Post-Reform Study

ALASKA

House Bill 13

Physicians
Hospital Inpatient
Hospital Outpatient
Ambulatory Surgical Center

January 2014

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Table of Contents

EXECUTIVE SUMMARY

NCCI performed a retrospective study of the medical fee schedule revisions in Alaska House Bill 13 (HB 13)[1]. This study includes the impact from medical fee schedule changes to the Physician, Hospital Inpatient, Hospital Outpatient and Ambulatory Surgical Centers (ASC) reimbursements.

The key findings of this study are:

- The average payment per transaction for physician services increased by 4.6% after accounting for price inflation.
- The average payment per claim for hospital inpatient services had the greatest increase among the categories analyzed, 32.5% after accounting for price inflation.
- The average payment per claim for hospital outpatient services grew in line with inflation while the average payment per claim for ASC services rose moderately.

The following table displays a summary of the average change in payments following the enactment of HB 13.

Average Changes in Payments		
Service Category	Observed	Inflation-Adjusted
Physician	+8.7%	+4.6%
Hospital Inpatient	+46.2%	+32.5%
Hospital Outpatient	+8.5%	+0.1%
ASC	+19.0%	+10.2%

Any conclusions concerning the ultimate impact of the reform are preliminary, as post-reform data continues to emerge. There is also potential seasonality influences not addressed in this study. Additional factors affecting average changes in payments for medical services between the pre- and post-reform periods include:

- Behavioral changes by service providers
- Changes in actual payments due to negotiated contracts between providers and insurance carriers.
- Changes in the mix of procedures provided between service years

[1] HB 13 was enacted by the legislature on April 17, 2011, signed by the Governor on September 28, 2011, and applies to all services beginning December 31, 2010.

BACKGROUND

Alaska HB 13 made modifications to the existing Workers' Compensation Fee schedules for various services. The notable changes from the prior fee schedule, which was effective March 31, 2009, are as follows:

- The new fee schedule must reflect the cost in the geographical area where services are provided
- The new fee schedule recalculates the 90th percentile of billed charges; it is no longer based on the December 1, 2004 fee schedule, adjusted by the Medical Care Component of the Consumer Price Index for Urban Consumers (MCC CPI-U)

The average change in maximum reimbursement amounts (MARs) due to HB 13 are as follows:

- Physicians: +22.0%
- Hospital Inpatient: +105.5% per diem
  - For Medical/Surgery stays: +127% per diem
  - For ICU/CCU stays: +100% per diem
- Hospital Outpatient and ASC: +62.1%

NCCI estimated the impact of the physician fee schedule portion of HB 13 as +4.7% on physician costs[2].

HB 13 was passed by the legislature on April 17, 2011, signed by the Governor on September 28, 2011, and applies to all services performed December 31, 2010 and after. HB 13 was enacted 10 months after the effective date of the fee schedule change. For this analysis, NCCI defined the time periods to compare as follows:

Due to potential seasonal variations in services provided, we determined that both the pre-reform and post-reform periods should contain 12 continuous months of data. Since the primary data source (the Medical Data Call) did not require transactional reporting prior to 7/1/2010, the pre-reform time period could not begin prior to 7/1/2010. NCCI also considered the impacts of defining the pre-reform time period from 10/1/2010 – 9/30/2011; the results for this period were not significantly different than those shown in this study.

[2] See "Analysis of House Bill 13, Alaska Physician Fee Schedule Changes Effective December 31, 2010", dated October 10, 2011

KEY OBSERVATIONS

- Physician costs changed by an average of +8.7%. When adjusted for inflation, physician costs changed by +4.6%.
- The impact across physician categories was not uniform; the impact ranged from -27.3% to +13.4%.
- The impact on overall physician costs is consistent with the change in payments for the top 3 Current Procedural Terminology (CPT®) codes that represent the greatest share of payments and transactions.
- Hospital inpatient average payments per claim changed by +46.2%, while average payments per stay changed by +56.7%. When adjusted for inflation, these changes are +32.5% and +42.0% respectively.
- For hospital inpatient, the inflation-adjusted change in average payment per stay of +42.0% was driven by both an increase in payments per day (+10.5%) and an increase in the average length of stay (+28.5%).
- Hospital outpatient total costs grew in line with inflation, both per claim and per visit, where the inflation-adjusted changes are +0.1% and +1.1% respectively. ASC inflation-adjusted average payments per claim changed by +10.2% and average payments per visit by +3.3%.

