WCRI BENCHMARKS

CompScope™ Medical Benchmarks for Indiana

22nd Edition

Evelina Radeva

WCRI
Workers Compensation Research Institute

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Workers Compensation Research Institute

CompScope™ Medical Benchmarks for Indiana, 22nd Edition

Evelina Radeva

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SUMMARY OF MAJOR FINDINGS FOR INDIANA

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This 22nd edition of CompScope™ Medical Benchmarks for Indiana focuses on the payments, prices, and utilization of workers' compensation medical care. It examines medical services in Indiana compared with 17 other states overall, by type of provider, and by type of medical service. The study also analyzes how various system performance metrics have changed over time from 2014 to 2019, with claims evaluated as of 2020. In some cases, we use a longer time frame to supply historical context.

Note that the results we report include experience on claims through March 2020, at the very beginning of the coronavirus (COVID-19) pandemic. The study, therefore, provides a pre-COVID-19 baseline for evaluating the impact of the virus on workers' compensation claims.[1]

MEDICAL PAYMENTS PER CLAIM HIGHER THAN TYPICAL, MOSTLY DUE TO HIGHER PRICES

The average medical payment per claim in Indiana was higher than the 18-state median, for claims with more than seven days of lost time at all maturities. Higher-than-typical prices paid were the main reason for the higher medical payments per claim. Prices paid for nonhospital (professional) services in Indiana were among the highest of 36 states, along with the other states that did not regulate reimbursement through a fee schedule.[2] Prices paid were higher than typical for all nonhospital services.

Facilities, particularly ambulatory surgery centers (ASCs), also contributed to the higher-than-typical medical payments per claim in Indiana. The average ASC facility payment per claim in Indiana was among the highest of the 18 states, and the percentage of claims with facility payments was higher than typical in Indiana for both ASCs and hospital outpatient departments. That result is likely related to the higher surgery rate in the state, at all claim maturities.

Hospital payments per claim, overall and for inpatient and outpatient services, were fairly typical in Indiana. Hospital payments per claim were among the highest of the study states prior to the implementation of the hospital fee schedule effective July 1, 2014.

One aspect of utilization, the number of visits per claim, was typical in Indiana for many types of nonhospital and hospital outpatient services when compared with the median study state.

MEDICAL PAYMENTS PER CLAIM INCREASED 13 PERCENT IN 2019 AFTER MODERATE GROWTH IN PRIOR YEARS; MAIN DRIVERS WERE PAYMENTS FOR ASCS, INPATIENT EPISODES, AND PT/OTS

Several factors affected the trends in medical payments per claim in Indiana since 2014: the introduction of the hospital fee schedule in 2014 and continuous growth in prices paid for professional services, payments to ASCs,[3] and payments to physical/occupational therapists (PT/OTs). In 2019, total medical payments per claim increased 13 percent in Indiana, which was faster than the 4 percent per year growth between 2015 and 2018.

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[1] Other WCRI research focuses on the early impact of the virus on the composition of claims and their costs, how the virus may have affected the delivery of care to workers, and the impact of that on worker and claims outcomes, including duration of disability.

[2] *WCRI Medical Price Index for Workers' Compensation, 13th Edition* (Yang and Fomenko, 2021). The other states with no medical fee schedules for professional services are Iowa, Missouri, New Hampshire, New Jersey, and Wisconsin.

[3] At the center of the recent policy debate in Indiana has been whether to regulate payments to ASCs and at what percentage over Medicare.

The largest contributors to the 2019 growth were payments to ASCs, hospital inpatient providers, and PT/OTs.

The average ASC facility payment per claim increased at a steady rate of 7 percent per year between 2014 and 2018; it grew 14 percent in 2019. Payments to ASCs in Indiana are based on the 80th percentile of charges for similar services in the same community. Payments per claim to ASCs grew faster in Indiana than in most study states between 2014 and 2019. In addition, in Indiana there was a 1 percentage point increase in the proportion of claims with ASC services and major surgery (performed in any facility). This trend was different from the trend observed in most study states—a steady decrease in the proportion of claims with major surgery and ASC services.

An increase in hospital payments per inpatient episode also contributed to the overall growth in medical payments in Indiana in 2019. The average hospital payment per inpatient episode increased 14 percent. Note that in some prior years Indiana also experienced large growth in hospital payments per inpatient episode. Given the smaller numbers of claims receiving inpatient care, inpatient measures can show large annual fluctuations, especially at 12 months of maturity. In examining the underlying mix of injuries, we found that 2019 was fairly unusual, with high-cost episodes for many injury types, when compared with 2018. Changes in the underling mix of injuries and their clinical severity likely explain the 2019 growth in Indiana hospital inpatient payments.

The average payment per claim to PT/OTs continued to increase in Indiana—7 percent in 2019, after 9 percent per year growth between 2014 and 2018. The growth was driven by a combination of factors: growth in prices paid (3 percent per year) and growth in the number of visits per claim (5 percent per year, which translates into one more visit per claim each year). The growth in prices paid in Indiana was similar to other states with no medical fee schedule. The average PT/OT payment per claim grew in many study states; both prices and utilization contributed. The growth in Indiana was faster than in most study states.

PRESCRIPTION DRUG PAYMENTS PER CLAIM WERE LOWER THAN IN OTHER STATES; PRICE AND UTILIZATION DECREASES SINCE 2014

Prescription drugs include medications dispensed by pharmacies and physicians, not hospitals. The average prescription payment per claim was lower in Indiana than the 18-state median, resulting from lower payments per prescription. The average number of prescriptions per claim and the proportion of claims with prescriptions were typical in Indiana. For the most part, Indiana does not regulate reimbursement for prescription drugs through a fee schedule. In 2019, Indiana adopted a drug formulary for both new and old prescriptions with effective dates of January 1, 2019, for new prescriptions, and January 1, 2020, for old prescriptions.

Between 2014 and 2019 (at 12 months), the average payment per prescription in Indiana decreased 1 percent per year, the number of prescriptions per claim decreased 5 percent per year, and the proportion of claims with prescriptions decreased (13 percentage points, cumulative). The combined effect of those changes was a decrease of 6 percent annually in the average prescription payment per claim. The magnitudes of Indiana's recent changes were similar to changes observed in most study states.

See details in the section "Discussion of Major Findings."

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This is the 22nd edition of an annual series of analyses that benchmarks the performance of the Indiana workers' compensation system. This study focuses on the costs, prices, and utilization of medical care received by workers with injuries. It examines these medical services in the aggregate, by type of provider and type of medical service. Related Workers Compensation Research Institute (WCRI) studies benchmark state fee schedules and worker outcomes. A companion study to this annual series benchmarks income benefits, claim costs, use of different types of benefits, litigiousness, timeliness of payment, etc. (CompScope™ Benchmarks, 2021). This annual series focuses on the performance of the workers' compensation benefit delivery system and does not address insurance markets, pricing, or regulation.

The unit of analysis in the CompScope™ benchmarking series is the individual workers' compensation claim, so most results are reported on a per claim basis. Therefore, changes in claim frequency do not directly factor into the measures we report. We do, however, discuss the percentage of claims with a particular service or provider when appropriate.

These benchmarks provide dual perspectives:

- How the Indiana system performance metrics have changed over time (trends), using claims that arose between October 2013 and September 2019, usually with an average of 12, 24, and 36 months of experience; and
- How Indiana compares with other states—specifically with 17 other mostly large states that were selected because they are geographically diverse, represent a variety of system features, and represent the range of states that are higher, medium, and lower on costs per claim. The average medical payment per claim in the median state in this group is similar to the median among all U.S. states (see the supporting materials).

HOW TO USE THIS BENCHMARKING REPORT

The format of this edition of the CompScope™ Medical Benchmarks study is designed to make the findings easily accessible while providing a rich and detailed set of benchmarks for those who want to drill down beneath the major findings.

- For those who want to get quickly to the bottom line, there is a short narrative summary of major findings and a slide presentation on major findings. The slides provide explanatory figures and charts, along with interactive links to the more detailed figures and tables that underlie the highlighted major findings.
- For those who want to drill down on a specific issue, the narrative summary and slide presentation both have links from each finding or slide to the underlying detailed tables and graphs.[1] In addition, we provide a narrative discussion of major findings and a separate slide presentation on other key findings

[1] Readers using a paper copy of the report can manually drill down and locate the underlying graphs and tables supporting the narrative summary or a presentation slide.

and supplemental material.

- For those who are not familiar with the CompScope™ benchmarking studies, there is an "Information for First-Time Users" section in the supporting materials to provide detail about the key benchmarks we analyze, the data we use and the adjustments we make to those data, and some presentational explanations.
- For those seeking a wide-ranging reference book to address the questions of interest, there are many detailed tables and graphs that are available for browsing or that may be accessed through links in the "Quick Reference Guide to Figures and Tables."
- For those who are interested in the medical management approaches used in each state, Tables 5 and 6 summarize the medical cost containment strategies in place in 2021.
- The glossary and list of common abbreviations help readers navigate this report. The references include other WCRI studies of interest for the audience in Indiana.
- The data and methods are fully described in the *Technical Appendix*. The following sub-section contains a short summary of the data and methods, with more explanation provided in the supporting materials.

Note: Each page of this report contains a "Back to Previous View" button that allows the reader to click on a link to another section and then return to the original page, eliminating the need for bookmarking. However, when a link goes to an external document, a separate window opens; the reader can go back to the original window to see the previous view.

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DATA AND METHODS

This analysis uses data from data sources that include national and regional insurers, claims administration organizations, state funds, and self-insured employers. The data are collected in the Detailed Benchmark/Evaluation (DBE) database, which presently includes about 7 million claims that are reasonably representative of the entire system in each of the 18 states, including all market segments: self-insurance, residual market, voluntary insurance, and state funds. These data include 53 percent of Indiana indemnity claims in 2019 evaluated in 2020 (40 to 70 percent of the claims from each state).

We used a variety of techniques to increase the comparability of the measures from state to state, including (1) standardizing definitions of variables that state regulators might have defined differently from state to state, (2) standardizing the reporting on cases with more than seven days of lost time to control for differences in state waiting periods for income benefits, and (3) adjusting for interstate differences in injury and industry mix.[2] The interstate differences in the performance measures presented in this report, therefore, should largely reflect variations in system features and/or in the practices and behavior of system participants.

The analytic framework in this study views medical payments per claim as a function of price and utilization. That is, medical payments per claim are equal to the price of a medical service multiplied by the number of times that service was provided. Changes in medical payments per claim are driven by changes in prices and/or changes in utilization of services. In the CompScope™ Medical Benchmarks study, all medical services are grouped by provider type and by service type. For more details, refer to the *Technical Appendix*.

[2] The trend analysis in this report is not adjusted for the interstate differences in injury and industry mix, as the unadjusted measures provide the most relevant information on how the system performance changed in each state over time.

INTRODUCTION TO MAJOR FINDINGS SLIDES

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The following pages present a slide discussion of *CompScope™ Medical Benchmarks for Indiana, 22nd Edition.* The slides highlight the major findings discussed in the "Summary of Major Findings" section and provide explanatory figures and charts. Notation on the bottom of the slides specifies the injury year and the maturity of the data shown, as applicable. The notes to the right of some slides provide additional technical or substantive information pertinent to that slide. For example, the notes might contain links to external summaries of legislation or workers' compensation agency reports, a reference to a related figure or table, or an explanation of a relevant workers' compensation system feature. References to source information and definitions of key terms or abbreviations are located below the slide to which they apply. To view the notes, references, and/or definitions, the document magnification on your computer may need to be set at 100 percent or lower. Please note that the slides are also interactive, linking to other areas of this report where useful. For example, bar charts generally link to the box plot figures that contain the numbers underlying the chart. Links are indicated by underlining.

When describing the performance of a state in this report, we generally use the criteria and key terms in the chart below. Words used to describe an increase include *growth* and *rise*. Words used to describe a decrease include *fall*, *drop*, and *decline*. For some measures, such as those based on percentages of payments and percentages of claims, often specific numeric criteria are not used to apply the characterization of a state's value relative to the median, as the distributions of states' values on different percentage measures are often subject to different degrees of variation. Instead, we apply the characterization by reviewing where each state's value falls relative to other states in the overall distribution. A characterization is assigned after taking into consideration the magnitude of the values, the range and clusters of states' values, and the homogeneity or heterogeneity of the overall distribution.

Key to Terms Used in Report

Multistate Values	**Comparison with Median State**	
Higher	More than 10 percent above median	
Lower	More than 10 percent below median	
Typical or close to	Within 10 percent above or below median	
Trends	**Change in Cost Measures (annual average percentage)**	**Change in Frequency Measures (annual average percentage points)**
Very rapid increase	+9% and higher	+4 points and higher
Rapid increase	+6% to 8.9%	+2 to 3.9 points
Moderate increase	+3% to 5.9%	+1 to 1.9 points
Flat, little change	+2.9% to -2.9%	+0.9 to -0.9 points
Moderate decrease	-3% to -5.9%	-1 to -1.9 points
Rapid decrease	-6% to -8.9%	-2 to -3.9 points
Very rapid decrease	-9% and lower	-4 points and lower

The thresholds in the multistate comparison above were chosen because a data point 10 percent above or below the median *usually, but not always*, indicates that the data point is notably different from the median. There are two exceptions. Sometimes the median state is part of a cluster of states with similar values that are all higher or lower than the remaining states. In that case, we describe a report state as being in the *higher*, *lower*, or *middle* group based on its cluster, not its relation to the median. In other cases, the range of states includes very different values, and even a state near the median differs from it by 10 percent or more. In that case, we would call that state *fairly typical* despite the criteria in the table. Review of the box plots may help resolve any confusion.

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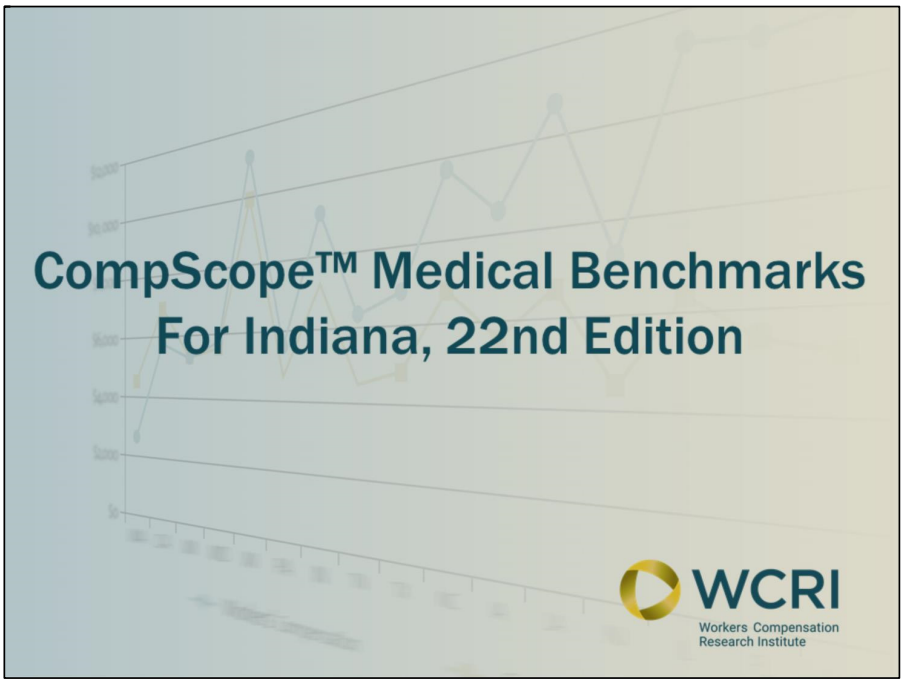

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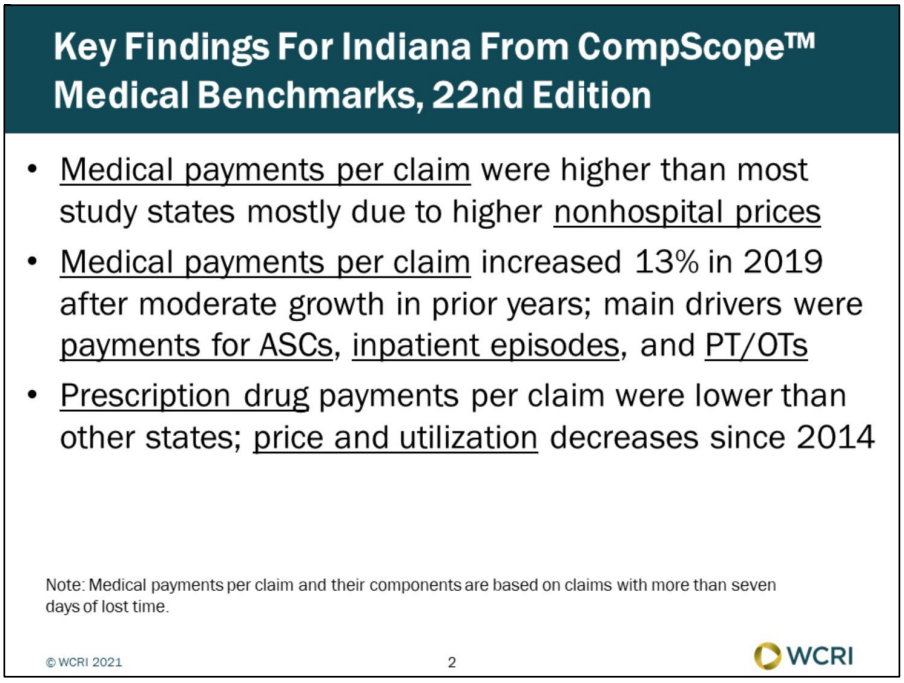


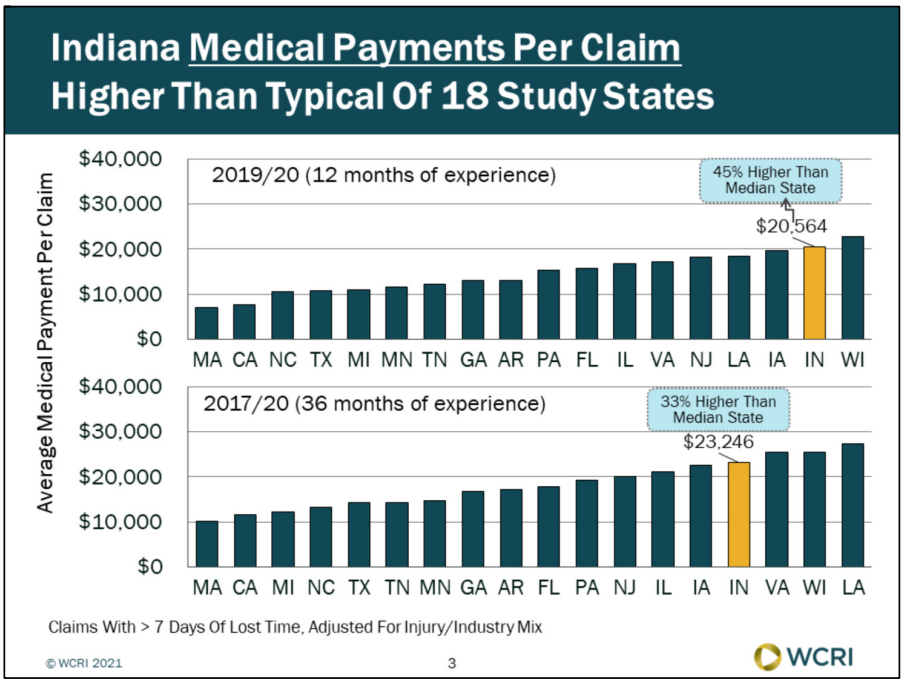
This 22nd edition of CompScope™ Medical Benchmarks for Indiana analyzes claims with experience through March 2020 for injuries up to and including 2019. In some cases, we report a longer time frame to supply historical context for key metrics.

For interstate comparisons, the components of medical payments per claim are calculated using claims with more than seven days of lost time at 12–36 months of maturity, adjusted for injury and industry mix of workers. The *Technical Appendix* provides a detailed description of how this is done.

We focus our analysis on claims with more than seven days of lost time because these claims account for the majority of workers' compensation payments in each state.

Key and definitions: **ASC:** Ambulatory surgery center. **Medical payments:** See Slide 3. **Prescription drugs:** See Slide 32. **Prices paid:** See Slide 9. **PT/OT:** Physical/occupational therapist. **Utilization:** See Slide 7.

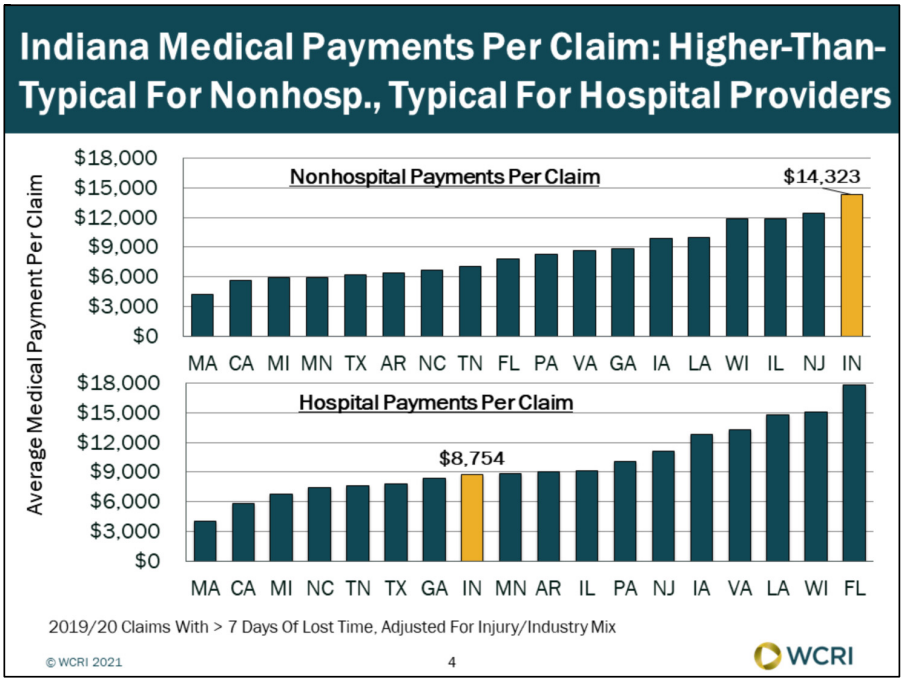
Notes: The terms *typical* and *median study state* are used interchangeably in this study. See the criteria for the characterization of state performance used in this report.
The terms *experience* and *maturity* are used interchangeably in this study.
The term *most* is used to describe more than half; the term *many* is used to describe more than just a few.



Medical payments per claim were higher than typical in Indiana mainly due to prices paid for medical services. Indiana does not regulate prices paid for professional services and ASCs. However, Indiana has a hospital fee schedule.

House Enrolled Act 1320, signed into law by the governor on May 11, 2013, established a hospital fee schedule with reimbursement set at 200 percent of Medicare. The hospital fee schedule became effective for services on or after July 1, 2014.

Key: **ASC:** Ambulatory surgery center. **Injury year/evaluation year:** See Naming Convention for Analysis Sets of Claims. **Medical payments:** Payments for all medical services delivered to workers with injuries. Included are services provided by physicians, physical/occupational therapists, chiropractors, and hospital outpatient and inpatient facilities. Included are only services for which payments were made. Medical payments reflect both price and utilization of services. Payments for medical bill review, case management, utilization review, and preferred provider networks are reported under a separate category—medical cost containment expenses per claim, published in *CompScope™ Benchmarks for Indiana, 21st Edition*. Lump-sum settlements for future medical treatments are reported as indemnity payments in all study states.



Medical payments per claim in Indiana reflect a combination of higher-than-typical payments per claim for nonhospital services and typical payments for hospital services (both inpatient and outpatient).

Medical payments per claim for nonhospital services in Indiana were the highest of the study states for 2019/20 claims. Higher prices paid were the main contributing factor to higher nonhospital payments per claim.

For hospital services, Indiana was typical of study states for both inpatient and outpatient services.

Key and definitions: **Hospital:** Trauma centers and inpatient and outpatient treatment facilities.
Nonhospital (nonhosp.): Combines mainly payments to physicians, PT/OTs, and chiropractors.
Physicians: Surgeons, general practitioners, radiologists, family practice physicians, psychiatrists, and other recognized medical doctors such as doctors of osteopathic medicine. Ambulatory surgery centers are included in the physician category (unless the billing is done through a hospital).
PT/OT: Physical/occupational therapist; payments to PT/OTs are for all services they provide and bill (whether or not the services are considered physical medicine services).

