Workers Compensation Medical Activity Report for Delaware

2016 Services

Delaware Compensation Rating Bureau, Inc.

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Introduction

The DCRB Governing Board authorized the DCRB to begin collecting detailed medical data in 2010. During this period, medical losses represented over 62 percent of loss costs in Delaware. The DCRB Governing Board acknowledged the potential importance and utility of detailed medical data for its members and recognized that:

- Medical detail data could enhance DCRB's ability to explain filings
- Medical detail data would allow the DCRB to be able to opine with authority on a variety of possible proposals to change the payment system for workers compensation in Delaware
- Medical cost containment concerns impact public policy in matters such as:
  - Fee Schedules – e.g., relationships to Medicare, overall richness of reimbursements
  - Treatment Protocols
  - Payments on prescription drugs

This report is intended to be one of several resources available to stakeholders, including regulators, to provide annual assessments and insights into potential medical cost drivers that impact the workers compensation system. At the end of each calendar year, the DCRB will publish the results for the prior complete service year. However, in 2017, the DCRB published the medical activity for both Service Years 2015 and 2016 to allow for comparisons. In 2018, the DCRB will publish the medical activity for Service Year 2017.

This report uses financial, unit statistical and medical data. The medical data contained in this report relies primarily upon the standard established by the National Council on Compensation Insurance, Inc. (NCCI) Medical Data Call and shared with all independent bureaus and the Workers Compensation Insurance Organizations (WCIO). The DCRB collects, summarizes and analyzes this information independently of the NCCI. This report looks at established key benchmarks related to analysis of medical payments to allow for general comparisons across states.

Over the last ten years Delaware has passed multiple legislative reforms designed to assist in the containment of medical costs. Some of those reforms may impact year-to-year comparisons. For a listing of the reforms, please refer to the **Legislative Summary** provided in Appendix D.

As an enhancement to the Medical Activity Reports for 2016, DCRB prepared a comparison of the Delaware fee schedule to the 2016 Medicare fee schedule. The results are available in Appendix E.

The DCRB welcomes feedback and encourages stakeholders to also view the DCRB companion report entitled, ***2016 State Activity Report***, published in 2017 and available at www.dcrb.com.

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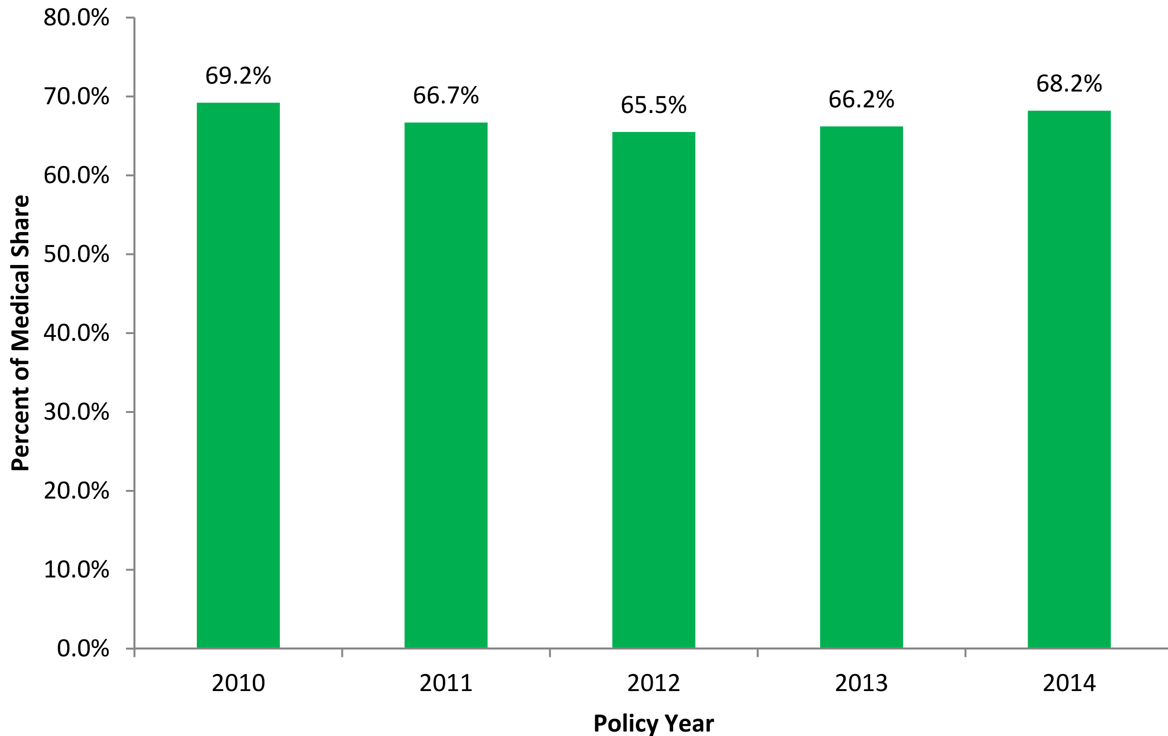
Exhibit 1
Medical Share of Total Benefit Costs



This exhibit displays the historical medical share of total benefit costs for the most recent five policy years.

There are two components to a workers compensation claim: medical compensation (hospital and doctor fees) and indemnity (lost wages). This relative measure may vary significantly from state-to-state because of different state indemnity and medical benefits provided to the injured worker. Delaware medical share results are higher than of countrywide averages.

This exhibit includes Policy Year Ultimate Unlimited Losses based on Financial Data Call for Compensation Experience valued as of 12/31/15 and includes medical only claims.

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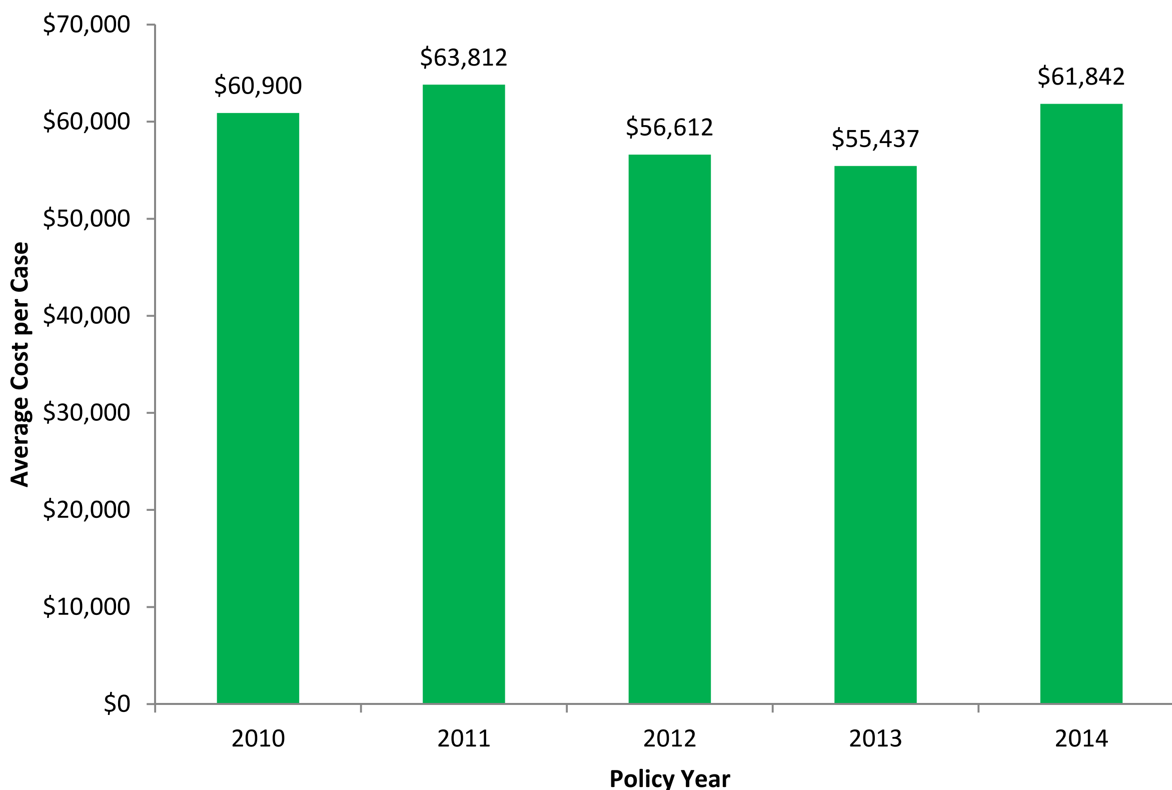
Exhibit 2
Medical Average Cost Per Case



This exhibit provides a high-level summary of medical average cost per case from 2010 to 2014.

As shown in the exhibit, medical average cost per case increased from 2010 through 2011, peaked in 2011 at $63,812, decreased in 2012 and 2013, then increased to $61,842 in 2014. The underlying data do not include medical only claims, which represent 71% of total claim volume but only 11% of total workers compensation costs. Note that policy year medical loss data is developed to ultimate without adjusting to current benefit level.

This exhibit includes Delaware Policy Year Unit Statistical Data Call for Compensation Experience valued as of 7/1/16. Unlimited incurred losses and claim counts are developed to ultimate. Medical only claim counts and losses are excluded.

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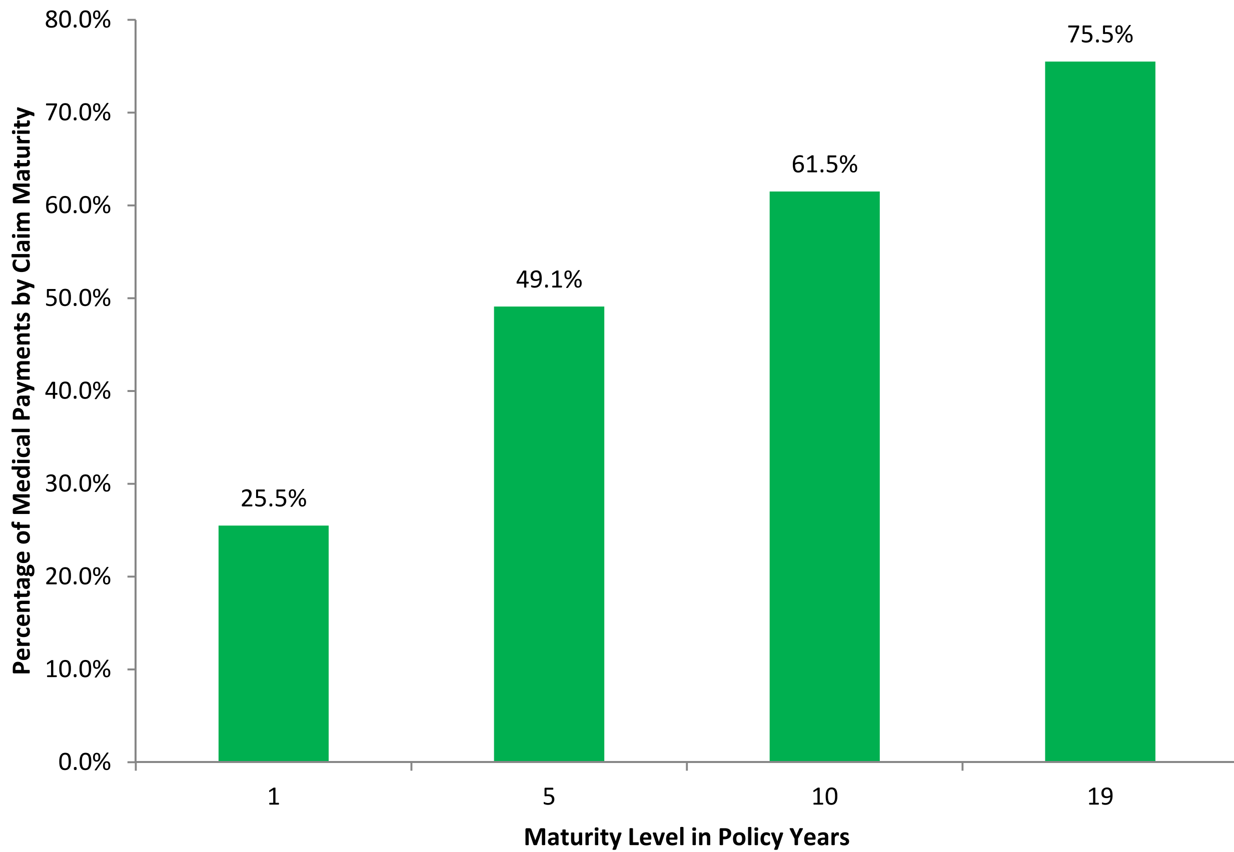
Exhibit 3
Percentage of Medical Paid by Claim Maturity



The Delaware Workers' Compensation Act provides for medical expenses that are necessary to diagnose and treat injuries and, in the event an individual is unable to work, wage-loss compensation benefits are provided.

The exhibit illustrates the percentage of medical claims paid at different claim maturities.

Workers compensation is a long-tail line of insurance with losses developing upward for over 30 years. In this report, policy year data is developed to an ultimate maturity to produce statistics that are comparable over time.

This exhibit includes Delaware Financial Year Data Call for Compensation Experience valued as of 12/31/15 and includes medical only claims.

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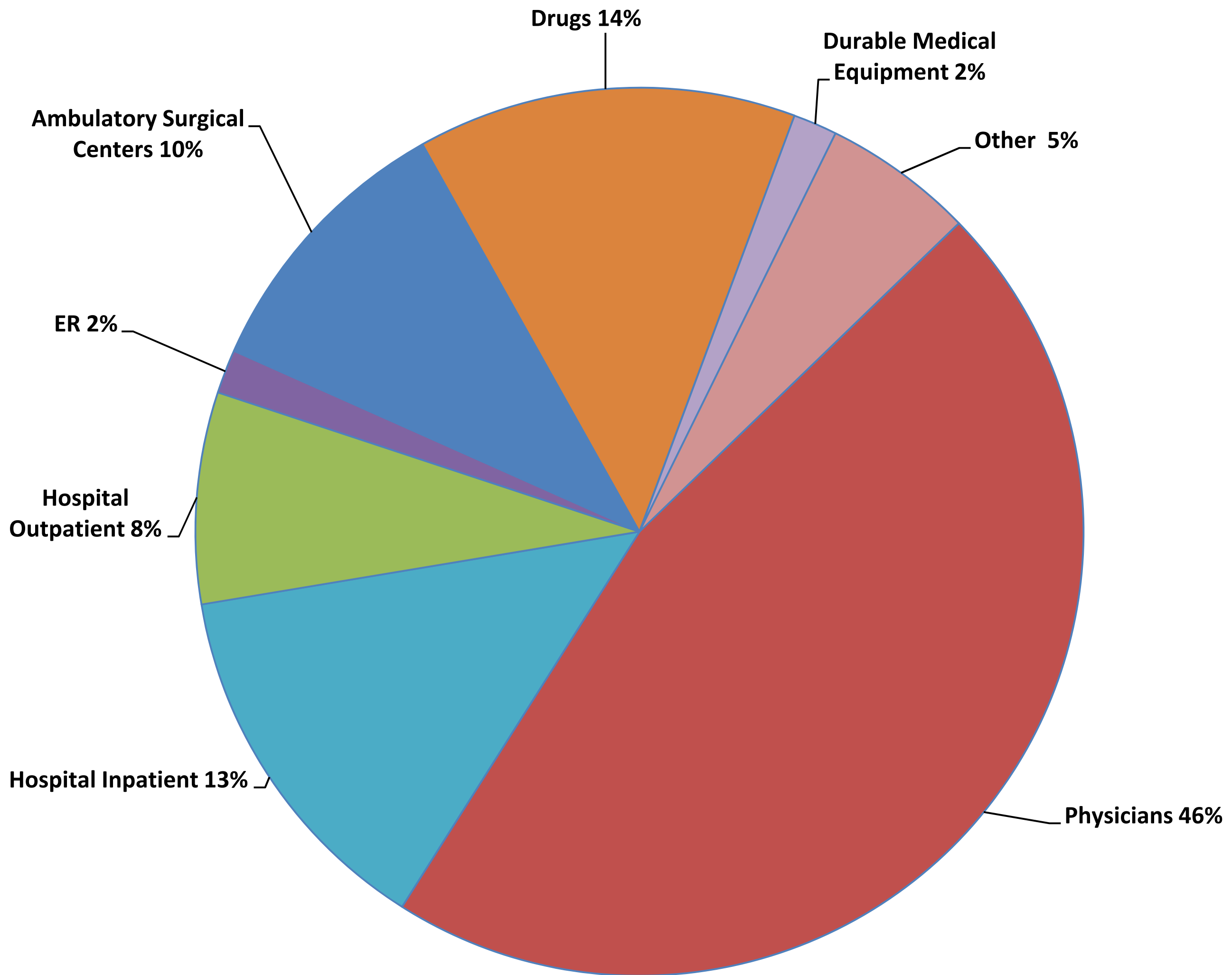

Exhibit 4 presents the distribution of medical payments by type of service groups for the state of Delaware. Payments to physicians represent the largest portion (46%) of medical paid in Service Year 2016. The service groups are defined based on paid procedure code type, provider taxonomy, and place of service regardless of where the service is performed. Delaware results are similar to results observed throughout the country.

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Exhibit 5
Distribution of Physician Payments by AMA Service Category

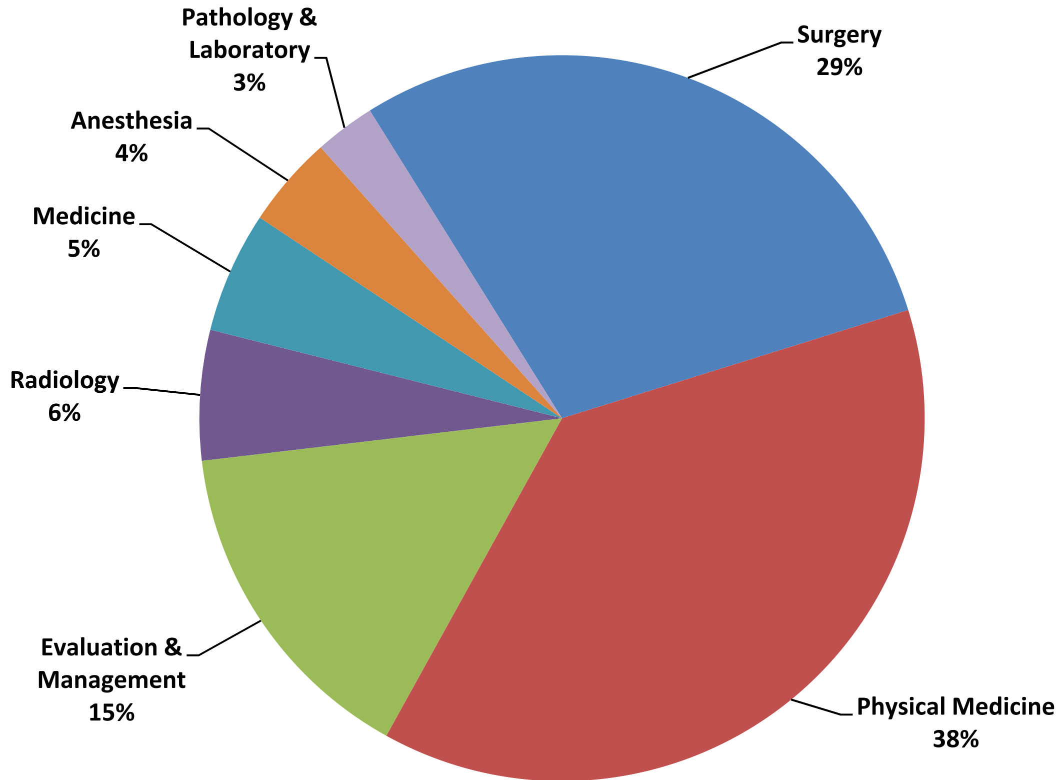

Exhibit 5 presents the distribution of physician payments by Current Procedural Terminology (CPT) code categories as defined by the American Medical Association (AMA). The Delaware Health Care Payment system (i.e., the fee schedule) dictates the maximum allowable reimbursement (MAR) when paying medical charges submitted by providers. Note that, in Delaware, if an insurer, employer and health care provider enter into a contract for different reimbursement levels, those negotiated amounts prevail over the fee schedule. Physical Medicine, Surgery and Evaluation and Management together accounted for 82% of physician payments. Delaware results are slightly atypical of patterns observed throughout the country where evaluation and management services represent a larger percentage of physician payments. Note that the Surgery category includes both major and minor surgery.

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Professional Information

Physicians use CPT codes to identify and bill for the professional services that they provide to injured workers. The next eleven exhibits represent different breakdowns of CPT procedure codes performed by physicians for the Surgery, Radiology, Physical/General Medicine, and Evaluation and Management service categories. These exhibits illustrate the most frequently performed procedures. At the bottom of each exhibit, the CPT codes are displayed with detailed descriptions.

Exhibit 6 presents the top 10 surgery paid procedure codes based on paid amount. **Exhibit 7** presents the top 10 surgery paid procedure codes based on transaction counts.

Exhibit 8 presents the top 10 radiology paid procedure codes based on paid amount. **Exhibit 9** presents the top 10 radiology paid procedure codes based on transaction counts.

Exhibit 10 displays the distribution of radiology payments by modifier code.

Exhibit 11 presents the top 10 physical and general medicine paid procedure codes based on paid amount. **Exhibit 12** presents the top 10 physical and general medicine paid procedure codes based on transaction counts.

Exhibit 13 presents the top 10 evaluation and management paid procedure codes based on paid amount. **Exhibit 14** presents the top 10 evaluation and management paid procedure codes based on transaction counts.

Exhibit 15 and 16 presents the most recent five-year trend for evaluation and management procedure codes.

The source for all data is the DCRB Medical Data Call for Service Year 2016. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

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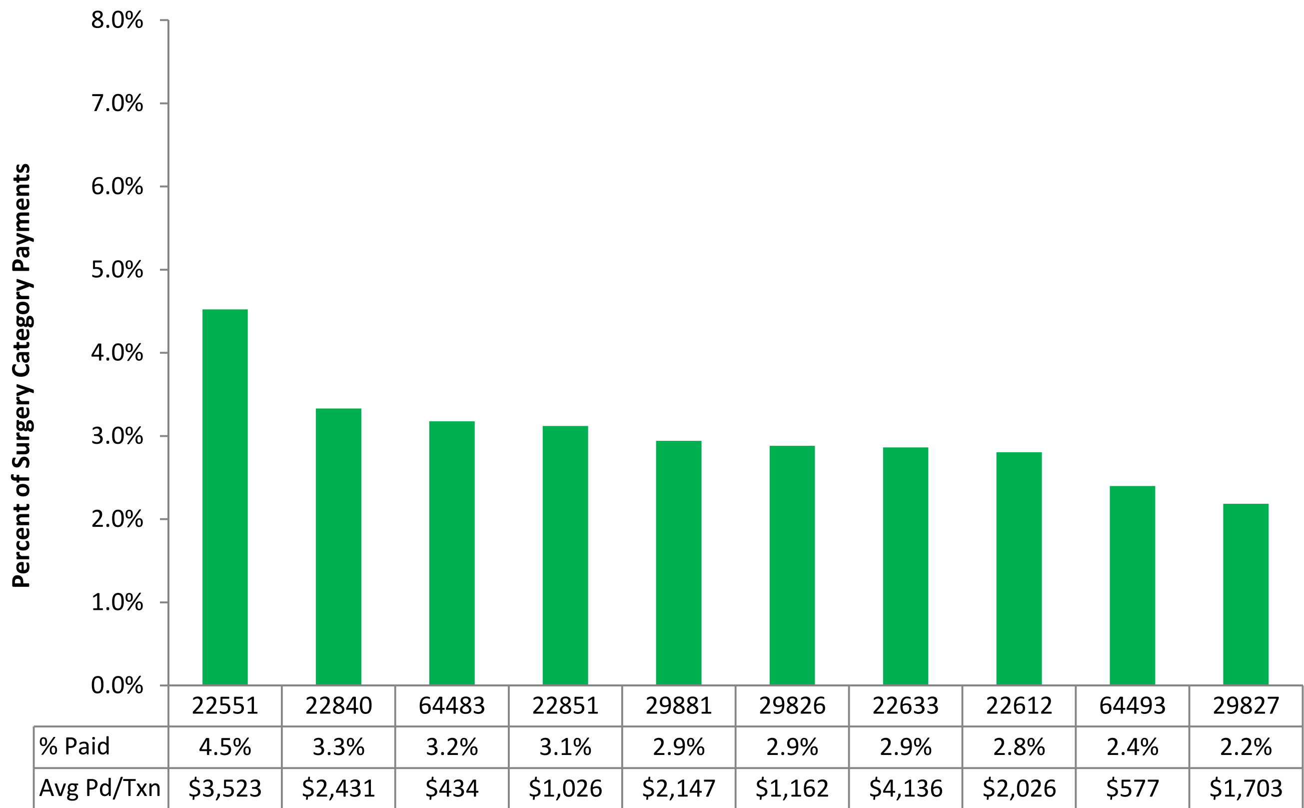
Exhibit 6
Top 10 Surgery Procedure Codes by Amount Paid



	22551	22840	64483	22851	29881	29826	22633	22612	64493	29827
% Paid	4.5%	3.3%	3.2%	3.1%	2.9%	2.9%	2.9%	2.8%	2.4%	2.2%
Avg Pd/Txn	$3,523	$2,431	$434	$1,026	$2,147	$1,162	$4,136	$2,026	$577	$1,703

Code	Description
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2
22840	Posterior non-segmental instrumentation (eg, harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at c1, facet screw fixation) (list separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or ct); lumbar or sacral, single level
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (list separately in addition to code for primary procedure)
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (list separately in addition to code for primary procedure)
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; single level
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair

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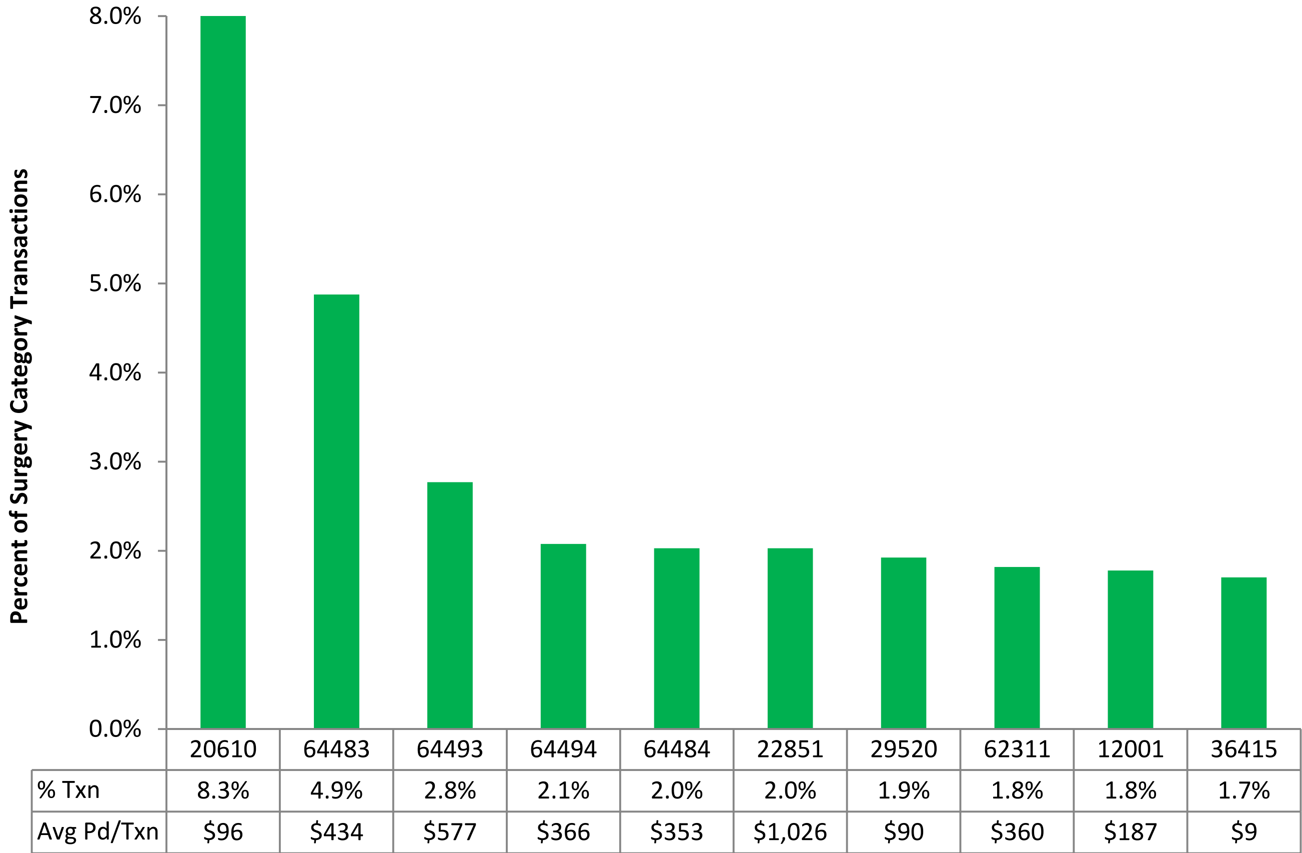
Exhibit 7
Top 10 Surgery Procedure Codes by Transaction Counts



	20610	64483	64493	64494	64484	22851	29520	62311	12001	36415
% Txn	8.3%	4.9%	2.8%	2.1%	2.0%	2.0%	1.9%	1.8%	1.8%	1.7%
Avg Pd/Txn	$96	$434	$577	$366	$353	$1,026	$90	$360	$187	$9

Code	Description
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or ct); lumbar or sacral, single level
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; second level (list separately in addition to code for primary procedure)
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or ct); lumbar or sacral, each additional level (list separately in addition to code for primary procedure)
22851	Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (list separately in addition to code for primary procedure)
29520	Strapping; hip
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
36415	Collection of venous blood by venipuncture

