



Medical Data Report

For the state of

ARIZONA

September 2022



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Introduction

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

This publication is a data source for regulators and others who are interested in the driving forces behind changing medical costs in WC claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that underlie the financial soundness of the WC system. When making comparisons to the region and countrywide (CW), it is important to note that some states in this report do not have a fee schedule.

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

- Physician
- Hospital Outpatient
- Hospital Inpatient
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Other

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

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

The data contained in this report represents medical transactions for Service Year 2021 (medical services delivered from January 1, 2021, to December 31, 2021), except where otherwise noted. WC insurance carriers must report paid medical transactions if, over the most recent three years, they write at least 1% of the market share in any one state for which NCCI is the rating or advisory organization. Once a carrier meets the eligibility criteria, it is required to report for all applicable states in which it writes WC insurance. All carriers within an insurance group are required to report.

No data adjustments have been made for the reporting of COVID-19-related claims. For more information on the impacts of COVID-19 on medical losses, please see the Medical Indicators & Trends dashboard¹ on [ncci.com](https://www.ncci.com).

Changes made to this edition of the Medical Data Report include:

- The addition of Texas data for 2019 and beyond
- A revision to the definition of major surgery to include spine/spinal cord neurostimulators surgical procedures (previously categorized as nonmajor surgery)
- The American Medical Association (AMA) updates for some evaluation and management procedure codes (i.e., removal of code 99201 and revised severity and time phraseology for Codes 99202–99205 and 99211–99215)

¹ www.ncci.com/Articles/Pages/Insights-Medical-Indicators-Trends-Dashboard.aspx



For Arizona in Service Year 2021, the reported number of transactions was more than 1,368,100, with more than \$281,453,300 paid, for more than 61,600 claims. This represents data from 95% of the workers compensation premium written, which includes experience for large-deductible policies. Bulk payments and lump-sum settlements are not required to be reported. Also, self-insured data is not included.

Unless otherwise noted, the source for all data in this report is NCCI's Medical Data Call, Service Year 2021.

Also:

- Region includes data from the following states: AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT.
- Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV
- Texas data is included for Service Year 2019 and beyond

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



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Medical Cost Statistics

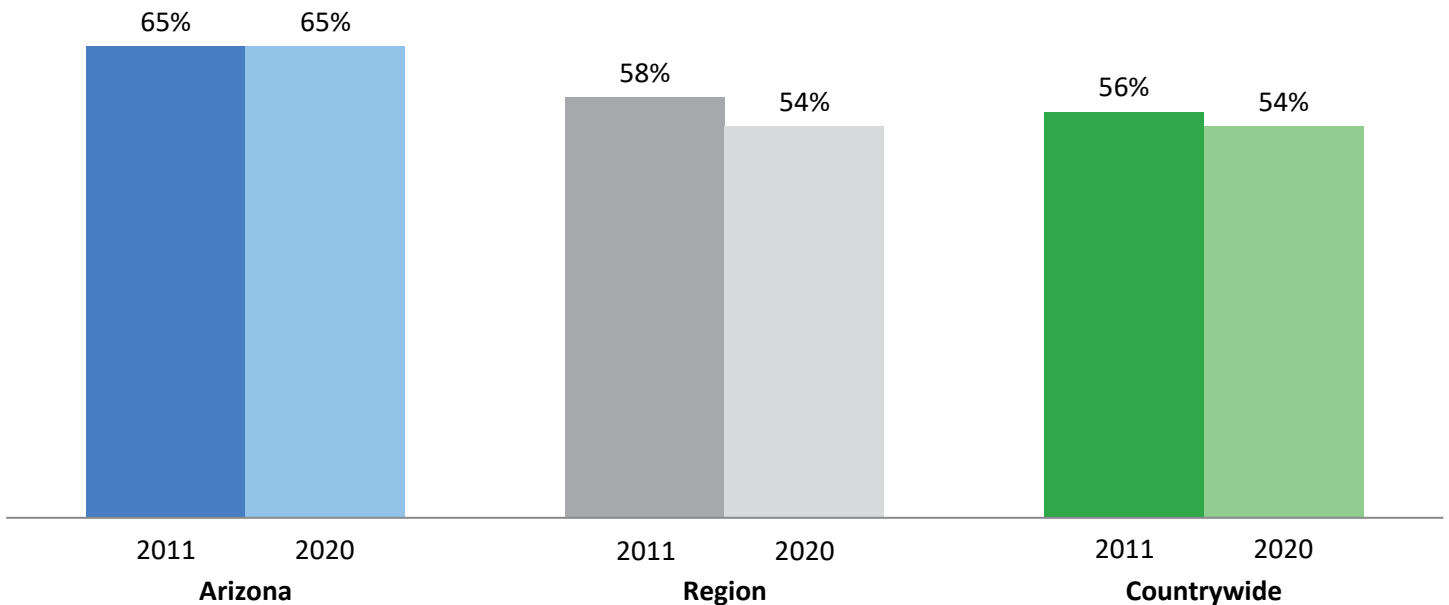
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

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

Chart 1 displays the medical percentage of total benefit costs for Arizona, the region, and countrywide for Accident Years 2011 and 2020.

Chart 1

Medical Share of Total Benefit Costs by Accident Year



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



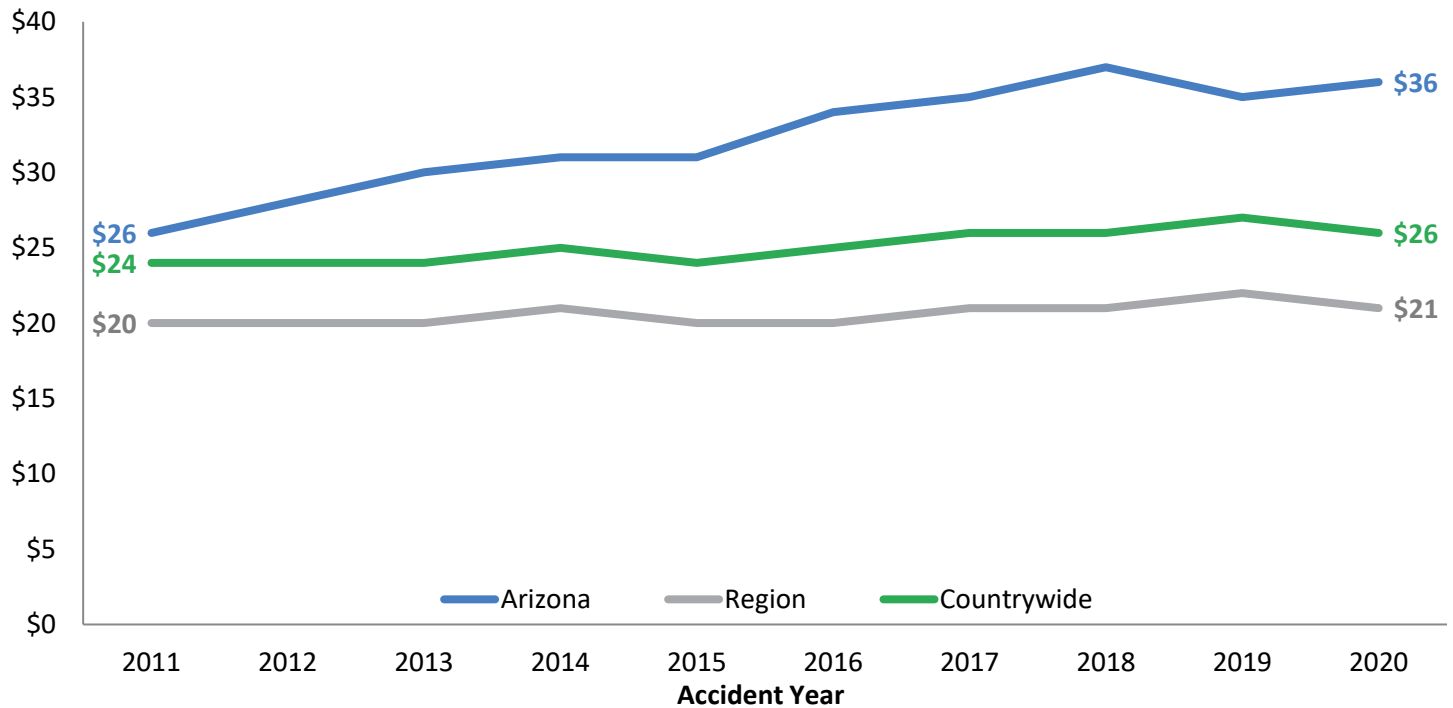
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging about 1% from Accident Years 2011 to 2020; this has increased at a slightly lower rate than the United States Personal Healthcare Spending per capita. ² Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for Arizona, the region, and countrywide.

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

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

Chart 2

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



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

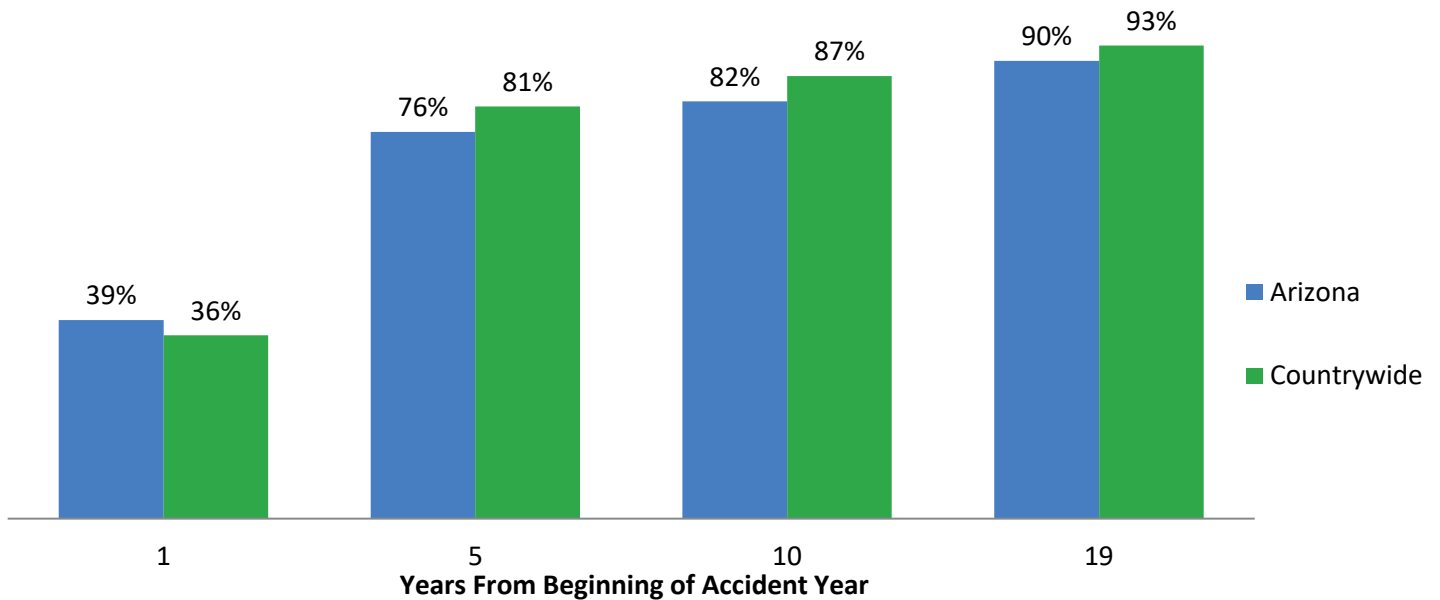
² State of the Line Report, Annual Issues Symposium, May 2022, www.ncci.com/Articles/Pages/AIS2022-SOTL-Presentation.pdf

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

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

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

Chart 3
Percentage of Medical Paid by Claim Maturity



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, and VT. The data for year 19 above does not include NV or TX.

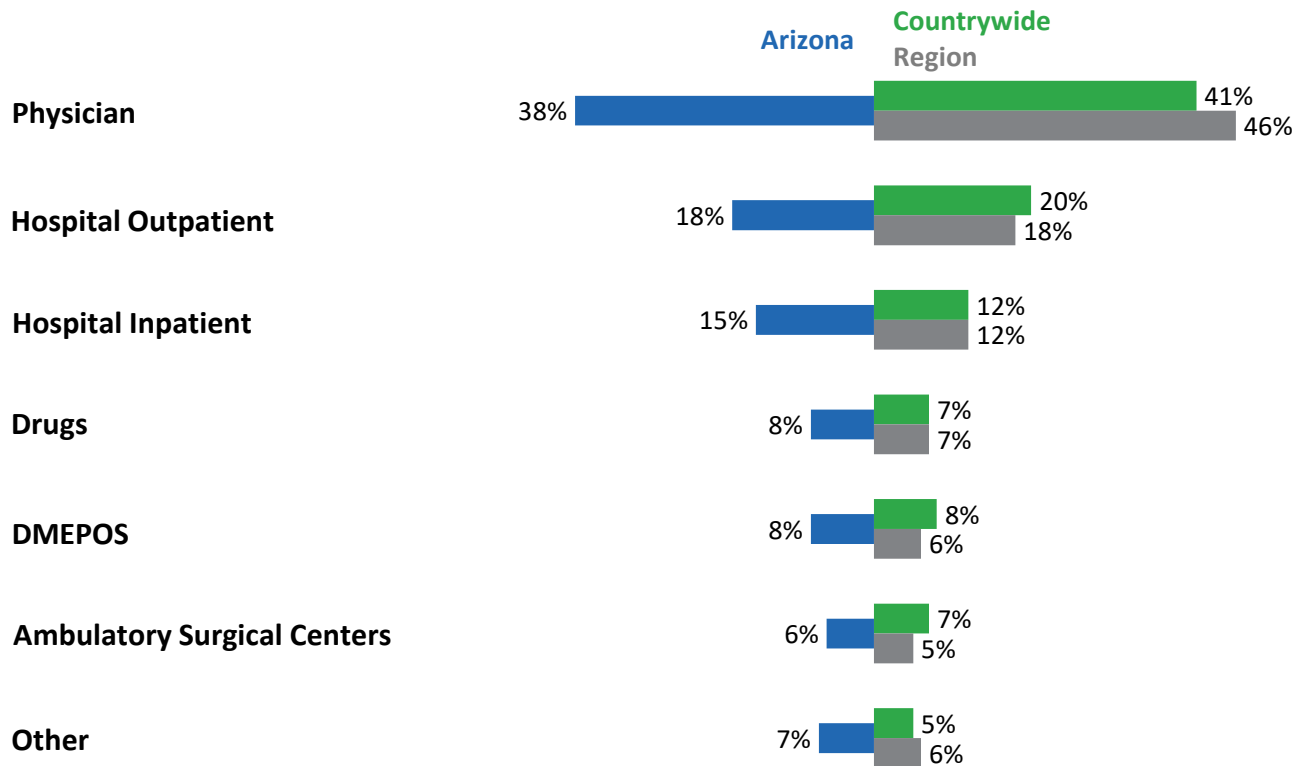
Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits.

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

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

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

Chart 4
Distribution of Medical Payments



Physicians

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

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

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

The chart below shows the average percentage of Medicare schedule reimbursement³ amounts for physician payments by category for Arizona, the region, and countrywide. Note that “all physician services” in Chart 5 below refers only to the categories listed in the chart, and the state comparison reflects Medicare’s geographic adjustments. In Arizona, 90% of “all physician services” payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

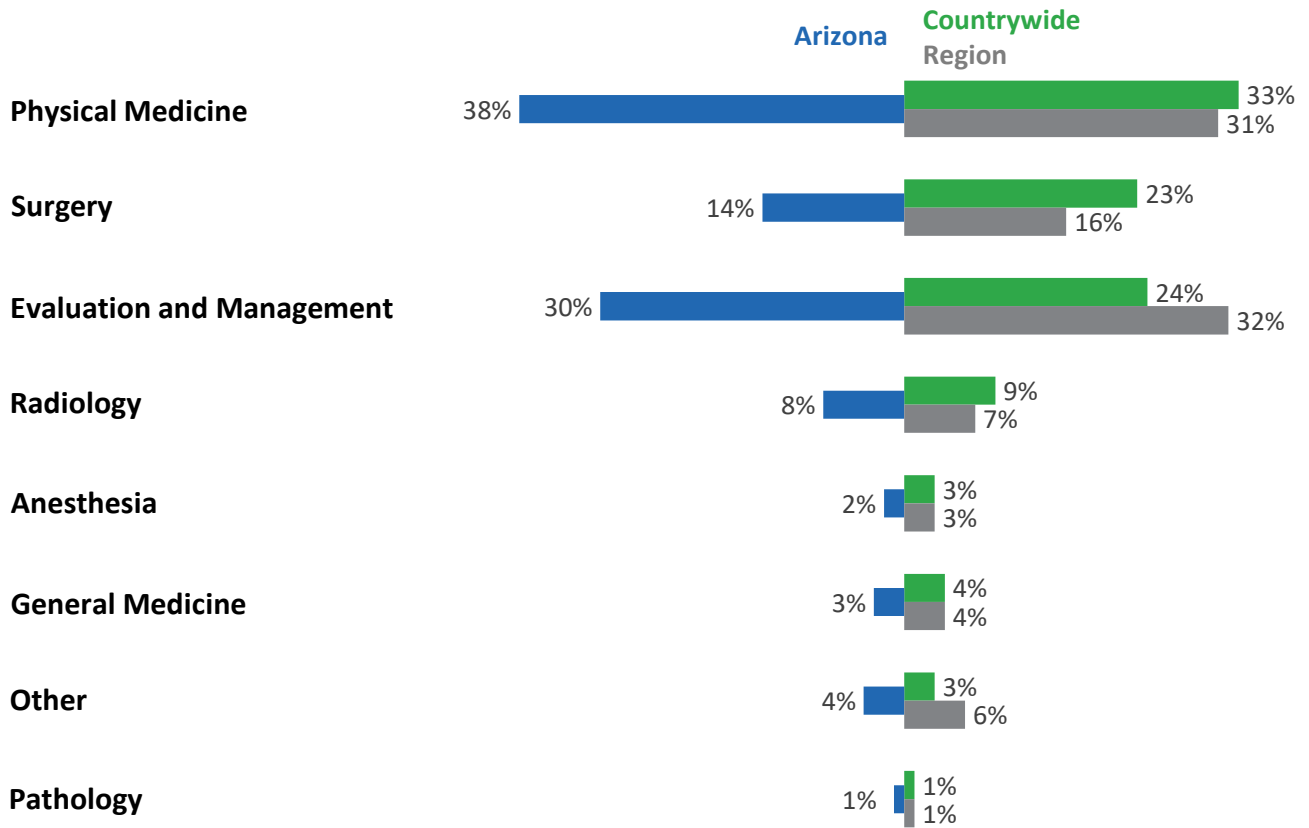
Physician Service Category	Arizona	Region	Countrywide
General and Physical Medicine	153%	138%	136%
Surgery	200%	211%	276%
Evaluation and Management	145%	147%	135%
Radiology	205%	199%	229%
Anesthesia	248%	264%	319%
All Physician Services	161%	157%	167%

³ The calculation for Surgery takes into account Medicare’s endoscopic procedures reimbursement rules.

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

Chart 6

Distribution of Physician Payments by AMA Service Category



In 2019, NCCI conducted a review of physician costs in workers compensation as compared to group health (GH). Results⁴ show that WC physician costs are 77% higher than GH in general, with variation across states ranging from 0% to 200%. The difference in costs for physician services is due to both prices and utilization of services. Most notably, physical medicine services in WC are almost three times the costs of physical medicine services in GH, largely due to the number of services provided.

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

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

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

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

Additional charts show time until first treatment and results for telemedicine services. Time to initial treatment (TTT) is a measure of the availability of medical services and is measured by the number of days between the date of injury and the date on which the worker first received medical services. Telemedicine services charts are based on transactions reported with a telemedicine-specific procedure code, modifier, or place of service and show the distribution, as well as the top 10 procedure codes, for telemedicine service.

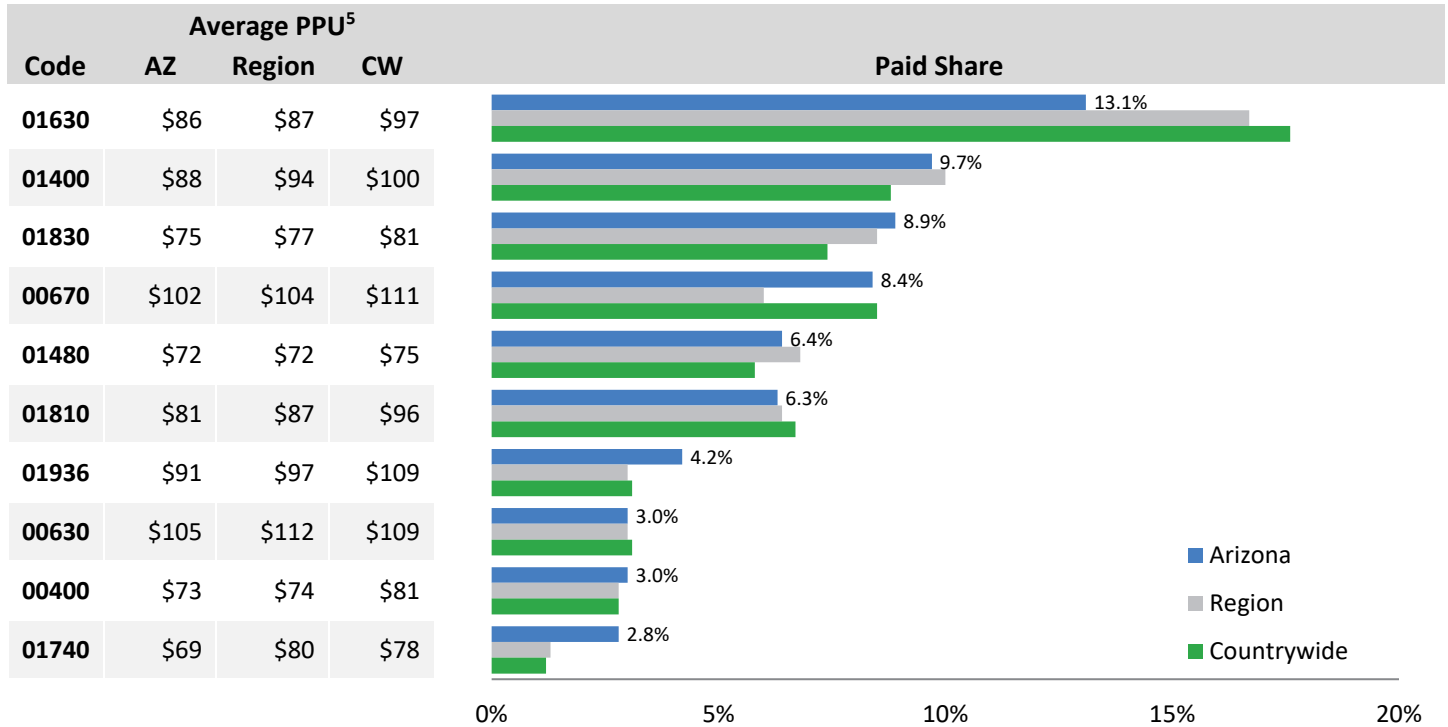
⁴ Lipton, Barry, *Work Comp vs. Group Health—The Price We Pay* (Channel NCCI, video file), May 23, 2019, www.youtube.com/watch?v=fb3tnbQoMSY



In Arizona, physician payments for anesthesia services provided in 2021 are, on average, 248% of Medicare-scheduled reimbursement amounts, compared to 264% in the region and 319% countrywide. Payments for these services comprise 2% of physician payments, compared to 3% in the region and 3% countrywide.

