

Casualty **Edition**



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Industry Trends Report

FEATURED IN THIS ISSUE

- ▶ **The State of Third Party Auto: Claim Costs, Consistency and a New Generation of Adjusters**

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Industry Trends Report

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A Message from the CEO

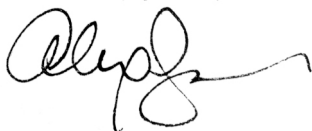
P&C Conference Trends

Welcome to the Q4 edition of the 2016 Mitchell Casualty *Industry Trends Report*. As you may know, we held our annual Property & Casualty Conference in mid-October. I enjoyed the opportunity to engage with many of our customers about how the industry is evolving as well as share my own insights for where I see it heading. In this issue, we're excited to share some of the top trends from the conference covering everything from augmented reality to information security. I hope you enjoy reading how technology and social trends are changing the way we do business and how they may affect your own organization.

In this issue, we have a selection of informative articles from our team of casualty solutions experts. In our feature article, *The State of Third Party Auto: Claim Costs, Consistency and a New Generation of Adjusters*, author Norman Tyrrell breaks down the three biggest industry challenges facing the auto casualty market. Norman goes into detail about each of these challenges and offers solutions for how insurance companies can increase efficiency, combat rising costs, reduce claim evaluation inconsistency, and better manage the aging workforce.

Additional articles include tips for successfully using visual reports to measure claims operations performance. Visual reporting can help insurance carriers ask the right questions and get on the right path to improving accuracy and consistency of claim settlements across the board. We also look into what the new California utilization review requirement means for workers' compensation programs and the various stakeholders that will be impacted by these new changes.

As we close out our 70th anniversary year, I'm grateful for all we've been able to achieve and the part you've played in helping us reach this milestone. It was an honor seeing so many of you at our conference, and I thank you for your continued partnership. I wish you all a safe and enjoyable holiday season.



Alex Sun
President and CEO
Mitchell



Alex Sun
President and CEO, Mitchell

View the Auto Physical Damage Edition





**TOP 10
TRENDS
FROM THE
MITCHELL
2016 P&C
CONFERENCE**

At the 2016 Mitchell Property and Casualty Conference, keynotes, breakouts and everything in between were focused on technology and social trends that are changing the way we interact with one another and do business.

From augmented reality to information security, here are 10 of the many trends that were top of mind at the conference.



VIRTUAL AND AUGMENTED REALITY ARE LITERALLY SHOWING US THE WAY

This summer's Pokémon Go craze reminded us that augmented reality can be really engaging and fun—but it also has incredible practical applications for the P&C and collision repair industries. For instance, Los Angeles-based Daqri makes a smart helmet that projects information to guide the wearer through complex repair scenarios. Technology like this could be a boon to auto insurers and collision repairers looking to ensure increasingly complex repairs are done correctly. It could also help prevent injuries in high-risk jobs, ultimately reducing workers' compensation claims.

Meanwhile, at Cedars Sinai Medical Center, a trial is underway that uses inexpensive virtual reality headsets to ease patient pain. Early results suggest an average 24 percent decrease—similar to the pain reduction they see when administering narcotics.



“Collision repairers are under incredible pressure to train their staff and ensure repairs can be certified. It’s easy to see how augmented reality solutions could be helpful.”

