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June 30, 2021

Patti Vaughn
Benefits Administration Manager
Idaho Industrial Commission
700 S. Clearwater Lane, PO Box 83720
Boise, Idaho 83720

Re: Idaho Commercial Reimbursement Benchmarking

Dear Patti:

At the request of the Idaho Industrial Commission (IIC), Milliman is pleased to provide this report on commercial reimbursement in Idaho for specific DRGs and HCPCS. This analysis provides average commercial allowed amounts, those amounts as a percentage of Medicare, and percentiles of those allowed amounts. A similar analysis was provided on March 12th, 2020 using a slightly different set of codes.

Along with the standard requested exhibits produced last year, we are again providing an alternative version of the exhibits that mimics the methodology used in the National Council on Compensation Insurance (NCCI) report which does not apply any modifier, POS, or specialty exclusions. The alternative version also shows allowed per procedure instead of allowed per unit. While IIC does not use the NCCI methodology in its analysis (instead relying on the same approach taken with the standard exhibits in this report), this NCCI version is provided so IIC can compare results on a similar basis to the NCCI Medical Data Report. We understand that you will use this information to assess commercial reimbursement levels in the State of Idaho. This analysis may not be appropriate for other purposes.

This analysis is subject to the terms and conditions of the Contract for Actuarial Services between Milliman and the Idaho Industrial Commission dated April 26th, 2021.

Results

All requested tables of information are being provided in the attached exhibits. For your reference, the following table summarizes the average percent of Medicare in the data for each table using the HCPCS/DRG distribution in the data:

Table 1
Summary of 2020 Commercial Average Allowed
As a Percentage of 2020 Medicare

Description	Percent of Medicare
Inpatient DRG	228%
Outpatient Surgery*	154%
Outpatient Non-Surgery*	298%
Physician Surgery	228%
Physician Radiology	276%
Physician Medicine	113%
Physician Evaluation and Management	153%

*Outpatient excludes additional bundled implant dollars

We have attached more detailed exhibits by HCPCS/DRG with average commercial payment amounts, those amounts as a percentage of 2020 Medicare, and the 10th, 25th 50th, 75th, and 90th percentile of the commercial payment amounts. For the Evaluation and Management HCPCS you provided us, we provide results separately by place of service. This is because of notably higher average reimbursement (around 30% higher) when performed at a non-facility location compared to a facility location.

Breaking out dollars for implants was greatly limited by the availability of allowed amounts by implant. Often an implant was performed on a claim but the allowed amount was at the claim level and not available for the implant. For the inpatient exhibit, we have provided the percent of dollars that are listed in claim lines that have implant revenue codes for each DRG. We also included the number of claims that had implant revenue codes and the portion of those where the allowed dollars were greater than $0. For the outpatient exhibit, we determined the additional implant dollars that are bundled to the given HCPCS. The exhibits we have provided are:

- Exhibits following standard methodology:
  - Exhibit 1: Average Inpatient Commercial Charge, Percentage of Medicare and Percentiles by DRG
    - Includes requested Inpatient DRGs
  - Exhibit 2: Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
    - Includes requested Outpatient HCPCS
  - Exhibit 3: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
    - Includes requested Physician surgery, radiology, and physical medicine HCPCS
  - Exhibit 4: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service
    - Includes requested Physician Evaluation and Management HCPCS
- Exhibits following NCCI-specific methodology (modified versions of Exhibits 2 through 4):
  - Exhibit 5: Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS – All modifiers, specialties, POS and based on allowed per procedure
  - Exhibit 6: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS – All modifiers, specialties, POS and based on allowed per procedure
  - Exhibit 7: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service – All modifiers, specialties, POS and based on allowed per procedure

Note that, while we did mimic the code groupings from the NCCI report, reimbursement levels vary notably within some of those groupings. For example, average surgery allowed amounts differ greatly between hospitals and ambulatory surgical centers (ASCs). Similarly, there is variance in reimbursement levels between the different Idaho markets.

A few observations from Exhibits 1-4:

- The results are generally similar to the deliverable provided on 3/12/2020. The DRGs/HCPCS with the largest differences have low procedure counts.
- Additional bundled implant dollars vary significantly by surgery HCPCS. The largest variation is driven by HCPCS codes that have a low procedure count in the data (e.g., 63685 "Insrt/redo spine n generator"). The additional dollars range from 0% to 29% of the commercial allowed dollars with the implants excluded (except for the low volume HCPCS 63685 which has 48% additional dollars due to implants). For non-surgery HCPCS, there are no implant dollars as expected.
- The range of amounts paid by commercial payers for specific DRG/HCPCS is relatively large. The ratio between the 10th percentile and 90th percentile is generally around 200%-350% for inpatient services, 200%-500% for outpatient services, and 125%-250% for physician professional services.
- The average allowed is between the 25th percentile and the 75th percentile in most cases. A few HCPCS have an average allowed outside of the range due to a few outlier claims. Also, professional ER visits have an average allowed amount above the 75th percentile due to the largest dollar claims significantly increasing the mean.

