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June 30, 2023

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, average percentages of Medicare, and percentiles of those commercial allowed amounts. A similar analysis was provided on June 30, 2021 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 commercial allowed per procedure instead of commercial 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 February 16th, 2023.

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 2022 Average Commercial Allowed
As a Percentage of 2022 Medicare

Description	Percent of Medicare
Inpatient DRG	243%
Outpatient Surgery*	119%
Outpatient Non-Surgery*	278%
Physician Surgery	218%
Physician Radiology	232%
Physician Medicine	121%
Physician Evaluation and Management	146%
Telehealth	124%

*Outpatient excludes additional bundled implant dollars

We have attached more detailed exhibits by HCPCS/DRG with average commercial allowed amounts, those amounts as a percentage of 2022 Medicare, and the 10th, 25th, 50th, 75th, and 90th percentile of the commercial allowed 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 commercial allowed amounts by implant. Often an implant was performed on a claim but the commercial 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 commercial 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, physical medicine, and telehealth 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 commercial allowed per procedure
  - Exhibit 6: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS – All modifiers, specialties, POS and based on commercial allowed per procedure. Telehealth codes are limited to modifiers 93, 95, and GT.

- Exhibit 7: Average Professional Commercial Charge, Percentage of Medicare and Percentiles by HCPCS and Place of Service – All modifiers, specialties, POS and based on commercial 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 commercial 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 6/30/2021. The DRGs/HCPCS with the largest differences have low procedure counts.
- Additional bundled implant dollars vary significantly by surgery HCPCS. The additional dollars range from 1% to 30% of the commercial allowed dollars with the implants excluded (except for HCPCS 27447 which has 59% additional dollars due to implants). For non-surgery HCPCS, there are minimal 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%-450% for inpatient services, 200%-400% for outpatient services, and 125%-250% for physician professional services.
- The average commercial allowed is between the 25th percentile and the 75th percentile in most cases. A few DRGs/HCPCS have an average commercial allowed outside of the range due to a few outlier claims. Also, professional ER visits (HCPCS code 99284) have an average commercial 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 commercial allowed per procedure instead of units. When units are ignored, the percentile range is much larger and the average commercial allowed is much larger. As expected, this matches closer to the NCCI Medical Data Report.
- The surgery HCPCS codes in Exhibit 6 have a notable decrease in average commercial 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 including them separately, which would make the average commercial 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 commercial allowed payments that are much lower. Including them drops the average commercial 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 commercial allowed since Exhibit 6 calculates the average per

procedure instead of units and these HCPCS often have multiple units. The values in the NCCI report tend to fall somewhere between the Exhibit 3 and Exhibit 6 values.

- 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 2021 Milliman Consolidated Health Cost Guidelines Sources Database (CHSD) commercial claim data for Idaho members. This database utilizes data from existing Milliman clients through data trade agreements. Average commercial allowed and commercial 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 2022 Medicare allowed. A single year of trend was applied to put the 2021 CHSD data on a 2022 basis. The 2021 to 2022 commercial allowed trends are listed below:
  - Inpatient: 2.1%
  - Outpatient: 3.4%
  - Professional: 2.3%
- 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, 57, 51, 76
  - The exception to this is the telehealth section. Telehealth services are identified by limiting these codes to modifiers 93, 95, and GT. This modifier restriction applies for Exhibit 3 and Exhibit 6.
- 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 2022 Medicare allowed levels using the *Milliman Medicare Repricer*. The following considerations apply to the repricing results:

- All results are based on data and information published by CMS or the Medicare Administrative Contractors (MACs).
- All repriced amounts reflect prospective amounts and do not reflect any settlements with CMS.
- No adjustments are made for sequestration.
- Medicare employs claim edits to deny payment for certain services. We assumed all services with a positive allowed amount were accepted for payment and included these services in the repricing analysis. The Government Accountability Office (GAO) estimated the impact of prepayment edits in fiscal year 2010 to be approximately 0.5% of Medicare fee-for-service costs.
- The Milliman Medicare Repricer does not adjust claims for information contained within condition codes, such as codes 42 and 43 which can be added on a claim to bypass the reduction for certain transfers, or ZA which can exclude a claim from COVID new technology payments.

