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May 3, 2024

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, 2023 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.

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 service category using the HCPCS/DRG distribution in the data:

Table 1
Summary of 2023 Average Commercial Allowed
As a Percentage of 2023 Medicare

Description	Percent of Medicare
Inpatient DRG	246%
Outpatient Surgery*	117%
Outpatient Non-Surgery*	297%
Outpatient Emergency Room*	257%
Physician Surgery	217%
Physician Radiology	240%
Physician Medicine	127%
Physician Evaluation and Management	158%

*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 2023 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 including ER services.
  - 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 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.
  - 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 6/30/2023. 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 35% of the commercial allowed dollars with the implants excluded (except for HCPCS 27447 which has 45% additional dollars due to implants and HCPCS 63685 with 81%). 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%-375% for inpatient services (excluding the low-volume codes), 60%-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.

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.
  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.
- The average allowed amounts in Exhibit 7 are notably lower than Exhibit 4, similar to the relationship between exhibits 6 and 3.

Methodology

Commercial reimbursement was calculated using the 2022 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 2023 Medicare allowed. A single year of trend was applied to put the 2022 CHSD data on a 2023 basis. The 2022 to 2023 commercial allowed trends are listed below:
  - Inpatient: 2.8%
  - Outpatient: 3.0%

   - Professional: 2.7%
- 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: GP, GO, TC, GT, RT, LT, MG, 95, 25, MF, CQ, 59, MH, CO, ME
   - Physician: GP, 25, 59, CS, 95, GT, AT, GO, RT, LT, XU, CQ, 57, 24, 76, 51
- 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 30% 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.

<u>Medicare Amounts</u>

The CHSD data was repriced to 2023 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.

<u>Inpatient Repricing</u>

- 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.

- Add-on payments for blood clotting factor administered to hemophilia inpatients are not included. Under IPPS hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. No add-on payment is made under SNF PPS.
- For the purposes of this analysis, no add-on payments are included in the Medicare allowed amount.
- 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' software.
- Pickle hospitals do not receive special pricing logic.
- 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.
- Organ acquisition costs are calculated based on organ specific information from the Medicare Cost Reports for the provider. Actual organ acquisition costs for Medicare Advantage payers are paid on a per case basis and are subject to contractual terms between the payer and provider. The organ acquisition costs included in the Medicare Allowed amount provides an estimate of the Medicare Allowable organ acquisition costs based on the per organ cost from the provider's Medicare Cost Reports.

<u>Outpatient Repricing</u>

- 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 *Milliman Medicare Repricer* 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 Supreme Court ruled in American Hospital Association v. Becerra that CMS violated their statutory authority when they reduced payments for drugs purchased under the 340B drug discount program for calendar years 2018 and 2019. Additionally, on September 28, 2022, the District Court for the District of Columbia vacated the differential payment rates for 340B-acquired drugs in the Calendar Year 2022 OPPS final rule with respect to their prospective application. As of the release of this software, CMS finalized their proposal to eliminate this reduction for CY 2023 and 2024. The 2024 Outpatient Prospective Payment System (OPPS) Final Rule notes CMS' decision not to reprocess all claims affected in calendar year 2020 through 2022 in favor of lump sum payments to affected facilities. This software no longer applies the reduction as originally implemented by CMS for January 1, 2020 through September 21,2022 dates of service.
- 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

- The *Milliman Medicare Repricer* does not include practitioner 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 practitioners in health practitioner shortage areas and to practitioners 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.

Models used in the preparation of our analysis were applied consistently with their intended use. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models, including all input, calculations, and output may not be appropriate for any other purpose. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of those models. We relied on input, review, and validation by other experts in the development of our models.

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.