SUPPORTING ANALYSIS

A. Data and Methods Used

The data contained in this report comes from the Medical Data Call, unless otherwise noted. For more information about the Medical Data Call, please refer to the Medical Data Call Reporting Guidebook on ncci.com.

For the pre-reform period, all medical transactions for medical services delivered from July 1, 2010, to June 30, 2011 are included. For the post-reform period, all medical transactions for medical services delivered from January 1, 2012, to December 31, 2012 are included.

Each time period considered summarizes the experience by the date in which the medical service was provided. There are no controls for mix of diagnosis or severity of claims between service years. No adjustments for seasonality influences were made in this analysis.

For this study, inflation adjustments are based on the Consumer Price Index for all Urban Consumers (CPI-U)[3]. For physicians, the professional services CPI-U average annual change from 2009 to 2011 of +2.6% is used; for hospital inpatient, the inpatient hospital services CPI-U average annual change from 2010 to 2012 of +6.9% is used; for hospital outpatient and ASC, the outpatient hospital services CPI-U average annual change from 2010 to 2012 of +5.4% is used. All payments were trended to 1/1/2013.

A service is defined as a bill line transaction as submitted by the medical provider. A medical provider may change its billing practice by itemizing charges on separate line item transactions of a bill whereas previously charges may have been bundled into one bill line transaction. However, this analysis primarily relies on observations of the annual percent change in payments per active claim. Since claim counts are not affected by changes in medical providers' billing practices, annual changes in payments per claim may be a better indicator of annual changes in medical payments.

A claim could have services performed in the pre-reform period and services performed in the post-reform period, based on the reported date of service. For the analysis of hospital inpatient, hospital outpatient, and ASC payments per claim, claims that have services performed in each of the pre-reform and the post-reform periods will be accounted for as two separate claims, one in each period. The date of service will determine which time period the payment and claim information are attributed.

For hospital inpatient data, an inpatient stay which extends beyond the defined pre- and post-reform time periods are excluded from this analysis. For example, an inpatient stay that started in the pre-reform period but ended in the interim period, the post-reform period or beyond, that particular stay would be excluded from the analysis. For an inpatient stay to be counted in the pre-reform period, it must start and end within the defined pre-reform period. Similarly, for an inpatient stay to be counted in the post-reform period, it must start and end within the defined post-reform period.

[3] Published by the Bureau of Labor Statistics

Furthermore, extreme values were removed from the hospital inpatient, hospital outpatient, and ASC data in order to limit the effect of anomalous values on the analysis. Extreme values (which are selected based on judgment after performing a sensitivity analysis on the data) are defined as follows:

- For hospital inpatient, payments per day below $250 or above $100,000
- For hospital outpatient, payments per visit below $10 or above $40,000
- For ASC, payments per visit below $10 or above $50,000

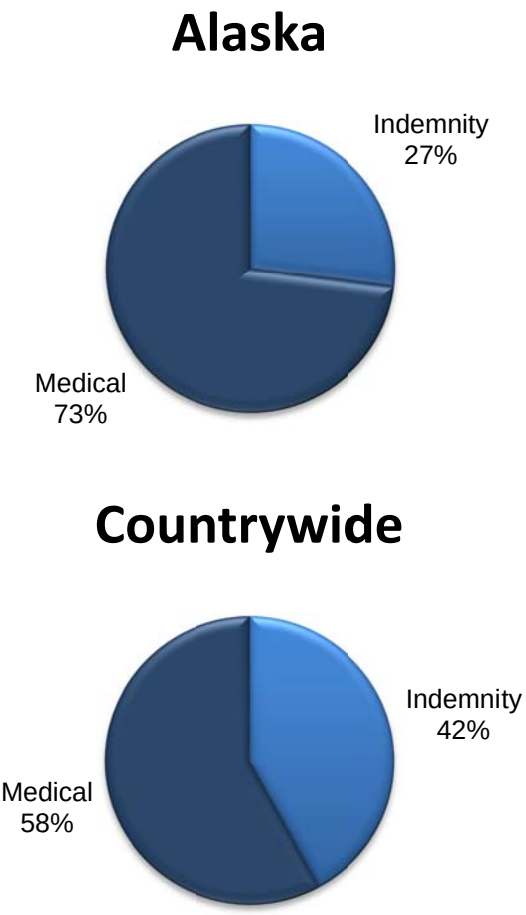
Extreme values account for 6.2% of the hospital inpatient payments, 1.5% of the hospital outpatient payments, and 0.7% of the ASC payments.

