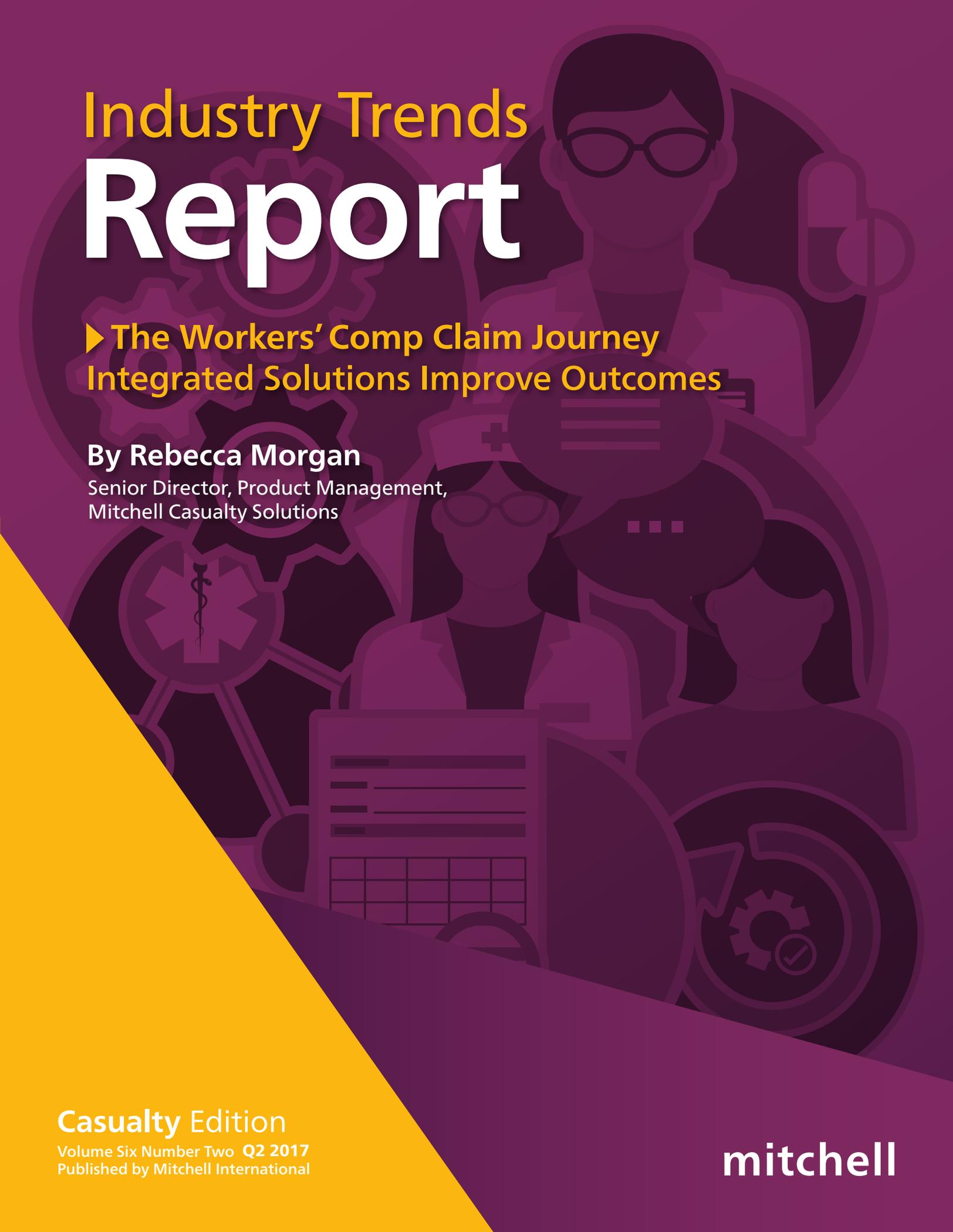


Industry Trends Report



► **The Workers' Comp Claim Journey
Integrated Solutions Improve Outcomes**

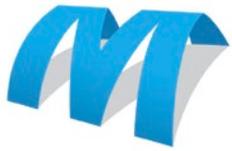
By Rebecca Morgan

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Mitchell Casualty Solutions

Casualty Edition

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Industry Trends Report

Table of Contents

- 4 Artificial Intelligence Gets Real—Three Ways AI Is Making Inroads in P&C Claims
- 8 The Workers' Comp Claim Journey: Integrated Solutions Improve Outcomes
- 14 The Value of Case Management: Advancing a People-First Approach
- 18 Managing Medical Records is Key to Improving Third Party Claim Settlements
- 22 Compliance Corner
- 28 Data Insights
- 30 Auto Casualty Medical Price Index
- 34 Workers' Compensation Medical Price Index
- 38 Current Events
- 42 About Mitchell
- 43 Mitchell in the News

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A Message from the CEO

AI's Industry Impact

Welcome to the Q2 edition of the 2017 Mitchell Casualty **Industry Trends Report**. In this issue, we start off by exploring a topic that is top of mind for many in the Property & Casualty industry, artificial intelligence (AI). From computer vision to natural language processing, there are numerous applications for AI, and since many organizations are turning their investment focus to it, we asked our general managers to explain how it's beginning to be used in the industry today.

In our feature article, *The Workers' Comp Claim Journey: Integrated Solutions Improve Outcomes*, author Rebecca Morgan explains how balancing the interests of each stakeholder in the claims process can be challenging, but that balance can be achieved by leveraging integrated technology to facilitate good communication and manage risks. By guiding us on this journey, Rebecca shows how improved communications position all stakeholders to achieve better outcomes for employers, providers and injured workers.

We continue our focus on the injured worker with insights into the value of nurse case management, and how, by taking a "people-first" approach, workers' compensation providers can deliver higher quality patient care along with cost-containing claims efficiencies. In addition, we look at the key steps in managing medical records to improve third party claim settlements. By using an end-to-end solution, organizations can achieve a more streamlined process.

Thank you for your continued readership of the **Industry Trends Report** and I look forward to sharing more insights on exciting changes in the industry and what they may mean for your business as the year progresses.

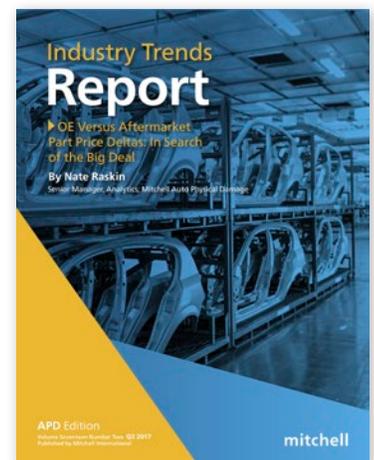


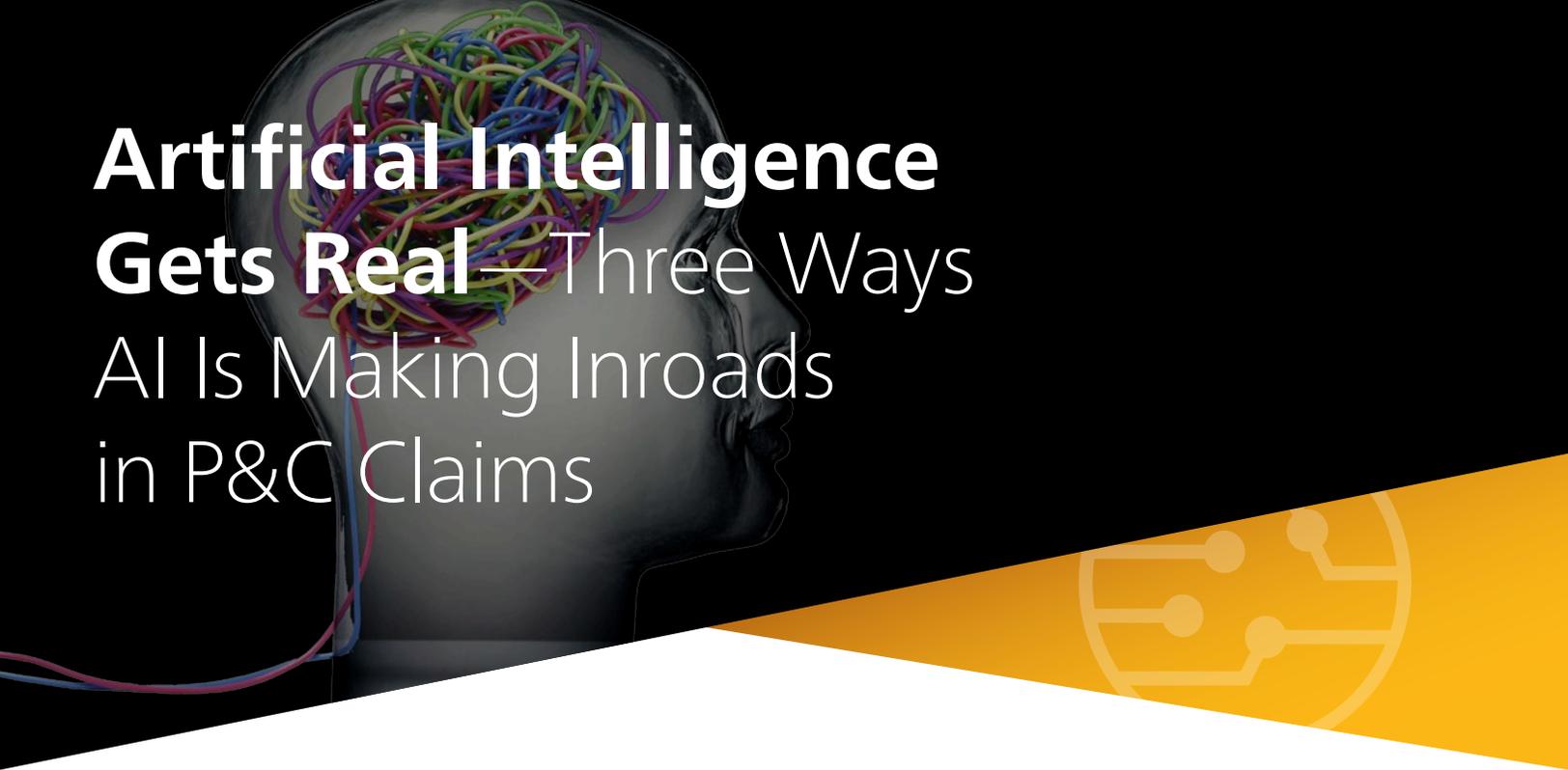
Alex Sun
President and CEO
Mitchell



Alex Sun
President and CEO, Mitchell

View the
[Auto Physical
Damage Edition](#)





Artificial Intelligence Gets Real—Three Ways AI Is Making Inroads in P&C Claims

FOR MANY OF US, ARTIFICIAL INTELLIGENCE (AI) STILL SEEMS LIKE THE STUFF OF SCIENCE FICTION, BUT IN REALITY, WE INTERACT WITH AI EVERYDAY THROUGH DEVICES LIKE AMAZON ECHO AND GOOGLE HOME.

