DELAWARE COMPENSATION RATING BUREAU, INC.

DCRB

MEDICAL ACTIVITY REPORT 2018

Based on 2017 Service Dates

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Table of Contents

Table of Contents

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:

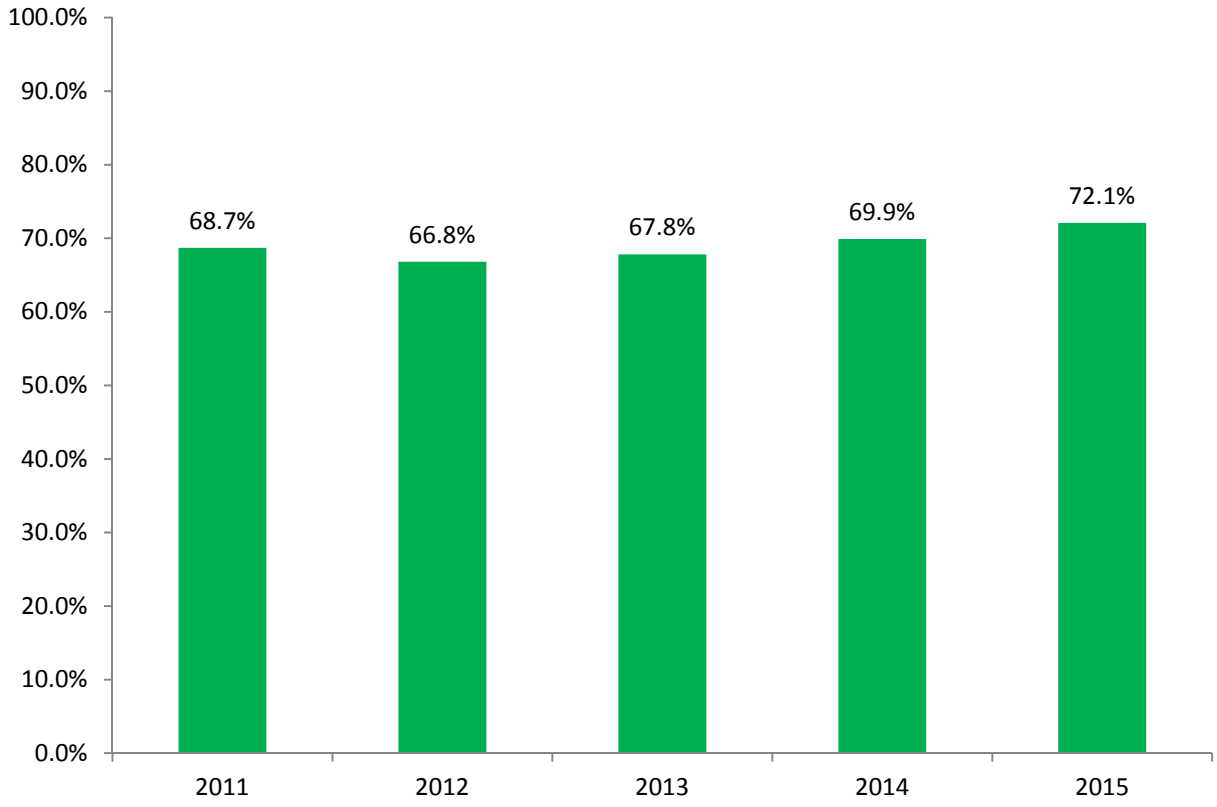
- Medical detail data could enhance the DCRB's ability to explain filings
- Medical detail data would allow the DCRB to be able to opine with authority on a variety of possible proposals to change the payment system for workers compensation in Delaware
- Medical cost containment concerns impact public 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.

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.

Exhibit 1
Medical Share of Total Benefit Costs

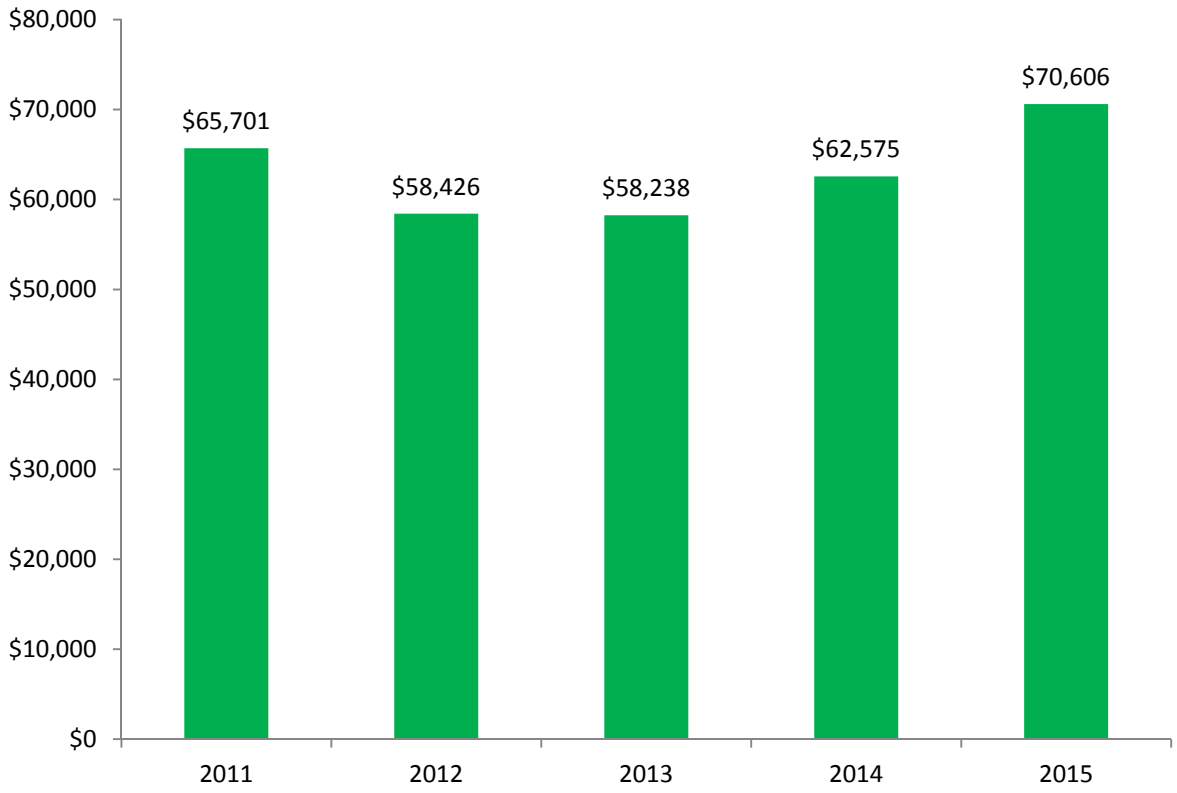


This exhibit displays the historical medical share of total benefit costs for the most recent five policy years.

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 12/31/2016 and includes medical only claims.

Exhibit 2
Medical Average Cost Per Case

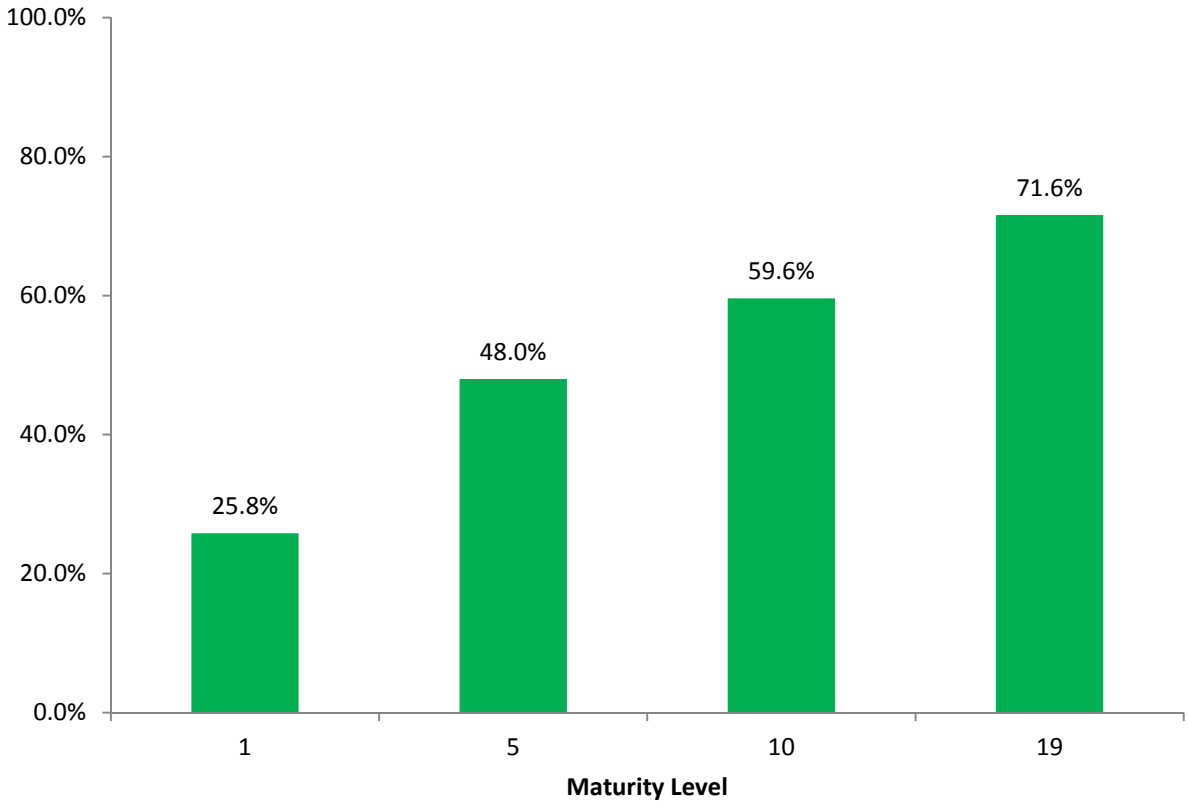


This exhibit provides a high-level summary of medical average cost per case from 2011 to 2015.

As shown in the exhibit, medical average cost per case displays an increasing trend since 2013. The underlying data do not include medical only claims, which represent 72% of total claim volume but only 9% 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 7/1/2017. Unlimited incurred losses and claim counts are developed to ultimate. Medical only claim counts and losses are excluded.

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 12/31/2016 and includes medical only claims.

Exhibit 4
Distribution of Medical Payments

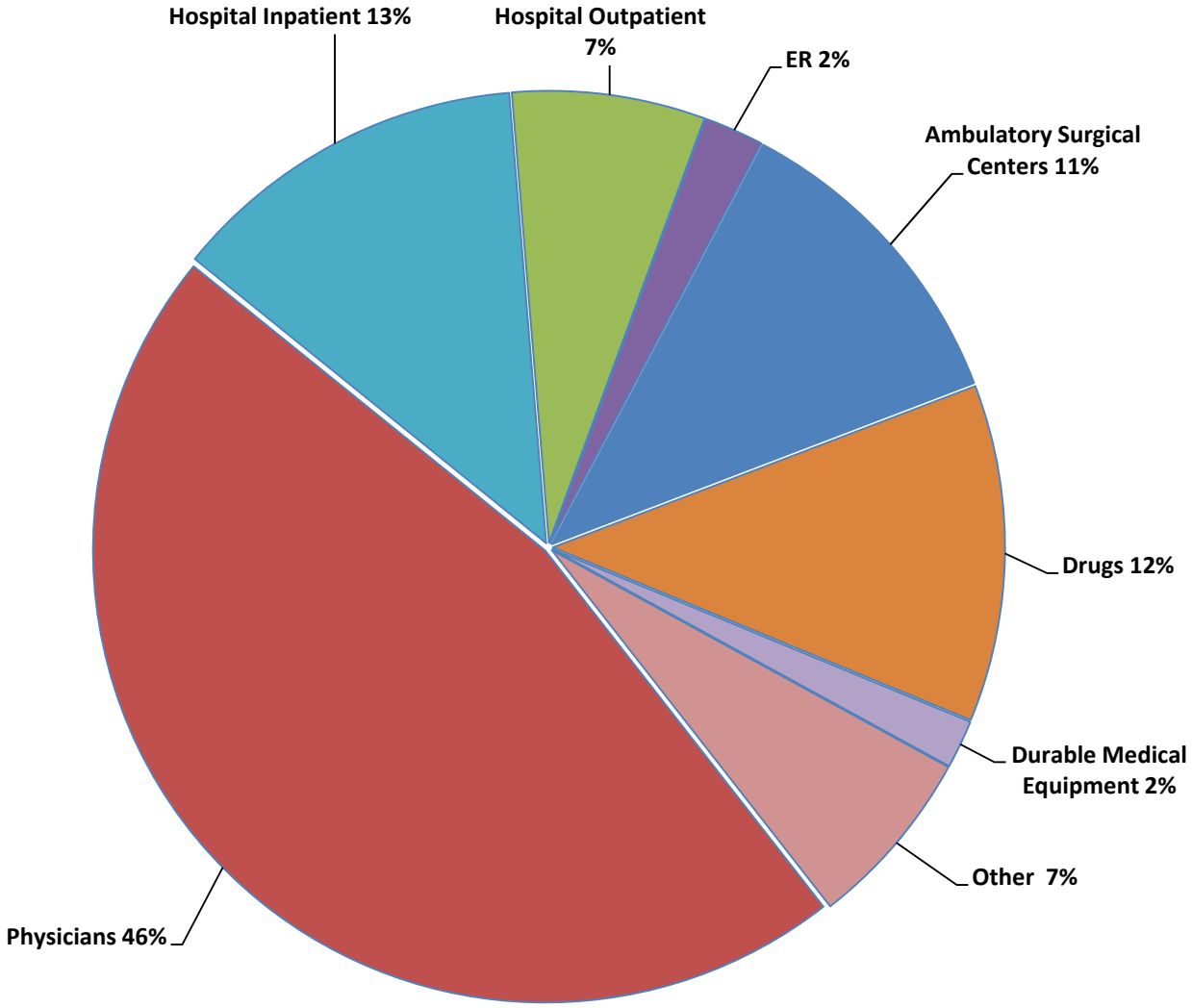


Exhibit 4 presents the distribution of medical payments by type of service groups for the state of Delaware. Payments to physicians represent the largest portion (46%) of medical paid in Service Year 2017. The service groups are defined based on paid procedure code type, provider taxonomy, and place of service regardless of where the service is performed. Delaware results are similar to results observed throughout the country.

Exhibit 5
Physician Payments as a Percentage of Medicare

Section 2322B(3), Chapter 23, Title 19, Delaware Code established 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 1/31/15 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 . The DCRB compared the 2017 Delaware professional (physician) fee schedule to 2017 Medicare National Physician Fee Schedule Relative Value File (January 2017 Release) and found that the physician fee schedule averages 209% of Medicare, with significant differences depending on the procedure code category. Overall, the DCRB determined that for geo zip 197/198, the fee schedule averages 222% of Medicare and for geo zip 199 the fee schedule averages 172% of Medicare. Detailed results are in the following Exhibit.

In the WCRI's report titled "Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware", the WCRI found that the 2017 professional fee schedule was 131% of Medicare. The WCRI uses a proprietary methodology to blend 197/198 and 199 geo zips for their calculations.

Exhibit 5 (cont'd)
Physician Payments as a Percentage of Medicare
Comparing DE 2017 Fee Schedules to Medicare 2017 Fee Schedules

Professional Code Category	% Range	Distinct Code Count 197/198/Non-DE	Distinct Code Count 199
(1) Surgery	Between 201% and 250% of Medicare	2,741	392
	Between 251% and 300% of Medicare	2,133	124
	Between 100% and 150% of Medicare	187	233
	Between 151% and 200% of Medicare	145	4,491
	Less than 100% of Medicare	124	145
	Over 300% of Medicare	68	13
(1) Surgery Total		5,398	5,398
(2) Radiology	Between 151% and 200% of Medicare	211	129
	Between 100% and 150% of Medicare	159	308
	Between 201% and 250% of Medicare	135	51
	Less than 100% of Medicare	19	36
(2) Radiology Total		524	524
(3) Pathology & Laboratory	Between 151% and 200% of Medicare	42	19
	Between 100% and 150% of Medicare	16	32
	Less than 100% of Medicare	13	20
(3) Pathology & Laboratory Total		71	71
(4) Medicine	Between 100% and 150% of Medicare	393	412
	Between 151% and 200% of Medicare	140	85
	Less than 100% of Medicare	69	105
(4) Medicine Total		602	602
(5) Physical Medicine	Between 151% and 200% of Medicare	25	12
	Between 100% and 150% of Medicare	15	22
	Less than 100% of Medicare	12	18
(5) Physical Medicine Total		52	52
(6) Evaluation & Management	Between 100% and 150% of Medicare	89	99
	Less than 100% of Medicare	38	33
	Between 151% and 200% of Medicare	15	10
(6) Evaluation & Management Total		142	142

Exhibit 6
Distribution of Medical Payments for Physicians

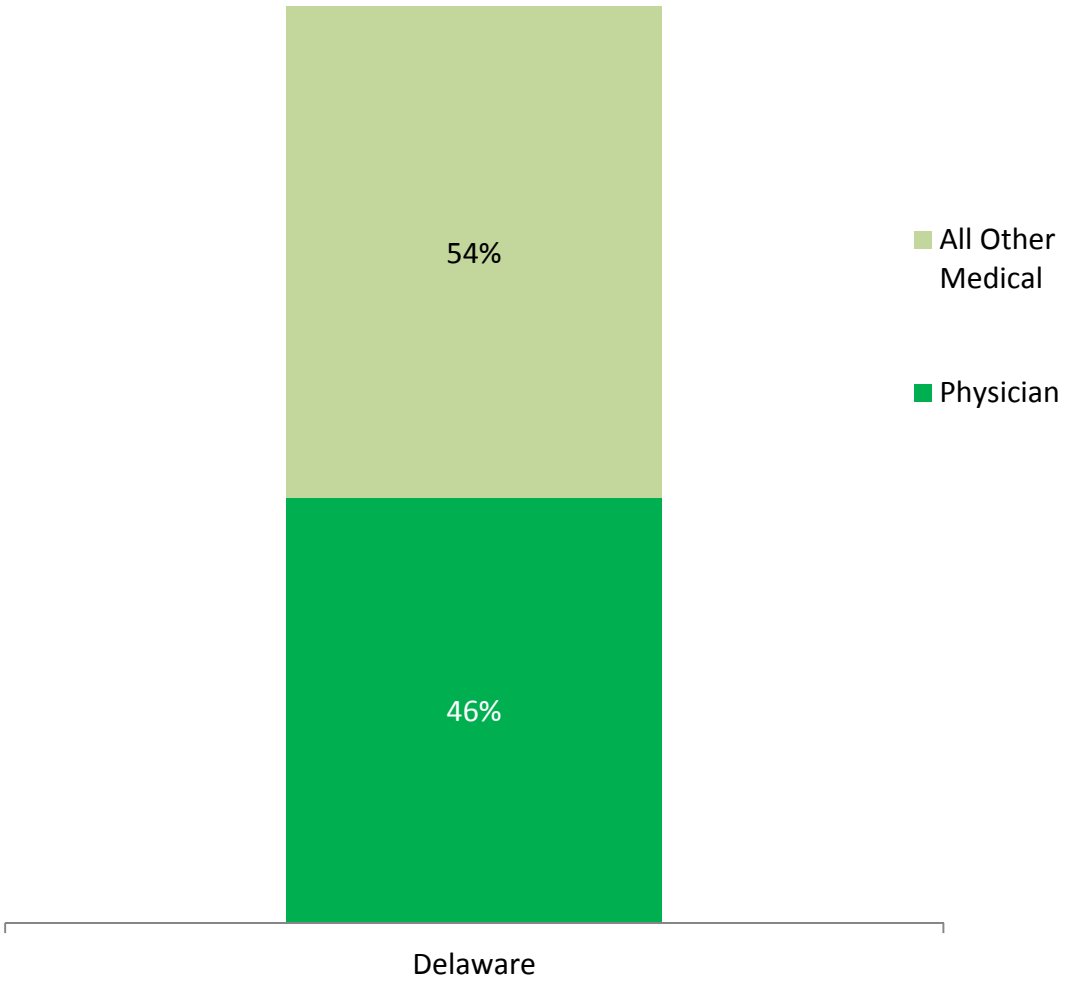


Exhibit 7
Distribution of Physician Payments by AMA Service Category

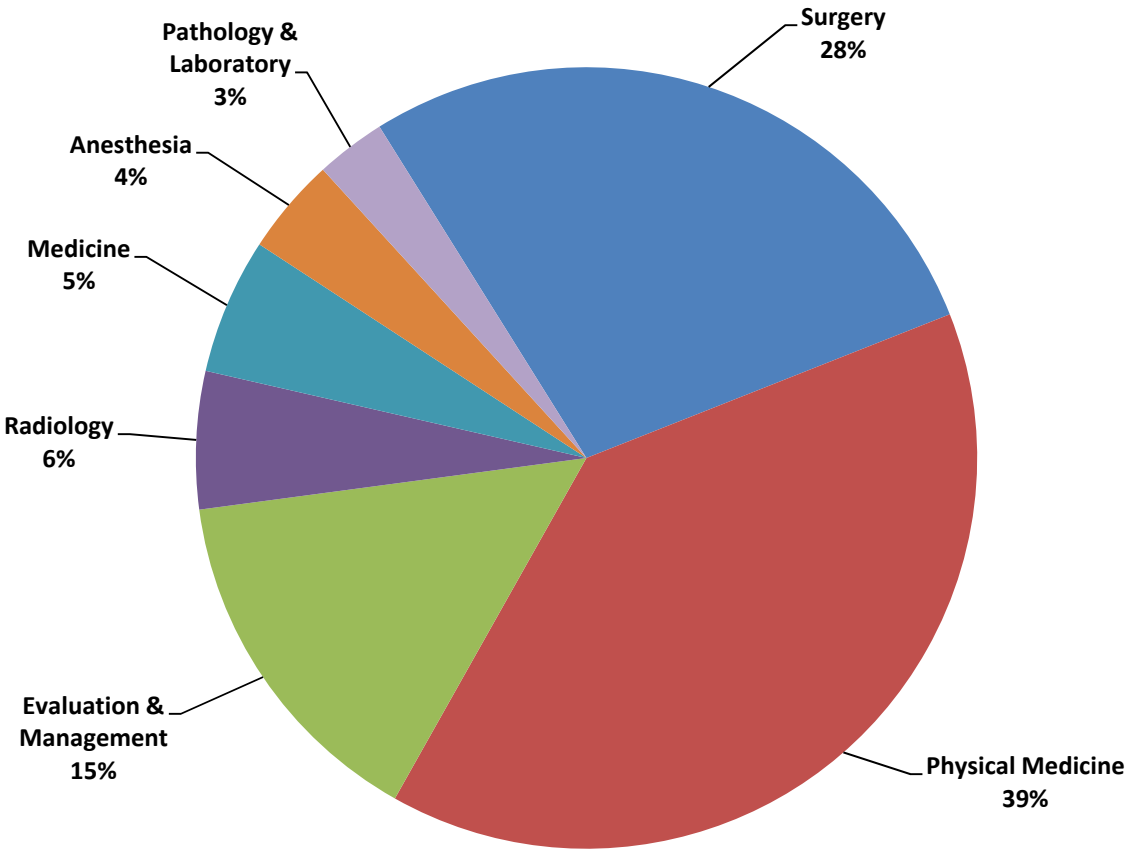


Exhibit 7 presents the distribution of physician payments by Current Procedural Terminology (CPT) code categories as defined by the American Medical Association (AMA). The Delaware Health Care Payment system (i.e., the fee schedule) dictates the maximum allowable reimbursement (MAR) when paying medical 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.

Professional Information

Physicians use CPT codes to identify and bill for the professional services that they provide to injured workers. The next fifteen 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 8 presents the top 10 surgery paid procedure codes based on paid amount. **Exhibit 9** presents the top 10 surgery paid procedure codes based on transaction counts.

Exhibit 10 presents the top 10 radiology paid procedure codes based on paid amount. **Exhibit 11** presents the top 10 radiology paid procedure codes based on transaction counts.

Exhibit 12 displays the distribution of radiology payments by modifier code.

Exhibit 13 presents the top 10 physical and general medicine paid procedure codes based on paid amount. **Exhibit 14** presents the top 10 physical and general medicine paid procedure codes based on transaction counts.

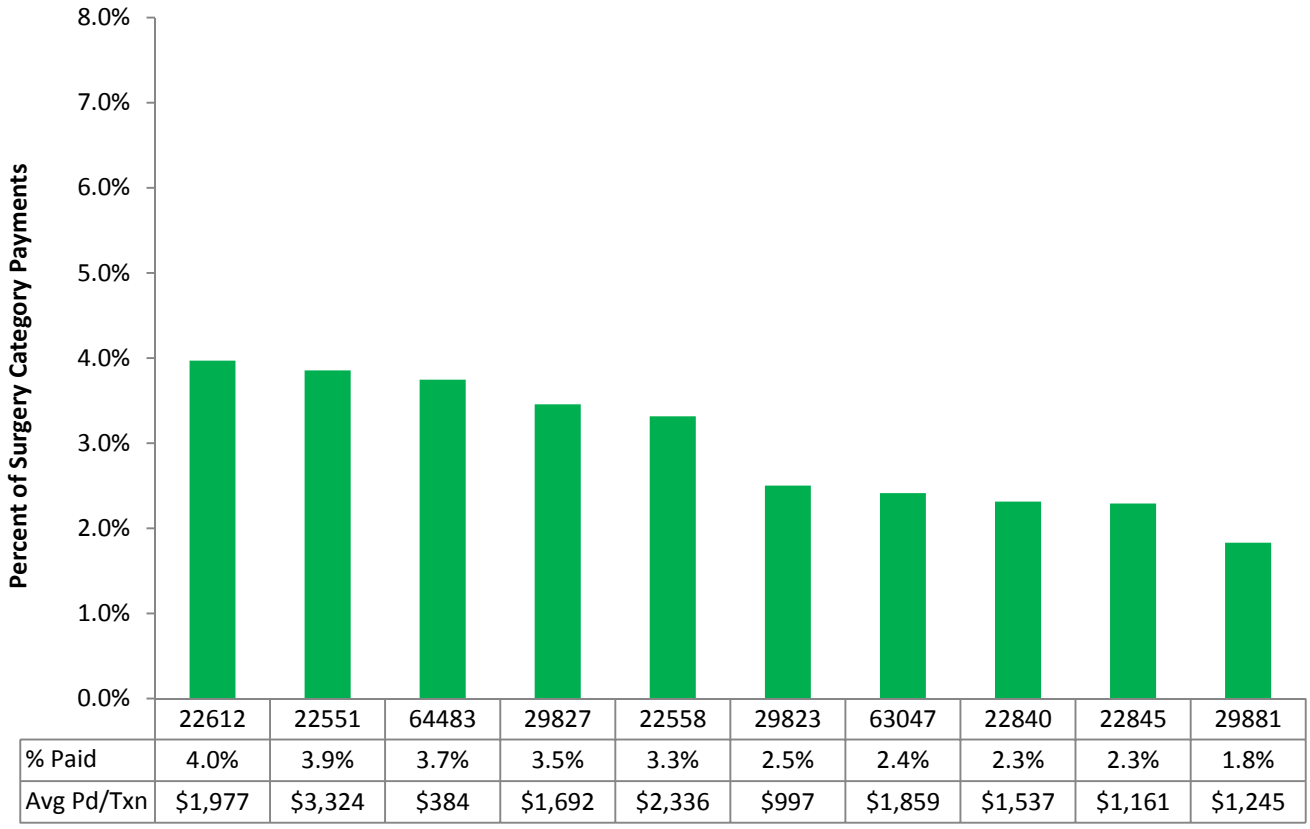
Exhibit 15 presents the top 10 evaluation and management paid procedure codes based on paid amount. **Exhibit 16** presents the top 10 evaluation and management paid procedure codes based on transaction counts.

Exhibit 17 and 18 presents the most recent five-year trend for evaluation and management procedure codes.

Exhibits 19 through 22 present various time to treatment metrics for professional services.

