Medical Data Report
for the state of:

ARIZONA
September 2014

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

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

Introduction

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

This publication is a data source for regulators and others who may be interested in the increasing medical costs in workers compensation claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that threaten the financial soundness of the workers compensation system.

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

- Physician
- Hospital
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment (DME), Supplies, and Implants
- Other

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

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

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

Additional information regarding the data underlying this report is described in more detail in the Appendix.

Table of Contents

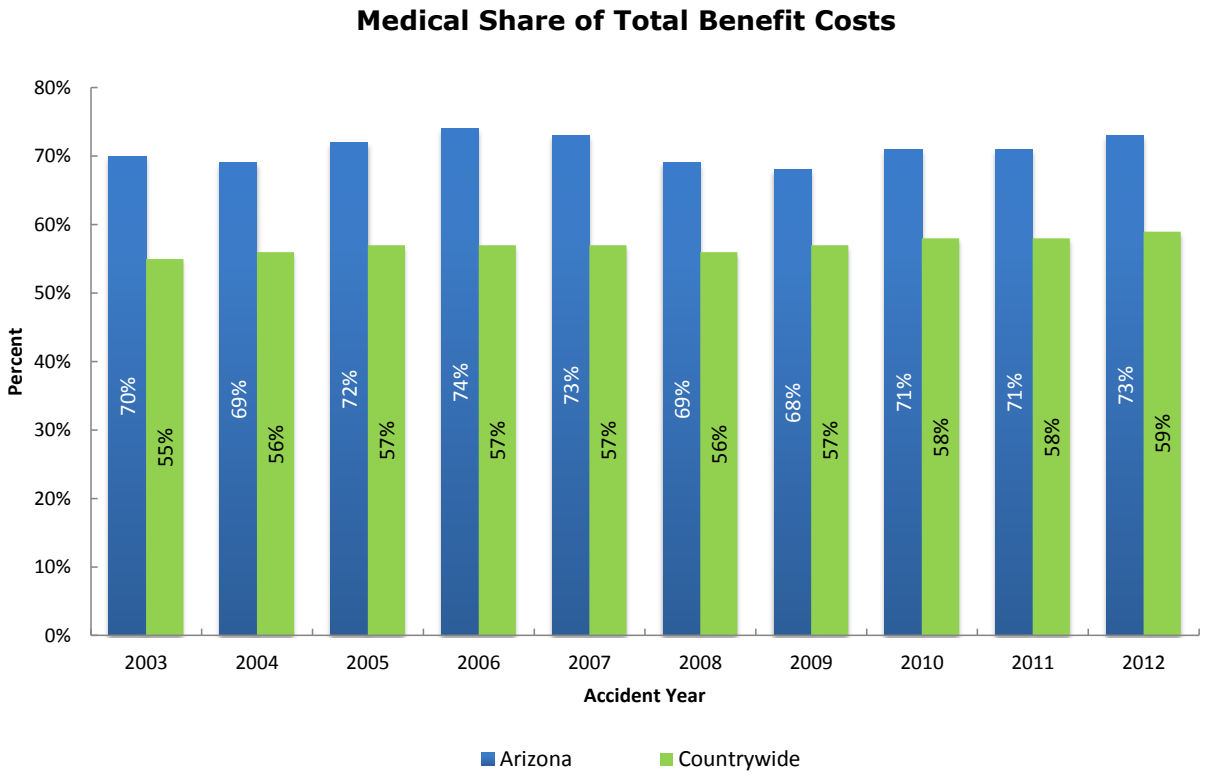
Medical Share of Total Benefit Costs 1
Overall Medical Average Cost per Case 2
Percentage of Medical Paid by Claim Maturity 3
Distribution of Medical Payments 4
Distribution of Physician Payments by AMA Service Category 6
Top 10 Surgery Procedure Codes by Amount Paid for Arizona 9
Top 10 Surgery Procedure Codes by Transaction Counts for Arizona 10
Top 10 Radiology Procedure Codes by Amount Paid for Arizona 11
Top 10 Radiology Procedure Codes by Transaction Counts for Arizona 12
Top 10 Physical and General Medicine Procedure Codes by Amount Paid for Arizona 13
Top 10 Physical and General Medicine Procedure Codes by Transaction Counts for Arizona 14
Top 10 Evaluation and Management Procedure Codes by Amount Paid for Arizona 15
Top 10 Evaluation and Management Procedure Codes by Transaction Counts for Arizona 16
Average Paid Amount per Claim for Hospital Inpatient Services 18
Distribution of Hospital Inpatient Payments by Procedure Code Type 19
Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services for Arizona 21
Top 10 Revenue Codes by Amount Paid for Hospital Inpatient Services for Arizona 22
Average Paid Amount per Visit for Hospital Outpatient Services 24
Distribution of Hospital Outpatient Payments by Procedure Code Type 25
Top 10 Surgery CPT Codes by Amount Paid for Hospital Outpatient Services for Arizona 27
Top 10 Non-surgery CPT Codes by Amount Paid for Hospital Outpatient Services for Arizona 28
Top 10 Revenue Codes by Amount Paid for Hospital Outpatient Services for Arizona 29
Average Paid Amount per Visit for Ambulatory Surgical Center Services 30
Distribution of Ambulatory Surgical Center Payments by Procedure Code Type 31
Top 10 Surgery CPT Codes by Amount Paid for ASC Services for Arizona 33
Top 10 Workers Compensation Drugs by Amount Paid for Arizona 34
Top 10 Workers Compensation Drugs by Prescription Counts for Arizona 35
Distribution of Drugs by Brand Name and Generic 36
Distribution of Prescription Drug Costs in Arizona by CSA Schedule 37
Distribution of Drugs by Pharmacy and Non-pharmacy 39
Distribution of Drug Payments by Repackaged and Non-repackaged 40
Distribution of Payments by DME, Supplies, and Implants 41
Top 10 ICD-9 Codes by Amount Paid for Dates of Injury in 2012 for Arizona 44
Distribution of Physician and Facility Payments by Provider State 45
Comparison of Selected Distributions by Service Year 46
Glossary 49
Appendix 51

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

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. As this is a relative measure and benefits for both indemnity and medical may vary from state to state, local share of medical benefit costs may vary. In particular, the medical share in a state may be large because the indemnity benefits are relatively less prominent.

Chart 1 displays the medical percentage of total benefit costs for Arizona and the countrywide average for the past 10 accident years.

Chart 1



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

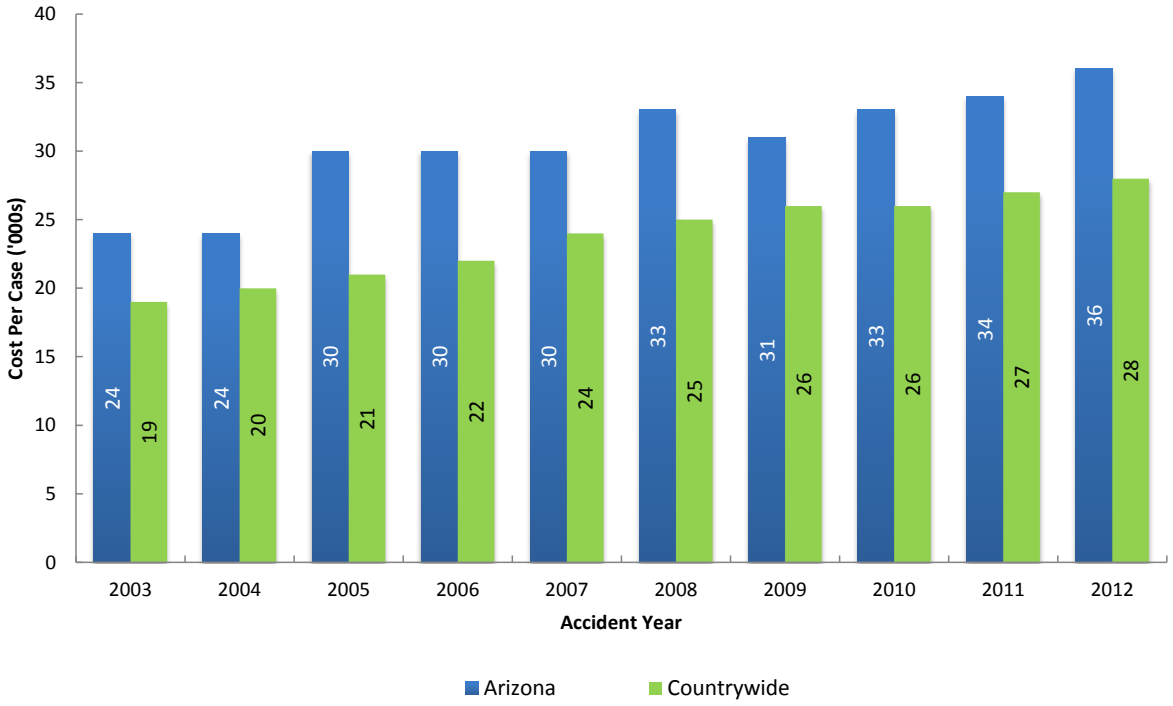
After a decade of medical cost inflation at an annual rate of 6%, since 2010 the countrywide overall medical average cost per claim has seen more moderate increases. Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for both Arizona and the countrywide average.

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

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

Chart 2

Overall Medical Average Cost per Case



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

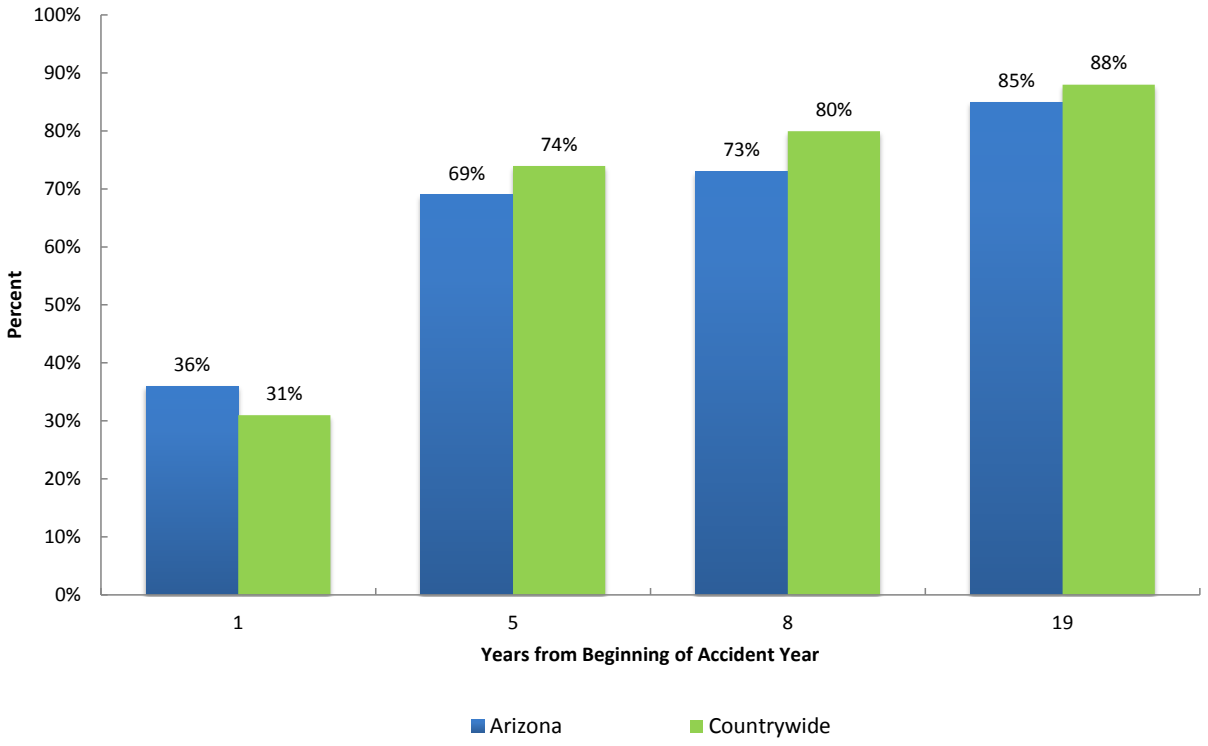
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. Recent NCCI research has found that it is likely that more than 10% of the cost of medical benefits for workplace injuries that occur this year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

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

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

Chart 3

Percentage of Medical Paid by Claim Maturity



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

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

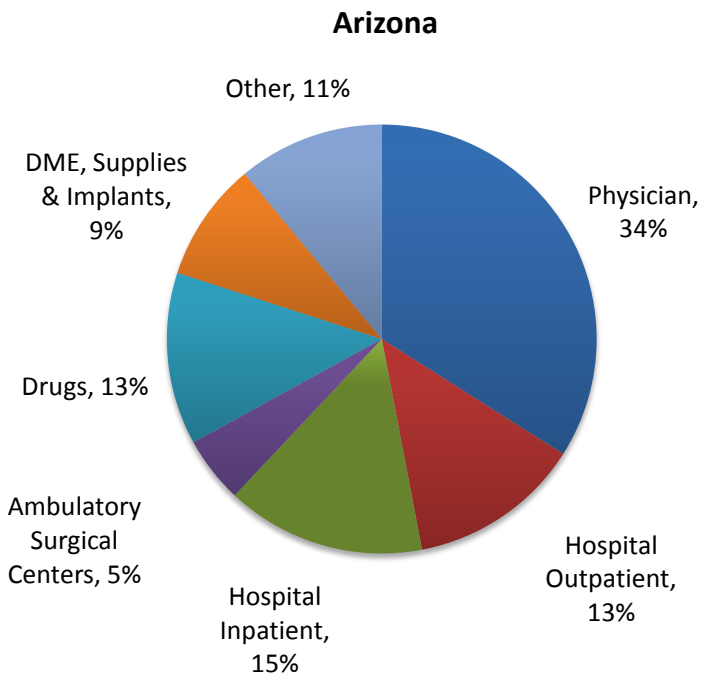
Chart 4 displays the distribution of medical payments by type of service.

