



# Medical Data Report

For the state of

# MONTANA

October 2019



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## Introduction

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

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

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

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

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

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

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

The data contained in this report represents medical transactions for Service Year 2018 (medical services delivered from January 1, 2018, to December 31, 2018), except where otherwise noted. Workers compensation insurance carriers must report paid medical transactions if they write at least 1% of the market share in any one state for which NCCI is the rating or advisory organization. Once a carrier meets the eligibility criteria, the carrier is required to report for all applicable states in which it writes workers compensation insurance, even if an individual state's market share is below the 1% threshold. All carriers within an insurance group are required to report, regardless of whether they write less than 1% of the market share in the state.

For the state of Montana in Service Year 2018, the reported number of transactions was more than 387,500, with more than \$78,177,400 paid, for more than 19,600 claims. This represents data from 97% of the workers compensation premium written, which includes experience for large-deductible policies. Lump-sum settlements are not required to be reported. Also, self-insured data is not included.



Unless otherwise noted, the source for all data in this report is NCCI's Medical Data Call, Service Year 2018. Region includes data from the following states: AK, AZ, CO, HI, ID, 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

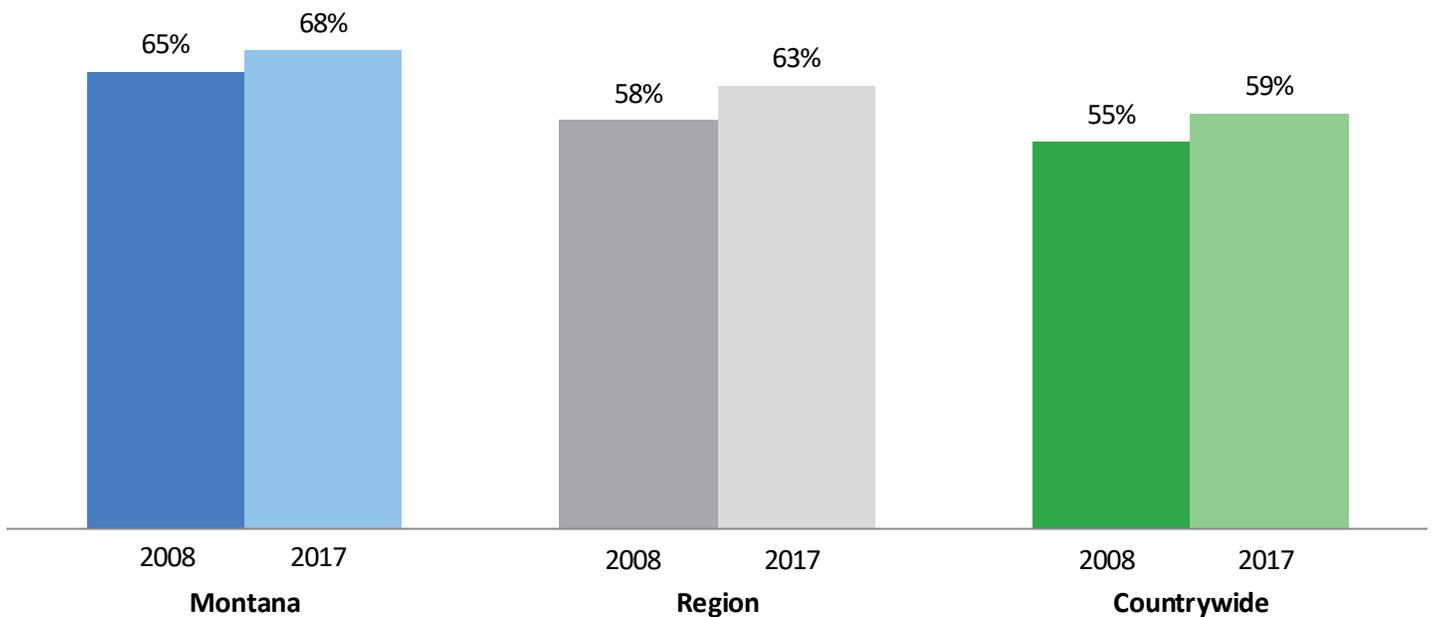
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

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 Montana, the region, and countrywide for Accident Years 2008 and 2017.

**Chart 1**

**Medical Share of Total Benefit Costs by Accident Year**



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AK, AZ, CO, HI, ID, 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.



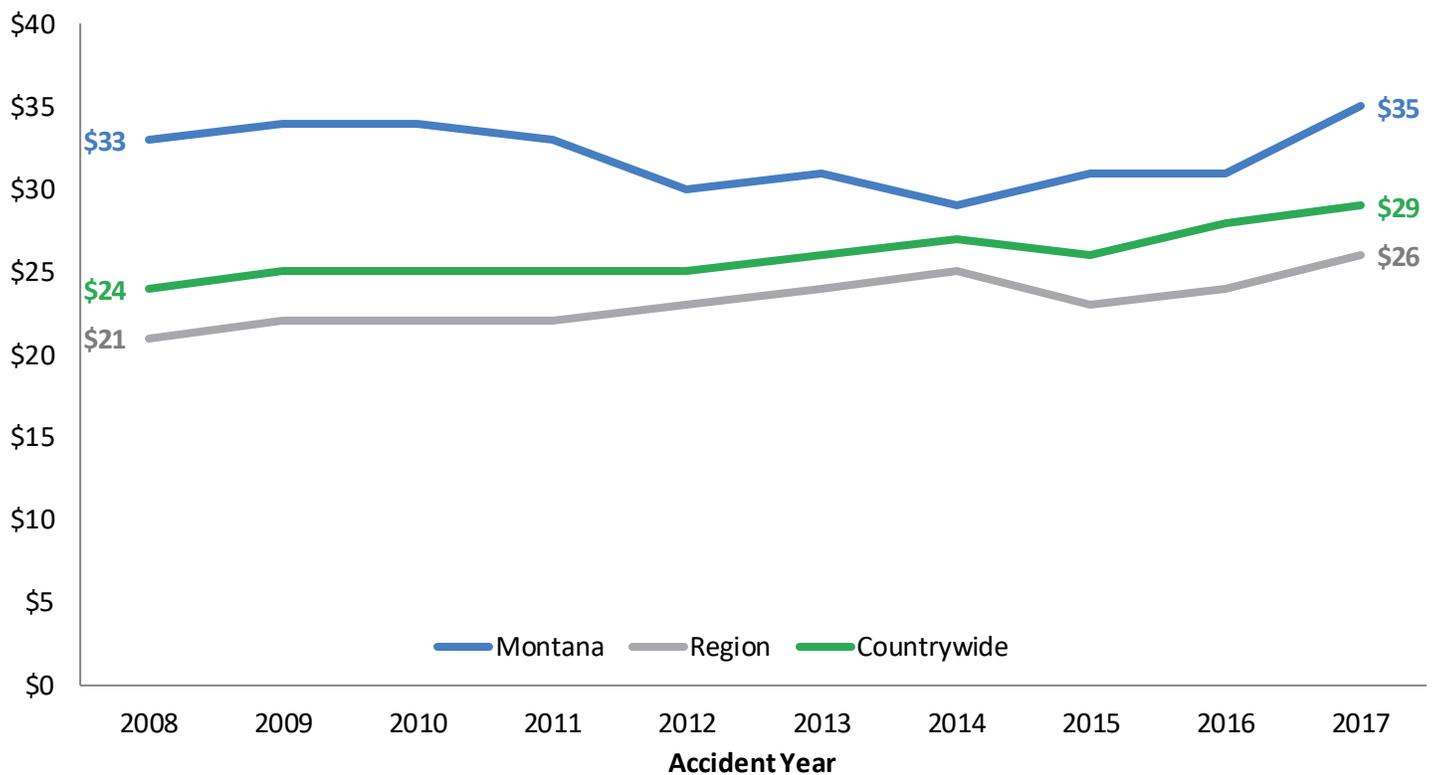
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging more than 2% from Accident Years 2008 to 2017; this has tracked annual growth for the United States Personal Healthcare Spending per capita.<sup>1</sup> Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for Montana, 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 Montana 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, AZ, CO, HI, ID, 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.

<sup>1</sup> State of the Line Report, *Annual Issues Symposium*, May 2019, [www.ncci.com/Articles/Documents/AIS2019-SOTL-Presentation.pdf](http://www.ncci.com/Articles/Documents/AIS2019-SOTL-Presentation.pdf).

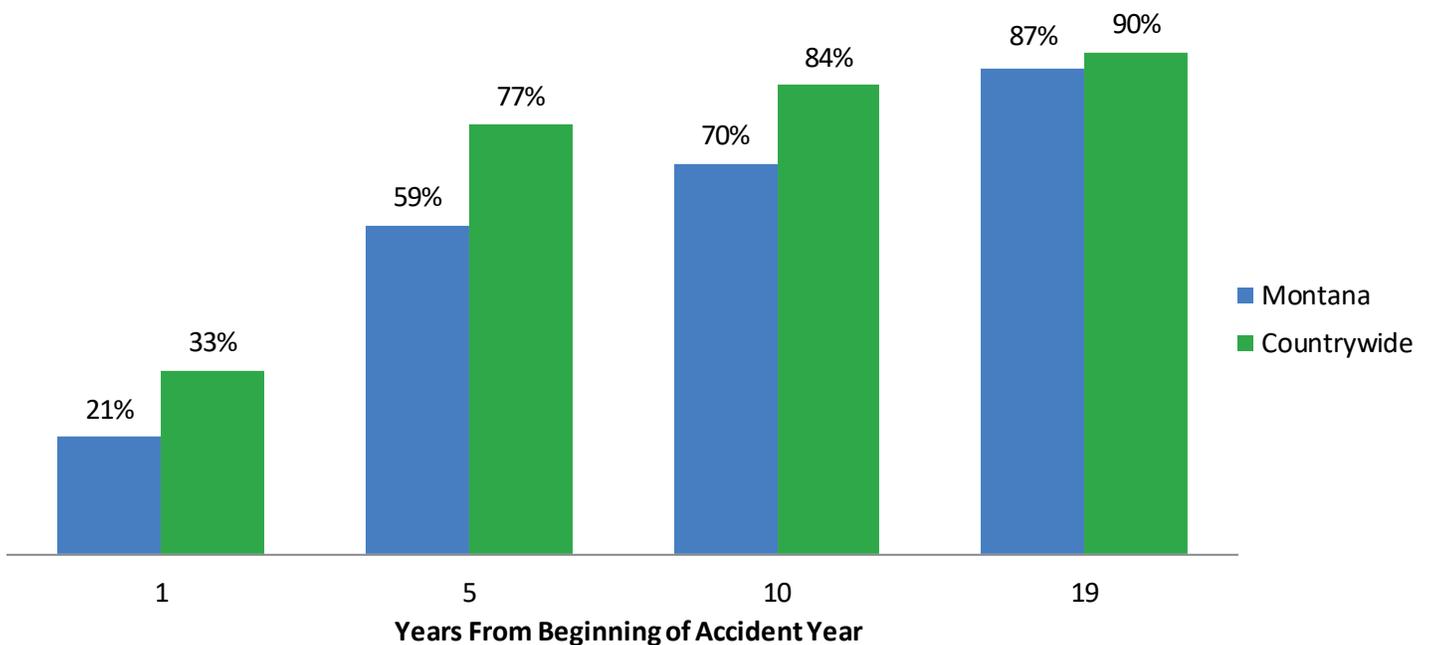
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. Recent NCCI research has found that it is likely that about 10% of the cost of medical benefits for workplace injuries that occur this year will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

**Chart 3**

**Percentage of Medical Paid by Claim Maturity**



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

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

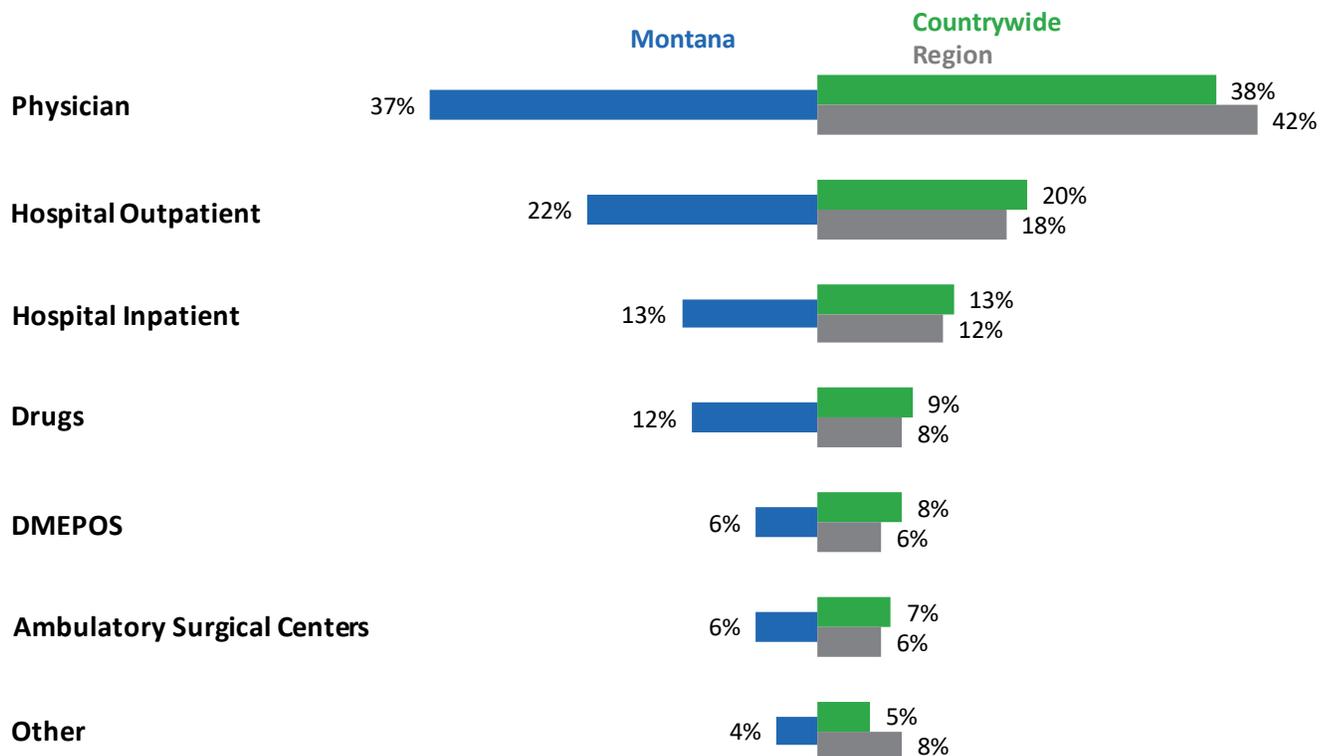
Payments are categorized as Drugs; DME, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed. For the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

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

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

Chart 4

Distribution of Medical Payments



## Physicians

Results from NCCI’s study, [“The Price Impact of Physician Fee Schedules”](#) (April 2014), show that the median workers compensation price for a physician service is always at, or very near, the maximum allowable reimbursement (MAR) amount set by the fee schedule. In the 1970s, 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.

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<sup>2</sup> amounts for physician payments by category for Montana, the region, and countrywide. Note that “all physician services” in Chart 5 below refers only to the five categories listed in the chart, and the state comparison reflects Medicare’s geographic adjustments.

**Chart 5**

### Physician Payments as a Percentage of Medicare

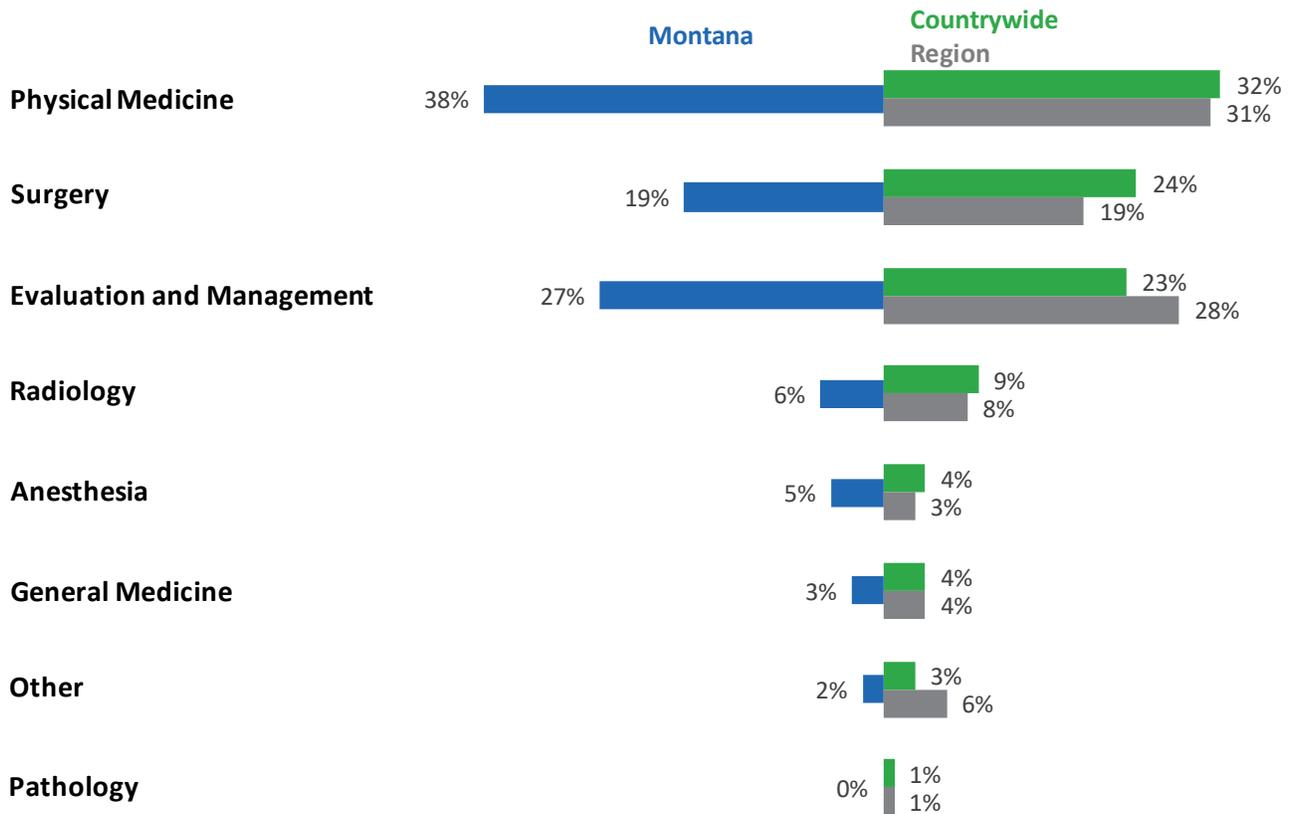
Physician Service Category	Montana	Region	Countrywide
General and Physical Medicine	150%	133%	131%
Surgery	157%	220%	269%
Evaluation and Management	163%	151%	142%
Radiology	173%	222%	228%
Anesthesia	260%	234%	281%
<b>All Physician Services</b>	<b>160%</b>	<b>160%</b>	<b>167%</b>

<sup>2</sup> 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 Montana, the region, and countrywide.

Chart 6

Distribution of Physician Payments by AMA Service Category



Recently, NCCI conducted a review of physician costs in workers compensation as compared to group health (GH). Results<sup>3</sup> 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.

With the exception of anesthesia, the charts also include the average amount paid per transaction (PPT) for these codes in Montana, 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 include the average amount paid per unit (PPU) for the codes in Montana, 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 anesthesia, a unit is defined as a 15-minute increment.

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

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

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

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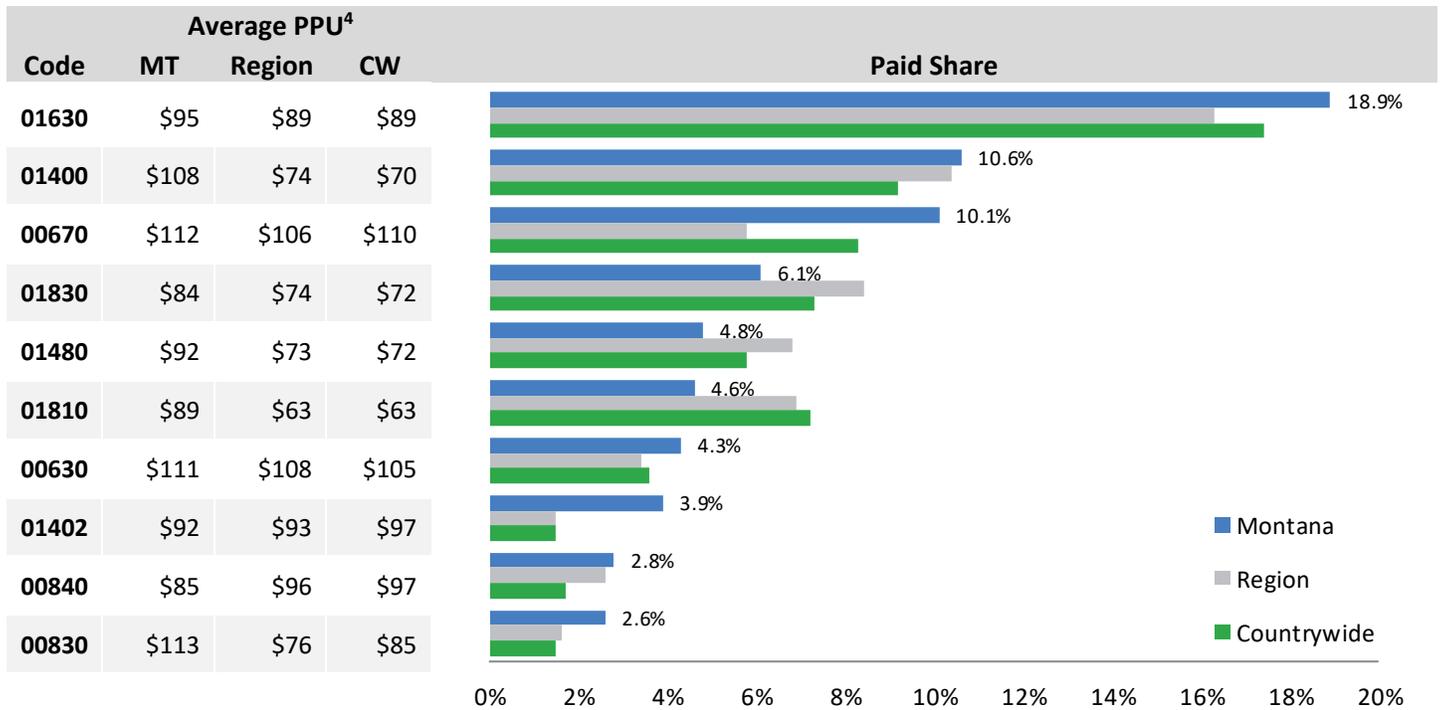
<sup>3</sup> Lipton, B. [Channel NCCI]. (2019, May 23). *Work Comp vs. Group Health-- The Price We Pay* [Video File]. Retrieved from <https://youtu.be/fb3tnbQoMSY>.



