

***Delaware Compensation Rating Bureau, Inc. (DCRB)***

Responses to "Questions Directed to Delaware Compensation Rating Bureau for February 15, 2013 Workers Compensation Task Force Meeting".

**1. For each approved workers compensation rate filing in 2009, 2010, 2011 and 2012, state the assumed increase in medical costs.**

DCRB's rate filings present medical trend indications separately for claim frequency and claim severity. Those filed indications for the most recent four annual rate filings were as follow:

December 1, 2009: Claim Frequency, -7.6% per year  
Medical Severity, +6.2% per year

December 1, 2010: Claim Frequency, -8.8% per year to January 1, 2009,  
-6.37% per year after January 1, 2009  
Medical Severity, +7.2% per year to September 1, 2008,  
+5.4% per year after September 1, 2008

December 1, 2011: Claim Frequency, -8.6% per year to January 1, 2009,  
+1.5% for Calendar Year 2009,  
-8.6% per year after December 31, 2009  
Medical Severity, +8.5% per year to September 1, 2008  
+6.7% per year after September 1, 2008

December 1, 2012: Claim Frequency, -6.5% per year  
Medical Severity, +12.5% to September 1, 2008,  
+10.7% per year after September 1, 2008

The adjudication of each DCRB filing involves the Insurance Commissioner's consideration of the filing, two independent actuarial reviews and other factors. Approved rating values sometimes fall within the range established by the filing and the independent actuarial reviews (this was the case for the 2009 and 2010 filings) and sometimes approved rating values have fallen outside that range (as was the case for the 2011 and 2012 filings). Each year, approved changes in overall rating values are produced using the DCRB filing and a "compromise factor" which reflects the change in overall rating values ultimately approved by the Insurance Commissioner. There is no retrofitting of a specific set of actuarial methods, assumptions and selections to derive the approved rating values (there would be many possible sets of such variables) and thus there is no defined trend differential between the original filing and the approved rating values.

The above series of trend values shows that in the last two filings claim frequency trend has become less favorable than the comparable levels for earlier DCRB filings (although claim frequency remains significantly negative). DCRB's measurements of medical severity trends have increased successively in each of the last four filings, as reflected in the trend values stated prior to September 1, 2008. As part of the adjudication of the 2009 filing the Insurance Commissioner required that medical severity trend be adjusted downward on the premise that such trend would be more favorable after the implementation of the Delaware medical fee schedule. The adjustment discussed for the 2009 filing was 1.8% per year. Anticipating that the Insurance Commissioner would continue to require this adjustment in future filings, the DCRB's 2010, 2011 and 2012 filings continued this approach, resulting in the changes noted above in medical severity trend at September 1, 2008. In each filing the trend measured in DCRB data was reduced to a value 1.8% lower than that measured rate of change.

- 2. Identify each medical procedure used in calculating rate requests filed in 2011 where the per-procedure cost for the procedure increased by more than 4% over the cost for the same procedure in the prior year, and state the amount of the increase.**
  
- 3. Identify each medical procedure used in calculating rate requests filed in 2012 where the per-procedure cost for the procedure increased by more than 4% over the cost for the same procedure in the prior year, and state the amount of the increase.**

The national standard protocol in use to collect detailed medical transactions for workers compensation insurance (WCMED) was launched countrywide to collect transactions beginning with the third quarter of calendar year 2010. Because data supporting the derivation of the overall rate change for the DCRB's 2011 filing ended December 31, 2010 and the counterpart data for the DCRB's 2012 filing ended December 31, 2011 the WCMED reports do not encompass two years within the experience of either of those filings. DCRB has used the two years of data currently available from WCMED (July 2010 through June 2012) to prepare the attached Exhibit 1 in response to these questions. The following discussion provides background to the use and interpretation of these materials.

DCRB has interpreted "procedure" to be a broad term including all of the numerous sets of defined services and/or products that may be provided to workers compensation claimants. Accordingly, we include Current Procedural Terminology (CPT) codes, Revenue Codes, Healthcare Common Procedure Coding System (HCPCS) codes, and National Drug Code (NDC) numbers as "procedures" for purposes of our report.

We compared the cost per procedure reported in the twelve months ending June 30, 2011 (hereinafter, the 2011 year or year 1) to the cost per procedure reported in the twelve months ending June 30, 2012 (hereinafter, the 2012 year or year 2) and identified each procedure code for which that average increased by more than 4.00% in the latter period compared to the former.

In first compiling this report we produced over 1,900 lines, most of which reflected very small numbers services and/or amounts of payments. Where very small volumes of data are included, variations in the presence or absence of services subject to modifiers and/or other special considerations can have material impact on calculations and/or comparisons. In addition, DCRB endeavors to avoid publicly distributing information at levels of detail which could isolate individual claimants, employers, carriers and/or providers, and thus often suppresses printing of report lines containing less than a selected number of records in the values being shown. In light of these considerations and in order to focus the reports on more meaningful entries we selected the 100 lines with the largest dollar amounts of payments over the two years of data and having no claim, record or procedure units entries of "1", and have separately listed those procedures.

DCRB is mindful of the instructions accompanying the questions being answered here that we avoid "numerical codes or abbreviations". While our listing of procedures includes the relevant alphanumeric procedure code, we have appended definitions of each such code to the report. The verbiage used for this purpose is obtained from outside sources including the American Medical Association (AMA), and it from these external resources that some of DCRB's toolsets for the understanding and use of the WCMED data was obtained. Where alternative definitions of successively increasing length were available to us, the DCRB has utilized the most expansive of the available entries for purposes of all of our responses here.

For each reported procedure, the DCRB has listed the number of records reported, number of units of service associated with those records, number of claims receiving services under the procedure, total amounts charged and paid for medical services and the average paid per record within each year. We also show the percentage change in average paid amount per record, and the dollar change in average paid amount per record. The report is sorted in descending order by the percentage change in average paid amount per record between the 2012 year and the 2011 year.

In order to guard against possible duplications of claim number assignments in our database, DCRB derives claim counts within any specified reporting criteria by looking for unique combinations of claim number, carrier, policy number and policy effective date. Claim counts thus derived may include some claims that do not

appear in other reporting lines or cells and may also include claims that will be encountered repeatedly in prior and/or subsequent reporting lines or cells. Accordingly, claim counts added across report lines or time periods in these tabulations will not reproduce the derived claim counts, and differences between derived counts and totals for component reporting lines or cells may be substantial.

This report has intentionally excluded all data attributable to Ambulatory Surgical Centers (ASCs). DCRB has previously done a substantial amount of analysis and reporting of data attributed to ASC's while working on a series of requests made of it by the Health Care Advisory Panel. As part of those endeavors we have learned that ASC's submit billings with duplicate procedure codes where some line items (records in WCMED) reflect surgical procedures while other line items are related to facility fees incurred in conjunction with the surgeries. With this billing dynamic in place, the average cost per procedure for ASC's is inherently different from that presented by other provider types.

The report includes records identified in the data with a given procedure regardless of whether the records include a modifier. Modifiers are used to address specific portions of a service such a professional or technical components. Separating procedure codes into subsets based on values for available modifiers would be a possible alternative to the approach used for these tabulations but doing so could substantially expand the length of the list while reducing the amount of data presented in individual lines.

- 4. Identify each injury classification used in calculating rate requests filed in 2011 where the total cost for providing medical treatment for that injury increased by more than 4% over the cost for the same injury in the prior year, and state the amount of the increase.**
- 5. Identify each injury classification used in calculating rate requests filed in 2012 where the total cost for providing medical treatment for that injury increased by more than 4% over the cost for the same injury in the prior year, and state the amount of the increase.**

Recognizing the implementation of the national standard protocol in use to collect detailed medical transactions for workers compensation insurance (WCMED) as described above, DCRB has again used the two years of data currently available from WCMED (July 2010 through June 2012) to prepare the attached Exhibit 2 in response to these questions. The following discussion provides background to the use and interpretation of these materials.

WCMED captures International Classification of Disease (ICD) diagnostic codes. These codes are not "injury classifications" per se, but alternative coding structures

for injury descriptions are not reported in WCMED. Accordingly, DCRB has used the available diagnostic codes as a means of organizing the costs of treatment summarized in our responses to these questions. We have employed the most detailed level of this coding for these purposes. Summarization at higher levels of this coding structure can be provided if those become of interest.

The questions posed ask for injury types for which total medical treatment costs have increased more than 4%. The medical treatment cost for any given claim or injury would include all the services needed by the injured worker. Such services may be provided over vastly different periods of time depending on the claim(s) in question, and can extend over decades in particularly protracted cases. Thus, currently available WCMED data cannot capture the total cost of treatment for any claim(s) that did not first receive treatment on or after July 1, 2010 and also conclude treatment before June 30, 2012.

The tabulations provided in Exhibit 2 show the costs of providing treatment to claims for individual diagnostic codes during the periods shown. Since there may be multiple diagnostic codes appearing for a single claim, the tabulations may not include all of the costs for treatment of a claim under a single diagnostic code.

The format of Exhibit 2 is similar to that used for Exhibit 1 except that diagnostic codes are used instead of procedure codes, and the average paid amount is computed by dividing total paid amounts by the number of claims receiving services during each year. We have computed the percentage change in average cost per claim for each diagnostic code, and list all diagnostic codes for which the average paid medical per claim has changed by more than 4% between the 2011 and 2012 years.

In first compiling this report we produced over 700 lines, most of which reflected nominal amounts of services and/or payments. Where very small volumes of data are included, variations in the presence or absence of services subject to modifiers and/or other special considerations can have material impact on calculations and/or comparisons. In addition, DCRB endeavors to avoid publicly distributing information at levels of detail which could isolate individual claimants, employers, carriers and/or providers, and thus often suppresses printing of report lines containing less than a selected number of records in the values being shown. In light of these considerations and in order to focus the reports on more meaningful entries we selected the 100 lines with the largest dollar amounts of payments over the two years of available data and having no claim, record or procedure units entries of "1", and have separately listed those diagnostic codes.

6. **Identify each medical procedure where the total number of procedures performed increased as a percentage of all procedures during the time period reviewed for purposes of the 2011 rate filing.**
7. **Identify each medical procedure where the total number of procedures performed increased as a percentage of all procedures during the time period reviewed for purposes of the 2012 rate filing.**

Using the two years of data currently available from WCMED (July 2010 through June 2012), DCRB has prepared the attached Exhibit 3 in response to these questions. The following discussion provides background to the use and interpretation of these materials.

We have counted the numbers of WCMED records associated with each procedure in the 2011 and 2012 years respectively. We approached procedures the same way in constructing Exhibit 3 as we did for purpose of Exhibit 1. We then computed the proportion of all records for each year that records associated with each procedure represented. We compared the proportions of records that each procedure represented for the 2012 year to the proportion it represented for the 2011 year. Where that comparison showed an increase, we have reported the procedure, the numbers and proportions of records attributable to the procedure in the 2011 and 2012 years, and the change in proportion of records represented by the procedure between those two years, with the procedures listed in descending order by change in proportion of services.

In first compiling this report we produced over 450 lines, most of which reflected nominal numbers of services. To focus the reports on more meaningful entries we selected the 100 lines with the largest numbers of services provided over the two years of available data and having no claim, record or procedure units entries of "1", and have separately listed those diagnostic codes.

8. **For each of the 30 medical procedures most frequently performed for persons with workers compensation injuries, indicate the average cost for that procedure in Delaware and the average cost for the identical procedure in each state for which DCRB has direct or indirect access to data.**

DCRB has defined the most frequently performed procedures by counting records across the two years of available WCMED data. The 30 procedures having the highest counts are listed in descending order by number of records in Exhibit 4. This Exhibit shows the procedure, number of records within the two year experience period, total units of service, number of claims, medical amounts charged, medical amounts paid and the average payment per record.

DCRB has access to WCMED data for the state of Pennsylvania which allows us to compare the average costs per procedure in that state to Delaware. Exhibit 5 shows those average costs, but excludes the numbers of claims attributed to each procedure in Pennsylvania. DCRB has not yet derived claim counts from the Pennsylvania data and cannot provide that information at this time.

DCRB does not have access directly or indirectly to average costs of the 30 procedures we have identified as most common in Delaware for additional states.

**9. For each of the 30 injury classifications most frequently reported in Delaware for persons with workers compensation injuries, indicate the average cost for treatment of that injury and the average cost for the identical procedure in each state for which DCRB has direct or indirect access to data.**

Using the same diagnostic codes as were applied for purposes of Exhibit 2, DCRB has identified the 30 diagnostic codes most commonly appearing in the two years of available Delaware WCMED data. The determination of total costs of treatment per injury or claim is subject to the considerations previously outlined, but DCRB has computed the average cost of treatment provided during the two-year period now available in WCMED by dividing the total medical payments for each diagnostic code by the number of claims receiving treatment for that diagnostic code. Those computations are presented in Exhibit 6 for the 30 diagnostic codes appearing most often in our data, together with the associated numbers of records, units of service, number of claims, and medical amounts charged and paid.

Because of the limitation on claim counts for Pennsylvania data we cannot presently replicate the Delaware calculations described above.

DCRB does not have access directly or indirectly to average costs of the 30 diagnostic codes we have identified as most common in Delaware for additional states.

**10. Other than any medical procedures listed above, indicate any medical costs that have contributed disproportionately to the requested trend increase in medical costs in the 2011 and 2012 rate filings.**

One metric of medical costs that DCRB does not see directly manifest in the questions discussed above is the amount of medical payments associated with a given procedure or diagnostic code. We attach Exhibit 7 which is a copy of information previously provided by DCRB to the Data Collection Committee, and

which shows all procedure codes having over \$500,000 in payments for the two years now available in WCMED.

Exhibit 8 (attached) is similar to Exhibit 7 in format, but is limited to diagnostic codes that individually account for \$500,000 or more in payments during the two years now available from WCMED.

The threshold used to provide Exhibits 7 and 8 (\$500,000 in payments over the two years of available WCMED data) can be adjusted downward should the Task Force wish to see expanded detail for those analyses.

DCRB is aware of a couple of additional system features which contribute to overall workers compensation system costs, including but not limited to medical costs. One of these is the matter of how quickly or slowly claims are resolved within the system. A simple measure of this feature of the system can be derived by comparing the numbers of claims left open at various points in time to the number of claims associated with a given policy period. The first page of Exhibit 9 is based on that analysis for indemnity claims in Delaware. The ratios of open claims to total reported claims are tracked for a series of policy years (rows) and across a series of annual evaluations or reporting points for each year (columns). Reading down any given column shows a series of successive comparisons of the rates of claim closures for the same average age as policy years included become more recent. Generally each column in Exhibit 9 shows a tendency for the ratio of open claims to increase for newer policy years.

The second page of Exhibit 9 reflects an identical analysis to that described above for Delaware, but done for Pennsylvania. To facilitate comparisons between the two states, page 3 of Exhibit 9 shows the relative ratios of open claims for Delaware compared to Pennsylvania at each reporting point and for each policy year. These ratios are all greater than 1.0000, and for reporting points more than 3 or 4 years along in each policy year the ratios are greater than 2.0000. This means that for an extended portion of the claims management process Delaware has more than twice the proportion of its reported indemnity claims remaining open than does Pennsylvania. The longer claims remain open the more opportunity exists for indemnity benefit payments, medical treatments, disputes about claim status and entitlement, etc.

