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May 15, 2008

Chris Voegele
Senior Policy and Research Specialist
Texas Department of Insurance
Division of Workers Compensation
ATTN: Health Care Policy, MS-7
7551 Metro Center Drive
Austin, TX 78744

Re: Texas Department of Insurance - Comparison of Commercial and Medicare ASC Payment Rates

Dear Chris:

Deloitte Consulting LLP (Deloitte Consulting) greatly appreciates the opportunity to provide actuarial services to the Texas Department of Insurance, Division of Workers Compensation (DWC). The goal of this project is to perform a review of commercial reimbursement for ASC services in Texas, and compare commercial reimbursement with APC based Medicare payments.

EXECUTIVE SUMMARY

Our analysis indicates that current 2006 commercial reimbursement in Texas for ASC services is consistent with 236% - 288% of 2008 Medicare reimbursement. Exhibit V and VI (enclosed) illustrate the impact by major APC (the most expensive APC on a given claim) for 2008. Our market analysis indicates an average reimbursement of 198% - 236% for the entire Texas market (commercial and Medicare). Our methodology in arriving at these figures is described in the body of this report.

BACKGROUND

In recent decades, Ambulatory Surgical Centers (ASCs) have become an integral part of healthcare delivery by providing a cost effective alternative to hospital outpatient surgery. Historically, approved services have been reimbursed by Medicare based on ASC surgical groupers.

Effective January 2008, CMS implemented a new payment system based on the Outpatient Prospective Payment System (OPPS) which adjusts OPPS payment rates for the lower cost of performing procedures in an ASC setting. Aggregate ASC reimbursement will be approximately 65% of full OPPS. CMS has published a list of 4,120 CPT and HCPCS codes that are eligible for reimbursement. Claims must contain one or more of these codes to be reimbursed through Medicare. CMS has implemented a four year transition period beginning in 2008 to smooth the reimbursement changes for individual procedures. Additionally, CMS increased the proportion of the payments that are wage index adjusted from 34.45% to 50%. The transition schedule is shown in Table 1 below.

Table 1 – Transition Schedule for 2008-2011 Medicare ASC Payments

Transition Year	2007 Payment Rate Proportion	Fully Implemented Rate Proportion
2008	75%	25%
2009	50%	50%
2010	25%	75%
2011	0%	100%

Texas Labor Code 413.011 requires DWC to adopt Medicare methodologies in developing fee guidelines for use in the Texas Workers Compensation System. Through 2007, the division reimbursed workers compensation ASC claims at 213.3% of Medicare. The significant changes in Medicare's ASC reimbursement as of 2008 require DWC to re-examine their current reimbursement for workers compensation ASC claims. This analysis assists DWC in their examination of market reimbursement rates for ASC services.

SCOPE OF SERVICES

We were engaged to perform the following tasks for DWC:

1) Perform a review of commercial reimbursement for ASC services in Texas, and compare commercial reimbursement with 2008 Medicare payments.

DATA SOURCE

The source of commercial data for this analysis is the 2006 Medstat MarketScan Databases (Medstat). The Medstat MarketScan databases capture person-specific clinical utilization, expenditures, and enrollment across inpatient, outpatient, prescription drug, and carve-out services from a selection of large employers, health plans, government and public organizations, Blue Cross Blue Shield plans, and third party administrators. The MarketScan Databases link paid claims and encounter data to detailed patient information across sites and types of providers, and over time. The annual medical databases include private sector health data from approximately 100 payers. Historically, more than 500 million claim records are available in the MarketScan Databases. These data represent the medical experience of insured employees and their dependents for active employees, early retirees, COBRA continues and Medicare-eligible retirees with employer-provided Medicare Supplemental plans. 2006 Texas Medstat data includes claims information for over one million members.

RELIANCE AND LIMITATIONS

In completing this analysis, Deloitte Consulting relied on information provided by Medstat. This data has been reviewed for reasonableness and consistency, but the nature of our service is not that of an audit or other attest service so no detailed audit of the data was performed. We note that in certain areas there were issues with the data provided by Medstat. In such cases, we applied Actuarial Standard of Practice No. 23 (ASOP 23) - Data Quality. ASOP 23 sets the following standard regarding imperfect data:

"Use of Imperfect Data - The actuary may be aware that the data are incomplete, inaccurate, or not as appropriate as desired. In such cases, the actuary should consider whether the use of such imperfect data may produce material biases in the results of the study, or whether the data are so inadequate that the data cannot be used to satisfy the purpose of the study."

In cases where we encountered issues with the data, we were able to make adjustments to the data or use other actuarial techniques that we believe do not produce material biases in the results of the study. Thus, we were able to complete our analysis based solely on the data as provided by Medstat. Data issues related to device intensive procedures are described further in the body of this report.

