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May 29, 2026

Patti Vaughn
Benefits Administration Manager
Idaho Industrial Commission
700 S. Clearwater Lane, PO Box 83720
Boise, Idaho 83720

Re: Idaho Commercial Reimbursement Benchmarking

Dear Patti:

At the request of the Idaho Industrial Commission (IIC), Milliman is pleased to provide this report on commercial reimbursement in Idaho for specific DRGs and HCPCS codes. This analysis provides average commercial allowed amounts, average percentages of Medicare, and percentiles of those commercial allowed amounts. A similar analysis was provided on May 3, 2024 using a slightly different set of codes.

Along with the standard requested exhibits (Exhibits 1-4), we are again providing an alternative version of the exhibits (Exhibits 5-7) that mimics the methodology used in the National Council on Compensation Insurance (NCCI) report which does not apply any modifier, POS, or specialty exclusions. The alternative version also shows commercial allowed per procedure instead of commercial allowed per unit. While IIC does not use the NCCI methodology in its analysis (instead relying on the same approach taken with the standard exhibits in this report), this NCCI version is provided so IIC can compare results on a similar basis to the NCCI Medical Data Report. We understand that you will use this information to assess commercial reimbursement levels in the State of Idaho. This analysis may not be appropriate for other purposes.

Results

All requested tables of information are being provided in the attached exhibits. For your reference, the following table summarizes the average Percent of Medicare in the data for each service category using the HCPCS/DRG distribution in the data:

Table 1
Summary of 2025 Average Commercial Allowed
As a Percentage of 2025 Medicare

Description	Percent of Medicare
Inpatient DRG	320%
Outpatient Surgery*	115%
Outpatient Non-Surgery*	287%
Outpatient Emergency Room*	290%
Physician Major Surgery	220%
Physician Nonmajor Surgery	216%
Physician Radiology	247%
Physician Medicine	141%
Physician Evaluation and Management	174%

*Outpatient excludes additional bundled implant dollars

We have attached more detailed exhibits by HCPCS/DRG with average commercial allowed amounts, those amounts as a percentage of 2025 Medicare, and the 10th, 25th, 50th, 75th, and 90th percentile of the commercial allowed amounts. For the Evaluation and Management HCPCS codes, we provide results separately by place of service, because these codes have notably higher average reimbursement (around 30% higher) when performed at a non-facility location compared to a facility location.

Breaking out dollars for implants was greatly limited by the availability of commercial allowed amounts by implant. Often an implant was performed on a claim but the commercial allowed amount was at the claim level and not available for the implant. For the inpatient exhibit, we have provided the percent of dollars that are listed in claim lines that have implant revenue codes for each DRG. We also included the number of claims that had implant revenue codes and the portion of those where the commercial allowed dollars were greater than $0. For the outpatient exhibit, we determined the additional implant dollars that are bundled to the given HCPCS. The exhibits we have provided are:

- Exhibits following standard methodology:
  - Exhibit 1: Average Inpatient Commercial Charge, Percentage of Medicare, and Percentiles by DRG
    - Includes requested Inpatient DRGs, except for 3 DRGs that no longer exist as of October 1, 2024.
    - DRG 454 (“Combined Anterior And Posterior Spinal Fusion With CC”) and 455 (“Combined Anterior And Posterior Spinal Fusion Without CC/MCC”) existed in FY2024 but were removed for FY2025 and beyond. The DRGs were replaced by the following codes, which are included in the exhibit:
      - DRG 427 – “Multiple Level Combined Anterior And Posterior Spinal Fusion Except Cervical With CC”
      - DRG 428 – “Multiple Level Combined Anterior And Posterior Spinal Fusion Except Cervical Without CC/MCC”
      - DRG 430 – “Combined Anterior And Posterior Cervical Spinal Fusion Without MCC”
    - Similarly, DRG 460 (“Spinal Fusion Except Cervical Without MCC”) is no longer valid and was replaced with the following codes:
      - DRG 448 – “Multiple Level Spinal Fusion Except Cervical Without MCC”
      - DRG 451 – “Single Level Spinal Fusion Except Cervical Without MCC”
  - Exhibit 2: Average Outpatient Commercial Charge, Percentage of Medicare, and Percentiles by HCPCS
    - Includes requested Outpatient HCPCS including ER services.
  - Exhibit 3: Average Professional Commercial Charge, Percentage of Medicare, and Percentiles by HCPCS
    - Includes requested Physician surgery, radiology, and physical medicine HCPCS codes.
  - Exhibit 4: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service
    - Includes requested Physician Evaluation and Management HCPCS codes.
- Exhibits following NCCI-specific methodology (modified versions of Exhibits 2 through 4):
  - Exhibit 5: Average Outpatient Commercial Charge, Percentage of Medicare, and Percentiles by HCPCS – All modifiers, specialties, POS and based on commercial allowed per procedure.
  - Exhibit 6: Average Professional Commercial Charge, Percentage of Medicare, and Percentiles by HCPCS – All modifiers, specialties, POS and based on commercial allowed per procedure.

- Exhibit 7: Average Professional Commercial Charge, Percentage of Medicare, and Percentiles by HCPCS and Place of Service – All modifiers, specialties, POS and based on commercial allowed per procedure.

Note that, while we did mimic the code groupings from the NCCI report, reimbursement levels vary notably within some of those groupings. For example, average surgery commercial allowed amounts differ greatly between hospitals and ambulatory surgical centers (ASCs). Similarly, there is variance in reimbursement levels between the different Idaho markets.

A few observations from Exhibits 1-4:

- The high-level results are generally similar to the deliverable provided on 5/3/2024 for outpatient and professional codes. The inpatient DRG reimbursement in Table 1 increased significantly from the prior analysis because the list of DRGs covered is entirely different from the list covered in the prior analysis. Only 3 DRG codes appear in both years' lists.
- Additional bundled implant dollars vary significantly by surgery HCPCS. The additional dollars range from 0.5% to 55% of the commercial allowed dollars with the implants excluded for an average of 22% across all 10 surgical codes. For non-surgery HCPCS, there are minimal implant dollars as expected.
- The range of amounts paid by commercial payers for specific DRG/HCPCS is relatively large. The ratio between the 10th percentile and 90th percentile is generally around 260%-490% for inpatient services (excluding the low-volume codes), 150%-510% for outpatient services, and 120%-410% for physician professional services.
- The average commercial allowed is between the 25th percentile and the 75th percentile in most cases. A few DRGs/HCPCS have an average commercial allowed outside of the range due to a few outlier claims.

