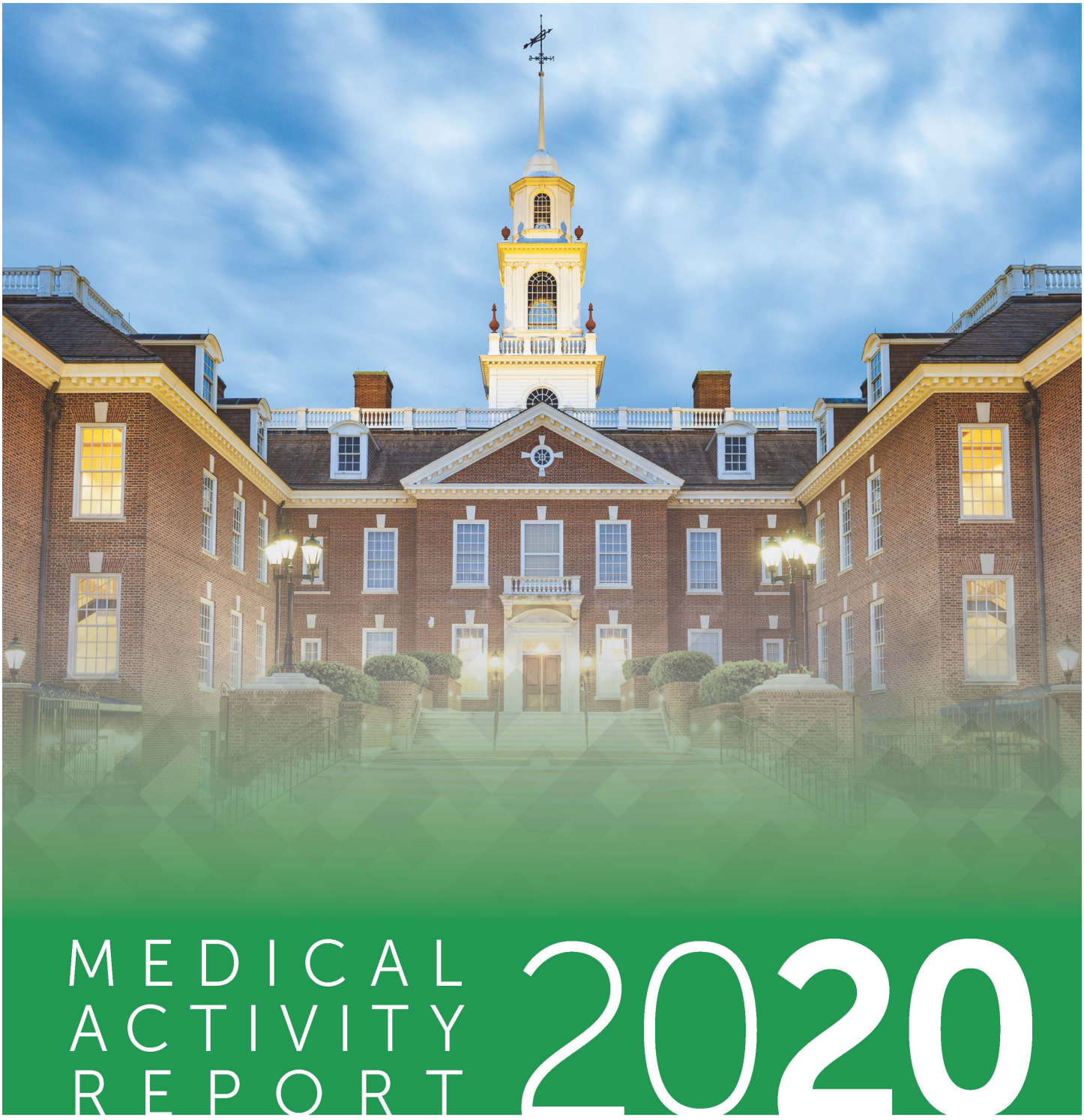

MEDICAL ACTIVITY REPORT 2020

BASED ON 2019 SERVICE DATES

DCRB DELAWARE
Compensation Rating Bureau, Inc

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Introduction

The Delaware Compensation Rating Bureau's (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:

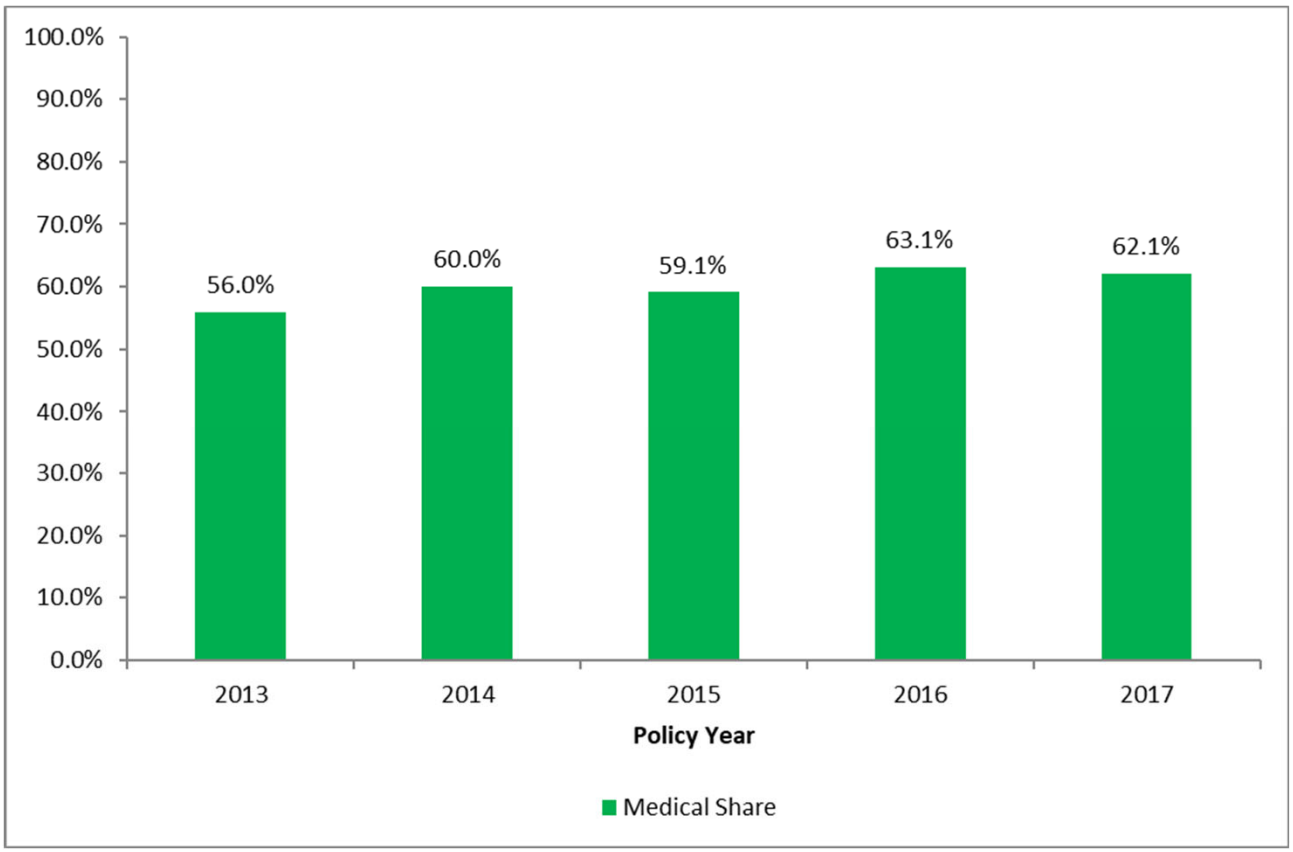
- Medical detail data could enhance the DCRB's ability to explain filings
- Medical detail data would allow the DCRB to be able to opine with authority on a variety of possible proposals to change the payment system for workers compensation in Delaware
- Medical cost containment concerns impact public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

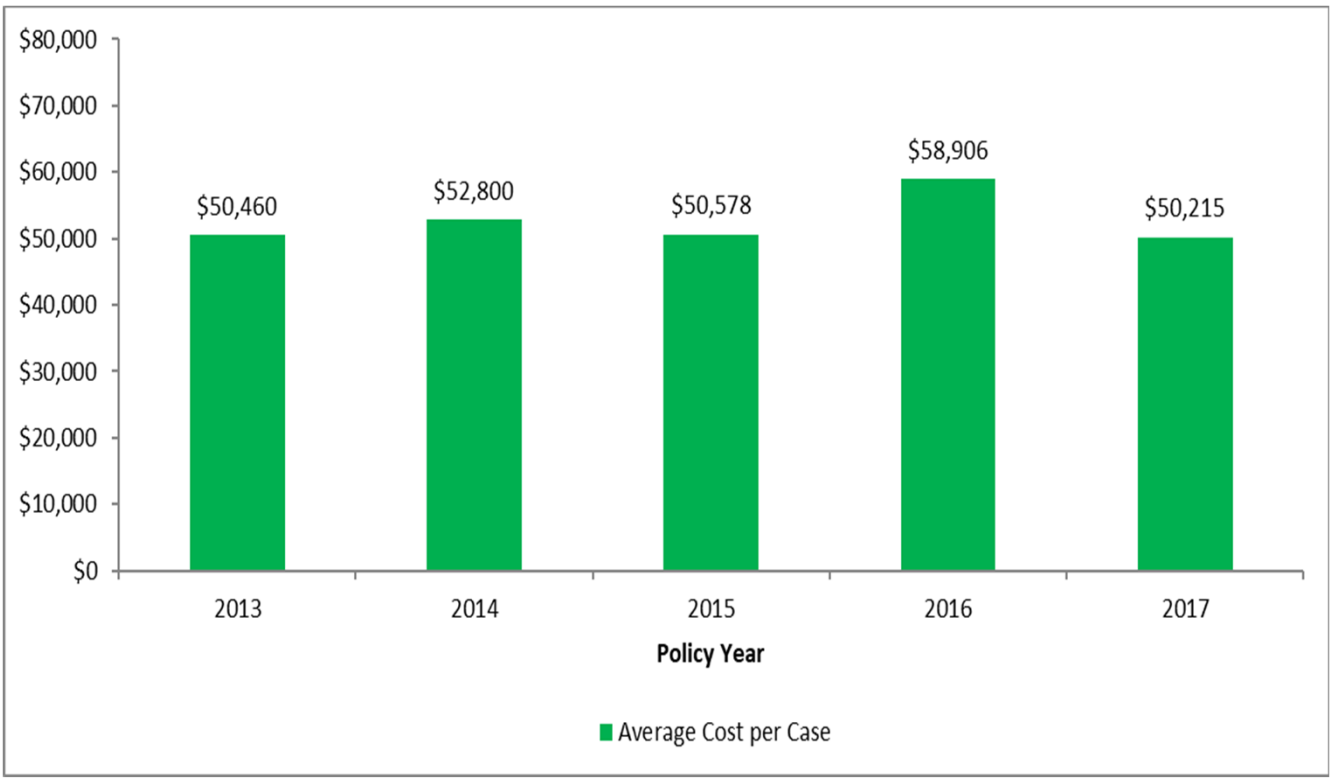


This exhibit displays the historical medical share of total benefit costs for the most recent five policy years.

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 12/31/2018 and includes medical only claims.

Exhibit 2
Medical Average Cost Per Case

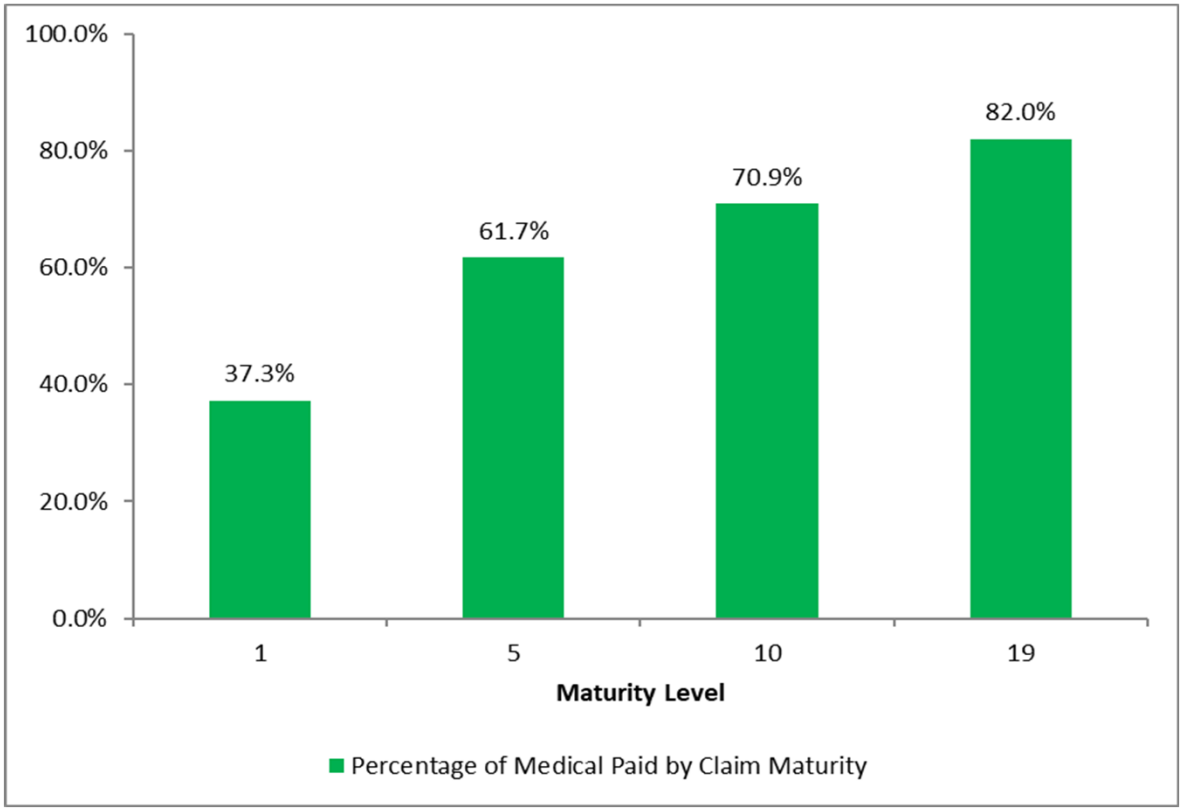


This exhibit provides a high-level summary of medical average cost per case from 2013 to 2018.

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 71% 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 7/1/2019. 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 12/31/2018 and includes medical only claims.

Exhibit 4
Distribution of Medical Payments

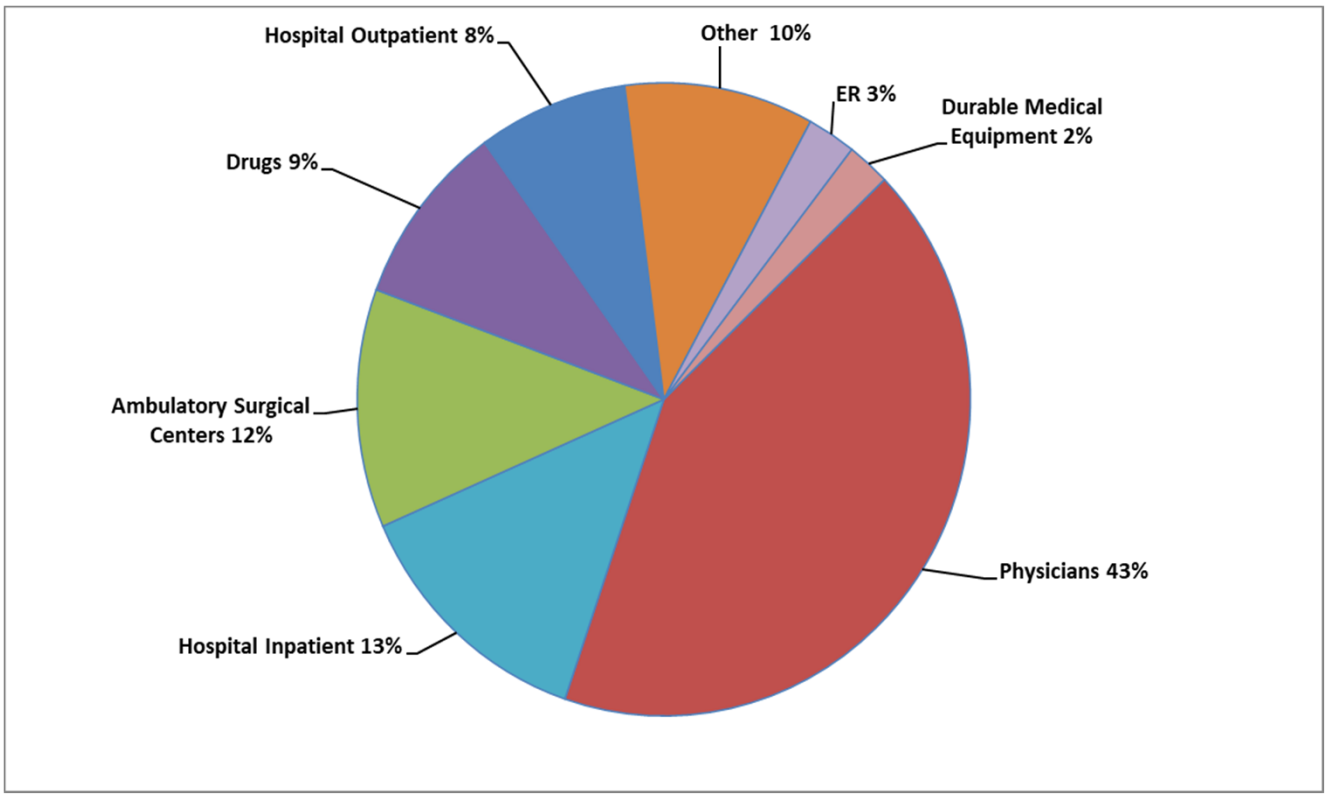


Exhibit 4 presents the distribution of medical payments by type of service groups for the state of Delaware. Payments to physicians represent the largest portion (43%) of medical paid for Service Year 2019. The service groups are defined based on paid procedure code type, provider taxonomy, and place 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

Background

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. **DCRB compared the 2019 Delaware professional (physician) fee schedule to 2019 Medicare National Physician Fee Schedule Relative Value File (January Release) and found that the physician fee schedule averages 244% of Medicare, with significant differences depending on the procedure code category. Overall, DCRB determined that for geo zip 197/198, the fee schedule averages 257% of Medicare and for geo zip 199 the fee schedule averages 206% of Medicare. Detailed results are in the following chart.**

In the WCRI's report titled "Evaluation of the 2015, 2016, and 2017 Fee Schedule Changes in Delaware" the WCRI found that the 2018 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 2019 Fee Schedules to Medicare 2019 Fee Schedules

Professional Code Category	% Range	Distinct Code Count 197/198/Non-DE	Distinct Code Count 199
(1) Surgery	Between 251% and 300% of Medicare	4,025	373
	Between 201% and 250% of Medicare	1,087	835
	Between 100% and 150% of Medicare	184	243
	Between 151% and 200% of Medicare	154	3,979
	Less than 100% of Medicare	115	134
	Over 350% of Medicare	17	16
	Between 301% and 350% of Medicare	0	2
(1) Surgery Total		5,582	5,582
(2) Radiology*	Between 151% to 200% of Medicare	589	184
*Distinct Code-Mod Count	Between 100% to 150% of Medicare	228	669
	Between 201% to 250% of Medicare	156	132
	Between 251% to 300% of Medicare	103	78
	Less than 100% of Medicare	38	67
	Over 300% of Medicare	30	14
(2) Radiology Total		1,144	1,144
(3) Pathology & Laboratory	Between 151% and 200% of Medicare	46	25
	Between 100% and 150% of Medicare	20	33
	Less than 100% of Medicare	16	24
(3) Pathology & Laboratory Total		82	82
(4) Medicine	Between 100% and 150% of Medicare	442	528
	Over 350% of Medicare	330	294
	Between 151% and 200% of Medicare	310	208
	Less than 100% of Medicare	90	114
	Between 251% and 300% of Medicare	38	34
	Between 301% and 350% of Medicare	30	34
	Between 201% and 250% of Medicare	22	50
(4) Medicine Total		1,262	1,262
(5) Physical Medicine	Between 151% and 200% of Medicare	35	24
	Between 100% and 150% of Medicare	16	18
	Less than 100% of Medicare	9	18
(5) Physical Medicine Total		60	60
(6) Evaluation & Management	Between 100% and 150% of Medicare	106	116
	Less than 100% of Medicare	31	29
	Between 151% and 200% of Medicare	19	11
(6) Evaluation & Management Total		156	156

Exhibit 6
Distribution of Physician Payments by AMA Service Category

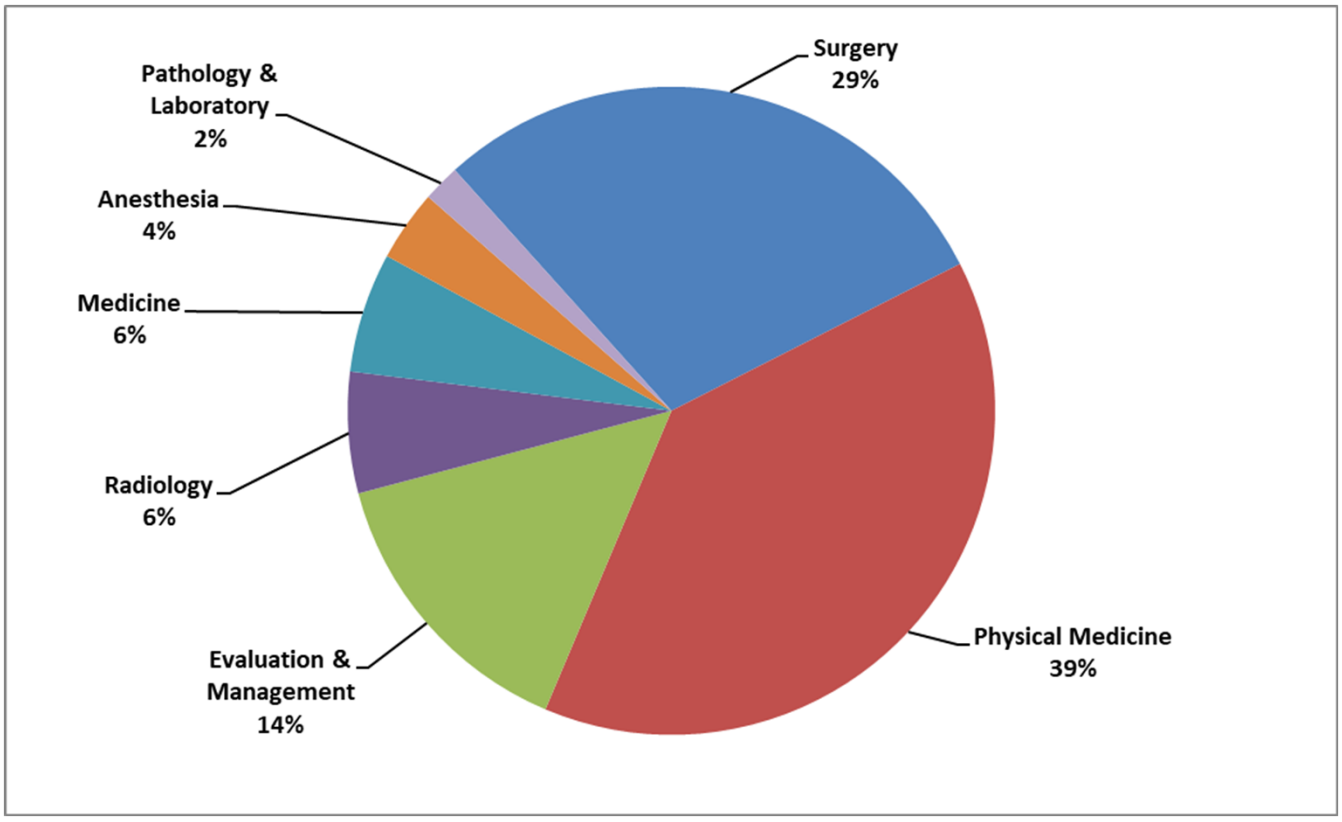


Exhibit 6 presents the distribution of physician payments by Current Procedural Terminology (CPT) code categories as defined by the American Medical Association (AMA). The Delaware Health Care Payment system (i.e., the fee schedule) dictates the maximum allowable reimbursement (MAR) when paying medical 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 sixteen exhibits represent different breakdowns of CPT procedure codes performed by physicians for the Anesthesia, 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 7 presents the top 10 anesthesia paid procedure codes based on paid amount. **Exhibit 8** presents the top 10 anesthesia paid procedure codes based on transaction counts.

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

Exhibits 11, 14, 17 and 20 present various time to treatment metrics for professional services.

Exhibit 12 presents the top 10 radiology paid procedure codes based on paid amount. **Exhibit 13** presents the top 10 radiology paid procedure codes based on transaction counts.

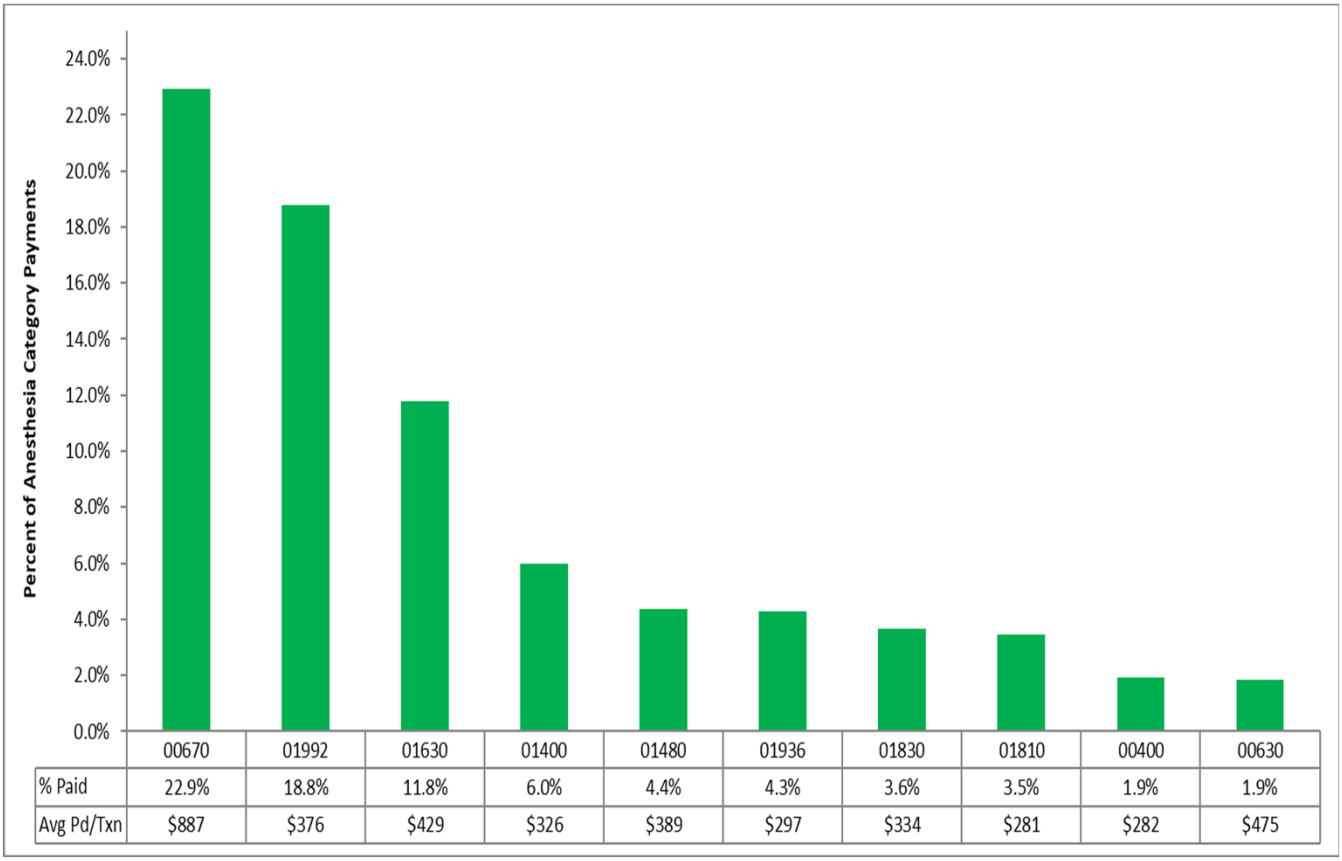
Exhibit 15 presents the top 10 physical and general medicine paid procedure codes based on paid amount. **Exhibit 16** presents the top 10 physical and general medicine paid procedure codes based on transaction counts.

Exhibit 18 presents the top 10 evaluation and management paid procedure codes based on paid amount. **Exhibit 19** presents the top 10 evaluation and management paid procedure codes based on transaction counts.

Exhibit 21 and 22 presents the most recent five-year trend for evaluation and management procedure codes.

The source for all data is the DCRB Medical Data Call for Service Year 2019. For detailed information on what is included in each exhibit, refer to the Technical Appendix.