Machine learning is powering **intelligent claims processes**

By Dave Torrence

Computer vision is driving more than just self-driving cars

By Debbie Day

Natural Language Processing Isn't Just for Customer Service Anymore

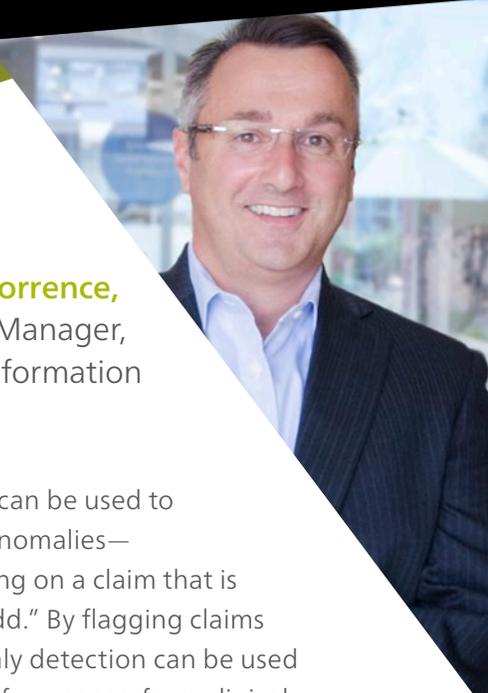
By Nina Smith

Gartner named AI a top strategic trend for 2017, and according to a recent study by **Accenture**, 85 percent of insurance executives surveyed plan to invest significantly in artificial intelligence over the next three years.

The value of AI applications in insurance is clear—it supports human decision making in a multitude of ways that could streamline the claims process, reduce fraud, and result in the better all-around outcomes for both claimant and insurance company. The insurance industry itself is at an inflection point in terms of AI. There are so many AI-related technologies, they are all in different stages of development, and there are many things they can and can't do—yet. The first step is to understand what each of these technologies is and where they have the potential to impact the claims process.

First, let's cover the basics: artificial intelligence is a broadly used term to describe the concept of machines carrying out activities that would normally require human intelligence to do. There are many different technologies that are considered AI. In this article, the general managers of each of Mitchell's business units break down a few of these technologies—computer vision, machine learning and natural language processing—and explain how they are beginning to be used in the P&C industry.

Machine learning is powering intelligent claims processes



By Dave Torrence,
Executive Vice President and General Manager,
Pharmacy Solutions and Strategy & Transformation

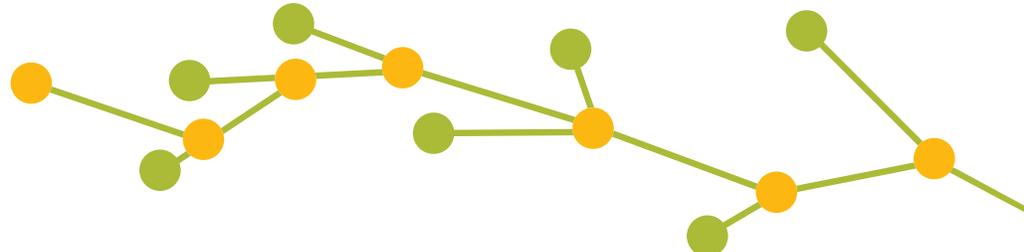


The insurance industry has plenty of data, but turning that data into actionable insights is easier said than done. That's where machine learning comes in. Very simply put, machine learning is a field of computer science that enables computers to learn without being explicitly programmed to do so. It can quickly review large quantities of data, organize it, extract information from it, and even make recommendations. But to really understand the value of machine learning, it's helpful to understand the types of problems it can solve and insights it can glean. Here are a couple of examples:

- Machine learning can be used to make predictions. By analyzing historical prescribing patterns and claim outcomes, it could be used to identify claimants at risk of opioid abuse. This would make it possible to intervene with clinical programs and prevent the abuse early in the process or prevent it all together.

- Machine learning can be used to generally detect anomalies—identifying anything on a claim that is atypical or just “odd.” By flagging claims in this way, anomaly detection can be used for a wide range of purposes, from clinical intervention to detecting fraud to just alerting an adjuster to review a file.

These are just a few, simple examples—the possibilities are limitless. Machine learning could potentially impact almost every stage of the claims process. And each step is a step closer to an intelligent claims process, one in which decisions are made more quickly, with greater efficiency, and with better outcomes for insurer and claimant.



VERY SIMPLY PUT, **MACHINE LEARNING IS A FIELD OF COMPUTER SCIENCE THAT ENABLES COMPUTERS TO LEARN** WITHOUT BEING EXPLICITLY PROGRAMMED TO DO SO.

Computer vision is driving more than just self-driving cars



By **Debbie Day**,
Executive Vice President and General
Manager, Auto Physical Damage

One reason artificial intelligence is particularly relevant to the P&C and collision repair industry is because of the role it plays in computer vision—and one of the most relevant applications for computer vision is self-driving cars. Computer vision basically seeks to enable computers to ‘see’ images and extract information from them, in much the same way a human does. It goes beyond sensors that simply capture data. It layers in deep learning—the ability to actually perceive, interpret and respond to what’s happening in the environment. The ability is essential for vehicles to be truly autonomous.

But there are other use cases for computer vision in insurance—ones that are having an immediate impact on the claims process. Take, for example, a couple of steps in the physical damage claims process that are based primarily on visual inspection: first notice of loss and repair vs. replace decisions.

With technology available today, photos taken by consumers and submitted via mobile device as part of first notice of loss could be used to inform a decision about whether or not the vehicle should be declared a total loss, potentially saving a costly tow to a repair facility. Similarly, these images could be used to determine whether to repair or replace a damaged part.

While these are just two use cases, a recent report by **Tractica** indicates that the global computer vision market is expected to grow to \$33.3 billion by 2019. Ultimately, both insurer and insured benefit from a streamlined claims process, and computer vision is just one of the many AI technologies available to deliver on that.

For more of Debbie’s thoughts on artificial intelligence and computer vision, read her blog post: [Computer Vision—from Diagnosing Cancer to Transforming the Claims Process](#).

GLOBAL COMPUTER VISION MARKET IS EXPECTED TO GROW

2019

\$33 billion

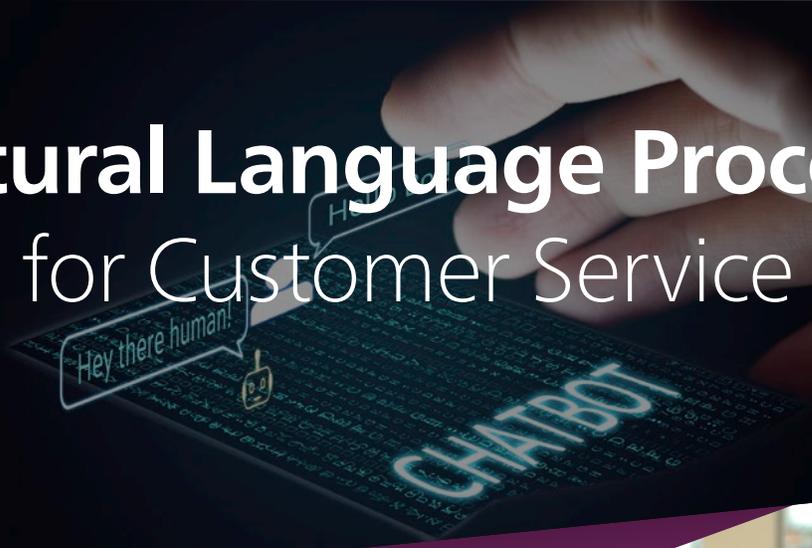
2018

\$20 billion

2017

\$12 billion

Natural Language Processing Isn't Just for Customer Service Anymore



By **Nina Smith**,

Executive Vice President and General
Manager, Casualty Solutions



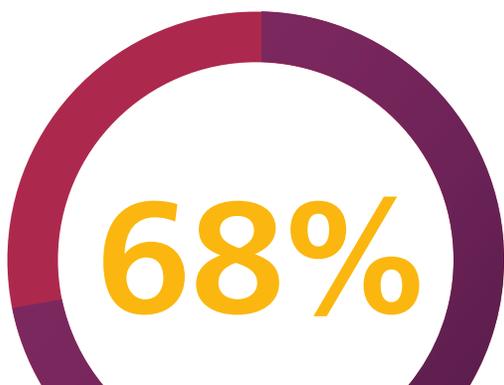
From **Geico's virtual assistant**, Kate, that answers basic policy and billing questions within an app, to Lemonade's chatbot, Maya, that signs people up for renters insurance and even processes simple claims, virtual assistants and chatbots are proliferating in the insurance industry. In fact, in a **recent Accenture study** of the insurance industry, 68 percent of respondents said their companies use some sort of AI-powered virtual assistant in at least one segment of their business.

The technology that enables chatbots to interpret language is called natural language processing (NLP). NLP hasn't yet advanced to the point where it can understand complex conversational language, but it can understand, ask questions and provide suggestions within a given context. Despite its limitations, it is already beginning to move out of the customer experience arena and into the enterprise in really interesting ways. Companies like Tableau Software and Rhiza are finding ways to integrate it into data analysis, and they are even incorporating voice interfaces—think Amazon Echo and Google Home—along the way.

Tableau's prototype software, **Eviza**, enables users who are looking at data visualizations, like points on a map showing earthquakes, to use basic queries to drill into the data—along the lines of “show me the area that had the strongest earthquake.” Rhiza offers a commercial product called the **Rhizabot** that enables sales and marketing teams to create data visualizations for presentations, simply by asking questions out loud.

As Tableau and Rhiza demonstrate, as natural language processing and voice interfaces mature, chatbot functionality is poised to move from customer-facing interactions to behind-the-scenes claims processes, but the concept and the potential value are similar. Ultimately, natural language processing will likely make the vast amounts of casualty, workers' compensation and other data easier to access and more actionable.

For more of Nina's thoughts on artificial intelligence and chatbots, read her blog post: [When Artificial Intelligence Gets Up Close and Personal, Does Human Interaction Fall by the Wayside?](#)



68% OF THE INSURANCE INDUSTRY USE SOME SORT OF AI-POWERED VIRTUAL ASSISTANT IN AT LEAST A SEGMENT OF THEIR BUSINESS.

The Workers' Comp Claim Journey Integrated Solutions Improve Outcomes

By **Rebecca Morgan**

Senior Director, Product Management, Mitchell Casualty Solutions



Integrated solutions help deliver better outcomes for all stakeholders involved in the claim.

From the moment an injury occurs, to the day an injured worker returns to work, the journey a workers' compensation claim may take is complex, involving numerous parties and diverse jurisdictional requirements. Adding to the complexity are the number of stakeholders interested in the claim outcome but working in disparate technologies: First and foremost the injured worker, but also the employer, the insurer and the provider. Balancing the interests of each stakeholder in a claim can prove challenging, but that balance can be achieved by leveraging integrated technology to facilitate good communication and manage risks.

With so many parties interested in the claim, it is easy to see how outcomes can be challenged by competing influences. However, it is imperative to align motivations by the singular question: "How can we best restore this injured worker's life?" The key to aligning these motivations really boils down to better communication—communication between people and communication between systems. When an insurer has a robust claims management system fully integrated with managed care, pharmacy benefit management, network optimization and bill review, better outcomes can be achieved for all stakeholders in the claim.

Joel was a long-term employee at a cable provider where his main duty was installations at customers' homes. One afternoon, while moving boxes out of his van, Joel heard a pop in his shoulder and immediately felt pain. Since it was almost the end of his shift and his doctor's office was on the way back home, Joel decided to drive himself to his doctor's office. After an x-ray and full examination, Dr. South diagnosed him with a potential torn rotator cuff in his left shoulder and requested an MRI to get a definitive diagnosis. Dr. South prescribed an opioid for the pain and a notice that Joel must refrain from any physical activity at his place of work. Joel returned home after picking up his prescription. He then called his employer to notify them of the situation. In a matter of hours, a workers' compensation claim was opened. The team who will assist Joel in his recovery process and return to work is beginning to assemble including his employer, a provider and a pharmacy. In addition, the insurer receives notification and assigns a claims adjuster to Joel's claim.