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

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

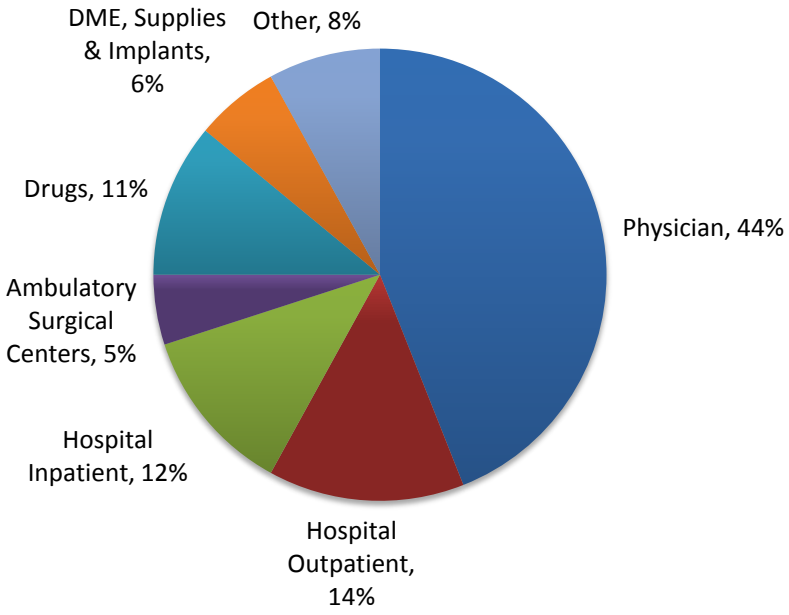
Chart 4

Distribution of Medical Payments

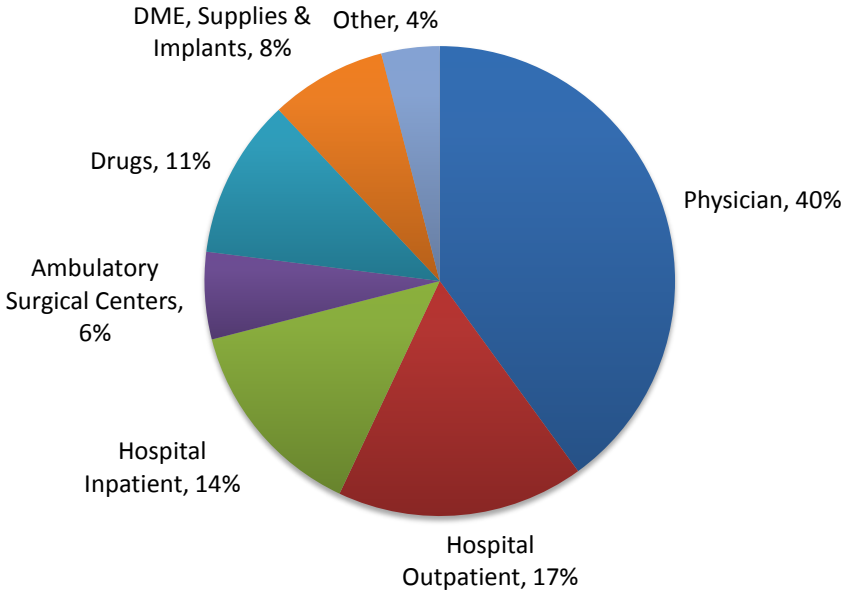


Distribution of Medical Payments

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

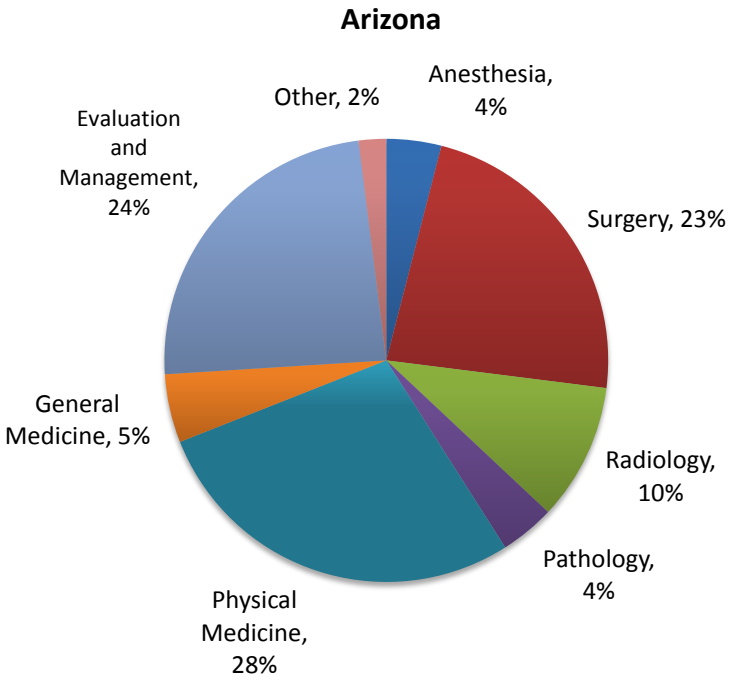
Results from NCCI's study "The Price Impact of Physician Fee Schedules" (April 2014), show that the median workers compensation price for a physician service is always at, or very near, the maximum allowable reimbursement (MAR) amount set by the fee schedule. In the 1970s, less than a dozen states had physician fee schedules in place. Several states established such schedules in the 1990s, and today only six states remain without a physician fee schedule. Recent changes in such schedules indicate greater attention to provisions that often seek to balance cost containment with service provider availability.

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

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

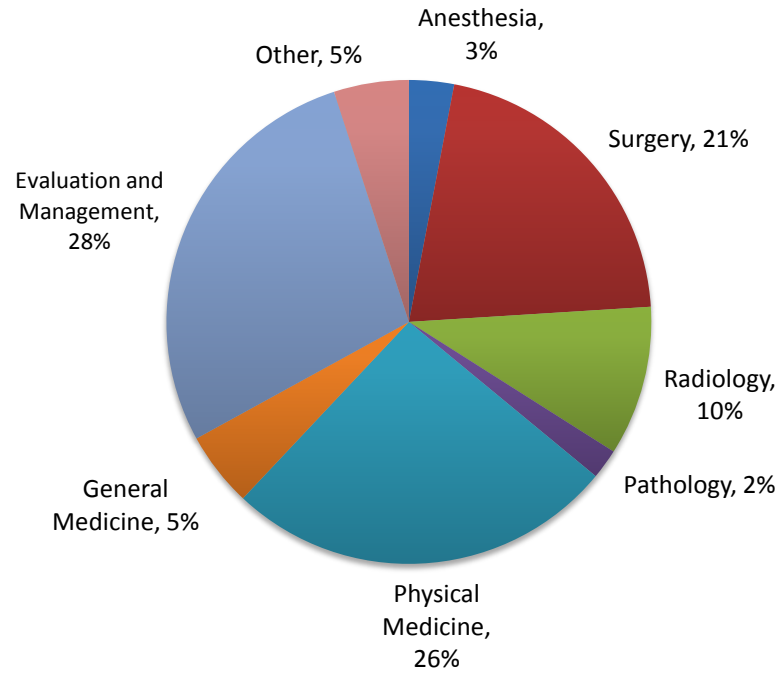
Chart 5

Distribution of Physician Payments by AMA Service Category

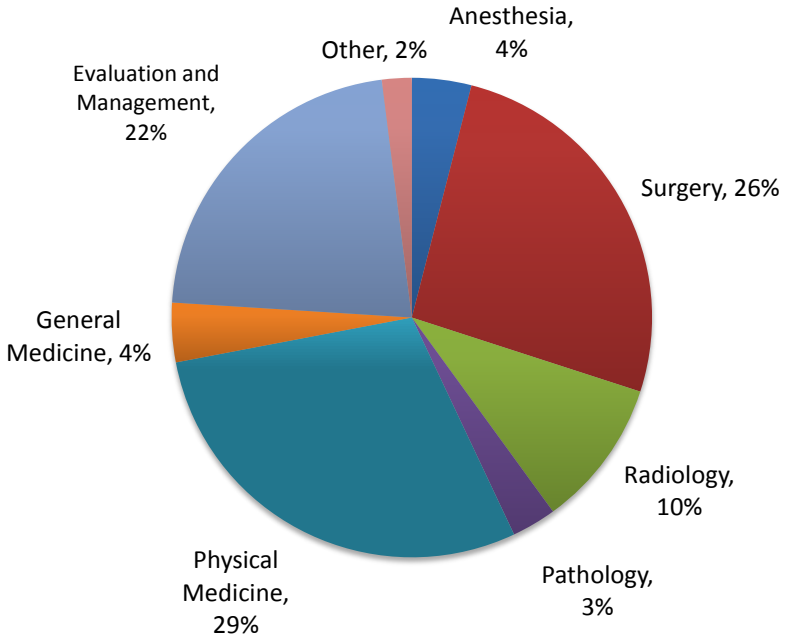


Distribution of Physician Payments by AMA Service Category

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Physicians typically use current procedure terminology (CPT) codes to identify the services they provide to claimants. These codes are specific and provide detailed information on what service was performed. Charts 6 through 13 display the top 10 procedure codes reported by physicians for the service categories: surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code is displayed in the corresponding table below each chart.

The charts also include the average amount paid per transaction for these codes in Arizona, in the region, and across the country. The average amount paid per transaction is calculated by taking the total payments for the procedure code and dividing by the number of transactions for the procedure code. Other fields, such as the secondary paid procedure code, modifier, diagnosis code, place of service, quantity/units, and others may need to be considered when evaluating average payments per service.

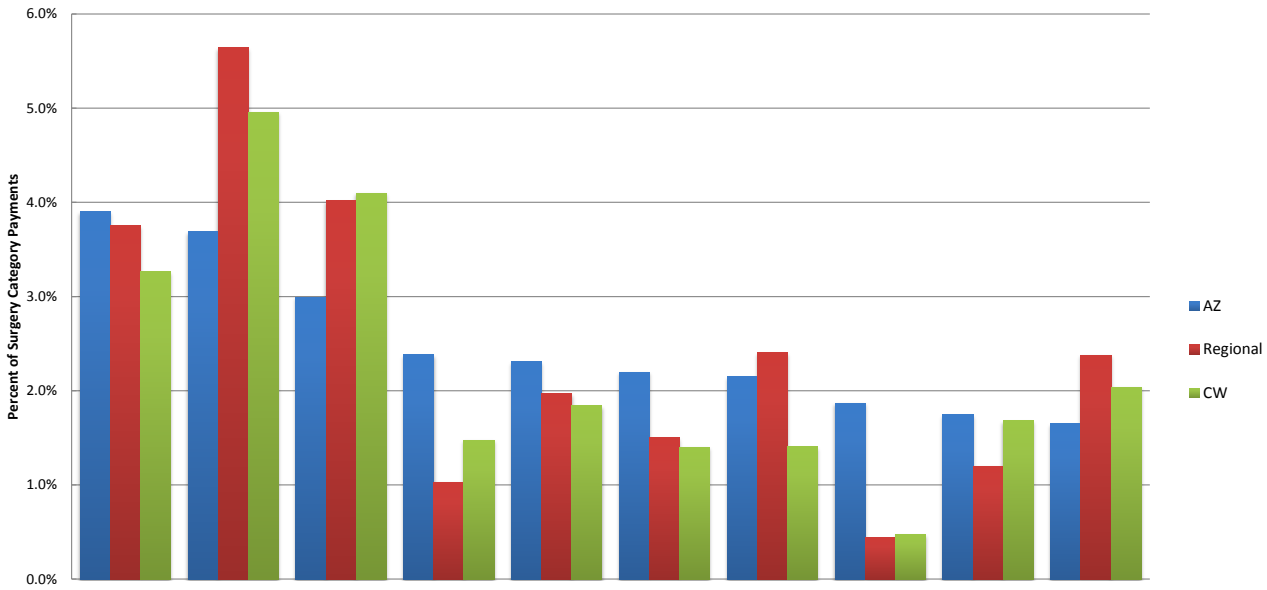
The top 10 charts rank the procedure codes for each service category using two different methods. The first method ranks procedure codes by total payments. Procedure codes are sorted from highest total payments to lowest total payments. The procedure code with the highest amount paid is ranked first;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

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

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

Chart 6

Top 10 Surgery Procedure Codes by Amount Paid for Arizona



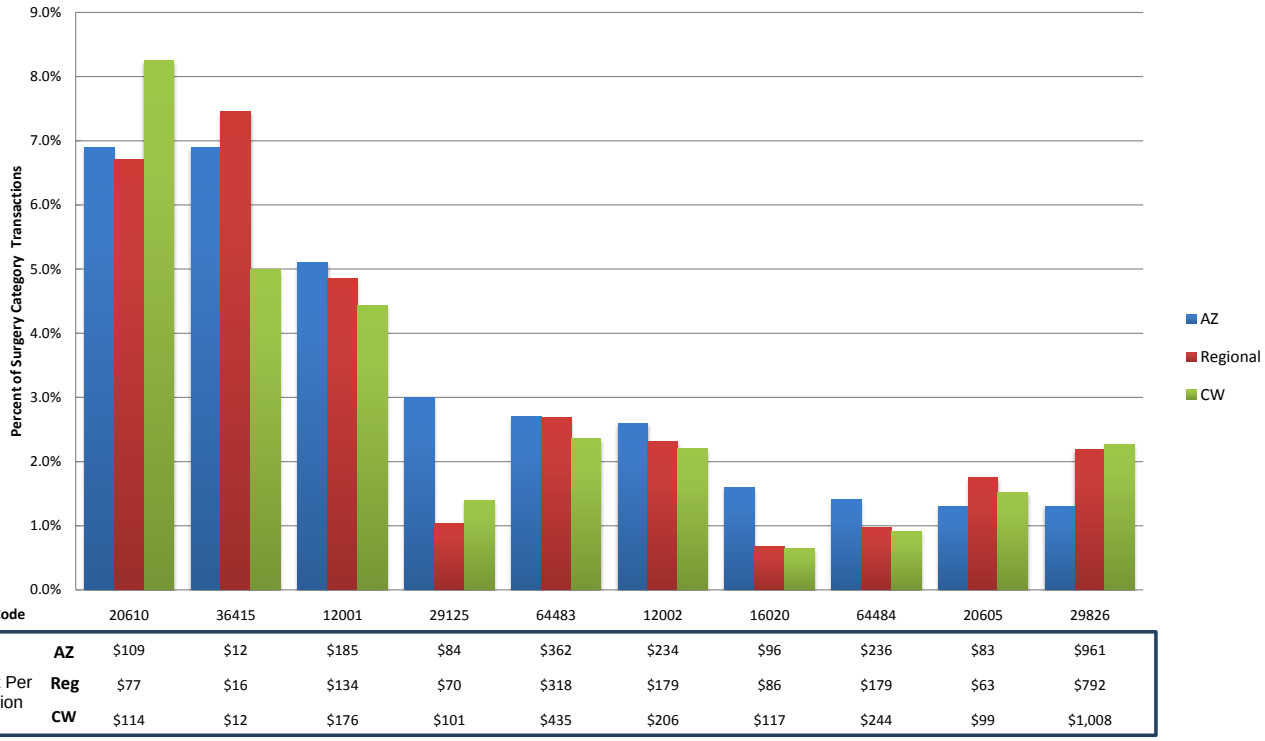
Procedure Code		29881	29827	29826	63047	64483	12001	29888	11012	20610	29823
Average Payment Per Transaction	AZ	$1,423	$1,574	$961	$2,513	$362	$185	$2,324	$1,089	$109	$962
	Reg	$1,120	$1,591	$792	$1,707	$318	$134	$2,035	$718	$77	$1,001
	CW	$1,349	$1,936	$1,008	$1,884	$435	$176	$2,097	$802	$114	$1,044

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	Description
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
63047	Laminectomy facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]) single vertebral segment; lumbar
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
12001	Simple repair of superficial wounds of scalp neck axillae external genitalia trunk and/or extremities (including hands and feet); 2.5 cm or less
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg excisional debridement); skin subcutaneous tissue muscle fascia muscle and bone
20610	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
29823	Arthroscopy shoulder surgical; debridement extensive

Chart 7

Top 10 Surgery Procedure Codes by Transaction Counts for Arizona



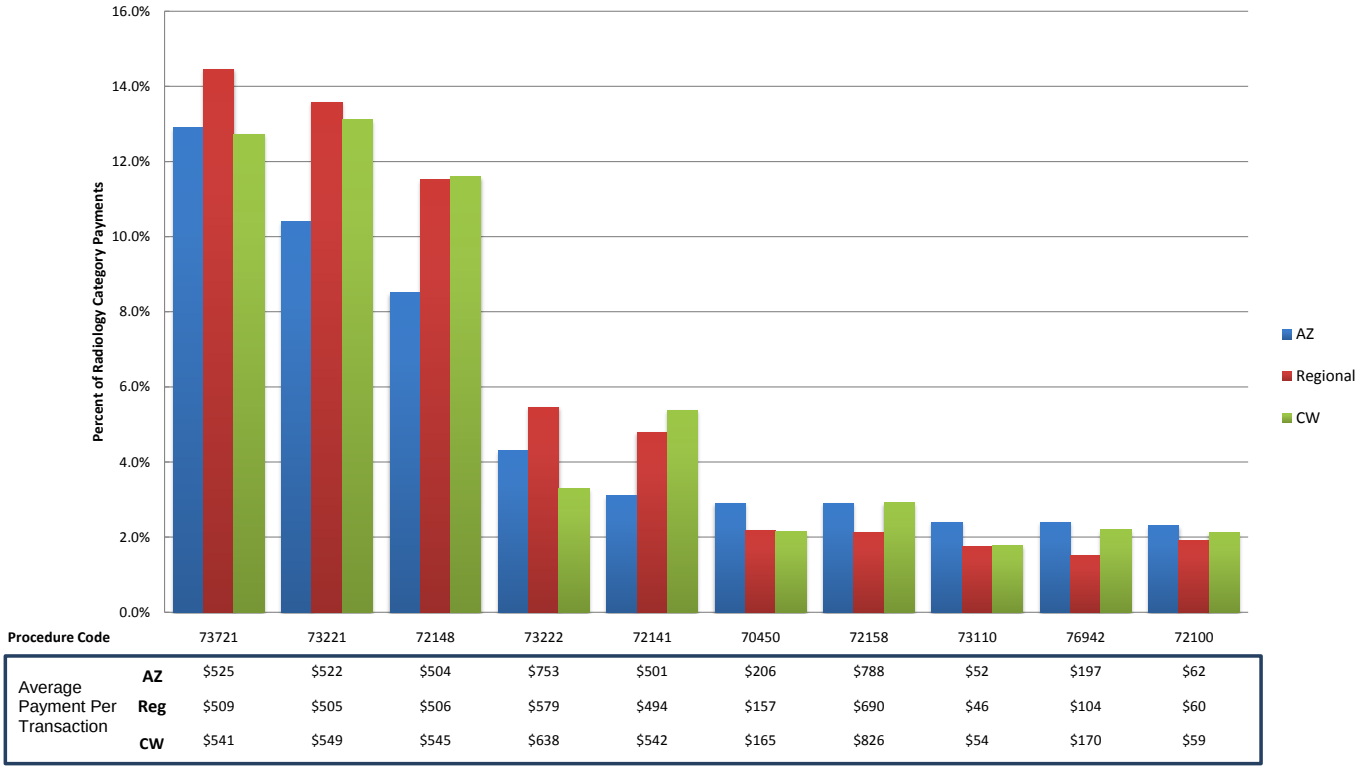
Procedure Code		20610	36415	12001	29125	64483	12002	16020	64484	20605	29826
Average Payment Per Transaction	AZ	$109	$12	$185	$84	$362	$234	$96	$236	$83	$961
	Reg	$77	$16	$134	$70	$318	$179	$86	$179	$63	$792
	CW	$114	$12	$176	$101	$435	$206	$117	$244	$99	$1,008

