



Medical Data Report

for the state of:

MONTANA

September 2013



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.

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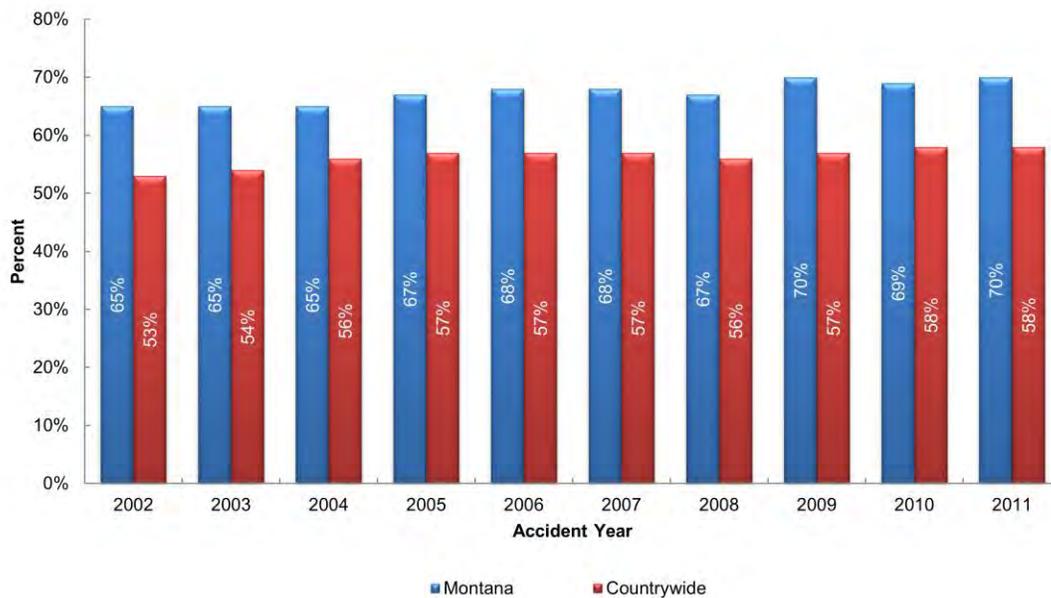
Traditional workers compensation policies cover two types of benefit payments: medical costs and indemnity (lost wages) costs.

Of the two, medical benefits resulting from a work-related injury or disease are the leading cost driver for workers compensation claims on a countrywide basis (the local share may vary).

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, UT, VA, VT, and WV.

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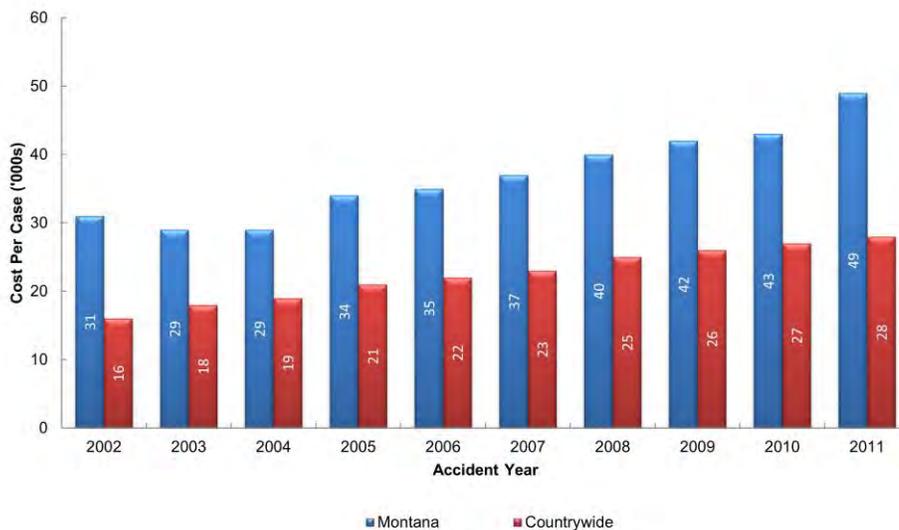
After a decade of medical cost inflation at an annual rate of 6%, since 2010 the countrywide overall medical average cost per claim has seen more moderate increases. Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results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

Medical losses are at historical benefit levels and historical dollar values—meaning no adjustment for inflation or changes in benefits have 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, UT, VA, VT, and WV.

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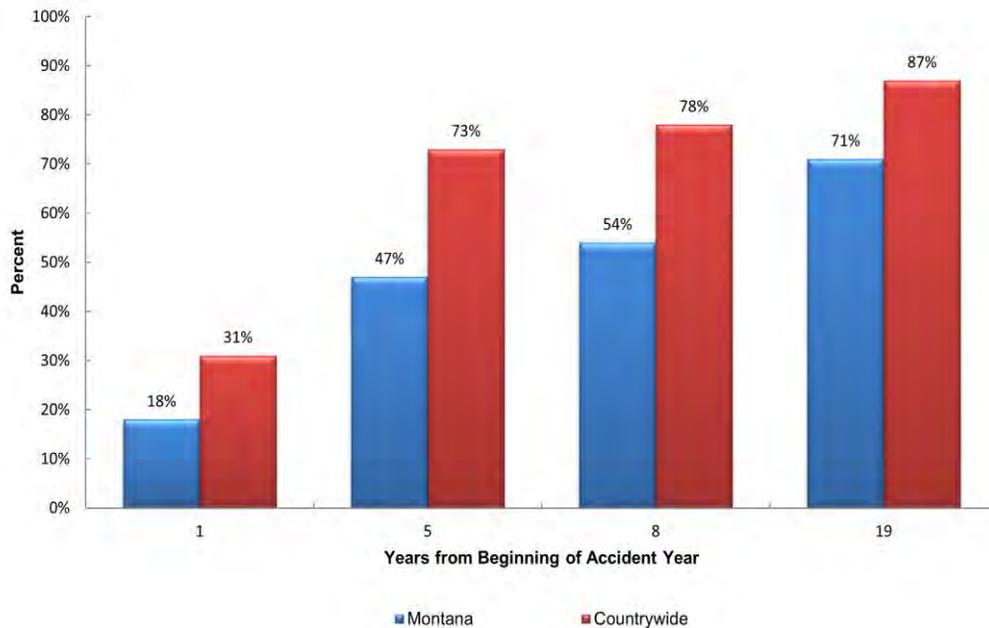
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. Recent NCCI research has found that it is likely that more than 10% of the cost of medical benefits for workplace injuries that occur this year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

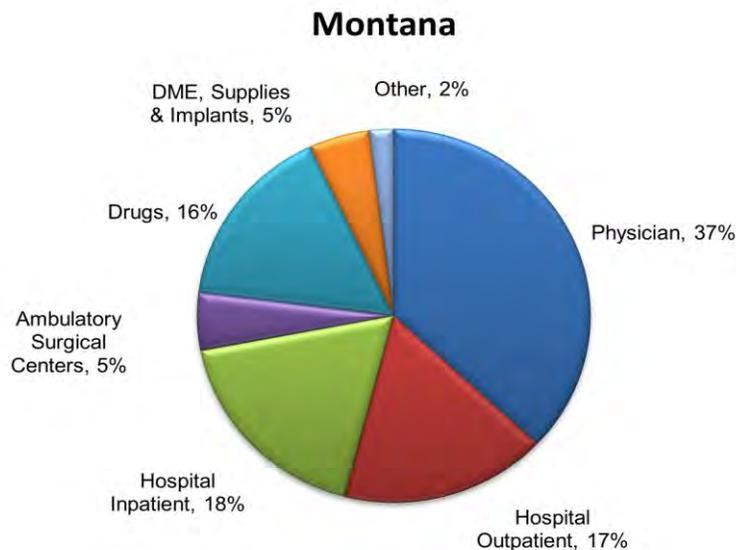
Chart 4 displays the distribution of medical payments by type of service.

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:

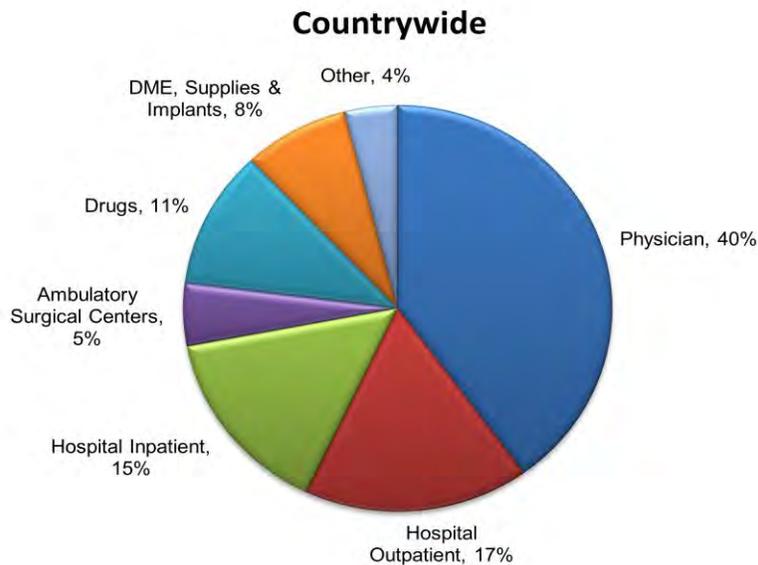
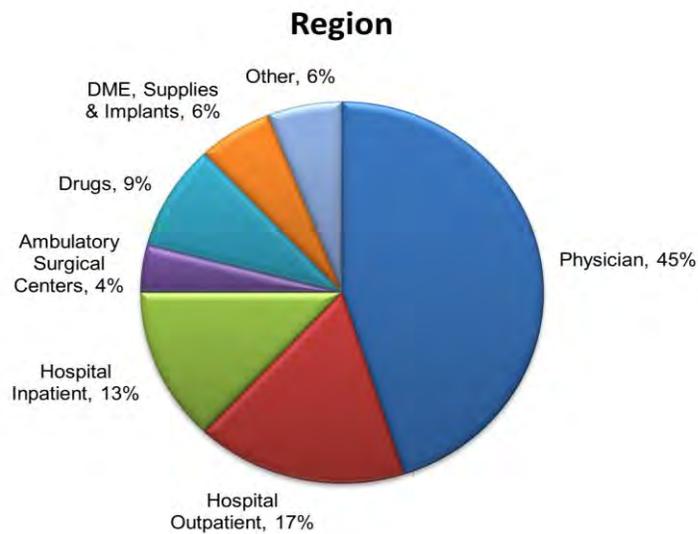
- Provider taxonomy code—identifies the type of provider that billed for, and is being paid for, the medical service—see Glossary
- Procedure code—alphanumeric code used to identify procedures performed by medical professionals
- Place of services—alphanumeric code used to identify places where procedures 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 2012. 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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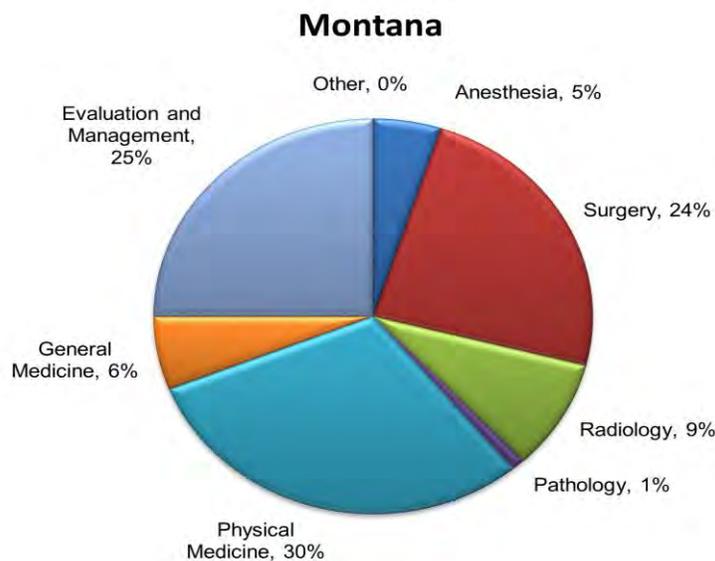
Preliminary results from a recent NCCI study, "[Price Impact of Workers Compensation Physician Fee Schedules](#)" (*Annual Issues Symposium*, 2013), show that the median workers compensation price for a physician service is always at, or very near, the maximum allowable reimbursement (MAR) amount set 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.