			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	2023 CHSD Allowed[1]	%-age of 2023 Medicare[2]	10th	25th	50th	75th	90th	Number	% of Total	Admits	Implant % of Total Allowed	Admits	Implant % of Total Allowed
957	Other O.R. Procedures For Multiple Significant Trauma With Mcc	11	$143,672	290%	$52,666	$75,991	$117,323	$200,575	$241,699	9	82%	4	5.3%	5	
493	Lower Extremity And Humerus Procedures Except Hip, Foot And Femur With Cc	26	$49,128	304%	$27,774	$34,879	$42,607	$45,954	$85,952	23	88%	11	10.6%	12	Cannot be determined.
455	Combined Anterior And Posterior Spinal Fusion Without Cc/Mcc	113	$78,190	239%	$42,903	$45,823	$56,438	$100,426	$146,068	113	100%	20	34.2%	93	
927	Extensive Burns Or Full Thickness Burns With Mv >96 Hours With Skin Graft	0	$0	0%						0	0%	0		0	
460	Spinal Fusion Except Cervical Without Mcc	73	$64,163	251%	$41,172	$45,823	$58,928	$76,673	$96,266	73	100%	22	32.1%	51	
494	Lower Extremity And Humerus Procedures Except Hip, Foot And Femur Without Cc/Mcc	47	$42,727	326%	$22,285	$27,745	$32,999	$47,635	$82,881	46	98%	15	15.6%	31	
999	Ungroupable	3	$51,319	0%	$12,797	$12,797	$24,812	$116,349	$116,349	1	33%	0		1	
958	Other O.R. Procedures For Multiple Significant Trauma With Cc	21	$76,485	261%	$51,889	$60,989	$66,572	$69,901	$76,147	19	90%	6	28.0%	13	
454	Combined Anterior And Posterior Spinal Fusion With Cc	71	$88,222	212%	$52,506	$53,812	$70,282	$110,418	$177,967	71	100%	20	32.5%	51	
935	Non-Extensive Burns	8	$34,278	255%	$7,855	$17,224	$17,721	$60,519	$75,442	1	13%	1	0.0%	0	

(1) Based on 2022 CHSD data trended to 2023.
(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	2023 CHSD Allowed[(2)]	%-age of 2023 Medicare	10th	25th	50th	75th	90th	APC Code[(3)]	Additional Bundled Implants[(4)]	Combined % of 2023 Medicare[(5)]
Surg	29827	Sho arthrs srg rt8tr cuf rpr	480	$5,534	126%	$2,101	$3,139	$5,334	$6,427	$9,364	5114	$782	143%
Surg	29881	Knee arthroscopy/surgery	743	$3,642	164%	$1,678	$2,603	$3,439	$4,572	$5,771	5113	$139	170%
Surg	63685	Insrt/redo spine n generator	40	$16,612	59%	$2,106	$3,481	$7,275	$27,275	$46,403	5465	$13,483	108%
Surg	23430	Repair biceps tendon	279	$5,605	95%	$1,546	$1,821	$3,952	$9,195	$13,853	5114	$598	105%
Surg	29828	Sho arthrs srg bicp tenodsis	182	$4,684	237%	$2,101	$2,101	$4,175	$6,266	$8,868	5114	$543	264%
Surg	29807	Sho arthrs srg rpr slap les	69	$6,073	140%	$3,406	$4,202	$5,972	$6,677	$9,680	5114	$1,037	164%
