

Industry Trends Report

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Mitchell's new website for the latest
ITR content & thought leadership

Coming in Q4



Casualty Edition

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Industry Trends Report

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A Message from the CEO

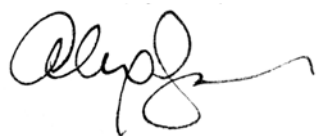
AR Meets AI

Welcome to the Q3 edition of the 2017 Mitchell Casualty Industry Trends Report. As you may remember from our last issue, we looked at several applications for artificial intelligence and how it's beginning to be used in the Property & Casualty and Collision Repair industries today. This quarter, we continue that conversation by focusing on how merging augmented reality and artificial intelligence along with advancements in smart glasses may provide new opportunities for process improvements in the industry, from streamlining workflows to complex vehicle repairs.

In our feature article, Data with Depth: Combining Data Analytics with Expertise to Optimize Claims Performance Management, authors Ed Olsen and Michele Hibbert-Iacobacci discuss the challenges facing insurance carriers dealing with an abundance of data being generated and collected in their claims systems and operational databases. Ed and Michele explain that by acquiring a combination of tools, techniques and expert personnel, insurers can gain a competitive edge and gather fresh insights into the performance of their claims workflows.

This quarter we also provide insights into settling unrepresented third party claims quickly and easily by partnering with a negotiation service. In addition, we share both the challenges surrounding drug testing in the midst of the opioid epidemic and how it can be an effective tool for clinicians in the assessment and ongoing management of patients.

Before I sign off, I'm excited to announce that in the next quarter we'll be launching a new website where you'll be able to find not only articles from past reports, but also fresh perspectives on what's trending in the industry. While our report will still be available in PDF format, you'll also be able to access all our articles plus more on our new site, to learn more about what's making an impact today and in the future. I look forward to sharing news of our live site with you soon.



Alex Sun
President and CEO
Mitchell

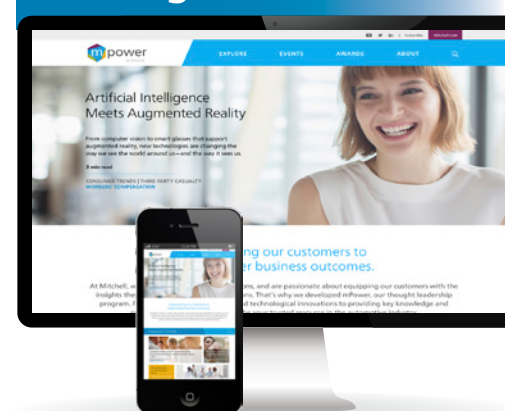


Alex Sun
President and CEO, Mitchell



Mitchell's new website for
the latest ITR content &
thought leadership.

Coming in Q4



AUGMENTED REALITY MEETS ARTIFICIAL INTELLIGENCE:

How New
Ways of Seeing
the World Are
Changing
Insurance

By Alex Sun
President and CEO,
Mitchell International

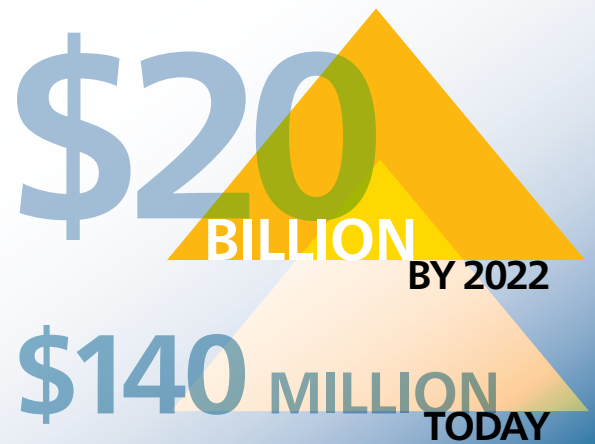


From Microsoft's sophisticated [HoloLens](#) to Snap Inc.'s somewhat frivolous [Spectacles](#), we're seeing a marked increase in smart glasses coming to market. Now, with the recent introduction of Google Glass Enterprise Edition, the technology may have found a mainstream application. In fact, Research and Markets predicts the market for smart, augmented reality glasses revenues will grow from about \$140 million today to almost \$20 billion by 2022.

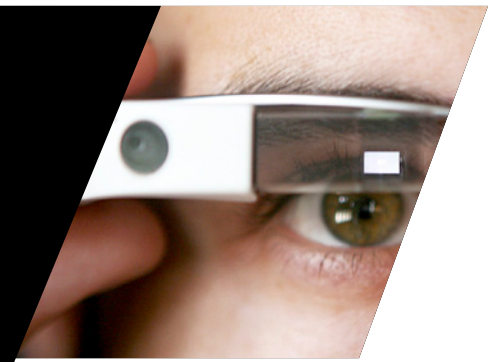
According to Robert Scoble and Shel Israel, authors of "The Fourth Transformation," we're entering a new stage in technology transformation, one in which augmented reality and artificial intelligence are merging, and smart glasses are leading the way. With that, **we may even see a move away from devices we carry—smart phones—to devices we wear**—smart glasses, or eventually, contact lenses and looking far into the future, perhaps ocular implants.

So what does this have to do with the Property & Casualty and collision repair industries? A lot, it turns out. **Smart glasses may change the way people in the insurance ecosystem work**—streamlining workflows, ensuring complex vehicle repairs are done correctly, and possibly even reinventing the healthcare paradigm.

AUGMENTED-REALITY GLASSES REVENUES



AUGMENTED REALITY + THE ENTERPRISE



© engadget.com

SMART GLASSES HIT THEIR STRIDE

In 2013, 8,000 or so Google Glass enthusiasts thought the first iteration of the devices were cool enough to shell out \$1,500 each for them. While Explorers, as the new owners were called, may have been pretty happy with the devices, people around them found them more bothersome than cool. People had privacy concerns. They were understandably uncomfortable with the idea that they might be photographed or videoed, and some businesses responded by banning them altogether.

It was clear from the get-go that Google missed its target audience. The general public wasn't ready—the enterprise would have been a much better fit. Competitors learned from Google's experience: smart helmet maker [Daqri](#) circumvented consumer acceptance and privacy issues by using similar technology to guide workers in high-risk environments.

When Google reintroduced Google Glass this past July, this time focused on workplace applications, the audience was a better fit and the market was ready. [Google Glass Enterprise Edition](#) is better in many ways. The technologies behind it—**augmented reality and natural language processing**—are more advanced, they offer more computer power, and it no longer has integrated frames. It can be worn with any eyewear, including safety glasses.

More than 50 companies are already using it, including GE, DHL, Boeing, Volkswagen, and numerous healthcare companies, and the applications are endless. GE Aviation employees, for example, use it to guide airplane repairs and inspections. It's much safer—they don't have to climb ladders with paper instructions in their hands.



© Edgylabs.com

There are likely to be many use cases for smart glasses in the P&C and collision repair industries. One can see how **collision repairers could use the glasses to guide them through increasingly complex repair procedures**, ensuring they are done correctly and the vehicle is safe and road-worthy. They might even use

the photography function to document the vehicle before and after repair. Healthcare workers are already using the glasses to dictate notes in real time. Not only do they get to spend more time focused on patient care, their notes are more accurate—both things that may enhance quality of care.

ARTIFICIAL INTELLIGENCE GETS IN ON THE ACTION

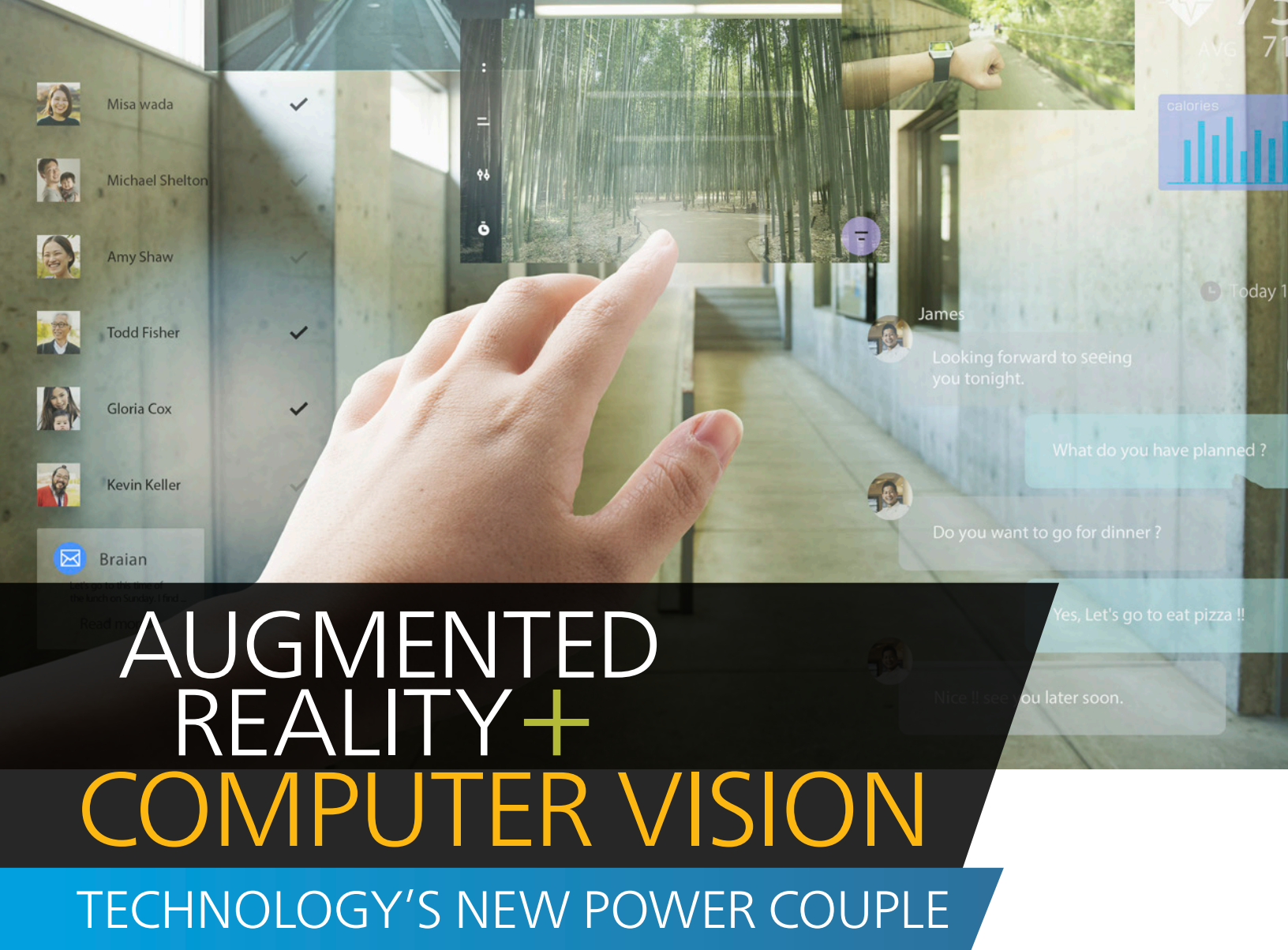
Artificial intelligence is a broad term that encompasses many different technologies. Computer vision is just one. Computer vision is the technology that allows connected and driverless cars to “see” obstacles and avoid them, but it has many other applications as well. In fact, [Mitchell](#) is exploring a computer vision application that uses image recognition to confirm repair vs. replace decisions.

