NORTH CAROLINA
Rate Bureau

November 14, 2024

CIRCULAR LETTER TO ALL MEMBER COMPANIES

Re: Workers Compensation Insurance
2024 Medical Data Report – North Carolina

The North Carolina Rate Bureau is pleased to provide you with the 2024 Medical Data Report for the state of North Carolina. This report has been compiled by the National Council on Compensation Insurance to provide insight into the medical cost drivers that impact the workers compensation system in North Carolina.

The data contained in this report represents medical transactions from NCCI's Medical Data Call aggregated by service year (2023), except where otherwise noted. Note that some data may extend through the first quarter of the following year. This data represents 94% of the workers compensation premium written, which includes experience for large deductible polices. Bulk payments and lump-sum settlements are not required to be reported. Self-insured data is not included.

This year's Medical Data Report Illustrates the breakdown of services by category as follows:

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

Highlights from this report:

- Medical expenses continue to make up just under half of all loss expenses in Workers Compensation, at 45.5% for North Carolina on 2022 accidents.
- Average medical costs are in line with and very similar to costs in other states.
- Shoulders make up the largest percentage of Payments in North Carolina, while Hand/Wrist injuries make up the largest percentage of claims.
- Relative to other states, North Carolina has more payments to Physicians with slightly less payments to Ambulatory Surgical Centers and Hospital Outpatient services.
- The percentage of claims with prescription drugs has decreased over the last 10 years but is starting to level off. A big contributor to the decrease over the last 10 years has been the decrease in Opioid prescriptions.

Of note, this year's report no longer contains a regional comparison.

We trust that this report will provide additional insight into the workers compensation cost drivers in North Carolina.

Sincerely,

Jarred Chappell
Chief Operating Officer

JC:ko
C-24-12
Attachments

Medical Data Report

For the state of

North Carolina

October 2024

Medical Data Report–North Carolina

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Medical Data Report–North Carolina

Introduction

Managing the cost and delivery of medical care is one of the major concerns facing workers compensation (WC) stakeholders now and in the foreseeable future.

This publication is a data source for regulators and others who are interested in the driving forces behind changing medical costs in WC claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that underlie the financial soundness of the WC system. When evaluating differences in medical cost between the base state and comparison state(s), it is important to note that medical cost containment can vary significantly across states; while some states may have one or more fee schedules, other states may not have any fee schedules or may provide for reimbursement based on charged amounts.

This report illustrates the breakdown of medical services by category, namely:

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

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.

Data

The data contained in this report represents medical transactions from NCCI's Medical Data Call aggregated by service year (the year in which the medical service was provided), except where otherwise noted. For each service year in this report, payments and transactions are limited to those occurring through the end of the first quarter of the following calendar year. For example, Service Year 2023 includes payments and transactions through 1Q2024. This ensures that data across service years can be compared at a consistent valuation.

WC insurance carriers must report paid medical transactions if the carrier meets NCCI's eligibility criteria in any one state for which NCCI is the rating or advisory organization. Once a carrier meets the eligibility criteria, it is required to report for all applicable states where it writes WC insurance. All carriers within an insurance group are required to report.

For North Carolina (displayed as Base State) in Service Year 2023, this represents data from 94% of the workers compensation premium written, which includes experience for large-deductible policies. Bulk payments and lump-sum settlements are not required to be reported. Also, self-insured data is not included.

Countrywide (displayed as Comparison States) includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TX, TN, UT, VA, VT, WV.

Please note that, where included in this report and based on MDC data, Texas medical services and associated payments are limited to those occurring on or after January 1, 2020. When information is based on service year, all Texas services and associated payments from January 1, 2020 and onward are included. When information is based on accident year, only services and associated payments from claims with an accident date on or after January 1, 2020 are included.

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

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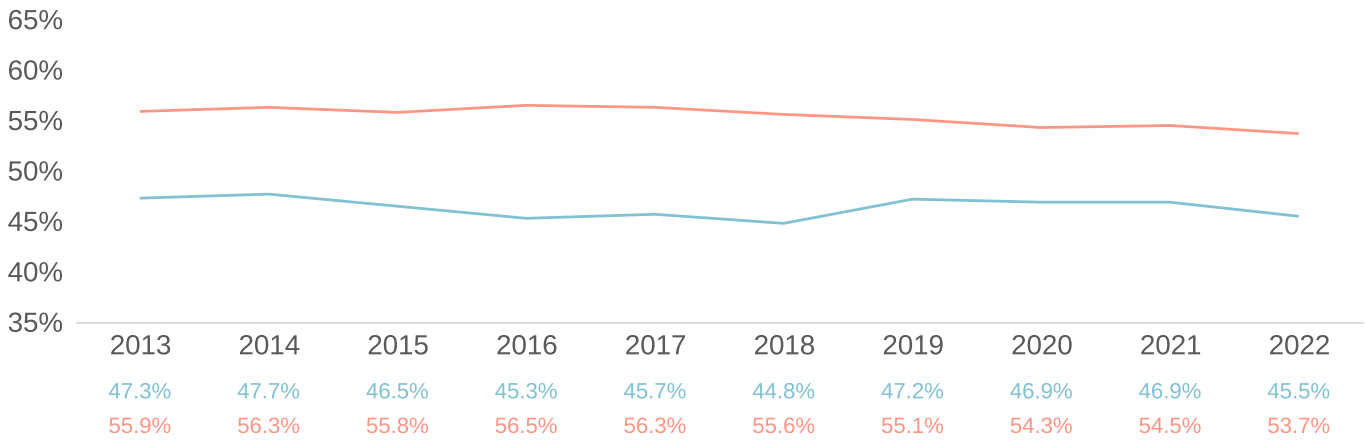
Overview

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. For example, the medical share in a state may be large because the indemnity benefits are relatively less prominent.

This chart displays the medical percentage of total benefit costs for Accident Years 2013 through 2022.

Medical Share of Total Benefit Costs

By Accident Year for Base State vs Comparison States

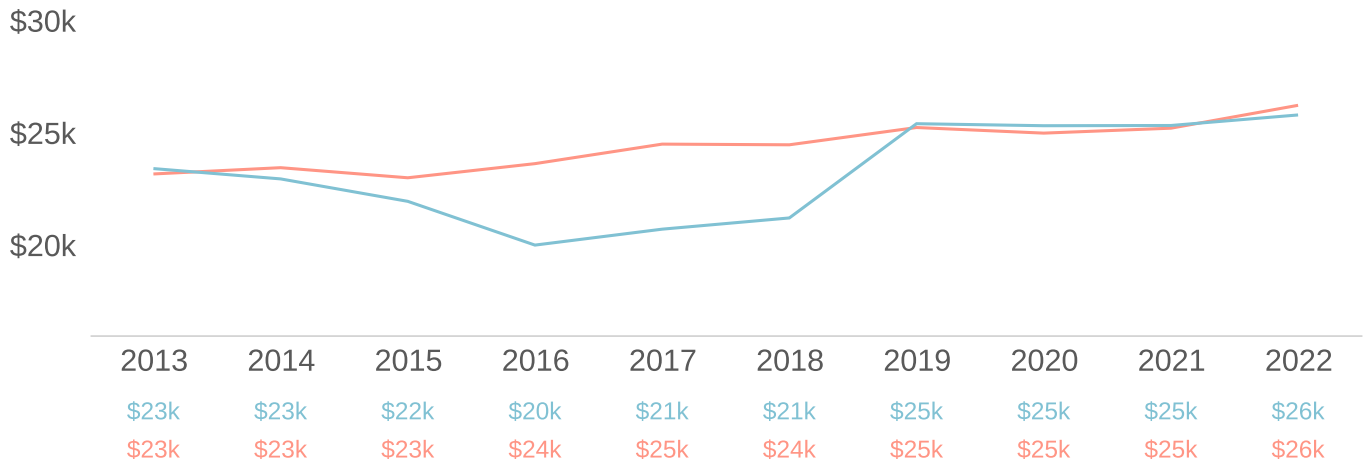


Source: NCCI's Calendar-Accident Year Call for Compensation Experience. MI data is provided by the Compensation Advisory Organization of Michigan. MN data provided by the Minnesota Workers' Compensation Insurers Association.

This chart allows for the comparison of the changes in average medical costs.

Overall Medical Average Cost per Lost-Time Claim

By Accident Year for Base State vs Comparison States



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. MI data is provided by the Compensation Advisory Organization of Michigan. MN data provided by the Minnesota Workers' Compensation Insurers Association.

A diagnosis group and a body system are identified for each claim based on the ICD-10 code, which is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems. 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 tables below provide detailed information on body systems and diagnoses—defined as those with 1 percent or more of total medical payments for Accident Year 2022 for services occurring through year-end 2023. Body systems are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state. For payments for a given body system, an average amount of paid per claim is displayed.

Top Body Systems by Payments

Accident Year 2022

Base State				Comparison States		
Body System	Paid per Claim	% of Payments	% of Claims	Paid per Claim	% of Payments	% of Claims
Shoulder	$7,624	16.5%	8.8%	$10,232	18.2%	8.9%
Hand/Wrist	$2,339	13.5%	23.5%	$2,842	13.3%	23.3%
Lumbar Spine	$3,915	9.9%	10.3%	$4,915	10.4%	10.5%
Knee	$4,685	8.5%	7.3%	$5,971	8.8%	7.3%
Ankle/Foot	$3,385	8.2%	9.8%	$3,874	7.4%	9.5%
Leg	$6,021	6.7%	4.5%	$6,535	5.6%	4.3%
Nonspecific/Miscellaneous Injury Part	$5,159	5.6%	4.5%	$5,333	4.0%	3.7%
Head	$3,770	5.5%	5.9%	$3,856	4.7%	6.0%
Neck	$4,962	3.8%	3.1%	$6,924	4.7%	3.4%
Hip/Pelvis	$10,418	3.3%	1.3%	$11,584	2.9%	1.2%
Total		**81.5%**	**79.0%**		**80.0%**	**78.1%**

Diagnoses are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state. For payments for a given diagnosis group, an average amount of paid per claim is displayed.

Top Diagnoses by Payments

Accident Year 2022

Base State				Comparison States		
Diagnosis	Paid per Claim	% of Payments	% of Claims	Paid per Claim	% of Payments	% of Claims
Minor Shoulder Injury	$4,097	6.4%	6.4%	$5,415	6.7%	6.2%
Rotator Cuff Tear	$18,876	6.2%	1.3%	$24,234	7.8%	1.6%
Minor Hand/Wrist Injuries	$1,382	6.0%	17.7%	$1,591	5.6%	17.6%
Low Back Pain	$2,271	4.5%	8.1%	$2,765	4.7%	8.4%
Hand/Wrist Fracture	$5,976	4.3%	2.9%	$7,809	4.2%	2.7%
Tibia Fibula Fracture	$29,592	3.7%	0.5%	$31,586	3.0%	0.5%
Minor Knee Injury	$2,730	3.6%	5.4%	$2,861	3.0%	5.2%
Minor Ankle/Foot Injuries	$2,009	3.6%	7.3%	$2,288	3.2%	7.0%
Injury of unspecified body region	$5,450	3.6%	2.7%	$5,105	2.0%	1.9%
Hip/Pelvis Fracture/Major Trauma	$36,004	2.6%	0.3%	$49,027	2.2%	0.2%
Total		**44.5%**	**52.6%**		**42.4%**	**51.3%**

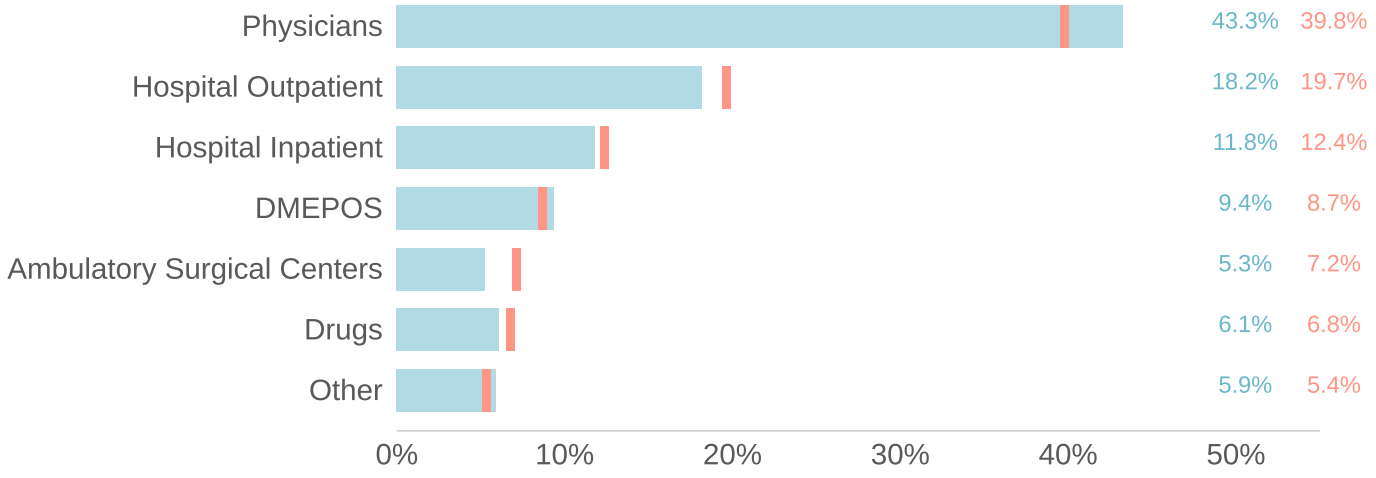
Payments categorized as Drugs; Durable Medical Equipment, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services) are based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service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

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

Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits. This chart shows the amounts paid for medical services broken down into various cost categories for the latest service year.

