Medical Data Report

For the state of

ARIZONA

September 2021

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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 2020 (medical services delivered from January 1, 2020, to December 31, 2020), 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 impacts of COVID-19 on medical losses, please see the Medical Indicators & Trends dashboard[1] on **ncci.com**.

For Arizona in Service Year 2020, the reported number of transactions was more than 1,364,500, with more than $290,044,300 paid, for more than 58,700 claims. This represents data from 94% 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.

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

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

- NCCI's Medical Data Call, Service Year 2020
- Region includes data from the following states: AK, CO, HI, ID, MT, NM, NV, OR, and UT.
- Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV

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

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Medical Cost Statistics

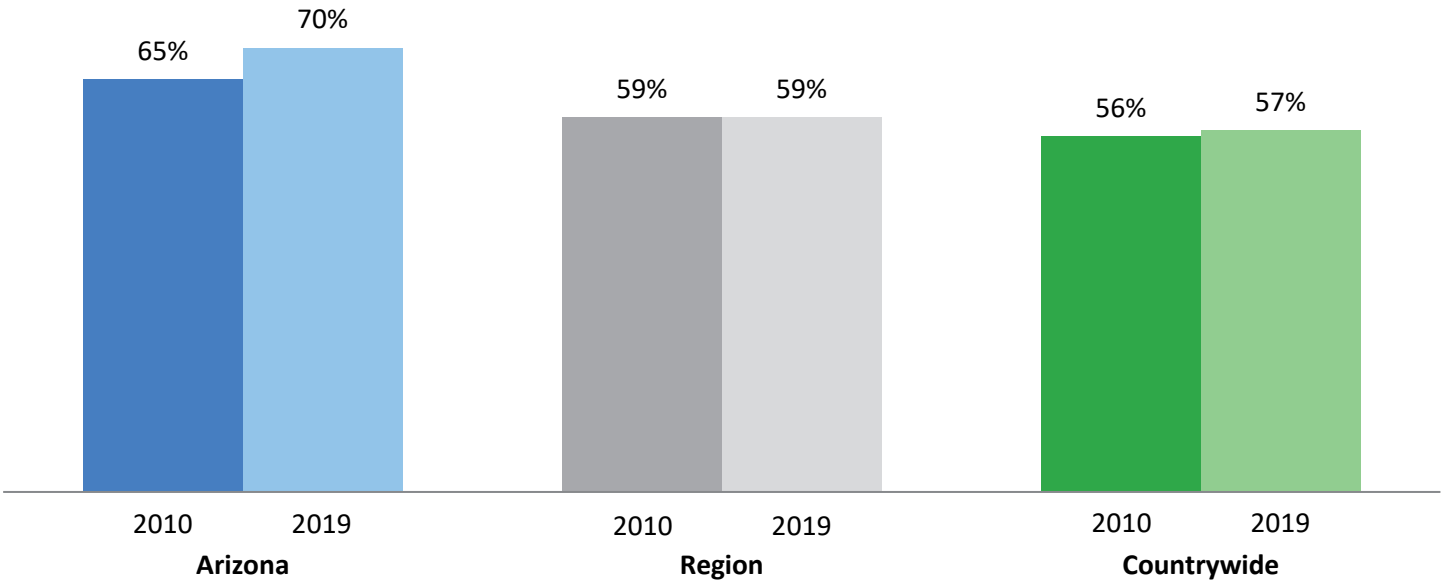
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

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 2010 and 2019.

Chart 1

Medical Share of Total Benefit Costs by Accident Year



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

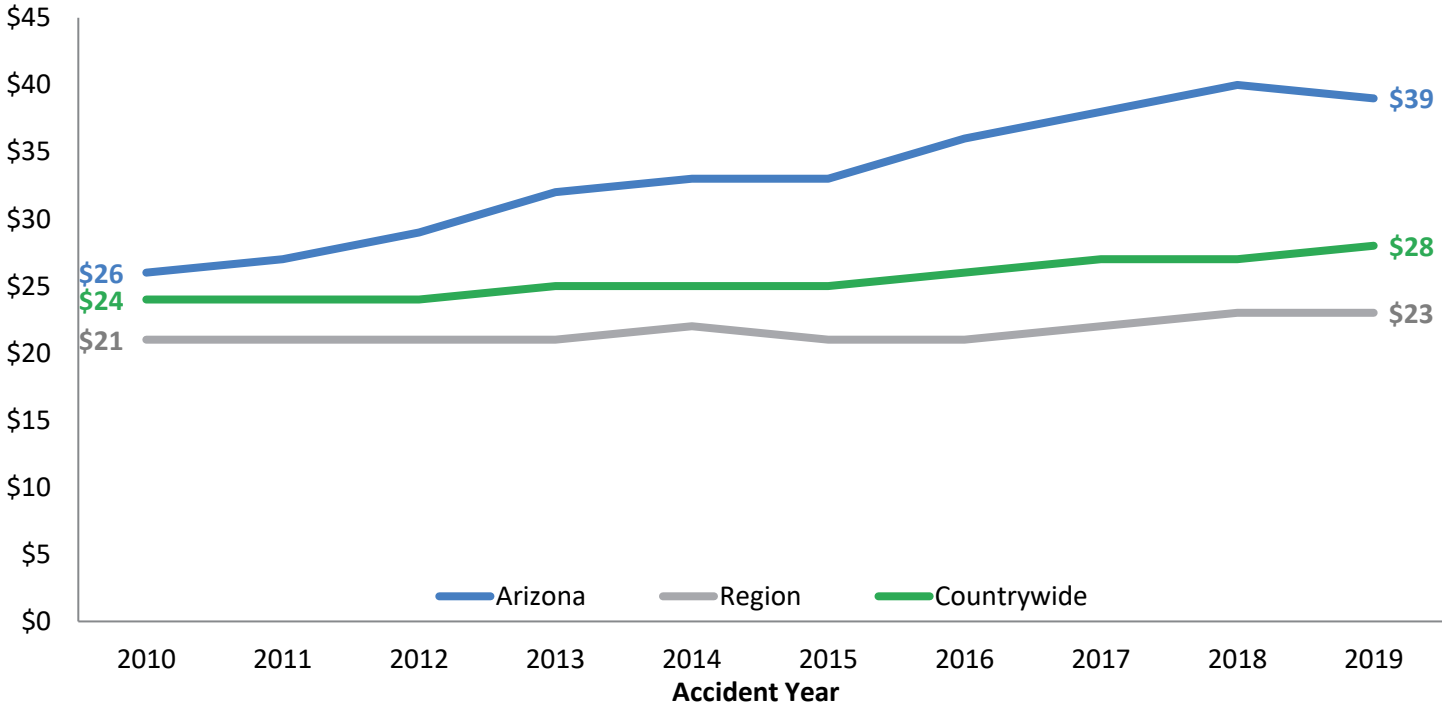
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging about 2% from Accident Years 2010 to 2019; this has increased at a slightly higher rate than the United States Personal Healthcare Spending per capita.[2] Chart 2 displays the historical overall 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 all medical losses by accident year, the results shown in this chart provide a high-level perspective of the average medical cost per case.

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

Chart 2

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



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

[2] **State of the Line Report, *Annual Issues Symposium***, May 2021, www.ncci.com/Articles/Documents/AIS2021-SOTL-Presentation.pdf

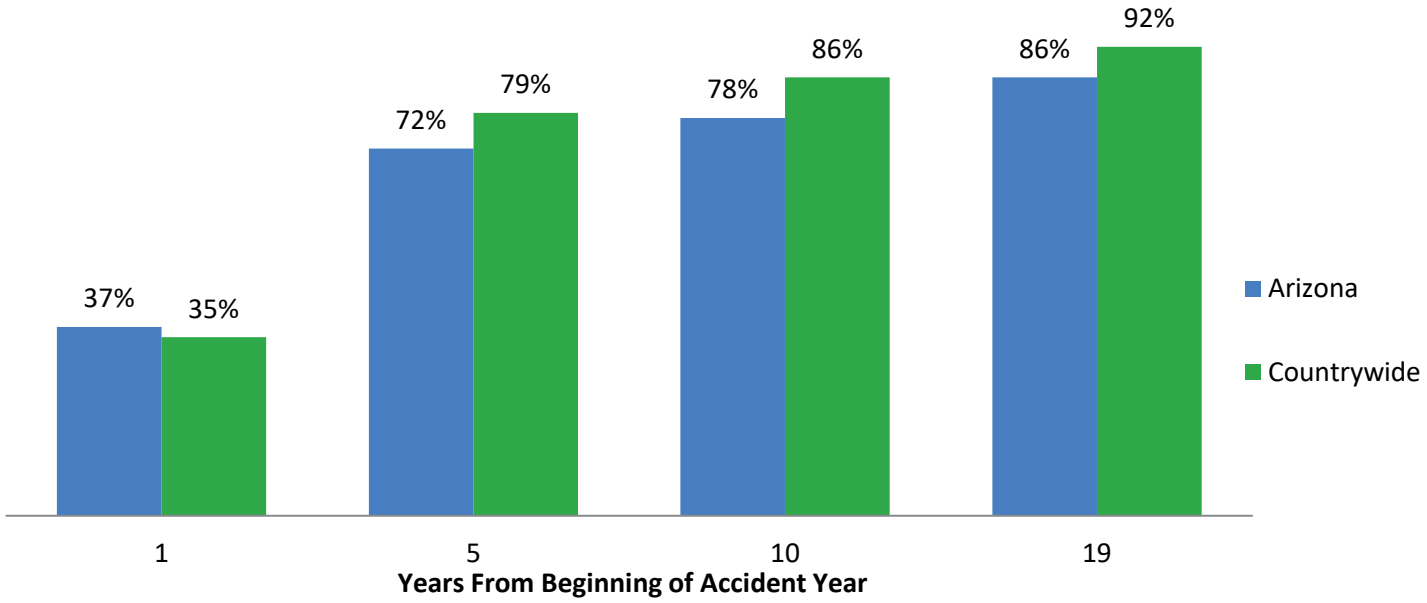
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. NCCI research has found that it is likely that about 10% of the cost of medical benefits for workplace injuries that occur this year will be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

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

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

Chart 3

Percentage of Medical Paid by Claim Maturity



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

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

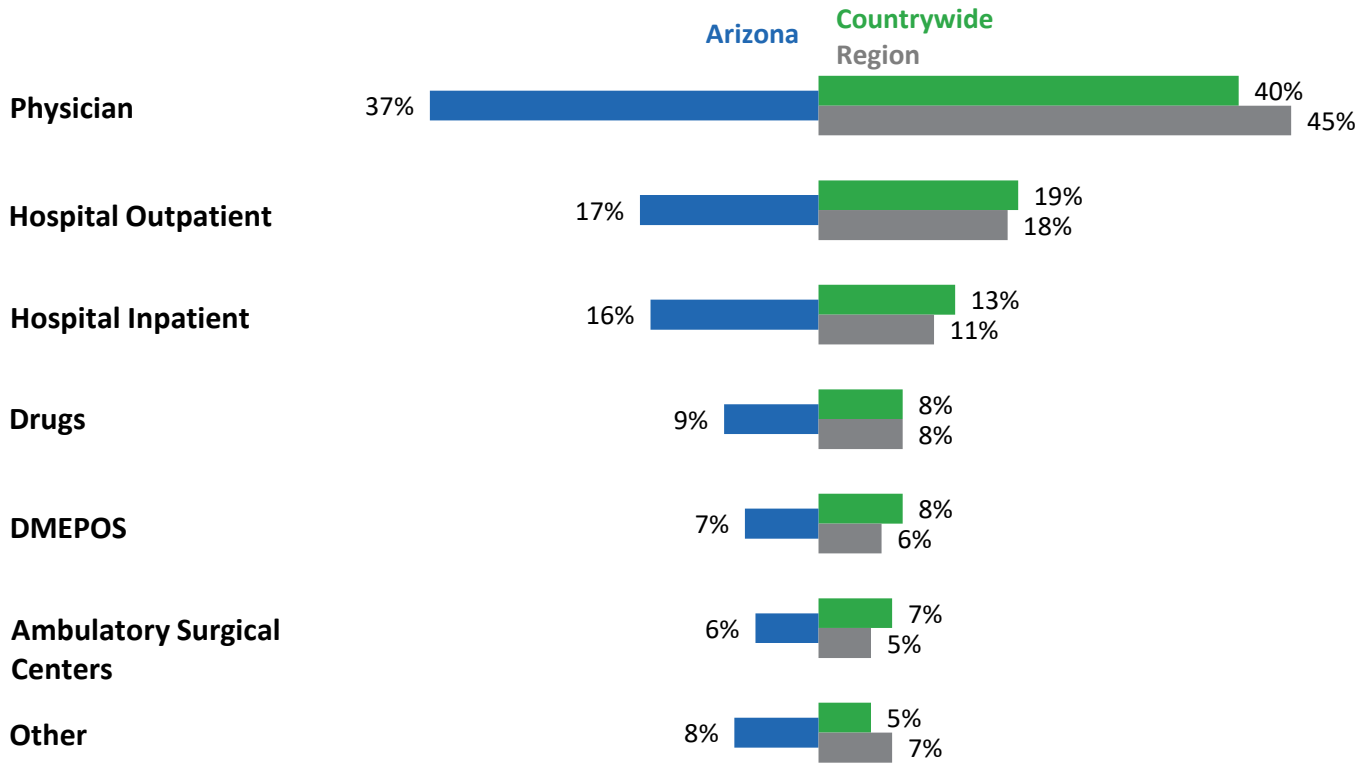
Payments are categorized as Drugs; DME, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed. For the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

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

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

Chart 4

Distribution of Medical Payments



Physicians

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

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

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

The chart below shows the average percentage of Medicare schedule reimbursement[3] 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, 87% of "all physician services" payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

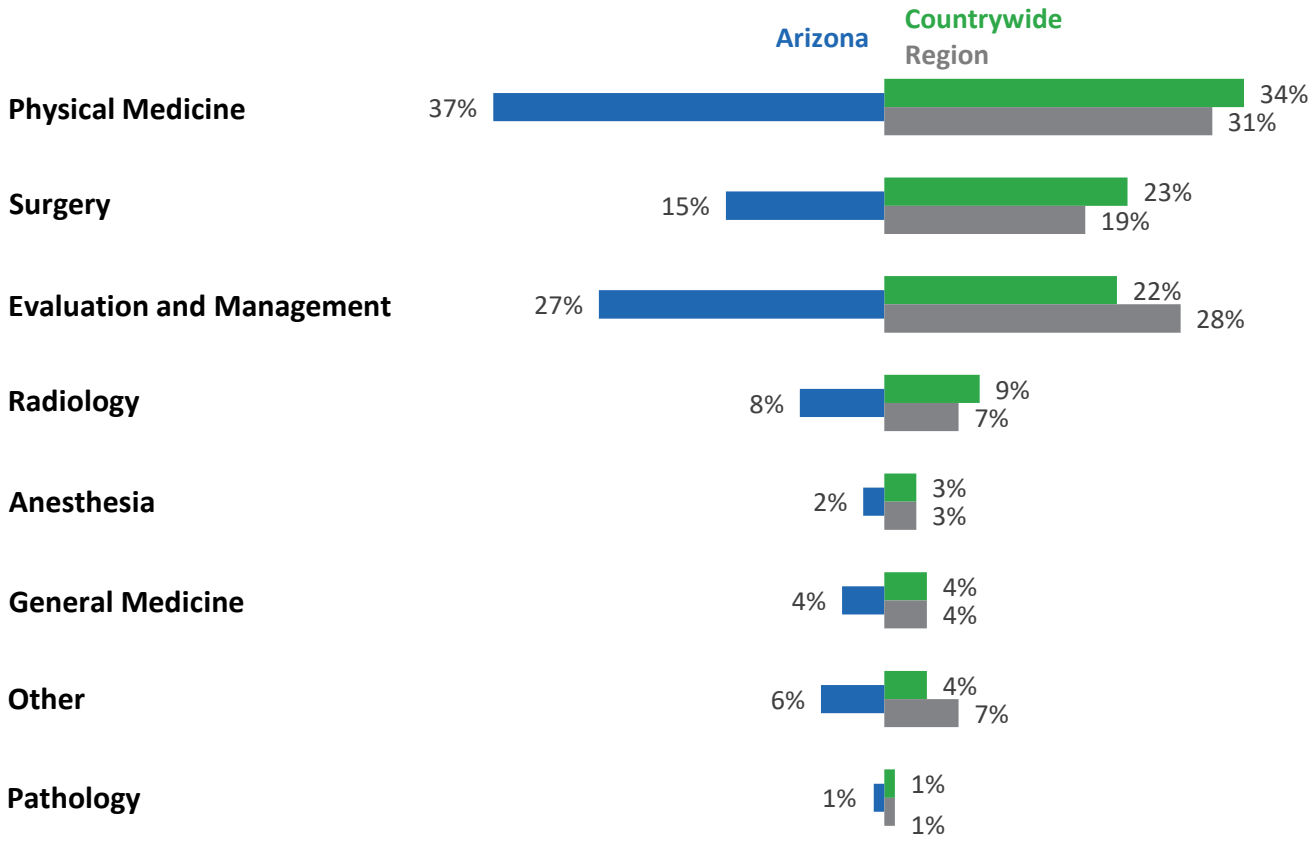
Physician Service Category	Arizona	Region	Countrywide
General and Physical Medicine	148%	134%	132%
Surgery	198%	211%	270%
Evaluation and Management	154%	154%	144%
Radiology	208%	214%	227%
Anesthesia	250%	252%	309%
All Physician Services	**163%**	**159%**	**167%**

[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). Results[4] show that WC physician costs are 77% higher than GH in general, with variation across states ranging from 0% to 200%. The difference in costs for physician services is due to both prices and utilization of services. Most notably, physical medicine services in WC are almost three times the costs of physical medicine services in GH, largely due to the number of services provided.

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

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

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

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

Additional charts show time until first treatment 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.