Recently, computer vision researchers at Carnegie Mellon demonstrated the ability to detect and understand [small movements](#), such as a person using his thumbs to text, in real time—even in a large group of people. This is an important advancement. Looking toward a future when computers will be embedded in everything, this type of technology could allow us to interact with

them in new ways—by pointing, for example, instead of by speaking or keying in text.

Another potential application: you are driving your computer vision-enabled connected car or riding in an autonomous vehicle. There is a crowd of people standing on the curb near an intersection. Sophisticated computer vision could be able to predict, based on the smallest gestures, that one of the people in the crowd was about to step into oncoming traffic, and you or your car could respond accordingly.



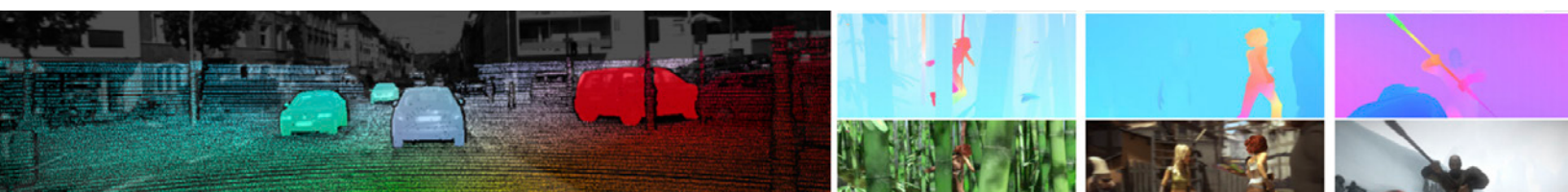


AUGMENTED REALITY + COMPUTER VISION

TECHNOLOGY'S NEW POWER COUPLE

Now imagine putting the powerful computer vision I've just described into the smart glasses form factor. Computer vision, backed by machine learning algorithms could conceivably **take in real-time information about the environment**, evaluate it against thousands of examples in its database, and **push immediate recommendations** to you **via augmented reality**. If the pedestrian were wearing computer vision-enabled smart glasses, they could receive an alert advising them not to step into traffic.

Other examples: instead of an automotive repairer just getting guidance on the next step in a given repair procedure, they could get **real-time evaluation** of ancillary problems detected by computer vision. A worker crossing a factory floor might be warned of an impending risk—a slippery floor that should be avoided. A surgeon in an operating room might be guided through the process and **advised on the best way to address the unpredictable variables** that are likely to arise. It might even take into consideration the individual patient's genetic background and health history.



As individual disciplines, augmented reality and artificial intelligence both have valuable applications in the broad P&C claims ecosystem today, but we're a long way from realizing their full potential. I suspect that when combined, the real-world applications for the two technologies will far surpass anything I've imagined here.



Auto Casualty Medical Price Index

By Ed Olsen

Director, Claims Performance Consulting, Mitchell Casualty Solutions



The unit cost for major radiology services decreased 4.85 percent in Q2 2017 from Q1 2017.

The National CPI for All Services, as reported by the Bureau of Labor Statistics in August 2017 is 120.9, which reflects a 1.7 percent decrease since Q1 2017. For the same period of time, Q1 2017 to Q2 2017, the National Auto Casualty MPI decreased 0.76 percent and as of August 2017, sits at 119.5. Since Q1 2006, the MPI has increased 19.5 percent while the National CPI for All Services increased 20.9 percent.

- Charges associated with physical medicine services remained virtually unchanged having experienced a 0.05 percent decrease from Q1 2017 to Q2 2017. Physical medicine has seen a 4.9 percent increase in unit charge since Q1 2006. Please recall that the physical medicine MPI

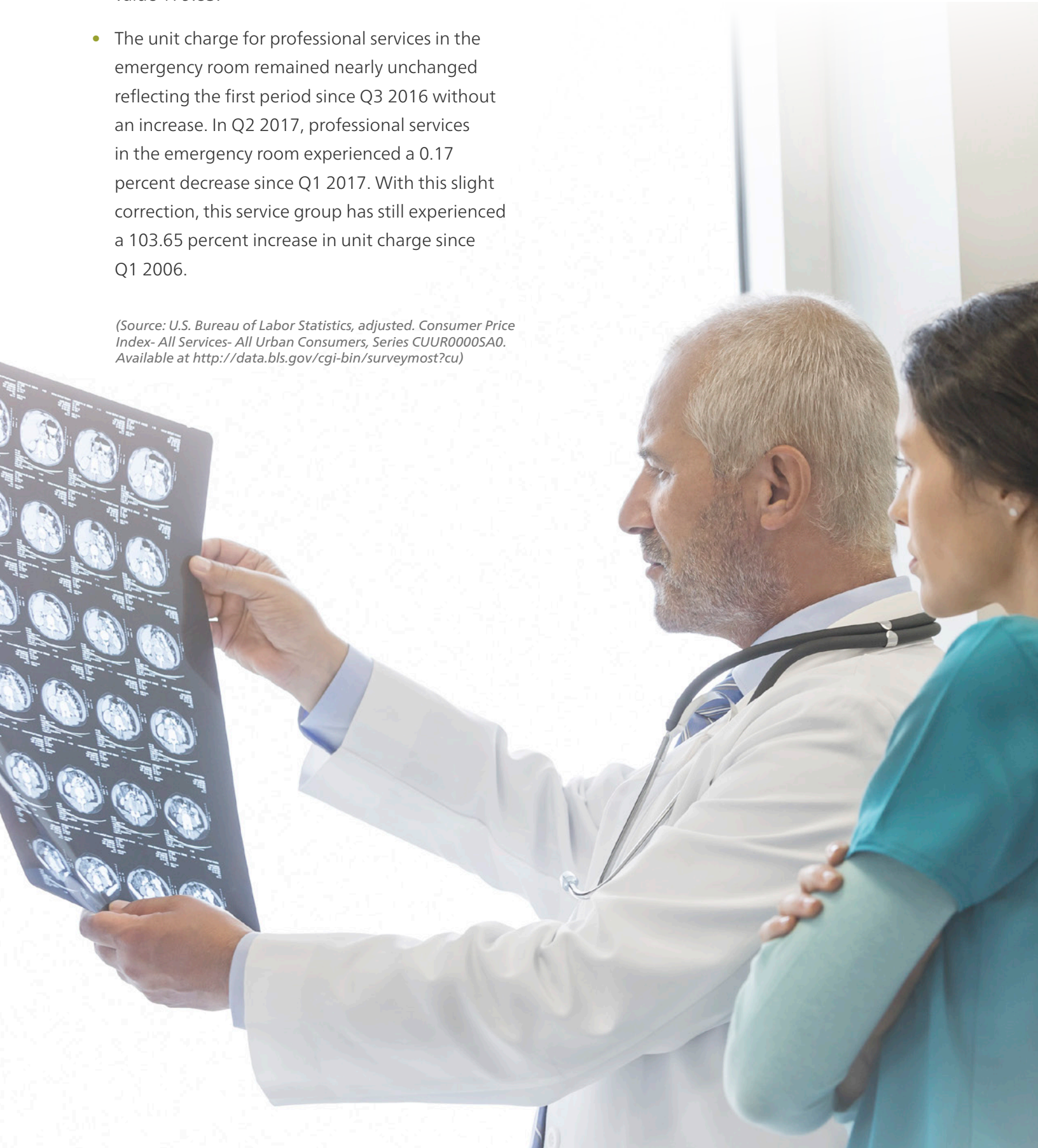
is looking strictly at unit charge while holding utilization constant.

