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March 12, 2020

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 21st, 2019 using a slightly different set of codes.

Along with the standard set of exhibits produced last year, we are also providing an alternative version of the exhibits 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 allowed per procedure instead of 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.

This analysis is subject to the terms and conditions of the Contract for Actuarial Services between Milliman and the Idaho Industrial Commission dated January 13th, 2020.

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 2019 Commercial Average Allowed
As a Percentage of 2019 Medicare

Description	Percent of Medicare
Inpatient DRG	236%
Outpatient Surgery*	173%
Outpatient Non-Surgery*	295%
Physician Surgery	224%
Physician Radiology	275%
Physician Medicine	110%
Physician Evaluation and Management	150%

*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 2019 Medicare, and the 10th, 25th 50th, 75th, and 90th percentile of the commercial payment amounts. For the Evaluation and Management HCPCS you provided us, we provide results separately by place of service. This is because of 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 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:

- Exhibits following standard methodology:
    - Exhibit 1: Average Inpatient Commercial Charge, Percentage of Medicare and Percentiles by DRG
        - Includes requested Inpatient DRGs
    - Exhibit 2: Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
        - Includes requested Outpatient HCPCS
    - 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
- 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 allowed per procedure
    - Exhibit 6: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS – All modifiers, specialties, POS and based on 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 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 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 results are generally similar to the deliverable provided on 5/21/2019. The DRGs/HCPCS with the largest differences have low procedure counts.
- Additional bundled implant dollars vary significantly by surgery HCPCS, but not as large as the 5/21/2019 report. The additional dollars range from 1% to 23% of the commercial allowed dollars with the implants excluded. For non-surgery HCPCS, there are no 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 200%-400% for inpatient and outpatient services. Physician professional services tend to be lower at around 125%-250%.
- 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. Also, professional ER visits have an average allowed amount above the 75th percentile due to the largest dollar claims significantly increasing the mean.

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 and 97140 using allowed per procedure instead of units. When units are ignored, the percentile range is much larger and the average allowed is much larger. As expected, this matches closer to the NCCI Medical Data Report.
- The surgery HCPCS codes in Exhibit 6 have a slight decrease in average 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 (Medicare pays these at 16% of the regular rate).

  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 include them separately, which would make the average 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 allowed payments that are much lower. Including them drops the average 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 allowed since Exhibit 6 calculates the average per procedure instead of units and these HCPCS often have multiple units. As Expected, exhibit 6 matches up better with the report results.

- Ø 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.
- Ø Exhibit 4 and Exhibit 7 also have very similar results since only a few claims are excluded in Exhibit 4.

Methodology

Commercial reimbursement was calculated using the 2018 Milliman CHSD commercial claim data for Idaho members. This database utilizes data from existing Milliman clients through data trade agreements. Average allowed and allowed percentiles were calculated for the DRG/HCPCS codes requested by the IIC.

The following adjustments were made to the CHSD repricing:

- Ø The exhibits use fiscal year 2019 Medicare allowed. A single year of trend was applied to put the 2018 CHSD data on a 2019 basis. The 2018 to 2019 commercial allowed trends are listed below:
  - o Inpatient: 2.3%
  - o Outpatient: 4.8%
  - o Professional: 2.6%
- 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 from Exhibits 2-4 (this exclusion was not applied to Exhibits 5-7.):
  - o Outpatient: GO, LT, RT, 59, TC, GP, 25
  - o Physician: 59, LT, RT, 25, XU, AT, GO, GP, 24, 54, 51
- Ø 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.
- 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 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 28% of claim lines. All other HCPCS had multiple units on less than 2% of claim lines. The following HCPCS are unit-dependent:
  - o Outpatient: 97110 and 97140
  - o Professional: 97110, 97112, 97140, and 97530
- Ø 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:

- 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.

- 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 CHSD data was repriced to 2019 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 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 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.

