Medical Data Report

For the state of

South Dakota

September 2024

Medical Data Report–South Dakota

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Medical Data Report–South Dakota

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 South Dakota (displayed as Base State) in Service Year 2023, this represents data from 97% 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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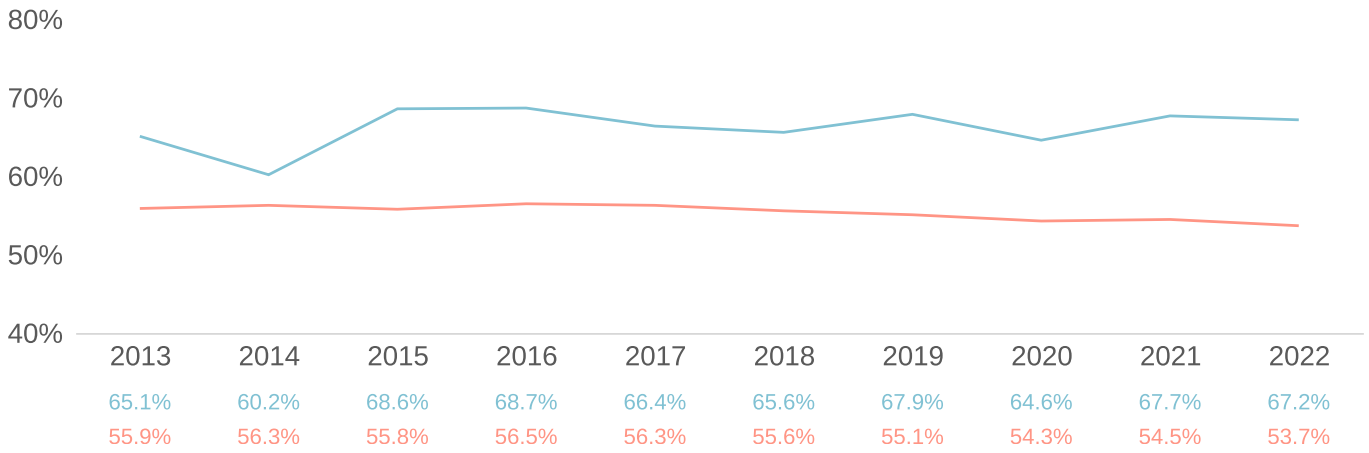
Overview

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

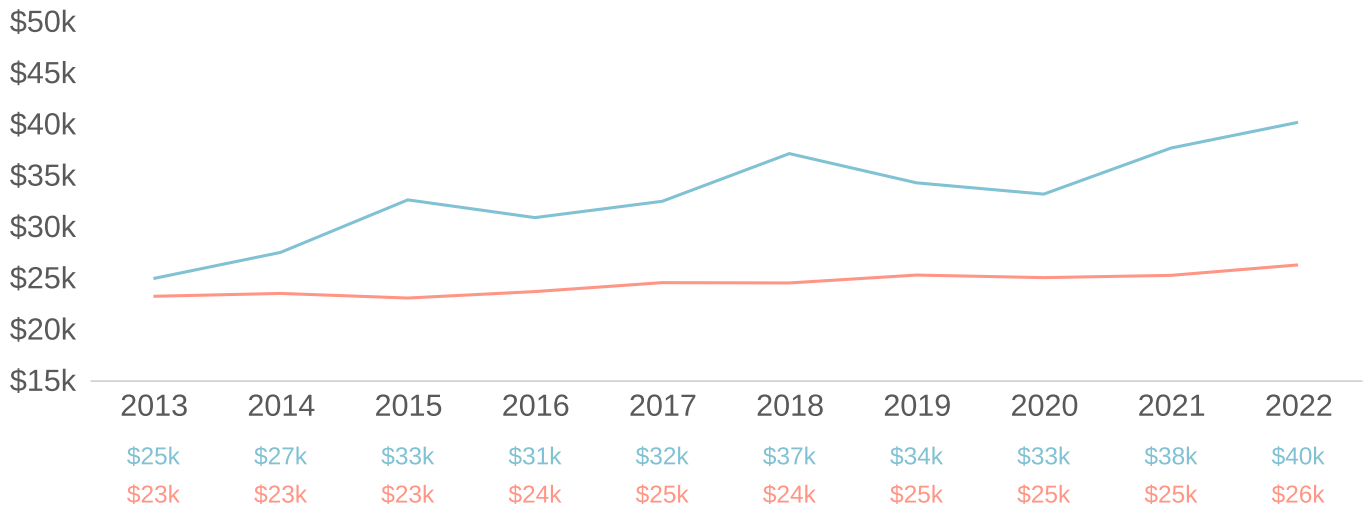


Source: NCCI's Calendar-Accident Year Call for Compensation Experience. MI data is provided by the Compensation Advisory Organization of Michigan. MN data provided by the Minnesota Workers' Compensation Insurers Association.

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	$11,996	20.2%	8.6%	$10,232	18.2%	8.9%
Hand/Wrist	$2,678	12.8%	24.6%	$2,842	13.3%	23.3%
Knee	$6,371	8.5%	6.8%	$5,971	8.8%	7.3%
Head	$6,487	8.0%	6.4%	$3,856	4.7%	6.0%
Nervous System	$91,350	6.2%	0.4%	$24,087	1.6%	0.3%
Leg	$7,373	6.0%	4.2%	$6,535	5.6%	4.3%
Lumbar Spine	$2,877	5.4%	9.7%	$4,915	10.4%	10.5%
Ankle/Foot	$2,788	4.5%	8.3%	$3,874	7.4%	9.5%
Neck	$4,478	3.7%	4.2%	$6,924	4.7%	3.4%
Hip/Pelvis	$13,862	3.6%	1.4%	$11,584	2.9%	1.2%
Total		**78.9%**	**74.6%**		**77.6%**	**74.7%**

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
Rotator Cuff Tear	$31,352	10.3%	1.7%	$24,234	7.8%	1.6%
Minor Shoulder Injury	$4,852	5.2%	5.5%	$5,415	6.7%	6.2%
Hand/Wrist Fracture	$8,276	4.8%	3.0%	$7,809	4.2%	2.7%
Injury of nerves and spinal cord at neck level	$1,153,455	4.8%	0.0%	$148,486	0.3%	0.0%
Tibia Fibula Fracture	$44,008	4.5%	0.5%	$31,586	3.0%	0.5%
Traumatic Brain Injury	$158,064	4.3%	0.1%	$68,809	1.7%	0.1%
Minor Hand/Wrist Injuries	$1,070	3.8%	18.4%	$1,591	5.6%	17.6%
Hip/Pelvis Fracture/Major Trauma	$87,672	3.6%	0.2%	$49,027	2.2%	0.2%
Knee Internal Derangement - Meniscus Injury	$11,866	2.8%	1.2%	$14,264	2.9%	1.0%
Low Back Pain	$1,892	2.1%	5.8%	$2,765	4.7%	8.4%
Total		**46.2%**	**36.4%**		**39.1%**	**38.3%**

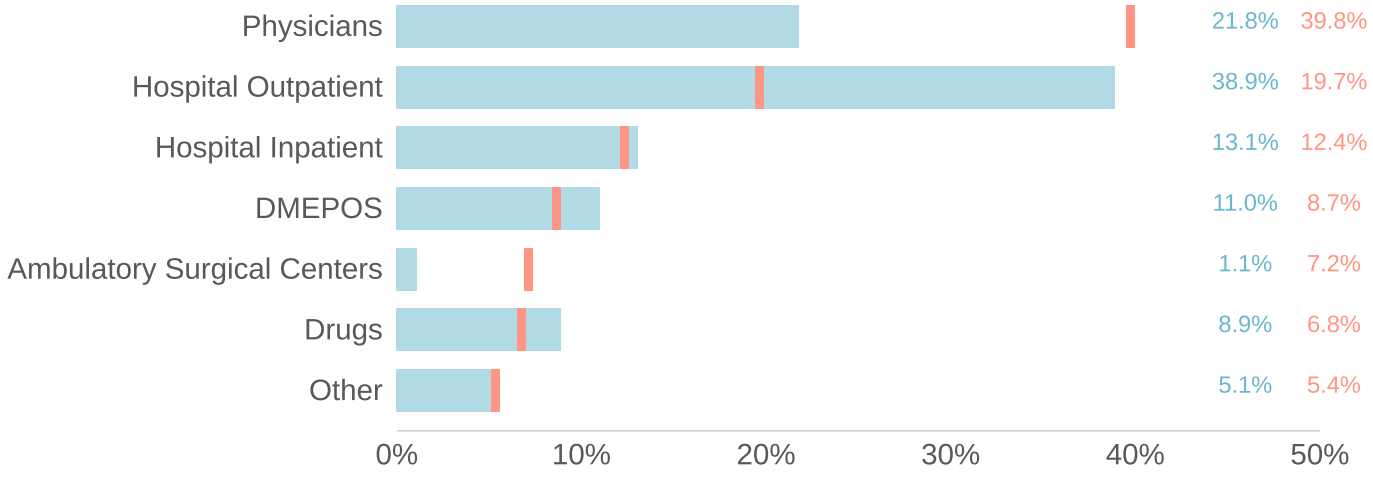
Payments categorized as Drugs; Durable Medical Equipment, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services) are based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service 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

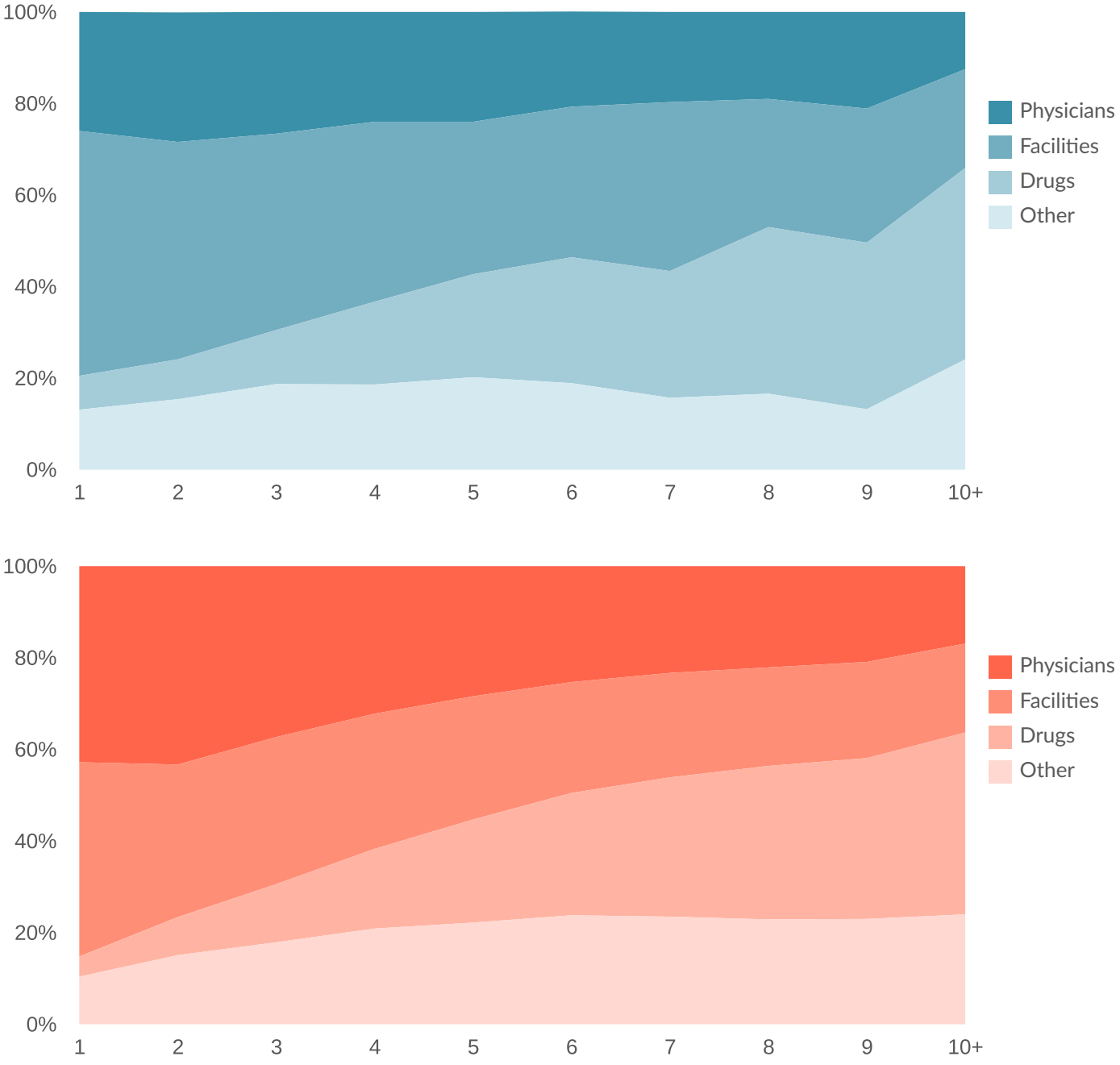
Base State vs Comparison States for Service Year 2023