Providing the Right Amount of Care through Data

Joel visited Dr. South a few days after the accident for a follow-up. Dr. South suggested some ways that Joel could expedite his healing, including physical therapy. Joel mentioned that his right wrist had also been giving him trouble since he fell off a ladder repairing his roof at home. Dr. South decided that both his shoulder and his wrist could benefit from physical therapy. As the insurer began to receive medical bills from the physical therapist, clinical edits triggered an additional review of the bills. The adjuster determined that the wrist injury was not a work-related injury, and therefore not compensable. The adjuster made an appropriate decision to pay the therapy bills related to the shoulder and deny the rest.



Adjuster workloads continue to increase making it more difficult for adjusters to monitor every aspect of their claims. Yet, the tools at an adjuster’s disposal are becoming increasingly more sophisticated. Data analytics and clinical edits embedded within an effective workflow help guide claims along the right path. The flexibility to adjust the course of the claims journey helps the adjuster ensure the injured worker is getting the right amount of care and creating a better claims outcome overall.

For example, by inspecting First Report of Injury data, diagnosis data or first-fill prescription data, adjusters can identify claims early that may require extra attention such as nurse case management, utilization review or even pharmacy intervention. By embedding

medical treatment guidelines in the workflow, claims can be programmatically flagged where treatments fall outside recommended guidelines. Clinical edits that identify these outlier billing conditions can increase cost efficiencies over all claims by 2 percent.¹ Not only does this help insurers contain costs by avoiding payment of potentially excess treatment, it also helps injured workers get the right level of care at the right time.

Failure to leverage data assets such as analytics and clinical edits can cause claims administrators to miss opportunities to redirect claims. Integrating these tools in the workflow puts smarter tools in the hands of the adjusters, improving consistency in decision-making and preventing overpayment of bills.

Integrated Solutions Lead to Optimal Outcomes

Pharmacy Benefit Management

A fully integrated PBM with first-fill in-network capability can increase network penetration from

65% to 95%



Managed Care & Utilization Review

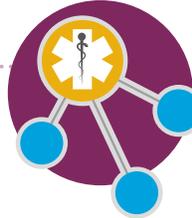
Specialized managed care pharmacy programs can reduce opioid spend by more than

60%



Market Value Pricing, Charge Validation Analysis and Negotiations

Average savings of **30%** per applicable bill in addition to or complementary to other network savings



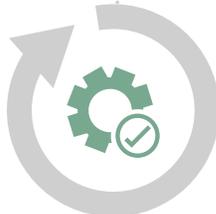
Provider Networks

Strong network portfolio + robust modeling capability achieve optimal network savings and penetration levels



Clinical Edits

Can catch an additional **2%** of charges that should not be paid



Data Integration with Pharmacy Benefit Management (PBM)



On the same day that the injury occurred, Joel went to the pharmacy to fill his prescription. He told the pharmacist that the prescription was related to an injury he received at work and he was not sure how he was supposed to pay for the prescription. The pharmacist knew exactly what to do. She was able to provide Joel with his prescription with no out-of-pocket costs.

First-fill prescriptions are notoriously costly. Hundreds of dollars can be spent on a claim before an insurer ever receives notification of the claim. An integrated PBM with first-fill in-network capabilities can reduce the insurer’s pharmacy spend by redirecting the prescription in-network when it otherwise would have been filled out-of-network. A typical PBM solution might reach network penetration levels of 65 percent, yet insurers with a tightly integrated PBM with first-fill in-network capabilities can see far greater penetration, as high as 95 percent.²

Additionally, a strong clinical program is an important component of managing this very risky part of a claim. According to **Dr. Mitch Freeman, PharmD and Chief Clinical Officer at Mitchell**, an integrated PBM solution helps to “successfully navigate the risks along the claim journey by monitoring potential roadblocks or pitfalls, identifying when any suboptimal or dangerous treatment pathways are taken, and intervening with the prescriber to keep drug therapy on an appropriate path.”³

Data integration also helps to solve a common pain point for adjusters: getting a full view of the claim. Getting the full claim view often requires visiting a variety of systems, each containing differing pieces of data related to the

About the Quarterly Feature author...



By Rebecca Morgan
Senior Director,
Product Management,
Mitchell Casualty Solutions

Rebecca Morgan is Senior Director of Product Management for Mitchell’s Workers’ Compensation Solutions. Her teams are responsible for both medical bill review and claims reporting software deliveries for the workers’ compensation market. Rebecca brings more than 20 years’ experience in software engineering and product management in the workers’ compensation industry. She has a passion for improving claims outcomes, leading teams to high performance and forming strong partnerships with customers.

claim. One system may contain medical bills, while another contains pharmacy benefits and yet another shows utilization review and nurse case management activity. As an industry, if we are ever going to curb the rising costs of pharmacy and the opioid epidemic, we are going to have to provide better data to those making the day-to-day decisions on the claim—the adjusters. A deep integration between PBM, medical bill review and pharmacy intervention will not only provide better outcomes for injured workers, but also a solution that is best positioned to contain the rising costs of pharmacy.

Utilization Review Integration

Joel's case was assigned to Utilization Review (UR).

Sarah, the nurse performing the UR, reviewed Joel's records and his physician's treatment plan, and identified a few aspects that caught her eye. She noted that Dr. South prescribed 12 physical therapy visits.

After consulting medical treatment guidelines, Sarah determined that the 12 visits may be excessive. After consulting a physician advisor, she recommended that Joel receive eight physical therapy visits.

Sarah also noted that Joel was still being prescribed opioids. She referred the case to a pharmacy intervention nurse, Barbara, for review. After Barbara reviewed the case with Dr. South, they were able to agree on an alternative medication instead of the opioid to reduce the risk of Joel becoming opioid dependent.



UR and other case management programs can provide much needed support for the injured worker and for providers. With pharmacy costs accounting

for 17 percent of the cost of claims,⁴ UR can reduce pharmacy spend by determining if the prescribed medications are the best option for the injured worker. Insurers can see more than a 60 percent reduction in opioid spend by integrating specialized managed care pharmacy programs to help mitigate serious risks and exorbitant spend.⁵ More importantly, if an injured worker is prescribed opioids to assist in the recovery process, pharmacy intervention through a nurse case manager can monitor and ensure appropriateness of ongoing prescriptions. These types of proactive clinical care can ensure that claimants receive the treatment they need and right level of care.

Without the proper clinical oversight, a workers' compensation claim can quickly become unnecessarily costly to the insurer and, more importantly, create excessive care for the injured worker. Outcomes can further be improved by integrating UR decisions into bill review. **Jackie Payne, Vice President of Medical Management Services at Mitchell**, explains that, "Collaborations between bill review and managed care, two typically 'siloed' work streams, can provide insights into an 'at-risk' claim,"⁶ which in turn helps curb costs and provides the right level of care to the injured worker.

Provider Networks

Throughout the course of Joel's treatment, provider networks have played an important role,

and in some cases a direct role, in the care that he received. For example, since the workers' compensation claim was in process at the time Joel was prescribed physical therapy, the payor was able to refer him to a physical therapist within the preferred provider network.



Provider networks not only help injured workers receive quality care, they also play a key role in an insurer's cost containment solution both prospectively and retrospectively. As shown in Joel's example, when an injured worker is treated within the preferred provider network, both the level of care and costs associated with the treatment improve the overall outcome of the claim.

In order to truly maximize cost containment, it is imperative for an insurer's bill review platform to have an optimized network solution. Optimal network penetration is achieved with a strong network portfolio combined with robust modeling capability. The breadth and depth of a network

portfolio is just as important as having flexibility to adjust the network stack. **Lee Haripko, Senior Director of Strategic Partners at Mitchell,** states, "The hierarchy of the networks and cost containment solutions have a tremendous impact on penetration rates, ... [savings], and turnaround times."⁷ Modeling capabilities are especially beneficial when utilizing specialty bill review solutions such as market value pricing and charge validation analysis in addition to standard provider networks. In certain instances, by placing these early in the network hierarchy, insurers can achieve an average of 30 percent greater cost containment in addition to or complementary to other network savings.⁸

Conclusion

Joel's pharmacy intervention nurse, Barbara, continued to stay close to Joel

and Dr. South throughout his recovery. Joel was able to return to work for light duty after three weeks as he continued his physical therapy. At 12 weeks, he saw Dr. South again. Dr. South was pleased with his progress and Joel was able to return to full, unrestricted duty.



A workers' compensation claim journey often involves numerous parties and complex technologies, but it doesn't have to be that way. The solution to the challenges facing our industry will need to include an optimized provider network strategy to improve savings for the insurer, integrated managed care and PBM programs that facilitate better care for

the injured worker and tighter integrations that enable better communication among systems and among all parties to the claim. By leveraging each of these important technologies, our industry will be positioned to achieve better outcomes for employers, providers and most importantly for injured workers.

Sources:

¹ Based on Mitchell internal data.

² Based on Mitchell internal data.

³ Freeman, Mitch. "PBM Challenges in Navigating Drug Therapy Issues – Integration Provides Insight." *WorkCompWire*. 2 Jan 2017. Web.

<http://www.workcompwire.com/2017/01/mitch-freeman-pbm-challenges-in-navigating-drug-therapy-issues-integration-provides-insight/>

⁴ Lipton, Barry, and David Colon. "Workers Compensation and Prescription Drugs: 2016 Update." *NCCI Research Brief 2016*. NCCI, Sept 2016. Web.

https://www.ncci.com/Articles/Documents/II_ResearchBrief_WC_Prescription_Drugs.pdf

⁵ According to Mitchell's book of business

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<http://www.mitchell.com/making-a-strong-case-for-case-management>

⁷ Haripko, Lee. "The Five Pillars of a Provider Network Program." *Mitchell*. 1 Jan 2015. Web.

<http://www.mitchell.com/news/id/117/the-five-pillars-of-a-provider-network-program>

⁸ Based on Mitchell internal data

The Value of Case Management Advancing a People-First Approach

By: Jackie Payne

Vice President, Medical Management Services, Mitchell Casualty Solutions

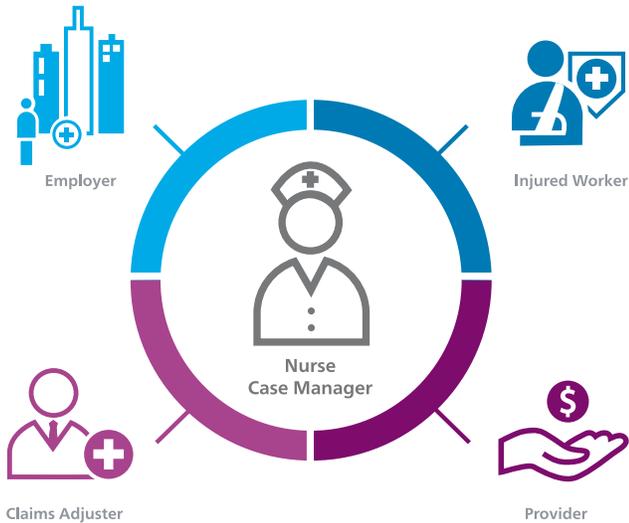


Utilizing a nurse case manager in the right instances can avert delays in a timely return to work.