Payments by Medical Cost Category

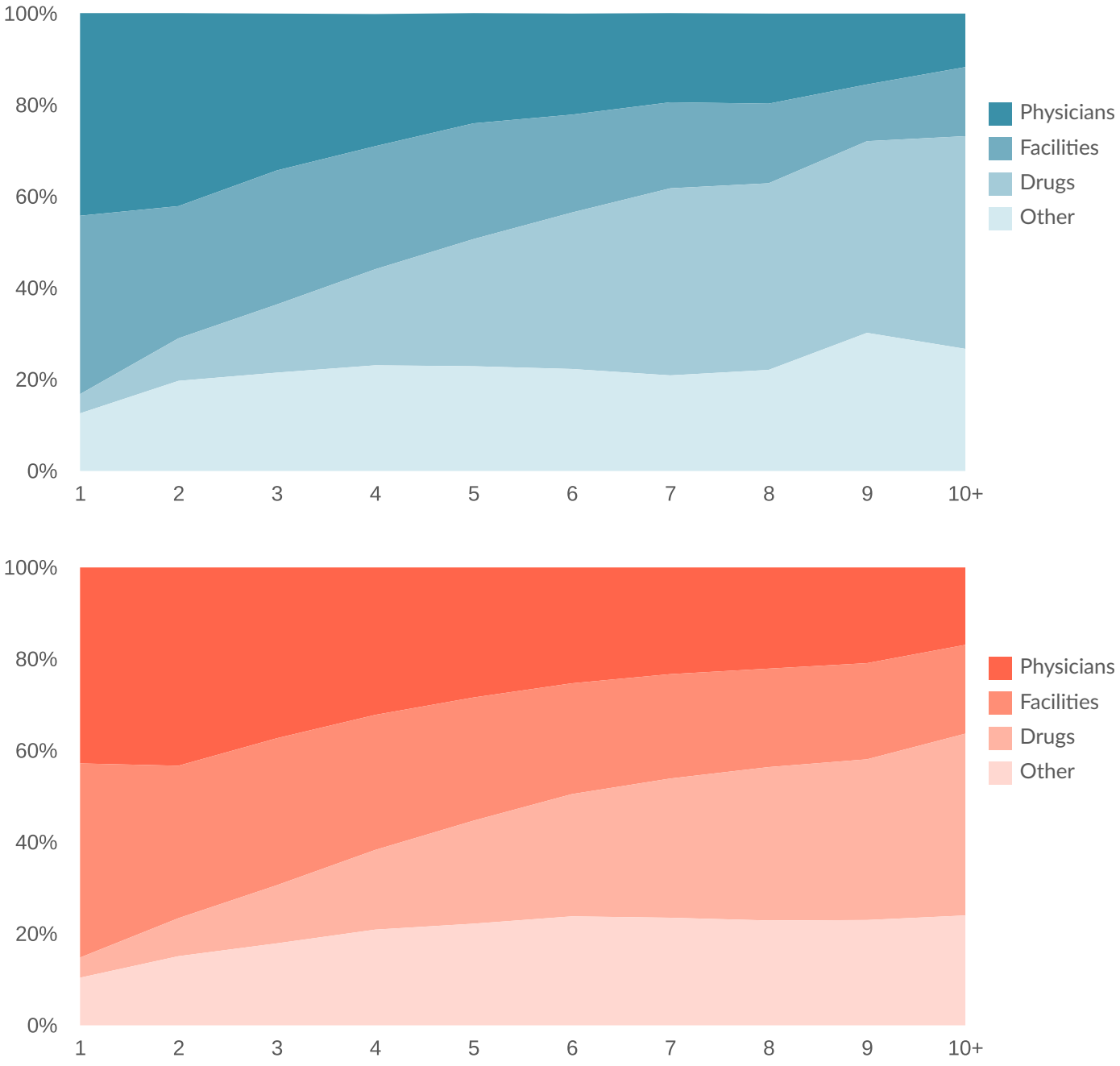
Base State vs Comparison States for Service Year 2023



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. The chart below shows the distribution of medical payments by type of service, further broken down by claim age for Service Years 2014 through 2023. Generally, in the first year after a claim, most medical services are for physicians and facility services, whereas drugs make up a higher percentage of medical costs in the later years of a claim.

Medical Cost Category Payments by Claim Age

Base State vs Comparison States



Physicians

This chart shows the average percentage of Medicare schedule reimbursement amounts for physician payments by category. Note that “All Physician Services” refers only to the categories listed in the chart.

Physician service categories are based on the groupings of procedure codes in the Medicare National Corrective Coding Initiative supplemented with categorization for certain state-specific codes.

Physician Payments as a Percentage of Medicare

Service Year 2023

Physician Service Category	Base State	Comparison States
Anesthesia	NA[1]	303%
Evaluation and Management	133%	145%
Physical and General Medicine	120%	138%
Surgery	189%	263%
Radiology	187%	231%
All Physician Services	**138%**	**167%**

[1] A majority of anesthesia services in North Carolina are made up of codes ANT01 and ANT02 which are not recognized by Medicare.

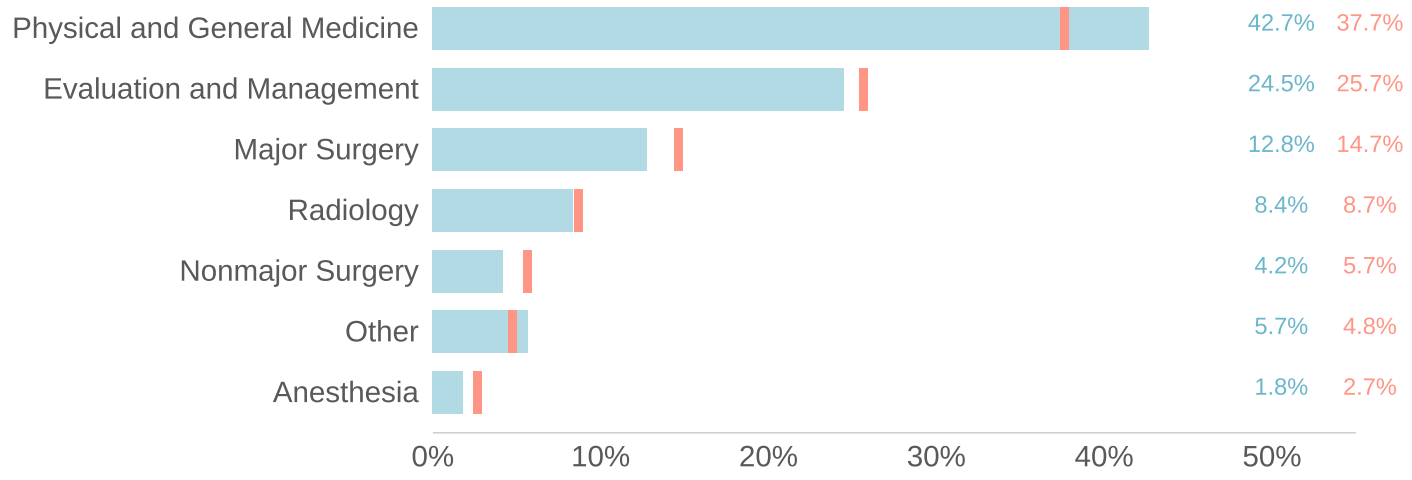
Physicians typically use Current Procedural Terminology (CPT) codes to identify the services that they provide to injured workers. These codes are specific and provide detailed information on what service was performed. The primary paid procedure code determines the physician service category.

This chart shows the distribution of physician payments by service category for the latest service year. Other includes pathology, independent medical examination, impairment rating by treating physician, drug testing, case management, etc. A service is classified as “surgical” if it falls within the surgical category as defined by the American Medical Association (AMA). A service is further classified as “major surgery” if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services (CMS), or the procedure involves spine/spinal cord neurostimulators.

While not shown in the report, the secondary paid procedure code, modifier, diagnosis code, place of service, and quantity/units can all be impactful when evaluating average payments per service.

Payments by Physician Service Category

Base State vs Comparison States for Service Year 2023

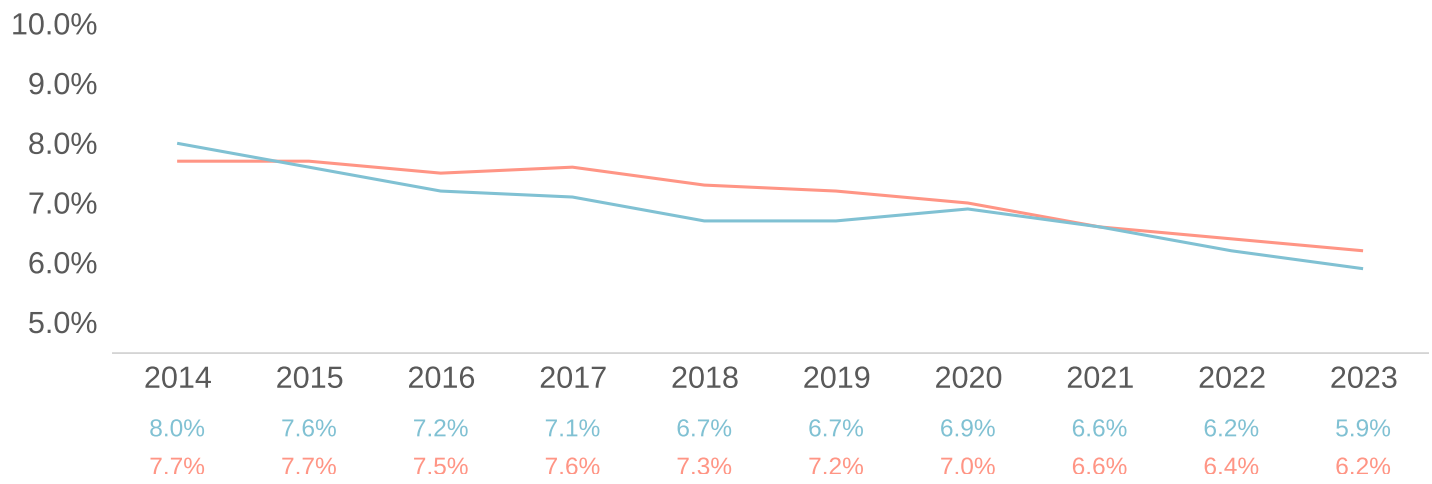


Physicians—Anesthesia

This chart shows the count of active claims receiving one or more anesthesia services divided by the count of all claims receiving a medical service.

Share of Total Claims With an **Anesthesia** Transaction

By Service Year for Base State vs Comparison States



For anesthesia codes, an average amount paid per unit is displayed. A unit is typically a measurement of time (15-minute increment, 30-minute increment, 1-hour increment, etc.) but can also be one transaction. For anesthesia procedures, the unit is an increment of 15 minutes unless otherwise defined in the procedure code description.

The table provides detailed information on procedure codes—defined as those with 1 percent or more of total anesthesia payments in the latest service year. Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Anesthesia Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Unit	% of Payments	% of Transactions	Paid per Unit	% of Payments	% of Transactions
ANT01	$3	57.7%	53.2%	$3	1.3%	2.3%
ANT02	$2	31.2%	39.5%	$2	0.7%	1.7%
01630	$54	1.3%	0.8%	$86	17.7%	15.0%
Total		**90.2%**	**93.5%**		**19.7%**	**19.0%**

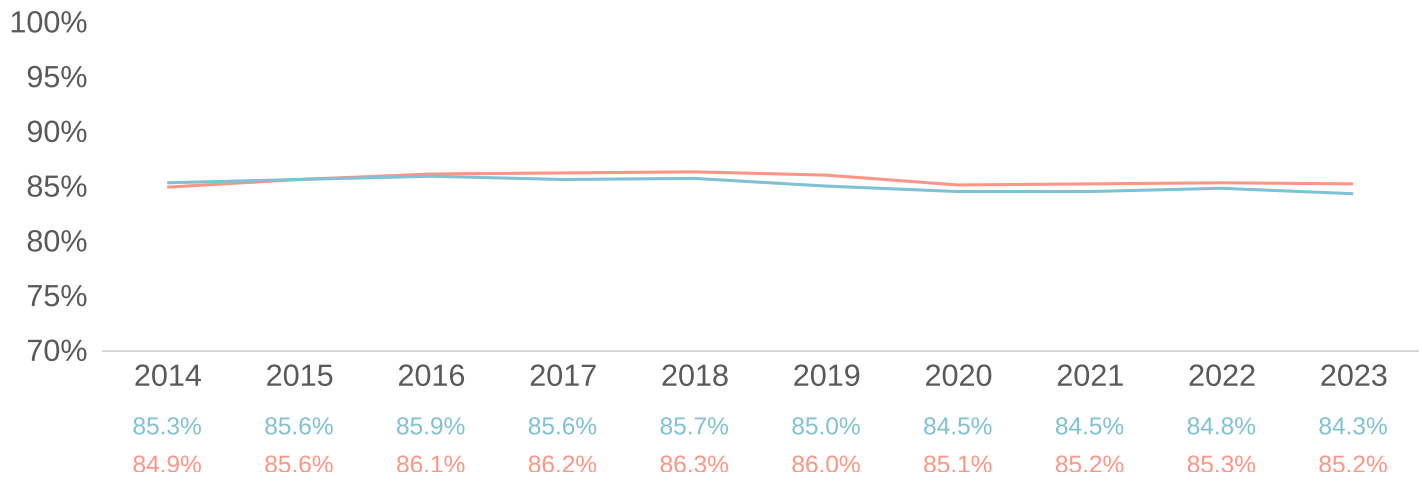
Code	Code Description
ANT01	**ANES- ANESTHESIOLOGIST PER MIN > 60 MIN
ANT02	**CRNA SERVICES FOR ANESTH - PER MIN > 60 MIN
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified

Physicians—Evaluation & Management

This chart shows the count of active claims receiving one or more evaluation and management services divided by the count of all claims receiving a medical service.

Share of Total Claims With an **Evaluation & Management** Transaction

By Service Year for Base State vs Comparison States



For evaluation and management codes, an average amount paid per transaction is displayed.

The table provides detailed information on procedure codes—defined as those with 1 percent or more of total evaluation and management payments in the latest service year. Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Evaluation & Management Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Transaction	% of Payments	% of Transactions	Paid per Transaction	% of Payments	% of Transactions
99213	$110	32.0%	42.1%	$124	29.7%	39.8%
99214	$157	21.3%	19.8%	$173	22.2%	21.3%
99204	$211	13.4%	9.3%	$241	13.0%	9.0%
99203	$141	12.0%	12.4%	$162	10.3%	10.6%
99455	$216	4.5%	3.0%	$200	2.2%	1.8%
99284	$218	3.5%	2.3%	$262	3.6%	2.3%
99215	$211	1.8%	1.2%	$230	2.2%	1.6%
99285	$308	1.4%	0.7%	$417	1.4%	0.6%
99244	$383	1.1%	0.4%	$283	0.6%	0.4%
99212	$67	1.1%	2.4%	$77	1.7%	3.7%
Total		**92.1%**	**93.6%**		**86.9%**	**91.1%**

Code	Code Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99455	Work related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/certificates and report.
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

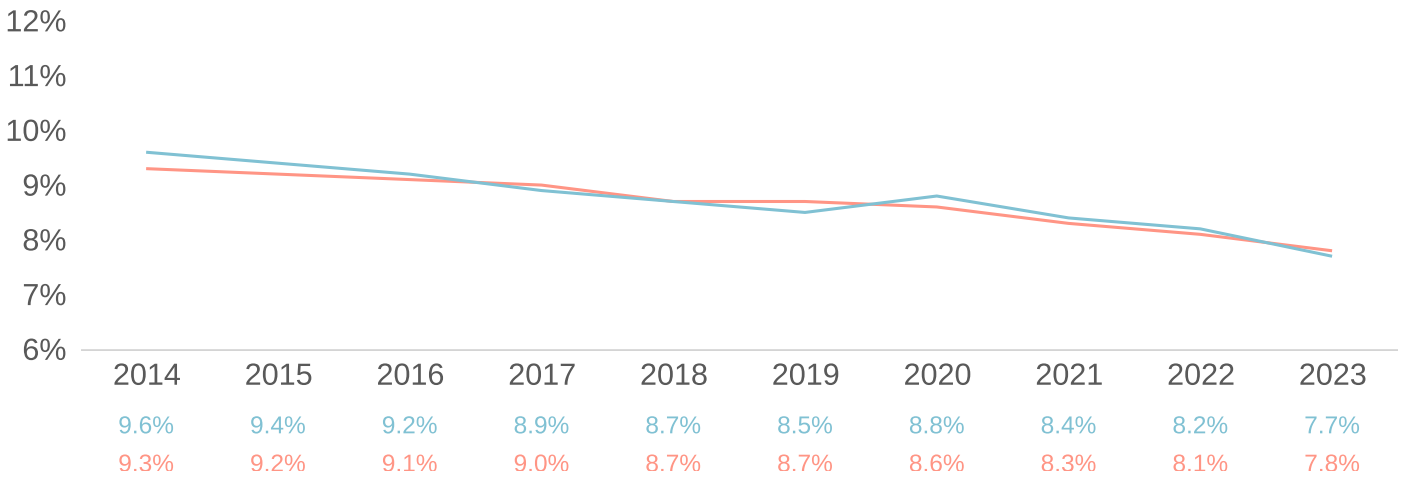
Physicians—Major Surgery

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

This chart shows the count of active claims receiving one or more major surgeries divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Major Surgery** Transaction

By Service Year for Base State vs Comparison States



For major surgery codes, an average amount paid per transaction is displayed.