A few additional observations from comparing Exhibits 5, 6 and 7 to Exhibits 2, 3 and 4, respectively:

- Outpatient results are similar between the two versions. The one large change is from HCPCS 97110, 97140, and 97530 using commercial allowed per procedure instead of units. When units are ignored, the percentile range is much larger and the average commercial allowed is much larger. As expected, this matches closer to the NCCI Medical Data Report.
- The major surgery HCPCS codes in Exhibit 6 have a notable decrease in average commercial allowed compared to Exhibit 3. This is primarily due to including claim lines performed for non-physician assistant (Modifier AS) in Exhibit 6. These often are paid at much lower rates.
  Also, there is generally a separate claim line for the same HCPCS for the primary surgeon. Since the HCPCS is listed twice on the claim and the service is just performed once, you would likely want to combine the dollars instead of including them separately, which would make the average commercial allowed per surgery increase. Exhibit 6 is actually further from the report values so it is possible that the NCCI Medical Data Report is already combining these. We added a 'Surgery – Combined' section to the bottom of Exhibit 6 that combines all results into one record that has the same HCPCS, memberID, and Date. These updated results match much closer to the NCCI Medical Data Report.
- The radiology HCPCS in Exhibit 6 decreased significantly compared to Exhibit 3. This is because most of the claim lines were excluded in Exhibit 3 for having modifier 26 (professional component only). Since these claim lines are just for the professional component, they have commercial allowed payments that are much lower. Including them drops the average commercial allowed.
- The physical and general medicine HCPCS in Exhibit 6 have very similar results for the HCPCS that are not unit-dependent. The unit-dependent HCPCS (97110, 97112, 97140, and 97530) have huge increases in average commercial allowed since Exhibit 6 calculates the average per

procedure instead of units and these HCPCS often have multiple units. The values in the NCCI report tend to fall somewhere between the Exhibit 3 and Exhibit 6 values.
- The overall percentage of Medicare is generally the same between versions with and without exclusions, other than physician radiology. The reason physician radiology differs significantly is because most of the claim lines are excluded due to modifier exclusions in Exhibit 3.
- The average allowed amounts in Exhibit 7 are slightly lower than Exhibit 4, similar to the relationship between exhibits 6 and 3.

Methodology

Commercial reimbursement was calculated using the 2024 Milliman Consolidated Health Cost Guidelines Sources Database (CHSD) commercial claim data for Idaho members. This database utilizes data from existing Milliman clients through data trade agreements. Average commercial allowed and commercial allowed percentiles were calculated for the DRG/HCPCS codes requested by the IIC.

The following adjustments were made to the CHSD repricing:

- The exhibits use fiscal year 2025 Medicare allowed. A single year of trend was applied to put the 2024 CHSD data on a 2025 basis. The 2024 to 2025 commercial allowed trends are listed below:
  - Inpatient: 4.6%
  - Outpatient: 2.5%
  - Professional: 2.6%
- Certain HCPCS have very few claims without a modifier. To increase the credibility of the percentiles, Milliman reviewed all modifiers in the data set and kept claims with high frequency modifiers that do not greatly alter the average paid amount. Claim lines with the following modifiers were kept. All other claim lines with modifiers were excluded from Exhibits 2-4 (this exclusion was not applied to Exhibits 5-7.):
  - Outpatient: 25, 50, 51, 59, 95, CO, CQ, ER, FA, GO, GP, GT, LT, ME, MG, MH, PN, PO, RT, SG, TC, XU
  - Physician: 24, 25, 51, 57, 59, 80, 90, 95, CQ, F1, GO, GP, GT, LT, RT, XU
- Services with specialties indicating that they were performed by assistants have been excluded. This exclusion was only applied to Exhibits 2-4 and was not applied to Exhibits 5-7. The specialty codes for these are 32, 43, 97, and Z0.
- For HCPCS that should rarely or never have more than one unit, claim lines with multiple units were excluded. Unit-dependent HCPCS are shown in Exhibits 2-4 on a ‘per unit’ basis (Exhibits 5-7 show HCPCS on a ‘per procedure’ basis). All HCPCS we identified as unit-dependent had two or more units on at least 30% of claim lines. All other HCPCS had multiple units on less than 2% of claim lines. The following HCPCS are unit-dependent:
  - Outpatient: 97110, 97140, and 97530
  - Professional: 22614, 22853, 97110, 97112, 97140, and 97530
- As requested, ambulatory surgical centers are excluded in the calculations. This was identified using POS 24. Also, inpatient services were excluded from the outpatient claims using POS 21. Both of these exclusions were only applied to Exhibits 2-4 and were not applied to Exhibits 5-7.

Implant carveout logic:

- Claim lines are identified as implants using revenue codes 0274, 0275, 0276, and 0278.
- For inpatient, the implant dollars are already included in the DRG average. For outpatient, we show separate calculations with and without implant dollars.
- To determine the outpatient implant dollars for each claim line, all implant commercial allowed dollars that are bundled by Medicare are assigned to the APC payment on the claim. The APC allowed dollar distribution is used to spread the implant dollars across claims where there are multiple claim lines with Medicare payments.

Medicare Amounts

The CHSD data was repriced to 2025 Medicare allowed levels using the *Milliman Medicare Repricer*. The following considerations apply to the repricing results:

- All results are based on data and information published by CMS or the Medicare Administrative Contractors (MACs).
- All repriced amounts reflect prospective amounts and do not reflect any settlements with CMS.
- No adjustments are made for sequestration.
- Medicare employs claim edits to deny payment for certain services. We assumed all services with a positive allowed amount were accepted for payment and included these services in the repricing analysis. The Government Accountability Office (GAO) estimated the impact of prepayment edits in fiscal year 2010 to be approximately 0.5% of Medicare fee-for-service costs.
- The Milliman Medicare Repricer does not adjust claims for information contained within condition codes, such as codes 42 and 43 which can be added on a claim to bypass the reduction for certain transfers, or ZA which can exclude a claim from COVID new technology payments.

