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May 30, 2018

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. This analysis provides average commercial allowed amounts, those amounts as a percentage of Medicare, and percentiles of those allowed amounts. A similar analysis was provided on May 15th, 2017 with a slightly different set of codes and breakouts. 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.

*This analysis is subject to the terms and conditions of the Contract for Actuarial Services between Milliman and the Idaho Industrial Commission dated May 10th, 2018.*

## 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 table using the HCPCS/DRG distribution in the data:

**Table 1**
**Summary of 2017 Commercial Average Allowed**
**As a Percentage of 2017 Medicare**

| Description | Percent of Medicare |
|---|---|
| Inpatient DRG | 242% |
| Outpatient Surgery* | 150% |
| Outpatient Non-Surgery* | 303% |
| Physician Surgery | 207% |
| Physician Radiology | 239% |
| Physician Medicine | 130% |
| Physician Evaluation and Management | 166% |

*Outpatient excludes additional bundled implant dollars

We have attached more detailed exhibits by HCPCS/DRG with average commercial payment amounts, those amounts as a percentage of 2016 Medicare, and the 10th, 25th 50th, 75th, and 90th percentile of the commercial payment amounts. For the HCPCS in the Table 9 list you provided us, we provide results separately by place of service. This is because of notably higher average reimbursement (around 50% higher) when performed at a non-facility location compared to a facility location.

Breaking out dollars for implants was a new request for the analysis this year and it was greatly limited by the availability of allowed amounts by implant. Often an implant was performed on a claim but the 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 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:

- Exhibit 1: Average Inpatient Commercial Charge, Percentage of Medicare and Percentiles by DRG
  - Includes requested Inpatient DRGs
  - New this year, we show the percent of dollars that are on an implant revenue code.
- Exhibit 2: Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
  - Includes requested Outpatient HCPCS
  - New this year, we show the average amount of implant dollars that are bundled into each HCPCS, and a separate percentage of Medicare for the combined allowed plus added implant dollars.
- Exhibit 3: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
  - Includes requested Physician surgery, radiology, and physical medicine HCPCS
- Exhibit 4: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service
  - Includes requested Physician evaluation and management HCPCS

A few observations from the exhibits:

- The results are generally similar to the deliverable provided on 5/1/2017.
- The outpatient HCPCS that have very low percentages of Medicare generally have large amounts of implants bundled to them. If you include the bundled amount, the percent of Medicare is much more reasonable. For example, HCPCS 63685 is 41% of Medicare but increases to 141% of Medicare once implants are included.
- 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 250%-300% for inpatient and outpatient services. Physician professional services tend to be lower at around 150%-200%.
- The average allowed is between the 25th percentile and the 75th percentile in most cases. A few HCPCS have an average allowed outside of the range due to a few outlier claims. Most of these are physician surgery and radiology HCPCS.

**Methodology**

Commercial reimbursement was calculated using the 2016 MarketScan commercial claim data for Idaho members. The MarketScan database (produced by Truven) covers tens of millions of lives across the United States. Average allowed and allowed percentiles were calculated for the DRG/HCPCS codes requested by the IIC.

The following adjustments were made to the MarketScan repricing:

- Ø The exhibits use fiscal year 2016 Medicare allowed. A single year of trend was applied to put the 2016 MarketScan data on a 2017 basis. The 2016 to 2017 commercial allowed trends are listed below:
    - o Inpatient: 4.0%
    - o Outpatient: 4.4%
    - o Professional: 2.4%
- Ø MarketScan does not provide billed amounts, making it difficult to distribute allowed dollars when a claim is paid as a case payment. Due to this, we have excluded claims with case payments.
- Ø 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:
    - o Outpatient: 25, TC, GP, LT, RT, GO, 59, F1-F9, FA
    - o Physician: 25, GP, LT, RT, AT, GO, 59, F1-F9, FA
- Ø Services with specialties indicating that they were performed by assistants have been excluded. The specialty codes for these are 32, 43, 97, and Z0.
- Ø 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 the exhibit on a 'per unit' basis. All HCPCS we identified as unit-dependent had two or more units on at least 21% of claim lines. All other HCPCS had multiple units on less than 5% of claim lines. The following HCPCS are unit-dependent:
    - o Outpatient: 97110, 97112, 97140, 97530, and J0696
    - o Professional: 97110, 97112, 97140, and 97530
- Ø As requested, ambulatory surgical centers are excluded in the calculations. We are unable to exclude critical access hospitals because they are not identifiable in the MarketScan data.

MarketScan is comprised of multiple contributors. Certain service categories are excluded for some contributors based on a review of the contributor coding by service category. Examples include:

- Ø Inpatient claims for MarketScan contributors where the ICD coding was not complete enough for DRG assignment.
- Ø Professional results for a subset of MarketScan contributors where HCPCS and Modifier were not reliably populated.