Surg	27447	Total knee arthroplasty	693	$12,959	103%	$5,662	$8,835	$10,182	$18,654	$24,997	5115	$5,869	150%
Surg	20680	Removal of support implant	322	$3,577	179%	$1,795	$2,154	$3,201	$4,529	$5,359	5073	$312	195%
Surg	25609	Treat fx radial 3+ frag	46	$7,004	110%	$4,912	$5,694	$5,896	$7,939	$9,860	5114	$2,468	148%
Surg	64721	Carpal tunnel surgery	393	$2,296	158%	$836	$1,577	$1,975	$3,068	$3,987	5431	$20	159%
Surg	29888	Knee arthroscopy/surgery	369	$8,322	114%	$4,828	$4,836	$7,140	$9,806	$15,816	5114	$1,666	137%
Surg	49650	Lap ing hernia repair init	256	$7,972	163%	$3,314	$4,676	$7,395	$10,510	$13,189	5361	$732	178%
Surg	29806	Sho arthrs srg capsulorraphy	155	$7,061	116%	$4,202	$4,202	$6,762	$9,155	$10,963	5114	$1,751	144%
Surg	24342	Repair of ruptured tendon	75	$7,579	119%	$3,952	$4,612	$6,495	$9,806	$10,922	5114	$1,186	137%
Surg	23472	Reconstruct shoulder joint	76	$14,325	113%	$4,822	$8,915	$11,664	$21,903	$24,354	5115	$7,441	172%
Surg	22551	Arthrd ant ntrbdy cervical	63	$10,372	82%	$3,423	$6,191	$10,044	$13,335	$21,620	5115	$2,754	104%
Non-Surg	97110	Therapeutic exercises	64,120	$65	279%	$48	$55	$70	$71	$74		$0	281%
Non-Surg	73222	Mri joint upr extrem w/dye	908	$1,498	210%	$722	$920	$1,099	$1,806	$3,245	5573	$0	210%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	5,243	$879	388%	$360	$581	$841	$1,115	$1,322	5523	$0	388%
Non-Surg	73221	Mri joint upr extrem w/o dye	2,310	$891	392%	$360	$560	$864	$1,115	$1,322	5523	$0	392%
Non-Surg	99213	Office O/P Est Low 20-29 Min	2,342	$111	90%	$47	$87	$98	$135	$164		$0	90%
Non-Surg	97140	Manual therapy 1/> regions	33,263	$62	301%	$45	$54	$65	$67	$73		$0	301%
Non-Surg	97545	Work hardening	0									$0	
Non-Surg	99214	Office O/P Est Mod 30-39 Min	4,453	$143	120%	$105	$112	$144	$144	$190		$0	120%
Non-Surg	72148	Mri lumbar spine w/o dye	3,537	$987	457%	$497	$737	$987	$1,115	$1,419	5523	$0	457%
Non-Surg	97161	Pt eval low complex 20 min	4,918	$168	195%	$106	$132	$167	$197	$245		$11	207%
ER	99281	Emr dpt vst mayx req phy/qhp	1,663	$192	267%	$124	$154	$181	$215	$283	5021	$0	267%
ER	99282	Emergency dept visit sf mdm	10,600	$354	263%	$226	$299	$367	$379	$481	5022	$0	263%
ER	99283	Emergency dept visit low mdm	21,871	$612	256%	$362	$522	$635	$663	$847	5023	$0	256%
ER	99284	Emergency dept visit mod mdm	25,912	$993	260%	$569	$874	$1,043	$1,094	$1,304	5024	$0	260%
ER	99285	Emergency dept visit hi mdm	9,416	$1,442	249%	$817	$1,169	$1,447	$1,609	$1,911	5025	$2	250%