ASSUMPTIONS AND METHODOLOGY

Non Device Intensive Procedures

The goal of this project is to compare 2008 Medicare ASC reimbursement to 2006 commercial reimbursement. The following steps outline our process in identifying, filtering, and manipulating the data –

1) Identify ASC facility claims using 'provider type'.

2) Supplement ASC claims with coding information from outpatient and physician claims based on member and date of service to ensure that all appropriate CPT codes were captured.

3) Remove claims with zero or negative allowed amounts.

4) Remove claims for patients less than 18 years of age. Claims for juveniles are not representative of a workers compensation population.

5) Exclude claims with no facility CPT procedure codes.

A significant number of Medstat facility claims lack CPT procedure codes due to commercial payment mechanisms that often do not require CPT codes for reimbursement. Our analysis indicates that procedure code information available in the physician claims cannot provide a full picture of patient care in the absence of facility CPT codes. As a result, all claims where facility procedure codes were omitted were analyzed and ultimately excluded from our analysis.

The following table summarizes the claims data and criteria for inclusion in our analysis.

Table 2 – Summary of Claims Included in Analysis

Medstat - Texas Data Summary (2006)	Non Device Intensive Claims	Device Intensive Claims
ASC Claims in Raw Data [1]	42,348	52
Reason for exclusion -		
Allowed <= 0	818	0
Patient Age < 18	3,476	0
Invalid Procedure Information	21,010	40
No Average Cost Information (Device Intensive Claims Only)	n/a	2
Claims Analyzed	**17,044**	**10**

[1] Number of claims based on unique member and service date combination.

Many claims containing one or more valid Medicare procedure codes also contain additional claim lines with no CPT. For these claims, it is not possible to determine whether the omitted CPT procedure codes are associated with a Medicare approved service. Due to the inclusion of physician CPT codes, many of these services may have been accounted for, but others likely have not. Medicare

reimbursement may be understated in cases where physician claims do not contain appropriate coding for the omitted services. As a result of this uncertainty, we have developed reimbursement ranges comparing commercial reimbursement to Medicare. The low end of each range includes only Medicare reimbursable facility line items, the high end of each range includes Medicare line items, and all facility line items where service type could not bet determined. Both figures exclude line items including procedure codes for services such as laboratory and radiology where Medicare reimburses through different fee structures. We believe actual commercial percentages of Medicare reimbursement lie between the endpoints of the range we created.

Device Intensive Procedures

As of 2008, Medicare bundles reimbursement rates for device intensive procedures to include payment for both the procedure and device. Each device intensive procedure code is reimbursed only in combination with the proper HCPCS device code. 2006 Medstat data included just 12 device claims for which grouping and pricing was possible. Few of these claims contained the device codes required for 2008 Medicare reimbursement. We analyzed the HCPCS codes contained in these claims to identify individual claim lines associated with implantable devices, and to determine which claims lacked device information.

In order to determine 2008 Medicare reimbursement for device intensive claims, we added an appropriate Medicare implantable HCPCS code to each device intensive procedure. We assumed that the device cost for these claims was equal to the average device cost for the CPT procedure code for claims containing device information. Average costs were based on CPT procedure code since we could not be certain which implantable device was used in each procedure. For procedures that already included a HCPCS device code, we revised the code to allow for Medicare grouping and pricing, but did not adjust the paid amounts from the original claim. While the quantity of device claims does not provide credible results, the following table summarizes the average costs used for each CPT procedure code. Device intensive claims where an average device cost could not be determined were excluded from our analysis. See Appendix VII for a complete list of 2008 Medicare device intensive procedures.

Table 3 – Summary of Average Device Costs by CPT Procedure Code

CPT Procedure Code	Claims Containing Procedure Code	Groupable Claims with Device Paid > 0	Average Device Paid for Groupable Claims with Device Paid > 0
63650	5	3	2,637
63650 & 63685	3	3	33,920
62361 & 62362	1	1	4,469
62361	1	1	990
53440	1	0	
62362	1	0	

TDI was interested in reviewing device intensive claims performed in an ASC environment for the commercial market. The results in Medstat, as described here, are not robust or credible enough to draw conclusions about commercial market reimbursement for ASC device intensive claims.

FINDINGS AND OBSERVATIONS

After the appropriate exclusions and adjustments were completed, all claims were run through the 3M Coding and Reimbursement Software. Our analysis indicates that 2006 Commerical reimbursement

falls between 236% and 288% of Medicare. These figures are based on the proportion of services in 2006 Medstat data, which closely represent the commercial mix present in Texas.

The following table summarizes the results by coverage type.