Facility Repricing

- The Medicare Allowed amount for inpatient is calculated as the sum of the DRG Price, Outlier, DSH, Uncompensated Care, and capital IME. Pass Thru payments and operating IME payments are excluded.
- Uncompensated Care payments were only added to the mother's claim and not to the Medicare allowed for well-newborn claims (MS-DRG 795).
- The *Milliman Medicare Repricer* prices inpatient facility discharges using Medicare's Acute Inpatient PPS fee schedule (used for about 94% of Medicare FFS inpatient, non-SNF payments in FY2014) and currently does not support the Inpatient Psychiatric Facility PPS, Inpatient Rehabilitation Facility PPS, Long-Term Care Hospital PPS, and Hospice PPS fee schedules. Critical Access Hospitals, which CMS initially pays at interim rates and later reconciles to 101% of cost, are paid the per diem interim rates. Other hospitals paid outside of PPS are excluded from this analysis. These include Cancer Hospitals (paid based on cost), and Children's Hospitals (paid based on cost).
- No adjustment is made for providers that participate in Medicare's Bundled Payment for Care Improvement (BPCI) initiative or the Rural Community Hospital Demonstration Program.
- The Milliman Medicare Repricer does not adjust capital payments for new hospitals.
- We compare the Milliman Medicare Repricer results against the CMS IPPS PC Pricer software. In general, the two are consistent for the same set of inputs unless noted otherwise in these caveats. When there is a difference, we contact CMS and work to resolve the issue; in some cases, this results in a change to CMS's software.
- CMS reduces a hospital's IPPS payment for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. Claims potentially subject to this adjustment typically have condition code 49 or 50 and value code FD. The Milliman Medicare Repricer does not make such adjustments.
- The Milliman Medicare Repricer prices outpatient facility claims using Medicare's Hospital Outpatient PPS fee schedule for hospital claims (used for about 90% of Medicare outpatient facility, non-ASC, non-dialysis payments in CY2014) and the Ambulatory Surgical Center (ASC) Payment for ASCs. For the following provider types the Milliman Medicare Repricer prices using the OPPS fee schedule, which will not match actual Medicare payments: Cancer Hospitals (paid based on cost), and Children's Hospitals (paid at cost).
- Beginning in 2014 Medicare makes device adjustments based on value code "FD" and the corresponding credit amount specified on the value line. The Medicare Reference Pricer does not support value code FD and device credits for hospitals. Therefore, hospital device credits must be manually applied. Device credits for ASCs are supported using modifiers FB and FC.

- For obsolete or deleted HCPCS, the Milliman Medicare Repricer maps the service to the current HCPCS with an equivalent meaning, when available.
- Reimbursement for outpatient services paid at cost (APC status F, H, and L) is estimated based on the billed charges for the service line and the provider specific cost-to-charge ratio published by CMS in the Outpatient Provider Specific File (OP PSF).
- The *Milliman Medicare Repricer* applies the site-neutral reductions for clinic visit services (HCPCS G0463) in 2019 (30% reduction) and in 2020 and later (60% reduction) when coded with the "PN" procedure code modifier. The *Milliman Medicare Repricer* also applies a reduction for all HCPCS coded with the "PO" procedure code modifier when furnished in off-campus provider-based departments (PBDs). This reduction is 50% in 2017 and 60% in 2018 and later.

Professional Repricing

- Medicare reduces payment for outpatient physical and occupational therapy services furnished by a therapy assistant to 85 percent of the rate that would have otherwise been paid. The *Milliman Medicare Repricer* does not apply this adjustment.
- The *Milliman Medicare Repricer* does not include physician incentive payment adjustments, such as those under the Electronic Prescribing (eRx) Incentive Program, the Physician Quality Reporting System (PQRS), the Maintenance of Certification Program (MOC), the Primary Care Incentive Payments (PCIP) program, or the Merit-Based Incentive Payment System (MIPS).
- Ambulance claims are paid by whether they begin in an 'urban', 'rural', or 'super rural' area, but the *Milliman Medicare Repricer* uses the ambulance provider's county in its pricing since the pickup location is not always available in the claims data.
- Medicare makes additional payments for professionals in health professional shortage areas and to physicians who have assigned their billing rights to Critical Access Hospitals (CAHs). These payments and adjustments are not incorporated into the *Milliman Medicare Repricer*.