Implant carveout logic:

- Ø Claim lines are identified as implants using revenue codes 0274, 0275, 0276, and 0278.
- Ø For inpatient, the implant dollars are already included in the DRG average. For outpatient, we show separate calculations with and without implant dollars. The values in the prior deliverable from 5/1/2017 show values that exclude implant dollars.

- Ø 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 MarketScan data was repriced to 2017 Medicare allowed levels using the *Milliman Medicare Repricer*. The following considerations apply to the repricing results:

- Ø All repriced amounts reflect prospective amounts and do not reflect any settlements with CMS.
- Ø No adjustments are made for sequestration.
- Ø Repriced amounts are based on information released at the beginning of each year (Federal fiscal year for inpatient and calendar year for other types of services).
- Ø No adjustment is made for providers that participate in Medicare's Bundled Payment for Care Improvement (BPCI) initiative.

Facility Repricing

- Ø Medicare facility payments are provider-specific; however MarketScan does not include provider information. We used Medicare FFS data to estimate the provider mix in each member area.
- Ø Inpatient Medicare payments exclude Indirect Medical Education (IME), Disproportional Share (DSH), Uncompensated Care, and outlier payment components.
- Ø Non-PPS hospitals are priced using PPS. This includes:
  - Critical access hospitals (paid at cost by Medicare)
  - Cancer and children's hospitals (paid at cost by Medicare)
- Ø Inpatient new technology payments are not included. The impact of these payments varies from year to year, but is generally is very small (i.e. less than 1%).
- Ø Inpatient rehabilitation and psychiatric hospital claims are priced using IPPS rather than the Rehab PPS and Psych PPS schedules.

Professional Repricing

- Ø Medicare employs claim edits to deny payment for certain professional services. We assumed all professional services with a positive allowed amount were accepted for payment and included these services in the repricing analysis.
- Ø No physician incentive payment adjustments are included, such as those under the Electronic Prescribing (eRx) Incentive Program, the Physician Quality Reporting System (PQRS), the Maintenance of Certification Program (MOC), or the Primary Care Incentive Payments (PCIP) program.
- Ø Medicare makes additional payments for professionals in Health Professional Shortage Areas. These payments are not incorporated.

**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 Truven Health MarketScan©. 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.