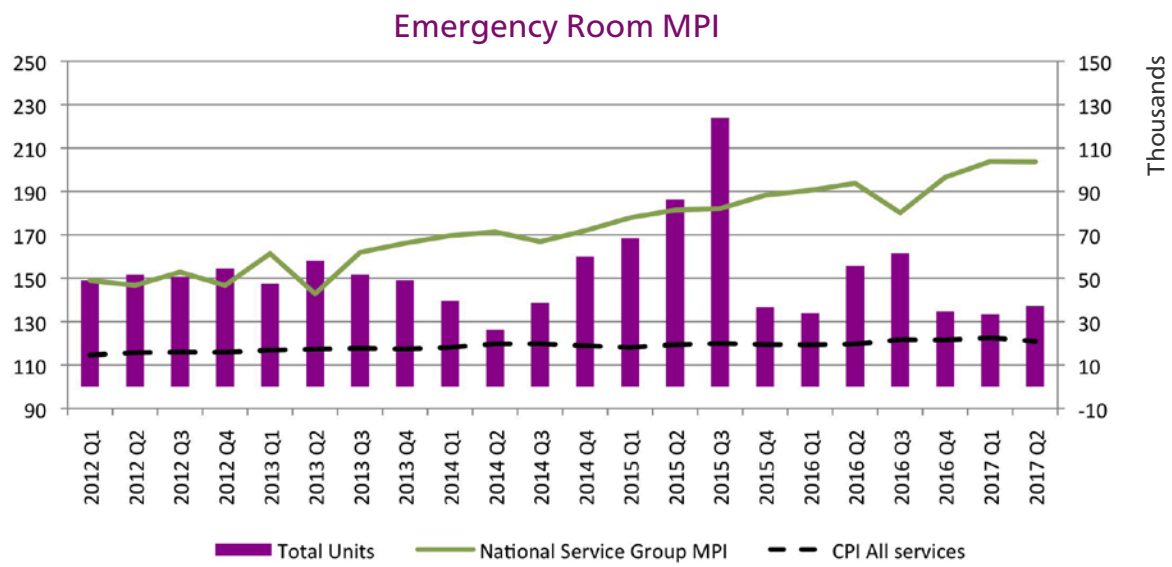
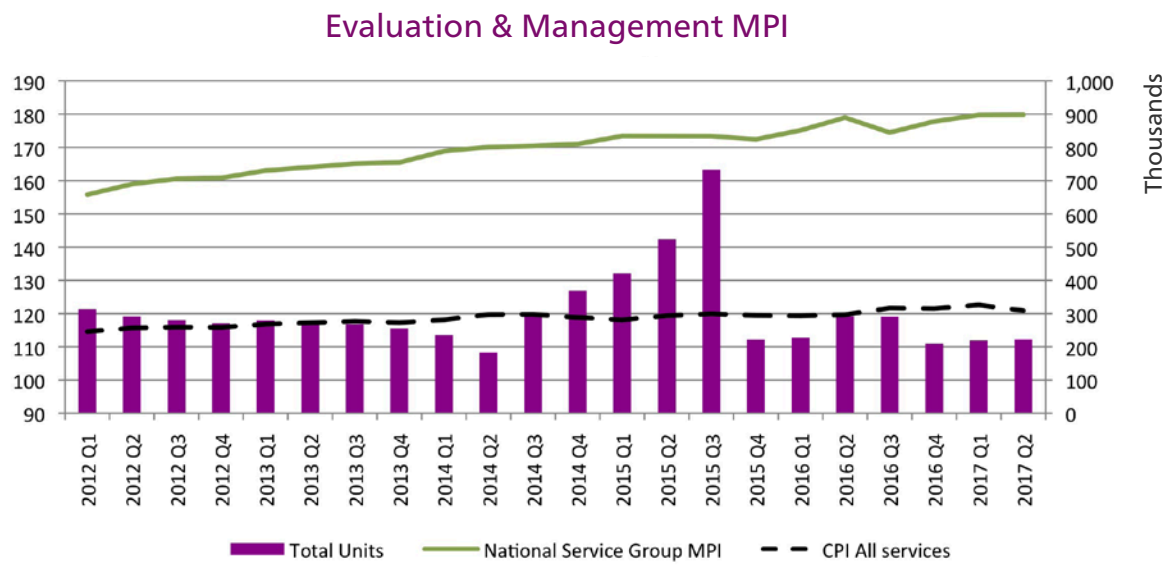
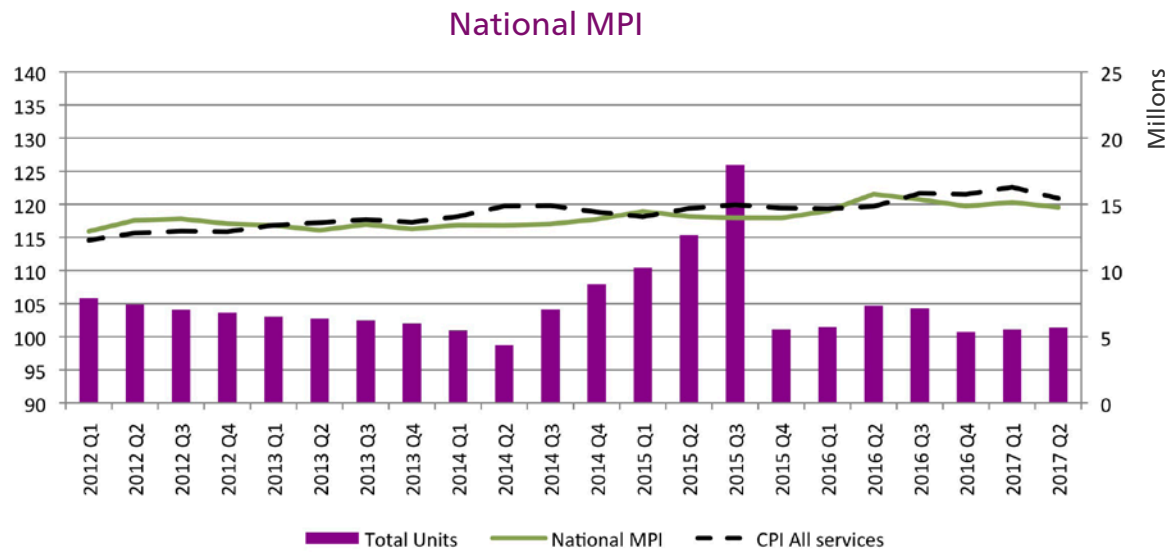
- The unit cost for major radiology services decreased 4.85 percent in Q2 2017 from Q1 2017 and as of August 2017, sits at 121.87. MPI remains 21.87 percent higher than its Q1 2006 benchmark unit charge.
- The unit cost for evaluation and management services remained virtually unchanged having experienced a 0.07 percent increase in Q2 2017 when compared to its Q1 2017 result. Over the past year, comparing Q2 2016 results with Q2 2017 results, the unit charge associated with evaluation and management services has increased 0.85 percent. Since Q1 2006, evaluation

and management services have seen unit charge increase 79.76 percent as reflected by the index value 179.83.

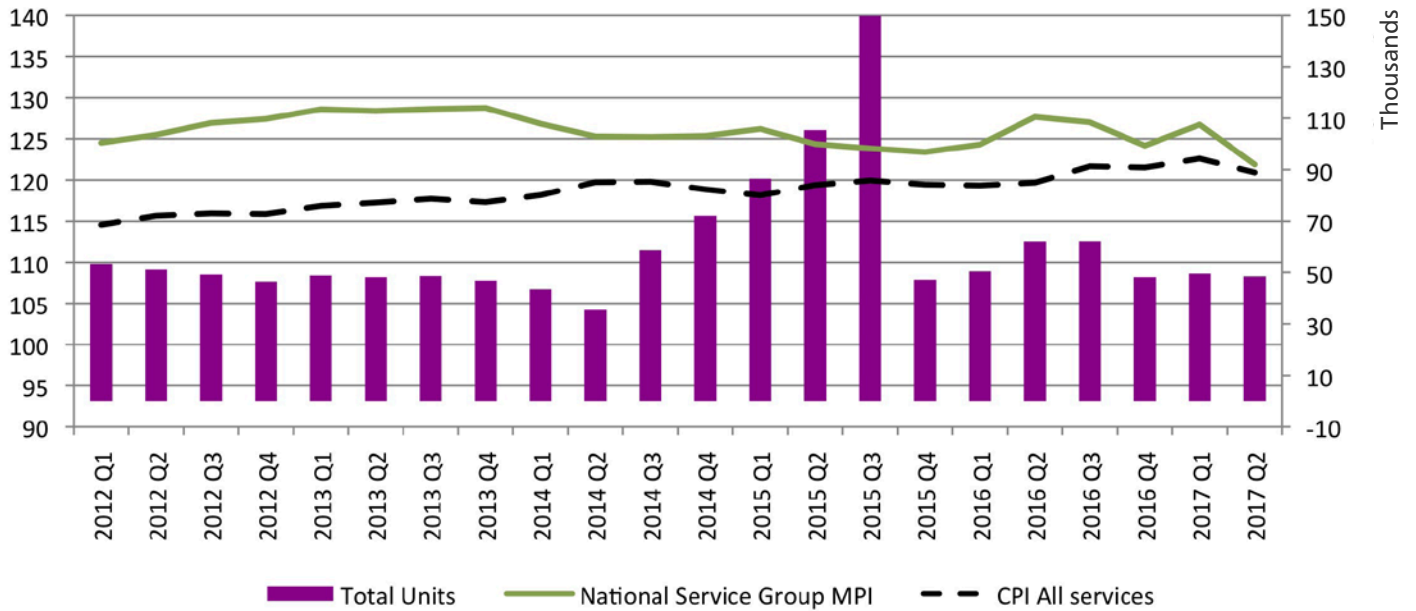
- The unit charge for professional services in the emergency room remained nearly unchanged reflecting the first period since Q3 2016 without an increase. In Q2 2017, professional services in the emergency room experienced a 0.17 percent decrease since Q1 2017. With this slight correction, this service group has still experienced a 103.65 percent increase in unit charge since Q1 2006.

(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>)

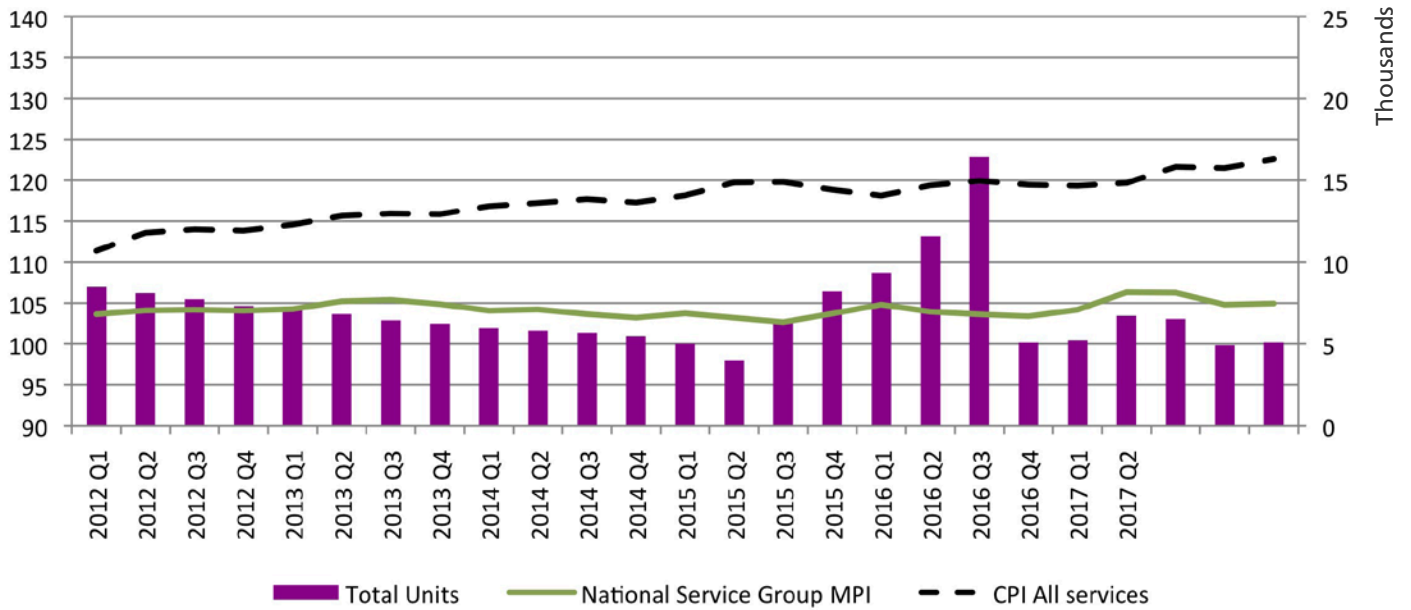




Major Radiology MPI



Physical Medicine MPI



Workers' Compensation Medical Price Index

By Ed Olsen

Director, Claims Performance Consulting, Mitchell Casualty Solutions



Since Q1 2006, the MPI has increased 10.7 percent while the National CPI for All Services increased 20.9 percent.