The table provides detailed information on procedure codes—defined as those with 1 percent or more of total major surgery payments in the latest service year. Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Major Surgery Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Transaction	% of Payments	% of Transactions	Paid per Transaction	% of Payments	% of Transactions
29827	$1,597	10.4%	6.9%	$2,214	11.1%	7.2%
29828	$1,180	3.7%	3.4%	$1,235	2.4%	2.7%
29823	$661	2.8%	4.5%	$971	2.9%	4.3%
23430	$1,155	2.8%	2.5%	$1,295	2.2%	2.4%
29824	$718	2.7%	4.0%	$814	1.8%	3.2%
29881	$955	2.6%	2.9%	$1,388	3.3%	3.4%
27447	$2,266	2.2%	1.0%	$2,801	1.4%	0.7%
25609	$1,818	2.2%	1.3%	$1,965	1.2%	0.8%
22551	$2,465	2.0%	0.9%	$3,962	2.6%	0.9%
29888	$1,578	2.0%	1.4%	$2,098	2.0%	1.4%
Total		**33.4%**	**28.8%**		**30.9%**	**27.0%**

Code	Code Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	Arthroscopy, shoulder, surgical; biceps tenodesis
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
23430	Tenodesis of long tendon of biceps
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

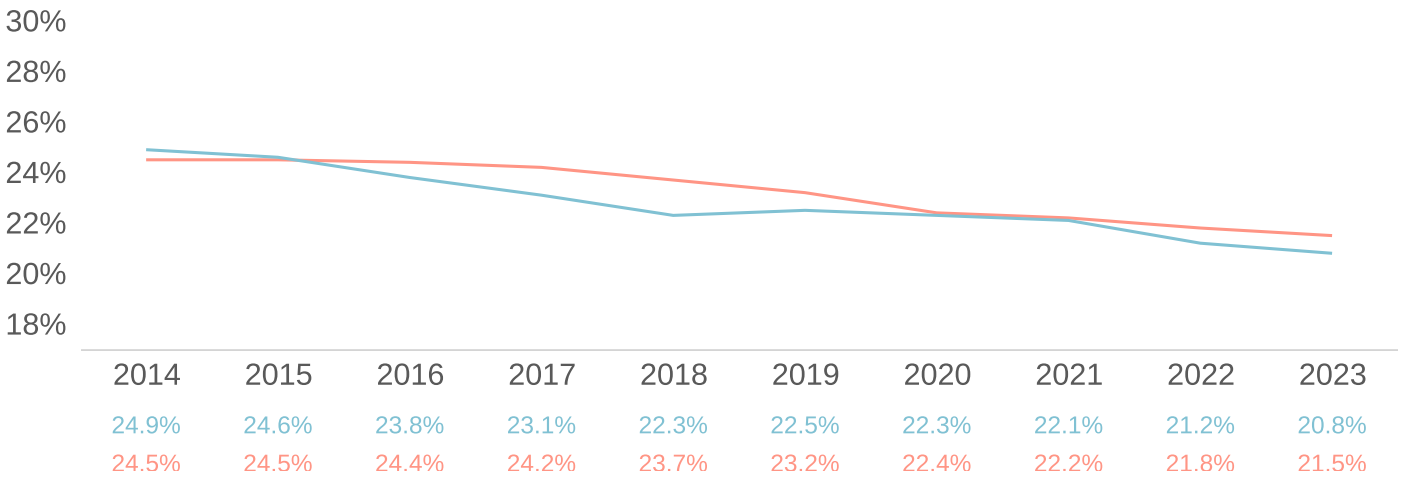
Physicians—Nonmajor Surgery

A service is classified as surgical if it falls within the surgical category as defined by the AMA. A surgical service that is not classified as “major surgery” is considered nonmajor surgery.

This chart shows the count of active claims receiving one or more nonmajor surgeries divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Nonmajor Surgery** Transaction

By Service Year for Base State vs Comparison States



For nonmajor surgery codes, an average amount paid per transaction is displayed.

The table provides detailed information on procedure codes—defined as those with 1 percent or more of total nonmajor surgery payments in the latest service year. Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Nonmajor Surgery Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Transaction	% of Payments	% of Transactions	Paid per Transaction	% of Payments	% of Transactions
64483	$367	8.8%	4.1%	$558	5.8%	2.8%
20610	$89	6.8%	12.8%	$127	5.1%	10.5%
12001	$115	4.6%	6.8%	$167	4.5%	7.1%
64415	$136	3.4%	4.2%	$249	3.7%	3.9%
12002	$135	3.1%	3.8%	$196	2.6%	3.5%
64493	$273	2.6%	1.6%	$540	3.0%	1.4%
62323	$354	2.5%	1.2%	$511	2.6%	1.4%
64635	$564	2.3%	0.7%	$986	2.6%	0.7%
11012	$632	1.9%	0.5%	$796	1.9%	0.6%
62321	$377	1.9%	0.8%	$552	1.9%	0.9%
Total		**37.9%**	**36.5%**		**33.7%**	**32.8%**

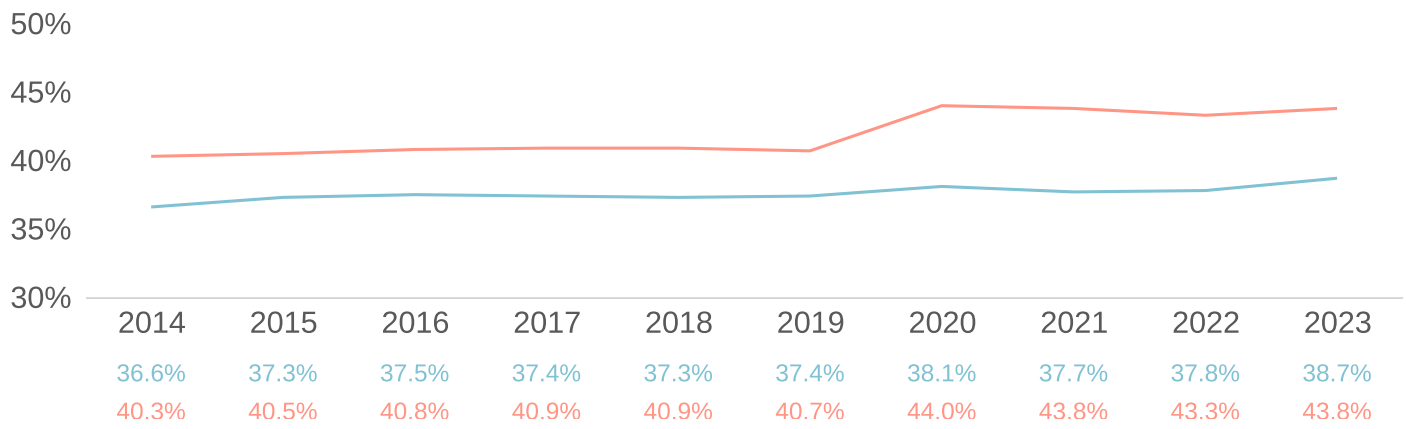
Code	Code Description
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
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
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, 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
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

Physicians—Physical & General Medicine

This chart shows the count of active claims receiving one or more physical and general medicine services divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Physical & General Medicine** Transaction

By Service Year for Base State vs Comparison States



For Physical & General Medicine, an average amount paid per unit is displayed. A unit is typically a measurement of time (15-minute increment, 30-minute increment, 1-hour increment, etc.) but can also be one transaction. The procedure code description indicates the unit measurement.

The table provides detailed information on procedure codes—defined as those with 1 percent or more of total Physical & General Medicine payments in the latest service year. Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Physical & General Medicine Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Unit	% of Payments	% of Transactions	Paid per Unit	% of Payments	% of Transactions
97110	$33	25.7%	27.3%	$41	30.1%	27.6%
97530	$41	19.2%	19.2%	$47	18.5%	17.9%
97112	$38	13.4%	16.2%	$44	11.8%	14.2%
97140	$30	10.0%	15.9%	$38	9.7%	14.7%
97545	$261	8.4%	1.9%	$195	3.3%	1.1%
97161	$123	2.2%	1.1%	$136	2.0%	1.0%
97546	$105	2.0%	0.8%	$88	1.8%	0.7%
97010	$21	1.8%	4.8%	$15	0.5%	2.2%
97750	$41	1.7%	0.3%	$53	1.4%	0.3%
97164	$73	1.6%	1.3%	$89	1.3%	1.0%
Total		**86.0%**	**88.8%**		**80.4%**	**80.7%**

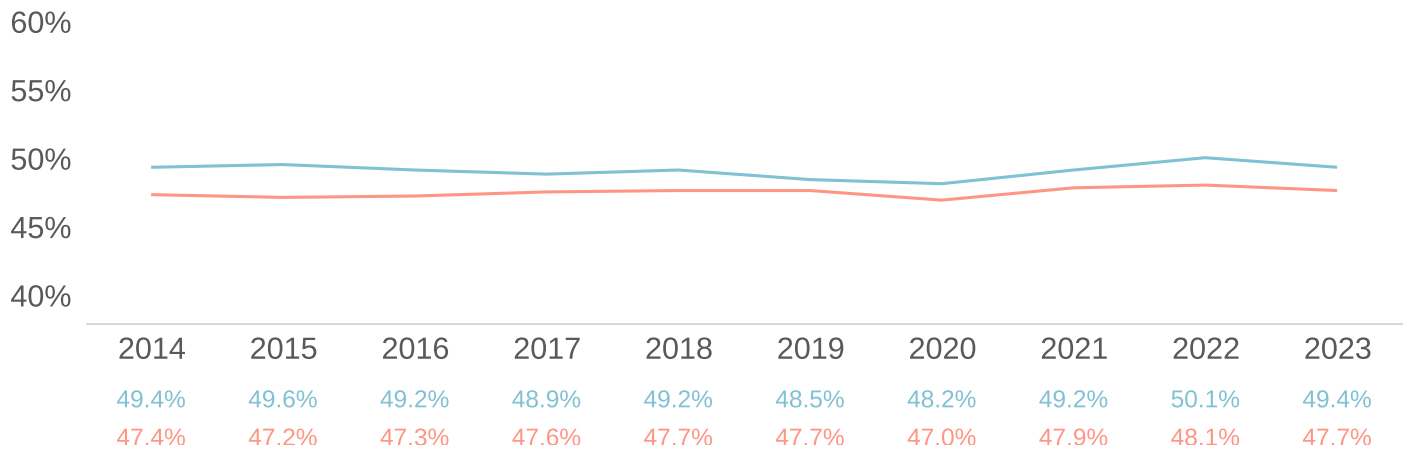
Code	Code Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97010	Application of a modality to 1 or more areas; hot or cold packs
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.

Physicians—Radiology

This chart shows the count of active claims receiving one or more radiology services divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Radiology** Transaction

By Service Year for Base State vs Comparison States



For radiology codes, an average amount paid per transaction is displayed.

The table provides detailed information on procedure codes—defined as those with 1 percent or more of total radiology payments in the latest service year. Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Radiology Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Transaction	% of Payments	% of Transactions	Paid per Transaction	% of Payments	% of Transactions
73221	$373	13.1%	3.8%	$474	14.4%	4.3%
73721	$374	12.8%	3.8%	$465	12.9%	3.9%
72148	$353	8.8%	2.7%	$462	8.8%	2.7%
72141	$349	4.2%	1.3%	$453	4.5%	1.4%
73030	$52	3.5%	7.4%	$60	3.1%	7.4%
73110	$59	3.1%	5.8%	$64	2.4%	5.2%
73140	$53	3.1%	6.3%	$56	2.0%	5.1%
73610	$53	3.0%	6.3%	$58	2.6%	6.2%
73630	$51	3.0%	6.3%	$55	2.3%	5.9%
73130	$50	2.5%	5.6%	$56	2.3%	5.7%
Total		**57.1%**	**49.3%**		**55.3%**	**47.8%**

Code	Code Description
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
73030	Radiologic examination, shoulder; complete, minimum of 2 views
73110	Radiologic examination, wrist; complete, minimum of 3 views
73140	Radiologic examination, finger(s), minimum of 2 views
73610	Radiologic examination, ankle; complete, minimum of 3 views
73630	Radiologic examination, foot; complete, minimum of 3 views
73130	Radiologic examination, hand; minimum of 3 views

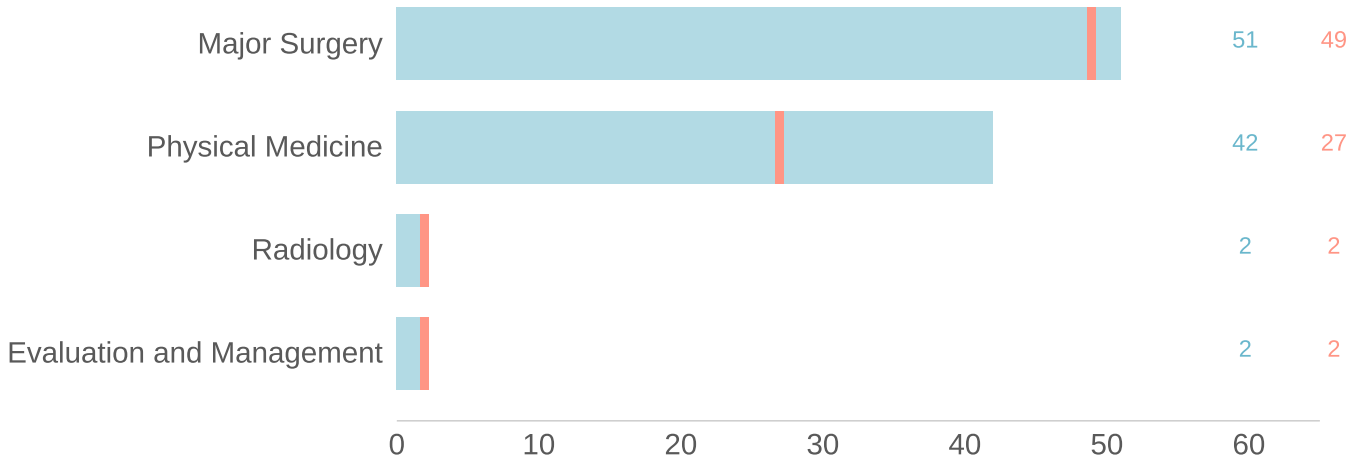
Time Until First Treatment—Physicians

Time Until First Treatment is measured by the number of days between the date of injury and the date the worker first received medical services. Services are limited to those occurring through year-end 2023.

The chart below shows the median Time Until First Treatment by physician service category.

Time Until First Treatment by Physician Service Category

Base State vs Comparison States for Accident Year 2022



Facilities

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, a fee schedule may also play a role. In many states, a fee schedule, if applicable, varies by type of facility, which may help explain differences observed between states.

This chart shows the average percentage of Medicare schedule reimbursement amounts by facility type.

