Medical Data Report
for the state of:

MONTANA
March 2013

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Introduction

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

This publication is a data source for regulators and others who may be interested in the increasing medical costs in workers compensation claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that threaten the financial soundness of the workers compensation system.

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

- Physician
- Hospital
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment (DME), Supplies, and Implants
- Other

Next, the report drills down into these categories to demonstrate which particular procedures represent the greatest share of payments and which are performed the most.

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

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.

Additional information regarding the data underlying this report is described in more detail in the appendix.

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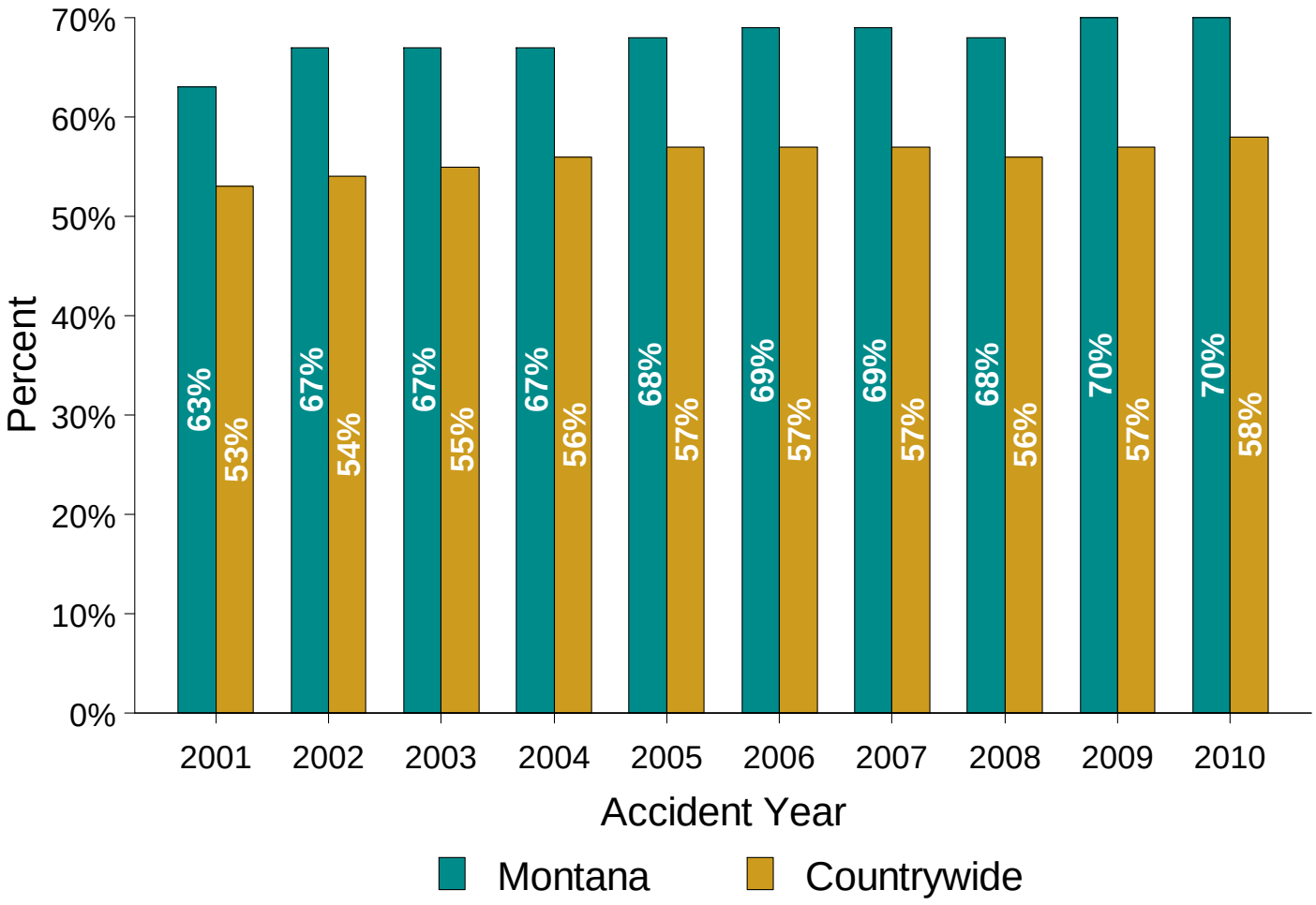
Workers compensation provides for two types of benefit payments: medical and indemnity. Medical benefits cover medical expenses resulting from a work-related injury or disease. Medical benefits are a key cost driver for workers compensation. The share of benefits attributable to medical costs has grown. Chart 1 displays the medical percentage of total benefit costs for Montana and the countrywide average for the past 10 accident years.

Chart 1

Medical Share of Total Benefit Costs

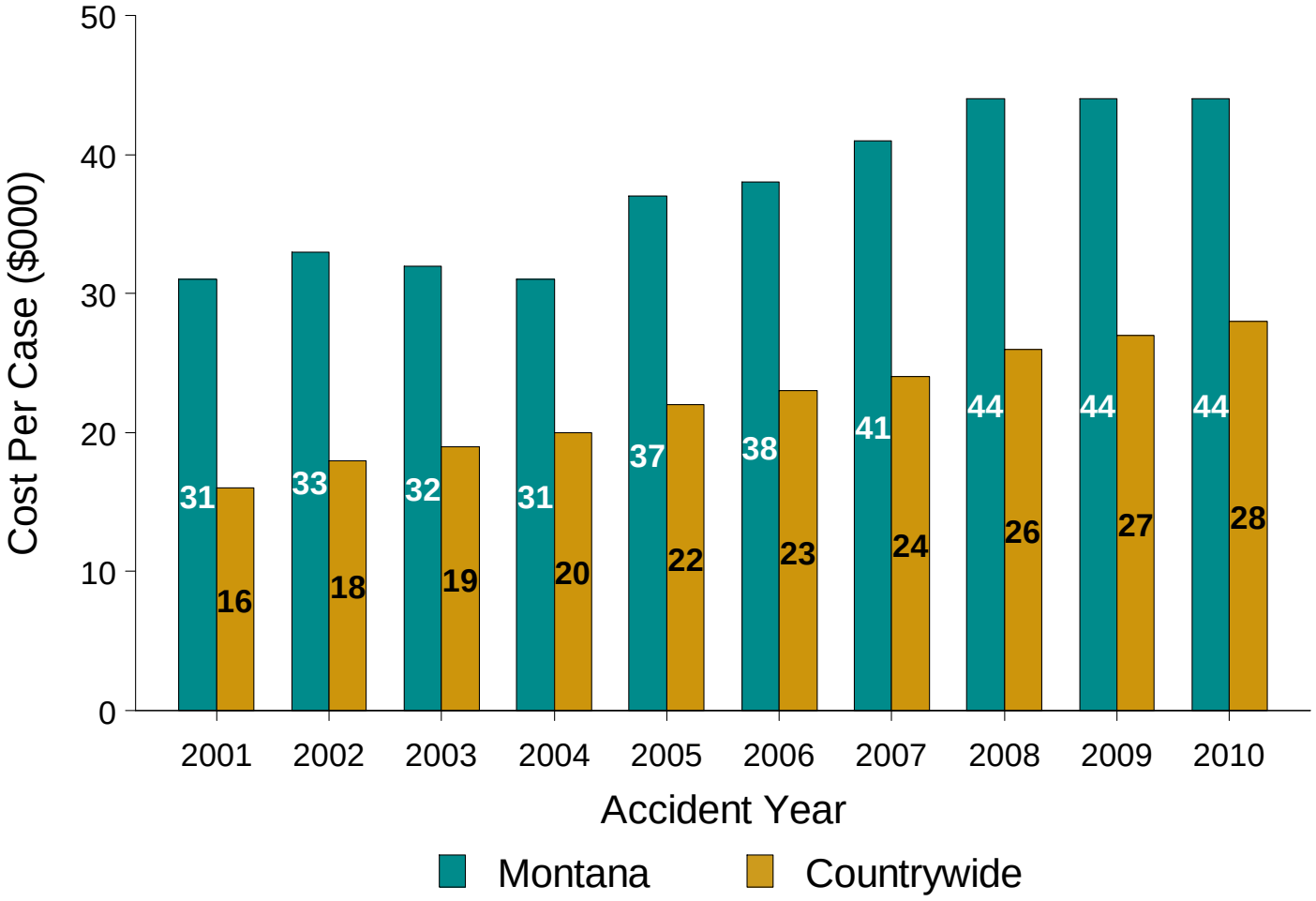


Source: NCCI Calendar-Accident Year Call for Compensation Experience. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, and VT.

Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for both Montana and the countrywide average. Medical losses are at historical benefit levels and historical dollar values.