Chart 7

Top 10 Anesthesia Procedure Codes by Amount Paid



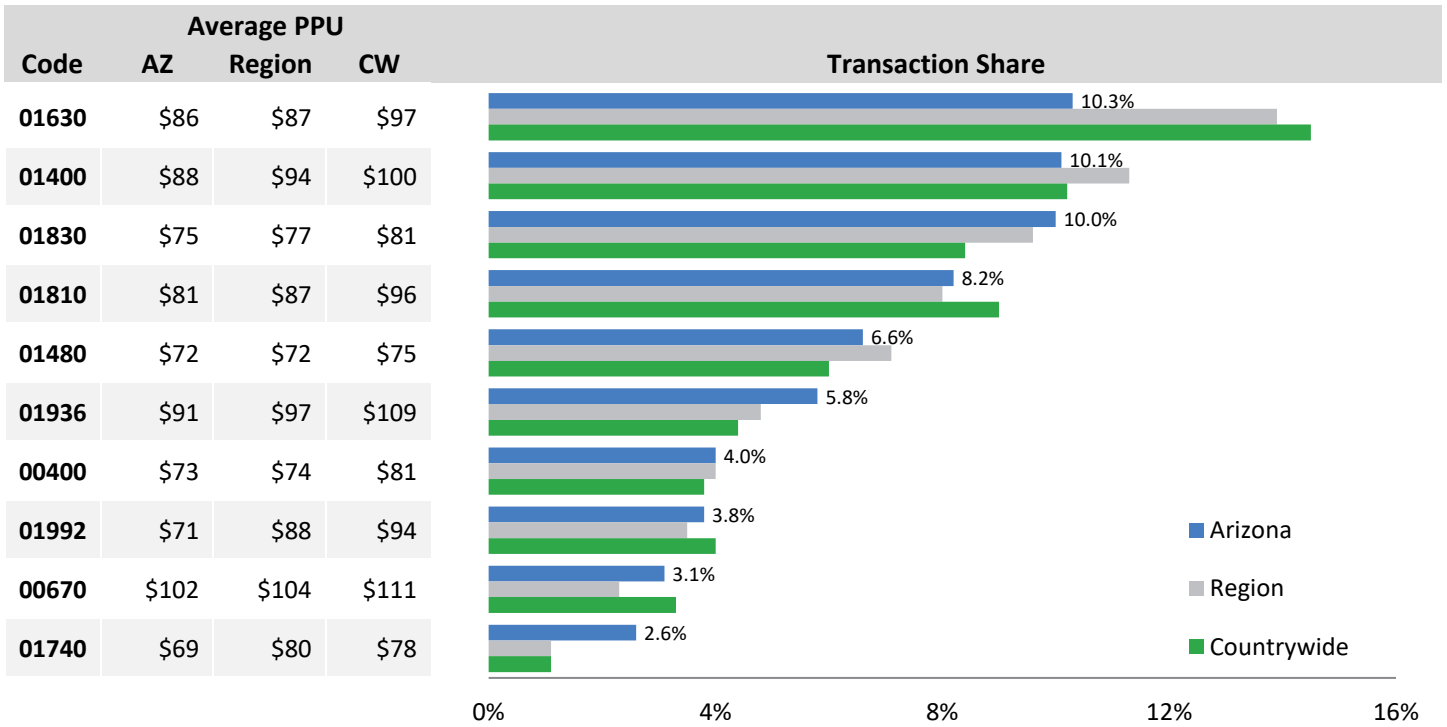
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
00630	Anesthesia for procedures in lumbar region; not otherwise specified
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified

⁵ A unit is an increment of 15 minutes unless otherwise defined in the description.



Chart 8

Top 10 Anesthesia Procedure Codes by Transaction Counts



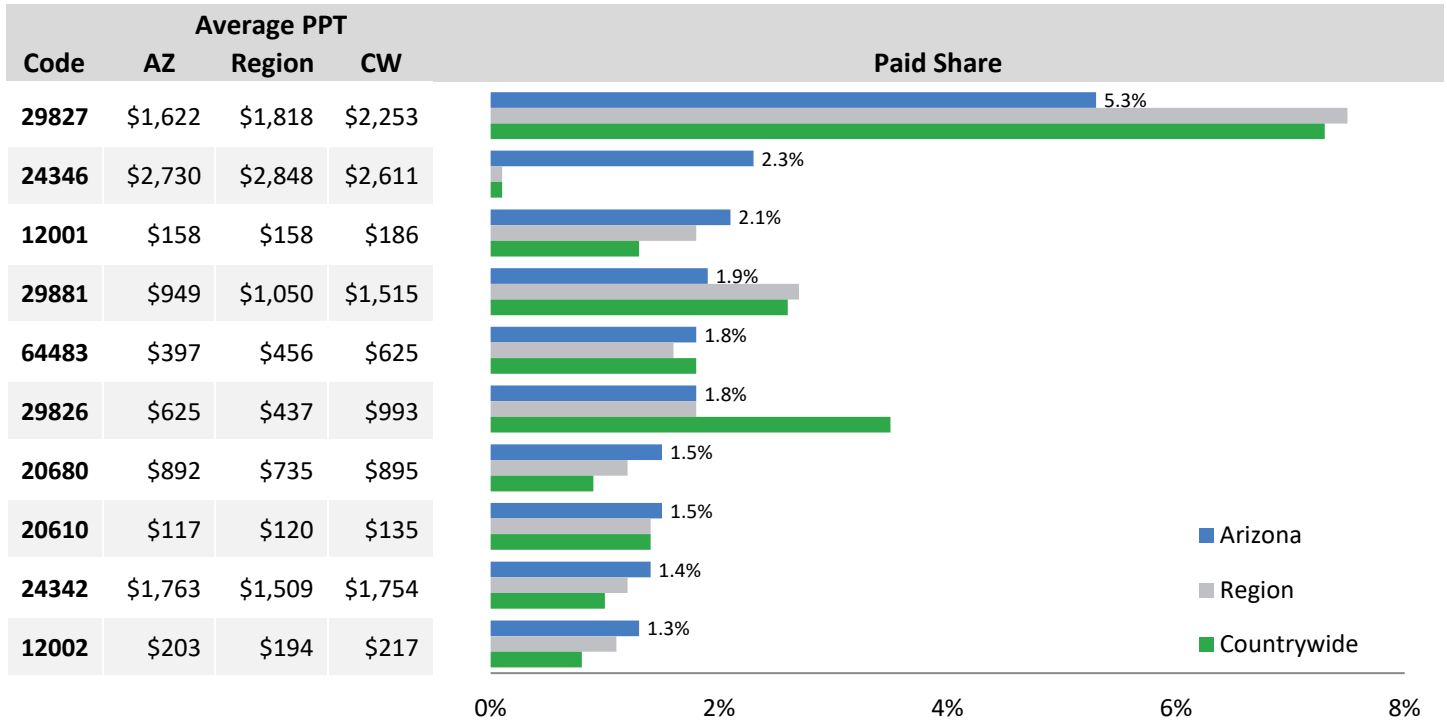
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified



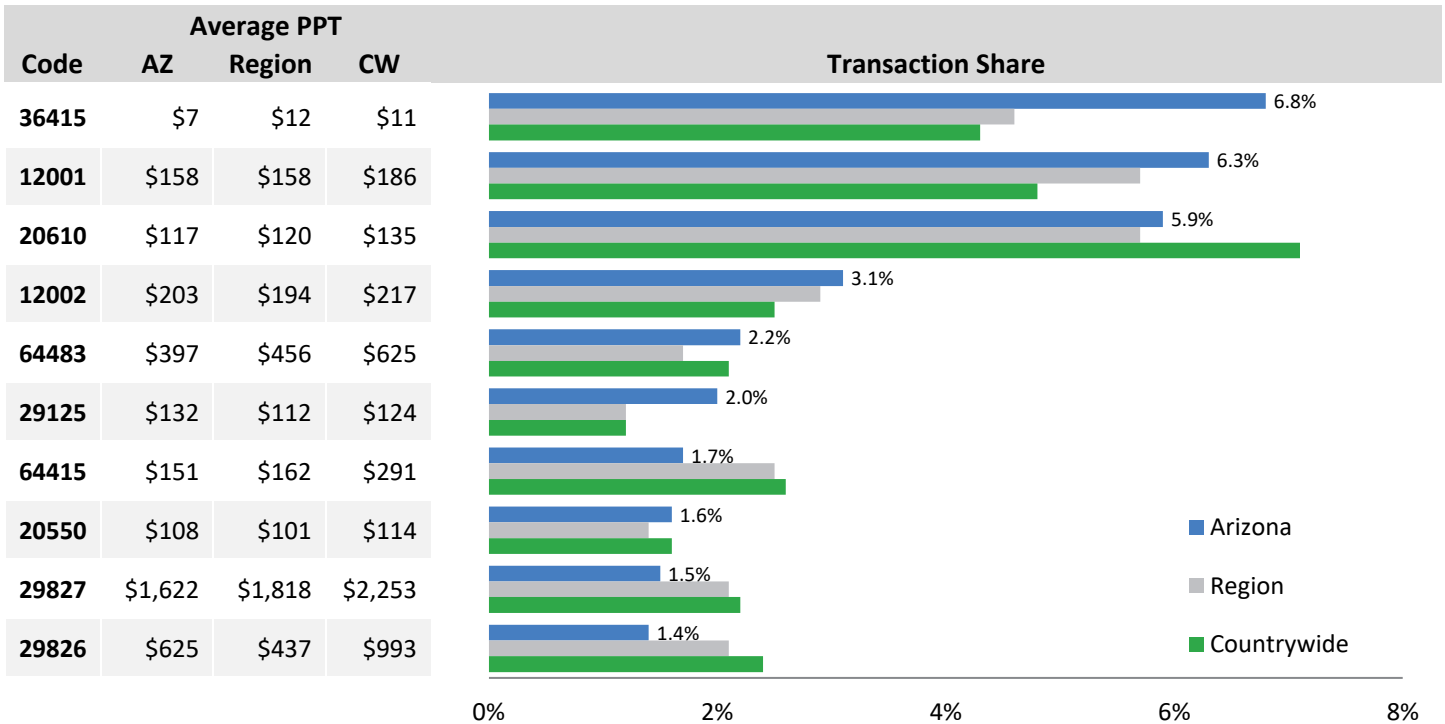
In Arizona, physician payments for surgery services provided in 2021 are, on average, 200% of Medicare-scheduled reimbursement amounts, compared to 211% in the region and 276% countrywide. Payments for these services comprise 14% of physician payments, compared to 16% in the region and 23% countrywide.

Chart 9

Top 10 Surgery Procedure Codes by Amount Paid



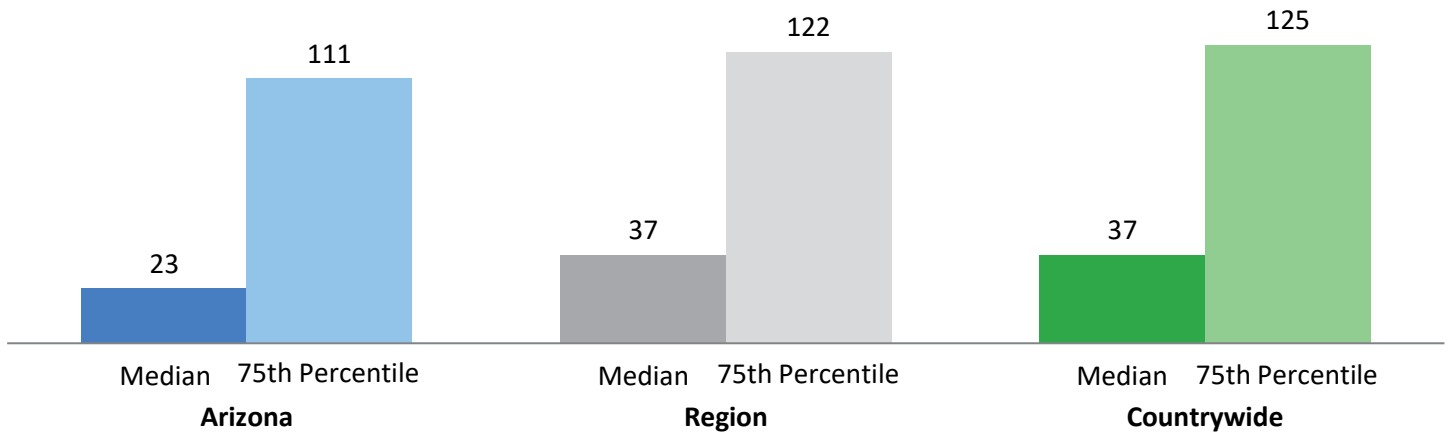
Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
24346	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

Chart 10
Top 10 Surgery Procedure Codes by Transaction Counts


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

Chart 11 shows the median and 75th percentile⁶ time until first treatment for major surgery for Arizona, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop such as an occupational disease, which may extend the time between the date a work-related injury or disease is reported and the first medical treatment takes place.

Chart 11
Time Until First Treatment for Major Surgery⁷ (in Days)



Source: NCCI’s Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

⁶ The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 11 indicates that out of 100 claimants, 75 will receive a major surgery within 111 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

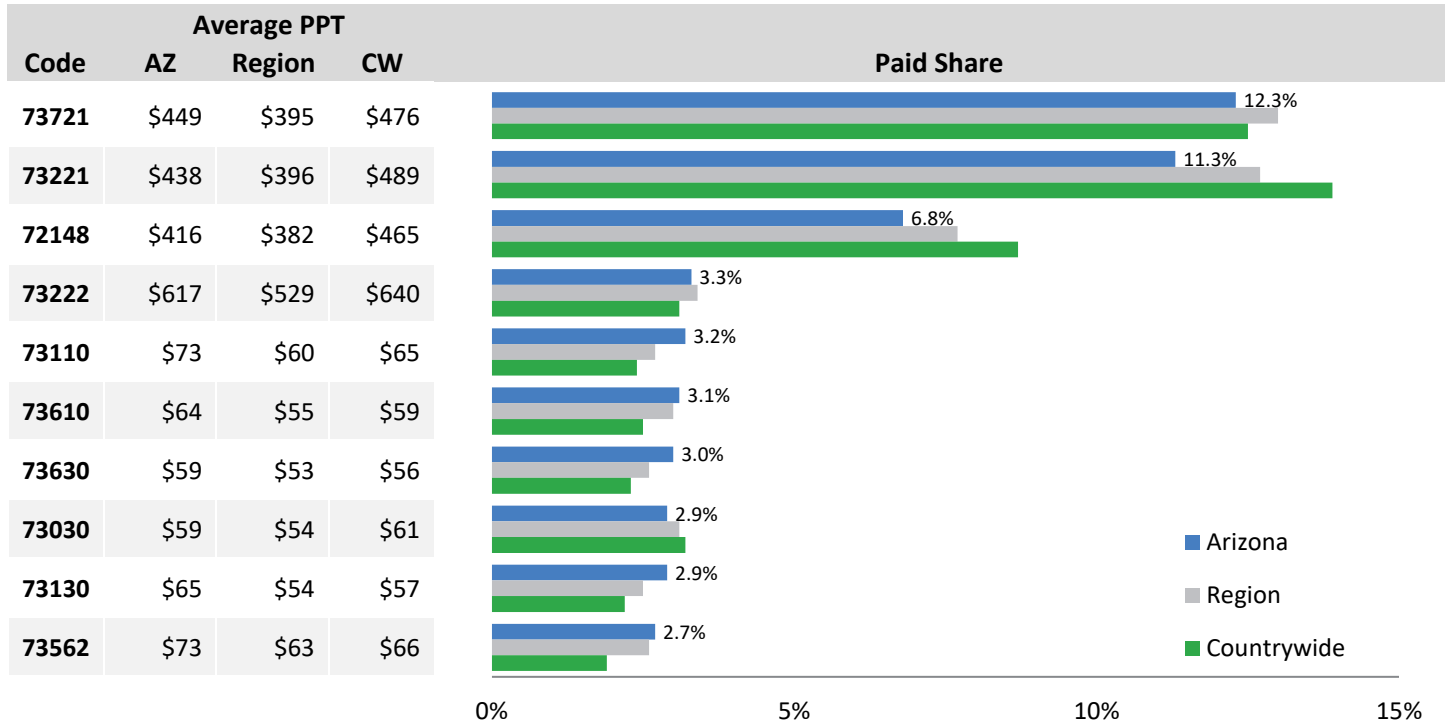
⁷ A service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, or the procedure involves spine/spinal cord neurostimulators.



In Arizona, physician payments for radiology services provided in 2021 are, on average, 205% of Medicare-scheduled reimbursement amounts, compared to 199% in the region and 229% countrywide. Payments for these services comprise 8% of physician payments, compared to 7% in the region and 9% countrywide.

Chart 12

Top 10 Radiology Procedure Codes by Amount Paid

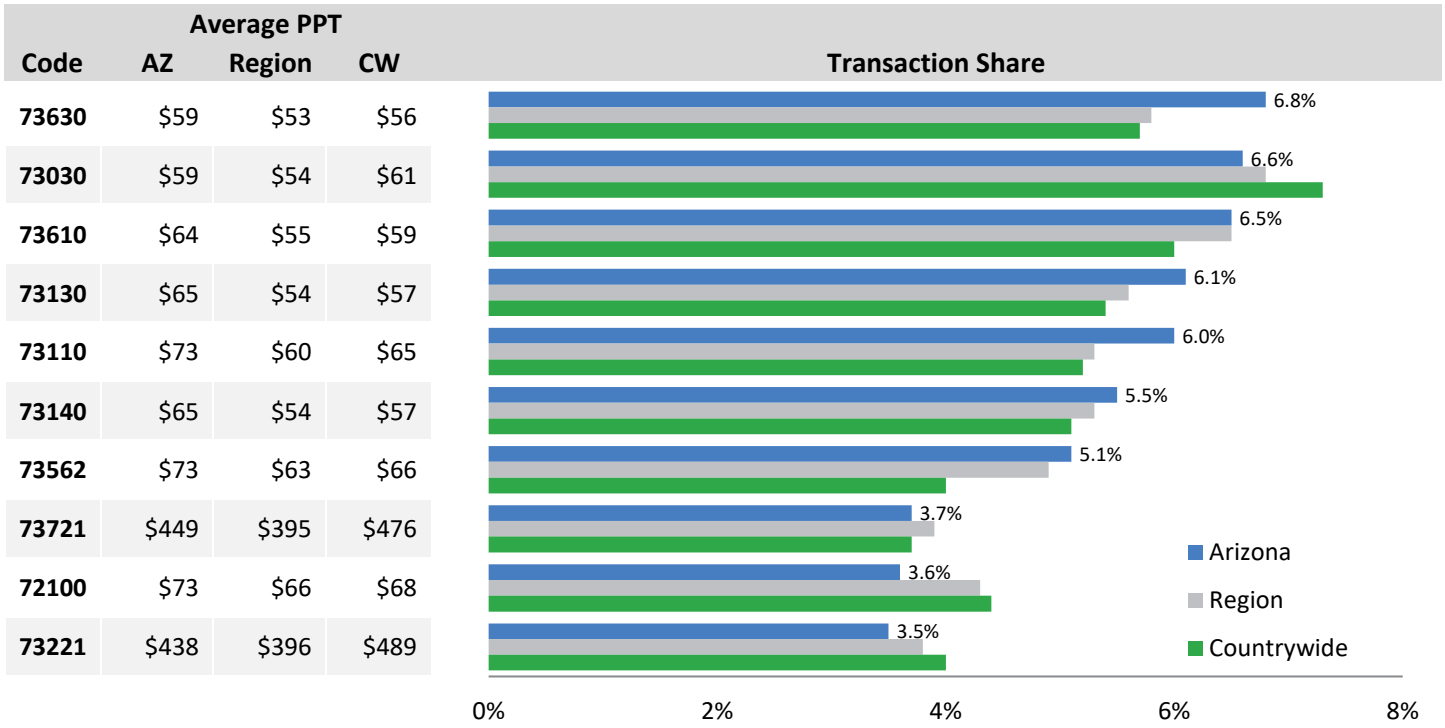


Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
73110	Radiologic examination, wrist; complete minimum of 3 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73630	Radiologic examination, foot; complete minimum of 3 views
73030	Radiologic examination, shoulder; complete minimum of 2 views
73130	Radiologic examination, hand; minimum of 3 views
73562	Radiologic examination, knee; 3 views



Chart 13

Top 10 Radiology Procedure Codes by Transaction Counts



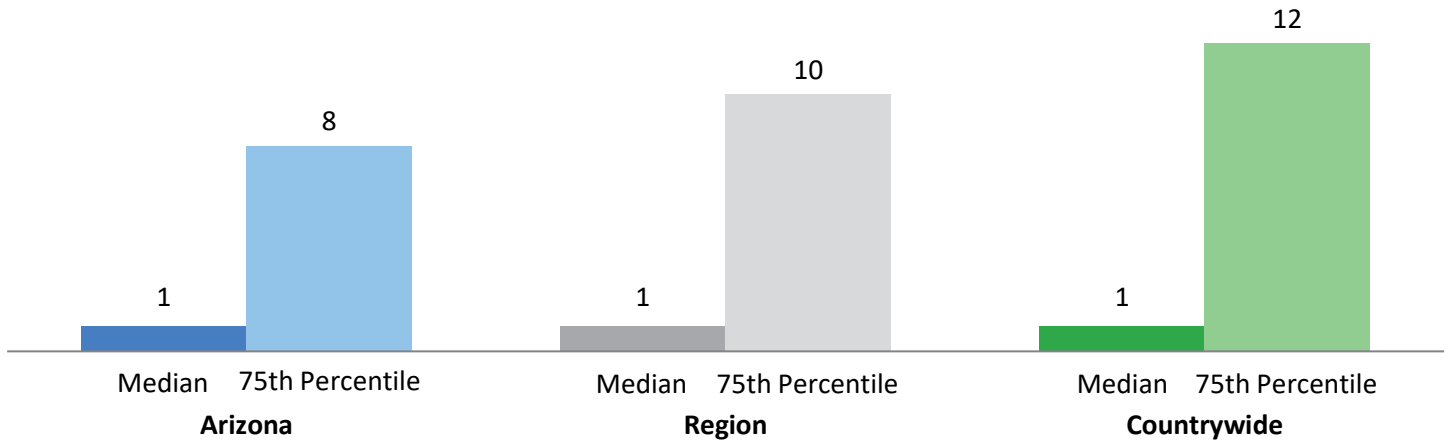
Code	Description
73630	Radiologic examination, foot; complete minimum of 3 views
73030	Radiologic examination, shoulder; complete minimum of 2 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73130	Radiologic examination, hand; minimum of 3 views
73110	Radiologic examination, wrist;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



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

Chart 14

Time Until First Treatment for Radiology (in Days)



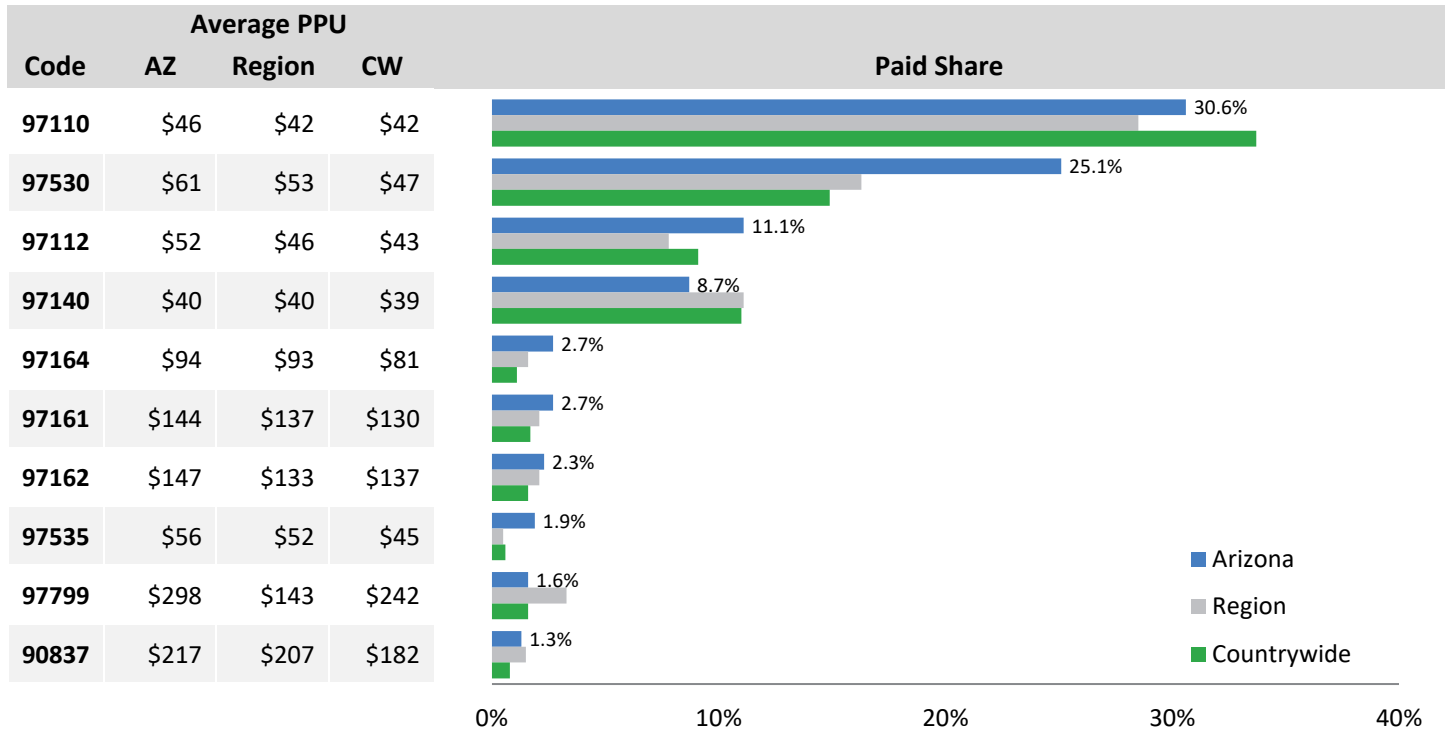
Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.



