



Medical Data Report

for the state of:

MONTANA

September 2015



Medical Data Report for the state of: MONTANA

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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, impact of changes 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 and controlled substances.

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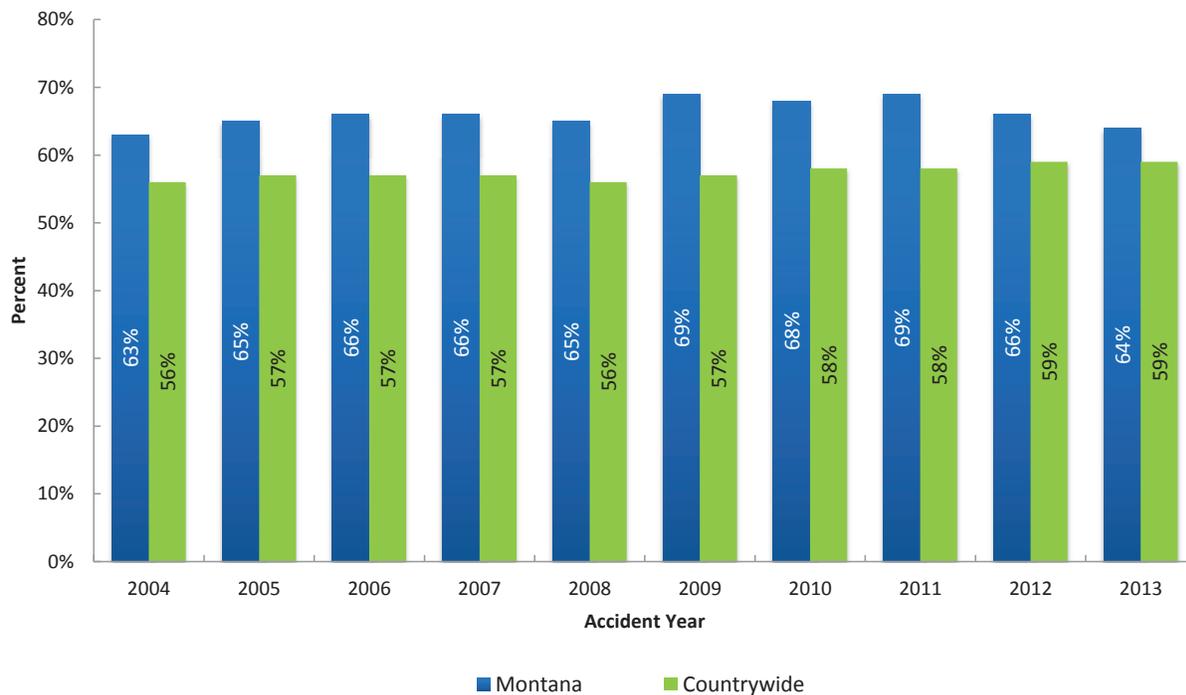
Traditional workers compensation policies cover two types of benefit payments: medical costs and indemnity (lost wages) costs.

Of the two, medical benefits resulting from a work-related injury or disease are the leading cost drivers for workers compensation claims on a countrywide basis. As this is a relative measure and benefits for both indemnity and medical may vary from state to state, local share of medical benefit costs may vary. In particular, the medical share in a state may be large because the indemnity benefits are relatively less prominent.

Chart 1 displays the medical percentage of total benefit costs for Montana 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, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, and VT.

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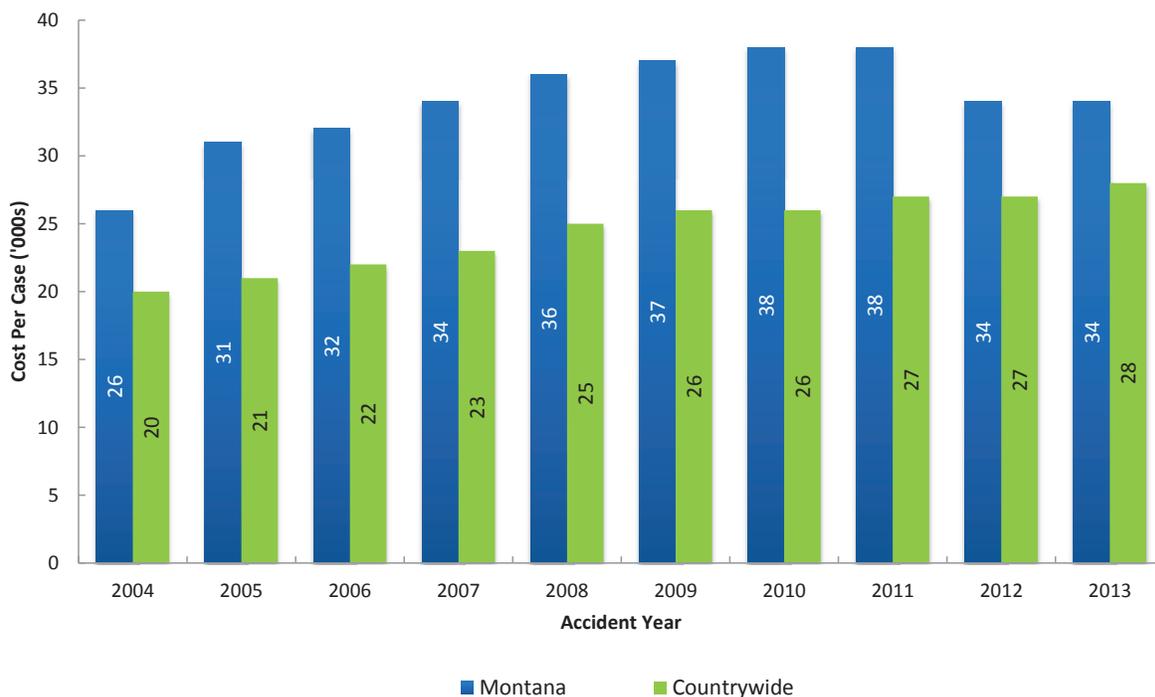
After a decade of medical cost inflation at an annual rate of 6%, since 2010 the countrywide overall medical average cost per claim has seen more moderate increases. Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for both Montana and the countrywide average.

Medical losses are at historical benefit levels and historical dollar values—meaning that no adjustment for inflation or changes in benefits has been made. Since the data is aggregated for all medical losses by accident year, the results shown in this chart provide a high-level perspective of the average medical cost per case.

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

Chart 2

Overall Medical Average Cost per 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, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, TX, UT, VA, and VT.

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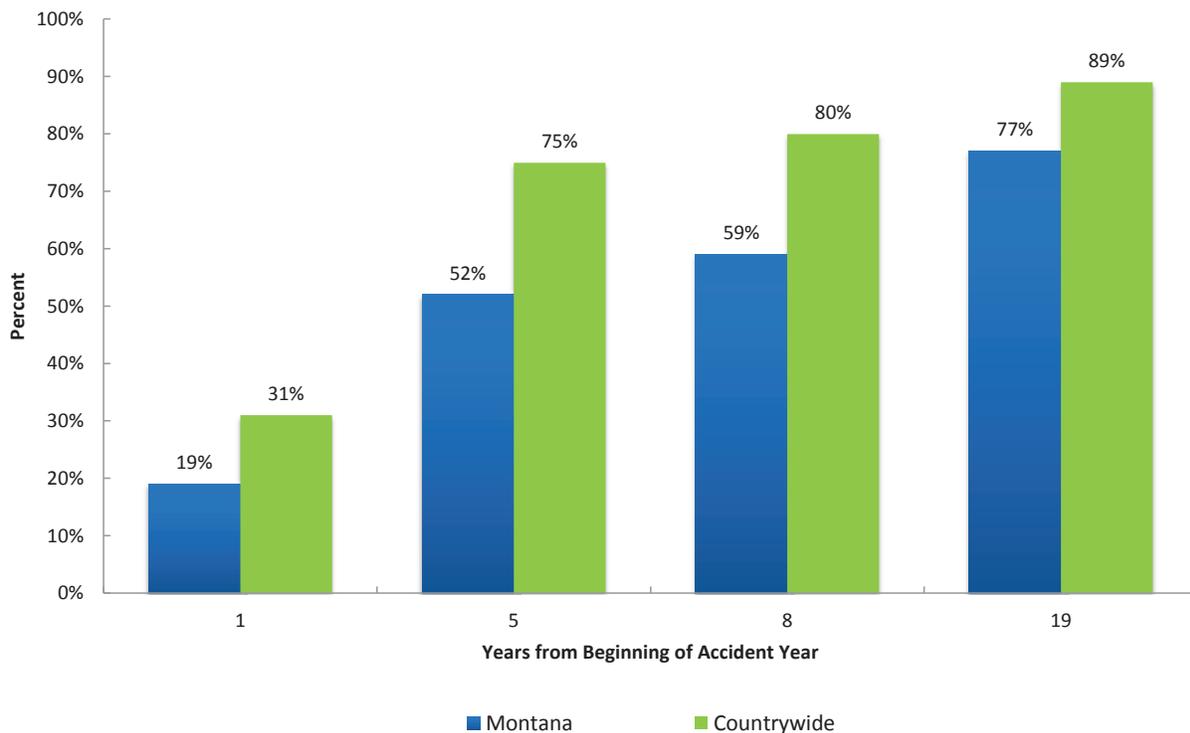
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. Recent NCCI research has found that it is likely that more than 10% of the cost of medical benefits for workplace injuries that occur this year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

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

Chart 3 shows the percentage of medical benefits paid (including medical settlements) at different claim maturities for Montana and 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, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, and VT.

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

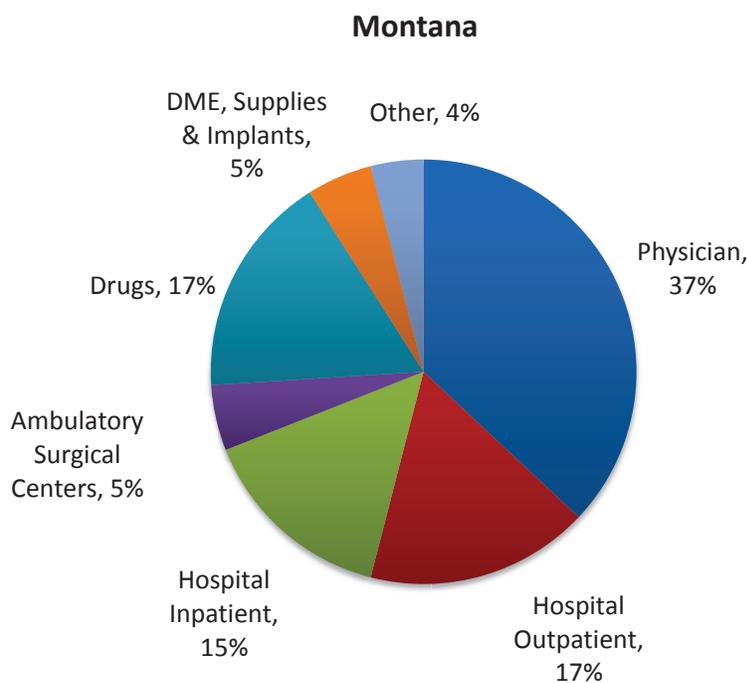
Chart 4 displays the distribution of medical payments by type of service.

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 Outpatient, Hospital Inpatient, and Ambulatory Surgical Centers (ASC)—NCCI relies on a combination of:

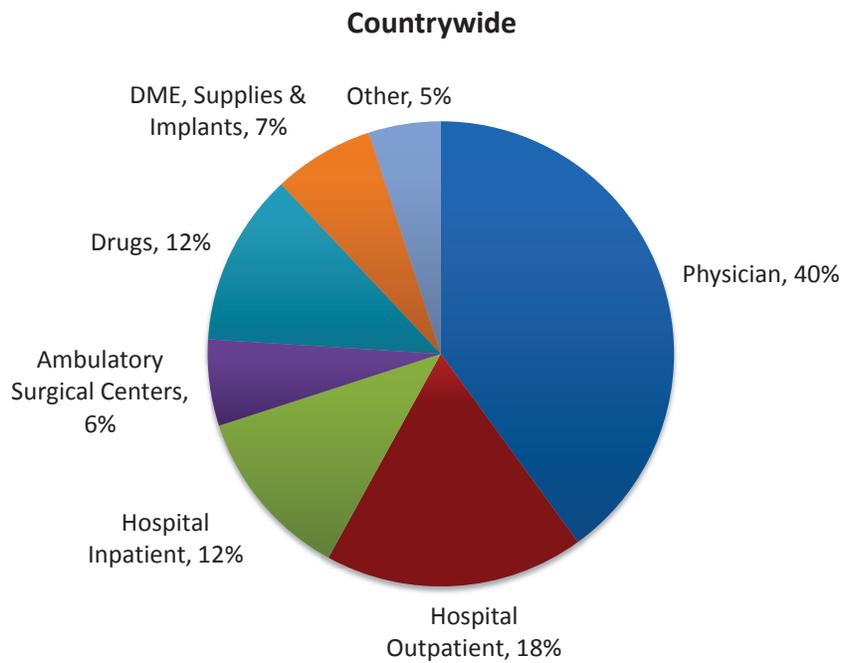
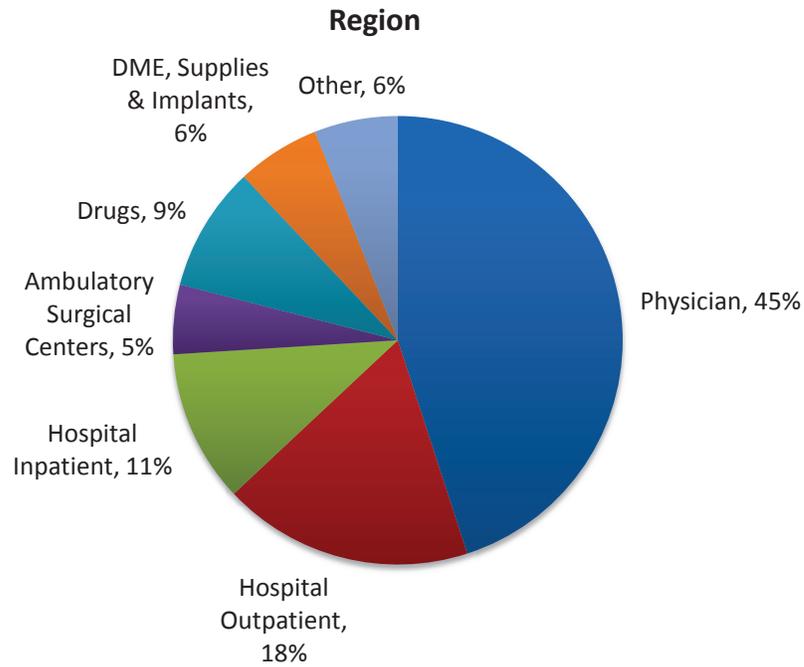
- Provider taxonomy code—identifies the type of provider that billed for and is being paid for a medical service; see Glossary
- Procedure code—alphanumeric code used to identify procedures performed by medical professionals
- Place of services—alphanumeric code used to identify places where procedures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

Chart 4

Distribution of Medical Payments



Distribution of Medical Payments



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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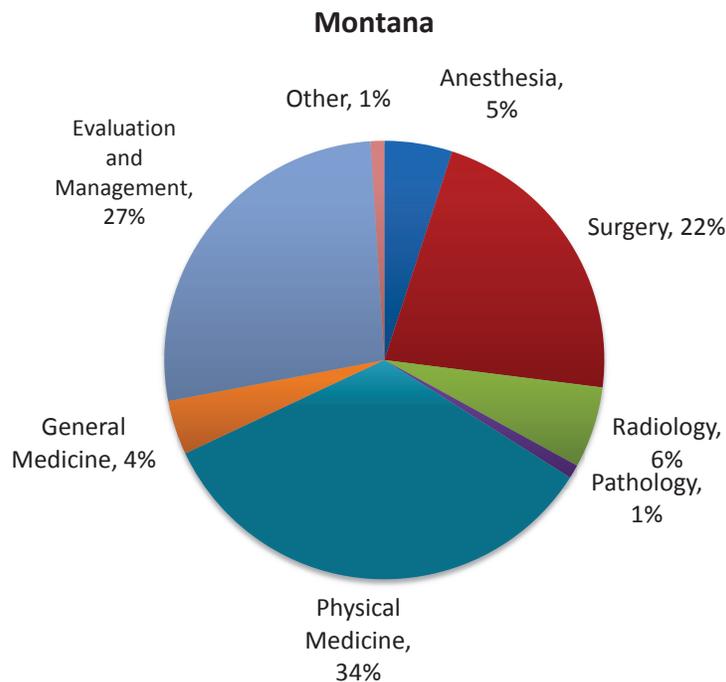
Results from NCCI's study "[The Price Impact of Physician Fee Schedules](#)" (April 2014), show that the median workers compensation price for a physician service is always at, or very near, the maximum allowable reimbursement (MAR) amount set by the fee schedule. In the 1970s, less than a dozen states had physician fee schedules in place. Several states established such schedules in the 1990s, and today only six states remain without a physician fee schedule. Recent changes in such schedules indicate greater attention to provisions that often seek to balance cost containment with service provider availability.

Chart 5 shows the distribution of physician payments by service category. Service categories are defined by the American Medical Association (AMA). 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, such as state-defined codes.