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	291%	303%
Evaluation and Management	98%	145%
Physical and General Medicine	111%	138%
Surgery	204%	263%
Radiology	220%	231%
All Physician Services	**138%**	**167%**

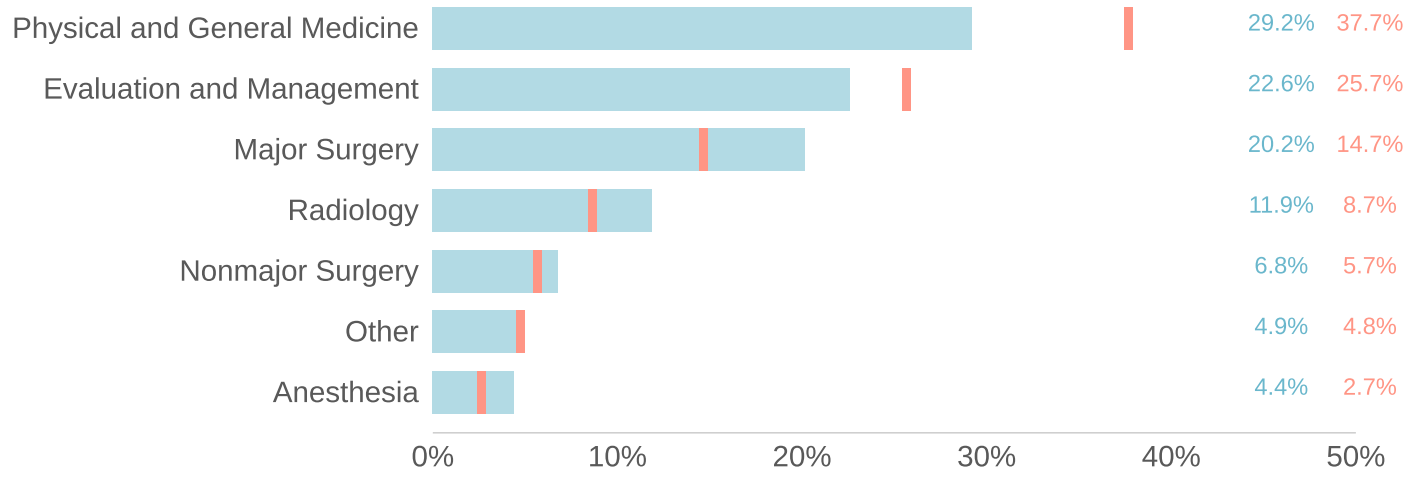
Physicians typically use Current Procedural Terminology (CPT) codes to identify the services that they provide to injured workers. These codes are specific and provide detailed information on what service was performed. The primary paid procedure code determines the physician service category.

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

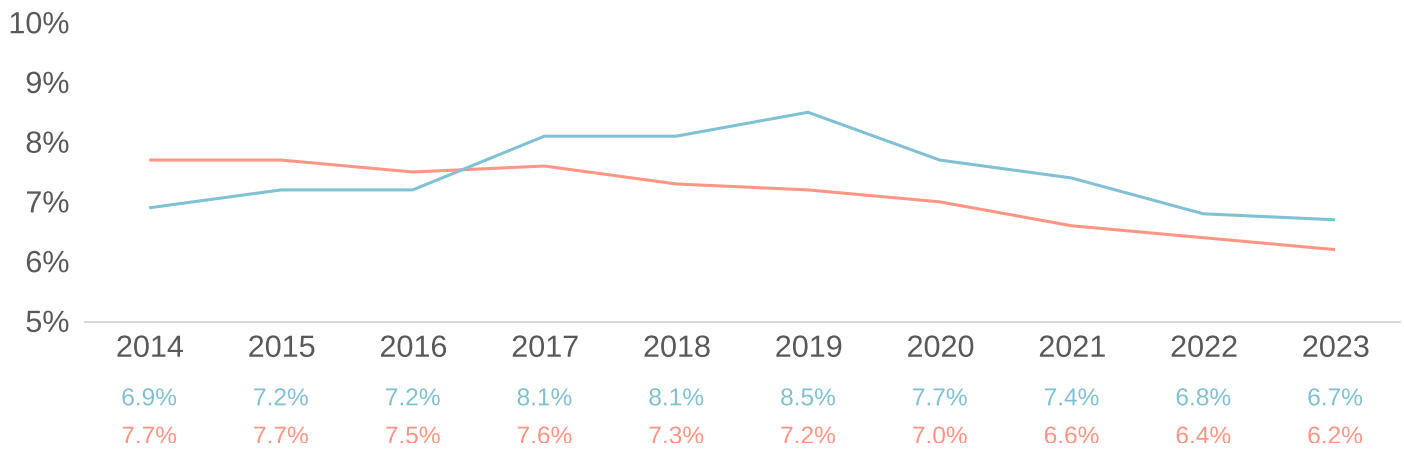


Physicians—Anesthesia

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
01630	$54	17.5%	16.4%	$86	17.7%	15.0%
01830	$53	10.6%	11.1%	$74	7.6%	9.0%
01400	$58	8.8%	10.4%	$89	8.9%	10.4%
01480	$47	6.6%	7.7%	$67	6.3%	6.5%
01810	$61	6.1%	9.1%	$85	6.3%	8.5%
01638	$90	3.8%	1.8%	$102	1.8%	1.0%
01740	$72	3.5%	1.9%	$69	1.4%	1.2%
01952	$127	3.4%	1.2%	$65	0.5%	0.4%
00630	$77	3.2%	2.3%	$100	2.8%	1.8%
00670	$70	3.1%	1.4%	$96	7.8%	3.3%
Total		**66.6%**	**63.3%**		**61.1%**	**57.1%**

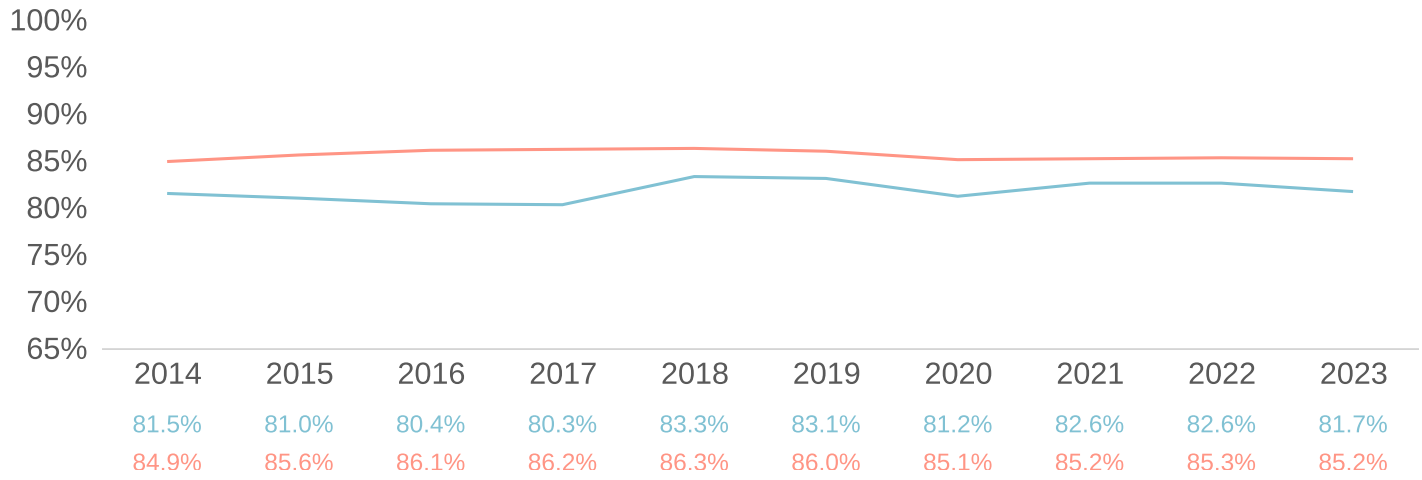
Code	Code Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
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
01638	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; total shoulder replacement
01740	Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified
01952	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between 4% and 9% of total body surface area
00630	Anesthesia for procedures in lumbar region; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)

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	$71	27.2%	41.3%	$124	29.7%	39.8%
99214	$109	15.3%	15.1%	$173	22.2%	21.3%
99203	$109	11.9%	11.8%	$162	10.3%	10.6%
99204	$155	7.3%	5.1%	$241	13.0%	9.0%
99455	$465	6.3%	1.5%	$200	2.2%	1.8%
99456	$694	5.0%	0.8%	$752	4.2%	0.9%
99284	$229	4.7%	2.2%	$262	3.6%	2.3%
99212	$45	3.9%	9.3%	$77	1.7%	3.7%
99283	$172	2.8%	1.8%	$195	1.5%	1.3%
99285	$375	2.8%	0.8%	$417	1.4%	0.6%
Total		**87.2%**	**89.7%**		**89.8%**	**91.3%**

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.
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.
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.
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.
99456	Work related or medical disability examination by other than 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
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.
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

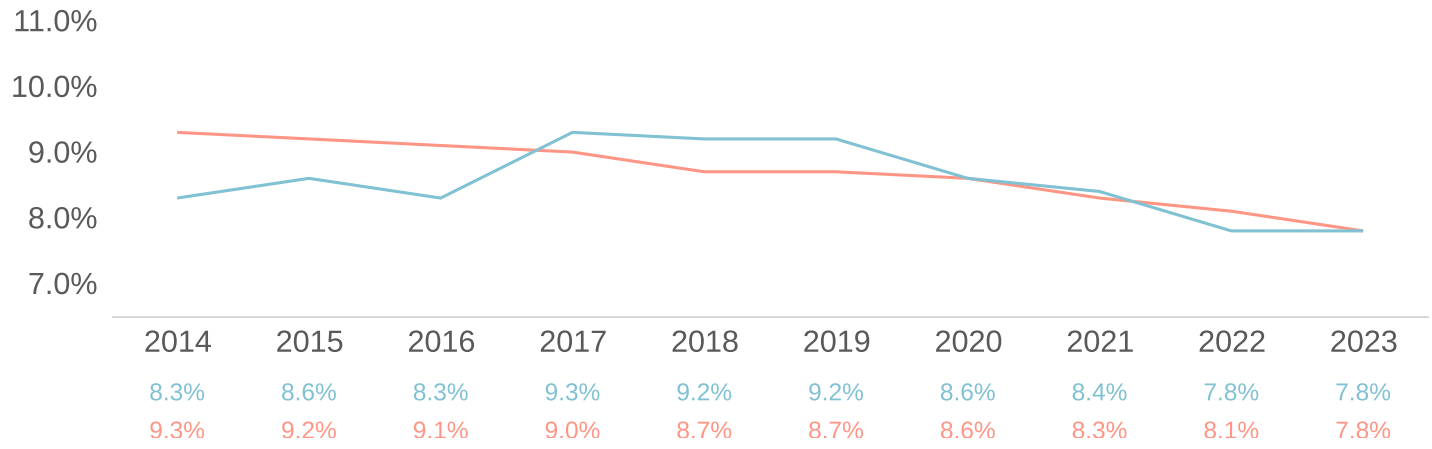
Physicians—Major Surgery

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	$1,529	12.0%	8.2%	$2,214	11.1%	7.2%
29826	$776	6.4%	8.6%	$889	4.4%	7.1%
23472	$2,842	4.1%	1.5%	$2,896	1.6%	0.8%
29881	$1,340	3.4%	2.7%	$1,388	3.3%	3.4%
29888	$2,559	3.2%	1.3%	$2,098	2.0%	1.4%
63030	$1,790	2.6%	1.5%	$2,344	1.3%	0.8%
29828	$653	2.5%	4.0%	$1,235	2.4%	2.7%
64721	$1,009	2.2%	2.3%	$1,100	1.3%	1.7%
27447	$3,180	2.1%	0.7%	$2,801	1.4%	0.7%
29824	$455	2.0%	4.6%	$814	1.8%	3.2%
Total		**40.5%**	**35.4%**		**30.6%**	**29.0%**

Code	Code Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
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
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
29828	Arthroscopy, shoulder, surgical; biceps tenodesis
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)