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	Description
20610	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
36415	Collection of venous blood by venipuncture
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
29125	Application of short arm splint (forearm to hand); static
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
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
16020	Dressings and/or debridement of partial-thickness burns initial or subsequent; small (less than 5% total body surface area)
64484	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral each additional level
20605	Arthrocentesis aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular acromioclavicular wrist elbow or ankle olecranon bursa)
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed

Chart 8

Top 10 Radiology Procedure Codes by Amount Paid for Arizona



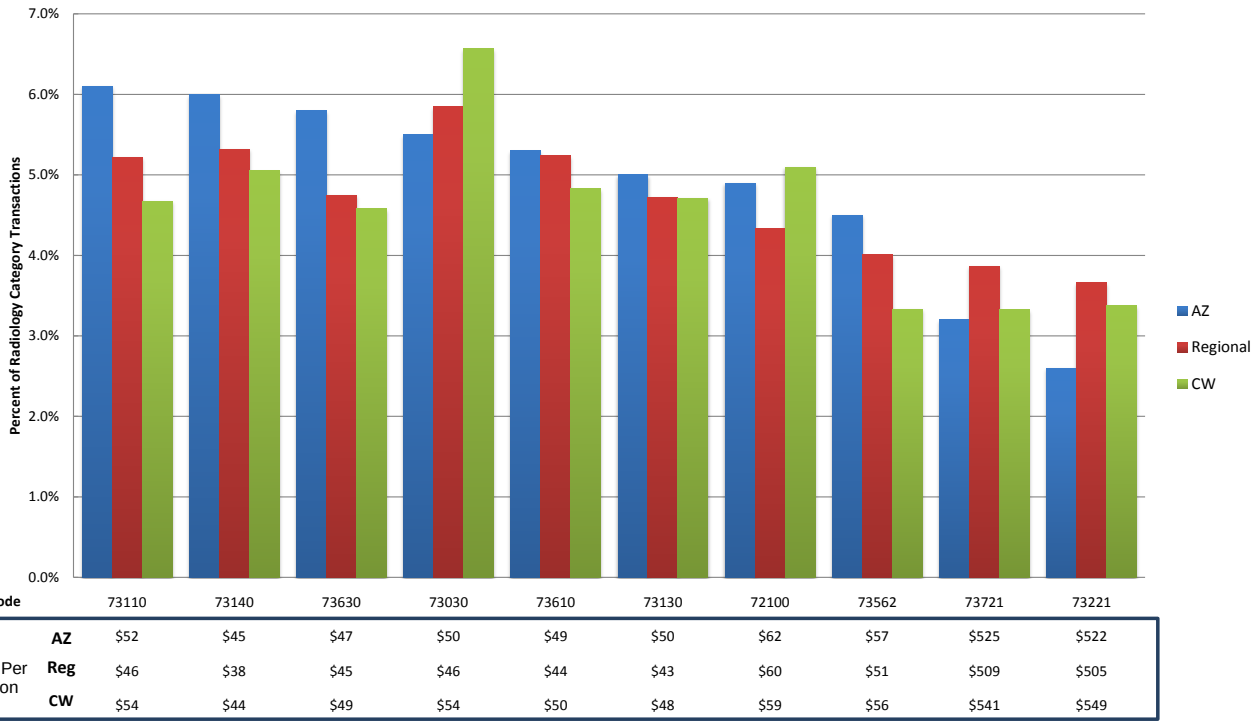
Procedure Code		73721	73221	72148	73222	72141	70450	72158	73110	76942	72100
Average Payment Per Transaction	AZ	$525	$522	$504	$753	$501	$206	$788	$52	$197	$62
	Reg	$509	$505	$506	$579	$494	$157	$690	$46	$104	$60
	CW	$541	$549	$545	$638	$542	$165	$826	$54	$170	$59

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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(s)
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(s)
72141	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material
70450	Computed tomography head or brain; without contrast material
72158	Magnetic resonance (e.g., proton) imaging spinal canal and contents without contrast material followed by contrast material(s) and further sequences
73110	Radiologic examination wrist; complete minimum of 3 views
76942	Ultrasonic guidance for needle placement (e.g., biopsy aspiration injection localization device) imaging supervision and interpretation
72100	Radiologic examination spine lumbosacral; 2 or 3 views

Chart 9

Top 10 Radiology Procedure Codes by Transaction Counts for Arizona



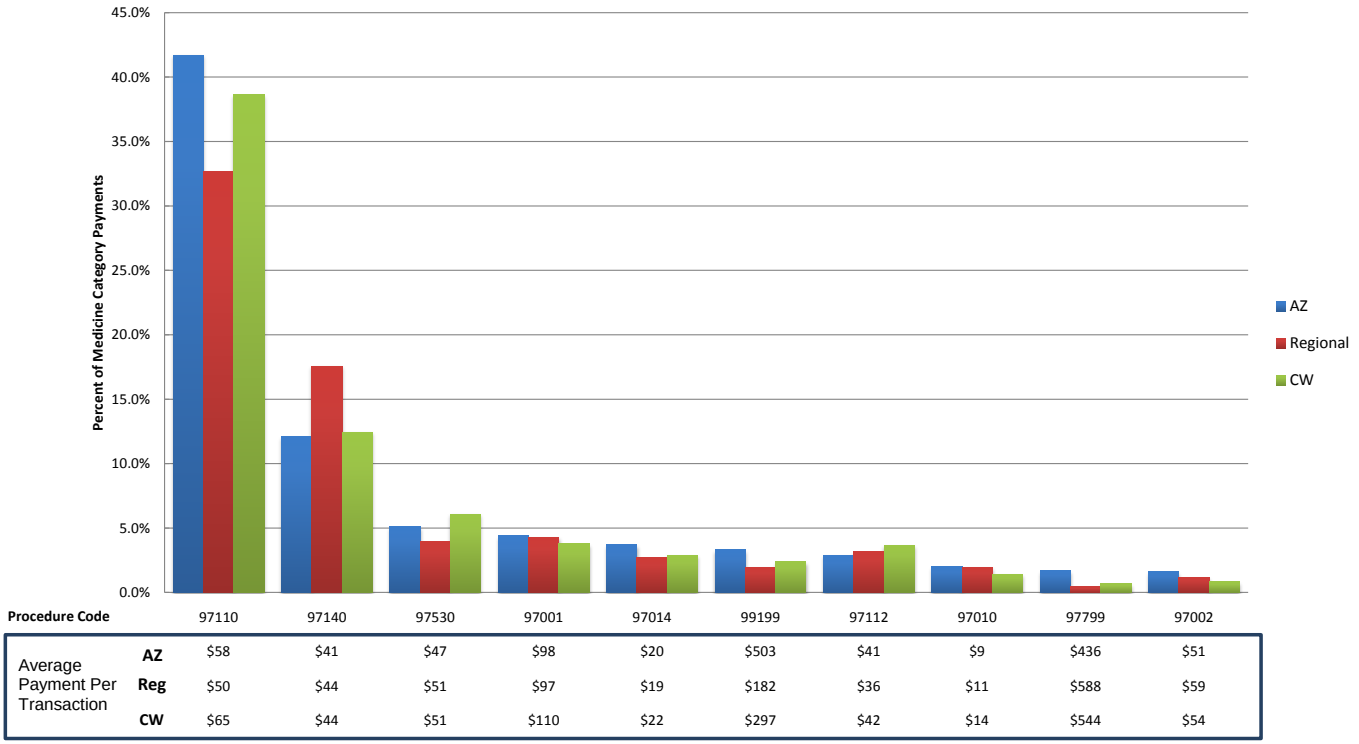
Procedure Code		73110	73140	73630	73030	73610	73130	72100	73562	73721	73221
Average Payment Per Transaction	AZ	$52	$45	$47	$50	$49	$50	$62	$57	$525	$522
	Reg	$46	$38	$45	$46	$44	$43	$60	$51	$509	$505
	CW	$54	$44	$49	$54	$50	$48	$59	$56	$541	$549

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	Description
73110	Radiologic examination wrist; complete minimum of 3 views
73140	Radiologic examination finger(s) minimum of 2 views
73630	Radiologic examination foot; complete minimum of 3 views
73030	Radiologic examination shoulder; complete minimum of 2 views
73610	Radiologic examination ankle; complete minimum of 3 views
73130	Radiologic examination hand; minimum of 3 views
72100	Radiologic examination spine lumbosacral; 2 or 3 views
73562	Radiologic examination knee; 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(s)

Chart 10

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



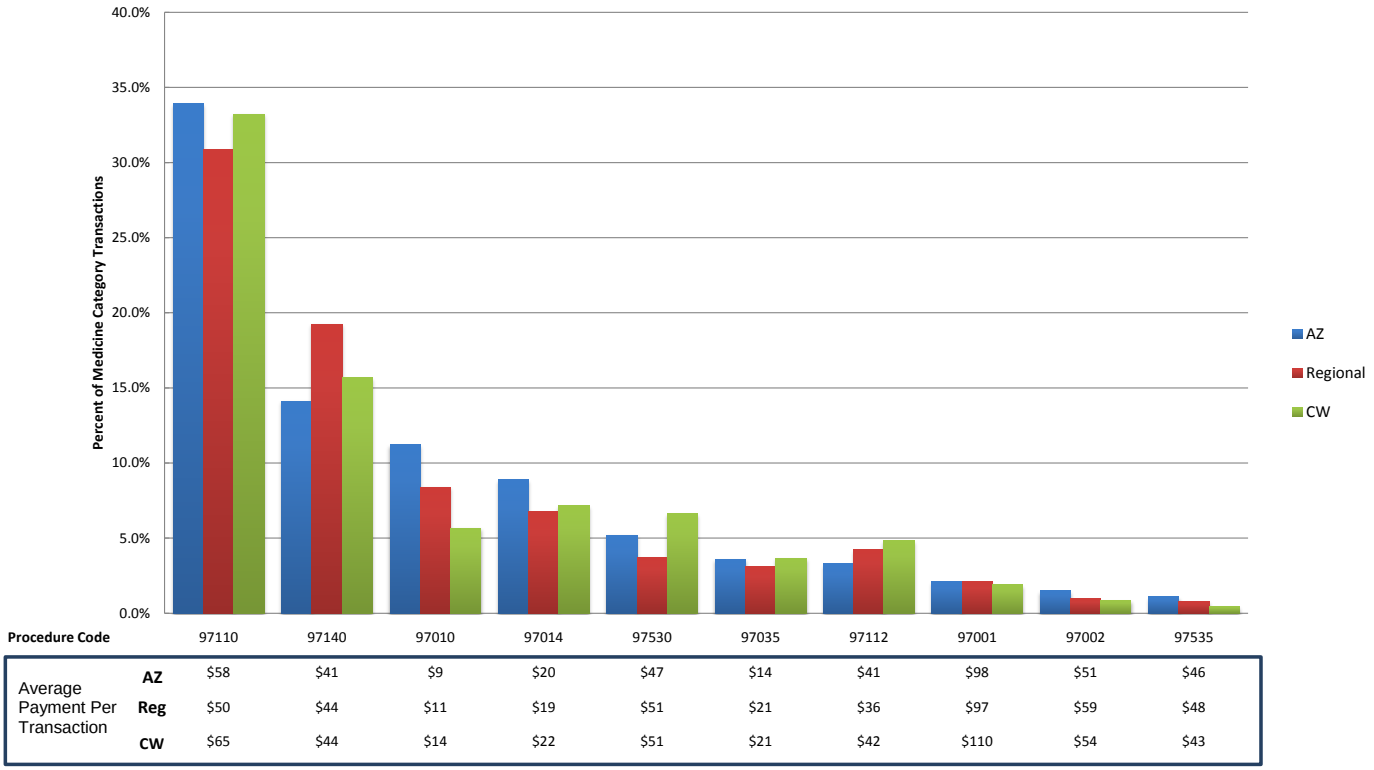
Procedure Code		97110	97140	97530	97001	97014	99199	97112	97010	97799	97002
Average Payment Per Transaction	AZ	$58	$41	$47	$98	$20	$503	$41	$9	$436	$51
	Reg	$50	$44	$51	$97	$19	$182	$36	$11	$588	$59
	CW	$65	$44	$51	$110	$22	$297	$42	$14	$544	$54

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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
97001	Physical therapy evaluation
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
99199	Unlisted special service procedure or report
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
97010	Application of a modality to 1 or more areas; hot or cold packs
97799	Unlisted physical medicine/rehabilitation service or procedure
97002	Physical therapy re-evaluation

Chart 11

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



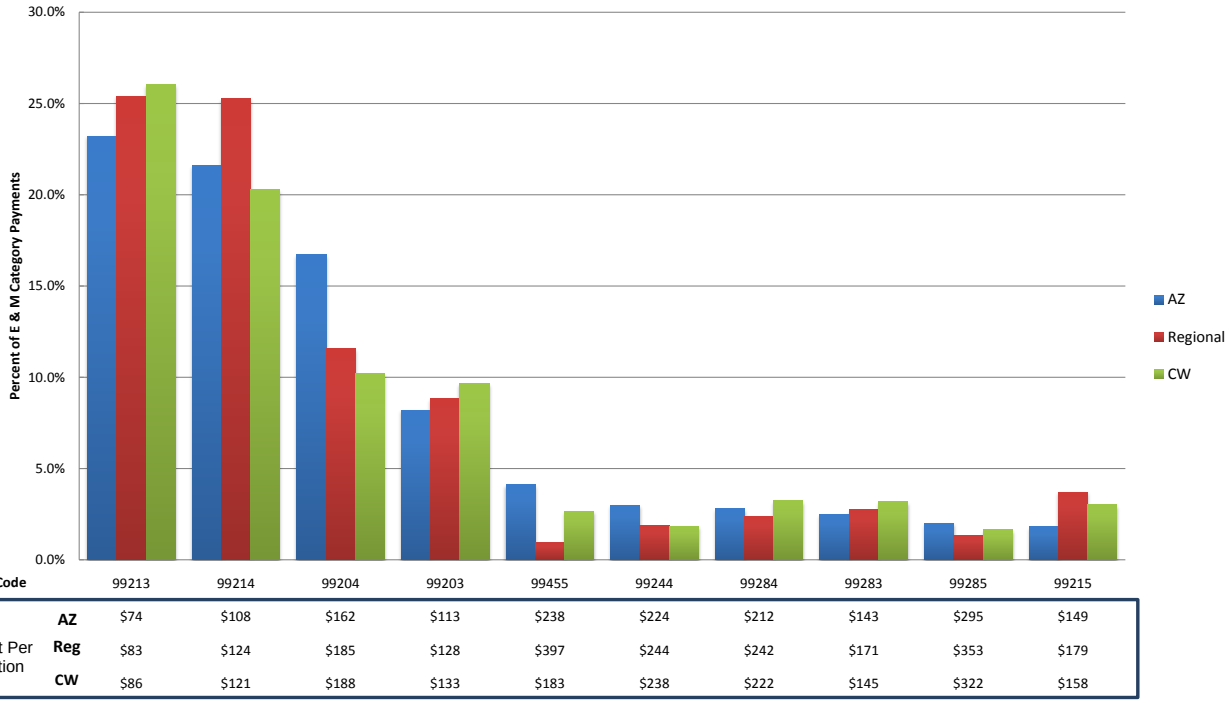
Procedure Code		97110	97140	97010	97014	97530	97035	97112	97001	97002	97535
Average Payment Per Transaction	AZ	$58	$41	$9	$20	$47	$14	$41	$98	$51	$46
	Reg	$50	$44	$11	$19	$51	$21	$36	$97	$59	$48
	CW	$65	$44	$14	$22	$51	$21	$42	$110	$54	$43