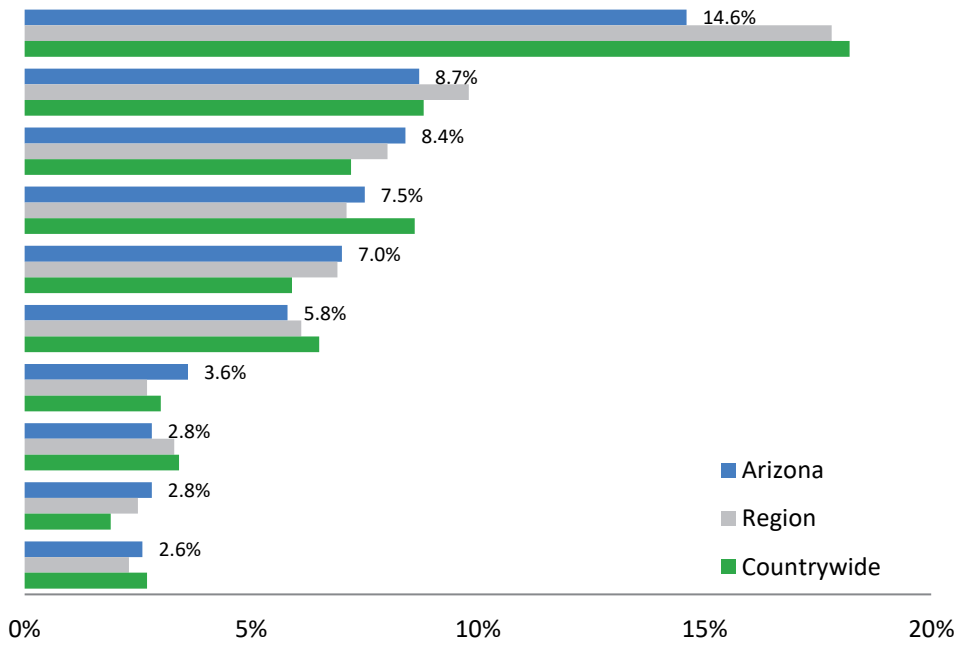
[4] Lipton, Barry, *Work Comp vs. Group Health—The Price We Pay* (Channel NCCI, video file), May 23, 2019, www.youtube/fb3tnbQoMSY

In Arizona, physician payments for anesthesia services provided in 2020 are, on average, 250% of Medicare-scheduled reimbursement amounts, compared to 252% in the region and 309% 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

	Average PPU[5]		
Code	**AZ**	**Region**	**CW**
01630	$84	$91	$95
01400	$93	$100	$101
01830	$74	$82	$81
00670	$94	$111	$110
01480	$70	$76	$76
01810	$82	$92	$94
01936	$91	$109	$111
00630	$104	$108	$107
00840	$105	$99	$103
00400	$79	$81	$83



Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
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
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified

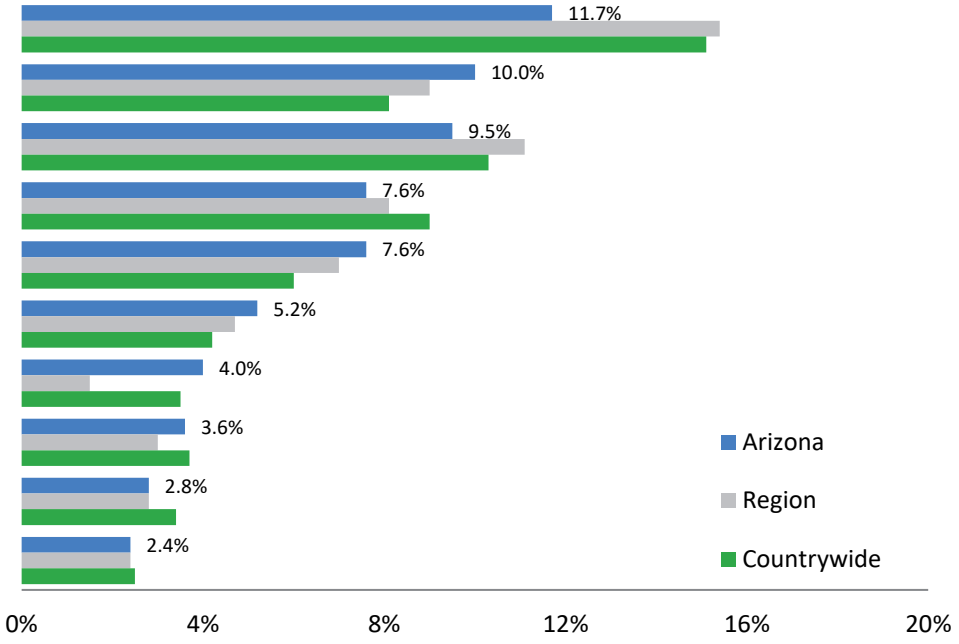
[5] A unit is an increment of 15 minutes unless otherwise defined in the description.

Chart 8

Top 10 Anesthesia Procedure Codes by Transaction Counts

Code	Average PPU AZ	Average PPU Region	Average PPU CW
01630	$84	$91	$95
01830	$74	$82	$81
01400	$93	$100	$101
01810	$82	$92	$94
01480	$70	$76	$76
01936	$91	$109	$111
01992	$73	$91	$94
00400	$79	$81	$83
00670	$94	$111	$110
01710	$77	$83	$86

Transaction Share



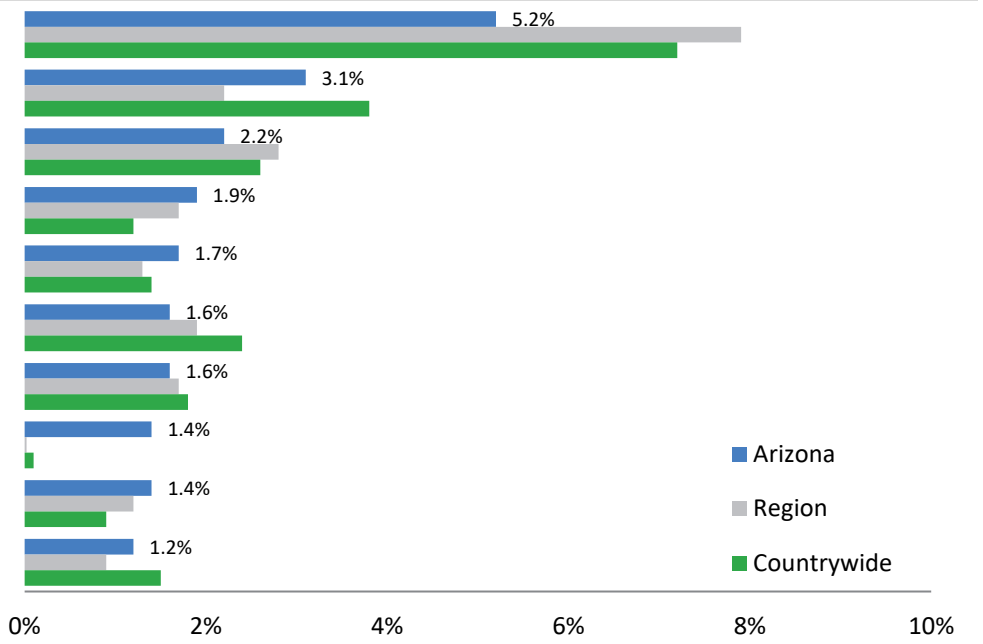
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna,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

In Arizona, physician payments for surgery services provided in 2020 are, on average, 198% of Medicare-scheduled reimbursement amounts, compared to 211% in the region and 270% countrywide. Payments for these services comprise 15% of physician payments, compared to 19% in the region and 23% countrywide.

Chart 9

Top 10 Surgery Procedure Codes by Amount Paid

Code	Average PPT AZ	Average PPT Region	Average PPT CW
29827	$1,440	$1,910	$2,155
29826	$842	$485	$987
29881	$1,105	$1,181	$1,500
12001	$162	$158	$182
20610	$128	$125	$131
29823	$609	$747	$1,043
64483	$317	$449	$576
14302	$887	$1,446	$1,605
20680	$718	$740	$858
63047	$1,637	$1,613	$2,676



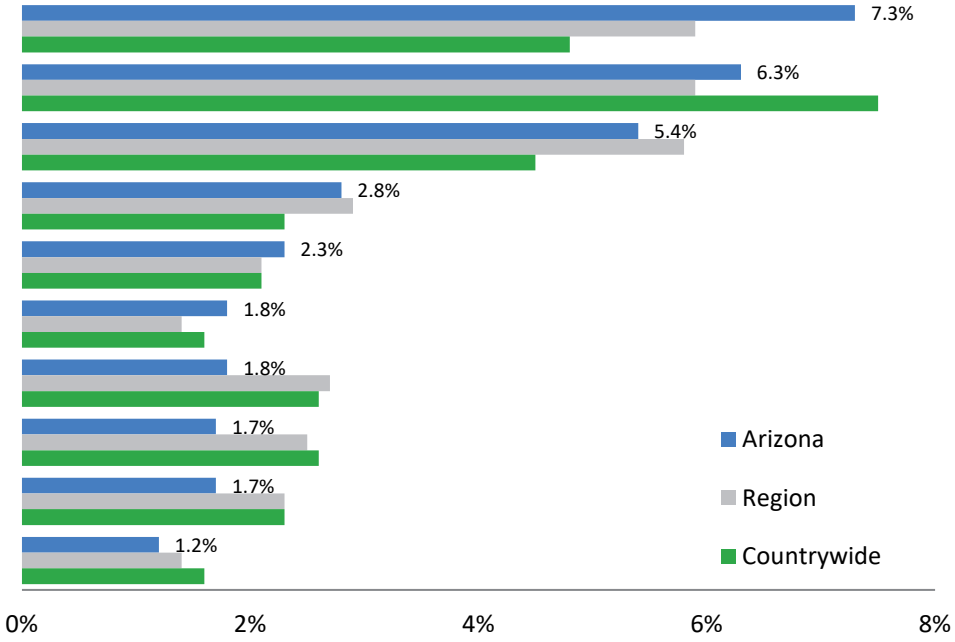
Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
29823	Arthroscopy, shoulder, surgical; debridement, extensive
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure)
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
63047	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root), single vertebral segment; lumbar

Chart 10

Top 10 Surgery Procedure Codes by Transaction Counts

Code	Average PPT AZ	Average PPT Region	Average PPT CW
36415	$10	$12	$11
20610	$128	$125	$131
12001	$162	$158	$182
12002	$196	$200	$215
64483	$317	$449	$576
20550	$110	$104	$111
64415	$174	$167	$286
29826	$842	$485	$987
29827	$1,440	$1,910	$2,155
29823	$609	$747	$1,043

Transaction Share

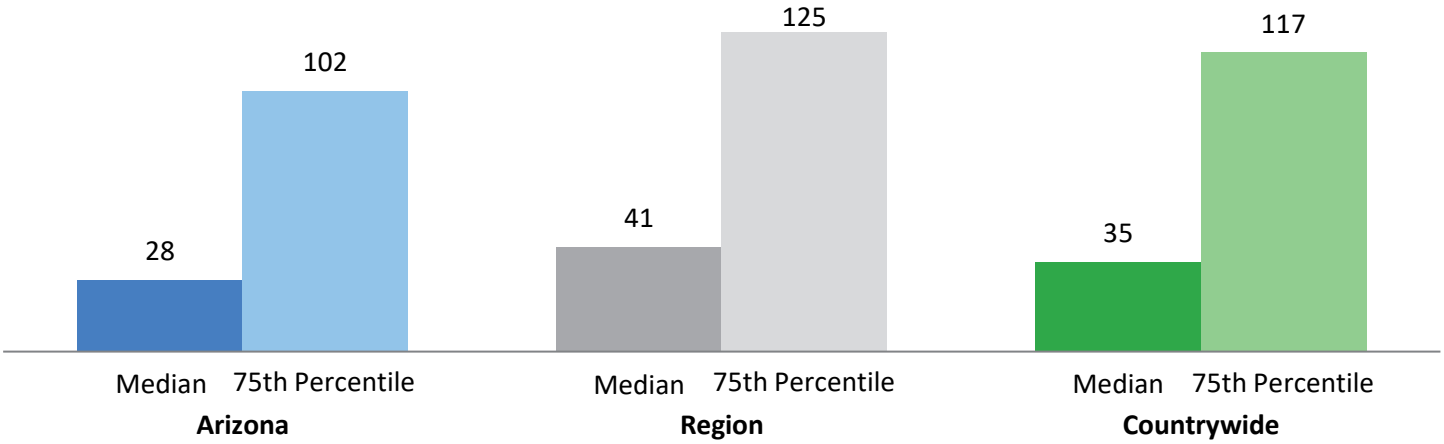


Code	Description
36415	Collection of venous blood by venipuncture
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.6 cm to 7.5 cm
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
20550	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)
64415	Injection, anesthetic agent; brachial plexus, single
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29823	Arthroscopy, shoulder, surgical; debridement, extensive

Chart 11 shows the median and 75th percentile[6] time until first treatment for major surgery for Arizona, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop such as an occupational disease, which may extend the time between the date a work-related injury or disease is reported and the first medical treatment takes place.

Chart 11

Time Until First Treatment for Major Surgery[7] (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

[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 102 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

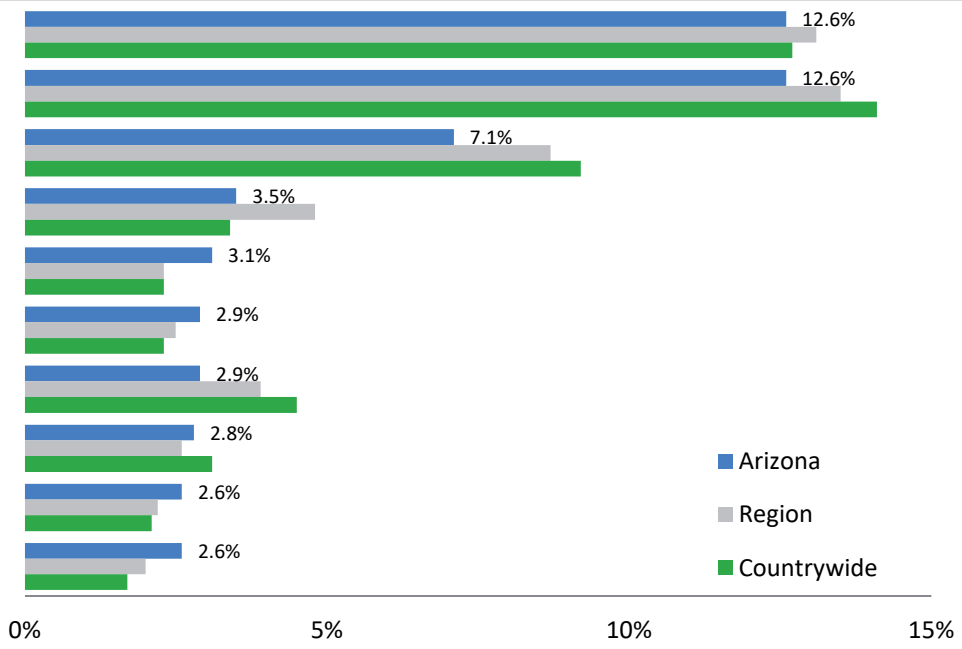
[7] A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it has a global follow-up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection.

In Arizona, physician payments for radiology services provided in 2020 are, on average, 208% of Medicare-scheduled reimbursement amounts, compared to 214% in the region and 227% 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	Average PPT AZ	Average PPT Region	Average PPT CW
73721	$483	$418	$484
73221	$485	$422	$492
72148	$455	$405	$470
73222	$623	$527	$633
73110	$69	$57	$62
73610	$60	$53	$56
72141	$448	$397	$464
73030	$56	$53	$59
73630	$55	$52	$54
73562	$71	$60	$64

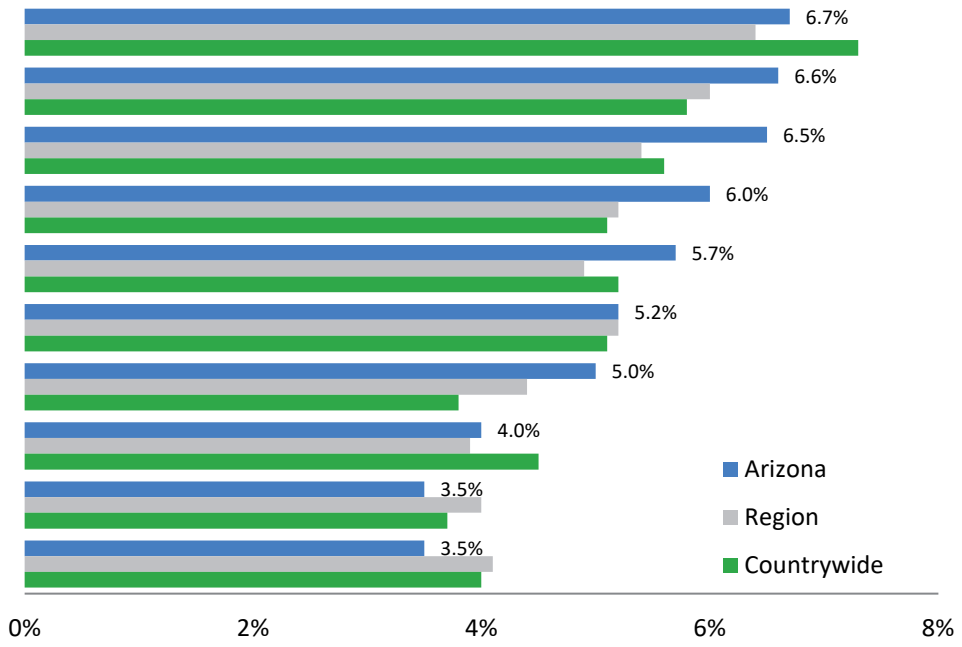


Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents,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

Chart 13

Top 10 Radiology Procedure Codes by Transaction Counts

Code	Average PPT AZ	Average PPT Region	Average PPT CW
73030	$56	$53	$59
73610	$60	$53	$56
73630	$55	$52	$54
73110	$69	$57	$62
73130	$61	$51	$54
73140	$64	$49	$54
73562	$71	$60	$64
72100	$70	$67	$65
73721	$483	$418	$484
73221	$485	$422	$492

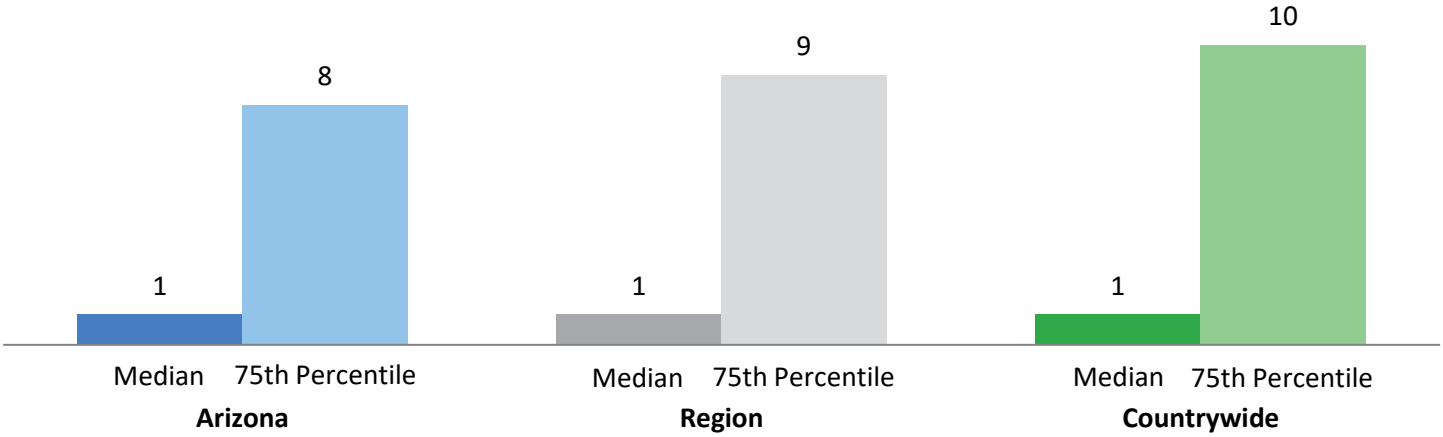


Code	Description
73030	Radiologic examination, shoulder; complete minimum of 2 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73630	Radiologic examination, foot; complete minimum of 3 views
73110	Radiologic examination, wrist; complete minimum of 3 views
73130	Radiologic examination,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

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

Chart 14

Time Until First Treatment for Radiology (in Days)



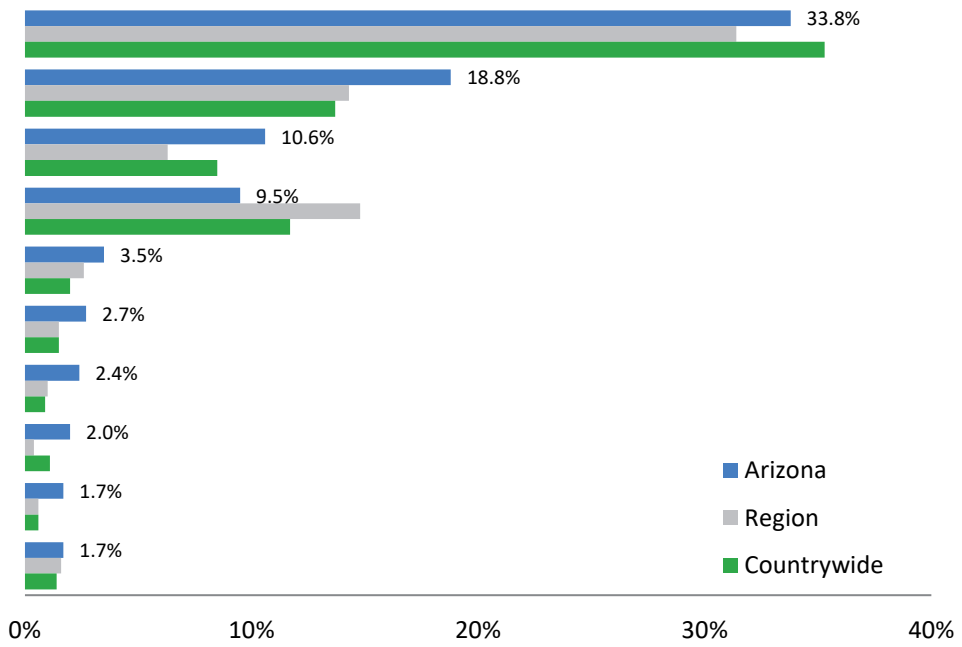
Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

In Arizona, physician payments for physical and general medicine services provided in 2020 are, on average, 148% of Medicare-scheduled reimbursement amounts, compared to 134% in the region and 132% countrywide. Payments for these services comprise 41% of physician payments, compared to 35% in the region and 38% countrywide.

