Medical Data Report
for the state of:

ARIZONA
September 2016

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Introduction

Medical costs have consistently been on the rise over the last 30 years. Today, in many states, close to 60% of workers compensation benefits are attributed to medical costs. The rising cost of medical care is 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 the 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 are 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

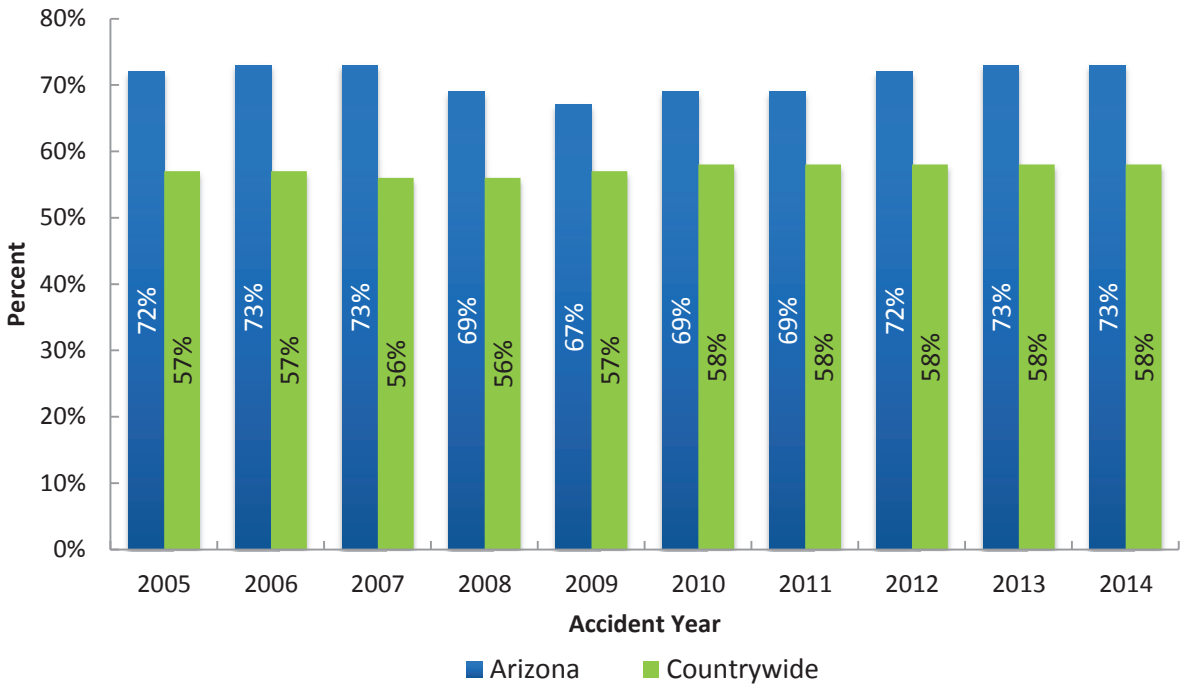
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

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, 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

Medical Share of Total Benefit Costs



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.

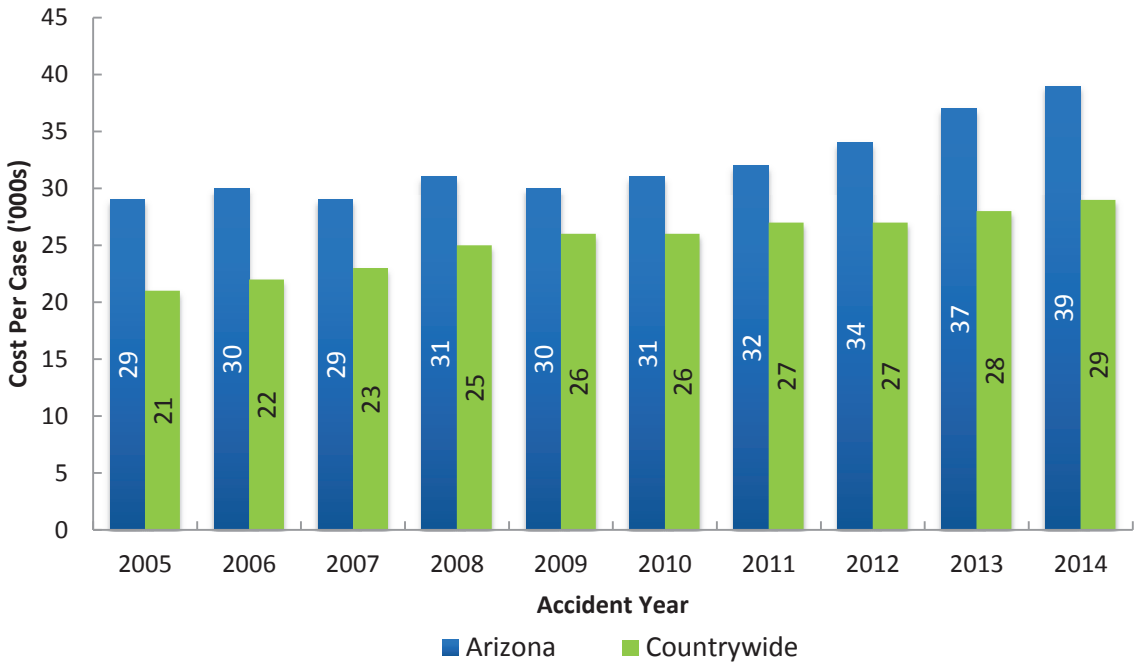
After a decade of medical cost inflation at an annual rate of 6%, since 2010 the countrywide overall medical average cost per claim has seen more moderate increases. Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results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

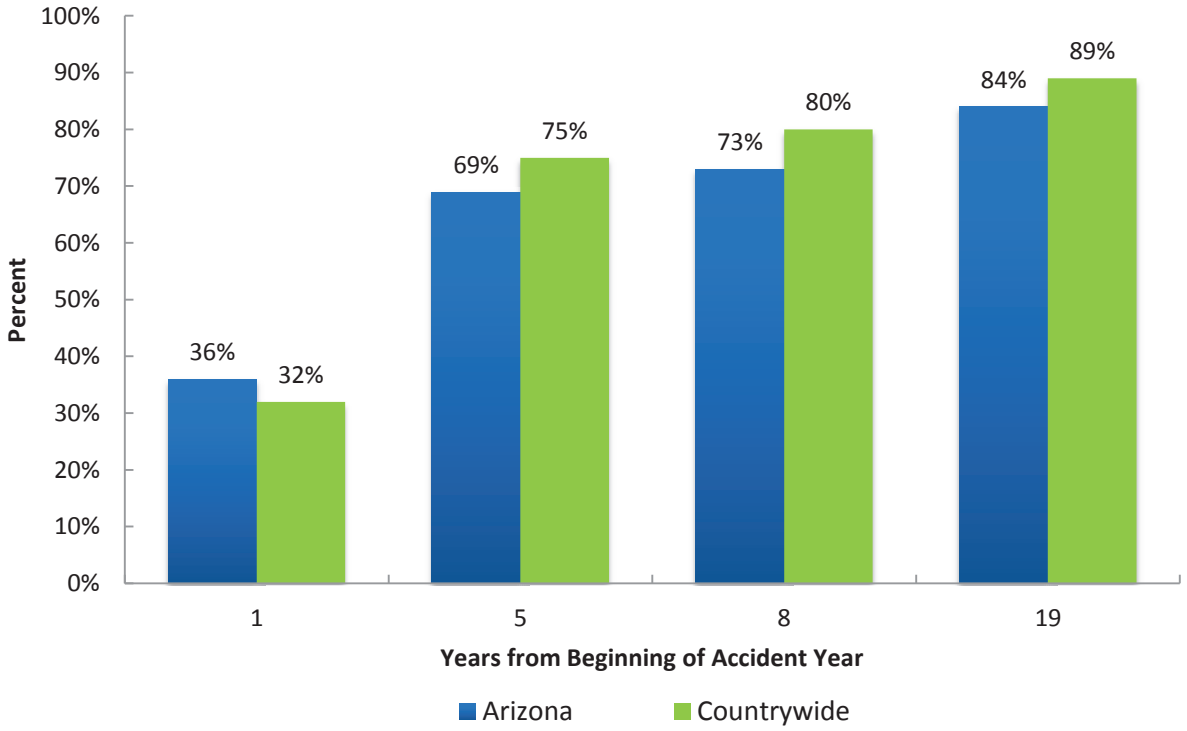
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. Recent NCCI research has found that it is likely that more than 10% of the cost of medical benefits for workplace injuries that occur this year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

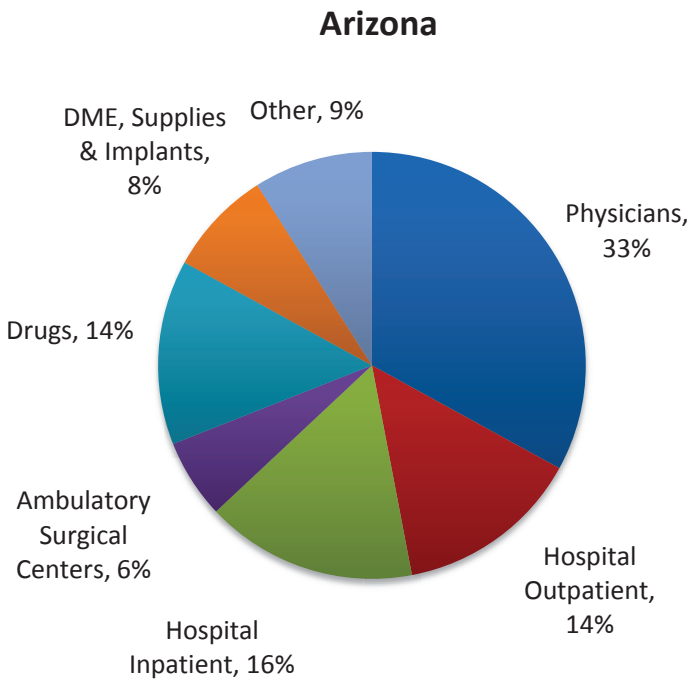
Chart 4 displays the distribution of medical payments by type of service.

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)

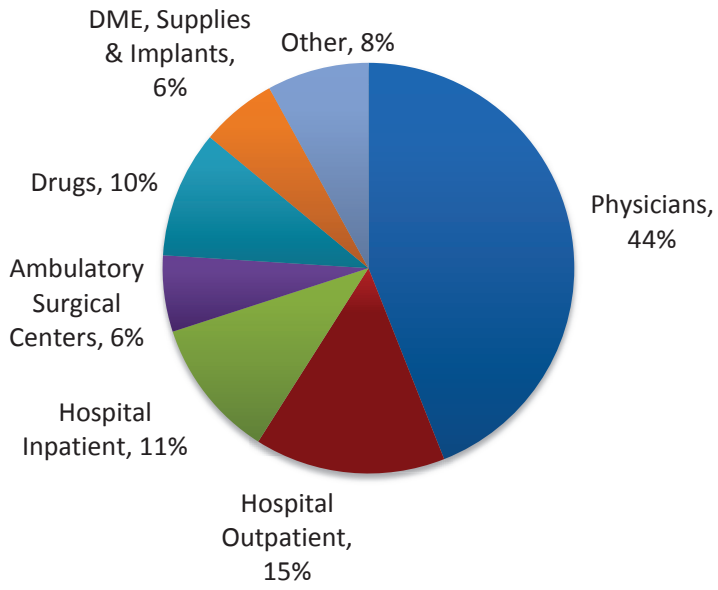
Chart 4

Distribution of Medical Payments

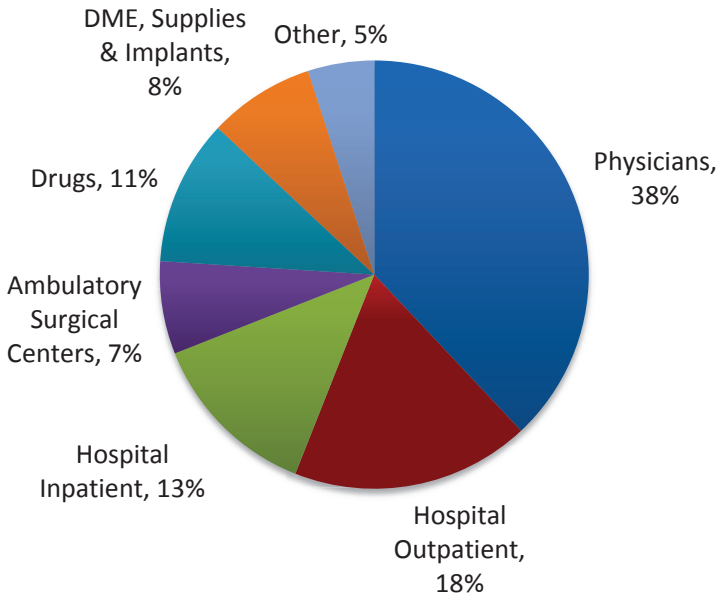


Distribution of Medical Payments (cont'd)

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2015. 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 seven 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.

One measure of workers compensation medical costs is a comparison of current payments to the Medicare rates. In Arizona, physician payments for services provided in 2015 are at 144% of Medicare schedule reimbursement amounts on average.

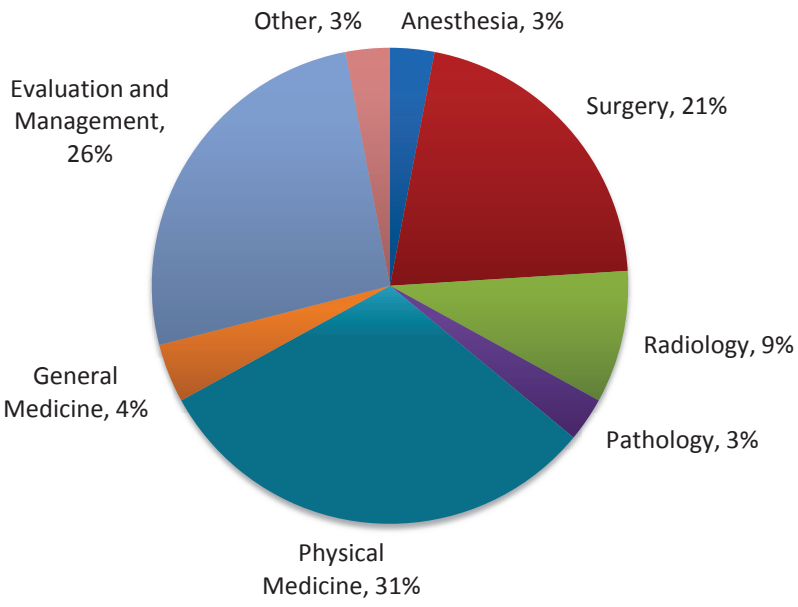
Chart 5 shows the distribution of physician payments by service category. Service categories are defined by the American Medical Association (AMA). Services involving office visits and consultations are included in the "Evaluation and Management" category. "Other" includes any codes not included in the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

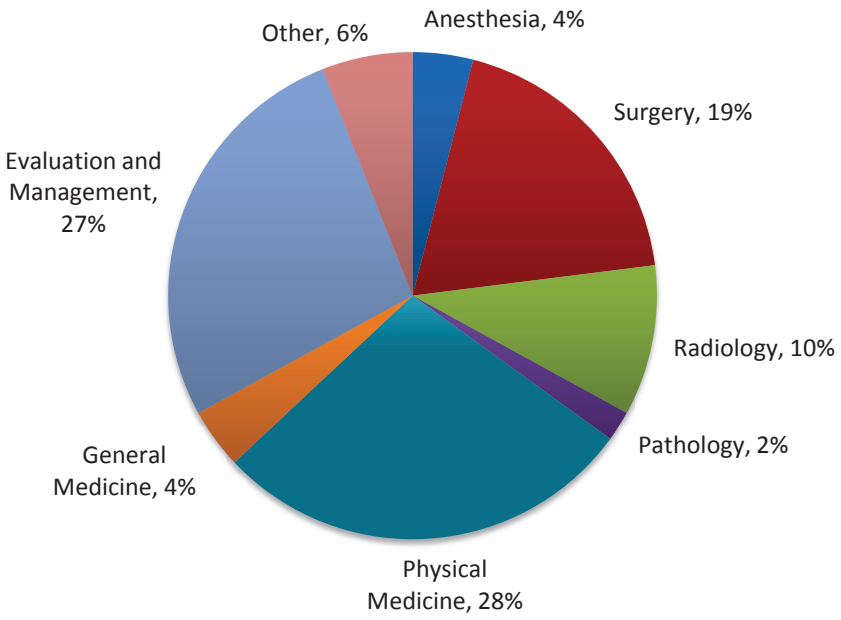
Distribution of Physician Payments by AMA Service Category

Arizona

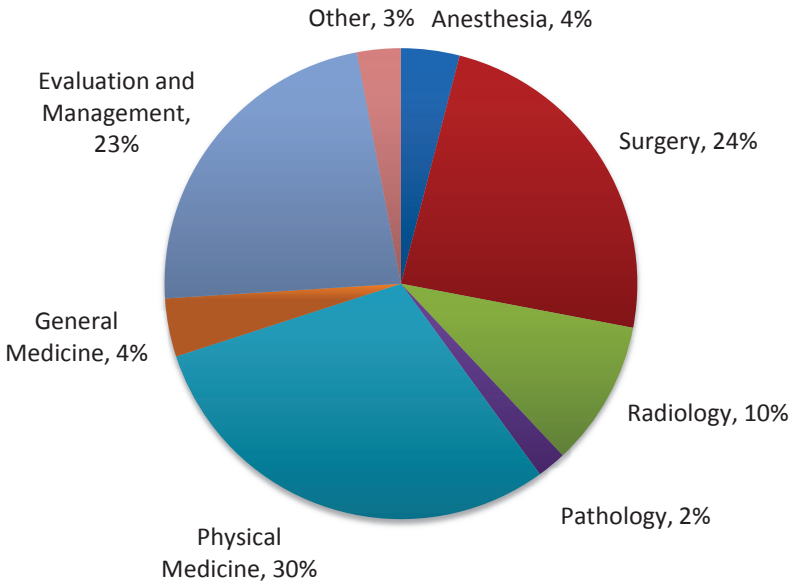


Distribution of Physician Payments by AMA Service Category (cont'd)

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2015. 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 that they provide to claimants. These codes are specific and provide detailed information on what service was performed. Charts 6 through 14 display the top 10 procedure codes reported by physicians for the following service categories: surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code, including the percent of payments that the code represents in Arizona, is displayed in the corresponding table below each chart.