In Montana, physician payments for anesthesia services provided in 2018 are, on average, 260% of Medicare-scheduled reimbursement amounts, compared to 234% in the region and 281% countrywide. Payments for these services comprise 5% of physician payments, compared to 3% in the region and 4% countrywide.

Chart 7

Top 10 Anesthesia Procedure Codes by Amount Paid

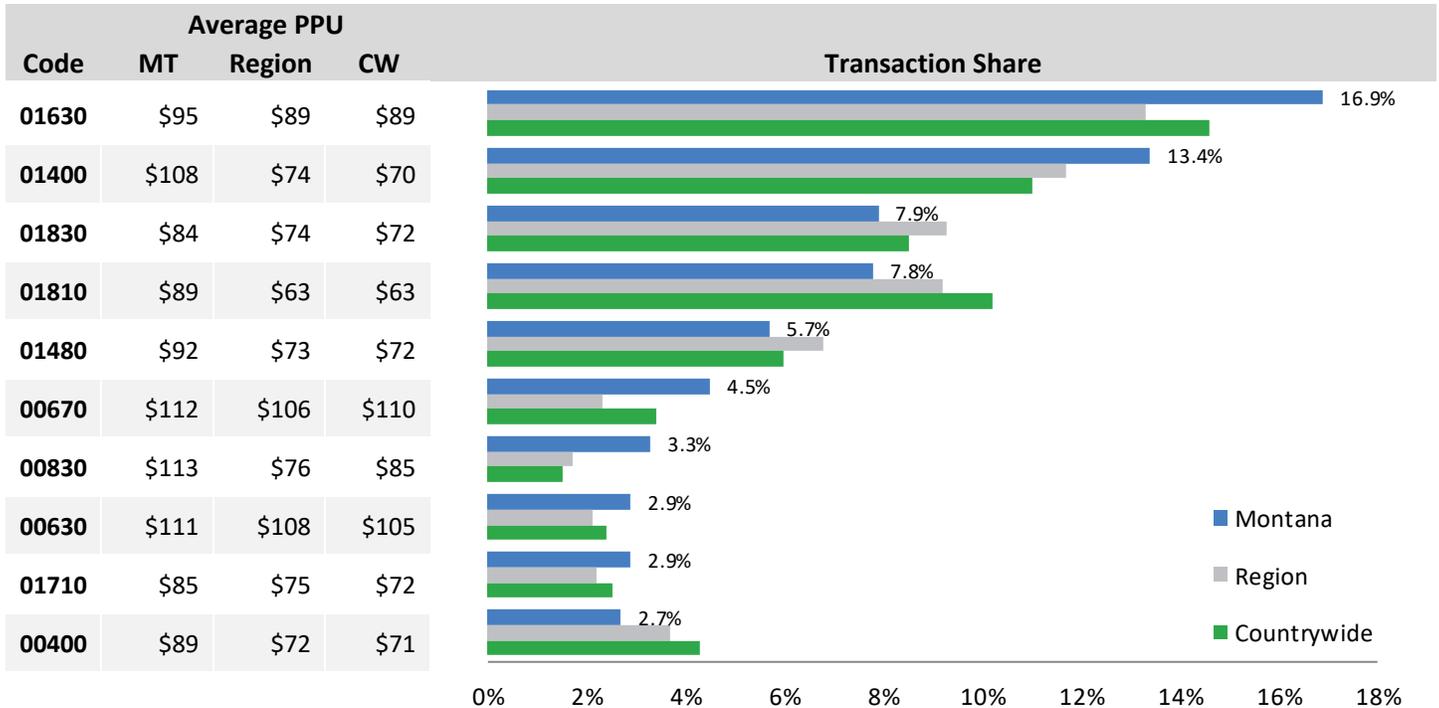


Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
00630	Anesthesia for procedures in lumbar region; not otherwise specified
01402	Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified

<sup>4</sup> A unit is defined as an increment of 15 minutes.

### Chart 8

#### Top 10 Anesthesia Procedure Codes by Transaction Counts



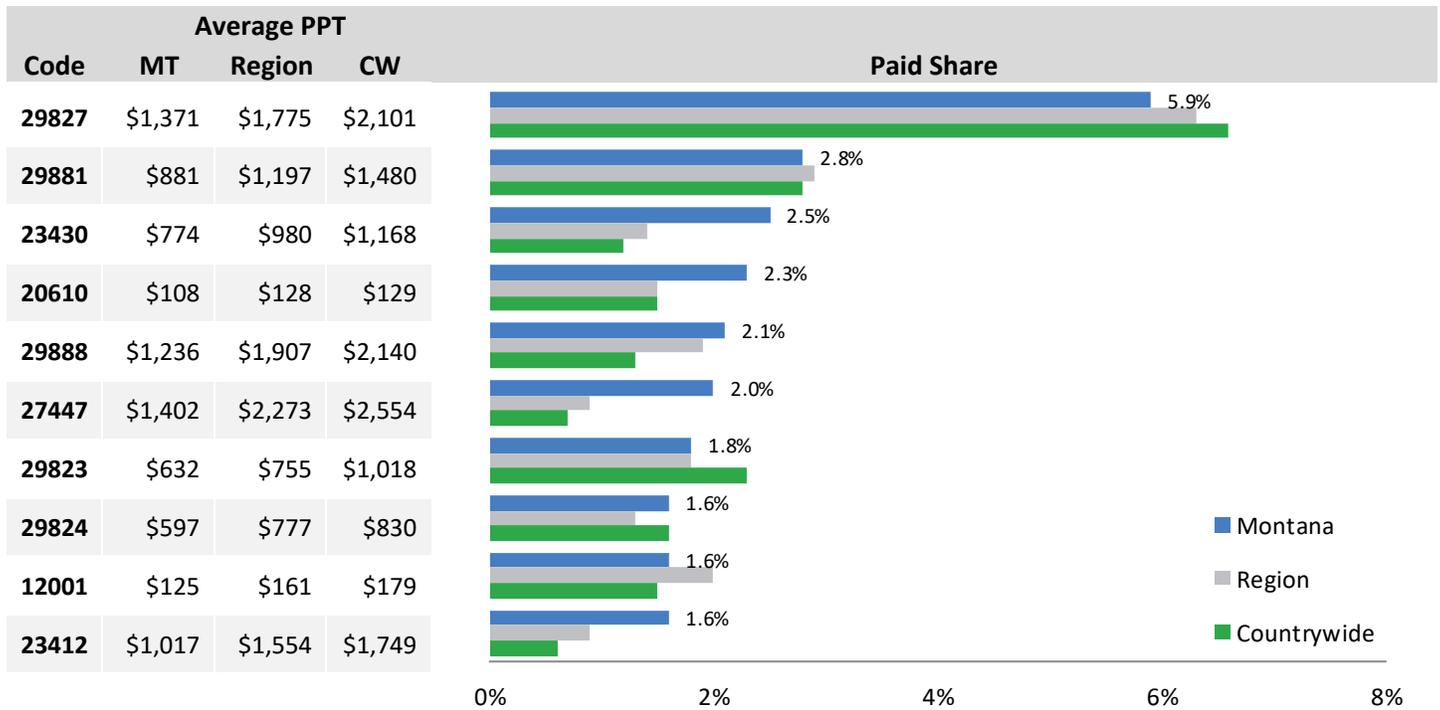
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
00830	Anesthesia for hernia repairs in lower abdomen; not otherwise specified
00630	Anesthesia for procedures in lumbar region; not otherwise specified
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified



In Montana, physician payments for surgery services provided in 2018 are, on average, 157% of Medicare-scheduled reimbursement amounts, compared to 220% in the region and 269% countrywide. Payments for these services comprise 19% of physician payments, compared to 19% in the region and 24% countrywide.

### Chart 9

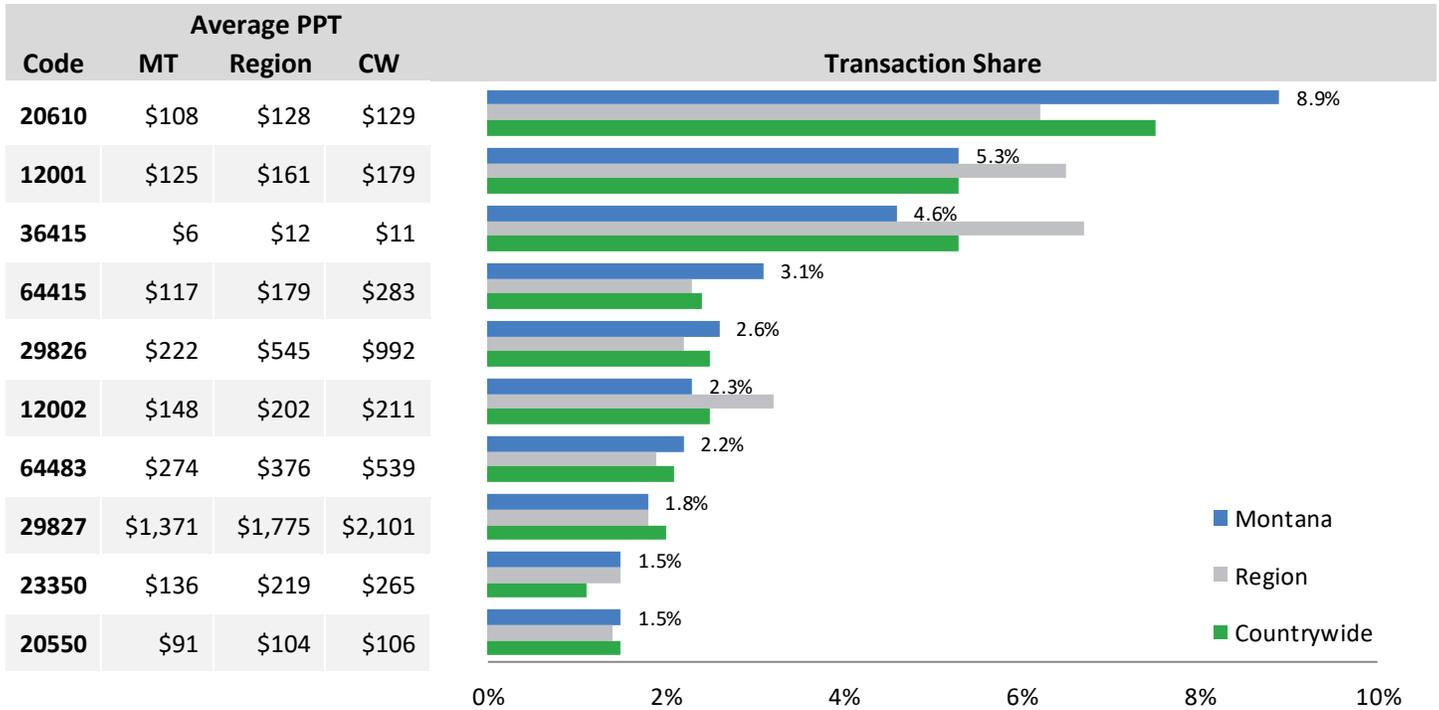
#### Top 10 Surgery Procedure Codes by Amount Paid



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
23430	Tenodesis of long tendon of biceps
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
27447	Arthroplasty, knee condyle and plateau; medial and lateral compartments, with or without patella resurfacing (total knee arthroplasty)
29823	Arthroscopy, shoulder, surgical; debridement extensive
29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
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
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic

Chart 10

Top 10 Surgery Procedure Codes by Transaction Counts

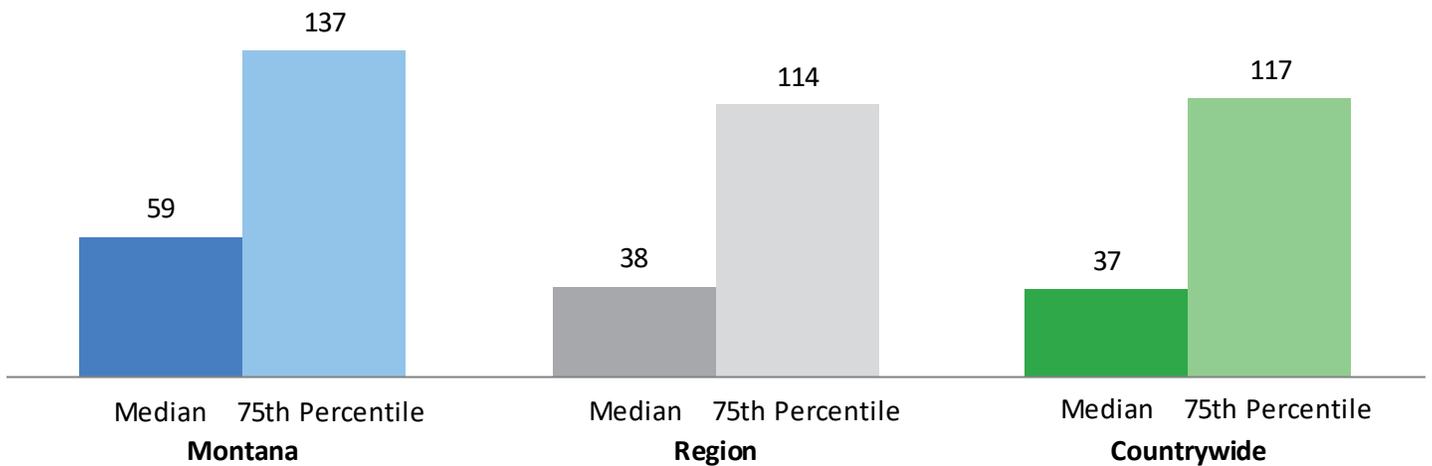


Code	Description
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
36415	Collection of venous blood by venipuncture
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
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
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23350	Injection procedure for shoulder arthrography or enhanced computed tomography (CT)/magnetic resonance imaging (MRI) shoulder arthrography
20550	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)

Chart 11 shows the median and 75th percentile<sup>5</sup> time until first treatment for major surgery for Montana, 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<sup>6</sup> (in Days)**



Source: NCCI's Medical Data Call for Accident Year 2017 and Service Years 2017 and 2018.

<sup>5</sup> 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 137 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

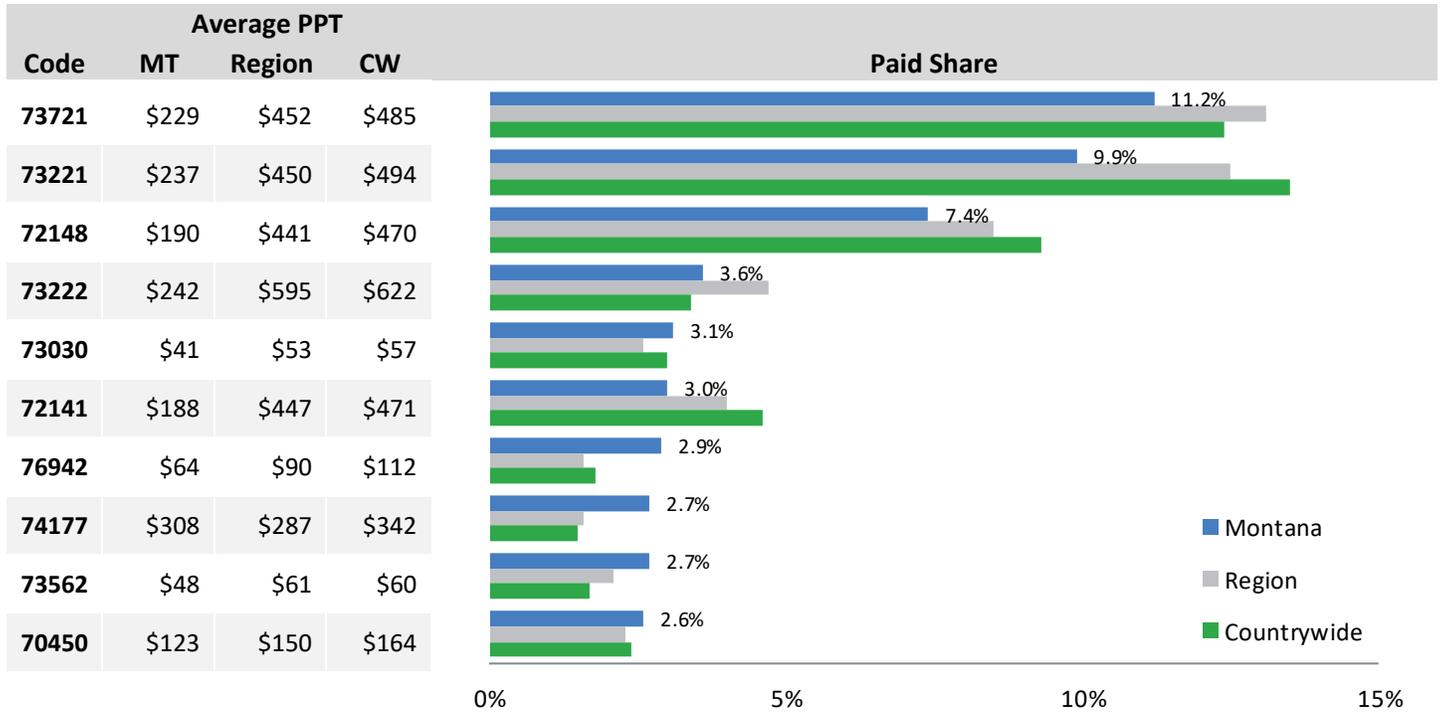
<sup>6</sup> A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it has a global follow up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection.



In Montana, physician payments for radiology services provided in 2018 are, on average, 173% of Medicare-scheduled reimbursement amounts, compared to 222% in the region and 228% countrywide. Payments for these services comprise 6% of physician payments, compared to 8% in the region and 9% countrywide.

Chart 12

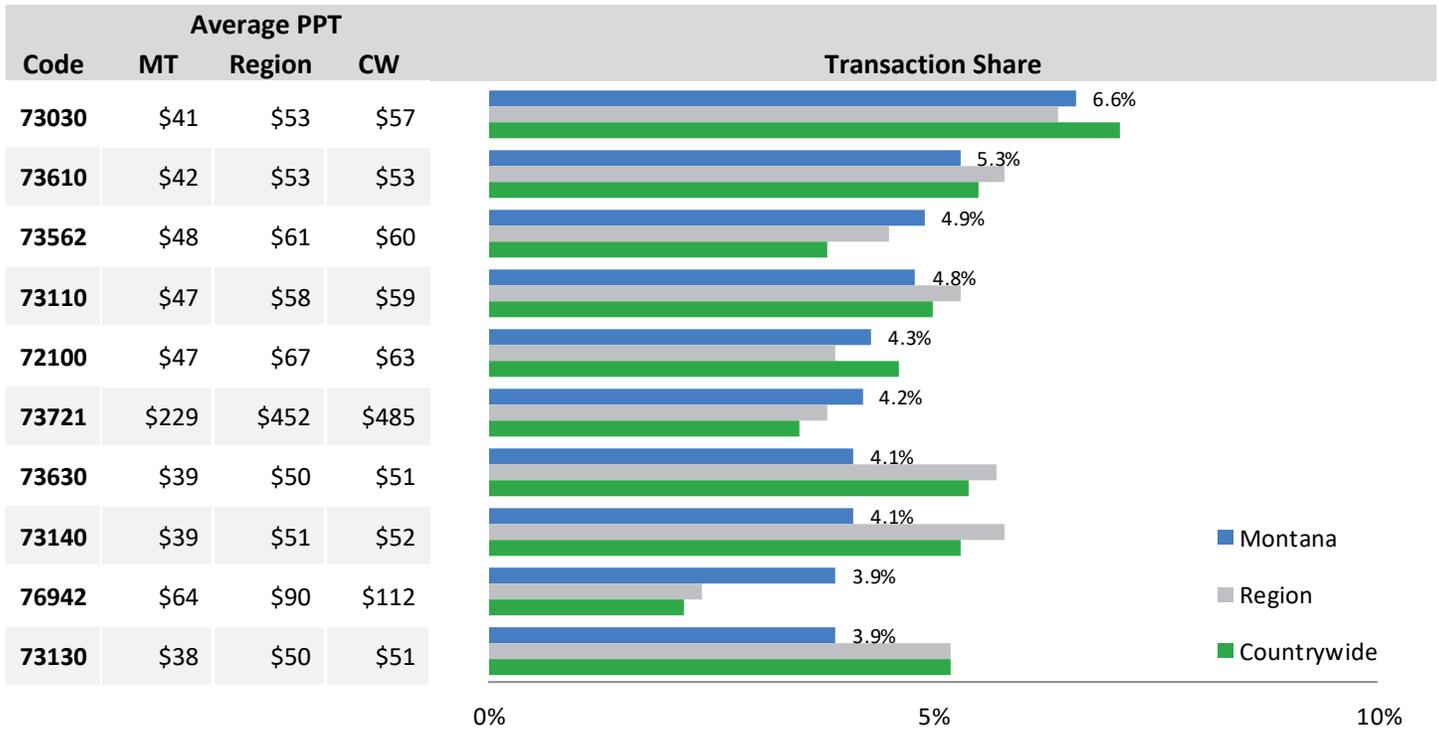
Top 10 Radiology Procedure Codes by Amount Paid