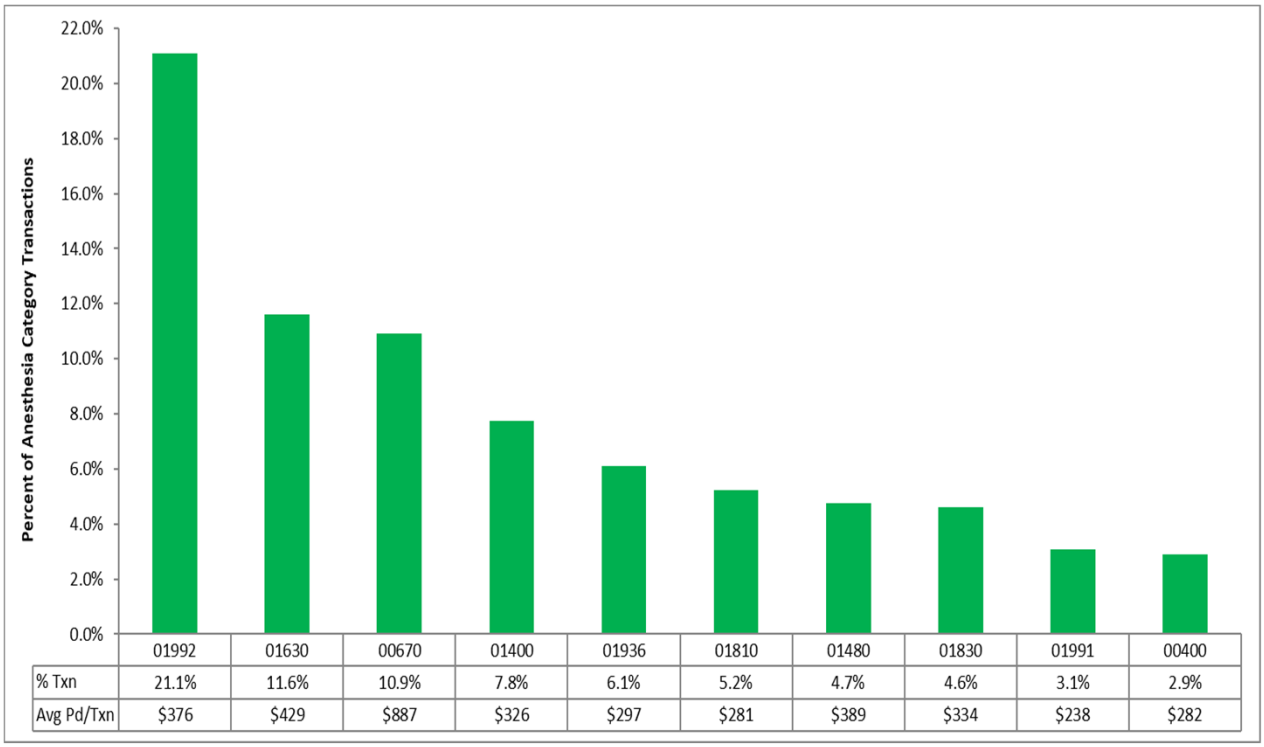
Exhibit 7
Top 10 Anesthesia Procedure Codes by Amount Paid



	00670	01992	01630	01400	01480	01936	01830	01810	00400	00630
% Paid	22.9%	18.8%	11.8%	6.0%	4.4%	4.3%	3.6%	3.5%	1.9%	1.9%
Avg Pd/Txn	$887	$376	$429	$326	$389	$297	$334	$281	$282	$475

Code	Description
00670	Anesthesia for procedure on spine and spinal cord
01992	Anesthesia for nerve block and injection procedure, prone position
01630	Anesthesia for open or endoscopic procedure at upper arm and shoulder joint
01400	Anesthesia for open or endoscopic procedure on knee
01480	Anesthesia for open procedure on bones of lower leg, ankle and foot
01936	Anesthesia for X-ray procedure (accessed through the skin) on spine and spinal cord
01830	Anesthesia for open or endoscopic procedure on bones of forearm, wrist, or hand
01810	Anesthesia for procedure on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
00400	Anesthesia for procedure on skin of arms, legs, or trunk
00630	Anesthesia for procedure on lower spine

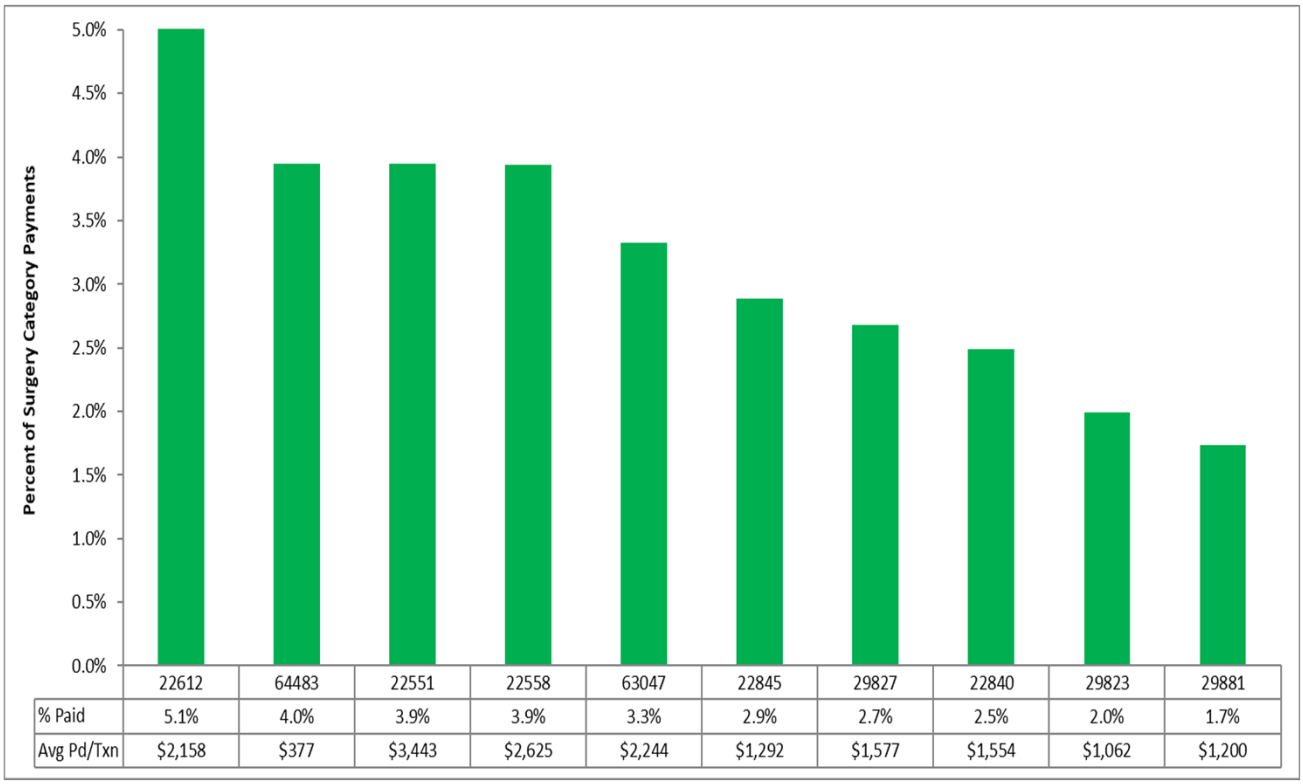
Exhibit 8
Top 10 Anesthesia Procedure Codes by Transaction Counts



	01992	01630	00670	01400	01936	01810	01480	01830	01991	00400
% Txn	21.1%	11.6%	10.9%	7.8%	6.1%	5.2%	4.7%	4.6%	3.1%	2.9%
Avg Pd/Txn	$376	$429	$887	$326	$297	$281	$389	$334	$238	$282

Code	Description
01992	Anesthesia for nerve block and injection procedure, prone position
01630	Anesthesia for open or endoscopic procedure at upper arm and shoulder joint
00670	Anesthesia for procedure on spine and spinal cord
01400	Anesthesia for open or endoscopic procedure on knee
01936	Anesthesia for X-ray procedure (accessed through the skin) on spine and spinal cord
01810	Anesthesia for procedure on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01480	Anesthesia for open procedure on bones of lower leg, ankle and foot
01830	Anesthesia for open or endoscopic procedure on bones of forearm, wrist, or hand
01991	Anesthesia for nerve block and injection procedure
00400	Anesthesia for procedure on skin of arms, legs, or trunk

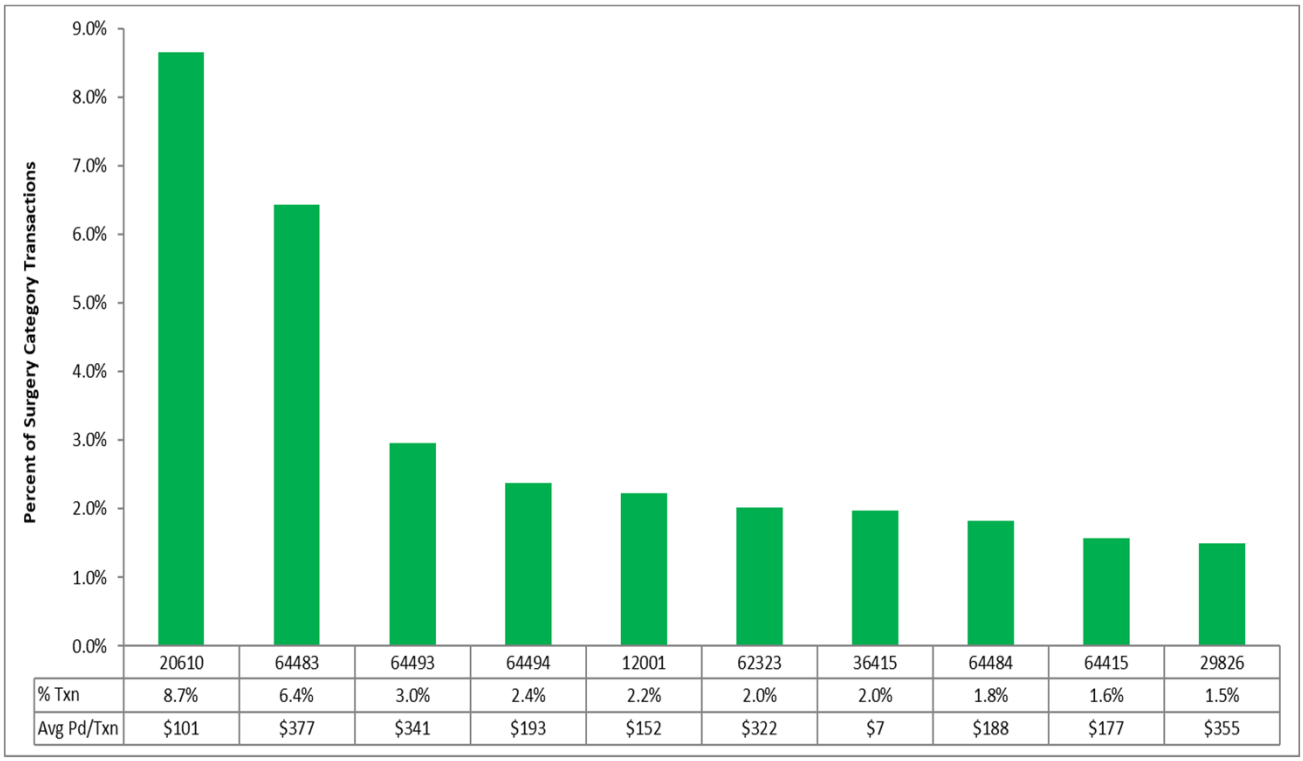
Exhibit 9
Top 10 Surgery Procedure Codes by Amount Paid



	22612	64483	22551	22558	63047	22845	29827	22840	29823	29881
% Paid	5.1%	4.0%	3.9%	3.9%	3.3%	2.9%	2.7%	2.5%	2.0%	1.7%
Avg Pd/Txn	$2,158	$377	$3,443	$2,625	$2,244	$1,292	$1,577	$1,554	$1,062	$1,200

Code	Description
22612	Fusion of lower spine bones, posterior or posterolateral approach
64483	Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance
22551	Fusion of spine bones with removal of disc at upper spinal column, anterior approach
22558	Fusion of spine bones with removal of disc at lower spinal column, anterior approach
63047	Partial removal of middle spine bone with release of spinal cord and/or nerves
22845	Insertion of anterior spinal instrumentation for spinal stabilization, 2 to 3 vertebral segments
29827	Repair of shoulder rotator cuff using an endoscope
22840	Insertion of posterior spinal instrumentation at base of neck for stabilization, 1 interspace
29823	Extensive removal of shoulder joint tissue using an endoscope
29881	Removal of one knee cartilage using an endoscope

Exhibit 10
Top 10 Surgery Procedure Codes by Transaction Counts



	20610	64483	64493	64494	12001	62323	36415	64484	64415	29826
% Txn	8.7%	6.4%	3.0%	2.4%	2.2%	2.0%	2.0%	1.8%	1.6%	1.5%
Avg Pd/Txn	$101	$377	$341	$193	$152	$322	$7	$188	$177	$355

Code	Description
20610	Aspiration and/or injection of large joint or joint capsule
64483	Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance
64493	Injections of lower or sacral spine facet joint using imaging guidance
64494	Injections of lower or sacral spine facet joint using imaging guidance
12001	Repair of wound (2.5 centimeters or less) of the scalp, neck, underarms, trunk, arms and/or legs
62323	Injection of substance into spinal canal of lower back or sacrum using imaging guidance
36415	Insertion of needle into vein for collection of blood sample
64484	Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance
64415	Injection of anesthetic agent and/or steroid into brachial nerve bundle of arm
29826	Shaving of shoulder bone using an endoscope

Exhibit 11
Time Until First Treatment for Major Surgery (in Days)

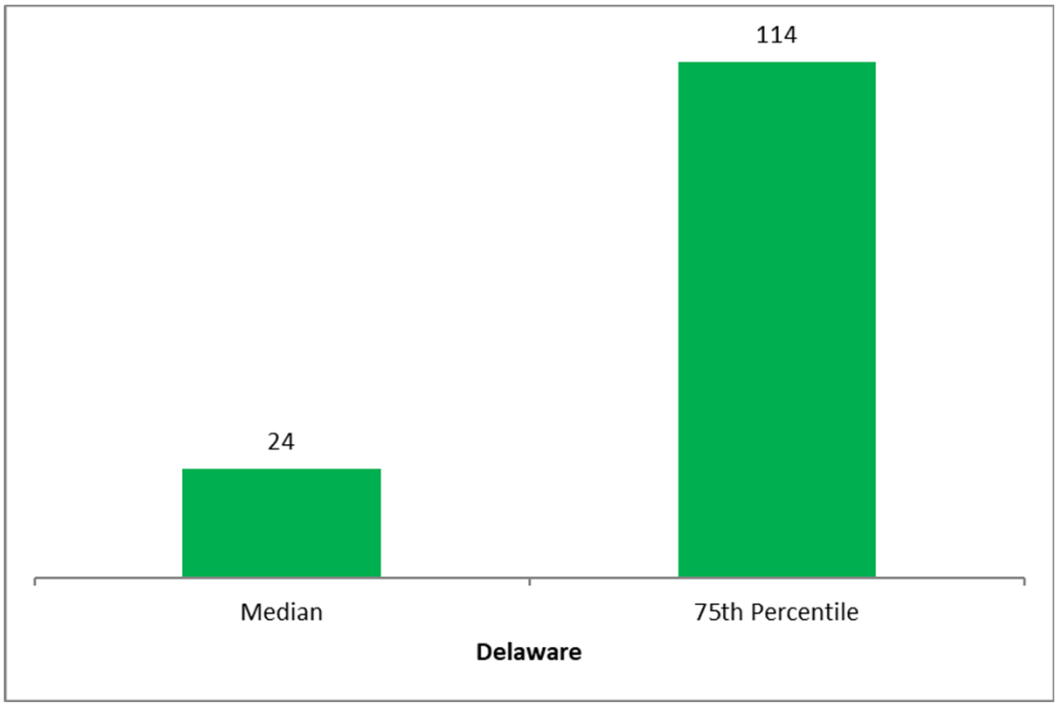
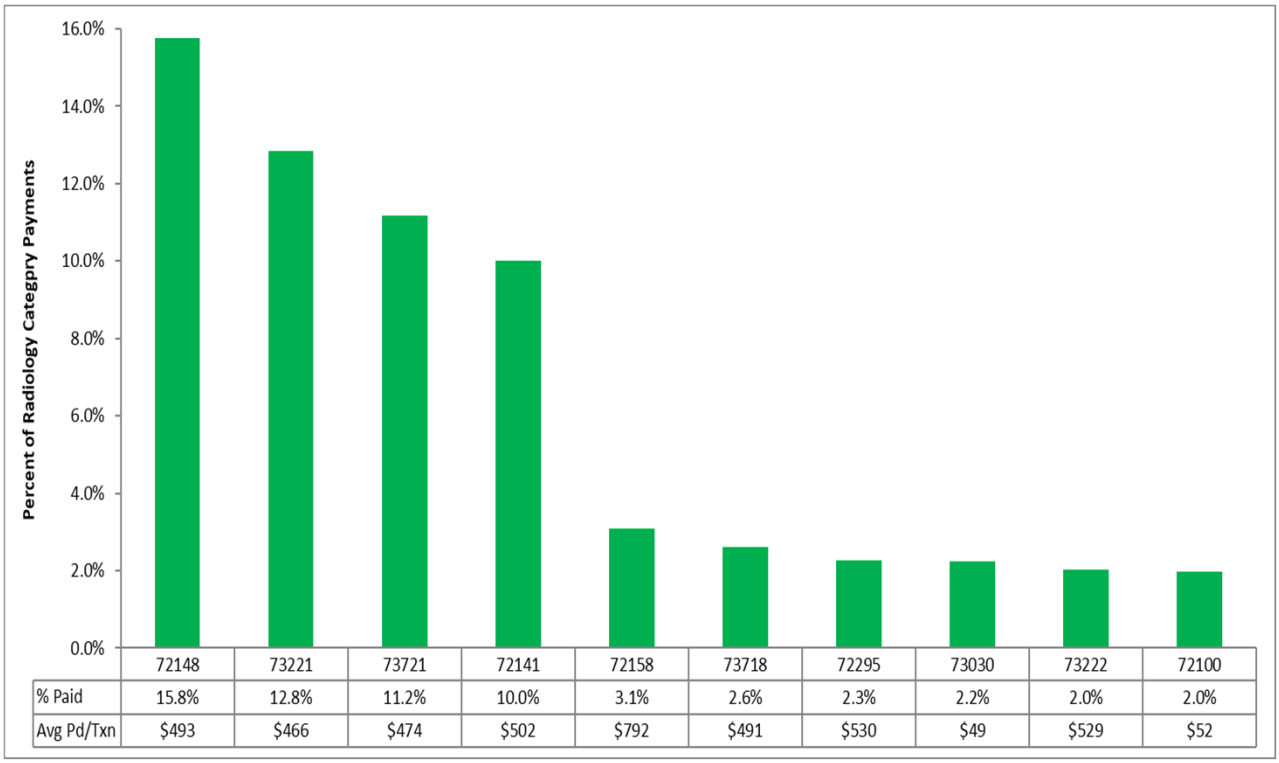


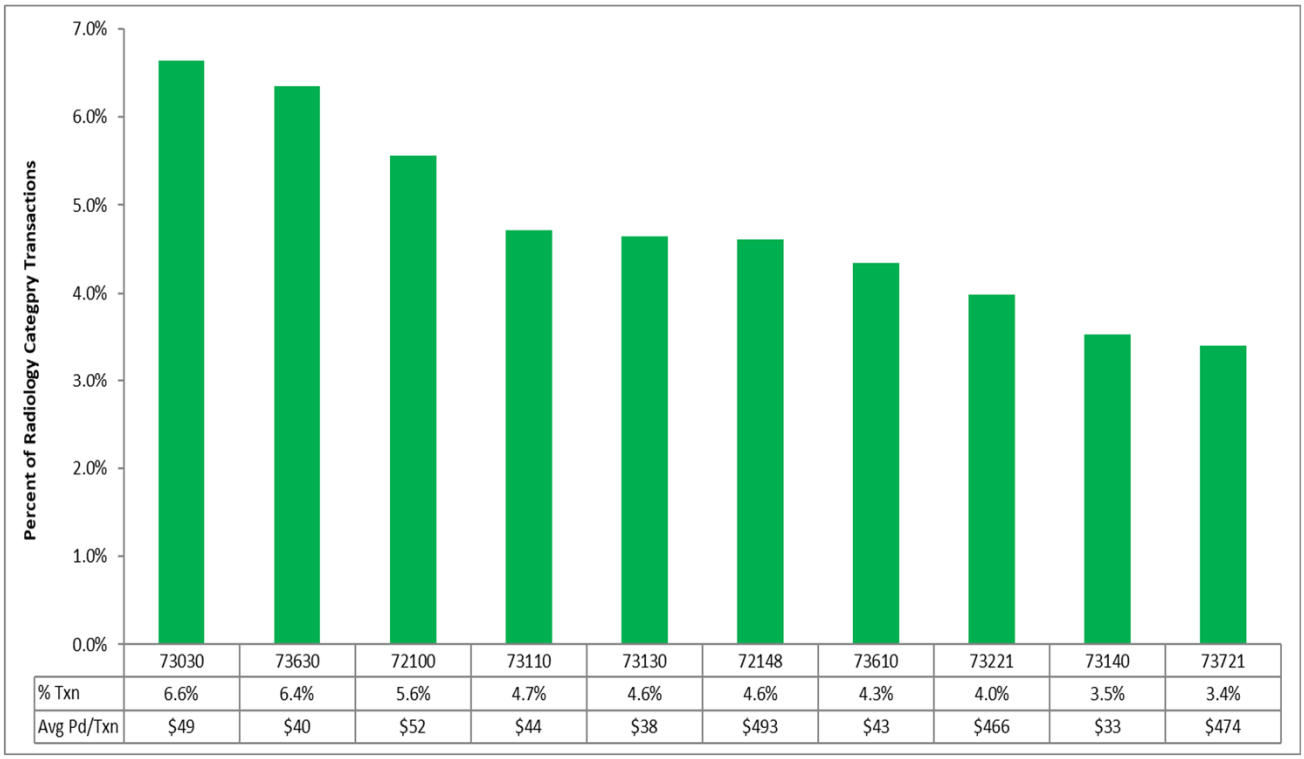
Exhibit 12
Top 10 Radiology Procedure Codes by Amount Paid



	72148	73221	73721	72141	72158	73718	72295	73030	73222	72100
% Paid	15.8%	12.8%	11.2%	10.0%	3.1%	2.6%	2.3%	2.2%	2.0%	2.0%
Avg Pd/Txn	$493	$466	$474	$502	$792	$491	$530	$49	$529	$52

Code	Description
72148	MRI scan of lower spinal canal
73221	MRI scan of arm joint
73721	MRI scan of leg joint
72141	MRI scan of upper spinal canal
72158	MRI scan of lower spinal canal before and after contrast
73718	MRI scan of leg
72295	Radiological supervision and interpretation X-ray of disc of vertebra, lower spine
73030	X-ray of shoulder, minimum of 2 views
73222	MRI scan of arm joint with contrast
72100	X-ray of lower and sacral spine, 2 or 3 views

Exhibit 13
Top 10 Radiology Procedure Codes by Transaction Counts



	73030	73630	72100	73110	73130	72148	73610	73221	73140	73721
% Txn	6.6%	6.4%	5.6%	4.7%	4.6%	4.6%	4.3%	4.0%	3.5%	3.4%
Avg Pd/Txn	$49	$40	$52	$44	$38	$493	$43	$466	$33	$474

Code	Description
73030	X-ray of shoulder, minimum of 2 views
73630	X-ray of foot, minimum of 3 views
72100	X-ray of lower and sacral spine, 2 or 3 views
73110	X-ray of wrist, minimum of 3 views
73130	X-ray of hand, minimum of 3 views
72148	MRI scan of lower spinal canal
73610	X-ray of ankle, minimum of 3 views
73221	MRI scan of arm joint
73140	X-ray of fingers, minimum of 2 views
73721	MRI scan of leg joint

Exhibit 14
Time Until First Treatment for Radiology (in Days)

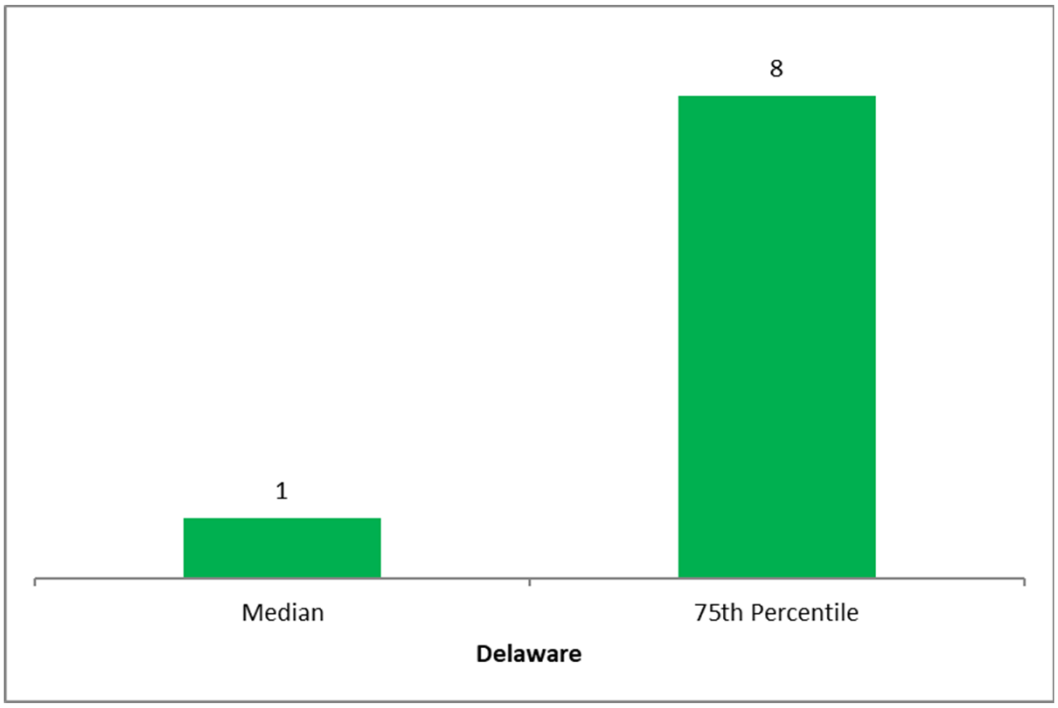
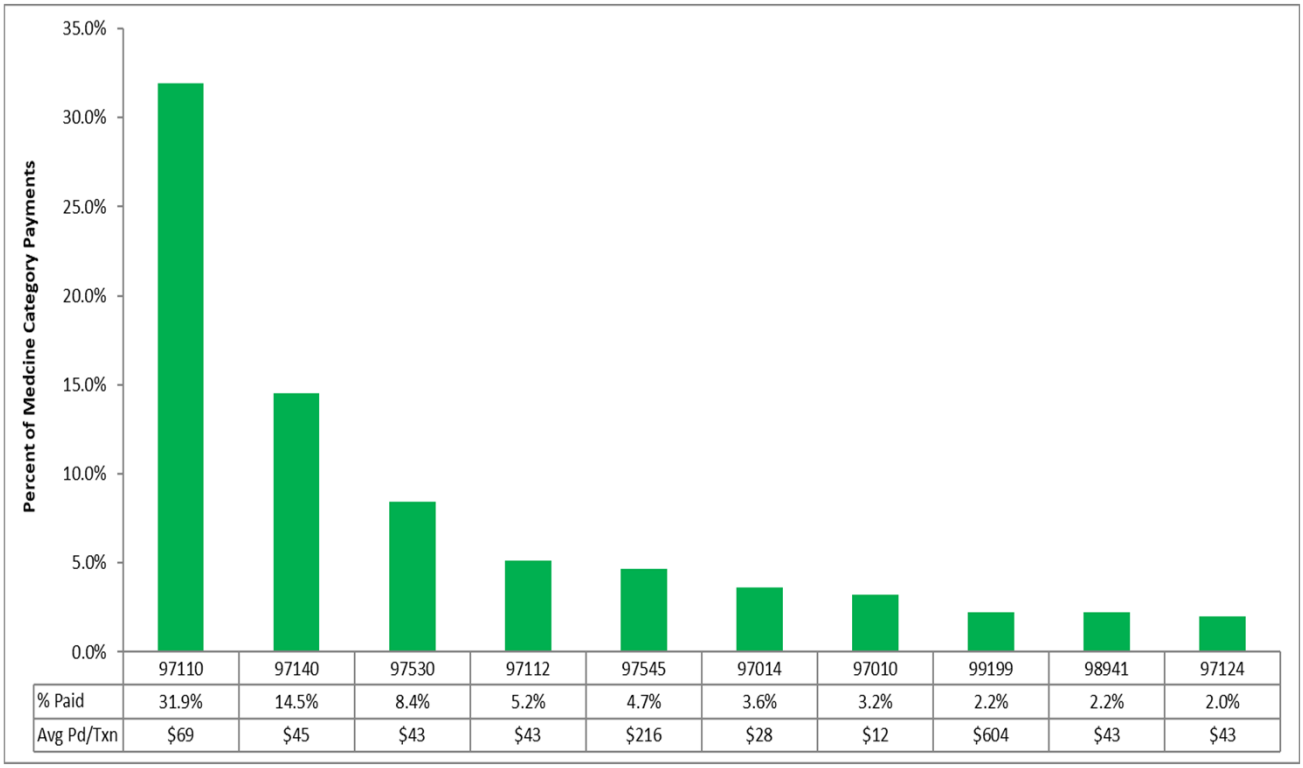


