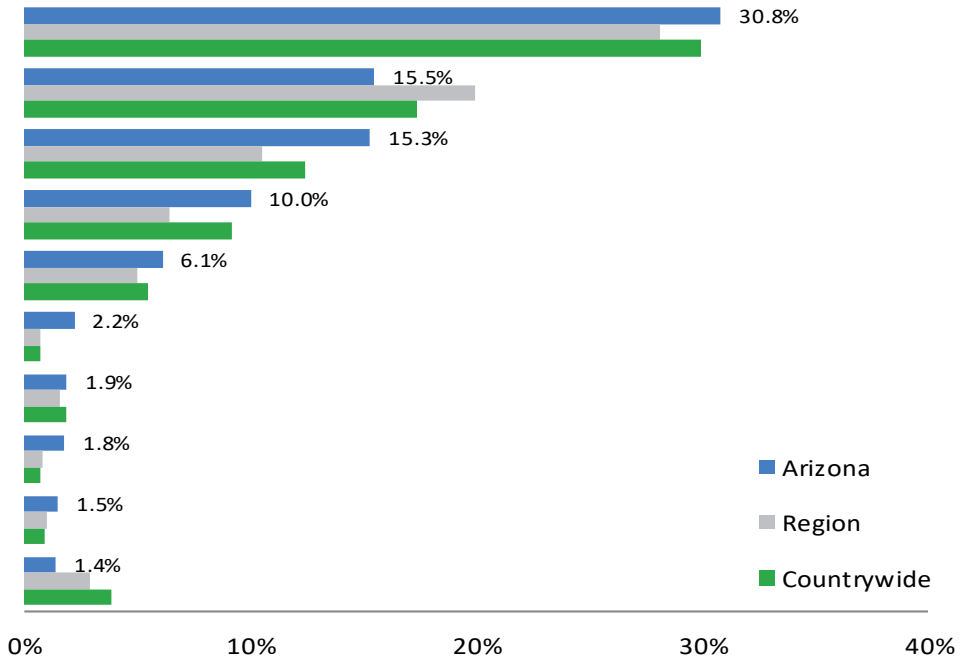


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, 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
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
97162	Physical therapy evaluation of moderate complexity; typically, 30 minutes are spent with the patient and/or family
97164	Re-evaluation of physical therapy and established plan of care; requires an examination with review of history and use of standardized tests and measures; revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome; 20 minutes face-to-face with patient and/or family
97799	Unlisted physical medicine/rehabilitation service or procedure
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes

Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

Code	Average PPU AZ	Region	CW
97110	$46	$42	$42
97140	$39	$39	$38
97530	$58	$53	$45
97112	$50	$44	$42
97014	$22	$21	$23
97535	$55	$48	$43
97035	$15	$19	$23
97164	$85	$70	$73
97161	$133	$104	$118
97010	$9	$11	$17

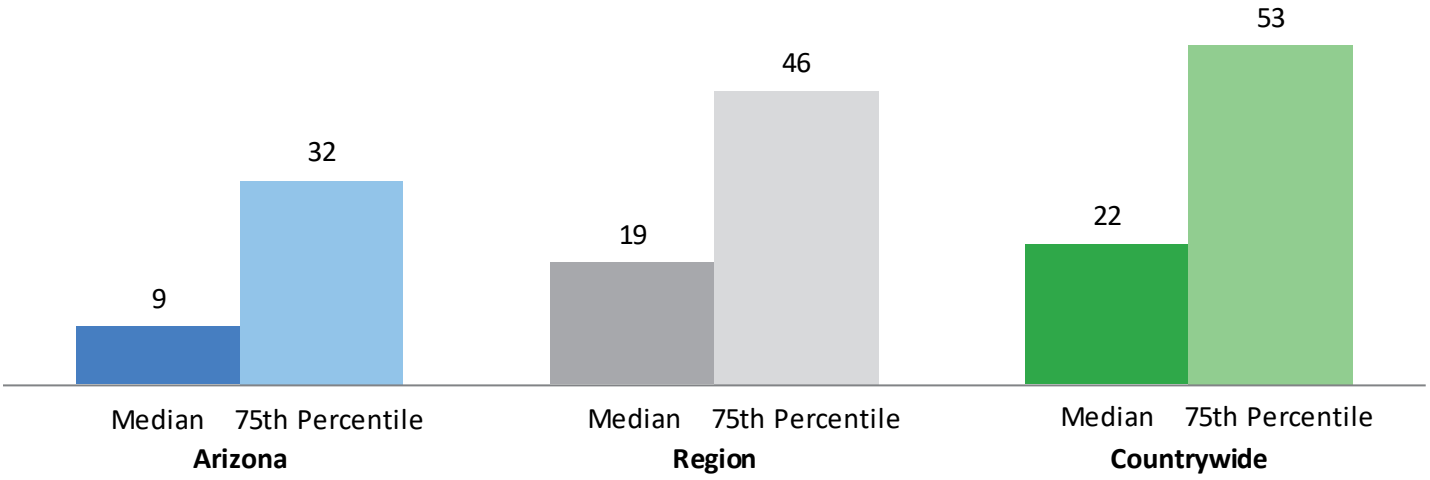


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 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)
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97164	Re-evaluation of physical therapy and established plan of care; requires an examination with review of history and use of standardized tests and measures; revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome; 20 minutes face-to-face with patient and/or family
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
97010	Application of a modality to 1 or more areas; hot or cold packs

Chart 17 shows the median and 75th percentile time until first treatment for physical and general medicine procedures for Arizona, the region, and countrywide.

Chart 17

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



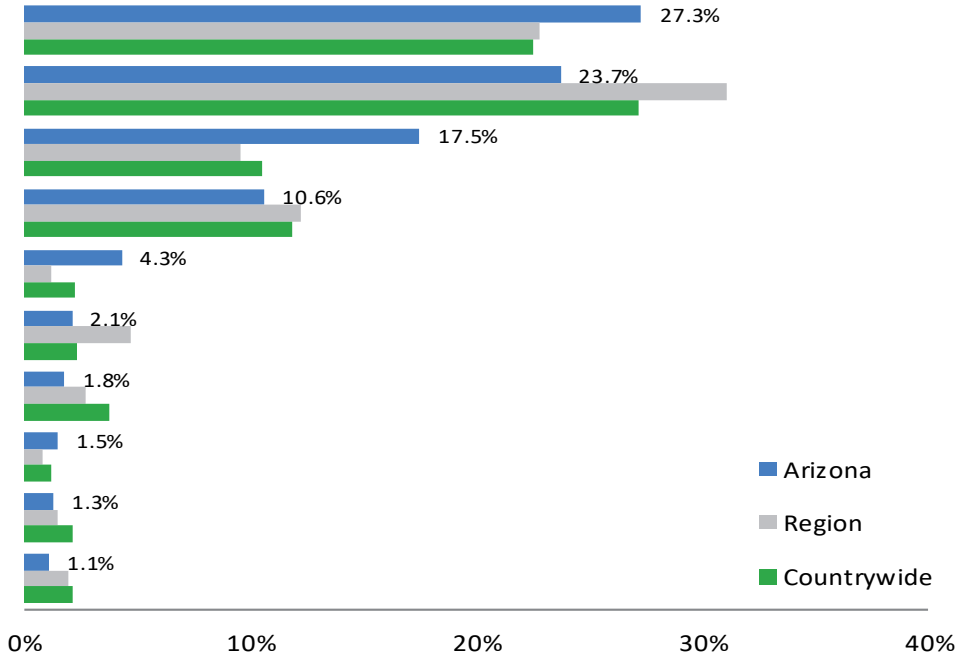
Source: NCCI's Medical Data Call for Accident Year 2018 and Service Years 2018 and 2019.

In Arizona, physician payments for evaluation and management services provided in 2019 are, on average, 153% of Medicare-scheduled reimbursement amounts, compared to 153% in the region and 143% countrywide. Payments for these services comprise 29% of physician payments, compared to 28% in the region and 23% countrywide.

Chart 18

Top 10 Evaluation and Management Procedure Codes by Amount Paid

	Average PPT		
Code	**AZ**	**Region**	**CW**
99214	$159	$162	$146
99213	$114	$114	$103
99204	$259	$239	$221
99203	$164	$169	$152
99455	$394	$570	$202
99456	$1,965	$1,328	$1,030
99284	$215	$238	$277
99244	$310	$306	$281
99285	$326	$371	$408
99212	$68	$72	$67

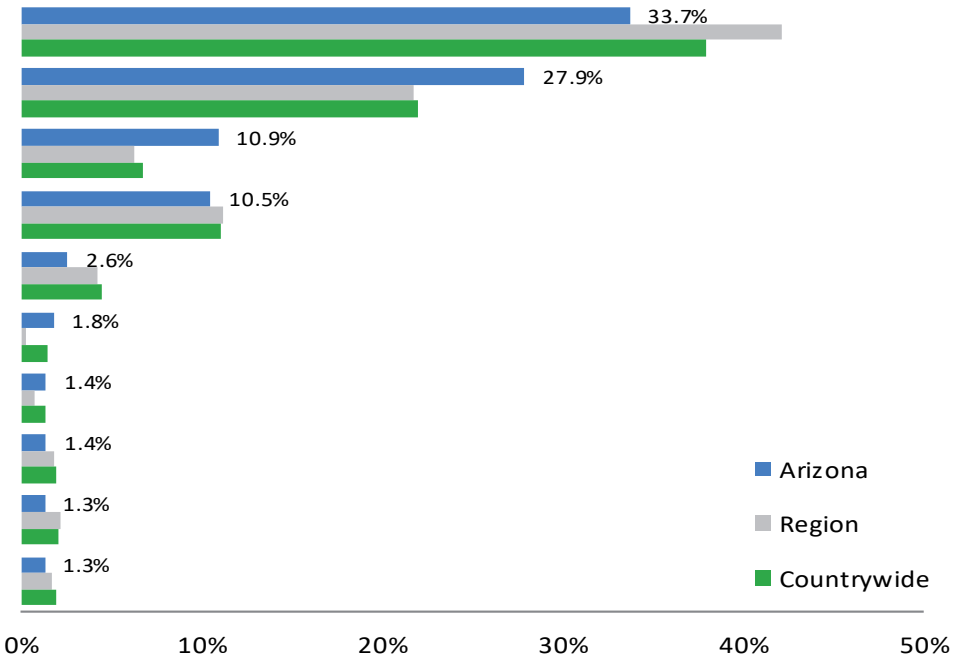


Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient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

Chart 19

Top 10 Evaluation and Management Procedure Codes by Transaction Counts

Code	Average PPT AZ	Region	CW
99213	$114	$114	$103
99214	$159	$162	$146
99204	$259	$239	$221
99203	$164	$169	$152
99212	$68	$72	$67
99455	$394	$570	$202
99232	$96	$128	$102
99284	$215	$238	$277
99283	$129	$140	$177
99202	$113	$123	$109

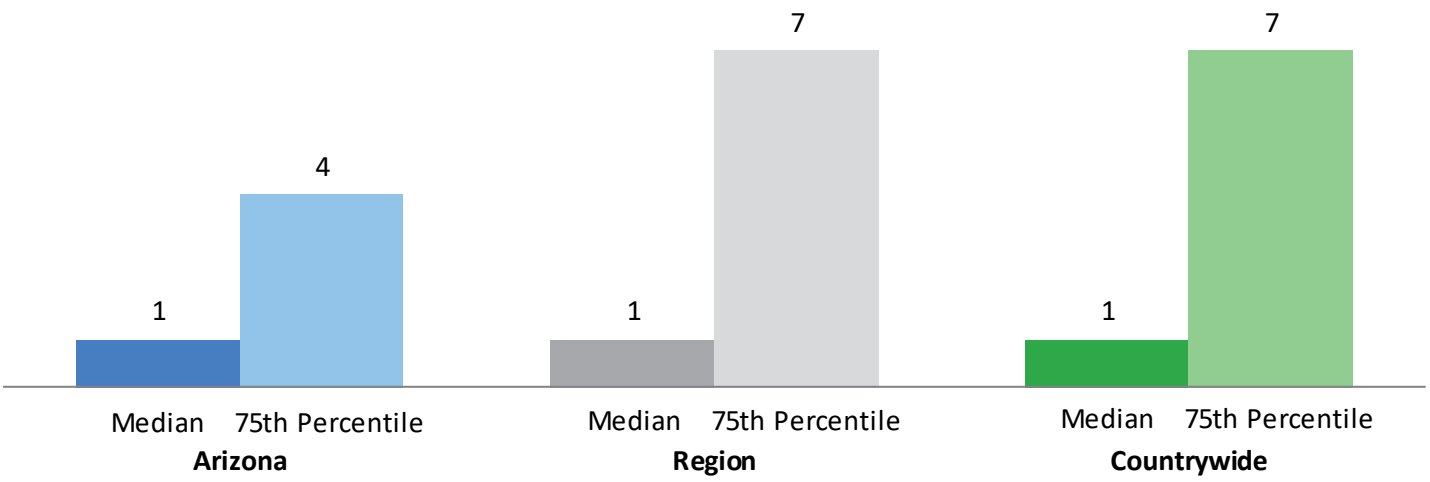


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit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

Chart 20 shows the median and 75th percentile time until first treatment for evaluation and management procedures for Arizona, the region, and countrywide.