In Arizona, physician payments for physical and general medicine services provided in 2021 are, on average, 153% of Medicare-scheduled reimbursement amounts, compared to 138% in the region and 136% countrywide. Payments for these services comprise 41% of physician payments, compared to 35% in the region and 37% countrywide.

Chart 15

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

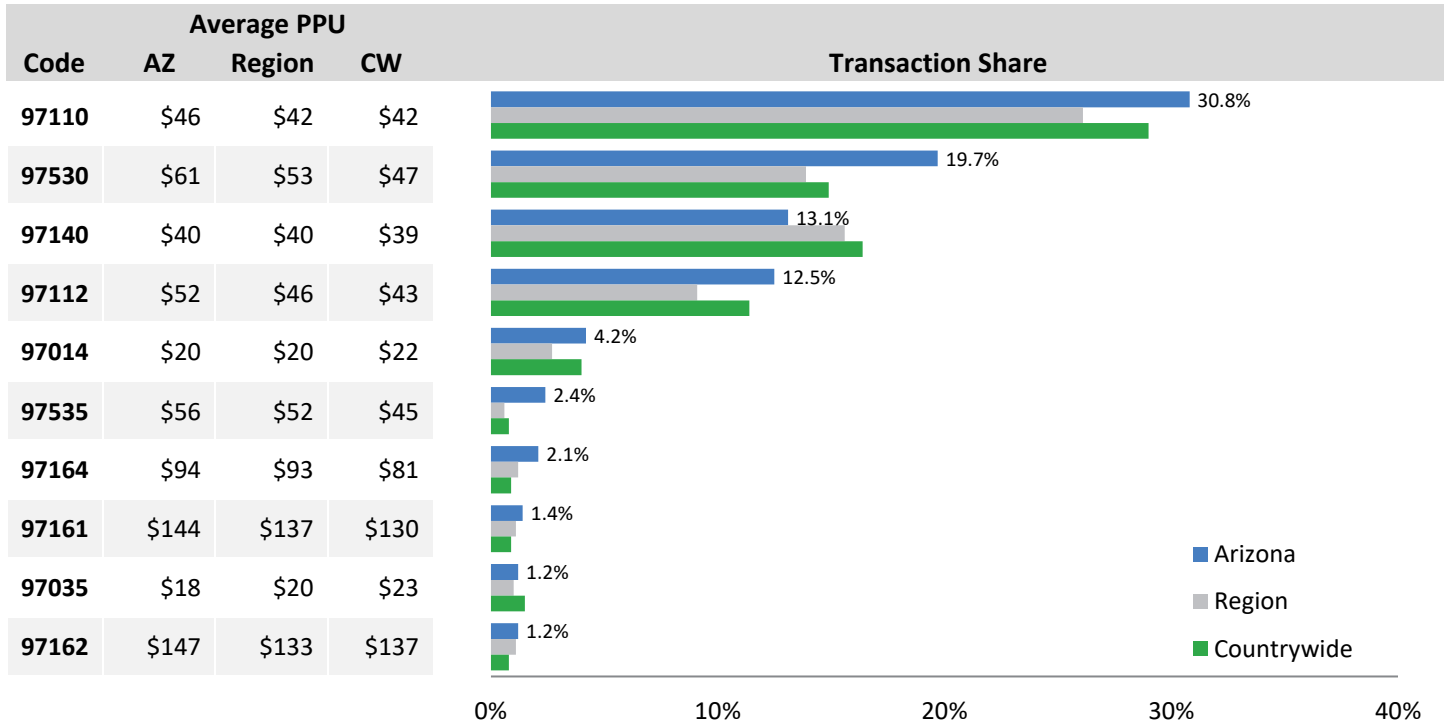


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97164	Re-evaluation of physical therapy and established plan of care; requires an examination with review of history and use of standardized tests and measures; revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome; 20 minutes face-to-face with patient and/or family
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
97162	Physical therapy evaluation of moderate complexity; typically, 30 minutes are spent with the patient and/or family
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
97799	Unlisted physical medicine/rehabilitation service or procedure
90837	Psychotherapy, 60 minutes with patient



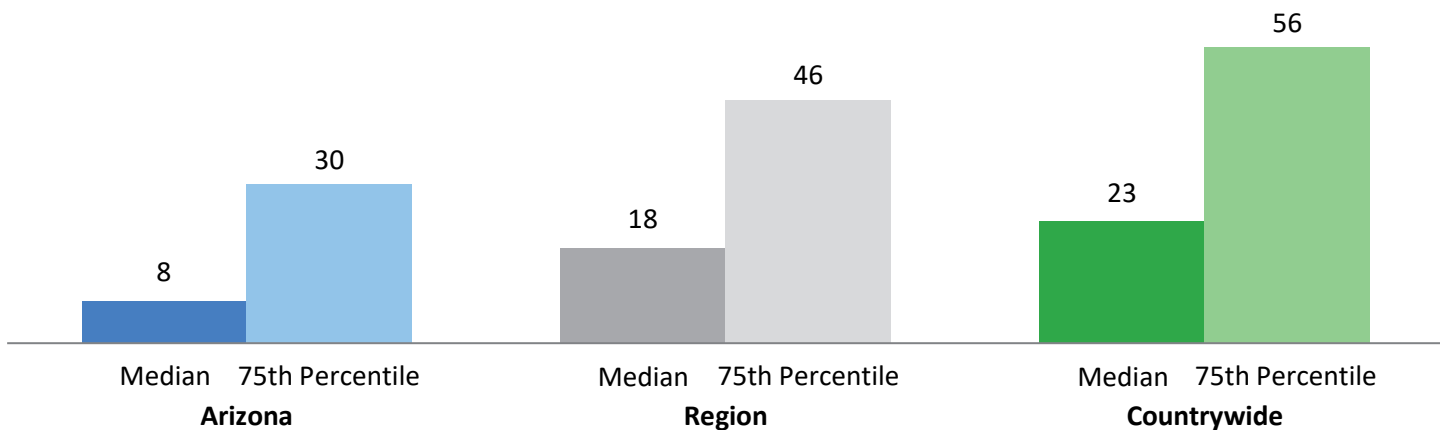
Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
97164	Re-evaluation of physical therapy and established plan of care; requires an examination with review of history and use of standardized tests and measures; revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome; 20 minutes face-to-face with patient and/or family
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97162	Physical therapy evaluation of moderate complexity; typically, 30 minutes are spent with the patient and/or family

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

Chart 17**Time Until First Treatment for Physical and General Medicine (in Days)**

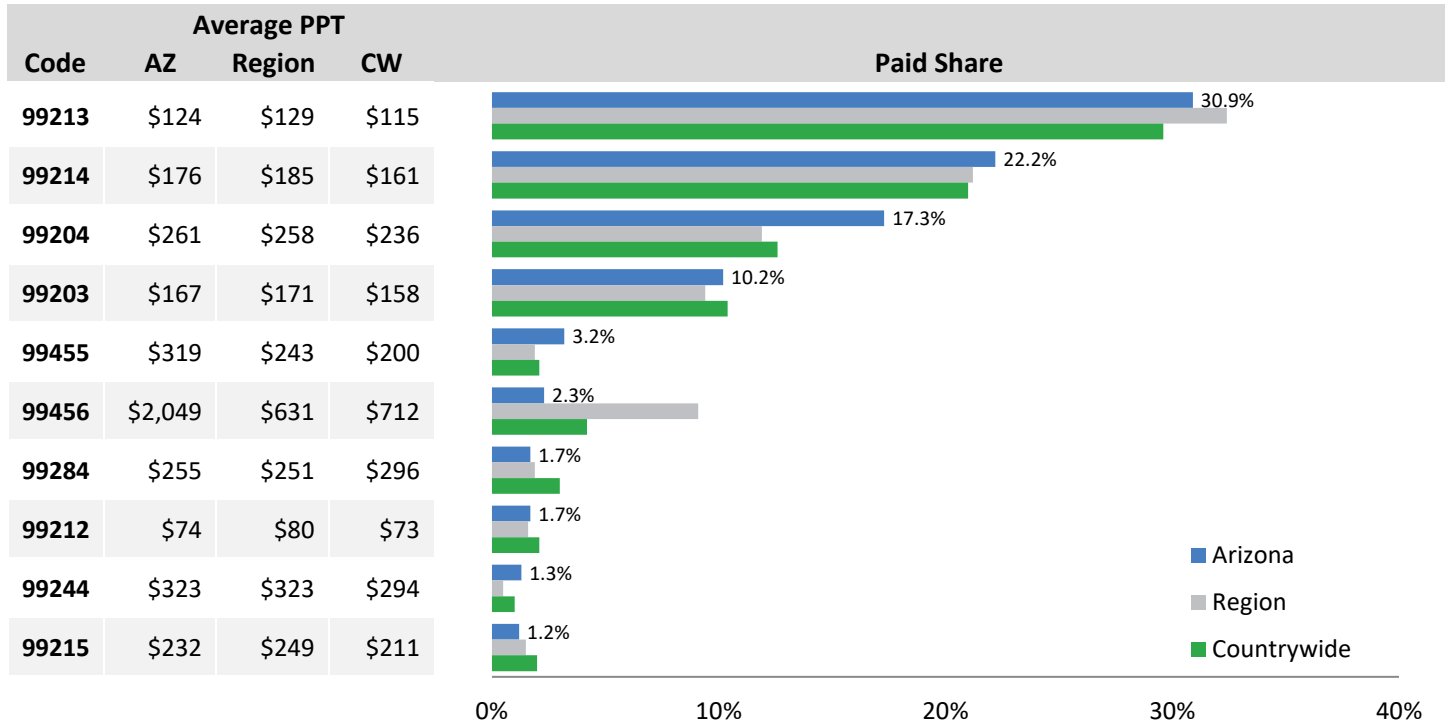
Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.



In Arizona, physician payments for evaluation and management services provided in 2021 are, on average, 145% of Medicare-scheduled reimbursement amounts, compared to 147% in the region and 135% countrywide. Payments for these services comprise 30% of physician payments, compared to 32% in the region and 24% countrywide.

Chart 18

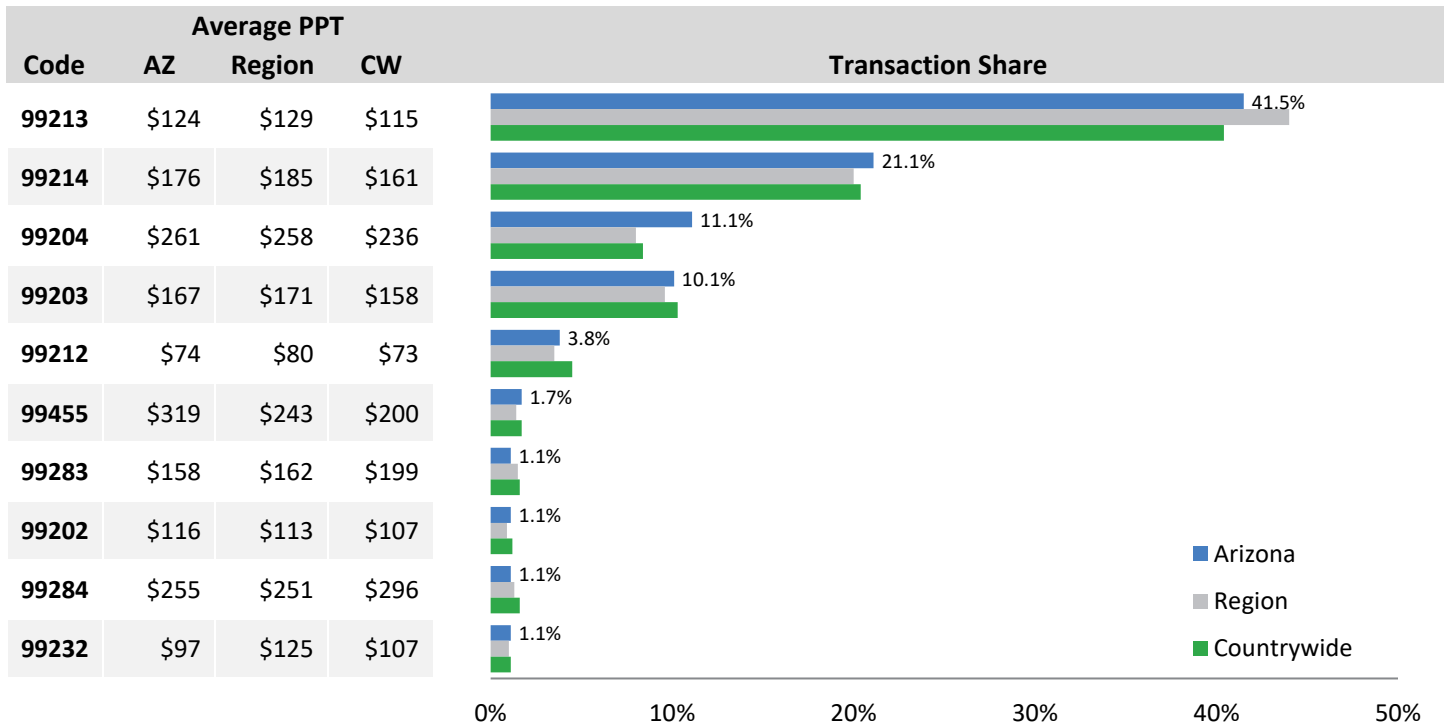
Top 10 Evaluation and Management Procedure Codes by Amount Paid



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.
99455	Work related or medical disability examination by the treating physician.
99456	Work related or medical disability examination by other than the treating physician.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
99244	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a high level of medical decision making. 40-54 minutes of total time is spent on the date of the encounter.

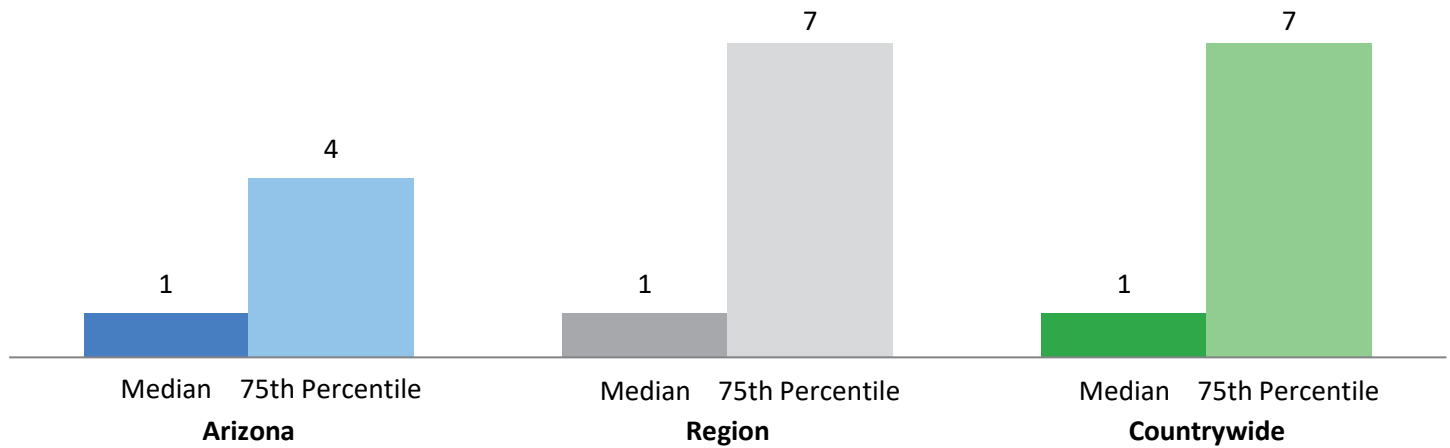
Chart 19

Top 10 Evaluation and Management Procedure Codes by Transaction Counts



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
99455	Work related or medical disability examination by the treating physician.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires straightforward medical decision making. 15-29 minutes of total time is spent on the date of the encounter.
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.
99232	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

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

Chart 20**Time Until First Treatment for Evaluation and Management (in Days)**

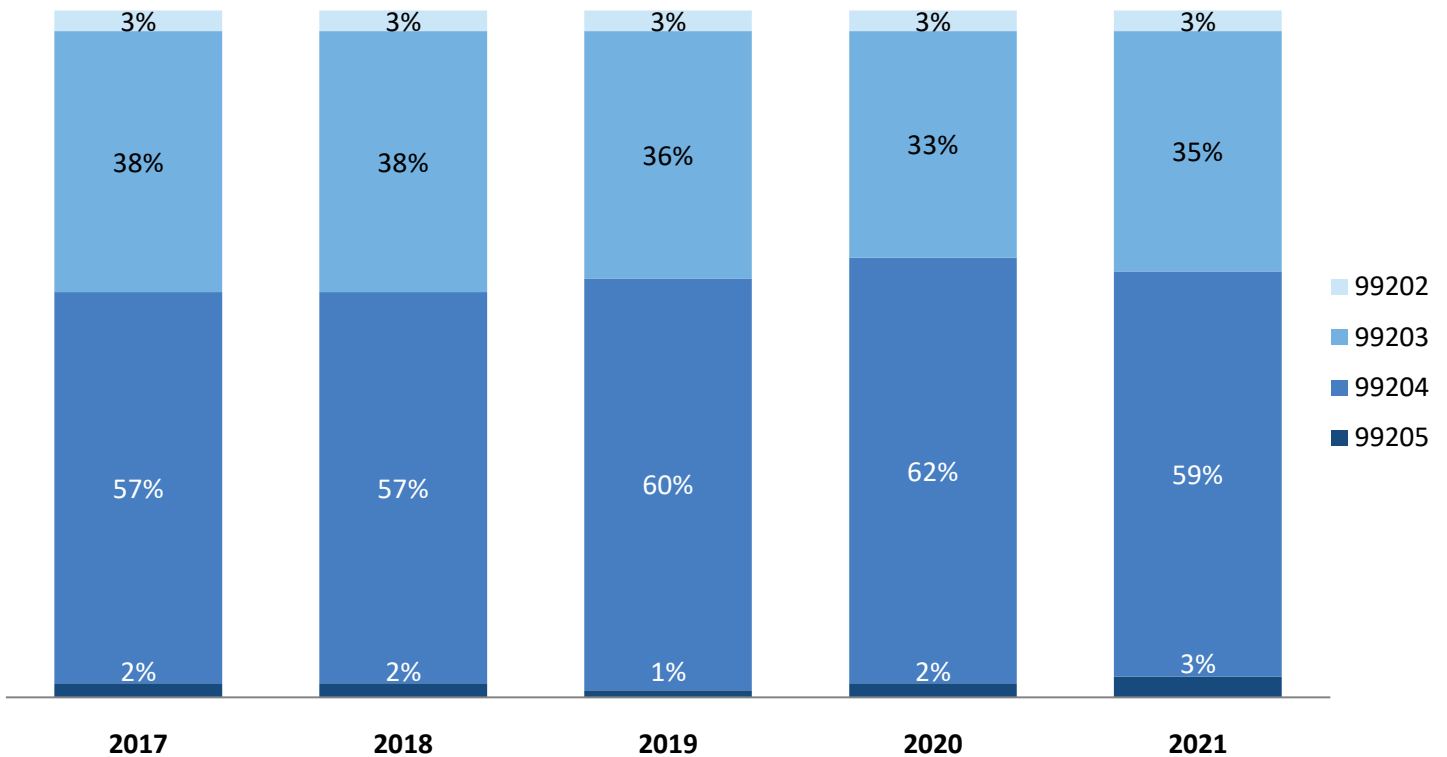
Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.



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

There are four periods of time spent with a *new* patient, ranging from 15–29 minutes for Procedure Code 99202 to 60–74 minutes for Procedure Code 99205. Chart 21 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for new patients.