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

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

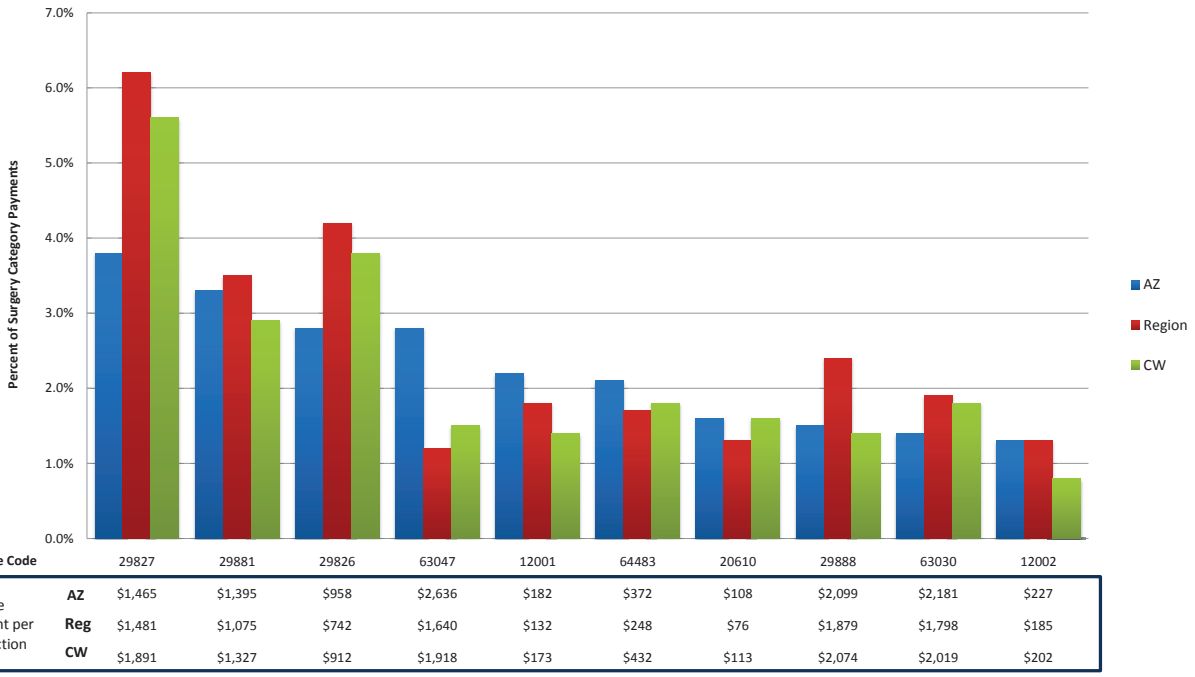
The second method ranks procedure codes by total count of transactions. The procedure code with the highest total transaction count is ranked first, the procedure code with the second highest total transaction count is ranked second, and so on. This method reveals the most frequently used procedures.

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

In Arizona, physician payments for surgery services provided in 2015 are, on average, 190% of Medicare scheduled reimbursement amounts.

Chart 6

Top 10 Surgery Procedure Codes by Amount Paid for Arizona



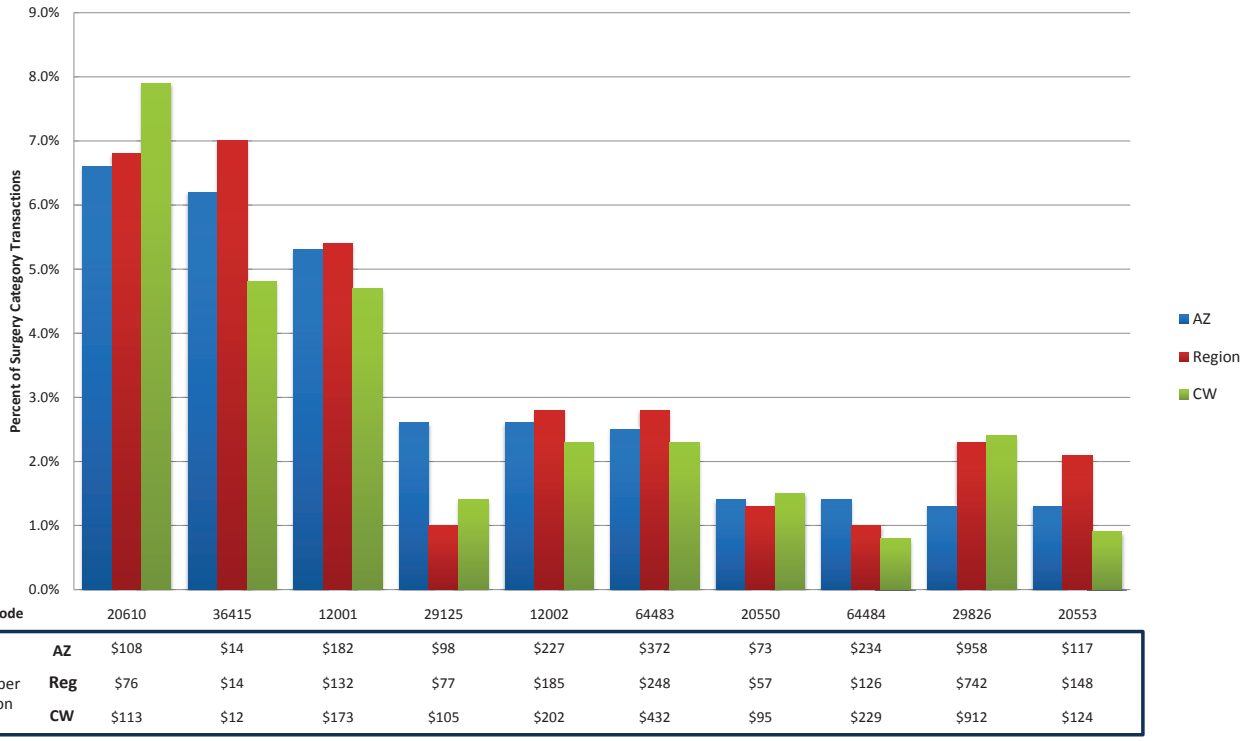
Procedure Code		29827	29881	29826	63047	12001	64483	20610	29888	63030	12002
Average Payment per Transaction	AZ	$1,465	$1,395	$958	$2,636	$182	$372	$108	$2,099	$2,181	$227
	Reg	$1,481	$1,075	$742	$1,640	$132	$248	$76	$1,879	$1,798	$185
	CW	$1,891	$1,327	$912	$1,918	$173	$432	$113	$2,074	$2,019	$202

Source: NCCI Medical Data Call, Service Year 2015. 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	% in AZ	Description
29827	3.8%	Arthroscopy shoulder surgical; with rotator cuff repair
29881	3.3%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29826	2.8%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
63047	2.8%	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root[s] [e.g., spinal or lateral recess stenosis]) single vertebral segment; lumbar
12001	2.2%	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
64483	2.1%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
20610	1.6%	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
29888	1.5%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
63030	1.4%	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
12002	1.3%	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

Chart 7

Top 10 Surgery Procedure Codes by Transaction Counts for Arizona



Procedure Code		20610	36415	12001	29125	12002	64483	20550	64484	29826	20553
Average Payment per Transaction	AZ	$108	$14	$182	$98	$227	$372	$73	$234	$958	$117
	Reg	$76	$14	$132	$77	$185	$248	$57	$126	$742	$148
	CW	$113	$12	$173	$105	$202	$432	$95	$229	$912	$124

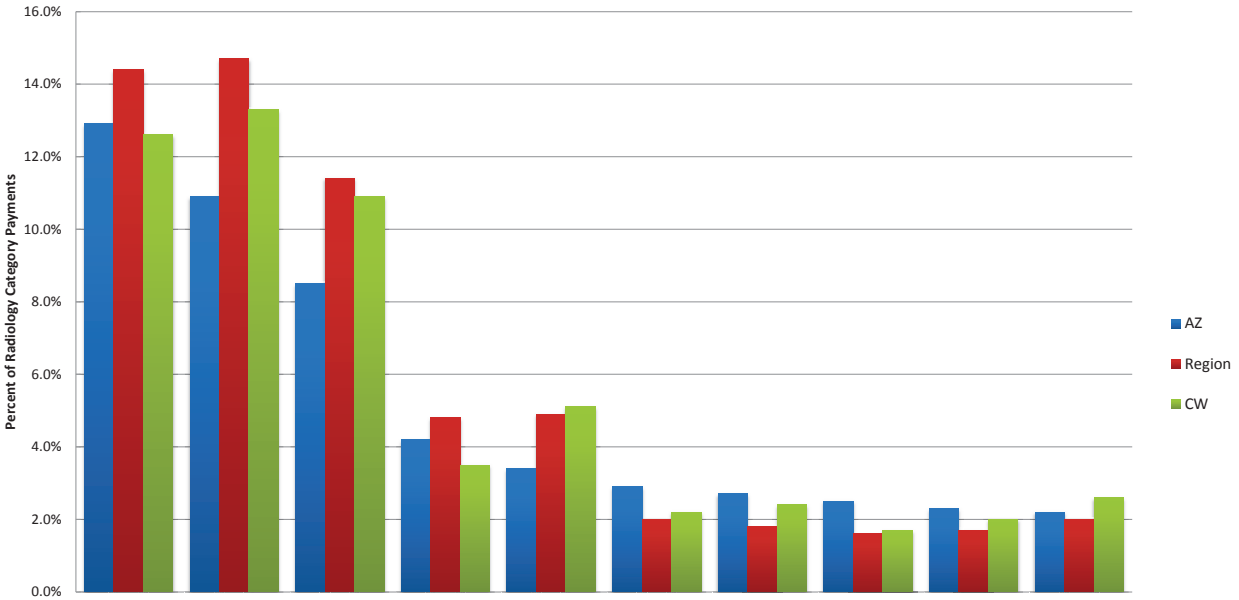
Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in AZ	Description
20610	6.6%	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
36415	6.2%	Collection of venous blood by venipuncture
12001	5.3%	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	2.6%	Application of short arm splint (forearm to hand); static
12002	2.6%	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	2.5%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
20550	1.4%	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)
64484	1.4%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral each additional level
29826	1.3%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
20553	1.3%	Injection(s); single or multiple trigger point(s), 3 or more muscles

In Arizona, physician payments for radiology services provided in 2015 are, on average, 214% of Medicare scheduled reimbursement amounts.

Chart 8

Top 10 Radiology Procedure Codes by Amount Paid for Arizona



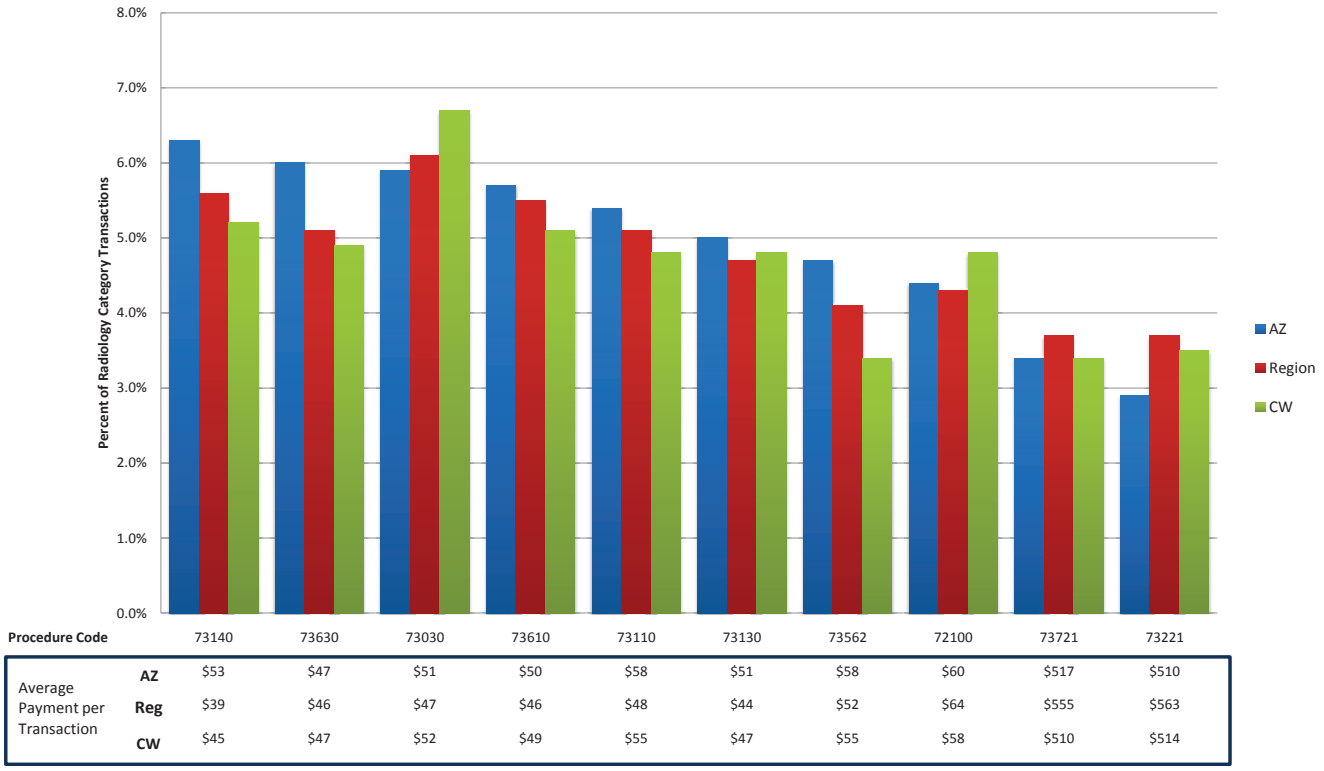
Procedure Code		73721	73221	72148	73222	72141	70450	72158	73140	73110	73030
Average Payment per Transaction	AZ	$517	$510	$497	$757	$495	$208	$742	$53	$58	$51
	Reg	$555	$563	$565	$679	$546	$152	$720	$39	$48	$47
	CW	$510	$514	$503	$641	$501	$157	$741	$45	$55	$52

Source: NCCI Medical Data Call, Service Year 2015. 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	% in AZ	Description
73721	12.9%	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
73221	10.9%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)
72148	8.5%	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
73222	4.2%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; with contrast material(s)
72141	3.4%	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material
70450	2.9%	Computed tomography head or brain; without contrast material
72158	2.7%	Magnetic resonance (e.g., proton) imaging spinal canal and contents without contrast material followed by contrast material(s) and further sequences
73140	2.5%	Radiologic examination finger(s) minimum of 2 views
73110	2.3%	Radiologic examination wrist; complete minimum of 3 views
73030	2.2%	Radiologic examination shoulder; complete minimum of 2 views

Chart 9

Top 10 Radiology Procedure Codes by Transaction Counts for Arizona



Procedure Code		73140	73630	73030	73610	73110	73130	73562	72100	73721	73221
Average Payment per Transaction	AZ	$53	$47	$51	$50	$58	$51	$58	$60	$517	$510
	Reg	$39	$46	$47	$46	$48	$44	$52	$64	$555	$563
	CW	$45	$47	$52	$49	$55	$47	$55	$58	$510	$514

Source: NCCI Medical Data Call, Service Year 2015. 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.

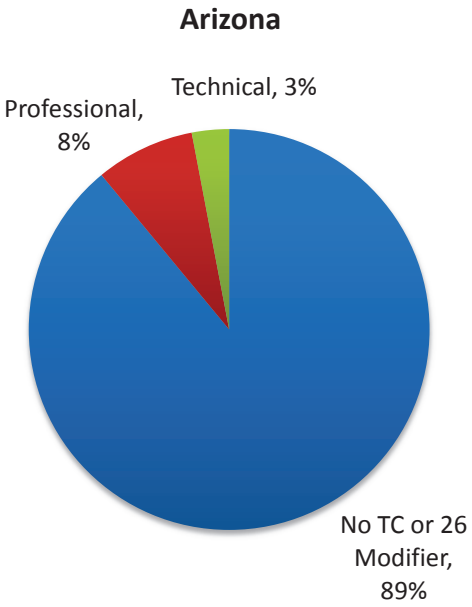
Code	% in AZ	Description
73140	6.3%	Radiologic examination finger(s) minimum of 2 views
73630	6.0%	Radiologic examination foot; complete minimum of 3 views
73030	5.9%	Radiologic examination shoulder; complete minimum of 2 views
73610	5.7%	Radiologic examination ankle; complete minimum of 3 views
73110	5.4%	Radiologic examination wrist; complete minimum of 3 views
73130	5.0%	Radiologic examination hand; minimum of 3 views
73562	4.7%	Radiologic examination knee; 3 views
72100	4.4%	Radiologic examination spine lumbosacral; 2 or 3 views
73721	3.4%	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
73221	2.9%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)

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

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

Chart 10

Distribution of Radiology Payments by Modifier Code for Arizona



Average Paid Amount per Transaction by Modifier Code for Arizona

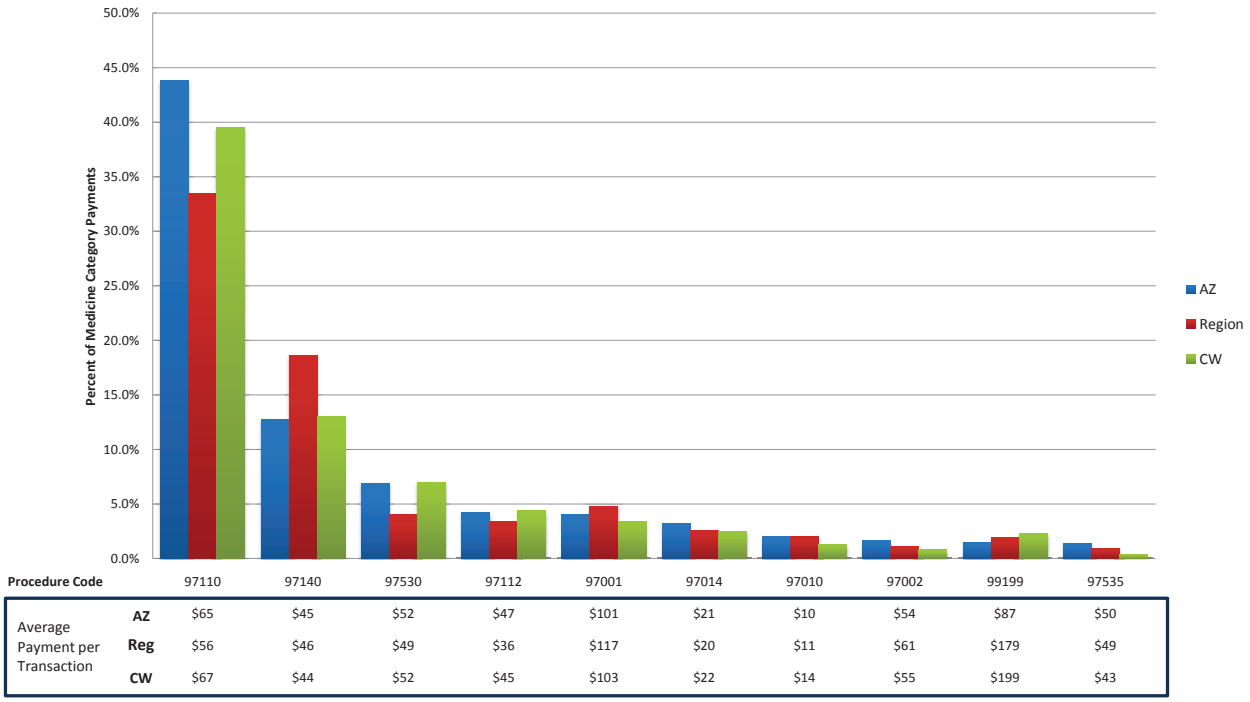
Code	No TC or 26 Modifier	Professional	Technical
73721	$547	$135	$698
73221	$542	$139	$796
72148	$538	$147	$964
73222	$794	$153	NA
72141	$538	$146	$2,155
70450	$461	$79	$1,693
72158	$815	$225	$2,757
73140	$58	$11	$83
73110	$65	$15	$85
73030	$56	$16	$100

Source: NCCI Medical Data Call, Service Year 2015

In Arizona, physician payments for physical and general medicine services provided in 2015 are, on average, 127% of Medicare scheduled reimbursement amounts.