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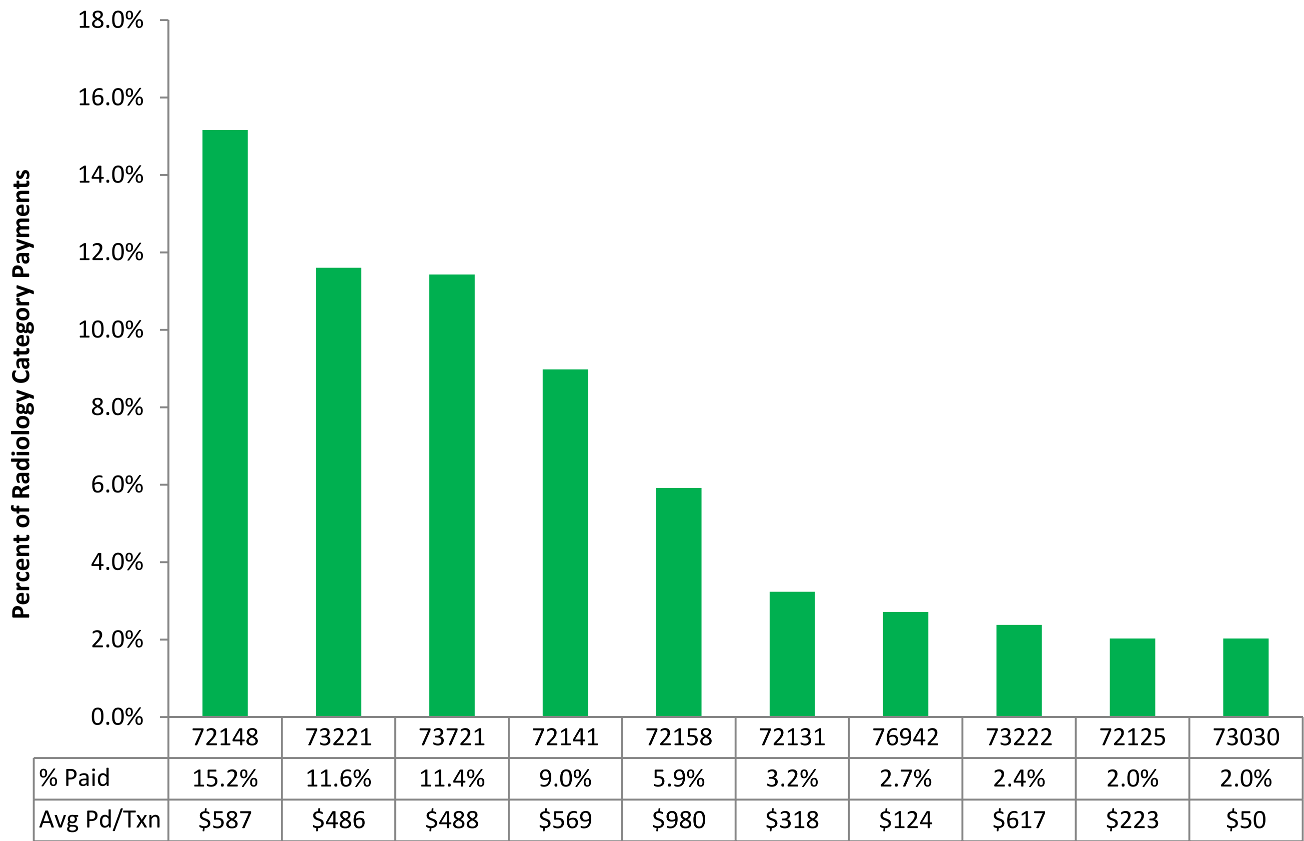
Exhibit 8
Top 10 Radiology Procedure Codes by Amount Paid



	72148	73221	73721	72141	72158	72131	76942	73222	72125	73030
% Paid	15.2%	11.6%	11.4%	9.0%	5.9%	3.2%	2.7%	2.4%	2.0%	2.0%
Avg Pd/Txn	$587	$486	$488	$569	$980	$318	$124	$617	$223	$50

Code	Description
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
73221	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73721	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72131	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation
76942	Discography, lumbar, radiological supervision and interpretation
73222	Radiologic examination, spine, lumbosacral; 2 or 3 views
72125	Computed tomography, lumbar spine; without contrast material
73030	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material

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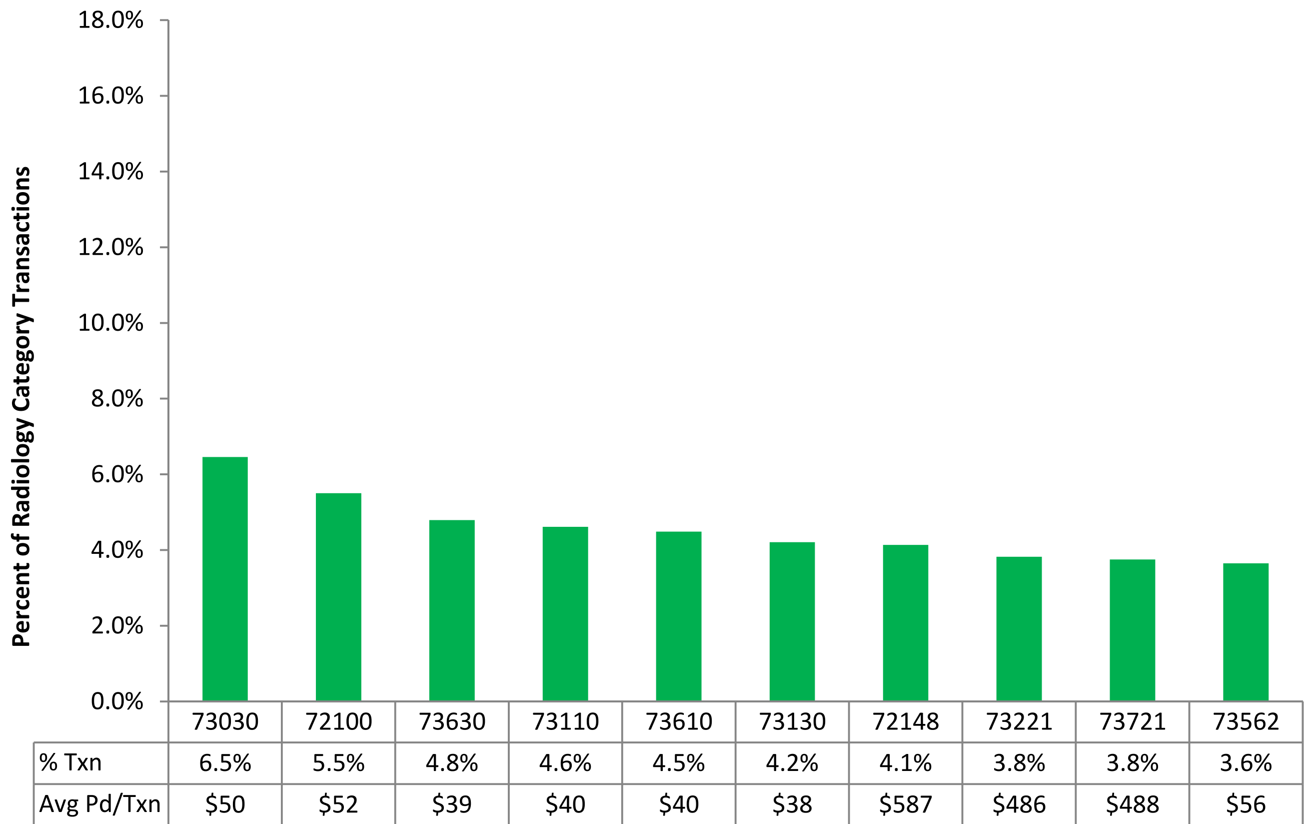
Exhibit 9
Top 10 Radiology Procedure Codes by Transaction Counts



	73030	72100	73630	73110	73610	73130	72148	73221	73721	73562
% Txn	6.5%	5.5%	4.8%	4.6%	4.5%	4.2%	4.1%	3.8%	3.8%	3.6%
Avg Pd/Txn	$50	$52	$39	$40	$40	$38	$587	$486	$488	$56

Code	Description
73030	Radiologic examination, spine, lumbosacral; 2 or 3 views
72100	Radiologic examination, shoulder; complete, minimum of 2 views
73630	Radiologic examination, foot; complete, minimum of 3 views
73110	Radiologic examination, ankle; complete, minimum of 3 views
73610	Radiologic examination, wrist; complete, minimum of 3 views
73130	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72148	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73221	Radiologic examination, finger(s), minimum of 2 views
73721	Radiologic examination, hand; minimum of 3 views
73562	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)

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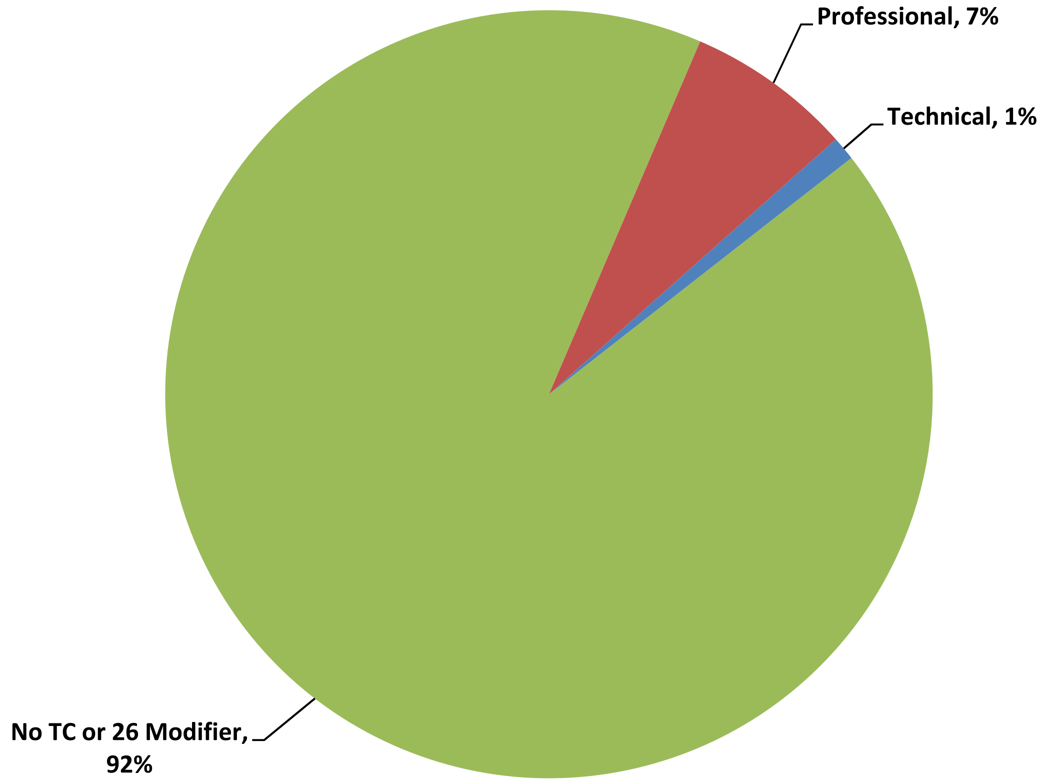
Exhibit 10
Distribution of Radiology Payments by Modifier Code



Average Paid Amount Per Transaction by Modifier Code

Code	No TC or 26 Modifier	Professional	Technical
72148	$1,750	$100	$655
73221	$1,332	$81	$484
73721	$1,149	$84	$0
72141	$1,116	$120	$0
72158	$1,048	$161	$864
72131	$750	$87	$0
76942	$331	$38	$0
73222	$1,297	$100	$0
72125	$640	$103	$282
73030	$121	$18	$23

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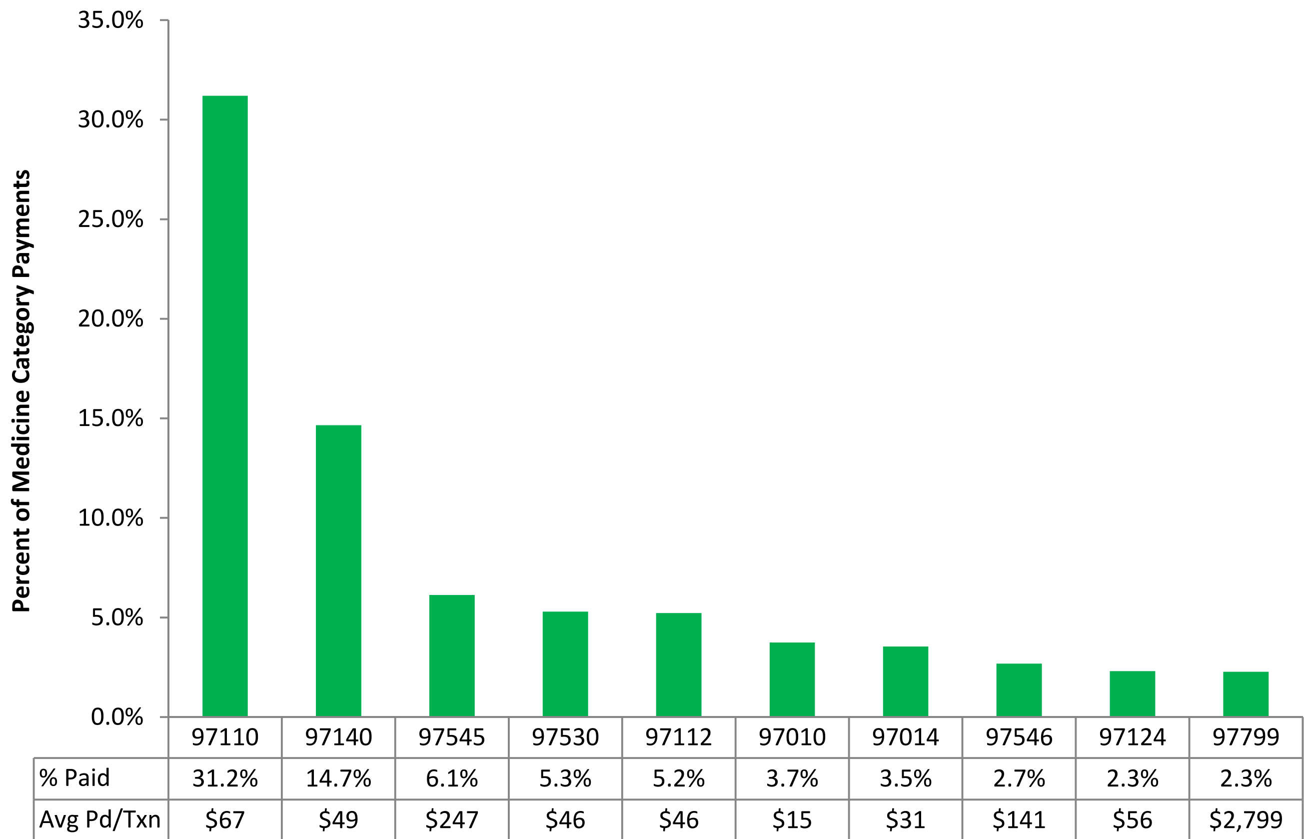
Exhibit 11
Top 10 Physical and General Medicine Procedure Codes by Amount Paid



	97110	97140	97545	97530	97112	97010	97014	97546	97124	97799
% Paid	31.2%	14.7%	6.1%	5.3%	5.2%	3.7%	3.5%	2.7%	2.3%	2.3%
Avg Pd/Txn	$67	$49	$247	$46	$46	$15	$31	$141	$56	$2,799

Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97530	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97112	Application of a modality to 1 or more areas; hot or cold packs
97010	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97014	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97546	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97799	Unlisted physical medicine/rehabilitation service or procedure

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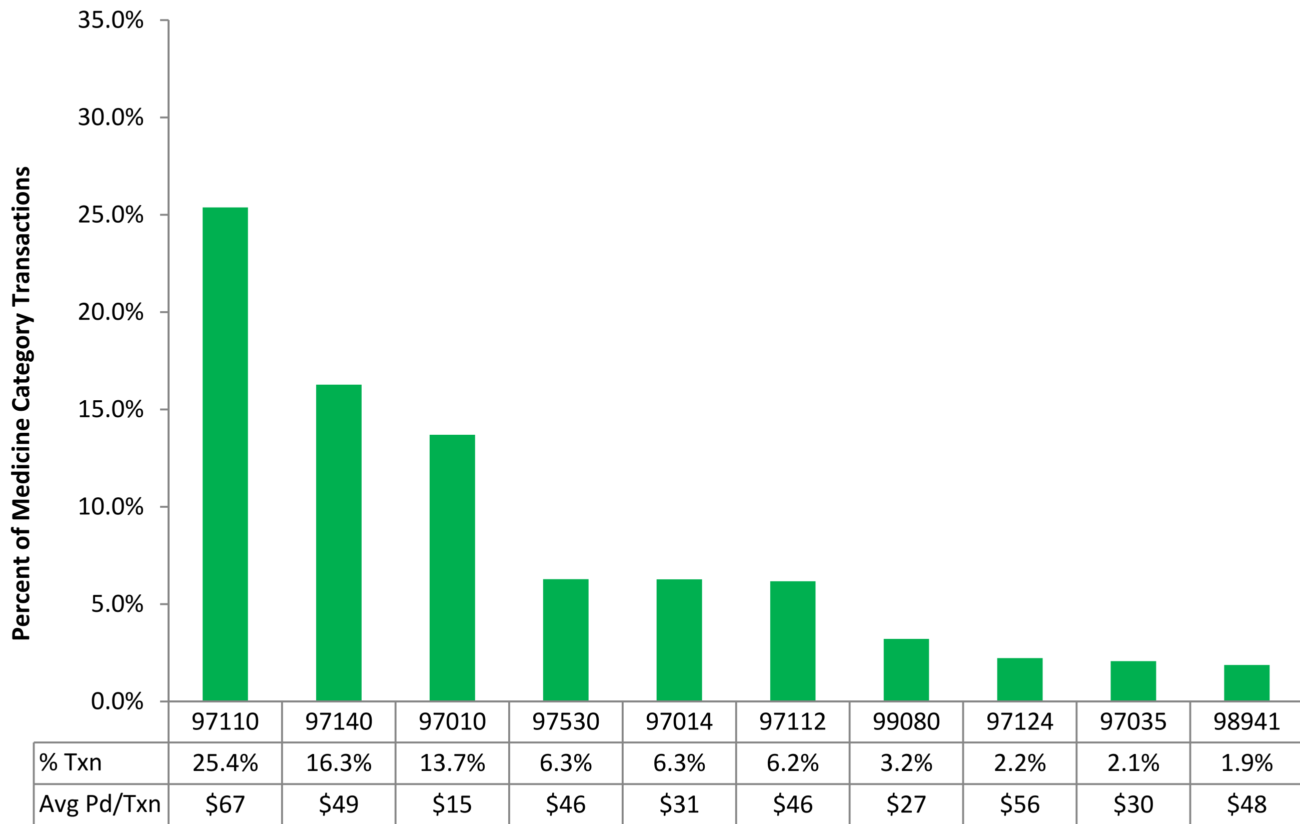
Exhibit 12

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts



	97110	97140	97010	97530	97014	97112	99080	97124	97035	98941
% Txn	25.4%	16.3%	13.7%	6.3%	6.3%	6.2%	3.2%	2.2%	2.1%	1.9%
Avg Pd/Txn	$67	$49	$15	$46	$31	$46	$27	$56	$30	$48

Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97010	Application of a modality to 1 or more areas; hot or cold packs
97530	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97014	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97112	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
98941	Chiropractic manipulative treatment (cmt); spinal, 3-4 regions

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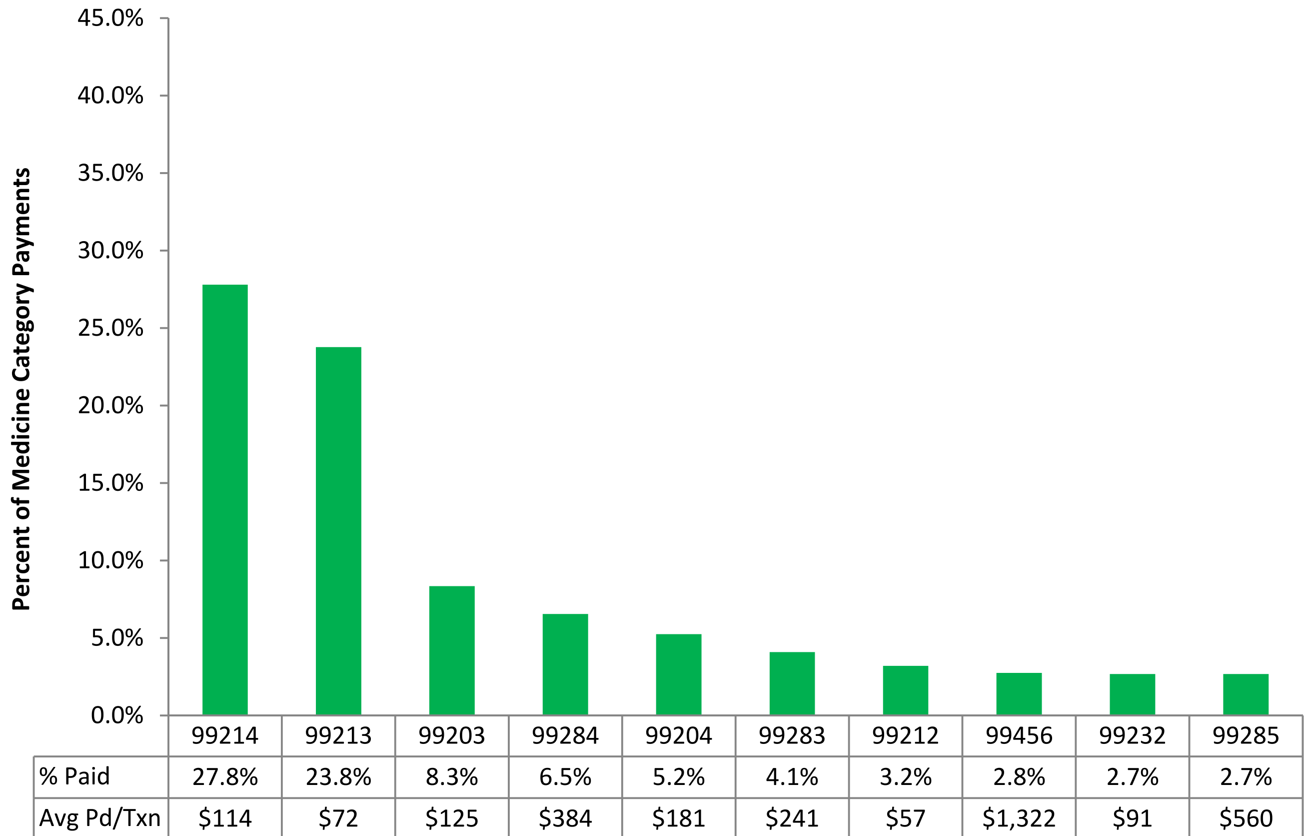
Exhibit 13

Top 10 Evaluation & Management Procedure Codes by Amount Paid



	99214	99213	99203	99284	99204	99283	99212	99456	99232	99285
% Paid	27.8%	23.8%	8.3%	6.5%	5.2%	4.1%	3.2%	2.8%	2.7%	2.7%
Avg Pd/Txn	$114	$72	$125	$384	$181	$241	$57	$1,322	$91	$560

Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99284	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99204	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99283	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99456	Work related or medical disability examination by other than the treating physician.
99232	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99285	Office consultation for a new or established patient. Typically, 60 minutes are spent face-to-face with the patient and/or family.

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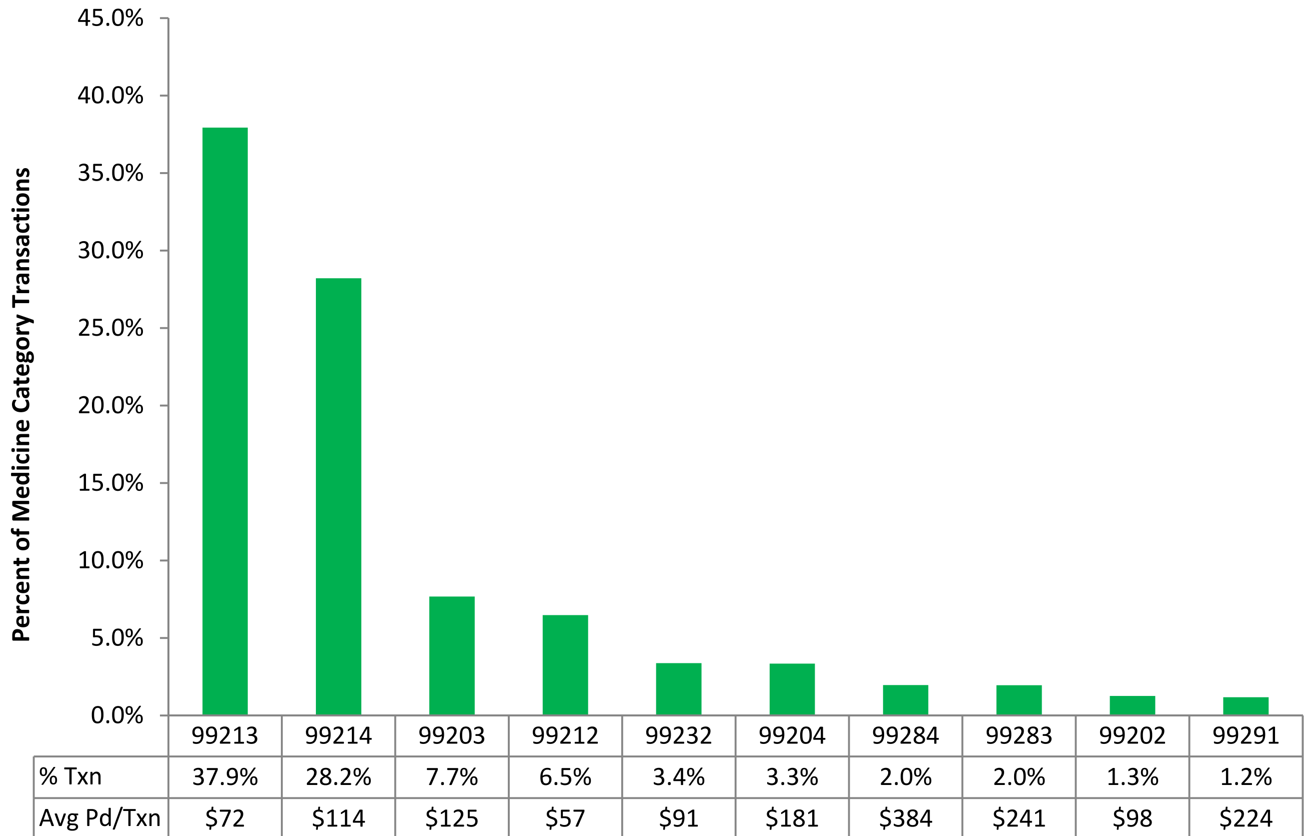
Exhibit 14
Top 10 Evaluation & Management Procedure Codes by Transaction Counts



	99213	99214	99203	99212	99232	99204	99284	99283	99202	99291
% Txn	37.9%	28.2%	7.7%	6.5%	3.4%	3.3%	2.0%	2.0%	1.3%	1.2%
Avg Pd/Txn	$72	$114	$125	$57	$91	$181	$384	$241	$98	$224

Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99232	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99204	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99284	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
99283	Subsequent hospital care, per day, for the evaluation and management of a patient. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99291	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 40 minutes are spent face-to-face with the patient and/or family.

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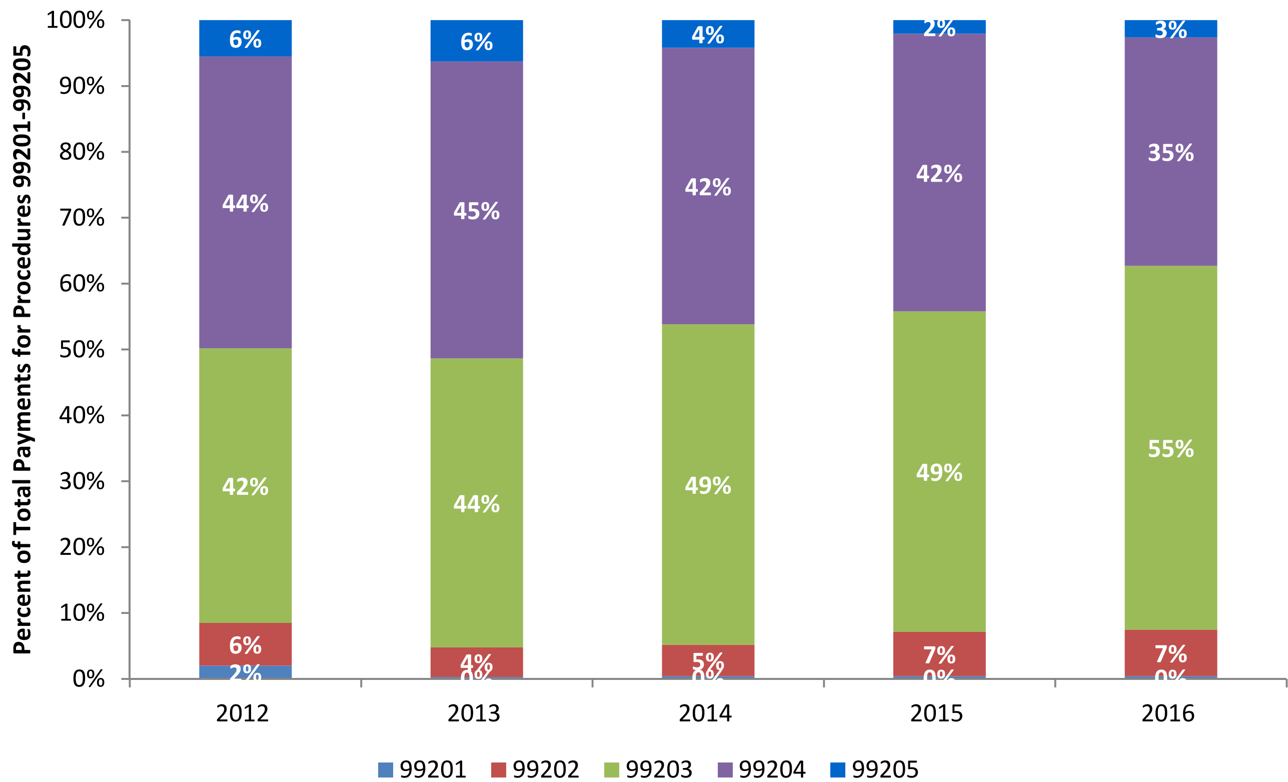
Exhibit 15
Top 10 Evaluation & Management Procedure Codes Trend



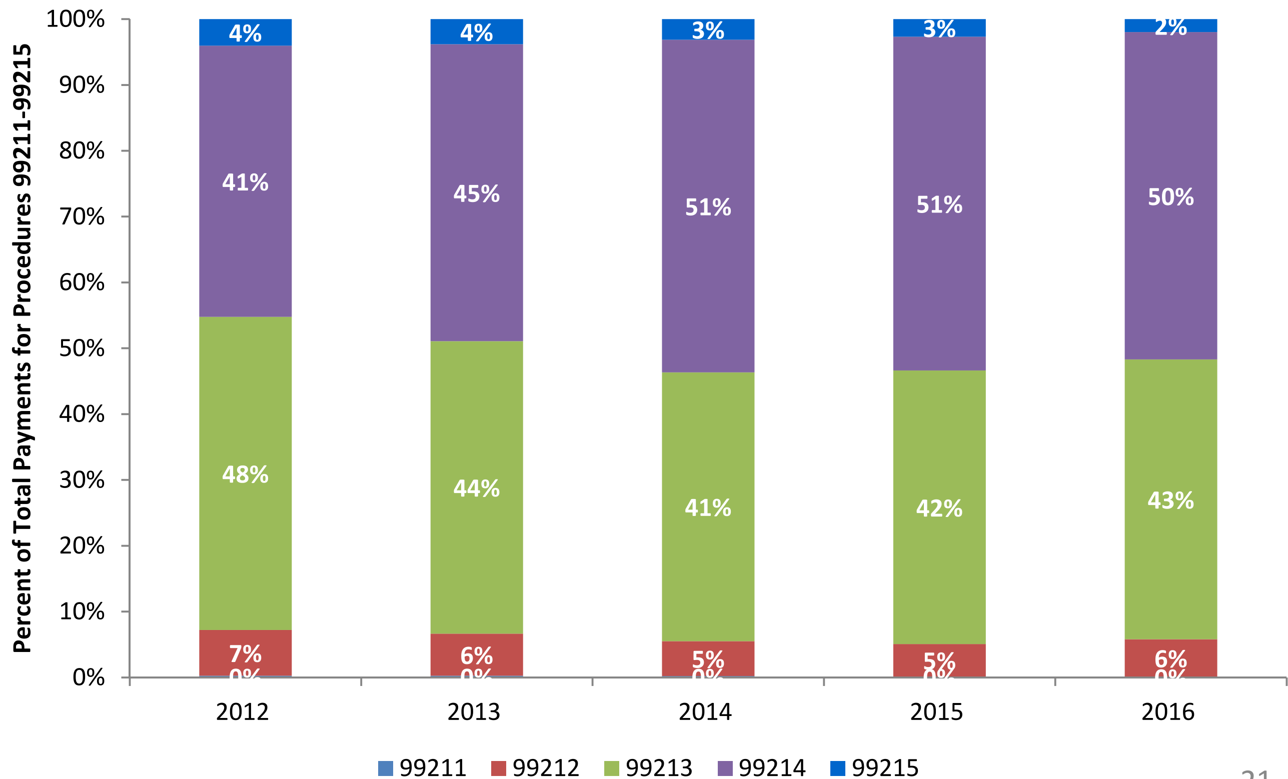


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Exhibit 16
Top 10 Evaluation & Management Procedure Codes Trend

Average Paid Per Transaction

	2012	2013	2014	2015	2016
99201	$467	$64	$69	$63	$65
99202	$99	$97	$102	$97	$98
99203	$138	$138	$137	$128	$125
99204	$208	$209	$207	$191	$181
99205	$236	$236	$237	$217	$216
99211	$28	$30	$31	$27	$27
99212	$63	$64	$62	$53	$57
99213	$81	$82	$81	$74	$72
99214	$127	$129	$131	$120	$114
99215	$150	$152	$175	$155	$148

Code	Description
99201	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 40 minutes are spent face-to-face with the patient and/or family.