Chart 21
Office or Other Outpatient Visit for the Evaluation and Management of a New Patient
Distribution of Payments by Procedure Code

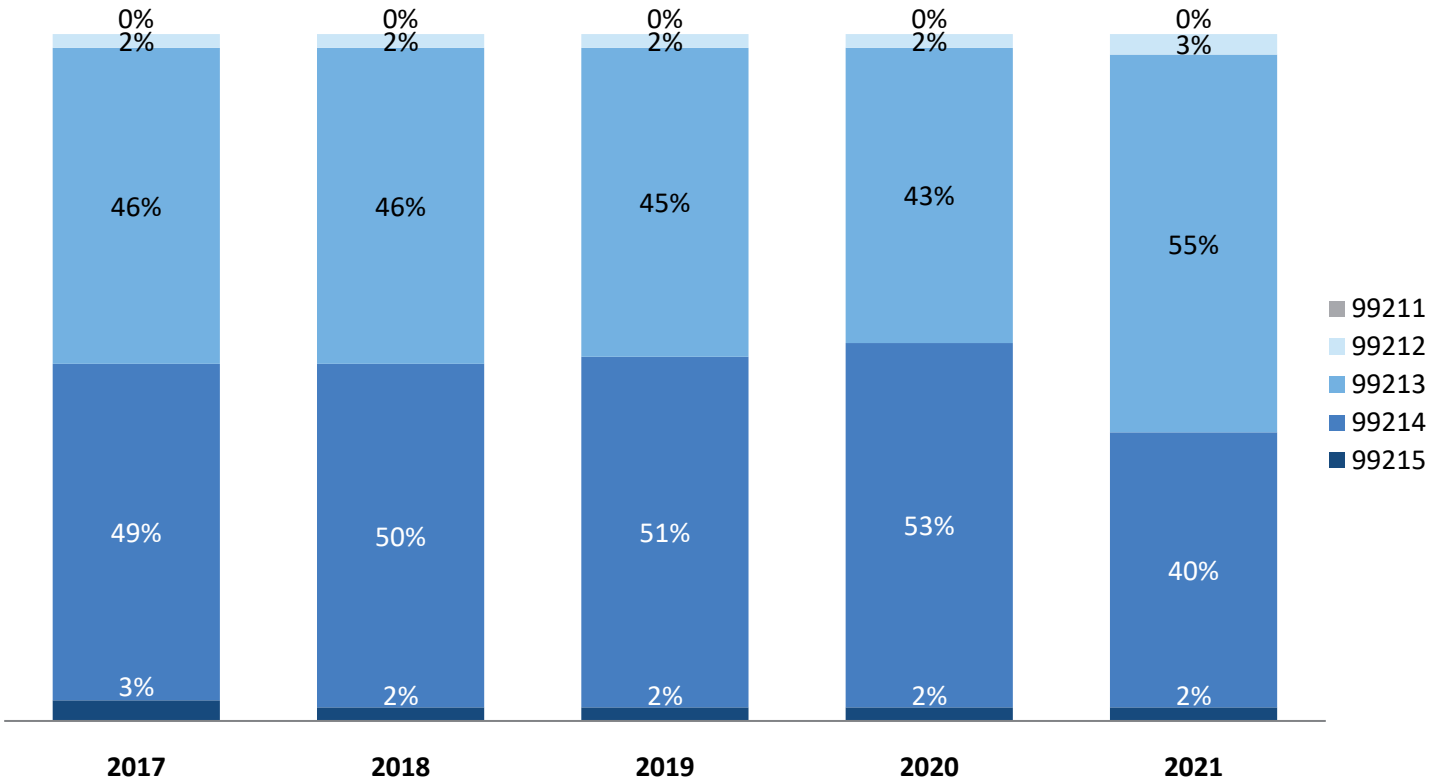


Source: NCCI’s Medical Data Call, Service Years 2017 to 2021.
Severity/Time description updated January 1, 2021.

Code	Severity/Time	Average PPT				
		2017	2018	2019	2020	2021
99202	Straightforward; 15-29 minutes with patient	\$101	\$109	\$112	\$114	\$116
99203	Low; 30-44 minutes with patient	\$147	\$163	\$164	\$162	\$167
99204	Moderate; 45-59 minutes with patient	\$230	\$257	\$259	\$261	\$261
99205	High; 60-74 minutes with patient	\$258	\$272	\$278	\$282	\$301

Similarly, for established patients, there are five periods of time spent with the patient, ranging from a patient not requiring any time with a physician for Procedure Code 99211 to 40–54 minutes for Procedure Code 99215. Chart 22 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for an established patient.

Chart 22
Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient
Distribution of Payments by Procedure Code



Source: NCCI’s Medical Data Call, Service Years 2017 to 2021.
 Severity/Time description updated January 1, 2021.

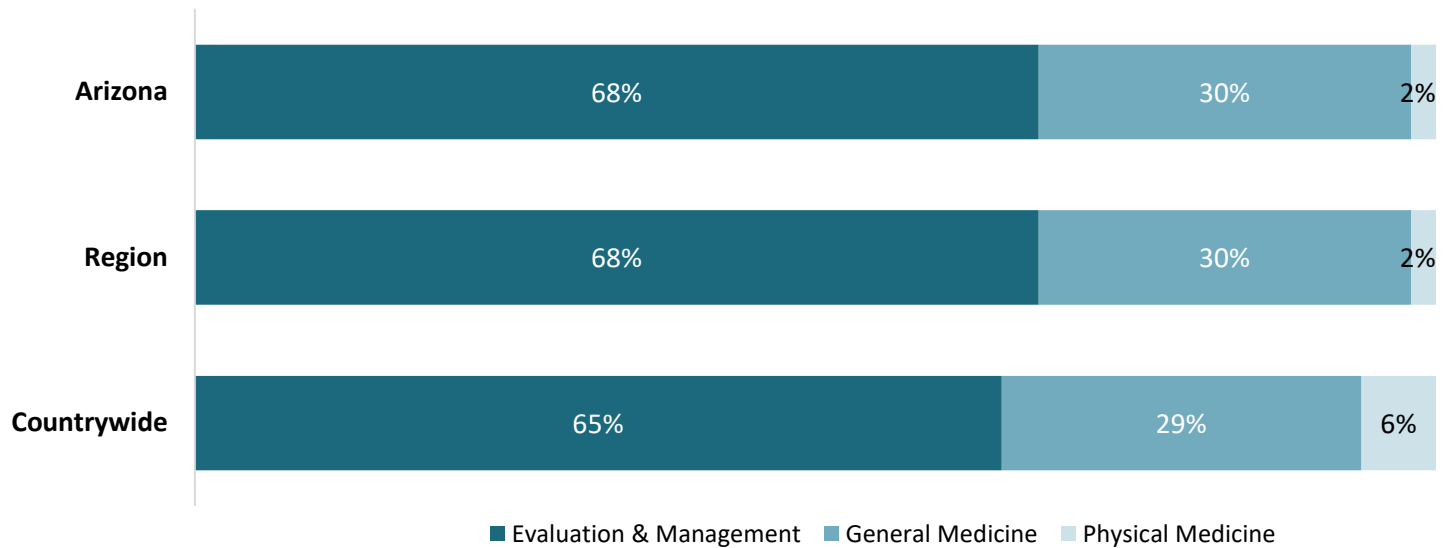
Code	Severity/Time	Average PPT				
		2017	2018	2019	2020	2021
99211	Minimal; May not require physician	\$30	\$29	\$31	\$31	\$35
99212	Straightforward; 10-19 minutes with patient	\$60	\$65	\$67	\$67	\$74
99213	Low; 20-29 minutes with patient	\$102	\$113	\$114	\$115	\$124
99214	Moderate; 30-39 minutes with patient	\$144	\$158	\$159	\$163	\$176
99215	High; 40-54 minutes with patient	\$196	\$213	\$204	\$211	\$232

Telemedicine services have been utilized more than in years prior to 2020⁸ and are generally observed in the evaluation and management, physical medicine, and general medicine physician service categories. In Service Year 2021, telemedicine services represent about 1% of the physician costs in these categories countrywide. The share of payments varies across jurisdictions, ranging from about 0% to about 4%.

In Arizona, the share of claimants receiving physician services (evaluation and management, physical medicine, and general medicine) who had telemedicine encounters changed from 8.0% in 2020 to 5.1% in 2021. Chart 23 shows the distribution of telemedicine payments for these physician service categories in Arizona, the region, and countrywide.

Chart 23

Distribution of Telemedicine Payments by Physician Service Category



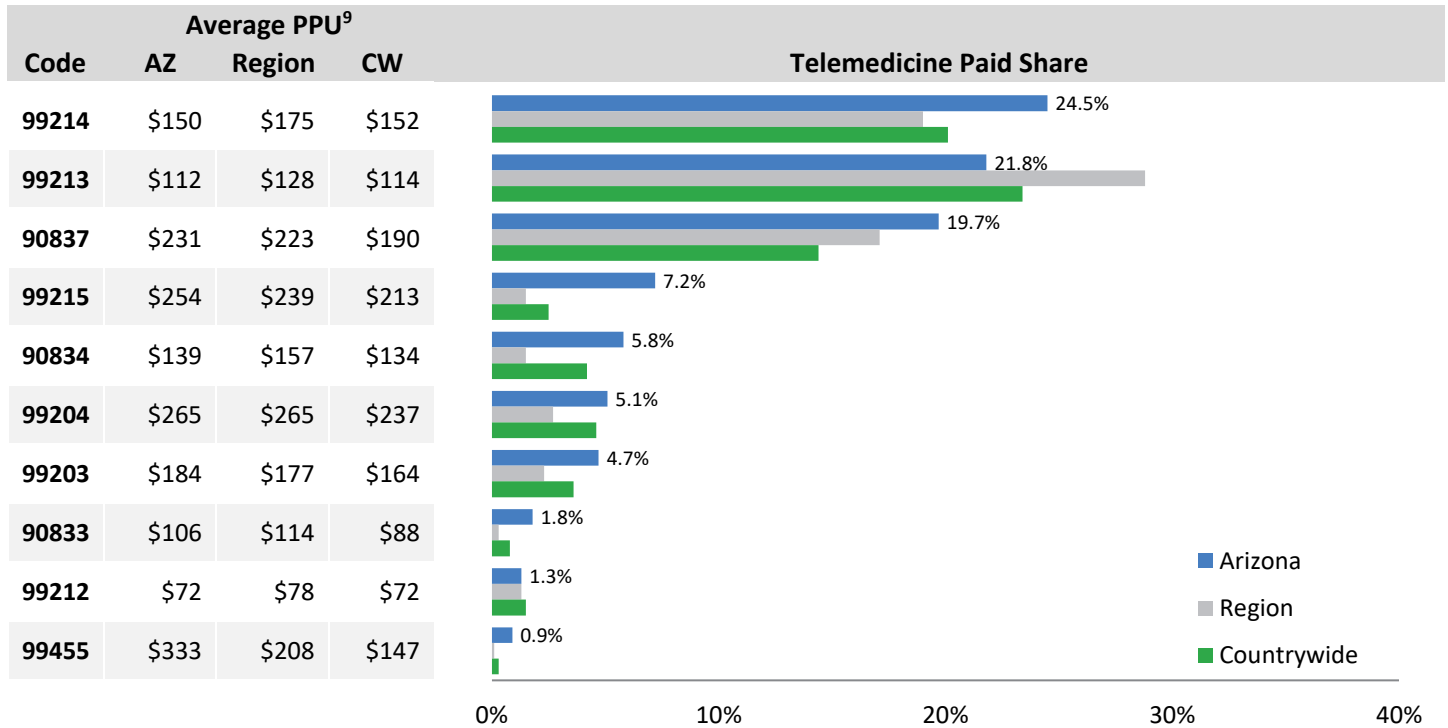
⁸ www.ncci.com/Articles/Documents/Insights-COVID-19-Impact-Medical-Treatment-Workers-Comp-3QTR-2020-Perspective.pdf



Chart 24 shows the top 10 procedure codes reported as a telemedicine service by paid amount for Arizona with comparative values for the region and countrywide.

Chart 24

Top 10 Procedure Codes by Amount Paid for Telemedicine Services



Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
90837	Psychotherapy, 60 minutes with patient
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a high level of medical decision making. 40-54 minutes of total time is spent on the date of the encounter.
90834	Psychotherapy, 45 minutes with patient
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
99455	Work related or medical disability examination by the treating physician.

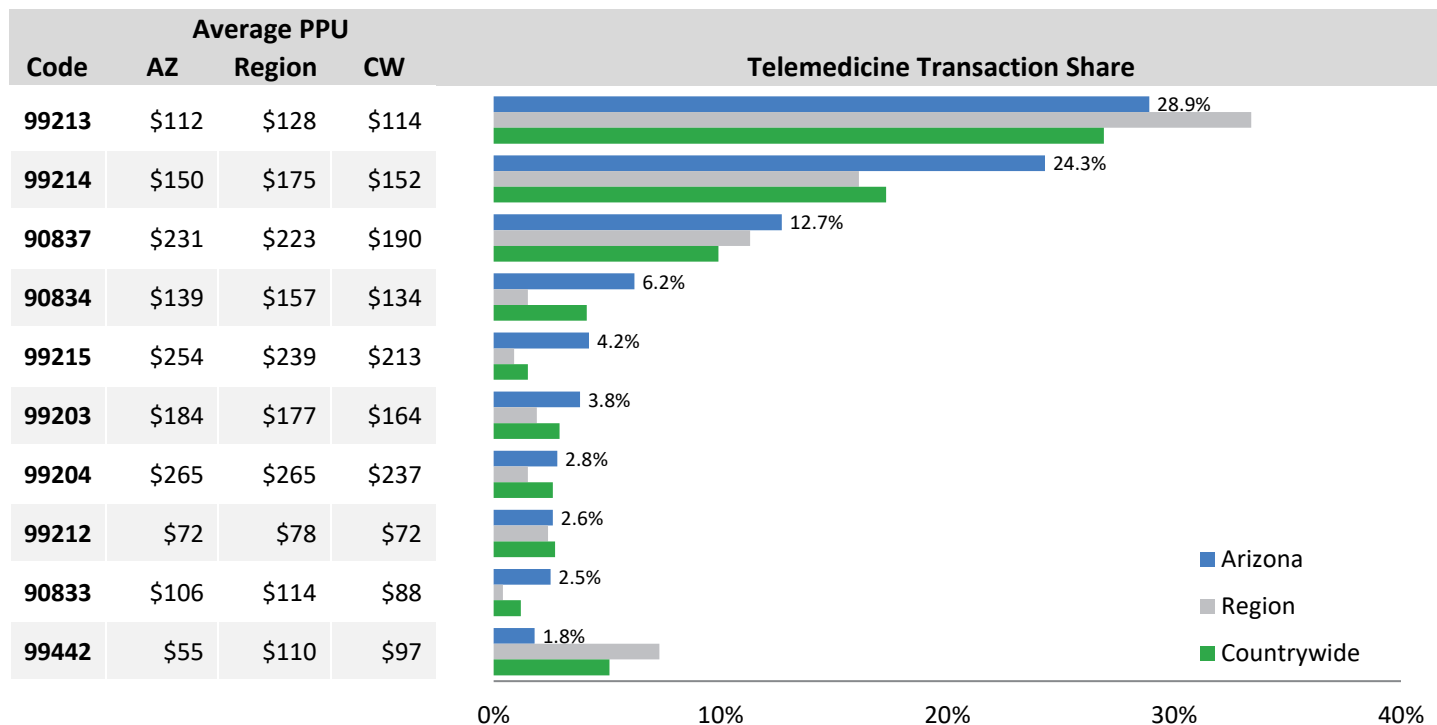
⁹ Based on the number of units for the procedure code (typically in increments of time) but can also be one transaction.



Chart 25 shows the top 10 procedure codes reported as a telemedicine service by transaction count for Arizona with comparative values for the region and countrywide.

Chart 25

Top 10 Procedure Codes by Transaction Counts for Telemedicine Services



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a low level of medical decision making. 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.
90837	Psychotherapy, 60 minutes with patient
90834	Psychotherapy, 45 minutes with patient
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a high level of medical decision making. 40-54 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a low level of medical decision making. 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a moderate level of medical decision making. 45-59 minutes of total time is spent on the date of the encounter.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires straightforward medical decision making. 10-19 minutes of total time is spent on the date of the encounter.
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
99442	Telephone evaluation and management service by a physician or other qualified health care professional; 11-20 minutes of medical discussion.



Hospital Inpatient

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

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

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

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In Arizona, 42% of hospital inpatient payments are reported with a DRG code.

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

Unless otherwise stated, the inpatient results are based on inpatient stays with a discharge date in 2021.

A measure of workers compensation hospital inpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital inpatient payments for Arizona, the region, and countrywide, based on hospital episodes that are reported with a DRG code.

Chart 26

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Hospital Inpatient	265%	161%	191%

Source: NCCI’s Medical Data Call for inpatient stays discharged in Calendar Year 2021. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.

The distribution of medical payments for hospital inpatient is 15% for Arizona, 12% for the region, and 12% for countrywide. One comparative measure of inpatient service costs is the average payment per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting, for a specific diagnosis. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

Chart 27 displays the average amount paid per stay for hospital inpatient services, while Chart 28 displays the average amount paid per day for hospital inpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

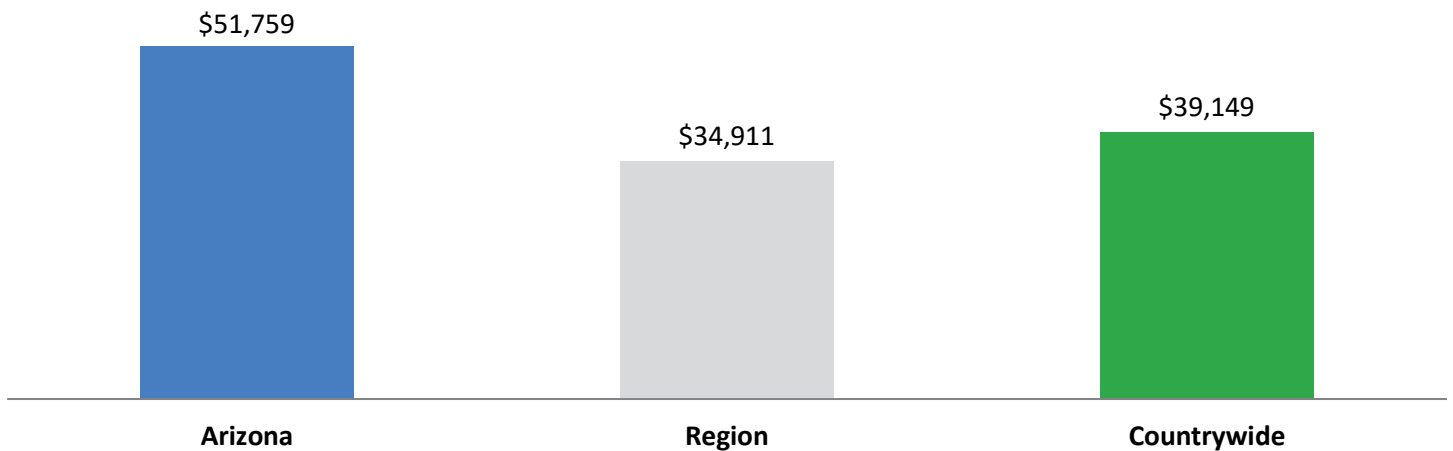
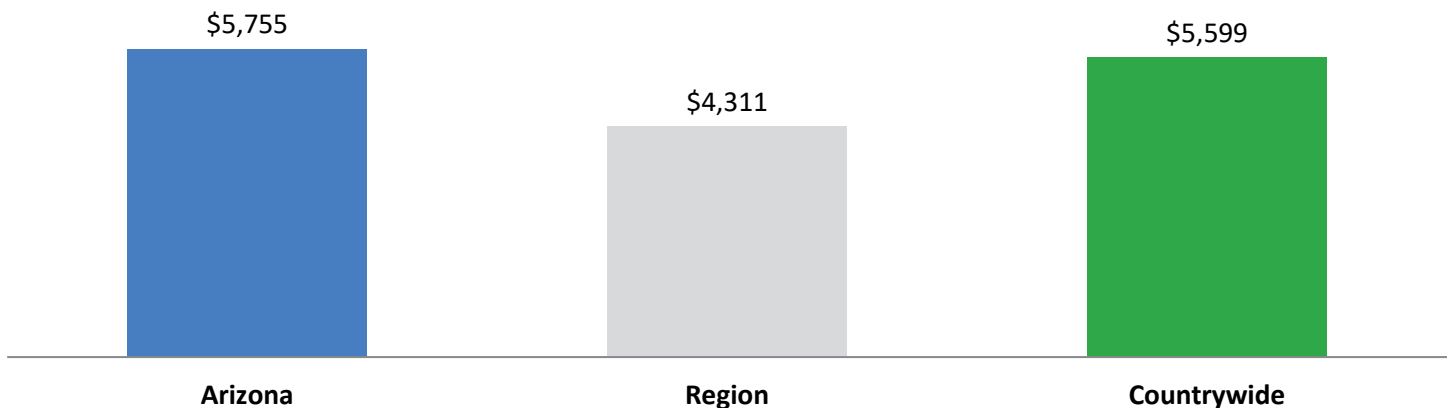
Chart 27**Average Amount Paid per Stay for Hospital Inpatient Services****Chart 28****Average Amount Paid per Day for Hospital Inpatient Services**



Chart 29 displays the average number of hospital inpatient stays per 1,000 active claims in 2021 for Arizona, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 30 displays the average and median length of stay for hospital inpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 29

Average Number of Inpatient Stays per 1,000 Active Claims

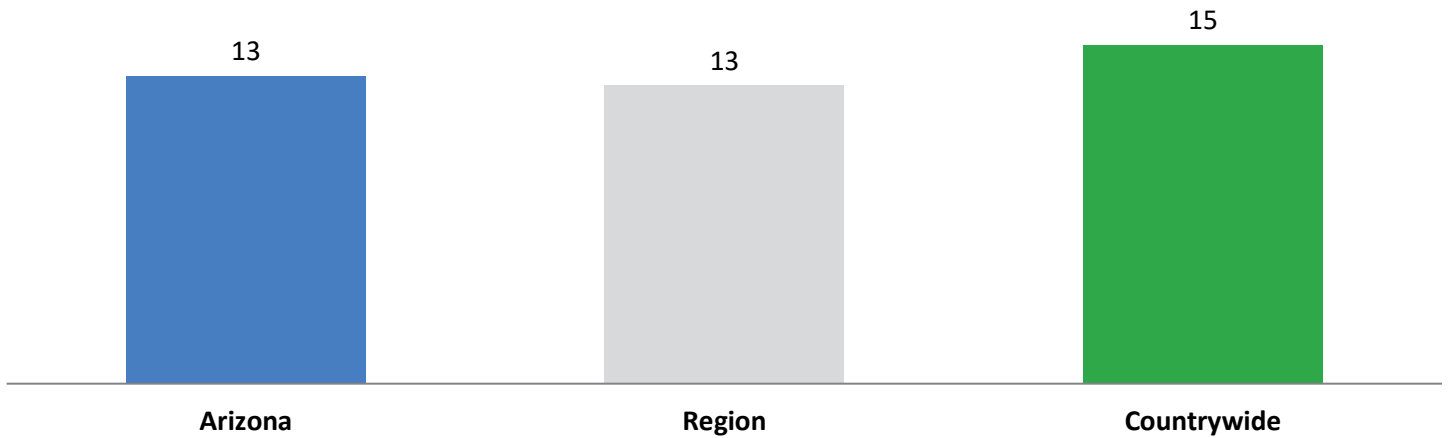


Chart 30

Length of Stay for Hospital Inpatient Services (in Days)