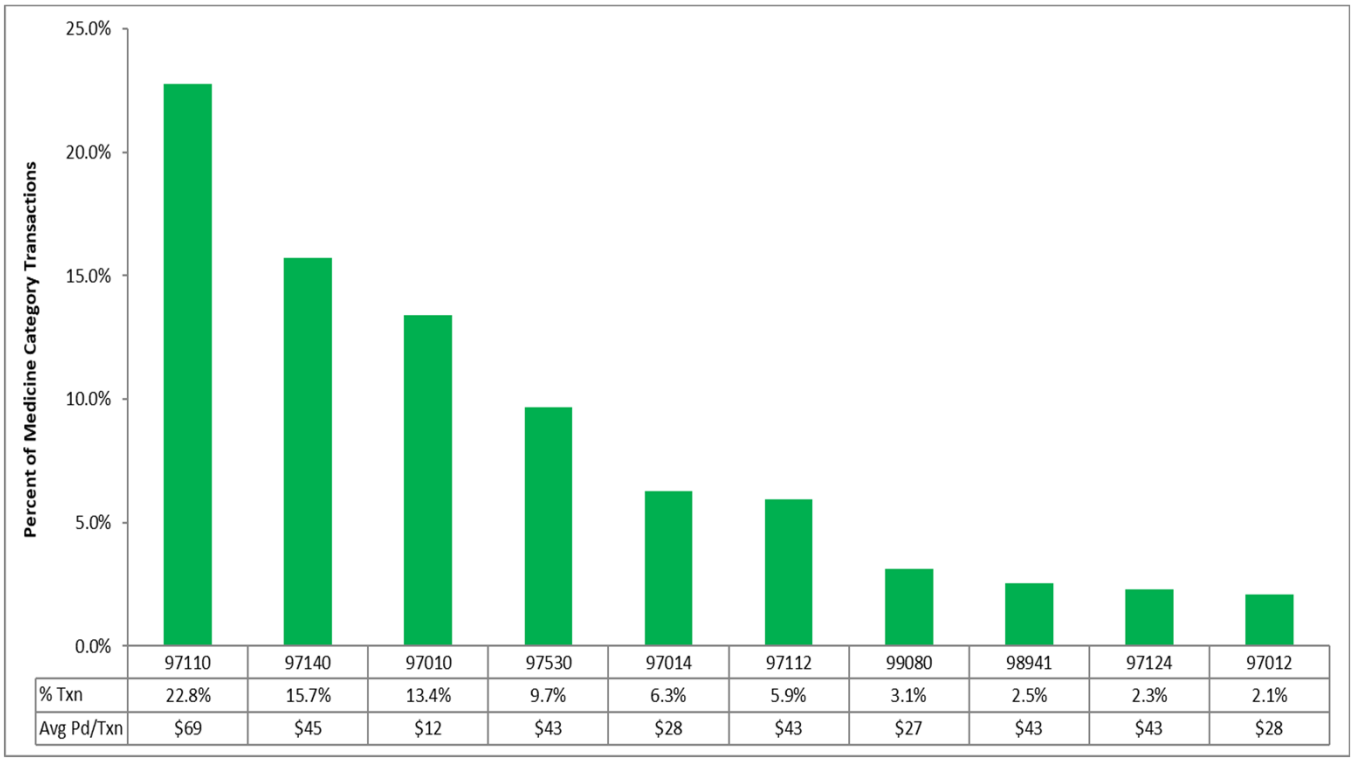
Exhibit 15
Top 10 Physical and General Medicine Procedure Codes by Amount Paid



	97110	97140	97530	97112	97545	97014	97010	99199	98941	97124
% Paid	31.9%	14.5%	8.4%	5.2%	4.7%	3.6%	3.2%	2.2%	2.2%	2.0%
Avg Pd/Txn	$69	$45	$43	$43	$216	$28	$12	$604	$43	$43

Code	Description
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
97545	Work hardening or conditioning, first 2 hours
97014	Application of electrical stimulation to 1 or more areas, unattended by physical therapist
97010	Application of hot or cold packs to 1 or more areas
99199	Procedure, service, or report
98941	Chiropractic manipulative treatment, 3 to 4 spinal regions
97124	Therapeutic massage to 1 or more areas, each 15 minutes

Exhibit 16
Top 10 Physical and General Medicine Procedure Codes by Transaction Counts



	97110	97140	97010	97530	97014	97112	99080	98941	97124	97012
% Txn	22.8%	15.7%	13.4%	9.7%	6.3%	5.9%	3.1%	2.5%	2.3%	2.1%
Avg Pd/Txn	$69	$45	$12	$43	$28	$43	$27	$43	$43	$28

Code	Description
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
97010	Application of hot or cold packs to 1 or more areas
97530	Therapeutic activities to improve function, with one-on-one contact between patient and provider, each 15 minutes
97014	Application of electrical stimulation to 1 or more areas, unattended by physical therapist
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes
99080	Preparation of special reports beyond that conveyed in the medical record
98941	Chiropractic manipulative treatment, 3 to 4 spinal regions
97124	Therapeutic massage to 1 or more areas, each 15 minutes
97012	Application of mechanical traction to 1 or more areas

Exhibit 17

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

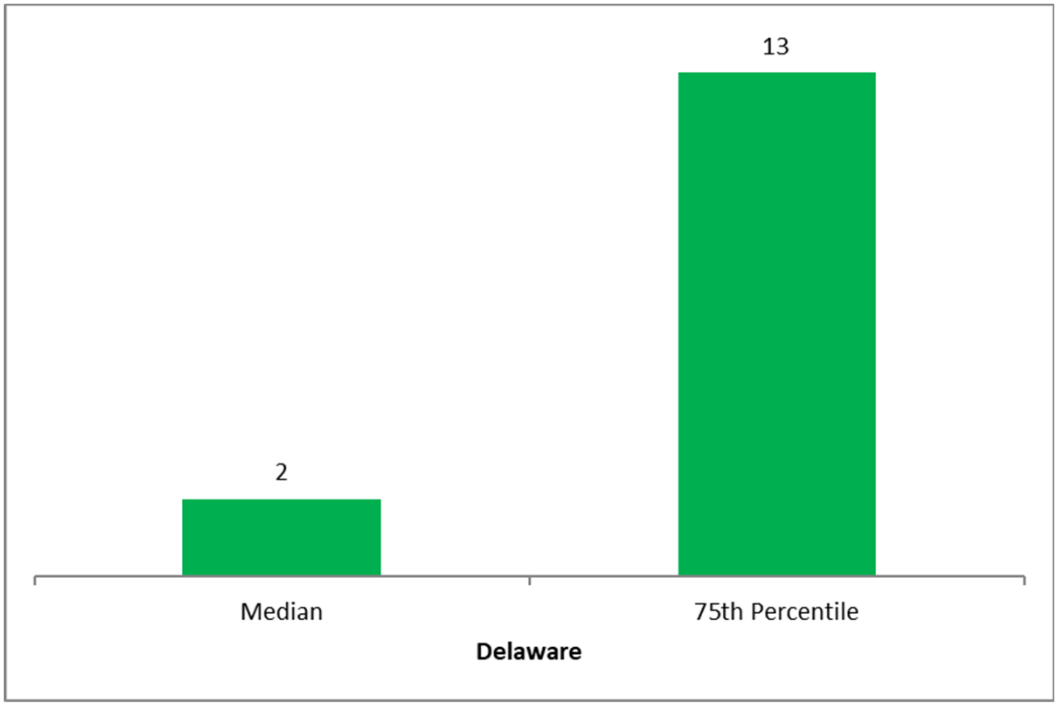
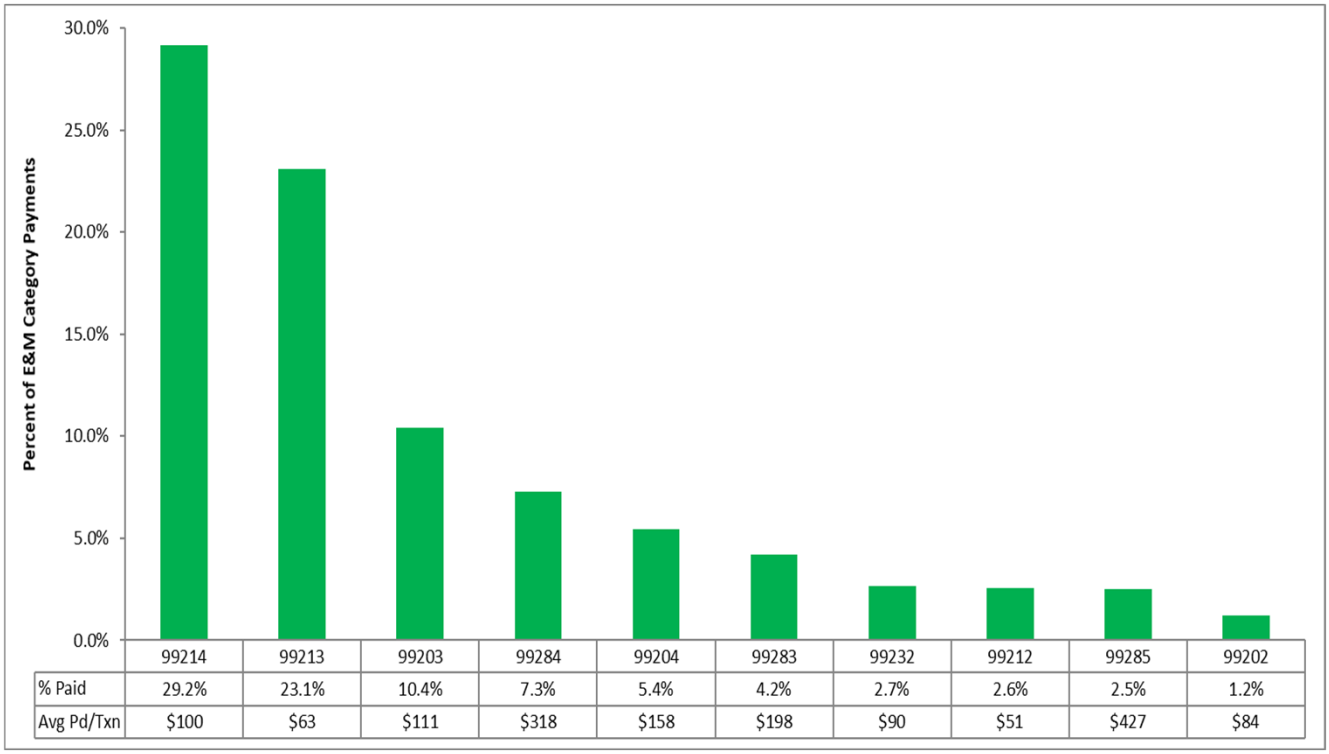


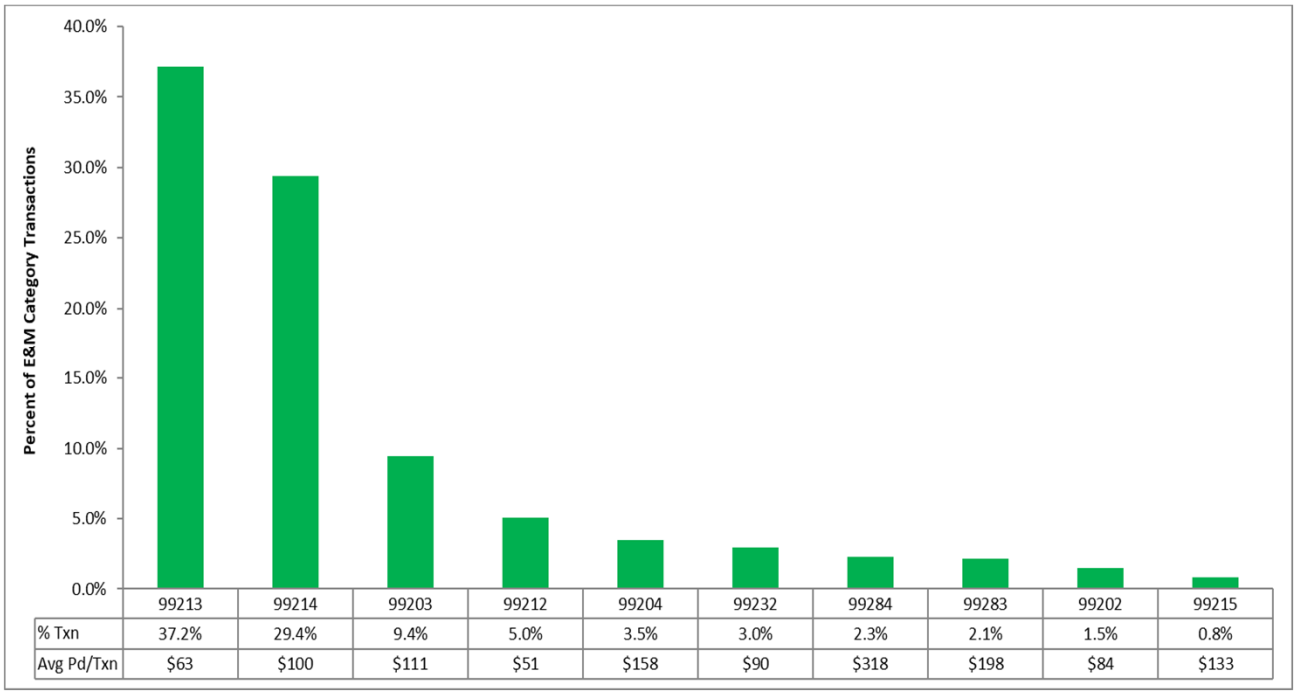
Exhibit 18
Top 10 Evaluation & Management Procedure Codes by Amount Paid



	99214	99213	99203	99284	99204	99283	99232	99212	99285	99202
% Paid	29.2%	23.1%	10.4%	7.3%	5.4%	4.2%	2.7%	2.6%	2.5%	1.2%
Avg Pd/Txn	$100	$63	$111	$318	$158	$198	$90	$51	$427	$84

Code	Description
99214	Established patient office or other outpatient, visit typically 25 minutes
99213	Established patient office or other outpatient visit, typically 15 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99284	Emergency department visit, problem of high severity
99204	New patient office or other outpatient visit, typically 45 minutes
99283	Emergency department visit, moderately severe problem
99232	Subsequent hospital inpatient care, typically 25 minutes per day
99212	Established patient office or other outpatient visit, typically 10 minutes
99285	Emergency department visit, problem with significant threat to life or function
99202	New patient office or other outpatient visit, typically 20 minutes

Exhibit 19
Top 10 Evaluation & Management Procedure Codes by Transaction Counts



	99213	99214	99203	99212	99204	99232	99284	99283	99202	99215
% Txn	37.2%	29.4%	9.4%	5.0%	3.5%	3.0%	2.3%	2.1%	1.5%	0.8%
Avg Pd/Txn	$63	$100	$111	$51	$158	$90	$318	$198	$84	$133

Code	Description
99213	Established patient office or other outpatient visit, typically 15 minutes
99214	Established patient office or other outpatient, visit typically 25 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99212	Established patient office or other outpatient visit, typically 10 minutes
99204	New patient office or other outpatient visit, typically 45 minutes
99232	Subsequent hospital inpatient care, typically 25 minutes per day
99284	Emergency department visit, problem of high severity
99283	Emergency department visit, moderately severe problem
99202	New patient office or other outpatient visit, typically 20 minutes
99215	Established patient office or other outpatient, visit typically 40 minutes

Exhibit 20

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

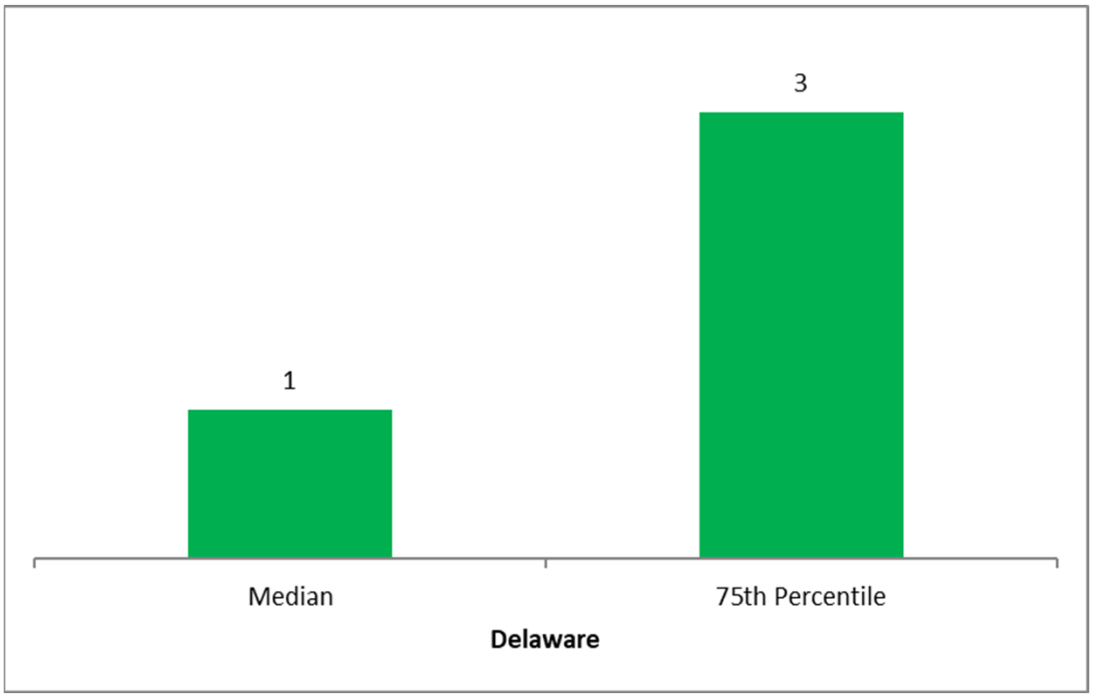
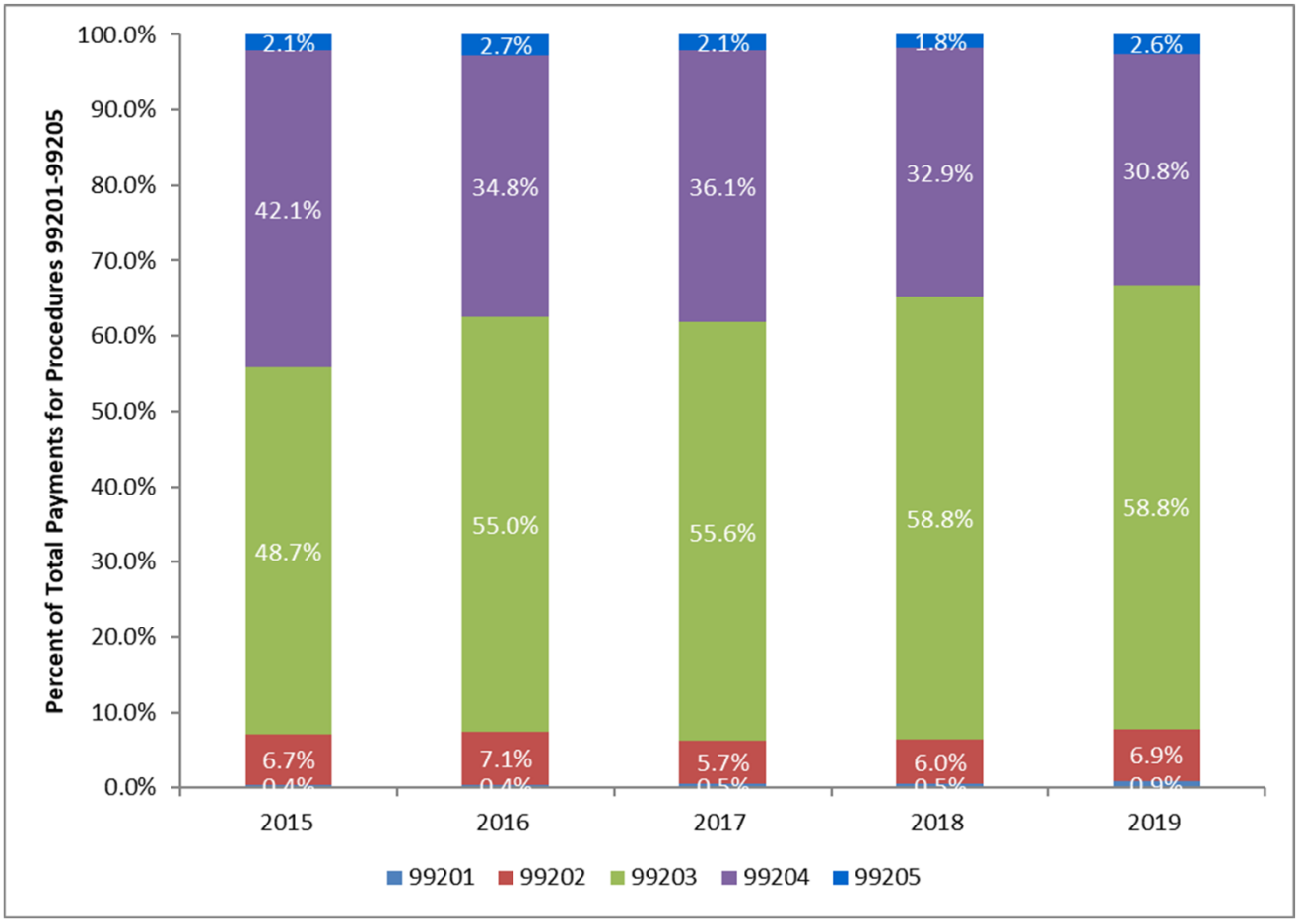
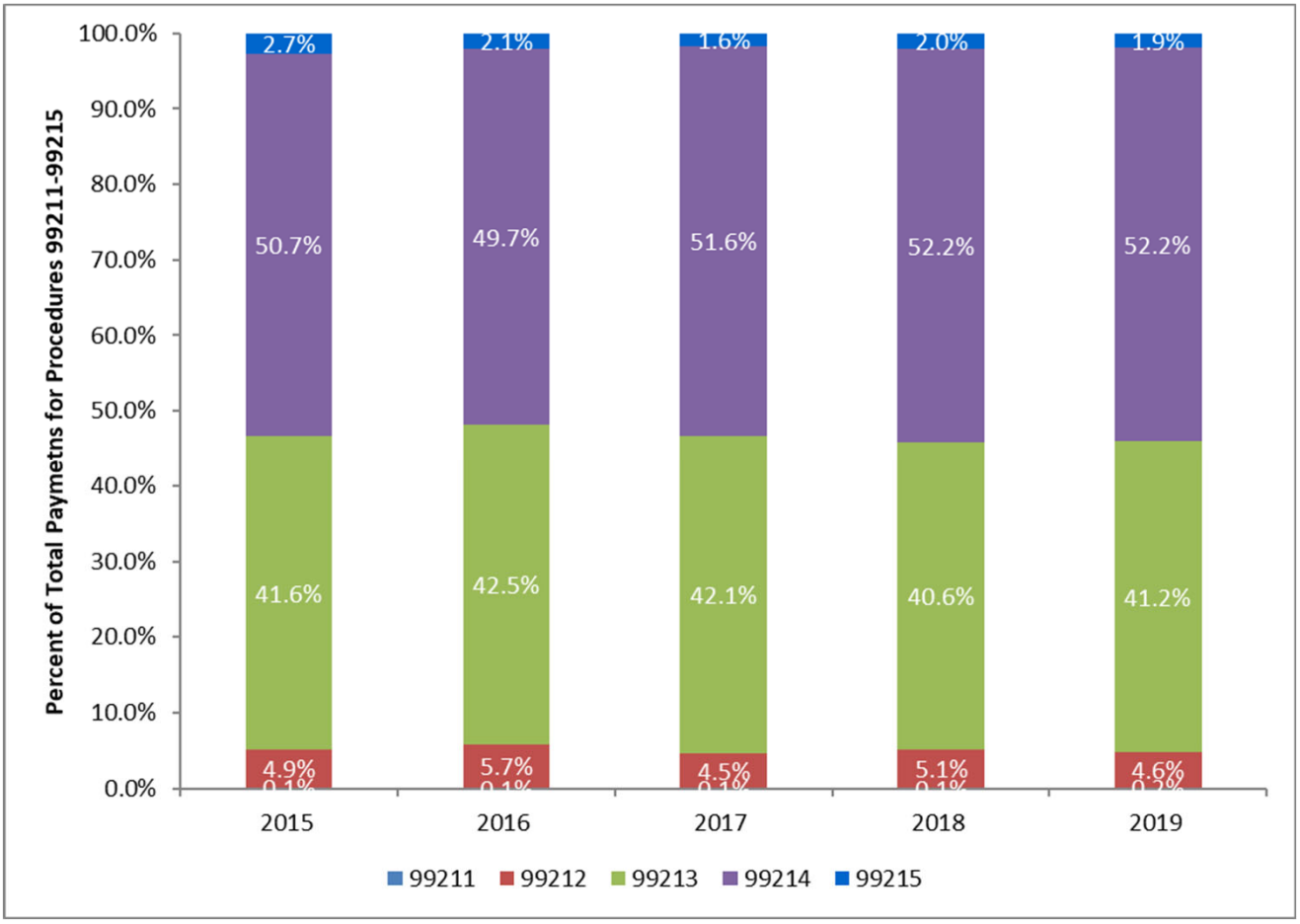


Exhibit 21
Top 10 Evaluation & Management Procedure Codes Trend



		Average Paid Per Transaction				
Code	Severity/Time	2015	2016	2017	2018	2019
99201	Low to Moderate; 10 minutes with patient	$63	$64	$65	$58	$94
99202	Low to Moderate; 20 minutes with patient	$97	$98	$80	$80	$84
99203	Moderate; 30 minutes with patient	$128	$125	$107	$107	$111
99204	Moderate to High; 45 minutes with patient	$191	$181	$159	$157	$158
99205	Moderate to High; 60 minutes with patient	$218	$217	$197	$197	$201

Exhibit 22
Top 10 Evaluation & Management Procedure Codes Trend



		Average Paid Per Transaction				
Code	Severity/Time	2015	2016	2017	2018	2019
99211	Low to Moderate; 5 minutes with patient	$27	$27	$25	$22	$25
99212	Low to Moderate; 10 minutes with patient	$53	$57	$50	$52	$51
99213	Moderate; 15 minutes with patient	$74	$72	$61	$61	$63
99214	Moderate to High; 25 minutes with patient	$120	$113	$98	$98	$100
99215	Moderate to High; 40 minutes with patient	$155	$148	$138	$148	$133

Exhibit 23
Hospital Inpatient Payments as a Percentage of Medicare

Background

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. DCRB does not collect all the adjustment factors and data required to accurately model the exact Medicare DRG reimbursement. Therefore, DCRB compared the 2019 Delaware inpatient hospital DRG fee schedule to the "DRG Summary for Medicare Inpatient Prospective Payment Hospitals, FY2018." From this publication, we compared the average amount that Medicare pays to Delaware providers for Medicare's share of the MS-DRG. The Medicare payment amounts include the MS-DRG amount, teaching, disproportionate share, capital, and outlier payments for all cases. **DCRB found that the DRG inpatient hospital fee schedule averaged between 119% 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 2018 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.

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

Exhibit 25 displays the average paid amount per day for Hospital Inpatient services.

Exhibit 26 displays the average number of inpatient stays per 1,000 active claims.

Exhibit 27 presents the average and median length of Hospital Inpatient stays.

Exhibit 28 presents time to treatment for Hospital Inpatient stays.

Exhibit 29 details the top 10 diagnosis groups by paid amount for Hospital Inpatient services. This exhibit shows the most frequently-billed diagnosis groups.

