Medical Data Report

For the state of

NEW MEXICO

October 2021

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Introduction

Medical costs have been growing over the last 30 years. Today, in many states, close to 60% of workers compensation benefits are attributed to medical costs. Managing the cost and delivery of medical care is one of the major concerns facing workers compensation (WC) stakeholders now and in the foreseeable future. The availability of medical data on WC claims is essential for the pricing of proposed state legislation and assessing impacts of changes to fee schedules.

This publication is a data source for regulators and others who are interested in the driving forces behind changing medical costs in WC claims. The information in this report provides important benchmarks against which cost containment strategies may be measured and gives valuable insight into the medical cost drivers that underlie the financial soundness of the WC system. When making comparisons to the region and countrywide (CW), it is important to note that some states in this report do not have a fee schedule.

Knowing how payments for different services contribute to WC medical benefit costs provides insight into the growth of medical benefits. This report illustrates the breakdown of services by category, namely:

- Physician
- Hospital Outpatient
- Hospital Inpatient
- Ambulatory Surgical Centers
- Drugs
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)
- Other

The report drills down into these categories to show which procedures represent the greatest share of payments and which are performed the most.

There is one important caveat: Information in this report may not coincide with an analysis of a medical fee schedule change performed in the future. An analysis of a medical fee schedule change requires evaluation of the specific procedures covered by the fee schedule, which may be different from how payments are categorized in this report.

The data contained in this report represents medical transactions for Service Year 2020 (medical services delivered from January 1, 2020, to December 31, 2020), except where otherwise noted. WC insurance carriers must report paid medical transactions if, over the most recent three years, they write at least 1% of the market share in any one state for which NCCI is the rating or advisory organization. Once a carrier meets the eligibility criteria, it is required to report for all applicable states in which it writes WC insurance. All carriers within an insurance group are required to report.

No data adjustments have been made for the reporting of COVID-19-related claims. For more information on impacts of COVID-19 on medical losses, please see the Medical Indicators & Trends dashboard[1] on **ncci.com**.

For New Mexico in Service Year 2020, the reported number of transactions was more than 517,800, with more than $70,061,200 paid, for more than 15,100 claims. This represents data from 94% of the workers compensation premium written, which includes experience for large-deductible policies. Bulk payments and lump-sum settlements are not required to be reported. Also, self-insured data is not included.

[1] www.ncci.com/Articles/Pages/Insights-Medical-Indicators-Trends-Dashboard.aspx

Unless otherwise noted, the source for all data in this report is:

- NCCI's Medical Data Call, Service Year 2020
- Region includes data from the following states: AK, AZ, CO, HI, ID, MT, NV, OR, and UT.
- Countrywide includes data from the following states: AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV

Additional information regarding the data underlying this report is available in the Appendix.

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Medical Cost Statistics

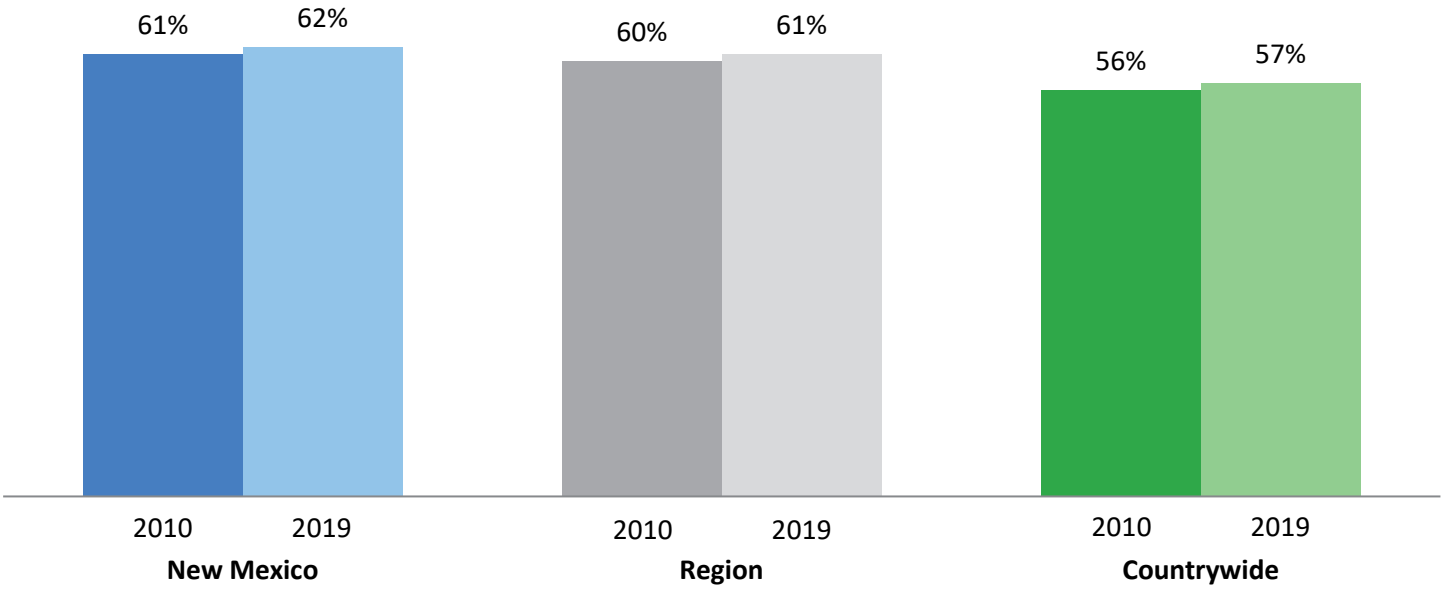
Traditional workers compensation policies cover two types of benefit payments: medical benefits and indemnity (lost wages) benefits.

Of the two, medical benefits resulting from a work-related injury or disease are the leading cost drivers for workers compensation claims on a countrywide basis. Because this is a relative measure and benefits for both indemnity and medical may vary from state to state, the share of medical benefit costs may vary across states. In particular, the medical share in a state may be large because the indemnity benefits are relatively less prominent.

Chart 1 displays the medical percentage of total benefit costs for New Mexico, the region, and countrywide for Accident Years 2010 and 2019.

Chart 1

Medical Share of Total Benefit Costs by Accident Year



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AK, AZ, CO, HI, ID, MT, NV, OR, and UT. Countrywide data includes 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, TX, UT, VA, VT, and WV.

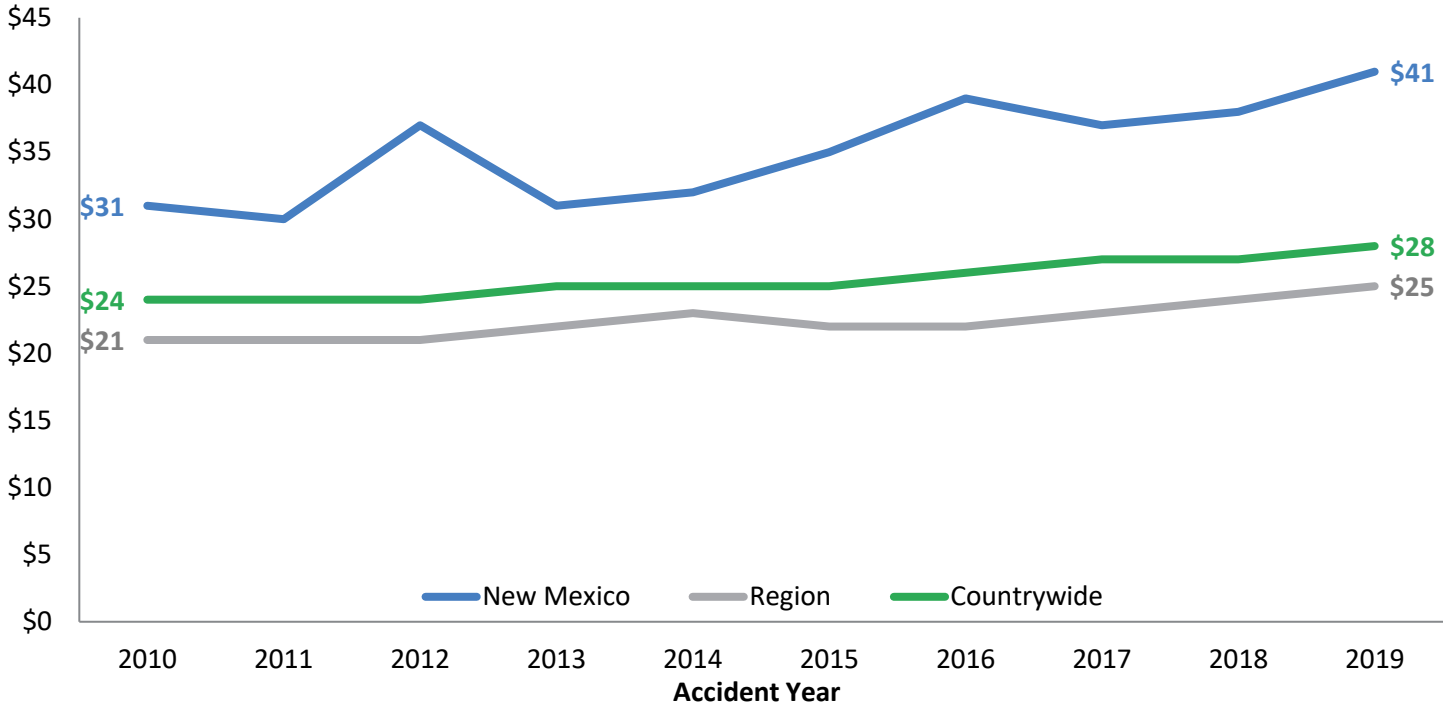
The countrywide overall medical average cost per claim has seen moderate increases in recent years, averaging about 2% from Accident Years 2010 to 2019; this has increased at a slightly higher rate than the United States Personal Healthcare Spending per capita.[2] Chart 2 displays the historical overall medical average cost per case (per lost-time claim) for the most recent 10 accident years. Results are displayed for New Mexico, the region, and countrywide.

Medical losses are at historical benefit levels and historical dollar values—meaning that no adjustment for inflation or changes in benefits has been made. Since the data is aggregated for all medical losses by accident year, the results shown in this chart provide a high-level perspective of the average medical cost per case.

This chart illustrates how New Mexico compares to the regional and countrywide average for each individual accident year and allows for the comparison of the growth in average medical costs.

Chart 2

Overall Medical Average Cost per Lost-Time Claim (in 000s)



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Region includes AK, AZ, CO, HI, ID, MT, NV, OR, and UT. Countrywide data 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, TX, UT, VA, VT, and WV.

[2] **State of the Line Report, *Annual Issues Symposium***, May 2021, www.ncci.com/Articles/Documents/AIS2021-SOTL-Presentation.pdf

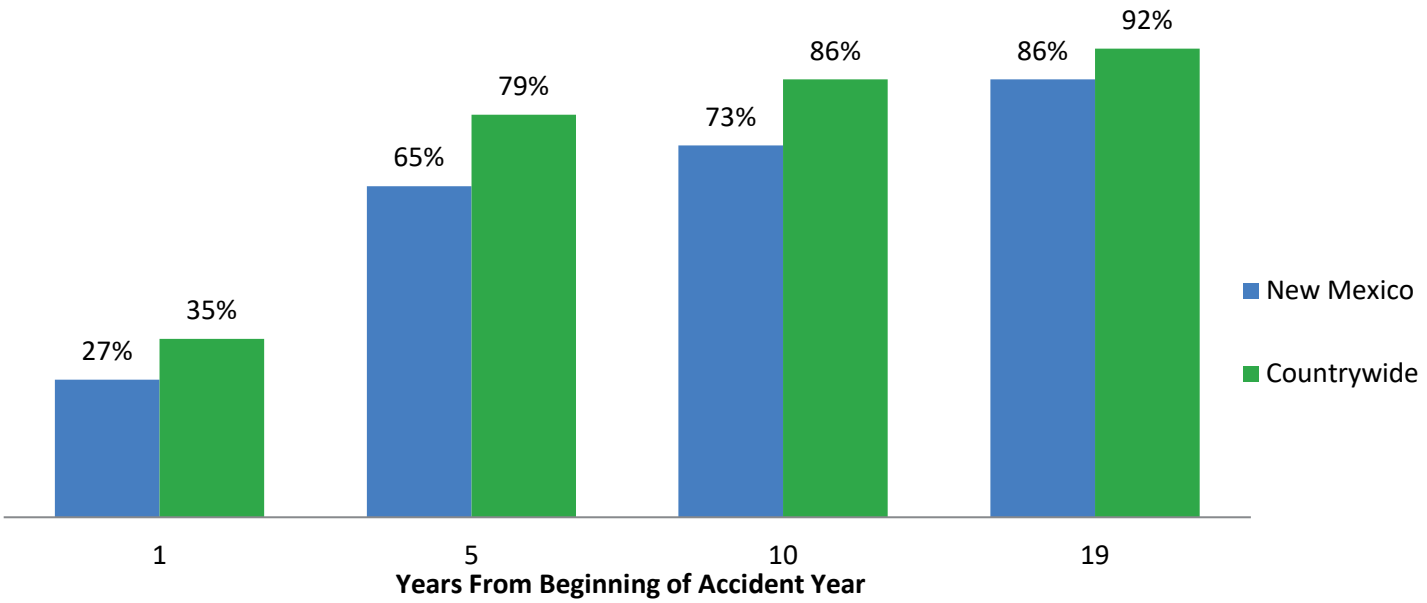
One factor that impacts medical costs is the time over which medical services are used. Payments on a workers compensation claim often continue for many years. NCCI research has found that it is likely that about 10% of the cost of medical benefits for workplace injuries that occur this year will be for services provided more than two decades into the future.

A key determinant driving payment patterns for medical services is the effectiveness of dispute resolution processes, settlement practices, and statutory provisions for medical benefits. An aging workforce and continued changes in rules for Medicare set-asides have created a shifting environment for the settlement of claims and, particularly, medical benefits.

Chart 3 shows the percentage of medical benefits paid (including medical settlements) at different claim maturities for New Mexico and countrywide.

Chart 3

Percentage of Medical Paid by Claim Maturity



Source: NCCI's Calendar-Accident Year Call for Compensation Experience. Countrywide data includes 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, OK, OR, RI, SC, SD, TN, UT, VA, and VT.

Knowing how payments for different medical services contribute to workers compensation medical benefit costs provides insight into the growth in medical benefits.

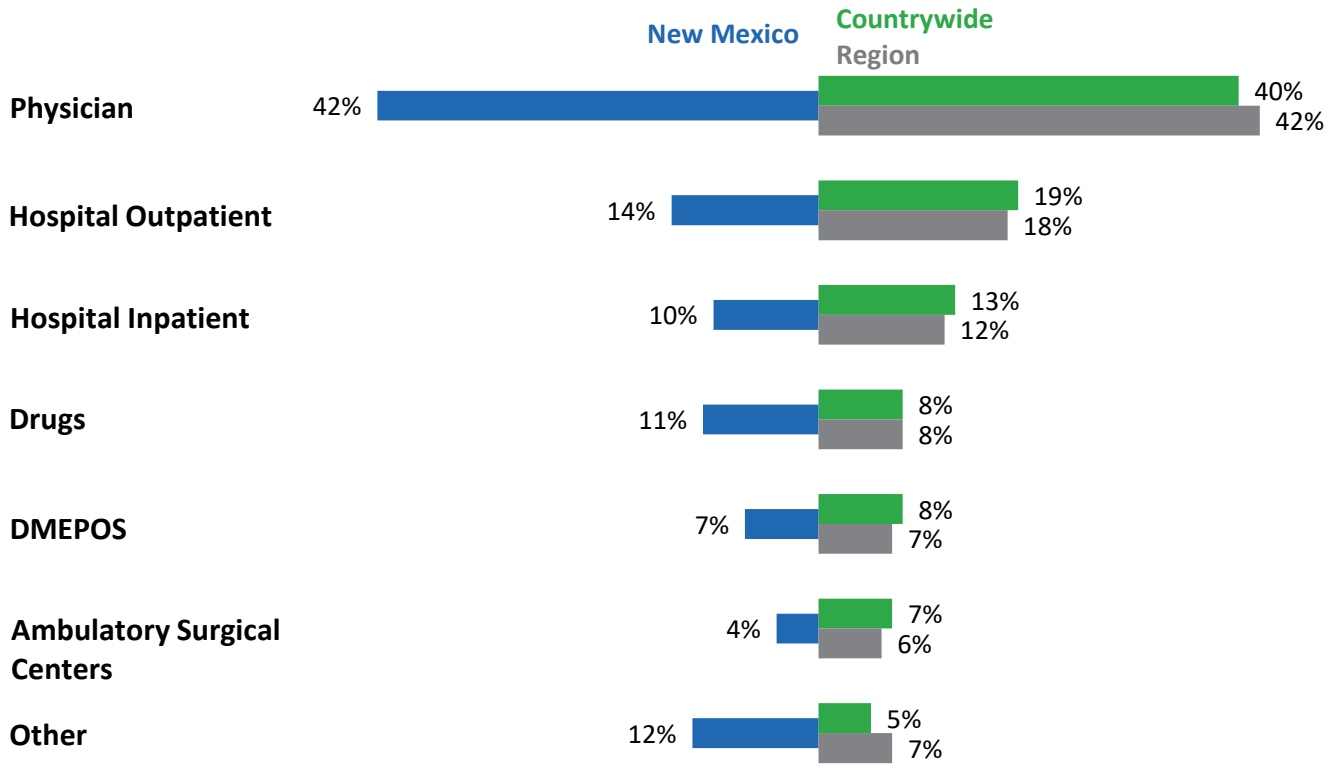
Payments are categorized as Drugs; DME, Supplies, and Implants; and Other (includes home health, transportation, vision, and dental services), based on the procedure code reported. Payments are mapped to these categories regardless of who provides the service or where the service is performed. For the remaining categories—Physicians, 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, a medical service
- 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 or ambulatory surgical center)

Chart 4 displays the distribution of medical payments by type of service.

Chart 4

Distribution of Medical Payments



Physicians

In the 1970s, fewer than a dozen states had physician fee schedules in place. In the 1990s, several states established such schedules. Today, few states remain without a physician fee schedule. Recent changes in the schedules indicate greater attention to provisions that often seek to balance cost containment with service provider availability. NCCI's most recent study, "The Impact of Fee Schedule Updates on Physician Payments" (December 2018), shows that:

- Approximately 80% of any change in the maximum allowable reimbursement (MAR) for a physician service will be realized as a change in prices paid
- Most of the impact of a MAR change on prices paid is realized within one year from the date of a fee schedule change

One measure of workers compensation medical costs is a comparison of current payments to the Medicare rates adjusted for your state.

The chart below shows the average percentage of Medicare schedule reimbursement[3] amounts for physician payments by category for New Mexico, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the categories listed in the chart, and the state comparison reflects Medicare's geographic adjustments. In New Mexico, 83% of "all physician services" payments are included in the chart below.

Chart 5

Physician Payments as a Percentage of Medicare

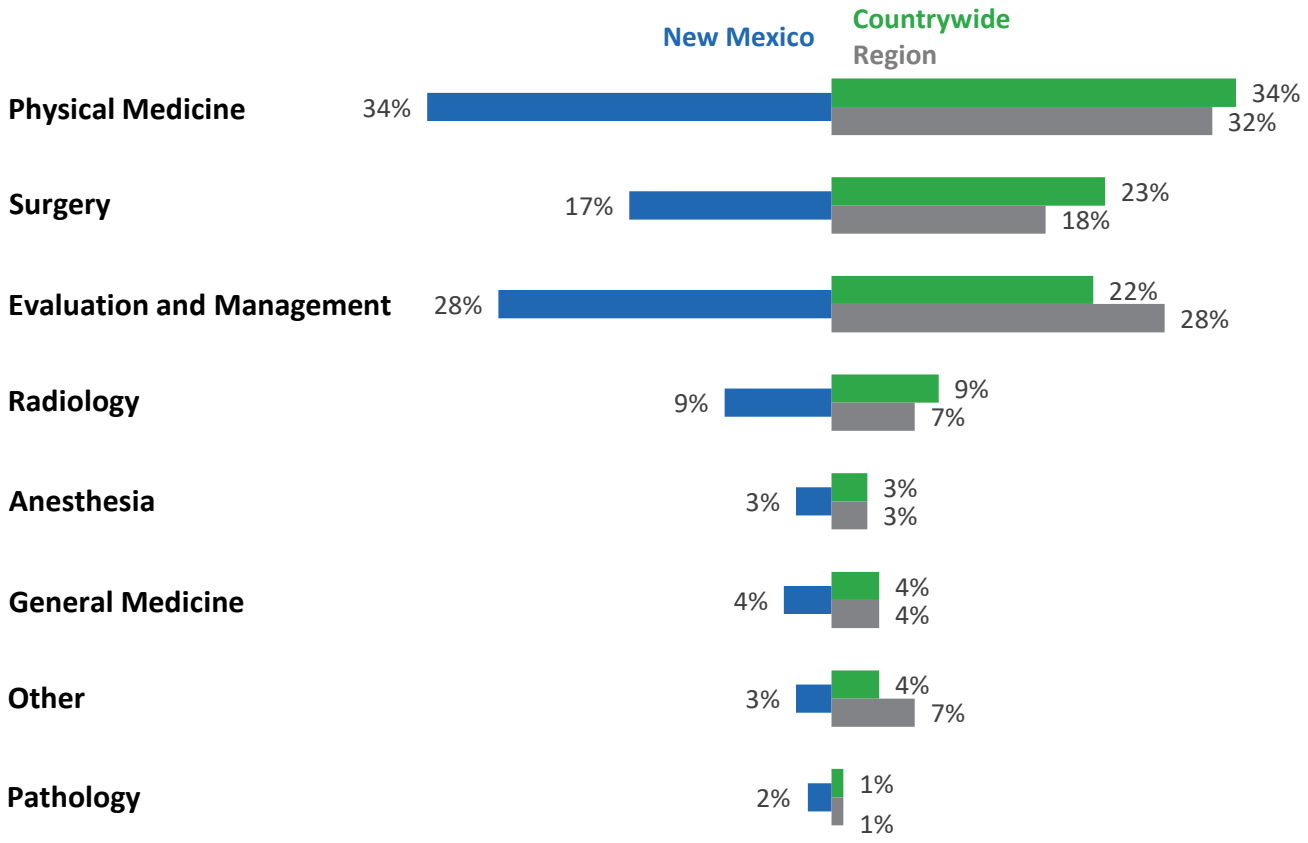
Physician Service Category	New Mexico	Region	Countrywide
General and Physical Medicine	146%	136%	132%
Surgery	215%	208%	270%
Evaluation and Management	151%	155%	144%
Radiology	246%	212%	227%
Anesthesia	290%	250%	309%
All Physician Services	**166%**	**159%**	**167%**

[3] The calculation for Surgery takes into account Medicare's endoscopic procedures reimbursement rules.

Chart 6 displays the distribution of physician payments by service category for New Mexico, the region, and countrywide.

Chart 6

Distribution of Physician Payments by AMA Service Category



In 2019, NCCI conducted a review of physician costs in workers compensation as compared to group health (GH). Results[4] show that WC physician costs are 77% higher than GH in general, with variation across states ranging from 0% to 200%. The difference in costs for physician services is due to both prices and utilization of services. Most notably, physical medicine services in WC are almost three times the costs of physical medicine services in GH, largely due to the number of services provided.

Physicians typically use current procedure terminology (CPT) codes to identify the services that they provide to claimants. These codes are specific and provide detailed information on what service was performed. The charts below display the top 10 procedure codes reported by physicians for the following service categories: anesthesia, surgery, radiology, physical and general medicine, and evaluation and management. A brief description of each procedure code is displayed in the corresponding table below each chart.

Except for anesthesia codes and physical & general medicine codes, the charts also include the average amount paid per transaction (PPT) for these codes in New Mexico, in the region, and countrywide. The average PPT is calculated by taking the total payments for the procedure code and dividing by the number of transactions for the procedure code. Other fields, such as the secondary paid procedure code, modifier, diagnosis code, place of service, and quantity/units, may need to be considered when evaluating average payments per service. The charts for the top 10 anesthesia codes and physical & general medicine codes include the average amount paid per unit (PPU) for the codes in New Mexico, in the region, and countrywide. The PPU is calculated by taking the total payments for the procedure code and dividing by the number of units for the procedure code. For these codes, a unit is typically a measurement of time (15-minute increment, 30-minute increment, 1-hour increment, etc.) but can also be one transaction. The procedure code description will indicate the unit measurement.