Table 4 – Comparison of Commercial and Medicare Reimbursement by Coverage Type [1]

Coverage Type	Claims	Including Only ASC Reimbursable Services	Including ASC Reimbursable Services and Unknown Services
PPO	10,514	265%	341%
HMO	2,991	148%	150%
All Other [2]	3,539	217%	234%
Total [3]	17,044	236%	288%

[1] Includes claims with valid Medicare CPT in facility data.
[2] The 'All Other' category includes traditional indemnity, high deductible, basic medical, and major medical coverages.
[3] Total based on proportion of data submitted for Medstat database. Included claims are 62% PPO, 17% HMO and 21% other.

Outlier Claims

We also reviewed the impact of outlier claims on these relativities. Our analysis includes 37 Medstat non-device intensive claims from 2006 with allowed amounts in excess of $30,000 while DWC data contains just two such claims. Because the 37 claims could not be identified as device intensive procedures and with allowed amounts of greater than $30,000, they appear to be outlier reimbursement amounts. As a result of the higher prevalence rate in Medstat, outliers represent a material impact to the overall commercial relativity to Medicare. Due to a higher rate of commercial reimbursement for claims with allowed amounts in excess of $30,000, their exclusion would result in a reduction to the relativities summarized in Table 4 of approximately 9-10% of Medicare.

Trend

The figures in Table 4 represent a comparison of 2006 commercial reimbursement to 2008 Medicare payments. It is likely that 2008 commercial payment levels are higher than 2006 due to medical inflation. Recent Government medical CPI statistics indicate an annual medical inflation rate 3.6% for 2006 and 5.2% for 2007. The application of trend to commercial claims would result in an aggregate increase to the results in Table 4.

Market Analysis

DWC also requested that we perform a market analysis to determine composite reimbursement for ASC services in Texas. This analysis includes individuals with commercial or Medicare coverage. Table 5, which follows, profiles the Texas ASC market based on our analysis of HealthLeaders, Medstat, and other internal sources.

Table 5 – Texas ASC Market Reimbursement Analysis

Coverage Type	Percentage of Texas Enrollment	Utilization/ Intensity Adjustment	Percentage of Texas Claim Costs	Reimbursement as a Percentage of Medicare	
				ASC Reimbursable Services Only	ASC Reimbursable and Unknown Services
Medicare	15%	2.70	32%	100%	100%
HMO	9%	0.89	6%	148%	150%
PPO / Other	76%	1.02	62%	253%	314%
Total	100%	1.26	100%	198%	236%

We appreciate the opportunity to work with the Texas Department of Insurance on this important project. Please contact Steve Wander at (612) 397-4312, Dan Feucht at (612) 397-4742, or Taylor Pruisner at (612) 659-2651 if you have any questions or need additional information.

Sincerely,

Steven N. Wander, Principal, FSA, MAAA

Texas Department of Insurance, Division of Workers Compensation
Exhibit I - Summary of DWC 2006 ASC Claims by Top APC [1]
Non-Device Intensive Procedures
Excludes Impact of Inflation Adjustment for 2010 and 2011