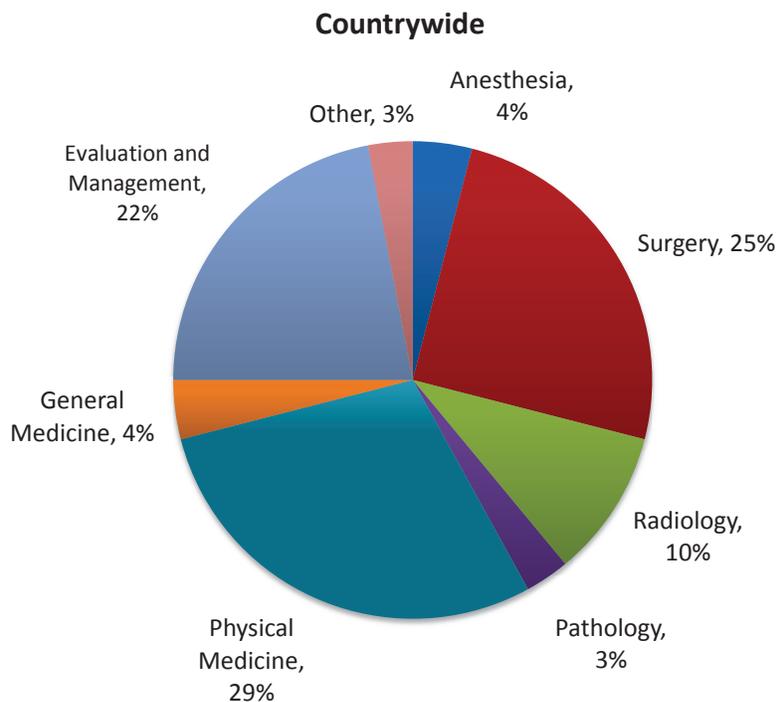
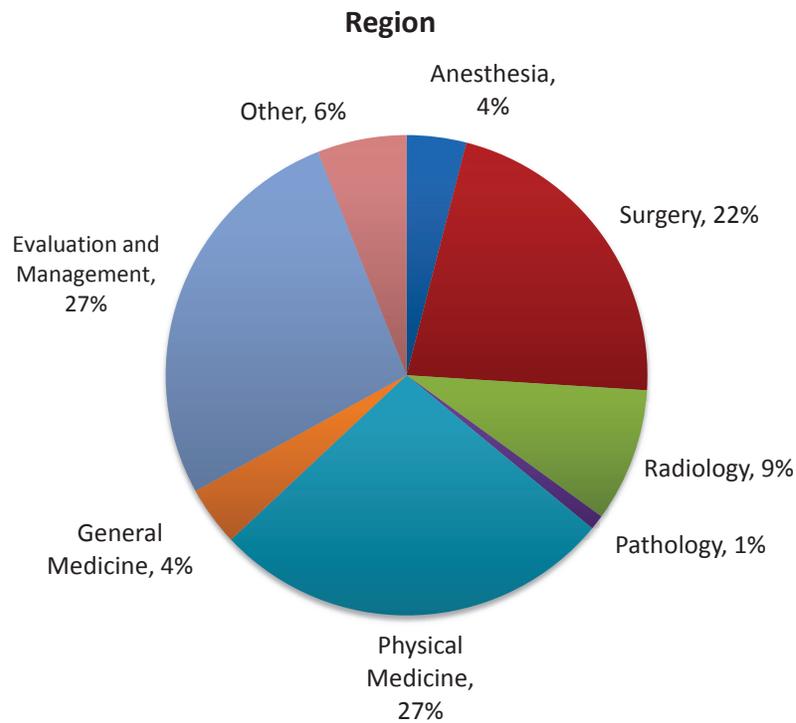
Since many states' medical fee schedule payment levels vary by service categories, an analysis of physician payments provides insights into the effectiveness of the fee schedule. For example, if the share of payments is high for a particular category compared to other states, a driver of the higher share could be higher maximum payment levels for that service category provided in the fee schedule.

Chart 5

Distribution of Physician Payments by AMA Service Category



Distribution of Physician Payments by AMA Service Category



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Physicians typically use current procedure terminology (CPT) codes to identify the services they provide to claimants. These codes are specific and provide detailed information on what service was performed. Charts 6 through 14 display the top 10 procedure codes reported by physicians for the service categories: surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code, including the percent of payments the code represents in Montana, is displayed in the corresponding table below each chart.

The charts also include the average amount paid per transaction for these codes in Montana, in the region, and across the country. The average amount paid per transaction is calculated by taking the total payments for the procedure code and dividing by the number of transactions for the procedure code. Other fields, such as the secondary paid procedure code, modifier, diagnosis code, place of service, quantity/units, and others may need to be considered when evaluating average payments per service.

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

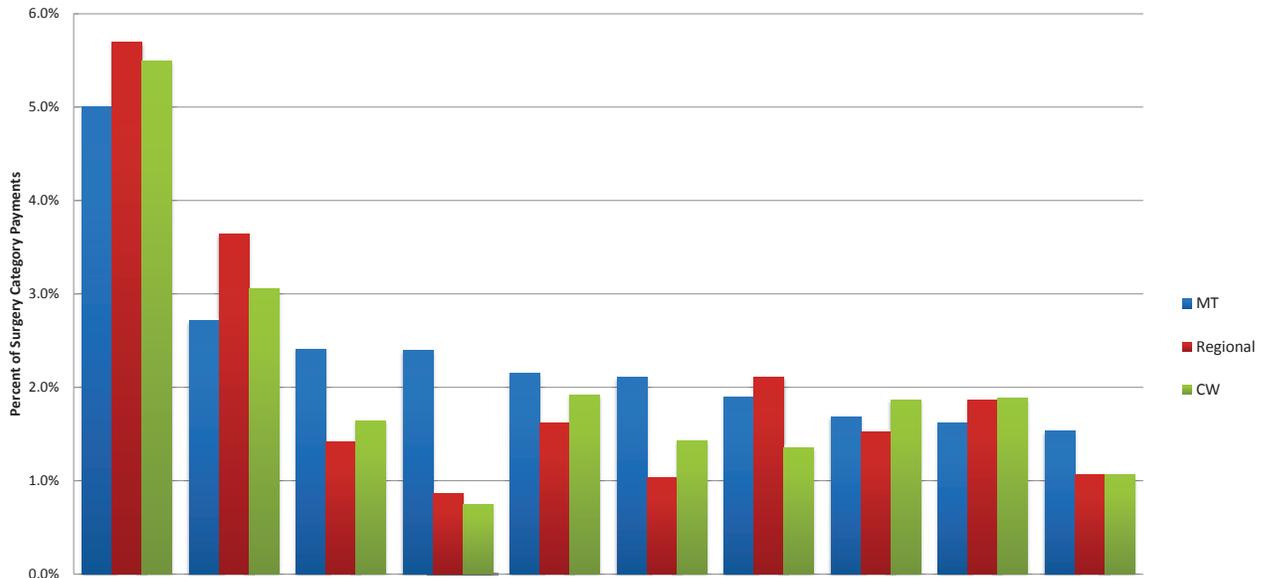
The second method ranks procedure codes by total count of transactions. The procedure code with the highest total transaction count is ranked first; the procedure code with the second highest total transaction count is ranked second; and so on. This method reveals the most frequently used procedures.

Results from NCCI's study "[The Price Impact of Physician Fee Schedules](#)" (April 2014) show that the influence of fee schedules is quite different between the high-volume "Evaluation and Management" (E&M) service category and the small-volume "Surgery" category. For Surgery, many workers compensation payments are well below the MAR but are considerably above group health payments. In contrast, for E&M, workers compensation payments are closer to the MAR than those for Surgery and are more in line with those for group health.

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Chart 6

Top 10 Surgery Procedure Codes by Amount Paid for Montana



Procedure Code	MT	Reg	CW
29827	\$1,327	\$1,715	\$1,979
29881	\$767	\$1,172	\$1,344
20610	\$102	\$98	\$113
27447	\$1,604	\$2,241	\$2,348
22551	\$2,033	\$2,999	\$3,239
63047	\$1,168	\$1,642	\$1,915
29888	\$1,295	\$1,913	\$2,122
64483	\$244	\$312	\$443
29823	\$760	\$914	\$1,120
29822	\$548	\$826	\$1,008

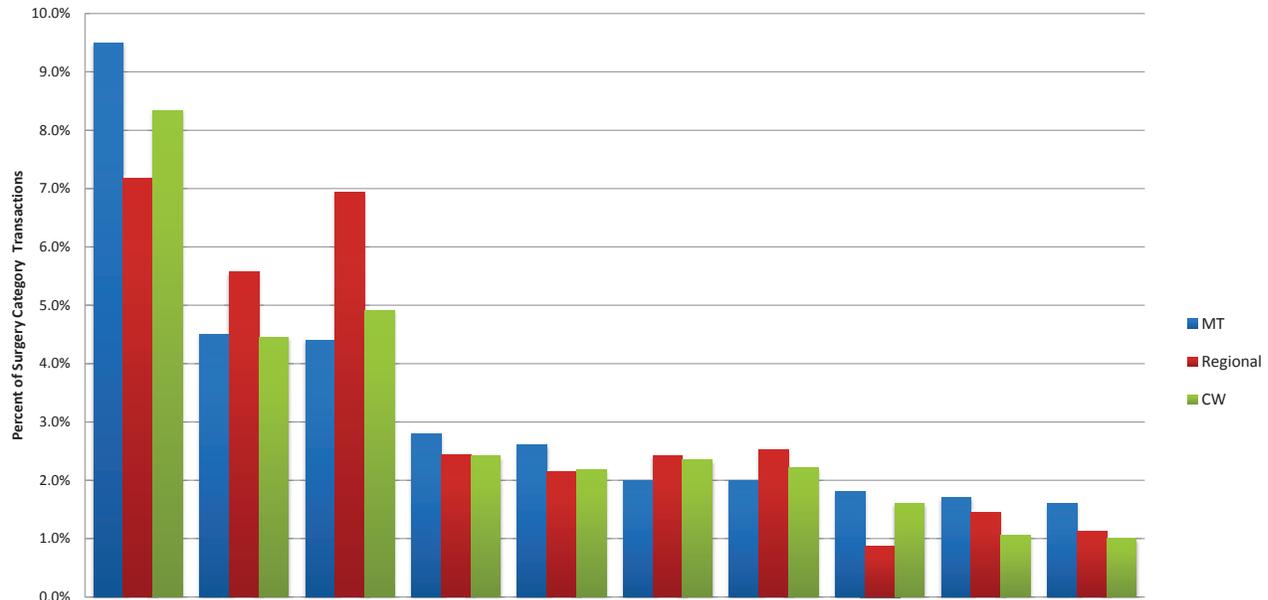
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
29827	5.0%	Arthroscopy shoulder surgical; with rotator cuff repair
29881	2.7%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
20610	2.4%	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
27447	2.4%	Arthroplasty knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)
22551	2.1%	Arthrodesis anterior interbody including disc space preparation discectomy osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
63047	2.1%	Laminectomy facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]) single vertebral segment; lumbar
29888	1.9%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
64483	1.7%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
29823	1.6%	Arthroscopy shoulder surgical; debridement extensive
29822	1.5%	Arthroscopy shoulder surgical; debridement limited

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Chart 7

Top 10 Surgery Procedure Codes by Transaction Counts for Montana



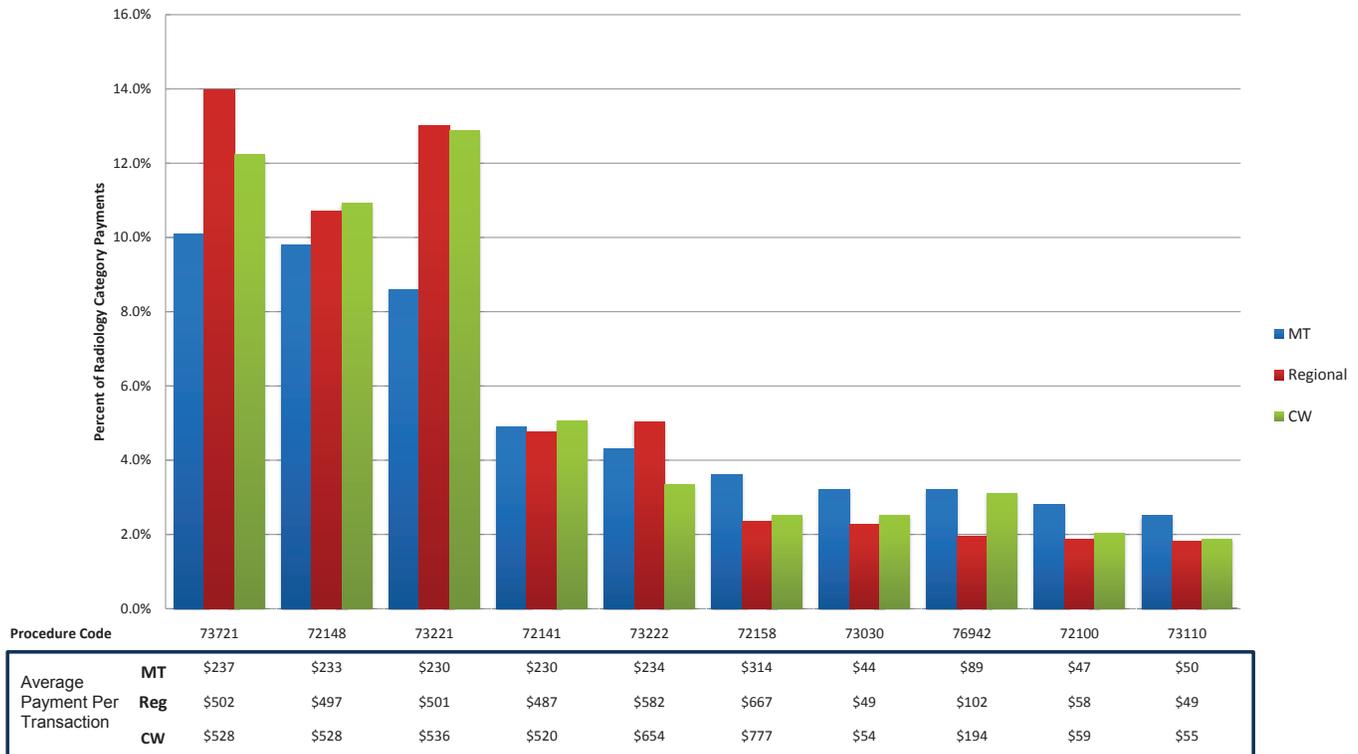
Procedure Code	MT	Reg	CW
20610	\$102	\$98	\$113
12001	\$127	\$147	\$174
36415	\$6	\$15	\$12
64483	\$244	\$312	\$443
64415	\$129	\$156	\$245
29826	\$228	\$702	\$1,003
12002	\$149	\$188	\$204
62311	\$177	\$252	\$345
23350	\$123	\$176	\$229
64493	\$192	\$262	\$386

Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
20610	9.5%	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
12001	4.5%	Simple repair of superficial wounds of scalp neck axillae external genitalia trunk and/or extremities (including hands and feet); 2.5 cm or less
36415	4.4%	Collection of venous blood by venipuncture
64483	2.8%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
64415	2.6%	Injection anesthetic agent; brachial plexus single
29826	2.0%	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
12002	2.0%	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
62311	1.8%	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
23350	1.7%	Injection procedure for shoulder arthrography or enhanced computed tomography (CT)/magnetic resonance imaging (MRI) shoulder arthrography
64493	1.6%	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

Top 10 Radiology Procedure Codes by Amount Paid for Montana



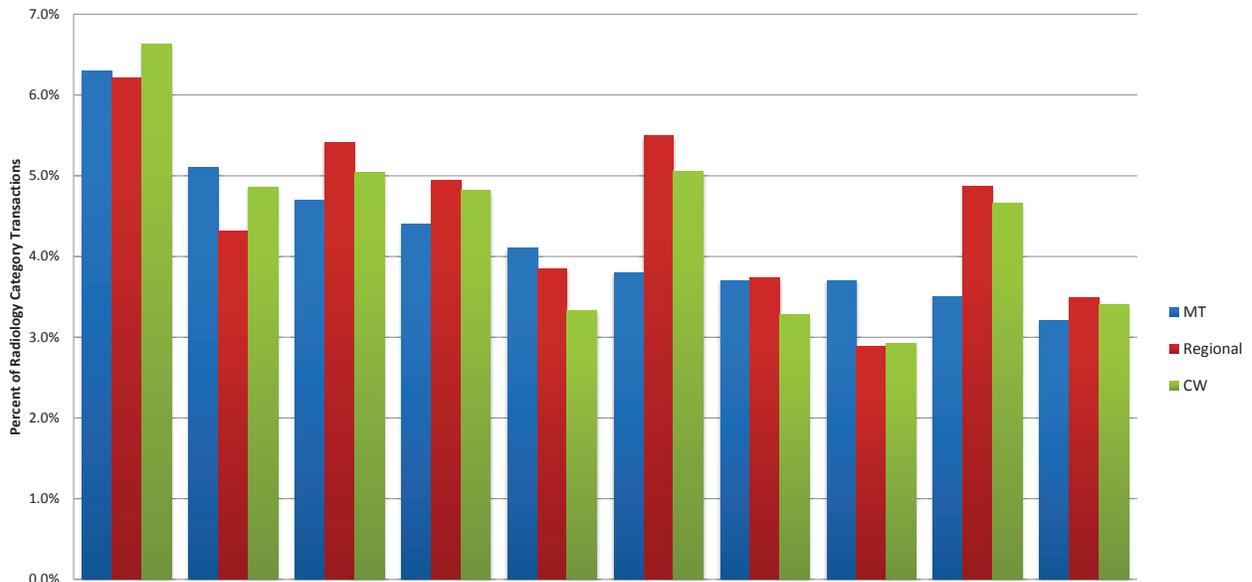
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Code	% in MT	Description
73721	10.1%	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
72148	9.8%	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
73221	8.6%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)
72141	4.9%	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material
73222	4.3%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; with contrast material(s)
72158	3.6%	Magnetic resonance (e.g., proton) imaging spinal canal and contents without contrast material followed by contrast material(s) and further sequences
73030	3.2%	Radiologic examination shoulder; complete minimum of 2 views
76942	3.2%	Ultrasonic guidance for needle placement (e.g., biopsy aspiration injection localization device) imaging supervision and interpretation
72100	2.8%	Radiologic examination spine lumbosacral; 2 or 3 views
73110	2.5%	Radiologic examination wrist; complete minimum of 3 views

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Chart 9

Top 10 Radiology Procedure Codes by Transaction Counts for Montana



Procedure Code	MT	Reg	CW
73030	\$44	\$49	\$54
72100	\$47	\$58	\$59
73610	\$44	\$48	\$51
73110	\$50	\$49	\$55
73562	\$50	\$54	\$57
73140	\$41	\$41	\$45
73721	\$237	\$502	\$528
72148	\$233	\$497	\$528
73630	\$41	\$46	\$49
73221	\$230	\$501	\$536

Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
73030	6.3%	Radiologic examination shoulder; complete minimum of 2 views
72100	5.1%	Radiologic examination spine lumbosacral; 2 or 3 views
73610	4.7%	Radiologic examination ankle; complete minimum of 3 views
73110	4.4%	Radiologic examination wrist; complete minimum of 3 views
73562	4.1%	Radiologic examination knee; 3 views
73140	3.8%	Radiologic examination finger(s) minimum of 2 views
73721	3.7%	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
72148	3.7%	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
73630	3.5%	Radiologic examination foot; complete minimum of 3 views
73221	3.2%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)

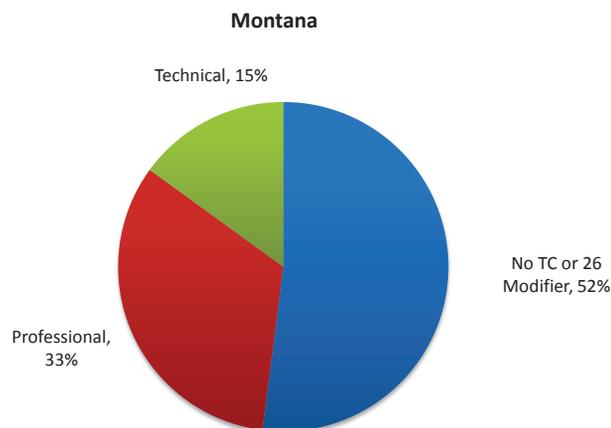
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Radiology procedures consist of two components. There is a technical component, which is the performance of the examination, and a professional component for the interpretation of the results. Radiology services may be billed for the entire procedure, or may be billed separately for each component. If billed by component, a modifier should be reported along with the CPT code. These modifiers may be "26" for the professional component or "TC" for the technical component.