Chart 2

Overall Medical Average Cost per Case

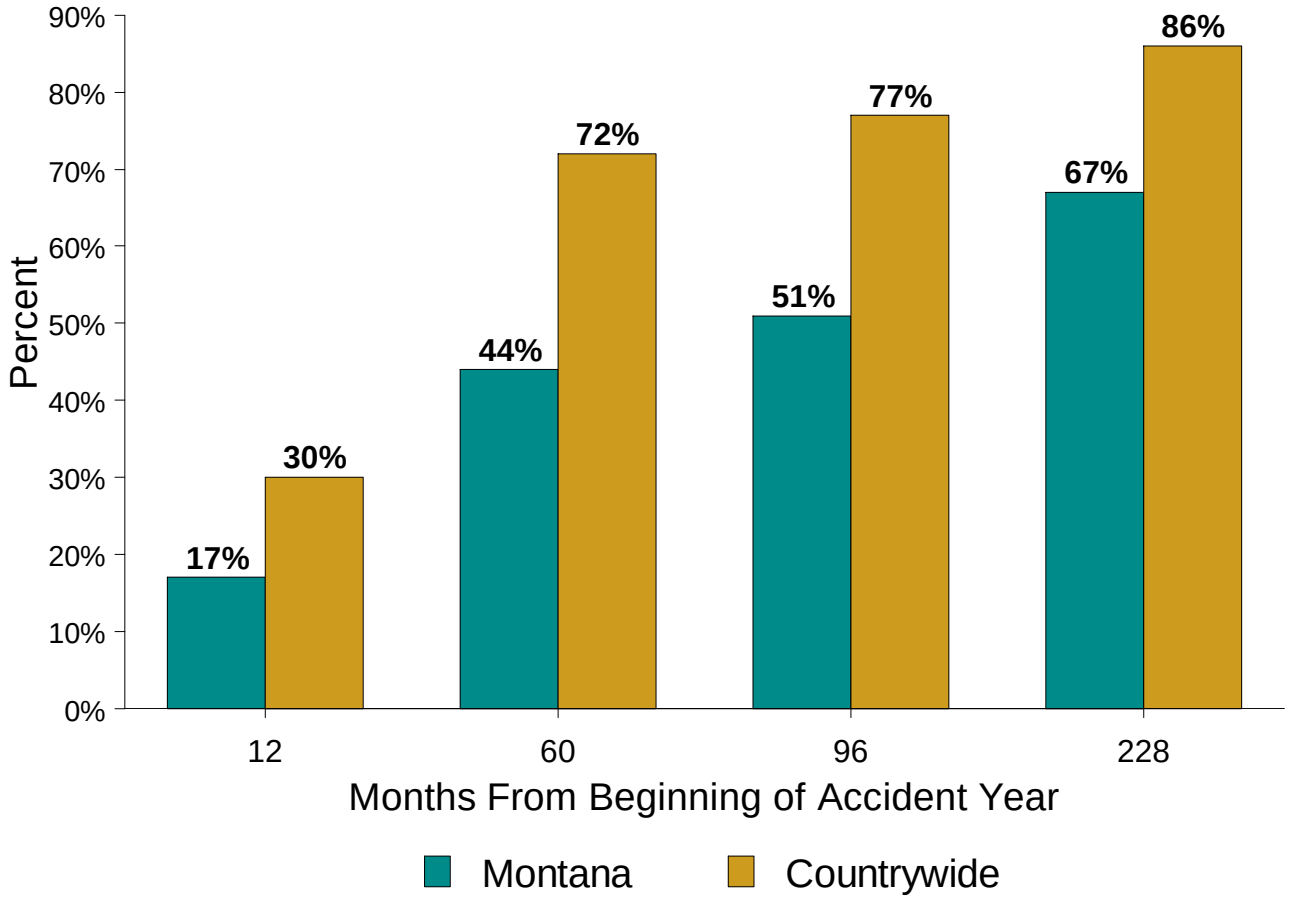


Source: NCCI Calendar-Accident Year Call for Compensation Experience. Losses and claim counts are developed to ultimate. Medical-only claim counts and losses are excluded. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, and VT.

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 payment patterns for medical services are partly determined by the dispute resolution mechanism in the state as well as statutory provisions for medical benefits. Chart 3 shows the percentage of medical benefits paid at different claim maturities for Montana and the countrywide average.

Chart 3

Percentage of Medical Paid by Claim Maturity



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

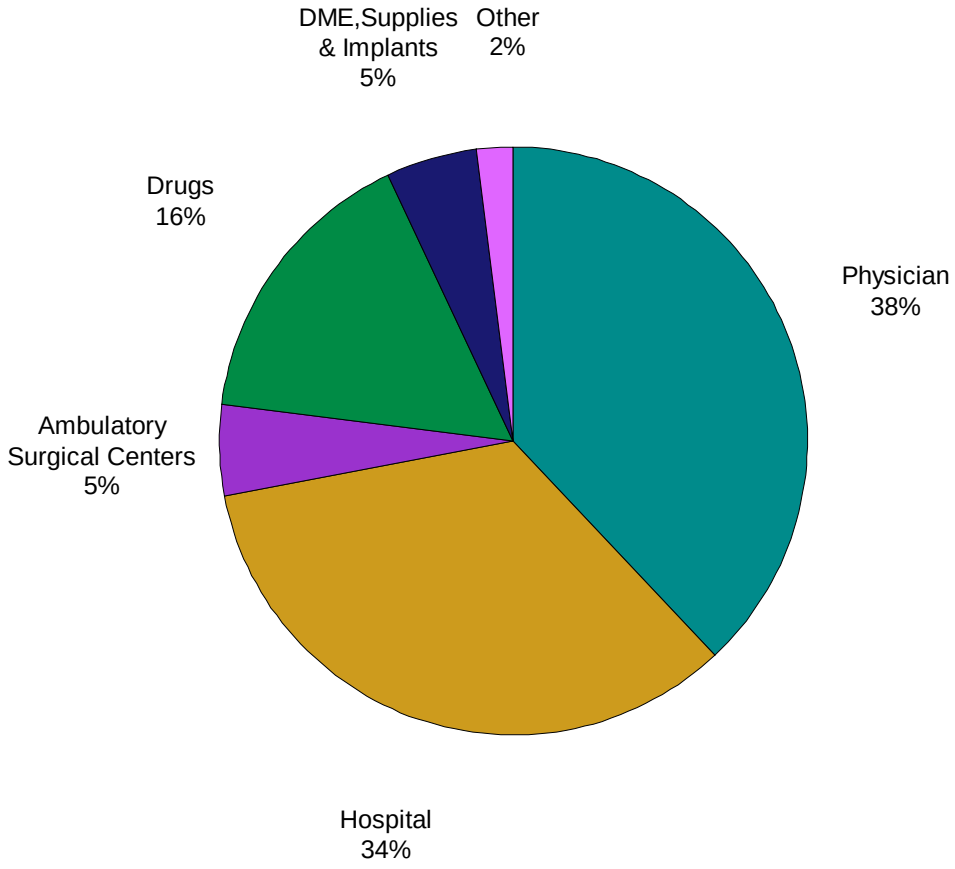
Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits. Chart 4 displays the distribution of medical payments by type of service.