Exhibit 30 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. 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 2019. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 24
Average Paid Amount Per Stay for Hospital Inpatient Services

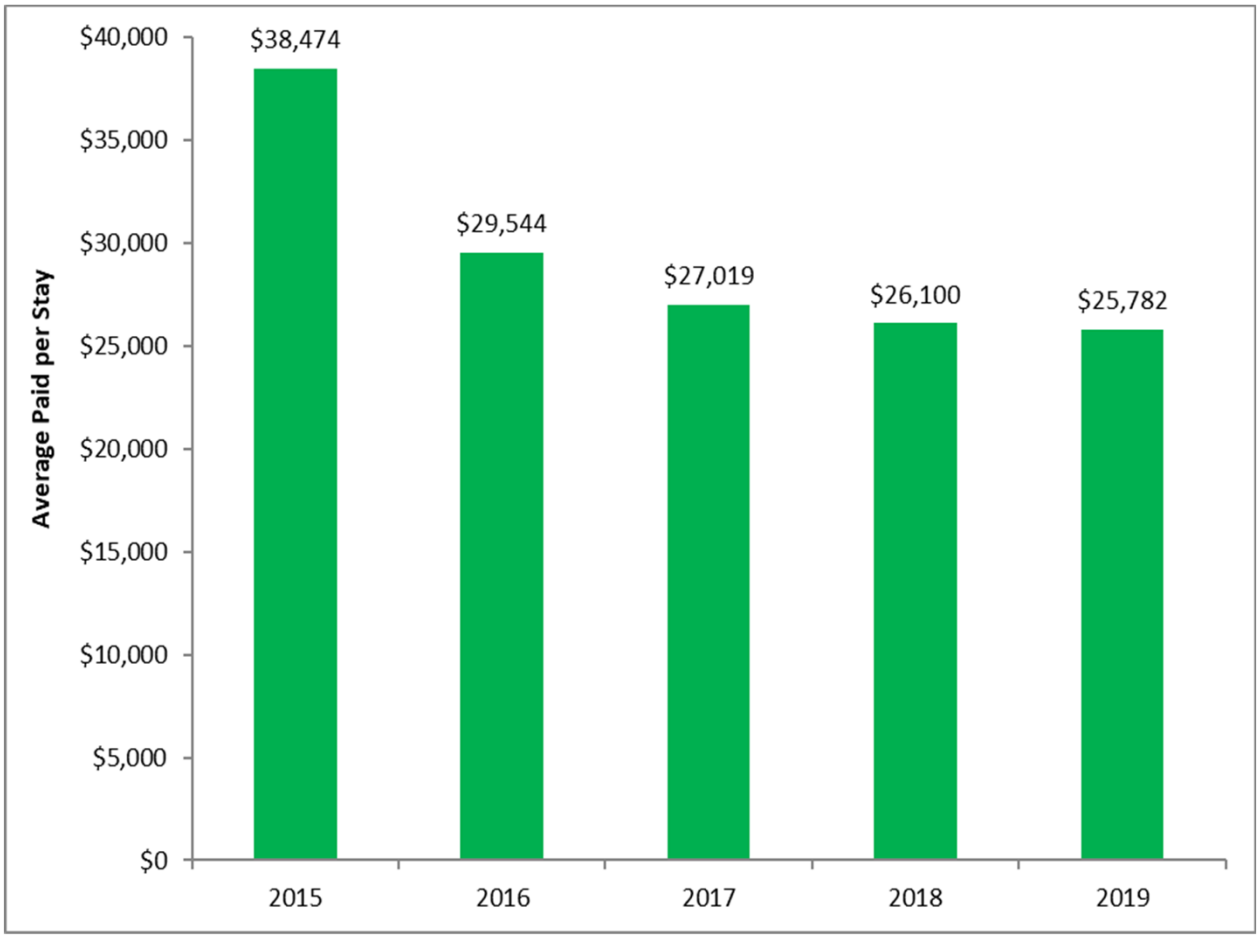


Exhibit 24 presents the average paid amount per stay for a Hospital Inpatient service by service year. This exhibit illustrates the trend of payments over a period of five service years.

Exhibit 25
Average Paid Amount per Day for Hospital Inpatient Services

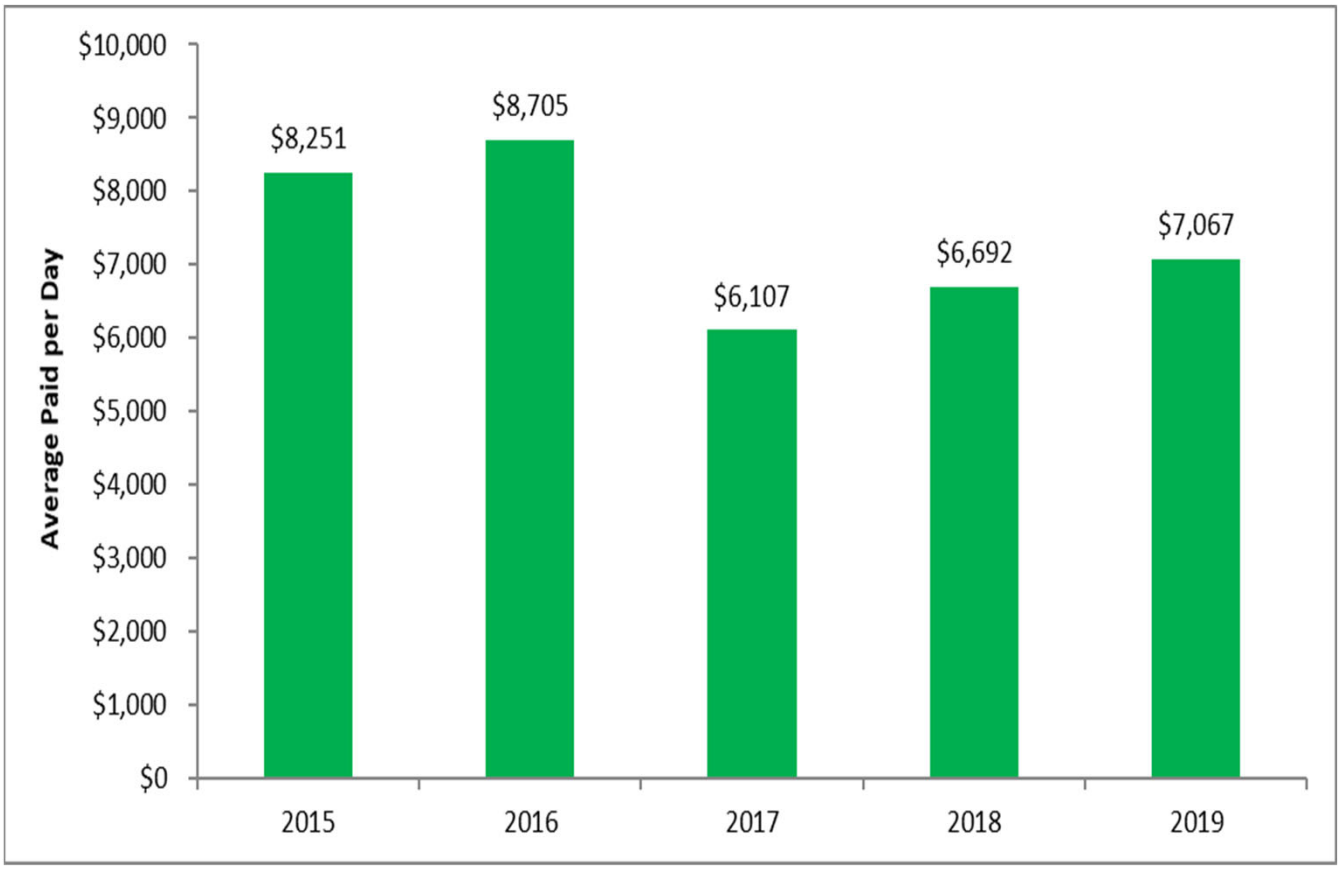


Exhibit 25 presents the average paid amount per day for Hospital Inpatient services by service year. This exhibit displays the pattern of payments over period of five service years.

Exhibit 26
Average Number of Stays per 1,000 Active Claims

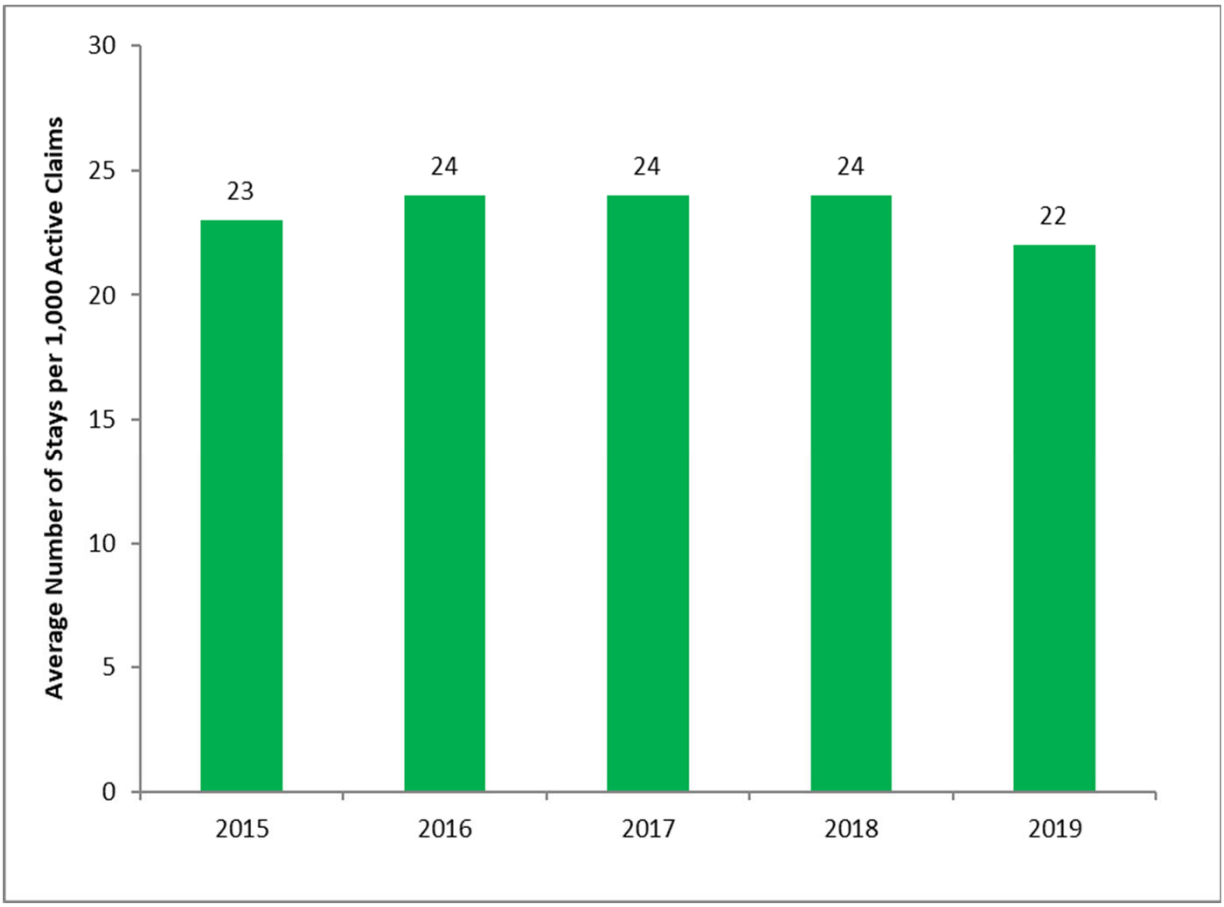


Exhibit 26 displays the average number of inpatient stays per 1,000 active claims by service year. This exhibit illustrates the trend in average number of stays over a period of five service years.

Exhibit 27
Inpatient Length of Stay for Hospital Inpatient Services

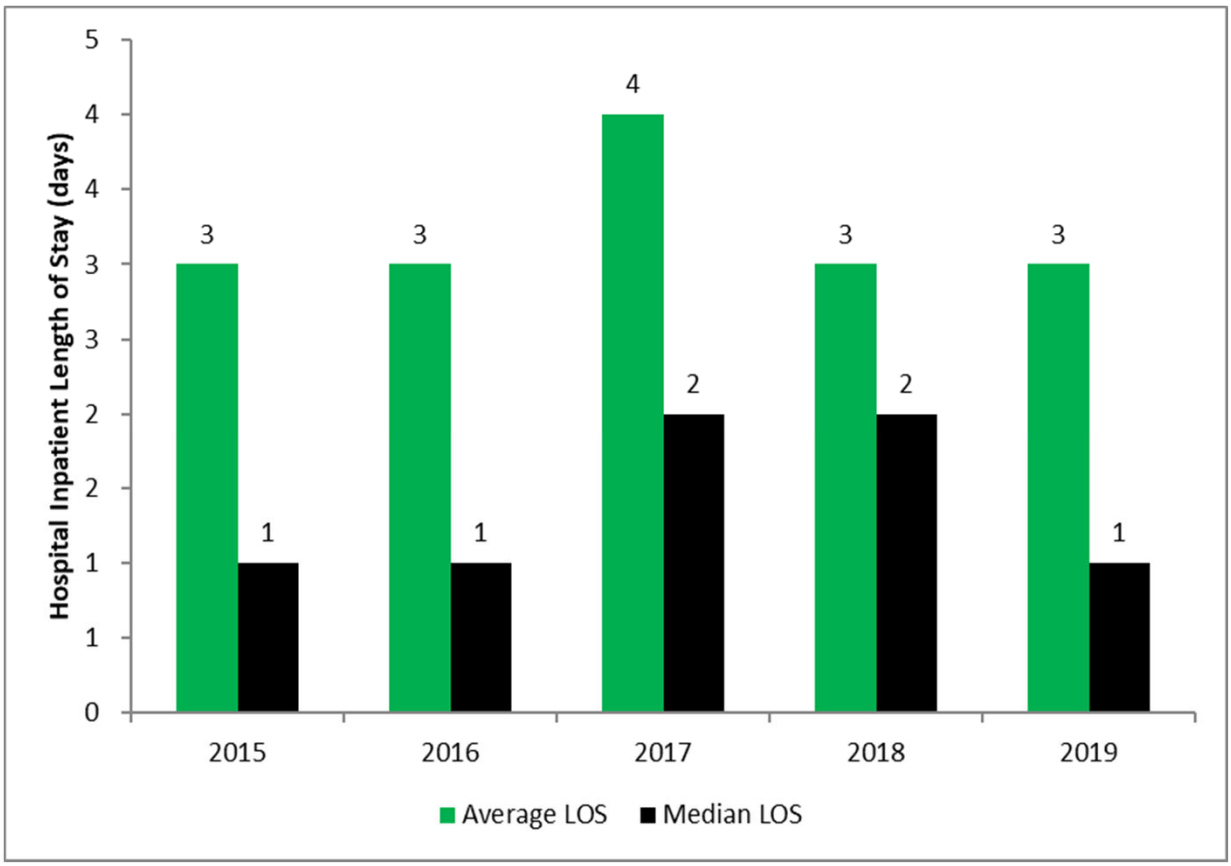


Exhibit 27 provides the average and median lengths of Hospital Inpatient stays over a five-year service period. This information suggests consistency in length of stay over the period examined.

Exhibit 28
Time Until First Treatment for Hospital Inpatient Stays (in Days)

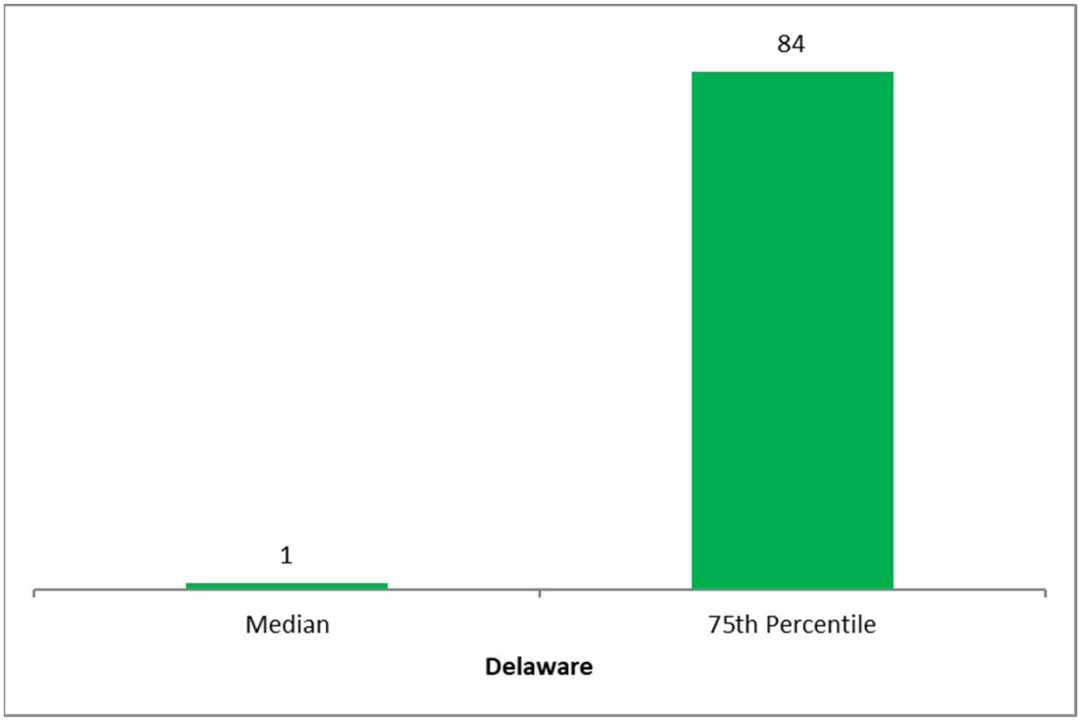
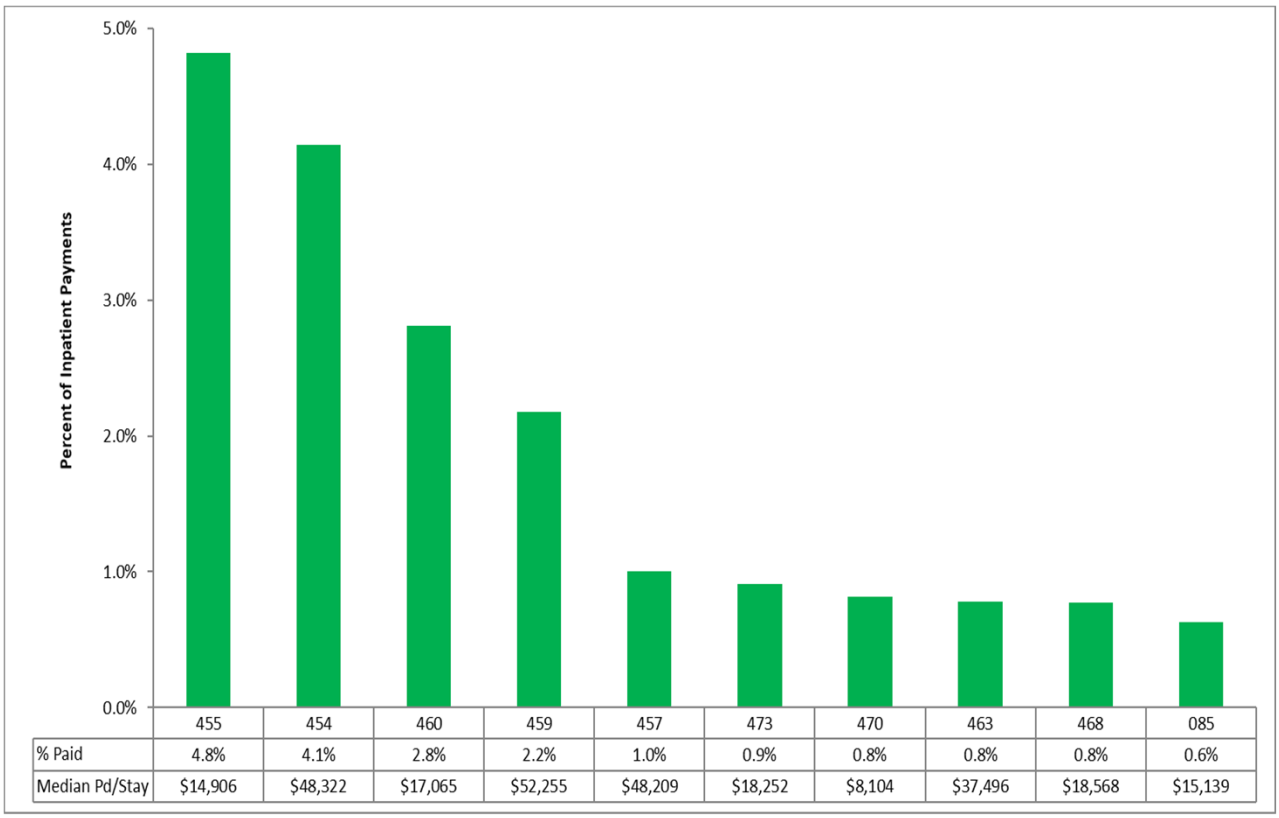


Exhibit 29
Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

Diagnosis Group	Paid Share	Median Amount Paid Per Stay
Other dorsopathies	32.4%	$47,247
Spondylopathies	9.4%	$49,089
Injuries to the hip and thigh	8.5%	$14,604
Complications of surgical and medical care, NOC	8.0%	$17,405
Injuries to the neck	5.0%	$118,910
Burns and corrosions of external body surface, specified by site	3.8%	$89,927
Injuries to the head	2.7%	$12,269
Deforming dorsopathies	2.4%	$56,916
Injuries to the abdomen, lower back, lumbar spine, pelvis	2.3%	$22,558
Osteoarthritis	2.2%	$16,061

Exhibit 30
Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services



	455	454	460	459	457	473	470	463	468	085
% Paid	4.8%	4.1%	2.8%	2.2%	1.0%	0.9%	0.8%	0.8%	0.8%	0.6%
Median Pd/Stay	$14,906	$48,322	$17,065	$52,255	$48,209	$18,252	$8,104	$37,496	$18,568	$15,139

Code	Description
455	Combined anterior/posterior spinal fusion w/o CC/MCC
454	Combined anterior/posterior spinal fusion w CC
460	Spinal fusion except cervical w/o MCC
459	Spinal fusion except cervical w MCC
457	Spinal fusion except cervical with spinal curvature or malignancy or infection or extensive fusions w CC
473	Cervical spinal fusion w/o CC/MCC
470	Major joint replacement or reattachment of lower extremity w/o MCC
463	Wound debridement and skin graft except hand for musculoskeletal system and connective tissue disorders w MCC
468	Revision of hip or knee replacement w/o CC/MCC
085	Traumatic stupor and coma, coma <1 hour w MCC
Note	CC = Complications and Comorbidites; MCC = Major Complications and Comorbidities

Exhibit 31
Hospital Outpatient Payments as a Percentage of Medicare

Background

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.

Facility Information

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

Exhibit 32 presents the average outpatient paid amount per surgical visit for Hospital Outpatient services. **Exhibit 33** displays the average number of surgical hospital outpatient visits per 1,000 active claims. **Exhibits 34 and 35** represent similar data, but for non-surgical visits.

Exhibit 36 presents time to treatment for Major Surgery Hospital Outpatient visits.

Exhibit 37 presents time to treatment for All Other Hospital Outpatient visits.

Exhibit 38 details the top 10 diagnosis groups by paid amount for Hospital Outpatient services. This exhibit identifies the most frequently-billed diagnosis groups.

Exhibit 39 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 40** presents the top 10 non-surgical CPT codes by paid amount for Hospital Outpatient services.

The source for all data is the DCRB Medical Data Call for Service Year 2019. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 32
Average Outpatient Paid Amount Per Surgical Visit for Hospital Outpatient Services

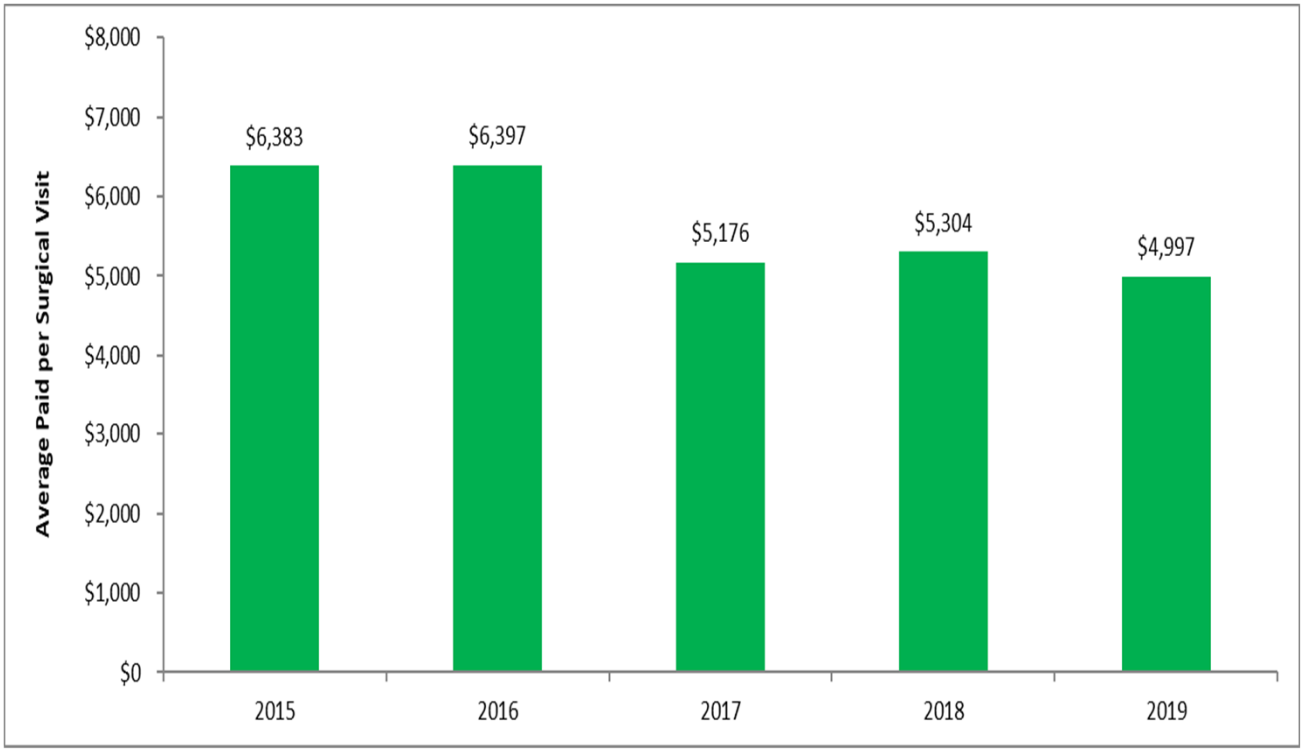


Exhibit 32 presents the average outpatient paid amount per surgical visit for Hospital Outpatient services by service year. This exhibit illustrates payments over period of five consecutive service years.

Exhibit 33
Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims

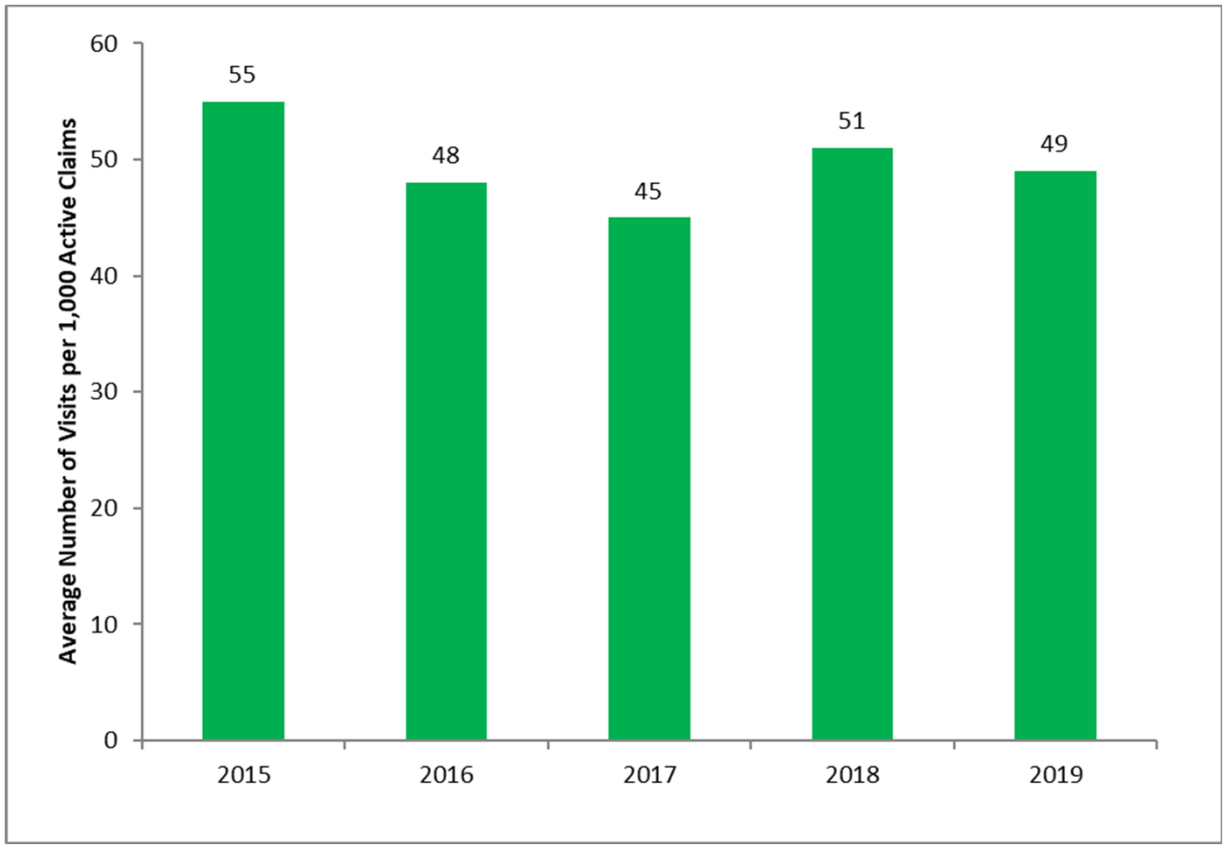


Exhibit 33 presents the average number of surgical Hospital Outpatient visits per 1,000 active claims.