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,

David C. Lewis
Senior Consultant

Attachments

**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.

| | | | Average | | Percentiles of MarketScan Allowed | | | | | 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 | Admits | 2017 Marketscan Allowed[1] | %-age of 2017 Medicare[2] | 10th | 25th | 50th | 75th | 90th | Number | % of Total | Admits | Implant % of Total Allowed | Admits | Implant % of Total Allowed |
| 460 | Spinal fusion except cervical w/o MCC | 275 | $51,907 | 221% | $29,415 | $34,505 | $47,241 | $62,128 | $84,827 | 273 | 99% | 32 | 41.2% | 241 | |
| 464 | Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC | 26 | $37,953 | 222% | $18,075 | $25,493 | $32,430 | $49,070 | $64,558 | 20 | 77% | 1 | 25.2% | 19 | |
| 468 | Revision of hip or knee replacement w/o CC/MCC | 52 | $37,123 | 225% | $20,676 | $29,759 | $34,808 | $43,822 | $54,195 | 52 | 100% | 3 | 51.8% | 49 | |
| 470 | Major joint replacement or reattachment of lower extremity w/o MCC | 1,297 | $30,976 | 254% | $17,120 | $23,163 | $30,213 | $40,082 | $43,822 | 1,275 | 98% | 161 | 38.6% | 1,114 | |
| 472 | Cervical spinal fusion w CC | 81 | $32,532 | 197% | $15,961 | $22,349 | $31,130 | $43,133 | $54,944 | 80 | 99% | 10 | 25.9% | 70 | |
| 473 | Cervical spinal fusion w/o CC/MCC | 179 | $27,626 | 207% | $15,349 | $18,367 | $23,840 | $37,536 | $45,153 | 179 | 100% | 28 | 27.5% | 151 | |
| 481 | Hip & femur procedures except major joint w CC | 24 | $33,330 | 280% | $17,151 | $22,180 | $34,959 | $38,919 | $42,020 | 23 | 96% | 4 | 18.7% | 19 | |
| 482 | Hip & femur procedures except major joint w/o CC/MCC | 36 | $23,135 | 224% | $12,120 | $18,067 | $21,689 | $27,138 | $32,027 | 31 | 86% | 3 | 16.0% | 28 | Cannot be |
| 483 | Major Joint/Limb Reattachment Procedure Of Upper Extremities | 82 | $28,143 | 192% | $16,356 | $17,823 | $25,681 | $36,354 | $43,815 | 81 | 99% | 12 | 54.5% | 69 | determined. |
| 493 | Lower extrem & humer proc except hip,foot,femur w CC | 39 | $27,598 | 219% | $13,893 | $21,194 | $27,395 | $31,399 | $37,326 | 36 | 92% | 2 | 24.1% | 34 | |
| 494 | Lower extrem & humer proc except hip,foot,femur w/o CC/MCC | 52 | $22,577 | 235% | $16,104 | $18,254 | $21,506 | $27,395 | $29,302 | 47 | 90% | 9 | 21.6% | 38 | |
| 518 | Back & Neck Proc Exc Spinal Fusion W Mcc Or Disc Device/Neurostim | 9 | $19,227 | 117% | $14,147 | $14,147 | $14,147 | $26,485 | $31,812 | 9 | 100% | 0 | | 9 | |
| 520 | Back & Neck Proc Exc Spinal Fusion W/O Cc/Mcc | 28 | $18,810 | 254% | $7,754 | $11,282 | $16,440 | $21,555 | $35,854 | 8 | 29% | 6 | 23.1% | 2 | |
| 552 | Medical back problems w/o MCC | 14 | $19,337 | 381% | $7,067 | $11,294 | $12,700 | $16,921 | $34,570 | 4 | 29% | 0 | | 4 | |
| 560 | Aftercare, musculoskeletal system & connective tissue w CC | 8 | $17,834 | 282% | $8,788 | $12,509 | $18,664 | $23,655 | $24,225 | 3 | 38% | 1 | 0.6% | 2 | |
| 561 | Aftercare, musculoskeletal system & connective tissue w/o CC/MCC | 1 | $30,028 | 679% | $30,028 | $30,028 | $30,028 | $30,028 | $30,028 | 0 | 0% | 0 | | 0 | |
| 563 | Fx, sprn, strn & disl except femur, hip, pelvis & thigh w/o MCC | 8 | $20,846 | 456% | $8,042 | $8,989 | $11,158 | $19,940 | $78,554 | 0 | 0% | 0 | | 0 | |
| 603 | Cellulitis w/o MCC | 58 | $11,669 | 235% | $6,074 | $8,715 | $12,492 | $13,875 | $14,121 | 2 | 3% | 0 | | 2 | |
| 871 | Septicemia or severe sepsis w/o MV 96+ hours w MCC | 253 | $27,650 | 265% | $9,988 | $12,973 | $28,150 | $38,269 | $39,274 | 22 | 9% | 3 | 1.9% | 19 | |
| 872 | Septicemia or severe sepsis w/o MV 96+ hours w/o MCC | 198 | $19,853 | 327% | $7,238 | $13,493 | $17,696 | $18,260 | $29,476 | 19 | 10% | 0 | | 19 | |
| 909 | Other O.R. procedures for injuries w/o CC/MCC | 8 | $23,400 | 298% | $12,971 | $14,566 | $18,476 | $20,953 | $66,240 | 4 | 50% | 2 | 44.4% | 2 | |
| 945 | Rehabilitation w CC/MCC | 7 | $23,826 | 336% | $15,697 | $19,690 | $22,840 | $24,991 | $37,542 | 1 | 14% | 0 | | 1 | |
| 964 | Other multiple significant trauma w CC | 12 | $17,511 | 210% | $8,383 | $13,915 | $17,042 | $22,991 | $23,181 | 0 | 0% | 0 | | 0 | |

(1) Based on 2016 MarketScan data trended to 2017.
(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[2]**