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

Chart 4

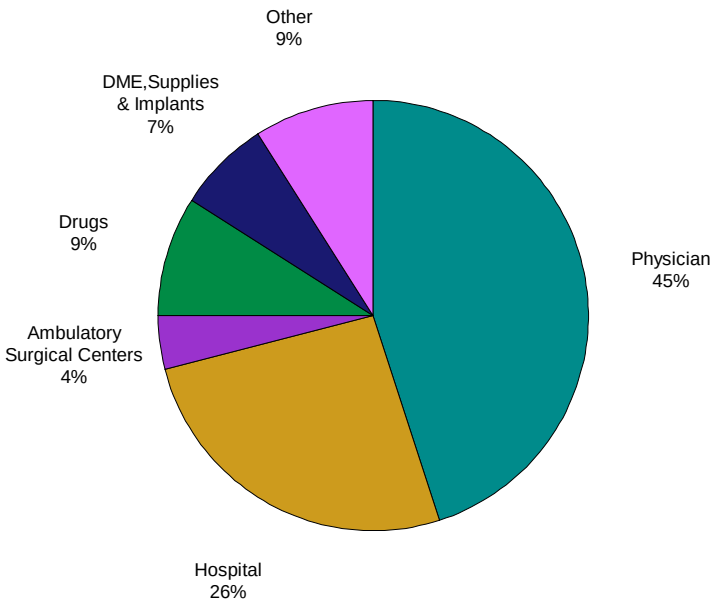
Distribution of Medical Payments

Montana

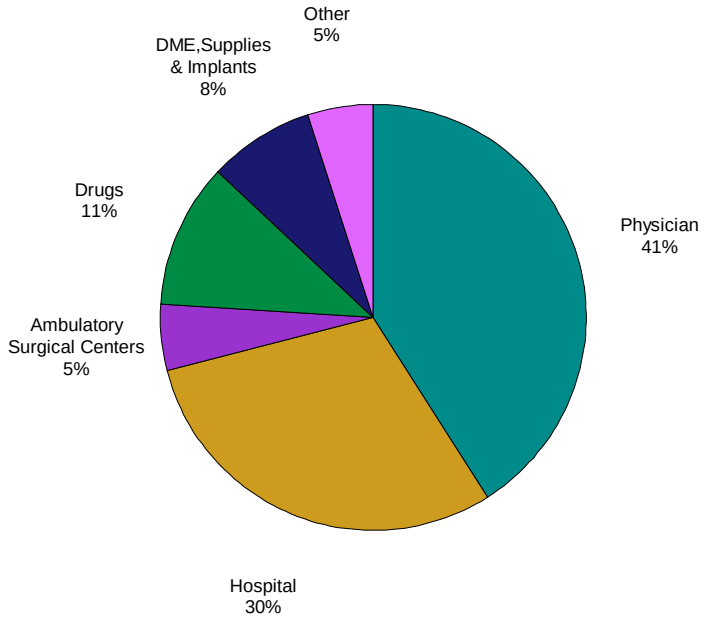


Distribution of Medical Payments

Region



Countrywide

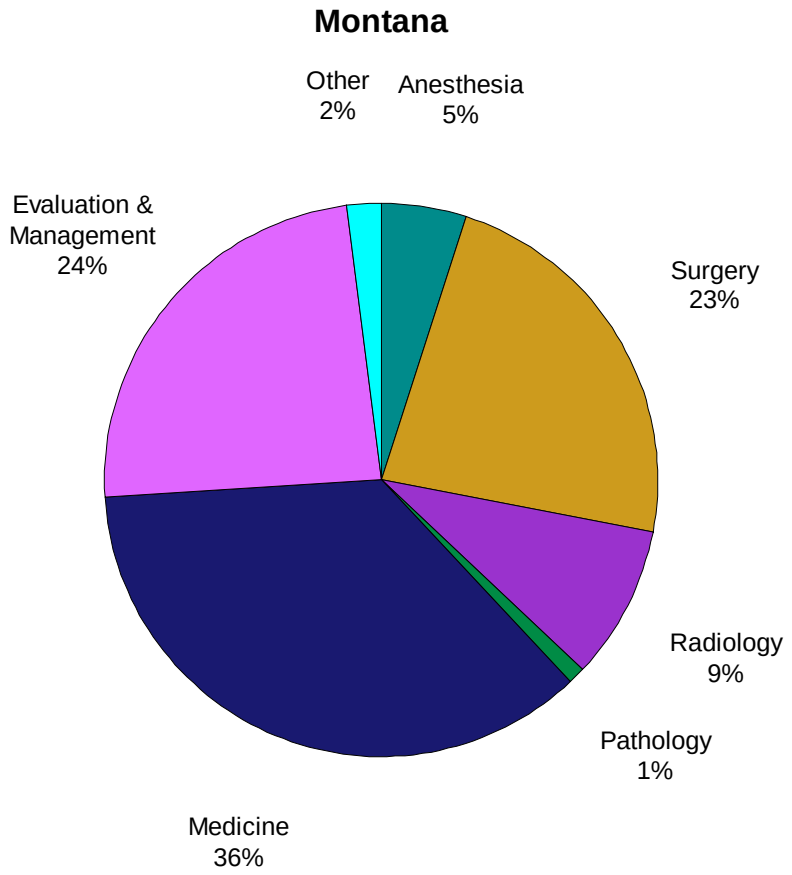


Source: NCCI Medical Data Call, Service Year 2011. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Charts 5 through 13 go into greater detail on physician payments. Chart 5 shows the distribution of physician payments by service category. Service categories are defined by the American Medical Association (AMA). The category labeled as "Medicine" includes physical therapy and occupational therapy services. Services involving office visits and consultations are included in the "Evaluation and Management" category. "Other" includes any codes not included in the AMA service categories.

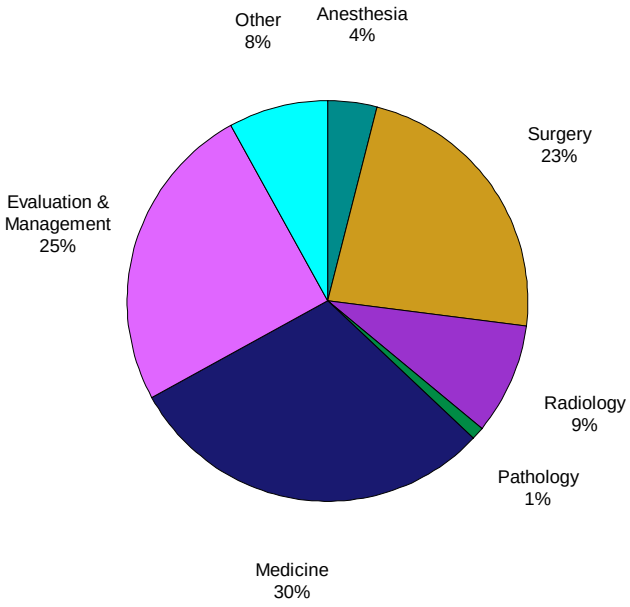
Chart 5

Distribution of Physician Payments by AMA Service Category

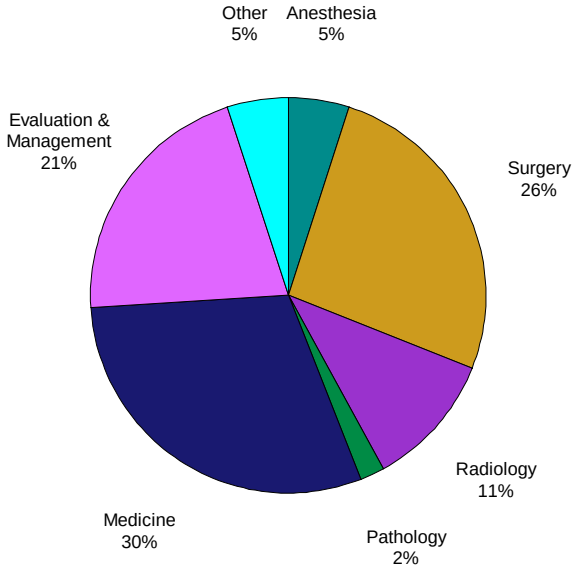


Distribution of Physician Payments by AMA Service Category

Region



Countrywide

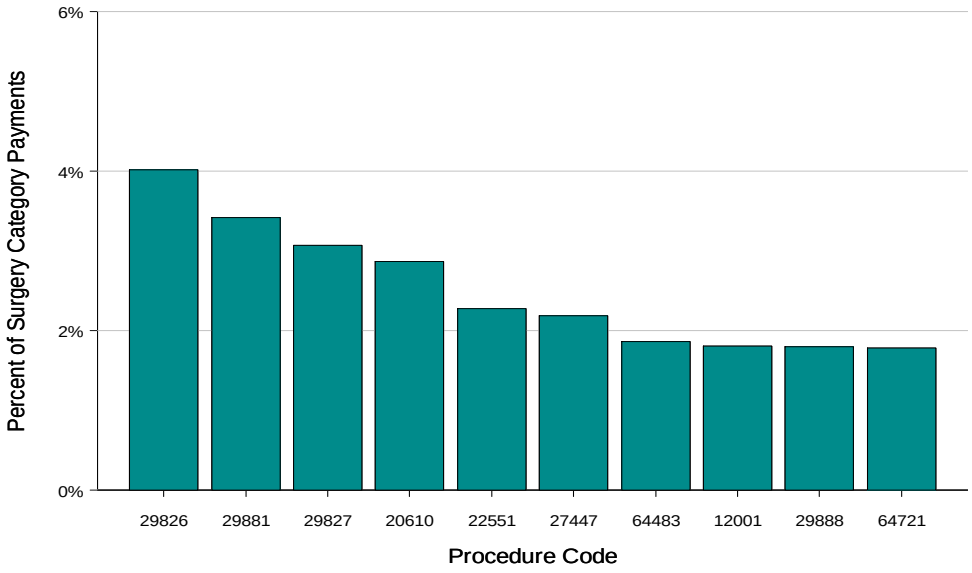


Source: NCCI Medical Data Call, Service Year 2011. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 6 displays the top 10 surgery codes reported by physicians. The total payments by procedure code are ranked from highest to lowest. The procedure code with the highest amount paid is ranked first. The procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows which procedures have the highest percent share of payments. A brief description of each procedure code is displayed in the table below.

Chart 6

Top 10 Surgery Procedure Codes by Amount Paid for Montana



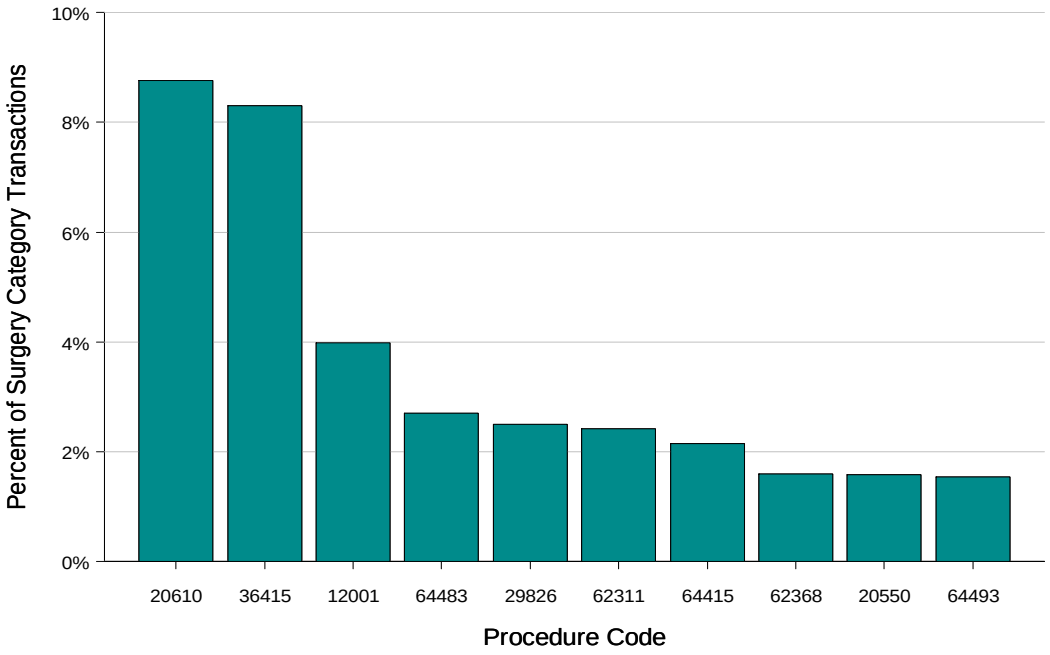
Source: NCCI Medical Data Call, Service Year 2011.