The National CPI for All Services as reported by the Bureau of Labor Statistics in August 2017 is 120.9, which reflects a 1.7 percent decrease since Q1 2017. For the same period of time, Q1 2017 to Q2 2017, the National Workers' Compensation MPI decreased 2.8 percent and as August 2017, sits at 110.7. Since Q1 2006, the MPI has increased 10.7 percent while the National CPI for All Services increased 20.9 percent.

- Charges associated with physical medicine services experienced a 2.04 percent increase from Q1 2017 to Q2 2017. This increase brings the total unit cost change for physical medicine since Q1 2006 to 6.1 percent – significantly below the National CPI for All Services reported by the

Bureau of Labor Statistics. Please 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 a 6.9 percent increase in Q2 2017 when compared to Q1 2017; it remains below the average unit charge seen by the industry in Q1 2006.
- The unit cost for evaluation and management services decreased 9.01 percent in Q2 2017 when compared with its Q1 2017 result. Over the past year, comparing Q2 2016 results with Q2 2017 results, the unit charge associated



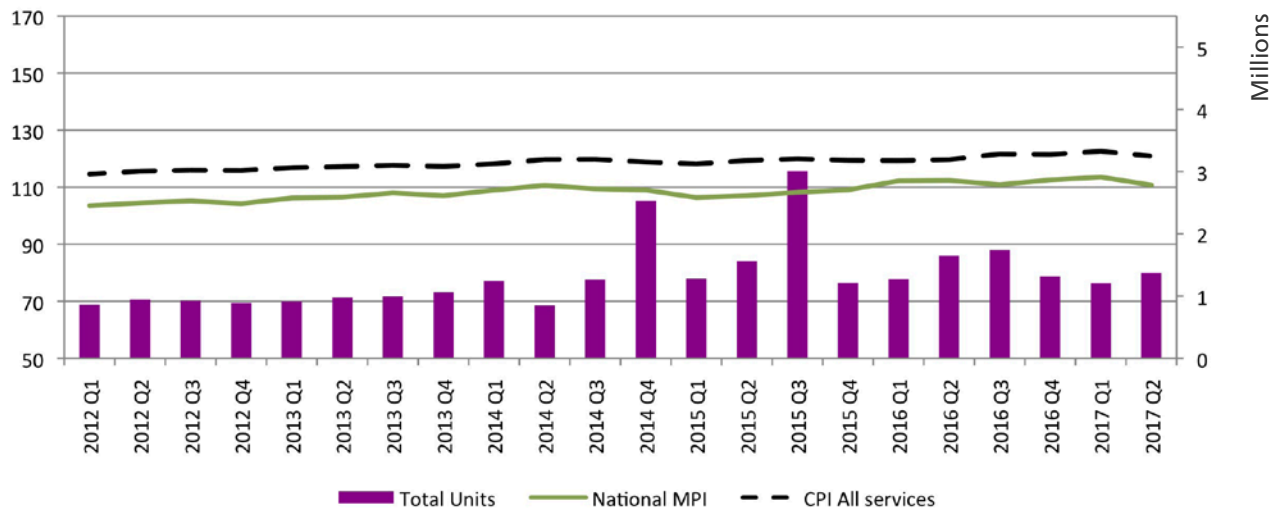
with evaluation and management services has increased 2.01 percent. Since Q1 2006, evaluation and management services have seen unit charge increase 30.7 percent as reflected by the index value 130.7.

- The unit charge for professional services in the emergency room experienced a 5.63 percent decrease in Q2 2017 when compared to Q1 2017. Despite this decrease, the index remains 67.8 percent higher than the Q1 2006 unit charge benchmark.

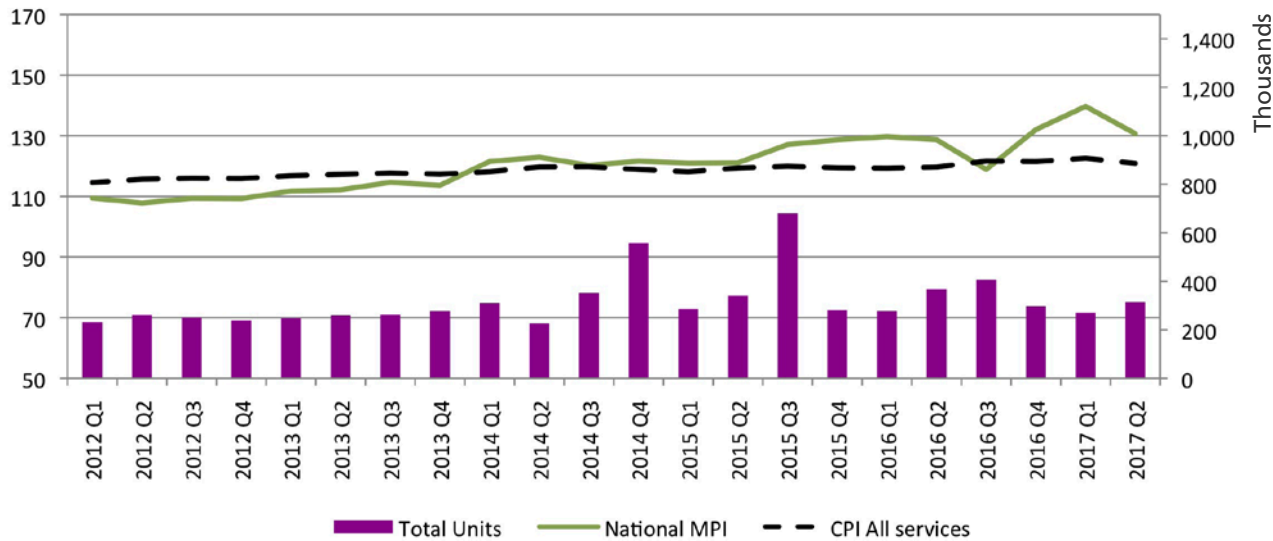


(Source: U.S. Bureau of Labor Statistics, adjusted. Consumer Price Index- All Services- All Urban Consumers, Series CUUR0000SA0. Available at <http://data.bls.gov/cgi-bin/surveymost?cu>)