Code	Description
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material
73030	Radiologic examination, shoulder; complete minimum of 2 views
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
74177	Computed tomography (CT), abdomen and pelvis; with contrast material
73562	Radiologic examination, knee; 3 views
70450	Computed tomography (CT), head or brain; without contrast material

Chart 13

Top 10 Radiology Procedure Codes by Transaction Counts

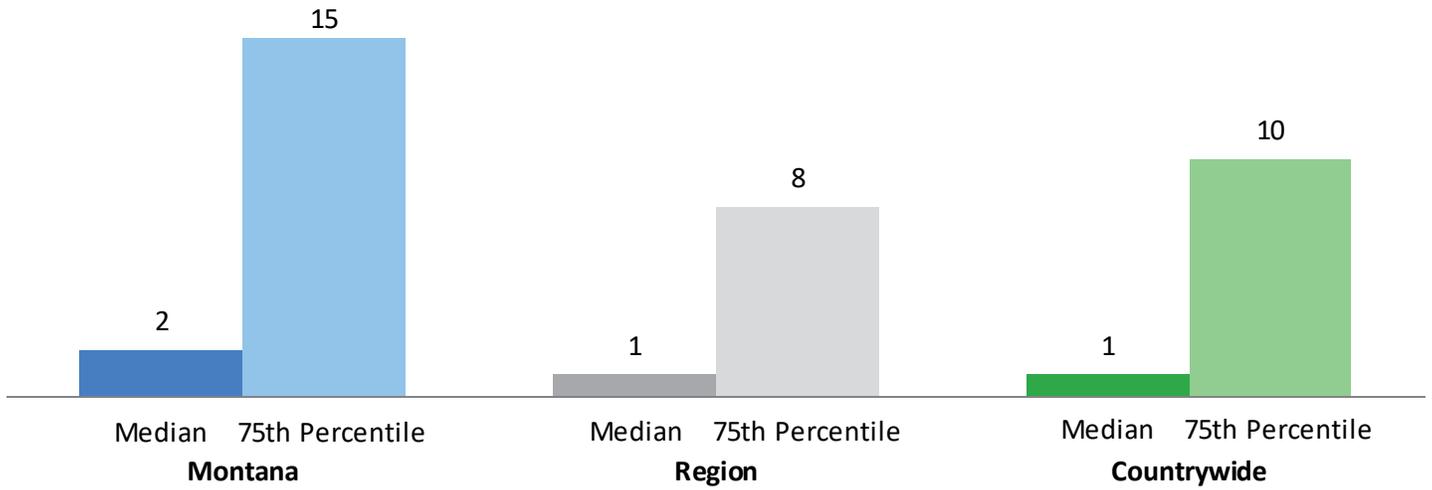


Code	Description
73030	Radiologic examination, shoulder; complete minimum of 2 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73562	Radiologic examination, knee; 3 views
73110	Radiologic examination, wrist; complete minimum of 3 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
73630	Radiologic examination, foot; complete minimum of 3 views
73140	Radiologic examination, finger(s); minimum of 2 views
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
73130	Radiologic examination, hand; minimum of 3 views

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

**Chart 14**

**Time Until First Treatment for Radiology (in Days)**

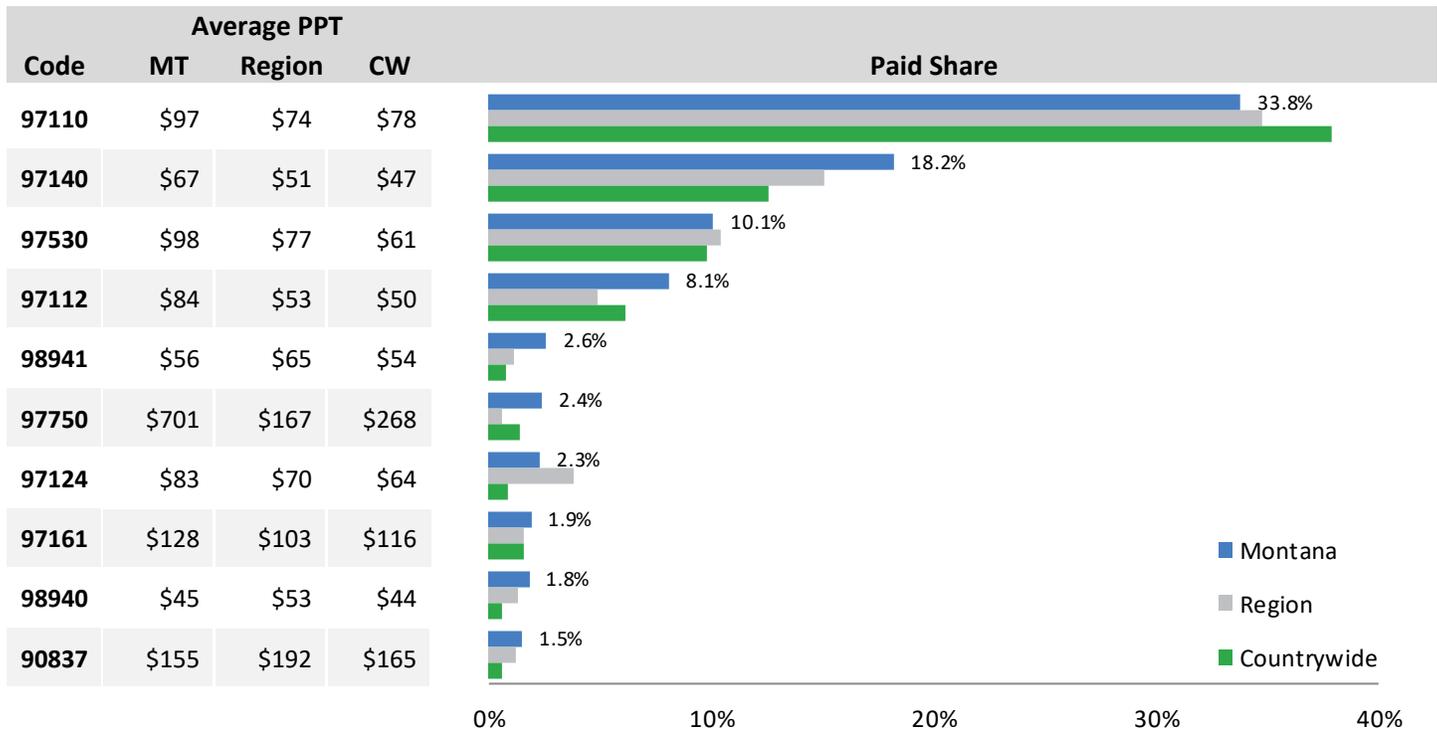


Source: NCCI's Medical Data Call for Accident Year 2017 and Service Years 2017 and 2018.

In Montana, physician payments for physical and general medicine services provided in 2018 are, on average, 150% of Medicare-scheduled reimbursement amounts, compared to 133% in the region and 131% countrywide. Payments for these services comprise 41% of physician payments, compared to 35% in the region and 36% countrywide.

**Chart 15**

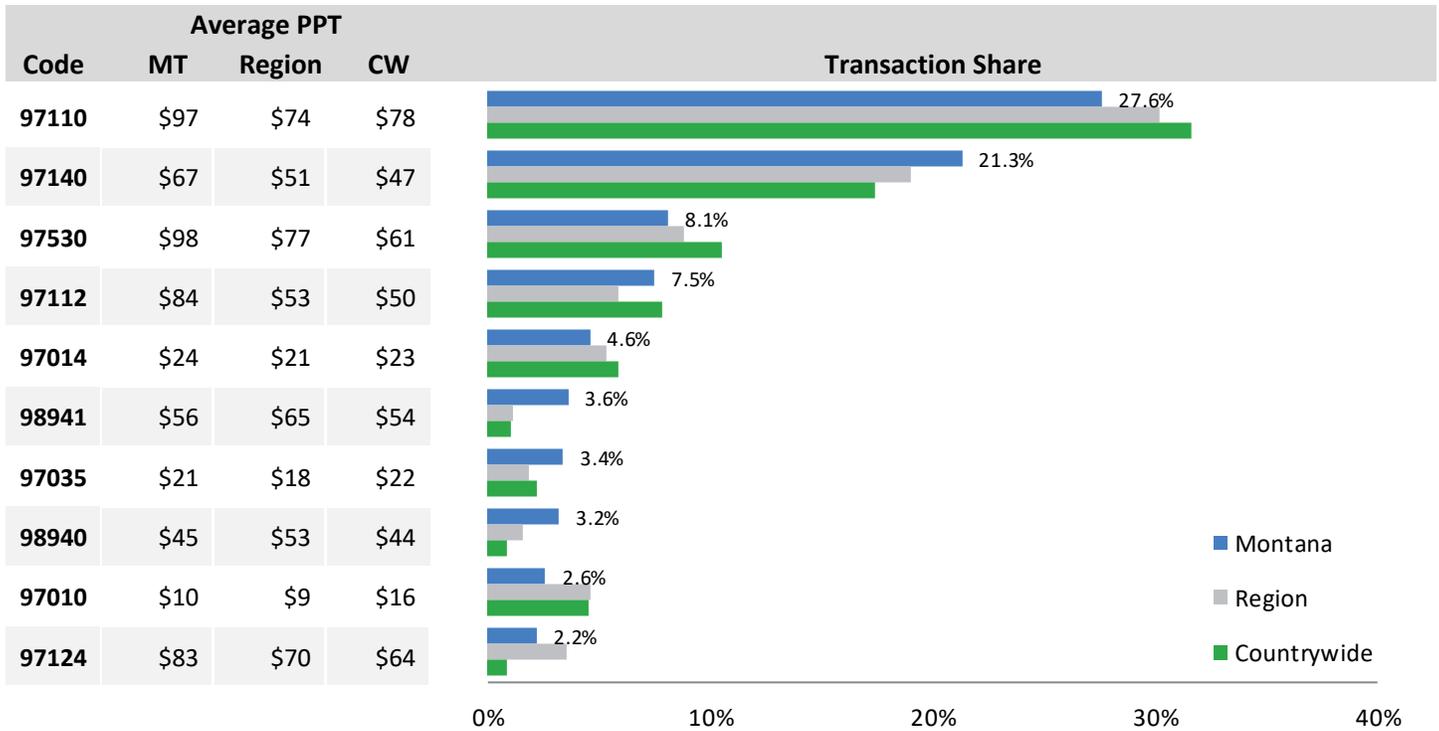
**Top 10 Physical and General Medicine Procedure Codes by Amount Paid**



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
97750	Physical performance test or measurement (e.g., musculoskeletal functional capacity), with written report, each 15 minutes
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
90837	Psychotherapy, 60 minutes with patient

Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

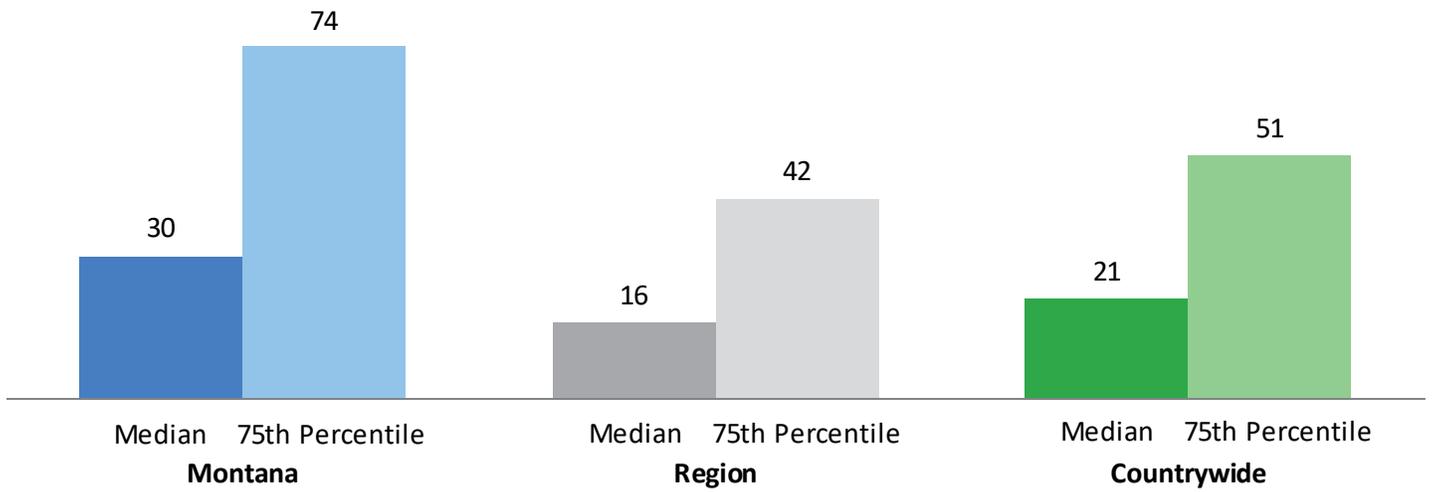


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
97010	Application of a modality to 1 or more areas; hot or cold packs
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

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

**Chart 17**

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



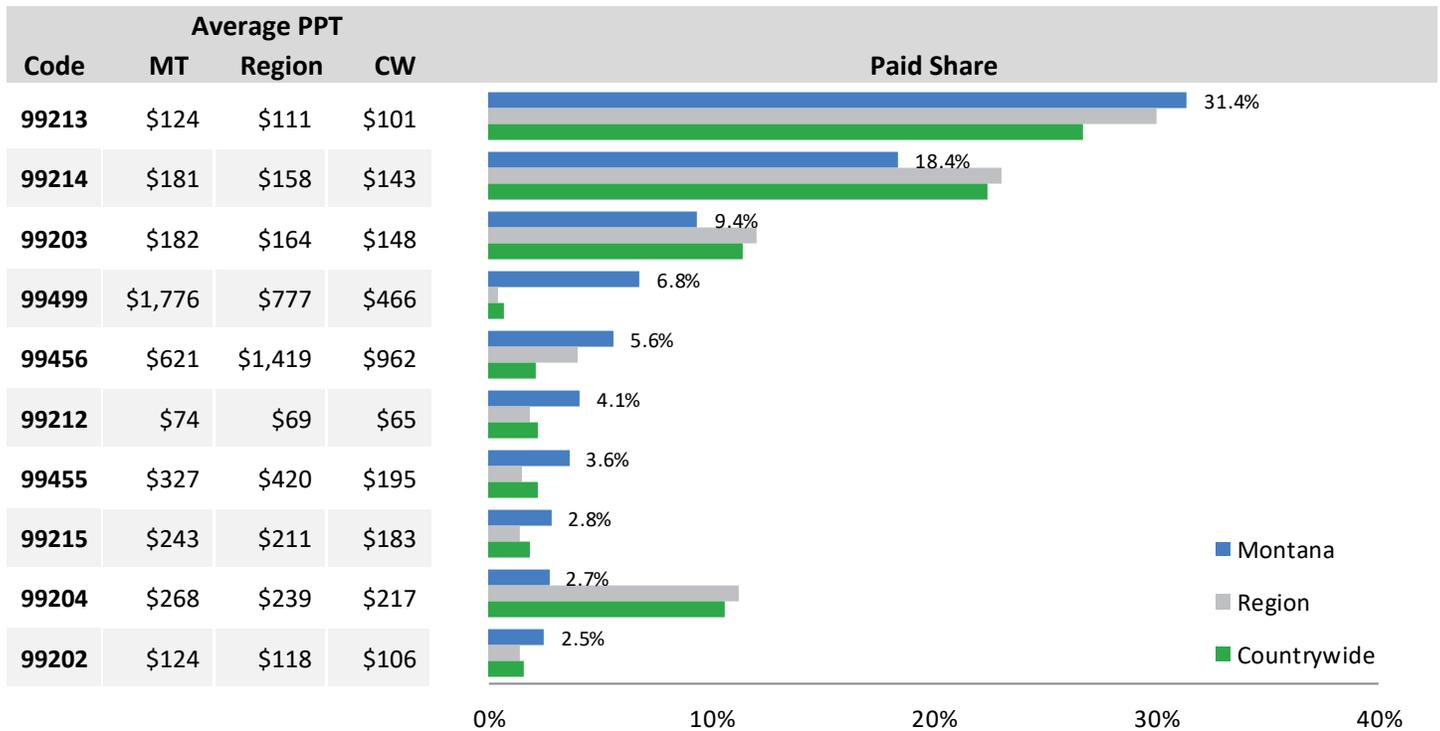
Source: NCCI's Medical Data Call for Accident Year 2017 and Service Years 2017 and 2018.



In Montana, physician payments for evaluation and management services provided in 2018 are, on average, 163% of Medicare-scheduled reimbursement amounts, compared to 151% in the region and 142% countrywide. Payments for these services comprise 27% of physician payments, compared to 28% in the region and 23% countrywide.

Chart 18

Top 10 Evaluation and Management Procedure Codes by Amount Paid

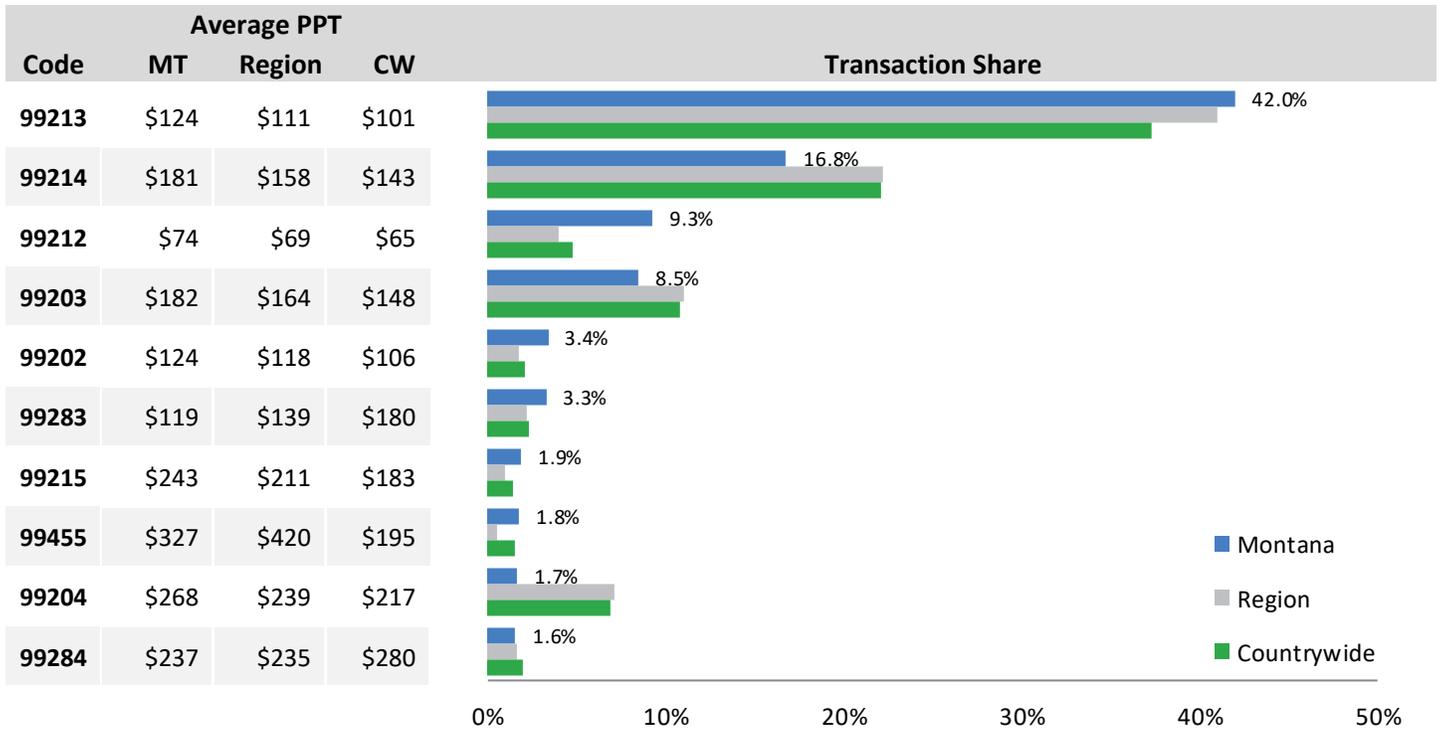


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit 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.
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.
99499	Unlisted evaluation and management service
99456	Work related or medical disability examination by other than the treating physician
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
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.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.



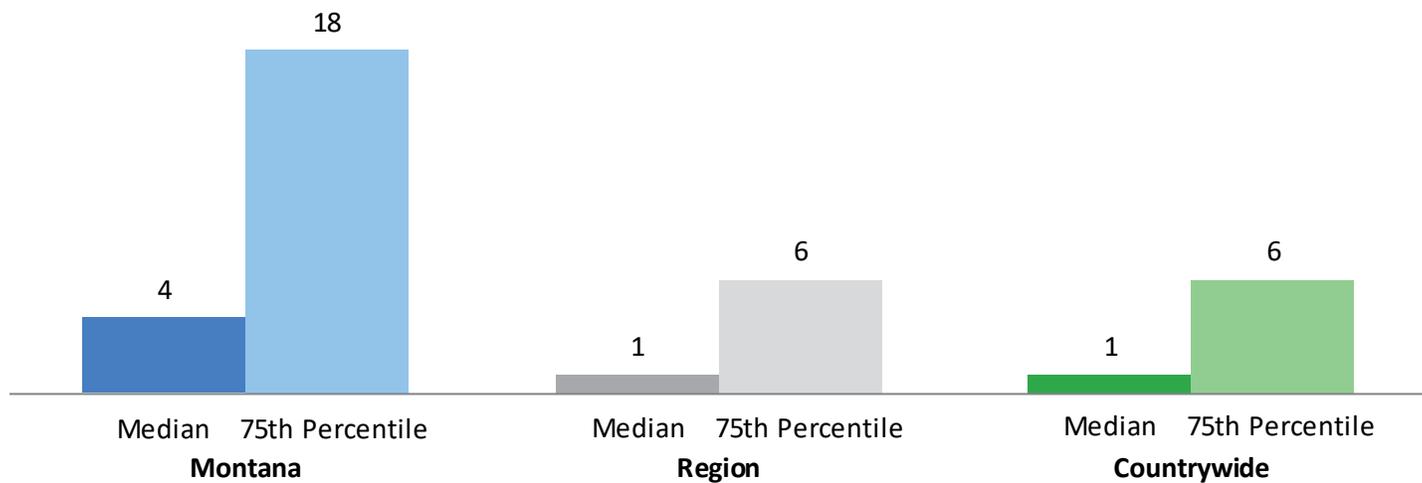
Chart 19

Top 10 Evaluation and Management Procedure Codes by Transaction Counts



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. 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.
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.
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.
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.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
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.
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.
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 Montana, the region, and countrywide.