Code	Description
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
29881	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29827	Arthroscopy shoulder surgical; with rotator cuff repair
20610	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
22551	Arthrodesis anterior interbody including disc space preparation discectomy osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
27447	Arthroplasty knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
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
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel

Chart 7 also displays the top 10 surgery codes reported by physicians. However, the total counts of transactions by procedure code are ranked from highest to lowest. The procedure code with the highest total transaction counts is ranked first. The procedure code with the second highest total transaction counts is ranked second, and so on. This method reveals the most frequently used procedures. A brief description of each procedure code is displayed in the table below.

Chart 7

Top 10 Surgery Procedure Codes by Transaction Counts for Montana



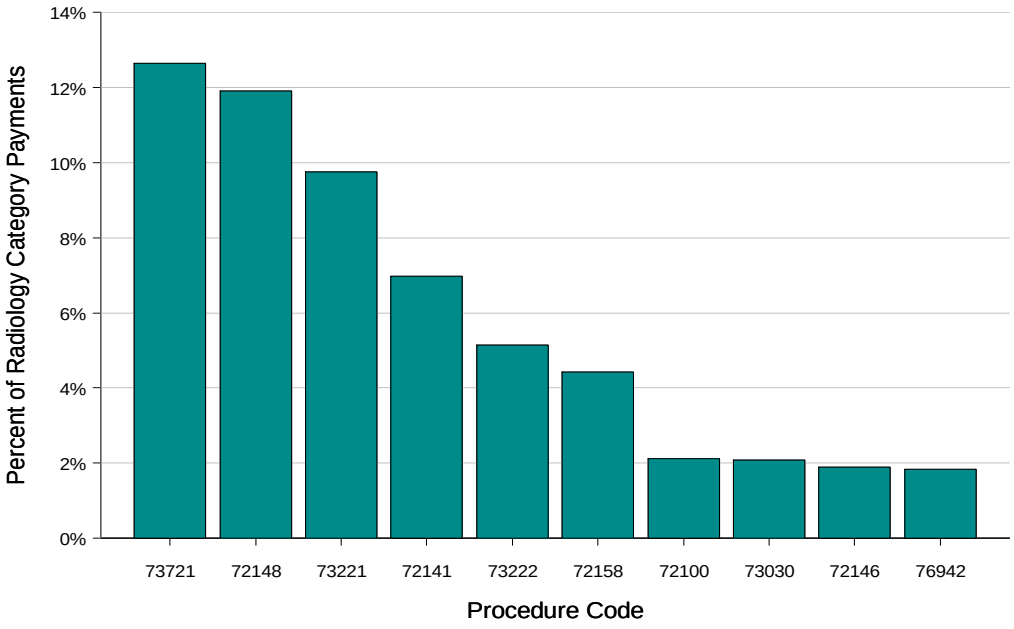
Source: NCCI Medical Data Call, Service Year 2011.

Code	Description
20610	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
36415	Collection of venous blood by venipuncture
12001	Simple repair of superficial wounds of scalp neck axillae external genitalia trunk and/or extremities (including hands and feet); 2.5 cm or less
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
62311	Injection(s) of diagnostic or therapeutic substance(s) (including anesthetic antispasmodic opioid steroid other solution) not including neurolytic substances including needle or catheter placement includes contrast for localization when performed epidural or subarachnoid
64415	Injection anesthetic agent; brachial plexus single
62368	Electronic analysis of programmable implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status alarm status drug prescription status); with reprogramming
20550	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)
64493	Injection(s) diagnostic or therapeutic agent paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or computed tomography (CT)) lumbar or sacral; single level

Chart 8 displays the top 10 radiology codes reported by physicians. The total payments by procedure code are ranked from highest to lowest. The procedure code with the highest amount paid is ranked first. The procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows which procedures have the highest percent share of payments. A brief description of each procedure code is displayed in the table below.

Chart 8

Top 10 Radiology Procedure Codes by Amount Paid for Montana



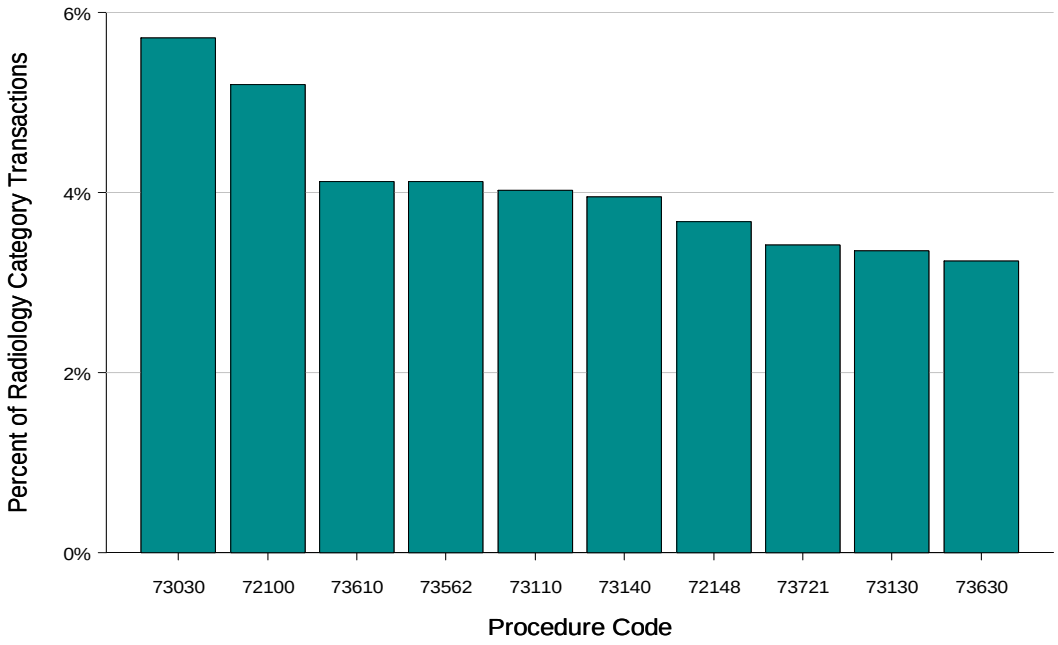
Source: NCCI Medical Data Call, Service Year 2011.

Code	Description
73721	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
73221	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)
72141	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material
73222	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; with contrast material(s)
72158	Magnetic resonance (e.g., proton) imaging spinal canal and contents without contrast material followed by contrast material(s) and further sequences
72100	Radiologic examination spine lumbosacral; 2 or 3 views
73030	Radiologic examination shoulder; complete minimum of 2 views
72146	Magnetic resonance (e.g. proton) imaging spinal canal and contents thoracic; without contrast material
76942	Ultrasonic guidance for needle placement (e.g. biopsy aspiration injection localization device) imaging supervision and interpretation

Chart 9 also displays the top 10 radiology codes reported by physicians. However, the total counts of transactions by procedure code are ranked from highest to lowest. The procedure code with the highest total transaction counts is ranked first. The procedure code with the second highest total transaction counts is ranked second, and so on. This method reveals the most frequently used procedures. A brief description of each procedure code is displayed in the table below.

Chart 9

Top 10 Radiology Procedure Codes by Transaction Counts for Montana



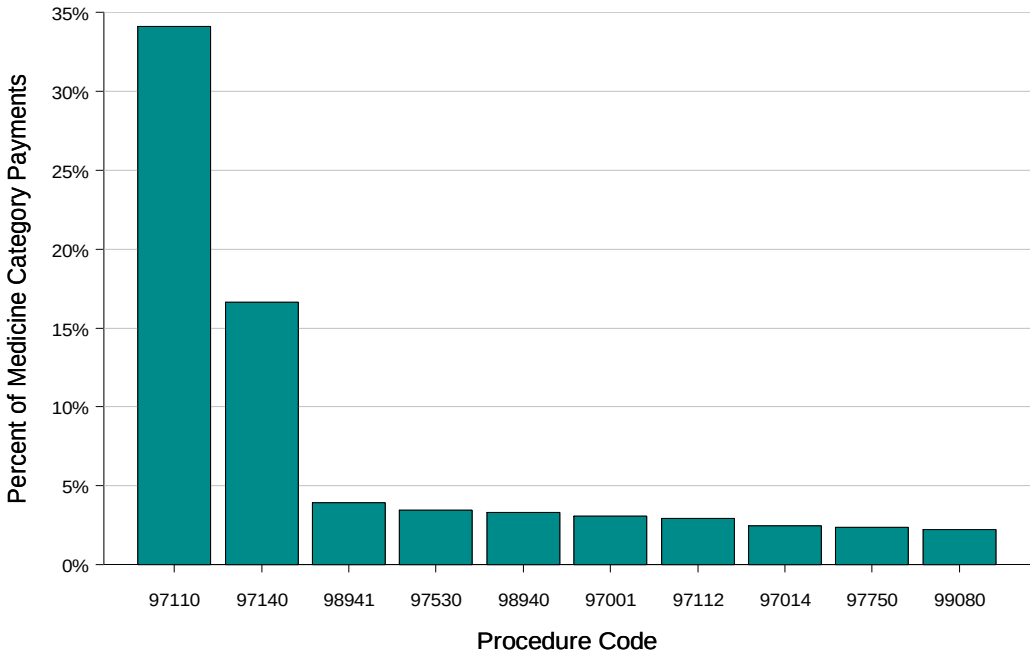
Source: NCCI Medical Data Call, Service Year 2011.

Code	Description
73030	Radiologic examination shoulder; complete minimum of 2 views
72100	Radiologic examination spine lumbosacral; 2 or 3 views
73610	Radiologic examination ankle; complete minimum of 3 views
73562	Radiologic examination knee; 3 views
73110	Radiologic examination wrist; complete minimum of 3 views
73140	Radiologic examination finger(s) minimum of 2 views
72148	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
73721	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
73130	Radiologic examination hand; minimum of 3 views
73630	Radiologic examination foot; complete minimum of 3 views

Chart 10 displays the top 10 medicine codes reported by physicians. The total payments by procedure code are ranked from highest to lowest. The procedure code with the highest amount paid is ranked first. The procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows which procedures have the highest percent share of payments. A brief description of each procedure code is displayed in the table below.

