



Medical Activity Report

Based on 2018 Service Dates

2019

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:

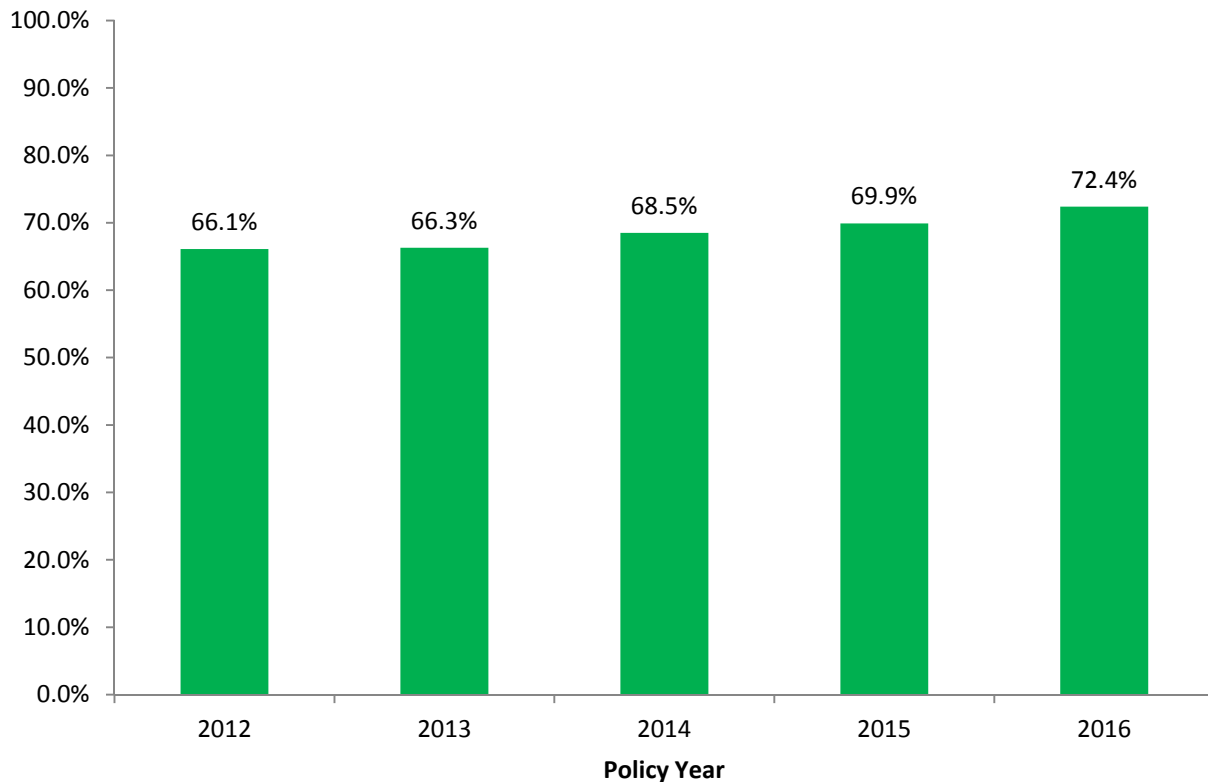
- Medical detail data could enhance the DCRB's ability to explain filings
- Medical detail data would allow the DCRB to be able to opine with authority on a variety of possible proposals to change the payment system for workers compensation in Delaware
- Medical cost containment concerns impact public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

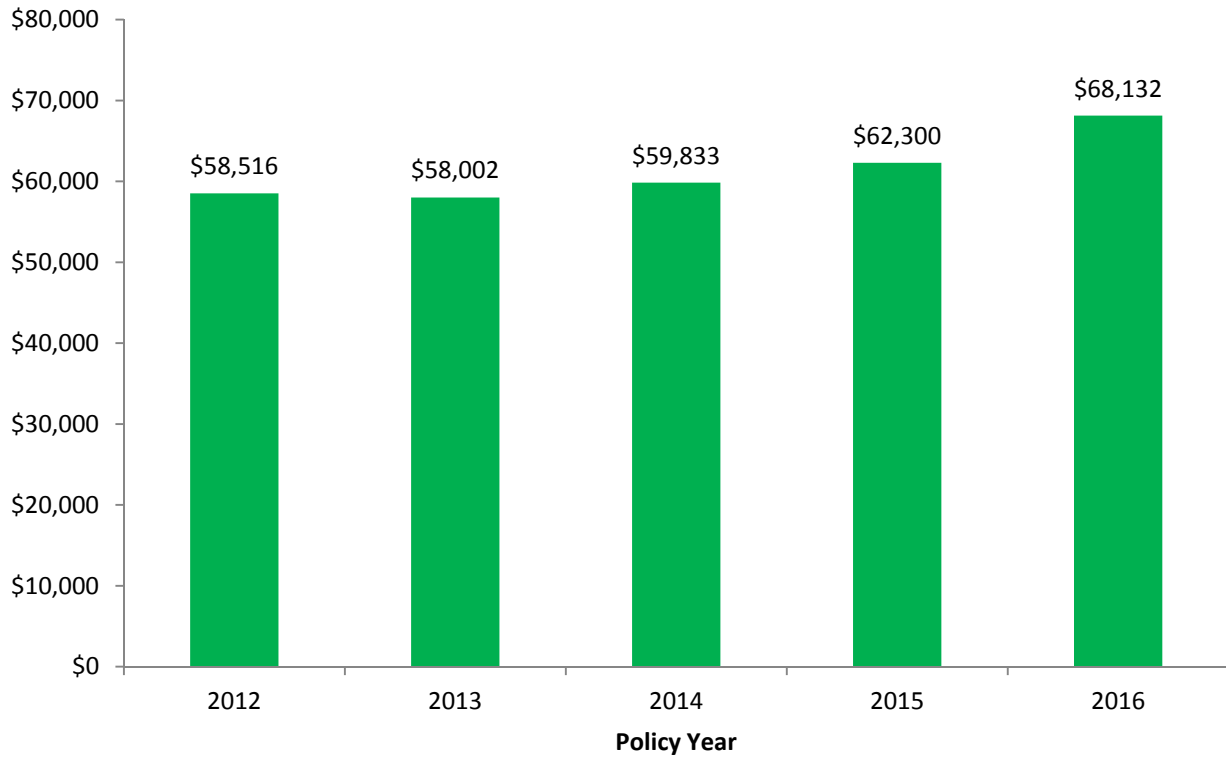


This exhibit displays the historical medical share of total benefit costs for the most recent five policy years.

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 12/31/2017 and includes medical only claims.

Exhibit 2
Medical Average Cost Per Case

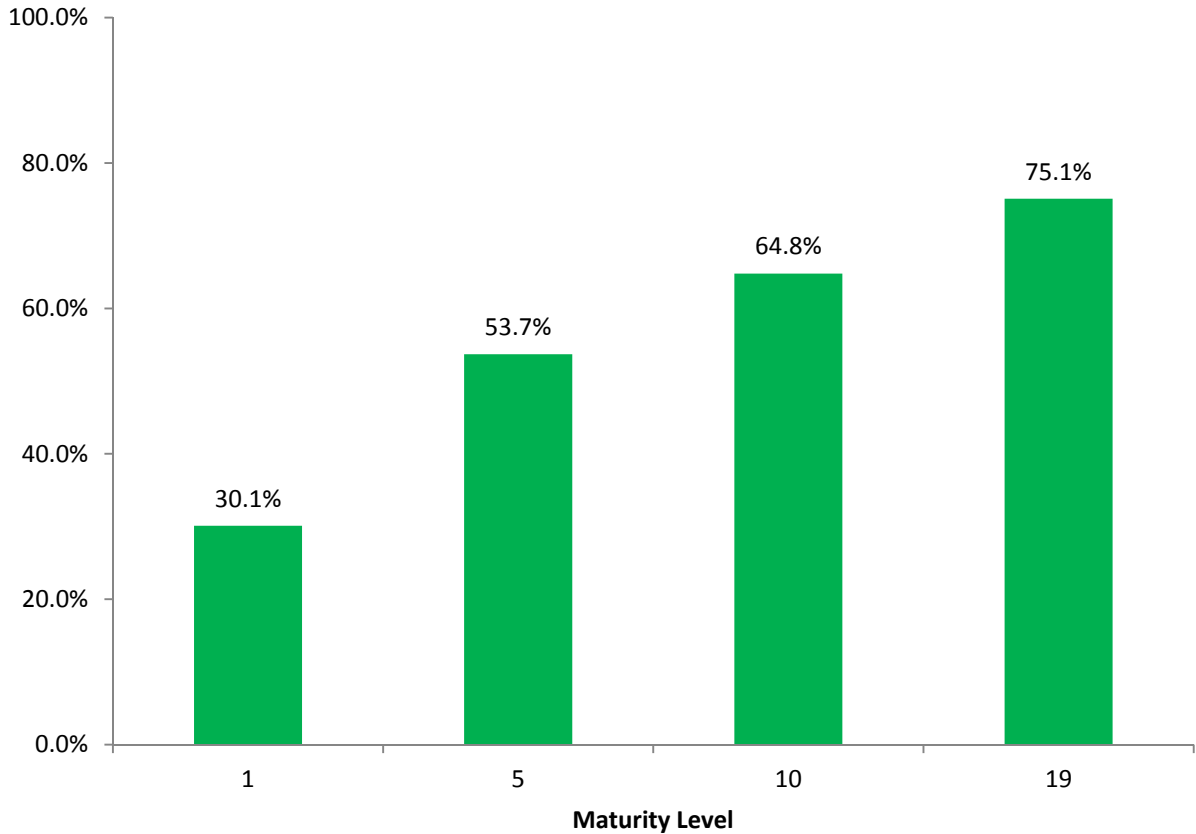


This exhibit provides a high-level summary of medical average cost per case from 2012 to 2016.

As shown in the exhibit, medical average cost per case displays an increasing trend since 2013. The underlying data do not include medical only claims, which represent 72% of total claim volume but only 9% of total workers compensation costs. Note that policy year medical loss data is developed to ultimate without adjusting to current benefit level.

This exhibit includes Delaware Policy Year Unit Statistical Data Call for Compensation Experience valued as of 7/1/2018. 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 12/31/2017 and includes medical only claims.

Exhibit 4
Distribution of Medical Payments

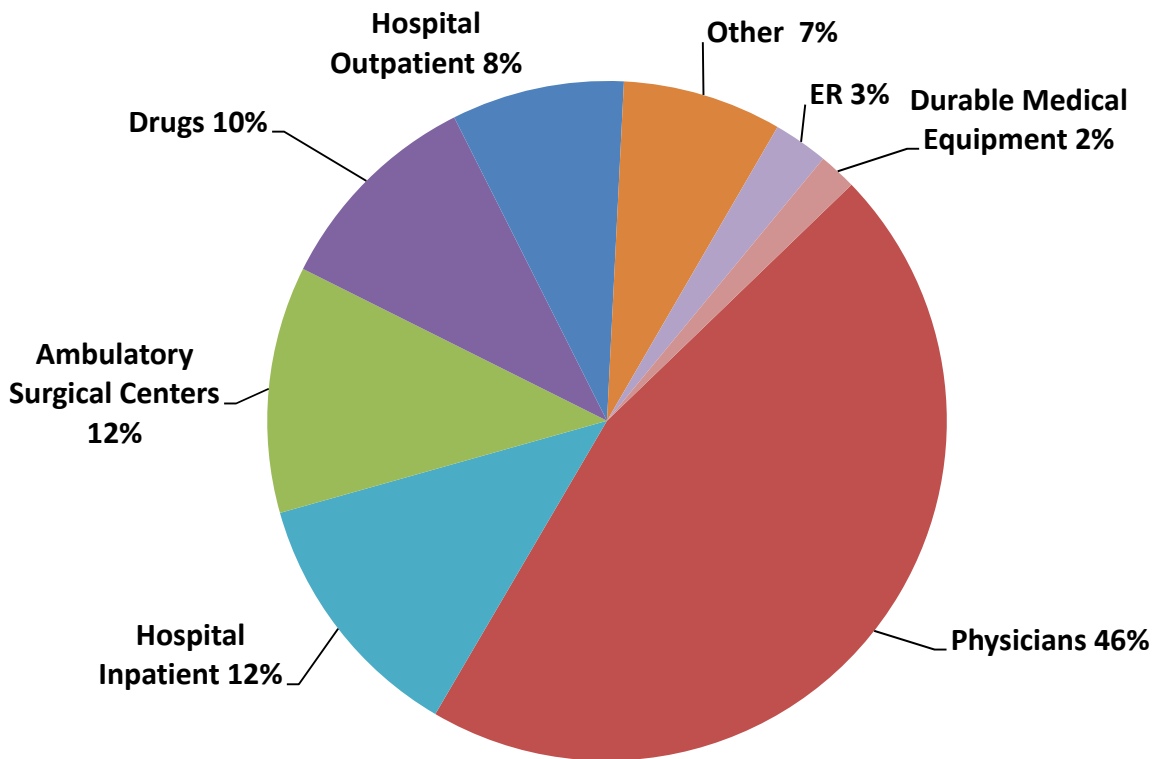


Exhibit 4 presents the distribution of medical payments by type of service groups for the state of Delaware. Payments to physicians represent the largest portion (46%) of medical paid in Service Year 2018. The service groups are defined based on paid procedure code type, provider taxonomy, and place 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 2018 Delaware professional (physician) fee schedule to 2018 Medicare National Physician Fee Schedule Relative Value File (January Release) and found that the physician fee schedule averages 214% of Medicare, with significant differences depending on the procedure code category. Overall, DCRB determined that for geo zip 197/198, the fee schedule averages 226% of Medicare and for geo zip 199 the fee schedule averages 178% 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 2017 professional fee schedule was 131% of Medicare. The WCRI uses a proprietary methodology to blend 197/198 and 199 geo zips for their calculations.

Exhibit 5 (cont'd)
Physician Payments as a Percentage of Medicare
Comparing DE 2018 Fee Schedules to Medicare 2018 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	2,974	321
	Between 201% and 250% of Medicare	2,116	558
	Between 100% and 150% of Medicare	181	253
	Between 151% and 200% of Medicare	161	4,282
	Less than 100% of Medicare	128	146
(1) Surgery Total		5,560	5,560
(2) Radiology	Between 151% and 200% of Medicare	235	143
	Between 201% and 250% of Medicare	180	93
	Between 100% and 150% of Medicare	113	275
	Less than 100% of Medicare	17	34
(2) Radiology Total		545	545
(3) Pathology & Laboratory	Between 151% and 200% of Medicare	41	23
	Between 100% and 150% of Medicare	21	31
	Less than 100% of Medicare	16	27
	Between 201% and 250% of Medicare	4	1
(3) Pathology & Laboratory Total		82	82
(4) Medicine	Between 100% and 150% of Medicare	359	411
	Between 151% and 200% of Medicare	186	99
	Less than 100% of Medicare	70	106
	Between 201% and 250% of Medicare	15	14
(4) Medicine Total		630	630
(5) Physical Medicine	Between 151% and 200% of Medicare	30	22
	Between 100% and 150% of Medicare	18	18
	Less than 100% of Medicare	11	18
	Between 201% and 250% of Medicare	0	1
(5) Physical Medicine Total		59	59
(6) Evaluation & Management	Between 100% and 150% of Medicare	94	104
	Less than 100% of Medicare	36	32
	Between 151% and 200% of Medicare	17	11
(6) Evaluation & Management Total		147	147

Exhibit 6
Distribution of Physician Payments by AMA Service Category

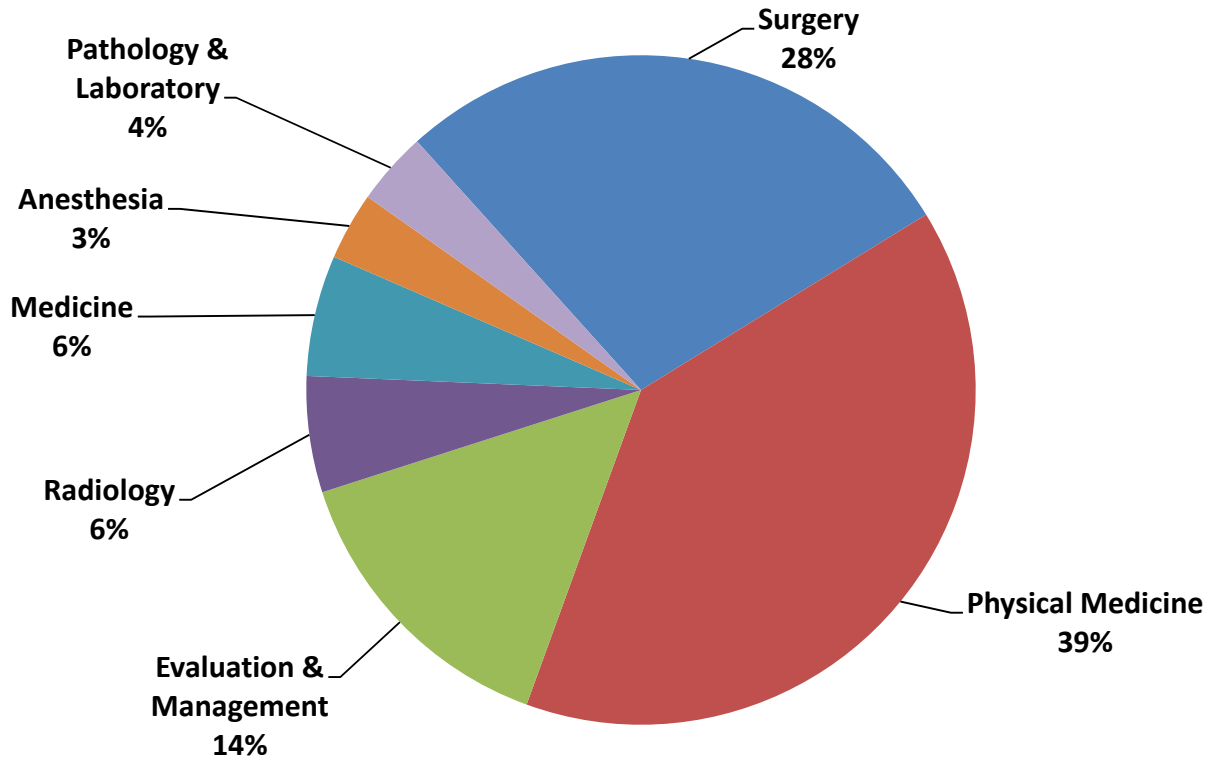


Exhibit 6 presents the distribution of physician payments by Current Procedural Terminology (CPT) code categories as defined by the American Medical Association (AMA). The Delaware Health Care Payment system (i.e., the fee schedule) dictates the maximum allowable reimbursement (MAR) when paying medical 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 81% 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.

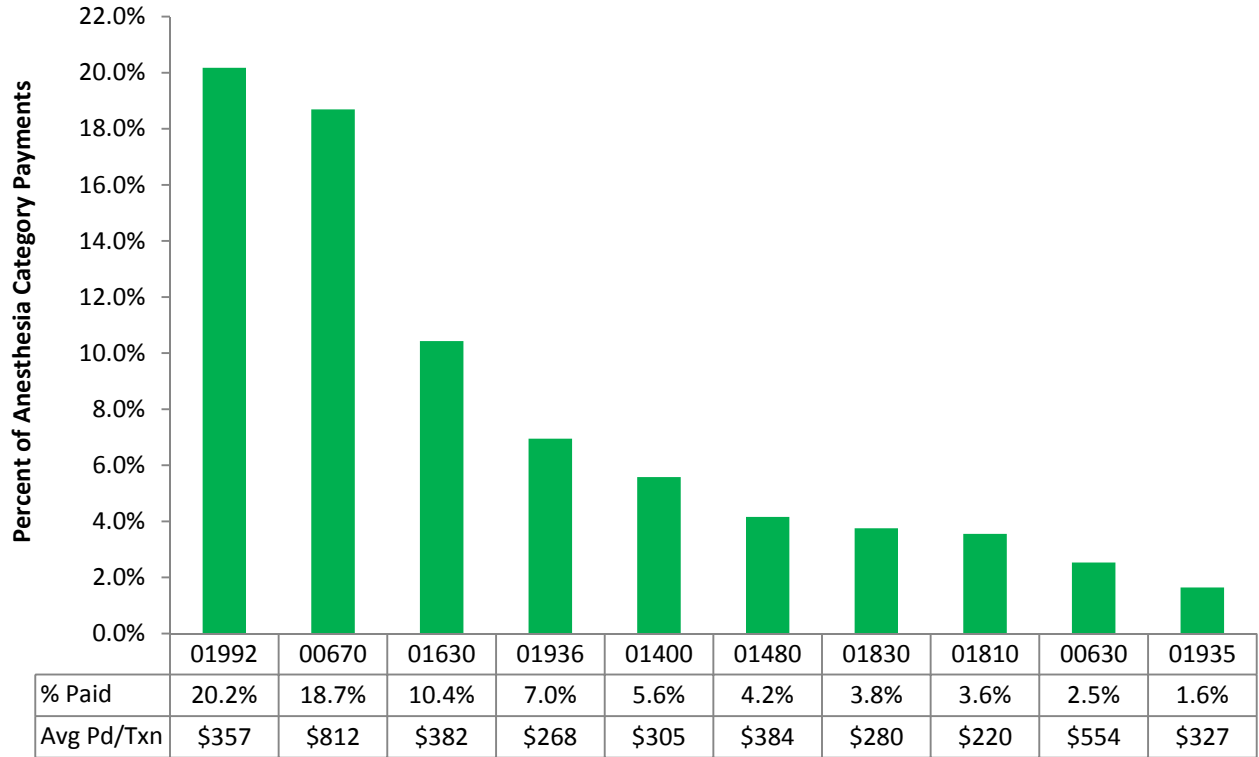
Exhibit 15 presents the top 10 physical and general medicine paid procedure codes based on paid amount. **Exhibit 16** presents the top 10 physical and general medicine paid procedure codes based on transaction counts.

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.

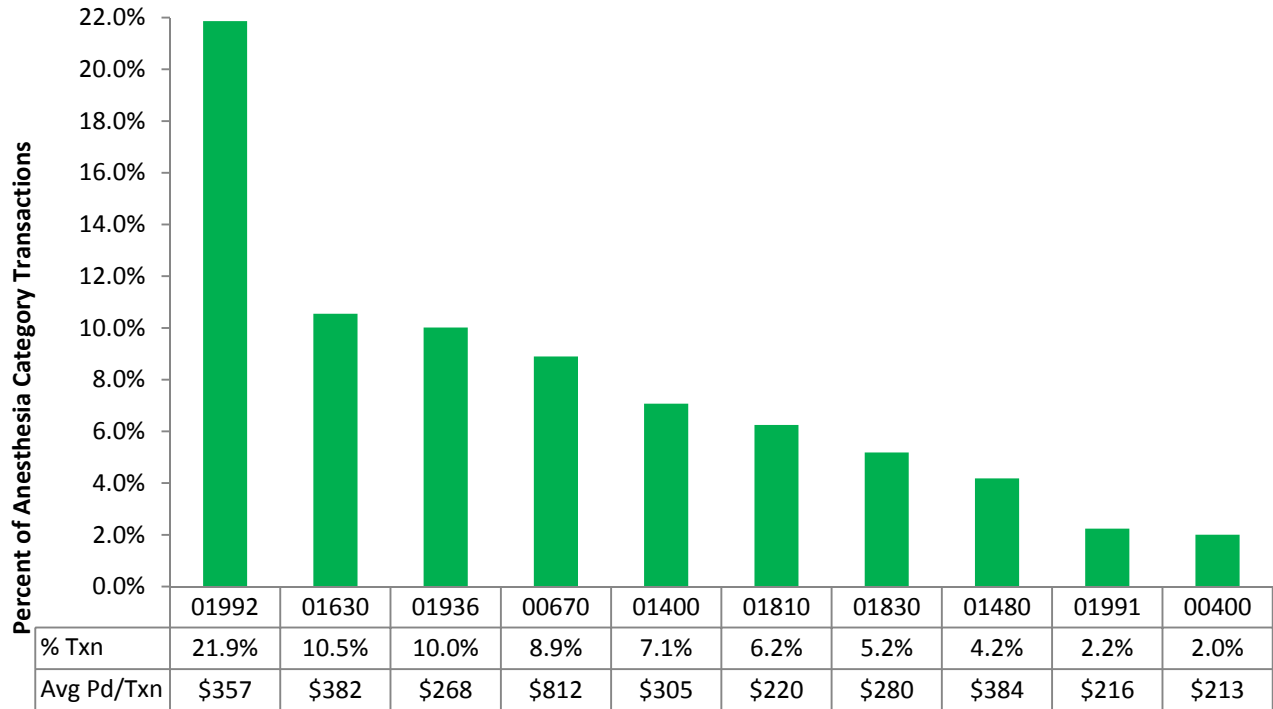
The source for all data is the DCRB Medical Data Call for Service Year 2018. For detailed information on what is included in each exhibit, refer to the Technical Appendix.