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

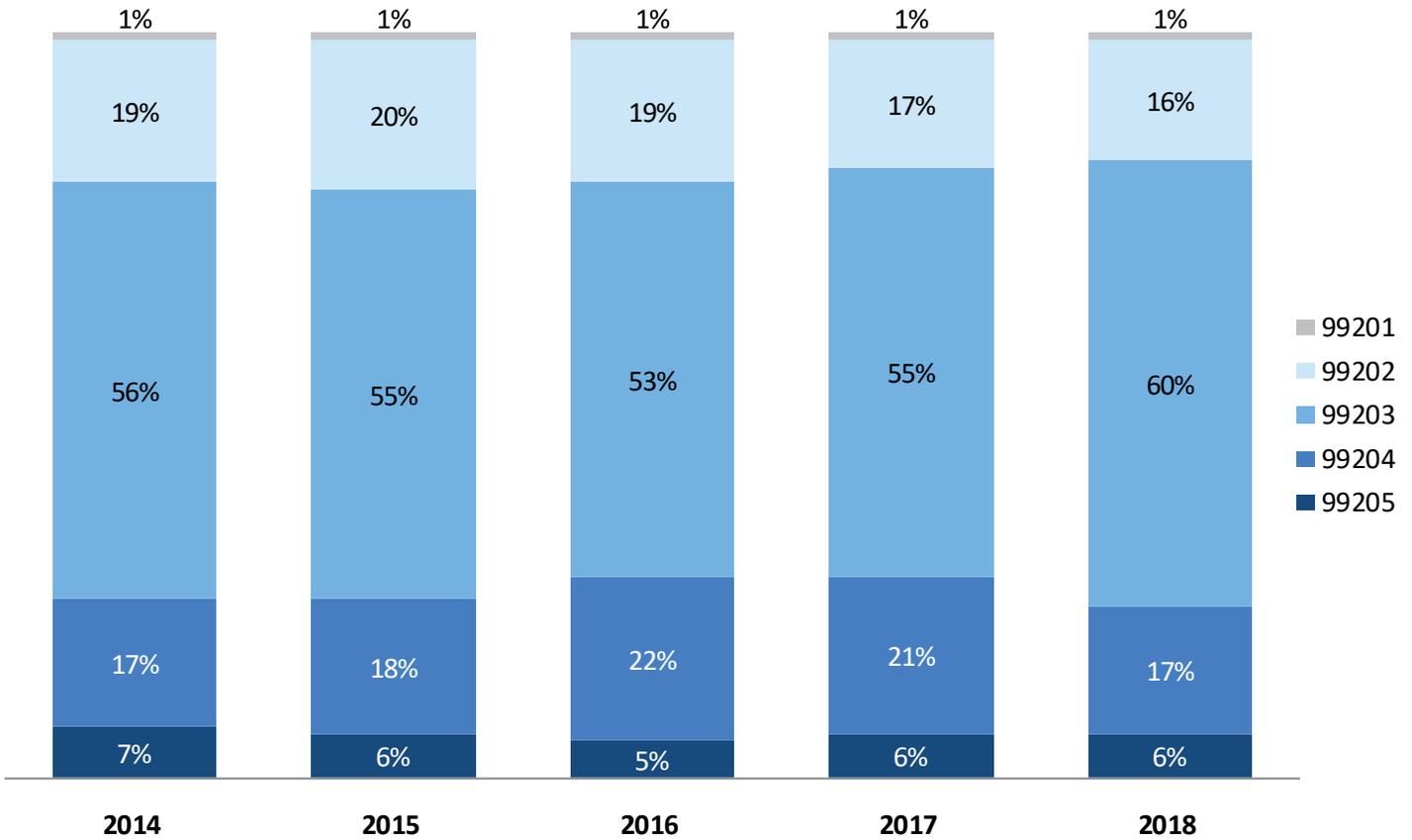
Source: NCCI's Medical Data Call for Accident Year 2017 and Service Years 2017 and 2018.

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

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

**Chart 21**

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



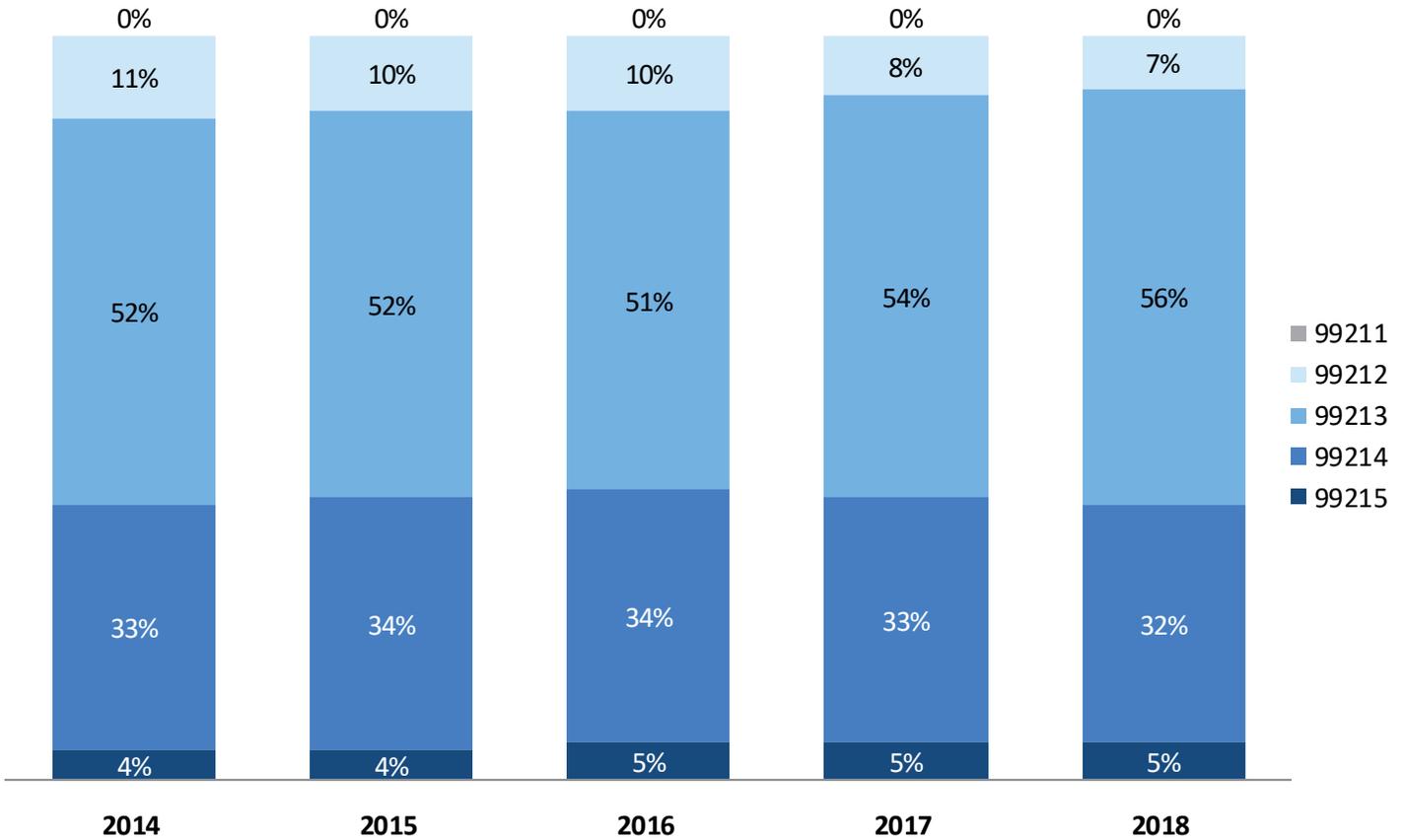
Source: NCCI's Medical Data Call, Service Years 2014 to 2018.

Code	Severity/Time	Average PPT				
		2014	2015	2016	2017	2018
99201	Low to Moderate; 10 minutes with patient	\$63	\$63	\$62	\$64	\$66
99202	Low to Moderate; 20 minutes with patient	\$118	\$118	\$120	\$121	\$124
99203	Moderate; 30 minutes with patient	\$172	\$173	\$177	\$180	\$182
99204	Moderate to High; 45 minutes with patient	\$255	\$261	\$264	\$270	\$268
99205	Moderate to High; 60 minutes with patient	\$319	\$320	\$330	\$342	\$349

Similarly, for established patients, there are five periods of time spent with the patient, ranging from five minutes for Procedure Code 99211 to 40 minutes for Procedure Code 99215. Chart 22 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for an established patient.

Chart 22

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



Source: NCCI's Medical Data Call, Service Years 2014 to 2018.

Code	Severity/Time	Average PPT				
		2014	2015	2016	2017	2018
99211	Low to Moderate; 5 minutes with patient	\$32	\$32	\$31	\$31	\$35
99212	Low to Moderate; 10 minutes with patient	\$72	\$71	\$74	\$74	\$74
99213	Moderate; 15 minutes with patient	\$116	\$116	\$120	\$122	\$124
99214	Moderate to High; 25 minutes with patient	\$170	\$169	\$176	\$178	\$181
99215	Moderate to High; 40 minutes with patient	\$229	\$225	\$235	\$237	\$243



### 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 Montana, 91% of hospital inpatient payments are reported with a DRG code.

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

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

**Chart 23**

#### **Hospital Inpatient Payments as a Percentage of Medicare**

<b>Medical Cost Category</b>	<b>Montana</b>	<b>Region</b>	<b>Countrywide</b>
Hospital Inpatient	149%	185%	198%

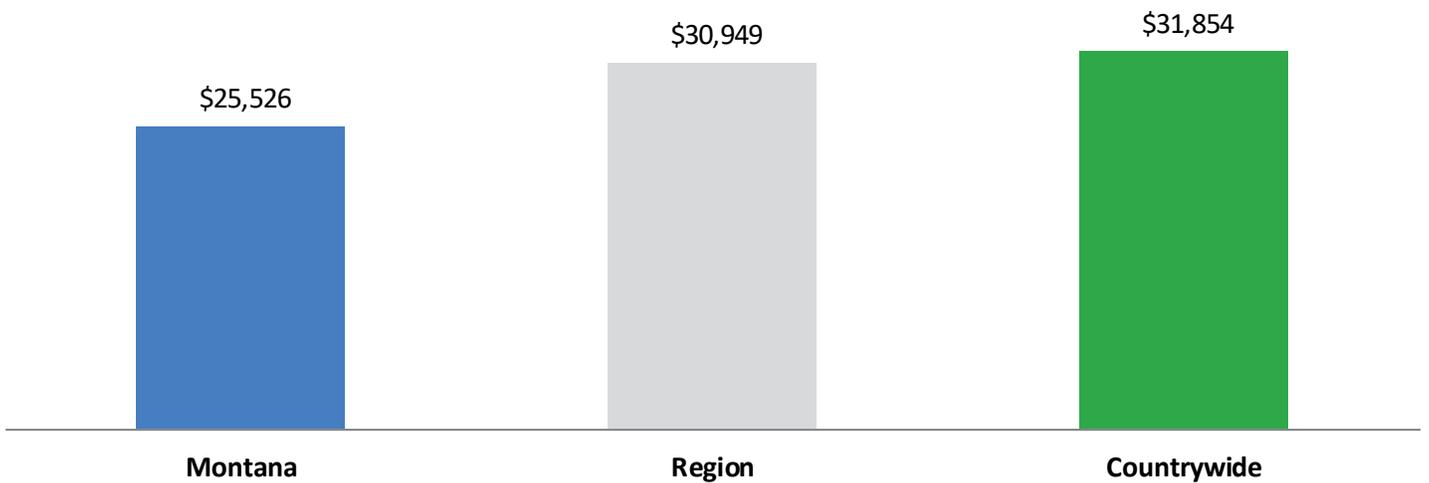
Source: NCCI’s Medical Data Call for Service Year 2018. Region includes AK, AZ, CO, HI, ID, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

The distribution of medical payments for Hospital Inpatient is 13% for Montana, 12% for the region, and 13% for CW. One comparative measure of inpatient service costs is the average payment per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting, for a specific diagnosis. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

Chart 24 displays the average amount paid per stay for hospital inpatient services, while Chart 25 displays the average amount paid per day for hospital inpatient services for Montana, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

**Chart 24**

**Average Inpatient Amount Paid per Stay for Hospital Inpatient Services**



**Chart 25**

**Average Inpatient Amount Paid per Day for Hospital Inpatient Services**

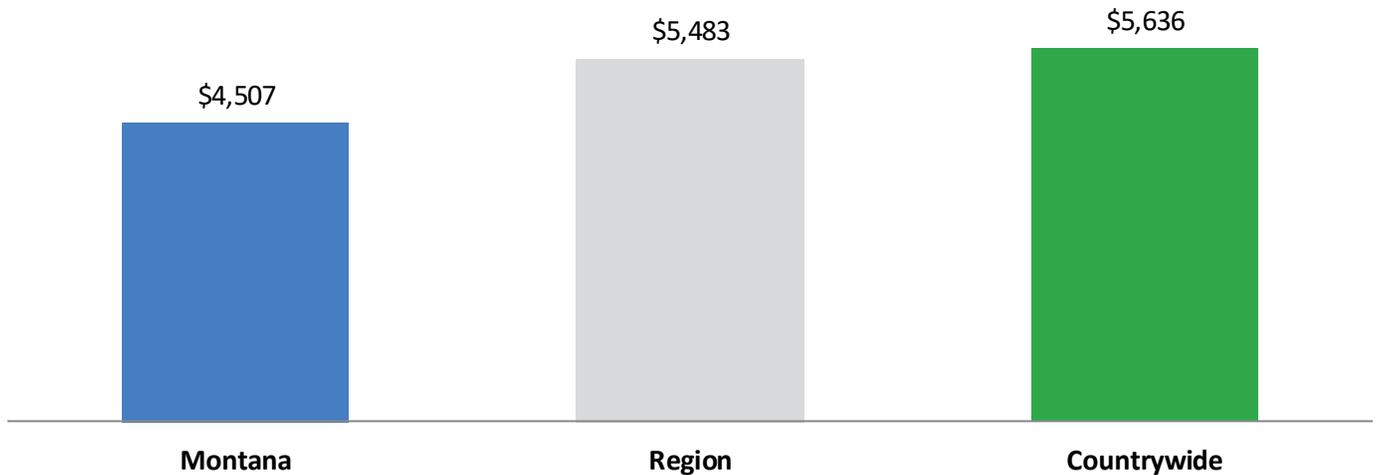




Chart 26 displays the average number of hospital inpatient stays per 1,000 active claims in 2018 for Montana, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 27 displays the average and median length of stay for hospital inpatient services for Montana, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 26

Average Number of Inpatient Stays per 1,000 Active Claims

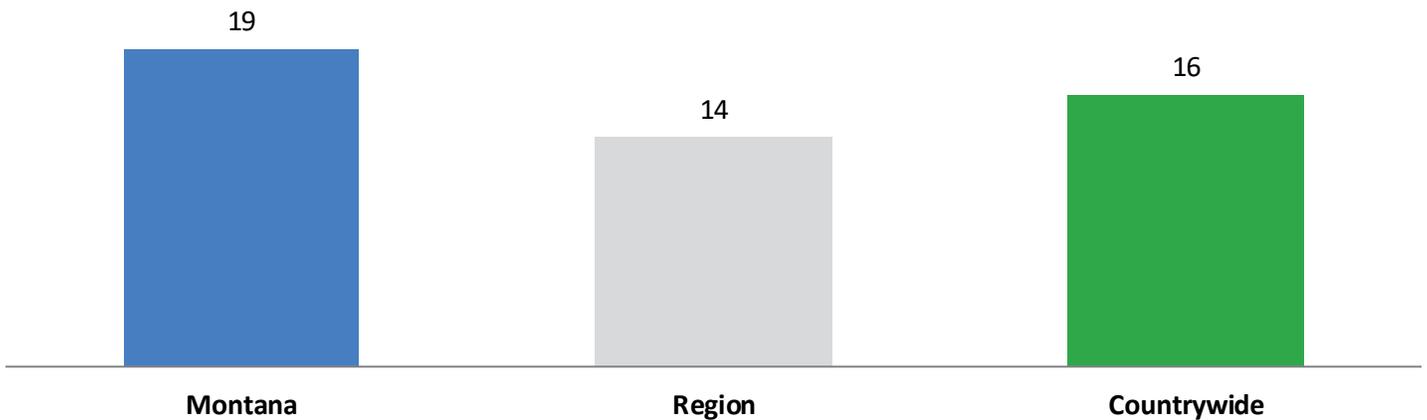


Chart 27

Length of Stay for Hospital Inpatient Services (in Days)

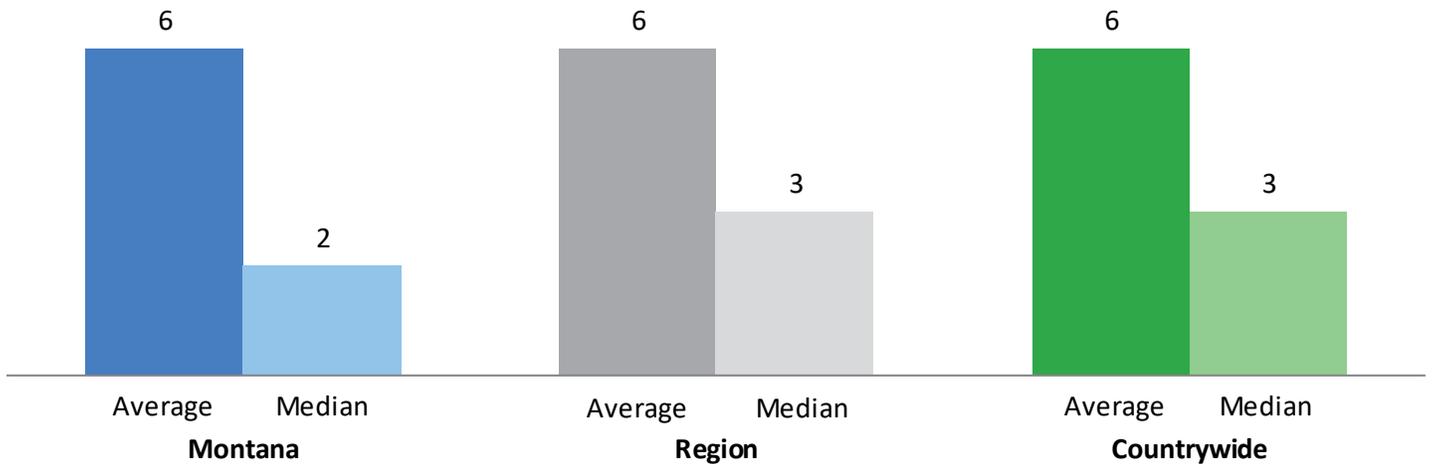
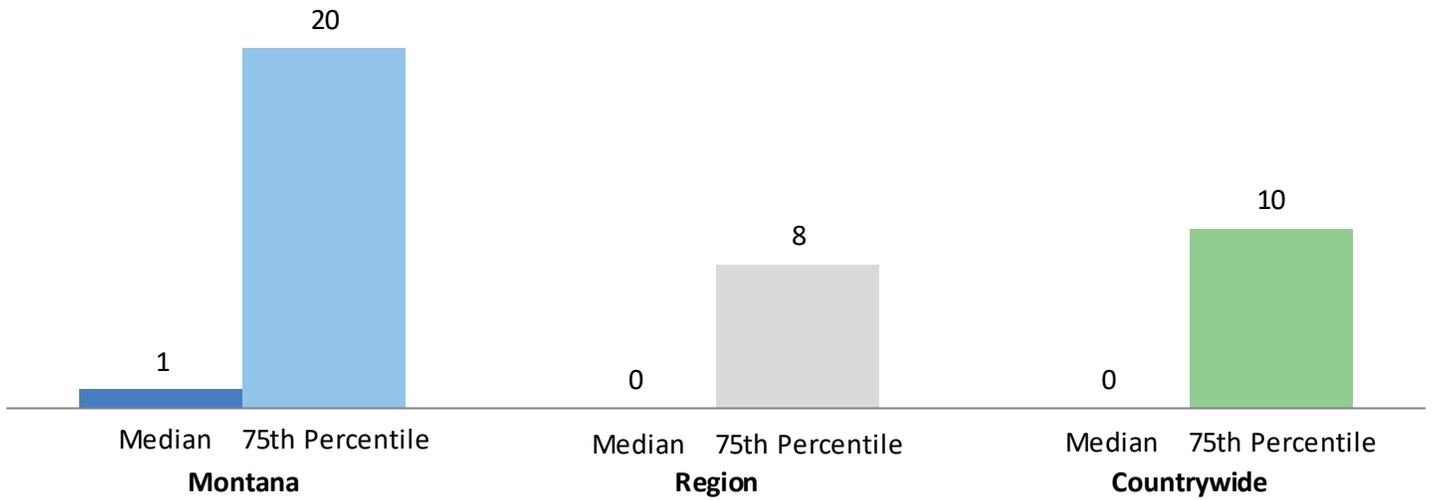


Chart 28 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for Montana, the region, and countrywide.

**Chart 28**

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



Source: NCCI's Medical Data Call for Accident Year 2017 and Service Years 2017 and 2018.

Charts 29 and 30 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient services, showing the most prevalent types of hospital inpatient stays. Diagnosis group is identified for each visit based on ICD-10 (International Classification of Diseases) code. The diagnosis groups and DRG codes are ranked based on total payments in Montana. A brief description of each DRG code is displayed in the table below chart 30.