The source for all data is the DCRB Medical Data Call for Service Year 2017. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

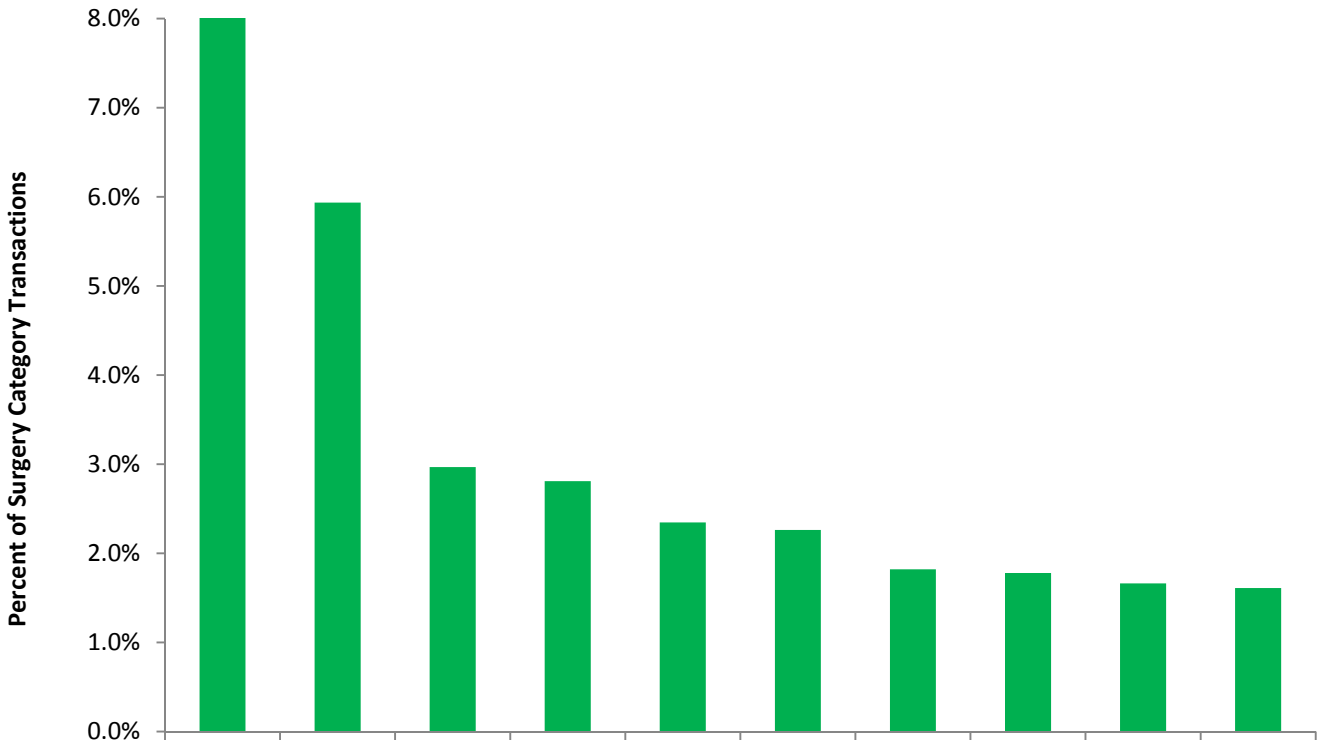
Exhibit 8
Top 10 Surgery Procedure Codes by Amount Paid



	22612	22551	64483	29827	22558	29823	63047	22840	22845	29881
% Paid	4.0%	3.9%	3.7%	3.5%	3.3%	2.5%	2.4%	2.3%	2.3%	1.8%
Avg Pd/Txn	$1,977	$3,324	$384	$1,692	$2,336	$997	$1,859	$1,537	$1,161	$1,245

Code	Description
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
29823	Arthroscopy, shoulder, surgical; debridement, extensive
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
22840	Posterior non-segmental instrumentation (e.g., 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 proced
22845	Anterior instrumentation; 2 to 3 vertebral segments (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

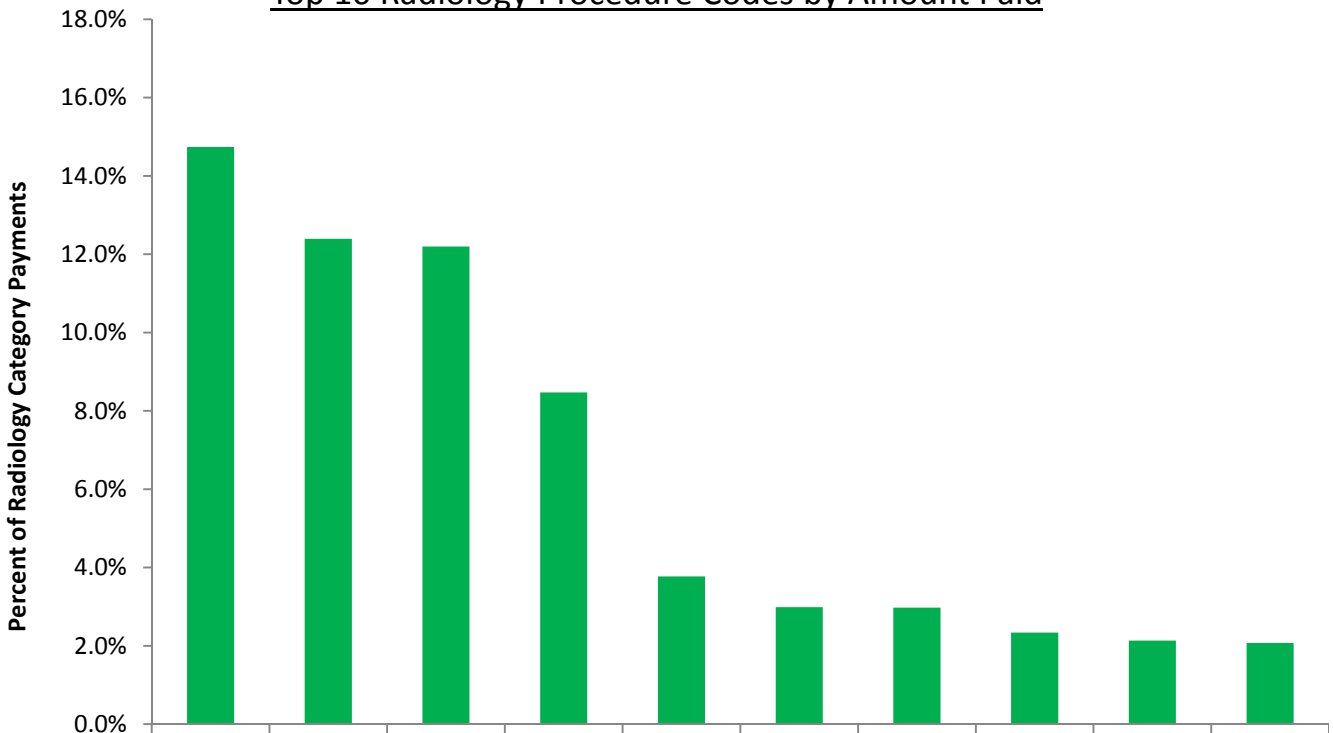
Exhibit 9
Top 10 Surgery Procedure Codes by Transaction Counts



	20610	64483	64493	12001	36415	64494	29826	64484	22853	62323
% Txn	8.2%	5.9%	3.0%	2.8%	2.3%	2.3%	1.8%	1.8%	1.7%	1.6%
Avg Pd/Txn	$99	$384	$366	$173	$8	$201	$393	$209	$469	$379

Code	Description
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., 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
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
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)
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (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)
22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each inter
62323	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral

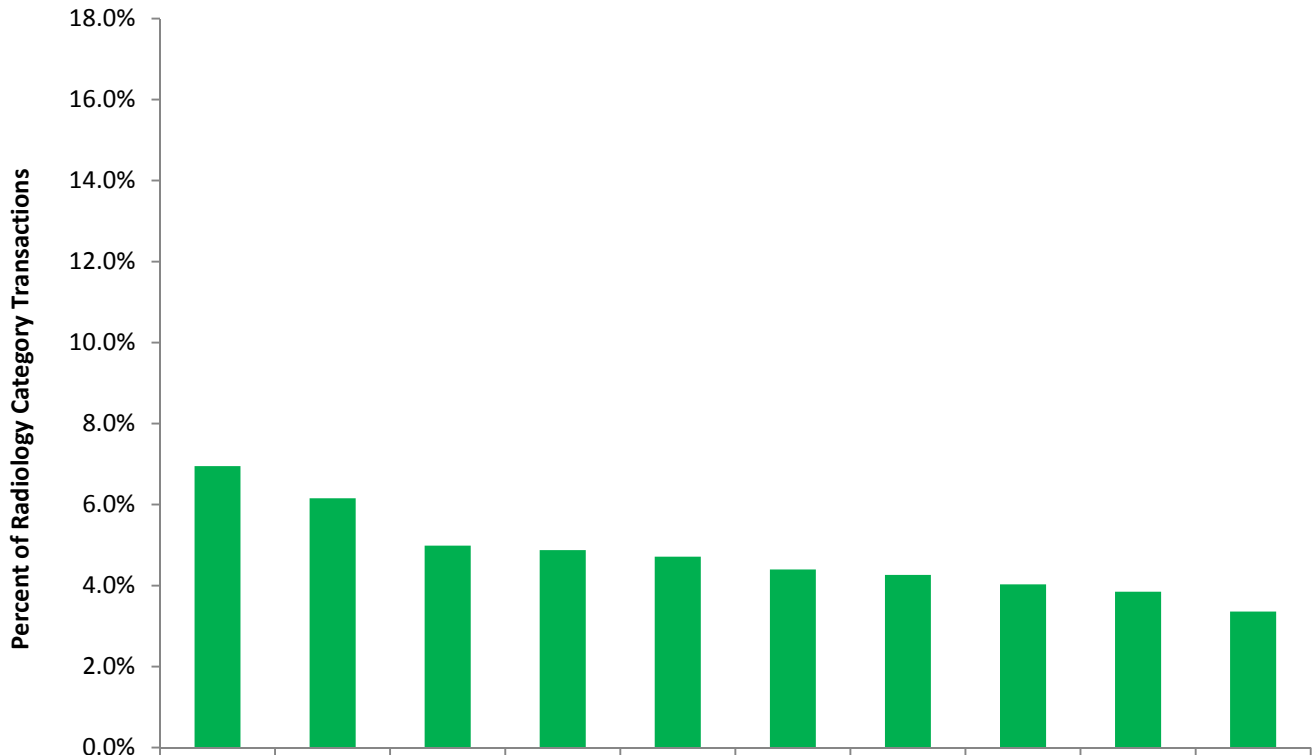
Exhibit 10
Top 10 Radiology Procedure Codes by Amount Paid



	72148	73221	73721	72141	72158	73222	72131	73030	72125	72100
% Paid	14.7%	12.4%	12.2%	8.5%	3.8%	3.0%	3.0%	2.3%	2.1%	2.1%
Avg Pd/Txn	$483	$443	$457	$492	$767	$568	$264	$48	$185	$49

Code	Description
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material(s)
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
72158	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
73222	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; with contrast material(s)
72131	Computed tomography, lumbar spine; without contrast material
73030	Radiologic examination, shoulder; complete, minimum of 2 views
72125	Computed tomography, cervical spine; without contrast material
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views

Exhibit 11
Top 10 Radiology Procedure Codes by Transaction Counts



	73030	72100	73630	73130	73110	72148	73610	73221	73721	73562
% Txn	7.0%	6.2%	5.0%	4.9%	4.7%	4.4%	4.3%	4.0%	3.8%	3.4%
Avg Pd/Txn	$48	$49	$36	$38	$42	$483	$41	$443	$457	$53

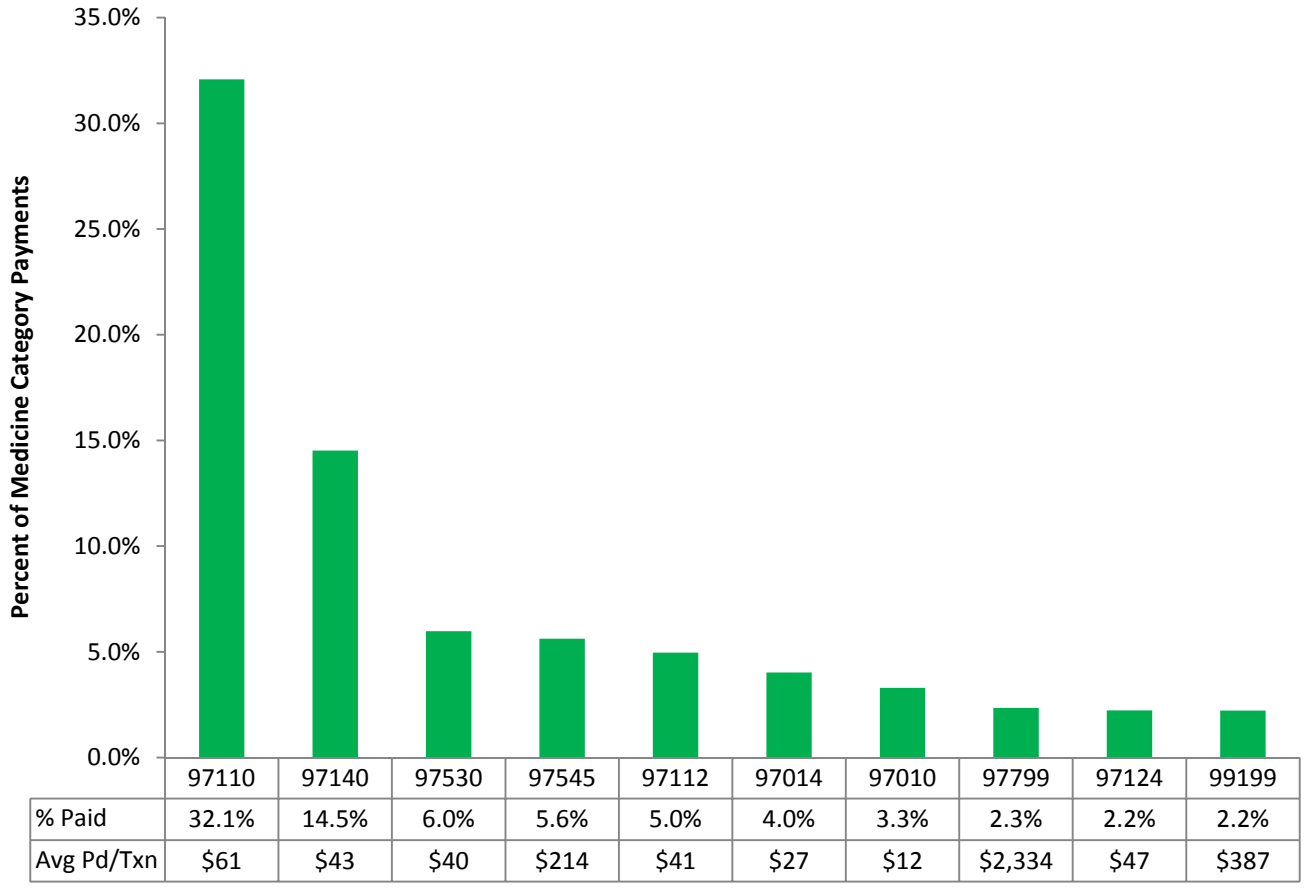
Code	Description
73030	Radiologic examination, shoulder; complete, minimum of 2 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
73630	Radiologic examination, foot; complete, minimum of 3 views
73130	Radiologic examination, hand; minimum of 3 views
73110	Radiologic examination, wrist;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

Exhibit 12

Average Paid Amount Per Transaction by Modifier Code

Code	No TC or 26 Modifier	Professional	Technical
72148	$1,272	$98	$556
73721	$1,086	$74	$451
73222	$1,196	$100	$0
72141	$1,085	$105	$0
73221	$1,069	$81	$0
72158	$864	$160	$0
72131	$333	$85	$352
72125	$318	$95	$0
73030	$114	$18	$26
72100	$104	$19	$25

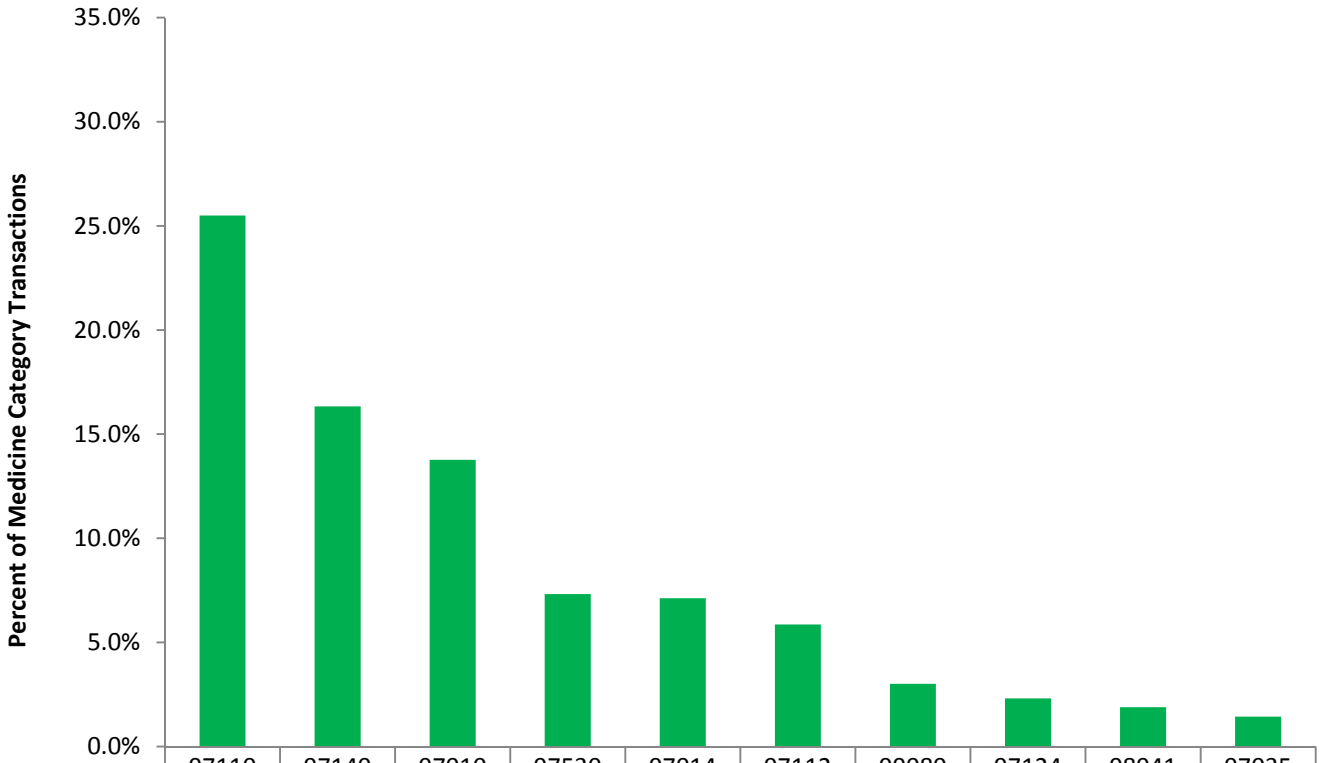
Exhibit 13
Top 10 Physical and General Medicine Procedure Codes by Amount Paid



	97110	97140	97530	97545	97112	97014	97010	97799	97124	99199
% Paid	32.1%	14.5%	6.0%	5.6%	5.0%	4.0%	3.3%	2.3%	2.2%	2.2%
Avg Pd/Txn	$61	$43	$40	$214	$41	$27	$12	$2,334	$47	$387

Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97010	Application of a modality to 1 or more areas; hot or cold packs
97799	Unlisted physical medicine/rehabilitation service or procedure
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
99199	Unlisted special service, procedure or report

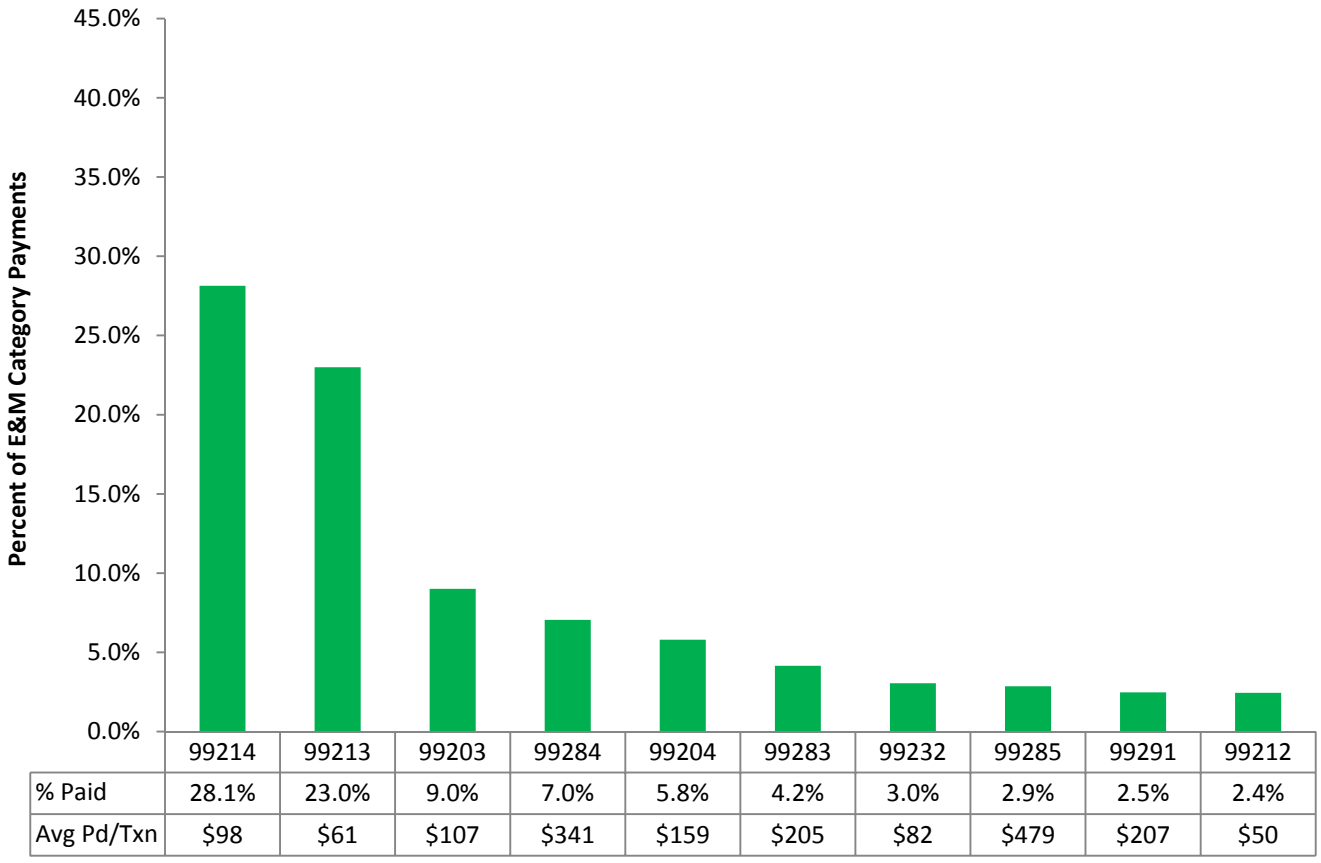
Exhibit 14
Top 10 Physical and General Medicine Procedure Codes by Transaction Counts



	97110	97140	97010	97530	97014	97112	99080	97124	98941	97035
% Txn	25.5%	16.3%	13.8%	7.3%	7.1%	5.9%	3.0%	2.3%	1.9%	1.4%
Avg Pd/Txn	$61	$43	$12	$40	$27	$41	$26	$47	$42	$23

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

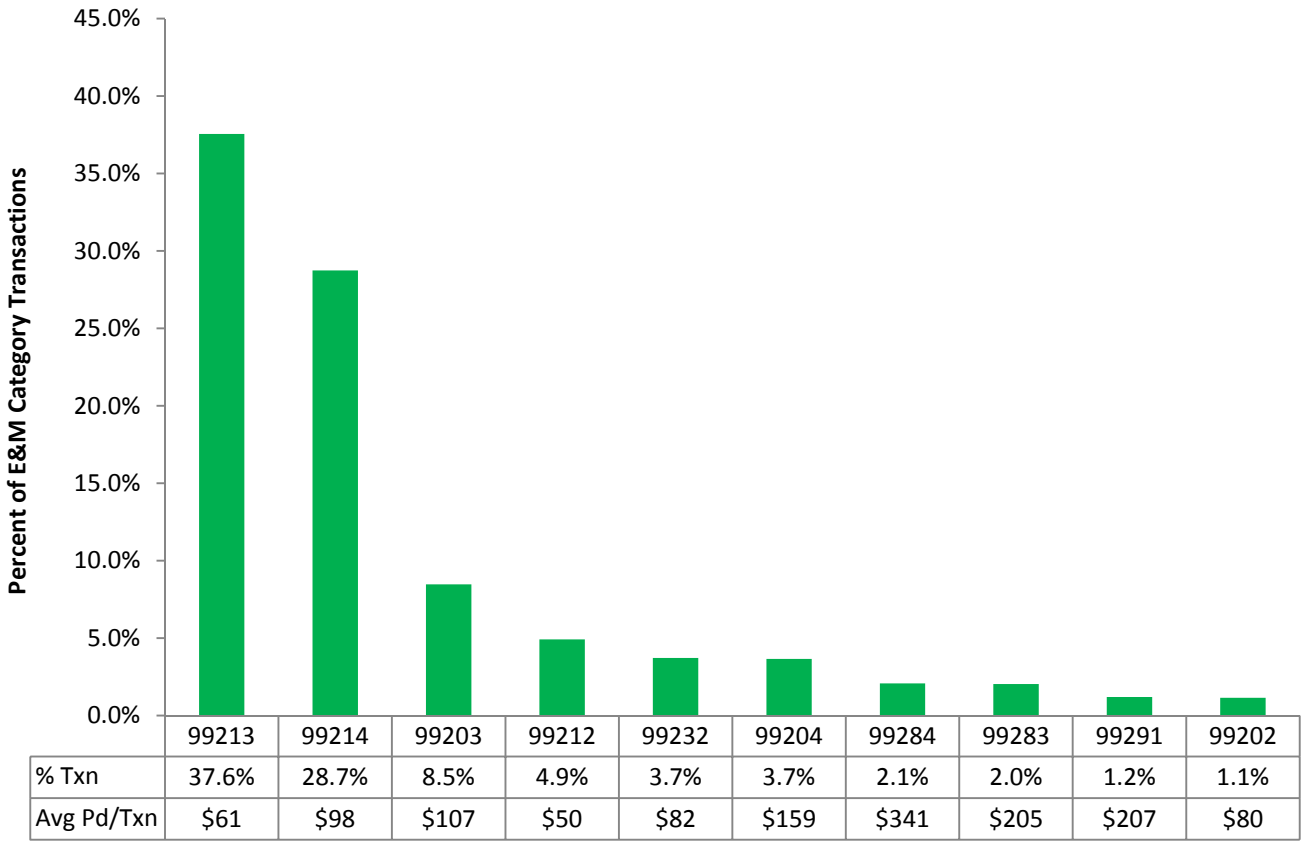
Exhibit 15
Top 10 Evaluation & Management Procedure Codes by Amount Paid



	99214	99213	99203	99284	99204	99283	99232	99285	99291	99212
% Paid	28.1%	23.0%	9.0%	7.0%	5.8%	4.2%	3.0%	2.9%	2.5%	2.4%
Avg Pd/Txn	$98	$61	$107	$341	$159	$205	$82	$479	$207	$50

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	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.
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.
99283	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
99232	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.
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.
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
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.

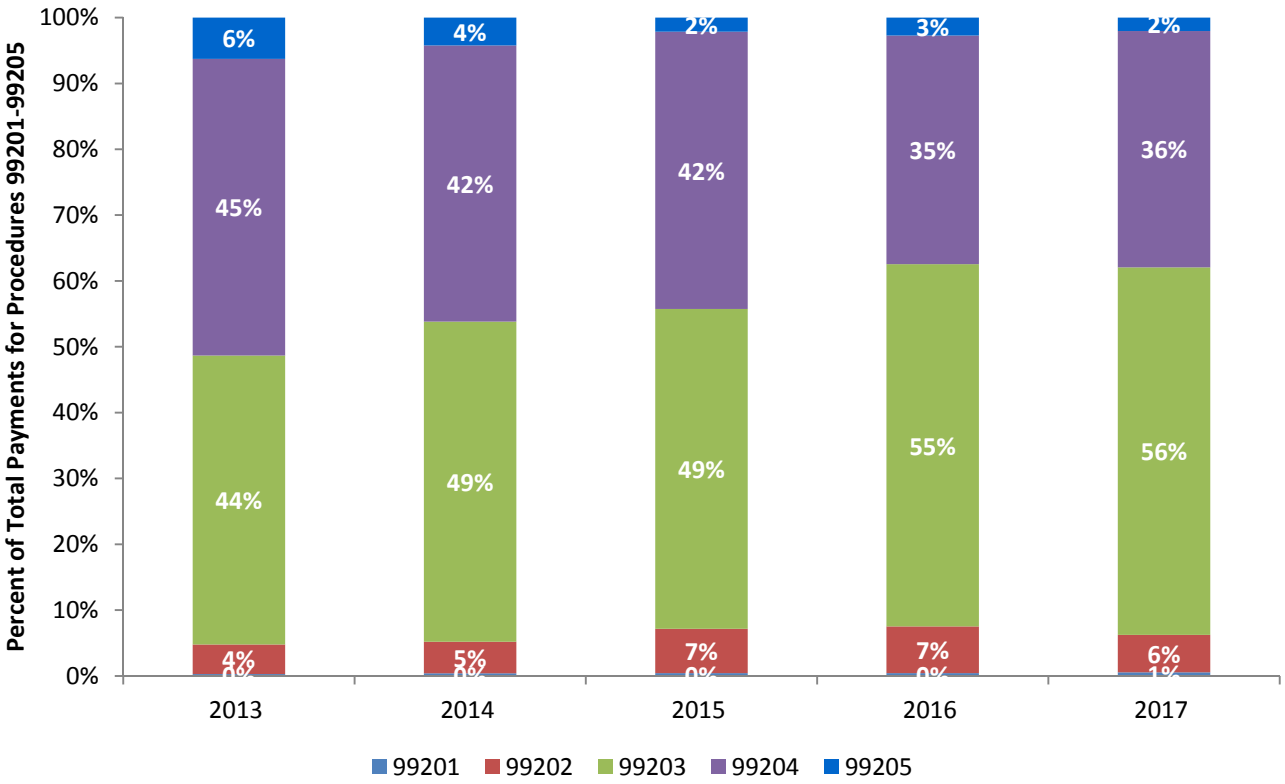
Exhibit 16
Top 10 Evaluation & Management Procedure Codes by Transaction Counts



	99213	99214	99203	99212	99232	99204	99284	99283	99291	99202
% Txn	37.6%	28.7%	8.5%	4.9%	3.7%	3.7%	2.1%	2.0%	1.2%	1.1%
Avg Pd/Txn	$61	$98	$107	$50	$82	$159	$341	$205	$207	$80

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	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.
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.
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.
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
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.