Exhibit 7
Top 10 Anesthesia Procedure Codes by Amount Paid



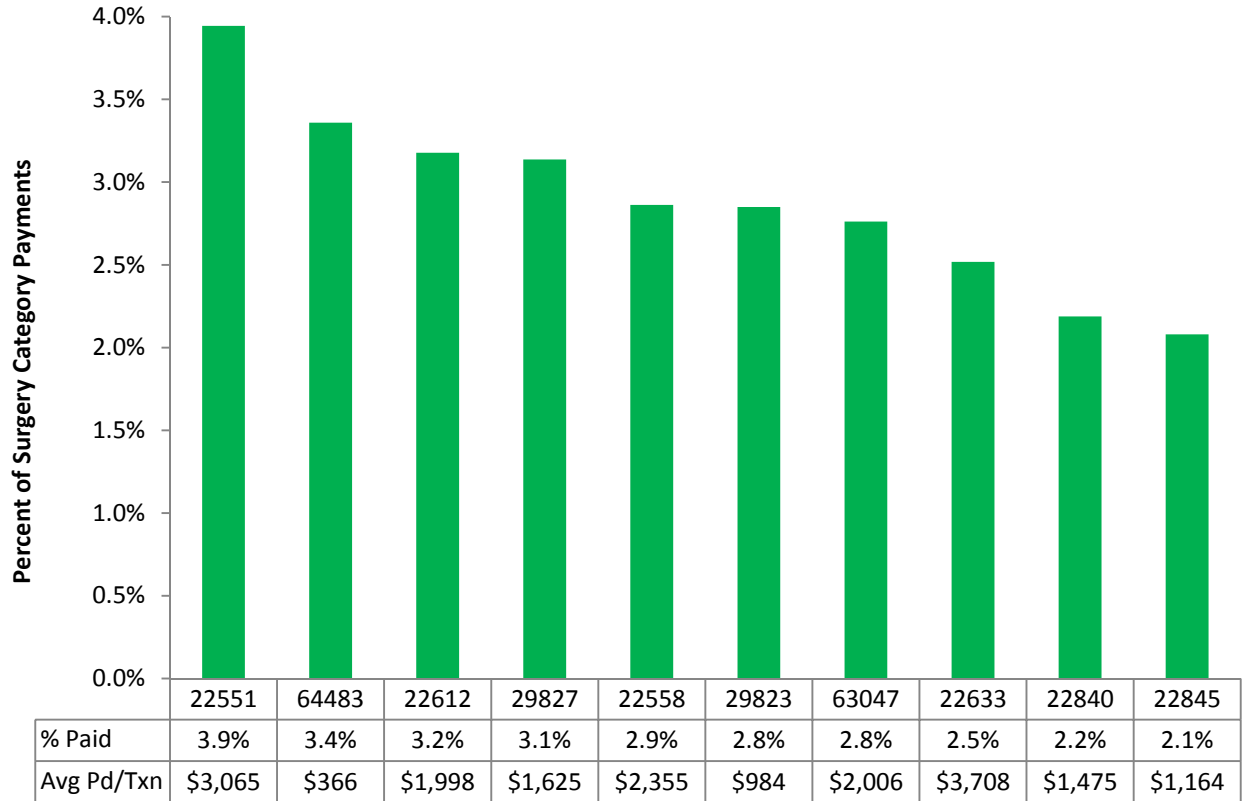
Code	Description
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
00630	Anesthesia for procedures in lumbar region; not otherwise specified
01935	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic

Exhibit 8
Top 10 Anesthesia Procedure Codes by Transaction Counts



Code	Description
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
00670	Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than the prone position
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified

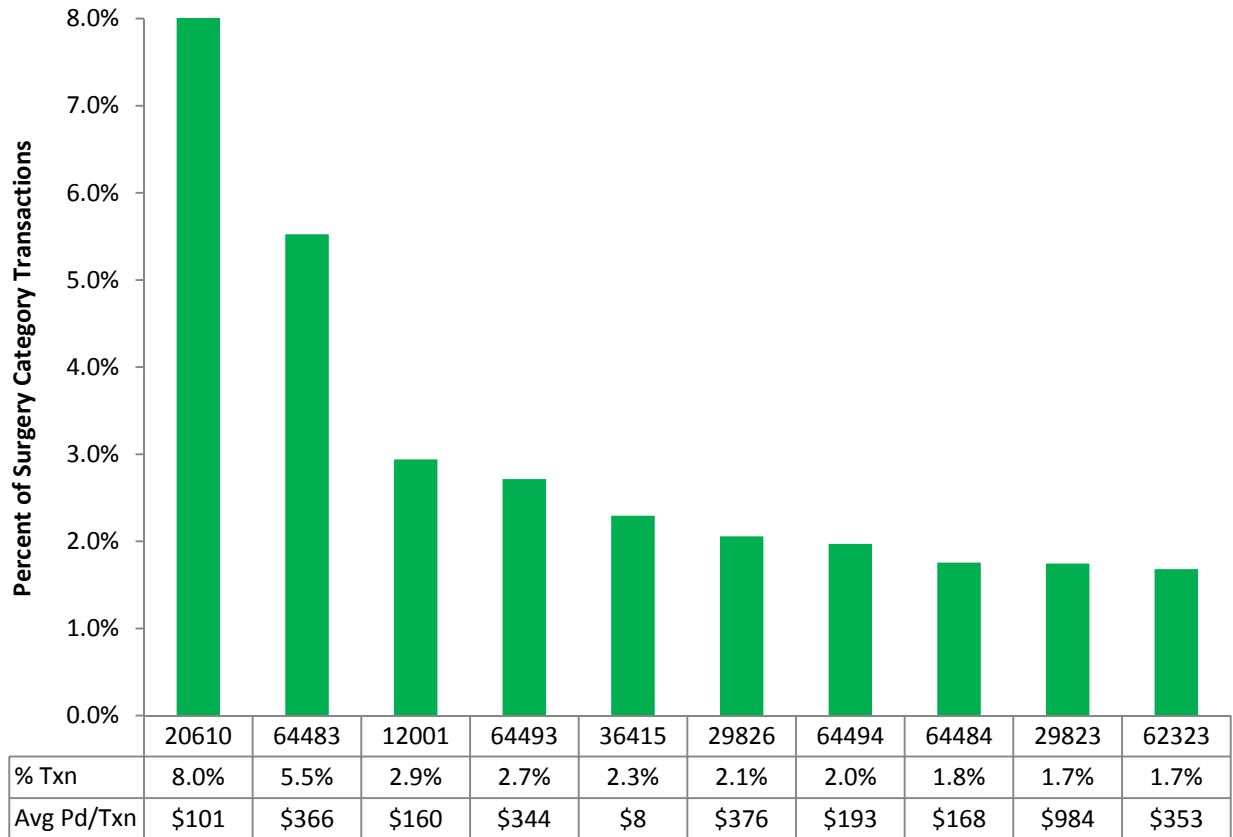
Exhibit 9
Top 10 Surgery Procedure Codes by Amount Paid



Code	Description
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
29823	Arthroscopy, shoulder, surgical; debridement, extensive
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary proced
22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)

Exhibit 10

Top 10 Surgery Procedure Codes by Transaction Counts



Code	Description
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
36415	Collection of venous blood by venipuncture
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
29823	Arthroscopy, shoulder, surgical; debridement, extensive
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral

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

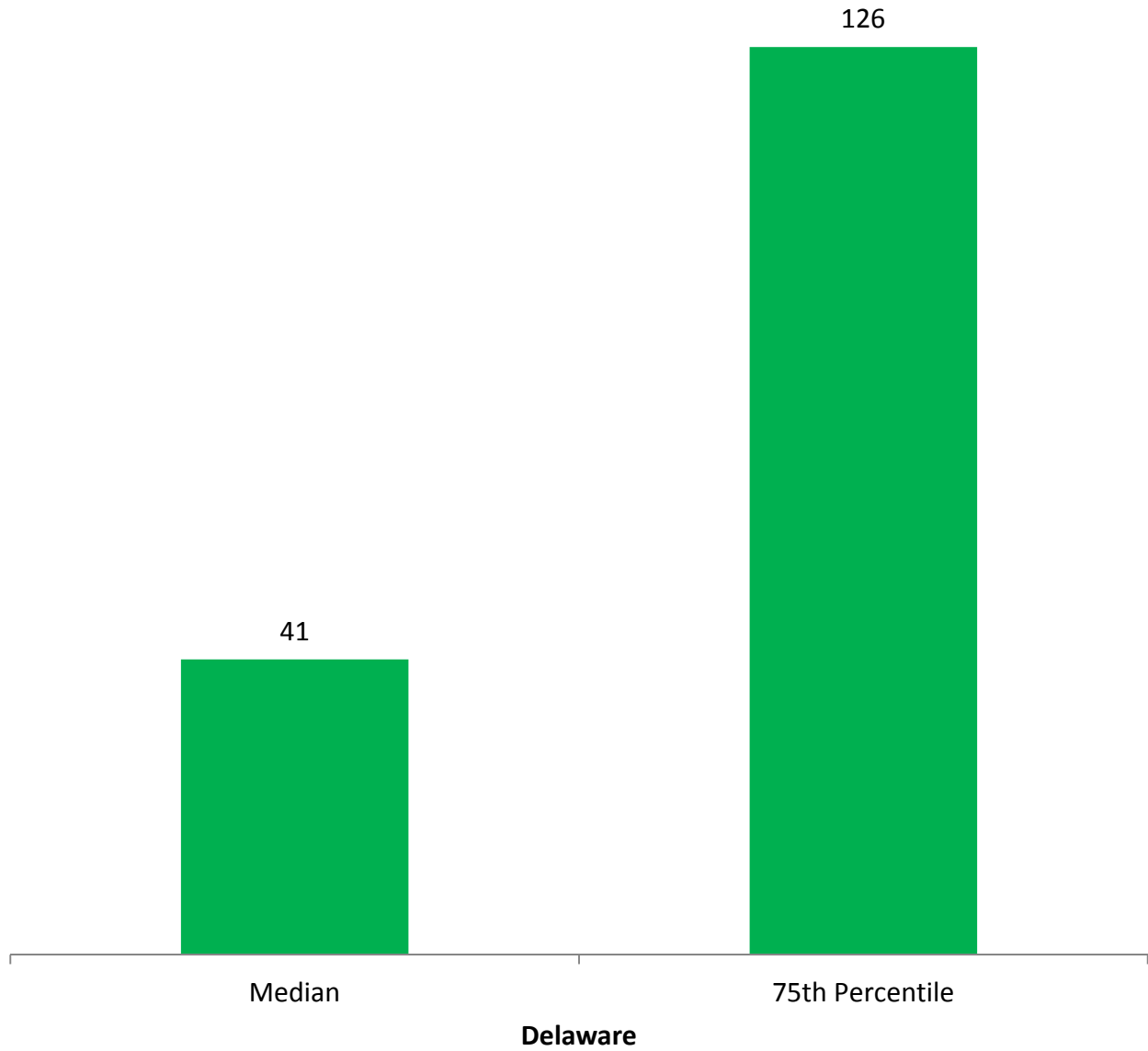
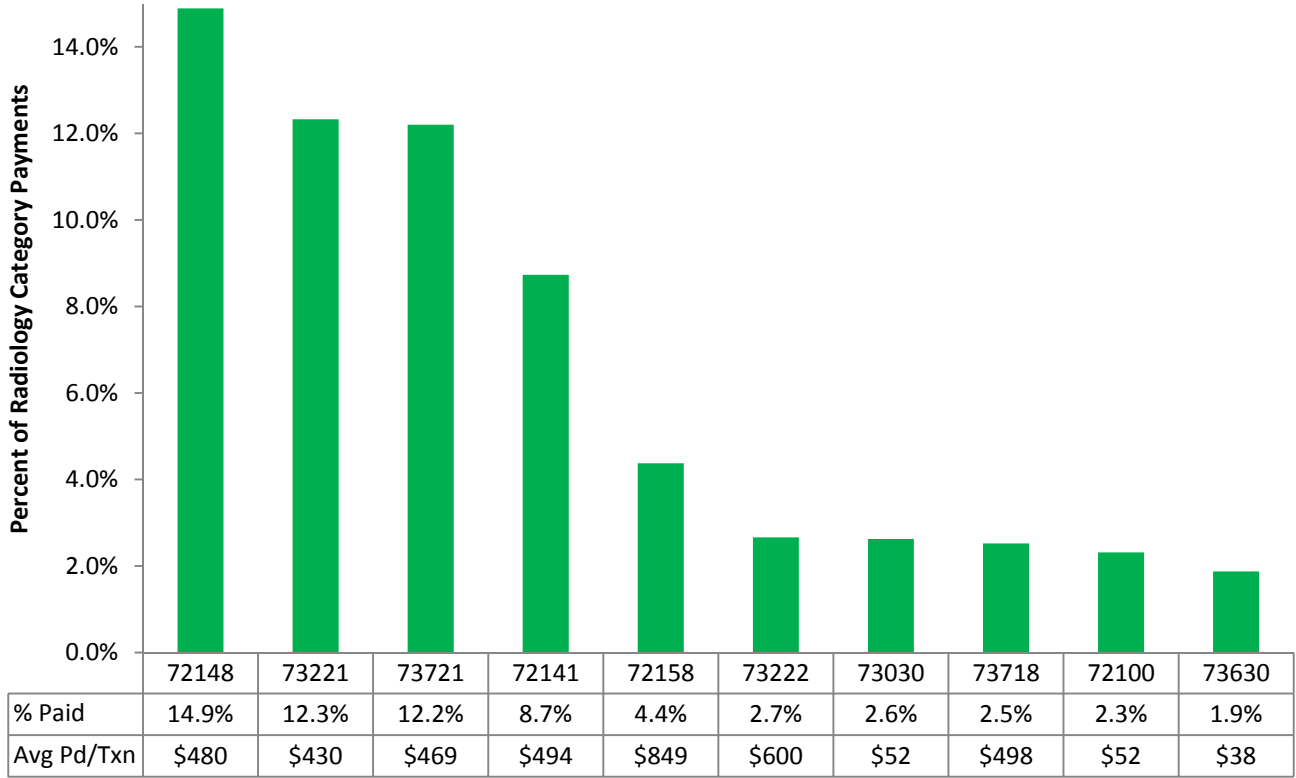
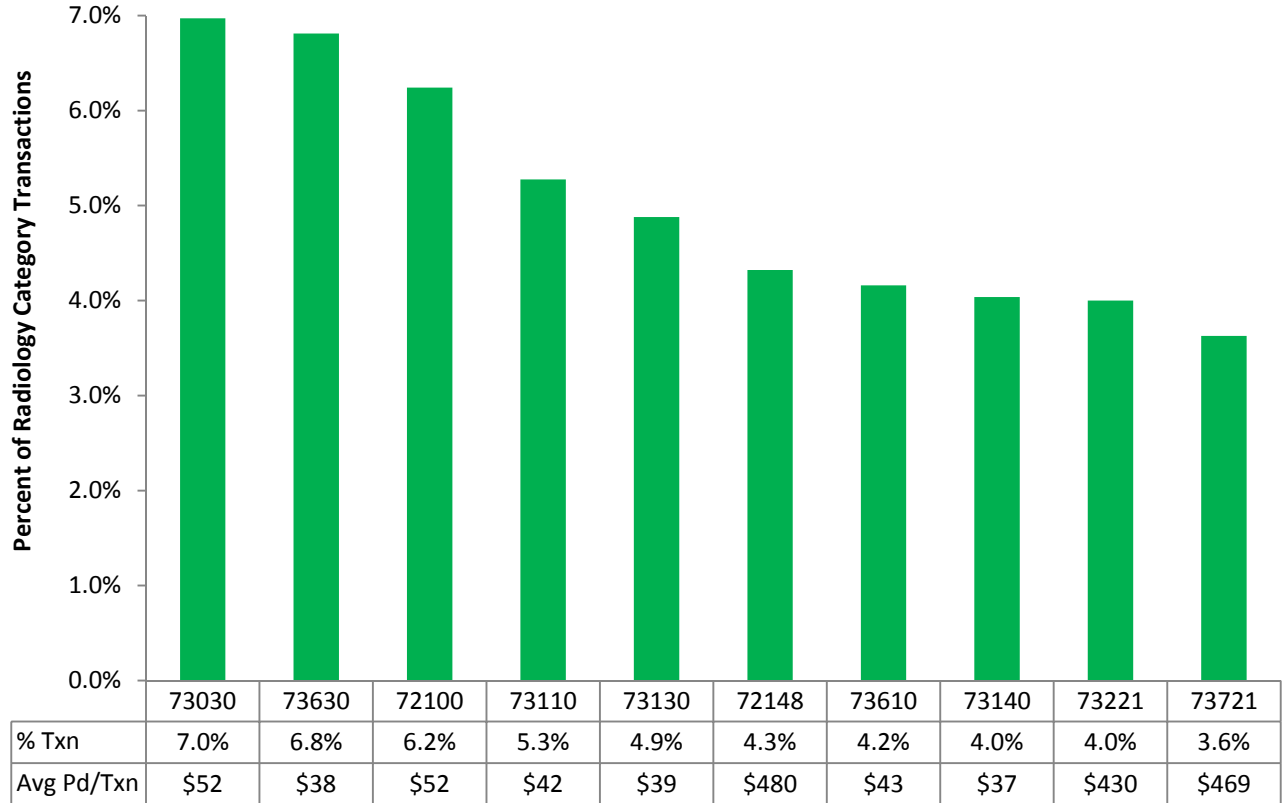


Exhibit 12
Top 10 Radiology Procedure Codes by Amount Paid



Code	Description
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
73222	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; with contrast material(s)
73030	Radiologic examination, shoulder; complete, minimum of 2 views
73718	Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
73630	Radiologic examination, foot; complete, minimum of 3 views

Exhibit 13
Top 10 Radiology Procedure Codes by Transaction Counts



Code	Description
73030	Radiologic examination, shoulder; complete, minimum of 2 views
73630	Radiologic examination, foot; complete, minimum of 3 views
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
73110	Radiologic examination, wrist; complete, minimum of 3 views
73130	Radiologic examination, hand; minimum of 3 views
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
73610	Radiologic examination, ankle; complete, minimum of 3 views
73140	Radiologic examination, finger(s), minimum of 2 views
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

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

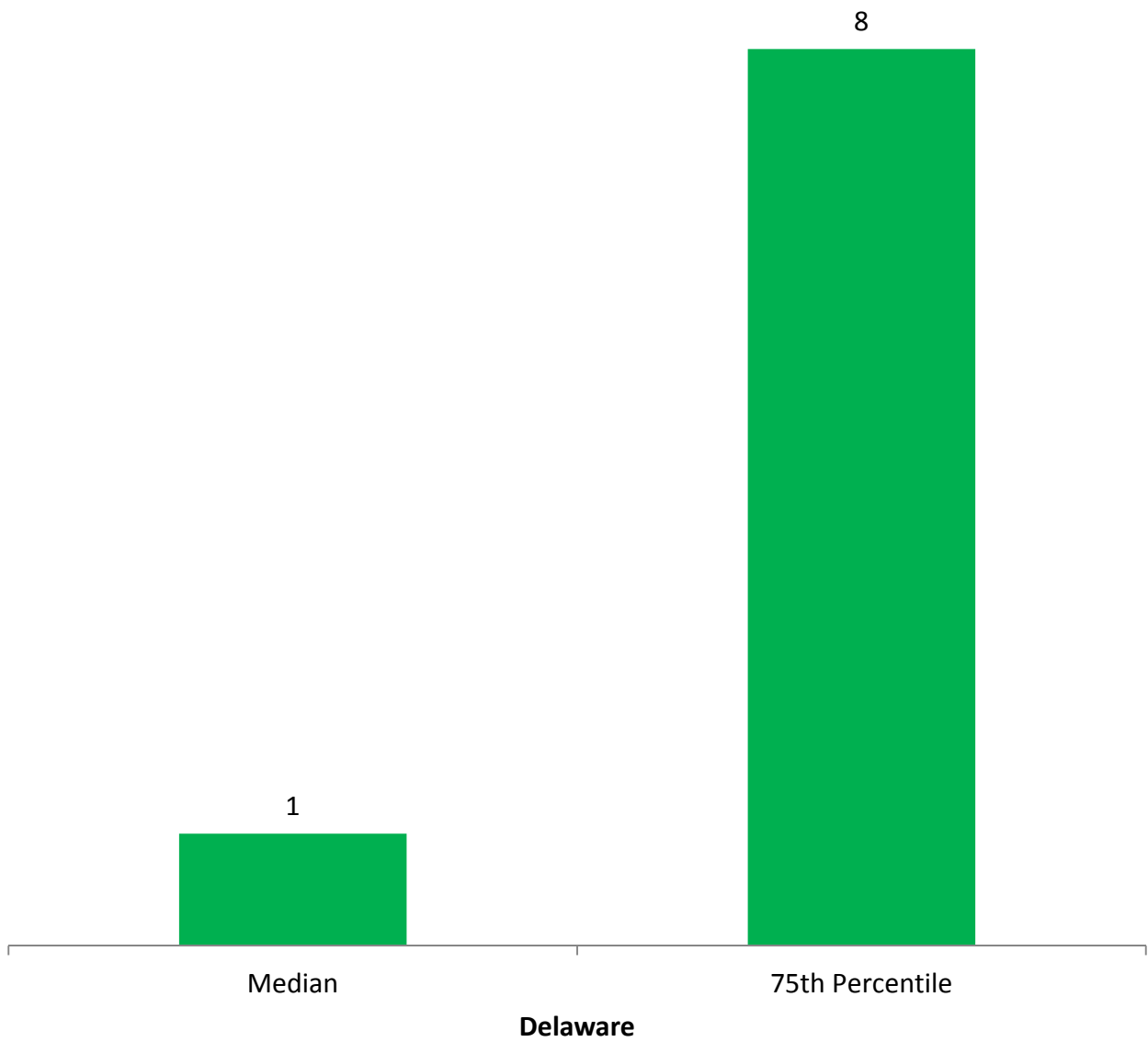
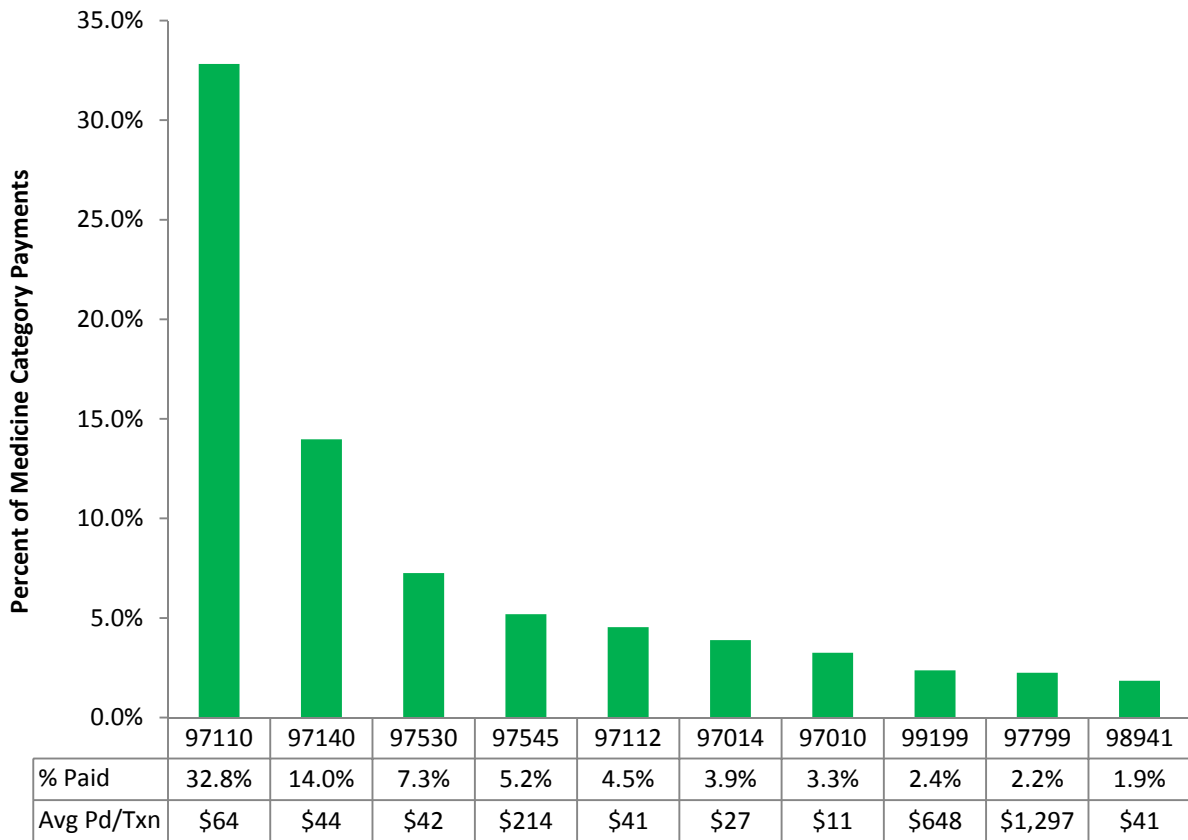


Exhibit 15

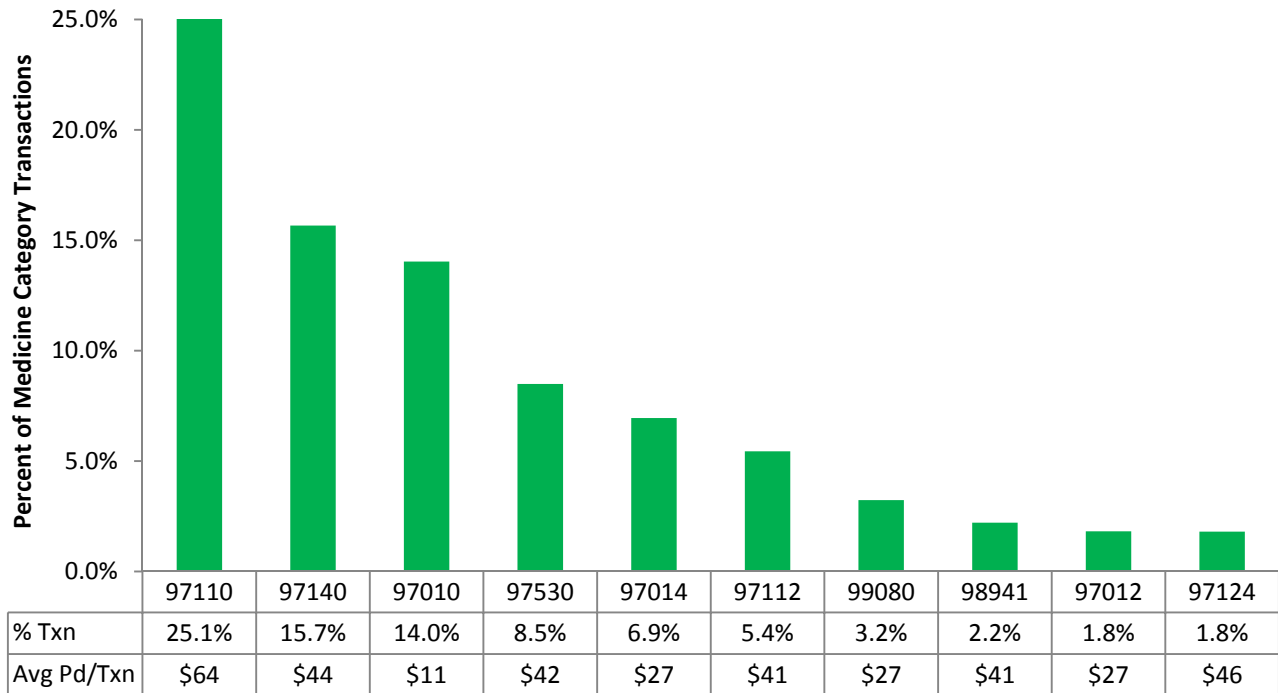
Top 10 Physical and General Medicine Procedure Codes by Amount Paid



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97010	Application of a modality to 1 or more areas; hot or cold packs
99199	Unlisted special service, procedure or report
97799	Unlisted physical medicine/rehabilitation service or procedure
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions

Exhibit 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97010	Application of a modality to 1 or more areas; hot or cold packs
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
97012	Application of a modality to 1 or more areas; traction, mechanical
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