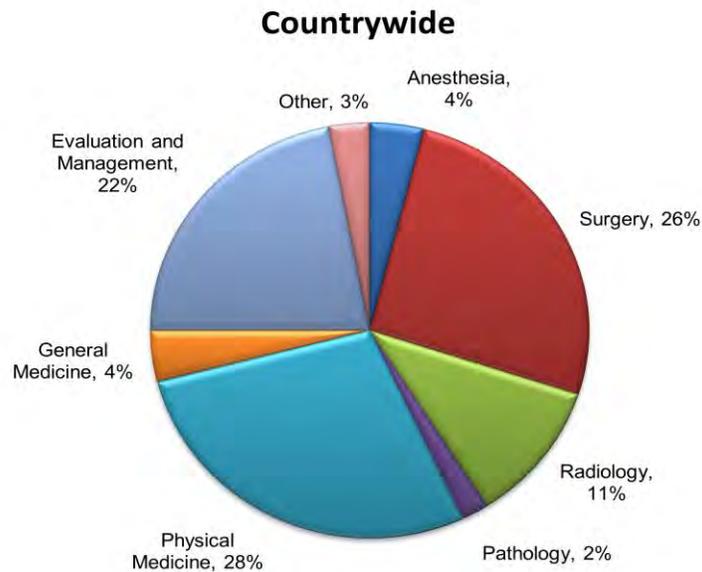
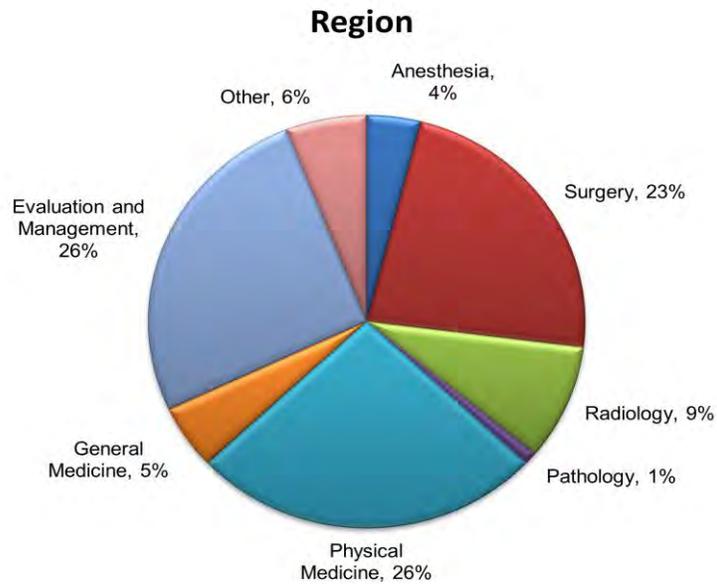
Since many states' medical fee schedule payment levels vary by service categories, an analysis of physician payments provides insights into the effectiveness of the fee schedule. For example, if the share of payments is high for a particular category compared to other states, a driver of the higher share 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 2012. 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 13 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 is displayed in the corresponding table below each chart.

The charts also include the average amount paid per transaction for these codes in Montana and on average 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.

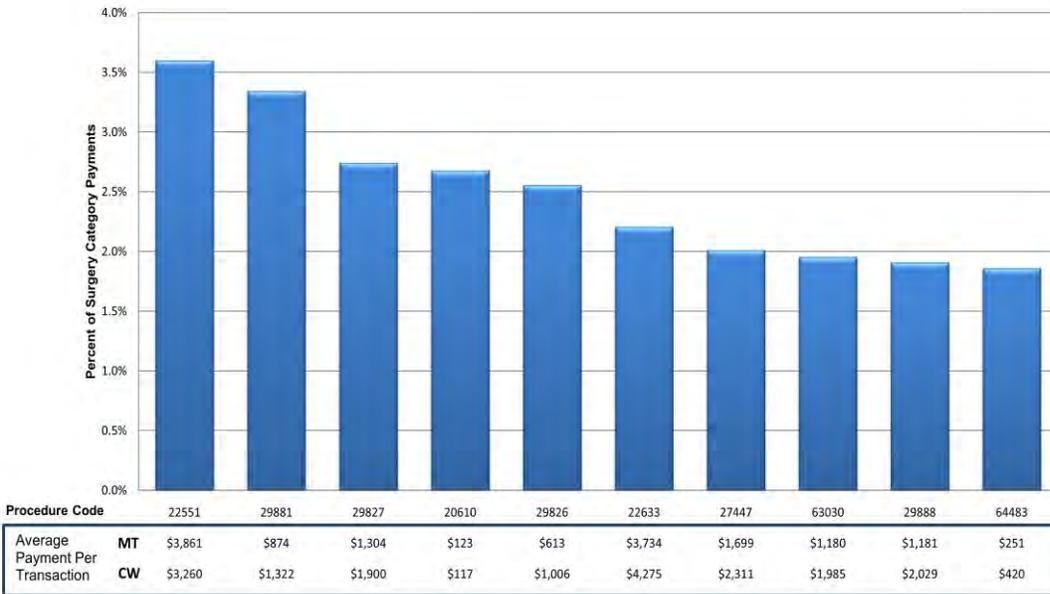
The top 10 charts rank the procedure codes for each service category using two different methods. The first method ranks procedure codes by total payments. Procedure codes are sorted from highest total payments to lowest total payments. The procedure code with the highest amount paid is ranked first; 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.

Preliminary results from NCCI's study on the ["Price Impact of Workers Compensation Physician Fee Schedules"](#) (*Annual Issues Symposium*, 2013) 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.

Chart 6

Top 10 Surgery Procedure Codes by Amount Paid for Montana



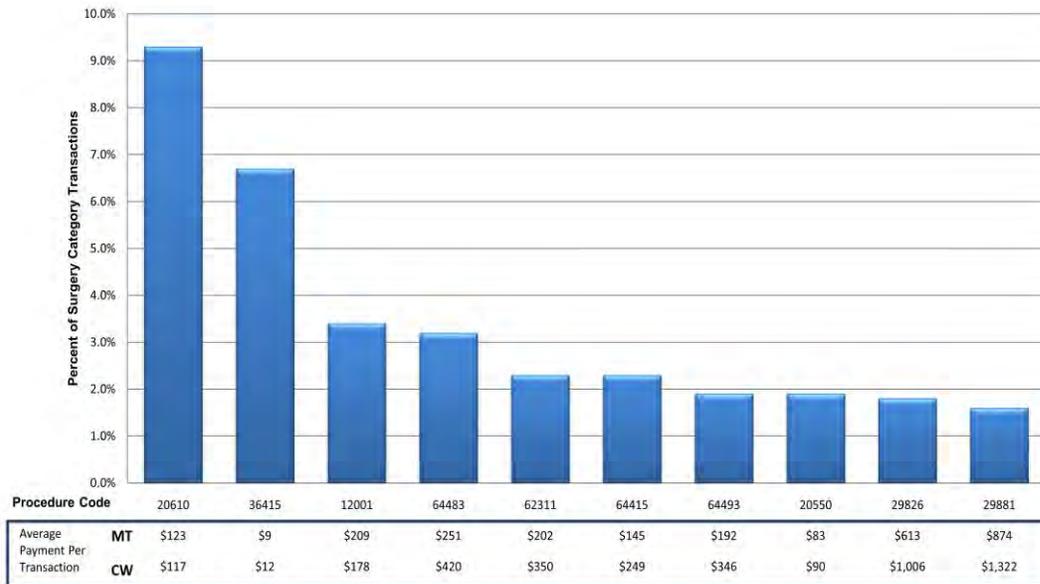
Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
22551	Arthrodesis anterior interbody including disc space preparation discectomy osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
29881	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29827	Arthroscopy shoulder surgical; with rotator cuff repair
20610	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
22633	Arthrodesis combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression) single interspace and segment; lumbar
27447	Arthroplasty knee condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy foraminotomy and/or excision of herniated intervertebral disc; 1 interspace lumbar
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level

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Chart 7

Top 10 Surgery Procedure Codes by Transaction Counts for Montana

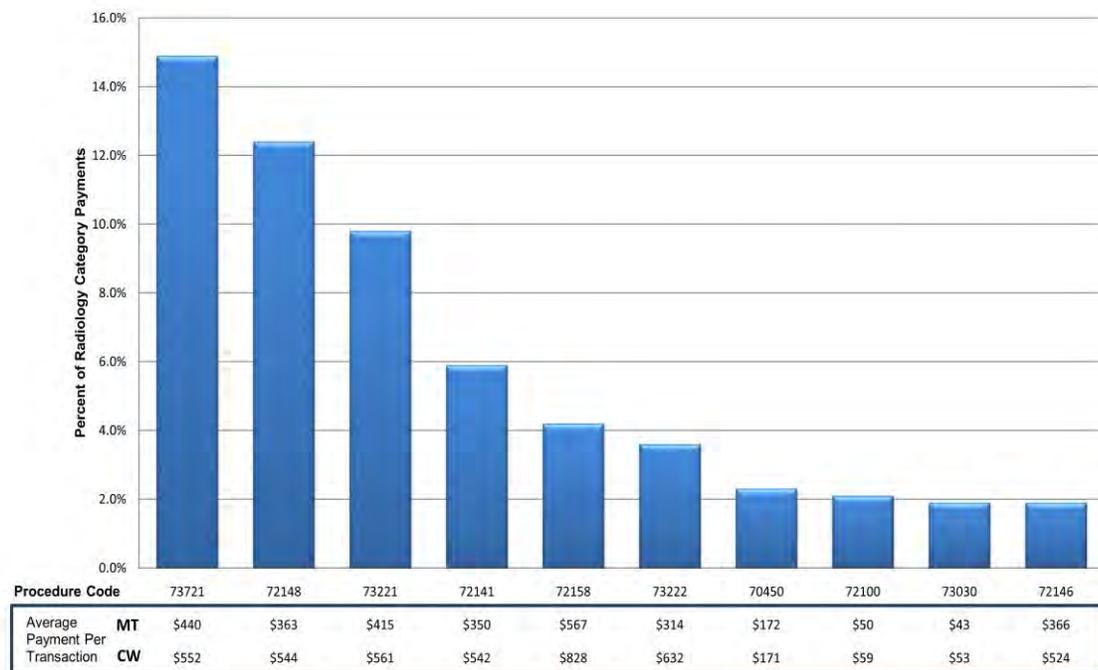


Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
20610	Arthrocentesis aspiration and/or injection; major joint or bursa (e.g., shoulder hip knee joint subacromial bursa)
36415	Collection of venous blood by venipuncture
12001	Simple repair of superficial wounds of scalp neck axillae external genitalia trunk and/or extremities (including hands and feet); 2.5 cm or less
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
62311	Injection(s) of diagnostic or therapeutic substance(s) (including anesthetic antispasmodic opioid steroid other solution) not including neurolytic substances including needle or catheter placement includes contrast for localization when performed epidural or subarachnoid
64415	Injection anesthetic agent; brachial plexus single
64493	Injection(s) diagnostic or therapeutic agent paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or computed tomography (CT)) lumbar or sacral: single level
20550	Injection(s); single tendon sheath or ligament aponeurosis (e.g., plantar fascia)
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
29881	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage