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Facility Information

Facilities use a variety of codes to identify and bill for the services that they provide to injured workers. Medical facility data is presented for the following places of service: Hospital Inpatient, Hospital Outpatient, Emergency Room, and Ambulatory Surgical Center.

The next six exhibits present different breakdowns of **Hospital Inpatient** data over the most recent five-year period.

Exhibit 17 presents the average paid amount per stay for Hospital Inpatient services.

Exhibit 18 displays the average number of inpatient stays per 1,000 active claims.

Exhibit 19 presents the average and median length of Hospital Inpatient stays.

Exhibit 20 displays the average paid amount per day for Hospital Inpatient services.

Exhibit 21 details the top 10 diagnoses by paid amount for Hospital Inpatient services. This exhibit shows the most frequently billed diagnoses. At the bottom of the exhibit, the ICD-10 diagnosis codes are displayed with detailed descriptions.

Exhibit 22 details the top 10 Diagnosis Related Group (DRG) codes by paid amount for Hospital Inpatient services. This exhibit allows us to better understand the most frequently billed DRG codes. DRG codes are defined as a system to classify hospital cases into one of approximately 800 groups which are expected to have similar hospital resource use. At the bottom of the exhibit, the DRG codes are displayed with detailed descriptions.

The source for all data is the DCRB Medical Data Call for Service Year 2016. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

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Exhibit 17
Average Paid Amount Per Stay for Hospital Inpatient Services

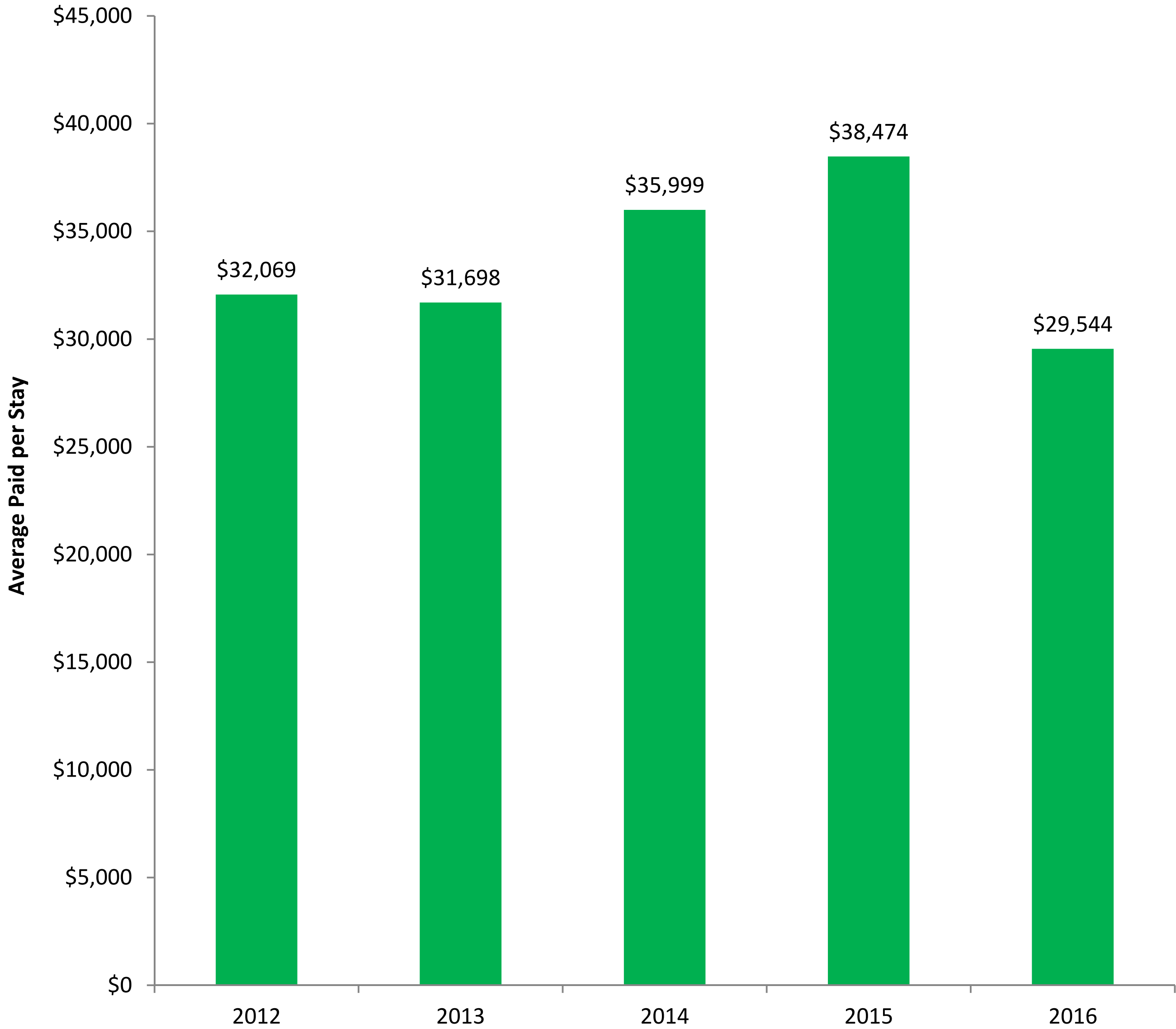

Exhibit 17 presents the average paid amount per stay for a Hospital Inpatient service by service year. This exhibit illustrates the trend of payments over a period of five service years.

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Exhibit 18
Average Number of Stays per 1,000 Active Claims

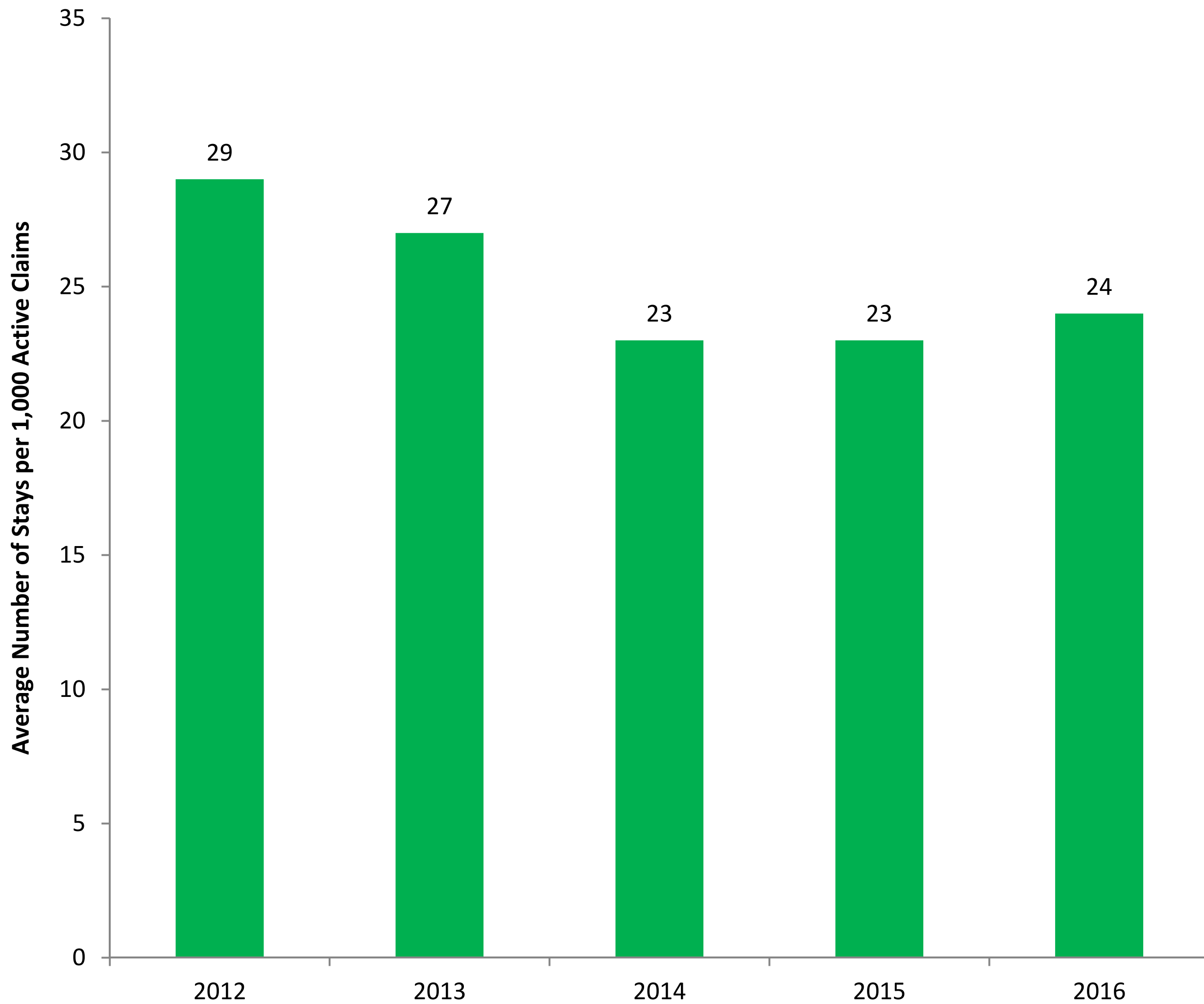

Exhibit 18 displays the average number of inpatient stays per 1,000 active claims by service year. This exhibit illustrates the trend in average number of stays over a period of five service years.

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Exhibit 19
Inpatient Length of Stay for Hospital Inpatient Services

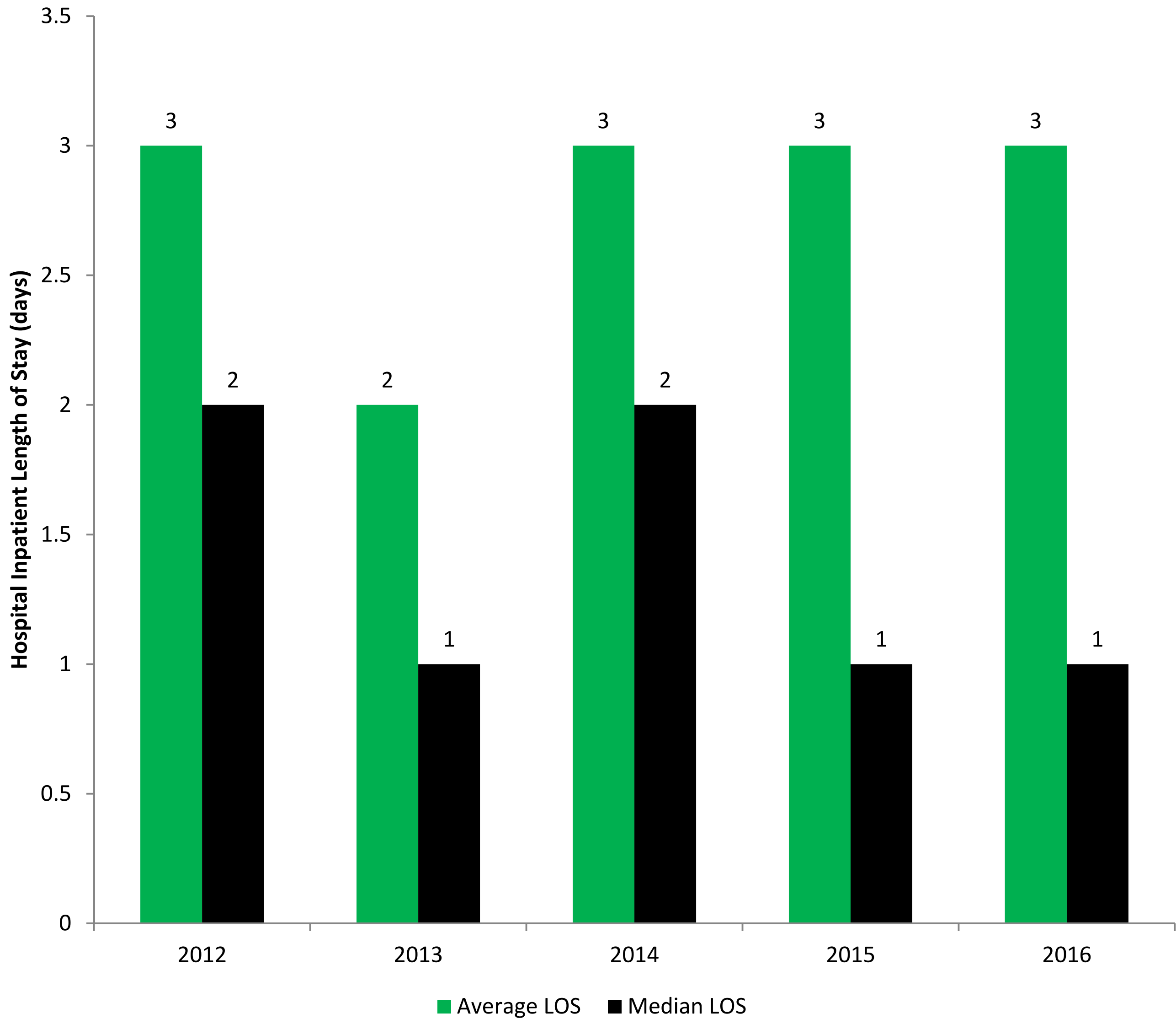

Exhibit 19 provides the average and median lengths of Hospital Inpatient stays over a five- year service period. This information suggests consistency in length of stay over the period examined.

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Exhibit 20
Average Paid Amount per Day for Hospital Inpatient Services

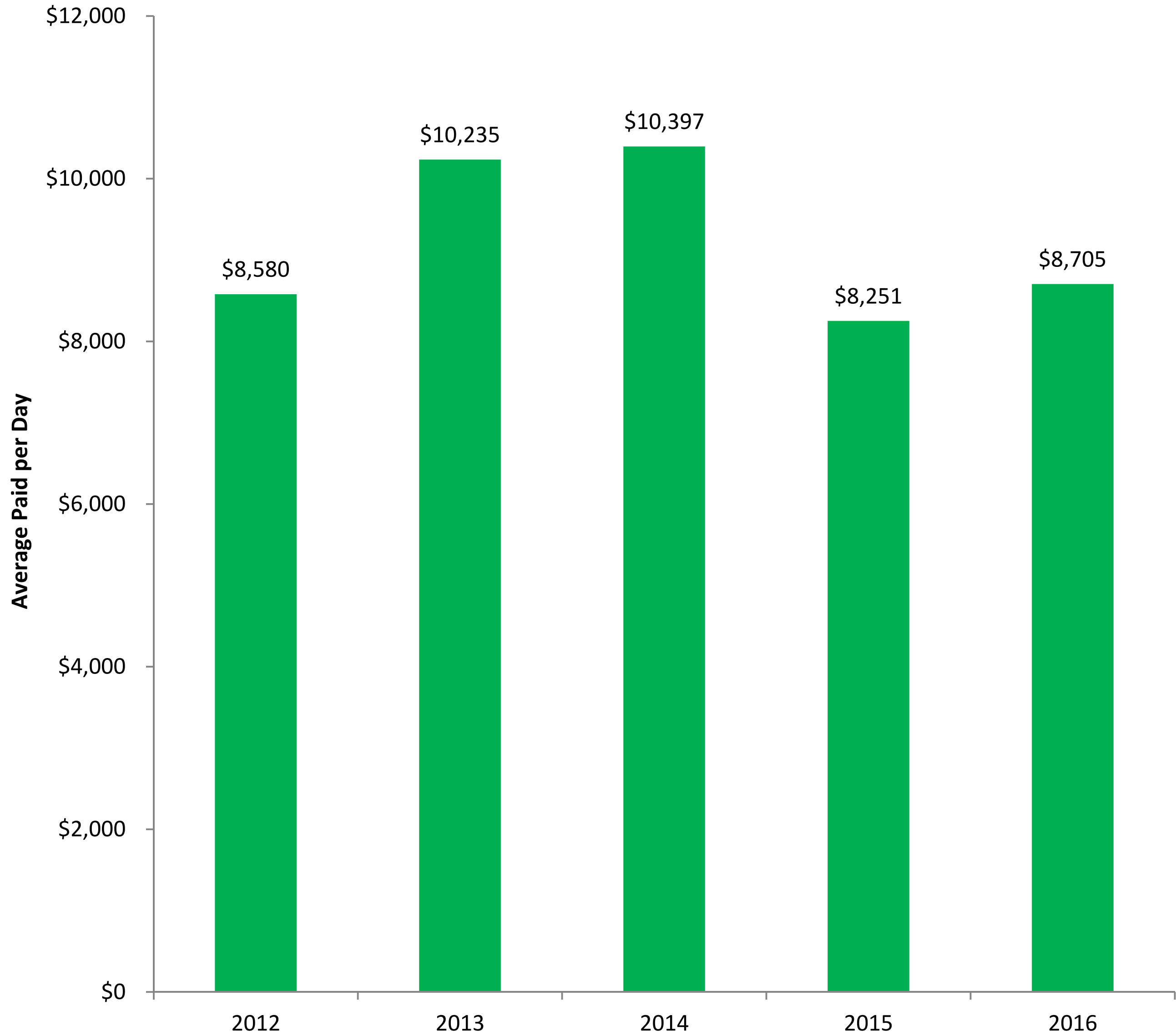

Exhibit 20 presents the average paid amount per day for Hospital Inpatient services by service year. This exhibit displays the pattern of payments over period of five service years.

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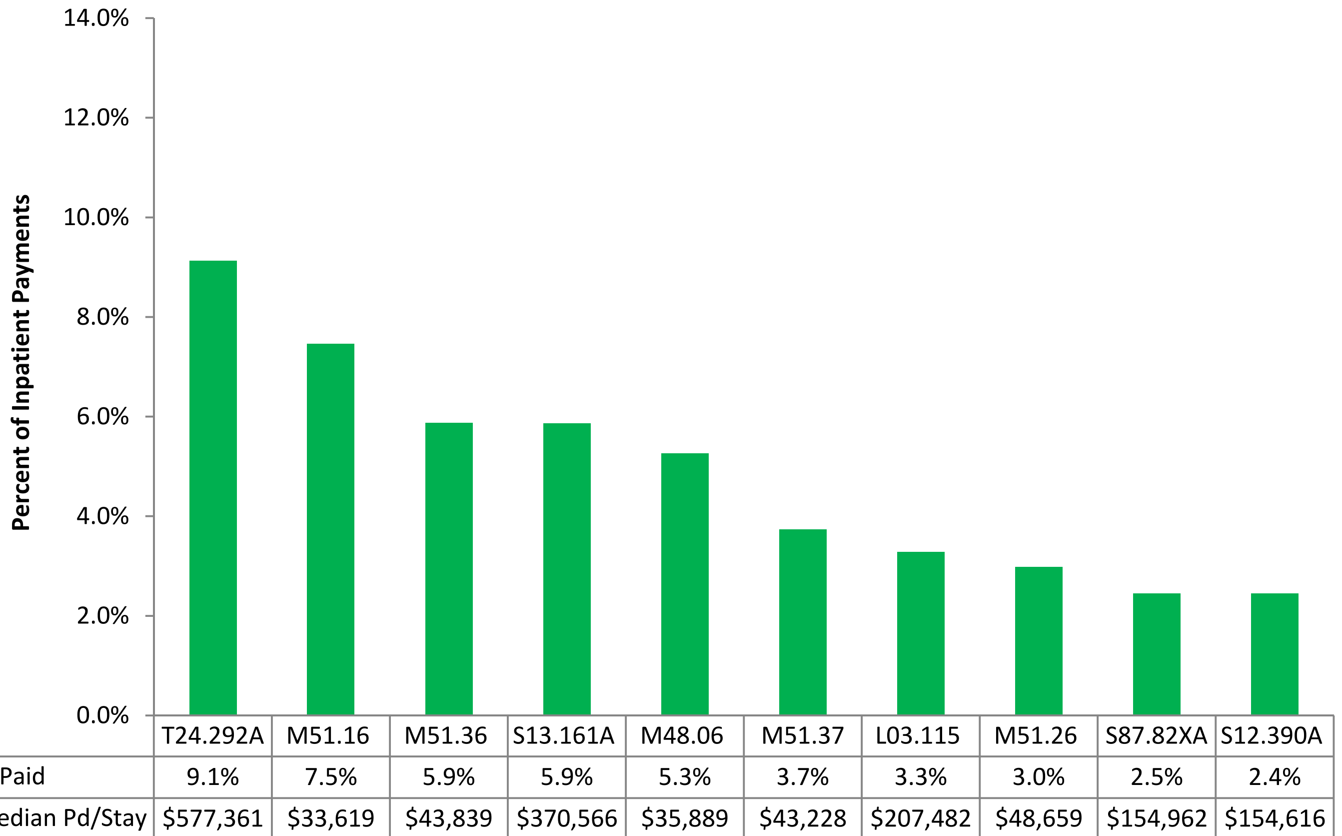
Exhibit 21
Top 10 Diagnosis by Amount Paid for Hospital Inpatient Services



	T24.292A	M51.16	M51.36	S13.161A	M48.06	M51.37	L03.115	M51.26	S87.82XA	S12.390A
% Paid	9.1%	7.5%	5.9%	5.9%	5.3%	3.7%	3.3%	3.0%	2.5%	2.4%
Median Pd/Stay	$577,361	$33,619	$43,839	$370,566	$35,889	$43,228	$207,482	$48,659	$154,962	$154,616

Code	Description
T24.292A	Burn of second degree of multiple sites of left lower limb, except ankle and foot, initial encounter
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
S13.161A	Dislocation of C5/C6 cervical vertebrae, initial encounter
M48.06	Spinal stenosis, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
L03.115	Cellulitis of right lower limb
M51.26	Other intervertebral disc displacement, lumbar region
S87.82XA	Crushing injury of left lower leg, initial encounter
S12.390A	Other displaced fracture of fourth cervical vertebra, initial encounter for closed fracture

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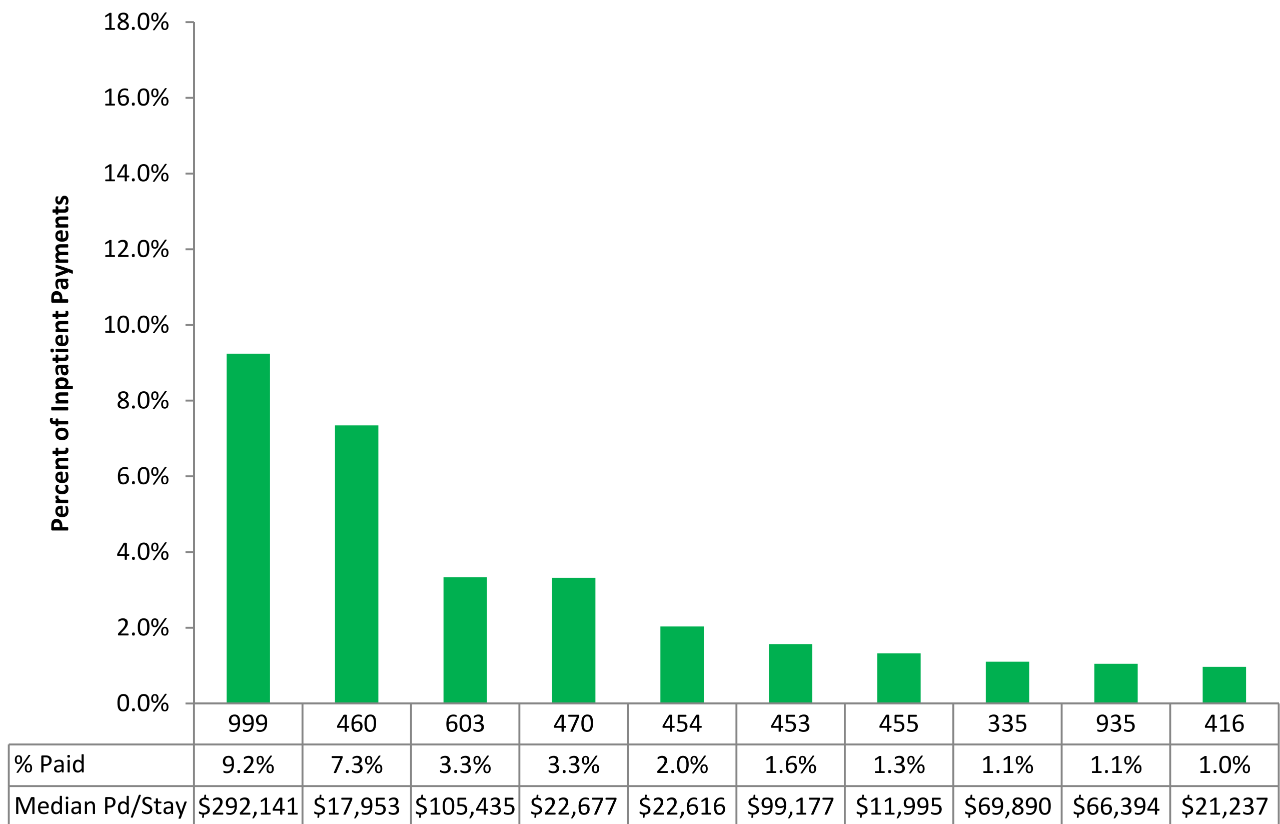
Exhibit 22
Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services



	999	460	603	470	454	453	455	335	935	416
% Paid	9.2%	7.3%	3.3%	3.3%	2.0%	1.6%	1.3%	1.1%	1.1%	1.0%
Median Pd/Stay	$292,141	$17,953	$105,435	$22,677	$22,616	$99,177	$11,995	$69,890	$66,394	$21,237

Code	Description
999	Ungroupable
460	Spinal fusion except cervical without major complications or comorbidities
603	Cellulitis without major complications or cormorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or cormorbidities
454	Combined anterior/posterior spinal fusion with complications or cormorbidities
453	Combined anterior/posterior spinal fusion with major complications or cormorbidities
455	Combined anterior/posterior spinal fusion without complications or cormorbidities/major complications or cormorbidities
335	Peritoneal adhesiolysis with major complications or cormorbidities
935	Non-extensive burns
416	Septicemia, patient age greater than 17

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Facility Information

The next seven exhibits in this section represent different breakdowns of **Hospital Outpatient** data trended over the most recent five year period.

Exhibit 23 represents the average outpatient paid amount per surgical visit for hospital outpatient services based on data as reported in the Medical Data Call. **Exhibit 23A** displays the average number of surgical hospital outpatient visits per 1,000 active claims. **Exhibits 24 and 24A** represent similar data, but for the non-surgical visits.

Exhibit 25 details the top 10 diagnosis by paid amount for hospital outpatient services. This exhibits allow us to better understand the most frequently billed diagnoses. At the bottom of the exhibit, the ICD-10 diagnosis codes are displayed with detailed descriptions.

Exhibit 26 details the top 10 surgery CPT codes by paid amount for hospital outpatient services. This exhibits allow us to better understand the most frequently billed CPT codes. At the bottom of the exhibit, the CPT codes are displayed with detailed descriptions. **Exhibit 27** presents the top 10 non-surgical CPT and HCPCS codes by paid amount for Hospital Outpatient services.

The source for all data is the DCRB Medical Data Call for Service Year 2016. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

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Exhibit 23
Average Outpatient Paid Amount Per Surgical Visit for Hospital Outpatient Services

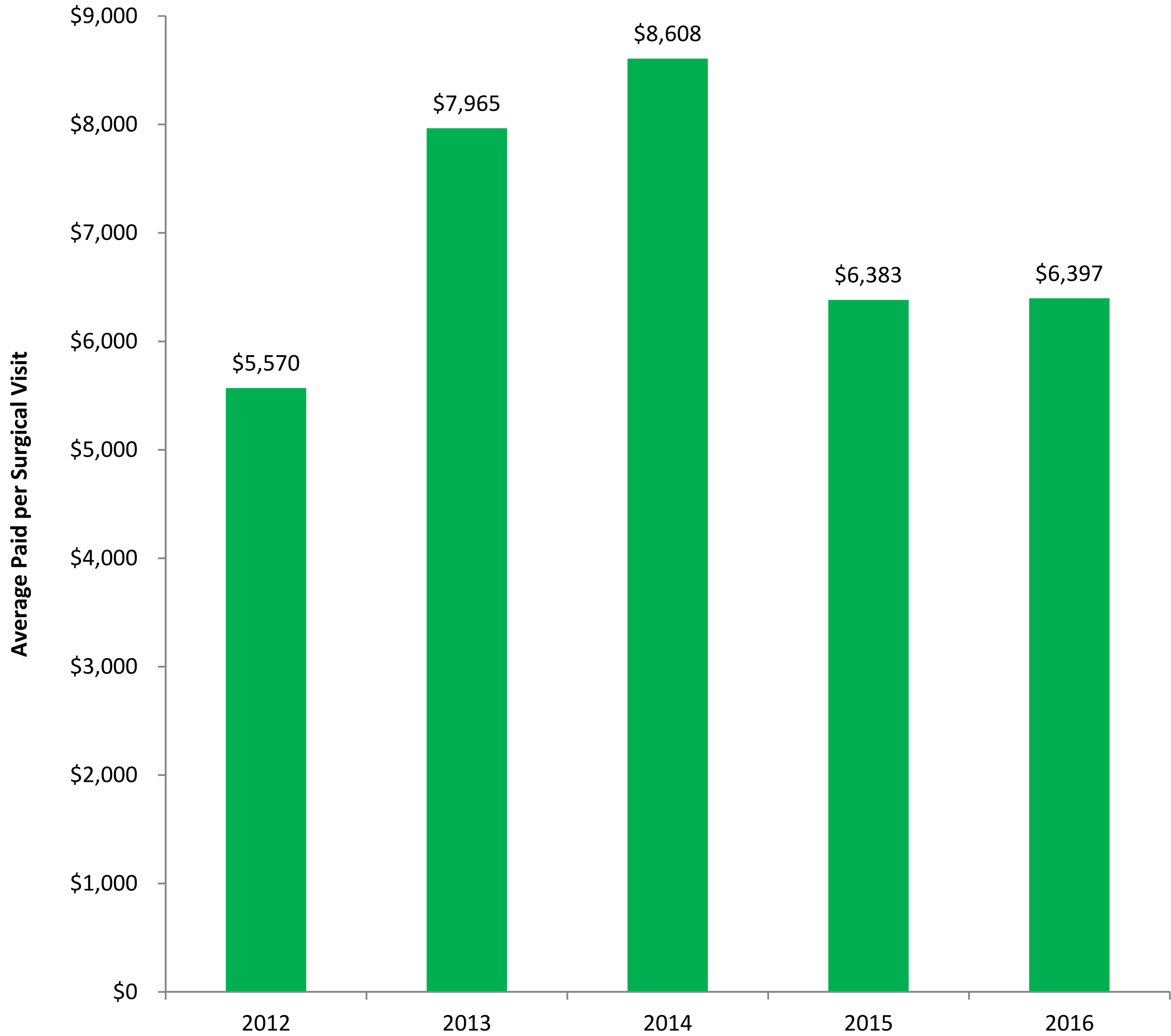

Exhibit 23 presents the average outpatient paid amount per surgical visit for Hospital Outpatient services by service year. This exhibit illustrates payments over period of five consecutive service years.