Exhibit 17

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

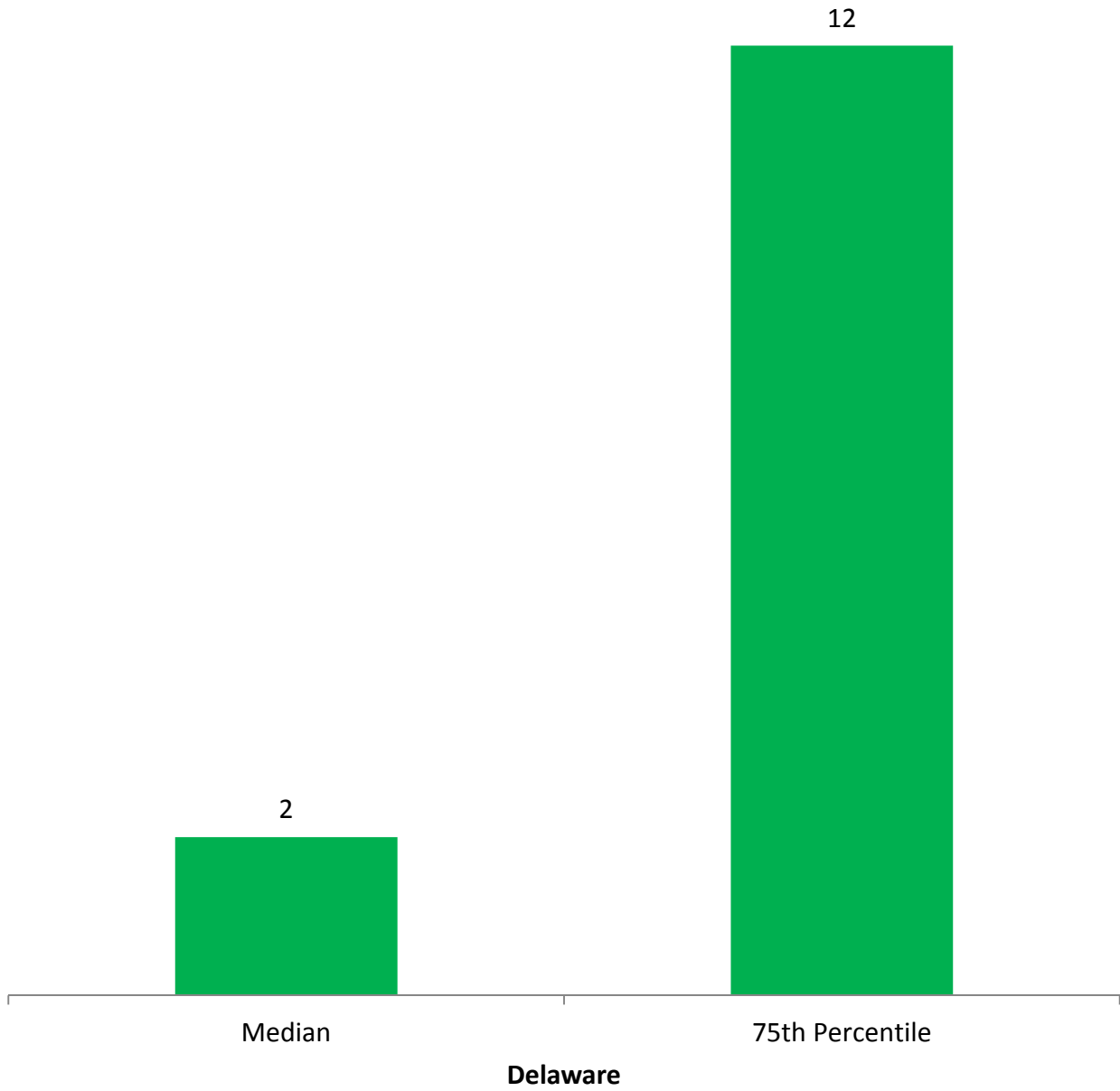
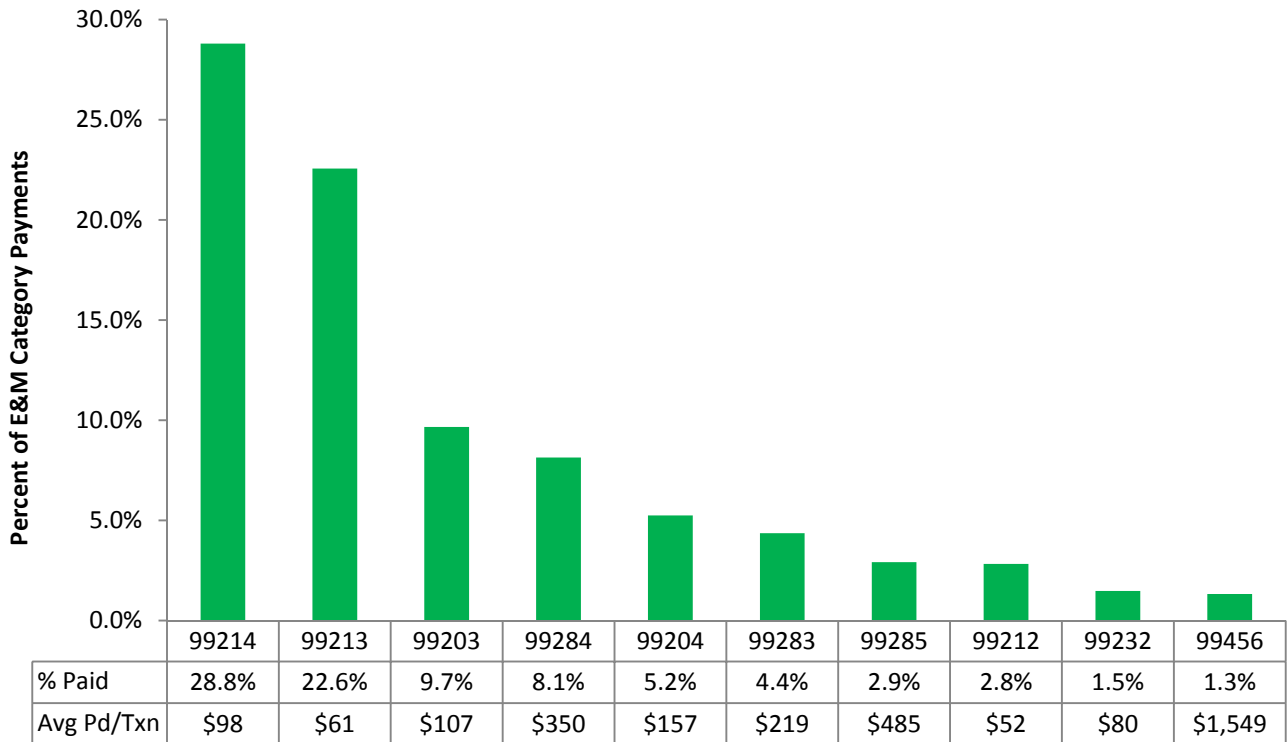


Exhibit 18

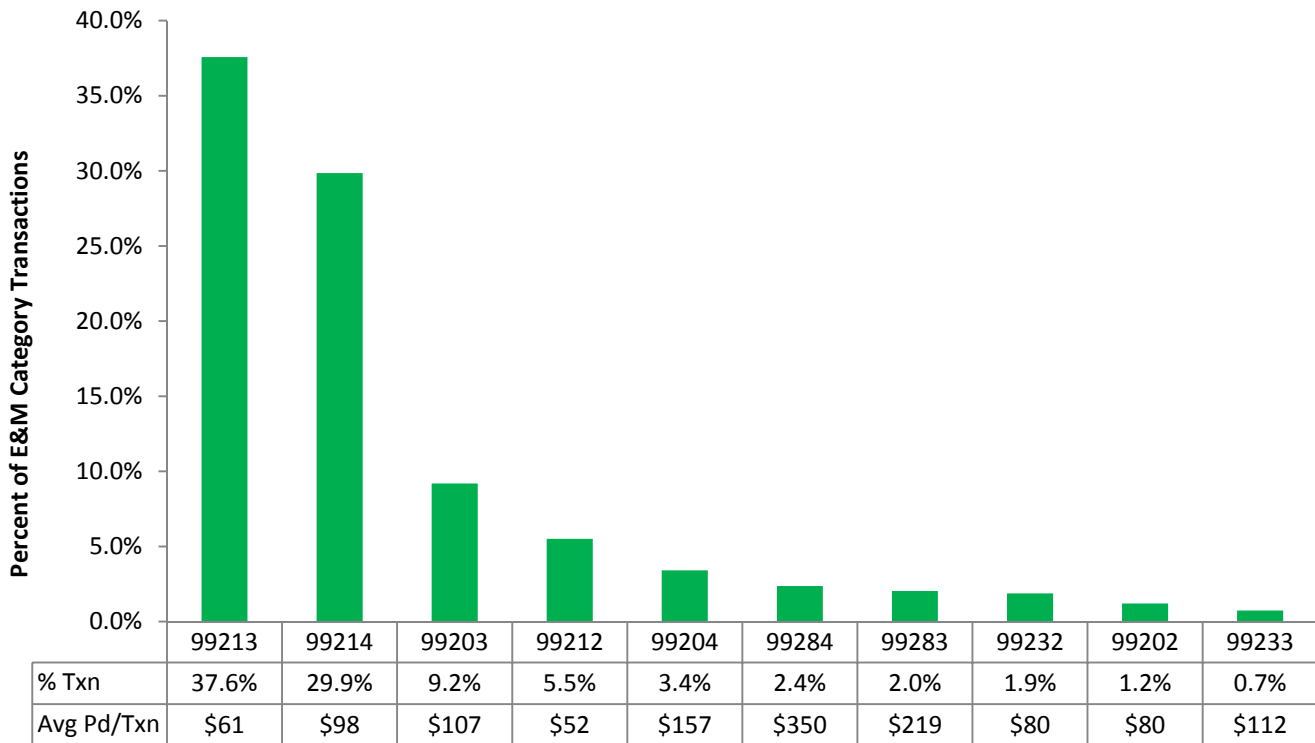
Top 10 Evaluation & Management Procedure Codes by Amount Paid



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

Exhibit 19

Top 10 Evaluation & Management Procedure Codes by Transaction Counts



Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 25 minutes are spent face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 45 minutes are spent face-to-face with the patient and/or family.
99284	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99283	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99202	Office or other outpatient visit for the evaluation and management of a new patient. Typically, 20 minutes are spent face-to-face with the patient and/or family.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

Exhibit 20

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

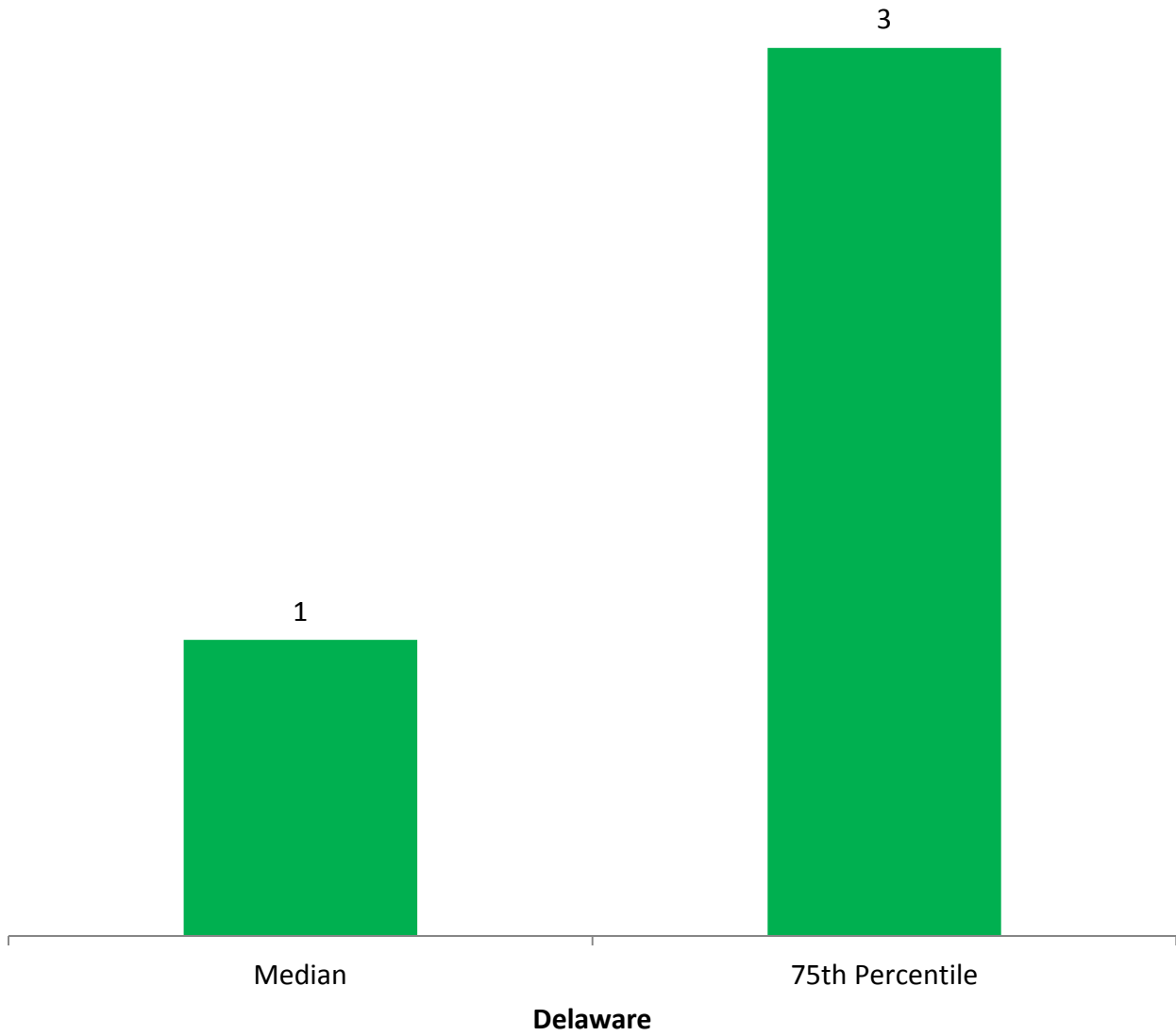


Exhibit 21-22
Top 10 Evaluation & Management Procedure Codes Trend

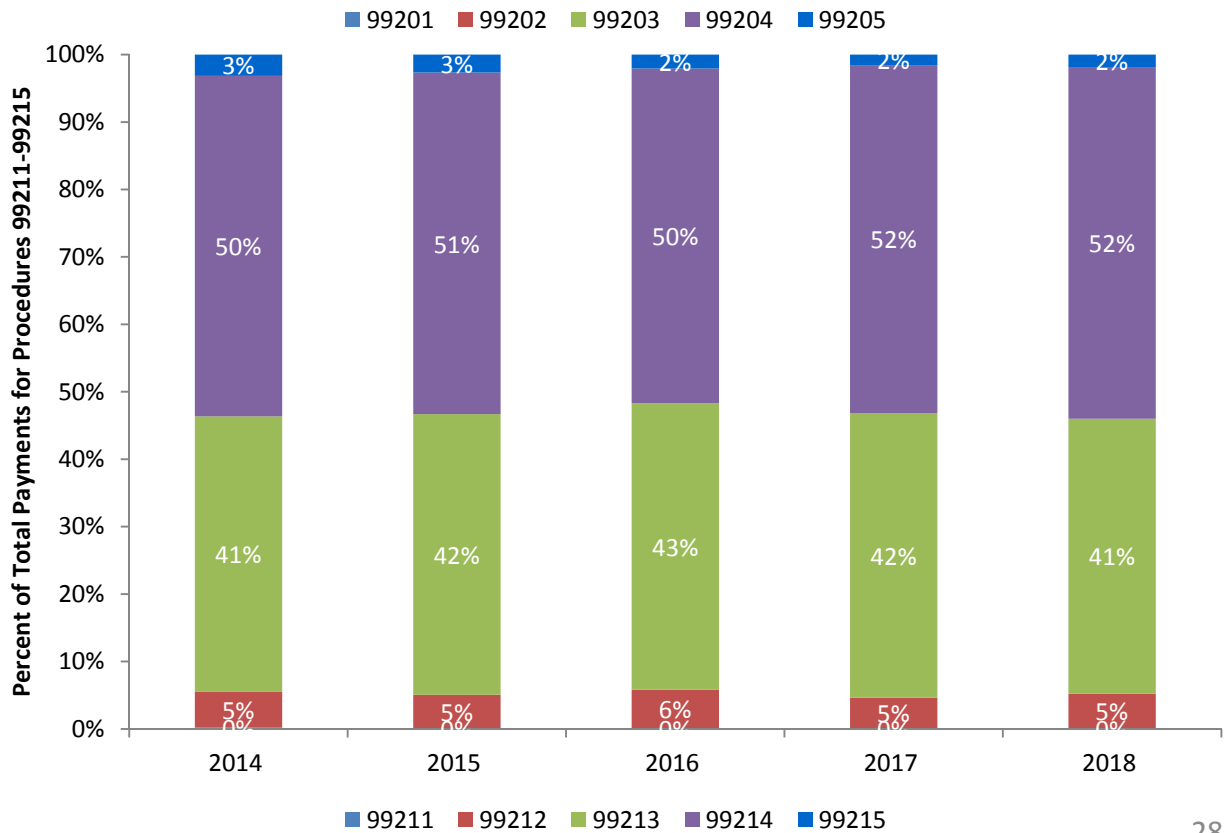
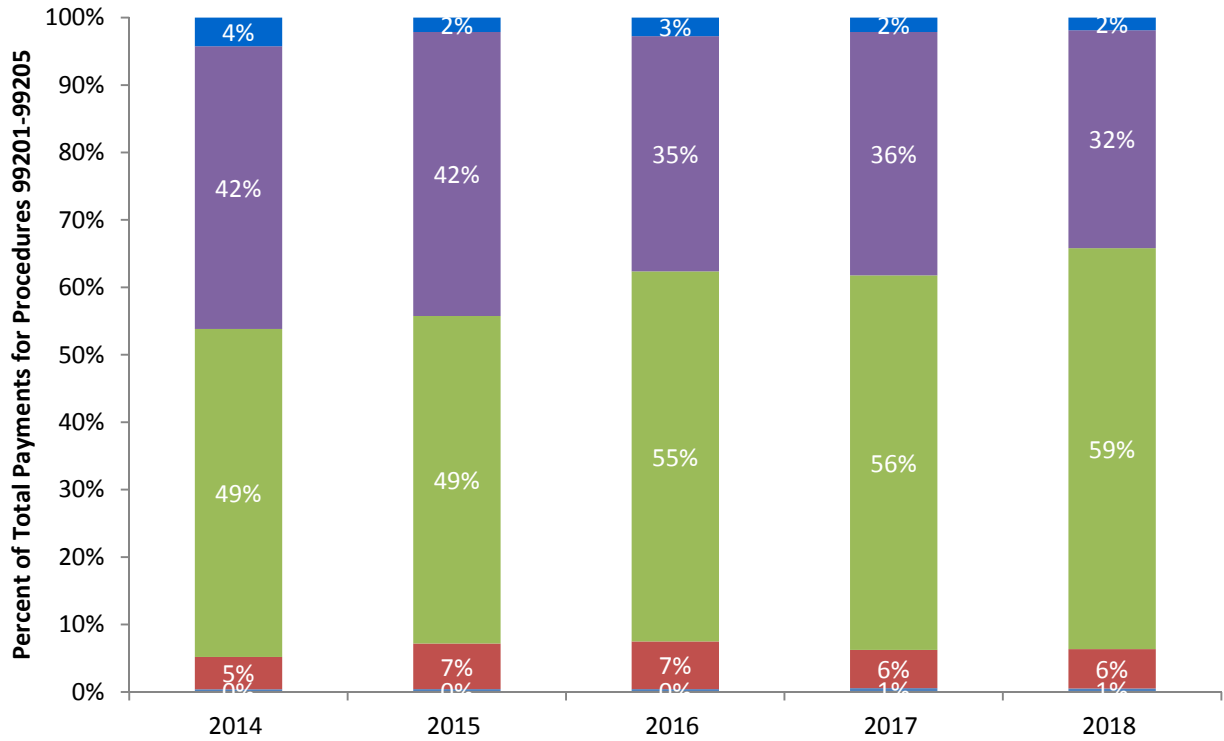


Exhibit 21-22 (cont'd)
Top 10 Evaluation & Management Procedure Codes Trend

Average Paid Per Transaction

Code	Severity/Time	Average Paid Per Transaction				
		2014	2015	2016	2017	2018
99201	Low to Moderate; 10 minutes with patient	\$69	\$63	\$65	\$64	\$59
99202	Low to Moderate; 20 minutes with patient	\$102	\$97	\$97	\$80	\$80
99203	Moderate; 30 minutes with patient	\$137	\$128	\$125	\$107	\$107
99204	Moderate to High; 45 minutes with patient	\$207	\$191	\$181	\$159	\$157
99205	Moderate to High; 60 minutes with patient	\$236	\$217	\$217	\$197	\$197

Code	Severity/Time	Average Paid Per Transaction				
		2014	2015	2016	2017	2018
99211	Low to Moderate; 5 minutes with patient	\$31	\$27	\$27	\$25	\$22
99212	Low to Moderate; 10 minutes with patient	\$62	\$53	\$57	\$50	\$52
99213	Moderate; 15 minutes with patient	\$81	\$74	\$72	\$61	\$61
99214	Moderate to High; 25 minutes with patient	\$131	\$120	\$113	\$98	\$98
99215	Moderate to High; 40 minutes with patient	\$175	\$155	\$147	\$139	\$148

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 2018 Delaware inpatient hospital DRG fee schedule to the "DRG Summary for Medicare Inpatient Prospective Payment Hospitals, FY2017." 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 121% to 147% of Medicare, depending on the Delaware geo zip.

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

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 exhibit allows us to better understand the most frequently billed DRG codes. DRG codes are defined as a system to classify hospital cases into one of approximately 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 2018. 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

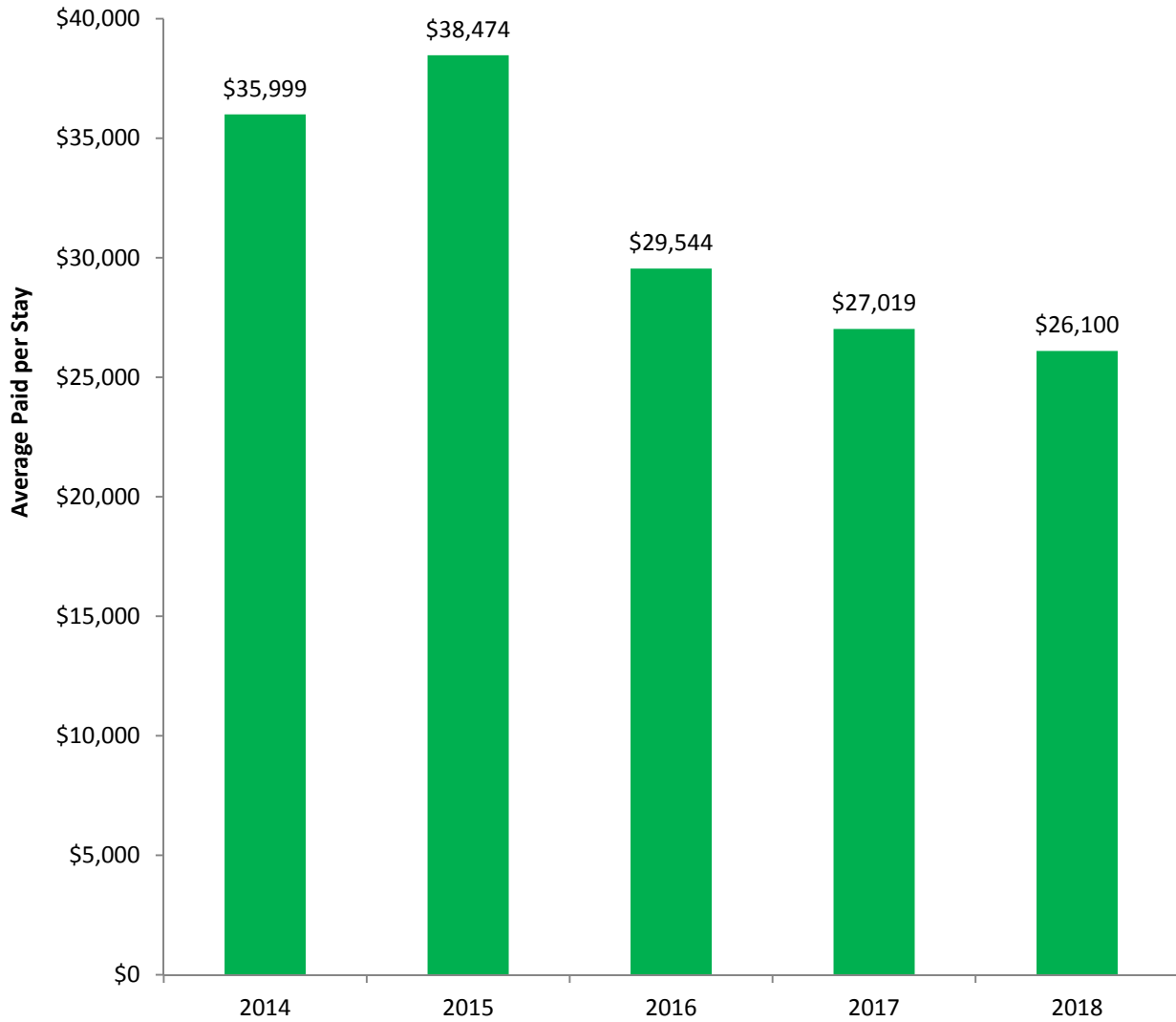


Exhibit 24 presents the average paid amount per stay for a Hospital Inpatient service by service year. This exhibit illustrates the trend of payments over a period of five service years.

Exhibit 25
Average Paid Amount per Day for Hospital Inpatient Services

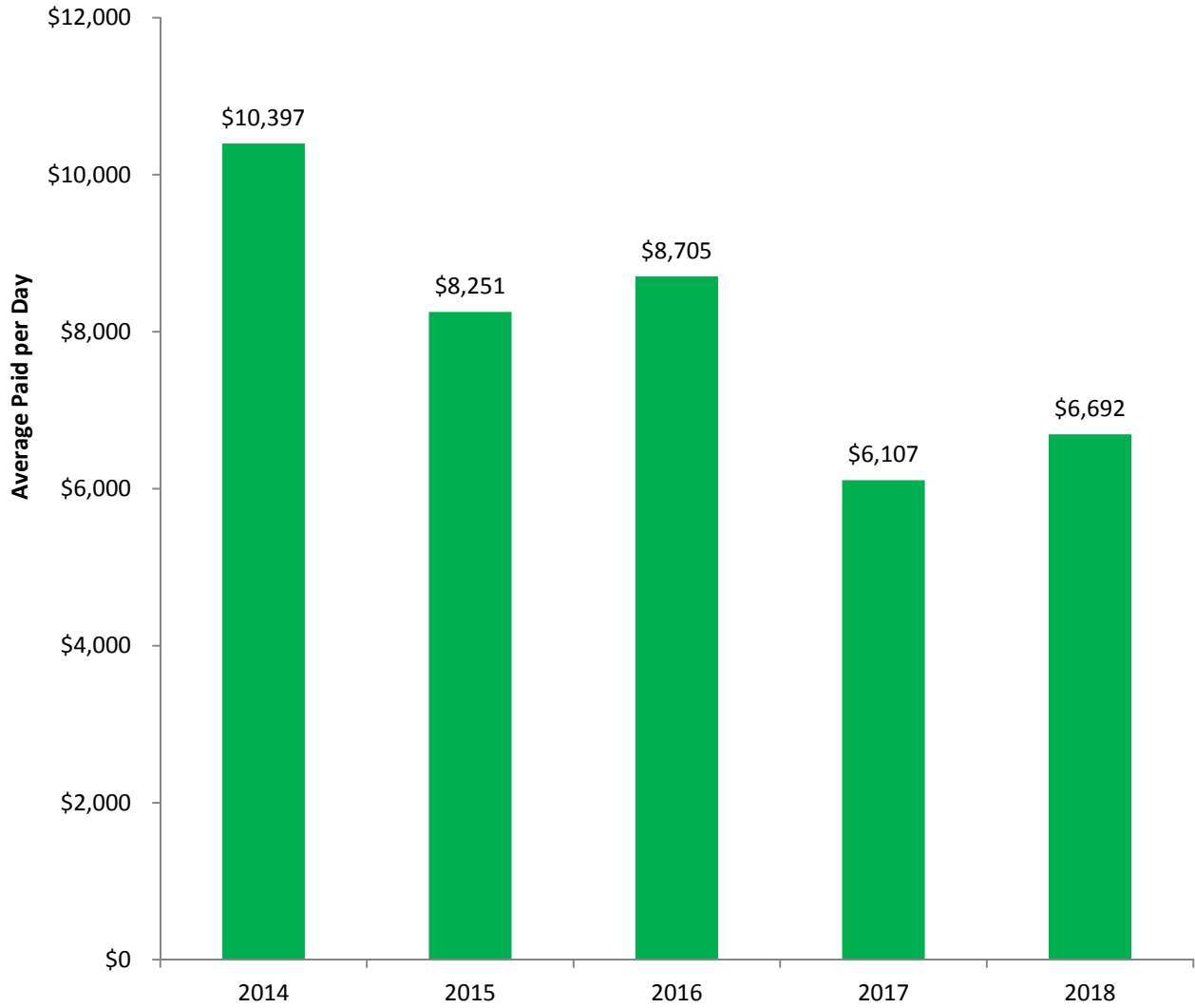


Exhibit 25 presents the average paid amount per day for Hospital Inpatient services by service year. This exhibit displays the pattern of payments over period of five service years.