Chart 8

Top 10 Radiology Procedure Codes by Amount Paid for Montana

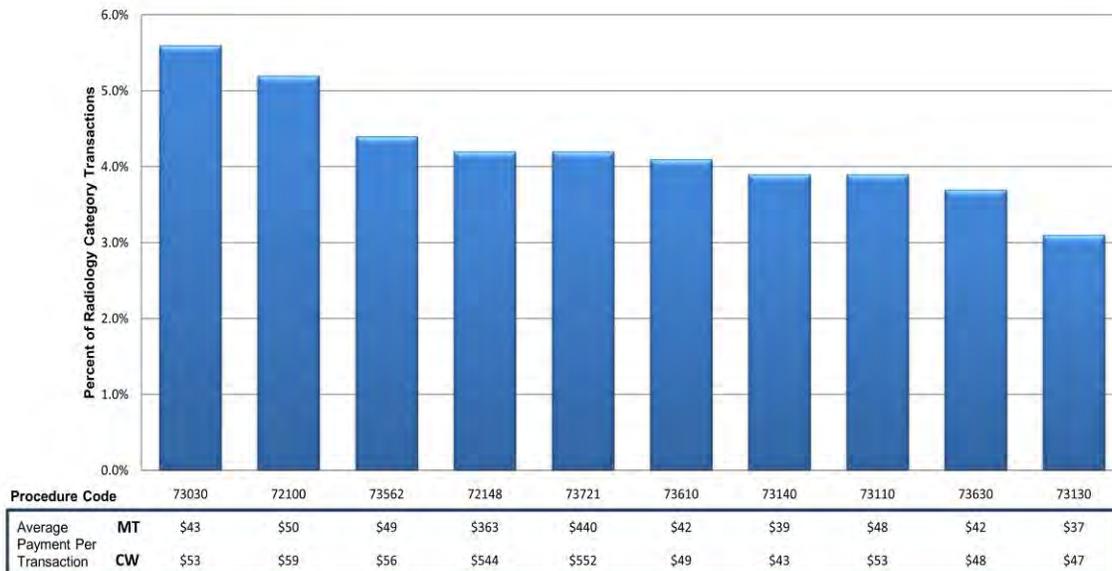


Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
73721	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
73221	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)
72141	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material
72158	Magnetic resonance (e.g., proton) imaging spinal canal and contents without contrast material followed by contrast material(s) and further sequences
73222	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; with contrast material(s)
70450	Computed tomography head or brain; without contrast material
72100	Radiologic examination spine lumbosacral; 2 or 3 views
73030	Radiologic examination shoulder; complete minimum of 2 views
72146	Magnetic resonance (e.g., proton) imaging spinal canal and contents thoracic; without contrast material

Chart 9

Top 10 Radiology Procedure Codes by Transaction Counts for Montana

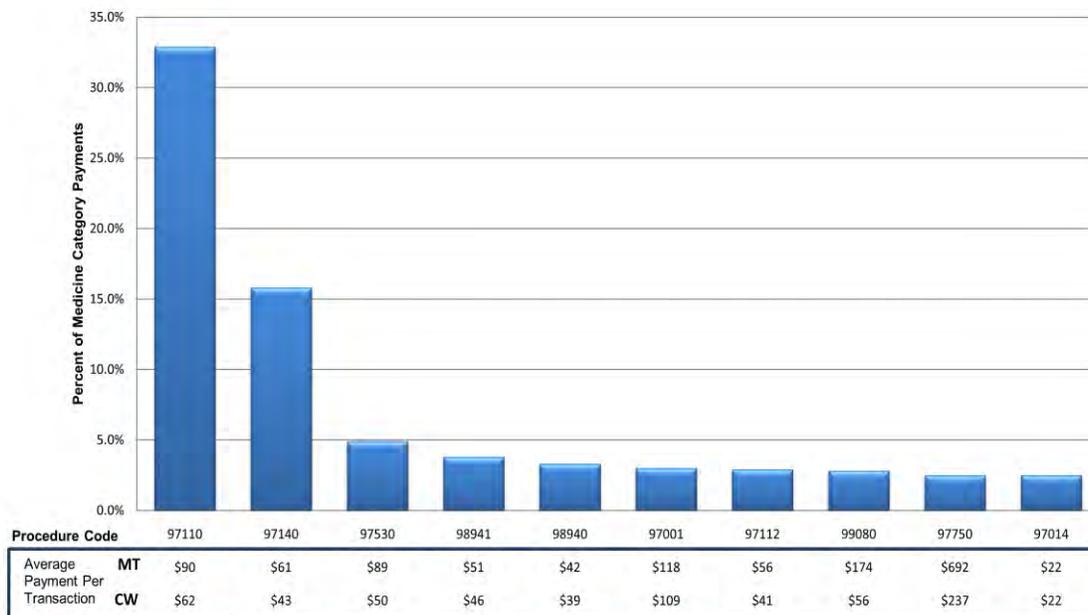


Source: NCCI Medical Data Call, Service Year 2012.

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

Chart 10

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

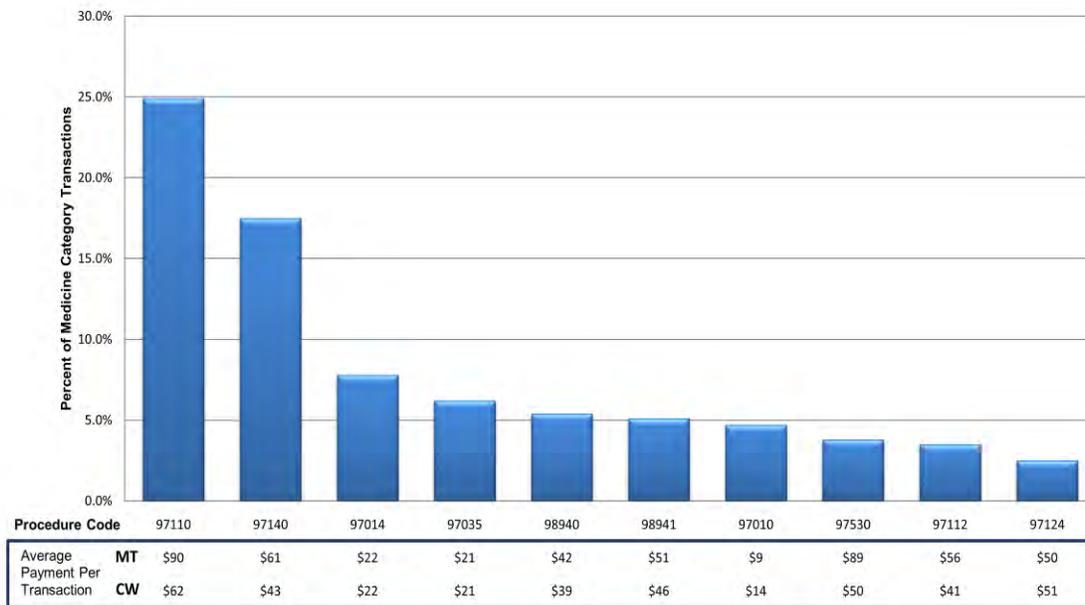


Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
97110	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
97140	Manual therapy techniques (e.g., mobilization/ manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes
97530	Therapeutic activities direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes
98941	Chiropractic manipulative treatment (CMT); spinal 3-4 regions
98940	Chiropractic manipulative treatment (CMT); spinal 1-2 regions
97001	Physical therapy evaluation
97112	Therapeutic procedure 1 or more areas each 15 minutes; neuromuscular reeducation of movement balance coordination kinesthetic sense posture and/or proprioception for sitting and/or standing activities
99080	Special reports such as insurance forms more than the information conveyed in the usual medical communications or standard reporting form
97750	Physical performance test or measurement (e.g., musculoskeletal functional capacity) with written report each 15 minutes
97014	Application of a modality to 1 or more areas: electrical stimulation (unattended)

Chart 11

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

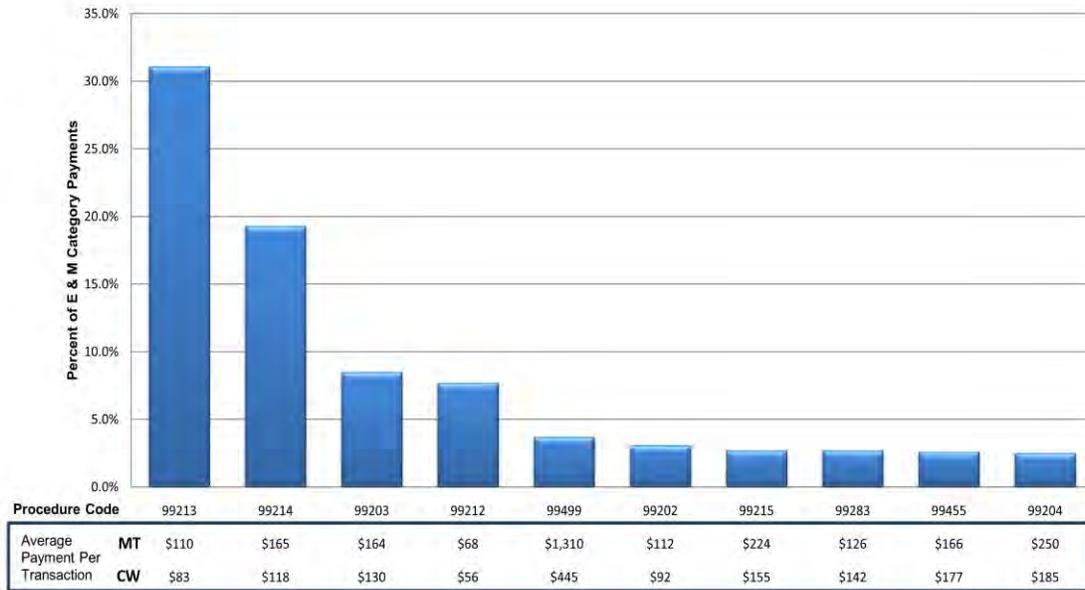


Source: NCCI Medical Data Call, Service Year 2012.