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: Adam Singleton, Milliman
Scott Phillips, 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.

DRG	Description	Admits	Average 2022 CHSD Allowed[1]	Average %-age of 2022 Medicare[2]	Percentiles of CHSD Allowed 10th	25th	50th	75th	90th
455	Combined anterior/posterior spinal fusion w/o CC/MCC	113	$71,495	229%	$40,895	$41,879	$48,184	$93,964	$141,688
957	Other O.R. procedures for multiple significant trauma w MCC	15	$100,936	218%	$37,364	$81,834	$112,864	$126,494	$160,934
460	Spinal fusion except cervical w/o MCC	67	$61,848	234%	$40,895	$41,793	$60,182	$75,876	$88,807
493	Lower extrem & humer proc except hip, foot, femur w CC	23	$48,332	316%	$25,488	$32,086	$41,312	$42,956	$84,421
958	Other O.R. procedures for multiple significant trauma w CC	15	$75,532	261%	$45,005	$54,089	$64,042	$71,941	$170,907
454	Combined anterior/posterior spinal fusion w CC	61	$83,710	209%	$46,652	$52,152	$60,709	$117,345	$162,711
208	Respiratory system diagnosis w ventilator support <=96 hours	55	$55,352	301%	$21,739	$32,819	$45,817	$59,016	$99,472
494	Lower extrem & humer proc except hip, foot, femur w/o CC/MCC	41	$35,977	286%	$18,696	$25,862	$29,913	$36,569	$60,079
040	Periph/cranial nerve & other nerv syst proc w MCC	4	$79,095	312%	$59,197	$63,984	$69,320	$94,207	$118,545
470	Major Hip & Knee Joint Replacement Or Reattachment Of Lower Extremity w/o MCC	121	$34,716	271%	$17,000	$24,285	$35,324	$39,644	$47,833

Implant Information

DRG	Admits w/ an Implant (Rev Codes 0274-0276, 0278) Number	% of Total	Admits with non-Zero Allowed $s by Implant Code Admits	Implant % of Total Allowed	Admits with Zero Allowed $s by Implant Code Admits	Implant % of Total Allowed
455	113	100%	22	39.8%	91	
957	14	93%	6	6.4%	8	Cannot be
460	67	100%	14	34.0%	53	determined.
493	19	83%	5	16.0%	14	
958	13	87%	6	11.5%	7	
454	61	100%	11	29.7%	50	
208	8	15%	1	0.6%	7	
494	37	90%	11	27.2%	26	
040	3	75%	1	2.9%	2	
470	119	98%	33	30.8%	86	