Aggregate % of Medicare					189%		166%		148%		134%	
					Estimated Medicare Reimbursement							
					2008		2009		2010		2011	
APC	APC Description	# of Claims	DWC_Billed	DWC Allowed	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare
00207	Level III Nerve Injections	5,662	$27,398,450	$5,534,766	$2,379,674	233%	$2,265,804	244%	$2,151,877	257%	$2,038,007	272%
00041	Level I Arthroscopy	1,857	19,898,167	3,163,608	1,928,267	164%	2,256,643	140%	2,585,044	122%	2,913,420	109%
00042	Level II Arthroscopy	949	15,263,786	2,221,924	1,376,171	161%	1,835,696	121%	2,295,224	97%	2,754,749	81%
00051	Level III Musculoskeletal Procedures Except Hand and Foot	575	8,232,179	1,444,884	892,845	162%	1,117,197	129%	1,341,557	108%	1,565,909	92%
00053	Level I Hand Musculoskeletal Procedures	474	3,432,944	668,608	354,493	189%	381,609	175%	408,730	164%	435,846	153%
00154	Hernia/Hydrocele Procedures	316	2,420,232	628,404	346,601	181%	382,611	164%	418,626	150%	454,637	138%
00220	Level I Nerve Procedures	490	3,536,217	542,993	292,478	186%	334,375	162%	376,273	144%	418,170	130%
00204	Level I Nerve Injections	257	2,657,866	492,559	199,192	247%	174,644	282%	150,098	328%	125,550	392%
00050	Level II Musculoskeletal Procedures Except Hand and Foot	229	2,626,731	475,854	252,506	188%	302,165	157%	351,825	135%	401,484	119%
00062	Level I Treatment Fracture/Dislocation	224	2,017,577	416,789	213,557	195%	239,520	174%	265,485	157%	291,447	143%
00022	Level IV Excision/ Biopsy	303	2,262,378	378,916	219,526	173%	252,347	150%	285,171	133%	317,992	119%
00203	Level IV Nerve Injections	253	1,593,039	353,037	155,916	226%	170,418	207%	184,923	191%	199,425	177%
00049	Level I Musculoskeletal Procedures Except Hand and Foot	244	1,955,197	328,366	181,881	181%	208,799	157%	235,714	139%	262,631	125%
00063	Level II Treatment Fracture/Dislocation	203	1,630,378	324,254	201,540	161%	266,340	122%	331,141	98%	395,942	82%
00206	Level II Nerve Injections	188	1,858,560	296,992	123,989	240%	112,373	264%	100,756	295%	89,140	333%
00054	Level II Hand Musculoskeletal Procedures	146	1,809,696	263,356	156,393	168%	181,773	145%	207,154	127%	232,534	113%
00052	Level IV Musculoskeletal Procedures Except Hand and Foot	87	1,322,038	247,753	173,927	142%	239,594	103%	305,262	81%	370,928	67%
00688	Revision/Removal of Neurostimulator Pulse Generator Receiver	48	831,801	141,157	36,595	386%	51,894	272%	67,193	210%	82,492	171%
00221	Level II Nerve Procedures	62	983,172	139,302	80,701	173%	96,315	145%	111,930	124%	127,545	109%
00131	Level II Laparoscopy	66	594,537	120,103	73,870	163%	97,589	123%	121,309	99%	145,029	83%
00136	Level IV Skin Repair	83	643,014	113,291	52,943	214%	56,232	201%	59,521	190%	62,810	180%
00137	Level V Skin Repair	62	537,351	101,492	49,517	205%	55,388	183%	61,258	166%	67,130	151%
00064	Level III Treatment Fracture/Dislocation	39	479,226	86,812	47,691	182%	68,281	127%	88,872	98%	109,463	79%
00055	Level I Foot Musculoskeletal Procedures	53	406,539	72,892	40,345	181%	45,493	160%	50,640	144%	55,788	131%
00045	Bone/Joint Manipulation Under Anesthesia	90	362,485	72,243	39,846	181%	45,792	158%	51,738	140%	57,684	125%
00256	Level V ENT Procedures	22	186,969	52,868	31,880	166%	37,232	142%	42,585	124%	47,938	110%
00047	Arthroplasty without Prosthesis	21	297,901	45,261	27,301	166%	33,307	136%	39,314	115%	45,320	100%
00134	Level II Skin Repair	20	213,610	43,763	2,114	2070%	2,112	2072%	2,110	2074%	2,108	2076%
00021	Level III Excision/ Biopsy	36	243,292	43,675	26,740	163%	31,011	141%	35,281	124%	39,552	110%
00056	Level II Foot Musculoskeletal Procedures	21	214,165	35,962	23,192	155%	30,925	116%	38,659	93%	46,392	78%
00687	Revision/Removal of Neurostimulator Electrodes	11	125,373	27,874	5,421	514%	7,100	393%	8,779	318%	10,457	267%
00254	Level IV ENT Procedures	12	101,603	22,000	13,361	165%	15,023	146%	16,685	132%	18,347	120%
00019	Level I Excision/ Biopsy	20	83,352	17,835	3,777	472%	3,589	497%	3,401	524%	3,212	555%
00008	Level III Incision and Drainage	19	81,363	17,429	10,110	172%	11,508	151%	12,906	135%	14,305	122%
00075	Level V Endoscopy Upper Airway	7	34,008	13,473	7,459	181%	8,591	157%	9,723	139%	10,855	124%
00246	Cataract Procedures with IOL Insert	6	19,814	13,427	6,055	222%	6,126	219%	6,196	217%	6,267	214%
00043	Closed Treatment Fracture Finger/Toe/Trunk	13	42,401	12,251	1,147	1068%	1,075	1140%	1,002	1223%	930	1318%
00135	Level III Skin Repair	11	37,470	12,182	2,510	485%	2,416	504%	2,323	524%	2,229	546%
00016	Level IV Debridement & Destruction	13	41,941	11,605	1,944	597%	1,787	649%	1,630	712%	1,472	788%
00224	Implantation of Catheter/Reservoir/Shunt	11	56,218	10,717	8,393	128%	11,318	95%	14,242	75%	17,166	62%
All Other Services		92	458,741	112,952	57,417	197%	64,698	175%	71,980	157%	79,261	143%
Total		13,295	106,991,779	19,123,633	10,099,287	189%	11,506,713	166%	12,914,137	148%	14,321,563	134%

[1] Each claim is classified according to its most expensive APC grouping for 2008.