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

Chart 12

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



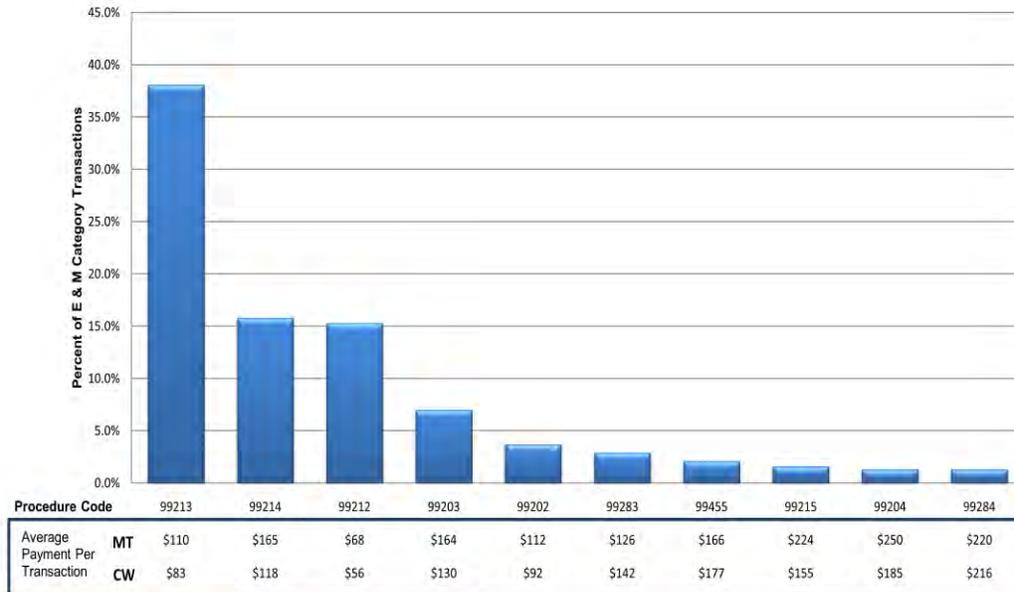
Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99499	Unlisted evaluation and management service
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99455	Work related or medical disability examination by the treating physician.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

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Chart 13

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



Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99455	Work related or medical disability examination by the treating physician.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

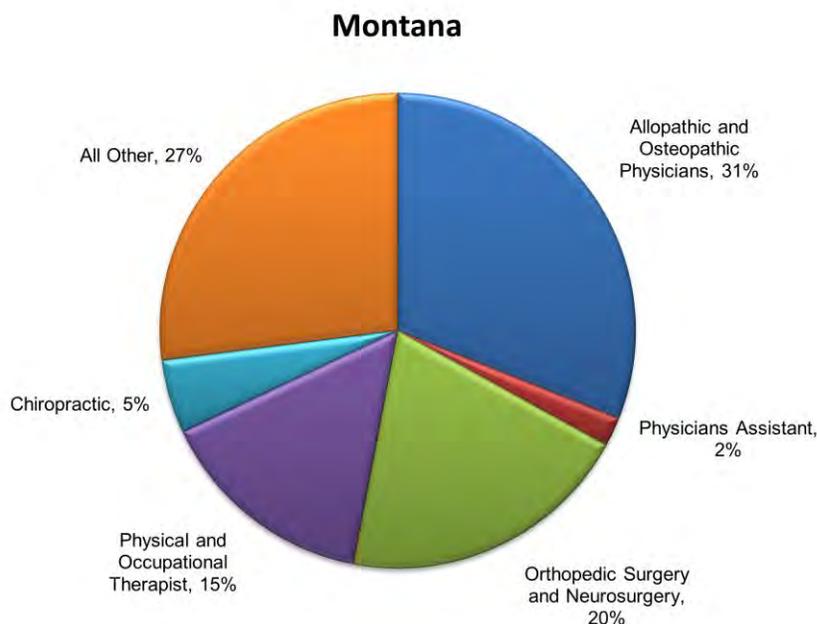
There are many different types of physician specialties. Various factors may contribute to the distribution of payments by physician specialty, which would mostly be driven by the general healthcare market in a state. However, the share of payments attributable to the physician specialties can be partially attributable to the workers compensation medical regulations in the state. For example, states have varying rules on which type of physician can act as a treating physician.

The most prevalent specialty within the Allopathic and Osteopathic Physicians category is general practitioners. The "All Other" category includes business entities under which one or more individuals practice within different areas of specialization, such as behavioral health professionals or groups with multiple specialties.

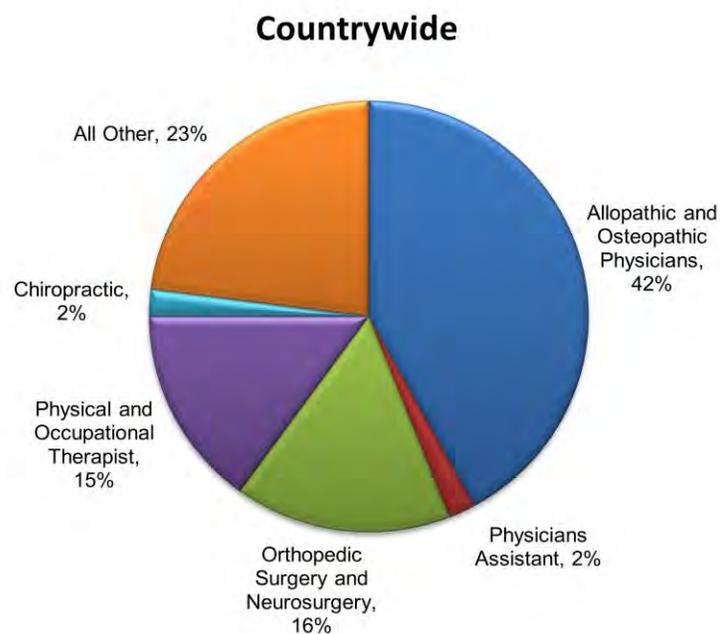
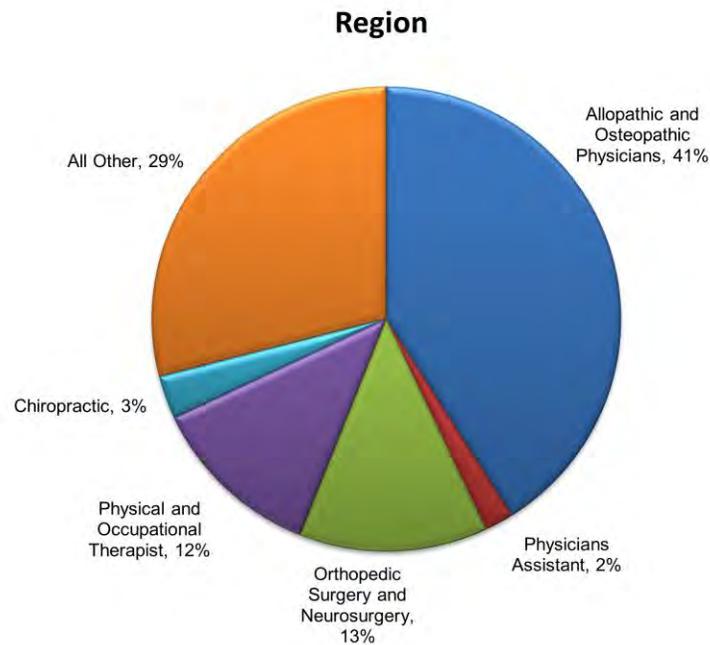
Chart 14 shows the distribution of physician payments by physician specialty.

Chart 14

Distribution of Physician Payments by Physician Specialty



Distribution of Physician Payments by Physician Specialty



Source: NCCI Medical Data Call, Service Year 2012. 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

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.

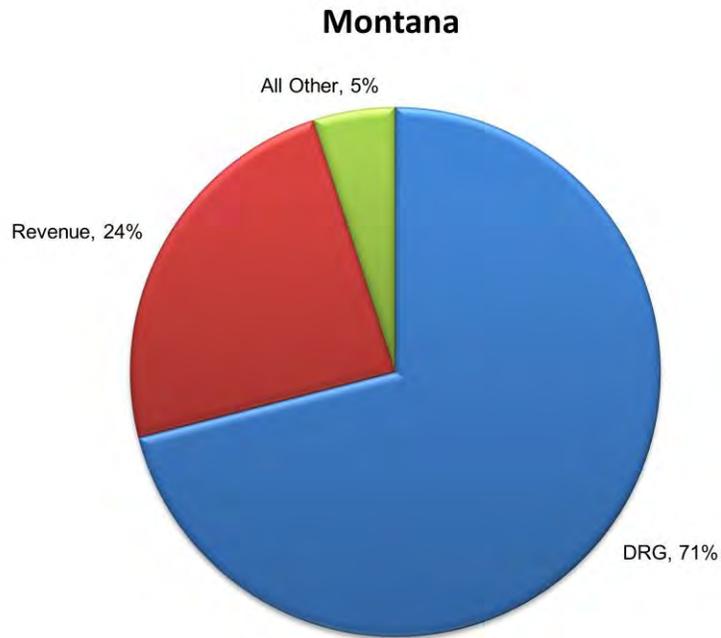
If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. If the hospital inpatient fee schedule is based on a discount from charged amounts, then revenue codes may be the more prevalent code type reported. Revenue codes are very generic and do not provide much information about the specific services that were performed.

The "All Other" category includes payments on a per diem basis and state-specific codes.

Chart 15 displays the distribution of hospital inpatient payments by procedure code type.

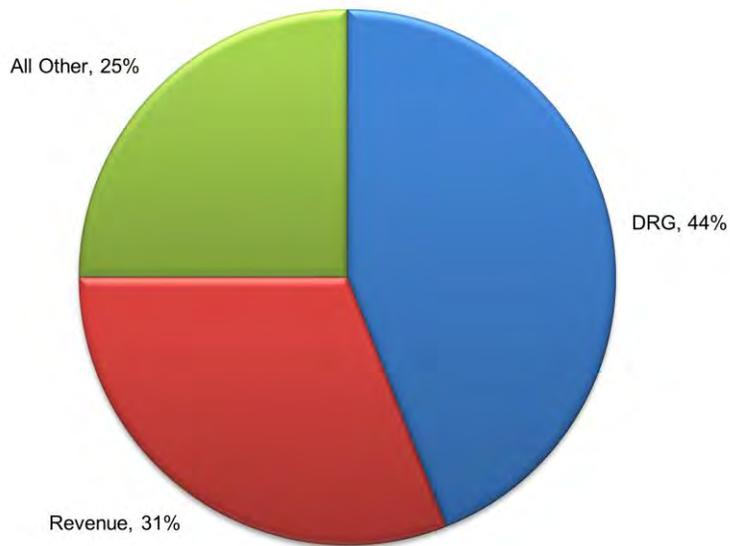
Chart 15

Distribution of Hospital Inpatient Payments by Procedure Code Type

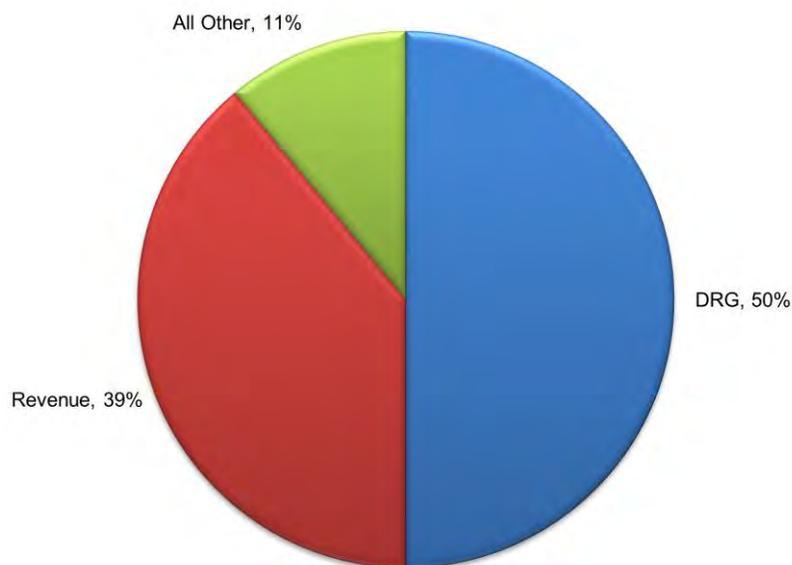


Distribution of Hospital Inpatient Payments by Procedure Code Type

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2012. 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.