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

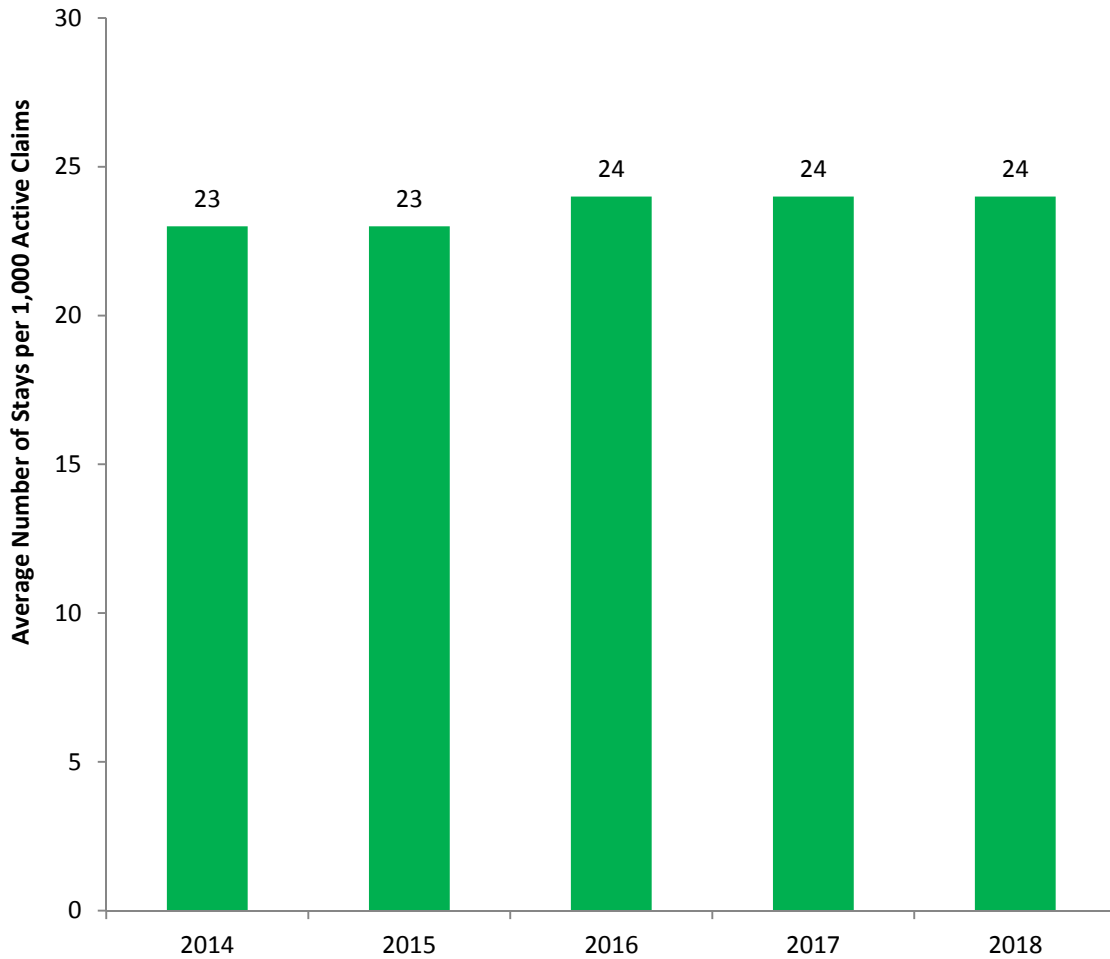


Exhibit 26 displays the average number of inpatient stays per 1,000 active claims by service year. This exhibit illustrates the trend in average number of stays over a period of five service years.

Exhibit 27
Inpatient Length of Stay for Hospital Inpatient Services

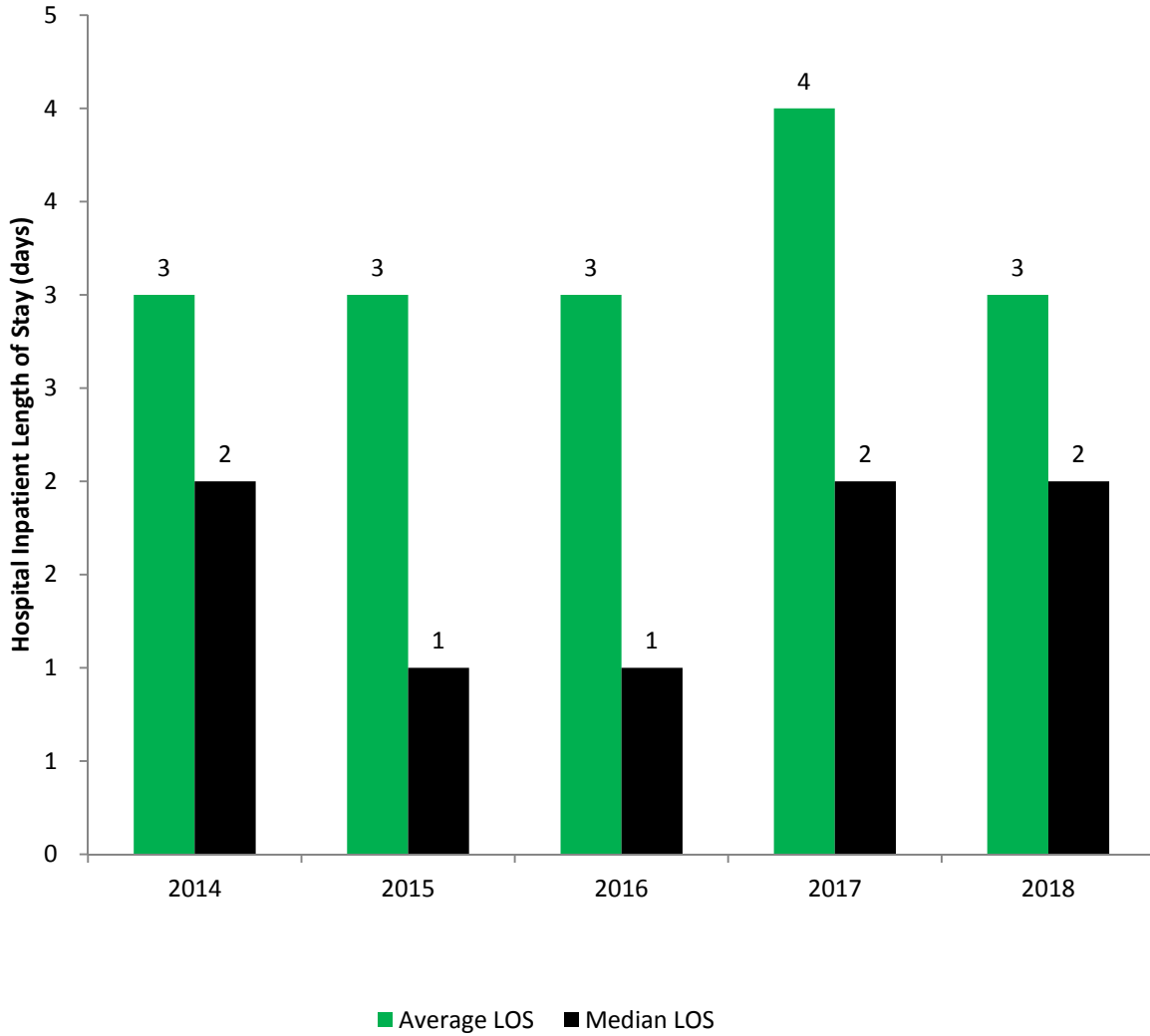


Exhibit 27 provides the average and median lengths of Hospital Inpatient stays over a five-year service period. This information suggests consistency in length of stay over the period examined.

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

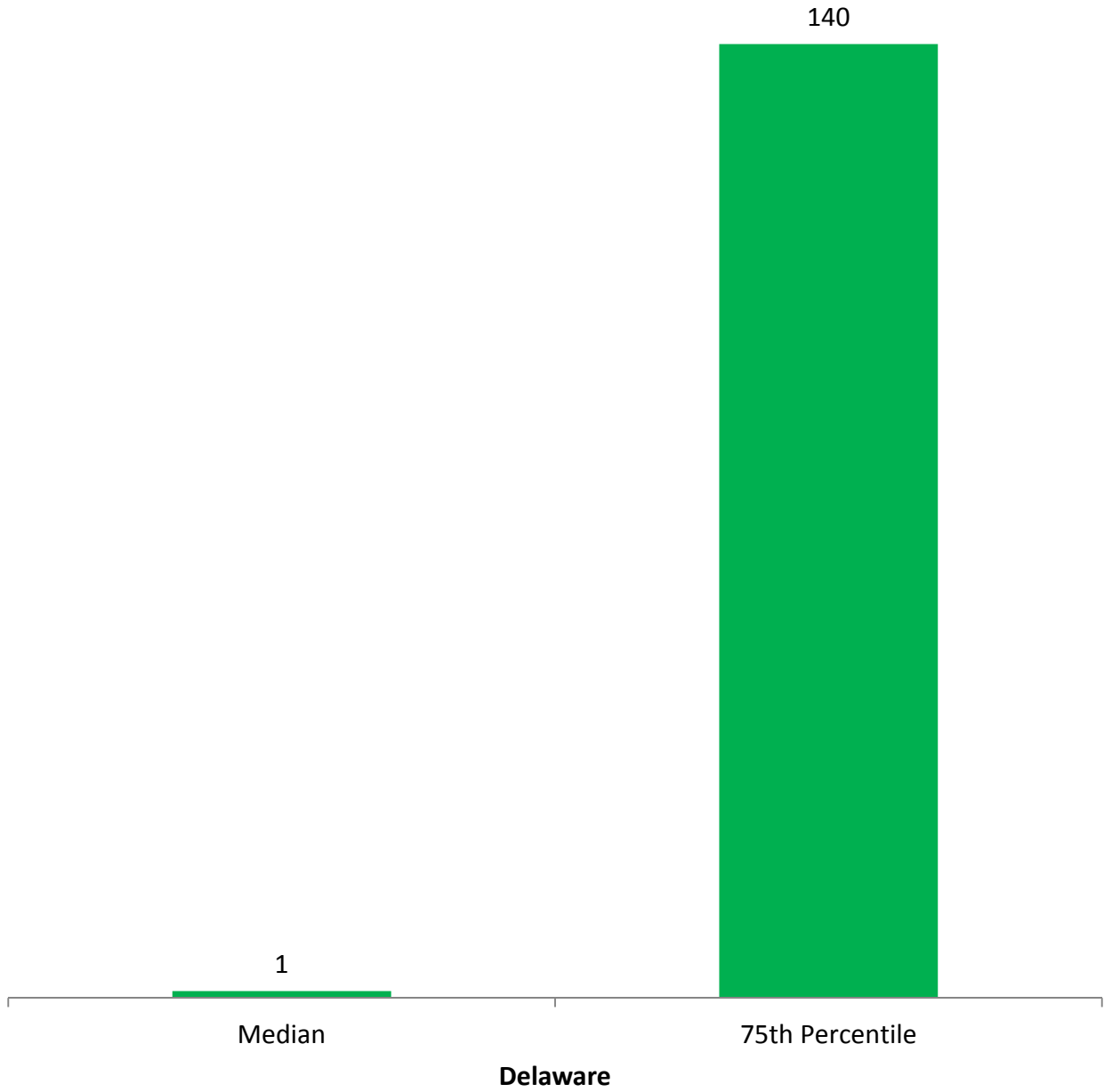


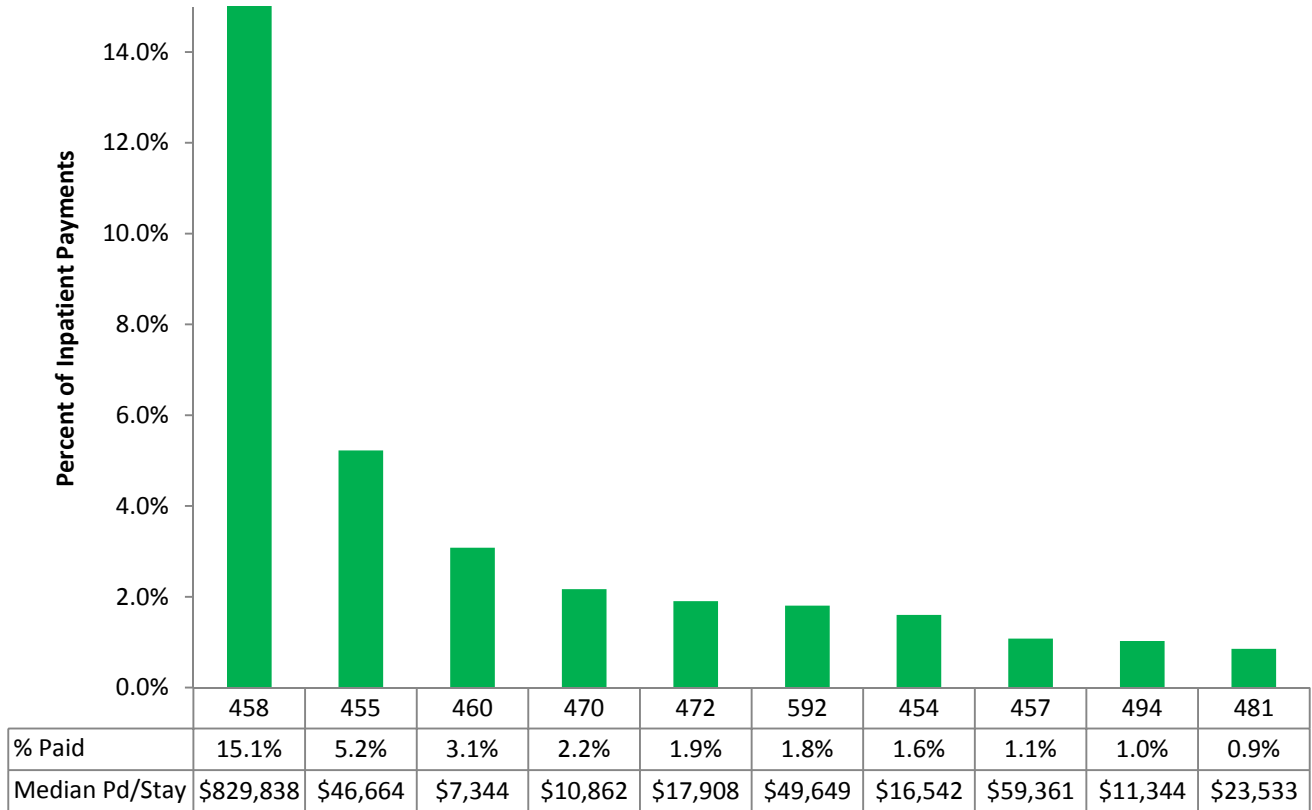
Exhibit 29

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

Diagnosis Group	Paid Share	Median Amount Paid Per Stay
Other dorsopathies	27.6%	\$32,785
Burns and corrosions of external body surface, specified by site	16.0%	\$38,576
Complications of surgical and medical care, NOC	10.5%	\$15,046
Spondylopathies	7.1%	\$19,835
Osteoarthritis	4.3%	\$15,669
Injuries to the hip and thigh	1.9%	\$14,437
Injuries to the knee and lower leg	1.9%	\$13,916
Other disorders of the skin and subcutaneous tissue	1.8%	\$49,649
Diabetes mellitus	1.8%	\$38,761
Other bacterial diseases	1.8%	\$16,515

Exhibit 30

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services



Code	Description
458	Spinal fusion except cervical with spinal curvature or malignancy or infection or extensive fusions without complications or comorbidities/major complications or comorbidities
455	Combined anterior/posterior spinal fusion without complications or comorbidities/major complications or comorbidities
460	Spinal fusion except cervical without major complications or comorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
472	Cervical spinal fusion with complications or comorbidities
592	Skin ulcers with major complications or comorbidities
454	Combined anterior/posterior spinal fusion with complications or comorbidities
457	Spinal fusion except cervical with spinal curvature or malignancy or infection or extensive fusions with complications or comorbidities
494	Lower extremity and humerus procedures except hip, foot, and femur without complication or comorbidity/major complication or comorbidity
481	Hip and femur procedures except major joint with complications or comorbidities

Exhibit 31

Hospital Outpatient Payments as a Percentage of Medicare

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

The Delaware workers' compensation health care payment system (HCPS) effective 1/31/15 moved towards an RBRVS, MS-DRG, and APC based system. While the Workers' Compensation Oversight Panel ("Panel") used these tools to form the foundation of the HCPS, Delaware has not adopted Medicare rules for workers' compensation. The Panel developed these Delaware specific rules and regulations to govern the HCPS. The HCPS does not support health care service or payment denials based on Medicare rules. The Delaware workers' compensation health care practice guidelines remain in effect and care is presumed compensable when followed. These regulations do not define compensable care, but rather a maximum allowable reimbursement (MAR). The Delaware workers' compensation regulations supersede when a conflict exists with the Centers for Medicare and Medicaid (CMS) rules.

Hospital Outpatient Payments

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

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

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 2018. 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

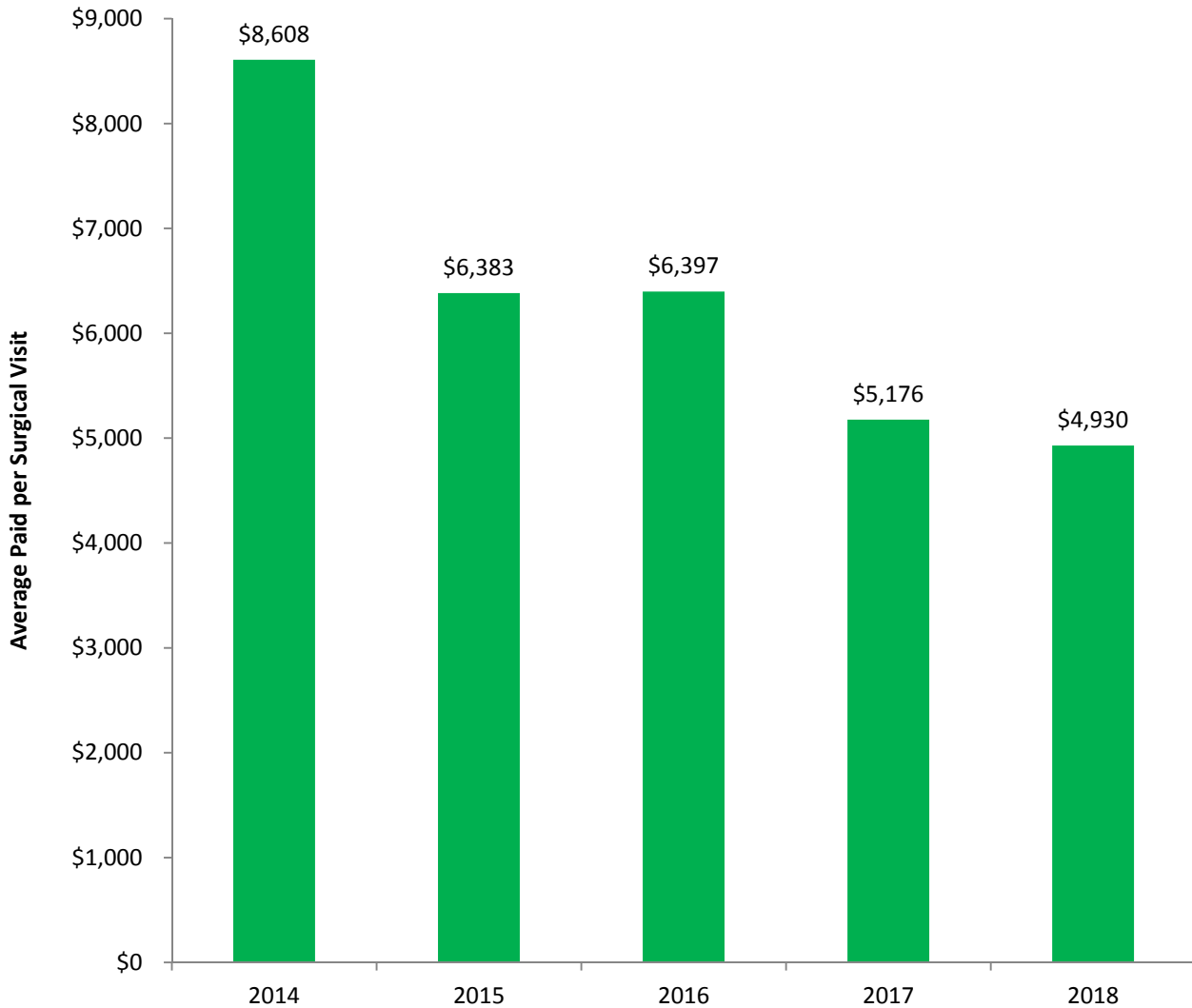


Exhibit 32 presents the average outpatient paid amount per surgical visit for Hospital Outpatient services by service year. This exhibit illustrates payments over period of five consecutive service years.

Exhibit 33

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

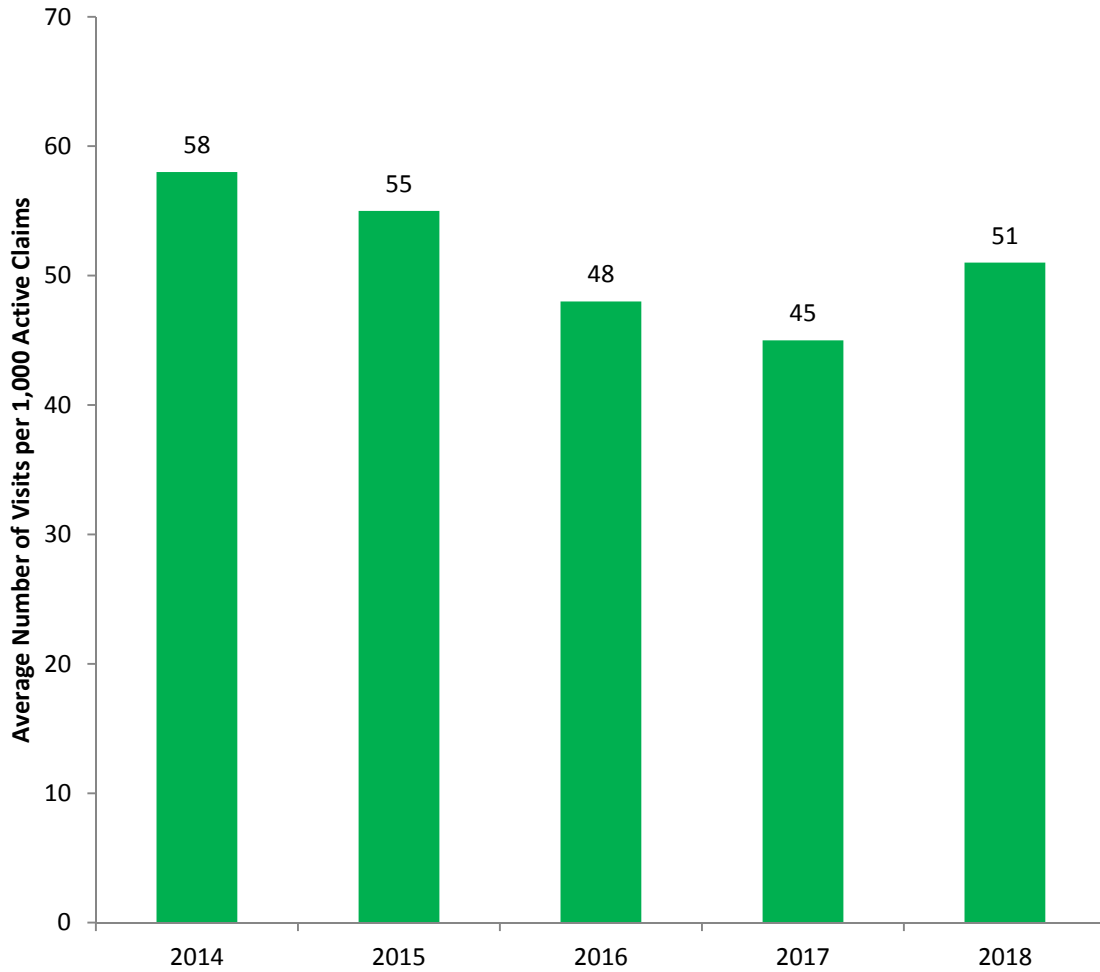


Exhibit 33 presents the average number of surgical Hospital Outpatient visits per 1,000 active claims.

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

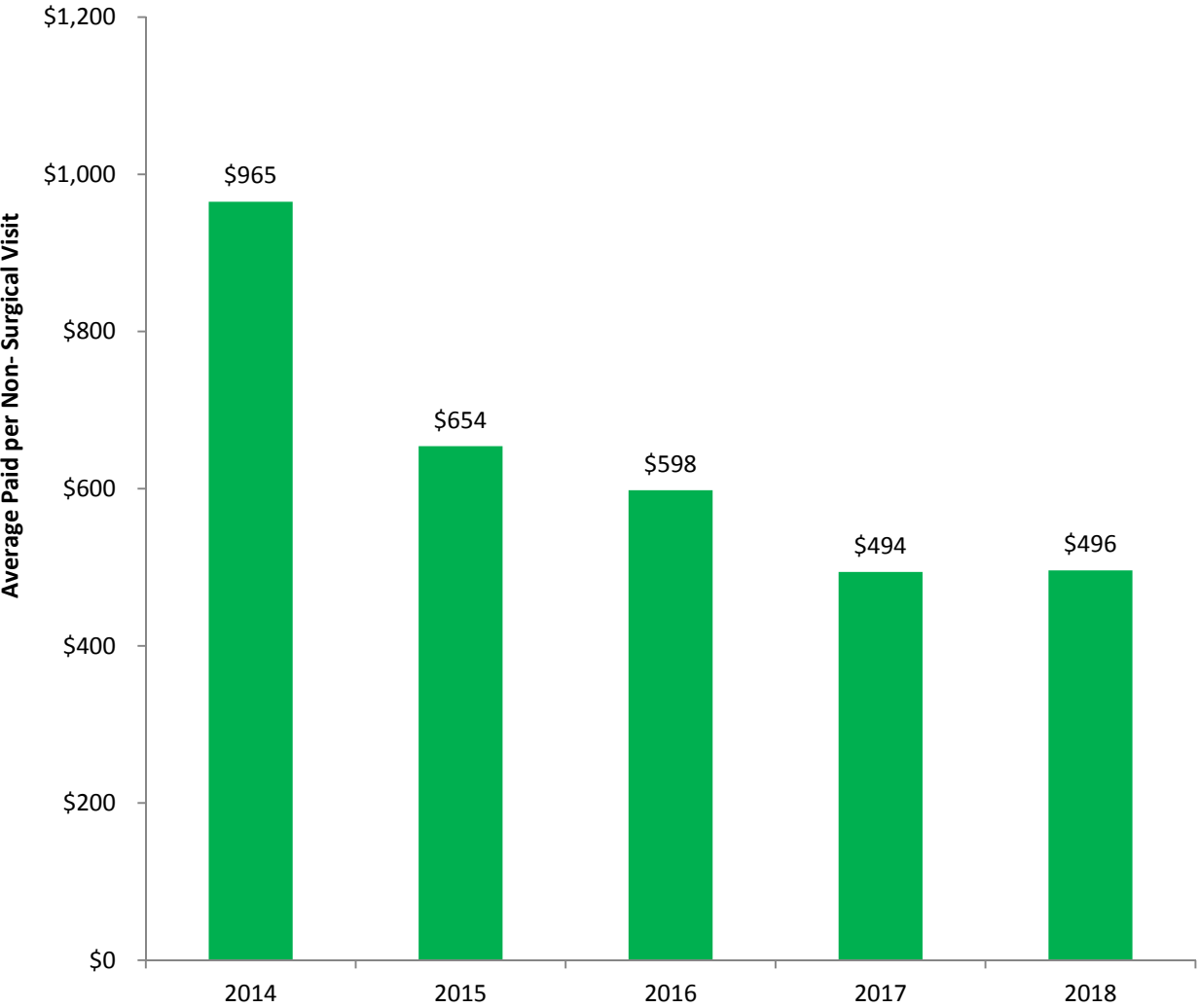


Exhibit 34 presents the average outpatient paid amount per non-surgical visit for Hospital Outpatient services by service year. This exhibit illustrates payments over a period of five consecutive service years.