One of the biggest challenges that the workers' compensation industry faces today is the continuous rise in medical costs. As a result, the industry fights for improved efficiencies and cost containment, and injured workers can often get lost in the shuffle. Until now, most employers have focused on containing costs and reducing days lost, representing a more transaction-centric approach. However, experts now say that changing the primary focus to supporting the injured worker can improve outcomes for all parties involved in a claim.¹

By focusing on the injured worker and the improvement of their health and wellness,

employers can shift their focus back to their most important goal: making people healthy again. Behind every claim is an injured worker seeking to get better. If a nurse case manager is engaged in a workers' compensation claim, they have the opportunity to deliver multiple benefits and build trust with the injured worker to ultimately support a timely recovery. In order to be an advocate in an injured worker's journey to recovery, a nurse case manager will facilitate their medical needs and ensure a continuous flow of communication between them, the injured worker, the provider, claim adjuster and the employer.



Engaging a nurse case manager on a claim can save an average of \$6,100 in medical and indemnity costs, resulting in an 8:1 ROI.

Serving as an injured worker's advocate by placing the injured worker first not only empowers the worker throughout the claims process, but it also reinforces the "people first" philosophy manifested in the "advocacy-based" claims model—a catchphrase that is growing in popularity within the industry.

In short, as an industry, we need to realign ourselves with the principle that healthcare was founded upon: protecting the patient's interests, prioritizing them first. The primary purpose of workers' compensation is to get injured workers back to work as quickly as possible and ensure appropriate care is rendered at the appropriate time. When that fundamental principle is the focus, reduced costs generally follow.

Moving Toward Better Timing to Address the Challenge Sooner

In 2015, the U.S. Bureau of Labor Statistics reported 2.9 million nonfatal workplace injuries occurred that year. Of this, over 50 percent of the injured workers experienced time lost from work.² Consequently, when expert analysis is done, the findings approximate that 75 percent of employees return to work after 12 weeks of lost work time, but only 20 percent return after a year. Based off these numbers, the observation turns out to be: the longer an injured worker is out of commission,

the more likely it is that they don't return to work at all. As a result, there is an imperative to helping injured workers avoid long delays in returning to work. According to industry statistics, only about 10 percent of U.S. workers' compensation claims are utilizing nurse case managers.³ Although case management may not be necessary for all workers' compensation claims, utilizing a nurse case manager in the right instances can avert delays in a timely return to work.

The most critical point in time to effect the outcomes in medical care, claim costs and return to optimum function and work is immediately after injury. Proactively assigning a nurse case manager to help guide the injured worker early in the claims process can empower and accelerate a return-to-work plan to avoid delays in progress.

In addition, there is the potential opportunity to realize cost efficiencies on medical spend should a case be referred to case management in a timely manner. Engaging a nurse case manager on a claim can save an average of \$6,100 in medical and indemnity costs, resulting in an 8:1 ROI.⁴ Time delays in referring a claim to case management have been found to increase claim costs 18 percent on cases reported at two weeks, as opposed to those reported at one week.⁵

Combating Costs

In an ideal world, First Reports of Injury (FROI) or the first notice of treatment of an injured worker should be forwarded to the medical management organization for case management triage. Realizing that not every case warrants a nurse at the beginning, employers and carriers benefit from having a “trigger” list of injuries on which it would be advantageous to enlist early case management. The key to cost containment is not to prohibit workers from care or provide less desirable care, but rather to ensure the right care is provided at the right time. Early case management facilitates treatment:

- Provided within networks, if applicable
- Provided within evidenced-based guidelines
- Education to the worker informing them of successful outcome expectations, including return to work (RTW) time points

Employees who are injured on the job tend to withdraw from their co-workers and supervisors when they are off work. Whether it be television advertisements about attorneys or the worker speaking to a neighbor, many injured workers seek legal advice and representation during the course of their rehabilitation, potentially adding significant costs and delays to the case. Early case management intervention promotes healthier relationships between all parties because the worker feels that they have someone to advocate for them. The nurse can explain the treatment in layman’s terms, facilitate earlier appointments, and collaborate with the physician resulting in more timely treatment, which typically results in a shorten time for which a claim is open.

Many times case management is compared to a train. If the nurse gets on at the beginning of the trip the case is far less likely to derail. If a nurse is assigned to a case months or years after the injury there is often little to do but pick up the pieces and attempt to move to resolution. Cost containment should commence at the beginning of the trip to help maximize the realization of positive outcomes. Collaboration with other units within the organization such as utilization review and bill review, as well as access to external claims systems are important components of this trip. Nurse case managers depend on documentation from these units to aid them in compiling a complete picture of the case.

Early case management intervention promotes healthier relationships between all parties.

Smarter Data Integration Offers Fuller Visibility into the Claim

Integration between bill review and managed care is an important component of effective case management. Not all claims will warrant a nurse case manager, but among those that do, advanced claims software technology solutions can help provide visibility into scenarios where a workers’ compensation claim may benefit from medical professional guidance. Claims should be evaluated for case management intervention using multiple triggers. Collaborations between bill review and managed care, two typically “siloesd” work streams, can provide insights into an “at-risk” claim. If an insurer has access to a staff of nurses with years of certified medical experience, not only can they identify and address clinical issues an injured

worker may be facing, but they can also successfully intervene with case management services to make sure the injured worker reaches optimal medical improvement.

These critical synergies support employers and payors to proactively monitor and identify suboptimal pathways throughout the claims journey. As a result, cost and process efficiencies are shown to improve for all stakeholders involved.

While the constantly changing nature of healthcare continues to evolve to drive new solutions to address

the many challenges within the workers' compensation industry, the goals remain the same for nurse case managers – to provide high quality care and cost-effective solutions to injured workers. By achieving these goals, nurse case managers can empower them to see improved value in their life at work and at home. When workers' compensation carriers begin to programmatically utilize nurse case managers, it can start an integrated system of delivering high quality patient care along with cost-containing claims efficiencies, allowing them to provide more trusting services and drive better outcomes.

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⁴ "Study Finds Nurse Case Managers Add Value to Workers' Comp Claims." *Claims Journal*. N.p., 31 July 2015. Web. 21 Mar. 2017.

⁵ Wojcik, Joanne. "Careful Use of Nurse Case Managers Can Improve Outcomes." *Business Insurance*. N.p., 25 Mar. 2011. Web. 21 Mar. 2017.

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Managing Medical Records is Key to Improving Third Party Claim Settlements

By **Monica Zylstra**

Vice President, Service Operations, Mitchell Casualty Solutions



High quality data capture is essential in order to achieve the most accurate and complete analysis of medical treatment.

This article is the first of Mitchell’s new third party blog series!

Each month, we will publish a blog post on a different topic related to third party claims as a part of our new blog series to help keep you up-to-date with what’s going on in this constantly-evolving part of our industry.

Check in here periodically for new third party content.

Documents that adjusters receive from attorneys or claimants related to third party claims are typically unorganized, inaccurately coded and seemingly stacked a mile high. It can feel like an insurmountable challenge to organize, digitize and understand every detail of the medical records, but processing a claim without first organizing, capturing the data and properly coding documents can make it difficult for an adjuster to efficiently reach the most accurate settlement.

An end-to-end third party solution can help organize and surface key details efficiently and effectively—starting with a service partner that provides the adjuster organized, fully coded and accurate documents with all of the necessary data in an easy-to-digest format. To increase efficiency and improve consistency, it is best to use a partner with expertise in these processes to perform the four services listed below for third party claims.

Smarter Solutions for Third Party Claims Technology, data and expertise guiding you at every step



Document Organization and Management

Though organizing, coding and digitizing documents is a huge, time-consuming task, it is a crucial first step to successful settlements of third party claims. Insurance companies receive claim documents of various page length with bills, medical records and supporting documentation in many different formats—from an official, fully coded bill to one written on a napkin—but it is best if an adjuster can work with organized and digitized claim documents. An adjuster should be utilizing an organized package of documents complete with a summarized table of contents for ease of reference. This type of preparation typically leads to better negotiation outcomes and a consistent and reliable process for the insurance operation.

Front-End Coding

Often, medical codes are missing from bills or are inaccurate, making it difficult to calculate the total value of the medical expenses, treatment and injuries being claimed. It is difficult to reach the best outcomes without the proper coding, so before starting to prepare for the negotiation process, an adjuster should have all medical treatment and diagnosis codes accurately identified and documented.

Certified coders will review all documents and check for inappropriate billing practices and accuracy of provider charges.



Data Capture

In order to appropriately settle a third party claim, it is valuable at the outset to accurately capture all of the data for the claim and claimant as well as the procedures included in the medical bills and records. This is particularly important when using bill review technology to provide expert analysis of the medical treatments as well as usual and customary fee data and American Medical Association (AMA) guidelines for provider billing. High quality data capture is essential in order to achieve the most accurate and complete analysis of medical treatment.

Certified Coding

Once the medical information has been accurately coded and digitized, a certified coder can provide a

focused review of billing practices to help to ensure the treatments provided were reasonable based on the medical records. Certified coders will review all documents and check for inappropriate billing practices and accuracy of provider charges. For example, providers frequently bill for the highest-level office visit, which is intended only for very serious injuries. A certified coder can identify this error and change it to the appropriate procedure code to match the actual office visit that occurred. Certified coders can also perform customized expert reviews based on regional or office performance, industry trends or individual carrier business requirements. This type of review is a crucial step to reaching fair and reasonable third party claim settlements and identifying potential waste and abuse in billing practices.



Leveraging a partner that is an expert in third party document management and medical and claim processing is often best suited to enable an insurance company to achieve the following key benefits:

1. By organizing, properly coding and capturing data from medical documents related to third party claims, a service partner can provide adjusters with information to negotiate what is reasonable on a claimant's medical charges. This can help eliminate leakage based on duplicates, inappropriate billing practices by providers or reasonableness of provider charges.
2. Using a service provider eliminates the necessity for an adjuster to have to understand coding and billing practices, helping them spend less time managing administrative activities and more time focusing on their core duty—negotiating settlements fairly and accurately.

3. Instead of each adjuster completing these steps their own way, if at all, a service partner provides an insurance company a consistent, efficient and reputable process for organizing documents, capturing data and analyzing medical treatments. By quickly placing tools and expert analysis in adjusters' hands, insurance carriers will achieve consistency and efficiency to reach the most accurate, reasonable and fair settlements across the organization.

By providing an adjuster up front with organized and reviewed claim documents, they are much more prepared to settle third party claims. A service partner can help an adjuster gain a full understanding of exactly what is being claimed—ultimately leading to improved, fair and reasonable outcomes for the insurance company.



The Compliance Corner

FAIR Health Pricing Methodology

By: Michele Hibbert-Iacobacci, CCSP, OHCC

Vice President, Information Management & Support, Mitchell Casualty Solutions



This year, FAIR Health has plans to update and make methodology changes to the Medical/Surgical Module payors use which will include a delineation of actual and derived benchmarks.

The Compliance Corner is also available online!

Check in here periodically for new Compliance Corner blog content.

Having access to a database with a transparent methodology for deriving provider market rates and insurance information serves as a valuable asset in the P&C industry for organizations largely involved in the healthcare market. Healthcare claims data is integral in helping identify and monitor trends in the healthcare market. This is where FAIR Health comes into play.

FAIR Health is a national, independent, nonprofit organization whose mission is to bring transparency to healthcare costs and health insurance information.¹ They strive to develop robust, unbiased data products and solutions to meet the needs of those

they serve. FAIR Health is widely recognized as a reliable, objective source of data, frequently cited in media reports and honored for its leadership in promoting and modeling transparency in the healthcare field.

Consumers and payors have limited choices when it comes to choosing a reliable database as comprehensive as FAIR Health and would provide a wide coverage of the United States. The vast databank from FAIR Health is accessible to anyone who wants to use it and because of the size of the underlying data, it has become one of the largest in the world.