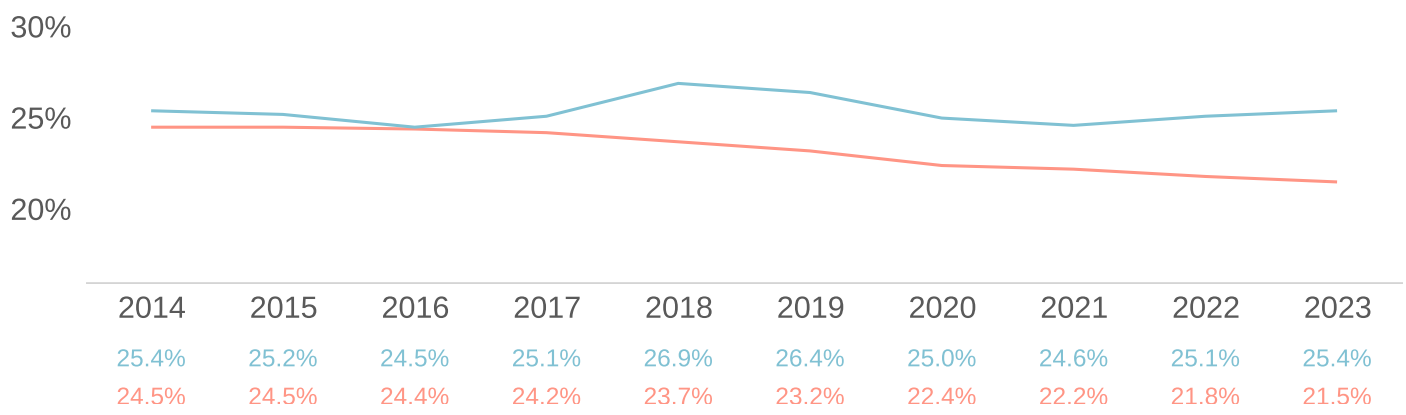
Physicians—Nonmajor Surgery

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
12001	$129	8.5%	10.0%	$167	4.5%	7.1%
64415	$256	6.0%	3.5%	$249	3.7%	3.9%
12002	$176	4.4%	3.8%	$196	2.6%	3.5%
20610	$60	3.8%	9.6%	$127	5.1%	10.5%
64635	$586	3.7%	1.0%	$986	2.6%	0.7%
64483	$260	3.5%	2.0%	$558	5.8%	2.8%
62323	$291	3.0%	1.6%	$511	2.6%	1.4%
11012	$875	2.7%	0.5%	$796	1.9%	0.6%
64493	$315	2.7%	1.3%	$540	3.0%	1.4%
20553	$177	2.5%	2.1%	$128	0.5%	1.0%
Total		**40.8%**	**35.4%**		**32.3%**	**32.9%**

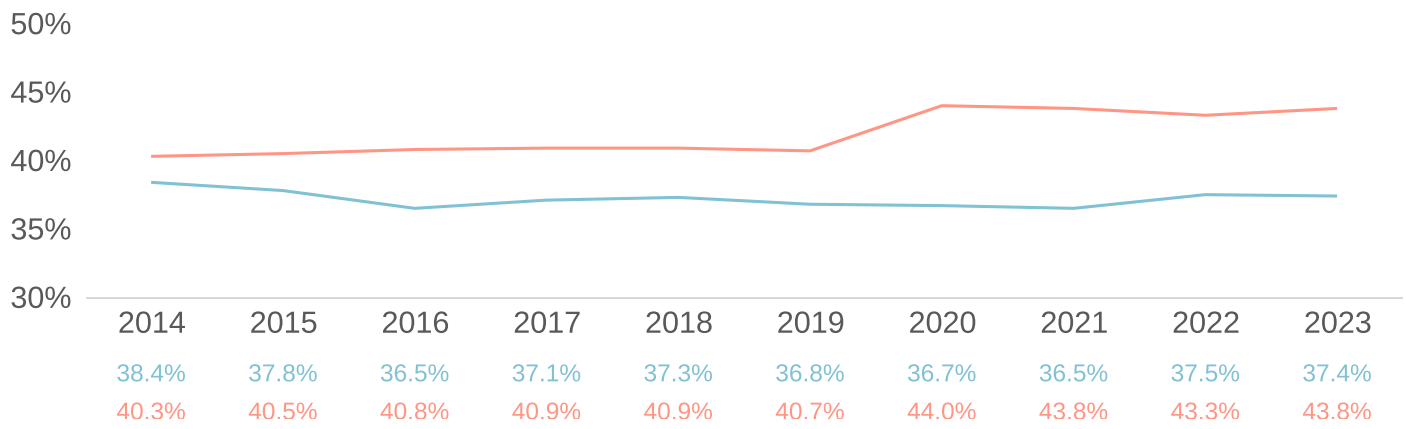
Code	Code Description
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed
12002	Simple 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
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging 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)
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
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
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles

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	$31	34.1%	30.1%	$41	30.1%	27.6%
97140	$35	15.0%	16.4%	$38	9.7%	14.7%
98941	$49	6.4%	6.0%	$57	0.5%	0.6%
97530	$30	6.2%	7.4%	$47	18.5%	17.9%
97112	$30	5.9%	7.7%	$44	11.8%	14.2%
97014	$19	2.7%	6.4%	$22	0.9%	3.0%
97161	$99	2.6%	1.2%	$136	2.0%	1.0%
98940	$41	2.4%	2.6%	$46	0.3%	0.5%
98943	$33	1.7%	2.4%	$37	0.2%	0.3%
97035	$22	1.6%	3.3%	$23	0.4%	1.1%
Total		**78.6%**	**83.5%**		**74.4%**	**80.9%**

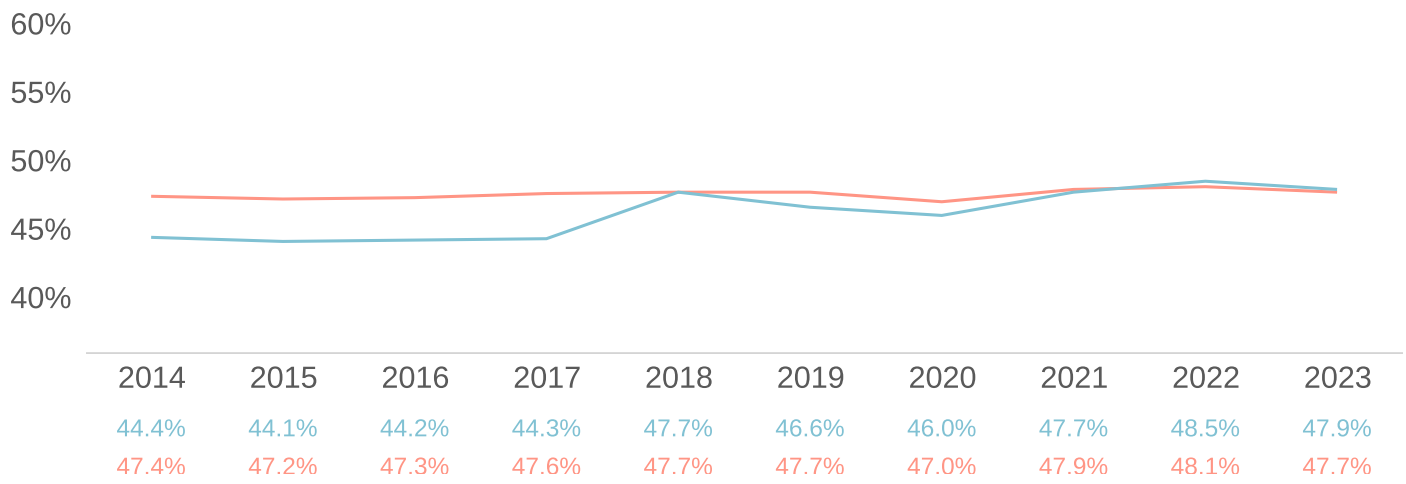
Code	Code Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
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
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
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.
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes

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



2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
44.4%	44.1%	44.2%	44.3%	47.7%	46.6%	46.0%	47.7%	48.5%	47.9%
47.4%	47.2%	47.3%	47.6%	47.7%	47.7%	47.0%	47.9%	48.1%	47.7%

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	$418	14.5%	3.0%	$474	14.4%	4.3%
73721	$429	14.1%	2.9%	$465	12.9%	3.9%
72148	$466	7.4%	1.4%	$462	8.8%	2.7%
70450	$162	4.1%	2.2%	$165	2.3%	1.9%
72141	$417	3.4%	0.7%	$453	4.5%	1.4%
73030	$33	3.1%	8.2%	$60	3.1%	7.4%
72125	$198	2.9%	1.3%	$207	1.8%	1.2%
73610	$33	2.7%	7.2%	$58	2.6%	6.2%
73110	$32	2.4%	6.7%	$64	2.4%	5.2%
74177	$281	2.4%	0.7%	$354	1.6%	0.7%
Total		**57.0%**	**34.3%**		**54.4%**	**34.9%**

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
70450	Computed tomography, head or brain; 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
72125	Computed tomography, cervical spine; without contrast material
73610	Radiologic examination, ankle; complete, minimum of 3 views
73110	Radiologic examination, wrist; complete, minimum of 3 views
74177	Computed tomography, abdomen and pelvis; with contrast material(s)

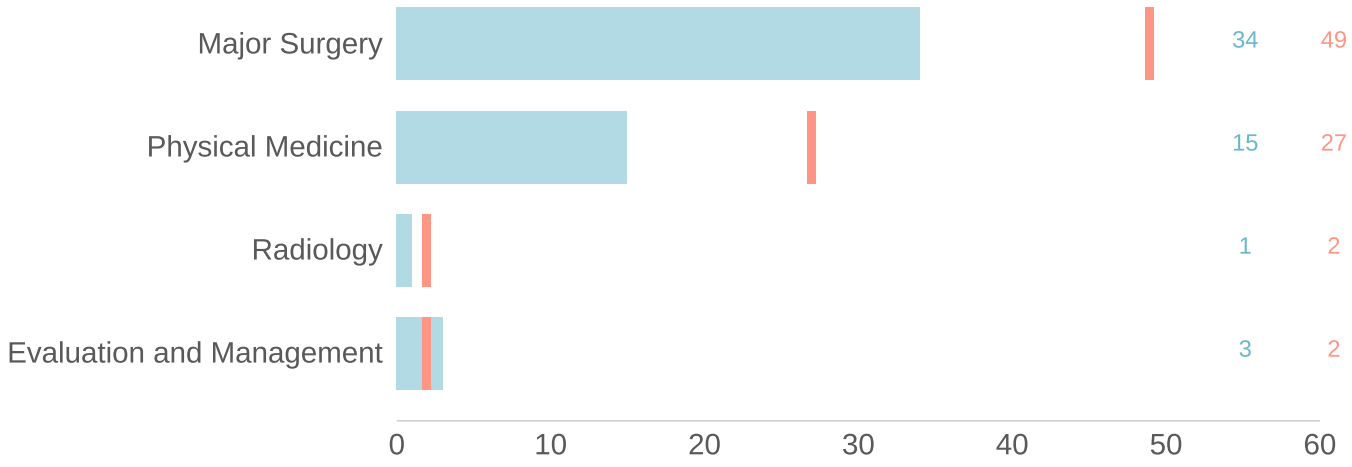
Time Until First Treatment—Physicians

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	NA	196%
Hospital Outpatient	247%	233%
Ambulatory Surgical Centers	189%	235%
All Facilities	**246%**	**223%**

Please note that “NA” will be displayed instead of the Hospital Inpatient value if there is limited reporting of DRG data, which is used to determine the Medicare amount for Hospital Inpatient facility services.