The Top 10 charts rank the procedure codes for each service category using two different methods. The first method ranks procedure codes by total payments. Procedure codes are sorted from highest total payments to lowest total payments. The procedure code with the highest amount paid is ranked first, the procedure code with the second highest amount paid is ranked second, and so on. This method of ranking shows those procedures that represent the highest percentage share of payments.

The second method ranks procedure codes by total count of transactions. The procedure code with the highest total transaction count is ranked first, the procedure code with the second highest total transaction count is ranked second, and so on. This method reveals the most frequently used procedures.

Additional charts show time until first treatment and results for telemedicine services. Time to initial treatment (TTT) is a measure of the availability of medical services and is measured by the number of days between the date of injury and the date on which the worker first received medical services. Telemedicine services charts are based on transactions reported with a telemedicine-specific procedure code, modifier, or place of service and show the distribution, as well as the top 10 procedure codes, for telemedicine service.

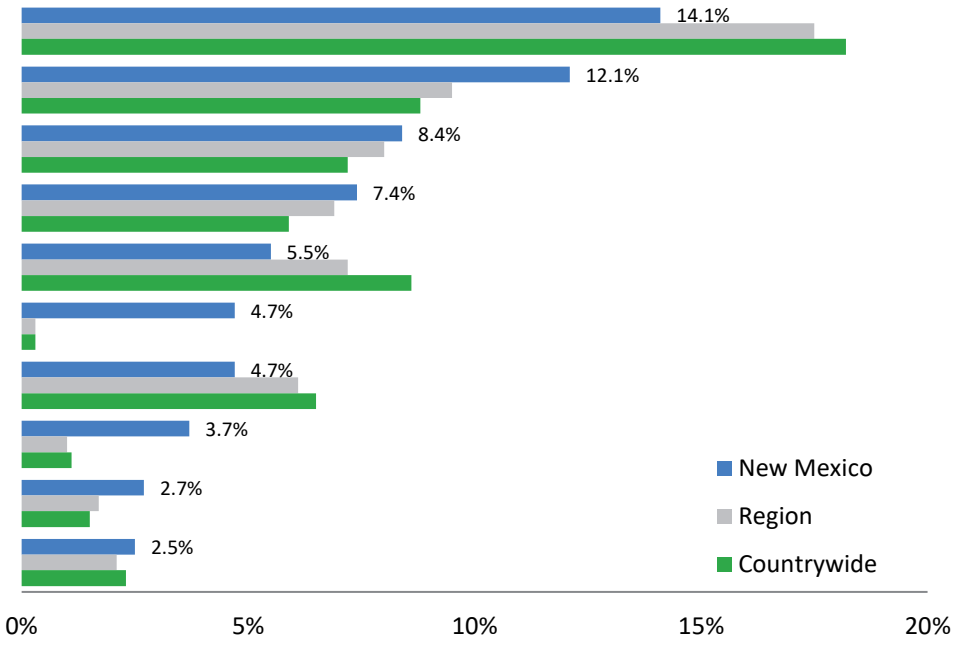
[4] Lipton, Barry, *Work Comp vs. Group Health—The Price We Pay* (Channel NCCI, video file), May 23, 2019, www.youtube/fb3tnbQoMSY

In New Mexico, physician payments for anesthesia services provided in 2020 are, on average, 290% of Medicare-scheduled reimbursement amounts, compared to 250% in the region and 309% countrywide. Payments for these services comprise 3% of physician payments, compared to 3% in the region and 3% countrywide.

Chart 7

Top 10 Anesthesia Procedure Codes by Amount Paid

	Average PPU[5]			
Code	**NM**	**Region**	**CW**	**Paid Share**
01630	$95	$90	$95	14.1%
01400	$102	$99	$101	12.1%
01830	$78	$81	$81	8.4%
01480	$70	$76	$76	7.4%
00670	$101	$108	$110	5.5%
01952	$78	$49	$73	4.7%
01810	$91	$91	$94	4.7%
01610	$104	$93	$102	3.7%
01392	$57	$74	$72	2.7%
01710	$85	$81	$86	2.5%



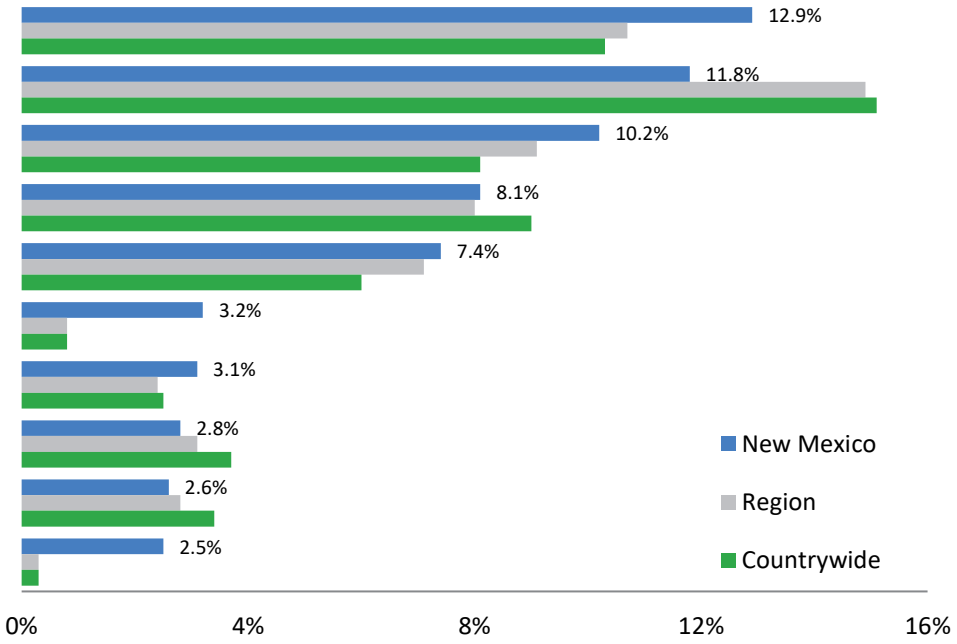
Code	Description
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01952	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between 4% and 9% of total body surface area
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
01392	Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified

[5] A unit is an increment of 15 minutes unless otherwise defined in the description.

Chart 8

Top 10 Anesthesia Procedure Codes by Transaction Counts

Code	Average PPU NM	Region	CW
01400	$102	$99	$101
01630	$95	$90	$95
01830	$78	$81	$81
01810	$91	$91	$94
01480	$70	$76	$76
01610	$104	$93	$102
01710	$85	$81	$86
00400	$80	$81	$83
00670	$101	$108	$110
01952	$78	$49	$73



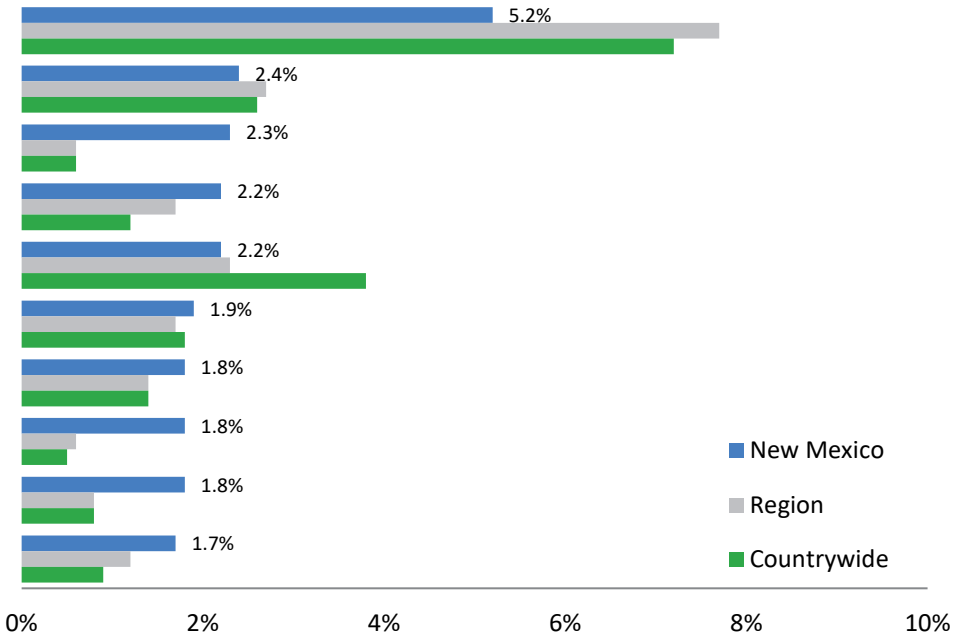
Code	Description
01400	Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified
01630	Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified
01830	Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified
01810	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand
01480	Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified
01610	Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of shoulder and axilla
01710	Anesthesia for procedures on nerves, muscles, tendons, fascia, and bursae of upper arm and elbow; not otherwise specified
00400	Anesthesia for procedures on the integumentary system on the extremities, anterior trunk, and perineum; not otherwise specified
00670	Anesthesia for extensive spine and spinal cord procedures (e.g., spinal instrumentation or vascular procedures)
01952	Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; between 4% and 9% of total body surface area

In New Mexico, physician payments for surgery services provided in 2020 are, on average, 215% of Medicare-scheduled reimbursement amounts, compared to 208% in the region and 270% countrywide. Payments for these services comprise 17% of physician payments, compared to 18% in the region and 23% countrywide.

Chart 9

Top 10 Surgery Procedure Codes by Amount Paid

Code	Average PPT NM	Region	CW
29827	$1,682	$1,857	$2,155
29881	$1,049	$1,177	$1,500
64635	$812	$817	$906
29888	$1,768	$1,762	$2,093
29826	$559	$527	$987
64483	$407	$426	$576
20610	$115	$126	$131
23412	$1,224	$1,441	$1,667
64493	$307	$433	$523
20680	$1,100	$720	$858

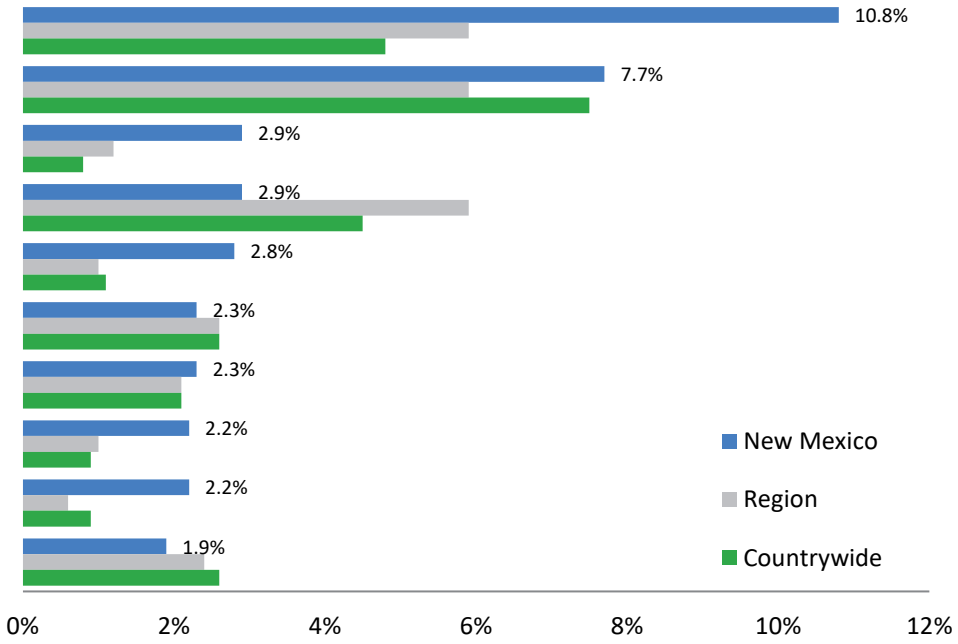


Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single facet joint
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint), with image guidance (fluoroscopy or computed tomography (CT)), lumbar or sacral; single level
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)

Chart 10

Top 10 Surgery Procedure Codes by Transaction Counts

Code	Average PPT NM	Region	CW
36415	$11	$11	$11
20610	$115	$126	$131
20553	$122	$133	$129
12001	$175	$158	$182
64493	$307	$433	$523
64415	$236	$165	$286
64483	$407	$426	$576
64450	$167	$126	$161
64494	$151	$187	$288
29826	$559	$527	$987

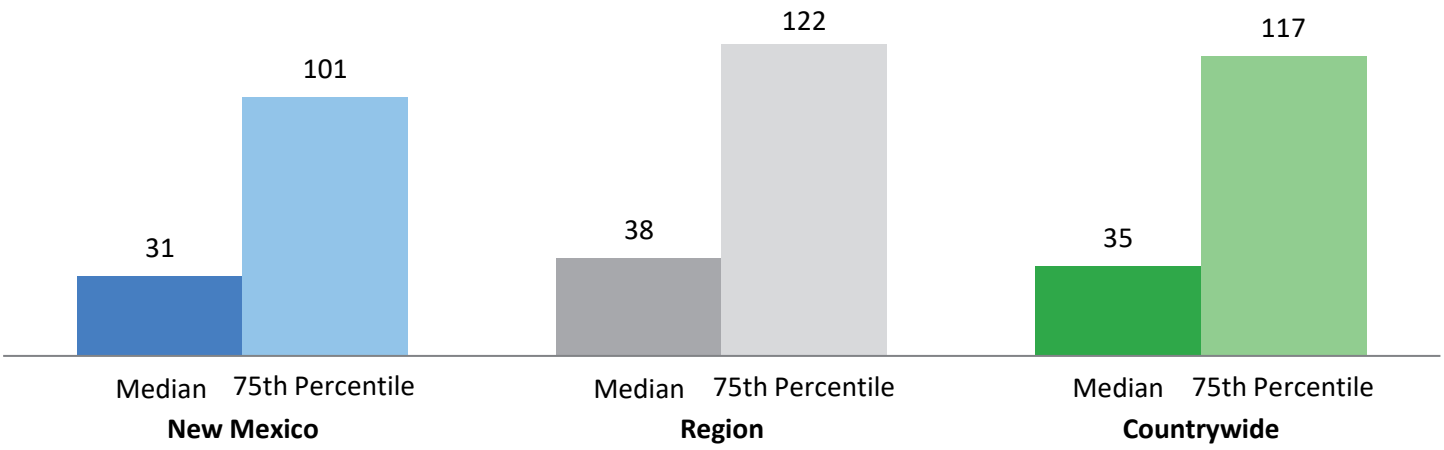


Code	Description
36415	Collection of venous blood by venipuncture
20610	Arthrocentesis, aspiration, and/or injection; major joint or bursa (e.g., shoulder, hip, knee, joint, subacromial bursa)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk, and/or extremities (including hands and feet); 2.5 cm or less
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint), with image guidance (fluoroscopy or computed tomography (CT)), lumbar or sacral; single level
64415	Injection, anesthetic agent; brachial plexus, single
64483	Injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single level
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint), with image guidance (fluoroscopy or computed tomography (CT)), lumbar or sacral; second level
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed

Chart 11 shows the median and 75th percentile[6] time until first treatment for major surgery for New Mexico, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop such as an occupational disease, which may extend the time between the date a work-related injury or disease is reported and the first medical treatment takes place.

Chart 11

Time Until First Treatment for Major Surgery[7] (in Days)



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

[6] The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 11 indicates that out of 100 claimants, 75 will receive a major surgery within 101 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

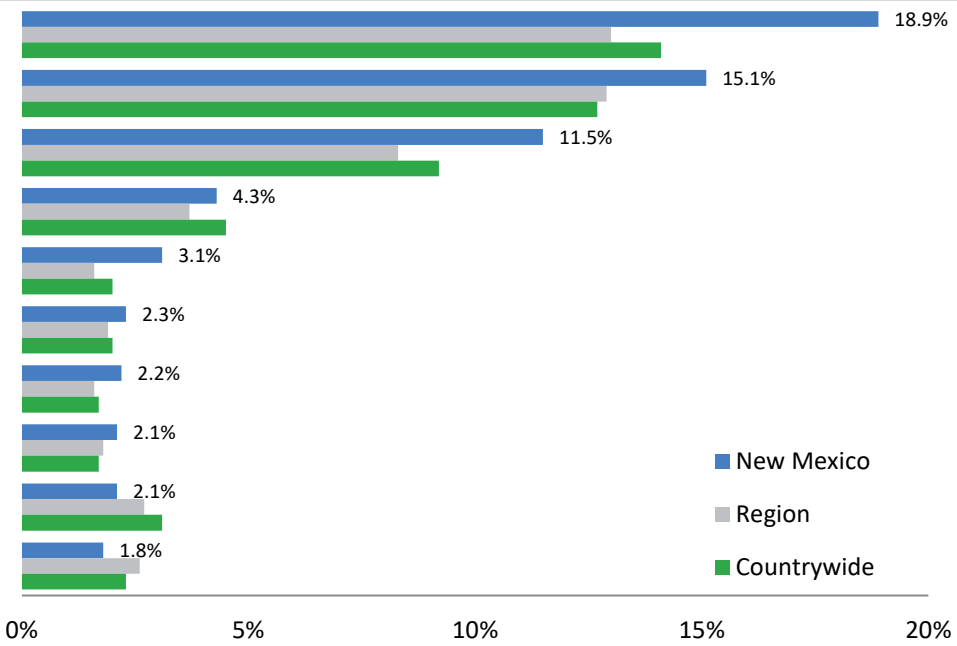
[7] A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it has a global follow-up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection.

In New Mexico, physician payments for radiology services provided in 2020 are, on average, 246% of Medicare-scheduled reimbursement amounts, compared to 212% in the region and 227% countrywide. Payments for these services comprise 9% of physician payments, compared to 7% in the region and 9% countrywide.

Chart 12

Top 10 Radiology Procedure Codes by Amount Paid

Code	Average PPT NM	Region	CW
73221	$658	$419	$492
73721	$641	$418	$484
72148	$659	$399	$470
72141	$652	$393	$464
76942	$126	$76	$112
70450	$185	$137	$164
73718	$656	$427	$491
73218	$672	$510	$542
73030	$47	$54	$59
73610	$48	$55	$56

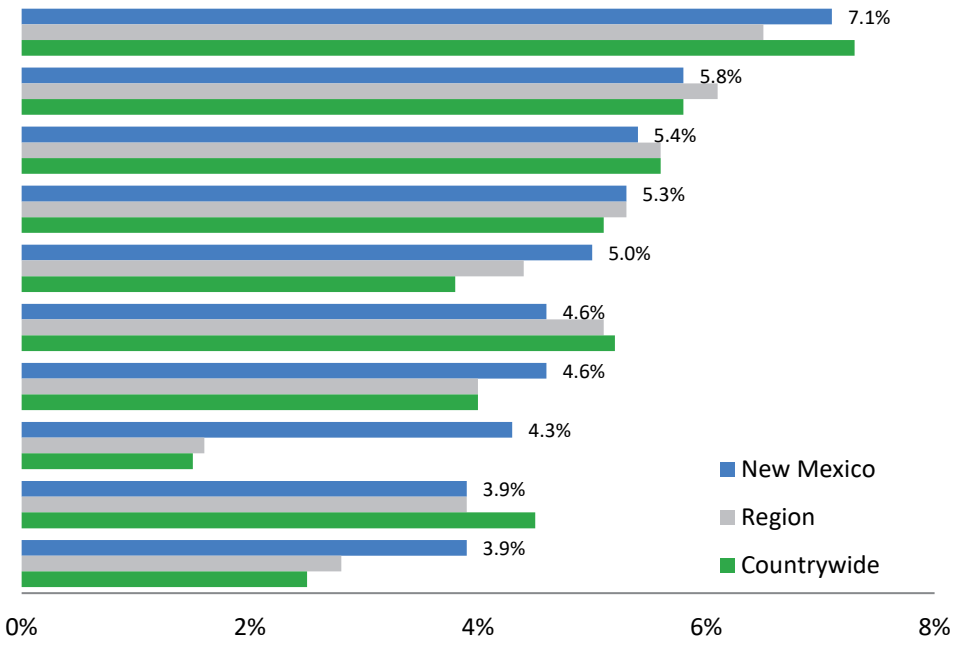


Code	Description
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
72148	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, lumbar; without contrast material
72141	Magnetic resonance (e.g., proton) imaging, spinal canal and contents, cervical; without contrast material
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
70450	Computed tomography (CT), head or brain; without contrast material
73718	Magnetic resonance (e.g., proton) imaging, lower extremity other than joint; without contrast material
73218	Magnetic resonance (e.g., proton) imaging, upper extremity other than joint; without contrast material
73030	Radiologic examination, shoulder; complete minimum of 2 views
73610	Radiologic examination, ankle; complete minimum of 3 views

Chart 13

Top 10 Radiology Procedure Codes by Transaction Counts

Code	Average PPT NM	Region	CW
73030	$47	$54	$59
73610	$48	$55	$56
73630	$46	$52	$54
73110	$52	$60	$62
73562	$57	$62	$64
73130	$45	$53	$54
73221	$658	$419	$492
71045	$22	$24	$28
72100	$54	$68	$65
76942	$126	$76	$112

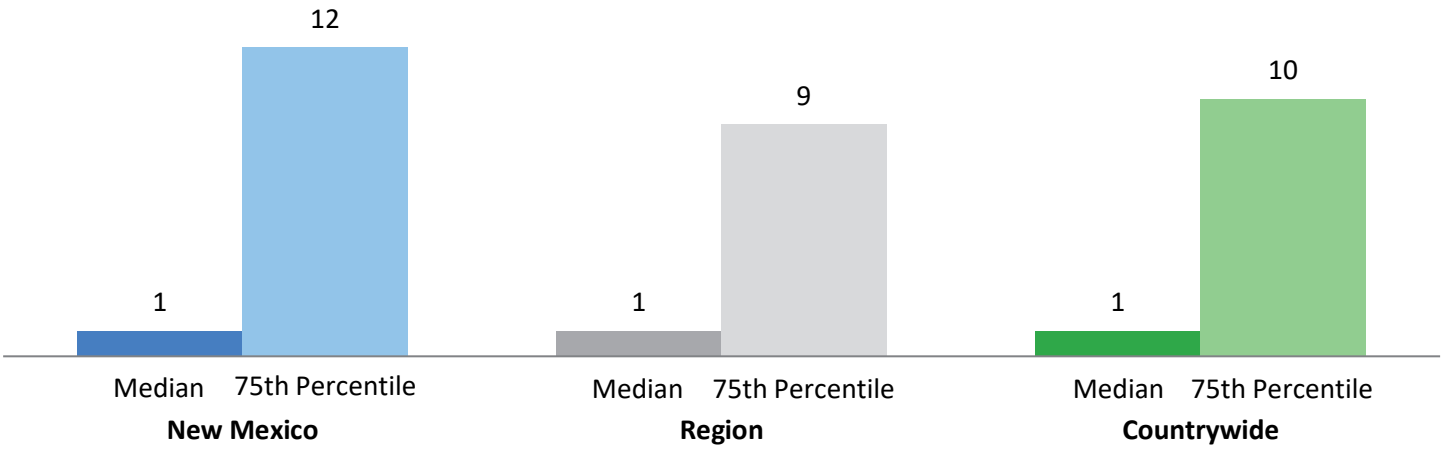


Code	Description
73030	Radiologic examination, shoulder; complete minimum of 2 views
73610	Radiologic examination, ankle; complete minimum of 3 views
73630	Radiologic examination, foot; complete minimum of 3 views
73110	Radiologic examination, wrist; complete minimum of 3 views
73562	Radiologic examination, knee; 3 views
73130	Radiologic examination, hand; minimum of 3 views
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
71045	Radiologic examination, chest; single view
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)

Chart 14 shows the median and 75th percentile time until first treatment for radiology procedures for New Mexico, the region, and countrywide.