Inpatient Repricing

- No adjustment is made for providers that participate in Medicare's Bundled Payment for Care Improvement (BPCI) initiative or the Rural Community Hospital Demonstration Program.
- Add-on payments for blood clotting factor administered to hemophilia inpatients are not included. Under IPPS hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. No add-on payment is made under SNF PPS.
- For the purposes of this analysis, no add-on payments are included in the Medicare allowed amount.
- The *Milliman Medicare Repricer* does not adjust capital payments for new hospitals.
- We compare the *Milliman Medicare Repricer* results against the CMS IPPS PC Pricer software. In general, the two are consistent for the same set of inputs unless noted otherwise in these caveats. When there is a difference, we contact CMS and work to resolve the issue; in some cases, this results in a change to CMS' software.
- Pickle hospitals do not receive special pricing logic.
- CMS reduces a hospital's IPPS payment for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. Claims potentially subject to this adjustment typically have condition code 49 or 50 and value code FD. The *Milliman Medicare Repricer* does not make such adjustments.
- Organ acquisition costs are calculated based on organ specific information from the Medicare Cost Reports for the provider. Actual organ acquisition costs for Medicare Advantage payers are paid on a per case basis and are subject to contractual terms between the payer and provider. The organ acquisition costs included in the Medicare Allowed amount provides an estimate of the Medicare Allowable organ acquisition costs based on the per organ cost from the provider's Medicare Cost Reports.

Outpatient Repricing

- The *Milliman Medicare Repricer* prices outpatient facility claims using Medicare's Hospital Outpatient PPS fee schedule for hospital claims (used for about 90% of Medicare outpatient facility, non-ASC, non-dialysis payments in CY2014) and the Ambulatory Surgical Center (ASC) Payment for ASCs. For the following provider types the *Milliman Medicare Repricer* prices using the OPPS fee schedule, which will not match actual Medicare payments: Cancer Hospitals (paid based on cost), and Children's Hospitals (paid at cost).
- Beginning in 2014 Medicare makes device adjustments based on value code "FD" and the corresponding credit amount specified on the value line. The *Milliman Medicare Repricer* does

not support value code FD and device credits for hospitals. Therefore, hospital device credits must be manually applied. Device credits for ASCs are supported using modifiers FB and FC.

- For obsolete or deleted HCPCS, the *Milliman Medicare Repricer* maps the service to the current HCPCS with an equivalent meaning, when available.
- Reimbursement for outpatient services paid at cost (APC status F, H, and L) is estimated based on the billed charges for the service line and the provider specific cost-to-charge ratio published by CMS in the Outpatient Provider Specific File (OP PSF).
- The Supreme Court ruled in American Hospital Association v. Becerra that CMS violated their statutory authority when they reduced payments for drugs purchased under the 340B drug discount program for calendar years 2018 and 2019. Additionally, on September 28, 2022, the District Court for the District of Columbia vacated the differential payment rates for 340B-acquired drugs in the Calendar Year 2022 OPPS final rule with respect to their prospective application. As of the release of this software, CMS finalized their proposal to eliminate this reduction for CY 2023 and 2024. The 2024 Outpatient Prospective Payment System (OPPS) Final Rule notes CMS' decision not to reprocess all claims affected in calendar year 2020 through 2022 in favor of lump sum payments to affected facilities. This software no longer applies the reduction as originally implemented by CMS for January 1, 2020 through September 21,2022 dates of service.
- The *Milliman Medicare Repricer* applies the site-neutral reductions for clinic visit services (HCPCS G0463) in 2019 (30% reduction) and in 2020 and later (60% reduction) when coded with the "PN" procedure code modifier. The *Milliman Medicare Repricer* also applies a reduction for all HCPCS coded with the "PO" procedure code modifier when furnished in off-campus provider-based departments (PBDs). This reduction is 50% in 2017 and 60% in 2018 and later.
- Some drugs and biologicals based on Average Sales Price (ASP) methodology may have Medicare payment rates that are corrected retroactively. These retroactive corrections began with the January 2015 OPPS payment system quarterly update change request and typically occur on a quarterly basis. The Medicare Repricer does not include these retroactive corrections because of the timing of the release of this information from CMS.
- Beginning in 2024, Medicare began paying for Intensive Outpatient (IOP) services under similar logic as Partial Hospitalization Program (PHP) services. These services are differentiated using condition codes: 41 for PHP and 92 for IOP. The Medicare Repricer does not support condition code inputs. Therefore, IOP APCs will not be assigned for such claims. The model will default to the PHP APCs. For CY2025, the IOP payment rates are the same as the PHP payment rates.

Professional Repricing

- For obsolete or deleted HCPCS, the Medicare Repricer assigns the Medicare allowed based on the last available published RVUs, adjusted for trends between the fee schedule year and the repricing year.
- The *Milliman Medicare Repricer* does not include practitioner incentive payment adjustments, such as those under the Electronic Prescribing (eRx) Incentive Program, the Physician Quality Reporting System (PQRS), the Maintenance of Certification Program (MOC), the Primary Care Incentive Payments (PCIP) program, or the Merit-Based Incentive Payment System (MIPS).
- Ambulance claims are paid by whether they begin in an 'urban', 'rural', or 'super rural' area, but the *Milliman Medicare Repricer* uses the ambulance provider's county in its pricing since the pickup location is not always available in the claims data.
- Medicare makes additional payments for practitioners in health practitioner shortage areas and to practitioners who have assigned their billing rights to Critical Access Hospitals (CAHs). These payments and adjustments are not incorporated into the *Milliman Medicare Repricer*.
- The Medicare Repricer does not include competitive bidding rates for durable medical equipment (DME) beyond the amounts included in the national DME fee schedule.

Data Reliance and Variability of Results

This report is not intended to benefit third parties. Regarding the contents of this report, Milliman makes no representations or warranties to third parties. Third parties are to place no reliance upon this report that would result in the creation of any duty or liability for Milliman or its employees to third parties, under any theory of law. Third parties receiving this report must rely on their own experts to draw conclusions about the report's contents.

In performing our analysis, we relied on data and other information provided to us by CMS and commercial data contributors. We have not audited or verified this data and other information, but we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Our estimates are not predictions of the future; they are estimates based on the assumptions. If the underlying data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete. Emerging results should be carefully monitored with assumptions adjusted as appropriate.

Models used in the preparation of our analysis were applied consistently with their intended use. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models, including all input, calculations, and output may not be appropriate for any other purpose. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of those models. We relied on input, review, and validation by other experts in the development of our models.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Please call us with any questions or concerns. We appreciate the opportunity to work with you on this review.