B. Overview of System Costs

Traditional workers compensation policies cover two types of benefit payments: medical costs and indemnity (lost wages) costs.

Chart 1 displays the medical percentage of total benefit costs for Alaska and the countrywide average for accident year 2011. Medical costs now comprise nearly 75% of the total Workers' Compensation costs in Alaska.

Chart 1
Medical Share of Total Benefit Costs



Source: Accident Year 2011, NCCI Calendar-Accident Year Call for Compensation Experience. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

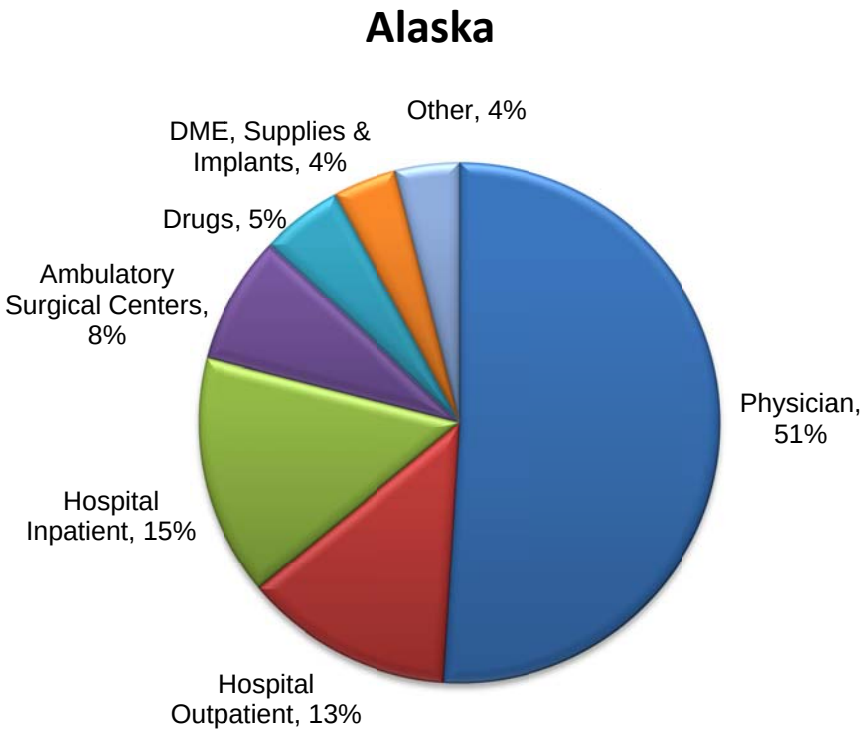
Chart 2 shows the distribution of medical payments for Service Year 2012, for Alaska and countrywide.

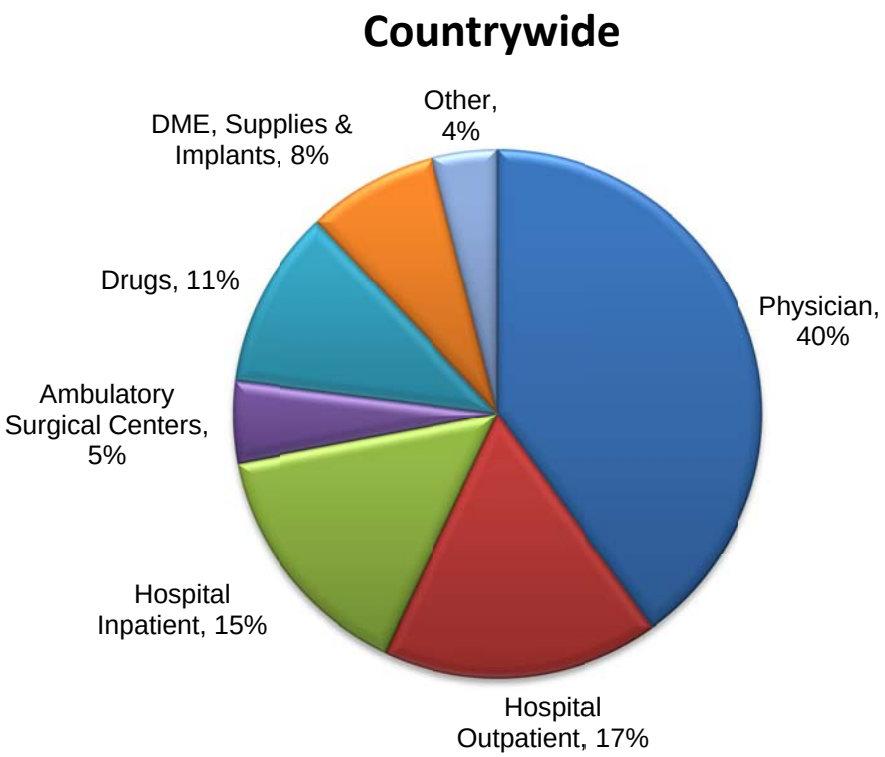
Payments are categorized as Drugs; Durable Medical Equipment (DME), Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed.