Facility Payments as a Percentage of Medicare

Service Year 2023

Facility Type	Base State	Comparison States
Hospital Inpatient	153%	196%
Hospital Outpatient	173%	233%
Ambulatory Surgical Centers	171%	235%
All Facilities	**166%**	**223%**

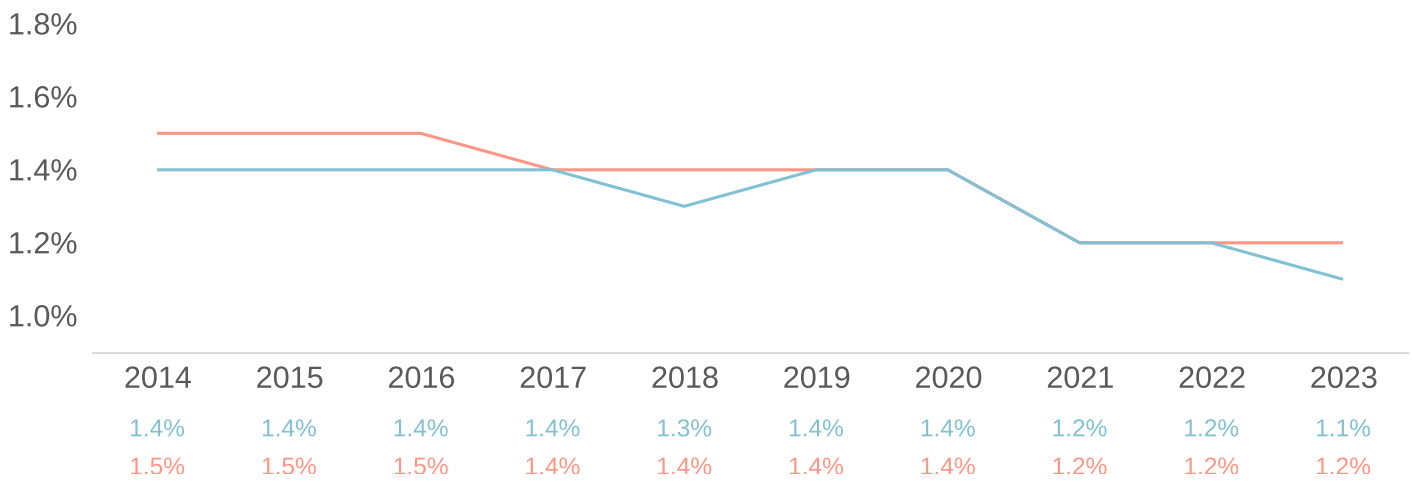
Hospital Inpatient Facility Services

Hospital inpatient fee schedules in workers compensation vary across jurisdictions. Some states have fee schedules based on a group of facility services related to the hospital admission, such as a Medicare Severity Diagnosis-Related Group (MS-DRG or DRG for short); others are on a per diem basis, with some variation on the per diem amount by type of admission. Other states have provisions for the reimbursement to be a certain percentage of hospital charges. Some states do not have a hospital inpatient fee schedule.

This chart shows the count of active claims receiving one or more hospital inpatient stays divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Hospital Inpatient** Stay

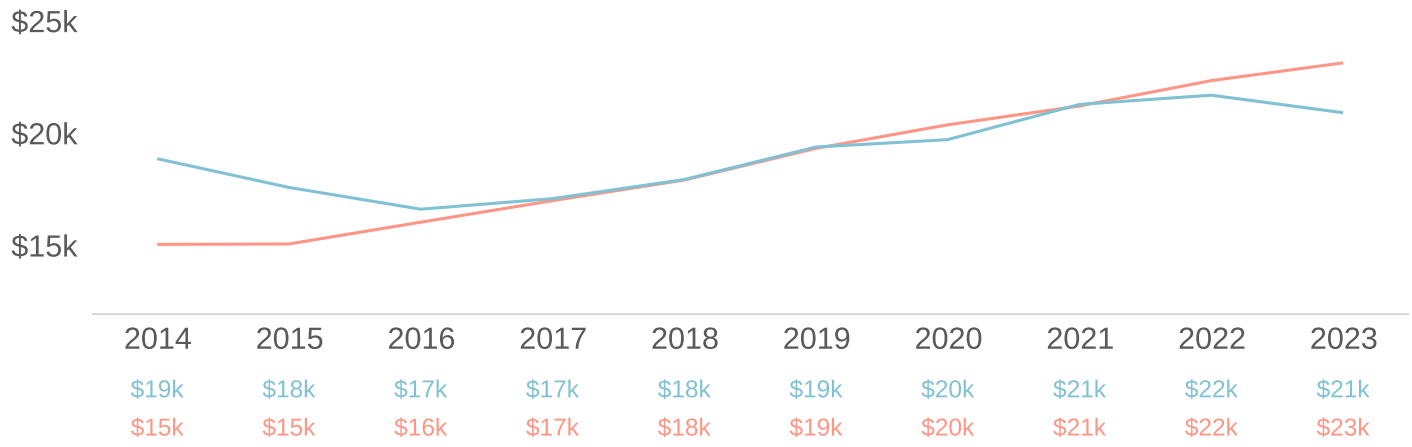
By Service Year for Base State vs Comparison States



This chart shows the median payment of a hospital inpatient stay.

Hospital Inpatient Paid per Stay

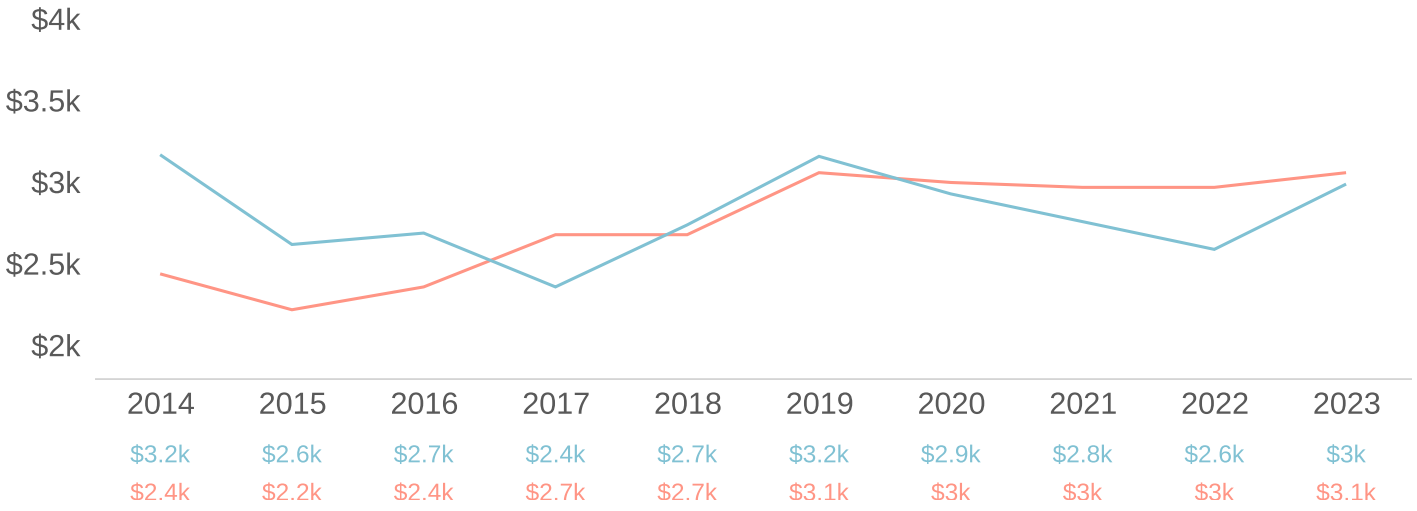
By Service Year for Base State vs Comparison States



This chart shows the median payment per day of a hospital inpatient stay.

Hospital Inpatient Paid per Day

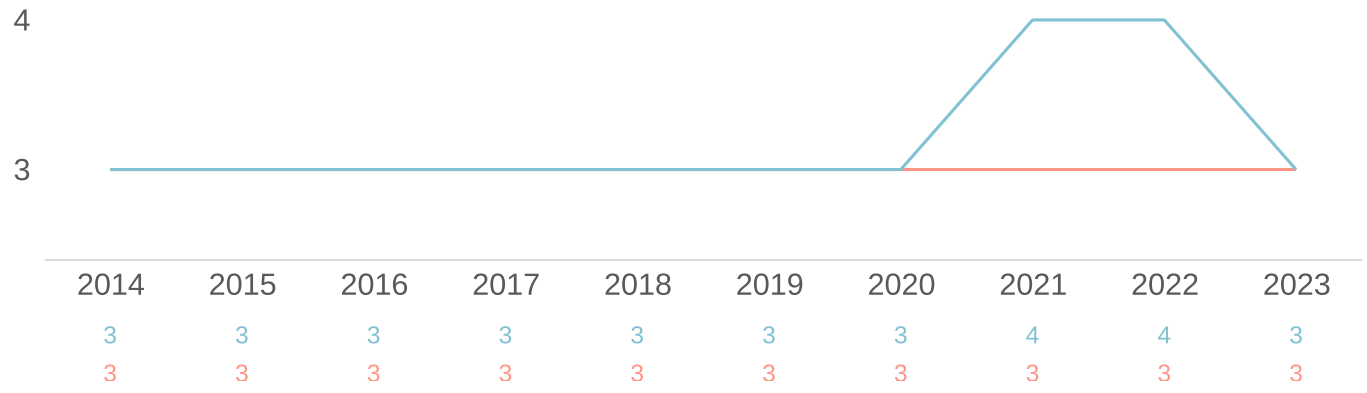
By Service Year for Base State vs Comparison States



This chart shows the median number of days per hospital inpatient stay.

Hospital Inpatient Days per Stay

By Service Year for Base State vs Comparison States



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. Comparisons by procedure code for inpatient costs should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions. For inpatient codes, payments are evaluated per stay, and an average amount paid per stay is displayed.

The tables below provide detailed information on diagnoses and DRG codes—defined as those with 1 percent or more of total hospital inpatient payments in the latest service year.

Diagnoses codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Inpatient Top Diagnosis by Payments

Service Year 2023

Base State				Comparison States		
Diagnosis	Paid per Stay	% of Payments	% of Stays	Paid per Stay	% of Payments	% of Stays
Hip/Pelvis Fracture/Major Trauma	$31,097	8.5%	8.4%	$40,900	8.5%	8.4%
Burn and Corrosion Third Degree other than Head Face and Neck	$92,666	8.0%	2.7%	$97,977	3.8%	1.6%
Lumbar Spine Degeneration	$38,055	6.5%	5.3%	$47,102	4.8%	4.2%
Tibia Fibula Fracture	$24,718	6.1%	7.6%	$40,862	6.5%	6.5%
Traumatic Brain Injury	$49,374	5.1%	3.2%	$57,597	5.2%	3.6%
Chest Trauma Major	$36,242	4.3%	3.7%	$46,049	2.8%	2.4%
Injury of nerves and spinal cord at neck level	$117,440	4.2%	1.1%	$96,322	1.6%	0.7%
Injury of intra-abdominal organs	$44,771	3.0%	2.1%	$63,370	1.5%	1.0%
Hypertension	$95,493	2.7%	0.9%	$26,337	0.3%	0.4%
Thoracic Vertebral Fracture	$42,182	2.7%	2.0%	$50,143	1.4%	1.1%
Total		**51.1%**	**37.0%**		**36.4%**	**29.9%**

DRG codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Inpatient Top DRG Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Stay	% of Payments	% of Stays	Paid per Stay	% of Payments	% of Stays
957	$84,793	3.3%	1.2%	$147,199	2.0%	0.5%
460	$34,479	2.8%	2.5%	$48,025	1.7%	1.5%
958	$47,252	2.7%	1.8%	$89,023	1.3%	0.6%
455	$35,521	2.5%	2.2%	$54,320	2.1%	1.5%
493	$25,121	2.3%	2.9%	$41,187	1.6%	1.6%
494	$19,387	2.2%	3.5%	$33,205	1.7%	2.0%
956	$147,883	2.1%	0.4%	$121,339	1.3%	0.4%
003	$196,210	2.1%	0.3%	$375,993	2.3%	0.2%
929	$39,338	1.7%	1.3%	$51,757	0.5%	0.4%
949	$57,794	1.7%	0.9%	$100,694	0.7%	0.3%
Total		**23.4%**	**17.0%**		**15.2%**	**9.0%**

Code	Code Description
957	Other O.R. Procedures for Multiple Significant Trauma with MCC
460	Spinal Fusion Except Cervical without MCC
958	Other O.R. Procedures for Multiple Significant Trauma with CC
455	Combined Anterior and Posterior Spinal Fusion without CC/MCC
493	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur with CC
494	Lower Extremity and Humerus Procedures Except Hip, Foot, Femur without CC/MCC
956	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedures
929	Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC
949	Aftercare with CC/MCC

In the descriptions above, CC stands for “Complications or Comorbidities”, and MCC stands for “Major Complications or Comorbidities”

Hospital Outpatient Facility Services

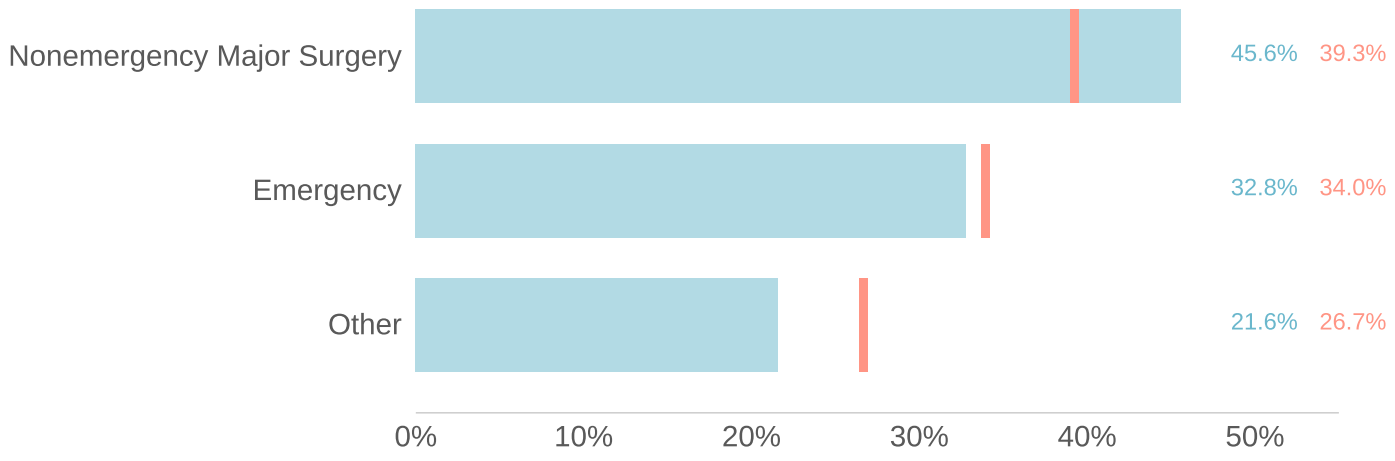
Hospital outpatient services are reported with several types of procedure codes. Data reporters are instructed to report the code that is consistent with the way the reimbursement was determined. Within hospital outpatient a visit is defined as any service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claim may have more than one visit.

Hospital outpatient visits can vary in nature and the level of reimbursement varies considerably by type of visit. A service is classified as “surgical” if it falls within the surgical category as defined by the AMA. A service is further classified as “major surgery” if it is not an injection and has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services (CMS), or the procedure involves spine/spinal cord neurostimulators. A hospital outpatient visit could be the result of an emergency visit and those visits are shown separately. Nonemergency outpatient visits are shown separately for those with and without major surgery services; those without a major surgery service are referred to as “All Other” outpatient visits.

This chart shows the breakdown of hospital outpatient visit types.