Chart 10

Top 10 Medicine Procedure Codes by Amount Paid for Montana



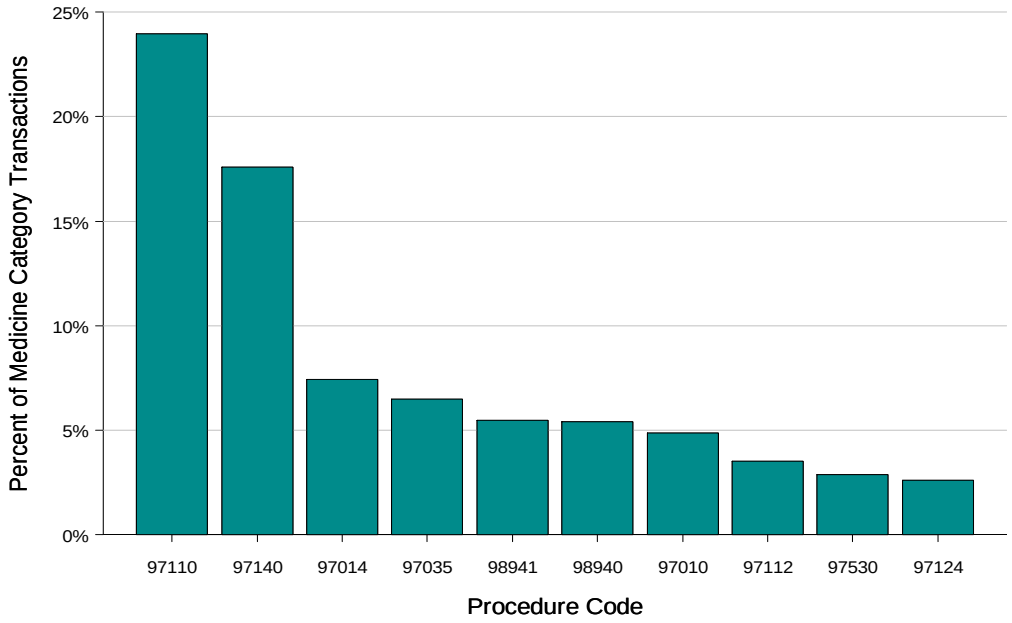
Source: NCCI Medical Data Call, Service Year 2011.

Code	Description
97110	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes
98941	Chiropractic manipulative treatment (CMT); spinal 3-4 regions
97530	Therapeutic activities direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes
98940	Chiropractic manipulative treatment (CMT); spinal 1-2 regions
97001	Physical therapy evaluation
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)
97750	Physical performance test or measurement (e.g., musculoskeletal functional capacity) with written report each 15 minutes
99080	Special reports such as insurance forms more than the information conveyed in the usual medical communications or standard reporting form

Chart 11 also displays the top 10 medicine codes reported by physicians. However, the total counts of transactions by procedure code are ranked from highest to lowest. The procedure code with the highest total transaction counts is ranked first. The procedure code with the second highest total transaction counts is ranked second, and so on. This method reveals the most frequently used procedures. A brief description of each procedure code is displayed in the table below.

Chart 11

Top 10 Medicine Procedure Codes by Transaction Counts for Montana



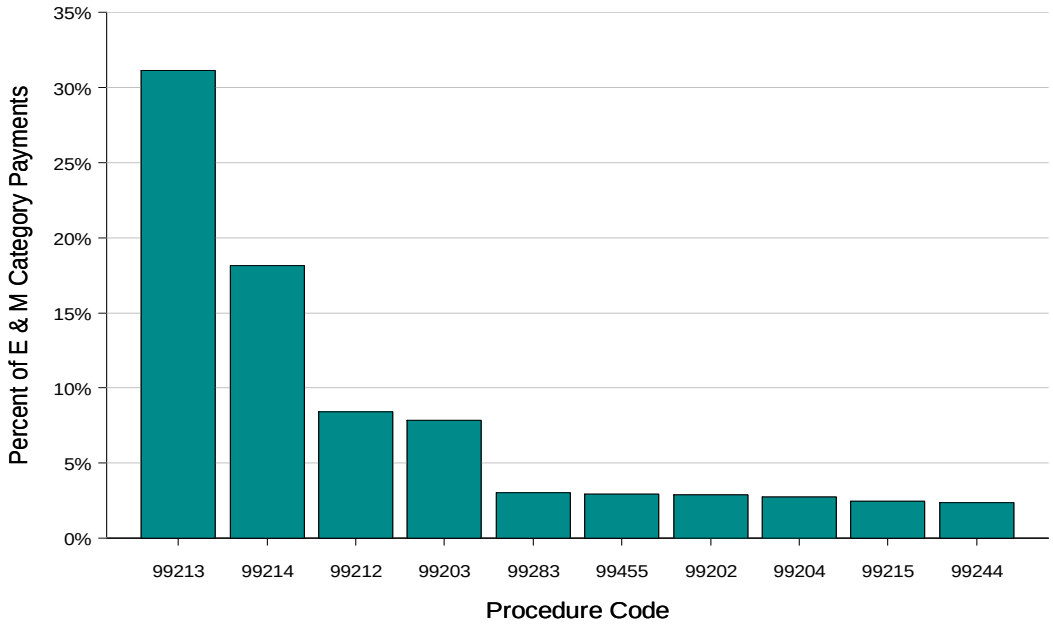
Source: NCCI Medical Data Call, Service Year 2011.

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

Chart 12 displays the top 10 evaluation and management codes reported by physicians. The total payments by procedure code are ranked from highest to lowest. The procedure code with the highest amount paid is ranked first. The procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows which procedures have the highest percent share of payments. A brief description of each procedure code is displayed in the table below.

Chart 12

Top 10 Evaluation and Management Procedure Codes by Amount Paid for Montana



Source: NCCI Medical Data Call, Service Year 2011.

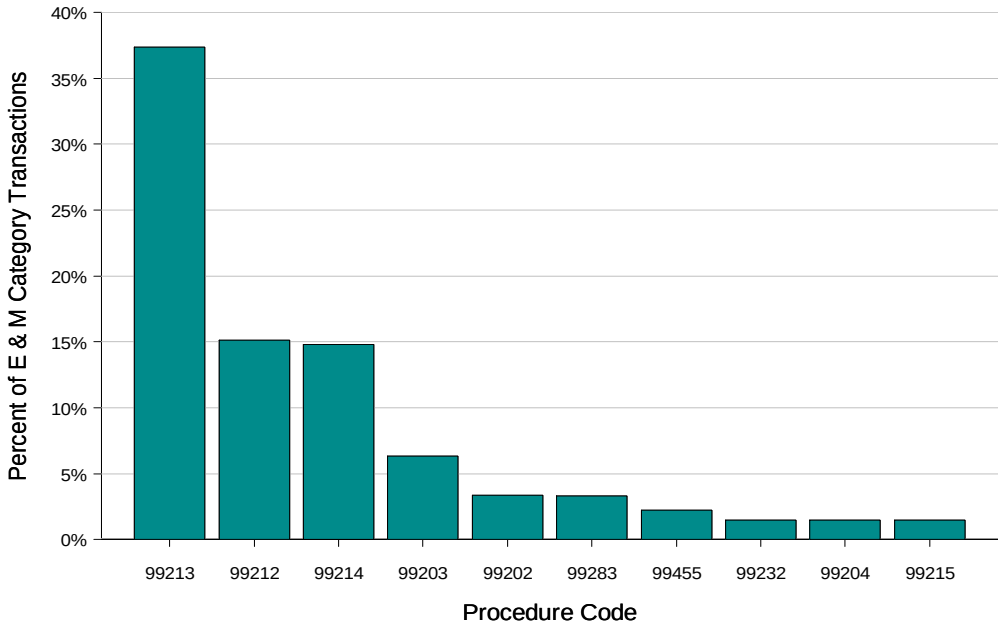
Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99455	Work related or medical disability examination by the treating physician.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Chart 13 displays the top 10 evaluation and management codes reported by physicians. However, the total counts of transactions by procedure code are ranked from highest to lowest. The procedure code with the highest total transaction counts is ranked first. The procedure code with the second highest total transaction counts is ranked second, and so on. This method reveals the most frequently used procedures. A brief description of each procedure code is displayed in the table below.

Chart 13

Top 10 Evaluation and Management Procedure Codes by Transaction Counts for Montana



Source: NCCI Medical Data Call, Service Year 2011.

Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99455	Work related or medical disability examination by the treating physician.