Chart 15

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

	Average PPU			
Code	**AZ**	**Region**	**CW**	**Paid Share**
97110	$46	$42	$42	33.8%
97530	$59	$53	$46	18.8%
97112	$51	$45	$43	10.6%
97140	$39	$40	$38	9.5%
99199	$837	$340	$228	3.5%
97161	$136	$113	$120	2.7%
97164	$88	$72	$73	2.4%
97799	$394	$172	$455	2.0%
97535	$56	$50	$44	1.7%
97162	$137	$110	$125	1.7%

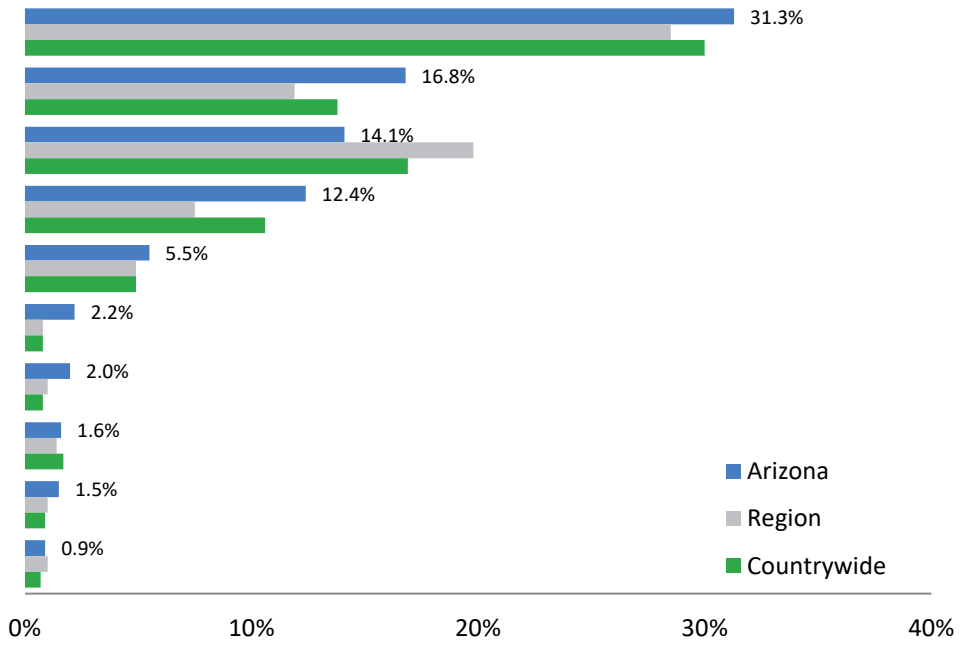


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional 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
99199	Unlisted special service procedure or report
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
97164	Re-evaluation of physical therapy and established plan of care; requires an examination with review of history and use of standardized tests and measures; revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome; 20 minutes face-to-face with patient and/or family
97799	Unlisted physical medicine/rehabilitation service or procedure
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
97162	Physical therapy evaluation of moderate complexity; typically, 30 minutes are spent with the patient and/or family

Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

Code	Average PPU AZ	Average PPU Region	Average PPU CW
97110	$46	$42	$42
97530	$59	$53	$46
97140	$39	$40	$38
97112	$51	$45	$43
97014	$22	$20	$22
97535	$56	$50	$44
97164	$88	$72	$73
97035	$16	$20	$22
97161	$136	$113	$120
97162	$137	$110	$125

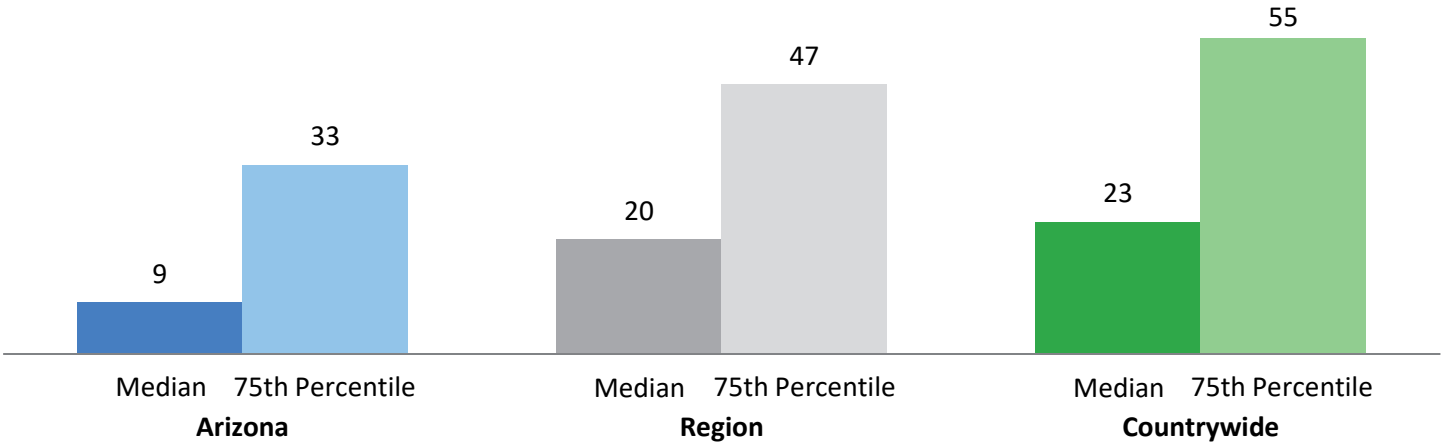


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional 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
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
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

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)



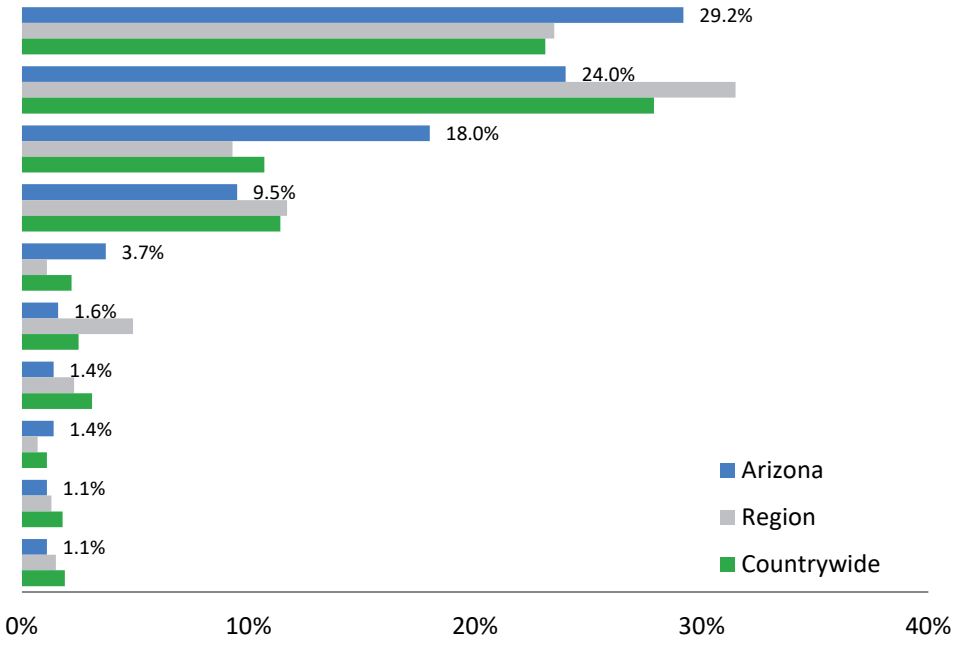
Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

In Arizona, physician payments for evaluation and management services provided in 2020 are, on average, 154% of Medicare-scheduled reimbursement amounts, compared to 154% in the region and 144% countrywide. Payments for these services comprise 27% of physician payments, compared to 28% in the region and 22% countrywide.

Chart 18

Top 10 Evaluation and Management Procedure Codes by Amount Paid

Code	Average PPT AZ	Average PPT Region	Average PPT CW
99214	$163	$163	$148
99213	$115	$116	$104
99204	$261	$243	$227
99203	$163	$169	$152
99455	$326	$503	$199
99456	$1,877	$1,503	$1,083
99284	$220	$238	$279
99244	$317	$317	$288
99285	$339	$393	$412
99215	$211	$225	$194

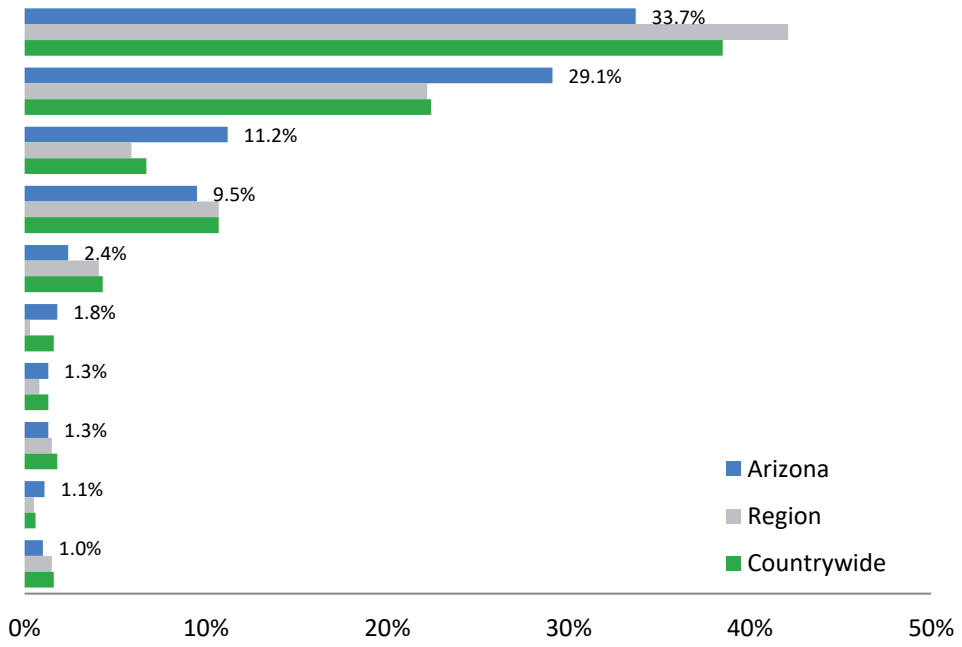


Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99455	Work related or medical disability examination by the treating physician.
99456	Work related or medical disability examination by other than the treating physician.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99244	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Chart 19

Top 10 Evaluation and Management Procedure Codes by Transaction Counts

Code	Average PPT AZ	Average PPT Region	Average PPT CW
99213	$115	$116	$104
99214	$163	$163	$148
99204	$261	$243	$227
99203	$163	$169	$152
99212	$67	$70	$67
99455	$326	$503	$199
99232	$95	$130	$104
99202	$114	$122	$109
99233	$131	$179	$153
99284	$220	$238	$279

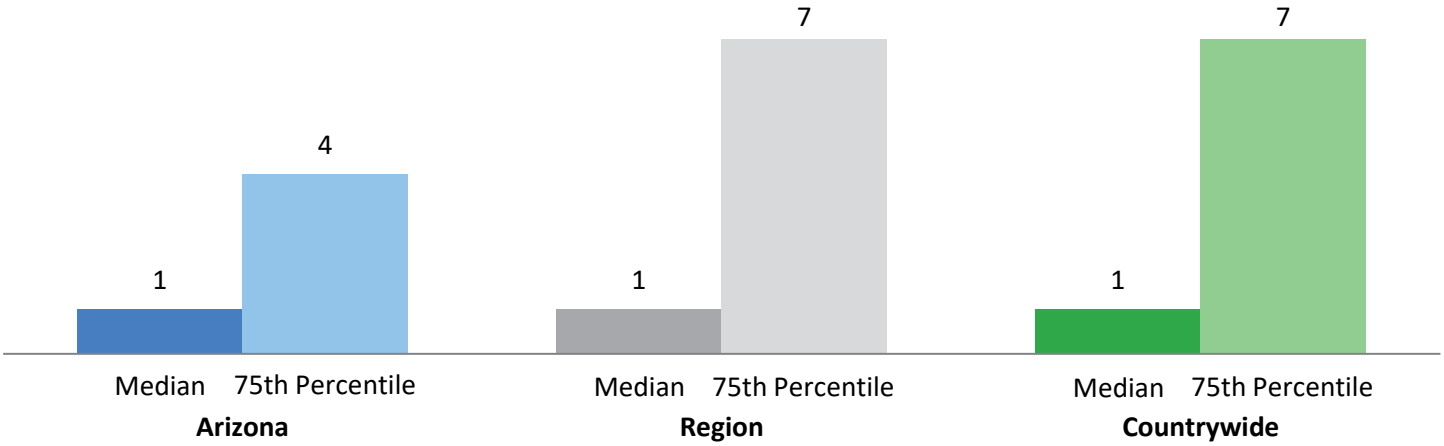


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99455	Work related or medical disability examination by the treating physician.
99232	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

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 2019 and Service Years 2019 and 2020.

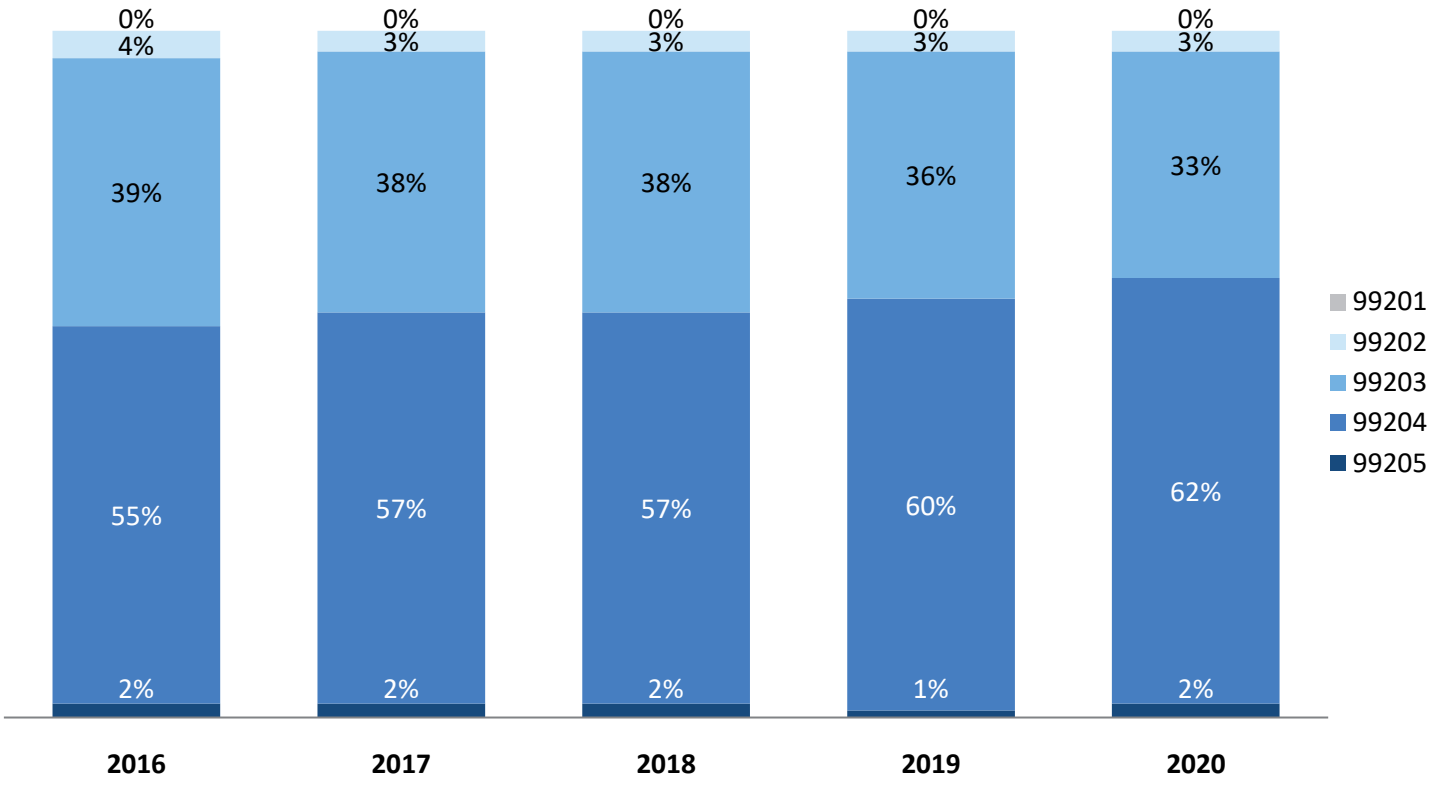
Evaluation and Management services consist largely of office or outpatient visits for a new patient or an established patient.

There are five periods of time spent with a *new* patient, ranging from 10 minutes for Procedure Code 99201 to 60 minutes for Procedure Code 99205. Chart 21 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for new patients.

Chart 21

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

Distribution of Payments by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2016 to 2020.