Chart 20

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



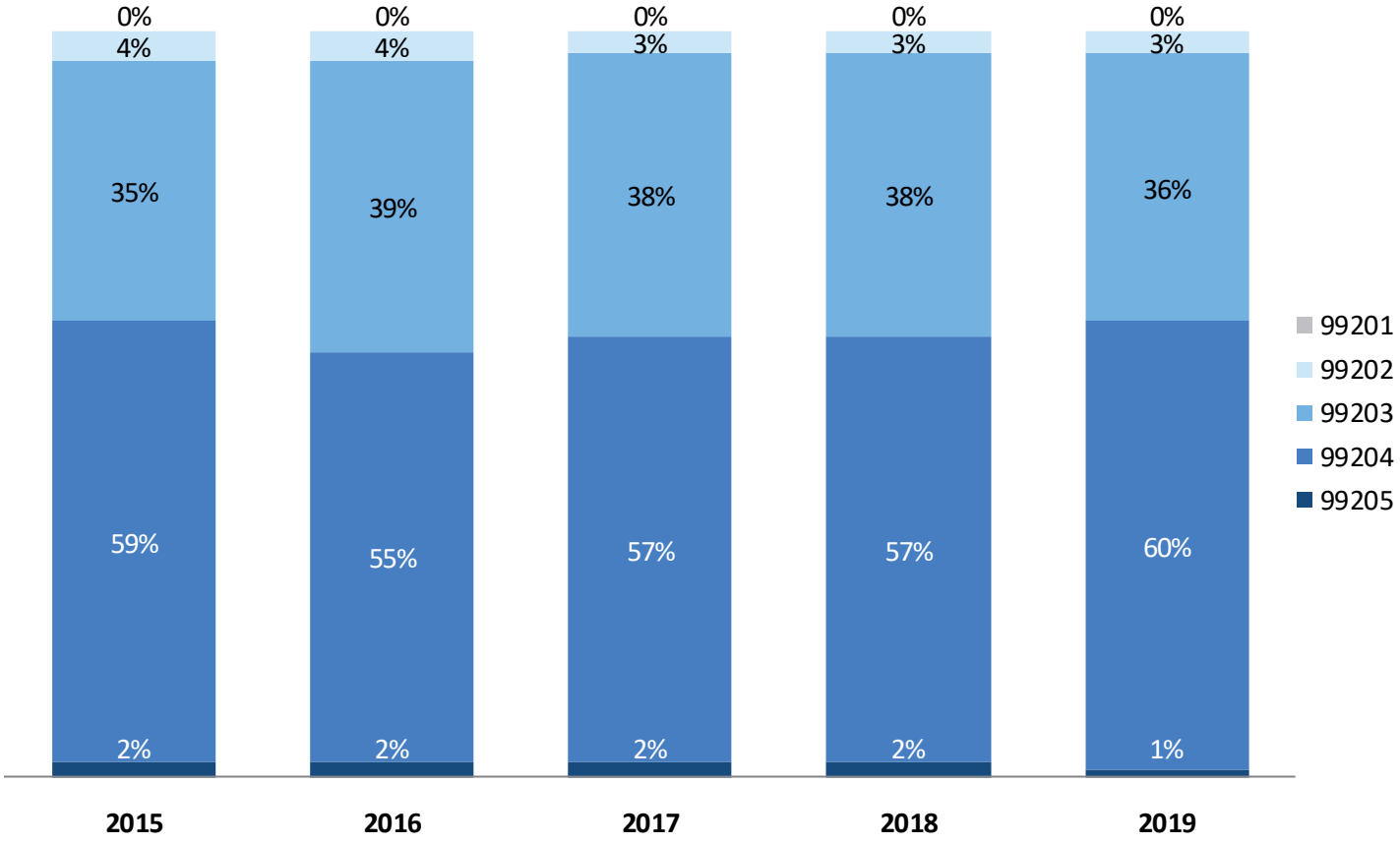
Source: NCCI's Medical Data Call for Accident Year 2018 and Service Years 2018 and 2019.

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

Chart 21

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



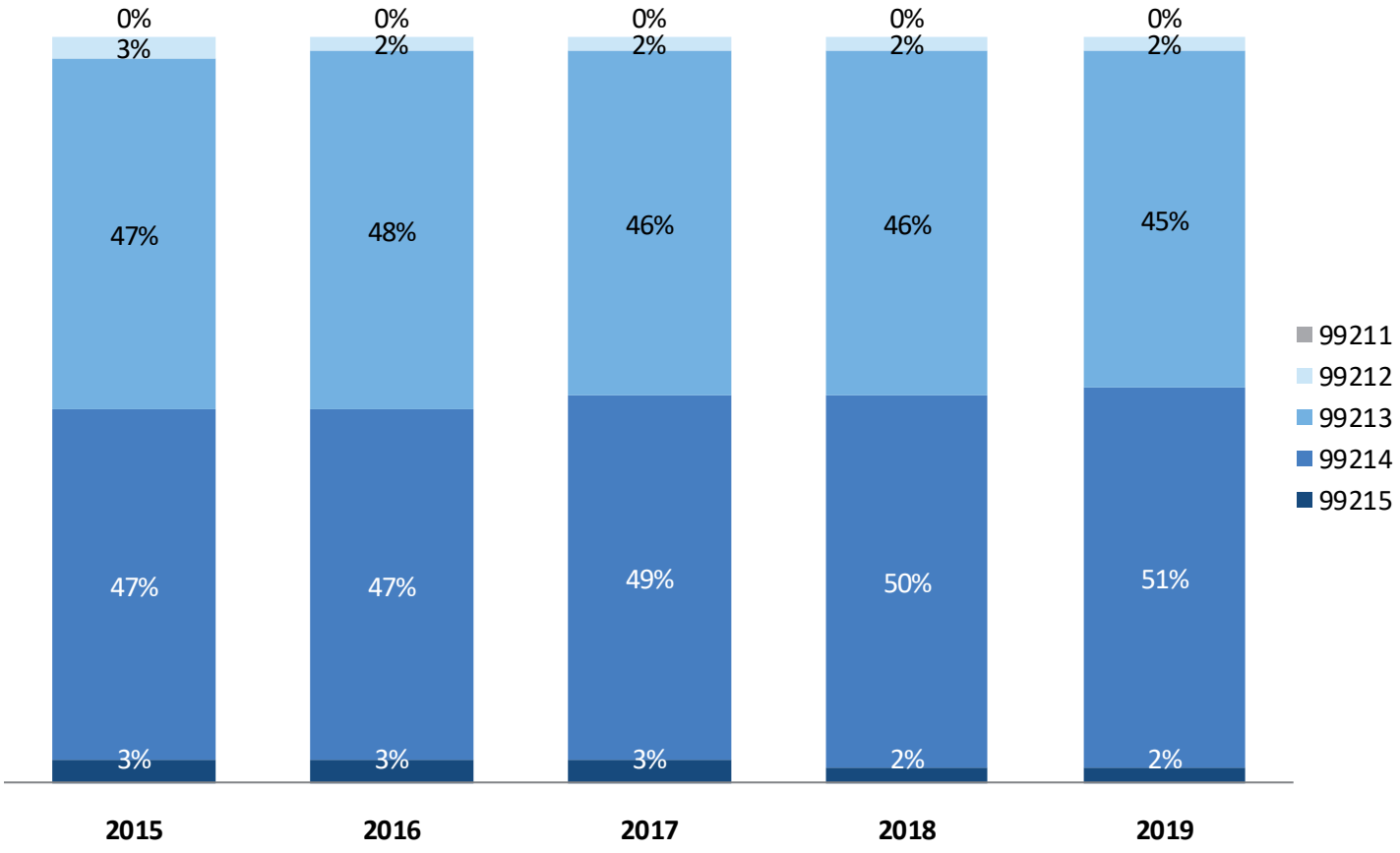
Source: NCCI's Medical Data Call, Service Years 2015 to 2019.

		Average PPT				
Code	**Severity/Time**	**2015**	**2016**	**2017**	**2018**	**2019**
99201	Low to Moderate; 10 minutes with patient	$53	$60	$63	$68	$64
99202	Low to Moderate; 20 minutes with patient	$92	$98	$101	$109	$113
99203	Moderate; 30 minutes with patient	$133	$143	$147	$163	$164
99204	Moderate to High; 45 minutes with patient	$194	$222	$230	$257	$259
99205	Moderate to High; 60 minutes with patient	$241	$262	$258	$273	$279

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

Chart 22

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



Source: NCCI's Medical Data Call, Service Years 2015 to 2019.

		Average PPT				
Code	**Severity/Time**	**2015**	**2016**	**2017**	**2018**	**2019**
99211	Low to Moderate; 5 minutes with patient	$32	$33	$30	$29	$31
99212	Low to Moderate; 10 minutes with patient	$56	$59	$60	$65	$68
99213	Moderate; 15 minutes with patient	$87	$98	$102	$113	$114
99214	Moderate to High; 25 minutes with patient	$127	$140	$144	$158	$159
99215	Moderate to High; 40 minutes with patient	$176	$193	$196	$213	$204

Hospital Inpatient

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

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

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

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In Arizona, 50% 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-scheduled reimbursement amounts for hospital inpatient payments for Arizona, the region, and countrywide, based on hospital episodes that are reported with a DRG code.

Chart 23

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Hospital Inpatient	253%	165%	195%

Source: NCCI's Medical Data Call for Service Year 2019. 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, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

The distribution of medical payments for Hospital Inpatient is 15% for Arizona, 11% for the region, and 13% for CW. 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 24 displays the average amount paid per stay for hospital inpatient services, while Chart 25 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 24

Average Amount Paid per Stay for Hospital Inpatient Services

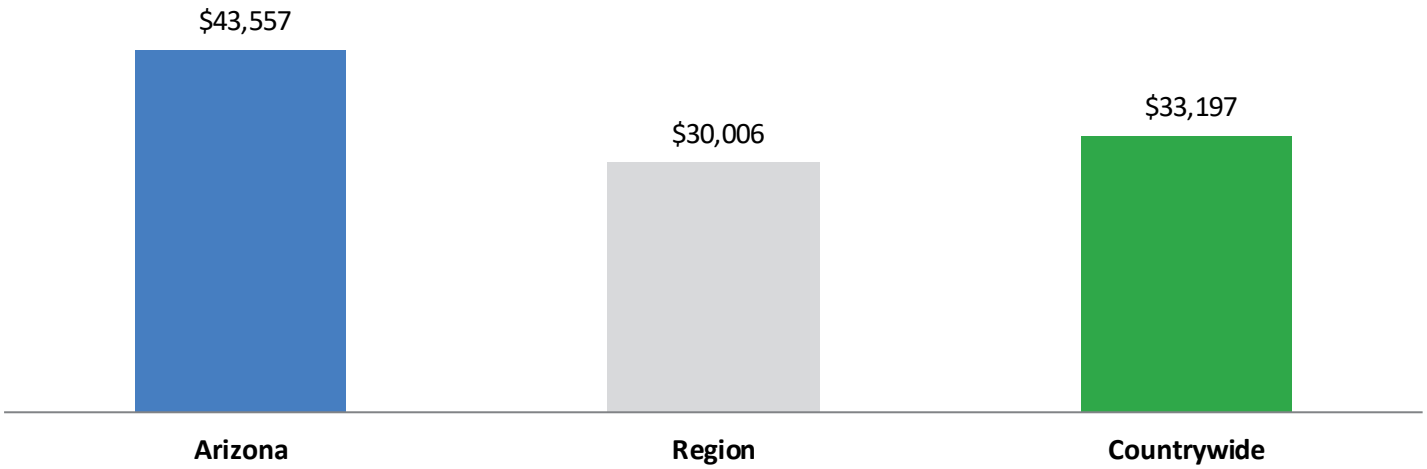


Chart 25

Average Amount Paid per Day for Hospital Inpatient Services

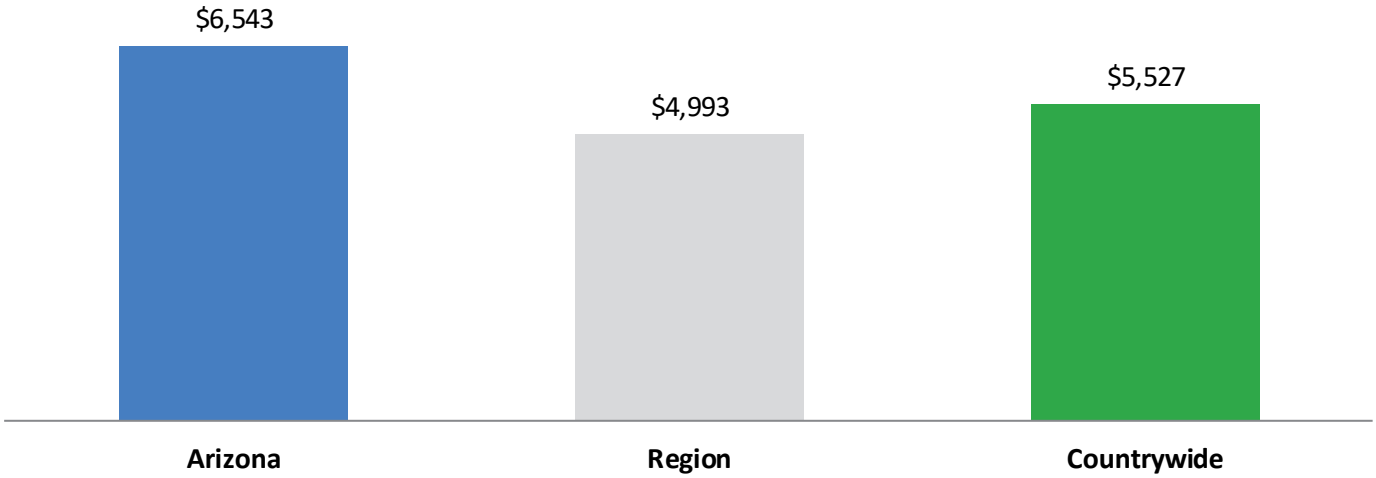


Chart 26 displays the average number of hospital inpatient stays per 1,000 active claims in 2019 for Arizona, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 27 displays the average and 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 26

Average Number of Inpatient Stays per 1,000 Active Claims

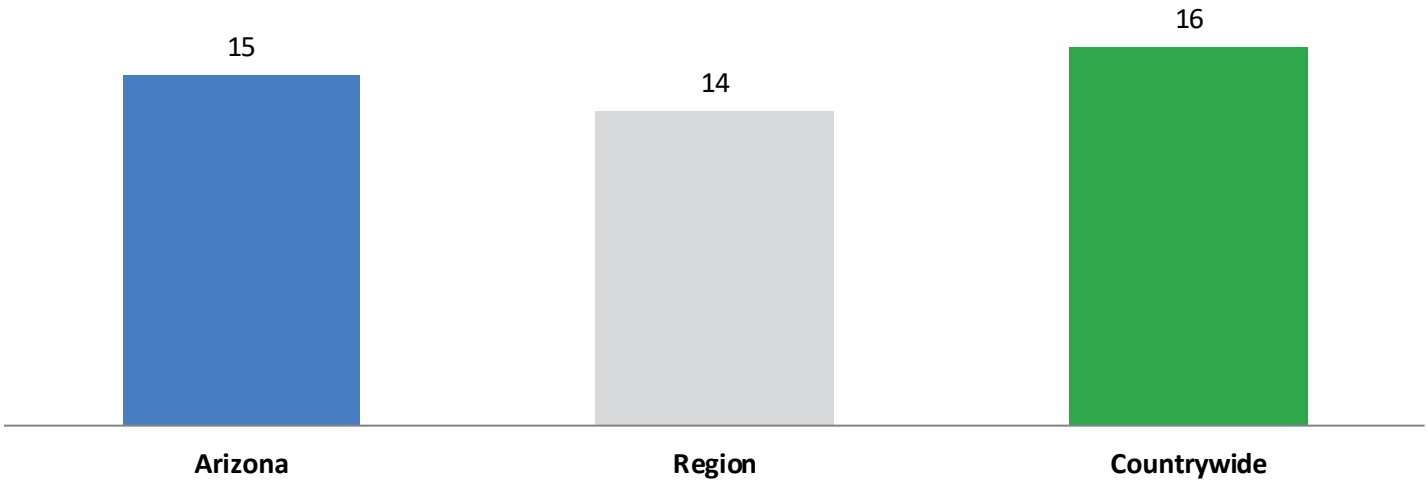


Chart 27

Length of Stay for Hospital Inpatient Services (in Days)