Chart 14

Time Until First Treatment for Radiology (in Days)



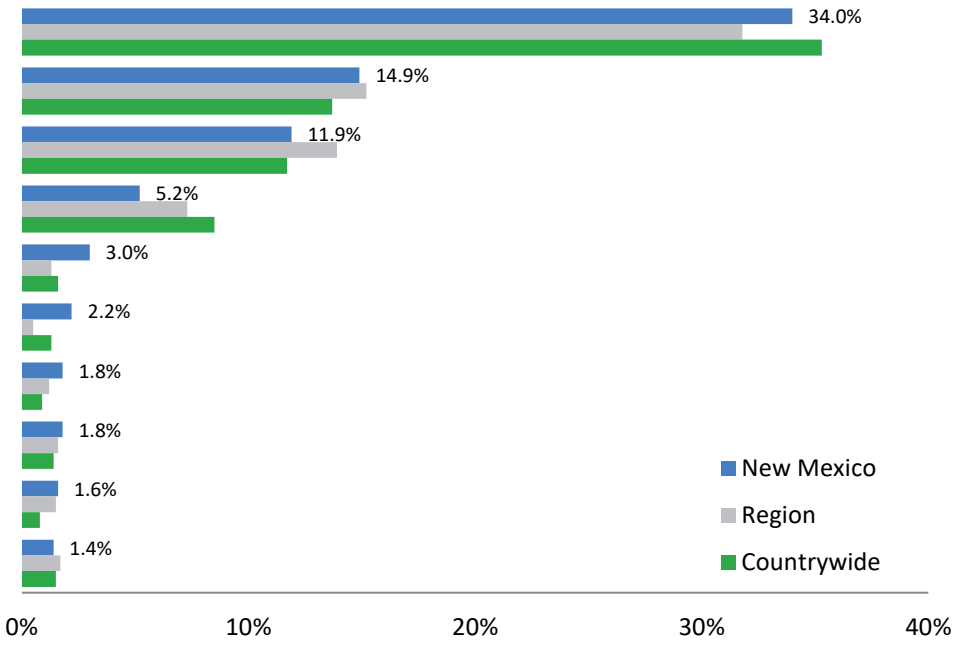
Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

In New Mexico, physician payments for physical and general medicine services provided in 2020 are, on average, 146% of Medicare-scheduled reimbursement amounts, compared to 136% in the region and 132% countrywide. Payments for these services comprise 38% of physician payments, compared to 36% in the region and 38% countrywide.

Chart 15

Top 10 Physical and General Medicine Procedure Codes by Amount Paid

	Average PPU			
Code	**NM**	**Region**	**CW**	**Paid Share**
97110	$44	$43	$42	34.0%
97530	$50	$55	$46	14.9%
97140	$41	$40	$38	11.9%
97112	$47	$47	$43	5.2%
97014	$22	$20	$22	3.0%
97750	$53	$43	$54	2.2%
97164	$78	$77	$73	1.8%
97162	$119	$114	$125	1.8%
90837	$187	$199	$171	1.6%
97161	$116	$119	$120	1.4%

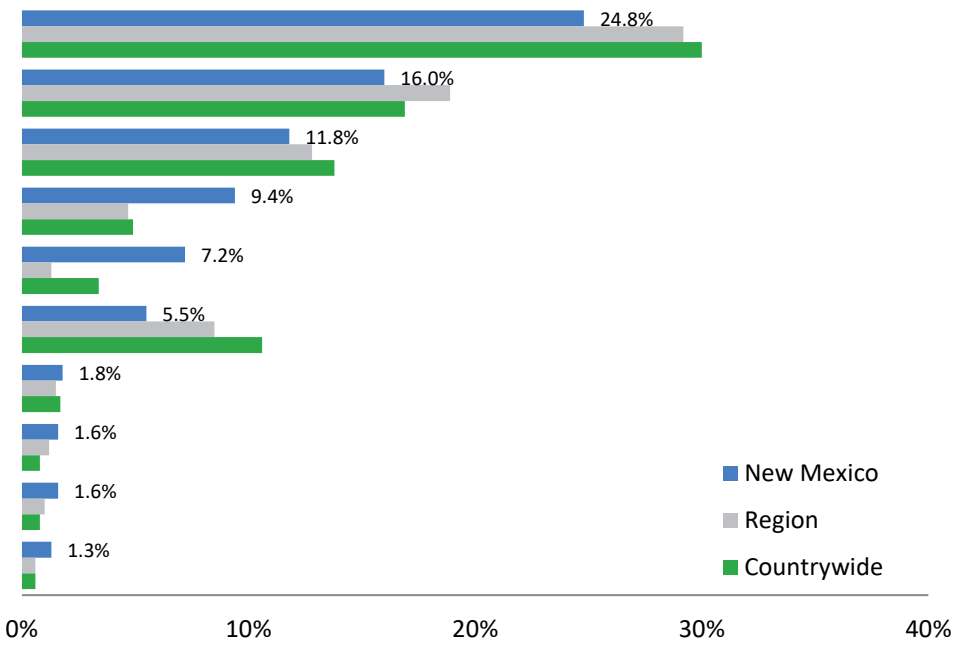


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97750	Physical performance test or measurement (e.g., musculoskeletal functional capacity), with written report, each 15 minutes
97164	Re-evaluation of physical therapy and established plan of care; requires an examination with review of history and use of standardized tests and measures; revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome; 20 minutes face-to-face with patient and/or family
97162	Physical therapy evaluation of moderate complexity; typically, 30 minutes are spent with the patient and/or family
90837	Psychotherapy, 60 minutes with patient
97161	Physical therapy evaluation of low complexity; typically, 20 minutes are spent with the patient and/or family

Chart 16

Top 10 Physical and General Medicine Procedure Codes by Transaction Counts

Code	Average PPU NM	Region	CW
97110	$44	$43	$42
97140	$41	$40	$38
97530	$50	$55	$46
97014	$22	$20	$22
97010	$12	$12	$17
97112	$47	$47	$43
97035	$20	$19	$22
97164	$78	$77	$73
97535	$49	$53	$44
97032	$27	$21	$25

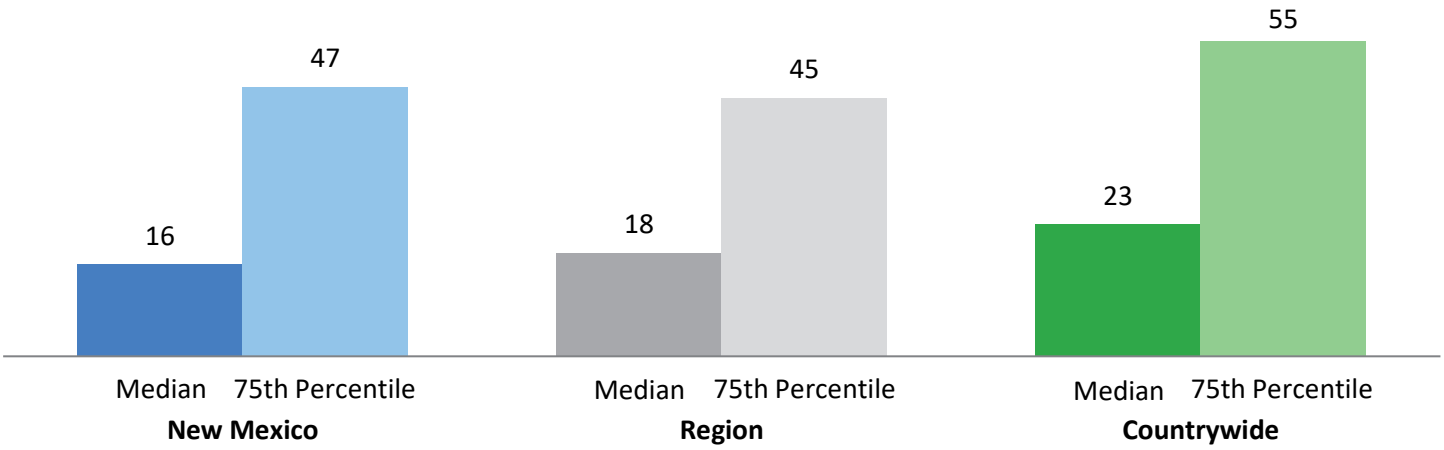


Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97010	Application of a modality to 1 or more areas; hot or cold packs
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
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97164	Re-evaluation of physical therapy and established plan of care; requires an examination with review of history and use of standardized tests and measures; revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome; 20 minutes face-to-face with patient and/or family
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes

Chart 17 shows the median and 75th percentile time until first treatment for physical and general medicine procedures for New Mexico, the region, and countrywide.

Chart 17

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



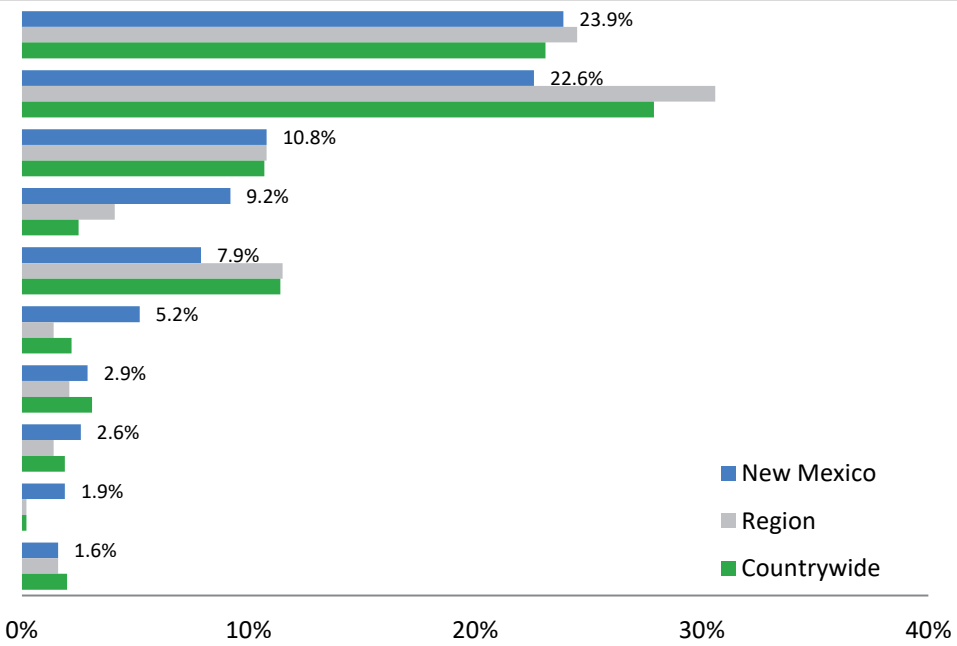
Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

In New Mexico, physician payments for evaluation and management services provided in 2020 are, on average, 151% of Medicare-scheduled reimbursement amounts, compared to 155% in the region and 144% countrywide. Payments for these services comprise 28% of physician payments, compared to 28% in the region and 22% countrywide.

Chart 18

Top 10 Evaluation and Management Procedure Codes by Amount Paid

Code	Average PPT NM	Region	CW
99214	$158	$163	$148
99213	$105	$116	$104
99204	$244	$248	$227
99456	$1,608	$1,513	$1,083
99203	$155	$169	$152
99455	$1,173	$369	$199
99284	$250	$235	$279
99215	$219	$223	$194
99358	$174	$202	$175
99283	$171	$141	$179

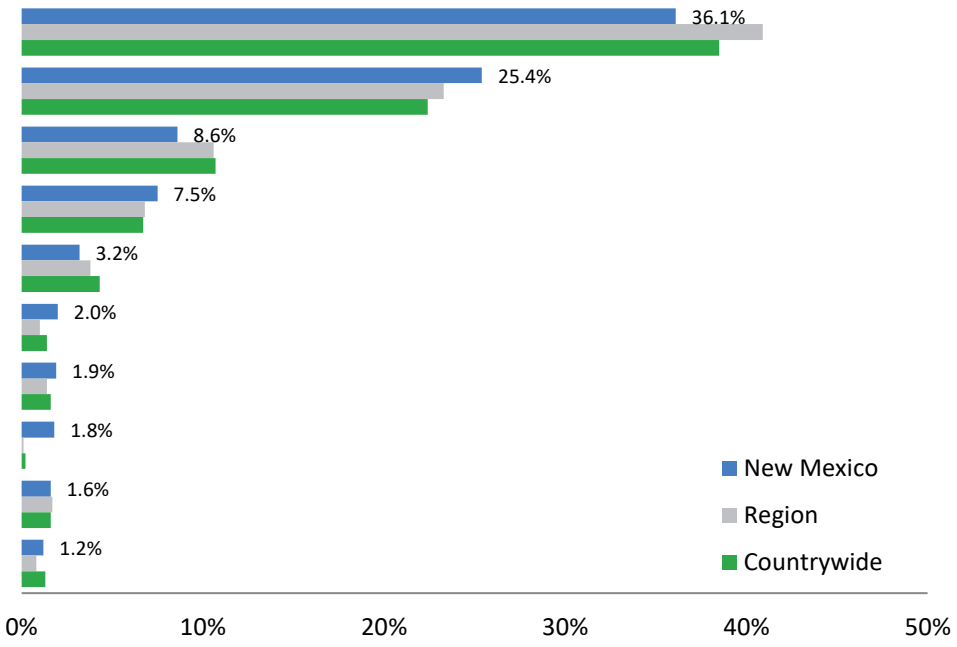


Code	Description
99214	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient 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.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99456	Work related or medical disability examination by other than the treating physician.
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.
99455	Work related or medical disability examination by the treating physician.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99215	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 40 minutes face-to-face with the patient and/or family.
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.

Chart 19

Top 10 Evaluation and Management Procedure Codes by Transaction Counts

Code	Average PPT NM	Region	CW
99213	$105	$116	$104
99214	$158	$163	$148
99203	$155	$169	$152
99204	$244	$248	$227
99212	$61	$70	$67
99215	$219	$223	$194
99284	$250	$235	$279
99358	$174	$202	$175
99283	$171	$141	$179
99232	$114	$121	$104

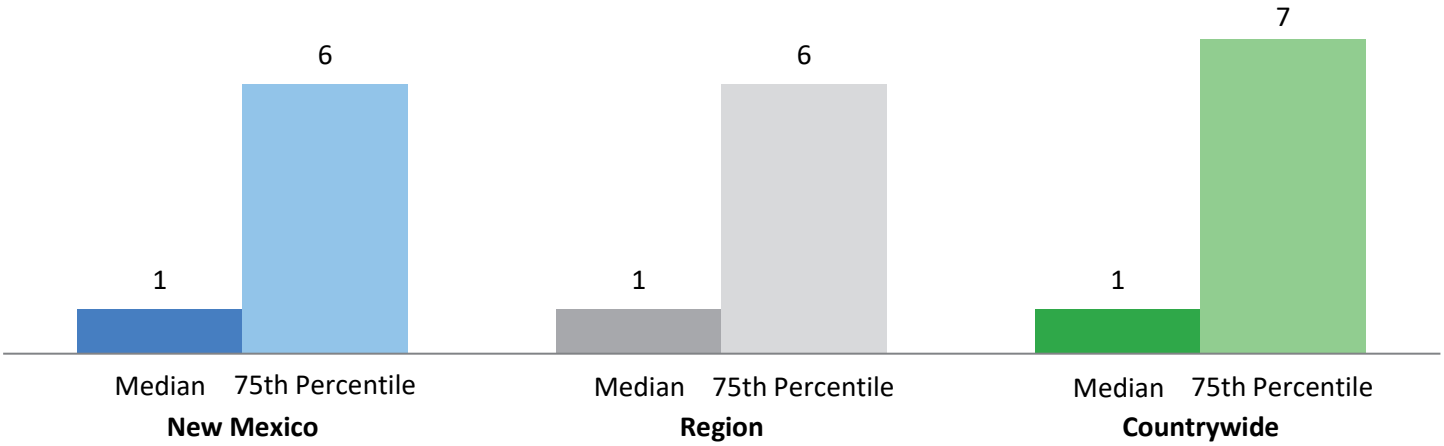


Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit 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.
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.
99204	Office or other outpatient visit for the evaluation and management of a new patient. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99215	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 40 minutes face-to-face with the patient and/or family.
99284	Emergency department visit. Usually the presenting problem(s) are of high severity and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99283	Emergency department visit. Usually the presenting problem(s) are of moderate severity.
99232	Subsequent hospital care per day for the evaluation and management of a patient. Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

Chart 20 shows the median and 75th percentile time until first treatment for evaluation and management procedures for New Mexico, the region, and countrywide.

Chart 20

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

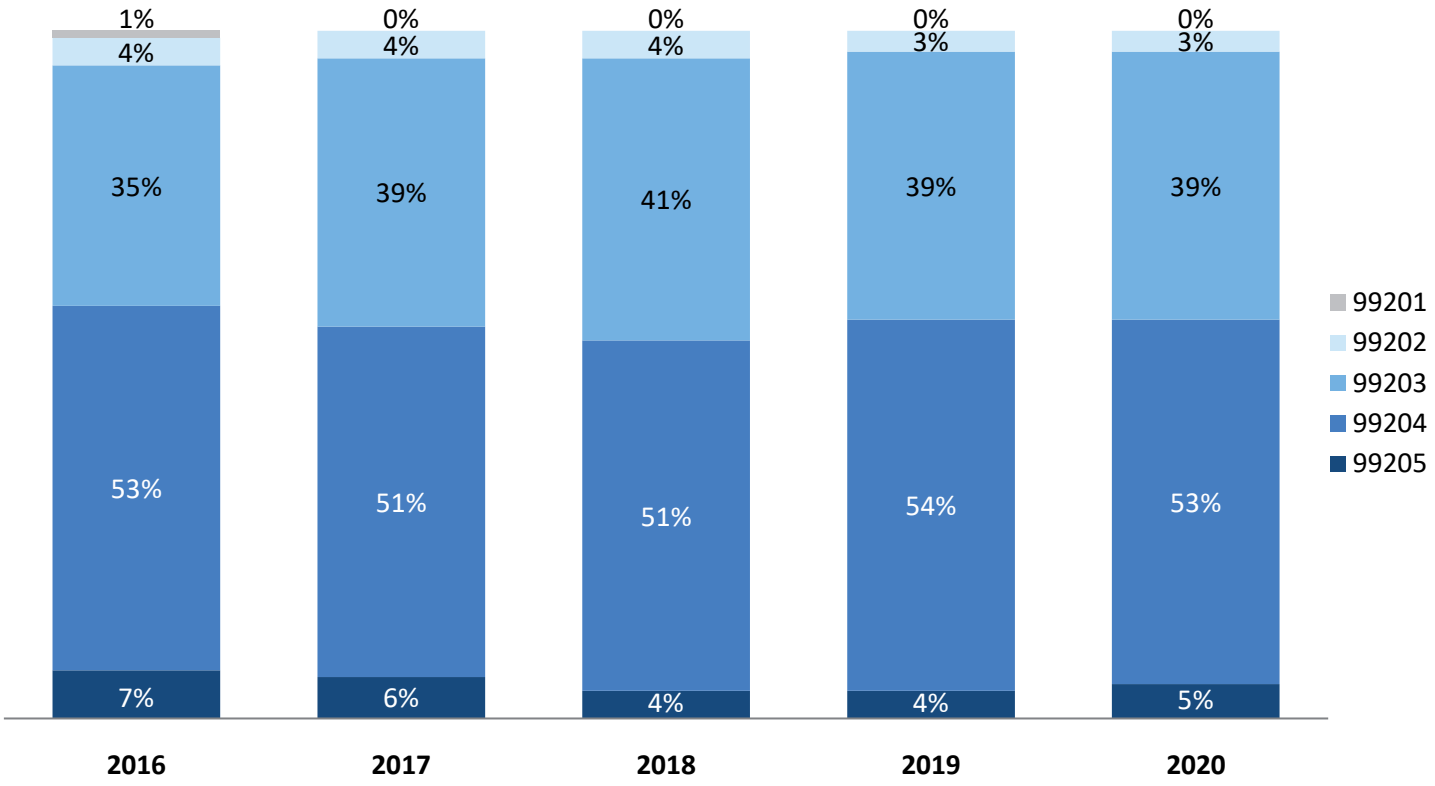
Evaluation and Management services consist largely of office or outpatient visits for a new patient or an established patient.

There are five periods of time spent with a *new* patient, ranging from 10 minutes for Procedure Code 99201 to 60 minutes for Procedure Code 99205. Chart 21 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for new patients.

Chart 21

Office or Other Outpatient Visit for the Evaluation and Management of a New Patient

Distribution of Payments by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2016 to 2020.

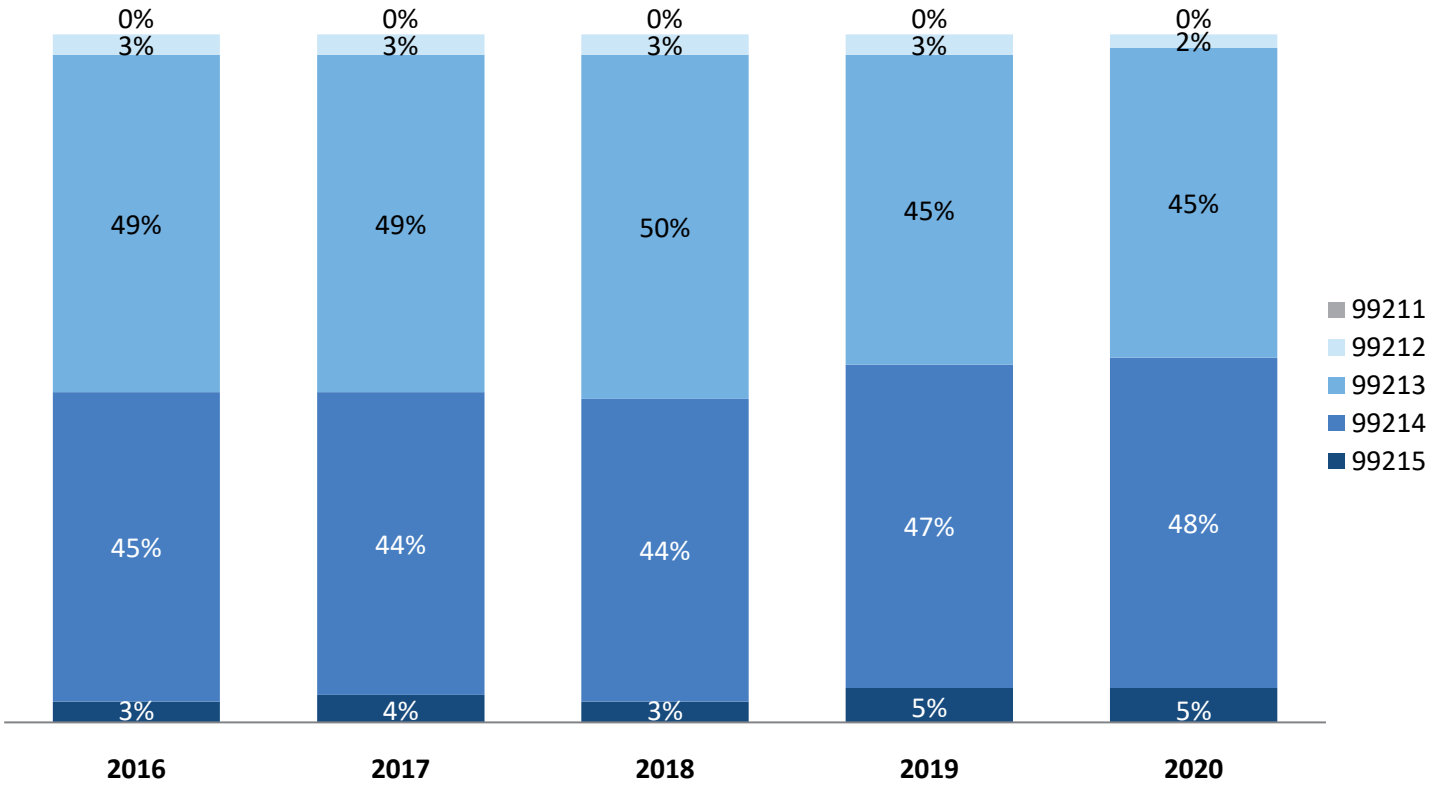
Code	Severity/Time	Average PPT				
		2016	2017	2018	2019	2020
99201	Low to Moderate; 10 minutes with patient	$145	$59	$61	$62	$60
99202	Low to Moderate; 20 minutes with patient	$92	$97	$99	$101	$105
99203	Moderate; 30 minutes with patient	$138	$147	$148	$151	$155
99204	Moderate to High; 45 minutes with patient	$215	$229	$231	$235	$244
99205	Moderate to High; 60 minutes with patient	$271	$289	$292	$299	$307

Similarly, for established patients, there are five periods of time spent with the patient, ranging from 5 minutes for Procedure Code 99211 to 40 minutes for Procedure Code 99215. Chart 22 shows a five-year snapshot of experience for each procedure type and the average amount paid per transaction for an established patient.