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 MarketScan Allowed | | | | | | Implant | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Source | HCPCS | Description | Units | 2017 Marketscan Allowed[1] | %-age of 2017 Medicare[3] | 10th | 25th | 50th | 75th | 90th | APC Code[4] | Additional Bundled Implants[5] | Combined % of 2017 Medicare[6] |
| Surg | 12001 | Rpr s/n/ax/gen/trnk 2.5cm/< | 710 | $206 | 2181% | $111 | $141 | $215 | $259 | $287 | 5051 | $0 | 2181% |
| Surg | 12002 | Rpr s/n/ax/gen/trnk2.6-7.5cm | 396 | $209 | 6388% | $107 | $140 | $212 | $259 | $296 | 5051 | $0 | 6388% |
| Surg | 20680 | Removal of support implant | 248 | $2,835 | 171% | $1,629 | $1,892 | $2,705 | $3,656 | $4,454 | 5073 | $93 | 176% |
| Surg | 22551 | Neck spine fuse&remov bel c2 | 32 | $8,140 | 89% | $1,710 | $5,941 | $6,017 | $9,630 | $14,633 | 5115 | $4,637 | 140% |
| Surg | 23120 | Partial removal collar bone | 29 | $3,581 | 328% | $2,366 | $2,617 | $3,709 | $3,966 | $5,116 | 5113 | $361 | 361% |
| Surg | 23410 | Repair rotator cuff acute | 22 | $4,688 | 94% | $2,280 | $3,999 | $4,526 | $5,599 | $7,508 | 5114 | $1,511 | 125% |
| Surg | 23412 | Repair rotator cuff chronic | 44 | $4,631 | 94% | $2,871 | $3,999 | $3,999 | $5,509 | $6,900 | 5114 | $1,229 | 119% |
| Surg | 23430 | Repair biceps tendon | 67 | $4,736 | 103% | $1,678 | $3,603 | $3,853 | $6,900 | $7,508 | 5114 | $774 | 120% |
| Surg | 23515 | Treat clavicle fracture | 77 | $7,715 | 155% | $4,394 | $5,309 | $7,963 | $10,133 | $10,721 | 5114 | $3,016 | 215% |
| Surg | 24342 | Repair of ruptured tendon | 41 | $4,787 | 96% | $3,461 | $3,461 | $3,853 | $5,973 | $7,508 | 5114 | $1,209 | 120% |
| Surg | 25608 | Treat fx rad intra-articul | 27 | $6,743 | 135% | $3,542 | $5,258 | $6,224 | $8,447 | $10,616 | 5114 | $2,755 | 190% |
| Surg | 25609 | Treat fx radial 3+ frag | 33 | $6,849 | 138% | $4,060 | $4,060 | $5,557 | $9,634 | $10,208 | 5114 | $3,819 | 215% |
| Surg | 26055 | Incise finger tendon sheath | 126 | $1,998 | 205% | $778 | $1,476 | $1,984 | $2,723 | $2,723 | 5112 | $1 | 206% |
| Surg | 26615 | Treat metacarpal fracture | 28 | $5,173 | 216% | $3,685 | $3,760 | $5,543 | $6,399 | $7,637 | 5113 | $1,220 | 267% |
| Surg | 26765 | Treat finger fracture each | 12 | $3,386 | 145% | $2,345 | $3,016 | $3,213 | $3,749 | $4,806 | 5113 | $22 | 146% |
| Surg | 26951 | Amputation of finger/thumb | 10 | $2,004 | 87% | $569 | $1,552 | $2,039 | $2,564 | $3,200 | 5113 | $0 | 87% |
| Surg | 27792 | Treatment of ankle fracture | 58 | $5,350 | 111% | $3,685 | $3,685 | $5,362 | $6,315 | $7,637 | 5114 | $2,019 | 153% |