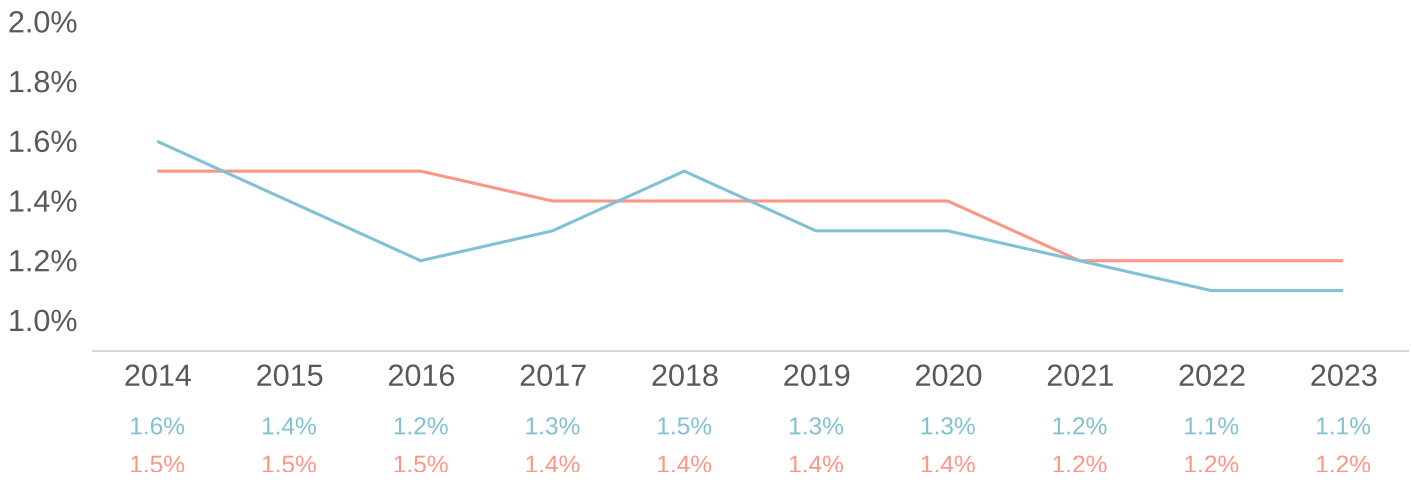
Hospital Inpatient Facility Services

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

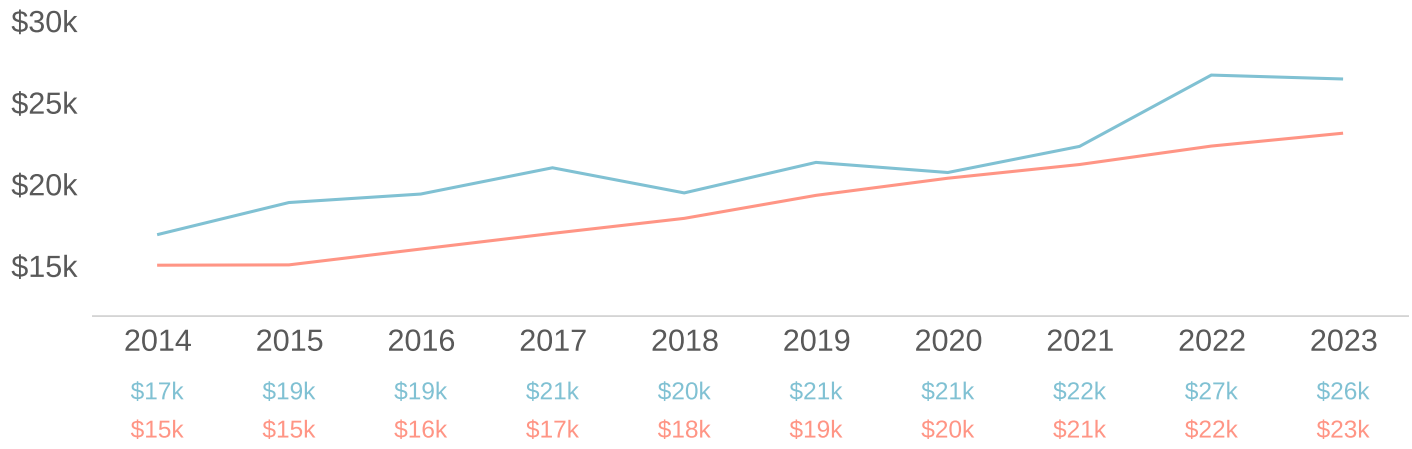
By Service Year for Base State vs Comparison States



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

Hospital Inpatient Paid per Stay

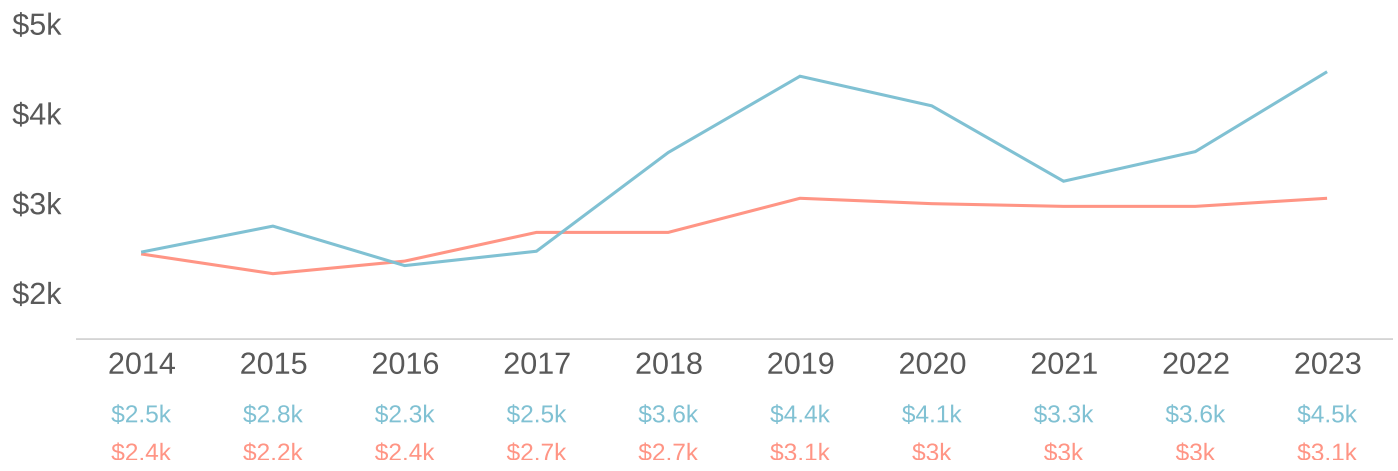
By Service Year for Base State vs Comparison States



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

Hospital Inpatient Paid per Day

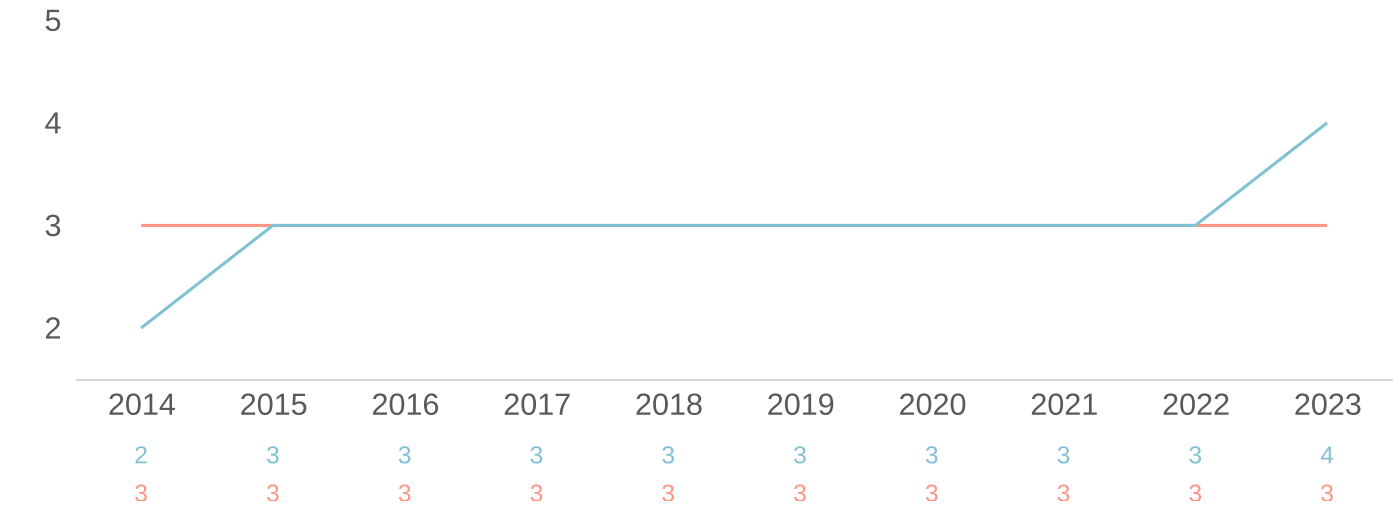
By Service Year for Base State vs Comparison States



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
Tibia Fibula Fracture	$58,168	6.8%	5.3%	$40,862	6.5%	6.5%
Hip/Pelvis Fracture/Major Trauma	$30,481	6.7%	10.0%	$40,900	8.5%	8.4%
Spinal Cord Injury	$494,510	6.4%	0.6%	$86,879	1.0%	0.5%
Injury of nerves and spinal cord at thorax level	$241,945	6.3%	1.2%	$118,388	0.9%	0.3%
Chest Trauma Major	$109,225	4.2%	1.8%	$46,049	2.8%	2.4%
Sepsis	$49,614	3.9%	3.5%	$41,202	2.1%	2.1%
Humeral Shaft Fracture	$92,939	3.6%	1.8%	$46,687	0.9%	0.7%
Complication From Surgical Device	$27,507	3.6%	5.9%	$37,900	2.6%	2.8%
Traumatic Brain Injury	$35,463	3.2%	4.1%	$57,597	5.2%	3.6%
Rib Sternal Fracture	$49,587	3.2%	2.9%	$31,471	1.2%	1.6%
Total		**47.9%**	**37.1%**		**31.7%**	**28.9%**

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
949	$417,979	10.8%	1.2%	$100,694	0.7%	0.3%
163	$189,025	2.4%	0.6%	$77,264	0.2%	0.1%
958	$165,924	2.1%	0.6%	$89,023	1.3%	0.6%
853	$155,928	2.0%	0.6%	$72,010	0.3%	0.2%
264	$129,770	1.7%	0.6%	$54,347	0.0%	0.0%
481	$58,254	1.5%	1.2%	$39,932	1.3%	1.3%
473	$56,041	1.4%	1.2%	$30,603	0.5%	0.6%
250	$101,393	1.3%	0.6%	$87,858	0.2%	0.1%
956	$88,542	1.1%	0.6%	$121,339	1.3%	0.4%
057	$84,750	1.1%	0.6%	$57,708	0.0%	0.0%
Total		**25.4%**	**7.8%**		**5.8%**	**3.6%**

Code	Code Description
949	Aftercare with CC/MCC
163	Major Chest Procedures with MCC
958	Other O.R. Procedures for Multiple Significant Trauma with CC
853	Infectious and Parasitic Diseases with O.R. Procedures with MCC
264	Other Circulatory System O.R. Procedures
481	Hip and Femur Procedures Except Major Joint with CC
473	Cervical Spinal Fusion without CC/MCC
250	Percutaneous Cardiovascular Procedures without Coronary Artery Stent with MCC
956	Limb Reattachment, Hip and Femur Procedures for Multiple Significant Trauma
057	Degenerative Nervous System Disorders without MCC

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

Hospital Outpatient Facility Services

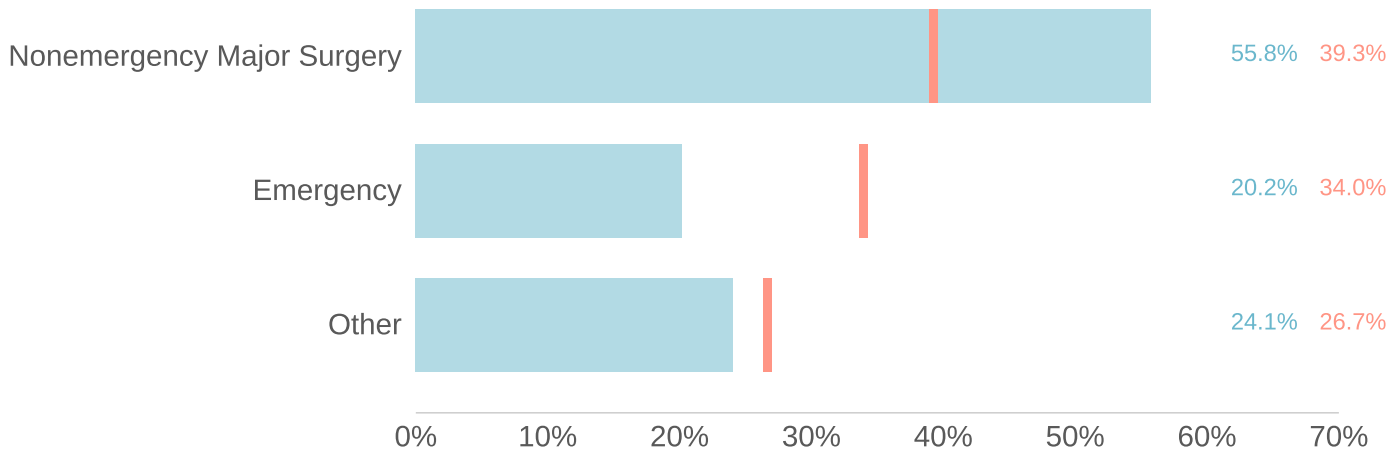
Hospital outpatient services are reported with several types of procedure codes. Data reporters are instructed to report the code that is consistent with the way the reimbursement was determined. Within hospital outpatient a visit is defined as any service or set of services provided to a claimant on 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

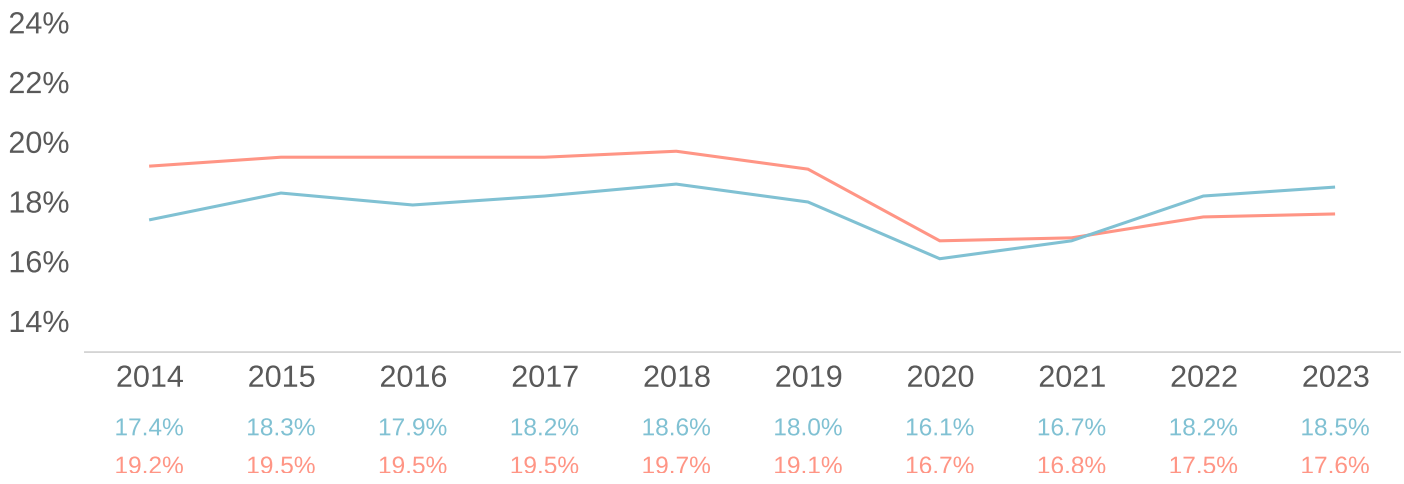
Base State vs Comparison States for Service Year 2023