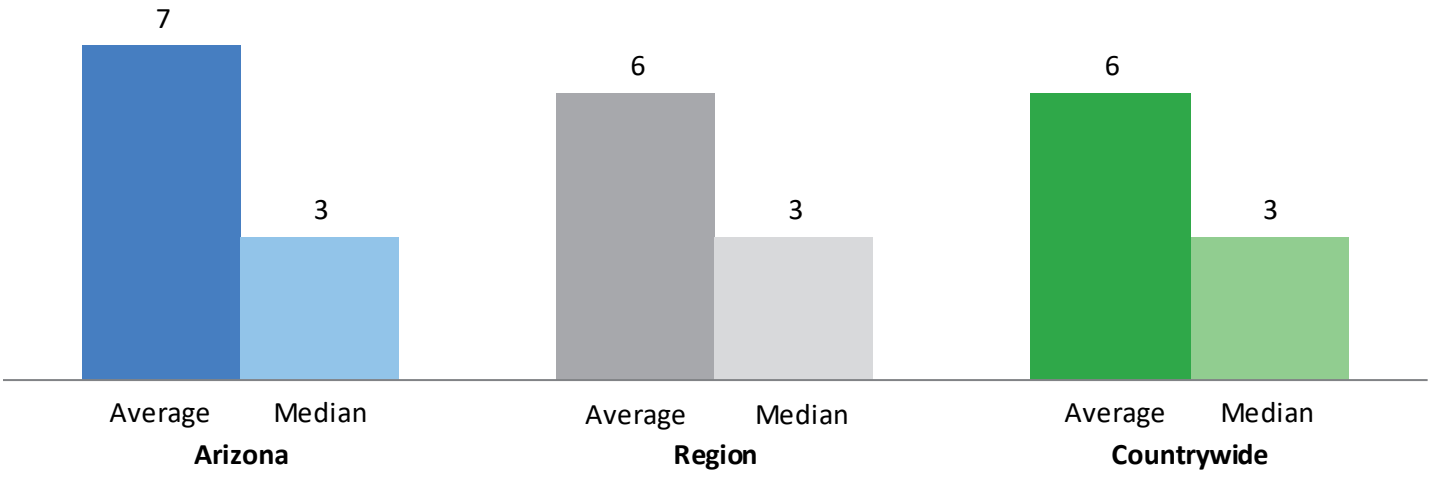
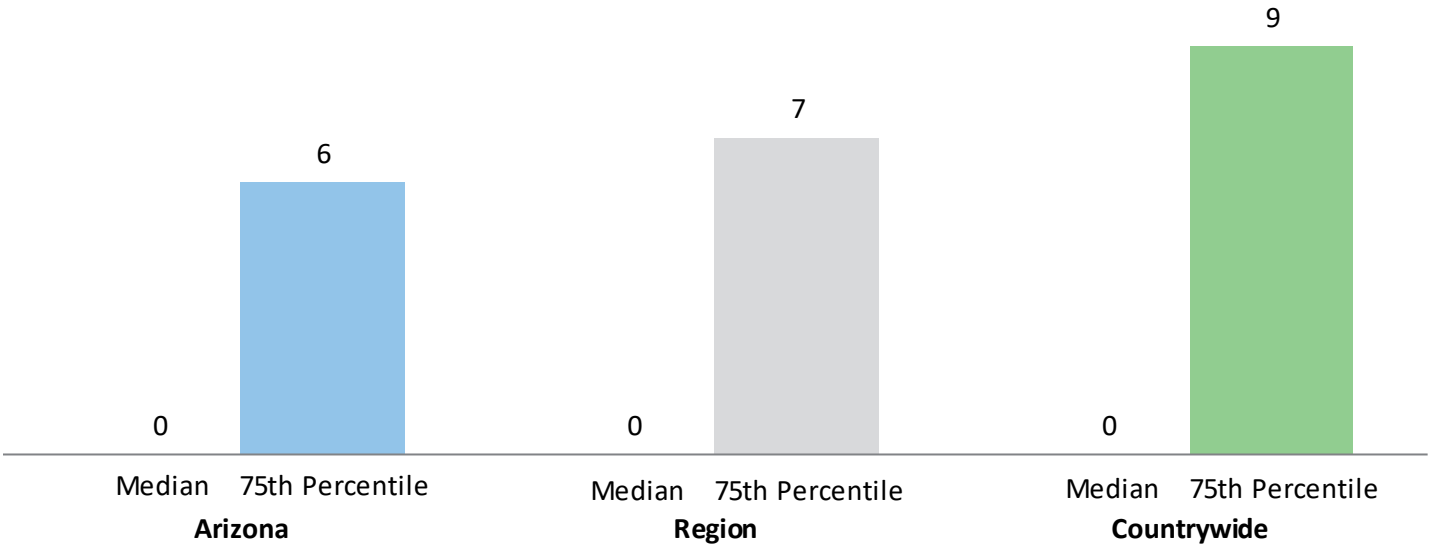


Chart 28 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Arizona, the region, and countrywide.

Chart 28

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



Source: NCCI's Medical Data Call for Accident Year 2018 and Service Years 2018 and 2019.

Charts 29 and 30 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient services, showing the most prevalent types of hospital inpatient stays. Diagnosis group is 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 30.

Chart 29

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

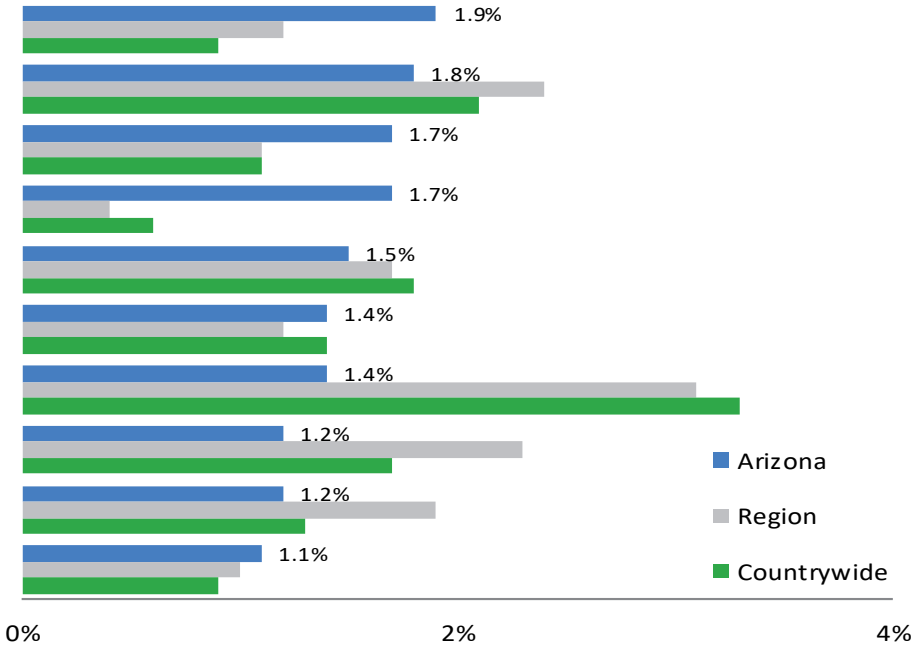
Diagnosis Group	Paid Share	Median Amount Paid per Stay		
		Arizona	Region	Countrywide
Lumbar spine degeneration	7.4%	$61,093	$34,810	$34,704
Tibia fibula fracture	6.7%	$31,500	$20,535	$21,778
Hip/pelvis fracture/major trauma	5.3%	$27,563	$20,418	$20,806
Traumatic brain injury	5.3%	$34,081	$25,509	$25,494
Burn and corrosion third degree other than head face and neck	4.6%	$78,005	$42,575	$42,575
Chest trauma major	3.2%	$67,220	$29,858	$30,189
Complication from surgical device	3.1%	$31,341	$23,509	$22,547
Knee degenerative/overuse injuries	2.7%	$30,540	$19,133	$18,972
Hand/wrist fracture	2.6%	$26,812	$17,798	$17,179
Complications of procedures, not elsewhere classified	2.1%	$33,297	$17,047	$18,597

Source: NCCI's Medical Data Call for Service Years 2018 and 2019.

Chart 30

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services

Code	Median Paid per Stay AZ	Region	CW
928	$106,954	$80,017	$70,274
470	$29,337	$20,296	$21,589
958	$122,511	$54,955	$60,209
464	$65,001	$33,965	$38,333
494	$31,047	$19,593	$20,069
493	$43,255	$26,164	$27,743
460	$54,368	$40,956	$39,744
003	$355,919	$232,295	$238,767
454	$87,625	$58,288	$58,528
481	$45,931	$24,843	$26,069



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

Source: NCCI's Medical Data Call for Service Years 2018 and 2019. 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, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

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 service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it has a global follow up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection. In this section, we provide measures of hospital outpatient payments that account for 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-scheduled reimbursement amounts for hospital outpatient payments for Arizona, the region, and countrywide. In Arizona, 76% of hospital outpatient payments are included in the chart below.

Chart 31

Hospital Outpatient Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Hospital Outpatient	316%	185%	247%

Source: NCCI’s Medical Data Call for Service Year 2019. 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.

The distribution of medical payments for Hospital Outpatient is 18% for Arizona, 18% for the region, and 20% for countrywide. Surgical services represent 51% of hospital outpatient payments in Arizona. Chart 32 displays the average amount paid per surgical visit for hospital outpatient services, while Chart 33 displays the average number of surgical visits per 1,000 active claims for hospital outpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 32

Average Amount Paid per Surgical Visit for Hospital Outpatient Services

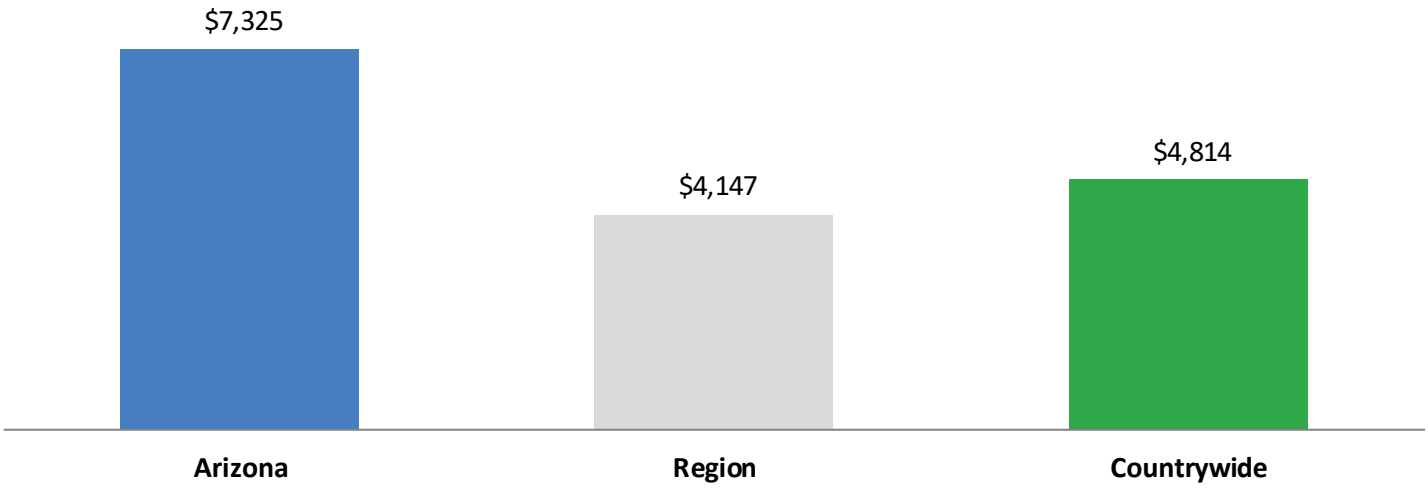
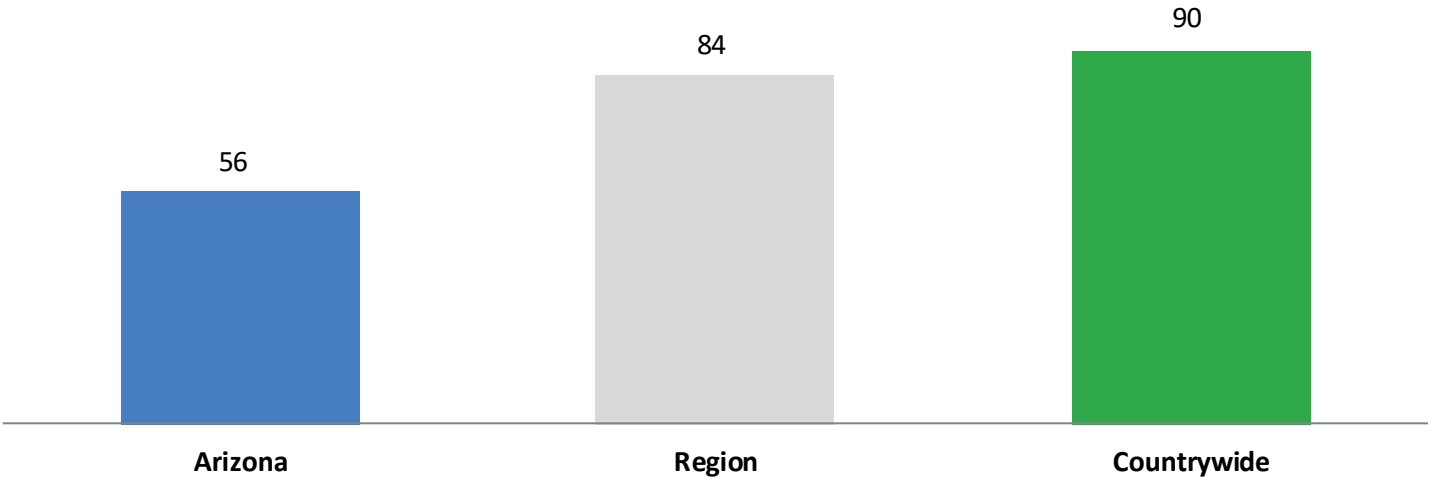


Chart 33

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



Nonsurgical services (such as physical therapy) represent 49% of hospital outpatient payments in Arizona. Chart 34 displays the average amount paid per nonsurgical visit for hospital outpatient services, while Chart 35 displays the average number of nonsurgical visits per 1,000 active claims for hospital outpatient services. Both charts display information 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 Nonsurgical Visit for Hospital Outpatient Services