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Exhibit 23A
Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims

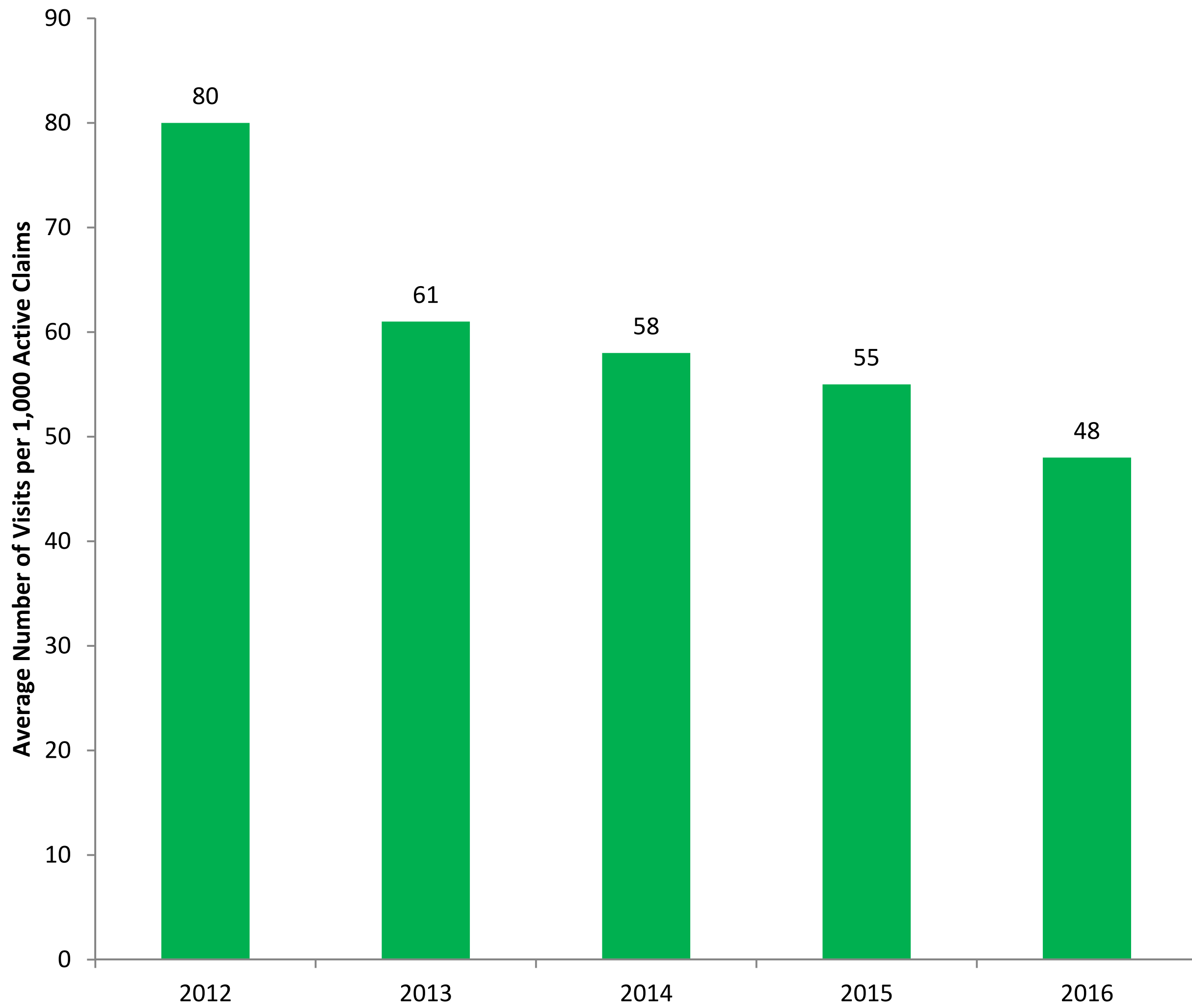

Exhibit 23A presents the average number of surgical hospital outpatient visits per 1,000 active claims.

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Exhibit 24
Average Outpatient Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services

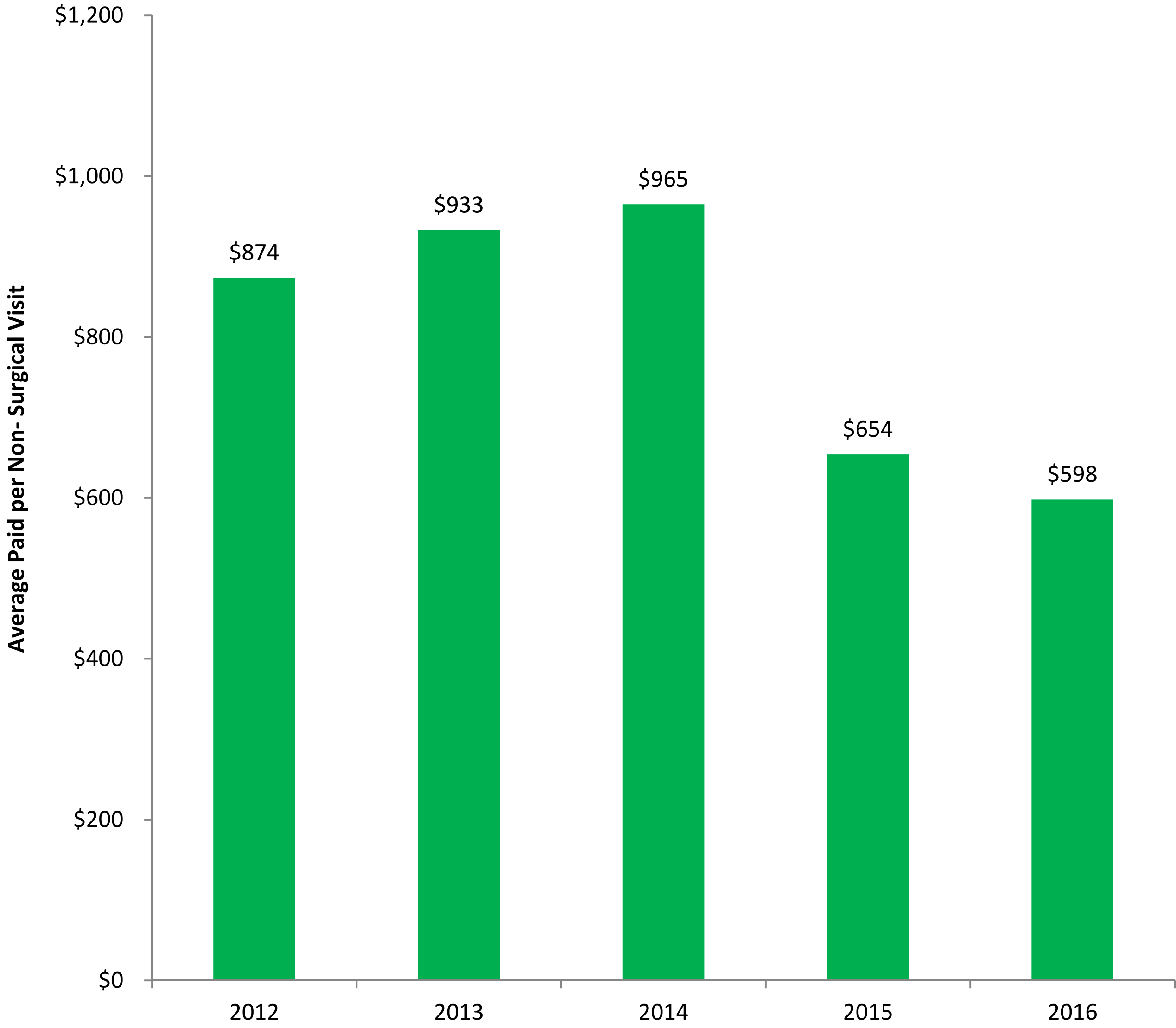

Exhibit 24 presents the average outpatient paid amount per non-surgical visit for Hospital Outpatient services by service year. This exhibit illustrates payments over a period of five consecutive service years.

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Exhibit 24A

Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims

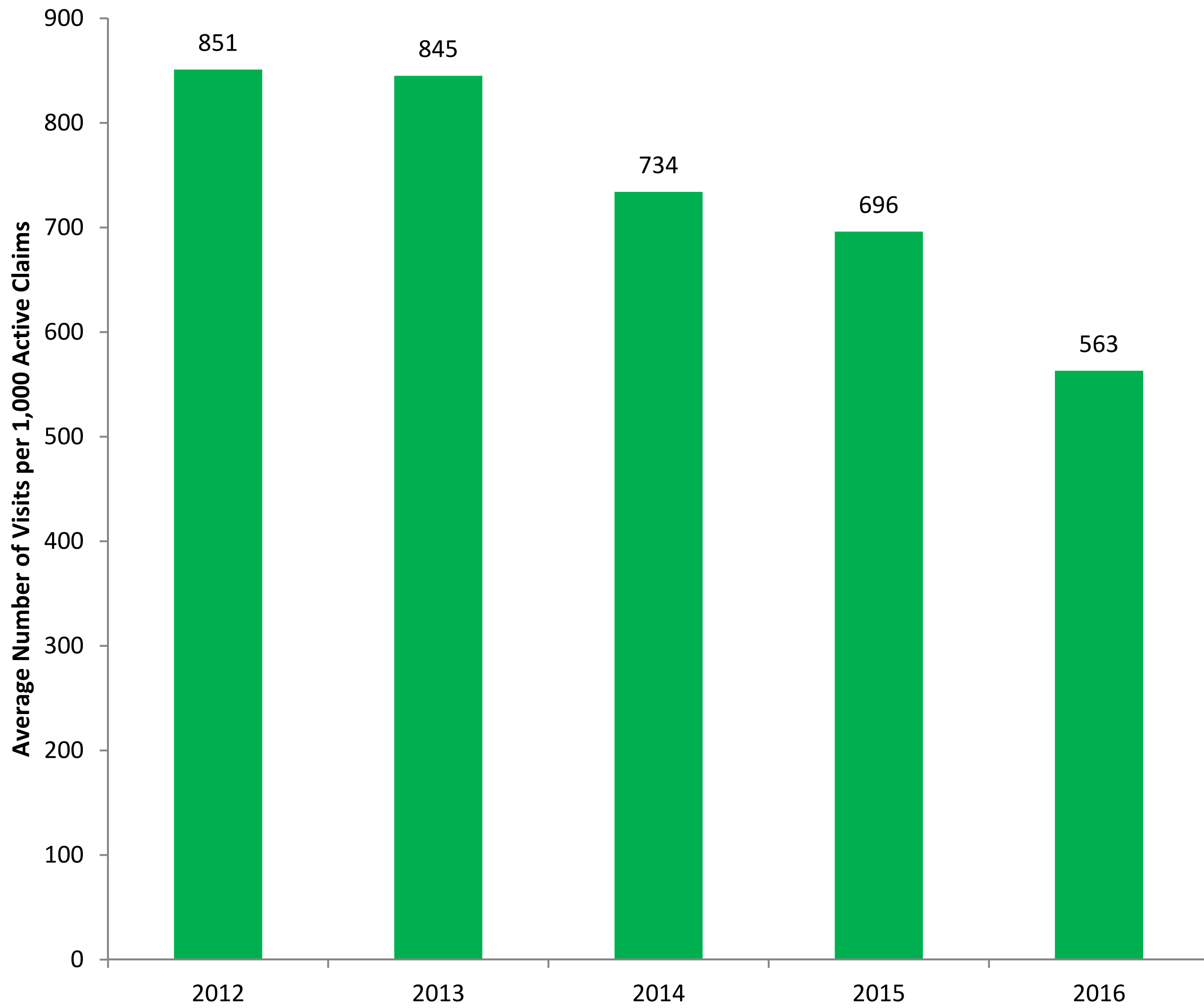

Exhibit 24A presents the average number of non-surgical hospital outpatient visits per 1,000 active claims.

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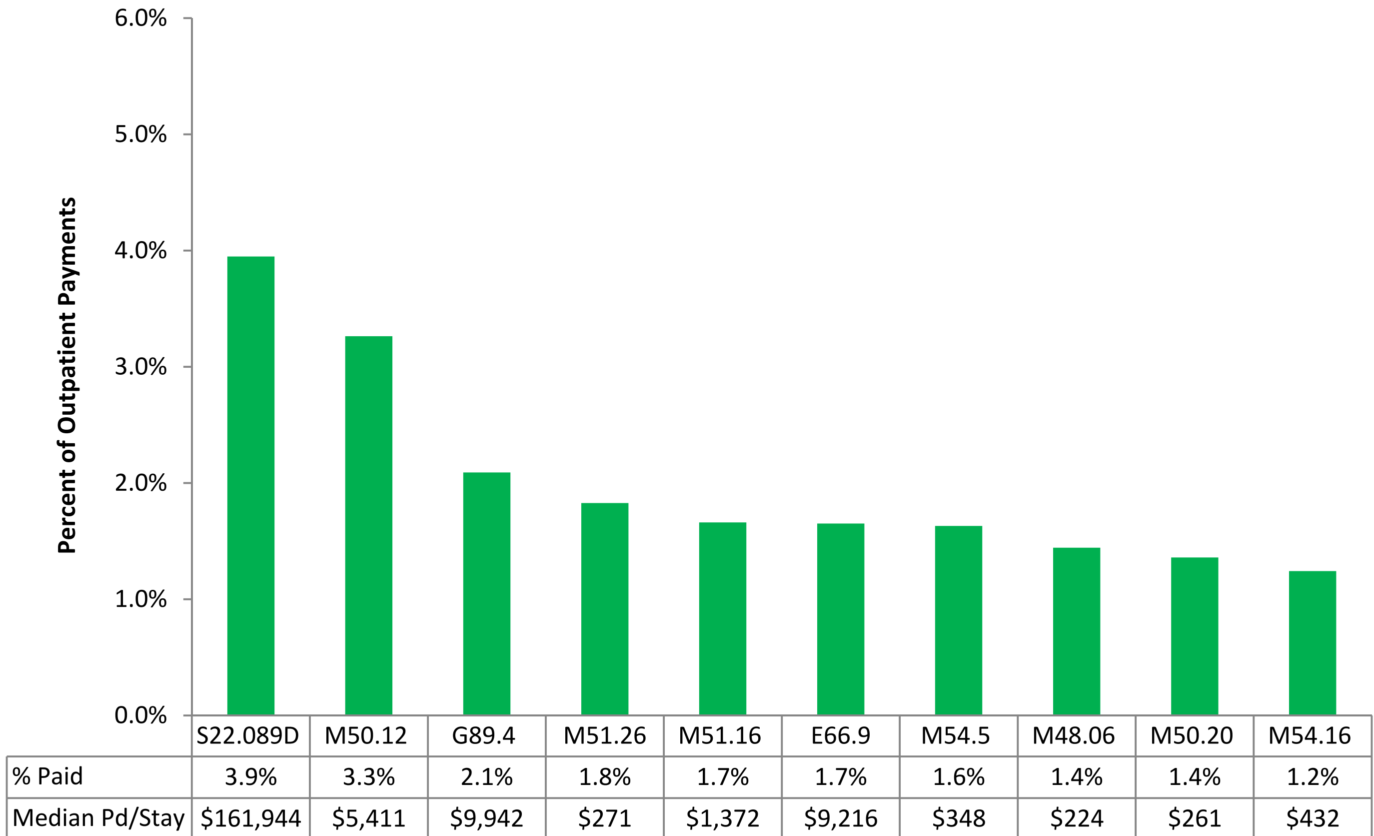
Exhibit 25

Top 10 Diagnoses by Amount Paid for Hospital Outpatient Services



	S22.089D	M50.12	G89.4	M51.26	M51.16	E66.9	M54.5	M48.06	M50.20	M54.16
% Paid	3.9%	3.3%	2.1%	1.8%	1.7%	1.7%	1.6%	1.4%	1.4%	1.2%
Median Pd/Stay	$161,944	$5,411	$9,942	$271	$1,372	$9,216	$348	$224	$261	$432

Code	Description
S22.089D	Unspecified fracture of T11-T12 vertebra, subsequent encounter for fracture with routine healing
M50.12	Cervical disc disorder with radiculopathy, mid-cervical region
G89.4	Chronic pain syndrome
M51.26	Other intervertebral disc displacement, lumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
E66.9	Obesity, unspecified
M54.5	Low back pain
M48.06	Spinal stenosis, lumbar region
M50.20	Other cervical disc displacement, unspecified cervical region
M54.16	Radiculopathy, lumbar region

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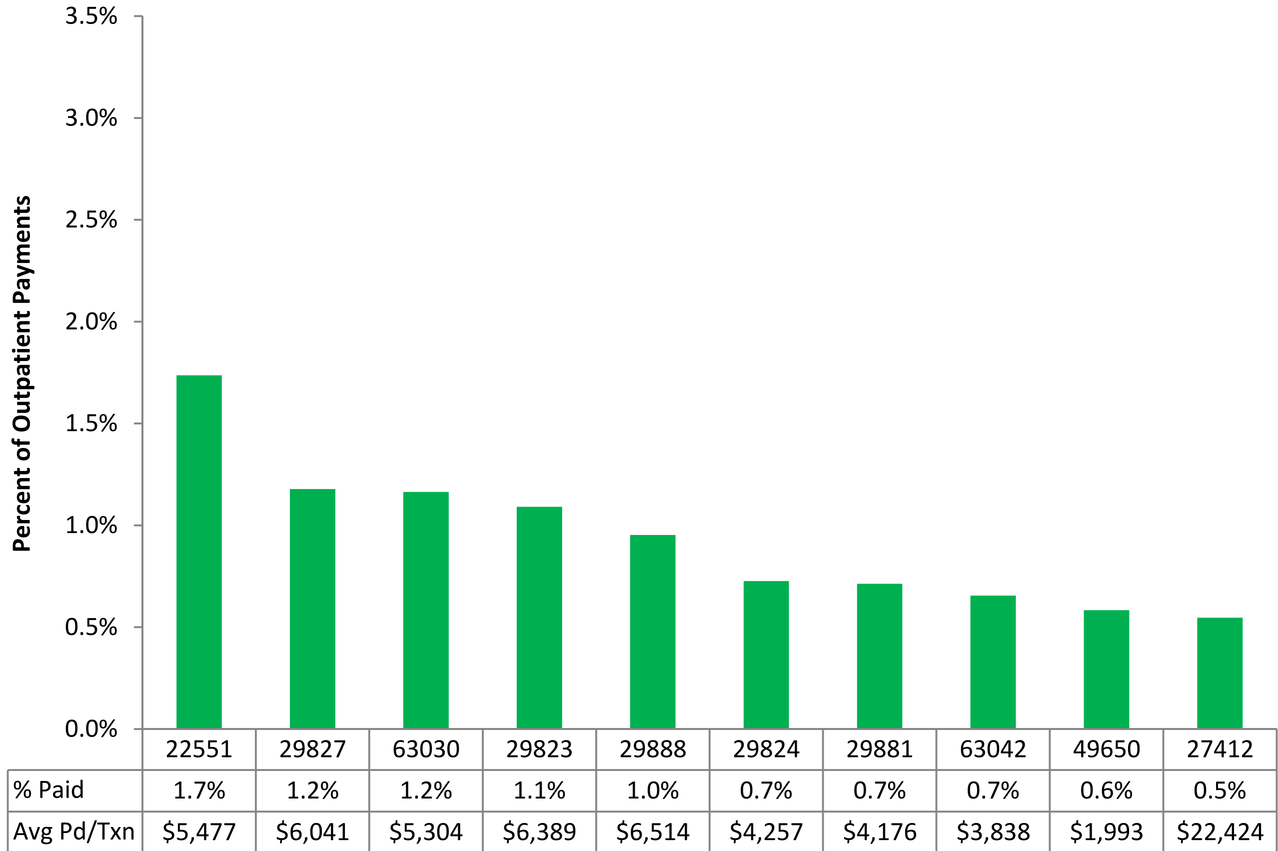
Exhibit 26
Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services



	22551	29827	63030	29823	29888	29824	29881	63042	49650	27412
% Paid	1.7%	1.2%	1.2%	1.1%	1.0%	0.7%	0.7%	0.7%	0.6%	0.5%
Avg Pd/Txn	$5,477	$6,041	$5,304	$6,389	$6,514	$4,257	$4,176	$3,838	$1,993	$22,424

Code	Description
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (mumford procedure)
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
49650	Laparoscopy, surgical; repair initial inguinal hernia
27412	Autologous chondrocyte implantation, knee

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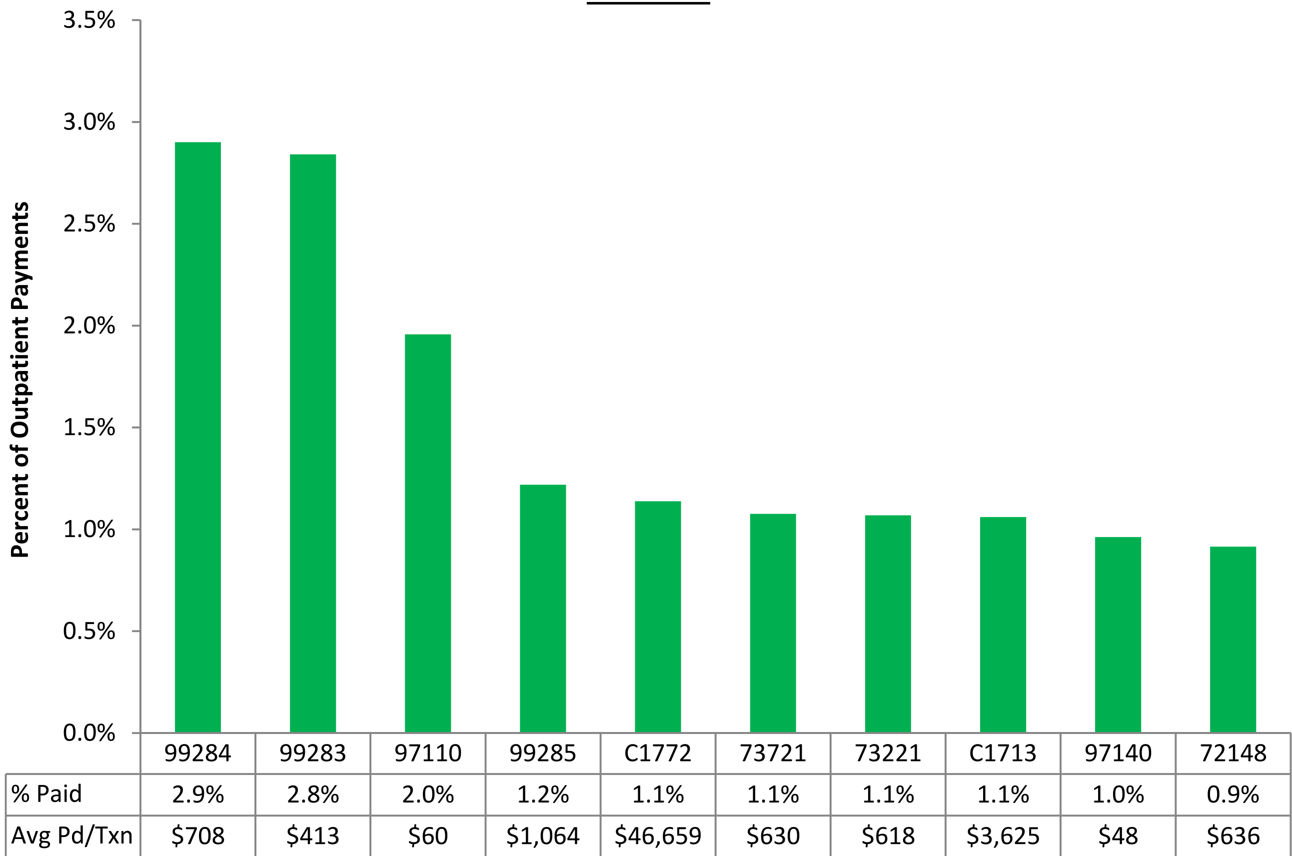
Exhibit 27
Top 10 Non-Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services



	99284	99283	97110	99285	C1772	73721	73221	C1713	97140	72148
% Paid	2.9%	2.8%	2.0%	1.2%	1.1%	1.1%	1.1%	1.1%	1.0%	0.9%
Avg Pd/Txn	$708	$413	$60	$1,064	$46,659	$630	$618	$3,625	$48	$636

Code	Description
99284	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99283	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
99285	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
C1772	Infusion pump, programmable (implantable)
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
C1713	Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material

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Facility Information

The next five exhibits represent different breakdowns of **Emergency Room** data trended over the most recent five year period.

Exhibit 28 presents the average paid amount per ER visits.

Exhibit 29 displays the average number of ER visits per 1,000 active claims.

Exhibit 30 presents a distribution of ER service payments by professional, facility and other categories.

Exhibit 31 presents the most recent five-year trend for Evaluation and Management procedure codes for Emergency Room Services. **Exhibit 31A** represents the same data, but sorted on transaction counts instead of paid amounts.

The source for all data is the DCRB Medical Data Call for Service Year 2016. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

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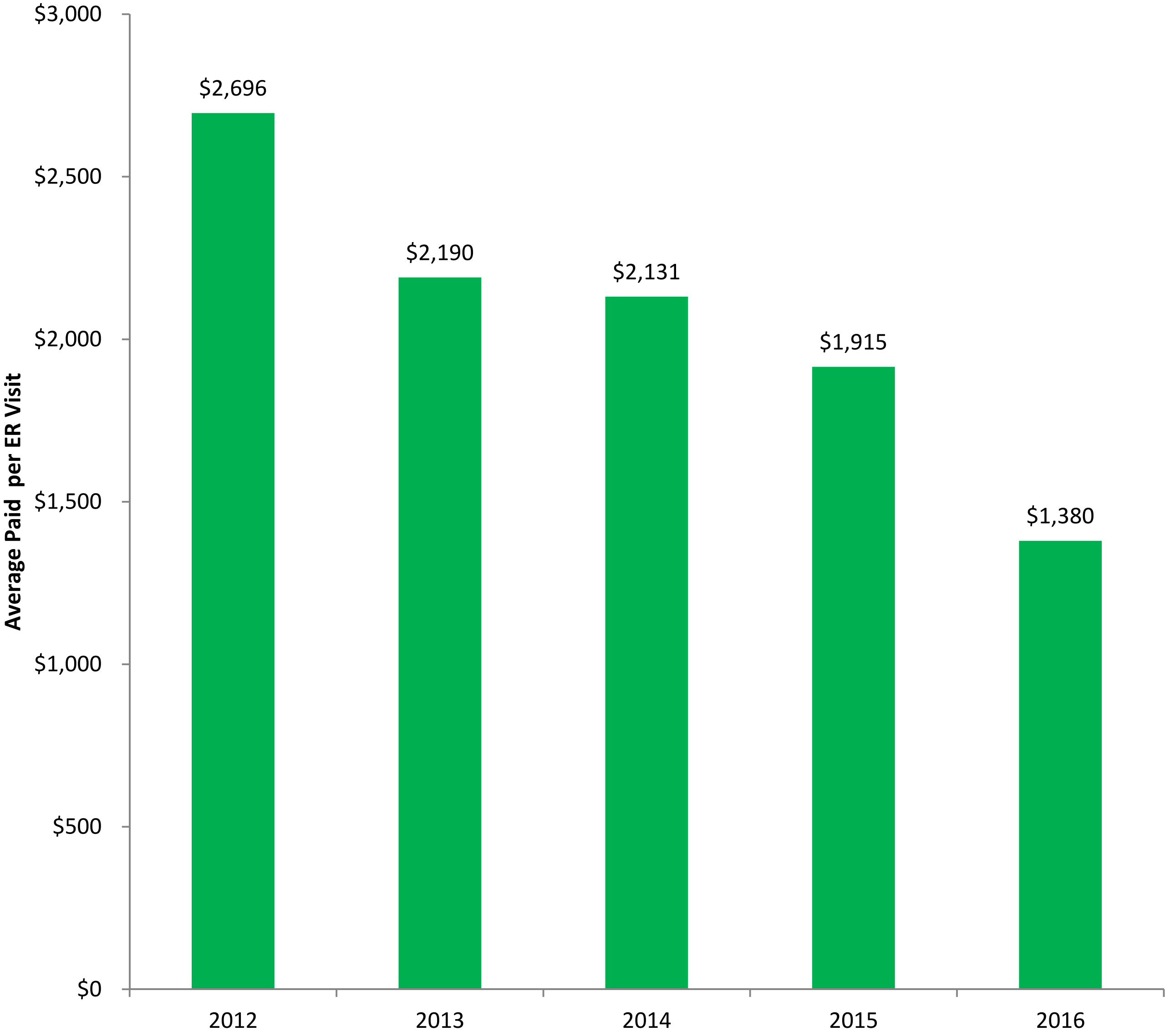

Exhibit 28 depicts the average amount paid per emergency room visit by service year. These results demonstrate a decline over the last five service years in the average amount paid per visit.