Chart 11

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



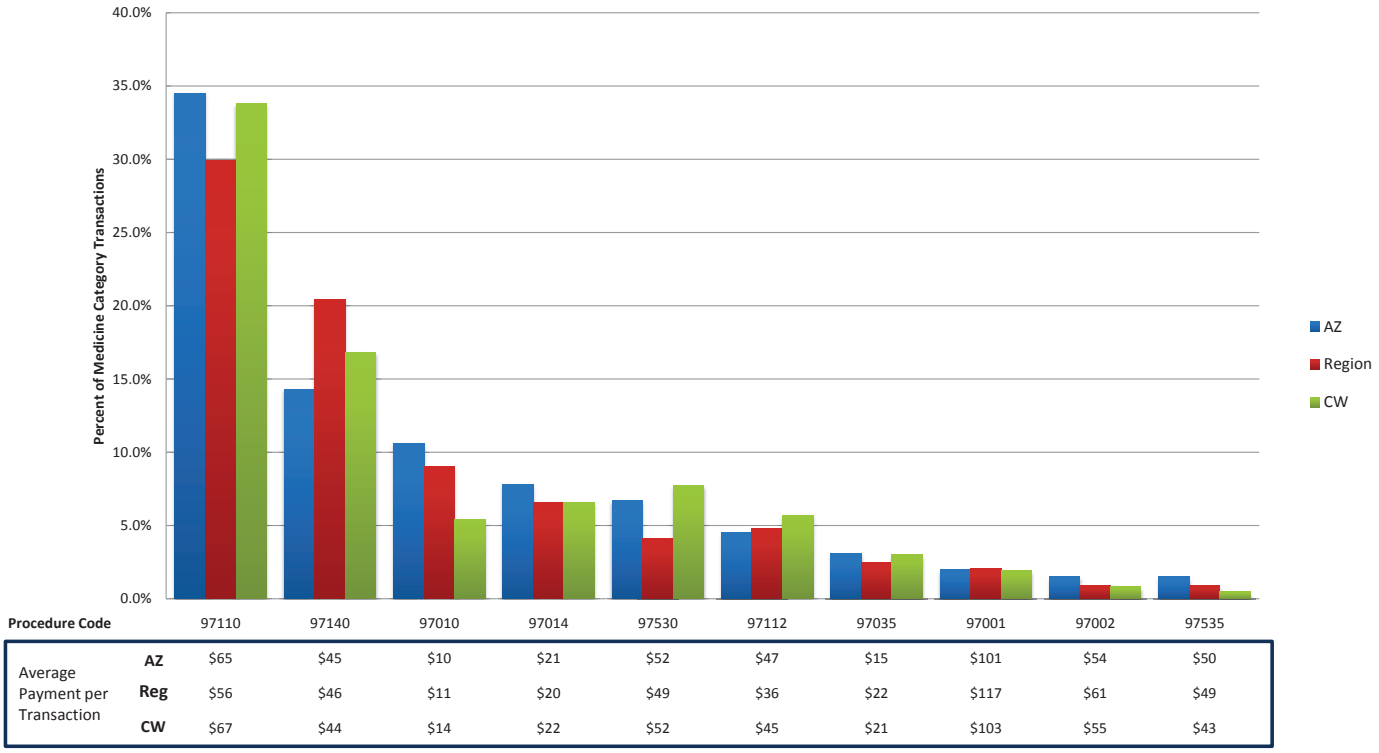
Procedure Code		97110	97140	97530	97112	97001	97014	97010	97002	99199	97535
Average Payment per Transaction	AZ	$65	$45	$52	$47	$101	$21	$10	$54	$87	$50
	Reg	$56	$46	$49	$36	$117	$20	$11	$61	$179	$49
	CW	$67	$44	$52	$45	$103	$22	$14	$55	$199	$43

Source: NCCI Medical Data Call, Service Year 2015. 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	% in AZ	Description
97110	43.8%	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	12.7%	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
97530	6.9%	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	4.2%	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97001	4.0%	Physical therapy evaluation
97014	3.2%	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97010	2.0%	Application of a modality to 1 or more areas; hot or cold packs
97002	1.6%	Physical therapy re-evaluation
99199	1.5%	Unlisted special service procedure or report
97535	1.4%	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 Physical and General Medicine Procedure Codes by Transaction Counts for Arizona



Procedure Code		97110	97140	97010	97014	97530	97112	97035	97001	97002	97535
Average Payment per Transaction	AZ	$65	$45	$10	$21	$52	$47	$15	$101	$54	$50
	Reg	$56	$46	$11	$20	$49	$36	$22	$117	$61	$49
	CW	$67	$44	$14	$22	$52	$45	$21	$103	$55	$43

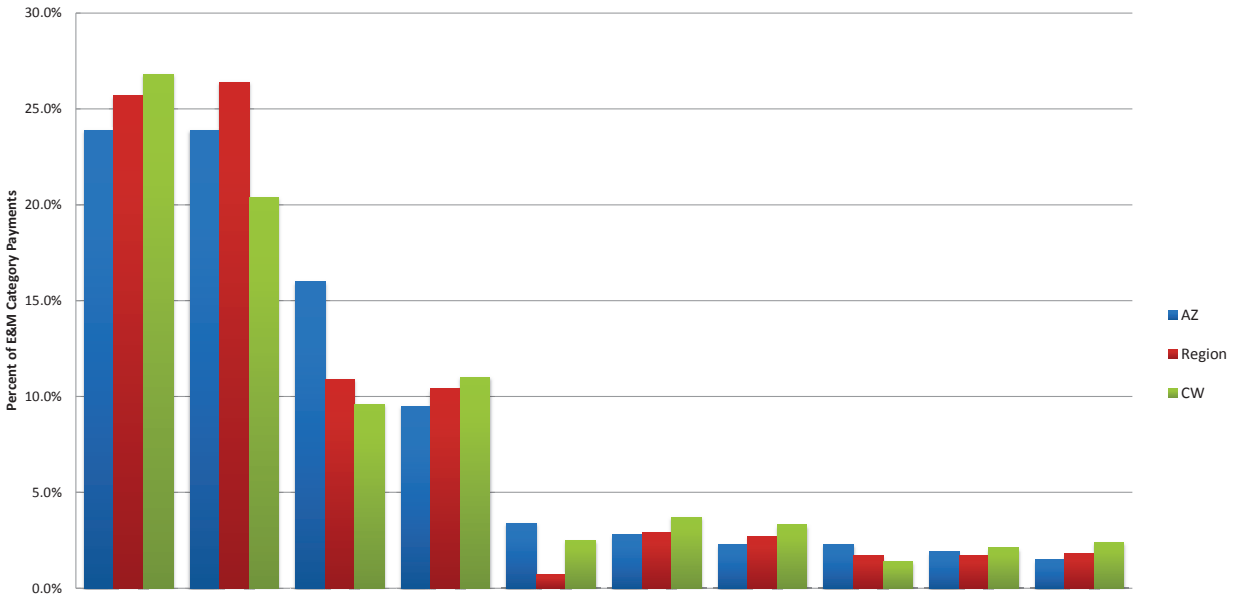
Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in AZ	Description
97110	34.5%	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	14.3%	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
97010	10.6%	Application of a modality to 1 or more areas; hot or cold packs
97014	7.8%	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97530	6.7%	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	4.5%	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97035	3.1%	Application of a modality to 1 or more areas; ultrasound each 15 minutes
97001	2.0%	Physical therapy evaluation
97002	1.5%	Physical therapy re-evaluation
97535	1.5%	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

In Arizona, physician payments for evaluation and management services provided in 2015 are, on average, 126% of Medicare scheduled reimbursement amounts.

Chart 13

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



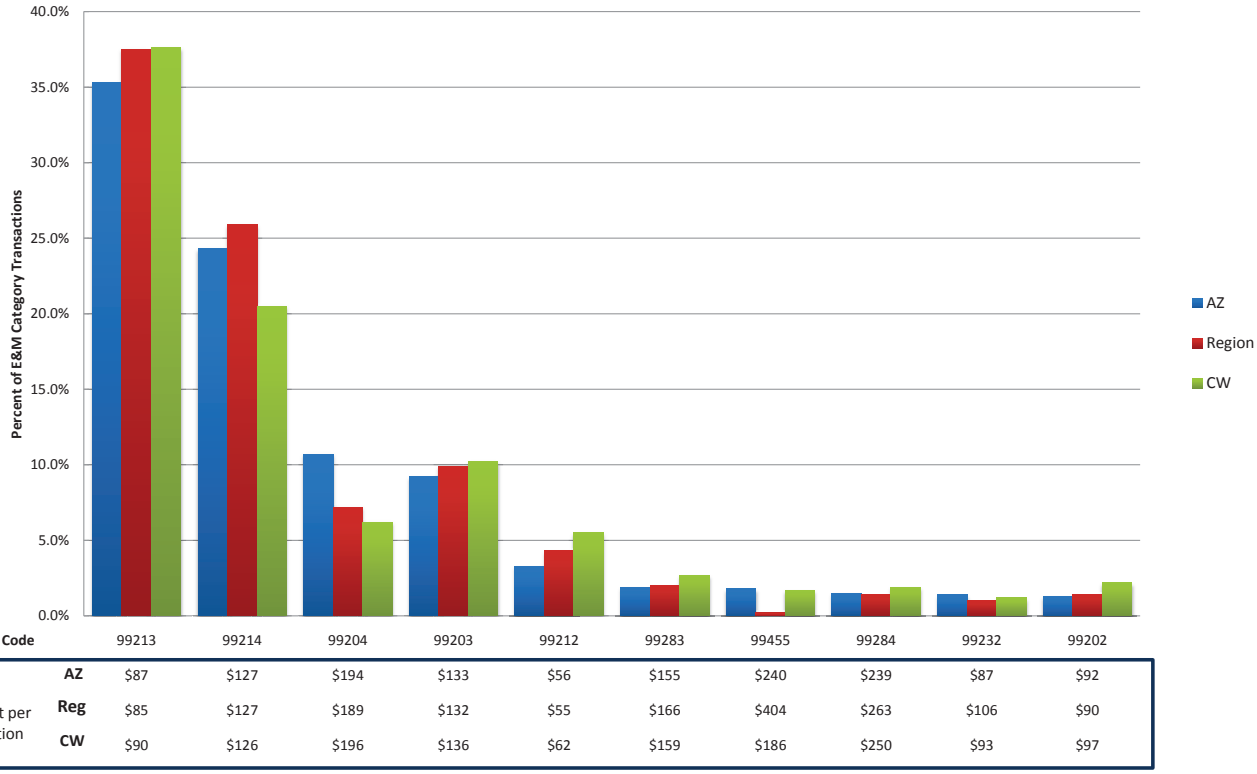
Procedure Code		99213	99214	99204	99203	99455	99284	99283	99244	99285	99456
Average Payment per Transaction	AZ	$87	$127	$194	$133	$240	$239	$155	$264	$343	$1,303
	Reg	$85	$127	$189	$132	$404	$263	$166	$244	$372	$590
	CW	$90	$126	$196	$136	$186	$250	$159	$246	$361	$707

Source: NCCI Medical Data Call, Service Year 2015. 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	% in AZ	Description
99213	23.9%	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	23.9%	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	16.0%	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	9.5%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99455	3.4%	Work related or medical disability examination by the treating physician.
99284	2.8%	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99283	2.3%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99244	2.3%	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99285	1.9%	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99456	1.5%	Work related or medical disability examination by other than the treating physician.

Chart 14

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



Procedure Code		99213	99214	99204	99203	99212	99283	99455	99284	99232	99202
Average Payment per Transaction	AZ	$87	$127	$194	$133	$56	$155	$240	$239	$87	$92
	Reg	$85	$127	$189	$132	$55	$166	$404	$263	$106	$90
	CW	$90	$126	$196	$136	$62	$159	$186	$250	$93	$97

Source: NCCI Medical Data Call, Service Year 2015. 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	% in AZ	Description
99213	35.3%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	24.3%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99204	10.7%	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	9.2%	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	3.3%	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	1.9%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99455	1.8%	Work related or medical disability examination by the treating physician.
99284	1.5%	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99232	1.4%	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99202	1.3%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

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

There are five periods of time spent with a *new* patient, ranging from 10 minutes for Procedure Code 99201 to 60 minutes for Procedure Code 99205. Chart 15 shows a 5-year snapshot of experience for each procedure type and the average cost per transaction.

Chart 15

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

Average Payment per Transaction	2011	2012	2013	2014	2015
99201	$54	$44	$48	$52	$53
99202	$77	$76	$78	$89	$92
99203	$109	$109	$113	$131	$133
99204	$156	$158	$162	$188	$194
99205	$173	$191	$204	$237	$241

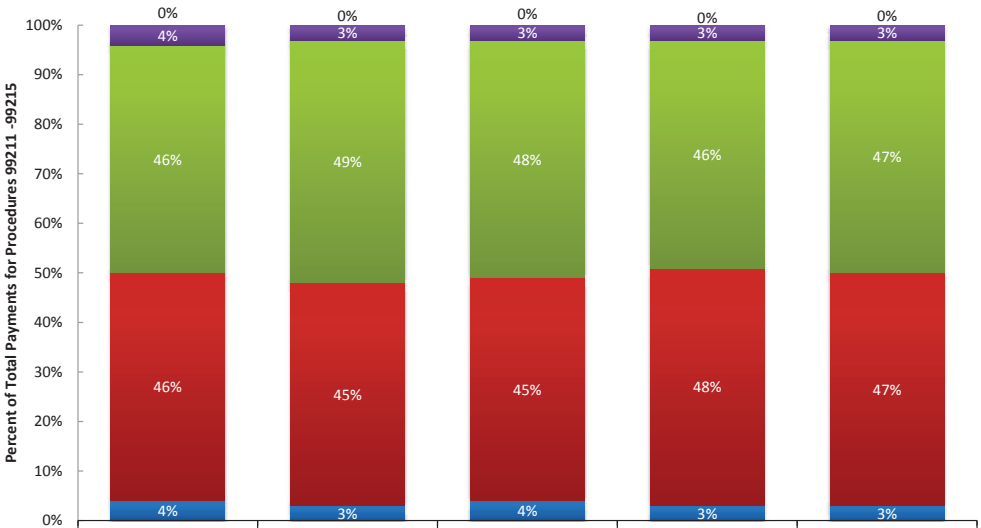
Source: NCCI Medical Data Call, Service Year 2015.

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

Similarly for *established* patients, there are five periods of time spent with the patient, ranging from 5 minutes for Procedure Code 99211 to 40 minutes for Procedure Code 99215. Chart 16 shows a 5-year snapshot of experience for each procedure type and the average cost per transaction.

Chart 16

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



Average Payment per Transaction	2011	2012	2013	2014	2015
99211	$28	$28	$27	$30	$33
99212	$47	$47	$48	$55	$56
99213	$71	$71	$74	$85	$87
99214	$103	$105	$108	$123	$127
99215	$118	$136	$150	$168	$176

Source: NCCI Medical Data Call, Service Year 2015.

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

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

- Taxonomy code
- Procedure code
- Place of service

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

Hospital inpatient fee schedules in workers compensation were mostly established in the last decade. 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.

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

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In Arizona, 35% of hospital inpatient codes are reported with a DRG code.

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

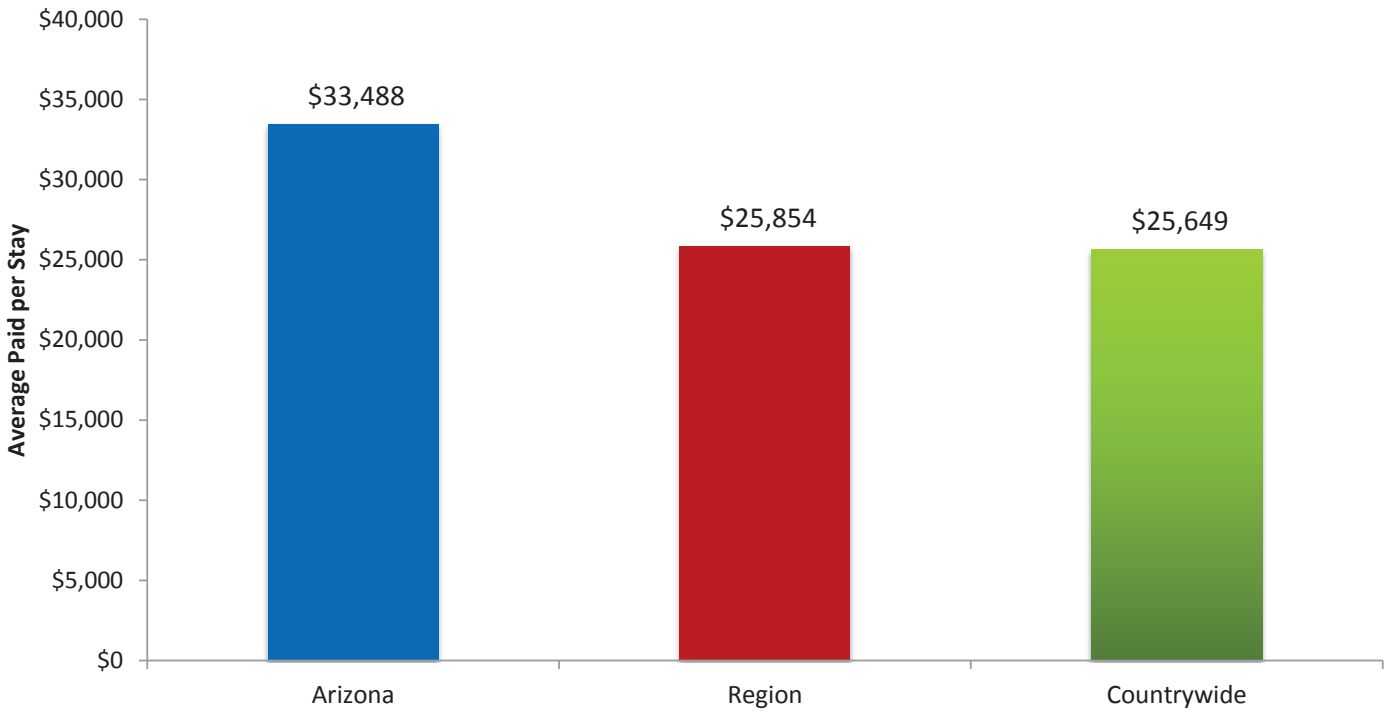
A measure of workers compensation hospital inpatient costs is a comparison of current payments to the Medicare rates. In Arizona, hospital inpatient payments for services provided in 2015 are, on average, 249% of Medicare scheduled reimbursement amounts.