Alex Sun, President and CEO, Mitchell

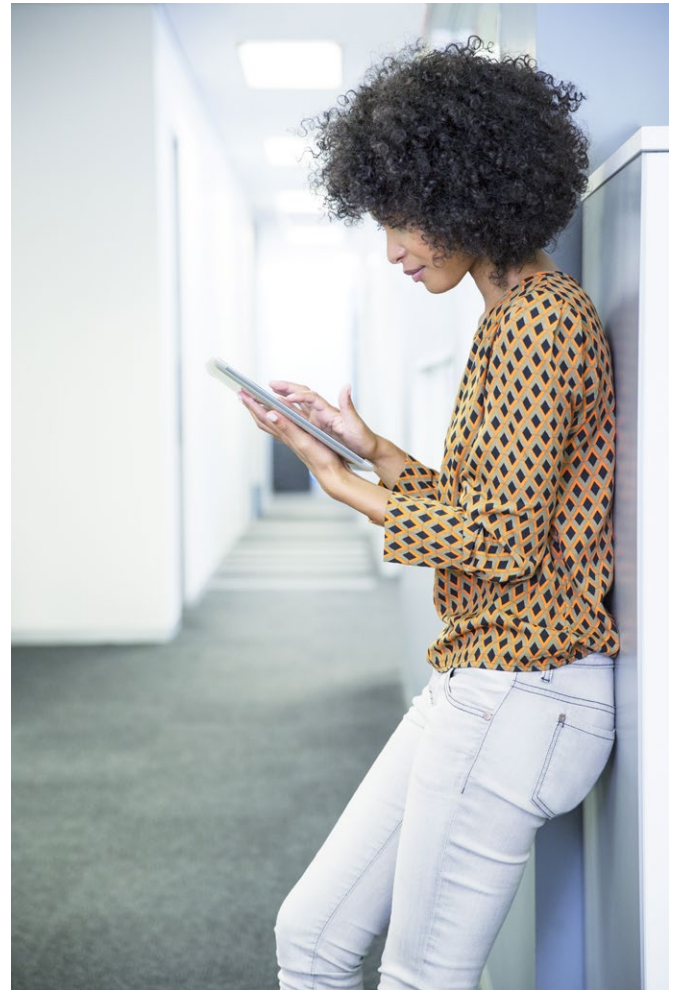
CONSUMER SELF SERVICE IS THE WAY OF THE FUTURE

Driven by the ubiquity of mobile devices and a growing preference among consumers, particularly Gen Y and Gen Xers, to communicate exclusively through digital self-service, Mitchell believes that consumer self-service interactions will grow from five percent today to 20 percent by 2020.

Since a positive first notice of loss (FNOL) experience is the second largest contributor to customer satisfaction—only settlement has a greater influence—insurers seeking to tap into this growing audience would do well to invest in technology that facilitates this process.

Further, when FNOL is submitted via a mobile app and incorporates images, cycle time is significantly reduced. An expeditious claims resolution process benefits both insurance companies, with less hands-on case-management time, and the insured, with a more user-friendly process.

Mitchell believes consumer self-service interactions will grow from five percent today to 20 percent by 2020.



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HUMAN LEADERSHIP IS THE FUTURE OF BUSINESS



83 percent of millennials want businesses to get more involved in solving today's issues.

In his keynote address, *Soft Power: The Software Engineering Humanity into Leadership*, social strategist John Gerzema spoke about how people—millennials in particular—are seeking human business leadership in which companies get more involved in solving today's issues. In fact, 72 percent of them would take a \$7,600 pay cut to work for a company with a culture and values they admire.

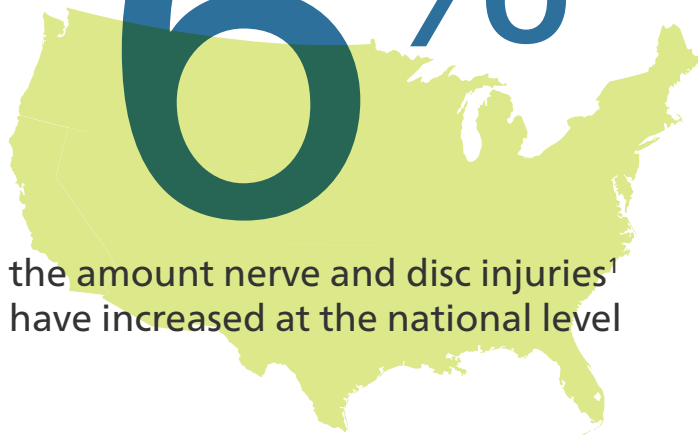
Why does this matter to the P&C industry? According to Gerzema, insurers can build trust with this important buying group by using AI interfaces and automating processes to reduce transaction time and claims costs.