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
Principal

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 CHSD Allowed				
DRG	Description	Admits	2019 CHSD Allowed[1]	%-age of 2019 Medicare[2]	10th	25th	50th	75th	90th
003	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	3	$283,298	262%	$195,191	$195,191	$309,181	$345,523	$345,523
454	Combined anterior/posterior spinal fusion w CC	9	$82,804	206%	$14,931	$56,561	$90,209	$93,121	$142,529
455	Combined anterior/posterior spinal fusion w/o CC/MCC	46	$67,693	232%	$36,155	$40,755	$71,422	$77,362	$99,561
460	Spinal fusion except cervical w/o MCC	68	$49,062	183%	$30,932	$39,669	$45,587	$56,360	$75,234
470	Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity w	520	$30,765	254%	$19,233	$23,893	$28,422	$36,795	$46,237
473	Cervical spinal fusion w/o CC/MCC	41	$32,803	226%	$22,862	$26,076	$26,076	$42,947	$50,148
482	Hip & femur procedures except major joint w/o CC/MCC	13	$25,715	259%	$15,106	$18,678	$21,690	$32,799	$37,494
483	Major Joint/Limb Reattachment Procedure Of Upper Extremities	44	$31,371	217%	$18,675	$23,961	$30,755	$39,581	$48,053
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC	18	$29,516	276%	$14,648	$18,095	$24,889	$33,085	$56,606
957	Other O.R. procedures for multiple significant trauma w MCC	1	$71,661	164%	$71,661	$71,661	$71,661	$71,661	$71,661

(1) Based on 2018 CHSD data trended to 2019.
(2) Medicare amount excludes DSH, IME, UCP, and Outlier add-on payments.

	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	Number	% of Total	Admits	Implant % of Total Allowed	Admits	Implant % of Total Allowed
003	1	33%	0		1	
454	8	89%	4	44.6%	4	
455	42	91%	21	48.3%	21	
460	62	91%	19	36.5%	43	
470	498	96%	181	35.5%	317	
473	40	98%	4	35.7%	36	
482	12	92%	8	12.6%	4	
483	41	93%	15	44.4%	26	Cannot be
494	14	78%	6	22.2%	8	determined.
957	0	0%	0		0	

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 CHSD Allowed						Implant	
Source	HCPCS	Description	Units	2019 CHSD Allowed(1)	%-age of 2019 Medicare	10th	25th	50th	75th	90th	APC Code[3]	Additional Bundled Implants[4]	Combined % of 2019 Medicare[5]
Surg	22551	Neck spine fuse&remov bel c2	37	$12,448	121%	$2,418	$8,438	$9,471	$15,492	$29,227	5115	$2,817	148%
Surg	23410	Repair rotator cuff acute	13	$8,079	150%	$2,305	$3,218	$6,243	$14,748	$14,748	5114	$1,631	180%
Surg	23430	Repair biceps tendon	117	$7,817	165%	$2,522	$4,029	$6,243	$13,465	$14,748	5114	$550	176%
Surg	29806	Shoulder arthroscopy/surgery	81	$7,472	126%	$3,786	$5,680	$6,243	$8,629	$12,330	5114	$1,586	152%
Surg	29824	Shoulder arthroscopy/surgery	166	$4,141	627%	$2,049	$2,776	$3,255	$3,574	$7,110	5113	$291	671%
Surg	29827	Arthroscop rotator cuff repr	173	$6,257	161%	$2,574	$3,266	$5,680	$7,374	$12,787	5114	$903	185%
Surg	29881	Knee arthroscopy/surgery	296	$4,105	236%	$1,979	$3,255	$3,574	$5,302	$6,334	5113	$173	246%
Surg	29888	Knee arthroscopy/surgery	149	$9,811	160%	$3,860	$5,680	$6,982	$12,693	$20,966	5114	$2,037	193%
Surg	49650	Lap ing hernia repair init	67	$7,751	176%	$3,219	$6,099	$7,587	$9,324	$11,855	5361	$526	188%
Surg	63030	Low back disk surgery	109	$8,000	146%	$3,929	$6,654	$7,099	$9,472	$12,194	5114	$70	148%
Non-Surg	73221	Mri joint upr extrem w/o dye	667	$841	385%	$430	$470	$750	$1,081	$1,505	5523	$0	385%
Non-Surg	73222	Mri joint upr extrem w/dye	418	$1,237	187%	$714	$781	$1,041	$1,432	$2,272	5573	$0	187%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	1,829	$809	367%	$430	$470	$750	$989	$1,422	5523	$0	367%
Non-Surg	74177	Ct abd & pelv w/contrast	3,686	$1,549	403%	$629	$838	$1,260	$2,428	$3,353	5572	$1	403%
Non-Surg	97110	Therapeutic exercises	32,682	$57	225%	$40	$48	$51	$64	$71		$0	225%
Non-Surg	97140	Manual therapy 1/> regions	16,049	$52	235%	$36	$46	$47	$54	$68		$0	235%
Non-Surg	99213	Office/outpatient visit est	1,692	$106	92%	$55	$95	$95	$112	$158		$0	92%
Non-Surg	99282	Emergency dept visit	5,900	$349	285%	$252	$312	$350	$374	$439	5022	$0	285%
Non-Surg	99283	Emergency dept visit	11,049	$629	285%	$448	$563	$630	$699	$793	5023	$0	285%
Non-Surg	99284	Emergency dept visit	7,012	$1,040	291%	$661	$871	$1,024	$1,189	$1,465	5024	$0	291%