Sincerely,

Adam Singleton, FSA, MAAA
Principal & Consulting Actuary

Attachments
cc: Scott Phillips, Milliman
Robert Cleve, IIC
Ann Young, IIC

Exhibit 1
Idaho Industrial Commision
Average Inpatient Commercial Charge, Percentage of Medicare and Percentiles by DRG

Notes on Implant Amounts
Inpatient allowed amounts by implant code were often not populated because the implant payment was bundled with the rest of the claim.
Amounts are shown to the right for claims where implants had separate allowed amounts, and where they did not.

DRG	Description	Admits	Average 2025 CHSD Allowed[1]	Average %-age of 2025 Medicare[2]	Percentiles of CHSD Allowed 10th	25th	50th	75th	90th
023	Craniotomy With Major Device Implant Or Acute Complex CNS Principal Diagnosis With MCC Or Antineoplastic Implant Or Epilepsy With Neurostimulator	30	$130,430	321%	$78,657	$92,699	$113,911	$150,904	$214,576
427	Multiple Level Combined Anterior And Posterior Spinal Fusion Except Cervical With CC	19	$106,218	205%	$41,871	$61,551	$73,616	$130,005	$164,313
428	Multiple Level Combined Anterior And Posterior Spinal Fusion Except Cervical Without CC/MCC	33	$95,394	238%	$48,300	$57,887	$83,080	$111,780	$182,681
430	Combined Anterior And Posterior Cervical Spinal Fusion Without MCC	5	$98,346	243%	$61,073	$61,551	$75,828	$133,452	$159,827
448	Multiple Level Spinal Fusion Except Cervical Without MCC	34	$98,306	328%	$41,871	$53,770	$72,686	$141,194	$203,745
451	Single Level Spinal Fusion Except Cervical Without MCC	94	$83,999	384%	$41,871	$43,631	$56,487	$85,558	$182,681
481	Hip And Femur Procedures Except Major Joint With CC	25	$52,185	338%	$24,306	$34,116	$44,465	$55,109	$94,034
493	Lower Extremity And Humerus Procedures Except Hip, Foot And Femur With CC	37	$56,564	323%	$31,357	$42,370	$47,172	$53,975	$82,007
494	Lower Extremity And Humerus Procedures Except Hip, Foot And Femur Without CC/MCC	38	$46,059	319%	$27,522	$30,358	$34,553	$45,630	$96,529
906	Hand Procedures For Injuries	2	$48,570	318%	$26,421	$26,421	$48,570	$70,718	$70,718
956	Limb Reattachment, Hip And Femur Procedures For Multiple Significant Trauma	8	$147,136	511%	$28,494	$69,765	$114,929	$183,791	$411,623
957	Other O.R. Procedures For Multiple Significant Trauma With MCC	14	$207,309	378%	$89,728	$112,670	$136,076	$340,390	$385,738

(1) Based on 2024 CHSD data trended to 2025.
(2) Medicare amount excludes DSH, IME, UCP, and Outlier add-on payments.

Exhibit 1
Idaho Industrial Commision
Average Inpatient Commercial Charge, Percentage of Medicare and Percentiles by DRG

Notes on Implant Amounts
Inpatient allowed amounts by implant code were often not populated because the implant payment was bundled with the rest of the claim.
Amounts are shown to the right for claims where implants had separate allowed amounts, and where they did not.

		Implant Information					
		Admits w/ an Implant (Rev Codes 0274-0276, 0278)		Admits with non-Zero Allowed $s by Implant Code		Admits with Zero Allowed $s by Implant Code	
DRG	Description	Number	% of Total	Admits	Implant % of Total Allowed	Admits	Implant % of Total Allowed
023	Craniotomy With Major Device Implant Or Acute Complex CNS Principal Diagnosis With MCC Or Antineoplastic Implant Or Epilepsy With Neurostimulator	17	57%	3	2.4%	14	
427	Multiple Level Combined Anterior And Posterior Spinal Fusion Except Cervical With CC	19	100%	5	48.4%	14	Cannot be
428	Multiple Level Combined Anterior And Posterior Spinal Fusion Except Cervical Without CC/MCC	33	100%	12	42.6%	21	determined.
430	Combined Anterior And Posterior Cervical Spinal Fusion Without MCC	5	100%	3	34.6%	2	
448	Multiple Level Spinal Fusion Except Cervical Without MCC	34	100%	8	27.1%	26	
451	Single Level Spinal Fusion Except Cervical Without MCC	94	100%	9	43.6%	85	
481	Hip And Femur Procedures Except Major Joint With CC	24	96%	6	6.1%	18	
493	Lower Extremity And Humerus Procedures Except Hip, Foot And Femur With CC	34	92%	8	10.4%	26	
494	Lower Extremity And Humerus Procedures Except Hip, Foot And Femur Without CC/MCC	37	97%	7	16.0%	30	
906	Hand Procedures For Injuries	2	100%	0		2	
956	Limb Reattachment, Hip And Femur Procedures For Multiple Significant Trauma	8	100%	4	24.8%	4	
957	Other O.R. Procedures For Multiple Significant Trauma With MCC	13	93%	6	6.8%	7	

(1) Based on 2024 CHSD data trended to 2025.
(2) Medicare amount excludes DSH, IME, UCP, and Outlier add-on payments.

Exhibit 2
Idaho Industrial Commision
Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
Excludes Modified Codes[1]

Notes on Implant Amounts
Implants are coded separate from the HCPCS codes listed below. When implants occurred on a claim, their allowed amounts were spread across claim lines that were paid under APCs.