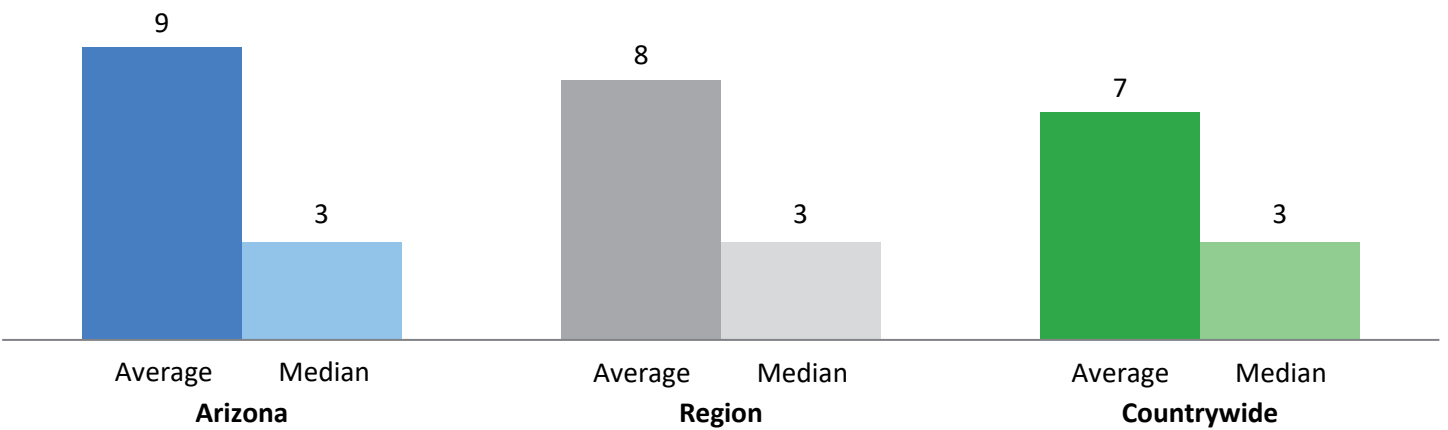
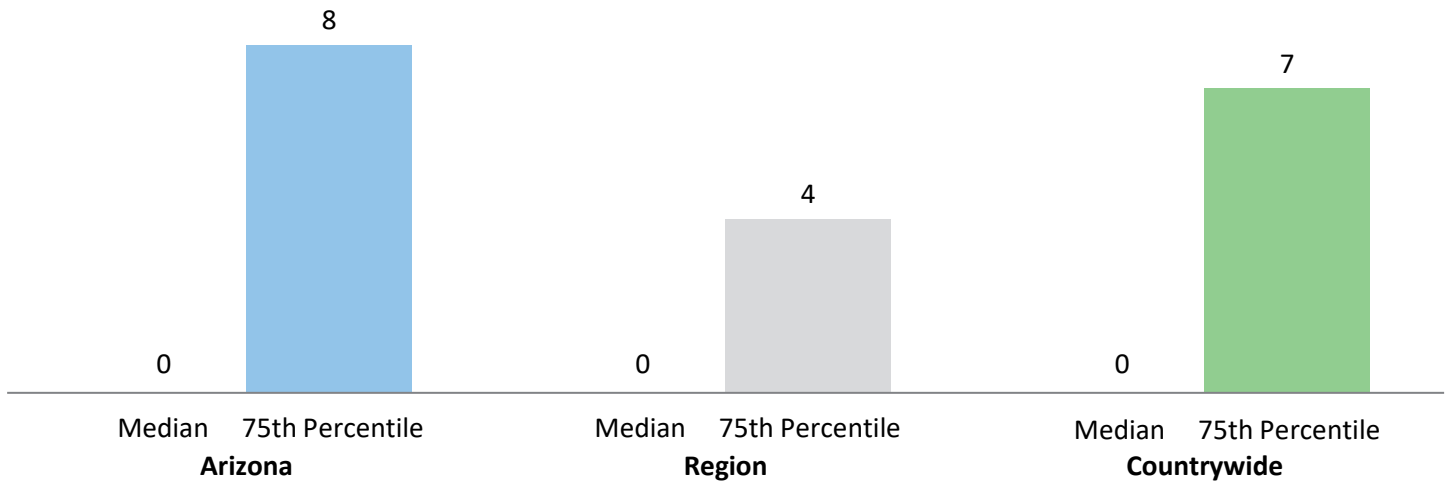


Chart 31 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Arizona, the region, and countrywide.

Chart 31**Time Until First Treatment for Hospital Inpatient Stays (in Days)**

Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.



Charts 32 and 33 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient stays. A diagnosis group is identified for each stay based on an ICD-10 (International Classification of Diseases) code. The diagnosis groups and DRG codes are ranked based on total payments for hospital inpatient services in Arizona. A brief description of each DRG code is displayed in the table below chart 33. The information is based on inpatient stays with a discharge date in 2020 or 2021.

Chart 32

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

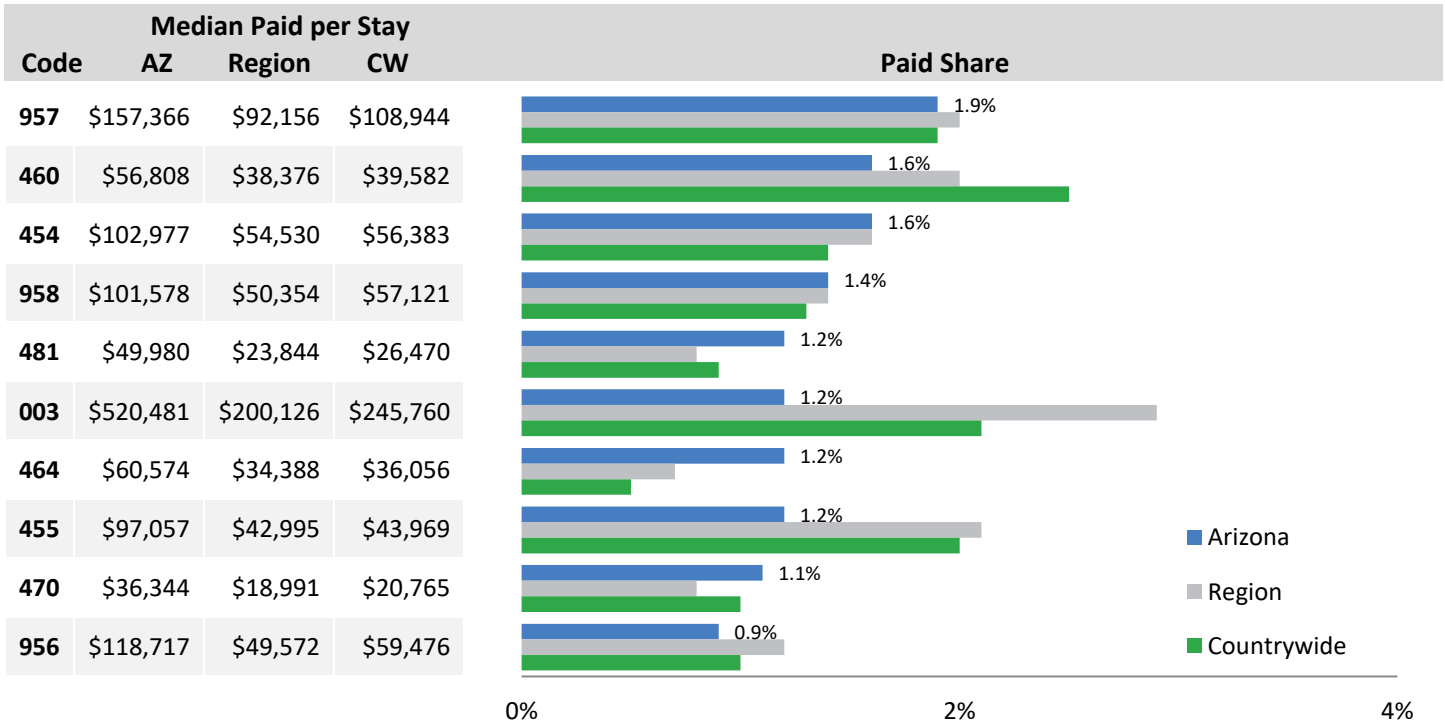
Diagnosis Group	Paid Share	Median Amount Paid per Stay		
		Arizona	Region	Countrywide
Traumatic brain injury	7.9%	\$34,316	\$26,897	\$29,027
Lumbar spine degeneration	5.6%	\$68,742	\$35,283	\$37,477
Hip/pelvis fracture/major trauma	5.3%	\$28,299	\$20,433	\$21,602
Sepsis	4.4%	\$27,001	\$20,902	\$23,067
Tibia/fibula fracture	3.7%	\$27,821	\$21,372	\$23,945
Complication from surgical device	3.6%	\$40,862	\$22,669	\$23,283
COVID-19	3.5%	\$29,100	\$20,442	\$20,814
Lumbosacral intervertebral disc disorders	3.0%	\$48,988	\$26,982	\$29,815
Chest trauma major	2.9%	\$32,972	\$21,854	\$22,574
Burn and corrosion, third degree, other than head, face, and neck	2.9%	\$56,289	\$57,039	\$46,543

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in Calendar Year 2020 or 2021.



Chart 33

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services



Code	Description
957	Other operation room procedures for multiple significant trauma with major complications or comorbidities
460	Spinal fusion, except cervical, without major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
958	Other operation room procedures for multiple significant trauma with complications or comorbidities
481	Hip and femur procedures except major joint with complications or comorbidities
003	Extracorporeal membrane oxygenation (ECMO) or tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth, and neck with major operating room
464	Wound debridement and skin graft except hand for musculoskeletal system and connective tissue disorders with complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
956	Limb reattachment, hip, and femur procedures for multiple significant trauma

Source: NCCI’s Medical Data Call for inpatient stays with a discharge date in 2020 or 2021. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.

Note: In Arizona, 42% of hospital inpatient payments are reported with a DRG code.



Hospital Outpatient

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

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

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

Comparisons by procedure code for outpatient benefits should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide. 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 and the level of reimbursement varies considerably by type of visit. A service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services (CMS), or the procedure involves spine/spinal cord neurostimulators. A hospital outpatient visit could be the result of an emergency visit and those visits are shown separately. Nonemergency outpatient visits are shown separately for those with and without major surgery services; those without a major surgery service are referred to as “Other” outpatient visits.

The distribution of medical payments for hospital outpatient is 18% for Arizona, 18% for the region, and 20% for countrywide.

One measure of workers compensation hospital outpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital outpatient payments for Arizona, the region, and countrywide. In Arizona, 79% of hospital outpatient payments are included in the chart below.

Chart 34

Hospital Outpatient Payments as a Percentage of Medicare

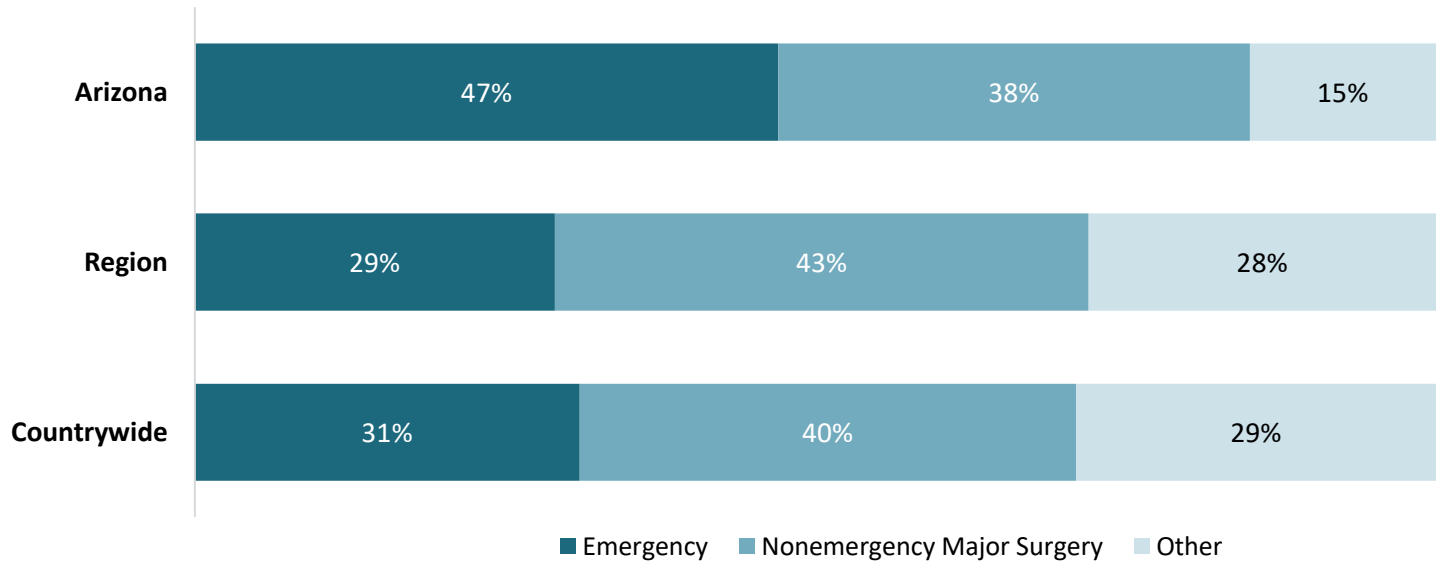
Medical Cost Category	Arizona	Region	Countrywide
Hospital Outpatient	334%	182%	236%

Source: NCCI’s Medical Data Call for Service Year 2021. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.

Chart 35 displays the distribution of hospital outpatient payments by visit type for Arizona, the region, and countrywide.

Chart 35

Distribution of Payments for Outpatient Services by Hospital Outpatient Visit Type





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

Chart 36

Average Amount Paid for Hospital Outpatient Services per Emergency Visit

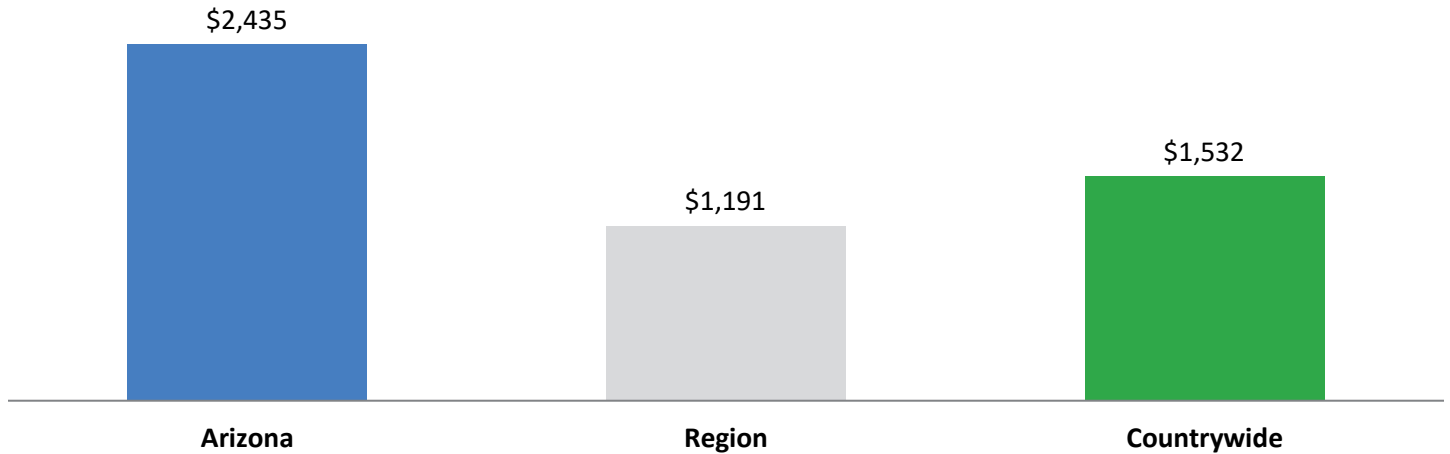


Chart 37

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

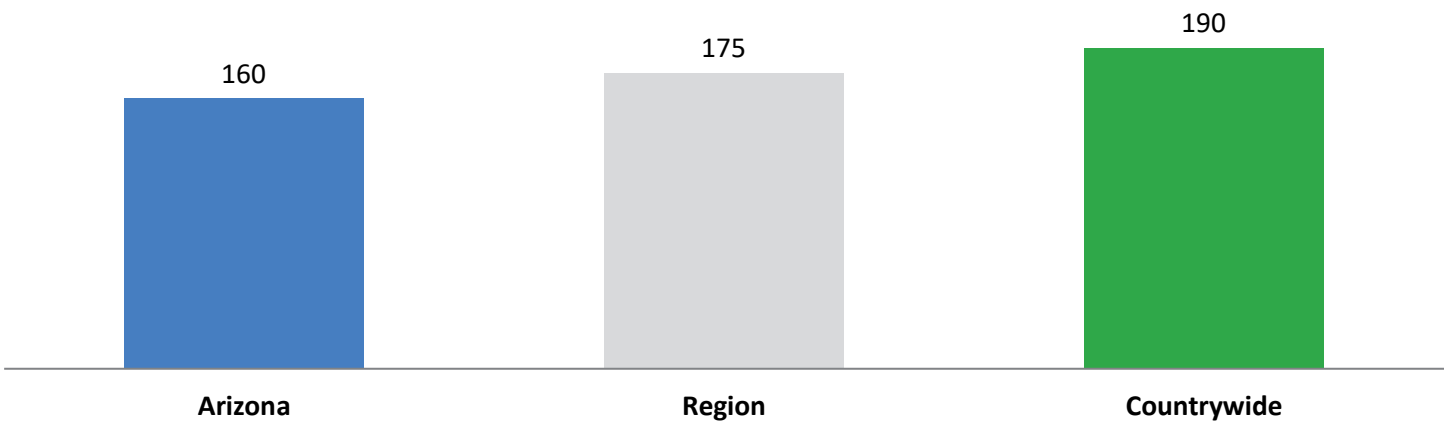




Chart 38 displays the top 10 diagnosis groups for emergency outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Arizona.

Chart 38

Top 10 Diagnosis Groups by Amount Paid for Emergency Hospital Outpatient Visits

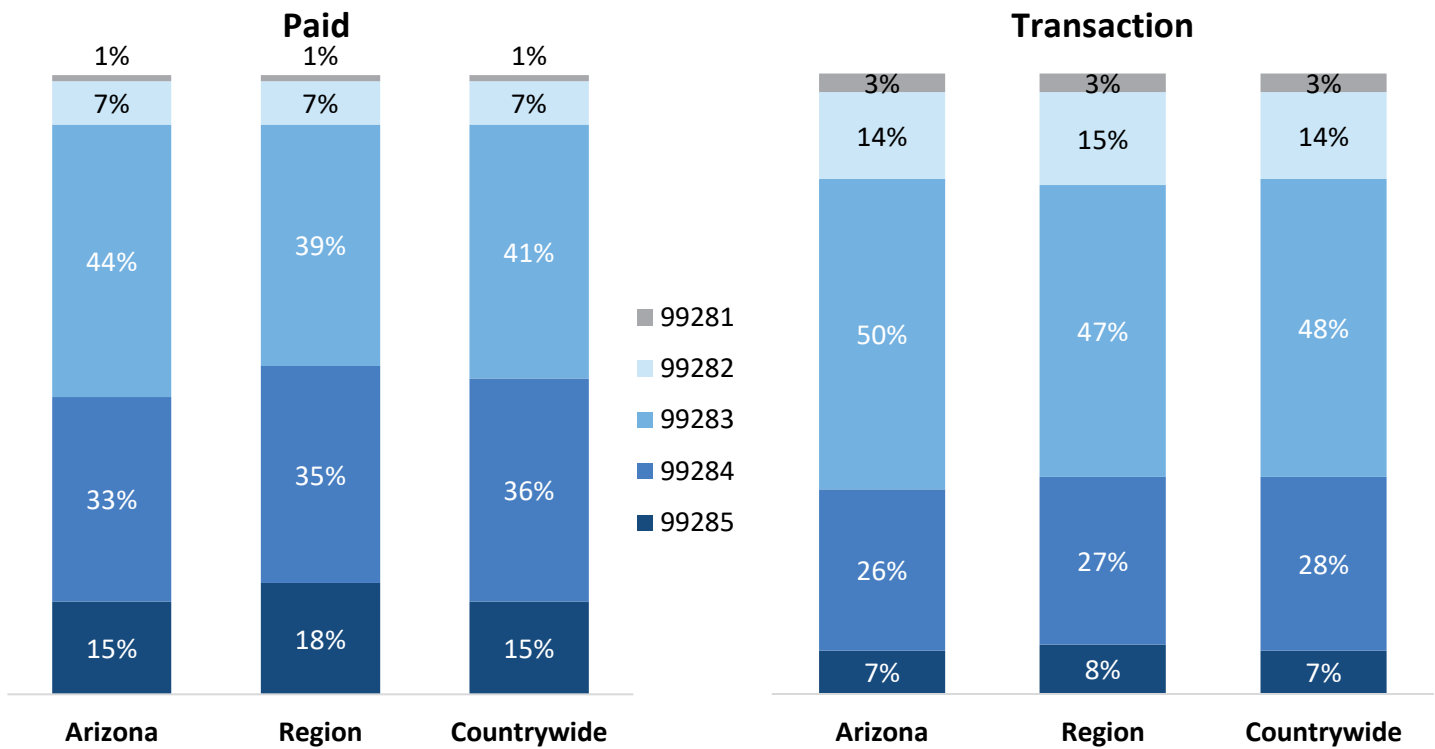
Diagnosis Group	Paid Share	Median Amount Paid Per Visit		
		Arizona	Region	Countrywide
Minor hand/wrist injuries	9.4%	\$799	\$636	\$713
Hand/wrist fracture	6.3%	\$1,534	\$961	\$1,114
Low back pain	5.4%	\$1,105	\$700	\$800
Head injury not otherwise classified	5.0%	\$1,696	\$939	\$1,133
Head/face wound	3.8%	\$1,325	\$825	\$922
Concussion/minor traumatic brain injury	3.7%	\$1,711	\$999	\$1,159
Neck pain	3.5%	\$1,903	\$1,030	\$1,219
Upper back pain	2.5%	\$1,340	\$787	\$915
Head injury minor	2.5%	\$1,500	\$867	\$1,024
Minor knee injury	2.1%	\$1,104	\$627	\$728



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. About 81% of all emergency visits had outpatient services. Chart 39 shows the distribution of emergency room outpatient services by procedure code for both paid amount and transactions for Service Year 2021 as well as the average payment per transaction.