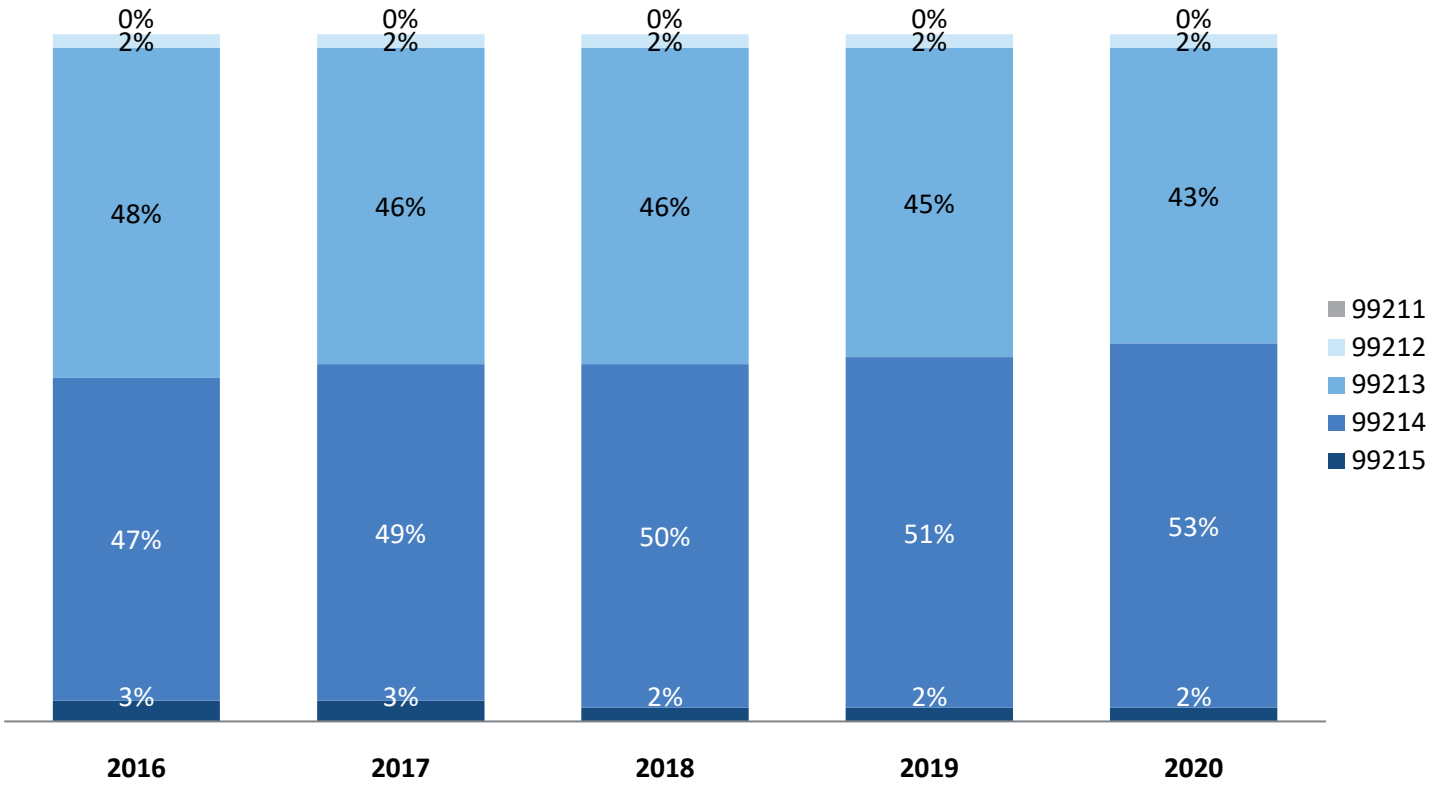
		Average PPT				
Code	**Severity/Time**	**2016**	**2017**	**2018**	**2019**	**2020**
99201	Low to Moderate; 10 minutes with patient	$60	$63	$67	$64	$65
99202	Low to Moderate; 20 minutes with patient	$98	$101	$109	$112	$114
99203	Moderate; 30 minutes with patient	$143	$147	$163	$164	$163
99204	Moderate to High; 45 minutes with patient	$222	$230	$257	$259	$261
99205	Moderate to High; 60 minutes with patient	$262	$258	$272	$278	$281

Similarly, for established patients, there are five periods of time spent with the patient, ranging from 5 minutes for Procedure Code 99211 to 40 minutes for Procedure Code 99215. Chart 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 2016 to 2020.

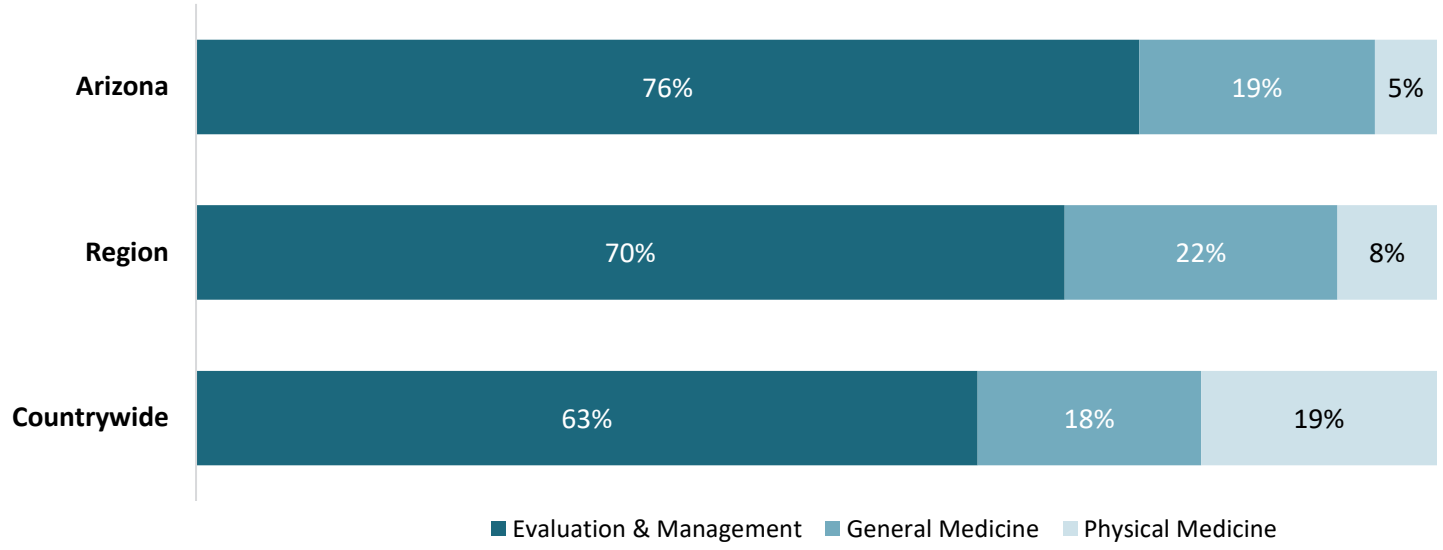
		Average PPT				
Code	**Severity/Time**	**2016**	**2017**	**2018**	**2019**	**2020**
99211	Low to Moderate; 5 minutes with patient	$33	$30	$29	$31	$31
99212	Low to Moderate; 10 minutes with patient	$59	$60	$65	$67	$67
99213	Moderate; 15 minutes with patient	$98	$102	$113	$114	$115
99214	Moderate to High; 25 minutes with patient	$140	$144	$158	$159	$163
99215	Moderate to High; 40 minutes with patient	$192	$196	$213	$204	$211

In Service Year 2020, telemedicine services were utilized more than in prior years[8] and were generally observed in the evaluation and management, physical medicine, and general medicine physician service categories. Telemedicine services represent about 2% of the physician costs in these categories countrywide. The share of payments varies across jurisdictions, ranging from about 1% to about 5%.

In Arizona, the share of claimants receiving physician services (evaluation and management, physical medicine, and general medicine) who had telemedicine encounters increased from 0.2% in 2019 to 8.1% in 2020. 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

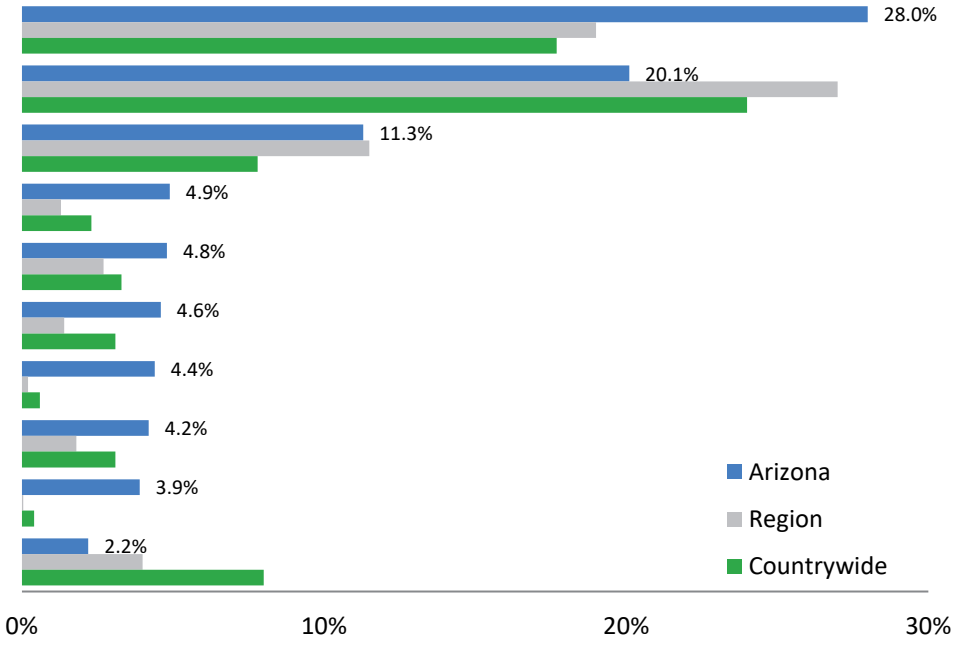
Chart 24 shows the top 10 procedure codes reported as a telemedicine service by paid amount for Arizona with comparative values for the region and countrywide.

Chart 24

Top 10 Procedure Codes by Amount Paid for Telemedicine Services

	Average PPU[9]		
Code	**AZ**	**Region**	**CW**
99214	$138	$159	$142
99213	$100	$115	$102
90837	$212	$219	$179
99215	$233	$208	$174
99203	$158	$169	$157
90834	$136	$143	$129
99455	$332	$587	$176
99204	$246	$262	$230
99499	$1,239	$230	$630
97110	$47	$46	$42

Telemedicine Paid Share



Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
90837	Psychotherapy, 60 minutes with patient
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
90834	Psychotherapy, 45 minutes with patient
99455	Work related or medical disability examination by the treating physician.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99499	Unlisted evaluation and management service
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility

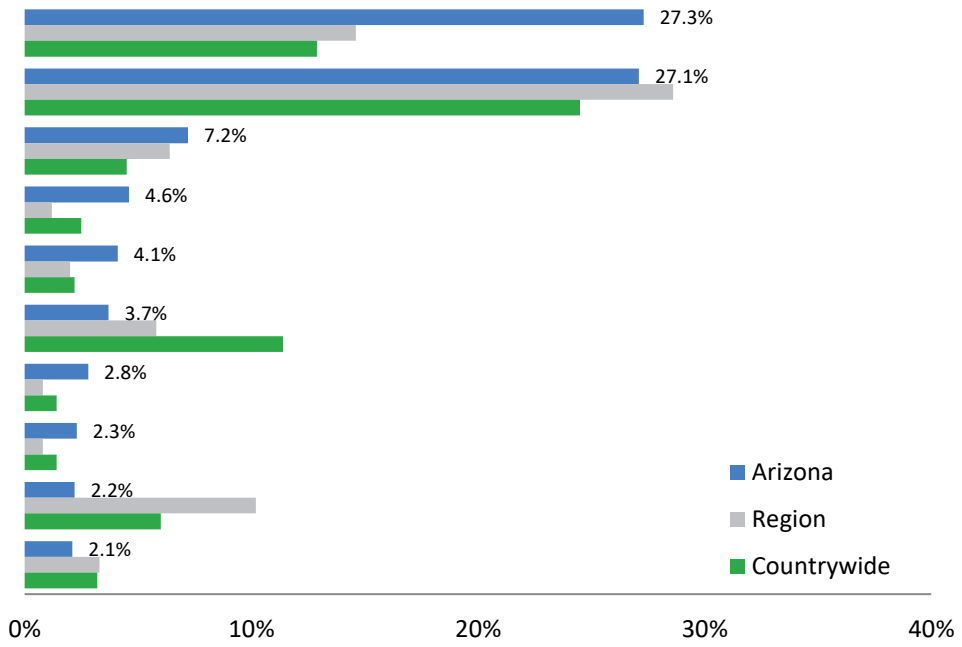
[9] Based on the number of units for the procedure code (typically in increments of time) but can also be one transaction.

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	Average PPU AZ	Average PPU Region	Average PPU CW
99214	$138	$159	$142
99213	$100	$115	$102
90837	$212	$219	$179
90834	$136	$143	$129
99203	$158	$169	$157
97110	$47	$46	$42
99215	$233	$208	$174
99204	$246	$262	$230
99442	$44	$77	$63
99212	$60	$68	$66



Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
90837	Psychotherapy, 60 minutes with patient
90834	Psychotherapy, 45 minutes with patient
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99442	Telephone evaluation and management service by a physician or other qualified health care professional; 11-20 minutes of medical discussion.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Hospital Inpatient

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

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

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

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

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

Unless otherwise stated, the inpatient results are based on inpatient stays with a discharge date in 2020.

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	254%	157%	194%

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

The distribution of medical payments for hospital inpatient is 16% for Arizona, 11% for the region, and 13% 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

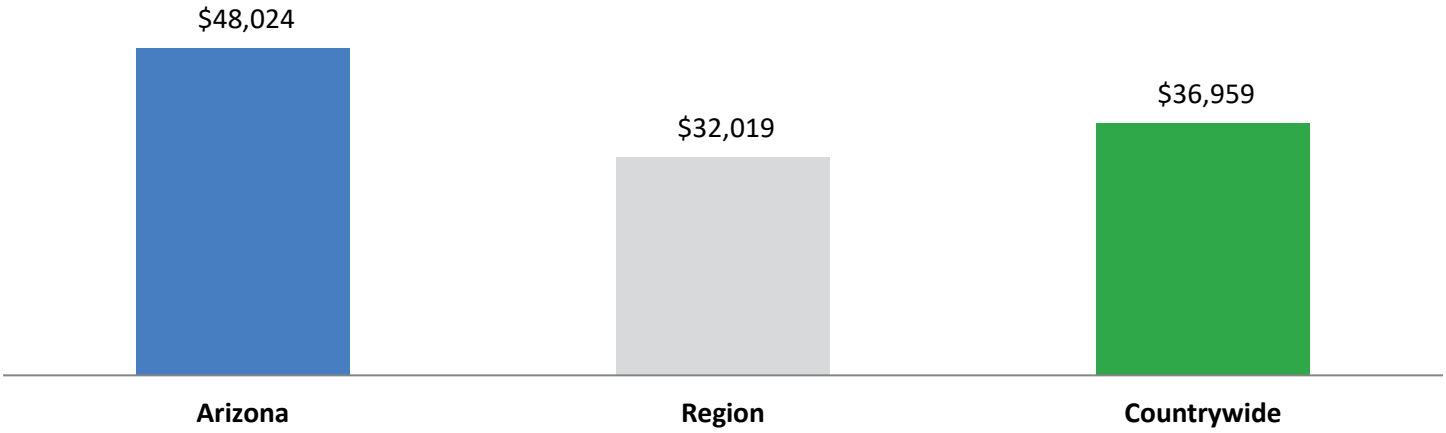


Chart 28

Average Amount Paid per Day for Hospital Inpatient Services

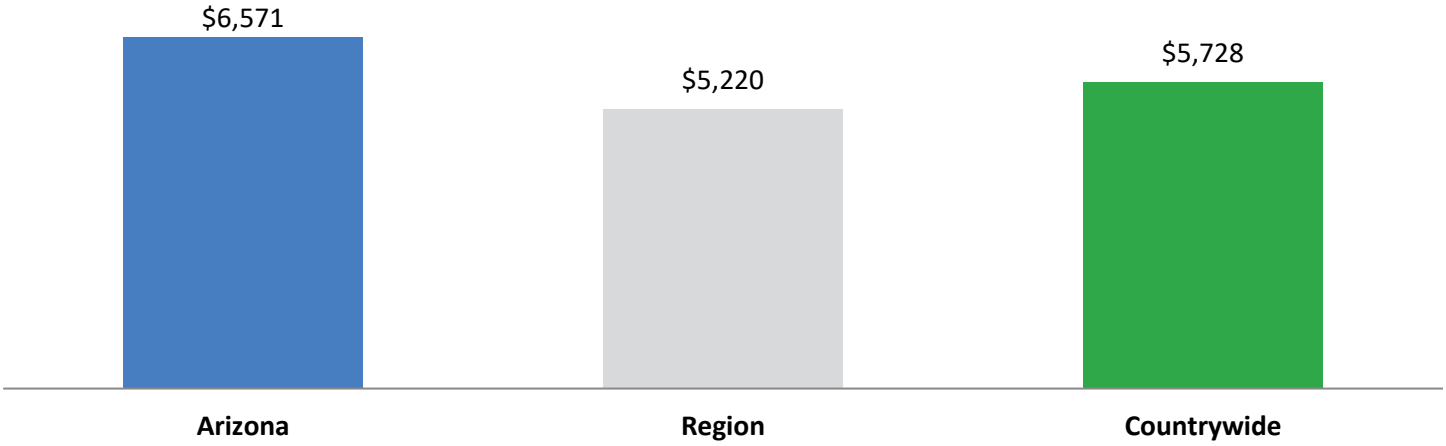


Chart 29 displays the average number of hospital inpatient stays per 1,000 active claims in 2020 for Arizona, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 30 displays the average and 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

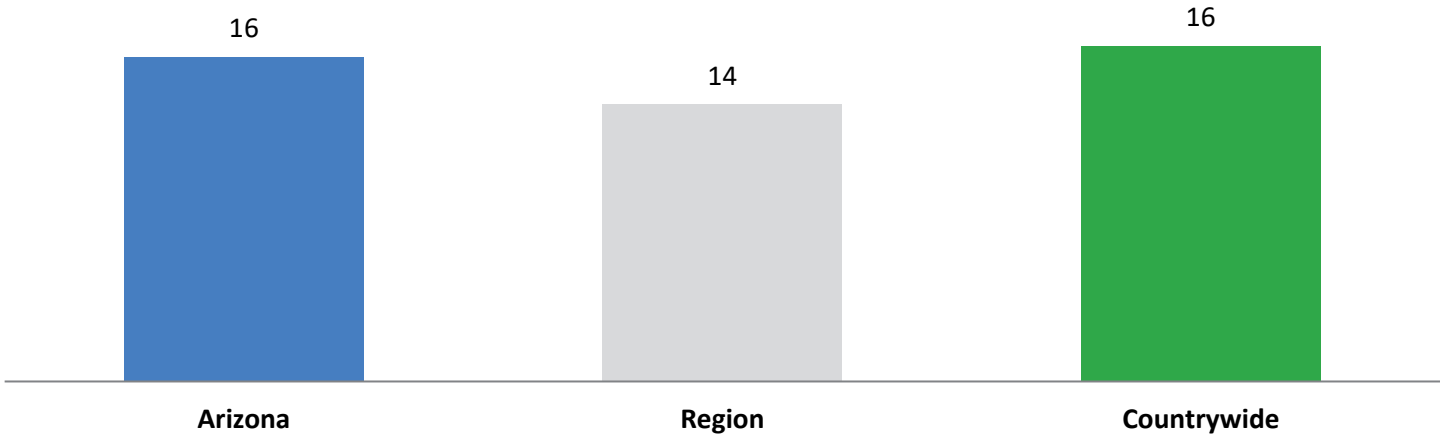


Chart 30

Length of Stay for Hospital Inpatient Services (in Days)

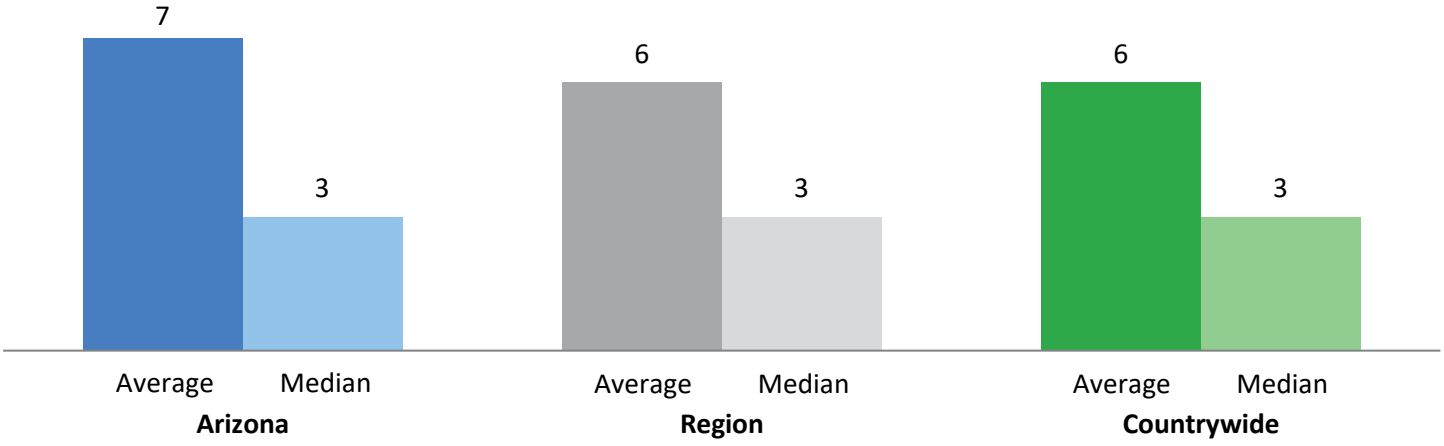
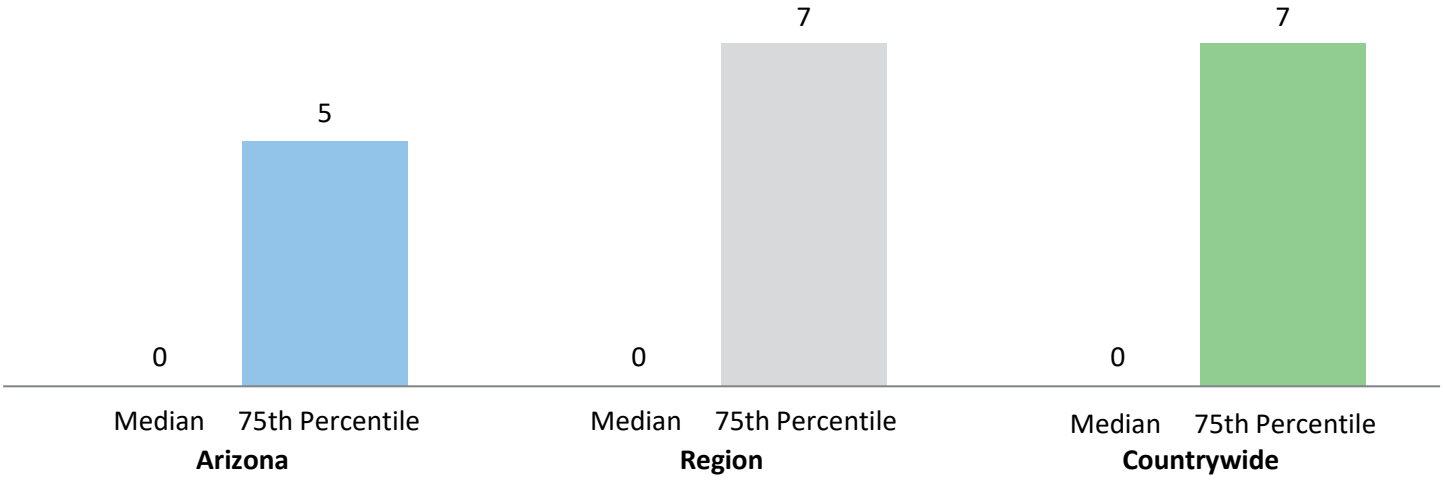


Chart 31 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Arizona, the region, and countrywide.