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

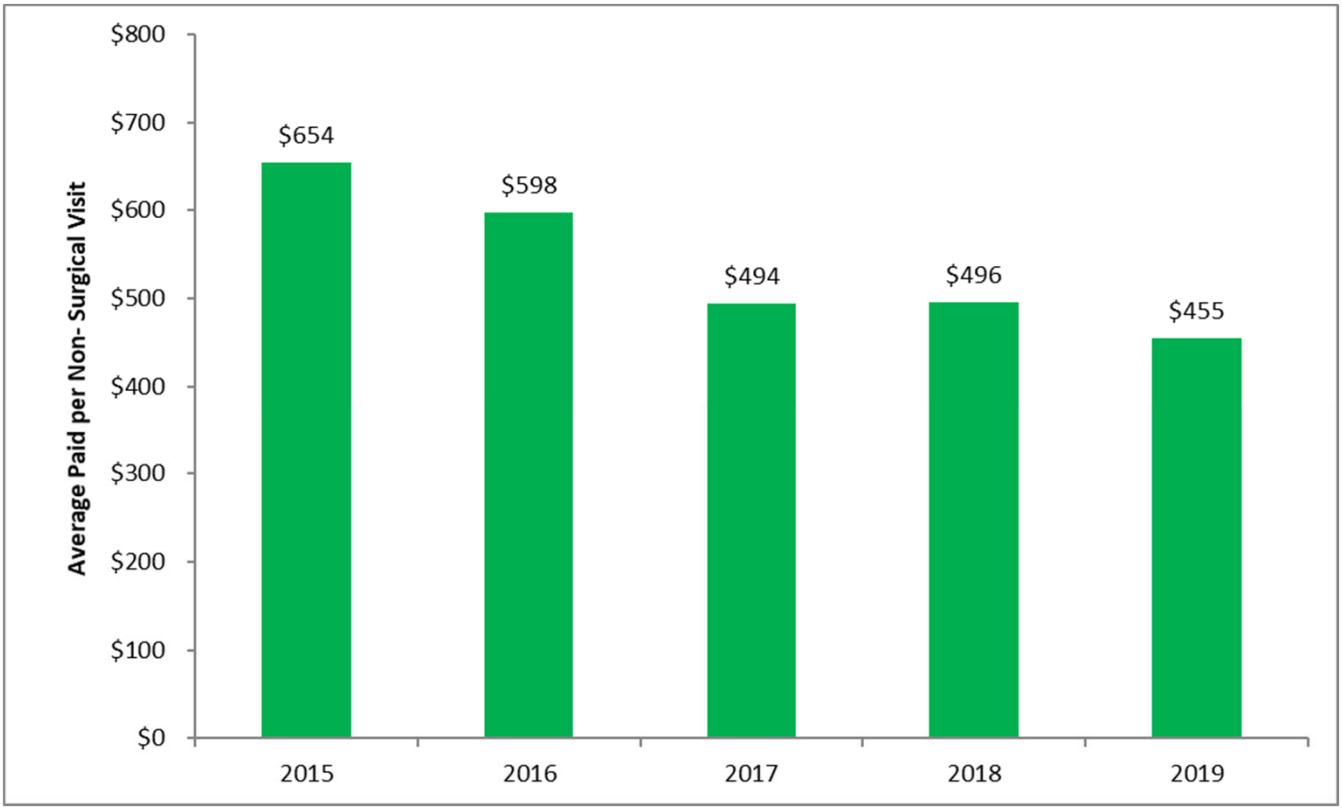


Exhibit 34 presents the average outpatient paid amount per non-surgical visit for Hospital Outpatient services by service year. This exhibit illustrates payments over a period of five consecutive service years.

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

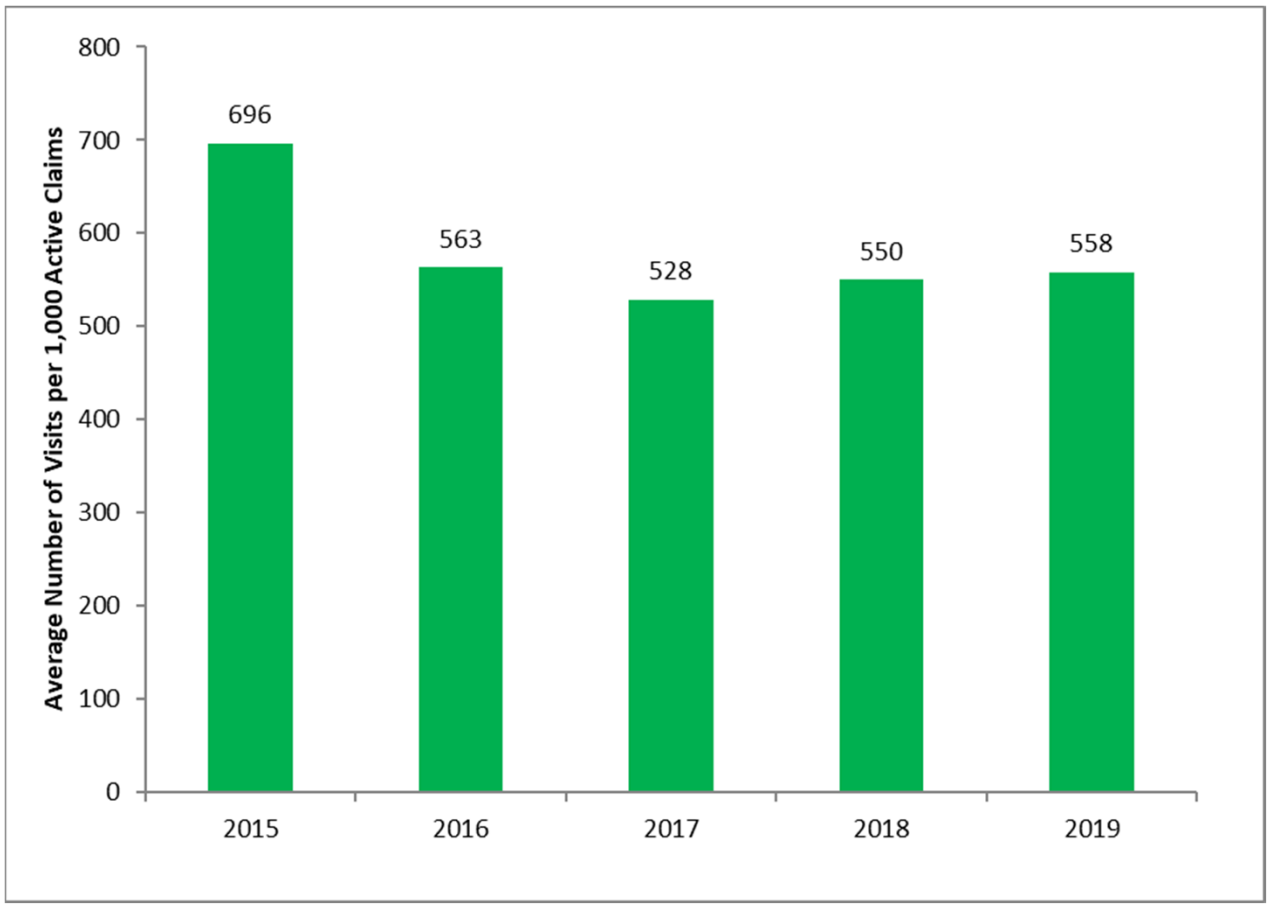


Exhibit 35 presents the average number of non-surgical Hospital Outpatient visits per 1,000 active claims.

Exhibit 36

Time Until First Treatment for Major Surgery Outpatient Visits (in Days)

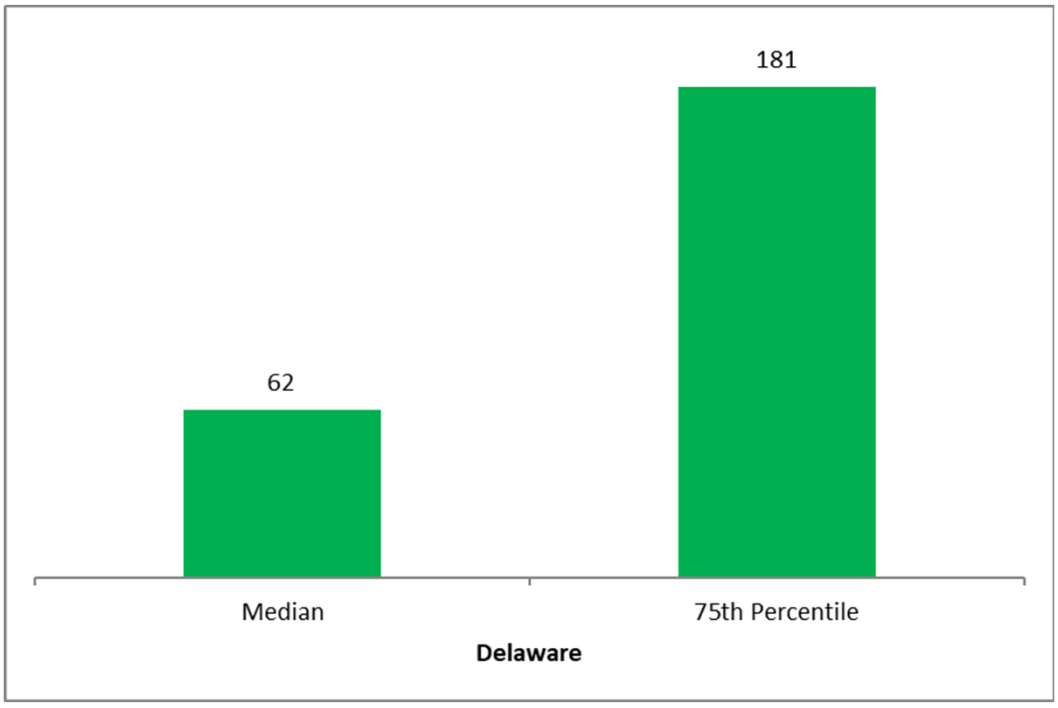


Exhibit 37
Time Until First Treatment for All Other Outpatient Visits (in Days)

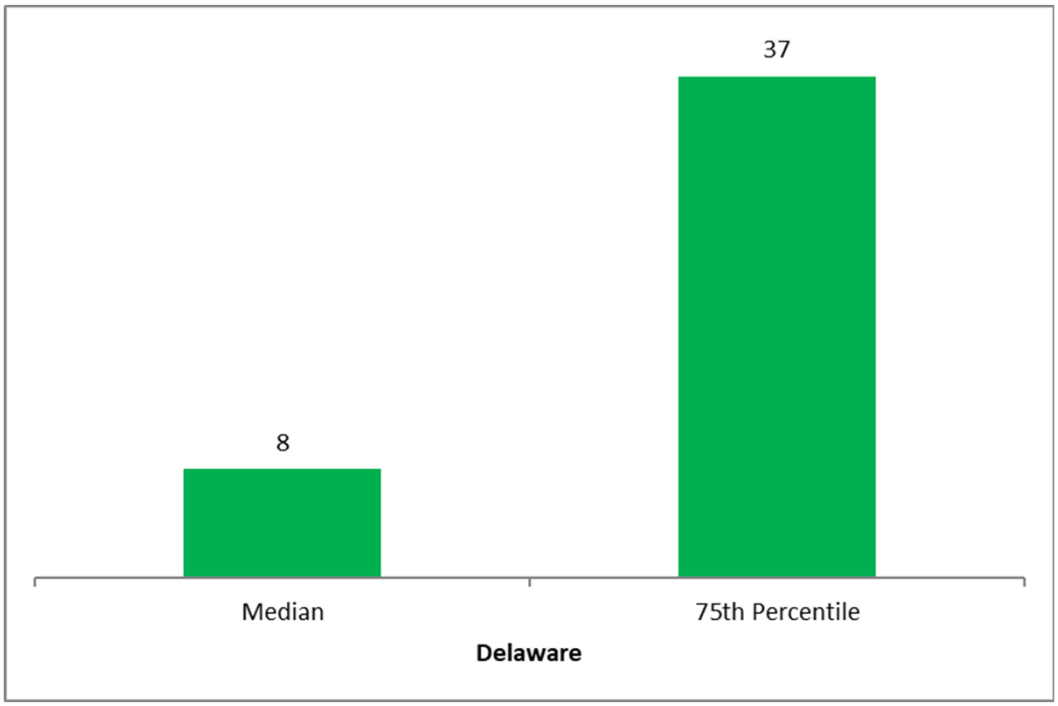
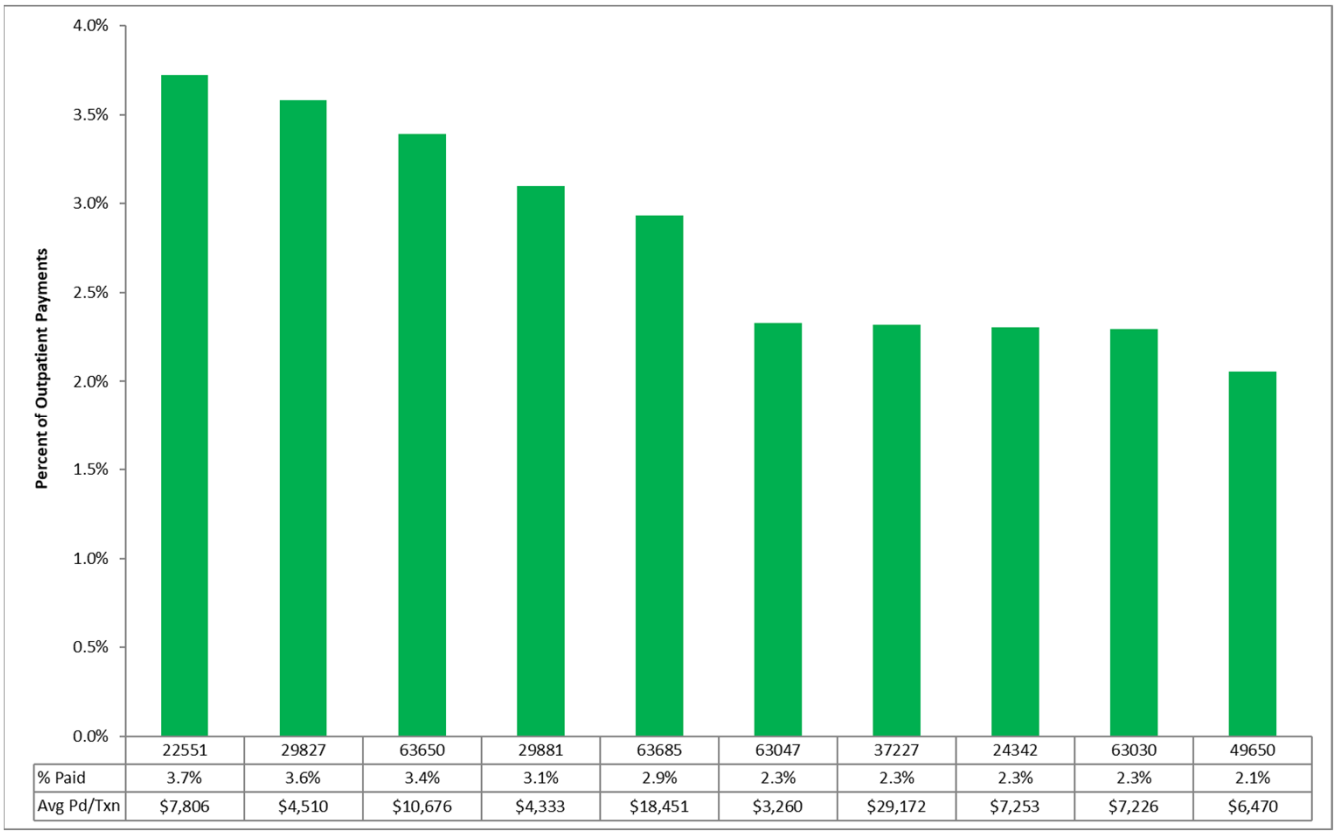


Exhibit 38
Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services

Diagnosis Group	Paid Share	Median Amount Paid Per Visit
Other dorsopathies	20.4%	$483
Injuries to the knee and lower leg	8.7%	$428
Other soft tissue disorders	6.6%	$225
Injuries to the wrist, hand and fingers	6.3%	$277
Injuries to the shoulder and upper arm	5.9%	$527
Other joint disorders	4.8%	$287
Complications of surgical and medical care, NOC	3.9%	$1,188
Injuries to the ankle and foot	3.7%	$243
Hernia	3.3%	$5,995
Spondylopathies	2.7%	$499

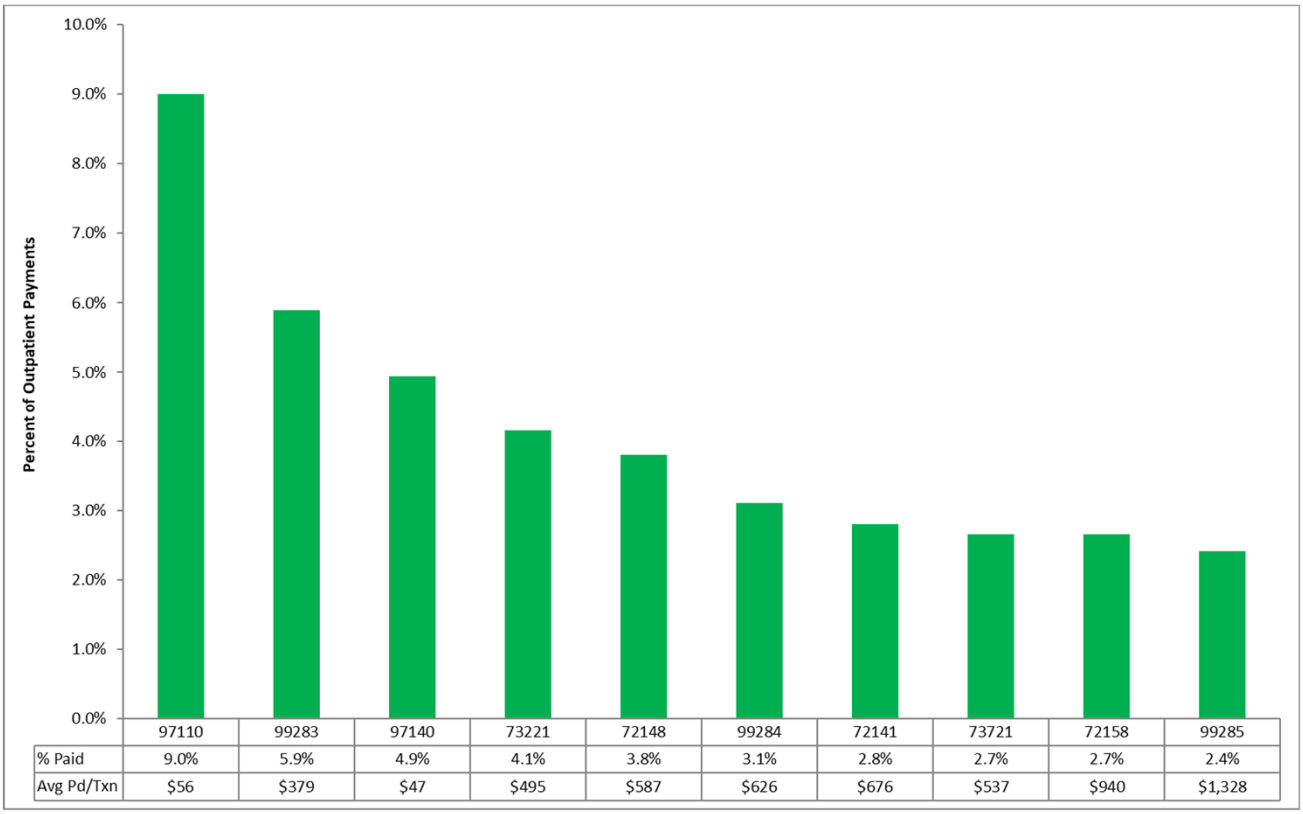
Exhibit 39
Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services



	22551	29827	63650	29881	63685	63047	37227	24342	63030	49650
% Paid	3.7%	3.6%	3.4%	3.1%	2.9%	2.3%	2.3%	2.3%	2.3%	2.1%
Avg Pd/Txn	$7,806	$4,510	$10,676	$4,333	$18,451	$3,260	$29,172	$7,253	$7,226	$6,470

Code	Description
22551	Fusion of spine bones with removal of disc at upper spinal column, anterior approach
29827	Repair of shoulder rotator cuff using an endoscope
63650	Implantation of spinal neurostimulator electrodes, accessed through the skin
29881	Removal of one knee cartilage using an endoscope
63685	Insertion of spinal neurostimulator pulse generator or receiver
63047	Partial removal of middle spine bone with release of spinal cord and/or nerves
37227	Removal of plaque and insertion of stents into arteries in one leg, endovascular, accessed through the skin or open procedure
24342	Reinsertion of torn biceps or triceps tendon at elbow
63030	Partial removal of bone with release of spinal cord or spinal nerves of 1 interspace in lower spine
49650	Repair of groin hernia using an endoscope

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



	97110	99283	97140	73221	72148	99284	72141	73721	72158	99285
% Paid	9.0%	5.9%	4.9%	4.1%	3.8%	3.1%	2.8%	2.7%	2.7%	2.4%
Avg Pd/Txn	$56	$379	$47	$495	$587	$626	$676	$537	$940	$1,328

Code	Description
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes
99283	Emergency department visit, moderately severe problem
97140	Manual (physical) therapy techniques to 1 or more regions, each 15 minutes
73221	MRI scan of arm joint
72148	MRI scan of lower spinal canal
99284	Emergency department visit, problem of high severity
72141	MRI scan of upper spinal canal
73721	MRI scan of leg joint
72158	MRI scan of lower spinal canal before and after contrast
99285	Emergency department visit, problem with significant threat to life or function

Facility Information

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

Exhibit 41 presents the average paid amount per ER visits.

Exhibit 42 displays the average number of ER visits per 1,000 active claims.

Exhibit 43 presents the most recent five-year trend for Evaluation and Management procedure codes for Emergency Room Services. **Exhibit 44** represents the same data, sorted on transaction counts instead of paid amounts.

The source for all data is the DCRB Medical Data Call for Service Year 2019. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 41
Average Amount Paid Per ER Visit

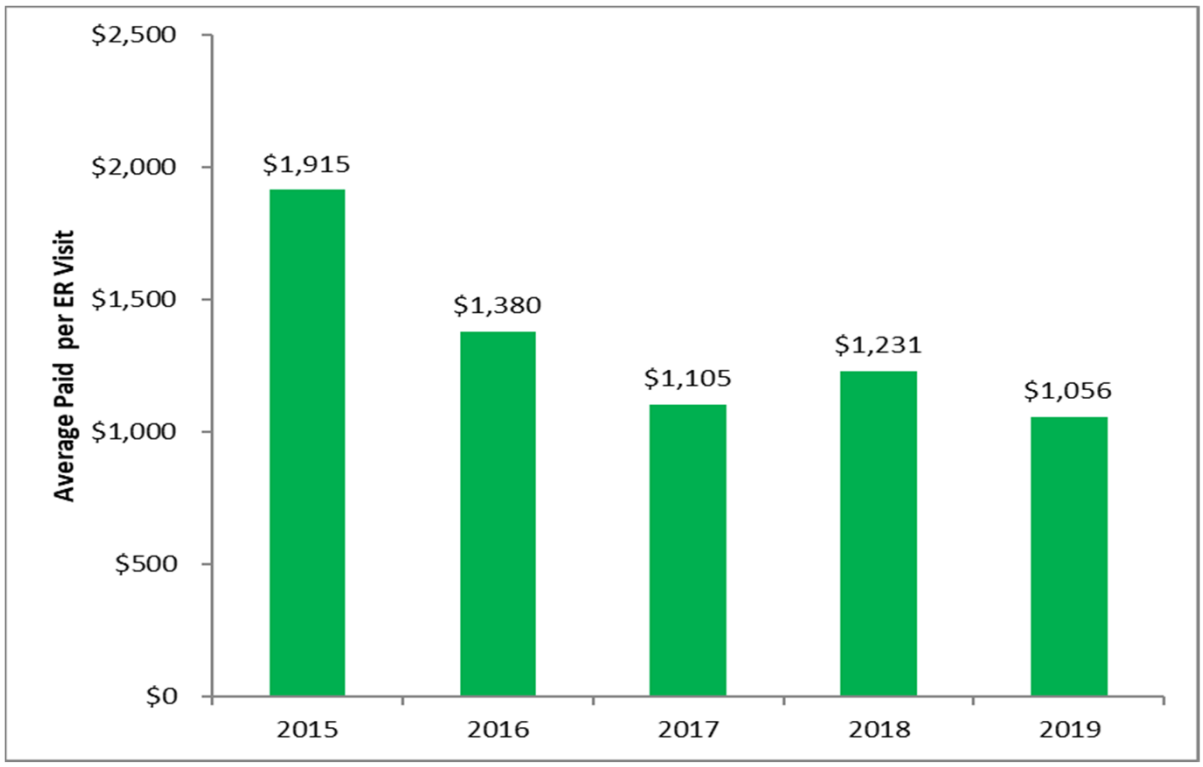


Exhibit 41 depicts the average amount paid per Emergency Room visit by service year. These results demonstrate a decline over the last five service years in the average amount paid per visit.

Exhibit 42
Average Number of ER Visits per 1,000 Active Claims

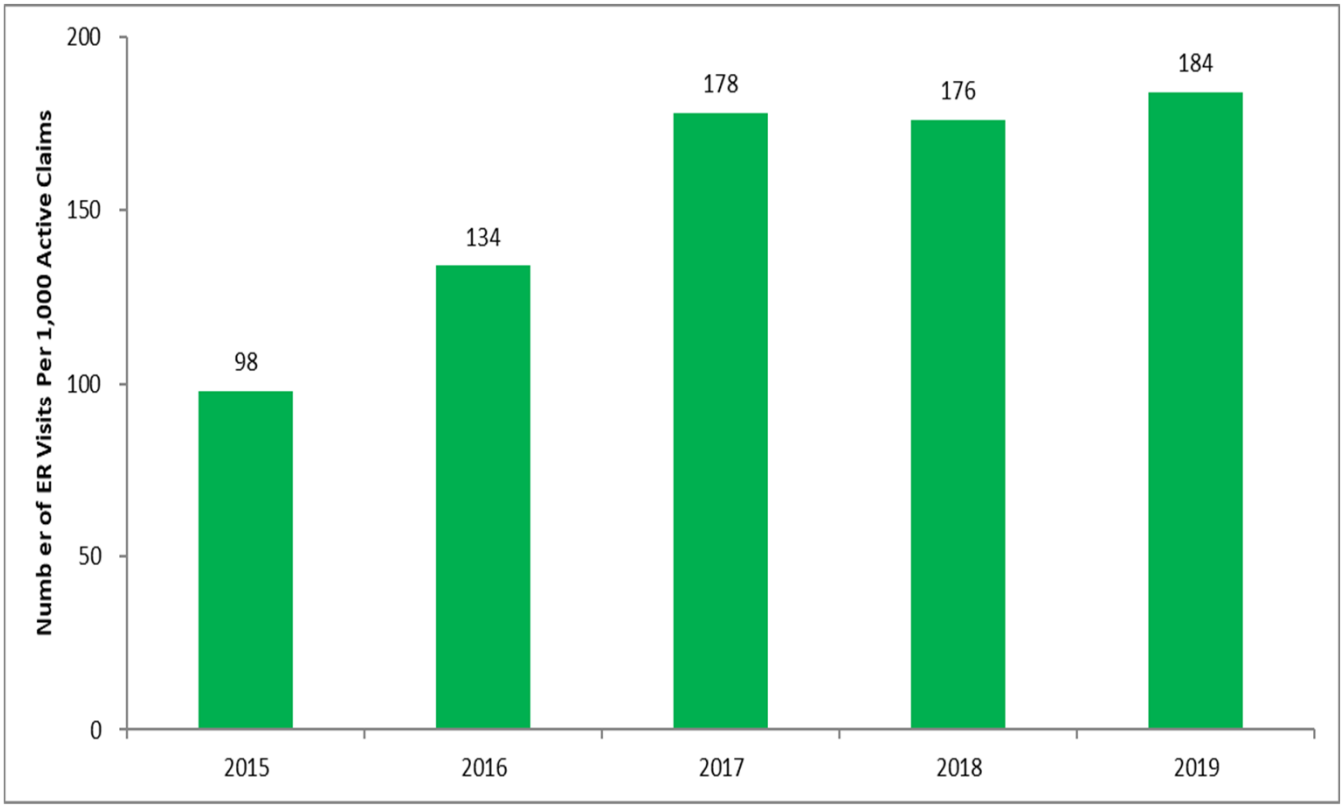


Exhibit 42 displays the number of emergency room visits per 1,000 active claims by service year. These results demonstrate a mostly increasing trend in the number of Emergency Room visits over the last five years.