Chart 39

Distribution of Emergency Room Outpatient Services by Procedure Code



Emergency Room Outpatient Paid per Transaction by Procedure Code

Code	Severity	Average PPT		
		Arizona	Region	Countrywide
99281	Minor	\$341	\$159	\$201
99282	Low to Moderate	\$377	\$268	\$291
99283	Moderate	\$674	\$460	\$504
99284	High	\$972	\$706	\$754
99285	High and immediately life-threatening	\$1,623	\$1,169	\$1,164



Nonemergency outpatient visits with major surgery services represent 38% of hospital outpatient payments in Arizona. Chart 40 displays the average amount paid per major surgery visit for outpatient services, while Chart 41 displays the average number of major surgery hospital outpatient visits per 1,000 active claims for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 40

Average Amount Paid for Hospital Outpatient Services per Nonemergency Major Surgery Visit

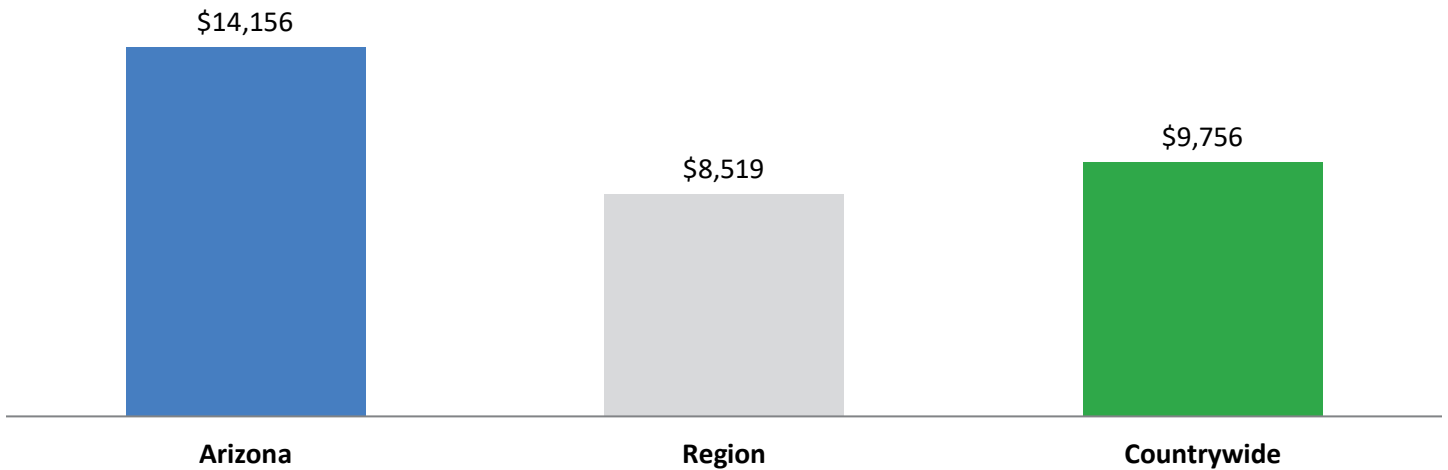


Chart 41

Average Number of Nonemergency Major Surgery Hospital Outpatient Visits per 1,000 Active Claims

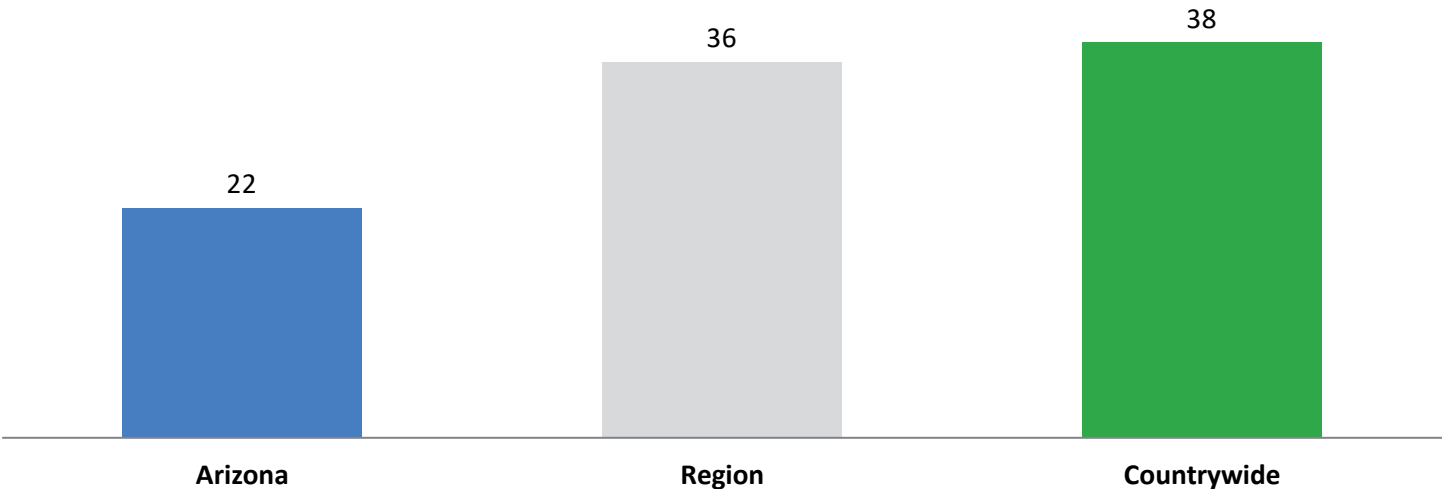
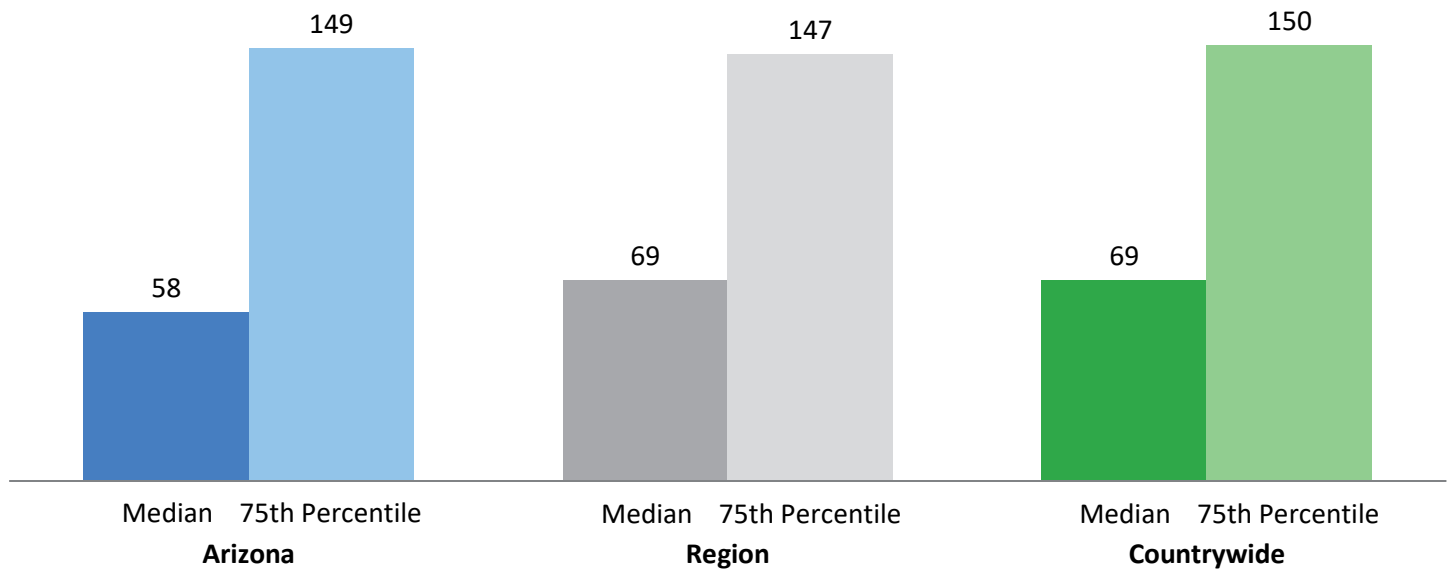


Chart 42 shows the median and 75th percentile time until first treatment for nonemergency major surgery outpatient visits for Arizona, the region, and countrywide.

Chart 42**Time Until First Treatment for Nonemergency Major Surgery Outpatient Visits (in Days)**

Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.

Chart 43 displays the top 10 diagnosis groups for nonemergency major surgery outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Arizona.

Chart 43

Top 10 Diagnosis Groups by Amount Paid for Nonemergency Major Surgery Hospital Outpatient Visits

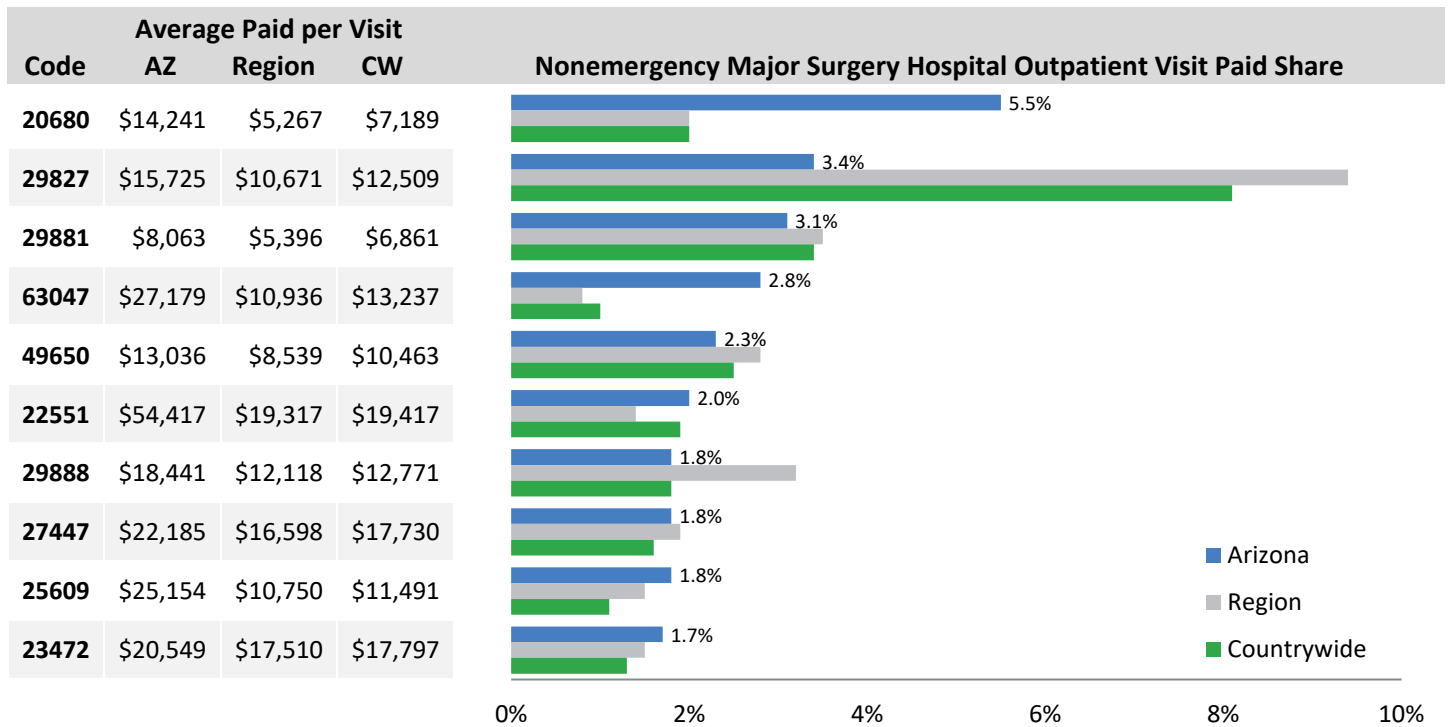
Diagnosis Group	Paid Share	Median Amount Paid Per Visit		
		Arizona	Region	Countrywide
Hand/wrist fracture	8.4%	\$8,830	\$5,665	\$6,002
Rotator cuff tear	6.4%	\$11,039	\$10,544	\$10,499
Complication from surgical device	5.1%	\$12,983	\$4,812	\$5,473
Inguinal hernia	4.1%	\$7,211	\$7,439	\$8,150
Knee internal derangement - meniscus injury	3.9%	\$5,338	\$5,124	\$5,491
Knee degenerative/overuse injuries	3.6%	\$12,603	\$8,030	\$8,492
Ankle fracture	3.4%	\$11,484	\$10,903	\$10,014
Lumbar spine degeneration	3.0%	\$13,024	\$10,673	\$11,700
Degenerative arthritis, ankle/foot	3.0%	\$19,961	\$11,998	\$12,445
Lumbosacral intervertebral disc disorders	2.8%	\$15,320	\$10,444	\$10,732



Charts 44 displays the average amount paid per nonemergency major surgery visit for outpatient services in Arizona, the region, and countrywide for the top 10 CPT codes in Arizona. The codes are ranked based on total outpatient payments in Arizona, where the code shown below is the code with the highest total paid on a nonemergency major surgery visit. In 2021, 80% of Hospital Outpatient costs were reported with a CPT code being the highest paid code. A brief description of each code is displayed in the table below.

Chart 44

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Nonemergency Major Surgery Visits



Code	Description
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
63047	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root), single vertebral segment; lumbar
49650	Laparoscopy, surgical; repair initial inguinal hernia
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy, and decompression of spinal cord and/or nerve roots; cervical below C2
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))



Nonemergency outpatient visits without a major surgery service, referred to as “Other” outpatient visits, represent 15% of hospital outpatient payments in Arizona. Chart 45 displays the average amount paid per other visit for hospital outpatient services, while Chart 46 displays the average number of other visits per 1,000 active claims for hospital outpatient services for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 45

Average Amount Paid for Hospital Outpatient Services per Other Outpatient Visit

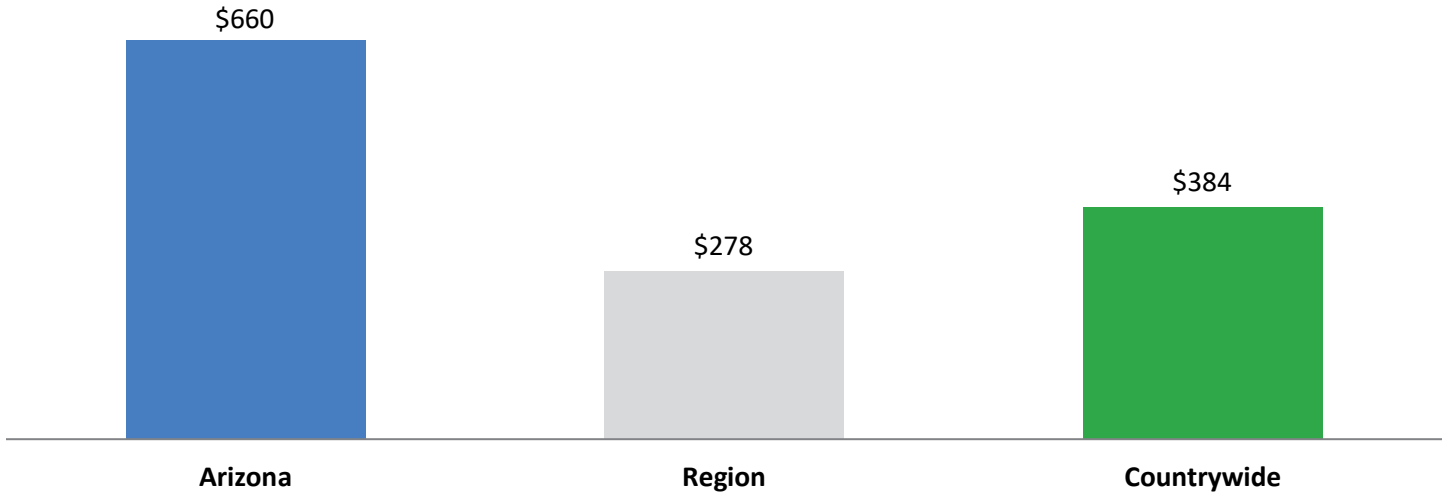


Chart 46

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

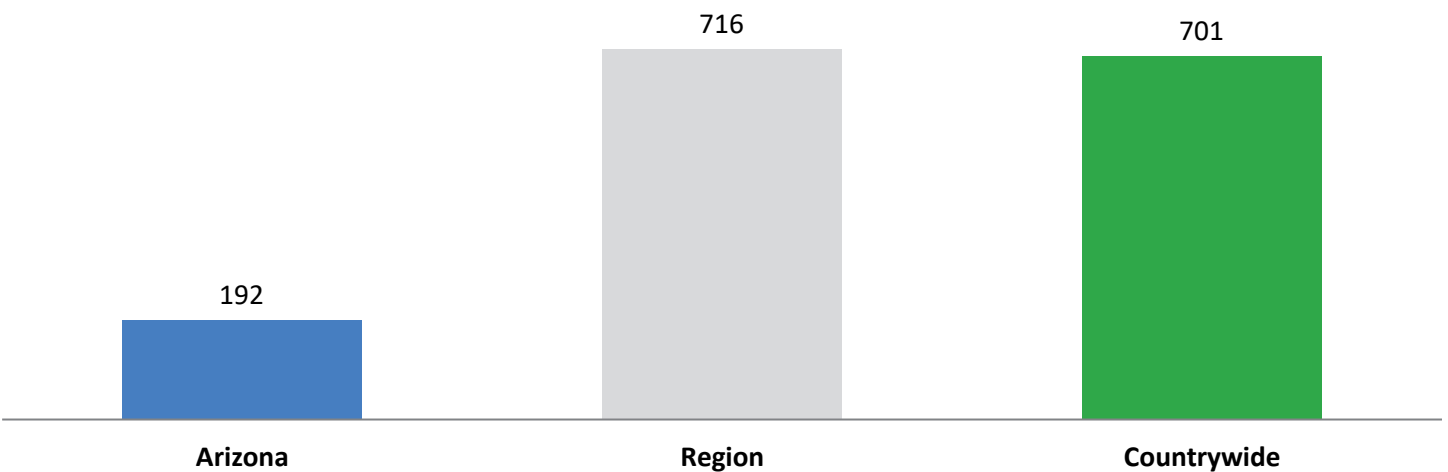
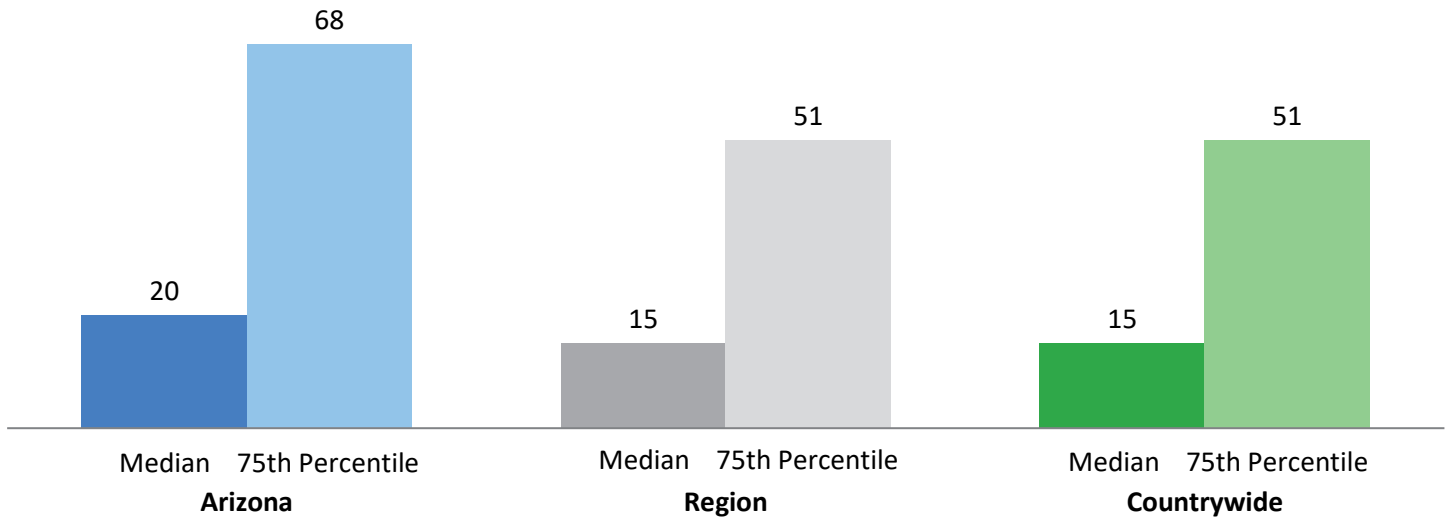


Chart 47 shows the median and 75th percentile time until first treatment for other outpatient visits for Arizona, the region, and countrywide.

Chart 47**Time Until First Treatment for Other Outpatient Visits (in Days)**

Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.



Chart 48 displays the top 10 diagnosis groups for other outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Arizona.

Chart 48

Top 10 Diagnosis Groups by Amount Paid for Other Hospital Outpatient Visits

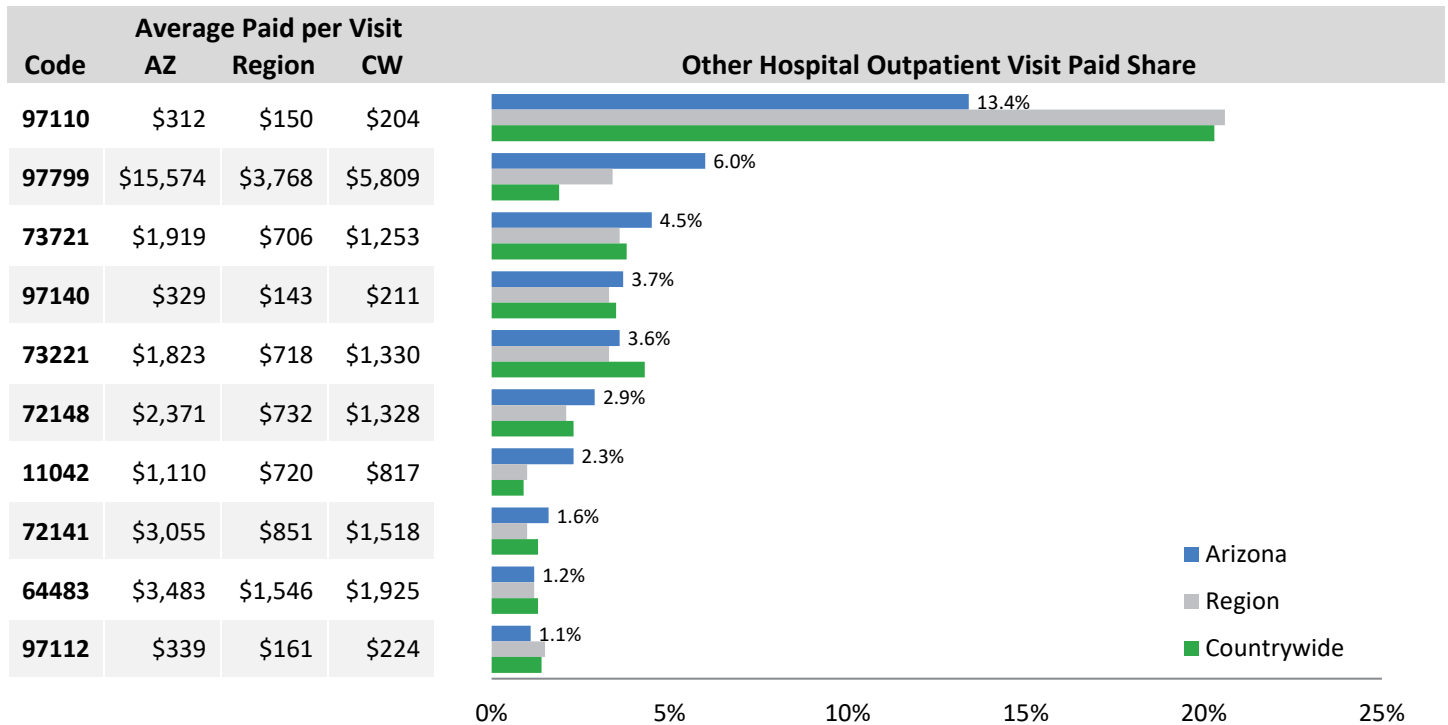
Diagnosis Group	Paid Share	Median Amount Paid per Visit		
		Arizona	Region	Countrywide
Traumatic brain injury	6.4%	\$676	\$375	\$331
Minor shoulder injury	4.2%	\$216	\$150	\$172
Minor hand/wrist injuries	3.8%	\$211	\$139	\$167
Hand/wrist fracture	3.6%	\$282	\$150	\$166
Low back pain	3.5%	\$212	\$155	\$172
Minor knee injury	2.7%	\$229	\$154	\$178
Lumbar spine degeneration	2.4%	\$488	\$268	\$383
Rotator cuff tear	2.3%	\$246	\$146	\$171
Minor ankle/foot injuries	2.0%	\$199	\$150	\$171
Lumbar radiculopathy/sciatica	2.0%	\$310	\$161	\$209



Charts 49 displays the average amount paid per other visit for outpatient services in Arizona, the region, and countrywide for the top 10 CPT codes in Arizona. The codes are ranked based on total outpatient payments in Arizona, where the code shown below is the code with the highest total paid on an "Other" outpatient visit. A brief description of each code is displayed in the table below.