One comparative measure of inpatient service costs is the average cost per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting, for a specific diagnosis. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

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

Chart 17

Average Paid Amount per Stay for Hospital Inpatient Services

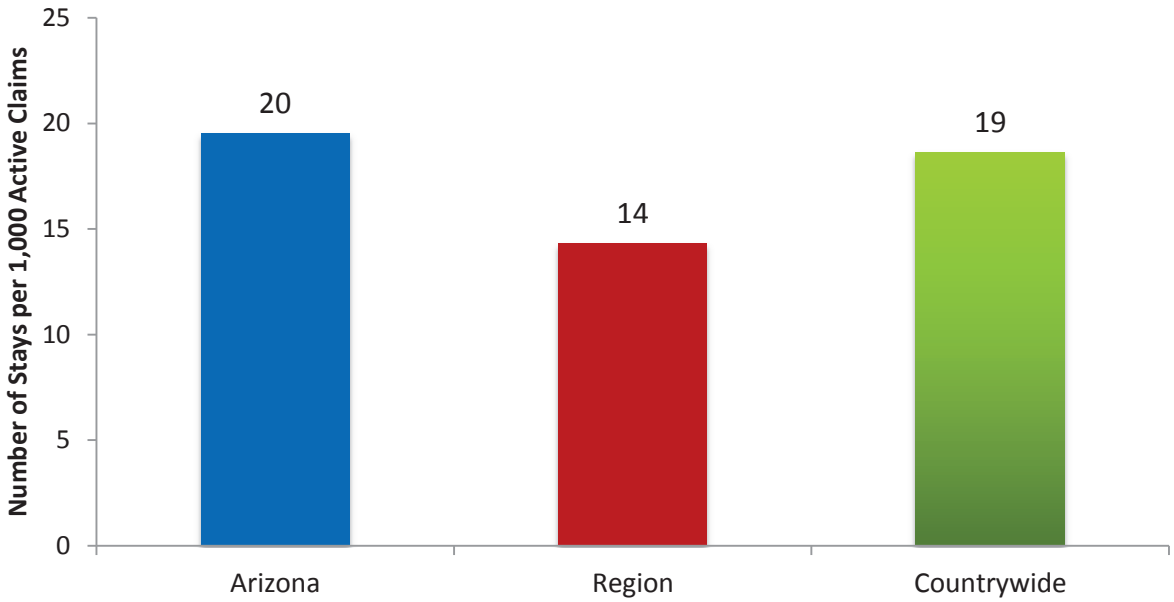


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 18 displays the average number of stays for hospital inpatient services per 1,000 active claims in 2015 for Arizona, the region and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 18

Average Number of Stays per 1,000 Active Claims

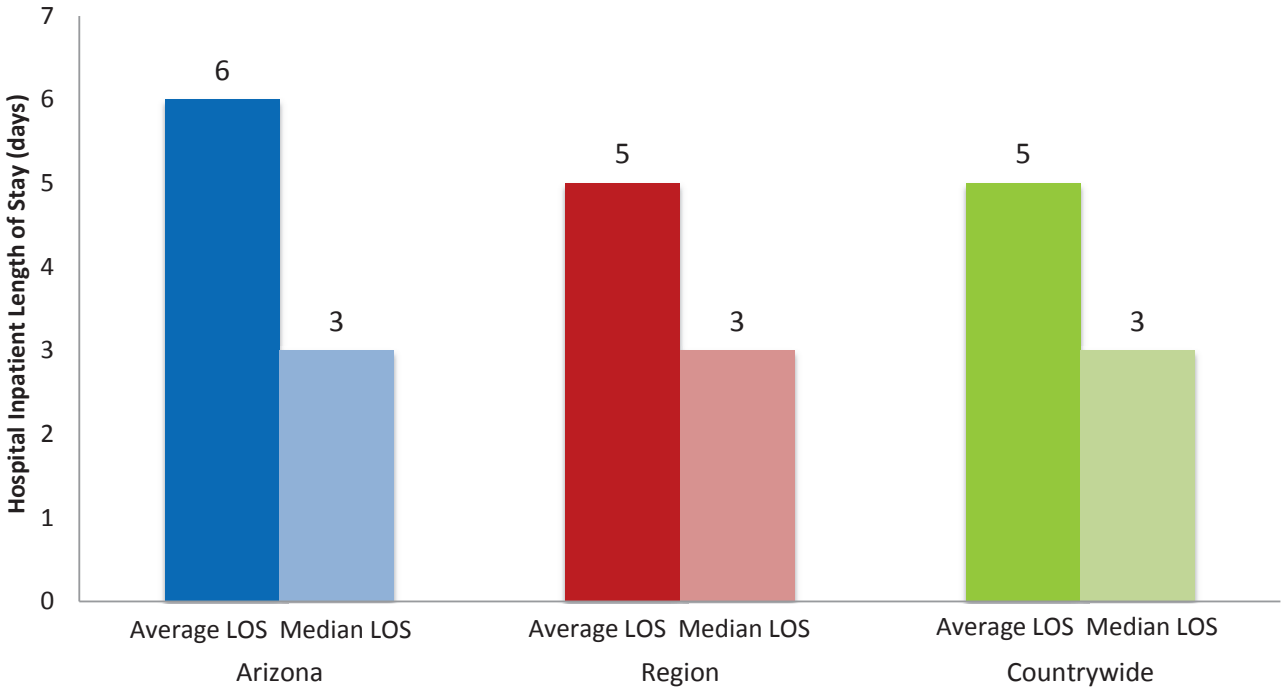


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 19 displays the average and median[1] length of stay (LOS) for hospital inpatient services for Arizona as well as for the region and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 19

Inpatient Length of Stay for Hospital Inpatient Services



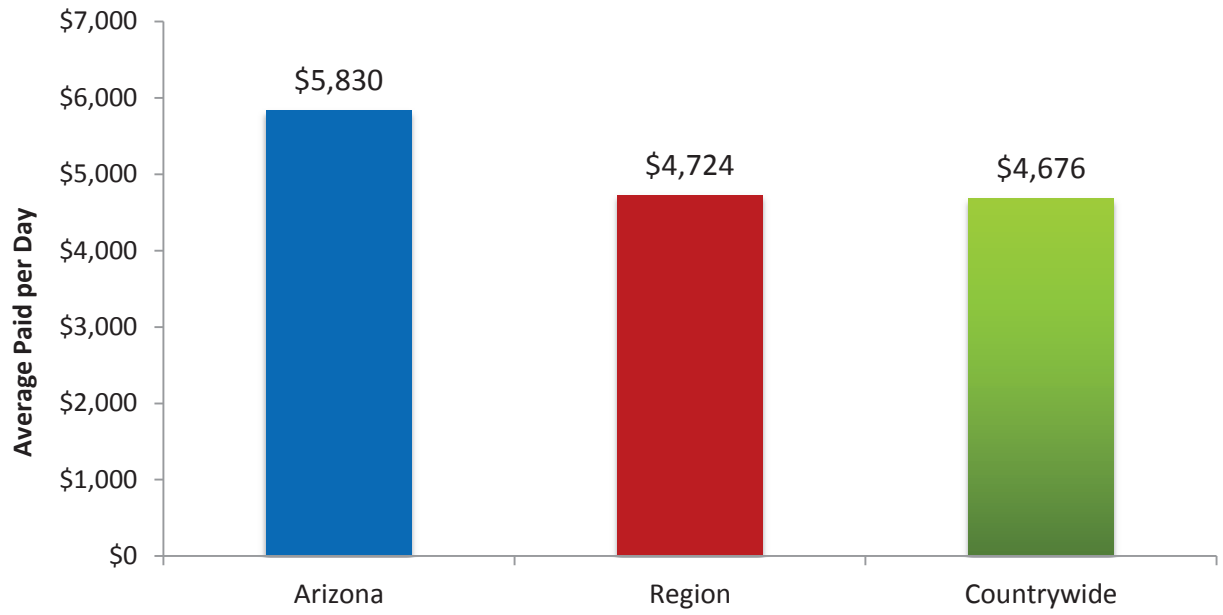
Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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

Chart 20 displays the average paid amount per day for hospital inpatient services for Arizona as well as for the region and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 20

Average Paid Amount per Day for Hospital Inpatient Services

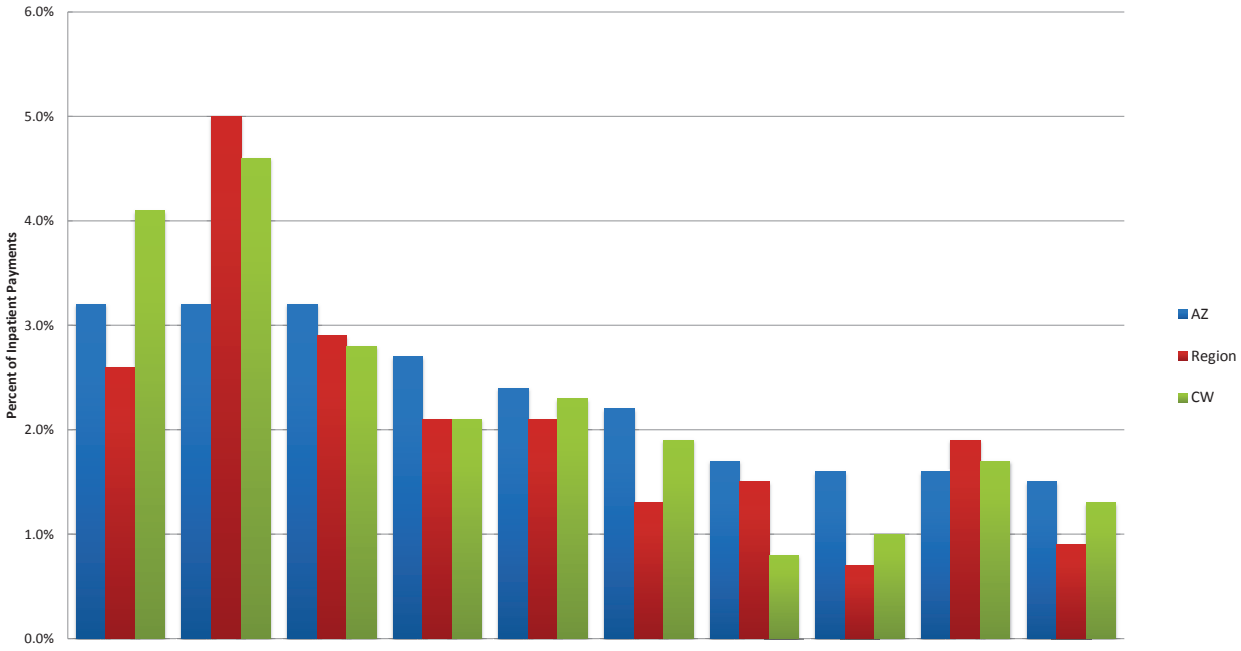


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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

Chart 21

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



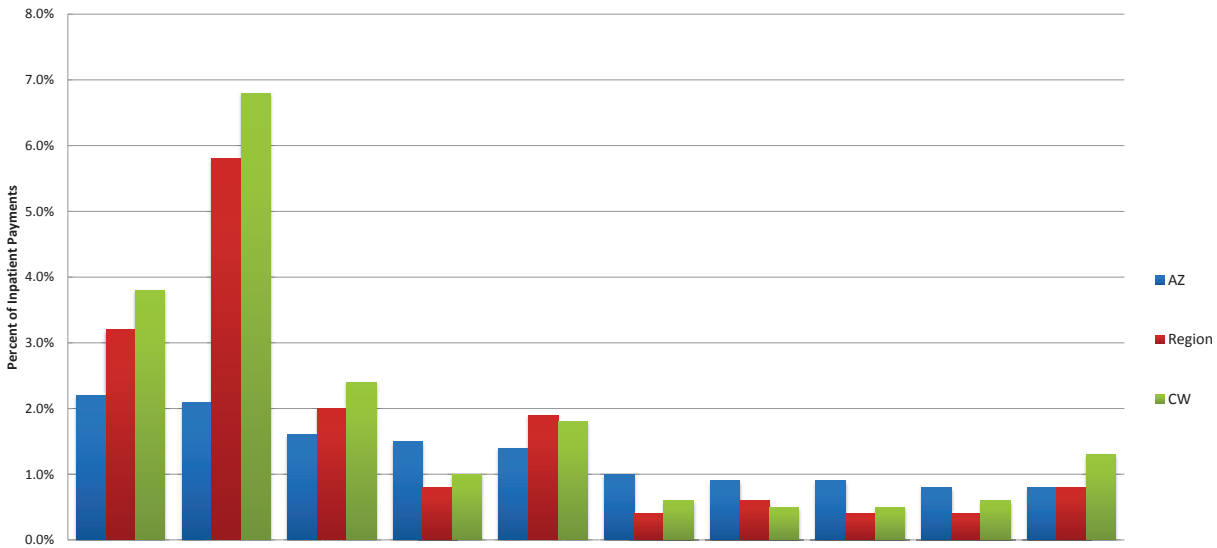
Diagnosis Code		M51.2	Z51.89	M51.3	M17.9	T84	M48.06	S06.890A	M47.817	S82	M43
Median Payment per Hospital Inpatient Stay	AZ	$28,129	$12,097	$38,500	$21,361	$30,733	$23,052	$41,867	$53,249	$25,031	$59,955
	Reg	$15,465	$15,446	$29,528	$22,614	$19,906	$24,043	$16,678	$26,723	$20,058	$38,399
	CW	$18,903	$14,587	$30,375	$17,675	$17,529	$23,041	$17,454	$27,579	$20,989	$31,778

Source: NCCI Medical Data Call, Service Years 2014 and 2015. 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	% in AZ	Description
M51.2	3.2%	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
Z51.89	3.2%	Encounter for other specified aftercare
M51.3	3.2%	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M17.9	2.7%	Osteoarthritis of knee, unspecified
T84	2.4%	Complications of internal orthopedic prosthetic devices, implants and grafts
M48.06	2.2%	Spinal stenosis, lumbar region
S06.890A	1.7%	Other specified intracranial injury without loss of consciousness, initial encounter
M47.817	1.6%	Spondylosis without myelopathy or radiculopathy, lumbosacral region
S82	1.6%	Fracture of lower leg, including ankle
M43	1.5%	Other deforming dorsopathies

Chart 22

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



Procedure Code		999	460	470	455	494	464	454	472	935	945
Median Payment per Hospital Inpatient Stay	AZ	$34,079	$50,519	$28,438	$101,351	$24,277	$59,749	$116,012	$33,763	$41,920	$17,297
	Reg	$18,590	$42,502	$22,674	$65,600	$16,605	$33,016	$76,497	$29,134	$13,142	$14,884
	CW	$23,703	$36,233	$20,668	$48,493	$16,872	$34,824	$68,964	$24,478	$13,008	$17,934

Source: NCCI Medical Data Call, Service Years 2014 and 2015. 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	% in AZ	Description
999	2.2%	Ungroupable
460	2.1%	Spinal fusion except cervical without major complications or comorbidities
470	1.6%	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
455	1.5%	Combined anterior / posterior spinal fusion without complications or comorbidities / major complications or comorbidities
494	1.4%	Lower extremity and humerus procedures except hip foot femur without complications or comorbidities / major complications or comorbidities
464	1.0%	Wound debridement and skin graft except hand for musculo-connective tissue disorders with complications or comorbidities
454	0.9%	Combined Anterior / Posterior Spinal Fusion with complications or comorbidities
472	0.9%	Cervical Spinal Fusion with complications or comorbidities
935	0.8%	Nonextensive Burns
945	0.8%	Rehabilitation with complications or comorbidities / major complications or comorbidities

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

If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by CPT or other healthcare common procedure coding system (HCPCS) codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Some payments are also reported by 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.

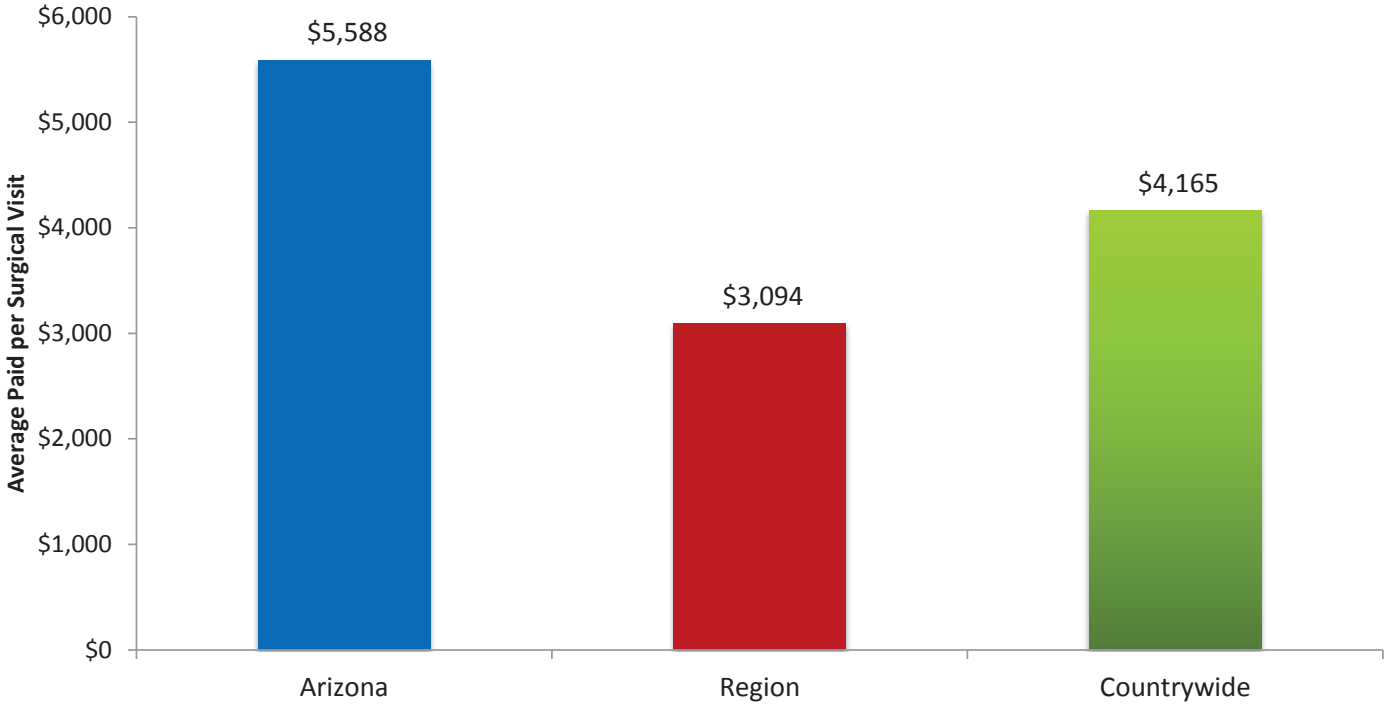
Hospital outpatient visits can vary in nature. A surgical visit includes at least one surgical service, while a non-surgical visit does not. A surgical service is defined as "major surgery" or "minor surgery" within the surgical category defined by the AMA. In this section, we provide measures of hospital outpatient payments that take into account the type of visit, since the level of reimbursement varies considerably by type of visit.

One measure of workers compensation hospital outpatient costs is a comparison of current payments to the Medicare rates. In Arizona, hospital outpatient payments for services provided in 2015 are, on average, 237% of Medicare scheduled reimbursement amounts.