| Surg | 27814 | Treatment of ankle fracture | 32 | $6,862 | 131% | $3,382 | $4,681 | $7,001 | $8,928 | $8,928 | 5114 | $2,570 | 180% |
| Surg | 27829 | Treat lower leg joint | 39 | $4,761 | 372% | $2,389 | $3,685 | $3,685 | $6,262 | $7,798 | 5114 | $1,859 | 518% |
| Surg | 29806 | Shoulder arthroscopy/surgery | 151 | $5,584 | 131% | $4,097 | $4,097 | $5,951 | $6,094 | $7,686 | 5114 | $1,181 | 158% |
| Surg | 29807 | Shoulder arthroscopy/surgery | 105 | $5,486 | 132% | $3,008 | $4,646 | $5,731 | $5,731 | $6,319 | 5114 | $1,066 | 158% |
| Surg | 29822 | Shoulder arthroscopy/surgery | 64 | $3,679 | 241% | $1,899 | $2,580 | $3,565 | $4,239 | $4,646 | 5113 | $243 | 257% |
| Surg | 29823 | Shoulder arthroscopy/surgery | 109 | $4,654 | 485% | $2,440 | $3,348 | $4,097 | $6,130 | $7,686 | 5113 | $204 | 506% |
| Surg | 29824 | Shoulder arthroscopy/surgery | 110 | $3,399 | 251% | $1,852 | $2,080 | $2,951 | $4,239 | $4,755 | 5113 | $237 | 269% |
| Surg | 29826 | Shoulder arthroscopy/surgery | 191 | $4,512 | | $2,170 | $3,235 | $4,097 | $5,420 | $7,686 | | $528 | |
| Surg | 29827 | Arthroscop rotator cuff repr | 230 | $4,639 | 123% | $1,902 | $3,399 | $4,449 | $5,528 | $6,965 | 5114 | $1,058 | 151% |
| Surg | 29828 | Arthroscopy biceps tenodesis | 63 | $6,180 | 533% | $3,008 | $5,224 | $6,094 | $6,319 | $7,686 | 5114 | $909 | 612% |
| Surg | 29846 | Wrist arthroscopy/surgery | 18 | $3,106 | 239% | $847 | $2,580 | $3,494 | $4,239 | $4,385 | 5113 | $252 | 258% |
| Surg | 29873 | Knee arthroscopy/surgery | 61 | $2,897 | 134% | $2,228 | $2,580 | $2,580 | $3,113 | $3,539 | 5113 | $44 | 136% |
| Surg | 29877 | Knee arthroscopy/surgery | 61 | $3,447 | 159% | $1,714 | $2,580 | $3,341 | $4,719 | $4,814 | 5113 | $88 | 163% |
| Surg | 29880 | Knee arthroscopy/surgery | 226 | $3,600 | 170% | $2,227 | $3,283 | $3,735 | $3,735 | $4,681 | 5113 | $122 | 176% |
| Surg | 29881 | Knee arthroscopy/surgery | 552 | $3,341 | 171% | $2,077 | $2,580 | $3,450 | $4,037 | $4,755 | 5113 | $184 | 180% |
| Surg | 29888 | Knee arthroscopy/surgery | 318 | $6,357 | 124% | $3,795 | $4,715 | $6,416 | $7,407 | $9,548 | 5114 | $2,544 | 173% |
| Surg | 49505 | Prp i/hern init reduc >5 yr | 209 | $4,042 | 151% | $2,007 | $2,750 | $3,956 | $5,485 | $5,485 | 5341 | $460 | 168% |
| Surg | 49585 | Rpr umbil hern reduc > 5 yr | 158 | $4,119 | 168% | $1,663 | $2,417 | $3,677 | $6,029 | $6,412 | 5341 | $526 | 190% |
| Surg | 49587 | Rpr umbil hern block > 5 yr | 60 | $4,223 | 159% | $1,987 | $3,348 | $4,661 | $5,485 | $5,485 | 5341 | $589 | 182% |