				Average		Percentiles of CHSD Allowed						Implant	
Source	HCPCS	Description	Units	2025 CHSD Allowed[2]	%-age of 2025 Medicare	10th	25th	50th	75th	90th	APC Code[3]	Additional Bundled Implants[4]	Combined % of 2025 Medicare[5]
Surg	29827	Sho arthrs srg rt8tr cuf rpr	431	$6,505	134%	$2,914	$4,183	$6,354	$6,895	$11,416	5114	$637	147%
Surg	23430	Repair biceps tendon	288	$6,498	111%	$1,647	$1,967	$3,934	$10,507	$13,789	5114	$522	120%
Surg	27447	Total knee arthroplasty	649	$12,841	101%	$6,162	$7,979	$10,399	$16,162	$24,898	5115	$6,272	151%
Surg	29881	Knee arthroscopy/surgery	576	$3,802	162%	$1,953	$2,634	$3,606	$4,461	$5,786	5113	$112	167%
Surg	49650	Lap ing hernia repair init	385	$9,793	176%	$4,023	$5,849	$9,236	$13,311	$16,931	5361	$518	185%
Surg	24342	Repair of ruptured tendon	67	$8,666	121%	$4,985	$6,659	$8,763	$10,816	$11,905	5114	$1,123	137%
Surg	23472	Reconstruct shoulder joint	118	$13,762	75%	$6,359	$7,987	$11,851	$21,059	$22,711	5116	$7,512	116%
Surg	29888	Knee arthroscopy/surgery	395	$8,389	105%	$4,814	$5,623	$7,687	$9,970	$13,275	5114	$1,536	124%
Surg	63030	Low back disk surgery	184	$10,074	142%	$4,280	$7,103	$10,292	$12,540	$14,170	5114	$47	142%
Surg	29806	Sho arthrs srg capsulorraphy	184	$7,418	97%	$4,183	$5,260	$7,138	$9,534	$10,507	5114	$1,382	115%
Non-Surg	97110	Therapeutic exercises	63,926	$68	301%	$46	$57	$69	$80	$82		$0	302%
Non-Surg	99213	Office o/p est low 20 min	3,138	$116	89%	$62	$88	$113	$144	$174		$0	89%
Non-Surg	73222	Mri joint upr extrem w/dye	952	$1,719	223%	$741	$1,048	$1,491	$1,951	$3,783	5573	$0	223%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	5,149	$930	388%	$357	$558	$915	$1,117	$1,543	5523	$0	388%
Non-Surg	73221	Mri joint upr extrem w/o dye	2,342	$945	393%	$357	$558	$915	$1,147	$1,559	5523	$0	393%
Non-Surg	97530	Therapeutic activities	27,166	$76	298%	$55	$62	$78	$90	$91		$1	302%
Non-Surg	99214	Office o/p est mod 30 min	9,503	$153	117%	$121	$121	$159	$159	$187		$0	117%
Non-Surg	97140	Manual therapy 1/> regions	32,161	$65	319%	$43	$53	$64	$72	$83		$0	319%
Non-Surg	72148	Mri lumbar spine w/o dye	3,683	$1,035	437%	$482	$647	$1,028	$1,261	$1,559	5523	$0	437%
Non-Surg	G0463	Hospital outpt clinic visit	1,266	$132	104%	$4	$51	$125	$168	$251	5012	$0	104%
ER	99283	Emergency dept visit low mdm	21,511	$696	251%	$389	$617	$691	$816	$923	5023	$0	251%
ER	99284	Emergency dept visit mod mdm	26,007	$1,113	258%	$606	$978	$1,104	$1,271	$1,442	5024	$0	258%
ER	99285	Emergency dept visit hi mdm	10,133	$1,635	243%	$871	$1,261	$1,596	$1,923	$2,098	5025	$3	244%
ER	74177	Ct abd & pelvis w/contrast	12,920	$1,572	442%	$778	$954	$1,465	$1,854	$2,786	5572	$1	442%
ER	99282	Emergency dept visit sf mdm	9,467	$409	257%	$286	$358	$399	$465	$526	5022	$0	257%
ER	G0390	Trauma Respons w/hosp criti	69	$2,761	201%	$492	$769	$1,811	$4,000	$4,635	5045	$0	201%
ER	70450	Ct head/brain w/o dye	4,814	$608	727%	$274	$311	$532	$681	$1,110	5522	$0	728%
ER	26951	Amputation of finger/thumb	3	$6,518	205%	$3,501	$3,501	$7,855	$8,199	$8,199	5113	$0	205%
ER	72125	Ct neck spine w/o dye	1,684	$676	1020%	$274	$324	$649	$845	$1,176	5522	$1	1021%
ER	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	971	$356	3991%	$155	$269	$338	$462	$545	5051	$0	3992%

(1) Only the following modifiers are included: blank, 25, 50, 51, 59, 95, CO, CQ, ER, FA, GO, GP, GT, LT, ME, MG, MH, PN, PO, RT, SG, TC, XU.
(2) Based on 2024 CHSD data trended to 2025. Does not include additional bundled implant dollars.
(3) A few HCPCS do not have APC codes because they are either bundled or paid using a different method than APC.
(4) Implants are defined as lines with revenue code 0274, 0275, 0276, or 0278.
(5) (CHSD Allowed + Additional Bundled Implants) / 2025 Medicare

Exhibit 3
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
Excludes Modified Codes[1]