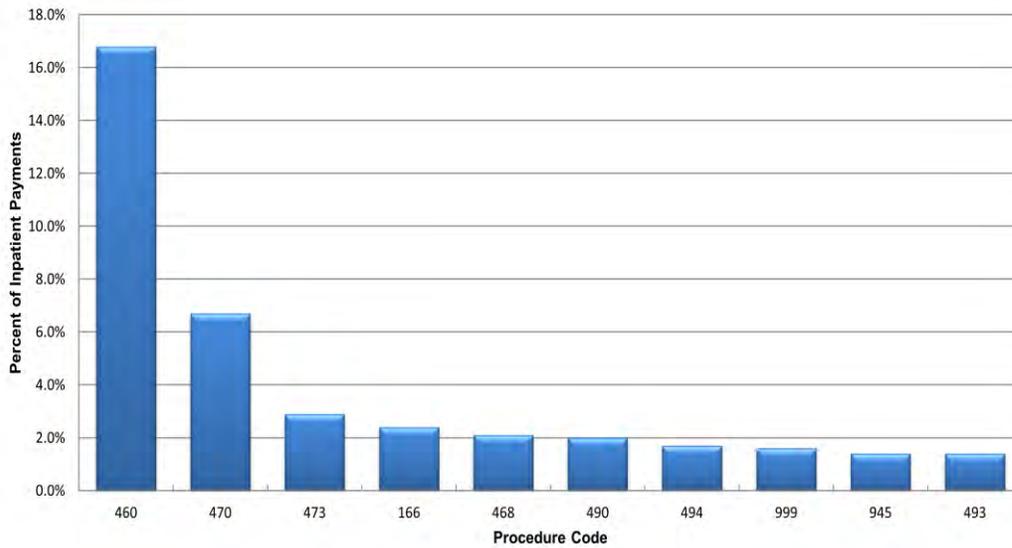
Medical Data Report for the state of: MONTANA

Chart 16 and Chart 17 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 16

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

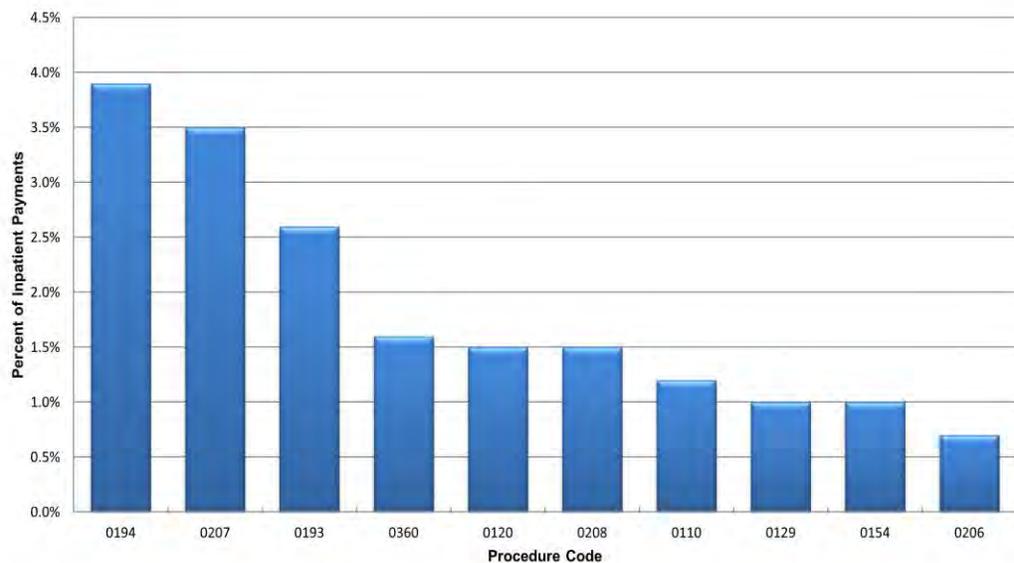


Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
460	Spinal fusion except cervical without major complications or comorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
473	Cervical spinal fusion without complications or comorbidities / major complications or comorbidities
166	Other respiratory system operating room procedures with major complications or comorbidities
468	Revision of Hip or Knee Replacement without complications or comorbidities/major complications or comorbidities
490	Back and neck procedures except spinal fusion with complications or comorbidities / major complications or comorbidities or disc device/neurostimulator
494	Lower extremity and humerus procedures except hip foot femur without complications or comorbidities / major complications or comorbidities
999	Ungroupable
945	Rehabilitation with complications or comorbidities / major complications or comorbidities
493	Lower extremity and humerus procedures except hip foot femur with complications or comorbidities

Chart 17

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



Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
0194	Subacute care - Level IV
0207	Intensive care: Burn care
0193	Subacute Care
0360	Operating room services: General
0120	Room & board-semiprivate (two beds): General
0208	Intensive care: Trauma
0110	Room & board-private (one bed): General
0129	Room & Board-Semiprivate (Two Beds)
0154	Room & Board-Ward
0206	Intensive care: Intermediate intensive care unit

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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).

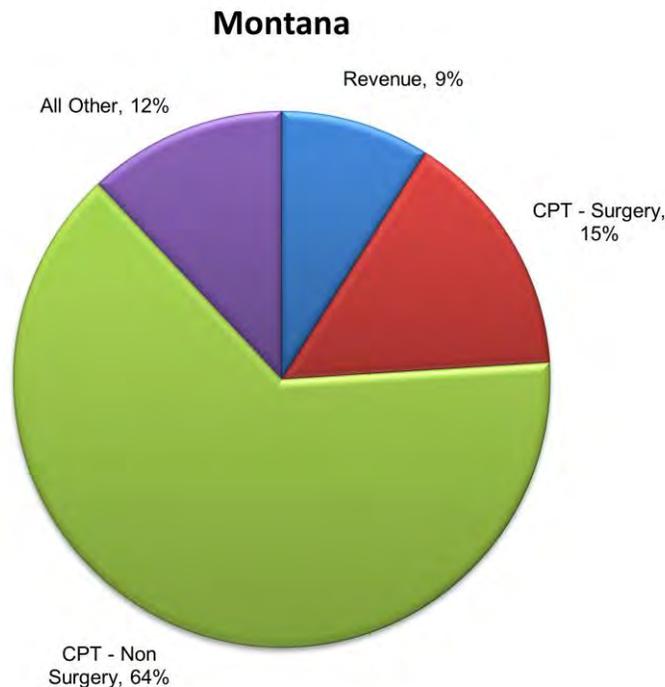
If the hospital outpatient fee schedule is based on a discount from charged amounts, then revenue codes may be the more prevalent code type. Revenue codes are very generic and do not provide much information about the specific services that were performed.

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

Chart 18 displays the distribution of hospital outpatient payments by procedure code type.

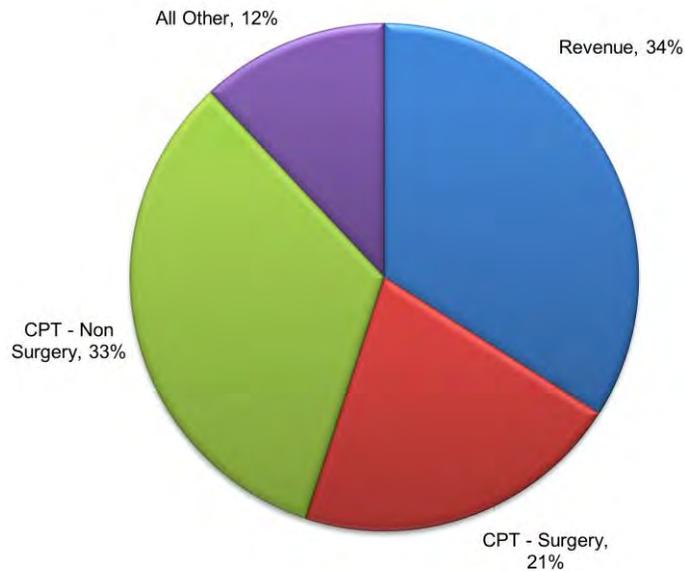
Chart 18

Distribution of Hospital Outpatient Payments by Procedure Code Type

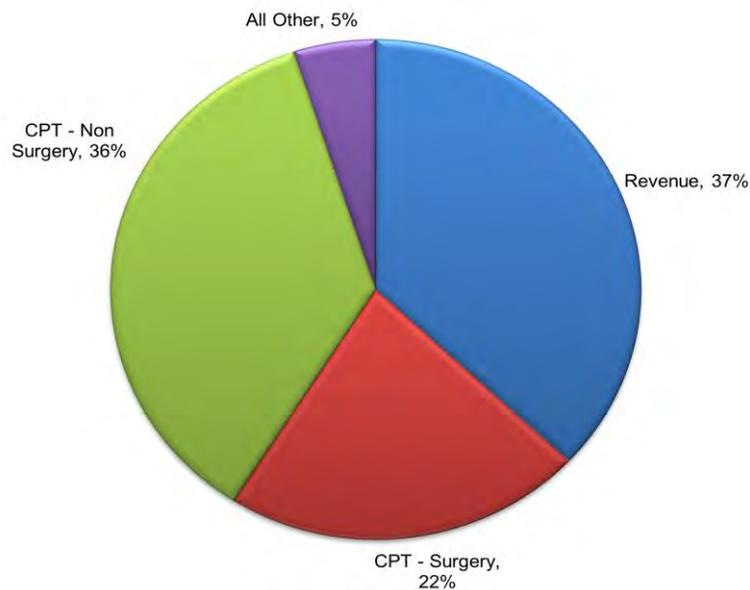


Distribution of Hospital Outpatient Payments by Procedure Code Type

Region



Countrywide



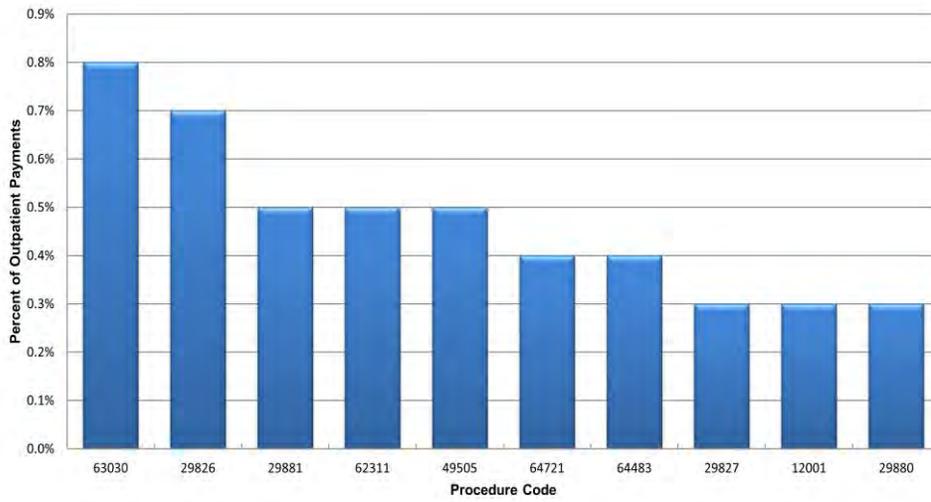
Source: NCCI Medical Data Call, Service Year 2012. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Charts 19 and 20 display the top 10 surgery CPT and non-surgery CPT codes. Chart 21 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 19