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Exhibit 29
Average Number of ER Visits per 1,000 Active Claims

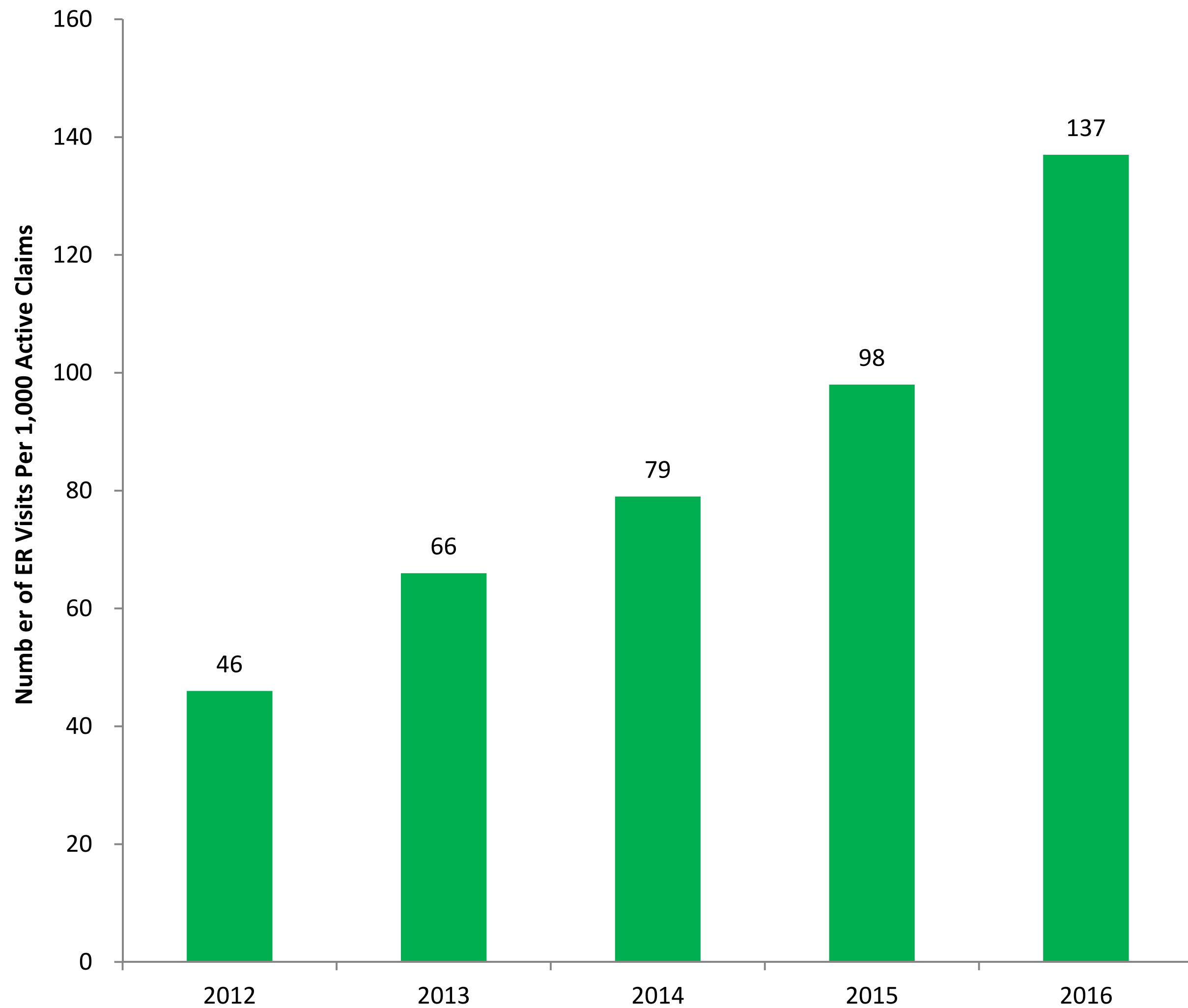

Exhibit 29 displays the number of emergency room visits per 1,000 active claims by service year. These results demonstrate an increasing trend in the number of emergency room visits over the last five years.

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Exhibit 30
Distribution of ER Service Payments

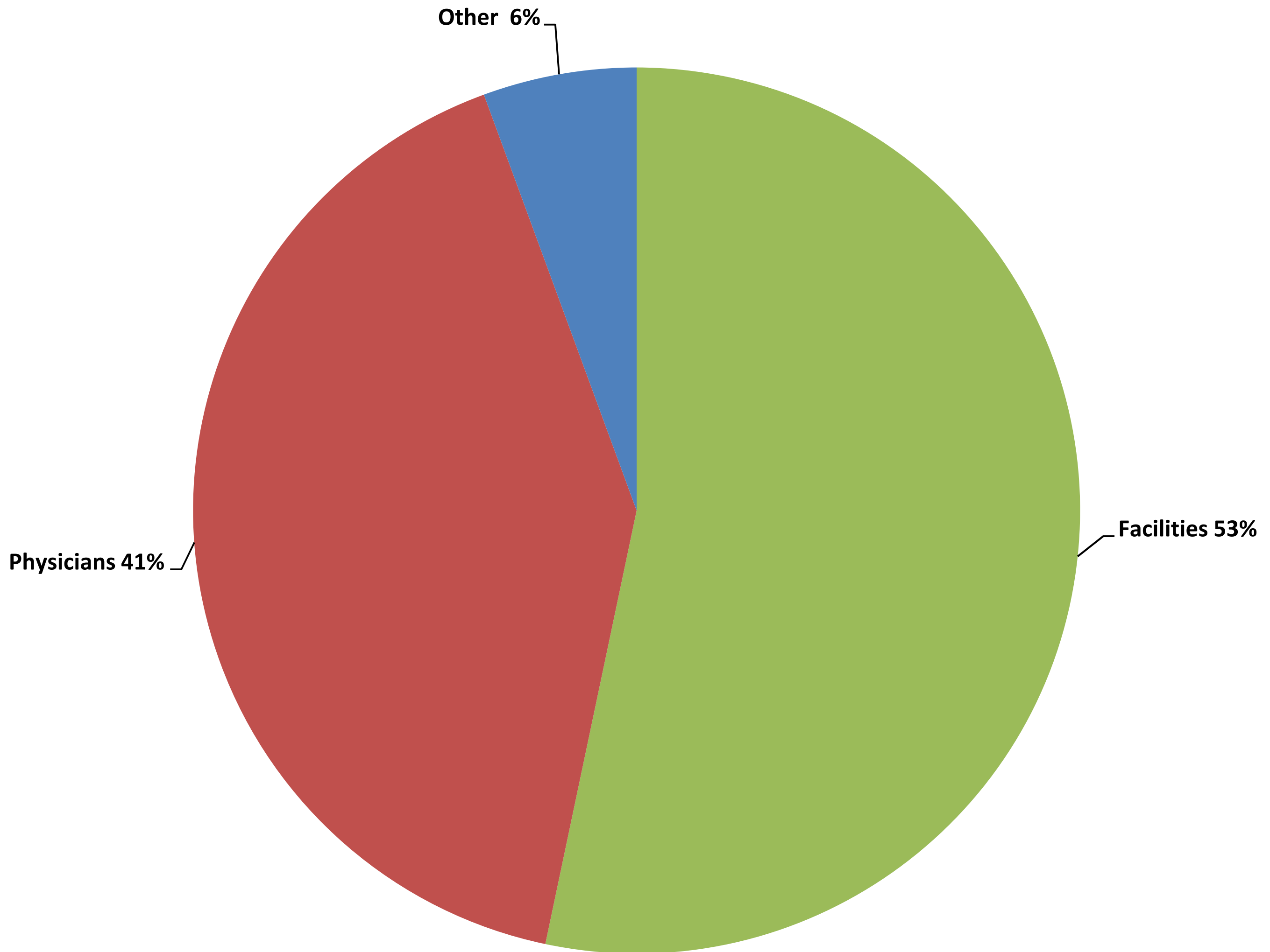

Exhibit 30 presents the distribution of payments by type of emergency room services. This exhibit describes the allocation of medical payments in this category. Payments to facilities represent the largest portion of payments made. Delaware results are typical of patterns observed in other states, where payments to facilities are the largest cost driver.

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Exhibit 31
Emergency Room Services by Procedure Codes Trend

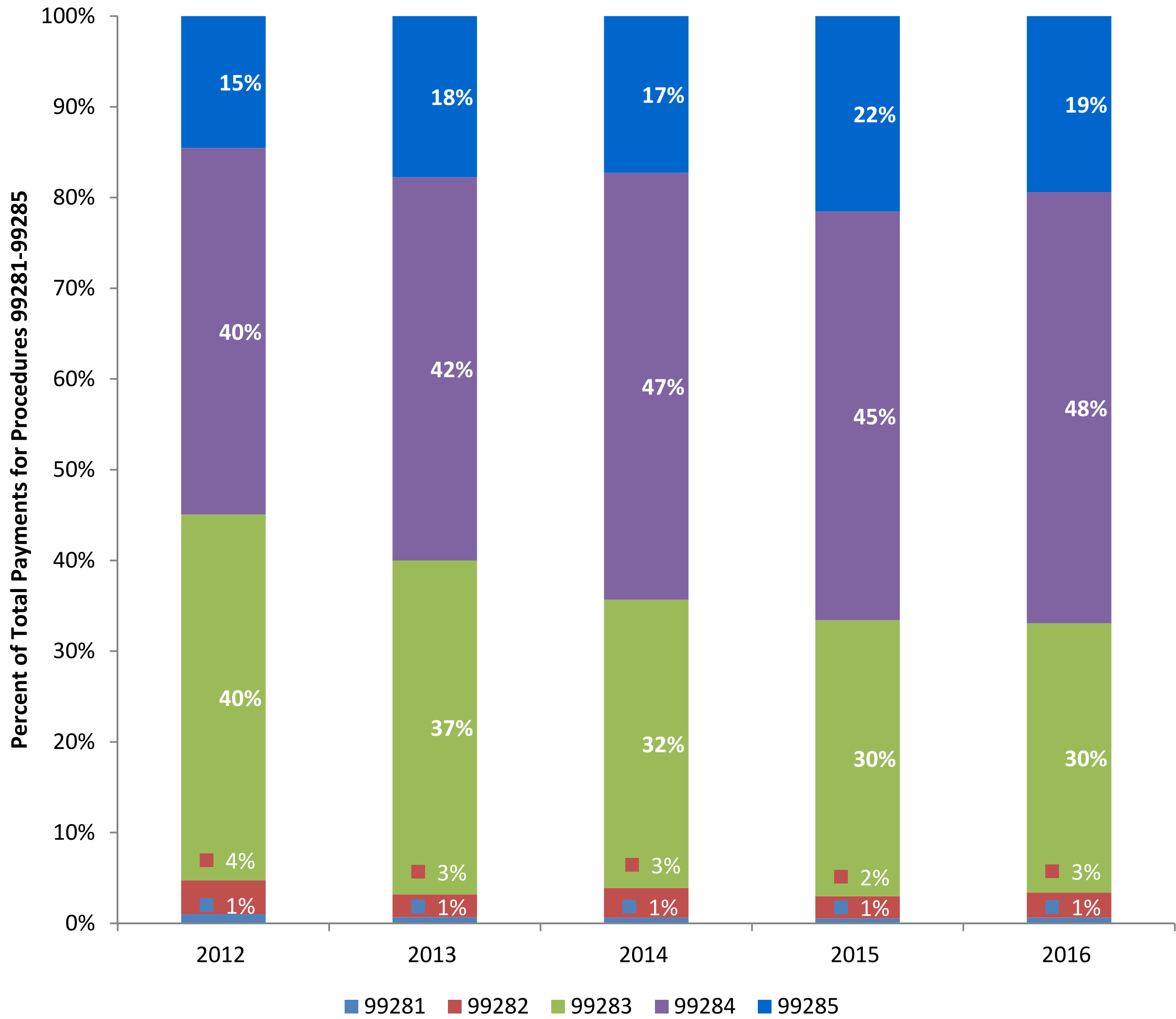

Exhibit 31 displays emergency room services by procedure codes trend by service year. This exhibit displays the distribution of payments for a period of five service years.

Refer to the Exhibit 31 continuation on the next page for the description of codes 99281-99285.

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Exhibit 31 (continued)
Top 5 Emergency Room Services by Procedure Codes Trend

Average Paid Per Transaction

	2012	2013	2014	2015	2016
99281	$116	$106	$91	$96	$109
99282	$154	$152	$154	$145	$141
99283	$228	$238	$242	$245	$241
99284	$362	$356	$378	$355	$384
99285	$479	$529	$554	$586	$560

Code	Description
99281	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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Exhibit 31A
Emergency Room Transactions by Procedure Code

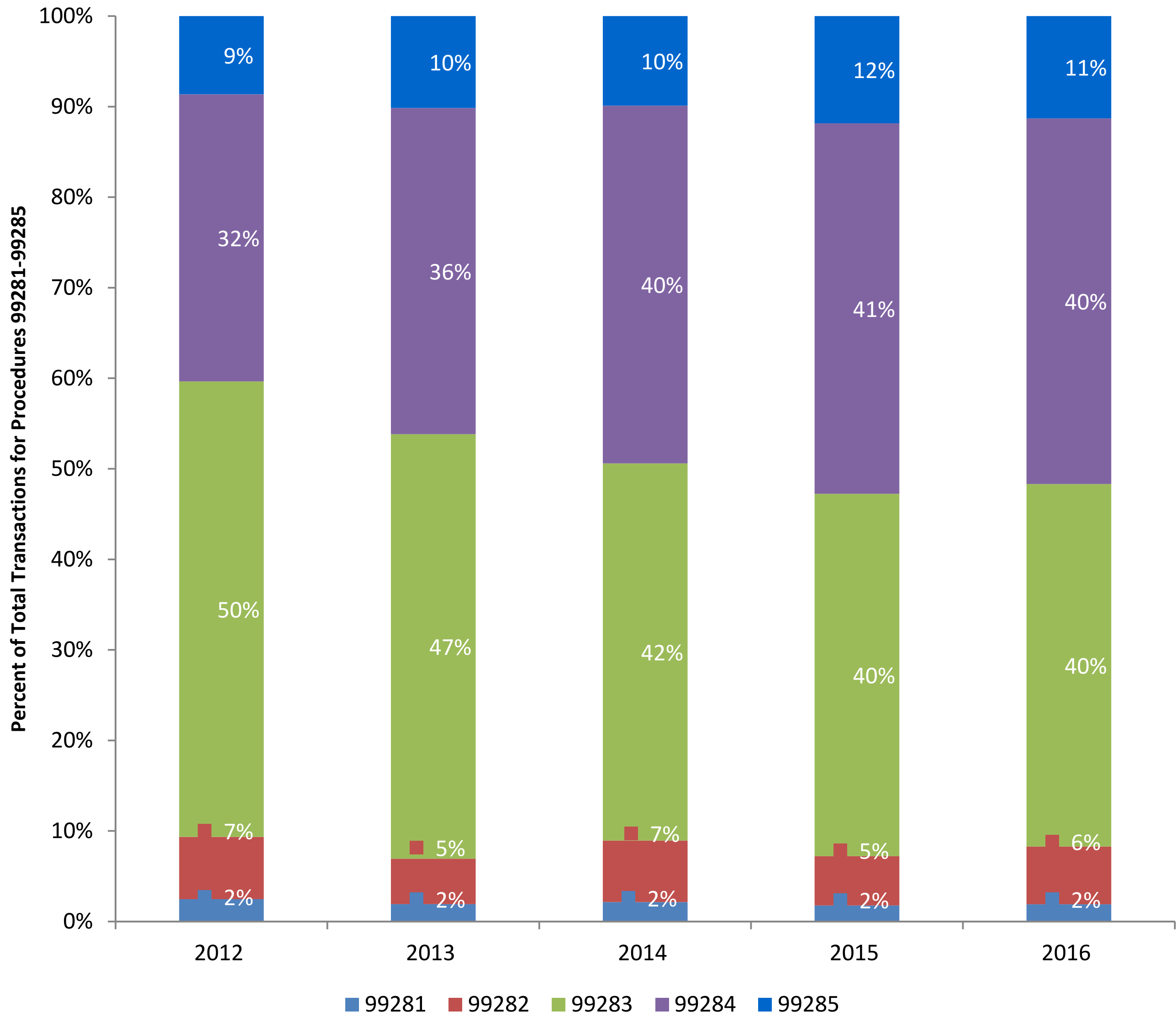

Exhibit 31A displays emergency room services by procedure codes trend by service year. This exhibit displays the distribution of transactions for a period of five service years.

Refer to the Exhibit 31A continuation on the next page for the description of codes 99281-99285.

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Exhibit 31A (continued)
Emergency Room Transactions by Procedure Code

Total Transactions

	2012	2013	2014	2015	2016
99281	49	33	34	26	29
99282	136	86	107	80	97
99283	996	803	657	588	610
99284	628	617	623	601	615
99285	171	174	156	174	172

Code	Description
99281	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are self-limited or minor.
99282	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of low to moderate severity.
99283	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.

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Facility Information

The next four exhibits in this section present different breakdowns of **Ambulatory Surgical Center (ASC)** data trended over the most recent five-year period.

Exhibit 32 presents the average outpatient paid amount per visit for ASC services. **Exhibit 32A** displays the average number of ASC visits per 1,000 active claims.

Exhibit 33 details the top 10 diagnoses by paid amount for ASC services. At the bottom of the exhibit, the ICD-10 diagnosis codes are displayed with detailed descriptions.

Exhibit 34 details the top 10 surgery CPT codes by paid amount for ASC services. At the bottom of the exhibit, the CPT codes are displayed with detailed descriptions.

The source for all data is the DCRB Medical Data Call for Service Year 2016. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

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Exhibit 32
Average Amount Paid Per Visit for ASC Services

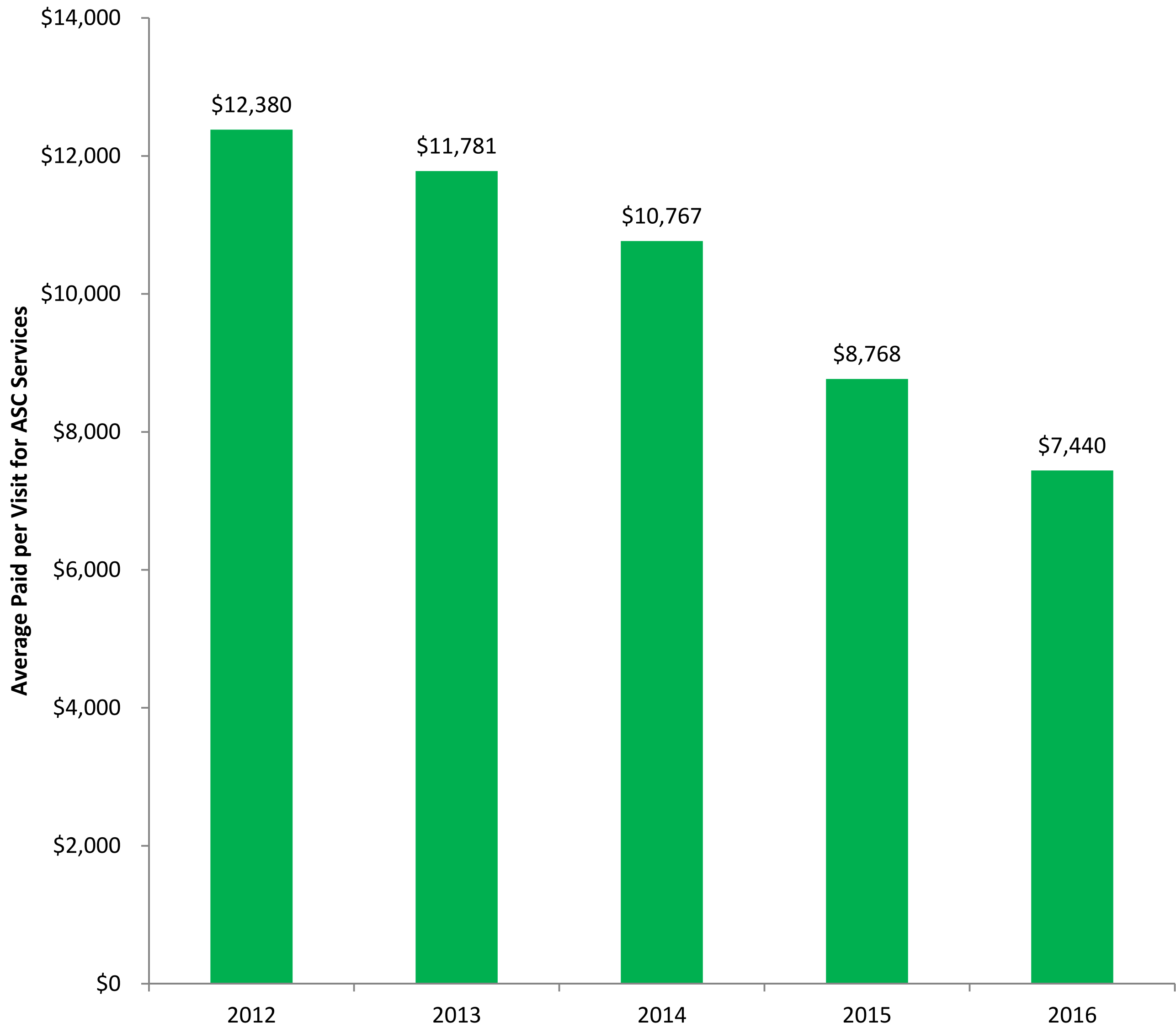

Exhibit 32 depicts the average amount paid per visit for Ambulatory Surgery Center services by service year over a five-year period. These results demonstrate a decline in the average amount paid per visit.

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<u>Exhibit 32A</u>
<u>Average Number of ASC Visits per 1,000 Active Claims</u>

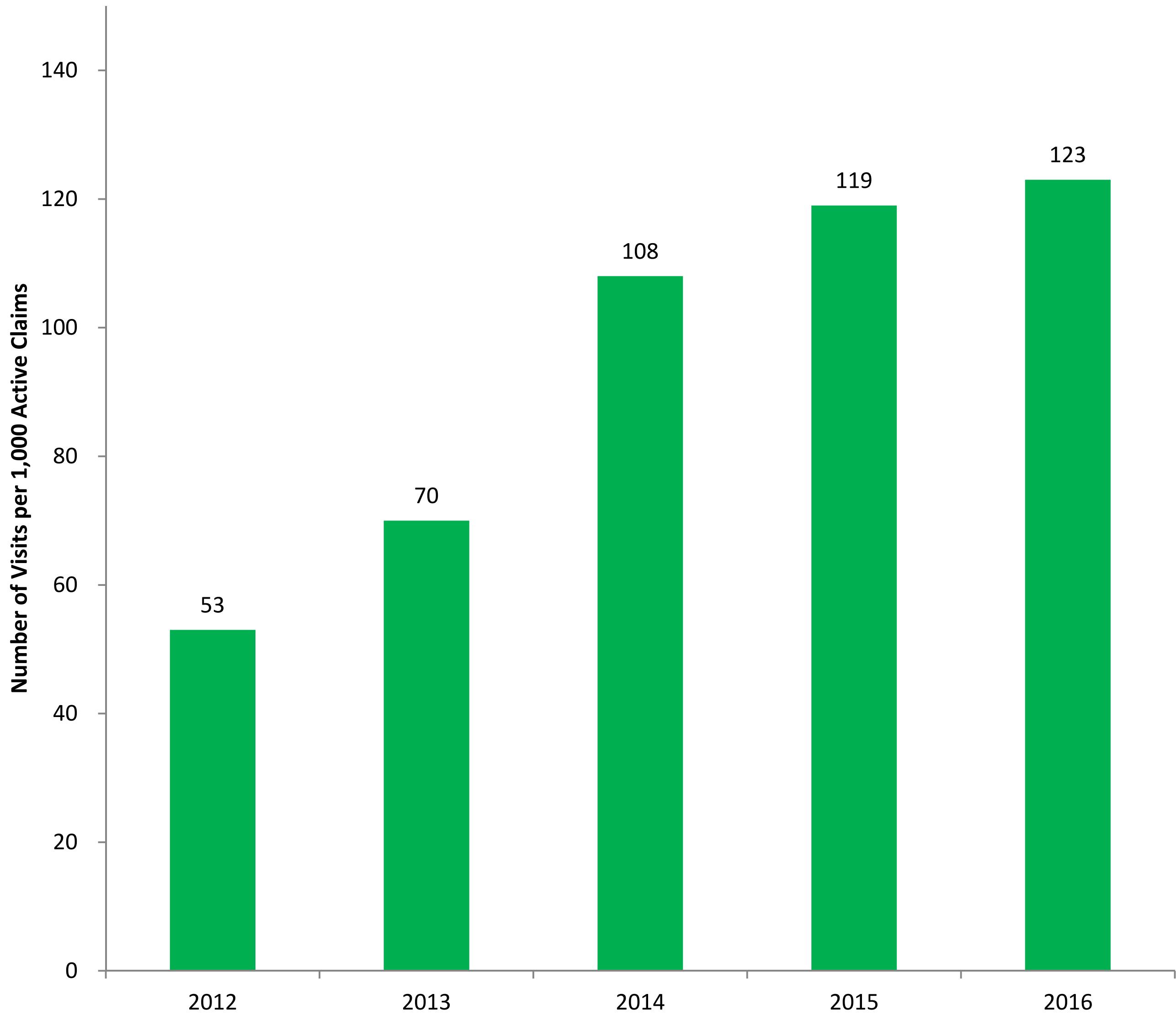

Exhibit 32A depicts the average number of for Ambulatory Surgery Center visits per 1,000 active claims over a five-year period.

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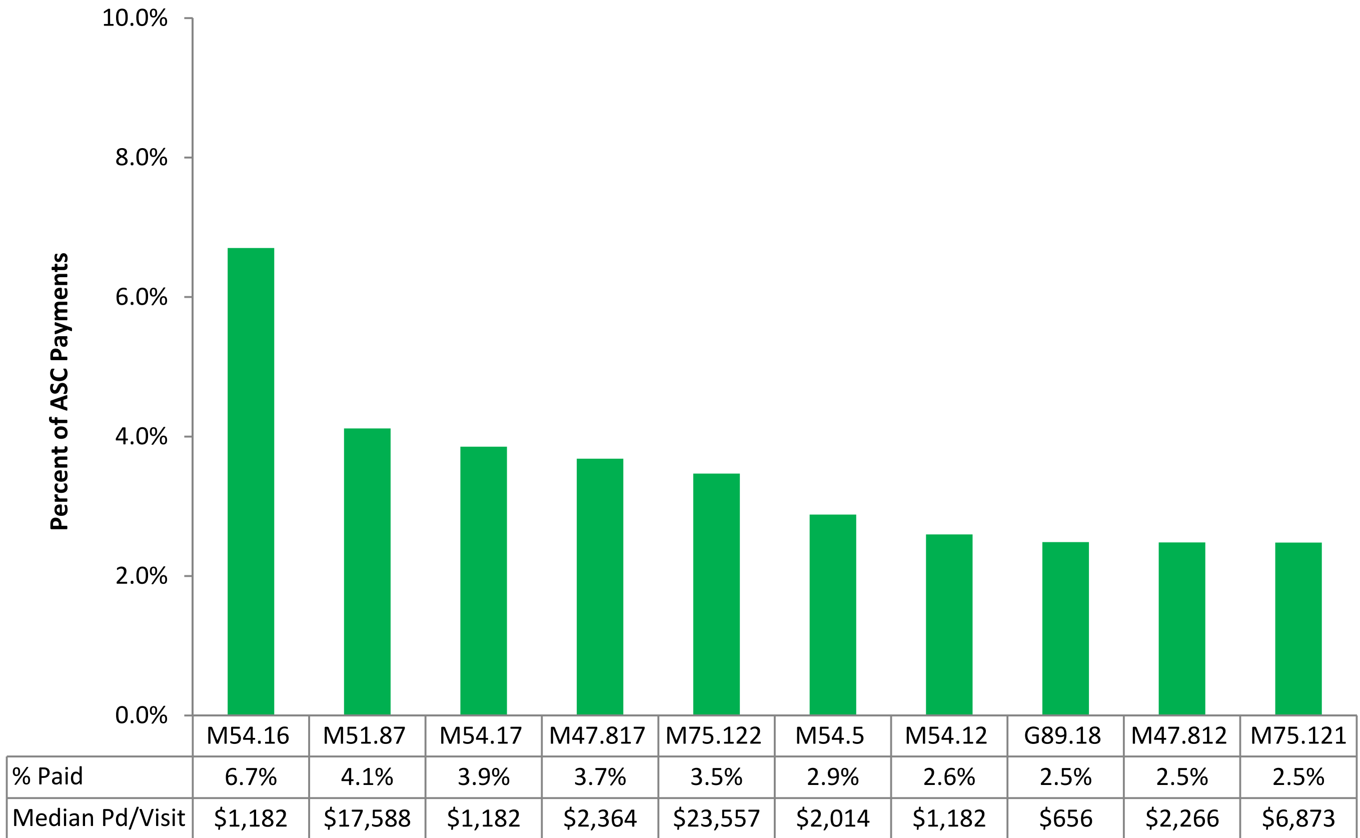
Exhibit 33
Top 10 Diagnoses by Amount Paid for ASC Services



	M54.16	M51.87	M54.17	M47.817	M75.122	M54.5	M54.12	G89.18	M47.812	M75.121
% Paid	6.7%	4.1%	3.9%	3.7%	3.5%	2.9%	2.6%	2.5%	2.5%	2.5%
Median Pd/Visit	$1,182	$17,588	$1,182	$2,364	$23,557	$2,014	$1,182	$656	$2,266	$6,873

Code	Description
M54.16	Radiculopathy, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M54.17	Radiculopathy, lumbosacral region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M75.122	Complete rotator cuff tear or rupture of left shoulder, not specified as traumatic
M54.5	Low back pain
M54.12	Radiculopathy, cervical region
G89.18	Other acute postprocedural pain
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M75.121	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic

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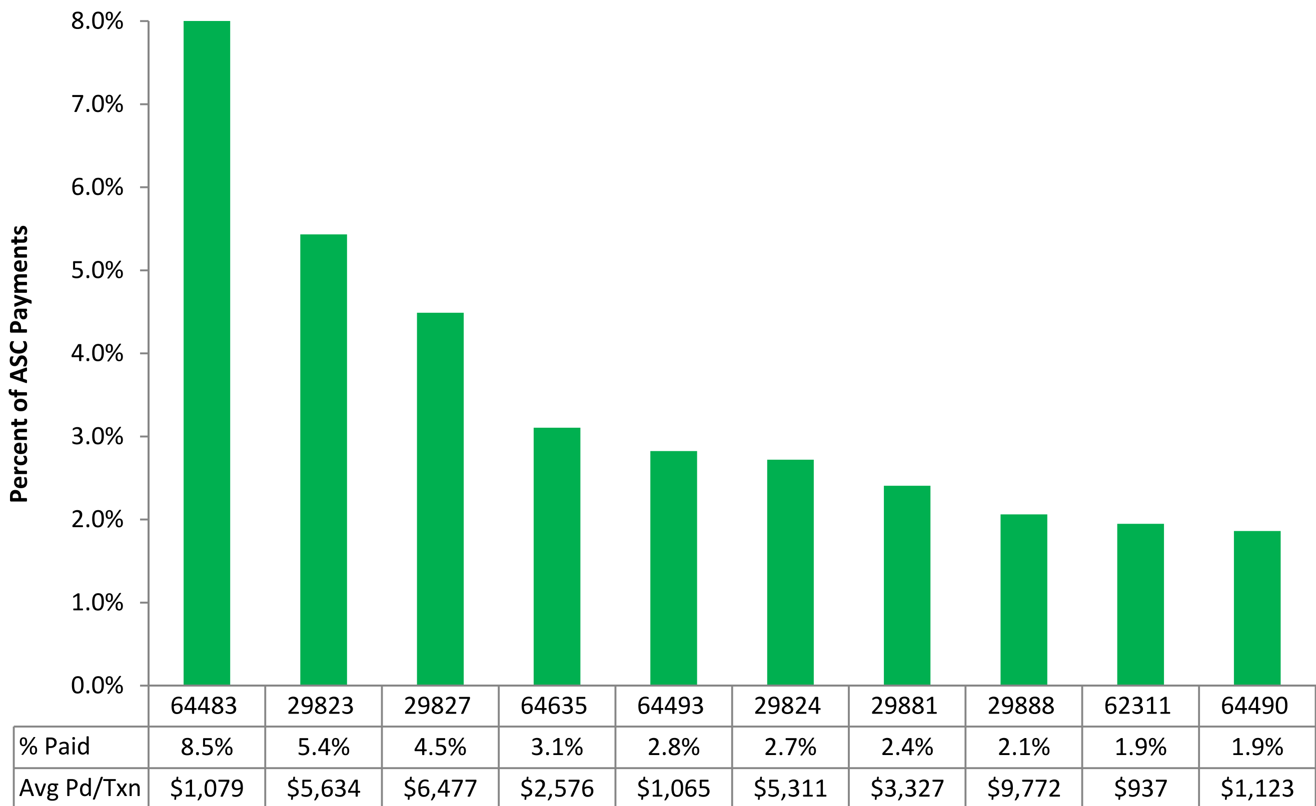
Exhibit 34
Top 10 Surgery Procedure Codes by Amount Paid for ASC Services



	64483	29823	29827	64635	64493	29824	29881	29888	62311	64490
% Paid	8.5%	5.4%	4.5%	3.1%	2.8%	2.7%	2.4%	2.1%	1.9%	1.9%
Avg Pd/Txn	$1,079	$5,634	$6,477	$2,576	$1,065	$5,311	$3,327	$9,772	$937	$1,123

Code	Description
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or ct); lumbar or sacral, single level
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); lumbar or sacral, single facet joint
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; single level
29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (mumford procedure)
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
62311	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; single level

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Prescription Drug Information

The next seven exhibits present different payment breakdowns of prescription drugs for the injured worker. Prescription drugs are identified and billed using national drug codes (NDC). The following exhibits identify the most frequently prescribed prescription drugs and other associated information.

