Detailed Definitions

Medical bills received – This is a count of invoice numbers with a BWC receipt date within the measurement period in which the total paid, including all adjustments to date, is greater than zero. Only bills paid through the Health Partnership Program (HPP) billing system (i.e., managed by BWC's managed care organization (MCO) partners) are included.

Total medical paid – This is the total costs paid on medical bills received, as defined earlier.

Median billing lag – This is the median of the number of days between the date of service and the BWC receipt date for all bills received (as defined earlier). In cases where a single invoice contains more than one date of service, we compute one billing lag for each of the service dates listed in that bill. This excludes bills where the date of service is before the date of injury, as might happen in occupational disease claims.

Total claims – This is the number of different claim numbers present among bills received during the measurement period (as defined earlier). A single patient could have one or more claim numbers, and each claim number could have one or more medical bills.

Average service dates per patient – This is the number of unique injured worker/date of service combinations found on the bills received (as defined earlier), divided by the number of patients present on those bills. If you provide more than one service to a patient on a given day, this would still be counted as a single service date for that patient.

Average services per patient – This is the number of services on the bills received (as defined earlier) divided by the number of patients present on those bills. Each combination of a date of service, an injury code (i.e., ICD) and a procedure code (i.e., CPT/HCPCS) represents one service. For example, assume you treat injury code A with services X, Y and Z, and you treat injury code B with service Y only, all on the same day. We would count this as four services, regardless of whether these were on a single bill or not.

Percent of claims treated on the date of injury (DOI) – This is the number of claims in which you submitted a bill with a date of service equal to the DOI (regardless of when that bill was received), divided by the total number of claims. Values in the peer group column are based on the number of claims in which those providers submitted a bill with a date of service equal to the DOI. The population of claims for computing this percentage is limited, however, to those claims where a bill was received during the measurement period.

Median days from DOI to initial treatment – This number is the median of the number of days between each claim's DOI and the first date you treated the patient in that claim. This is regardless of when the bill for those services was received. Values in the peer group column represent the median number of days between each claim's DOI and the first time those providers treated their patients' claims. In both columns, the population of claims for computing this median is limited to those claims where a bill was received during the measurement period.

Median treatment duration – This number is the median of the number of days (by claim) between the earliest service date and the latest service date for which you were paid, regardless of when the bills for those services were received. Values in the peer group column represent the median number of days (by claim) between the earliest service date and the latest service date for which those providers were paid in claims they treated, regardless of when the bills for those services were received. In both columns, the population of claims for computing this median is limited to those claims where a bill was received during the measurement period. We also exclude those service dates after the end of the measurement period.

Detailed Definitions (continued)

Top five diagnoses treated – We sort diagnoses in descending order by the number of claims, then the number of services (as defined earlier), and finally by the ICD code (in ascending order). We compile this list from those bills received during the measurement period (as defined earlier). We count diagnoses once per claim number, regardless of the number of service dates or bills for that diagnosis.

Top five services provided – We first sort services in descending order by the number of services. As defined earlier, we may count the same code numerous times for the same claim. Then we sort them by the total amount paid (not shown) and finally by the service code (in ascending order). We compile this list from those bills received during the measurement period (as defined earlier).

Top five drug types – We group drugs into one of 25 larger groups, and then sort those groups in descending order by the number of prescriptions, then by the total paid (not shown) and finally by the description (in ascending order). We compile this list from all the pharmacy bills that list you as the prescribing provider. The "Avg Units" are determined by dividing the total number of units by the number of claims referenced in those pharmacy bills. For narcotic analgesics and anti-anxiety drugs, those units are 'normalized' as mg of morphine and diazepam, respectively. For the peer comparison column, we include all prescriptions where the pharmacy bill was received during the measurement period, even if we received no other medical service bills during the measurement year for the prescribing provider/claim number combination shown on the bill.

Return-to-Work (RTW) rate(*) – We determine each claim to be at work or off work on five specific dates:

- The 45th day after the injury;
- Your initial treatment date (i.e., first date you treated the patient in that claim on bills paid through the HPP billing system);
- The 45th day after your initial treatment;
- The third month after your initial treatment;
- The sixth month after your initial treatment.

We determine a claim to be off work if we have an episode of disability where the last day worked is before, and the actual RTW date is after, the date in question. We ignore episodes of disability labeled as incarceration. We consider a claim to be at work if it cannot be determined to be off work. The RTW rate is then calculated by dividing the number of at-work claims by the total number of claims. The population of claims includes those where the sixth month after your initial treatment falls within the measurement year, whether or not we received a bill during the measurement year. We base values in the peer group column on each of those providers' initial treatment dates.

Average days absent(*) – We compile days absent for each claim using the same claim population and episodes of disability used in computing the RTW Rate. We count days absent up to the end of the measurement period. We count days absent from the DOI and from the initial treatment date as defined earlier, regardless of when we received those bills. To the extent you (or your peers) were paid for services through an earlier billing system, the days absent since the initial treatment will fail to capture those days. We total days across all claims in the population as defined earlier, and then divide that number of days by the number of claims shown in the RTW section.

Average medical cost(*) – Average medical costs since date of injury only include payments made on or after Jan. 1, 1993, because detailed payment data does not exist prior to that date. Average medical costs since initial treatment are aggregated by date of service. Both measures include costs whether they were paid to you or any other medical provider.

(*) Includes only those claims where the sixth month after your initial treatment is in the measurement period.