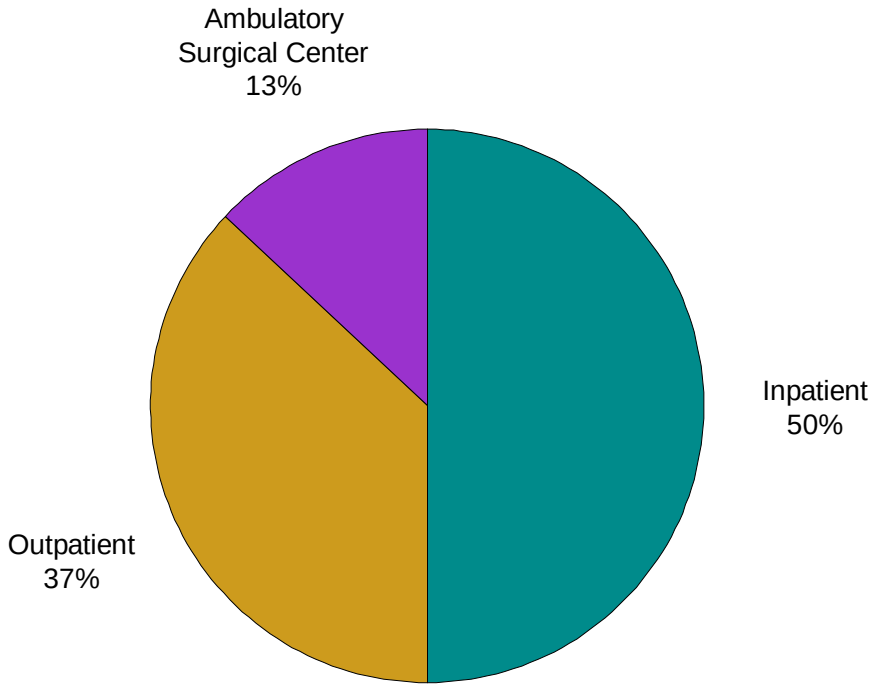
99232	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

Payments attributed to facilities represent inpatient hospital services, outpatient hospital services, and ambulatory surgical center services. Payments are mapped to these categories based on a combination of data elements reported for each transaction such as the taxonomy code (identifies the provider type), procedure code (identifies what type of service was performed), and the place of service (identifies where the service was performed). Charts 14 through 17 go into greater detail on facility payments. Chart 14 displays the distribution of payments by type of facility.

Chart 14

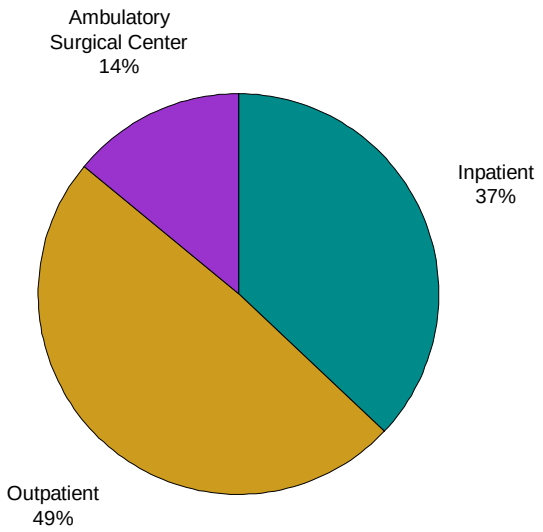
Distribution of Payments by Facility Type

Montana

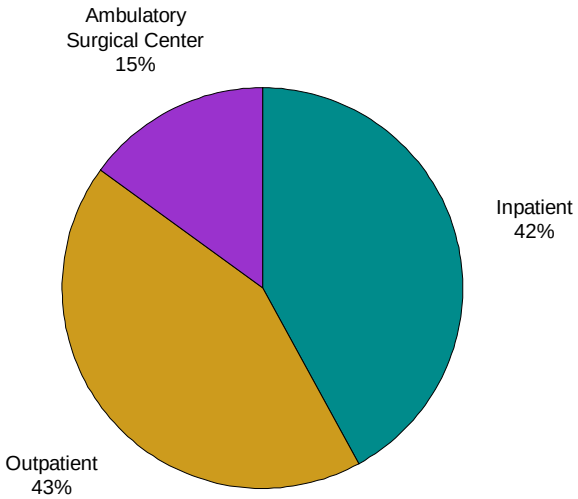


Distribution of Payments by Facility Type

Region



Countrywide

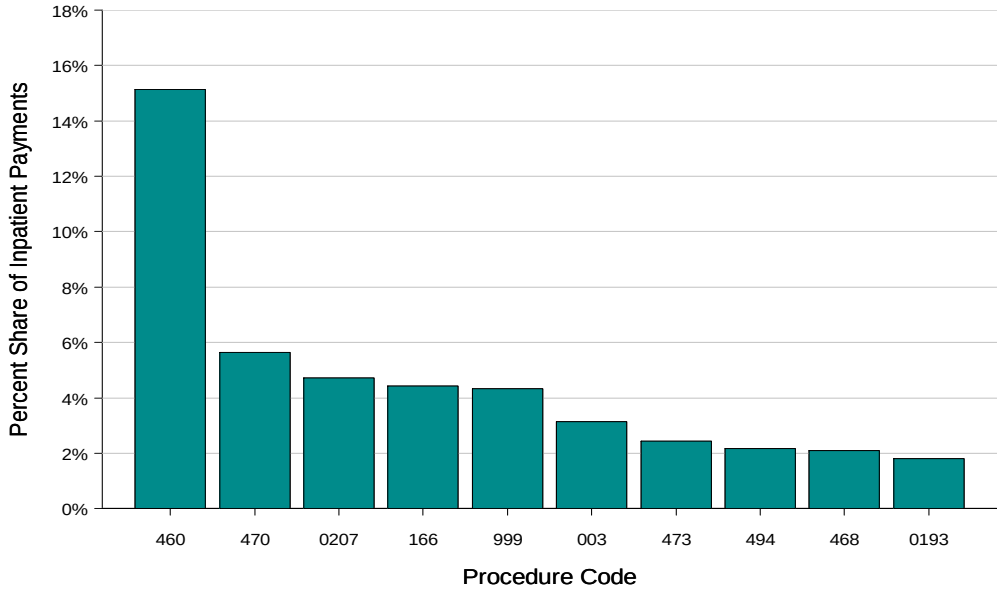


Source: NCCI Medical Data Call, Service Year 2011. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 15 displays the top 10 procedure codes for inpatient hospital services. The total payments by procedure code are ranked from highest to lowest. The procedure code with the highest amount paid is ranked first. The procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows which procedures have the highest percent share of payments. A brief description of each procedure code is displayed in the table below.

Chart 15

Top 10 Procedure Codes by Amount Paid for Inpatient Hospital Services for Montana



Source: NCCI Medical Data Call, Service Year 2011.

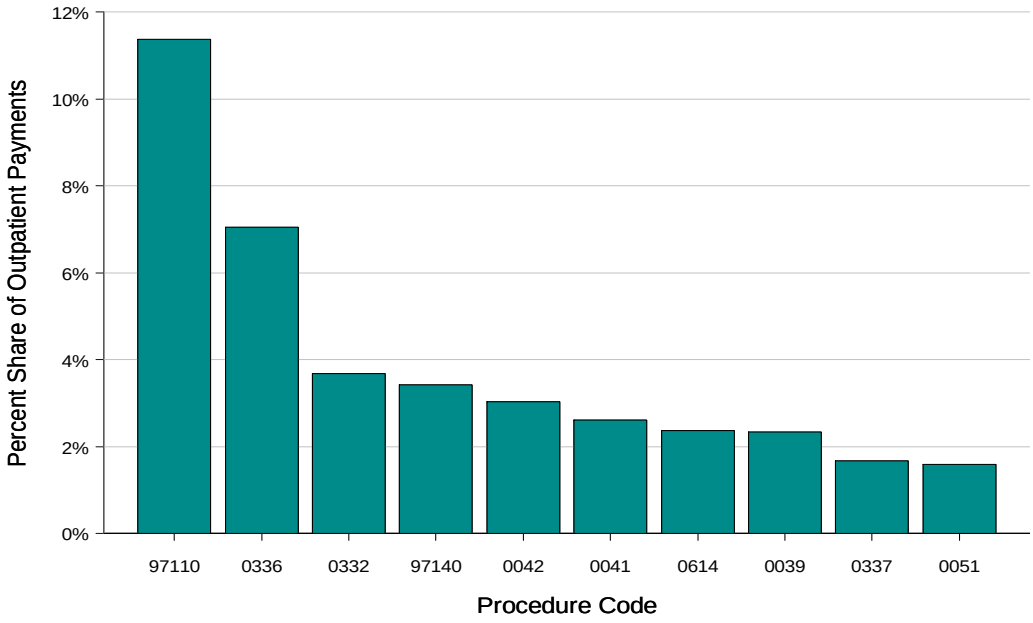
Code	Code Type	Description
460	DRG	Spinal fusion except cervical without major complications or comorbidities
470	DRG	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
0207	Revenue	Intensive care / Burn care
166	DRG	Other respiratory system operating room procedures with major complications or comorbidities
999	DRG	Ungroupable
003	DRG	Extracorporeal membrane oxygenation (ECMO) or tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face mouth and neck with major operating room
473	DRG	Cervical spinal fusion without complications or comorbidities / major complications or comorbidities
494	DRG	Lower extremity and humerus procedures except hip foot femur without complications or comorbidities / major complications or comorbidities
468	DRG	Revision of Hip or Knee Replacement without complications or comorbidities / major complications or comorbidities
0193	Revenue	Subacute Care

The procedure code "999" appears to be used as a catch-all code by data reporters.

Chart 16 displays the top 10 procedure codes for outpatient hospital services. The total payments by procedure code are ranked from highest to lowest. The procedure code with the highest amount paid is ranked first. The procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows which procedures have the highest percent share of payments. A brief description of each procedure code is displayed in the table below.