(1) Based on 2018 CHSD data trended to 2019. Does not include additional bundled implant dollars.
(2) Only the following modifiers are included: GO, LT, RT, 59, TC, GP, 25
(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) / 2019 Medicare

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

Source	HCPCS	Description	Units	Average		Percentiles of CHSD Allowed				
				2019 CHSD Allowed(1)	%-age of 2019 Medicare	10th	25th	50th	75th	90th
Surgery	22551	Neck spine fuse&remov bel c2	122	$3,605	227%	$2,860	$3,278	$3,436	$4,108	$4,359
Surgery	22633	Lumbar spine fusion combined	67	$4,198	242%	$3,111	$3,563	$3,910	$4,427	$4,592
Surgery	23430	Repair biceps tendon	162	$984	198%	$631	$722	$786	$1,343	$1,541
Surgery	29823	Shoulder arthroscopy/surgery	95	$860	268%	$593	$600	$695	$1,201	$1,319
Surgery	29824	Shoulder arthroscopy/surgery	196	$889	247%	$603	$648	$712	$1,287	$1,383
Surgery	29826	Shoulder arthroscopy/surgery	323	$401	240%	$338	$344	$344	$396	$471
Surgery	29827	Arthroscop rotator cuff repr	215	$2,147	213%	$2,031	$2,057	$2,057	$2,370	$2,421
Surgery	29881	Knee arthroscopy/surgery	310	$944	225%	$524	$613	$1,047	$1,069	$1,207
Surgery	29888	Knee arthroscopy/surgery	171	$2,016	216%	$1,885	$1,911	$1,911	$2,204	$2,410
Surgery	63030	Low back disk surgery	128	$1,922	218%	$1,269	$1,697	$2,098	$2,212	$2,325
Radiology	70450	Ct head/brain w/o dye	41	$309	285%	$221	$251	$294	$381	$425
Radiology	72141	Mri neck spine w/o dye	267	$675	339%	$423	$423	$567	$877	$952
Radiology	72148	Mri lumbar spine w/o dye	563	$646	311%	$421	$421	$565	$865	$939
Radiology	72158	Mri lumbar spine w/o & w/dye	71	$988	281%	$635	$716	$954	$1,269	$1,350
Radiology	73030	X-ray exam of shoulder	1,567	$54	193%	$42	$48	$54	$55	$71
Radiology	73221	Mri joint upr extrem w/o dye	205	$613	278%	$446	$446	$597	$640	$1,028
Radiology	73222	Mri joint upr extrem w/dye	160	$932	266%	$713	$918	$948	$1,002	$1,087
Radiology	73610	X-ray exam of ankle	1,546	$58	186%	$47	$50	$59	$59	$72
Radiology	73721	Mri jnt of lwr extre w/o dye	531	$591	268%	$445	$445	$596	$640	$695
Radiology	76942	Echo guide for biopsy	368	$178	324%	$96	$116	$116	$184	$437
Phys. Med.	97014	Electric stimulation therapy	23,441	$16	112%	$11	$15	$16	$16	$20
Phys. Med.	97110	Therapeutic exercises	139,439	$31	121%	$24	$27	$32	$32	$38
Phys. Med.	97112	Neuromuscular reeducation	25,246	$33	106%	$26	$31	$34	$34	$39
Phys. Med.	97140	Manual therapy 1/> regions	81,490	$28	125%	$21	$22	$30	$30	$35
Phys. Med.	97161	Pt eval low complex 20 min	4,344	$80	99%	$62	$78	$81	$81	$86
Phys. Med.	97162	Pt eval mod complex 30 min	3,664	$83	102%	$74	$81	$81	$83	$93
Phys. Med.	97530	Therapeutic activities	52,327	$34	106%	$28	$34	$35	$37	$40
Phys. Med.	97545	Work hardening	0							
Phys. Med.	98941	Chiropract manj 3-4 regions	73,471	$37	92%	$34	$34	$34	$41	$46
Phys. Med.	99199	Special service/proc/report	0							