Exhibit 17-18
Top 10 Evaluation & Management Procedure Codes Trend



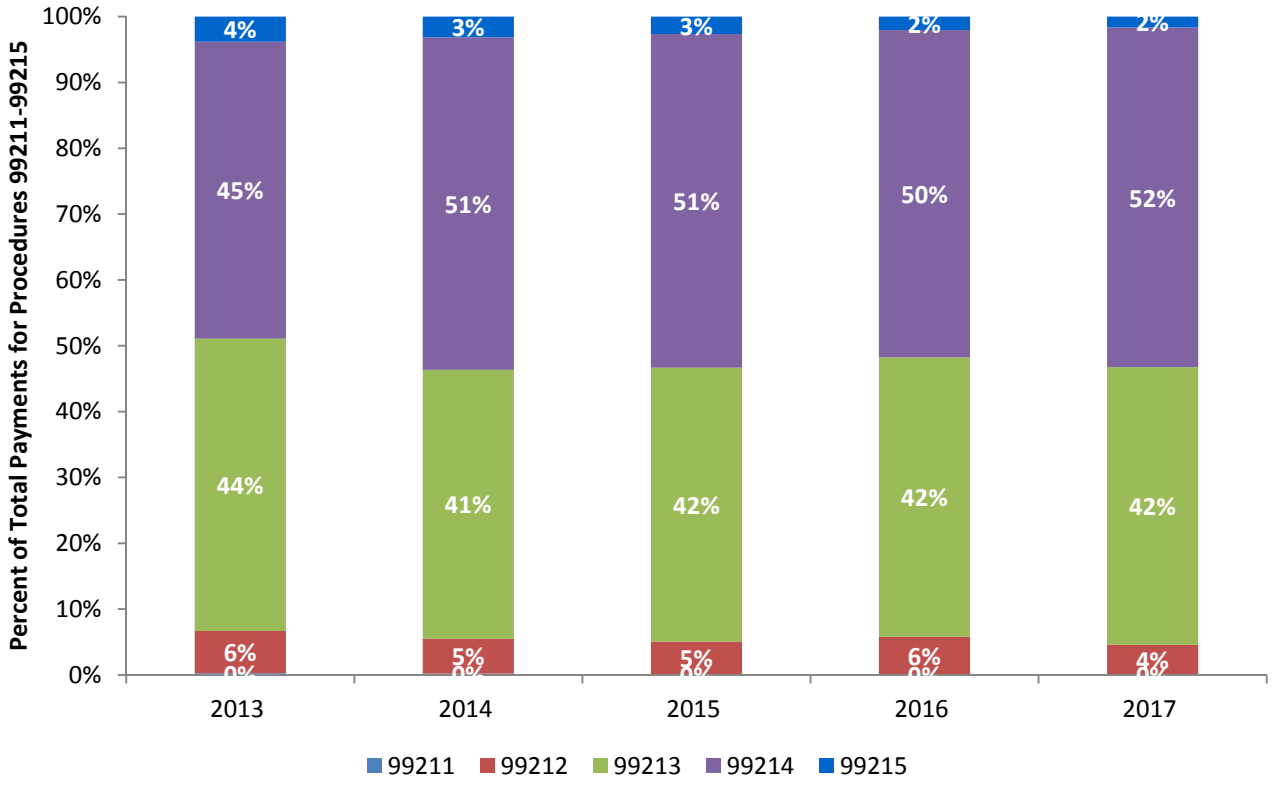


Exhibit 17-18 (cont'd)
Top 10 Evaluation & Management Procedure Codes Trend

Average Paid Per Transaction

		Average Paid Per Transaction				
Code	Severity/Time	2013	2014	2015	2016	2017
99201	Low to Moderate; 10 minutes with patient	$64	$69	$63	$65	$63
99202	Low to Moderate; 20 minutes with patient	$97	$102	$97	$98	$80
99203	Moderate; 30 minutes with patient	$138	$137	$128	$125	$107
99204	Moderate to High; 45 minutes with patient	$209	$207	$191	$180	$159
99205	Moderate to High; 60 minutes with patient	$236	$236	$217	$217	$197

		Average Paid Per Transaction				
Code	Severity/Time	2013	2014	2015	2016	2017
99211	Low to Moderate; 5 minutes with patient	$30	$31	$27	$27	$25
99212	Low to Moderate; 10 minutes with patient	$64	$62	$53	$57	$50
99213	Moderate; 15 minutes with patient	$82	$81	$74	$72	$61
99214	Moderate to High; 25 minutes with patient	$129	$131	$120	$114	$98
99215	Moderate to High; 40 minutes with patient	$152	$175	$155	$147	$139

Exhibit 19
Time Until First Treatment for Major Surgery (in Days)

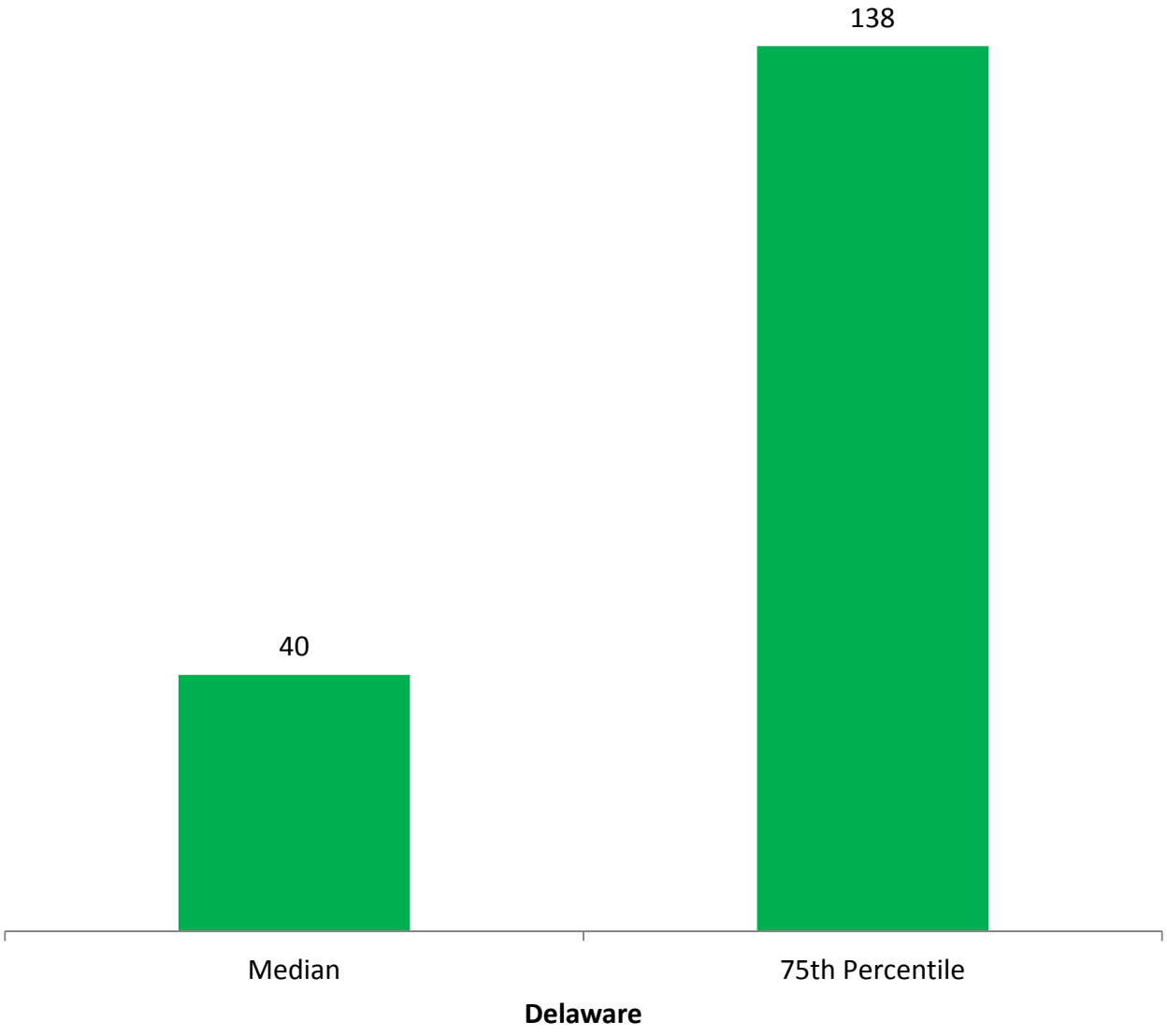


Exhibit 20
Time Until First Treatment for Radiology (in Days)

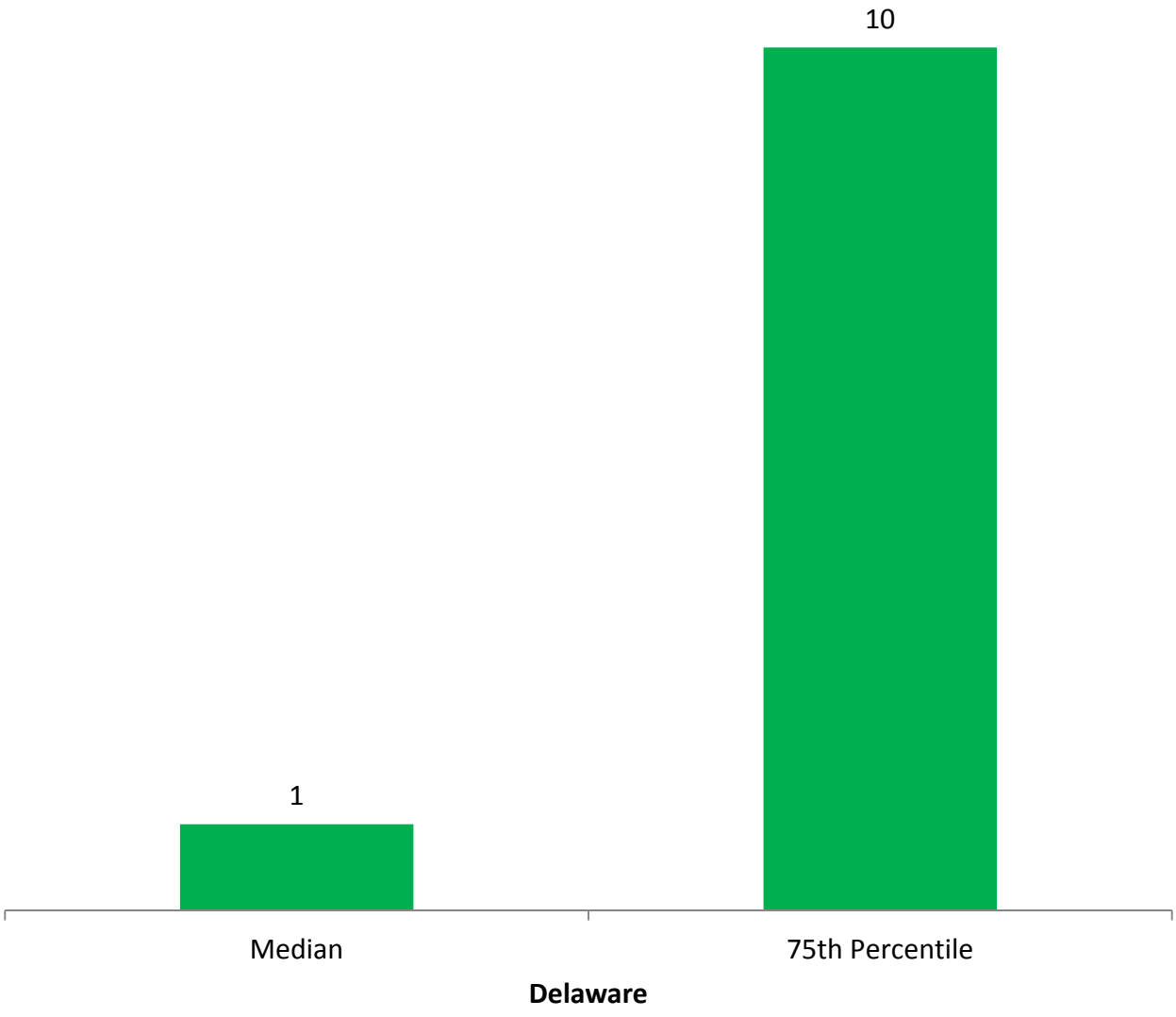


Exhibit 21
Time Until First Treatment for Physical and General Medicine (in Days)

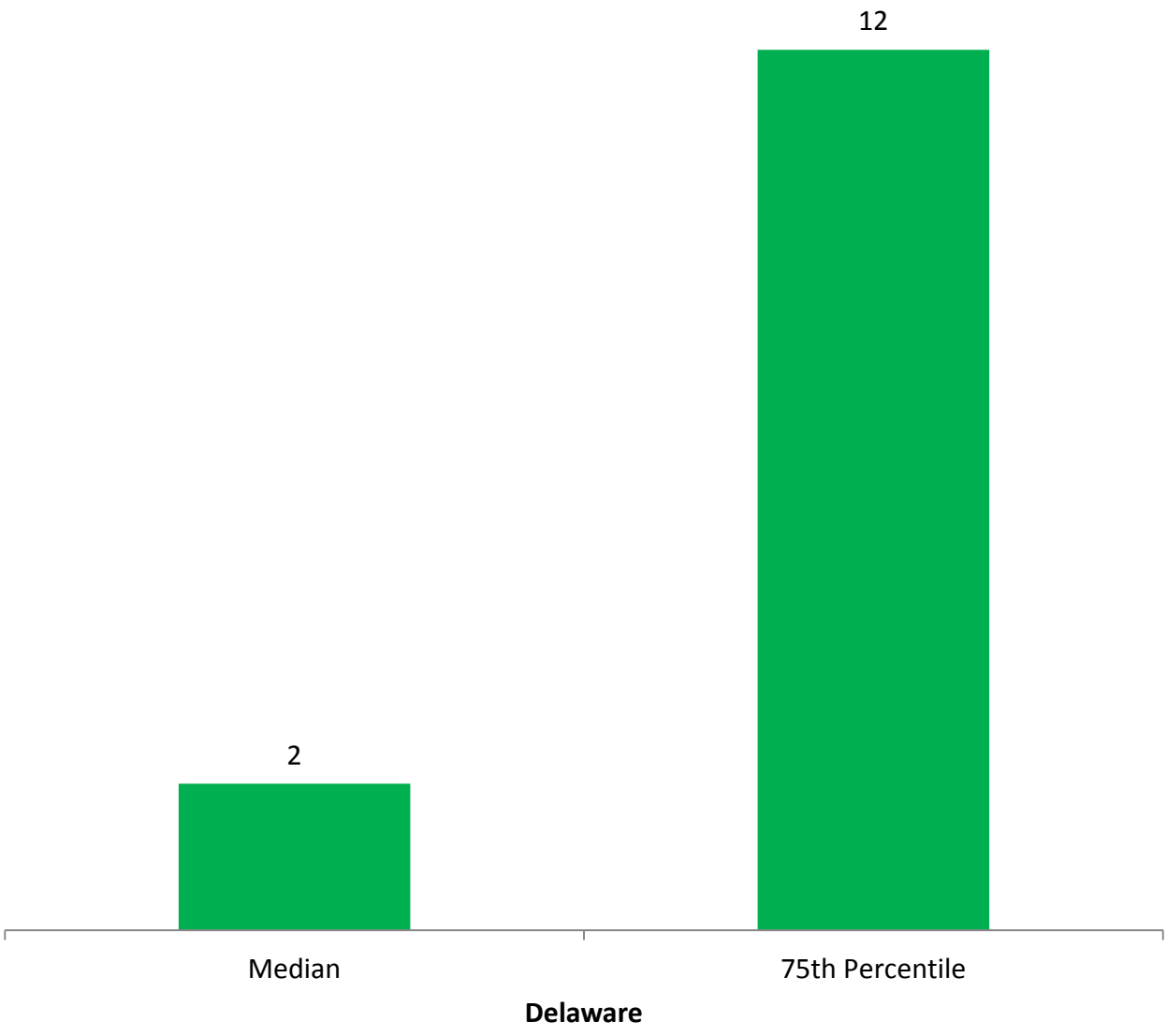


Exhibit 22

Time Until First Treatment for Initial Evaluation and Management Visit (in Days)

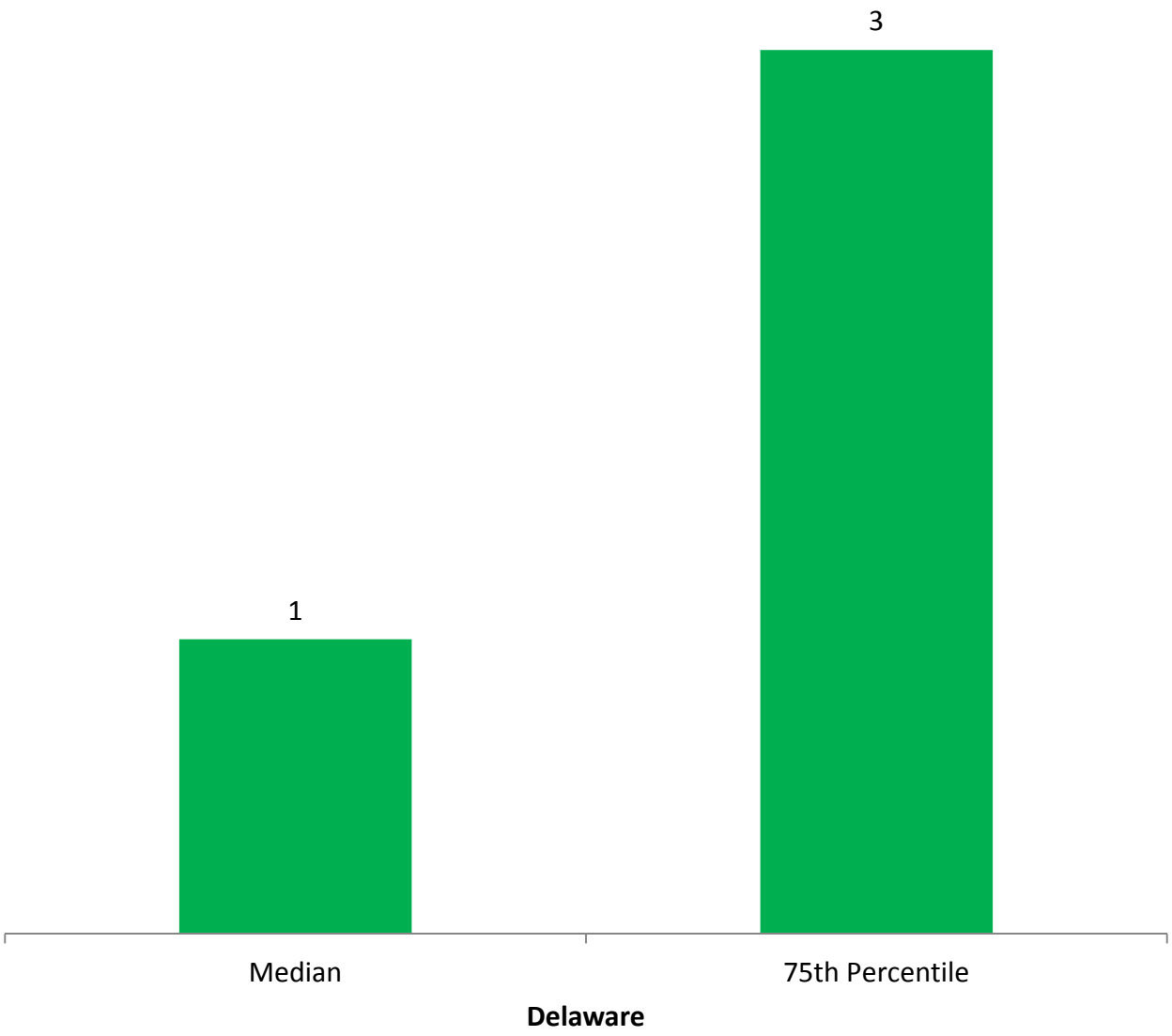


Exhibit 23
Hospital Inpatient Payments as a Percentage of Medicare

Section 2322B(3), Chapter 23, Title 19, Delaware Code established 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.

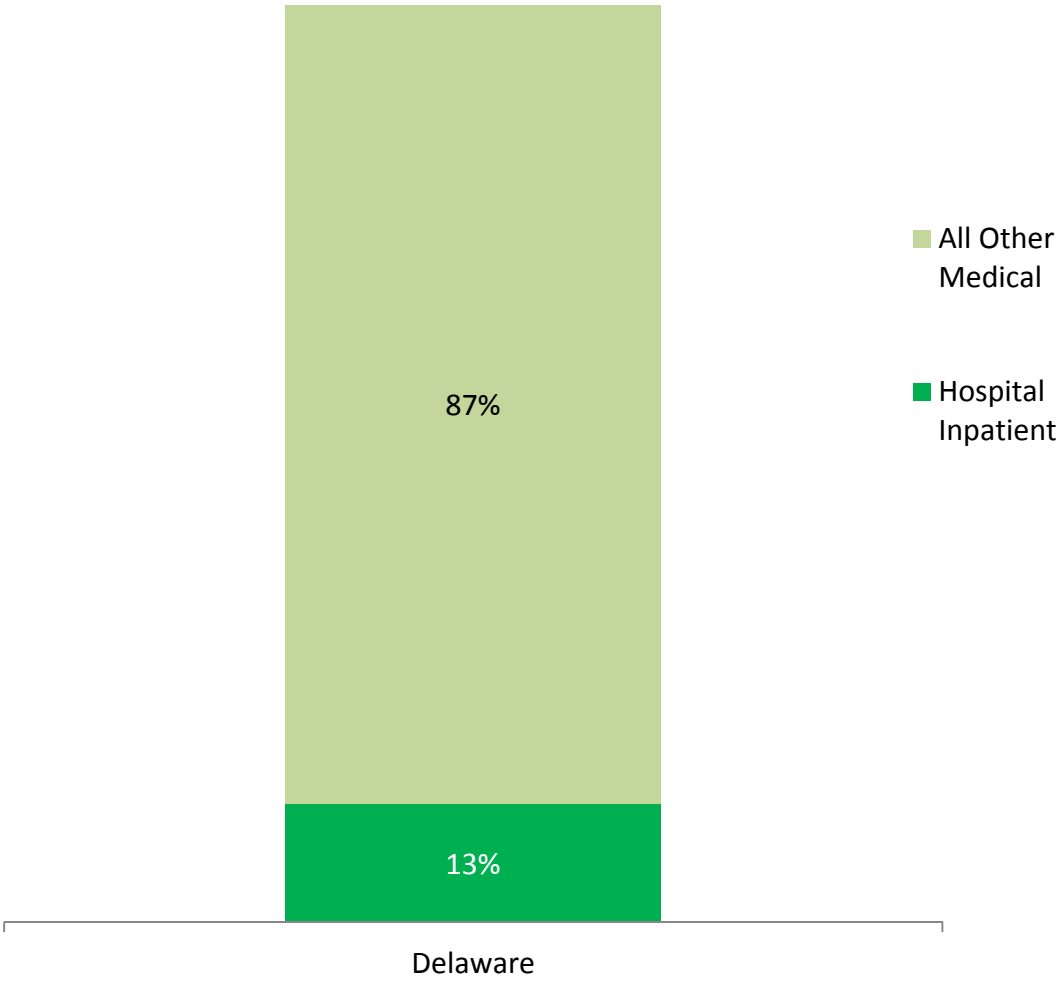
The Delaware workers' compensation health care payment system (HCPS) effective 1/31/15 moved towards an RBRVS, MS-DRG, and APC based system. While the Workers' Compensation Oversight Panel ("Panel") used these tools to form the foundation of the HCPS, Delaware has not adopted Medicare rules for workers' 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.

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. The DCRB does not collect all the adjustment factors and data required to accurately model the exact Medicare DRG reimbursement. Therefore, the DCRB compared the 2017 Delaware inpatient hospital DRG fee schedule to the "DRG Summary for Medicare Inpatient Prospective Payment Hospitals, FY2016." 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. The DCRB found that the DRG inpatient hospital fee schedule averaged between 118% to 144% of Medicare, depending on the Delaware geo zip.

In the WCRI's report titled "Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware", the WCRI found that the 2017 inpatient hospital fee schedule was 111% to 130% of Medicare. The WCRI uses a proprietary methodology to blend the 197/198 and 199 geo zips for their calculations.

Exhibit 24
Distribution of Medical Payments for Hospital Inpatient



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

Exhibit 25 presents the average paid amount per stay for Hospital Inpatient services.

Exhibit 26 displays the average paid amount per day for Hospital Inpatient services.

Exhibit 27 displays the average number of inpatient stays per 1,000 active claims.

Exhibit 28 presents the average and median length of Hospital Inpatient stays.

Exhibit 29 presents time to treatment for Hospital Inpatient stays.

Exhibit 30 details the top 10 diagnosis groups by paid amount for Hospital Inpatient services. This exhibit shows the most frequently-billed diagnosis groups.

Exhibit 31 details the top 10 DRG (Diagnosis Related Grouper) codes by paid amount for hospital inpatient services. This exhibits allow 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 500 groups, also referred to as DRGs, expected to have similar hospital resource use. Pennsylvania is frozen on DRG version 12 from 1994. 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 2017. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 25
Average Paid Amount Per Stay for Hospital Inpatient Services

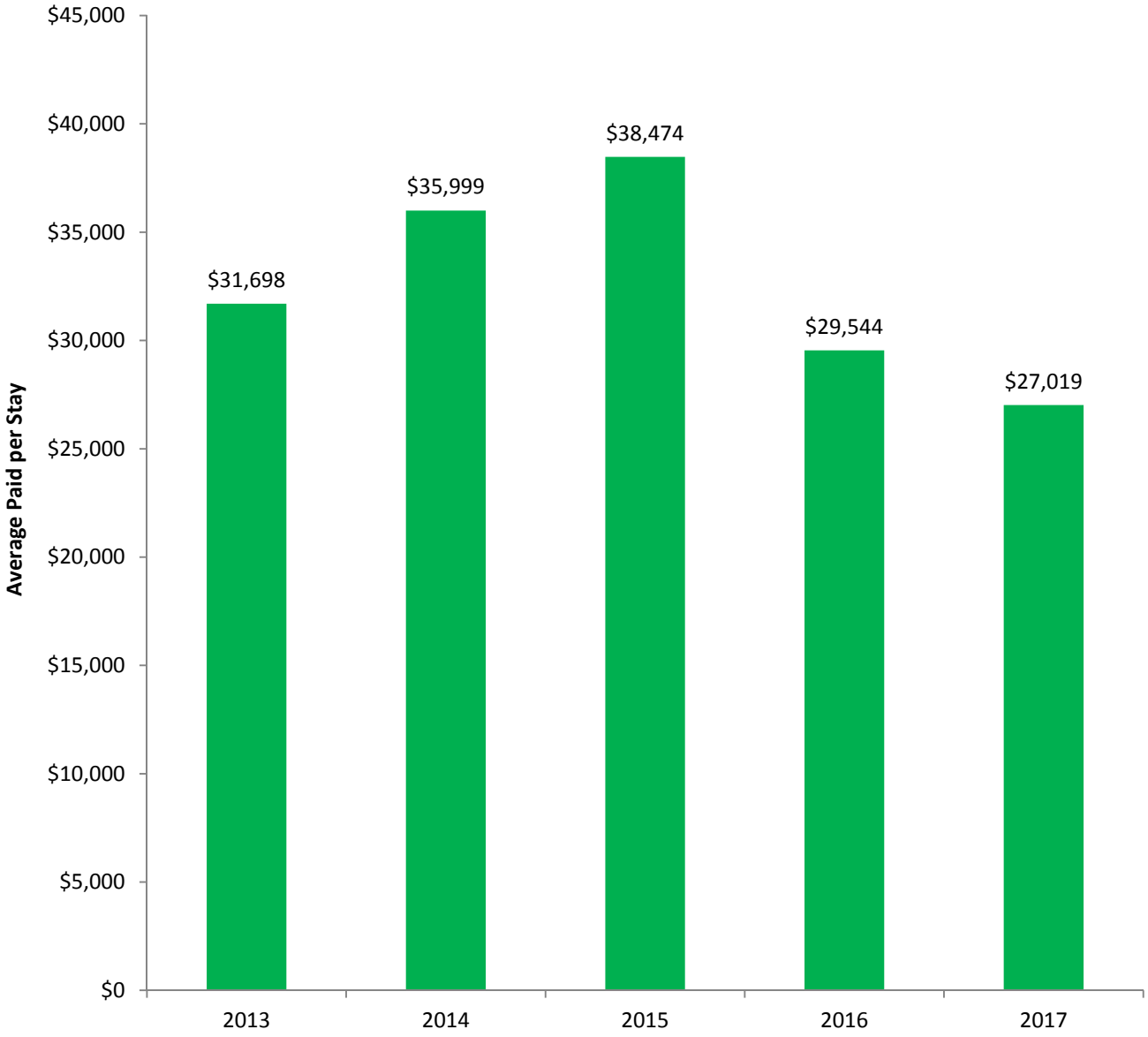


Exhibit 25 presents the average paid amount per stay for a Hospital Inpatient service by service year. This exhibit illustrates the trend of payments over a period of five service years.

Exhibit 26
Average Paid Amount per Day for Hospital Inpatient Services

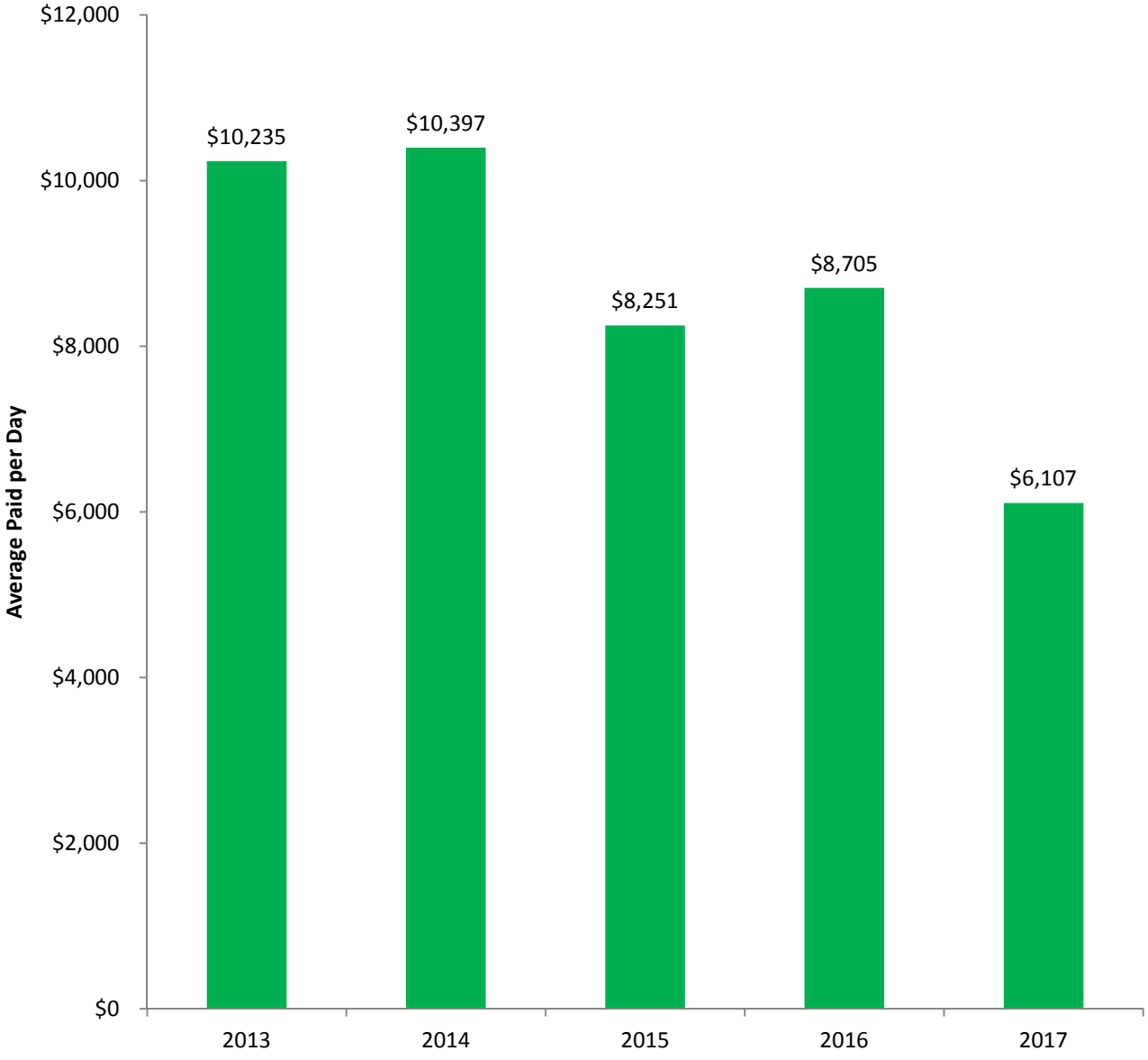


Exhibit 26 presents the average paid amount per day for Hospital Inpatient services by service year. This exhibit displays the pattern of payments over period of five service years.