Another notable feature of Delaware's workers compensation system is a relatively high incidence of relatively large claims. Because indemnity benefits are generally limited to specified amounts per period of time, really large workers compensation claims almost universally entail extensive amounts of medical benefits. The Annual Statistical Bulletin published by the National Council on Compensation Insurance, Inc. (NCCI) includes an Exhibit 11 which presents average claim costs

by state over a period of five years. Exhibit 10 attached is derived from NCCI's 2012 Annual Statistical Bulletin, and shows Delaware's rankings against all other states for indemnity and medical costs by year. In each year shown Delaware's average medical claim is the highest in the nation, and because of those medical costs Delaware also has the highest overall average claim cost for five years running. Delaware ranks 10<sup>th</sup> to 12<sup>th</sup> countrywide for average indemnity cost, despite the fact that Delaware is one of very few states where the maximum indemnity benefit is set as low as 2/3 of the Statewide Average Weekly Wage.

The comparisons shown in Exhibit 10 are impacted by the collective factors which determine entitlements to payments and services, but the relative incidence of major medical losses would be among the reasons for the results presented.

Delaware Compensation Rating Bureau, Inc.  
 Per Procedure Cost (>4% Increase) for Transactions Reported July 2010 - June 2012  
 Year 1 (July 2010 - June 2011) Compared to Year 2 (July 2011 - June 2012)  
 Excludes Ambulatory Surgical Center (POS 24)

Procedure Code/Description	Year 1						Year 2						Year 1 vs. Year 2	
	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Difference	% Difference
0207 - BURN CARE	5	10	22	\$671,361	\$494,973	\$49,497.27	4	4	36	\$792,786	\$802,614	\$200,653.50	\$151,156.23	305.38%
00173044700 - ZOFRAN	4	14	1,440	\$63,748	\$62,028	\$4,430.56	2	4	1,080	\$47,811	\$42,234	\$10,558.55	\$6,127.99	138.31%
L8687 - IMPLANTABLE NEUROSTIMULATOR PULSE GENERATOR, DUAL ARRAY, RECHARGEABLE, INCLUDES EXTENSION	2	2	2	\$35,404	\$30,093	\$15,046.70	4	4	4	\$208,290	\$140,722	\$35,180.38	\$20,133.68	133.81%
00228287911 - OXYCODONE HYDROCHLORIDE	2	2	105	\$117	\$117	\$58.47	273	699	79,169	\$108,696	\$91,604	\$131.05	\$72.58	124.13%
90375 - RABIES IMMUNE GLOBULIN (RIG), HUMAN, FOR INTRAMUSCULAR AND/OR SUBCUTANEOUS USE	5	8	11	\$15,841	\$15,565	\$1,945.58	10	11	39	\$46,170	\$44,784	\$4,071.29	\$2,125.71	109.26%
0121 - MEDICAL/SURGICAL/GYN	7	7	16	\$27,929	\$23,401	\$3,342.98	11	11	40	\$92,248	\$75,923	\$6,902.05	\$3,559.07	106.46%
0300 - LABORATORY - CLINICAL DIAGNOSTIC	168	333	1,143	\$62,300	\$36,768	\$110.41	196	412	1,858	\$220,942	\$87,804	\$213.12	\$102.70	93.02%
0260 - IV THERAPY	202	231	690	\$47,728	\$32,569	\$140.99	130	167	684	\$68,353	\$45,183	\$270.56	\$129.57	91.90%
0120 - ROOM & BOARD (SEMI-PRIVATE 2 BEDS)	161	180	533	\$727,066	\$578,816	\$3,215.65	162	185	848	\$850,420	\$1,139,702	\$6,160.55	\$2,944.90	91.58%
0272 - MEDICAL/SURGICAL SUPPLIES: STERILE SUPPLIES	503	634	3,921	\$279,340	\$190,073	\$299.80	495	531	4,438	\$409,784	\$299,330	\$563.71	\$263.91	88.03%
00120 - ANESTHESIA FOR PROCEDURES ON EXTERNAL, MIDDLE, AND INNER EAR INCLUDING BIOPSY; NOT OTHERWISE SPECIFIED	18	18	45	\$496,522	\$210,983	\$11,721.26	11	11	28	\$417,290	\$225,100	\$20,463.65	\$8,742.40	74.59%
0360 - OPERATING ROOM SERVICES	275	334	2,113	\$1,854,560	\$1,197,971	\$3,586.74	245	273	6,134	\$2,418,102	\$1,646,448	\$6,030.95	\$2,444.21	68.15%
22600 - ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; CERVICAL BELOW C2 SEGMENT	5	10	10	\$62,942	\$23,466	\$2,346.64	24	41	39	\$211,945	\$157,625	\$3,844.52	\$1,497.88	63.83%
S5165 - HOME MODIFICATIONS; PER SERVICE	2	3	3	\$17,757	\$17,757	\$5,918.99	6	13	13	\$124,653	\$124,653	\$9,588.72	\$3,669.74	62.00%
L8680 - IMPLANTABLE NEUROSTIMULATOR ELECTRODE, EACH	12	17	224	\$139,082	\$71,957	\$4,232.74	11	13	200	\$111,638	\$88,954	\$6,842.60	\$2,609.87	61.66%
63481057170 - OPANA ER	20	52	2,771	\$28,415	\$27,147	\$522.06	22	69	5,752	\$59,872	\$57,172	\$828.58	\$306.52	58.71%
80104 - DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE	111	239	581	\$27,555	\$12,427	\$52.00	378	785	2,609	\$117,615	\$64,776	\$82.52	\$30.52	58.70%
99455 - WORK RELATED OR MEDICAL DISABILITY EXAMINATION BY THE TREATING PHYSICIAN THAT INCLUDES: COMPLETION OF A MEDICAL HISTORY COMMENSURATE WITH THE PATIENT'S CONDITION; PERFORMANCE OF AN EXAMINATION COMMENSURATE WITH THE PATIENT'S CONDITION; FORMULATION OF A DIAGNOSIS, ASSESSMENT OF CAPABILITIES AND STABILITY, AND CALCULATION OF IMPAIRMENT; DEVELOPMENT OF FUTURE MEDICAL TREATMENT PLAN; AND COMPLETION OF NECESSARY DOCUMENTATION/CERTIFICATES AND REPORT.	59	81	180	\$61,325	\$54,418	\$671.83	47	54	54	\$56,052	\$55,355	\$1,025.10	\$353.27	52.58%
0430 - OCCUPATIONAL THERAPY	60	482	1,247	\$145,509	\$95,095	\$197.29	62	411	1,890	\$203,560	\$122,425	\$297.87	\$100.58	50.98%
0370 - ANESTHESIA	451	479	9,485	\$369,206	\$250,161	\$522.26	392	413	10,904	\$481,795	\$318,262	\$770.61	\$248.35	47.55%
01480 - ANESTHESIA FOR OPEN PROCEDURES ON BONES OF LOWER LEG, ANKLE, AND FOOT; NOT OTHERWISE SPECIFIED	35	44	2,148	\$52,079	\$26,032	\$591.63	32	38	2,046	\$49,472	\$33,040	\$869.48	\$277.85	46.96%
J8499 - PRESCRIPTION DRUG, ORAL, NON CHEMOTHERAPEUTIC, NOS	250	557	12,539	\$62,526	\$45,928	\$82.46	140	285	8,093	\$41,100	\$33,617	\$117.95	\$35.50	43.05%
29806 - ARTHROSCOPY, SHOULDER, SURGICAL; CAPSULORRHAPHY	4	6	6	\$22,391	\$16,720	\$2,786.62	8	11	11	\$57,531	\$42,270	\$3,842.68	\$1,056.07	37.90%
01402 - ANESTHESIA FOR OPEN OR SURGICAL ARTHROSCOPIC PROCEDURES ON KNEE JOINT; TOTAL KNEE ARTHROPLASTY	26	29	1,690	\$51,506	\$25,904	\$893.25	26	31	2,196	\$64,490	\$37,547	\$1,211.20	\$317.95	35.59%
23420 - RECONSTRUCTION OF COMPLETE SHOULDER (ROTATOR) CUFF AVULSION, CHRONIC (INCLUDES ACROMIOPLASTY)	12	13	12	\$60,868	\$47,773	\$3,674.88	9	10	10	\$56,942	\$48,925	\$4,892.50	\$1,217.62	33.13%
A0431 - AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)	6	6	6	\$91,073	\$71,158	\$11,859.67	7	7	7	\$112,762	\$109,432	\$15,633.08	\$3,773.42	31.82%
22630 - ARTHRODESIS, POSTERIOR INTERBODY TECHNIQUE, INCLUDING LAMINECTOMY AND/OR DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE; LUMBAR	32	53	51	\$289,421	\$151,763	\$2,863.45	32	47	47	\$281,685	\$177,026	\$3,766.51	\$903.06	31.54%
0710 - RECOVERY ROOM	488	533	11,987	\$517,839	\$367,573	\$689.63	450	486	13,966	\$598,475	\$439,615	\$904.56	\$214.93	31.17%

Delaware Compensation Rating Bureau, Inc.  
 Per Procedure Cost (>4% Increase) for Transactions Reported July 2010 - June 2012  
 Year 1 (July 2010 - June 2011) Compared to Year 2 (July 2011 - June 2012)  
 Excludes Ambulatory Surgical Center (POS 24)

Procedure Code/Description	Year 1						Year 2						Year 1 vs. Year 2	
	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Difference	% Difference
0002327030 - CYMBALTA	172	390	15,284	\$83,079	\$77,940	\$199.85	218	470	21,504	\$136,505	\$123,152	\$262.03	\$62.18	31.11%
00630 - ANESTHESIA FOR PROCEDURES IN LUMBAR REGION; NOT OTHERWISE SPECIFIED	43	48	1,449	\$91,380	\$52,277	\$1,089.11	41	47	2,252	\$102,626	\$66,707	\$1,419.30	\$330.19	30.32%
0302 - LABORATORY - CLINICAL DIAGNOSTIC: IMMUNOLOGY	115	141	437	\$37,475	\$25,631	\$181.78	131	209	524	\$84,002	\$49,063	\$234.75	\$52.97	29.14%
00378912498 - FENTANYL	42	111	2,170	\$123,006	\$99,907	\$900.06	31	68	1,875	\$102,405	\$78,760	\$1,158.23	\$258.17	28.68%
63459070060 - AMRIX	71	115	3,900	\$44,900	\$40,532	\$352.45	20	32	1,085	\$16,030	\$14,507	\$453.35	\$100.89	28.63%
29807 - ARTHROSCOPY, SHOULDER, SURGICAL; REPAIR OF SLAP LESION	8	10	113	\$33,796	\$23,402	\$2,340.23	8	10	10	\$41,495	\$29,128	\$2,912.78	\$572.55	24.47%
22856 - TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY WITH END PLATE PREPARATION (INCLUDES OSTEOPHYECTOMY FOR NERVE ROOT OR SPINAL CORD DECOMPRESSION AND MICRODISSECTION), SINGLE INTERSPACE, CERVICAL	9	16	16	\$128,507	\$96,973	\$6,060.79	18	31	31	\$366,676	\$233,163	\$7,521.39	\$1,460.60	24.10%
51927101900 - FENTANYL CITRATE	4	63	60,941	\$314,685	\$36,754	\$583.39	4	31	29,972	\$154,850	\$22,319	\$719.96	\$136.57	23.41%
99456 - WORK RELATED OR MEDICAL DISABILITY EXAMINATION BY OTHER THAN THE TREATING PHYSICIAN THAT INCLUDES: COMPLETION OF A MEDICAL HISTORY COMMENSURATE WITH THE PATIENT'S CONDITION; PERFORMANCE OF AN EXAMINATION COMMENSURATE WITH THE PATIENT'S CONDITION; FORMULATION OF A DIAGNOSIS, ASSESSMENT OF CAPABILITIES AND STABILITY, AND CALCULATION OF IMPAIRMENT; DEVELOPMENT OF FUTURE MEDICAL TREATMENT PLAN; AND COMPLETION OF NECESSARY DOCUMENTATION/CERTIFICATES AND REPORT.	65	73	72	\$59,872	\$56,530	\$774.39	51	57	46	\$56,331	\$53,786	\$943.61	\$169.23	21.85%
22850 - REMOVAL OF POSTERIOR NONSEGMENTAL INSTRUMENTATION (EG, HARRINGTON ROD)	17	27	27	\$57,489	\$30,419	\$1,126.62	20	36	34	\$70,488	\$48,983	\$1,360.63	\$234.01	20.77%
97124 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)	642	4,442	7,077	\$301,575	\$172,723	\$38.88	657	6,038	14,759	\$450,682	\$283,243	\$46.91	\$8.03	20.64%
63481069370 - OPANA ER	41	103	6,594	\$88,052	\$75,437	\$732.39	32	69	4,642	\$65,748	\$60,854	\$881.94	\$149.55	20.42%
16590014130 - LIDODERM	31	55	2,700	\$28,117	\$24,527	\$445.95	49	85	4,596	\$54,124	\$45,219	\$531.99	\$86.03	19.29%
0258 - PHARMACY: IV SOLUTIONS	514	576	2,677	\$138,393	\$96,778	\$168.02	478	541	3,538	\$154,009	\$108,094	\$199.80	\$31.79	18.92%
60793060801 - AVINZA	22	56	2,580	\$41,469	\$39,553	\$706.31	13	35	1,891	\$31,308	\$29,183	\$833.79	\$127.49	18.05%
A0425 - GROUND MILEAGE, PER STATUTE MILE	357	554	12,224	\$123,597	\$63,795	\$115.15	293	470	12,634	\$130,917	\$63,781	\$135.70	\$20.55	17.85%
0612 - MAGNETIC RESONANCE TECH. (MRT): SPINAL CORD (INCL. SPINE)	62	76	76	\$135,471	\$98,111	\$1,290.93	64	71	73	\$142,233	\$107,378	\$1,512.36	\$221.43	17.15%
63402019310 - LUNESTA	91	208	6,290	\$46,627	\$42,285	\$203.29	85	212	7,251	\$57,482	\$50,292	\$237.23	\$33.94	16.69%
63057 - TRANSPEDICULAR APPROACH WITH DECOMPRESSION OF SPINAL CORD, EQUINA AND/OR NERVE ROOT(S) (EG, HERNIATED INTERVERTEBRAL DISC), SINGLE SEGMENT; EACH ADDITIONAL SEGMENT, THORACIC OR LUMBAR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	11	33	33	\$53,343	\$34,852	\$1,056.13	9	36	36	\$57,316	\$44,220	\$1,228.32	\$172.19	16.30%
64483 - INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL	199	308	414	\$315,260	\$212,243	\$689.10	215	360	368	\$381,314	\$288,439	\$801.22	\$112.12	16.27%