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

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 MarketScan Allowed | | | | | | Implant | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Source | HCPCS | Description | Units | 2017 Marketscan Allowed[1] | %-age of 2017 Medicare[3] | 10th | 25th | 50th | 75th | 90th | APC Code[4] | Additional Bundled Implants[5] | Combined % of 2017 Medicare[6] |
| Surg | 49650 | Lap ing hernia repair init | 118 | $5,453 | 136% | $2,230 | $2,968 | $5,036 | $7,934 | $7,934 | 5361 | $565 | 150% |
| Surg | 49652 | Lap vent/abd hernia repair | 43 | $8,279 | 252% | $3,655 | $5,274 | $9,107 | $11,789 | $11,789 | 5361 | $963 | 282% |
| Surg | 62310 | Inject spine cerv/thoracic | 344 | $781 | 162% | $401 | $611 | $611 | $996 | $1,259 | | $0 | 162% |
| Surg | 62311 | Inject spine lumbar/sacral | 566 | $830 | 175% | $259 | $611 | $611 | $1,259 | $1,445 | | $2 | 176% |
| Surg | 62362 | Implant spine infusion pump | 6 | $6,582 | 44% | $356 | $356 | $928 | $3,875 | $33,051 | 5471 | $10,777 | 116% |
| Surg | 63030 | Low back disk surgery | 210 | $6,555 | 134% | $4,193 | $4,193 | $5,875 | $8,067 | $10,000 | 5114 | $34 | 134% |
| Surg | 63042 | Laminotomy single lumbar | 30 | $6,767 | 136% | $4,193 | $4,193 | $6,448 | $8,106 | $9,952 | 5114 | $65 | 137% |
| Surg | 63047 | Remove spine lamina 1 lmbr | 74 | $6,450 | 135% | $4,193 | $4,193 | $6,181 | $8,106 | $9,952 | 5114 | $102 | 138% |
| Surg | 63685 | Insrt/redo spine n generator | 34 | $10,602 | 41% | $2,934 | $3,749 | $4,111 | $21,585 | $24,587 | 5464 | $25,832 | 141% |
| Surg | 64415 | N block inj brachial plexus | 94 | $977 | 1839% | $180 | $438 | $1,297 | $1,297 | $1,328 | 5443 | $243 | 2296% |
| Surg | 64483 | Inj foramen epidural l/s | 590 | $884 | 146% | $559 | $653 | $660 | $1,259 | $1,259 | 5443 | $0 | 146% |
| Surg | 64721 | Carpal tunnel surgery | 265 | $2,184 | 164% | $1,326 | $1,618 | $1,888 | $2,901 | $3,173 | 5431 | $31 | 166% |
| Surg | 64831 | Repair of digit nerve | 12 | $3,350 | 84% | $1,874 | $2,489 | $3,197 | $4,444 | $4,444 | 5432 | $1 | 84% |
| Non-Surg | 36415 | Routine venipuncture | 101,986 | $11 | 591% | $5 | $7 | $9 | $12 | $20 | | $0 | 593% |
| Non-Surg | 70450 | Ct head/brain w/o dye | 3,300 | $630 | 528% | $334 | $471 | $614 | $650 | $997 | 5522 | $0 | 528% |
| Non-Surg | 72125 | Ct neck spine w/o dye | 877 | $701 | 1801% | $412 | $451 | $631 | $697 | $1,232 | 5522 | $1 | 1802% |
| Non-Surg | 72141 | Mri neck spine w/o dye | 1,281 | $1,053 | 440% | $721 | $883 | $1,060 | $1,181 | $1,588 | 5523 | $0 | 440% |
| Non-Surg | 72148 | Mri lumbar spine w/o dye | 2,284 | $1,060 | 524% | $715 | $883 | $1,060 | $1,181 | $1,588 | 5523 | $0 | 524% |
| Non-Surg | 73030 | X-ray exam of shoulder | 2,575 | $137 | 411% | $78 | $105 | $109 | $168 | $216 | 5521 | $12 | 448% |
| Non-Surg | 73221 | Mri joint upr extrem w/o dye | 1,129 | $1,032 | 488% | $546 | $883 | $1,030 | $1,181 | $1,574 | 5523 | $0 | 488% |
| Non-Surg | 73222 | Mri joint upr extrem w/dye | 759 | $1,183 | 189% | $758 | $760 | $997 | $1,466 | $1,742 | 5573 | $0 | 189% |
| Non-Surg | 73721 | Mri jnt of lwr extre w/o dye | 3,057 | $994 | 469% | $546 | $883 | $1,007 | $1,151 | $1,316 | 5523 | $1 | 469% |
| Non-Surg | 74177 | Ct abd & pelv w/contrast | 6,204 | $1,563 | 774% | $832 | $1,115 | $1,418 | $1,901 | $2,119 | 5571 | $0 | 774% |
| Non-Surg | 81025 | Urine pregnancy test | 7,178 | $24 | 3995% | $15 | $16 | $25 | $26 | $35 | | $1 | 4106% |
| Non-Surg | 84703 | Chorionic gonadotropin assay | 3,341 | $33 | 2618% | $16 | $20 | $30 | $37 | $51 | | $1 | 2677% |
| Non-Surg | 87491 | Chylmd trach dna amp probe | 3,861 | $94 | 197% | $63 | $83 | $91 | $101 | $138 | | $0 | 197% |
| Non-Surg | 87591 | N.gonorrhoeae dna amp prob | 3,712 | $97 | 202% | $60 | $83 | $93 | $101 | $138 | | $0 | 202% |
| Non-Surg | 96365 | Ther/proph/diag iv inf init | 6,886 | $296 | 216% | $147 | $147 | $261 | $390 | $521 | 5693 | $2 | 217% |
| Non-Surg | 97110 | Therapeutic exercises | 70,050 | $54 | 271% | $45 | $46 | $51 | $59 | $66 | | $0 | 271% |
| Non-Surg | 97112 | Neuromuscular reeducation | 9,304 | $55 | 240% | $44 | $50 | $53 | $60 | $73 | | $0 | 240% |
| Non-Surg | 97140 | Manual therapy 1/> regions | 28,666 | $52 | 290% | $42 | $46 | $48 | $55 | $66 | | $0 | 290% |
| Non-Surg | 97530 | Therapeutic activities | 19,534 | $52 | 304% | $34 | $46 | $53 | $56 | $71 | | $0 | 304% |
| Non-Surg | 99205 | Office/outpatient visit new | 60 | $239 | 235% | $93 | $153 | $275 | $318 | $360 | | $0 | 235% |
| Non-Surg | 99213 | Office/outpatient visit est | 2,208 | $108 | 106% | $25 | $51 | $112 | $137 | $161 | | $0 | 106% |
| Non-Surg | 99214 | Office/outpatient visit est | 1,848 | $156 | 153% | $57 | $108 | $153 | $184 | $227 | | $0 | 153% |
| Non-Surg | 99281 | Emergency dept visit | 2,652 | $148 | 263% | $92 | $121 | $152 | $184 | $211 | 5021 | $0 | 263% |