Exhibit 35

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

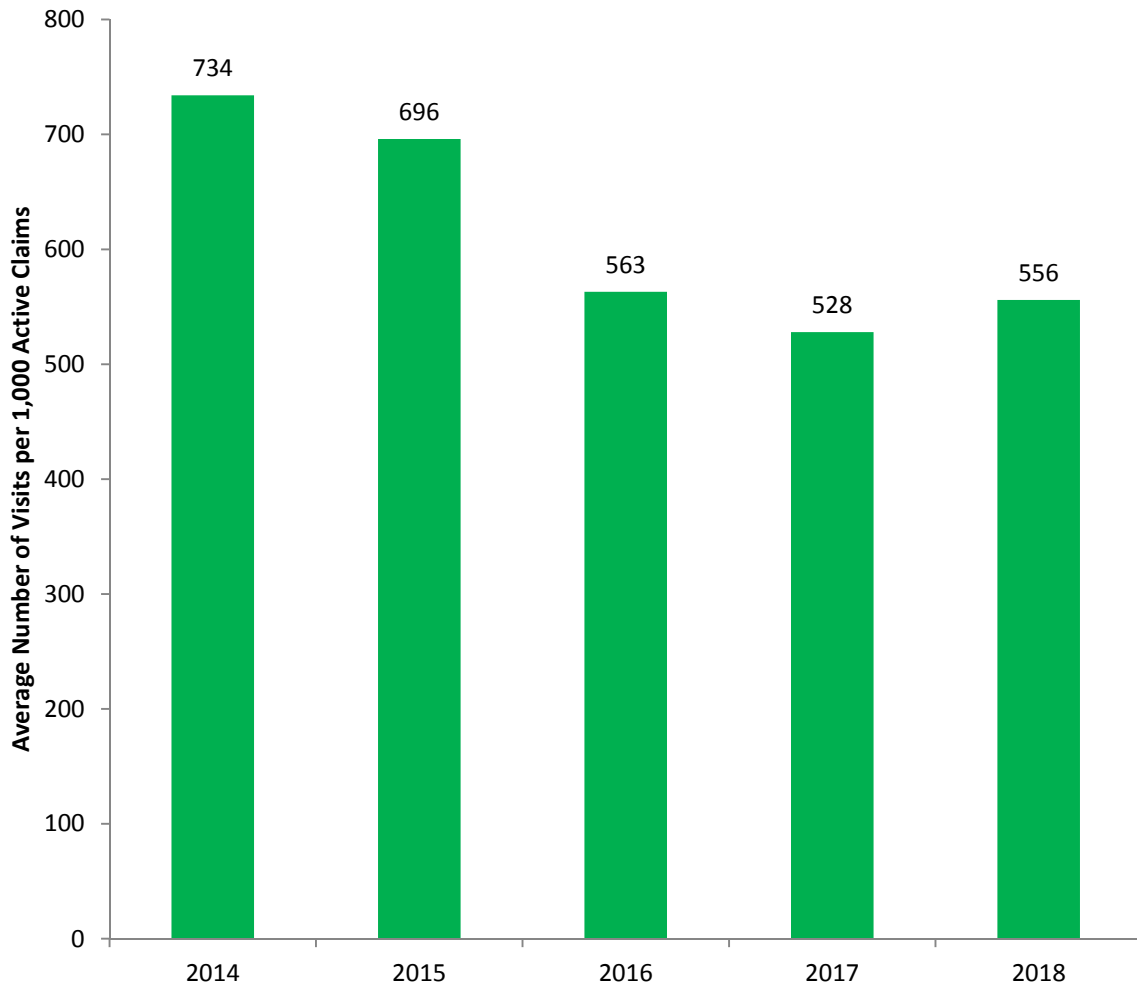


Exhibit 35 presents the average number of non-surgical Hospital Outpatient visits per 1,000 active claims.

Exhibit 36

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

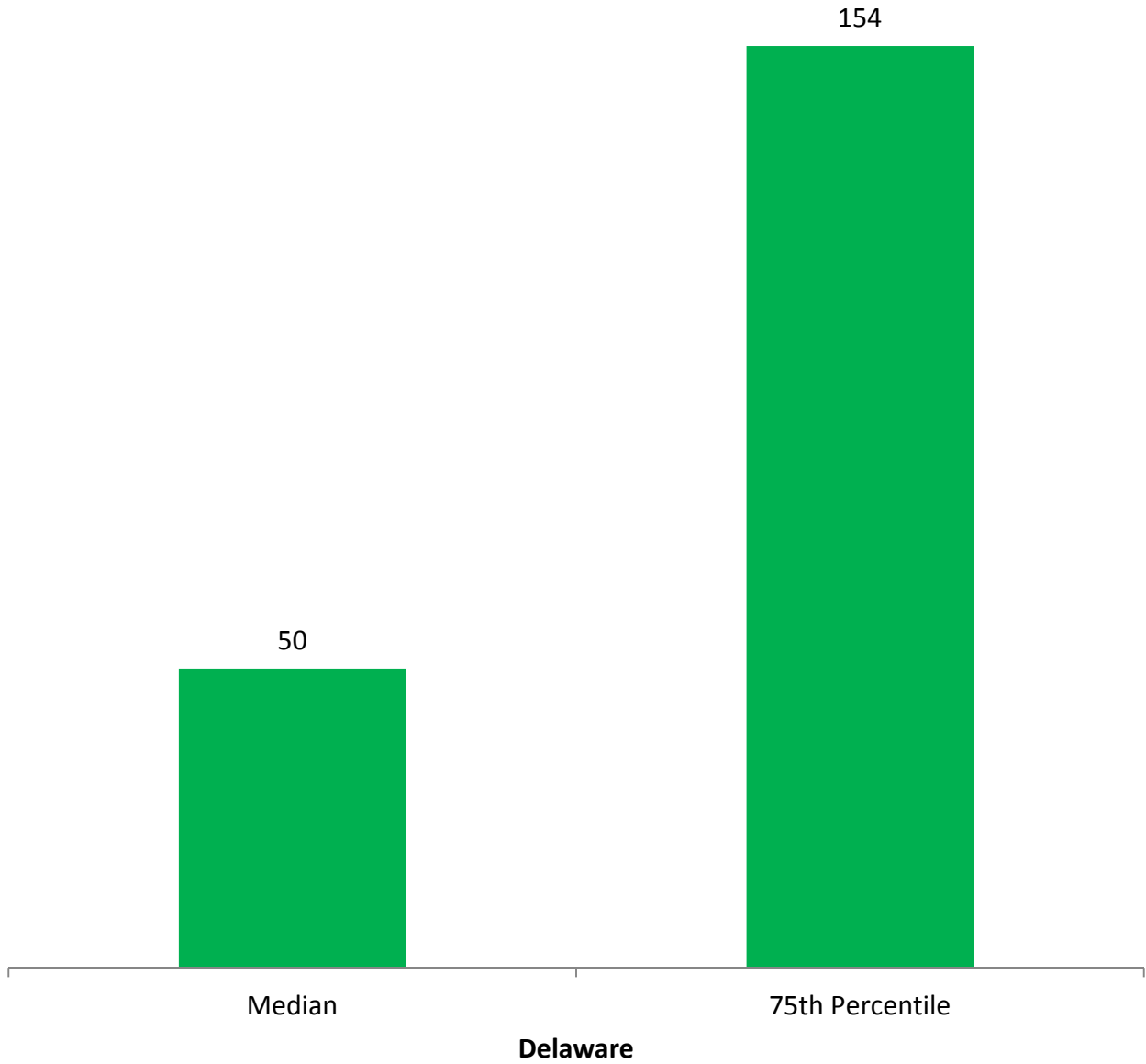


Exhibit 37
Time Until First Treatment for All Other Outpatient Visits (in Days)

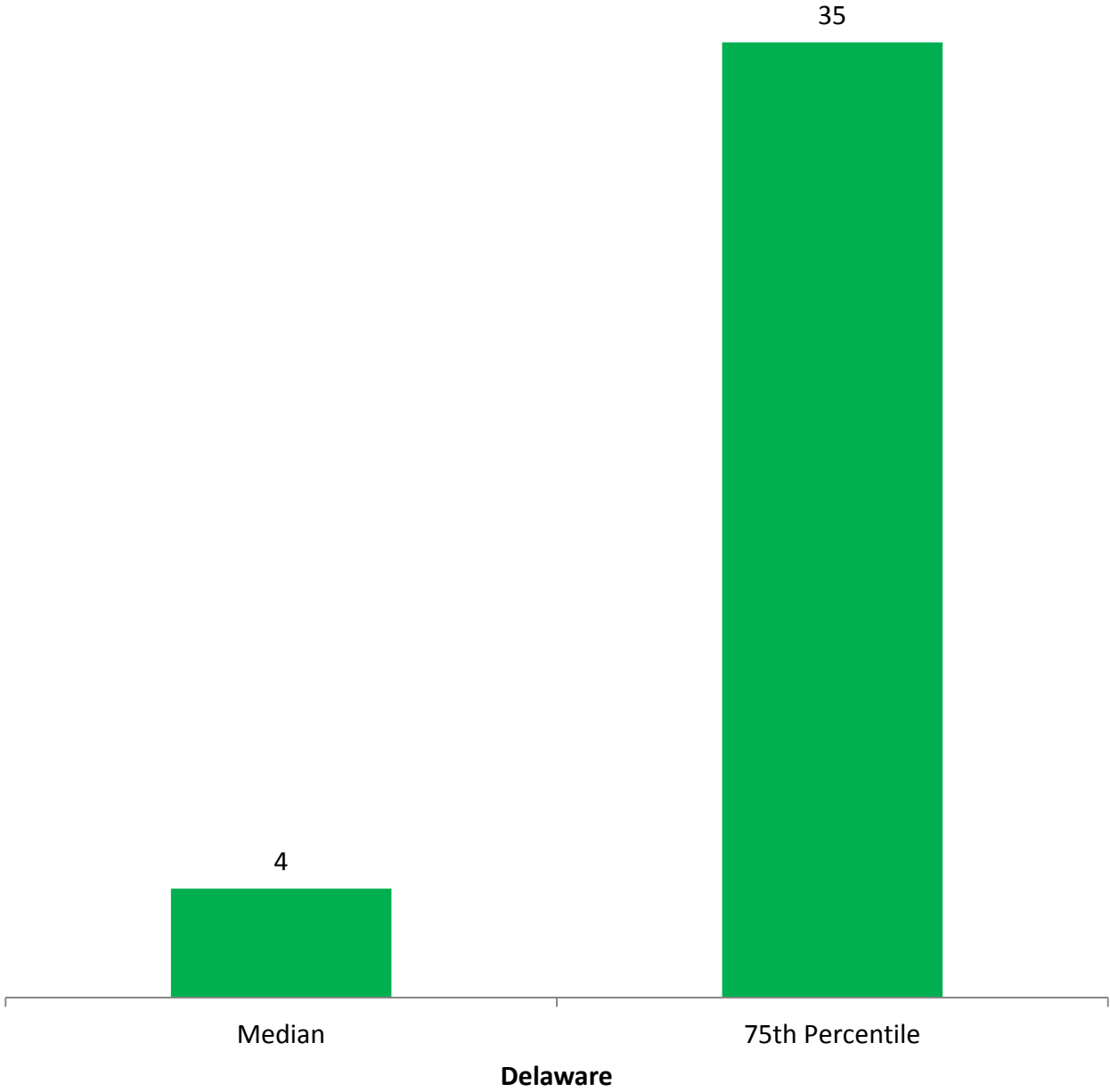


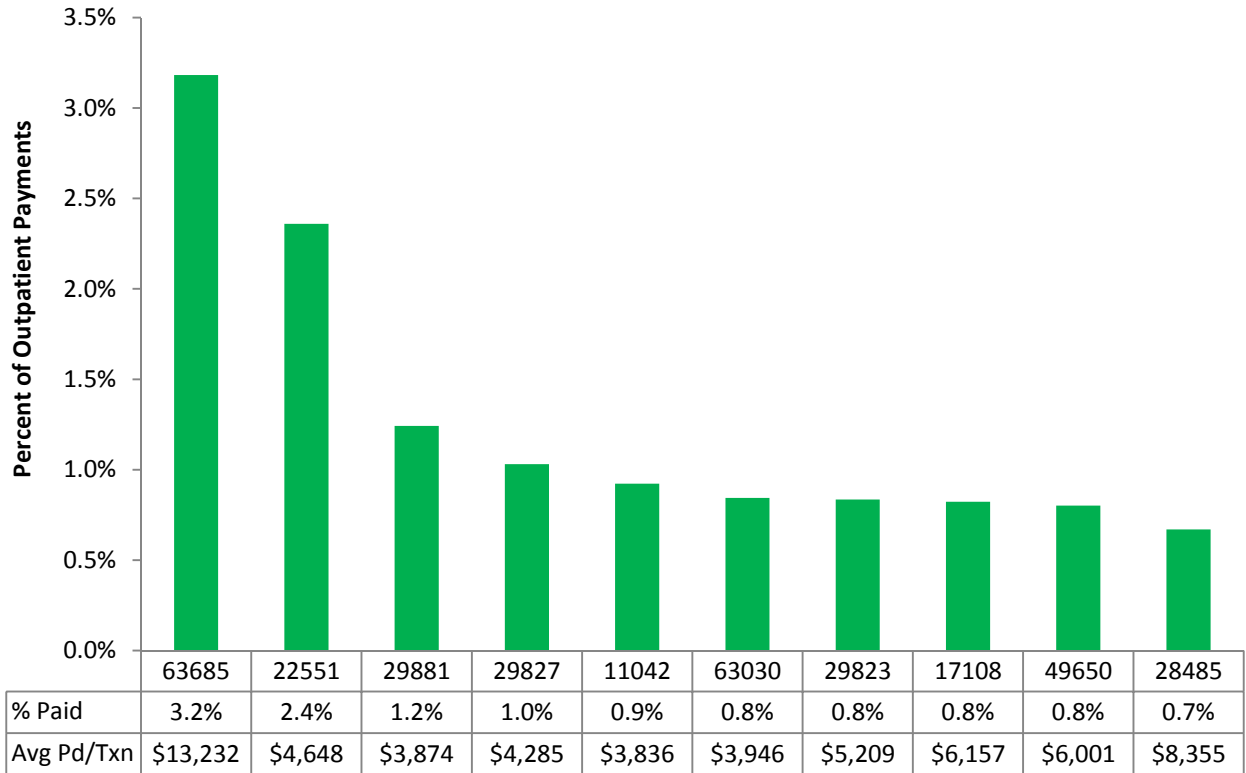
Exhibit 38

Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services

Diagnosis Group	Paid Share	Median Amount Paid Per Visit
Other dorsopathies	19.0%	\$337
Injuries to the knee and lower leg	8.8%	\$390
Other disorders of the nervous system	7.2%	\$513
Injuries to the wrist, hand and fingers	7.1%	\$270
Other soft tissue disorders	7.0%	\$257
Other joint disorders	5.9%	\$411
Injuries to the shoulder and upper arm	4.0%	\$514
Injuries to the elbow and forearm	3.9%	\$240
Hernia	3.6%	\$4,170
Spondylopathies	3.5%	\$308

Exhibit 39

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



Code	Description
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below c2
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
29823	Arthroscopy, shoulder, surgical; debridement, extensive
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm
49650	Laparoscopy, surgical; repair initial inguinal hernia
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each

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



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
99283	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of moderate severity.
73221	Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material
99284	Emergency department visit for the evaluation and management of a patient. The presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views

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, but sorted on transaction counts instead of paid amounts.

The source for all data is the DCRB Medical Data Call for Service Year 2018. 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

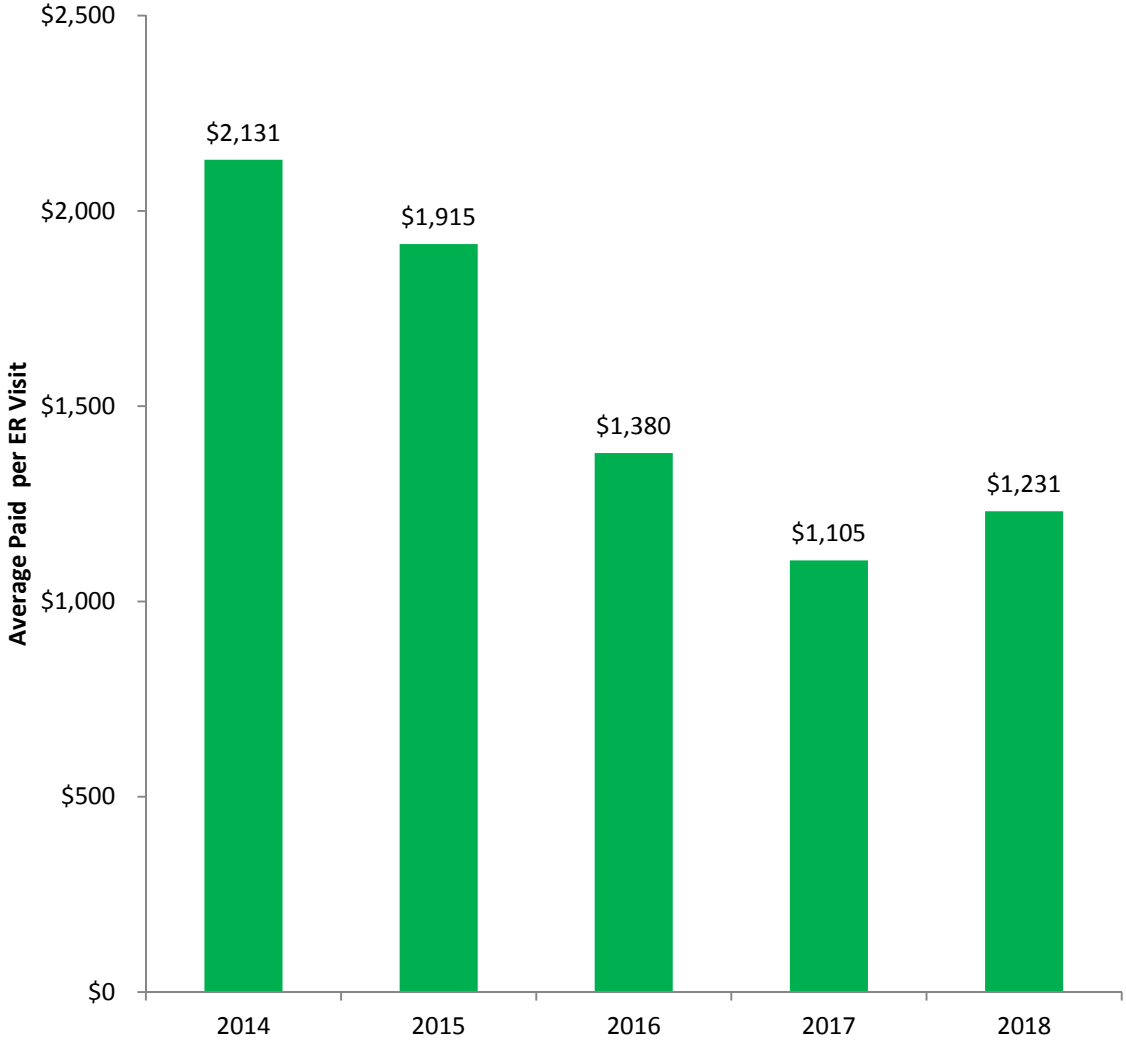


Exhibit 41 depicts the average amount paid per Emergency Room visit by service year. These results demonstrate a decline over the last five service years in the average amount paid per visit.

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

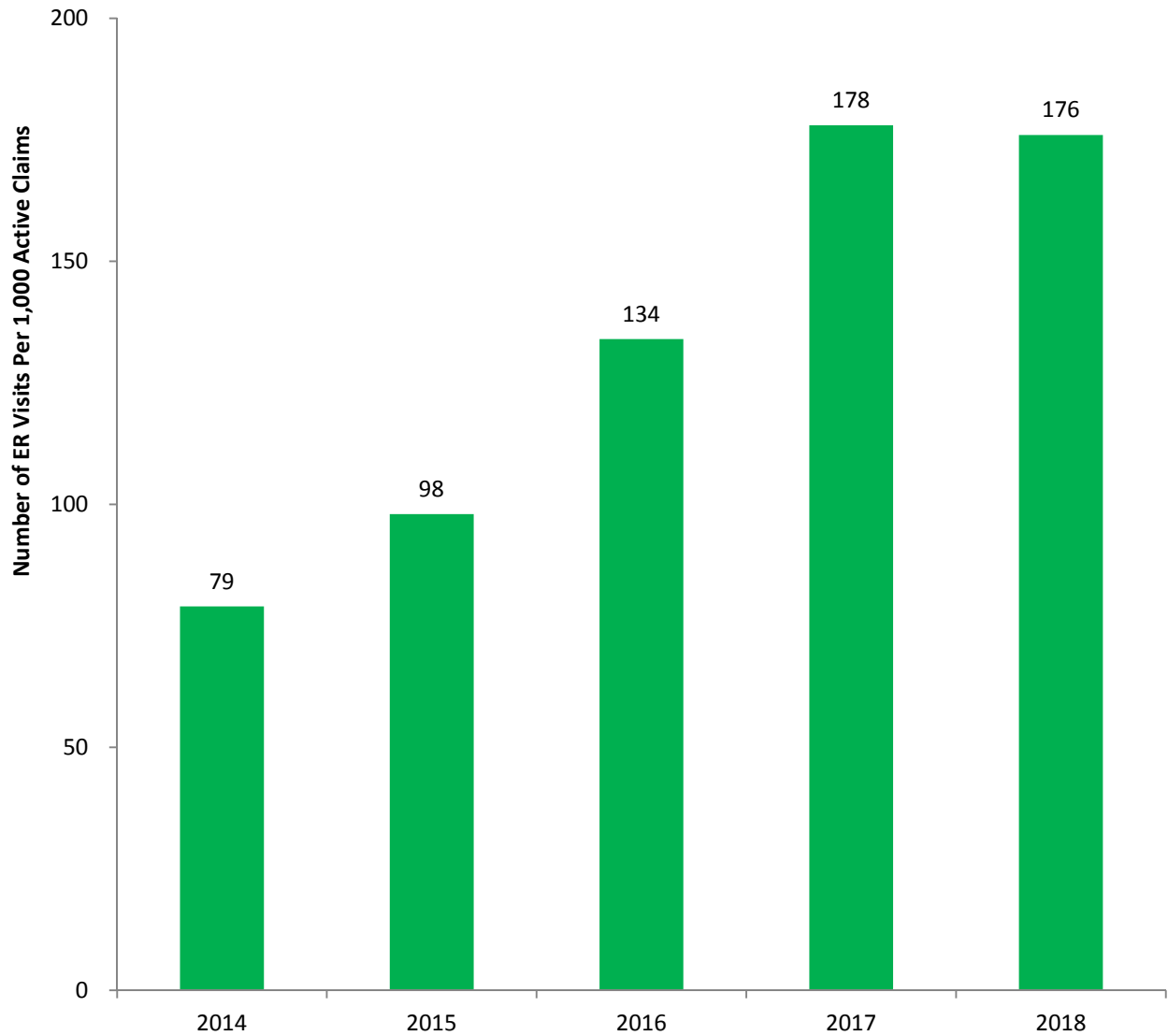


Exhibit 42 displays the number of emergency room visits per 1,000 active claims by service year. These results demonstrate an increasing trend in the number of Emergency Room visits over the last five years.

Exhibit 43
Emergency Room Services by Procedure Codes Trend

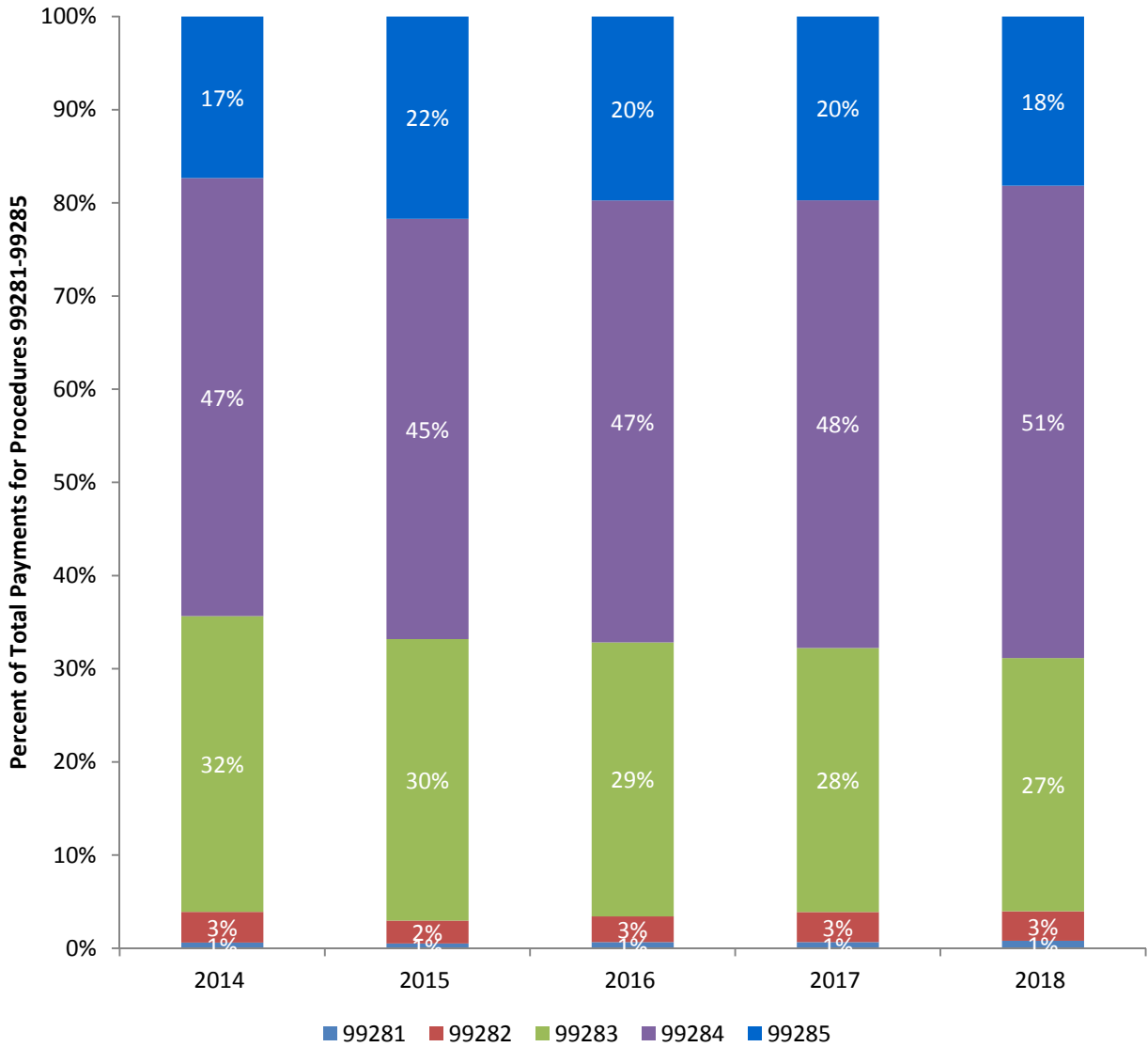


Exhibit 43 displays Emergency Room services by procedure codes trend by service year. This exhibit displays the distribution of payments for a period of five service years.

Refer to the Exhibit 43 continuation on the next page for the description of codes 99281-99285.