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Procedure Code/Description	Year 1						Year 2						Year 1 vs. Year 2	
	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Difference	% Difference
99232 - SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED INTERVAL HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS RESPONDING INADEQUATELY TO THERAPY OR HAS DEVELOPED A MINOR COMPLICATION. PHYSICIANS TYPICALLY SPEND 25 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.	145	522	526	\$71,011	\$35,760	\$68.51	161	697	699	\$92,613	\$55,307	\$79.35	\$10.84	15.83%
99282 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY.	446	488	488	\$96,564	\$82,458	\$168.97	396	430	430	\$94,588	\$84,072	\$195.52	\$26.54	15.71%
00450 - ANESTHESIA FOR PROCEDURES ON CLAVICLE AND SCAPULA; NOT OTHERWISE SPECIFIED	76	110	240	\$51,391	\$36,931	\$335.74	99	133	289	\$64,332	\$51,625	\$388.16	\$52.42	15.61%
73700 - COMPUTED TOMOGRAPHY, LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL	64	75	75	\$36,512	\$24,586	\$327.82	72	95	91	\$51,911	\$35,796	\$376.80	\$48.99	14.94%
0352 - CT SCAN; BODY	98	114	146	\$129,389	\$95,439	\$837.18	107	122	150	\$177,809	\$117,216	\$960.79	\$123.61	14.76%
E1399 - DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS	335	643	2,153	\$375,594	\$270,133	\$420.11	355	660	3,000	\$391,529	\$317,288	\$480.74	\$60.63	14.43%
0350 - CT SCAN	38	51	59	\$83,487	\$54,896	\$1,076.40	53	66	77	\$144,716	\$81,052	\$1,228.06	\$151.66	14.09%
59011048010 - OXYCONTIN	94	245	22,329	\$305,663	\$271,773	\$1,109.28	95	279	26,280	\$385,234	\$353,062	\$1,265.46	\$156.18	14.08%
01992 - ANESTHESIA FOR DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS AND INJECTIONS (WHEN BLOCK OR INJECTION IS PERFORMED BY A DIFFERENT PROVIDER); PRONE POSITION	143	201	1,905	\$178,691	\$126,960	\$631.64	188	247	2,468	\$221,091	\$176,881	\$716.12	\$84.48	13.37%
E0731 - FORM FITTING CONDUCTIVE GARMENT FOR DELIVERY OF TENS OR NMES (WITH CONDUCTIVE FIBERS SEPARATED FROM THE PATIENT'S SKIN BY LAYERS OF FABRIC)	81	85	86	\$43,767	\$34,258	\$403.04	91	95	95	\$54,170	\$43,260	\$455.37	\$52.33	12.98%
73140 - RADIOLOGIC EXAMINATION, FINGER(S), MINIMUM OF 2 VIEWS	358	465	467	\$38,368	\$29,695	\$63.86	409	593	613	\$56,284	\$42,599	\$71.84	\$7.98	12.49%
95900 - NERVE CONDUCTION, AMPLITUDE AND LATENCY/VELOCITY STUDY, EACH NERVE; MOTOR, WITHOUT F-WAVE STUDY	363	595	1,135	\$159,615	\$114,798	\$192.94	259	394	801	\$115,196	\$85,413	\$216.79	\$23.85	12.36%
72156 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SEQUENCES; CERVICAL	19	24	24	\$40,325	\$31,371	\$1,307.13	16	19	19	\$39,264	\$27,896	\$1,468.22	\$161.09	12.32%

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	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Claim Count	Record Count	Proc Units	Charged Amt	Paid Amt	Per Proc Cost	Difference	% Difference
99233 - SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED INTERVAL HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS UNSTABLE OR HAS DEVELOPED A SIGNIFICANT COMPLICATION OR A SIGNIFICANT NEW PROBLEM. PHYSICIANS TYPICALLY SPEND 35 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.	75	250	250	\$51,403	\$23,191	\$92.77	88	291	295	\$61,200	\$30,193	\$103.76	\$10.99	11.85%
0424 - PHYSICAL THERAPY: EVALUATION/RE-EVALUATION	188	207	214	\$55,417	\$34,666	\$167.47	204	236	241	\$68,422	\$44,182	\$187.21	\$19.74	11.79%
A4595 - ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G. TENS, NMES)	265	476	2,749	\$60,189	\$43,879	\$92.18	219	382	3,156	\$52,559	\$39,194	\$102.60	\$10.42	11.30%
0278 - MEDICAL/SURGICAL SUPPLIES: OTHER IMPLANTS	273	321	1,901	\$4,006,395	\$2,650,819	\$8,258.00	256	325	1,856	\$4,379,086	\$2,985,253	\$9,185.39	\$927.39	11.23%
72125 - COMPUTED TOMOGRAPHY, CERVICAL SPINE; WITHOUT CONTRAST MATERIAL	215	268	267	\$156,429	\$113,944	\$425.16	224	273	270	\$181,383	\$129,068	\$472.78	\$47.61	11.20%
22585 - ARTHRODESIS, ANTERIOR INTERBODY TECHNIQUE, INCLUDING MINIMAL DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION); EACH ADDITIONAL INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	27	59	59	\$121,997	\$40,622	\$688.50	29	49	49	\$81,965	\$37,477	\$764.84	\$76.34	11.09%
0014000601 - VALIUM	24	63	4,478	\$27,640	\$25,534	\$405.30	24	64	4,654	\$30,523	\$28,782	\$449.71	\$44.41	10.96%
00071101568 - LYRICA	61	152	12,419	\$36,575	\$31,134	\$204.83	75	154	11,896	\$39,971	\$34,921	\$226.76	\$21.93	10.71%
22852 - REMOVAL OF POSTERIOR SEGMENTAL INSTRUMENTATION	18	29	27	\$74,193	\$37,561	\$1,295.20	15	27	27	\$80,622	\$38,578	\$1,428.83	\$133.63	10.32%
59011010710 - OXYCONTIN	44	114	11,338	\$152,238	\$142,385	\$1,248.99	2	4	450	\$6,001	\$5,507	\$1,376.81	\$127.81	10.23%
63481062970 - PERCOCET	201	540	54,959	\$320,304	\$303,727	\$562.46	150	382	40,212	\$266,370	\$236,304	\$618.60	\$56.14	9.98%
00071101468 - LYRICA	222	419	28,376	\$136,178	\$82,118	\$195.99	214	405	28,977	\$96,412	\$87,295	\$215.54	\$19.56	9.98%
00670 - ANESTHESIA FOR EXTENSIVE SPINE AND SPINAL CORD PROCEDURES (EG, SPINAL INSTRUMENTATION OR VASCULAR PROCEDURES)	146	162	16,821	\$554,637	\$328,629	\$2,028.57	157	170	16,445	\$593,360	\$378,779	\$2,228.11	\$199.54	9.84%
22551 - ARTHRODESIS, ANTERIOR INTERBODY, INCLUDING DISC SPACE PREPARATION, DISCECTOMY, OSTEOPHYTECTOMY AND DECOMPRESSION OF SPINAL CORD AND/OR NERVE ROOTS; CERVICAL BELOW C2	5	6	6	\$32,177	\$24,992	\$4,165.33	38	67	67	\$475,894	\$305,527	\$4,560.10	\$394.76	9.48%
64484 - INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	101	181	196	\$154,670	\$120,948	\$668.22	132	261	278	\$247,279	\$190,688	\$730.60	\$62.38	9.34%
0490 - AMBULATORY SURGERY	158	342	338	\$721,492	\$569,563	\$1,665.39	227	537	571	\$1,328,649	\$977,441	\$1,820.19	\$154.80	9.30%
E0730 - TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS) DEVICE, FOUR OR MORE LEADS, FOR MULTIPLE NERVE STIMULATION	188	210	209	\$94,104	\$63,793	\$303.77	155	162	171	\$83,688	\$53,566	\$330.66	\$26.88	8.85%
29877 - ARTHROSCOPY, KNEE, SURGICAL; DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY)	25	34	33	\$87,834	\$54,967	\$1,616.66	15	21	21	\$61,576	\$36,827	\$1,753.68	\$137.02	8.48%
64494 - INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	116	169	173	\$146,470	\$104,931	\$620.90	139	222	233	\$205,023	\$149,459	\$673.24	\$52.34	8.43%

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97010 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS	4,333	35,932	35,938	\$1,257,057	\$805,593	\$22.42	4,115	32,213	32,205	\$1,148,848	\$782,683	\$24.30	\$1.88	8.37%
22830 - EXPLORATION OF SPINAL FUSION	41	71	69	\$239,677	\$108,807	\$1,532.49	39	65	65	\$262,290	\$107,864	\$1,659.45	\$126.95	8.28%
97140 - MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES	4,144	36,446	41,343	\$2,457,306	\$1,799,420	\$49.37	3,783	33,119	38,837	\$2,464,130	\$1,768,054	\$53.38	\$4.01	8.13%
00002324030 - CYMBALTA	95	189	7,711	\$45,229	\$40,479	\$214.18	133	265	10,507	\$74,555	\$61,156	\$230.78	\$16.60	7.75%
95861 - NEEDLE ELECTROMYOGRAPHY; 2 EXTREMITIES WITH OR WITHOUT RELATED PARASPINAL AREAS	309	339	348	\$133,292	\$86,670	\$255.67	243	259	264	\$109,003	\$71,160	\$274.75	\$19.08	7.46%
00025152531 - CELEBREX	240	465	20,527	\$123,796	\$93,416	\$200.90	238	438	19,670	\$105,074	\$94,118	\$214.88	\$13.99	6.96%
59011042010 - OXYCONTIN	95	206	13,516	\$57,192	\$52,010	\$252.48	142	344	22,729	\$103,405	\$92,825	\$269.84	\$17.36	6.88%
60793041130 - FLECTOR	118	166	9,598	\$59,291	\$56,775	\$342.02	168	288	17,055	\$127,323	\$105,256	\$365.47	\$23.45	6.86%
99285 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS WITHIN THE CONSTRAINTS IMPOSED BY THE URGENCY OF THE PATIENT'S CLINICAL CONDITION AND/OR MENTAL STATUS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY AND POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION.	223	251	254	\$146,929	\$119,559	\$476.33	215	241	244	\$164,170	\$122,385	\$507.82	\$31.49	6.61%
63481068706 - LIDODERM	422	717	35,141	\$280,021	\$254,629	\$355.13	444	804	40,298	\$341,288	\$304,247	\$378.42	\$23.29	6.56%
73721 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL	382	434	531	\$510,480	\$288,697	\$665.20	415	489	483	\$576,415	\$346,045	\$707.66	\$42.46	6.38%
00025152551 - CELEBREX	63	107	13,786	\$35,582	\$32,833	\$306.85	49	80	6,092	\$29,518	\$26,089	\$326.11	\$19.26	6.28%
97014 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)	2,753	21,173	21,454	\$879,799	\$657,333	\$31.05	2,462	18,023	18,007	\$774,246	\$593,090	\$32.91	\$1.86	6.00%
72295 - DISCOGRAPHY, LUMBAR, RADIOLOGICAL SUPERVISION AND INTERPRETATION	31	83	90	\$67,004	\$54,101	\$651.82	38	106	122	\$95,300	\$73,098	\$689.60	\$37.78	5.80%
97110 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY	5,202	61,483	96,824	\$5,662,306	\$4,112,736	\$66.89	4,846	56,254	90,485	\$5,516,088	\$3,976,438	\$70.69	\$3.79	5.67%
73718 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, LOWER EXTREMITY OTHER THAN JOINT; WITHOUT CONTRAST MATERIAL(S)	64	77	77	\$89,569	\$53,545	\$695.40	46	51	48	\$58,567	\$37,459	\$734.50	\$39.10	5.62%
50458009405 - DURAGESIC	13	32	710	\$61,174	\$60,384	\$1,887.00	10	36	805	\$77,361	\$70,853	\$1,968.13	\$81.13	4.30%
97112 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES	1,525	8,670	9,649	\$566,746	\$434,316	\$50.09	1,530	9,033	10,668	\$660,982	\$471,946	\$52.25	\$2.15	4.30%

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99214 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	4,345	8,026	8,122	\$1,432,819	\$895,096	\$111.52	4,953	9,446	9,772	\$1,747,498	\$1,097,544	\$116.19	\$4.67	4.18%
S9124 - NURSING CARE, IN THE HOME; BY LICENSED PRACTICAL NURSE, PER HOUR	0	0	0	\$0	\$0	\$0.00	4	88	1,445	\$119,510	\$73,266	\$832.57	\$832.57	n/a
<b>SUBTOTAL</b>	<b>34,451</b>	<b>194,269</b>	<b>658,189</b>	<b>31,233,489</b>	<b>21,592,167</b>	<b>\$111.15</b>	<b>34,163</b>	<b>183,438</b>	<b>713,998</b>	<b>35,751,305</b>	<b>25,888,498</b>	<b>\$141.13</b>	<b>\$29.98</b>	<b>26.98%</b>
<b>ALL OTHER DATA REPORTED</b>	<b>126,755</b>	<b>256,662</b>	<b>3,447,822</b>	<b>61,027,652</b>	<b>41,370,856</b>	<b>\$161.19</b>	<b>134,839</b>	<b>267,677</b>	<b>4,135,548</b>	<b>62,491,863</b>	<b>41,433,279</b>	<b>\$154.79</b>	<b>-\$6.40</b>	<b>-3.97%</b>
<b>GRAND TOTAL</b>	<b>22,151</b>	<b>450,931</b>	<b>4,106,011</b>	<b>\$92,261,141</b>	<b>\$62,963,023</b>	<b>\$139.63</b>	<b>22,327</b>	<b>451,115</b>	<b>4,849,546</b>	<b>\$98,243,169</b>	<b>\$67,321,777</b>	<b>\$149.23</b>	<b>\$9.61</b>	<b>6.88%</b>