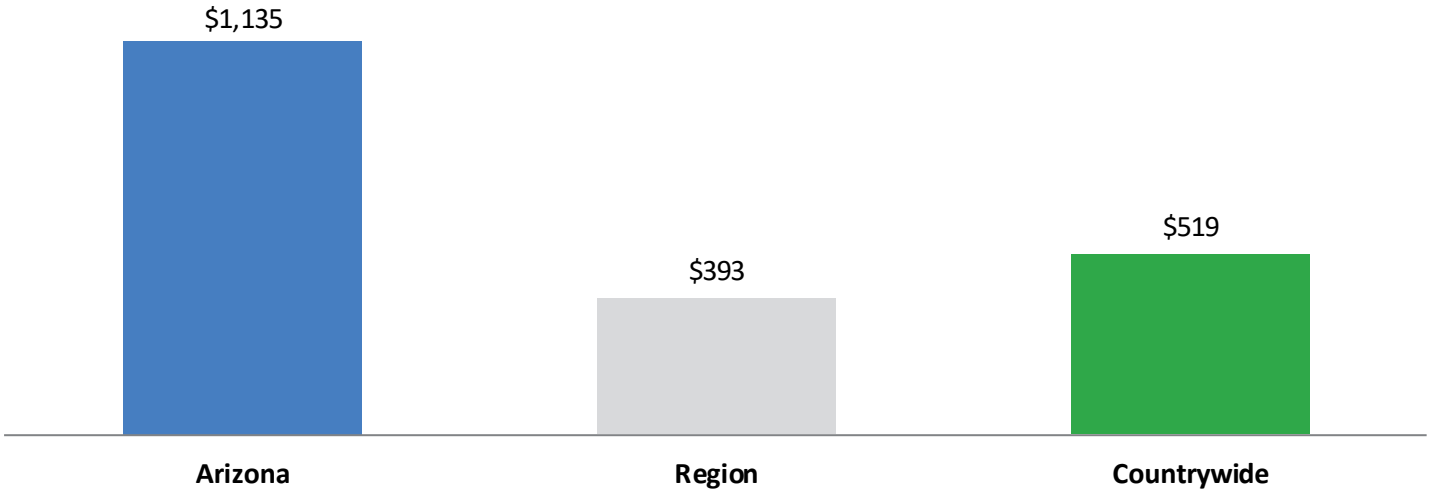


Chart 35

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

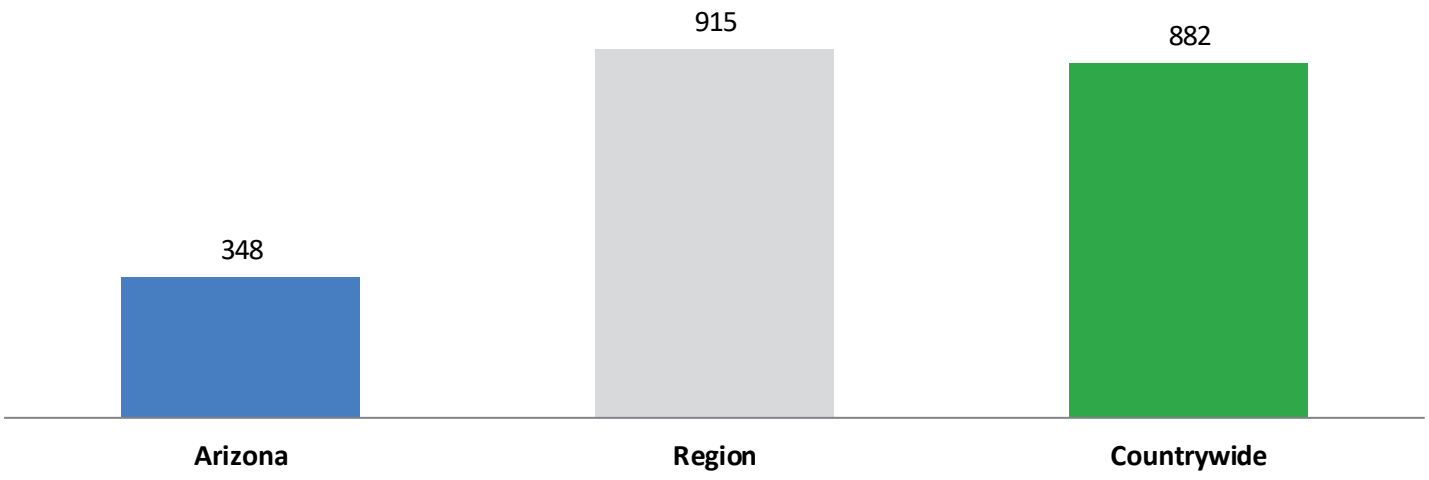


Chart 36 shows the median and 75th percentile time until first treatment for major surgery outpatient visits. Chart 37 shows the median and 75th percentile time until first treatment for all other outpatient visits, other than emergency room visits, for Arizona, the region, and countrywide.

Chart 36

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

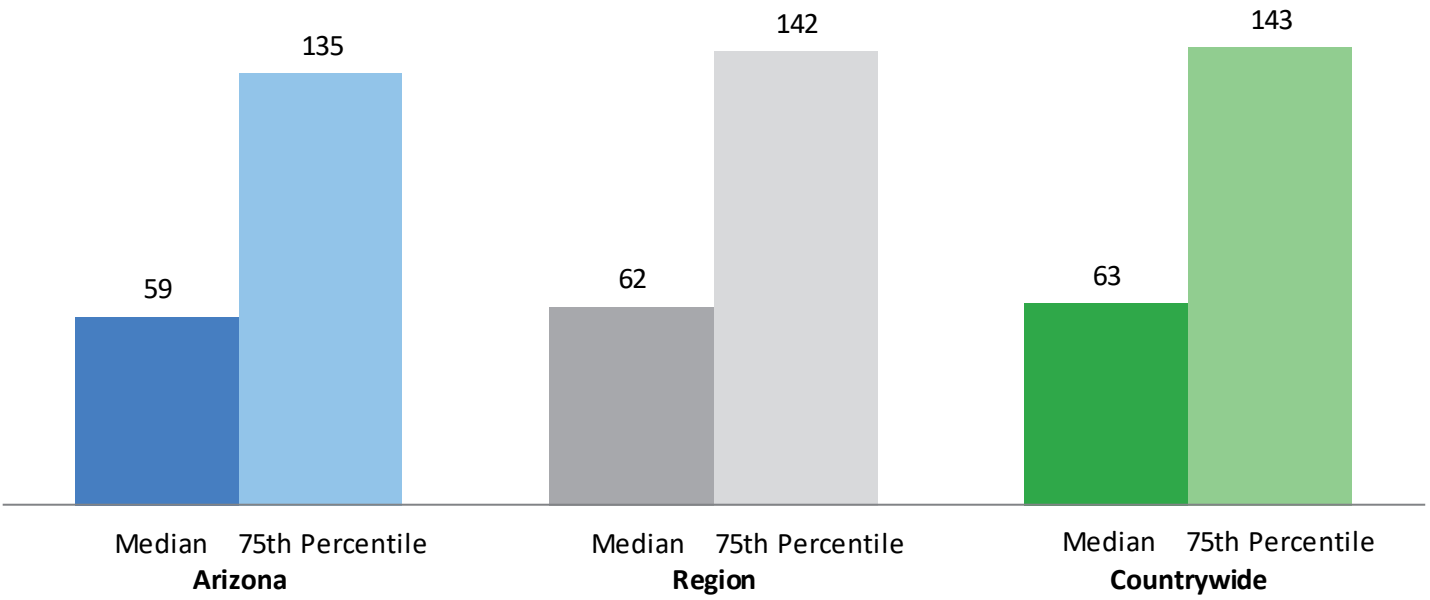
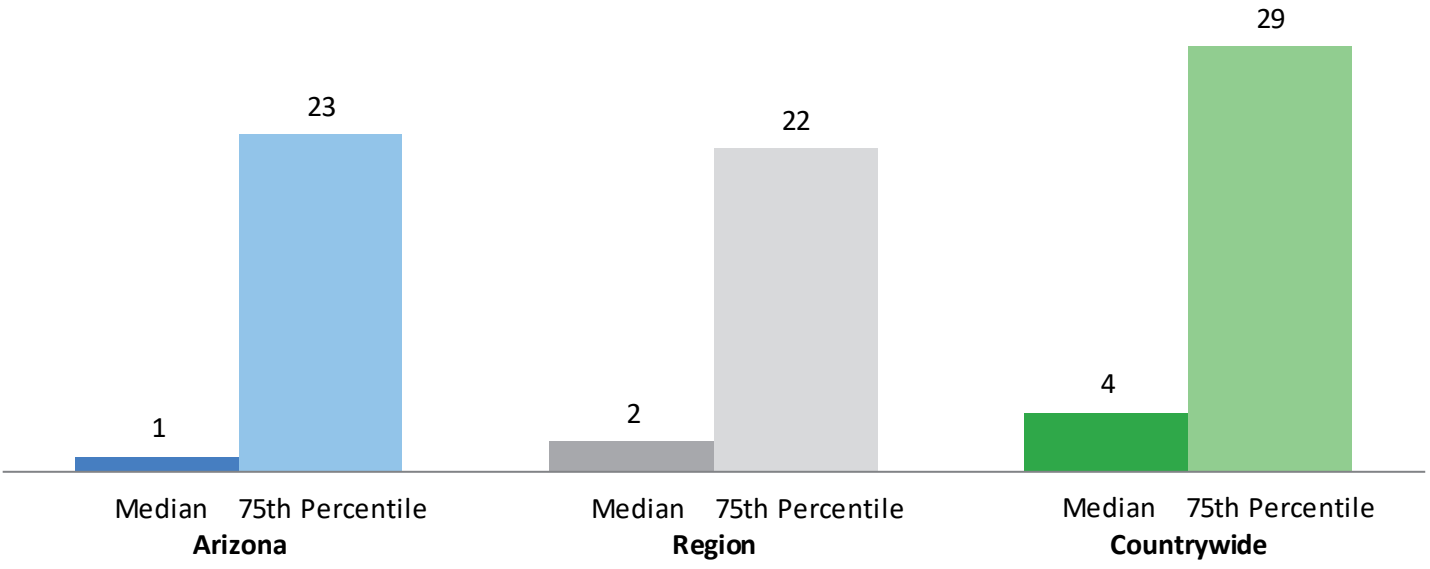


Chart 37

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



Source: NCCI's Medical Data Call for Accident Year 2018 and Service Years 2018 and 2019.

Chart 38 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 38

Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services

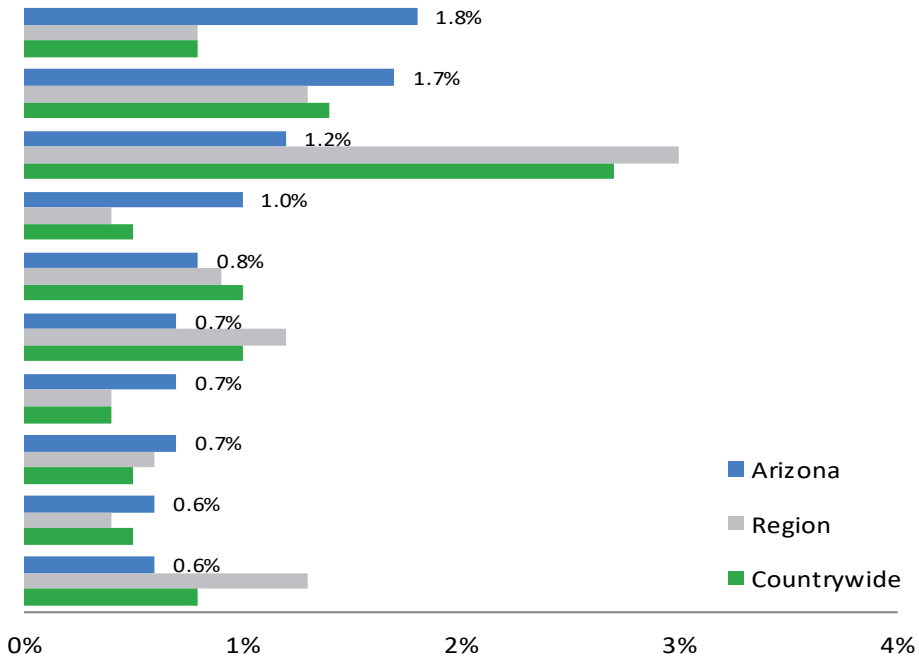
Diagnosis Group	Paid Share	Median Amount Paid Per Visit		
		Arizona	Region	Countrywide
Minor hand/wrist injuries	6.6%	$691	$259	$332
Hand/wrist fracture	5.0%	$602	$191	$281
Rotator cuff tear	3.6%	$294	$165	$213
Low back pain	3.1%	$485	$169	$217
Minor shoulder injury	3.1%	$353	$159	$197
Neck pain	2.5%	$599	$167	$235
Knee internal derangement - meniscus injury	2.5%	$2,656	$199	$303
Inguinal hernia	2.3%	$5,777	$2,927	$4,234
Tibia fibula fracture	2.2%	$365	$160	$221
Head injury not otherwise classified	2.1%	$1,365	$645	$915

Charts 39 and 40 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. The codes are ranked based on total payments in Arizona, where the code shown below is the code with the highest total paid on a visit.[7] In 2019, 78% of Hospital Outpatient costs were reported with a CPT code being the highest paid code. A brief description of each code is displayed in the table below.

Chart 39

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

Code	Average Paid per Visit AZ	Region	CW
20680	$12,815	$4,929	$6,487
29881	$8,881	$4,953	$6,432
29827	$14,221	$10,195	$11,619
29826	$16,469	$10,364	$11,602
63030	$19,294	$9,258	$11,615
49650	$13,500	$7,459	$9,676
25609	$16,238	$9,918	$10,675
49505	$12,406	$5,777	$6,998
24342	$13,017	$8,357	$10,122
23430	$18,148	$11,649	$11,876



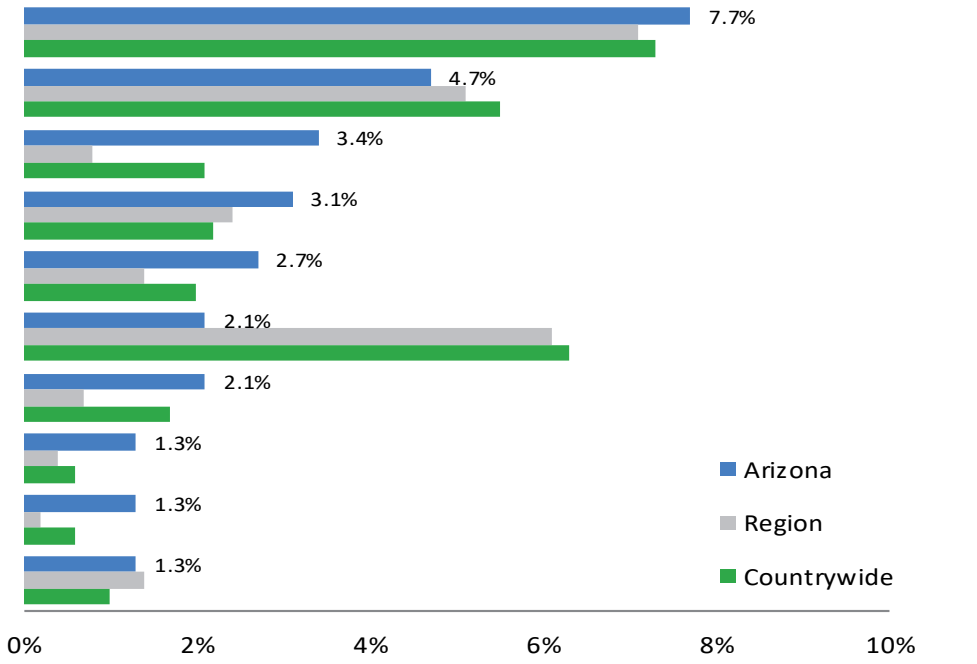
Code	Description
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
29827	Arthroscopy, shoulder, 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
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
49650	Laparoscopy, surgical; repair initial inguinal hernia
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
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
23430	Tenodesis of long tendon of biceps

[7] A visit is defined as any hospital outpatient 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.