Chart 22

Office or Other Outpatient Visit for the Evaluation and Management of an Established Patient

Distribution of Payments by Procedure Code



Source: NCCI's Medical Data Call, Service Years 2016 to 2020.

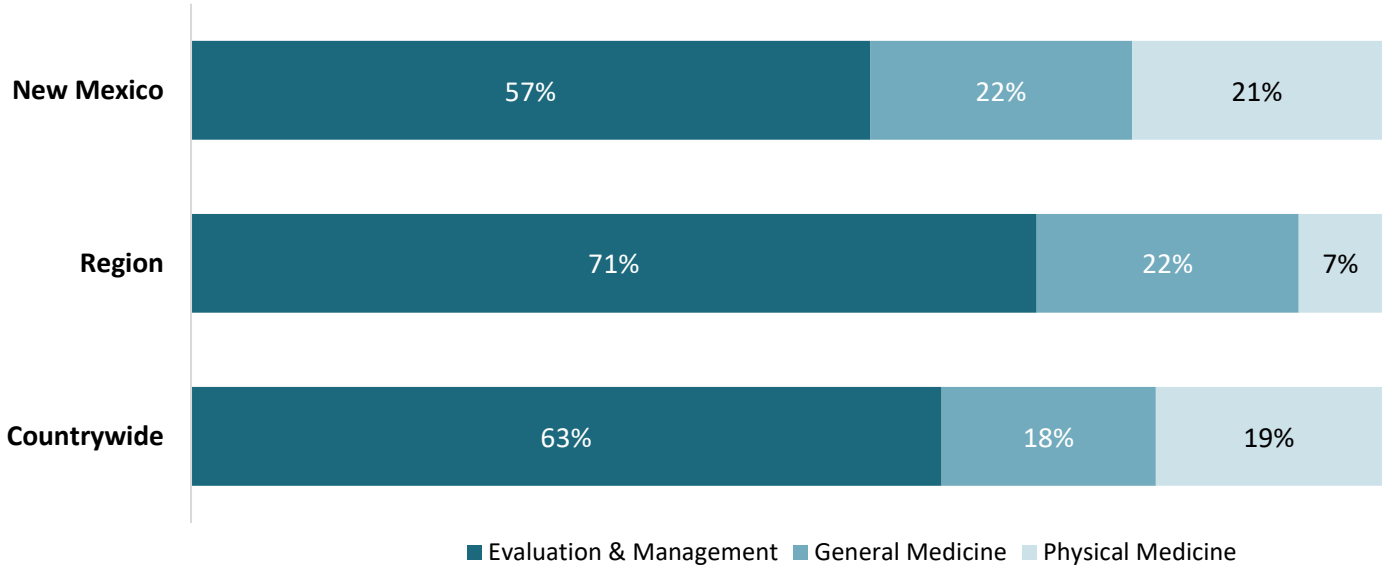
		Average PPT				
Code	**Severity/Time**	**2016**	**2017**	**2018**	**2019**	**2020**
99211	Low to Moderate; 5 minutes with patient	$28	$28	$31	$30	$34
99212	Low to Moderate; 10 minutes with patient	$55	$58	$60	$60	$61
99213	Moderate; 15 minutes with patient	$92	$98	$100	$102	$105
99214	Moderate to High; 25 minutes with patient	$140	$147	$150	$153	$158
99215	Moderate to High; 40 minutes with patient	$190	$196	$199	$206	$219

In Service Year 2020, telemedicine services were utilized more than in prior years[8] and were generally observed in the evaluation and management, physical medicine, and general medicine physician service categories. Telemedicine services represent about 2% of the physician costs in these categories countrywide. The share of payments varies across jurisdictions, ranging from about 1% to about 5%.

In New Mexico, the share of claimants receiving physician services (evaluation and management, physical medicine, and general medicine) who had telemedicine encounters increased from 0.4% in 2019 to 15.5% in 2020. Chart 23 shows the distribution of telemedicine payments for these physician service categories in New Mexico, the region, and countrywide.

Chart 23

Distribution of Telemedicine Payments by Physician Service Category



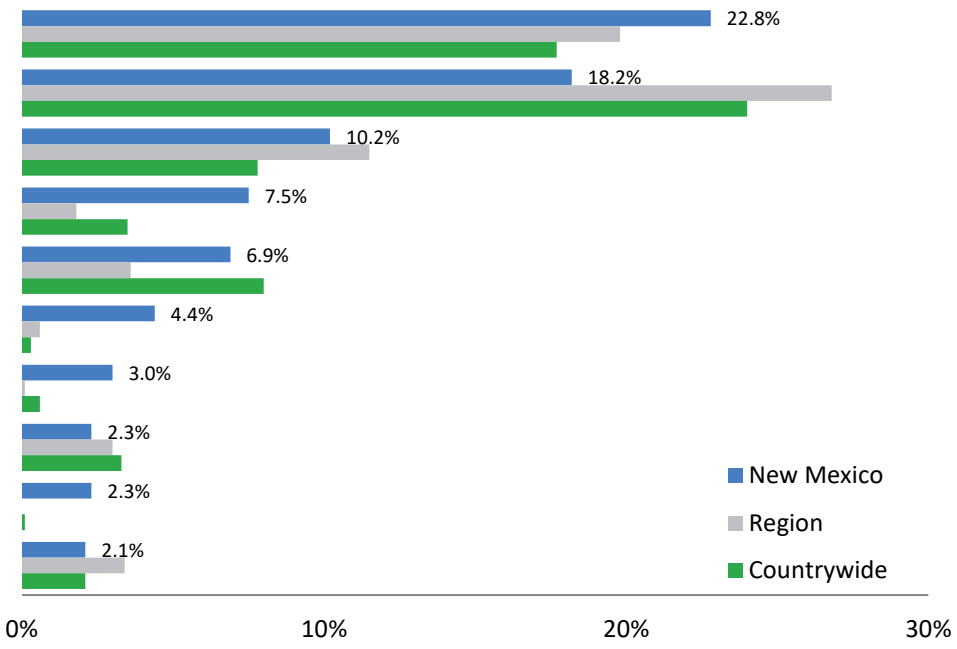
[8] www.ncci.com/Articles/Documents/Insights-COVID-19-Impact-Medical-Treatment-Workers-Comp-3QTR-2020-Perspective.pdf

Chart 24 shows the top 10 procedure codes reported as a telemedicine service by paid amount for New Mexico with comparative values for the region and countrywide.

Chart 24

Top 10 Procedure Codes by Amount Paid for Telemedicine Services

Code	Average PPU[9] NM	Region	CW
99214	$158	$155	$142
99213	$103	$114	$102
90837	$205	$219	$179
97530	$50	$59	$46
97110	$43	$46	$42
96152	$44	$49	$47
97535	$47	$49	$41
99203	$165	$167	$157
90838	$189	$174	$188
99443	$74	$118	$97



Code	Description
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.
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.
90837	Psychotherapy, 60 minutes with patient
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
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.
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
99443	Telephone evaluation and management service by a physician or other qualified health care professional; 21-30 minutes of medical discussion.

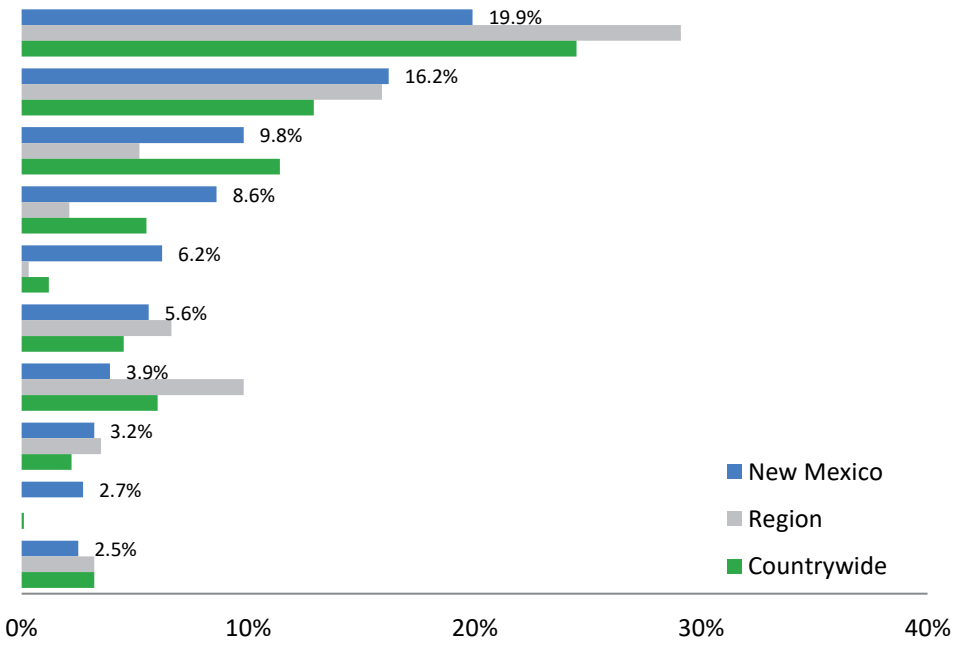
[9] Based on the number of units for the procedure code (typically in increments of time) but can also be one transaction.

Chart 25 shows the top 10 procedure codes reported as a telemedicine service by transaction count for New Mexico with comparative values for the region and countrywide.

Chart 25

Top 10 Procedure Codes by Transaction Counts for Telemedicine Services

Code	Average PPU NM	Region	CW
99213	$103	$114	$102
99214	$158	$155	$142
97110	$43	$46	$42
97530	$50	$59	$46
97535	$47	$49	$41
90837	$205	$219	$179
99442	$47	$77	$63
99443	$74	$118	$97
99490	$74	$69	$73
99212	$66	$67	$66



Code	Description
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.
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.
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training, direct one-on-one contact, each 15 minutes
90837	Psychotherapy, 60 minutes with patient
99442	Telephone evaluation and management service by a physician or other qualified health care professional; 11-20 minutes of medical discussion.
99443	Telephone evaluation and management service by a physician or other qualified health care professional; 21-30 minutes of medical discussion.
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
99212	Office or other outpatient visit for the evaluation and management of an established patient. Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

Hospital Inpatient

Payments attributed to facilities represent hospital inpatient services, hospital outpatient services, and ambulatory surgical center services. General healthcare trends may be the primary driver of the cost distribution; however, the fee schedule may also play a role. In many states, the fee schedule varies by type of facility, which may help explain differences observed between states.

Hospital inpatient fee schedules in workers compensation vary across jurisdictions. Some states have fee schedules based on a group of facility services related to the hospital admission, such as a diagnosis-related group (DRG); others are on a per-diem basis, with some variation on the per-diem amount by type of admission. Other states have provisions for the reimbursement to be a certain percentage of hospital charges. Several states remain without any regulation today.

A hospital inpatient stay is typically reported with one of two types of codes: DRG code or revenue code. Data reporters are instructed to report the code that is consistent with how the reimbursement was determined.

If the hospital inpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by DRG codes would be expected. DRG codes are a system of hospital payment classifications that group patients with similar clinical problems who are expected to require similar amounts of hospital resources. DRG codes provide detailed information about the type of services performed during the inpatient stay. In New Mexico, 17% of hospital inpatient payments are reported with a DRG code.

Due to differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide, comparisons by procedure code for inpatient costs should be interpreted with caution. Some measures for hospital inpatient services include the average cost of an inpatient stay, the average length of stay, or the average cost per day.

Unless otherwise stated, the inpatient results are based on inpatient stays with a discharge date in 2020.

A measure of workers compensation hospital inpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital inpatient payments for New Mexico, the region, and countrywide, based on hospital episodes that are reported with a DRG code.

Chart 26

Hospital Inpatient Payments as a Percentage of Medicare

Medical Cost Category	New Mexico	Region	Countrywide
Hospital Inpatient	115%	173%	194%

Source: NCCI's Medical Data Call for inpatient stays discharged in Calendar Year 2020. Region includes AK, AZ, CO, HI, ID, MT, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

The distribution of medical payments for hospital inpatient is 10% for New Mexico, 12% for the region, and 13% for countrywide. One comparative measure of inpatient service costs is the average payment per inpatient stay. An inpatient stay is defined as any hospital service or set of services provided to a claimant during the period of time when the claimant is in an inpatient setting, for a specific diagnosis. Any stay may have more than one procedure performed, and any claimant may have more than one stay.

Chart 27 displays the average amount paid per stay for hospital inpatient services, while Chart 28 displays the average amount paid per day for hospital inpatient services for New Mexico, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 27

Average Amount Paid per Stay for Hospital Inpatient Services

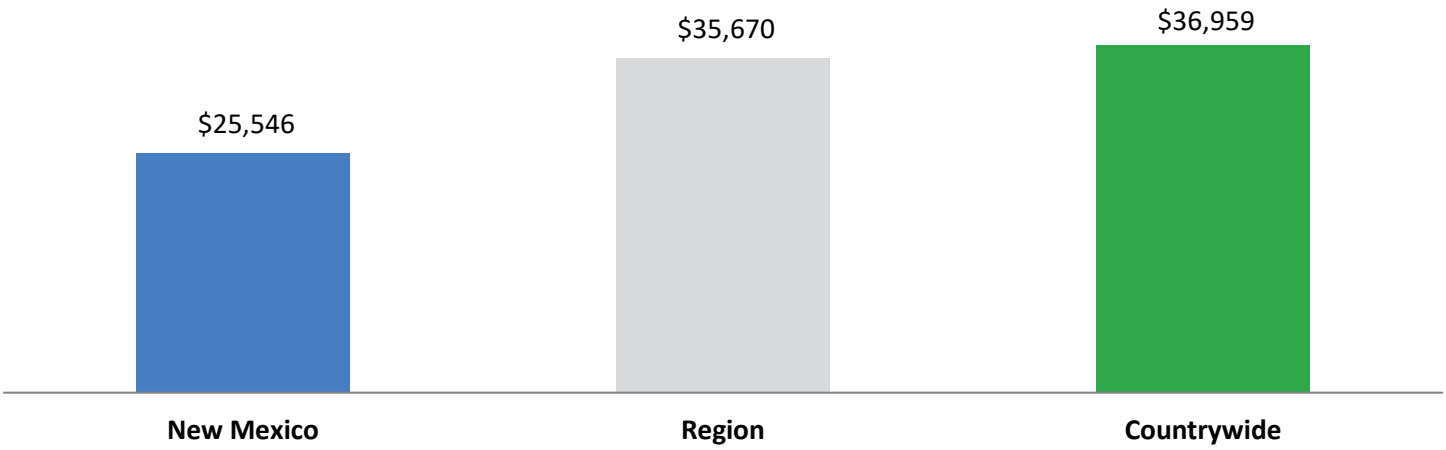


Chart 28

Average Amount Paid per Day for Hospital Inpatient Services

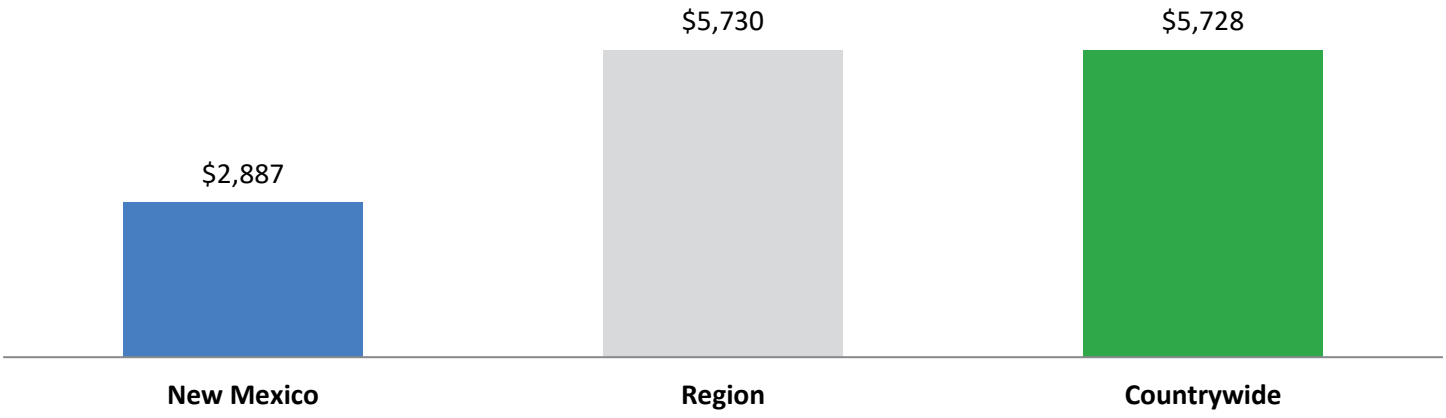


Chart 29 displays the average number of hospital inpatient stays per 1,000 active claims in 2020 for New Mexico, the region, and countrywide. An active claim is a workers compensation claim for which there is at least one medical service provided during that service year. Chart 30 displays the average and median length of stay for hospital inpatient services for New Mexico, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 29

Average Number of Inpatient Stays per 1,000 Active Claims

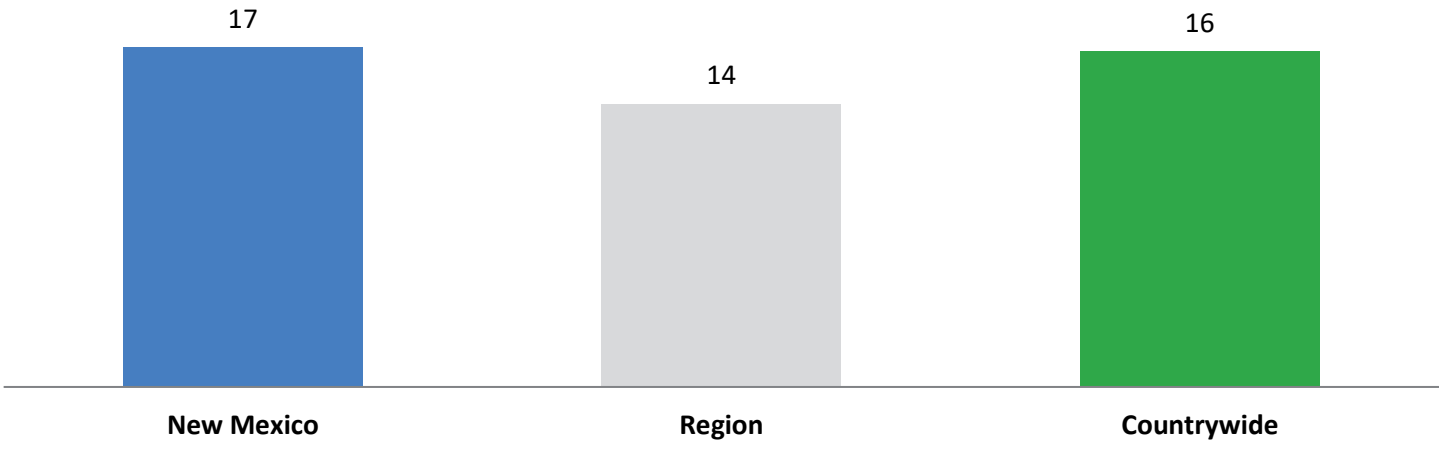


Chart 30

Length of Stay for Hospital Inpatient Services (in Days)

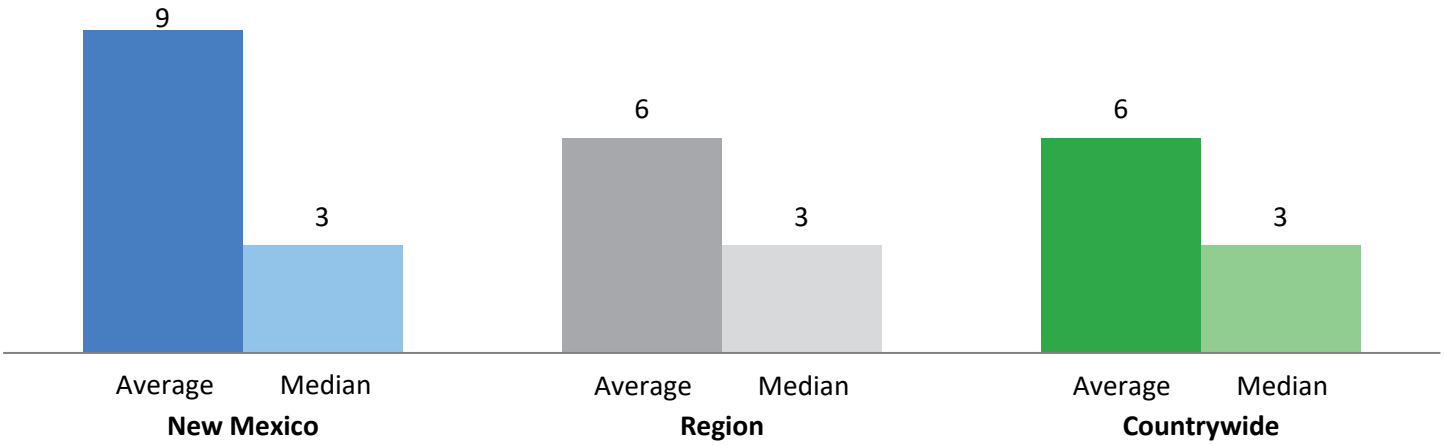
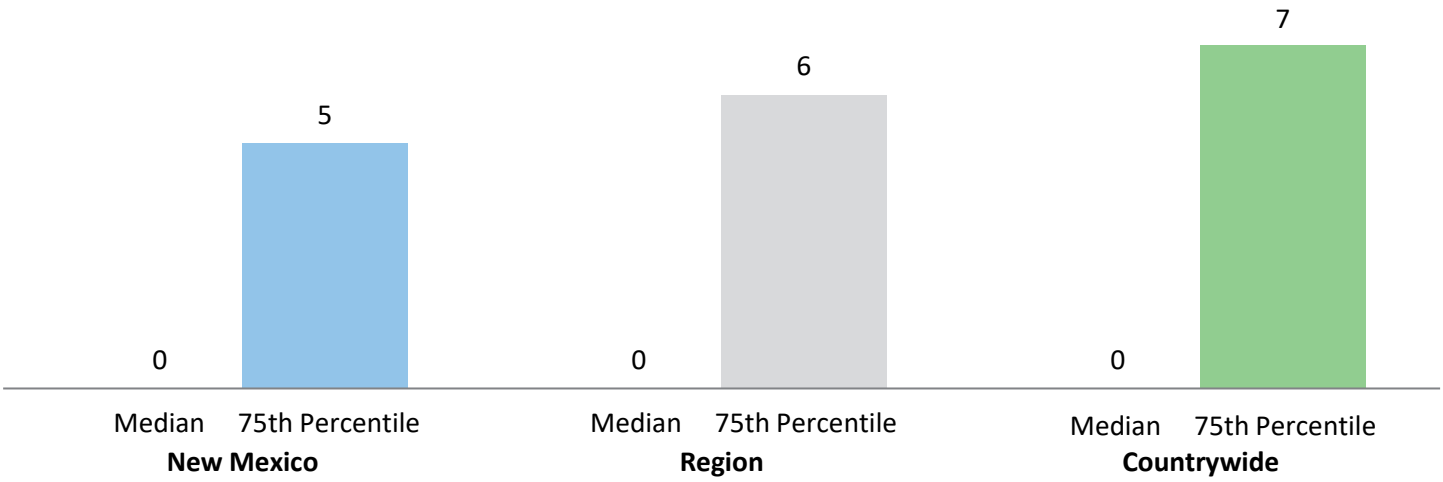


Chart 31 shows the median and 75th percentile time until first treatment for inpatient stays, other than emergency room visits, for New Mexico, the region, and countrywide.