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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
97010	Application of a modality to 1 or more areas; hot or cold packs
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97530	Therapeutic activities direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound 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
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97535	Self-care/home management training (eg activities of daily living (ADL) and compensatory training meal preparation safety procedures and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact each 15 minutes

Chart 12

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



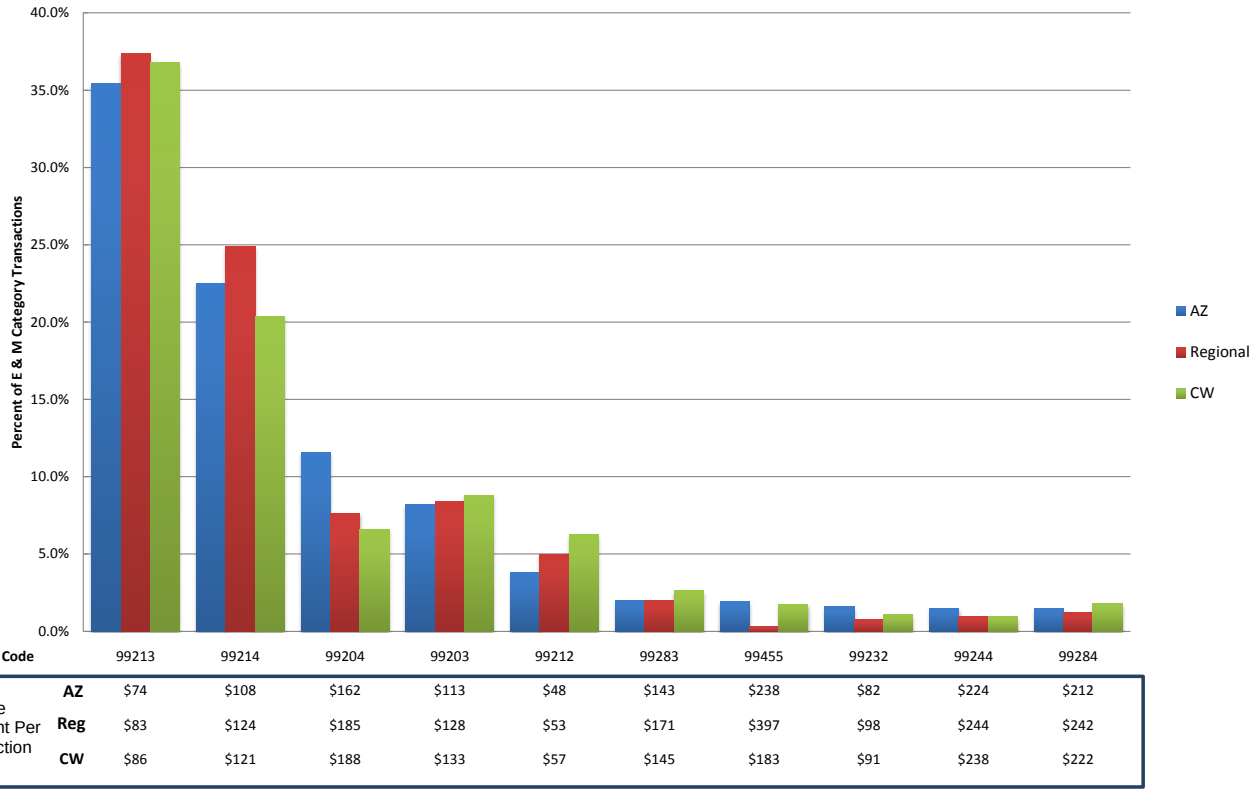
Procedure Code		99213	99214	99204	99203	99455	99244	99284	99283	99285	99215
Average Payment Per Transaction	AZ	$74	$108	$162	$113	$238	$224	$212	$143	$295	$149
	Reg	$83	$124	$185	$128	$397	$244	$242	$171	$353	$179
	CW	$86	$121	$188	$133	$183	$238	$222	$145	$322	$158

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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.
99455	Work related or medical disability examination by the treating physician.
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.
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.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Chart 13

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



Procedure Code		99213	99214	99204	99203	99212	99283	99455	99232	99244	99284
Average Payment Per Transaction	AZ	$74	$108	$162	$113	$48	$143	$238	$82	$224	$212
	Reg	$83	$124	$185	$128	$53	$171	$397	$98	$244	$242
	CW	$86	$121	$188	$133	$57	$145	$183	$91	$238	$222

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
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.
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.
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.

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

- Taxonomy code
- Procedure code
- Place of service

General healthcare trends may be the primary driver of the cost distribution; however, the fee schedule may also play a role. In many states, the fee schedule varies by type of facility, which may help explain differences observed between states.

Hospital inpatient fee schedules in workers compensation were mostly established in the last decade. More than 10 states remain without such regulation today. Unlike physician fee schedules, hospital inpatient fee schedules vary a great deal. Some are based on Medicare; others reflect a discount off the charge master established by the hospitals; and yet others are based on a per diem basis.

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

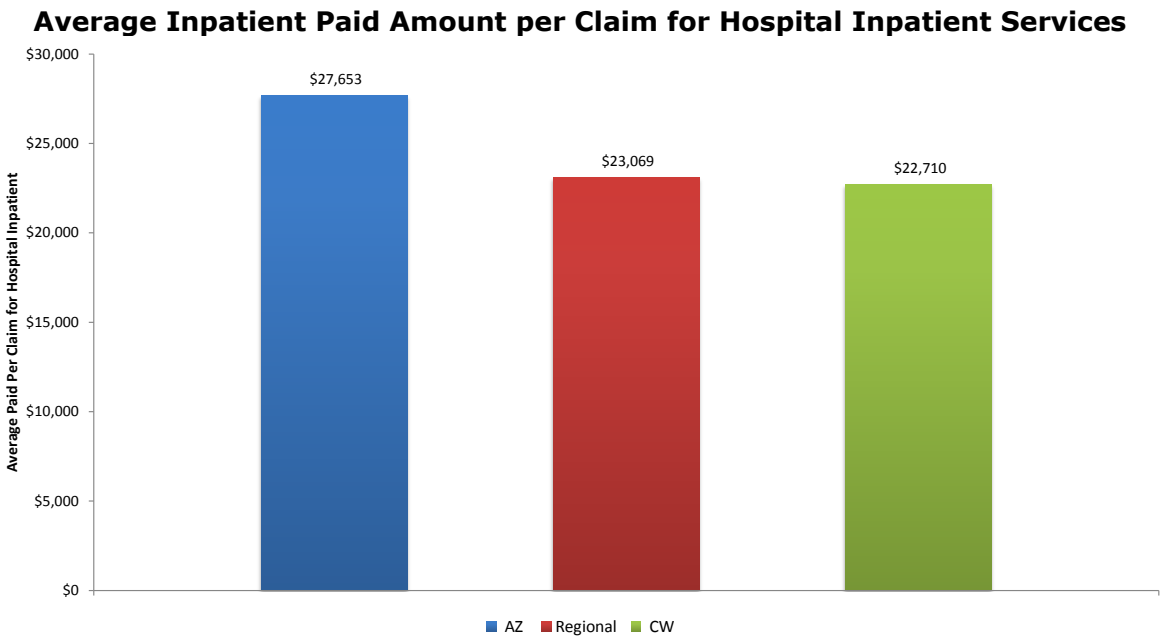
If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. If the hospital inpatient fee schedule is based on a discount from charged amounts, then revenue codes may be the more prevalent code type reported. Revenue codes are very generic and do not provide much information about the specific services that were performed.

The “All Other” category includes payments on a per diem basis and state-specific codes.

Due to these differences in fee schedules, which may result in varied reporting of codes across jurisdictions, regional and countrywide comparisons by procedure code for inpatient costs should be interpreted with caution. An alternative measure is the average paid amount per claim for hospital inpatient services. Because claim counts are not affected by billing practices, payments for hospital inpatient services per claim provide another metric to compare costs.

Chart 14 displays the average paid amount per claim for hospital inpatient services for Arizona as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 14

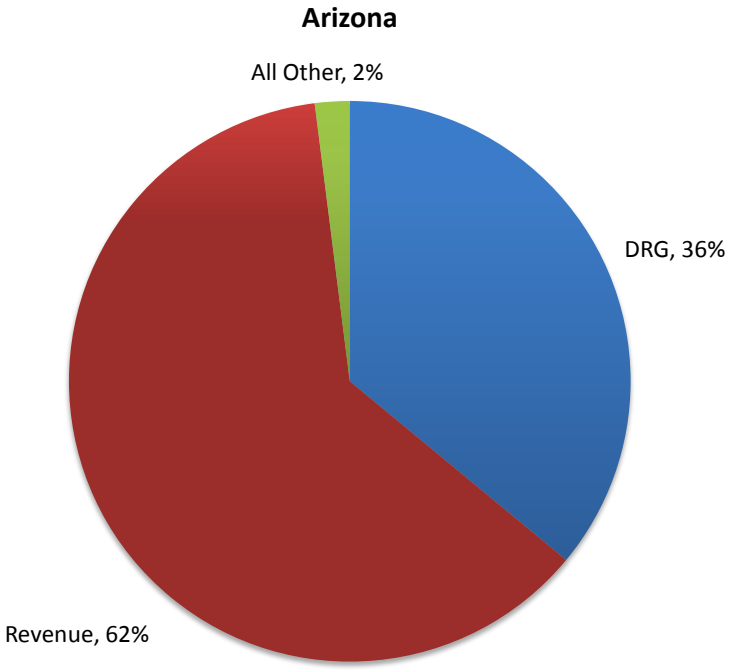


Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

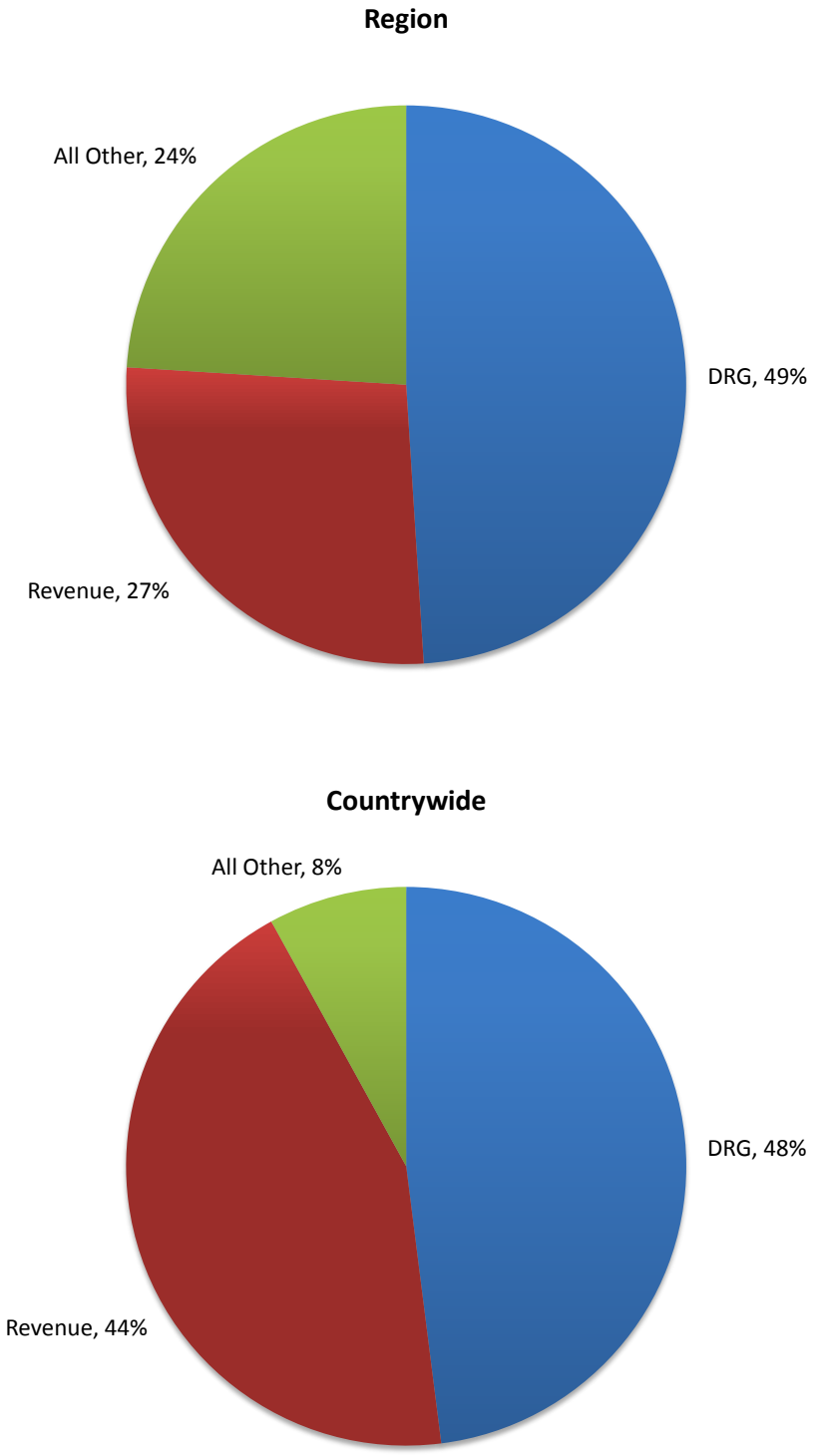
Chart 15 displays the distribution of hospital inpatient payments by procedure code type.

Chart 15

Distribution of Hospital Inpatient Payments by Procedure Code Type



Distribution of Hospital Inpatient Payments by Procedure Code Type



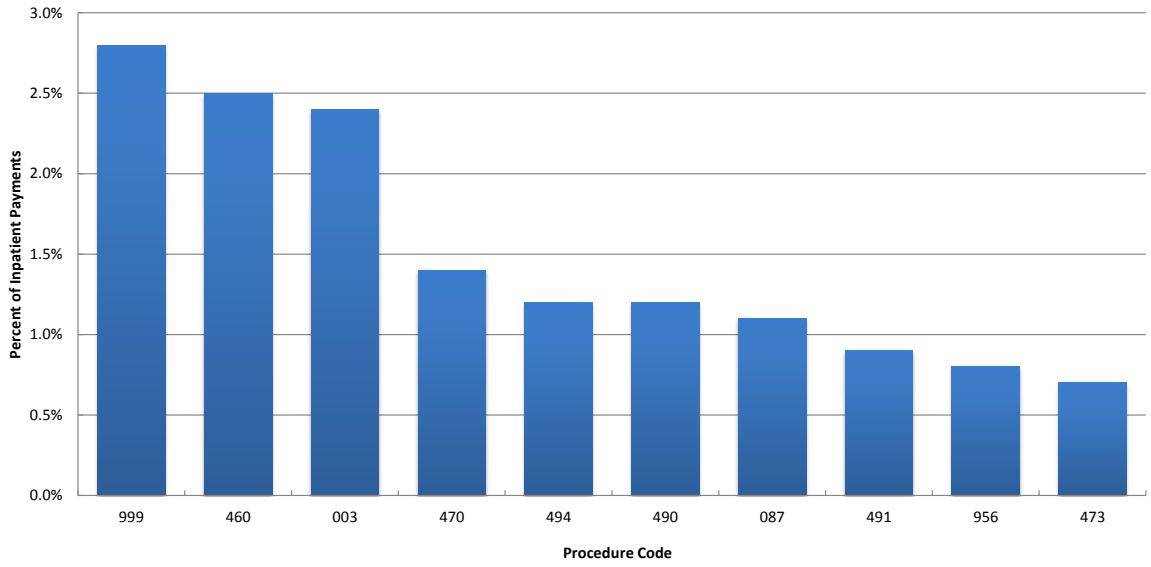
Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 16 and Chart 17 display the top 10 DRG codes and top 10 revenue codes for hospital inpatient services, revealing the most prevalent inpatient hospital services. The codes are ranked based on total payments.