(1) Only the following modifiers are included: (blank), GP, GO, TC, GT, RT, LT, MG, 95, 25, MF, CQ, 59, MH, CO, ME.
(2) Based on 2022 CHSD data trended to 2023. 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) / 2023 Medicare

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

				Average		Percentiles of CHSD Allowed				
Source	HCPCS	Description	Units	2023 CHSD Allowed[2]	%-age of 2023 Medicare	10th	25th	50th	75th	90th
Surgery	29827	Sho arthrs srg rt8tr cuf rpr	524	$2,076	215%	$1,868	$2,057	$2,110	$2,161	$2,458
Surgery	29881	Knee arthroscopy/surgery	768	$951	220%	$531	$743	$1,063	$1,083	$1,222
Surgery	23430	Repair biceps tendon	331	$965	207%	$636	$733	$754	$1,339	$1,492
Surgery	29828	Sho arthrs srg bicp tenodsis	190	$1,158	222%	$801	$882	$916	$1,588	$2,062
Surgery	27447	Total knee arthroplasty	929	$2,559	220%	$2,188	$2,336	$2,671	$2,692	$3,072
Surgery	29824	Sho arthrs srg dstl claviclc	372	$870	251%	$607	$660	$678	$1,301	$1,370
Surgery	29888	Knee arthroscopy/surgery	442	$1,942	218%	$1,712	$1,882	$1,953	$1,976	$2,248
Surgery	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	2,951	$127	176%	$68	$80	$137	$160	$171
Surgery	22551	Arthrd ant ntrbdy cervical	179	$3,170	226%	$1,570	$2,902	$3,314	$3,735	$4,070
Surgery	22633	Arthrd cmbn 1ntrspc lumbar	138	$3,256	221%	$741	$3,082	$3,605	$3,707	$4,437
Radiology	73721	Mri jnt of lwr extre w/o dye	1,493	$541	274%	$404	$463	$577	$577	$577
Radiology	73222	Mri joint upr extrem w/dye	406	$852	280%	$701	$781	$918	$918	$918
Radiology	73221	Mri joint upr extrem w/o dye	649	$550	279%	$404	$463	$576	$576	$576
Radiology	72148	Mri lumbar spine w/o dye	1,103	$541	292%	$424	$536	$546	$546	$546
Radiology	73030	X-ray exam of shoulder	4,530	$58	179%	$49	$57	$57	$62	$62
Radiology	73610	X-ray exam of ankle	5,097	$61	178%	$52	$60	$60	$66	$66
Radiology	74177	Ct abd & pelv w/contrast	538	$784	263%	$607	$744	$760	$760	$916
Radiology	77002	Needle localization by xray	869	$210	194%	$179	$187	$222	$227	$227
Radiology	73562	X-ray exam of knee 3	3,553	$68	182%	$59	$67	$67	$74	$74
Radiology	76942	Echo guide for biopsy	1,223	$108	196%	$95	$102	$107	$107	$117
Phys. Med.	97110	Therapeutic exercises	416,829	$33	139%	$29	$31	$35	$35	$35
Phys. Med.	97530	Therapeutic activities	269,868	$42	137%	$34	$41	$45	$45	$45
Phys. Med.	97140	Manual therapy 1/> regions	296,689	$30	142%	$28	$28	$32	$32	$32
Phys. Med.	97112	Neuromuscular reeducation	165,450	$38	134%	$30	$36	$40	$40	$40
Phys. Med.	97014	Electric stimulation therapy	77,633	$16	132%	$14	$15	$16	$16	$16
Phys. Med.	97161	Pt eval low complex 20 min	14,635	$94	99%	$86	$86	$99	$99	$99
Phys. Med.	99080	Special reports or forms	0							
Phys. Med.	97162	Pt eval mod complex 30 min	12,772	$95	99%	$86	$86	$99	$99	$99
Phys. Med.	98941	Chiropract manj 3-4 regions	227,188	$38	99%	$34	$34	$39	$39	$39
Phys. Med.	99199	Unlisted special svc px/rprt	0							

(1) Only the following modifiers are included: (blank), GP, 25, 59, CS, 95, GT, AT, GO, RT, LT, XU, CQ, 57, 24, 76, 51.
(2) Based on 2022 CHSD data trended to 2023.

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	2023 CHSD Allowed(2)	%-age of 2023 Medicare	10th	25th	50th	75th	90th	Units	2023 CHSD Allowed(2)	%-age of 2023 Medicare	10th	25th	50th	75th	90th
99213	Office O/P Est Low 20-29 Min	23,945	$106	169%	$68	$80	$106	$130	$135	588,438	$130	153%	$97	$114	$130	$141	$163
99214	Office O/P Est Mod 30-39 Min	30,243	$160	173%	$105	$130	$159	$190	$202	385,747	$187	156%	$143	$167	$190	$201	$232
99203	Office O/P New Low 30-44 Min	2,255	$141	178%	$102	$116	$133	$154	$193	133,149	$171	164%	$143	$161	$173	$193	$201
99204	Office O/P New Mod 45-59 Min	3,386	$229	179%	$177	$203	$213	$245	$292	79,881	$262	167%	$219	$247	$259	$287	$301
99212	Office O/P Est Sf 10-19 Min	3,704	$57	161%	$39	$43	$56	$66	$81	57,326	$74	141%	$50	$65	$74	$87	$101
99215	Office O/P Est Hi 40-54 Min	5,727	$227	164%	$148	$174	$227	$264	$326	38,020	$256	152%	$193	$220	$256	$282	$326
99284	Emergency dept visit mod mdm	21,536	$214	184%	$175	$184	$212	$222	$232	Not Applicable to Non-Facility							
99283	Emergency dept visit low mdm	16,466	$117	170%	$96	$97	$114	$129	$135								
99456	Disability examination	HCPCS Have No/Very Little Utilization															
99455	Work related disability exam																

(1) Only the following modifiers are included: (blank), GP, 25, 59, CS, 95, GT, AT, GO, RT, LT, XU, CQ, 57, 24, 76, 51.
(2) Based on 2022 CHSD data trended to 2023.