(1) Based on 2021 CHSD data trended to 2022.
(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	2022 CHSD Allowed[2]	%-age of 2022 Medicare	10th	25th	50th	75th	90th	APC Code[3]	Additional Bundled Implants[4]	Combined % of 2022 Medicare[5]
Surg	29827	Sho arthrs srg rt8tr cuf rpr	349	$6,583	147%	$3,195	$4,220	$6,039	$8,418	$10,892	5114	$1,252	175%
Surg	23430	Repair biceps tendon	232	$5,969	109%	$1,597	$3,507	$3,968	$7,396	$13,911	5114	$905	126%
Surg	29881	Knee arthroscopy/surgery	624	$3,942	169%	$2,357	$2,657	$3,843	$5,023	$5,571	5113	$70	172%
Surg	27447	Total knee arthroplasty	707	$12,936	107%	$5,856	$8,734	$10,589	$16,990	$23,000	5115	$7,610	170%
Surg	22551	Arthrd ant ntrbdy cervical	83	$9,389	79%	$1,863	$4,442	$9,459	$13,513	$16,582	5115	$2,592	100%
Surg	63030	Low back disk surgery	206	$8,655	143%	$4,318	$6,399	$7,571	$10,999	$13,178	5114	$100	145%
Surg	29888	Knee arthroscopy/surgery	363	$8,154	112%	$4,856	$4,856	$7,171	$9,176	$14,201	5114	$2,032	140%
Surg	49650	Lap ing hernia repair init	248	$6,510	135%	$3,383	$3,988	$5,751	$7,626	$9,950	5361	$755	150%
Surg	29807	Sho arthrs srg rpr slap les	74	$5,961	136%	$3,453	$4,383	$6,227	$6,656	$7,396	5114	$1,137	162%
Surg	29806	Sho arthrs srg capsulorraphy	160	$7,285	129%	$4,220	$5,326	$6,905	$9,157	$10,115	5114	$2,152	168%
Non-Surg	97110	Therapeutic exercises	70,550	$61	258%	$49	$50	$59	$69	$71		$1	260%
Non-Surg	73222	Mri joint upr extrem w/dye	1,003	$1,488	212%	$796	$930	$1,124	$1,788	$3,085	5573	$0	212%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	4,859	$868	382%	$362	$596	$800	$1,082	$1,310	5523	$0	382%
Non-Surg	73221	Mri joint upr extrem w/o dye	2,050	$879	382%	$362	$596	$800	$1,082	$1,328	5523	$0	382%
Non-Surg	97140	Manual therapy 1/> regions	36,127	$57	273%	$44	$46	$54	$64	$66		$0	273%
Non-Surg	99213	Office O/P Est Low 20-29 Min	2,301	$105	87%	$45	$73	$98	$128	$145		$0	87%
Non-Surg	72148	Mri lumbar spine w/o dye	3,281	$977	450%	$462	$740	$946	$1,082	$1,573	5523	$0	450%
Non-Surg	99214	Office O/P Est Mod 30-39 Min	3,500	$141	117%	$95	$105	$144	$147	$189		$0	117%
Non-Surg	97161	Pt eval low complex 20 min	5,335	$154	185%	$107	$130	$159	$168	$199		$18	206%
Non-Surg	G0463	Hospital outpt clinic visit	1,205	$129	84%	$31	$61	$107	$170	$262	5012	$0	84%