John Gerzema, Chairman & CEO, BAV Consulting



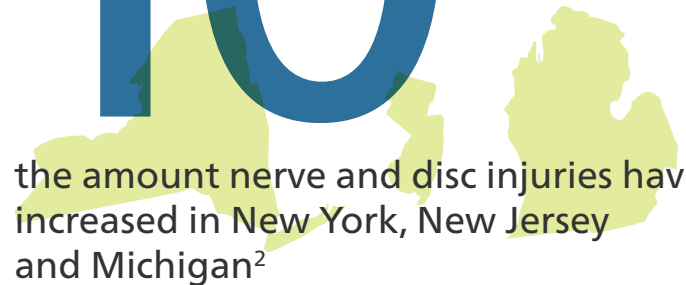
FIRST PARTY AUTO CASUALTY: NERVE AND DISC INJURIES ARE ON THE RISE

6%



the amount nerve and disc injuries¹ have increased at the national level

10%



the amount nerve and disc injuries have increased in New York, New Jersey and Michigan²

While charge severity has remained flat in first party auto casualty—influenced, in part, by policy limits—overall severity is on the rise. This time, the culprit is an increase in nerve and disc injuries over the typically more common—and less expensive—soft tissue injuries. Certain states are seeing a higher incidence than others—in New York, New Jersey and Michigan diagnoses of nerve and disc injuries have increased by 10 percent². At the national level, the increase is approximately 6 percent¹.

Third party auto and workers' compensation insurers should also take heed—regardless of coverage type, the introduction of a nerve and disc-related diagnosis is generally at least twice as costly as soft tissue damage.

¹ Mitchell data

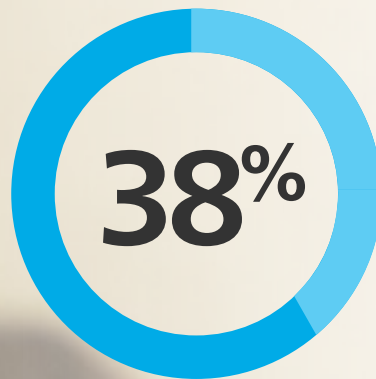
² Mitchell data

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INFORMATION SECURITY MATTERS MORE THAN EVER

“ Companies that experience a data breach have more to lose than money—reputation and customer trust are hard to win back. ”

Erez Nir, Mitchell, Executive Vice President and CTO



the amount security incidents increased between 2014 and 2015

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In 2015, there was a 38 percent increase in security incidents over 2014. And at an average cost of \$1.2 million to contain an incident—out of the average \$3 million security budget¹—there is a lot at stake. Companies that experience a data breach have more to lose than money—reputation and customer trust are hard to win back.

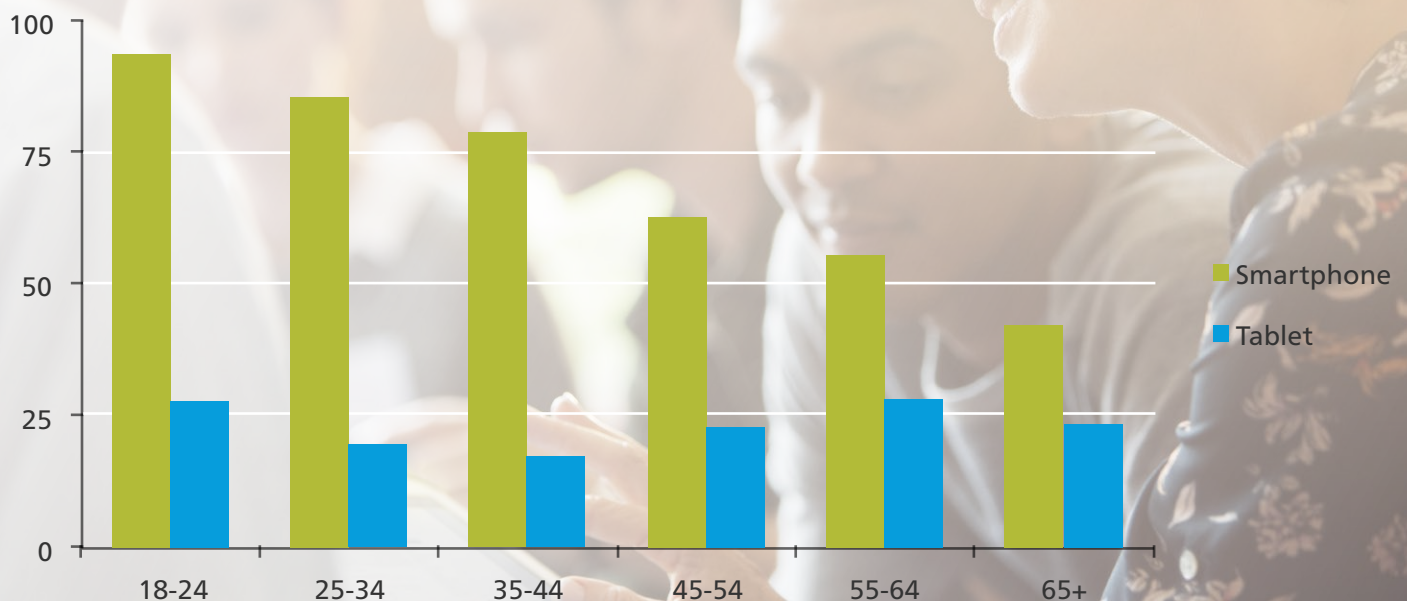
So what's a business to do? According to Verizon's 2016 Data Breach Investigations Report, there's no easy answer. However, two tactics that could prove to be particularly useful are web app patching and multifactor authentication. Together, these could have prevented almost half the 2015 incidents.