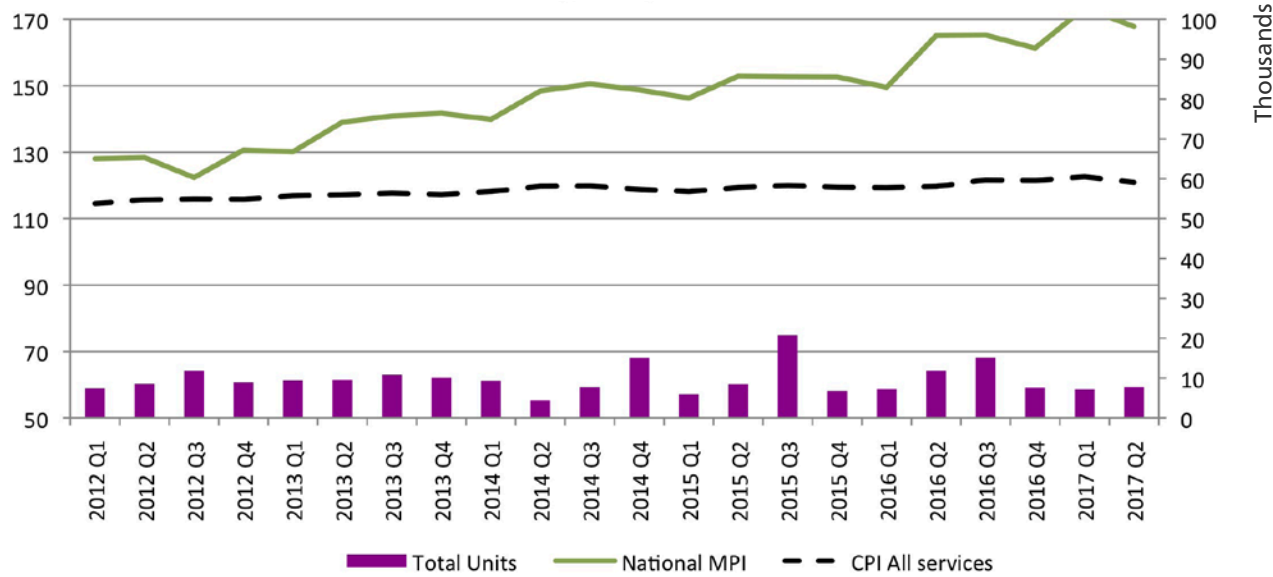
National MPI



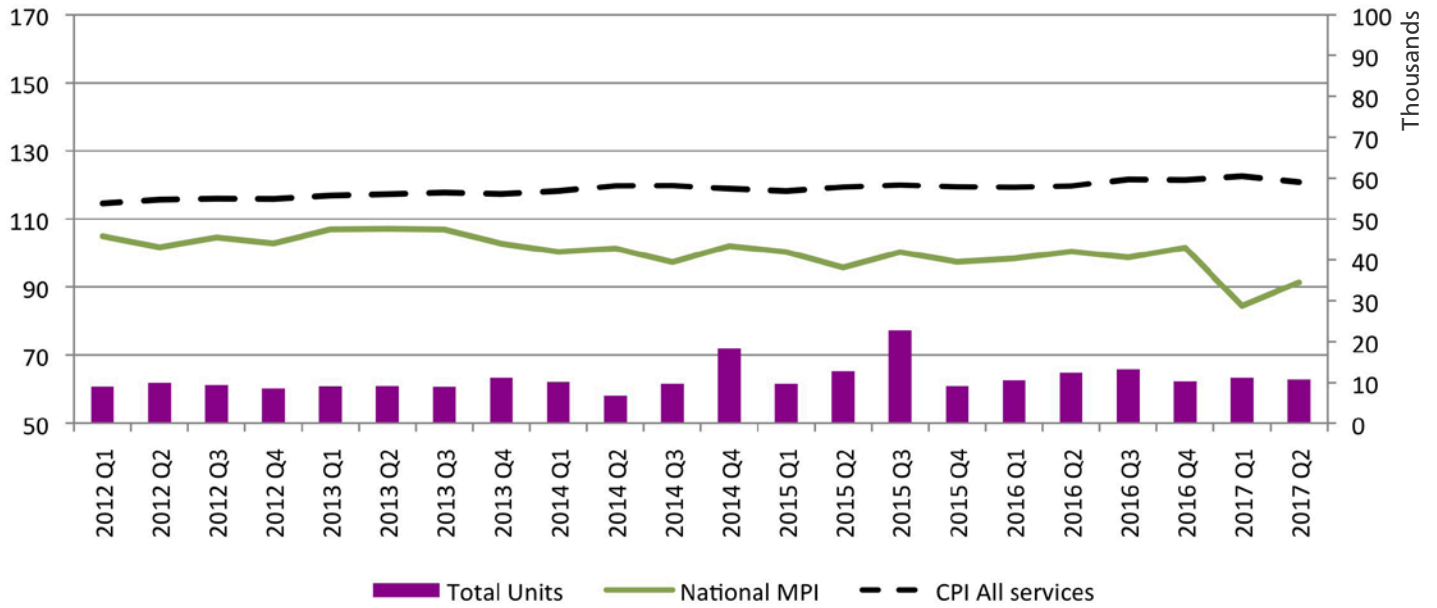
Evaluation & Management MPI



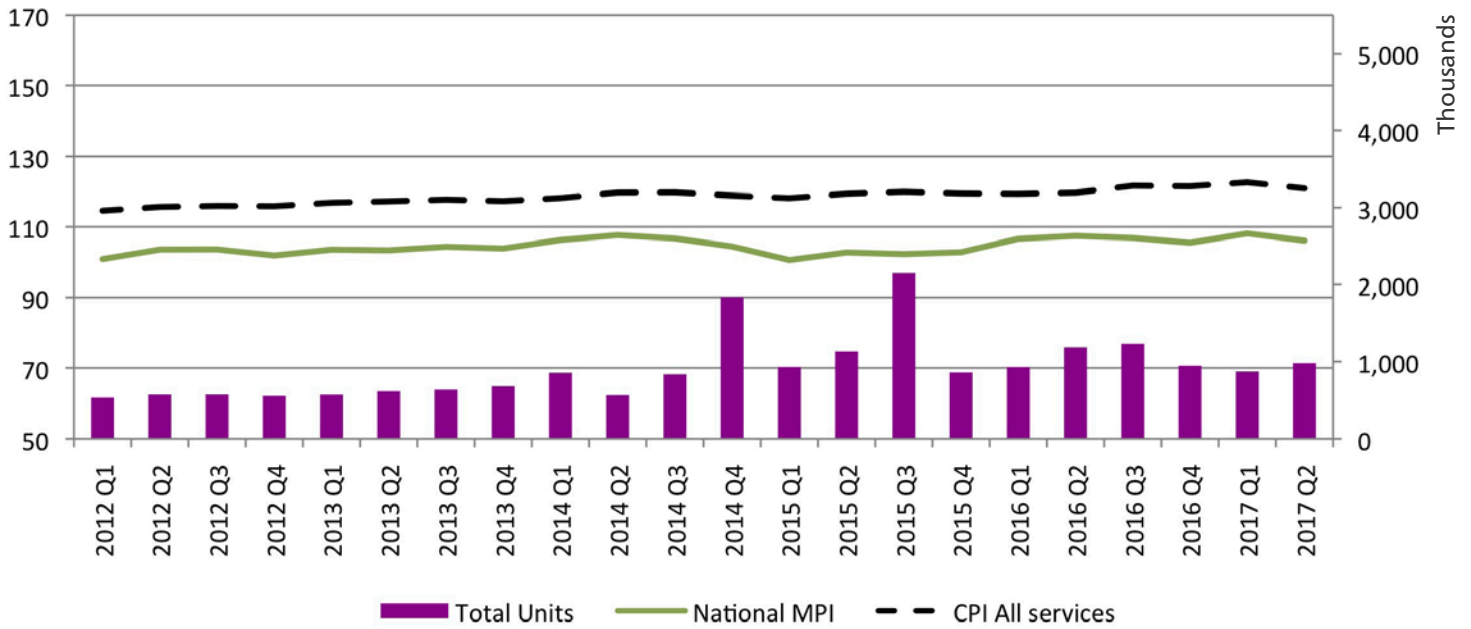
Emergency Room MPI



Major Radiology MPI



Physical Medicine MPI



An Untapped Opportunity

How to Settle Unrepresented Third Party Claims Quickly and Easily

By **Monica Zylstra**

Vice President, Service Operations, Mitchell Casualty Solutions



A negotiation service can help insurance carriers get impactful results quickly without changing workflows or adding additional tasks to their adjusters' plates.

This article is part of Mitchell's third party blog series!

Each month, Mitchell publishes a blog post on a different topic related to third party claims 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.

Here's a familiar scenario: A driver gets rear-ended and bumps her head. The driver, like many others who are injured in auto accidents, makes a visit to the emergency room for treatment. Fortunately, the claimant was not seriously injured in the accident, but has acquired medical expenses from the ER visit and additional ongoing treatments for her injuries. After receiving treatment, she contacts the other driver's insurance carrier for reimbursement. The insurance carrier pays her a lump sum for the expenses she incurred. Now, it's up to the insurance carrier to pay her medical bills.

This is where the story starts to differ depending on an insurance carrier's method for handling third party auto casualty claims when the claimant is not represented by an attorney. Typically, insurers take one of three paths to settle these unrepresented claims, each of which lead to different results:

- 1. PAY IN FULL: Pay the bills related to the claim at the full price charged by the treating medical providers.**

In this case, a carrier usually ends up paying more than a fair price for the treatments rendered.

2. ADJUSTER NEGOTIATION: Rely on adjusters to negotiate directly with the provider.

In this case, insurance carriers bog down their adjusters and take away precious time where they could be focusing on their core duties. In addition, they often get inconsistent results, since it is difficult for management to drive consistency when adjusters are not skilled or trained in provider negotiation best practices.

3. PARTNER WITH THE EXPERTS: Partner with a negotiation service that leverages a wealth of data, expert negotiators, and a history of successful provider negotiations for third party claims, specifically facility bills.

In this case, an insurance carrier that chooses to use a negotiation service will have the most success in paying the fairest price consistently without disrupting their workflow or putting extra, time-consuming tasks on their adjusters' plates. This is the ideal way carriers should handle unrepresented third party claims to save on both hard and soft costs.

Why Partner with a Negotiation Service?

Impactful Solutions and Results

Choosing the third path, which leverages the services of expert negotiators who negotiate directly with providers on unrepresented third party claims, can positively impact insurance carriers' outcomes—20–30 percent savings on average according to Mitchell's negotiation data. That can make a significant difference, especially for carriers that weren't previously successfully negotiating on unrepresented claims.

Specifically, a negotiation service can be very successful in negotiating facility bills. As an example, in a span of six months, Mitchell's negotiation

service successfully negotiated more than 3,000 facility bills from third party claims on behalf of auto insurance carriers. On average, each bill amounted to \$3,500 in charges. Mitchell's expert negotiators were able to secure an average savings of \$800 per bill – that's about \$3 million in total savings from the original charged amount.

According to Mitchell data, there has been a significant increase since 2010 in claimants seeking emergency room treatment. As more and more claimants go to the emergency room, insurance carriers should have effective methods in place to make sure they can get the fairest price on these and other types of facility bills.

Easy Implementation & A Simple Workflow

Sometimes, adding a new solution to an insurance carrier's claims processing workflow can pose many challenges and difficulties, like long implementation processes and high IT costs. A negotiation service doesn't come with any of those issues—it is very easy to implement and has significantly less start-up costs. Negotiators can help insurance carriers get impactful results quickly without changing workflows or adding additional tasks to their adjusters' plates.



Smarter Solutions for Third Party Claims

Technology, data and expertise guiding you at every step



Here is a simple example of how a negotiation service can simply and easily fit into an insurance carrier’s workflow:

- The adjuster sends a claim (a single bill or group of bills) to the negotiation service by leveraging existing integrations or through a simple web portal, customized to what fits best for the carrier’s workflow.
- The negotiation service successfully negotiates the bill(s).
- Adjusters receive the negotiated bill(s) back to them in their adjuster workspace in a timely manner.
- The adjuster arranges for payment of the bill(s) at the negotiated price.

Choosing a Negotiation Service

When it comes to choosing a negotiation service, it’s important to remember that not all are equal. In order to get the best results, there are three main areas to consider when choosing a negotiation service: data, technology and expertise.

Data

A powerful, successful negotiation service is backed by data. A wealth of data can provide invaluable insights that can not only save time in the negotiation process, but also show negotiation patterns. Ideally, a negotiation service should have a history of working with almost every provider in the country and have records on the process and outcome of each negotiation. This type of data provides insight to negotiators in advance of provider outreach. For example, the negotiation service should keep track of who the correct contact is at each facility, if a certain provider is typically more difficult to negotiate with and many more characteristics of how past negotiations went with each provider. By having this type of information in advance, negotiators can use different tactics and methods that can lead to more successful negotiations.

Technology

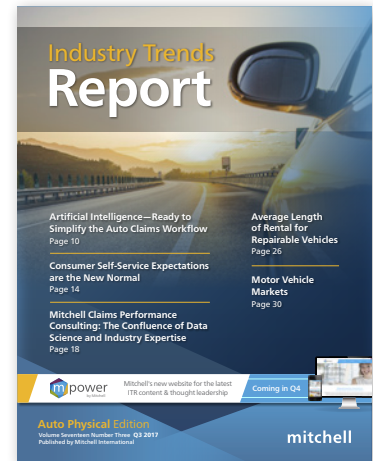
A robust technology platform takes all of the data a negotiation service collects and makes it actionable. Each negotiator should work out of a technology solution that collects, analyzes and displays the most important data and history on each provider to help with the negotiation process. This type of technology helps keep turn-around times low and make negotiations successful.