Chart 16

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



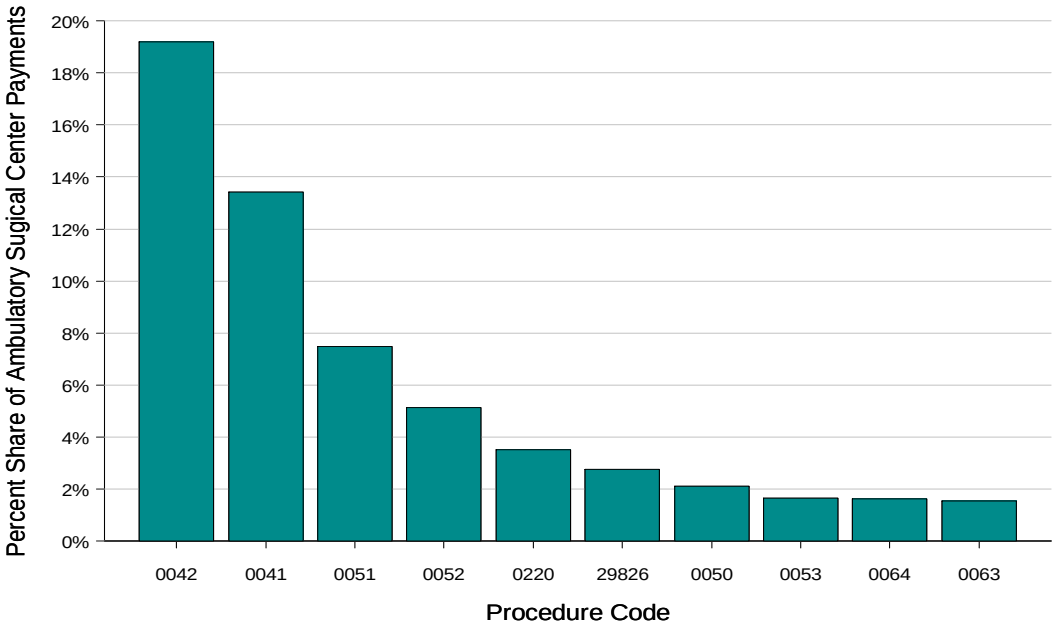
Source: NCCI Medical Data Call, Service Year 2011.

Code	Code Type	Description
97110	CPT	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
0336	APC	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast
0332	APC	Computed Tomography without Contrast
97140	CPT	Manual therapy techniques (e.g. mobilization/ manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes
0042	APC	Level II Arthroscopy
0041	APC	Level I Arthroscopy
0614	Revenue	Magnetic Resonance Technology(MRT)
0039	APC	Level I Implantation of Neurostimulator Generator
0337	APC	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0051	APC	Level III Musculoskeletal Procedures Except Hand and Foot

Chart 17 displays the top 10 procedure codes for ambulatory surgical center services. The total payments by procedure code are ranked from highest to lowest. The procedure code with the highest amount paid is ranked first. The procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows which procedures have the highest percent share of payments. A brief description of each procedure code is displayed in the table below.

Chart 17

Top 10 Procedure Codes by Amount Paid for Ambulatory Surgical Center Services for Montana



Source: NCCI Medical Data Call, Service Year 2011.

Code	Code Type	Description
0042	APC	Level II Arthroscopy
0041	APC	Level I Arthroscopy
0051	APC	Level III Musculoskeletal Procedures Except Hand and Foot
0052	APC	Level IV Musculoskeletal Procedures Except Hand and Foot
0220	APC	Level I Nerve Procedures
29826	CPT	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
0050	APC	Level II Musculoskeletal Procedures Except Hand and Foot
0053	APC	Level I Hand Musculoskeletal Procedures
0064	APC	Level III Treatment Fracture/Dislocation
0063	APC	Level II Treatment Fracture/Dislocation

Charts 18 through 21 go into greater detail on payments for prescription drugs reported with a national drug code (NDC). Payments are categorized as drugs if the procedure code reported on the transaction is an NDC. Payments for drugs can also be reported using procedure codes other than NDC codes, such as revenue codes, healthcare common procedure coding system (HCPCS), and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC code.

Chart 18 displays the shares of the payments of prescription medication for the top 10 workers compensation (WC) drugs. This method of ranking shows which drugs have the highest percent share of payments.

Chart 18

Top 10 Drugs by Amount Paid for Montana

Name of Drug	Type	Percent of Drug Payments
OXYCONTIN	Brand Name	15.6%
CYMBALTA	Brand Name	6.3%
CELEBREX	Brand Name	5.0%
LYRICA	Brand Name	4.8%
GABAPENTIN	Generic	4.0%
HYDROCODONE-ACETAMINOPHEN	Generic	3.4%
FENTANYL	Generic	2.5%
OXYCODONE HCL	Generic	2.1%
TRAMADOL HCL	Generic	2.1%
LIDODERM	Brand Name	1.8%

Top 10 Drugs by Amount Paid for Countrywide

Name of Drug	Type	Percent of Drug Payments
OXYCONTIN	Brand Name	6.6%
LYRICA	Brand Name	4.7%
LIDODERM	Brand Name	4.4%
HYDROCODONE-ACETAMINOPHEN	Generic	4.2%
GABAPENTIN	Generic	4.1%
MELOXICAM	Generic	3.5%
CYMBALTA	Brand Name	3.4%
CELEBREX	Brand Name	3.3%
TRAMADOL HCL	Generic	2.8%
OPANA ER	Brand Name	2.3%

Source: NCCI Medical Data Call, Service Year 2011. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 19 displays the top 10 workers compensation drugs according to count of prescriptions. This chart reveals the most frequently prescribed drugs. The results in this chart are based only on payments reported with an NDC code.

Chart 19

Top 10 Drugs by Prescription Counts for Montana

Name of Drug	Type	Percent of Prescription Counts
HYDROCODONE-ACETAMINOPHEN	Generic	13.9%
CYCLOBENZAPRINE HCL	Generic	4.3%
TRAMADOL HCL	Generic	4.0%
GABAPENTIN	Generic	3.7%
OXYCONTIN	Brand Name	3.6%
OXYCODONE HCL	Generic	3.5%
CYMBALTA	Brand Name	3.1%
CELEBREX	Brand Name	3.0%
LYRICA	Brand Name	2.3%
MELOXICAM	Generic	2.1%

Top 10 Drugs by Prescription Counts for Countrywide

Name of Drug	Type	Percent of Prescription Counts
HYDROCODONE-ACETAMINOPHEN	Generic	15.3%
TRAMADOL HCL	Generic	5.0%
CYCLOBENZAPRINE HCL	Generic	4.5%
IBUPROFEN	Generic	4.2%
GABAPENTIN	Generic	3.2%
MELOXICAM	Generic	2.7%
OXYCODONE-ACETAMINOPHEN	Generic	2.6%
LYRICA	Brand Name	2.3%
NAPROXEN	Generic	2.2%
CARISOPRODOL	Generic	2.1%

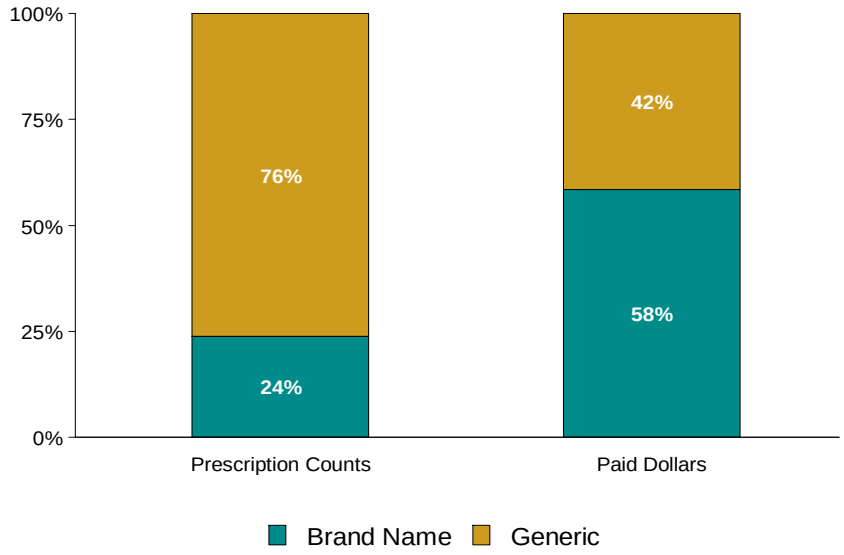
Source: NCCI Medical Data Call, Service Year 2011. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 20 shows the distribution of prescription drugs by brand name and generics. The share between brand name and generics is displayed based on both prescription counts and payments. The results in this chart are based only on transactions reported with an NDC code.