Exhibit 43 (continued)
Top 5 Emergency Room Services by Procedure Codes Trend

Average Paid Per Transaction

	2014	2015	2016	2017	2018
99281	\$91	\$96	\$111	\$93	\$140
99282	\$154	\$146	\$143	\$163	\$145
99283	\$242	\$245	\$242	\$207	\$219
99284	\$378	\$356	\$382	\$341	\$350
99285	\$553	\$593	\$552	\$469	\$485

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

Exhibit 44
Emergency Room Transactions by Procedure Code

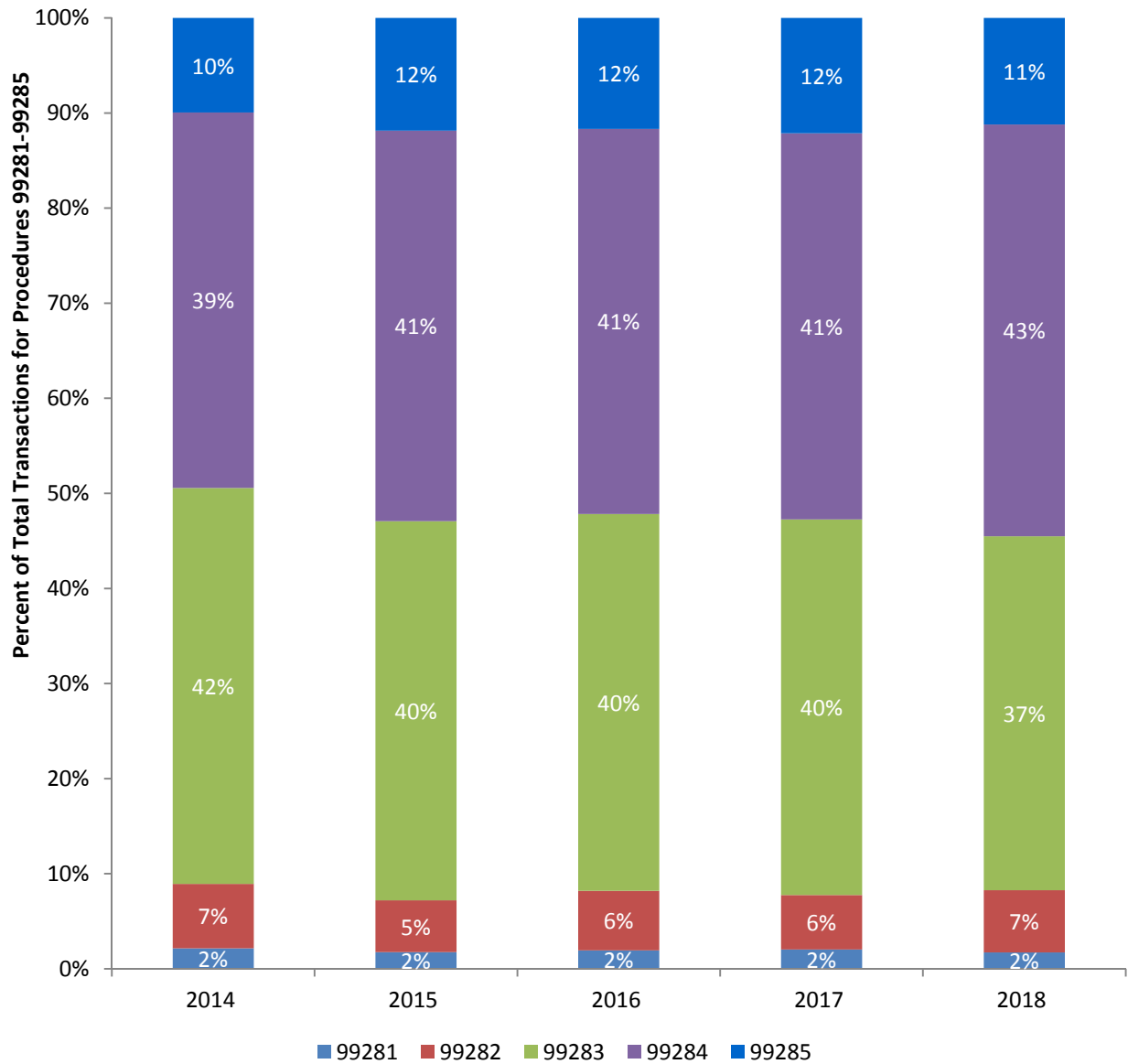


Exhibit 44 displays Emergency Room services by procedure codes trend by service year. This exhibit displays the distribution of transactions for a period of five service years.

Refer to the Exhibit 44 continuation on the next page for the description of codes 99281-99285.

Exhibit 44 (continued)
Emergency Room Transactions by Procedure Code

Total Transactions

	2014	2015	2016	2017	2018
99281	34	26	31	33	27
99282	107	81	100	93	102
99283	657	592	632	642	581
99284	623	610	646	660	676
99285	157	176	186	197	175

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

Exhibit 45
ASC Payments as a Percentage of Medicare

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

The Delaware workers' compensation health care payment system (HCPS) effective 1/31/15 moved towards an RBRVS, MS-DRG, and APC based system. While the Workers' Compensation Oversight Panel ("Panel") used these tools to form the foundation of the HCPS, Delaware has not adopted Medicare rules for workers' compensation. The Panel developed these Delaware specific rules and regulations to govern the HCPS. The HCPS does not support health care service or payment denials based on Medicare rules. The Delaware workers' compensation health care practice guidelines remain in effect and care is presumed compensable when followed. These regulations do not define compensable care, but rather a maximum allowable reimbursement (MAR). The Delaware workers' compensation regulations supersede when a conflict exists with the Centers for Medicare and Medicaid (CMS) rules.

Ambulatory Surgery Center Payments

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

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

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 2018.. 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

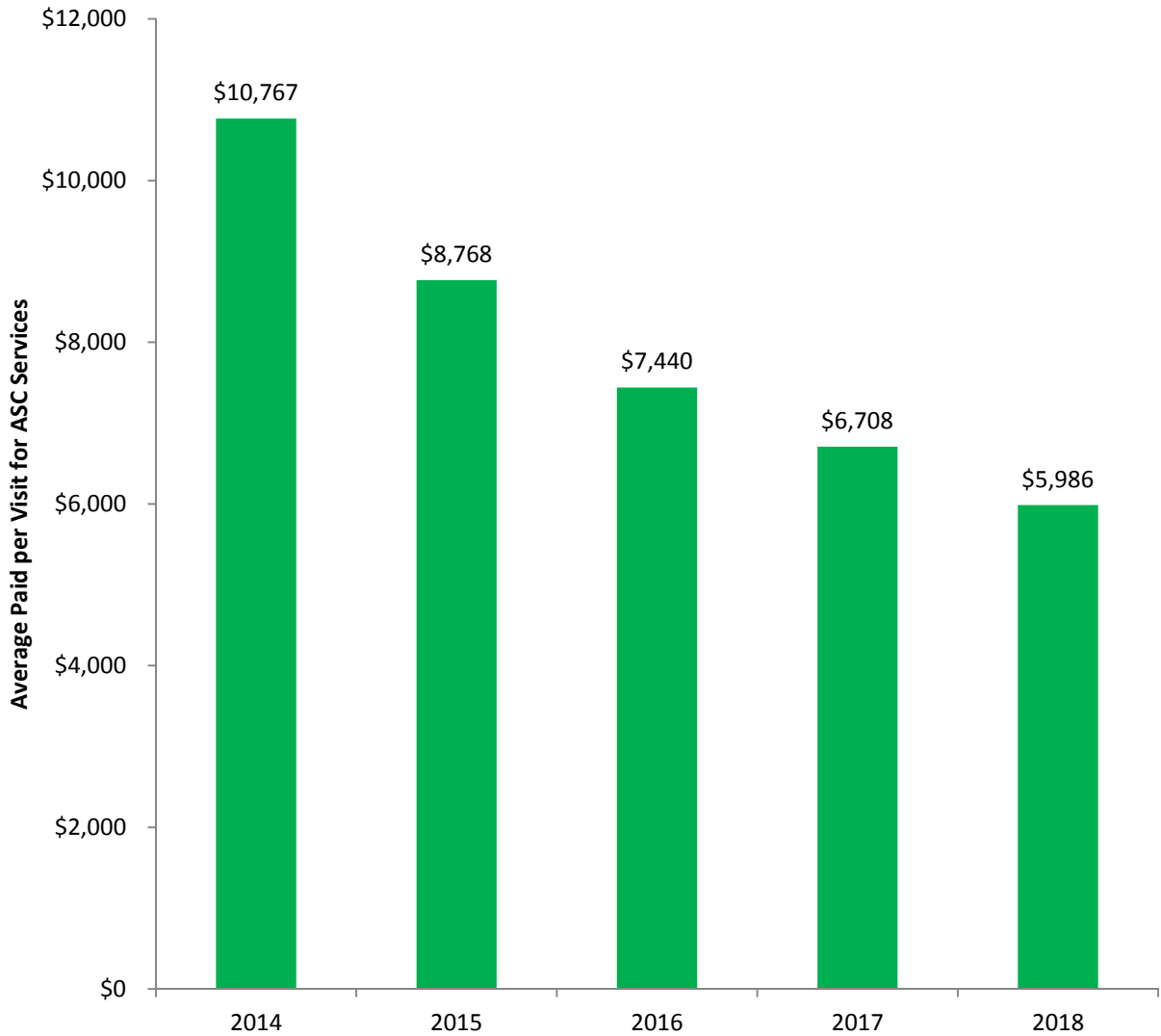


Exhibit 46 depicts the average amount paid per visit for Ambulatory Surgery Center services by service year over a five-year period. These results demonstrate a decline in the average amount paid per visit.

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

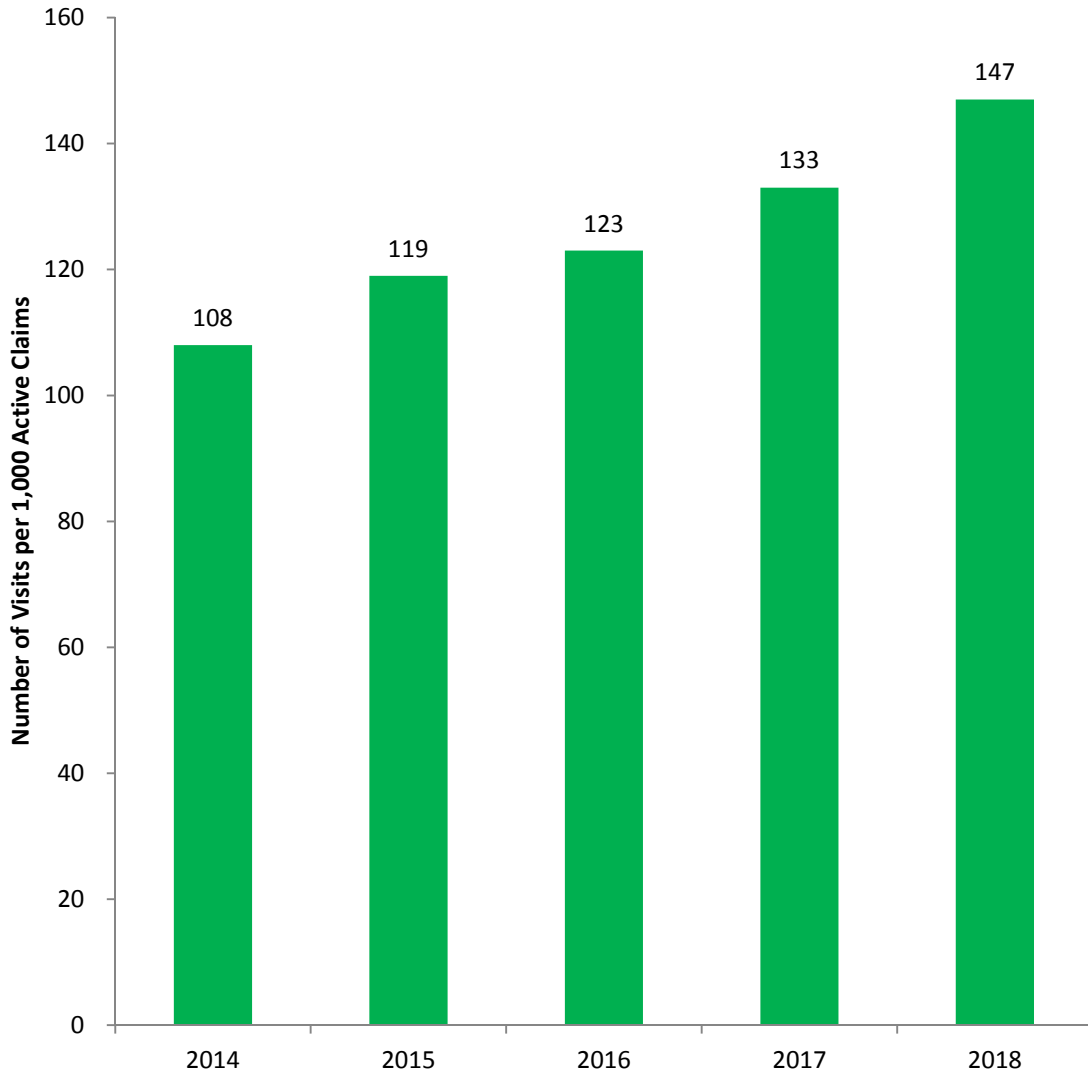


Exhibit 47 depicts the average number of for Ambulatory Surgery Center visits per 1,000 active claims over a five-year period.

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

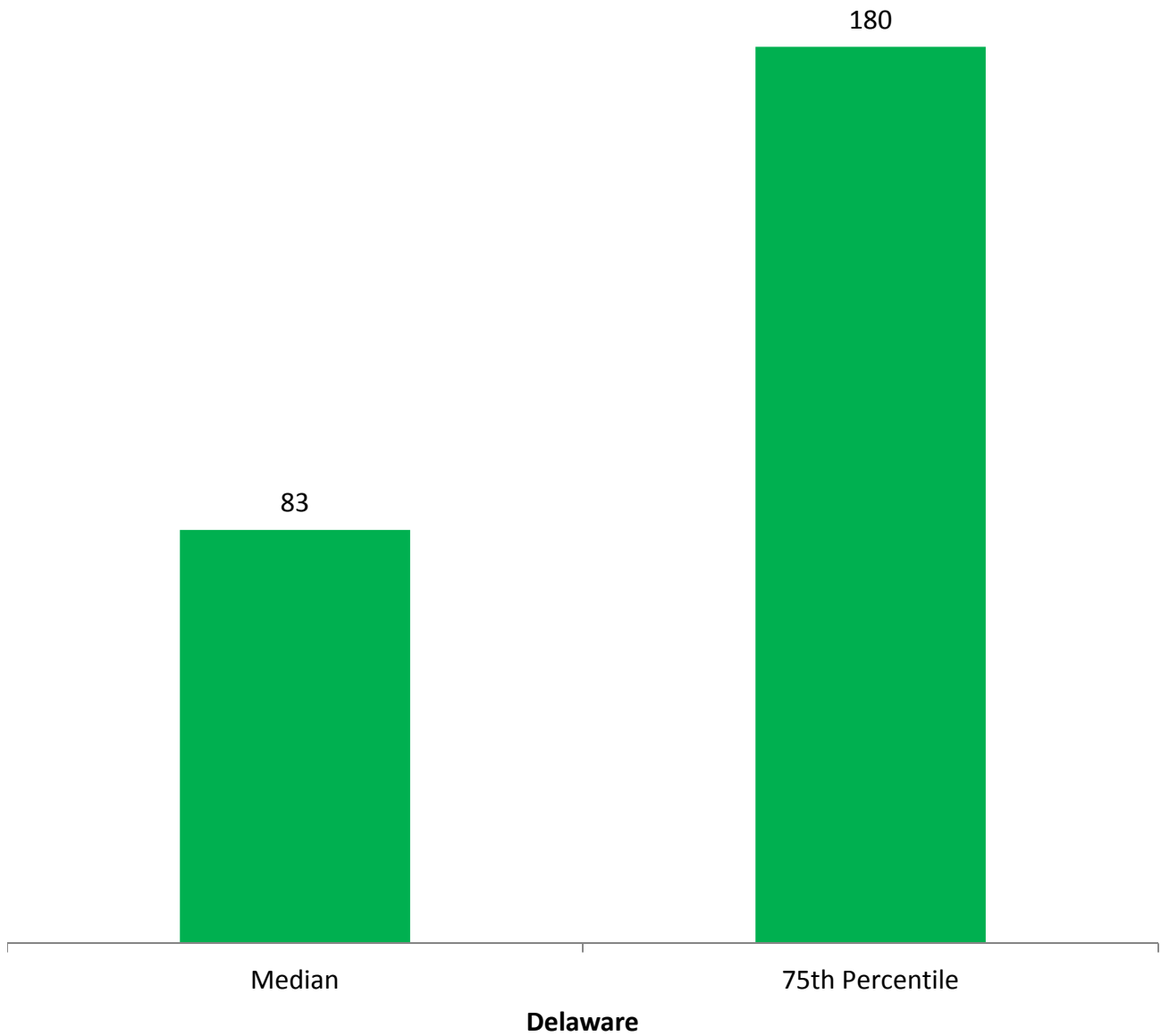
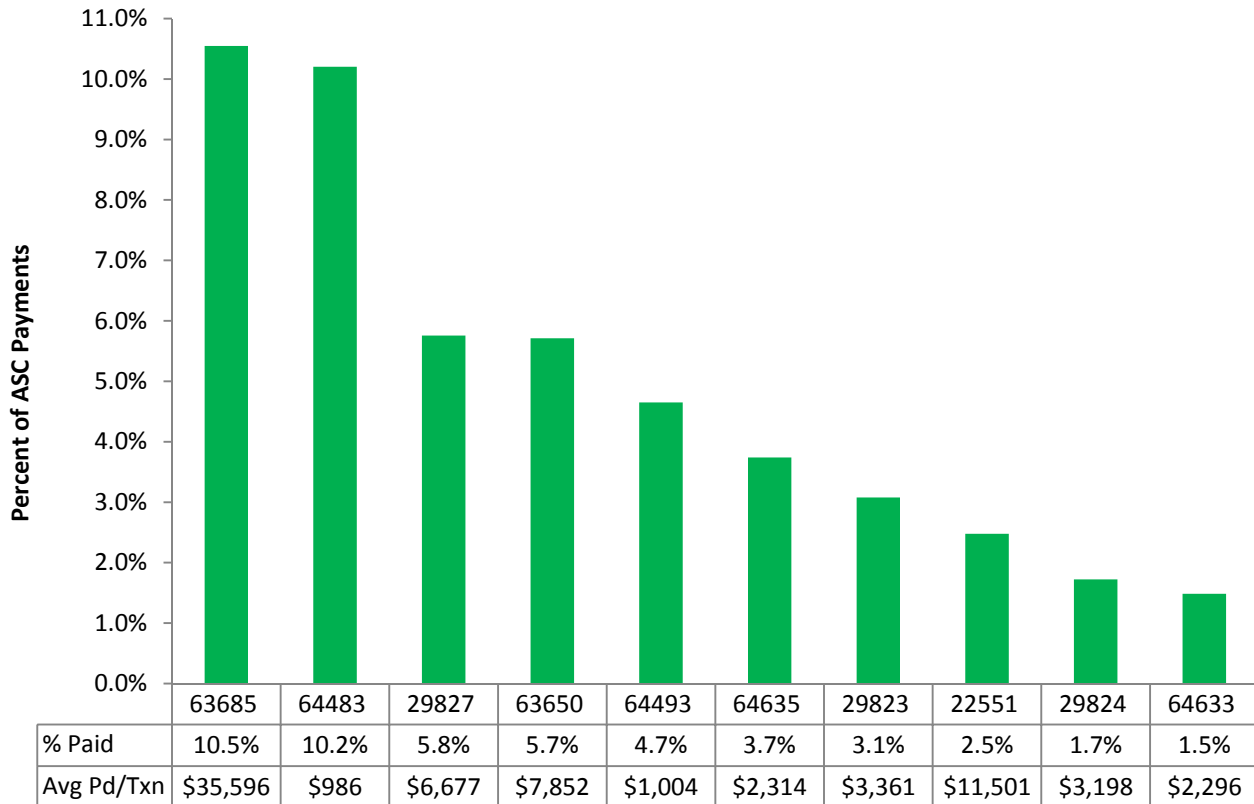


Exhibit 49
Top 10 Diagnosis Groups by Amount Paid for ASC Services

Diagnosis Group	Paid Share	Median Amount Paid Per Visit
Other dorsopathies	36.2%	\$1,061
Spondylopathies	12.5%	\$2,015
Other soft tissue disorders	9.8%	\$4,408
Other disorders of the nervous system	7.9%	\$643
Injuries to the shoulder and upper arm	6.1%	\$6,853
Intraoperative and postprocedural complications and disorders	4.6%	\$8,206
Other joint disorders	4.0%	\$3,594
Injuries to the knee and lower leg	3.8%	\$3,712
Injuries to the wrist, hand and fingers	3.0%	\$2,253
Osteoarthritis	2.8%	\$6,440

Exhibit 50

Top 10 Surgery Procedure Codes by Amount Paid for ASC Services



Code	Description
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
63650	Percutaneous implantation of neurostimulator electrode array, epidural
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
29823	Arthroscopy, shoulder, surgical; debridement, extensive
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

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 2018. 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

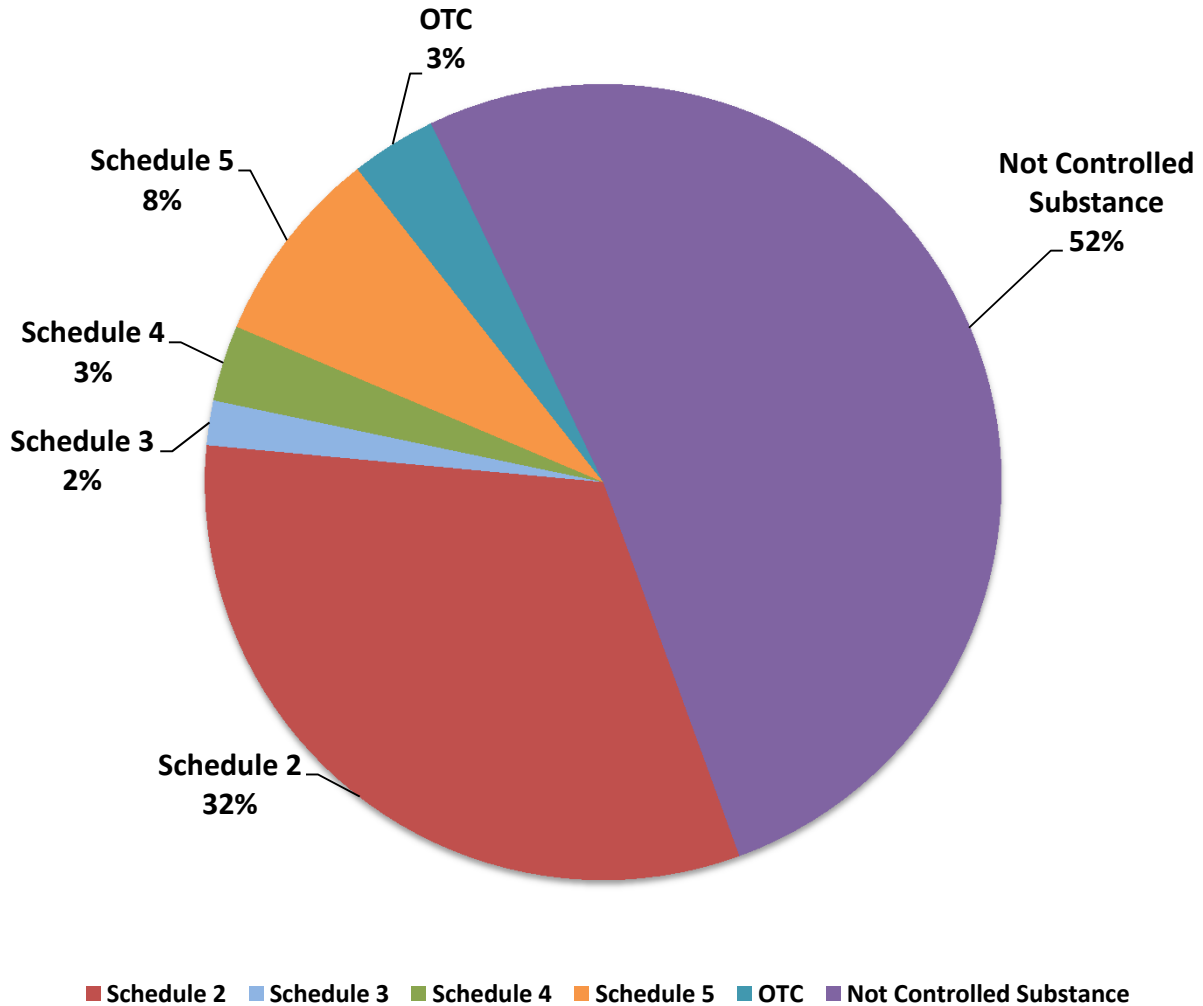
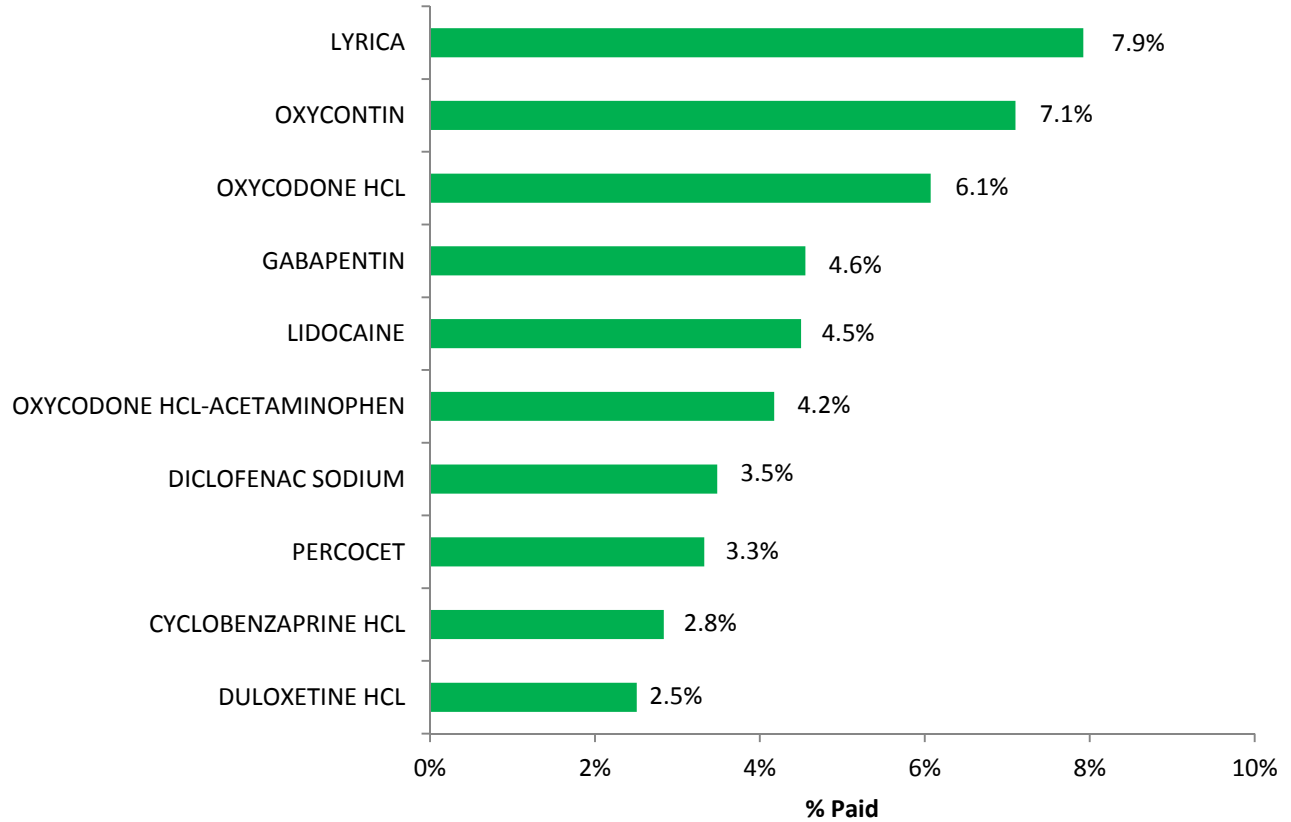