A few additional observations from comparing Exhibits 5, 6 and 7 to Exhibits 2, 3 and 4, respectively:

- Outpatient results are similar between the two versions. The one large change is from HCPCS 97110 and 97140 using allowed per procedure instead of units. When units are ignored, the percentile range is much larger and the average allowed is much larger. As expected, this matches closer to the NCCI Medical Data Report.
- The surgery HCPCS codes in Exhibit 6 have a slight decrease in average allowed compared to Exhibit 3. This is primarily due to including claim lines performed for non-physician assistant (Modifier AS) in Exhibit 6. These often are paid at much lower rates (Medicare pays these at 16% of the regular rate).

  Also, there is generally a separate claim line for the same HCPCS for the primary surgeon. Since the HCPCS is listed twice on the claim and the service is just performed once, you would likely want to combine the dollars instead of include them separately, which would make the average allowed per surgery increase. Exhibit 6 is actually further from the report values so it is possible that the NCCI Medical Data Report is already combining these. We added a 'Surgery – Combined' section to the bottom of Exhibit 6 that combines all results into one record that has the same HCPCS, memberID, and Date. These updated results match much closer to the NCCI Medical Data Report.
- The radiology HCPCS in Exhibit 6 decreased significantly compared to Exhibit 3. This is because most of the claim lines were excluded in Exhibit 3 for having modifier 26 (professional component only). Since these claim lines are just for the professional component, they have allowed payments that are much lower. Including them drops the average allowed.
- The physical and general medicine HCPCS in Exhibit 6 have very similar results for the HCPCS that are not unit-dependent. The unit-dependent HCPCS (97110, 97112, 97140, and 97530) have huge increases in average allowed since Exhibit 6 calculates the average per procedure instead of units and these HCPCS often have multiple units. As expected, Exhibit 6 matches up better with the report results.

- The overall percentage of Medicare is generally the same between versions with and without exclusions, other than physician radiology. The reason physician radiology differs significantly is because most of the claim lines are excluded due to modifier exclusions in Exhibit 3.
- Exhibit 4 and Exhibit 7 also have very similar results since only a few claims are excluded in Exhibit 4.

Methodology

Commercial reimbursement was calculated using the 2019 Milliman CHSD commercial claim data for Idaho members. This database utilizes data from existing Milliman clients through data trade agreements. Average allowed and allowed percentiles were calculated for the DRG/HCPCS codes requested by the IIC.

The following adjustments were made to the CHSD repricing:

- The exhibits use fiscal year 2020 Medicare allowed. A single year of trend was applied to put the 2019 CHSD data on a 2020 basis. The 2019 to 2020 commercial allowed trends are listed below:
    - Inpatient: 2.5%
    - Outpatient: 4.8%
    - Professional: 2.6%
- Certain HCPCS have very few claims without a modifier. To increase the credibility of the percentiles, Milliman reviewed all modifiers in the data set and kept claims with high frequency modifiers that do not greatly alter the average paid amount. Claim lines with the following modifiers were kept. All other claim lines with modifiers were excluded from Exhibits 2-4 (this exclusion was not applied to Exhibits 5-7.):
    - Outpatient: GO, LT, RT, 59, TC, GP, 25
    - Physician: 59, LT, RT, 25, XU, AT, GO, GP, 24, 51, 57, 76
- Services with specialties indicating that they were performed by assistants have been excluded. This exclusion was only applied to Exhibits 2-4 and was not applied to Exhibits 5-7. The specialty codes for these are 32, 43, 97, and Z0.
- For HCPCS that should rarely or never have more than one unit, claim lines with multiple units were excluded. Unit-dependent HCPCS are shown in Exhibits 2-4 on a ‘per unit’ basis (Exhibits 5-7 show HCPCS on a ‘per procedure’ basis). All HCPCS we identified as unit-dependent had two or more units on at least 28% of claim lines. All other HCPCS had multiple units on less than 2% of claim lines. The following HCPCS are unit-dependent:
    - Outpatient: 97110 and 97140
    - Professional: 97110, 97112, 97140, and 97530
- As requested, ambulatory surgical centers are excluded in the calculations. This was identified using POS 24. Also, inpatient services were excluded from the outpatient claims using POS 21. Both of these exclusions were only applied to Exhibits 2-4 and were not applied to Exhibits 5-7.