Chart 31

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Charts 32 and 33 display the top 10 diagnosis groups and top 10 DRG codes for hospital inpatient stays. A diagnosis group is identified for each stay based on an ICD-10 (International Classification of Diseases) code. The diagnosis groups and DRG codes are ranked based on total payments for hospital inpatient services in New Mexico. A brief description of each DRG code is displayed in the table below chart 33. The information is based on inpatient stays with a discharge date in 2019 or 2020.

Chart 32

Top 10 Diagnosis Groups by Amount Paid for Hospital Inpatient Services

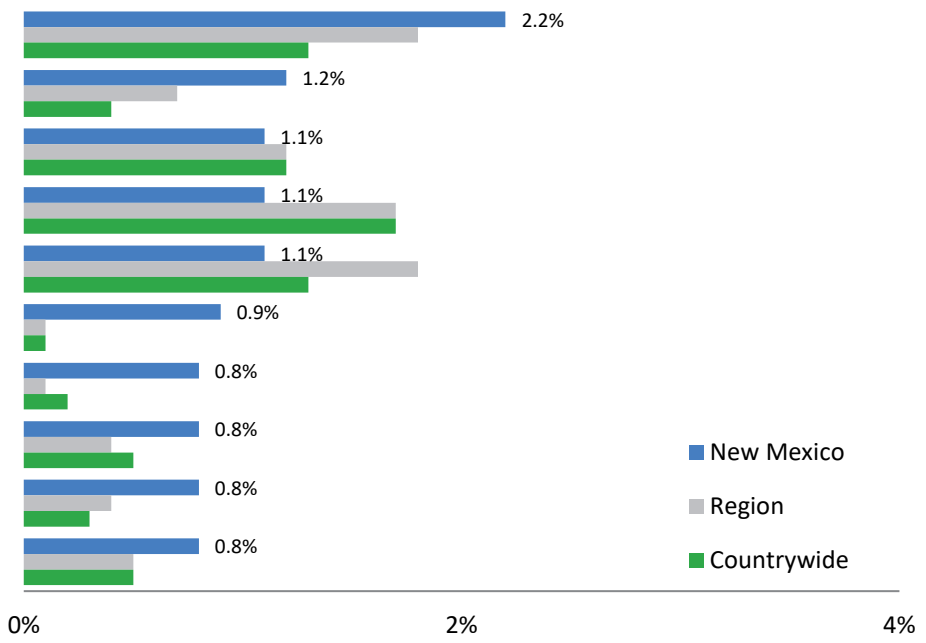
		Median Amount Paid per Stay		
Diagnosis Group	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Sepsis	6.1%	$14,279	$21,192	$21,322
Lumbar spine degeneration	5.9%	$32,476	$40,394	$37,580
Complication from surgical device	4.6%	$22,259	$27,170	$24,149
Burn and corrosion, third degree, other than head, face, and neck	4.6%	$35,257	$56,225	$44,946
Traumatic brain injury	4.3%	$17,018	$24,695	$24,706
Tibia/fibula fracture	3.6%	$16,468	$22,587	$23,339
Hip/pelvis fracture/major trauma	3.5%	$14,467	$21,523	$21,518
Concussion/minor traumatic brain injury	3.4%	$63,878	$18,579	$15,076
Lumbosacral intervertebral disc disorders	2.9%	$22,197	$32,983	$30,566
Thoracic vertebral fracture	2.9%	$10,144	$29,565	$23,049

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in Calendar Year 2019 or 2020.

Chart 33

Top 10 DRG Codes by Amount Paid for Hospital Inpatient Services

Code	Median Paid per Stay NM	Region	CW
454	$49,267	$60,703	$58,357
871	$21,323	$21,529	$21,282
958	$84,091	$53,851	$60,923
470	$21,765	$20,296	$21,894
483	$24,112	$25,643	$24,904
918	$34,355	$8,251	$8,117
488	$61,229	$24,694	$26,201
560	$22,316	$18,376	$15,537
467	$44,668	$39,768	$36,544
464	$115,038	$39,482	$39,120



Code	Description
454	Combined anterior/posterior spinal fusion with complications or comorbidities
871	Septicemia or severe sepsis without mechanical ventilation >96 hours with major complications or comorbidities
958	Other operation room procedures for multiple significant trauma with complications or comorbidities
470	Major joint replacement or reattachment of lower extremity without major complications or comorbidities
483	Major joint/limb reattachment procedure of upper extremities
918	Poisoning and Toxic Effects of Drugs without MCC
488	Knee Procedures without Principal Diagnosis of Infection with CC/MCC
560	Aftercare, musculoskeletal system and connective tissue with complications or comorbidities
467	Revision of hip or knee replacement with complications or comorbidities
464	Wound debridement and skin graft except hand for musculoskeletal system and connective tissue disorders with complications or comorbidities

Source: NCCI's Medical Data Call for inpatient stays with a discharge date in 2019 or 2020. Region includes AK, AZ, CO, HI, ID, MT, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, NC, NE, NH, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.
Note: In New Mexico, 17% of hospital inpatient payments are reported with a DRG code.

Hospital Outpatient

Hospital outpatient services are reported with several types of procedure codes. Data reporters are instructed to report the code that is consistent with the way the reimbursement was determined.

If the hospital outpatient fee schedule is a Medicare-based fee schedule, then a greater share of payments reported by current procedure terminology (CPT) or other healthcare common procedure coding system (HCPCS) codes would be expected. These codes are very specific and provide detailed information about the actual services performed. Some payments are also reported by a specific ambulatory payment classification (APC) code. An APC code represents a group of services provided by the facility on an outpatient basis.

If the hospital outpatient fee schedule is based on a discount from charged amounts, then revenue codes may be the more prevalent code type. Revenue codes are very generic and do not provide much information about the specific services that were performed.

Due to these differences in fee schedules, which may result in varied reporting of codes across jurisdictions, the region, and countrywide, comparisons by procedure code for outpatient benefits should be interpreted with caution. One comparative measure of outpatient service costs is the average cost per outpatient visit. A visit is defined as any service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claim may have more than one visit.

Hospital outpatient visits can vary in nature. A service is classified as "surgical" if it falls within the surgical category as defined by the AMA. A service is further classified as "major surgery" if it has a global follow-up period of 90 days as defined by the Centers for Medicare & Medicaid Services and is not an injection. In this section, we provide measures of hospital outpatient payments that account for the type of visit because the level of reimbursement varies considerably by type of visit. A hospital outpatient visit could be the result of an emergency visit. Outpatient visits arising from emergency room services are shown separately. Next, nonemergency outpatient visits are shown for visits with major surgery services and for visits without major surgery services.

The distribution of medical payments for hospital outpatient is 14% for New Mexico, 18% for the region, and 19% for countrywide.

One measure of workers compensation hospital outpatient costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for hospital outpatient payments for New Mexico, the region, and countrywide. In New Mexico, 74% of hospital outpatient payments are included in the chart below.

Chart 34

Hospital Outpatient Payments as a Percentage of Medicare

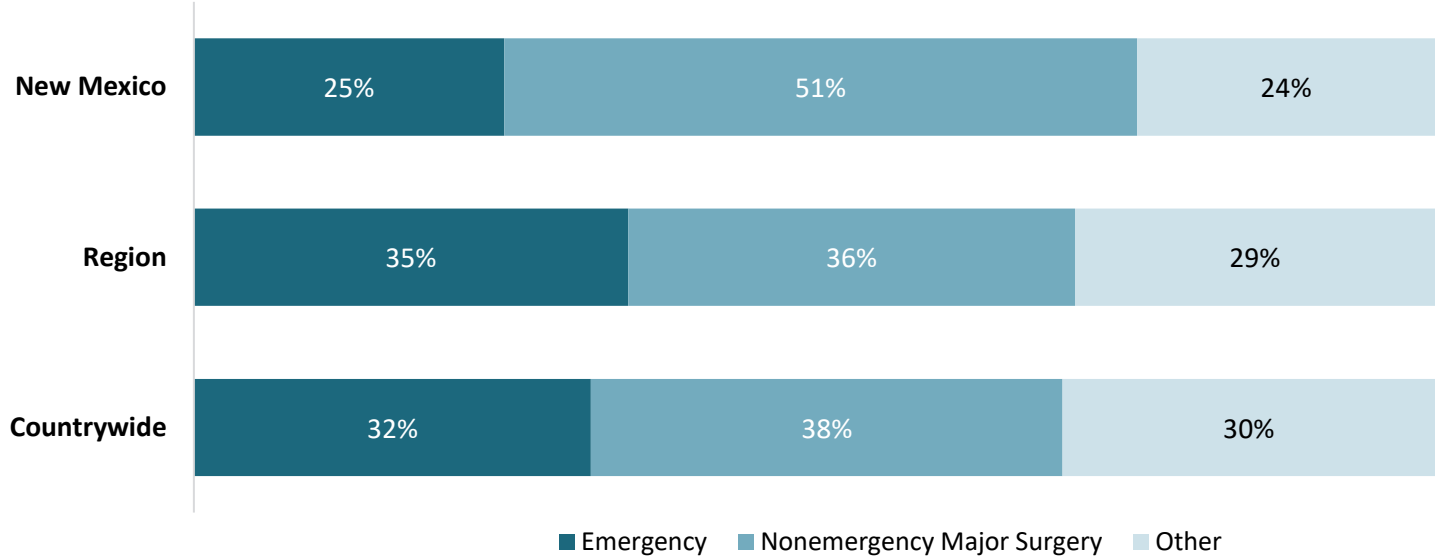
Medical Cost Category	New Mexico	Region	Countrywide
Hospital Outpatient	173%	200%	242%

Source: NCCI's Medical Data Call for Service Year 2020. Region includes AK, AZ, CO, HI, ID, MT, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

Chart 35 displays the distribution of hospital outpatient payments by visit type for New Mexico, the region, and countrywide.

Chart 35

Distribution of Payments for Outpatient Services by Hospital Outpatient Visit Type



Emergency hospital outpatient visits represent 25% of hospital outpatient payments in New Mexico. Chart 36 displays the average amount paid per emergency visit for outpatient services, while Chart 37 displays the average number of emergency hospital outpatient visits per 1,000 active claims for New Mexico, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 36

Average Amount Paid for Hospital Outpatient Services per Emergency Visit

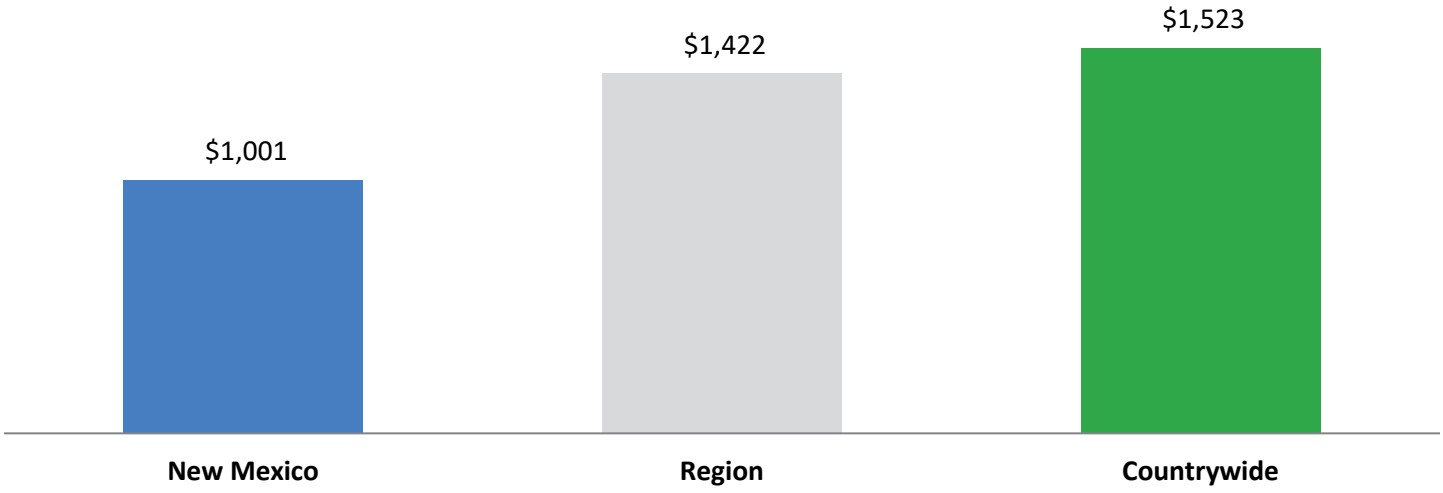


Chart 37

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

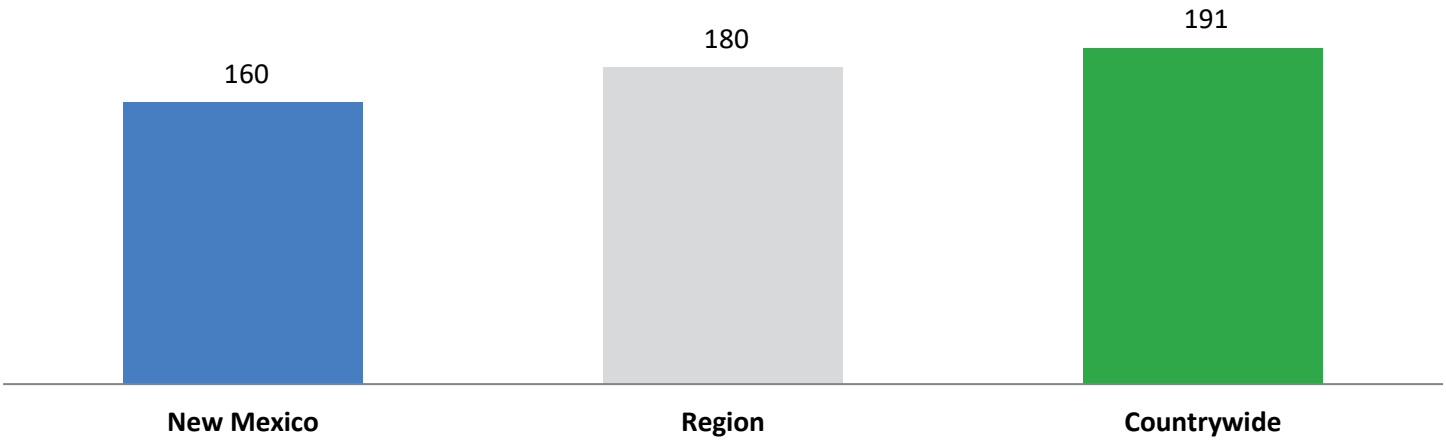


Chart 38 displays the top 10 diagnosis groups for emergency outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in New Mexico.

Chart 38

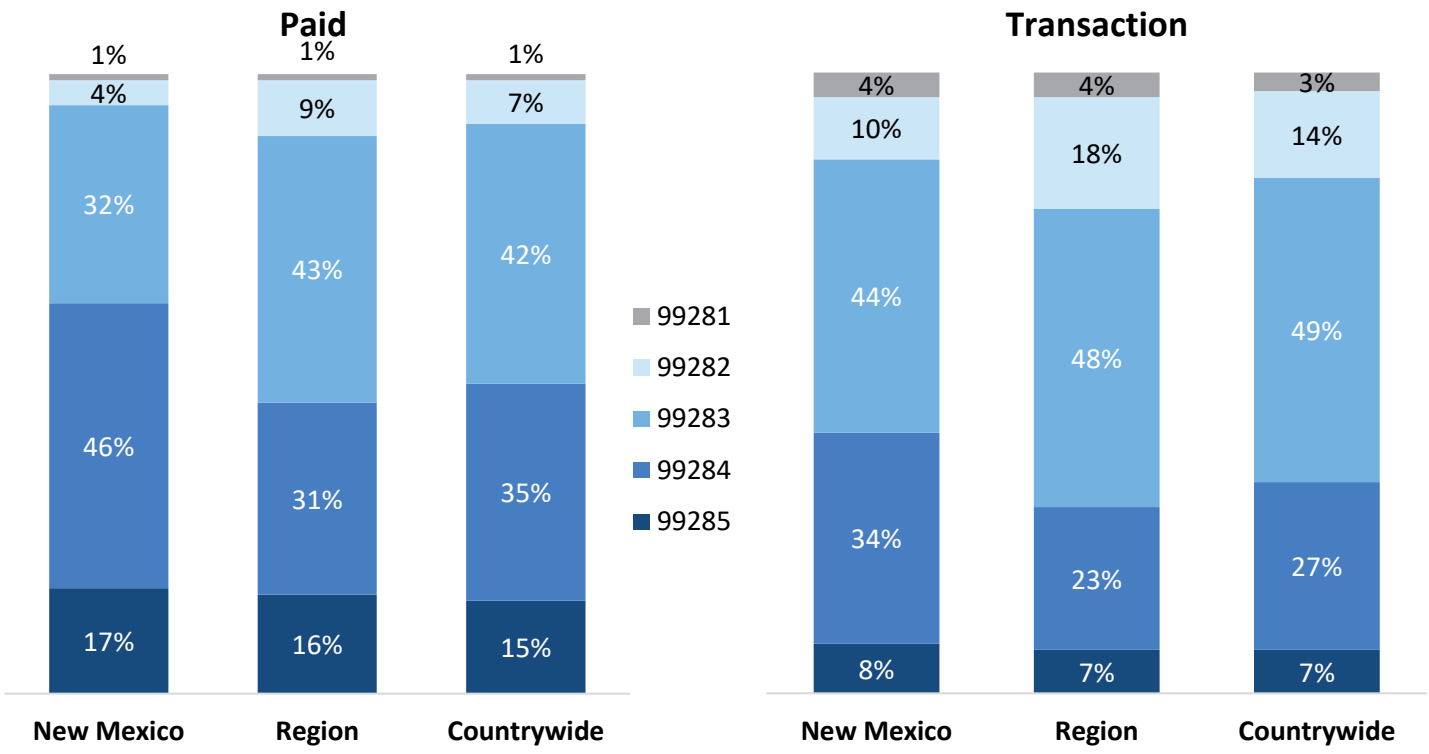
Top 10 Diagnosis Groups by Amount Paid for Emergency Hospital Outpatient Visits

		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Minor hand/wrist injuries	11.1%	$547	$650	$710
Hand/wrist fracture	7.1%	$873	$1,117	$1,139
Low back pain	4.3%	$577	$740	$794
Head/face wound	3.6%	$739	$904	$929
Head injury not otherwise classified	3.4%	$947	$975	$1,151
Concussion/minor traumatic brain injury	3.3%	$977	$1,030	$1,206
Upper back pain	2.9%	$610	$831	$895
Head injury minor	2.7%	$966	$957	$1,028
Neck pain	2.4%	$827	$1,097	$1,218
Traumatic amputation, hand/wrist	2.4%	$1,023	$1,740	$1,653

For emergency room visits, there are five levels of severity, ranging from limited or minor problems reported with Procedure Code 99281 to life-threatening situations reported with Procedure Code 99285. About 70% of all emergency visits had outpatient services. Chart 39 shows the distribution of emergency room outpatient services by procedure code for both paid amount and transactions for Service Year 2020 as well as the average payment per transaction.

Chart 39

Distribution of Emergency Room Outpatient Services by Procedure Code



Emergency Room Outpatient Paid per Transaction by Procedure Code

		Average PPT		
Code	Severity	New Mexico	Region	Countrywide
99281	Minor	$130	$175	$190
99282	Low to Moderate	$173	$289	$288
99283	Moderate	$307	$506	$491
99284	High	$525	$782	$739
99285	High and immediately life-threatening	$822	$1,269	$1,153

Nonemergency outpatient visits with major surgery services represent 51% of hospital outpatient payments in New Mexico. Chart 40 displays the average amount paid per major surgery visit for outpatient services, while Chart 41 displays the average number of major surgery hospital outpatient visits per 1,000 active claims for New Mexico, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 40

Average Amount Paid for Hospital Outpatient Services per Nonemergency Major Surgery Visit

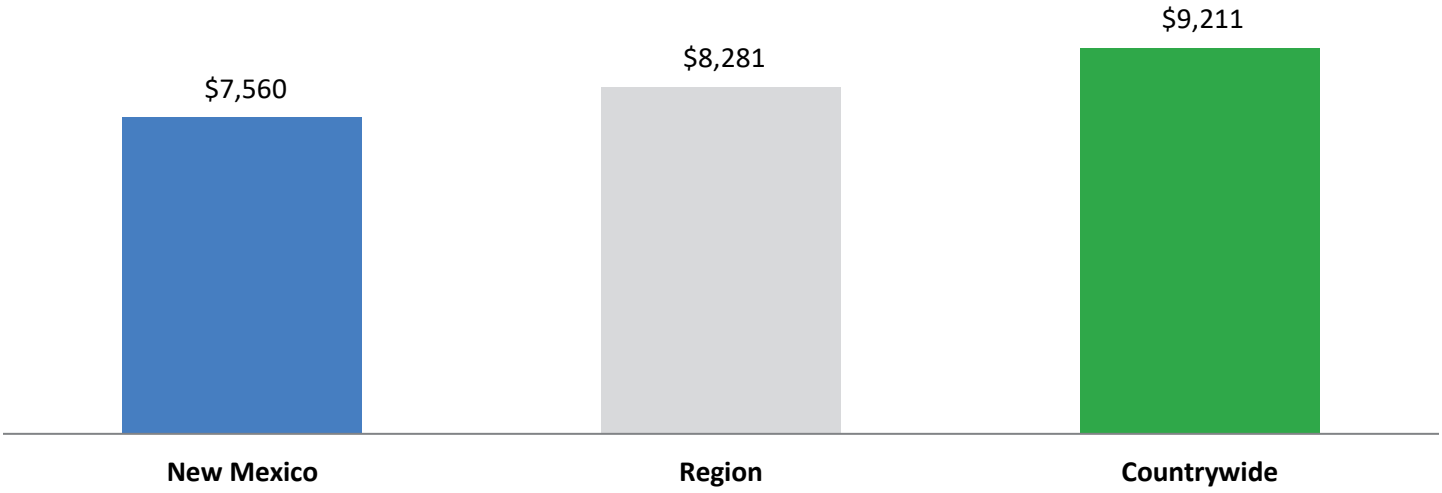


Chart 41

Average Number of Nonemergency Major Surgery Hospital Outpatient Visits per 1,000 Active Claims

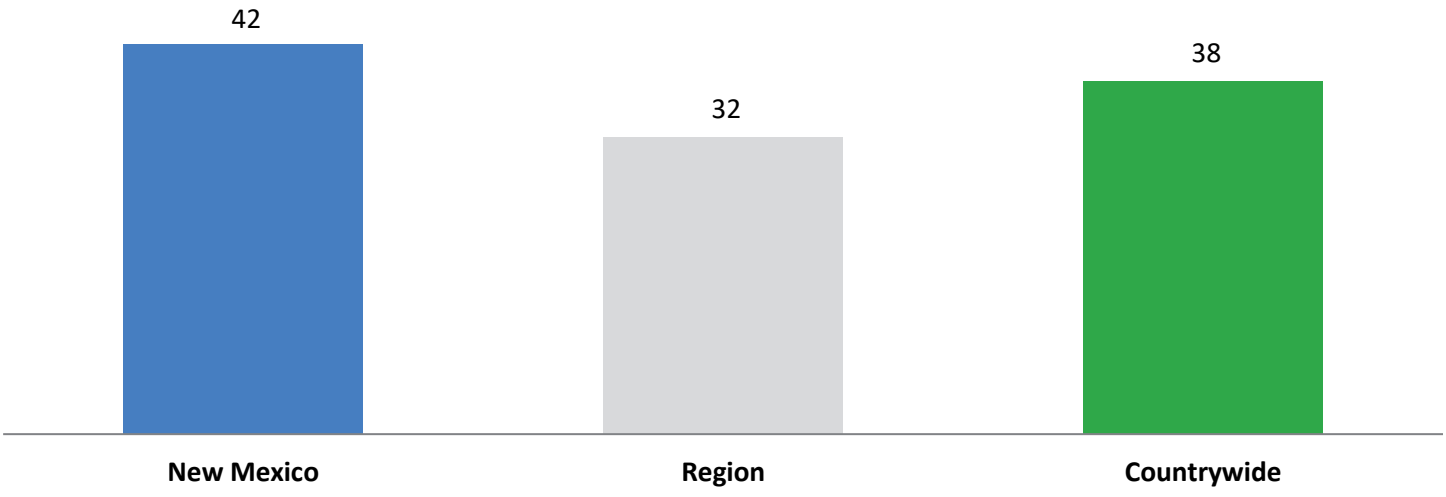
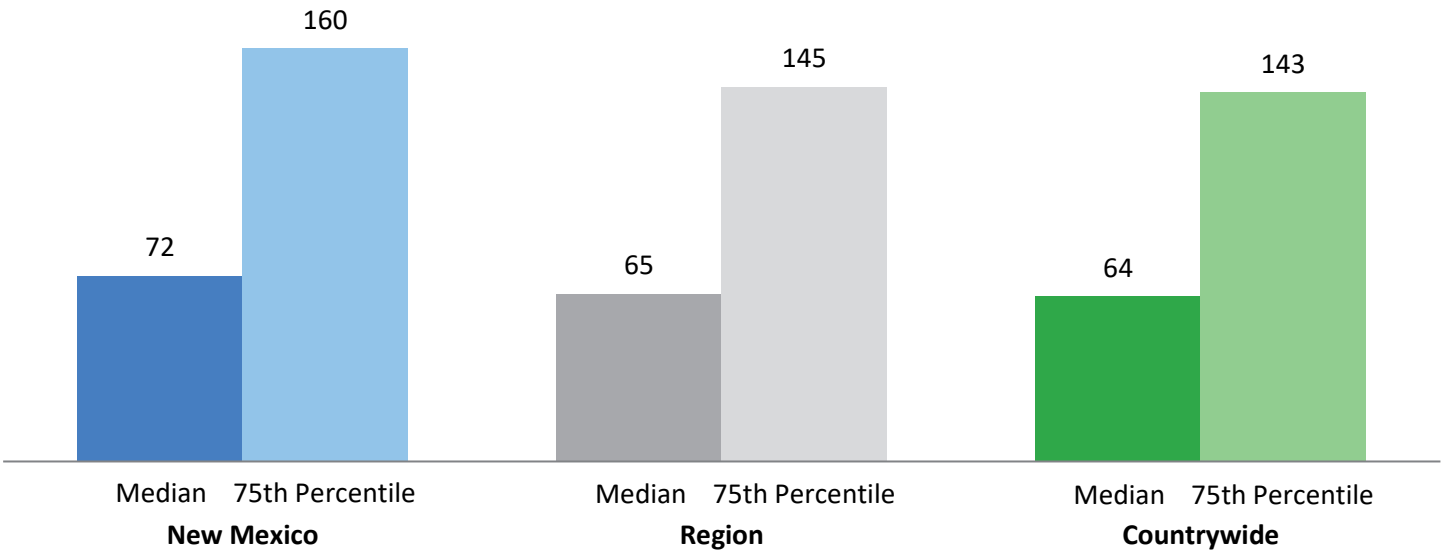


Chart 42 shows the median and 75th percentile time until first treatment for nonemergency major surgery outpatient visits for New Mexico, the region, and countrywide.