¹ PWC Global State of Information Security® Survey 2016

MOBILE IS A MUST

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Hours Spent Using Mobile Apps Each Month by Age Range¹



According to comScore’s 2016 Mobile App report, “digital media time in the U.S. continues to increase—growing more than 50 percent in the past three years, with nearly 90 percent of that growth directly attributable to the mobile app.”

For insurance companies, mobile applications help improve customer relationships and build satisfaction in a number of ways: delivering information to prevent claims, allowing them to submit claims information like first notice of loss, and providing real-time updates of claims status.

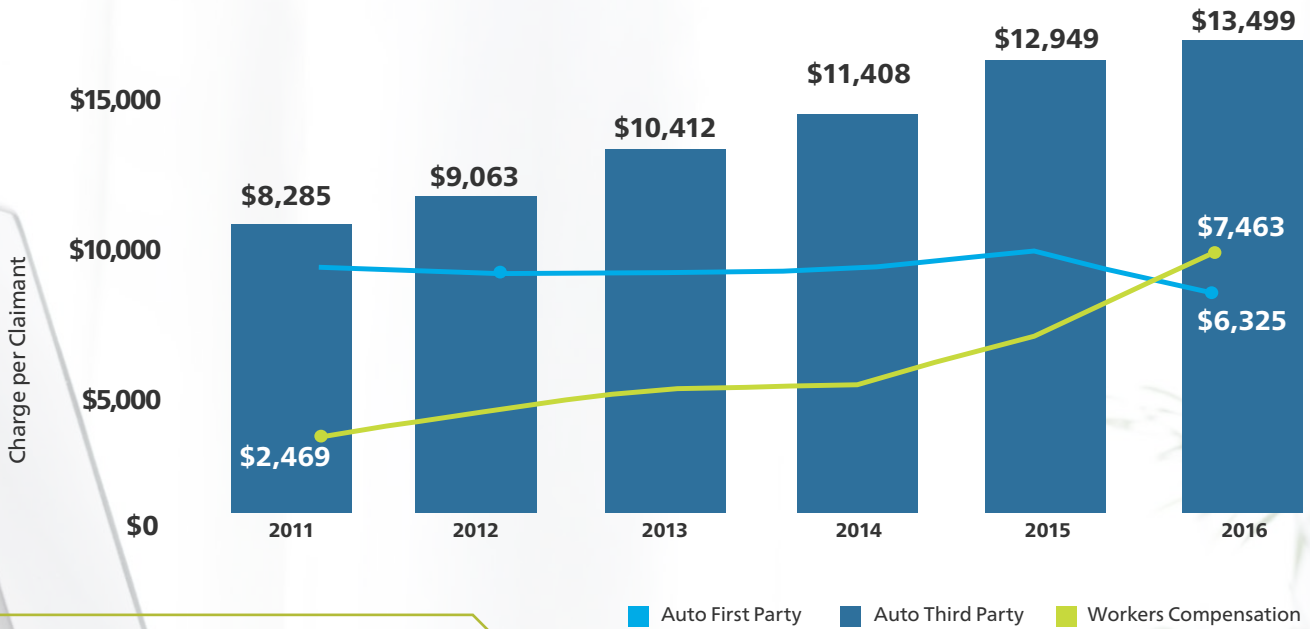
Companies like Lemonade, recently licensed in New York, and Spixii, soon to be licensed in the U.K., are even using artificial intelligence-driven chat bots to power 100 percent digital interactions with customers.