Chart 31

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

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 2019 or 2020.

Chart 32

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

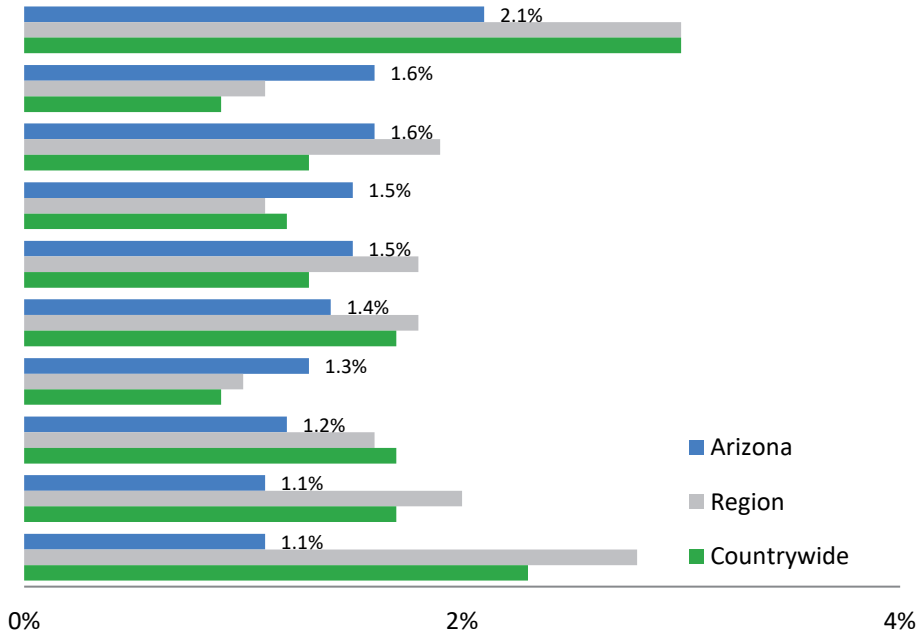
		Median Amount Paid per Stay		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Tibia/fibula fracture	5.8%	$30,945	$21,444	$23,339
Traumatic brain injury	5.6%	$30,446	$23,300	$24,706
Lumbar spine degeneration	5.5%	$65,474	$37,249	$37,580
Burn and corrosion, third degree, other than head, face, and neck	4.8%	$101,908	$44,173	$44,946
Hip/pelvis fracture/major trauma	4.8%	$29,117	$20,041	$21,518
Complication from surgical device	4.4%	$37,619	$24,190	$24,149
Sepsis	3.8%	$28,767	$20,873	$21,322
Lumbosacral intervertebral disc disorders	3.1%	$41,848	$30,367	$30,566
Chest trauma major	2.5%	$35,547	$22,567	$21,188
COVID-19	2.5%	$25,321	$19,953	$20,611

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in Calendar Year 2019 or 2020.

Chart 33

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services

Code	Median Paid per Stay AZ	Region	CW
460	$56,808	$40,507	$40,533
928	$101,908	$77,460	$77,097
454	$92,830	$57,464	$58,357
958	$94,574	$52,149	$60,923
483	$31,197	$24,399	$24,904
470	$27,959	$20,187	$21,894
481	$48,153	$25,539	$27,537
494	$21,159	$19,995	$20,349
957	$146,229	$92,204	$111,199
455	$87,402	$49,096	$48,060



Code	Description
460	Spinal fusion, except cervical, without major complications or comorbidities
928	Full thickness burn with skin graft or inhalation injury with complications or comorbidities/major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
958	Other operation room procedures for multiple significant trauma with complications or comorbidities
483	Major joint/limb reattachment procedure of upper extremities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
481	Hip and femur procedures except major joint with complications or comorbidities
494	Lower extremity and humerus procedures except hip, foot, and femur without complications or comorbidities/major complications or comorbidities
957	Other operation room procedures for multiple significant trauma with major complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in 2019 or 2020. Region includes AK, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.
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 procedure terminology (CPT) or other healthcare common procedure coding system (HCPCS) codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Some payments are also reported by a specific ambulatory payment classification (APC) code. An APC code represents a group of services provided by the facility on an outpatient basis.

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

Due to these differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide, comparisons by procedure code for outpatient benefits should be interpreted with caution. One comparative measure of outpatient service costs is the average cost per outpatient visit. A visit is defined as any service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claim may have more than one visit.

Hospital outpatient visits can vary in nature. A service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it has a global follow-up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection. In this section, we provide measures of hospital outpatient payments that account for the type of visit because the level of reimbursement varies considerably by type of visit. A hospital outpatient visit could be the result of an emergency visit. Outpatient visits arising from emergency room services are shown separately. Next, nonemergency outpatient visits are shown for visits with major surgery services and for visits without major surgery services.

The distribution of medical payments for hospital outpatient is 17% for Arizona, 18% for the region, and 19% 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, 75% of hospital outpatient payments are included in the chart below.

Chart 34

Hospital Outpatient Payments as a Percentage of Medicare

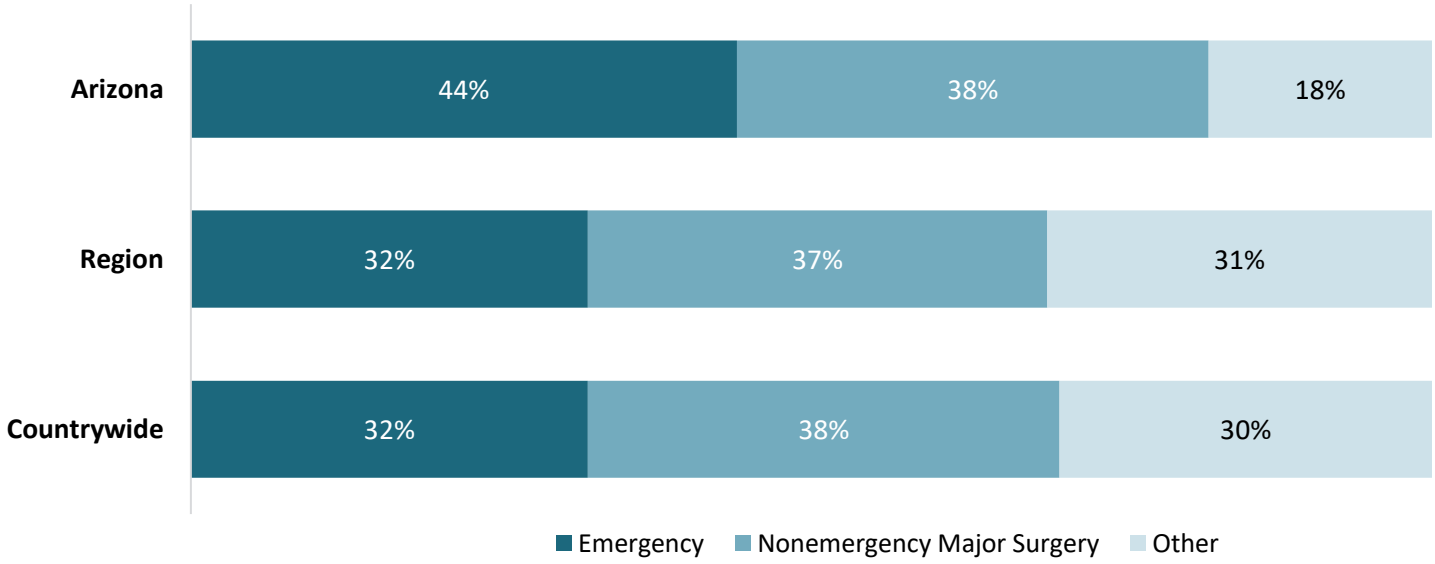
Medical Cost Category	Arizona	Region	Countrywide
Hospital Outpatient	315%	183%	242%

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

Chart 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 44% 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

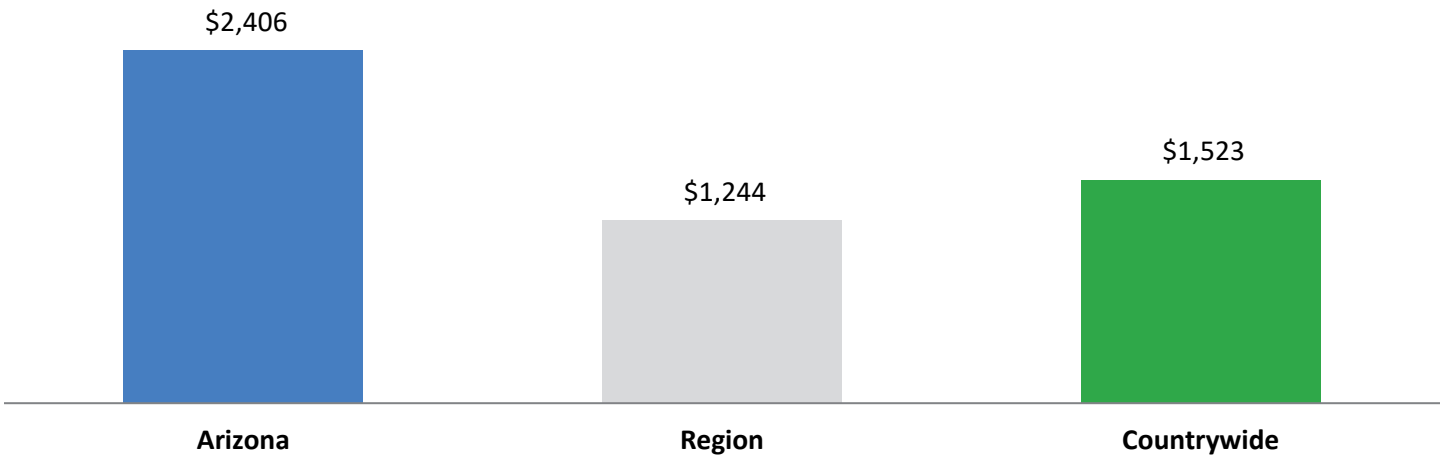


Chart 37

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

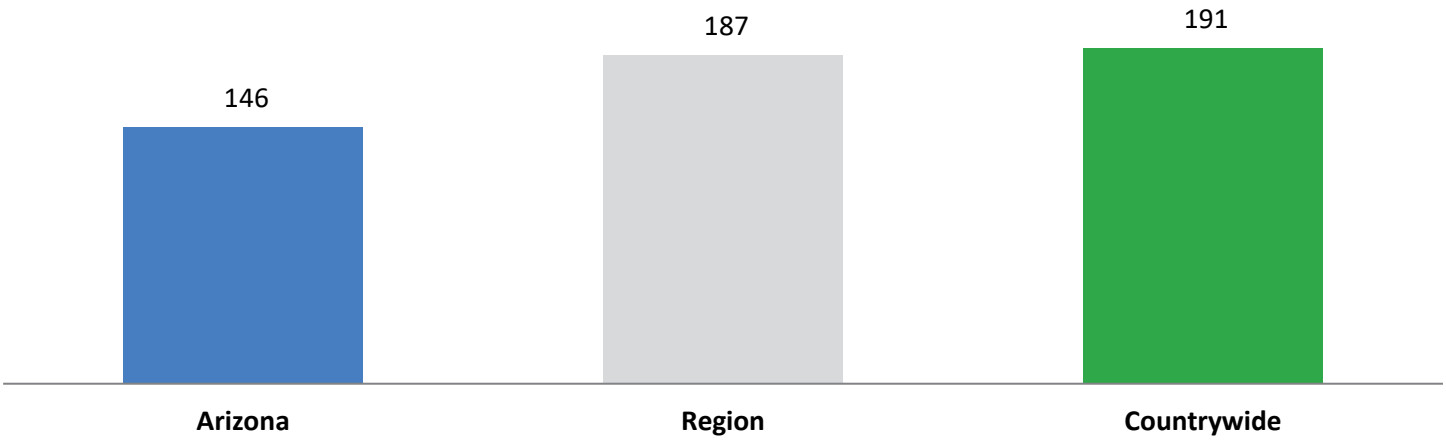


Chart 38 displays the top 10 diagnosis groups for emergency outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in Arizona.

Chart 38

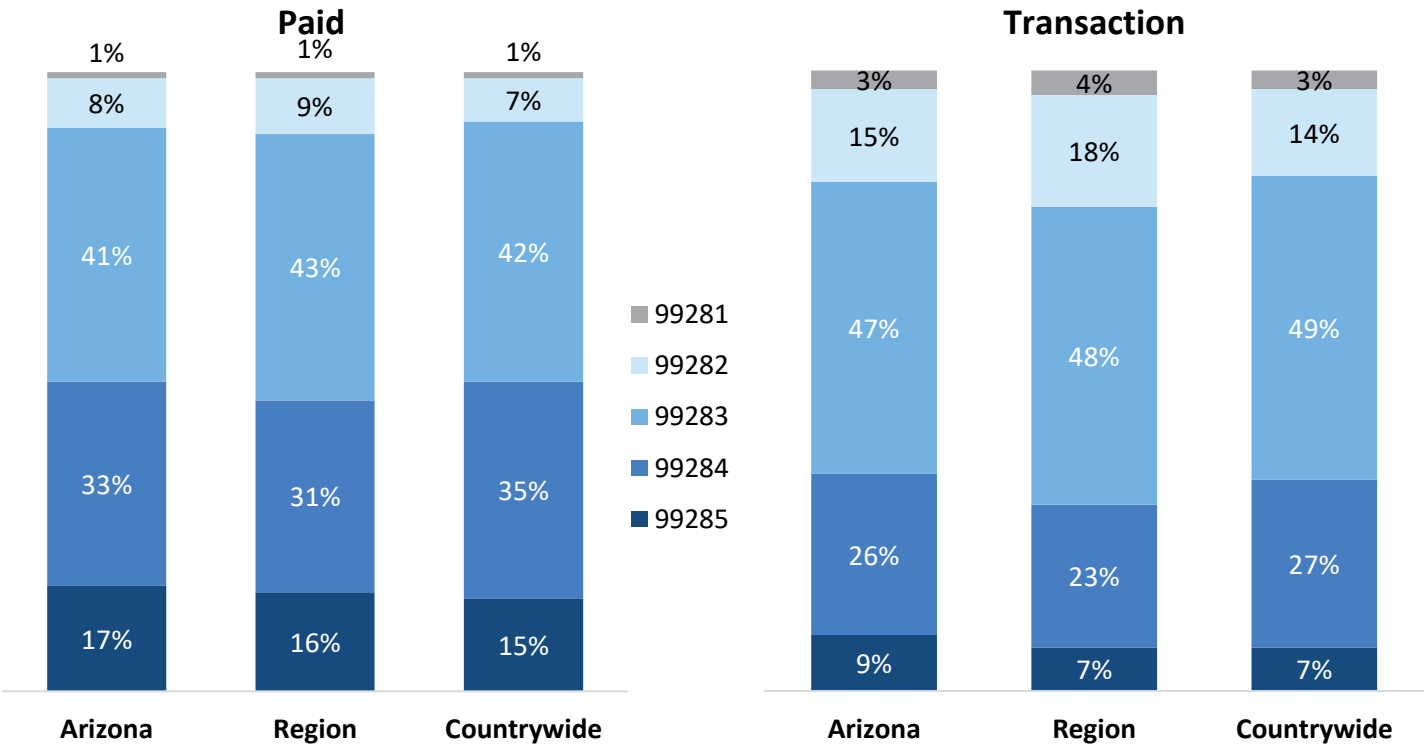
Top 10 Diagnosis Groups by Amount Paid for Emergency Hospital Outpatient Visits

		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Minor hand/wrist injuries	10.5%	$816	$633	$710
Hand/wrist fracture	7.2%	$1,606	$1,074	$1,139
Head/face wound	5.2%	$1,378	$861	$929
Low back pain	3.9%	$1,135	$702	$794
Concussion/minor traumatic brain injury	3.8%	$2,122	$968	$1,206
Head injury not otherwise classified	3.7%	$2,110	$932	$1,151
Traumatic amputation, hand/wrist	3.0%	$2,582	$1,555	$1,653
Neck pain	2.7%	$2,174	$1,014	$1,218
Minor ankle/foot injuries	2.3%	$979	$626	$706
Minor knee injury	2.2%	$1,132	$628	$756

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 2020 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

		Average PPT		
Code	**Severity**	**Arizona**	**Region**	**Countrywide**
99281	Minor	$256	$166	$190
99282	Low to Moderate	$374	$276	$288
99283	Moderate	$648	$478	$491
99284	High	$933	$739	$739
99285	High and immediately life-threatening	$1,469	$1,211	$1,153