Chart 42

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Chart 43 displays the top 10 diagnosis groups for nonemergency major surgery outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in New Mexico.

Chart 43

Top 10 Diagnosis Groups by Amount Paid for Nonemergency Major Surgery Hospital Outpatient Visits

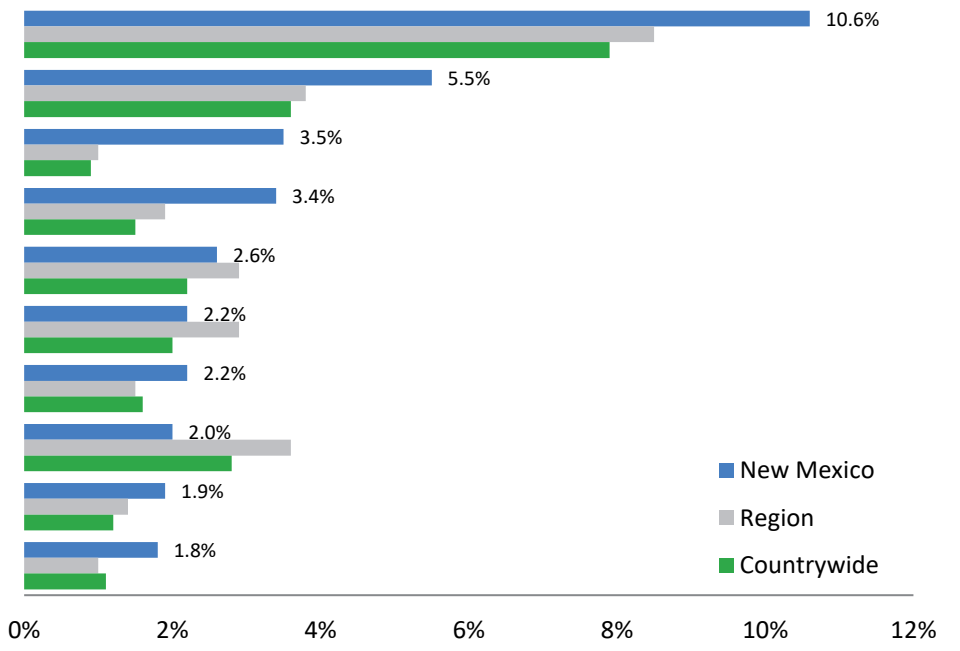
		Median Amount Paid Per Visit		
Diagnosis Group	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Rotator cuff tear	16.0%	$10,694	$9,673	$9,808
Knee internal derangement - meniscus injury	7.2%	$5,314	$4,682	$5,219
Inguinal hernia	5.4%	$6,899	$7,359	$7,809
Hand/wrist fracture	5.3%	$5,157	$5,650	$5,946
Minor shoulder injury	4.3%	$9,044	$7,962	$8,814
Knee internal derangement - cruciate ligament tear	4.2%	$11,142	$9,766	$10,360
Superior labral tear from anterior to posterior (SLAP) lesion	3.9%	$9,776	$8,996	$8,660
Shoulder impingement syndrome	3.0%	$10,976	$8,450	$7,877
Knee degenerative/overuse injuries	2.4%	$9,140	$9,139	$7,603
Minor hand/wrist injuries	2.4%	$6,715	$5,119	$5,381

Charts 44 displays the average amount paid per nonemergency major surgery visit for outpatient services in New Mexico, the region, and countrywide for the top 10 CPT codes in New Mexico. The codes are ranked based on total outpatient payments in New Mexico, where the code shown below is the code with the highest total paid on a nonemergency major surgery visit. In 2020, 85% of Hospital Outpatient costs were reported with a CPT code being the highest paid code. A brief description of each code is displayed in the table below.

Chart 44

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Nonemergency Major Surgery Visits

Code	Average Paid per Visit NM	Region	CW
29827	$12,132	$10,439	$12,107
29881	$6,917	$5,448	$6,726
23410	$11,937	$10,973	$11,926
29888	$11,504	$11,261	$12,255
20680	$5,138	$5,796	$6,816
23430	$20,895	$10,398	$12,519
24342	$9,560	$8,540	$10,551
49650	$8,540	$8,727	$10,322
49505	$7,443	$6,590	$7,415
63047	$12,062	$10,708	$12,842



Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
20680	Removal of implant; deep (e.g., buried wire, pin, screw, metal, band, nail, rod, or plate)
23430	Tenodesis of long tendon of biceps
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
49650	Laparoscopy, surgical; repair initial inguinal hernia
49505	Repair initial inguinal hernia, age 5 years or older; reducible
63047	Laminectomy, facetectomy, and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equine, and/or nerve root), single vertebral segment; lumbar

Nonemergency outpatient visits without a major surgery service, referred to as "Other" outpatient visits, represent 24% of hospital outpatient payments in New Mexico. Chart 45 displays the average amount paid per other visit for hospital outpatient services, while Chart 46 displays the average number of other visits per 1,000 active claims for hospital outpatient services for New Mexico, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 45

Average Amount Paid for Hospital Outpatient Services per Other Outpatient Visit

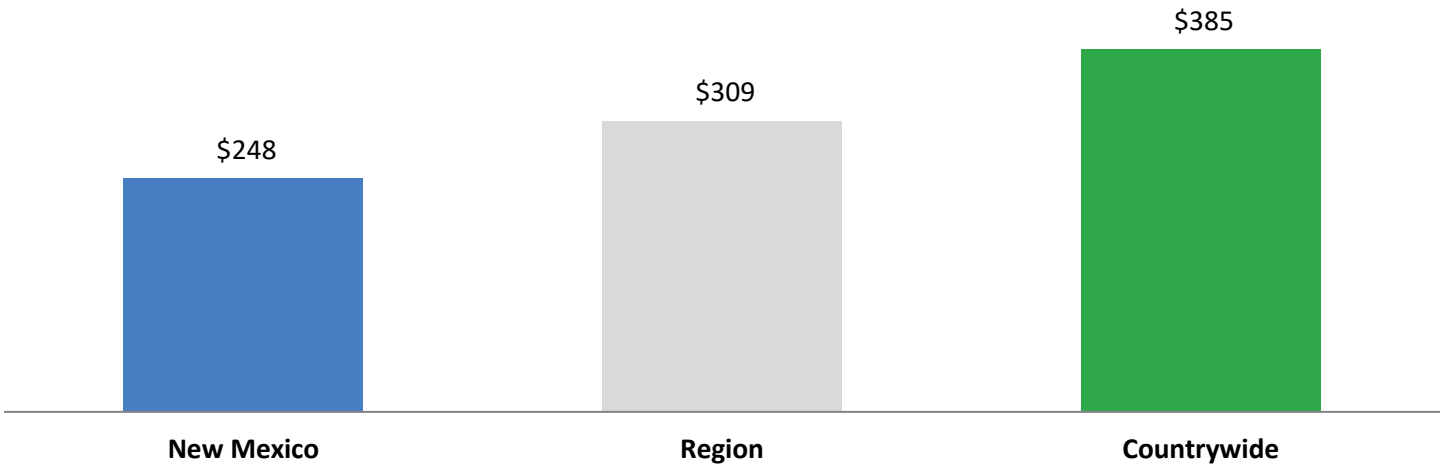


Chart 46

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

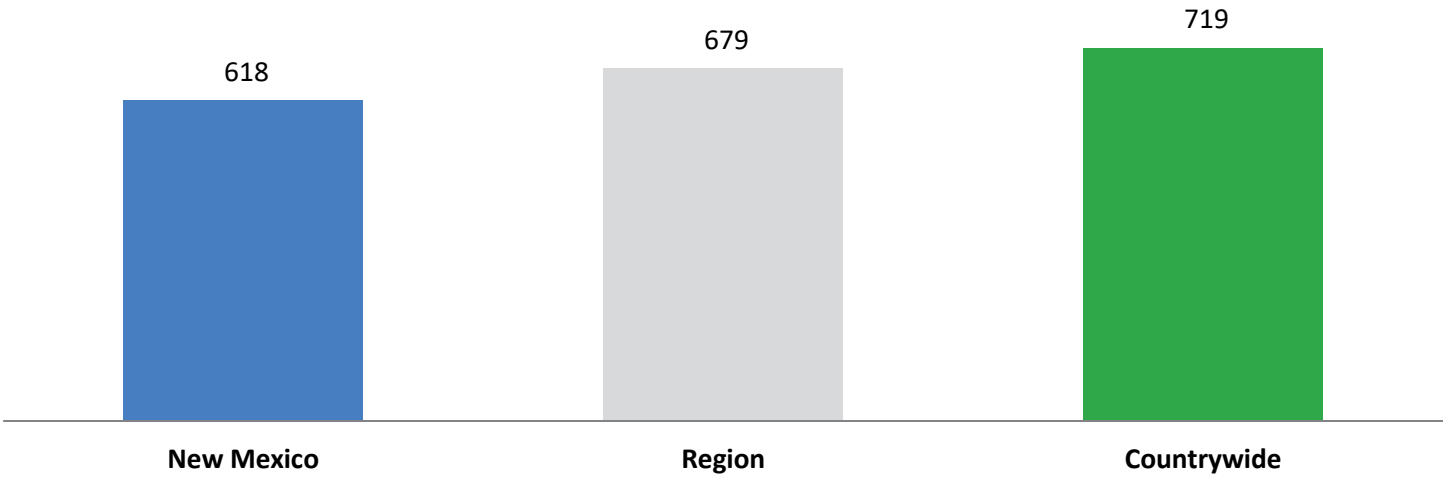
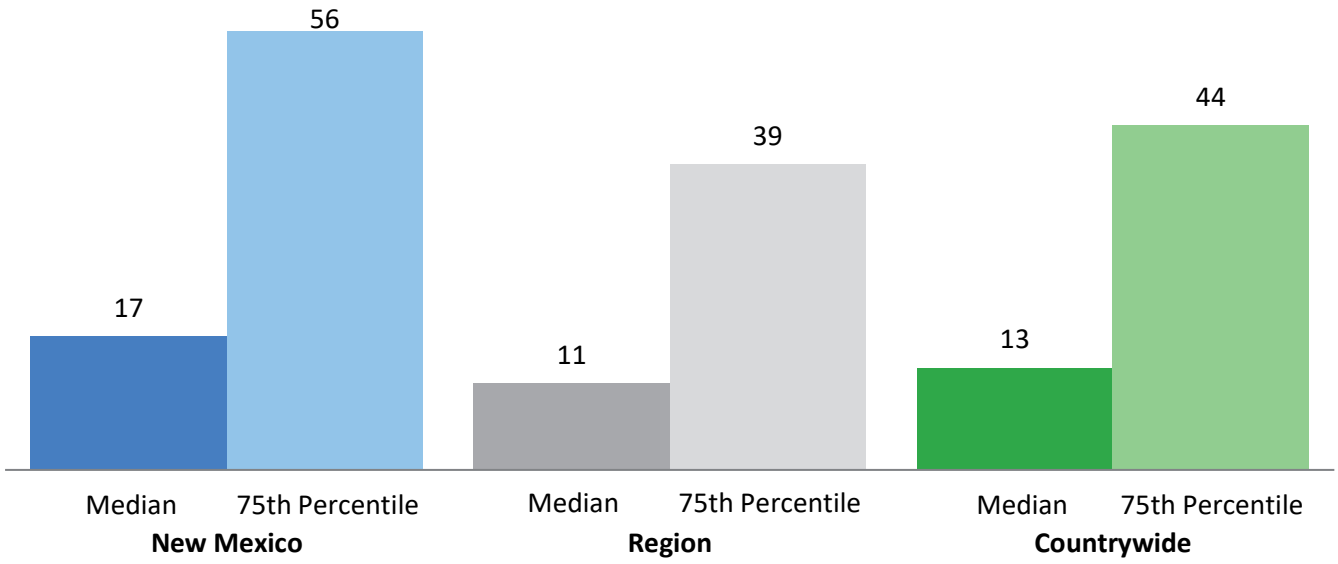


Chart 47 shows the median and 75th percentile time until first treatment for other outpatient visits for New Mexico, the region, and countrywide.

Chart 47

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Chart 48 displays the top 10 diagnosis groups for other outpatient visits. The diagnosis groups are ranked based on total payments for outpatient services in New Mexico.

Chart 48

Top 10 Diagnosis Groups by Amount Paid for Other Hospital Outpatient Visits

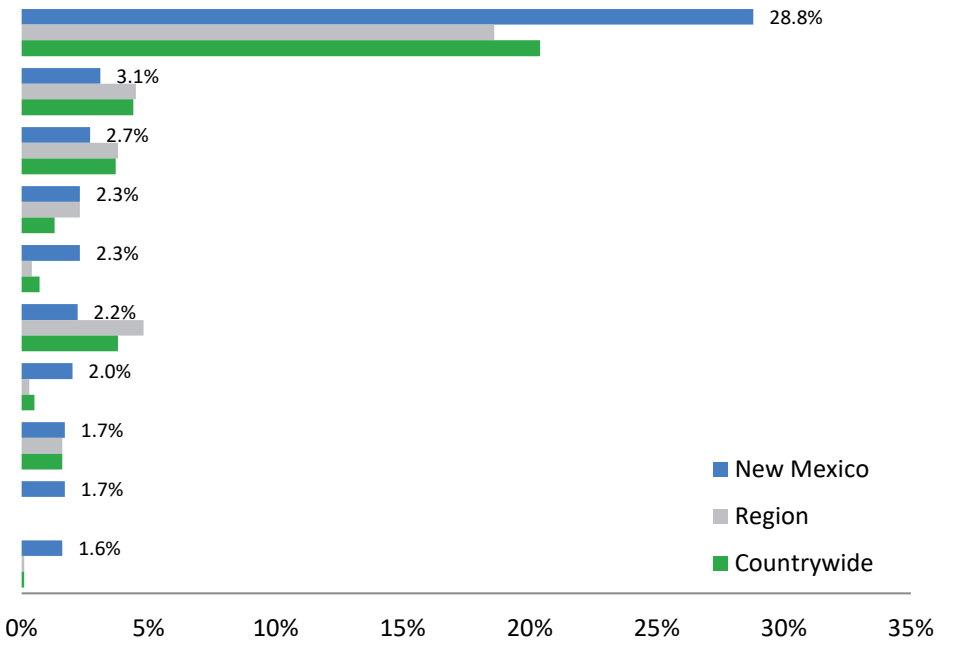
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Lumbar spine degeneration	8.9%	$580	$302	$349
Minor shoulder injury	7.7%	$154	$152	$175
Low back pain	5.7%	$154	$152	$166
Rotator cuff tear	4.5%	$152	$152	$173
Minor hand/wrist injuries	4.4%	$138	$138	$163
Traumatic brain injury	4.3%	$464	$489	$312
Minor knee injury	3.9%	$149	$152	$176
Hand/wrist fracture	3.0%	$148	$138	$161
Chronic pain	2.6%	$149	$169	$194
Lumbosacral intervertebral disc disorders	2.5%	$321	$240	$279

Charts 49 displays the average amount paid per other visit for outpatient services in New Mexico, the region, and countrywide for the top 10 CPT codes in New Mexico. The codes are ranked based on total outpatient payments in New Mexico, where the code shown below is the code with the highest total paid on an "Other" outpatient visit. A brief description of each code is displayed in the table below.

Chart 49

Top 10 Procedure Codes by Amount Paid for Hospital Outpatient Services in Other Visits

Code	Average Paid per Visit NM	Region	CW
97110	$165	$158	$206
73221	$665	$926	$1,349
97140	$156	$157	$216
99213	$119	$130	$132
64493	$1,491	$1,862	$2,443
73721	$590	$904	$1,282
64635	$3,954	$2,698	$3,947
97530	$175	$185	$234
97150	$701	$38	$224
G0283	$271	$168	$211



Code	Description
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
73221	Magnetic resonance (e.g., proton) imaging, any joint of upper extremity; without contrast material
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
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.
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint), with image guidance (fluoroscopy or computed tomography (CT)), lumbar or sacral; single level
73721	Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; without contrast material
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or computed tomography (CT)); lumbar or sacral, single facet joint
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
G0283	Electrical stimulation (unattended) to one or more areas for indication(s) other than wound care as part of a therapy plan of care

Ambulatory Surgical Centers

An Ambulatory Surgical Center (ASC) is often used as an alternative facility to a hospital for conducting outpatient surgeries. The distribution of medical payments for ASCs is 4% for New Mexico, 6% for the region, and 7% for countrywide.

Typically, surgery-related services are performed in ASCs. The most prevalent procedure code types reported are CPT codes and revenue codes.

One measure of workers compensation ASC costs is a comparison of current payments to the Medicare rates. The chart below shows the average percentage of Medicare-scheduled reimbursement amounts for ASC payments for New Mexico, the region, and countrywide. In New Mexico, 94% of ASC payments are included in the chart below.

Chart 50

ASC Payments as a Percentage of Medicare

Medical Cost Category	New Mexico	Region	Countrywide
Ambulatory Surgical Center	216%	212%	265%

Source: NCCI's Medical Data Call for Service Year 2020. Region includes AK, AZ, CO, HI, ID, MT, NV, OR, and UT. Countrywide data includes AK, AL, AR, AZ, CO, CT, DC, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, ME, MI, MN, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OK, OR, RI, SC, SD, TN, UT, VA, VT, WI, and WV.

ASC visits with major surgery services represent 80% of ASC payments in New Mexico. Other ASC visits typically include minor procedures, with injections for therapeutic or diagnostic purposes being the most common. Chart 51 displays the average amount paid per major surgery visit for ASC services, while Chart 52 displays the average number of major surgery ASC visits per 1,000 active claims for New Mexico, the region, and countrywide. Note that there are no controls for mix of diagnosis or severity of claims between jurisdictions.