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

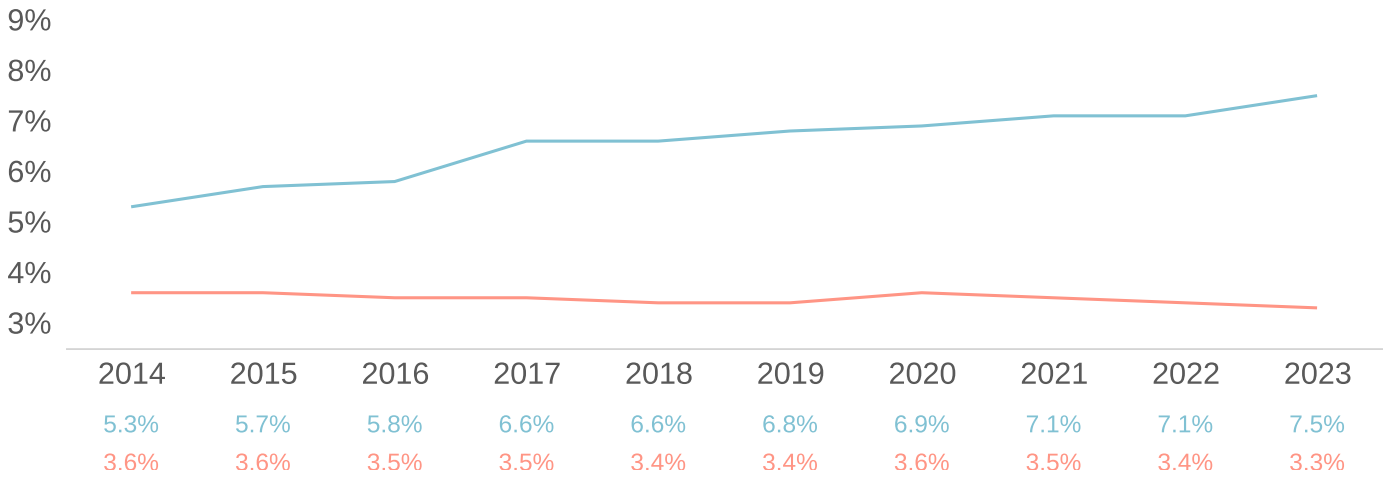
By Service Year for Base State vs Comparison States



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

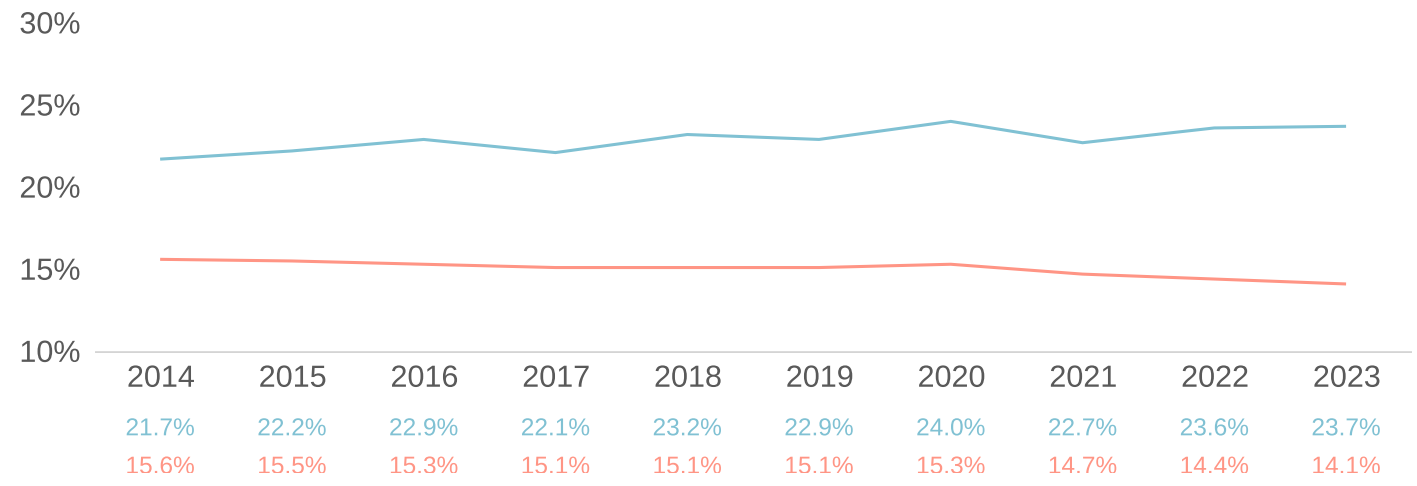
By Service Year for Base State vs Comparison States



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

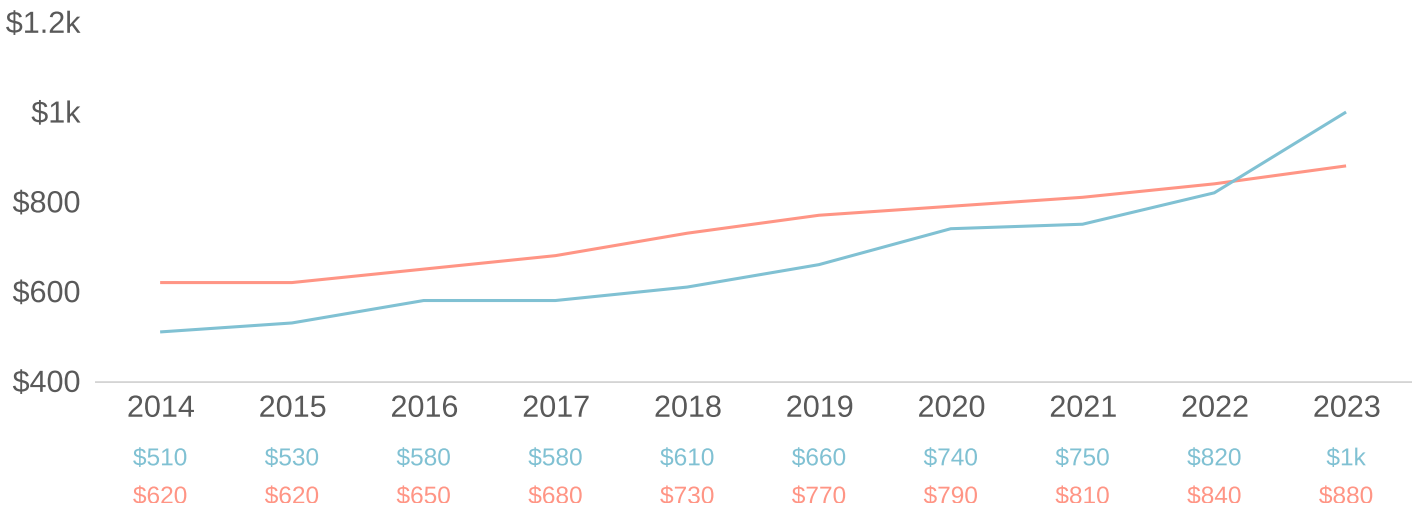
By Service Year for Base State vs Comparison States



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

Hospital Outpatient Paid per Visit for **Emergency**

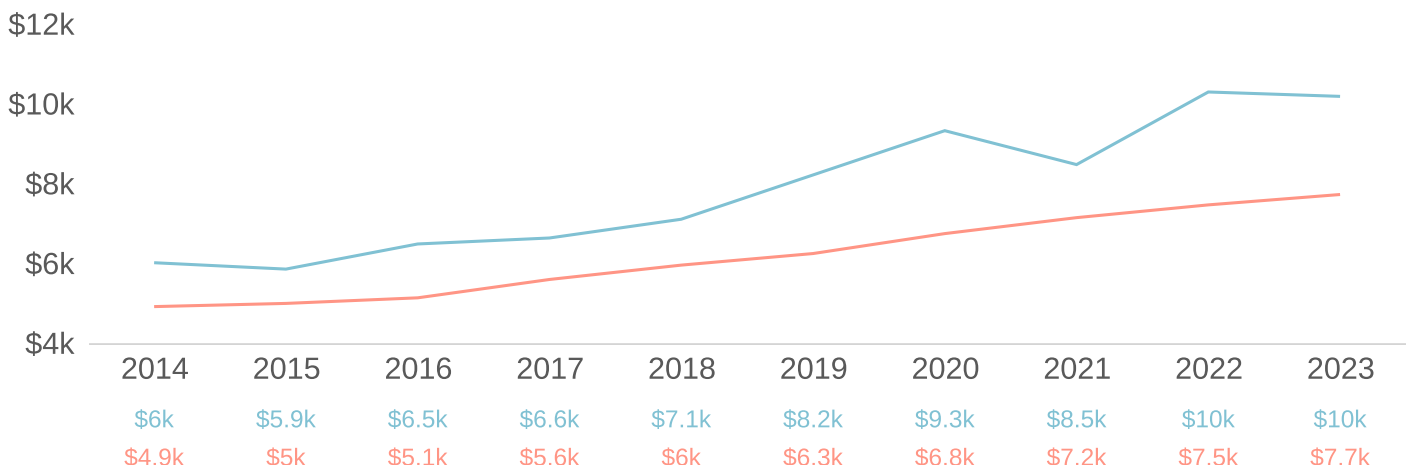
By Service Year for Base State vs Comparison States



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

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

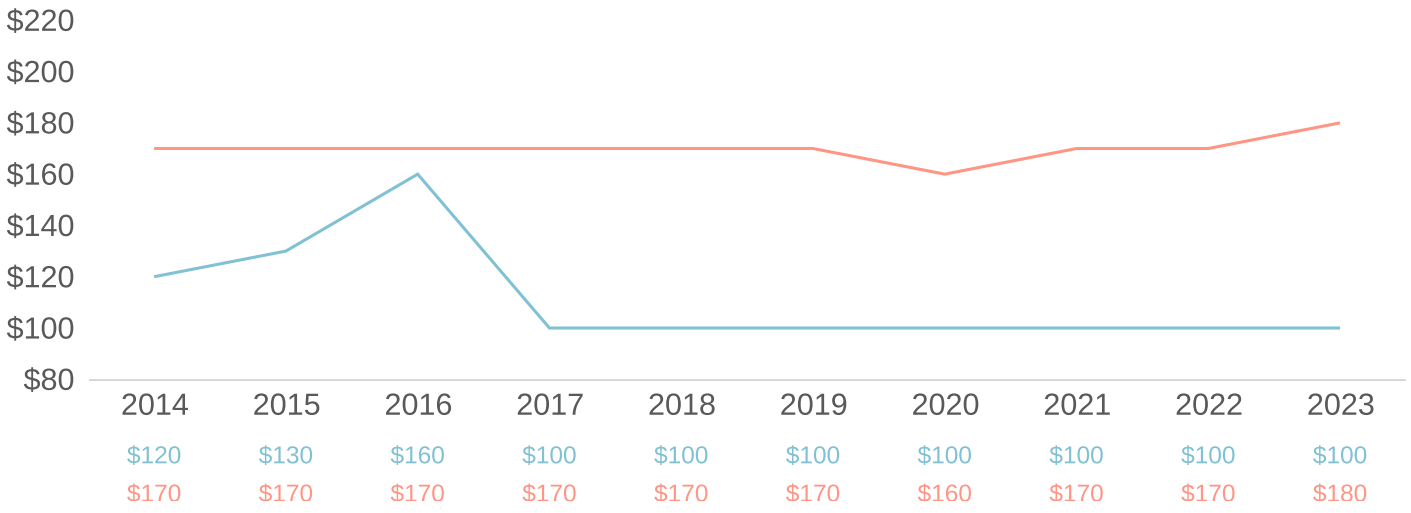
By Service Year for Base State vs Comparison States