**Chart 29**

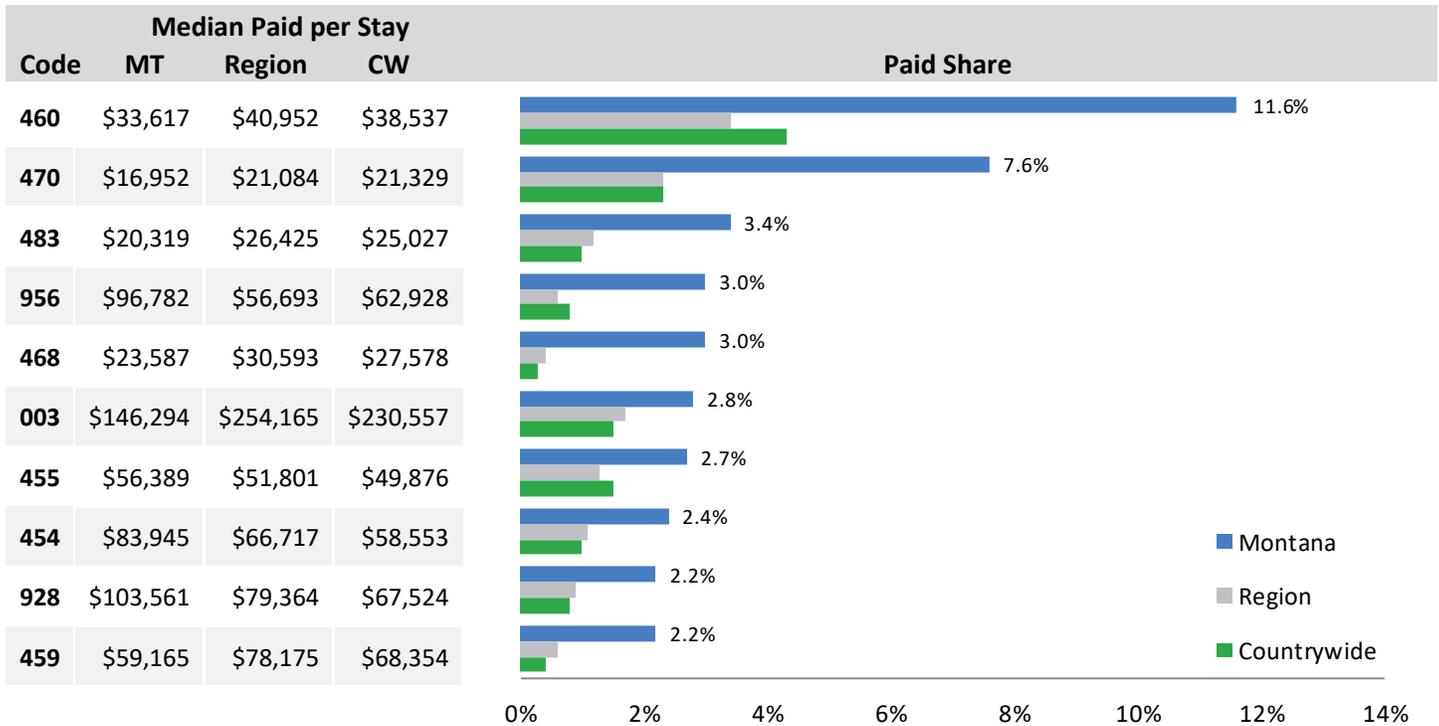
**Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services**

Diagnosis Group	Paid Share	Median Amount Paid per Stay		
		Montana	Region	Countrywide
Lumbar spine degeneration	11.3%	\$33,493	\$34,890	\$32,178
Intracranial injury	6.1%	\$27,568	\$24,047	\$22,176
Knee degenerative/overuse injuries	5.7%	\$16,952	\$20,325	\$18,679
Complication from surgical device	5.7%	\$22,666	\$24,659	\$21,173
Lumbosacral intervertebral disc disorders	4.2%	\$32,717	\$24,932	\$26,965
Hip/pelvis fracture/major trauma	3.8%	\$14,545	\$21,282	\$19,779
Fracture of rib(s), sternum and thoracic spine	3.1%	\$12,752	\$17,531	\$16,916
Other and unspecified osteoarthritis	2.8%	\$20,319	\$24,445	\$20,243
Fracture of lower leg, including ankle	2.7%	\$15,602	\$20,342	\$19,973
Other sepsis	2.4%	\$15,263	\$17,355	\$16,860

Source: NCCI's Medical Data Call for Service Years 2017 and 2018.

### Chart 30

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



Code	Description
460	Spinal fusion, except cervical, without major complications or comorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
483	Major joint/limb reattachment procedure of upper extremities
956	Limb reattachment, hip, and femur procedures for multiple significant trauma
468	Revision of hip or knee replacement without complications or comorbidities/major complications or comorbidities
003	Extracorporeal membrane oxygenation (ECMO) or tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth, and neck with major operating room
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
928	Full thickness burn with skin graft or inhalation injury with complications or comorbidities/major complications or comorbidities
459	Spinal fusion, except cervical, with major complications or comorbidities

Source: NCCI's Medical Data Call for Service Years 2017 and 2018.



### Hospital Outpatient

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

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

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

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

Hospital outpatient visits can vary in nature. A surgical visit includes at least one surgical service, while a nonsurgical visit does not. A service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it has a global follow up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection. In this section, we provide measures of hospital outpatient payments that account for the type of visit because the level of reimbursement varies considerably by type of visit.

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

**Chart 31**

**Hospital Outpatient Payments as a Percentage of Medicare**

Medical Cost Category	Montana	Region	Countrywide
Hospital Outpatient	161%	202%	244%

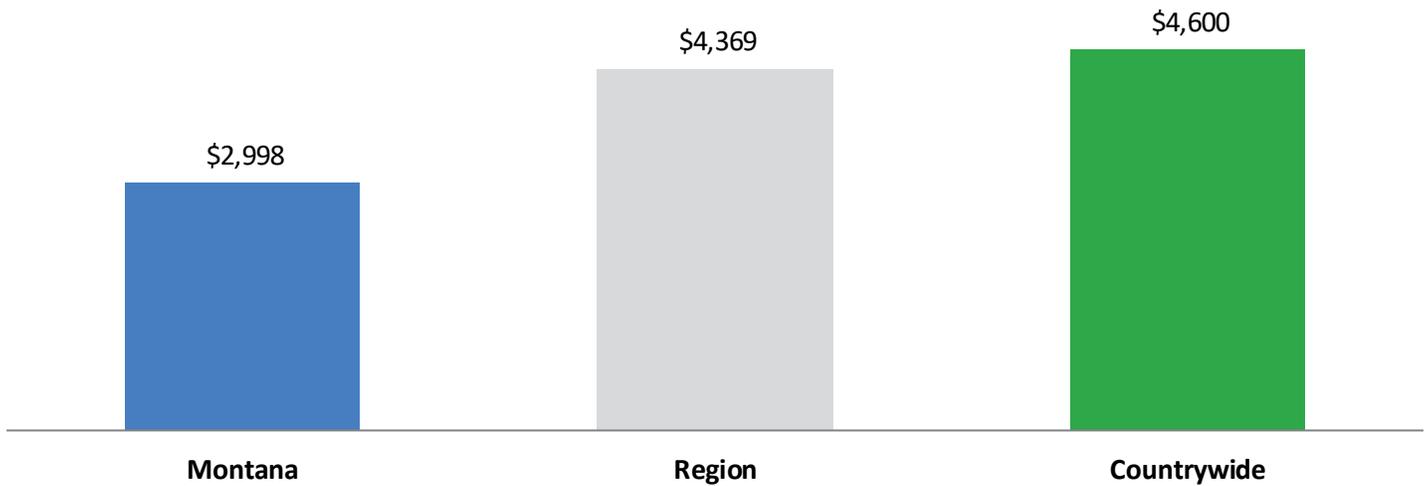
Source: NCCI’s Medical Data Call for Service Year 2018. Region includes AK, AZ, CO, HI, ID, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.



The distribution of medical payments for Hospital Outpatient is 22% for Montana, 18% for the region, and 20% for countrywide. Surgical services represent 44% of hospital outpatient payments in Montana. Chart 32 displays the average amount paid per visit for hospital outpatient surgical services, while Chart 33 displays the average number of visits per year per 1,000 active claims for hospital outpatient surgical services for Montana, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

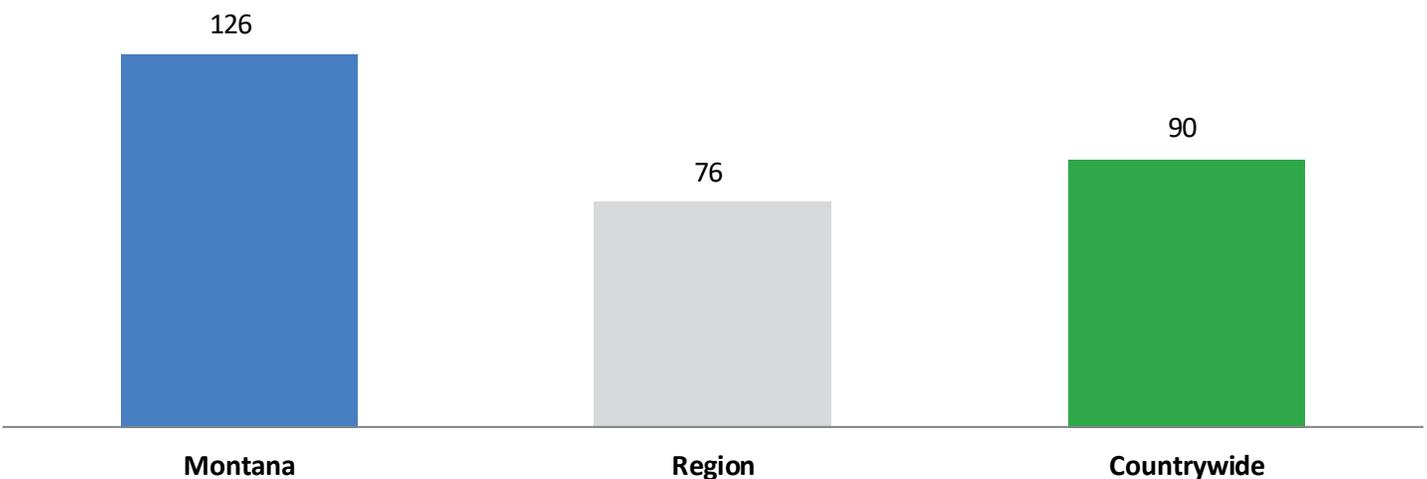
### Chart 32

#### Average Amount Paid per Surgical Visit for Hospital Outpatient Services



### Chart 33

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

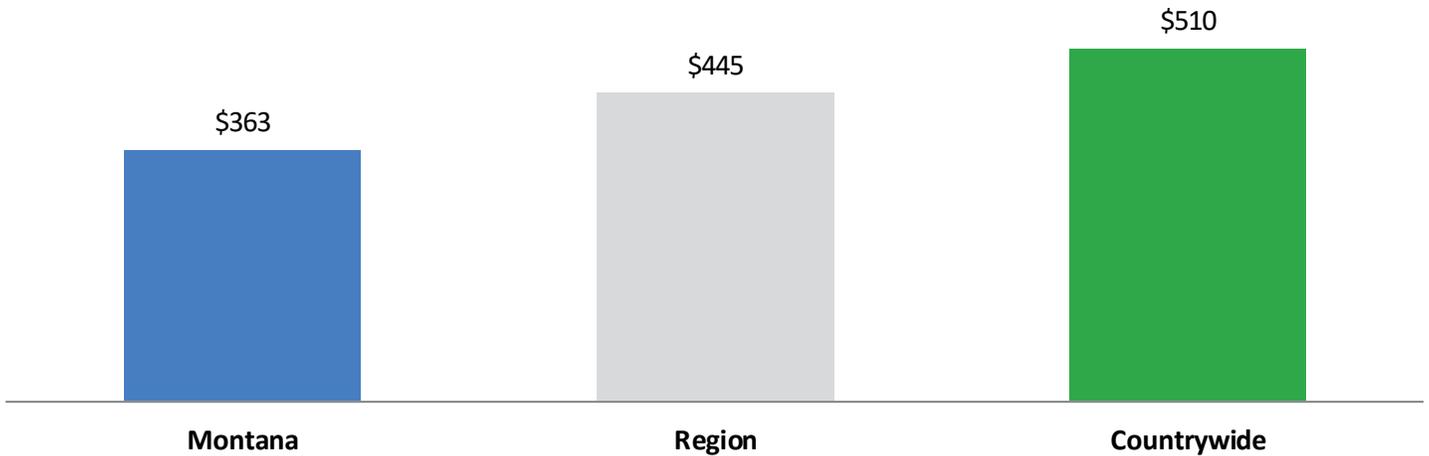




Nonsurgical services (such as physical therapy) represent 56% of hospital outpatient payments in Montana. Chart 34 displays the average amount paid per visit for hospital outpatient nonsurgical services, while Chart 35 displays the average number of visits per year per 1,000 active claims for hospital outpatient nonsurgical services for Montana, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

**Chart 34**

**Average Amount Paid per Nonsurgical Visit for Hospital Outpatient Services**



**Chart 35**

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

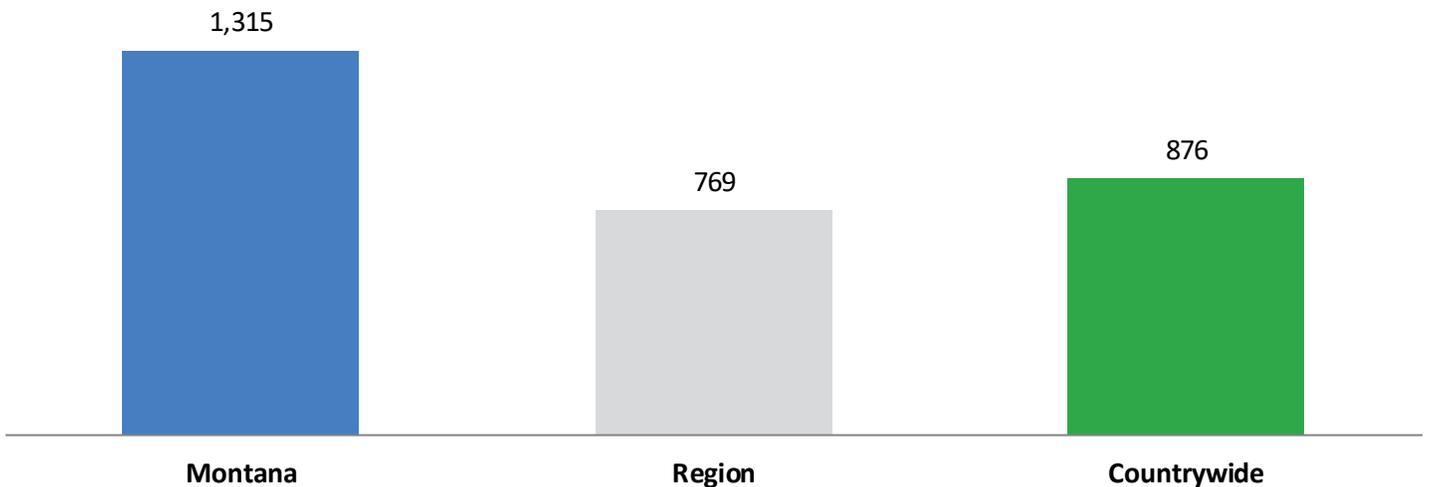




Chart 36 shows the median and 75th percentile time until first treatment for major surgery outpatient visits. Chart 37 shows the median and 75th percentile time until first treatment for all other outpatient visits, other than emergency room visits, for Montana, the region, and countrywide.

Chart 36

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

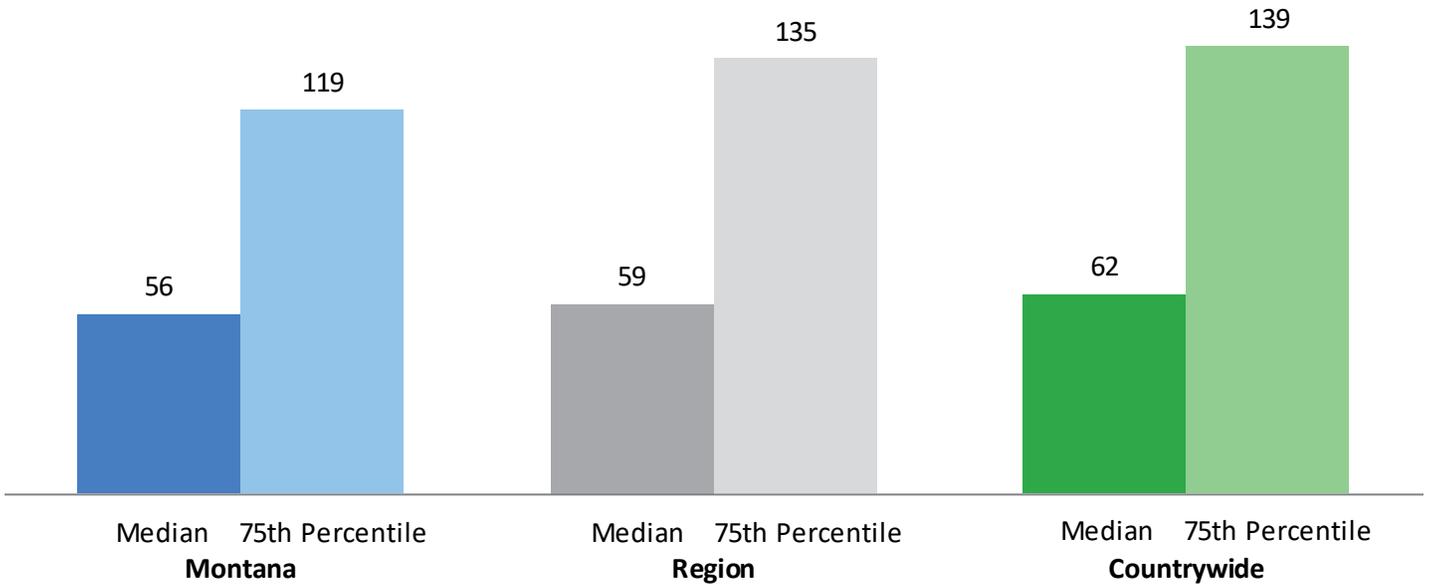
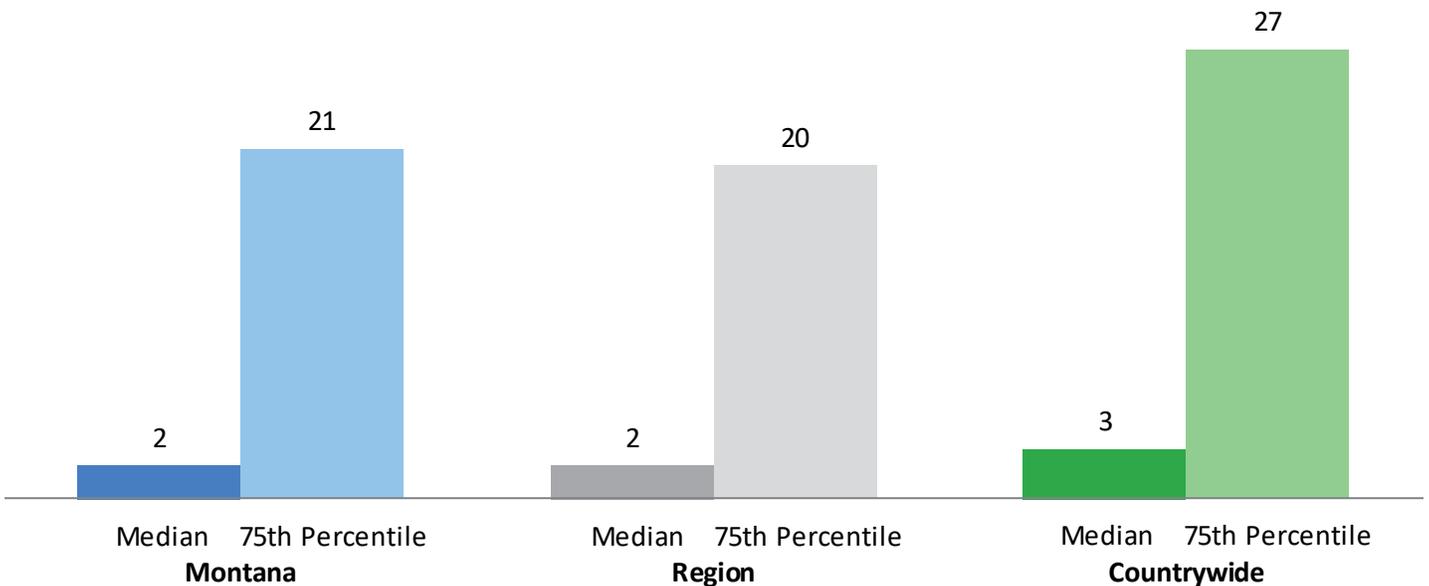


Chart 37

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



Source: NCCI's Medical Data Call for Accident Year 2017 and Service Years 2017 and 2018.



Chart 38 displays the median amount paid per visit for outpatient services in Montana, the region, and countrywide for the top 10 diagnosis groups in Montana. The diagnosis groups are ranked based on total payments in Montana.