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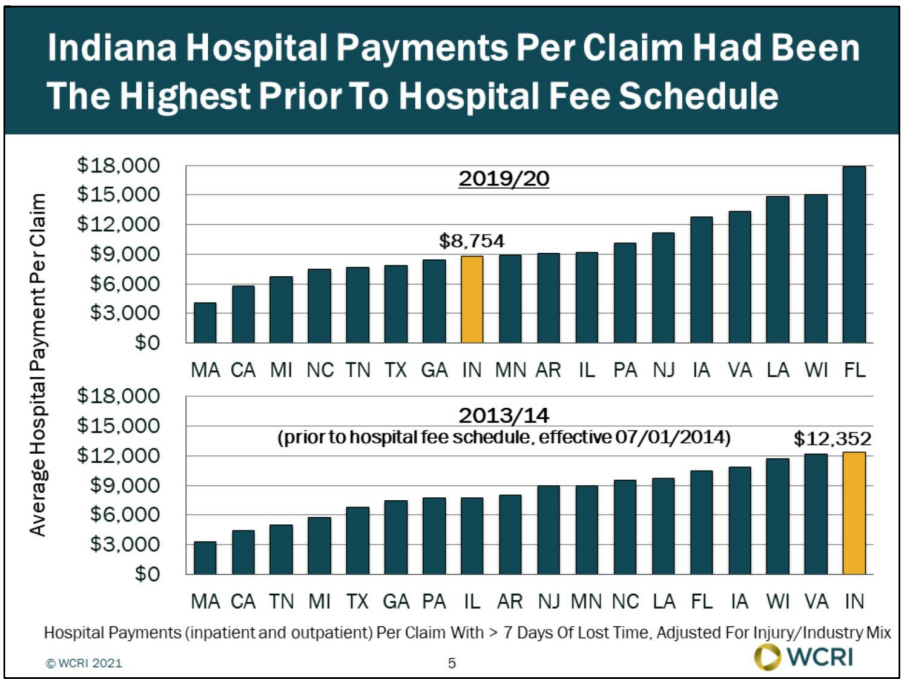
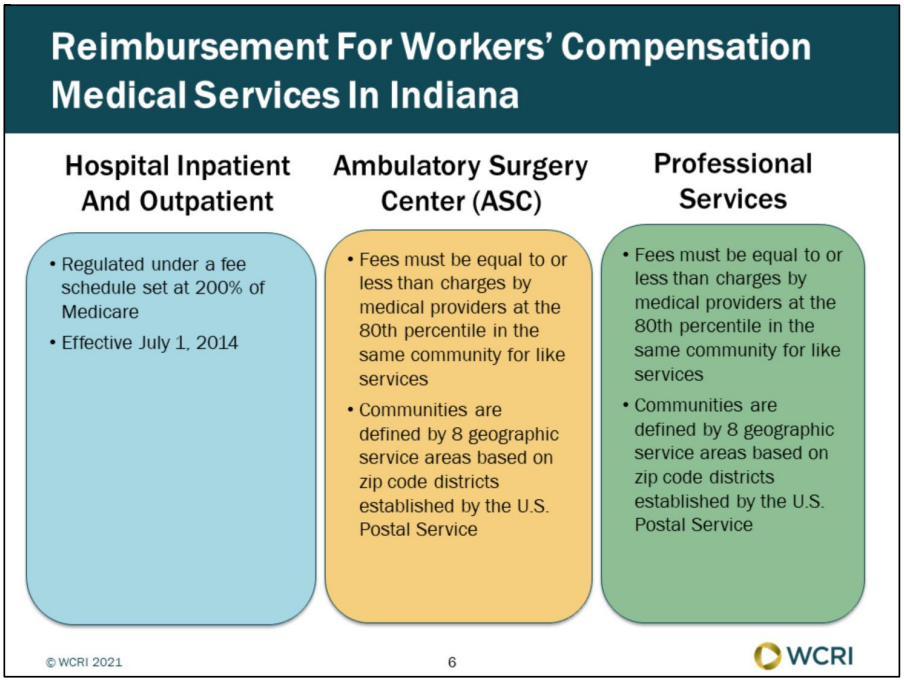


Prior to the introduction of the hospital fee schedule, the average hospital payment per claim was the highest in Indiana of all the study states. The shift in the multistate ranking for Indiana from higher to typical was similar for hospital inpatient and outpatient services (for comparisons, see *CompScope™ Medical Benchmarks for Indiana, 21st Edition*).

The study states that do not regulate reimbursement for hospital services are Iowa, New Jersey, and Wisconsin. Virginia adopted a fee schedule for all medical services effective January 1, 2018.



Key: **ASC:** Ambulatory surgery center.

Indiana enacted a hospital fee schedule effective July 1, 2014, with reimbursement set at 200 percent of Medicare. Prior to that change, reimbursement was not regulated through a fee schedule.

Fees for medical services in a defined community must be equal to or less than charges by medical providers at the 80th percentile in the same community for like services. Communities are defined by eight geographic service areas based on zip code districts established by the U.S. Postal Service (IC 22-3-3-5). This method applies to ASC services and professional (nonhospital) services, and applied to hospital services prior to the adoption of the fee schedule.

Indiana is unusual among states in adopting a fee schedule applicable to medical services for hospitals only. States that enact workers' compensation fee schedules typically regulate reimbursement for all medical services.

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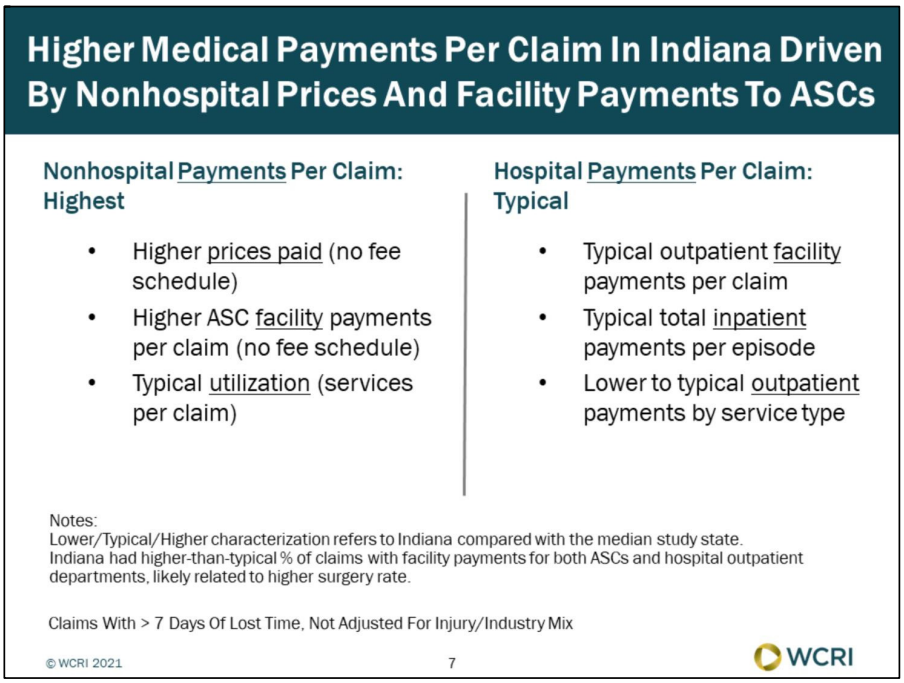
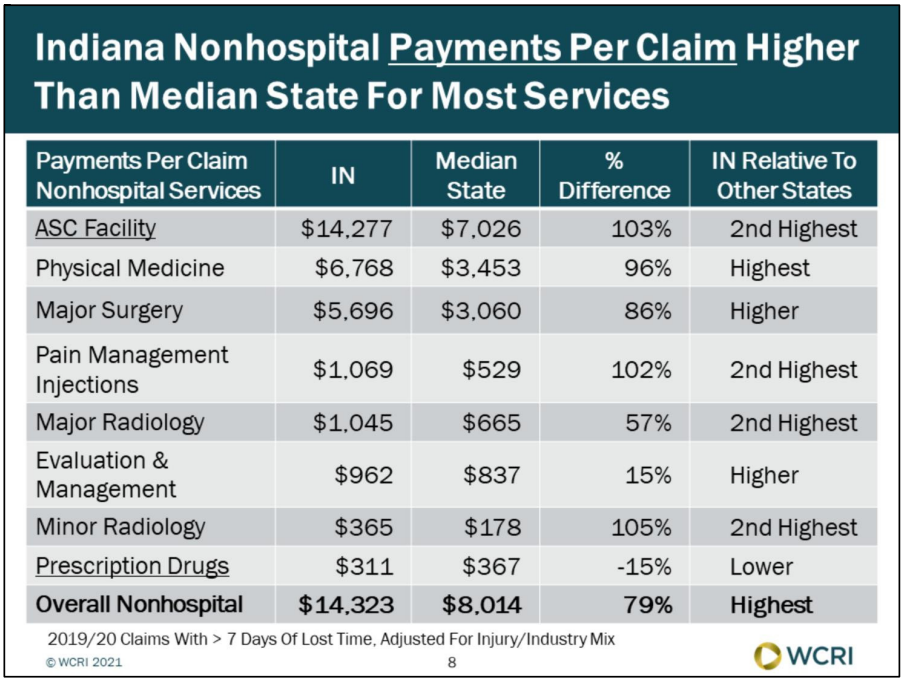


Key and definitions: **ASC:** Ambulatory surgery center. **Facility:** See Slide 12. **Hospital inpatient payments:** Payments made to a hospital for all services related to an inpatient stay. Payments made for professional services are not included if billed separately. **Utilization** or **services per claim:** Combination of number of visits per claim and number of services per visit.



Key and definitions: **ASC:** Ambulatory surgery center. ASC facility payments are for treatment/operating/recovery room services and miscellaneous ambulatory surgical care. ASCs are included in the physician category (unless the billing is done through a hospital). **Evaluation and management:** Office visits. **Major radiology:** Computed tomography (CT) scans and magnetic resonance imaging (MRI). **Major surgery:** See the definition on Slide 10. **Minor radiology:** X rays and ultrasounds. **Pain management injections:** Epidural or steroid injections on nerve roots and muscles for lumbar, sacral, cervical, or thoracic areas. **Physical medicine:** Physical medicine and chiropractic care. **Prescription drugs:** See the definition on Slide 32.

The next slides are related to prices paid and utilization of services. Before discussing those two particular aspects of medical costs, here we show payments per claim by type of service for nonhospital services.

Most types of nonhospital services had higher-than-typical payments per claim in Indiana relative to the median study state. The only exception was prescription drugs, which had lower-than-typical payments per claim.

See Figures 10 and 11 for the percentage of claims and percentage of medical payments made for each service type.

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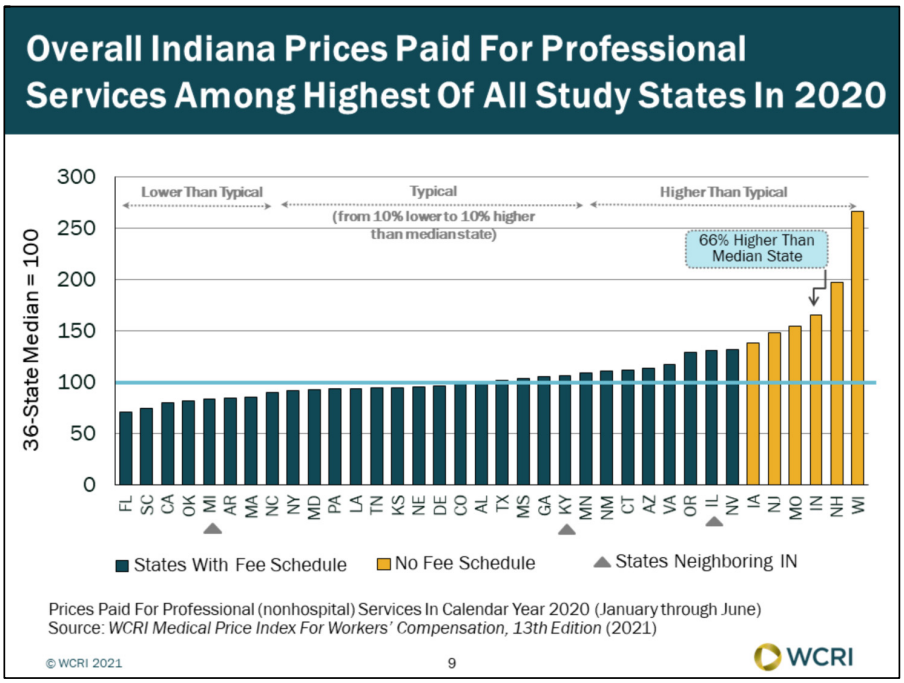


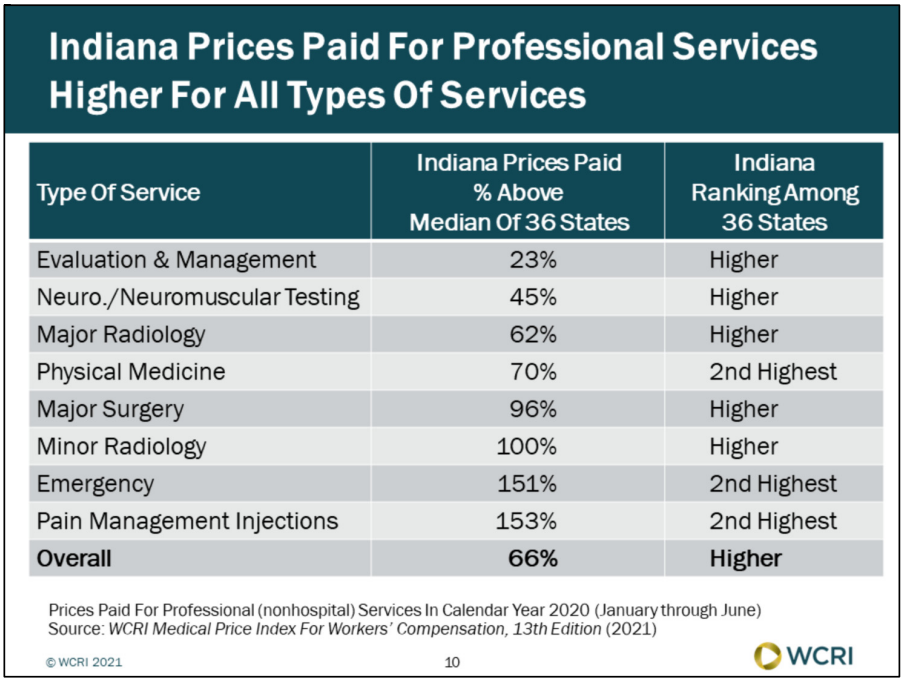
This slide compares prices paid for professional services in each state with the median state (designated by the solid line at 100) in 2020. Prices paid include network discounts and other price negotiations between the payors and medical providers.

Overall prices paid for professional services in Indiana were 66 percent higher than the median study state. Of the states neighboring Indiana, Illinois had higher prices paid, Kentucky had typical prices paid, and Michigan had lower prices paid than the median study state. Ohio was not included in the study.

Among the 36 states, Indiana (along with Iowa, Missouri, New Hampshire, New Jersey, and Wisconsin) does not regulate reimbursement for medical services through a fee schedule. Virginia adopted a fee schedule effective January 1, 2018.

Key and definitions: **Price index for professional (nonhospital) services:** Measures the unit prices paid holding utilization constant. It is based on a marketbasket of common medical procedures used in workers' compensation cases, using detailed Current Procedural Terminology (CPT®) billing codes (CPT® is a registered trademark of the American Medical Association). Prices paid are based on all claims, i.e., claims with more than seven days of lost time and medical-only claims. Prices paid reflect network discounts and other price negotiations between the payors and medical providers. Price information includes services in and out of health care networks. Prices paid do not include facility fees and prices for prescription drugs paid to pharmacies. **Professional services:** Nonhospital services billed by physicians, physical therapists, and chiropractors, excluding bills for ambulatory surgery center facilities, durable medical equipment, or pharmaceuticals.

Source: Yang and Fomenko. 2021. *WCRI Medical Price Index for Workers' Compensation, 13th Edition (MPI-WC).*



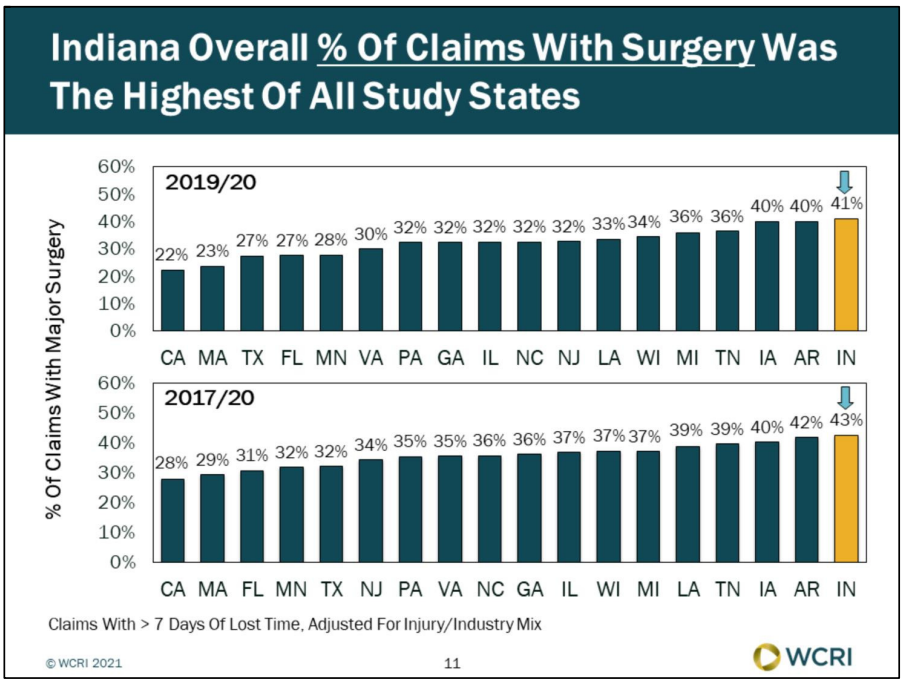
Type Of Service	Indiana Prices Paid % Above Median Of 36 States	Indiana Ranking Among 36 States
Evaluation & Management	23%	Higher
Neuro./Neuromuscular Testing	45%	Higher
Major Radiology	62%	Higher
Physical Medicine	70%	2nd Highest
Major Surgery	96%	Higher
Minor Radiology	100%	Higher
Emergency	151%	2nd Highest
Pain Management Injections	153%	2nd Highest
Overall	**66%**	**Higher**

Prices paid were higher in Indiana than in other states for frequently used services in workers' compensation.

In Indiana most services were provided in networks, and stakeholders suggested that prices paid likely reflect the network agreements for these types of services.

Key and definitions: **Evaluation and management:** Office visits. **Emergency:** Emergency department visits. **Major radiology:** Computed tomography (CT) scans and magnetic resonance imaging (MRI). **Major surgery:** A subset of the surgery section of the Current Procedural Terminology (CPT) manual. It includes invasive surgical procedures, as opposed to surgical treatments and pain management injections. Common surgeries include knee and shoulder arthroscopies, laminectomies, laminotomies, lumbar fusion, discectomies, carpal tunnel, and hernia repair. See Table TA.2 in the *Technical Appendix*. **Minor radiology:** X rays and ultrasounds. **Neuro.:** Neurological. **Pain management injections:** Epidural or steroid injections on nerve roots and muscles for lumbar, sacral, cervical, or thoracic areas. **Physical medicine:** Physical medicine and chiropractic care. Includes procedures and modalities, such as exercises to develop flexibility, activities to improve function, and application of electrical stimulation.

Source: Yang and Fomenko. 2021. *WCRI Medical Price Index for Workers' Compensation, 13th Edition (MPI-WC).*



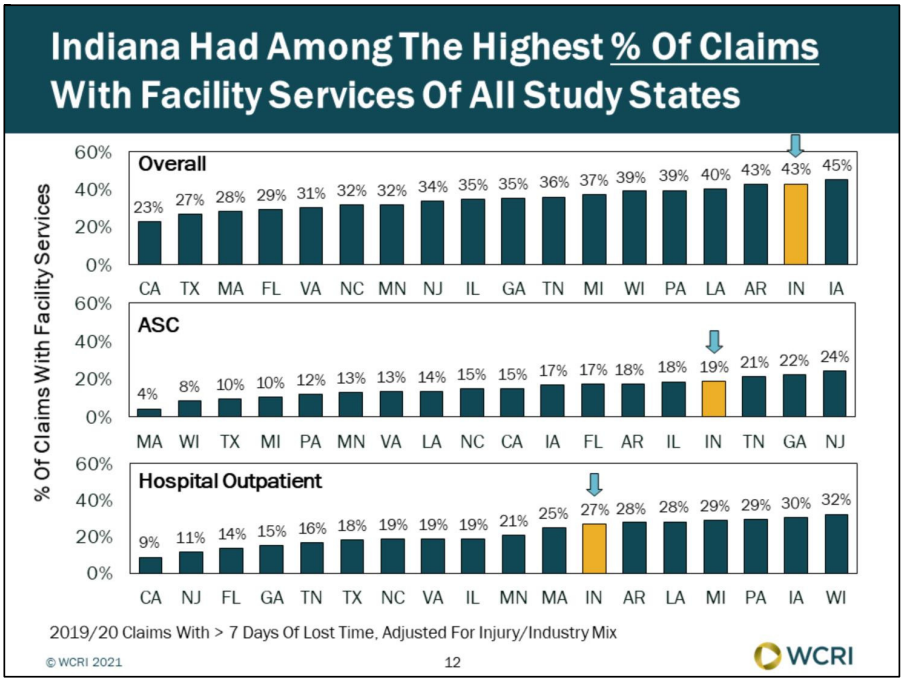
Indiana had the highest percentage of claims with major surgery for all claim maturities compared with other study states.

When injury type and surgery type were held constant among the study states, Indiana had the highest percentage of low back claims with lumbar spine surgeries (Yang and Lea, 2020).

See the "Discussion of Major Findings" for factors affecting the surgery rates.

Definition: **Major surgery:** A subset of the surgery section of the Current Procedural Terminology (CPT) manual. Includes invasive surgical procedures, as opposed to surgical treatments and pain management injections. Common surgeries include knee and shoulder arthroscopic, laminectomies, laminotomies, lumbar fusion, discectomies, carpal tunnel, and hernia repair. See Table TA.2 in the *Technical Appendix*. The terms *surgery* and *major surgery* are used interchangeably in this study to describe invasive surgical procedures.

Note: Surgery rate and *percentage of claims with major surgery* are used interchangeably in this study. There is a slight difference between the percentage of claims with major surgery on this slide and Figure 10. The base on this slide is all types of providers, while the information on Figure 10 is based on nonhospital providers.



In contrast to previous slides where the focus was on percentage of claims with major surgery, here we show the proportion of claims with facility services associated with surgical procedures.

Indiana had a higher percentage of claims with facility services for procedures performed in both ASCs and hospital outpatient departments. This is likely related to the higher percentage of claims with major surgery.

Note that the overall percentage of claims with facility services reflects claims that had at least one service provided in an ASC, hospital outpatient department, or both.

Key: **ASC:** Ambulatory surgery center. **Facility:** Services performed in hospital outpatient and ASC settings mainly related to surgical procedures. Include payments for treatment/operating/recovery room services and miscellaneous ambulatory surgical care. The facility payments in CompScope™ Medical Benchmarks are for all types of major surgeries (see Table TA. 2) and may also include payments for pain management injections, emergency department services, and other minor surgical procedures. Payments for anesthesia, drugs, supplies, and professional services are not included in facility payments if billed separately.