Payments by **Hospital Outpatient** Visit

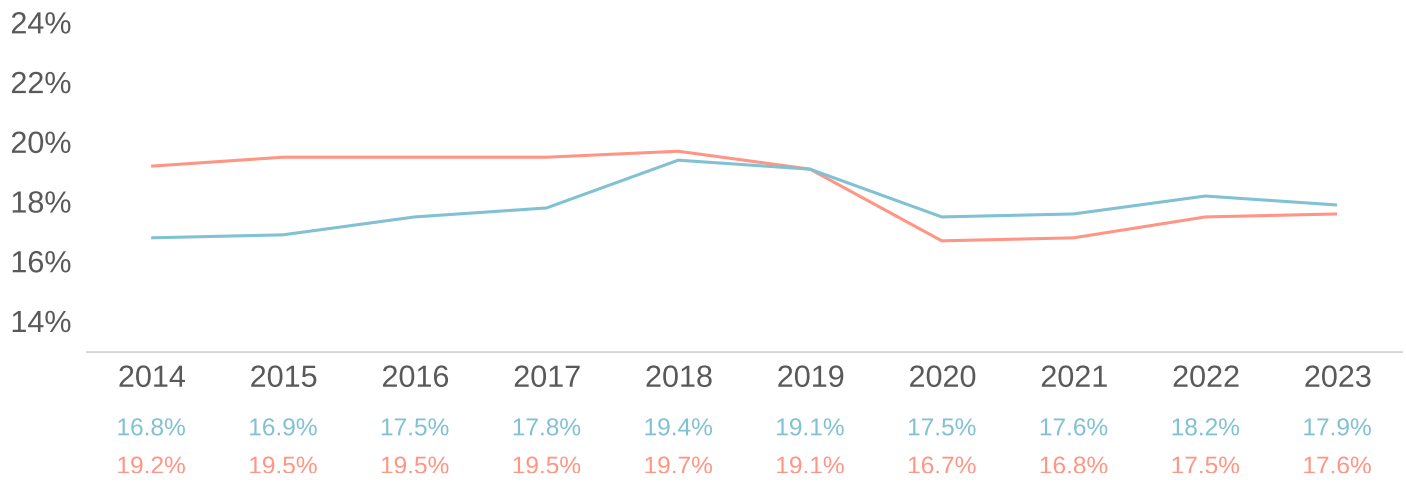
Base State vs Comparison States for Service Year 2023



This chart shows the count of active claims with one or more hospital outpatient visits receiving an emergency service divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Hospital Outpatient Emergency** Visit

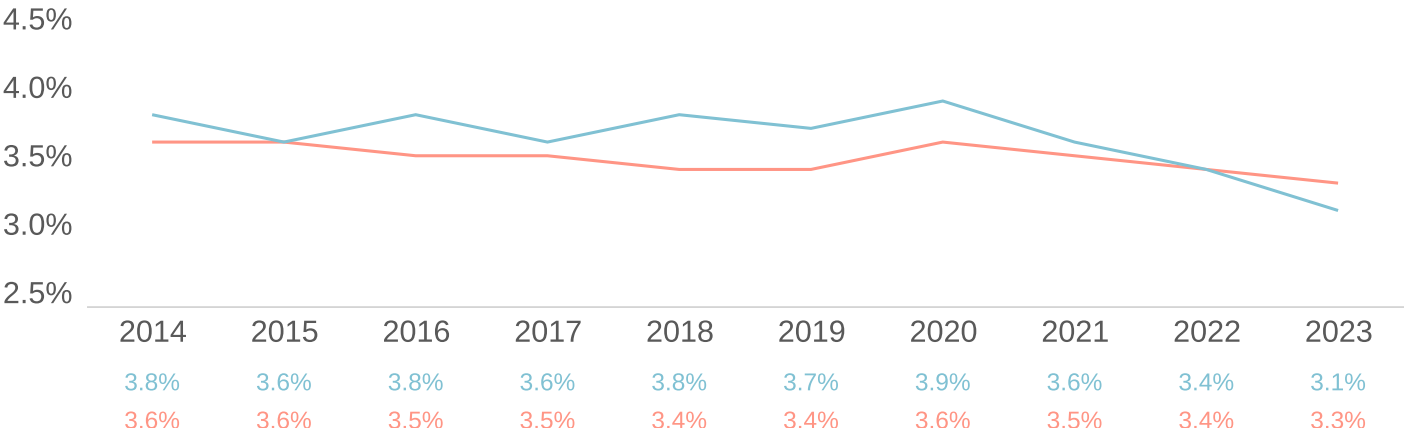
By Service Year for Base State vs Comparison States



This chart shows the count of active claims with one or more hospital outpatient visits receiving an nonemergency major surgery service divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Hospital Outpatient Nonemergency Major Surgery** Visit

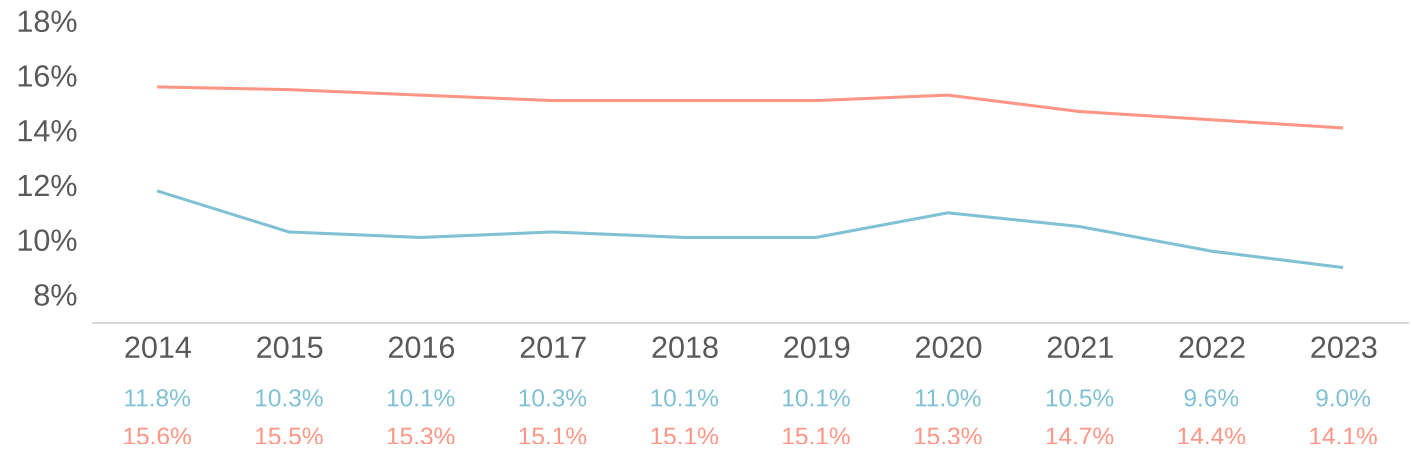
By Service Year for Base State vs Comparison States



This chart shows the count of active claims with one or more nonemergency hospital outpatient visits receiving an all other service divided by the count of all claims receiving a medical service.

Share of Total Claims With a **Hospital Outpatient All Other** Visit

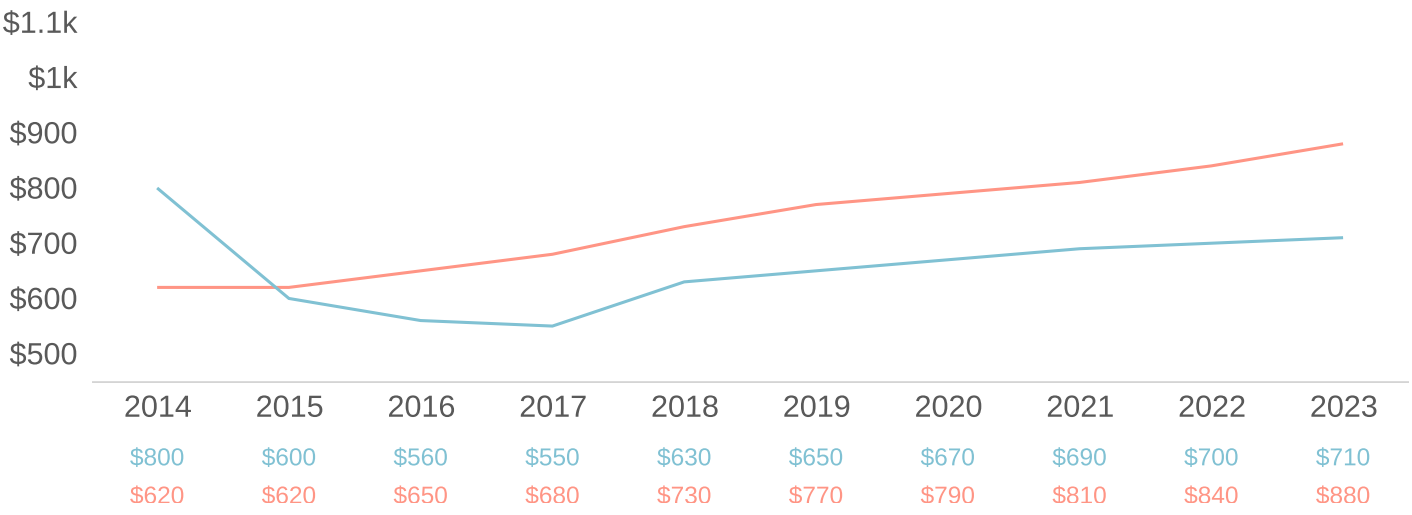
By Service Year for Base State vs Comparison States



This chart shows the median amount paid per emergency visit for outpatient services.

Hospital Outpatient Paid per Visit for **Emergency**

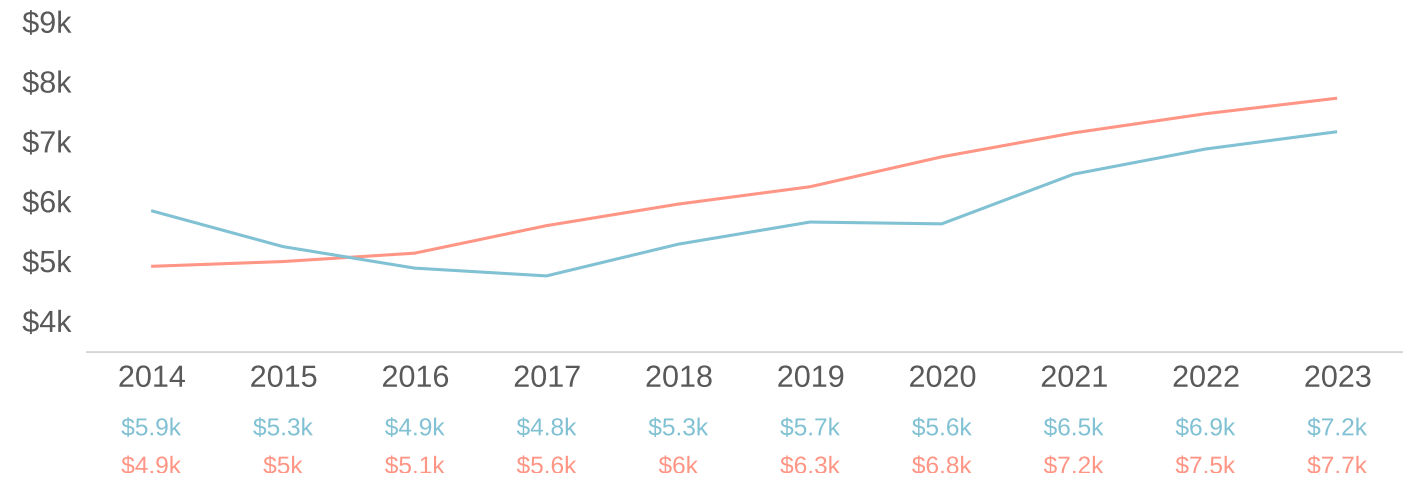
By Service Year for Base State vs Comparison States



This chart shows the median amount paid per nonemergency major surgery visit for outpatient services.

Hospital Outpatient Paid per Visit for **Nonemergency Major Surgery**

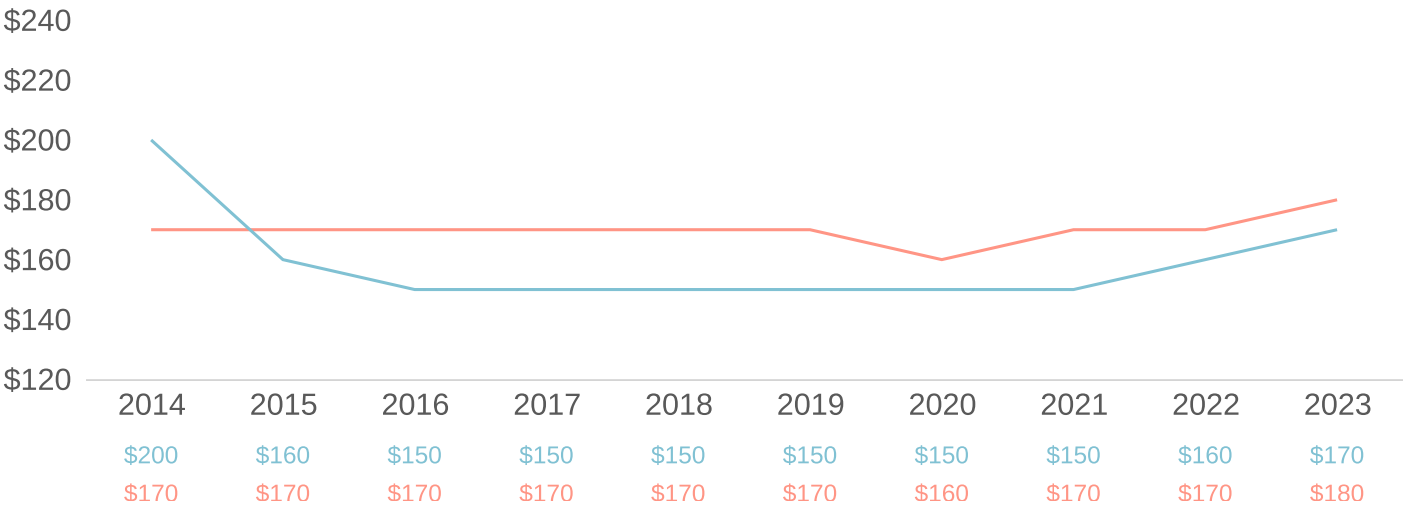
By Service Year for Base State vs Comparison States



This chart shows the median amount paid per all other visit for outpatient services.

Hospital Outpatient Paid per Visit for **All Other**

By Service Year for Base State vs Comparison States



If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by Current Procedural Terminology (CPT) or other Healthcare Common Procedure Coding System (HCPCS) codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Some payments are also reported by a specific Ambulatory Payment Classification (APC) code. An APC code represents a group of services provided by the facility on an outpatient basis.

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

Comparisons by procedure code for outpatient services should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions. Hospital outpatient facility services are grouped on a visit level. 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. The code shown for an outpatient visit is the code with the highest total paid for the outpatient visit. For outpatient codes, payments are evaluated per visit, and an average amount paid per visit is displayed.