Implant carveout logic:

- Claim lines are identified as implants using revenue codes 0274, 0275, 0276, and 0278.
- For inpatient, the implant dollars are already included in the DRG average. For outpatient, we show separate calculations with and without implant dollars.

- To determine the outpatient implant dollars for each claim line, all implant commercial allowed dollars that are bundled by Medicare are assigned to the APC payment on the claim. The APC allowed dollar distribution is used to spread the implant dollars across claims where there are multiple claim lines with Medicare payments.

Medicare Amounts

The CHSD data was repriced to 2020 Medicare allowed levels using the *Milliman Medicare Repricer*. The following considerations apply to the repricing results:

- All repriced amounts reflect prospective amounts and do not reflect any settlements with CMS.
- No adjustments are made for sequestration.
- Repriced amounts are based on information released at the beginning of each year (Federal fiscal year for inpatient and calendar year for other types of services).
- No adjustment is made for providers that participate in Medicare's Bundled Payment for Care Improvement (BPCI) initiative.

Facility Repricing

- Inpatient Medicare payments exclude Indirect Medical Education (IME), Disproportional Share (DSH), Uncompensated Care, and outlier payment components.
- Non-PPS hospitals are priced using PPS. This includes:
  - Critical access hospitals (paid at cost by Medicare)
  - Cancer and children's hospitals (paid at cost by Medicare)
- Inpatient new technology payments are not included. The impact of these payments varies from year to year, but is generally is very small (i.e. less than 1%).
- Inpatient rehabilitation and psychiatric hospital claims are priced using IPPS rather than the Rehab PPS and Psych PPS schedules.

Professional Repricing

- Medicare employs claim edits to deny payment for certain professional services. We assumed all professional services with a positive allowed amount were accepted for payment and included these services in the repricing analysis.
- No physician incentive payment adjustments are included, such as those under the Electronic Prescribing (eRx) Incentive Program, the Physician Quality Reporting System (PQRS), the Maintenance of Certification Program (MOC), or the Primary Care Incentive Payments (PCIP) program.
- Medicare makes additional payments for professionals in Health Professional Shortage Areas. These payments are not incorporated.

Data Reliance and Variability of Results

This report is not intended to benefit third parties. Regarding the contents of this report, Milliman makes no representations or warranties to third parties. Third parties are to place no reliance upon this report that would result in the creation of any duty or liability for Milliman or its employees to third parties, under any theory of law. Third parties receiving this report must rely on their own experts to draw conclusions about the report's contents.

In performing our analysis, we relied on data and other information provided to us by CMS and commercial data contributors. We have not audited or verified this data and other information, but we have reviewed it for reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Our estimates are not predictions of the future; they are estimates based on the assumptions. If the underlying data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete. Emerging results should be carefully monitored with assumptions adjusted as appropriate.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Please call us with any questions or concerns. We appreciate the opportunity to work with you on this review.

Sincerely,

David C. Lewis
Principal

Attachments

cc: Chris Smith, Milliman

Exhibit 1
Idaho Industrial Commision
Average Inpatient Commercial Charge, Percentage of Medicare and Percentiles by DRG

Notes on Implant Amounts
Inpatient allowed amounts by implant code were often not populated because the implant payment was bundled with the rest of the claim.
Amounts are shown to the right for claims where implants had separate allowed amounts, and where they did not.