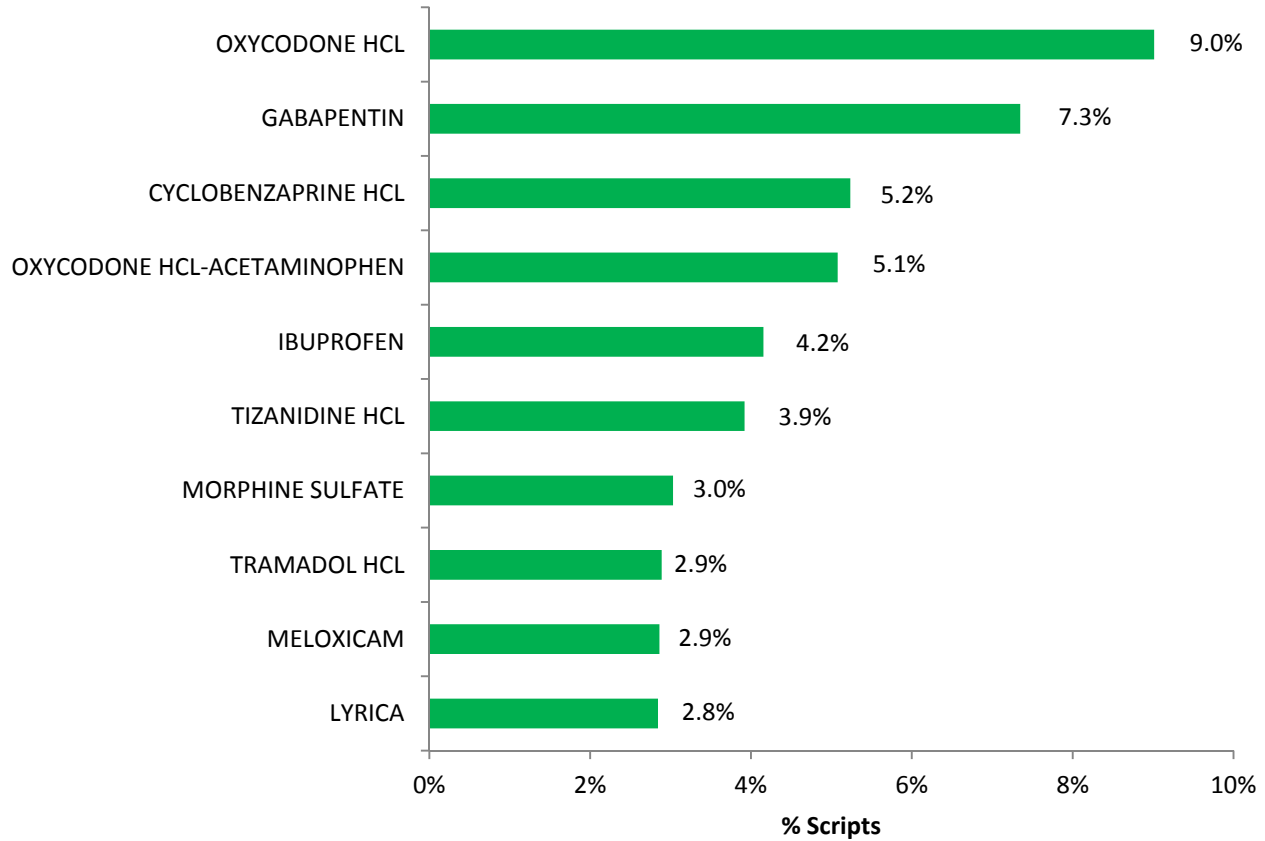
Exhibit 51 presents the distribution of payments of prescription drug costs by CSA schedule. This exhibit displays the allocation of drug payments by schedule. Payments in the non-controlled substances category make up the largest portion of payments (52%), followed by payments made for Schedule 2 drugs (32%). 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
LYRICA	B	N/A	MISC CENTRAL NERVOUS SYSTEM AGENTS	5	\$4.11
OXYCONTIN	B	N/A	ANALGESICS/ANTIPYRETICS	2	\$8.13
OXYCODONE HCL	G	OXYCONTIN	ANALGESICS/ANTIPYRETICS	2	\$0.98
GABAPENTIN	G	NEURONTIN	ANTICONVULSANTS	N/A	\$0.81
LIDOCAINE	G	XYLOCAINE	SKIN & MUCOUS MEMBRANE AGENTS	N/A	\$2.34
OXYCODONE HCL-ACETAMINOPHEN	G	PERCOCET	ANALGESICS/ANTIPYRETICS	2	\$0.99
DICLOFENAC SODIUM	G	VOLTAREN	ANALGESICS/ANTIPYRETICS	N/A	\$2.33
PERCOCET	B	N/A	ANALGESICS/ANTIPYRETICS	2	\$15.46
CYCLOBENZAPRINE HCL	G	FLEXERIL	MUSCLE RELAXANTS, SKELETAL	N/A	\$1.16
DULOXETINE HCL	G	CYMBALTA	CENTRAL NERVOUS SYSTEM AGENTS	N/A	\$4.32

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	\$0.98
GABAPENTIN	G	NEURONTIN	ANTICONVULSANTS	N/A	\$0.81
CYCLOBENZAPRINE HCL	G	FLEXERIL	MUSCLE RELAXANTS, SKELETAL	N/A	\$1.16
OXYCODONE HCL-ACETAMINOPHEN	G	PERCOCET	ANALGESICS/ANTIPYRETICS	2	\$0.99
IBUPROFEN	G	ADVIL	ANALGESICS/ANTIPYRETICS	N/A	\$0.31
TIZANIDINE HCL	G	ZANAFLEX	MUSCLE RELAXANTS, SKELETAL	N/A	\$0.63
MORPHINE SULFATE	G	DURAMORPH	ANALGESICS/ANTIPYRETICS	2	\$0.88
TRAMADOL HCL	G	ULTRAM	ANALGESICS/ANTIPYRETICS	4	\$0.58
MELOXICAM	G	MOBIC	ANALGESICS/ANTIPYRETICS	N/A	\$1.43
LYRICA	B	N/A	MISC CENTRAL NERVOUS SYSTEM AGENTS	5	\$4.11

Exhibit 53A
Top 30 Drugs for Service Year 2018

Paid Share Service Year 2018	Drug Name	Brand/Generic Status	Rank By Service Year				
			2018	2017	2016	2015	2014
7.6%	Oxycontin	Brand	1	1	1	1	1
7.2%	Lyrica	Brand	2	3	3	5	5
5.9%	Oxycodone HCL	Generic for Oxycontin if extended release	3	4	4	3	3
4.5%	Gabapentin	Generic for Neurontin	4	2	2	2	2
4.4%	Oxycodone HCL-Acetaminophen	Generic for Percocet	5	5	5	4	4
4.3%	Lidocaine	Generic for Xylocaine	6	6	8	8	8
3.9%	Percocet	Brand	7	7	6	6	6
3.5%	Diclofenac Sodium	Generic for Cambia, Cataflam, Voltaren-XR, etc.	8	8	38	47	45
2.7%	Cyclobenzaprine HCL	Generic for Flexeril	9	10	10	10	14
2.6%	Duloxetine HCL	Generic for Cymbalta	10	9	9	9	7
2.2%	Duragesic	Brand for Fentanyl	11	14	15	17	12
1.7%	Tizanidine HCL	Generic for Zanaflex	12	13	13	15	16
1.6%	Morphine Sulfate	Generic for Avinza, Kadian, Ms Contin	13	12	11	11	9
1.5%	Terocin	Brand	14	11	7	7	10
1.4%	Nucynta	Brand	15	16	16	20	27
1.4%	Meloxicam	Generic for Mobic, Vivlodex	16	21	18	19	15
1.2%	Movantik	Brand	17	27	42	72	n/a
1.2%	Zofran	Brand	18	22	26	26	26
1.2%	Topiramate	Generic for Topamax	19	17	24	23	24
1.1%	Oxymorphone HCL	Generic for Opana, Opana ER	20	28	27	29	33
1.0%	Celecoxib	Generic for Celebrex	21	23	19	18	115
1.0%	Suboxone	Brand	22	29	36	41	39
1.0%	Lidopro Patch	Brand	23	20	17	80	n/a
1.0%	Flector	Brand	24	31	21	16	23
1.0%	Ondansetron	Generic for Zofran	25	24	25	83	103
1.0%	Lidoderm	Brand	26	38	52	53	50
0.9%	Metaxalone	Generic for Skelaxin	27	30	28	21	25
0.9%	Baclofen	Generic for Lioresal, Gablofen	28	25	22	25	35
0.8%	Nucynta ER	Brand	29	19	31	34	38
0.8%	Hydromorphone HCL	Generic for Dllaudid, Dilaudid-5, Exalgo	30	15	12	12	21

Exhibit 54
Distribution of Drugs by Brand Name and Generic

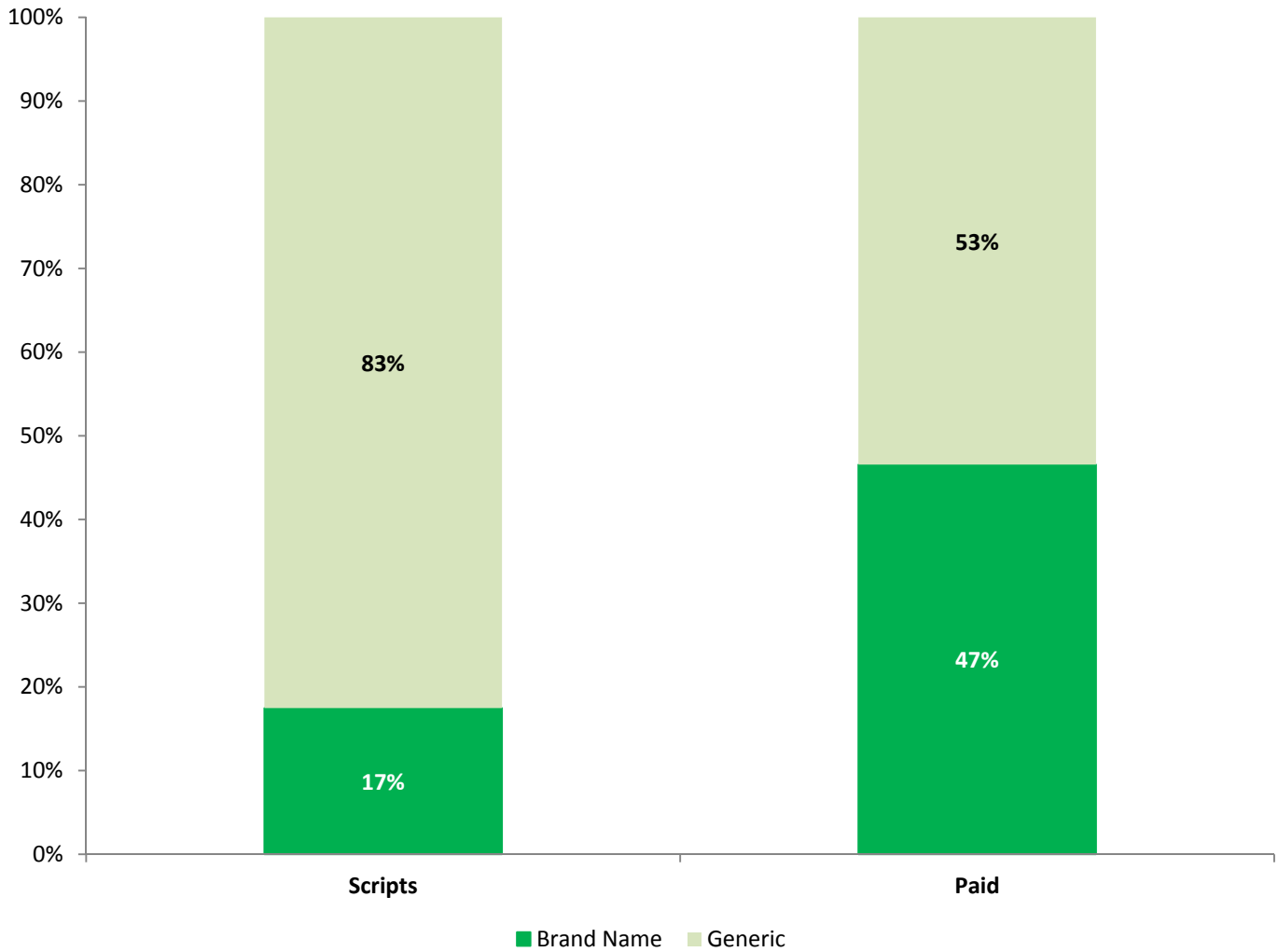


Exhibit 54 depicts the distribution of drugs organized by brand name versus generic. These results reveal that significantly fewer prescriptions are written using the brand name than generic equivalent.

Exhibit 55
Distribution of Drugs by Pharmacy and Non-Pharmacy

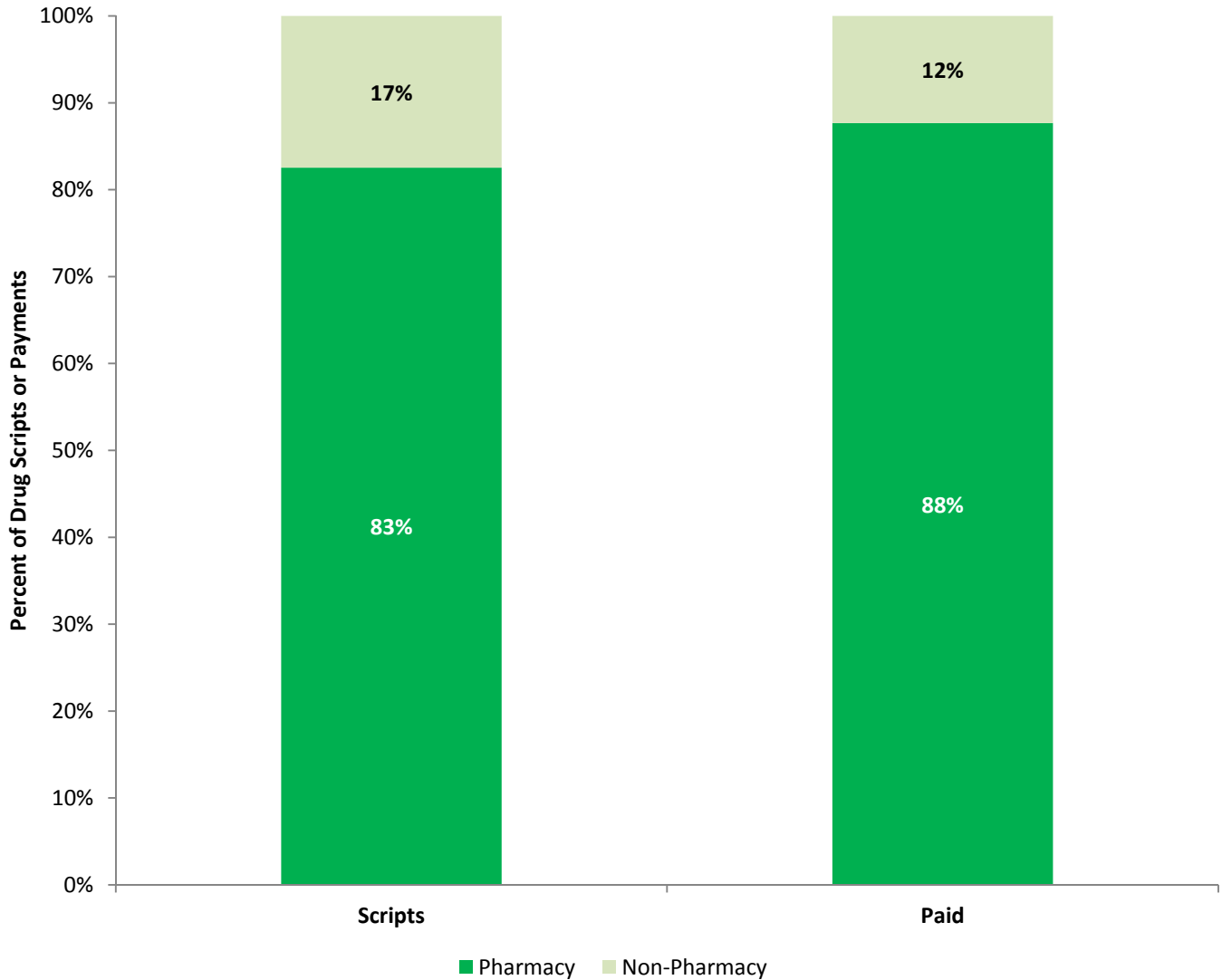


Exhibit 55 is a distribution of drugs dispensed at either a pharmacy (retail, mail order, or institutional) or a non-pharmacy facility. Examples of non-pharmacy dispensing locations include doctor's offices, home health care and hospitals. These results suggest that a large majority of prescription drugs 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 2017 for claims with an implant or prosthetic.

Exhibit 58 details the average paid amount per claim for Dates of Injury in 2017 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 2017. 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 2017. This exhibit includes diagnosis data that is more mature.

The source for all data is the DCRB Medical Data Call for Service Year 2018. 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

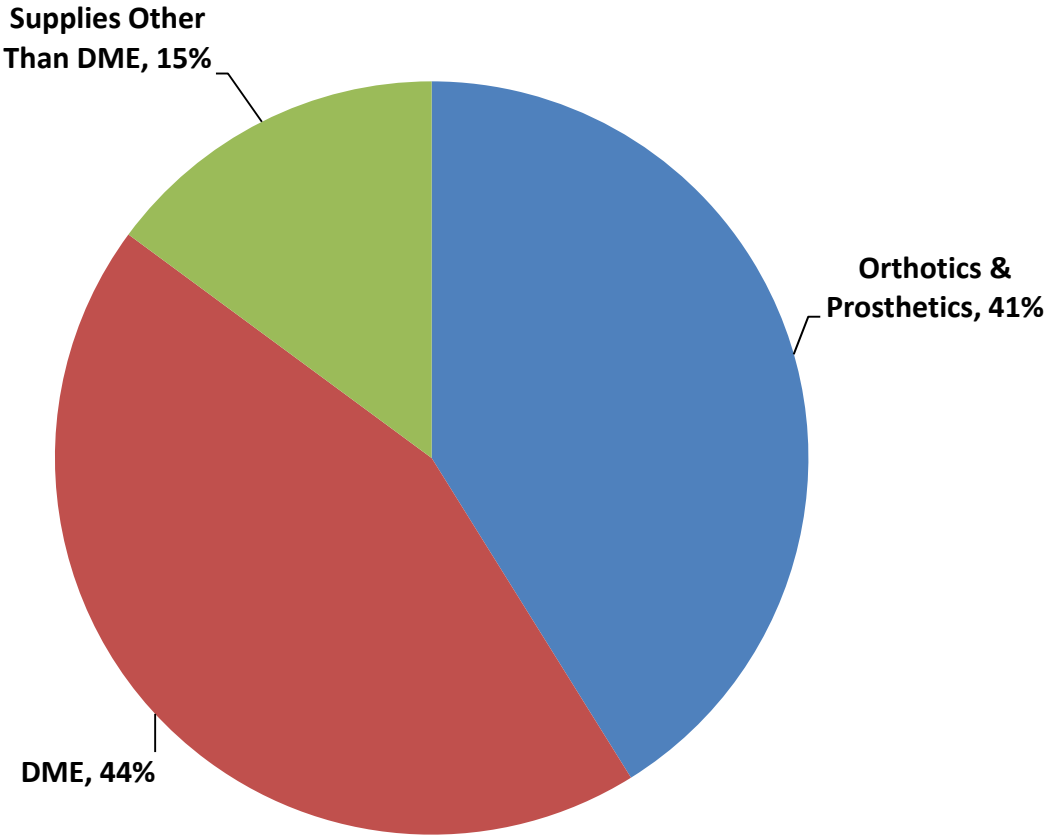


Exhibit 56 presents the distribution of payments by durable medical equipment (DME), orthotics and prosthetics, medical supplies and implants. This exhibit shows us that DME makes up the largest portion of payments followed by payments made for orthotics and prosthetics.

Exhibit 57

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2017 for Claims with an Implant or Prosthetic

Diagnosis Group	Paid Share	Average Amount Paid Per Claim
Other dorsopathies	16.0%	\$4,489
Other joint disorders	10.8%	\$2,292
Injuries to the shoulder and upper arm	9.9%	\$4,162
Other soft tissue disorders	9.5%	\$2,674
Injuries to the abdomen, lower back, lumbar spine, pelvis	5.5%	\$2,284
Injuries to the knee and lower leg	5.5%	\$4,694
Injuries involving multiple body regions	4.2%	\$1,218
Injuries to the wrist, hand and fingers	3.8%	\$3,848
Spondylopathies	3.2%	\$2,193
Injuries to the ankle and foot	2.9%	\$3,720

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	\$4,554
Other joint disorders	\$1,149
Injuries to the shoulder and upper arm	\$2,065
Other soft tissue disorders	\$2,081
Injuries to the abdomen, lower back, lumbar spine, pelvis	\$1,152
Injuries to the knee and lower leg	\$2,377
Injuries involving multiple body regions	\$527
Injuries to the wrist, hand and fingers	\$1,096
Spondylopathies	\$3,970
Injuries to the ankle and foot	\$851

Exhibit 59
Average Payment per Bill for Ground Ambulance Services

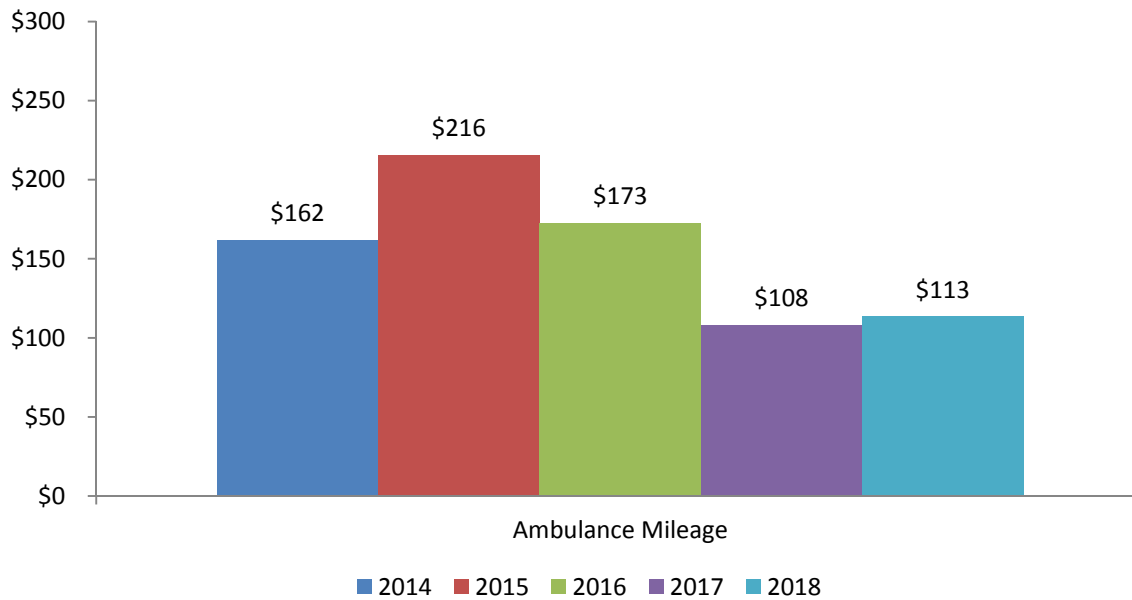
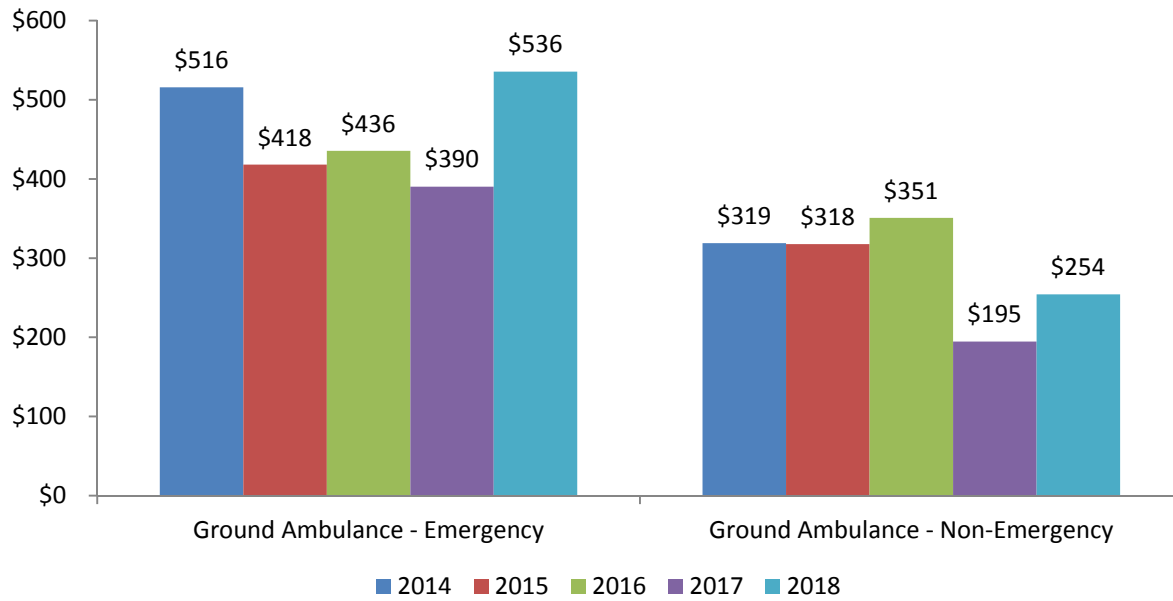
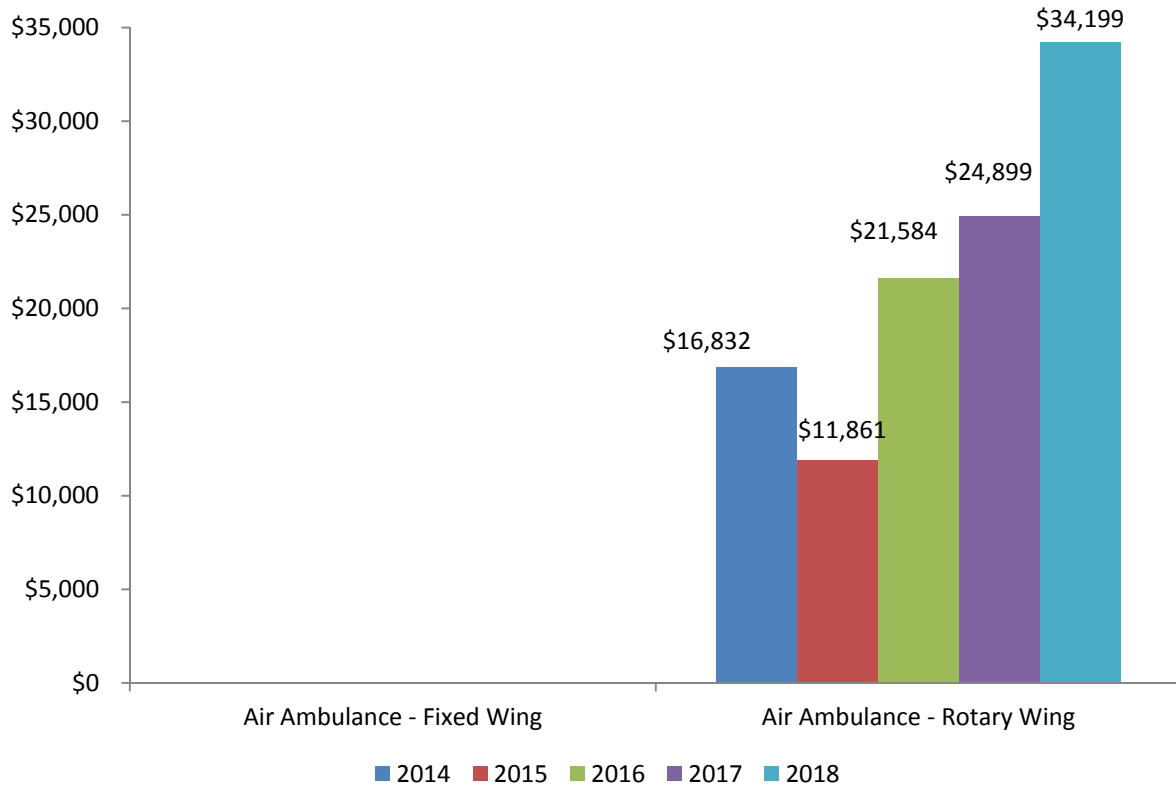


Exhibit 60
Average Payment per Bill for Fixed and Rotary Wing Air Ambulance Services



Note: There was no utilization for fixed wing air ambulance for 2014-2018 service dates.