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722.80 - POSTLAMINECTOMY SYNDROME OF UNSPECIFIED REGION	3	9	9	\$3,712	\$3,370	\$1,123.32	5	44	167	\$154,282	\$93,799	\$18,759.77	\$17,636.46	1570.03%	
824.5 - BIMALLEOLAR FRACTURE OPEN	10	142	205	\$18,572	\$10,700	\$1,070.04	7	53	524	\$186,967	\$105,605	\$15,086.49	\$14,016.45	1309.90%	
805.6 - CLOSED FRACTURE OF SACRUM AND COCCYX WITHOUT SPINAL CORD INJURY	7	100	122	\$9,438	\$7,353	\$1,050.38	13	150	893	\$245,113	\$173,157	\$13,319.78	\$12,269.40	1168.10%	
892.1 - OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE COMPLICATED	12	41	659	\$19,112	\$15,591	\$1,299.23	6	38	627	\$91,107	\$71,966	\$11,994.40	\$10,695.17	823.19%	
722.5 - DEGENERATION OF THORACIC OR LUMBAR INTERVERTEBRAL DISC	16	174	853	\$20,247	\$14,554	\$909.65	36	390	5,158	\$306,525	\$236,928	\$6,581.32	\$5,671.68	623.50%	
756.12 - SPONDYLOLISTHESIS CONGENITAL	32	156	177	\$25,140	\$15,504	\$484.50	26	188	204	\$99,024	\$68,864	\$2,648.63	\$2,164.13	446.67%	
860.0 - TRAUMATIC PNEUMOTHORAX WITHOUT OPEN WOUND INTO THORAX	8	27	27	\$19,182	\$14,755	\$1,844.33	7	61	1,105	\$79,784	\$68,432	\$9,776.05	\$7,931.71	430.06%	
726.33 - OLECRANON BURSTITIS	22	142	352	\$26,229	\$19,238	\$874.44	26	271	721	\$147,830	\$120,140	\$4,620.76	\$3,746.32	428.43%	
721.2 - THORACIC SPONDYLOSIS WITHOUT MYELOPATHY	20	62	121	\$30,433	\$19,007	\$950.37	15	101	757	\$95,221	\$72,724	\$4,848.30	\$3,897.92	410.15%	
715.35 - OSTEOARTHROSIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING PELVIC REGION AND THIGH	13	84	355	\$77,723	\$32,367	\$2,489.74	6	85	1,053	\$158,616	\$73,254	\$12,209.03	\$9,719.29	390.37%	
848.9 - UNSPECIFIED SITE OF SPRAIN AND STRAIN	49	393	432	\$46,657	\$38,787	\$791.58	43	264	463	\$174,483	\$165,035	\$3,838.02	\$3,046.44	384.86%	
718.42 - CONTRAURE OF UPPER ARM JOINT	9	261	303	\$26,327	\$15,294	\$1,699.36	15	246	882	\$133,022	\$86,650	\$5,776.67	\$4,077.31	239.93%	
709.2 - SCAR CONDITIONS AND FIBROSIS OF SKIN	43	130	348	\$59,352	\$35,879	\$834.41	32	114	910	\$112,940	\$86,436	\$2,701.11	\$1,866.70	223.72%	
854.00 - INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED	17	66	449	\$71,247	\$58,340	\$3,431.75	17	267	473	\$205,611	\$174,046	\$10,238.02	\$6,806.27	198.33%	
813.42 - OTHER CLOSED FRACTURES OF DISTAL END OF RADIUS (ALONE)	73	906	1,723	\$169,221	\$127,518	\$1,746.82	78	1,391	3,954	\$519,552	\$387,327	\$4,965.73	\$3,218.90	184.27%	
820.8 - FRACTURE OF UNSPECIFIED PART OF NECK OF FEMUR CLOSED	24	412	1,188	\$138,348	\$52,494	\$2,187.24	14	124	1,030	\$115,375	\$84,814	\$6,058.14	\$3,870.90	176.98%	
V57.89 - CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE	30	402	4,220	\$414,029	\$236,709	\$7,890.29	29	504	9,334	\$900,130	\$598,044	\$20,622.20	\$12,731.92	161.36%	
852.20 - SUBDURAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED	7	167	868	\$87,131	\$36,441	\$5,205.84	13	161	3,457	\$295,360	\$169,686	\$13,052.73	\$7,846.90	150.73%	
996.41 - MECHANICAL LOOSENING OF PROSTHETIC JOINT	6	41	348	\$129,551	\$69,476	\$11,579.41	8	105	1,586	\$300,768	\$222,038	\$27,754.81	\$16,175.40	139.69%	
897.2 - TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL AT OR ABOVE KNEE WITHOUT COMPLICATION	9	45	152	\$42,549	\$32,756	\$3,639.53	11	189	208	\$111,697	\$94,094	\$8,554.04	\$4,914.51	135.03%	
996.77 - OTHER COMPLICATIONS DUE TO INTERNAL JOINT PROSTHESIS	9	58	866	\$56,819	\$35,841	\$3,982.36	11	90	1,092	\$182,990	\$97,244	\$8,840.40	\$4,858.04	121.99%	
738.4 - ACQUIRED SPONDYLOLISTHESIS	32	147	904	\$438,066	\$196,846	\$6,151.42	44	356	2,895	\$842,569	\$580,892	\$13,202.09	\$7,050.67	114.62%	
813.01 - FRACTURE OF OLECRANON PROCESS OF ULNA CLOSED	15	130	389	\$40,015	\$32,453	\$2,163.50	16	524	1,365	\$98,256	\$74,264	\$4,641.49	\$2,477.99	114.54%	
842.09 - OTHER WRIST SPRAIN	25	265	404	\$33,489	\$23,704	\$948.17	30	594	849	\$75,592	\$59,983	\$1,999.44	\$1,051.27	110.87%	
927.3 - CRUSHING INJURY OF FINGER(S)	65	323	862	\$62,798	\$40,845	\$628.38	60	705	1,909	\$108,256	\$628,380	\$76,714	\$1,278.56	\$650.19	103.47%
781.2 - ABNORMALITY OF GAIT	28	309	536	\$34,071	\$24,187	\$863.80	43	761	1,056	\$102,244	\$74,771	\$1,738.87	\$875.06	101.30%	
719.4 - PAIN IN JOINT	45	144	2,680	\$31,891	\$23,821	\$529.36	80	1,198	4,033	\$107,760	\$84,434	\$1,055.42	\$526.06	99.38%	
726.5 - ENTHESOPATHY OF HIP REGION	45	607	681	\$59,318	\$37,963	\$843.62	35	563	778	\$78,160	\$55,957	\$1,598.78	\$755.16	89.51%	
824.4 - BIMALLEOLAR FRACTURE CLOSED	29	238	845	\$76,312	\$69,194	\$2,385.99	26	168	1,071	\$136,814	\$110,176	\$4,237.53	\$1,851.54	77.60%	
816.12 - OPEN FRACTURE OF DISTAL PHALANX OR PHALANGES OF HAND	37	369	447	\$40,008	\$34,033	\$919.80	39	423	817	\$73,679	\$62,552	\$1,603.90	\$684.10	74.37%	
780.2 - SYNCOPE AND COLLAPSE	32	164	344	\$39,525	\$25,495	\$796.73	50	369	638	\$102,110	\$68,969	\$1,379.37	\$582.65	73.13%	
038.9 - UNSPECIFIED SEPTICEMIA	6	67	807	\$48,909	\$39,495	\$6,582.48	6	64	1,386	\$77,926	\$68,217	\$11,369.49	\$4,787.01	72.72%	
682.6 - CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT	41	220	2,525	\$56,949	\$44,642	\$1,088.82	36	374	10,583	\$85,264	\$67,211	\$1,866.97	\$778.15	71.47%	
920 - CONTUSION OF FACE SCALP AND NECK EXCEPT EYE(S)	161	551	654	\$90,441	\$73,765	\$458.17	155	674	831	\$164,883	\$119,282	\$769.56	\$311.39	67.96%	
722.91 - OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION	115	464	668	\$123,672	\$77,239	\$671.64	99	465	815	\$168,588	\$109,271	\$1,103.75	\$432.11	64.34%	
924.20 - CONTUSION OF FOOT	113	526	652	\$59,955	\$42,938	\$379.98	110	715	911	\$81,858	\$67,116	\$610.15	\$230.17	60.57%	

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723.0 - SPINAL STENOSIS IN CERVICAL REGION	83	846	5,087	\$139,657	\$97,690	\$1,176.98	76	282	3,137	\$209,973	\$143,575	\$1,889.15	\$712.17	60.51%
806.4 - CLOSED FRACTURE OF LUMBAR SPINE WITH SPINAL CORD INJURY	8	58	58	\$109,805	\$73,963	\$9,245.39	6	74	74	\$165,883	\$88,397	\$14,732.87	\$5,487.48	59.35%
816.02 - CLOSED FRACTURE OF DISTAL PHALANX OR PHALANGES OF HAND	64	317	671	\$71,713	\$39,233	\$613.02	80	859	1,356	\$132,952	\$77,292	\$966.15	\$353.13	57.60%
V58.69 - LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS	126	624	1,477	\$67,178	\$34,877	\$276.80	215	1,384	3,216	\$147,291	\$92,104	\$428.39	\$151.59	54.76%
724.00 - SPINAL STENOSIS OF UNSPECIFIED REGION	54	148	150	\$68,436	\$51,441	\$952.61	55	165	173	\$81,870	\$80,414	\$1,462.07	\$509.47	53.48%
814.01 - CLOSED FRACTURE OF NAVICULAR (SCAPHOID) BONE OF WRIST	40	346	422	\$64,083	\$49,030	\$1,225.75	19	312	429	\$43,304	\$35,413	\$1,863.84	\$638.08	52.06%
337.21 - REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER LIMB	94	2,632	19,703	\$1,034,290	\$220,250	\$2,343.09	113	1,658	6,606	\$712,968	\$402,202	\$3,559.31	\$1,216.22	51.91%
721.1 - CERVICAL SPONDYLOSIS WITH MYELOPATHY	61	585	1,465	\$303,070	\$231,752	\$3,799.21	57	395	1,491	\$445,261	\$328,154	\$5,757.09	\$1,957.88	51.53%
883.1 - OPEN WOUND OF FINGERS COMPLICATED	91	555	1,199	\$124,453	\$102,317	\$1,124.36	72	870	1,869	\$170,913	\$120,557	\$1,674.40	\$550.03	48.92%
786.50 - UNSPECIFIED CHEST PAIN	124	396	578	\$81,558	\$56,366	\$454.57	101	310	737	\$89,925	\$67,630	\$669.61	\$215.04	47.31%
823.00 - CLOSED FRACTURE OF UPPER END OF TIBIA	51	1,326	2,174	\$199,885	\$147,159	\$2,885.48	37	562	1,321	\$195,938	\$152,840	\$4,130.80	\$1,245.32	43.16%
726.0 - ADHESIVE CAPSULITIS OF SHOULDER	110	1,227	1,924	\$166,177	\$104,502	\$950.02	88	1,225	2,206	\$166,860	\$119,511	\$1,358.08	\$408.06	42.95%
722.4 - DEGENERATION OF CERVICAL INTERVERTEBRAL DISC	214	1,440	4,190	\$447,670	\$217,086	\$1,014.42	229	1,501	3,941	\$492,920	\$331,815	\$1,448.97	\$434.55	42.84%
550.90 - UNILATERAL OR UNSPECIFIED INGUINAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE	62	348	2,951	\$174,191	\$111,765	\$1,802.66	41	228	1,813	\$138,335	\$103,827	\$2,532.36	\$729.70	40.48%
722.1 - DISPLACEMENT OF THORACIC OR LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY	46	1,278	2,257	\$114,973	\$65,014	\$1,413.34	88	1,754	3,692	\$271,157	\$173,791	\$1,974.90	\$561.56	39.73%
727.00 - SYNOVITIS AND TENOSYNOVITIS UNSPECIFIED	80	503	651	\$58,929	\$42,974	\$537.17	56	261	266	\$62,004	\$41,419	\$739.63	\$202.46	37.69%
923.20 - CONTUSION OF HAND(S)	100	415	633	\$44,118	\$34,100	\$341.00	135	822	997	\$78,626	\$63,013	\$466.76	\$125.76	36.88%
724.9 - OTHER UNSPECIFIED BACK DISORDERS	44	282	428	\$102,155	\$52,894	\$1,202.15	48	713	959	\$152,748	\$78,609	\$1,637.70	\$435.55	36.23%
813.41 - COLLES' FRACTURE CLOSED	35	180	725	\$59,809	\$50,953	\$1,455.81	29	165	987	\$77,442	\$57,142	\$1,970.42	\$514.61	35.35%
823.92 - OPEN FRACTURE OF UNSPECIFIED PART OF FIBULA WITH TIBIA	10	85	914	\$90,476	\$73,211	\$7,321.10	7	187	1,548	\$87,964	\$68,848	\$9,835.44	\$2,514.34	34.34%
724.8 - OTHER SYMPTOMS REFERABLE TO BACK	225	3,407	8,891	\$702,644	\$484,532	\$2,153.48	258	5,305	14,708	\$1,064,543	\$746,330	\$2,892.75	\$739.28	34.33%
354.2 - LESION OF ULNAR NERVE	79	737	1,099	\$120,709	\$85,293	\$1,079.66	79	853	1,406	\$191,576	\$112,334	\$1,421.95	\$342.29	31.70%
805.2 - CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY	23	195	548	\$145,124	\$118,109	\$5,135.19	23	368	1,218	\$204,342	\$151,909	\$6,604.72	\$1,469.53	28.62%
854.04 - INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE WITHOUT OPEN INTRACRANIAL WOUND WITH PROLONGED (MORE THAN 24 HOURS) LOSS OF CONSCIOUSNESS AND RETURN TO PRE-EXISTING CONSCIOUS LEVEL	4	39	513	\$254,227	\$170,688	\$42,672.03	4	29	413	\$217,789	\$217,739	\$54,434.65	\$11,762.62	27.57%
720.2 - SACROILIITIS NOT ELSEWHERE CLASSIFIED	88	485	660	\$113,278	\$71,398	\$811.34	95	917	2,096	\$162,683	\$97,212	\$1,023.28	\$211.95	26.12%
844.2 - SPRAIN OF CRUCIATE LIGAMENT OF KNEE	64	796	1,851	\$253,893	\$181,989	\$2,843.58	99	2,439	3,697	\$606,884	\$351,081	\$3,546.27	\$702.69	24.71%
883.2 - OPEN WOUND OF FINGERS WITH TENDON INVOLVEMENT	67	724	1,657	\$187,918	\$136,162	\$2,032.27	63	773	2,181	\$208,873	\$157,977	\$2,507.56	\$475.29	23.39%
891.0 - OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE WITHOUT COMPLICATION	80	444	1,852	\$77,351	\$48,597	\$607.47	90	528	1,254	\$84,126	\$66,940	\$743.77	\$136.31	22.44%
840.4 - ROTATOR CUFF (CAPSULE) SPRAIN	543	6,008	12,049	\$1,076,422	\$782,711	\$1,441.46	580	9,159	16,360	\$1,729,742	\$1,022,230	\$1,762.47	\$321.01	22.27%
719.43 - PAIN IN JOINT INVOLVING FOREARM	291	2,751	3,856	\$282,070	\$201,509	\$692.47	275	2,716	5,268	\$319,467	\$230,863	\$839.50	\$147.03	21.23%
726.31 - MEDIAL EPICONDYLITIS ELBOW REGION	51	714	864	\$64,942	\$45,712	\$896.31	36	469	598	\$51,210	\$39,060	\$1,085.01	\$188.70	21.05%
715.96 - OSTEOARTHRITIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING LOWER LEG	301	2,251	4,757	\$399,778	\$285,245	\$947.66	330	2,672	6,923	\$563,456	\$378,194	\$1,146.04	\$198.39	20.93%
354.0 - CARPAL TUNNEL SYNDROME	346	4,775	7,218	\$582,359	\$388,042	\$1,121.51	321	4,865	9,270	\$639,115	\$433,442	\$1,350.29	\$228.78	20.40%
344.1 - PARAPLEGIA	22	704	26,827	\$137,401	\$103,100	\$4,686.35	32	1,096	40,769	\$289,981	\$180,434	\$5,638.57	\$952.22	20.32%
722.73 - INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION	80	1,118	1,416	\$97,086	\$71,230	\$890.37	71	1,149	1,437	\$100,801	\$75,562	\$1,064.25	\$173.87	19.53%
724.2 - LUMBAGO	2,343	23,554	51,386	\$2,968,122	\$2,032,613	\$867.53	2,411	26,416	58,979	\$3,783,907	\$2,461,644	\$1,021.01	\$153.48	17.69%