A brief description of each code is displayed in the table below the charts.

Chart 16

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

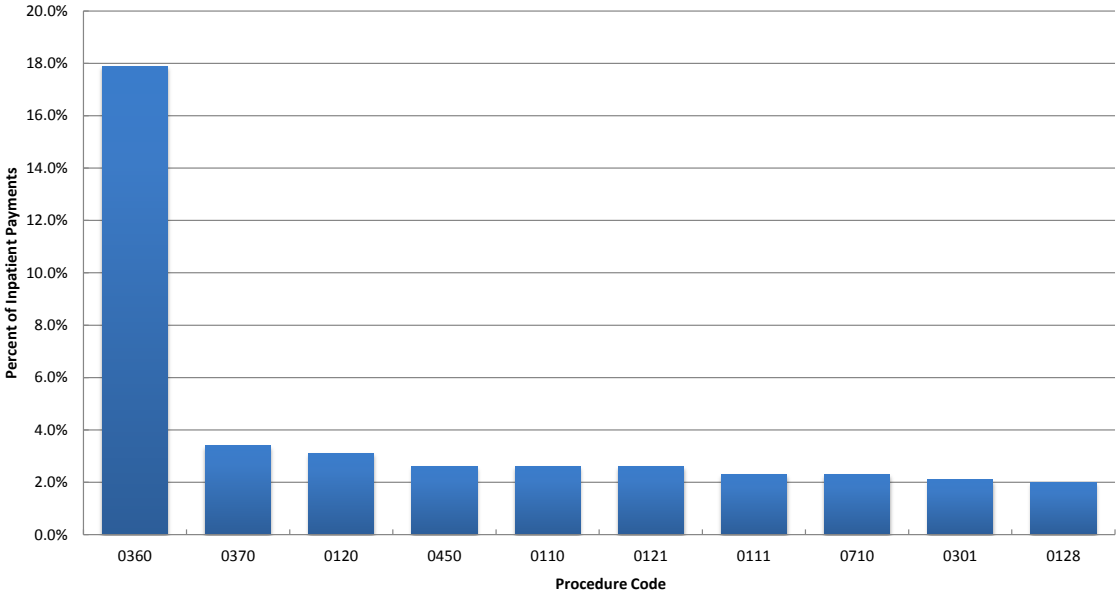


Source: NCCI Medical Data Call, Service Year 2013.

Code	Description
999	Ungroupable
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
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
494	Lower extremity and humerus procedures except hip foot femur without complications or comorbidities / major complications or comorbidities
490	Back and neck procedures except spinal fusion with complications or comorbidities / major complications or comorbidities or disc device/neurostimulator
087	Traumatic stupor and coma, coma less than one hour without complications or comorbidities/major complications or comorbidities
491	Back and neck procedures except spinal fusion without complications or comorbidities / major complications or comorbidities
956	Limb reattachment hip and femur procedures for multiple significant trauma
473	Cervical spinal fusion without complications or comorbidities / major complications or comorbidities

Chart 17

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



Source: NCCI Medical Data Call, Service Year 2013.

Code	Description
0360	Operating room services: General
0370	Anesthesia: General
0120	Room & board-semiprivate (two beds): General
0450	Emergency room: General
0110	Room & board-private (one bed): General
0121	Room & board-semiprivate (two beds): Medical, surgical, gynecological
0111	Room & board-private (one bed): Medical, surgical, gynecological
0710	Recovery room: General
0301	Laboratory - Clinical Diagnostic: Chemistry
0128	Room & board-semiprivate (two beds): Rehabilitation

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

If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by CPT codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Payments reported by CPT codes are shown in the chart separately by surgery and non-surgery as categorized by the American Medical Association (AMA).

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.

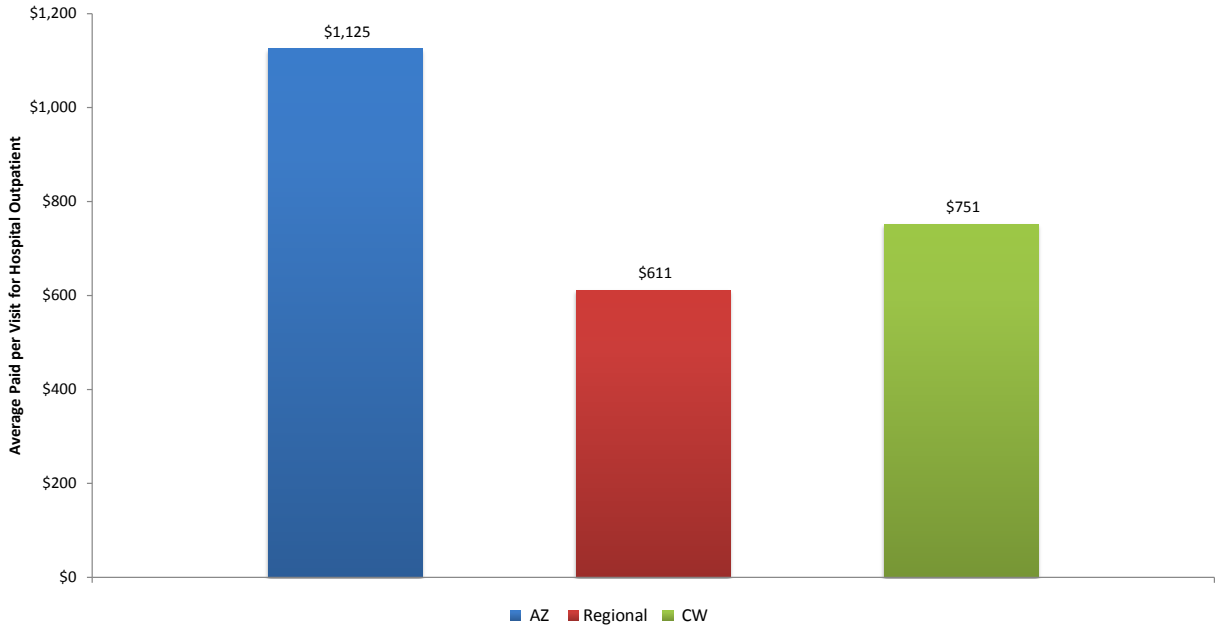
The "All Other" category includes healthcare common procedure coding system (HCPCS) codes and state-specific codes.

Due to these differences in fee schedules, which may result in varied reporting of codes across jurisdictions, regional and countrywide comparisons by procedure code for outpatient costs 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.

Chart 18 displays the average paid amount per visit for hospital outpatient services for Arizona as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 18

Average Outpatient Paid Amount per Visit for Hospital Outpatient Services

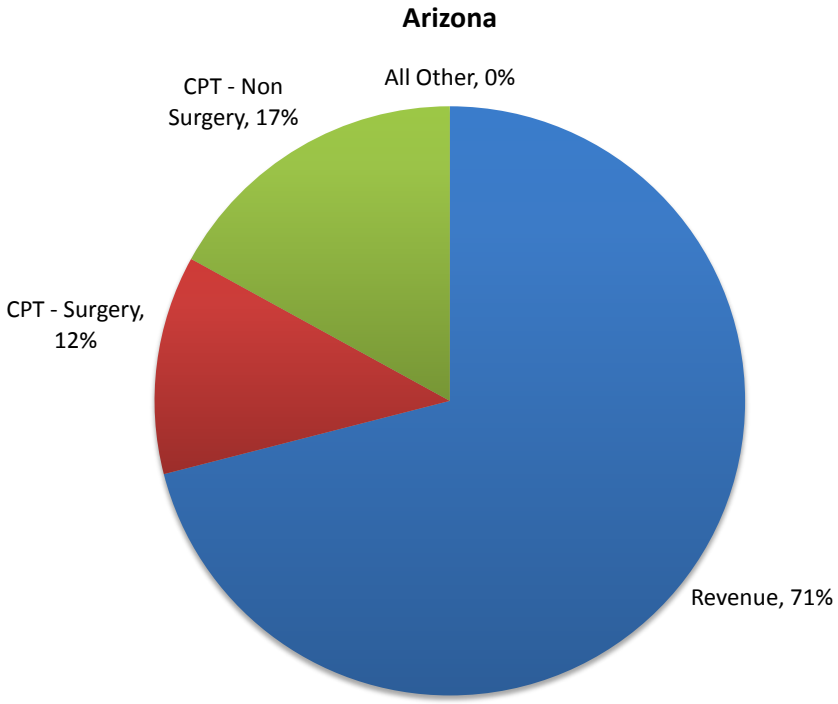


Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

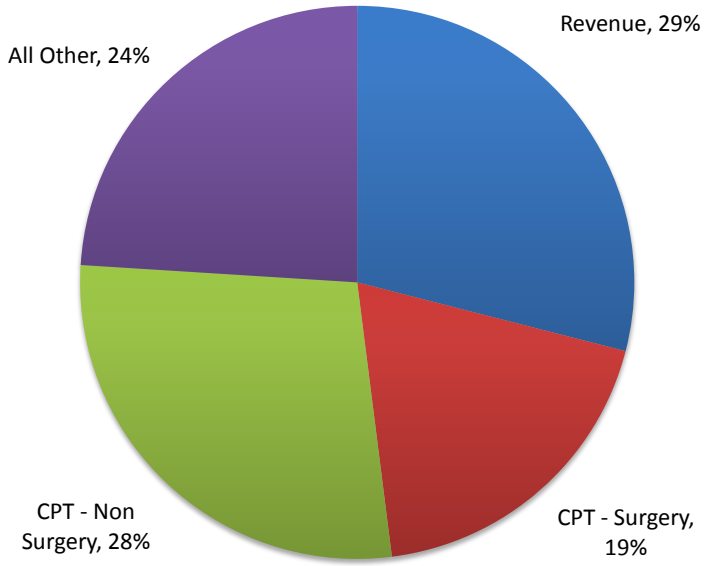
Chart 19 displays the distribution of hospital outpatient payments by procedure code type.

Chart 19

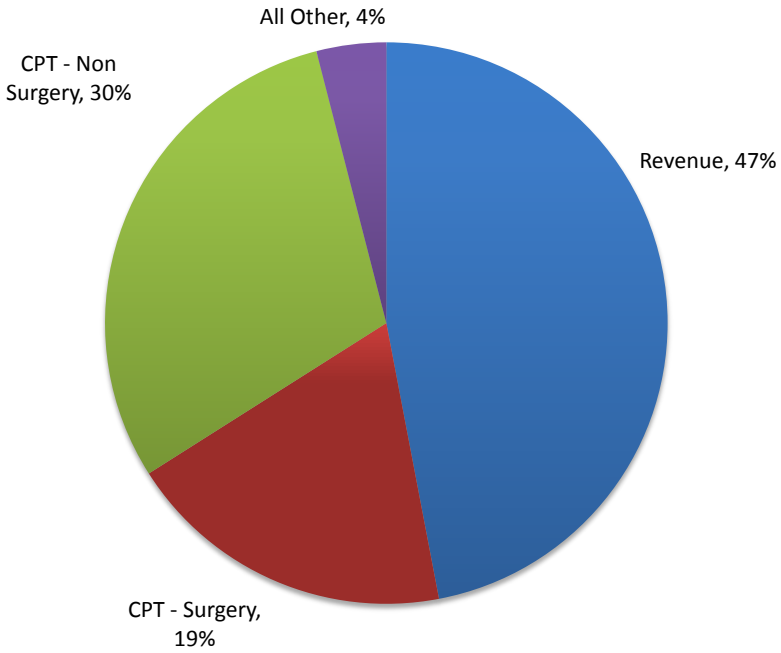
Distribution of Hospital Outpatient Payments by Procedure Code Type



Region



Countrywide

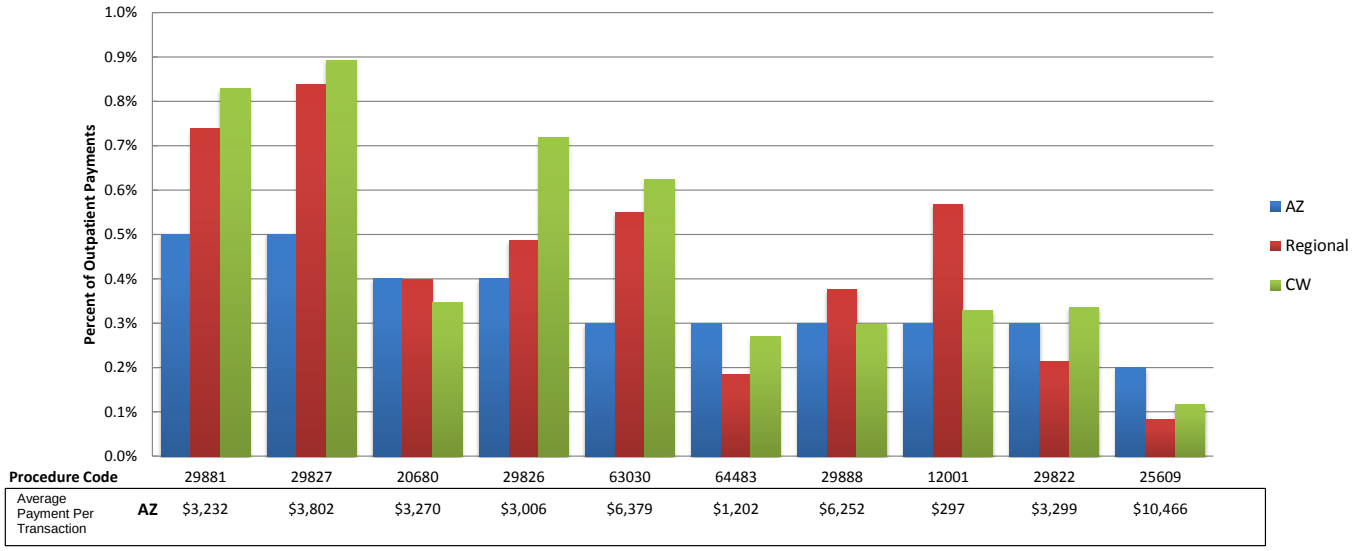


Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Charts 20 and 21 display the top 10 surgery CPT and non-surgery CPT codes. Chart 22 displays the top 10 revenue codes for hospital outpatient services. The codes are ranked based on total payments. A brief description of each code is displayed in the table below.