Chart 51

Average Amount Paid per Major Surgery Visit for ASC Services

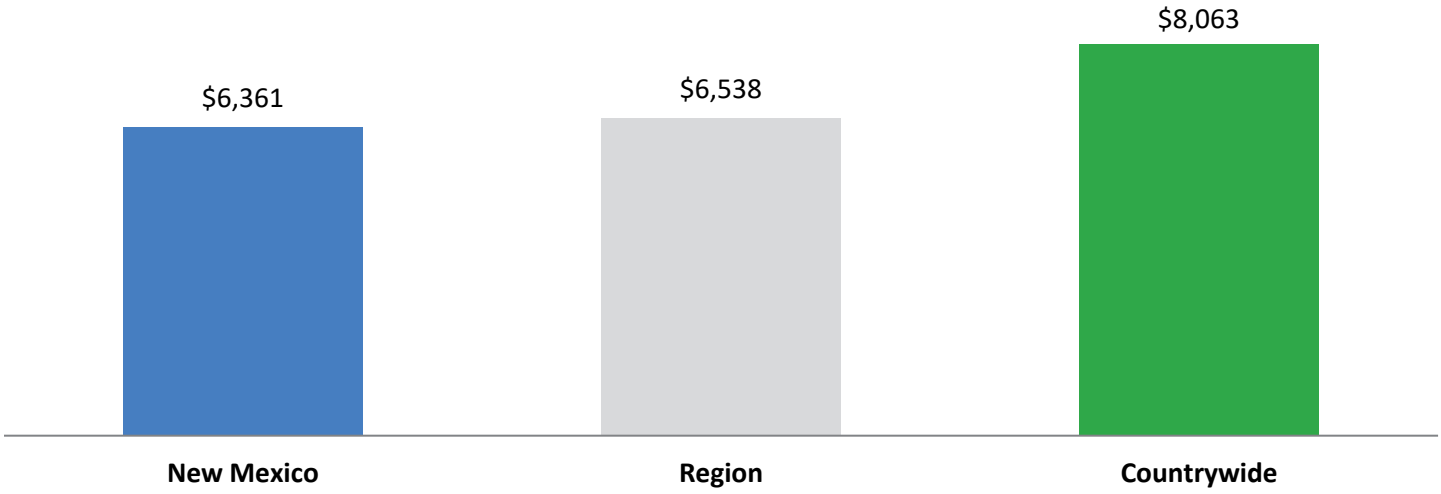


Chart 52

Average Number of ASC Major Surgery Visits per 1,000 Active Claims

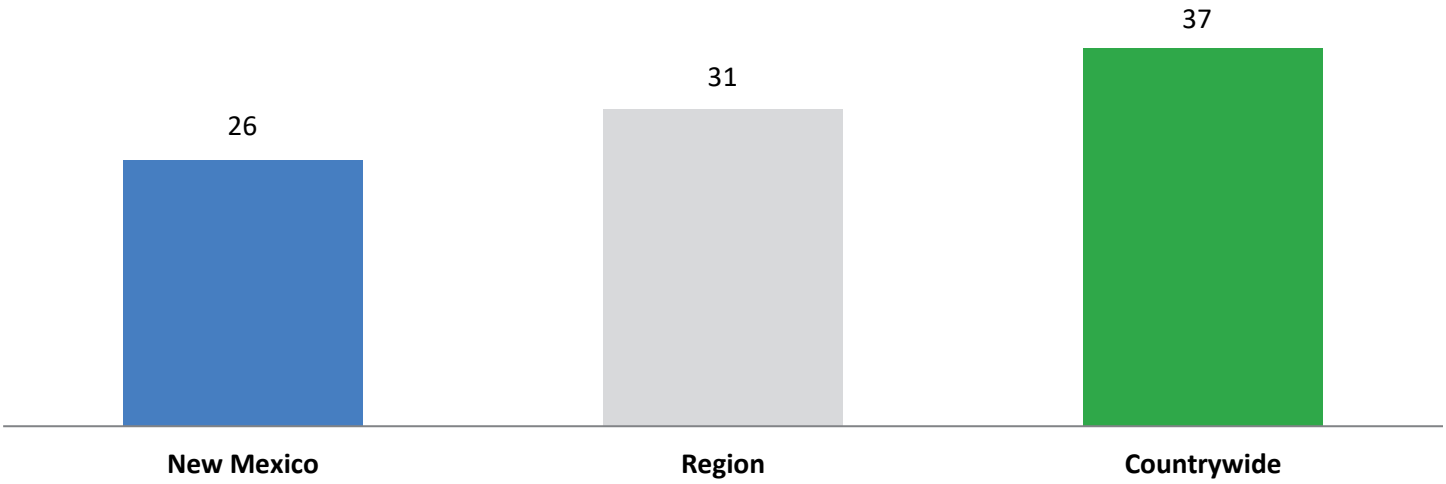
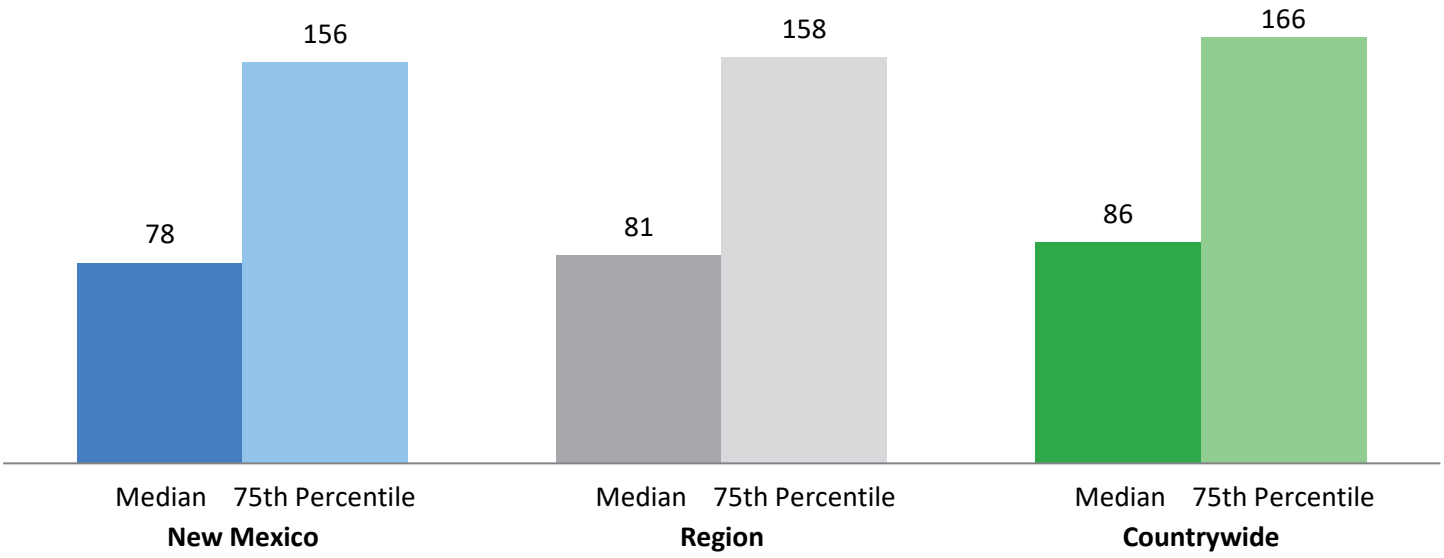


Chart 53 shows the median and 75th percentile time until first treatment for ASC major surgery visits for New Mexico, the region, and countrywide.

Chart 53

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



Source: NCCI's Medical Data Call for Accident Year 2019 and Service Years 2019 and 2020.

Chart 54 displays the top 10 diagnosis groups for ASC major surgery visits. The diagnosis groups are ranked based on total payments for ASC services in New Mexico.

Chart 54

Top 10 Diagnosis Groups by Amount Paid for ASC Major Surgery Visits

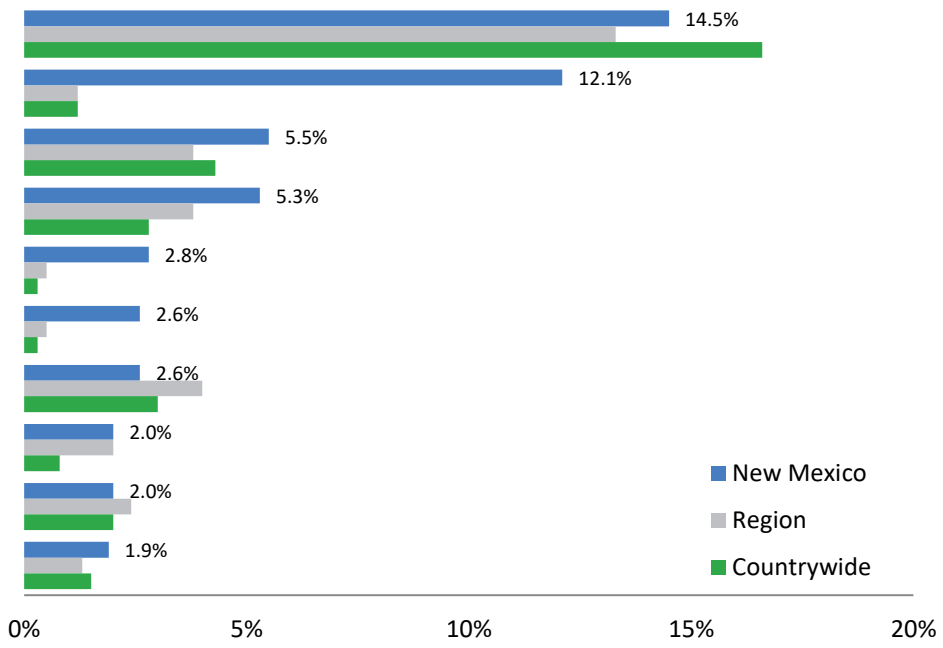
		Median Amount Paid per Visit		
Diagnosis Group	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Rotator cuff tear	25.4%	$9,710	$7,393	$10,347
Knee internal derangement - meniscus injury	9.0%	$3,449	$3,354	$4,196
Knee internal derangement - cruciate ligament tear	5.0%	$9,594	$8,508	$9,355
Minor shoulder injury	4.3%	$7,641	$6,381	$7,932
Hand/wrist fracture	4.1%	$4,035	$4,554	$5,351
Minor ankle/foot injuries	3.7%	$10,338	$7,907	$7,521
Heel/midfoot fracture	3.5%	$8,816	$7,904	$7,624
Knee degenerative/overuse injuries	3.3%	$3,897	$3,933	$5,651
Degenerative shoulder	3.2%	$6,593	$5,759	$8,092
Ankle fracture	3.2%	$8,236	$6,946	$8,546

Chart 55 displays the average amount paid per major surgery visit for ASC services in New Mexico, the region, and countrywide for the top 10 CPT codes in New Mexico. The codes are ranked based on total ASC payments in New Mexico, where the code shown below is the code with the highest total paid on a major surgery visit. A brief description of each procedure code is displayed in the table beneath the chart. Chart 56 displays similar results for visits in an outpatient setting for the list of codes in Chart 55, if applicable.

Chart 55

Top 10 Procedure Codes by Amount Paid for ASC Services in Major Surgery Visits

Code	Average Paid per Visit NM	Region	CW
29827	$11,032	$8,747	$12,497
23412	$10,813	$10,704	$11,825
29881	$3,468	$3,694	$4,651
29888	$9,510	$9,843	$10,931
27829	$11,791	$12,086	$11,658
27695	$9,408	$8,871	$10,184
23430	$10,724	$9,841	$12,811
27698	$12,698	$11,247	$10,722
29806	$9,916	$8,858	$10,417
29880	$3,413	$3,785	$4,771



Code	Description
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
29881	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), including debridement/shaving of articular cartilage
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, includes internal fixation, when performed
27695	Repair, primary, disrupted ligament, ankle; collateral
23430	Tenodesis of long tendon of biceps
27698	Repair, secondary, disrupted ligament, ankle, collateral (e.g., Watson-Jones procedure)
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29880	Arthroscopy, knee, surgical; with meniscectomy (medial and lateral, including any meniscal shaving), including debridement/shaving of articular cartilage

Chart 56

Major Surgery Outpatient Visit Comparisons for Procedure Codes in Chart 55

Code	Average Paid per Visit in NM ASC	Outpatient	Distribution of Major Surgery Visits in NM in an ASC or Outpatient Setting
29827	$11,032	$12,132	44% / 56%
23412	$10,813	$12,247	82% / 18%
29881	$3,468	$6,917	51% / 49%
29888	$9,510	$11,504	50% / 50%
27829	$11,791	$7,294	75% / 25%
27695	$9,408	N/A	100%
23430	$10,724	$20,895	55% / 45%
27698	$12,698	N/A	100%
29806	$9,916	$8,214	50% / 50%
29880	$3,413	$5,090	70% / 30%

Prescription Drugs

The distribution of medical payments for drugs is 11% for New Mexico, 8% for the region, and 8% for countrywide. Prescription drugs are uniquely identified by a national drug code (NDC). Charts 57 through 62 provide greater detail on payments for prescription drugs reported with an NDC, whether the drugs were provided in a pharmacy, physician's office, hospital, or other place of service. Payments are categorized as drugs if the code reported on the transaction is an NDC. Payments for drugs can also be reported using codes other than NDCs, such as revenue codes, HCPCS codes, and other state-specific procedure codes. The results in these charts are based only on payments reported with an NDC.

The Controlled Substances Act (CSA) was passed in 1970 to regulate the manufacture, distribution, possession, and use of certain drugs. There are five schedules, or groups of drugs, determined by varying qualifications, such as the drug's medical uses, if any, and its potential for abuse. For example, Schedule V drugs are defined as having the lowest potential for abuse, while Schedule I drugs are illegal at the federal level, mainly because they are defined as having no currently accepted medical uses and a high potential for abuse.

In New Mexico, the share of claims observed in Service Year 2020 with at least one controlled substance was 14%. This compares to the region and countrywide shares of 9% and 10%, respectively. In 2020, New Mexico spent $1.2M on Schedule II and Schedule III drugs for workers compensation claims.

Chart 57 shows the distribution of prescription drug payments by CSA schedule in New Mexico, the region, and countrywide.

Chart 57

Distribution of Prescription Drug Payments by CSA Schedule

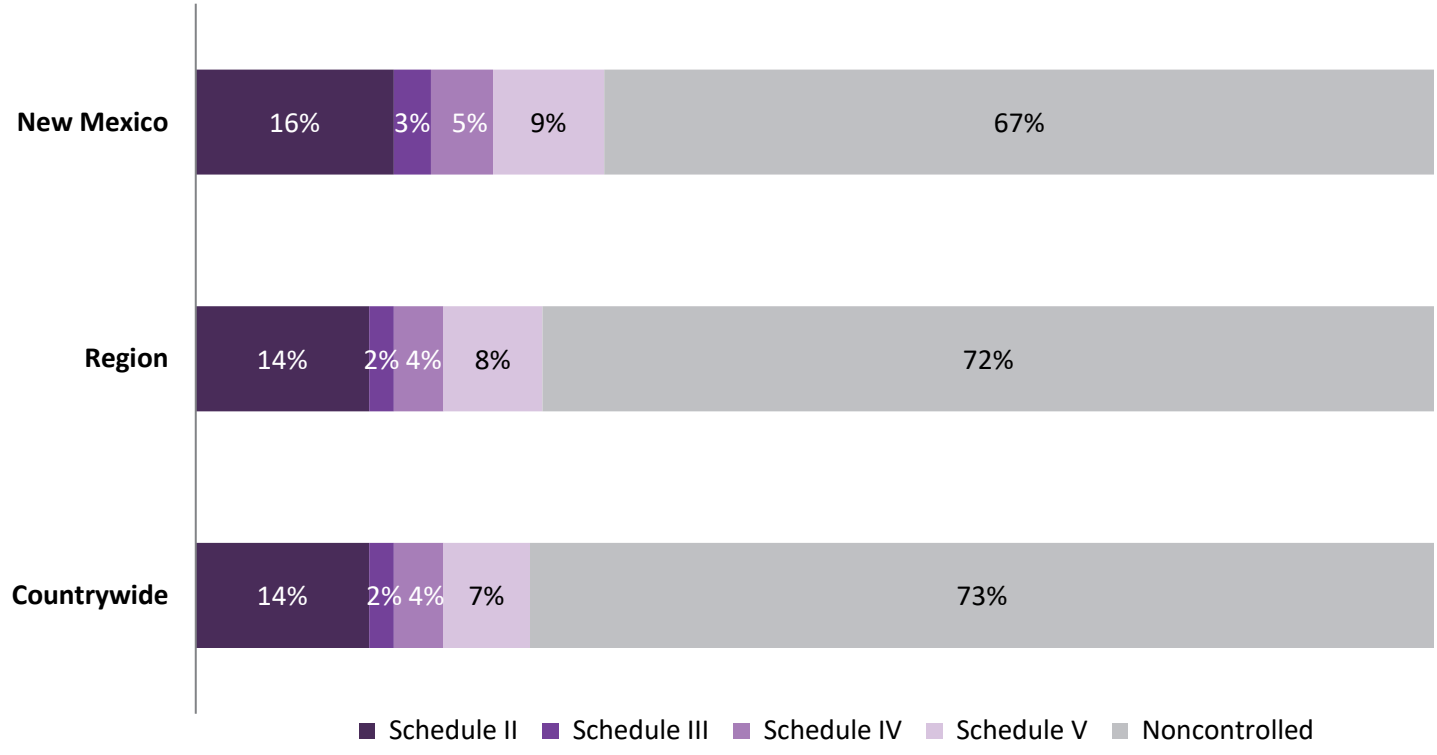


Chart 58 displays the shares of the payments of prescription medication for the top 10 drugs used in workers compensation treatment, by amount paid in New Mexico. This chart also indicates whether the drugs are generic (G) or brand name (B); for generic drugs, a commonly used brand name equivalent is also provided. This method of ranking shows which drugs have the highest percentage share of payments. Also included is the average price per unit (PPU). (See the Glossary for the definition of *unit*.)

Chart 58

Top 10 Workers Compensation Drugs by Amount Paid

Drug Name	Average PPU NM	Average PPU Region	Average PPU CW	New Mexico Paid Share
Pregabalin	$3.56	$4.69	$4.61	6.2%
Oxycontin®	$8.39	$8.95	$9.67	5.4%
Gabapentin	$0.68	$0.87	$0.91	3.7%
Lidocaine	$3.99	$5.90	$6.49	3.0%
Celecoxib	$3.64	$4.48	$5.11	3.0%
Pennsaid®	$22.98	$22.74	$22.99	2.9%
Duloxetine HCl	$3.52	$4.47	$4.44	2.5%
Lidopro®	$3.38	$3.69	$3.91	2.2%
Oxycodone HCl-Acetaminophen	$1.08	$1.14	$0.97	2.1%
Lyrica®	$8.52	$8.44	$8.47	2.1%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	1
Oxycontin®	B	N/A	Analgesics/Antipyretics	II	5
Gabapentin	G	Neurontin®	Anticonvulsants	None	4
Lidocaine	G	Lidoderm®	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	3
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	6
Pennsaid®	B	N/A	Analgesics/Antipyretics	None	39
Duloxetine HCl	G	Cymbalta®	Psychotherapeutic Agents	None	8
Lidopro®	B	N/A	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	26
Oxycodone HCl-Acetaminophen	G	Percocet®	Analgesics/Antipyretics	II	10
Lyrica®	B	N/A	Miscellaneous Central Nervous System Agents	V	24

Chart 59 displays the top 10 drugs used in workers compensation treatment, according to the number of prescriptions in New Mexico. This chart reveals the most frequently prescribed drugs and the average PPU.

Chart 59

Top 10 Workers Compensation Drugs by Prescription Counts

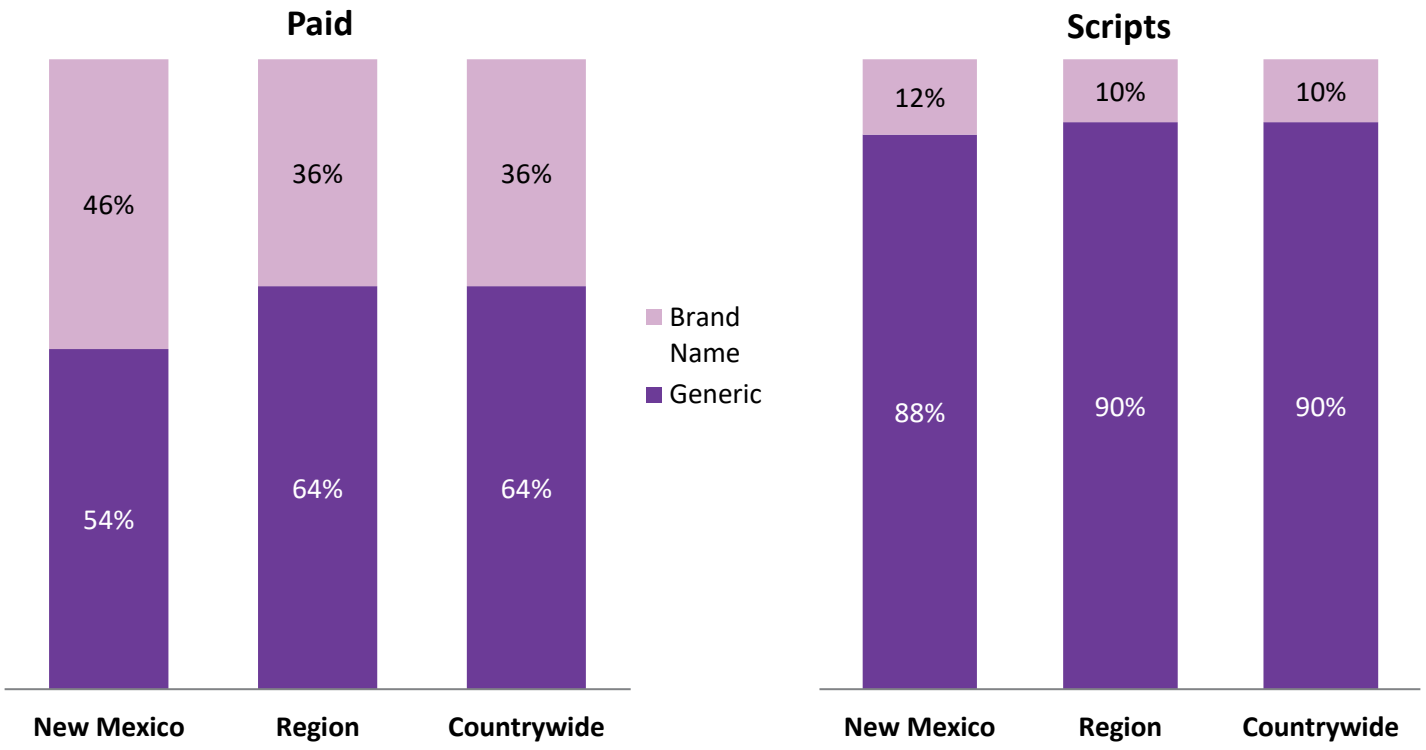
Drug Name	Average PPU NM	Region	CW	New Mexico Prescription Share
Gabapentin	$0.68	$0.87	$0.91	7.3%
Hydrocodone Bitartrate-Acetaminophen	$0.46	$0.57	$0.53	7.0%
Ibuprofen	$0.47	$0.46	$0.44	6.6%
Tramadol HCl	$0.60	$0.78	$0.90	4.6%
Oxycodone HCl	$0.67	$0.71	$0.80	3.9%
Tizanidine HCl	$0.90	$1.13	$1.06	3.5%
Pregabalin	$3.56	$4.69	$4.61	2.9%
Cyclobenzaprine HCl	$0.71	$1.07	$1.74	2.7%
Diclofenac Sodium (NSAID)	$0.36	$1.29	$1.83	2.6%
Naproxen	$0.72	$0.90	$0.92	2.5%

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	CW Rank
Gabapentin	G	Neurontin®	Anticonvulsants	None	2
Hydrocodone Bitartrate-Acetaminophen	G	Vicodin®	Analgesics/Antipyretics	II	1
Ibuprofen	G	Advil®	Analgesics/Antipyretics	None	4
Tramadol HCl	G	Ultram®	Analgesics/Antipyretics	IV	6
Oxycodone HCl	G	Oxycontin®	Analgesics/Antipyretics	II	9
Tizanidine HCl	G	Zanaflex®	Muscle Relaxants, Skeletal	None	10
Pregabalin	G	Lyrica®	Miscellaneous Central Nervous System Agents	V	12
Cyclobenzaprine HCl	G	Flexeril®	Muscle Relaxants, Skeletal	None	3
Diclofenac Sodium (NSAID)	G	Voltaren®	Analgesics/Antipyretics	None	8
Naproxen	G	Aleve®	Analgesics/Antipyretics	None	11

Chart 60 shows the distribution of prescription drugs by brand name and generic for New Mexico, the region, and countrywide. The share between brand name and generic is displayed based on the prescription counts and the payments. Typically, a higher percentage of drugs is given in the generic form; however, higher costs occur when brand name drugs are prescribed. In many states, a prescription drug fee schedule includes rules regarding the dispensing and reimbursement rates for brand name and generic drugs.

Chart 60

Distribution of Drugs by Brand Name and Generic



The rules on drug dispensing vary from state to state. Some states allow physician dispensing of drugs, while other states limit or prohibit physician dispensing. Analysis of the share of drugs dispensed from a pharmacy and from a nonpharmacy (e.g., physicians and hospitals) may provide insight into the drivers of drug costs.

Chart 61 shows the distribution of prescription drugs dispensed by pharmacies and nonpharmacies. The share between pharmacy-dispensed and nonpharmacy-dispensed is displayed, based on both prescription counts and payments, for New Mexico, the region, and countrywide.