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959.2 - OTHER AND UNSPECIFIED INJURY TO SHOULDER AND UPPER ARM	113	214	425	\$57,845	\$40,082	\$354.71	141	460	710	\$84,710	\$57,768	\$409.70	\$54.99	15.50%
739.3 - NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED	137	2,572	3,397	\$180,177	\$130,476	\$952.38	120	2,847	3,238	\$178,822	\$131,595	\$1,096.63	\$144.25	15.15%
723.8 - OTHER SYNDROMES AFFECTING CERVICAL REGION	71	919	1,386	\$193,797	\$125,875	\$1,772.89	69	1,037	2,681	\$199,019	\$140,045	\$2,029.64	\$256.75	14.48%
825.0 - FRACTURE OF CALCANEUS CLOSED	32	428	739	\$147,433	\$62,085	\$1,940.16	43	466	778	\$123,132	\$95,176	\$2,213.39	\$273.23	14.08%
840.8 - SPRAIN OF OTHER SPECIFIED SITES OF SHOULDER AND UPPER ARM	98	1,268	1,765	\$129,780	\$96,008	\$979.67	107	939	1,078	\$148,688	\$119,052	\$1,112.64	\$132.97	13.57%
722.0 - DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY	556	8,015	16,423	\$3,225,222	\$2,001,574	\$3,599.95	607	8,531	18,534	\$3,810,461	\$2,477,990	\$4,082.36	\$482.40	13.40%
724.3 - SCIATICA	148	1,800	2,818	\$160,708	\$104,726	\$707.61	129	1,750	3,106	\$152,653	\$103,260	\$800.47	\$92.86	13.12%
844.9 - SPRAIN OF UNSPECIFIED SITE OF KNEE AND LEG	363	2,677	3,724	\$262,171	\$202,117	\$556.80	319	2,401	3,284	\$258,691	\$199,907	\$626.67	\$69.87	12.55%
873.0 - OPEN WOUND OF SCALP WITHOUT COMPLICATION	58	236	246	\$46,860	\$41,477	\$715.12	59	220	230	\$56,537	\$47,075	\$797.88	\$82.76	11.57%
959.9 - OTHER AND UNSPECIFIED INJURY TO UNSPECIFIED SITE	1,670	9,309	19,831	\$2,083,234	\$1,602,067	\$959.32	1,787	10,871	39,276	\$2,407,900	\$1,907,831	\$1,067.62	\$108.29	11.29%
724.5 - BACKACHE UNSPECIFIED	460	1,982	6,148	\$319,684	\$242,148	\$526.41	440	1,943	4,502	\$343,595	\$255,424	\$580.51	\$54.10	10.28%
V57.1 - CARE INVOLVING OTHER PHYSICAL THERAPY	94	2,318	2,924	\$202,749	\$142,683	\$1,517.91	85	1,828	2,292	\$199,872	\$142,020	\$1,670.83	\$152.92	10.07%
824.2 - FRACTURE OF LATERAL MALLEOLUS CLOSED	66	621	1,306	\$87,283	\$66,291	\$1,004.40	38	243	949	\$54,761	\$41,935	\$1,103.54	\$99.14	9.87%
715.16 - OSTEOARTHRITIS LOCALIZED PRIMARY INVOLVING LOWER LEG	104	968	1,669	\$230,965	\$138,593	\$1,332.62	121	1,539	2,260	\$242,504	\$177,063	\$1,463.33	\$130.71	9.81%
719.46 - PAIN IN JOINT INVOLVING LOWER LEG	788	10,364	15,121	\$1,088,363	\$720,908	\$914.86	881	9,771	15,510	\$1,224,373	\$875,698	\$993.98	\$79.12	8.65%
717.9 - UNSPECIFIED INTERNAL DERANGEMENT OF KNEE	93	950	1,495	\$121,202	\$74,662	\$802.82	113	1,146	2,133	\$146,227	\$97,181	\$860.01	\$57.19	7.12%
847.2 - SPRAIN LUMBAR REGION	1,591	22,490	40,903	\$1,954,688	\$1,457,997	\$916.40	1,561	20,788	40,225	\$2,091,939	\$1,531,464	\$981.08	\$64.68	7.06%
726.19 - OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION	128	1,326	2,308	\$264,379	\$169,667	\$1,325.52	116	1,461	2,742	\$235,397	\$164,426	\$1,417.46	\$91.94	6.94%
338.4 - CHRONIC PAIN SYNDROME	118	597	1,851	\$411,137	\$233,573	\$1,979.43	170	992	3,999	\$569,024	\$358,255	\$2,107.38	\$127.95	6.46%
722.10 - DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY	1,362	19,080	41,637	\$7,792,573	\$4,840,669	\$3,554.09	1,347	17,304	40,510	\$7,640,379	\$5,064,144	\$3,759.57	\$205.48	5.78%
784.0 - HEADACHE	171	538	813	\$155,310	\$93,688	\$547.88	177	1,027	1,559	\$150,713	\$102,494	\$579.06	\$31.18	5.69%
840.9 - SPRAIN OF UNSPECIFIED SITE OF SHOULDER AND UPPER ARM	457	5,395	7,268	\$464,824	\$347,168	\$759.67	470	5,543	7,500	\$499,845	\$375,232	\$798.37	\$38.70	5.09%
724.4 - THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED	1,475	13,822	36,662	\$3,161,347	\$1,999,077	\$1,355.31	1,533	15,148	35,614	\$3,290,207	\$2,176,162	\$1,419.54	\$64.24	4.74%
924.11 - CONTUSION OF KNEE	259	1,556	1,797	\$160,689	\$132,108	\$510.07	240	1,542	1,996	\$171,283	\$127,320	\$530.50	\$20.43	4.01%
821.30 - FRACTURE OF LOWER END OF FEMUR UNSPECIFIED PART OPEN	0	0	0	\$0	\$0	\$0.00	2	58	3,231	\$132,998	\$123,773	\$61,886.36	\$61,886.36	n/a
342.00 - FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE	0	0	0	\$0	\$0	\$0.00	3	371	13,168	\$180,033	\$115,831	\$38,610.29	\$38,610.29	n/a
989 - TOXIC EFFECT OF OTHER SUBSTANCES CHIEFLY NONMEDICINAL AS TO SOURCE	0	0	0	\$0	\$0	\$0.00	10	24	0	\$91,574	\$91,526	\$9,152.62	\$9,152.62	n/a
865.03 - LACERATION OF SPLEEN EXTENDING INTO PARENCHYMA WITHOUT OPEN WOUND INTO CAVITY	0	0	0	\$0	\$0	\$0.00	2	36	1,083	\$105,190	\$84,941	\$42,470.41	\$42,470.41	n/a
<b>SUBTOTAL</b>	<b>17,724</b>	<b>180,080</b>	<b>412,932</b>	<b>36,614,810</b>	<b>23,807,817</b>	<b>\$1,343.25</b>	<b>18,256</b>	<b>196,556</b>	<b>520,118</b>	<b>45,853,712</b>	<b>31,464,185</b>	<b>\$1,723.50</b>	<b>\$380.25</b>	<b>28.31%</b>
<b>ALL OTHER DATA REPORTED</b>	<b>33,342</b>	<b>270,851</b>	<b>558,708</b>	<b>55,646,331</b>	<b>39,155,205</b>	<b>\$1,174.35</b>	<b>33,947</b>	<b>254,559</b>	<b>532,773</b>	<b>52,389,457</b>	<b>35,857,592</b>	<b>\$1,056.28</b>	<b>-\$118.07</b>	<b>-10.05%</b>
<b>GRAND TOTAL</b>	<b>22,151</b>	<b>450,931</b>	<b>971,640</b>	<b>\$92,261,141</b>	<b>\$62,963,023</b>	<b>\$2,842.45</b>	<b>22,327</b>	<b>451,115</b>	<b>1,052,891</b>	<b>\$98,243,169</b>	<b>\$67,321,777</b>	<b>\$3,015.26</b>	<b>\$172.82</b>	<b>6.08%</b>

**Delaware Compensation Rating Bureau, Inc.**  
**Total Number of Procedures Performed for Transactions Reported July 2010 - June 2012**  
**Year 1 (July 2010 - June 2011) Compared to Year 2 (July 2011 - June 2012)**  
**Excludes Ambulatory Surgical Center (POS 24)**

Procedure Code/Description	Year 1 Record Count	Year 1 % of Total Records	Year 2 Record Count	Year 2 % of Total Records	Year 2 - Year 1
97112 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES	8,670	1.92%	9,033	2.00%	0.08%
99214 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	8,026	1.78%	9,446	2.09%	0.31%
99080 - SPECIAL REPORTS SUCH AS INSURANCE FORMS, MORE THAN THE INFORMATION CONVEYED IN THE USUAL MEDICAL COMMUNICATIONS OR STANDARD REPORTING FORM	8,429	1.87%	8,915	1.98%	0.11%
97124 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)	4,442	0.99%	6,038	1.34%	0.35%
98940 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS	4,354	0.97%	4,437	0.98%	0.01%
97113 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES	3,750	0.83%	3,919	0.87%	0.04%
99070 - SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED (LIST DRUGS, TRAYS, SUPPLIES, OR MATERIALS PROVIDED)	3,259	0.72%	4,366	0.97%	0.25%
A4556 - ELECTRODES, (E.G., APNEA MONITOR), PER PAIR	3,113	0.69%	3,254	0.72%	0.03%
80101 - DRUG SCREEN, QUALITATIVE; SINGLE DRUG CLASS METHOD (EG, IMMUNOASSAY, ENZYME ASSAY), EACH DRUG CLASS	2,227	0.49%	3,213	0.71%	0.22%
98943 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, 1 OR MORE REGIONS	2,454	0.54%	2,484	0.55%	0.01%
99204 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	1,798	0.40%	1,910	0.42%	0.02%
0420 - PHYSICAL THERAPY	1,194	0.26%	2,493	0.55%	0.29%
0250 - PHARMACY	1,621	0.36%	1,668	0.37%	0.01%
A4362 - SKIN BARRIER; SOLID, 4 X 4 OR EQUIVALENT; EACH	1,445	0.32%	1,589	0.35%	0.03%
A9901 - DME DELIVERY, SET UP, AND/OR DISPENSING SERVICE COMPONENT OF ANOTHER HCPCS CODE	1,261	0.28%	1,511	0.33%	0.05%
A4245 - ALCOHOL WIPES, PER BOX	1,239	0.27%	1,469	0.33%	0.06%
20610 - ARTHROCENTESIS, ASPIRATION AND/OR INJECTION; MAJOR JOINT OR BURSA (EG, SHOULDER, HIP, KNEE JOINT, SUBACROMIAL BURSA)	1,199	0.27%	1,260	0.28%	0.01%
99199 - UNLISTED SPECIAL SERVICE, PROCEDURE OR REPORT	982	0.22%	1,451	0.32%	0.10%
83925 - OPIATE(S), DRUG AND METABOLITES, EACH PROCEDURE	707	0.16%	1,636	0.36%	0.20%
82570 - CREATININE; OTHER SOURCE	688	0.15%	1,437	0.32%	0.17%
72100 - RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; 2 OR 3 VIEWS	1,038	0.23%	1,066	0.24%	0.01%
0450 - EMERGENCY ROOM	974	0.22%	1,061	0.24%	0.02%
0320 - RADIOLOGY - DIAGNOSTIC	927	0.21%	1,019	0.23%	0.02%

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Procedure Code/Description	Year 1 Record Count	Year 1 % of Total Records	Year 2 Record Count	Year 2 % of Total Records	Year 2 - Year 1
82542 - COLUMN CHROMATOGRAPHY/MASS SPECTROMETRY (EG, GC/MS, OR HPLC/MS), ANALYTE NOT ELSEWHERE SPECIFIED; QUANTITATIVE, SINGLE STATIONARY AND MOBILE PHASE	492	0.11%	1,234	0.27%	0.16%
80103 - TISSUE PREPARATION FOR DRUG ANALYSIS	767	0.17%	923	0.20%	0.03%
99284 - EMERGENCY DEPARTMENT VISIT HIGH/URGENT SEVERITY	825	0.18%	836	0.19%	0.01%
80154 - DRUG SCREEN QUALITATIVE BENZODIAZEPINES	420	0.09%	1,184	0.26%	0.17%
83840 - METHADONE	421	0.09%	1,145	0.25%	0.16%
63481068706 - LIDODERM	717	0.16%	804	0.18%	0.02%
73630 - RADIOLOGIC EXAMINATION, FOOT; COMPLETE, MINIMUM OF 3 VIEWS	720	0.16%	770	0.17%	0.01%
99215 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 40 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	679	0.15%	767	0.17%	0.02%
83986 - PH; BODY FLUID, NOT OTHERWISE SPECIFIED	388	0.09%	1,044	0.23%	0.14%
90806 - INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 45 TO 50 MINUTES FACE-TO-FACE WITH THE PATIENT;	685	0.15%	733	0.16%	0.01%
73130 - RADIOLOGIC EXAMINATION, HAND; MINIMUM OF 3 VIEWS	673	0.15%	723	0.16%	0.01%
0301 - LABORATORY - CLINICAL DIAGNOSTIC: CHEMISTRY	586	0.13%	777	0.17%	0.04%
E1399 - DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS	643	0.14%	660	0.15%	0.01%
82145 - AMPHETAMINE OR METHAMPHETAMINE	356	0.08%	933	0.21%	0.13%
84311 - SPECTROPHOTOMETRY, ANALYTE NOT ELSEWHERE SPECIFIED	329	0.07%	938	0.21%	0.14%
36415 - COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE	605	0.13%	652	0.14%	0.01%
97116 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; GAIT TRAINING (INCLUDES STAIR CLIMBING)	554	0.12%	681	0.15%	0.03%
99232 - SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED INTERVAL HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PATIENT IS RESPONDING INADEQUATELY TO THERAPY OR HAS DEVELOPED A MINOR COMPLICATION. PHYSICIANS TYPICALLY SPEND 25 MINUTES AT THE BEDSIDE AND ON THE PATIENT'S HOSPITAL FLOOR OR UNIT.	522	0.12%	697	0.15%	0.03%
97810 - ACUPUNCTURE, 1 OR MORE NEEDLES; WITHOUT ELECTRICAL STIMULATION, INITIAL 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT	428	0.09%	739	0.16%	0.07%
J3301 - INJECTION, TRIAMCINOLONE ACETONIDE, NOT OTHERWISE SPECIFIED, 10 MG	400	0.09%	698	0.15%	0.06%
99202 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 20 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	508	0.11%	566	0.13%	0.02%

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Procedure Code/Description	Year 1 Record Count	Year 1 % of Total Records	Year 2 Record Count	Year 2 % of Total Records	Year 2 - Year 1
73140 - RADIOLOGIC EXAMINATION, FINGER(S), MINIMUM OF 2 VIEWS	465	0.10%	593	0.13%	0.03%
97811 - ACUPUNCTURE, 1 OR MORE NEEDLES; WITHOUT ELECTRICAL STIMULATION, EACH ADDITIONAL 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT, WITH RE-INSERTION OF NEEDLE(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	300	0.07%	738	0.16%	0.09%
83992 - PHENCYCLIDINE (PCP)	303	0.07%	732	0.16%	0.09%
98942 - CHIROPRACTIC MANIPULATIVE TX SPINAL 5 REGIONS	508	0.11%	527	0.12%	0.01%
82205 - BARBITURATES, NOT ELSEWHERE SPECIFIED	347	0.08%	683	0.15%	0.07%
80104 - DRUG SCREEN, QUALITATIVE; MULTIPLE DRUG CLASSES OTHER THAN CHROMATOGRAPHIC METHOD, EACH PROCEDURE	239	0.05%	785	0.17%	0.12%
00406055201 - OXYCODONE HCL	427	0.09%	593	0.13%	0.04%
A4649 - SURGICAL SUPPLY; MISCELLANEOUS	468	0.10%	519	0.12%	0.02%
72040 - RADIOLOGIC EXAMINATION, SPINE, CERVICAL; 2 OR 3 VIEWS	408	0.09%	569	0.13%	0.04%
97535 - SELF-CARE/HOME MANAGEMENT TRAINING (EG, ACTIVITIES OF DAILY LIVING (ADL) AND COMPENSATORY TRAINING, MEAL PREPARATION, SAFETY PROCEDURES, AND INSTRUCTIONS IN USE OF ASSISTIVE TECHNOLOGY DEVICES/ADAPTIVE EQUIPMENT) DIRECT ONE-ON-ONE CONTACT BY PROVIDER, EACH 15 MINUTES	456	0.10%	484	0.11%	0.01%
73721 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL	434	0.10%	489	0.11%	0.01%
0490 - AMBULATORY SURGERY	342	0.08%	537	0.12%	0.04%
90471 - IMMUNIZATION ADMINISTRATION (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMUSCULAR INJECTIONS); 1 VACCINE (SINGLE OR COMBINATION VACCINE/TOXOID)	400	0.09%	476	0.11%	0.02%
00228287811 - OXYCODONE HYDROCHLORIDE	3	0.00%	863	0.19%	0.19%
00002327030 - CYMBALTA	390	0.09%	470	0.10%	0.01%
99999999999 - COMPOUND DRUGS	75	0.02%	761	0.17%	0.15%
55111018015 - TIZANIDINE HCL	379	0.08%	445	0.10%	0.02%
83516 - IMMUNOASSAY FOR ANALYTE OTHER THAN INFECTIOUS AGENT ANTIBODY OR INFECTIOUS AGENT ANTIGEN; QUALITATIVE OR SEMIQUANTITATIVE, MULTIPLE STEP METHOD	261	0.06%	558	0.12%	0.06%
59746017710 - CYCLOBENZAPRINE HYDROCHLORIDE	370	0.08%	423	0.09%	0.01%
0300 - LABORATORY - CLINICAL DIAGNOSTIC	333	0.07%	412	0.09%	0.02%
00378075110 - CYCLOBENZAPRINE HCL	352	0.08%	385	0.09%	0.01%
00228287911 - OXYCODONE HYDROCHLORIDE	2	0.00%	699	0.15%	0.15%
00071101668 - LYRICA	304	0.07%	368	0.08%	0.01%
64483 - INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL	308	0.07%	360	0.08%	0.01%
73562 - RADIOLOGIC EXAMINATION, KNEE; 3 VIEWS	302	0.07%	363	0.08%	0.01%
00603499121 - OXYCODONE HYDROCHLORIDE	129	0.03%	497	0.11%	0.08%
81003 - URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANY NUMBER OF THESE CONSTITUENTS; AUTOMATED, WITHOUT MICROSCOPY	201	0.04%	421	0.09%	0.05%
94760 - NONINVASIVE EAR OR PULSE OXIMETRY FOR OXYGEN SATURATION; SINGLE DETERMINATION	270	0.06%	346	0.08%	0.02%
A5120 - SKIN BARRIER, WIPES OR SWABS, EACH	285	0.06%	322	0.07%	0.01%
00603258232 - CARISOPRODOL	274	0.06%	319	0.07%	0.01%
97139 - UNLISTED THERAPEUTIC PROCEDURE (SPECIFY)	118	0.03%	467	0.10%	0.07%
97814 - ACUPUNCTURE, 1 OR MORE NEEDLES; WITH ELECTRICAL STIMULATION, EACH ADDITIONAL 15 MINUTES OF PERSONAL ONE-ON-ONE CONTACT WITH THE PATIENT, WITH RE-INSERTION OF NEEDLE(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	276	0.06%	307	0.07%	0.01%
00591551305 - CARISOPRODOL	177	0.04%	378	0.08%	0.04%
59011042010 - OXYCONTIN	206	0.05%	344	0.08%	0.03%
59011048010 - OXYCONTIN	245	0.05%	279	0.06%	0.01%
59011044010 - OXYCONTIN	218	0.05%	294	0.07%	0.02%
90805 - INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING AND/OR SUPPORTIVE, IN AN OFFICE OR OUTPATIENT FACILITY, APPROXIMATELY 20 TO 30 MINUTES FACE-TO-FACE WITH THE PATIENT; WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES	239	0.05%	273	0.06%	0.01%