The tables below provide detailed information on procedure codes and diagnoses—defined as those with 1 percent or more of total hospital outpatient emergency payments in the latest service year. Diagnoses are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Outpatient Emergency Top Diagnosis by Payments

Service Year 2023

Base State				Comparison States		
Diagnosis	Paid per Visit	% of Payments	% of Visits	Paid per Visit	% of Payments	% of Visits
Minor Hand/Wrist Injuries	$768	13.0%	17.9%	$1,043	12.2%	18.8%
Hand/Wrist Fracture	$1,552	7.0%	4.8%	$2,014	5.4%	4.3%
Head Injury (not otherwise classified)	$1,115	4.4%	4.2%	$2,092	4.5%	3.5%
Low Back Pain	$858	4.0%	5.0%	$1,493	4.5%	4.9%
Head/Face Wound	$1,089	3.6%	3.5%	$1,855	4.1%	3.6%
Neck Pain	$1,249	3.3%	2.8%	$2,414	4.1%	2.8%
Minor Ankle/Foot Injuries	$678	2.9%	4.6%	$1,010	3.0%	4.7%
Minor Knee Injury	$807	2.6%	3.5%	$1,115	2.5%	3.6%
Tibia Fibula Fracture	$2,720	2.4%	0.9%	$2,983	1.6%	0.9%
Minor Shoulder Injury	$814	2.3%	3.0%	$1,236	2.5%	3.3%
Total		**45.5%**	**50.2%**		**44.4%**	**50.4%**

Codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Outpatient Emergency Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Visit	% of Payments	% of Visits	Paid per Visit	% of Payments	% of Visits
99284	$1,093	28.0%	27.2%	$1,398	17.6%	20.3%
99283	$627	22.3%	37.8%	$860	19.1%	35.6%
99285	$1,934	11.7%	6.4%	$2,544	8.1%	5.1%
90375	$7,222	3.3%	0.5%	$10,181	1.3%	0.2%
74177	$2,994	2.9%	1.0%	$7,317	6.3%	1.4%
99282	$311	2.4%	8.2%	$483	2.5%	8.2%
G0390	$5,518	1.3%	0.3%	$9,609	0.8%	0.1%
99291	$2,716	1.2%	0.5%	$3,918	0.6%	0.2%
J0840	$24,383	1.1%	0.0%	$23,146	0.0%	0.0%
72125	$2,113	1.1%	0.6%	$4,596	5.6%	2.0%
Total		**75.3%**	**82.5%**		**61.9%**	**73.1%**

Code	Code Description
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
90375	Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use
74177	Computed tomography, abdomen and pelvis; with contrast material(s)
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
G0390	Trauma response team associated with hospital critical care service
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
J0840	Injection, crotalidae polyvalent immune fab (ovine), up to 1 g
72125	Computed tomography, cervical spine; without contrast material

The tables below provide detailed information on diagnoses and procedure codes—defined as those with 1 percent or more of total hospital outpatient nonemergency major surgery payments in the latest service year.

Diagnoses are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Outpatient Nonemergency Major Surgery Top Diagnosis by Payments

Service Year 2023

Base State				Comparison States		
Diagnosis	Paid per Visit	% of Payments	% of Visits	Paid per Visit	% of Payments	% of Visits
Rotator Cuff Tear	$10,949	13.1%	10.9%	$12,864	14.0%	11.2%
Hand/Wrist Fracture	$7,629	6.3%	7.4%	$8,084	5.8%	7.4%
Knee Degenerative/Overuse Injuries	$13,140	4.9%	3.4%	$13,622	3.1%	2.3%
Knee Internal Derangement - Meniscus Injury	$5,194	3.9%	6.9%	$7,149	5.4%	7.8%
Minor Shoulder Injury	$9,884	3.8%	3.4%	$10,968	4.2%	3.9%
Inguinal Hernia	$7,886	3.5%	4.0%	$10,260	4.6%	4.6%
Tibia Fibula Fracture	$11,649	3.4%	2.6%	$13,057	2.5%	1.9%
Ankle Fracture	$10,992	3.1%	2.5%	$11,530	2.6%	2.3%
Degenerative Shoulder	$12,820	3.0%	2.1%	$13,879	2.1%	1.5%
Knee Internal Derangement - Cruciate Ligament Tear	$12,147	2.5%	1.8%	$13,718	2.3%	1.7%
Total		**47.5%**	**45.0%**		**46.6%**	**44.6%**

Codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Outpatient Nonemergency Major Surgery Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Visit	% of Payments	% of Visits	Paid per Visit	% of Payments	% of Visits
29827	$11,132	8.4%	6.8%	$12,513	7.4%	6.1%
23472	$19,566	4.5%	2.1%	$19,564	2.5%	1.3%
27447	$16,291	3.5%	1.9%	$18,889	2.0%	1.1%
22551	$18,378	2.6%	1.3%	$19,494	1.8%	0.9%
23430	$9,469	2.5%	2.4%	$13,056	2.3%	1.8%
49650	$8,865	2.4%	2.4%	$11,081	2.9%	2.7%
29881	$5,169	2.3%	4.1%	$6,973	3.1%	4.5%
24342	$11,211	1.9%	1.5%	$11,361	1.8%	1.6%
25609	$11,024	1.9%	1.5%	$11,955	1.3%	1.2%
63030	$11,669	1.7%	1.4%	$13,571	1.7%	1.3%
Total		**31.7%**	**25.4%**		**26.8%**	**22.5%**

Code	Code Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
23430	Tenodesis of long tendon of biceps
49650	Laparoscopy, surgical; repair initial inguinal hernia
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

Nonemergency outpatient visits without a major surgery service are referred to as “All Other” outpatient visits. The tables below provide detailed information on diagnoses and procedure codes—defined as those with 1 percent or more of total hospital outpatient all other payments in the latest service year.

Diagnoses are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Outpatient All Other Top Diagnosis by Payments

Service Year 2023

Base State				Comparison States		
Diagnosis	Paid per Visit	% of Payments	% of Visits	Paid per Visit	% of Payments	% of Visits
Concussion/Minor Traumatic Brain Injury	$4,039	13.9%	1.5%	$461	1.5%	1.3%
Traumatic Brain Injury	$3,368	11.3%	1.5%	$2,229	2.9%	0.5%
Minor Hand/Wrist Injuries	$206	4.3%	9.3%	$288	5.2%	7.0%
Spinal Cord Injury	$2,545	3.6%	0.6%	$1,012	1.1%	0.4%
Minor Shoulder Injury	$198	3.2%	7.3%	$307	7.6%	9.7%
Lumbar Spine Degeneration	$843	2.8%	1.5%	$1,168	3.3%	1.1%
Low Back Pain	$267	2.5%	4.3%	$317	4.4%	5.4%
Chronic Pain	$565	2.4%	1.9%	$680	1.3%	0.8%
Minor Ankle/Foot Injuries	$253	2.3%	4.1%	$292	2.8%	3.8%
Minor Knee Injury	$192	2.1%	5.0%	$313	4.2%	5.2%
Total		**48.4%**	**37.0%**		**34.3%**	**35.2%**

Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Hospital Outpatient All Other Top Procedure Codes by Payments

Service Year 2023

Base State				Comparison States		
Code	Paid per Visit	% of Payments	% of Visits	Paid per Visit	% of Payments	% of Visits
97799	$8,950	27.0%	1.4%	$6,150	2.5%	0.2%
97110	$144	8.2%	25.4%	$202	19.1%	37.1%
G0463	$226	8.1%	16.1%	$222	2.1%	3.7%
97530	$172	2.2%	5.7%	$229	2.6%	4.5%
11042	$713	1.6%	1.0%	$850	1.0%	0.5%
64555	$12,879	1.3%	0.0%	$8,430	0.1%	0.0%
73721	$641	1.3%	0.9%	$1,085	3.5%	1.3%
73221	$601	1.2%	0.9%	$1,146	4.1%	1.4%
90675	$782	1.2%	0.7%	$916	0.3%	0.1%
64635	$2,554	1.1%	0.2%	$4,108	0.6%	0.1%
Total		**53.2%**	**52.3%**		**35.9%**	**48.9%**

Code	Code Description
97799	Unlisted physical medicine/rehabilitation service or procedure
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
G0463	Hospital outpatient clinic visit for assessment and management of a patient
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
90675	Rabies vaccine, for intramuscular use
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

Ambulatory Surgical Center Facility Services

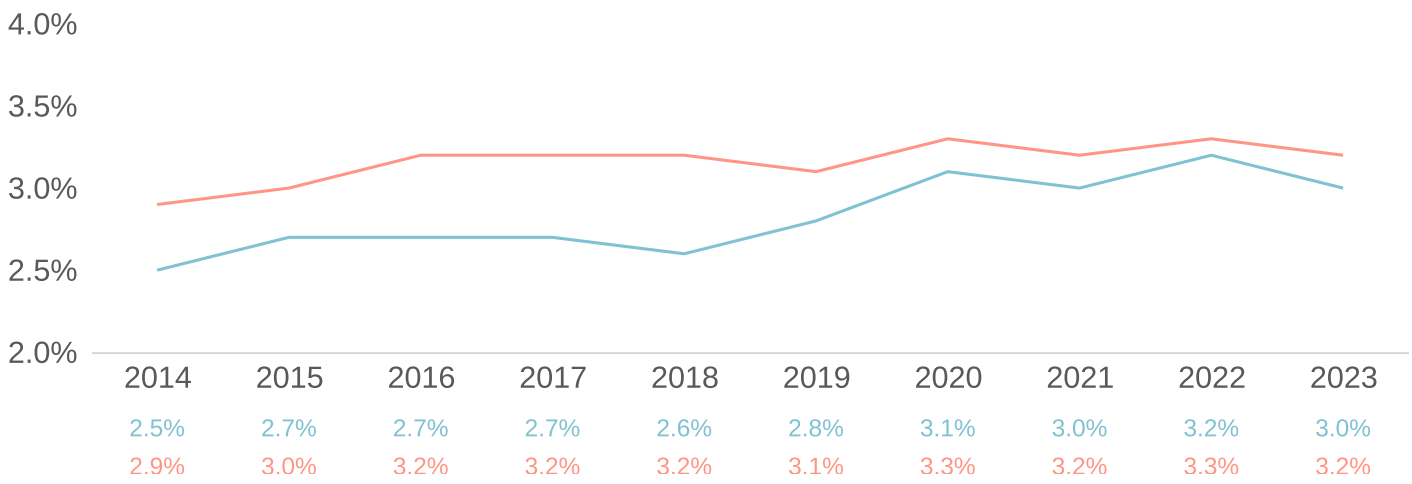
An Ambulatory Surgical Center (ASC) is often used as an alternative facility to a hospital for conducting outpatient surgeries.

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

This chart shows the count of active claims with one or more ASC visits receiving a major surgery service divided by the count of all claims receiving a medical service.

Share of Total Claims With an **Ambulatory Surgical Center Major Surgery** Visit

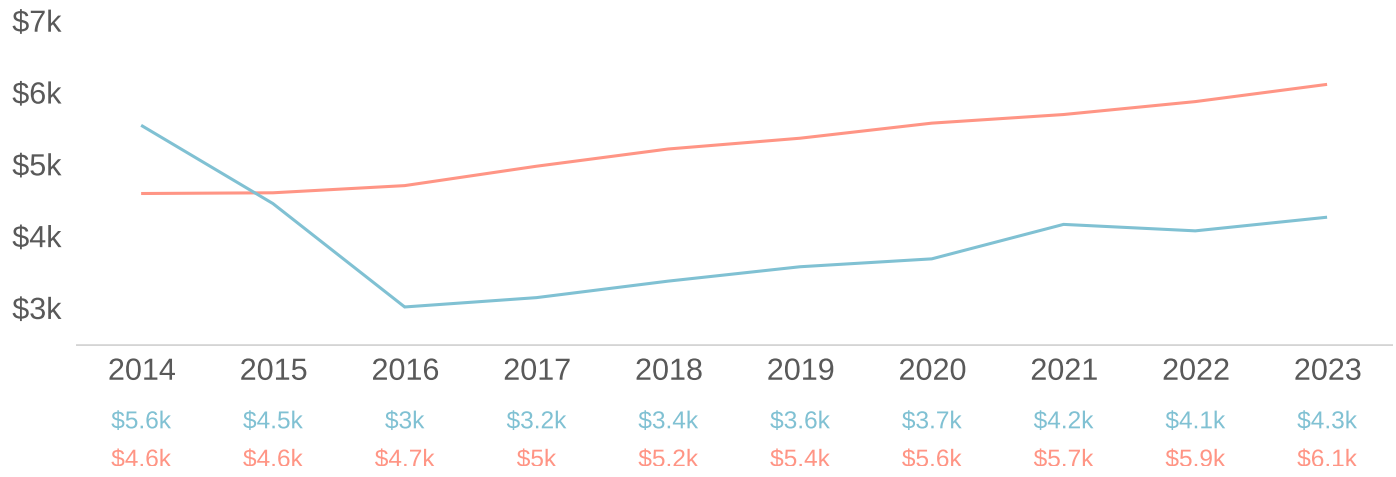
By Service Year for Base State vs Comparison States



This chart shows the median amount paid per major surgery visit for ASC services.

Ambulatory Surgical Center Major Surgery Paid per Visit

By Service Year for Base State vs Comparison States



Comparisons by procedure code for ASC services should be interpreted with caution due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions. ASC facility services are grouped on a visit level. 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. The code shown for an ASC visit is the code with the highest total paid for the ASC visit. For ASC codes, payments are evaluated per visit, and an average amount paid per visit is displayed.

The tables below provide detailed information on diagnoses and procedure codes—defined as those with 1 percent or more of total ASC payments in the latest service year.

Diagnoses are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Ambulatory Surgical Center Top Diagnosis by Payments

Service Year 2023

Base State				Comparison States		
Diagnosis	Paid per Visit	% of Payments	% of Visits	Paid per Visit	% of Payments	% of Visits
Rotator Cuff Tear	$7,875	17.7%	12.1%	$12,522	18.2%	9.4%
Hand/Wrist Fracture	$4,883	5.8%	6.4%	$6,632	5.0%	4.9%
Knee Internal Derangement - Meniscus Injury	$3,163	5.4%	9.2%	$5,112	5.6%	7.0%
Minor Shoulder Injury	$6,319	4.5%	3.9%	$9,430	5.3%	3.6%
Degenerative Shoulder	$5,988	4.1%	3.7%	$11,238	2.2%	1.2%
Chronic Pain	$37,009	3.6%	0.5%	$27,575	2.7%	0.6%
Knee Degenerative/Overuse Injuries	$7,621	3.1%	2.2%	$11,649	2.4%	1.4%
Knee Internal Derangement - Cruciate Ligament Tear	$8,536	2.6%	1.6%	$10,618	2.4%	1.4%
Other joint disorder, not elsewhere classified	$8,352	2.4%	1.6%	$10,064	1.3%	0.9%
Ankle Fracture	$9,268	2.4%	1.4%	$9,928	1.2%	0.8%
Total		**51.6%**	**42.6%**		**46.3%**	**31.2%**

Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state. This chart includes two additional fields, which allow for comparison between procedures performed at an ASC relative to the same procedure performed in an outpatient setting. “HOP Paid per Visit” displays the average amount paid per visit when the procedure is performed in an outpatient setting. “ASC Visit Share” displays the share of all visits (combined across ASC and outpatient) that are performed in an ASC setting.