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

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 MarketScan Allowed | | | | | | Implant | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Source | HCPCS | Description | Units | 2017 Marketscan Allowed[1] | %-age of 2017 Medicare[3] | 10th | 25th | 50th | 75th | 90th | APC Code[4] | Additional Bundled Implants[5] | Combined % of 2017 Medicare[6] |
| Non-Surg | 99282 | Emergency dept visit | 8,794 | $282 | 273% | $188 | $227 | $307 | $323 | $323 | 5022 | $0 | 273% |
| Non-Surg | 99283 | Emergency dept visit | 14,950 | $471 | 242% | $309 | $362 | $455 | $574 | $620 | 5023 | $0 | 242% |
| Non-Surg | 99284 | Emergency dept visit | 15,109 | $775 | 237% | $468 | $647 | $710 | $882 | $1,053 | 5024 | $0 | 238% |
| Non-Surg | 99285 | Emergency dept visit | 5,925 | $1,182 | 218% | $840 | $1,062 | $1,175 | $1,279 | $1,315 | 5025 | $2 | 219% |
| Non-Surg | J0696 | Ceftriaxone sodium injection | 7,719 | $9 | | $1 | $2 | $5 | $15 | $28 | | $0 | |

(1) Based on 2016 MarketScan data trended to 2017. Does not include additional bundled implant dollars.
(2) Only the following modifiers are included: 25, TC, GP, LT, RT, GO, 59, F1-F9, FA
(3) HCPCS 29826 and J0696 are bundled, so they do not have a percent of Medicare amount.
(4) A few HCPCS do not have APC codes because they are either bundled or paid using a different method than APC.
(5) Implants are defined as lines with revenue code 0274, 0275, 0276, or 0278.
(6) (Marketscan Allowed + Additional Bundled Implants) / 2017 Medicare

**Exhibit 3**
**Idaho Industrial Commision**
**Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS**
**Excludes Modified Codes[2]**

| | | | | Average | | Percentiles of MarketScan Allowed | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Source | HCPCS | Description | Units | 2017 Marketscan Allowed[1] | %-age of 2017 Medicare | 10th | 25th | 50th | 75th | 90th |
| Surgery | 22551 | Neck spine fuse&remov bel c2 | 240 | $3,253 | 211% | $2,538 | $3,203 | $3,340 | $3,422 | $3,422 |
| Surgery | 22633 | Lumbar spine fusion combined | 149 | $3,519 | 205% | $2,117 | $3,250 | $3,630 | $3,719 | $3,719 |
| Surgery | 23430 | Repair biceps tendon | 78 | $1,387 | 210% | $729 | $1,413 | $1,472 | $1,692 | $1,693 |
| Surgery | 27447 | Total knee arthroplasty | 782 | $2,563 | 202% | $2,096 | $2,555 | $2,686 | $2,689 | $2,719 |
| Surgery | 29807 | Shoulder arthroscopy/surgery | 110 | $2,048 | 216% | $1,837 | $2,045 | $2,052 | $2,073 | $2,360 |
| Surgery | 29823 | Shoulder arthroscopy/surgery | 56 | $1,043 | 216% | $212 | $898 | $1,224 | $1,244 | $1,415 |
| Surgery | 29824 | Shoulder arthroscopy/surgery | 159 | $1,311 | 216% | $927 | $1,293 | $1,328 | $1,451 | $1,535 |
| Surgery | 29826 | Shoulder arthroscopy/surgery | 675 | $358 | 214% | $327 | $348 | $348 | $352 | $400 |
| Surgery | 29827 | Arthroscop rotator cuff repr | 396 | $2,053 | 207% | $1,822 | $2,053 | $2,109 | $2,109 | $2,411 |
| Surgery | 29828 | Arthroscopy biceps tenodesis | 34 | $1,614 | 213% | $614 | $1,572 | $1,723 | $1,823 | $1,939 |
| Surgery | 29881 | Knee arthroscopy/surgery | 427 | $1,053 | 214% | $926 | $1,045 | $1,072 | $1,079 | $1,227 |
| Surgery | 29888 | Knee arthroscopy/surgery | 339 | $1,900 | 206% | $1,687 | $1,875 | $1,947 | $1,953 | $1,974 |
| Surgery | 63030 | Low back disk surgery | 174 | $1,833 | 204% | $1,692 | $1,841 | $1,891 | $1,937 | $1,937 |
| Radiology | 70450 | Ct head/brain w/o dye | 110 | $306 | 285% | $235 | $284 | $284 | $297 | $355 |
| Radiology | 72141 | Mri neck spine w/o dye | 714 | $521 | 258% | $396 | $416 | $546 | $546 | $571 |
| Radiology | 72148 | Mri lumbar spine w/o dye | 1,326 | $515 | 253% | $394 | $415 | $544 | $544 | $568 |
| Radiology | 72158 | Mri lumbar spine w/o & w/dye | 296 | $855 | 248% | $670 | $705 | $876 | $922 | $966 |
| Radiology | 73030 | X-ray exam of shoulder | 3,806 | $51 | 188% | $38 | $51 | $51 | $53 | $53 |
| Radiology | 73221 | Mri joint upr extrem w/o dye | 571 | $511 | 233% | $306 | $417 | $545 | $574 | $601 |
| Radiology | 73222 | Mri joint upr extrem w/dye | 338 | $850 | 244% | $667 | $870 | $916 | $916 | $961 |
| Radiology | 73562 | X-ray exam of knee 3 | 3,413 | $62 | 187% | $60 | $63 | $63 | $63 | $63 |
| Radiology | 73721 | Mri jnt of lwr extre w/o dye | 1,373 | $524 | 239% | $237 | $438 | $570 | $575 | $600 |
| Radiology | 74177 | Ct abd & pelv w/contrast | 287 | $794 | 273% | $669 | $756 | $758 | $795 | $795 |
| Phys. Med. | 97001 | Pt evaluation | 15,950 | $86 | 119% | $77 | $87 | $87 | $87 | $87 |
| Phys. Med. | 97014 | Electric stimulation therapy | 58,315 | $17 | 126% | $14 | $15 | $18 | $18 | $18 |
| Phys. Med. | 97035 | Ultrasound therapy | 18,796 | $14 | 139% | $12 | $14 | $14 | $15 | $15 |
| Phys. Med. | 97110 | Therapeutic exercises | 246,698 | $35 | 139% | $31 | $34 | $37 | $37 | $37 |
| Phys. Med. | 97112 | Neuromuscular reeducation | 32,611 | $35 | 126% | $31 | $34 | $39 | $39 | $39 |
| Phys. Med. | 97140 | Manual therapy 1/> regions | 152,312 | $33 | 140% | $28 | $33 | $35 | $35 | $35 |
| Phys. Med. | 97530 | Therapeutic activities | 62,976 | $37 | 135% | $31 | $33 | $40 | $40 | $40 |
| Phys. Med. | 97545 | Work hardening | 0 | | | | | | | |
| Phys. Med. | 98941 | Chiropract manj 3-4 regions | 178,742 | $39 | 116% | $36 | $38 | $38 | $41 | $41 |
| Phys. Med. | 99199 | Special service/proc/report | 0 | | | | | | | |