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	$1,035	11.9%	20.7%	$1,043	12.2%	18.8%
Hand/Wrist Fracture	$2,668	7.2%	4.9%	$2,014	5.4%	4.3%
Head Injury (not otherwise classified)	$2,171	5.2%	4.3%	$2,092	4.5%	3.5%
Head/Face Wound	$1,854	4.6%	4.5%	$1,855	4.1%	3.6%
Neck Pain	$2,951	3.4%	2.1%	$2,414	4.1%	2.8%
Minor Ankle/Foot Injuries	$1,108	2.9%	4.6%	$1,010	3.0%	4.7%
Concussion/Minor Traumatic Brain Injury	$1,831	2.9%	2.8%	$2,000	2.6%	2.1%
Low Back Pain	$1,403	2.6%	3.4%	$1,493	4.5%	4.9%
Nonspecific Cardiopulmonary	$2,923	2.6%	1.6%	$1,946	1.8%	1.5%
Upper Back Pain	$2,180	2.3%	1.9%	$1,863	2.2%	1.9%
Total		**45.6%**	**50.8%**		**44.4%**	**48.1%**

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	$1,452	15.4%	19.1%	$1,398	17.6%	20.3%
99283	$896	12.8%	25.7%	$860	19.1%	35.6%
99285	$2,610	8.1%	5.6%	$2,544	8.1%	5.1%
74177	$10,840	6.6%	1.1%	$7,317	6.3%	1.4%
72125	$5,016	4.3%	1.6%	$4,596	5.6%	2.0%
70450	$3,881	4.3%	2.0%	$2,764	3.6%	2.1%
99282	$548	3.6%	11.8%	$483	2.5%	8.2%
G0378	$6,021	2.6%	0.8%	$3,787	1.3%	0.6%
12001	$668	1.3%	3.6%	$836	0.9%	1.7%
Total		**59.0%**	**71.3%**		**65.0%**	**77.0%**

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
74177	Computed tomography, abdomen and pelvis; with contrast material(s)
72125	Computed tomography, cervical spine; without contrast material
70450	Computed tomography, head or brain; without contrast material
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
G0378	Hospital observation service, per hour
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

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	$20,643	20.5%	12.2%	$12,864	14.0%	11.2%
Minor Shoulder Injury	$14,886	6.6%	5.5%	$10,968	4.2%	3.9%
Knee Internal Derangement - Meniscus Injury	$8,810	5.9%	8.3%	$7,149	5.4%	7.8%
Hand/Wrist Fracture	$9,063	5.6%	7.6%	$8,084	5.8%	7.4%
Knee Degenerative/Overuse Injuries	$15,300	3.8%	3.1%	$13,622	3.1%	2.3%
Degenerative Shoulder	$17,362	3.7%	2.6%	$13,879	2.1%	1.5%
Inguinal Hernia	$14,011	3.2%	2.8%	$10,260	4.6%	4.6%
Knee Internal Derangement - Cruciate Ligament Tear	$15,341	2.6%	2.1%	$13,718	2.3%	1.7%
SLAP Lesion	$18,068	2.5%	1.7%	$10,874	2.3%	2.2%
Minor Hand/Wrist Injuries	$10,050	2.5%	3.1%	$7,127	1.9%	2.8%
Total		**56.9%**	**49.0%**		**45.7%**	**45.4%**

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

Hospital Outpatient 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	$16,675	7.9%	5.9%	$12,513	7.4%	6.1%
29826	$28,031	4.4%	1.9%	$14,121	0.9%	0.7%
29824	$25,164	3.7%	1.8%	$10,910	0.7%	0.7%
20680	$8,548	2.7%	3.9%	$7,241	2.0%	2.9%
29881	$8,361	2.6%	3.8%	$6,973	3.1%	4.5%
29806	$17,557	2.2%	1.5%	$11,811	1.0%	0.9%
27447	$21,425	2.2%	1.2%	$18,889	2.0%	1.1%
24342	$11,624	2.1%	2.2%	$11,361	1.8%	1.6%
29823	$23,539	2.0%	1.1%	$9,743	1.1%	1.2%
29888	$16,107	1.9%	1.4%	$13,369	1.7%	1.3%
Total		**31.7%**	**24.7%**		**21.7%**	**21.0%**

Code	Code Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)
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
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
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])
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction

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
Minor Shoulder Injury	$197	8.1%	13.6%	$307	7.6%	9.7%
Lumbar Spine Degeneration	$2,072	7.6%	1.2%	$1,168	3.3%	1.1%
Minor Knee Injury	$205	4.5%	7.3%	$313	4.2%	5.2%
Low Back Pain	$293	4.0%	4.5%	$317	4.4%	5.4%
Lumbosacral Intervertebral Disc Disorders	$1,193	3.3%	0.9%	$728	1.9%	1.0%
Minor Hand/Wrist Injuries	$206	3.3%	5.3%	$288	5.2%	7.0%
Rotator Cuff Tear	$330	3.0%	3.0%	$323	3.5%	4.3%
Lumbar Radiculopathy/Sciatica	$577	2.8%	1.6%	$512	2.5%	1.9%
Orthopedic aftercare	$132	2.4%	6.1%	$214	1.1%	2.0%
Tibia Fibula Fracture	$444	2.3%	1.7%	$343	1.4%	1.6%
Total		**41.3%**	**45.2%**		**35.1%**	**39.2%**

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
97110	$122	16.5%	44.5%	$202	19.1%	37.1%
73221	$1,081	6.4%	2.0%	$1,146	4.1%	1.4%
73721	$1,039	5.4%	1.7%	$1,085	3.5%	1.3%
97140	$109	4.4%	13.3%	$200	2.9%	5.6%
72148	$1,040	2.7%	0.9%	$1,254	2.3%	0.7%
73222	$1,829	2.5%	0.4%	$2,361	1.8%	0.3%
64493	$3,731	2.3%	0.2%	$2,658	0.8%	0.1%
64483	$1,932	2.2%	0.4%	$1,989	1.2%	0.2%
64635	$5,041	1.9%	0.1%	$4,108	0.6%	0.1%
97161	$185	1.6%	2.9%	$264	1.3%	1.9%
Total		**45.9%**	**66.4%**		**37.6%**	**48.7%**

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
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
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
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
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
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.

Ambulatory Surgical Center Facility Services

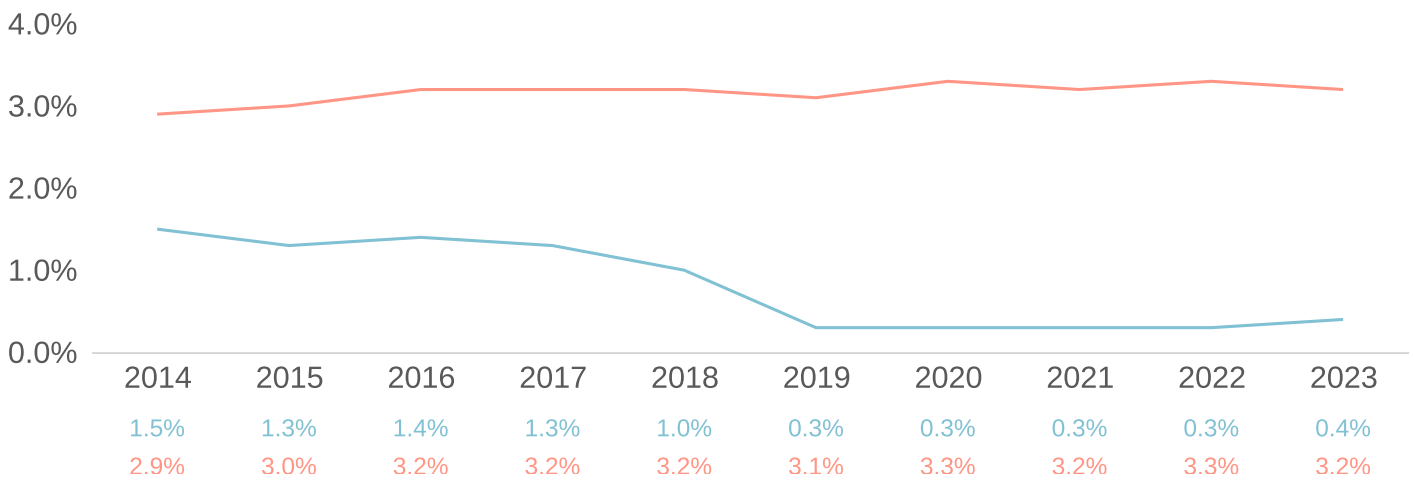
An Ambulatory Surgical Center (ASC) is often used as an alternative facility to a hospital for conducting outpatient surgeries.

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

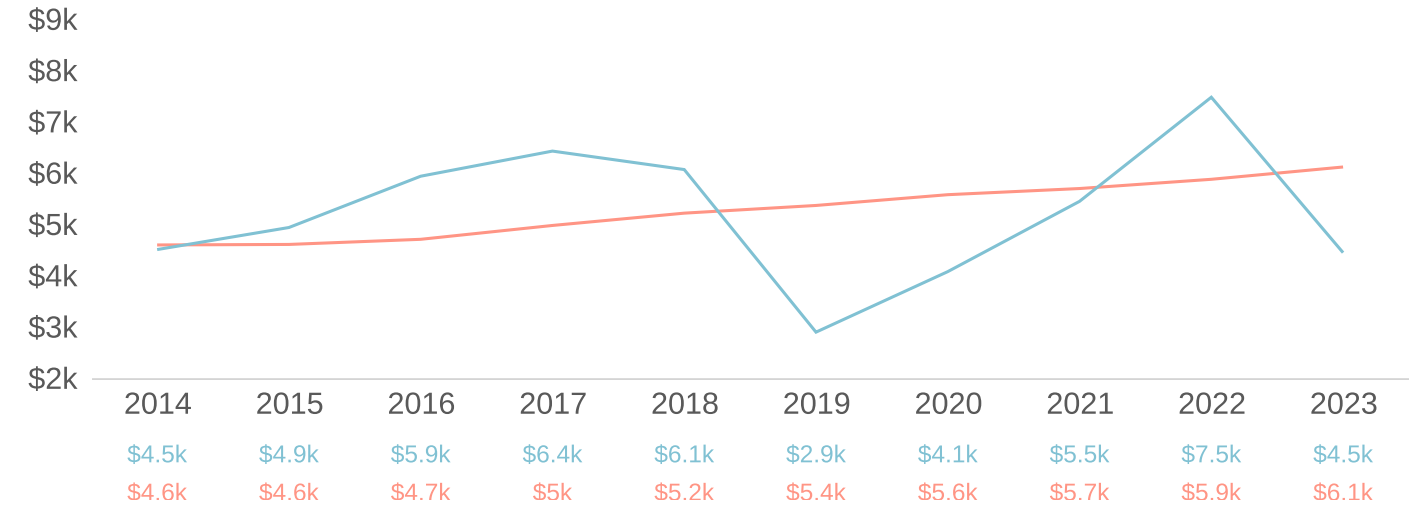
By Service Year for Base State vs Comparison States



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
Chronic Pain	$48,963	22.3%	2.2%	$27,575	2.7%	0.6%
Rotator Cuff Tear	$21,769	9.9%	2.2%	$12,522	18.2%	9.4%
Hand/Wrist Fracture	$6,998	8.5%	5.9%	$6,632	5.0%	4.9%
Shoulder Impingement Syndrome	$12,330	3.8%	1.5%	$9,453	0.8%	0.6%
Facial Fracture	$10,361	3.2%	1.5%	$7,022	0.1%	0.1%
Knee Internal Derangement - Cruciate Ligament Tear	$18,952	2.9%	0.7%	$10,618	2.4%	1.4%
Other joint disorder, not elsewhere classified	$8,535	2.6%	1.5%	$10,064	1.3%	0.9%
Knee Internal Derangement - Meniscus Injury	$5,315	2.4%	2.2%	$5,112	5.6%	7.0%
Ventrical Incisional Hernia	$7,892	2.4%	1.5%	$6,069	0.3%	0.4%
Carpal Tunnel Syndrome	$3,574	2.2%	3.0%	$3,743	1.9%	3.3%
Total		**60.2%**	**22.2%**		**38.3%**	**28.6%**

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
29823	$17,392	$23,539	15%	5.3%	1.5%	$8,633	$9,743	51%	1.1%	0.8%
29827	$31,735	$16,675	2%	4.8%	0.7%	$12,526	$12,513	64%	14.3%	7.3%
63650	$29,071	$16,511	17%	4.4%	0.7%	$13,879	$11,874	65%	0.9%	0.4%
26615	$12,021	$6,145	40%	3.7%	1.5%	$5,393	$8,117	56%	0.3%	0.4%
29888	$18,952	$16,107	6%	2.9%	0.7%	$11,055	$13,369	62%	2.5%	1.5%
21336	$17,479		100%	2.7%	0.7%	$5,955	$7,666	40%	0.0%	0.0%
49591	$7,892	$12,925	33%	2.4%	1.5%	$4,528	$8,756	16%	0.1%	0.1%
64721	$3,574	$4,453	10%	2.2%	3.0%	$3,359	$4,644	61%	1.1%	2.2%
29826	$13,214	$28,031	5%	2.0%	0.7%	$15,406	$14,121	58%	1.5%	0.6%
25608	$10,575	$15,303	14%	1.6%	0.7%	$8,978	$11,672	45%	0.4%	0.3%
Total				**32.0%**	**11.7%**				**22.2%**	**13.6%**