Texas Department of Insurance, Division of Workers Compensation
Exhibit II - Summary of DWC 2006 ASC Claims by Top APC [1]
Device Intensive Procedures
Excludes Impact of Inflation Adjustment for 2010 and 2011

Aggregate % of Medicare				112%		108%		105%		101%	
				Estimated Medicare Reimbursement							
				2008		2009		2010		2011	
APC	APC Description	# of Claims	DWC Allowed [2]	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare
00040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	103	$625,796	$415,605	151%	$441,424	142%	$467,242	134%	$493,061	127%
00222	Level II Implantation of Neurostimulator	77	1,345,901	1,326,146	101%	1,360,661	99%	1,395,175	96%	1,429,689	94%
00227	Implantation of Drug Infusion Device	30	326,721	309,615	106%	320,285	102%	330,955	99%	341,626	96%
00061	Laminectomy, Laparoscopy, or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	1	1,976	7,016	28%	7,381	27%	7,747	26%	8,112	24%
Total		211	2,300,393	2,058,381	112%	2,129,751	108%	2,201,119	105%	2,272,488	101%

2006 DWC Claims with no Average Cost Information

APC	APC Description	# of Claims	DWC Allowed
00039	Level I Implantation of Neurostimulator	3	$3,850
00040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	1	1,310
00222	Level II Implantation of Neurostimulator	1	1,901
00225	Implantation of Neurostimulator Electrodes, Cranial Nerve	1	672

[1] Each claim is classified according to its most expensive APC grouping for 2008.
[2] Includes inferred device costs for claims where devices are omitted.

Texas Department of Insurance, Division of Workers Compensation
Exhibit III - Summary of DWC 2006 Average Device Costs by CPT Procedure Code

CPT Procedure Code(s)	Claims Containing Procedure Code	Groupable Claims with Device paid >0 [1]	Average Device Paid for Groupable Claims with Device Paid > 0
63650	104	21	$4,824
63650 & 63685	55	10	17,481
63685	29	4	10,915
62362	24	5	11,309
62361	8	1	400
64590	2	0	0
64553	1	0	0
64555 & 64590	1	0	0
64561 & 64581	1	0	0
64581 & 64590	1	0	0

[1] Device intensive claims where an average device cost could not be determined were excluded from our analysis.

Texas Department of Insurance, Division of Workers Compensation
Exhibit IV - Comparison of 2006 and 2008 Medicare Fees for Common DWC Procedure Codes

CPT Procedure	Percentage of 2006 Paid Dollars	2006 Medicare Fee	2008 Medicare Fee	Percentage Change
64483	7.0%	$333.00	$322.77	-3.1%
29881	6.4%	630.00	770.38	22.3%
62311	5.1%	333.00	322.77	-3.1%
64476	3.3%	333.00	273.78	-17.8%
64484	3.3%	333.00	292.15	-12.3%
64475	3.1%	333.00	322.77	-3.1%
29826	2.8%	510.00	855.58	67.8%
29880	2.6%	630.00	770.38	22.3%
62310	2.3%	333.00	322.77	-3.1%
29848	2.2%	1339.00	1302.13	-2.8%
29827	2.0%	717.00	1010.83	41.0%
29824	1.9%	717.00	835.63	16.5%
64721	1.9%	446.00	521.34	16.9%
23412	1.5%	995.00	1191.16	19.7%
20680	1.5%	510.00	600.99	17.8%

Texas Department of Insurance, Division of Workers Compensation
Exhibit V - Summary of 2006 Commercial ASC Claims by Top APC [1]
Includes Only Medicare Approved Services