Exhibit 43
Emergency Room Services by Procedure Codes Trend

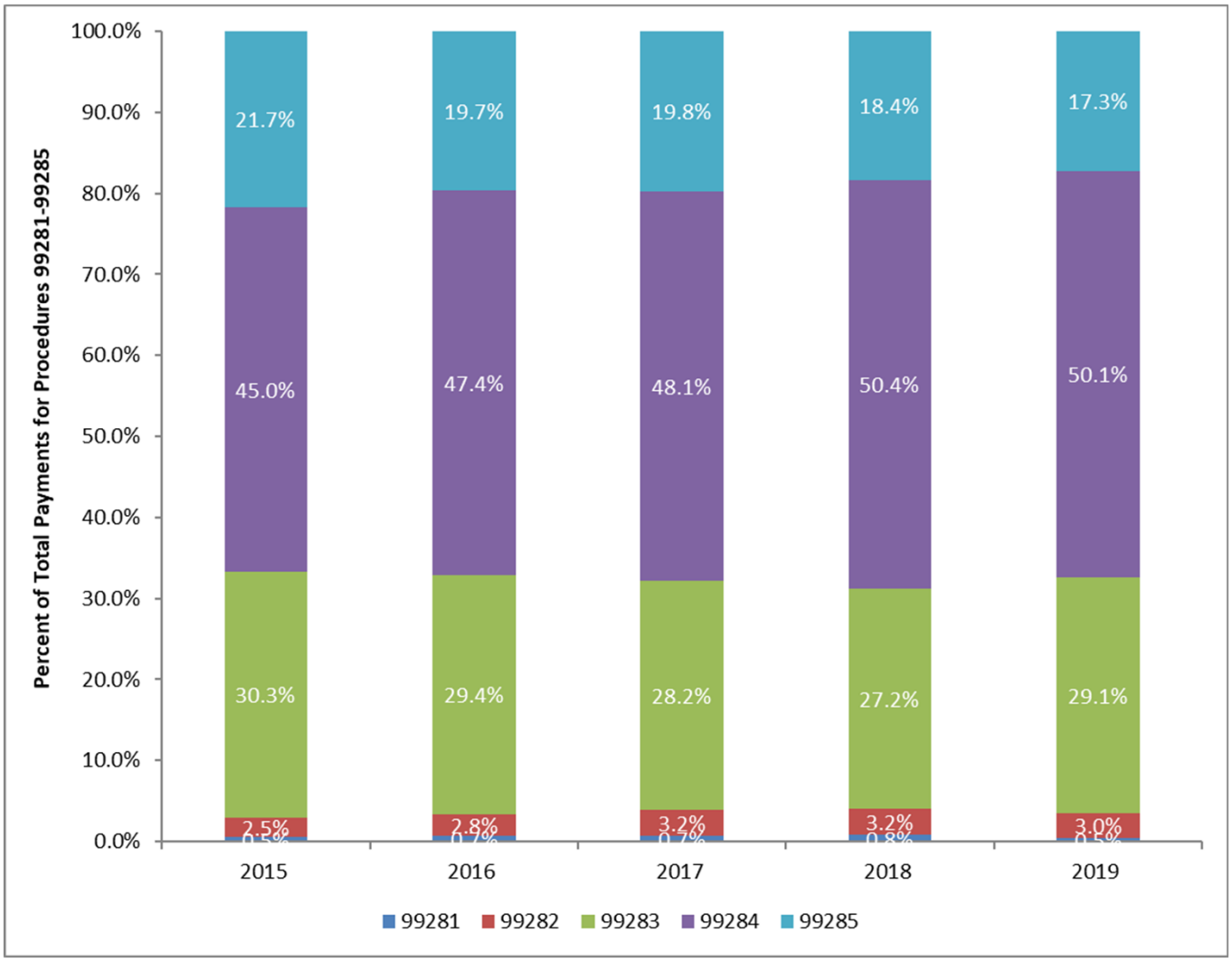


Exhibit 43 displays Emergency Room services by procedure codes trend by service year. This exhibit displays the distribution of payments for a period of five service years.

		Average Paid Per Transaction				
Code	Severity	2015	2016	2017	2018	2019
99281	Minor	$96	$111	$93	$136	$139
99282	Low to moderate	$145	$143	$163	$144	$133
99283	Moderate	$246	$242	$207	$219	$198
99284	High	$355	$381	$341	$350	$318
99285	High and immediately life-threatening	$593	$552	$469	$490	$427

Exhibit 44
Emergency Room Transactions by Procedure Code

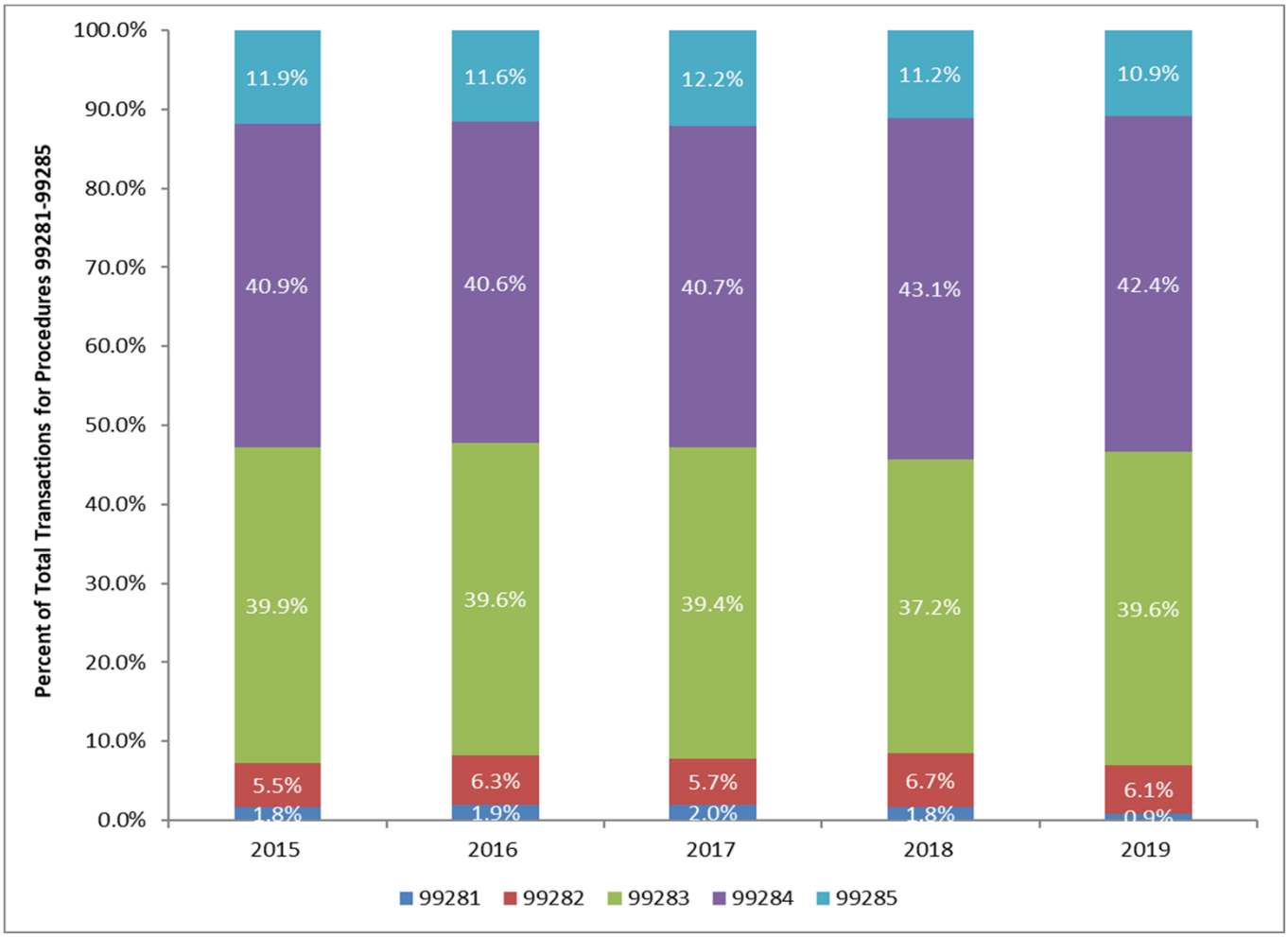


Exhibit 44 displays Emergency Room services by procedure codes trend by service year. This exhibit displays the distribution of transactions for a period of five service years.

		Total Trasactions				
Code	Severity	2015	2016	2017	2018	2019
99281	Minor	26	31	33	28	12
99282	Low to moderate	82	100	93	107	83
99283	Moderate	593	633	639	595	537
99284	High	608	649	659	689	575
99285	High and immediately life-threatening	176	186	197	179	148

Exhibit 45
ASC Payments as a Percentage of Medicare

Background

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.

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 46 presents the average outpatient paid amount per visit for ASC services. **Exhibit 47** displays the average number of ASC visits per 1,000 active claims.

Exhibit 48 presents time to treatment for ASC visits.

Exhibit 49 details the top 10 diagnosis groups by paid amount for ASC services.

Exhibit 50 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 2019. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 46
Average Amount Paid Per Visit for ASC Services

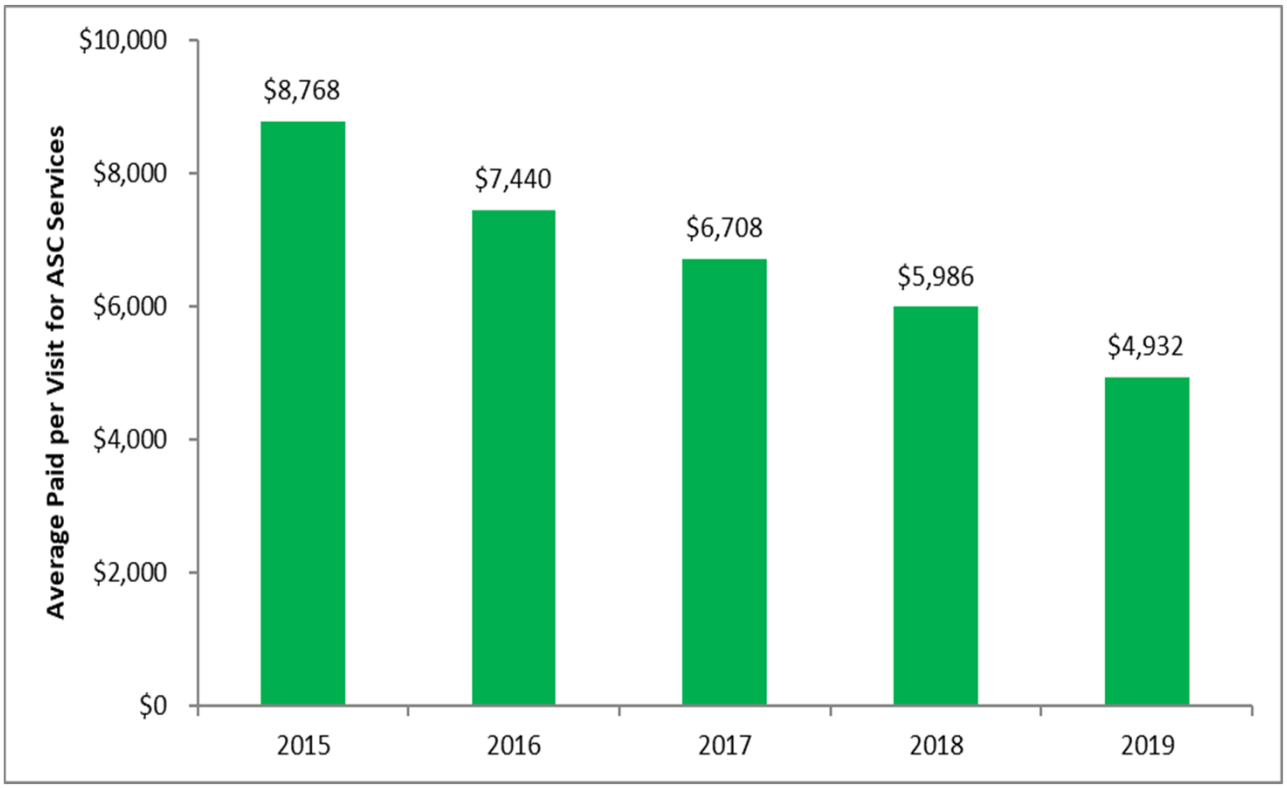


Exhibit 46 depicts the average amount paid per visit for Ambulatory Surgery Center services by service year over a five-year period. These results demonstrate a decline in the average amount paid per visit.

Exhibit 47
Average Number of ASC Visits per 1,000 Active Claims

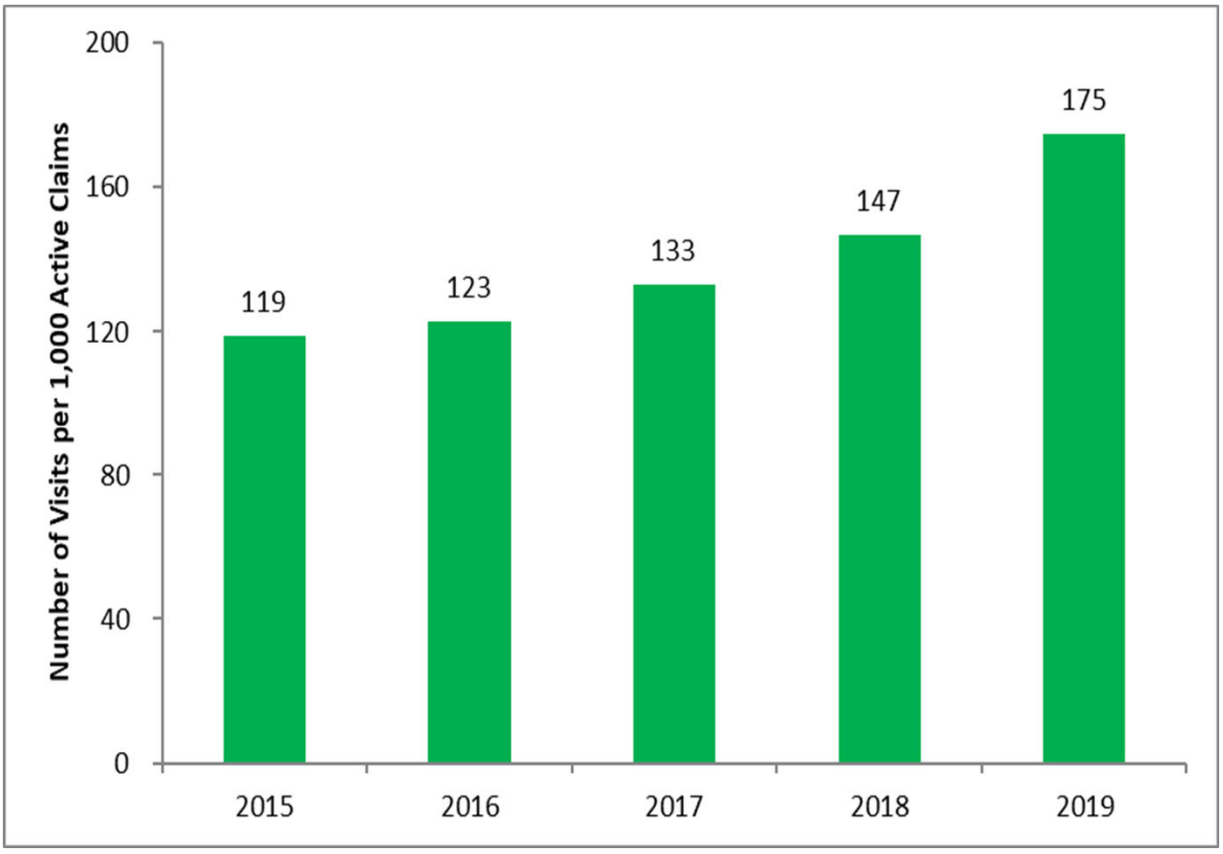


Exhibit 47 depicts the average number of for Ambulatory Surgery Center visits per 1,000 active claims over a five-year period.

Exhibit 48
Time Until First Treatment for ASC Visits (in Days)

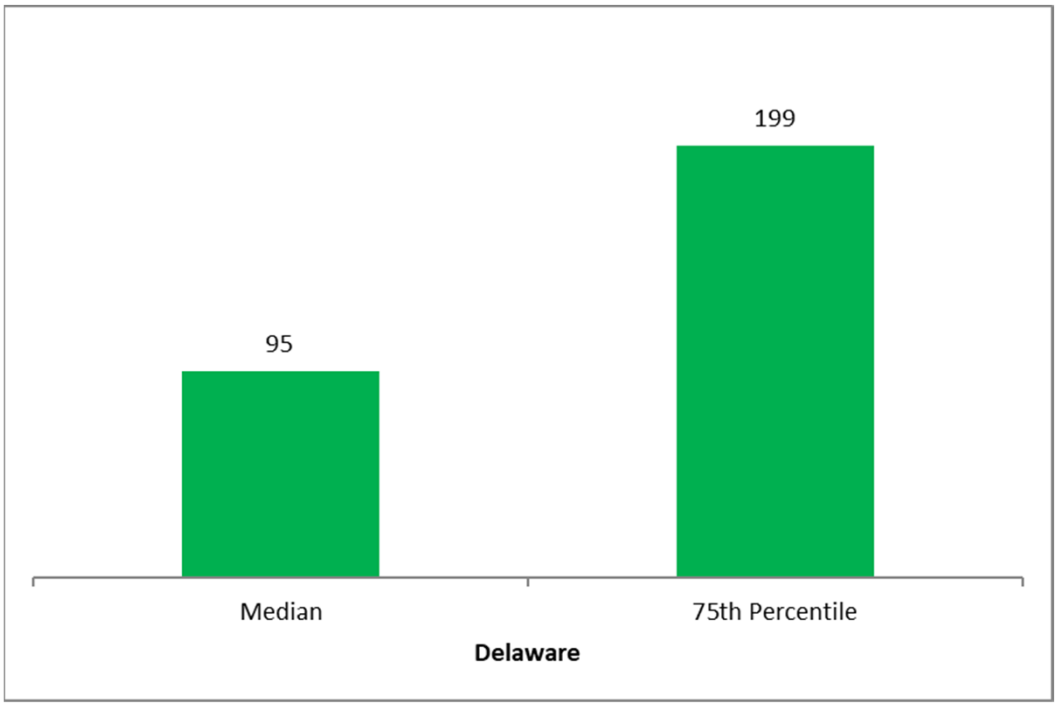
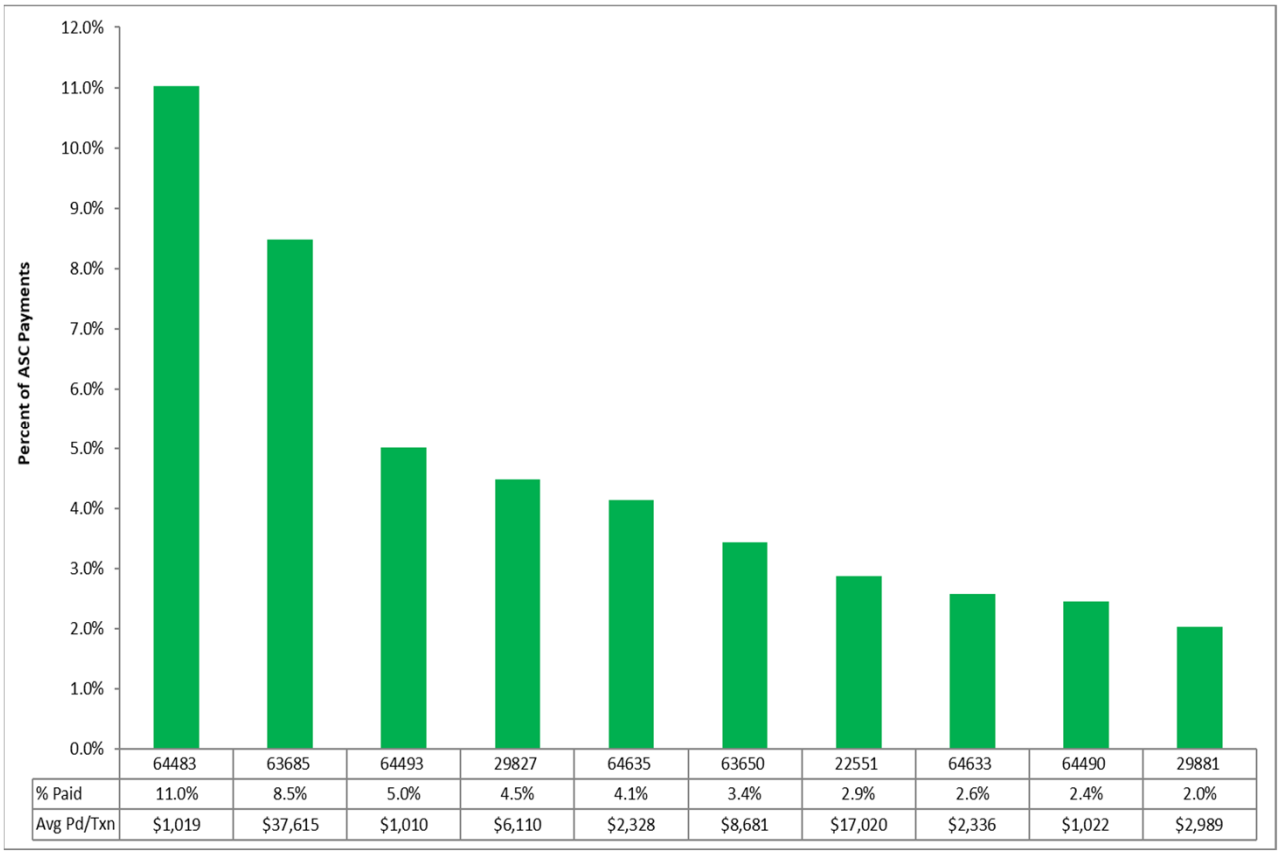


Exhibit 49
Top 10 Diagnosis Groups by Amount Paid for ASC Services

Diagnosis Group	Paid Share	Median Amount Paid Per Visit
Other dorsopathies	31.2%	$1,039
Spondylopathies	17.3%	$1,087
Other soft tissue disorders	8.0%	$4,122
Other disorders of the nervous system	7.2%	$659
Other joint disorders	7.2%	$3,526
Complications of surgical and medical care, NOC	4.6%	$4,997
Injuries to the shoulder and upper arm	4.2%	$6,784
Injuries to the knee and lower leg	4.0%	$3,614
Injuries to the elbow and forearm	3.0%	$5,977
Injuries to the wrist, hand and fingers	2.4%	$2,717

Exhibit 50
Top 10 Surgery Procedure Codes by Amount Paid for ASC Services



	64483	63685	64493	29827	64635	63650	22551	64633	64490	29881
% Paid	11.0%	8.5%	5.0%	4.5%	4.1%	3.4%	2.9%	2.6%	2.4%	2.0%
Avg Pd/Txn	$1,019	$37,615	$1,010	$6,110	$2,328	$8,681	$17,020	$2,336	$1,022	$2,989

Code	Description
64483	Injections of anesthetic and/or steroid drug into lower or sacral spine nerve root using imaging guidance
63685	Insertion of spinal neurostimulator pulse generator or receiver
64493	Injections of lower or sacral spine facet joint using imaging guidance
29827	Repair of shoulder rotator cuff using an endoscope
64635	Destruction of lower or sacral spinal facet joint nerves using imaging guidance
63650	Implantation of spinal neurostimulator electrodes, accessed through the skin
22551	Fusion of spine bones with removal of disc at upper spinal column, anterior approach
64633	Destruction of upper or middle spinal facet joint nerves using imaging guidance
64490	Injections of upper or middle spine facet joint using imaging guidance
29881	Removal of one knee cartilage using an endoscope

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.

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

Exhibit 51 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 52 lists the top 10 drugs based on the paid amount. **Exhibit 53** lists the top 10 drugs based on prescription counts.

Exhibit 53A 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 54 provides the distribution of drugs prescribed as brand name and generic.

Exhibit 55 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 2019. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 51
Distribution of Prescription Drug Costs by CSA Schedule

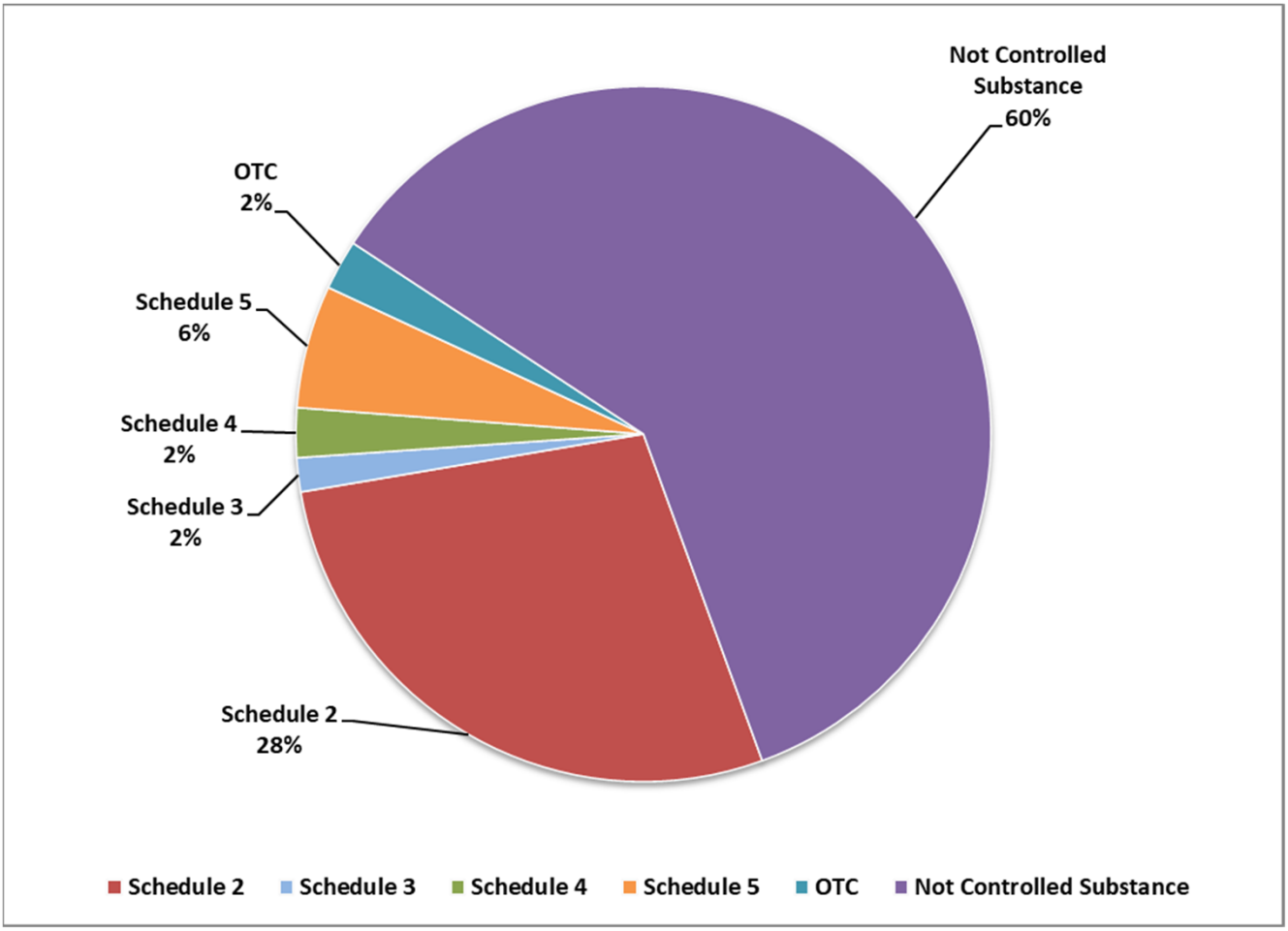
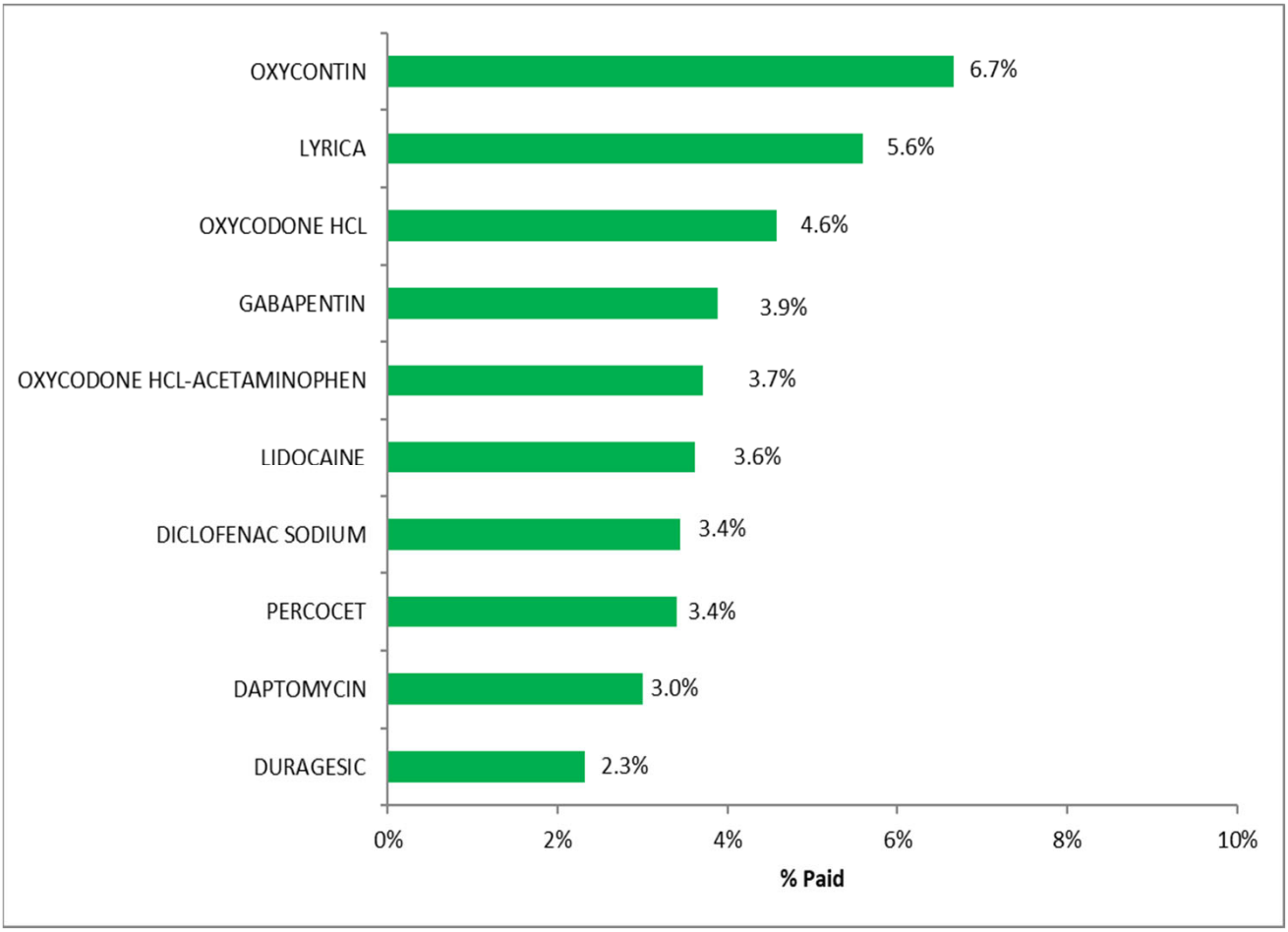