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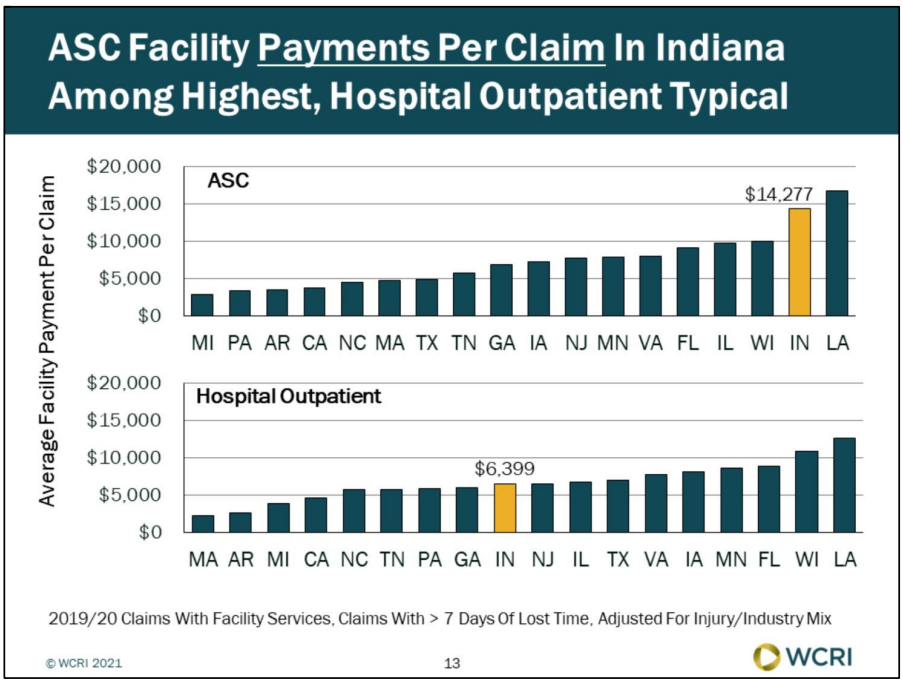


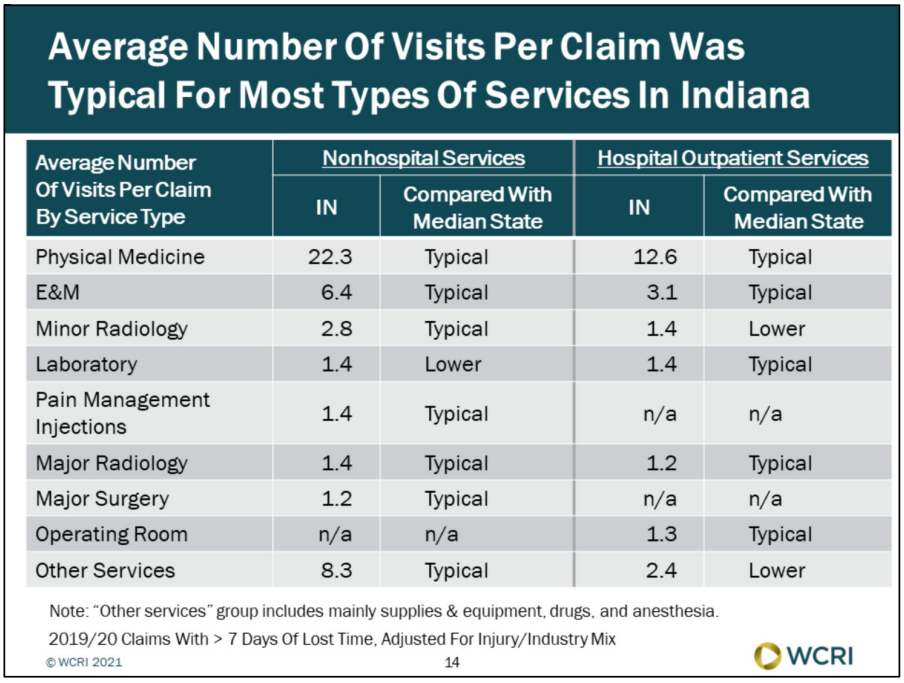
When a surgical procedure was performed, facility payments per claim to ASCs were among the highest of the study states while payments to hospital outpatient departments were fairly typical (see comparisons at 36 months).

Indiana does not have specific fee regulations for payments to ASCs. Typically, payments for surgeries would reflect charges for these services. If payors have network agreements with providers, payments for surgeries may reflect discounts from the charges or rates that were negotiated between payors and providers.

Facility Services, 2017/20		IN	Median State
% Of Claims	All Facilities	47%	40%
	ASC	20%	18%
	Hospital Outpatient	31%	24%
Average Payment Per Claim	All Facilities	$9,319	$7,441
	ASC	$14,147	$7,791
	Hospital Outpatient	$6,125	$6,539

Key: **ASC:** Ambulatory surgery center.

Note: The global nature of ASC payment reimbursement methodology, compared with more itemized billing in hospital outpatient departments, may be a factor in the differences in amounts paid between the two settings by state. For a proper comparison of payments in ASC versus hospital outpatient departments, see Slides 23 and 24, and Table 18.



Indiana had a typical number of visits per claim for most types of services. Utilization for prescription drugs is discussed in a separate section. Indiana had a typical number of prescriptions per claim.

Note that for physical medicine, when we combine the number of visits per claim and services per visit, Indiana was higher than the median study state in 2019/20. However, for claims at 36 months, Indiana was typical.

Key and definitions: **E&M:** Evaluation and management (office visits). **n/a:** Not applicable. **Operating room:** Treatment/operating/recovery room services. **Other services:** Comprises mainly drugs, supplies and equipment, anesthesia, and unknown services. **Physical medicine:** Includes procedures and modalities, such as exercises to develop flexibility, activities to improve function, and application of electrical stimulation. Included are services billed under Current Procedural Terminology (CPT) codes 97*xxx* and/or chiropractic or osteopathic manipulations billed under CPT codes 98*xxx*, regardless of the type of provider billing the codes (physician, physician's assistant, chiropractor, physical or occupational therapist, etc.).

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Key Findings For Indiana From CompScope™ Medical Benchmarks, 22nd Edition

- Medical payments per claim were higher than most study states mostly due to higher nonhospital prices
- ➢ **Medical payments per claim increased 13% in 2019 after moderate growth in prior years; main drivers were payments for ASCs, inpatient episodes, and PT/OTs**
- Prescription drug payments per claim were lower than other states; price and utilization decreases since 2014

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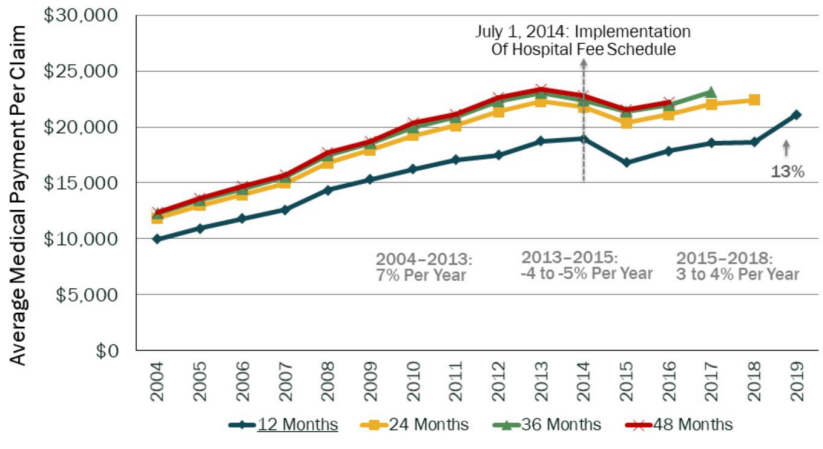
Key: **ASC:** Ambulatory surgery center. **PT/OT:** Physical/occupational therapist.

Faster Growth In Indiana Medical Payments/Claim In 2019 After Moderate Increases In Prior Years



Claims With > 7 Days Of Lost Time, Not Adjusted For Injury/Industry Mix

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Definition: **Medical payments:** Payments for all medical services delivered to workers with injuries. Included are services rendered by physicians, physical/occupational therapists, chiropractors, and hospital outpatient and inpatient facilities.

Note: For claims at 12 months, 2019 refers to injury year/evaluation 2019/20. For claims at 36 months, 2017 refers to injury year/evaluation 2017/20. Other injury year/evaluation combinations are denoted similarly.

Several factors have affected the trends in medical payments per claim in Indiana since 2014.

Medical payments per claim decreased at all claim maturities from 2013 to 2015. Those decreases were related, in large part, to the introduction of the hospital fee schedule, effective for services delivered on or after July 1, 2014.

From 2015 to 2018, however, medical payments per claim resumed growth at 3–4 percent per year. Prior WCRI studies found continuous growth in prices paid for professional and facility services to ambulatory surgery centers. Both are not regulated through a fee schedule.

In 2019, medical payments per claim increased 13 percent. See the next slides.

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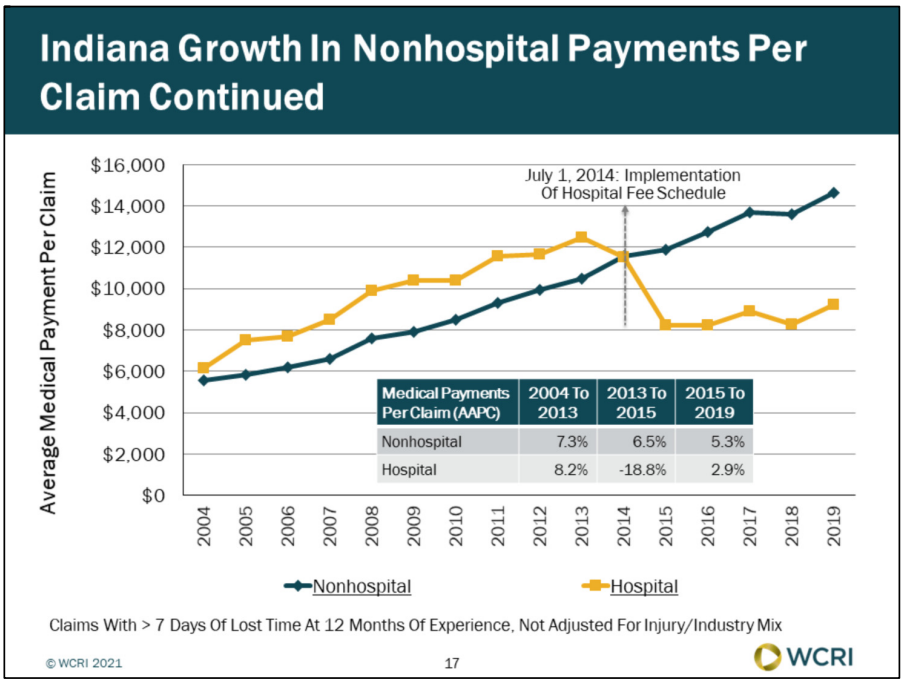
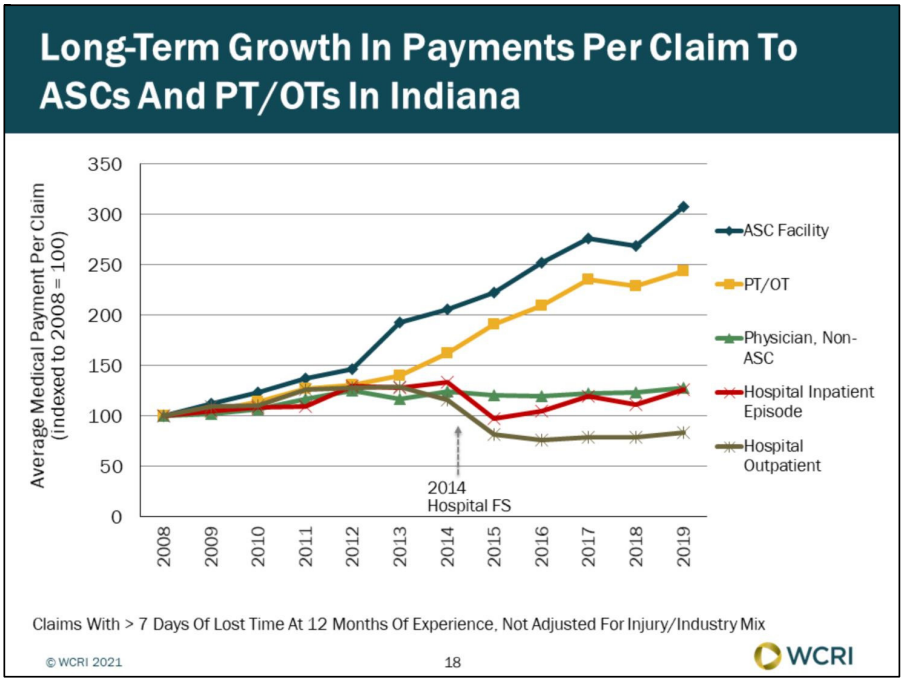


Nonhospital payments per claim continued to increase in Indiana. The rate of growth has been between 5 and 7 percent per year since 2004.

Between 2013 and 2015, payments to hospitals decreased 34 percent (cumulative), after the introduction of the hospital fee schedule in July 2014. After 2015, hospital payments per claim grew on average 3 percent per year. In 2019, the growth was faster than in prior years due to 6 percent growth in hospital outpatient payments per claim and a 14 percent increase in hospital payments per inpatient episode. More details are provided on subsequent slides.

Key and definition: **AAPC:** Annual average percentage change. **Nonhospital:** Providers of nonhospital services include physicians, chiropractors, physical/occupational therapists, pharmacies, suppliers of medical equipment, nurses, psychologists, ambulance/transportation providers, and home health care providers.

Note: 2019 refers to 2019/20. Other injury year/evaluation combinations are denoted similarly.



Over a longer period of time, we identified two main trends in Indiana medical payments per claim. First, continued growth in payments per claim to ASCs and PT/OTs. Second, small changes in payments per claim to physicians and hospital inpatient and outpatient providers.

On the next slides we discuss the main drivers of the 2019 growth in medical payments per claim in Indiana. Some of these drivers also contributed to the medical growth in prior years.

Key: **ASC:** Ambulatory surgery center. **FS:** Fee schedule. **PT/OT:** Physical/occupational therapist.

Note: 2019 refers to 2019/20. Other injury year/evaluation combinations are denoted similarly.

2019 Growth In Indiana Medical Payments Per Claim Driven Mostly By ASCs, Inpatient, & PT/OTs

Payments Per Claim By Provider Type In Indiana	AAPC 2014/15 To 2018/19	% Change 2018/19 To 2019/20
ASC Facility	6.9%	14.5%
Hospital Inpatient Episode	-4.6%	14.0%
PT/OT	9.1%	6.7%
Hospital Outpatient	-9.3%	6.0%
Physician (non-ASC)	-0.1%	3.4%
Total Medical	**-0.4%**	**13.3%**

Note: For hospital services, 2014/15 reflects the introduction of the hospital inpatient and outpatient fee schedules.

Claims With > 7 Days Of Lost Time, Not Adjusted For Injury/Industry Mix

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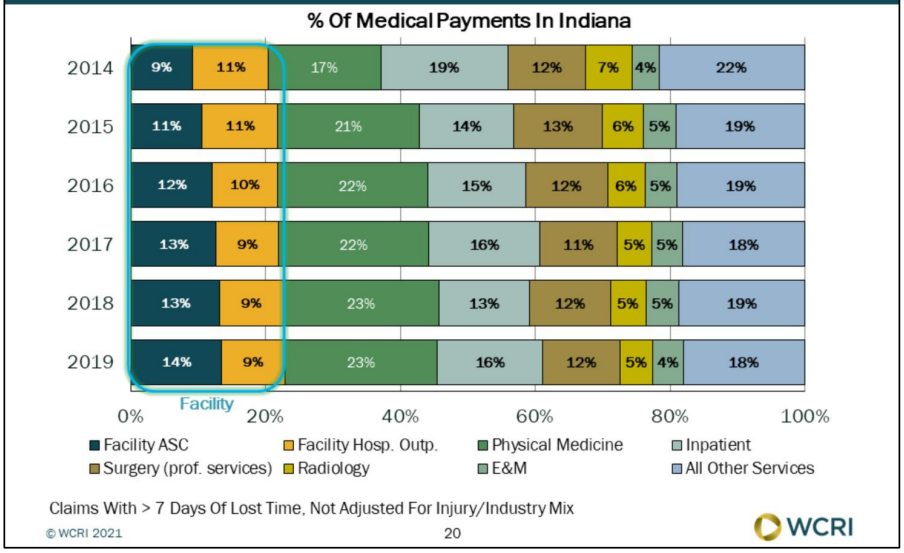
The 13 percent growth in total medical payments per claim in 2019 in Indiana was driven by payments to ASCs, hospital inpatient providers, and PT/OTs. Each of these three categories contributed almost equally to the total medical growth.

Key: **ASC:** Ambulatory surgery center. **PT/OT:** Physical/occupational therapist.

Facility Payments Accounted For Increasing Share In Total Medical Payments In Indiana



Claims With > 7 Days Of Lost Time, Not Adjusted For Injury/Industry Mix

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This slide provides a different perspective on the change in the distribution of medical payments.

Facility payments (along with payments for physical medicine) accounted for an increasing share of total medical payments. The share of facility payments increased from 20 to 23 percent between 2014 and 2019. This was driven by payments to ASCs. The relatively high share of medical payments for facility services may relate to the surgery rate in Indiana, which was the highest of the 18 study states in 2019 (see Slide 11).

When facility and physical medicine are combined, the share of payments increased from 37 to 46 percent.

See how Indiana compares with other study states in Table 24.

Key and definitions: **E&M:** Evaluation and management (office visits). **Facility:** Refers to ambulatory surgery center (ASC) and hospital outpatient facilities. **Inpatient:** Payments made to a hospital for all services related to an inpatient stay. Payments made for professional services are not included if billed separately. **Prof.:** Professional. **Radiology:** Includes minor and major radiology. **Surgery:** Refers to professional payments for surgery.

Note: 2019 refers to 2019/20. Other injury year/evaluation combinations are denoted similarly.

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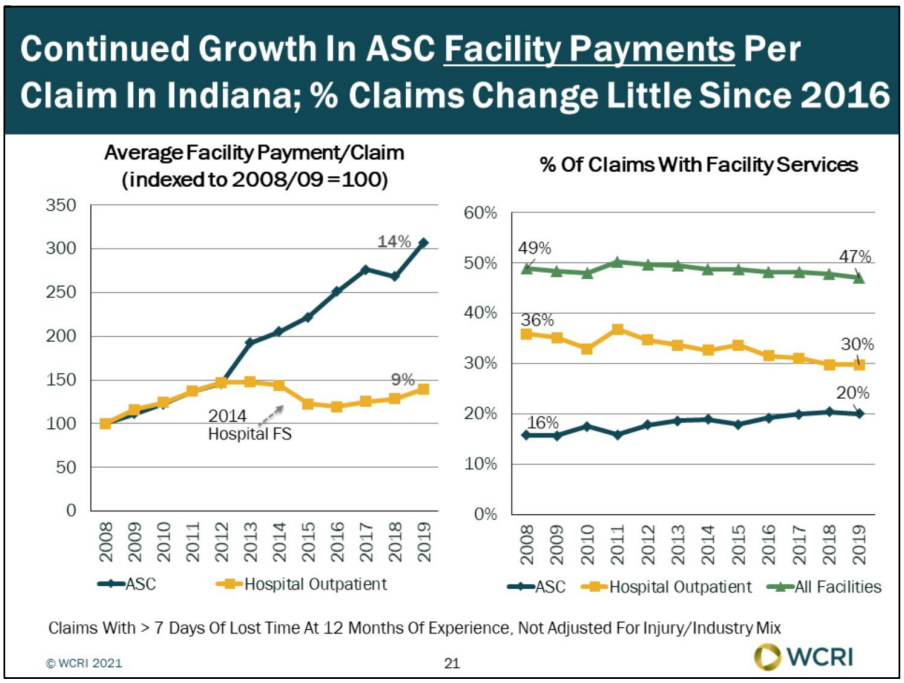


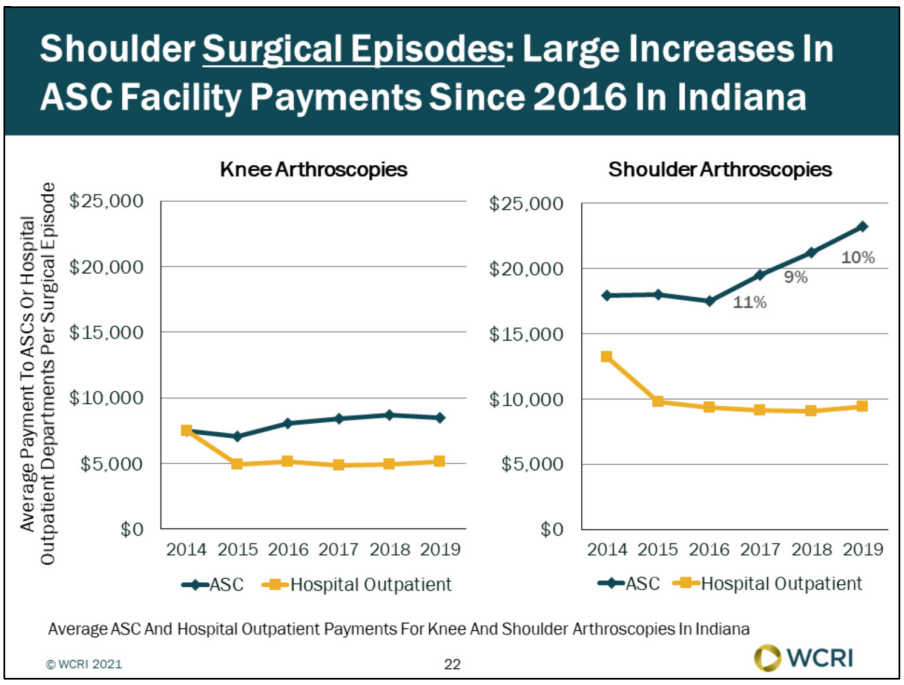
Key and definition: **AAPC:** Annual average percentage change. **ASC:** Ambulatory surgery center. **ASC facility:** Payments to ASCs for both treatment/operating/recovery rooms and miscellaneous ambulatory surgical care, mostly related to surgical procedures. ASCs are identified based on provider coding information. **FS:** Fee schedule. **Hosp. Outp.:** Hospital outpatient.

Note: 2019 refers to 2019/20. Other injury year/evaluation combinations are denoted similarly.

ASC facility payments per claim increased at rapid rates throughout the period from 2008 to 2019. In 2019, ASC facility payments per claim increased 14 percent. Payments to ASCs are not regulated through a fee schedule in Indiana. In contrast, from 2015 to 2018, hospital outpatient facility payments per claim changed little; in 2019, they increased 9 percent. Note that in 2019 the average medical payment for major surgery also increased 6 percent. The combined growth in all surgery-related payments per claim in 2019 may indicate that Indiana experienced a somewhat different mix of injuries or changes in the characteristics of and severity of claims.

Over a longer period of time, the percentage of claims with ASC facility services gradually increased in Indiana, while the proportion of claims with services performed in hospital outpatient departments decreased. There were no material changes in the surgery rate between 2014 and 2019 at 12 months.

AAPC In Payments	2008–2013	2013–2015	2015–2019
ASC	14.0%	7.4%	8.5%
Hosp. Outp.	8.1%	-8.8%	3.3%



Key: **AAPC:** Annual average percentage change. **APC:** Ambulatory payment classification. **ASC:** Ambulatory surgery center. **Hosp. Outp.:** Hospital outpatient.

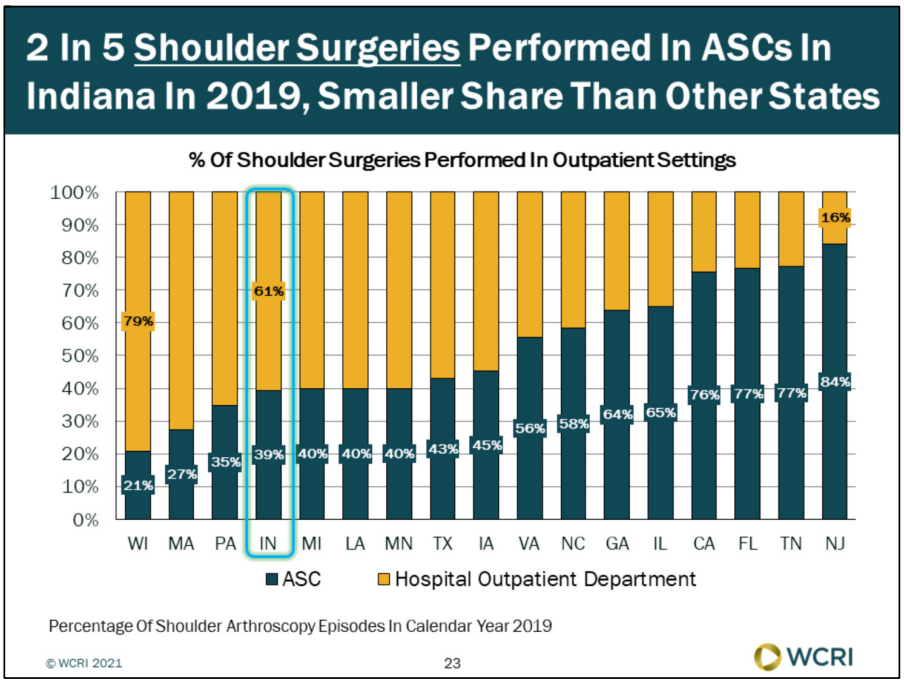
Notes: Knee arthroscopies include surgical episodes with level 1 knee arthroscopies (primary procedure classified as APC code 41 using the 2012 APC definition). Shoulder arthroscopies include surgical episodes with a combination of level 1 and level 2 arthroscopies that were performed as part of the episode (primary and secondary procedures classified as APC code 41 and APC 42 using the 2012 APC definition).