Chart 38

Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services

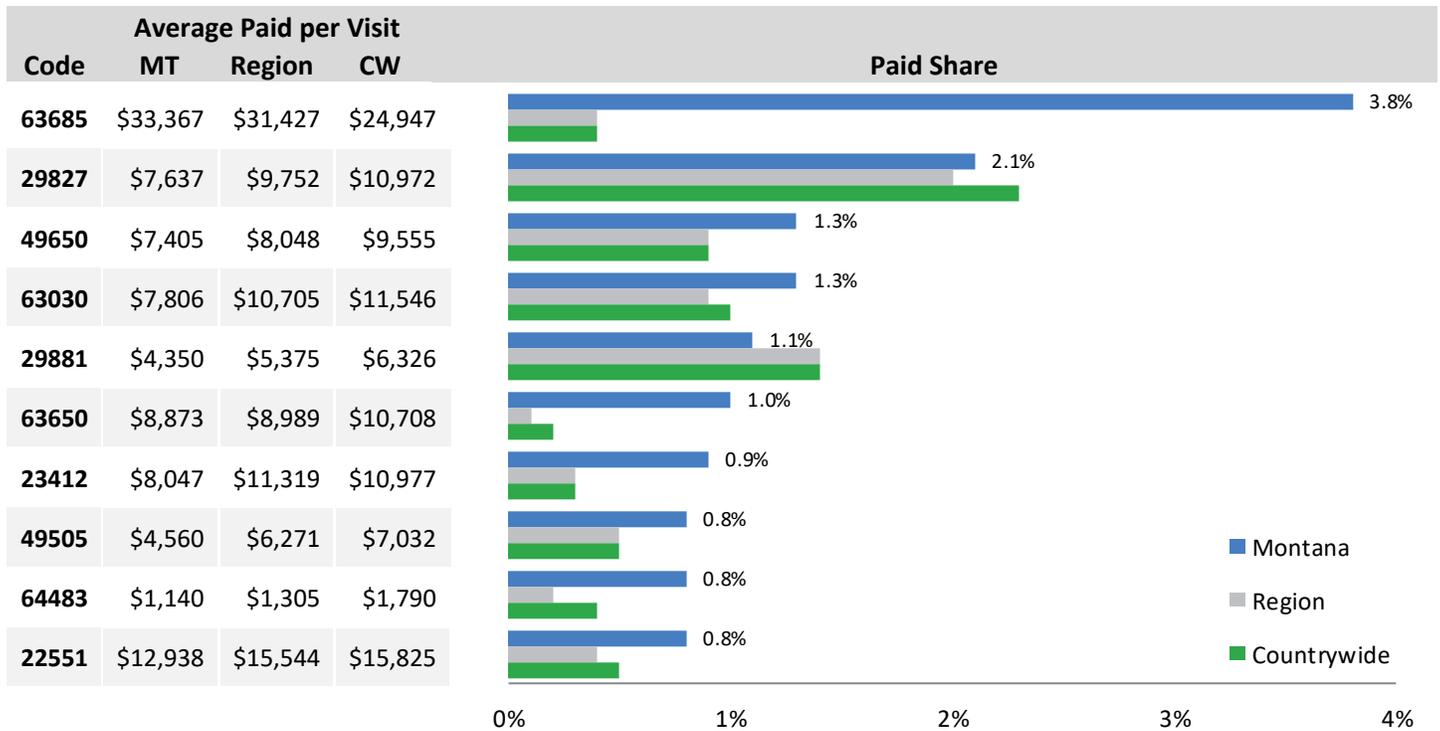
Diagnosis Group	Paid Share	Median Amount Paid Per Visit		
		Montana	Region	Countrywide
Minor shoulder injury	5.6%	\$195	\$161	\$197
Minor hand/wrist injuries	4.9%	\$307	\$287	\$331
Intracranial injury	4.2%	\$225	\$302	\$338
Rotator cuff tear	4.1%	\$187	\$163	\$212
Low back pain	3.7%	\$193	\$175	\$213
Minor knee injury	3.1%	\$225	\$174	\$220
Hand/wrist fracture	2.9%	\$212	\$207	\$283
Lumbosacral intervertebral disc disorders	2.9%	\$343	\$245	\$327
Lumbar radiculopathy/sciatica	2.5%	\$205	\$189	\$254
Lumbar spine degeneration	2.5%	\$343	\$362	\$391



Charts 39 and 40 display the average amount paid per visit for outpatient services in Montana, the region, and countrywide for the top 10 surgery CPT and nonsurgery CPT codes in Montana. In 2018, 97% of Hospital Outpatient costs were reported with a CPT code. The codes are ranked based on total payments in Montana, where the CPT code is the code with the highest total paid on a visit.<sup>7</sup> A brief description of each code is displayed in the table below.

Chart 39

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

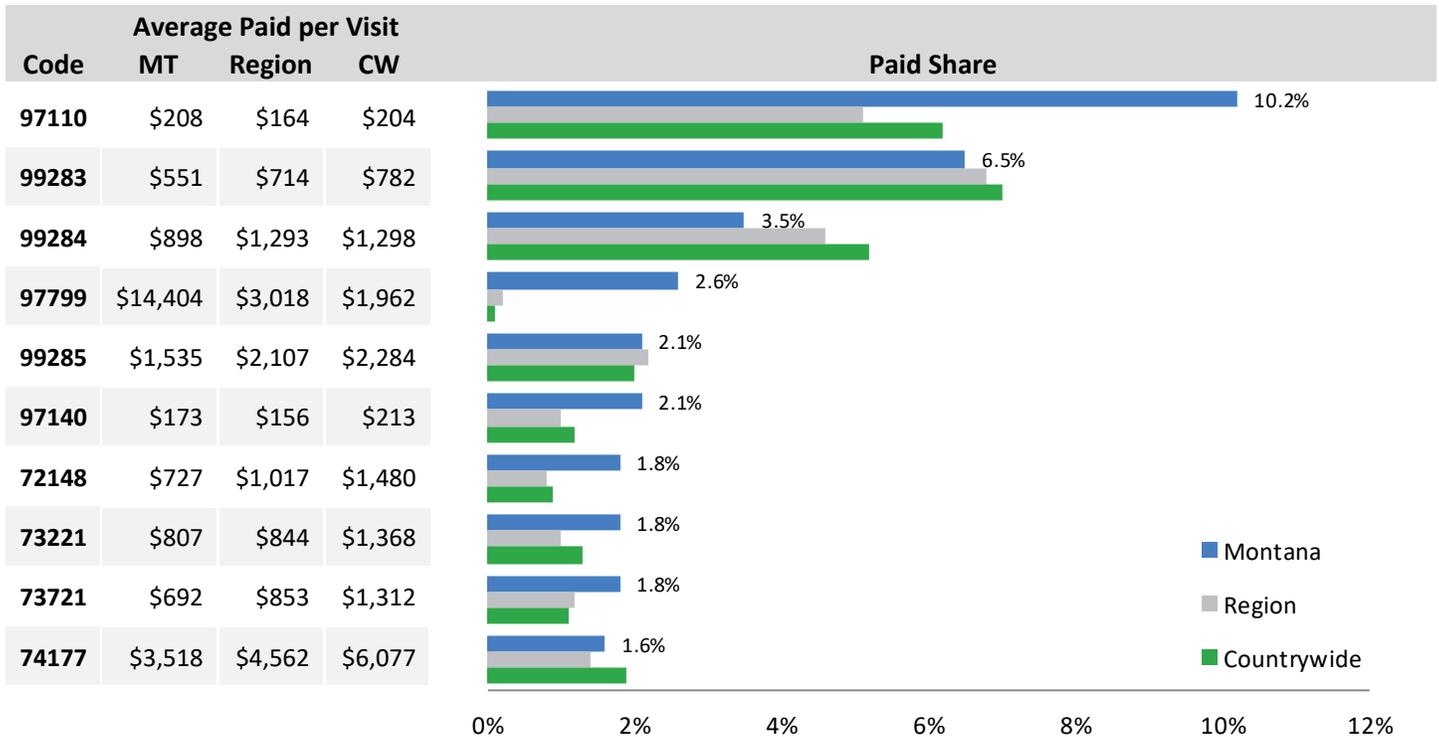


Code	Description
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
49650	Laparoscopy, surgical; repair initial inguinal hernia
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy, foraminotomy, and/or excision of herniated intervertebral disc; 1 interspace lumbar
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
63650	Percutaneous implantation of neurostimulator electrode array, epidural
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
49505	Repair initial inguinal hernia, age 5 years or older; reducible
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy, and decompression of spinal cord and/or nerve roots; cervical below C2

<sup>7</sup> Any hospital outpatient service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claimant may have more than one visit.

Chart 40

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



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
97799	Unlisted physical medicine/rehabilitation service or procedure
99285	Emergency department visit. Usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
74177	Computed tomography (CT), abdomen and pelvis; with contrast material

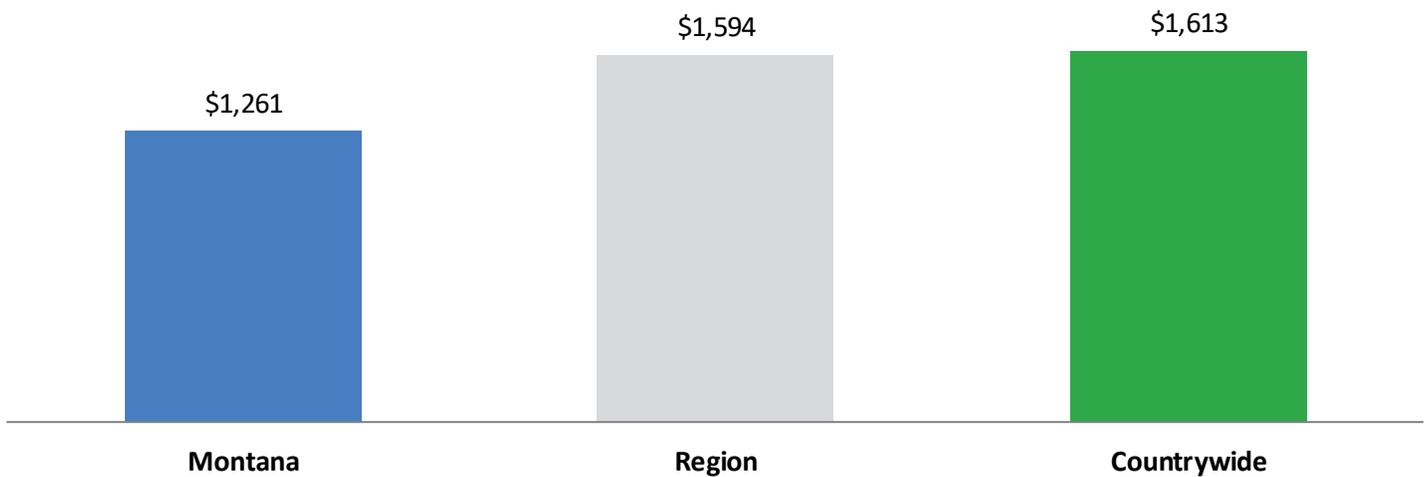


In Montana, 12% of the payments associated with facilities (ASC, hospital outpatient, and hospital inpatient) are for emergency room payments, compared to 18% countrywide.

Chart 41 displays the average amount paid per visit for emergency room services for Montana, the region, and countrywide. The average amount paid includes all payments for an emergency room visit such as payments for facility services, physician services, and drugs. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions. Chart 42 displays the number of visits per year per 1,000 active claims for emergency room services for Montana, as well as for the region and countrywide.

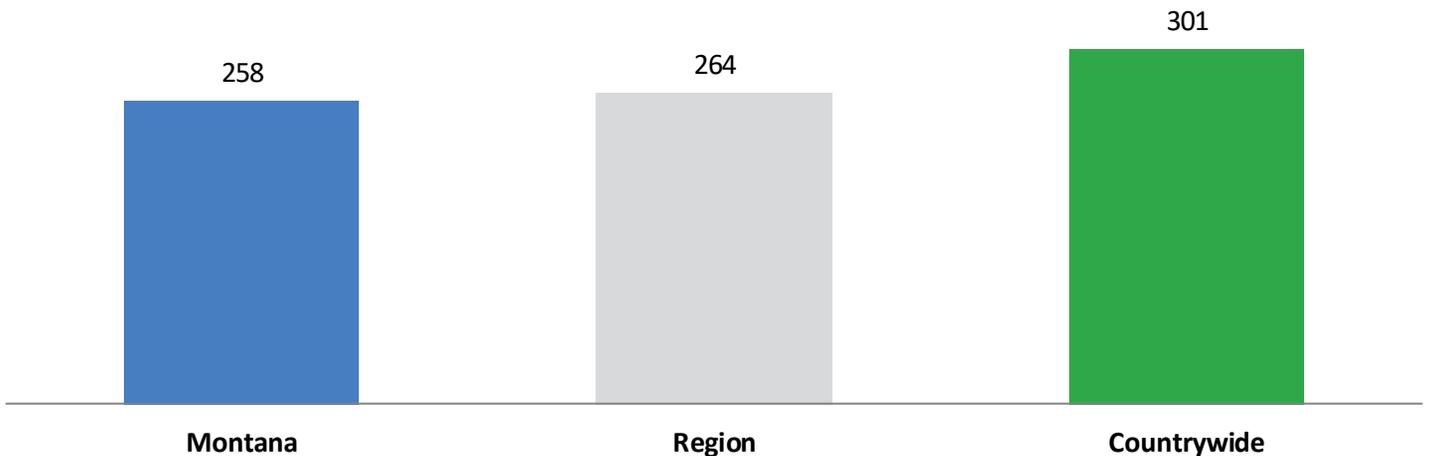
**Chart 41**

**Average Amount Paid per Emergency Room Visit**



**Chart 42**

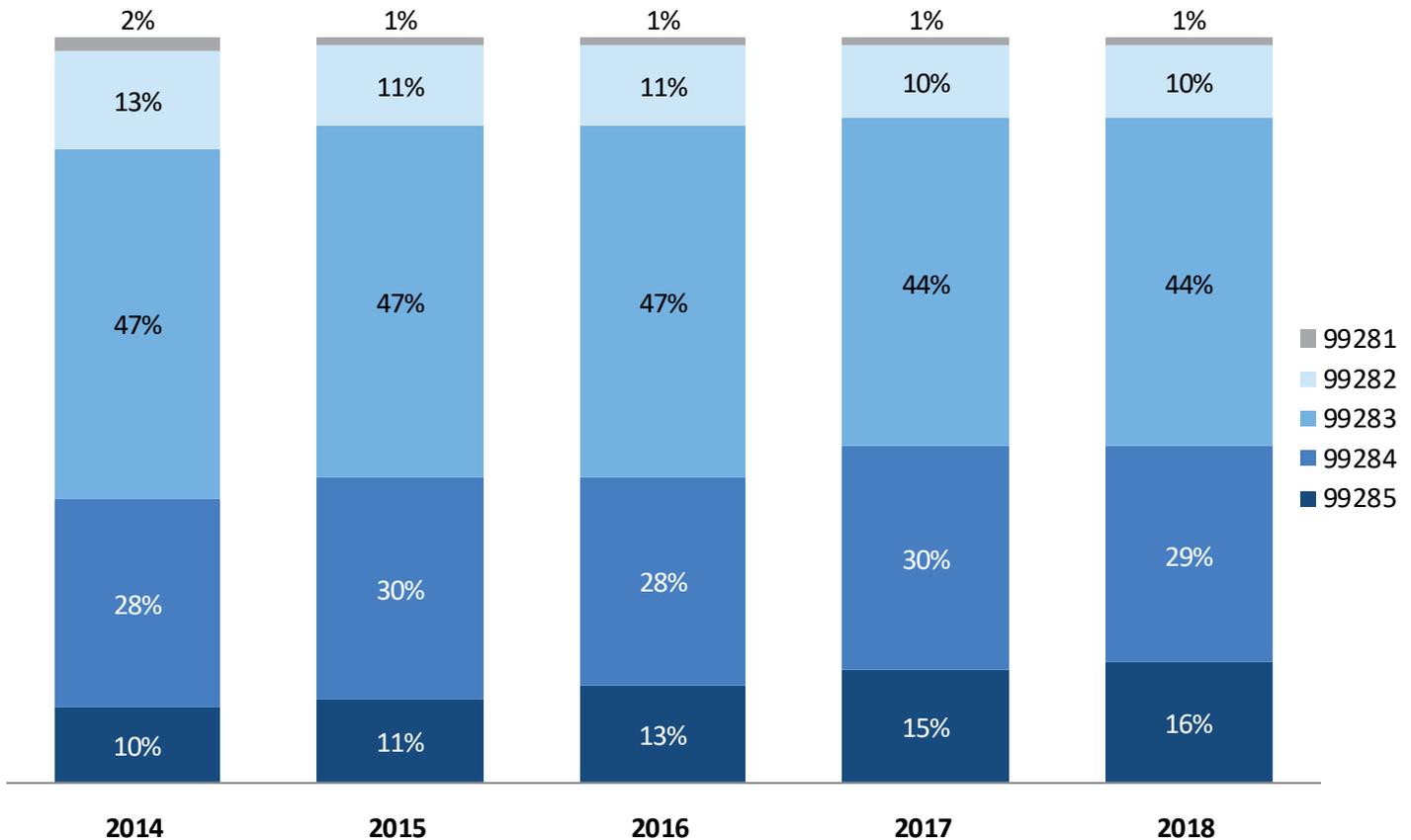
**Average Number of Emergency Room Visits per 1,000 Active Claims**



For emergency room visits, there are five levels of severity, ranging from limited or minor problems reported with Procedure Code 99281 to life-threatening situations reported with Procedure Code 99285. Chart 43 shows a five-year snapshot of experience for each procedure type and the average payment per transaction.

**Chart 43**

**Emergency Room Payments by Procedure Code**



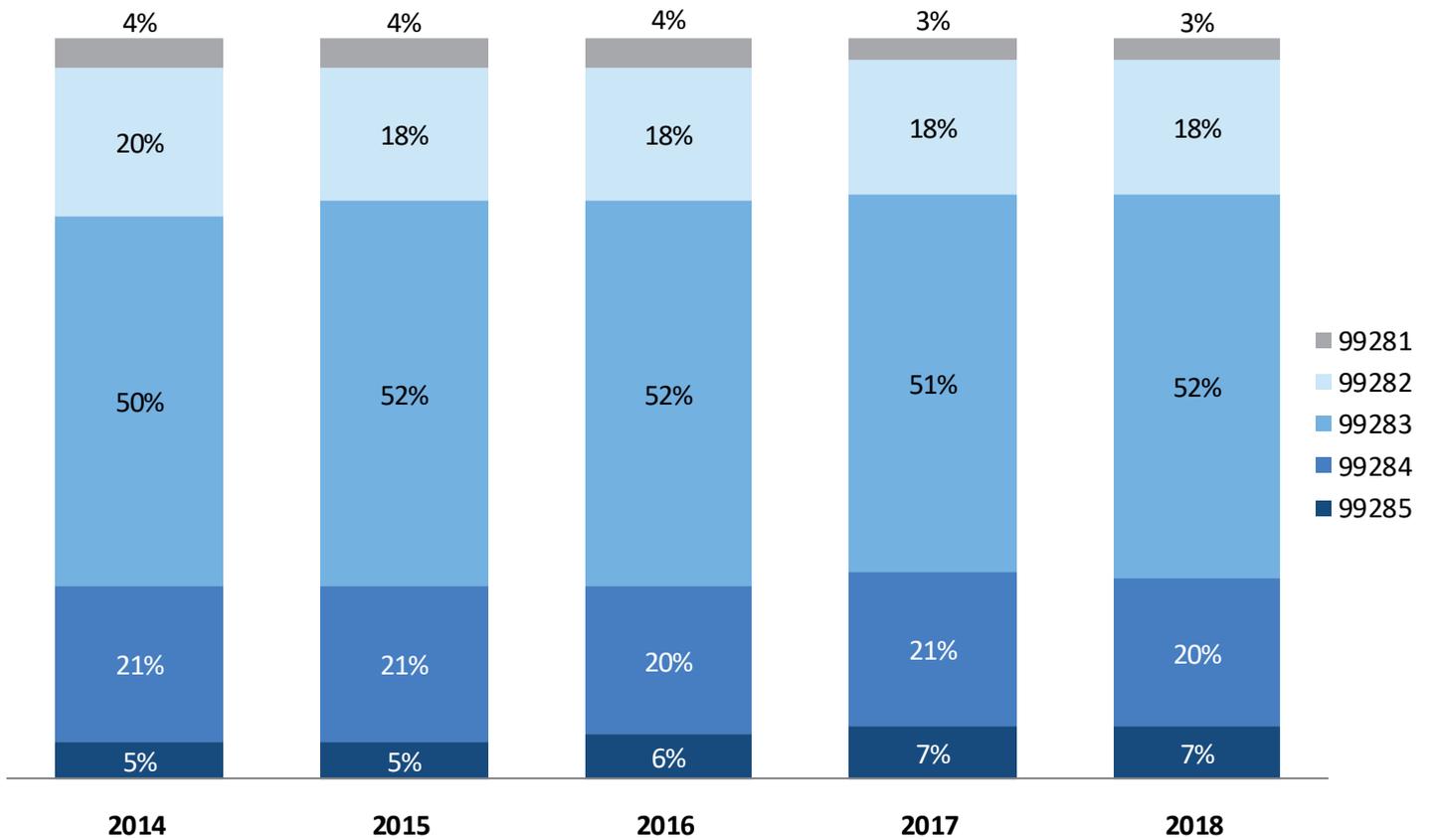
Source: NCCI's Medical Data Call, Service Years 2014 to 2018.

Code	Severity	Average PPT				
		2014	2015	2016	2017	2018
99281	Minor	\$74	\$79	\$84	\$92	\$88
99282	Low to moderate	\$134	\$142	\$148	\$150	\$150
99283	Moderate	\$191	\$205	\$216	\$223	\$235
99284	High	\$275	\$336	\$357	\$362	\$387
99285	High and immediately life-threatening	\$426	\$524	\$574	\$575	\$615

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

**Chart 44**

**Emergency Room Transactions by Procedure Code**



Source: NCCI's Medical Data Call, Service Years 2014 to 2018.

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



### Ambulatory Surgical Centers

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

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

**Chart 45**

#### ASC Payments as a Percentage of Medicare

Medical Cost Category	Montana	Region	Countrywide
Ambulatory Surgical Center	207%	227%	279%

Source: NCCI's Medical Data Call for Service Year 2018. Region includes AK, AZ, CO, HI, ID, NM, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.



Chart 46 displays the average amount paid per visit for ASC services for Montana, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions. Chart 47 displays the number of ASC visits per year per 1,000 active claims for Montana, the region, and countrywide.