Exhibit 5
Idaho Industrial Commision
Average Outpatient Commercial Charge, Percentage of Medicare and Percentiles by HCPCS
All modifiers, specialties, POS and based on commercial 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	2023 CHSD Allowed[1]	%-age of 2023 Medicare	10th	25th	50th	75th	90th	APC Code[2]	Additional Bundled Implants[3]	Combined % of 2023 Medicare[4]
Surg	29827	Sho arthrs srg rt8tr cuf rpr	552	$5,331	127%	$2,101	$3,187	$4,968	$6,218	$9,234	5114	$697	144%
Surg	29881	Knee arthroscopy/surgery	878	$3,390	162%	$1,328	$2,573	$3,253	$4,243	$5,607	5113	$119	167%
Surg	63685	Insrt/redo spine n generator	51	$17,029	63%	$2,132	$3,481	$11,171	$27,856	$30,639	5465	$10,575	102%
Surg	23430	Repair biceps tendon	343	$5,125	92%	$1,546	$1,746	$3,952	$7,365	$13,853	5114	$528	102%
Surg	29828	Sho arthrs srg bicp tenodsis	224	$4,395	220%	$1,758	$2,101	$3,619	$5,694	$7,555	5114	$447	243%
Surg	29807	Sho arthrs srg rpr slap les	85	$5,583	140%	$3,153	$3,774	$5,370	$6,359	$7,776	5114	$866	161%
Surg	27447	Total knee arthroplasty	771	$13,268	108%	$5,662	$8,968	$10,841	$18,654	$24,504	5115	$5,471	152%
Surg	20680	Removal of support implant	496	$3,020	186%	$1,235	$1,941	$3,003	$4,529	$5,359	5073	$209	199%
Surg	25609	Treat fx radial 3+ frag	55	$6,762	108%	$4,459	$5,445	$5,720	$7,939	$9,860	5114	$2,131	142%
Surg	64721	Carpal tunnel surgery	574	$2,111	161%	$830	$999	$1,660	$2,715	$3,987	5431	$20	163%
Surg	29888	Knee arthroscopy/surgery	426	$7,936	112%	$4,470	$4,836	$7,140	$9,320	$15,816	5114	$1,496	134%
Surg	49650	Lap ing hernia repair init	382	$7,720	149%	$3,314	$4,782	$7,401	$11,554	$15,241	5361	$753	163%
Surg	29806	Sho arthrs srg capsulorraphy	175	$6,640	114%	$3,309	$4,202	$5,993	$8,998	$10,692	5114	$1,578	141%
Surg	24342	Repair of ruptured tendon	89	$6,999	118%	$3,492	$3,952	$6,185	$9,234	$10,922	5114	$1,013	135%
Surg	23472	Reconstruct shoulder joint	80	$14,325	113%	$4,718	$8,915	$11,709	$21,156	$24,354	5115	$7,497	172%
Surg	22551	Arthrd ant ntrbdy cervical	76	$9,580	79%	$3,269	$5,334	$8,226	$12,862	$16,125	5115	$2,304	97%
Non-Surg	97110	Therapeutic exercises	49,256	$125	281%	$56	$74	$145	$259	$532		$0	282%
Non-Surg	73222	Mri joint upr extrem w/dye	926	$1,494	210%	$722	$920	$1,099	$1,806	$3,245	5573	$0	210%
Non-Surg	73721	Mri jnt of lwr extre w/o dye	5,552	$886	386%	$387	$581	$864	$1,115	$1,323	5523	$0	386%
Non-Surg	73221	Mri joint upr extrem w/o dye	2,447	$904	393%	$360	$560	$891	$1,115	$1,437	5523	$0	393%
Non-Surg	99213	Office O/P Est Low 20-29 Min	2,524	$108	89%	$45	$80	$97	$135	$164		$0	89%
Non-Surg	97140	Manual therapy 1/> regions	27,934	$87	298%	$46	$66	$97	$186	$327		$0	298%
Non-Surg	97545	Work hardening	0										
Non-Surg	99214	Office O/P Est Mod 30-39 Min	4,555	$143	120%	$105	$105	$144	$144	$190		$0	120%
Non-Surg	72148	Mri lumbar spine w/o dye	3,605	$991	459%	$497	$737	$991	$1,115	$1,529	5523	$0	459%
Non-Surg	97161	Pt eval low complex 20 min	4,989	$168	195%	$106	$130	$167	$197	$245		$11	208%
ER	99281	Emr dpt vst mayx req phy/qhp	1,739	$192	268%	$124	$154	$181	$215	$283	5021	$0	268%
ER	99282	Emergency dept visit sf mdm	10,978	$353	263%	$226	$299	$367	$379	$481	5022	$0	263%
ER	99283	Emergency dept visit low mdm	22,533	$610	256%	$362	$522	$635	$663	$847	5023	$0	256%
ER	99284	Emergency dept visit mod mdm	26,562	$991	260%	$569	$874	$1,043	$1,094	$1,304	5024	$0	260%
ER	99285	Emergency dept visit hi mdm	9,625	$1,439	250%	$817	$1,169	$1,447	$1,609	$1,911	5025	$2	251%