**Delaware Compensation Rating Bureau, Inc.**  
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<b>Procedure Code/Description</b>	<b>Year 1 Record Count</b>	<b>Year 1 % of Total Records</b>	<b>Year 2 Record Count</b>	<b>Year 2 % of Total Records</b>	<b>Year 2 - Year 1</b>
22851 - APPLICATION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE(S), METHYLMETHACRYLATE) TO VERTEBRAL DEFECT OR INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	230	0.05%	272	0.06%	0.01%
Q9967 - LOW OSMOLAR CONTRAST MATERIAL, 300-399 MG/ML IODINE CONCENTRATION, PER ML	226	0.05%	272	0.06%	0.01%
72170 - RADIOLOGIC EXAMINATION, PELVIS; 1 OR 2 VIEWS	203	0.05%	275	0.06%	0.01%
64493 - INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL	194	0.04%	269	0.06%	0.02%
82520 - COCAINE OR METABOLITE	100	0.02%	359	0.08%	0.06%
00002324030 - CYMBALTA	189	0.04%	265	0.06%	0.02%
60793041130 - FLECTOR	166	0.04%	288	0.06%	0.02%
01992 - ANESTHESIA FOR DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS AND INJECTIONS (WHEN BLOCK OR INJECTION IS PERFORMED BY A DIFFERENT PROVIDER); PRONE POSITION	201	0.04%	247	0.05%	0.01%
64484 - INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	181	0.04%	261	0.06%	0.02%
00603499821 - APAP/OXYCODONE	197	0.04%	243	0.05%	0.01%
J3490 - UNCLASSIFIED DRUGS	172	0.04%	262	0.06%	0.02%
60760013520 - IBUPROFEN	166	0.04%	254	0.06%	0.02%
97799 - UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE	129	0.03%	283	0.06%	0.03%
62290 - INJECTION PROCEDURE FOR DISCOGRAPHY, EACH LEVEL; LUMBAR	175	0.04%	233	0.05%	0.01%
00603233832 - ACETAMINOPHEN/CODEINE	184	0.04%	221	0.05%	0.01%
0730 - EKG/ECG	180	0.04%	214	0.05%	0.01%
64494 - INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	169	0.04%	222	0.05%	0.01%
00406052301 - APAP/OXYCODONE	147	0.03%	236	0.05%	0.02%
00603307932 - CYCLOBENZAPRINE HYDROCHLORIDE	173	0.04%	205	0.05%	0.01%
<b>SUBTOTAL</b>	<b>89,711</b>	<b>19.89%</b>	<b>115,139</b>	<b>25.52%</b>	<b>5.63%</b>
<b>ALL OTHER</b>	<b>361,220</b>	<b>80.11%</b>	<b>335,976</b>	<b>74.48%</b>	<b>-5.63%</b>
<b>GRAND TOTAL</b>	<b>450,931</b>	<b>100.00%</b>	<b>451,115</b>	<b>100.00%</b>	<b>0.00%</b>

**Delaware Compensation Rating Bureau, Inc.**  
**Average Cost for Top 30 Procedures**  
**Transactions Reported July 2010 - June 2012**  
**Excludes Ambulatory Surgical Center (POS 24)**

<b>Procedure Code and Description</b>	<b>Claim Count</b>	<b>Record Count</b>	<b>Procedure Units</b>	<b>Charged Amount</b>	<b>Paid Amount</b>	<b>Average Cost (Paid Amt/Record Count)</b>
97110 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY	5,426	117,737	187,309	\$11,178,394	\$8,089,173	\$68.71
97140 - MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES	4,411	69,565	80,180	\$4,921,436	\$3,567,474	\$51.28
97010 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS	4,735	68,145	68,143	\$2,405,905	\$1,588,277	\$23.31
97014 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)	3,031	39,196	39,461	\$1,654,045	\$1,250,423	\$31.90
99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	9,132	36,132	36,655	\$4,523,312	\$2,686,571	\$74.35
97530 - THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES	2,400	24,057	27,715	\$1,742,509	\$1,112,447	\$46.24
97035 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES	1,825	18,474	18,807	\$829,974	\$550,502	\$29.80
97112 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES	1,957	17,703	20,317	\$1,227,728	\$906,262	\$51.19
99214 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	4,642	17,472	17,894	\$3,180,317	\$1,992,640	\$114.05
99080 - SPECIAL REPORTS SUCH AS INSURANCE FORMS, MORE THAN THE INFORMATION CONVEYED IN THE USUAL MEDICAL COMMUNICATIONS OR STANDARD REPORTING FORM	7,675	17,344	18,363	\$555,685	\$453,420	\$26.14
98941 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS	723	11,788	11,901	\$849,087	\$566,088	\$48.02
97124 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)	749	10,480	21,836	\$752,257	\$455,966	\$43.51

**Delaware Compensation Rating Bureau, Inc.**  
**Average Cost for Top 30 Procedures**  
**Transactions Reported July 2010 - June 2012**  
**Excludes Ambulatory Surgical Center (POS 24)**

<b>Procedure Code and Description</b>	<b>Claim Count</b>	<b>Record Count</b>	<b>Procedure Units</b>	<b>Charged Amount</b>	<b>Paid Amount</b>	<b>Average Cost (Paid Amt/Record Count)</b>
97012 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL	824	9,518	9,636	\$438,196	\$300,481	\$31.57
98940 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS	777	8,791	8,748	\$516,764	\$357,213	\$40.63
97113 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES	427	7,669	14,491	\$901,785	\$682,361	\$88.98
99070 - SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED (LIST DRUGS, TRAYS, SUPPLIES, OR MATERIALS PROVIDED)	2,298	7,625	154,519	\$916,872	\$641,588	\$84.14
G0283 - ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE	644	7,531	7,620	\$289,589	\$211,772	\$28.12
99212 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 10 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	3,130	7,348	7,641	\$623,307	\$415,567	\$56.56
A4556 - ELECTRODES, (E.G., APNEA MONITOR), PER PAIR	923	6,367	75,531	\$770,433	\$555,414	\$87.23
97032 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES	528	5,946	6,122	\$270,491	\$209,712	\$35.27
97039 - UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)	445	5,644	5,693	\$286,413	\$200,401	\$35.51
80101 - DRUG SCREEN, QUALITATIVE; SINGLE DRUG CLASS METHOD (EG, IMMUNOASSAY, ENZYME ASSAY), EACH DRUG CLASS	955	5,440	25,033	\$909,513	\$507,909	\$93.37
99203 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	4,653	5,345	5,351	\$993,296	\$670,938	\$125.53
97001 - PHYSICAL THERAPY EVALUATION	3,878	5,083	5,274	\$838,745	\$603,935	\$118.81
97545 - WORK HARDENING/CONDITIONING; INITIAL 2 HOURS	320	5,035	5,341	\$1,139,293	\$883,522	\$175.48
98943 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, 1 OR MORE REGIONS	299	4,938	4,967	\$242,336	\$156,170	\$31.63
97546 - WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	257	4,700	7,917	\$731,911	\$578,208	\$123.02
A4630 - REPLACEMENT BATTERIES, MEDICALLY NECESSARY, TRANSCUTANEOUS ELECTRICAL STIMULATOR, OWNED BY PATIENT	468	4,402	13,566	\$108,199	\$66,531	\$15.11

**Delaware Compensation Rating Bureau, Inc.**  
**Average Cost for Top 30 Procedures**  
**Transactions Reported July 2010 - June 2012**  
**Excludes Ambulatory Surgical Center (POS 24)**

Procedure Code and Description	Claim Count	Record Count	Procedure Units	Charged Amount	Paid Amount	Average Cost (Paid Amt/Record Count)
99283 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY.	3,192	4,237	4,239	\$1,324,424	\$1,110,785	\$262.16
99204 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	3,330	3,708	3,706	\$1,050,139	\$702,796	\$189.54
ALL OTHER DATA REPORTED	32,082	344,626	1,110,555	\$144,331,954	\$98,210,256	\$284.98
GRAND TOTAL	19,380	902,046	2,024,531	\$190,504,310	\$130,284,800	\$144.43

**Pennsylvania Compensation Rating Bureau  
Average Cost for Top 30 Procedures  
Transactions Reported July 2010 - June 2012  
Excludes Ambulatory Surgical Center (POS 24)**

<b>Procedure Code and Description</b>	<b>Claim Count</b>	<b>Record Count</b>	<b>Procedure Units</b>	<b>Charged Amount</b>	<b>Paid Amount</b>	<b>Average Cost (Paid Amt/Record Count)</b>
97110 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY	n/a	1,816,999	3,023,120	\$156,956,499	\$92,731,623	\$51.04
97140 - MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES	n/a	876,530	995,612	\$50,334,247	\$29,556,427	\$33.72
97010 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS	n/a	451,472	543,789	\$16,081,532	\$3,426,246	\$7.59
97014 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)	n/a	749,341	754,379	\$27,180,496	\$16,691,921	\$22.28
99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	n/a	521,554	521,151	\$49,823,610	\$29,613,895	\$56.78
97530 - THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES	n/a	482,529	684,460	\$36,523,070	\$24,838,005	\$51.47
97035 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES	n/a	386,226	387,519	\$13,991,199	\$7,395,640	\$19.15
97112 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES	n/a	238,659	273,710	\$13,576,524	\$7,421,792	\$31.10
99214 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	n/a	245,021	242,760	\$33,484,571	\$21,024,124	\$85.81
99080 - SPECIAL REPORTS SUCH AS INSURANCE FORMS, MORE THAN THE INFORMATION CONVEYED IN THE USUAL MEDICAL COMMUNICATIONS OR STANDARD REPORTING FORM	n/a	9,230	10,861	\$600,337	\$234,679	\$25.43
98941 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS	n/a	142,434	150,883	\$7,850,930	\$5,168,609	\$36.29
97124 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; MASSAGE, INCLUDING EFFLEURAGE, PETRISSAGE AND/OR TAPOTEMENT (STROKING, COMPRESSION, PERCUSSION)	n/a	177,578	219,332	\$8,062,020	\$4,372,976	\$24.63

**Pennsylvania Compensation Rating Bureau  
Average Cost for Top 30 Procedures  
Transactions Reported July 2010 - June 2012  
Excludes Ambulatory Surgical Center (POS 24)**

<b>Procedure Code and Description</b>	<b>Claim Count</b>	<b>Record Count</b>	<b>Procedure Units</b>	<b>Charged Amount</b>	<b>Paid Amount</b>	<b>Average Cost (Paid Amt/Record Count)</b>
97012 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL	n/a	157,896	157,720	\$6,100,611	\$3,454,632	\$21.88
98940 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS	n/a	164,999	162,873	\$7,582,110	\$5,077,935	\$30.78
97113 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES	n/a	61,524	117,244	\$6,730,571	\$3,719,271	\$60.45
99070 - SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED (LIST DRUGS, TRAYS, SUPPLIES, OR MATERIALS PROVIDED)	n/a	84,483	1,242,699	\$8,869,488	\$4,966,929	\$58.79
G0283 - ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATION(S) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE	n/a	49,171	48,282	\$2,065,289	\$619,105	\$12.59
99212 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. PHYSICIANS TYPICALLY SPEND 10 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	n/a	152,904	149,339	\$10,144,594	\$5,713,329	\$37.37
A4556 - ELECTRODES, (E.G., APNEA MONITOR), PER PAIR	n/a	77,800	716,304	\$8,511,008	\$6,080,424	\$78.15
97032 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES	n/a	96,566	197,134	\$8,750,940	\$2,233,910	\$23.13
97039 - UNLISTED MODALITY (SPECIFY TYPE AND TIME IF CONSTANT ATTENDANCE)	n/a	48,705	48,987	\$2,181,783	\$1,123,290	\$23.06
80101 - DRUG SCREEN, QUALITATIVE; SINGLE DRUG CLASS METHOD (EG, IMMUNOASSAY, ENZYME ASSAY), EACH DRUG CLASS	n/a	36,479	93,659	\$3,691,649	\$2,114,737	\$57.97
99203 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	n/a	109,643	105,362	\$15,554,818	\$9,786,138	\$89.25
97001 - PHYSICAL THERAPY EVALUATION	n/a	74,735	73,817	\$10,305,351	\$6,400,659	\$85.64
97545 - WORK HARDENING/CONDITIONING; INITIAL 2 HOURS	n/a	24,273	23,948	\$5,127,046	\$3,178,719	\$130.96
98943 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, 1 OR MORE REGIONS	n/a	90,187	89,158	\$4,549,376	\$2,706,102	\$30.01
97546 - WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	n/a	12,609	19,470	\$1,866,365	\$1,384,660	\$109.82
A4630 - REPLACEMENT BATTERIES, MEDICALLY NECESSARY, TRANSCUTANEOUS ELECTRICAL STIMULATOR, OWNED BY PATIENT	n/a	25,389	79,037	\$690,953	\$477,406	\$18.80

**Pennsylvania Compensation Rating Bureau**  
**Average Cost for Top 30 Procedures**  
**Transactions Reported July 2010 - June 2012**  
**Excludes Ambulatory Surgical Center (POS 24)**

Procedure Code and Description	Claim Count	Record Count	Procedure Units	Charged Amount	Paid Amount	Average Cost (Paid Amt/Record Count)
99283 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY.	n/a	91,258	85,973	\$29,359,621	\$10,891,410	\$119.35
99204 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	n/a	74,091	71,795	\$15,122,507	\$10,214,349	\$137.86

**Delaware Compensation Rating Bureau, Inc.**  
**Average Cost for Top 30 Diagnoses**  
**Transactions Reported July 2010 - June 2012**  
**Excludes Ambulatory Surgical Center (POS 24)**