(1) Only the following modifiers are included: GO, LT, RT, 59, TC, GP, 25
(2) Based on 2021 CHSD data trended to 2022. 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) / 2022 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		Percentiles of CHSD Allowed				
				2022 CHSD Allowed[2]	%-age of 2022 Medicare	10th	25th	50th	75th	90th
Surgery	29827	Sho arthrs srg rt8tr cuf rpr	333	$2,125	216%	$1,920	$2,081	$2,102	$2,124	$2,417
Surgery	29881	Knee arthroscopy/surgery	462	$934	221%	$535	$598	$1,058	$1,069	$1,075
Surgery	23430	Repair biceps tendon	254	$974	210%	$667	$730	$733	$1,460	$1,476
Surgery	29824	Sho arthrs srg dstl claviclc	268	$832	258%	$658	$658	$661	$1,191	$1,322
Surgery	29828	Sho arthrs srg bicp tenodsis	135	$1,142	220%	$871	$898	$911	$1,356	$1,822
Surgery	22551	Arthrd ant ntrbdy cervical	152	$3,377	222%	$2,799	$3,191	$3,407	$3,720	$4,265
Surgery	29888	Knee arthroscopy/surgery	296	$1,927	213%	$1,705	$1,885	$1,945	$1,947	$2,175
Surgery	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	2,550	$128	172%	$68	$90	$138	$160	$160
Surgery	63030	Low back disk surgery	179	$1,859	219%	$1,398	$1,674	$1,896	$1,932	$2,181
Surgery	29823	Sho Arthrs Srg Xtnsv Dbrdmt	213	$817	351%	$584	$614	$621	$829	$1,242
Radiology	73721	Mri jnt of lwr extre w/o dye	1,417	$562	269%	$403	$461	$574	$574	$664
Radiology	73222	Mri joint upr extrem w/dye	290	$858	258%	$691	$895	$915	$915	$994
Radiology	73221	Mri joint upr extrem w/o dye	552	$523	249%	$403	$448	$564	$573	$608
Radiology	72148	Mri lumbar spine w/o dye	900	$536	273%	$383	$437	$543	$543	$622
Radiology	73030	X-ray exam of shoulder	4,315	$56	180%	$48	$57	$57	$57	$62
Radiology	74177	Ct abd & pelv w/contrast	438	$791	255%	$604	$741	$757	$757	$915
Radiology	73610	X-ray exam of ankle	4,705	$59	177%	$52	$60	$60	$61	$65
Radiology	73562	X-ray exam of knee 3	3,453	$66	180%	$59	$67	$67	$67	$70
Radiology	76942	Echo guide for biopsy	974	$113	208%	$99	$101	$101	$116	$116
Radiology	77002	Needle localization by xray	591	$206	192%	$172	$187	$211	$226	$226
Phys. Med.	97110	Therapeutic exercises	331,884	$33	135%	$28	$31	$33	$35	$37
Phys. Med.	97140	Manual therapy 1/> regions	230,410	$30	138%	$24	$28	$32	$32	$35
Phys. Med.	97530	Therapeutic activities	177,774	$40	128%	$32	$40	$41	$44	$44
Phys. Med.	97112	Neuromuscular reeducation	105,955	$37	126%	$30	$35	$38	$40	$40
Phys. Med.	97014	Electric stimulation therapy	59,537	$16	123%	$14	$15	$16	$16	$18
Phys. Med.	97161	Pt eval low complex 20 min	12,184	$88	93%	$62	$84	$85	$99	$99
Phys. Med.	97545	Work hardening	0							
Phys. Med.	97162	Pt eval mod complex 30 min	10,321	$93	98%	$85	$85	$93	$99	$99
Phys. Med.	98941	Chiropract manj 3-4 regions	205,098	$38	97%	$34	$34	$39	$39	$39
Phys. Med.	99080	Special reports or forms	0							
Telehealth	90837	Psytx w pt 60 minutes	47,868	$112	90%	$93	$105	$111	$114	$133
Telehealth	99213	Office O/P Est Low 20-29 Min	36,811	$111	152%	$74	$97	$113	$130	$134
Telehealth	99214	Office O/P Est Mod 30-39 Min	29,936	$163	156%	$116	$143	$164	$189	$195
Telehealth	99212	Office O/P Est Sf 10-19 Min	4,216	$62	149%	$40	$43	$65	$78	$80
Telehealth	99215	Office O/P Est Hi 40-54 Min	4,305	$224	146%	$159	$185	$221	$255	$263
Telehealth	99443	Phone e/m phys/qhp 21-30 min	1,886	$152	135%	$82	$145	$145	$189	$189
Telehealth	98968	Hc pro phone call 21-30 min	57	$52	142%	$28	$34	$35	$62	$97
Telehealth	99442	Phone e/m phys/qhp 11-20 min	3,152	$101	129%	$42	$96	$100	$130	$130
Telehealth	99204	Office O/P New Mod 45-59 Min	1,982	$249	175%	$183	$202	$248	$286	$295
Telehealth	99441	Phone e/m phys/qhp 5-10 min	2,286	$58	126%	$20	$46	$60	$78	$78

(1) Only the following modifiers are included: 59, LT, RT, 25, XU, AT, GO, GP, 24, 57, 51, 76. Telehealth codes are limited to modifiers 93, 95, and GT.
(2) Based on 2021 CHSD data trended to 2022.

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	2022 CHSD Allowed[2]	%-age of 2022 Medicare	10th	25th	50th	75th	90th	Units	2022 CHSD Allowed[2]	%-age of 2022 Medicare	10th	25th	50th	75th	90th
99213	Office O/P Est Low 20-29 Min	33,538	$104	162%	$68	$80	$105	$130	$134	533,833	$118	139%	$97	$112	$114	$130	$134
99212	Office O/P Est Sf 10-19 Min	4,618	$54	156%	$35	$40	$45	$69	$80	62,058	$68	130%	$53	$64	$68	$78	$80
99214	Office O/P Est Mod 30-39 Min	32,812	$155	163%	$109	$123	$156	$189	$195	340,776	$173	143%	$143	$163	$168	$189	$195
99203	Office O/P New Low 30-44 Min	2,786	$144	180%	$102	$116	$133	$177	$192	124,675	$166	159%	$142	$160	$168	$186	$192
99204	Office O/P New Mod 45-59 Min	3,633	$229	175%	$184	$198	$228	$248	$286	76,012	$258	163%	$218	$246	$257	$286	$295
99215	Office O/P Est Hi 40-54 Min	5,886	$218	153%	$158	$173	$204	$255	$263	30,767	$232	136%	$192	$219	$226	$255	$263
99283	Emergency dept visit	12,583	$114	165%	$92	$97	$111	$116	$119	Not Applicable to Non-Facility							
99284	Emergency dept visit	17,115	$216	184%	$175	$183	$212	$212	$234								
99456	Disability examination	HCPCS Have No/Very Little Utilization															
99455	Work related disability exam																