Ambulatory Surgical Center Top Procedure Codes by Payments

Service Year 2023

Base State						Comparison States				
Code	ASC Paid per Visit	HOP Paid per Visit	ASC Visit Share	% of Payments	% of Visits	ASC Paid per Visit	HOP Paid per Visit	ASC Visit Share	% of Payments	% of Visits
29827	$7,876	$11,132	61%	14.1%	9.6%	$12,526	$12,513	64%	14.3%	7.3%
23430	$9,986	$9,469	60%	6.0%	3.2%	$12,307	$13,056	57%	3.1%	1.6%
63685	$52,141	$26,084	77%	3.9%	0.4%	$44,144	$28,132	65%	2.5%	0.4%
29828	$7,635	$10,149	70%	3.4%	2.4%	$13,629	$11,940	73%	2.8%	1.3%
29881	$2,749	$5,169	63%	3.3%	6.4%	$4,633	$6,973	59%	3.2%	4.5%
29888	$8,936	$11,348	64%	2.9%	1.8%	$11,055	$13,369	62%	2.5%	1.5%
24342	$5,548	$11,211	63%	2.5%	2.4%	$7,183	$11,361	62%	1.9%	1.7%
25609	$7,986	$11,024	52%	2.3%	1.5%	$9,319	$11,955	53%	1.3%	0.9%
27447	$15,718	$16,291	30%	2.2%	0.8%	$22,722	$18,889	35%	1.4%	0.4%
27698	$12,203	$11,691	79%	2.1%	0.9%	$11,177	$11,795	62%	0.8%	0.4%
Total				**42.7%**	**29.4%**				**33.8%**	**20.0%**

Code	Code Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23430	Tenodesis of long tendon of biceps
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
29828	Arthroscopy, shoulder, surgical; biceps tenodesis
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
25609	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
27698	Repair, secondary, disrupted ligament, ankle, collateral (eg, Watson-Jones procedure)

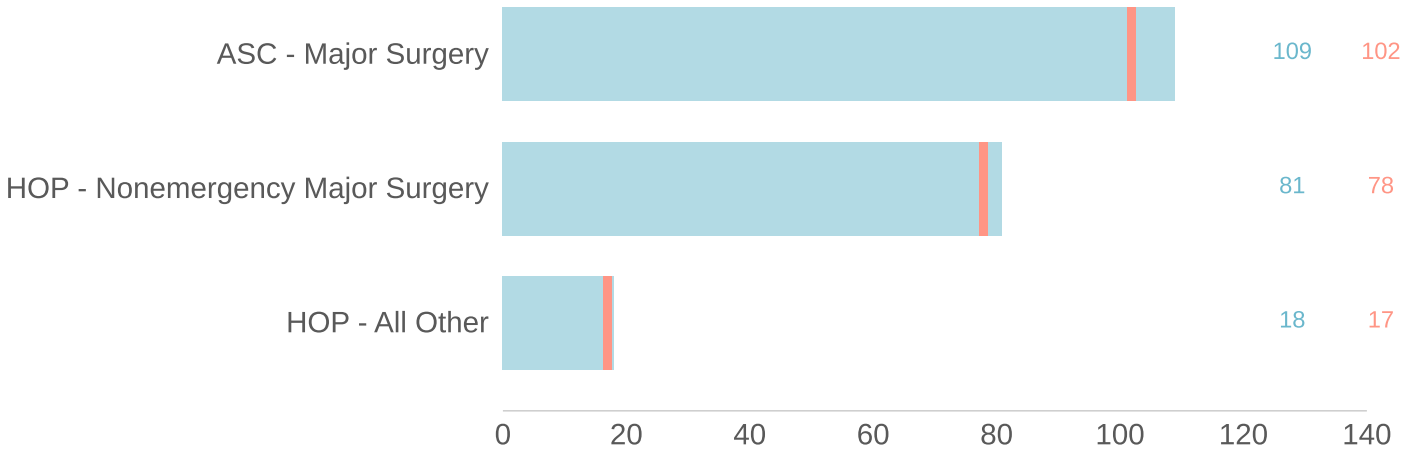
Time Until First Treatment—Facilities

Time Until First Treatment 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 the worker first received medical services. Services are limited to those occurring through year-end 2023.

The chart below shows the median Time Until First Treatment by facility visit type.

Time Until First Treatment by Facility Visit

Base State vs Comparison States for Accident Year 2022



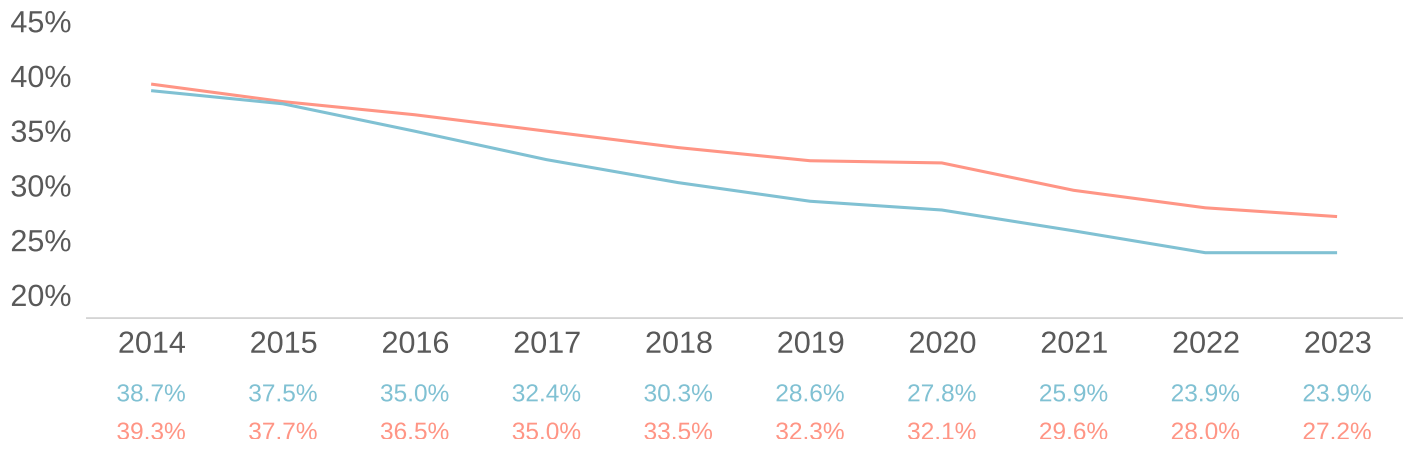
Prescription Drugs

Prescription drugs are uniquely identified by a national drug code (NDC). Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, Healthcare Common Procedure Coding System (HCPCS) codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

This chart shows the count of active claims receiving one or more prescription drugs.

Share of Total Claims With a **Prescription Drug**

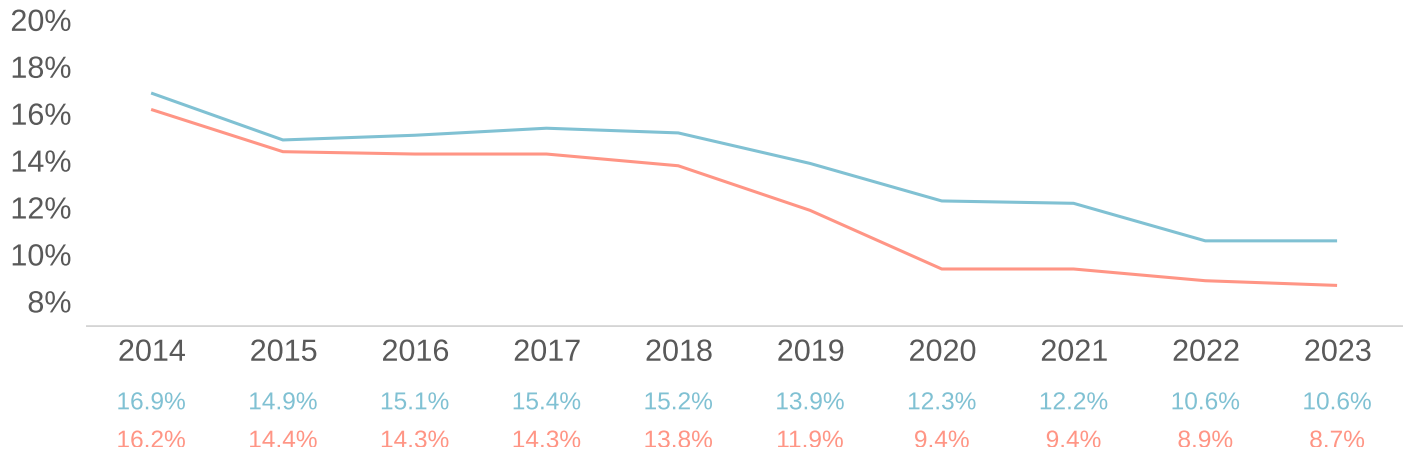
By Service Year for Base State vs Comparison States



In many states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand name and generic drugs. These charts show the count of brand name prescriptions divided by the total number of prescriptions.

Share of **Brand** Prescriptions to Total Prescriptions

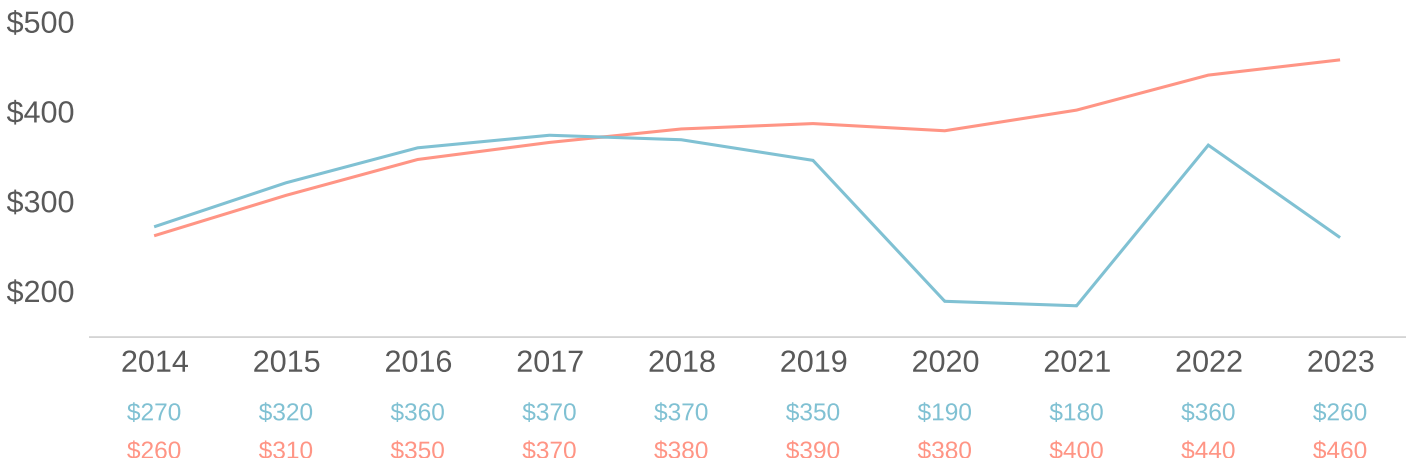
By Service Year for Base State vs Comparison States



These charts show the median prescription drug payment by brand name and generic.

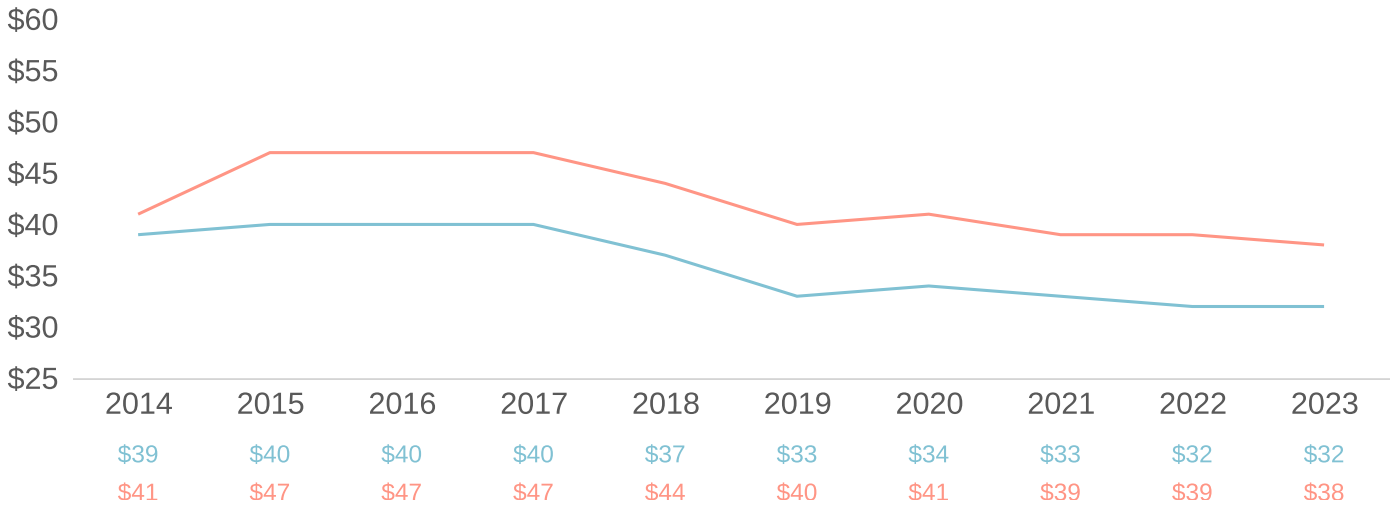
Brand Paid per Prescription

By Service Year for Base State vs Comparison States



Generic Paid per Prescription

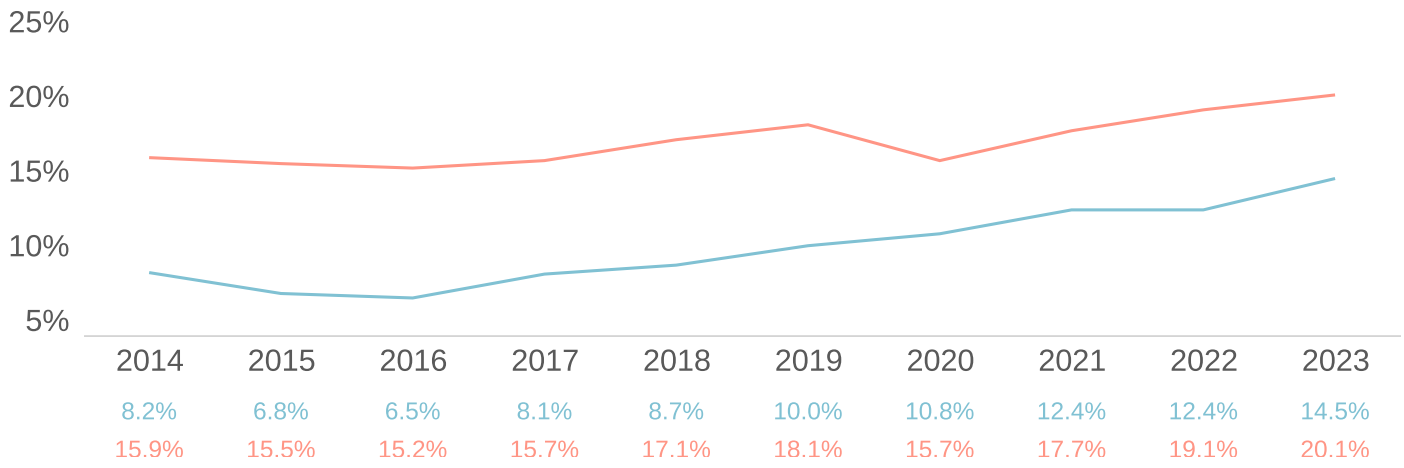
By Service Year for Base State vs Comparison States



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. These charts show the count of nonpharmacy (e.g., physicians and hospitals) prescriptions divided by the total number of prescriptions.