				Average		Percentiles of CHSD Allowed				
Source	HCPCS	Description	Units	2025 CHSD Allowed[2]	%-age of 2025 Medicare	10th	25th	50th	75th	90th
Maj. Surg.	29827	Sho arthrs srg rt8tr cuf rpr	482	$2,036	216%	$1,630	$1,972	$2,120	$2,133	$2,453
Maj. Surg.	23430	Repair biceps tendon	327	$950	204%	$610	$735	$763	$1,380	$1,481
Maj. Surg.	29881	Knee arthroscopy/surgery	546	$907	221%	$528	$627	$1,056	$1,078	$1,112
Maj. Surg.	29828	Sho arthrs srg bicp tenodsis	197	$1,063	221%	$713	$860	$910	$1,057	$1,820
Maj. Surg.	27447	Total knee arthroplasty	774	$2,497	218%	$1,948	$2,357	$2,539	$2,562	$3,227
Maj. Surg.	22551	Arthrd ant ntrbdy cervical	167	$3,055	216%	$2,427	$2,886	$3,295	$3,376	$3,413
Maj. Surg.	22633	Arthrd cmbn 1ntrspc lumbar	109	$3,536	238%	$2,365	$3,246	$3,584	$3,670	$4,731
Maj. Surg.	29824	Sho arthrs srg dstl claviclc	356	$816	263%	$519	$639	$674	$967	$1,347
Maj. Surg.	29888	Knee arthroscopy/surgery	384	$1,878	215%	$1,488	$1,827	$1,938	$1,947	$2,249
Maj. Surg.	24342	Repair of ruptured tendon	69	$1,506	217%	$1,206	$1,530	$1,542	$1,555	$1,663
Non-Maj. Surg.	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	2,690	$130	186%	$68	$83	$138	$172	$179
Non-Maj. Surg.	23350	Injection for shoulder x-ray	1,289	$177	233%	$89	$98	$101	$326	$339
Non-Maj. Surg.	20610	Drain/inj joint/bursa w/o us	8,390	$117	206%	$91	$109	$122	$128	$130
Non-Maj. Surg.	22853	Insj biomechanical device	625	$460	223%	$102	$382	$493	$509	$523
Non-Maj. Surg.	64415	Njx aa&/strd brch plxs img	1,445	$187	290%	$115	$123	$141	$142	$470
Non-Maj. Surg.	12002	Rpr s/n/ax/gen/trnk2.6-7.5cm	1,069	$145	189%	$89	$107	$144	$181	$217
Non-Maj. Surg.	22845	Insert spine fixation device	145	$1,266	221%	$287	$1,181	$1,372	$1,435	$1,472
Non-Maj. Surg.	22842	Insert spine fixation device	145	$1,400	224%	$887	$1,355	$1,488	$1,504	$1,847
Non-Maj. Surg.	64483	Njx Aa&/Strd Tfrm Epi L/S 1	1,069	$309	221%	$201	$207	$218	$466	$497
Non-Maj. Surg.	22614	Arthrd pst tq 1ntrspc ea add	218	$728	223%	$573	$694	$754	$771	$861
Radiology	73721	Mri jnt of lwr extre w/o dye	1,783	$524	281%	$391	$435	$552	$576	$582
Radiology	73222	Mri joint upr extrem w/dye	411	$817	288%	$605	$685	$870	$918	$918
Radiology	73221	Mri joint upr extrem w/o dye	859	$527	281%	$404	$436	$553	$575	$575
Radiology	72148	Mri lumbar spine w/o dye	1,300	$503	286%	$380	$413	$523	$545	$545
Radiology	73030	X-ray exam of shoulder	4,791	$63	204%	$52	$60	$64	$65	$71
Radiology	73610	X-ray exam of ankle	5,408	$67	206%	$56	$64	$68	$68	$76
Radiology	74177	Ct abd & pelvis w/contrast	587	$724	261%	$359	$656	$759	$759	$840
Radiology	77002	Needle localization by xray	884	$228	222%	$200	$215	$227	$240	$283
Radiology	73630	X-ray exam of foot	8,668	$63	209%	$52	$60	$63	$65	$71
Radiology	73110	X-ray exam of wrist	3,853	$74	199%	$62	$71	$75	$77	$84
Phys. Med.	97110	Therapeutic exercises	383,197	$33	142%	$28	$31	$32	$35	$35
Phys. Med.	97530	Therapeutic activities	382,763	$41	145%	$35	$40	$41	$45	$45
Phys. Med.	97112	Neuromuscular reeducation	228,281	$38	145%	$28	$36	$40	$40	$40
Phys. Med.	97140	Manual therapy 1/> regions	276,887	$30	143%	$26	$29	$30	$32	$32
Phys. Med.	97014	Electric stimulation therapy	73,053	$15	126%	$13	$13	$15	$16	$16
Phys. Med.	99199	Unlisted special svc px/rprt	66	$60	184%	$7	$19	$37	$100	$166
Phys. Med.	97161	Pt eval low complex 20 min	15,046	$101	109%	$96	$99	$99	$106	$106
Phys. Med.	99080	Special reports or forms	0							
Phys. Med.	97162	Pt eval mod complex 30 min	13,572	$102	109%	$98	$99	$99	$106	$106

(1) Only the following modifiers are included: blank, 24, 25, 51, 57, 59, 80, 90, 95, CQ, F1, GO, GP, GT, LT, RT, XU.
(2) Based on 2024 CHSD data trended to 2025.

Exhibit 4
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service
Excludes Modified Codes[1]

Evaluation and Management Codes

		Facility								Non-Facility							
			Average		Percentiles of CHSD Allowed						Average		Percentiles of CHSD Allowed				
HCPCS	Description	Units	2025 CHSD Allowed[2]	%-age of 2025 Medicare	10th	25th	50th	75th	90th	Units	2025 CHSD Allowed[2]	%-age of 2025 Medicare	10th	25th	50th	75th	90th
99213	Office o/p est low 20 min	15,366	$111	183%	$79	$83	$103	$126	$170	572,165	$144	172%	$113	$120	$149	$170	$175
99214	Office o/p est mod 30 min	26,226	$171	191%	$121	$135	$174	$190	$240	428,287	$204	174%	$159	$175	$203	$240	$248
99203	Office o/p new low 30 min	1,775	$137	180%	$104	$110	$129	$156	$162	131,279	$179	176%	$140	$155	$189	$211	$216
99204	Office o/p new mod 45 min	3,430	$224	181%	$168	$197	$226	$252	$262	88,770	$271	176%	$208	$245	$268	$314	$323
99215	Office o/p est hi 40 min	6,894	$251	188%	$180	$212	$245	$277	$349	49,074	$287	173%	$224	$246	$281	$338	$349
99212	Office o/p est sf 10 min	2,895	$57	166%	$43	$43	$56	$67	$69	54,354	$83	161%	$45	$70	$83	$105	$109
99284	Emergency dept visit mod mdm	33,957	$217	195%	$178	$178	$213	$231	$238	Not Applicable to Non-Facility							
99283	Emergency dept visit low mdm	12,244	$122	186%	$93	$105	$121	$136	$139								
99456	Disability examination	HCPCS Have No/Very Little Utilization															
99455	Work related disability exam																

(1) Only the following modifiers are included: blank, 24, 25, 51, 57, 59, 80, 90, 95, CQ, F1, GO, GP, GT, LT, RT, XU.
(2) Based on 2024 CHSD data trended to 2025.

Exhibit 5
Idaho Industrial Commision
Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
All modifiers, specialties, POS and based on allowed per procedure

Notes on Implant Amounts
Implants are coded separate from the HCPCS codes listed below. When implants occurred on a claim, their allowed amounts were spread across claim lines that were paid under APCs.