For the remaining categories—Physician, Hospital Outpatient, Hospital Inpatient, and Ambulatory Surgical Centers (ASC)—NCCI relies on a combination of:

- Provider taxonomy code—identifies the type of provider that billed for, and is being paid for, the medical service—see Glossary
- Procedure code—alphanumeric code used to identify procedures performed by medical professionals
- Place of services—alphanumeric code used to identify places where procedures were performed (e.g., physician's office, ambulatory surgical center)

Chart 2
Distribution of Medical Payments for Service Year 2012





Source: NCCI Medical Data Call, Service Year 2012. Countrywide includes data for the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, and WV.

The distributions illustrate what service categories incur the most medical payments in Alaska, and how that compares to countrywide. Most notably the percentage of costs is higher in Alaska for the Physician and ASC categories.

This post-reform analysis focuses on physician, hospital outpatient, hospital inpatient, and ASC payments, which account for over 85% of medical costs in Alaska.

C. Physician Payment Analysis

Physician payments represent approximately 51% of medical payments in Alaska. Chart 3 shows the counts of transactions for both the pre-reform and post-reform periods, as well as the total payments for physician services, both observed and inflation-adjusted. The professional services CPI-U average change of +2.6%, used to adjust the observed payments to a common point in time, is assumed to be representative of the average inflation across all physician services in Alaska.

Chart 3
Counts and Total Payments for Physician Services

	Pre-Reform	Post-Reform	Change
Transactions	197,605	193,884	-1.9%
Observed Payments	$40,816,241	$43,534,147	+6.7%
Inflation-Adjusted Payments	$42,954,371	$44,100,091	+2.7%

Chart 4 shows the distribution of transactions and payments for each physician service category.

Chart 4
Transactions and Payments Distribution by Physician Service Category

	Transaction Distribution		Payment Distribution	
Category	**Pre-Reform**	**Post-Reform**	**Pre-Reform**	**Post-Reform**
Anesthesia	1%	1%	4%	4%
Surgery	5%	5%	33%	34%
Radiology	8%	8%	15%	14%
Pathology	3%	4%	1%	1%
Medicine	66%	66%	30%	30%
E&M[4]	16%	16%	15%	15%
All Others	1%	1%	2%	2%
Overall	100%	100%	100%	100%

Chart 4 shows that the distribution of transactions as well as the distribution of payments remained essentially unchanged from the pre-reform to the post-reform period. Note that the payment distributions shown in Chart 4 are based on observed amounts, however the distributions would be unchanged when based on inflation-adjusted payments.

[4] Evaluation and Management

The average observed payment per transaction changed by +8.7% for physician services overall. Chart 5 shows the inflation-adjusted average payments per transaction and average payment change overall and for each physician category.

Chart 5
Average Inflation-Adjusted Payment per Transaction and Average Inflation-Adjusted Payment Change by Physician Service Category

	Average Payment		Average Payment Change
Category	**Pre-Reform**	**Post-Reform**	**Post/Pre**
Anesthesia	$1,111	$1,161	+4.6%
Surgery	$1,430	$1,621	+13.4%
Radiology	$420	$408	-3.0%
Pathology	$77	$61	-21.6%
Medicine	$99	$104	+5.2%
E&M	$198	$221	+11.5%
All Others	$372	$271	-27.3%
Overall	$217	$227	+4.6%

As shown in Chart 5, the inflation-adjusted average payment change varies widely across service categories, from -27.3% to +13.4%. The overall change of +4.6% is mainly driven by the 4 largest service categories by number of transactions and paid amounts (as shown in Chart 4): Surgery, Radiology, Medicine, and Evaluation and Management (E&M).