(1) Only the following modifiers are included: 59, LT, RT, 25, XU, AT, GO, GP, 24, 57, 51, 76
(2) Based on 2021 CHSD data trended to 2022.

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	2022 CHSD Allowed[1]	%-age of 2022 Medicare	10th	25th	50th	75th	90th	APC Code[2]	Additional Bundled Implants[3]	Combined % of 2022 Medicare[4]
Surg	29827	Sho arthrs srg rt8tr cuf rpr	496	$5,507	131%	$2,110	$3,059	$4,894	$6,955	$9,690	5114	$1,034	156%
Surg	23430	Repair biceps tendon	327	$4,859	99%	$1,522	$1,599	$3,968	$6,905	$10,170	5114	$728	114%
Surg	29881	Knee arthroscopy/surgery	810	$3,497	173%	$1,513	$2,498	$3,453	$4,449	$5,367	5113	$95	178%
Surg	27447	Total knee arthroplasty	805	$13,200	113%	$5,856	$8,734	$11,480	$17,744	$23,000	5115	$7,028	173%
Surg	22551	Arthrd ant ntrbdy cervical	97	$8,396	70%	$1,658	$3,200	$6,922	$12,636	$16,156	5115	$2,310	89%
Surg	63030	Low back disk surgery	231	$8,219	142%	$4,318	$5,944	$7,568	$10,090	$13,043	5114	$103	144%
Surg	29888	Knee arthroscopy/surgery	436	$7,546	108%	$4,021	$4,856	$7,030	$9,173	$14,201	5114	$1,834	135%
Surg	49650	Lap ing hernia repair init	366	$6,518	145%	$3,328	$4,175	$5,894	$8,284	$11,098	5361	$856	164%
Surg	29807	Sho arthrs srg rpr slap les	92	$5,425	128%	$2,924	$3,674	$5,658	$6,388	$7,143	5114	$980	151%
Surg	29806	Sho arthrs srg capsulorraphy	183	$6,930	128%	$3,507	$4,220	$6,657	$9,011	$10,070	5114	$1,931	164%
Non-Surg	97110	Therapeutic exercises	52,883	$119	261%	$52	$72	$141	$215	$479		$1	263%
Non-Surg	73222	Mri joint upr extrem w/dye	1,021	$1,493	213%	$796	$930	$1,124	$1,788	$3,125	5573	$0	213%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	5,117	$871	379%	$362	$596	$801	$1,082	$1,328	5523	$0	379%
Non-Surg	73221	Mri joint upr extrem w/o dye	2,169	$891	382%	$362	$596	$805	$1,082	$1,350	5523	$0	382%
Non-Surg	97140	Manual therapy 1/> regions	29,944	$80	273%	$44	$59	$88	$160	$309		$0	273%
Non-Surg	99213	Office O/P Est Low 20-29 Min	2,562	$105	87%	$45	$69	$98	$128	$152		$0	87%
Non-Surg	72148	Mri lumbar spine w/o dye	3,462	$973	446%	$467	$740	$946	$1,082	$1,573	5523	$0	446%
Non-Surg	99214	Office O/P Est Mod 30-39 Min	3,639	$141	117%	$95	$105	$144	$148	$191		$0	117%
Non-Surg	97161	Pt eval low complex 20 min	5,412	$154	185%	$107	$130	$159	$168	$200		$18	207%
Non-Surg	G0463	Hospital outpt clinic visit	1,586	$119	80%	$20	$49	$95	$169	$285	5012	$0	80%