Chart 49

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Other Visits



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97799	Unlisted physical medicine/rehabilitation service or procedure
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities



Ambulatory Surgical Centers

An Ambulatory Surgical Center (ASC) is often used as an alternative facility to a hospital for conducting outpatient surgeries. The distribution of medical payments for ASCs is 6% for Arizona, 5% for the region, and 7% for countrywide.

Typically, surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes.

One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for ASC payments for Arizona, the region, and countrywide. In Arizona, 80% of ASC payments are included in the chart below.

Chart 50

ASC Payments as a Percentage of Medicare

Medical Cost Category	Arizona	Region	Countrywide
Ambulatory Surgical Center	238%	187%	251%

Source: NCCI’s Medical Data Call for Service Year 2021. Region includes AK, CO, HI, ID, MT, NM, NV, OR, TX, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, VT, WI, and WV.



ASC visits with major surgery services represent 88% of ASC payments in Arizona. Other ASC visits typically include minor procedures, with injections for therapeutic or diagnostic purposes being the most common. Chart 51 displays the average amount paid per major surgery visit for ASC services, while Chart 52 displays the average number of major surgery ASC visits per 1,000 active claims for Arizona, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 51

Average Amount Paid per Major Surgery Visit for ASC Services

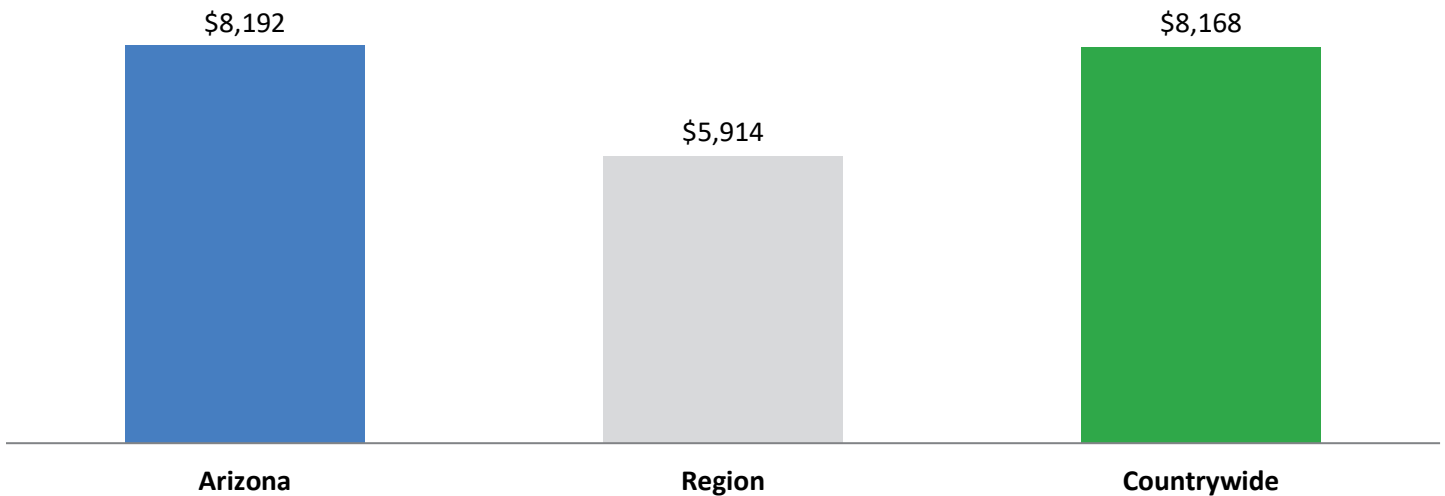


Chart 52

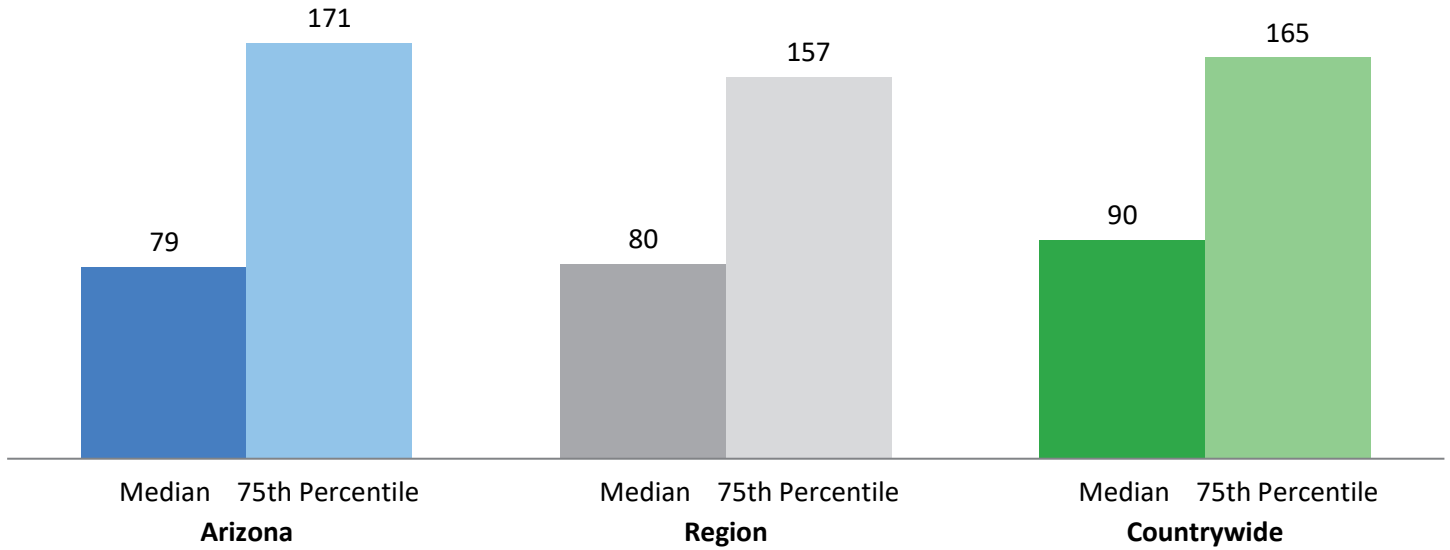
Average Number of ASC Major Surgery Visits per 1,000 Active Claims



Chart 53 shows the median and 75th percentile time until first treatment for ASC major surgery visits for Arizona, the region, and countrywide.

Chart 53

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



Source: NCCI's Medical Data Call for Accident Year 2020 and Service Years 2020 and 2021.



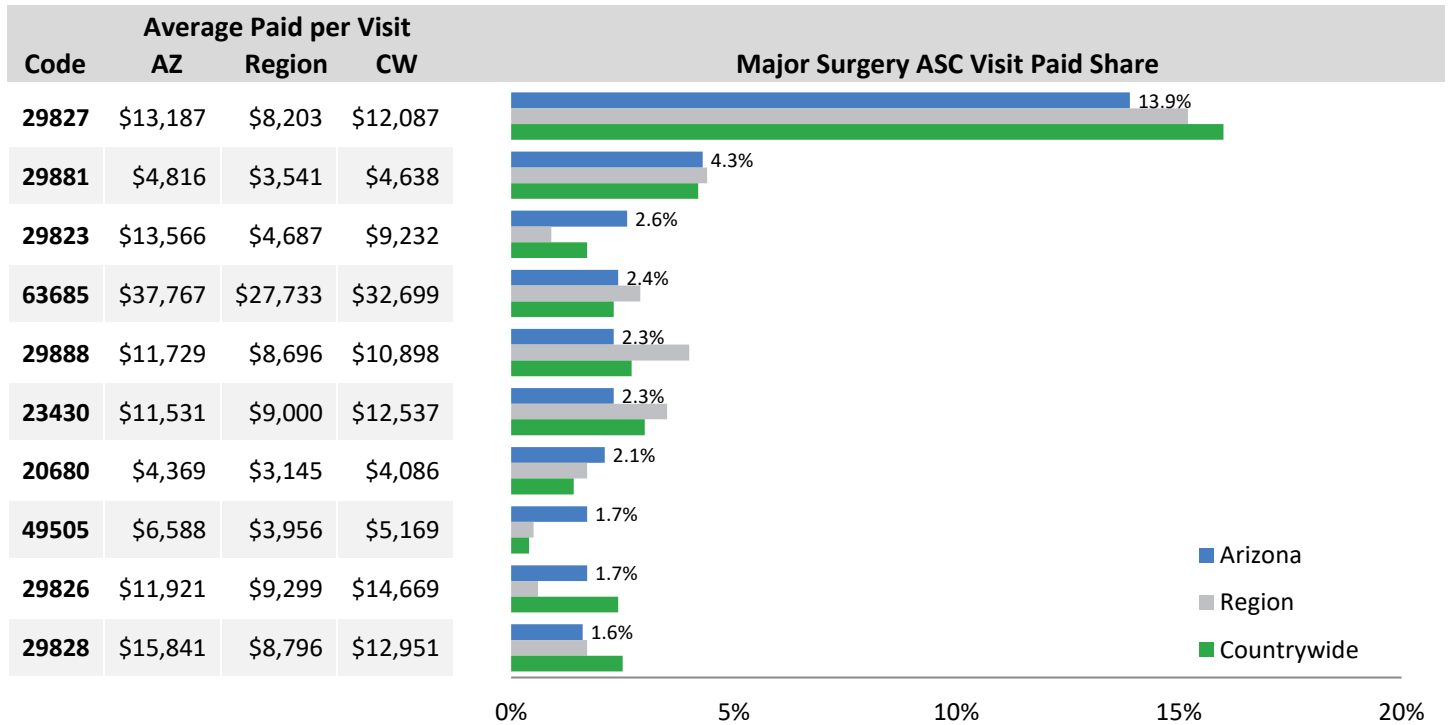
Chart 54 displays the top 10 diagnosis groups for ASC major surgery visits. The diagnosis groups are ranked based on total payments for ASC services in Arizona.

Chart 54

Top 10 Diagnosis Groups by Amount Paid for ASC Major Surgery Visits

Diagnosis Group	Paid Share	Median Amount Paid per Visit		
		Arizona	Region	Countrywide
Rotator cuff tear	17.3%	\$9,397	\$8,237	\$9,839
Knee internal derangement - meniscus injury	6.2%	\$3,802	\$3,165	\$4,188
Hand/wrist fracture	5.1%	\$4,675	\$3,979	\$5,369
Minor shoulder injury	4.1%	\$6,995	\$6,794	\$7,780
Inguinal hernia	3.6%	\$6,322	\$4,519	\$5,038
Degenerative shoulder	3.5%	\$6,968	\$6,810	\$8,184
Complication from surgical device	2.7%	\$3,155	\$3,193	\$3,441
Knee internal derangement - cruciate ligament tear	2.6%	\$10,875	\$7,738	\$9,322
Chronic pain	2.3%	\$27,265	\$11,174	\$13,548
Heel/midfoot fracture	2.3%	\$8,801	\$7,059	\$7,999

Chart 55 displays the average amount paid per major surgery visit for ASC services in Arizona, the region, and countrywide for the top 10 CPT codes in Arizona. The codes are ranked based on total ASC payments in Arizona, where the code shown below is the code with the highest total paid on a major surgery visit. A brief description of each procedure code is displayed in the table beneath the chart. Chart 56 displays similar results for visits in an outpatient setting for the list of codes in Chart 55, if applicable.

Chart 55
Top 10 Procedure Codes by Amount Paid for ASC Services in Major Surgery Visits


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
29823	Arthroscopy, shoulder, surgical; debridement, extensive
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
23430	Tenodesis of long tendon of biceps
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
49505	Repair initial inguinal hernia, age 5 years or older; reducible
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
29828	Arthroscopy, shoulder, surgical; biceps tenodesis



Chart 56

Major Surgery Outpatient Visit Comparisons for Procedure Codes in Chart 55

Code	Average Paid per Visit in AZ		Distribution of Major Surgery Visits in AZ in an ASC or Outpatient Setting	
	ASC	Outpatient		
29827	\$13,187	\$15,725	80%	20%
29881	\$4,816	\$8,063	65%	35%
29823	\$13,566	\$17,989	81%	19%
63685	\$37,767	N/A	100%	
29888	\$11,729	\$18,441	62%	38%
23430	\$11,531	\$15,388	72%	28%
20680	\$4,369	\$14,241	50%	50%
49505	\$6,588	\$5,934	73%	27%
29826	\$11,921	\$15,857	56%	44%
29828	\$15,841	\$17,476	67%	33%

Prescription Drugs

The distribution of medical payments for drugs is 8% for Arizona, 7% for the region, and 7% for countrywide. Prescription drugs are uniquely identified by a national drug code (NDC). Charts 57 through 62 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician’s office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

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

In Arizona, the share of claims observed in Service Year 2021 with at least one controlled substance was 7%. This compares to the region and countrywide shares of 9% and 8%, respectively. In 2021, Arizona spent \$2.0M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 57 shows the distribution of prescription drug payments by CSA schedule in Arizona, the region, and countrywide.

Chart 57

Distribution of Prescription Drug Payments by CSA Schedule

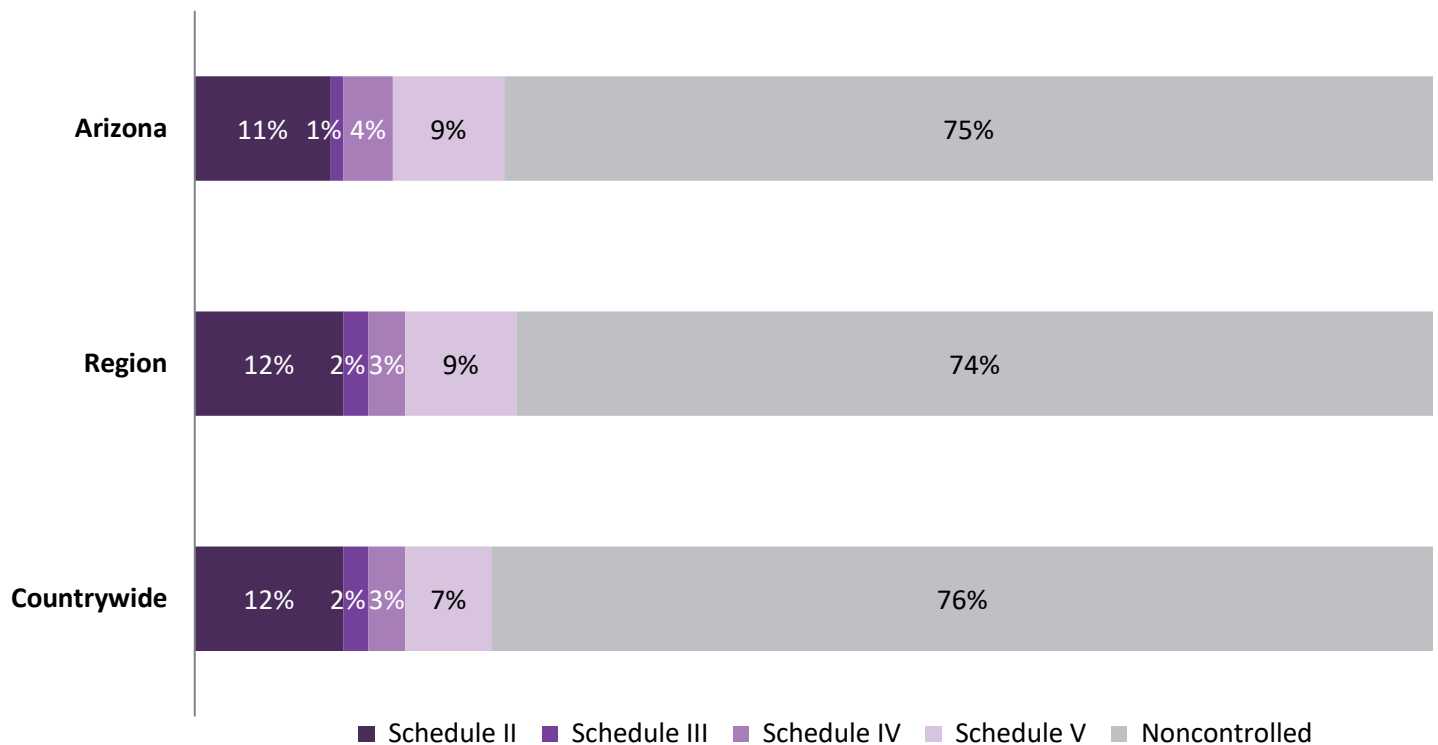




Chart 58 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Arizona. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also provided. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the average price per unit (PPU). (See the Glossary for the definition of *units*.)

Chart 58

Top 10 Workers Compensation Drugs by Amount Paid

Drug Name	Average PPU			Arizona Paid Share
	AZ	Region	CW	
Pregabalin	\$4.96	\$4.51	\$4.50	7.2%
Diclofenac Sodium (NSAID)	\$1.33	\$0.90	\$2.02	4.3%
Duloxetine HCl	\$5.46	\$4.43	\$4.35	4.2%
Lidocaine	\$6.00	\$5.50	\$6.22	4.1%
Celecoxib	\$4.73	\$4.36	\$5.25	4.1%
Lidopro Patch®	\$39.77	\$42.54	\$44.98	3.8%
Gabapentin	\$1.06	\$0.92	\$0.90	3.6%
Oxycontin®	\$8.66	\$9.31	\$9.91	3.6%
Diclofenac Sodium (3% Gel)	\$6.89	\$8.72	\$9.70	3.1%
Metaxalone	\$5.55	\$3.92	\$5.17	3.0%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	1
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	2
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	8
Lidocaine	G	Lidoderm®	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	5
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	3
Lidopro Patch®	B	N/A	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	16
Gabapentin	G	Neurontin®	Anticonvulsants	None	4
Oxycontin®	B	N/A	Analgesics/Antipyretics	II	7
Diclofenac Sodium (3% Gel)	G	Solaraze®	Skin/Mucous Membrane	None	10
Metaxalone	G	Skelaxin®	Muscle Relaxants, Skeletal	None	14



Chart 59 displays the top 10 drugs used in workers compensation treatment, according to the number of prescriptions in Arizona. This chart reveals the most frequently prescribed drugs and the average PPU.

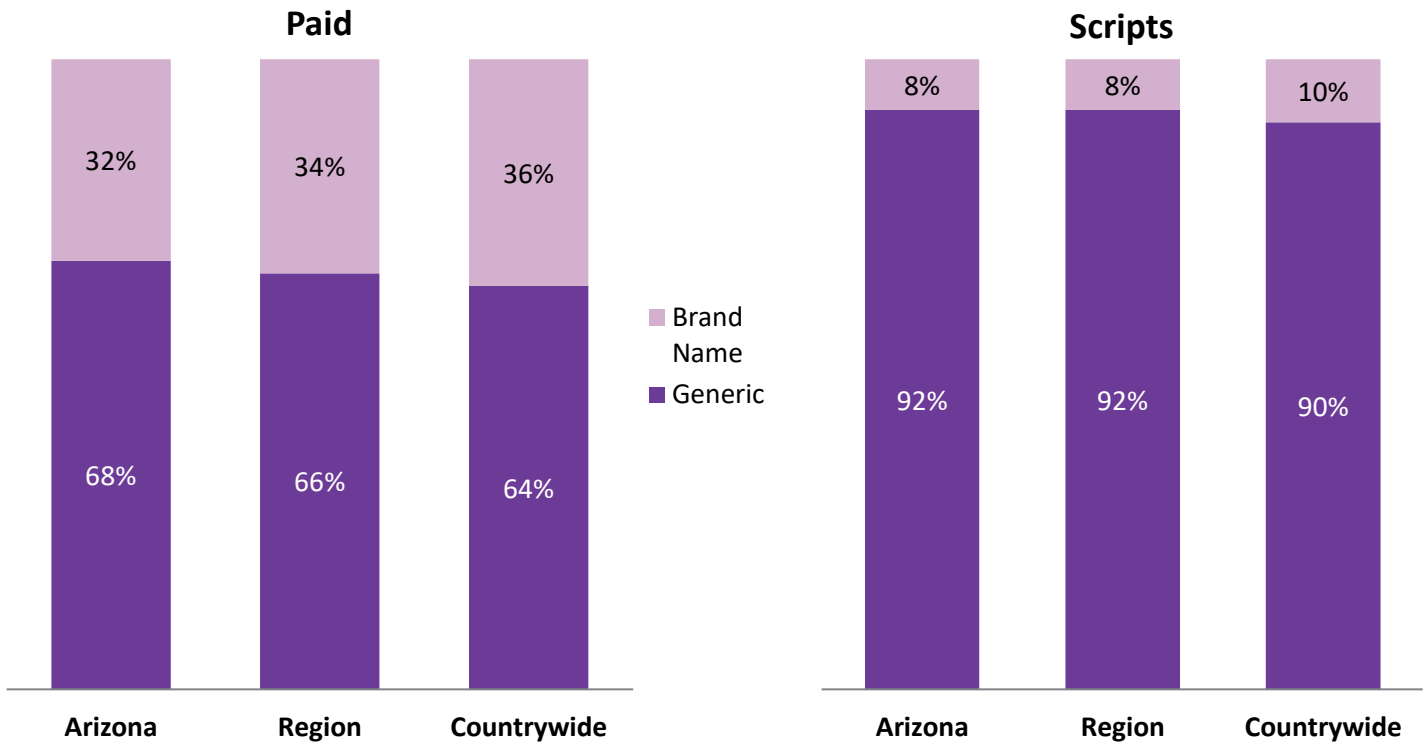
Chart 59

Top 10 Workers Compensation Drugs by Prescription Counts

Drug Name	Average PPU			Arizona Prescription Share
	AZ	Region	CW	
Ibuprofen	\$0.47	\$0.55	\$0.49	7.0%
Diclofenac Sodium (NSAID)	\$1.33	\$0.90	\$2.02	5.1%
Cyclobenzaprine HCl	\$1.73	\$1.07	\$1.88	5.0%
Gabapentin	\$1.06	\$0.92	\$0.90	4.6%
Hydrocodone Bitartrate-Acetaminophen	\$0.52	\$0.50	\$0.49	3.9%
Naproxen	\$0.98	\$0.95	\$0.95	3.7%
Acetaminophen	\$0.01	\$0.03	\$0.02	3.6%
Tramadol HCl	\$0.88	\$0.65	\$0.75	3.3%
Oxycodone HCl	\$0.65	\$0.58	\$0.70	3.2%
Meloxicam	\$2.75	\$2.83	\$3.04	3.1%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	4
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	7
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Naproxen	G	Aleve®	Analgesics/Antipyretics	None	9
Acetaminophen	G	Tylenol®	Analgesics/Antipyretics	None	27
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	6
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	12
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	5

Chart 60 shows the distribution of prescription drugs by brand name and generic for Arizona, the region, and countrywide. The share between brand name and generic is displayed based on the prescription counts and the payments. Typically, a higher percentage of drugs is given in the generic form; however, higher costs occur when brand name drugs are prescribed. In many states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand name and generic drugs.