Exhibit 61
Top 10 Body Systems by Amount Paid for Dates of Injury in 2017

Body System	Paid Share	Average Amount Paid Per Claim
Diseases of the musculoskeletal system and connective tissue	45.5%	\$5,010
Injury, poisoning and certain other consequences of external causes	40.6%	\$2,336
Diseases of the nervous system	3.4%	\$2,708
Factors influencing health status and contact with health services	1.5%	\$727
Symptoms, signs and abnormal clinical and laboratory findings, NOC	1.3%	\$848
Diseases of the digestive system	1.3%	\$5,042
Mental, Behavioral and Neurodevelopmental disorders	1.2%	\$2,631
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1.0%	\$11,493
Endocrine, nutritional and metabolic diseases	0.9%	\$3,557
Diseases of the circulatory system	0.9%	\$1,914

Exhibit 62
Top 10 Diagnosis Groups by Amount Paid for Dates of Injury in 2017

Diagnosis Group	Paid Share	Average Amount Paid Per Claim
Other dorsopathies	19.6%	\$5,543
Other joint disorders	10.6%	\$2,299
Other soft tissue disorders	7.8%	\$2,755
Injuries to the wrist, hand and fingers	6.9%	\$1,372
Injuries to the knee and lower leg	6.4%	\$2,796
Injuries to the shoulder and upper arm	5.3%	\$2,801
Injuries to the abdomen, lower back, lumbar spine, pelvis	5.3%	\$1,684
Spondylopathies	4.0%	\$3,252
Injuries to the head	2.7%	\$1,328
Burns and corrosions of external body surface, specified by site	2.7%	\$5,447

Appendix A: Comparison of Selected Distributions by Service Year

Distribution of Medical Payments (Exhibit 4)

Medical Category	2014	2015	2016	2017	2018
Physicians	51%	44%	46%	46%	46%
Hospital Inpatient	10%	13%	13%	13%	13%
Hospital Outpatient	10%	8%	8%	7%	8%
ER	1%	2%	2%	2%	2%
Ambulatory Surgical Centers	8%	11%	10%	12%	10%
Drugs (NDC Codes + Medical Drugs)	11%	14%	14%	12%	14%
Durable Medical Equipment	1%	1%	2%	2%	2%
Other	8%	7%	6%	7%	5%

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

AMA Service Category	2014	2015	2016	2017	2018
Surgery	33%	28%	29%	28%	28%
Physical Medicine	33%	37%	38%	39%	39%
Evaluation & Management	13%	15%	15%	15%	15%
Radiology	7%	6%	6%	6%	6%
Medicine	6%	6%	5%	6%	6%
Anesthesia	4%	5%	4%	4%	3%
Pathology & Laboratory	4%	3%	3%	3%	3%

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 2013	AY 2014	AY 2015	AY 2016	AY 2017
Physicians - Major Surgery	47	55	41	40	41
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 Sugary	97	104	103	70	50
Hospital Outpatient - All Other	1	1	1	1	4
ASC	119	104	94	98	83

75th Percentile of Time Until First Treatment (in Days)

(Exhibits 11, 14, 17, 20, 28, 36, 37, and 48)

Medical Category	AY 2013	AY 2014	AY 2015	AY 2016	AY 2017
Physicians - Major Surgery	158	150	148	138	126
Physicians - Radiology	12	9	10	10	8
Physicians - Physical Medicine	11	10	12	12	12
Physicians - Evaluation and Management	4	3	3	3	3
Hospital Inpatient	89	224	52	45	140
Hospital Outpatient - Major Sugary	366	464	236	209	154
Hospital Outpatient - All Other	18	24	20	28	35
ASC	280	207	188	180	180

Appendix A: Comparison of Selected Distributions by Service Year

Hospital Inpatient Statistics (Exhibit 24 and 26)

Hospital Inpatient Statistics	2014	2015	2016	2017	2018
Average Payment per Stay	\$35,999	\$38,474	\$29,544	\$27,019	\$26,100
Number of Stays per 1,000 Active Claims	23	23	24	24	24

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

Visit Type	2014	2015	2016	2017	2018
Surgery (CPT: 10021-69990)	14%	24%	31%	32%	39%
Non-Surgery	86%	76%	69%	68%	61%

Hospital Outpatient Surgery Statistics (Exhibit 32 and Exhibit 33)

Hospital Outpatient Surgery Statistics	2014	2015	2016	2017	2018
Average Payment per Visit	\$8,608	\$6,383	\$6,397	\$5,176	\$4,930
Number of Visits per 1,000 Active Claims	58	55	48	45	51

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

Hospital Outpatient Non-Surgery Statistics	2014	2015	2016	2017	2018
Average Payment per Visit	\$965	\$654	\$598	\$494	\$496
Number of Visits per 1,000 Active Claims	734	696	563	528	556

Appendix A: Comparison of Selected Distributions by Service Year

Emergency Room Statistics (Exhibit 41 and Exhibit 42)

Emergency Room Statistics	2014	2015	2016	2017	2018
Average Payment per Visit	\$2,131	\$1,915	\$1,380	\$1,105	\$1,231
Number of Visits per 1,000 Active Claims	79	98	134	178	176

ASC Statistics (Exhibit 46 and Exhibit 47)

ASC Statistics	2014	2015	2016	2017	2018
Average Payment per Visit	\$10,767	\$8,768	\$7,440	\$6,708	\$5,986
Number of Visits per 1,000 Active Claims	108	119	123	133	147

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

CSA Schedule	2014	2015	2016	2017	2018
Schedule 2	40%	38%	35%	35%	32%
Schedule 3	3%	3%	2%	2%	2%
Schedule 4	5%	4%	3%	3%	3%
Schedule 5	4%	5%	6%	6%	8%
OTC	3%	5%	6%	5%	3%
Non-Controlled	45%	46%	48%	49%	52%

Appendix A: Comparison of Selected Distributions by Service Year

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

Type of Drug	2014	2015	2016	2017	2018
Brand	46%	49%	50%	55%	53%
Generic	46%	51%	50%	45%	47%

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

Type of Provider	2014	2015	2016	2017	2018
Pharmacy	88%	85%	85%	87%	88%
Non-Pharmacy	12%	15%	15%	13%	12%

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

Category	2014	2015	2016	2017	2018
Orthotics & Prosthetics	29%	37%	29%	39%	41%
DME	39%	40%	51%	45%	44%
Supplies Other Than DME	32%	23%	20%	16%	15%

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2018
1	Medical Share of Total Benefit Costs	72.4% (2016)
2	Overall Medical Average Cost per Lost Time Claim (in 000s)	\$68,132 (2016)
3	Percentage of Medical Paid by Claim Maturity	30.1% (Year 1); 53.7% (Year 5); 64.8% (Year 10); 75.1% (Year 19)
4	Distribution of Medical Payments	Physicians 46%; Hospital Outpatient 8%; Hospital Inpatient 12%; ASC 12%; Drugs 10%; DME 2%; ER 3%; Other 8%
5	Physician Payments as % of Medicare	Surgery 232%; Radiology 173%; General and Physical Medicine 137%; Evaluation and Management 112%; Pathology & Laboratory 138%; All Physician Services 214%
6	Distribution of Physician Payments by AMA Service Category	Surgery 28%; Radiology 6%; Laboratory & Pathology 4%; Physical Medicine 39%; General Medicine 6%; Evaluation & Management 15%; Anesthesia 3%
7	Top 10 Anesthesia Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 01992 (\$357); 00670 (\$812); 01630 (\$382); 01936 (\$268); 01400 (\$305); 01480 (\$384); 01830 (\$280); 01810 (\$220); 00630 (\$554); 01935 (\$327)
8	Top 10 Anesthesia Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 01992 (\$357); 01630 (\$382); 01936 (\$268); 00670 (\$812); 01400 (\$305); 01810 (\$220); 01830 (\$280); 01480 (\$384); 01991 (\$216); 00400 (\$213)
9	Top 10 Surgery Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 22551 (\$3,065); 64483 (\$366); 22612 (\$1,998); 29827 (\$1,625); 22558 (\$2,355); 29823 (\$984); 63047 (\$2,006); 22633 (\$3,708); 22840 (\$1,475); 22845 (\$1,164)
10	Top 10 Surgery Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 20610 (\$101); 64483 (\$366); 12001 (\$160); 64493 (\$344); 36415 (\$8); 29826 (\$376); 64494 (\$193); 64484 (\$168); 29823 (\$984); 62323 (\$353)
11	Time Until First Treatment for Major Surgery (in Days)	Median = 41; 75th Percentile = 126

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2018
12	Top 10 Radiology Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 72148 (\$480); 73221 (\$430); 73721 (\$469); 72141 (\$494); 72158 (\$849); 73222 (\$600); 73030 (\$52); 73718 (\$498); 72100 (\$52); 73630 (\$38)
13	Top 10 Radiology Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 73030 (\$52); 73630 (\$38); 72100 (\$52); 73110 (\$42); 72148 (\$480); 73610 (\$43); 73140 (\$37); 73221 (\$430); 73721 (\$469)
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 (\$64); 97140 (\$44); 97530 (\$42); 97545 (\$214); 97112 (\$41); 97014 (\$27); 97010 (\$11); 99199 (\$648); 97799 (\$1,297); 98941 (\$41)
16	Top 10 Physical and General Medicine Procedure Codes by Transaction Counts	Average Paid Per Transaction for top 10 codes: 97110 (\$64); 97140 (\$44); 97010 (\$11); 97530 (\$42); 97014 (\$27); 97112 (\$41); 99080 (\$27); 98941 (\$41); 97012 (\$27); 97124 (\$46)
17	Time Until First Treatment for Physical and General Medicine (in Days)	Median = 2; 75th Percentile = 12
18	Top 10 Evaluation and Management Procedure Codes by Amount Paid	Average Paid Per Transaction for top 10 codes: 99214 (\$98); 99213 (\$61); 99203 (\$107); 99284 (\$350); 99204 (\$157); 99283 (\$219); 99285 (\$485); 99212 (\$52); 99232 (\$80); 99456 (\$1,549)
19	Top 10 Evaluation and Management Procedure Codes by Transaction Count	Average Paid Per Transaction for top 10 codes: 99213 (\$61); 99214 (\$98); 99203 (\$107); 99212 (\$52); 99204 (\$157); 99284 (\$350); 99283 (\$219); 99232 (\$80); 99202 (\$80); 99233 (\$112)
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 2018
21	Office or Other Outpatient Visit for the Evaluation and Management of a New Patient	99201 (1%); 99202 (6%); 99203 (59%); 99204 (32%); 99205 (2%)
22	Office or Other Outpatient Visit for the Evaluation and Management of a Established Patient	99211 (0%); 99212 (5%); 99213 (41%); 99214 (52%); 99215 (2%)
23	Hospital Inpatient Payments as % of Medicare	121% to 147%
24	Average Paid Amount per Stay for Hospital Inpatient Services	\$26,100
25	Average Paid Amount per Day for Hospital Inpatient Services	\$6,692
26	Average Number of Stays per 1,000 Active Claims	24
27	Length of Stay for Hospital Inpatient Services	Average LOS = 3; Median LOS = 2
28	Time Until First Treatment for Hospital Inpatient Stays (in Days)	Median = 1; 75th Percentile = 140
29	Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services	Median Payment per Stay for top 10 groups: Other dorsopathies (\$32,785); Burns and corrosions of external body surface, specified by site (\$38,576); Complications of medical and surgical care, NOC (\$15,046); Spondylopathies (\$19,385); Osteoarthritis (\$15,669); Injuries to the hip and thigh (\$14,437); Injuries to the knee and lower leg (\$13,916); Other disorders of the skin and subcutaneous tissue (\$49,649); Diabetes mellitus (\$38,761); Other bacterial diseases (\$16,515)
30	Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services	Median Payment per Stay for top 10 codes: 458 (\$829,838); 455 (\$46,664); 460 (\$7,344); 470 (\$10,862); 472 (\$17,908); 592 (\$49,649); 454 (\$16,542); 457 (\$59,361); 494 (\$11,344); 481 (\$23,533)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2018
31	Hospital Outpatient Payments as % of Medicare	n/a
32	Average Outpatient Paid Amount Per Major Surgical Visit for Hospital Outpatient Services	\$4,930
33	Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims	51
34	Average Outpatient Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services	\$496
35	Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims	556
36	Time Until First Treatment for Major Surgery Outpatient Visits (in Days)	Median = 50; 75th Percentile = 154
37	Time Until First Treatment for All Other Outpatient Visits (in Days)	Median = 4; 75th Percentile = 35
38	Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services	Median Payment per Visit for top 10 groups: Other dorsopathies (\$337); Injuries to the knee and lower leg (\$390); Other disorders of the nervous system (\$513); Injuries to the wrist, hand and fingers (\$270); Other soft tissue disorders (\$257); Other joint disorders (\$411); Injuries to the shoulder and upper arm (\$514); Injuries to the elbow and forearm (\$240); Hernia (\$4,170); Spondylopathies (\$308)
39	Top 10 Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Payment per Visit for top 10 codes: 63685 (\$13,232); 22551 (\$4,648); 29881 (\$3,874); 29827 (\$4,285); 11042 (\$3,836); 63030 (\$3,946); 29823 (\$5,209); 17108 (\$6,157); 49650 (\$6,001); 28485 (\$8,355)
40	Top 10 Non-Surgery CPT Codes by Amount Paid for Hospital Outpatient Services	Average Payment per Visit for top 10 codes: 97110 (\$51); 99283 (\$376); 73221 (\$537); 97140 (\$42); 73721 (\$550); 99284 (\$641); 72148 (\$511); 72158 (\$942); 72141 (\$525); 72100 (\$215)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2018
41	Average Amount Paid per ER Visit	\$1,231
42	Average Number of ER Visits per 1,000 Active Claims	176
43	Emergency Room Payments by Procedure Code	99281 (1%); 99282 (3%); 99283 (27%); 99284 (51%); 99285 (18%)
44	ER Transactions by Procedure Code	99281 (2%); 99282 (7%); 99283 (37%); 99284 (43%); 99285 (11%)
45	ASC Payments as % of Medicare	n/a
46	Average Amount Paid per Visit for ASC Services	\$5,986
47	Average Number of ASC Visits per 1,000 Active Claims	147
48	Time Until First Treatment for ASC Visits (in Days)	Median = 83; 75th Percentile = 180
49	Top 10 Diagnosis Groups by Amount Paid for ASC Services	Median Payment per Visit for top 10 groups: Other dorsopathies (\$1,061); Spondylopathies (\$2,015); Other soft tissue disorders (\$4,408); Other disorders of the nervous system (\$643); Injuries to the shoulder and upper arm (\$6,853); Intraoperative and post procedural complications and disorders (\$8,206); Other joint disorders (\$3,594); Injuries to the knee and lower leg (\$3,712); Injuries to the wrist, hand and fingers (\$2,253); Osteoarthritis (\$6,440)
50	Top 10 Surgery Procedure Codes by Amount Paid for ASC Services	Average Paid Per Transaction for top 10 codes: 63685 (\$35,596); 64483 (\$986); 29827 (\$6,677); 63650 (\$7,852); 64493 (\$1,004); 64635 (\$2,314); 29823 (\$3,361); 22551 (\$11,501); 29824 (\$3,198); 64633 (\$2,296)
51	Distribution of Prescription Drug Costs by CSA Schedule	Schedule 2 = 32%; Schedule 3 = 2%; Schedule 4 = 3%; Schedule 5 = 8%; OTC = 3%; Non-Controlled = 52%
52	Top 10 Workers Compensation Drugs by Amount Paid	Average Paid Per Unit for top 10 drugs: Lyrica (\$4.11); Oxycontin (\$8.13); Oxycodone HCL (\$0.98); Gabapentin (\$0.81); Lidocaine (\$2.34); Oxycodone HCL-Acetaminophen (\$0.99); Diclofenac Sodium (\$2.33); Percocet (\$15.46); Cyclobenzaprine HCL (\$1.16); Duloxetine HCL (\$4.32)

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2018
53	Top 10 Workers Compensation Drugs by Prescription Counts	Average Paid Per Unit for top 10 drugs: Oxycodone HCL (\$0.98); Gabapentin (\$0.81); Cyclobenzaprine HCL (\$1.16); Oxycodone HCL-Acetaminophen (\$0.99); Ibuprofen (\$0.31); Tizanidine HCL (\$0.63); Morphine Sulfate (\$0.88); Tramadol HCL (\$0.58); Meloxicam (\$1.43); Lyrica (\$4.11)
54	Distribution of Drugs by Brand Name and Generic	By Paid Amount = Brand Name 47%; Generic 53%; By Script Count = Brand Name 17%, Generic 83%
55	Distribution of Drugs by Pharmacy and Non-pharmacy by Amount Paid	By Paid Amount = Pharmacy 88%; Non-Pharmacy 12%; By Script Count = Pharmacy 83%, Non-Pharmacy = 17%
56	Distribution of Payments by DMEPOS	DME = 44%; Prosthetics, Orthotics and Implants = 41%; Supplies Other Than DME = 15%
57	Top Diagnosis by Amount Paid for Dates of Injury in 2017 for Claims with and Implant or Prosthetic	Average Paid Per Claim for top 10 groups: Other dorsopathies (\$4,489); Other joint disorders (\$2,292); Injuries to the shoulder and upper arm (\$4,162); Other soft tissue disorders (\$2,674); Injuries to the abdomen, lower back, lumbar spine, pelvis (\$2,284); Injuries to the knee and lower leg (\$4,694); Injuries involving multiple body regions (\$1,218); Injuries to the wrist, hand and fingers (\$3,848); Spondylopathies (\$2,193); Injuries to the ankle and foot (\$3,720)
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 (\$4,554); Other joint disorders (\$1,149); Injuries to the shoulder and upper arm (\$2,065); Other soft tissue disorders (\$2,081); Injuries to the abdomen, lower back, lumbar spine, pelvis (\$1,152); Injuries to the knee and lower leg (\$2,377); Injuries involving multiple body regions (\$527); Injuries to the wrist, hand and fingers (\$1,096); Spondylopathies (\$3,970); Injuries to the ankle and foot (\$851)
59	Average Payment per Episode for Ground Ambulance Services	Ground ambulance emergency = \$536; Ground ambulance non-emergency = \$254; Mileage = \$113
60	Average Payment per Episode for Fixed and Rotary Wing Air Ambulance Services	Air ambulance fixed wing = n/a; Air ambulance rotary wing = \$34,199

Appendix B: Summary Reference of Key Results

#	Exhibit Name	Delaware Results 2018
61	Top Body Systems by Amount Paid for Dates of Injury in 2017	Average Paid Per Claim for top 10 groups: Muscles (\$5,010); Injury or poisoning, NOC (\$2,336); Nervous System (\$2,708); Health status factors (\$727); Symptoms/signs, NOC (\$848); Digestive System (\$5,042); Mental (\$2,631); Blood disorders (\$11,493); Endocrine System (\$3,557); Circulatory System (\$1,914)
62	Top Diagnosis Groups by Amount Paid for Dates of Injury in 2017	Average Paid Per Claim for top 10 groups: Other dorsopathies (\$5,543); Other joint disorders (\$2,299); Other soft tissue disorders (\$2,755); Injuries to the wrist, hand and fingers (\$1,372); Injuries to the knee and lower leg (\$2,796); Injuries to the shoulder and upper arm (\$2,801); Injuries to the abdomen, lower back, lumbar spine, pelvis (\$1,684); Spondylopathies (\$3,252); Injuries to the head (\$1,328); Burns and corrosions of external body surface, specified by site (\$5,447)

Appendix C: Technical Appendix

The data contained in this report includes Medical Data Call transactions for Service Year 2018 (medical services delivered from January 1, 2018 to December 31, 2018) 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 2018, the reported number of transactions were 325,584 with more than \$45 million paid, for over 8,800 claims, representing data from 89% of the workers compensation premium written, which includes experience for large-deductible policies. Self-insured data is not collected.

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

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

Unit Statistical Data Call

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

Policy Effective Date...	Data Valued as of...	Due to the DCRB by...	Edited during...	Used for reporting starting...
January, Prior Year	July, Current Year	September, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
February, Prior Year	August, Current Year	October, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
March, Prior Year	September, Current Year	November, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
April, Prior Year	October, Current Year	December, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
May, Prior Year	November, Current Year	January, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
June, Prior Year	December, Current Year	February, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
July, Prior Year	January, Current Year	March, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
August, Prior Year	February, Current Year	April, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
September, Prior Year	March, Current Year	May, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
October, Prior Year	April, Current Year	June, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
November, Prior Year	May, Current Year	July, Current Year	2 nd and 3 rd quarter, Following Year	On or before April 1, Two years following
December, Prior Year	June, Current Year	August, Current Year	2 nd and 3 rd 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, 2018 and December 31, 2018
- 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, 2014 – December 31, 2014
 - January 1, 2015 – December 31, 2015
 - January 1, 2016 – December 31, 2016
 - January 1, 2017 – December 31, 2017
 - January 1, 2018 – December 31, 2018

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 2018 Delaware professional (physician) fee schedule to 2018 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

Appendix C: Technical Appendix

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 2018 Delaware inpatient hospital DRG fee schedule to the "DRG Summary for Medicare Inpatient Prospective Payment Hospitals, FY2017." 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 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 OPSS 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)

Appendix C: Technical Appendix

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.

Appendix C: Technical Appendix

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, 2017 and December 31, 2017. The paid amount for each diagnosis group was divided by the total paid amount for dates of service in 2017 and 2018 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, 2017 and December 31, 2017. The paid amount for each diagnosis group was divided by the total paid amount for dates of service in 2017 and 2018 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.

Appendix C: Technical Appendix

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, 2017 and December 31, 2017. The paid amount for each diagnosis group was divided by the total paid amount for dates of service in 2017 and 2018 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, 2017; and (c) increased independence for the Ratepayer Advocate who represents ratepayers during the workers compensation rate approval process and for the committee that oversees the cost control practices of individual workers compensation insurance carriers.

Appendix E: Exhibit Number Cross Reference

Exhibit Name	2018 Reports Exhibit #	2017 Reports Exhibit #
Medical Share of Total Benefit Costs	1	1
Overall Medical Average Cost per Lost Time Claim (in 000s)	2	2
Percentage of Medical Paid by Claim Maturity	3	3
Distribution of Medical Payments	4	4
Physician Payments as % of Medicare	5	5
Distribution of Medical Payments for Physicians	n/a	6
Distribution of Physician Payments by AMA Service Category	6	7
Top 10 Anesthesia Procedure Codes by Amount Paid	7	n/a
Top 10 Anesthesia Procedure Codes by Transaction Counts	8	n/a
Top 10 Surgery Procedure Codes by Amount Paid	9	8
Top 10 Surgery Procedure Codes by Transaction Counts	10	9
Time Until First Treatment for Major Surgery (in Days)	11	19
Top 10 Radiology Procedure Codes by Amount Paid	12	10
Top 10 Radiology Procedure Codes by Transaction Counts	13	11
Time Until First Treatment for Radiology (in Days)	14	20
Average Amount Paid per Transaction by Modifier Code	n/a	12
Top 10 Physical and General Medicine Procedure Codes by Amount Paid	15	13
Top 10 Physical and General Medicine Procedure Codes by Transaction Counts	16	14
Time Until First Treatment for Physical and General Medicine (in Days)	17	21
Top 10 Evaluation & Management Procedure Codes by Amount Paid	18	15
Top 10 Evaluation & Management Procedure Codes by Transaction Count	19	16
Time Until First Treatment for Initial Evaluation and Management Visit (in Days)	20	22
Office or Other Outpatient Visit for the Evaluation and Management of a New Patient	21	17
Office or Other Outpatient Visit for the Evaluation and Management of a Established Patient	22	18
Hospital Inpatient Payments as % of Medicare	23	23
Distribution of Medical Payments for Hospital Inpatient	n/a	24
Average Inpatient Paid Amount per Stay for Hospital Inpatient Services	24	25
Average Inpatient Paid Amount per Day for Hospital Inpatient Services	25	26
Average Number of Inpatient Stays per 1,000 Active Claims	26	27
Length of Stay for Hospital Inpatient Services (in Days)	27	28
Time Until First Treatment for Hospital Inpatient Stays (in Days)	28	29
Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services	29	30
Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services	30	31
Hospital Outpatient Payments as % of Medicare	31	32
Distribution of Medical Payments for Hospital Outpatient	n/a	33
Average Paid Amount Per Surgical Visit for Hospital Outpatient Services	32	34
Average Number of Surgical Hospital Outpatient Visits per 1,000 Active Claims	33	35
Average Paid Amount Per Non-Surgical Visit for Hospital Outpatient Services	34	36
Average Number of Non-Surgical Hospital Outpatient Visits per 1,000 Active Claims	35	37

Appendix E: Exhibit Number Cross Reference

Exhibit Name	2018 Reports Exhibit #	2017 Reports Exhibit #
Time Until First Treatment for Major Surgery Outpatient Visits (in Days)	36	n/a
Time Until First Treatment for All Other Outpatient Visits (in Days)	37	38
Top 10 Diagnosis Groups by Amount Paid for Hospital Outpatient Services	38	39
Top 10 Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services	39	40
Top 10 Non-Surgery Procedure Codes by Amount Paid for Hospital Outpatient Services	40	41
Average Amount Paid per ER Visit	41	42
Average Number of ER Visits per 1,000 Active Claims	42	43
Distribution of ER Service Payments	n/a	n/a
Emergency Room Payments by Procedure Code and Average Paid per Transaction	43	44
ER Transactions by Procedure Code and Number of Transactions	44	45
ASC Payments as % of Medicare	45	46
Distribution of Medical Payments for ASC	n/a	47
Average Amount Paid per Visit for ASC Services	46	48
Average Number of ASC Visits per 1,000 Active Claims	47	49
Time Until First Treatment for ASC Visits (in Days)	48	50
Top 10 Diagnosis Groups by Amount Paid for ASC Services	49	51
Top 10 Surgery Procedure Codes by Amount Paid for ASC Services	50	52
Distribution of Medical Payments for Drugs	n/a	53
Distribution of Prescription Drug Costs by CSA Schedule	51	54
Top 10 Workers Compensation Drugs by Amount Paid	52	55
Top 10 Workers Compensation Drugs by Prescription Counts	53	56
Top 30 Drugs for Service Year 2018	53A	56A
Distribution of Drugs by Brand Name and Generic	54	57
Distribution of Drugs by Pharmacy and Non-pharmacy	55	58
Distribution of Drugs by Repackaged and Non-Repackaged	n/a	n/a
Distribution of Medical Payments for DME, Supplies, and Implants	n/a	59
Distribution of Payments by DMEPOS	56	60
Top 5 DME Codes by Amount Paid	n/a	61
Top 5 Supplies Other than DME Codes by Amount Paid	n/a	62
Top 5 Orthotics and Prosthetics Codes by Amount Paid	n/a	63
Top Diagnosis Groups by Amount Paid for Dates of Injury in 2017 for Claims with an Implant or Prosthetic	57	n/a
Average Amount Paid per Claim Without an Implant or Prosthetic for Diagnosis Groups in Exhibit 57	58	n/a
Average Payment per Claim for Ground Ambulance Services	59	n/a
Average Payment per Claim for Fixed and Rotary Wing Air Ambulance Services	60	n/a
Top Body Systems by Amount Paid for Dates of Injury in 2017	61	64
Top Diagnosis Groups by Amount Paid for Dates of Injury in 2017	62	65