Delaware implemented House Bill 175 of 2013 providing further regulation of prescription drugs in workers compensation. The formulary and fee methodology developed by the Health Care Advisory Panel for pharmacy services, prescription drugs and other pharmaceuticals included a mandated discount from average wholesale price for prescription drugs, elimination of repackaging fees, a requirement that all repackaged drugs be billed under the original NDC code for that drug, and the adoption of a preferred drug list.

Exhibit 35 lists the top 10 drugs based on the paid amount. **Exhibit 36** lists the top 10 drugs based on prescription counts.

Exhibit 36A displays the top 30 drugs by paid share percentage for 2016 and then shows the rank of those same drugs for the previous four years. This exhibit is intended to show escalating drugs over time.

Exhibit 37 provides the distribution of drugs prescribed as brand name and generic.

Exhibit 38 provides the distribution of prescription drug costs by the Controlled Substances Act (CSA) Schedule. For example, Schedule 2 drugs have a higher potential for abuse than Schedule 5 drugs.

Exhibit 39 provides the distribution of drugs dispensed at either a pharmacy or a non-pharmacy facility.

Exhibit 40 provides the distribution of drugs prescribed as repackaged and non-repackaged. Non-repackaged drugs account for 100% of this category, as repackaged drug billing was eliminated by House Bill 175.

For purposes of these exhibits, only NDC codes were used. If a payment for a prescription drug was made using other codes such as a HCPCS or revenue code, it was excluded from this analysis. The source for all data is the DCRB Medical Data Call for Service Year 2016. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

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Exhibit 35
Top 10 Workers Compensation Drugs by Amount Paid

#	Name of Drug	Type B/G	Category	% of Drug Payments
1	Oxycontin	B	Analgesics/Antipyretics	9.3%
2	Gabapentin	G	Anticonvulsants	8.3%
3	Lyrica	B	Misc. Central Nervous System Agents	6.2%
4	Oxycodone HCL	G	Analgesics/Antipyretics	5.9%
5	Oxycodone HCL-Acetaminophen	G	Analgesics/Antipyretics	4.4%
6	Lidocaine	G	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	3.1%
7	Percocet	B	Analgesics/Antipyretics	3.1%
8	Terocin	B	Skin & Mucous Membrane Agents	2.9%
9	Duloxetine HCL	G	Central Nervous System Agents	2.2%
10	Cyclobenzaprine HCL	G	Muscle Relaxants, Skeletal	2.2%

Exhibit 36
Top 10 Workers Compensation Drugs by Prescription Counts

#	Name of Drug	Type B/G	Category	% of Drug Prescriptions
1	Oxycodone HCL	G	Analgesics/Antipyretics	10.5%
2	Gabapentin	G	Anticonvulsants	6.8%
3	Oxycodone HCL-Acetaminophen	G	Analgesics/Antipyretics	6.7%
4	Cyclobenzaprine HCL	G	Muscle Relaxants, Skeletal	5.9%
5	Ibuprofen	G	Analgesics/Antipyretics	4.0%
6	Tizanidine HCL	G	Muscle Relaxants, Skeletal	3.6%
7	Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	3.5%
8	Morphine Sulfate	G	Analgesics/Antipyretics	3.4%
9	Oxycontin	B	Analgesics/Antipyretics	3.3%
10	Tramadol HCL	G	Analgesics/Antipyretics	3.2%

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Exhibit 36A
Top 30 Drugs for Service Year 2016

Paid Share Service Year 2016	Drug Name	Brand/Generic Status	2016	2015	2014	2013	2012
10.2%	Oxycontin	Brand	1	1	1	1	1
8.3%	Gabapentin	Generic for Neurontin	2	2	2	5	6
6.1%	Lyrica	Brand	3	5	5	4	4
5.8%	Oxycodone HCL	Generic for Oxycontin (if extended release)	4	3	3	7	3
4.6%	Oxycodone HCL-Acetaminophen	Generic for Percocet	5	4	4	8	7
3.5%	Percocet	Brand	6	6	6	6	8
3.0%	Terocin	Brand	7	7	10	53	n/a
3.0%	Lidocaine	Generic for Xylocaine	8	8	8	35	230
2.3%	Duloxetine HCL	Generic for Cymbalta	9	9	7	115	n/a
2.0%	Cyclobenzaprine HCL	Generic for Flexeril	10	10	14	17	18
2.0%	Morphine sulfate	Generic for Avinza, Kadian, Ms Contin	11	11	9	16	11
1.6%	Hydromorphone HCL	Generic for Dllaudid, Dilaudid-5, Exalgo	12	12	21	37	30
1.5%	Tizanidine HCL	Generic for Zanaflex	13	15	16	15	16
1.4%	Flurbiprofen	Generic for Ansaid	14	13	32	77	n/a
1.3%	Duragesic	Brand for Fentanyl	15	17	12	18	24
1.3%	Nucynta	Brand	16	20	27	29	33
1.1%	Lidopro Patch	Brand	17	80	n/a	n/a	n/a
1.1%	Meloxicam	Generic for Mobic, Vivlodex	18	19	15	14	20
1.1%	Celecoxib	Generic for Celebrex	19	18	115	n/a	n/a
1.1%	Ketamine HCL	Generic for Ketalar	20	14	22	32	82
1.0%	Flector	Brand	21	16	23	9	13
1.0%	Baclofen	Generic for Lioresal, Gablofen	22	25	35	65	67
0.9%	Relistor	Brand	23	33	122	n/a	n/a
0.9%	Topiramate	Generic for Topamax	24	23	24	24	29
0.9%	Ondansetron	Generic for Zofran	25	83	103	64	64
0.9%	Zofran	Brand	26	26	26	28	45
0.9%	Oxymorphone HCL	Generic for Opana, Opana ER	27	29	33	42	55
0.8%	Metaxalone	Generic for Skelaxin	28	21	25	23	27
0.8%	Opana ER	Brand	29	22	19	12	9
0.8%	Tramadol HCL	Generic for Conzip, Ultram	30	28	18	20	25

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Exhibit 37
Distribution of Drugs by Brand Name and Generic

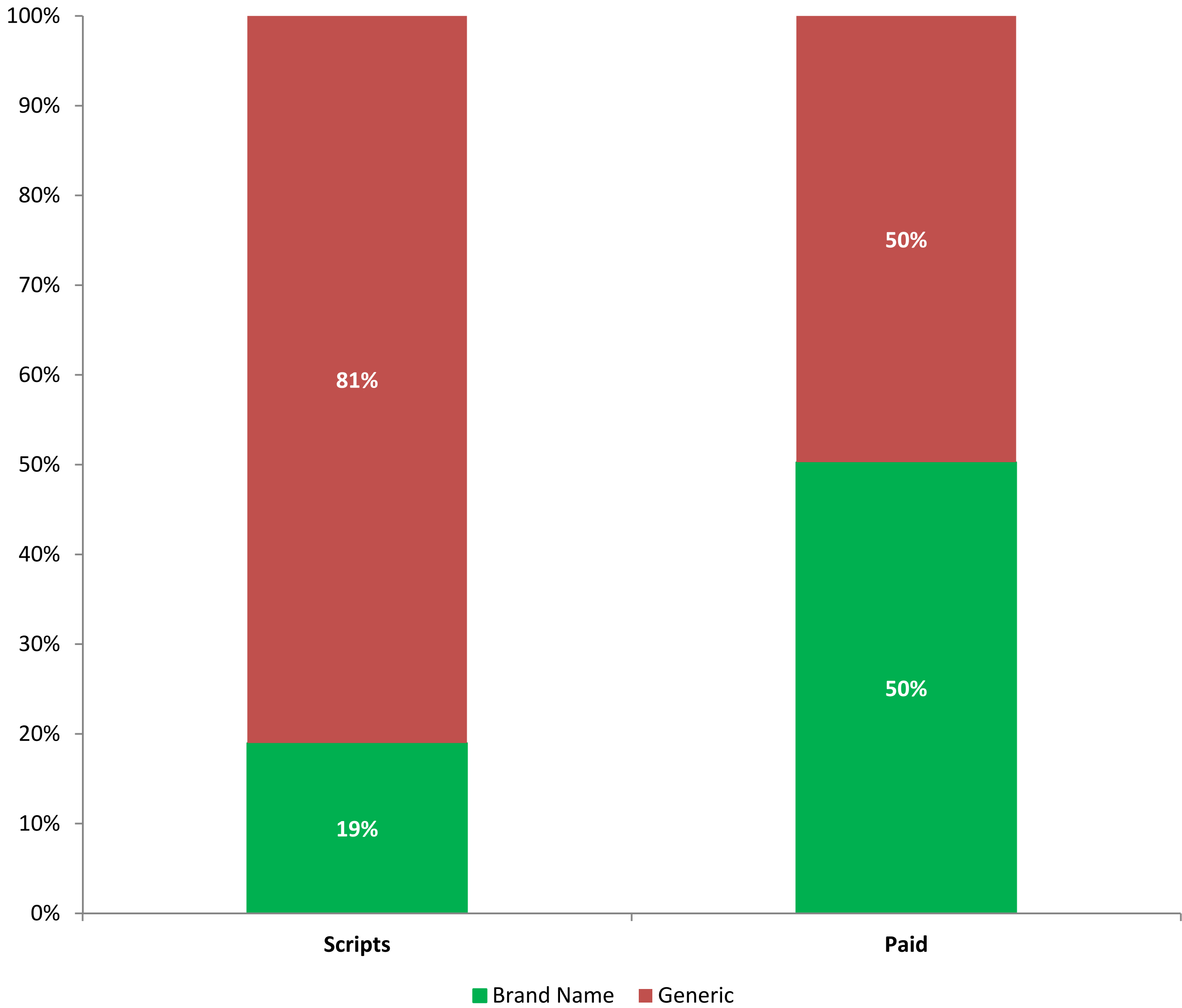

Exhibit 37 depicts the distribution of drugs organized by brand name versus generic. These results reveal that significantly fewer prescriptions are written using the brand name than generic equivalent. However, the brand name drugs represent half of the total dollars paid.

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Exhibit 38
Distribution of Prescription Drug Costs by CSA Schedule

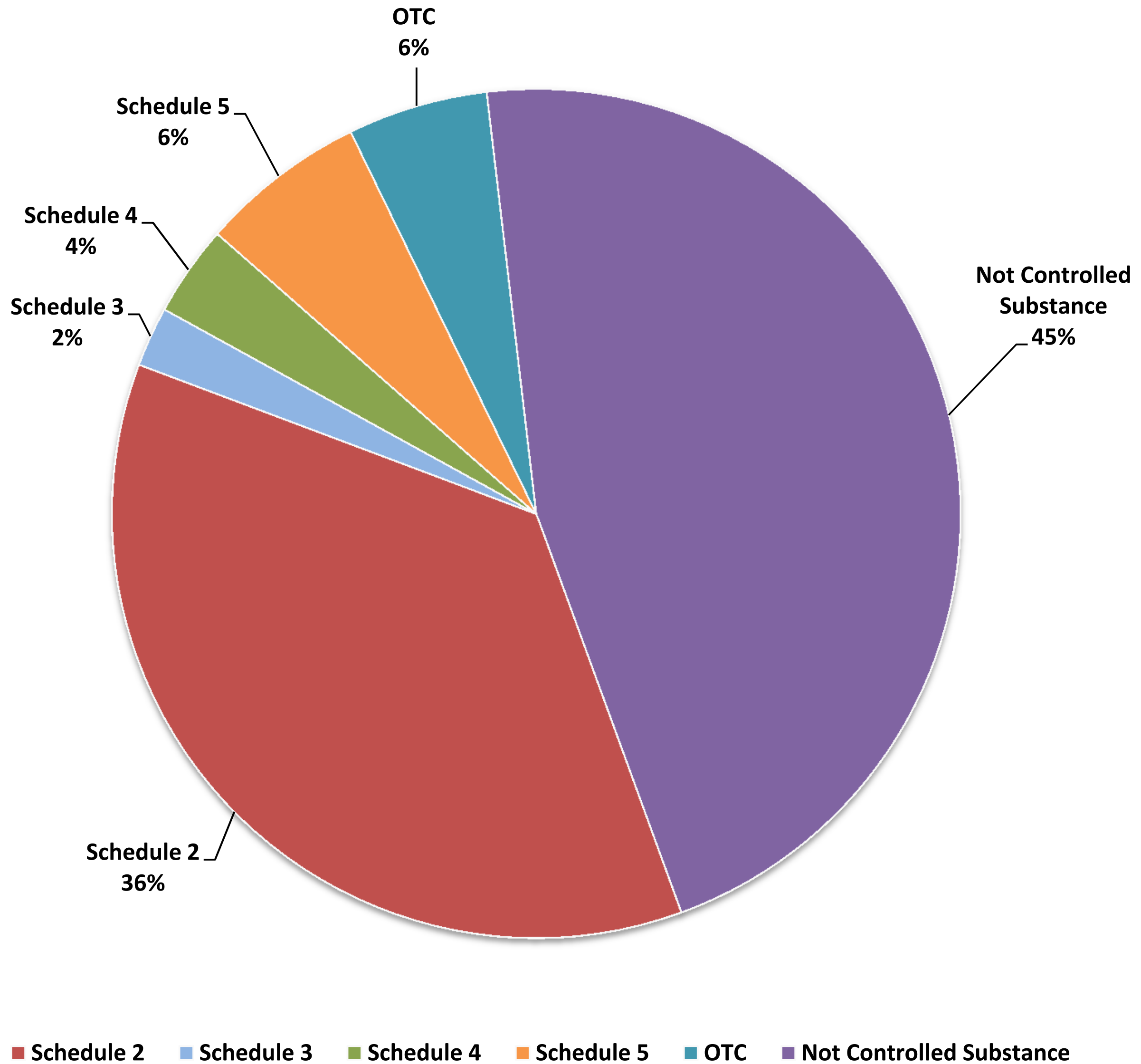

Exhibit 38 presents the distribution of payments of prescription drug costs by CSA schedule. This exhibit displays the allocation of drug payments by schedule. Payments in the non-controlled substances category make up the largest portion of payments (45%), followed by payments made for Schedule 2 drugs (36%). Note that Schedule 1 is not included because Schedule 1 drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse.

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Exhibit 39
Distribution of Drugs by Pharmacy and Non-Pharmacy

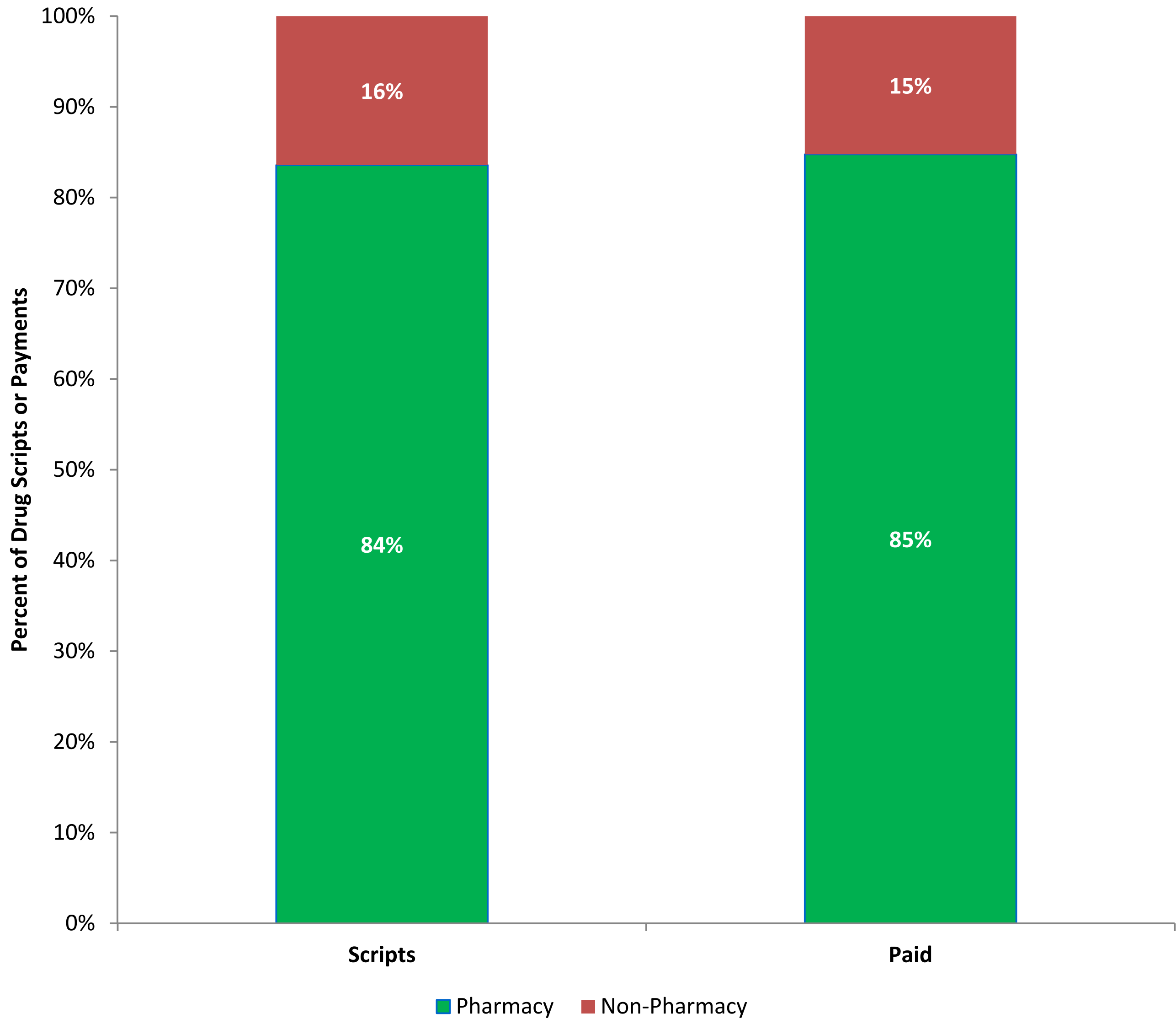

Exhibit 39 is a distribution of drugs dispensed at either a pharmacy (retail, mail order, or institutional) or a non-pharmacy facility. Examples of non-pharmacy dispensing locations include doctor's offices, home health care and hospitals. These results suggest that a large majority of prescription drugs are dispensed at a pharmacy.

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Exhibit 40
Distribution of Drugs by Repackaged and Non-Repackaged

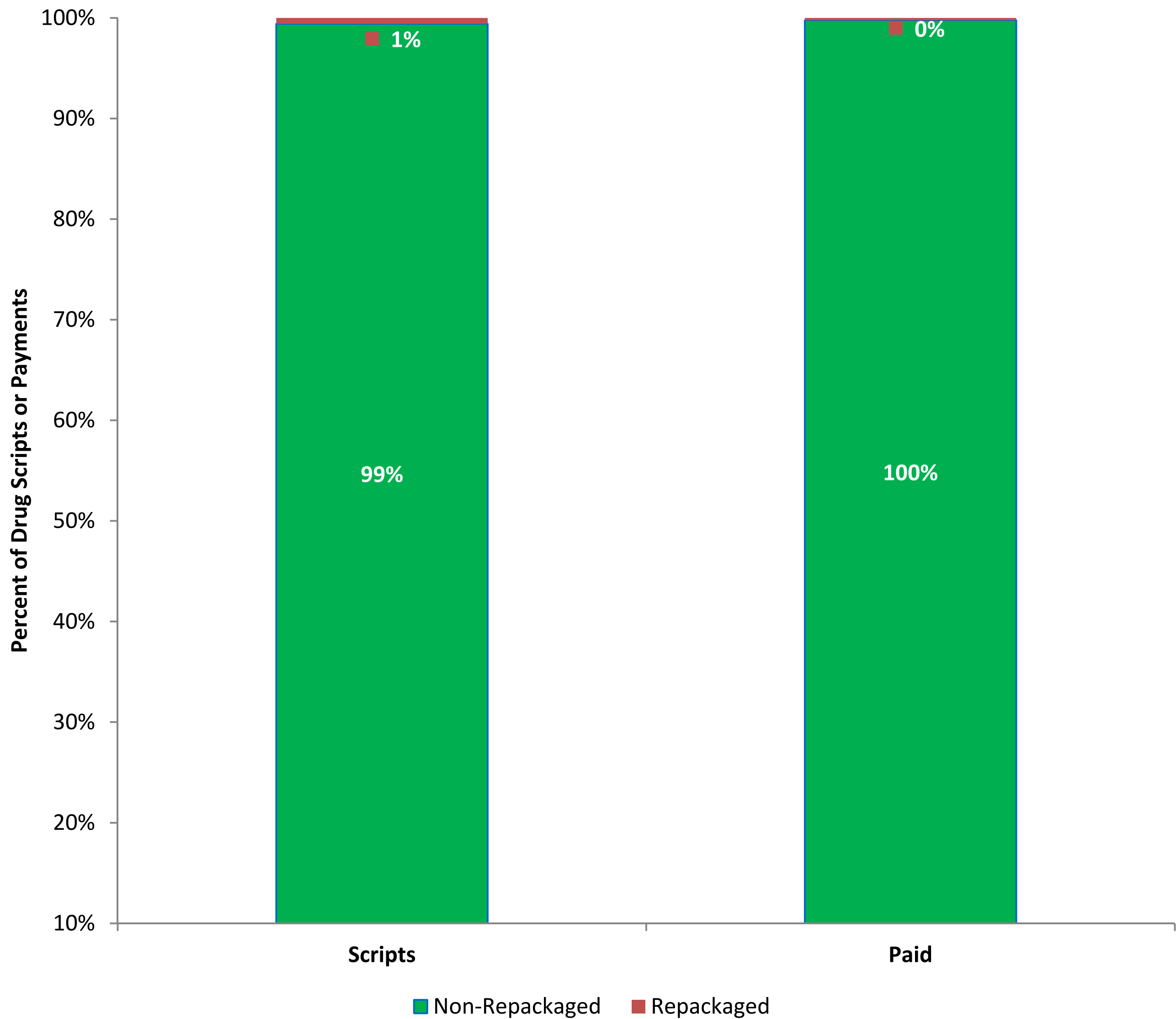

Exhibit 40 is a distribution of drugs prescribed as repackaged and non-repackaged. Per House Bill 175 of 2013, if a prescription drug or medicine has been repackaged, the Average Wholesale Price (AWP) used to determine the maximum reimbursement shall be the AWP for the underlying drug product, as identified by its national drug code (NDC) from the original labeler. Non-repackaged drugs account for 100% of this category, as repackaged drug billing was eliminated by House Bill 175. This exhibit suggests that 100% of all prescription drugs are reimbursed at the underlying NDC amount.

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Other Medical Activity Information

The next six exhibits represent additional medical activity information which may be of interest.

Exhibit 41 presents the distribution of payments by durable medical equipment (DME), supplies and implants.

Exhibit 42 details the top five orthotics and prosthetics codes by paid amount.

Exhibit 43 details the top five DME codes by paid amount.

Exhibit 44 details the top five medical supplies, other than DME codes, by paid amount.

Exhibits 42 through 44 identify the most frequently billed codes in each category. At the bottom of each exhibit, the codes are displayed with detailed descriptions.

Exhibit 45 details the top 10 diagnoses by paid amount for Dates of Injury in 2014. This exhibit includes diagnosis data that is more mature. At the bottom of the exhibit, the ICD-10 diagnosis codes are displayed with detailed descriptions.

Exhibit 46 provides the distribution of physician and facility payments based on the state in which the performing provider is located.

The source for all data is the DCRB Medical Data Call for Service Year 2016. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

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Exhibit 41
Distribution of Payments by DME, Suppliers and Implants

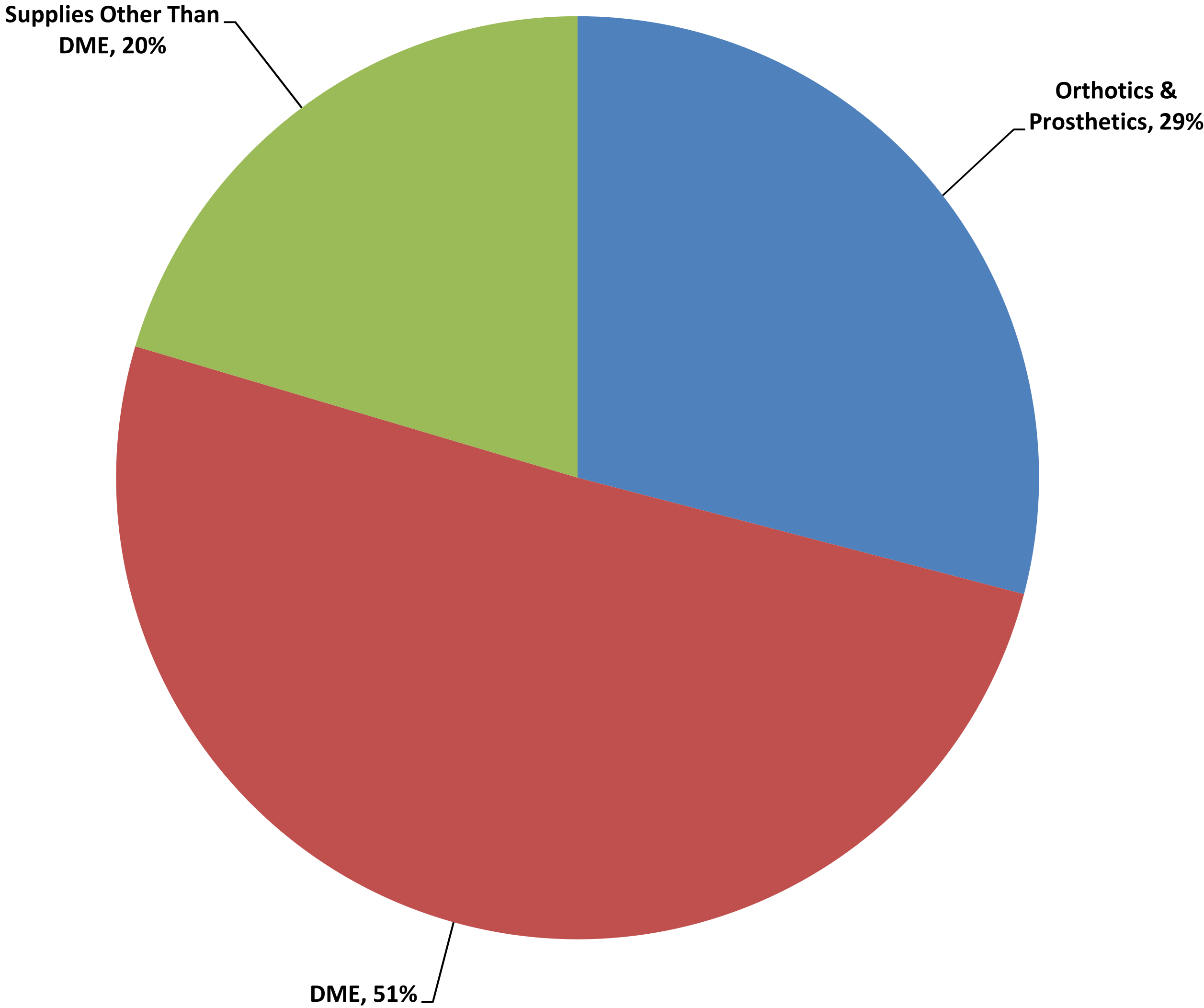

Exhibit 41 presents the distribution of payments by durable medical equipment (DME), orthotics and prosthetics, medical supplies and implants. This exhibit shows us that DME makes up the largest portion of payments followed by payments made for orthotics and prosthetics.