Expertise

The third key to a successful negotiation service is expert negotiators with a history of results. Negotiators should be trained in best practices and have experience calling providers on a daily basis and building relationships with the provider market. This type of expertise results in better and more consistent outcomes for the insurance carrier.

By choosing both to negotiate third party unrepresented claims and to use a negotiation service to do so, insurance carriers are filling a major gap in their claims process. A negotiation service helps carriers get better results on unrepresented claims quickly without disrupting workflows or adding to their employee's already-full workloads.

View the Auto Physical Damage Edition



The Opioid Epidemic

Setting Changes for Drug Testing

By Jackie Payne

Vice President, Medical Management Services, Mitchell Casualty Solutions

By Suzette Price

Director, Utilization Review, Mitchell Casualty Solutions



Although further clinical studies are needed to standardize best practice for UDS utilization, we know much more about opioid pharmacology and analysis now than we did 10 years ago because of the growth in pain management UDS.

According to the Centers for Disease Control and Prevention (CDC), in 2014, more than 28,000 people died of opioid overdoses, 129 people every day as a result of drug poisoning, and 61 percent are pharmaceutical opioid or heroin related.¹ High-profile deaths from opioid overdose have brought into the headlines obscure words from our world—fentanyl, hydrocodone, buprenorphine, quantitative mass urine assay, genetic dependency analysis and liquid chromatography-mass spectrometry. High complexity urine drug screening (UDS), once limited to specialized laboratories, has found a home in physicians' office laboratories and at both large and small commercial laboratories specializing in UDS to support pain management and substance abuse treatment. So it is no surprise that carriers, adjusters and patients can be overwhelmed when facing decision making about UDS.

Some have commented on the conundrum of regulating screening for pain management UDS, as it straddles the divide between medical and legal requirements for management of a workers' compensation claim. Further complicating the picture, revenues for some UDS laboratories soared in the last decade. This in part was due to a disconnect between the capability of modern technology to rapidly quantify multiple drugs and metabolites in a single test versus each drug or drug class reported.

This growth in spending on UDS caught the eyes of both regulators and the public. In 2014, The Wall Street Journal reported that Medicare's spending on 22 "high-tech" tests for drugs of abuse hit \$445 million in 2012, up 1,423 percent in 5 years.² In October 2015, the U.S. Department of Justice

announced that Millennium Health, one of the largest UDS laboratories in the country, agreed to pay \$256 million to resolve alleged violations of the False Claims Act for medically unnecessary urine drug and genetic testing.³

In response, the Centers for Medicare and Medicaid Services (CMS) in the last 2 years made big changes to drug testing codes that are expected to decrease reimbursement.⁴ According to CMS, the agency does not recognize the 2015 American Medical Association current procedural terminology code changes for UDS because of “our concern about the potential for overpayment when billing for each individual drug test rather than a single code that pays the same amount regardless of the number of drugs that are being tested.”⁵ CMS has disallowed billing for multiple, individual, quantitative drug tests/sample using definitive methods (mass spectrometry) and substituted instead just four definitive method G-codes based on the number of drug classes reported either qualitatively or quantitatively.

The CMS recently changed codes for UDS from 80101 to G0431 due to excessive use of UDS and abuse. The new G-code is defined as “drug screen, qualitative; single drug class method (e.g. Immunoassay, enzyme assay) each drug class” and excludes chromatography.⁶ An example of

reimbursement by CMS for CPT code G0431 at POC is \$160. This may vary for state fee guidelines and/or geographic location. CMS has revised G0431 such that now it may be billed only once per patient encounter, regardless of the number of drug classes tested.

In March 2016, the Centers for Disease Control and Prevention (CDC) also weighed in on UDS in its Guideline for Prescribing Opioids for Chronic Pain. CDC includes a recommendation for UDS but with an evidence grade 4, the lowest level. Furthermore, the CDC guideline notes that UDS “does not provide accurate information about how much or what dose of opioids or other drugs a patient took. The clinical evidence review did not find studies evaluating the effectiveness of urine drug screening for risk mitigation during opioid prescribing for pain.”⁷ Although further clinical studies are needed to standardize best practice for UDS utilization, we know much more about opioid pharmacology and analysis now than we did 10 years ago because of the growth in pain management UDS. Missing from all this is a consensus guideline on laboratory best practice for pain management UDS.

Official Disability Guidelines (ODG) indications for UDS include testing at the onset of treatment of a new patient who is already receiving a controlled



substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings; in cases in which the patient asks for a specific drug, particularly if the drug has high abuse potential; the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution; if the patient has a positive or “at risk” addiction screen on evaluation, including evidence of a history of comorbid psychiatric disorder. ODG recommendations for ongoing monitoring only apply if a patient has evidence of a high risk of addiction, including evidence of a comorbid psychiatric disorder, has a history of aberrant behavior, personal or family history of substance abuse or sexual trauma or if dose increases are not decreasing pain and increasing function, but fails to establish the specific frequency or type of testing necessary for ongoing testing.

Conversely, American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines indicates the initial evaluation and treatment plan will not necessarily require urine drug monitoring to ascertain that the prescribed medication is being used, since the use of opioids should generally be short-term, and supports a focus on risk screening for addiction instead. However, Timeframes for UDS in patient’s considered for long term opiate use are recommended to undergo random urine testing, with frequency of testing being at least yearly or more often as needed.

Here at Mitchell, in the first two months of 2017, we have averaged at least five reviews a day inclusive of UDS related to opiate use, with more than half being approved. Almost 40 percent of those approvals are driven by adjuster level decisions. However, 40 percent of requests for UDS are on claims that are more than five years old and 60 percent of requests

for UDS are on claims that are more than two years old. None were for claims with dates of injury within the last 90 days, the target timeframe to establish expectations and best practices around opiate use.

There remains significant controversy as to whether some well selected and carefully monitored patients with chronic pain experience improved function, meaningful pain relief, and improved quality of life from opioid therapy. For others, opioid treatment

Because substance abuse disorders are not uncommon, UDS should be considered a core clinical tool in primary care as part of a comprehensive risk management strategy.

may result in misuse, abuse, and may not improve function. Therefore, proper prescribing of controlled substances is critical to patients’ health and to safeguard society against abuse and diversion. A number of organizations and agencies have developed recommendations and guidelines that include the use of UDS as a tool to assist clinicians to responsibly prescribe opioids when managing chronic pain; for example, clinical practice guidelines for chronic pain management published by the American Pain Society/American Academy of Pain Medicine and the Department of Veterans Affairs/Department of Defense include a provision for UDS. However, neither guideline provides instruction for how UDS should be performed in clinical practice, nor how to interpret UDS results. In addition many state medical boards/agencies have developed policies or guidelines that require or suggest the use of UDS in certain situations.

Despite potentially serious outcomes from UDS for pain patients (e.g., dismissal or changes to the treatment plan), clinicians often lack training in the use of UDS, and UDS is often underused or used inappropriately in clinical practice. Before ordering UDS, clinicians should understand methods of testing, the potential benefits and limitations of UDS, and how to interpret results, so that they can rationally employ patient-centered UDS in clinical practice. UDS can be an effective tool for clinicians in the assessment and ongoing management of patients who:

- Will be, or are being, treated over the long term with controlled substances, including opioids for chronic pain.
- Are at increased risk for substance-use disorders.
- Have other relevant medical conditions or diagnoses.

Because substance abuse disorders are not uncommon, UDS should be considered a core clinical tool in primary care as part of a comprehensive risk management strategy. The clinician can use UDS to help motivate patient behavioral changes and maintain healthy changes that have already been made. However, testing without an appropriate strategy for frequency and interpreting results can do significant harm and drive increased cost without significant improvement on the patient or the claim resolution. Repetitive UDS for the sake of monitoring adds little value. Clinicians must be aware of the limitations of UDS, and not rely on test results alone to make irreversible patient care decisions or decisions that have other potentially negative ramifications for the patient. Most importantly, a clinician should strive for a relationship of mutual trust and honesty with the patient when using UDS in his or her clinical practice. Ideally, the use of UDS should be a consensual process between clinician and patient that is designed to assist in managing patient care and empowering better outcomes.

Sources:

¹ <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>: "Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014", *Weekly*, January 1, 2016 / 64(50);1378–82

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³ <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>: CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, *Recommendations and Reports* / March 18, 2016 / 65(1);1–49

⁴ <https://www.aacc.org/publications/cln/articles/2016/august/qanda-urine-drug-testing-for-monitoring-compliance-with-prescribed-opioids>

⁵ <https://www.aacc.org/publications/cln/articles/2016/august/qanda-urine-drug-testing-for-monitoring-compliance-with-prescribed-opioids>

⁶ https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30574_2/G0430_codeguide.htm

⁷ <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

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<https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>: "Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014", *Weekly*, January 1, 2016 / 64(50);1378–82

<https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>: "Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014", *Weekly*, January 1, 2016 / 64(50);1378–82

Data with Depth

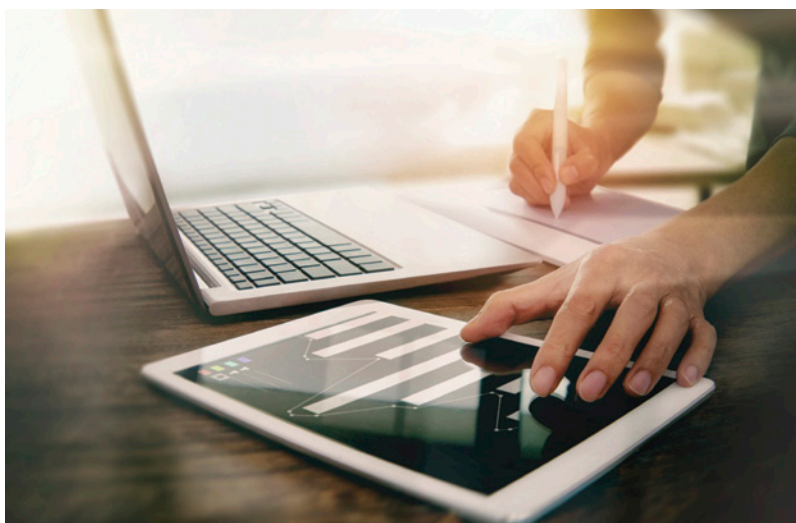
Combining Data Analytics with Expertise to Optimize Claims Performance Management

By Michele Hibbert-Iacobacci, CCSP, OHCC

Vice President, Information Management & Support, Mitchell Casualty Solutions

By Ed Olsen

Director, Claims Performance Consulting, Mitchell Casualty Solutions



Faster and better insights will give insurers the ability to interpret what is going on in their claims processes and claim population.