This slide shows the trends in facility payments per surgical episode for the same types of episodes (knee and shoulder) in Indiana.

From 2016 to 2019, the average payment per claim to ASCs increased 9–11 percent per year for shoulder arthroscopies. The median payment per claim also increased at similar rates. This result likely indicates an increase in charges for those types of surgeries. There was no material change in the proportion of claims with shoulder surgeries performed in ASCs between 2014 and 2019.

In contrast, payments to hospital outpatient departments were stable after 2015 for both knee and shoulder surgeries. The decrease in 2014 was largely related to the implementation of the hospital fee schedule, with reimbursement set at 200 percent of Medicare.

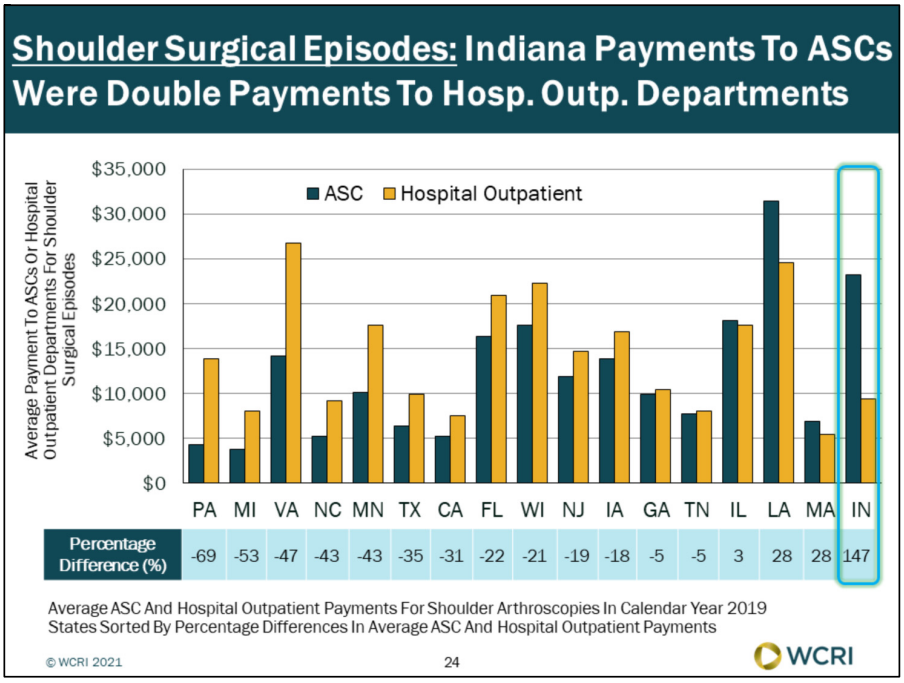
AAPC In Payments Per Surgical Episode In Indiana		2014 To 2015	2015 To 2019
Knee	ASC	-5.8%	4.7%
	Hosp. Outp.	-33.6%	1.0%
Shoulder	ASC	0.1%	6.7%
	Hosp. Outp.	-26.0%	-1.0%



Shoulder surgeries are one of the most common types of surgery in workers' compensation. The percentage of outpatient arthroscopic shoulder surgeries that were performed in ASCs varied from 21 percent in Wisconsin to 84 percent in New Jersey. In Indiana, ASCs performed 39 percent of outpatient arthroscopic shoulder surgeries while hospital departments performed 61 percent. Similar results were observed for knee arthroscopic surgeries (Indiana had 40 percent of surgeries performed in ASCs).

Key: **APC:** Ambulatory payment classification, a payment methodology developed by Medicare to reimburse outpatient hospital and ASC services. The methodology categorizes visits according to clinical characteristics and typical resource use, as well as the costs associated with the diagnoses and procedures performed. **ASC:** Ambulatory surgery center. **Medicare:** Centers for Medicare & Medicaid Services (CMS). **Shoulder arthroscopies:** Include surgical episodes with a combination of level 1 and level 2 arthroscopies that were performed as part of the episode (primary and secondary procedures classified as APC code 41 and APC code 42 using the 2012 APC definition).

Note: Arkansas is excluded from the payments for shoulder surgeries done in both ASCs and hospital outpatient departments because the cell sizes underlying the data are too small to support a meaningful multistate comparison.



In most study states, ASC payments for common shoulder surgeries were at least 5 percent lower than payments to hospital outpatient departments for similar surgeries.

In Indiana, the average ASC payment for shoulder surgeries was more than double the payments for similar common surgeries performed in hospital outpatient settings.

Factors that may contribute to differences in average payments to ASCs and hospital outpatient departments include participation in networks and billing for multiple procedures within a surgical episode.

Key: **APC:** Ambulatory payment classification. **ASC:** Ambulatory surgery center. **Hops. Outp.:** Hospital outpatient.

Notes: Shoulder arthroscopies include surgical episodes with a combination of level 1 and level 2 arthroscopies that were performed as part of the episode (primary and secondary procedures classified as APC code 41 and APC 42 using the 2012 APC definition). Arkansas is excluded from the payments for shoulder surgeries done in both ASCs and hospital outpatient departments because the cell sizes underlying the data are too small to support a meaningful multistate comparison; hence, this state is not shown in this chart.

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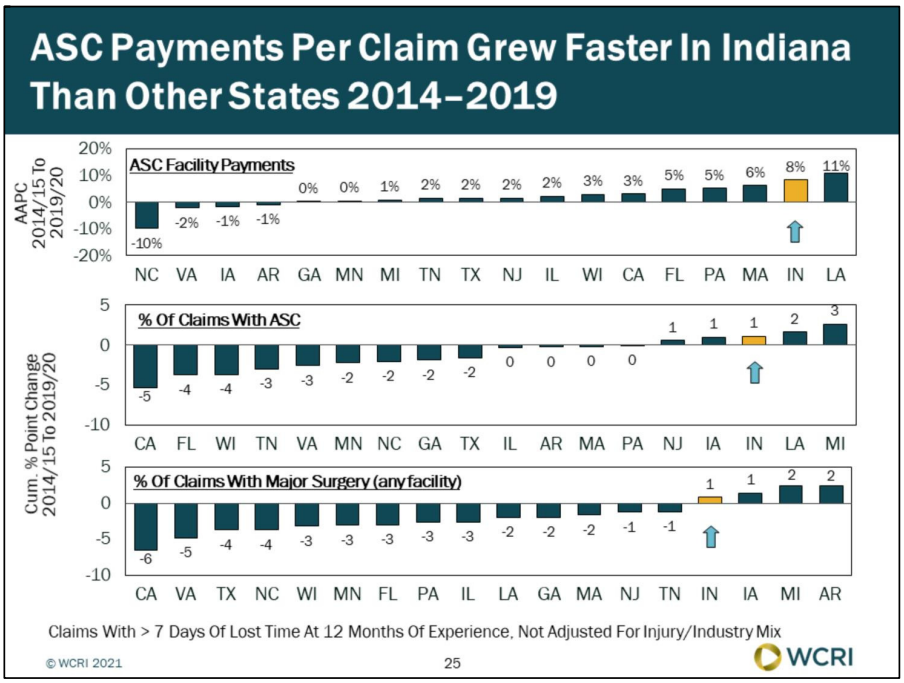
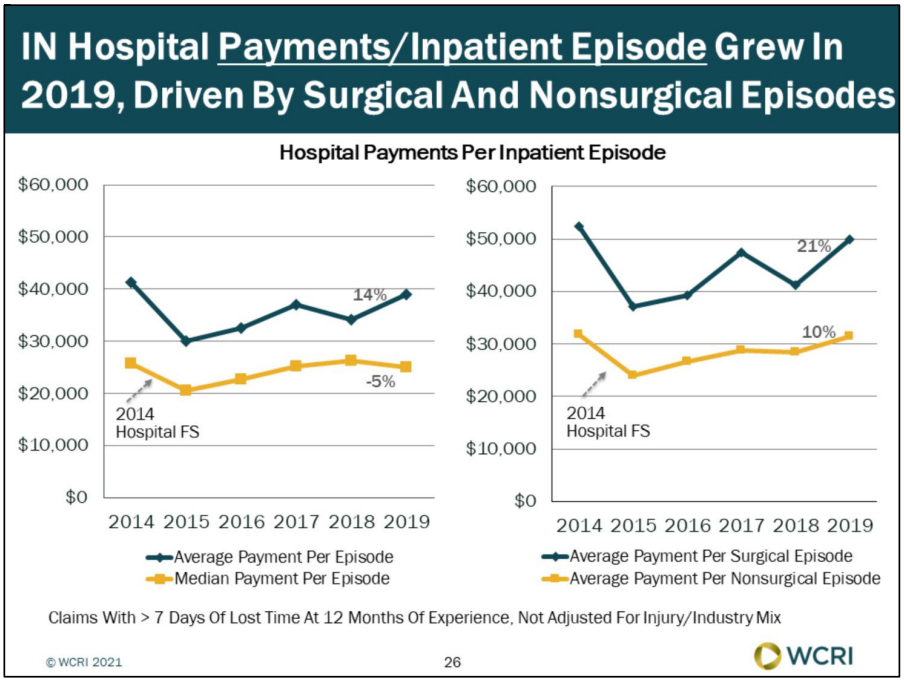


Between 2014 and 2019, payments per claim to ASCs grew faster in Indiana than in most study states; the percentage of claims with ASCs increased slightly. In addition, there was a slight increase in the proportion of claims with major surgery performed in any facility. In contrast, in most study states, the surgery rate decreased and the proportion of claims with ASC services decreased. Note that in some states surgeries were performed more often in hospital outpatient departments than in ASCs. We also observed a decrease in the proportion of claims with hospital outpatient facility services.

Key: **AAPC:** Annual average percentage change. **ASC:** Ambulatory surgery center. **Cum.:** Cumulative.



Growth in hospital payments per inpatient episode was another driver of the 13 percent increase in total medical payments per claim in Indiana in 2019.

The average hospital payment per inpatient episode had large year-to-year variation and is very sensitive to the number of episodes and length of stay. It is likely that the changes in the average cost per episode were partially driven by different lengths of stay and an increase in the occurrence of episodes involving longer, higher-cost stays. See details on the next slide and in the "Discussion of Major Findings."

Hospital Payments Per Inpatient Episode In Indiana 2018 To 2019

	% Of Claims	Average Payment	Median (50th percentile)
All Episodes	0.5 ppt	14%	-5%
Surgical	0.1 ppt	21%	-1%
Nonsurgical	0.5 ppt	10%	11%

Key: **FS:** Fee schedule. **Hospital payments per inpatient episode:** Payments made to a hospital for all services related to an inpatient stay. Payments made for professional services are not included if billed separately. The hospital inpatient episode or overnight stay was constructed as the unit of analysis. Specifically, hospital inpatient care was identified based on room and board revenue codes. The service dates, which include one day before and one day after the day of the room and board charge, were used to capture all other hospital services provided during the inpatient stay. **Median:** Middle number in a sorted, ascending or descending, list of numbers. **Nonsurgical episode:** Treatment related to fractures, infections, and burns. **ppt:** percentage points. **Surgical episode:** Invasive surgical procedures such as spine fusion, vertebral discectomy, and muscle laceration repair. Hospital payments per inpatient episode with surgery may include professional fees for surgery and other related services if billed as part of the global surgical package.

Note: 2019 refers to injury year/evaluation 2019/20. Other injury year/evaluation combinations are denoted similarly.

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2019 Inpatient Growth Partly Due To Unusually Severe Injuries In Indiana

Mix of unusually severe injuries with expensive hospital inpatient payments in 2019 compared with 2018:

- **Injury type**: fractures, contusions, concussions, lacerations, sprains, electric shock, vascular loss
- **Cause of accident**: fall/slip from ladder/scaffolding, collision with motor vehicle or object, contact with electric current, explosion/flare, struck by object/worker
- **Industry**: more claims from construction, low-risk services, and clerical/professional

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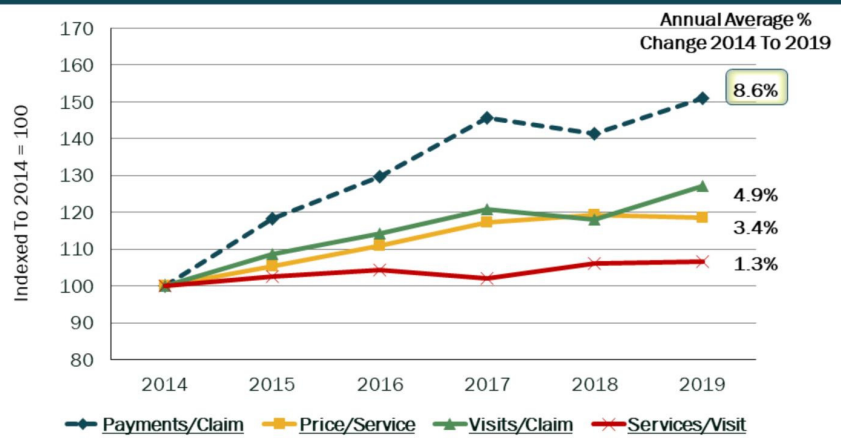
Part of the large growth in the average hospital payment per inpatient episode in 2019 in Indiana was due to some unusually severe injuries with expensive hospital inpatient payments in that year.

For instance, among the inpatient episodes in 2019, there were more cases with concussions, contusions, and brain injuries. These types of injuries were not frequent in 2018. Indiana had more inpatient episodes with fractures in 2019. These cases were associated with nearly two times higher hospital inpatient payments than in 2018.

Changes in inpatient episode costs over a period longer than one year will be measured in future reports.

Indiana PT/OT Payments Per Claim Increased, Driven By Both Prices Paid And Utilization



PT/OT Payments And Services, Claims With > 7 Days Of Lost Time At 12 Months Of Experience, Not Adjusted For Injury/Industry Mix

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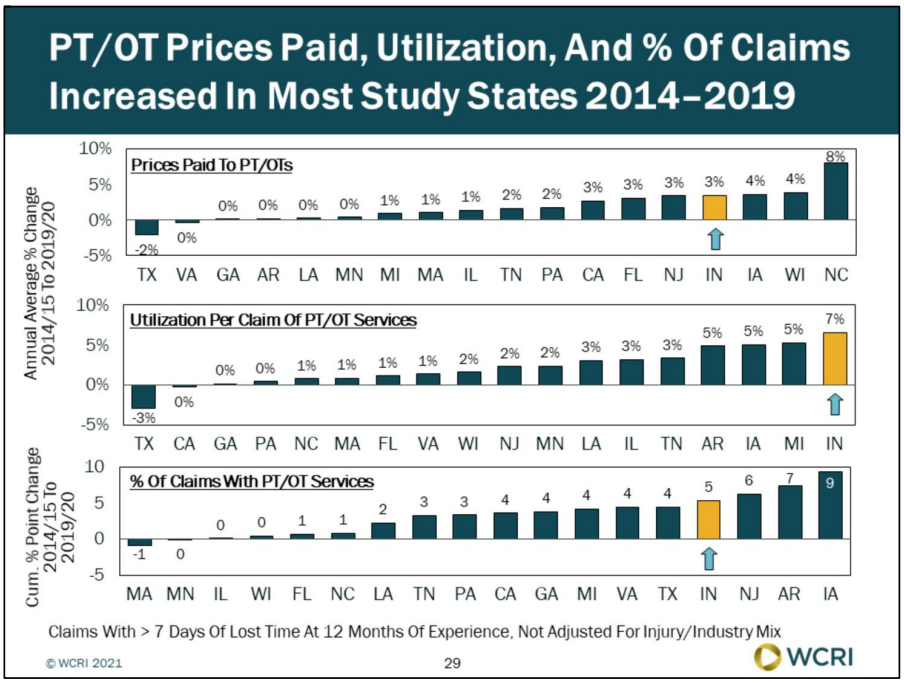
Since 2014, growth in payments per claim to PT/OTs has been driven by a combination of factors. First, growth in prices paid (3 percent per year). Second, growth in the number of visits per claim (5 percent per year). This growth translates into one more visit per claim each year.

Participation in health care networks may also impact the level and trend of prices paid. The share of medical payments in networks for PT/OTs in Indiana did not change between 2014 and 2019. Indiana had a typical share of network payments for PT/OTs.

Additional details are provided in the "Discussion of Major Findings."

Key: **PT/OT:** Physical/occupational therapist; payments to PT/OTs are for all services they provide and bill (whether or not the services are considered physical medicine services).

Notes: 2019 refers to injury year/evaluation 2019/20. Other injury year/evaluation combinations are denoted similarly. Prices paid are based on calendar year; payments and utilization are based on injury/evaluation year.



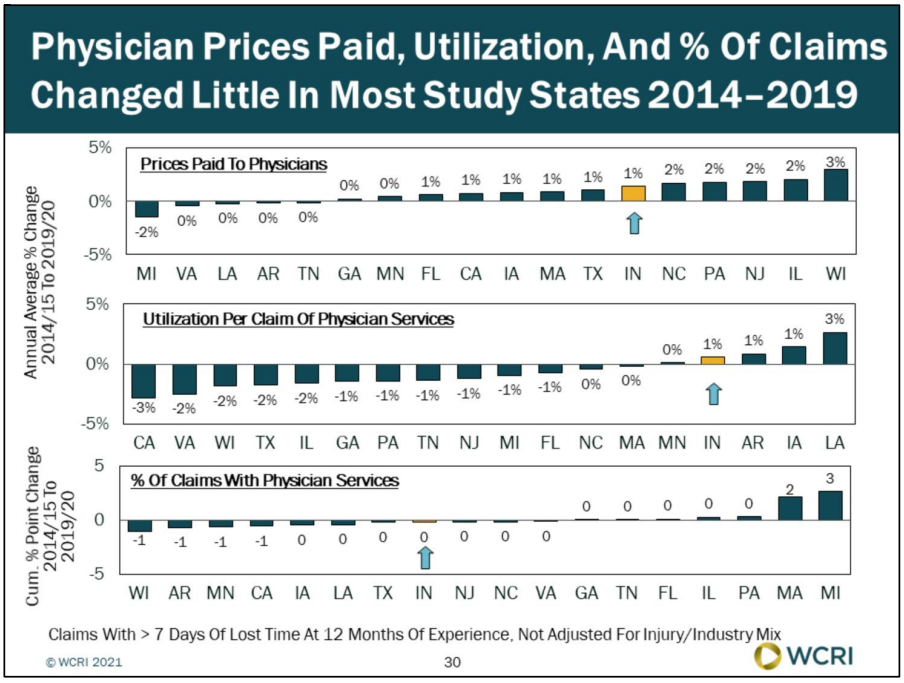
Key and definitions: **Cum.:** Cumulative. **Prices** are benchmarked using a price index which measures the unit prices paid holding utilization constant. **PT/OT:** Physical/occupational therapist. **Utilization** is benchmarked using a utilization index that incorporates number of visits per claim, number of services per visit, and the resource intensity of services provided. See the *Technical Appendix* for more detail on how the price and utilization indices were constructed.

Note: Prices paid are based on calendar year; utilization is based on injury/evaluation year.

In Indiana, prices paid and utilization for PT/OT services increased at rates higher than in most study states. When we combine prices and utilization, the overall payments per claim to PT/OTs increased 9 percent per year in Indiana, which was faster than the 4 percent per year growth in the median study state.

Note that the 3 percent growth in prices paid was faster in Indiana than in many states but consistent with the growth in other non-fee-schedule states (Iowa, New Jersey, and Wisconsin).

The reason for the growth in PT/OT utilization in Indiana was increases in the number of visits per claim. Also see Supplemental Slide S14. In addition, the percentage of claims with PT/OT services increased in Indiana and most study states. This is partly due to the fact that some physical therapy services are now billed by independent practices; in the past, physical therapy was performed and billed by hospital-affiliated clinics. See the trend in the overall percentage of claims with physical medicine in Indiana in Supplemental Slide S13.



Key and definitions: **Cum.:** Cumulative. **CPI-U:** Bureau of Labor Statistics, Consumer Price Index for physician services in U.S. city average, all urban consumers. **Prices paid and utilization** are benchmarked using an index. See the *Technical Appendix* for more detail on how the price and utilization indices were constructed.

Note: Prices paid are based on calendar year; utilization is based on injury/evaluation year.

In Indiana, for physician services, prices paid, utilization per claim, and percentage of claims changed little. The rate of change in Indiana was similar to the other study states.

For reference, the CPI-U for physician services in the United States (which may include services not relevant to workers' compensation) grew on average 1.3 percent per year from 2014 to 2019.

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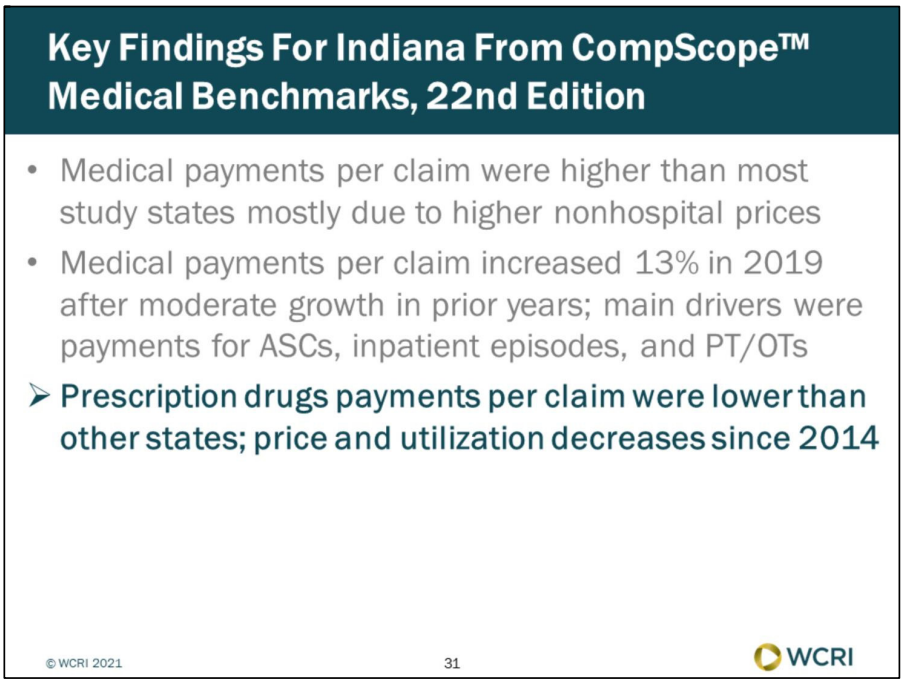
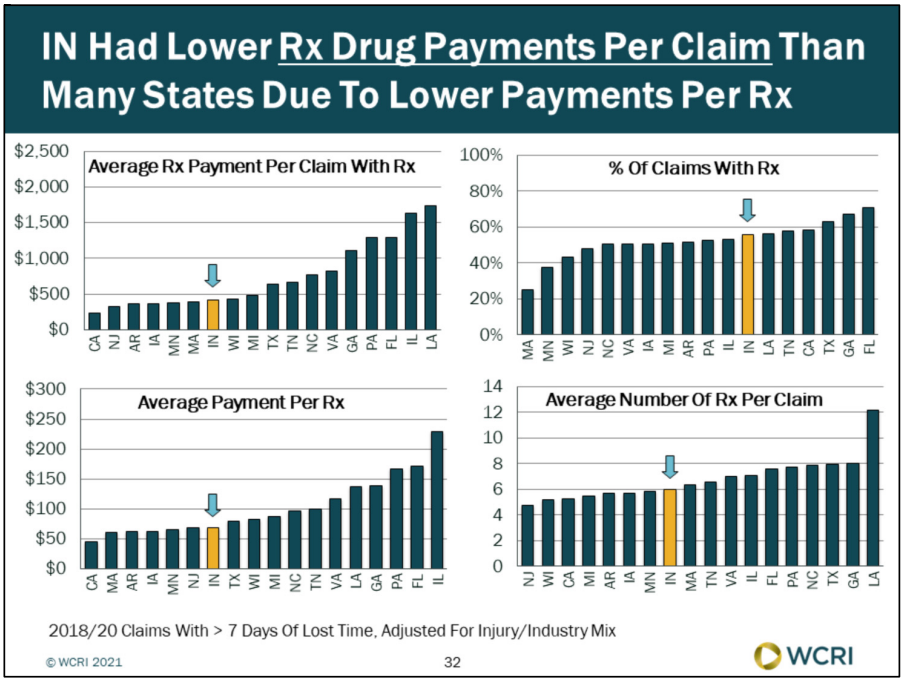


Key: **ASC:** Ambulatory surgery center. **PT/OT:** Physical/occupational therapist.