				Average		Percentiles of CHSD Allowed						Implant	
Source	HCPCS	Description	Procedures	2025 CHSD Allowed[1]	%-age of 2025 Medicare	10th	25th	50th	75th	90th	APC Code[2]	Additional Bundled Implants[3]	Combined % of 2025 Medicare[4]
Surg	29827	Sho arthrs srg rt8tr cuf rpr	520	$6,011	133%	$2,539	$3,503	$5,324	$6,787	$11,083	5114	$529	145%
Surg	23430	Repair biceps tendon	362	$5,840	105%	$1,647	$1,751	$3,354	$9,534	$13,789	5114	$417	113%
Surg	27447	Total knee arthroplasty	768	$13,439	111%	$6,338	$8,824	$11,017	$18,341	$24,898	5115	$5,342	155%
Surg	29881	Knee arthroscopy/surgery	710	$3,455	158%	$1,503	$2,307	$2,929	$4,461	$5,468	5113	$108	163%
Surg	49650	Lap ing hernia repair init	449	$9,321	181%	$3,332	$5,810	$9,323	$13,353	$16,931	5361	$446	190%
Surg	24342	Repair of ruptured tendon	83	$7,760	120%	$3,775	$4,985	$7,212	$10,507	$11,540	5114	$909	134%
Surg	23472	Reconstruct shoulder joint	138	$14,343	82%	$6,622	$8,227	$12,541	$21,059	$22,711	5116	$6,501	119%
Surg	29888	Knee arthroscopy/surgery	464	$7,938	105%	$4,644	$4,814	$7,495	$9,534	$11,660	5114	$1,319	123%
Surg	63030	Low back disk surgery	204	$9,512	140%	$4,280	$6,420	$9,098	$12,350	$14,150	5114	$43	140%
Surg	29806	Sho arthrs srg capsulorraphy	213	$6,931	96%	$3,503	$4,183	$6,534	$9,534	$10,507	5114	$1,216	113%
Non-Surg	97110	Therapeutic exercises	49,523	$128	302%	$62	$82	$161	$287	$569		$0	303%
Non-Surg	99213	Office o/p est low 20 min	3,331	$116	89%	$52	$86	$113	$147	$174		$0	89%
Non-Surg	73222	Mri joint upr extrem w/dye	960	$1,715	222%	$741	$1,048	$1,491	$1,951	$3,783	5573	$0	222%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	5,427	$937	387%	$357	$558	$915	$1,132	$1,559	5523	$0	387%
Non-Surg	73221	Mri joint upr extrem w/o dye	2,426	$949	392%	$357	$558	$915	$1,147	$1,559	5523	$0	392%
Non-Surg	97530	Therapeutic activities	27,233	$192	282%	$72	$91	$256	$650	$1,064		$1	283%
Non-Surg	99214	Office o/p est mod 30 min	9,662	$153	117%	$121	$121	$159	$159	$187		$0	117%
Non-Surg	97140	Manual therapy 1/> regions	27,875	$88	317%	$43	$67	$85	$195	$354		$0	317%
Non-Surg	72148	Mri lumbar spine w/o dye	3,688	$1,034	436%	$482	$641	$1,028	$1,257	$1,559	5523	$0	436%
Non-Surg	G0463	Hospital outpt clinic visit	1,645	$127	99%	$4	$48	$122	$180	$268	5012	$0	99%
ER	99283	Emergency dept visit low mdm	21,724	$697	251%	$389	$617	$691	$816	$923	5023	$0	251%
ER	99284	Emergency dept visit mod mdm	26,222	$1,114	258%	$606	$978	$1,104	$1,271	$1,443	5024	$0	258%
ER	99285	Emergency dept visit hi mdm	10,290	$1,640	245%	$871	$1,261	$1,629	$1,945	$2,157	5025	$3	246%
ER	74177	Ct abd & pelvis w/contrast	13,050	$1,574	442%	$778	$956	$1,465	$1,854	$2,786	5572	$1	442%
ER	99282	Emergency dept visit sf mdm	9,582	$409	257%	$287	$358	$399	$465	$526	5022	$0	257%
ER	G0390	Trauma Respons w/hosp criti	73	$2,818	209%	$492	$769	$1,811	$4,000	$4,635	5045	$5	209%
ER	70450	Ct head/brain w/o dye	4,916	$608	734%	$274	$311	$532	$681	$1,110	5522	$0	735%
ER	26951	Amputation of finger/thumb	20	$3,516	166%	$897	$1,631	$2,986	$7,026	$8,080	5113	$253	178%
ER	72125	Ct neck spine w/o dye	1,709	$674	1013%	$274	$315	$649	$845	$1,176	5522	$1	1014%
ER	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	994	$355	3987%	$155	$269	$338	$462	$545	5051	$0	3989%

(1) Based on 2024 CHSD data trended to 2025. Does not include additional bundled implant dollars.
(2) A few HCPCS do not have APC codes because they are either bundled or paid using a different method than APC.
(3) Implants are defined as lines with revenue code 0274, 0275, 0276, or 0278.
(4) (CHSD Allowed + Additional Bundled Implants) / 2025 Medicare

Exhibit 6
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
All modifiers, specialties, POS and based on allowed per procedure