Chart 40

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

Code	Average Paid per Visit AZ	Region	CW
99283	$1,143	$699	$812
99284	$1,806	$1,218	$1,341
72125	$4,876	$2,471	$3,910
99285	$3,674	$2,027	$2,344
74177	$7,700	$3,922	$5,885
97110	$285	$158	$203
70450	$3,187	$1,345	$2,332
G0378	$4,084	$2,067	$2,980
72131	$5,419	$1,281	$3,014
99282	$602	$430	$472



Code	Description
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.
72125	Computed tomography (CT), cervical spine; 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.
74177	Computed tomography (CT), abdomen and pelvis; with contrast material
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
70450	Computed tomography (CT), head or brain; without contrast material
G0378	Hospital observation service, per hour
72131	Computed tomography (CT), lumbar spine; without contrast material
99282	Emergency department visit. Usually the presenting problem(s) are of low to moderate severity.

In Arizona, 22% of the payments associated with facilities (ASC, hospital outpatient, and hospital inpatient) are for emergency service payments, compared to 18% countrywide.

Chart 41 displays the average amount paid per visit for emergency services for Arizona, the region, and countrywide. The average amount paid includes all payments for an emergency service 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 42 displays the number of visits per year per 1,000 active claims for emergency services for Arizona, as well as for the region and countrywide.

Chart 41

Average Amount Paid per Emergency Service Visit

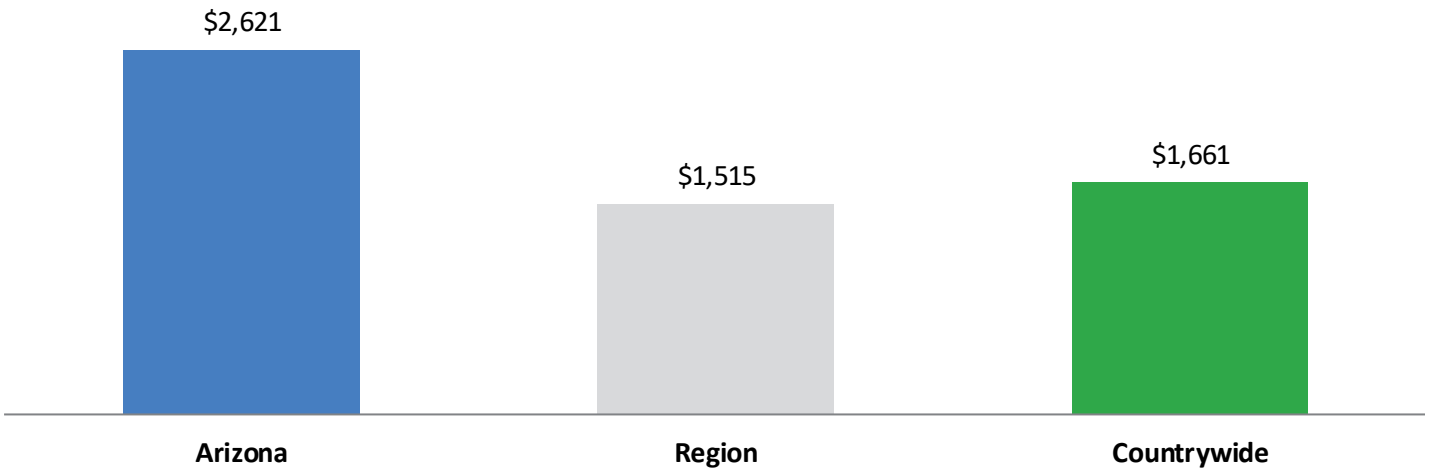
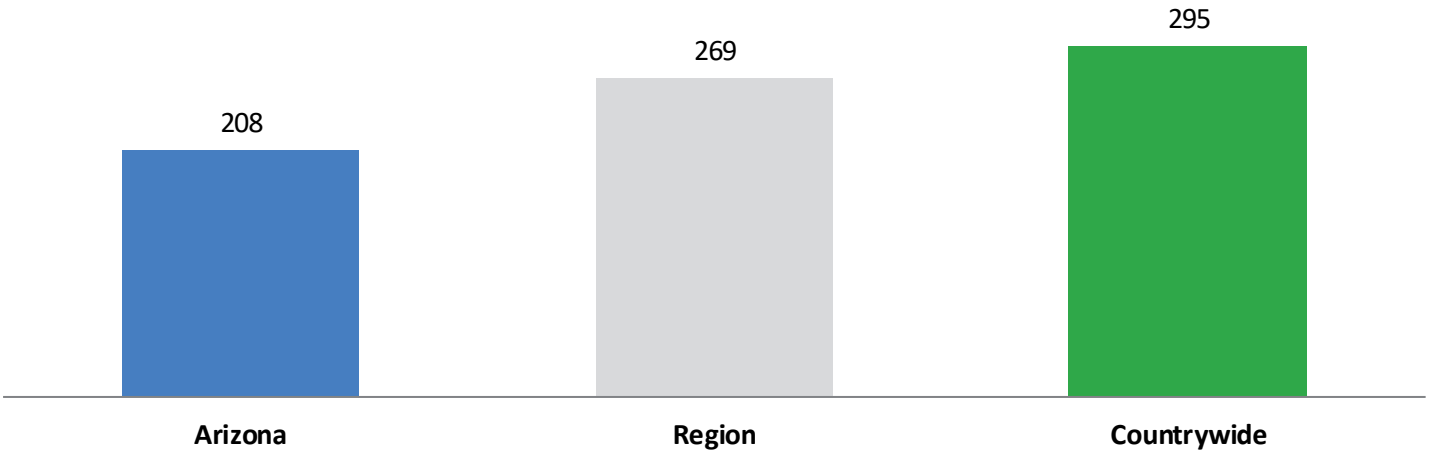


Chart 42

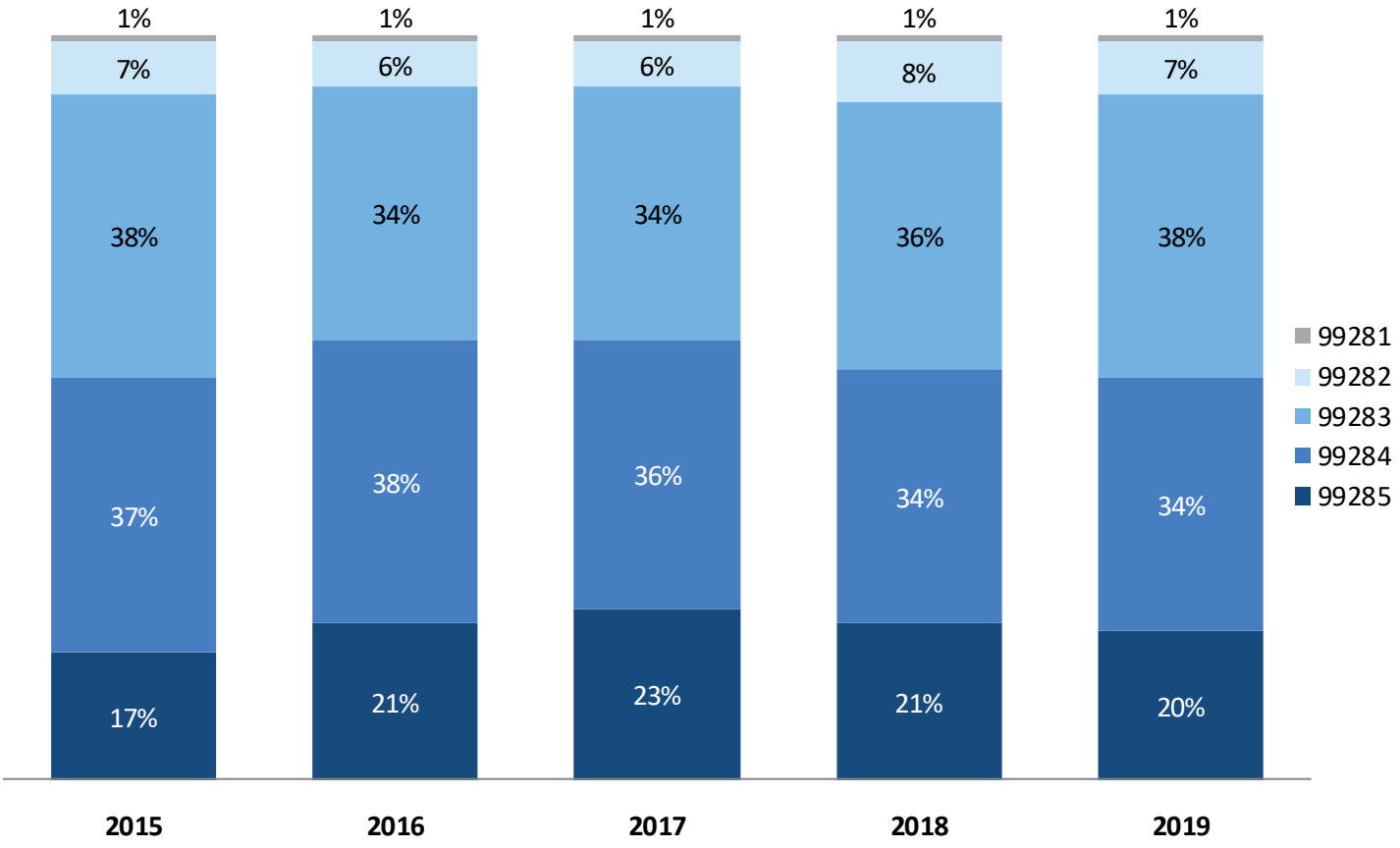
Average Number of Emergency Service Visits per 1,000 Active Claims



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

Chart 43

Emergency Room Payments by Procedure Code



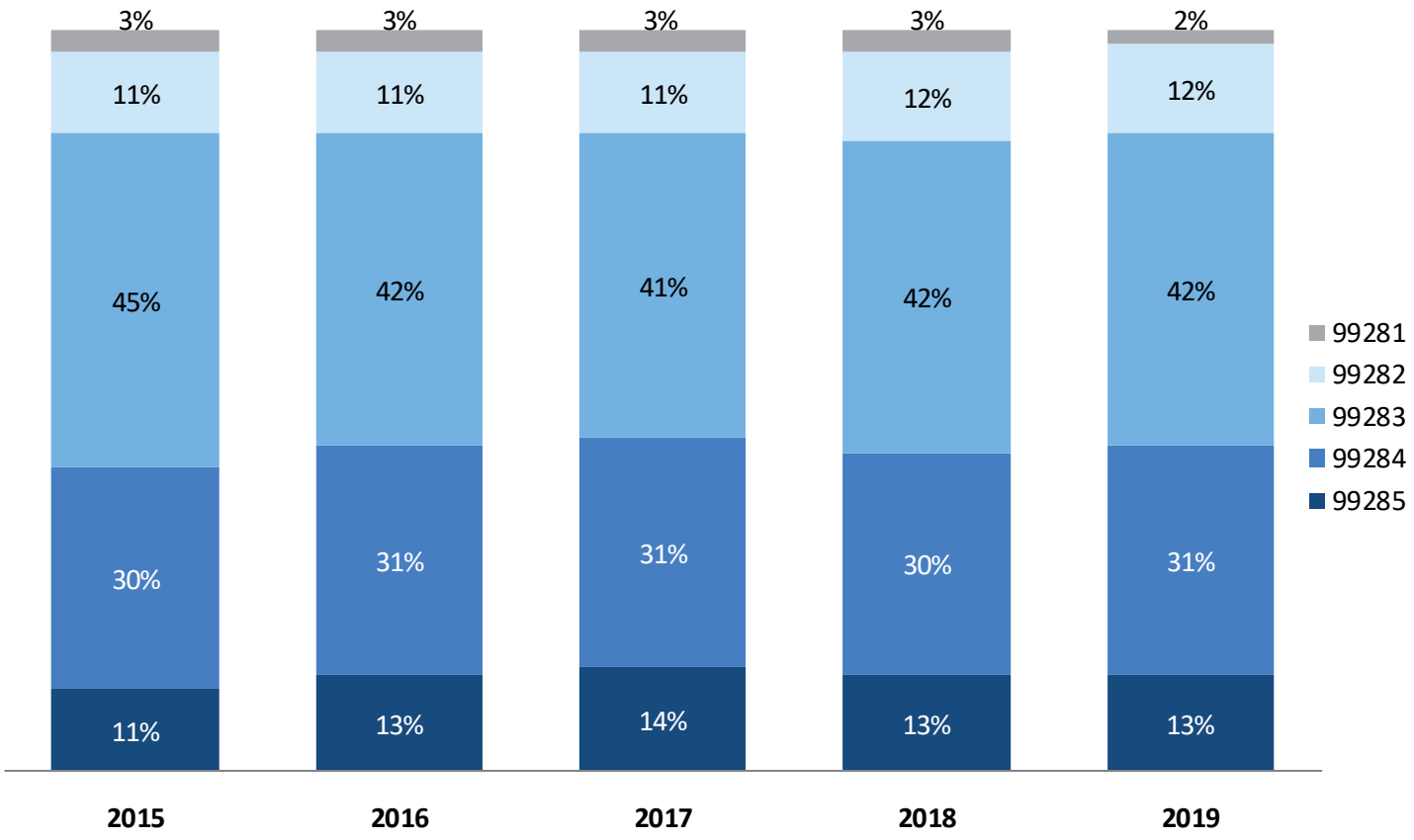
Source: NCCI's Medical Data Call, Service Years 2015 to 2019.

		Average PPT				
Code	**Severity**	**2015**	**2016**	**2017**	**2018**	**2019**
99281	Minor	$175	$201	$179	$167	$189
99282	Low to moderate	$242	$251	$271	$295	$313
99283	Moderate	$315	$345	$359	$389	$455
99284	High	$457	$500	$530	$503	$562
99285	High and immediately life-threatening	$544	$679	$734	$727	$787

Chart 44 shows a five-year snapshot of experience for each procedure type per service year.

Chart 44

Emergency Room Transactions by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2015 to 2019.

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

Ambulatory Surgical Centers

ASCs are often used as an alternative facility to hospitals for conducting outpatient surgeries. The distribution of medical payments for ASCs is 6% for Arizona, 5% for the region, and 7% for countrywide.