FAIR Health licenses its provider charge modules separately. The modules are updated twice a year and the data included in the modules fall within a 12-month moving window. For example, the May 2016 release included data from the preceding year, trended forward using the consumer price index.

FAIR Health’s methodology can be found on their website for each module they provide.

This year, FAIR Health has plans to update and make methodology changes to the Medical/Surgical Module payors use which will include a delineation of actual and derived benchmarks. This new database will be the unification of two differing products and

create unified benchmarks for all. The FAIR Health website will match the data used by payors after deployment.

The majority of charges we will see in relation to the industry will be actual charge data as the top codes used represent approximately 150 of the approximate 10,000 Current Procedural Terminology (CPT) codes used today. Mitchell will keep customers apprised when deployment is ready in our products with the new unified database. There will be educational materials and information provided for a clear understanding prior to usage.

Source:

¹ www.fairhealthus.org

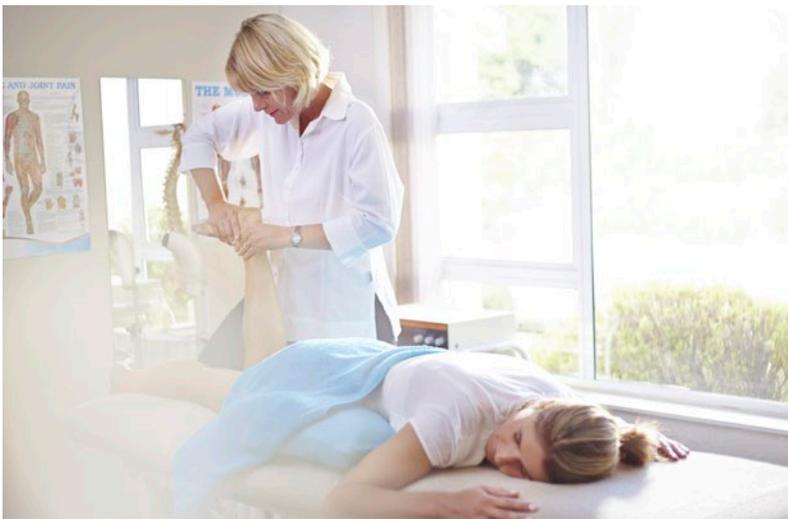


The Compliance Corner

New Physical Therapy Evaluation Codes for 2017: Moving Toward Value Based Payment

By: Michele Hibbert-Iacobacci, CCSP, OHCC

Vice President, Information Management & Support, Mitchell Casualty Solutions



PT Evaluations now require the following components in selecting the correct evaluation level—History, Examination, Clinical Presentation and Clinical Decision Making.

The American Medical Association (AMA) shook up the Property and Casualty industry by bringing a big change to the 2017 Current Procedural Terminology (CPT) code set. Two very familiar CPT codes, 97001 Physical Therapy (PT) Evaluation and 97002 Physical Therapy Re-evaluation were deleted effective January 1, 2017. The change was brought about because these codes were felt to provide minimal detail regarding the severity of a patient’s condition and the complexity of medical decision making that is required for evaluation. As a result, four new physical therapy evaluation codes have been established. **See Chart on page 25.**

Immediately noticeable is the similarity of the new PT Evaluation codes to Evaluation and Management (E/M) services. These codes have the “look and feel” of E/M codes, right down to the tiered selection of low, moderate or high complexity, and typical times required to perform the service(s). The American Medical Association (AMA) states that this new structure allows for greater specificity of a patient’s history and clinical presentation, as well as medical decision making required for the evaluation.

Despite the similarity, it is important to remember that though the elements or concepts of history,

Physical Therapy Evaluation Codes

Code	Description	CMS RVU
97161	PHYSICAL THERAPY EVALUATION: LOW COMPLEXITY , requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1–2 elements from any of the following: body structures and functions, activity limitations, and/or participation/restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	1.20
96162	PHYSICAL THERAPY EVALUATION: MODERATE COMPLEXITY , requiring these components: A history of present problem with 1–2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument, and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	1.20
97163	PHYSICAL THERAPY EVALUATION: HIGH COMPLEXITY , requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and function, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	1.20
97164	RE-EVALUATION OF PHYSICAL THERAPY established plan of care, requiring these components: An examination including review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, a 20 minutes are spent face-to-face with the patient and/or family.	0.75

examination and decision making may be similar to E/M services, the AMA instructs users that the definitions that are listed in the E/M sections (ie, history, examination types) are NOT to be used to determine the appropriate selection. Any pertinent definitions for the new PT Evaluation codes, including body regions, body systems, body structures and personal factors are provided in the CPT 2017 Physical Medicine and Rehabilitation section.

Another glaringly noticeable item is the CMS (Centers for Medicare and Medicaid Services) Relative Value Units (RVU) assigned to the new PT Evaluation codes. The American Physical Therapy Association (APTA) recommended a tiered fee schedule to reflect the new code structure. However, CMS did not accept the recommendation, holding in its final rule, to the original proposal for a single payment value, which did not change from the 1.20 value for the old 97001 code. CMS did adjust the value of the new re-evaluation code from 0.60 to 0.75.

So why is the RVU value the same for three different codes of increasingly higher complexities? One word—up-coding – and potential fraud. In their final ruling, CMS stated, “we are concerned that the coding stratification in the PT and Occupational Therapy (OT) evaluation codes may result in up-coding incentives, especially while physical and occupational therapists gain familiarity and expertise in the differential coding of the new PT and OT evaluation codes that now include the typical face-to-face times and new required components that are not enumerated in the current codes. We are also concerned that stratified payment rates may provide, in some cases, a payment incentive to therapists to up-code to a higher complexity level than was actually furnished to receive a higher payment.” After all, who wouldn’t want to use the higher complexity code if it means a bigger payout? CMS went on to state that “assessment for each family of codes is dependent on the accuracy of the utilization forecast for the different complexity levels within the PT or OT family.”



APTA initially projected that the moderate complexity PT evaluation code, CPT 97162, would be reported 50 percent of the time as it seems to represent a “typical” evaluation. The low and high complexity codes (97161 and 97163) were each projected to be reported 25 percent of the time. Will this be the way it works out? CMS plans to collect utilization data on the new PT Evaluation codes during 2017 for analysis on which possible future changes in payment policy might be based. Therefore, the impetus is on physical therapists to be as thoughtful and accurate as possible in the selection of an evaluation code.

Despite the effort of CMS to maintain “work neutrality” by maintaining the single payment value, the changes to the CPT code set are definitely a step in the right direction towards a value-based payment for physical therapy evaluations. PT Evaluations now require the following components in selecting the correct evaluation level—history, examination, clinical presentation and clinical decision making. Other factors include coordination, consultation, and collaboration of care consistent with the clinical presentation of the patient. Documentation of these elements will ensure proper valuation in the future.

Sources:

1. *CPT 2017 Changes: An Insider’s View*
2. *New Physical Therapy Evaluation and Reevaluation CPT Codes.” APTA. Web. <http://www.apta.org/PaymentReform/NewEvalReevalCPTcodes/>*
3. *Federal Register / Vol. 81, No. 136 / Friday, July 15, 2016 / Proposed Rules*
4. *APTA Physical Therapy Evaluation Reference Table*
5. *MLN Matters Number: MM9782*



Data Insights

By Ed Olsen

Director, Claims Performance Consulting, Mitchell Casualty Solutions

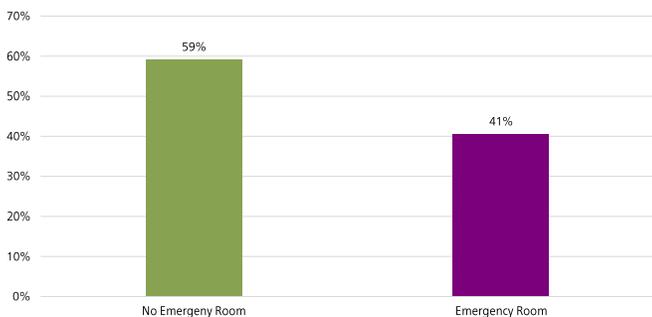


The difference in percent of claimants seeking emergency room treatment seen may be the result of policy limit challenges, injury mix and environmental factors.

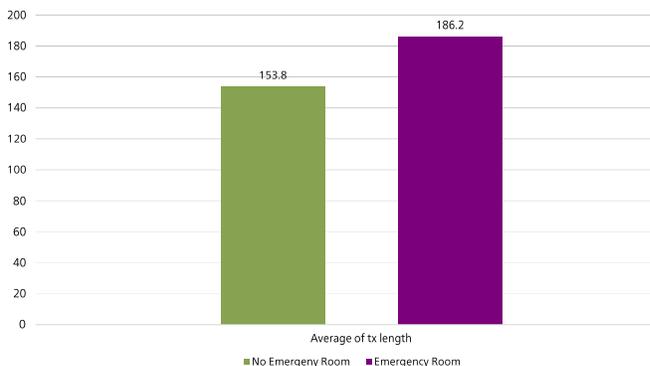
On a national basis, nearly 41 percent of claimants seek emergency room treatment.

Claimants who do seek emergency room treatment have longer average treatment length and higher average recommended allowances per claimant.

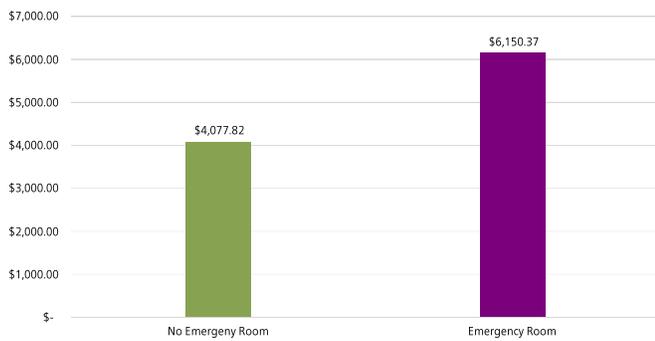
Emergency Room Treatment Received



Average Treatment Length



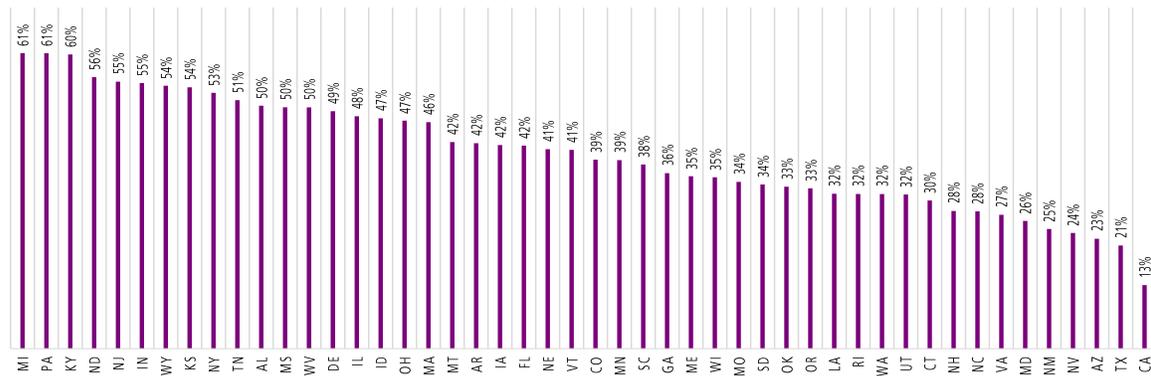
Average of Allowed Per Claimant



Looking at emergency room utilization by auto claimants at the state of jurisdiction level reveals that not all states are the same. The difference in percent of claimants seeking emergency room treatment seen may be the result of policy limit challenges, injury mix and environmental factors.