(1) Based on 2022 CHSD data trended to 2023. 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) / 2023 Medicare

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

				Average		Percentiles of CHSD Allowed				
Source	HCPCS	Description	Procedures	2023 CHSD Allowed[1]	%-age of 2023 Medicare	10th	25th	50th	75th	90th
Surgery	29827	Sho arthrs srg rt8tr cuf rpr	1,054	$1,436	216%	$209	$257	$1,914	$2,138	$2,427
Surgery	29881	Knee arthroscopy/surgery	1,129	$880	223%	$135	$537	$1,063	$1,083	$1,222
Surgery	23430	Repair biceps tendon	656	$686	214%	$74	$120	$733	$858	$1,492
Surgery	29828	Sho arthrs srg bicp tenodsis	438	$891	230%	$91	$176	$901	$1,054	$1,833
Surgery	27447	Total knee arthroplasty	1,797	$1,722	218%	$267	$311	$2,267	$2,692	$2,941
Surgery	29824	Sho arthrs srg dstl claviclc	708	$588	253%	$66	$93	$660	$763	$1,327
Surgery	29888	Knee arthroscopy/surgery	815	$1,403	219%	$193	$253	$1,882	$1,953	$2,224
Surgery	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	3,364	$126	177%	$68	$80	$134	$160	$171
Surgery	22551	Arthrd ant ntrbdy cervical	285	$2,388	223%	$338	$454	$2,935	$3,421	$4,070
Surgery	22633	Arthrd cmbn 1ntrspc lumbar	202	$2,520	220%	$371	$516	$3,190	$3,707	$4,437
Radiology	73721	Mri jnt of lwr extre w/o dye	7,489	$221	238%	$124	$124	$133	$208	$577
Radiology	73222	Mri joint upr extrem w/dye	1,432	$372	253%	$148	$150	$160	$740	$918
Radiology	73221	Mri joint upr extrem w/o dye	3,161	$226	239%	$124	$124	$133	$245	$576
Radiology	72148	Mri lumbar spine w/o dye	5,067	$233	244%	$135	$135	$146	$216	$546
Radiology	73030	X-ray exam of shoulder	12,128	$37	184%	$17	$17	$38	$57	$62
Radiology	73610	X-ray exam of ankle	13,313	$39	183%	$16	$16	$44	$60	$66
Radiology	74177	Ct abd & pelv w/contrast	16,649	$201	213%	$166	$166	$168	$179	$193
Radiology	77002	Needle localization by xray	2,755	$104	196%	$46	$51	$51	$187	$227
Radiology	73562	X-ray exam of knee 3	8,581	$47	184%	$17	$17	$59	$69	$74
Radiology	76942	Echo guide for biopsy	9,025	$74	224%	$54	$58	$59	$63	$107
Phys. Med.	97110	Therapeutic exercises	249,978	$56	139%	$31	$35	$45	$70	$105
Phys. Med.	97530	Therapeutic activities	147,162	$79	138%	$40	$45	$72	$89	$164
Phys. Med.	97140	Manual therapy 1/> regions	211,808	$43	142%	$28	$29	$32	$58	$64
Phys. Med.	97112	Neuromuscular reeducation	118,310	$53	134%	$35	$36	$40	$71	$85
Phys. Med.	97014	Electric stimulation therapy	88,454	$16	131%	$14	$15	$16	$16	$16
Phys. Med.	97161	Pt eval low complex 20 min	14,779	$94	99%	$86	$86	$99	$99	$99
Phys. Med.	99080	Special reports or forms	0							
Phys. Med.	97162	Pt eval mod complex 30 min	12,892	$95	99%	$86	$86	$99	$99	$99
Phys. Med.	98941	Chiropract manj 3-4 regions	280,688	$38	99%	$34	$34	$39	$39	$49
Phys. Med.	99199	Unlisted special svc px/rprt	0							
Surgery - Combined	29827	Sho arthrs srg rt8tr cuf rpr	674	$2,242	216%	$1,658	$2,090	$2,298	$2,455	$2,749
Surgery - Combined	29881	Knee arthroscopy/surgery	965	$1,029	223%	$531	$811	$1,073	$1,095	$1,246
Surgery - Combined	23430	Repair biceps tendon	413	$1,089	214%	$636	$754	$858	$1,473	$1,680
Surgery - Combined	29828	Sho arthrs srg bicp tenodsis	276	$1,410	230%	$795	$901	$1,030	$1,831	$2,358
Surgery - Combined	27447	Total knee arthroplasty	1,140	$2,715	218%	$2,188	$2,557	$2,700	$2,961	$3,339
Surgery - Combined	29824	Sho arthrs srg dstl claviclc	467	$891	253%	$607	$667	$743	$1,301	$1,453
Surgery - Combined	29888	Knee arthroscopy/surgery	555	$2,060	219%	$1,556	$1,882	$1,955	$2,214	$2,464
Surgery - Combined	12001	Rpr s/n/ax/gen/trnk 2.5cm/<	3,359	$126	177%	$68	$80	$134	$160	$171
Surgery - Combined	22551	Arthrd ant ntrbdy cervical	201	$3,386	223%	$1,867	$2,956	$3,547	$3,791	$4,105
Surgery - Combined	22633	Arthrd cmbn 1ntrspc lumbar	140	$3,636	220%	$1,791	$3,258	$3,743	$4,140	$4,674