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

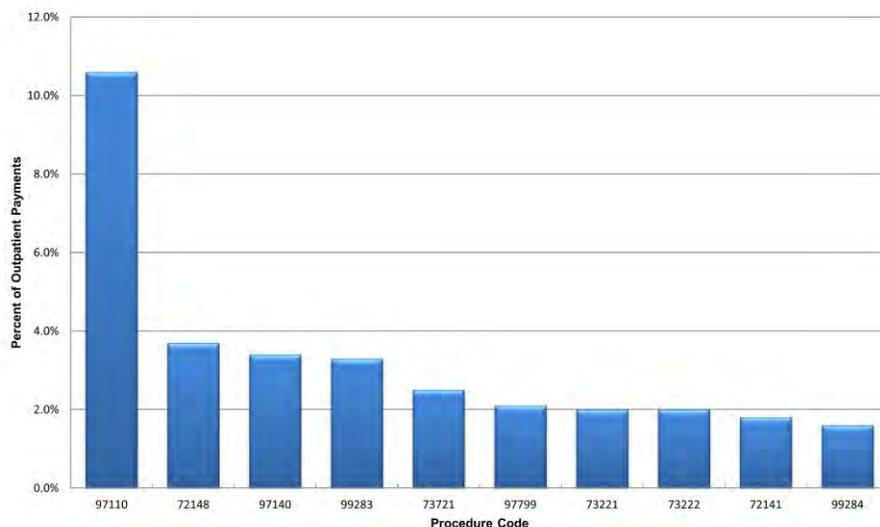


Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy foraminotomy and/or excision of herniated intervertebral disc; 1 interspace lumbar
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
29881	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
62311	Injection(s) of diagnostic or therapeutic substance(s) (including anesthetic antispasmodic opioid steroid other solution) not including neurolytic substances including needle or catheter placement includes contrast for localization when performed epidural or subarachnoid
49505	Repair initial inguinal hernia age 5 years or older; reducible
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
29827	Arthroscopy shoulder surgical; with rotator cuff repair
12001	Simple repair of superficial wounds of scalp neck axillae external genitalia trunk and/or extremities (including hands and feet); 2.5 cm or less
29880	Arthroscopy knee surgical; with meniscectomy (medial and lateral including any meniscal shaving) including debridement/shaving of articular cartilage

Chart 20

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

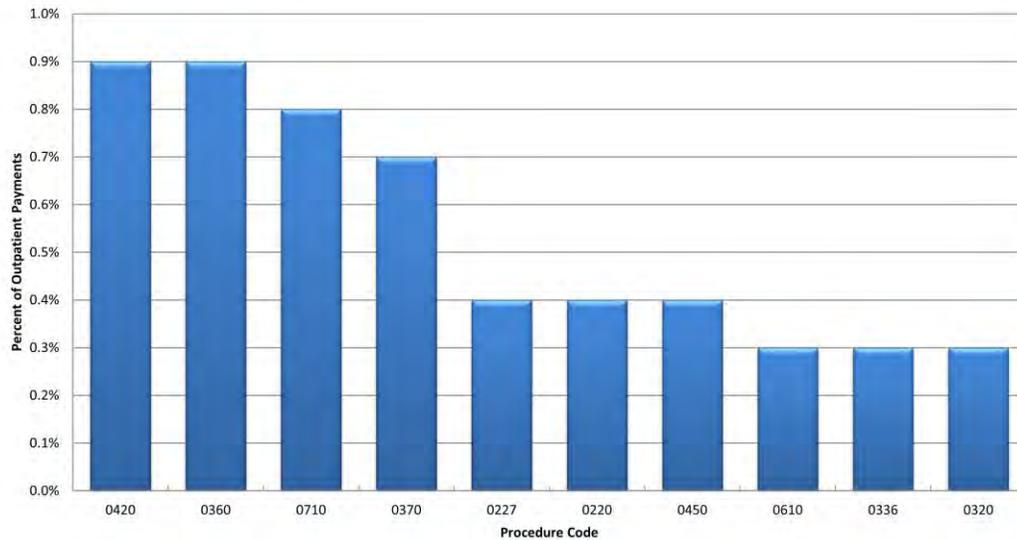


Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
97110	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility
72148	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material
97140	Manual therapy techniques (e.g., mobilization/ manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
73721	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material
97799	Unlisted physical medicine/rehabilitation service or procedure
73221	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)
73222	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; with contrast material(s)
72141	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.

Chart 21

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



Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
0420	Physical therapy: General
0360	Operating room services: General
0710	Recovery room: General
0370	Anesthesia: General
0227	Special Charges - General Classification
0220	Special Charges - Other
0450	Emergency room: General
0610	Magnetic Resonance Technology (MRT): General
0336	Radiology - Therapeutic: Chemotherapy - General
0320	Radiology - Diagnostic: General

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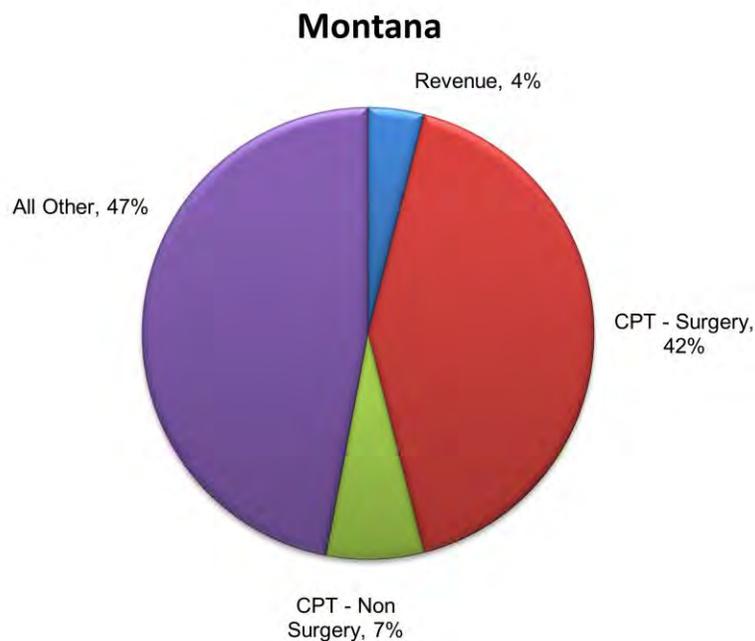
The share of payments attributable to ambulatory surgical centers (ASC) has grown in most states. Typically, only surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes. The predominant revenue code reported for ASC services is 0490—Ambulatory surgical care. In Montana, 0490 represents 9% of ASC payments reported by revenue codes.

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

Chart 22 displays the distribution of ASC payments by procedure code type.

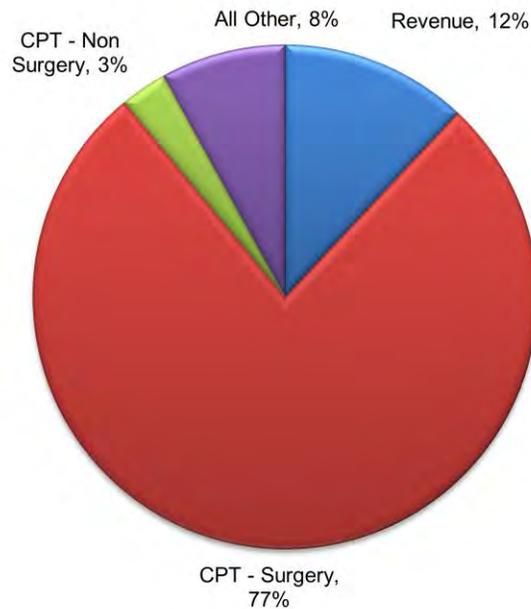
Chart 22

Distribution of Ambulatory Surgical Center Payments by Procedure Code Type

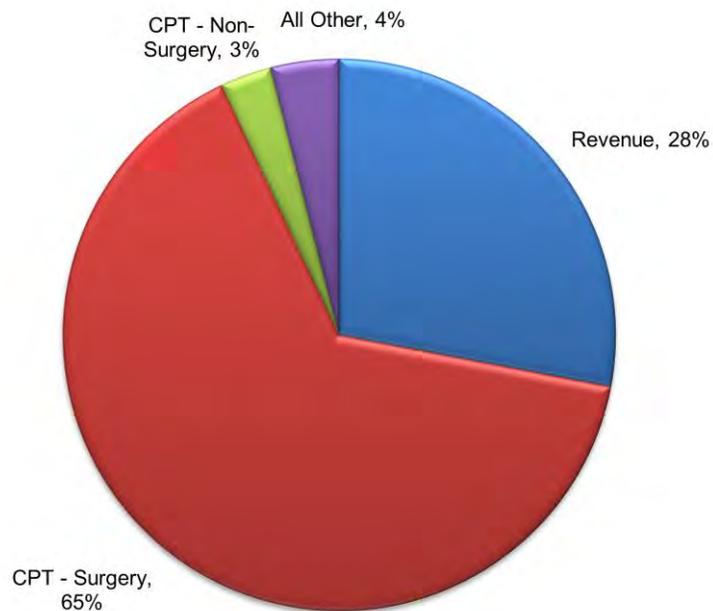


Distribution of Ambulatory Surgical Center Payments by Procedure Code Type

Region



Countrywide



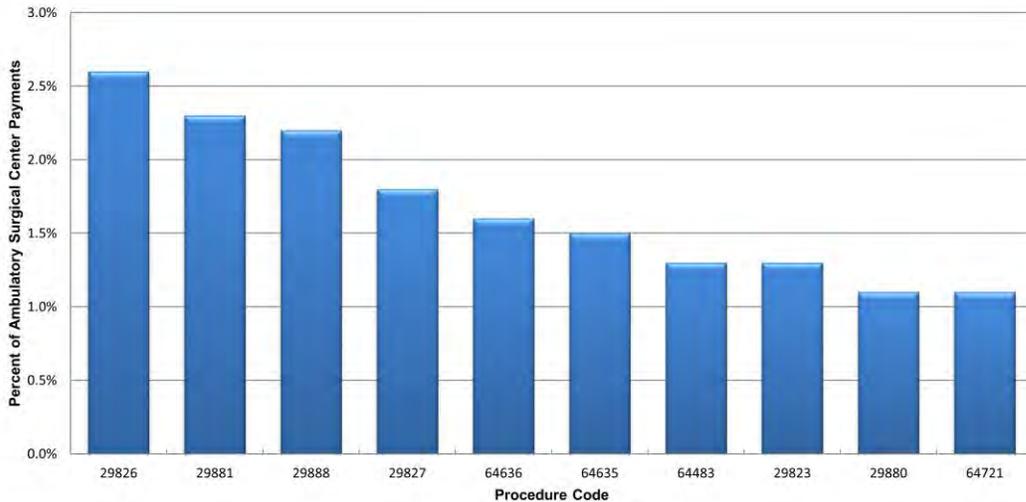
Source: NCCI Medical Data Call, Service Year 2012. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Chart 23 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 23

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



Source: NCCI Medical Data Call, Service Year 2012.