The Alaska physician fee schedule is based on a CPT® system. This system assigns a unique CPT® code to each procedure and then assigns a corresponding MAR amount to these procedures.

Chart 6 shows the inflation-adjusted average payments per transaction and average payment change for the 5 CPT® codes with the most payments in each of the following service categories: Surgery, Radiology, Medicine, and E&M. The average payments shown are calculated by inflation-adjusting the payments for each CPT® code and dividing the payments by the number of transactions for that CPT® code. The CPT® codes are ranked according to the total amount paid in both the pre-reform and post-reform period combined.

Chart 6
Average Inflation-Adjusted Payment per Transaction and
Average Inflation-Adjusted Payment Change
by Top CPT® codes for Select Service Categories

Surgery

CPT®		Average Payment		Average Payment Change
Code	**Description**	**Pre-Reform**	**Post-Reform**	**Post/Pre**
29881	Arthroscopy knee surgical; with meniscectomy (medial or lateral including any meniscal shaving) including debridement/shaving of articular cartilage	$3,759	$3,839	+2.1%
29826	Arthroscopy shoulder surgical; decompression of subacromial space with partial acromioplasty with coracoacromial ligament (i.e., arch) release when performed	$2,435	$3,074	+26.2%
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic	$4,103	$5,036	+22.7%
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	$5,127	$5,509	+7.4%
63030	Laminotomy (hemilaminectomy) with decompression of nerve root(s) including partial facetectomy foraminotomy and/or excision of herniated intervertebral disc; 1 interspace lumbar	$4,534	$5,697	+25.7%

Radiology

CPT®		Average Payment		Average Payment Change
Code	**Description**	**Pre-Reform**	**Post-Reform**	**Post/Pre**
72148	Magnetic resonance (e.g., proton) imaging spinal canal and contents lumbar; without contrast material	$1,670	$1,488	-10.9%
73721	Magnetic resonance (e.g., proton) imaging any joint of lower extremity; without contrast material	$1,279	$1,249	-2.3%
73221	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; without contrast material(s)	$1,290	$1,266	-1.9%
72141	Magnetic resonance (e.g., proton) imaging spinal canal and contents cervical; without contrast material	$1,596	$1,407	-11.9%
73222	Magnetic resonance (e.g., proton) imaging any joint of upper extremity; with contrast material(s)	$1,471	$1,603	+9.0%

Medicine				
CPT®		Average Payment		Average Payment Change
Code	Description	Pre-Reform	Post-Reform	Post/Pre
97110	Therapeutic procedure 1 or more areas each 15 minutes; therapeutic exercises to develop strength and endurance range of motion and flexibility	$125	$139	+11.0%
97140	Manual therapy techniques (e.g., mobilization/ manipulation manual lymphatic drainage manual traction) 1 or more regions each 15 minutes	$104	$104	-0.3%
98941	Chiropractic manipulative treatment (CMT); spinal 3-4 regions	$74	$73	-0.9%
97112	Therapeutic procedure 1 or more areas each 15 minutes; neuromuscular reeducation of movement balance coordination kinesthetic sense posture and/or proprioception for sitting and/or standing activities	$95	$100	+5.0%
97124	Therapeutic procedure 1 or more areas each 15 minutes; massage including effleurage petrissage and/or tapotement (stroking compression percussion)	$90	$103	+14.4%
E&M				
CPT®		Average Payment		Average Payment Change
Code	Description	Pre-Reform	Post-Reform	Post/Pre
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	$143	$148	+3.8%
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.	$195	$205	+5.2%
99203	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.	$216	$237	+9.4%
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.	$265	$346	+30.5%
99456	Work related or medical disability examination by other than the treating physician.	$1,319	$1,381	+4.7%

As shown in Chart 6, the inflation-adjusted average payment change varies widely across CPT® codes. The CPT® codes with the highest amount of payment dollars as well as highest amount of transaction counts are Medicine codes 97110 and 97140 and E&M code 99213; these 3 codes represent almost 20% of all physician payments and almost 33% of all physician transactions. The overall average inflation-adjusted average payment change for these 3 codes is +5.4%; as such, the overall average inflation-adjusted average payment change for physicians of +4.6% is consistent with the change for these 3 codes.