Chart 61

Distribution of Drugs by Pharmacy and Nonpharmacy

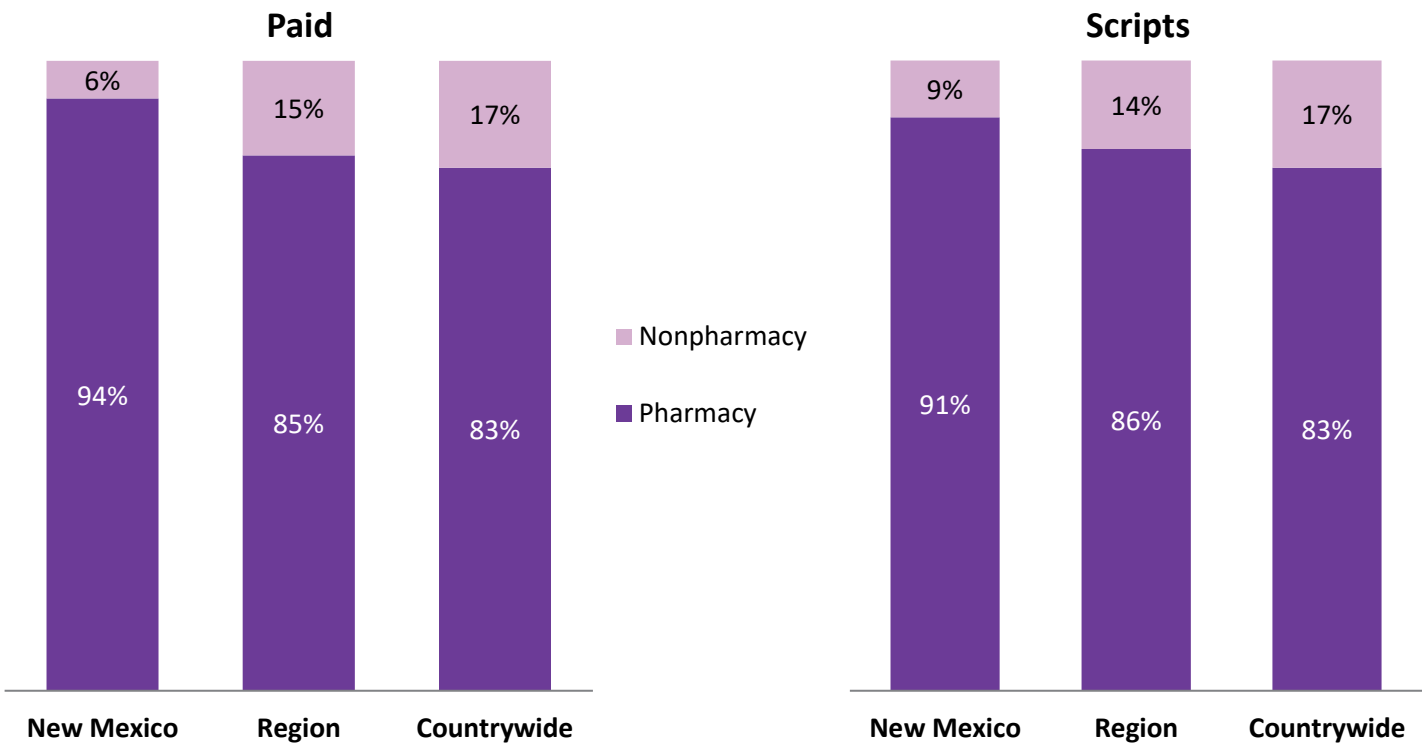


Chart 62 displays the shares of the payments for the top 5 nonpharmacy-dispensed prescription drugs used in workers compensation treatment, by amount paid in New Mexico. A pharmacy-dispensed comparison, along with values for the region and countrywide, are also included. All values shown below are specific either to nonpharmacy-dispensed prescription drugs or to pharmacy-dispensed prescription drugs.

Chart 62

Top 5 Nonpharmacy-Dispensed Drugs by Amount Paid with Pharmacy-Dispensed Comparison

	Nonpharmacy-dispensed				Pharmacy-dispensed			
Drug Name	Paid Share	NM PPU	Region PPU	CW PPU	Paid Share	NM PPU	Region PPU	CW PPU
Lidopro®	19.8%	$3.31	$3.62	$3.82	1.0%	$3.47	$3.72	$4.00
Botox®	12.1%	$344.53	$302.22	$252.95	0.2%	$864.89	$488.48	$650.14
Lidopro Patch®	10.9%	$39.66	$40.24	$44.79	0.5%	$43.02	$43.94	$46.95
Celecoxib	6.1%	$6.26	$8.03	$7.61	2.8%	$3.43	$4.07	$4.50
Euflexxa®	3.1%	$165.96	$194.21	$195.14	0.1%	$205.39	$164.63	$184.13

Drug Name	B/G	Common Brand Name	Category	CSA Schedule	Nonpharmacy CW Rank
Lidopro®	B	N/A	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	12
Botox®	B	N/A	Toxins	None	9
Lidopro Patch®	B	N/A	Antipruritics/Local Anesthesia, Skin/Mucous Membrane	None	8
Celecoxib	G	Celebrex®	Analgesics/Antipyretics	None	2
Euflexxa®	B	N/A	Biological Lubricant	None	50

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

The distribution of medical payments for DMEPOS is 7% for New Mexico, 7% for the region, and 8% for countrywide.

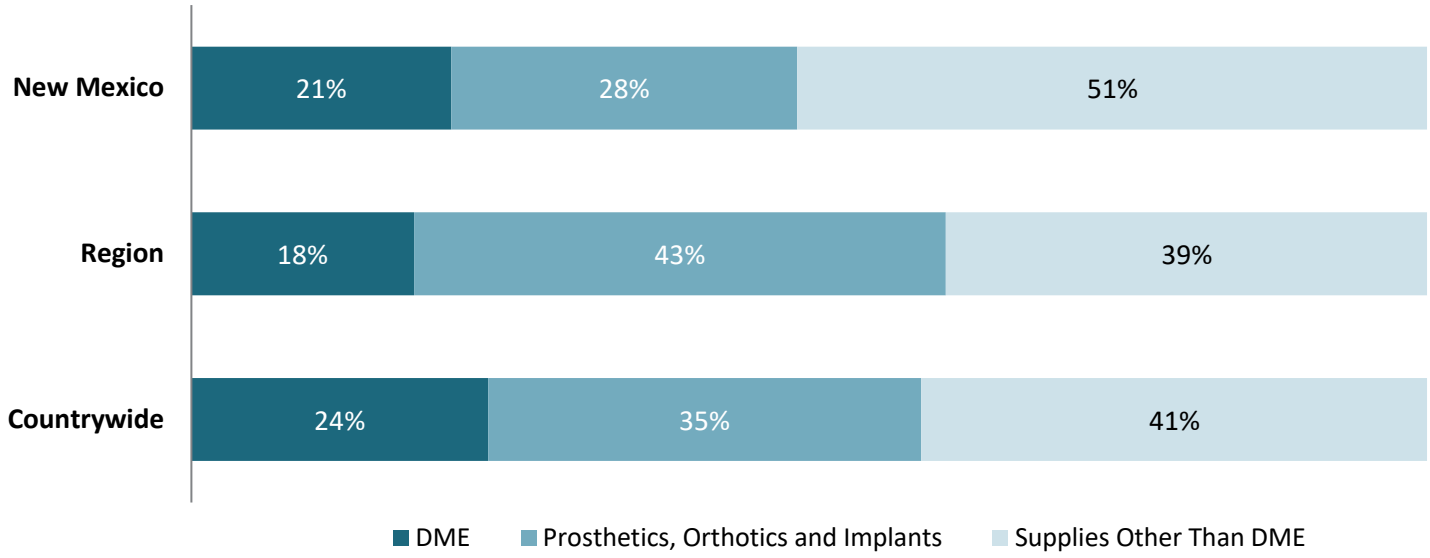
Chart 63 displays the distribution of payments among three separate DMEPOS categories:

- Durable Medical Equipment (DME)
- Prosthetics, Orthotics and Implants
- Supplies Other Than DME

Payments are mapped to each of these categories based on the procedure code reported, regardless of who provides the service or where the service is performed.

Chart 63

Distribution of Payments by DMEPOS



Injuries that include an implant or prosthetic device tend to be more expensive than other injuries. Chart 64 shows the top 10 diagnosis groups for claims that include an implant or a prosthetic device by total paid amount. Chart 65 shows the same diagnosis groups with the average amount paid per claim for claims that do not include an implant or prosthetic.

Chart 64

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2019 for Claims *With* an Implant or Prosthetic

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Rotator cuff tear	7.6%	$35,826	$33,087	$39,641
Traumatic brain injury	6.7%	$724,675	$277,780	$274,511
Injury of unspecified body region	5.7%	$206,772	$110,886	$77,648
Certain early complications of trauma, not elsewhere classified	5.3%	$289,435	$157,241	$124,108
Cervical fracture	5.1%	$558,666	$109,101	$130,848
Femur fracture	4.6%	$100,375	$77,303	$98,871
Minor shoulder injury	4.0%	$39,956	$27,122	$31,575
Hip/pelvis fracture/major trauma	3.9%	$46,785	$63,645	$80,031
Tibia/fibula fracture	3.7%	$58,189	$75,318	$78,888
Ankle fracture	3.7%	$50,128	$32,857	$38,542

Chart 65

Average Amount Paid per Claim *Without* an Implant or Prosthetic for Diagnosis Groups in Chart 64

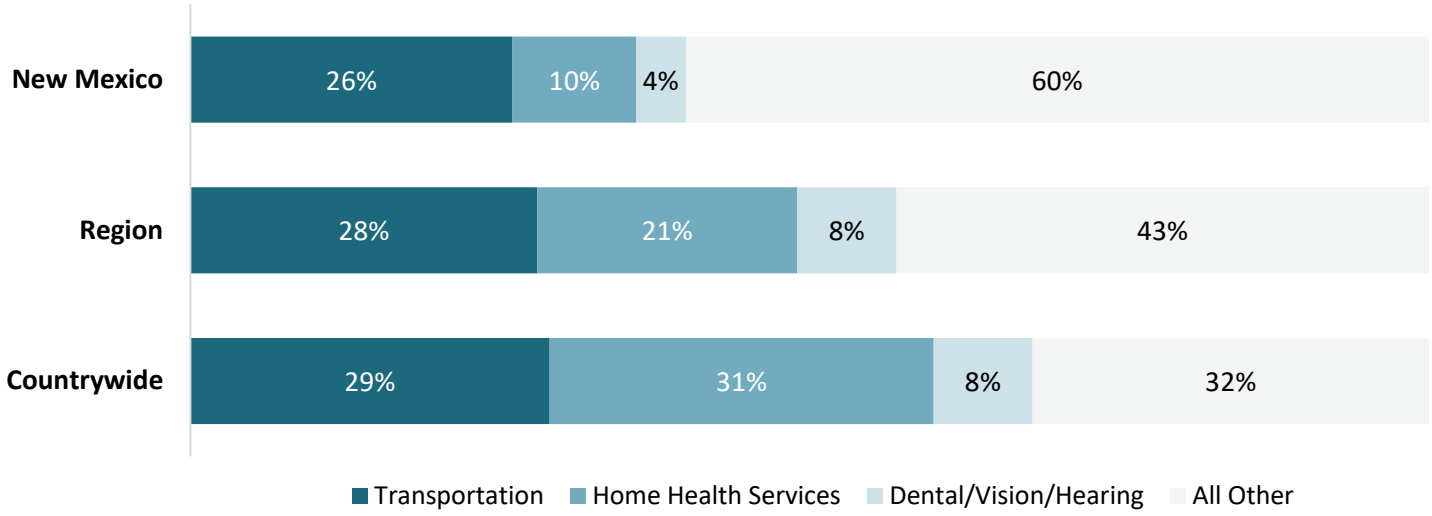
	Average Amount Paid Per Claim		
Diagnosis Group	**New Mexico**	**Region**	**Countrywide**
Rotator cuff tear	$19,619	$15,816	$19,965
Traumatic brain injury	$203,446	$38,193	$46,768
Injury of unspecified body region	$3,372	$3,726	$3,200
Certain early complications of trauma, not elsewhere classified	$13,401	$108,053	$40,218
Cervical fracture	$33,335	$33,361	$36,576
Femur fracture	$43,897	$40,013	$50,113
Minor shoulder injury	$4,094	$3,824	$4,051
Hip/pelvis fracture/major trauma	$16,165	$33,793	$38,263
Tibia/fibula fracture	$16,460	$18,785	$18,063
Ankle fracture	$9,757	$15,902	$15,730

Other Medical Services

For Service Year 2020, other medical services represent 5% of total medical costs countrywide. Chart 66 shows the distribution of these services by four categories: transportation, home health services, dental/vision/hearing, and all other. The "All Other" category typically includes services that may have a missing, invalid, or unlisted procedure, in addition to some other valid services (e.g., payments for interpreters, vehicle modifications, etc.).

Chart 66

Distribution of Other Medical Services Payments



Diagnosis Group and Body System

Charts 67 and 68 display the top 10 body systems and diagnosis groups, respectively. A body system and diagnosis group are identified for each claim based on an ICD-10 code. The ICD-10 code indicates the condition for which the care is provided. NCCI assigns an ICD-10 code to each workers compensation claim based on the severity of the ICD-10 codes reported on bills by medical providers for services provided to the injured worker.

The top 10 body systems and diagnosis groups are ranked by total claim payments for New Mexico. This method of ranking shows which body systems and diagnosis groups have the highest percentage share of payments. Payments are based on claims with dates of injury between January 1, 2019, and December 31, 2019, and they include all reported services provided for those claims through December 31, 2020.

Chart 67

Top Body Systems by Amount Paid for Dates of Injury in 2019

		Average Amount Paid Per Claim		
Body System	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Shoulder	17.1%	$9,083	$8,523	$9,995
Hand/wrist	10.0%	$2,196	$2,074	$2,427
Head	9.4%	$9,227	$3,504	$3,934
Lumbar spine	9.2%	$3,845	$3,922	$4,584
Knee	9.0%	$5,341	$5,676	$6,096
Ankle/foot	7.5%	$3,691	$3,414	$3,666
Leg	6.7%	$6,657	$5,590	$6,606
Arm	5.4%	$7,102	$5,418	$5,895
Neck	5.1%	$5,795	$5,151	$6,178
Chest/upper torso	2.4%	$3,263	$3,077	$3,268

Chart 68

Top Diagnosis Groups by Amount Paid for Dates of Injury in 2019

		Average Amount Paid Per Claim		
Diagnosis Group	**Paid Share**	**New Mexico**	**Region**	**Countrywide**
Traumatic brain injury	7.4%	$232,403	$67,484	$71,118
Rotator cuff tear	7.0%	$21,667	$18,640	$23,192
Minor shoulder injury	5.9%	$4,642	$4,315	$4,660
Low back pain	5.5%	$2,728	$2,472	$2,427
Minor hand/wrist injuries	4.0%	$1,176	$1,215	$1,330
Hand/wrist fracture	3.7%	$7,771	$7,285	$7,480
Minor knee injury	3.3%	$2,890	$2,562	$2,647
Neck pain	3.0%	$4,030	$3,514	$3,368
Minor ankle/foot injuries	2.6%	$1,868	$1,751	$1,824
Knee internal derangement - meniscus injury	2.3%	$11,411	$11,313	$13,347

Comparison of Selected Results by Year

The charts in this section provide a comparison of results for New Mexico. These comparisons are over the latest five service years unless otherwise noted. Analysis in the growth of shares may provide additional insight into medical cost drivers above and beyond an analysis at a specific point in time.

Results in the charts below may vary compared to medical reports from previous years. This is due to a lag in reporting, as well as improved derivations affecting categories for certain charts.

Distribution of Medical Payments (Chart 4)

Medical Category	2016	2017	2018	2019	2020
Physician	41%	41%	38%	42%	42%
Hospital Outpatient	15%	15%	14%	14%	14%
Hospital Inpatient	9%	10%	13%	10%	10%
Drugs	16%	14%	13%	11%	11%
DMEPOS	7%	6%	7%	7%	7%
ASC	4%	4%	4%	4%	4%
Other	8%	10%	11%	12%	12%

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

AMA Service Category	2016	2017	2018	2019	2020
Physical Medicine	31%	32%	34%	35%	34%
Surgery	18%	16%	16%	17%	17%
Evaluation and Management	27%	28%	27%	26%	28%
Radiology	10%	10%	10%	9%	9%
Anesthesia	3%	3%	3%	3%	3%
General Medicine	4%	5%	5%	5%	4%
Other	3%	2%	2%	3%	3%
Pathology	4%	4%	3%	2%	2%

Median Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53)[10]

Medical Category	AY 2015	AY 2016	AY 2017	AY 2018	AY 2019
Physicians – Major Surgery	43	42	44	35	31
Physicians – Radiology	1	2	1	2	1
Physicians – Physical and General Medicine	14	13	14	14	16
Physicians – Evaluation and Management	2	1	1	1	1
Hospital Inpatient	0	0	1	0	0
Hospital Outpatient – Major Surgery	76	91	87	77	72
Hospital Outpatient – All Other	26	20	21	20	17
ASC – Major Surgery	93	70	74	74	78

75th Percentile of Time Until First Treatment (in Days) (Charts 11, 14, 17, 20, 31, 42, 47, and 53)[10]

Medical Category	AY 2015	AY 2016	AY 2017	AY 2018	AY 2019
Physicians – Major Surgery	121	120	124	116	101
Physicians – Radiology	14	15	13	15	12
Physicians – Physical and General Medicine	45	43	44	46	47
Physicians – Evaluation and Management	7	6	6	6	6
Hospital Inpatient	11	8	8	3	5
Hospital Outpatient – Major Surgery	162	159	158	147	160
Hospital Outpatient – All Other	80	66	68	60	56
ASC – Major Surgery	165	154	134	161	156

Hospital Inpatient Statistics (Charts 27 and 29)

	2016	2017	2018	2019	2020
Average Amount Paid Per Stay	$22,705	$26,299	$31,964	$27,961	$25,546
Number of Stays per 1,000 Active Claims	17	16	18	17	17

[10] In the charts displaying the distribution of time until first treatment, the data is organized by the year in which the injury occurred, rather than by service year, and includes services performed within 365 days of the date of injury.

Distribution of Hospital Outpatient Payments by Outpatient Visit Type (Chart 35)

Visit Type	2016	2017	2018	2019	2020
Emergency	25%	28%	30%	29%	25%
Nonemergency Major Surgery	43%	43%	44%	47%	51%
Other	32%	29%	26%	24%	24%

Emergency Hospital Outpatient Statistics (Charts 36 and 37)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$998	$976	$1,035	$999	$1,001
Number of Visits per 1,000 Active Claims	168	180	184	189	160

Emergency Room Outpatient Services Paid per Transaction (Chart 39)

Code	Severity	2016	2017	2018	2019	2020
99281	Minor	$170	$155	$151	$122	$130
99282	Low to moderate	$207	$175	$189	$176	$173
99283	Moderate	$363	$318	$307	$286	$307
99284	High	$632	$571	$535	$525	$525
99285	High and immediately life-threatening	$967	$815	$752	$802	$822

Nonemergency Major Surgery Hospital Outpatient Statistics (Charts 40 and 41)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$7,737	$7,318	$7,253	$7,129	$7,560
Number of Visits per 1,000 Active Claims	37	37	38	42	42

Other Hospital Outpatient Statistics (Charts 45 and 46)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$442	$353	$297	$260	$248
Number of Visits per 1,000 Active Claims	479	518	567	597	618

ASC Major Surgery Statistics (Charts 51 and 52)

	2016	2017	2018	2019	2020
Average Amount Paid Per Visit	$5,568	$6,387	$5,824	$5,961	$6,361
Number of Visits per 1,000 Active Claims	25	23	25	25	26

Distribution of Prescription Drug Payments by CSA Schedule (Chart 57)

CSA Schedule	2016	2017	2018	2019	2020
Schedule II	22%	21%	18%	16%	16%
Schedule III	4%	4%	3%	2%	3%
Schedule IV	7%	6%	6%	6%	5%
Schedule V	10%	11%	13%	12%	9%
Noncontrolled	57%	58%	60%	64%	67%

Distribution of Drug Payments by Brand Name and Generic (Chart 60)

Type of Drug	2016	2017	2018	2019	2020
Brand Name	48%	51%	52%	49%	46%
Generic	52%	49%	48%	51%	54%

Distribution of Drug Payments by Pharmacy and Nonpharmacy (Chart 61)

Type of Provider	2016	2017	2018	2019	2020
Pharmacy	94%	96%	95%	94%	94%
Nonpharmacy	6%	4%	5%	6%	6%

Distribution of Payments by DMEPOS (Chart 63)

Category	2016	2017	2018	2019	2020
DME	16%	25%	20%	22%	21%
Prosthetics, Orthotics and Implants	37%	27%	37%	31%	28%
Supplies Other Than DME	47%	48%	43%	47%	51%

Distribution of Payments by Other Medical Services (Chart 66)

Category	2016	2017	2018	2019	2020
Transportation	26%	25%	25%	22%	26%
Home Health Services	12%	14%	11%	8%	10%
Dental/Vision/Hearing	4%	5%	4%	4%	4%
All Other	58%	56%	60%	66%	60%

Glossary

75th Percentile: The point on a distribution that is higher than 75% of observations and lower than 25% of observations.

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

Ambulatory Payment Classification (APC): Unit of payment under Medicare's Outpatient Prospective Payment System (OPPS) for hospital outpatient services where individual services are grouped based on similar characteristics and similar costs.

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 it generally has a separate fee schedule.

Controlled Substances: Drugs that are regulated by the Controlled Substances Act (CSA) of 1970. Each controlled substance is contained in one of five schedules based on its medical use(s) and its potential for abuse and addiction.

CPT Code Modifiers: Modifiers are codes added to a CPT code that further describe the procedure performed without changing the meaning of the original code.

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.

Diagnosis Groups: Based on ICD-10 codes; groups based on similar injuries and parts of body.

Diagnosis-Related Groups (DRG): A system of hospital payment classifications that groups patients with similar clinical problems who are expected to require similar amounts of hospital resources.

Drugs: Includes any data reported by a National Drug Code (NDC), which is referred to as a prescription drug. Also included are data for revenue codes, the 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.

Emergency Services: Services performed for patients requiring immediate attention.

Emergency Visit: A visit where emergency services are performed.

Healthcare Common Procedure Coding System (HCPCS): Alphanumeric codes that include mostly nonphysician items or services such as medical supplies, ambulatory services, prostheses, etc. These are items and services not covered by Current Procedure Terminology (CPT) procedures.

ICD-10 Codes: The *International Classification of Diseases, Tenth Revision,* is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms, and procedures recorded in conjunction with hospital care in the United States.

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 Inpatient Stay: A hospital admission of a patient requiring hospitalization of at least one 24-hour period.

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).

International Statistical Classification of Diseases and Related Health Problems (ICD-10): A classification of diseases and other health problems based on a diagnosis maintained by the World Health Organization (WHO).

Length of Stay: The amount of time, in days, between admission to a hospital and discharge.

Major Surgery Visit: A visit in which at least one surgery procedure is performed based on the reported procedure code, and where the surgery procedure has a global follow-up period of 90 days, as defined by the Centers for Medicare & Medicaid Services, and is not an injection.

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.

Other Outpatient Visit: A nonemergency outpatient visit where no major surgery services are performed.

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

Revenue Code: A numeric coding system used in hospital billings that provides broad classifications of the types of services provided. Some examples are emergency room, operating room, recovery room, room and board, and supplies.

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

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

Telemedicine Service: Services reported with a telemedicine-specific procedure code, modifier, or place of service.

Time to Treatment (TTT): The amount of time, measured in days, between the date on which an accident occurs and the date on which the first medical service in a given category is provided.

Transaction: A line item of a medical bill.

Units: The number of units of service performed or the quantity of drugs dispensed. For Paid Procedure Codes related to medications, the quantity/units depend on the type of drug:

- For tablets, capsules, suppositories, nonfilled syringes, etc., *units* represent the actual number of the drug provided. For example, a bottle of 30 pills would have 30 units.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., dispensed in standard packages, the units are specified by the procedure code. For example, a cream is dispensed in a standard tube, which is defined as a single unit.
- For liquids, suspensions, solutions, creams, ointments, bulk powders, etc., that are not dispensed in standard packages, the number of units is the amount provided in its standard unit of measurement, such as milliliters, grams, or ounces. For example, codeine cough syrup dispensed by a pharmacist into a four-ounce bottle would be reported as four units.

Visit: Any hospital outpatient or ASC service or set of services provided to a claimant on a specific date. Any visit may have more than one procedure performed, and any claimant may have more than one visit.

Appendix

The data contained in this report is reported under the jurisdiction state—the state under whose workers compensation act the claimant's benefits are being paid. Medical transactions must continue to be reported until the transactions no longer occur (i.e., the claim is closed) or 30 years from the accident date. There are nearly 30 data elements reported.

Wherever possible, standard industry codes are used because they provide a clear definition of the data, improve its accuracy and quality, and increase efficiency of computer systems.

Carriers differ in their handling of medical data reporting. Some carriers retain all medical claims handling internally and submit the data themselves. Others use business partners for various aspects of medical claim handling, such as third party administrators or medical bill review vendors. It is possible for a carrier to authorize its vendor to report the data on its behalf. Some carriers may use a combination of direct reporting and vendors. Although data may have been provided by an authorized vendor on behalf of a carrier, the quality, timeliness, and completeness of the data is the responsibility of the carrier.

Before a medical data provider can send files, each submitter's electronic data file must pass certification testing. This ensures that all connections, data files, and systems are functioning and processing correctly. Each medical data provider within a reporting group is required to pass certification testing. If a medical data provider reports data for more than one reporting group, that data must be certified for each group.

For more information about the Medical Data Call, please refer to the ***Medical Data Call Reporting Guidebook*** on **ncci.com**.