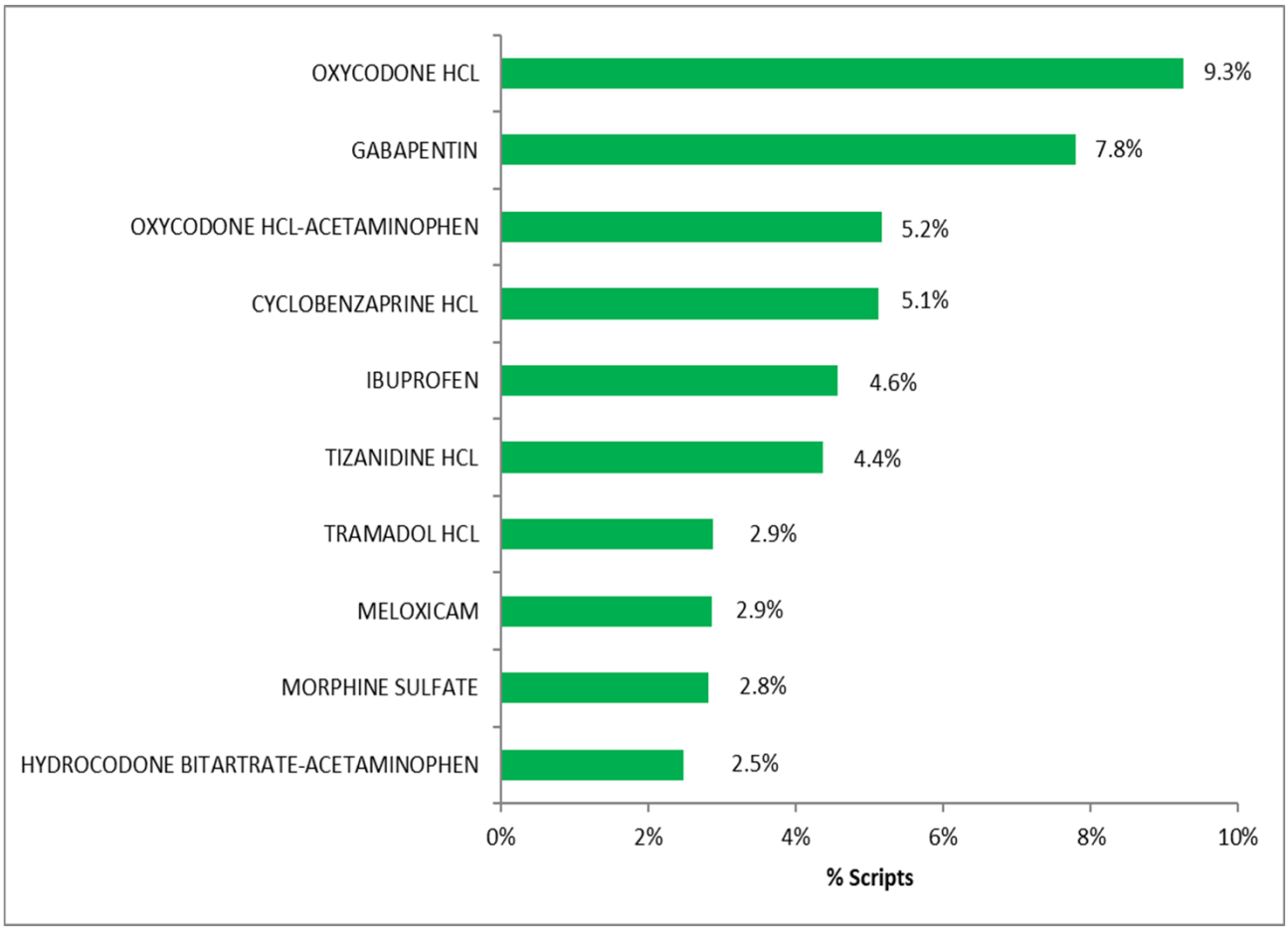
Exhibit 51 presents the distribution of payments of prescription drug costs by CSA schedule. This exhibit displays the allocation of drug payments by schedule. Payments in the non-controlled substances category make up the largest portion of payments (60%), followed by payments made for Schedule 2 drugs (28%). 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 52
Top 10 Workers Compensation Drugs by Amount Paid



Drug Name	B/G	Common Brand Name	Category	CSA Schedule	Average PPU
OXYCONTIN	B	N/A	ANALGESICS/ANTIPYRETICS	2	$8.90
LYRICA	B	N/A	MISC CENTRAL NERVOUS SYSTEM AGENTS	5	$3.99
OXYCODONE HCL	G	OXYCONTIN	ANALGESICS/ANTIPYRETICS	2	$0.67
GABAPENTIN	G	NEURONTIN	ANTICONVULSANTS	N/A	$0.57
OXYCODONE HCL-ACETAMINOPHEN	G	PERCOCET	ANALGESICS/ANTIPYRETICS	2	$1.12
LIDOCAINE	G	XYLOCAINE HCL	SKIN/MUCOUS MEMBRANE AGENTS	N/A	$3.03
DICLOFENAC SODIUM	G	VOLTAREN	ANALGESICS/ANTIPYRETICS	N/A	$2.32
PERCOCET	B	N/A	ANALGESICS/ANTIPYRETICS	2	$18.55
DAPTOMYCIN	G	CUBICIN	ANTIBIOTICS	N/A	$2.28
DURAGESIC	B	N/A	ANALGESICS/ANTIPYRETICS	2	$114.24

Exhibit 53
Top 10 Workers Compensation Drugs by Prescription Counts



Drug Name	B/G	Common Brand Name	Category	CSA Schedule	Average PPU
OXYCODONE HCL	G	OXYCONTIN	ANALGESICS/ANTIPYRETICS	2	$0.67
GABAPENTIN	G	NEURONTIN	ANTICONVULSANTS	N/A	$0.57
OXYCODONE HCL-ACETAMINOPHEN	G	PERCOCET	ANALGESICS/ANTIPYRETICS	2	$1.12
CYCLOBENZAPRINE HCL	G	FLEXERIL	MUSCLE RELAXANTS, SKELETAL	N/A	$1.41
IBUPROFEN	G	ADVIL	ANALGESICS/ANTIPYRETICS	N/A	$0.27
TIZANIDINE HCL	B	ZANAFLEX	MUSCLE RELAXANTS, SKELETAL	N/A	$0.83
TRAMADOL HCL	G	ULTRAM	ANALGESICS/ANTIPYRETICS	4	$0.50
MELOXICAM	G	MOBIC	ANALGESICS/ANTIPYRETICS	N/A	$2.01
MORPHINE SULFATE	G	DURAMORPH	ANALGESICS/ANTIPYRETICS	2	$1.23
HYDROCODONE BITARTRATE-ACETAMINOPHEN	G	VICODIN	ANALGESICS/ANTIPYRETICS	2	$0.23

Exhibit 53A
Top 30 Drugs for Service Year 2019

			Rank By Service Year				
Paid Share Service Year 2019	Drug Name	Brand/Generic Status	2019	2018	2018	2016	2015
6.7%	Oxycontin	Brand	1	1	1	1	1
5.6%	Lyrica	Brand	2	2	3	3	5
4.6%	Oxycodone HCL	Generic for Oxycontin (if extended release)	3	3	4	4	3
3.9%	Gabapentin	Generic for Neurontin	4	4	2	2	2
3.7%	Oxycodone HCL-Acetaminophen	Generic for Percocet	5	5	5	5	4
3.6%	Lidocaine	Generic for Xylocaine	6	6	6	8	8
3.4%	Diclofenac Sodium	Generic for Cambia, Cataflam, Voltaren-XR, etc.	7	8	8	38	47
3.4%	Percocet	Brand	8	7	7	6	6
3.0%	Daptomycin	Generic for Cubicin, Cubicin RF	9	n/a	n/a	n/a	n/a
2.3%	Duragesic	Brand for Fentanyl	10	11	14	15	17
2.2%	Cyclobenzaprine HCL	Generic for Flexeril	11	9	10	10	10
2.2%	Sivextro	Brand	12	n/a	n/a	n/a	n/a
2.1%	Teflaro	Brand	13	n/a	n/a	n/a	n/a
2.0%	Duloxetine HCL	Generic for Cymbalta	14	10	9	9	9
1.6%	Tizanidine HCL	Generic for Zanaflex	15	12	13	13	15
1.4%	Nucynta	Brand	16	15	16	16	20
1.4%	Meloxicam	Generic for Mobic, Vivlodex	17	16	21	18	19
1.3%	Duexis	Brand	18	n/a	n/a	n/a	n/a
1.3%	Morphine Sulfate	Generic for Avinza, Kadian, Ms Contin	19	13	12	11	11
1.2%	Zofran	Brand	20	18	22	26	26
1.1%	Movantik	Brand	21	17	27	42	72
1.1%	Lidoderm	Brand	22	26	38	52	53
1.1%	Baxdela	Brand	23	n/a	n/a	n/a	n/a
1.1%	Fasenra	Brand	24	n/a	n/a	n/a	n/a
1.0%	Topiramate	Generic for Topamax, Trokendi XR	25	19	17	24	23
1.0%	Trokendi XR	Brand for Topiramate	26	n/a	n/a	n/a	n/a
1.0%	Lidopro Patch	Brand	27	23	20	17	80
0.9%	Celecoxib	Generic for Celebrex	28	21	23	19	18
0.8%	Baclofen	Generic for Lioresal, Gablofen	29	28	25	22	25
0.8%	Terocin	Brand	30	14	11	7	7

Exhibit 54
Distribution of Drugs by Brand Name and Generic

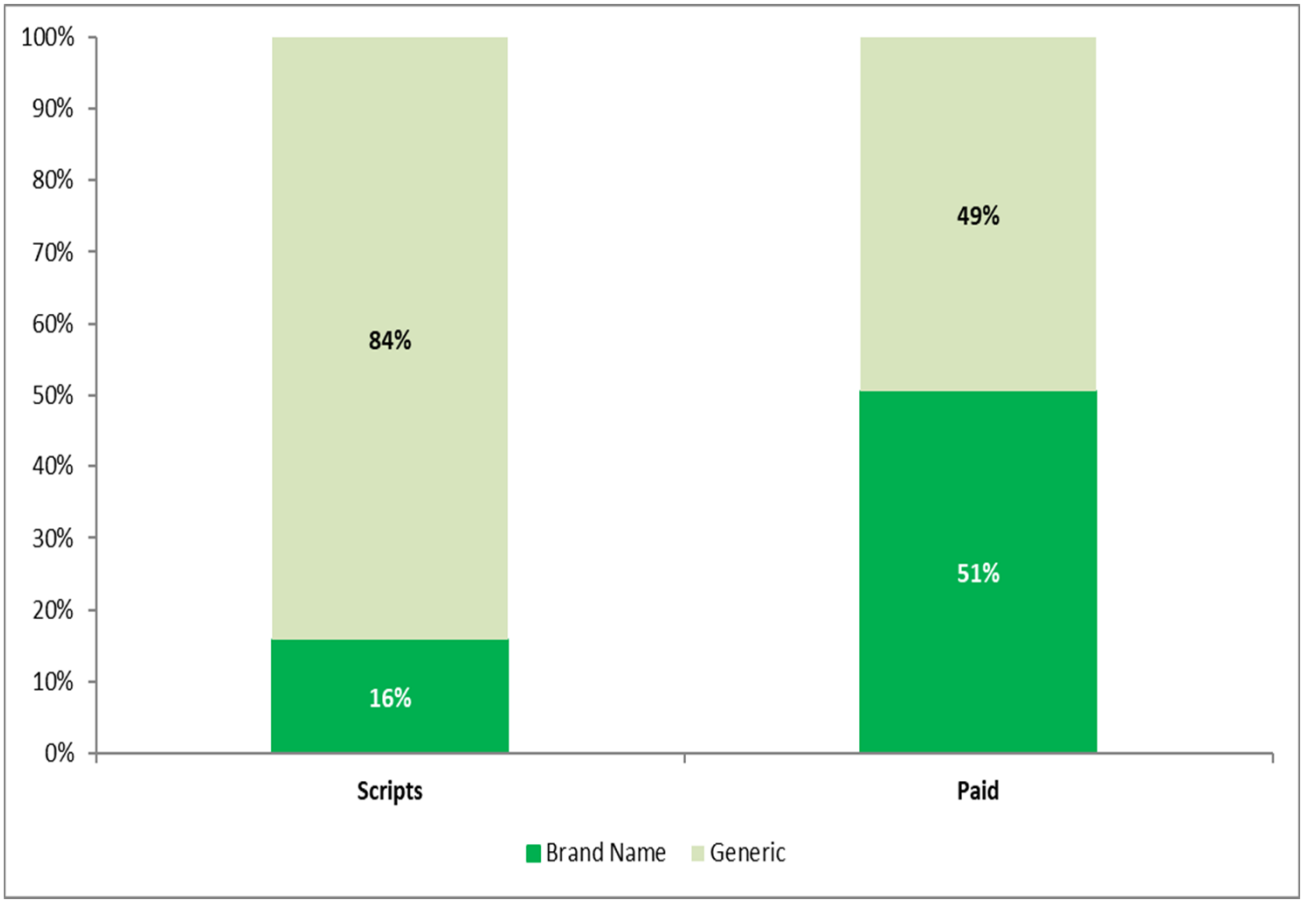


Exhibit 54 depicts the distribution of drugs organized by brand name versus generic. These results reveal that significantly fewer prescriptions are written using the brand name than generic equivalent.

Exhibit 55
Distribution of Drugs by Pharmacy and Non-Pharmacy

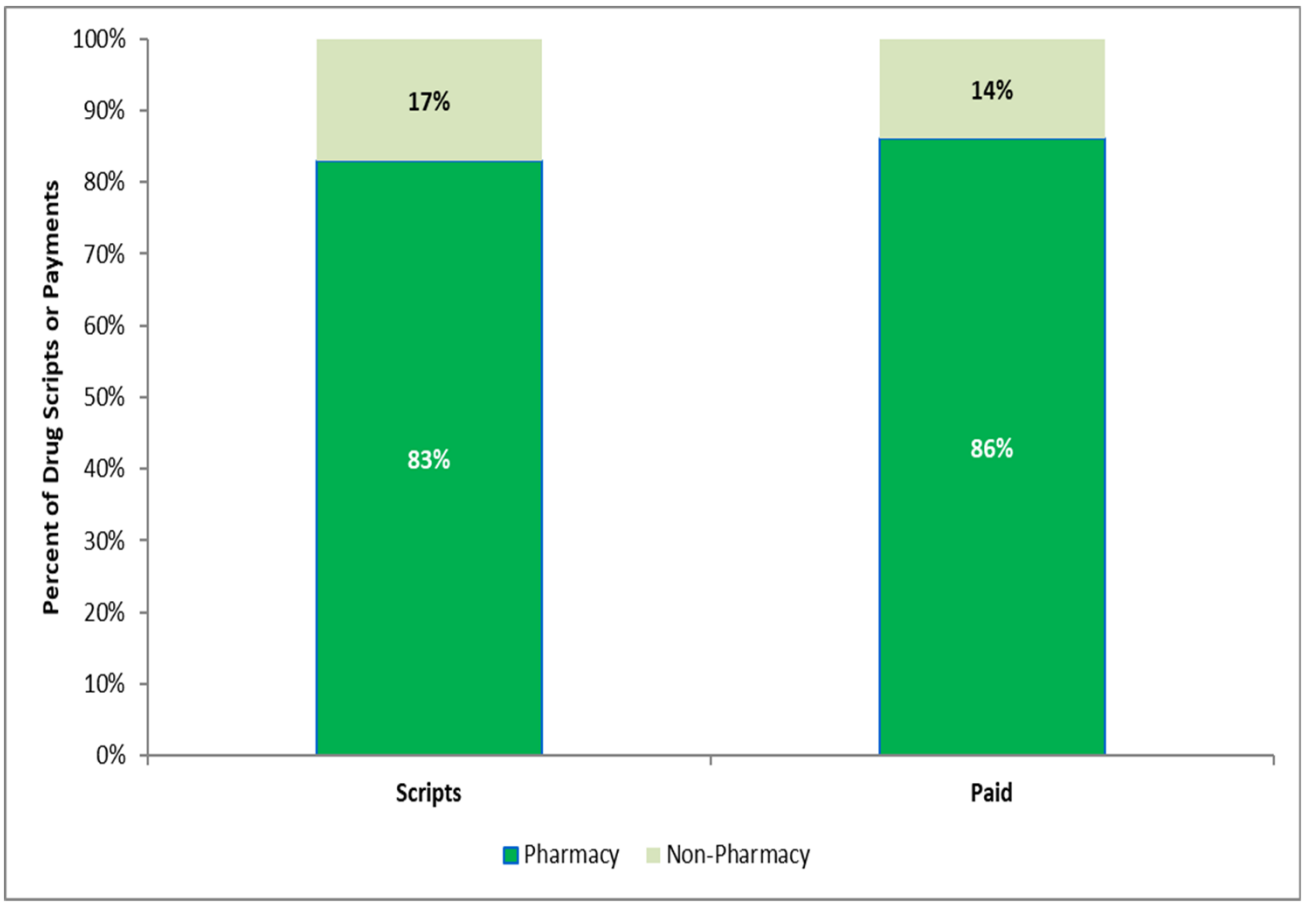


Exhibit 55 is a distribution of drugs dispensed at either a pharmacy (retail, mail order, or institutional) or a non-pharmacy facility. Examples of non-pharmacy dispensing locations include doctor's offices, home health care and hospitals. These results suggest that a large majority of prescription drugs are dispensed at a pharmacy.

Other Medical Activity Information

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

Exhibit 56 presents the distribution of payments by durable medical equipment (DME), supplies and implants.

Exhibit 57 details the top 10 diagnosis groups by average paid amount per claim for Dates of Injury in 2018 for claims with an implant or prosthetic.

Exhibit 58 details the average paid amount per claim for Dates of Injury in 2018 for claims without an implant or prosthetic for the diagnosis groups in **Exhibit 57**.

Exhibit 59 displays the average payment per bill for ground ambulance services, along with mileage.

Exhibit 60 displays the average payment per bill for air ambulance services.

Exhibit 61 details the top 10 body systems by paid amount for Dates of Injury in 2018. This exhibit includes diagnosis data that is more mature.

Exhibit 62 details the top 10 diagnosis groups by paid amount for Dates of Injury in 2018. This exhibit includes diagnosis data that is more mature.

The source for all data is the DCRB Medical Data Call for Service Year 2019. For detailed information on what is included in each of the following exhibits, refer to the Technical Appendix.

Exhibit 56
Distribution of Payments by DME, Suppliers and Implants

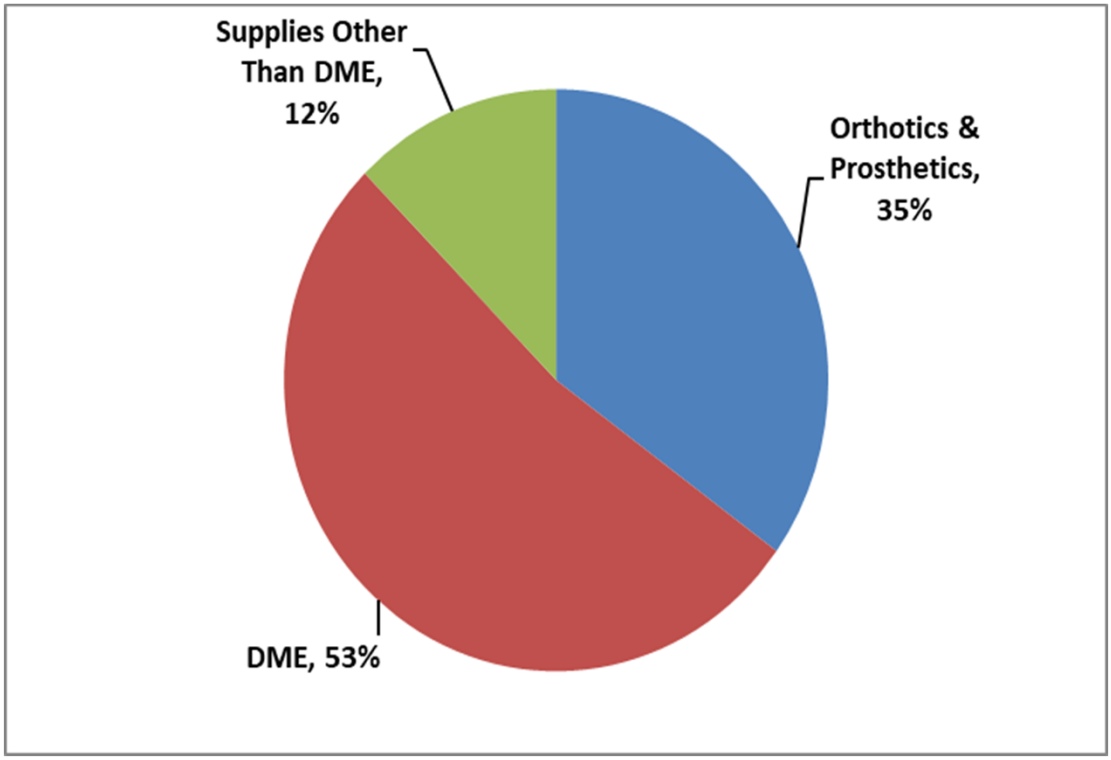


Exhibit 56 presents the distribution of payments by durable medical equipment (DME), orthotics and prosthetics, medical supplies and implants. This exhibit shows us that DME makes up the largest portion of payments followed by payments made for orthotics and prosthetics.

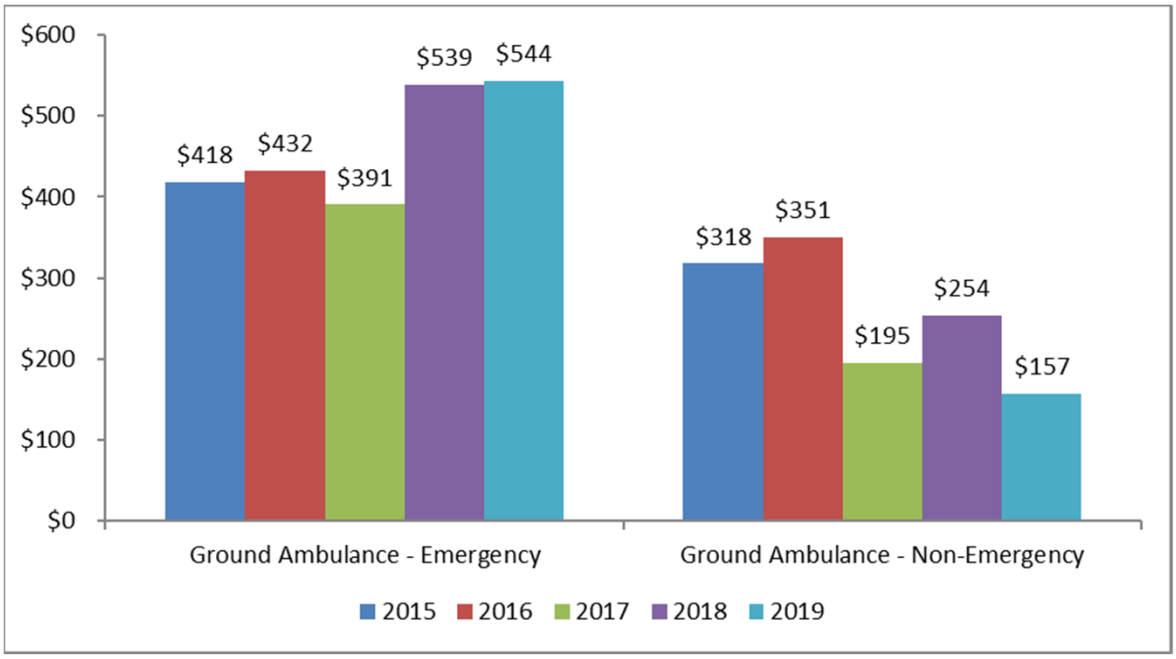
Exhibit 57
Top Diagnosis Groups by Amount Paid for Dates of Injury in 2018 for Claims with an Implant or Prosthetic

Diagnosis Group	Paid Share	Average Amount Paid Per Claim
Other dorsopathies	34.3%	$12,720
Spondylopathies	10.6%	$7,979
Other soft tissue disorders	6.4%	$4,793
Injuries to the wrist, hand and fingers	5.8%	$13,898
Injuries to the knee and lower leg	5.3%	$5,414
Other joint disorders	5.2%	$2,244
Injuries to the ankle and foot	5.0%	$9,444
Injuries to the shoulder and upper arm	3.3%	$3,974
Intraoperative and postprocedural complications	2.4%	$21,380
Injuries to the elbow and forearm	1.8%	$5,437

Exhibit 58
Average Amount Paid per Claim without an Implant or Prosthetic for Diagnosis Groups in Exhibit 57

Diagnosis Group	Average Amount Paid Per Claim
Other dorsopathies	$4,043
Spondylopathies	$3,235
Other soft tissue disorders	$1,725
Injuries to the wrist, hand and fingers	$1,144
Injuries to the knee and lower leg	$2,205
Other joint disorders	$1,097
Injuries to the ankle and foot	$1,236
Injuries to the shoulder and upper arm	$1,848
Intraoperative and postprocedural complications	$10,603
Injuries to the elbow and forearm	$2,039

Exhibit 59
Average Payment per Bill for Ground Ambulance Services



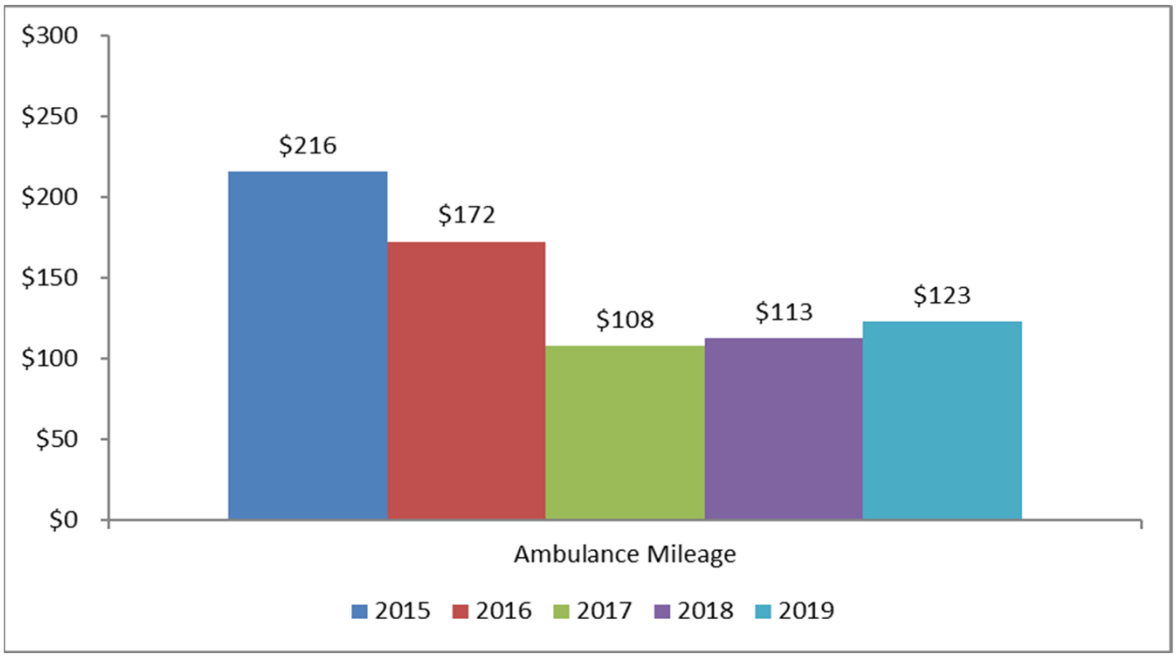
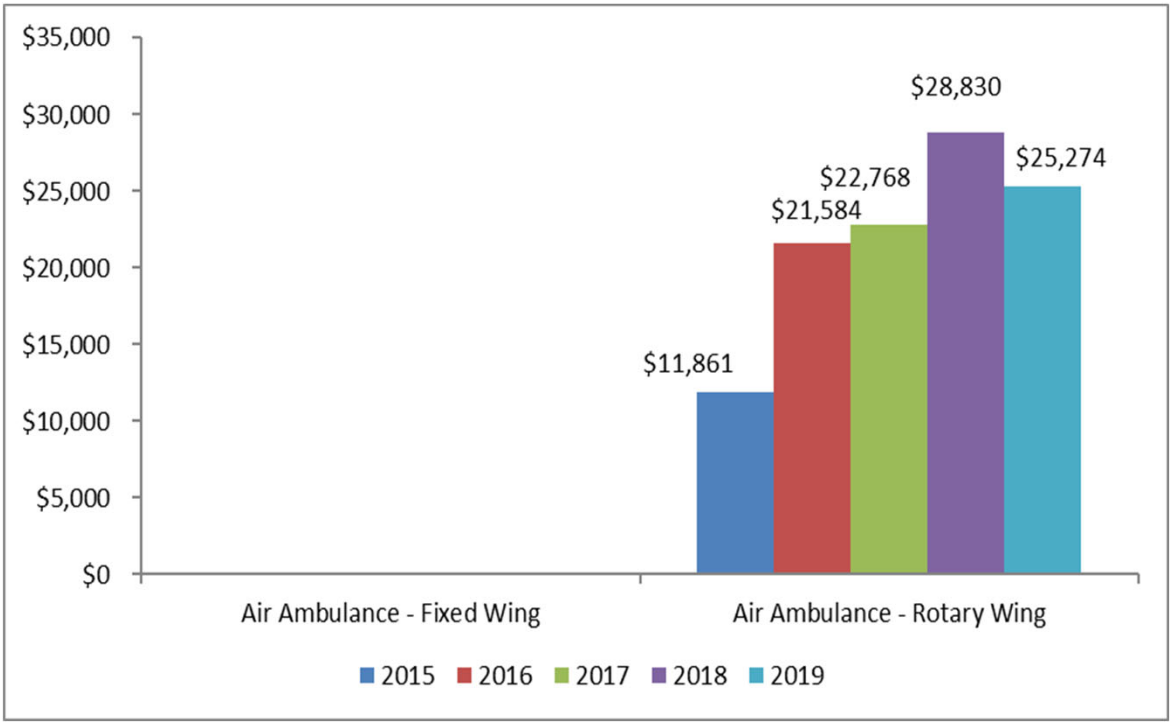


Exhibit 60
Average Payment per Bill for Fixed and Rotary Wing Air Ambulance Services



Note: There was no utilization for fixed wing air ambulance for 2015-2019 service dates.