Here we see that Michigan has the greatest percent of claimants seeking emergency room treatment at nearly 61 percent or a full 20 percent higher than the national average, while California has the lowest percent of claimants seeking emergency room care.

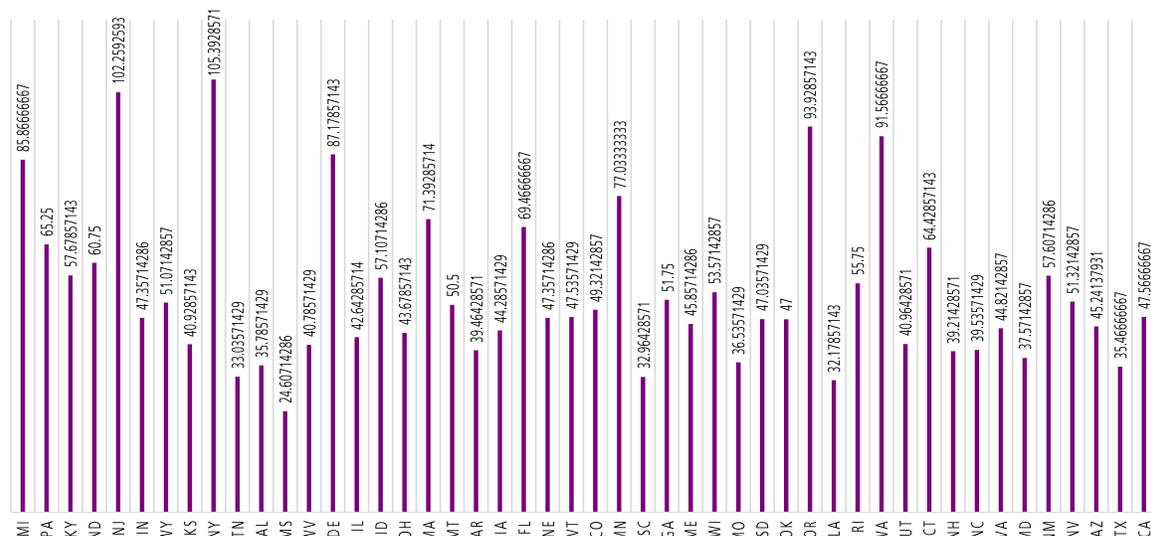
Percent of Claimants Seeking Emergency Room Treatment



When the average treatment length of claimants who do seek emergency room treatment are compared at a state level, quite a bit of variability arises.

Those claimants seeking emergency room care in New York and New Jersey tend to average in excess of 100 days from date of loss to last date of service.

Average Treatment Length of Claimants Seeking Emergency Room Treatment



Auto Casualty Medical Price Index

By Ed Olsen

Director, Claims Performance Consulting, Mitchell Casualty Solutions



Since Q1 2006, the MPI has increased 20.3 percent while the National CPI for All Services increased 22.6 percent.

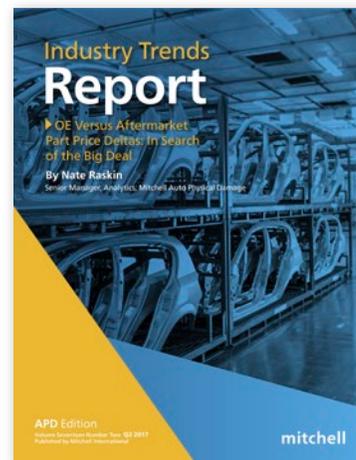
The National CPI for All Services, as reported by the Bureau of Labor Statistics in May 2017, is 122.6. That is up 1.1 since Q4 2016, but up 3.15 since Q4 2015. For the same period of time, Q4 2015 to Q1 2017, the National Auto Casualty MPI increased 0.59 percent and sits at 120.3. Since Q1 2006, the MPI has increased 20.3 percent while the National CPI for All Services increased 22.6 percent.

- Charges associated with physical medicine services experienced a 0.15 percent increase in Q1 2017 from Q4 2016. Physical medicine has seen unit charge increase 1.4 percent since Q4 2006 and 4.9 percent since Q1 2006. Recall that the physical medicine MPI is looking strictly at unit charge while holding utilization constant.
- The unit cost for major radiology services decreased 2.56 percent in Q1 2017 from Q4 2016 and as of May 2017 sits at 126.72. MPI remains 26.73 percent higher than its Q1 2006 benchmark unit charge.
- The unit cost for evaluation & management services increased 1.94 percent in Q1 2017 when compared with its Q4 2016 result. Over the past year, the unit charge associated with evaluation and management services has increased 4.65 when comparing its Q1 2016 results with its Q1 2017 result. Since Q1 2006, evaluation and management services have seen unit charge increase by 779.76 percent as reflected by the index value 179.76.

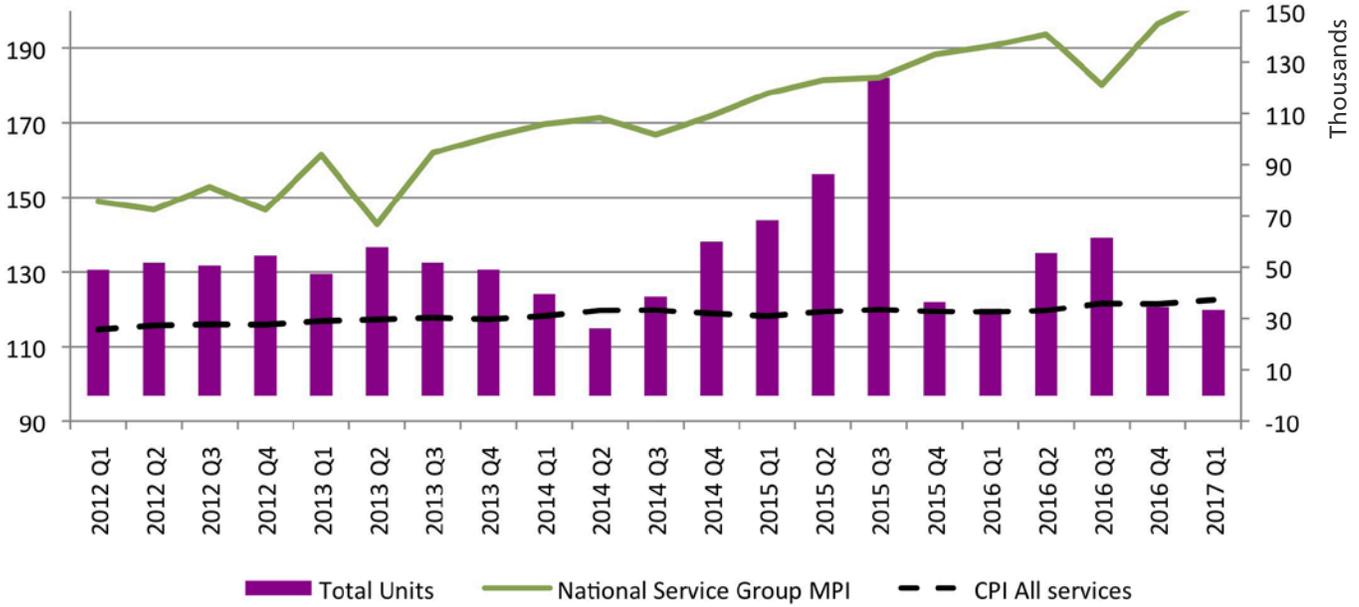
- The unit charge for professional services in the emergency room continues to rise at a rate significantly higher than all other service groups and the national CPI for all services. In Q1 2017, professional services in the emergency room experienced a 7.3 percent increase since Q4 2016. Since Q1 2006, this service group has experienced a 103.82 percent increase in the unit charge of professional emergency room evaluation and management services.

(Source: U.S. Bureau of Labor Statistics, adjusted. Consumer Price Index- All Services- All Urban Consumers, Series CUUR0000SA0. Available at <http://data.bls.gov/cgi-bin/surveymost?cu>)

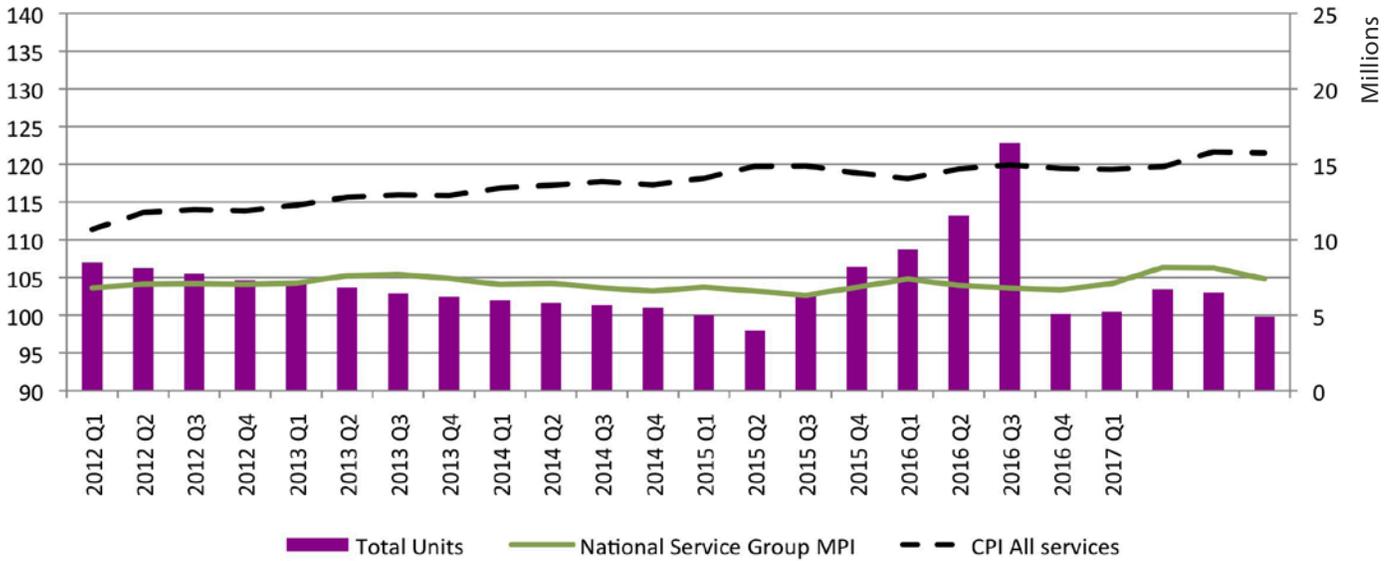
View the [Auto Physical Damage Edition](#)