Chart 10 shows the distribution of radiology payments by component for the latest service year, and the breakdown for the identified top ten radiology procedures, by paid amount, in the state.

Chart 10

Distribution of Radiology Payments by Modifier Code



Average Paid Amount per Transaction by Modifier Code

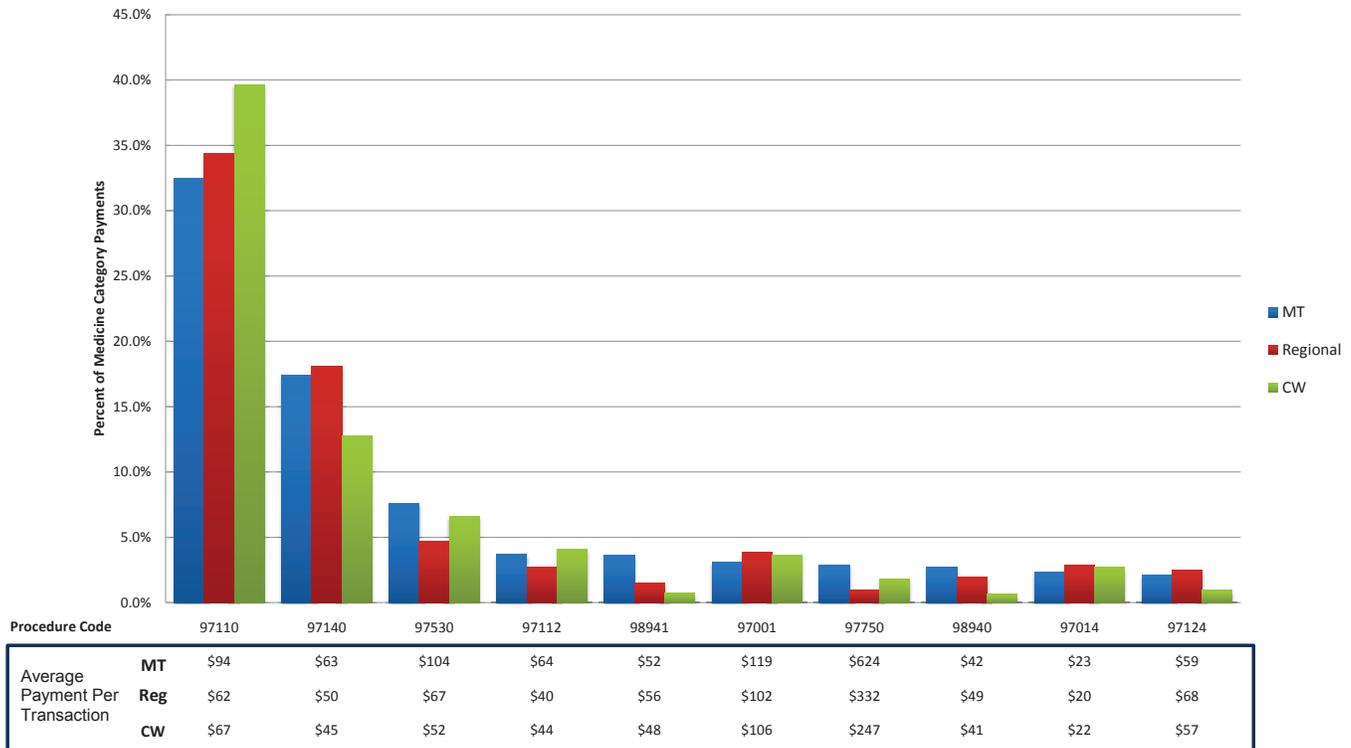
Code	No TC or 26 Modifier	Professional	Technical
73721	\$475	\$117	\$338
72148	\$564	\$123	\$374
73221	\$456	\$117	\$337
72141	\$461	\$124	\$403
73222	\$629	\$135	\$554
72158	\$797	\$191	\$720
73030	\$55	\$18	\$58
76942	\$165	\$55	\$313
72100	\$62	\$20	\$57
73110	\$67	\$15	\$58

Source: NCCI Medical Data Call, Service Year 2014

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Chart 11

Top 10 Physical and General Medicine Procedure Codes by Amount Paid for Montana



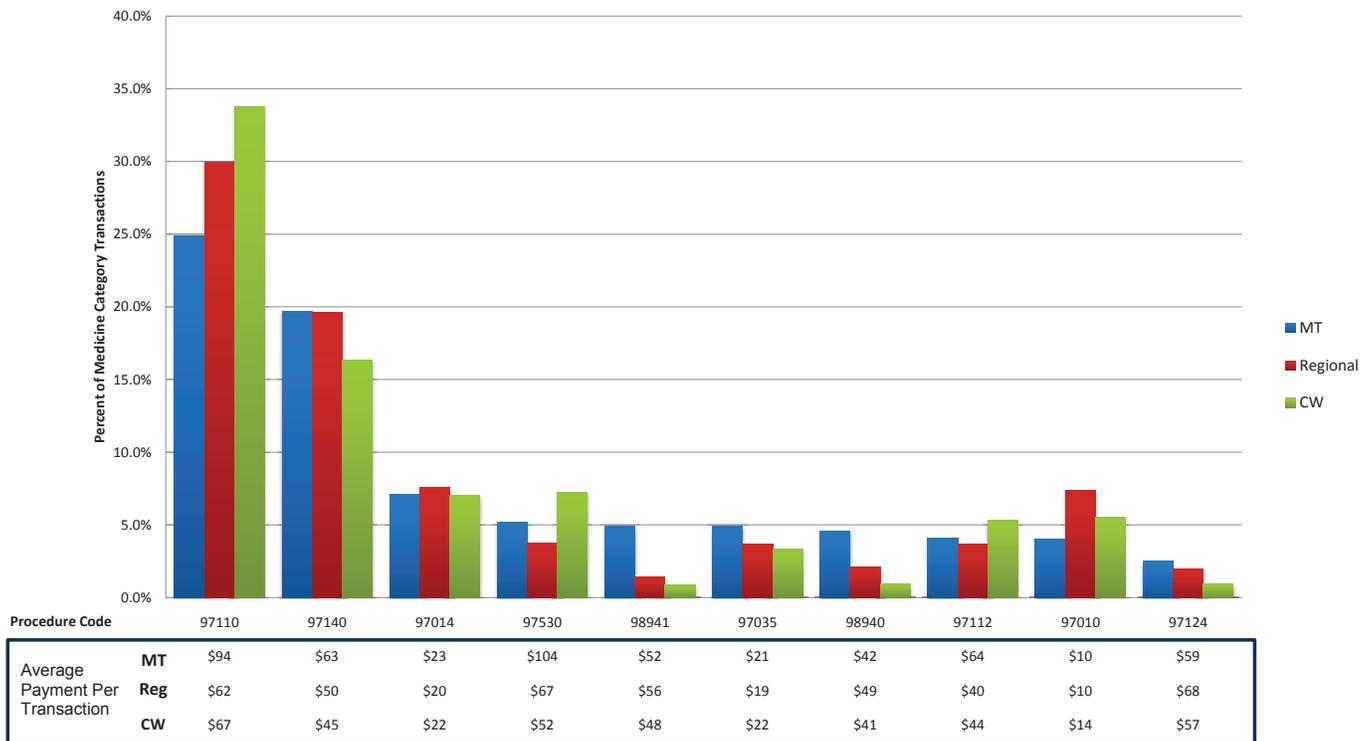
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Code	% in MT	Description
97110	32.5%	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	17.4%	Manual therapy techniques (e.g., mobilization/ manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes
97530	7.6%	Therapeutic activities direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes
97112	3.7%	Therapeutic procedure 1 or more areas each 15 minutes; neuromuscular reeducation of movement balance coordination kinesthetic sense posture and/or proprioception for sitting and/or standing activities
98941	3.6%	Chiropractic manipulative treatment (CMT); spinal 3-4 regions
97001	3.1%	Physical therapy evaluation
97750	2.9%	Physical performance test or measurement (e.g., musculoskeletal functional capacity) with written report each 15 minutes
98940	2.7%	Chiropractic manipulative treatment (CMT); spinal 1-2 regions
97014	2.3%	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97124	2.1%	Therapeutic procedure 1 or more areas each 15 minutes; massage including effleurage petrissage and/or tapotement (stroking compression percussion)

Medical Data Report for the state of: MONTANA

Chart 12

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts for Montana



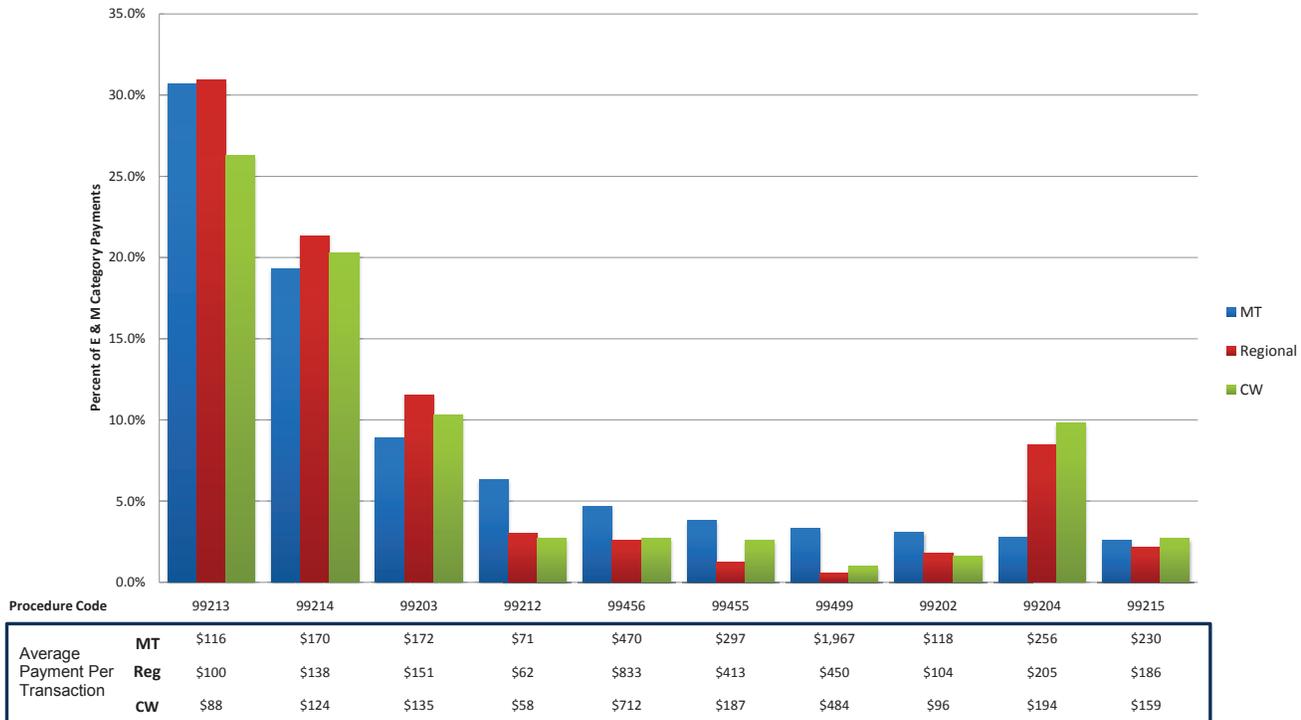
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
97110	24.9%	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	19.7%	Manual therapy techniques (e.g., mobilization/ manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes
97014	7.1%	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97530	5.2%	Therapeutic activities direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes
98941	4.9%	Chiropractic manipulative treatment (CMT); spinal 3-4 regions
97035	4.9%	Application of a modality to 1 or more areas; ultrasound each 15 minutes
98940	4.6%	Chiropractic manipulative treatment (CMT); spinal 1-2 regions
97112	4.1%	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
97010	4.0%	Application of a modality to 1 or more areas; hot or cold packs
97124	2.5%	Therapeutic procedure 1 or more areas each 15 minutes; massage including effleurage petrissage and/or tapotement (stroking compression percussion)

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Chart 13

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



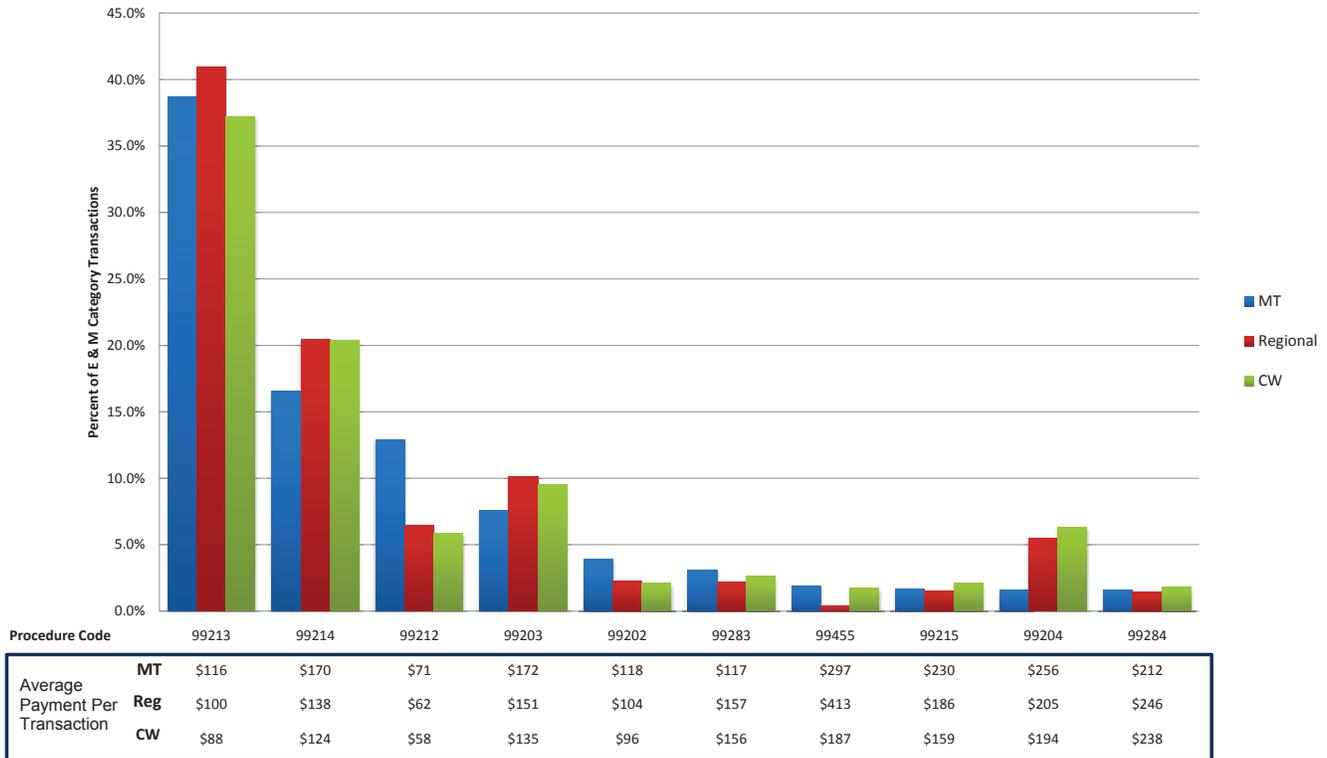
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
99213	30.7%	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	19.3%	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	8.9%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99212	6.3%	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.
99456	4.7%	Work related or medical disability examination by other than the treating physician.
99455	3.8%	Work related or medical disability examination by the treating physician.
99499	3.3%	Unlisted evaluation and management service
99202	3.1%	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	2.8%	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	2.6%	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.

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Chart 14

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



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
99213	38.7%	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	16.6%	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	12.9%	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	7.6%	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	3.9%	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	3.1%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99455	1.9%	Work related or medical disability examination by the treating physician.
99215	1.7%	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99204	1.6%	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99284	1.6%	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

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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, including:

- Taxonomy code
- Procedure code
- Place of service

General healthcare trends may be the primary driver of the cost distribution; however, the fee schedule may also play a role. In many states, the fee schedule varies by type of facility, which may help explain differences observed between states.

Hospital inpatient fee schedules in workers compensation were mostly established in the last decade. More than 10 states remain without such regulation today. Unlike physician fee schedules, hospital inpatient fee schedules vary a great deal. Some are based on Medicare; others reflect a discount off the charge master established by the hospitals; and yet others are based on a per diem basis.

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

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In Montana, 76% of hospital inpatient codes are reported with a DRG code.

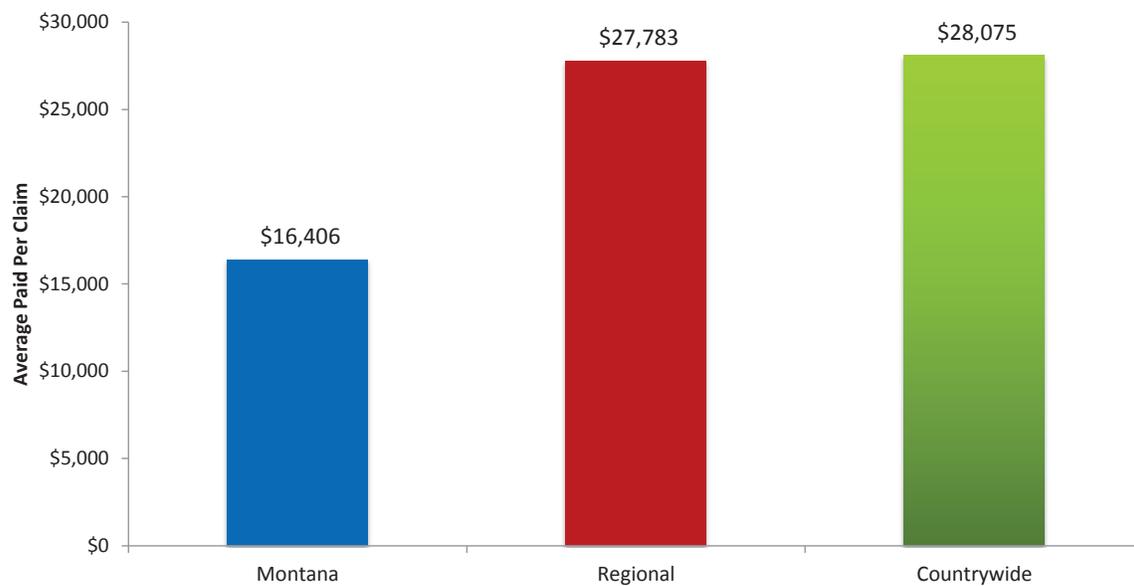
Due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, regional and countrywide comparisons by procedure code for inpatient costs should be interpreted with caution. One measure for hospital inpatient services is the average paid amount per claim. Because claim counts are not affected by billing practices, payments for hospital inpatient services per claim provide another metric to compare costs.

Another measure would be the average cost of inpatient stay. One claim may have more than one hospital stay.