(1) Based on 2021 CHSD data trended to 2022. 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) / 2022 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	2022 CHSD Allowed(2)	%-age of 2022 Medicare	10th	25th	50th	75th	90th
Surgery	29827	Sho arthrs srg rt8tr cuf rpr	654	$1,489	217%	$208	$212	$2,081	$2,102	$2,373
Surgery	29881	Knee arthroscopy/surgery	656	$924	228%	$511	$575	$1,058	$1,069	$1,195
Surgery	23430	Repair biceps tendon	478	$709	215%	$73	$146	$730	$839	$1,476
Surgery	29824	Sho arthrs srg dstl claviclc	492	$584	242%	$66	$90	$658	$746	$1,315
Surgery	29828	Sho arthrs srg bicp tenodsis	273	$933	232%	$91	$181	$898	$1,283	$1,822
Surgery	22551	Arthrd ant ntrbdy cervical	303	$2,546	230%	$327	$560	$3,265	$3,720	$4,053
Surgery	29888	Knee arthroscopy/surgery	590	$1,390	218%	$193	$195	$1,885	$1,945	$2,175
Surgery	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	2,971	$127	175%	$68	$81	$138	$160	$160
Surgery	63030	Low back disk surgery	358	$1,356	218%	$188	$310	$1,674	$1,932	$2,306
Surgery	29823	Sho Arthrs Srg Xtnsv Dbrdmt	422	$534	333%	$61	$83	$610	$694	$1,220
Radiology	73721	Mri jnt of lwr extre w/o dye	5,407	$251	240%	$124	$124	$133	$403	$574
Radiology	73222	Mri joint upr extrem w/dye	1,089	$353	238%	$149	$149	$159	$608	$915
Radiology	73221	Mri joint upr extrem w/o dye	2,225	$239	229%	$125	$125	$133	$374	$573
Radiology	72148	Mri lumbar spine w/o dye	3,805	$241	238%	$136	$136	$145	$346	$543
Radiology	73030	X-ray exam of shoulder	11,099	$37	185%	$17	$17	$37	$57	$57
Radiology	74177	Ct abd & pelv w/contrast	12,313	$204	212%	$167	$167	$178	$184	$197
Radiology	73610	X-ray exam of ankle	12,715	$38	183%	$16	$16	$37	$60	$61
Radiology	73562	X-ray exam of knee 3	8,214	$46	181%	$17	$19	$59	$67	$70
Radiology	76942	Echo guide for biopsy	6,435	$81	238%	$54	$58	$58	$87	$116
Radiology	77002	Needle localization by xray	1,844	$101	190%	$46	$51	$54	$187	$226
Phys. Med.	97110	Therapeutic exercises	190,588	$57	135%	$31	$31	$56	$70	$105
Phys. Med.	97140	Manual therapy 1/> regions	160,606	$43	138%	$28	$28	$32	$58	$69
Phys. Med.	97530	Therapeutic activities	98,310	$75	128%	$40	$41	$64	$89	$160
Phys. Med.	97112	Neuromuscular reeducation	76,472	$51	126%	$33	$35	$40	$71	$80
Phys. Med.	97014	Electric stimulation therapy	68,267	$15	122%	$14	$15	$16	$16	$18
Phys. Med.	97161	Pt eval low complex 20 min	12,257	$88	93%	$62	$84	$85	$99	$99
Phys. Med.	97545	Work hardening	0							
Phys. Med.	97162	Pt eval mod complex 30 min	10,398	$93	98%	$85	$85	$93	$99	$99
Phys. Med.	98941	Chiropract manj 3-4 regions	255,629	$38	97%	$34	$34	$39	$39	$51
Phys. Med.	99080	Special reports or forms	0							
Surgery - Combined	29827	Sho arthrs srg rt8tr cuf rpr	443	$2,198	217%	$1,736	$2,081	$2,154	$2,337	$2,658
Surgery - Combined	29881	Knee arthroscopy/surgery	606	$1,001	228%	$535	$740	$1,058	$1,070	$1,217
Surgery - Combined	23430	Repair biceps tendon	320	$1,059	215%	$626	$733	$813	$1,460	$1,631
Surgery - Combined	29824	Sho arthrs srg dstl claviclc	327	$879	242%	$638	$661	$727	$1,277	$1,447
Surgery - Combined	29828	Sho arthrs srg bicp tenodsis	185	$1,377	232%	$871	$901	$1,002	$1,795	$2,253
Surgery - Combined	22551	Arthrd ant ntrbdy cervical	226	$3,413	230%	$681	$3,247	$3,720	$4,053	$4,265
Surgery - Combined	29888	Knee arthroscopy/surgery	397	$2,065	218%	$1,633	$1,926	$1,947	$2,142	$2,431
Surgery - Combined	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	2,955	$127	175%	$68	$81	$138	$160	$160
Surgery - Combined	63030	Low back disk surgery	248	$1,958	218%	$1,220	$1,726	$2,051	$2,272	$2,443
Surgery - Combined	29823	Sho Arthrs Srg Xtnsv Dbrdmt	268	$841	333%	$498	$614	$683	$1,020	$1,381
Telehealth	90837	Psytx w pt 60 minutes	58,630	$112	90%	$93	$107	$111	$118	$156
Telehealth	99213	Office O/P Est Low 20-29 Min	38,163	$110	152%	$70	$97	$113	$130	$134
Telehealth	99214	Office O/P Est Mod 30-39 Min	30,751	$163	156%	$114	$143	$164	$189	$195
Telehealth	99212	Office O/P Est Sf 10-19 Min	4,401	$61	149%	$40	$43	$65	$78	$80
Telehealth	99215	Office O/P Est Hi 40-54 Min	4,383	$224	146%	$156	$185	$221	$255	$263
Telehealth	99443	Phone e/m phys/qhp 21-30 min	1,929	$151	135%	$78	$145	$145	$189	$189
Telehealth	98968	Hc pro phone call 21-30 min	57	$52	142%	$28	$34	$35	$62	$97
Telehealth	99442	Phone e/m phys/qhp 11-20 min	3,206	$101	130%	$42	$91	$100	$130	$130
Telehealth	99204	Office O/P New Mod 45-59 Min	2,010	$249	176%	$181	$202	$248	$286	$295
Telehealth	99441	Phone e/m phys/qhp 5-10 min	2,340	$58	127%	$20	$46	$60	$78	$78