			Average		Percentiles of CHSD Allowed					Implant Information					
										Admits w/ an Implant (Rev Codes 0274-0276, 0278)		Admits with non-Zero Allowed $s by Implant Code		Admits with Zero Allowed $s by Implant Code	
DRG	Description	Admits	2020 CHSD Allowed[1]	%-age of 2020 Medicare[2]	10th	25th	50th	75th	90th	Number	% of Total	Admits	Implant % of Total Allowed	Admits	Implant % of Total Allowed
455	Combined anterior/posterior spinal fusion w/o CC/MCC	70	$62,547	202%	$35,021	$41,941	$64,397	$73,178	$91,385	63	90%	30	37.3%	33	
470	Major Hip & Knee Joint Replacement Or Reattachment Of Lower Extremity w/o M	450	$31,040	246%	$19,871	$24,354	$28,196	$36,878	$46,665	430	96%	177	36.9%	253	
460	Spinal fusion except cervical w/o MCC	44	$53,775	211%	$32,990	$39,746	$46,365	$59,958	$80,026	41	93%	16	44.0%	25	
454	Combined anterior/posterior spinal fusion w CC	20	$65,100	167%	$36,273	$52,258	$53,686	$91,283	$98,706	17	85%	7	33.0%	10	
957	Other O.R. procedures for multiple significant trauma w MCC	5	$105,315	221%	$39,453	$42,680	$66,501	$128,260	$249,681	3	60%	3	7.1%	0	
483	Major Joint/Limb Reattachment Procedures Of Upper Extremities	42	$35,760	239%	$19,871	$23,115	$30,825	$46,026	$56,224	42	100%	17	46.1%	25	
003	ECMO or trach w MV 96+ hrs or PDX exc face, mouth & neck w maj O.R.	3	$230,974	309%	$30,456	$30,456	$264,971	$397,496	$397,496	2	67%	1	19.6%	1	
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC	23	$30,164	259%	$17,541	$17,541	$22,069	$35,005	$57,447	21	91%	6	22.9%	15	Cannot be
473	Cervical spinal fusion w/o CC/MCC	32	$30,854	194%	$21,828	$22,993	$26,135	$36,366	$45,677	31	97%	8	22.6%	23	determined.
481	Hip & femur procedures except major joint w CC	10	$36,406	262%	$17,909	$21,037	$34,717	$43,486	$59,694	8	80%	3	15.5%	5	

(1) Based on 2019 CHSD data trended to 2020.
(2) Medicare amount excludes DSH, IME, UCP, and Outlier add-on payments.

Exhibit 2
Idaho Industrial Commision
Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
Excludes Modified Codes[1]

Notes on Implant Amounts
Implants are coded separate from the HCPCS codes listed below. When implants occurred on a claim, their allowed amounts were spread across claim lines that were paid under APCs.

				Average		Percentiles of CHSD Allowed						Implant	
Source	HCPCS	Description	Units	2020 CHSD Allowed[2]	%-age of 2020 Medicare	10th	25th	50th	75th	90th	APC Code[3]	Additional Bundled Implants[4]	Combined % of 2020 Medicare[5]
Surg	20680	Removal of support implant	153	$3,720	211%	$2,178	$3,191	$3,267	$4,759	$5,454	5073	$151	220%
Surg	22551	Neck spine fuse&remov bel c2	45	$12,270	103%	$1,524	$5,785	$11,770	$14,500	$29,233	5115	$3,592	134%
Surg	23430	Repair biceps tendon	129	$7,983	156%	$1,572	$3,869	$6,572	$13,468	$14,105	5114	$576	168%
Surg	29806	Shoulder arthroscopy/surgery	93	$7,594	118%	$3,475	$5,792	$6,572	$9,621	$14,105	5114	$1,722	145%
Surg	29827	Arthroscop rotator cuff repr	192	$6,696	180%	$2,712	$3,777	$6,245	$7,376	$12,790	5114	$1,066	208%
Surg	29881	Knee arthroscopy/surgery	351	$4,448	210%	$2,582	$3,575	$3,840	$5,512	$6,655	5113	$184	219%
Surg	29888	Knee arthroscopy/surgery	178	$9,277	136%	$4,917	$6,245	$7,336	$11,790	$18,271	5114	$1,833	163%
Surg	49650	Lap ing hernia repair init	108	$7,601	170%	$2,579	$5,833	$7,589	$9,636	$12,087	5361	$570	183%
Surg	63030	Low back disk surgery	104	$9,524	161%	$6,059	$7,806	$8,186	$11,658	$13,374	5114	$32	162%
Surg	63685	Insrt/redo spine n generator	9	$22,672	81%	$2,896	$2,964	$7,346	$9,297	$85,016	5464	$10,801	119%
Non-Surg	73221	Mri joint upr extrem w/o dye	740	$839	366%	$308	$470	$751	$1,111	$1,505	5523	$0	366%
Non-Surg	73222	Mri joint upr extrem w/dye	425	$1,422	214%	$781	$781	$1,119	$1,888	$2,484	5573	$0	214%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	2,023	$809	355%	$308	$470	$751	$1,081	$1,468	5523	$0	355%
Non-Surg	74177	Ct abd & pelv w/contrast	3,899	$1,597	412%	$629	$722	$984	$2,516	$3,354	5572	$1	412%
Non-Surg	97110	Therapeutic exercises	35,978	$55	196%	$40	$48	$51	$62	$71		$0	197%
Non-Surg	97140	Manual therapy 1/> regions	18,992	$53	216%	$36	$45	$47	$58	$68		$0	216%
Non-Surg	99213	Office O/P Est Low 20-29 Min	1,972	$109	94%	$46	$95	$99	$117	$160		$0	94%
Non-Surg	99282	Emergency dept visit	5,020	$366	294%	$272	$335	$351	$418	$465	5022	$0	294%
Non-Surg	99283	Emergency dept visit	11,300	$661	298%	$489	$588	$633	$735	$848	5023	$0	298%
Non-Surg	99284	Emergency dept visit	8,167	$1,095	301%	$731	$954	$1,063	$1,208	$1,511	5024	$0	301%