Exhibit 61
Top 10 Body Systems by Amount Paid for Dates of Injury in 2018

Body System	Paid Share	Average Amount Paid Per Claim
Diseases of the musculoskeletal system and connective tissue	44.2%	$4,782
Injury, poisoning and certain other consequences of external causes	43.4%	$2,273
Diseases of the nervous system	3.1%	$2,119
Factors influencing health status and contact with health services	1.5%	$693
Symptoms, signs and abnormal clinical and laboratory findings, NOC	1.2%	$786
Diseases of the digestive system	1.2%	$4,531
Diseases of the circulatory system	1.0%	$2,093
Certain infectious and parasitic diseases	0.8%	$1,967
Diseases of the skin and subcutaneous tissue	0.5%	$1,103
Mental, behavioral and neurodevelopmental disorders	0.5%	$893

Exhibit 62
Top 10 Diagnosis Groups by Amount Paid for Dates of Injury in 2018

Diagnosis Group	Paid Share	Average Amount Paid Per Claim
Other dorsopathies	18.4%	$5,237
Other joint disorders	10.7%	$2,340
Injuries to the wrist, hand and fingers	8.0%	$1,427
Other soft tissue disorders	7.0%	$2,321
Injuries to the knee and lower leg	7.0%	$2,769
Injuries to the shoulder and upper arm	5.2%	$2,529
Burns and corrosions of external body surface, specified by site	5.2%	$8,080
Spondylopathies	3.8%	$3,996
Injuries to the abdomen, lower back, lumbar spine, pelvis	3.5%	$1,337
Injuries to the elbow and forearm	3.2%	$2,480

Appendix A: Comparison of Selected Distributions by Service Year

Distribution of Medical Payments (Exhibit 4)

Medical Category	2015	2016	2017	2018	2019
Physicians	44.4%	46.2%	46.4%	46.0%	42.5%
Hospital Inpatient	13.0%	13.4%	12.9%	13.0%	13.2%
Hospital Outpatient	8.0%	7.7%	6.9%	8.0%	7.9%
ER	1.6%	1.6%	2.2%	2.0%	2.6%
Ambulatory Surgical Centers	10.8%	10.2%	11.5%	10.0%	12.2%
Drugs (NDC Codes + Medical Drugs)	14.0%	13.8%	12.0%	14.0%	9.4%
Durable Medical Equipment	1.5%	1.6%	1.7%	2.0%	2.3%
Other	6.5%	5.5%	6.5%	5.0%	10.0%

Distribution of Physician Payments by AMA Service Category (Exhibit 6)

AMA Service Category	2015	2016	2017	2018	2019
Surgery	28.1%	29.1%	27.9%	28.0%	28.5%
Physical Medicine	36.9%	37.9%	39.1%	39.0%	38.5%
Evaluation & Management	15.3%	15.1%	14.7%	15.0%	15.0%
Radiology	6.0%	5.8%	5.7%	6.0%	6.0%
Medicine	5.9%	5.4%	5.6%	6.0%	6.0%
Anesthesia	4.5%	4.1%	4.0%	3.0%	4.0%
Pathology & Laboratory	3.3%	2.7%	2.9%	3.0%	2.0%

Appendix A: Comparison of Selected Distributions by Accident Year

Median Time Until First Treatment (in Days)
(Exhibits 11, 14, 17, 20, 28, 36, 37 and 48)

Medical Category	AY 2014	AY 2015	AY 2016	AY 2017	AY 2018
Physicians - Major Surgery	55	41	40	41	24
Physicians - Radiology	1	1	1	1	1
Physicians - Physical Medicine	2	2	2	2	2
Physicians - Evaluation and Management	1	1	1	1	1
Hospital Inpatient	1	1	1	1	1
Hospital Outpatient - Major Sugery	104	103	70	50	62
Hospital Outpatient - All Other	1	1	1	4	8
ASC	104	94	98	83	95

75th Percentile of Time Until First Treatment (in Days)
(Exhibits 11, 14, 17, 20, 28, 36, 37, and 48)

Medical Category	AY 2014	AY 2015	AY 2016	AY 2017	AY 2018
Physicians - Major Surgery	150	148	138	126	114
Physicians - Radiology	9	10	10	8	8
Physicians - Physical Medicine	10	12	12	12	13
Physicians - Evaluation and Management	3	3	3	3	3
Hospital Inpatient	224	52	45	140	84
Hospital Outpatient - Major Sugery	464	236	209	154	181
Hospital Outpatient - All Other	24	20	28	35	37
ASC	207	188	180	180	199

Appendix A: Comparison of Selected Distributions by Service Year

Hospital Inpatient Statistics (Exhibit 24 and 26)

Hospital Inpatient Statistics	2015	2016	2017	2018	2019
Average Payment per Stay	$38,474	$29,544	$27,019	$26,100	$25,782
Number of Stays per 1,000 Active Claims	23	24	24	24	22

Distribution of Hospital Outpatient Payments by Surgery and Non-Surgery (Based on Exhibit 32 and Exhibit 34)

Visit Type	2015	2016	2017	2018	2019
Surgery (CPT: 10021-69990)	24%	31%	32%	39%	37%
Non-Surgery	76%	69%	68%	61%	63%

Hospital Outpatient Surgery Statistics (Exhibit 32 and Exhibit 33)

Hospital Outpatient Surgery Statistics	2015	2016	2017	2018	2019
Average Payment per Visit	$6,383	$6,397	$5,176	$4,930	$4,997
Number of Visits per 1,000 Active Claims	55	48	45	51	49

Hospital Outpatient Non-Surgery Statistics (Exhibit 34 and Exhibit 35)

Hospital Outpatient Non-Surgery Statistics	2015	2016	2017	2018	2019
Average Payment per Visit	$654	$598	$494	$496	$455
Number of Visits per 1,000 Active Claims	696	563	528	556	558

Appendix A: Comparison of Selected Distributions by Service Year

Emergency Room Statistics (Exhibit 41 and Exhibit 42)

Emergency Room Statistics	2015	2016	2017	2018	2019
Average Payment per Visit	$1,915	$1,380	$1,105	$1,231	$1,056
Number of Visits per 1,000 Active Claims	98	134	178	176	184

ASC Statistics (Exhibit 46 and Exhibit 47)

ASC Statistics	2015	2016	2017	2018	2019
Average Payment per Visit	$8,768	$7,440	$6,708	$5,986	$4,932
Number of Visits per 1,000 Active Claims	119	123	133	147	175

Distribution of Prescription Drug Payments by CSA Schedule (Exhibit 51)

CSA Schedule	2015	2016	2017	2018	2019
Schedule 2	38%	35%	35%	32%	28%
Schedule 3	3%	2%	2%	2%	2%
Schedule 4	4%	3%	3%	3%	2%
Schedule 5	5%	6%	6%	8%	6%
OTC	5%	6%	5%	3%	2%
Non-Controlled	46%	48%	49%	52%	60%

Appendix A: Comparison of Selected Distributions by Service Year

Distribution of Drug Payments by Brand Name and Generic (Exhibit 54)

Type of Drug	2015	2016	2017	2018	2019
Brand	49%	50%	55%	53%	51%
Generic	51%	50%	45%	47%	49%

Distribution of Drug Payments by Pharmacy and Non-Pharmacy (Exhibit 55)

Type of Provider	2015	2016	2017	2018	2019
Pharmacy	85%	85%	87%	88%	86%
Non-Pharmacy	15%	15%	13%	12%	14%

Distribution of Payments by DME, Supplies, and Implants (Exhibit 56)

Category	2015	2016	2017	2018	2019
Orthotics & Prosthetics	37%	29%	39%	41%	35%
DME	40%	51%	45%	44%	53%
Supplies Other Than DME	23%	20%	16%	15%	12%

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2019
1	Medical Share of Total Benefit Costs	62.1% (2017)
2	Overall Medical Average Cost per Lost Time Claim (in 000s)	$50,215 (2017)
3	Percentage of Medical Paid by Claim Maturity	37.3% (Year 1); 61.7% (Year 5); 70.9% (Year 10); 82.0% (Year 19)
4	Distribution of Medical Payments	Physicians 43%; Hospital Outpatient 8%; Hospital Inpatient 13%; ASC 12%; Drugs 9%; DME 2%; ER 3%; Other 10%
5	Physician Payments as % of Medicare	Surgery 238%; Radiology 174%; Physical Medicine 141%; General Medicine 295%; Evaluation and Management 116%; Pathology & Laboratory 142%; All Physician Services 243%
6	Distribution of Physician Payments by AMA Service Category	Surgery 29%; Radiology 6%; Laboratory & Pathology 2%; Physical Medicine 39%; General Medicine 6%; Evaluation & Management 15%; Anesthesia 4%
7	Top 10 Anesthesia Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes 00670 ($887); 01992 ($376); 01630 ($429); 01400 ($326); 01480 ($389); 01936 ($297); 01830 ($334); 01810 ($281); 00400 ($282); 00630 ($475)
8	Top 10 Anesthesia Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 01992 ($376); 01630 ($429); 00670 ($887); 01400 ($326); 01936 ($297); 01810 ($281); 01480 ($389); 01830 ($334); 01991 ($238); 00400 ($282)
9	Top 10 Surgery Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 22612 ($2,158); 64483 ($377); 22551 ($3,443); 22558 ($2,625); 63047 ($2,244); 22845 ($1,292); 29827 ($1,577); 22840 ($1,554); 29823 ($1,062); 29881 ($1,200)
10	Top 10 Surgery Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 20610 ($101); 64483 ($377); 64493 ($341); 64494 ($193); 12001 ($152); 62323 ($322); 36415 ($7); 64484 ($188); 64415 ($177); 29826 ($355)
11	Time Until First Treatment for Major Surgery (in Days)	Median = 24; 75th Percentile = 114

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2019
12	Top 10 Radiology Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 72148 ($493); 73221 ($466); 73721 ($474); 72141 ($502); 72158 ($792); 73718 ($491); 72295 ($530); 73030 ($49); 73222 ($529); 72100 ($52)
13	Top 10 Radiology Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 73030 ($49); 73630 ($40); 72100 ($52); 73110 ($44); 73130 ($38); 72148 ($493); 73610 ($43); 73221 ($466); 73140 ($33); 73721 ($474)
14	Time Until First Treatment for Radiology (in Days)	Median = 1; 75th Percentile = 8
15	Top 10 Physical and General Medicine Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 97110 ($69); 97140 ($45); 97530 ($43); 97112 ($43); 97545 ($216); 97014 ($28); 97010 ($12); 99199 ($604); 98941 ($43); 97124 ($43)
16	Top 10 Physical and General Medicine Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 97110 ($69); 97140 ($45); 97010 ($12); 97530 ($43); 97014 ($28); 97112 ($43); 99080 ($27); 98941 ($43); 97124 ($43) ; 97012 ($28)
17	Time Until First Treatment for Physical and General Medicine (in Days)	Median = 2; 75th Percentile = 13
18	Top 10 Evaluation and Management Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 99214 ($100); 99213 ($63); 99203 ($111); 99284 ($318); 99204 ($158); 99283 ($198); 99232 ($90); 99212 ($51); 99285 ($427); 99202 ($84)
19	Top 10 Evaluation and Management Procedure Codes by Transaction Count	Average Paid Per Transaction for top 10 codes: 99213 ($63); 99214 ($100); 99203 ($111); 99212 ($51); 99204 ($158); 99232 ($90); 99284 ($318); 99283 ($198); 99202 ($84); 99215 ($133)
20	Time Until First Treatment for Initial Evaluation and Management Visit (in Days)	Median = 1; 75th Percentile = 3

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2019
21	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient	99201 (0.9%); 99202 (6.9%); 99203 (58.8%); 99204 (30.8%); 99205 (2.6%)
22	Office or Other Outpatient Visit for the Evaluation and Management of a Established Patient	99211 (0.2%); 99212 (4.6%); 99213 (41.2%); 99214 (52.2%); 99215 (1.9%)
23	Hospital Inpatient Payments as % of Medicare	119% to 144%
24	Average Paid Amount per Stay for Hospital Inpatient Services	$25,782
25	Average Paid Amount per Day for Hospital Inpatient Services	$7,067
26	Average Number of Stays per 1,000 Active Claims	22
27	Length of Stay for Hospital Inpatient Services	Average LOS = 3; Median LOS = 1
28	Time Until First Treatment for Hospital Inpatient Stays (in Days)	Median = 1; 75th Percentile = 84
29	Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services	Median Payment per Stay for top 10 groups: Other dorsopathies ($47,247); Spondylopathies ($49,089); Injuries to the hip and thigh ($14,604); Complications of medical and surgical care, NOC ($17,405); Injuries to the neck ($118,910); Burns and corrosions of external body surface, specified by site ($89,927); Injuries to the head ($12,269); Deforming dorsopathies ($56,916); Injuries to the abdomen, lower back, lumbar spine, pelvis ($22,558); Osteoarthritis ($16,061)
30	Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services	Median Payment per Stay for top 10 codes: 455 ($14,906); 454 ($48,322); 460 ($17,065); 459 ($52,255); 457 ($48,209); 473 ($18,252); 470 ($8,104); 463 ($37,496); 468 ($18,568); 085 ($15,139)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2019
31	Hospital Outpatient Payments as % of Medicare	n/a
32	Average Outpatient Paid Amount Per Major Surgical Visit for Hospital Outpatient Services	$4,997
33	Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims	49
34	Average Outpatient Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services	$455
35	Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims	558
36	Time Until First Treatment for Major Surgery Outpatient Visits (in Days)	Median = 62; 75th Percentile = 181
37	Time Until First Treatment for All Other Outpatient Visits (in Days)	Median = 8; 75th Percentile = 37
38	Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services	Median Payment per Visit for top 10 groups: Other dorsopathies ($483); Injuries to the knee and lower leg ($428); Other soft tissue disorders ($225); Injuries to the wrist, hand and fingers ($277); Injuries to the shoulder and upper arm ($527); Other joint disorders ($287); Complications of surgical and medical care, NOC ($1,188); Injuries to the ankle and foot ($243); Hernia ($5,995); Spondylopathies ($499)
39	Top 10 Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Payment per Visit for top 10 codes: 22551 ($7,806); 29827 ($4,510); 63650 ($10,676); 29881 ($4,333); 63685 ($18,451); 63047 ($3,260); 37227 ($29,172); 24342 ($7,253); 63030 ($7,226); 49650 ($6,470)
40	Top 10 Non-Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Payment per Visit for top 10 codes: 97110 ($56); 99283 ($379); 97140 ($47); 73221 ($495); 72148 ($587); 99284 ($626); 72141 ($676); 73721 ($537); 72158 ($940); 99285 ($1,328)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2019
41	Average Amount Paid per ER Visit	$1,056
42	Average Number of ER Visits per 1,000 Active Claims	184
43	Emergency Room Payments by Procedure Code	99281 (0.5%); 99282 (3.0%); 99283 (29.1%); 99284 (50.1%); 99285 (17.3%)
44	ER Transactions by Procedure Code	99281 (0.9%); 99282 (6.1%); 99283 (39.6%); 99284 (42.4%); 99285 (10.9%)
45	ASC Payments as % of Medicare	n/a
46	Average Amount Paid per Visit for ASC Services	$4,932
47	Average Number of ASC Visits per 1,000 Active Claims	175
48	Time Until First Treatment for ASC Visits (in Days)	Median = 95; 75th Percentile = 199
49	Top 10 Diagnosis Groups by Amount Paid for ASC Services	Median Payment per Visit for top 10 groups: Other dorsopathies ($1,039); Spondylopathies ($1,087); Other soft tissue disorders ($4,122); Other disorders of the nervous system ($659); Other joint disorders ($3,526); Complications of surgical and medical care, NOC ($4,997); Injuries to the shoulder and upper arm ($6,784); Injuries to the knee and lower leg ($3,614); Injuries to the elbow and forearm ($5,977); Injuries to the wrist, hand and fingers ($2,717)
50	Top 10 Surgery Procedure Codes by Amount Paid for ASC Services	Average Paid Per Transaction for top 10 codes: 64483 ($1,019); 63685 ($37,615); 64493 ($1,010); 29827 ($6,110); 64635 ($2,328); 63650 ($8,681); 22551 ($17,020); 64633 ($2,336); 64490 ($1,022); 29881 ($2,989)
51	Distribution of Prescription Drug Costs by CSA Schedule	Schedule 2 = 28%; Schedule 3 = 2%; Schedule 4 = 2%; Schedule 5 = 6%; OTC = 2%; Non-Controlled = 60%
52	Top 10 Workers Compensation Drugs by Amount Paid	Average Paid Per Unit for top 10 drugs: Oxycontin ($8.90); Lyrica ($3.99); Oxycodone HCL ($0.67); Gabapentin ($0.57); Oxycodone HCL-Acetaminophen ($1.12); Lidocaine ($3.03); Diclofenac Sodium ($2.32); Percocet ($18.55); Daptomycin ($2.28); Duragesic ($114.24)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2019
53	Top 10 Workers Compensation Drugs by Prescription Counts	Average Paid Per Unit for top 10 drugs: Oxycodone HCL ($0.67); Gabapentin ($0.57); Oxycodone HCL-Acetaminophen ($1.12); Cyclobenzaprine HCL ($1.41); Ibuprofen ($0.27); Tizanidine HCL ($0.83); Tramadol HCL ($0.50); Meloxicam ($2.01); Morphine Sulfate ($1.23); Hydrocodone Bitartrate-Acetaminophen ($0.23)
54	Distribution of Drugs by Brand Name and Generic	By Paid Amount = Brand Name 49%; Generic 51%; By Script Count = Brand Name 16%, Generic 84%
55	Distribution of Drugs by Pharmacy and Non-pharmacy by Amount Paid	By Paid Amount = Pharmacy 86%; Non-Pharmacy 14%; By Script Count = Pharmacy 83%, Non-Pharmacy = 17%
56	Distribution of Payments by DMEPOS	DME = 53%; Prosthetics, Orthotics and Implants = 35%; Supplies Other Than DME = 12%
57	Top Diagnosis by Amount Paid for Dates of Injury in 2018 for Claims with and Implant or Prosthetic	Average Paid Per Claim for top 10 groups: Other dorsopathies ($12,720); Spondylopathies ($7,979); Other soft tissue disorders ($4,793); Injuries to the wrist, hand and fingers ($13,898); Injuries to the knee and lower leg ($5,414); Other joint disorders ($2,244); Injuries to the ankle and foot ($9,444); Injuries to the shoulder and upper arm ($3,974); Intraoperative and postprocedural complications ($21,380); Injuries to the elbow and forearm ($5,437)
58	Average Amount Paid per Claim without an Implant or Prosthetic for Diagnosis Groups in Exhibit 57	Average Paid Per Claim for top 10 groups: Other dorsopathies ($4,043); Spondylopathies ($3,235); Other soft tissue disorders ($1,725); Injuries to the wrist, hand and fingers ($1,144); Injuries to the knee and lower leg ($2,205); Other joint disorders ($1,097); Injuries to the ankle and foot ($1,236); Injuries to the shoulder and upper arm ($1,848); Intraoperative and postprocedural complications ($10,603); Injuries to the elbow and forearm ($2,039)
59	Average Payment per Episode for Ground Ambulance Services	Ground ambulance emergency = $544; Ground ambulance non-emergency = $157; Mileage = $123
60	Average Payment per Episode for Fixed and Rotary Wing Air Ambulance Services	Air ambulance fixed wing = n/a; Air ambulance rotary wing = $25,274

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2019
61	Top Body Systems by Amount Paid for Dates of Injury in 2018	Average Paid Per Claim for top 10 groups: Muscles ($4,782); Injury or poisoning, NOC ($2,273); Nervous System ($2,119); Health status factors ($693); Symptoms/signs, NOC ($786); Digestive System ($4,531); Circulatory System ($2,093); Certain infectious and parasitic diseases ($1,967); Skin/subcutaneous tissue ($1,103); Mental ($893)
62	Top Diagnosis Groups by Amount Paid for Dates of Injury in 2018	Average Paid Per Claim for top 10 groups: Other dorsopathies ($5,237); Other joint disorders ($2,340); Injuries to the wrist, hand and fingers ($1,427); Other soft tissue disorders ($2,321); Injuries to the knee and lower leg ($2,769); Injuries to the shoulder and upper arm ($2,529); Burns and corrosions of external body surface, specified by site ($8,080); Spondylopathies ($3,996); Injuries to the abdomen, lower back, lumbar spine, pelvis ($1,337); Injuries to the elbow and forearm ($2,480)

Appendix C: Technical Appendix

The data contained in this report includes Medical Data Call transactions for Service Year 2019 (medical services delivered from January 1, 2019 to December 31, 2019) 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 website.

For the state of Delaware in Service Year 2019, the reported number of transactions were 325,584 with more than $42 million paid, for over 8,600 claims, representing data from 83% 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, 2019 and December 31, 2019
- 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, 2015 – December 31, 2015
  - January 1, 2016 – December 31, 2016
  - January 1, 2017 – December 31, 2017
  - January 1, 2018 – December 31, 2018
  - January 1, 2019 – December 31, 2019

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

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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)

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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, we compared the 2019 Delaware professional (physician) fee schedule to 2019 Medicare National Physician Fee Schedule Relative Value File (January Release). The percent difference was calculated for each fee compared.

Exhibit 6

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

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

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Exhibit 7

This exhibit includes data for the Anesthesia CPT codes (CPT: 00100-01999). The top 10 anesthesia 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 anesthesia CPT codes to calculate the percent of anesthesia 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 8

Same as exhibit 7, except the top 10 anesthesia CPT codes were selected based on transaction counts (record counts) in descending order.

Exhibit 9-10

Same as exhibits 7 – 8 except the exhibits include data for the Surgery CPT codes (CPT: 10021–69990).

Exhibit 11

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 2018 National Physician Fee Schedule Relative Value File was used to identify Major Surgery codes.

Exhibit 12-13

Same as exhibits 7 – 8 except the exhibits include data for the Radiology CPT codes (CPT: 70010-79999).

Exhibit 14

Same as exhibit 11 except the exhibits includes data for the Radiology CPT codes (CPT: 70010-79999).

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Exhibits 15-16

Same as exhibits 7 – 8 except the exhibits includes data for the Physical and General Medicine CPT codes (90281-99199, 99500-99602, 99605-99607).

Exhibit 17

Same as exhibit 11 except the exhibits includes data for the Physical and General Medicine CPT codes (90281-99199, 99500-99602, 99605-99607).

Exhibits 18-19

Same as exhibits 7 – 8 except the exhibits includes data for the Evaluation and Management CPT codes (CPT: 99201-99499).

Exhibit 20

Same as exhibit 11 except the exhibits includes data for the Evaluation and Management CPT codes (CPT: 99201-99499).

Exhibits 21-22

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 (CPT: 99201-99205) and management of established patients (CPT: 99211-99215.) 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 23

For this exhibit, we compared the 2019 Delaware inpatient hospital DRG fee schedule to the "DRG Summary for Medicare Inpatient Prospective Payment Hospitals, FY2018." From this publication, we compared the average amount that Medicare pays to Delaware providers for Medicare's share of the MS-DRG.

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Exhibit 24

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 25

Using the criteria from exhibit 24, 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 26

Using the criteria from exhibit 24, 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. This result was then multiplied by 1000.

Exhibit 27

Using the criteria from exhibit 24, we extracted the Length of Stay (LOS) by Bill ID. Using this LOS data, we then calculated the average LOS and the median LOS.

Exhibit 28

Same as Exhibit 11 except the exhibits includes data for the Place of Service Code = 21 (Inpatient Hospital) and Provider Taxonomy Code starts with 28.

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Exhibit 29

Using the criteria from Exhibit 24, 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 30

Same as Exhibit 29, 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 31

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.

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Exhibit 32

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 33

Based on data from exhibit 32, 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 34

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.

Exhibit 35

Based on data from 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.

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Exhibit 36-37

Same as exhibit 11 except the exhibits includes data for the Place of Service Code = 22 (Outpatient Hospital) and Provider Taxonomy Code starts with 28. Major Surgery was first defined as Surgery CPT codes (CPT: 10021-69990). Next the Medicare Global Surgery Indicator from the Medicare 2018 National Physician Fee Schedule Relative Value File was used to identify Major Surgery codes. All Other was defined as any data not considered Major Surgery.

Exhibit 38

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 39

Same as Exhibit 7, 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 surgery services to calculate the percent of hospital outpatient category payments.

Exhibit 40

Same as exhibit 39, except the non-surgery procedure codes were defined as any CPT code which is not Surgery CPT codes (CPT: 10021-69990).

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Exhibit 41

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 42

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 43

Same as Exhibits 21-22, except we selected the Emergency Department Svc (CPT: 99281-99285) sub-category.

Exhibit 44

Same as exhibit 43, except this exhibit displays the trend based on transaction counts, instead of paid amounts.

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Exhibit 45

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 46

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 47

Based on data from exhibit 46, 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 48

Same as exhibit 11 except the exhibit includes data for the Place of Service Code = 24 (Ambulatory Surgical Center) and Provider Taxonomy Code = Ambulatory Surgical (TAX: 261QA1903X)

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Exhibit 49

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 50

Same as Exhibit 7, 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 51 – 55

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.

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Exhibit 56

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 57

For this exhibit, we defined claims with a prosthetic, neurostimulator or C-code implant as:

- Prosthetics (HCPCS: L5000-L9999)
- Transcutaneous & Neuromuscular Electrical Nerve Stimulators (HCPCS: E0720-E0770)
- Temporary Hospital Outpatient PPS Codes (HCPCS: C1000-C9999)

The top 10 ICD-10 diagnosis groups were selected for these identified claims based on paid amount in descending order for Accident Dates between January 1, 2018 and December 31, 2018. The paid amount for each diagnosis group was divided by the total paid amount for dates of service in 2018 and 2019 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 58

The same top 10 ICD-10 diagnosis groups for claims not identified in exhibit 57 were selected based on paid amount in descending order for Accident Dates between January 1, 2018 and December 31, 2018. The paid amount for each diagnosis group was divided by the total paid amount for dates of service in 2018 and 2019 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.

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Exhibit 59-60

For this exhibit, we selected five years of trend data from the HCPCS category Transportation Including Ambulance (HCPCS: A0000-A0999). We reported the average paid per bill for the ground ambulance, air ambulance and mileage.

Exhibit 61

The top 10 ICD-10 diagnosis groups were selected based on paid amount in descending order for Accident Dates between January 1, 2018 and December 31, 2018. The paid amount for each diagnosis group was divided by the total paid amount for dates of service in 2018 and 2019 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.
selected.

Exhibit 62

Same as exhibit 61, except that the top 10 ICD-10 diagnosis sub-groups were selected.

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, 2018; 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.