Chart 15 displays the average paid amount per claim for hospital inpatient services for Montana as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 15

Average Inpatient Paid Amount per Claim for Hospital Inpatient Services



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

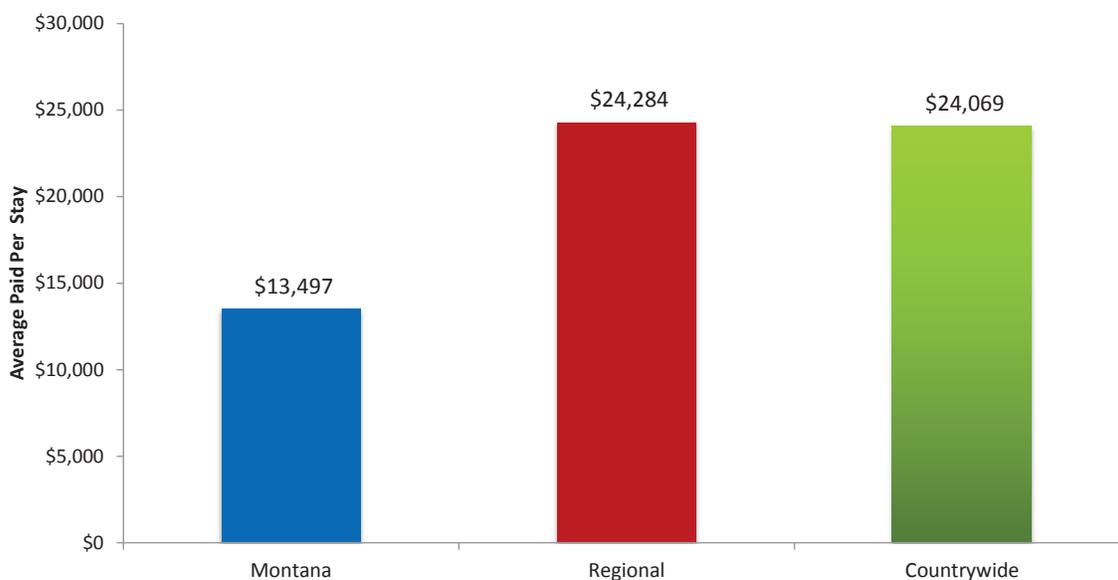
Medical Data Report for the state of: MONTANA

One comparative measure of inpatient service costs is the average cost per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

Chart 16 displays the average paid amount per stay for hospital inpatient services for Montana as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 16

Average Inpatient Paid Amount per Stay for Hospital Inpatient Services

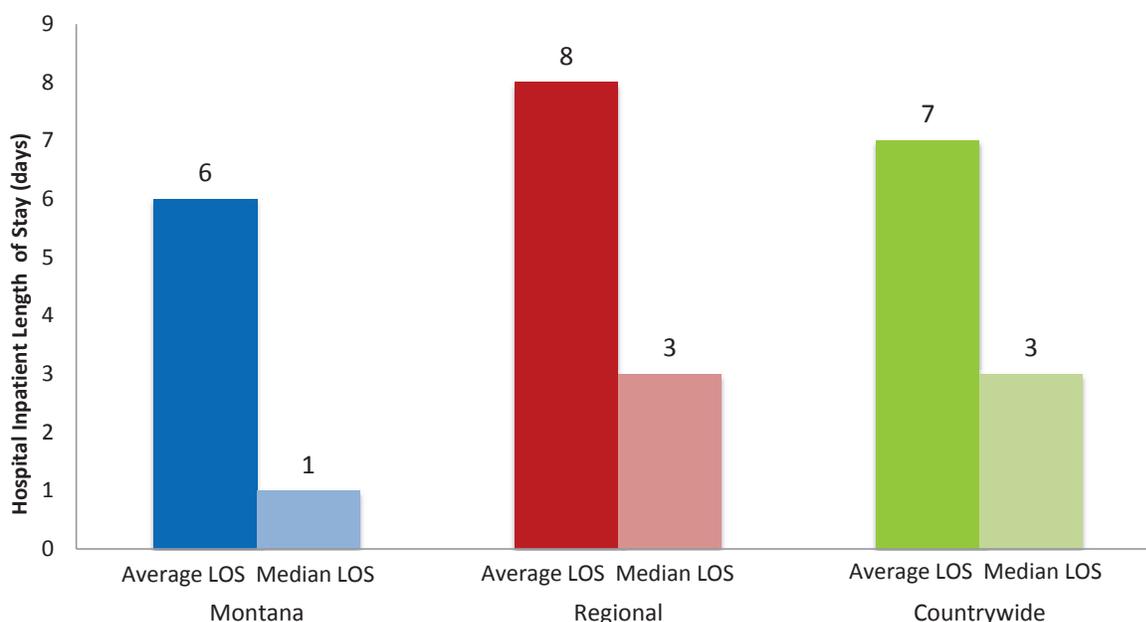


Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 17 displays the average and median¹ length of stay (LOS) for hospital inpatient services for Montana as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 17

Inpatient Length of Stay for Hospital Inpatient Services



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

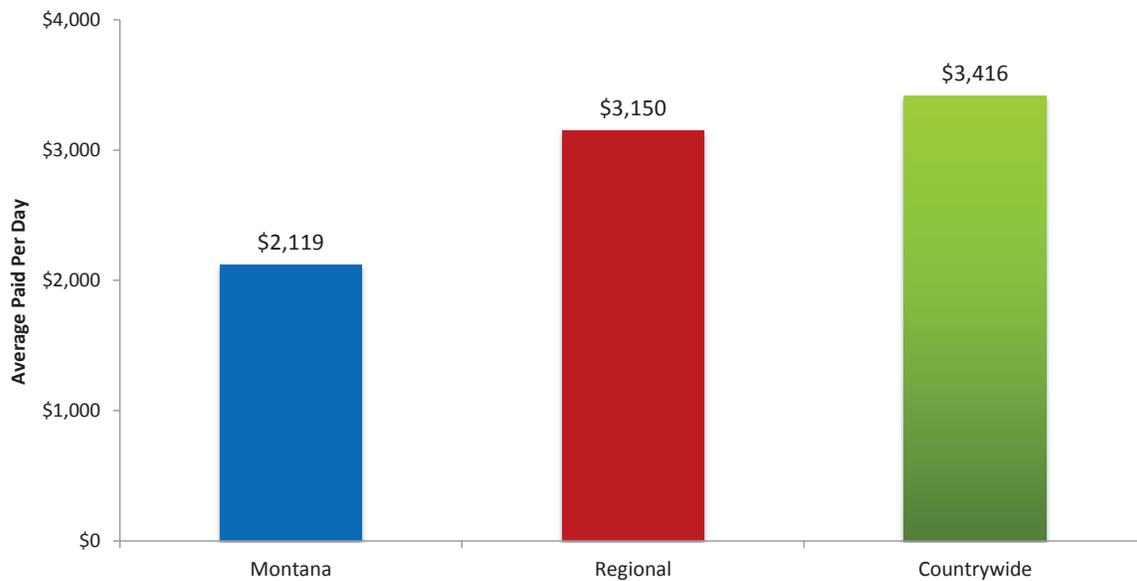
¹ The median LOS is the LOS where one half of all LOS values is higher and one half is lower. This statistic is less affected by extremely low or extremely high values.

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Chart 18 displays the average paid amount per day for hospital inpatient services for Montana as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 18

Average Inpatient Paid Amount per Day for Hospital Inpatient Services



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

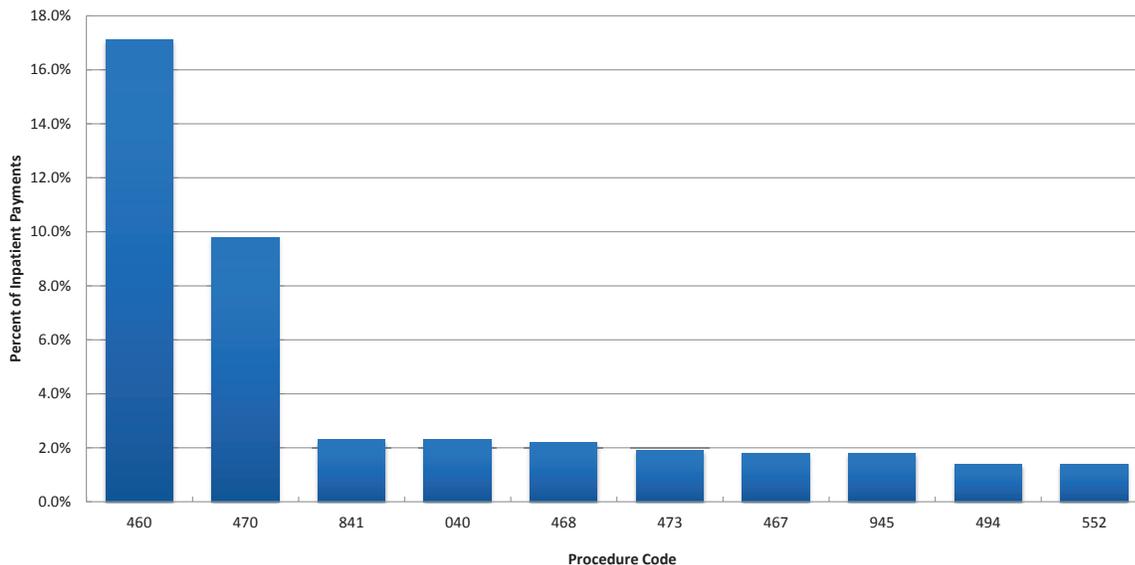
Medical Data Report for the state of: MONTANA

Chart 19 and Chart 20 display the top 10 DRG codes and top 10 revenue codes for hospital inpatient services, revealing the most prevalent inpatient hospital services. The codes are ranked based on total payments.

A brief description of each code is displayed in the table below the charts.

Chart 19

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

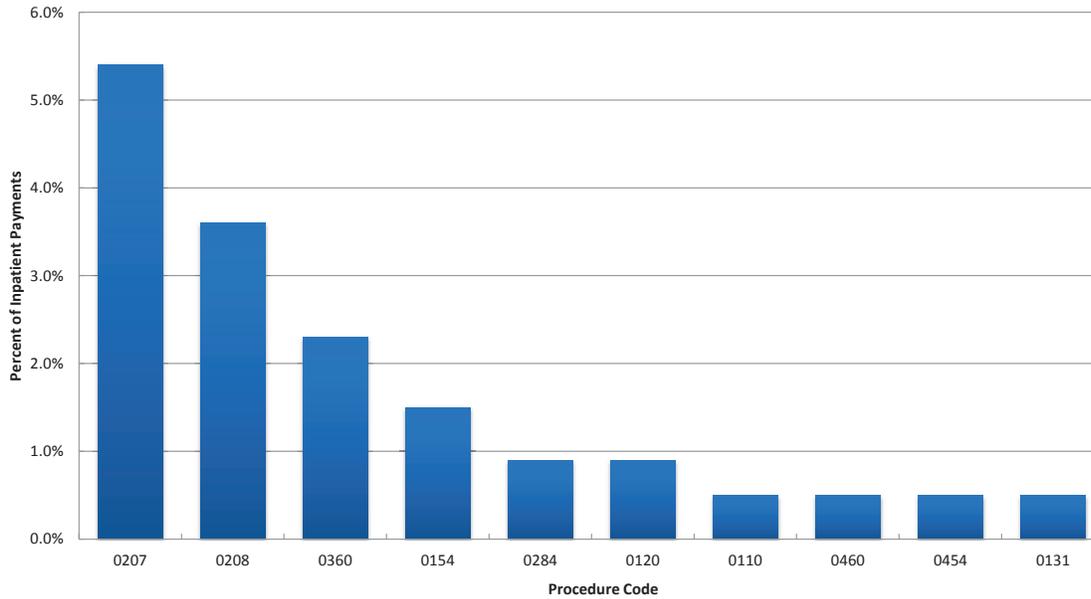


Source: NCCI Medical Data Call, Service Year 2014.

Code	% in MT	Description
460	17.1%	Spinal fusion except cervical without major complications or comorbidities
470	9.8%	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
841	2.3%	Lymphoma and Nonacute Leukemia with complications or comorbidities
040	2.3%	Peripheral/Cranial Nerve and Other Nervous System Procedures with major complications or comorbidities
468	2.2%	Revision of Hip or Knee Replacement without complications or comorbidities/major complications or comorbidities
473	1.9%	Cervical spinal fusion without complications or comorbidities / major complications or comorbidities
467	1.8%	Revision of Hip or Knee Replacement with complications or comorbidities
945	1.8%	Rehabilitation with complications or comorbidities / major complications or comorbidities
494	1.4%	Lower extremity and humerus procedures except hip foot femur without complications or comorbidities / major complications or comorbidities
552	1.4%	Medical back problems without major complications or comorbidities

Chart 20

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



Source: NCCI Medical Data Call, Service Year 2014.

Code	% in MT	Description
0207	5.4%	Intensive care: Burn care
0208	3.6%	Intensive care: Trauma
0360	2.3%	Operating room services: General
0154	1.5%	Psychiatric
0284	0.9%	Oncology
0120	0.9%	Room & board-semiprivate (two beds): General
0110	0.5%	Room & board-private (one bed): General
0460	0.5%	Pulmonary function
0454	0.5%	Emergency Room
0131	0.5%	Room & board-semiprivate (3-4 beds): Medical/Surgical/Gyn

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

If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by CPT codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Payments reported by CPT codes are shown in the chart separately by surgery and non-surgery as categorized by the American Medical Association (AMA).

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.

The "All Other" category includes healthcare common procedure coding system (HCPCS) codes and state-specific codes.

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

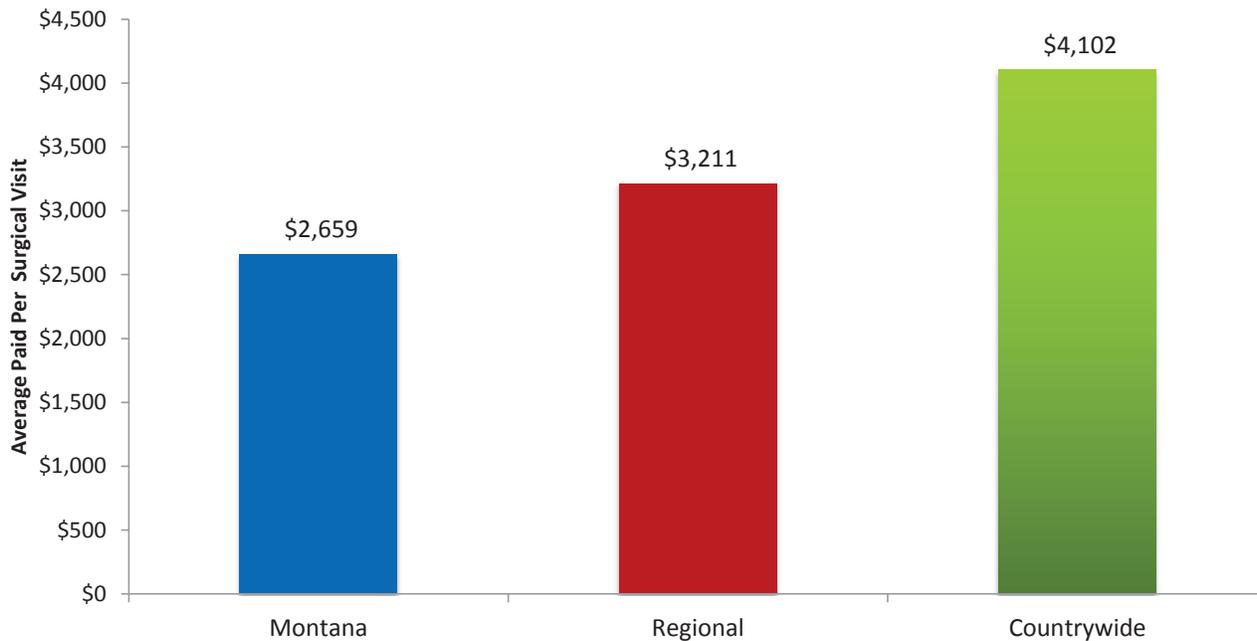
Medical Data Report for the state of: MONTANA

Hospital outpatient visits can vary in nature. A surgical visit includes at least one surgical service, while a non-surgical visit does not. A surgical service is defined as “major surgery” or “minor surgery” within the surgical category defined by the AMA. In this section we provide measures of hospital outpatient payments that take into account the type of visit since the level of reimbursement varies considerably by type of visit.