(1) Only the following modifiers are included: GO, LT, RT, 59, TC, GP, 25
(2) Based on 2019 CHSD data trended to 2020. Does not include additional bundled implant dollars.
(3) A few HCPCS do not have APC codes because they are either bundled or paid using a different method than APC.
(4) Implants are defined as lines with revenue code 0274, 0275, 0276, or 0278.
(5) (CHSD Allowed + Additional Bundled Implants) / 2020 Medicare

Exhibit 3
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
Excludes Modified Codes[1]

Source	HCPCS	Description	Units	Average 2020 CHSD Allowed[2]	Average %-age of 2020 Medicare	Percentiles of CHSD Allowed 10th	25th	50th	75th	90th
Surgery	22551	Neck spine fuse&remov bel c2	127	$3,541	231%	$2,856	$3,279	$3,540	$3,732	$4,352
Surgery	22633	Lumbar spine fusion combined	70	$4,287	251%	$3,114	$3,704	$4,056	$4,596	$5,003
Surgery	23430	Repair biceps tendon	152	$999	209%	$632	$722	$789	$1,445	$1,572
Surgery	27447	Total knee arthroplasty	381	$2,844	223%	$2,312	$2,579	$2,690	$3,309	$3,746
Surgery	29823	Sho Arthrs Srg Xtnsv Dbrdmt	112	$757	270%	$383	$601	$695	$814	$1,232
Surgery	29824	Shoulder arthroscopy/surgery	203	$898	247%	$413	$648	$750	$1,296	$1,428
Surgery	29826	Shoulder arthroscopy/surgery	347	$394	240%	$339	$344	$350	$397	$428
Surgery	29827	Arthroscop rotator cuff repr	226	$2,196	219%	$1,941	$2,058	$2,088	$2,380	$2,618
Surgery	29881	Knee arthroscopy/surgery	389	$1,001	232%	$524	$829	$1,048	$1,142	$1,326
Surgery	29888	Knee arthroscopy/surgery	215	$2,050	223%	$1,889	$1,889	$1,951	$2,209	$2,411
Radiology	70450	Ct head/brain w/o dye	50	$299	272%	$128	$226	$285	$404	$425
Radiology	72148	Mri lumbar spine w/o dye	501	$684	337%	$422	$438	$565	$865	$1,177
Radiology	72158	Mri lumbar spine w/o & w/dye	83	$1,028	305%	$717	$739	$1,062	$1,270	$1,270
Radiology	73030	X-ray exam of shoulder	1,650	$55	181%	$43	$49	$54	$57	$70
Radiology	73221	Mri joint upr extrem w/o dye	261	$632	291%	$446	$462	$575	$640	$1,042
Radiology	73222	Mri joint upr extrem w/dye	193	$932	272%	$713	$898	$909	$1,002	$1,147
Radiology	73610	X-ray exam of ankle	1,829	$59	185%	$47	$52	$59	$61	$75
Radiology	73721	Mri jnt of lwr extre w/o dye	623	$660	306%	$445	$463	$576	$645	$1,212
Radiology	74177	Ct abd & pelv w/contrast	205	$739	242%	$478	$606	$744	$843	$918
Radiology	76942	Echo guide for biopsy	396	$157	291%	$96	$99	$116	$120	$416
Phys. Med.	97014	Electric stimulation therapy	23,950	$16	117%	$11	$14	$16	$16	$23
Phys. Med.	97110	Therapeutic exercises	150,905	$31	123%	$23	$26	$31	$32	$41
Phys. Med.	97112	Neuromuscular reeducation	32,195	$33	108%	$26	$30	$34	$36	$41
Phys. Med.	97140	Manual therapy 1/> regions	90,595	$28	127%	$20	$22	$28	$30	$36
Phys. Med.	97161	Pt eval low complex 20 min	4,600	$83	102%	$70	$80	$81	$85	$97
Phys. Med.	97162	Pt eval mod complex 30 min	4,034	$85	104%	$74	$81	$84	$85	$96
Phys. Med.	97530	Therapeutic activities	68,031	$36	111%	$28	$33	$35	$41	$44
Phys. Med.	97545	Work hardening	0							
Phys. Med.	98941	Chiropract manj 3-4 regions	79,244	$37	95%	$32	$34	$35	$41	$48
Phys. Med.	99199	Special service/proc/report	0							

(1) Only the following modifiers are included: 59, LT, RT, 25, XU, AT, GO, GP, 24, 57, 51, 76
(2) Based on 2019 CHSD data trended to 2020.