Exhibit 27
Average Number of Stays per 1,000 Active Claims

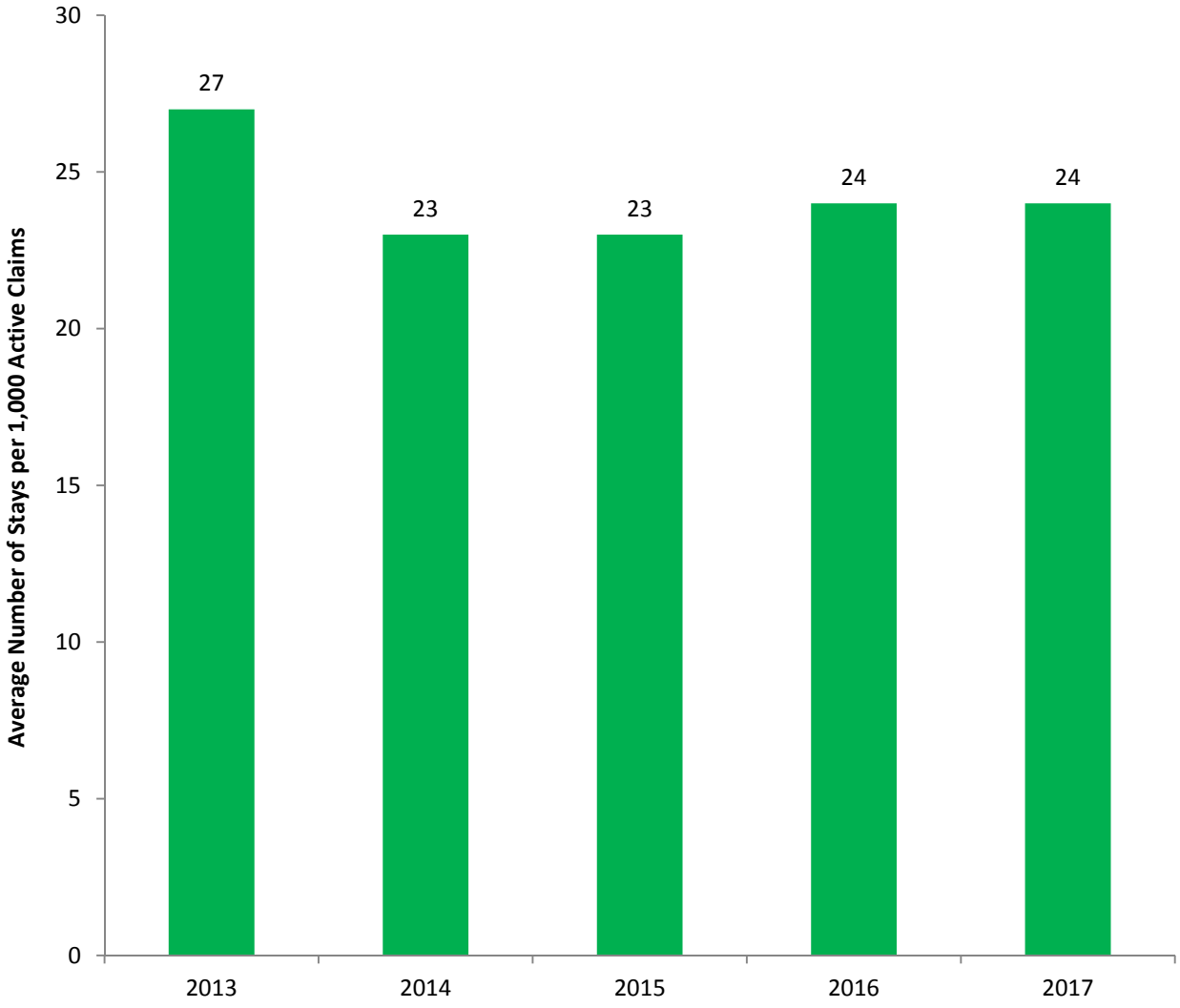


Exhibit 27 displays the average number of inpatient stays per 1,000 active claims by service year. This exhibit illustrates the trend in average number of stays over a period of five service years.

Exhibit 28
Inpatient Length of Stay for Hospital Inpatient Services

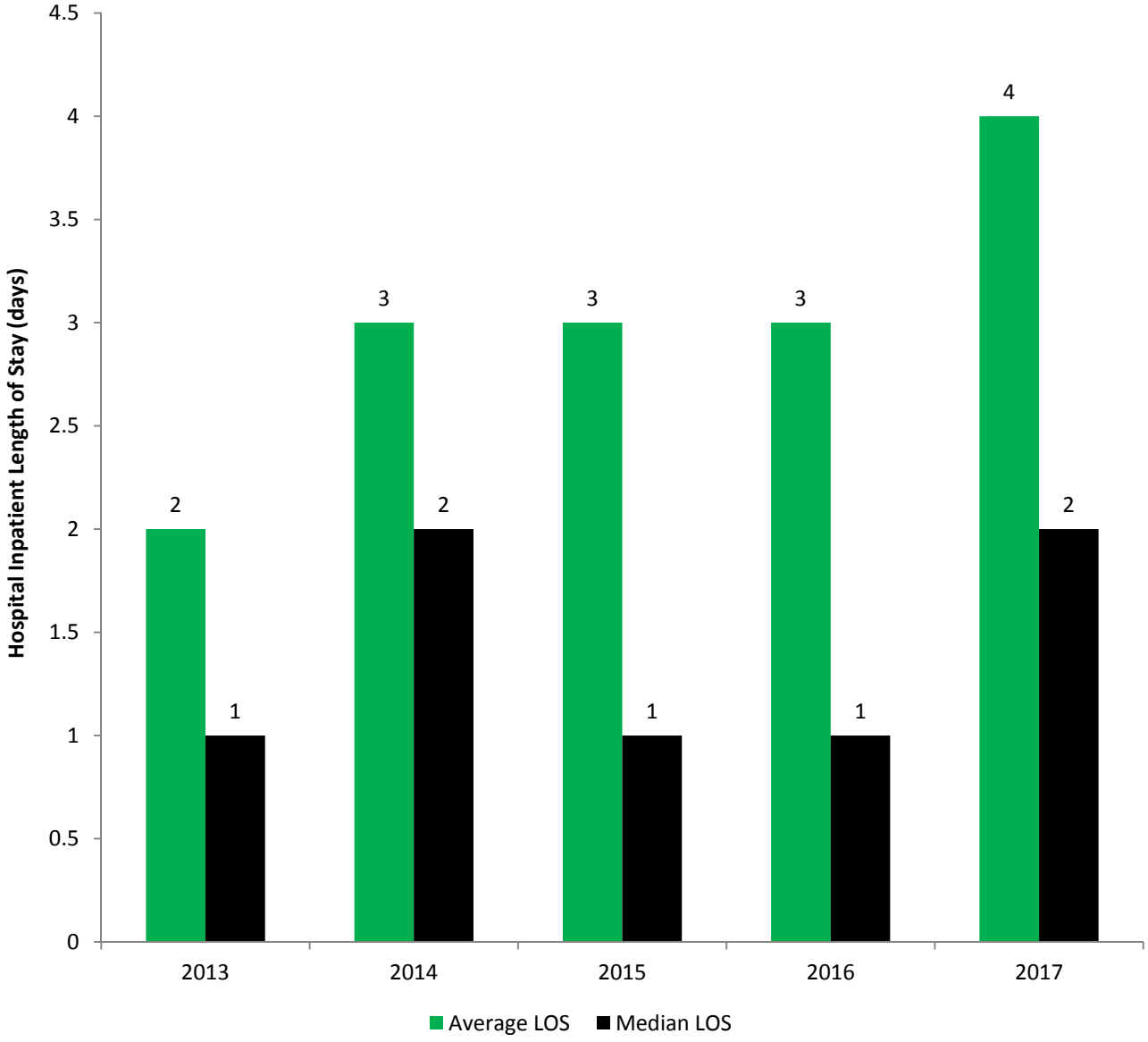


Exhibit 28 provides the average and median lengths of Hospital Inpatient stays over a five-year service period. This information suggests consistency in length of stay over the period examined.

Exhibit 29
Time Until First Treatment for Hospital Inpatient Stays (in Days)

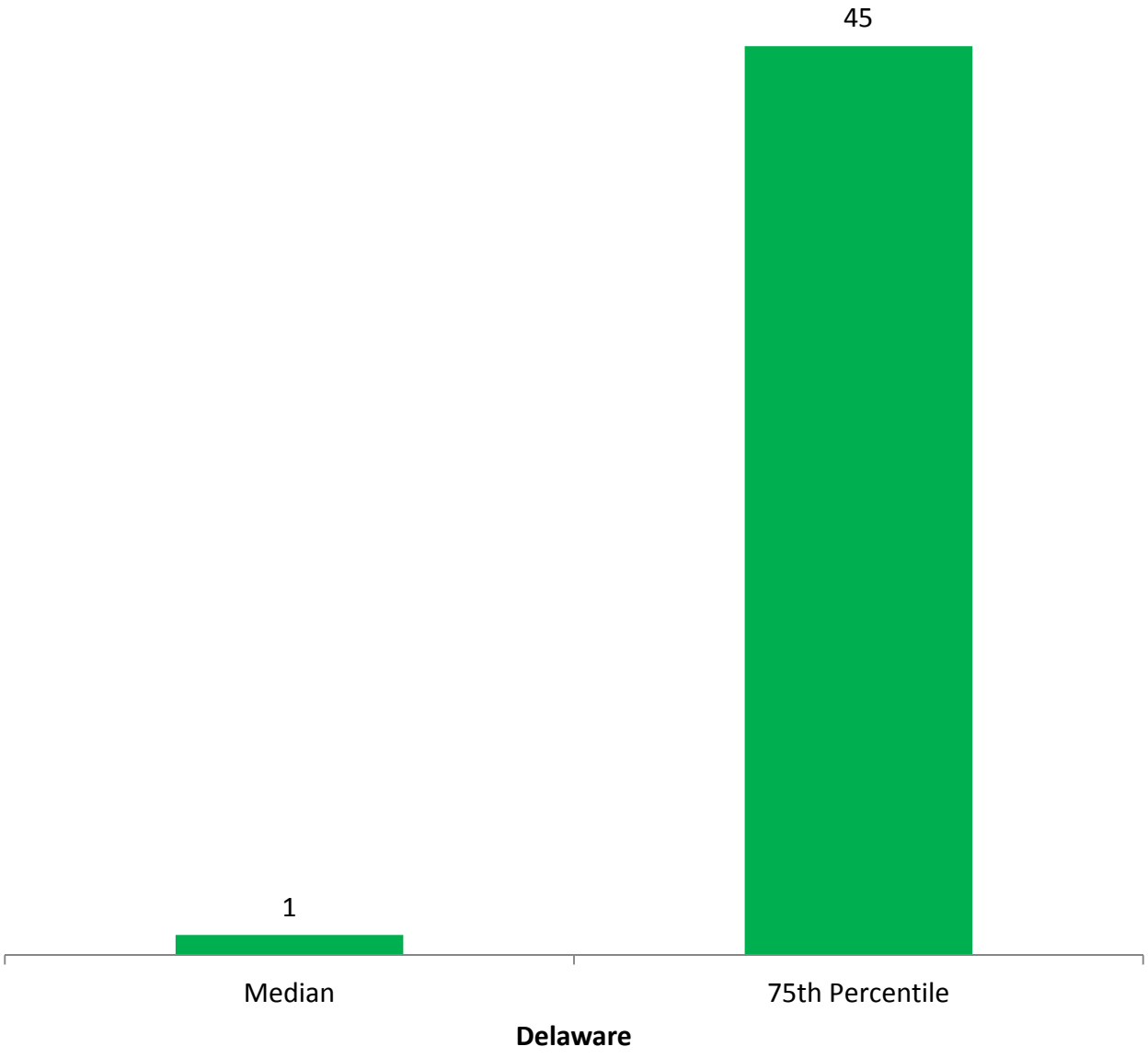
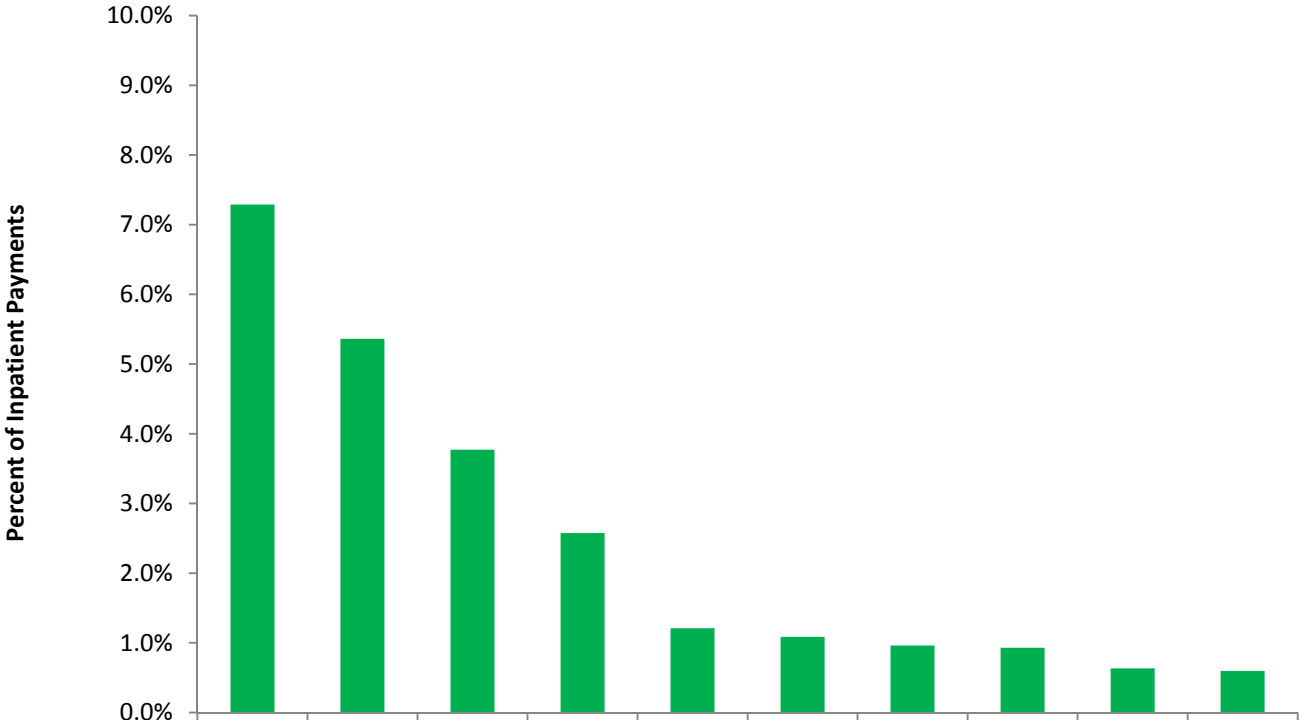


Exhibit 30
Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

Diagnosis Group	Paid Share	Median Amount Paid Per Stay
Other dorsopathies	27.0%	$30,611
Spondylopathies	8.5%	$37,098
Burns and corrosions of external body surface, specified by site	8.0%	$40,690
Injuries to the knee and lower leg	5.3%	$13,465
Deforming dorsopathies	4.8%	$60,661
Aplastic and other anemias and other bone marrow failure syndrome	3.7%	$34,040
Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals	3.6%	$12,647
Injuries to the head	3.4%	$15,629
Osteoarthritis	3.2%	$16,155
Injuries to the hip and thigh	3.1%	$11,176

Exhibit 31
Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services



	460	454	455	462	470	481	552	167	092	602
% Paid	7.3%	5.4%	3.8%	2.6%	1.2%	1.1%	1.0%	0.9%	0.6%	0.6%
Median Pd/Stay	$29,081	$29,395	$45,704	$73,754	$15,347	$17,691	$6,597	$53,239	$7,772	$34,238

Code	Description
460	Spinal fusion except cervical without major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
462	Bilateral or multiple major joint procedures of lower extremity without major complications or comorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
481	Hip & femur procedures except major joint with complications or comorbidities
552	Medical back problems without major complications or comorbidities
167	Other respiratory system operating room procedures w complications and comorbidities
092	Other disorders of nervous system with complications and comorbidities
602	Cellulitis with major complications or comorbidities

Exhibit 32
Hospital Outpatient Payments as a Percentage of Medicare

Section 2322B(3), Chapter 23, Title 19, Delaware Code established 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.

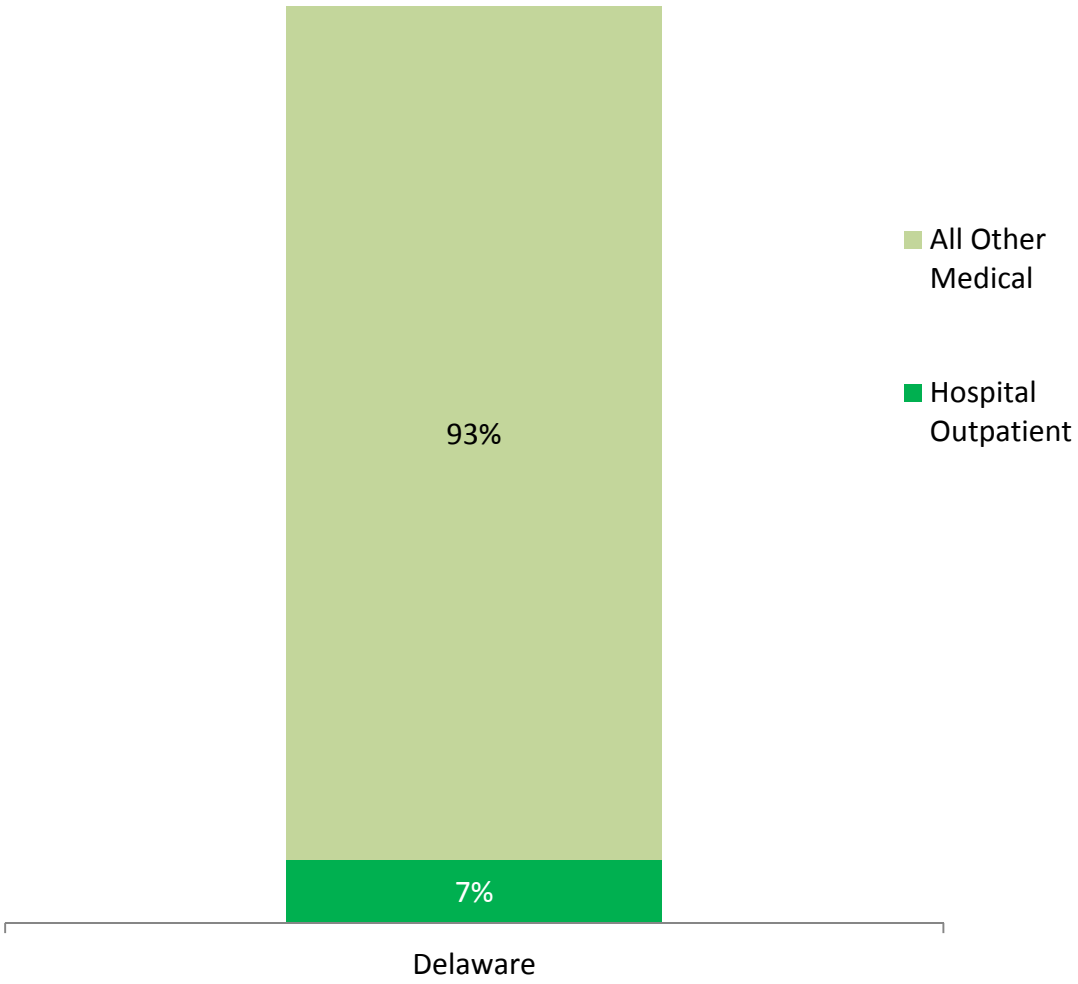
The Delaware workers' compensation health care payment system (HCPS) effective 1/31/15 moved towards an RBRVS, MS-DRG, and APC based system. While the Workers' Compensation Oversight Panel ("Panel") used these tools to form the foundation of the HCPS, Delaware has not adopted Medicare rules for workers' 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.

Hospital Outpatient Payments

The Centers for Medicare and Medicaid Services (CMS) 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). Due to this complexity, a DCRB rate comparison to Medicare is not available for the hospital outpatient.

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

Exhibit 33
Distribution of Medical Payments for Hospital Outpatient



Facility Information

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

Exhibit 34 presents the average outpatient paid amount per surgical visit for Hospital Outpatient services. **Exhibit 35** displays the average number of surgical hospital outpatient visits per 1,000 active claims. **Exhibits 36 and 37** represent similar data, but for non-surgical visits.

Exhibit 38 presents time to treatment for Hospital Outpatient visits.

Exhibit 39 details the top 10 diagnosis groups by paid amount for Hospital Outpatient services. This exhibit identifies the most frequently-billed diagnosis groups.

Exhibit 40 details the top 10 surgery CPT codes by paid amount for Hospital Outpatient services. This exhibit identifies the most frequently billed CPT codes. At the bottom of the exhibit, the CPT codes are displayed with detailed descriptions. **Exhibit 41** 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 2017. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 34
Average Outpatient Paid Amount Per Surgical Visit for Hospital Outpatient Services

Exhibit 34 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.

Exhibit 35
Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims

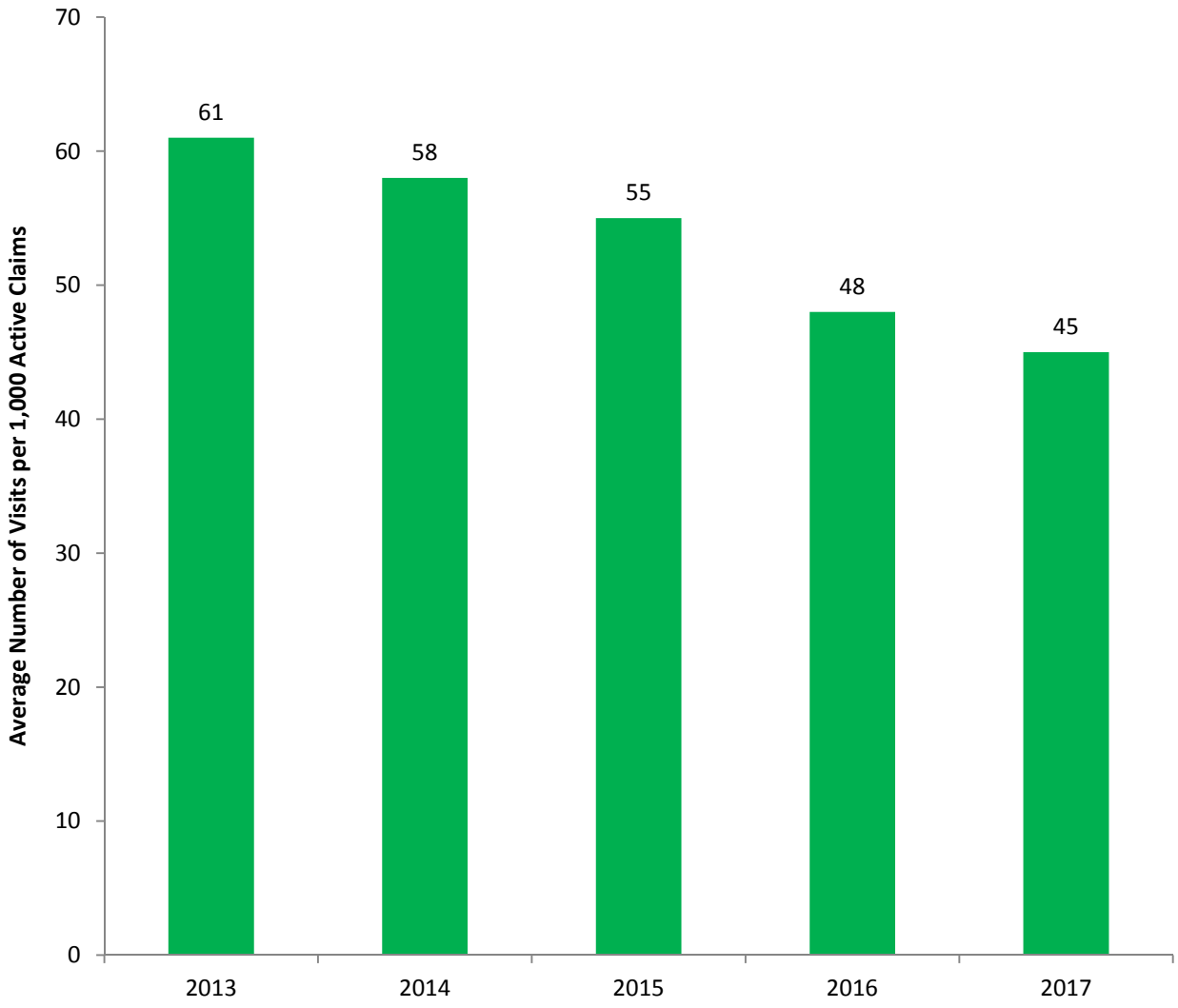


Exhibit 35 presents the average number of surgical Hospital Outpatient visits per 1,000 active claims.

Exhibit 36
Average Outpatient Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services

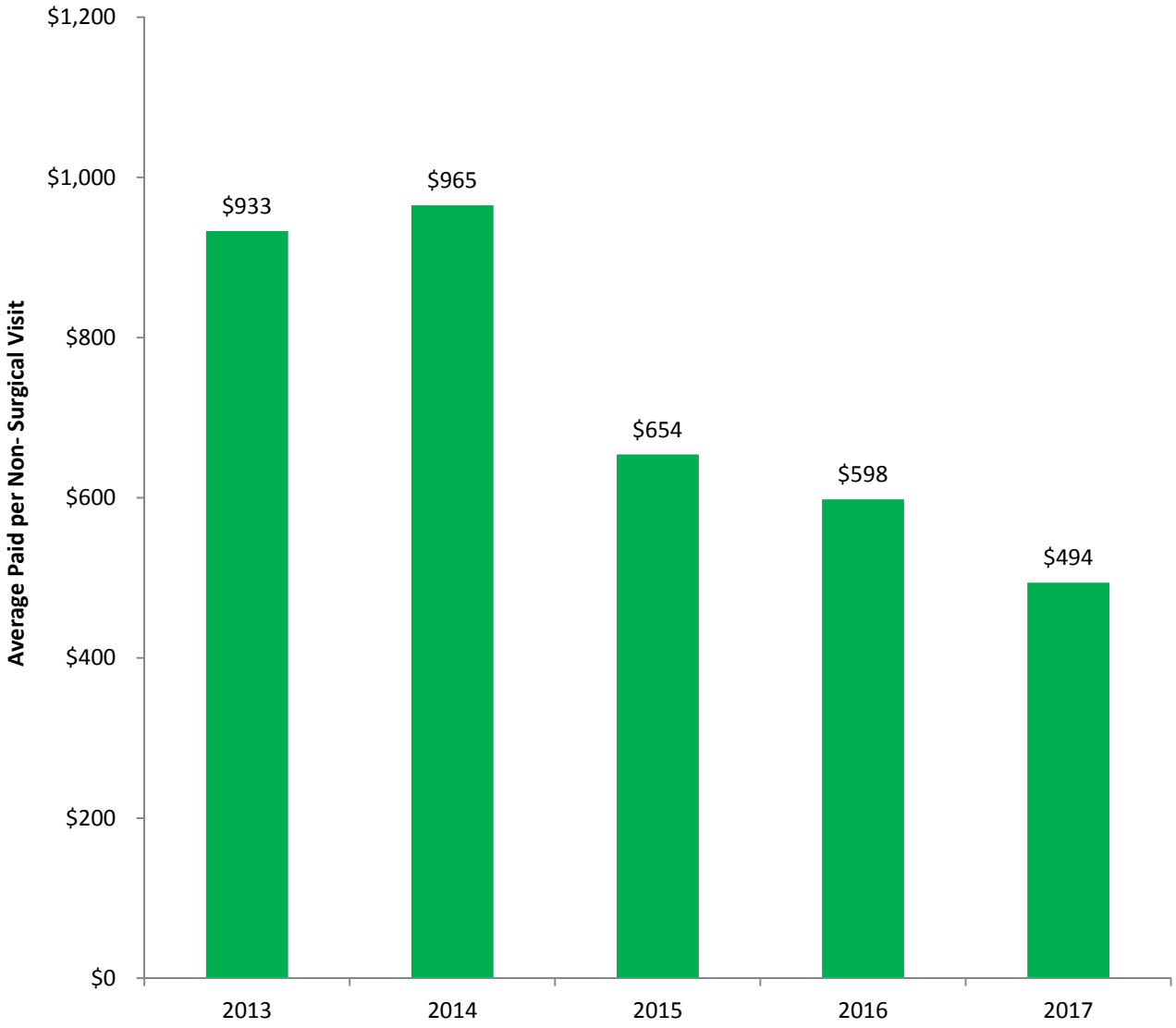


Exhibit 36 presents the average outpatient paid amount per non-surgical visit for Hospital Outpatient services by service year. This exhibit illustrates payments over a period of five consecutive service years.

Exhibit 37
Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims

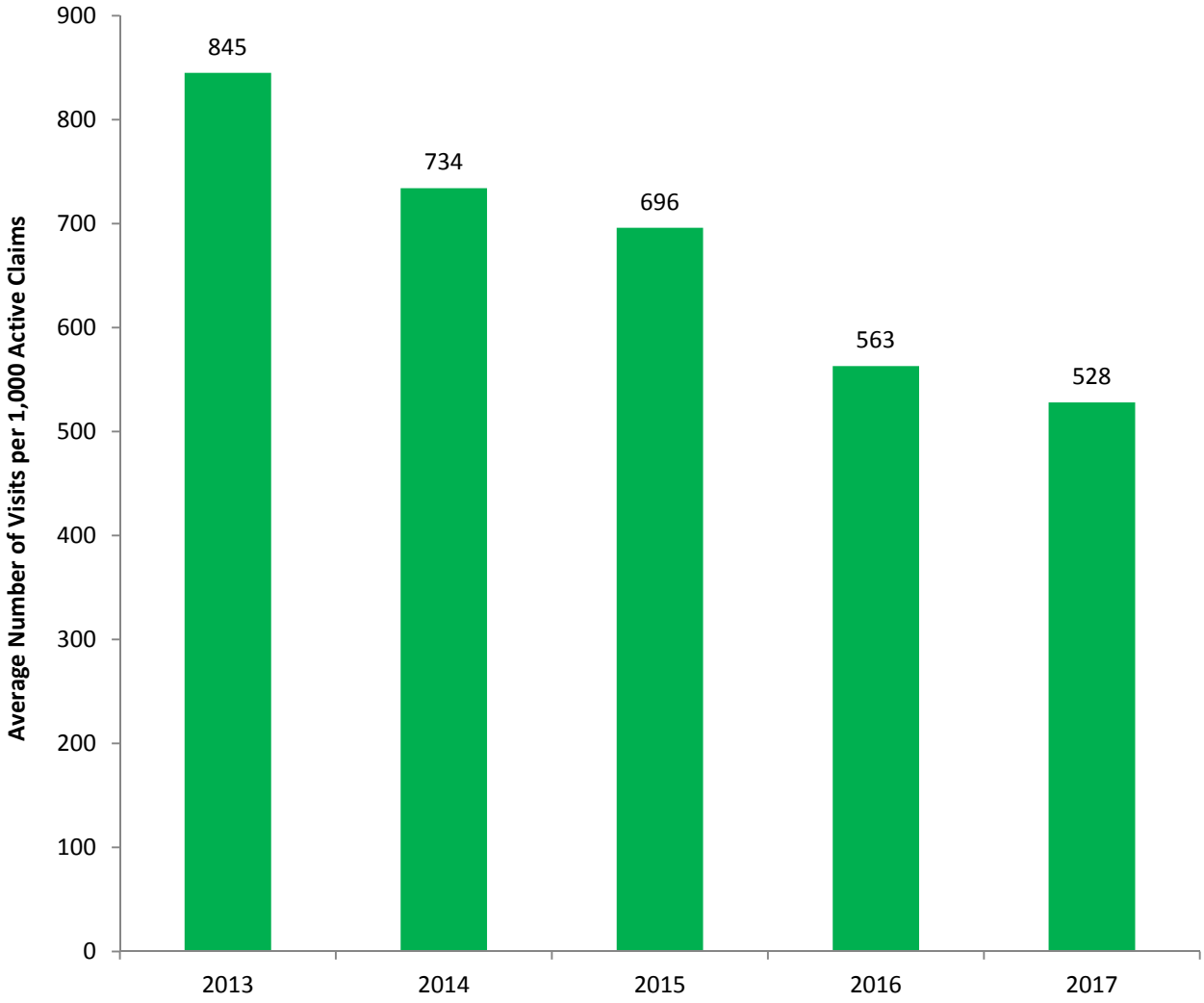


Exhibit 37 presents the average number of non-surgical Hospital Outpatient visits per 1,000 active claims.