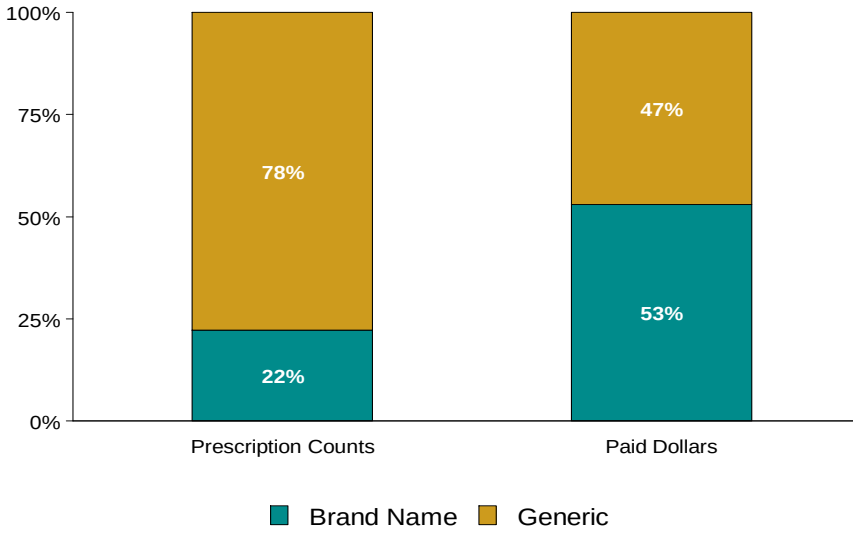
Chart 20

Distribution of Drugs by Brand Name and Generic

Montana



Countrywide



Source: NCCI Medical Data Call, Service Year 2011. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

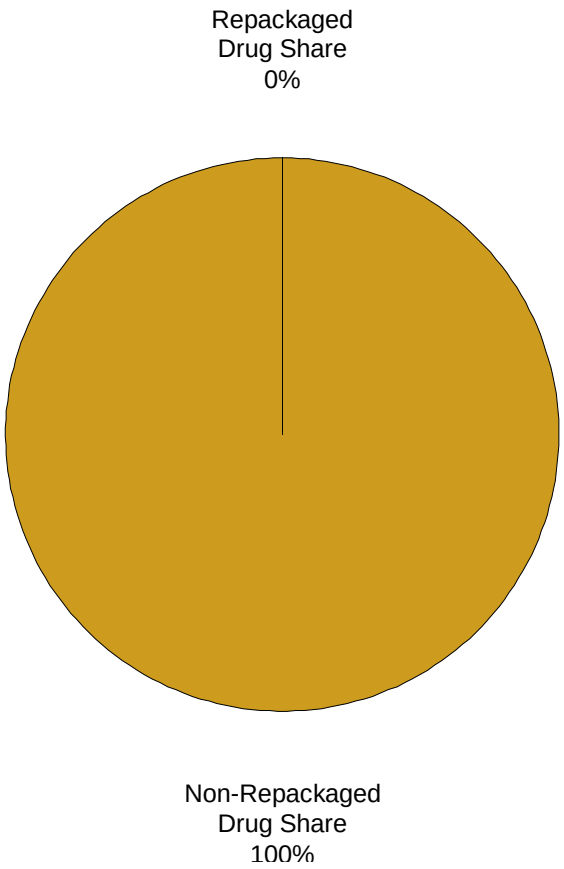
Drugs are uniquely identified by a National Drug Code (NDC). NDCs are specific not only to the product (including strength and formulation) and package size but also to the labeler. Labelers are manufacturers, repackagers, and distributors.

Workers compensation (WC) drug fee schedules are typically based on Average Wholesale Price (AWP). Because each NDC comes with a unique AWP, any firm that repackages a drug can set both a new NDC and a new, possibly artificially inflated, AWP. As a result, WC costs for repackaged drugs have grown out of proportion to the number of prescriptions written for repackaged drugs. Some states have introduced limits on reimbursements for repackaged drugs. Chart 21 shows the distribution of payments for repackaged and non-repackaged drugs. The results in this chart are based only on payments reported with an NDC code.

Chart 21

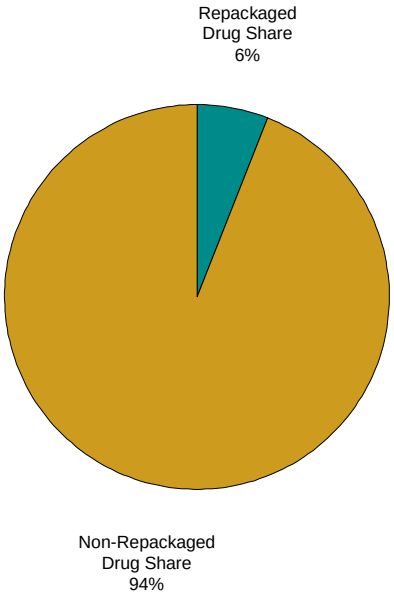
Distribution of Drug Payments

Montana

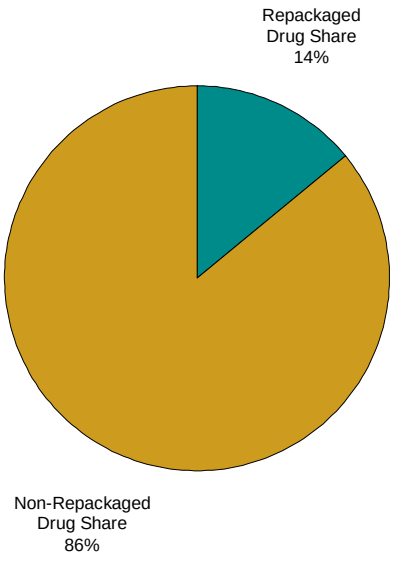


Distribution of Drug Payments

Region



Countrywide



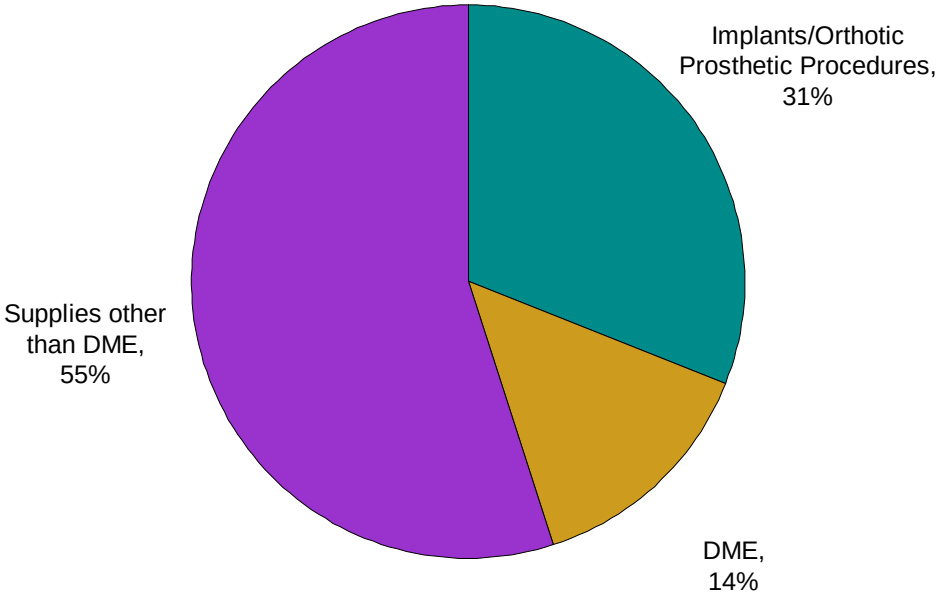
Source: NCCI Medical Data Call, Service Year 2011. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 22 displays the distribution of payments separately by durable medical equipment (DME); Supplies other than DME; and Implants/Orthotic and Prosthetic Procedures. 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. The source for the mapping of procedure code to each category is the AMA.

Chart 22

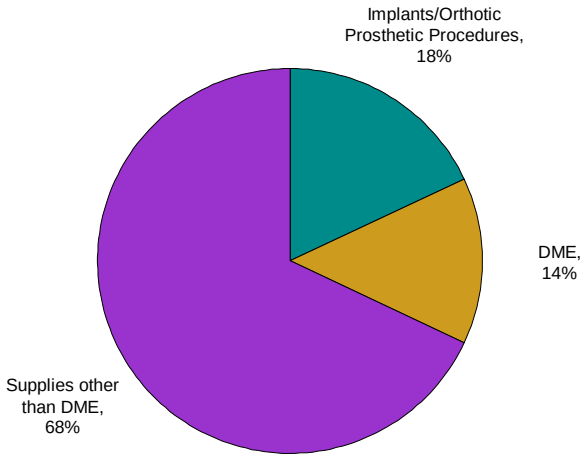
Distribution of Payments by DME, Supplies, and Implants

Montana

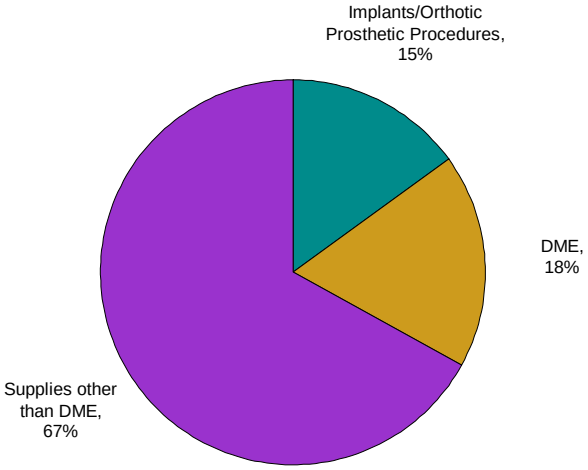


Distribution of Payments by DME, Supplies, and Implants

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2011. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following 35 states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, KS, KY, LA, MD, ME, MO, MS, MT, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Glossary

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

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

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

Current Procedure Terminology (CPT): A numeric coding system maintained by the American Medical Association (AMA). The CPT coding system consists of 5 digit codes that are primarily used to identify medical services and procedures performed by physicians and other healthcare professionals.

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

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

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

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

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

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

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

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

Transaction: A line item of a medical bill.

APPENDIX

The data contained in this report represents medical transactions for Service Year 2011 (medical services delivered from January 1, 2011 to December 31, 2011). Insurance carriers must report paid medical transactions if they write at least 1% of the market share in any one state for which NCCI is the advisory organization. Once a carrier meets the eligibility criteria, the carrier will be required to report for all applicable states in which it writes, even if an individual state's market share is below the threshold. All carriers within a group are required to report, regardless if they write less than 1% of the market share in the state.

The data is reported under the jurisdiction state; this is 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, increase efficiency of computer systems, and improve the accuracy and quality of the data.

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, medical bill review vendors, etc. 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 using vendors. Although data may have been provided by an authorized vendor on behalf of a carrier, the quality, timeliness, and completeness of the data is the responsibility of the carrier.

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

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

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