Chart 23 displays the average paid amount per visit for hospital outpatient surgical services for Arizona as well as the region and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 23

Average Outpatient Paid Amount per Surgical Visit for Hospital Outpatient Services

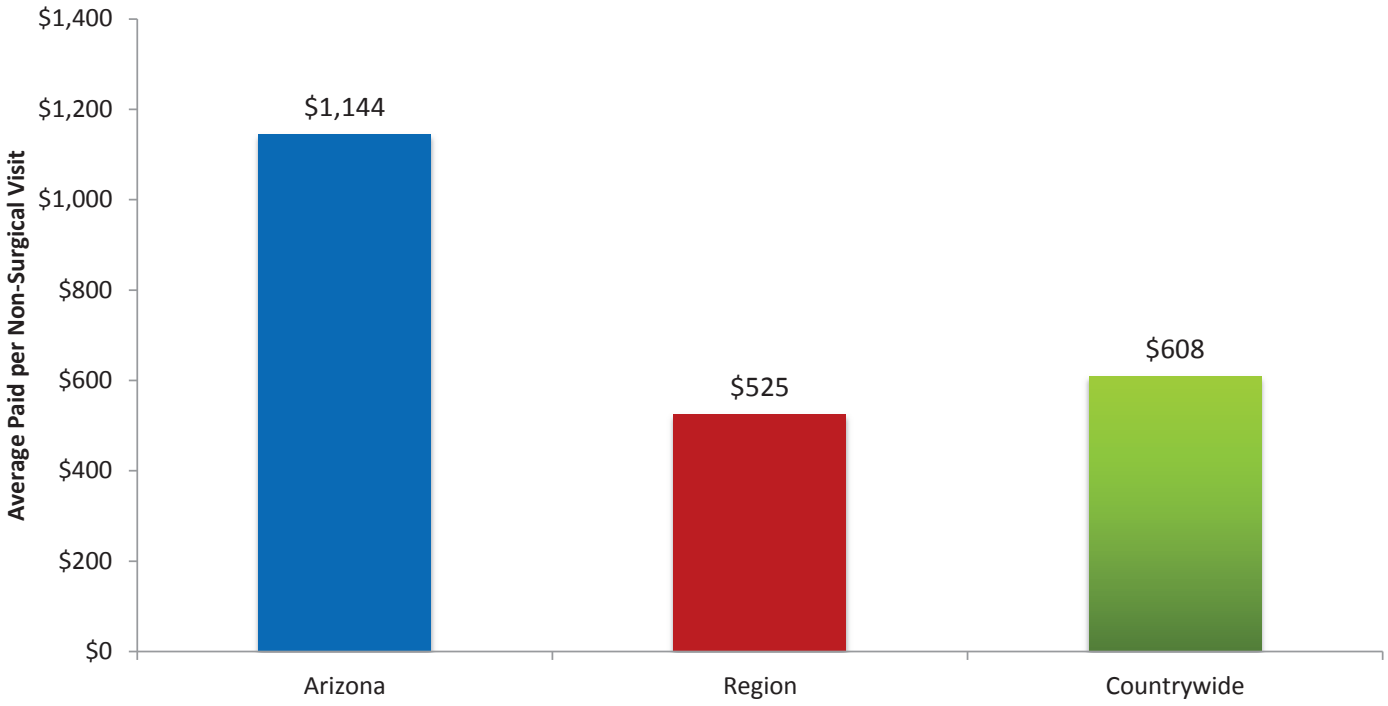


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 24 displays the average paid amount per visit for hospital outpatient non-surgical services (such as physical therapy) for Arizona as well as for the region and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 24

Average Outpatient Paid Amount per Non-Surgical Visit for Hospital Outpatient Services

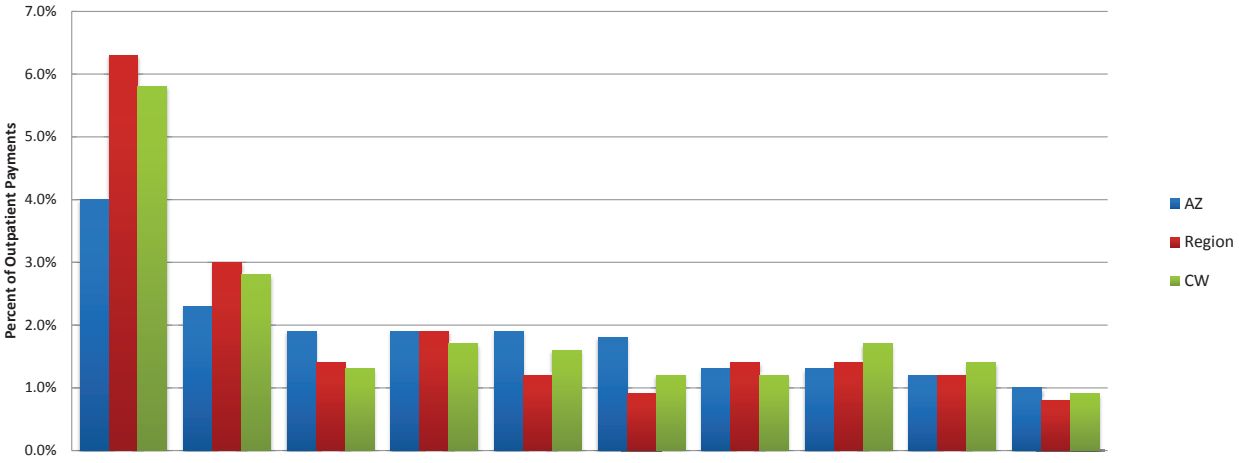


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 25 displays the average paid amount per visit for outpatient services in Arizona, the region and countrywide for top 10 diagnoses in Arizona. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the table below.

Chart 25

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



Diagnosis Code		Z51.89	S43.429A	K40.90	S61.209A	M75	S09	S62	M54.5	S83.2	S13
Median Payment per Hospital Outpatient Visit	AZ	$239	$981	$4,094	$703	$1,566	$1,849	$1,007	$343	$3,936	$1,220
	Reg	$114	$623	$1,514	$487	$559	$871	$589	$153	$571	$389
	CW	$158	$271	$2,884	$503	$256	$915	$542	$222	$1,554	$381

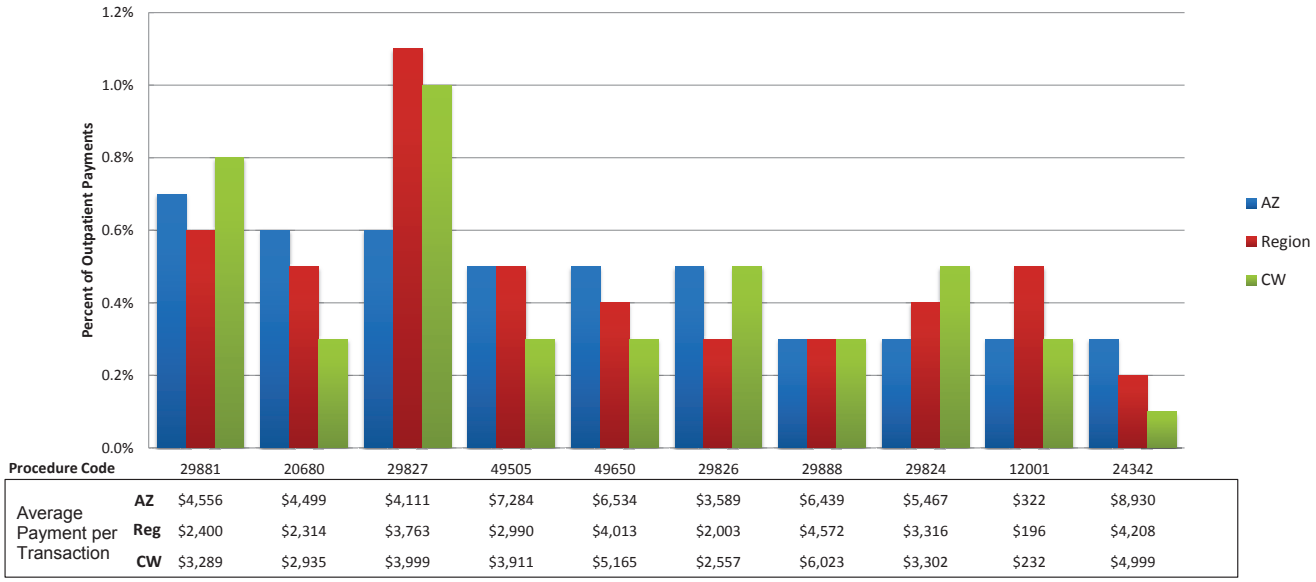
Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in AZ	Description
Z51.89	4.0%	Encounter for other specified aftercare
S43.429A	2.3%	Sprain of unspecified rotator cuff capsule, initial encounter
K40.90	1.9%	Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
S61.209A	1.9%	Unspecified open wound of unspecified finger without damage to nail, initial encounter
M75	1.9%	Shoulder lesions
S09	1.8%	Other and unspecified injuries of head
S62	1.3%	Fracture at wrist and hand level
M54.5	1.3%	Low back pain
S83.2	1.2%	Tear of meniscus, current injury
S13	1.0%	Dislocation and sprain of joints and ligaments at neck level

Charts 26 and 27 display the average paid amount per visit for outpatient services in Arizona, the region and countrywide for the top 10 surgery CPT and non-surgery CPT codes in Arizona. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the table below.

Chart 26

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



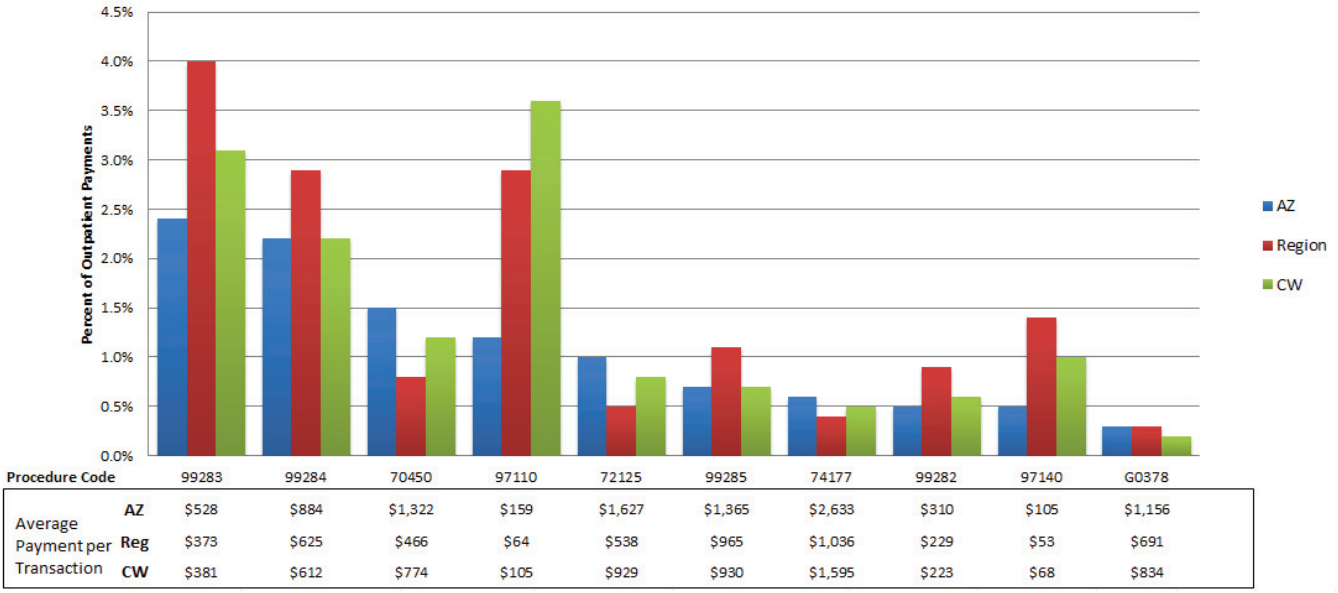
Procedure Code		29881	20680	29827	49505	49650	29826	29888	29824	12001	24342
Average Payment per Transaction	AZ	$4,556	$4,499	$4,111	$7,284	$6,534	$3,589	$6,439	$5,467	$322	$8,930
	Reg	$2,400	$2,314	$3,763	$2,990	$4,013	$2,003	$4,572	$3,316	$196	$4,208
	CW	$3,289	$2,935	$3,999	$3,911	$5,165	$2,557	$6,023	$3,302	$232	$4,999

Source: NCCI Medical Data Call, Service Year 2015. 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	% in AZ	Description
29881	0.7%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
20680	0.6%	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
29827	0.6%	Arthroscopy shoulder surgical; with rotator cuff repair
49505	0.5%	Repair initial inguinal hernia, age 5 years or older; reducible
49650	0.5%	Laparoscopy, surgical; repair initial inguinal hernia
29826	0.5%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
29888	0.3%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29824	0.3%	Arthroscopy shoulder surgical; distal claviculectomy including distal articular surface (Mumford procedure)
12001	0.3%	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
24342	0.3%	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft

Chart 27

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



Procedure Code		99283	99284	70450	97110	72125	99285	74177	99282	97140	G0378
Average Payment per Transaction	AZ	$528	$884	$1,322	$159	$1,627	$1,365	$2,633	$310	$105	$1,156
	Reg	$373	$625	$466	$64	$538	$965	$1,036	$229	$53	$691
	CW	$381	$612	$774	$105	$929	$930	$1,595	$223	$68	$834

Source: NCCI Medical Data Call, Service Year 2015. 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.

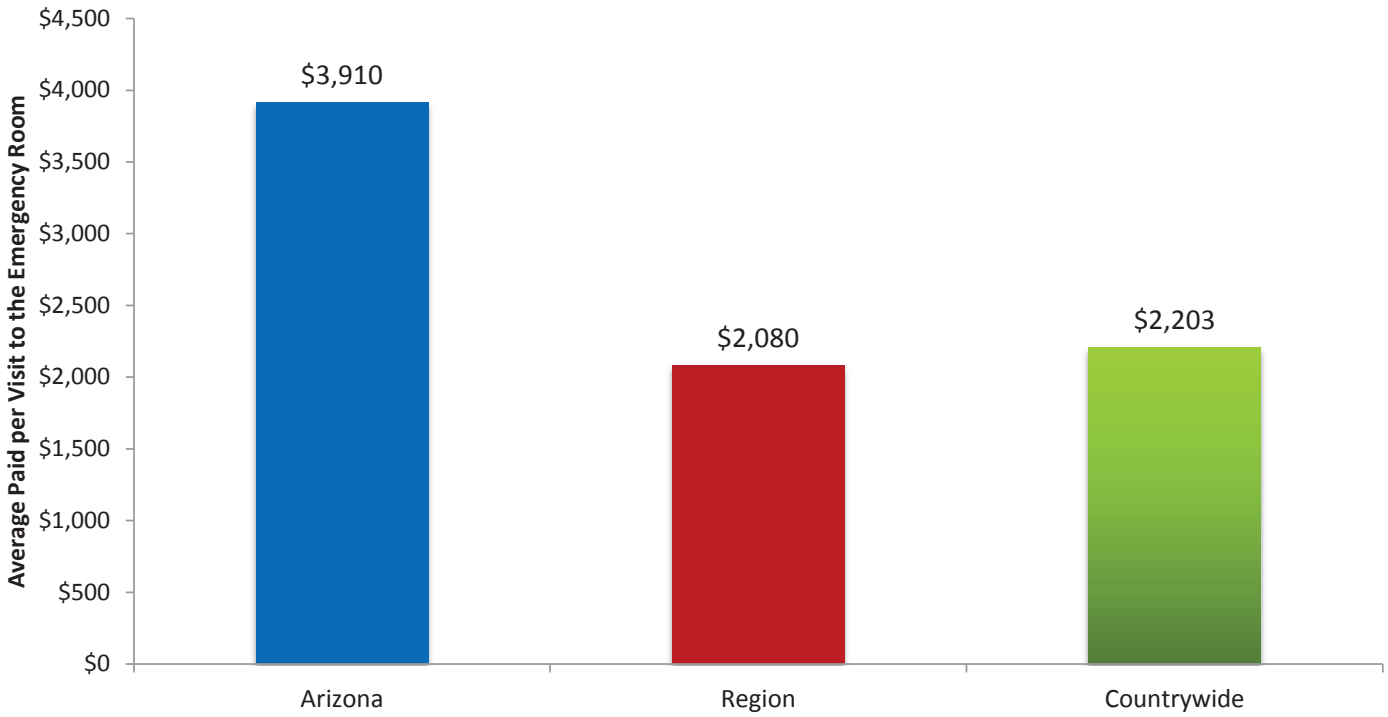
Code	% in AZ	Description
99283	2.4%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99284	2.2%	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
70450	1.5%	Computed tomography head or brain; without contrast material
97110	1.2%	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
72125	1.0%	Computed tomography (CT) cervical spine; without contrast material
99285	0.7%	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
74177	0.6%	Computed tomography, abdomen and pelvis; with contrast material(s)
99282	0.5%	Emergency department visit. Usually the presenting problem(s) are of low to moderate severity.
97140	0.5%	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
G0378	0.3%	Hospital observation service, per hour

In Arizona, 36% of the payments associated with facilities (ASC, Hospital Outpatient, and Hospital Inpatient) are for emergency room payments, compared to 30% countrywide.

Chart 28 displays the average paid amount per visit for emergency room services for Arizona as well as for the region and countrywide. The average paid amount includes all payments for an emergency room visit such as payments for facility services, physician services, and drugs. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 28

Average Amount Paid per Emergency Room Visit

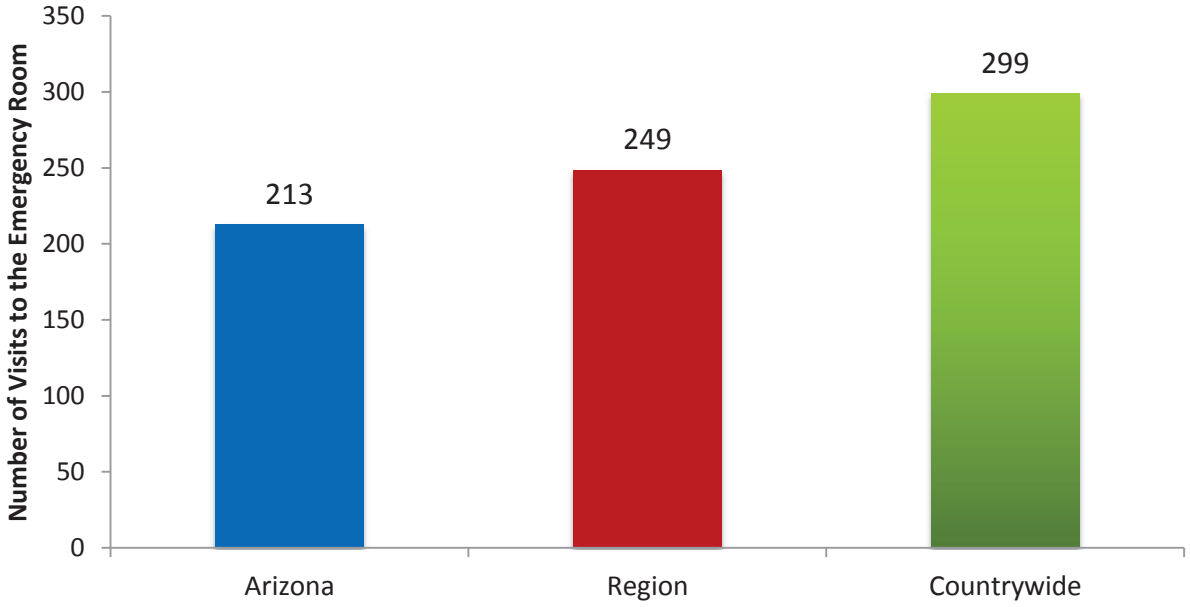


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 29 displays the number of visits per year per 1,000 active claims for emergency room services for Arizona as well as the average visits per 1,000 active claims for the region and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year.

Chart 29

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

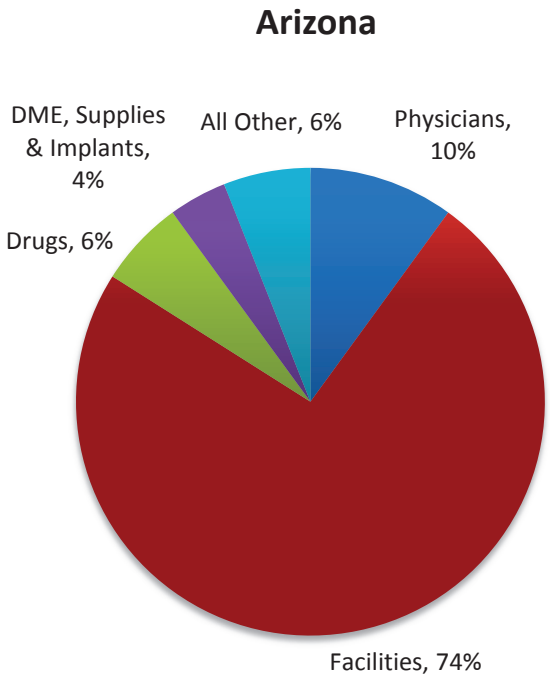


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 30 displays the distribution of medical payments by type of service for emergency room services.

Chart 30

Distribution of Emergency Room Service Payments

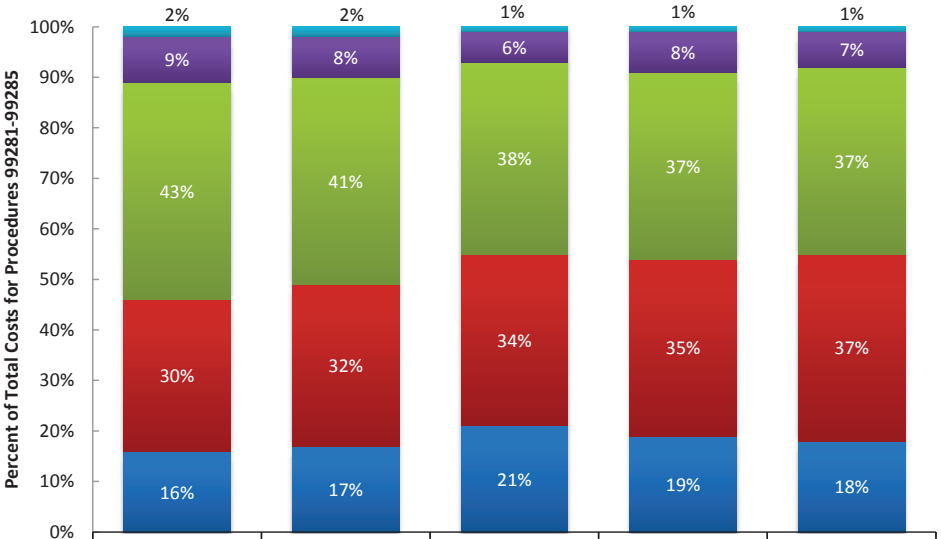


Source: NCCI Medical Data Call, Service Year 2015.