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

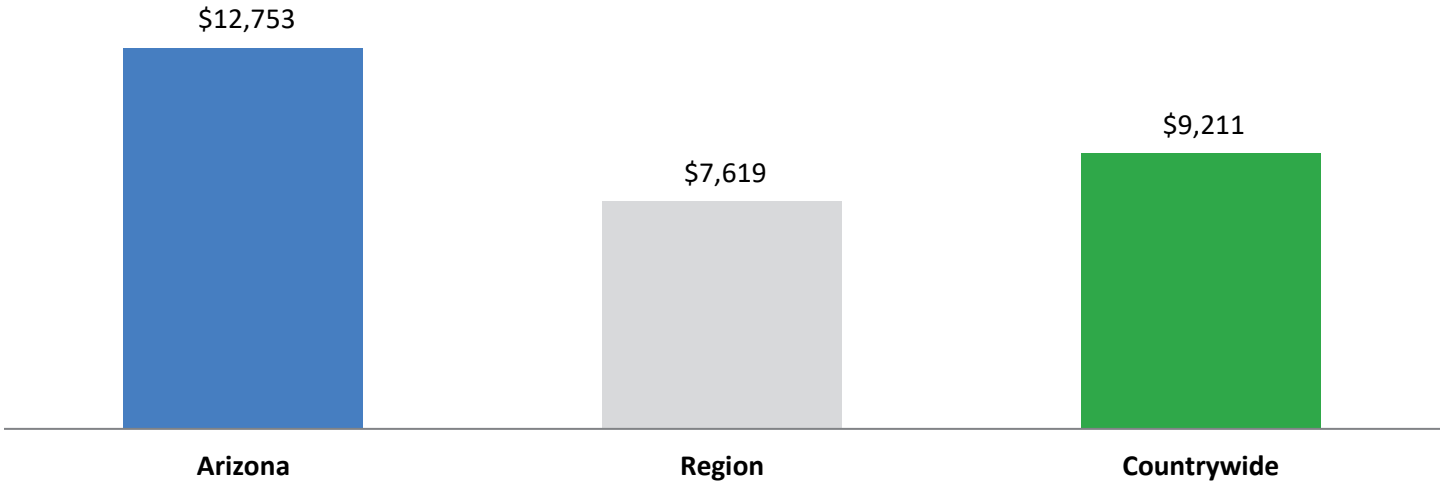


Chart 41

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

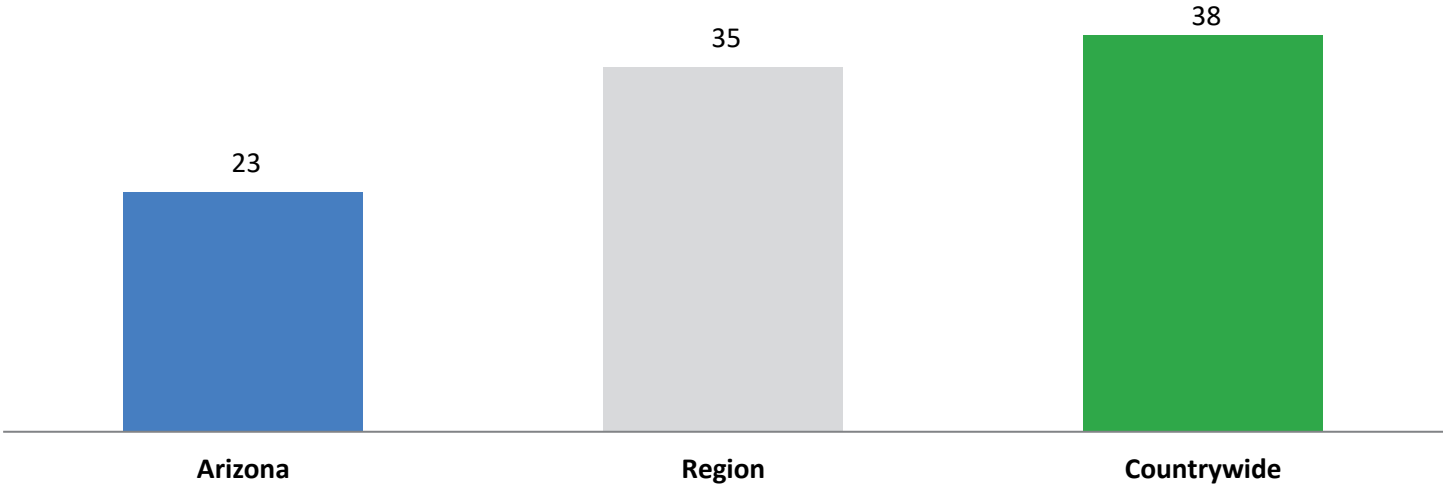
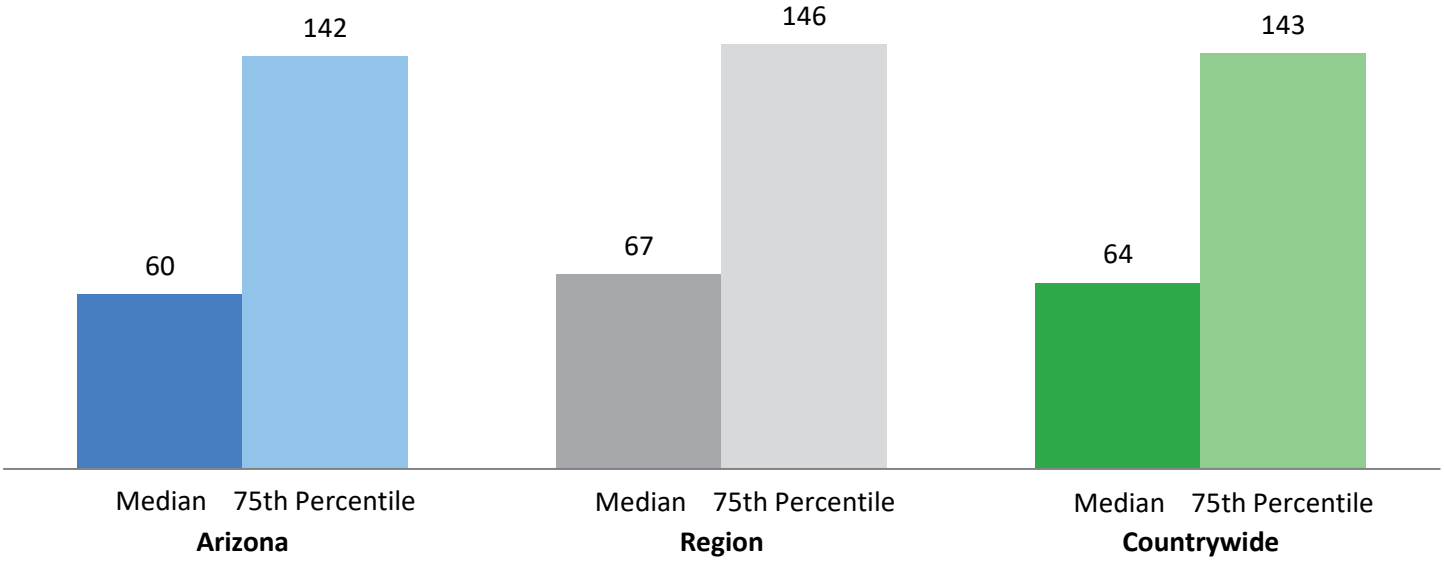


Chart 42 shows the median and 75th percentile time until first treatment for nonemergency major surgery outpatient visits for Arizona, the region, and countrywide.

Chart 42

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

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

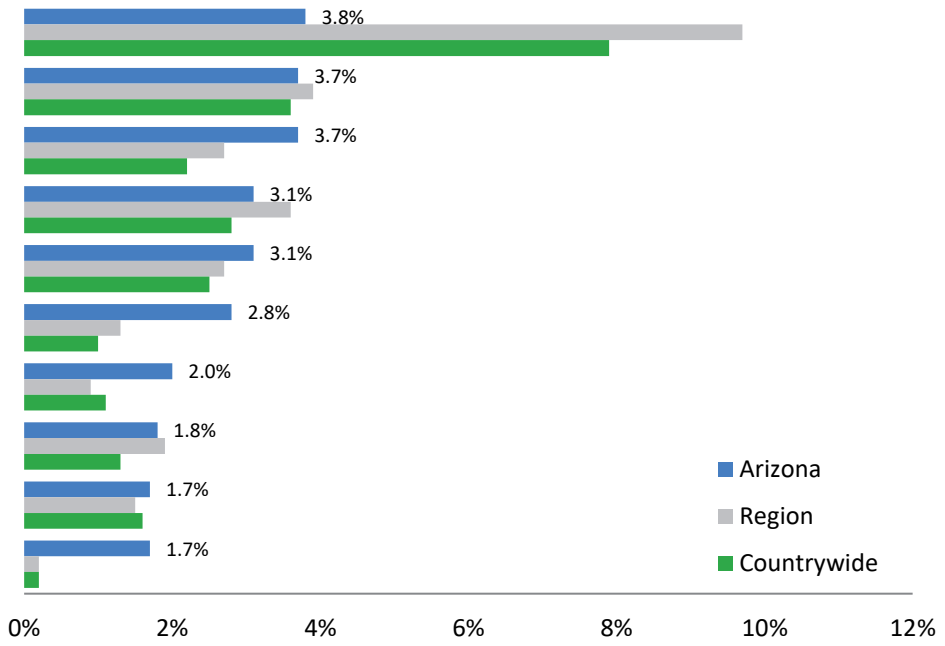
		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Rotator cuff tear	7.9%	$10,063	$9,665	$9,808
Hand/wrist fracture	7.8%	$7,296	$5,487	$5,946
Inguinal hernia	5.6%	$9,875	$7,162	$7,809
Knee internal derangement - meniscus injury	5.3%	$4,376	$4,721	$5,219
Tibia/fibula fracture	5.1%	$12,180	$9,244	$8,880
Knee degenerative/overuse injuries	3.6%	$15,536	$8,548	$7,603
Degenerative arthritis, ankle/foot	3.2%	$20,097	$7,863	$11,570
Complication from surgical device	3.0%	$4,761	$4,206	$5,209
Lumbosacral intervertebral disc disorders	2.7%	$13,851	$9,664	$10,417
Ventrical incisional hernia	2.6%	$8,578	$5,389	$6,748

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 2020, 79% 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

	Average Paid per Visit		
Code	**AZ**	**Region**	**CW**
29827	$15,322	$10,245	$12,107
29881	$8,741	$5,120	$6,726
20680	$9,239	$5,149	$6,816
49650	$16,998	$7,949	$10,322
63030	$21,379	$9,866	$12,455
25609	$19,294	$10,493	$11,065
29826	$17,942	$10,719	$12,281
27447	$31,766	$14,614	$17,121
24342	$15,006	$7,742	$10,551
27446	$33,604	$12,068	$20,873



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
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
49650	Laparoscopy, surgical; repair initial inguinal hernia
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

Nonemergency outpatient visits without a major surgery service, referred to as "Other" outpatient visits, represent 18% 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

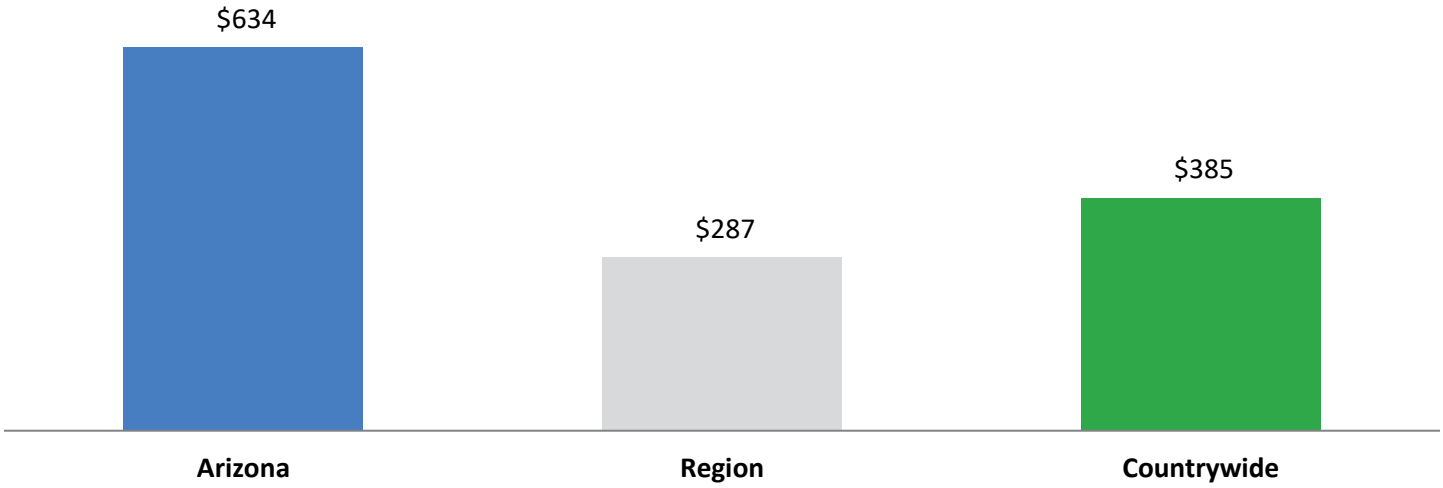


Chart 46

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

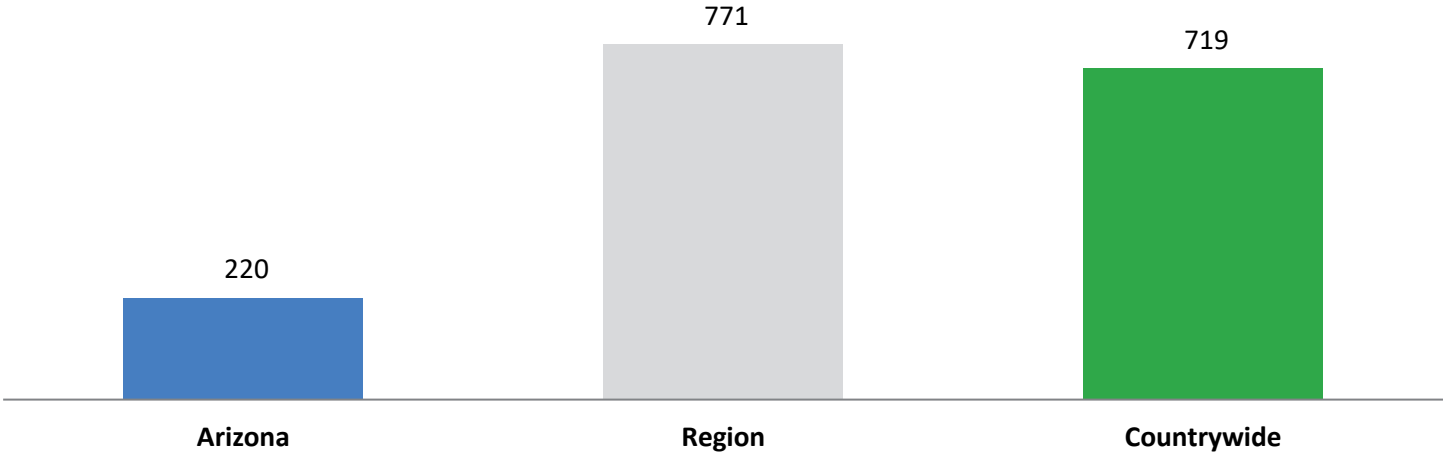
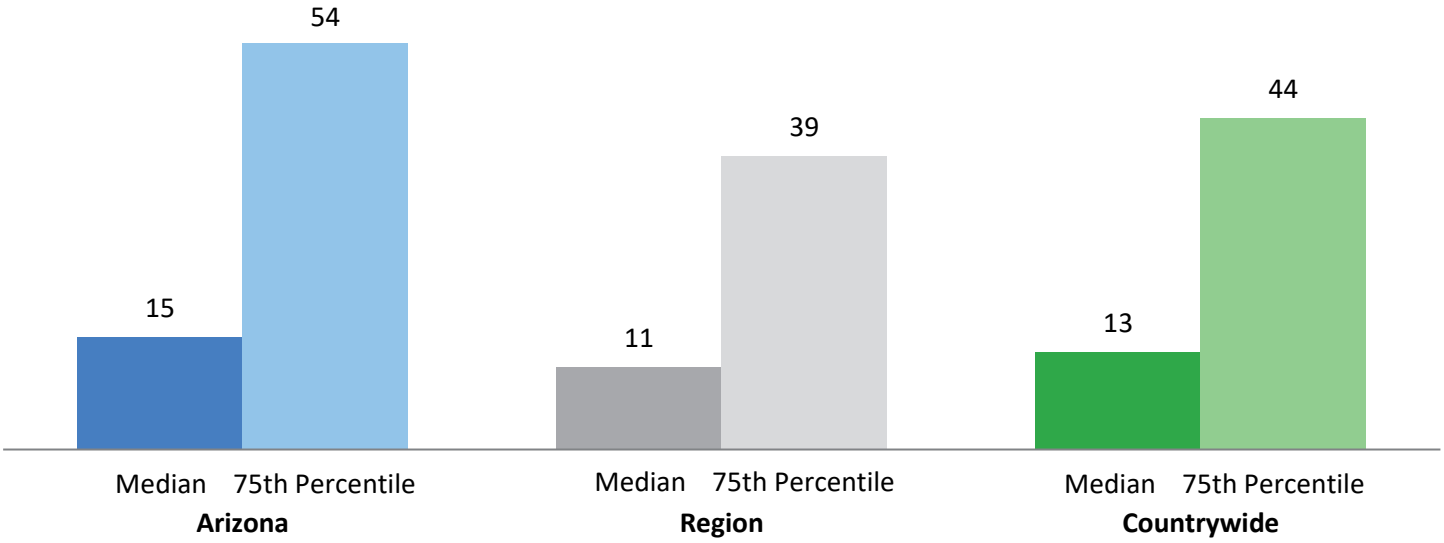


Chart 47 shows the median and 75th percentile time until first treatment for other outpatient visits for Arizona, the region, and countrywide.