For insurance carriers, finding ways to capitalize on the growing volume and velocity of information being generated and collected in their claims systems and operational databases is a critical challenge. Today's overabundance of data can be an asset. However, without the professional expertise to turn this disparate data into actionable optimization and measurable intelligence, the data is powerless.

Since property and casualty is a dynamic and consistently evolving industry, carriers are discovering the need to boost the results from targeted claims data analytics by combining the data with a consultative approach to claims management. The potential advantages to be

gained from this convergence are substantial, ranging from the pure economics to the ability to outperform in your industry.

But getting it right is the key. That's why it is vitally important for insurance carriers and organizations in the property and casualty space to acquire the available tools, techniques and personnel with breadth of knowledge and expertise to leverage the vast amount of data effectively—or risk potentially losing millions of dollars in revenue. The power-inspired combination of data and expertise changes the information landscape to help carriers strategize for optimal outcomes and stay a step ahead of foreseeable industry changes based off trending data.

The Stress Created by the Explosion of Information Into Big Datasets

First, let's define big data. Big data is "extremely large data sets that may be analyzed computationally to reveal patterns, trends and associations, especially relating to human behavior and interactions." The insurance industry is rich in data, and the claims arena is no exception. As the industry collects huge amounts of data on each claim, all of that information becomes a resource for ongoing discovery and analysis. However, big data on its own, with its increasing volume and variety, can stress any carrier's data processing operation, preventing any kind of effective use of it.

Relieving the Stress: Infuse Human Expertise Into Your Big Data for Results

It is quintessential to see not only carriers, but many other companies as well, proactively integrating analytics-fluent expertise into their big data. Being able to leverage and interpret these datasets increases the value of professional experts and consultants who know how to drive the value of large medical claims data that exists, to identify untapped opportunities leading to claims management efficiencies and an effective overall cost-containment strategy.

If we want to capitalize on the data available to us, we need to match it up with human insight. Having the right personnel performing data analysis—and taking the next step to communicate the results they find in a clear, concise narrative form—is the way to truly cultivate new opportunities and benefit from the data available.

The Critical First Step: Unlock the Powers of Two by Combining Data Analytics With Expertise

The marriage between the two facets, data and expertise, relative to the property and casualty industry, is a powerful union that helps carriers optimize claims performance management by being able to:



- Assess and influence claims processes at the most critical point, providing a proactive and impactful analysis



- Offer litigation support



- Analyze and reveal meaningful patterns and trends



- Identify fraudulent activity and behavior



- Develop additional tools and intellectual properties through uncovering problems within the data and presenting it with corrections

Leveraging Data and Expertise to Assess and Influence Claims Processes

Faster and better insights will give insurers the ability to interpret what is going on in their claims processes and claim population. Together, data and expertise improves their speed in identifying previously hidden correlations and untapped opportunities to respond quickly to potential challenges. A carrier that can respond faster than its peers to emerging trends or consistently pursue untapped opportunities will significantly improve claims results over the long term. This suggests that the ability to identify and capture untapped opportunities over time can be a source to gaining a competitive advantage.

A claims optimization example: one customer's path to better business outcomes

In this case, Mitchell's Claims Performance Consulting analytics were used to optimize Mitchell's medical bill review application in a Personal Injury Protection (PIP) state. The Mitchell team was asked to analyze a company's performance and compare it to others in

The company saw an 18 percent improvement by implementing our recommended changes.

the same industry and market. The team reviewed the functionality of the products that the company was using, then compared the company's results to overall industry experiences based on the large data repository. What they found was that the trend and best practices for bill review options in that state were not being leveraged to the company's advantage. Our data consulting and analysis allowed us to affect the customer's results by providing the right solutions down to the state and regional areas of the country and address the challenges one company is experiencing over the industry. As a result, the company saw an 18 percent improvement by implementing our recommended changes.

Leveraging Data and Expertise to Reveal Meaningful Patterns and Trends in Data

Data and expertise by themselves cannot create a game changer. It takes the right combination of talented, experienced and analytic personnel to effectively reveal meaningful patterns and trends and interpret them in ways to make them actionable intelligence for others.

A fraud revealing example: leveraging data and expertise to identify fraudulent activity and behavior

Possibly the most popular use for data insights and analytics is in identifying a claim's potential for fraud. We recently had the opportunity to have a roundtable session with a group of surgeons. During the course of discussion, one of the surgeons mentioned that he regularly billed his surgery procedure codes several weeks after the procedure was performed and well after all of the global surgical follow-up periods were completed. He explained that he did this simply as a record-keeping process. A conversation like this encountered by someone less familiar with correct coding (i.e., claim adjuster) may have been dismissed as nothing more than a quirk in the provider's workflow. Luckily, the conversation was part of a consultative discovery meeting attended by our consultation team. Documenting the provider's statements, they thought to initiate a detailed investigation of claim data to discover if this provider's strange workflow was unique or widespread and whether this practice adversely affected claim severity.

According to National Correct Coding rules, follow-up office visits performed during a global follow-up period are included in the surgical procedure and should not be reimbursed separately. The length of the global follow-up period is specific to the surgical procedure code and based on the surgery's level of complexity. When providers bill in a manner consistent with date of service, it is easy to see that a surgery was performed and that a global follow up period should be applied. However,

when the provider bills out of date of service order, the application of this simple rule becomes much more difficult. An investigation into provider billing patterns as they relate to surgery revealed that this provider's unique billing workflow was anything but unique. These patterns of billing surgical follow-up visits prior to the surgery are wide spread and accounts for several million dollars of billed services.

We were able to enhance our product and add a functionality that can help catch fraud.

In this case, it was our medical experts on the team that detected fraud and leveraged our data and analytics to ultimately develop additional tools in order to uncover potential future problems within the data and present it with corrections. The outcome of the story was that we were able to enhance our product and add a functionality that can help catch fraud.

Your Path to Optimized Utilization of Data and Expertise

Tools are now available to help shine a light on important issues within the property and casualty industry. Utilizing data analytics, coupled with the deep industry experience and consultative guidance, provides the opportunity to optimize claims to achieve greater efficiencies and effectiveness. There's value in having outside personnel with deep industry expertise assess your claims and compare results with industry benchmark data and data analytics. The process can result in greater efficiencies and effectiveness throughout all your business processes. Leveraging a consulting partner who works shoulder-to-shoulder with you to help reach the next level of claims management is often best suited to help enable an insurance carrier find answers in data they did not know previously existed.

About the Cover Story author...



Michele Hibbert-Iacobacci, CCSP, OHCC

Vice President, Information Management and Support, Mitchell Casualty Solutions

Michele Hibbert-Iacobacci's responsibilities include managing the Health Information Management Group, Regulatory Compliance, Litigation Support, Professional Services and Consulting within Mitchell's Casualty Solutions Group. Ms. Hibbert-Iacobacci spent 10 years working with Inpatient and Outpatient medical billing and reimbursement on the provider side, working at four different, large inpatient facilities as a Coding and Reimbursement Manager. She spent 10 years as President of GRG Associates, working with outpatient providers consulting on proper coding and reimbursement for outpatient medical offices. Ms. Hibbert-Iacobacci worked with the National Academy of Science as Chief Nosologist facilitating major studies for congress to enable veteran benefits. For the past 30 years, Ms. Hibbert-Iacobacci's focus has been working with major casualty insurers in implementing rules committees, quality assurance, risk management, compliance programs and review processes necessary in delivering objective bill review systems. Ms. Hibbert-Iacobacci is a Certified Clinical Coding Specialist (CCS-P), an Officer of Healthcare Compliance (OHCC) and a member of the American Health Information Management Association (AHIMA) and American Institute of Healthcare Compliance. Ms. Hibbert-Iacobacci has authored many articles on insurance fraud, analytics, training, claims processing and ICD-10 implementations.

Three insights and best practices for any insurer who decides to engage with claims consultants with readily available data:



Develop an analytics-driven culture from the outside in

Carriers don't have the breadth of data to see trends going on in the industry, or within the scope of their claims operations for that matter. They only see what's going in their own house.



Have a conversation

What it really comes down to is engaging in a conversation. If you have the slightest inkling of an anomaly, or if you have a suspicion, but you can't put your finger on it, talk to a consultant. Let them ask you the questions that will identify where the research needs to go. There are no wrong questions in conversations like these. You hear this often, but asking questions can help uncover new opportunities and reveal leakages in the data that you may not be familiar with.



Engage with a consultant in ongoing, multiple intervals

It's a matter of going back and revisiting the data often. When recommendations are implemented, you should also implement ongoing monitoring of the changes so they can continually be optimized. You should be monitoring the data consistently to see if new trends are developing, make adjustments and proactively manage the processes.



Conclusion

The competitive edge to be gained from the combination of data analytics and expertise is vast. Carriers that commit to making the most out of a partner with the power of two are already ahead of the curve. A wait-and-see attitude is a comfort that competitive companies may not be able to afford.

We were able to enhance our product and add a functionality that can help catch fraud.

About the Cover Story author...