Aggregate % of Medicare				236%		220%		206%		193%	
				Estimated Medicare Reimbursement							
				2008		2009		2010		2011	
APC	APC Description	# of Claims	2006 Commercial Allowed Dollars	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare
00143	Lower GI Endoscopy	5,816	$5,151,909	$2,906,355	177%	$2,770,604	186%	$2,634,866	196%	$2,499,071	206%
00041	Level I Arthroscopy	795	3,459,447	1,085,483	319%	1,277,032	271%	1,468,588	236%	1,660,132	208%
00207	Level III Nerve Injections	1,794	3,232,371	813,565	397%	777,835	416%	742,079	436%	706,342	458%
00042	Level II Arthroscopy	275	1,245,429	456,945	273%	606,143	205%	755,339	165%	904,535	138%
00141	Level I Upper GI Procedures	1,541	1,231,081	701,609	175%	666,280	185%	630,935	195%	595,607	207%
00246	Cataract Procedures with IOL Insert	690	1,187,127	690,993	172%	699,078	170%	702,477	169%	705,883	168%
00131	Level II Laparoscopy	398	1,083,136	698,843	155%	781,407	139%	863,970	125%	946,530	114%
00055	Level I Foot Musculoskeletal Procedures	378	986,100	440,867	224%	498,028	198%	555,188	178%	612,348	161%
00075	Level V Endoscopy Upper Airway	167	949,866	461,220	206%	524,457	181%	587,693	162%	650,934	146%
00051	Level III Musculoskeletal Procedures Except Hand and Foot	129	680,480	243,432	280%	306,461	222%	369,493	184%	432,522	157%
00220	Level I Nerve Procedures	182	584,290	128,000	456%	146,376	399%	164,753	355%	183,130	319%
00057	Bunion Procedures	209	579,607	211,837	274%	259,312	224%	306,788	189%	354,263	164%
00254	Level IV ENT Procedures	155	543,971	232,610	234%	264,880	205%	297,152	183%	329,422	165%
00154	Hernia/Hydrocele Procedures	209	532,662	267,549	199%	299,455	178%	331,363	161%	363,269	147%
00022	Level IV Excision/ Biopsy	248	438,921	199,110	220%	231,321	190%	263,535	167%	295,746	148%
00387	Level II Hysteroscopy	127	398,469	203,809	196%	215,082	185%	226,355	176%	237,629	168%
00169	Lithotripsy	79	361,671	145,782	248%	146,763	246%	147,743	245%	148,724	243%
00053	Level I Hand Musculoskeletal Procedures	160	335,664	115,737	290%	126,424	266%	137,112	245%	147,799	227%
00193	Level V Female Reproductive Proc	237	335,261	162,449	206%	176,733	190%	191,015	176%	205,295	163%
00050	Level II Musculoskeletal Procedures Except Hand and Foot	72	274,218	95,519	287%	113,923	241%	132,327	207%	150,730	182%
00204	Level I Nerve Injections	132	268,319	77,381	347%	67,946	395%	58,502	459%	49,056	547%
00049	Level I Musculoskeletal Procedures Except Hand and Foot	89	257,747	76,595	337%	88,006	293%	99,417	259%	110,829	233%
00190	Level I Hysteroscopy	111	229,098	71,462	321%	83,314	275%	95,168	241%	107,021	214%
00021	Level III Excision/ Biopsy	66	227,866	48,748	467%	54,886	415%	61,025	373%	67,164	339%
00203	Level IV Nerve Injections	81	216,187	59,034	366%	63,207	342%	67,382	321%	71,555	302%
00030	Level III Breast Surgery	50	215,590	75,263	286%	95,476	226%	115,688	186%	135,901	159%
00136	Level IV Skin Repair	41	204,973	29,850	687%	31,705	647%	33,558	611%	35,413	579%
00054	Level II Hand Musculoskeletal Procedures	45	203,115	59,712	340%	68,668	296%	77,625	262%	86,581	235%
00063	Level II Treatment Fracture/Dislocation	72	198,661	89,477	222%	118,553	168%	147,629	135%	176,705	112%
00206	Level II Nerve Injections	74	191,912	48,382	397%	43,774	438%	39,166	490%	34,559	555%
00028	Level I Breast Surgery	143	188,900	101,145	187%	115,542	163%	129,936	145%	144,333	131%
00256	Level V ENT Procedures	44	168,600	76,484	220%	88,367	191%	100,250	168%	112,134	150%
00336	Magnetic Resonance Imaging and Magnetic Resonance Angiogra	119	158,517	40,072	396%	40,062	396%	40,053	396%	40,043	396%
00258	Tonsil and Adenoid Procedures	91	155,543	74,248	209%	80,858	192%	87,465	178%	94,071	165%
00149	Level III Anal/Rectal Procedures	95	142,679	77,888	183%	90,973	157%	104,057	137%	117,143	122%
00045	Bone/Joint Manipulation Under Anesthesia	46	136,105	50,897	267%	56,407	241%	61,918	220%	67,429	202%
00052	Level IV Musculoskeletal Procedures Except Hand and Foot	27	125,102	55,027	227%	77,678	161%	100,329	125%	122,980	102%
00283	Computed Tomography with Contrast	62	120,371	22,256	541%	22,257	541%	22,257	541%	22,257	541%
00412	IMRT Treatment Delivery	65	119,517	17,952	666%	17,985	665%	17,985	665%	17,985	665%
00332	Computed Tomography without Contrast	82	115,427	15,383	750%	15,383	750%	15,383	750%	15,383	750%
00247	Laser Eye Procedures	158	109,710	42,394	259%	39,560	277%	36,725	299%	33,891	324%
00163	Level IV Cystourethroscopy and other Genitourinary Procedures	29	108,347	35,364	306%	43,783	247%	52,201	208%	60,621	179%
00130	Level I Laparoscopy	42	108,152	50,444	214%	$62,531	173%	74,618	145%	86,705	125%
00137	Level V Skin Repair	59	105,909	70,174	151%	$74,807	142%	79,439	133%	84,072	126%
All Other Services		1,560	2,160,350	998,321	216%	$1,131,325	191%	1,263,255	171%	1,395,183	155%
Total		17,044	29,828,378	12,625,666	236%	13,560,645	220%	14,489,805	206%	15,418,923	193%

[1] Each claim is classified according to its most expensive APC grouping for 2008.