Key and definition: **ODG:** Official Disability Guidelines by Loss Data Institute. **Rx:** Prescription(s). Prescription drugs include prescription and over-the-counter strengths and compounded drugs dispensed by a pharmacy or a physician. They do not include prescription or over-the-counter drugs administered in a physician's office or in a hospital. They also do not include medical supplies and equipment. The total medical payments metric in this report includes all of the categories mentioned above. See the *Technical Appendix* for more details. **WC:** Workers' compensation.

The average prescription payment per claim for claims with prescriptions was 26 percent lower in Indiana than in the median study state. This was due to lower payments per prescription. Utilization (number of prescriptions per claim and proportion of claims with prescriptions) was typical.

Effective January 1, 2019, all medications prescribed for WC treatment in Indiana must be in accordance with ODG. The drug formulary applies to new prescriptions written after January 1, 2019, while claims with dates of injury prior to January 1, 2019, became subject to the formulary on January 1, 2020 (IN Code § 22-3-7-17.6 (2019)).

In addition, House Enrolled Act 1320 capped the price of repackaged drugs at the average wholesale price set by the original manufacturer, effective July 1, 2013. Details are provided in the "Discussion of Major Findings."

Payments for prescription drugs accounted for 1.1 percent of medical payments in Indiana for 2018/20 claims; they varied from 0.7 to 5.2 percent in other study states.

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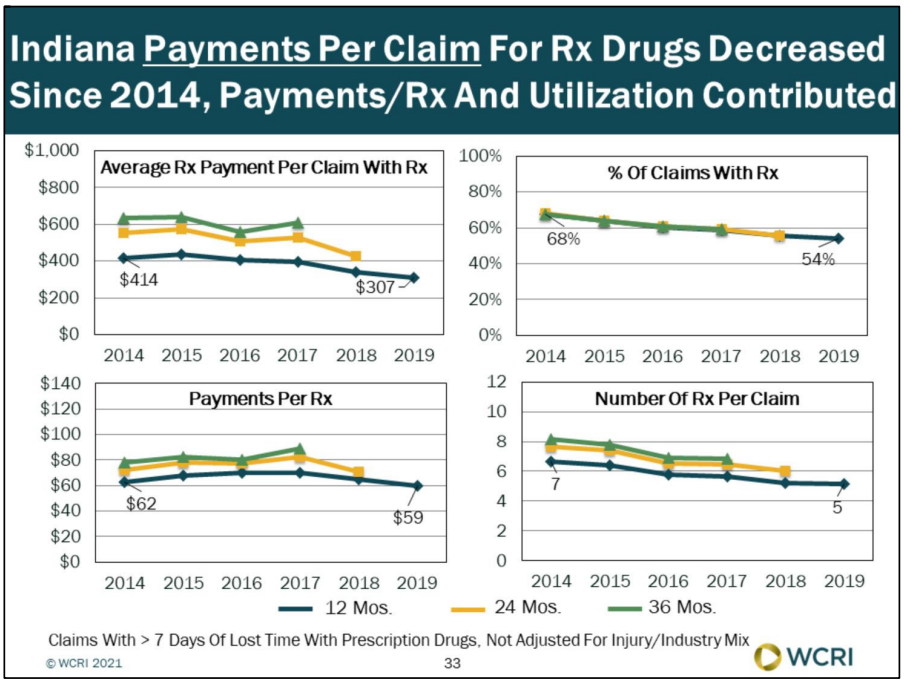


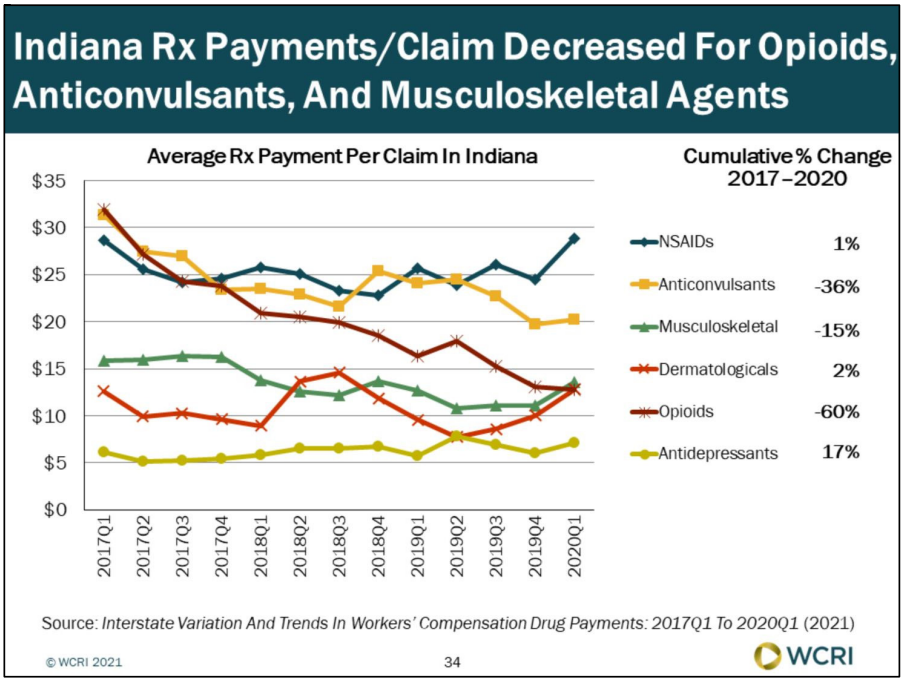
Key and definition: **AAPC:** Annual average percentage change. **Cum. ppt:** Cumulative percentage points. **Dermatological agents:** Medications that are applied topically, directly on the area to be treated, including creams, gels, ointments, etc. The majority of prescriptions in this category are for prescription or over-the-counter strength topical analgesics. Examples of prescription strength dermatological agents include lidocaine (Lidoderm®), diclofenac sodium (Pennsaid®), and diclofenac epolamine (Flector Patch®). Over-the-counter dermatological agents include lidocaine, capsaicin, menthol, methyl salicylate (Lidopro®); capsaicin, menthol, methyl salicylate (Dendracin®); and lidocaine, menthol (Terocin Patch). **Mos.:** Months. **Rx:** Prescription(s).

Note: For claims at 12 months, 2019 refers to injury year/evaluation 2019/20. Other injury year/evaluation combinations are denoted similarly.

The average Rx drug payment per claim in Indiana decreased 6 percent per year from 2014 to 2019. This result was driven by a steady decrease in the proportion of claims and the average number of Rx received. The average payment per Rx decreased 15 percent between 2017 and 2019, after growing 12 percent between 2014 and 2017 (cumulative increases).

A recent WCRI report found substantial growth in the payment share for dermatological agents in most study states, but not in Indiana (see next slide).

Rx Drugs Metrics In IN 2014–2019			
AAPC	12 Mos.	24 Mos.	36 Mos.
Rx Payment Per Claim	-6%	-6%	-2%
Payments Per Rx	-1%	-1%	4%
Number Of Rx Per Claim	-5%	-6%	-6%
% Of Claims (cum. ppt)	-13	-12	-8



Key and definitions: **Anticonvulsants:** Medications used for treatment of neuropathic pain. Examples: gabapentin, pregabalin. **Antidepressants:** Medications used for treatment of depressive disorders. **Compound drugs:** A unique mix of two or more active ingredients prepared for a specific patient. **Dermatological agents:** See Slide 33. **Musculoskeletal therapy agents:** A group of medications that act centrally or peripherally to relieve muscle spasms. Example: cyclobenzaprine HCl (Flexeril®). **NSAIDs:** Nonsteroidal anti-inflammatory drugs. Examples: ibuprofen, meloxicam. **Opioids:** Prescription opioids approved for pain relief, including natural and synthetic opioids. **Q:** Quarter. **Rx:** Prescription(s).

Source: Thumula, Liu, and Wang. 2021. WCRI FlashReport—*Interstate Variation and Trends in Workers' Compensation Drug Payments: 2017Q1 to 2020Q1*.

Between 2017Q1 and 2020Q1, the average Rx payment per claim decreased in Indiana and most states included in that study. Note that the decrease for anticonvulsants reflects the approval of the generic version of Lyrica® in 2019.

Therapeutic Drug Groups	Cumulative % Change 2017Q1 To 2020Q1	
	IN	28-State Median
Opioids	-60%	-56%
Anticonvulsants	-36%	-28%
Musculoskeletal Therapy Agents	-15%	-4%
NSAIDs	1%	-5%
Dermatologicals	2%	19%
Antidepressants	17%	-8%
All Drug Groups	-21%	-41%

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Indiana Relative To Median State: Payment Share Mostly Typical; Rx Payments/Claim Lower To Typical

Therapeutic Drug Groups	% Of All Rx Payments 2020Q1			Rx Payments Per Claim 2020Q1		
	Indiana	28-State Median	IN Ranking Among 28 States	Indiana	28-State Median	IN Ranking Among 28 States
NSAIDs	19%	20%	Typical	$29	$40	Lower
Anticonvulsants	13%	11%	Typical	$20	$26	Typical
Musculoskeletal Therapy Agents	9%	10%	Typical	$14	$23	Lower
Dermatological Agents	8%	19%	Lower	$13	$40	Lower
Opioids	8%	8%	Typical	$13	$18	Typical
Antidepressants	5%	4%	Typical	$7	$9	Typical
Compounds	1%	1%	Typical	n/a	n/a	n/a
Other Drugs	36%	26%	Higher	n/a	n/a	n/a

Source: *Interstate Variation And Trends In Workers' Compensation Drug Payments: 2017Q1 To 2020Q1* (2021)

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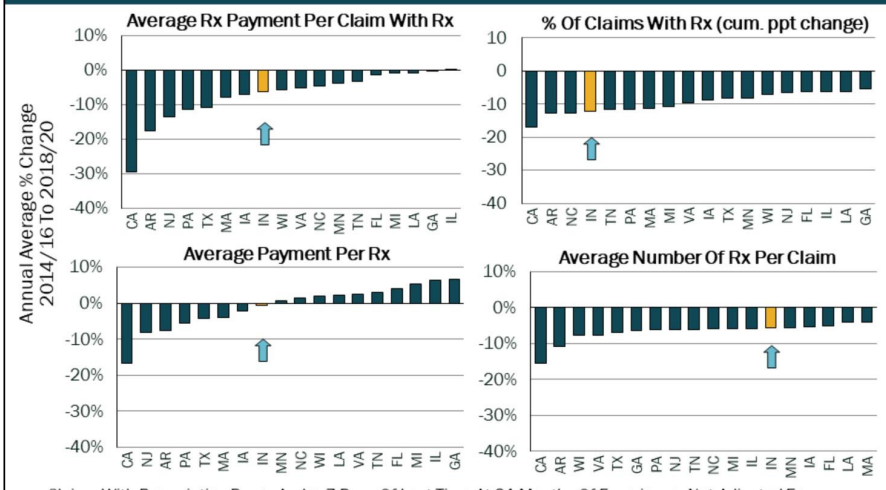
Key and definitions: **NSAIDs:** Nonsteroidal anti-inflammatory drugs. **n/a:** Not applicable. **Other drugs:** A combination of various drugs. Examples: drugs to prevent blood clots, drugs to treat depression or acid-related conditions such as ulcers. **Payment share:** In this context, percentage of all Rx payments. **Q:** Quarter. **Rx:** Prescription(s).

Source: Thumula, Liu, and Wang. 2021. WCRI FlashReport—*Interstate Variation and Trends in Workers' Compensation Drug Payments: 2017Q1 to 2020Q1*.

Indiana had a typical share of all Rx payments for most drug groups in 2020Q1. The average Rx payment per claim in Indiana was lower to typical compared with the 28-state median. The comparisons varied depending on the drug group.

Since 2017, the payment share of *other drugs* increased substantially in most study states. In Indiana, 4 percent of all Rx payments were for ondansetron (Zofran®). This drug is used for the prevention of nausea and vomiting. Among the 28 study states, at least half of the Rx payments were for anticoagulants, antiemetics, antiretrovirals, antibiotics, and ulcer drugs.

2014–2018 (24 Months): Large Decreases In Prescription Drug Metrics In Most Study States



Claims With Prescription Drugs And > 7 Days Of Lost Time At 24 Months Of Experience, Not Adjusted For Injury/Industry Mix

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Key: **AWP:** Average wholesale price. **CDC:** Centers for Disease Control and Prevention. **CMS:** Centers for Medicare & Medicaid Services. **Cum.:** Cumulative. **ppt:** Percentage point. **Rx:** Prescription(s).

Note: According to the Bureau of Labor Statistics, the Consumer Price Index for All Urban Consumers for prescription drugs (which may include services not relevant to workers' compensation) grew on average 2.8 percent per year from 2014 to 2019 in the United States. Series ID: CUUR0000SEMF01,CUUS0000SEMF01.

The average number of prescriptions per claim and the percentage of claims with prescriptions decreased in all study states, which likely reflects a combination of factors: providers' education, changes in prescribing practices following the CDC-recommended guidelines for opioid prescriptions, use of drug formularies, and tight utilization control.

WCRI's *Interstate Variation and Trends in Workers' Compensation Drug Payments: 2017Q1 to 2020Q1* provides trends in Rx payments by groups of therapeutic drugs in 28 states.

California had the largest decreases of all the study states. This is due to several factors: the introduction of an independent medical review process in July 2013, the effect of the Medi-Cal fee schedule changes in April 2017, and the early impact of the drug formulary, effective in January 2018. California follows the Medicaid (Medi-Cal) fee schedule for pharmaceuticals and pharmacy services. In 2017, CMS adopted National Average Drug Acquisition Cost as a basis for drug ingredient reimbursement (replacing AWP).

The decrease in opioid prescriptions is a national trend, according to the report *Medicine Use and Spending in the U.S.*

DISCUSSION OF MAJOR FINDINGS

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This 22nd edition of CompScope™ Medical Benchmarks for Indiana analyzes claims with experience through March 2020 for injuries up to and including 2019. In some cases, we report a longer time frame to supply historical context for key metrics. We also include information from other WCRI studies to provide a more complete picture of the system in Indiana.

In order to make the interstate comparisons more meaningful, the data are adjusted for interstate differences in injury and industry mix. We focus our analysis on claims with more than seven days of lost time because those claims account for the majority of total payments in each state.

Note that fees for medical bill review, case management, utilization review, and preferred provider networks are reported under a separate category—medical cost containment (MCC) expenses per claim. Interstate comparisons and trends in MCC expenses per claim are published in our companion study *CompScope™ Benchmarks for Indiana, 21st Edition*.

MEDICAL PAYMENTS PER CLAIM HIGHER THAN TYPICAL, MOSTLY DUE TO HIGHER PRICES

Medical payments per claim with more than seven days of lost time were higher than typical in Indiana at all claim maturities. Medical payments accounted for 57 percent of total costs per claim in Indiana. The share of medical payments in Indiana total costs was the second highest of all study states for 2017 claims evaluated in 2020.

The average medical payment per claim in Indiana reflects a combination of higher-than-typical payments per claim for nonhospital services (combines mainly payments to physicians, PT/OTs, and ASCs unless the billing is done through a hospital) and typical payments per claim for hospital services (both inpatient and outpatient). Indiana had among the highest payments per claim to PT/OTs and ASCs of all study states. These provider types accounted for half of all medical payments to nonhospital providers in 2019. The other half were payments for various services provided by physicians. Payments per claim for these services were also higher than typical. Reimbursements for professional and ASC services are not regulated through a fee schedule in Indiana.

The typical hospital payments per claim reflect at least five years of experience following the introduction of the hospital fee schedule, effective July 1, 2014. The 2013 legislation (House Enrolled Act 1320) established hospital inpatient and outpatient fee schedules, effective for services on or after July 1, 2014. For 2019 claims (evaluated in 2020), hospital outpatient payments per claim were similar to other states.[1] Hospital payments per inpatient episode were also typical following implementation of the fee schedule.[2] For common knee and shoulder surgeries performed in hospital outpatient departments in 2019,

[1] For 2013 claims (evaluated as of March 2014), prior to the implementation of the hospital fee schedule, the average hospital outpatient payment per claim in Indiana was among the highest of the states. See *CompScope™ Medical Benchmarks for Indiana, 21st Edition*.

[2] For 2012 claims (evaluated as of March 2014), prior to the implementation of the hospital fee schedule, the average hospital payment per inpatient episode was the highest in Indiana of all the study states. See *CompScope™ Medical Benchmarks for Indiana, 21st Edition*.

payments per surgical episode were 10 percent lower in Indiana than in the median of 36 study states.[3] Prior to the introduction of the hospital fee schedule, the average hospital payment per claim in Indiana was the highest of all the study states.

The primary reason for higher medical payments per claim in Indiana relative to other study states was higher prices paid. Prices paid include network discounts or other fee negotiations between payors and providers. Overall prices paid for professional services in Indiana were higher than the median of 36 study states in 2020,[4] along with the other states that did not regulate reimbursement through a fee schedule. Prices paid were higher than typical for all nonhospital services.

In general, prices paid to providers are affected by several factors: (1) fee schedules—scope of coverage, level of reimbursement, the basis for determining the relative payments for procedures, and the method used to review and update fee schedule rates; (2) network participation and price discounts; and (3) negotiations between the payors and the medical providers. In Indiana, the share of medical payments for services provided in networks was slightly higher than typical in 2019. This resulted from higher-than-typical network use for physicians but typical use for hospitals, PT/OTs, and ASCs. Between 2014 and 2019, the percentage of medical payments for care in networks in Indiana increased mostly for physicians and ASCs. Since 2016, however, the percentage of medical payments in networks to ASCs has decreased. We also observed similar decreases in other study states.

Indiana had higher prices paid than most study states, but the use of medical services was lower to typical. There are two aspects of medical utilization: volume of services delivered and frequency of use (how often a specific service occurs). For many types of services, both nonhospital and hospital outpatient, Indiana had a typical number of visits per claim. For physical medicine services, overall utilization per claim was higher than typical at 12 months. However, at 36 months, utilization was fairly typical.

Indiana is different from most study states in that major surgery occurred more often and the proportion of claims with facility services was higher than in other states. There are two aspects of medical care costs when a major surgery is involved in treatment: what was paid to the provider who performed the surgery and what was paid to the facility where the surgery was performed. This report provides insights on both of these aspects of medical care costs in workers' compensation. Payments to facilities are measured by payments for treatment, operating, and recovery room services, not including professional services (for example, surgeon fees) and other surgery-related costs (supplies and equipment and anesthesia). The facility payments in CompScope™ Medical Benchmarks are for all types of surgical procedures and are reported for ASCs and hospital outpatient departments separately.

Indiana had the highest percentage of claims with major surgery (all types of surgeries combined) at all claim maturities. For 2017 claims (evaluated in 2020), 43 percent of workers had major surgery in Indiana, compared with 36 percent in the median study state.[5] It is possible that the mix of surgeries in Indiana was

[3] Fomenko and Yang. 2021. *Hospital Outpatient Payment Index: Interstate Variations and Policy Analysis, 10th Edition*. The study defines facility payments as payments made for operating, treatment, and recovery rooms and other surgery-related costs (supplies and equipment and anesthesia), not including the professional component (for example, surgeon fees).

[4] Yang and Fomenko. 2021. *WCRI Medical Price Index for Workers' Compensation, 13th Edition (MPI-WC)*.

[5] Another WCRI study, *Why Surgery Rates Vary*, found that for low back surgery—typically with less clinical consensus among providers than for knee surgery—several factors explain the variation in surgery rates among study states. These factors are practice norms in the local area, reimbursement rates for surgery, the number of surgeons in the area, and access to nonsurgical providers. The study also found that little of the area variation in knee surgery rates was explained by the factors listed above. Having more agreement among providers on whether surgery is appropriate could play a key role in determining whether certain factors affect surgery rates.

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somewhat different from in other study states; this is beyond the scope of the study.[6] However, according to other WCRI research, among claims with low back pain, Indiana had the highest percentage of lumbar spine surgeries of all study states.[7] Indiana had a higher percentage of claims with facility services for procedures performed in both ASCs and hospital outpatient departments. This is likely related to the higher percentage of claims with major surgery.

When a surgical procedure was performed, facility payments per claim to ASCs in Indiana were among the highest of the study states, while payments to hospital outpatient departments were fairly typical. In addition to payments to the facility associated with a surgical procedure, this report provides information on payments for major surgery (the professional component, e.g., payments to surgeons). The average payment per claim for major surgery was higher in Indiana than in most study states. Indiana does not have a medical fee schedule for payments to ASCs[8] or for professional services but does regulate payments to hospitals. Typically, in a state with no medical fee schedule, payments to providers would reflect charges for these services. If payors have network agreements with providers, payments for surgeries may reflect discounts from the charges or rates that were negotiated between payors and providers.

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REIMBURSEMENTS FOR MEDICAL SERVICES IN INDIANA

Indiana is one of a few states that does not currently regulate payments for professional or ASC services with medical fee schedules. The other states with no medical fee schedules for professional or hospital services (including ASCs) are Iowa, Missouri, New Hampshire, New Jersey, and Wisconsin.

In Indiana, payments for professional and ASC services are based on the 80th percentile of charges in the same community for similar services. In recent years, stakeholders in Indiana have discussed the introduction of an ASC fee schedule.

Effective July 1, 2014, payment to a medical service facility is either a negotiated amount between the employer and provider or 200 percent of the amount that would be paid under the Medicare medical service facility reimbursement rate (IC 22-3-3-5 and IC 22-3-6-1). The provisions of the law defined a *medical service facility* as a hospital, a hospital-based health facility, or a medical center. The term does not include professional corporations—health care professionals who render professional services in an individual or group practice, including ASCs. Indiana's fee schedules are largely based on the Centers for Medicare & Medicaid Services (CMS)[9] payment system for hospital inpatient and outpatient services.

Indiana adopted the CMS Outpatient Prospective Payment System (OPPS) for hospital outpatient services. Reimbursements for these services are based on ambulatory payment classification (APC) groups. APC methodology categorizes visits according to clinical characteristics and typical resource use, as well as the costs associated with the diagnoses and procedures performed.

Furthermore, in Indiana, payments for physical and occupational therapy and speech therapy provided in hospital settings are reimbursed based on the Medicare physician fee schedule. In addition, Indiana

[6] Note that claims with more than seven days of lost time represented only 13 percent of all claims in Indiana, compared with a typical range of 16 to 23 percent in most other study states in 2019 (at 12 months).

[7] Wang, Mueller, and Lea. 2020. *Reoperation & Readmission Rates for Workers' Compensation Patients Undergoing Lumbar Surgery*.

[8] All states that have medical fee schedules for hospital services also have them for ASC services, except Indiana and Utah. These two states have a hospital fee schedule but no ASC fee schedule. Source: WCRI's *Workers' Compensation Medical Cost Containment: A National Inventory, 2021*.

[9] Also referred to as *Medicare* in other sections of the discussion.

adopted the Medicare Clinical Laboratory fee schedule used for outpatient diagnostic laboratory services and the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS) for outpatient orthotics and prosthetics.

For hospital inpatient services, Indiana adopted the CMS Inpatient Prospective Payment System (IPPS), which is based on diagnosis codes (Medicare Severity Diagnosis Related Groups [MS-DRGs]). The DRGs incorporate the principal diagnosis; secondary diagnoses; surgical procedures; and age, sex, and discharge status of the patient.

Furthermore, similar to Medicare, Indiana introduced a per diem rate for inpatient stays in critical access hospitals (CAHs). There are 35 CAHs in Indiana. In general, CHAs are rural community hospitals that receive cost-based reimbursement as determined by Medicare.

For workers' compensation purposes, payments to hospital providers are determined by multiplying the Medicare rate (inpatient or outpatient) by a factor of 2.0.

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MEDICAL PAYMENTS INCREASED 13 PERCENT IN 2019 AFTER MODERATE GROWTH IN PRIOR YEARS; MAIN DRIVERS WERE PAYMENTS FOR ASCS, INPATIENT EPISODES, AND PT/OTS

Several factors have affected the trends in medical payments per claim in Indiana since 2014: the introduction of the hospital fee schedule in 2014 and continuous growth in prices paid for professional services, payments to ASCs, and payments to PT/OTs. In 2019, total medical payments per claim increased 13 percent in Indiana, which was faster than the 4 percent per year growth between 2015 and 2018. The largest contributors to the 2019 growth were payments to ASCs, hospital inpatient providers, and PT/OTs.