Exhibit 38
Time Until First Treatment for Outpatient Visit (in Days)

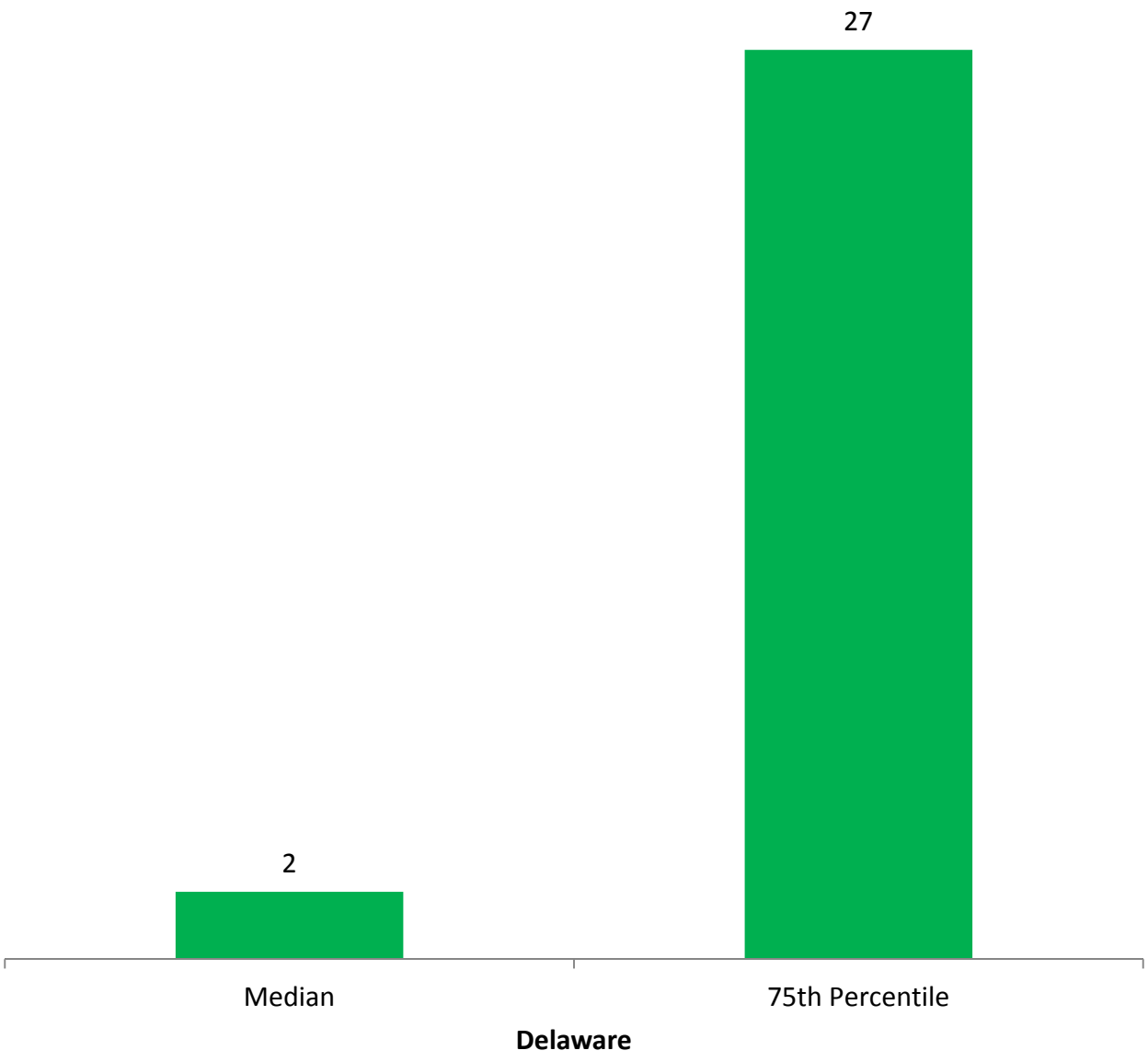
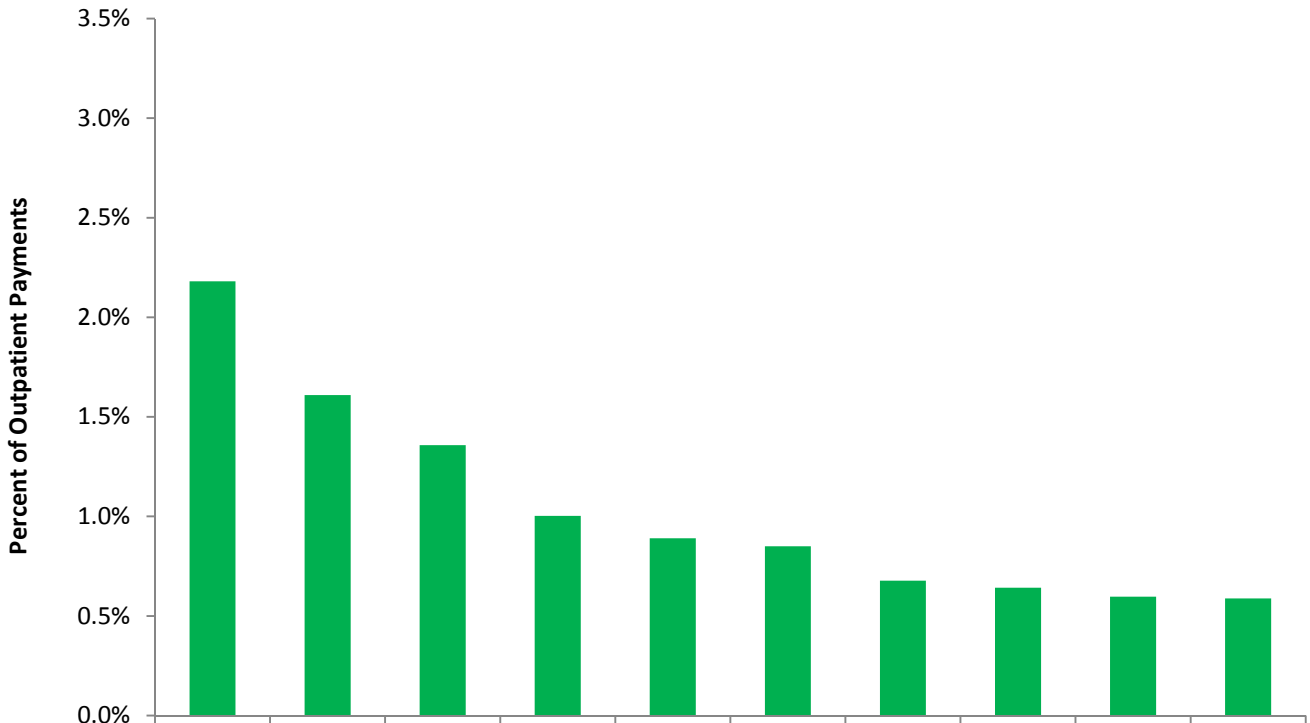


Exhibit 39
Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services

Diagnosis Group	Paid Share	Median Amount Paid Per Visit
Other dorsopathies	20.9%	$315
Other soft tissue disorders	7.5%	$378
Injuries to the wrist, hand and fingers	7.3%	$405
Other joint disorders	6.8%	$285
Complications of surgical and medical care, NOC	5.4%	$479
Injuries to the shoulder and upper arm	4.7%	$514
Spondylopathies	4.5%	$530
Injuries to the knee and lower leg	3.5%	$369
Hernia	3.5%	$2,687
Osteoarthritis	2.3%	$359

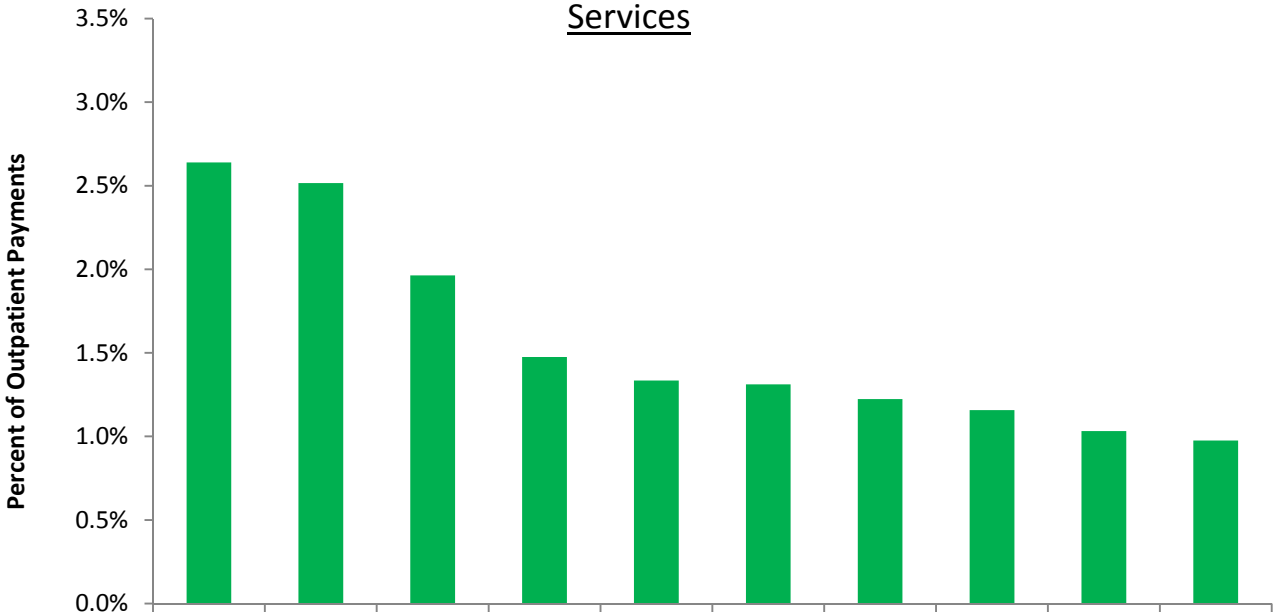
Exhibit 40
Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services



	22551	29827	63047	29881	49505	22856	63685	26489	17108	63030
% Paid	2.2%	1.6%	1.4%	1.0%	0.9%	0.8%	0.7%	0.6%	0.6%	0.6%
Avg Pd/Txn	$5,322	$4,255	$3,916	$3,181	$4,707	$6,739	$5,371	$20,376	$4,735	$6,217

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
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
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
49505	Repair initial inguinal hernia, age 5 years or older; reducible
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
26489	Transfer or transplant of tendon, palmar; with free tendon graft (includes obtaining graft), each tendon
17108	Destruction of cutaneous vascular proliferative lesions (e.g., laser technique); over 50.0 sq cm
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

Exhibit 41
Top 10 Non-Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services



	97110	C1820	99283	99284	73221	C1767	97140	73721	72148	72141
% Paid	2.6%	2.5%	2.0%	1.5%	1.3%	1.3%	1.2%	1.2%	1.0%	1.0%
Avg Pd/Txn	$63	$39,900	$373	$616	$523	$41,610	$47	$496	$511	$499

Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
C1820	Generator, neurostimulator (implantable), non high-frequency with rechargeable battery and charging system
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material(s)
C1767	Generator, neurostimulator (implantable), non-rechargeable
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material

Facility Information

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

Exhibit 42 presents the average paid amount per ER visits.

Exhibit 43 displays the average number of ER visits per 1,000 active claims.

Exhibit 44 presents the most recent five-year trend for Evaluation and Management procedure codes for Emergency Room Services. **Exhibit 45** 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 2017. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 42
Average Amount Paid Per ER Visit

Exhibit 42 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.

Exhibit 43
Average Number of ER Visits per 1,000 Active Claims

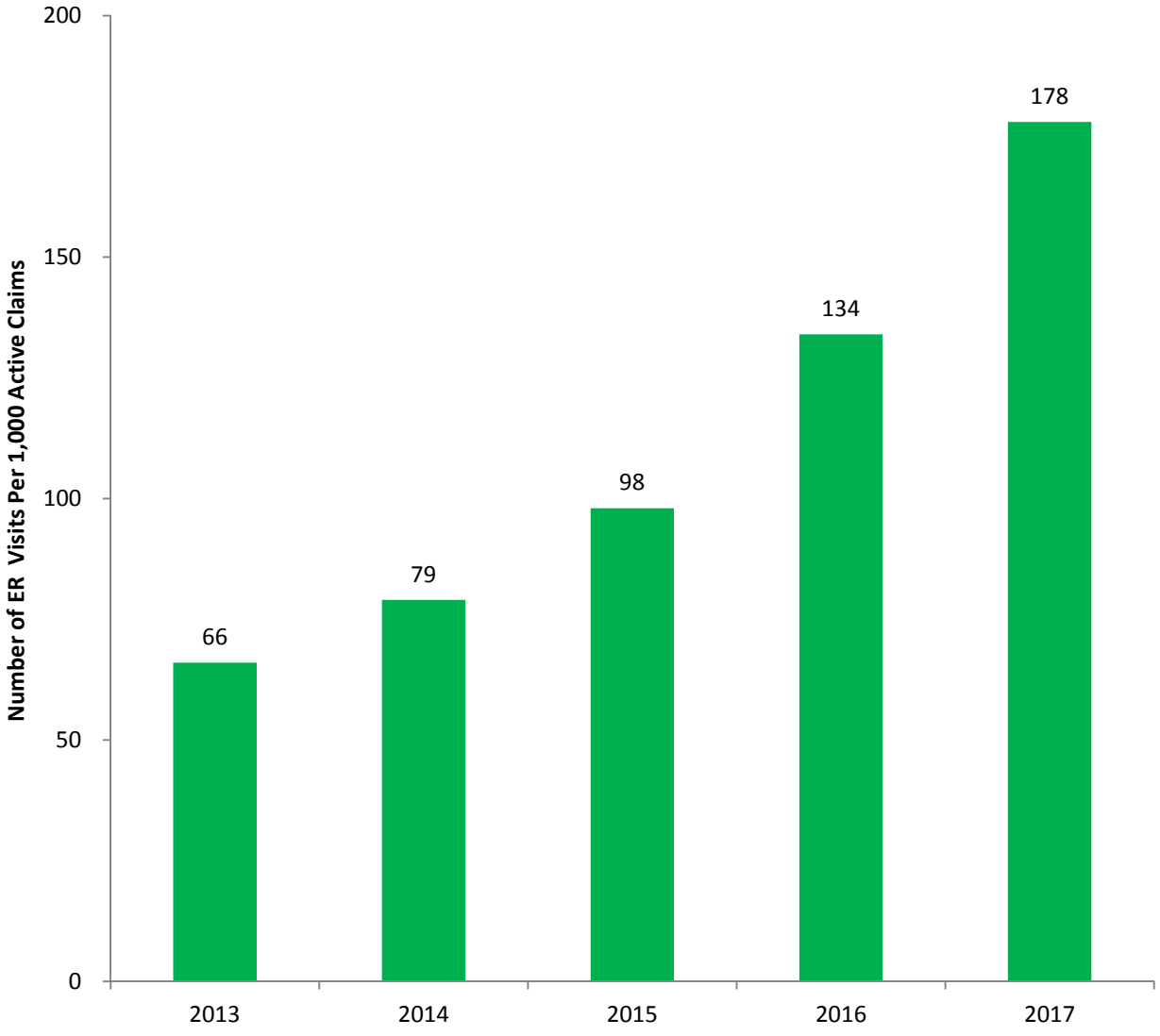


Exhibit 43 displays the number of emergency room visits per 1,000 active claims by service year. These results demonstrate an increasing trend in the number of Emergency Room visits over the last five years.

Exhibit 44
Emergency Room Services by Procedure Codes Trend

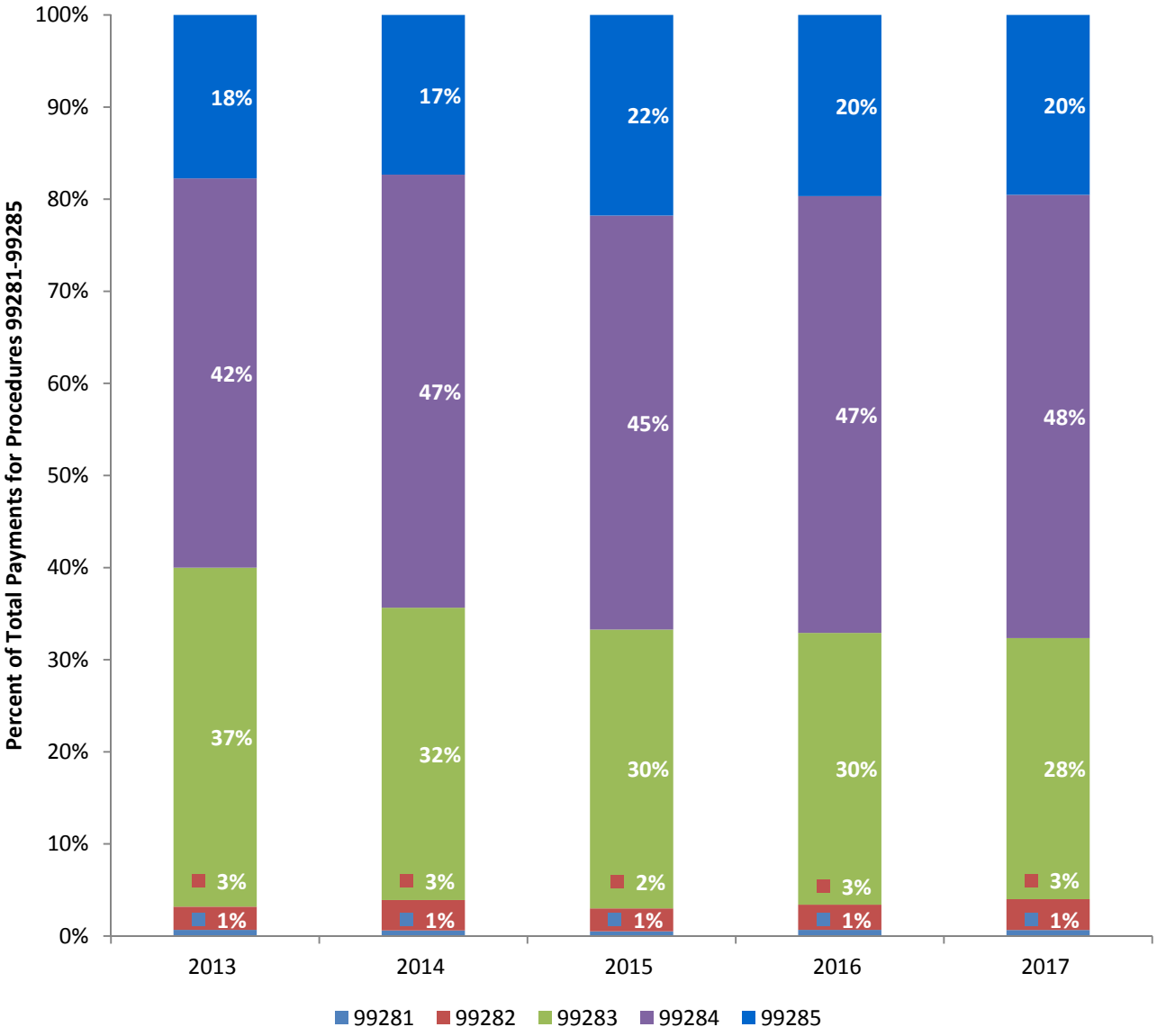


Exhibit 44 displays Emergency Room services by procedure codes trend by service year. This exhibit displays the distribution of payments for a period of five service years.

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

Exhibit 44 (continued)
Top 5 Emergency Room Services by Procedure Codes Trend

Average Paid Per Transaction

	2013	2014	2015	2016	2017
99281	$106	$91	$96	$111	$93
99282	$152	$154	$146	$142	$164
99283	$238	$242	$245	$241	$205
99284	$356	$378	$355	$383	$341
99285	$529	$553	$593	$550	$479

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.

Exhibit 45
Emergency Room Transactions by Procedure Code

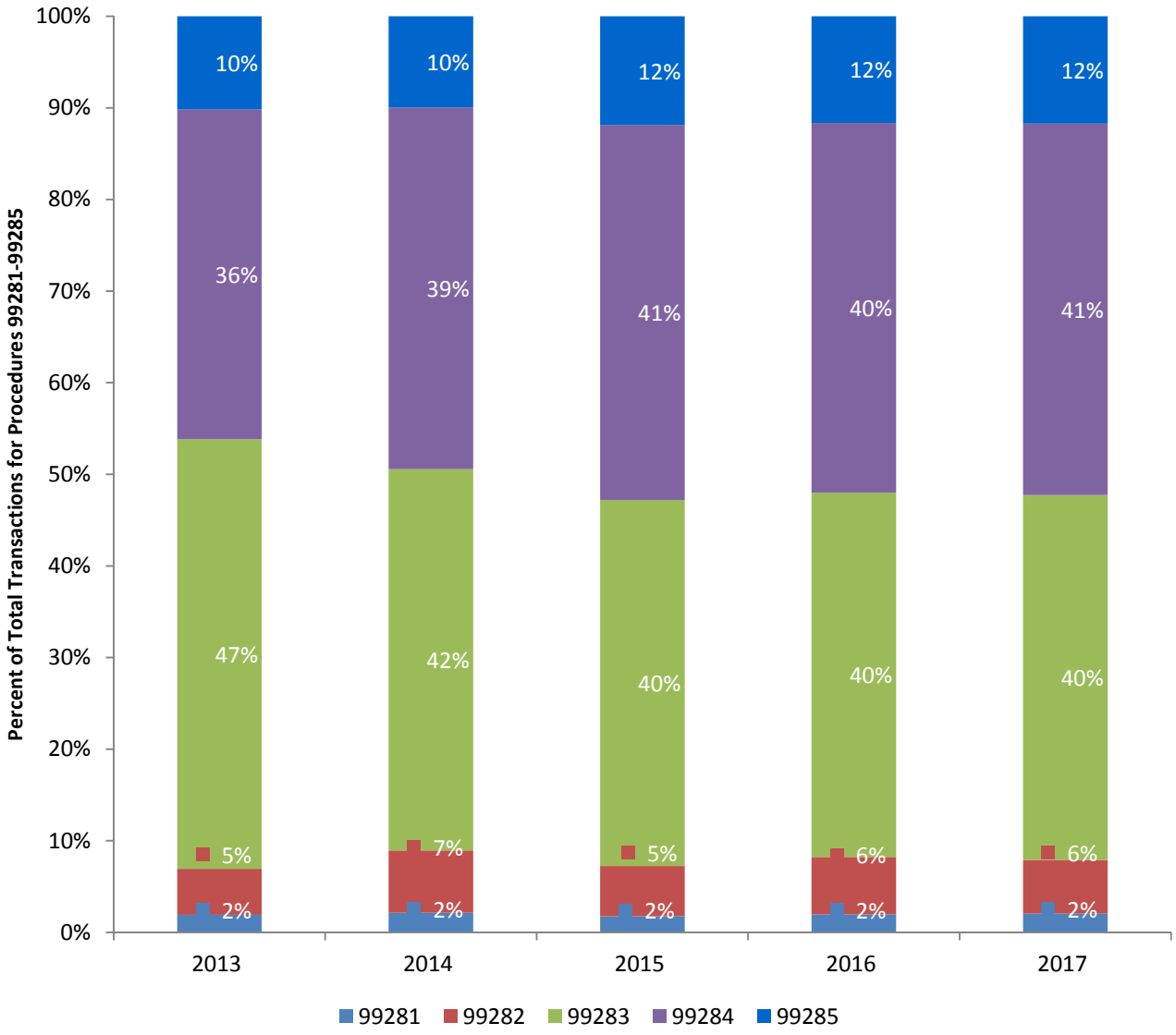


Exhibit 45 displays Emergency Room services by procedure codes trend by service year. This exhibit displays the distribution of transactions for a period of five service years.

Refer to the Exhibit 45 continuation on the next page for the description of codes 99281-99285.

Exhibit 45 (continued)
Emergency Room Transactions by Procedure Code

Total Transactions

	2013	2014	2015	2016	2017
99281	33	34	26	31	32
99282	86	107	81	99	91
99283	803	657	589	628	619
99284	617	623	604	637	630
99285	174	157	175	184	182

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.

Exhibit 46
ASC Payments as a Percentage of Medicare

Section 2322B(3), Chapter 23, Title 19, Delaware Code established 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.

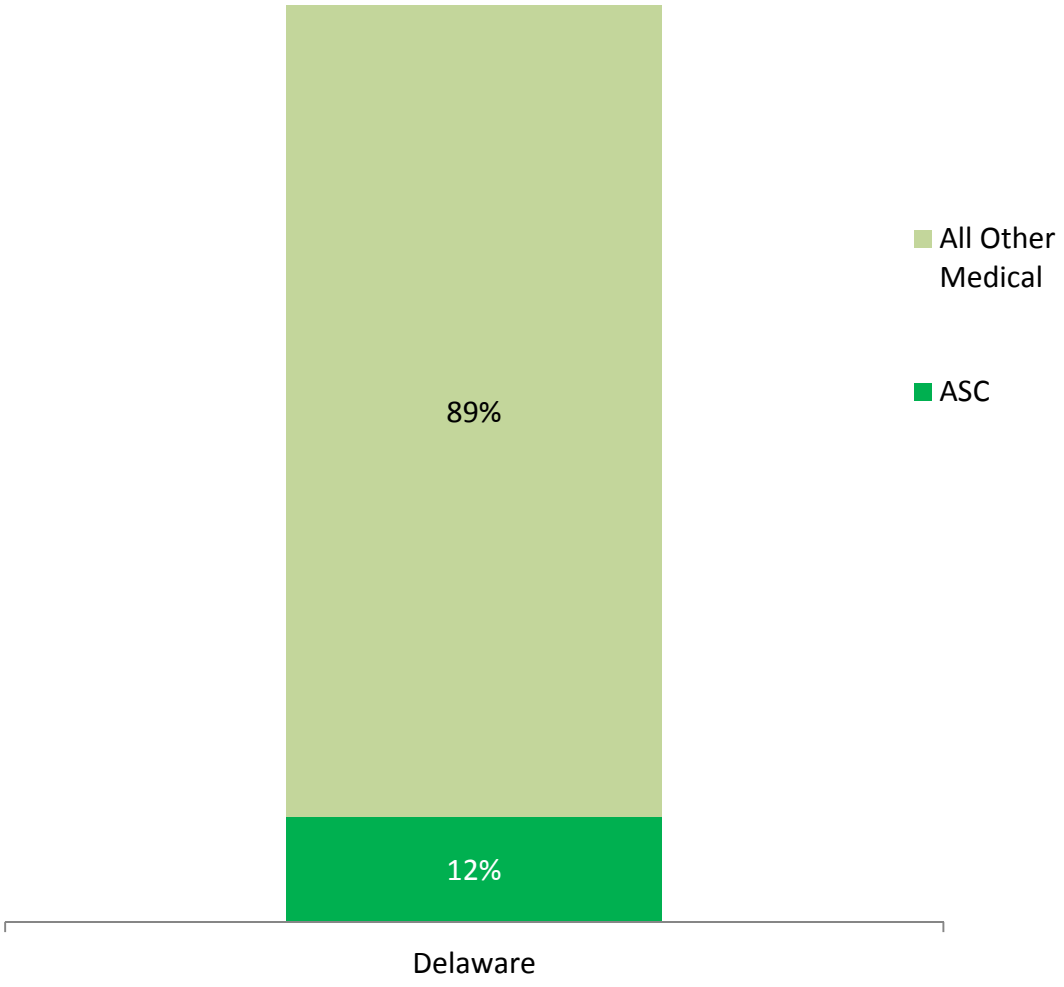
The Delaware workers' compensation health care payment system (HCPS) effective 1/31/15 moved towards an RBRVS, MS-DRG, and APC based system. While the Workers' Compensation Oversight Panel ("Panel") used these tools to form the foundation of the HCPS, Delaware has not adopted Medicare rules for workers' 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.

Ambulatory Surgery Center Payments

The Centers for Medicare and Medicaid Services (CMS) 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 ASC fees.

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

Exhibit 47
Distribution of Medical Payments for ASC



Facility Information

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

Exhibit 48 presents the average outpatient paid amount per visit for ASC services. **Exhibit 49** displays the average number of ASC visits per 1,000 active claims.

Exhibit 50 presents time to treatment for ASC visits.

Exhibit 51 details the top 10 diagnosis groups by paid amount for ASC services.