D. Hospital Inpatient Payment Analysis

Hospital inpatient payments represent approximately 15% of medical payments in Alaska. The number of claims with an inpatient stay and the number of inpatient stays are less than 500 for each period. Therefore caution is advised in drawing conclusions from the available data.

Chart 7 shows the counts of claims, stays, transactions, and total days for hospital inpatient services for both the pre-reform and post-reform periods, as well as the respective percent changes in these measures.

Chart 7
Counts for Hospital Inpatient Services

	Pre-Reform	Post-Reform	Change
Claims	334	380	+13.8%
Stays	439	466	+6.2%
Transactions	2,785	4,234	+52.0%
Total Days	994	1,356	+36.4%

All of the counts shown in Chart 7 increased in the post-reform period compared to the pre-reform period. The transactions per claim also changed by +33.6% from 8.3 to 11.1 transactions per claim, and the days per stay changed by +28.5% from 2.3 to 2.9 days per stay.

Chart 8 shows the total payments for hospital inpatient services, both observed and inflation-adjusted. The inpatient hospital services CPI-U average change of +6.9%, used to adjust the observed payments to a common point in time, is assumed to be representative of the average inflation across all hospital inpatient services in Alaska.

Chart 8
Total Payments for Hospital Inpatient Services

	Pre-Reform	Post-Reform	Change
Observed Payments	$7,148,253	$11,887,485	+66.3%
Inflation-Adjusted Payments	$8,170,971	$12,317,969	+50.8%

The average observed payment per claim changed by +46.2% for hospital inpatient services.

Chart 9 shows the inflation-adjusted average payments per claim, per stay and per day for hospital inpatient services. The average payments are calculated by taking the inflation-adjusted payments from Chart 8 and dividing them by the corresponding claims/stays/days from Chart 7.

Chart 9
Average Inflation-Adjusted Payments and Average Inflation-Adjusted Payment Change for Hospital Inpatient Services

	Pre-Reform	Post-Reform	Average Change
Payment per Claim	$24,464	$32,416	+32.5%
Payment per Stay	$18,613	$26,433	+42.0%
Payment per Day	$8,220	$9,084	+10.5%

Chart 9 shows the average payment changed in the range of +10.5% to +42.0% per these measures. The largest average increase is the average payment per stay. The change of +42.0% can be broken down into the payment per day change of +10.5% and the days per stay change of +28.5%[5]. Note that the main driver is the increase in days per stay, not the increase in payments per day.

[5] (1+10.5%) x (1+28.5%) = (1+42.0%)

E. Hospital Outpatient and Ambulatory Surgical Center Payment Analysis

Hospital outpatient payments represent approximately 13% of medical payments in Alaska, the third largest category after physicians and hospital inpatient as shown in Chart 2.

Chart 10 shows the counts of claims, visits, and transactions for hospital outpatient services for both the pre-reform and post-reform periods, as well as the respective percent changes in these measures.

Chart 10
Counts for Hospital Outpatient Services

	Pre-Reform	Post-Reform	Change
Claims	4,420	4,021	-9.0%
Visits	11,997	10,806	-9.9%
Transactions	30,623	24,212	-20.9%

All of the counts shown in Chart 10 decreased in the post-reform period compared to the pre-reform period. The transactions per claim also changed by -13.1% from 6.9 to 6.0 transactions per claim.

Chart 11 shows the total payments for hospital inpatient services, both observed and inflation-adjusted. The outpatient hospital services CPI-U average change of +5.4%, used to adjust the observed payments to a common point in time, is assumed to be representative of the average inflation across all hospital outpatient and ASC services in Alaska.

Chart 11
Total Payments for Hospital Outpatient Services

	Pre-Reform	Post-Reform	Change
Observed Payments	$11,331,192	$11,185,998	-1.3%
Inflation-Adjusted Payments	$12,621,467	$11,496,568	-8.9%

The average observed payment per claim changed by +8.5% for hospital outpatient services.

Chart 12 shows the inflation-adjusted average payments per claim and per visit for hospital outpatient services. The average payments are calculated by taking the inflation-adjusted payments from Chart 11 and dividing them by the corresponding claims and visits from Chart 10.