Between 2013 and 2015, medical payments per claim in Indiana decreased 10 percent for claims at 12 months of experience and decreased 7 percent for claims at 36 months of experience. That decrease reflects the introduction of the hospital fee schedule effective July 1, 2014.[10] From 2015 to 2018, medical payments per claim increased 4 percent per year (at 12 months). Some of the increase came from growth in prices paid for professional services. The growth in prices paid in Indiana was similar to that in other non-fee schedule states. Another contributing factor was an increase in ASC payments per claim. Indiana does not have a fee schedule for professional services or services provided in ASCs. At the center of the recent policy debate in Indiana has been whether to regulate payments to ASCs and at what percentage over Medicare. Legislation in 2020 (House Bill 1332) intended to limit reimbursements for ASCs treating workers with injuries. We will continue to monitor if new proposals are introduced in the future and how an ASC fee schedule may impact medical payments per claim in Indiana.

In 2019, however, medical payments per claim with more than seven days of lost time[11] in Indiana increased 13 percent. This growth was driven by a combination of growth in hospital payments per inpatient episode, payments to ASCs, and payments to PT/OTs. These three categories contributed almost equally to the 13 percent growth in medical payments per claim in 2019. Hospital payments per inpatient episode have grown in some years, and not in others. Payments to ASCs and payments to PT/OTs have grown in every year (except 2018) since 2012. Between 2012 and 2019, the average ASC facility payment per claim grew 11 percent per year and the average PT/OT payment per claim grew 9 percent per year. Payments per claim to

[10] The impact of the hospital fee schedule on medical payments per claim in Indiana is discussed in detail in the 20th and 21st editions of CompScope™ Medical Benchmarks for Indiana.

[11] Note that claims with more than seven days of lost time represented only 13 percent of all claims in Indiana, compared with a typical range of 16 to 23 percent in most other study states in 2019 (at 12 months).

other types of providers increased little or decreased as a result of the introduction of the hospital fee schedule.

Examining how the distribution of medical payments has changed provides another perspective on medical trends. Facility payments along with payments for physical medicine accounted for an increasing share of total medical payments in Indiana. The share of facility payments increased from 20 to 23 percent between 2014 and 2019. This was driven by payments to ASCs. The relatively high share of medical payments for facility services may relate to the surgery rate in Indiana, which was the highest of the 18 study states in 2019. The payment share for physical medicine also increased, from 17 percent in 2014 to 23 percent in 2019. The payment share for inpatient care decreased, from 19 to 16 percent, with the largest decrease occurring between 2014 and 2015 when the hospital fee schedule was introduced. To summarize, facility payments (ASC and hospital outpatient), physical medicine, and hospital payments per inpatient episode accounted for 62 percent of all medical payments in Indiana in 2019 compared with 56 percent in 2014.

In the sections below, we provided more details regarding the recent growth in Indiana medical payments per claim.

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INCREASE IN INDIANA ASC PAYMENTS PER CLAIM 2014–2019

ASC facility payments per claim in Indiana were among the highest of the states and growing rapidly. ASC facility payments per claim increased at rapid rates throughout the period from 2008 to 2019; the rate of growth was especially higher after 2012.[12] In 2019, ASC facility payments per claim increased 14 percent. We observed a shift in the percentage of claims with facility services to ASCs from hospital outpatient, which also contributed to the higher and growing medical payments per claim in Indiana. From 2011 to 2019, there was a 4 percentage point increase in the percentage of claims with ASC facility payments and a 7 percentage point decrease for hospital outpatient facilities. The overall surgery rate has been fairly stable in Indiana since 2012. Only for 36-month claims did the surgery rate in Indiana increase, about 2 percentage points, from 44 percent in 2014 (was the same percentage in prior years) to 47 percent in 2019.

We also compared payments to ASCs and hospital outpatient departments for the most common group of surgeries performed in outpatient settings—knee and shoulder arthroscopies. We include payments per surgical episode, excluding payments to surgeons or other medical professionals. From 2014 to 2019, payments to ASCs increased in Indiana, especially for shoulder arthroscopies. Between 2016 and 2019, the average ASC facility payment per shoulder surgical episode increased between 9 and 11 percent per year. The median ASC payment per claim also increased at similar rates. This result suggests that ASC charges may have increased during that period. There were no material changes in the proportion of shoulder surgeries performed in ASCs between 2014 and 2019. In contrast to the above trend, payments to hospital outpatient departments in Indiana decreased for both knee arthroscopies and shoulder arthroscopies, largely related to the adoption of the hospital fee schedule.

Another factor that can impact reimbursement is the use of networks. We measure this as the percentage of medical payments for services within networks, based on identification of network care provided by the data sources. The share of medical payments for ASC services provided in networks in Indiana increased from 63 percent in 2014 to 78 percent in 2016 and then dropped to 70 percent in 2019. Indiana had a typical percentage of ASC services in networks in 2019. These results may relate to the fact

[12] From 2008 to 2013—prior to the introduction of the hospital fee schedule—hospital outpatient facility payments per claim grew 8 percent per year.

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that ASCs are not regulated by a fee schedule and ASC providers may be less inclined to participate in networks and accept reimbursement discounts. During the study period, stakeholders discussed whether to regulate payments to ASCs.

In Indiana, 39 percent of shoulder surgeries were performed in ASCs compared with 61 percent performed in hospital outpatient departments. Indiana had a smaller share of surgeries performed in ASCs relative to other study states. In most states, payments to ASCs were lower than payments to hospital outpatient departments for similar surgeries in 2019. In contrast, in Indiana, payments for outpatient surgeries were higher to ASCs than to hospital outpatient departments. For instance, payments for shoulder arthroscopy surgeries to ASCs were more than double the payments to hospital outpatient departments. In Indiana, hospital outpatient payments are regulated through a fee schedule; ASC payments are not subject to regulation through a fee schedule. Other factors that may contribute to differences in average payments to ASCs and hospital outpatient departments include participation in networks and billing for multiple procedures within a surgical episode.

Comparing Indiana trends with changes in other states shows that between 2014 and 2019, facility payments per claim to ASCs in Indiana increased at a much faster rate (8 percent per year) than in many study states (2–3 percent per year). In addition, in Indiana there was a 1 percentage point increase in the proportion of claims with ASC services and major surgery (performed in any facility). This trend was different from the trend observed in most study states—a steady decrease in the proportion of claims with major surgery and ASC services. For reference, the national Consumer Price Index (CPI) for all hospital outpatient services[13] (which may include services not relevant to workers' compensation) grew 3.5 percent per year between 2014 and 2019.

It is also worth emphasizing that the growth in facility and hospital payments in Indiana and other study states may have been influenced by some price and policy changes introduced by CMS. Although some states do not have workers' compensation medical fee schedules, providers in those states most likely follow CMS coding and billing practices. Between 2015 and 2017, Medicare made changes related to reimbursements for outpatient procedures performed in ASC or hospital outpatient facilities. In 2015, Medicare introduced a comprehensive APC (C-APC)[14] payment model to simplify reporting and reimbursement for high-cost, complex outpatient procedures; all related payments are packaged under a single rate. In 2016, the list of C-APCs was expanded to include most common shoulder surgeries, which are typically performed in workers' compensation. In 2017, the list of C-APCs was further expanded to include most common knee surgeries (also typically performed in workers' compensation). Furthermore, starting in 2021, CMS finalized the addition of 11 procedures to the ASC covered procedures list. Under the ASC final rule, Medicare will pay providers for furnishing common services like total hip arthroplasty in ASCs.

CMS also made changes to the IPPS, which is the Medicare diagnosis-related-group-based system. For instance, in 2018, the reimbursement rates increased for many common MS-DRGs, such as back and neck

[13] Bureau of Labor Statistics, Consumer Price Index in U.S. city average, all urban consumers.

[14] Ambulatory payment classification (APC) is a payment methodology developed by Medicare to reimburse outpatient hospital and ambulatory surgery center services and procedures. The methodology categorizes visits according to clinical characteristics and typical resource use, as well as the costs associated with the diagnoses and procedures performed.
Comprehensive APCs (C-APCs) package payment for a primary service and payment for all adjunctive services reported on the same claim into a single payment. With a few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

procedures and arthroscopy. Additionally, the Medicare IPPS fee schedule in 2018 included more items eligible for new technology add-on payments.[15] All of these changes may have contributed to the growth in both hospital inpatient and outpatient payments per claim in workers' compensation.

INCREASE IN INDIANA HOSPITAL PAYMENTS PER INPATIENT EPISODE IN 2019

An increase in hospital payments per inpatient episode also contributed to the overall medical payment growth in Indiana in 2019. The average hospital payment per inpatient episode increased 14 percent in 2019. At the same time, the median payment per episode decreased 5 percent. This result suggests that the 2019 increase was likely driven by more costly inpatient episodes. We also observed 21 percent growth in hospital inpatient payments per surgical episode and 10 percent growth in payments per nonsurgical episode in 2019. In examining the underlying mix of injuries, we found that 2019 was fairly unusual, with high-cost episodes for many injury types, when compared with 2018. For instance, among the inpatient episodes in 2019, there were more cases with concussions, contusions, and brain injuries. These types of injuries were not frequent in 2018. Indiana had more inpatient episodes with fractures in 2019; these cases were associated with nearly two times higher hospital inpatient payments than in 2018. Note that in some prior years Indiana also experienced large growth in hospital payments per inpatient episode. For instance, in 2017, the average hospital payment per inpatient episode increased 14 percent. A prior edition of this report found that this growth was likely due to changes in injury mix and severity. Given the smaller numbers of claims receiving inpatient care, inpatient measures can show large annual fluctuations, especially at 12 months of maturity.

Effective July 1, 2014, Indiana regulates payments for inpatient services with a fee schedule. See the description in the section above. Indiana's fee schedule largely follows the CMS IPPS system, with one exception. CMS inpatient prospective payment rules list certain procedures that are eligible for Medicare payments only if they are performed on an inpatient basis (Addendum E).[16] For the purposes of Indiana's workers' compensation fee schedule, for outpatient procedures performed on an inpatient basis, facilities must be reimbursed for reasonable and necessary procedures in contradiction of Addendum E, as agreed upon between the facility, the employer, and the medical provider. Services and procedures thus rendered are payable according to a negotiated fee arrangement between the facility and the employer, or a preexisting contract. It is possible that this specific rule in Indiana has contributed to some of the growth in payments per hospital inpatient episode. However, it is difficult to determine the extent of this impact.

Overall, the inpatient trends may reflect the impact of several factors, including (1) annual increases in medical prices paid for hospital inpatient services; (2) changes in the characteristics of and/or severity of claims receiving inpatient care; (3) a shift in care from hospital inpatient to outpatient and/or ASCs; or (4) other changes in patterns of care provided to workers who might have previously received care on an inpatient basis. Over a longer period of time, we observed less frequent use of inpatient care in most study states and a decrease in the proportion of claims with major surgery. The latter trend was not observed in Indiana. From 2014 to 2019, hospital payments per inpatient episode grew about 4 to 7 percent per year in

[15] CMS provided a list of devices and International Classification of Diseases-10 (ICD-10) codes eligible for maximum add-on payments.

[16] Starting January 1, 2021, CMS eliminated the inpatient-only list as part of the agency's effort to increase choices around surgery. The inpatient-only list refers to services that were previously considered not appropriate to be furnished in hospital outpatient departments for Medicare beneficiaries. Note that under the 2022 Hospital Outpatient Prospective Payment System and ASC Payment System proposed rule, CMS is planning to reinstate the inpatient-only list. The final rule will be issued in November 2021.

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most study states. The rate of growth in Indiana was much smaller due to the impact of the implementation of the hospital fee schedule in 2014. In addition, the CPI for inpatient services[17] in the United States (which may include services not relevant to workers' compensation) increased 1.8 percent in 2019, and about 4.3 percent per year between 2014 and 2018.

Over the past five years, there has been an increase in the proportion of high-cost claims in both workers' compensation and Medicare. A workers' compensation report[18] shows that the number of claims that cost at least $3 million increased, especially after 2015. A significant portion of these claims were in the construction industry, and also in the office and clerical industry. Most of these high-cost claims were related to head and brain injuries; burns and electrical shock injuries increased too. Outside workers' compensation, a report from the U.S. Office of Inspector General[19] shows that since 2014 for Medicare patients, there has been a trend toward more expensive inpatient hospital stays. Hospitals were increasingly billing for inpatient stays at the highest severity level, which is the most expensive one. The number of stays at the highest severity level increased almost 20 percent from 2014 to 2019, accounting for nearly half of the Medicare spending on inpatient hospital stays.

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INCREASE IN INDIANA PT/OT PAYMENTS PER CLAIM 2014–2019

The average payment per claim to PT/OTs continued to increase in Indiana: 7 percent in 2019, similar to the 9 percent per year growth between 2014 and 2018. The growth was driven by a combination of factors. First, prices paid increased 3 percent per year. This growth was higher than the changes in many study states (0 to 1 percent growth); however, compared with states with no medical fee schedule, growth was similar. Second, the average number of visits per claim increased 5 percent per year, which translates into one more visit per claim each year. Participation in health care networks may also impact the levels and trends of prices paid. Between 2014 and 2019, the proportion of PT/OT payments that were in networks was stable. Indiana was typical on that measure compared with other study states.

For all providers combined, the percentage of claims with physical medicine services has been fairly stable in Indiana, ranging from about 72 to 74 percent from 2014 to 2019 for claims at 12 months of experience. There has been, however, a general shift to nonhospital providers from hospital outpatient providers. From 2014 to 2019, the percentage of claims with physical medicine services decreased about 3 points for hospital outpatient providers and increased 4 points for nonhospital providers. The shift began prior to the implementation of the hospital fee schedule. Some of the shift observed in Indiana (and in other states) may reflect general trends involving ownership of physical therapy practices, hospital divestment of physical therapy clinics, referrals to outside facilities, and other such changes.

After implementation of the hospital fee schedule, payments per claim for physical medicine services decreased for hospitals and increased rapidly for nonhospital providers. Since 2013, payments per claim

[17] Bureau of Labor Statistics, Consumer Price Index in U.S. city average, all urban consumers.

[18] National Council on Compensation Insurance (NCCI). 2020. *Countrywide Mega Claims*. Results are based on injuries between 2001 and 2017, and evaluated as of December 31, 2018, with incurred losses from 18 to 126 months from policy inception. A threshold of $3 million was used at 2018 cost levels.

[19] U.S. Department of Health and Human Services, Office of Inspector General. 2021. *Data Brief: Trend Toward More Expensive Inpatient Hospital Stays in Medicare Emerged*. The study is based on the number of inpatient stays and payments by severity level. Between 2014 and 2019, there were no significant changes in the Medicare beneficiary populations, i.e., in general, beneficiaries were not sicker in 2019 than they had been in 2014. Therefore, most of the observed changes were driven by changes in hospital billing practices rather than by changes in the beneficiary population.

have increased 9 percent per year for nonhospital providers but have decreased 7 percent per year for hospital outpatient providers. Note that payments per service became similar for the two billing providers[20] after the fee schedule. However, the numbers of physical medicine visits per claim and services per visit were much higher for nonhospital providers than for hospital outpatient providers. Since 2013, the average number of physical medicine visits per claim has increased from 18 to 22 among nonhospital providers; it decreased from 14 to 13 for hospital outpatient providers. Payments for physical medicine services (all providers combined) accounted for 23 percent of total medical payments in 2019, up from about 17 percent in 2014. The increase was due to nonhospital providers.

Between 2014 and 2019, the average PT/OT payment per claim grew in many study states; both prices and utilization contributed. Growth in Indiana was faster than in most study states.

There are several reasons for the overall growth in payments for physical medicine. In 2017 and 2018, CMS made changes related to reimbursements for physical medicine. In 2017, Medicare replaced a single code (CPT 97001) for physical therapy evaluation with three new codes (CPT 97161, 97162, and 97163). It is important to note that workers' compensation payors may continue to use the old code. Furthermore, in 2018, payments for several procedure codes (also frequently used in workers' compensation) increased 15–20 percent.[21] Although some states do not have workers' compensation medical fee schedules (or have a fee schedule different from Medicare), it is common practice that some providers' contracts are based on specific reimbursement amounts by CPT code, rather than a discounted percentage of billed charges; these contracts likely follow CMS changes.

Another reason for the growth in physical medicine payments could be that the Centers for Disease Control and Prevention (CDC) recommended physical therapy as the preferred first treatment for chronic pain and an effective alternative for surgery and opioids in many cases. In addition, according to stakeholders with multistate perspectives, more states are now using physical therapy as preventative treatment. Stakeholders also suggested that the growth in physical medicine payments per claim among most study states might be related to a decline in opioid use.

STABILITY IN INDIANA PHYSICIAN PAYMENTS PER CLAIM 2014–2019

For physician services, prices paid, utilization per claim, and the percentage of claims changed little. The rate of change in Indiana was similar to the other study states. From other WCRI research,[22] prices paid for professional services in Indiana have grown at a fairly steady rate from 2014 to 2020, averaging about 2 percent per year. Note that most of the growth occurred between 2014 and 2016; after that, prices paid increased at 1 percent per year. Between 2014 and 2020, the growth rate in Indiana was similar to that in the median of the states without fee schedules. In contrast, nonhospital prices paid changed little in the median of the states with fee schedules. For reference, the national CPI for physicians' services[23] (which may include services not relevant to workers' compensation) grew 1.3 percent per year between 2014 and 2019.

[20] Billing provider: Medical professional or entity that bills for the services rendered. In some cases, the billing provider and rendering provider are the same. In some cases, the billing provider may have multiple rendering providers.

[21] In 2018, CMS increased the reimbursements for some physical medicine CPT codes and decreased reimbursements for others. Among the largest increases were for CPT 97124 (massage therapy) and CPT 97530 (therapeutic activities).

[22] Yang and Fomenko. 2021. *WCRI Medical Price Index for Workers' Compensation, 13th Edition (MPI-WC)*.

[23] Bureau of Labor Statistics, Consumer Price Index in U.S. city average, all urban consumers.

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PRESCRIPTION DRUGS PAYMENTS PER CLAIM WERE LOWER THAN OTHER STATES; PRICE AND UTILIZATION DECREASES SINCE 2014

Prescription drugs include medications dispensed by pharmacies and physicians, not hospitals. The average prescription payment per claim with prescriptions was 26 percent lower in Indiana than the 18-state median, resulting from lower payments per prescription based on 2018 claims (at 24 months). The average number of prescriptions per claim and the proportion of claims with prescriptions were typical in Indiana. For the most part, Indiana does not regulate reimbursement for prescription drugs through a fee schedule. House Enrolled Act 1302 capped the price of repackaged drugs at the average wholesale price (AWP) set by the original manufacturer, effective July 1, 2013. Senate Enrolled Act 369 required adoption of a workers' compensation drug formulary (Official Disability Guidelines) that restricts opioid prescribing. The ban on reimbursement for prohibited drugs took effect January 1, 2019, but workers who began taking the medications before July 1, 2018, and whose use continued after January 1, 2019, might continue using those drugs until January 1, 2020. In future WCRI studies, we will monitor the effects of the drug formulary. It is too early to associate recent changes in prescription drug payments and utilization in Indiana with the introduction of the drug formulary.

Payments for prescription drugs accounted for 1 percent of total medical payments in Indiana for 2018 claims (at 24 months); this percentage varied from 1 to 5 percent in other study states.

Between 2014 and 2019 (at 12 months), the average payment per prescription in Indiana decreased 1 percent per year, the number of prescriptions per claim decreased 5 percent per year, and the proportion of claims with prescriptions decreased (13 percentage points, cumulative). The combined effect of those changes was a decrease of 6 percent annually in the average prescription payment per claim. The magnitudes of Indiana's recent changes were similar to changes observed in most study states. The decrease in the number of prescriptions per claim and percentage of claims with prescriptions observed in all states likely reflects a combination of factors: provider education, changes in prescribing practices following the CDC-recommended guidelines for opioid prescriptions, use of drug formularies, and tight utilization control.

A recent WCRI report found substantial growth in the payment share and payments per claim for dermatological agents in most study states, based on changes between the first quarters of 2017 and 2020.[24] Indiana did not follow this particular trend. The increase in the average payment per claim for dermatological agents was much smaller in Indiana (2 percent) relative to the change in the median study state (19 percent). On the other hand, Indiana experienced large decreases in payments per claim for opioids, anticonvulsants, and musculoskeletal agents. The decrease for anticonvulsants reflects the approval of the generic version of Lyrica® in 2019. Compared with the median study state, prescription payments per claim in Indiana were lower to typical, depending on the drug group.

Another WCRI study[25] found that must-access prescription drug monitoring programs[26] (PDMPs) reduced the morphine milligram equivalent amount (MME) of opioids by 12 percent due to a decrease in the amount of opioids prescribed and the number of opioid prescriptions. Must-access PDMPs contributed to a 12 percent decrease in the likelihood that workers received opioids on a longer-term basis. The analysis includes data from 33 states with injuries between 2009 and 2018.

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[24] Thumula, Liu, and Wang. 2021. *WCRI FlashReport—Interstate Variation and Trends in Workers' Compensation Drug Payments: 2017Q1 to 2020Q1*.

[25] Neumark and Savych. 2021. *Effects of Opioid-Related Policies on Opioid Utilization, Nature of Medical Care, and Duration of Disability*.

[26] The primary goal of PDMP policies is to limit excessive prescribing and simultaneous prescribing by multiple providers.

This section includes supplemental slides on several topics:

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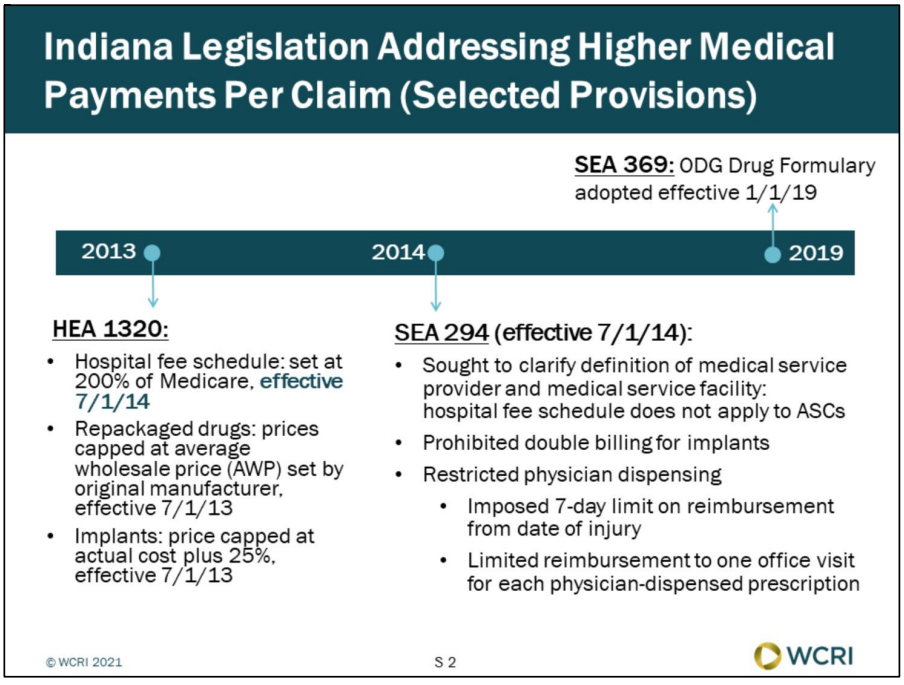

Key: **ASC:** Ambulatory surgery center. **HEA:** House enrolled act. **ODG:** Official Disability Guidelines. **SEA:** Senate enrolled act.

Note: For ASCs and professional services, fees for medical services in a defined community in Indiana must be equal to or less than charges by medical providers at the 80th percentile in the same community for like services. Also, Indiana does not have a pharmacy fee schedule; reimbursement is based on providers' usual and customary charges.

HEA 1320 addressed several key policy issues concerning the higher and growing medical costs in Indiana. In particular, the legislation required adoption of a hospital fee schedule, with reimbursement set at 200 percent of Medicare.

Following HEA 1320, concerns were raised about how to clearly determine which medical services were subject to the hospital fee schedule. SEA 294 distinguished a medical service provider from a medical service facility based on the billing forms used for Medicare reimbursement. Based on the specific language of the legislation, reimbursement for services provided by ASCs is not covered by the hospital fee schedule.

SEA 369 required adoption of a workers' compensation drug formulary (ODG) that restricts opioid prescribing. The ban on reimbursement for prohibited drugs took effect January 1, 2019, but workers who began taking the medications before July 1, 2018, and whose use continued after January 1, 2019, could continue using those drugs until January 1, 2020.