Exhibit 52 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 2017. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 48
Average Amount Paid Per Visit for ASC Services

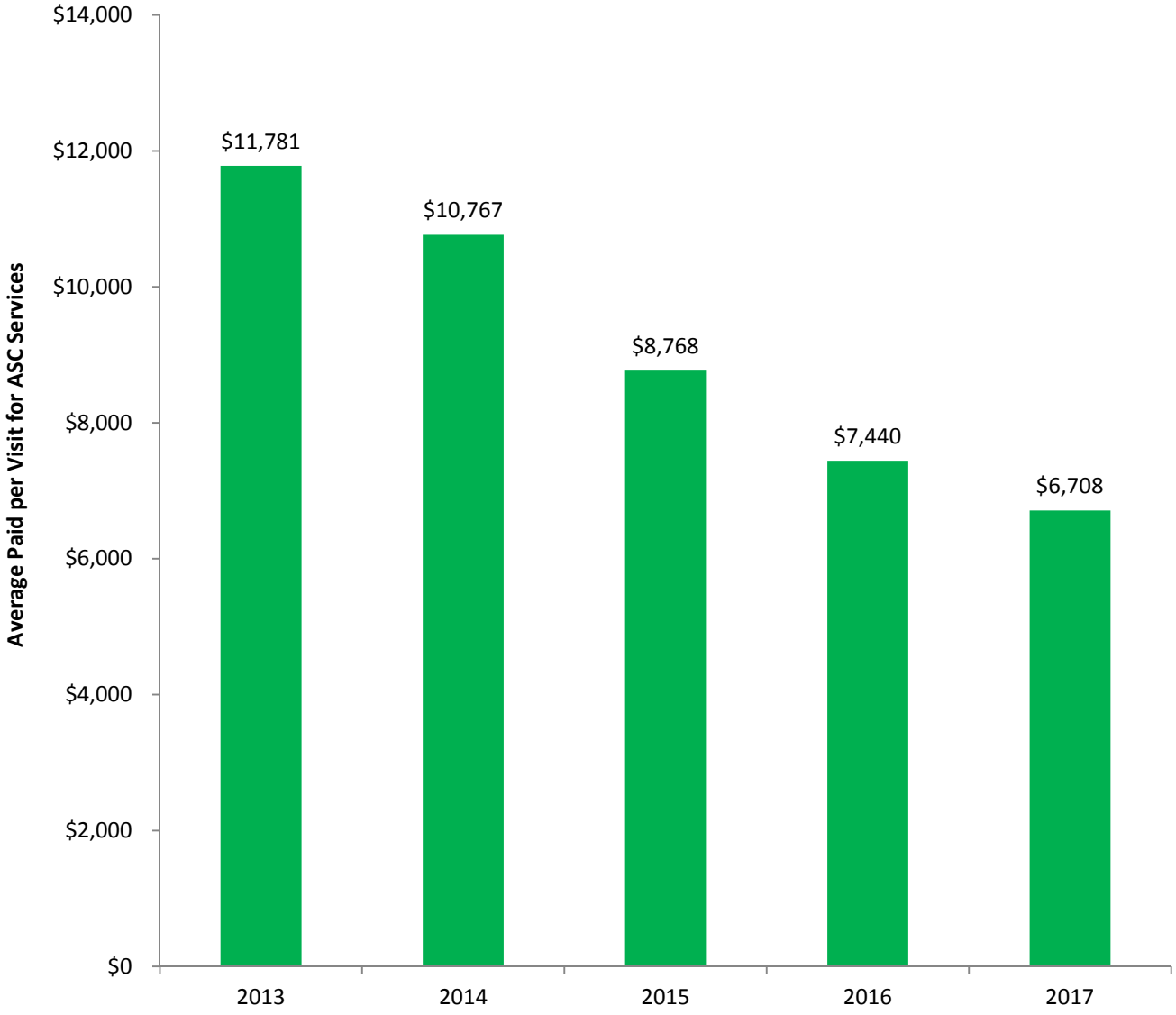


Exhibit 48 depicts the average amount paid per visit for Ambulatory Surgery Center services by service year over a five-year period. These results demonstrate a decline in the average amount paid per visit.

Exhibit 49
Average Number of ASC Visits per 1,000 Active Claims

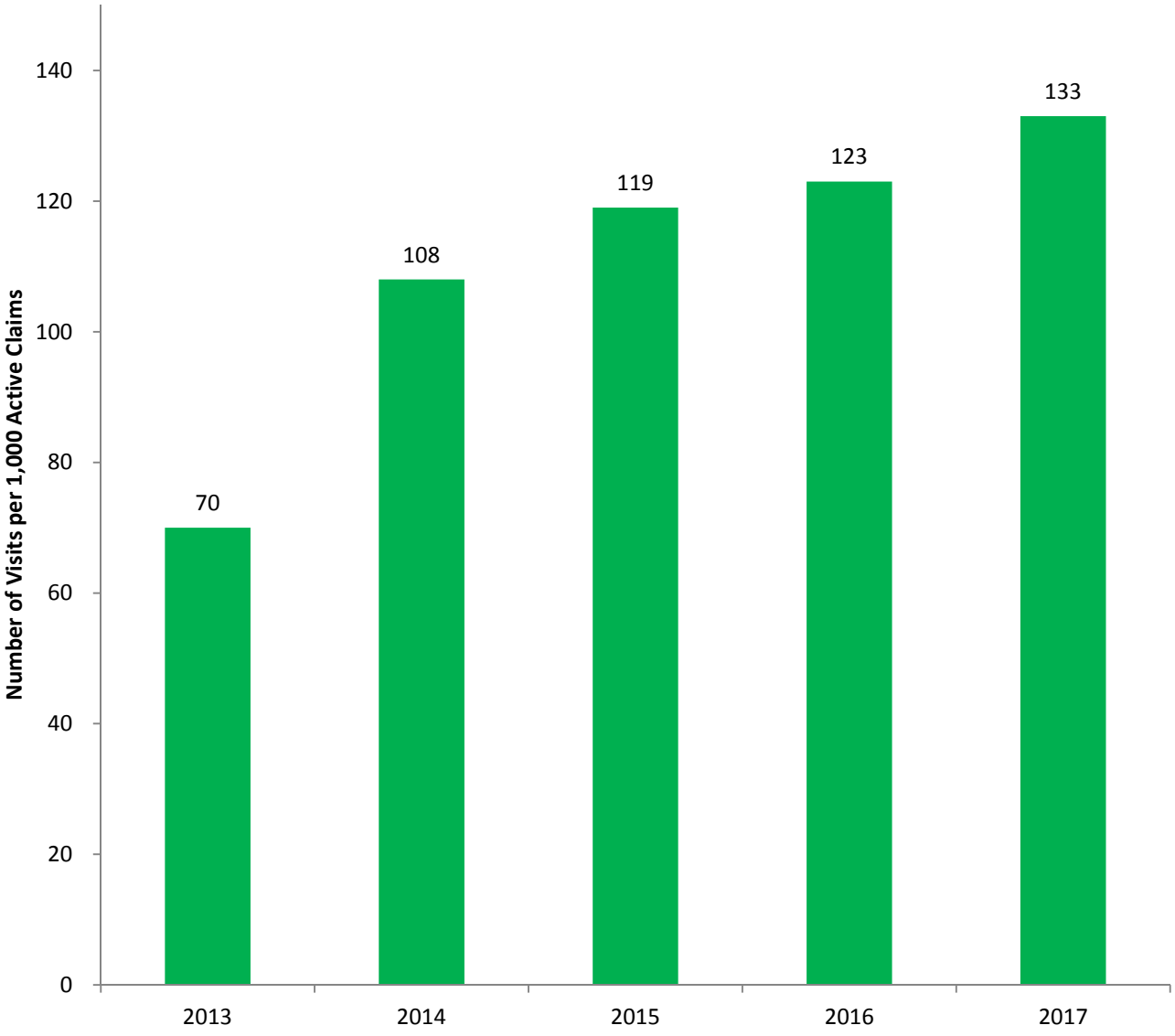


Exhibit 49 depicts the average number of for Ambulatory Surgery Center visits per 1,000 active claims over a five-year period.

Exhibit 50
Time Until First Treatment for ASC Visits (in Days)

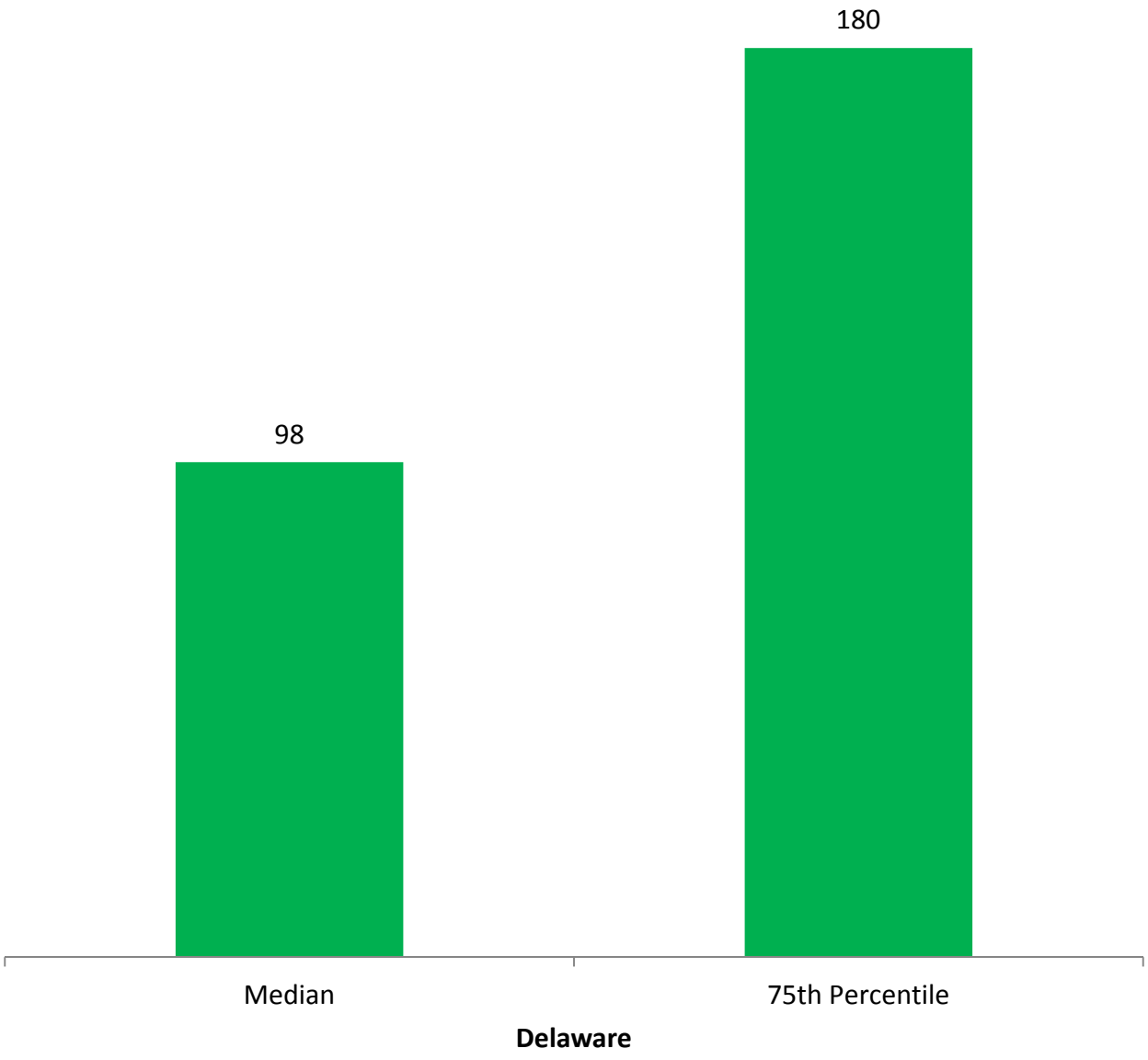
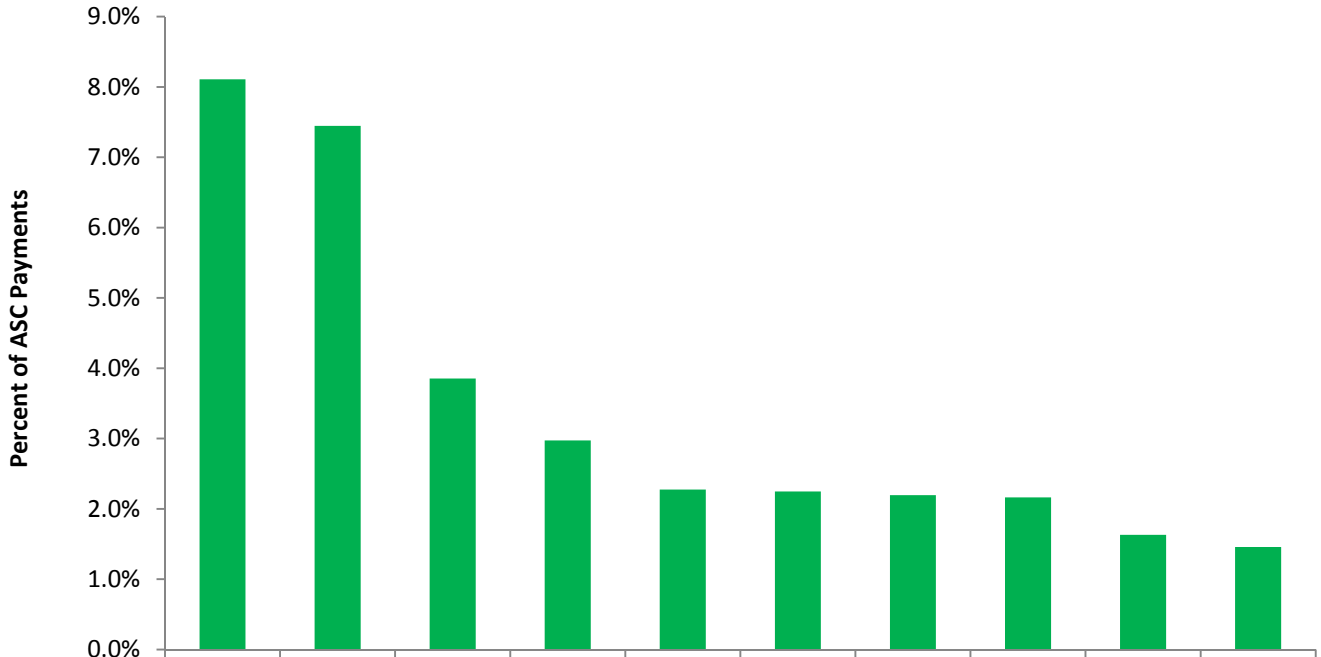


Exhibit 51

Top 10 Diagnosis Groups by Amount Paid for ASC Services

Diagnosis Group	Paid Share	Median Amount Paid Per Visit
Other dorsopathies	26.3%	$1,039
Other soft tissue disorders	22.1%	$6,358
Spondylopathies	9.7%	$2,078
Other disorders of the nervous system	8.2%	$630
Injuries to the knee and lower leg	6.4%	$3,635
Other joint disorders	5.5%	$3,635
Injuries to the wrist, hand and fingers	4.3%	$3,484
Injuries to the shoulder and upper arm	3.9%	$7,113
Complications of surgical and medical care, NOC	2.7%	$4,546
Injuries to the elbow and forearm	2.5%	$9,410

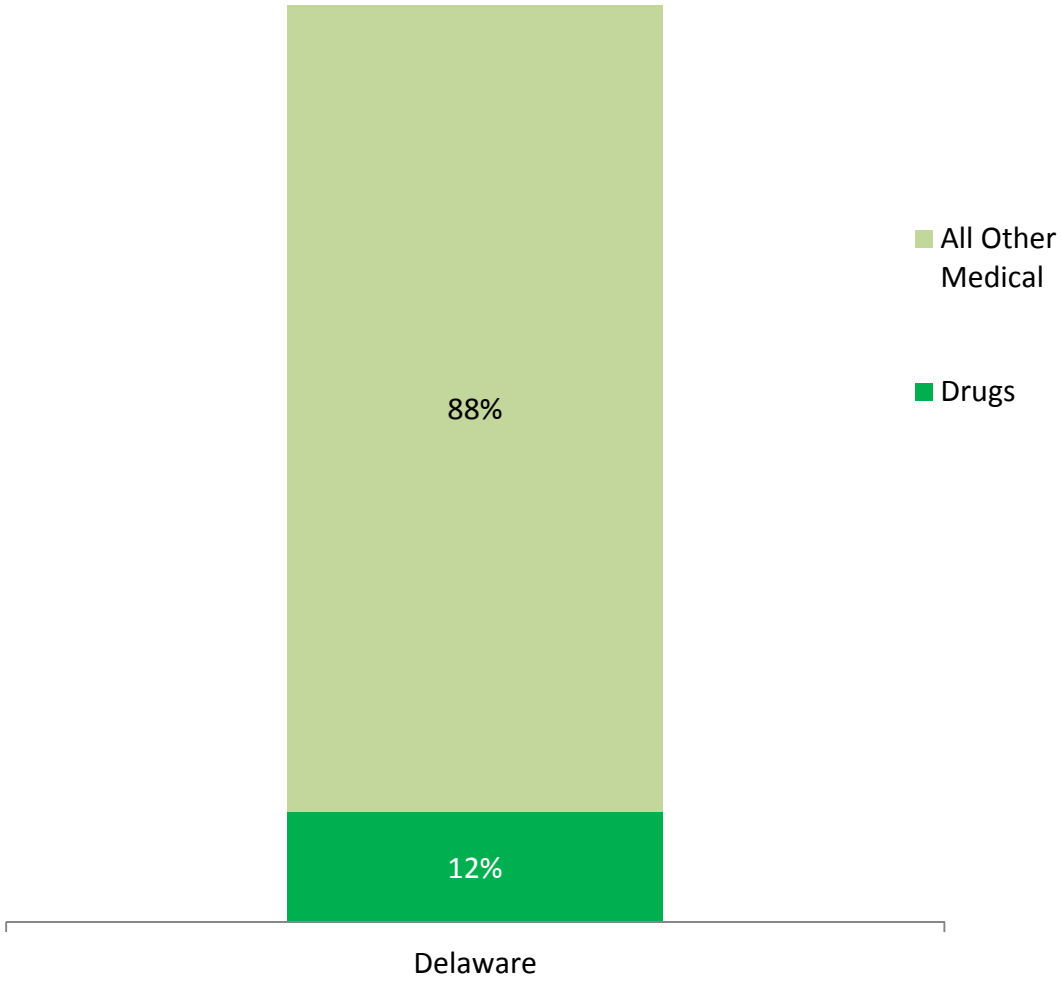
Exhibit 52
Top 10 Surgery Procedure Codes by Amount Paid for ASC Services



	64483	29827	64493	64635	29823	29881	63685	23412	29888	22551
% Paid	8.1%	7.4%	3.9%	3.0%	2.3%	2.2%	2.2%	2.2%	1.6%	1.5%
Avg Pd/Txn	$997	$5,929	$986	$2,481	$2,951	$3,425	$19,228	$5,832	$8,159	$12,781

Code	Description
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or ct); lumbar or sacral, single level
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
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
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); lumbar or sacral, single facet joint
29823	Arthroscopy, shoulder, surgical; debridement, extensive
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
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2

Exhibit 53
Distribution of Medical Payments for Drugs



Prescription Drug Information

The next six 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.

Pennsylvania implemented House Bill 1846 of 2014 regulating reimbursement for prescription drugs to 110% AWP on a per unit basis. Physicians seeking reimbursement must include the original NDC code on all bills. Physicians may not seek reimbursement greater than 110% AWP of the original NDC code. Repackaged NDC codes may not be submitted for reimbursement. The bill also limited the days supply allowed for drugs dispensed by any outpatient provider (including physicians) but not including pharmacies. Multiple providers were restricted for billing for the same drug on the same claim. The bill also limited any outpatient provider (including physicians) but not including pharmacies from seeking reimbursement for over-the-counter drugs.

Exhibit 54 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 55 lists the top 10 drugs based on the paid amount. **Exhibit 56** lists the top 10 drugs based on prescription counts.

Exhibit 56A 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 57 provides the distribution of drugs prescribed as brand name and generic.

Exhibit 58 provides the distribution of drugs dispensed at either a pharmacy or a non-pharmacy facility.

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 2017. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 54
Distribution of Prescription Drug Costs by CSA Schedule

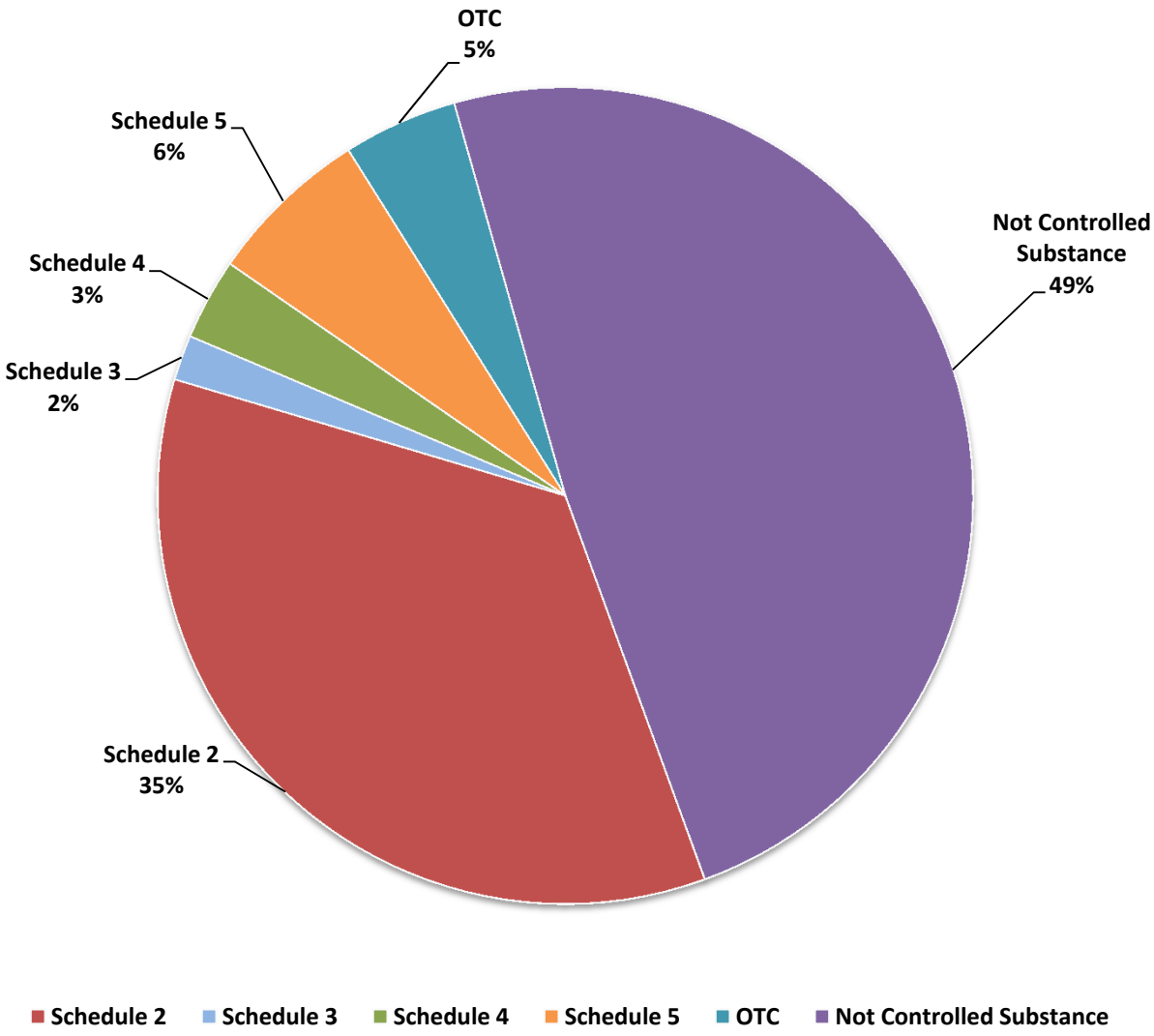


Exhibit 54 presents the distribution of payments of prescription drug costs by CSA schedule. This exhibit displays the allocation of drug payments by schedule. Payments in the non-controlled substances category make up the largest portion of payments (49%), followed by payments made for Schedule 2 drugs (35%). 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.

Exhibit 55
Top 10 Workers Compensation Drugs by Amount Paid

#	Name of Drug	Type B/G	Category	% of Drug Payments
1	Oxycontin	B	Analgesics/Antipyretics	8.1%
2	Lyrica	B	Misc. Central Nervous System Agents	6.4%
3	Gabapentin	G	Anticonvulsants	6.1%
4	Oxycodone HCL	G	Analgesics/Antipyretics	5.9%
5	Lidocaine	G	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	4.5%
6	Oxycodone HCL-Acetaminophen	G	Analgesics/Antipyretics	4.4%
7	Percocet	B	Analgesics/Antipyretics	3.7%
8	Diclofenac Sodium	G	Analgesics/Antipyretics	3.2%
9	Duloxetine HCL	G	Central Nervous System Agents	2.6%
10	Terocin	B	Skin & Mucous Membrane Agents	2.3%

Exhibit 56
Top 10 Workers Compensation Drugs by Prescription Counts

#	Name of Drug	Type B/G	Category	% of Drug Prescriptions
1	Oxycodone HCL	G	Analgesics/Antipyretics	9.1%
2	Gabapentin	G	Anticonvulsants	7.4%
3	Oxycodone HCL-Acetaminophen	G	Analgesics/Antipyretics	5.5%
4	Cyclobenzaprine HCL	G	Muscle Relaxants, Skeletal	5.1%
5	Ibuprofen	G	Analgesics/Antipyretics	3.7%
6	Tizanidine HCL	G	Muscle Relaxants, Skeletal	3.7%
7	Morphine Sulfate	G	Analgesics/Antipyretics	3.1%
8	Hydrocodone Bitartrate-Acetaminophen	G	Analgesics/Antipyretics	3.0%
9	Tramadol HCL	G	Analgesics/Antipyretics	2.6%
10	Lyrica	B	Misc. Central Nervous System Agents	2.6%

Exhibit 56A
Top 30 Drugs for Service Year 2017

Paid Share Service Year 2017	Drug Name	Brand/Generic Status	2017	2016	2015	2014	2013
8.4%	Oxycontin	Brand	1	1	1	1	1
6.1%	Gabapentin	Generic for Neurontin	2	2	2	2	5
6.0%	Lyrica	Brand	3	3	5	5	4
5.8%	Oxycodone HCL	Generic for Oxycontin if extended release	4	4	3	3	7
4.6%	Oxycodone HCL-Acetaminophen	Generic for Percocet	5	5	4	4	8
4.5%	Lidocaine	Generic for Xylocaine	6	8	8	8	35
4.1%	Percocet	Brand	7	6	6	6	6
2.9%	Diclofenac Sodium	Generic for Cambia, Cataflam, Voltaren-XR, etc.	8	38	47	45	45
2.8%	Duloxetine HCL	Generic for Cymbalta	9	9	9	7	115
2.2%	Cyclobenzaprine HCL	Generic for Flexeril	10	10	10	14	17
2.1%	Terocin	Brand	11	7	7	10	53
2.1%	Morphine sulfate	Generic for Avinza, Kadian, Ms Contin	12	11	11	9	16
1.7%	Tizanidine HCL	Generic for Zanaflex	13	13	15	16	15
1.6%	Duragesic	Brand for Fentanyl	14	15	17	12	18
1.6%	Hydromorphone HCL	Generic for Dllaudid, Dilaudid-5, Exalgo	15	12	12	21	37
1.5%	Nucynta	Brand	16	16	20	27	29
1.3%	Topiramate	Generic for Topamax	17	24	23	24	24
1.3%	Flurbiprofen	Generic for Ansaid	18	14	13	32	77
1.2%	Nucynta ER	Brand	19	31	34	38	41
1.2%	Lidopro Patch	Brand	20	17	80	n/a	n/a
1.1%	Meloxicam	Generic for Mobic, Vivlodex	21	18	19	15	14
1.1%	Zofran	Brand	22	26	26	26	28
1.0%	Celecoxib	Generic for Celebrex	23	19	18	115	n/a
1.0%	Ondansetron	Generic for Zofran	24	25	83	103	64
1.0%	Baclofen	Generic for Lioresal, Gablofen	25	22	25	35	65
0.9%	Fentanyl Transdermal System	Generic for Duragesic, Ionsys	26	33	24	17	13
0.9%	Movantik	Brand	27	42	72	n/a	n/a
0.9%	Oxymorphone HCL	Generic for Opana, Opana ER	28	27	29	33	42
0.9%	Suboxone	Brand	29	36	41	39	30
0.8%	Metaxalone	Generic for Skelaxin	30	28	21	25	23

Exhibit 57
Distribution of Drugs by Brand Name and Generic

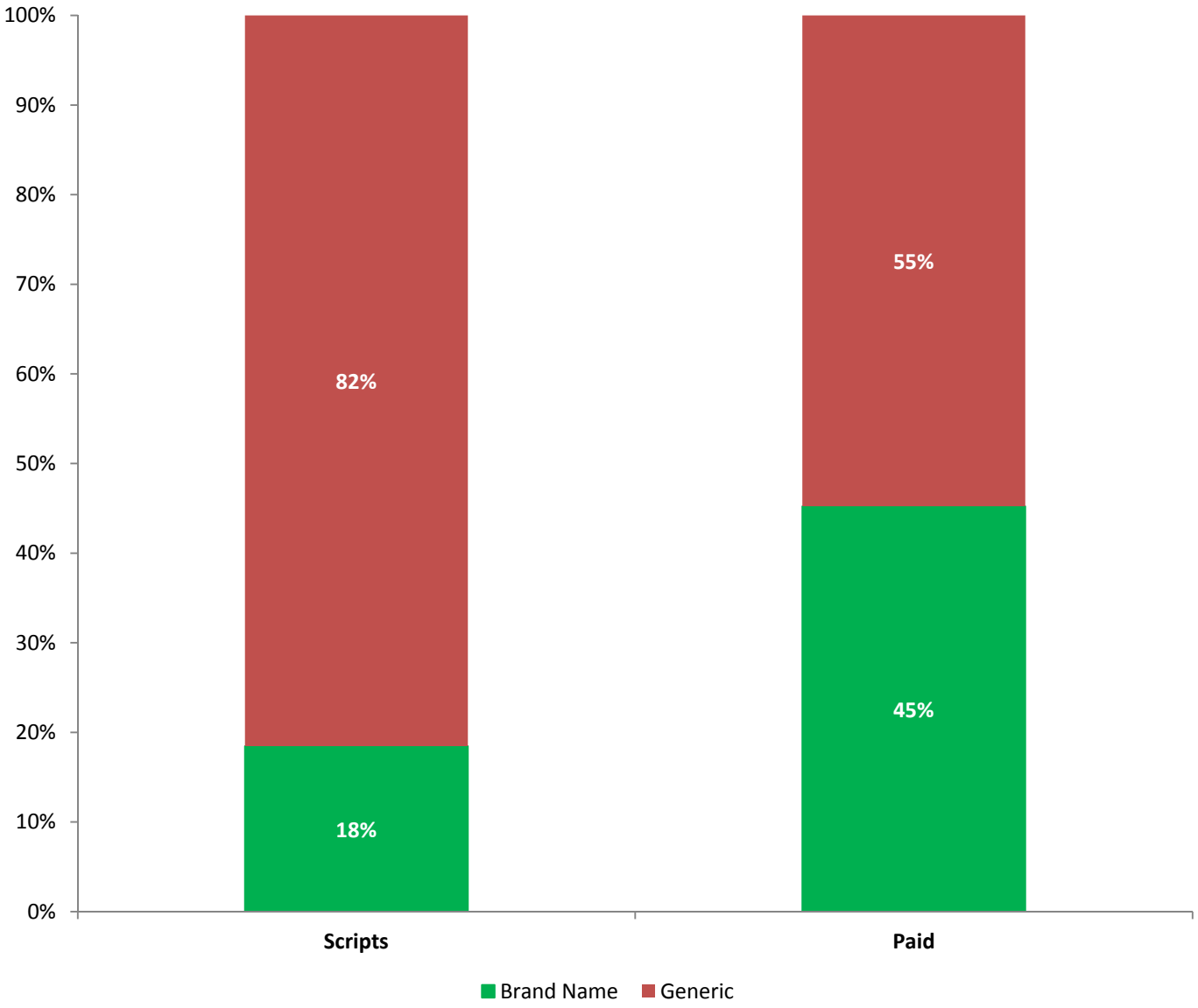


Exhibit 57 depicts the distribution of drugs organized by brand name versus generic. These results reveal that significantly fewer prescriptions are written using the brand name than generic equivalent. However, the brand name drugs represent over half of the total dollars paid.