Share of **Nonpharmacy** Prescriptions to Total Prescriptions

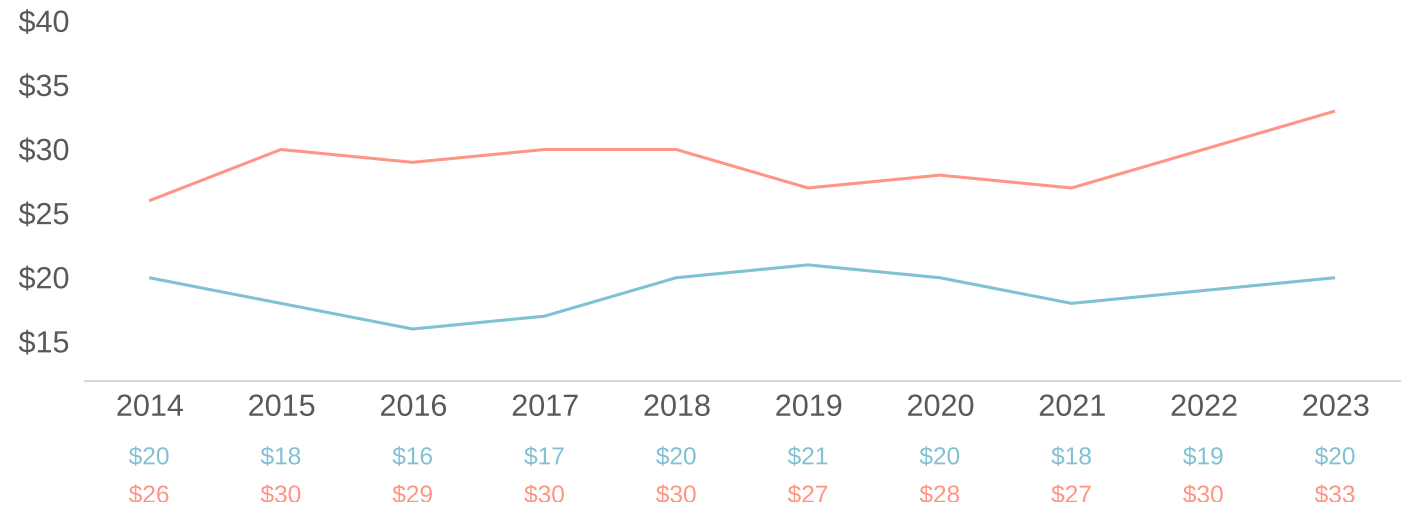
By Service Year for Base State vs Comparison States



These charts show the median prescription drug payment by pharmacy and non-pharmacy.

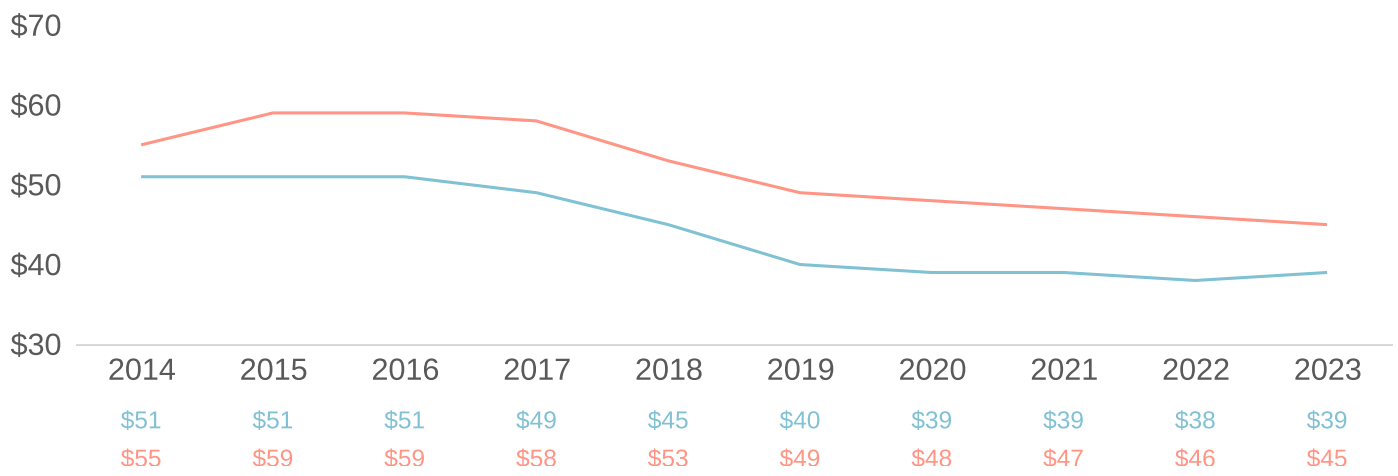
Nonpharmacy Paid per Prescription

By Service Year for Base State vs Comparison States



Pharmacy Paid per Prescription

By Service Year for Base State vs Comparison States



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Base State	$51	$51	$51	$49	$45	$40	$39	$39	$38	$39
Comparison States	$55	$59	$59	$58	$53	$49	$48	$47	$46	$45

The table provides detailed information on prescription drugs—defined as those with 1 percent or more of total prescription drug payments in the latest service year. Procedure codes are sorted from highest total payments to lowest total payments, up to a maximum of 10, for the selected base state.

Top **Prescription Drugs** by Payments

Service Year 2023

Base State							Comparison States		
Drug Name	Brand/ Generic	Common Brand Name	Opioid	Paid per Unit	% of Payments	% of Prescriptions	Paid per Unit	% of Payments	% of Prescriptions
Hemlibra®	brand		N	$17,760.85	7.0%	0.0%	$17,760.85	0.2%	0.0%
Pregabalin	generic	Lyrica®	N	$4.10	4.9%	2.3%	$4.77	5.8%	2.7%
Meloxicam	generic	Mobic®	N	$2.50	3.7%	6.5%	$3.14	3.4%	4.9%
Nucynta®	brand		Y	$13.26	3.3%	0.4%	$12.08	0.9%	0.2%
Diclofenac Sodium (3% Gel)	generic	Solaraze®	N	$8.53	3.3%	0.5%	$9.67	3.3%	0.4%
Gabapentin	generic	Neurontin®	N	$0.67	3.0%	6.8%	$0.93	3.2%	6.0%
Lidocaine	generic	Lidoderm®	N	$5.06	2.8%	2.1%	$7.06	4.4%	2.4%
Nurtec ODT®	brand		N	$120.73	2.5%	0.2%	$125.60	1.0%	0.1%
Cyclobenzaprine HCl	generic	Flexeril®	N	$1.62	2.2%	4.9%	$2.11	2.8%	5.5%
Diclofenac Sodium (NSAID)	generic	Voltaren®	N	$0.80	2.1%	3.7%	$1.91	4.1%	3.5%
Total					**34.8%**	**27.4%**		**29.1%**	**25.7%**

Drug Name	Category
Hemlibra®	Coagulants & Anticoagulants
Pregabalin	Miscellaneous CNS Agents
Meloxicam	Analgesics/Antipyretics
Nucynta®	Analgesics/Antipyretics
Diclofenac Sodium (3% Gel)	Skin/Mucous Membrane Ag.,Misc.
Gabapentin	Anticonvulsants
Lidocaine	Antipruritics/Local Anest.,S/M
Nurtec ODT®	Miscellaneous CNS Agents
Cyclobenzaprine HCl	Muscle Relaxants, Skeletal
Diclofenac Sodium (NSAID)	Analgesics/Antipyretics

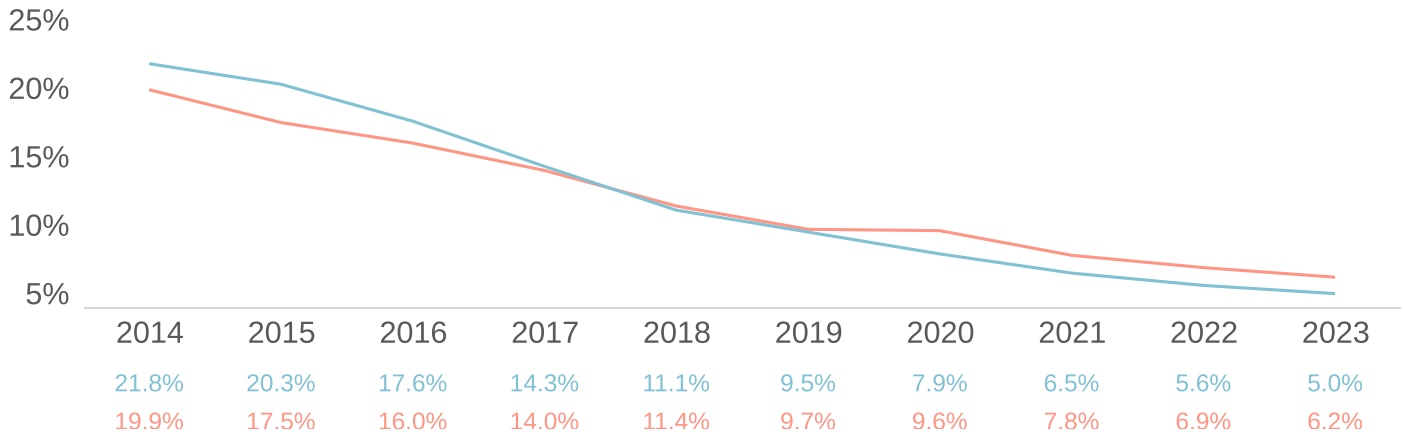
Prescription Drugs—Opioid Prescriptions

There can be a multitude of medications prescribed during an injured worker's path to recovery from a workplace injury. Opioids are one type of drug used to treat moderate to severe pain—often when pain is chronic and troublesome.

This chart shows the count of active claims receiving one or more opioid prescriptions divided by the count of all claims receiving a medical service.

Share of Total Claims With an **Opioid**

By Service Year for Base State vs Comparison States



Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

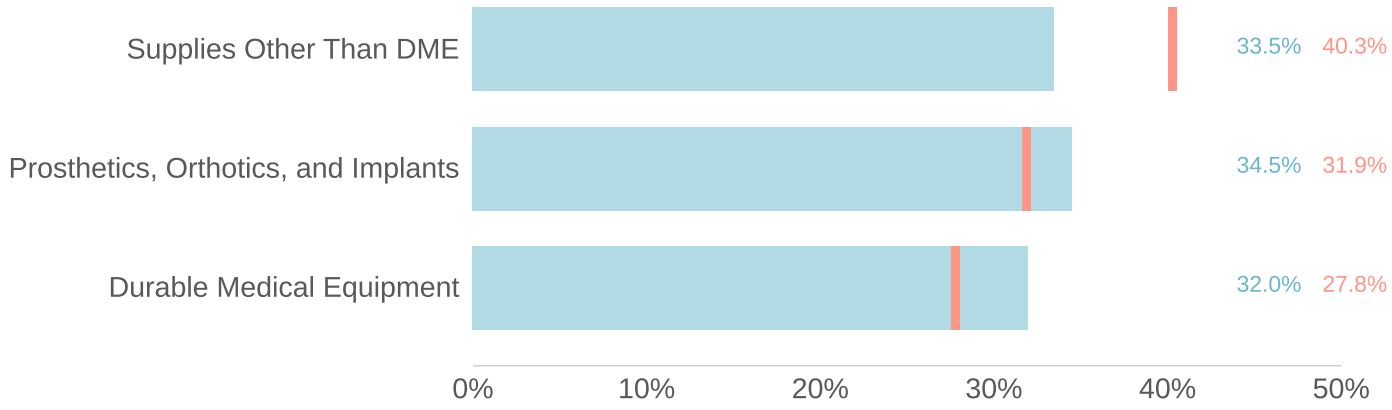
This chart displays the distribution of payments among three separate DMEPOS categories:

- 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.

Distribution of Payments by DMEPOS

Base State vs Comparison States for Service Year 2023

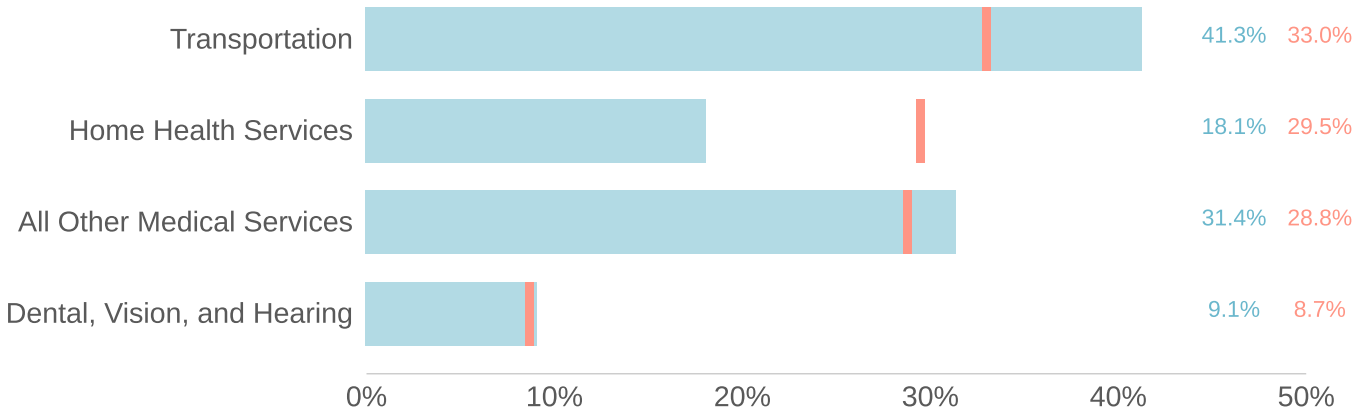


Other Medical Services

The chart below shows the breakdown of Other Medical Services into four categories: transportation, home health services, dental/vision/hearing, and all other. The “All Other” category typically includes services that may have a missing, invalid, or unlisted procedure, in addition to some other valid services (e.g., payments for interpreters, vehicle modifications, etc.).

Payments by Other Medical Services

Base State vs Comparison States for Service Year 2023



Glossary

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

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.

Claim: In this context, *claim* refers to an active workers compensation claim for the specified data subset, or a workers compensation claim receiving at least one service in the time period referenced. *Total claims* refers to all active claims for the time period referenced.

Claim Age: Also known as claim maturity, is calculated as the length of time, in years, between the accident date and the date on which the medical service is provided.

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

Diagnosis Related Group (DRG): 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.

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

Durable Medical Equipment (DME): Equipment that primarily and customarily serves a medical purpose, can withstand repeated use, can 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.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS): This includes DME, in addition to prosthetics, orthotics, and supplies.

Emergency Services: Services performed for patients requiring immediate attention.

Facilities: A hospital inpatient, hospital outpatient or ASC setting.

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

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

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

Median: The median is the data value where one-half of all data values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values.

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.

Morphine Milligram Equivalents (MME): The Centers for Disease Control and Prevention provides a way to convert daily—or hourly—doses of opioids to an equivalent daily dose of morphine by assigning a conversion factor to each type of drug.

Paid Amount: The amount on the bill line paid by the coverage provider for the medical service.

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

Service Year: A loss accounting definition where experience is summarized by the calendar year when a medical service is provided. For hospital inpatient stays, the service year for the entire stay is determined based on the year in which the discharge from the hospital occurs.

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

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

Time Until First Treatment: The amount of time, measured in days, between the date an accident occurs and the date 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**.