Chart 21 displays the average paid amount per visit for hospital outpatient surgical services for Montana as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 21

Average Outpatient Paid Amount per Surgical Visit for Hospital Outpatient Services



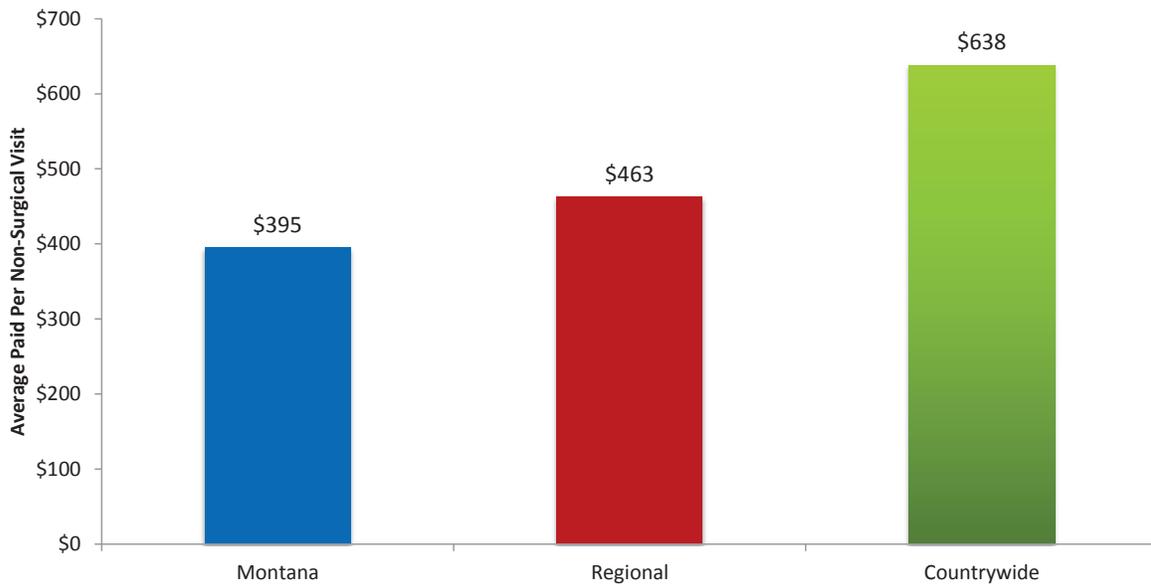
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Chart 22 displays the average paid amount per visit for hospital outpatient non-surgical services (such as physical therapy) for Montana as well as for regional and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 22

Average Outpatient Paid Amount per Non-Surgical Visit for Hospital Outpatient Services

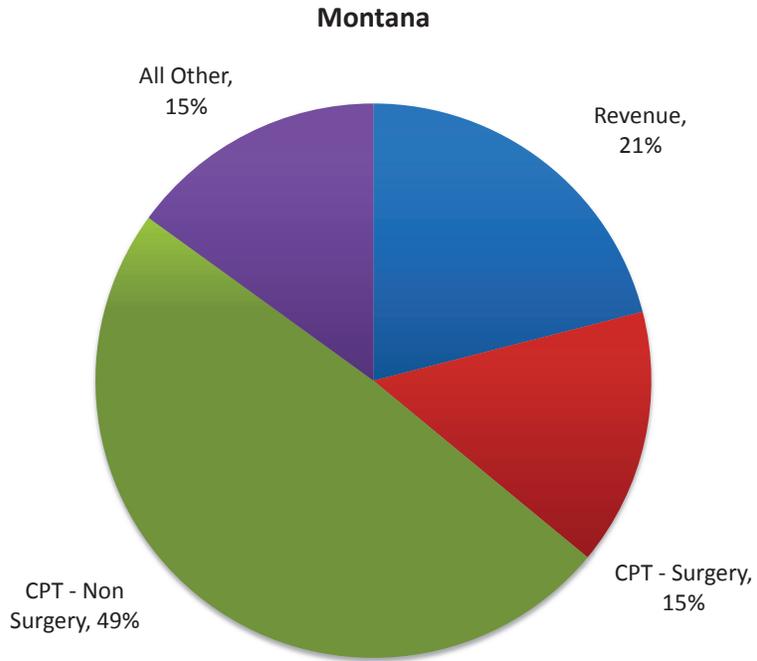


Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

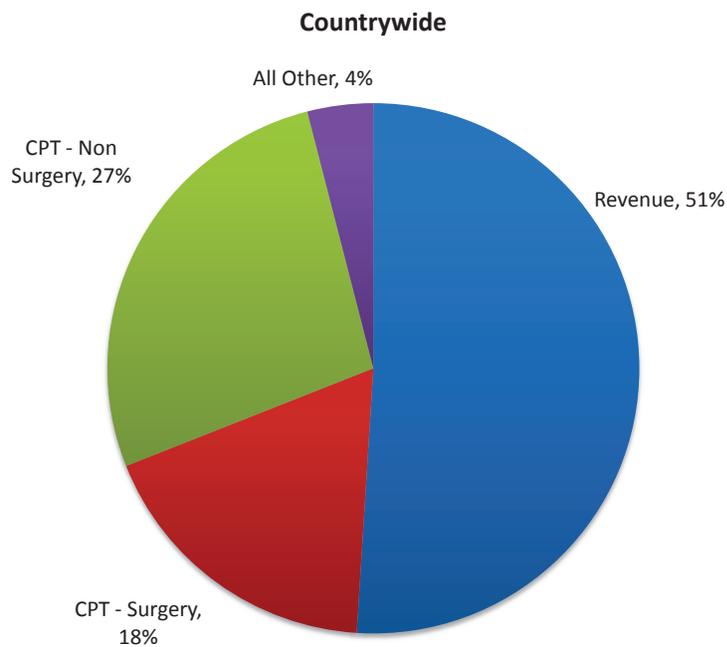
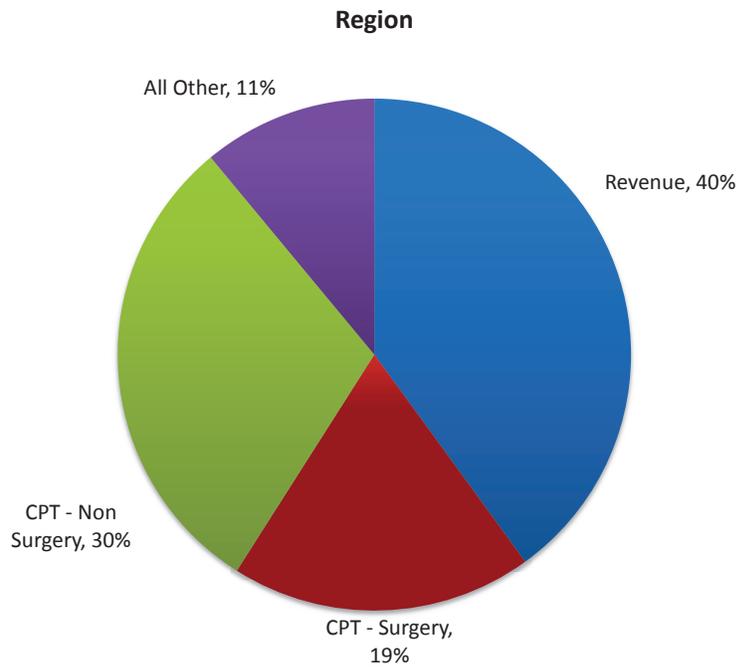
Chart 23 displays the distribution of hospital outpatient payments by procedure code type.

Chart 23

Distribution of Hospital Outpatient Payments by Procedure Code Type



Distribution of Hospital Outpatient Payments by Procedure Code Type



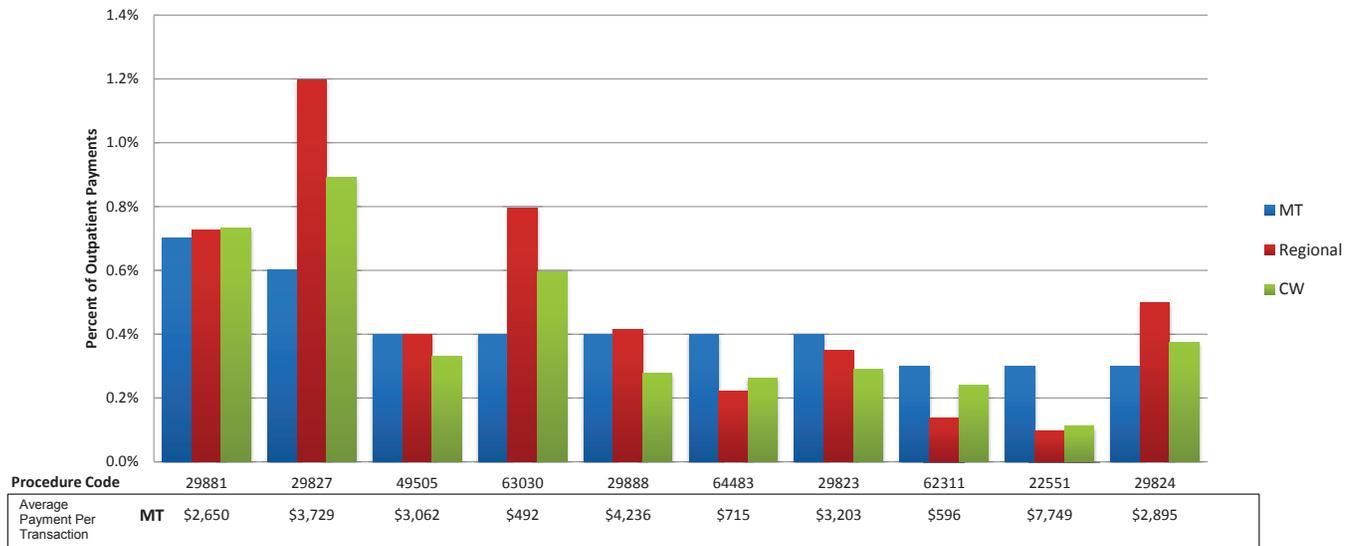
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Charts 24 and 25 display the top 10 surgery CPT and non-surgery CPT codes. Chart 26 displays the top 10 revenue codes for hospital outpatient services. The codes are ranked based on total payments. A brief description of each code is displayed in the table below.

Chart 24

Top 10 Surgery CPT Codes by Amount Paid for Hospital Outpatient Services for Montana

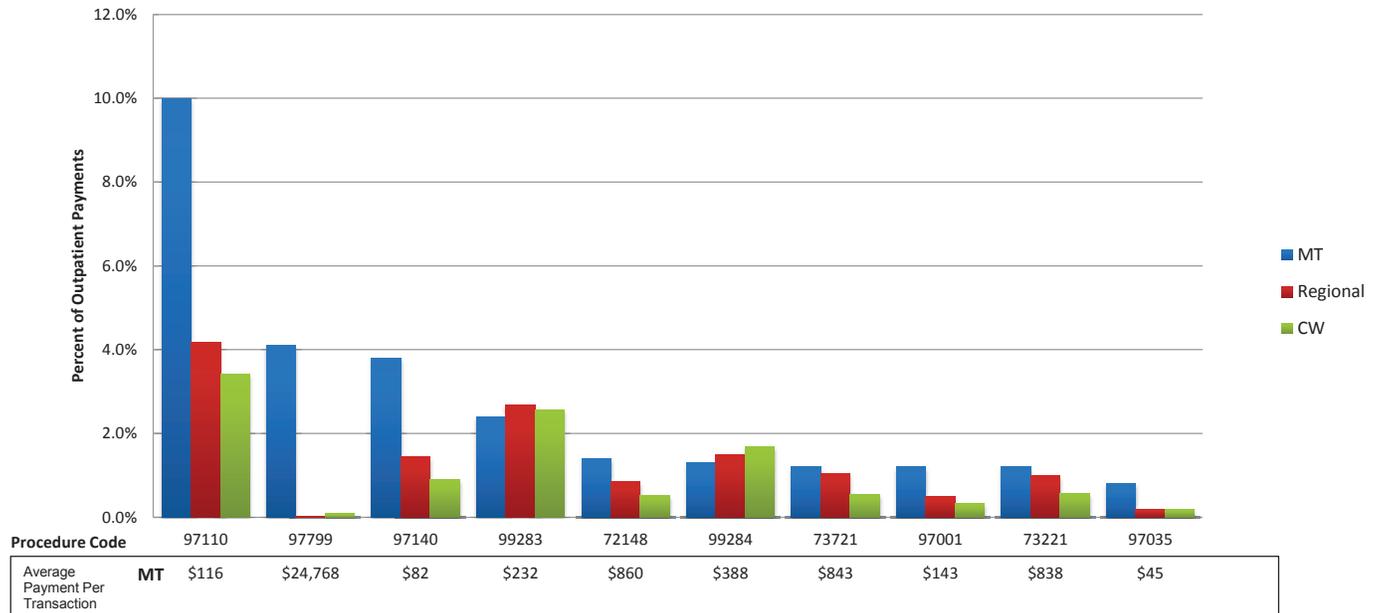


Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
29881	0.7%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29827	0.6%	Arthroscopy shoulder surgical; with rotator cuff repair
49505	0.4%	Repair initial inguinal hernia age 5 years or older; reducible
63030	0.4%	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy foraminotomy and/or excision of herniated intervertebral disc; 1 interspace lumbar
29888	0.4%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
64483	0.4%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
29823	0.4%	Arthroscopy shoulder surgical; debridement extensive
62311	0.3%	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
22551	0.3%	Arthrodesis anterior interbody including disc space preparation discectomy osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below C2
29824	0.3%	Arthroscopy shoulder surgical; distal claviclectomy including distal articular surface (Mumford procedure)

Chart 25

Top 10 Non-surgery CPT Codes by Amount Paid for Hospital Outpatient Services for Montana



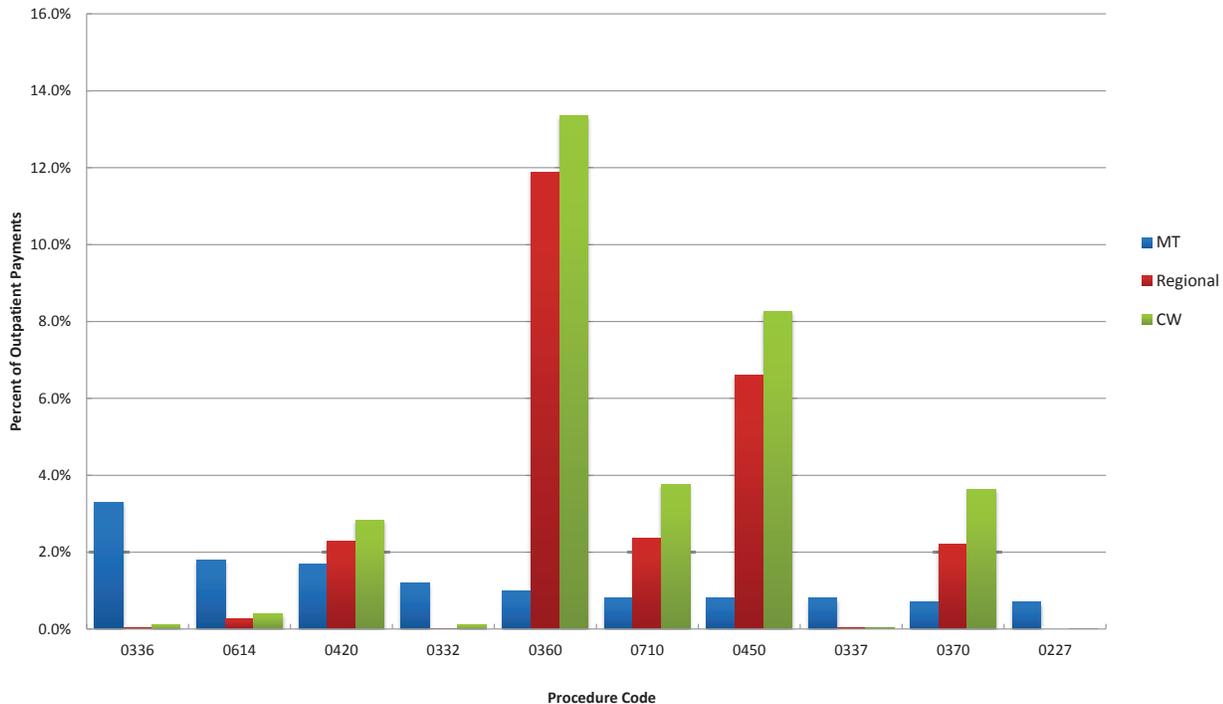
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
97110	10.0%	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97799	4.1%	Unlisted physical medicine/rehabilitation service or procedure
97140	3.8%	Manual therapy techniques (e.g., mobilization/ manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes
99283	2.4%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
72148	1.4%	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
99284	1.3%	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
73721	1.2%	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
97001	1.2%	Physical therapy evaluation
73221	1.2%	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)
97035	0.8%	Application of a modality to 1 or more areas; ultrasound each 15 minutes

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Chart 26

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



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
0336	3.3%	Radiology - Therapeutic: Chemotherapy - General
0614	1.8%	Magnetic Resonance Technology (MRT): Magnetic Resonance Imaging (MRI) - Other
0420	1.7%	Physical therapy: General
0332	1.2%	Radiology - Therapeutic: Chemotherapy - Oral
0360	1.0%	Operating room services: General
0710	0.8%	Recovery room: General
0450	0.8%	Emergency room: General
0337	0.8%	Radiology-Therapeutic and/or Chemotherapy Administration
0370	0.7%	Anesthesia: General
0227	0.7%	Special Charges

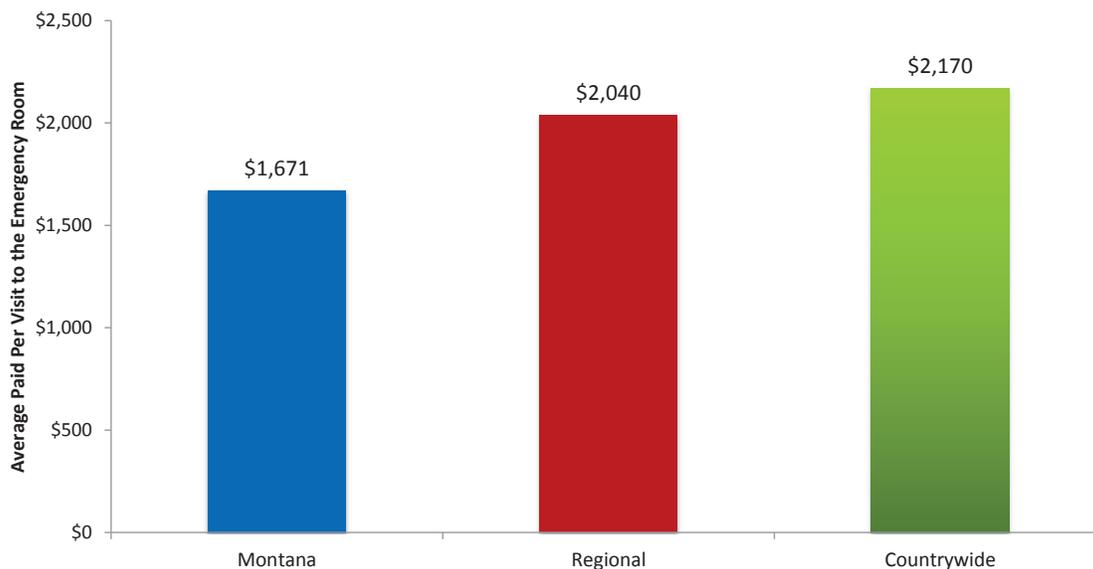
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In Montana, 18% of the payments associated with facilities (ASC, Hospital Outpatient and Hospital Inpatient) are for emergency room payments.

Chart 27 displays the average paid amount per visit for emergency room services for Montana as well as for regional and countrywide. The average paid amount includes all payments for an emergency room visit such as payments for facility services, physician services and drugs. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 27

Average Paid Amount per Emergency Room Visit

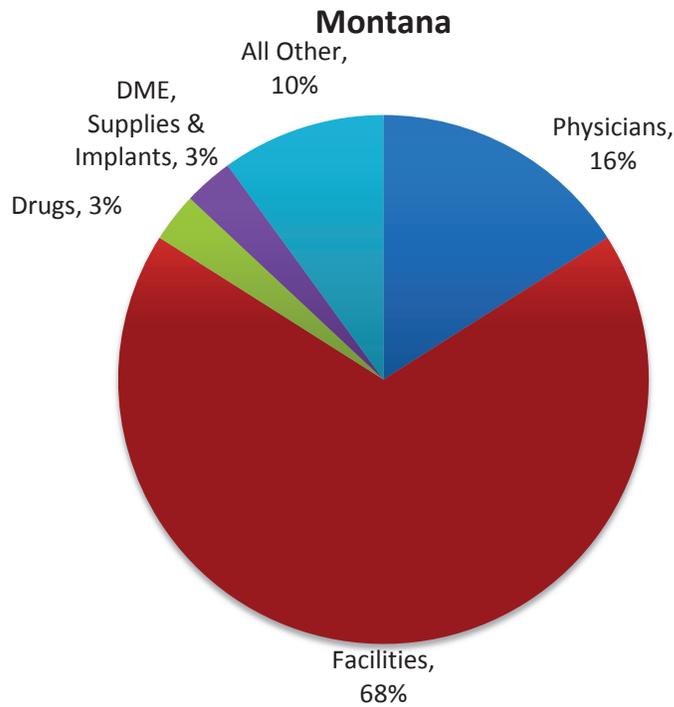


Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 28 displays the distribution of medical payments by type of service for emergency room services.