Exhibit 58
Distribution of Drugs by Pharmacy and Non-Pharmacy

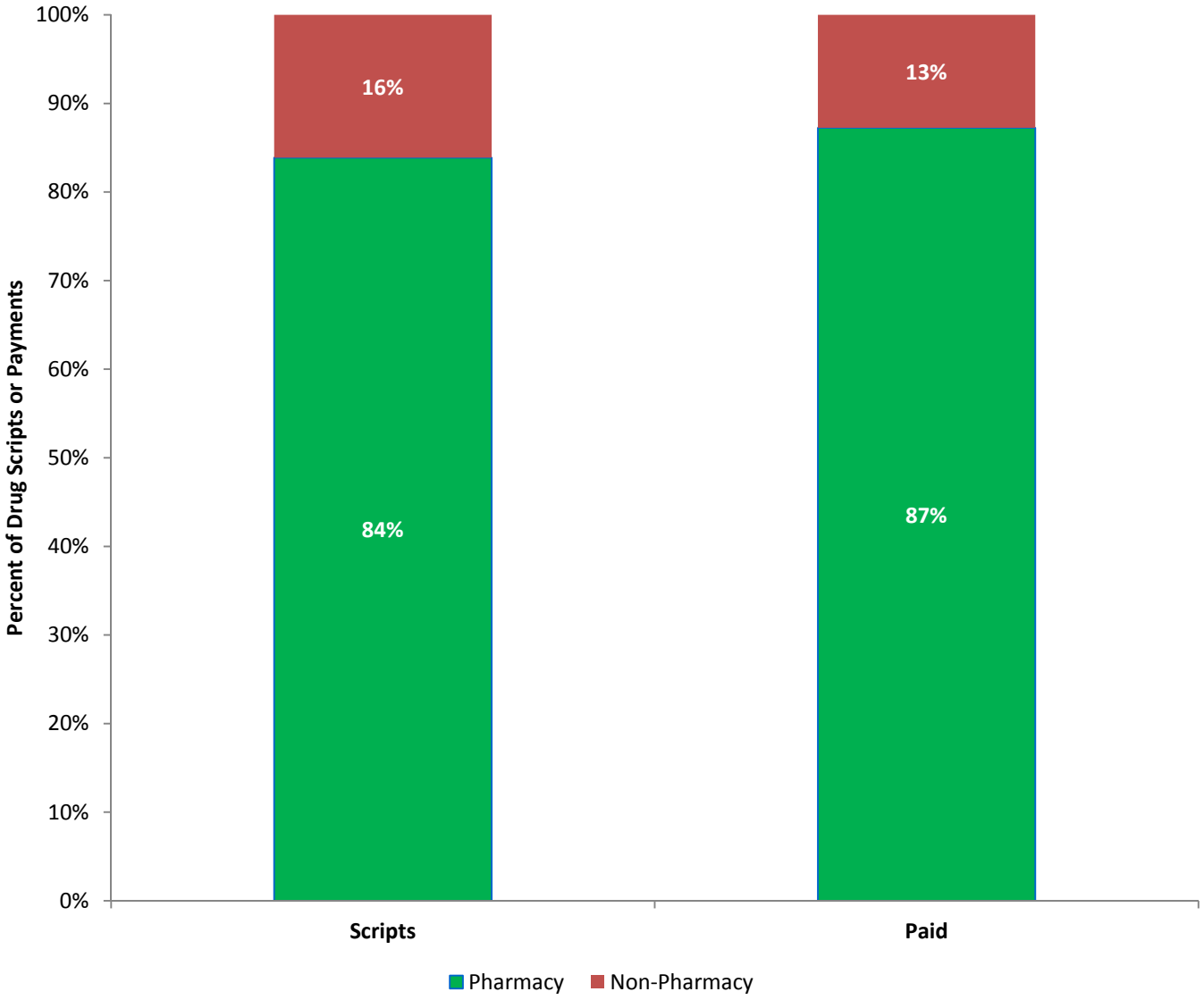
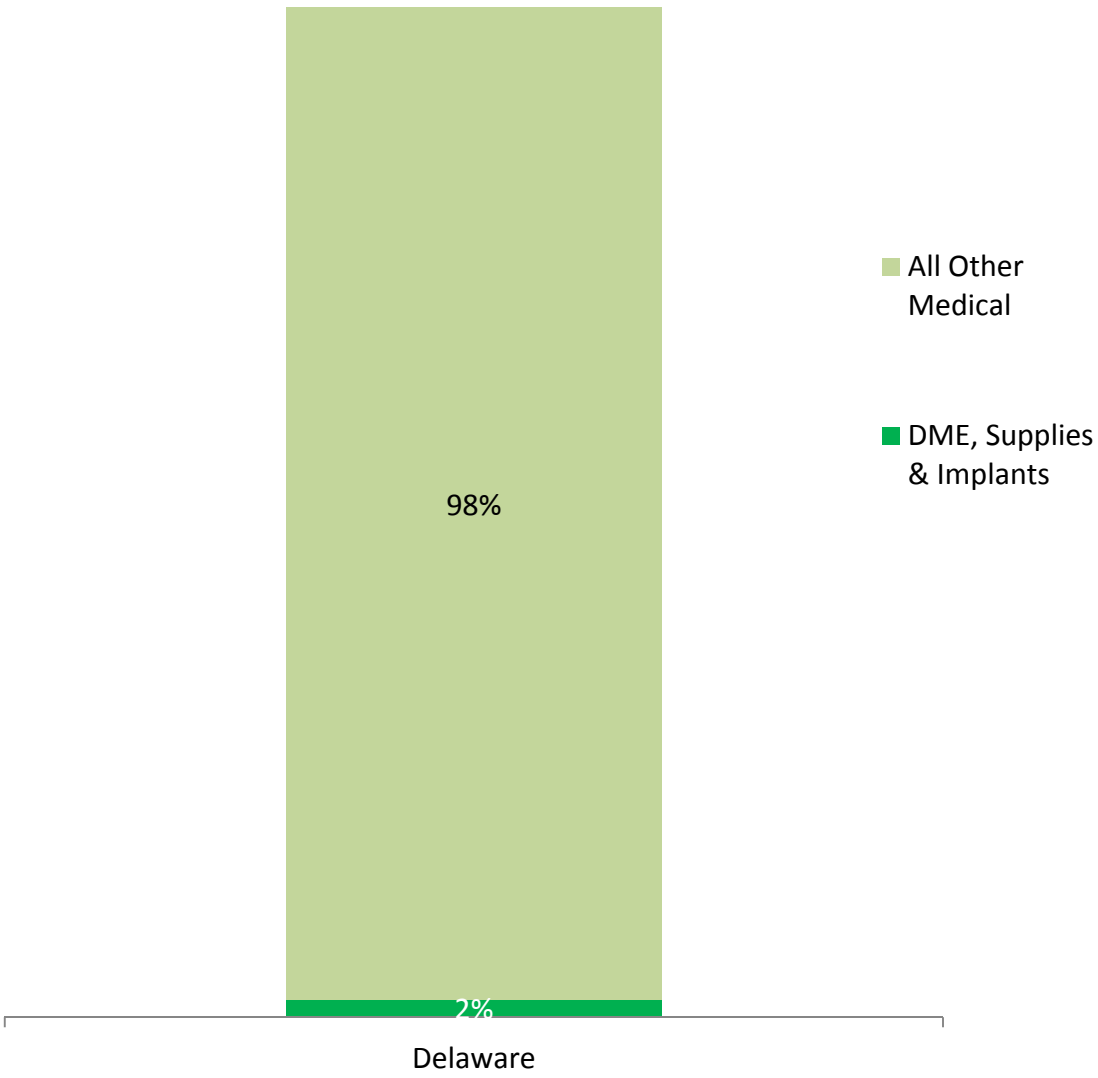


Exhibit 58 is a distribution of drugs dispensed at either a pharmacy (retail, mail order, or institutional) or a non-pharmacy facility. Examples of non-pharmacy dispensing locations include doctor's offices, home health care and hospitals. These results suggest that a large majority of prescription drugs are dispensed at a pharmacy.

Exhibit 59
Distribution of Medical Payments for DME, Supplies and Implants



Other Medical Activity Information

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

Exhibit 60 presents the distribution of payments by durable medical equipment (DME), supplies and implants.

Exhibit 61 details the top five DME codes by paid amount.

Exhibit 62 details the top five medical supplies, other than DME codes, by paid amount.

Exhibit 63 details the top five orthotics and prosthetics codes by paid amount.

Exhibit 64 details the top 10 body systems by paid amount for Dates of Injury in 2016. This exhibit includes diagnosis data that is more mature.

Exhibit 65 details the top 10 diagnosis groups by paid amount for Dates of Injury in 2016. This exhibit includes diagnosis data that is more mature.

The source for all data is the DCRB Medical Data Call for Service Year 2017. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 60
Distribution of Payments by DME, Suppliers and Implants

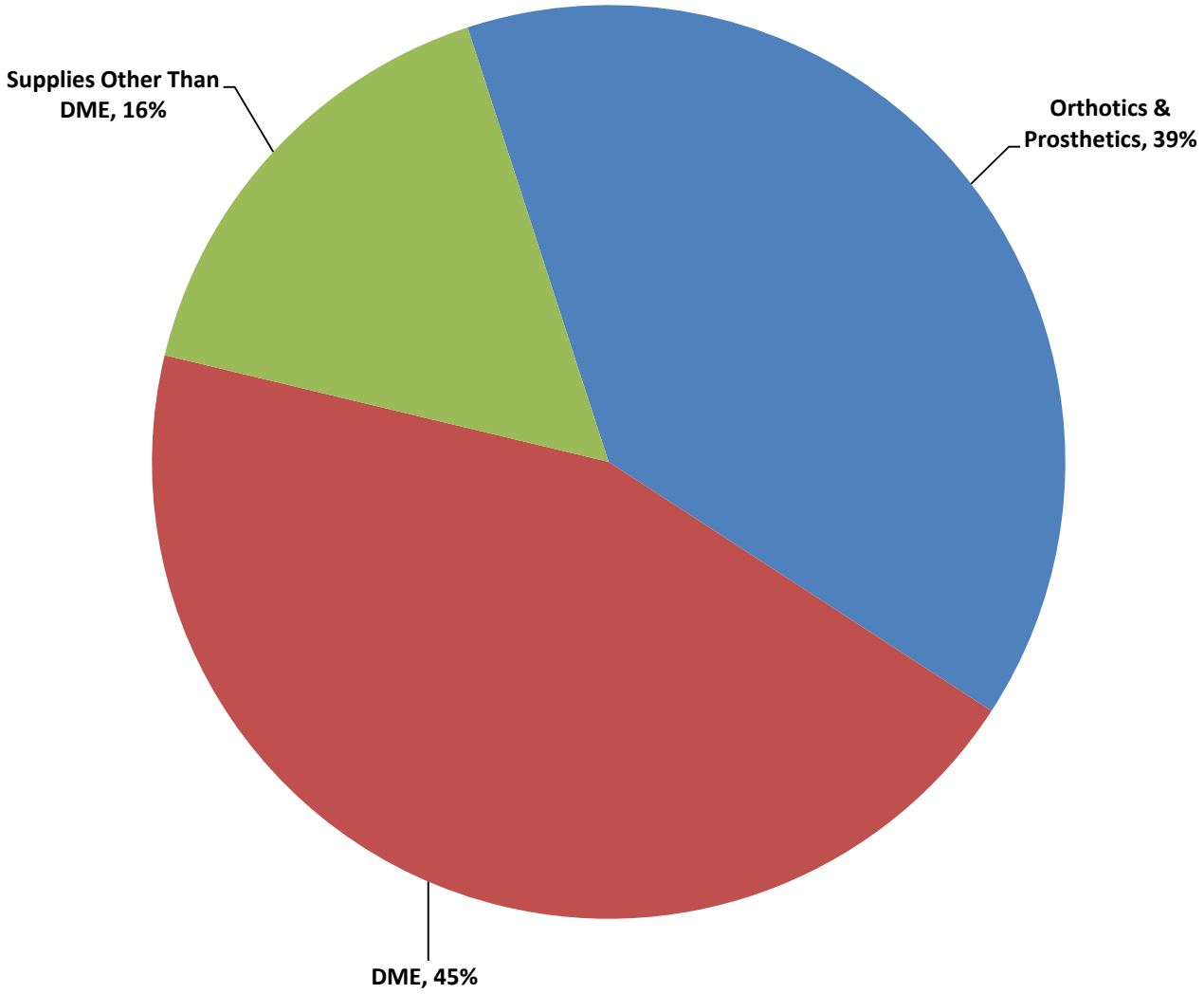
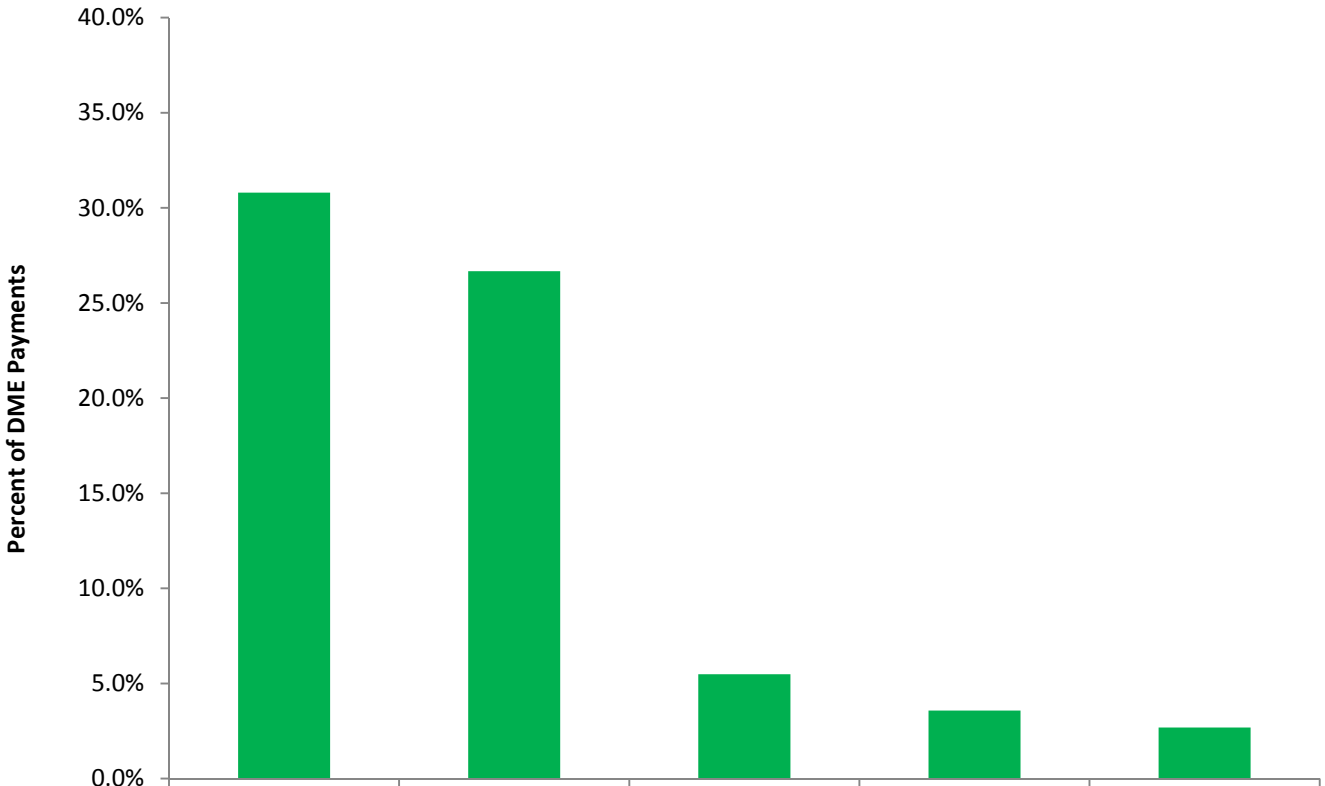


Exhibit 60 presents the distribution of payments by durable medical equipment (DME), orthotics and prosthetics, medical supplies and implants. This exhibit shows us that DME makes up the largest portion of payments followed by payments made for orthotics and prosthetics.

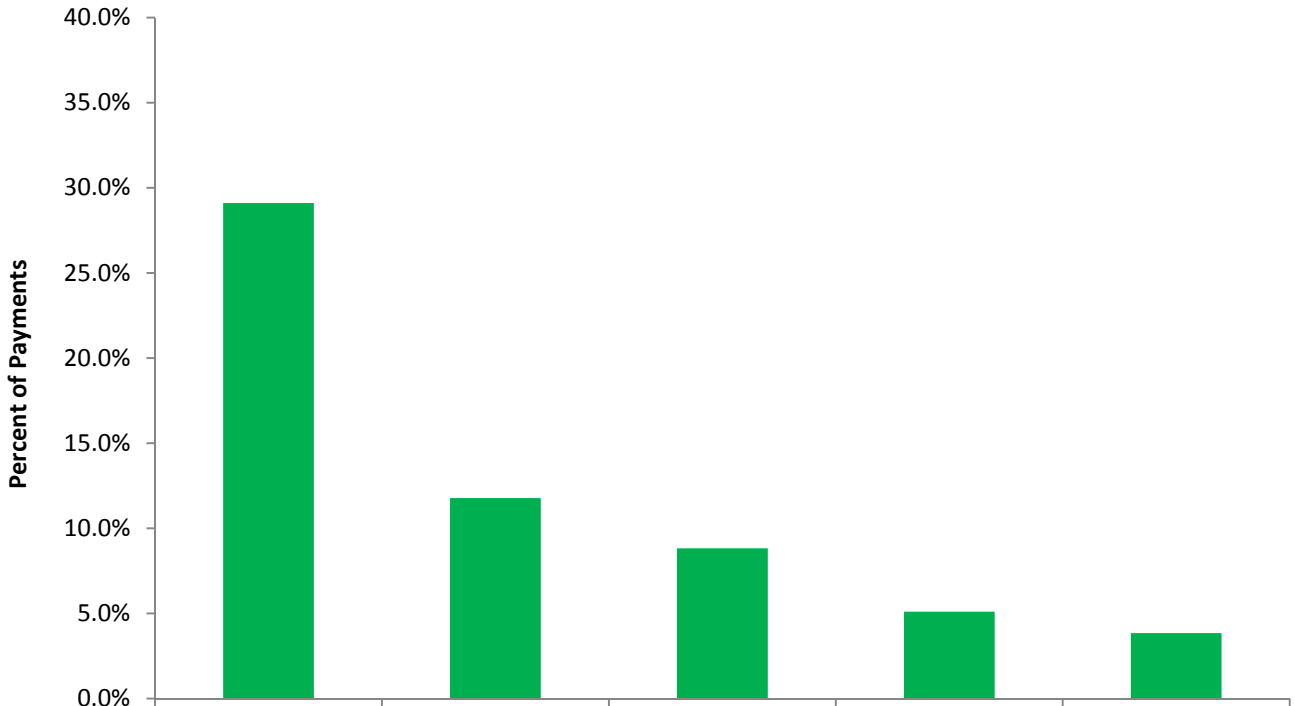
Exhibit 61
Top 5 DME Codes by Amount Paid



	E1399	E0748	E0673	E0675	E0730
% Paid	30.8%	26.7%	5.5%	3.6%	2.7%
Avg Pd/Txn	$520	$2,900	$175	$239	$113

Code	Description
E1399	Durable medical equipment, miscellaneous
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications
E0673	Segmental gradient pressure pneumatic appliance, half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system)
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation

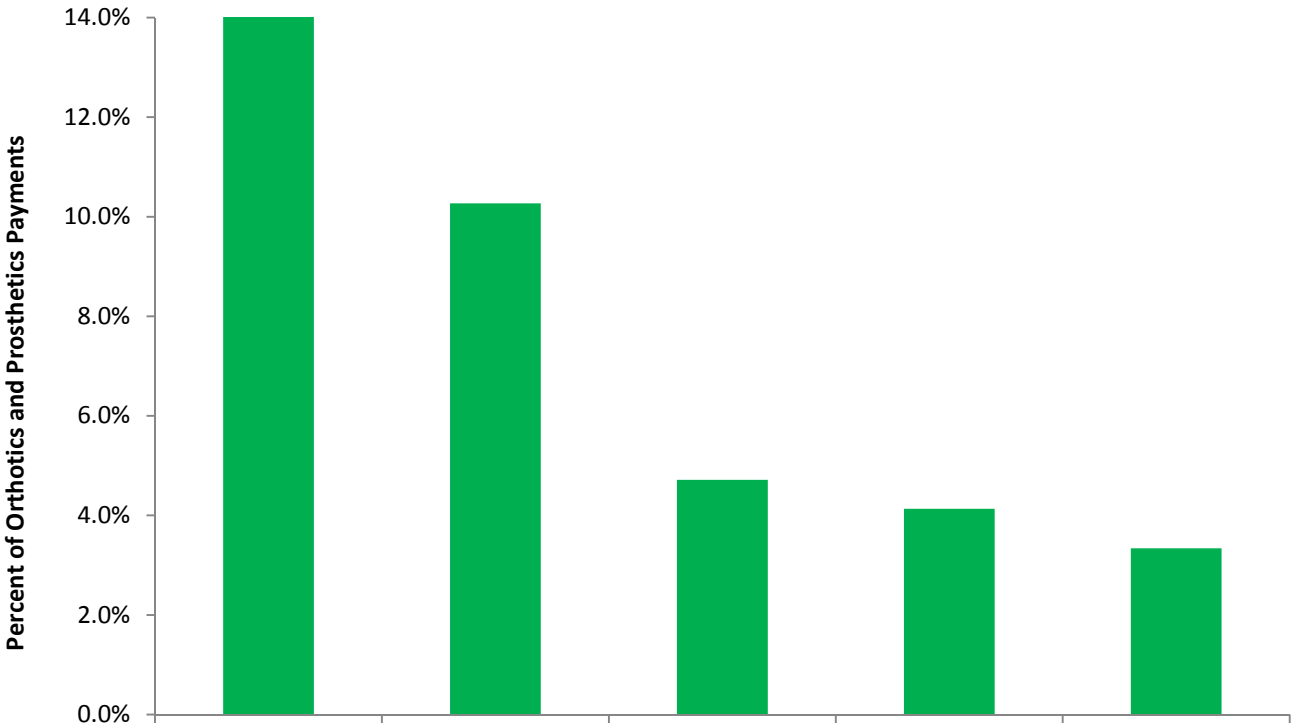
Exhibit 62
Top 5 Supplies Other Than DME Codes by Amount Paid



	A4556	A4353	99070	A4245	A4595
% Paid	29.1%	11.8%	8.8%	5.1%	3.8%
Avg Pd/Txn	$78	$970	$26	$29	$45

Code	Description
A4556	Electrodes, (e.g., apnea monitor), per pair
A4353	Intermittent urinary catheter, with insertion supplies
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)
A4245	Alcohol wipes, per box
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g. TENS, NMES)

Exhibit 63
Top 5 Orthotics and Prosthetics Codes by Amount Paid



	L5999	L0648	L8680	L4361	L1833
% Paid	15.8%	10.3%	4.7%	4.1%	3.3%
Avg Pd/Txn	$11,624	$869	$608	$257	$783

Code	Description
L5999	Lower extremity prosthesis, not otherwise specified
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
L8680	Implantable neurostimulator electrode, each
L4361	Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf
L1833	Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf

Exhibit 64
Top 10 Body Systems by Amount Paid for Dates of Injury in 2016

Body System	Paid Share	Average Amount Paid Per Claim
Diseases of the musculoskeletal system and connective tissue	45.4%	$5,522
Injury, poisoning and certain other consequences of external causes	43.5%	$2,811
Diseases of the nervous system	3.9%	$3,166
Factors influencing health status and contact with health services	1.6%	$898
Symptoms, signs and abnormal clinical and laboratory findings, NOC	1.2%	$813
Diseases of the digestive system	0.8%	$3,720
Diseases of the circulatory system	0.8%	$2,608
Mental, Behavioral and Neurodevelopmental disorders	0.8%	$1,676
Diseases of the skin and subcutaneous tissue	0.8%	$1,875
Endocrine, nutritional and metabolic diseases	0.7%	$2,978

Exhibit 65
Top 10 Diagnosis Groups by Amount Paid for Dates of Injury in 2016

Diagnosis Group	Paid Share	Average Amount Paid Per Claim
Other dorsopathies	18.0%	$5,818
Other joint disorders	12.2%	$2,935
Other soft tissue disorders	8.0%	$2,944
Injuries to the knee and lower leg	7.7%	$3,730
Injuries to the wrist, hand and fingers	6.1%	$1,453
Injuries to the neck	4.9%	$4,403
Injuries to the shoulder and upper arm	4.9%	$2,759
Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals	4.8%	$1,548
Spondylopathies	3.4%	$4,474
Injuries to the thorax	3.2%	$2,848

Appendix A: Comparison of Selected Distributions by Service Year

Distribution of Medical Payments (Exhibit 4)

Medical Category	**2013**	**2014**	**2015**	**2016**	**2017**
Physicians	50%	50%	44%	46%	46%
Hospital Inpatient	11%	10%	13%	13%	13%
Hospital Outpatient	11%	10%	8%	8%	7%
ER	1%	1%	2%	2%	2%
Ambulatory Surgical Centers	7%	8%	11%	10%	12%
Drugs (NDC Codes + Medical Drugs)	12%	11%	14%	14%	12%
Durable Medical Equipment	3%	1%	1%	2%	2%
Other	5%	8%	7%	6%	7%

Distribution of Physician Payments by AMA Service Category (Exhibit 7)

AMA Service Category	**2013**	**2014**	**2015**	**2016**	**2017**
Surgery	31%	33%	28%	29%	28%
Physical Medicine	33%	33%	37%	38%	39%
Evaluation & Management	13%	13%	15%	15%	15%
Radiology	8%	7%	6%	6%	6%
Medicine	6%	6%	6%	5%	6%
Anesthesia	4%	4%	5%	4%	4%
Pathology & Laboratory	4%	4%	3%	3%	3%

Appendix A: Comparison of Selected Distributions by Accident Year

Median Time Until First Treatment (in Days) (Exhibits 19-22, 29, 38, and 50)

Medical Category	2012	2013	2014	2015	2016
Physicians - Major Surgery	41	47	55	41	40
Physicians - Radiology	1	1	1	1	1
Physicians - Physical Medicine	1	2	2	2	2
Physicians - Evaluation and Management	1	1	1	1	1
Hospital Inpatient	1	1	1	1	1
Hospital Outpatient	1	1	1	1	2
ASC	126	119	104	94	98

75th Percentile of Time Until First Treatment (in Days) (Exhibits 19-22, 29, 38, and 50)

Medical Category	2012	2013	2014	2015	2016
Physicians - Major Surgery	144	158	150	148	138
Physicians - Radiology	7	12	9	10	10
Physicians - Physical Medicine	10	11	10	12	12
Physicians - Evaluation and Management	3	4	3	3	3
Hospital Inpatient	114	89	224	52	45
Hospital Outpatient	8	11	15	20	27
ASC	238	280	207	188	180

Appendix A: Comparison of Selected Distributions by Service Year

Hospital Inpatient Statistics (Exhibit 25 and 27)

Hospital Inpatient Statistics	2013	2014	2015	2016	2017
Average Payment per Stay	$31,698	$35,999	$38,474	$29,544	$27,019
Number of Stays per 1,000 Active Claims	27	23	23	24	24

Distribution of Hospital Outpatient Payments by Surgery and Non-Surgery (Exhibit 34 and Exhibit 36)

Visit Type	2013	2014	2015	2016	2017
Surgery (CPT: 10021-69990)	13%	14%	24%	31%	31%
Non-Surgery	87%	86%	76%	69%	69%

Hospital Outpatient Surgery Statistics (Exhibit 34 and Exhibit 35)

Hospital Outpatient Surgery Statistics	2013	2014	2015	2016	2017
Average Payment per Visit	$7,965	$8,608	$6,383	$6,397	$5,176
Number of Visits per 1,000 Active Claims	61	58	55	48	45

Hospital Outpatient Non-Surgery Statistics (Exhibit 36 and Exhibit 37)

Hospital Outpatient Non-Surgery Statistics	2013	2014	2015	2016	2017
Average Payment per Visit	$933	$965	$654	$598	$494
Number of Visits per 1,000 Active Claims	845	734	696	563	528

Appendix A: Comparison of Selected Distributions by Service Year

Emergency Room Statistics (Exhibit 42 and Exhibit 43)

Emergency Room Statistics	**2013**	**2014**	**2015**	**2016**	**2017**
Average Payment per Visit	$2,190	$2,131	$1,915	$1,380	$1,105
Number of Visits per 1,000 Active Claims	66	79	98	134	178

ASC Statistics (Exhibit 48 and Exhibit 49)

ASC Statistics	**2013**	**2014**	**2015**	**2016**	**2017**
Average Payment per Visit	$11,781	$10,767	$8,768	$7,440	$6,708
Number of Visits per 1,000 Active Claims	70	108	119	123	133

Distribution of Prescription Drug Payments by CSA Schedule (Exhibit 54)

CSA Schedule	**2013**	**2014**	**2015**	**2016**	**2017**
Schedule 2	39%	40%	38%	35%	35%
Schedule 3	3%	3%	3%	2%	2%
Schedule 4	6%	5%	4%	3%	3%
Schedule 5	5%	4%	5%	6%	6%
OTC	1%	3%	5%	6%	5%
Non-Controlled	46%	45%	46%	48%	49%

Appendix A: Comparison of Selected Distributions by Service Year

Distribution of Drug Payments by Brand Name and Generic (Exhibit 57)

Type of Drug	2013	2014	2015	2016	2017
Brand	63%	46%	49%	50%	55%
Generic	33%	46%	51%	50%	45%

Distribution of Drug Payments by Pharmacy and Non-Pharmacy (Exhibit 58)

Type of Provider	2013	2014	2015	2016	2017
Pharmacy	83%	88%	85%	85%	87%
Non-Pharmacy	17%	12%	15%	15%	13%