One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for ASC payments for Arizona, the region, and countrywide. In Arizona, 77% of ASC payments are included in the chart below.

Chart 45

ASC Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Ambulatory Surgical Center	260%	214%	274%

Source: NCCI's Medical Data Call for Service Year 2019. 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 46 displays the average amount paid per surgical 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 47 displays the number of surgical ASC visits per year per 1,000 active claims for Arizona, the region, and countrywide.

Chart 46

Average Amount Paid per Surgical Visit for ASC Services

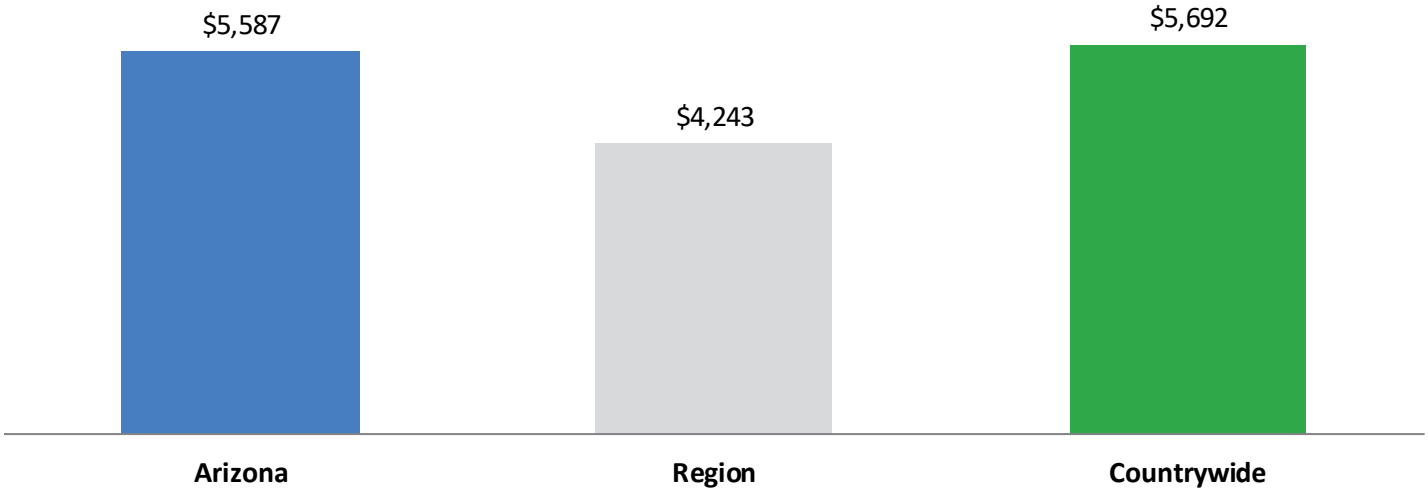


Chart 47

Average Number of Surgical ASC Visits per 1,000 Active Claims

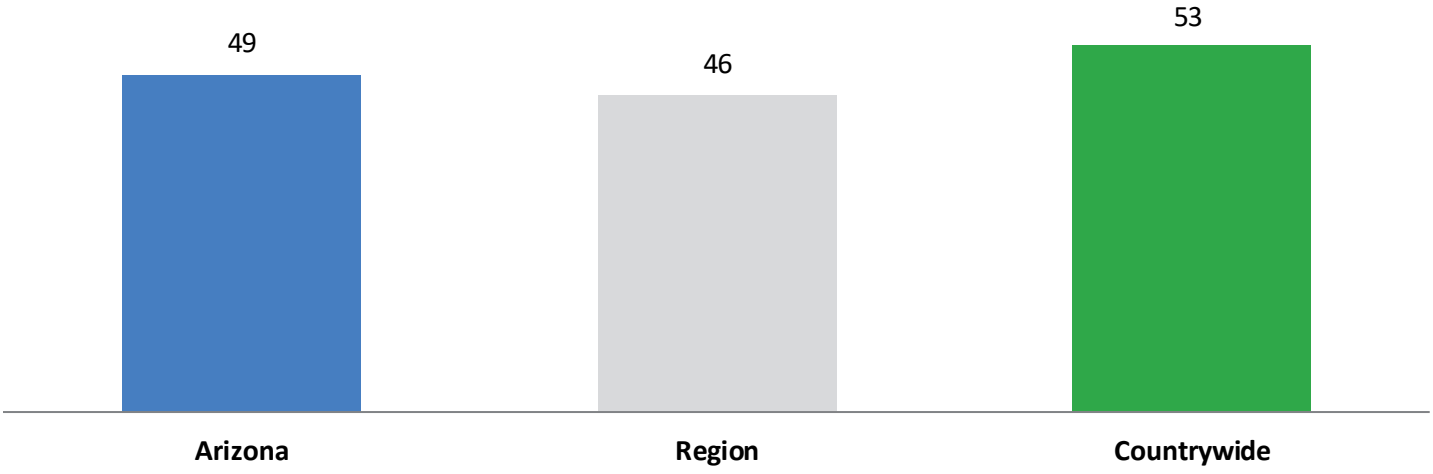
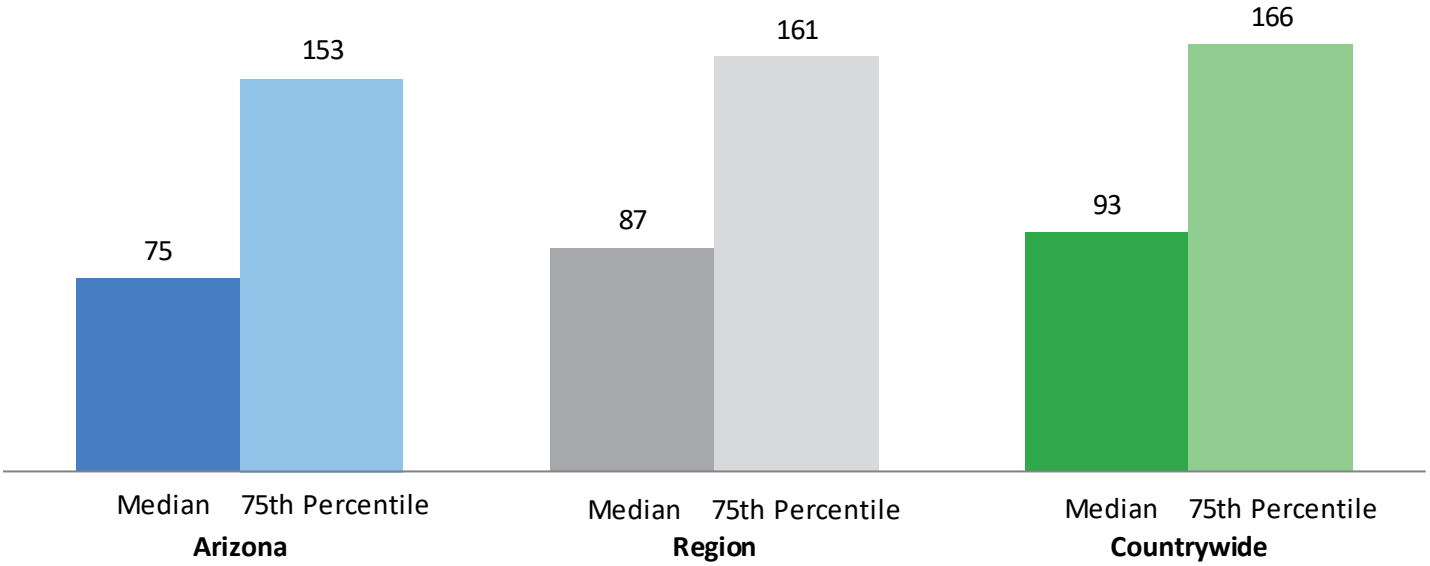


Chart 48 shows the median and 75th percentile time until first treatment for surgical ASC visits for Arizona, the region, and countrywide.

Chart 48

Time Until First Treatment for Surgical ASC Visits (in Days)



Source: NCCI's Medical Data Call for Accident Year 2018 and Service Years 2018 and 2019.

Chart 49 displays the top 10 diagnosis groups for surgical ASC visits. The diagnosis groups are ranked based on total payments in Arizona.

Chart 49

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	10.3%	$7,773	$7,180	$9,686
Lumbar spine degeneration	6.6%	$2,863	$1,417	$1,989
Minor shoulder injury	5.4%	$7,014	$6,381	$7,002
Knee internal derangement - meniscus injury	5.4%	$3,442	$3,220	$4,136
Hand/wrist fracture	4.4%	$4,762	$4,047	$5,185
Inguinal hernia	3.6%	$6,086	$4,231	$4,718
Degenerative shoulder	3.5%	$7,340	$6,067	$8,516
Lumbosacral intervertebral disc disorders	3.1%	$1,444	$1,028	$1,562
Lumbar radiculopathy/sciatica	3.1%	$1,012	$926	$1,385
Knee degenerative/overuse injuries	2.6%	$3,562	$3,845	$4,520

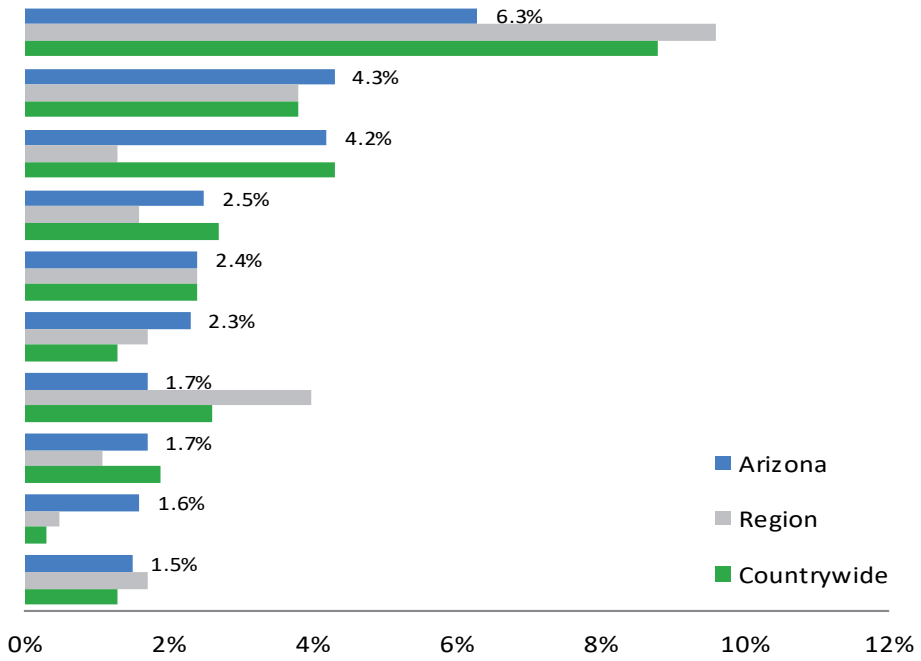
Typically, only surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes. The predominant revenue code reported for ASC services is code 0490—Ambulatory Surgical Care. In Arizona, code 0490 represents 87% of ASC payments reported by revenue codes.

Chart 50 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 50

Top 10 Surgery Procedure Codes by Amount Paid for ASC Services

Code	Average PPT AZ	Region	CW
29827	$5,412	$5,704	$6,165
29881	$4,489	$2,853	$3,818
29826	$3,677	$2,165	$4,103
29823	$4,075	$2,034	$3,378
64483	$967	$831	$1,209
20680	$2,802	$2,276	$2,759
23430	$4,894	$5,338	$5,374
63685	$19,692	$18,888	$21,914
49505	$3,959	$3,371	$3,739
24342	$6,734	$5,954	$5,691



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
29823	Arthroscopy, shoulder, surgical; debridement extensive
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)
23430	Tenodesis of long tendon of biceps
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
49505	Repair initial inguinal hernia, age 5 years or older; reducible
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft

Prescription Drugs

The distribution of medical payments for drugs is 9% for Arizona, 7% for the region, and 8% for countrywide. Prescription drugs are uniquely identified by a national drug code (NDC). Charts 51 through 55 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

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

In Arizona, the share of claims observed in Service Year 2019 with at least one controlled substance was 10%. This compares to the region and countrywide shares of 10% and 10%, respectively. In 2019, Arizona spent $3.4M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 51 shows the distribution of prescription drug payments by CSA schedule in Arizona, the region, and countrywide.

Chart 51

Distribution of Prescription Drug Payments by CSA Schedule

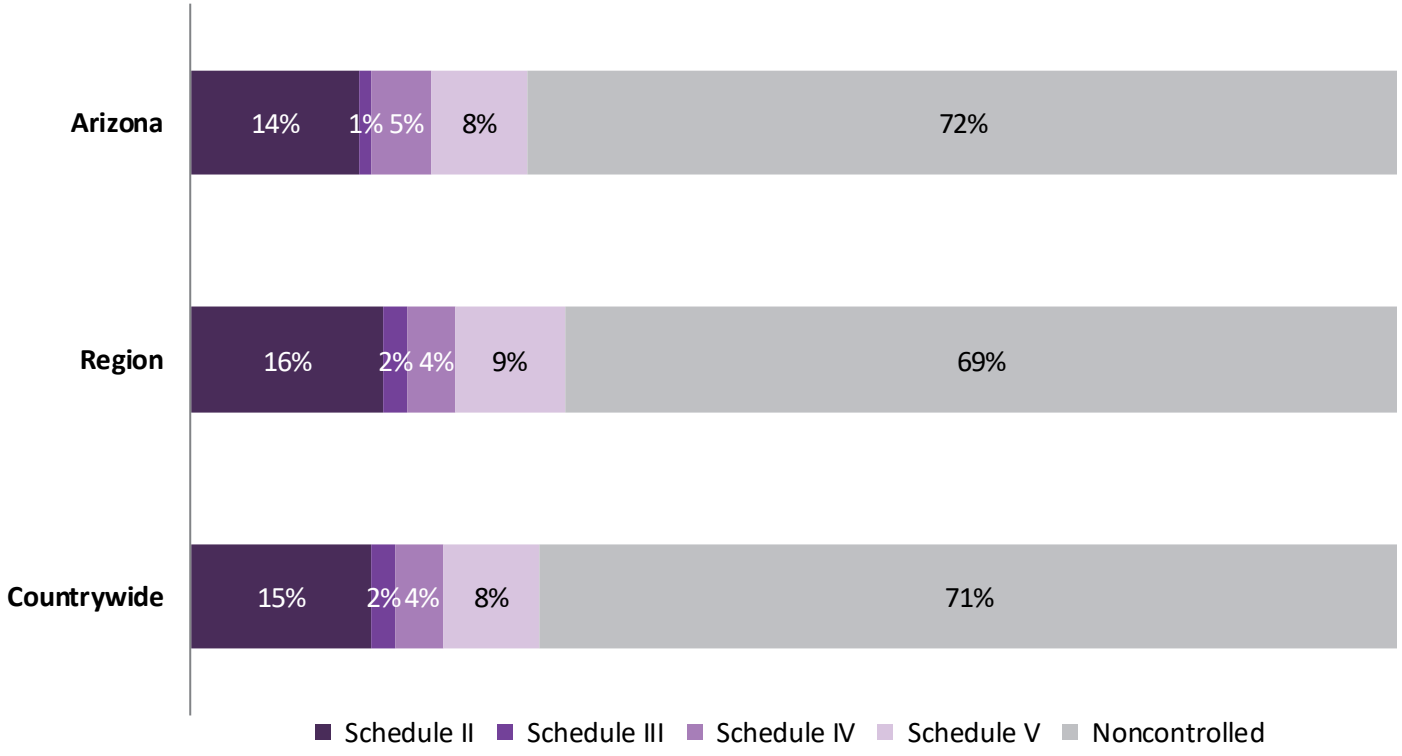


Chart 52 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Arizona. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also 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 52