Chart 28

Distribution of Emergency Room Service Payments



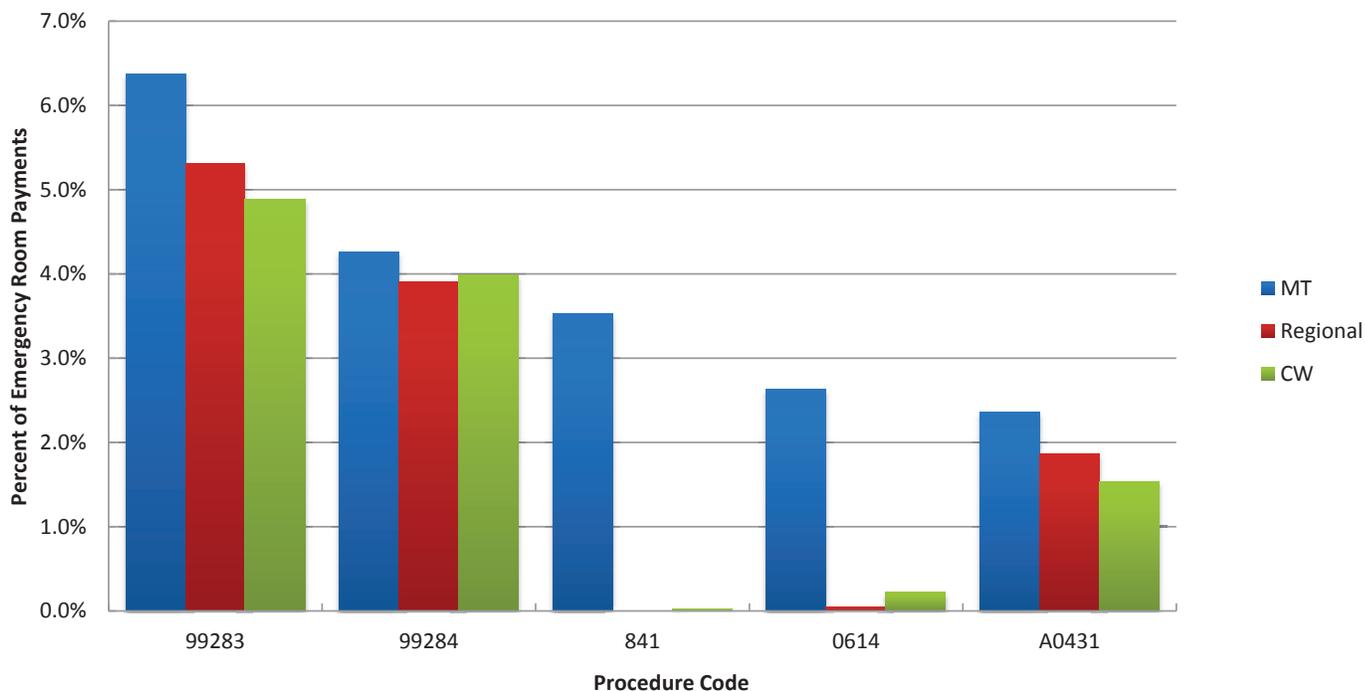
Source: NCCI Medical Data Call, Service Year 2014.

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Chart 29 displays the top 5 emergency room procedures. The codes are ranked based on total payments. A brief description of each code is displayed in the table below.

Chart 29

Top 5 Procedure Codes by Amount Paid for Emergency Room Services for Montana



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
99283	6.4%	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99284	4.3%	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
841	3.5%	Lymphoma and Nonacute Leukemia with complications or comorbidities
0614	2.6%	Magnetic Resonance Technology (MRT): Magnetic Resonance Imaging (MRI) - Other
A0431	2.4%	Ambulance service, conventional air services, transport, one way (rotary wing)

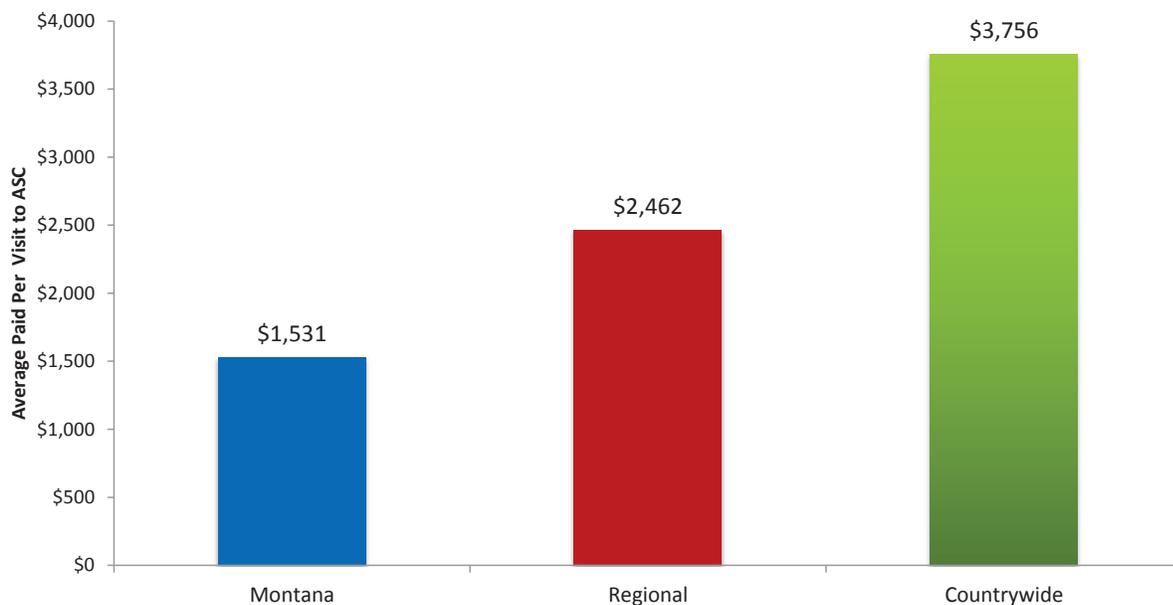
Medical Data Report for the state of: MONTANA

The share of payments attributable to ambulatory surgical centers (ASC) has grown in most states.

Chart 30 displays the average paid amount per visit for ASC for Montana as well as for regional and countrywide. Note there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 30

Average Paid Amount per Visit for Ambulatory Surgical Center Services



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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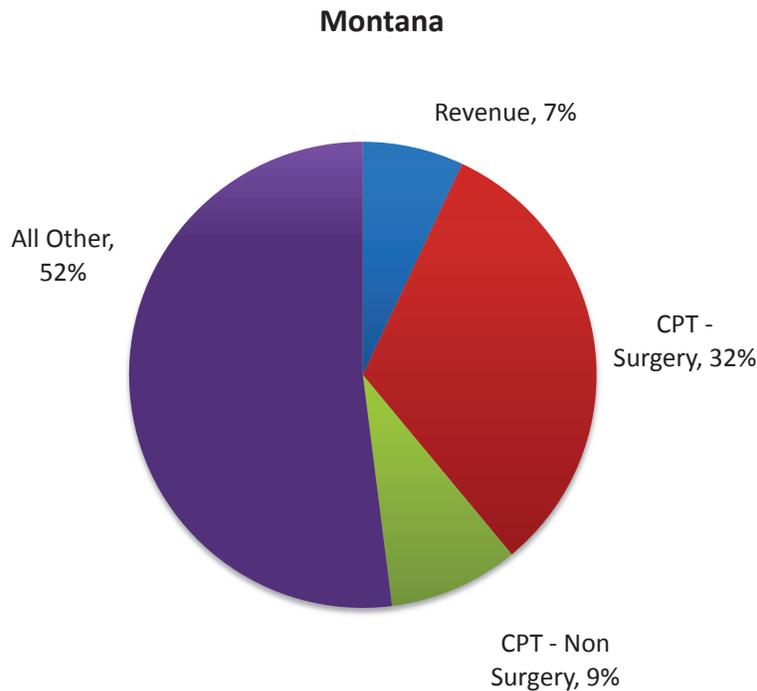
Typically, only surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes. The predominant revenue code reported for ASC services is 0490—Ambulatory Surgical Care. In Montana, 0490 represents 35% of ASC payments reported by revenue codes.

Similar to hospital services, the procedure code type reported for ASCs is often driven by the fee schedule.

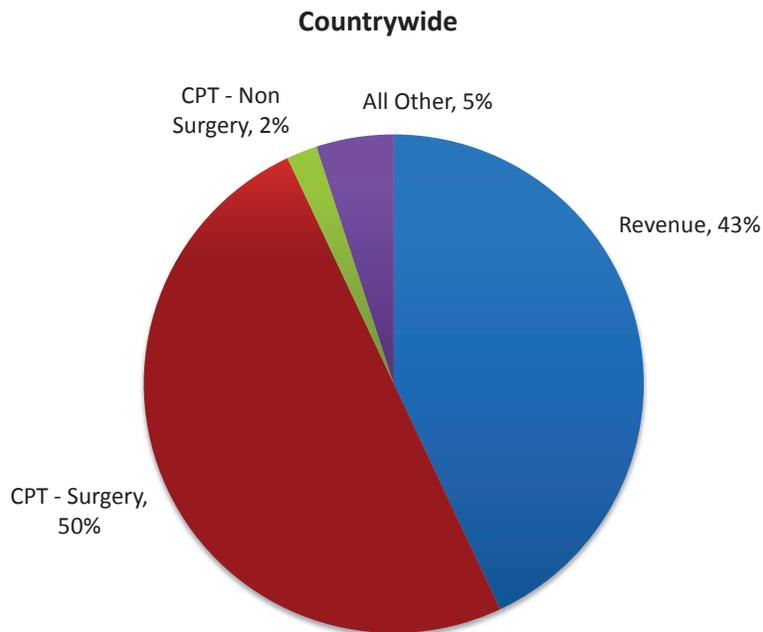
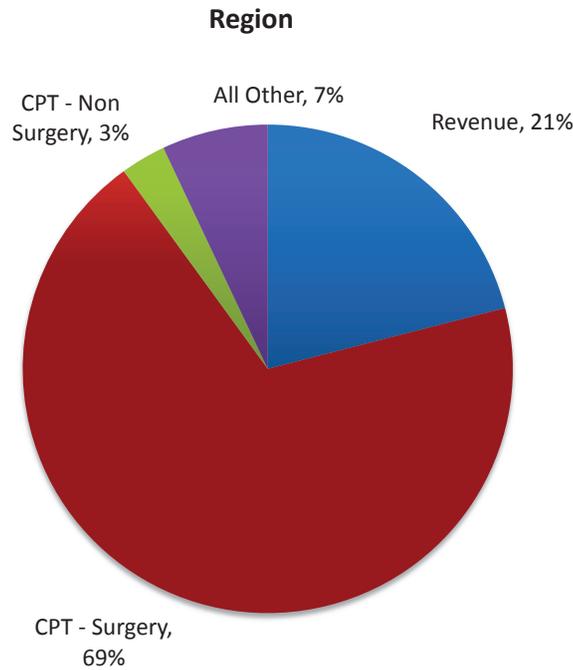
Chart 31 displays the distribution of ASC payments by procedure code type.

Chart 31

Distribution of Ambulatory Surgical Center Payments by Procedure Code Type



Distribution of Ambulatory Surgical Center Payments by Procedure Code Type



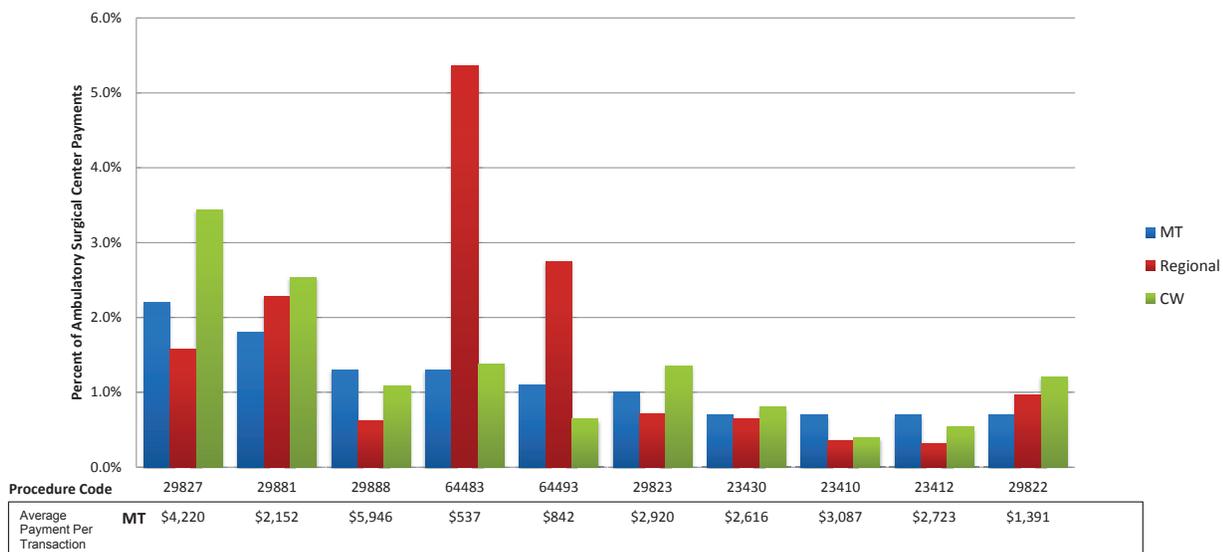
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Chart 32 displays the top 10 surgery CPT codes for ASC services. The procedure codes are ranked based on total payments. A brief description of each procedure code is displayed in the table below.

Chart 32

Top 10 Surgery CPT Codes by Amount Paid for ASC Services for Montana



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
29827	2.2%	Arthroscopy shoulder surgical; with rotator cuff repair
29881	1.8%	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29888	1.3%	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
64483	1.3%	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
64493	1.1%	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
29823	1.0%	Arthroscopy shoulder surgical; debridement extensive
23430	0.7%	Tenodesis of long tendon of biceps
23410	0.7%	Repair of ruptured musculotendinous cuff (e.g. rotator cuff) open; acute
23412	0.7%	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
29822	0.7%	Arthroscopy shoulder surgical; debridement limited

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NCCI's research, "Workers Compensation Prescription Drug Study: 2013 Update," published in September 2013, states that in 2011 the narcotics Oxycontin® and Hydrocodone-Acetaminophen were among the most popular drugs prescribed in workers compensation.

Drugs are uniquely identified by a national drug code (NDC). Charts 33 through 38 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, 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.

Chart 33 displays the shares of the payments of prescription medication for the top 10 workers compensation drugs and whether the drugs are generic or brand name. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the amount paid per unit (see Glossary for definition).

Chart 33
Top 10 Workers Compensation Drugs by Amount Paid for Montana

Name of Drug	Type	% of Drug Payments	Paid Per Unit Montana	Paid Per Unit Region	Paid Per Unit Countrywide
Oxycontin®	Brand Name	13.6%	\$7.22	\$6.42	\$7.32
Lyrica®	Brand Name	6.5%	\$4.50	\$4.55	\$4.65
Celebrex®	Brand Name	6.1%	\$6.97	\$6.88	\$7.03
Duloxetine HCl	Generic	5.1%	\$4.76	\$5.53	\$5.78
Gabapentin	Generic	4.5%	\$1.04	\$1.05	\$1.27
Oxycodone HCl	Generic	3.7%	\$0.95	\$0.82	\$1.07
Morphine Sulfate ER	Generic	3.3%	\$2.57	\$2.72	\$3.18
Hydrocodone-Acetaminophen	Generic	3.0%	\$0.42	\$0.53	\$0.56
Oxycodone-Acetaminophen	Generic	2.5%	\$1.50	\$1.59	\$1.81
Meloxicam	Generic	1.8%	\$1.88	\$2.49	\$2.63

Top 10 Workers Compensation Drugs by Amount Paid for Countrywide

Name of Drug	Type	% of Drug Payments	Paid Per Unit Montana	Paid Per Unit Region	Paid Per Unit Countrywide
Lyrica®	Brand Name	5.6%	\$4.50	\$4.55	\$4.65
Oxycontin®	Brand Name	5.5%	\$7.22	\$6.42	\$7.32
Gabapentin	Generic	4.2%	\$1.04	\$1.05	\$1.27
Oxycodone-Acetaminophen	Generic	4.0%	\$1.50	\$1.59	\$1.81
Celebrex®	Brand Name	3.7%	\$6.97	\$6.88	\$7.03
Meloxicam	Generic	3.6%	\$1.88	\$2.49	\$2.63
Hydrocodone-Acetaminophen	Generic	3.3%	\$0.42	\$0.53	\$0.56
Duloxetine HCl	Generic	3.0%	\$4.76	\$5.53	\$5.78
Lidocaine	Generic	2.4%	\$5.67	\$6.46	\$7.02
Cyclobenzaprine HCl	Generic	1.9%	\$0.67	\$0.79	\$1.15

Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Chart 34 displays the top 10 workers compensation drugs according to the number of prescriptions. This chart reveals the most frequently prescribed drugs and the amount paid per unit.

The results in this chart are based only on payments reported with an NDC.