Chart 47

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

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

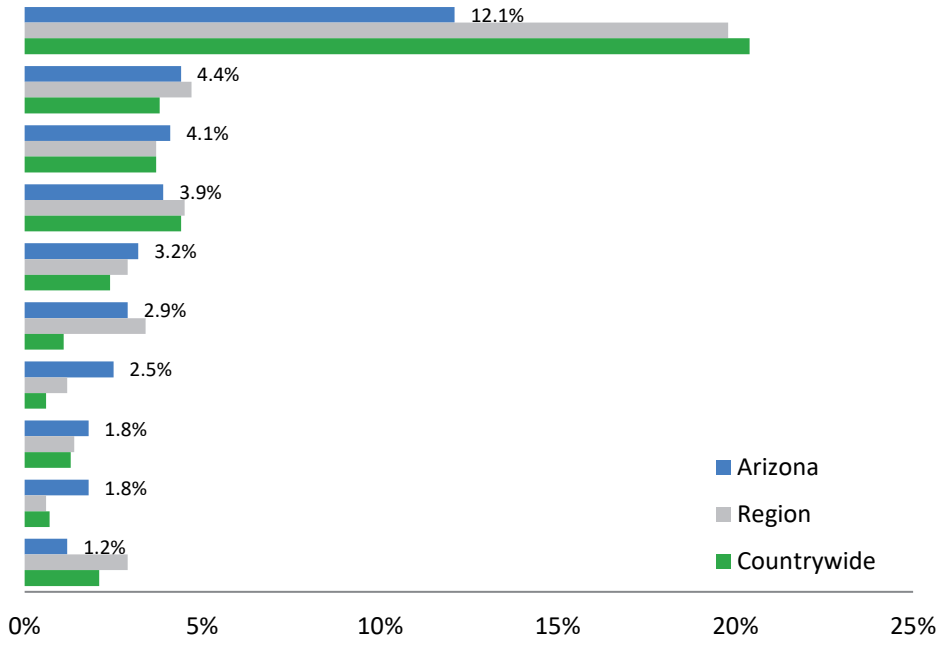
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Traumatic brain injury	7.1%	$295	$563	$312
Rotator cuff tear	3.9%	$255	$150	$173
Minor shoulder injury	3.6%	$238	$150	$175
Hand/wrist fracture	3.6%	$212	$138	$161
Low back pain	3.4%	$216	$150	$166
Minor hand/wrist injuries	3.4%	$195	$137	$163
Spinal cord injury	2.9%	$713	$218	$240
Minor knee injury	2.5%	$222	$150	$176
Minor ankle/foot injuries	2.4%	$201	$139	$169
Lumbar radiculopathy/sciatica	2.3%	$261	$160	$208

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	Average Paid per Visit AZ	Region	CW
97110	$269	$153	$206
73721	$2,002	$840	$1,282
97140	$328	$146	$216
73221	$1,855	$869	$1,349
72148	$2,601	$872	$1,361
97799	$9,102	$5,198	$3,883
99199	$4,809	$4,058	$2,643
72141	$3,358	$968	$1,540
11042	$1,062	$633	$798
73222	$3,107	$1,607	$2,461



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
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
97799	Unlisted physical medicine/rehabilitation service or procedure
99199	Unlisted special service procedure or report
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material

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, 78% 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	249%	204%	265%

Source: NCCI's Medical Data Call for Service Year 2020. Region includes AK, CO, HI, ID, MT, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

ASC visits with major surgery services represent 84% 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

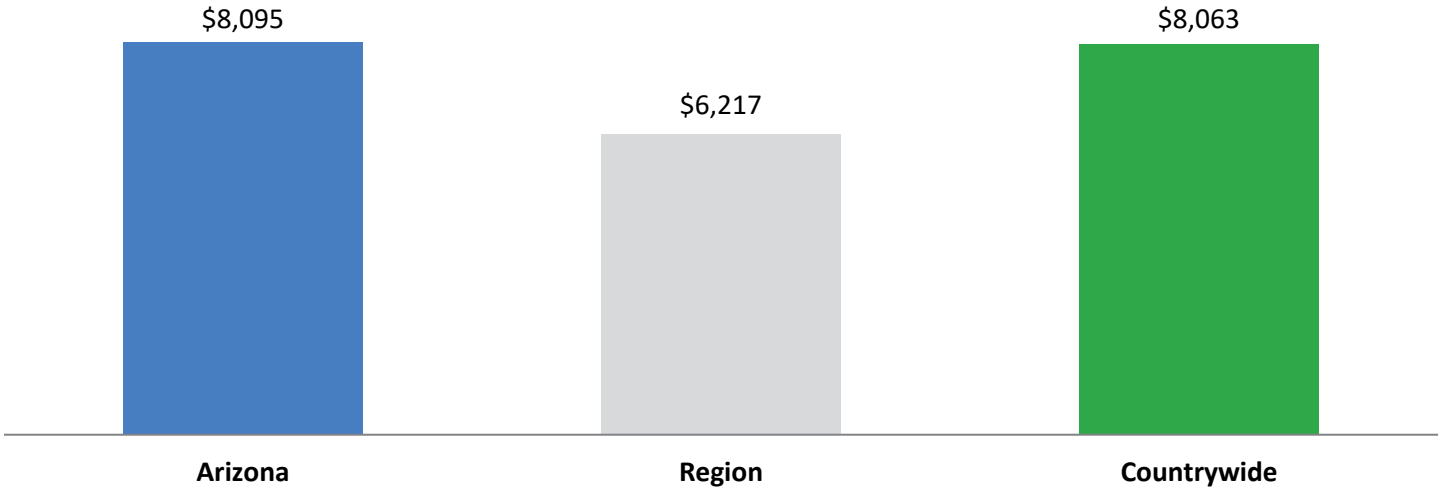


Chart 52

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

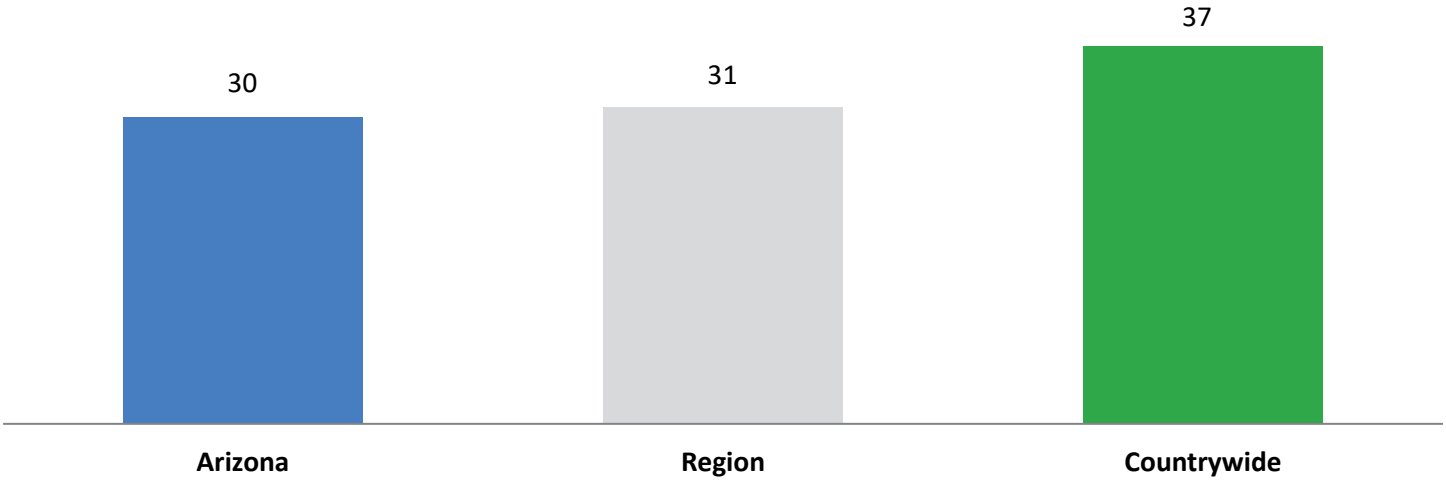
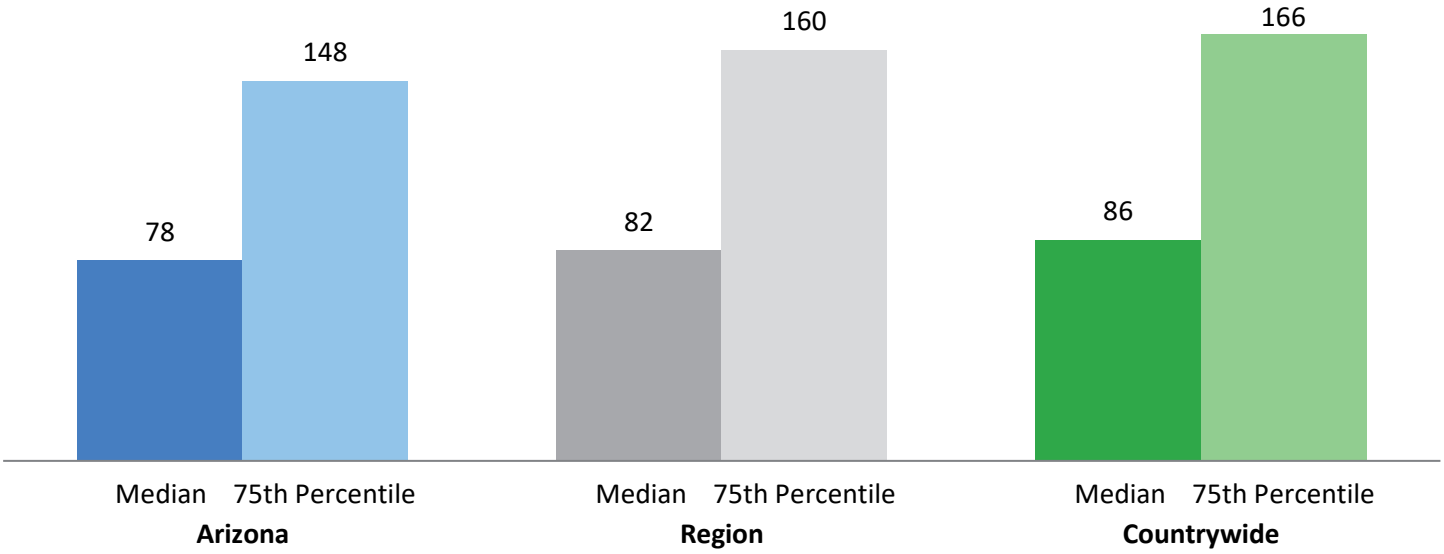


Chart 53 shows the median and 75th percentile time until first treatment for ASC major surgery visits for Arizona, the region, and countrywide.

Chart 53

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

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

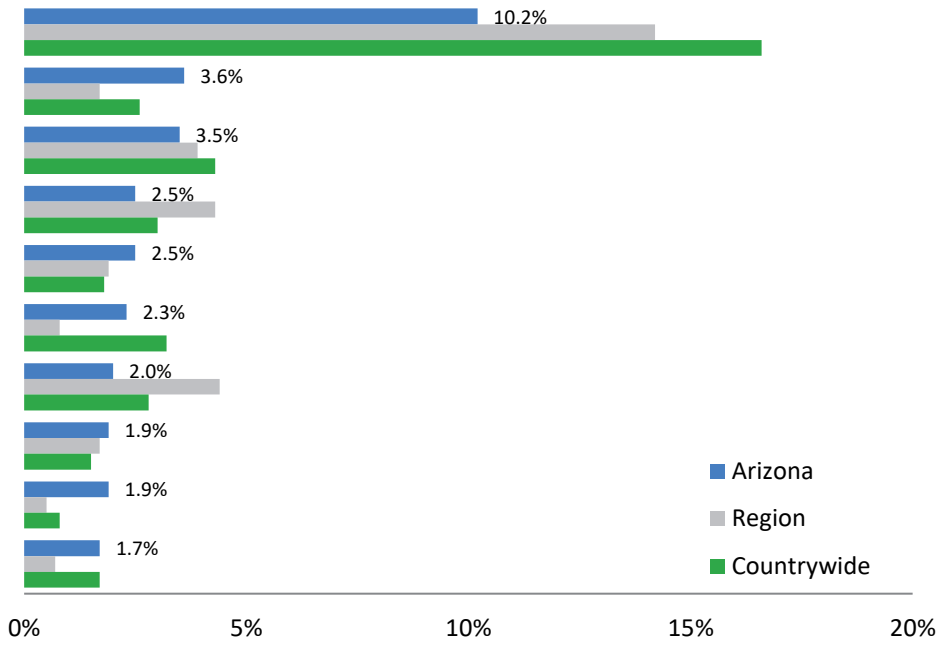
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Rotator cuff tear	17.3%	$8,184	$7,537	$10,347
Hand/wrist fracture	5.9%	$4,651	$4,515	$5,351
Minor shoulder injury	5.1%	$6,513	$6,409	$7,932
Knee internal derangement - meniscus injury	5.0%	$3,352	$3,412	$4,196
Heel/midfoot fracture	3.3%	$7,610	$8,098	$7,624
Inguinal hernia	3.3%	$7,640	$4,058	$4,897
Lumbar spine degeneration	3.3%	$11,335	$8,284	$10,214
Synovitis/tenosynovitis, hand/wrist	2.6%	$3,201	$1,909	$2,763
Complication from surgical device	2.6%	$3,367	$3,290	$3,500
Minor hand/wrist injuries	2.4%	$4,207	$3,813	$4,665

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	Average Paid per Visit AZ	Region	CW
29827	$9,872	$8,646	$12,497
29823	$12,600	$4,999	$9,497
29881	$4,143	$3,589	$4,651
23430	$12,859	$9,523	$12,811
24342	$6,737	$6,182	$7,083
29826	$9,827	$10,696	$15,264
29888	$14,346	$9,470	$10,931
20680	$4,330	$3,268	$4,048
63047	$17,923	$7,387	$11,341
22551	$24,769	$14,158	$24,616



Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
23430	Tenodesis of long tendon of biceps
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
63047	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root), single vertebral segment; lumbar
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; cervical below C2

Chart 56

Major Surgery Outpatient Visit Comparisons for Procedure Codes in Chart 55

Code	Average Paid per Visit in AZ ASC	Average Paid per Visit in AZ Outpatient	Distribution of Major Surgery Visits in AZ in an ASC or Outpatient Setting
29827	$9,872	$15,322	77% / 23%
29823	$12,600	$11,436	71% / 29%
29881	$4,143	$8,741	62% / 38%
23430	$12,859	$14,949	70% / 30%
24342	$6,737	$15,006	73% / 27%
29826	$9,827	$17,942	64% / 36%
29888	$14,346	$17,166	61% / 39%
20680	$4,330	$9,239	48% / 52%
63047	$17,923	$18,980	54% / 46%
22551	$24,769	$22,537	67% / 33%

Prescription Drugs

The distribution of medical payments for drugs is 9% for Arizona, 8% for the region, and 8% 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 2020 with at least one controlled substance was 8%. This compares to the region and countrywide shares of 10% and 10%, respectively. In 2020, Arizona spent $2.6M 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

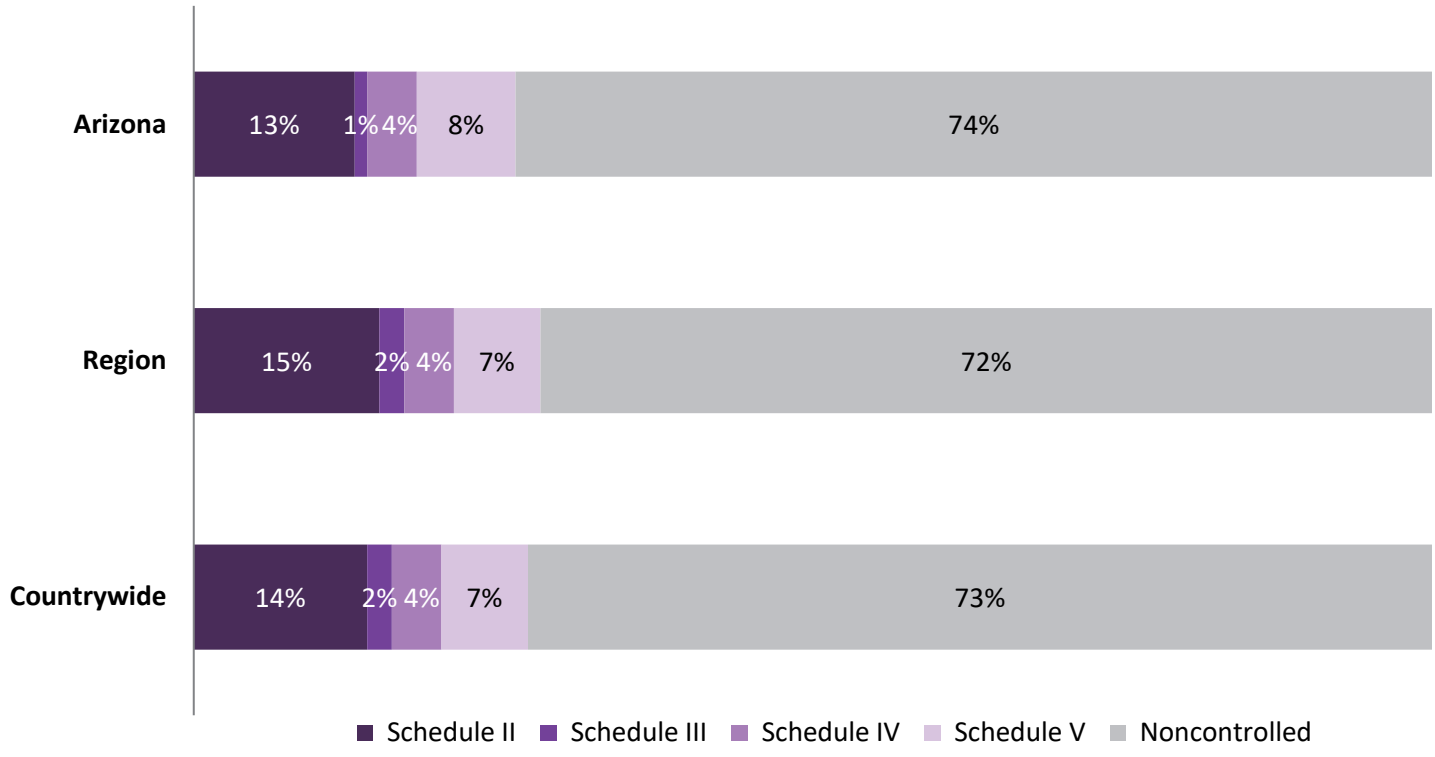


Chart 58 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Arizona. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also 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 *unit*.)

Chart 58

Top 10 Workers Compensation Drugs by Amount Paid

Drug Name	Average PPU AZ	Average PPU Region	Average PPU CW	Arizona Paid Share
Pregabalin	$4.91	$4.49	$4.61	6.7%
Oxycontin®	$9.08	$8.85	$9.67	4.4%
Lidocaine	$5.94	$5.67	$6.49	4.4%
Duloxetine HCl	$5.47	$4.04	$4.44	4.4%
Gabapentin	$1.05	$0.80	$0.91	4.3%
Celecoxib	$4.84	$4.25	$5.11	4.1%
Diclofenac Sodium (3% Gel)	$8.07	$9.50	$9.60	3.2%
Meloxicam	$2.82	$2.68	$3.03	3.0%
Metaxalone	$4.57	$3.94	$4.62	2.8%
Diclofenac Sodium (NSAID)	$0.97	$1.28	$1.83	2.5%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	1
Oxycontin®	B	N/A	Analgesics/Antipyretics	II	5
Lidocaine	G	Lidoderm®	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	3
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	8
Gabapentin	G	Neurontin®	Anticonvulsants	None	4
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	6
Diclofenac Sodium (3% Gel)	G	Solaraze®	Skin/Mucous Membrane	None	11
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	7
Metaxalone	G	Skelaxin®	Muscle Relaxants, Skeletal	None	16
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	2

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

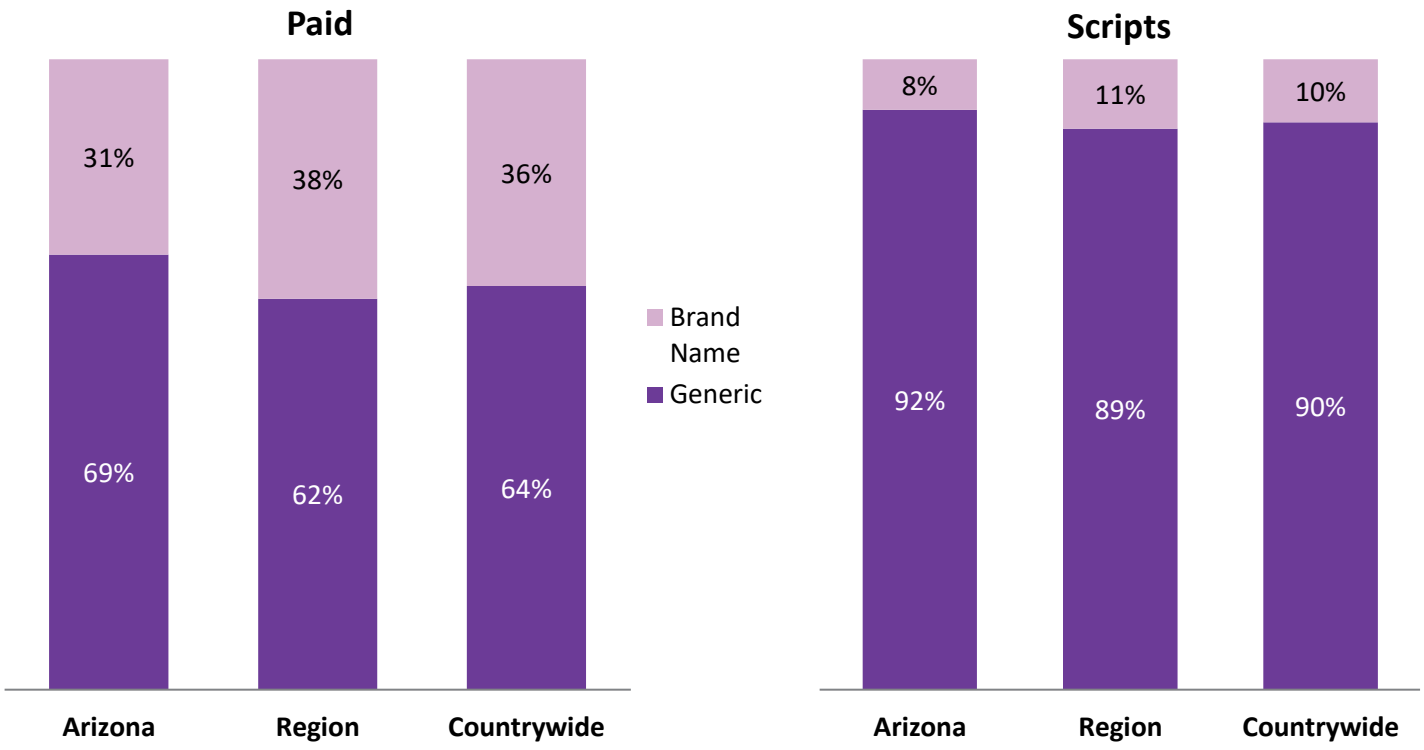
Drug Name	Average PPU AZ	Average PPU Region	Average PPU CW	Arizona Prescription Share
Ibuprofen	$0.41	$0.48	$0.44	7.5%
Gabapentin	$1.05	$0.80	$0.91	5.2%
Cyclobenzaprine HCl	$1.18	$1.01	$1.74	4.5%
Hydrocodone Bitartrate-Acetaminophen	$0.53	$0.56	$0.53	4.2%
Diclofenac Sodium (NSAID)	$0.97	$1.28	$1.83	3.5%
Tramadol HCl	$0.94	$0.70	$0.90	3.5%
Oxycodone HCl	$0.74	$0.69	$0.80	3.5%
Acetaminophen	$0.02	$0.02	$0.01	3.3%
Naproxen	$0.99	$0.85	$0.92	3.3%
Meloxicam	$2.82	$2.68	$3.03	3.0%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	4
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	8
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	6
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	9
Acetaminophen	G	Tylenol®	Analgesics/Antipyretics	None	28
Naproxen	G	Aleve®	Analgesics/Antipyretics	None	11
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