Edward H. Olsen, DC, CPCU

Director, Claims Performance Consulting, Mitchell Casualty Solutions

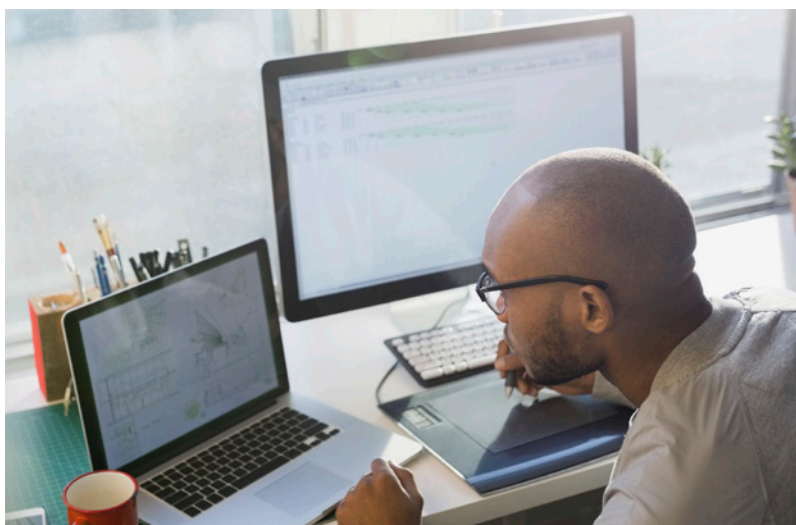
Ed's diverse background as a provider and payor provides a unique perspective to casualty claims, medical management, and automated medical bill review and claim adjudication. Practicing chiropractic in New Jersey for five years afforded ample time to understand auto casualty and workers' compensation claims from both the provider and injured claimants perspective. Subsequent to leaving active practice, Ed worked as a medical trainer and ultimately a claim team manager for a large P&C insurer where additional duties first exposed him to automated medical bill review and the inherent value of the data captured. Since 2003, Ed has been an integral part of the Mitchell team serving several roles working with customers. His most recent role affords him the ability to continually monitor and report industry trends and provider billing behavior in both workers' compensation and auto casualty insurance.

Readily Accessible Compliance-Based Content

Supporting End Users to Make the Right Decision the First Time

By: Michele Hibbert-Iacobacci, CCSP, OHCC

Vice President, Information Management & Support, Mitchell Casualty Solutions Group



Automated alerts and integrated social media channels makes sharing content more efficient.

Property and Casualty insurance carriers have a daunting task when it comes to handling injury claims within the rapidly evolving world of regulatory compliance. As requirements constantly evolve, the number of insurance policies and injury claims an insurer/payor services in each jurisdiction can create an abundance of complex and often-confusing set of rules and regulations to follow.

Moreover, throughout time, both medical bill review and regulatory compliance have become increasingly complex. Long gone are the days of flat-rate pay, percent of charge and other simple reimbursement methods. There are always new regulations

introduced for cost containment and management. Introduction of new rules, statutes and regulations occurs on a state-by-state basis without comparison to other states. Essentially, each state in property and casualty has been referred to as its own country.

As more guidelines are applied, managing large quantities of information has proven to be very challenging. Additionally, ensuring compliance is prompt, comprehensive, accurate and consistent is becoming more and more difficult as state regulators propose and implement an ever-changing series of requirements around bill evaluation and payment. Within property and casualty, payors not only have

to stay well informed of these mandates, but also ensure timely and accurate implementation of process updates to implement required changes in place. Having information and striving for proactive engagement in applying these rules creates a more proficient and streamlined claims operation.

So how can payors stay abreast of the changes and keep up with the regulatory environment?

Through access of a single repository and web-based portal comprising of the most current regulatory rules and jurisdiction-based information.

A web-based portal serves as an organized “single source of truth” comprising all compliance-related information including state regulations, fee schedule administration, bill review rules, state reporting and so on. There are thousands, if not, millions of pieces of information and documents around regulatory changes pertaining to specific states in all lines of businesses and service types. Having a place to find all of this information available at a central location becomes very valuable to payors.

A single repository should allow readily accessible compliance-based content for the end user.

Availability with the most current content 24/7/365 at an end user’s fingertips is important as it is supporting the claims examiner, nurse, bill reviewer and others to provide real-time, accurate data to help make the right decision the first time.

The content should be easily digestible and easy to understand.

Regulations, statutes and legislation can contain ambiguity and subjectivity in the language and rules that accompany not only bill review guidelines but also a majority of compliance-related content.

This can cause confusion or uncertainty for claims payors and others like consumers who depended upon clarity. The information shared needs to translate into easy to read and easy to understand terminology.

Notifications that alert users of important legislative updates and matters.

In the past, many organizations faced the challenge of ensuring content reached customers in the shortest possible amount of time. Automated alerts and integrated social media channels makes sharing content more efficient. Through timely updates, users can gain immediate visibility into the regulatory requirements and environment affecting the property and casualty industry.

About Mitchell Compliance Connection

Mitchell Compliance Connection is a web-based portal that provides Mitchell customers with a comprehensive and central resource for medical bill review information, state administration activity and jurisdictional content.

Through this portal, customers have up-to-date visibility into the ever-changing regulatory environment that affects our industry. Our regulatory compliance professionals are responsible for maintaining the data bank, which provides useful information to customers so that they can be proactive in assessing the regulatory changes that arise.

[Click here](#) for more information about the new Mitchell Compliance Connection portal.

Are Insurers Paying for Marijuana?

By Michele Hibbert-Iacobacci, CCSP, OHCC

Vice President, Information Management and Support, Mitchell Casualty Solutions

Published by propertycasualty360.com



Medical Marijuana is legal in a majority of states, but there still exists a black hole when it comes to claims guidelines for its reimbursements.

The industry is in a haze, and it's from marijuana – legalized medical marijuana. Medical Marijuana is legal in a majority of states, but there still exists a black hole when it comes to claims guidelines for its reimbursements. So many questions and not enough answers.

[Read more.](#)

Easing the 'Return-to-Work' Process for Injured Workers

By Jackie Payne

Vice President, Medical Management Services, Mitchell Casualty Solutions

Published by ClaimsJournal.com

Let's start with defining what the goal of any return-to-work program is: it's to get the injured worker back to their pre-injury condition in a safe and timely manner.



In 2015, the U.S. Bureau of Labor Statistics reported that 2.9 million non-fatal workplace accidents occurred that year. Of this, over 50 percent of the injured workers experienced time lost from work. A number this large obviously eats into a company's productivity, which is why employers and carriers are continuously looking for ways to ensure their return-to-work programs are effective and focused on what's best for injured workers.

Let's start with defining what the goal of any return-to-work program is: it's to get the injured worker back to their pre-injury condition in a safe and timely

manner. Typically, these programs are comprised of all of the accommodations and resources that are needed to facilitate the processes that make up the return-to-work program for injured workers. Employers and insurers generally collaborate to create these return-to-work programs and are responsible for identifying and providing work arrangements that accommodate any restrictions or limitations that may interfere with an injured worker's return to work.

[Read more.](#)

Guest Post: The Workers' Comp Claim Journey—Integrated Solutions Improve Outcomes

By Rebecca Morgan

Senior Director, Product Management, Mitchell Casualty Solutions

Published by WorkCompWire.com



The key to aligning these motivations really boils down to better communication —communication between people and communication between systems.

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.

[Read more.](#)

Unlocking the Powers of Two

By Michele Hibbert-Iacobacci, CCSP, OHCC

Vice President, Information Management and Support, Mitchell Casualty Solutions

By Ed Olsen

Director, Claims Performance Consulting, Mitchell Casualty Solutions

Published by propertycasualty360.com

Carriers are starting to discover that without professional expertise to turn disparate data into actionable optimization and measurable intelligence, data is powerless.



Carriers are starting to discover that without professional expertise to turn disparate data into actionable optimization and measurable intelligence, data is powerless.

With property and casualty being a dynamic and constantly evolving industry, carriers are recognizing the need to boost the results from targeted claims data analytics by combining the data with a consultative approach to claims management. This powerful combination changes the information landscape to help carriers strategize for optimal outcomes and stay a step ahead of foreseeable industry changes based off trending data.

[Read more.](#)

Partner Spotlight— Anthem



Anthem's ever growing network offering includes best-in-class networks

Anthem Workers' Compensation provides industry leading California Medical Provider Network solutions, serving as an exceptional asset to Mitchell's portfolio of cost containment solutions and strategic partners. Anthem leverages advanced technology to provide network strategies, identify top physicians, help optimize care for injured workers, and assesses utilization and treatment trends. Through this partnership, Mitchell is able to extend a network offering that includes the deepest and broadest in California, combined with an outcomes-based care network. Anthem's ever growing network offering includes best-in-class networks in Arizona, Arkansas, California, Colorado, Illinois, Indiana, Iowa, Kansas, Missouri, Nebraska and Nevada. In addition, Mitchell and Anthem are able to collaboratively optimize care for injured workers and offer additional ways to better contain costs.

Managing a Medical Provider Network (MPN) in California can be complicated, but not with Anthem and Mitchell as your MPN partners. We take care of the details so you can spend more time on your business and less time being frustrated. The combination of Mitchell and Anthem offers the following solutions (among others):

- Anthem Premier MPN
- Anthem Premier Plus MPN
- MPN Management Services
- Full Suite of MPN Software Solutions
- Total Compliance Management
- MPN Filing Support
- MAA Appointment Scheduling
- Direct Provider Contracts
- Physician Performance Analytics
- Outcomes Based Networks
- and more

You Get More with Anthem and Mitchell

- Customizable Medical Provider Networks based on one of the industry's largest network resources
- Strong relationship with providers in eleven states (growing and expanding regularly)
- Significant discounts unmatched in the industry
- More data and the analytical know-how to make it actionable
- An outcome-based MPN that's top of the line that's like no other on the market





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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 payors 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

VentureBeat

How Chatbots Can Settle an Insurance Claim in 3 Seconds

VentureBeat included an article by Alex Sun about how artificial intelligence can transform both the customer experience and the claims process for insurance companies.

[Read More](#)

BodyShop BUSINESS

Mitchell Announces Closing of \$70 Million First-Lien Term Loan

BodyShop Business included Mitchell's announcement of the closing of a \$70 million senior secured first lien term loan to continue the track record of investing in technologies and companies that drive better outcomes in the markets we serve.

[Read More](#)

A.M. BestTV

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

A.M. Best TV interviewed Shahin Hatamian at the RIMS conference about how increasing costs of medical treatments are forcing workers' compensation providers to examine better ways to manage overall costs.

[Watch the Video](#)

WorkCompWire

Guest Post: The Workers' Comp Claim Journey: Integrated Solutions Improve Outcomes

WorkCompWire included an article by Rebecca Morgan explaining 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.

[Read More](#)

IIR INSURANCE INNOVATION REPORTER

Mitchell Acquires UniMed Direct to Strengthen Medical Management Capabilities

Insurance Innovation Reporter included Mitchell's announcement about acquiring UniMed Direct, a provider of proprietary enterprise managed care software and physician peer review services to the workers' compensation industry.

[Read More](#)

For More Mitchell News:

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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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