Exhibit 4
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service
Excludes Modified Codes[1]

Evaluation and Management Codes

		Facility								Non-Facility							
			Average		Percentiles of CHSD Allowed						Average		Percentiles of CHSD Allowed				
HCPCS	Description	Units	2020 CHSD Allowed[2]	%-age of 2020 Medicare	10th	25th	50th	75th	90th	Units	2020 CHSD Allowed[2]	%-age of 2020 Medicare	10th	25th	50th	75th	90th
99202	Office O/P New Sf 15-29 Min	225	$80	167%	$62	$71	$77	$79	$110	23,186	$103	146%	$75	$95	$103	$112	$128
99203	Office O/P New Low 30-44 Min	669	$119	165%	$97	$107	$117	$121	$147	45,197	$154	153%	$126	$148	$160	$167	$185
99204	Office O/P New Mod 45-59 Min	747	$200	160%	$159	$181	$199	$206	$255	21,023	$238	154%	$204	$228	$249	$258	$287
99212	Office O/P Est Sf 10-19 Min	686	$41	169%	$28	$36	$39	$40	$55	28,517	$61	145%	$44	$58	$60	$67	$73
99213	Office O/P Est Low 20-29 Min	4,954	$75	154%	$51	$69	$74	$80	$90	241,095	$105	150%	$93	$99	$105	$114	$127
99214	Office O/P Est Mod 30-39 Min	4,087	$117	155%	$78	$110	$119	$124	$153	132,873	$155	153%	$138	$145	$159	$168	$187
99283	Emergency dept visit	5,624	$127	201%	$81	$87	$97	$135	$201	Not Applicable to Non-Facility							
99284	Emergency dept visit	10,563	$226	197%	$163	$165	$182	$206	$313								
99455	Work related disability exam	HCPCS Have No/Very Little Utilization															
99456	Disability examination																

(1) Only the following modifiers are included: 59, LT, RT, 25, XU, AT, GO, GP, 24, 57, 51, 76
(2) Based on 2019 CHSD data trended to 2020.

Exhibit 5
Idaho Industrial Commision
Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
All modifiers, specialties, POS and based on allowed per procedure

Notes on Implant Amounts
Implants are coded separate from the HCPCS codes listed below. When implants occurred on a claim, their allowed amounts were spread across claim lines that were paid under APCs.

				Average		Percentiles of CHSD Allowed						Implant	
Source	HCPCS	Description	Procedures	2020 CHSD Allowed[1]	%-age of 2020 Medicare	10th	25th	50th	75th	90th	APC Code[2]	Additional Bundled Implants[3]	Combined % of 2020 Medicare[4]
Surg	20680	Removal of support implant	221	$3,291	226%	$1,257	$1,991	$3,267	$4,629	$5,786	5073	$130	234%
Surg	22551	Neck spine fuse&remov bel c2	46	$12,234	103%	$1,524	$5,785	$11,499	$14,500	$29,233	5115	$3,514	132%
Surg	23430	Repair biceps tendon	151	$7,200	152%	$1,351	$2,790	$6,245	$12,350	$14,105	5114	$492	163%
Surg	29806	Shoulder arthroscopy/surgery	108	$6,971	117%	$2,841	$3,869	$6,245	$9,325	$14,105	5114	$1,527	143%
Surg	29827	Arthroscop rotator cuff repr	226	$6,351	179%	$2,477	$3,350	$6,245	$7,376	$12,790	5114	$910	205%
Surg	29881	Knee arthroscopy/surgery	430	$3,987	208%	$1,545	$3,066	$3,657	$5,250	$6,395	5113	$153	216%
Surg	29888	Knee arthroscopy/surgery	210	$8,665	136%	$4,192	$6,237	$6,572	$9,654	$16,888	5114	$1,554	161%
Surg	49650	Lap ing hernia repair init	154	$7,843	180%	$2,580	$5,567	$7,589	$10,105	$12,355	5361	$653	195%
Surg	63030	Low back disk surgery	122	$8,948	162%	$4,880	$7,128	$8,065	$11,476	$13,152	5114	$28	162%
Surg	63685	Insrt/redo spine n generator	19	$25,780	103%	$2,896	$7,346	$25,711	$33,617	$79,346	5464	$5,116	123%
Non-Surg	73221	Mri joint upr extrem w/o dye	771	$844	362%	$308	$470	$751	$1,126	$1,505	5523	$0	362%
Non-Surg	73222	Mri joint upr extrem w/dye	433	$1,415	214%	$781	$781	$1,119	$1,915	$2,484	5573	$0	214%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	2,096	$816	353%	$308	$470	$751	$1,082	$1,493	5523	$0	353%
Non-Surg	74177	Ct abd & pelv w/contrast	3,937	$1,595	411%	$629	$722	$984	$2,516	$3,354	5572	$1	411%
Non-Surg	97110	Therapeutic exercises	25,300	$106	207%	$48	$70	$118	$207	$403		$0	208%
Non-Surg	97140	Manual therapy 1/> regions	15,198	$77	223%	$44	$47	$89	$142	$270		$0	223%
Non-Surg	99213	Office O/P Est Low 20-29 Min	2,156	$110	96%	$46	$95	$99	$117	$166		$0	96%
Non-Surg	99282	Emergency dept visit	5,056	$366	294%	$269	$335	$351	$418	$465	5022	$0	294%
Non-Surg	99283	Emergency dept visit	11,375	$660	298%	$489	$588	$633	$735	$849	5023	$0	298%
Non-Surg	99284	Emergency dept visit	8,235	$1,094	301%	$731	$954	$1,063	$1,208	$1,515	5024	$0	301%