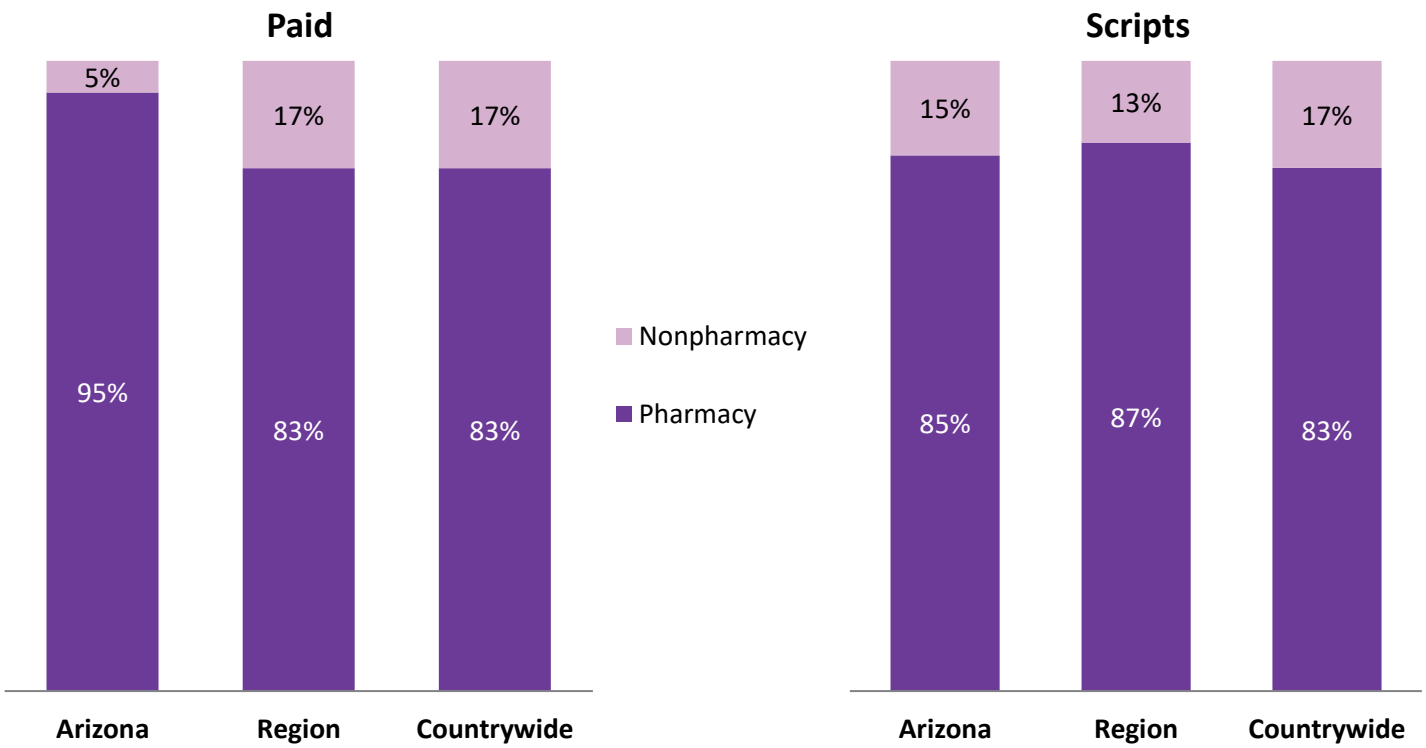


Chart 62 displays the shares of the payments for the top 5 nonpharmacy-dispensed prescription drugs used in workers compensation treatment, by amount paid in Arizona. A pharmacy-dispensed comparison, along with values for the region and countrywide, are also included. All values shown below are specific either to nonpharmacy-dispensed prescription drugs or to pharmacy-dispensed prescription drugs.

Chart 62

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

	Nonpharmacy-dispensed				Pharmacy-dispensed			
Drug Name	**Paid Share**	**AZ PPU**	**Region PPU**	**CW PPU**	**Paid Share**	**AZ PPU**	**Region PPU**	**CW PPU**
Lidopro Patch®	9.1%	$40.64	$39.89	$44.79	1.0%	$41.34	$45.34	$46.95
Metaxalone	7.2%	$6.02	$8.53	$7.49	2.6%	$4.43	$3.46	$3.82
Diclofenac Sodium (3% Gel)	5.8%	$8.93	$9.15	$10.30	3.1%	$7.99	$10.01	$9.28
Ibuprofen	5.1%	$0.24	$0.72	$0.46	1.0%	$0.50	$0.45	$0.44
Celecoxib	4.4%	$6.14	$8.14	$7.61	4.1%	$4.79	$3.71	$4.50

Drug Name	**B/G**	**Common Brand Name**	**Category**	**CSA Schedule**	**Nonpharmacy CW Rank**
Lidopro Patch®	B	N/A	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	8
Metaxalone	G	Skelaxin®	Muscle Relaxants, Skeletal	None	11
Diclofenac Sodium (3% Gel)	G	Solaraze®	Skin/Mucous Membrane	None	6
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	22
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	2

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

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

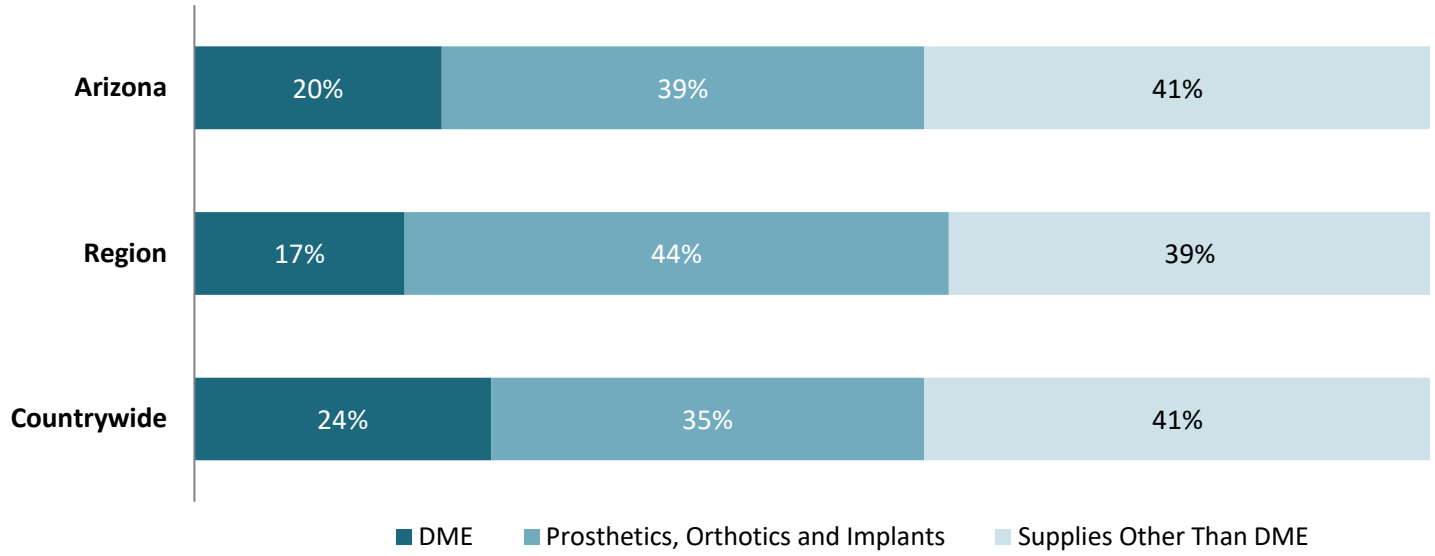
Chart 63 displays the distribution of payments among three separate DMEPOS categories:

- 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 2019 for Claims *With* an Implant or Prosthetic

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Rotator cuff tear	8.1%	$37,662	$32,162	$39,641
Tibia/fibula fracture	7.1%	$100,201	$69,931	$78,888
Burns classified according to extent of body surface involved	4.8%	$2,708,456	$55,072	$194,365
Minor shoulder injury	3.6%	$30,196	$26,890	$31,575
Hand/wrist fracture	3.4%	$27,578	$23,131	$28,519
Respiratory failure	2.8%	$523,522	$208,067	$272,519
Hip/pelvis fracture/major trauma	2.3%	$63,767	$62,477	$80,031
Ankle fracture	2.3%	$39,696	$32,308	$38,542
Injury of unspecified body region	2.2%	$248,922	$92,590	$77,648
Complication from surgical device	1.9%	$182,003	$86,246	$103,519

Chart 65

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

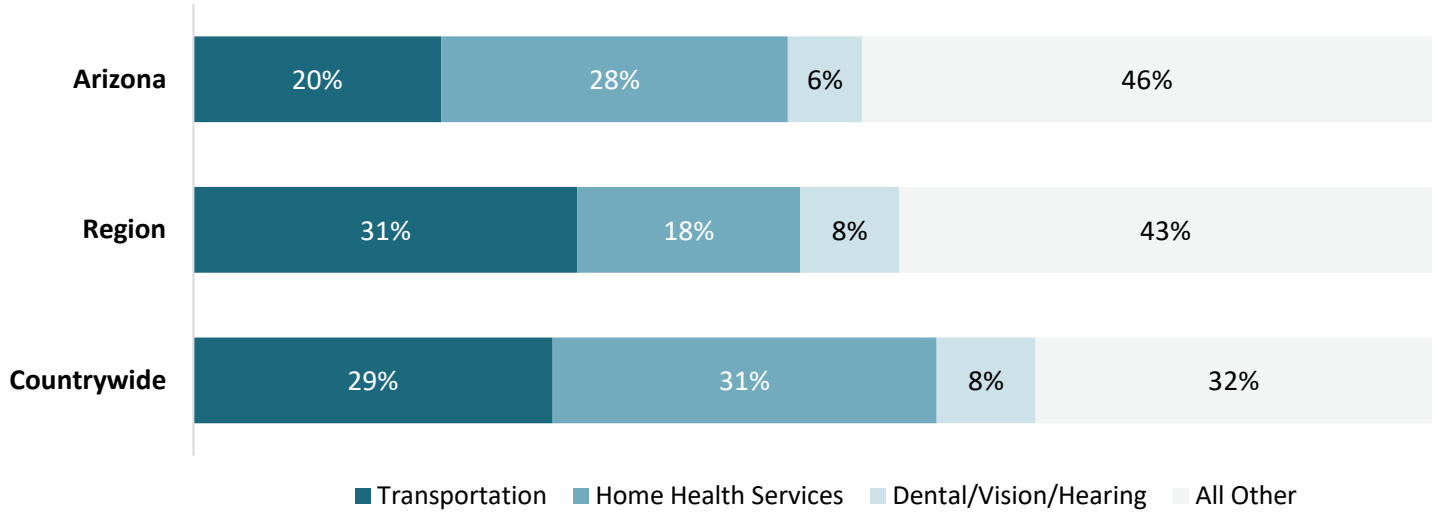
	Average Amount Paid Per Claim		
Diagnosis Group	**Arizona**	**Region**	**Countrywide**
Rotator cuff tear	$12,672	$16,519	$19,965
Tibia/fibula fracture	$25,027	$17,428	$18,063
Burns classified according to extent of body surface involved	$5,319	$9,030	$18,378
Minor shoulder injury	$3,505	$3,899	$4,051
Hand/wrist fracture	$7,421	$5,840	$5,981
Respiratory failure	$193,234	$31,481	$152,156
Hip/pelvis fracture/major trauma	$47,739	$29,918	$38,263
Ankle fracture	$18,110	$14,950	$15,730
Injury of unspecified body region	$3,876	$3,673	$3,200
Complication from surgical device	$30,240	$19,482	$21,776

Other Medical Services

For Service Year 2020, 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, 2019, and December 31, 2019, and they include all reported services provided for those claims through December 31, 2020.

Chart 67

Top Body Systems by Amount Paid for Dates of Injury in 2019

		Average Amount Paid Per Claim		
Body System	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Hand/wrist	12.9%	$2,429	$2,009	$2,427
Shoulder	12.8%	$7,916	$8,662	$9,995
Lumbar spine	9.9%	$4,004	$3,901	$4,584
Knee	8.9%	$5,845	$5,622	$6,096
Ankle/foot	8.5%	$4,041	$3,289	$3,666
Leg	6.1%	$5,815	$5,595	$6,606
Arm	5.4%	$6,568	$5,245	$5,895
Head	4.4%	$3,609	$3,716	$3,934
Neck	3.6%	$4,519	$5,311	$6,178
Chest/upper torso	2.3%	$3,023	$3,097	$3,268

Chart 68

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2019

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**Arizona**	**Region**	**Countrywide**
Minor hand/wrist injuries	5.7%	$1,415	$1,173	$1,330
Minor shoulder injury	4.8%	$4,171	$4,360	$4,660
Low back pain	4.7%	$2,152	$2,555	$2,427
Rotator cuff tear	4.4%	$17,886	$18,927	$23,192
Hand/wrist fracture	3.8%	$8,818	$7,007	$7,480
Tibia/fibula fracture	3.3%	$41,459	$28,880	$30,785
Minor ankle/foot injuries	2.8%	$1,947	$1,713	$1,824
Minor knee injury	2.8%	$2,576	$2,577	$2,647
Injury of unspecified body region	2.3%	$5,012	$4,125	$3,632
Neck pain	2.1%	$2,968	$3,657	$3,368

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	2016	2017	2018	2019	2020
Physician	35%	34%	34%	38%	37%
Hospital Outpatient	15%	17%	17%	17%	17%
Hospital Inpatient	14%	14%	15%	15%	16%
Drugs	13%	12%	11%	9%	9%
DMEPOS	7%	8%	7%	7%	7%
ASC	7%	7%	6%	6%	6%
Other	9%	8%	10%	8%	8%

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

AMA Service Category	2016	2017	2018	2019	2020
Physical Medicine	30%	31%	35%	34%	37%
Surgery	20%	19%	16%	17%	15%
Evaluation and Management	28%	28%	29%	29%	27%
Radiology	9%	9%	8%	8%	8%
Anesthesia	3%	3%	3%	3%	2%
General Medicine	4%	4%	3%	3%	4%
Other	3%	3%	4%	4%	6%
Pathology	3%	3%	2%	2%	1%

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

Medical Category	AY 2015	AY 2016	AY 2017	AY 2018	AY 2019
Physicians – Major Surgery	26	28	22	25	28
Physicians – Radiology	1	1	1	1	1
Physicians – Physical and General Medicine	9	9	10	9	9
Physicians – Evaluation and Management	1	1	1	1	1
Hospital Inpatient	0	0	0	0	0
Hospital Outpatient – Major Surgery	57	63	50	55	60
Hospital Outpatient – All Other	11	12	12	13	15
ASC – Major Surgery	63	66	66	70	78

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

Medical Category	AY 2015	AY 2016	AY 2017	AY 2018	AY 2019
Physicians – Major Surgery	104	109	98	101	102
Physicians – Radiology	6	7	7	7	8
Physicians – Physical and General Medicine	30	32	32	31	33
Physicians – Evaluation and Management	3	4	4	4	4
Hospital Inpatient	5	4	4	6	5
Hospital Outpatient – Major Surgery	135	141	127	126	142
Hospital Outpatient – All Other	46	47	47	48	54
ASC – Major Surgery	137	137	134	150	148

Hospital Inpatient Statistics (Charts 27 and 29)

	2016	2017	2018	2019	2020
Average Amount Paid Per Stay	$37,443	$37,335	$40,490	$44,262	$48,024
Number of Stays per 1,000 Active Claims	17	17	15	15	16

[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	2016	2017	2018	2019	2020
Emergency	44%	43%	46%	46%	44%
Nonemergency Major Surgery	36%	39%	37%	37%	38%
Other	20%	18%	17%	17%	18%

Emergency Hospital Outpatient Statistics (Charts 36 and 37)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$1,883	$2,042	$2,078	$2,213	$2,406
Number of Visits per 1,000 Active Claims	162	170	169	160	146

Emergency Room Outpatient Services Paid per Transaction (Chart 39)

Code	Severity	2016	2017	2018	2019	2020
99281	Minor	$279	$235	$222	$257	$256
99282	Low to moderate	$315	$325	$355	$358	$374
99283	Moderate	$553	$559	$610	$646	$648
99284	High	$861	$938	$936	$920	$933
99285	High and immediately life-threatening	$1,490	$1,532	$1,492	$1,500	$1,469

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

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$9,780	$12,131	$12,495	$13,315	$12,753
Number of Visits per 1,000 Active Claims	25	26	22	21	23

Other Hospital Outpatient Statistics (Charts 45 and 46)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$527	$557	$554	$627	$634
Number of Visits per 1,000 Active Claims	260	271	233	209	220

ASC Major Surgery Statistics (Charts 51 and 52)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$7,723	$8,540	$8,349	$8,036	$8,095
Number of Visits per 1,000 Active Claims	31	29	28	29	30

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

CSA Schedule	2016	2017	2018	2019	2020
Schedule II	25%	22%	19%	14%	13%
Schedule III	1%	1%	1%	1%	1%
Schedule IV	8%	7%	6%	5%	4%
Schedule V	6%	7%	9%	8%	8%
Noncontrolled	60%	63%	65%	72%	74%

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

Type of Drug	2016	2017	2018	2019	2020
Brand Name	47%	45%	45%	39%	31%
Generic	53%	55%	55%	61%	69%

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

Type of Provider	2016	2017	2018	2019	2020
Pharmacy	91%	91%	86%	82%	95%
Nonpharmacy	9%	9%	14%	18%	5%

Distribution of Payments by DMEPOS (Chart 63)

Category	2016	2017	2018	2019	2020
DME	17%	15%	16%	18%	20%
Prosthetics, Orthotics and Implants	50%	49%	46%	44%	39%
Supplies Other Than DME	33%	36%	38%	38%	41%

Distribution of Payments by Other Medical Services (Chart 66)

Category	2016	2017	2018	2019	2020
Transportation	16%	18%	15%	19%	20%
Home Health Services	28%	28%	21%	24%	28%
Dental/Vision/Hearing	4%	5%	4%	5%	6%
All Other	52%	49%	60%	52%	46%

Glossary

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

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

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

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

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

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

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

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

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

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

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

Emergency Services: Services performed for patients requiring immediate attention.

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 Procedure Terminology (CPT) procedures.

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

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 surgery procedure has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, and is not an injection.

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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