(1) Based on 2018 CHSD data trended to 2019.
(2) Only the following modifiers are included: 59, LT, RT, 25, XU, AT, GO, GP, 24, 57, 51

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 CHSD Allowed						Average		Percentiles of CHSD Allowed				
HCPCS	Description	Units	2019 CHSD Allowed[(1)]	%-age of 2019 Medicare	10th	25th	50th	75th	90th	Units	2019 CHSD Allowed[(1)]	%-age of 2019 Medicare	10th	25th	50th	75th	90th
99202	Office/outpatient visit new	248	$78	159%	$64	$70	$77	$77	$95	23,072	$102	143%	$77	$95	$102	$112	$123
99203	Office/outpatient visit new	661	$119	161%	$76	$106	$117	$121	$154	42,017	$152	149%	$128	$144	$156	$162	$177
99204	Office/outpatient visit new	595	$192	153%	$128	$181	$199	$205	$239	19,823	$236	151%	$203	$227	$248	$249	$282
99212	Office/outpatient visit est	644	$42	170%	$29	$35	$39	$40	$55	28,980	$61	143%	$44	$56	$60	$65	$71
99213	Office/outpatient visit est	4,788	$74	151%	$51	$71	$73	$78	$89	230,010	$104	148%	$93	$96	$104	$110	$125
99214	Office/outpatient visit est	3,641	$115	151%	$78	$110	$116	$124	$142	123,058	$154	149%	$138	$142	$159	$163	$186
99283	Emergency dept visit	6,259	$117	193%	$81	$87	$95	$110	$181	Not Applicable to Non-Facility							
99284	Emergency dept visit	10,275	$210	183%	$165	$165	$181	$200	$297								
99455	Work related disability exam	HCPCS Have No/Very Little Utilization															
99456	Disability examination																

(1) Based on 2018 CHSD data trended to 2019.
(2) Only the following modifiers are included: 59, LT, RT, 25, XU, AT, GO, GP, 24, 57, 51