(1) Based on 2019 CHSD data trended to 2020. Does not include additional bundled implant dollars.
(2) A few HCPCS do not have APC codes because they are either bundled or paid using a different method than APC.
(3) Implants are defined as lines with revenue code 0274, 0275, 0276, or 0278.
(4) (CHSD Allowed + Additional Bundled Implants) / 2020 Medicare

Exhibit 6
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
All modifiers, specialties, POS and based on allowed per procedure

				Average		Percentiles of CHSD Allowed				
Source	HCPCS	Description	Procedures	2020 CHSD Allowed[(1)]	%-age of 2020 Medicare	10th	25th	50th	75th	90th
Surgery	22551	Neck spine fuse&remov bel c2	180	$2,715	231%	$364	$738	$3,279	$3,732	$4,170
Surgery	22633	Lumbar spine fusion combined	104	$3,355	248%	$443	$1,102	$3,815	$4,428	$4,596
Surgery	23430	Repair biceps tendon	270	$705	204%	$79	$147	$722	$1,145	$1,471
Surgery	27447	Total knee arthroplasty	640	$2,063	219%	$269	$403	$2,579	$2,812	$3,585
Surgery	29823	Sho Arthrs Srg Xtnsv Dbrdmt	184	$549	250%	$79	$163	$606	$696	$1,190
Surgery	29824	Shoulder arthroscopy/surgery	311	$714	235%	$76	$350	$660	$1,141	$1,342
Surgery	29826	Shoulder arthroscopy/surgery	565	$294	237%	$35	$101	$344	$368	$428
Surgery	29827	Arthroscop rotator cuff repr	397	$1,565	212%	$209	$281	$2,058	$2,255	$2,439
Surgery	29881	Knee arthroscopy/surgery	462	$989	229%	$524	$829	$1,048	$1,142	$1,326
Surgery	29888	Knee arthroscopy/surgery	377	$1,464	220%	$195	$289	$1,911	$2,102	$2,411
Radiology	70450	Ct head/brain w/o dye	2,668	$91	214%	$77	$83	$86	$90	$98
Radiology	72148	Mri lumbar spine w/o dye	1,990	$294	275%	$145	$149	$151	$408	$817
Radiology	72158	Mri lumbar spine w/o & w/dye	308	$469	269%	$222	$231	$233	$717	$1,265
Radiology	73030	X-ray exam of shoulder	4,645	$38	193%	$19	$19	$32	$54	$67
Radiology	73221	Mri joint upr extrem w/o dye	1,057	$270	254%	$132	$137	$139	$434	$640
Radiology	73222	Mri joint upr extrem w/dye	622	$408	251%	$160	$164	$166	$898	$1,002
Radiology	73610	X-ray exam of ankle	5,218	$40	199%	$17	$18	$35	$59	$72
Radiology	73721	Mri jnt of lwr extre w/o dye	2,763	$266	261%	$133	$136	$139	$279	$628
Radiology	74177	Ct abd & pelv w/contrast	5,758	$210	215%	$176	$184	$186	$195	$210
Radiology	76942	Echo guide for biopsy	2,730	$93	269%	$54	$56	$66	$85	$170
Phys. Med.	97014	Electric stimulation therapy	28,355	$16	117%	$11	$14	$16	$18	$25
Phys. Med.	97110	Therapeutic exercises	83,897	$56	123%	$26	$32	$50	$75	$110
Phys. Med.	97112	Neuromuscular reeducation	23,796	$45	108%	$27	$34	$36	$57	$72
Phys. Med.	97140	Manual therapy 1/> regions	63,137	$41	127%	$22	$28	$31	$57	$73
Phys. Med.	97161	Pt eval low complex 20 min	4,617	$83	102%	$70	$80	$81	$85	$97
Phys. Med.	97162	Pt eval mod complex 30 min	4,056	$85	104%	$74	$81	$84	$85	$95
Phys. Med.	97530	Therapeutic activities	35,796	$70	111%	$35	$39	$67	$88	$140
Phys. Med.	97545	Work hardening	0							
Phys. Med.	98941	Chiropract manj 3-4 regions	103,015	$37	96%	$34	$34	$36	$42	$67
Phys. Med.	99199	Special service/proc/report	0							
Surgery - Combined	22551	Neck spine fuse&remov bel c2	133	$3,674	231%	$2,856	$3,327	$3,732	$4,069	$4,602
Surgery - Combined	22633	Lumbar spine fusion combined	80	$4,362	248%	$3,092	$3,815	$4,074	$4,596	$5,686
Surgery - Combined	23430	Repair biceps tendon	175	$1,088	204%	$722	$793	$878	$1,475	$1,640
Surgery - Combined	27447	Total knee arthroplasty	434	$3,042	219%	$2,312	$2,588	$2,901	$3,476	$4,121
Surgery - Combined	29823	Sho Arthrs Srg Xtnsv Dbrdmt	133	$760	250%	$383	$601	$673	$843	$1,286
Surgery - Combined	29824	Shoulder arthroscopy/surgery	245	$907	235%	$413	$660	$747	$1,296	$1,451
Surgery - Combined	29826	Shoulder arthroscopy/surgery	400	$416	237%	$339	$344	$378	$428	$560
Surgery - Combined	29827	Arthroscop rotator cuff repr	272	$2,284	212%	$1,828	$2,058	$2,264	$2,493	$2,859
Surgery - Combined	29881	Knee arthroscopy/surgery	457	$1,000	229%	$524	$829	$1,048	$1,142	$1,326
Surgery - Combined	29888	Knee arthroscopy/surgery	254	$2,172	220%	$1,889	$1,911	$2,102	$2,466	$2,624