Code	Code Description
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])
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
63650	Percutaneous implantation of neurostimulator electrode array, epidural
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
21336	Open treatment of nasal septal fracture, with or without stabilization
49591	RPR AA HERNIA 1ST < 3 CM REDUCIBLE
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
25608	Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments

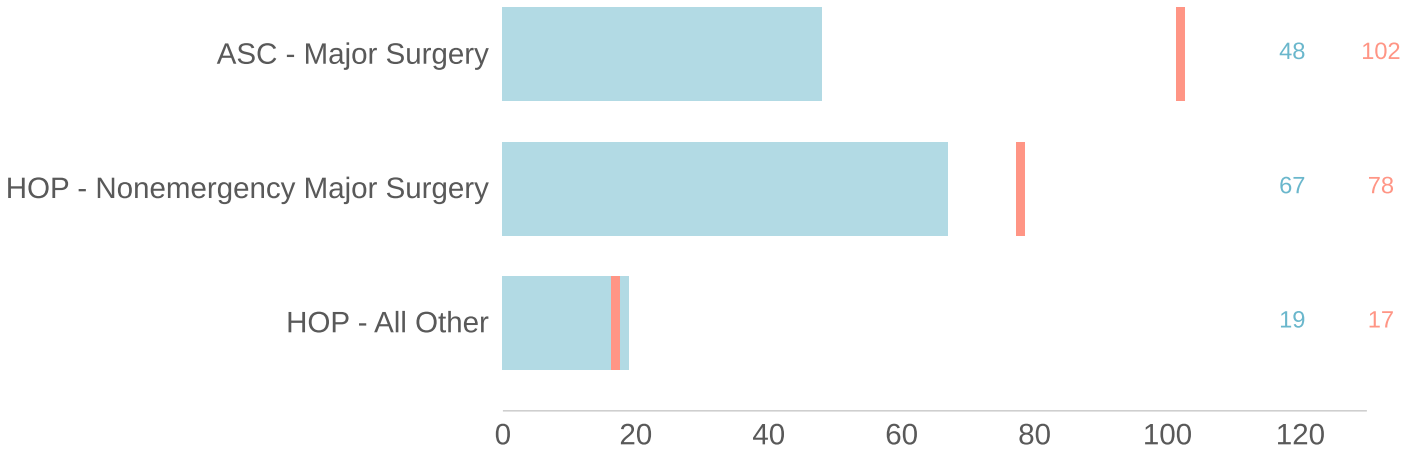
Time Until First Treatment—Facilities

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



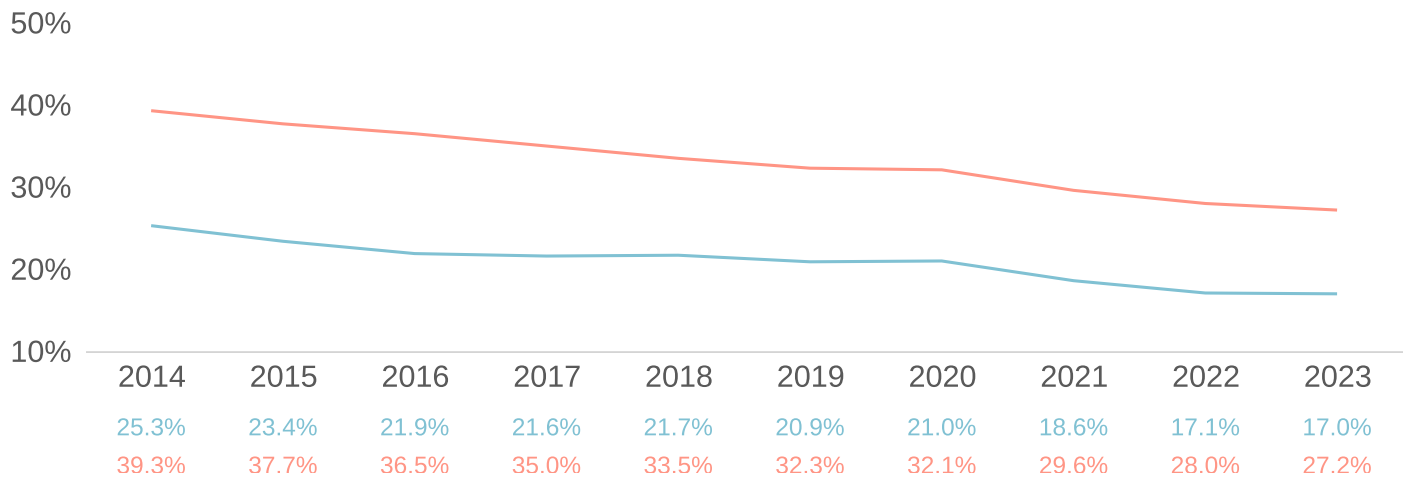
Prescription Drugs

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**

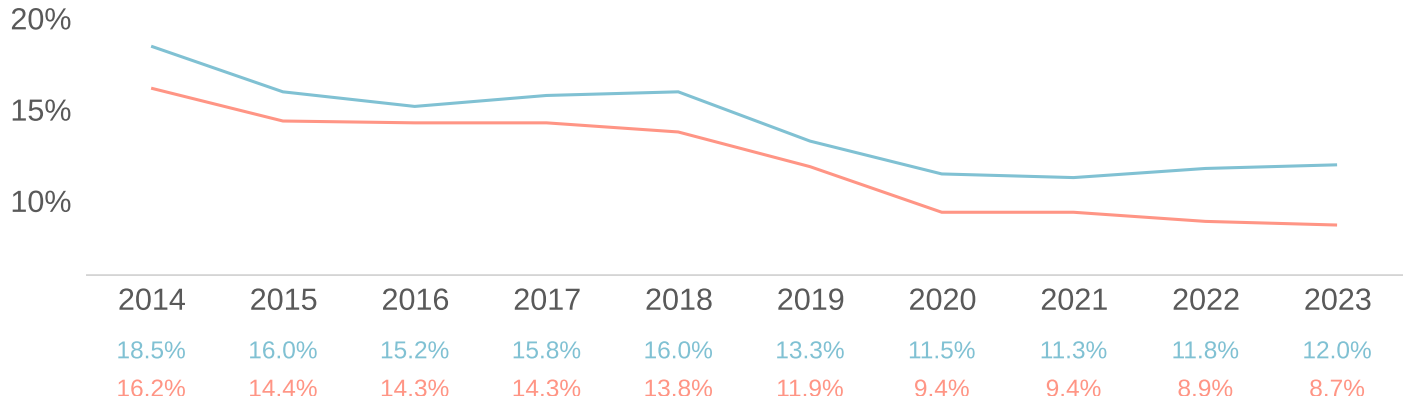
By Service Year for Base State vs Comparison States



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

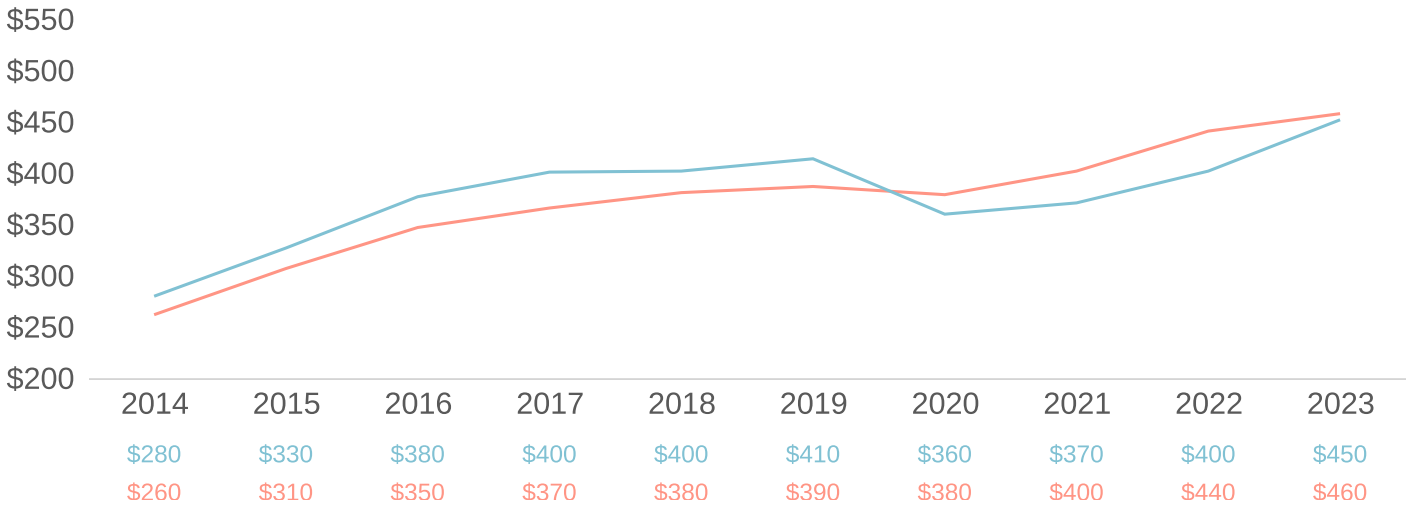
By Service Year for Base State vs Comparison States



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

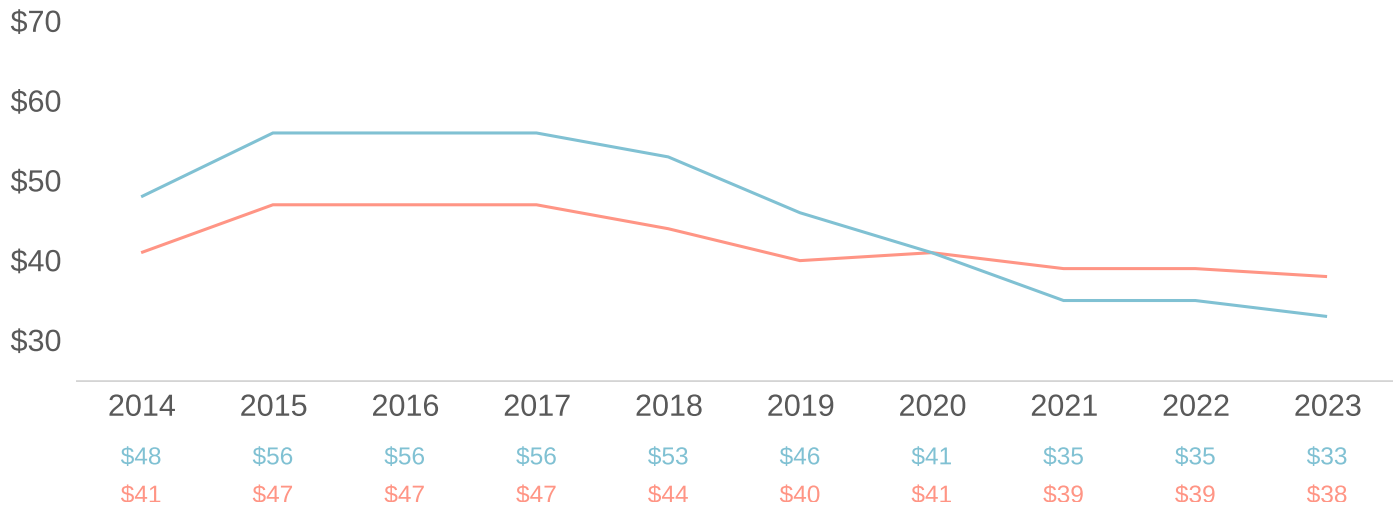
Brand Paid per Prescription

By Service Year for Base State vs Comparison States



Generic Paid per Prescription

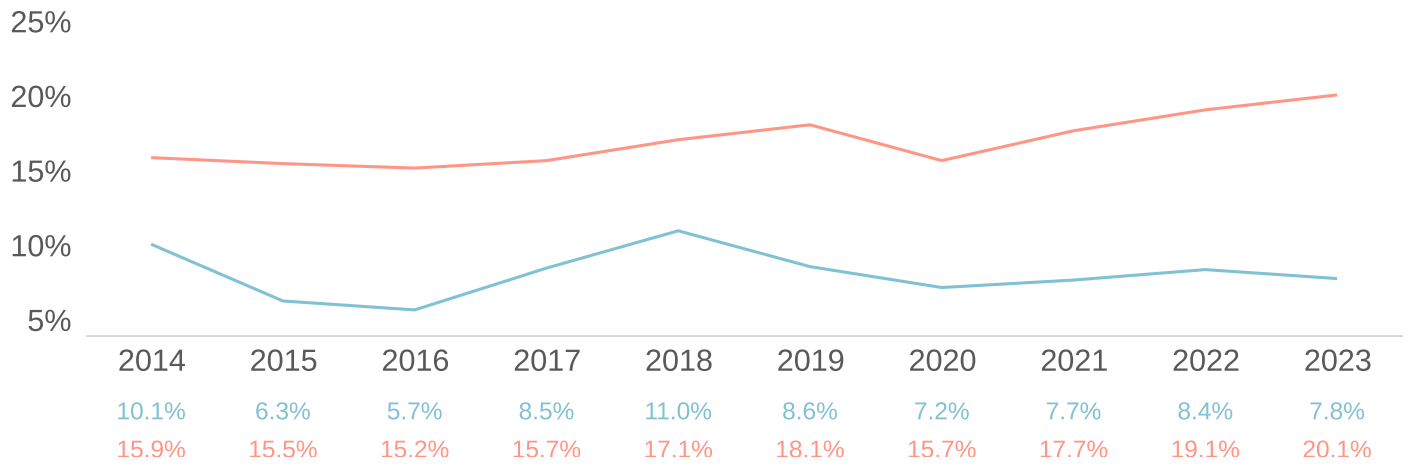
By Service Year for Base State vs Comparison States