Chart 34

Top 10 Workers Compensation Drugs by Prescription Counts for Montana

Name of Drug	Type	% of Drug Prescriptions	Paid Per Unit Montana	Paid Per Unit Region	Paid Per Unit Countrywide
Hydrocodone-Acetaminophen	Generic	12.5%	\$0.42	\$0.53	\$0.56
Gabapentin	Generic	4.9%	\$1.04	\$1.05	\$1.27
Cyclobenzaprine HCl	Generic	4.3%	\$0.67	\$0.79	\$1.15
Oxycodone HCl	Generic	4.3%	\$0.95	\$0.82	\$1.07
Tramadol HCl	Generic	3.9%	\$0.51	\$0.60	\$0.68
Oxycontin®	Brand Name	3.5%	\$7.22	\$6.42	\$7.32
Duloxetine HCl	Generic	3.3%	\$4.76	\$5.53	\$5.78
Meloxicam	Generic	2.7%	\$1.88	\$2.49	\$2.63
Celebrex®	Brand Name	2.7%	\$6.97	\$6.88	\$7.03
Oxycodone-Acetaminophen	Generic	2.6%	\$1.50	\$1.59	\$1.81

Top 10 Workers Compensation Drugs by Prescription Counts for Countrywide

Name of Drug	Type	% of Drug Prescriptions	Paid Per Unit Montana	Paid Per Unit Region	Paid Per Unit Countrywide
Hydrocodone-Acetaminophen	Generic	12.7%	\$0.42	\$0.53	\$0.56
Tramadol HCl	Generic	5.2%	\$0.51	\$0.60	\$0.68
Cyclobenzaprine HCl	Generic	4.8%	\$0.67	\$0.79	\$1.15
Oxycodone-Acetaminophen	Generic	4.3%	\$1.50	\$1.59	\$1.81
Gabapentin	Generic	4.2%	\$1.04	\$1.05	\$1.27
Ibuprofen	Generic	3.7%	\$0.38	\$0.47	\$0.44
Meloxicam	Generic	3.6%	\$1.88	\$2.49	\$2.63
Naproxen	Generic	2.4%	\$0.75	\$0.89	\$0.95
Oxycodone HCl	Generic	2.3%	\$0.95	\$0.82	\$1.07
Lyrica®	Brand Name	2.1%	\$4.50	\$4.55	\$4.65

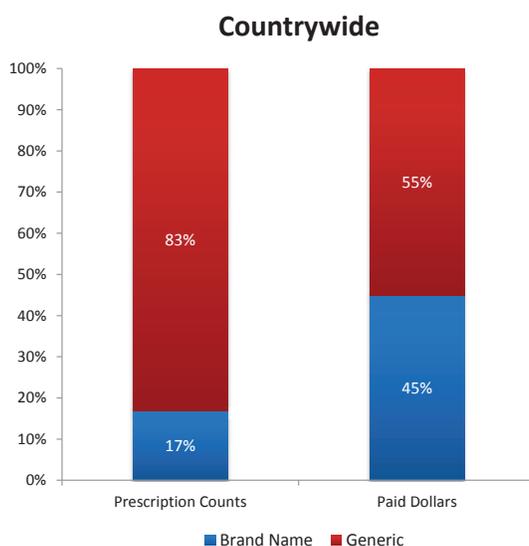
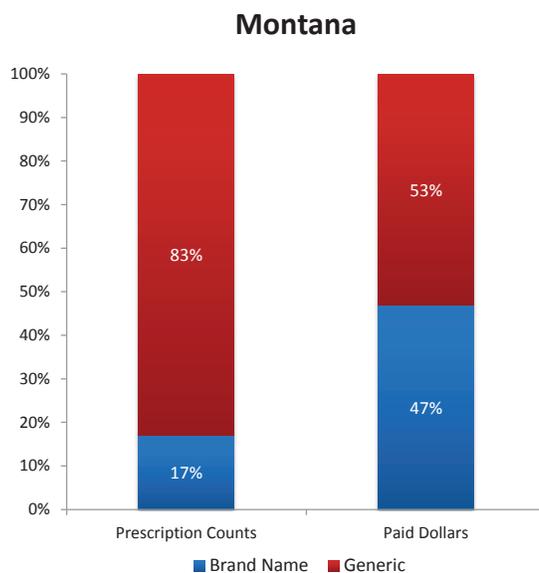
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Chart 35 shows the distribution of prescription drugs by brand name and generics for Montana and the countrywide average. The share between brand name and generics is displayed based on both prescription counts and payments. Typically, a higher percentage of drugs are given in the generic form; however, higher costs occur when brand name drugs are prescribed. In several states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates of brand name and generic drugs. The results in this chart are based only on transactions reported with an NDC.

Chart 35

Distribution of Drugs by Brand Name and Generic



Source: NCCI Medical Data Call, Service Year 2014. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

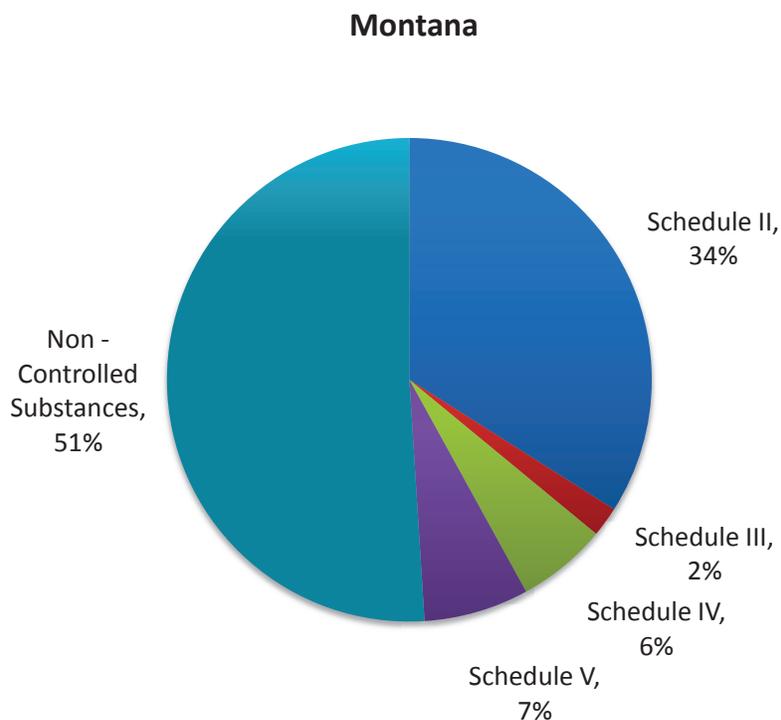
The Controlled Substance Act (CSA) was passed in 1970 to regulate the manufacture, distribution, possession, and use of certain drugs. There are five schedules, or groups, determined by varying qualifications, such as the drug's medical uses, if any, and its potential for abuse. For example, Schedule V drugs have the lowest potential for abuse, while Schedule I drugs are illegal due to the fact that they have no known medical uses.

The share of claims observed in Service Year 2014 with at least one controlled substance in Montana is 23.4%. This compares to the regional and countrywide shares of 18.7% and 20.3% respectively.

Chart 36 shows the distribution of prescription drug costs in Montana by its CSA schedule. Regional and countrywide distributions are also shown.

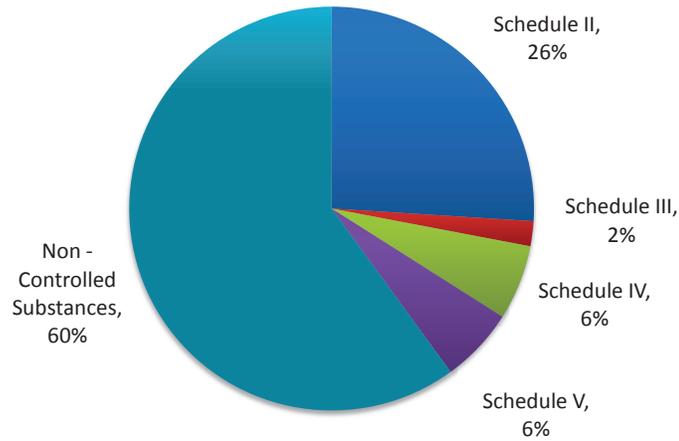
Chart 36

Distribution of Prescription Drug Costs by CSA Schedule

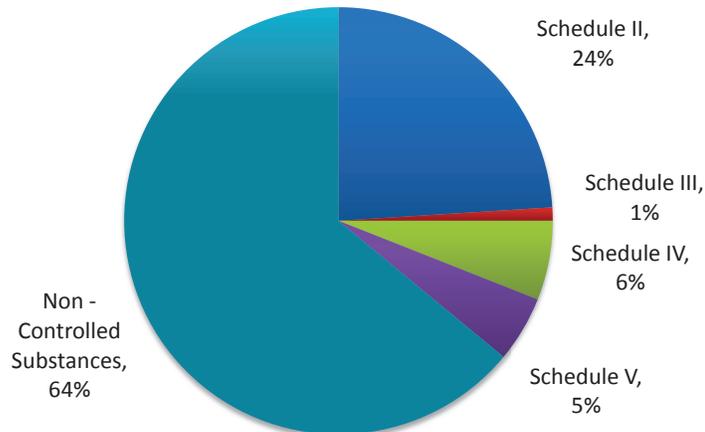


Distribution of Prescription Drug Costs by CSA Schedule

Regional



Countrywide



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

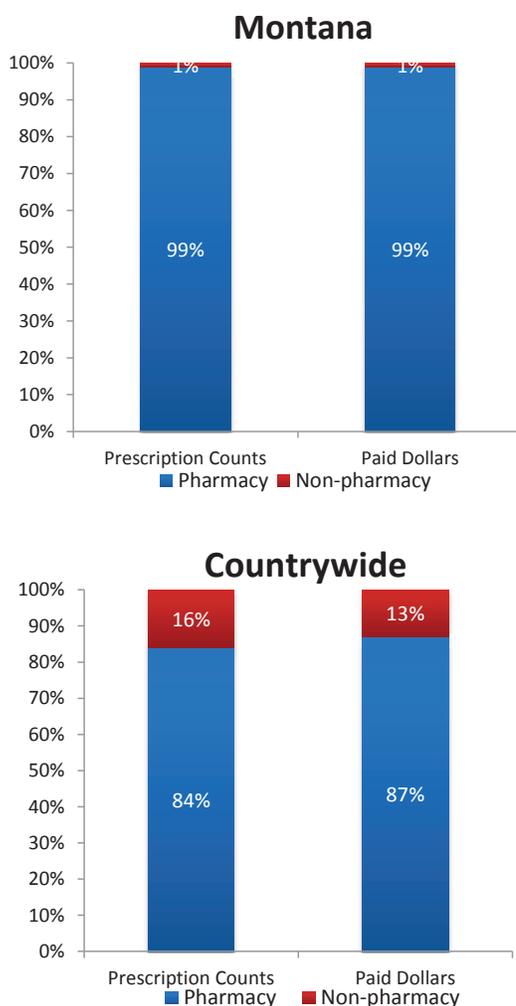
Medical Data Report for the state of: MONTANA

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

Chart 37 shows the distribution of prescription drugs dispensed by pharmacies and non-pharmacies. The share between pharmacy dispensed and non-pharmacy dispensed is displayed, based on both prescription counts and payments, for Montana and the countrywide average. The results in this chart are based only on transactions reported with an NDC.

Chart 37

Distribution of Drugs by Pharmacy and Non-pharmacy



Source: NCCI Medical Data Call, Service Year 2014. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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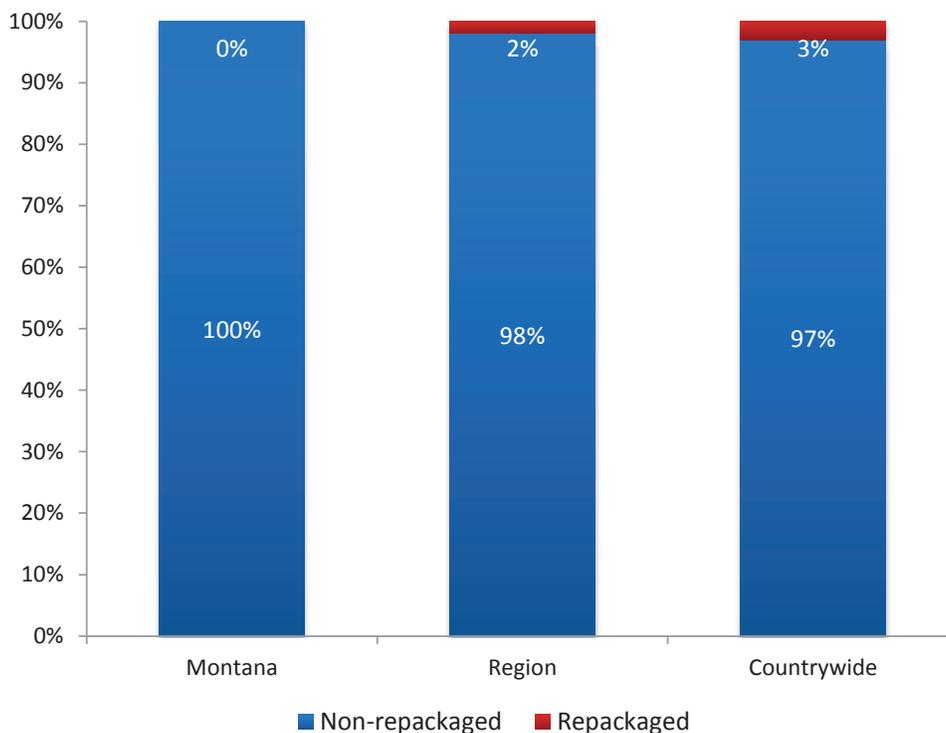
NDCs are specific not only to the product (including strength and formulation) and the package size but also to the labeler. Labelers are manufacturers, repackagers, and distributors.

Workers compensation 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 higher, AWP. As a result, workers compensation 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 38 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.

Chart 38

Distribution of Drug Payments by Repackaged and Non-repackaged

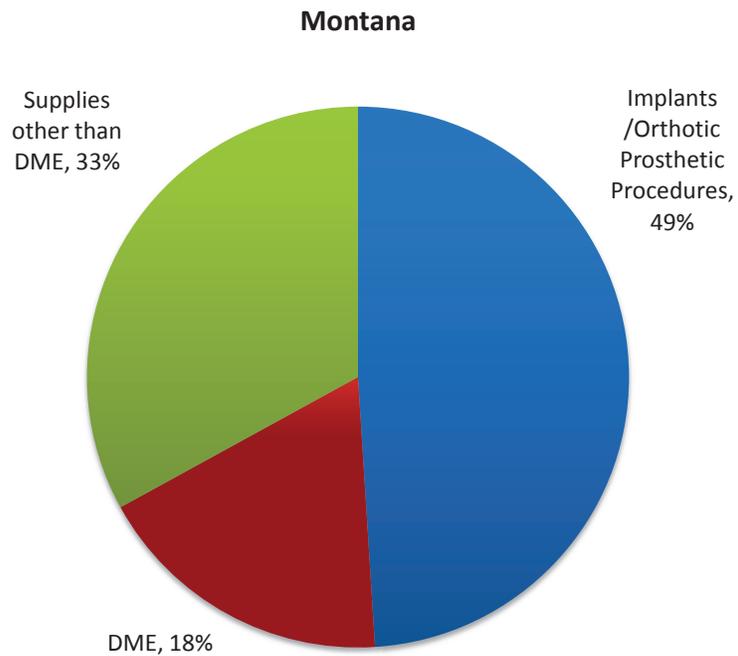


Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 39 displays the distribution of payments separately by Implants/Orthotic and Prosthetic Procedures; Durable Medical Equipment (DME); and Supplies Other Than DME. Payments are mapped to each of these categories based on the procedure code reported, regardless of who provides the service or where the service is performed.

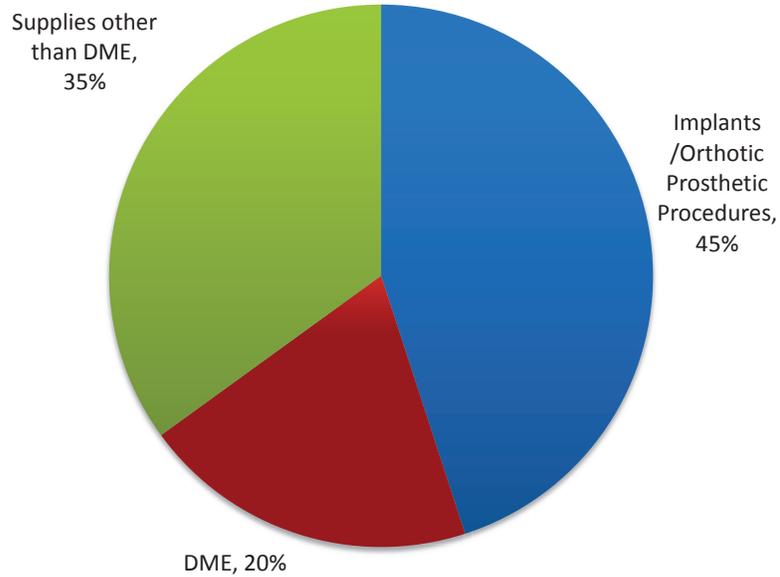
Chart 39

Distribution of Payments by DME, Supplies, and Implants

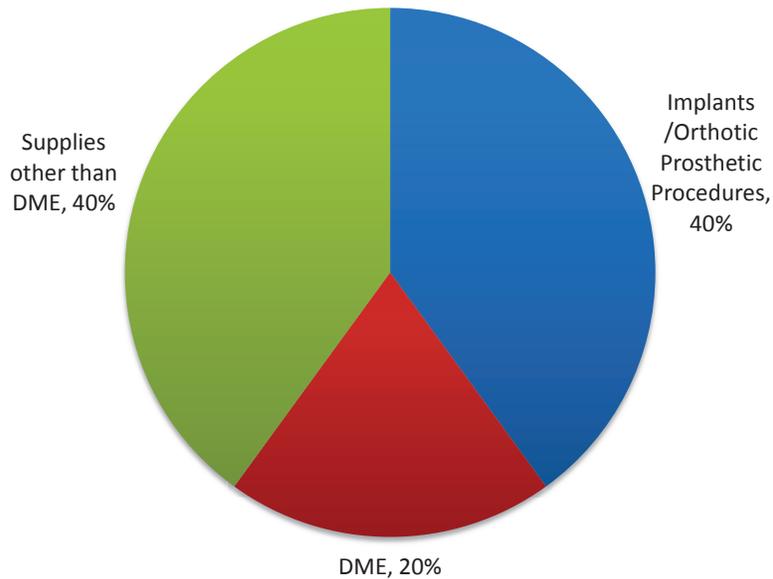


Distribution of Payments by DME, Supplies, and Implants

Region



Countrywide



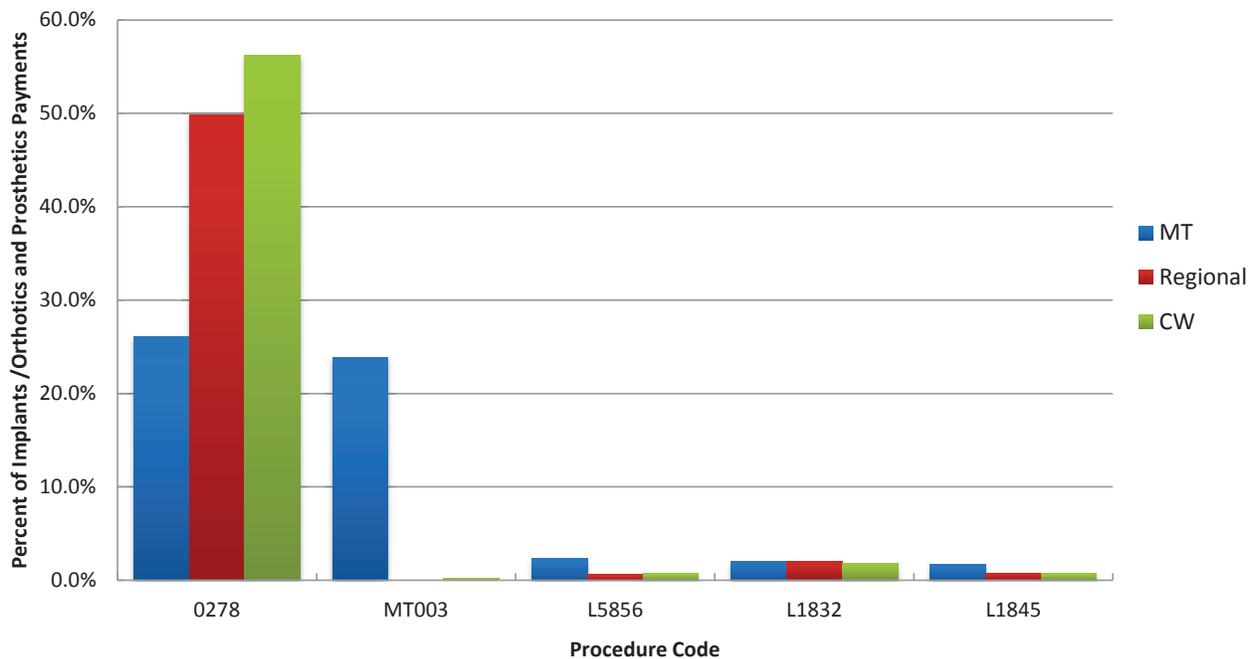
Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Chart 40 displays the top 5 procedure codes for Implants/Orthotic and Prosthetic Procedures. The procedure codes are ranked based on total payments. A brief description of each procedure code is displayed in the table below.