Chart 46

Average Amount Paid per Visit for ASC Services

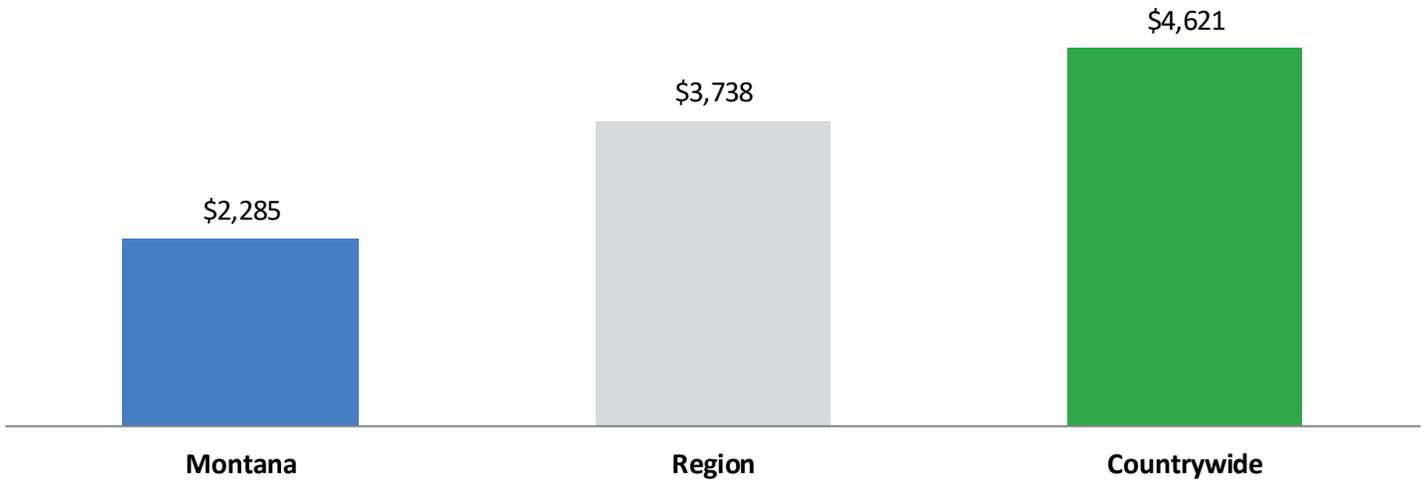


Chart 47

Average Number of ASC Visits per 1,000 Active Claims

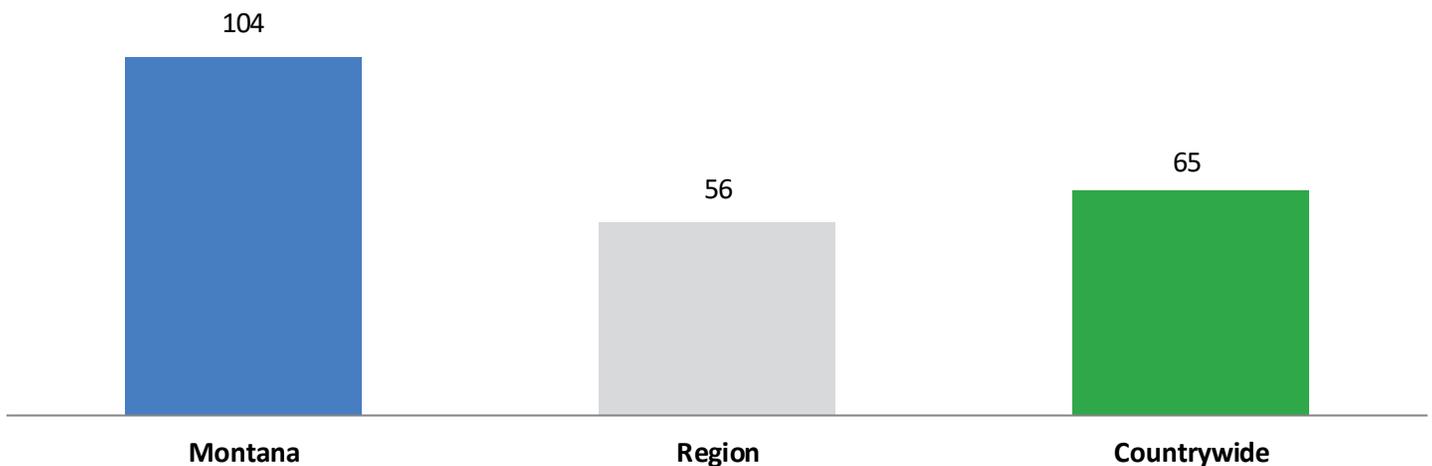
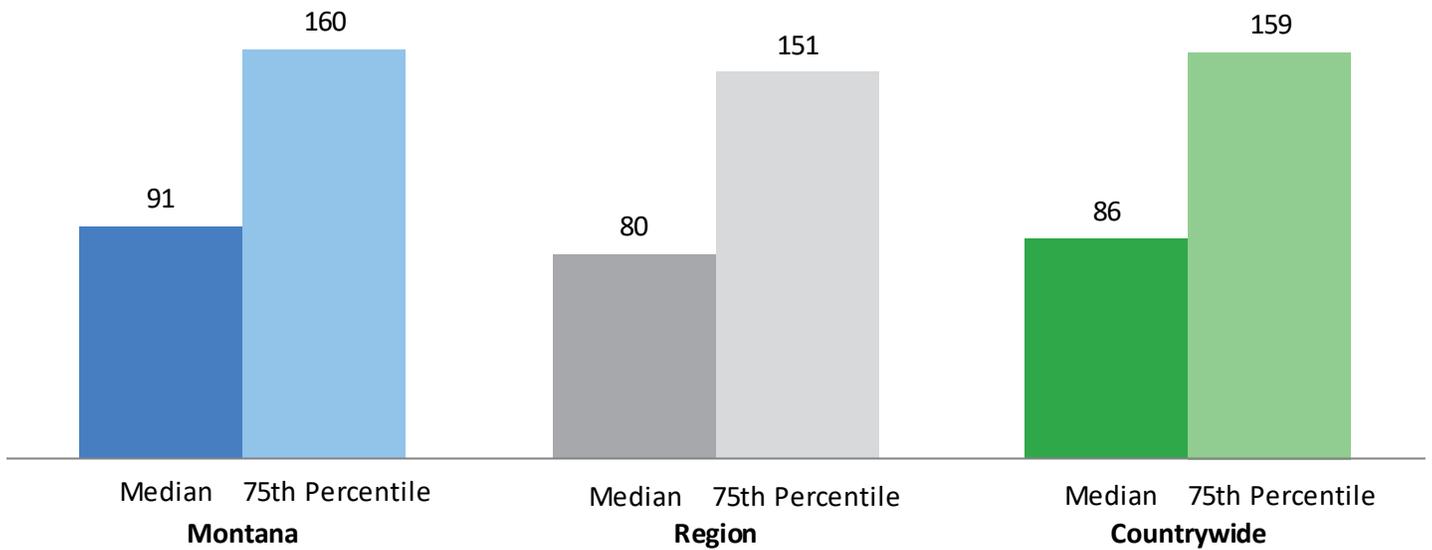


Chart 48 shows the median and 75th percentile time until first treatment for ASC visits for Montana, the region, and countrywide.

**Chart 48****Time Until First Treatment for ASC Visits (in Days)**

Source: NCCI's Medical Data Call for Accident Year 2017 and Service Years 2017 and 2018.



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

**Chart 49**

**Top 10 Diagnosis Groups by Amount Paid for ASC Services**

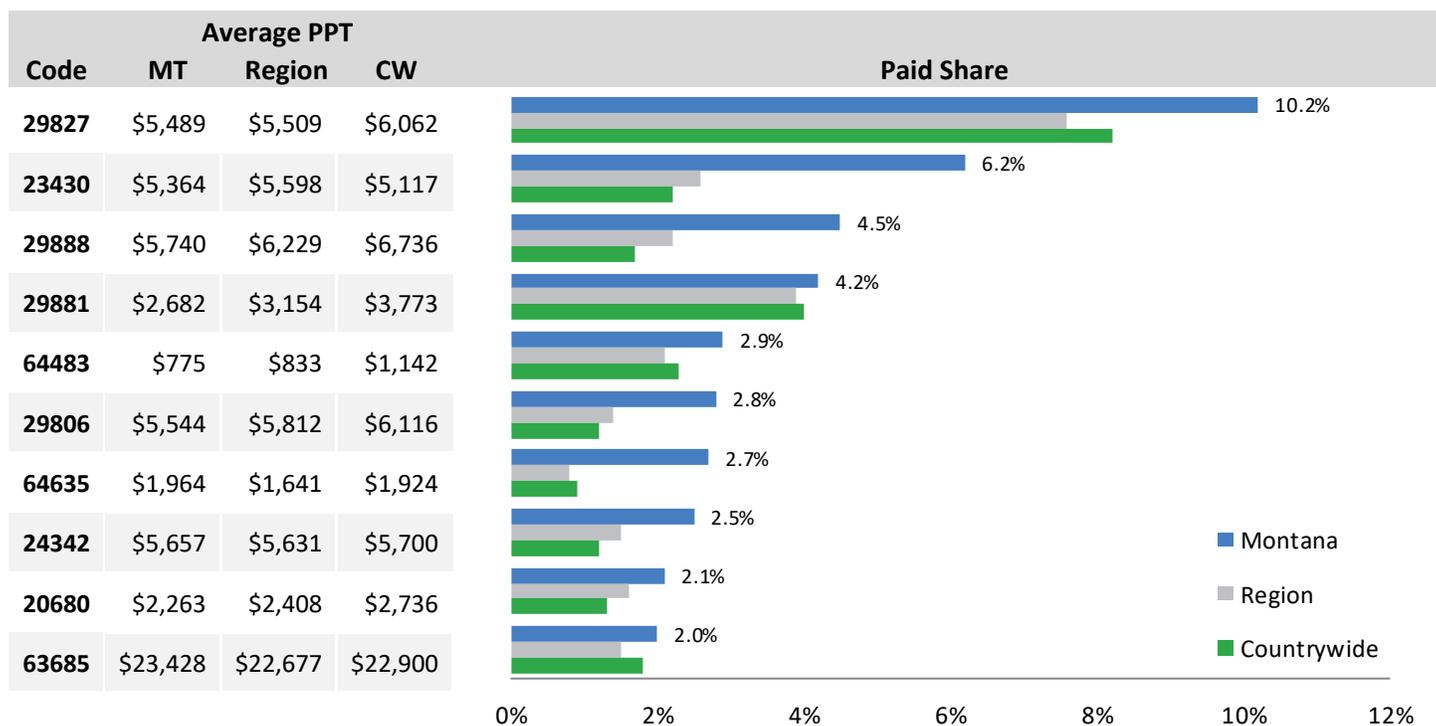
Diagnosis Group	Paid Share	Median Amount Paid per Visit		
		Montana	Region	Countrywide
Rotator cuff tear	12.2%	\$5,987	\$7,172	\$9,375
Minor shoulder injury	5.9%	\$5,940	\$3,409	\$4,336
Lumbar spine degeneration	5.3%	\$1,099	\$1,320	\$1,732
Knee internal derangement - meniscus injury	5.1%	\$2,796	\$3,354	\$3,938
Hand/wrist fracture	3.9%	\$2,927	\$3,693	\$4,698
Lumbosacral intervertebral disc disorders	3.7%	\$582	\$1,149	\$1,320
Knee internal derangement - cruciate ligament tear	3.6%	\$5,987	\$7,190	\$8,763
Other and unspecified osteoarthritis	3.3%	\$5,987	\$6,915	\$8,557
Other specific joint derangements	3.1%	\$5,987	\$4,250	\$5,885
Lumbar radiculopathy/sciatica	3.0%	\$733	\$880	\$1,247

Typically, only surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes. The predominant revenue code reported for ASC services is code 0490—Ambulatory Surgical Care. In Montana, code 0490 represents 100% of ASC payments reported by revenue codes.

Chart 50 displays the top 10 surgery CPT codes for ASC services. The procedure codes are ranked based on total payments in Montana. A brief description of each procedure code is displayed in the table below.

**Chart 50**

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



Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23430	Tenodesis of long tendon of biceps
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving), including debridement/shaving of articular cartilage
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling



## Prescription Drugs

The distribution of medical payments for drugs is 12% for Montana, 8% for the region, and 9% for countrywide. Drugs are uniquely identified by a national drug code (NDC). Charts 51 through 55 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

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

In Montana, the share of claims observed in Service Year 2018 with at least one controlled substance was 16%. This compares to the region and countrywide shares of 12% and 12% , respectively. In 2018, Montana spent \$2.1M on Schedule II and Schedule III drugs for workers compensation claims.

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

**Chart 51**

**Distribution of Prescription Drug Payments by CSA Schedule**

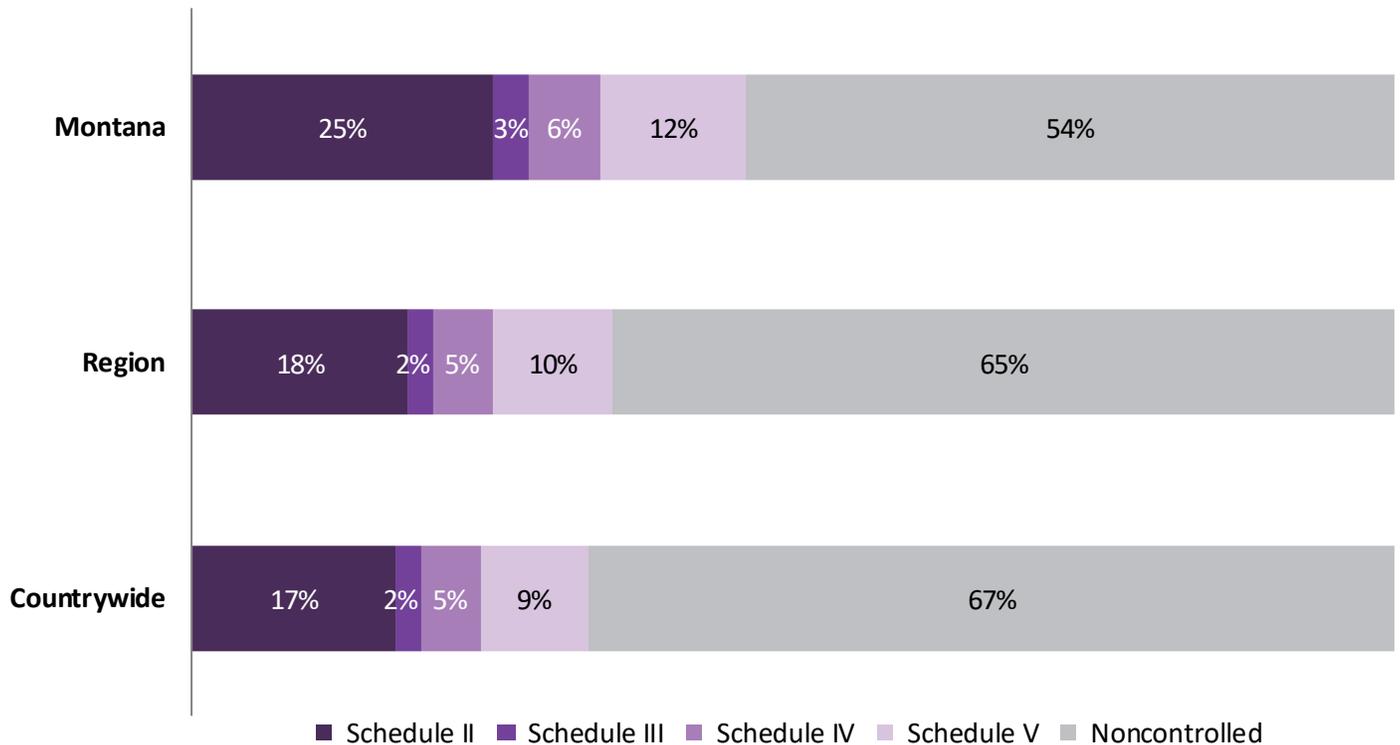


Chart 52 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in Montana. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also provided. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the average price per unit (PPU). (See Glossary for the definition of *unit*.)

**Chart 52**

**Top 10 Workers Compensation Drugs by Amount Paid**

Drug Name	Average PPU			Montana Paid Share
	MT	Region	CW	
Lyrica®	\$7.69	\$7.86	\$7.92	11.8%
Oxycontin®	\$9.12	\$9.02	\$9.27	10.4%
Duloxetine HCl	\$4.43	\$4.79	\$4.94	4.8%
Gabapentin	\$0.75	\$1.02	\$1.06	4.2%
Celecoxib	\$3.14	\$4.75	\$5.00	2.7%
Oxycodone HCl	\$0.76	\$0.97	\$1.10	2.4%
Hydrocodone Bitartrate-Acetaminophen	\$0.42	\$0.56	\$0.57	2.1%
Morphine Sulfate	\$1.35	\$1.53	\$1.64	2.0%
Oxycodone HCl-Acetaminophen	\$1.05	\$1.64	\$1.69	1.5%
Meloxicam	\$1.38	\$3.00	\$3.17	1.2%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Lyrica®	B	N/A	Miscellaneous Central Nervous System Agents	V	1
Oxycontin®	B	N/A	Analgesics/Antipyretics	II	2
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	8
Gabapentin	G	Neurontin®	Anticonvulsants	None	3
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	9
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	13
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	12
Morphine Sulfate	G	Duramorph®	Analgesics/Antipyretics	II	29
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	7
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	5

Chart 53 displays the top 10 drugs used in workers compensation treatment, according to the number of prescriptions in Montana. This chart reveals the most frequently prescribed drugs and the average PPU.

**Chart 53**
**Top 10 Workers Compensation Drugs by Prescription Counts**

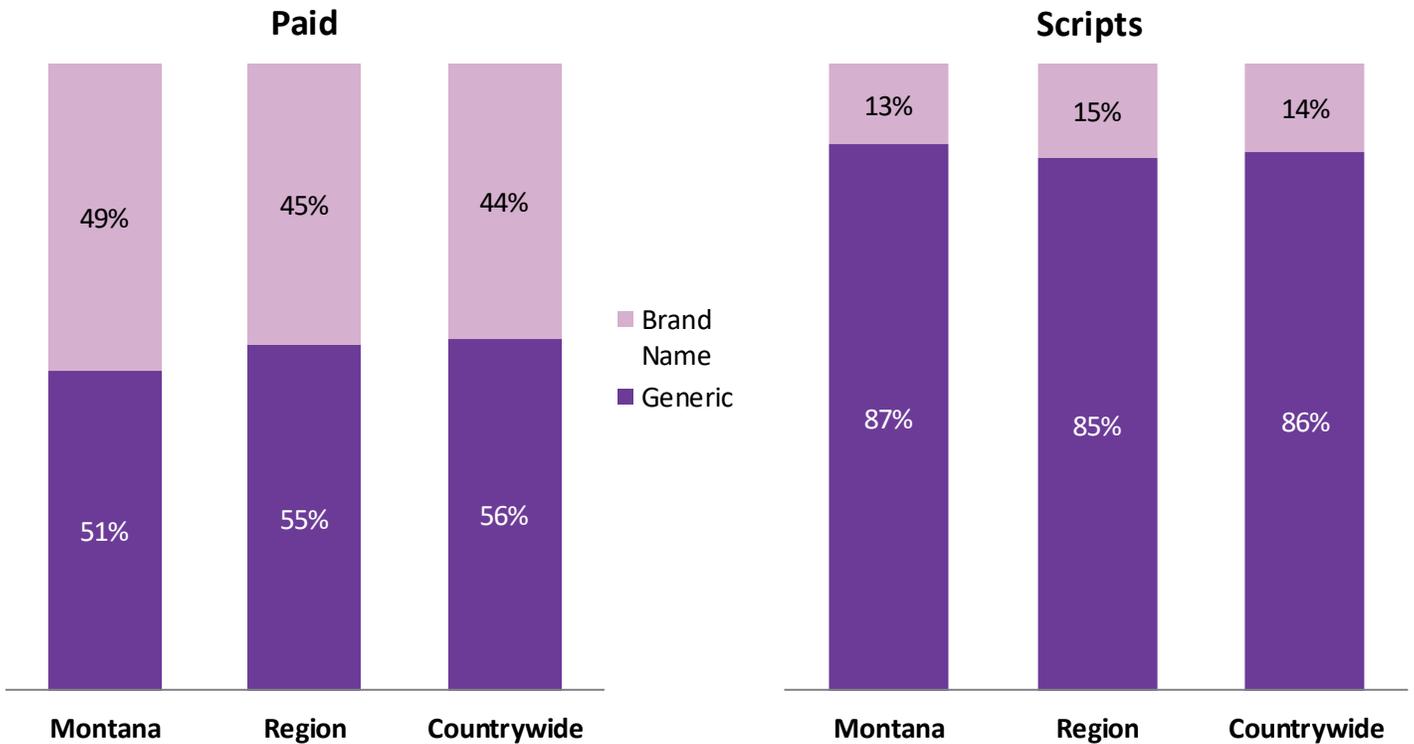
Drug Name	Average PPU			Montana Prescription Share
	MT	Region	CW	
Hydrocodone Bitartrate-Acetaminophen	\$0.42	\$0.56	\$0.57	8.8%
Gabapentin	\$0.75	\$1.02	\$1.06	6.6%
Oxycodone HCl	\$0.76	\$0.97	\$1.10	4.4%
Cyclobenzaprine HCl	\$0.65	\$1.20	\$1.59	4.3%
Tramadol HCl	\$0.50	\$1.00	\$1.12	3.7%
Meloxicam	\$1.38	\$3.00	\$3.17	3.6%
Duloxetine HCl	\$4.43	\$4.79	\$4.94	3.4%
Lyrica®	\$7.69	\$7.86	\$7.92	2.8%
Morphine Sulfate	\$1.35	\$1.53	\$1.64	2.8%
Celecoxib	\$3.14	\$4.75	\$5.00	2.7%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	9
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	4
Meloxicam	G	Mobic®	Analgesics/Antipyretics	None	5
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	13
Lyrica®	B	N/A	Miscellaneous Central Nervous System Agents	V	12
Morphine Sulfate	G	Duramorph®	Analgesics/Antipyretics	II	22
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	14