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	2019 CHSD Allowed(1)	%-age of 2019 Medicare	10th	25th	50th	75th	90th	APC Code(2)	Additional Bundled Implants(3)	Combined % of 2019 Medicare(4)
Surg	22551	Neck spine fuse&remov bel c2	40	$11,983	118%	$2,321	$7,802	$9,471	$15,022	$28,531	5115	$2,609	144%
Surg	23410	Repair rotator cuff acute	14	$7,592	146%	$1,906	$3,175	$5,961	$14,748	$14,748	5114	$1,515	176%
Surg	23430	Repair biceps tendon	135	$7,079	160%	$1,351	$2,821	$5,680	$10,960	$14,748	5114	$476	171%
Surg	29806	Shoulder arthroscopy/surgery	91	$7,089	125%	$3,296	$4,914	$6,243	$8,515	$12,330	5114	$1,412	150%
Surg	29824	Shoulder arthroscopy/surgery	199	$3,833	589%	$1,295	$2,533	$3,255	$3,555	$6,888	5113	$244	626%
Surg	29827	Arthroscop rotator cuff repr	203	$5,823	157%	$1,756	$2,797	$5,680	$7,374	$12,787	5114	$776	178%
Surg	29881	Knee arthroscopy/surgery	378	$3,661	229%	$1,415	$1,957	$3,408	$4,879	$6,322	5113	$135	237%
Surg	29888	Knee arthroscopy/surgery	171	$9,311	162%	$3,630	$4,883	$6,243	$12,340	$20,966	5114	$1,793	193%
Surg	49650	Lap ing hernia repair init	117	$7,889	188%	$2,495	$5,637	$7,612	$10,501	$13,383	5361	$765	206%
Surg	63030	Low back disk surgery	125	$7,586	148%	$3,306	$5,225	$7,099	$9,370	$12,194	5114	$61	149%
Non-Surg	73221	Mri joint upr extrem w/o dye	683	$846	383%	$430	$470	$750	$1,081	$1,505	5523	$0	383%
Non-Surg	73222	Mri joint upr extrem w/dye	429	$1,244	188%	$714	$781	$1,119	$1,432	$2,272	5573	$0	188%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	1,895	$813	362%	$430	$470	$750	$1,021	$1,465	5523	$0	362%
Non-Surg	74177	Ct abd & pelv w/contrast	3,694	$1,547	403%	$629	$838	$1,260	$2,428	$3,353	5572	$1	403%
Non-Surg	97110	Therapeutic exercises	22,816	$112	232%	$48	$70	$102	$193	$386		$0	232%
Non-Surg	97140	Manual therapy 1/> regions	12,774	$72	237%	$36	$47	$68	$127	$227		$0	237%
Non-Surg	99213	Office/outpatient visit est	1,800	$108	94%	$55	$95	$95	$113	$169		$0	94%
Non-Surg	99282	Emergency dept visit	5,949	$349	286%	$252	$312	$350	$374	$439	5022	$0	286%
Non-Surg	99283	Emergency dept visit	11,097	$628	285%	$448	$563	$630	$699	$793	5023	$0	285%
Non-Surg	99284	Emergency dept visit	7,026	$1,040	291%	$661	$871	$1,024	$1,189	$1,465	5024	$0	291%