Code	Description
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed
29881	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29827	Arthroscopy shoulder surgical; with rotator cuff repair
64636	Destruction by neurolytic agent paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); lumbar or sacral each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); lumbar or sacral single facet joint
64483	Injection(s) anesthetic agent and/or steroid transforaminal epidural with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral single level
29823	Arthroscopy shoulder surgical; debridement extensive
29880	Arthroscopy knee surgical; with meniscectomy (medial and lateral including any meniscal shaving) including debridement/shaving of articular cartilage
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel

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NCCI's research, "Narcotics in Workers Compensation," published in June 2012, states that in 2009 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 24 through 28 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

Chart 24 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 24

Top 10 Workers Compensation Drugs by Amount Paid for Montana

Name of Drug	Type	Percentage of Drug Payments	Paid Per Unit
Oxycontin	Brand Name	14.9%	\$6.62
Cymbalta	Brand Name	7.3%	\$6.29
Lyrica	Brand Name	5.2%	\$2.95
Celebrex	Brand Name	5.1%	\$4.33
Gabapentin	Generic	4.4%	\$1.05
Hydrocodone-Acetaminophen	Generic	3.2%	\$0.35
Morphine Sulfate ER	Generic	2.8%	\$1.81
Oxycodone HCl	Generic	2.2%	\$0.52
Fentanyl Patch	Generic	2.1%	\$20.28
Tramadol HCl	Generic	2.0%	\$0.53

Top 10 Workers Compensation Drugs by Amount Paid for Countrywide

Name of Drug	Type	Percentage of Drug Payments	Paid Per Unit
Oxycontin	Brand Name	6.5%	\$5.83
Lyrica	Brand Name	4.9%	\$2.82
Gabapentin	Generic	4.4%	\$0.92
Lidoderm	Brand Name	4.3%	\$5.99
Cymbalta	Brand Name	4.2%	\$5.03
Hydrocodone-Acetaminophen	Generic	3.8%	\$0.33
Meloxicam	Generic	3.6%	\$1.85
Celebrex	Brand Name	3.5%	\$4.02
Tramadol HCl	Generic	2.9%	\$0.46
Opana ER	Brand Name	1.9%	\$6.84

Source: NCCI Medical Data Call, Service Year 2012. 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 25 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 25

Top 10 Workers Compensation Drugs by Prescription Counts for Montana

Name of Drug	Type	Percentage of Prescription	Paid Per Unit
		Counts	
Hydrocodone-Acetaminophen	Generic	13.5%	\$0.35
Cyclobenzaprine HCl	Generic	4.2%	\$0.67
Gabapentin	Generic	4.2%	\$1.05
Tramadol HCl	Generic	4.1%	\$0.53
Oxycodone HCl	Generic	3.7%	\$0.52
Oxycontin	Brand Name	3.5%	\$6.62
Cymbalta	Brand Name	3.2%	\$6.29
Celebrex	Brand Name	2.8%	\$4.33
Morphine Sulfate ER	Generic	2.3%	\$1.81
Lyrica	Brand Name	2.3%	\$2.95

Top 10 Workers Compensation Drugs by Prescription Counts for Countrywide

Name of Drug	Type	Percentage of Prescription	Paid Per Unit
		Counts	
Hydrocodone-Acetaminophen	Generic	14.5%	\$0.33
Tramadol HCl	Generic	5.3%	\$0.46
Cyclobenzaprine HCl	Generic	4.6%	\$0.65
Ibuprofen	Generic	4.2%	\$0.21
Gabapentin	Generic	3.5%	\$0.92
Meloxicam	Generic	2.9%	\$1.85
Oxycodone-Acetaminophen	Generic	2.5%	\$0.52
Naproxen	Generic	2.2%	\$0.36
Lyrica	Brand Name	2.2%	\$2.82
Oxycodone HCl	Generic	2.1%	\$0.58

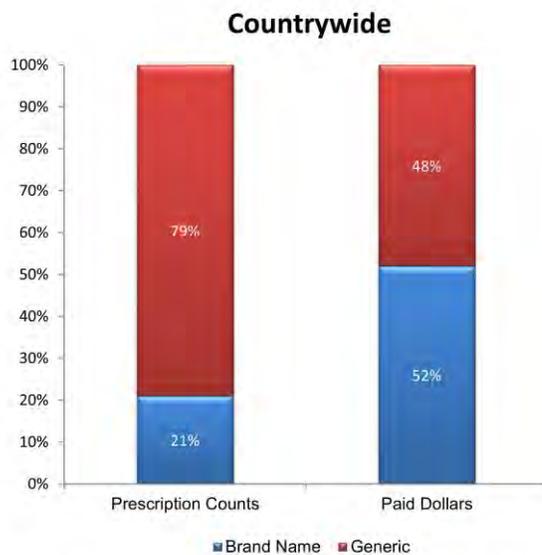
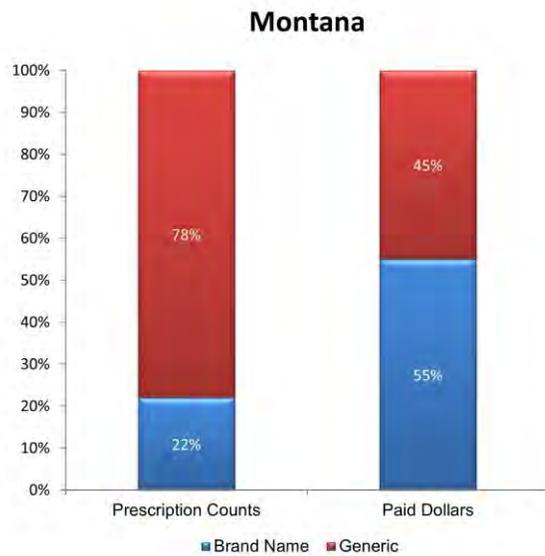
Source: NCCI Medical Data Call, Service Year 2012. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

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Chart 26 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 26

Distribution of Drugs by Brand Name and Generic



Source: NCCI Medical Data Call, Service Year 2012. 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.

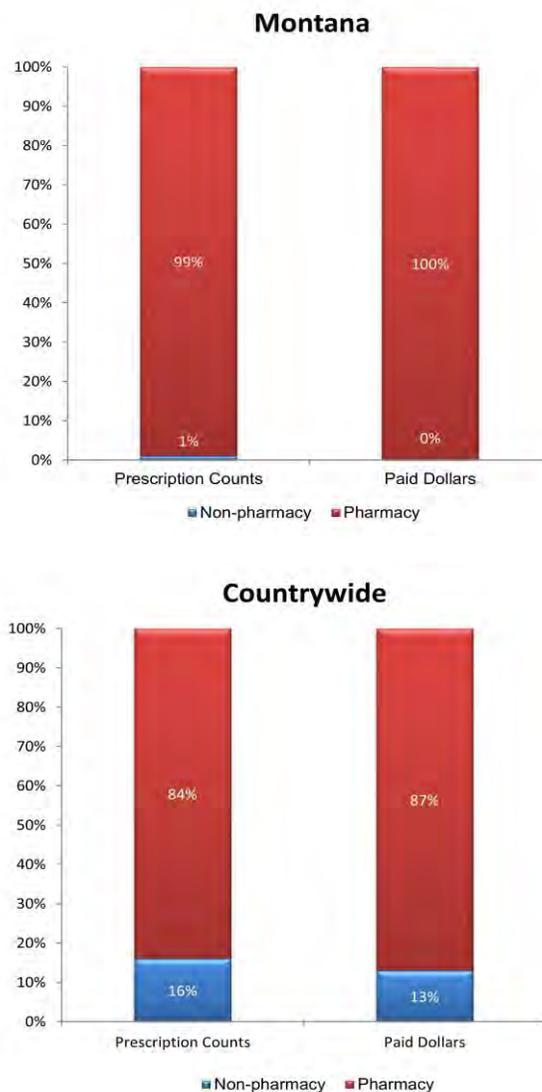
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The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states place limits or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a non-pharmacy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

Chart 27 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 27

Distribution of Drugs by Pharmacy and Non-pharmacy



Source: NCCI Medical Data Call, Service Year 2012. 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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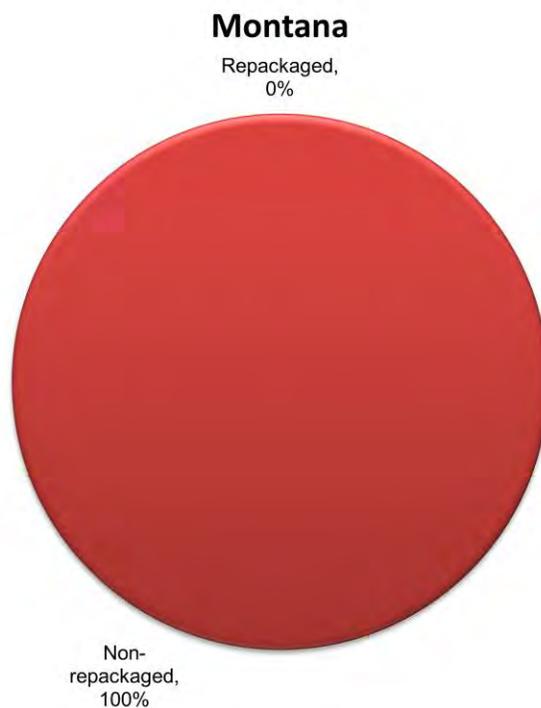
NDCs are specific not only to the product (including strength and formulation) and package size but also to the labeler. Labelers are manufacturers, repackagers, and distributors.

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.

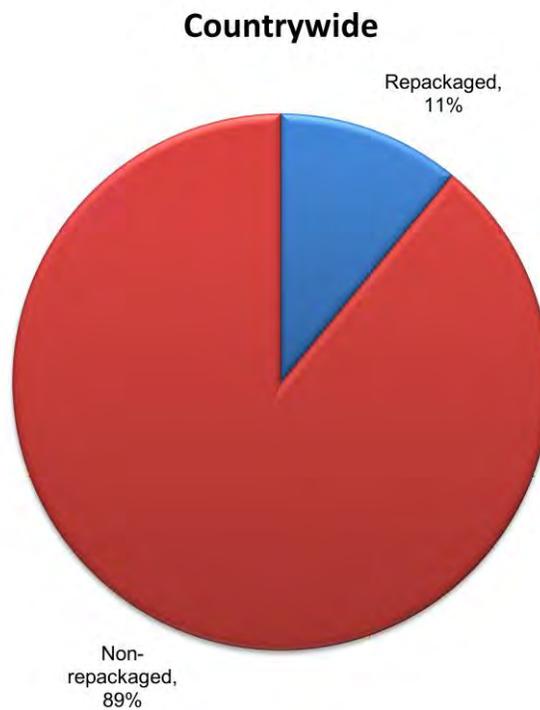
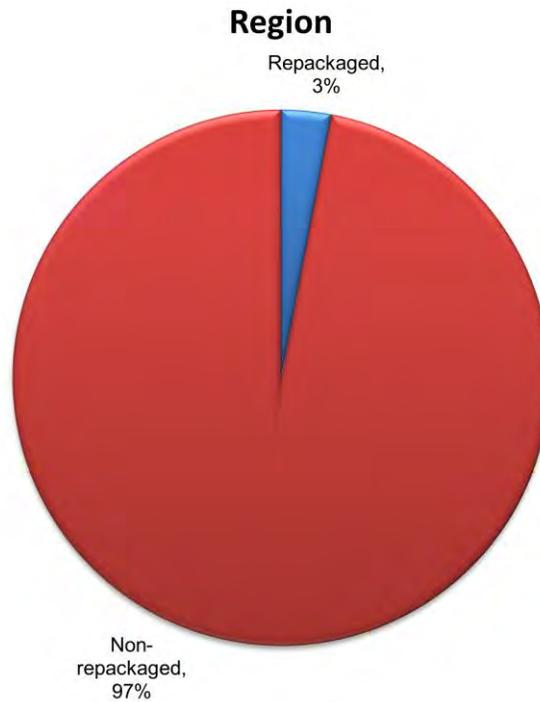
Chart 28 shows the distribution of payments for repackaged and non-repackaged drugs. The results in this chart are based only on payments reported with an NDC.