				Average		Percentiles of CHSD Allowed				
Source	HCPCS	Description	Procedures	2025 CHSD Allowed[(1)]	%-age of 2025 Medicare	10th	25th	50th	75th	90th
Maj. Surg.	29827	Sho arthrs srg rt8tr cuf rpr	1,083	$1,548	227%	$214	$292	$2,002	$2,133	$2,463
Maj. Surg.	23430	Repair biceps tendon	723	$768	232%	$94	$158	$741	$1,083	$1,496
Maj. Surg.	29881	Knee arthroscopy/surgery	968	$876	234%	$175	$539	$1,058	$1,090	$1,254
Maj. Surg.	29828	Sho arthrs srg bicp tenodsis	450	$889	247%	$115	$205	$902	$1,057	$1,820
Maj. Surg.	27447	Total knee arthroplasty	1,884	$2,120	277%	$254	$335	$2,234	$2,546	$3,047
Maj. Surg.	22551	Arthrd ant ntrbdy cervical	274	$2,063	214%	$338	$429	$2,555	$3,361	$3,376
Maj. Surg.	22633	Arthrd cmbn 1ntrspc lumbar	178	$2,586	238%	$367	$480	$3,275	$3,670	$3,731
Maj. Surg.	29824	Sho arthrs srg dstl claviclc	723	$597	263%	$83	$135	$659	$784	$1,347
Maj. Surg.	29888	Knee arthroscopy/surgery	933	$1,444	240%	$202	$265	$1,827	$1,947	$2,249
Maj. Surg.	24342	Repair of ruptured tendon	148	$1,177	234%	$154	$216	$1,542	$1,549	$1,663
Non-Maj. Surg.	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	3,074	$129	189%	$68	$83	$137	$172	$179
Non-Maj. Surg.	23350	Injection for shoulder x-ray	1,372	$177	237%	$83	$98	$101	$326	$339
Non-Maj. Surg.	20610	Drain/inj joint/bursa w/o us	11,040	$121	205%	$94	$109	$123	$130	$179
Non-Maj. Surg.	22853	Insj biomechanical device	640	$491	221%	$65	$102	$476	$754	$1,018
Non-Maj. Surg.	64415	Njx aa&/strd brch plxs img	2,341	$171	265%	$105	$123	$133	$142	$227
Non-Maj. Surg.	12002	Rpr s/n/ax/gen/trnk2.6-7.5cm	1,189	$146	192%	$89	$107	$141	$183	$217
Non-Maj. Surg.	22845	Insert spine fixation device	225	$912	217%	$145	$183	$1,181	$1,415	$1,435
Non-Maj. Surg.	22842	Insert spine fixation device	215	$1,050	227%	$150	$198	$1,395	$1,504	$1,636
Non-Maj. Surg.	64483	Njx Aa&/Strd Tfrm Epi L/S 1	1,953	$344	226%	$206	$218	$302	$494	$685
Non-Maj. Surg.	22614	Arthrd pst tq 1ntrspc ea add	174	$1,093	231%	$101	$301	$763	$1,495	$2,898
Radiology	73721	Mri jnt of lwr extre w/o dye	7,637	$233	252%	$124	$124	$133	$303	$576
Radiology	73222	Mri joint upr extrem w/dye	1,423	$355	262%	$149	$149	$159	$622	$918
Radiology	73221	Mri joint upr extrem w/o dye	3,501	$235	251%	$124	$125	$133	$362	$575
Radiology	72148	Mri lumbar spine w/o dye	5,305	$236	252%	$136	$136	$144	$319	$545
Radiology	73030	X-ray exam of shoulder	12,120	$41	207%	$17	$17	$46	$64	$70
Radiology	73610	X-ray exam of ankle	12,857	$45	210%	$16	$16	$52	$68	$72
Radiology	74177	Ct abd & pelvis w/contrast	18,450	$196	222%	$166	$167	$177	$177	$197
Radiology	77002	Needle localization by xray	2,751	$111	220%	$47	$51	$55	$215	$233
Radiology	73630	X-ray exam of foot	21,623	$47	211%	$15	$17	$57	$64	$97
Radiology	73110	X-ray exam of wrist	9,189	$49	204%	$16	$17	$61	$75	$77
Phys. Med.	97110	Therapeutic exercises	249,854	$51	142%	$31	$31	$35	$70	$94
Phys. Med.	97530	Therapeutic activities	212,025	$78	145%	$40	$45	$78	$89	$158
Phys. Med.	97112	Neuromuscular reeducation	159,558	$54	145%	$36	$36	$40	$73	$81
Phys. Med.	97140	Manual therapy 1/> regions	204,782	$41	143%	$29	$29	$32	$57	$64
Phys. Med.	97014	Electric stimulation therapy	81,807	$15	125%	$13	$13	$15	$16	$16
Phys. Med.	99199	Unlisted special svc px/rprt	76	$106	221%	$7	$21	$62	$166	$208
Phys. Med.	97161	Pt eval low complex 20 min	15,091	$101	109%	$96	$99	$99	$106	$106
Phys. Med.	99080	Special reports or forms	0							
Phys. Med.	97162	Pt eval mod complex 30 min	13,619	$102	109%	$98	$99	$99	$106	$106
Surgery - Combined	29827	Sho arthrs srg rt8tr cuf rpr	683	$2,454	227%	$1,687	$2,102	$2,274	$2,472	$3,073
Surgery - Combined	23430	Repair biceps tendon	459	$1,210	232%	$659	$748	$879	$1,481	$1,699
Surgery - Combined	29881	Knee arthroscopy/surgery	805	$1,053	234%	$539	$764	$1,072	$1,112	$1,429
Surgery - Combined	29828	Sho arthrs srg bicp tenodsis	285	$1,404	247%	$815	$910	$1,024	$1,800	$2,356
Surgery - Combined	27447	Total knee arthroplasty	1,120	$3,563	277%	$1,974	$2,539	$2,793	$2,950	$3,683
Surgery - Combined	22551	Arthrd ant ntrbdy cervical	169	$3,339	214%	$2,516	$3,294	$3,512	$3,714	$3,867
Surgery - Combined	22633	Arthrd cmbn 1ntrspc lumbar	118	$3,901	238%	$2,596	$3,513	$3,724	$4,037	$5,042
Surgery - Combined	29824	Sho arthrs srg dstl claviclc	467	$925	263%	$544	$674	$749	$1,229	$1,545
Surgery - Combined	29888	Knee arthroscopy/surgery	573	$2,350	240%	$1,510	$1,924	$2,132	$2,256	$2,733
Surgery - Combined	24342	Repair of ruptured tendon	97	$1,796	234%	$1,348	$1,542	$1,586	$1,697	$1,898

(1) Based on 2024 CHSD data trended to 2025.

Exhibit 7
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service
All modifiers, specialties, POS and based on allowed per procedure

Evaluation and Management Codes

		Facility								Non-Facility							
			Average		Percentiles of CHSD Allowed						Average		Percentiles of CHSD Allowed				
HCPCS	Description	Procedures	2025 CHSD Allowed[1]	%-age of 2025 Medicare	10th	25th	50th	75th	90th	Procedures	2025 CHSD Allowed[1]	%-age of 2025 Medicare	10th	25th	50th	75th	90th
99213	Office o/p est low 20 min	8,298	$107	178%	$83	$93	$111	$125	$128	604,492	$143	173%	$113	$114	$145	$170	$175
99214	Office o/p est mod 30 min	12,320	$160	180%	$121	$143	$167	$185	$190	460,312	$203	175%	$159	$168	$202	$240	$248
99203	Office o/p new low 30 min	1,563	$137	183%	$104	$115	$132	$156	$161	138,037	$178	176%	$140	$153	$189	$211	$216
99204	Office o/p new mod 45 min	2,942	$225	183%	$174	$197	$227	$252	$258	92,431	$270	177%	$208	$245	$267	$313	$323
99215	Office o/p est hi 40 min	5,153	$246	185%	$180	$212	$245	$275	$300	53,235	$285	174%	$224	$241	$281	$338	$349
99212	Office o/p est sf 10 min	1,122	$56	176%	$40	$47	$59	$67	$69	58,408	$82	161%	$45	$70	$83	$105	$109
99284	Emergency dept visit mod mdm	35,765	$217	195%	$178	$178	$207	$231	$238	Not Applicable to Non-Facility							
99283	Emergency dept visit low mdm	12,908	$122	187%	$93	$105	$119	$136	$139								
99456	Disability examination	HCPCS Have No/Very Little Utilization															
99455	Work related disability exam																

(1) Based on 2024 CHSD data trended to 2025.