(1) Based on 2019 CHSD data trended to 2020.

Exhibit 7
Idaho Industrial Commision
Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service
All modifiers, specialties, POS and based on allowed per procedure

Evaluation and Management Codes

		Facility								Non-Facility							
			Average		Percentiles of CHSD Allowed						Average		Percentiles of CHSD Allowed				
HCPCS	Description	Procedures	2020 CHSD Allowed[1]	%-age of 2020 Medicare	10th	25th	50th	75th	90th	Procedures	2020 CHSD Allowed[1]	%-age of 2020 Medicare	10th	25th	50th	75th	90th
99202	Office O/P New Sf 15-29 Min	262	$79	165%	$50	$67	$77	$79	$106	26,436	$104	150%	$77	$95	$103	$115	$130
99203	Office O/P New Low 30-44 Min	735	$119	166%	$95	$107	$117	$121	$147	49,494	$155	156%	$128	$148	$161	$169	$188
99204	Office O/P New Mod 45-59 Min	763	$200	160%	$157	$181	$199	$206	$255	22,364	$239	156%	$204	$228	$249	$258	$288
99212	Office O/P Est Sf 10-19 Min	769	$42	172%	$28	$36	$39	$40	$56	30,746	$62	147%	$46	$58	$63	$67	$76
99213	Office O/P Est Low 20-29 Min	5,411	$74	154%	$51	$68	$75	$80	$90	268,426	$105	153%	$92	$99	$108	$114	$127
99214	Office O/P Est Mod 30-39 Min	4,415	$117	156%	$78	$108	$121	$124	$153	145,437	$156	155%	$135	$145	$163	$168	$187
99283	Emergency dept visit	6,155	$127	203%	$81	$90	$97	$129	$201	Not Applicable to Non-Facility							
99284	Emergency dept visit	11,468	$226	197%	$165	$165	$184	$206	$313								
99455	Work related disability exam	HCPCS Have No/Very Little Utilization															
99456	Disability examination																

(1) Based on 2019 CHSD data trended to 2020.