Texas Department of Insurance, Division of Workers Compensation
Exhibit VI - Summary of 2006 Commercial ASC Claims by Top APC [1]
Includes Medicare Approved Services and Unknown Services

Aggregate % of Medicare				288%		268%		251%		236%	
				Estimated Medicare Reimbursement							
				2008		2009		2010		2011	
APC	APC Description	# of Claims	2006 Commercial Allowed Dollars	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare	Medicare	% Medicare
00143	Lower GI Endoscopy	5,816	$5,716,339	$2,906,355	197%	$2,770,604	206%	$2,634,866	217%	$2,499,071	229%
00041	Level I Arthroscopy	795	3,997,550	1,085,483	368%	1,277,032	313%	1,468,588	272%	1,660,132	241%
00207	Level III Nerve Injections	1,794	3,557,496	813,565	437%	777,835	457%	742,079	479%	706,342	504%
00131	Level II Laparoscopy	398	1,837,333	698,843	263%	781,407	235%	863,970	213%	946,530	194%
00042	Level II Arthroscopy	275	1,728,641	456,945	378%	606,143	285%	755,339	229%	904,535	191%
00141	Level I Upper GI Procedures	1,541	1,469,414	701,609	209%	666,280	221%	630,935	233%	595,607	247%
00246	Cataract Procedures with IOL Insert	690	1,212,027	690,993	175%	699,078	173%	702,477	173%	705,883	172%
00075	Level V Endoscopy Upper Airway	167	1,078,191	461,220	234%	524,457	206%	587,693	183%	650,934	166%
00055	Level I Foot Musculoskeletal Procedures	378	1,078,118	440,867	245%	498,028	216%	555,188	194%	612,348	176%
00154	Hernia/Hydrocele Procedures	209	856,410	267,549	320%	299,455	286%	331,363	258%	363,269	236%
00051	Level III Musculoskeletal Procedures Except Hand and Foot	129	823,920	243,432	338%	306,461	269%	369,493	223%	432,522	190%
00220	Level I Nerve Procedures	182	660,157	128,000	516%	146,376	451%	164,753	401%	183,130	360%
00057	Bunion Procedures	209	645,431	211,837	305%	259,312	249%	306,788	210%	354,263	182%
00254	Level IV ENT Procedures	155	592,820	232,610	255%	264,880	224%	297,152	200%	329,422	180%
00022	Level IV Excision/ Biopsy	248	562,375	199,110	282%	231,321	243%	263,535	213%	295,746	190%
00169	Lithotripsy	79	529,790	145,782	363%	146,763	361%	147,743	359%	148,724	356%
00193	Level V Female Reproductive Proc	237	492,830	162,449	303%	176,733	279%	191,015	258%	205,295	240%
00387	Level II Hysteroscopy	127	465,384	203,809	228%	215,082	216%	226,355	206%	237,629	196%
00050	Level II Musculoskeletal Procedures Except Hand and Foot	72	366,512	95,519	384%	113,923	322%	132,327	277%	150,730	243%
00053	Level I Hand Musculoskeletal Procedures	160	366,021	115,737	316%	126,424	290%	137,112	267%	147,799	248%
00260	Level I Plain Film Except Teeth	172	346,091	5,970	5797%	5,970	5797%	5,970	5797%	5,970	5797%
00204	Level I Nerve Injections	132	340,259	77,381	440%	67,946	501%	58,502	582%	49,056	694%
00030	Level III Breast Surgery	50	325,505	75,263	432%	95,476	341%	115,688	281%	135,901	240%
00049	Level I Musculoskeletal Procedures Except Hand and Foot	89	317,233	76,595	414%	88,006	360%	99,417	319%	110,829	286%
00028	Level I Breast Surgery	143	300,620	101,145	297%	115,542	260%	129,936	231%	144,333	208%
00190	Level I Hysteroscopy	111	298,469	71,462	418%	83,314	358%	95,168	314%	107,021	279%
00021	Level III Excision/ Biopsy	66	269,625	48,748	553%	54,886	491%	61,025	442%	67,164	401%
00063	Level II Treatment Fracture/Dislocation	72	236,432	89,477	264%	118,553	199%	147,629	160%	176,705	134%
00203	Level IV Nerve Injections	81	227,275	59,034	385%	63,207	360%	67,382	337%	71,555	318%
00206	Level II Nerve Injections	74	220,293	48,382	455%	43,774	503%	39,166	562%	34,559	637%
00149	Level III Anal/Rectal Procedures	95	211,319	77,888	271%	90,973	232%	104,057	203%	117,143	180%
00054	Level II Hand Musculoskeletal Procedures	45	208,746	59,712	350%	68,668	304%	77,625	269%	86,581	241%
00130	Level I Laparoscopy	42	208,514	50,444	413%	62,531	333%	74,618	279%	86,705	240%
00136	Level IV Skin Repair	41	206,546	29,850	692%	31,705	651%	33,558	615%	35,413	583%
00052	Level IV Musculoskeletal Procedures Except Hand and Foot	27	198,362	55,027	360%	77,678	255%	100,329	198%	122,980	161%
00163	Level IV Cystourethroscopy and other Genitourinary Procedures	29	193,153	35,364	546%	43,783	441%	52,201	370%	60,621	319%
00256	Level V ENT Procedures	44	188,293	76,484	246%	88,367	213%	100,250	188%	112,134	168%
00137	Level V Skin Repair	59	177,679	70,174	253%	74,807	238%	79,439	224%	84,072	211%
00258	Tonsil and Adenoid Procedures	91	176,989	74,248	238%	80,858	219%	87,465	202%	94,071	188%
00162	Level III Cystourethroscopy and other Genitourinary Procedures	56	166,371	57,465	290%	68,217	244%	78,969	211%	89,722	185%
00283	Computed Tomography with Contrast	62	164,449	22,256	739%	22,257	739%	22,257	739%	22,257	739%
00336	Magnetic Resonance Imaging and Magnetic Resonance Angiogra	119	158,786	40,072	396%	40,062	396%	40,053	396%	40,043	397%
00045	Bone/Joint Manipulation Under Anesthesia	46	144,933	50,897	285%	$56,407	257%	61,918	234%	67,429	215%
00332	Computed Tomography without Contrast	82	132,768	15,383	863%	$15,383	863%	15,383	863%	15,383	863%
00672	Level IV Posterior Segment Eye Procedures	39	125,068	51,961	241%	$59,156	211%	66,351	188%	73,545	170%
00412	IMRT Treatment Delivery	65	119,550	17,952	666%	17,985	665%	17,985	665%	17,985	665%
00247	Laser Eye Procedures	158	111,844	42,394	264%	39,560	283%	36,725	305%	33,891	330%
00195	Level VI Female Reproductive Procedures	32	103,950	48,487	214%	53,667	194%	58,847	177%	64,027	162%
All Other Services		1,261	2,411,382	834,439	289%	944,315	255%	1,053,118	229%	1,161,919	208%
Total		17,044	36,327,268	12,625,666	288%	13,560,645	268%	14,489,805	251%	15,418,923	236%