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 31 shows a 5-year snapshot of experience for each procedure type and the average cost per transaction.

Chart 31

Emergency Room Services Experience by Procedure Code for Arizona



Average Payment per Transaction	2011	2012	2013	2014	2015
99281	$190	$181	$123	$139	$160
99282	$190	$192	$181	$219	$217
99283	$250	$245	$230	$247	$279
99284	$323	$328	$303	$355	$403
99285	$430	$421	$423	$458	$484

Source: NCCI Medical Data Call, Service Year 2015.

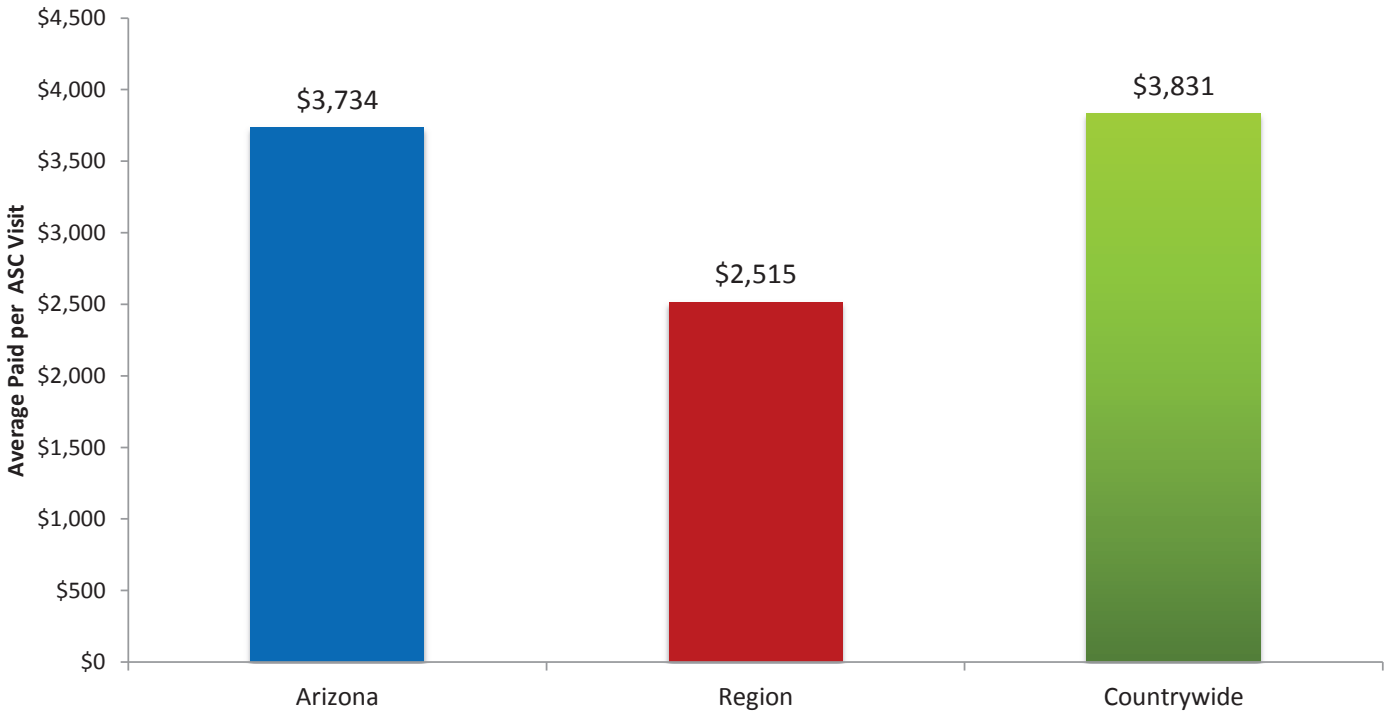
Code	Description
99281	Emergency department visit for the evaluation and management of a patient. Usually the presenting problem(s) are self limited or minor.
99282	Emergency department visit. Usually the presenting problem(s) are of low to moderate severity.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

Ambulatory surgical centers (ASC) are often used as an alternative facility to hospitals for conducting outpatient surgeries. One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. In Arizona, ASC payments for services provided in 2015 are, on average, 283% of Medicare scheduled reimbursement amounts.

Chart 32 displays the average paid amount per visit for ASC for Arizona as well as for 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 Visit for ASC Services

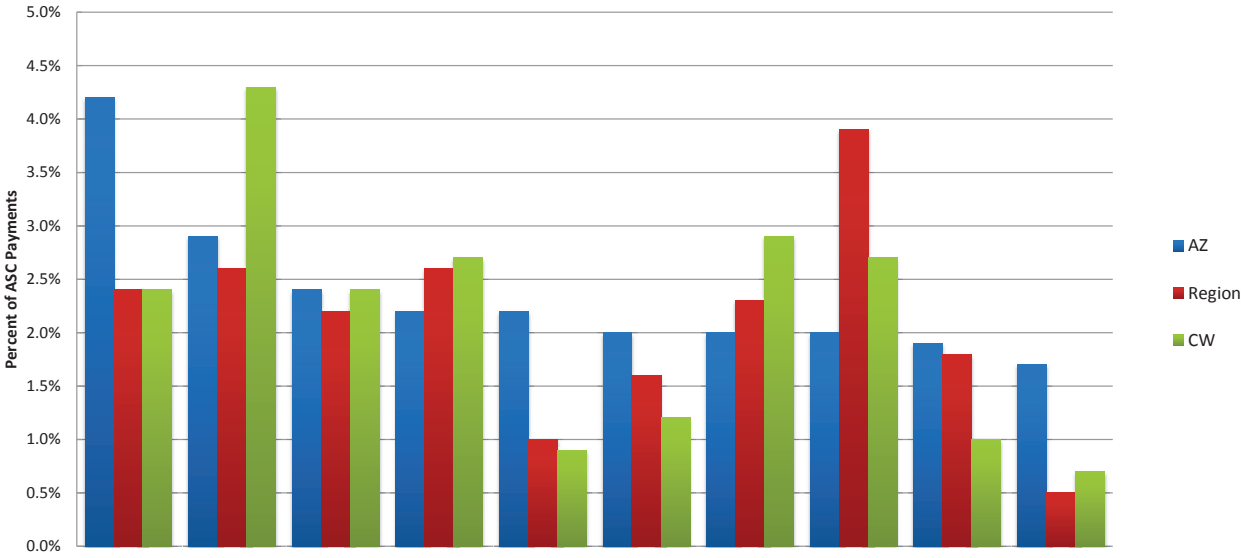


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 33 displays the top 10 diagnoses for ASC visits. The codes are ranked based on total payments in Arizona. A brief description of each code is displayed in the table below.

Chart 33

Top 10 Diagnoses for ASC Services for Arizona



Diagnosis Code		M54.1	S43.429A	M51.2	S83.2	T84	M54.5	M75	S43.80XA	K40.90	M48.06
Median Payment per ASC Visit	AZ	$980	$7,450	$1,036	$3,808	$4,049	$1,335	$1,843	$11,193	$4,778	$1,244
	Reg	$967	$4,743	$967	$2,938	$2,366	$958	$5,218	$6,706	$3,479	$967
	CW	$1,005	$7,510	$1,378	$3,230	$2,792	$967	$6,619	$8,791	$4,144	$1,230

Source: NCCI Medical Data Call, Service Year 2015. 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.

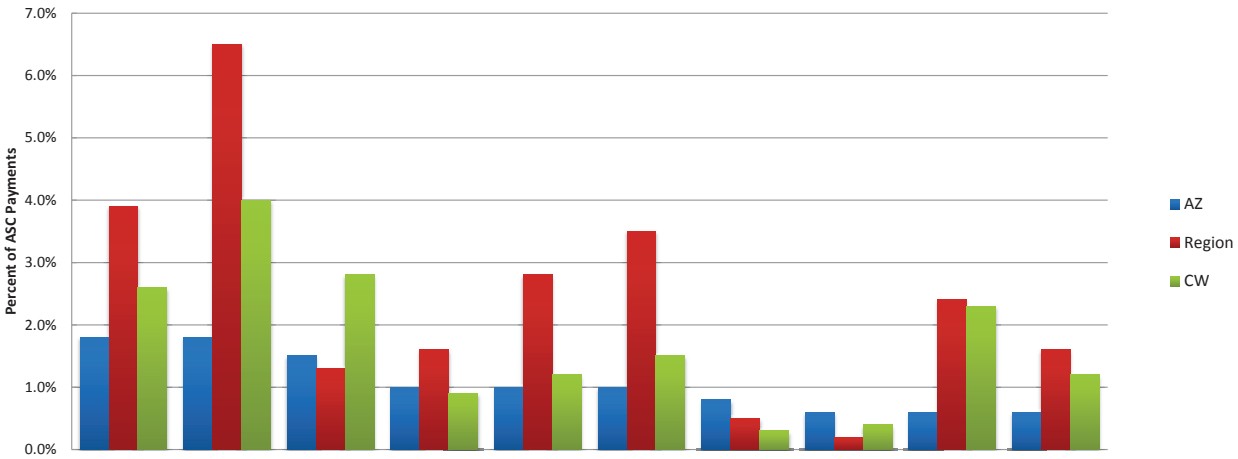
Code	% in AZ	Description
M54.1	4.2%	Radiculopathy
S43.429A	2.9%	Sprain of unspecified rotator cuff capsule, initial encounter
M51.2	2.4%	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
S83.2	2.2%	Tear of meniscus, current injury
T84	2.2%	Complications of internal orthopedic prosthetic devices, implants and grafts
M54.5	2.0%	Low back pain
M75	2.0%	Shoulder lesions
S43.80XA	2.0%	Sprain of other specified parts of unspecified shoulder girdle, initial encounter
K40.90	1.9%	Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
M48.06	1.7%	Spinal stenosis, lumbar region

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, code 0490 represents 97% of ASC payments reported by revenue codes.

Chart 34 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 34

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



Procedure Code		29881	29827	29826	20680	29888	64483	49505	22551	29824	29822
Average Payment per Transaction	AZ	$3,610	$5,753	$3,883	$3,446	$10,416	$979	$5,219	$66,291	$4,824	$3,301
	Reg	$2,382	$3,764	$1,798	$1,859	$5,604	$715	$2,564	$3,821	$2,914	$1,828
	CW	$3,230	$4,896	$3,778	$2,510	$6,500	$904	$3,896	$11,673	$3,787	$3,169

Source: NCCI Medical Data Call, Service Year 2015. 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	% in AZ	Description
29881	1.8%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29827	1.8%	Arthroscopy shoulder surgical; with rotator cuff repair
29826	1.5%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
20680	1.0%	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod or plate)
29888	1.0%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
64483	1.0%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
49505	0.8%	Repair initial inguinal hernia, age 5 years or older; reducible
22551	0.6%	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
29824	0.6%	Arthroscopy shoulder surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29822	0.6%	Arthroscopy shoulder surgical; debridement limited

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

Drugs are uniquely identified by a national drug code (NDC). Charts 35 through 40 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

Chart 35 displays the shares of the payments of prescription medication for the top 10 workers compensation drugs and whether the drugs are generic (G) or brand name (B). This method of ranking shows which drugs have the highest percentage share of payments. Also included is the amount paid per unit (PPU). (See Glossary for definition of unit.)

Chart 35

Top 10 Workers Compensation Drugs by Amount Paid for Arizona

Name of Drug	Type B/G	Category	% of Drug Payments	PPU Arizona	PPU Region	PPU Countrywide
Oxycontin®	B	Analgesics/Antipyretics	8.6%	$8.67	$6.77	$7.76
Lyrica®	B	Miscellaneous Central Nervous System Agents	5.3%	$5.57	$5.35	$5.54
Gabapentin	G	Anticonvulsants	3.6%	$1.36	$1.07	$1.25
Tramadol HCl	G	Analgesics/Antipyretics	3.3%	$1.48	$0.71	$1.21
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	3.3%	$1.73	$1.66	$1.83
Celecoxib	G	Analgesics/Antipyretics	3.0%	$5.45	$4.77	$5.24
Oxycodone HCl	G	Analgesics/Antipyretics	3.0%	$1.35	$1.01	$1.15
Meloxicam	G	Analgesics/Antipyretics	2.5%	$3.41	$2.78	$3.34
Duloxetine HCl	G	Psychotherapeutic Agents	2.3%	$5.40	$5.15	$5.41
Lidocaine	G	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	2.2%	$7.03	$6.24	$7.08

Top 10 Workers Compensation Drugs by Amount Paid for Countrywide

Name of Drug	Type B/G	Category	% of Drug Payments	PPU Arizona	PPU Region	PPU Countrywide
Lyrica®	B	Miscellaneous Central Nervous System Agents	6.1%	$5.57	$5.35	$5.54
Oxycontin®	B	Analgesics/Antipyretics	4.8%	$8.67	$6.77	$7.76
Gabapentin	G	Anticonvulsants	4.1%	$1.36	$1.07	$1.25
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	4.0%	$1.73	$1.66	$1.83
Meloxicam	G	Analgesics/Antipyretics	3.5%	$3.41	$2.78	$3.34
Tramadol HCl	G	Analgesics/Antipyretics	3.0%	$1.48	$0.71	$1.21
Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	2.8%	$0.64	$0.57	$0.61
Duloxetine HCl	G	Psychotherapeutic Agents	2.7%	$5.40	$5.15	$5.41
Celecoxib	G	Analgesics/Antipyretics	2.3%	$5.45	$4.77	$5.24
Lidocaine	G	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	2.2%	$7.03	$6.24	$7.08

Source: NCCI Medical Data Call, Service Year 2015. 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 36 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 (PPU).

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

Chart 36

Top 10 Workers Compensation Drugs by Prescription Counts for Arizona

Name of Drug	Type B/G	Category	% of Drug Prescriptions	PPU Arizona	PPU Region	PPU Countrywide
Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	7.8%	$0.64	$0.57	$0.61
Ibuprofen	G	Analgesics/Antipyretics	5.0%	$0.42	$0.53	$0.46
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	4.8%	$1.73	$1.66	$1.83
Tramadol HCl	G	Analgesics/Antipyretics	4.8%	$1.48	$0.71	$1.21
Cyclobenzaprine HCl	G	Muscle Relaxants, Skeletal	4.2%	$1.18	$0.94	$1.32
Oxycodone HCl	G	Analgesics/Antipyretics	3.8%	$1.35	$1.01	$1.15
Gabapentin	G	Anticonvulsants	3.7%	$1.36	$1.07	$1.25
Meloxicam	G	Analgesics/Antipyretics	2.7%	$3.41	$2.78	$3.34
Oxycontin®	B	Analgesics/Antipyretics	2.2%	$8.67	$6.77	$7.76
Lyrica®	B	Miscellaneous Central Nervous System Agents	2.0%	$5.57	$5.35	$5.54

Top 10 Workers Compensation Drugs by Prescription Counts for Countrywide

Name of Drug	Type B/G	Category	% of Drug Prescriptions	PPU Arizona	PPU Region	PPU Countrywide
Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	10.4%	$0.64	$0.57	$0.61
Tramadol HCl	G	Analgesics/Antipyretics	5.3%	$1.48	$0.71	$1.21
Cyclobenzaprine HCl	G	Muscle Relaxants, Skeletal	5.0%	$1.18	$0.94	$1.32
Oxycodone HCl-Acetaminophen	G	Analgesics/Antipyretics	4.7%	$1.73	$1.66	$1.83
Gabapentin	G	Anticonvulsants	4.5%	$1.36	$1.07	$1.25
Meloxicam	G	Analgesics/Antipyretics	3.9%	$3.41	$2.78	$3.34
Ibuprofen	G	Analgesics/Antipyretics	3.8%	$0.42	$0.53	$0.46
Oxycodone HCl	G	Analgesics/Antipyretics	2.6%	$1.35	$1.01	$1.15
Naproxen	G	Analgesics/Antipyretics	2.3%	$0.94	$0.93	$0.93
Lyrica®	B	Miscellaneous Central Nervous System Agents	2.1%	$5.57	$5.35	$5.54

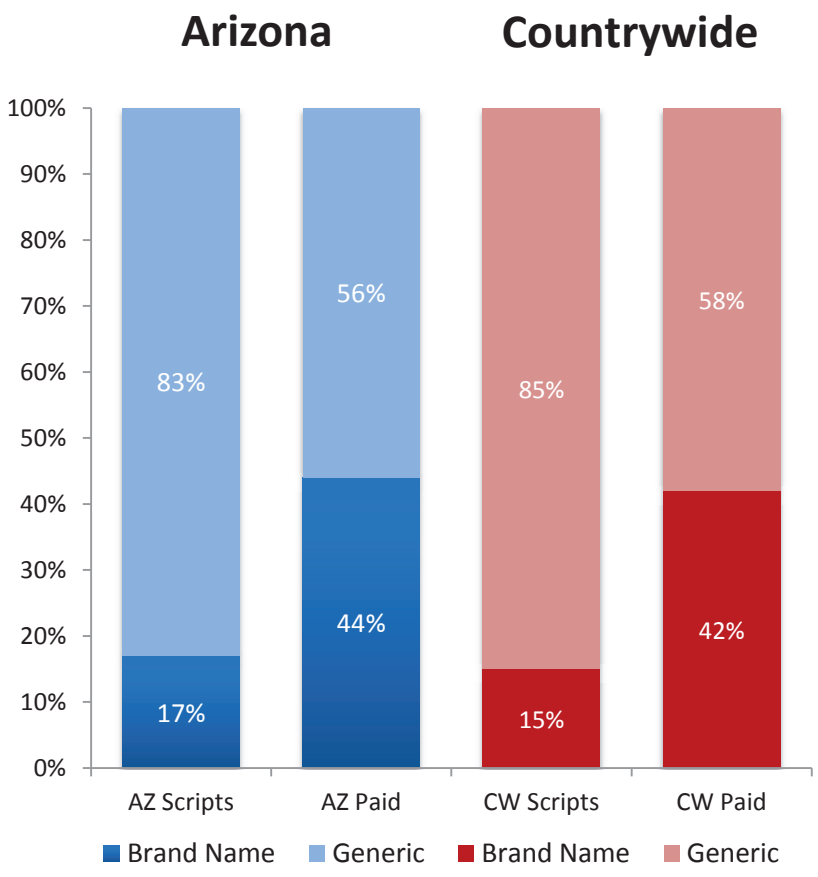
Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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

Chart 37 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 the prescription counts and the 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 for brand-name and generic drugs. The results in this chart are based only on transactions reported with an NDC.

Chart 37

Distribution of Drugs by Brand Name and Generic



Source: NCCI Medical Data Call, Service Year 2015. 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.