Chart 20

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

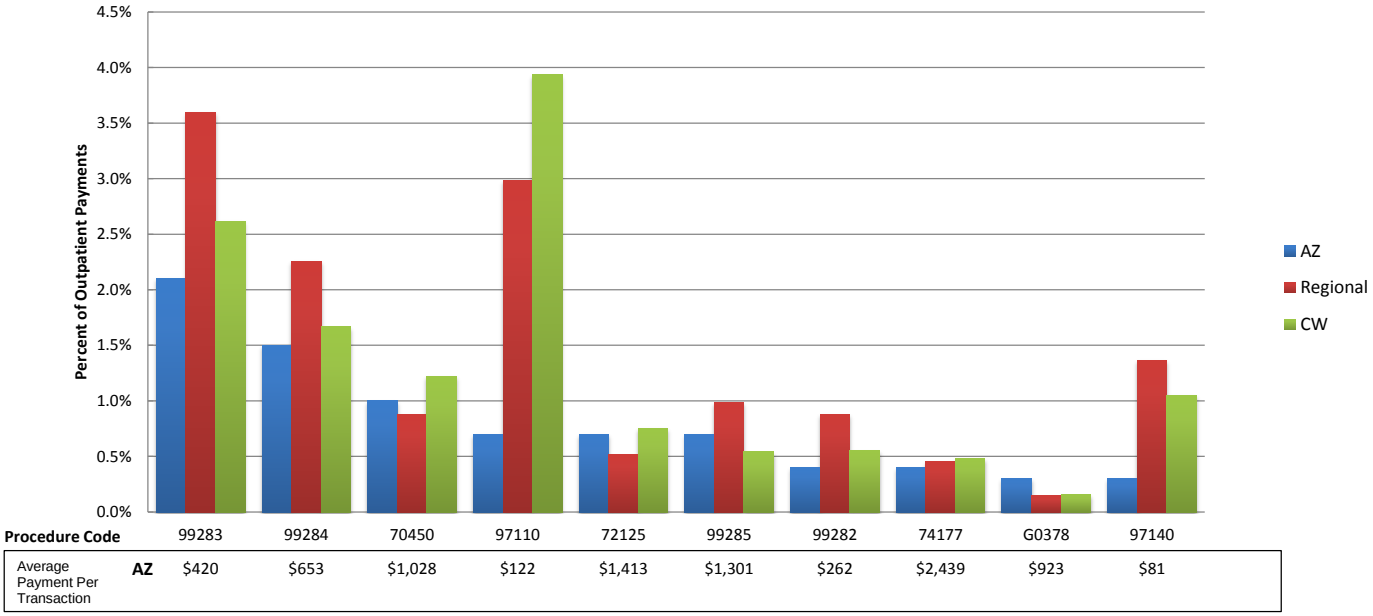


Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	Description
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
20680	Removal of implant; deep (e.g., buried wire pin screw metal band nail rod or plate)
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
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
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
29822	Arthroscopy shoulder surgical; debridement limited
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments

Chart 21

Top 10 Non-surgery CPT Codes by Amount Paid for Hospital Outpatient Services for Arizona

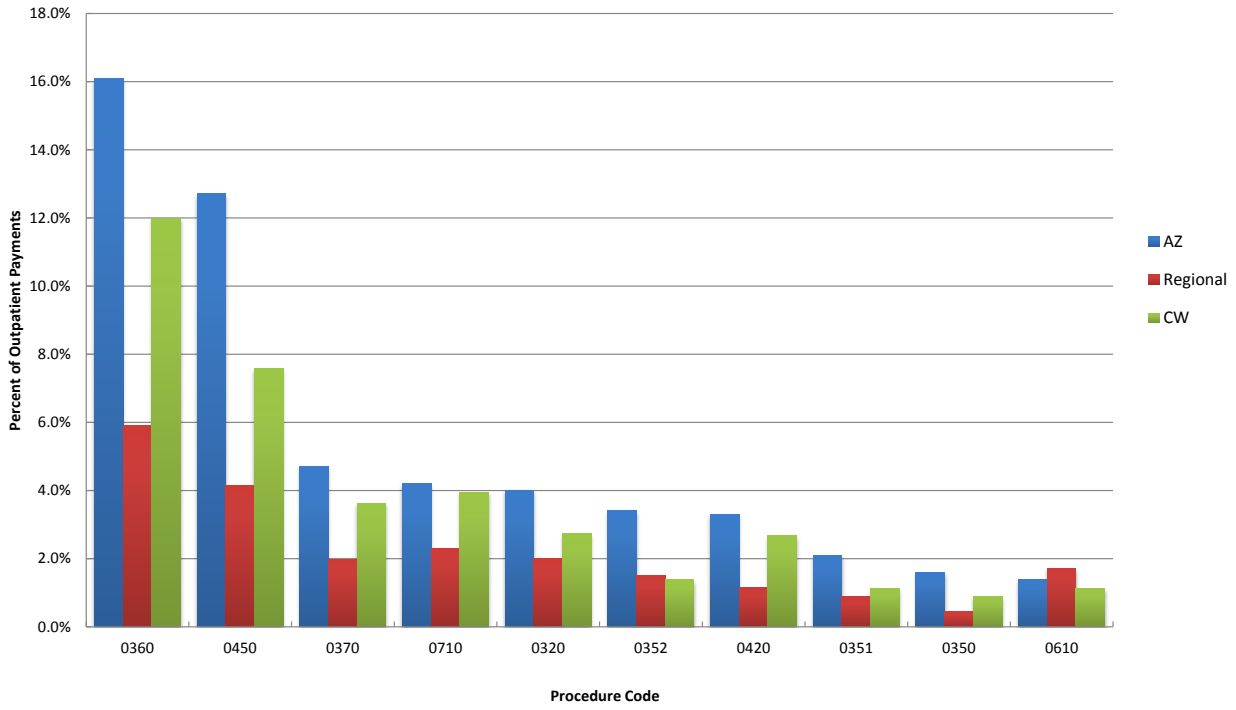


Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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

Chart 22

Top 10 Revenue Codes by Amount Paid for Hospital Outpatient Services for Arizona



Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	Description
0360	Operating room services: General
0450	Emergency room: General
0370	Anesthesia: General
0710	Recovery room: General
0320	Radiology - Diagnostic: General
0352	Computed tomography (CT) scan: Body
0420	Physical therapy: General
0351	Computed tomography (CT) scan: Head
0350	Computed tomography (CT) scan
0610	Magnetic Resonance Technology (MRT): General

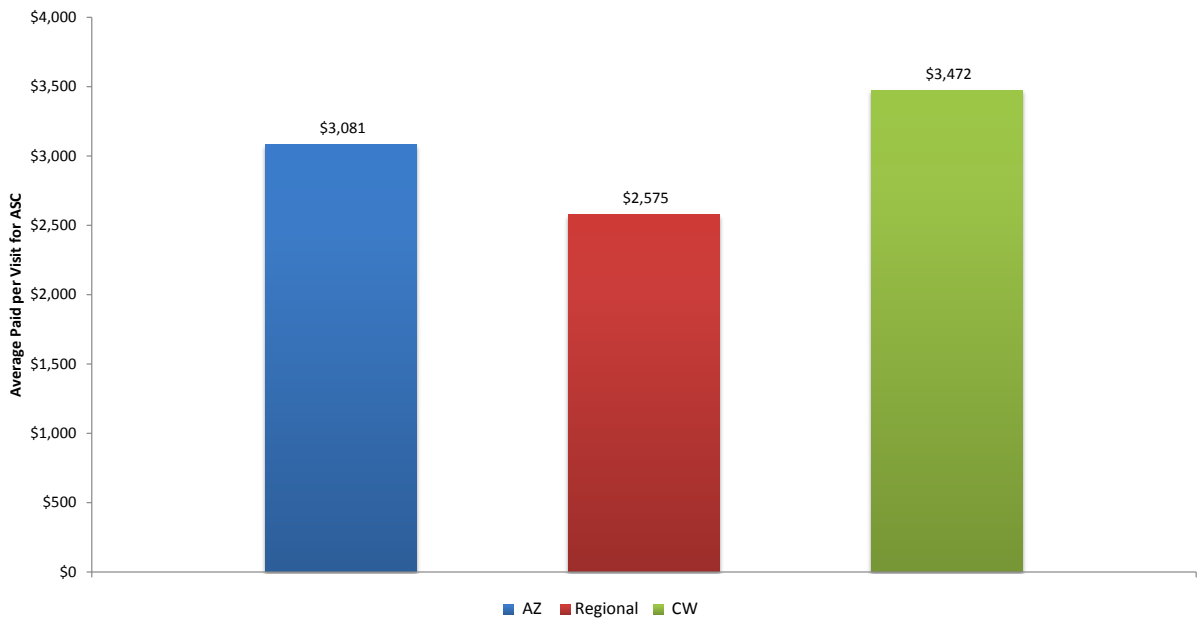
The share of payments attributable to ambulatory surgical centers (ASC) has grown in most states. Typically, only surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes. The predominant revenue code reported for ASC services is 0490—Ambulatory Surgical Care. In Arizona, 0490 represents 94% of ASC payments reported by revenue codes.

Similar to hospital services, the procedure code type reported for ASCs may be driven by the fee schedule.

Chart 23 displays the average paid amount per visit for ASC for Arizona as well as for regional and countrywide. Note there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 23

Average Paid Amount per Visit for Ambulatory Surgical Center Services

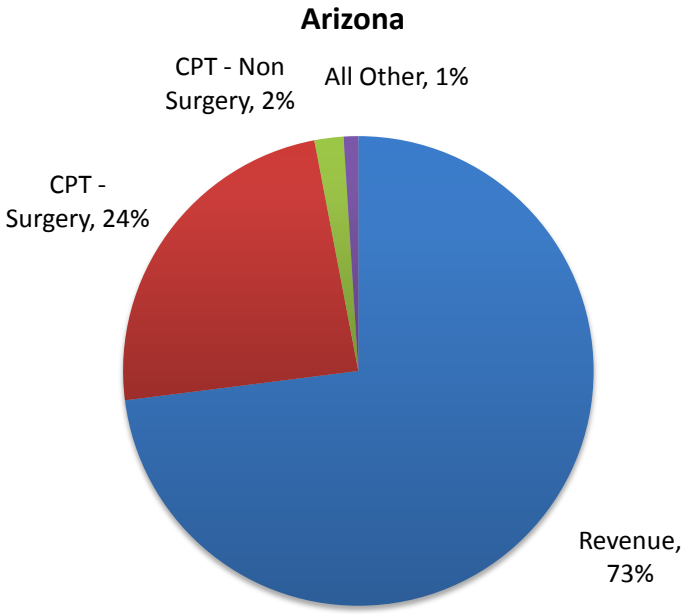


Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 24 displays the distribution of ASC payments by procedure code type.

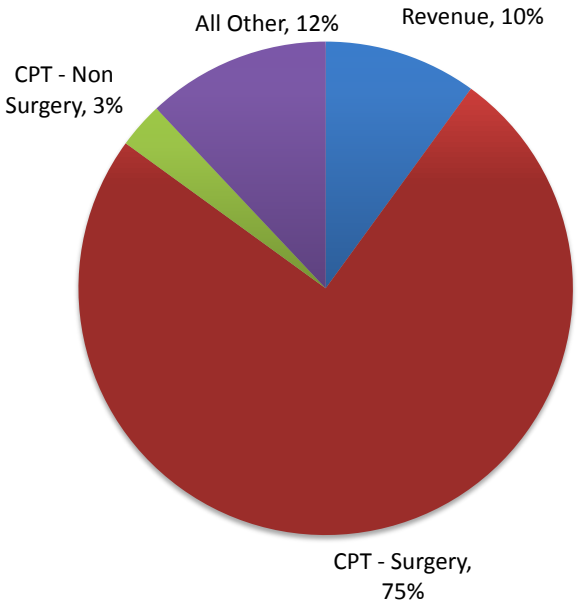
Chart 24

Distribution of Ambulatory Surgical Center Payments by Procedure Code Type

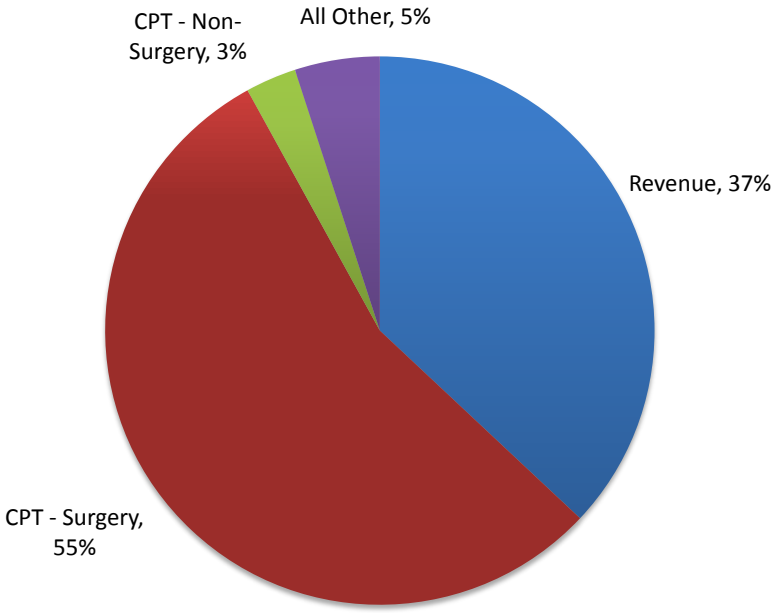


Distribution of Ambulatory Surgical Center Payments by Procedure Code Type

Region



Countrywide

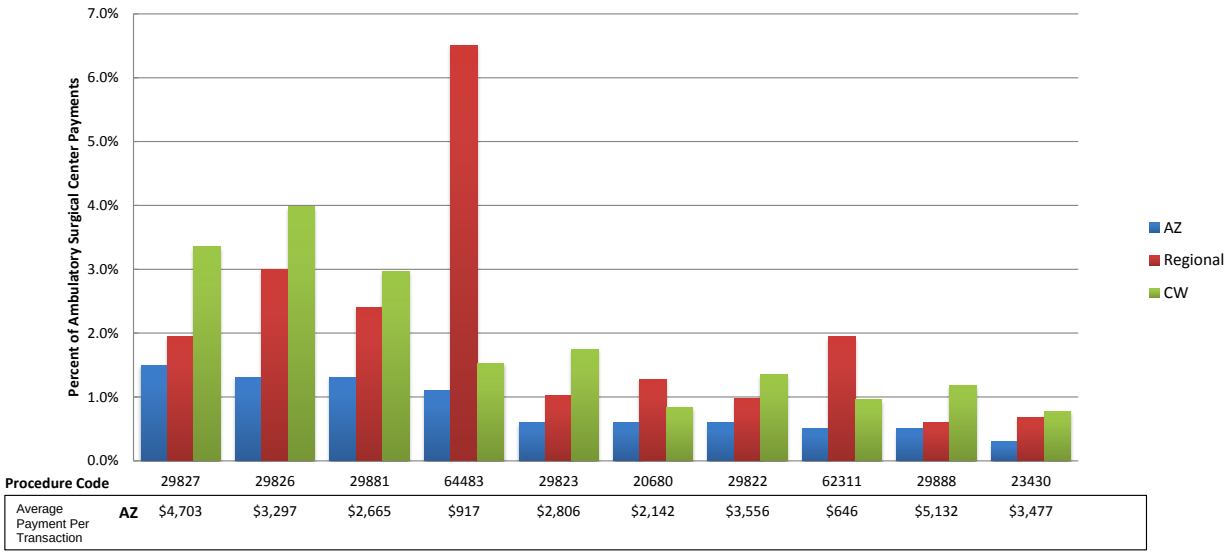


Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 25 displays the top 10 surgery CPT codes for ASC services. The procedure codes are ranked based on total payments. A brief description of each procedure code is displayed in the table below.

Chart 25

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



Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
29823	Arthroscopy shoulder surgical; debridement extensive
20680	Removal of implant; deep (e.g., buried wire pin screw metal band nail rod or plate)
29822	Arthroscopy shoulder surgical; debridement limited
62311	Injection(s) of diagnostic or therapeutic substance(s) (including anesthetic antispasmodic opioid steroid other solution) not including neurolytic substances including needle or catheter placement includes contrast for localization when performed epidural or subarachnoid
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23430	Tenodesis of long tendon of biceps

NCCI's research, "Narcotics in Workers Compensation," published in June 2012, states that in 2009 the narcotics Oxycontin® and Hydrocodone-Acetaminophen were among the most popular drugs prescribed in workers compensation.

Drugs are uniquely identified by a national drug code (NDC). Charts 26 through 31 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, Healthcare Common Procedure Coding System (HCPCS) codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

Chart 26 displays the shares of the payments of prescription medication for the top 10 workers compensation drugs and whether the drugs are generic or brand name. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the amount paid per unit (see Glossary for definition).