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 commercial allowed per procedure

Evaluation and Management Codes

		Facility								Non-Facility							
			Average		Percentiles of CHSD Allowed						Average		Percentiles of CHSD Allowed				
HCPCS	Description	Procedures	2023 CHSD Allowed(1)	%-age of 2023 Medicare	10th	25th	50th	75th	90th	Procedures	2023 CHSD Allowed(1)	%-age of 2023 Medicare	10th	25th	50th	75th	90th
99213	Office O/P Est Low 20-29 Min	10,020	$93	149%	$68	$79	$91	$106	$122	635,099	$129	154%	$97	$114	$130	$141	$163
99214	Office O/P Est Mod 30-39 Min	11,571	$141	152%	$105	$122	$140	$157	$180	424,775	$186	157%	$143	$165	$190	$201	$232
99203	Office O/P New Low 30-44 Min	1,631	$131	167%	$102	$115	$130	$138	$156	141,355	$171	165%	$138	$159	$173	$193	$201
99204	Office O/P New Mod 45-59 Min	2,650	$217	170%	$176	$199	$211	$229	$245	84,169	$262	168%	$219	$247	$259	$287	$301
99212	Office O/P Est Sf 10-19 Min	1,182	$51	153%	$35	$40	$46	$57	$66	62,965	$73	142%	$45	$62	$73	$87	$101
99215	Office O/P Est Hi 40-54 Min	3,272	$223	161%	$157	$174	$209	$266	$301	42,658	$254	153%	$193	$220	$256	$282	$326
99284	Emergency dept visit mod mdm	23,351	$214	185%	$175	$184	$212	$222	$236	Not Applicable to Non-Facility							
99283	Emergency dept visit low mdm	17,789	$117	170%	$95	$97	$114	$129	$135								
99456	Disability examination	HCPCS Have No/Very Little Utilization															
99455	Work related disability exam																

(1) Based on 2022 CHSD data trended to 2023.