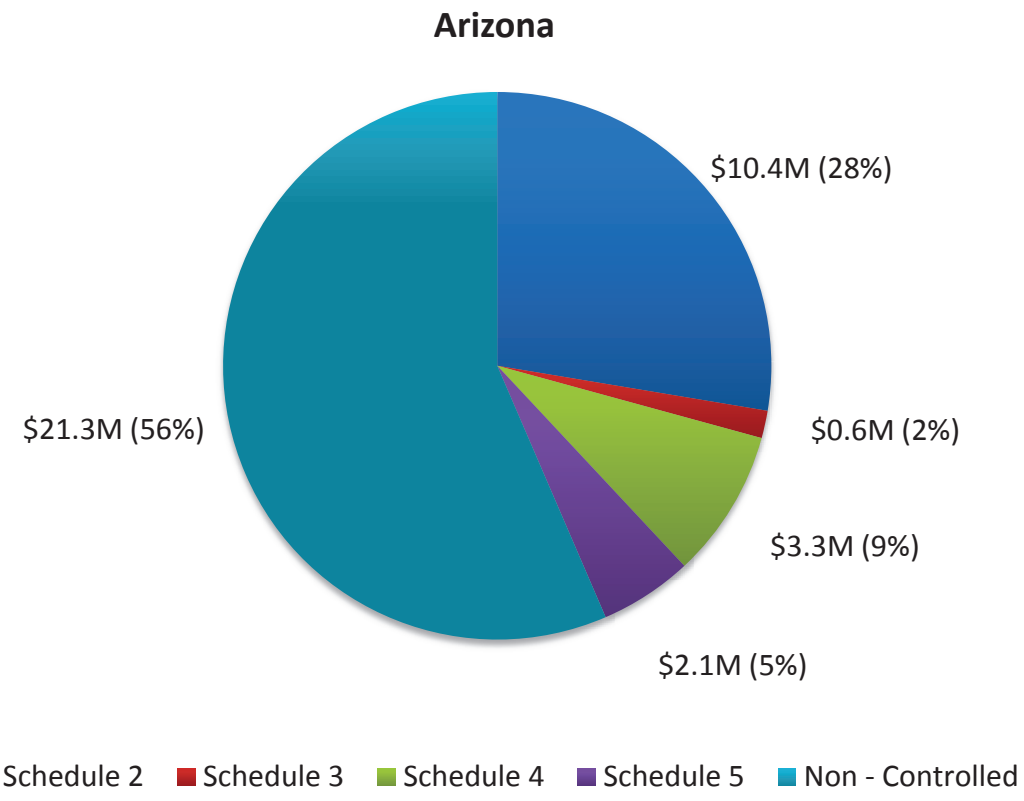
The share of claims observed in Service Year 2015 with at least one controlled substance in Arizona is 21%. This compares to the region and countrywide shares of 20% and 19% respectively.

According to NCCI's study, "Workers Compensation and Prescription Drugs: 2016 Update" (***Annual Issues Symposium***, May 2016), controlled substance prices increased 16% in 2014 while utilization was down 7%, resulting in an 8% increase in controlled substance costs countrywide. In 2015, Arizona spent $11M on opioids for workers compensation claims.

Chart 38 shows the distribution of prescription drug costs in Arizona by its CSA schedule (paid amounts shown in millions of dollars). Regional and countrywide distributions are also shown.

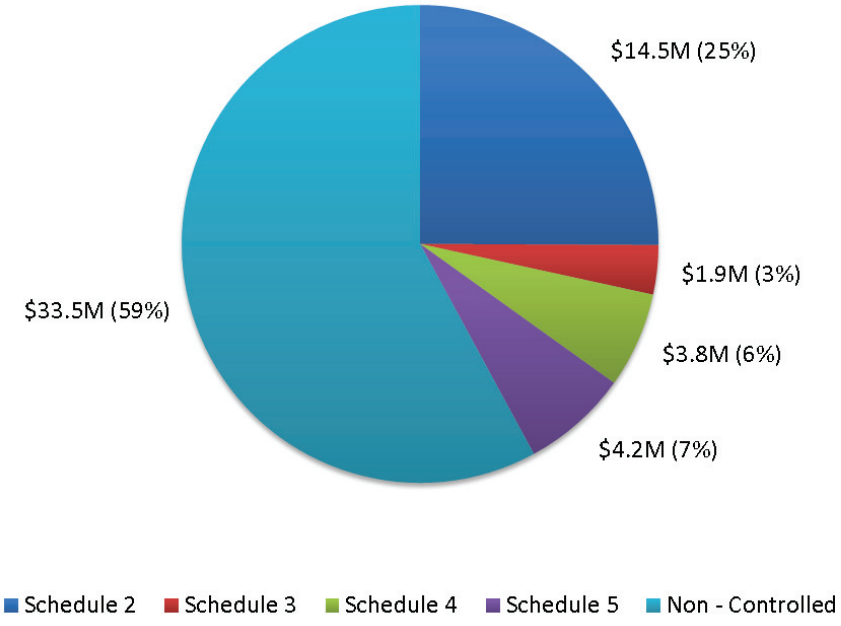
Chart 38

Distribution of Prescription Drug Costs by CSA Schedule

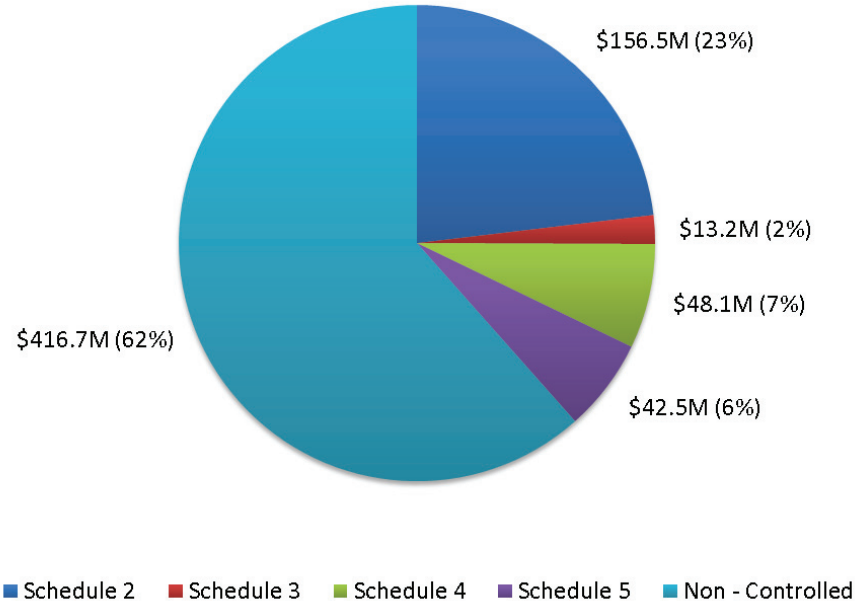


Distribution of Prescription Drug Costs by CSA Schedule (cont'd)

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2015. 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.

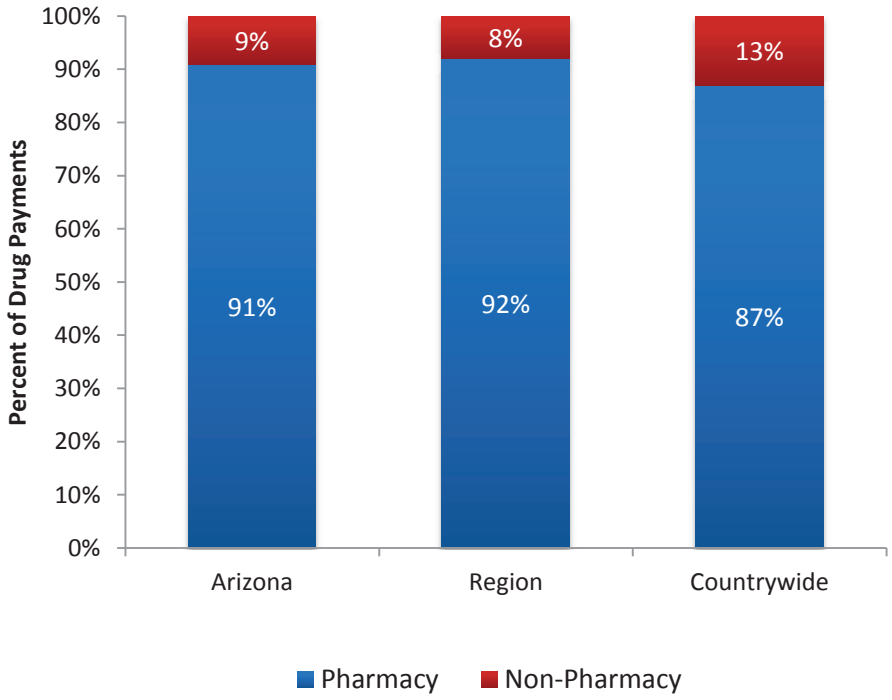
The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states place limits or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a non-pharmacy (e.g., physicians and hospitals) may provide insight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

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

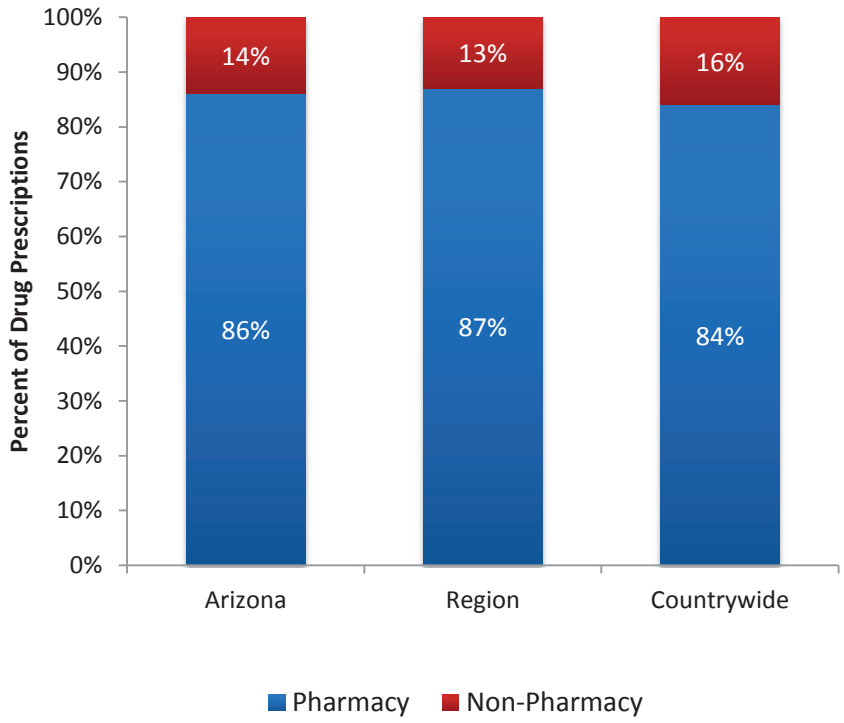
Chart 39 shows the distribution of prescription drugs dispensed by pharmacies and non-pharmacies. The share between pharmacy-dispensed and non-pharmacy-dispensed is displayed, based on both prescription counts and payments, for Arizona, the region, and the countrywide average. The results in this chart are based only on transactions reported with an NDC.

Chart 39

Distribution of Drugs by Pharmacy and Non-Pharmacy by Amount Paid



Distribution of Drugs by Pharmacy and Non-Pharmacy by Number of Prescriptions



Source: NCCI Medical Data Call, Service Year 2015. 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.

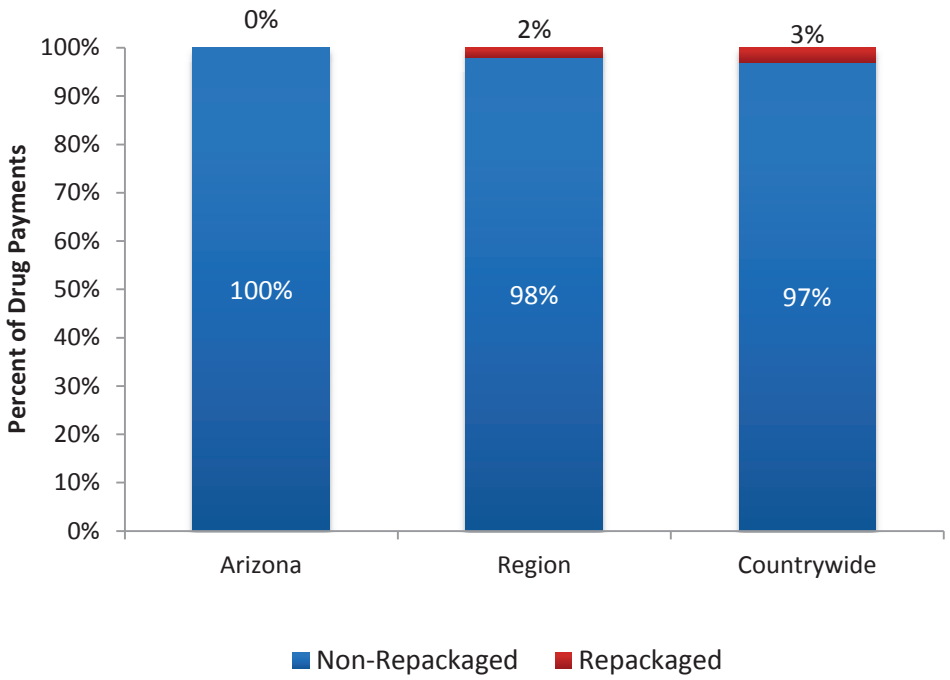
NDCs are specific not only to the product (including strength and formulation) and the package size but also to the labeler. Labelers are manufacturers, repackagers, and distributors.

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 40 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 40

Distribution of Drug Payments by Repackaged and Non-Repackaged

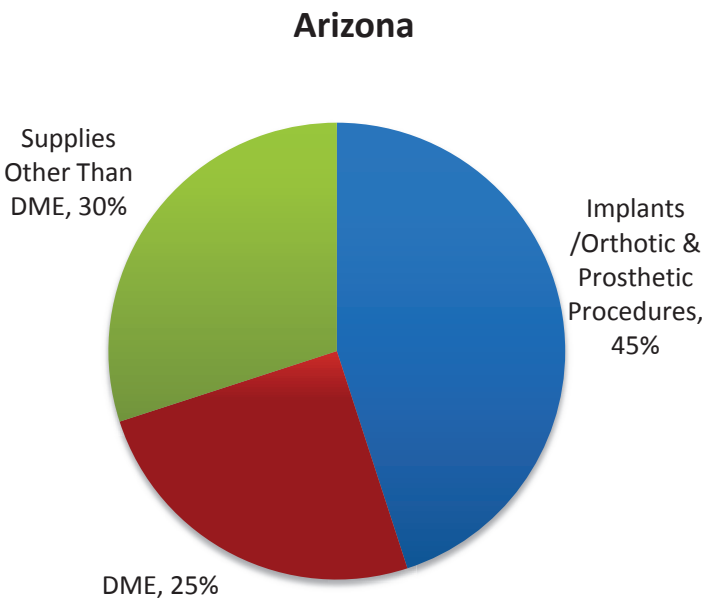


Source: NCCI Medical Data Call, Service Year 2015. Region includes CO, NV, NM, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 41 displays the distribution of payments separately by Implants/Orthotic and Prosthetic Procedures; Durable Medical Equipment (DME); and 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.

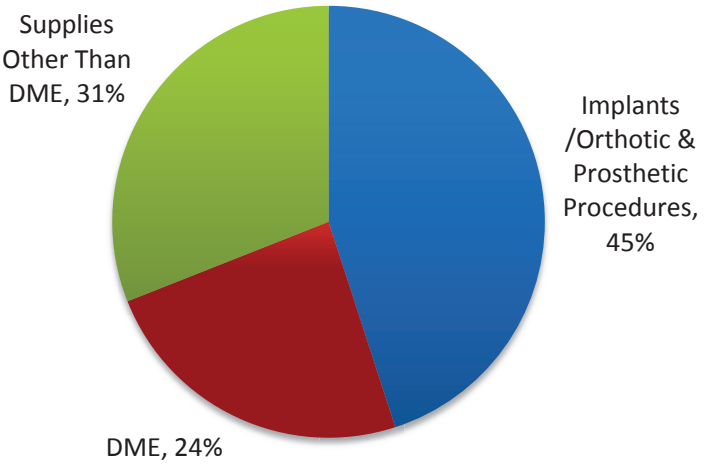
Chart 41

Distribution of Payments by DME, Supplies, and Implants

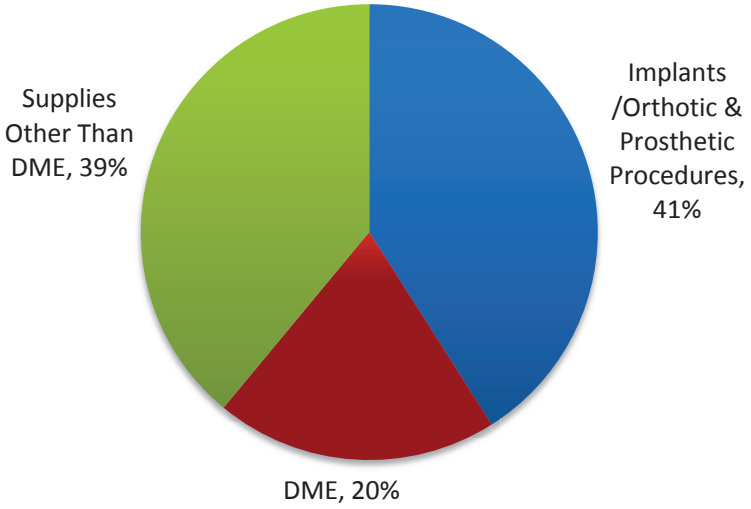


Distribution of Payments by DME, Supplies, and Implants (cont'd)

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2015. 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.

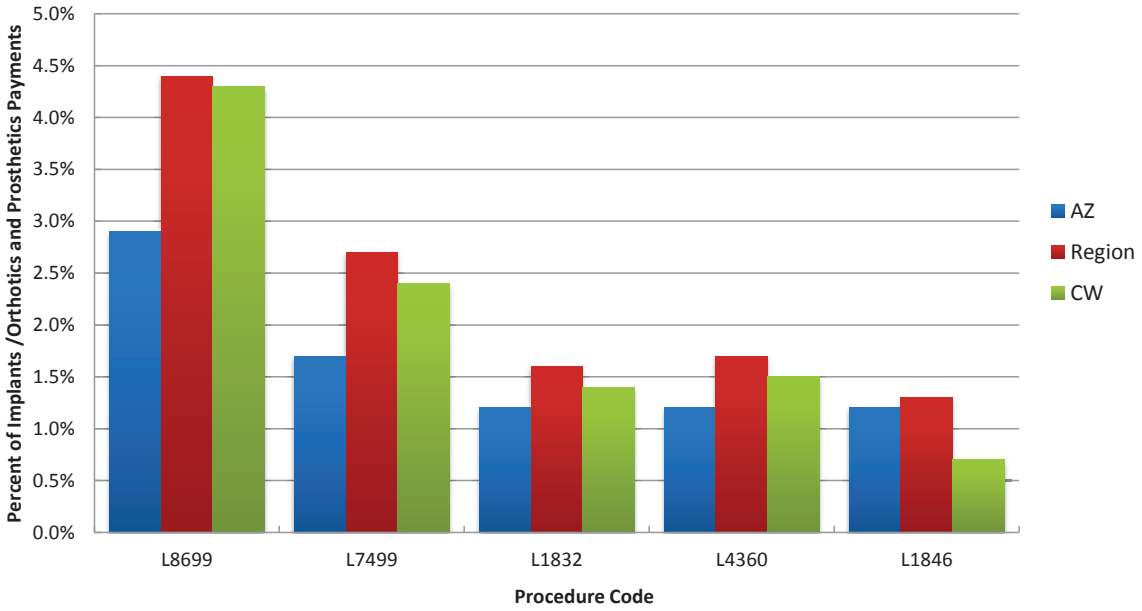
The most prevalent procedure code types reported for Implants/Orthotics and Prosthetics are HCPCS codes and revenue codes. Revenue codes represent 66% of Implants/Orthotic and Prosthetic payments, while HCPCS codes represent 34%.

The predominant revenue code reported for Implants/Orthotics and Prosthetics is 0278—Medical/Surgical Supplies: Other implants. In Arizona, payments for code 0278 represent 65% of Implants/Orthotic and Prosthetic payments.

Chart 42 displays the top 5 HCPCS procedure codes for Implants/Orthotic and Prosthetic Procedures. 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 42

Top 5 Implants/Orthotic and Prosthetic Codes by Amount Paid for Arizona



Source: NCCI Medical Data Call, Service Year 2015. 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.