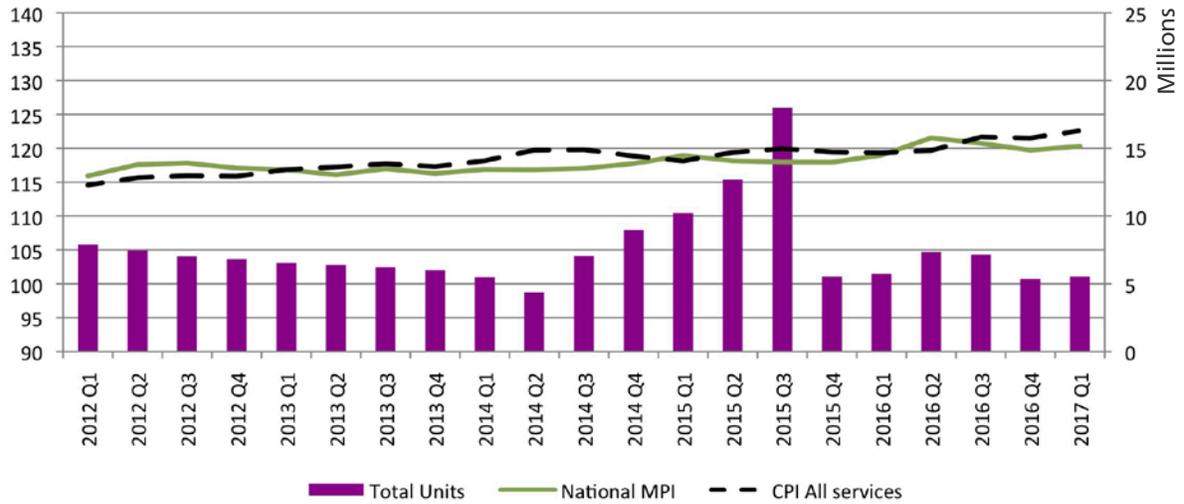
Emergency Room MPI



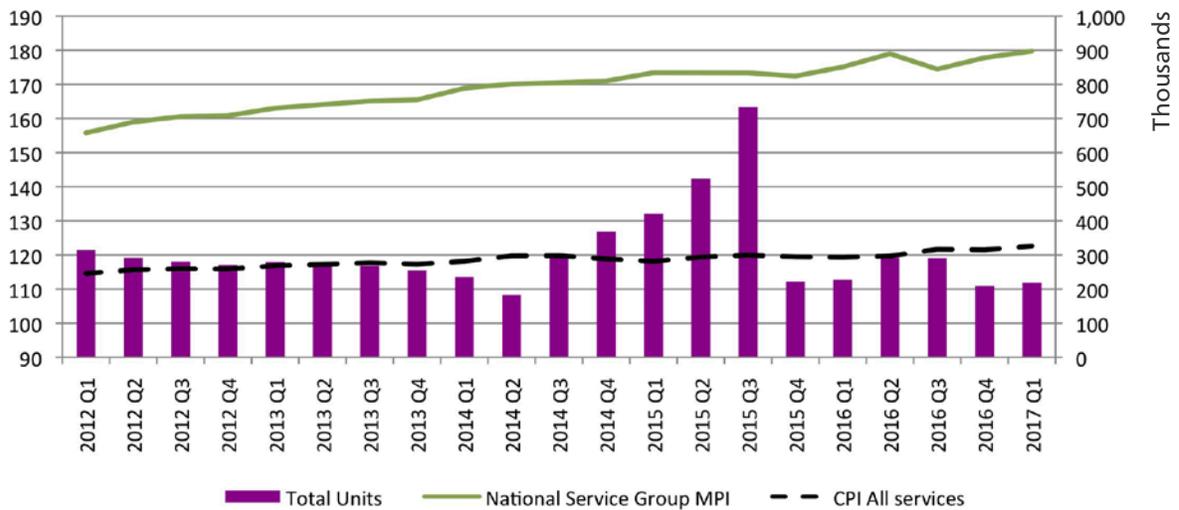
Physical Medicine MPI



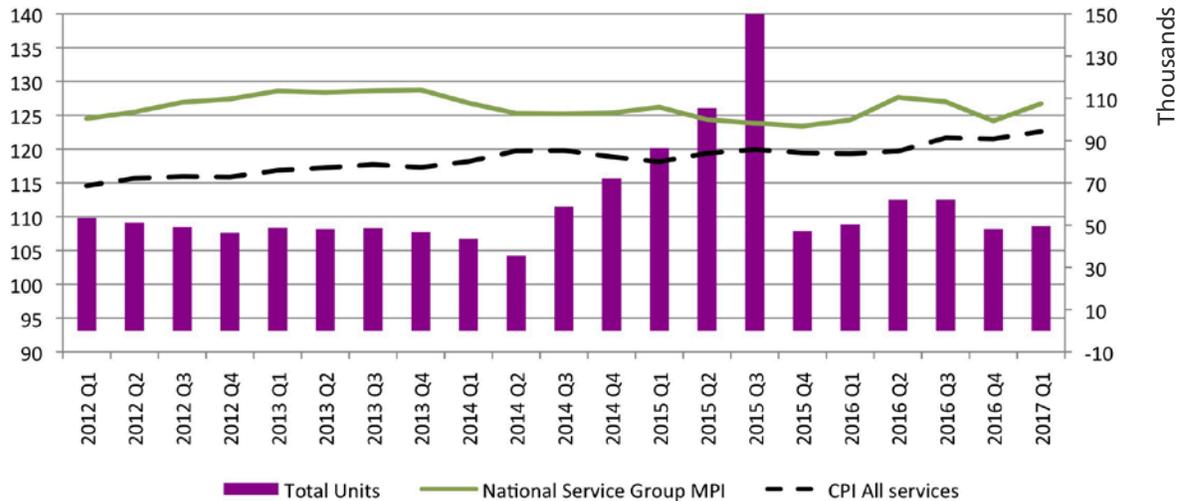
National MPI



Evaluation & Management MPI



Major Radiology MPI



Workers' Compensation Medical Price Index

By Ed Olsen

Director, Claims Performance Consulting, Mitchell Casualty Solutions



Charges associated with physical medicine services experienced a 2.64 percent increase since Q1 2017

The National CPI for All Services, as reported by the Bureau of Labor Statistics as of May 2017, is 122.6. That is up 1.1 since Q4 2016 and up 3.15 since Q4 2015. For the same period of time, Q4 2015 to Q1 2017, the national workers' compensation MPI increased 1.02 and as of May 2017 sits at 113.57. Since Q1 2006, the MPI has increased 13.57 percent while the National CPI for All Services increased 22.6 percent.

- Charges associated with physical medicine services experienced a 2.64 percent increase since Q1 2017. This increase brings the total unit cost change for physical medicine since Q1 2006 to 8.13 percent—significantly below the National CPI for All Services reported by the Bureau of Labor Statistics. Recall that the physical medicine MPI is looking strictly at

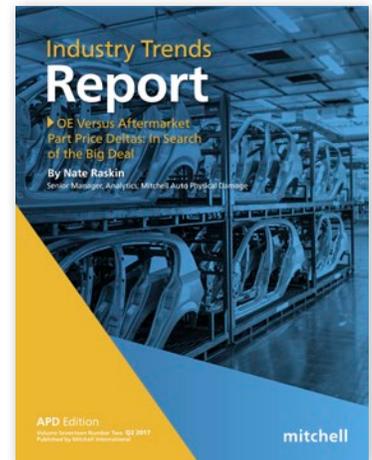
unit charge while holding utilization constant.

- Major radiology services experienced by the workers' compensation industry experienced an 18 percent decrease in Q1 2017 when compared to Q4 2016; it remains below the average unit charge seen in by the industry in Q1 2006.
- The unit cost for evaluation and management services increased 7.67 percent in Q1 2017 when compared with its Q4 2016 result. Over the past year, comparing Q1 2016 results with Q1 2017 result, the unit charge associated with evaluation and management services has increased 9.98. Since Q1 2006, evaluation and management services have seen unit charge increase 39.71 percent as reflected by the index value 139.71.

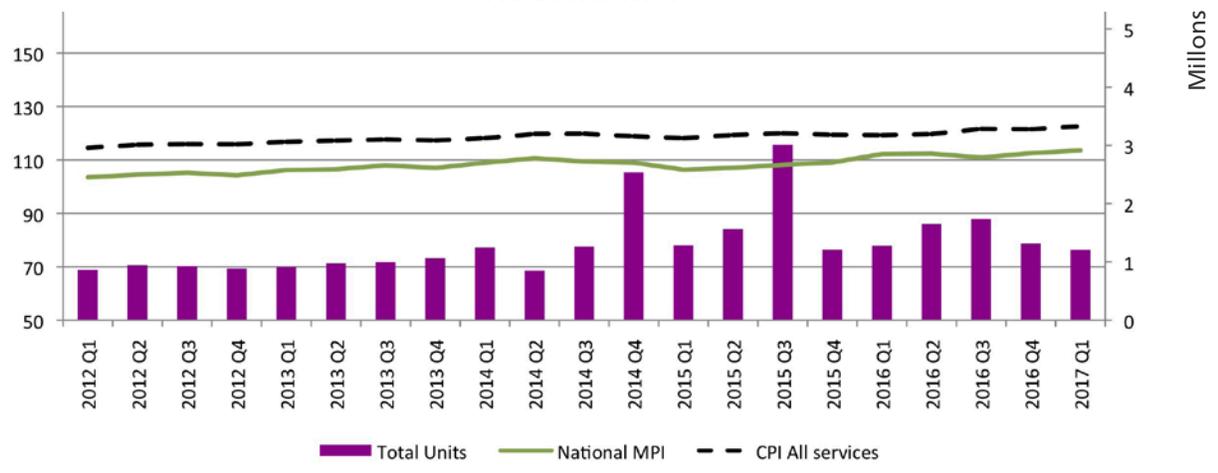
- The unit charge for professional services in the emergency room continues to rise at a rate significantly higher than all other service groups and the national CPI for all services. In Q1 2017, professional services in the emergency room experienced a 12.12 percent increase since Q4 2016. Since Q1 2006, this service group has experienced a 73.44 percent increase in the unit charge of professional emergency room evaluation and management services.

(Source: U.S. Bureau of Labor Statistics, adjusted. Consumer Price Index- All Services- All Urban Consumers, Series CUUR0000SA0. Available at <http://data.bls.gov/cgi-bin/surveymost?cu>)