Chart 12
Average Inflation-Adjusted Payments and Average Inflation-Adjusted Payment Change for Hospital Outpatient Services

	Pre-Reform	Post-Reform	Average Change
Payment per Claim	$2,856	$2,859	+0.1%
Payment per Visit	$1,052	$1,064	+1.1%

Chart 12 shows the average payment for hospital outpatient services remained largely unchanged after adjusting for inflation.

ASC payments represent only approximately 8% of medical costs in Alaska, and the number of claims is less than 750 for each of the pre-reform and post-reform periods. Therefore, caution is advised in drawing conclusions from the available data.

Chart 13 shows the counts of claims, visits, and transactions for ASC services for both the pre-reform and post-reform periods, as well as the respective percent changes in these measures.

Chart 13
Counts for ASC Services

	Pre-Reform	Post-Reform	Change
Claims	701	733	+4.6%
Visits	1,016	1,134	+11.6%
Transactions	2,446	2,442	-0.2%

Chart 13 shows that the number of claims and visits increased moderately in the post-reform period compared to the pre-reform period, while the number of transactions remained unchanged. The transactions per claim changed by -4.5% from 3.5 to 3.3 transactions per claim.

Chart 14 shows the total payments for ASC services, both observed and inflation-adjusted. The outpatient hospital services CPI-U average change of +5.4%, used to adjust the observed payments to a common point in time, is assumed to be representative of the average inflation across all hospital outpatient and ASC services in Alaska.

Chart 14
Total Payments for ASC Services

	Pre-Reform	Post-Reform	Change
Observed Payments	$5,273,241	$6,560,704	+24.4%
Inflation-Adjusted Payments	$5,851,785	$6,744,502	+15.3%

Chart 15 shows the inflation-adjusted average payments per claim and per visit for ASC services. The average payments are calculated by taking the inflation-adjusted payments from Chart 14 and dividing them by the corresponding claims and visits from Chart 13.

Chart 15
Average Inflation-Adjusted Payments and Average Inflation-Adjusted Payment Change for ASC Services

	Pre-Reform	Post-Reform	Average Change
Payment per Claim	$8,348	$9,201	+10.2%
Payment per Visit	$5,760	$5,948	+3.3%

Chart 15 shows the average payment for ASC services increased moderately after adjusting for inflation.

APPENDIX

GLOSSARY

Accident Year: A loss accounting definition in which experience is summarized by the calendar year in which an accident occurred.

Ambulatory Surgical Center (ASC): A state-licensed facility that is used mainly to perform outpatient surgery; has a staff of physicians; has continuous physician and nursing care; and does not provide for overnight stays. An ASC can bill for facility fees much like a hospital, but generally has a separate fee schedule.

Current Procedure Terminology (CPT®): A numeric coding system maintained by the American Medical Association (AMA). The CPT® coding system consists of five-digit codes that are primarily used to identify medical services and procedures performed by physicians and other healthcare professionals.

Drugs: Includes any data reported by a National Drug Code (NDC). Also included are data for revenue codes, Healthcare Common Procedure Code System (HCPCS), and other state-specific codes that represent drugs.

Durable Medical Equipment (DME): Equipment that is primarily and customarily used to serve a medical purpose; can withstand repeated use; could normally be rented and used by successive patients; is appropriate for use in the home; and is not generally useful to a person in the absence of an illness or injury.

Hospital Inpatient Service: Services for a patient who is admitted to a hospital for treatment that requires at least one overnight stay (more than 24 hours in a hospital).

Hospital Outpatient Service: Any type of medical or surgical care performed at a hospital that is not expected to result in an overnight hospital stay (less than 24 hours in a hospital).

Medical Data Call: Captures transaction level detail for medical billings that were processed on or after July 1, 2010. All medical transactions with the jurisdiction state in any applicable Medical Data Call state are reportable. This includes all workers compensation claims, including medical-only claims.

(Paid) Procedure Code: A code from the jurisdiction-approved code table that identifies the procedure associated with the reimbursement. Examples include CPT® code, CDT code, or revenue code.

Service Year: A loss accounting definition in which experience is summarized by the calendar year in which the medical service was provided.

Taxonomy: A taxonomy code identifies the type of provider that billed for and is being paid for the medical service. Data reporters are instructed to use the provider taxonomy list of standard codes maintained by the National Uniform Claim Committee.

Transaction: A line item of a medical bill.

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