(1) Telehealth codes limited to modifiers 93, 95, and GT.

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	2022 CHSD Allowed[1]	%-age of 2022 Medicare	10th	25th	50th	75th	90th	Procedures	2022 CHSD Allowed[1]	%-age of 2022 Medicare	10th	25th	50th	75th	90th
99213	Office O/P Est Low 20-29 Min	9,776	$85	133%	$69	$78	$80	$91	$96	587,944	$118	141%	$97	$112	$114	$130	$134
99212	Office O/P Est Sf 10-19 Min	1,555	$43	127%	$34	$39	$39	$45	$53	68,671	$68	133%	$48	$62	$68	$78	$80
99214	Office O/P Est Mod 30-39 Min	10,257	$133	141%	$107	$122	$129	$140	$151	380,714	$172	145%	$143	$163	$168	$189	$195
99203	Office O/P New Low 30-44 Min	1,465	$129	162%	$102	$115	$120	$133	$160	132,926	$166	160%	$139	$158	$168	$186	$192
99204	Office O/P New Mod 45-59 Min	2,337	$215	165%	$184	$198	$202	$228	$236	80,194	$258	165%	$218	$246	$257	$286	$295
99215	Office O/P Est Hi 40-54 Min	3,018	$204	143%	$161	$172	$198	$210	$266	35,346	$231	138%	$192	$210	$226	$255	$263
99283	Emergency dept visit	13,506	$115	166%	$89	$97	$111	$116	$119	Not Applicable to Non-Facility							
99284	Emergency dept visit	18,371	$218	186%	$175	$183	$212	$212	$234								
99456	Disability examination	HCPCS Have No/Very Little Utilization															
99455	Work related disability exam																

(1) Based on 2021 CHSD data trended to 2022.