[1] Each claim is classified according to its most expensive APC grouping for 2008.

Texas Department of Insurance, Division of Workers Compensation
Exhibit VII - List of 2008 Medicare Device Intensive Procedures

CPT	Procedure
33206	Insertion of heart pacemaker
33207	Insertion of heart pacemaker
33208	Insertion of heart pacemaker
33210	Insertion of heart electrode
33211	Insertion of heart electrode
33212	Insertion of pulse generator
33213	Insertion of pulse generator
33214	Upgrade of pacemaker system
33216	Insert lead pace-defib, one
33217	Insert lead pace-defib, dual
33224	Insert pacing lead & connect
33225	L ventric pacing lead add-on
33240	Insert pulse generator
33249	Eltrd/insert pace-defib
33282	Implant pat-active ht record
36566	Insert tunneled cv cath
53440	Male sling procedure
53444	Insert tandem cuff
53445	Insert uro/ves nck sphincter
53447	Remove/replace ur sphincter
54400	Insert semi-rigid prosthesis
54401	Insert self-contd prosthesis
54405	Insert multi-comp penis pros

CPT	Procedure
54410	Remove/replace penis prosth
54416	Remv/repl penis contain pros
55873	Cryoablate prostate
61885	Insrt/redo neurostim 1 array
61886	Implant neurostim arrays
62361*	Implant spine infusion pump
62362*	Implant spine infusion pump
63650*	Implant neuroelectrodes
63655	Implant neuroelectrodes
63685*	Insrt/redo spine n generator
64553	Implant neuroelectrodes
64555	Implant neuroelectrodes
64560	Implant neuroelectrodes
64561	Implant neuroelectrodes
64565	Implant neuroelectrodes
64573	Implant neuroelectrodes
64575	Implant neuroelectrodes
64577	Implant neuroelectrodes
64580	Implant neuroelectrodes
64581	Implant neuroelectrodes
64590	Insrt/redo pn/gastr stimul
69930	Implant cochlear device

*Device intensive procedures included in analysis