(1) Based on 2016 MarketScan data trended to 2017.
(2) Only the following modifiers are included: 25, GP, LT, RT, AT, GO, 59, F1-F9, FA

**Exhibit 4**
**Idaho Industrial Commision**
**Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service**
**Excludes Modified Codes[2]**

**Evaluation and Management Codes**

| | | Facility | | | | | | | | Non-Facility | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Average | | Percentiles of MarketScan Allowed | | | | | | Average | | Percentiles of MarketScan Allowed | | | | |
| HCPCS | Description | Units | 2017 Marketscan Allowed[1] | %-age of 2017 Medicare | 10th | 25th | 50th | 75th | 90th | Units | 2017 Marketscan Allowed[1] | %-age of 2017 Medicare | 10th | 25th | 50th | 75th | 90th |
| 99202 | Office/outpatient visit new | 363 | $76 | 155% | $50 | $66 | $76 | $83 | $89 | 48,161 | $114 | 161% | $80 | $107 | $122 | $127 | $130 |
| 99203 | Office/outpatient visit new | 943 | $115 | 156% | $73 | $85 | $117 | $132 | $135 | 76,723 | $165 | 162% | $131 | $158 | $164 | $184 | $186 |
| 99204 | Office/outpatient visit new | 1,236 | $198 | 158% | $124 | $171 | $210 | $225 | $229 | 37,166 | $253 | 163% | $211 | $242 | $251 | $281 | $285 |
| 99212 | Office/outpatient visit est | 1,319 | $38 | 154% | $25 | $33 | $39 | $41 | $45 | 61,646 | $66 | 162% | $49 | $62 | $66 | $74 | $75 |
| 99213 | Office/outpatient visit est | 9,579 | $76 | 154% | $49 | $66 | $78 | $89 | $89 | 446,681 | $115 | 167% | $97 | $109 | $124 | $124 | $127 |
| 99214 | Office/outpatient visit est | 8,294 | $113 | 149% | $72 | $78 | $120 | $136 | $138 | 233,569 | $170 | 167% | $142 | $162 | $184 | $184 | $187 |
| 99283 | Emergency dept visit | 10,711 | $112 | 188% | $91 | $95 | $108 | $108 | $114 | Not Applicable to Non-Facility | | | | | | | |
| 99284 | Emergency dept visit | 19,582 | $205 | 181% | $173 | $181 | $205 | $205 | $209 | | | | | | | | |
| 99455 | Work related disability exam | HCPCS Have No/Very Little Utilization | | | | | | | | | | | | | | | |
| 99456 | Disability examination | | | | | | | | | | | | | | | | |

(1) Based on 2016 MarketScan data trended to 2017.
(2) Only the following modifiers are included: 25, GP, LT, RT, AT, GO, 59, F1-F9, FA