Chart 40

Top 5 Implants/Orthotic and Prosthetic Procedure Codes by Amount Paid for Montana



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

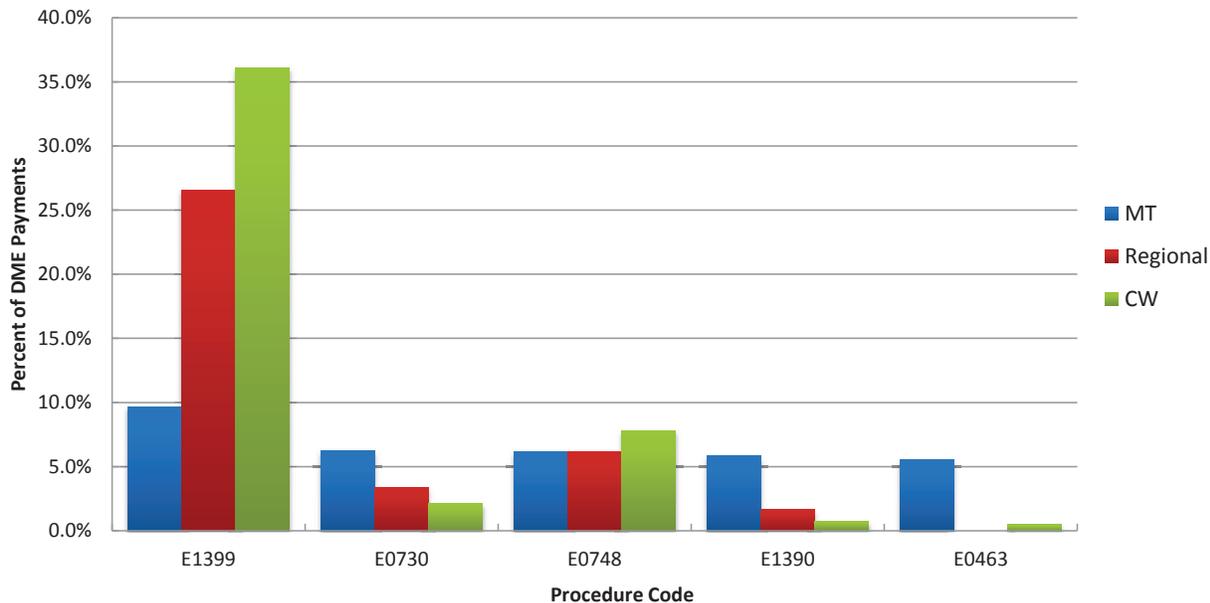
Code	% in MT	Description
0278	26.1%	Medical/Surgical Supplies: Other implants
MT003	23.9%	Inpatient/Outpatient Implant
L5856	2.3%	Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type
L1832	2.0%	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L1845	1.7%	Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

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Chart 41 displays the top 5 procedure codes for DME. The procedure codes are ranked based on total payments. A brief description of each procedure code is displayed in the table below.

Chart 41

Top 5 DME Procedure Codes by Amount Paid for Montana



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

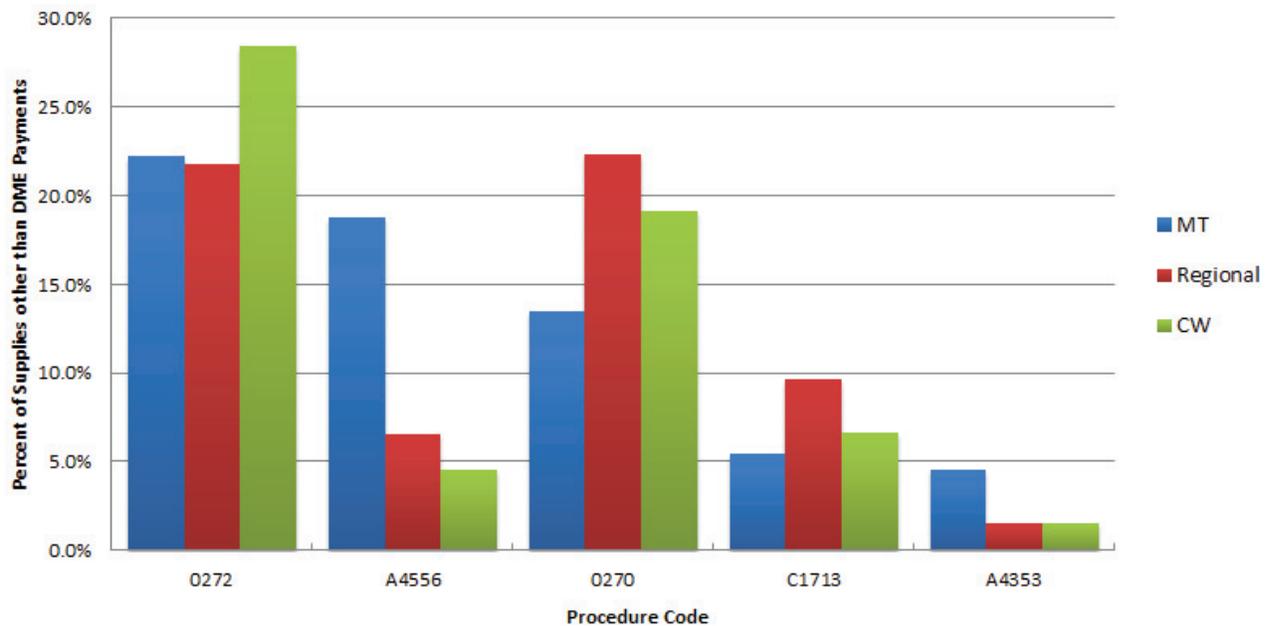
Code	% in MT	Description
E1399	9.7%	Durable medical equipment, miscellaneous
E0730	6.3%	Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation
E0748	6.2%	Osteogenesis stimulator, electrical, noninvasive, spinal applications
E1390	5.8%	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E0463	5.5%	Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube)

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Chart 42 displays the top 5 procedure codes for Supplies Other Than DME. The procedure codes are ranked based on total payments. A brief description of each procedure code is displayed in the table below.

Chart 42

Top 5 Supplies Other Than DME Procedure Codes by Amount Paid for Montana



Source: NCCI Medical Data Call, Service Year 2014. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
0272	22.2%	Medical/Surgical Supplies: Sterile supplies
A4556	18.8%	Electrodes (e.g., apnea monitor), per pair
0270	13.5%	Medical/Surgical Supplies: General
C1713	5.5%	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone
A4353	4.6%	Intermittent urinary catheter, with insertion supplies

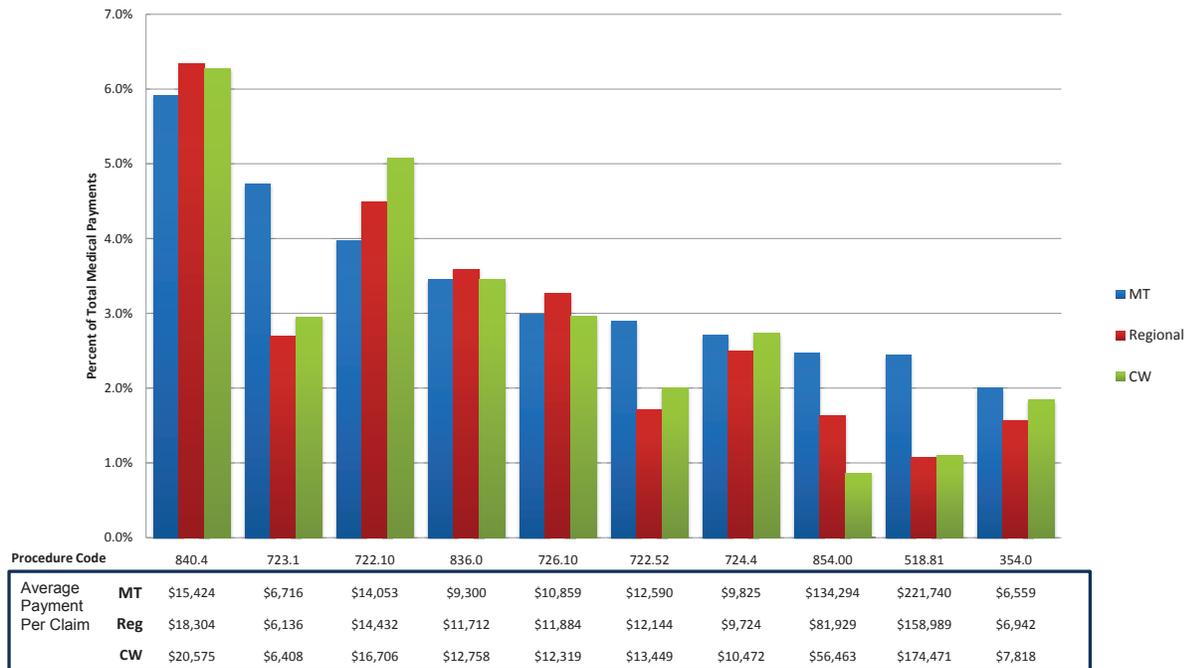
Chart 43 displays the top 10 diagnoses, identified by the ICD-9 (International Classification of Diseases) codes. The ICD-9 code indicates the condition for which the care is provided. NCCI assigns an ICD-9 code to each workers compensation claim based on the severity of the ICD-9 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 diagnosis codes are ranked by total claim payments for Montana. This method of ranking shows which diagnostic codes have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2013, and December 31, 2013, and include all reported services provided for those claims through December 31, 2014. As these claims mature, the mix of ICD-9 codes may change, thus impacting the percentage share of payments for a specific code over time. This mix may also affect how costs per code in Montana compare to countrywide costs. The state, regional and countrywide average payment per claim are also displayed for each diagnostic code. A brief description of each diagnostic code is displayed in the table below.

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Chart 43

Top 10 ICD-9 Codes by Amount Paid for Dates of Injury in 2013 for Montana



Source: NCCI Medical Data Call, Dates of Injury in 2013. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Code	% in MT	Description
840.4	5.9%	Rotator cuff (capsule) sprain and strain
723.1	4.7%	Cervicalgia
722.10	4.0%	Displacement of lumbar intervertebral disc without myelopathy
836.0	3.4%	Tear of medial cartilage or meniscus of knee, current
726.10	3.0%	Unspecified disorders of bursae and tendons in shoulder region
722.52	2.9%	Degeneration of lumbar or lumbosacral intervertebral disc
724.4	2.7%	Thoracic or lumbosacral neuritis or radiculitis, unspecified
854.00	2.5%	Intracranial injury of other and unspecified nature, without mention of open intracranial wound, unspecified state of consciousness
518.81	2.4%	Acute respiratory failure
354.0	2.0%	Carpal tunnel syndrome

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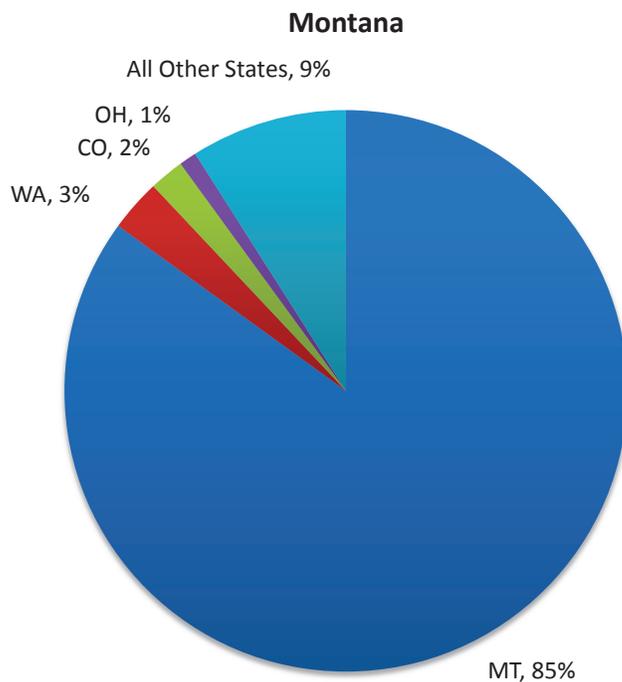
Medical benefit rules typically have different payment provisions for procedures performed in state versus out of state.

A medical service is considered to be performed "in state" if it is performed in the same state or jurisdiction that determines the workers compensation benefits. Similarly, a medical service is considered "out of state" if it is performed outside of the state of jurisdiction.

Chart 44 displays the distribution of medical payments for professional/physician and facility services according to the location where the medical service was provided. The Countrywide average for "in-state" medical payments is 80%.

Chart 44

Distribution of Physician and Facility Payments by Provider State



Source: NCCI Medical Data Call, Service Year 2014.

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The table below shows the top 5 physicians and facility procedure codes for services provided out of state. The shares of out of state payments, as well as the average payment per transaction for in-state and out of state services, are also included.

Top 5 Procedures Performed Out of State by Amount Paid for Montana

Code	Share of out of State Payments	Out of State Average Cost	In - State Average Cost	Description
460	6.1%	\$2,152	\$2,325	Spinal fusion except cervical without major complications or comorbidities
97799	6.1%	\$24,705	\$217	Physical Medicine Procedure
97110	3.9%	\$89	\$100	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
841	3.2%	\$10,613	NA	Lymphoma and Nonacute Leukemia with complications or comorbidities
040	3.2%	\$1,776	NA	Peripheral/Cranial Nerve and Other Nervous System Procedures with major complications or comorbidities

Source: NCCI Medical Data Call, Service Year 2014.

Comparison of Selected Distributions by Service Year

The tables in this section provide a comparison of results for Montana for the latest four service years. Analysis in the growth of shares may provide additional insight into medical cost drivers above and beyond an analysis at a specific point in time. The oldest data available from the Medical Data Call is for Service Year 2011, as this is the first full service year of data since the inception of the Call.

Results in the charts below may vary compared to medical reports from previous years. This is due to a lag in reporting as well as improved derivations affecting categories for certain charts.

Distribution of Medical Payments for Montana (Chart 4)

Medical Category	2011	2012	2013	2014
Physician	36%	35%	36%	37%
Hospital Outpatient	15%	18%	17%	17%
Hospital Inpatient	19%	16%	16%	15%
ASC	5%	5%	5%	5%
Drugs	16%	16%	17%	17%
DME, Supplies, and Implants	6%	6%	6%	5%
Other	3%	4%	3%	4%

Distribution of Physician Payments by AMA Service Category for Montana (Chart 5)

AMA Service Category	2011	2012	2013	2014
Anesthesia	5%	5%	5%	5%
Surgery	23%	24%	23%	22%
Radiology	9%	9%	8%	6%
Pathology	1%	1%	1%	1%
Physical Medicine	29%	29%	31%	34%
General Medicine	6%	6%	5%	4%
Evaluation and Management	25%	25%	26%	27%
Other	2%	1%	1%	1%

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Distribution of Hospital Outpatient Payments by Procedure Code Type for Montana (Chart 23)

Procedure Code Type	2011	2012	2013	2014
Revenue	30%	11%	17%	21%
CPT - Surgery	11%	15%	16%	15%
CPT - Non-surgery	42%	63%	55%	49%
All Other	17%	11%	12%	15%

Distribution of Emergency Room Payments for Montana (Chart 28)

Medical Category	2011	2012	2013	2014
Facilities	66%	65%	66%	68%
Physicians	20%	20%	17%	16%
Drugs	4%	3%	4%	3%
DME, Supplies, and Implants	3%	3%	3%	3%
All Other	7%	9%	10%	10%

Distribution of Ambulatory Surgical Center Payments by Procedure Code Type for Montana (Chart 31)

Procedure Code Type	2011	2012	2013	2014
Revenue	7%	4%	5%	7%
CPT - Surgery	33%	41%	51%	32%
CPT - Non-surgery	4%	7%	8%	9%
All Other	56%	48%	36%	52%

Distribution of Drug Payments by Brand Name and Generic for Montana (Chart 35)

Type of Drug	2011	2012	2013	2014
Brand Name	59%	55%	56%	47%
Generic	41%	45%	44%	53%

Distribution of Drug Payments by Pharmacy and Non-pharmacy for Montana (Chart 37)

Type of Provider	2011	2012	2013	2014
Non-pharmacy	1%	0%	1%	1%
Pharmacy	99%	100%	99%	99%

Distribution of Drug Payments by Repackaged and Non-repackaged for Montana (Chart 38)

Type of Drug	2011	2012	2013	2014
Repackaged	0%	0%	0%	0%
Non-repackaged	100%	100%	100%	100%

Distribution of Payments by DME, Supplies, and Implants for Montana (Chart 39)

Category	2011	2012	2013	2014
Implants/Orthotic Prosthetic Procedures	40%	42%	46%	49%
DME	15%	18%	15%	18%
Supplies Other Than DME	45%	40%	39%	33%

Distribution of Payments by Provider State (Chart 44)

Category	2011	2012	2013	2014
In-State	88%	88%	85%	85%
Out of State	12%	12%	15%	15%

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 ASC can bill for facility fees much like a hospital, but generally has a separate fee schedule.

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

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

Critical Access Hospital (CAH): A small, generally geographically remote facility that provides outpatient and inpatient hospital services to people in rural areas. The designation was established by law for special payments under the Medicare program. To be designated as a CAH, a hospital must be located in a rural area, provide 24-hour emergency services, have an average length of stay for its patients of 96 hours or less, and be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital or be designated by its state as a "necessary provider." CAHs may have no more than 25 beds.

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

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

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

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

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

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

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).

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

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

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

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

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

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

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

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

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

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, non-filled syringes, etc., it represents 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 represents medical transactions for Service Year 2014 (medical services delivered from January 1, 2014, to December 31, 2014). 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—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.

For the state of Montana in Service Year 2014, the reported number of transactions was over 497,200, with more than \$85,000,000 paid, for over 22,400 claims, representing data from 98% of the workers compensation premium written, which includes experience for large-deductible policies. Lump sum settlements are not required to be reported. Also, self-insured data is not included.

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***.