Chart 28

Distribution of Drug Payments by Repackaged and Non-repackaged



Distribution of Drug Payments Repackaged and Non-repackaged

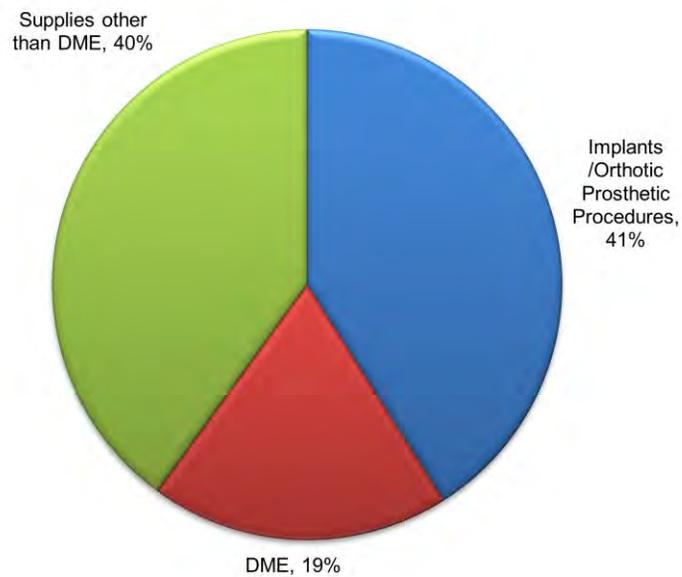


Source: NCCI Medical Data Call, Service Year 2012. Region includes CO, ID, NE, NV, OR, SD, and UT. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

Chart 29 displays the distribution of payments separately by Durable Medical Equipment (DME); Supplies Other Than DME; and Implants/Orthotic and Prosthetic Procedures. Payments are mapped to each of these categories based on the AMA procedure code reported regardless of who provides the service or where the service is performed.

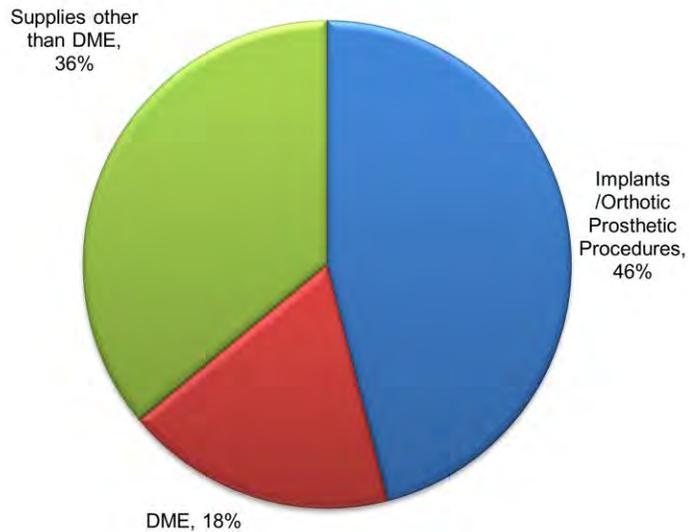
Chart 29

Distribution of Payments by DME, Supplies, and Implants Montana

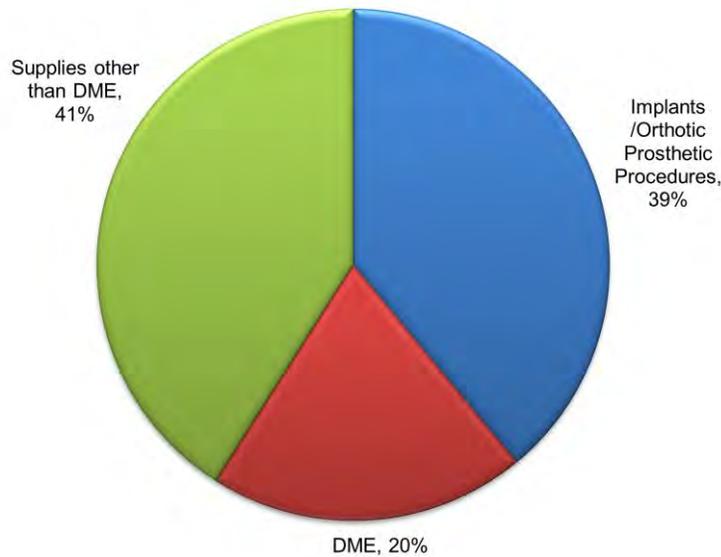


Distribution of Payments by DME, Supplies, and Implants

Region



Countrywide



Source: NCCI Medical Data Call, Service Year 2012. 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.

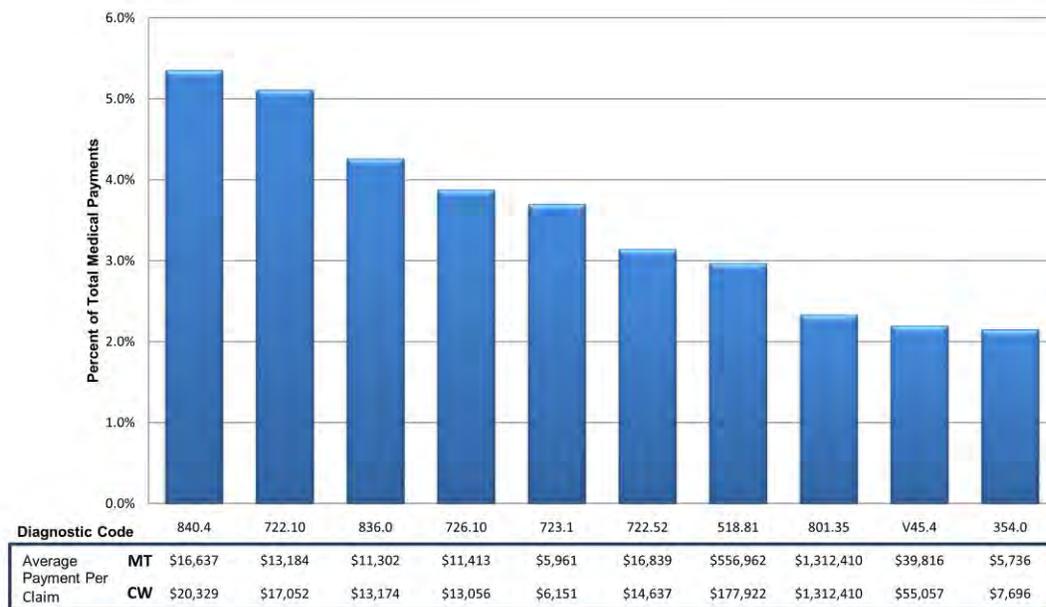
Medical Data Report for the state of: MONTANA

Chart 30 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. 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, 2011, and December 31, 2011, and include all reported services provided for those claims through December 31, 2012. 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. The state 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.

Chart 30

Top 10 ICD-9 Codes by Amount Paid for Dates of Injury in 2011 for Montana



Source: NCCI Medical Data Call, Dates of Injury in 2011.

Code	Description
840.4	Rotator cuff (capsule) sprain and strain
722.10	Displacement of lumbar intervertebral disc without myelopathy
836.0	Tear of medial cartilage or meniscus of knee, current
726.10	Unspecified disorders of bursae and tendons in shoulder region
723.1	Cervicalgia
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
518.81	Acute respiratory failure
801.35	Closed fracture of base of skull with other and unspecified intracranial hemorrhage, prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level
V45.4	Arthrodesis status
354.0	Carpal tunnel syndrome

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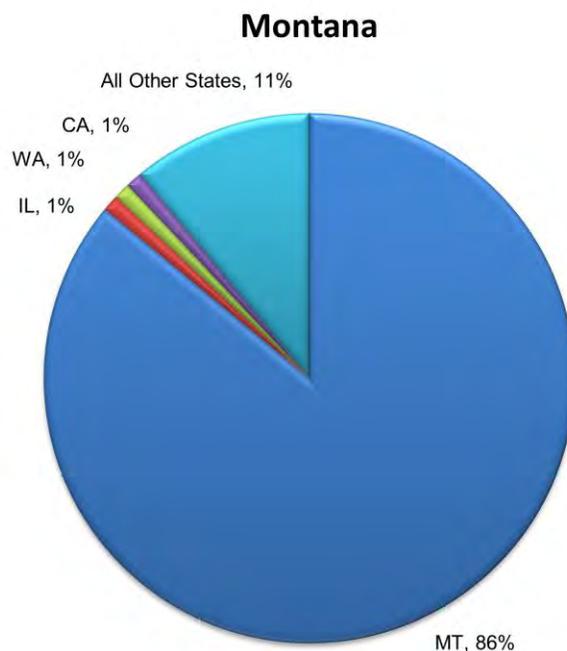
Medical benefit rules typically have different payment provisions for procedures performed in state versus out of state.

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 31 displays the distribution of medical payments according to the location where the medical service was provided.

Chart 31

Distribution of Medical Payments by Provider State



Source: NCCI Medical Data Call, Service Year 2012.

Comparison of Selected Distributions

The tables in this section provide a comparison of results for Montana for the latest two 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 inception of the Call.

Distribution of Medical Payments for Montana (Chart 4)

Medical Category	SY 2011	SY 2012
Physician	38%	37%
Hospital Outpatient	14%	17%
Hospital Inpatient	20%	18%
ASC	5%	5%
Drugs	16%	16%
DME, Supplies, and Implants	5%	5%
Other	2%	2%

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

AMA Service Category	SY 2011	SY 2012
Anesthesia	5%	5%
Surgery	23%	24%
Radiology	9%	9%
Pathology	1%	1%
Physical Medicine	29%	30%
General Medicine	6%	6%
Evaluation and Management	25%	25%
Other	2%	0%

Distribution of Physician Payments by Physician Specialty for Montana (Chart 14)

Physician Specialty	SY 2011	SY 2012
Allopathic and Osteopathic Physicians	31%	31%
Physicians' Assistant	5%	2%
Orthopedic Surgery and Neurosurgery	20%	20%
Physical and Occupational Therapist	21%	15%
Chiropractic	5%	5%
All Other	18%	27%

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Distribution of Hospital Inpatient Payments by Procedure Code Type for Montana (Chart 15)

Procedure Code Type	SY 2011	SY 2012
DRG	77%	71%
Revenue	20%	24%
All Other	3%	5%

Distribution of Hospital Outpatient Payments by Procedure Code Type for Montana (Chart 18)

Procedure Code Type	SY 2011	SY 2012
Revenue	29%	9%
CPT - Surgery	11%	15%
CPT - Non-surgery	42%	64%
All Other	18%	12%

Distribution of Ambulatory Surgical Center Payments by Procedure Code Type for Montana (Chart 22)

Procedure Code Type	SY 2011	SY 2012
Revenue	7%	4%
CPT - Surgery	33%	42%
CPT - Non-surgery	4%	7%
All Other	56%	47%

Distribution of Drug Payments by Brand Name and Generic for Montana (Chart 26)

Type of Drug	SY 2011	SY 2012
Brand Name	58%	55%
Generic	42%	45%

Distribution of Drug Payments by Pharmacy and Non-pharmacy for Montana (Chart 27)

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

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Distribution of Drug Payments by Repackaged and Non-repackaged for Montana (Chart 28)

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

Distribution of Payments by DME, Supplies, and Implants for Montana (Chart 29)

Category	SY 2011	SY 2012
Implants/Orthotic Prosthetic Procedures	40%	41%
DME	15%	19%
Supplies Other Than DME	45%	40%

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.

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; 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, 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.

Healthcare Common Procedure Coding System (HCPCS): The alphanumeric codes that include mostly nonphysician 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).

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, CDT code, or revenue code.

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

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

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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.

Taxonomy: A taxonomy code identifies the type of provider that billed for and is being paid for the 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.

Appendix

The data contained in this report represents medical transactions for Service Year 2012 (medical services delivered from January 1, 2012, to December 31, 2012). 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 Service Year 2012, the reported number of transactions was 527,010 representing data from 96% of the workers compensation premium written, which includes experience for large-deductible policies.

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**.