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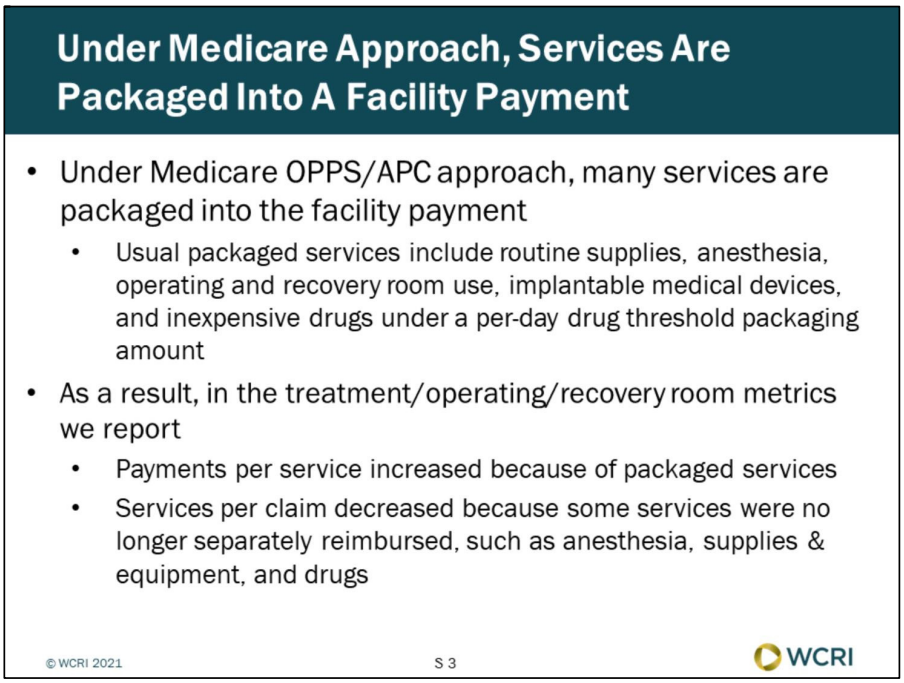
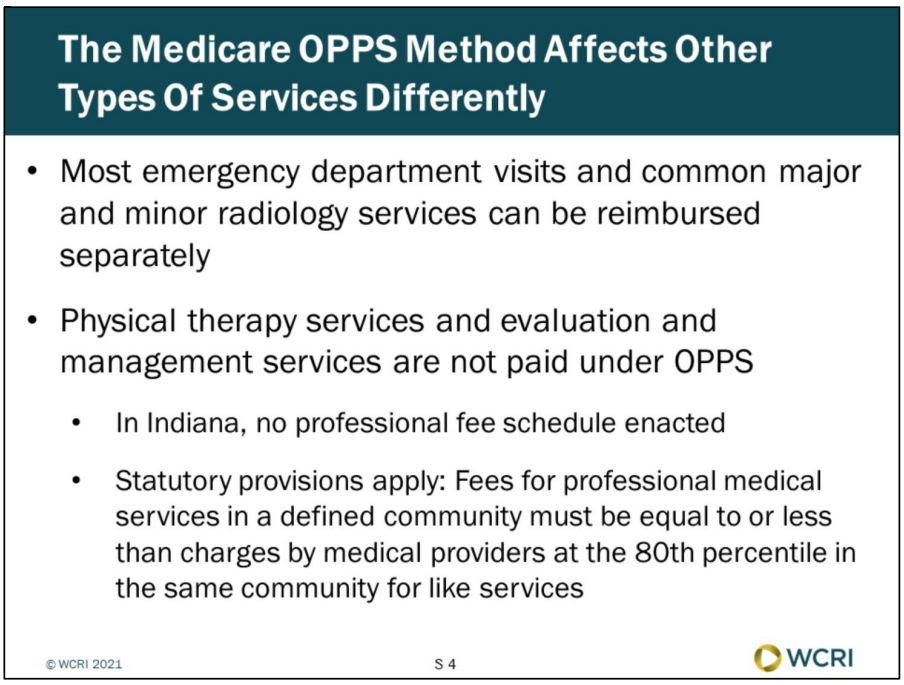


Key: **APC:** Ambulatory payment classification, a payment methodology developed by Medicare to reimburse outpatient hospital and ambulatory surgery center services and procedures. The methodology categorizes visits according to clinical characteristics and typical resource use, as well as the costs associated with the diagnoses and procedures performed. **CPT:** Current Procedural Terminology. **Medicare:** Centers for Medicare & Medicaid Services. **OPPS:** Hospital Outpatient Prospective Payment System.

Medicare establishes the hospital outpatient fee schedules at the APC level. APCs are established by grouping together CPT codes that utilize a similar combination of resources to treat a patient. For each APC, a single rate is paid for the primary independent service, and payment for supportive services is packaged into this APC rate.

For additional information on the Hospital Outpatient Prospective Payment System, see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html.



Key: **Medicare:** Centers for Medicare & Medicaid Services. **OPPS:** Hospital Outpatient Prospective Payment System.

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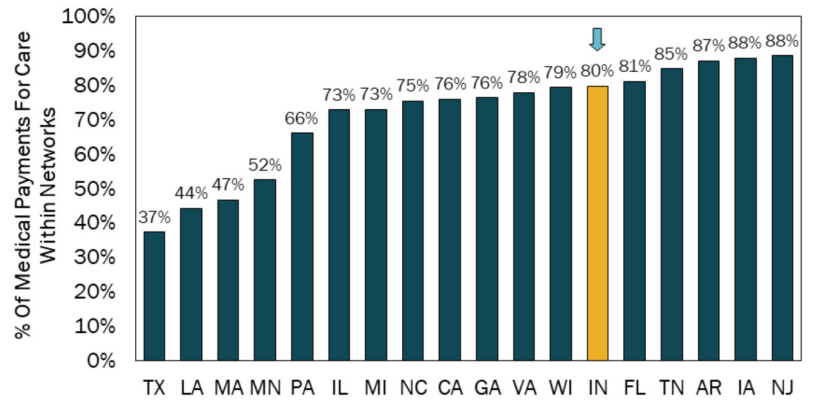
Other Factors That May Have Contributed To Recent Trends In Hospital Outpatient Payments

- Medicare reimbursement changes
  - 2015: Introduction of comprehensive-APC (C-APC) payment model to simplify reporting and reimbursement for high-cost, complex outpatient procedures; all related payments are packaged under a single rate
  - 2016: List of C-APCs expanded to include most common shoulder surgeries typically used in WC
  - 2017: List of C-APCs expanded to include most common knee surgeries typically used in WC
- Changes in network use

 S 5 WCRI

Key: **APC:** Ambulatory payment classification, a payment methodology developed by Medicare to reimburse outpatient hospital and ambulatory surgery center services and procedures. The methodology categorizes visits according to clinical characteristics and typical resource use, as well as the costs associated with the diagnoses and procedures performed. **Medicare:** Centers for Medicare & Medicaid Services. **WC:** Workers' compensation.

Indiana % Of Medical Payments For Care In Networks Slightly Higher Than Other States



Note: IN enacted a hospital fee schedule effective July 1, 2014. States with no medical fee schedules: IA, NJ, and WI.
Claims With > 7 Days Of Lost Time, Calendar Year 2019

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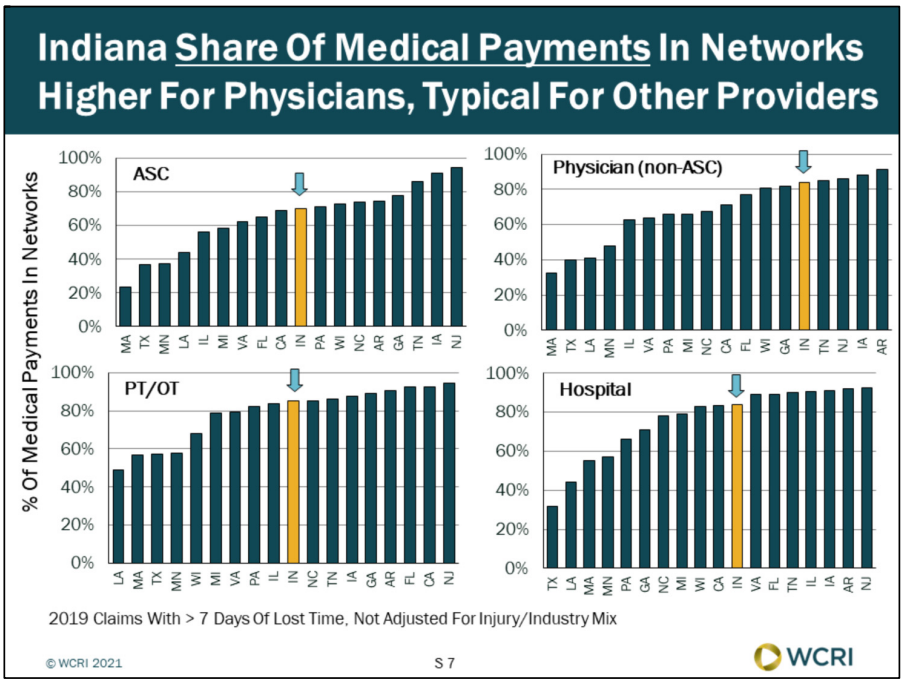
This slide shows the percentage of overall medical payments to health care providers in networks in 2019. Note that here we capture medical payments made in any type of health care network (HMO and PPO).

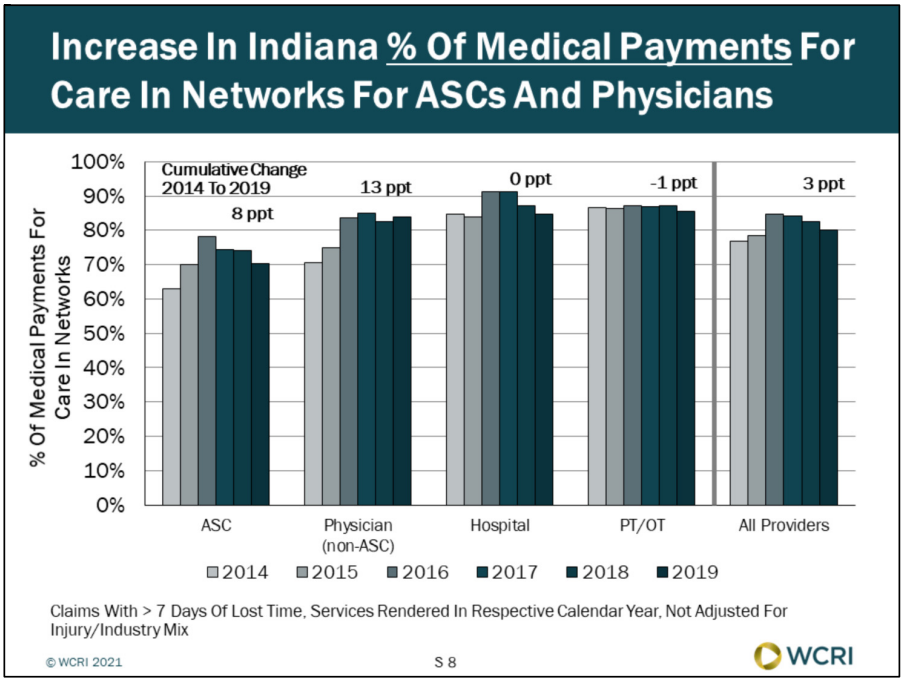
States that do not regulate reimbursement for medical care through a traditional fee schedule tend to use medical networks frequently as a way to help control medical costs. Indiana enacted a hospital fee schedule effective July 1, 2014. Reimbursement for nonhospital services is not regulated through a fee schedule in Indiana.

Key and definition: **ASC:** Ambulatory surgery center. **HMO:** Health maintenance organization. **PPO:** Preferred provider organization. **% of payments for care in networks:** This measure is based upon identification of network care provided by the data sources. We calculate this percentage as the total payments to providers for medical care rendered within a health care network divided by the total payments to providers for all medical care, in and out of networks.



We have separated the comparison for medical payments for care in networks by physicians into two charts—for physician services in freestanding ASCs and for physician services in non-ASC facilities. At 84 percent, the percentage of medical payments for care in networks by physicians in Indiana was higher than typical. For all other provider types, the percentage of medical payments in networks was typical.

Key: **ASC:** Ambulatory surgery center. **PT/OT:** Physical/occupational therapist.



This slide shows the trend in the percentage of medical payments for care in networks by type of provider in Indiana.

The percentage of medical payments made to physicians for network care increased in Indiana compared with small changes in other provider types. Although the proportion of payments for network care increased for ASCs overall, after 2016, there was a decline in network use. For hospital services, the decrease from 2017 to 2019 was driven by a decrease in the share of payments for evaluation and management and physical medicine.

Between 2014 and 2019, many states experienced an increase in network use overall. We also observed a decrease in the proportion of medical payments made to ASCs in networks.

Key: **ASC:** Ambulatory surgery center. **PT/OT:** Physical/occupational therapist. **ppt:** Percentage points.

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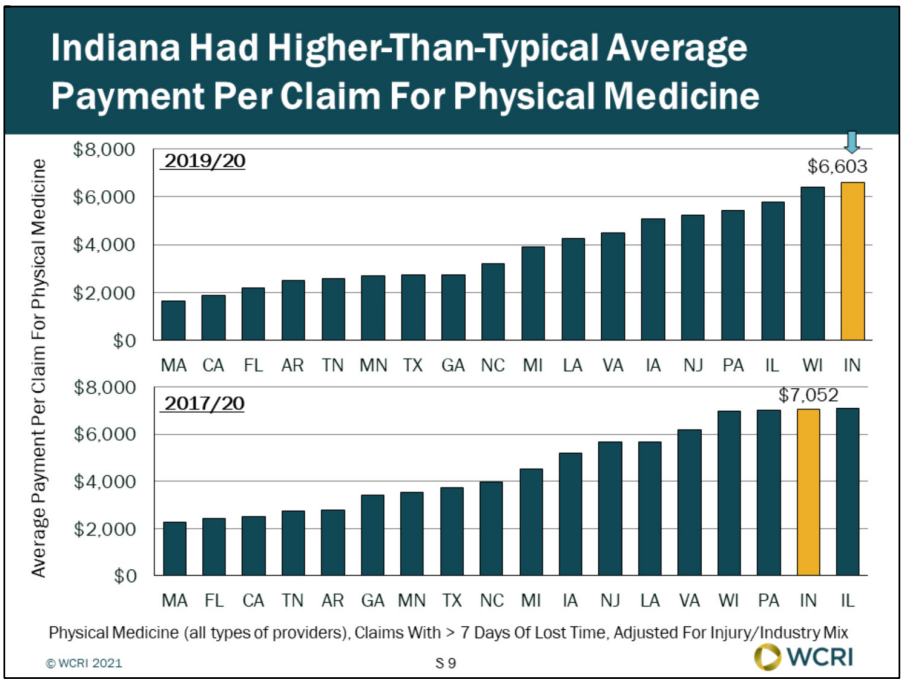
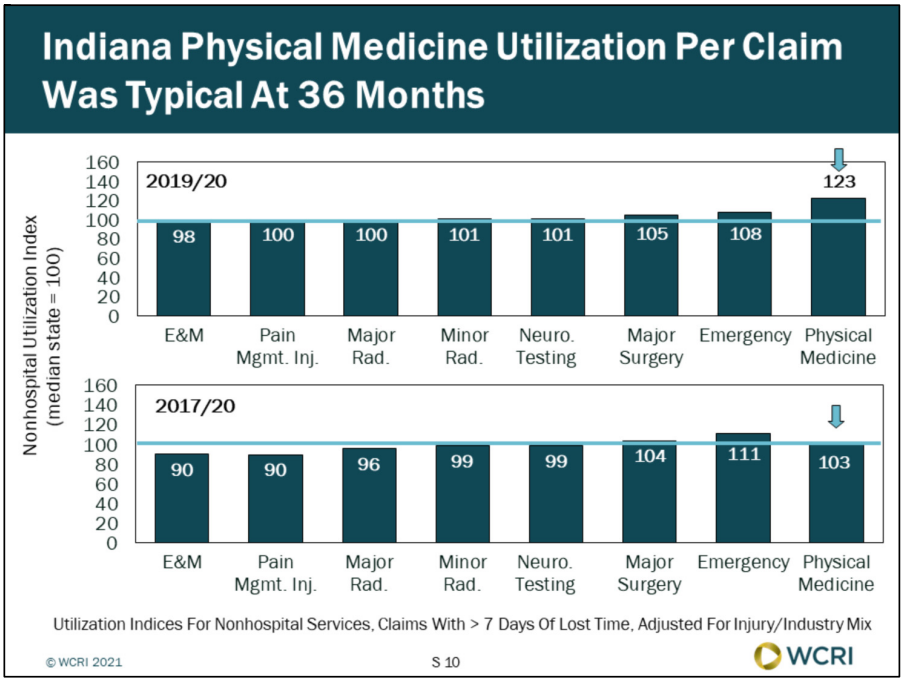


Indiana had a higher average payment per claim for physical medicine than other study states. The result is based on all types of providers of physical medicine. Higher-than-typical payments per claim in Indiana resulted mostly from higher prices paid for these services. Utilization per claim was higher than other states at 12 months but typical at 36 months.

Key: **All types of providers:** In the context of physical medicine, includes nonhospital and hospital outpatient providers.



This slide shows a utilization index for commonly billed nonhospital services, with the median state set at 100.

Physical medicine utilization per claim in Indiana was higher among the study states for claims at 12 months (top chart). However, for claims at 36 months (bottom chart) utilization per claim was typical.

Utilization of other nonhospital services in Indiana was similar to or lower than the median study state at all claim maturities.

Key and definitions: **E&M:** Evaluation and management (office visits). **Emergency:** Emergency department visits. **Major surgery:** Includes invasive surgical procedures such as knee and shoulder arthroscopies, laminectomies, and laminotomies. **Neuro. Testing:** Neurological and neuromuscular testing. **Pain Mgmt. Inj.:** Pain management injections. **Rad.:** Radiology. **Utilization** is benchmarked using a utilization index that incorporates several aspects of medical care: number of visits per claim, number of services per visit, and the resource intensity of services provided. The average number of services per claim was relative value unit weighted. See the *Technical Appendix* for more detail on how the utilization index was constructed.

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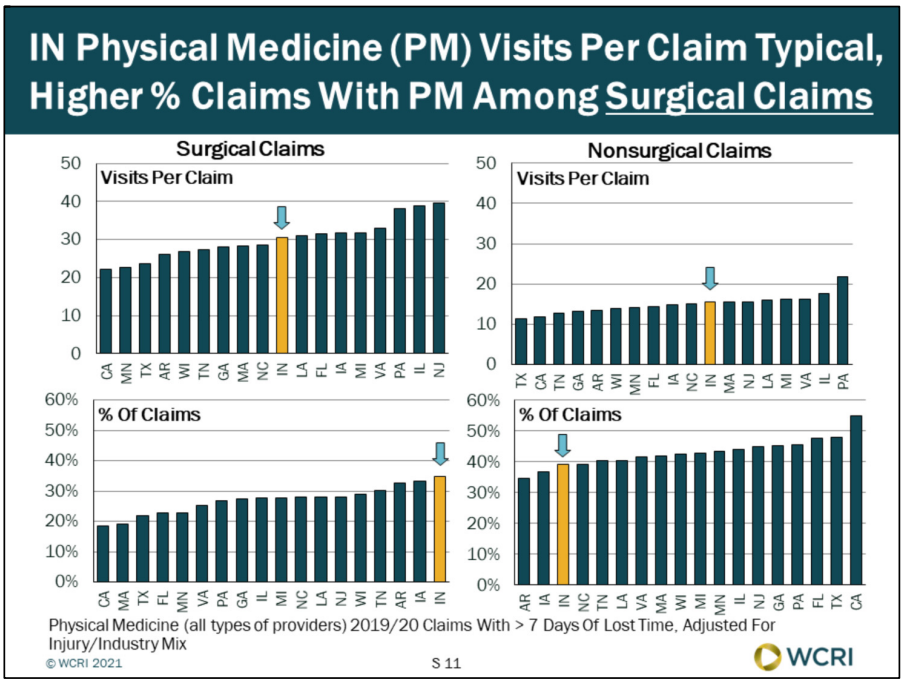
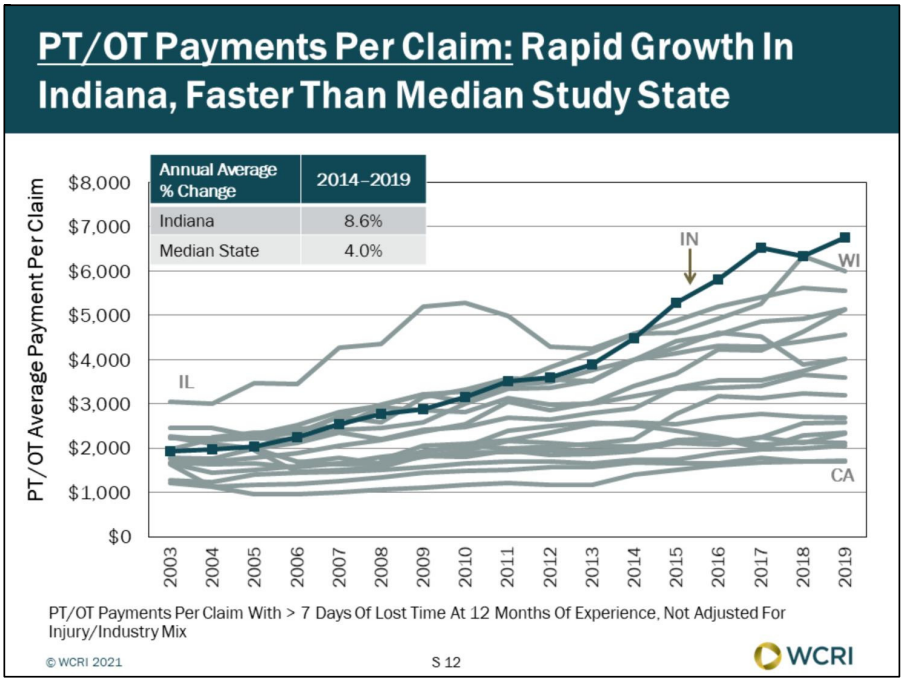


Another way of looking at utilization of physical medicine is by examining surgical and nonsurgical claims.

Indiana had a higher percentage of claims with physical medicine among surgical claims. However, providers in Indiana used a typical number of visits per claim compared with other study states. Indiana had the highest surgery rate among the study states (for all claim maturities).

Definitions: **All types of providers:** In the context of physical medicine, includes nonhospital and hospital outpatient providers. The overall number of visits per claim and services per visit takes into account all combinations of number of visits and services to nonhospital and hospital outpatient providers. Some claims may have visits for more than one provider type. **Nonsurgical claim:** Includes treatment related to fractures, infections, and burns. **Surgical claim:** Includes treatment involving invasive surgical procedures such as knee/shoulder arthroscopy and carpal tunnel.

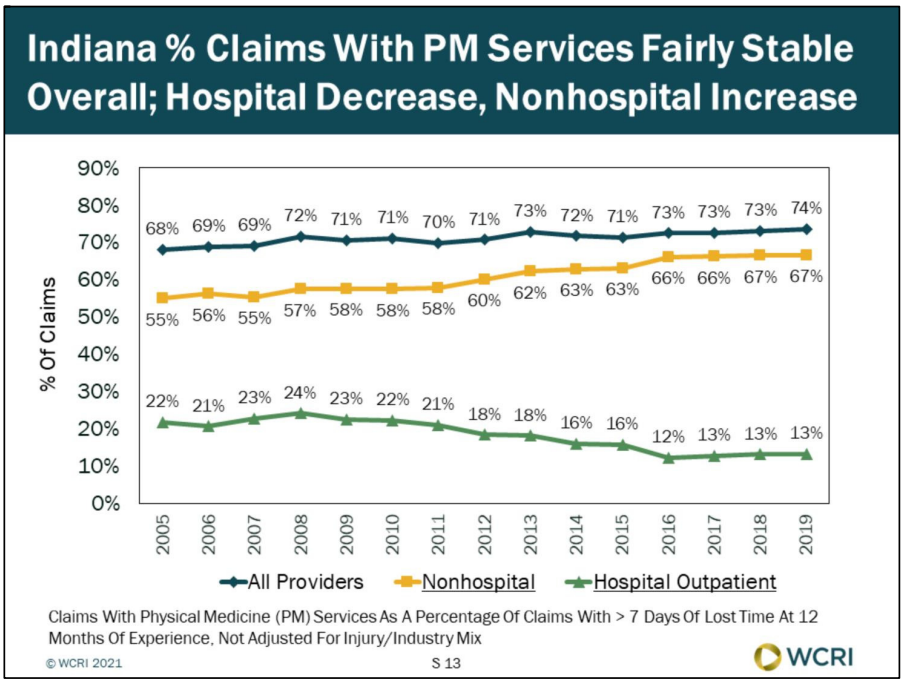


Another major category of medical providers is PT/OTs. They represented 21 percent of total medical payments in Indiana in 2019. The average payment per claim to PT/OTs in Indiana grew rapidly between 2014 and 2019. This growth in Indiana was faster than the median study state. Stakeholders with multistate perspectives suggested that the growth in physical medicine payments per claim among most study states might be related to a decline in opioid use. See the "Discussion of Major Findings" for details.