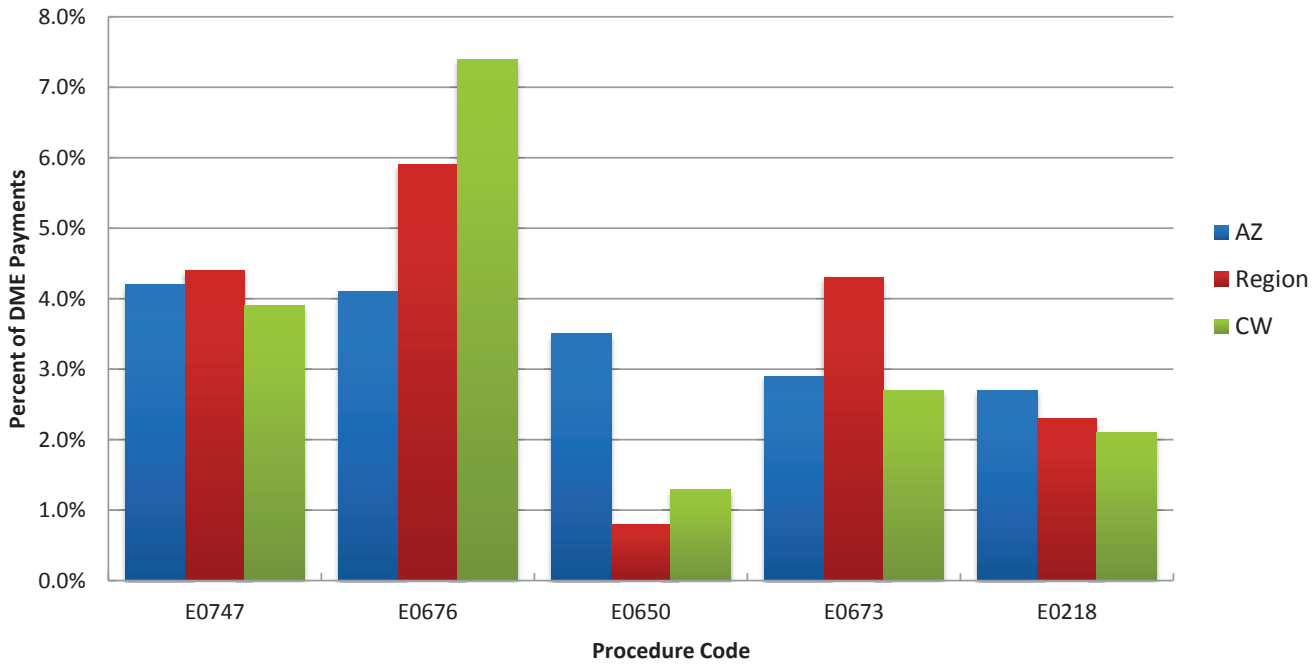
Code	% in AZ	Description
L8699	2.9%	Prosthetic implant, not otherwise specified
L7499	1.7%	Upper extremity prosthesis, not otherwise specified
L1832	1.2%	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L4360	1.2%	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L1846	1.2%	Knee orthotic, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated

The most prevalent procedure code types reported for DMEs are HCPCS codes. The predominant HCPCS code reported for DMEs is E1399—Durable Medical Equipment, Miscellaneous. In Arizona, the code E1399 represents 54% of DME payments.

Chart 43 displays the top 5 procedure codes for DME other than code E1399. The procedure codes are ranked based on total payments in Arizona. A brief description of each procedure code is displayed in the table below.

Chart 43

Top 5 DME Codes by Amount Paid for Arizona



Source: NCCI Medical Data Call, Service Year 2015. 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.

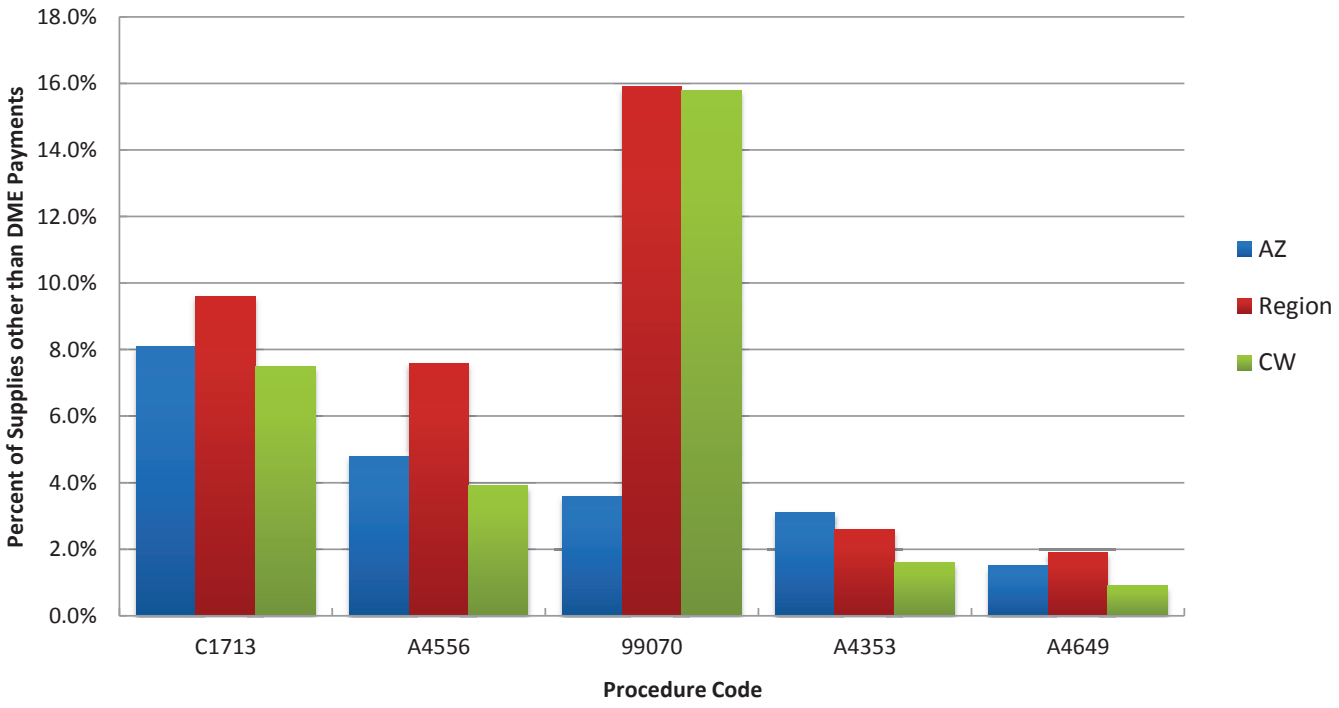
Code	% in AZ	Description
E0747	4.2%	Osteogenesis stimulator, electrical, noninvasive, other than spinal applications
E0676	4.1%	Intermittent limb compression device (includes all accessories), not otherwise specified
E0650	3.5%	Pneumatic compressor, nonsegmental home model
E0673	2.9%	Segmental gradient pressure pneumatic appliance, half leg
E0218	2.7%	Water circulating cold pad with pump

The most prevalent procedure code types reported for Supplies Other Than DME are HCPCS codes and revenue codes. HCPCS codes represent 42% of Supplies Other Than DME Payments, while revenue and other codes represent the other 58%.

Chart 44 displays the top 5 HCPCS codes for Supplies Other Than DME. The procedure codes are ranked based on total payments in Arizona. A brief description of each procedure code is displayed in the table below.

Chart 44

Top 5 Supplies Other Than DME Codes by Amount Paid for Arizona



Source: NCCI Medical Data Call, Service Year 2015. 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.

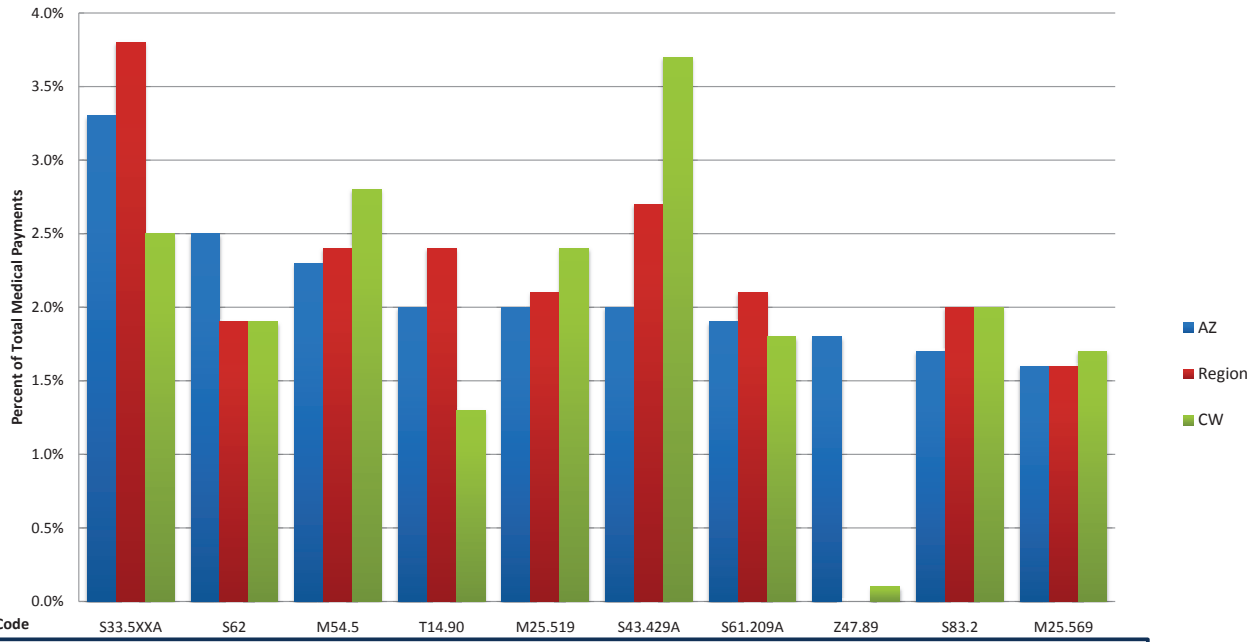
Code	% in AZ	Description
C1713	8.1%	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
A4556	4.8%	Electrodes (e.g., apnea monitor), per pair
99070	3.6%	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
A4353	3.1%	Intermittent urinary catheter, with insertion supplies
A4649	1.5%	Surgical supply; miscellaneous

Chart 45 displays the top 10 diagnoses, identified by the ICD-10 (International Classification of Diseases) codes. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 diagnosis codes are ranked by total claim payments for Arizona. This method of ranking shows which diagnostic codes have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2014, and December 31, 2014, and include all reported services provided for those claims through December 31, 2015. As these claims mature, the mix of ICD-10 codes may change, thus impacting the percentage share of payments for a specific code over time. This mix may also affect how costs per code in Arizona compare to countrywide costs. The state, region and countrywide average payments per claim are also displayed for each diagnostic code. A brief description of each diagnostic code is displayed in the table below the chart.

Chart 45

Top 10 ICD-10 Codes by Amount Paid for Dates of Injury in 2014 for Arizona



Diagnosis Code		S33.5XXA	S62	M54.5	T14.90	M25.519	S43.429A	S61.209A	Z47.89	S83.2	M25.569
Average Payment per Claim	AZ	$1,700	$6,407	$2,542	$4,105	$3,490	$16,520	$762	$245,010	$11,492	$2,380
	Reg	$1,942	$4,314	$2,613	$3,253	$3,448	$14,147	$701	$3,781	$10,709	$2,599
	CW	$1,711	$4,814	$2,888	$2,327	$3,648	$18,809	$815	$13,365	$11,658	$2,775

Source: NCCI Medical Data Call, Dates of Injury in 2014. 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	% in AZ	Description
S33.5XXA	3.3%	Sprain of ligaments of lumbar spine, initial encounter
S62	2.5%	Fracture at wrist and hand level
M54.5	2.3%	Low back pain
T14.90	2.0%	Injury, unspecified
M25.519	2.0%	Pain in unspecified shoulder
S43.429A	2.0%	Sprain of unspecified rotator cuff capsule, initial encounter
S61.209A	1.9%	Unspecified open wound of unspecified finger without damage to nail, initial encounter
Z47.89	1.8%	Encounter for other orthopedic aftercare
S83.2	1.7%	Tear of meniscus, current injury
M25.569	1.6%	Pain in unspecified knee

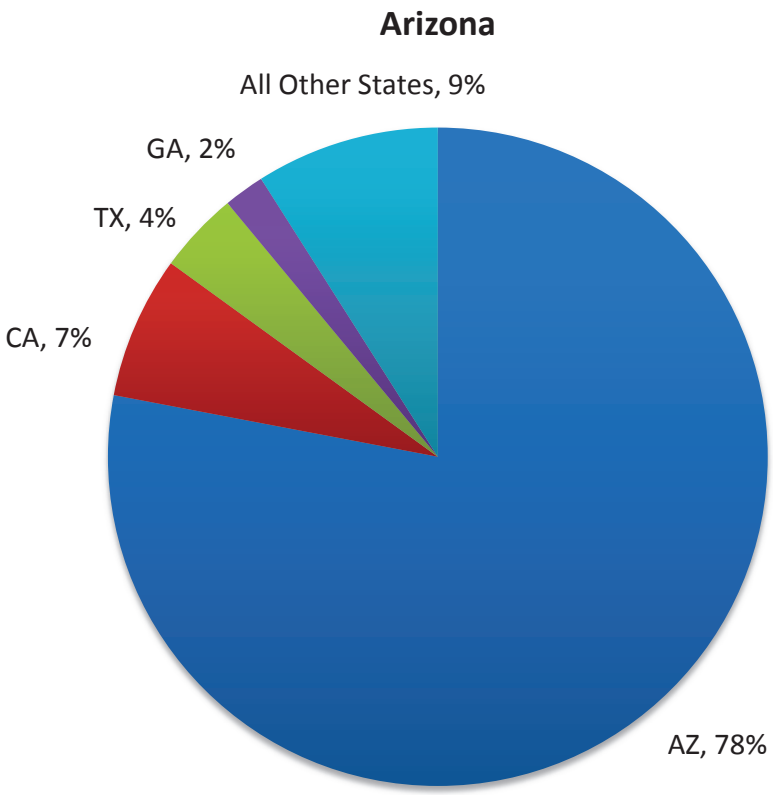
Medical benefit rules typically have different payment provisions for procedures performed in-state versus out-of-state.

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 46 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 76%.

Chart 46

Distribution of Physician and Facility Payments by Provider State



Source: NCCI Medical Data Call, Service Year 2015.

The table below shows the top 3 physicians and/or facility procedure codes for services provided in each of the top 3 states other than Arizona. The shares of out-of-state payments, as well as the average payment per transaction for in-state and out-of-state services, are also included.

Top 3 Procedures Performed in California by Amount Paid for Arizona

Code	Share of out of State Payments	Out of State Average Cost	In - State Average Cost	Description
0360	3.1%	$7,132	$7,168	Operating room services: General
0128	1.8%	$18,287	$13,324	Room & board-semiprivate (two beds): Rehabilitation
99214	1.4%	$126	$127	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.

Top 3 Procedures Performed in Texas by Amount Paid for Arizona

Code	Share of out of State Payments	Out of State Average Cost	In - State Average Cost	Description
0360	2.8%	$4,386	$7,168	Operating room services: General
0128	1.0%	$7,917	$13,324	Room & board-semiprivate (two beds): Rehabilitation
0450	0.9%	$539	$616	Emergency room: General

Top 3 Procedures Performed in Georgia by Amount Paid for Arizona

Code	Share of out of State Payments	Out of State Average Cost	In - State Average Cost	Description
97110	3.3%	$56	$66	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	0.9%	$42	$47	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction) 1 or more regions, each 15 minutes
97530	0.6%	$50	$53	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Source: NCCI Medical Data Call, Service Year 2015.

Comparison of Selected Distributions by Service Year

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

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

Distribution of Medical Payments for Arizona (Chart 4)

Medical Category	2011	2012	2013	2014	2015
Physician	33%	32%	34%	31%	33%
Hospital Outpatient	13%	13%	13%	14%	14%
Hospital Inpatient	15%	16%	15%	14%	16%
ASC	5%	5%	5%	6%	6%
Drugs	14%	14%	13%	14%	14%
DME, Supplies, and Implants	9%	10%	9%	8%	8%
All Other	11%	10%	11%	13%	9%

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

AMA Service Category	2011	2012	2013	2014	2015
Anesthesia	5%	4%	4%	3%	3%
Surgery	22%	23%	23%	22%	21%
Radiology	10%	10%	10%	10%	9%
Pathology	3%	3%	4%	3%	3%
Physical Medicine	29%	29%	27%	30%	31%
General Medicine	5%	5%	6%	4%	4%
Evaluation and Management	23%	24%	24%	26%	26%
All Other	3%	2%	2%	2%	3%

Distribution of Hospital Outpatient Payments by Surgery and Non-Surgery for Arizona

Visit Type	2011	2012	2013	2014	2015
Surgery	24%	23%	18%	21%	24%
Non-Surgery	76%	77%	82%	79%	76%

Distribution of Emergency Room Payments for Arizona (Chart 30)

Medical Category	2011	2012	2013	2014	2015
Physicians	13%	11%	11%	11%	10%
Facilities	67%	70%	72%	72%	74%
Drugs	6%	7%	5%	6%	6%
DME, Supplies, and Implants	6%	5%	5%	4%	4%
All Other	8%	7%	7%	7%	6%

Distribution of Drug Payments by Brand Name and Generic for Arizona (Chart 37)

Type of Drug	2011	2012	2013	2014	2015
Brand Name	54%	53%	52%	48%	44%
Generic	46%	47%	48%	52%	56%

Distribution of Drug Payments by Pharmacy and Non-Pharmacy for Arizona (Chart 39)

Type of Provider	2011	2012	2013	2014	2015
Pharmacy	93%	92%	92%	92%	91%
Non-pharmacy	7%	8%	8%	8%	9%

Distribution of Drug Payments by Repackaged and Non-Repackaged for Arizona (Chart 40)

Type of Drug	2011	2012	2013	2014	2015
Repackaged	3%	1%	1%	1%	0%
Non-repackaged	97%	99%	99%	99%	100%

Distribution of Payments by DME, Supplies, and Implants for Arizona (Chart 41)

Category	2011	2012	2013	2014	2015
Implants/Orthotic and Prosthetic Procedures	44%	41%	41%	45%	45%
DME	22%	28%	30%	26%	25%
Supplies Other Than DME	34%	31%	29%	29%	30%

Distribution of Payments by Provider State (Chart 46)

Category	2011	2012	2013	2014	2015
In-State	83%	82%	81%	79%	78%
Out of State	17%	18%	19%	21%	22%

Glossary

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

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

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

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

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

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.

Emergency Room Services: Services performed in a hospital for patients requiring immediate attention.

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

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

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

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

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

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

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

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

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

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

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

Transaction: A line item of a medical bill.

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

- For tablets, capsules, suppositories, 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 claimant may have more than one visit.

Appendix

The data contained in this report represents medical transactions for Service Year 2015 (medical services delivered from January 1, 2015, to December 31, 2015). Insurance carriers must report paid medical transactions if they write at least 1% of the market share in any one state for which NCCI is the advisory organization. Once a carrier meets the eligibility criteria, the carrier will be required to report for all applicable states in which it writes, even if an individual state's market share is below the threshold. All carriers within a group are required to report, regardless of whether they write less than 1% of the market share in the state.

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

For the state of Arizona in Service Year 2015, the reported number of transactions was more than 1,815,700, with more than $335,000,000 paid, for more than 71,800 claims, representing data from 94% of the workers compensation premium written, which includes experience for large-deductible policies. Lump-sum settlements are not required to be reported. Also, self-insured data is not included.

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

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

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

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