Chart 60
Distribution of Drugs by Brand Name and Generic


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

Chart 61 shows the distribution of prescription drugs dispensed by pharmacies and nonpharmacies. The share between pharmacy-dispensed and nonpharmacy-dispensed is displayed, based on both prescription counts and payments, for Arizona, the region, and countrywide.

Chart 61

Distribution of Drugs by Pharmacy and Nonpharmacy

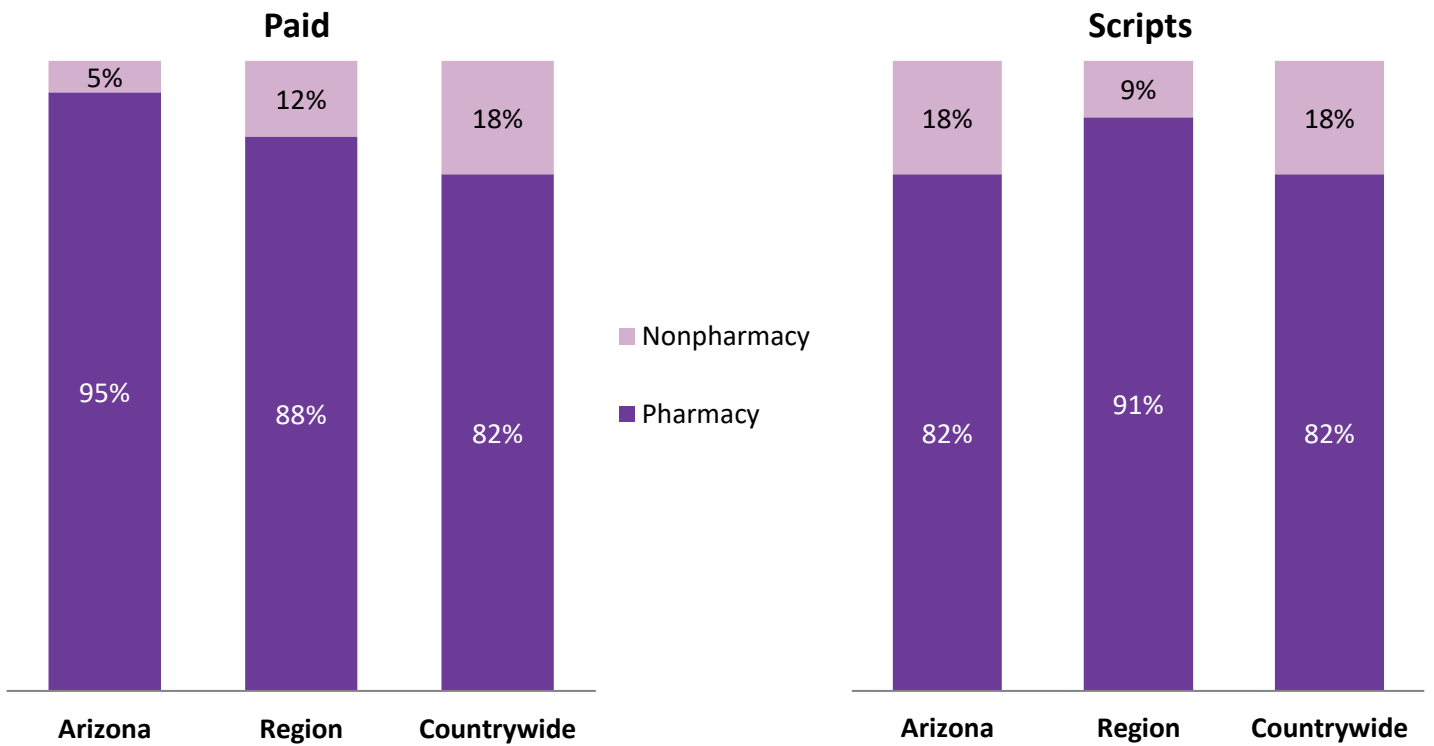


Chart 62 displays the shares of the payments for the top 5 nonpharmacy-dispensed prescription drugs used in workers compensation treatment, by amount paid in Arizona. It also provides a comparison for those same drugs when dispensed in a pharmacy for the state, region, and countrywide.

Chart 62
Top 5 Nonpharmacy-Dispensed Drugs by Amount Paid with Pharmacy-Dispensed Comparison

Drug Name	Nonpharmacy-dispensed				Pharmacy-dispensed			
	Paid Share	AZ PPU	Region PPU	CW PPU	Paid Share	AZ PPU	Region PPU	CW PPU
Metaxalone	18.5%	\$6.67	\$8.12	\$8.45	2.2%	\$5.18	\$3.53	\$3.98
Diclofenac Sodium (NSAID)	6.9%	\$0.62	\$4.11	\$5.41	4.2%	\$1.48	\$0.68	\$1.42
Botox®	5.7%	\$303.11	\$362.86	\$295.89	0.3%	\$630.82	\$847.85	\$785.65
Ibuprofen	5.5%	\$0.44	\$0.71	\$0.56	0.9%	\$0.48	\$0.53	\$0.47
Lidothol®	3.7%	\$15.37	\$38.31	\$31.83	0.6%	\$12.52	\$35.13	\$28.37

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	Nonpharmacy CW Rank
Metaxalone	G	Skelaxin®	Muscle Relaxants, Skeletal	None	8
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	1
Botox®	B	N/A	Toxins	None	10
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	20
Lidothol®	B	N/A	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	7

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

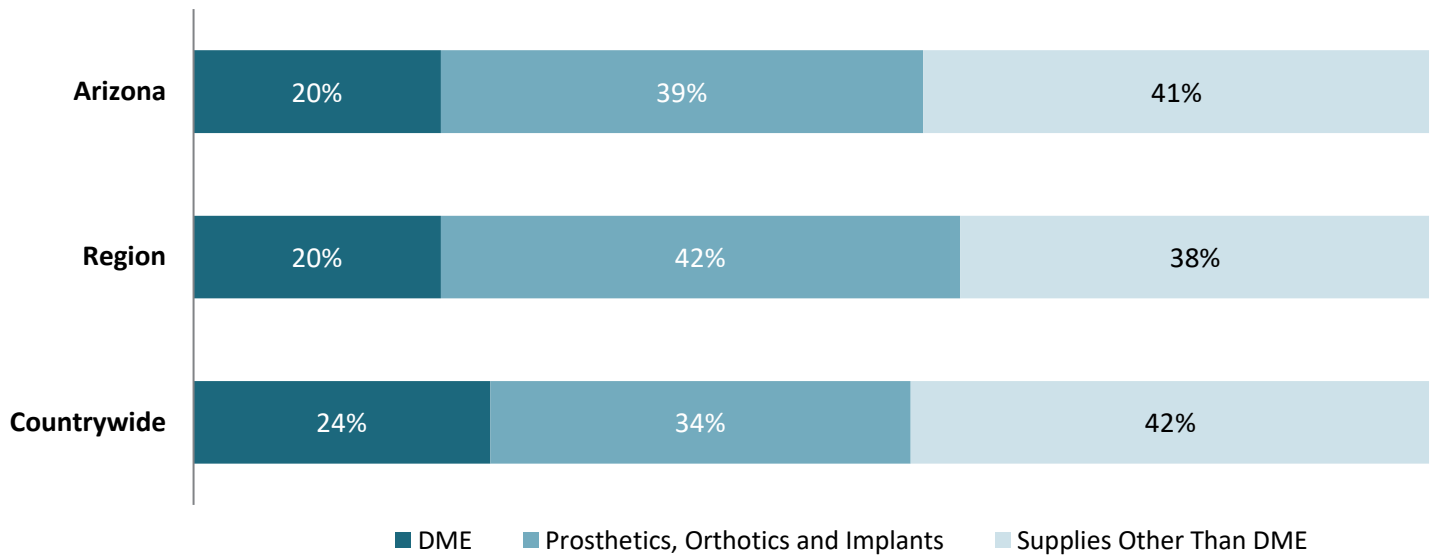
The distribution of medical payments for DMEPOS is 8% for Arizona, 6% for the region, and 8% for countrywide.

Chart 63 displays the distribution of payments among three separate DMEPOS categories:

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

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

Chart 63
Distribution of Payments by DMEPOS





Injuries that include an implant or prosthetic device tend to be more expensive than other injuries. Chart 64 shows the top 10 diagnosis groups for claims that include an implant or a prosthetic device by total paid amount. Chart 65 shows the same diagnosis groups with the average amount paid per claim for claims that do not include an implant or prosthetic.

Chart 64

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2020 for Claims *With* an Implant or Prosthetic

Diagnosis Group	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Rotator cuff tear	7.8%	\$44,530	\$29,132	\$39,232
Tibia/fibula fracture	6.9%	\$88,879	\$62,568	\$75,001
Hand/wrist fracture	5.7%	\$39,328	\$26,017	\$29,246
Elbow/forearm fracture	4.6%	\$142,400	\$40,969	\$52,796
Minor shoulder injury	3.5%	\$29,068	\$23,706	\$29,463
COVID-19	3.0%	\$470,376	\$183,332	\$254,180
Lumbar spine degeneration	2.8%	\$144,202	\$79,187	\$94,065
Burn and corrosion, third degree, other than head, face, and neck	2.6%	\$300,321	\$254,534	\$387,120
Ankle fracture	2.4%	\$51,966	\$33,222	\$38,185
Burn and corrosion, second degree, of head, face, and neck	2.4%	\$1,121,738	\$94,099	\$271,906

Chart 65

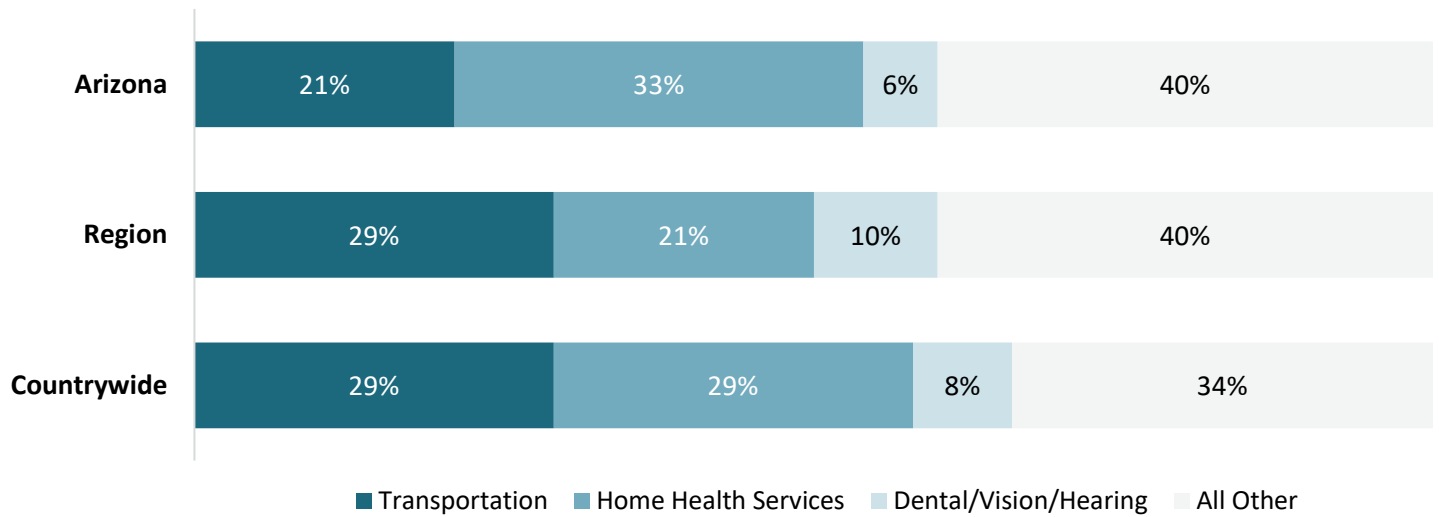
Average Amount Paid per Claim *Without* an Implant or Prosthetic for Diagnosis Groups in Chart 64

Diagnosis Group	Average Amount Paid Per Claim		
	Arizona	Region	Countrywide
Rotator cuff tear	\$14,394	\$15,620	\$20,188
Tibia/fibula fracture	\$20,096	\$13,741	\$16,248
Hand/wrist fracture	\$7,249	\$6,020	\$6,212
Elbow/forearm fracture	\$13,928	\$9,343	\$9,775
Minor shoulder injury	\$3,683	\$3,826	\$4,252
COVID-19	\$25,288	\$8,542	\$12,373
Lumbar spine degeneration	\$17,646	\$11,285	\$14,778
Burn and corrosion, third degree, other than head, face, and neck	\$54,326	\$41,100	\$46,388
Ankle fracture	\$19,933	\$14,308	\$14,982
Burn and corrosion, second degree, of head, face, and neck	\$5,461	\$9,385	\$9,263

Other Medical Services

For Service Year 2021, other medical services represent 5% of total medical costs countrywide. Chart 66 shows the distribution of these services by four categories: transportation, home health services, dental/vision/hearing, and all other. The “All Other” category typically includes services that may have a missing, invalid, or unlisted procedure, in addition to some other valid services (e.g., payments for interpreters, vehicle modifications, etc.).

Chart 66
Distribution of Other Medical Services Payments



Diagnosis Group and Body System

Charts 67 and 68 display the top 10 body systems and diagnosis groups, respectively. A body system and diagnosis group are identified for each claim based on an ICD-10 code. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 body systems and diagnosis groups are ranked by total claim payments for Arizona. This method of ranking shows which body systems and diagnosis groups have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2020, and December 31, 2020, and they include all reported services provided for those claims through December 31, 2021.

Chart 67

Top Body Systems by Amount Paid for Dates of Injury in 2020

Body System	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Shoulder	13.0%	\$7,965	\$8,109	\$10,188
Hand/wrist	13.0%	\$2,602	\$2,338	\$2,609
Lumbar spine	9.3%	\$3,853	\$3,874	\$4,786
Knee	8.4%	\$5,863	\$5,725	\$6,477
Ankle/foot	8.0%	\$3,896	\$3,464	\$3,863
Arm	6.7%	\$8,598	\$5,538	\$6,403
Leg	6.4%	\$6,425	\$5,734	\$6,796
Head	6.2%	\$5,397	\$4,184	\$4,308
Respiration	4.1%	\$26,347	\$11,331	\$16,506
Chest/upper torso	3.3%	\$4,147	\$3,377	\$3,586

Chart 68

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2020

Diagnosis Group	Paid Share	Average Amount Paid Per Claim		
		Arizona	Region	Countrywide
Minor hand/wrist injuries	5.8%	\$1,518	\$1,282	\$1,407
Minor shoulder injury	5.1%	\$4,265	\$4,194	\$4,769
Low back pain	5.1%	\$2,390	\$2,612	\$2,499
Rotator cuff tear	4.5%	\$19,801	\$17,331	\$22,884
Hand/wrist fracture	4.4%	\$9,580	\$7,257	\$7,619
Minor ankle/foot injuries	3.2%	\$2,227	\$1,849	\$1,908
Minor knee injury	3.0%	\$2,920	\$2,595	\$2,833
Tibia/fibula fracture	3.0%	\$34,007	\$25,229	\$28,413
COVID-19	2.6%	\$33,793	\$9,529	\$14,772
Neck pain	1.8%	\$3,075	\$3,434	\$3,464



Comparison of Selected Results by Year

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

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

Distribution of Medical Payments (Chart 4)

Medical Category	2017	2018	2019	2020	2021
Physician	35%	37%	39%	38%	38%
Hospital Outpatient	18%	17%	17%	17%	18%
Hospital Inpatient	14%	15%	15%	16%	15%
Drugs	12%	11%	9%	9%	8%
DMEPOS	8%	7%	7%	7%	8%
ASC	7%	6%	6%	6%	6%
Other	6%	7%	7%	7%	7%

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

AMA Service Category	2017	2018	2019	2020	2021
Physical Medicine	31%	35%	35%	38%	38%
Surgery	20%	16%	17%	15%	14%
Evaluation and Management	28%	29%	29%	28%	30%
Radiology	9%	8%	8%	8%	8%
Anesthesia	3%	3%	3%	3%	2%
General Medicine	3%	3%	3%	3%	3%
Other	3%	4%	3%	4%	4%
Pathology	3%	2%	2%	1%	1%

**Median Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53)¹⁰**

Medical Category	AY 2016	AY 2017	AY 2018	AY 2019	AY 2020
Physicians – Major Surgery	28	22	25	28	23
Physicians – Radiology	1	1	1	1	1
Physicians – Physical and General Medicine	9	10	9	9	8
Physicians – Evaluation and Management	1	1	1	1	1
Hospital Inpatient	0	0	0	0	0
Hospital Outpatient – Major Surgery	63	50	55	57	58
Hospital Outpatient – All Other	12	12	13	15	20
ASC – Major Surgery	66	66	70	78	79

75th Percentile of Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53)¹⁰

Medical Category	AY 2016	AY 2017	AY 2018	AY 2019	AY 2020
Physicians – Major Surgery	109	98	101	102	111
Physicians – Radiology	7	7	7	8	8
Physicians – Physical and General Medicine	32	32	31	33	30
Physicians – Evaluation and Management	4	4	4	4	4
Hospital Inpatient	4	4	6	5	8
Hospital Outpatient – Major Surgery	141	129	126	139	149
Hospital Outpatient – All Other	48	47	49	53	68
ASC – Major Surgery	137	134	150	149	171

Hospital Inpatient Statistics (Charts 27 and 29)

	2017	2018	2019	2020	2021
Average Amount Paid Per Stay	\$37,335	\$40,450	\$44,318	\$47,814	\$51,759
Number of Stays per 1,000 Active Claims	17	15	15	15	13

¹⁰ In the charts displaying the distribution of time until first treatment, the data is organized by the year in which the injury occurred, rather than by service year, and includes services performed within 365 days of the date of injury.

**Distribution of Hospital Outpatient Payments by Outpatient Visit Type (Chart 35)**

Visit Type	2017	2018	2019	2020	2021
Emergency	43%	46%	46%	45%	47%
Nonemergency Major Surgery	39%	37%	37%	37%	38%
Other	18%	17%	17%	18%	15%

Emergency Hospital Outpatient Statistics (Charts 36 and 37)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	\$2,046	\$2,078	\$2,217	\$2,390	\$2,435
Number of Visits per 1,000 Active Claims	171	169	160	141	160

Emergency Room Outpatient Services Paid per Transaction (Chart 39)

Code	Severity	2017	2018	2019	2020	2021
99281	Minor	\$235	\$222	\$257	\$255	\$341
99282	Low to moderate	\$325	\$354	\$358	\$377	\$377
99283	Moderate	\$559	\$610	\$648	\$654	\$674
99284	High	\$938	\$936	\$922	\$948	\$972
99285	High and immediately life-threatening	\$1,531	\$1,492	\$1,501	\$1,504	\$1,623

Nonemergency Major Surgery Hospital Outpatient Statistics (Charts 40 and 41)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	\$12,135	\$12,545	\$13,349	\$12,920	\$14,156
Number of Visits per 1,000 Active Claims	26	22	21	22	22

Other Hospital Outpatient Statistics (Charts 45 and 46)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	\$550	\$544	\$620	\$628	\$660
Number of Visits per 1,000 Active Claims	270	232	209	219	192

ASC Major Surgery Statistics (Charts 51 and 52)

	2017	2018	2019	2020	2021
Average Amount Paid Per Visit	\$8,670	\$8,435	\$8,172	\$8,128	\$8,192
Number of Visits per 1,000 Active Claims	29	28	30	30	31

Distribution of Prescription Drug Payments by CSA Schedule (Chart 57)

CSA Schedule	2017	2018	2019	2020	2021
Schedule II	22%	19%	14%	13%	11%
Schedule III	1%	1%	1%	1%	1%
Schedule IV	7%	6%	5%	4%	4%
Schedule V	7%	9%	8%	8%	9%
Noncontrolled	63%	65%	72%	74%	75%

Distribution of Drug Payments by Brand Name and Generic (Chart 60)

Type of Drug	2017	2018	2019	2020	2021
Brand Name	45%	45%	39%	31%	32%
Generic	55%	55%	61%	69%	68%

Distribution of Drug Payments by Pharmacy and Nonpharmacy (Chart 61)

Type of Provider	2017	2018	2019	2020	2021
Pharmacy	91%	86%	82%	95%	95%
Nonpharmacy	9%	14%	18%	5%	5%

Distribution of Payments by DMEPOS (Chart 63)

Category	2017	2018	2019	2020	2021
DME	15%	16%	18%	21%	20%
Prosthetics, Orthotics and Implants	49%	46%	44%	38%	39%
Supplies Other Than DME	36%	38%	38%	41%	41%

Distribution of Payments by Other Medical Services (Chart 66)

Category	2017	2018	2019	2020	2021
Transportation	22%	22%	22%	22%	21%
Home Health Services	36%	30%	29%	31%	33%
Dental/Vision/Hearing	6%	6%	6%	7%	6%
All Other	36%	42%	43%	40%	40%



Glossary

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

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

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

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

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

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

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

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

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

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

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

Emergency Services: Services performed for patients requiring immediate attention.

Emergency Visit: A visit where emergency services are performed.



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

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

Hospital Inpatient 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).

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

Hospital Outpatient 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).

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

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

Major Surgery Visit: A visit in which at least one surgery procedure is performed based on the reported procedure code, and where the surgical procedure is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, or the procedure involves spine/spinal cord neurostimulators.

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.

Other Outpatient Visit: A nonemergency outpatient visit where no major surgery services are performed.

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

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

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

Taxonomy 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.



Telemedicine Service: Services reported with a telemedicine-specific procedure code, modifier, or place of service.

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

Transaction: A line item of a medical bill.

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

- For tablets, capsules, suppositories, nonfilled syringes, etc., *units* represent the actual number of the drug provided. For example, a bottle of 30 pills would have 30 units.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, the units are specified by the procedure code. For example, a cream is dispensed in a standard tube, which is defined as a single unit.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, the number of units is the amount provided in its standard unit of measurement, such as milliliters, grams, or ounces. For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as four units.

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



Appendix

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

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

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

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

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

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