Distribution of Payments by DME, Supplies, and Implants (Exhibit 60)

Category	2013	2014	2015	2016	2017
Orthotics & Prosthetics	28%	29%	37%	29%	39%
DME	43%	39%	40%	51%	45%
Supplies Other Than DME	30%	32%	23%	20%	16%

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2017
1	Medical Share of Total Benefit Costs	72.1% (2015)
2	Medical Average Cost per Case	$70,606 (2015)
3	Percentage of Medical Paid by Claim Maturity	35.5% (Year 1); 48.2% (Year 5); 59.6% (Year 10); 77.9% (Year 19)
4	Distribution of Medical Payments	Physicians 46%; Hospital Outpatient 7%; Hospital Inpatient 13%; ASC 11%; Drugs 12%; ER 2%; DME 2%; Other 7%
5	Physician Payments as % of Medicare	For geo zip 197/198, the fee schedule averages 222% of Medicare and for geo zip 199 the fee schedule averages 172% of Medicare. Detailed results are available in Exhibit 5.
6	Distribution of Medical Payments for Physicians	46%
7	Distribution of Physician Payments by AMA Service Category	Surgery 28%; Radiology 6%; Pathology & Laboratory 3%; Physical Medicine 39%; General Medicine 5%; Evaluation & Management 15%; Anesthesia 4%
8	Top 10 Surgery Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 22612 ($1,977); 22551 ($3,324); 64483 ($384); 29827 ($1,692); 22558 ($2,336); 29823 ($997); 63047 ($1,859); 22840 ($1,537); 22845 ($1,161); 29881 ($1,245)
9	Top 10 Surgery Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 20160 ($99); 64483 ($384); 64494 ($366); 12001 ($173); 36415 ($8); 64494 ($201); 29826 ($393); 64484 ($209); 22853 ($469); 62323 ($379)
10	Top 10 Radiology Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 72148 ($483); 73221 ($443); 73721 ($457); 72141 ($492); 72158 ($767); 73222 ($568); 72131 ($264); 73030 ($48); 72125 ($185); 72100 ($49)
11	Top 10 Radiology Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 73030 ($48); 72100 ($49); 73630 ($36); 73130 ($38); 73110 ($42); 72148 ($483); 73610 ($41); 73221 ($443); 73721 ($457); 73562 ($53)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2017
12	Average Amount Paid per Transaction by Modifier Code	Top code: 72148 - $1,272 - No 26 or TC modifier; $98 - Professional; $556 Technical
13	Top 10 Physical and General Medicine Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 97110 ($61); 97140 ($43); 97530 ($40); 97545 ($214); 97112 ($41); 97014 ($27); 97010 ($12); 97799 ($2,334); 97124 ($47); 99199 ($387)
14	Top 10 Physical and General Medicine Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 97110 ($61); 97140 ($43); 97010 ($12); 97530 ($40); 97014 ($27); 97112 ($41); 99080 ($26); 97124 ($47); 98941 ($42); 97035 ($23)
15	Top 10 Evaluation and Management Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 99214 ($98); 99213 ($61); 99203 ($107); 99284 ($341); 99204 ($159); 99283 ($205); 99232 ($82); 99285 ($479); 99291 ($207); 99212 ($50)
16	Top 10 Evaluation and Management Procedure Codes by Transaction Count	Average Paid Per Transaction for top 10 codes: 99213 ($61); 99214 ($98); 99203 ($107); 99212 ($50); 99232 ($82); 99204 ($159); 99284 ($341); 99283 ($205); 99291 ($207); 99202 ($80)
17	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient	2017 Results: 99201 (1%); 99202 (6%); 99203 (56%); 99204 (36%); 99205 (2%); 99211 (0%); 99212 (4%); 99213 (42%); 99214 (52%); 99215 (2%)
18	Office or Other Outpatient Visit for the Evaluation and Management of a Established Patient	2017 Results: 99201 ($63); 99202 ($80); 99203 ($1107); 99204 ($159); 99205 ($197); 99211 ($25); 99212 ($50); 99213 ($61); 99214 ($98); 99215 ($139)
19	Time Until First Treatment for Major Surgery (in Days)	Median = 40; 75th Percentile = 138
20	Time Until First Treatment for Radiology (in Days)	Median = 1; 75th Percentile = 10

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2017
21	Time Until First Treatment for Physical and General Medicine (in Days)	Median = 2; 75th Percentile = 12
22	Time Until First Treatment for Initial Evaluation and Management Visit (in Days)	Median = 1; 75th Percentile = 3
23	Hospital Inpatient Payments as % of Medicare	118% to 144%, depending on the Delaware geo zip.
24	Distribution of Medical Payments for Hospital Inpatient	13%
25	Average Paid Amount per Stay for Hospital Inpatient Services	$27,019
26	Average Paid Amount per Day for Hospital Inpatient Services	$6,107
27	Average Number of Stays per 1,000 Active Claims	24
28	Inpatient Length of Stay for Hospital Inpatient Services	Average LOS = 4; Median LOS = 2
29	Time Until First Treatment for Hospital Inpatient Stays (in Days)	Median = 1; 75th Percentile = 45
30	Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services	Median Payment per Hospital Inpatient Stay for top 10 groups: Other dorsopathies ($30,611); Spondylopathies ($37,098); Burns and corrosions of external body surface, specified by site ($40,690); Injuries to the knee and lower leg ($13,465); Deforming dorsopathies ($60,661); Aplastic and other anemias ($34,040); Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals ($12,647); Injuries to the head ($15,629); Osteoarthritis ($16,155); Injuries to the hip and thigh ($11,176)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2017
31	Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services	Median Payment per Hospital Inpatient Stay for top 10 codes: 460 ($29,081); 454 ($29,395); 455 ($45,704); 462 ($73,754); 470 ($15,347); 481 ($17,691); 552 ($6,597); 167 ($53,239); 092 ($7,772); 602 ($34,238)
32	Hospital Outpatient Payments as % of Medicare	n/a
33	Distribution of Medical Payments for Hospital Outpatient	7%
34	Average Outpatient Paid Amount Per Major Surgical Visit for Hospital Outpatient Services	$5,176
35	Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims	45
36	Average Outpatient Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services	$494
37	Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims	528
38	Time Until First Treatment for Outpatient Visits (in Days)	Median = 2; 75th Percentile = 27
39	Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services	Median Payment per Hospital Outpatient Visit for top 10 groups: Other dorsopathies ($315); Other soft tissue disorders ($378); Injuries to the wrist, hand and fingers ($405); Other joint disorders ($285); Complications of surgical and medical care, NOC ($479); Injuries to the shoulder and upper arm ($514); Spondylopathies ($530); Injuries to the knee and lower leg ($369); Hernia ($2,687); Osteoarthritis ($359)
40	Top 10 Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Paid Per Transaction for top 10 codes: 22551 ($5,322); 29827 ($4,255); 63047 ($3,916); 29881 ($3,181); 49505 ($4,707); 22856 ($6,739); 63685 ($5,371); 26489 ($20,376); 17108 ($4,735); 63030 ($6,217)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2017
41	Top 10 Non-Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Paid Per Transaction for top 10 codes: 97110 ($63); C1820 ($39,900); 99283 ($373); 99284 ($616); 73221 ($523); C1767 ($41,610); 97140 ($47); 73721 ($496); 72148 ($511); 72141 ($499)
42	Average Amount Paid per ER Visit	$1,105
43	Average Number of ER Visits per 1,000 Active Claims	178
44	Emergency Room Services by Procedure Code Trend and Average Paid per Transaction	2017 Results: 99281 (1%); 99282 (3%); 99283 (28%); 99284 (48%); 99285 (20%)
45	ER Transactions by Procedure Code Trend and Average Paid per Transaction	2017 Results: 99281 (2%); 99282 (6%); 99283 (40%); 99284 (41%); 99285 (12%)
46	ASC Payments as % of Medicare	n/a
47	Distribution of Medical Payments for ASC	12%
48	Average Amount Paid per Visit for ASC Services	$6,708
49	Average Number of ASC Visits per 1,000 Active Claims	133
50	Time Until First Treatment for ASC Visits (in Days)	Median = 98; 75th Percentile = 180
51	Top 10 Diagnosis Groups by Amount Paid for ASC Services	Median Payment per ASC Visit for top 10 groups: Other dorsopathies ($1,039); Other soft tissue disorders ($6,358); Spondylopathies ($2,078); Other disorders of the nervous system ($630); Injuries to the knee and lower leg ($3,635); Other joint disorders ($3,635); Injuries to the wrist, hand and fingers ($3,484); Injuries to the shoulder and upper arm ($7,113); Complications of surgical and medical care, NOC ($4,546); Injuries to the elbow and forearm ($9,410)
52	Top 10 Surgery Procedure Codes by Amount Paid for ASC Services	Average Paid Per Transaction for top 10 codes: 64483 ($997); 29827 ($5,929); 64493 ($986); 64635 ($2,481); 29823 ($2,951); 29881 ($3,425); 63685 ($19,228); 23412 ($5,832); 29888 ($8,159); 22551 ($12,781)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2017
53	Distribution of Medical Payments for Drugs	12%
54	Distribution of Prescription Drug Costs in Pennsylvania by CSA Schedule	Schedule 2 = 35%; Schedule 3 = 2%; Schedule 4 = 3%; Schedule 5 = 6%; OTC = 5%; Non-Controlled = 49%
55	Top 10 Workers Compensation Drugs by Amount Paid	Top 10 WC Drugs by amount paid: Oxycontin (8.1%); Lyrica (6.4%); Gabapentin (6.1%); Oxycodone HCL (5.9%); Lidocaine (4.5%); Oxycodone HCL-Acetaminophen (4.4%); Percocet (3.7%); Diclofenac Sodium (3.2%); Duloxetine HCL (2.6%); Terocin (2.3%)
56	Top 10 Workers Compensation Drugs by Prescription Counts	Top 10 WC Drugs by script count: Oxycodone HCL (9.1%); Gabapentin (7.4%); Oxycodone HCL-Acetaminophen (5.5%); Cyclobenzaprine HCL (5.1%); Ibuprofen (3.7%); Tizanidine HCL (3.7%); Morphine Sulfate (3.1%); Hydrocodone Bitartrate-Acetaminophen (3.0%); Tramadol HCL (2.6%); Lyrica (2.6%)
57	Distribution of Drugs by Brand Name and Generic	Brand Name: 18% scripts, 45% paid; Generic: 82% scripts, 55% paid
58	Distribution of Drugs by Pharmacy and Non-pharmacy by Amount Paid	By Paid Amount = Pharmacy 87%; Non-Pharmacy 13%; By Script Count = Pharmacy 84%, Non-Pharmacy = 16%
59	Distribution of Medical Payments for DME, Supplies and Implants	2%
60	Distribution of Payments by DME, Supplies, and Implants	DME = 45%; Supplies Other than DME = 16%; Orthotics & Prosthetics = 39%
61	Top 5 DME Codes by Amount Paid	% of Payments for top 5 codes: E1399 (30.8%); E0748 (26.7%); E0673 (5.5%); E0676 (3.6%); E0730 (2.7%)
62	Top 5 Supplies Other than DME Codes by Amount Paid	% of Payments for top 5 codes: A4556 (29.1%); A4353 (11.8%); 99070 (8.8%); A4245 (5.1%); A4595 (3.8%)
63	Top 5 Orthotics and Prosthetics Codes by Amount Paid	% of Payments for top 5 codes: L5999 (15.8%); L0648 (10.3%); L8680 (4.7%); L4361 (4.1%); L1833 (3.3%)
64	Top Body Systems by Amount Paid for Dates of Injury in 2016	Average Paid Per Claim for top 10 groups: Muscles ($5,522); Injury or Poisoning ($2,811); Nervous system ($3,166); Health status factors ($898); Symptoms, NOC ($813); Digestive system ($3,720); Circulatory system ($2,608); Mental disorders ($1,676); Skin ($1,875); Endocrine system ($2,978)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2017
65	Top Diagnosis Groups by Amount Paid for Dates of Injury in 2016	Average Paid Per Claim for top 10 groups: Other dorsopathies ($5,818); Other joint disorders ($2,935); Other soft tissue disorders ($2,944); Injuries to the knee and lower leg ($3,730); Injuries to the wrist, hand and fingers ($1,453); Injuries to the neck ($4,403); Injuries to the shoulder and upper arm ($2,759); Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals ($1,548); Spondylopathies ($4,474); Injuries to the thorax ($2,848)

Appendix C: Technical Appendix

The data contained in this report includes Medical Data Call transactions for Service Year 2017 (medical services delivered from January 1, 2017, to December 31, 2017) 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 the DCRB's website.

For the state of Delaware in Service Year 2017, the reported number of transactions was 334,711 with nearly $46 million paid, for close to 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.

In this Technical Appendix, we describe in detail the data and methodology used to prepare the Delaware Medical Data Report. We also comment on data limitations which were applicable to this report.

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

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 the 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 April 1, Two years following
February, Prior Year	August, Current Year	October, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
March, Prior Year	September, Current Year	November, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
April, Prior Year	October, Current Year	December, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
May, Prior Year	November, Current Year	January, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
June, Prior Year	December, Current Year	February, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
July, Prior Year	January, Current Year	March, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
August, Prior Year	February, Current Year	April, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
September, Prior Year	March, Current Year	May, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
October, Prior Year	April, Current Year	June, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
November, Prior Year	May, Current Year	July, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following
December, Prior Year	June, Current Year	August, Current Year	2nd and 3rd quarter, Following Year	On or before April 1, Two years following

Appendix C: Technical Appendix

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	April 15, Current Year	2nd & 3rd quarter, Current Year	On or before April 1, Next 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

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

Exhibit 1

Source: Policy Year Ultimate Unlimited Losses based on Financial Data Call for Compensation Experience

Exhibit 2

Source: Delaware Policy Year Unit Statistical Data Call for Compensation Experience. Unlimited incurred losses and claim counts are developed to ultimate. Medical-only claim counts and losses are excluded.

Exhibit 3

Source: Delaware Financial Year Data Call for Compensation Experience

Appendix C: Technical Appendix

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, 2017 and December 31, 2017
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, 2013 – December 31, 2013
- January 1, 2014 – December 31, 2014
- January 1, 2015 – December 31, 2015
- January 1, 2016 – December 31, 2016
- January 1, 2017 – December 31, 2017

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 an NDC code; HCPCS Codes - Drugs Other Than Chemotherapy (HCPCS: J0100-J8999) and Chemotherapy Drugs (HCPCS: J9000-J9999); or Pharmacy revenue codes (REV: 0250-0259, 0630-0637) were reported as the paid procedure code.

The **DME** category includes:

Provider Taxonomy Code starts 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

Appendix C: Technical Appendix

The **Hospital Inpatient** category includes:

Provider Taxonomy Code starts 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 Code starts with 27 or 28
AND
Place of Service Code = 22

The **Emergency Room** category includes:

Provider Taxonomy Code starts with 27 or 28
AND
Place of Service Code = 23

The **Ambulatory Surgical Center** category includes:

Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)
AND
Place of Service Code is NOT equal 24

Place of Service Code = 24
AND
Provider Taxonomy Code NOT equal Ambulatory Surgical (TAX: 261QA1903X)

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

Appendix C: Technical Appendix

The **Physicians** Category includes:

Provider Taxonomy Code does NOT start with 3328, 332H, 3325 or 335E

AND

CPT or HCPCS code 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

For this Exhibit, the published fees in the Pennsylvania Part B Professional (Physician) Fee Schedule were compared to the published fees in the Medicare 2017 National Physician Fee Schedule Relative Value File (October Release). Pennsylvania location 001 was compared to Medicare location Metropolitan Philadelphia while Pennsylvania locations 002, 003 and 004 were compared to Medicare location Rest of Pennsylvania. The percent difference was calculated for each fee compared.

Exhibit 6

This Exhibit displays the percentage for this specific category found in Exhibit 4.

Exhibit 7

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

Appendix C: Technical Appendix

Exhibit 8

This Exhibit includes 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 9

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

Exhibit 10-11

Same as Exhibits 8 – 9 except the Exhibits includes data for the Radiology CPT codes (CPT: 70010-79999.)

Exhibit 12

Using the data from Exhibit 10 for the Radiology CPT codes (CPT: 70010-79999), we calculated 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.

Exhibits 13-14

Same as Exhibits 8 – 9 except the Exhibits includes data for the Physical and General Medicine CPT codes (90281-99199, 99500-99602, 99605-99607.)

Exhibits 15-16

Same as Exhibits 8 – 9 except the Exhibits includes data for the Evaluation and Management CPT codes (CPT: 99201-99499.)

Appendix C: Technical Appendix

Exhibit 17-18

Within the Evaluation and Management CPT codes (CPT: 99201-99499), we focused on the Office or Other Outpatient Svc (CPT: 99201-99215) sub-category which includes codes for the management of a 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. We divided the paid amount by the transaction count (record count) for each of these codes to calculate the average paid per transaction. We trended this data across a five-year period with service dates as defined above. The CPT code long form description was included.

Exhibit 19

To calculate the time to first treatment, we measured the number of days between accident date and the earliest service date for each claim and accident date combination. We considered any service which occurred on the accident date as a one (1) day difference.

Major Surgery was first defined as Surgery CPT codes (CPT: 10021-69990). Next the Medicare Global Surgery Indicator from the Medicare 2017 National Physician Fee Schedule Relative Value File was used to identify Major Surgery codes.

Exhibit 20

Same as Exhibit 19 except the Exhibits includes data for the Radiology CPT codes (CPT: 70010-79999.)

Exhibit 21

Same as Exhibit 19 except the Exhibits includes data for the Physical and General Medicine CPT codes (90281-99199, 99500-99602, 99605-99607.)

Exhibit 22

Same as Exhibit 19 except the Exhibits includes data for the Evaluation and Management CPT codes (CPT: 99201-99499.)

Exhibit 23

The DCRB compared the 2017 Delaware inpatient hospital DRG fee schedule to the "DRG Summary for Medicare Inpatient Prospective Payment Hospitals, FY2016." From this publication, we compared the average amount that Medicare pays to Delaware providers for Medicare's share of the MS-DRG.

Appendix C: Technical Appendix

Exhibit 24

This Exhibit displays the percentage for this specific category found in Exhibit 4.

Exhibit 25

For this Exhibit, we include 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

Our system derives the following to compute Length of Stay:
If the [Srv_Date] is populated and [Srv_From] and [Srv_To] are not populated, then 1 day. If the [Srv_From] and [Srv_To] dates are the same, then 1 day. Otherwise, [Srv_To] minus [Srv_From] 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. Since our system does not include a derived inpatient stay count, we selected Bill ID count as a proxy for stay count.

Exhibit 26

Using the criteria from Exhibit 25, we extracted the Length of Stay (LOS) and paid amount by Bill ID. We divided the sum of the paid amounts by the sum of the LOS counts.

Exhibit 27

Using the same Bill ID count from Exhibit 17, we divided the total number of claims for the service year (with no criteria other than excluding prescription drug only records) by the Bill ID count from Exhibit 17. This result was then multiplied by 1000.

Exhibit 28

Using the criteria from Exhibit 25, we extracted the Length of Stay (LOS) by Bill ID. Using this LOS data, we then calculated the average LOS and the median LOS.

Appendix C: Technical Appendix

Exhibit 29

Same as Exhibit 19 except the Exhibits includes data for the Place of Service Code = 21 (Inpatient Hospital) and Provider Taxonomy Code starts with 28.

Exhibit 30

Using the criteria from Exhibit 25, the top 10 ICD-10 diagnosis sub-groups were selected based on paid amount in descending order. The paid amount for each diagnosis sub-group was divided by the total paid amount for Hospital Inpatient services to calculate the percent of inpatient payments.

Next we extracted the Bill ID and the paid amount for each of the top 10 ICD-10 diagnosis sub-groups. Using this data, we calculated the median bill payment for each of these codes which was reported as the median payment per hospital inpatient stay. Since our system does not include a derived inpatient stay count, we selected the Bill ID count as a proxy for stay count.

Exhibit 31

Same as Exhibit 30, except the top 10 DRG codes were selected based on paid amount in descending order and we extracted the Bill ID and the paid amount for each of the top 10 DRG codes.

Exhibit 32

The Delaware Health Care Payment System (HCPS) 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). Due to this complexity, a DCRB rate comparison to Medicare is not available for the hospital outpatient.

Exhibit 33

This Exhibit displays the percentage for this specific category found in Exhibit 4.

Appendix C: Technical Appendix

Exhibit 34

For this Exhibit, we include data 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)

Our 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, we divided the total paid amount by the total visit count to calculate the average outpatient paid amount per surgical visit.

Exhibit 35

This Exhibit is based on Exhibit 34.

We divided the total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) by the visit count. This result was then multiplied by 1000.

Exhibit 36

For this Exhibit, we include data 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, we divided the total paid amount by the total visit count to calculate the average outpatient paid amount per non-surgical visit.

Appendix C: Technical Appendix

Exhibit 37

This Exhibit is based on Exhibit 36.

We divided the total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) by the visit count. This result was then multiplied by 1000.

Exhibit 38

Same as Exhibit 19 except the Exhibits includes data for the Place of Service Code = 22 (Outpatient Hospital) and Provider Taxonomy Code starts with 28.

Exhibit 39

We selected the hospital outpatient criteria of:
Place of Service Code = 22 (Outpatient Hospital)
Provider Taxonomy Code starts with 27 or 28

The top 10 ICD-10 diagnosis sub-groups were selected based on paid amount in descending order. The paid amount for each diagnosis sub-group was divided by the total paid amount for Hospital Outpatient services to calculate the percent of outpatient payments.

We extracted the Bill ID and the paid amount for each of the top 10 ICD-10 diagnosis sub-groups. Using this data, we calculated the median bill payment for each of these codes which was reported as the median payment per hospital outpatient visit. Due to the way in which our system reflects the visit count, we selected the Bill ID count as a proxy for visit count in order to compute the median payment per hospital outpatient visit.

Exhibit 40

Same as Exhibit 8, except the top 10 surgery CPT codes were selected using the hospital outpatient criteria of:
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.

Appendix C: Technical Appendix

Exhibit 41

Same as Exhibit 40, 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 42

For this Exhibit, we include data with the following criteria:
Place of Service Code = 23 (Emergency Room - Hospital)
Provider Taxonomy Code starts with 27 or 28

Our 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 = 23 (Emergency Room - Hospital)
All Provider Taxonomy Codes

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

Exhibit 43

For this Exhibit, we include visits with the following criteria:
Place of Service Code = 23 (Emergency Room - Hospital)
Provider Taxonomy Code starts with 27 or 28

We divided the total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) by the visit count. This result was then multiplied by 1000.

Exhibit 44

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

Appendix C: Technical Appendix

Exhibit 45

Same as Exhibit 44, except this Exhibit displays the trend based on transaction counts, instead of paid amounts.

Exhibit 46

The Delaware Health Care Payment System (HCPS) 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 ASC fees.

Exhibit 47

This Exhibit displays the percentage for this specific category found in Exhibit 4.

Exhibit 48

For this Exhibit, we include data with the following criteria:
Place of Service Code = 24 (Ambulatory Surgical Center)
Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)

Our 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, we divided the total paid amount by the total visit count to calculate the average paid amount per ASC visit.

Exhibit 49

This Exhibit is based on Exhibit 48.

We divided the total number of claims for the service year (with no criteria other than excluding prescription drug only transactions) by the visit count. This result was then multiplied by 1000.

Appendix C: Technical Appendix

Exhibit 50

Same as Exhibit 19 except the Exhibit includes data for the Place of Service Code = 24 (Ambulatory Surgical Center) and Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)

Exhibit 51

We selected the ambulatory surgical center criteria of:
Place of Service Code = 24 (Ambulatory Surgical Center)
Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)

The top 10 ICD-10 diagnosis sub-groups were selected based on paid amount in descending order. The paid amount for each diagnosis sub-group was divided by the total paid amount for Hospital Outpatient services to calculate the percent of outpatient payments.

We extracted the Bill ID and the paid amount for each of the top 10 ICD-10 diagnosis sub-groups. Using this data, we calculated the median bill payment for each of these codes which was reported as the median payment per hospital outpatient visit. Due to the way in which our system reflects the visit count, we selected the Bill ID count as a proxy for visit count in order to compute the median payment per hospital outpatient visit.

Exhibit 52

Same as Exhibit 8, except the top 10 surgery CPT codes were selected using the Ambulatory Surgical Center criteria of:
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 53

This Exhibit displays the percentage for this specific category found in Exhibit 4.

Appendix C: Technical Appendix

Exhibit 54 – 58

These Exhibits reflect the prescription drug data reported using an NDC code as the paid procedure code. We supplemented the Medical Data Call prescription drug transactions 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.
- We consider repackaged drugs as branded drugs.

Exhibit 59

This Exhibit displays the percentage for this specific category found in Exhibit 4.

Exhibit 60

For this Exhibit, we defined Orthotics & Prosthetics 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)
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)

We did not identify Implants as a specific category, but Implants are included throughout the categories of Orthotics & Prosthetics, DME, and Supplies Other Than DME.

Exhibit 61

Same as Exhibit 8, except the top five Durable Medical Equipment (DME) HCPCS codes were selected using the criteria defined in Exhibit 60. The HCPCS code long form description was included.

Exhibit 62

Same as Exhibit 8, except the top five Supplies Other Than DME Codes HCPCS codes and CPT codes were selected using the criteria defined in Exhibit 60. The HCPCS code long form description was included.

Appendix C: Technical Appendix

Exhibit 63

Same as Exhibit 8, except the top five Orthotics and Prosthetics HCPCS codes were selected using the criteria defined in Exhibit 60. The HCPCS code long form description was included.

Exhibit 64

The top 10 ICD-10 diagnosis groups were selected based on paid amount in descending order for Accident Dates between January 1, 2016 and December 31, 2016. The paid amount for each diagnosis group was divided by the total paid amount for calendar year 2016 and 2017 services to calculate the percent of total medical payments.

The paid amount for each group was divided by the number of claims for that group to calculate the average payment per claim.

Exhibit 65

The top 10 ICD-10 diagnosis sub-groups were selected based on paid amount in descending order for Accident Dates between January 1, 2016 and December 31, 2016. The paid amount for each diagnosis sub-group was divided by the total paid amount for calendar year 2016 and 2017 services to calculate the percent of total medical payments.

The paid amount for each sub-group was divided by the number of claims for that sub-group to calculate the average payment per claim.

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.

Appendix E: Exhibit Number Cross Reference

Exhibit Name	2017 Reports Exhibit #	2016 Reports Exhibit #
Medical Share of Total Benefit Costs	1	1
Medical Average Cost per Case	2	2
Percentage of Medical Paid by Claim Maturity	3	3
Distribution of Medical Payments	4	4
Physician Payments as % of Medicare	5	Appendix E
Distribution of Medical Payments for Physicians	6	n/a
Distribution of Physician Payments by AMA Service Category	7	5
Top 10 Surgery Procedure Codes by Amount Paid	8	6
Top 10 Surgery Procedure Codes by Transaction Counts	9	7
Top 10 Radiology Procedure Codes by Amount Paid	10	8
Top 10 Radiology Procedure Codes by Transaction Counts	11	9
Average Amount Paid per Transaction by Modifier Code	12	10
Top 10 Physical and General Medicine Procedure Codes by Amount Paid	13	11
Top 10 Physical and General Medicine Procedure Codes by Transaction Counts	14	12
Top 10 Evaluation & Management Procedure Codes by Amount Paid	15	13
Top 10 Evaluation & Management Procedure Codes by Transaction Count	16	14
Office or Other Outpatient Visit for the Evaluation and Management of a New Patient	17	15/16
Office or Other Outpatient Visit for the Evaluation and Management of a Established Patient	18	15/16
Time Until First Treatment for Major Surgery (in Days)	19	n/a
Time Until First Treatment for Radiology (in Days)	20	n/a
Time Until First Treatment for Physical and General Medicine (in Days)	21	n/a
Time Until First Treatment for Initial Evaluation and Management Visit (in Days)	22	n/a
Hospital Inpatient Payments as % of Medicare	23	Appendix E
Distribution of Medical Payments for Hospital Inpatient	24	n/a
Average Inpatient Paid Amount per Stay for Hospital Inpatient Services	25	17
Average Inpatient Paid Amount per Day for Hospital Inpatient Services	26	20
Average Number of Inpatient Stays per 1,000 Active Claims	27	18
Inpatient Length of Stay for Hospital Inpatient Services	28	19
Time Until First Treatment for Hospital Inpatient Stays (in Days)	29	n/a
Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services	30	21
Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services	31	22
Hospital Outpatient Payments as % of Medicare	32	Appendix E
Distribution of Medical Payments for Hospital Outpatient	33	n/a
Average Outpatient Paid Amount Per Surgical Visit for Hospital Outpatient Services	34	23
Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims	35	23A
Average Outpatient Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services	36	24
Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims	37	24A

Appendix E: Exhibit Number Cross Reference

Exhibit Name	2017 Reports Exhibit #	2016 Reports Exhibit #
Time Until First Treatment for Outpatient Visits (in Days)	38	n/a
Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services	39	25
Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services	40	26
Top 10 Non-Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services	41	27
Average Amount Paid per ER Visit	42	28
Average Number of ER Visits per 1,000 Active Claims	43	29
Distribution of ER Service Payments	n/a	30
Emergency Room Services by Procedure Code Trend and Average Paid per Transaction	44	31
ER Transactions by Procedure Code Trend and Average Paid per Transaction	45	31A
ASC Payments as % of Medicare	46	Appendix E
Distribution of Medical Payments for ASC	47	n/a
Average Amount Paid per Visit for ASC Services	48	32
Average Number of ASC Visits per 1,000 Active Claims	49	32A
Time Until First Treatment for ASC Visits (in Days)	50	n/a
Top 10 Diagnosis Groups by Amount Paid for ASC Services	51	33
Top 10 Surgery Procedure Codes by Amount Paid for ASC Services	52	34
Distribution of Medical Payments for Drugs	53	n/a
Distribution of Prescription Drug Costs by CSA Schedule	54	38
Top 10 Workers Compensation Drugs by Amount Paid	55	35
Top 10 Workers Compensation Drugs by Prescription Counts	56	36
Top 30 Drugs for Service Year 2017	56A	36A
Distribution of Drugs by Brand Name and Generic	57	37
Distribution of Drugs by Pharmacy and Non-pharmacy	58	39
Distribution of Drugs by Repackaged and Non-Repackaged	n/a	40
Distribution of Medical Payments for DME, Supplies and Implants	59	n/a
Distribution of Payments by DME, Supplies, and Implants	60	41
Top 5 DME Codes by Amount Paid	61	43
Top 5 Supplies Other than DME Codes by Amount Paid	62	44
Top 5 Orthotics and Prosthetics Codes by Amount Paid	63	42
Top Body Systems by Amount Paid for Dates of Injury in 2016	64	n/a
Top Diagnosis Groups by Amount Paid for Dates of Injury in 2016	65	45
Distribution of Physician and Facility Payments by Provider State	n/a	46