Top 10 Workers Compensation Drugs by Amount Paid

Drug Name	Average PPU AZ	Average PPU Region	Average PPU CW	Arizona Paid Share
Lyrica®	$8.09	$8.11	$8.18	5.2%
Oxycontin®	$9.56	$8.79	$9.54	4.8%
Gabapentin	$1.12	$0.85	$0.97	4.4%
Lidocaine	$6.72	$6.15	$7.01	4.2%
Duloxetine HCl	$5.51	$4.29	$4.71	3.8%
Celecoxib	$4.83	$4.23	$4.97	3.7%
Metaxalone	$6.03	$4.38	$4.96	3.2%
Meloxicam	$2.93	$2.82	$3.12	2.8%
Tramadol HCl	$1.36	$0.82	$1.08	2.2%
Diclofenac Sodium	$0.95	$1.35	$1.68	1.9%

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	3
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Lidocaine	G	Lidoderm®	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	4
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	8
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	7
Metaxalone	G	N/A	Muscle Relaxants, Skeletal	None	16
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	6
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	12
Diclofenac Sodium	G	Voltaren®	Analgesics/Antipyretics	None	5

Chart 53 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 53

Top 10 Workers Compensation Drugs by Prescription Counts

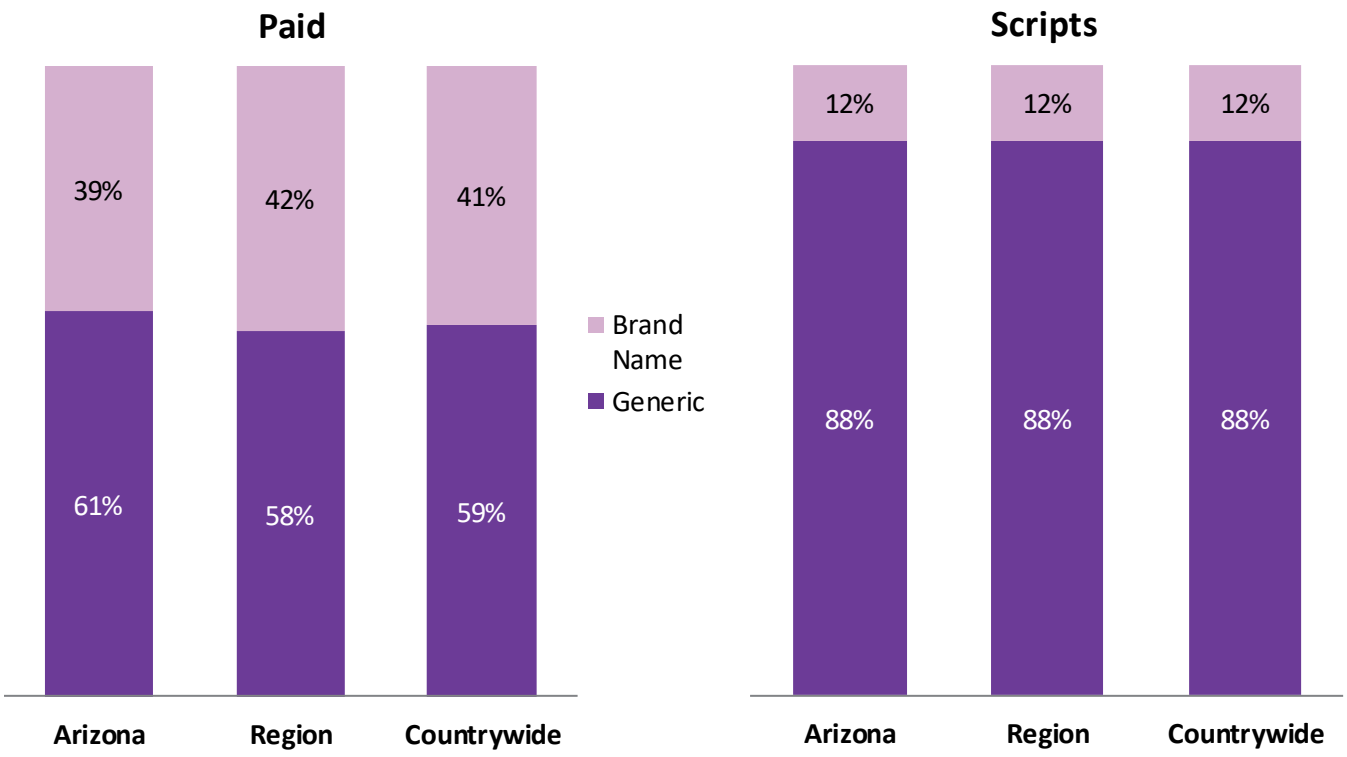
Drug Name	Average PPU AZ	Average PPU Region	Average PPU CW	Arizona Prescription Share
Ibuprofen	$0.32	$0.49	$0.43	6.9%
Gabapentin	$1.12	$0.85	$0.97	5.0%
Cyclobenzaprine HCl	$1.22	$1.05	$1.58	4.5%
Hydrocodone Bitartrate-Acetaminophen	$0.52	$0.56	$0.56	4.5%
Naproxen	$0.94	$0.85	$0.91	3.5%
Tramadol HCl	$1.36	$0.82	$1.08	3.3%
Oxycodone HCl	$0.74	$0.79	$0.91	3.2%
Diclofenac Sodium	$0.95	$1.35	$1.68	3.0%
Oxycodone HCl-Acetaminophen	$1.33	$1.54	$1.51	2.9%
Meloxicam	$2.93	$2.82	$3.12	2.8%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	4
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Naproxen	G	Aleve®	Analgesics/Antipyretics	None	9
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	6
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	10
Diclofenac Sodium	G	Voltaren®	Analgesics/Antipyretics	None	8
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	7
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	5

Chart 54 shows the distribution of prescription drugs by brand name and generic for Arizona, the region, and countrywide. The share between brand name and generic is displayed based on the prescription counts and the payments. Typically, a higher percentage of drugs is given in the generic form; however, higher costs occur when brand name drugs are prescribed. In many states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand name and generic drugs.

Chart 54

Distribution of Drugs by Brand Name and Generic

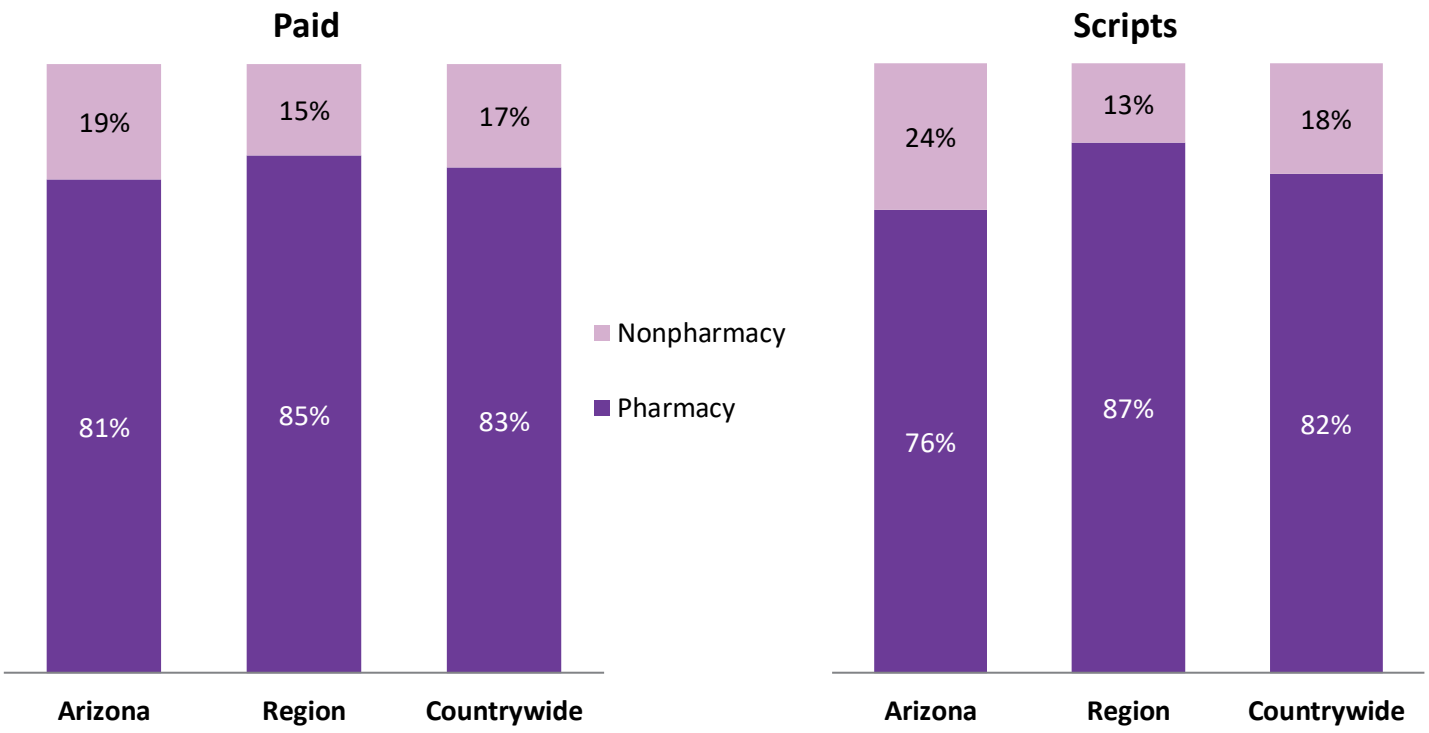


The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states limit or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight into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

Chart 55 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 55

Distribution of Drugs by Pharmacy and Nonpharmacy



Durable Medical Equipment, Prosthetics, Orthotics and Supplies

The distribution of medical payments for DMEPOS is 7% for Arizona, 6% for the region, and 8% for countrywide.

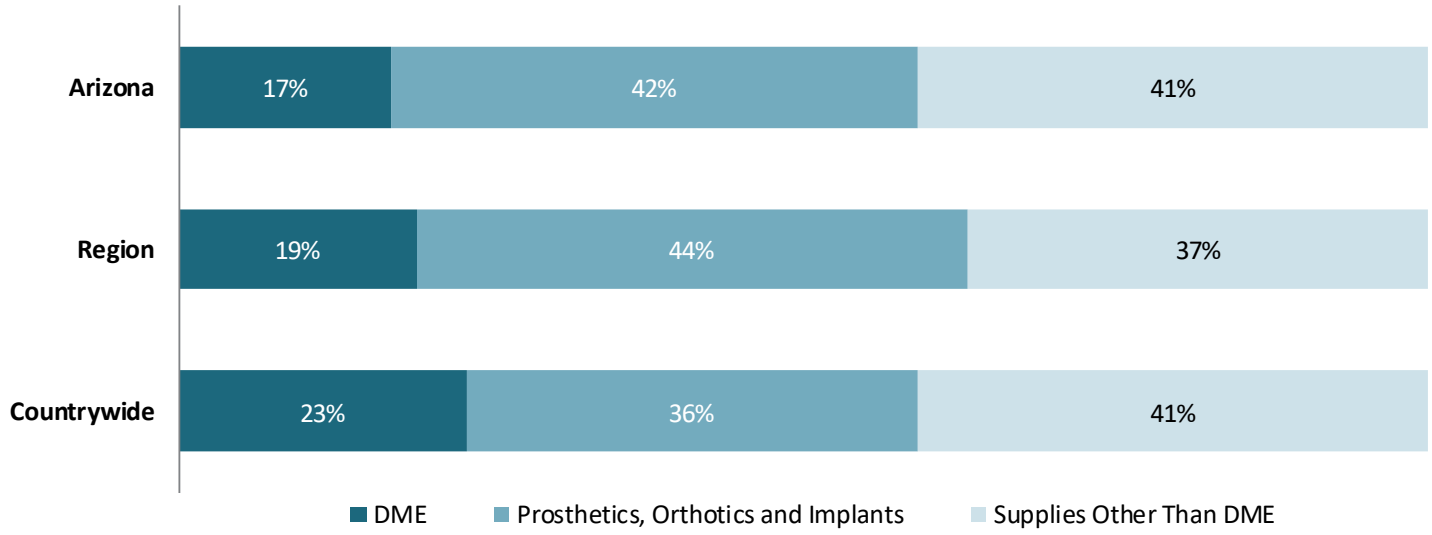
Chart 56 displays the distribution of payments among three separate DMEPOS categories:

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

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

Chart 56

Distribution of Payments by DMEPOS



Injuries that include an implant or prosthetic device tend to be more expensive than other injuries. Chart 57 shows the top 10 diagnosis groups for claims that include an implant or a prosthetic device, by total paid amount. Chart 58 shows the same diagnosis groups with the average amount paid per claim for claims that do not include an implant or prosthetic.