<b>Diagnosis Code and Description</b>	<b>Claim Count</b>	<b>Record Count</b>	<b>Procedure Units</b>	<b>Charged Amount</b>	<b>Paid Amount</b>	<b>Average Cost (Paid Amt/Claim Count)</b>
724.2 - LUMBAGO	2,180	49,970	110,365	\$6,752,028	\$4,494,256	\$2,061.59
847.2 - SPRAIN LUMBAR REGION	1,803	43,278	81,128	\$4,046,626	\$2,989,461	\$1,658.05
847.0 - SPRAIN OF NECK	1,244	37,450	66,604	\$3,202,193	\$2,214,374	\$1,780.04
722.10 - DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY	1,187	36,384	82,147	\$15,432,953	\$9,904,812	\$8,344.41
724.4 - THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED	1,325	28,970	72,276	\$6,451,553	\$4,175,240	\$3,151.12
719.41 - PAIN IN JOINT INVOLVING SHOULDER REGION	961	25,844	45,813	\$2,667,964	\$1,849,682	\$1,924.75
959.9 - OTHER AND UNSPECIFIED INJURY TO UNSPECIFIED SITE	1,544	20,180	59,107	\$4,491,134	\$3,509,897	\$2,273.25
719.46 - PAIN IN JOINT INVOLVING LOWER LEG	978	20,135	30,631	\$2,312,736	\$1,596,606	\$1,632.52
723.1 - CERVICALGIA	901	19,061	32,888	\$2,369,525	\$1,607,291	\$1,783.90
722.0 - DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY	531	16,546	34,957	\$7,035,683	\$4,479,564	\$8,436.09
840.4 - ROTATOR CUFF (CAPSULE) SPRAIN	556	15,167	28,409	\$2,806,164	\$1,804,941	\$3,246.30
723.4 - BRACHIAL NEURITIS OR RADICULITIS NOT OTHERWISE SPECIFIED	654	12,329	24,442	\$2,516,013	\$1,653,731	\$2,528.64
722.52 - DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC	805	11,992	39,017	\$9,985,132	\$6,222,991	\$7,730.42
726.10 - DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION UNSPECIFIED	366	11,518	19,700	\$1,376,530	\$986,900	\$2,696.45
846.0 - LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN	627	11,468	31,341	\$878,495	\$616,743	\$983.64
847.1 - SPRAIN THORACIC REGION	503	11,349	21,094	\$984,586	\$639,077	\$1,270.53
840.9 - SPRAIN OF UNSPECIFIED SITE OF SHOULDER AND UPPER ARM	641	10,938	14,768	\$964,669	\$722,400	\$1,126.99
719.47 - PAIN IN JOINT INVOLVING ANKLE AND FOOT	460	10,640	14,801	\$1,049,113	\$753,072	\$1,637.11
354.0 - CARPAL TUNNEL SYNDROME	372	9,640	16,488	\$1,221,474	\$821,484	\$2,208.29
724.8 - OTHER SYMPTOMS REFERABLE TO BACK	218	8,712	23,599	\$1,767,187	\$1,230,862	\$5,646.16
729.5 - PAIN IN LIMB	935	8,681	19,431	\$1,232,193	\$800,408	\$856.05
845.00 - UNSPECIFIED SITE OF ANKLE SPRAIN	505	7,474	8,934	\$723,793	\$538,529	\$1,066.39
719.44 - PAIN IN JOINT INVOLVING HAND	301	6,961	9,848	\$599,069	\$414,802	\$1,378.08
883.0 - OPEN WOUND OF FINGERS WITHOUT COMPLICATION	1,233	6,548	8,407	\$980,278	\$789,710	\$640.48
722.83 - POSTLAMINECTOMY SYNDROME OF LUMBAR REGION	275	6,273	17,614	\$1,385,551	\$856,428	\$3,114.28
836.0 - TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE CURRENT	339	5,491	12,703	\$1,367,927	\$997,308	\$2,941.91
719.43 - PAIN IN JOINT INVOLVING FOREARM	385	5,467	9,124	\$601,537	\$432,372	\$1,123.04
739.3 - NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED	136	5,419	6,635	\$358,999	\$262,071	\$1,926.99
844.9 - SPRAIN OF UNSPECIFIED SITE OF KNEE AND LEG	515	5,078	7,008	\$520,862	\$402,023	\$780.63
739.1 - NONALLOPATHIC LESIONS OF CERVICAL REGION NOT ELSEWHERE CLASSIFIED	109	4,994	5,771	\$277,748	\$146,831	\$1,347.08
ALL OTHER DATA REPORTED	37,822	377,938	1,038,217	\$93,987,570	\$63,239,309	\$1,672.02
GRAND TOTAL	19,380	902,046	2,024,531	\$190,504,310	\$130,284,800	\$6,722.64

**Delaware Compensation Rating Bureau, Inc.**  
**Top Procedures (>=\$500K Paid Amount) for Transactions Reported July 2010 - June 2012**  
**Year 1 (July 2010 - June 2011) Compared to Year 2 (July 2011 - June 2012)**  
**Excludes Ambulatory Surgical Center (POS 24)**

Procedure Code/Description	Year 2	Year 1	Grand Total	Year 2 Rank	Year 1 Rank	Year 2 vs. Year 1	
						Amt Dif	% Dif
0120 - ROOM & BOARD (SEMI-PRIVATE 2 BEDS)	\$1,139,702	\$578,816	\$1,718,518	6	11	\$560,885	96.90%
0360 - OPERATING ROOM SERVICES	\$1,646,448	\$1,197,971	\$2,844,419	4	5	\$448,477	37.44%
0490 - AMBULATORY SURGERY	\$977,441	\$569,563	\$1,547,004	8	12	\$407,879	71.61%
0278 - MEDICAL/SURGICAL SUPPLIES: OTHER IMPLANTS	\$2,985,253	\$2,650,819	\$5,636,072	2	2	\$334,433	12.62%
0207 - BURN CARE	\$802,614	\$494,973	\$1,297,587	10	14	\$307,641	62.15%
0250 - PHARMACY (HOSPITAL-BASED)	\$558,928	\$264,533	\$823,461	13	41	\$294,395	111.29%
99214 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 25 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	\$1,097,544	\$895,096	\$1,992,640	7	7	\$202,448	22.62%
97799 - UNLISTED PHYSICAL MEDICINE/REHABILITATION SERVICE OR PROCEDURE	\$413,954	\$244,603	\$658,557	19	44	\$169,351	69.24%
0420 - PHYSICAL THERAPY	\$348,676	\$179,843	\$528,518	28	48	\$168,833	93.88%
80101 - DRUG SCR QUAL 1 DRUG CLASS METH EA DRUG CLASS	\$311,760	\$196,149	\$507,909	36	47	\$115,611	58.94%
64483 - INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE LEVEL	\$288,439	\$212,243	\$500,682	39	46	\$76,196	35.90%
0710 - RECOVERY ROOM	\$439,615	\$367,573	\$807,188	18	20	\$72,042	19.60%
99070 - SUPPLIES AND MATERIALS (EXCEPT SPECTACLES), PROVIDED BY THE PHYSICIAN OVER AND ABOVE THOSE USUALLY INCLUDED WITH THE OFFICE VISIT OR OTHER SERVICES RENDERED (LIST DRUGS, TRAYS, SUPPLIES, OR MATERIALS PROVIDED)	\$356,369	\$285,219	\$641,588	26	37	\$71,150	24.95%
0370 - ANESTHESIA	\$318,262	\$250,161	\$568,423	33	42	\$68,101	27.22%
E0748 - OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, SPINAL APPLICATIONS	\$310,763	\$243,982	\$554,745	37	45	\$66,782	27.37%
0450 - EMERGENCY ROOM	\$402,347	\$338,686	\$741,033	21	24	\$63,661	18.80%
22840 - POSTERIOR NON-SEGMENTAL INSTRUMENTATION (EG, HARRINGTON ROD TECHNIQUE, PEDICLE FIXATION ACROSS 1 INTERSPACE, ATLANTOAXIAL TRANSARTICULAR SCREW FIXATION, SUBLAMINAR WIRING AT C1, FACET SCREW FIXATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	\$371,295	\$313,033	\$684,328	24	29	\$58,263	18.61%
73721 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF LOWER EXTREMITY; WITHOUT CONTRAST MATERIAL	\$346,045	\$288,697	\$634,742	29	36	\$57,348	19.86%
22851 - APPLICATION OF INTERVERTEBRAL BIOMECHANICAL DEVICE(S) (EG, SYNTHETIC CAGE(S), METHYLMETHACRYLATE) TO VERTEBRAL DEFECT OR INTERSPACE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	\$342,328	\$291,273	\$633,601	30	35	\$51,055	17.53%
00670 - ANESTHESIA FOR EXTENSIVE SPINE AND SPINAL CORD PROCEDURES (EG, SPINAL INSTRUMENTATION OR VASCULAR PROCEDURES)	\$378,779	\$328,629	\$707,409	23	27	\$50,150	15.26%
E1399 - DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS	\$317,288	\$270,133	\$587,420	34	40	\$47,155	17.46%

**Delaware Compensation Rating Bureau, Inc.**  
**Top Procedures (>=\$500K Paid Amount) for Transactions Reported July 2010 - June 2012**  
**Year 1 (July 2010 - June 2011) Compared to Year 2 (July 2011 - June 2012)**  
**Excludes Ambulatory Surgical Center (POS 24)**

Procedure Code/Description	Year 2	Year 1	Grand Total	Year 2 Rank	Year 1 Rank	Year 2 vs. Year 1	
						Amt Dif	% Dif
22 97112 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; NEUROMUSCULAR REEDUCATION OF MOVEMENT, BALANCE, COORDINATION, KINESTHETIC SENSE, POSTURE, AND/OR PROPRIOCEPTION FOR SITTING AND/OR STANDING ACTIVITIES	\$471,946	\$434,316	\$906,262	17	17	\$37,631	8.66%
23 22612 - ARTHRODESIS, POSTERIOR OR POSTEROLATERAL TECHNIQUE, SINGLE LEVEL; LUMBAR (WITH LATERAL TRANSVERSE TECHNIQUE, WHEN PERFORMED)	\$413,234	\$387,251	\$800,485	20	19	\$25,984	6.71%
24 99284 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY, AND REQUIRE URGENT EVALUATION BY THE PHYSICIAN BUT DO NOT POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION.	\$331,736	\$306,490	\$638,227	32	31	\$25,246	8.24%
25 97113 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; AQUATIC THERAPY WITH THERAPEUTIC EXERCISES	\$353,141	\$329,220	\$682,361	27	26	\$23,920	7.27%
26 99204 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE TO HIGH SEVERITY. PHYSICIANS TYPICALLY SPEND 45 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	\$358,521	\$344,275	\$702,796	25	22	\$14,247	4.14%
27 72148 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, LUMBAR; WITHOUT CONTRAST MATERIAL	\$499,821	\$485,677	\$985,498	16	16	\$14,144	2.91%
28 A4556 - ELECTRODES, (E.G., APNEA MONITOR), PER PAIR	\$284,759	\$270,655	\$555,414	41	39	\$14,104	5.21%
29 63030 - LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC; 1 INTERSPACE, LUMBAR	\$256,140	\$250,074	\$506,214	44	43	\$6,066	2.43%
30 99283 - EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY.	\$554,236	\$556,548	\$1,110,785	14	13	-\$2,312	-0.42%

**Delaware Compensation Rating Bureau, Inc.**  
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Procedure Code/Description	Year 2	Year 1	Grand Total	Year 2 Rank	Year 1 Rank	Year 2 vs. Year 1	
						Amt Dif	% Dif
31 62311 - INJECTION(S), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTHER SOLUTION), NOT INCLUDING NEUROLYTIC SUBSTANCES, INCLUDING NEEDLE OR CATHETER PLACEMENT, INCLUDES CONTRAST FOR LOCALIZATION WHEN PERFORMED, EPIDURAL OR SUBARACHNOID; LUMBAR OR SACRAL (CAUDAL)	\$270,082	\$276,115	\$546,198	43	38	-\$6,033	-2.18%
32 99203 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 30 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	\$332,153	\$338,786	\$670,938	31	23	-\$6,633	-1.96%
33 97546 - WORK HARDENING/CONDITIONING; EACH ADDITIONAL HOUR (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	\$285,301	\$292,907	\$578,208	40	34	-\$7,606	-2.60%
34 98941 - CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS	\$272,916	\$293,171	\$566,088	42	33	-\$20,255	-6.91%
35 97001 - PHYSICAL THERAPY EVALUATION	\$291,412	\$312,523	\$603,935	38	30	-\$21,111	-6.76%
36 73221 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, ANY JOINT OF UPPER EXTREMITY; WITHOUT CONTRAST MATERIAL(S)	\$316,444	\$338,454	\$654,898	35	25	-\$22,010	-6.50%
37 97010 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS	\$782,683	\$805,593	\$1,588,277	11	8	-\$22,910	-2.84%
38 97140 - MANUAL THERAPY TECHNIQUES (EG, MOBILIZATION/ MANIPULATION, MANUAL LYMPHATIC DRAINAGE, MANUAL TRACTION), 1 OR MORE REGIONS, EACH 15 MINUTES	\$1,768,054	\$1,799,420	\$3,567,474	3	3	-\$31,366	-1.74%
39 99213 - OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST 2 OF THESE 3 KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; MEDICAL DECISION MAKING OF LOW COMPLEXITY. COUNSELING AND COORDINATION OF CARE WITH OTHER PROVIDERS OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF LOW TO MODERATE SEVERITY. PHYSICIANS TYPICALLY SPEND 15 MINUTES FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.	\$1,327,387	\$1,359,184	\$2,686,571	5	4	-\$31,797	-2.34%
40 72141 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, SPINAL CANAL AND CONTENTS, CERVICAL; WITHOUT CONTRAST MATERIAL	\$252,944	\$293,721	\$546,665	45	32	-\$40,777	-13.88%
41 97014 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)	\$593,090	\$657,333	\$1,250,423	12	9	-\$64,243	-9.77%
42 97530 - THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES	\$520,878	\$591,569	\$1,112,447	15	10	-\$70,691	-11.95%
43 97035 - APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES	\$232,635	\$317,868	\$550,502	46	28	-\$85,233	-26.81%

**Delaware Compensation Rating Bureau, Inc.**  
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						Year 2 vs. Year 1	
Procedure Code/Description	Year 2	Year 1	Grand Total	Year 2 Rank	Year 1 Rank	Amt Dif	% Dif
44 0270 - MEDICAL/SURGICAL SUPPLIES	\$842,230	\$937,604	\$1,779,834	9	6	-\$95,374	-10.17%
45 97545 - WORK HARDENING/CONDITIONING; INITIAL 2 HOURS	\$393,801	\$489,720	\$883,522	22	15	-\$95,919	-19.59%
46 97110 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY	\$3,976,438	\$4,112,736	\$8,089,173	1	1	-\$136,298	-3.31%
47 0128 - REHAB	\$202,548	\$410,218	\$612,766	47	18	-\$207,670	-50.62%
48 22857 - TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, INCLUDING DISCECTOMY TO PREPARE INTERSPACE (OTHER THAN FOR DECOMPRESSION), SINGLE INTERSPACE, LUMBAR	\$140,604	\$365,291	\$505,896	48	21	-\$224,687	-61.51%
SUB-TOTAL	\$30,478,988	\$27,818,713	\$58,297,701			\$2,660,275	9.56%
ALL OTHER DATA REPORTED	\$36,842,789	\$35,144,309	\$71,987,099			\$1,698,480	4.83%
GRAND TOTAL	\$67,321,777	\$62,963,023	\$130,284,800			\$4,358,755	6.92%