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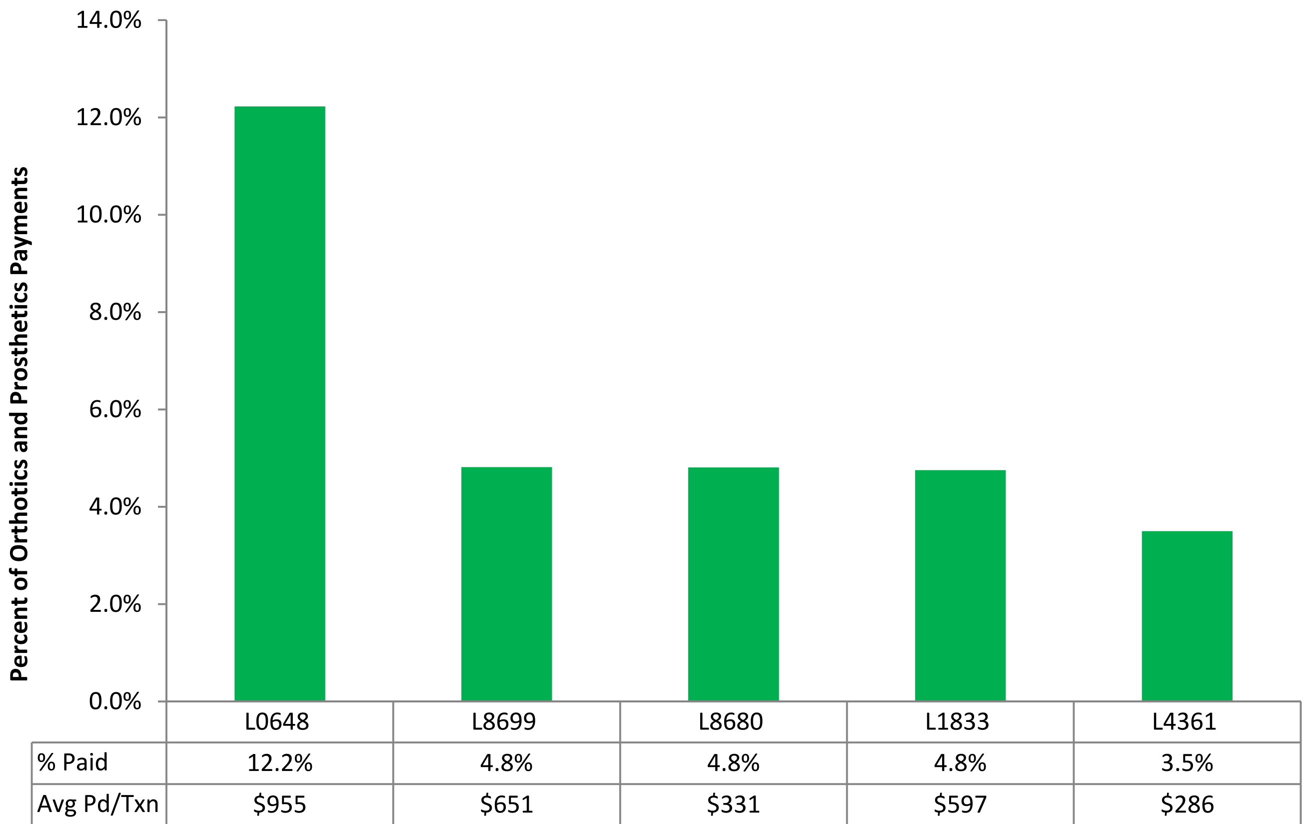
Exhibit 42
Top 5 Orthotics and Prosthetics Codes by Amount Paid



	L0648	L8699	L8680	L1833	L4361
% Paid	12.2%	4.8%	4.8%	4.8%	3.5%
Avg Pd/Txn	$955	$651	$331	$597	$286

Code	Description
L0648	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may
L8699	Prosthetic implant, not otherwise specified
L8680	Implantable neurostimulator electrode, each
L1833	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf
L4361	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf

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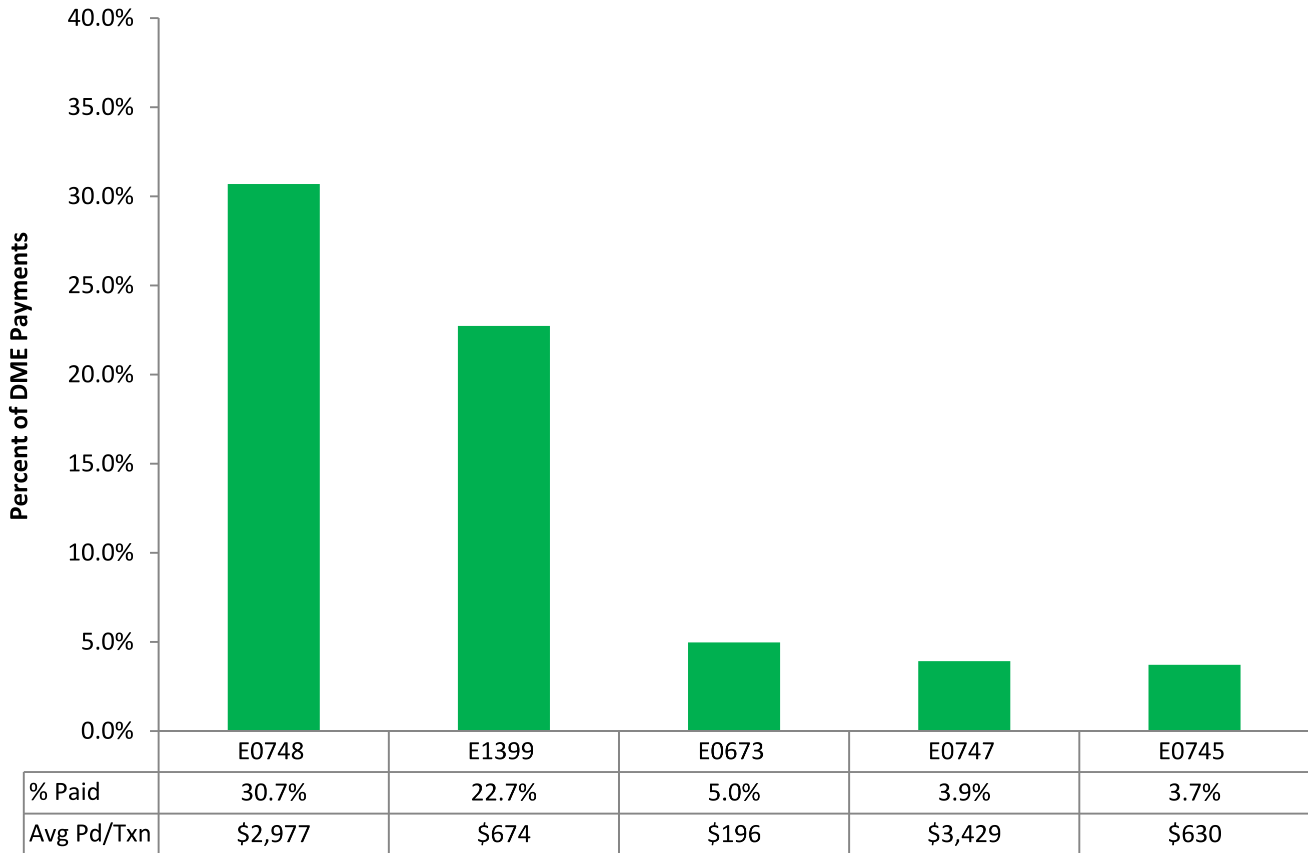

	E0748	E1399	E0673	E0747	E0745
% Paid	30.7%	22.7%	5.0%	3.9%	3.7%
Avg Pd/Txn	$2,977	$674	$196	$3,429	$630

Code	Description
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications
E1399	Durable medical equipment, miscellaneous
E0673	Segmental gradient pressure pneumatic appliance, half leg
E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications
E0745	Neuromuscular stimulator, electronic shock unit

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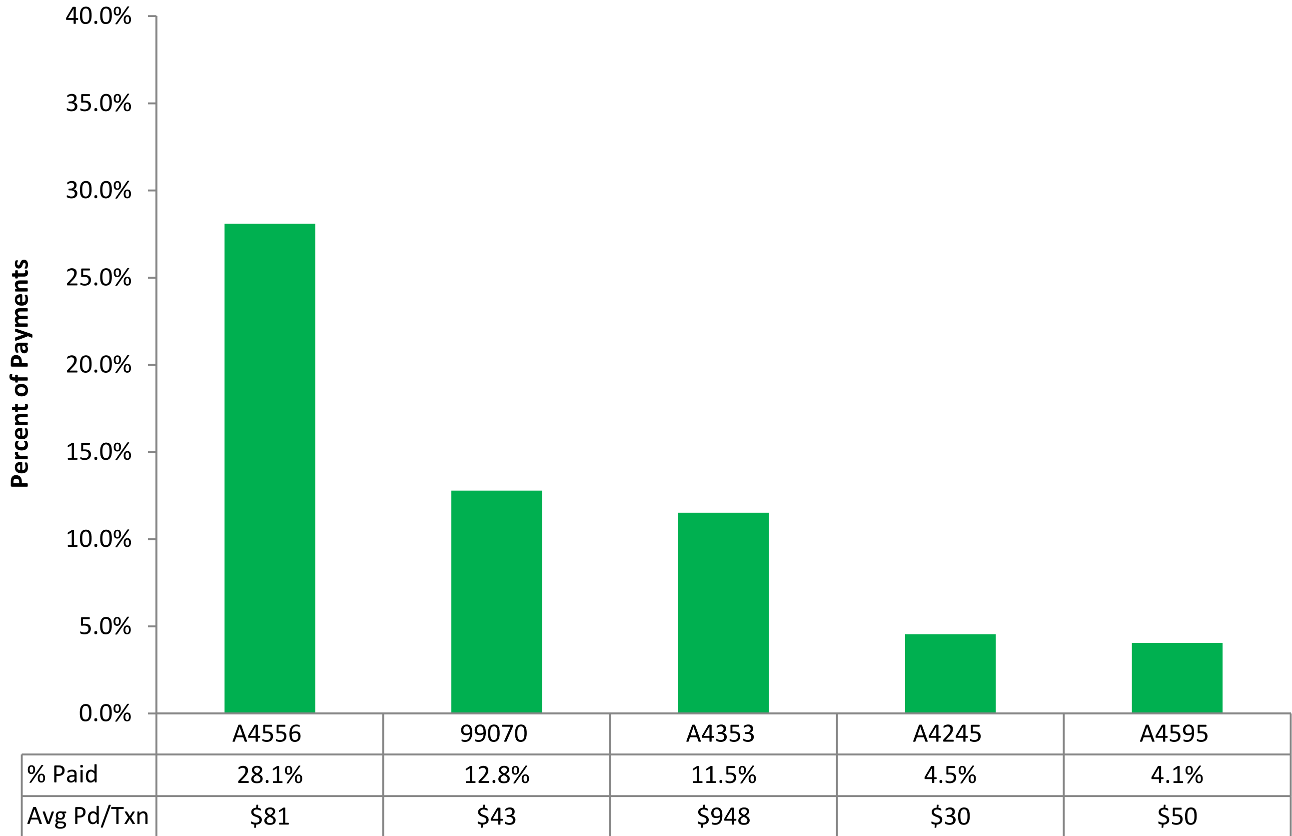

	A4556	99070	A4353	A4245	A4595
% Paid	28.1%	12.8%	11.5%	4.5%	4.1%
Avg Pd/Txn	$81	$43	$948	$30	$50

Code	Description
A4556	Electrodes, (e.g., apnea monitor), per pair
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
A4353	Intermittent urinary catheter, with insertion supplies
A4245	Alcohol wipes, per box
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES)

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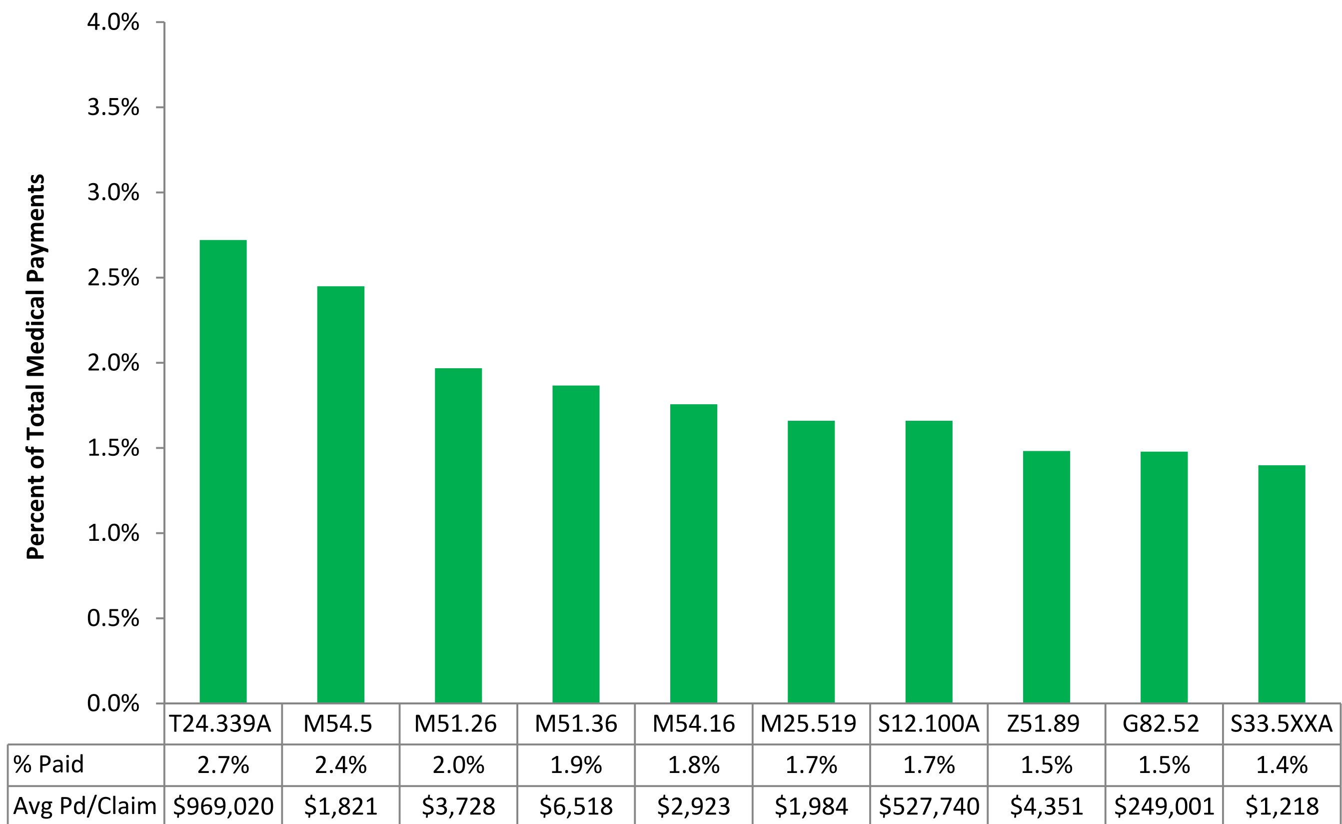
Exhibit 45
Top 10 Diagnoses by Amount Paid for Dates of Injury in 2015



	T24.339A	M54.5	M51.26	M51.36	M54.16	M25.519	S12.100A	Z51.89	G82.52	S33.5XXA
% Paid	2.7%	2.4%	2.0%	1.9%	1.8%	1.7%	1.7%	1.5%	1.5%	1.4%
Avg Pd/Claim	$969,020	$1,821	$3,728	$6,518	$2,923	$1,984	$527,740	$4,351	$249,001	$1,218

Code	Description
T24.339A	Burn of third degree of unspecified lower leg, initial encounter
M54.5	Low back pain
M51.26	Other intervertebral disc displacement, lumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M54.16	Radiculopathy, lumbar region
M25.519	Pain in unspecified shoulder
S12.100A	Unspecified displaced fracture of second cervical vertebra, initial encounter for closed fracture
Z51.89	Encounter for other specified aftercare
G82.52	Quadriplegia, C1-C4 incomplete
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter

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Exhibit 46
Distribution of Physician and Facility Payments by Provider State

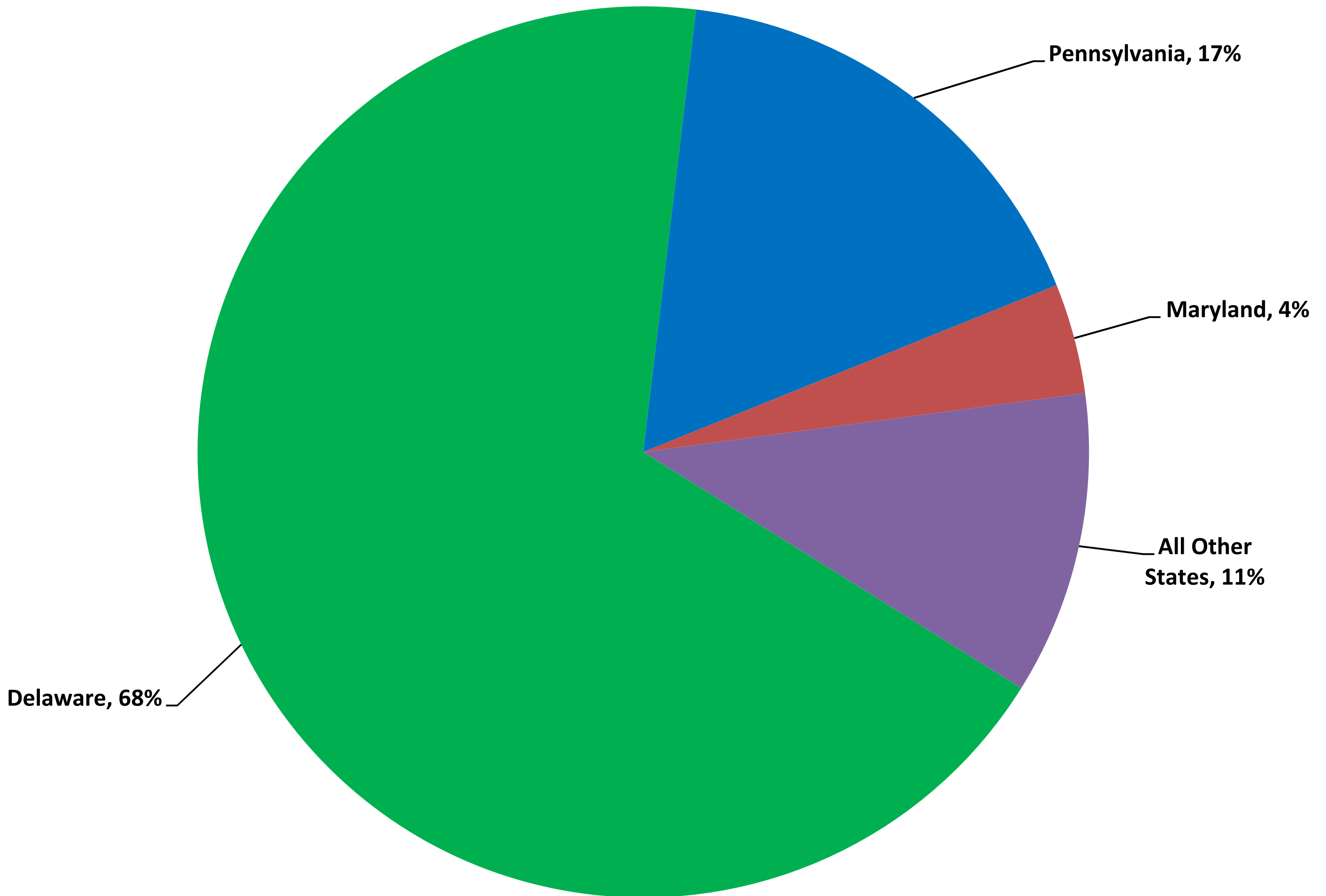

Exhibit 46 presents the distribution of payments to the medical/service provider by the address where the service was performed. Injured workers receiving Delaware benefits may seek treatment within Delaware or outside the state of Delaware. The majority of injured workers access services in the state of Delaware but approximately 32% of services are paid to a provider with an out-of-state zip code. This scenario may occur for a variety of reasons but one example is if the injured worker has since moved out of state and still requires treatment.

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Appendix A: Comparison of Selected Distributions by Service Year

Distribution of Medical Payments (Exhibit 4)

Medical Category	**2012**	**2013**	**2014**	**2015**	**2016**
Physicians	47%	50%	50%	44%	46%
Hospital Inpatient	12%	11%	10%	13%	13%
Hospital Outpatient	11%	11%	10%	8%	8%
ER	1%	1%	1%	2%	2%
Ambulatory Surgical Centers	6%	7%	8%	11%	10%
Drugs (NDC Codes + Medical Drugs)	13%	12%	11%	14%	14%
Durable Medical Equipment	3%	3%	1%	1%	2%
Other	7%	5%	8%	7%	5%

Distribution of Physician Payments by AMA Service Category (Exhibit 5)

AMA Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Surgery	32%	31%	33%	28%	29%
Physical Medicine	31%	33%	33%	37%	38%
Evaluation & Management	13%	13%	13%	15%	15%
Radiology	8%	8%	7%	6%	6%
Medicine	7%	6%	6%	6%	5%
Anesthesia	5%	4%	4%	5%	4%
Pathology & Laboratory	4%	4%	4%	3%	3%

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Appendix A: Comparison of Selected Distributions by Service Year

Hospital Inpatient Statistics (Exhibit 17 and 18)

Hospital Inpatient Statistics	2012	2013	2014	2015	2016
Average Payment per Stay	$32,069	$31,698	$35,999	$38,474	$29,544
Number of Stays per 1,000 Active Claims	29	27	23	23	24

Distribution of Hospital Outpatient Payments by Surgery and Non-Surgery (Exhibit 23 and Exhibit 24)

Visit Type	2012	2013	2014	2015	2016
Surgery (CPT: 10021-69990)	14%	11%	14%	23%	15%
Non-Surgery	86%	89%	86%	77%	85%

Hospital Outpatient Surgery Statistics (Exhibit 23 and Exhibit 23A)

Hospital Outpatient Surgery Statistics	2012	2013	2014	2015	2016
Average Payment per Visit	$5,570	$7,965	$8,608	$6,383	$6,397
Number of Visits per 1,000 Active Claims	80	61	58	55	48

Hospital Outpatient Non-Surgery Statistics (Exhibit 24 and Exhibit 24A)

Hospital Outpatient Non-Surgery Statistics	2012	2013	2014	2015	2016
Average Payment per Visit	$874	$933	$965	$654	$598
Number of Visits per 1,000 Active Claims	851	845	734	696	563

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Appendix A: Comparison of Selected Distributions by Service Year

Emergency Room Statistics (Exhibit 28 and Exhibit 29)

Emergency Room Statistics	2012	2013	2014	2015	2016
Average Payment per Visit	$2,696	$2,190	$2,131	$1,915	$1,380
Number of Visits per 1,000 Active Claims	46	66	79	98	137

ASC Statistics (Exhibit 32 and Exhibit 32A)

ASC Statistics	2012	2013	2014	2015	2016
Average Payment per Visit	$12,380	$11,781	$10,767	$8,768	$7,440
Number of Visits per 1,000 Active Claims	53	70	108	119	123

Distribution of Drug Payments by Brand Name and Generic (Exhibit 37)

Type of Drug	2012	2013	2014	2015	2016
Brand	66%	63%	46%	49%	50%
Generic	31%	33%	46%	51%	50%

Distribution of Drug Payments by Pharmacy and Non-Pharmacy (Exhibit 39)

Type of Provider	2012	2013	2014	2015	2016
Pharmacy	77%	83%	88%	85%	85%
Non-Pharmacy	23%	17%	12%	15%	15%

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Appendix A: Comparison of Selected Distributions by Service Year

Distribution of Drug Payments by Repackaged and Non-Repackaged (Exhibit 40)

Type of Drug	**2012**	**2013**	**2014**	**2015**	**2016**
Repackaged	19%	12%	1%	0%	0%
Non-Repackaged	81%	88%	99%	100%	100%

Distribution of Payments by DME, Supplies, and Implants (Exhibit 41)

Category	**2012**	**2013**	**2014**	**2015**	**2016**
Orthotics & Prosthetics	35%	28%	29%	37%	29%
DME	36%	43%	39%	40%	51%
Supplies Other Than DME	29%	30%	32%	23%	20%

Distribution of Payments by Provider State (Exhibit 46)

Category	**2012**	**2013**	**2014**	**2015**	**2016**
Delaware	74%	75%	71%	66%	68%
Out of State	26%	25%	29%	34%	32%

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Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2016
1	Medical Share of Total Benefit Costs	68.2% (2014)
2	Overall Medical Average Cost per Case	$61,842 (2014)
3	Percentage of Medical Paid by Claim Maturity	25.5% (Year 1); 49.1% (Year 5); 61.5% (Year 10); 75.5% (Year 19)
4	Distribution of Medical Payments	Physicians 46%; Hospital Outpatient 8%; Hospital Inpatient 13%; ASC 10%; Drugs 14%; ER 2%; DME 2%; Other 5%
	Percentage of Medicare:	
	Surgery	200% to 250%
	Radiology	150% to 200%
	Medicine	100% to 150%
	Evaluation & Management	100% to 150%
	All Physician Services	150% to 250%
5	Distribution of Physician Payments by AMA Service Category	Surgery 29%; Radiology 6%; Pathology & Laboratory 3%; Physical Medicine 38%; General Medicine 5%; Evaluation & Management 15%; Anesthesia 4%
6	Top 10 Surgery Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 22551 ($3,523); 22840 ($2,431); 64483 ($434); 22851 ($1,026); 29881 ($2,147); 29826 ($1,162); 22633 ($4,136); 22612 ($2,026); 64493 ($577); 29827 ($1,703)
7	Top 10 Surgery Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 20160 ($96); 64483 ($434); 64493 ($577); 64494 ($366); 64484 ($353); 22851 ($1,026); 29520 ($90); 62311 ($360); 12001 ($187); 36415 ($9)
8	Top 10 Radiology Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 72148 ($587); 73221 ($486); 73721 ($488); 72141 ($569); 72158 ($980); 72131 ($318); 76942 ($124); 73222 ($617); 72125 ($223); 73030 ($50)
9	Top 10 Radiology Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 73030 ($50); 72100 ($52); 73630 ($39); 73110 ($40); 73610 ($40); 73130 ($38); 72148 ($587); 73221 ($486); 73721 ($488); 73562 ($56)
10	Distribution of Radiology Payments by Modifier Code	Professional modifier 7%; Technical modifier 1%, No TC or 26 modifier 92%

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Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2016
11	Top 10 Physical and General Medicine Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 97110 ($67); 97140 ($49); 97545 ($247); 97530 ($46); 97112 ($46); 97010 ($15); 97014 ($31); 97546 ($141); 97124 ($56); 97799 ($2,799)
12	Top 10 Physical and General Medicine Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 97110 ($67); 97140 ($49); 97010 ($15); 97530 ($46); 97014 ($31); 97112 ($46); 99080 ($27); 97124 ($56); 97035 ($30); 98941 ($48)
13	Top 10 Evaluation and Management Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 99214 ($114); 99213 ($72); 99203 ($125); 99284 ($384); 99204 ($181); 99283 ($241); 99212 ($57); 99458 ($1,322); 99232 ($91); 99285 ($560)
14	Top 10 Evaluation and Management Procedure Codes by Transaction Count	Average Paid Per Transaction for top 10 codes: 99213 ($72); 99214 ($114); 99203 ($125); 99212 ($57); 99232 ($91); 99204 ($181); 99284 ($384); 99283 ($241); 99202 ($98); 99291 ($224)
15	Top 10 Evaluation & Management Procedure Codes Trend	2016 Results: 99201 (0%); 99202 (7%); 99203 (55%); 99204 (35%); 99205 (3%); 99211 (0%); 99212 (6%); 99213 (43%); 99214 (50%); 99215 (2%)
16	Top 10 Evaluation & Management Procedure Codes Average Paid per Transaction	2016 Results: 99201 ($65); 99202 ($98); 99203 ($125); 99204 ($181); 99205 ($216); 99211 ($27); 99212 ($57); 99213 ($72); 99214 ($114); 99215 ($148)
	Percentage of Medicare:	
	Hospital Inpatient	144% to 174%
17	Average Paid Amount per Stay for Hospital Inpatient Services	$29,544
18	Average Number of Stays per 1,000 Active Claims	24
19	Inpatient Length of Stay for Hospital Inpatient Services	Average LOS = 3; Median LOS = 1
20	Average Paid Amount per Day for Hospital Inpatient Services	$8,705

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Appendix B: Summary Reference of Key Results

#	Chart Name	Delaware Results 2016
21	Top 10 Diagnoses by Amount Paid for Hospital Inpatient Services	Median Payment per Hospital Inpatient Stay for top 10 codes: T24.339A ($577,361); M51.16 ($33,619); M51.36 ($43,839); S13.161A ($370,566); M48.06 ($35,889); M51.37 ($43,228); L03.115 ($207,482); M51.26 ($48,659); S87.82XA ($154,962); S12.390A ($154,616)
22	Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services	Median Payment per Hospital Inpatient Stay for top 10 codes: 999 ($292,141); 460 ($17,953); 603 ($105,435); 470 ($22,677); 454 ($22,616); 453 ($99,177); 455 ($11,995); 335 ($69,890); 935 ($66,394); 416 ($21,327)
	Percentage of Medicare:	
	Hospital Outpatient	Results not available
23	Average Outpatient Paid Amount Per Major Surgical Visit for Hospital Outpatient Services	$6,397
23A	Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims	48
24	Average Outpatient Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services	$598
24A	Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims	563
25	Top 10 Diagnoses by Amount Paid for Hospital Outpatient Services	Median Payment per Hospital Outpatient Visit for top 10 codes: S22.089D ($161,944); M50.12 ($5,411); G89.4 ($9,942); M51.26 ($271); M51.16 ($1,372); E66.9 ($9,216); M54.5 ($348); M48.06 ($224); M50.20 ($261); M54.16 ($432)
26	Top 10 Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Paid Per Transaction for top 10 codes: 22551 ($5,477); 29827 ($6,041); 63030 ($5,304); 29823 ($6,389); 29888 ($6,514); 29824 ($4,257); 29881 ($4,176); 63042 ($3,838); 49650 ($1,993); 27412 ($22,424)

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Appendix B: Summary Reference of Key Results

#	Chart Name	Delaware Results 2016
27	Top 10 Non-Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Paid Per Transaction for top 10 codes: 99284 ($708); 99283 ($413); 97110 ($60); 99285 ($1,064); C1772 ($46,659); 73721 ($630); 73221 ($618); C1713 ($3,625); 97140 ($48); 72148 ($636)
28	Average Amount Paid per ER Visit	$1,380
29	Average Number of ER Visits per 1,000 Active Claims	137
30	Distribution of ER Service Payments	Facilities 53%; Physicians 41%; Other 6%
31	Emergency Room Payments by Procedure Code Trend	2016 Results: 99281 (1%); 99282 (3%); 99283 (30%); 99284 (48%); 99285 (19%)
31A	Emergency Room Transactions by Procedure Code Trend	2016 Results: 99281 (2%); 99282 (6%); 99283 (40%); 99284 (40%); 99285 (11%)
	Percentage of Medicare:	
	Ambulatory Surgical Center	Results not available
32	Average Amount Paid per Visit for ASC Services	$7,440
32A	Average Number of ASC Visits per 1,000 Active Claims	123
33	Top 10 Diagnoses for ASC Services	Median Payment per ASC Visit for top 10 codes: M54.16 ($1,182); M51.87 ($17,588); M54.17 ($1,182); M47.817 ($2,364); M75.122 ($23,557); M54.5 ($2,014); M54.12 ($1,182); G89.18 ($656); M47.812 ($2,266); M75.121 ($6,873)
34	Top 10 Surgery Procedure Codes by Amount Paid for ASC Services	Average Paid Per Transaction for top 10 codes: 64483 ($1,079); 29823 ($5,634); 29827 ($6,477); 64635 ($2,576); 64493 ($1,065); 29824 ($5,311); 29881 ($3,327); 29888 ($9,772); 62311 ($937); 64490 ($1,123)

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Appendix B: Summary Reference of Key Results

#	Chart Name	Delaware Results 2016
35	Top 10 Workers Compensation Drugs by Amount Paid	Top 10 WC Drugs by amount paid: Oxycontin (9.3%); Gabapentin (8.3%); Lyrica (6.2%); Oxycodone HCL (5.9%); Oxycodone HCL-Acetaminophen (4.4%); Lidocaine (3.1%); Percocet (3.1%); Terocin (2.9%); Duloxetine HCL (2.2%); Cyclobenzaprine (2.2%)
36	Top 10 Workers Compensation Drugs by Prescription Counts	Top 10 WC Drugs by script count: Oxycodone HCL (10.5%); Gabapentin (6.8%); Oxycodone HCL-Acetaminophen (6.7%); Cyclobenzaprine HCL (5.9%); Ibuprofen (4.0%); Tizanidine HCL (3.6%); Hydrocodone Bitartrate-Acetaminophen (3.5%); Morphine Sulfate (3.4%); Oxycontin (3.3%); Tramadol HCL (3.2%)
37	Distribution of Drugs by Brand Name and Generic	Brand Name: 19% scripts, 50% paid; Generic 81% scripts, 50% paid
38	Distribution of Prescription Drug Costs in Pennsylvania by CSA Schedule	Schedule 2 = 36%; Schedule 3 = 2%; Schedule 4 = 4%; Schedule 5 = 6%; OTC = 6%; Non-Controlled = 45%
39	Distribution of Drugs by Pharmacy and Non-pharmacy by Amount Paid	By Paid Amount = Pharmacy 85%; Non-Pharmacy 15%; By Script Count = Pharmacy 84%, Non-Pharmacy = 16%
40	Distribution of Drug Payments by Repackaged and Non-repackaged	By Paid Amount = Non-repackaged 100%; Repackaged 0%; By Script Count = Non-repackaged 99%; Repackaged= 1%

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<u>Appendix B: Summary Reference of Key Results</u>

#	Exhibit Name	Delaware Results 2016
41	Distribution of Payments by DME, Supplies, and Implants	DME = 51%; Supplies Other than DME = 20%; Orthotics & Prosthetics = 29%
42	Top 5 Orthotics and Prosthetics Codes by Amount Paid	% of Payments for top 5 codes: L0648 (12.2%); L8699 (4.8%); L8680 (4.8%); L1833 (4.8%); L4361 (3.5%)
43	Top 5 DME Codes by Amount Paid	% of Payments for top 5 codes: E0748 (30.7%); E1399 (22.7%); E0673 (5.0%); E0747 (3.9%); E0745 (3.7%)
44	Top 5 Supplies Other than DME Codes by Amount Paid	% of Payments for top 5 codes: A4556 (28.1%); 99070 (12.8%); A4353 (11.5%); A4245 (4.5%); A4595 (4.1%)
45	Top 10 Diagnoses by Amount Paid for Dates of Injury in 2014	Average Paid Per Claim for top 10 codes: T24.339A ($969,020); M54.5 ($1,821); M51.26 ($3,728); M51.36 ($6,518); M54.16 ($2,923); M25.519 ($1,984); S12.100A ($527,740); Z51.89 ($4,351); G82.52 ($249,001); S33.5XXA ($1,218)
46	Distribution of Payments by Provider State	Delaware 68%; Pennsylvania 17%; Maryland 4%; All Other States 11%

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Appendix C: Technical Appendix

The data contained in this report includes Medical Data Call transactions for Service Year 2016 (medical services delivered from January 1, 2016, to December 31, 2016) for all insurance carriers who participate in the Delaware Medical Data Call. For more information about the Medical Data Call, please refer to the Delaware Medical Data Call Manual, which is found in the Data Reporting section on www.dcrb.com.