Chart 57

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2018 for Claims *With* an Implant or Prosthetic

Diagnosis Group	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Tibia fibula fracture	7.2%	$130,466	$55,893	$80,160
Hand/wrist fracture	6.3%	$32,600	$23,127	$27,006
Hip/pelvis fracture/major trauma	5.7%	$133,888	$75,283	$82,633
Rotator cuff tear	5.6%	$39,740	$31,325	$38,968
Lumbar spine degeneration	4.2%	$146,251	$87,980	$96,882
Injury of unspecified body region	3.4%	$447,831	$72,833	$74,329
Acute posthemorrhagic anemia	3.2%	$695,968	$137,142	$126,211
Traumatic brain injury	3.0%	$485,241	$352,641	$255,002
Minor shoulder injury	2.9%	$30,288	$24,438	$29,941
Femur fracture	2.8%	$257,659	$79,637	$106,938

Chart 58

Average Amount Paid per Claim *Without* an Implant or Prosthetic for Diagnosis Groups in Chart 57

Diagnosis Group	Average Amount Paid Per Claim		
	Arizona	Region	Countrywide
Tibia fibula fracture	$18,943	$16,115	$17,907
Hand/wrist fracture	$8,035	$5,453	$6,001
Hip/pelvis fracture/major trauma	$43,466	$34,275	$38,260
Rotator cuff tear	$12,819	$16,706	$20,199
Lumbar spine degeneration	$16,063	$10,520	$14,124
Injury of unspecified body region	$3,288	$3,797	$3,348
Acute posthemorrhagic anemia	N/A	$51,506	$107,567
Traumatic brain injury	$63,279	$45,382	$44,126
Minor shoulder injury	$3,597	$3,841	$3,950
Femur fracture	$34,283	$53,691	$47,049

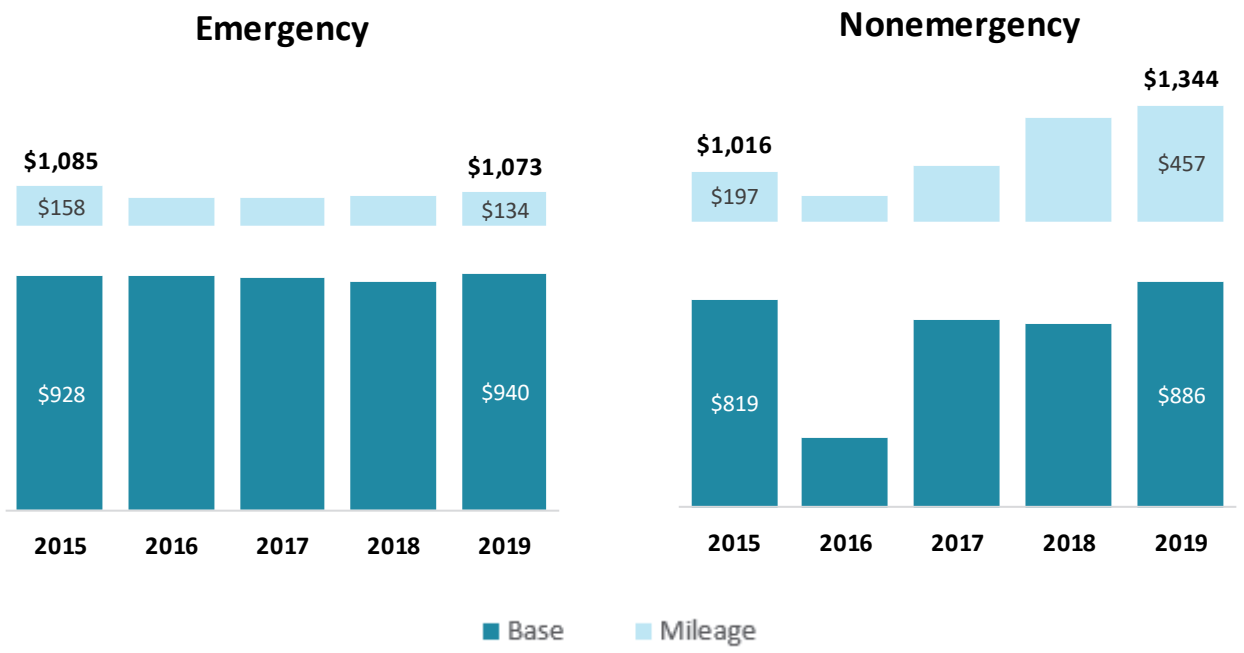
Transportation

For Service Year 2019, transportation services represent less than 2% of total medical costs countrywide. The share of payments varies across jurisdictions, ranging from less than 1% to about 4% of total medical costs. Ambulance services, both ground and air, are the primary driver of transportation costs.

Ground ambulance can be split into two categories: emergency and nonemergency. In 2019, 93% of ground ambulance episodes[8] were emergencies in Arizona. Chart 59 displays the average payment per episode for emergency and nonemergency ground ambulance episodes, and it shows this separately for the base payment and mileage payment in Arizona. The base payment reflects the service intensity of the transport and is higher for emergency services. The mileage payment per episode is higher for nonemergency services due to the average number of miles travelled; typically, nonemergency episodes travel farther than emergency and the intensity of the service is greatly reduced.

Chart 59

Average Payment per Episode for Ground Ambulance Services



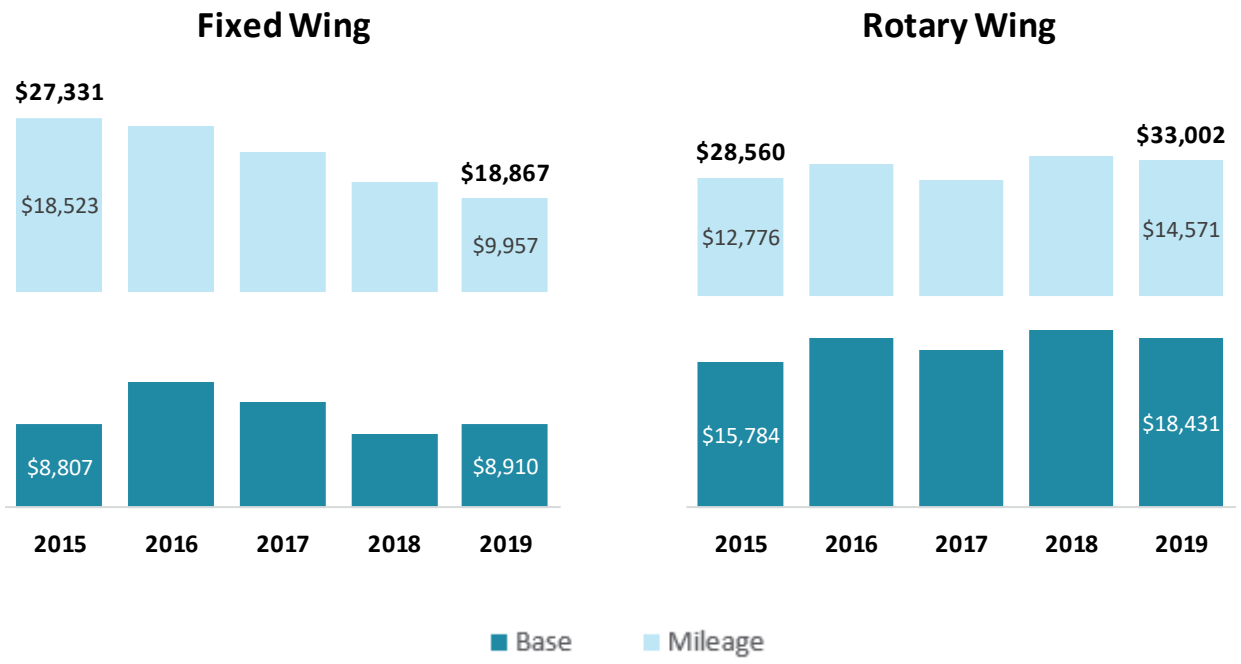
[8]An episode refers to a service or set of services provided to a claimant on a specific date.

Air ambulance episodes represent about 4% of all ambulance episodes countrywide in 2019 but account for approximately half of all ambulance payments. Air ambulance is split into two categories: rotary wing (helicopter) and fixed wing (airplane). Rotary wing episodes represent more than 85% of both payments and episodes for air ambulance services on a countrywide basis. Chart 60 displays the average payment per fixed wing and rotary wing episodes in Arizona separately for the base payment and mileage payment.

The base rate for fixed wing transport is generally less than rotary wing because rotary wing is typically used in emergencies and fixed wing for nonemergency transport. The countrywide average distance per fixed wing transport is approximately four times that of the average rotary wing transport, making the average total payment for fixed wing transport typically higher than rotary wing transport.

Chart 60

Average Payment per Episode for Fixed and Rotary Wing Air Ambulance Services



Diagnosis Group and Body System

Charts 61 and 62 display the top 10 body systems and diagnosis groups, respectively. Body system and diagnosis group are identified for each claim based on ICD-10 code. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 body systems and diagnosis groups are ranked by total claim payments for Arizona. This method of ranking shows which body systems and diagnosis groups have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2018, and December 31, 2018, and they include all reported services provided for those claims through December 31, 2019. 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 system and diagnosis group.

Chart 61

Top Body Systems by Amount Paid for Dates of Injury in 2018

Body System	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Hand/wrist	13.2%	$2,524	$1,958	$2,365
Shoulder	11.8%	$7,519	$8,597	$9,901
Lumbar spine	9.9%	$4,014	$4,073	$4,669
Knee	9.3%	$6,218	$5,699	$5,972
Ankle/foot	7.5%	$3,763	$3,122	$3,491
Leg	6.5%	$6,532	$4,810	$6,430
Head	5.9%	$4,917	$3,614	$3,822
Arm	5.4%	$6,343	$4,657	$5,513
Neck	3.6%	$4,363	$4,858	$5,798
Abdomen	2.4%	$10,192	$6,359	$7,779

Chart 62

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2018

Diagnosis Group	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Minor hand/wrist injuries	5.4%	$1,328	$1,123	$1,304
Minor shoulder injury	4.9%	$4,210	$4,266	$4,559
Hand/wrist fracture	4.8%	$11,029	$6,754	$7,514
Low back pain	4.8%	$2,233	$2,628	$2,427
Rotator cuff tear	3.7%	$17,915	$18,980	$23,487
Tibia fibula fracture	3.1%	$41,372	$24,635	$31,349
Minor knee injury	2.7%	$2,591	$2,579	$2,621
Minor ankle/foot injuries	2.6%	$1,899	$1,593	$1,741
Injury of unspecified body region	2.3%	$5,497	$4,224	$3,803
Hip/pelvis fracture/major trauma	2.3%	$81,254	$48,503	$54,073

Comparison of Selected Results by Year

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

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

Distribution of Medical Payments (Chart 4)

Medical Category	2015	2016	2017	2018	2019
Physician	34%	35%	34%	35%	37%
Hospital Outpatient	14%	15%	17%	17%	18%
Hospital Inpatient	15%	14%	14%	15%	15%
Drugs	14%	13%	12%	10%	9%
DMEPOS	7%	7%	8%	7%	7%
ASC	6%	7%	7%	6%	6%
Other	10%	9%	8%	10%	8%

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

AMA Service Category	2015	2016	2017	2018	2019
Physical Medicine	32%	31%	31%	35%	34%
Surgery	20%	20%	19%	16%	17%
Evaluation and Management	26%	27%	28%	29%	29%
Radiology	9%	9%	9%	8%	8%
Anesthesia	3%	3%	3%	3%	3%
General Medicine	4%	4%	4%	3%	3%
Other	3%	3%	3%	4%	4%
Pathology	3%	3%	3%	2%	2%

Median Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 28, 36, 37, and 48)[9]

Medical Category	AY 2014	AY 2015	AY 2016	AY 2017	AY 2018
Physicians – Major Surgery	30	26	28	22	25
Physicians – Radiology	1	1	1	1	1
Physicians – Physical and General Medicine	9	9	9	10	9
Physicians – Evaluation and Management	1	1	1	1	1
Hospital Inpatient	0	0	0	0	0
Hospital Outpatient – Major Surgery	49	43	56	41	59
Hospital Outpatient – All Other	0	0	1	1	1
ASC – Surgery	76	68	73	70	75

75th Percentile of Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 28, 36, 37, and 48)[9]

Medical Category	AY 2014	AY 2015	AY 2016	AY 2017	AY 2018
Physicians – Major Surgery	108	104	109	98	102
Physicians – Radiology	6	6	7	7	7
Physicians – Physical and General Medicine	29	30	32	32	32
Physicians – Evaluation and Management	3	3	4	4	4
Hospital Inpatient	8	5	5	4	6
Hospital Outpatient – Major Surgery	136	125	139	132	135
Hospital Outpatient – All Other	9	7	12	13	23
ASC – Surgery	145	144	146	142	153

Hospital Inpatient Statistics (Charts 24 and 26)

Hospital Inpatient Statistics	2015	2016	2017	2018	2019
Average Amount Paid Per Stay	$33,348	$36,701	$36,507	$39,729	$43,557
Number of Stays per 1,000 Active Claims	18	17	17	15	15

[9] 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.

Distribution of Hospital Outpatient Payments by Surgery and Nonsurgery (Paragraphs preceding Charts 32 and 34)

Visit Type	2015	2016	2017	2018	2019
Surgery	48%	50%	52%	51%	51%
Nonsurgery	52%	50%	48%	49%	49%

Hospital Outpatient Surgery Statistics (Charts 32 and 33)

Hospital Outpatient Surgery Statistics	2015	2016	2017	2018	2019
Average Amount Paid Per Visit	$5,201	$5,847	$6,780	$6,843	$7,325
Number of Visits per 1,000 Active Claims	58	58	61	57	56

Hospital Outpatient Nonsurgery Statistics (Charts 34 and 35)

Hospital Outpatient Nonsurgery Statistics	2015	2016	2017	2018	2019
Average Amount Paid Per Visit	$841	$885	$953	$1,021	$1,135
Number of Visits per 1,000 Active Claims	387	389	406	372	348

Emergency Service Statistics (Charts 41 and 42)

Emergency Service Statistics	2015	2016	2017	2018	2019
Average Amount Paid Per Visit	$2,076	$2,290	$2,428	$2,547	$2,621
Number of Visits per 1,000 Active Claims	210	209	215	211	208

ASC Surgery Statistics (Charts 46 and 47)

ASC Surgery Statistics	2015	2016	2017	2018	2019
Average Amount Paid Per Visit	$4,589	$4,994	$5,431	$5,599	$5,587
Number of Visits per 1,000 Active Claims	55	56	50	45	49

Distribution of Prescription Drug Payments by CSA Schedule (Chart 51)

CSA Schedule	2015	2016	2017	2018	2019
Schedule II	28%	25%	22%	19%	14%
Schedule III	2%	1%	1%	1%	1%
Schedule IV	9%	8%	7%	6%	5%
Schedule V	6%	6%	7%	9%	8%
Noncontrolled	55%	60%	63%	65%	72%

Distribution of Drug Payments by Brand Name and Generic (Chart 54)

Type of Drug	2015	2016	2017	2018	2019
Brand Name	44%	47%	45%	45%	39%
Generic	56%	53%	55%	55%	61%

Distribution of Drug Payments by Pharmacy and Nonpharmacy (Chart 55)

Type of Provider	2015	2016	2017	2018	2019
Pharmacy	91%	91%	91%	86%	81%
Nonpharmacy	9%	9%	9%	14%	19%

Distribution of Payments by DMEPOS (Chart 56)

Category	2015	2016	2017	2018	2019
DME	16%	17%	15%	15%	17%
Prosthetics, Orthotics and Implants	49%	50%	49%	46%	42%
Supplies Other Than DME	35%	33%	36%	39%	41%

Glossary

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

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

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

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

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

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

Current 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 classifications that groups patients with similar clinical problems who are expected to require similar amounts of hospital resources.

Drugs: Includes any data reported by a National Drug Code (NDC). 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 Services: Services performed 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.

Injury or poisoning not otherwise classified: Body system grouping consisting of ICD-10 codes without a specific body part or system related to the injury. An example is ICD-10 code T31.0 which is "Burns involving less than 10% of body surface".

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

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

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

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

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