**Delaware Compensation Rating Bureau, Inc.**  
**Top Diagnoses (>=\$500K Paid Amount) for Transactions Reported July 2010 - June 2012**  
**Year 1 (July 2010 - June 2011) Compared to Year 2 (July 2011 - June 2012)**  
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Diagnosis Code/Description	Year 2	Year 1	Grand Total	Year 2 Rank	Year 1 Rank	Year 2 vs. Year 1	
						Amt Dif	% Dif
942.32 - FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE) OF CHEST WALL EXCLUDING BREAST AND NIPPLE	\$850,685	\$472	\$851,157	12	45	\$850,213	180179.50%
813.42 - OTHER CLOSED FRACTURES OF DISTAL END OF RADIUS (ALONE)	\$387,327	\$127,518	\$514,845	28	44	\$259,809	203.74%
738.4 - ACQUIRED SPONDYLOLISTHESIS	\$580,892	\$196,846	\$777,738	17	42	\$384,047	195.10%
V57.89 - CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE	\$598,044	\$236,709	\$834,752	16	37	\$361,335	152.65%
844.2 - SPRAIN OF CRUCIATE LIGAMENT OF KNEE	\$351,081	\$181,989	\$533,070	33	43	\$169,092	92.91%
337.21 - REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER LIMB	\$402,202	\$220,250	\$622,452	26	40	\$181,952	82.61%
724.8 - OTHER SYMPTOMS REFERABLE TO BACK	\$746,330	\$484,532	\$1,230,862	15	19	\$261,798	54.03%
338.4 - CHRONIC PAIN SYNDROME	\$358,255	\$233,573	\$591,828	32	38	\$124,682	53.38%
722.4 - DEGENERATION OF CERVICAL INTERVERTEBRAL DISC	\$331,815	\$217,086	\$548,901	34	41	\$114,728	52.85%
721.1 - CERVICAL SPONDYLOSIS WITH MYELOPATHY	\$328,154	\$231,752	\$559,906	35	39	\$96,402	41.60%
715.96 - OSTEOARTHRITIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING LOWER LEG	\$378,194	\$285,245	\$663,439	29	34	\$92,949	32.59%
840.4 - ROTATOR CUFF (CAPSULE) SPRAIN	\$1,022,230	\$782,711	\$1,804,941	9	12	\$239,519	30.60%
722.0 - DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY	\$2,477,990	\$2,001,574	\$4,479,564	3	4	\$476,416	23.80%
719.46 - PAIN IN JOINT INVOLVING LOWER LEG	\$875,698	\$720,908	\$1,596,606	11	13	\$154,790	21.47%
724.2 - LUMBAGO	\$2,461,644	\$2,032,613	\$4,494,256	4	3	\$429,031	21.11%
959.9 - OTHER AND UNSPECIFIED INJURY TO UNSPECIFIED SITE	\$1,907,831	\$1,602,067	\$3,509,897	6	6	\$305,764	19.09%
354.0 - CARPAL TUNNEL SYNDROME	\$433,442	\$388,042	\$821,484	23	23	\$45,400	11.70%
724.4 - THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED	\$2,176,162	\$1,999,077	\$4,175,240	5	5	\$177,085	8.86%
840.9 - SPRAIN OF UNSPECIFIED SITE OF SHOULDER AND UPPER ARM	\$375,232	\$347,168	\$722,400	30	31	\$28,064	8.08%
883.0 - OPEN WOUND OF FINGERS WITHOUT COMPLICATION	\$407,007	\$382,703	\$789,710	25	25	\$24,303	6.35%
847.2 - SPRAIN LUMBAR REGION	\$1,531,464	\$1,457,997	\$2,989,461	7	7	\$73,467	5.04%
722.10 - DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY	\$5,064,144	\$4,840,669	\$9,904,812	1	1	\$223,475	4.62%
845.00 - UNSPECIFIED SITE OF ANKLE SPRAIN	\$271,306	\$267,223	\$538,529	39	36	\$4,083	1.53%
836.0 - TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE CURRENT	\$495,493	\$501,815	\$997,308	20	18	-\$6,321	-1.26%
729.5 - PAIN IN LIMB	\$395,014	\$405,394	\$800,408	27	22	-\$10,380	-2.56%
847.0 - SPRAIN OF NECK	\$1,090,160	\$1,124,214	\$2,214,374	8	8	-\$34,054	-3.03%
719.47 - PAIN IN JOINT INVOLVING ANKLE AND FOOT	\$369,536	\$383,537	\$753,072	31	24	-\$14,001	-3.65%
723.4 - BRACHIAL NEURITIS OR RADICULITIS NOT OTHERWISE SPECIFIED	\$805,519	\$848,212	\$1,653,731	13	11	-\$42,694	-5.03%
722.83 - POSTLAMINECTOMY SYNDROME OF LUMBAR REGION	\$415,911	\$440,517	\$856,428	24	20	-\$24,606	-5.59%
719.41 - PAIN IN JOINT INVOLVING SHOULDER REGION	\$898,145	\$951,537	\$1,849,682	10	9	-\$53,392	-5.61%
724.02 - SPINAL STENOSIS OF LUMBAR REGION WITHOUT NEUROGENIC CLAUDICATION	\$507,176	\$545,826	\$1,053,001	19	16	-\$38,650	-7.08%
722.93 - OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION	\$276,415	\$301,600	\$578,015	38	33	-\$25,185	-8.35%
722.52 - DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC	\$2,935,325	\$3,287,665	\$6,222,991	2	2	-\$352,340	-10.72%
723.1 - CERVICALGIA	\$750,448	\$856,843	\$1,607,291	14	10	-\$106,395	-12.42%
726.10 - DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION UNSPECIFIED	\$460,541	\$526,359	\$986,900	22	17	-\$65,818	-12.50%
846.0 - LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN	\$285,687	\$331,056	\$616,743	37	32	-\$45,369	-13.70%
727.61 - COMPLETE RUPTURE OF ROTATOR CUFF	\$235,540	\$274,077	\$509,617	43	35	-\$38,537	-14.06%
715.36 - OSTEOARTHRITIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING LOWER LEG	\$294,330	\$348,445	\$642,776	36	30	-\$54,115	-15.53%

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Diagnosis Code/Description	Year 2	Year 1	Grand Total	Year 2 Rank	Year 1 Rank	Year 2 vs. Year 1	
						Amt Dif	% Dif
39 996.49 - OTHER MECHANICAL COMPLICATION OF INTERNAL ORTHOPEDIC DEVICE IMPLANT AND GRAFT	\$579,156	\$708,256	\$1,287,412	18	14	-\$129,099	-18.23%
40 799.8 - OTHER ILL-DEFINED CONDITIONS	\$259,555	\$359,299	\$618,854	40	29	-\$99,744	-27.76%
41 721.3 - LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY	\$490,745	\$706,369	\$1,197,114	21	15	-\$215,624	-30.53%
42 847.1 - SPRAIN THORACIC REGION	\$258,563	\$380,514	\$639,077	41	28	-\$121,951	-32.05%
43 726.2 - OTHER AFFECTIONS OF SHOULDER REGION NOT ELSEWHERE CLASSIFIED	\$252,725	\$381,543	\$634,267	42	27	-\$128,818	-33.76%
44 996.78 - OTHER COMPLICATIONS DUE TO OTHER INTERNAL ORTHOPEDIC DEVICE IMPLANT AND GRAFT	\$201,031	\$381,894	\$582,925	44	26	-\$180,863	-47.36%
45 733.82 - NONUNION OF FRACTURE	\$139,873	\$433,041	\$572,914	45	21	-\$293,168	-67.70%
SUB-TOTAL	\$36,714,018	\$33,716,736	\$70,430,754			\$2,997,281	8.89%
ALL OTHER	\$30,607,760	\$29,246,286	\$59,854,046			\$1,361,473	4.66%
GRAND TOTAL	\$67,321,777	\$62,963,023	\$130,284,800			\$4,358,755	6.92%

## Delaware Compensation Rating Bureau, Inc.

Exhibit 9

### Claim Settlement Rates in Unit Data - Portion of Reported Indemnity Claims Open by Report Level

Policy Year	First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report	Seventh Report	Eighth Report	Ninth Report	Tenth Report
1993	0.3402	0.2003	0.1318	0.0865	0.0615	0.0502	0.0386	0.0336	0.0312	0.0270
1994	0.3311	0.1953	0.1117	0.0733	0.0536	0.0435	0.0377	0.0323	0.0274	0.0263
1995	0.3418	0.1971	0.1202	0.0781	0.0535	0.0422	0.0370	0.0342	0.0291	0.0268
1996	0.3472	0.1931	0.1210	0.0862	0.0655	0.0520	0.0413	0.0367	0.0339	0.0302
1997	0.3302	0.1838	0.1181	0.0761	0.0583	0.0493	0.0409	0.0360	0.0314	0.0280
1998	0.3439	0.1856	0.1160	0.0840	0.0649	0.0550	0.0429	0.0364	0.0315	0.0274
1999	0.3885	0.2104	0.1286	0.0819	0.0638	0.0502	0.0384	0.0353	0.0308	0.0280
2000	0.3839	0.2264	0.1494	0.1077	0.0820	0.0655	<b>0.0552</b>	<b>0.0464</b>	0.0392	<b>0.0359</b>
2001	0.4023	0.2381	0.1498	0.1015	0.0805	0.0643	0.0539	0.0448	<b>0.0399</b>	
2002	0.3743	0.2261	0.1372	0.1011	0.0719	0.0586	0.0478	0.0382		
2003	0.3670	0.2346	0.1423	0.1002	0.0761	0.0615	0.0531			
2004	0.3721	0.2309	0.1535	0.1020	<b>0.0863</b>	<b>0.0671</b>				
2005	0.3847	0.2353	<b>0.1653</b>	0.1089	0.0850					
2006	0.3997	0.2671	0.1593	<b>0.1115</b>						
2007	0.4205	0.2525	0.1623							
2008	0.4333	<b>0.2720</b>								
2009	<b>0.4563</b>									

**Note:** Bold, boxed entries are highest open claims ratios for that maturity (column)  
6 of 10 are for latest year

## Pennsylvania Compensation Rating Bureau

Claim Settlement Rates in Unit Data - Portion of Reported Indemnity Claims Open by Report Level

Policy Year	First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report	Seventh Report	Eighth Report	Ninth Report	Tenth Report
1993	0.3327	0.2000	<b>0.1457</b>	<b>0.1076</b>	<b>0.0809</b>	<b>0.0616</b>	<b>0.0491</b>	<b>0.0417</b>	<b>0.0345</b>	<b>0.0307</b>
1994	0.3202	0.1961	0.1395	0.1015	0.0734	0.0576	0.0475	0.0376	0.0309	0.0274
1995	0.3253	0.1908	0.1326	0.0944	0.0699	0.0546	0.0421	0.0326	0.0288	0.0254
1996	0.3142	0.1823	0.1232	0.0886	0.0666	0.0499	0.0378	0.0324	0.0280	0.0249
1997	0.3167	0.1721	0.1150	0.0809	0.0570	0.0418	0.0342	0.0293	0.0251	0.0221
1998	0.3196	0.1748	0.1133	0.0763	0.0515	0.0389	0.0308	0.0249	0.0213	0.0182
1999	0.3355	0.1854	0.1170	0.0752	0.0525	0.0392	0.0302	0.0244	0.0203	0.0182
2000	0.3347	0.1858	0.1134	0.0765	0.0519	0.0365	0.0293	0.0234	0.0196	0.0177
2001	0.3439	0.1923	0.1167	0.0722	0.0484	0.0346	0.0266	0.0215	0.0184	
2002	0.3396	0.1887	0.1152	0.0748	0.0496	0.0370	0.0292	0.0242		
2003	0.3493	0.1975	0.1190	0.0743	0.0469	0.0333	0.0250			
2004	0.3642	0.2014	0.1158	0.0701	0.0432	0.0321				
2005	0.3678	<b>0.2022</b>	0.1098	0.0653	0.0422					
2006	<b>0.3741</b>	0.1967	0.1057	0.0648						
2007	0.3700	0.1829	0.1020							
2008	0.3537	0.1772								
2009	0.3639									

**Note:** Bold, boxed entries are highest open claims ratios for that maturity (column)  
8 of 10 are for earliest year

## Delaware Compensation Rating Bureau, Inc.

Claim Settlement Rates in Unit Data - Portion of Reported Indemnity Claims Open by Report Level

### Ratio of Delaware Open Claim Rates to Pennsylvania Open Claim Rates

Policy Year	First Report	Second Report	Third Report	Fourth Report	Fifth Report	Sixth Report	Seventh Report	Eighth Report	Ninth Report	Tenth Report
1993	1.0225	1.0015	0.9046	0.8039	0.7602	0.8149	0.7862	0.8058	0.9043	0.8795
1994	1.0340	0.9959	0.8007	0.7222	0.7302	0.7552	0.7937	0.8590	0.8867	0.9599
1995	1.0507	1.0330	0.9065	0.8273	0.7654	0.7729	0.8789	1.0491	1.0104	1.0551
1996	1.1050	1.0592	0.9821	0.9729	0.9835	1.0421	1.0926	1.1327	1.2107	1.2124
1997	1.0426	1.0680	1.0270	0.9407	1.0234	1.1794	1.1959	1.2287	1.2530	1.2678
1998	1.0760	1.0618	1.0238	1.1004	1.2600	1.4139	1.3929	1.4622	1.4810	1.5060
1999	1.1580	1.1348	1.0992	1.0885	1.2159	1.2806	1.2696	1.4470	1.5164	1.5395
2000	1.1470	1.2184	1.3173	1.4081	1.5806	1.7948	1.8857	1.9833	2.0028	2.0267
2001	1.1699	1.2380	1.2839	1.4057	1.6640	1.8566	2.0285	2.0813	2.1664	
2002	1.1022	1.1980	1.1904	1.3511	1.4497	1.5827	1.6392	1.5793		
2003	1.0509	1.1881	1.1960	1.3486	1.6224	1.8470	2.1255			
2004	1.0216	1.1467	1.3246	1.4556	1.9951	2.0908				
2005	1.0460	1.1639	1.5065	1.6682	2.0156					
2006	1.0686	1.3577	1.5081	1.7195						
2007	1.1365	1.3810	1.5906							
2008	1.2252	1.5350								
2009	1.2539									

**Note:** Bold, boxed entries are highest open claims ratios for that maturity (column)  
9 of 10 are for latest year

**Delaware Compensation Rating Bureau, Inc.**

*Summary Based on 2012 National Council on Compensation Insurance, Inc. (NCCI) Annual Statistical Bulletin*

*Exhibit 11 - Average Cost per Case*

	First Report Indemnity	First Report Medical	First Report Total	Second Report Indemnity	Second Report Medical	Second Report Total	Third Report Indemnity	Third Report Medical	Third Report Total	Fourth Report Indemnity	Fourth Report Medical	Fourth Report Total	Fifth Report Indemnity	Fifth Report Medical	Fifth Report Total
Delaware	\$29,288	\$17,009	\$25,182	\$28,272	\$17,886	\$25,929	\$25,325	\$14,862	\$22,023	\$26,220	\$16,820	\$24,505	\$23,957	\$15,096	\$22,002
Delaware Rank*	10	2	1	11	1	1	12	1	1	10	1	1	10	1	1
NCCI Average	\$21,723	\$7,126	\$12,379	\$21,111	\$6,648	\$11,664	\$19,678	\$6,188	\$10,790	\$18,637	\$5,821	\$10,131	\$17,887	\$5,522	\$9,658
Ratio DE to NCCI	134.82%	238.69%	203.43%	133.92%	269.04%	222.30%	128.70%	240.17%	204.11%	140.69%	288.95%	241.88%	133.94%	273.38%	227.81%

\* - Compared to State Systems but Excluding USL&HW Average