In Service Year 2016, the state of Delaware reported number of transactions was 347,564 with more than $53 million paid, for over 9,000 claims, representing data from 89% of the workers compensation premium written, which includes experience for large-deductible policies. Self-insured data is not collected.

This Technical Appendix describes in detail the data and methodology used to prepare the Delaware Medical Data Report. Data limitations applicable to this report are also discussed.

This report includes data sourced from the Financial Data Call , Unit Statistical Reporting, and the Medical Data Call. These various calls collect and use data under different reporting schedules.

Financial Data Call

The following exhibit illustrates the data reporting and usage schedule for the Financial Data Call.

Data Valued as of…	Due to DCRB by...	Edited during...	Used for reporting starting...
December 31, Prior Year	March 15, Current Year	2nd quarter, Current Year	On or before December 1, Current Year

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Unit Statistical Data Call

The following exhibit illustrates the data reporting and usage schedule for the Unit Statistical Data Call.

Policy Effective Date…	Data Valued as of…	Due to DCRB by…	Edited during…	Used for reporting starting…
January, Prior Year	July, Current Year	September, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
February, Prior Year	August, Current Year	October, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
March, Prior Year	September, Current Year	November, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
April, Prior Year	October, Current Year	December, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
May, Prior Year	November, Current Year	January, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
June, Prior Year	December, Current Year	February, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
July, Prior Year	January, Current Year	March, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
August, Prior Year	February, Current Year	April, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
September, Prior Year	March, Current Year	May, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
October, Prior Year	April, Current Year	June, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
November, Prior Year	May, Current Year	July, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year
December, Prior Year	June, Current Year	August, Current Year	2nd and 3rd quarter, Following Year	On or before December 1, Following Year

Medical Data Call

The following exhibit illustrates the data reporting and usage schedule for the Medical Data Call.

Reporting quarter…	Due to DCRB by end of...	Edited during...	Used for reporting starting...
1st quarter 201x	2nd quarter 201x	3rd quarter 201x	4th quarter 201x
2nd quarter 201x	3rd quarter 201x	4th quarter 201x	1st quarter 201x
3rd quarter 201x	4th quarter 201x	1st quarter 201x	2nd quarter 201x
4th quarter 201x	1st quarter 201x	2nd quarter 201x	3rd quarter 201x

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Data obtained from the Unit Statistical Data Call and the Financial Data Call was used for Exhibits 1 – 3.

Exhibit 1

Delaware Policy Year Ultimate Unlimited Losses based on Financial Data Call for Compensation Experience values as of 12/31/2015.

Exhibit 2

Delaware Policy Year Unit Statistical Data Call for Compensation Experience valued as of 7/1/2016. Unlimited incurred losses and claim counts are developed to ultimate. Medical-only claim counts and losses are excluded.

Exhibit 3

Delaware Financial Year Data Call for Compensation Experience valued as of 12/31/15.

Data obtained from the Delaware Medical Data Call data was used for all exhibits starting with Exhibit 4. The following criteria were applied to all exhibits prepared using Medical Data Call data.

- Service Dates between January 1, 2016 and December 31, 2016
- Included records where Charged Amount was greater than Paid Amount
- Included records where Charged Amount equaled Paid Amount
- Excluded records with any other relationship between Charged Amount and Paid Amount
- Excluded data known to have poor data quality
- Exhibits which include a five-year trend reflect the following Service Dates:
    - January 1, 2012 – December 31, 2012
    - January 1, 2013 – December 31, 2013
    - January 1, 2014 – December 31, 2014
    - January 1, 2015 – December 31, 2015
    - January 1, 2016 – December 31, 2016

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Professional or Facility Indicator was applied as needed on most of the exhibits. The specifications for this indicator are as follows.

The following criteria were applied to exclude data from both the Facility and Professional indicator:

-Procedure Code Type = NDC (Drug) or CDT (Dental)

-Place of Service Code = 01 (Pharmacy)

-Taxonomy Code = 333600000X (Pharmacy)

-Taxonomy Code starts with 122 through 126 (Dental Providers), except where paid proc code is CPT between 10021-69990

-Taxonomy Code starts with 183 (Pharmacy Service Providers)

-Records where Provider Taxonomy Code is blank (not reported), except where place of service code = 11

The following criteria were used as the basis for indicating Facility data:

Procedure Code Type = CPT or HCPCS or REV or APC or DRGv12 or DRGv29, and

Provider Taxonomy Code starts with any of the following: 25, 26, 27, 28, 31, 32, 38, and Provider Taxonomy Code does not start with any of the following: 10, 11, 29, 30, 33, 34, 152-156, 163-167, 1711, 173C, 174, 193, 202, 204, 207, 208, 21, 221-229, 23, 24, 363-367, 372-376, 39

Taxonomy Code Definitions:

25 = Agencies

26 = Ambulatory Health Care Facilities

27 = Hospital Units

28 = Hospitals

31 = Nursing & Custodial Care Facilities

32 = Residential Treatment Facilities

38 = Respite Care Facility

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The following criteria were used as the basis for indicating Professional data:

Procedure Code Type = CPT or HCPCS, and

Provider Taxonomy Code does not start with any of the following: 25, 26, 27, 28, 31, 32, 38, and Provider Taxonomy Code starts with any of the following: 10, 11, 29, 30, 33, 34, 152-156, 163-167, 1711, 173C, 174, 193, 202, 204, 207, 208, 21, 221-229, 23, 24, 363-367, 372-376, 39

Taxonomy Code Definitions:

10 = Behavioral Health & Social Service Providers

11 = Chiropractic Providers

29 = Laboratories

30 = Managed Care Organizations

33 = Suppliers (DME, Pharmacy, other suppliers)

34 = Transportation Services

152 through 156 = Eye and Vision Services Providers

163 through 167 = Nursing Service Providers

1711 = Acupuncturist

173C = Reflexologist

174 = Specialist

193 = Group Practice

202 = Allopathic & Osteopathic Physicians

204 = Allopathic & Osteopathic Physicians

207 = Allopathic & Osteopathic Physicians

208 = Allopathic & Osteopathic Physicians

21 = Podiatric Medicine & Surgery Service Providers

221 through 229 = Respiratory, Developmental, Rehabilitation and Restorative Service Providers (includes 225X = Occupational Therapist and 2251 = Physical Therapist)

23 = Speech, Language and Hearing Service Providers

24 = Technologists, Technicians & Other Tech Service Providers

363 through 367 = Physician Assistants & Advanced Practice Nursing Providers

372 through 376 = Nursing Service Related Providers (Home Health Aide)

39 = Student, Health Care

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The following methodology applicable to each exhibit is specified as follows:

Exhibit 4

The categories in this exhibit were identified with the following criteria:

The **Drug** category includes all records where the paid procedure code is an NDC code; HCPCS Codes - Drugs Other Than Chemotherapy (HCPCS: J0100-J8999) or Chemotherapy Drugs (HCPCS: J9000-J9999); or Pharmacy revenue codes (REV: 0250-0259, 0630-0637) .

The **DME** category includes provider taxonomy codes starting with 3328, 332H, 3325 or 335E or place of service code 21, 22, or 23 and paid procedure code 0290, 0291, 0292, 0293, 0294, or 0299 or paid procedure code 99070 or paid procedure code starts with E, L or K.

The **Hospital Inpatient** category includes provider taxonomy codes starting with 27 or 28 and place of service code 21 or paid procedure code is a DRG Code or Revenue Code (with Place of Service = 21)

The **Hospital Outpatient** category includes provider taxonomy codes starting with 27 or 28 and place of service code 22.

The **Emergency Room** category includes provider taxonomy codes starting with 27 or 28 and place of service code 23.

The **Ambulatory Surgical Center** category includes provider taxonomy code 261QA1903X (Ambulatory Surgical) and place of service code not 24; or place of service code 24 and provider taxonomy code not 261QA1903X (Ambulatory Surgical); or place of service code 24 and provider taxonomy code 261QA1903X (Ambulatory Surgical).

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The **Physicians** Category includes provider taxonomy codes not starting with 3328, 332H, 3325 or 335E, and CPT or HCPCS codes reported as the paid procedure code with the exception of any records that were included in any of the categories above.

The **Other** category is the difference of the grand total minus the seven other defined categories.

Exhibit 5

The categories in this exhibit were identified based on the CPT code categories defined by the American Medical Association (AMA.)

Anesthesia	00100–01999, 99100–99140
Evaluation & Management	99201–99499
General Medicine	90281–96999, 97802–97804, 98960–99091, 99143-99199, 99500-99607
Radiology	70010–79999
Pathology & Laboratory	80048–89356
Physical Medicine	97001–97799, 97810–98943
Physicians – Other	0016T-0999T, 0001F-9999F
Surgery	10021–69990

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Exhibit 6

This exhibit includes professional (non-facility data) for the Surgery CPT codes (CPT: 10021-69990.) The top 10 surgery CPT codes were selected based on paid amount in descending order. The paid amount for each code was divided by the total paid amount for the Surgery CPT codes to calculate the percent of Surgery category payments. The paid amount for each code was divided by the number of transactions for that code to calculate the average payment per transaction. Outlier records were not excluded, which will have an impact on the average payment per transaction for some codes. The CPT code long form description was included.

Exhibit 7

Same as Exhibit 6, except the top 10 surgery CPT codes were selected based on transaction counts (record counts) in descending order.

Exhibit 8 - 9

Same as Exhibits 6 – 7 except the exhibits includes professional (non-facility data) for the Radiology CPT codes (CPT: 70010-79999.)

Exhibit 10

Data from Exhibit 8 for the professional Radiology CPT codes (CPT: 70010-79999), was used to calculate the reported rate of the professional modifier 26, the technical modifier TC, and all other records in this category (either reporting a modifier other than 26 or TC or reporting no modifier.) For the top 10 radiology codes based on paid amount in descending order, the paid amount for each code was divided by the number of transactions for that code to calculate the average payment per transaction by 1) the professional modifier 26, 2) the technical modifier TC and 3) reporting a modifier other than 26 or TC or reporting no modifier.

Exhibit 11 - 12

Same as Exhibits 6 – 7 except the exhibits includes professional (non-facility data) for the Physical and General Medicine CPT codes (90281-99199, 99500-99602, 99605-99607.)

Exhibit 13 - 14

Same as Exhibits 6 – 7 except the exhibits includes professional (non-facility data) for the Evaluation and Management CPT codes (CPT: 99201-99499.)

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Exhibit 15 - 16

Within the Evaluation and Management CPT codes (CPT: 99201-99499), this exhibit focuses on the Office or Other Outpatient Svc (CPT: 99201-99215) sub-category which includes codes for the management of new patients and management of established patients. The paid amount for each code was divided by the total paid amount for the sub-category of codes (either 99201-99205 or 99211-99215) to calculate the percent of total payments for new patient codes and established patient codes. The paid amount was divided by the transaction count (record count) for each of these codes to calculate the average paid per transaction. The data is provided across a five-year period with service dates as defined above. The CPT code long form description was included.

Exhibit 17

This exhibit includes facility (non-professional) data with the following criteria:

- Place of Service Code = 21 (Inpatient Hospital)
- Provider Taxonomy Code starts with 27 or 28
- Paid Procedure Code is either DRG, Revenue or Per-Diem
- Length of Stay >=1

DCRB's system derives the following to compute Length of Stay: If the Service Date is populated and Service From Date and Service To Date are not populated, then 1 day. If the Service From Date and Service To Dates are the same, then 1 day. Otherwise, Service To Date minus Service From Date plus 1 day. Using these criteria, we divided the total paid amount by the total bill ID count to calculate the average paid amount per stay. The system does not include a derived inpatient stay count, so Bill ID count as a proxy for stay count.

Exhibit 18

Using the same Bill ID count from Exhibit 17, the total number of claims for the service year (with no criteria other than excluding prescription drug only records) was divided by the Bill ID count from Exhibit 17. This result was then multiplied by 1,000.

Exhibit 19

Using the criteria from Exhibit 17, the Length of Stay (LOS) by Bill ID was extracted. This LOS data was used to calculated the average LOS and the median LOS.

Exhibit 20

Using the criteria from Exhibit 17, the Length of Stay (LOS) and paid amount by Bill ID was extracted. The sum of the paid amounts was divided by the sum of the LOS counts to get average paid amount per day.

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Exhibit 21

Using the criteria from Exhibit 17, the top 10 ICD-10 diagnosis codes were selected based on paid amount in descending order. The paid amount for each diagnosis code was divided by the total paid amount for Hospital Inpatient services to calculate the percent of inpatient payments. The Bill ID and the paid amount for each of the top 10 ICD-10 diagnosis codes were used to calculate the median bill payment for each of these codes, which was reported as the median payment per hospital inpatient stay. The system does not include a derived inpatient stay count, so the Bill ID count is used as a proxy for stay count. Outlier records were not excluded, and in the case of some of the top 10 diagnosis codes, there were only a small number of bills available to be included in the median calculation. The ICD-10 diagnosis code long form description was included.

Exhibit 22

Same as Exhibit 21, except the top 10 DRG codes were selected based on paid amount in descending order, with the Bill ID and the paid amount extracted for each of the top 10 DRG codes.

Exhibit 23

For this exhibit, facility (non-professional) data is included with the following criteria:

- Place of Service Code = 22 (Outpatient Hospital)
- Provider Taxonomy Code starts with 27 or 28
- Paid Procedure Code = Surgery (CPT: 10021-69990)

DCRB's system derives the following to compute visits:

Visit ID = Unique combination of Provider ID + Service/Service From Date + Bill ID+ Claim Number

The total paid amount includes the following criteria:

- Place of Service Code = 22 (Outpatient Hospital)
- All Provider Taxonomy Codes
- Paid Procedure Code = Surgery (CPT: 10021-69990) OR Anesthesia (CPT: 00100-10999) OR any Revenue Code.

Using these criteria, the total paid amount was divided by the total visit count to calculate the average outpatient paid amount per surgical visit.

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Exhibit 23A

This exhibit is based on Exhibit 23. The total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) was divided by the visit count. This result was then multiplied by 1,000.

Exhibit 24

For this exhibit, facility and professional data are included with the following criteria:

- Place of Service Code = 22 (Outpatient Hospital)
- All Provider Taxonomy Codes
- Paid Procedure Code NOT Surgery (CPT: 10021-69990)

Using these criteria, the total paid amount was divided by the total visit count to calculate the average outpatient paid amount per non-surgical visit.

Exhibit 24A

This exhibit is based on Exhibit 24. The total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) was divided by the visit count. This result was then multiplied by 1,000.

Exhibit 25

The following the hospital outpatient criteria was selected:

- Facility (non-professional) data
- Place of Service Code = 22 (Outpatient Hospital)
- Provider Taxonomy Code starts with 27 or 28

The top 10 ICD-10 diagnosis codes were selected based on paid amount in descending order. The paid amount for each diagnosis code was divided by the total paid amount for Hospital Outpatient services to calculate the percent of outpatient payments. The Bill ID and the paid amount for each of the top 10 ICD-10 diagnosis codes were extracted. Using this data, the median bill payment for each of these codes was calculated and reported as the median payment per hospital outpatient visit. Due to the way in which our system reflects the visit count, the Bill ID count was used as a proxy for visit count in order to compute the median payment per hospital outpatient visit. Outlier records were not excluded, and in the case of some of the top 10 diagnosis codes, there were only a small number of bills available to be included in the median calculation. The ICD-10 diagnosis code long form description was included.

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Exhibit 26

Same as Exhibit 6, except the top 10 surgery CPT codes were selected using the hospital outpatient criteria of:

- Facility (non-professional) data
- Place of Service Code = 22 (Outpatient Hospital)
- Provider Taxonomy Code starts with 27 or 28

The paid amount for each surgery code was divided by the total paid amount for hospital outpatient services to calculate the percent of hospital outpatient category payments.

Exhibit 27

Same as Exhibit 26, except the non-surgery procedure codes were defined as: 1) any CPT code which is not Surgery CPT codes (CPT: 10021-69990) and 2) any HCPCS code (A0000-V5999.)

Exhibit 28

This exhibit includes facility (non-professional) data with the following criteria:

- Place of Service Code = 23 (Emergency Room - Hospital)
- Provider Taxonomy Code starts with 27 or 28

Visits are derived using:

Visit ID = Unique combination of Provider ID + Service/Service From Date + Bill ID + Claim Number

The total paid amount includes the following criteria:

- Place of Service Code = 23 (Emergency Room - Hospital)
- All Provider Taxonomy Codes

Using these criteria, the total paid amount was divided by the total visit count to calculate the average paid amount per ER visit.

Exhibit 29

This exhibit includes professional and facility visits with the following criteria:

- Place of Service Code = 23 (Emergency Room - Hospital)
- Provider Taxonomy Code starts with 27 or 28

The total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) was divided by the visit count to determine average ER visits. This result was then multiplied by 1,000.

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Appendix C: Technical Appendix

Exhibit 30

For this exhibit, the same logic as in Exhibit 4 to define the usage of Drug, DME, Hospital (Facility) and Physician services but limited to the Place of Service Code = 23 (Emergency Room – Hospital.) Once the data was identified into these categories, we summarized the data into Facility, Physician and Other category. The Other category is the difference of the Emergency Room grand total less the other defined categories (Facility, Physician) plus Drug in the ER place of service and DME in the ER place of service. To express this as a formula it would appear as: Other = ER Grand Total – (Facility + Physician) + (Drug +DME)

Exhibit 31

Same as Exhibits 15-16, except the Emergency Department Svc (CPT: 99281-99285) sub-category was selected.

Exhibit 31A

Same as Exhibit 31, except this exhibit displays the trend based on transaction counts, instead of paid amounts.

Exhibit 32

This exhibit includes professional and facility data with the following criteria:

- Place of Service Code = 24 (Ambulatory Surgical Center)
- Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)

The system derives the following to compute visits:

Visit ID = Unique combination of Provider ID + Service/Service From Date + Bill ID + Claim Number

The total paid amount includes the following criteria:

- Place of Service Code = 24 (Ambulatory Surgical Center)
- All Provider Taxonomy Codes

Using these criteria, the total paid amount was divided by the total visit count to calculate the average paid amount per ASC visit.

Exhibit 32A

This exhibit is based on Exhibit 32. The total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) was divided by the visit count. This result was then multiplied by 1,000.

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Appendix C: Technical Appendix

Exhibit 33

Same as Exhibit 25, using the Ambulatory Surgical Center criteria of:

- Facility (non-professional) data
- Place of Service Code = 24 (Ambulatory Surgical Center)
- Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)

Exhibit 34

Same as Exhibit 6, except the top 10 surgery CPT codes were selected using the Ambulatory Surgical Center criteria of:

- Facility (non-professional) data
- Place of Service Code = 24 (Ambulatory Surgical Center)
- Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)

The paid amount for each surgery code was divided by the total paid amount for Ambulatory Surgical Center services to calculate the percent of Ambulatory Surgical Center category payments.

Exhibit 35 – 40

These exhibits reflect the prescription drug data reported using an NDC code as the paid procedure code. The Medical Data Call prescription drug transactions were supplemented with descriptive data from a nationally recognized drug reference database. The definitions used for each exhibit are proprietary to the nationally recognized drug reference database. Additional criteria include:

- FDA regulations consider branded generics as branded drugs.
- DCRB considers repackage drugs as branded drugs.

Exhibit 41

For this exhibit, Orthotics & Prosthetics are defined as HCPCS codes for Orthotics (L0100-L4999) and Prosthetics (L5000 – L9999); Durable Medical Equipment (DME) as HCPCS codes E0100-E9999; and Supplies Other Than DME as: HCPCS codes A4000-A7999 (Medical/Surgical Supplies) and CPT code 99070 (Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided). Implants were not identified as a specific category, but are included throughout the categories of Orthotics & Prosthetics, DME, and Supplies Other Than DME. The computation of this exhibit's data is the same as Exhibit 6.

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Appendix C: Technical Appendix

Exhibit 42

Same as Exhibit 6, except the top five Orthotics and Prosthetics HCPCS codes were selected using the criteria defined in Exhibit 41. The HCPCS code long form description was included.

Exhibit 43

Same as Exhibit 6, except the top five Durable Medical Equipment (DME) HCPCS codes were selected using the criteria defined in Exhibit 41. The HCPCS code long form description was included.

Exhibit 44

Same as Exhibit 6, except the top five Supplies Other Than DME Codes HCPCS codes and CPT codes were selected using the criteria defined in Exhibit 41. The HCPCS code long form description was included.

Exhibit 45

The top 10 ICD-10 diagnosis codes were selected based on paid amount in descending order for Accident Dates between January 1, 2015 and December 31, 2015. The paid amount for each diagnosis code was divided by the total paid amount for calendar year 2015 and 2016 services to calculate the percent of total medical payments. The paid amount for each code was divided by the number of claims for that code to calculate the average payment per claim. Outlier records were not excluded, which will have an impact on the average payment per transaction for some codes. The ICD-10 diagnosis code long form description was included.

Exhibit 46

For this exhibit, the total paid amount was extracted by the provider postal (ZIP) code. Medical Data Call collects the first three digits of the zip code. Using the zip code data, we assigned the paid amount to various geographic (state) categories. We focused on Delaware and the bordering states of Pennsylvania and Maryland. All the other geographic areas were summarized as All Other States.

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Appendix D: Legislative Summary

Delaware Senate Bill 1 of 2007 – Requires fee schedule and treatment guidelines; established HCAP and data collection requirement.

Delaware Senate Bill 238 of 2012 - Facilitates hospital and ambulatory surgery center compliance with the medical treatment expense cost savings measures required by the Workers' Compensation Healthcare Payment System. This addressed lack of compliance with anchor dates and prescribed Consumer Price Index (CPI) indices.

Delaware House Bill 175 of 2013 - Expands the responsibilities and resources of the Data Collection Committee; implements a number of changes to Delaware's medical cost control provisions for workers' compensation recipients, including a two-year inflation freeze on fees; inclusion of many procedures on the state's current medical fee schedule which were previously exempted, and new cost control provisions for pharmaceuticals, drug testing, and anesthesia.

- Hot/cold packs limitation
- Preferred Drug List implemented
- Repackaged Drugs elimination
- Drugs paid less than 100% AWP
- Also, reforms the procedure used to scrutinize industry-wide rate requests submitted by the workers compensation insurance industry, creating an advocate in the rate-setting process for Delaware businesses

Delaware House Bill 373 of 2014 - The most significant changes are (a) a 33% reduction in medical costs to the workers' compensation system, phased in over a period of three years; (b) absolute caps, expressed as a percentage of Medicare per-procedure reimbursements (RVUs), on all workers' compensation medical procedures beginning on January 1, 2017; and (c) increased independence for the Ratepayer Advocate who represents ratepayers during the workers compensation rate approval process and for the committee that oversees the cost control practices of individual workers compensation insurance carriers.

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Appendix E: Delaware Fee Schedule Comparison to 2016 Medicare

Section 2322B(3), Chapter 23, Title 19, Delaware Code establishes the fee schedule framework for hospitals, ambulatory surgery centers, and professional services based upon Resource Based Relative Value Scale (RVRBS), Medical Severity Diagnosis Related Group (MS-DRG), Ambulatory Payment Classification (APC) or other equivalent scale used by the Centers for Medicare and Medicaid Services, and Delaware geographic adjustments.

The Delaware workers' compensation health care payment system (HCPS) effective January 31, 2015 has moved towards an RBRVS, MS-DRG, and APC based system. While the Workers' Compensation Oversight Panel ("Panel") used these tools to form the foundation of the HCPS, Delaware has not adopted Medicare rules for workers' compensation. The Panel developed these Delaware specific rules and regulations to govern the HCPS. The HCPS does not support health care service or payment denials based on Medicare rules. The Delaware workers' compensation health care practice guidelines remain in effect and care is presumed compensable when followed. These regulations do not define compensable care, but rather a maximum allowable reimbursement (MAR). The Delaware workers' compensation regulations supersede when a conflict exists with the Centers for Medicare and Medicaid (CMS) rules.

Physician Payments

The Workers' Compensation Oversight Panel established a fee schedule for all Delaware workers' compensation funded procedures, treatment and services based on the Resource Based Relative Value Scale ("RBRVS") or equivalent scale used by the Centers for Medicare and Medicaid Services. The RBRVS or other equivalent factor shall be multiplied by a Delaware specific geographically adjusted factor to ensure adequate participation by providers. DCRB compared the 2016 Delaware professional (physician) fee schedule to 2016 Medicare National Physician Fee Schedule Relative Value File (January 2016 Release) and found that the physician fee schedule averaged between 150% to 250% of Medicare, depending on the procedure code. **Overall, DCRB determined that for geo zip 197/198, the fee schedule averages 215% of Medicare and for geo zip 199, the fee schedule averages 167% of Medicare.** Detailed results are in the following exhibit.

In the WCRI's report[1] titled "Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware", **the WCRI found that the 2016 Delaware fee schedule was 147% of Medicare**. The WCRI uses a proprietary methodology to blend 197/198 and 199 geo zips for their calculations.

[1]Source: Workers Compensation Research Institute: Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware. Oleysa Fomenko and Te-Chun Liu, September 2017

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Appendix E: Delaware Fee Schedule Comparison to 2016 Medicare

Professional Code Category	% Range	Distinct Code Count 197/198/Non-DE	Distinct Code Count 199
(1) Surgery	Between 201% and 250% Medicare	4,465	147
	Between 251% and 300% Medicare	325	43
	Between 100% and 150% Medicare	195	274
	Between 151% and 200% Medicare	178	4,708
	Less than 100% Medicare	159	188
	Over 300% Medicare	100	62
(1) Surgery Total		5,422	5,422
(2) Radiology	Between 151% and 200% Medicare	292	159
	Between 201% and 250% Medicare	109	59
	Between 100% and 150% Medicare	76	269
	Between 251% and 300% Medicare	28	13
	Over 300% Medicare	19	11
	Less than 100% Medicare	11	24
(2) Radiology Total		535	535
(3) Pathology & Laboratory	Between 151% and 200% Medicare	28	11
	Between 100% and 150% Medicare	12	35
	Less than 100% Medicare	11	14
	Over 300% Medicare	9	3
	Between 201% and 250% Medicare	7	6
	Between 251% and 300% Medicare	4	2
(3) Pathology & Laboratory Total		71	71
(4) Medicine	Between 100% and 150% Medicare	375	430
	Between 151% and 200% Medicare	119	40
	Less than 100% Medicare	67	98
	Over 300% Medicare	25	20
	Between 201% and 250% Medicare	22	26
	Between 251% and 300% Medicare	19	13
(4) Medicine Total		627	627
(5) Physical Medicine	Between 100% and 150% Medicare	12	12
	Between 151% and 200% Medicare	10	9
	Less than 100% Medicare	5	8
	Between 201% and 250% Medicare	2	0
(5) Physical Medicine Total		29	29
(6) Evaluation & Management	Between 100% and 150% Medicare	104	113
	Between 151% and 200% Medicare	20	11
	Less than 100% Medicare	12	14
	Between 201% and 250% Medicare	4	3
	Over 300% Medicare	2	1
	Between 251% and 300% Medicare	1	1
(6) Evaluation & Mgmt Total		143	143

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Appendix E: Delaware Fee Schedule Comparison to 2016 Medicare

Hospital Inpatient Payments

The inpatient hospital fee schedule includes fee amounts for specific groupings of medical services and procedures as identified using the Medical Severity Diagnosis Related Group (MS-DRG) used by the Centers for Medicare and Medicaid Services. Medicare considers primarily two factors in determining the inpatient reimbursement: 1) the DRG code reported and 2) geographic adjustment for market conditions in the hospital's location relative to national conditions. There are several other adjustments which hospitals can qualify for which determine the ultimate reimbursement. DCRB does not collect all the adjustment factors and data required to accurately model the exact Medicare DRG reimbursement. Therefore, **DCRB compared the 2016 Delaware inpatient hospital DRG fee schedule to the "DRG Summary for Medicare Inpatient Prospective Payment Hospitals, FY2015."** From this publication, we compared the average amount that Medicare pays to Delaware providers for Medicare's share of the MS-DRG. The Medicare payment amounts include the MS-DRG amount, teaching, disproportionate share, capital, and outlier payments for all cases. **DCRB found that the DRG inpatient hospital fee schedule averaged between 144% to 174% of Medicare, depending on the Delaware geo zip.**

In the WCRI's report[1] titled "Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware", **the WCRI found that the 2016 fee schedule was 140% to 152% of Medicare**. The WCRI uses a proprietary methodology to blend the 197/198 and 199 geo zips for their calculations.

Hospital Outpatient and ASC Payments

The Centers for Medicare and Medicaid Services (CMS) has established the Hospital Outpatient Prospective Payment System (OPPS) for reimbursement of hospital outpatient services. The OPPS Rules and Guidelines are followed for hospital outpatient and ambulatory surgery center (ASC) services unless otherwise indicated in the Delaware rules and regulations. The Delaware Health Care Payment System (HCPS) guidelines shall apply if there is a difference between the OPPS guidelines and the HCPS. This system is based on the Ambulatory Payment Classification (APC) group, however the Delaware fee schedule for hospital outpatient and ASC publishes fees by CPT and HCPCS code. Medicare considers primarily two factors in determining the OPPS reimbursement: 1) the APC code reported and 2) geographic adjustment including the hospital wage index (for outpatient hospital). There is further complexity in calculating the Medicare reimbursement for ASCs. Due to this complexity, a DCRB rate comparison to Medicare is not available for the hospital outpatient and ASC fees.

In the WCRI's report[1] titled "Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware", the WCRI studied the most common knee and shoulder surgeries for hospital outpatient and ASC. Therefore, an overall WCRI rate comparison to Medicare is not available for the hospital outpatient and ASC fees.

[1]Source: Workers Compensation Research Institute: Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware. Oleysa Fomenko and Te-Chun Liu, September 2017

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