The line on the top of the chart until 2014 represents Illinois. In September 2011, as part of major reforms, Illinois reduced the fee schedule rates for all medical services by 30 percent. Subsequently, the average medical payment per claim to PT/OTs decreased 19 percent between 2010 and 2012.

Key: **PT/OT:** Physical/occupational therapist; payments to PT/OTs are for all services they provide and bill (whether or not the services are considered physical medicine services).

Note: 2019 refers to injury year/evaluation 2019/20. Other injury year/evaluation combinations are denoted similarly.

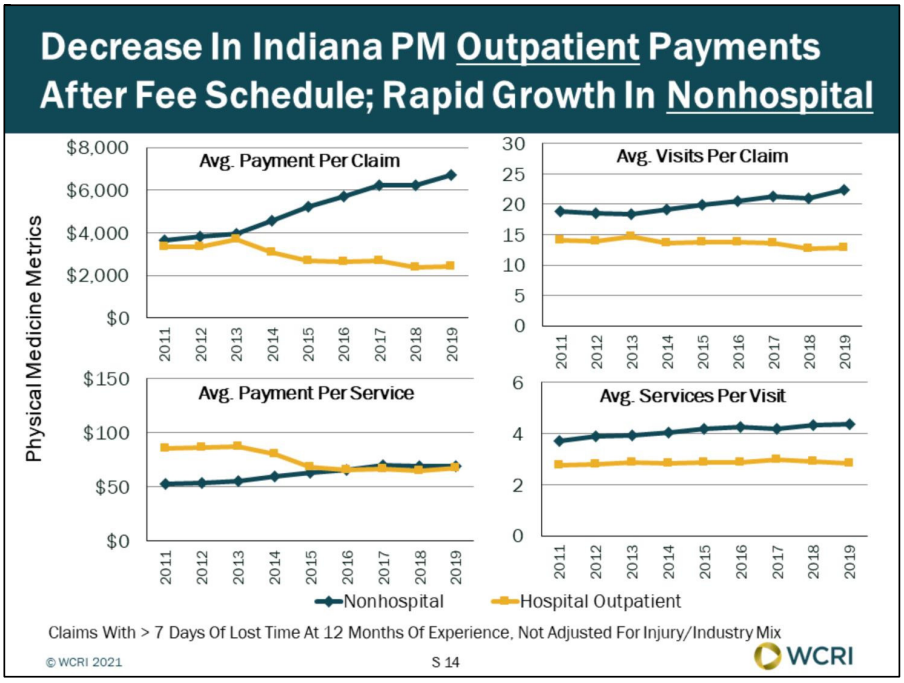


This chart shows the trend in the percentage of claims with physical medicine services, overall and for services billed by nonhospital and hospital providers, for claims at 12 months of experience. For all providers combined, the percentage of claims with physical medicine services was fairly stable, at 72–74 percent from 2014 to 2019. There has been, however, a notable shift to nonhospital providers from hospital outpatient providers.

From 2014 to 2019, the percentage of claims with physical medicine services decreased about 3 percentage points for hospital outpatient providers and increased 4 points for nonhospital providers. Note that the shift began 2008–2009, prior to the implementation of the hospital fee schedule.

Key: **PM:** Physical medicine.

Note: 2019 refers to 2019/20. Other injury year/evaluation combinations are denoted similarly.



These charts compare the trends in metrics for physical medicine services billed by nonhospital and hospital outpatient providers.

As shown in the upper left chart, from 2013 to 2019, payments per claim increased 9 percent per year for nonhospital providers but decreased 7 percent per year for hospital outpatient providers, after implementation of the hospital fee schedule effective July 1, 2014. Note that payments per service became similar for the two billing providers after the fee schedule (see lower left chart).

The average number of visits per claim increased for nonhospital providers but decreased for hospital outpatient providers. Since 2011, the average number of PM visits per claim has increased from 18–19 to 22 among nonhospital providers; decreased from 14–15 to 13 among hospital outpatient providers.

Key and definition: **Avg.:** Average. **Billing provider:** Medical professional or entity that bills for the services rendered. In some cases, the billing provider and rendering provider are the same. In some cases, the billing provider may have multiple rendering providers. **PM:** Physical medicine.

Note: 2019 refers to 2019/20. Other injury year/evaluation combinations are denoted similarly.

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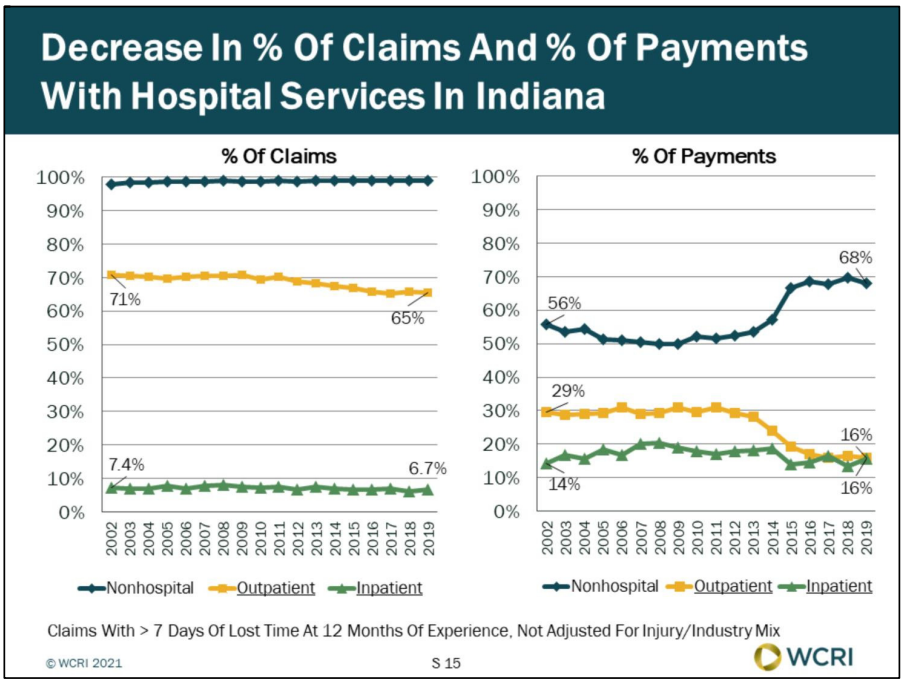


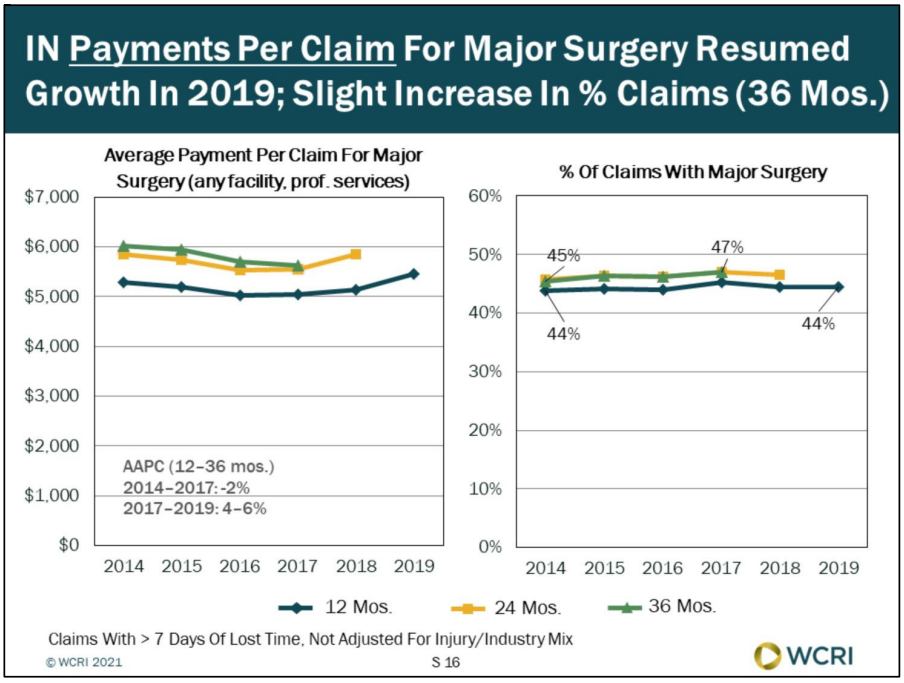
Note: 2019 refers to injury year/evaluation 2019/20. Other injury year/evaluation combinations are denoted similarly.

One dimension of medical utilization is the percentage of claims that received a specific service. The proportion of claims with hospital services decreased in Indiana.

A number of factors drove the trends in medical costs and utilization by provider. Some services have shifted from inpatient to hospital outpatient, while others have shifted from hospital outpatient to nonhospital settings. In Indiana, the introduction of the hospital fee schedule also contributed, as there was a shift in the billing provider for some services, particularly physical medicine.

Evidence from the general health care market also shows that hospital-provided care has shifted steadily from inpatient to outpatient settings. Much of this shift has been driven by advancements in technology, which allows complex procedures to be performed in an outpatient setting.

Trends in health care spending for the Medicare program from 2006 to 2014 showed a shift in services from inpatient to outpatient settings. See recent publications here.



From 2014 to 2019, there was a slight increase in the proportion of claims with major surgery in Indiana at 36 months; no change at 12 months. The average payment per claim for major surgery decreased about 2 percent per year between 2014 and 2017, followed by a 4–6 percent growth per year between 2017 and 2019.

Key: **AAPC:** Annual average percentage change. **Mos.:** Months. **Prof.:** Professional.

Note: For claims at 12 months, 2019 refers to injury year/evaluation 2019/20. For claims at 36 months, 2017 refers to injury year/evaluation 2017/20. Other injury year/evaluation combinations are denoted similarly.

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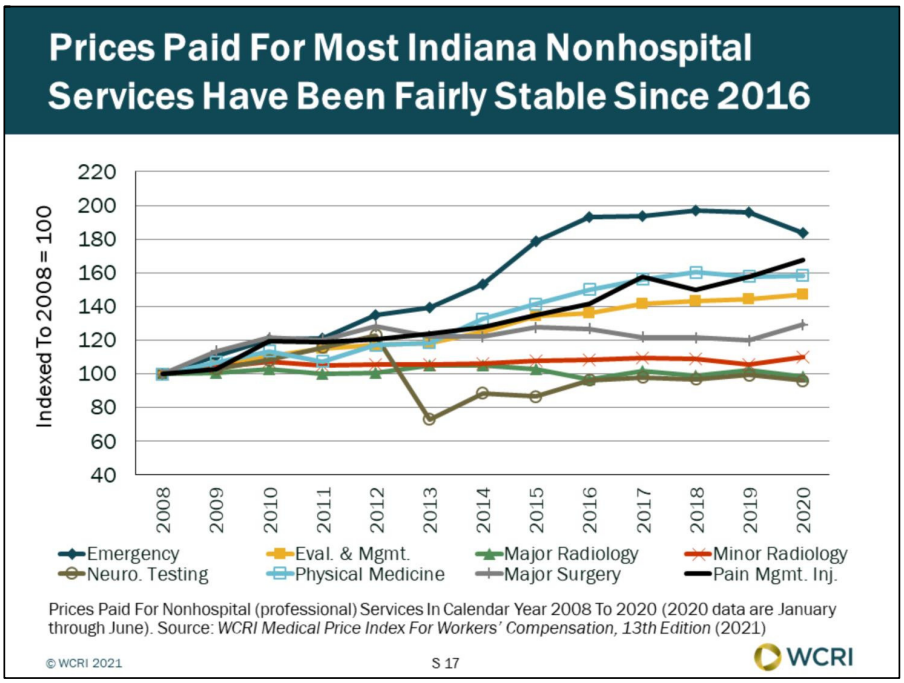


From 2013 to 2019, prices paid for nonhospital (professional) services increased 2.6 percent per year in Indiana. Within that period, however, there were different trends.

From 2016 to 2020, prices paid for most nonhospital services changed little in Indiana. The exception was pain management injections, for which prices paid increased about 4 percent per year.

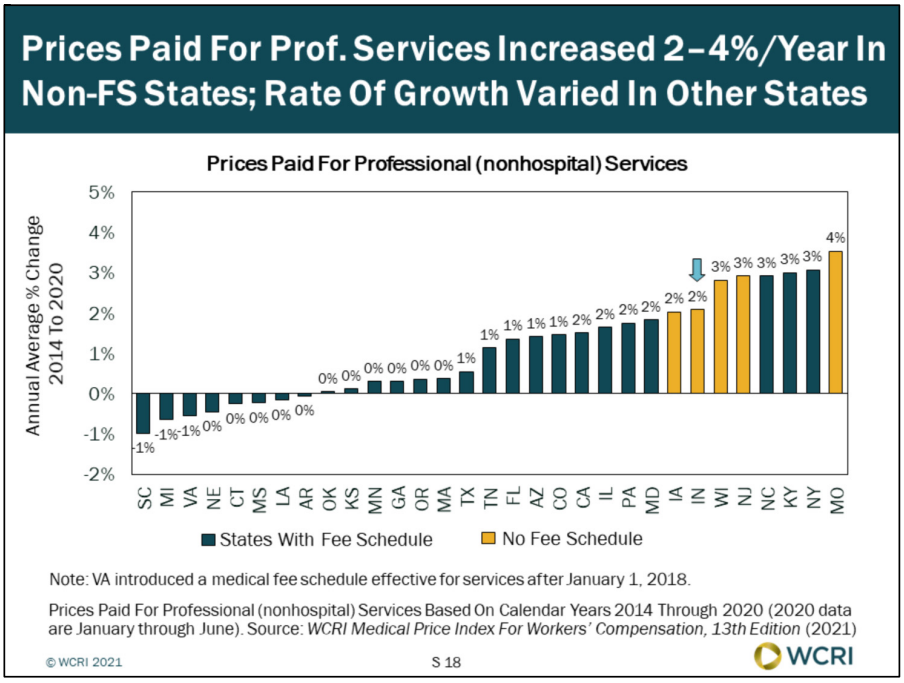
In contrast, prices paid for some nonhospital services in Indiana increased from 2013 to 2016.

More prevalent network participation and larger discounts in the negotiated prices under network agreements may have contributed to nonhospital price trends.

Nonhospital Prices Paid (AAPC)	2013–2016	2016–2020
Emergency	11.5%	-1.3%
Neuro. Testing	9.7%	-0.1%
Minor Radiology	0.9%	0.4%
Major Surgery	1.2%	0.5%
Major Radiology	-2.8%	0.5%
Physical Medicine	8.2%	1.3%
Eval. & Mgmt.	4.8%	2.0%
Pain Mgmt. Inj.	4.5%	4.3%
Overall	**4.6%**	**1.2%**

Key and definitions: **AAPC:** Annual average percentage change. **Emergency:** Includes emergency department visits for patients with various levels of severity and office services provided on an emergency basis. **Eval. & Mgmt.:** Evaluation & management (office visits). **FS:** Fee schedule. **Neuro. Testing:** Neurological and neuromuscular testing, such as F-wave studies. **Pain Mgmt. Inj.:** Pain management injections, including injection procedures that are commonly used for pain management, such as epidural or steroid injections on nerve roots and muscles for lumbar, sacral, cervical, or thoracic areas.

Source: Yang and Fomenko. 2021. *WCRI Medical Price Index for Workers' Compensation, 13th Edition*.

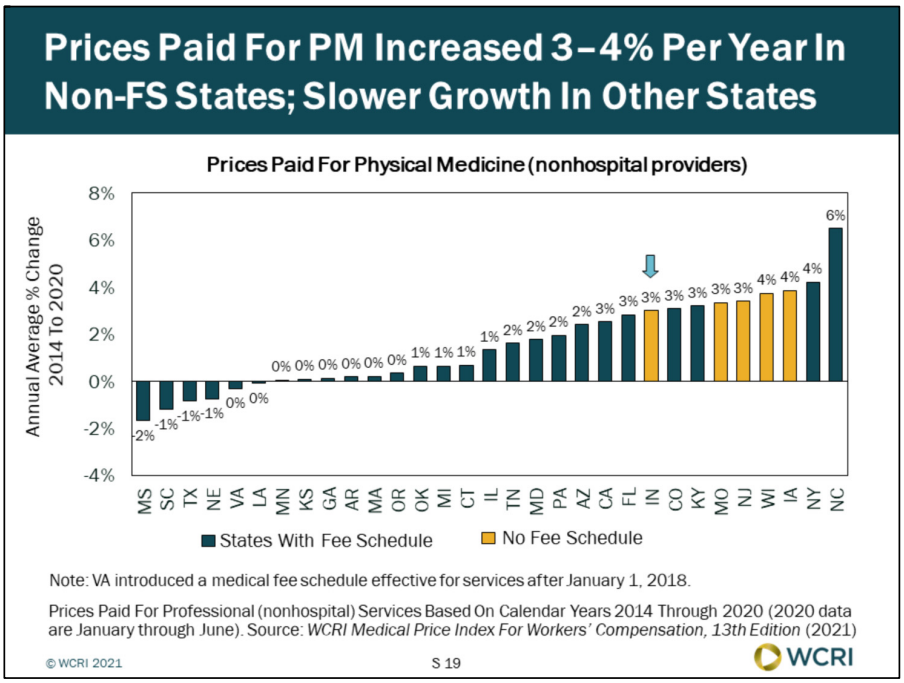


Prices paid for all professional services grew mostly in states that do not have medical fee schedules. Other states experienced no change or a small increase in prices paid from 2014 to 2020.

Increases for Kentucky, New York, and North Carolina reflect fee schedule changes in these states.

Key: **FS:** Fee schedule. **Prof.:** Professional.

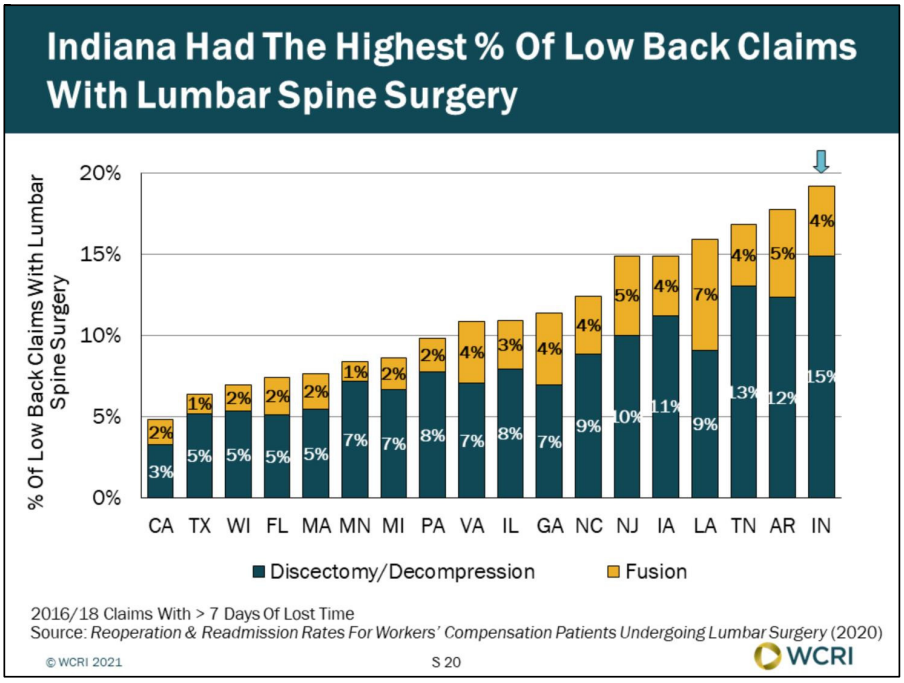
Source: Yang and Fomenko. 2021. *WCRI Medical Price Index for Workers' Compensation, 13th Edition (MPI-WC)*.



Prices paid for physical medicine grew mostly in states that do not have medical fee schedules. Other states experienced no change or a small decrease in prices paid from 2014 to 2020.

Key: **FS:** Fee schedule. **PM:** Physical medicine.

Source: Yang and Fomenko. 2021. *WCRI Medical Price Index for Workers' Compensation, 13th Edition (MPI-WC)*.



The analysis in WCRI's *Reoperation & Readmission Rates for Workers' Compensation Patients Undergoing Lumbar Surgery* focuses on claims with low back conditions, including claims with radiating leg pain or neurological findings, and low-back-pain-only claims. Among these claims, common lumbar spine surgeries were identified. These include discectomy and fusion surgery.

Indiana had the highest percentage of claims with lumbar spine surgery of the study states.

See the "Discussion of Major Findings" for factors affecting the surgery rates.

Source: Wang, Mueller, and Liu. 2020. *Reoperation & Readmission Rates for Workers' Compensation Patients Undergoing Lumbar Surgery*. See the "Data and Methods" section for a description of how low back claims and lumbar spine surgery were identified.

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QUICK REFERENCE GUIDE TO FIGURES AND TABLES

PART 1: INTERSTATE COMPARISONS

(FIGURES ARE FOR CLAIMS WITH 12 MONTHS OF MATURITY; FIGURES FOR CLAIMS WITH 24 OR 36 MONTHS OF MATURITY ARE NOTED)

Measures	Overall	Nonhospital Providers (physicians, chiropractors, and PT/OTs)			Hospital Providers			
		Overall	By Provider Type	By Service Group	Overall	Hospital Outpatient Services		Hospital Inpatient Services
						Overall	By Service Group	
Average medical payment per claim	Figure 2 Figure 3 (36 mos.)	Figure 4	Figure 5	Figure 9	Figure 4 Figure 17	Figure 17 Figure 18	Figure 18	Figure 17
Percentage of claims		Figure 4	Figure 5	Figure 10	Figure 4	Figure 17	Figure 19	Figure 17
Percentage of medical payments		Figure 4	Figure 5	Figure 11	Figure 4		Figure 20	
Average price/ payment per service		Figure 6	Figure 6	Figure 12		Figure 21	Figure 22	
Utilization/services per claim		Figure 6	Figure 6	Figure 13		Figure 21	Figure 23	
Visits per claim		Figure 7	Figure 7	Figure 14			Figure 24	
Services per visit		Figure 7	Figure 7	Figure 15			Figure 25	
Resource intensity		Figure 7	Figure 7	Figure 16				
Payments for network care	Figure 29	Figure 29	Figure 29		Figure 29			

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PART 2: INTRASTATE TRENDS

Measures	All Providers, All Services	Nonhospital Providers (physicians, chiropractors, and PT/OTs)	Hospital Providers		
			Overall	Outpatient	Inpatient
Average medical payment per claim, all paid claims	Figure 30				
Claims with more than 7 days of lost time					
Average medical payment per claim, percentage of claims, and percentage of payments	Figure 31	Figure 32	Figure 33	Figure 73	Figure 72
Prices/payments per service		Figure 34		Figure 73	
Utilization/services per claim and components		Figure 35		Figure 73	
Average medical payment per claim, prices, utilization, and components, by provider type					
Physician		Figures 36–41			
Chiropractor		Figures 42–47			
Physical/occupational therapist		Figures 48–53			
Average medical payment per claim, prices/payments per service, utilization/services per claim, and components, by service group					
Evaluation and management		Figures 54–56		Figure 79	
Major radiology		Figures 57–59		Figure 75	
Minor radiology		Figures 60–62		Figure 76	
Pain management injections		Figures 63–65			
Physical medicine		Figures 66–68		Figure 78	
Major surgery		Figures 69–71			
Treatment/operating/recovery room				Figure 74	
Laboratory/pathology				Figure 77	
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Notes: The number of states included in the calculation of the median state can vary for different measures due to exclusion of the data for some states. Data for certain states can be excluded if the data are not sufficiently representative of a state's trends or cannot support an interstate comparison, or if the underlying data show extreme volatility for a specific measure, among other reasons. The footnotes for each table provide details regarding the calculation of the median state for a specific measure.

Website Addresses for Additional Data

All figures and tables for Indiana: https://www.wcrinet.org/images/uploads/files/csmed22_IN.pdf

CompScope™ Medical Benchmarks: Technical Appendix, 22nd Edition:
https://www.wcrinet.org/images/uploads/files/csmed22_technical_appendix.pdf

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Of course, any errors or omissions that remain are the responsibility of the authors.

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