Chart 26

Top 10 Workers Compensation Drugs by Amount Paid for Arizona

Name of Drug	Type	% of Drug Payments	Paid Per Unit Arizona	Paid Per Unit Region	Paid Per Unit Countrywide
Oxycontin®	Brand Name	6.5%	$7.12	$6.43	$7.04
Celebrex®	Brand Name	4.8%	$5.96	$5.88	$6.00
Lyrica®	Brand Name	4.8%	$3.91	$3.83	$3.96
Gabapentin	Generic	4.0%	$1.46	$1.20	$1.36
Cymbalta®	Brand Name	3.8%	$7.69	$7.48	$7.67
Lidoderm®	Brand Name	2.9%	$9.35	$9.14	$9.55
Hydrocodone-Acetaminophen	Generic	2.7%	$0.54	$0.46	$0.51
Oxycodone HCl	Generic	2.4%	$0.80	$0.63	$0.70
Meloxicam	Generic	2.1%	$0.71	$0.87	$0.94
Tramadol HCl ER	Generic	2.0%	$7.22	$4.56	$7.00

Top 10 Workers Compensation Drugs by Amount Paid for Countrywide

Name of Drug	Type	% of Drug Payments	Paid Per Unit Arizona	Paid Per Unit Region	Paid Per Unit Countrywide
Oxycontin®	Brand Name	5.9%	$7.12	$6.43	$7.04
Lyrica®	Brand Name	5.3%	$3.91	$3.83	$3.96
Cymbalta®	Brand Name	4.8%	$7.69	$7.48	$7.67
Gabapentin	Generic	4.4%	$1.46	$1.20	$1.36
Celebrex®	Brand Name	3.7%	$5.96	$5.88	$6.00
Meloxicam	Generic	3.5%	$0.71	$0.87	$0.94
Hydrocodone-Acetaminophen	Generic	3.5%	$0.54	$0.46	$0.51
Lidoderm®	Brand Name	3.4%	$9.35	$9.14	$9.55
Tramadol HCl	Generic	2.2%	$0.56	$0.38	$0.54
Oxycodone HCl-Acetaminophen	Generic	1.8%	$1.44	$1.31	$1.39

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 27 displays the top 10 workers compensation drugs according to the number of prescriptions. This chart reveals the most frequently prescribed drugs and the amount paid per unit.

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

Chart 27

Top 10 Workers Compensation Drugs by Prescription Counts for Arizona

Name of Drug	Type	% of Prescription Counts	Paid Per Unit Arizona	Paid Per Unit Region	Paid Per Unit Countrywide
Hydrocodone-Acetaminophen	Generic	10.5%	$0.54	$0.46	$0.51
Ibuprofen	Generic	7.0%	$0.27	$0.31	$0.28
Tramadol HCl	Generic	4.6%	$0.56	$0.38	$0.54
Cyclobenzaprine HCl	Generic	4.0%	$0.78	$0.72	$0.94
Oxycodone HCl	Generic	3.3%	$0.80	$0.63	$0.70
Gabapentin	Generic	3.2%	$1.46	$1.20	$1.36
Oxycodone-Acetaminophen	Generic	3.2%	$0.61	$0.62	$0.64
Carisoprodol	Generic	2.3%	$0.53	$0.48	$0.88
Celebrex®	Brand Name	2.2%	$5.96	$5.88	$6.00
Lyrica®	Brand Name	2.0%	$3.91	$3.83	$3.96

Top 10 Workers Compensation Drugs by Prescription Counts for Countrywide

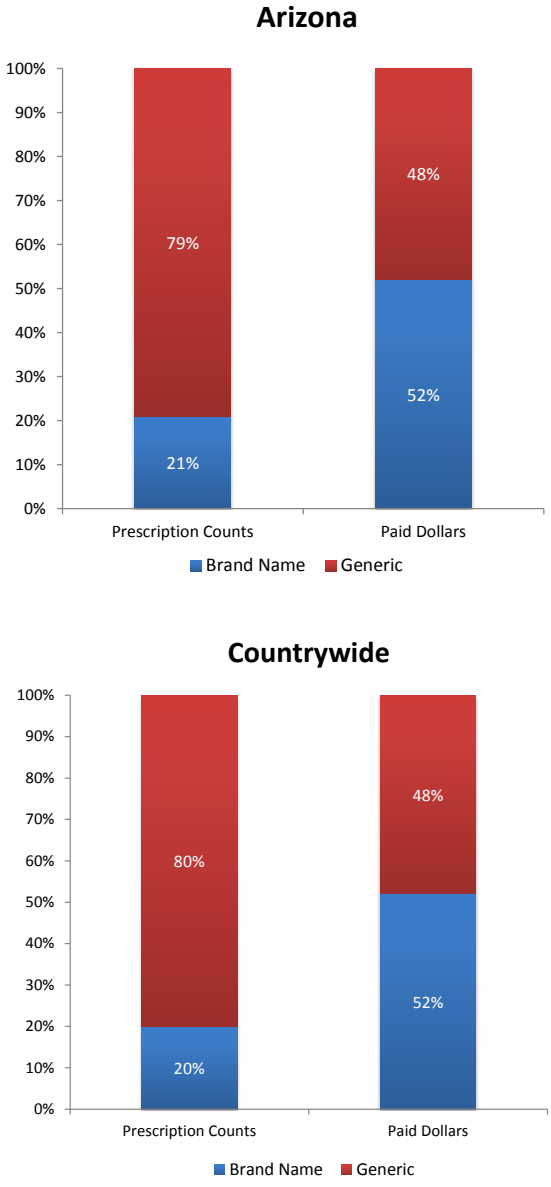
Name of Drug	Type	% of Prescription Counts	Paid Per Unit Arizona	Paid Per Unit Region	Paid Per Unit Countrywide
Hydrocodone-Acetaminophen	Generic	13.8%	$0.54	$0.46	$0.51
Tramadol HCl	Generic	5.3%	$0.56	$0.38	$0.54
Cyclobenzaprine HCl	Generic	4.7%	$0.78	$0.72	$0.94
Ibuprofen	Generic	4.3%	$0.27	$0.31	$0.28
Gabapentin	Generic	3.8%	$1.46	$1.20	$1.36
Meloxicam	Generic	3.2%	$0.71	$0.87	$0.94
Oxycodone-Acetaminophen	Generic	2.6%	$0.61	$0.62	$0.64
Naproxen	Generic	2.3%	$0.77	$0.86	$0.90
Oxycodone HCl	Generic	2.1%	$0.80	$0.63	$0.70
Lyrica®	Brand Name	2.1%	$3.91	$3.83	$3.96

Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 28 shows the distribution of prescription drugs by brand name and generics for Arizona and the countrywide average. The share between brand name and generics is displayed based on both prescription counts and payments. Typically, a higher percentage of drugs are given in the generic form; however, higher costs occur when brand name drugs are prescribed. In several states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates of brand name and generic drugs. The results in this chart are based only on transactions reported with an NDC.

Chart 28

Distribution of Drugs by Brand Name and Generic



Source: NCCI Medical Data Call, Service Year 2013. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

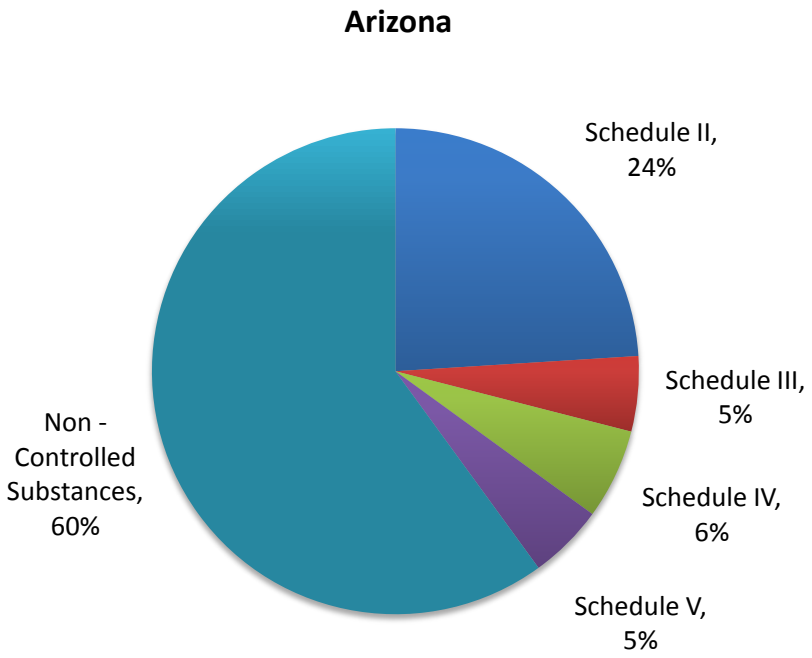
The Controlled Substance Act (CSA) was passed in 1970 to regulate the manufacture, distribution, possession, and use of certain drugs. There are five schedules, or groups, determined by varying qualifications, such as the drug's medical uses, if any, and its potential for abuse. For example, Schedule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

The share of claims observed in Service Year 2013 with at least one controlled substance in Arizona is 21.9%. This compares to the regional and countrywide shares of 20.4% and 18.7% respectively.

Chart 29 shows the distribution of prescription drug costs in Arizona by its CSA schedule. Regional and countrywide distributions are also shown.

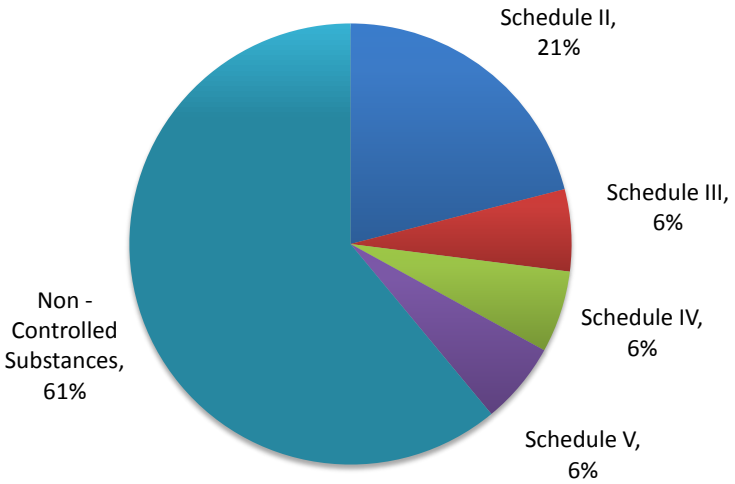
Chart 29

Distribution of Prescription Drug Costs in Arizona by CSA Schedule

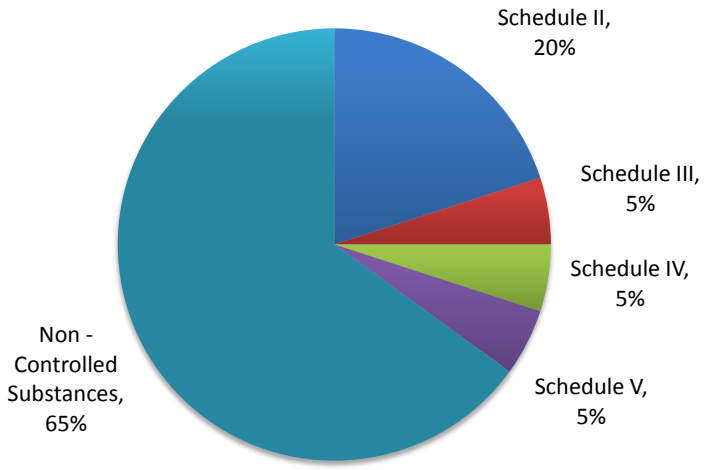


Distribution of Prescription Drug Costs in Arizona by CSA Schedule

Regional



Countrywide



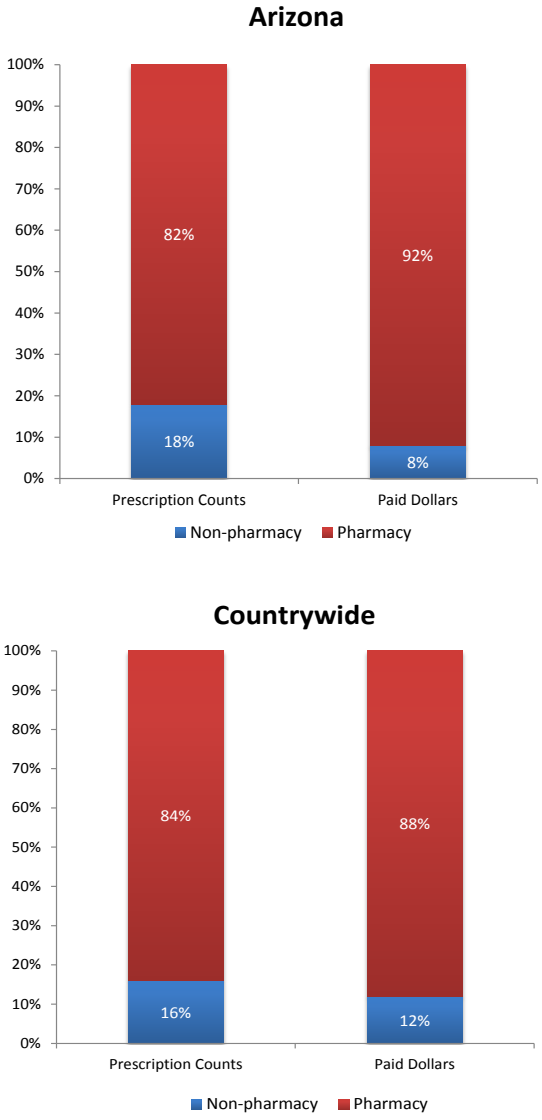
Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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

Chart 30 shows the distribution of prescription drugs dispensed by pharmacies and non-pharmacies. The share between pharmacy dispensed and non-pharmacy dispensed is displayed, based on both prescription counts and payments, for Arizona and the countrywide average. The results in this chart are based only on transactions reported with an NDC.

Chart 30

Distribution of Drugs by Pharmacy and Non-pharmacy



Source: NCCI Medical Data Call, Service Year 2013. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

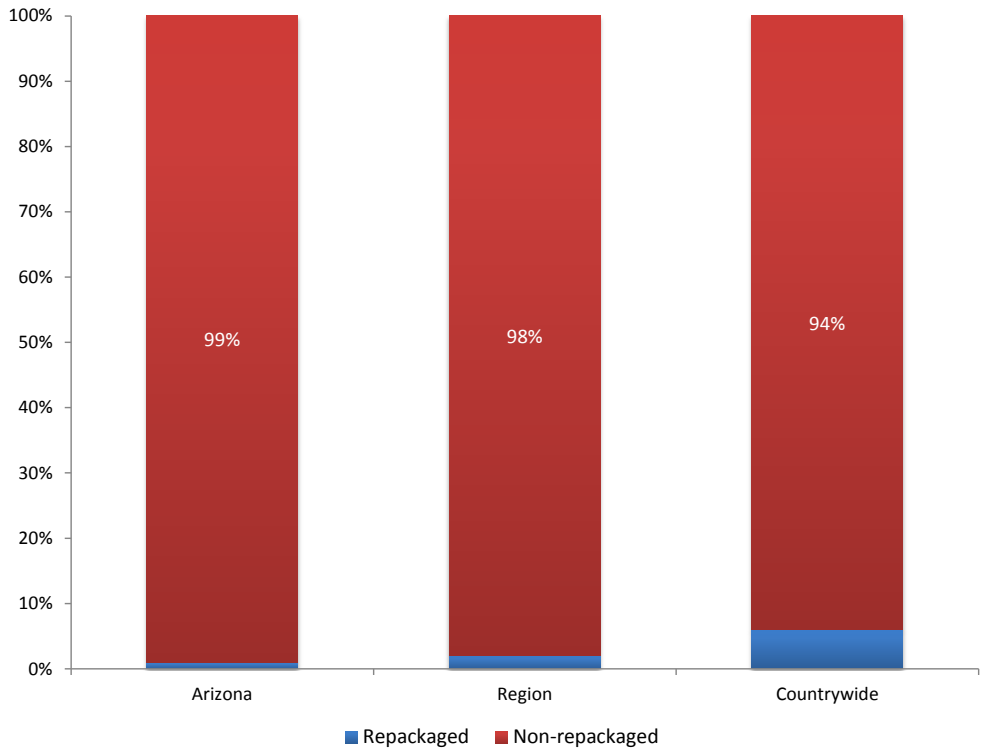
NDCs are specific not only to the product (including strength and formulation) and the package size but also to the labeler. Labelers are manufacturers, repackagers, and distributors.