(1) Based on 2018 CHSD data trended to 2019. 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) / 2019 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	2019 CHSD Allowed(1)	%-age of 2019 Medicare	10th	25th	50th	75th	90th
Surgery	22551	Neck spine fuse&remov bel c2	181	$2,768	225%	$411	$677	$3,278	$3,731	$4,359
Surgery	22633	Lumbar spine fusion combined	108	$2,951	237%	$356	$512	$3,563	$4,055	$4,592
Surgery	23430	Repair biceps tendon	269	$720	195%	$92	$170	$722	$1,235	$1,445
Surgery	29823	Shoulder arthroscopy/surgery	142	$662	257%	$94	$201	$607	$1,131	$1,228
Surgery	29824	Shoulder arthroscopy/surgery	291	$711	237%	$76	$356	$648	$1,218	$1,324
Surgery	29826	Shoulder arthroscopy/surgery	516	$295	233%	$34	$68	$344	$368	$427
Surgery	29827	Arthroscop rotator cuff repr	357	$1,550	207%	$206	$291	$2,057	$2,130	$2,409
Surgery	29881	Knee arthroscopy/surgery	395	$951	225%	$524	$663	$1,047	$1,072	$1,207
Surgery	29888	Knee arthroscopy/surgery	310	$1,442	215%	$191	$285	$1,911	$1,959	$2,278
Surgery	63030	Low back disk surgery	215	$1,441	211%	$186	$339	$1,856	$2,113	$2,325
Radiology	70450	Ct head/brain w/o dye	2,515	$91	212%	$77	$86	$86	$88	$98
Radiology	72141	Mri neck spine w/o dye	978	$299	275%	$147	$148	$151	$423	$835
Radiology	72148	Mri lumbar spine w/o dye	1,863	$304	266%	$145	$149	$151	$421	$827
Radiology	72158	Mri lumbar spine w/o & w/dye	301	$422	247%	$231	$231	$234	$438	$1,148
Radiology	73030	X-ray exam of shoulder	4,350	$37	202%	$19	$19	$30	$54	$64
Radiology	73221	Mri joint upr extrem w/o dye	862	$265	248%	$129	$137	$138	$350	$640
Radiology	73222	Mri joint upr extrem w/dye	534	$400	247%	$164	$164	$166	$713	$1,002
Radiology	73610	X-ray exam of ankle	4,642	$38	199%	$17	$18	$33	$59	$70
Radiology	73721	Mri jnt of lwr extre w/o dye	2,324	$253	241%	$134	$136	$138	$309	$640
Radiology	76942	Echo guide for biopsy	2,863	$106	301%	$55	$56	$66	$110	$273
Phys. Med.	97014	Electric stimulation therapy	28,502	$16	113%	$12	$15	$16	$17	$25
Phys. Med.	97110	Therapeutic exercises	78,157	$56	121%	$26	$32	$53	$76	$103
Phys. Med.	97112	Neuromuscular reeducation	18,450	$45	106%	$27	$34	$34	$60	$78
Phys. Med.	97140	Manual therapy 1/> regions	58,895	$40	124%	$22	$30	$30	$57	$69
Phys. Med.	97161	Pt eval low complex 20 min	4,350	$80	99%	$62	$78	$81	$81	$86
Phys. Med.	97162	Pt eval mod complex 30 min	3,673	$83	102%	$74	$81	$81	$83	$93
Phys. Med.	97530	Therapeutic activities	27,156	$68	106%	$34	$35	$67	$96	$140
Phys. Med.	97545	Work hardening	0							
Phys. Med.	98941	Chiropract manj 3-4 regions	96,598	$37	93%	$34	$34	$35	$41	$68
Phys. Med.	99199	Special service/proc/report	0							
Surgery - Combined	22551	Neck spine fuse&remov bel c2	134	$3,739	225%	$2,860	$3,278	$3,731	$4,229	$4,442
Surgery - Combined	22633	Lumbar spine fusion combined	74	$4,307	237%	$3,111	$3,814	$4,210	$4,592	$5,214
Surgery - Combined	23430	Repair biceps tendon	187	$1,036	197%	$631	$722	$867	$1,445	$1,615
Surgery - Combined	29823	Shoulder arthroscopy/surgery	110	$855	253%	$430	$593	$702	$1,201	$1,382
Surgery - Combined	29824	Shoulder arthroscopy/surgery	230	$900	237%	$449	$648	$724	$1,278	$1,426
Surgery - Combined	29826	Shoulder arthroscopy/surgery	376	$405	234%	$338	$344	$377	$412	$550
Surgery - Combined	29827	Arthroscop rotator cuff repr	255	$2,170	208%	$1,811	$2,031	$2,255	$2,421	$2,660
Surgery - Combined	29881	Knee arthroscopy/surgery	394	$954	225%	$524	$687	$1,047	$1,072	$1,207
Surgery - Combined	29888	Knee arthroscopy/surgery	207	$2,159	215%	$1,885	$1,911	$2,102	$2,382	$2,651
Surgery - Combined	63030	Low back disk surgery	152	$2,038	211%	$1,424	$1,856	$2,110	$2,232	$2,534

(1) Based on 2018 CHSD data trended to 2019.

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	2019 CHSD Allowed[1]	%-age of 2019 Medicare	10th	25th	50th	75th	90th	Procedures	2019 CHSD Allowed[1]	%-age of 2019 Medicare	10th	25th	50th	75th	90th
99202	Office/outpatient visit new	284	$77	159%	$53	$70	$77	$77	$95	25,518	$104	147%	$79	$95	$102	$112	$130
99203	Office/outpatient visit new	697	$118	160%	$75	$106	$117	$121	$154	45,269	$153	152%	$129	$146	$162	$162	$188
99204	Office/outpatient visit new	606	$192	153%	$128	$181	$199	$205	$239	20,914	$237	152%	$203	$227	$249	$255	$288
99212	Office/outpatient visit est	688	$42	171%	$29	$35	$39	$40	$55	31,213	$61	145%	$46	$56	$62	$65	$76
99213	Office/outpatient visit est	5,161	$74	151%	$51	$69	$73	$78	$89	250,119	$105	151%	$93	$100	$110	$111	$127
99214	Office/outpatient visit est	3,878	$114	151%	$78	$110	$121	$124	$142	132,237	$155	152%	$138	$145	$163	$166	$187
99283	Emergency dept visit	6,845	$119	197%	$81	$87	$95	$110	$190	Not Applicable to Non-Facility							
99284	Emergency dept visit	11,135	$213	187%	$165	$165	$181	$205	$297								
99455	Work related disability exam	HCPCS Have No/Very Little Utilization															
99456	Disability examination																

(1) Based on 2018 CHSD data trended to 2019.