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

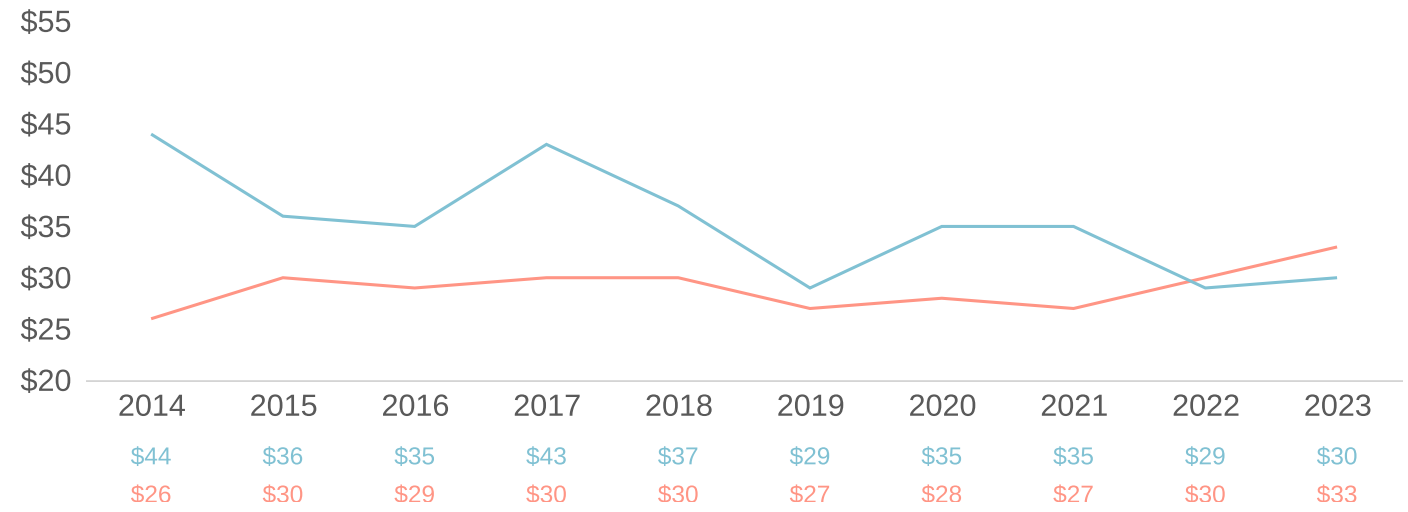
By Service Year for Base State vs Comparison States



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

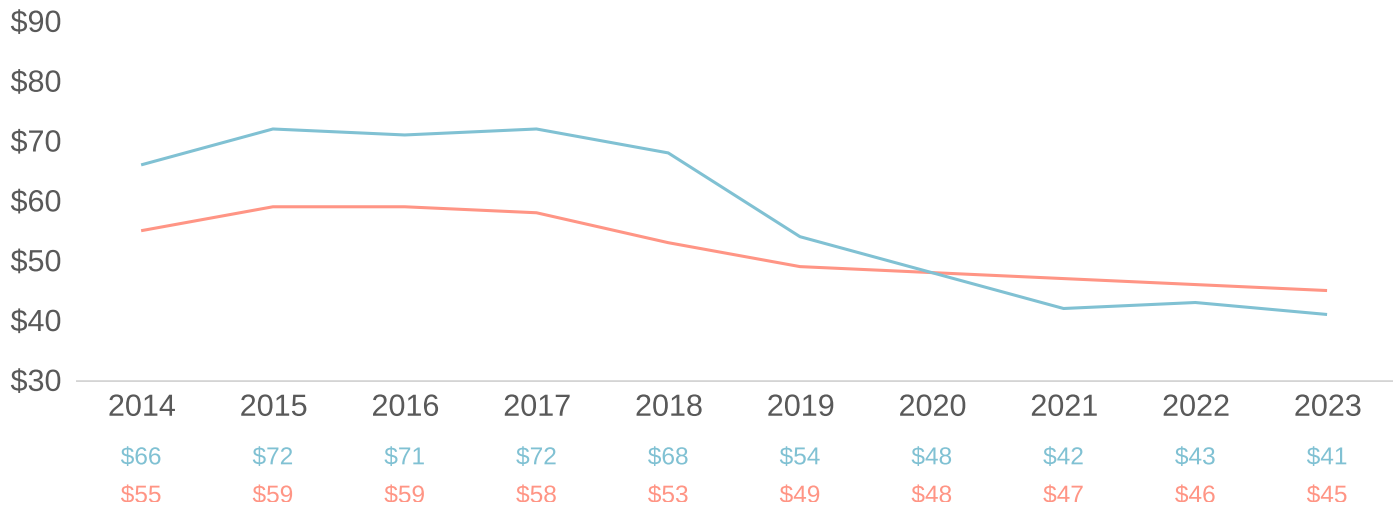
Nonpharmacy Paid per Prescription

By Service Year for Base State vs Comparison States



Pharmacy Paid per Prescription

By Service Year for Base State vs Comparison States



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
Pregabalin	generic	Lyrica®	N	$3.17	7.3%	4.2%	$4.77	5.8%	2.7%
Nucynta®	brand		Y	$11.33	6.0%	0.8%	$12.08	0.9%	0.2%
Oxycontin®	brand		Y	$8.32	5.8%	1.5%	$10.25	2.3%	0.6%
Dupixent Pfs®	brand		N	$947.46	4.6%	0.1%	$901.57	0.2%	0.0%
Duloxetine HCl	generic	Cymbalta®	N	$2.95	4.1%	4.7%	$4.40	2.3%	1.9%
Gabapentin	generic	Neurontin®	N	$0.66	3.7%	6.3%	$0.93	3.2%	6.0%
Eliquis®	brand		N	$9.66	3.6%	0.8%	$9.58	1.1%	0.3%
Lyrica®	brand		N	$9.96	3.3%	0.6%	$9.93	0.6%	0.1%
Botox®	brand		N	$254.06	3.0%	0.2%	$374.68	0.7%	0.1%
Savella®	brand		N	$7.50	1.8%	0.5%	$7.95	0.1%	0.0%
Total					**43.2%**	**19.7%**		**17.2%**	**11.9%**

Drug Name	Category
Pregabalin	Miscellaneous CNS Agents
Nucynta®	Analgesics/Antipyretics
Oxycontin®	Analgesics/Antipyretics
Dupixent Pfs®	Immunosuppressants
Duloxetine HCl	Psychotherapeutic Agents
Gabapentin	Anticonvulsants
Eliquis®	Coagulants & Anticoagulants
Lyrica®	Miscellaneous CNS Agents
Botox®	Toxins
Savella®	Miscellaneous CNS Agents

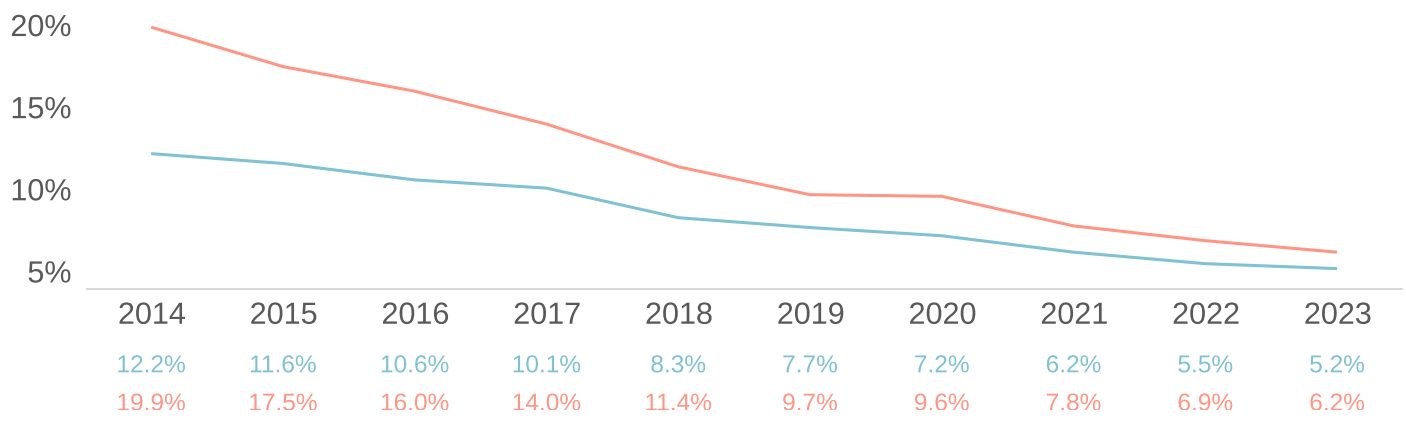
Prescription Drugs—Opioid Prescriptions

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

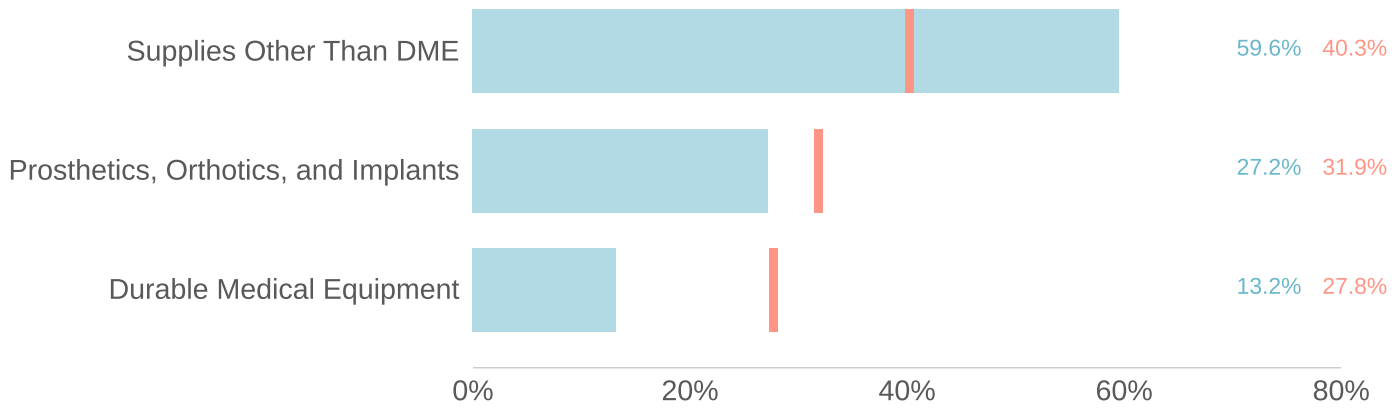
This chart displays the distribution of payments among three separate DMEPOS categories:

- 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

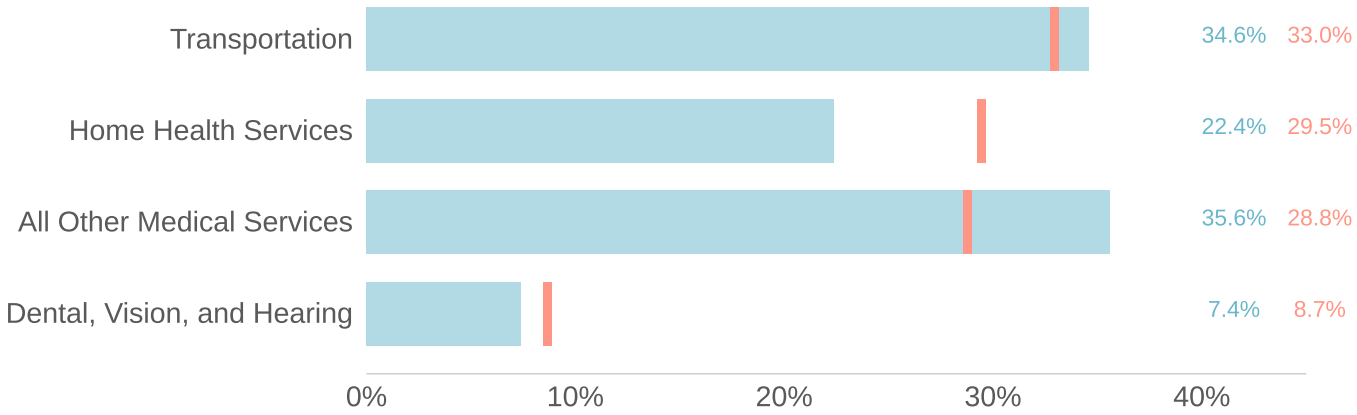


Other Medical Services

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**.