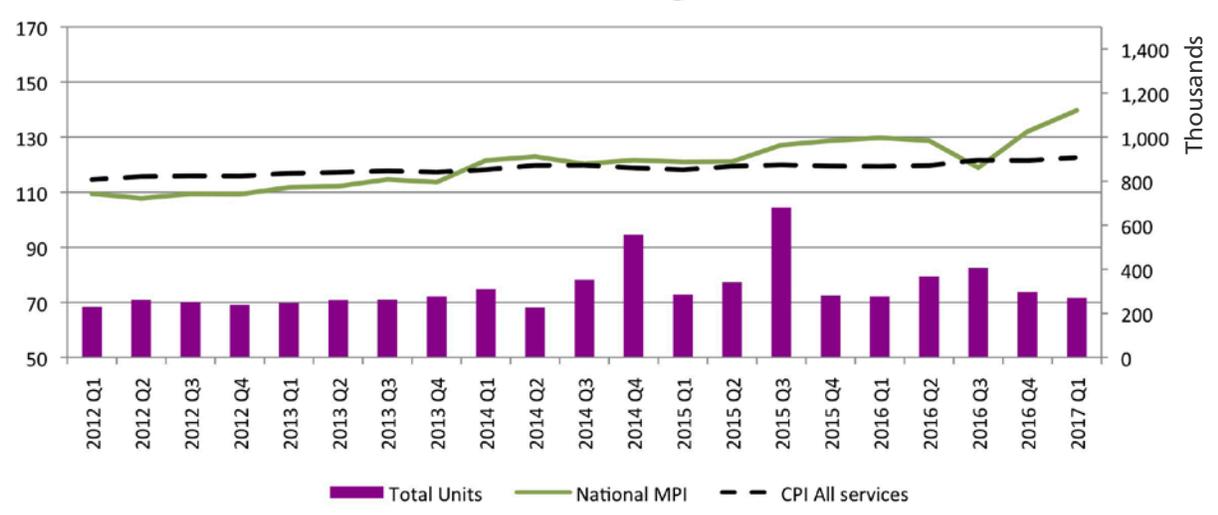
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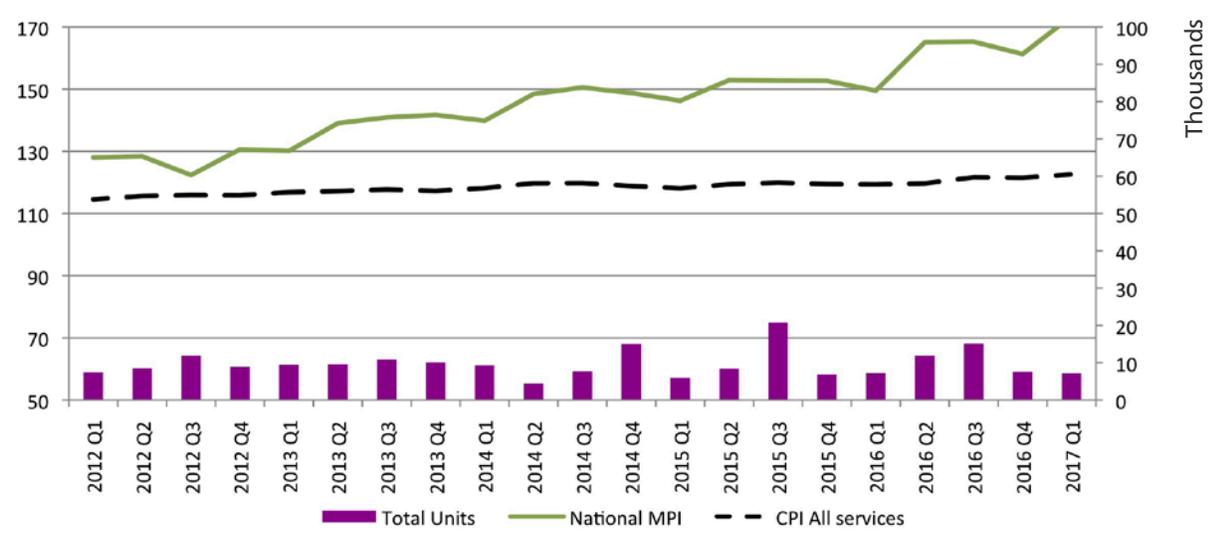
National MPI



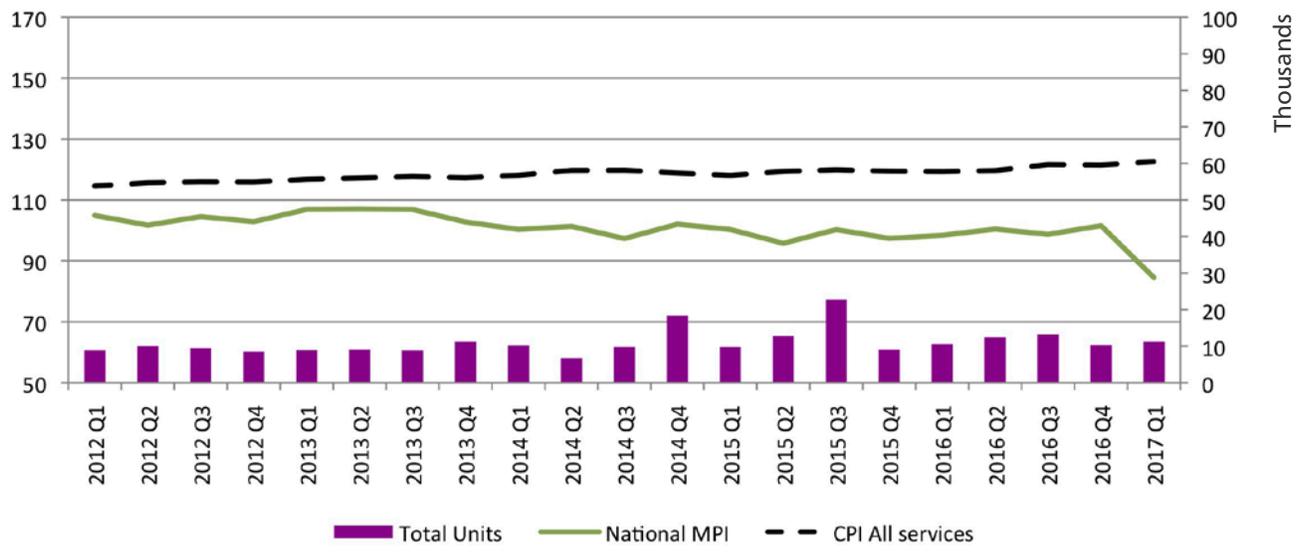
Evaluation & Management MPI



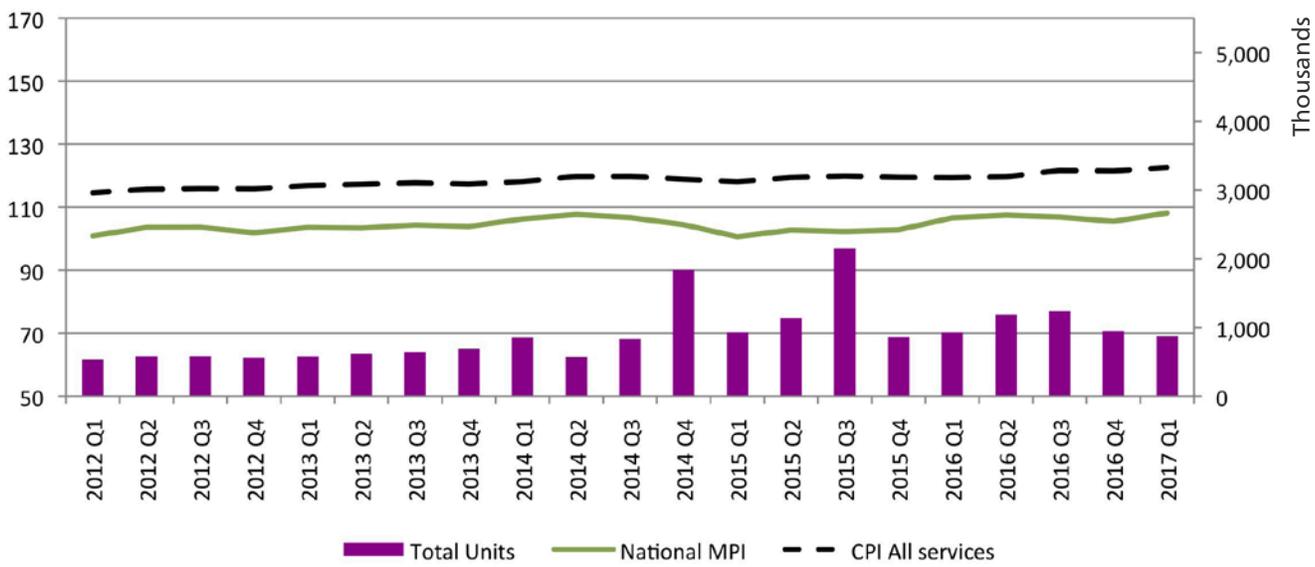
Emergency Room MPI



Major Radiology MPI



Physical Medicine MPI



Mitchell Enhances Bill Review Offering with Qmedtrix Technology

Published by Insurance Innovation Reporter



Mitchell's acquisition of Qmedtrix has delivered a new layer of value for workers' compensation carriers.

Mitchell's acquisition of Qmedtrix has delivered a new layer of value for workers' compensation carriers. Advanced capabilities and greater savings potential position Mitchell's SmartPrice Solutions above and beyond traditional specialty bill review systems.

"The integration of these three proven platforms, combined with Mitchell's expert ability to optimize cost containment workflows on a state-by-state basis, helps deliver a new layer of value for workers' compensation carriers, third party administrators and self-insured employers," said Michael Parker, the new product leader for SmartPrice Solutions.

[Read more.](#)

Three Ways to Improve Demand Management

By **Monica Zylstra**

Vice President, Service Operations, Mitchell Casualty Solutions

Published by **ClaimsJournal.com**



The insurance industry continues to evolve each year, forcing carriers to adjust processes and policies in order to keep up with changing demands.

In order to efficiently manage third party bodily injury claims and streamline the process, adjusters should leverage innovative technology and strategic process optimization designed specifically for demand management.

[Read more.](#)

Four Ways Analytics Can Help Improve Third Party Bodily Injury Outcomes

By Norman Tyrrell

Senior Director, Product Management, Mitchell Casualty Solutions

Published by propertycasualty360.com



Effectively adjudicating third party auto casualty claims can be a complex web of analysis and decision-making that challenges even the most experienced adjusters.

Effectively adjudicating third party auto casualty claims can be a complex web of analysis and decision-making that challenges even the most experienced adjusters. By incorporating data—especially first notice of loss, medical, provider and physical damage data—and insightful guidance in their workspace, an adjuster is more prepared to make thoughtful, data-driven, defensible decisions throughout each stage of a third party claim.

[Read more.](#)

Mitchell's Hatamian: Workers' Comp Insurers Moving Toward Managed Care

Published by AM Best TV



We are seeing more utilization of the nurse case management and the utilization review services and as a result of that we're seeing more of a need for technology driven products.

Shahin Hatamian, Senior Vice President at Mitchell said increasing costs of medical treatments are forcing workers' comp providers to examine better ways to manage overall costs.

[Watch the interview here.](#)



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Mitchell empowers clients to achieve measurably better outcomes. Providing unparalleled breadth of technology, connectivity and information solutions to the Property & Casualty claims and Collision Repair industries, Mitchell is uniquely able to simplify and accelerate the claims management and collision repair processes.

As a leading provider of Property & Casualty claims technology

solutions, Mitchell processes over 50 million transactions annually for over 300 insurance companies/claims payers and over 30,000 collision repair facilities throughout North America. Founded in 1946, Mitchell is headquartered in San Diego, California, and has approximately 2,000 employees. The company is privately owned primarily by KKR, a leading global investment firm.

For more information on Mitchell, visit www.mitchell.com.

Mitchell in the News



Executive Vision: Debbie Day and Jack Rozint of Mitchell on Industry Trends and Mitchell Parts

Collision Repair magazine interviewed Debbie Day and Jack Rozint during SEMA about Mitchell Parts and the trends impacting the industry today and in the future.

[Read More at Collision Repair Magazine](#)

AUTOSPHERE

Mitchell Wraps Up 2016 Roadshow, Announces 2017 Schedule

Mitchell concludes four regions Canadian and three regions U.S. roadshows and announces schedule for 2017.

[Read More at Autosphere.ca](#)



Two Sides of the Insurance Coin

Workers' Compensation Magazine included an article by Ed Olsen about the Medical Price Index which shows that providers charge differently in workers' comp and auto casualty markets.

[Read More at Workers' Compensation Magazine](#)



Payers Benefit From Newer Claims Technology

Risk & Insurance included a quote by Shahin Hatamian in an article on the shift from legacy to cloud-based systems and the benefits and possibilities these bring to employers and other claim payers.

[Read More at Risk & Insurance](#)



3 Ways to Improve Demand Management

Norman Tyrrell and Monica Zylstra share ways to improve demand management by leveraging a team of professionals for document organization, medical coding and specialty review and providing adjusters with an expert claim workspace.

[Read More at Claims Journal](#)

For More Mitchell News:



Industry Trends Report

The Industry Trends Report is a quarterly snapshot of the auto physical damage collision and casualty industries. Just inside—industry highlights, plus illuminating statistics and measures, and more. Stay informed on ongoing and emerging trends impacting the industry, and you, with the Industry Trends Report!

Questions or comments about the Industry Trends Report may be directed to:

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