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

**Chart 54**

**Distribution of Drugs by Brand Name and Generic**

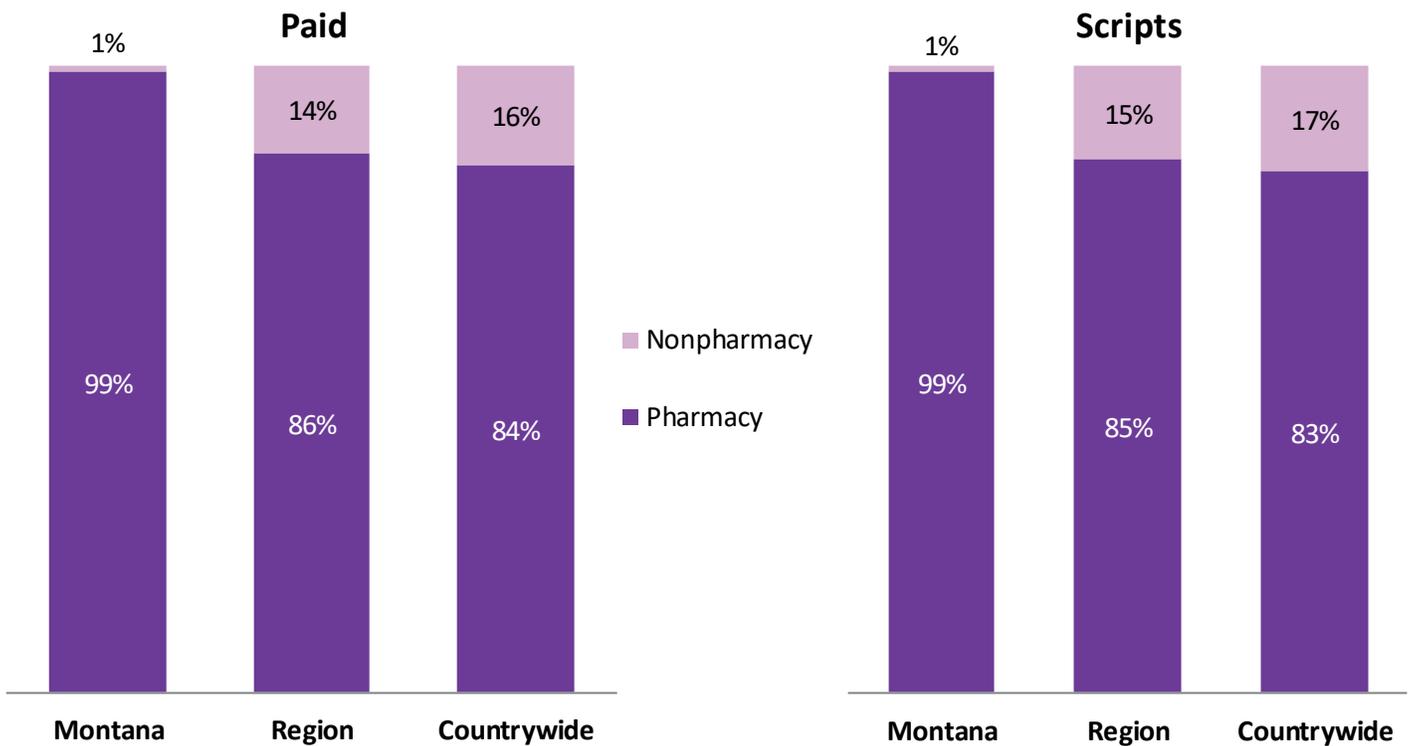


The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states limit or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight into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

Chart 55 shows the distribution of prescription drugs dispensed by pharmacies and nonpharmacies. The share between pharmacy-dispensed and nonpharmacy-dispensed is displayed, based on both prescription counts and payments, for Montana, the region, and countrywide.

**Chart 55**

**Distribution of Drugs by Pharmacy and Nonpharmacy**



### Durable Medical Equipment, Prosthetics, Orthotics and Supplies

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

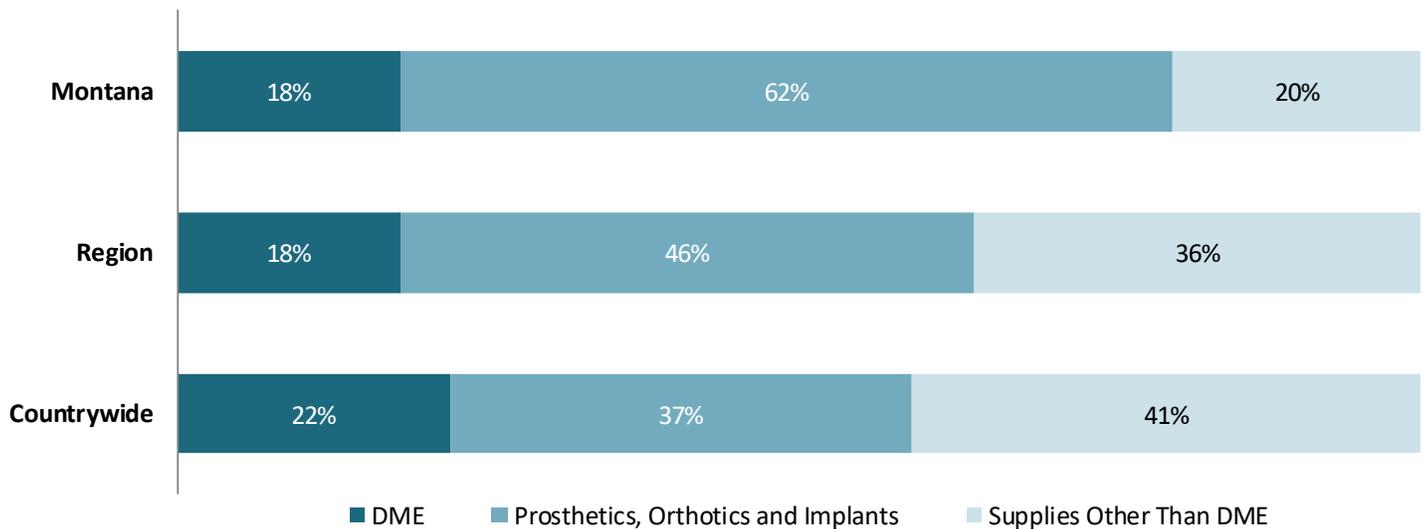
Chart 56 displays the distribution of payments among three separate DMEPOS categories:

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

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

**Chart 56**

**Distribution of Payments by DMEPOS**





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

**Chart 57**

**Top Diagnosis Groups by Amount Paid for Dates of Injury in 2017 for Claims *With* an Implant or Prosthetic**

Diagnosis Group	Paid Share	Average Amount Paid Per Claim		
		Montana	Region	Countrywide
Rotator cuff tear	17.1%	\$20,858	\$31,016	\$35,389
Minor shoulder injury	8.6%	\$20,778	\$23,137	\$27,516
Knee internal derangement - cruciate ligament tear	6.3%	\$23,428	\$29,439	\$33,338
Fracture of lower leg, including ankle	6.2%	\$23,718	\$42,274	\$44,411
Hand/wrist fracture	5.6%	\$15,728	\$23,404	\$25,019
Hip/pelvis fracture/major trauma	3.9%	\$66,747	\$57,044	\$69,013
Inguinal hernia	3.5%	\$10,005	\$11,427	\$12,842
Burn and corrosion of trunk	3.2%	\$333,290	\$20,642	\$129,375
Shoulder impingement syndrome	2.6%	\$24,135	\$27,542	\$34,045
Knee fracture	2.5%	\$42,653	\$51,043	\$53,576

**Chart 58**

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

Diagnosis Group	Average Amount Paid Per Claim		
	Montana	Region	Countrywide
Rotator cuff tear	\$11,740	\$14,181	\$17,290
Minor shoulder injury	\$2,997	\$3,145	\$3,360
Knee internal derangement - cruciate ligament tear	\$10,466	\$19,266	\$20,851
Fracture of lower leg, including ankle	\$8,759	\$11,435	\$12,185
Hand/wrist fracture	\$3,004	\$5,589	\$5,777
Hip/pelvis fracture/major trauma	\$34,962	\$28,257	\$30,478
Inguinal hernia	\$6,800	\$8,605	\$9,823
Burn and corrosion of trunk	\$15,314	\$818	\$4,160
Shoulder impingement syndrome	\$7,758	\$11,427	\$14,330
Knee fracture	\$11,954	\$12,321	\$13,187

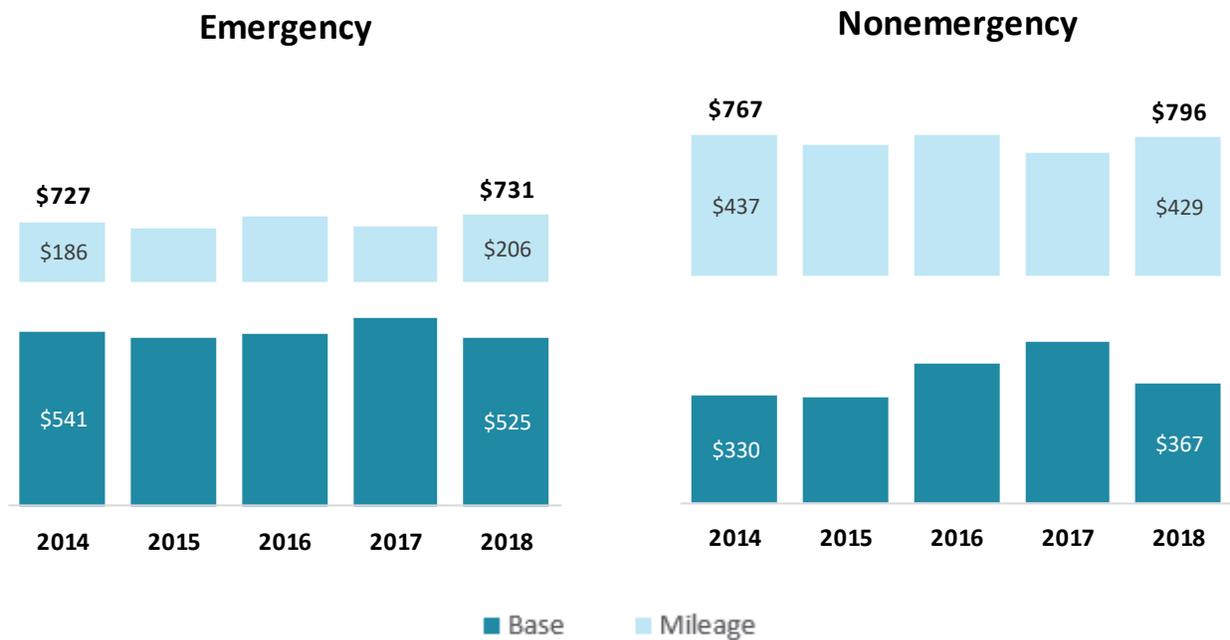
## Transportation

For Service Year 2018, transportation services represent less than 2% of total medical costs countrywide. The share of payments varies across jurisdictions, ranging from less than 1% to over 3% of total medical costs. Ambulance services, both ground and air, are the primary driver of transportation costs.

Ground ambulance can be split into two categories: emergency and nonemergency. In 2018, nearly 88% of ground ambulance episodes<sup>8</sup> were emergencies in Montana. Chart 59 displays the average payment per episode for emergency and nonemergency ground ambulance episodes, and it shows this separately for the base payment and mileage payment in Montana. The base payment reflects the service intensity of the transport and is higher for emergency services. The mileage payment per episode is higher for nonemergency services due to the average number of miles travelled; typically, nonemergency episodes travel farther than emergency and the intensity of the service is greatly reduced.

**Chart 59**

**Average Payment per Episode for Ground Ambulance Services**



<sup>8</sup>An episode refers to a service or set of services provided to a claimant on a specific date.

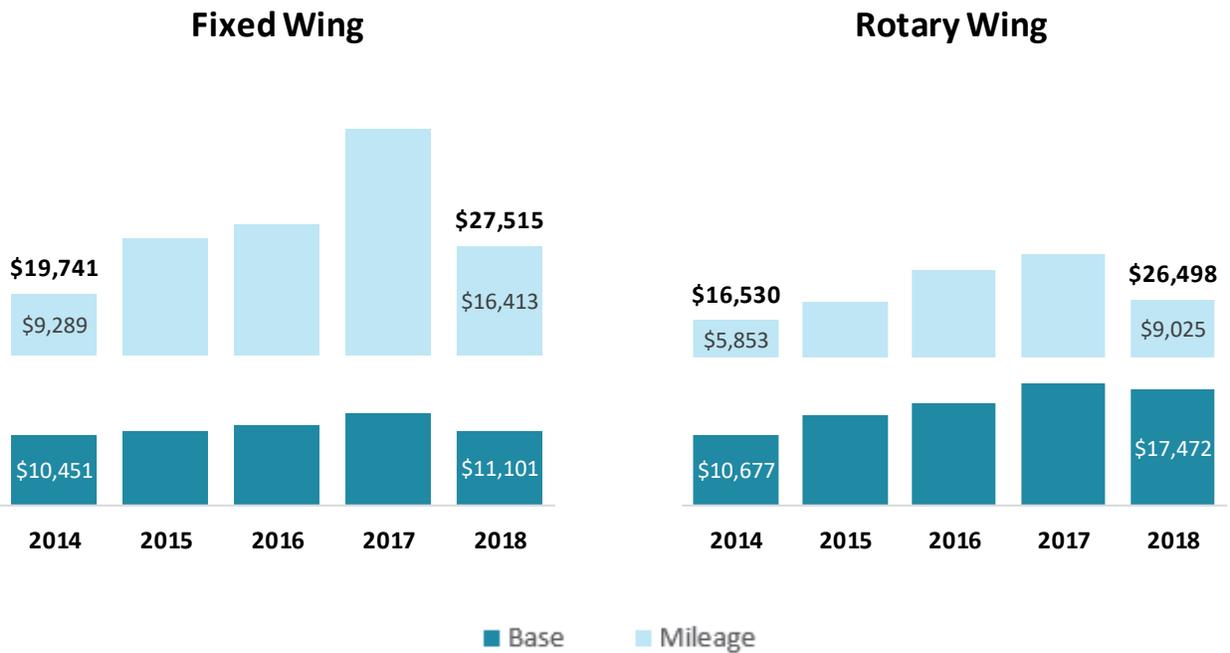


Air ambulance episodes represent approximately 5% of all ambulance episodes countrywide in 2018 but account for nearly half of all ambulance payments. Air ambulance is split into two categories: rotary wing (helicopter) and fixed wing (airplane). Rotary wing episodes represent more than 85% of both payments and episodes for air ambulance services. Chart 60 displays the average payment per fixed wing and rotary wing episodes in Montana separately for the base payment and mileage payment.

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

**Chart 60**

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





## Diagnosis Group and Body System

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

The top 10 body systems and diagnosis groups are ranked by total claim payments for Montana. 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, 2017, and December 31, 2017, and they include all reported services provided for those claims through December 31, 2018. As these claims mature, the mix of ICD-10 codes may change, thus impacting the percentage share of payments for a specific code over time. This mix may also affect how costs per code in Montana compare to countrywide costs. The state, region, and countrywide average payments per claim are also displayed for each body system and diagnosis group.

**Chart 61**
**Top Body Systems by Amount Paid for Dates of Injury in 2017**

Body System	Paid Share	Average Amount Paid Per Claim		
		Montana	Region	Countrywide
Injury or poisoning not otherwise classified	20.6%	\$2,667	\$2,749	\$3,108
Shoulder	17.2%	\$6,931	\$6,400	\$7,543
Knee	10.5%	\$4,348	\$4,784	\$5,026
Hand/wrist	9.6%	\$1,351	\$1,822	\$2,085
Lumbar spine	8.7%	\$3,549	\$3,609	\$4,010
Muscles	6.8%	\$3,364	\$5,038	\$5,141
Neck	3.9%	\$3,294	\$3,854	\$4,565
Hip	3.9%	\$11,236	\$7,230	\$7,585
Ankle/foot	3.5%	\$1,896	\$1,864	\$1,998
Abdomen	1.8%	\$8,111	\$9,084	\$10,401

**Chart 62**
**Top Diagnosis Groups by Amount Paid for Dates of Injury in 2017**

Diagnosis Group	Paid Share	Average Amount Paid Per Claim		
		Montana	Region	Countrywide
Minor shoulder injury	7.3%	\$4,100	\$3,446	\$3,848
Rotator cuff tear	7.0%	\$16,409	\$16,498	\$20,248
Low back pain	5.2%	\$2,712	\$2,552	\$2,491
Minor hand/wrist injuries	5.1%	\$871	\$1,107	\$1,234
Minor knee injury	4.1%	\$2,352	\$2,192	\$2,283
Hip/pelvis fracture/major trauma	3.1%	\$41,538	\$39,366	\$44,081
Hand/wrist fracture	3.0%	\$5,016	\$7,040	\$7,220
Knee internal derangement - meniscus injury	2.9%	\$8,924	\$11,656	\$13,278
Fracture of lower leg, including ankle	2.7%	\$14,217	\$17,397	\$18,766
Minor ankle/foot injuries	2.5%	\$1,480	\$1,426	\$1,499



### Comparison of Selected Results by Year

The charts in this section provide a comparison of results for Montana. 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	2014	2015	2016	2017	2018
Physician	37%	35%	38%	36%	37%
Hospital Outpatient	19%	21%	21%	21%	22%
Hospital Inpatient	13%	13%	12%	14%	13%
Drugs	17%	16%	15%	13%	12%
DMEPOS	5%	5%	5%	6%	6%
ASC	6%	6%	5%	5%	6%
Other	3%	4%	4%	5%	4%

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

AMA Service Category	2014	2015	2016	2017	2018
Physical Medicine	34%	32%	34%	33%	38%
Surgery	22%	21%	19%	20%	19%
Evaluation and Management	27%	27%	29%	29%	27%
Radiology	6%	6%	6%	6%	6%
Anesthesia	5%	5%	5%	5%	5%
General Medicine	4%	5%	4%	4%	3%
Other	1%	3%	2%	2%	2%
Pathology	1%	1%	1%	1%	0%

**Median Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 28, 36, 37, and 48)<sup>9</sup>**

Medical Category	AY 2013	AY 2014	AY 2015	AY 2016	AY 2017
Physicians – Major Surgery	58	53	57	56	59
Physicians – Radiology	2	2	2	2	2
Physicians – Physical and General Medicine	25	27	30	29	30
Physicians – Evaluation and Management	4	4	4	4	4
Hospital Inpatient	1	1	1	2	1
Hospital Outpatient – Major Surgery	55	66	56	46	56
Hospital Outpatient – All Other	1	1	1	1	2
ASC	93	92	97	103	91

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

Medical Category	AY 2013	AY 2014	AY 2015	AY 2016	AY 2017
Physicians – Major Surgery	144	130	142	141	137
Physicians – Radiology	15	16	16	15	15
Physicians – Physical and General Medicine	70	74	73	74	74
Physicians – Evaluation and Management	17	17	20	18	18
Hospital Inpatient	39	50	54	68	20
Hospital Outpatient – Major Surgery	142	145	133	133	119
Hospital Outpatient – All Other	16	16	16	16	21
ASC	175	168	174	174	160

**Hospital Inpatient Statistics (Charts 24 and 26)**

Hospital Inpatient Statistics	2014	2015	2016	2017	2018
Average Amount Paid Per Stay	\$21,009	\$23,671	\$21,431	\$25,688	\$25,526
Number of Stays per 1,000 Active Claims	21	21	19	21	19

<sup>9</sup> In the charts displaying the distribution of time until first treatment, data is organized by the year in which the injury occurred, rather than by service year and include services performed within 365 days of the date of injury.

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

Visit Type	2014	2015	2016	2017	2018
Surgery	42%	45%	43%	45%	44%
Nonsurgery	58%	55%	57%	55%	56%

**Hospital Outpatient Surgery Statistics (Charts 32 and 33)**

Hospital Outpatient Surgery Statistics	2014	2015	2016	2017	2018
Average Amount Paid Per Visit	\$2,363	\$2,642	\$2,830	\$2,985	\$2,998
Number of Visits per 1,000 Active Claims	126	138	116	126	126

**Hospital Outpatient Nonsurgery Statistics (Charts 34 and 35)**

Hospital Outpatient Nonsurgery Statistics	2014	2015	2016	2017	2018
Average Amount Paid Per Visit	\$311	\$315	\$336	\$338	\$363
Number of Visits per 1,000 Active Claims	1,318	1,394	1,284	1,351	1,315

**Emergency Room Statistics (Charts 41 and 42)**

Emergency Room Statistics	2014	2015	2016	2017	2018
Average Amount Paid Per Visit	\$1,014	\$1,140	\$1,219	\$1,315	\$1,261
Number of Visits per 1,000 Active Claims	242	248	252	264	258

**ASC Statistics (Charts 46 and 47)**

ASC Statistics	2014	2015	2016	2017	2018
Average Amount Paid Per Visit	\$1,455	\$2,026	\$1,999	\$2,217	\$2,285
Number of Visits per 1,000 Active Claims	154	110	101	99	104

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

<b>CSA Schedule</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Schedule II	34%	34%	32%	28%	25%
Schedule III	2%	2%	2%	3%	3%
Schedule IV	7%	7%	7%	6%	6%
Schedule V	7%	8%	9%	10%	12%
Noncontrolled	50%	49%	50%	53%	54%

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

<b>Type of Drug</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Brand Name	47%	43%	44%	46%	49%
Generic	53%	57%	56%	54%	51%

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

<b>Type of Provider</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
Pharmacy	99%	99%	99%	100%	99%
Nonpharmacy	1%	1%	1%	0%	1%

**Distribution of Payments by DMEPOS (Chart 56)**

<b>Category</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>
DME	18%	18%	23%	17%	18%
Prosthetics, Orthotics and Implants	49%	52%	55%	57%	62%
Supplies Other Than DME	33%	30%	22%	26%	20%



## Glossary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

**Transaction:** A line item of a medical bill.

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

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



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



## Appendix

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

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

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

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

For more information about the Medical Data Call, please refer to the *Medical Data Call Reporting Guidebook* on [ncci.com](http://ncci.com).