Workers compensation drug fee schedules are typically based on Average Wholesale Price (AWP). Because each NDC comes with a unique AWP, any firm that repackages a drug can set both a new NDC and a new, possibly higher, AWP. As a result, workers compensation costs for repackaged drugs have grown out of proportion to the number of prescriptions written for repackaged drugs. Some states have introduced limits on reimbursements for repackaged drugs.

Chart 31 shows the distribution of payments for repackaged and non-repackaged drugs. The results in this chart are based only on payments reported with an NDC.

Chart 31

Distribution of Drug Payments by Repackaged and Non-repackaged



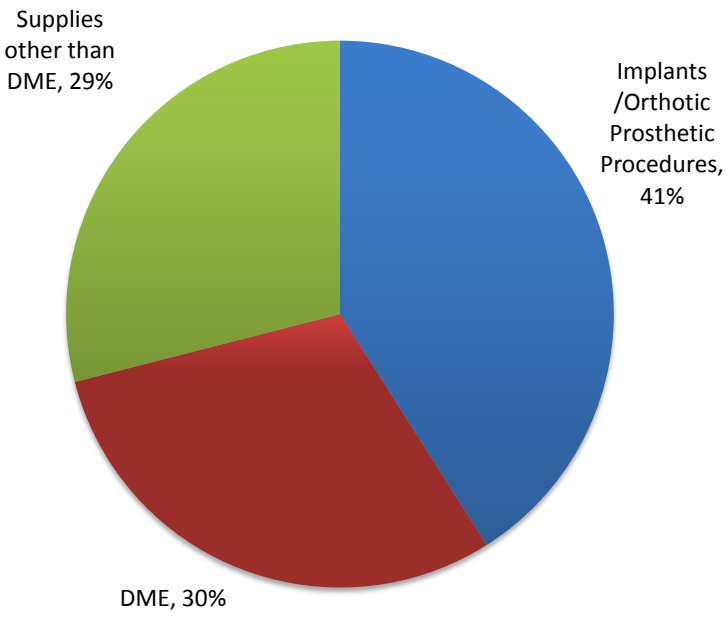
Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 32 displays the distribution of payments separately by Durable Medical Equipment (DME); Supplies Other Than DME; and Implants/Orthotic and Prosthetic Procedures. Payments are mapped to each of these categories based on the AMA procedure code reported, regardless of who provides the service or where the service is performed.

Chart 32

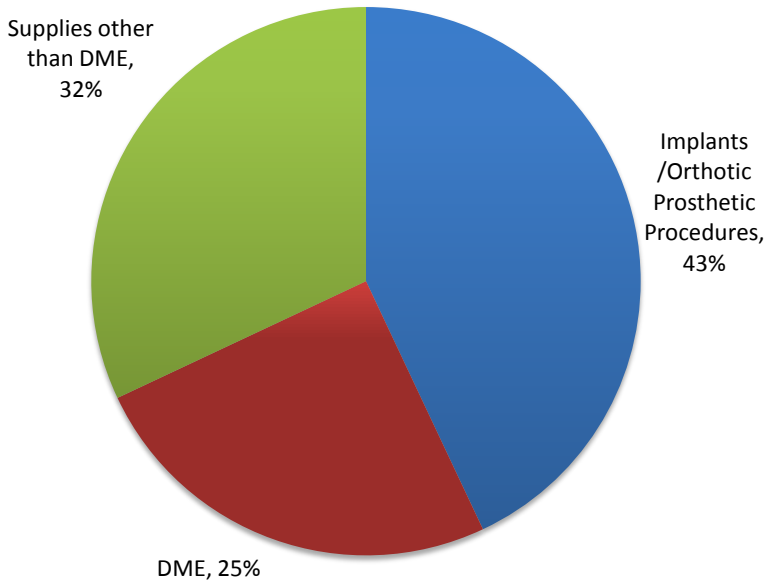
Distribution of Payments by DME, Supplies, and Implants

Arizona

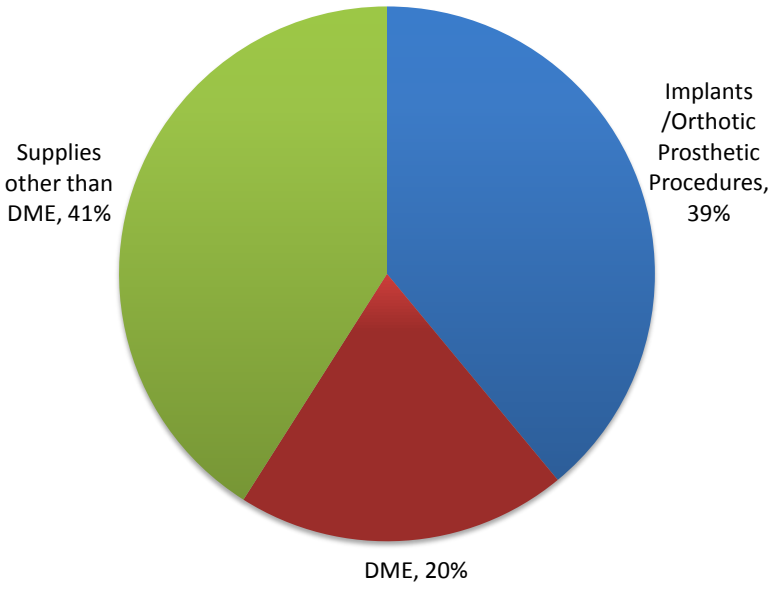


Distribution of Payments by DME, Supplies, and Implants

Region



Countrywide



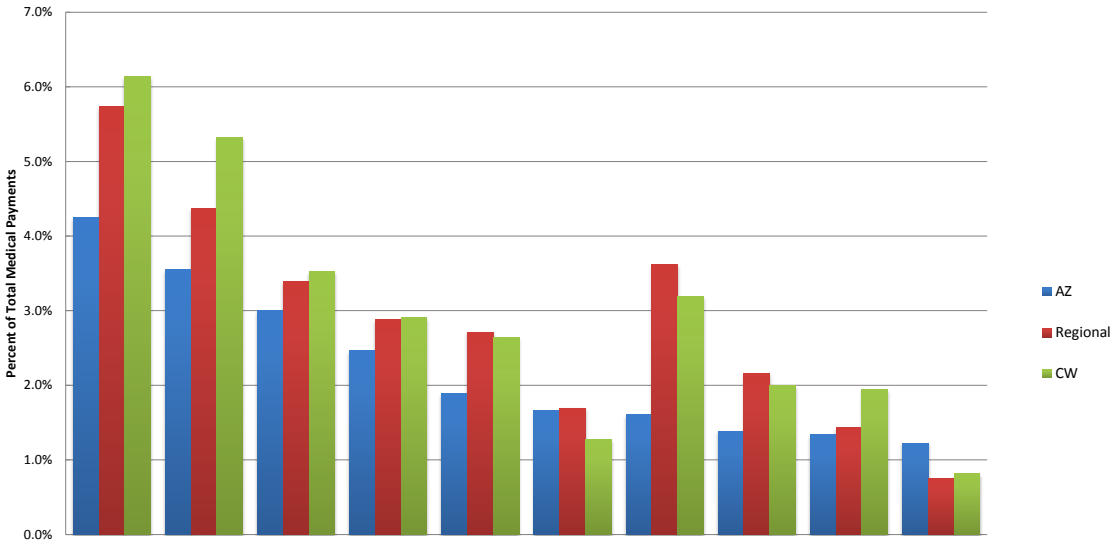
Source: NCCI Medical Data Call, Service Year 2013. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 33 displays the top 10 diagnoses, identified by the ICD-9 (International Classification of Diseases) codes. The ICD-9 code indicates the condition for which the care is provided. NCCI assigns an ICD-9 code to each workers compensation claim based on the severity of the ICD-9 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 diagnosis codes are ranked by total claim payments. This method of ranking shows which diagnostic codes have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2012, and December 31, 2012, and include all reported services provided for those claims through December 31, 2013. As these claims mature, the mix of ICD-9 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 and countrywide average payment per claim are also displayed for each diagnostic code. A brief description of each diagnostic code is displayed in the table below.

Chart 33

Top 10 ICD-9 Codes by Amount Paid for Dates of Injury in 2012 for Arizona



Procedure Code		840.4	722.10	836.0	723.1	724.4	847.2	726.10	722.52	354.0	883.2
Average Payment Per Claim	AZ	$18,962	$15,872	$11,152	$6,097	$8,107	$1,313	$9,816	$11,446	$9,530	$12,878
	Reg	$16,529	$14,291	$11,139	$6,898	$10,106	$1,325	$12,578	$12,387	$6,629	$7,293
	CW	$20,359	$16,815	$12,673	$6,351	$10,103	$1,314	$13,196	$13,032	$7,627	$9,755

Source: NCCI Medical Data Call, Dates of Injury in 2012. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	Description
840.4	Rotator cuff (capsule) sprain and strain
722.10	Displacement of lumbar intervertebral disc without myelopathy
836.0	Tear of medial cartilage or meniscus of knee, current
723.1	Cervicalgia
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
847.2	Lumbar sprain and strain
726.10	Unspecified disorders of bursae and tendons in shoulder region
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
354.0	Carpal tunnel syndrome
883.2	Open wound of finger(s), with tendon involvement

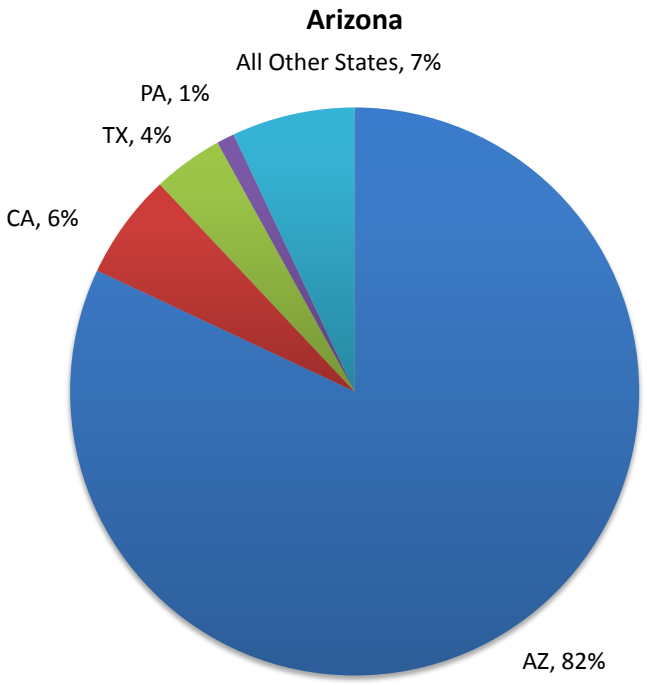
Medical benefit rules typically have different payment provisions for procedures performed in state versus out of state.

A medical service is considered to be performed "in state" if it is performed in the same state or jurisdiction that determines the workers compensation benefits. Similarly, a medical service is considered "out of state" if it is performed outside of the state of jurisdiction.

Chart 34 displays the distribution of medical payments for professional/physician and facility services according to the location where the medical service was provided. The Countrywide average for "in-state" medical payments is 82%.

Chart 34

Distribution of Physician and Facility Payments by Provider State



Source: NCCI Medical Data Call, Service Year 2013.

Comparison of Selected Distributions by Service Year

The tables in this section provide a comparison of results for Arizona for the latest three service years. Analysis in the growth of shares may provide additional insight into medical cost drivers above and beyond an analysis at a specific point in time. The oldest data available from the Medical Data Call is for Service Year 2011, as this is the first full service year of data since the inception of the Call.

Distribution of Medical Payments for Arizona (Chart 4)

Medical Category	2011	2012	2013
Physician	34%	32%	34%
Hospital Outpatient	11%	12%	13%
Hospital Inpatient	16%	17%	15%
ASC	5%	5%	5%
Drugs	14%	14%	13%
DME, Supplies, and Implants	9%	10%	9%
Other	11%	10%	11%

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

AMA Service Category	2011	2012	2013
Anesthesia	5%	4%	4%
Surgery	22%	23%	23%
Radiology	10%	10%	10%
Pathology	3%	3%	4%
Physical Medicine	29%	29%	28%
General Medicine	5%	5%	5%
Evaluation and Management	23%	24%	24%
Other	3%	2%	2%

Distribution of Hospital Inpatient Payments by Procedure Code Type for Arizona (Chart 15)

Procedure Code Type	2011	2012	2013
DRG	27%	36%	36%
Revenue	67%	62%	62%
All Other	6%	2%	2%

Distribution of Hospital Outpatient Payments by Procedure Code Type for Arizona (Chart 19)

Procedure Code Type	2011	2012	2013
Revenue	59%	61%	71%
CPT - Surgery	14%	16%	12%
CPT - Non-surgery	26%	22%	17%
All Other	1%	1%	0%

Distribution of Ambulatory Surgical Center Payments by Procedure Code Type for Arizona (Chart 24)

Procedure Code Type	2011	2012	2013
Revenue	47%	59%	73%
CPT - Surgery	49%	38%	24%
CPT - Non-surgery	3%	2%	2%
All Other	1%	1%	1%

Distribution of Drug Payments by Brand Name and Generic for Arizona (Chart 28)

Type of Drug	2011	2012	2013
Brand Name	54%	53%	52%
Generic	46%	47%	48%

Distribution of Drug Payments by Pharmacy and Non-pharmacy for Arizona (Chart 30)

Type of Provider	2011	2012	2013
Non-pharmacy	7%	8%	8%
Pharmacy	93%	92%	92%

Distribution of Drug Payments by Repackaged and Non-repackaged for Arizona (Chart 31)

Type of Drug	2011	2012	2013
Repackaged	3%	1%	1%
Non-repackaged	97%	99%	99%

Distribution of Payments by DME, Supplies, and Implants for Arizona (Chart 32)

Category	2011	2012	2013
Implants/Orthotic Prosthetic Procedures	44%	41%	41%
DME	22%	28%	30%
Supplies Other Than DME	34%	31%	29%

Glossary

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

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

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

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

Critical Access Hospital (CAH): A small, generally geographically remote facility that provides outpatient and inpatient hospital services to people in rural areas. The designation was established by law for special payments under the Medicare program. To be designated as a CAH, a hospital must be located in a rural area, provide 24-hour emergency services, have an average length of stay for its patients of 96 hours or less, and be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital or be designated by its state as a "necessary provider." CAHs may have no more than 25 beds.

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

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

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

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

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

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

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.

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

Transaction: A line item of a medical bill.

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

- For tablets, capsules, suppositories, non-filled syringes, etc., it represents the actual number of the drug provided. For example, a bottle of 30 pills would have 30 units.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, the units are specified by the Procedure Code. For example, a cream is dispensed in a standard tube, which is defined as a single unit.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, the number of units is the amount provided in its standard unit of measurement (e.g., milliliters, grams, ounces). For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as four units.

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

Appendix

The data contained in this report represents medical transactions for Service Year 2013 (medical services delivered from January 1, 2013, to December 31, 2013). Insurance carriers must report paid medical transactions if they write at least 1% of the market share in any one state for which NCCI is the advisory organization. Once a carrier meets the eligibility criteria, the carrier will be required to report for all applicable states in which it writes, even if an individual state's market share is below the threshold. All carriers within a group are required to report, regardless if they write less than 1% of the market share in the state.

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

For the state of Arizona in Service Year 2013, the reported number of transactions was over 1,885,800, for over 73,800 claims, representing data from 88% of the workers compensation premium written, which includes experience for large-deductible policies.

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

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

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

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