¹ ComScore, 2016 Mobile App Report

THIRD PARTY AUTO CASUALTY AND WORKERS' COMPENSATION: CHARGE SEVERITY IS RISING

Charge severity is on the rise for third party auto and workers' compensation insurers. In third party auto, average charge per claimant in 2011 was \$8,285. Through the third quarter of 2016, it was \$13,499—that's a 62 percent increase¹. Workers' compensation is seeing an even more dramatic increase over 2011—a whopping 202 percent². The third party charge severity increase is being driven by a combination of increased unit cost and utilization, while the workers' compensation increase is primarily due to increased utilization.

Interestingly, first party auto charge severity has stayed relatively flat, influenced, in part, by policy limits.



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¹ Mitchell data
² Mitchell data

DATA IS DELIVERING ON ITS PROMISE

The insurance industry as a whole is seeing technology transformations of all types—and making use of data is at the forefront of their investments. In fact, a recent study by Strategy Meets Action indicates 82 percent of insurers are focusing on strategic projects related to data analytics. This expenditure is second only to customer experience projects.

So how do companies go from Big Data to actionable insights? One good place to start is by understanding claims analytics personas. What a claims executive is looking for is not necessary what an adjuster needs to know. Further, where and when that information is available makes a difference—while dashboards and reports are cornerstones of any analytics program, it's important that access to information that informs decision making is embedded throughout claims workflows.

82 percent of insurers are focusing on strategic projects related to data analytics.

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“While dashboards and reports are cornerstones of any analytics program, it’s important that access to information that informs decision making is embedded throughout claims workflows.

Shahin Hatamian, Vice President of Product Management, Mitchell

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OPIOID ABUSE IS AN INSURANCE PAIN POINT



spent in workers' compensation on prescription drugs¹



is spent on pain management drugs¹



of those are opioids¹

Mitch Freeman, Pharm. D., Vice President and Chief Clinical Officer, Mitchell

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Opioid abuse has reached epidemic proportions—in fact, every 19 minutes, someone in the U.S. dies from an opioid overdose. With \$1.5 billion in opioid-related expenditures, the P&C industry has a lot at stake. Earlier this year, the CDC released their official Guideline for Prescribing Opioids for Chronic Pain that offers specific steps physicians can take to curb the problem.

There are also some actions insurers can take, including using formularies with built-in controls; putting first-fill restrictions in place; monitoring total morphine equivalent doses by patient; ensuring their PBM solution has built-in risk calculation alerts; and implementing managed care solutions.

¹ Prescription Drug Management in Workers' Compensation, The Twelfth Annual Survey Report (2014 data)

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MILLENNIALS ARE DRIVING ADOPTION OF USAGE BASED INSURANCE

93% of millennials in the U.S. would buy a usage-based insurance policy if the rates didn't increase



72% of millennials in the U.S. believe it's a better way to calculate rates



80% of millennials in the U.S. would pay more than \$45 a month for options like theft tracking or automated emergency calls



A recent Towers Watson study indicates that to succeed, insurers will need to adapt to meet the needs of the next generation of customers. In fact, in the U.S., 93 percent of millennials would buy a usage-based insurance (UBI) policy if the rates didn't increase, while 72 percent believe it's a better way to calculate rates. UBI presents additional opportunity with value-added services: 80 percent of millennials would pay more than \$45 a month for options like theft tracking or automated emergency calls.

While the trend toward UBI is just getting off the ground in the U.S.—Towers Watson anticipates 17 million people will have tried it by the end of 2016—it's gaining ground in other countries. It's achieved double-digit market share in Italy and markets are maturing in Germany, Spain and France.

The State of Third Party Auto: Claim Costs, Consistency and a New Generation of Adjusters

By Norman Tyrrell

Director of Product Management, Mitchell Casualty Solutions Group



Since 2011, the average bodily injury claim cost for third party medical specials has increased about 12 percent.

The cost of third party auto claims is rising quickly, and many insurance carriers are struggling to keep up. As the number of attorney-represented claims grows, adjusters are getting more and more demand packages, which are often disorganized or incomplete, though they require a timely response. Without the correct tools, these complex demand packages often result in lost opportunities or inconsistencies, which can expose insurers to lawsuits. Because there are so many different variables when handling represented third party claims, things can quickly get complicated for adjusters. Often, those complications and problems lead to unnecessary spending. In a competitive auto

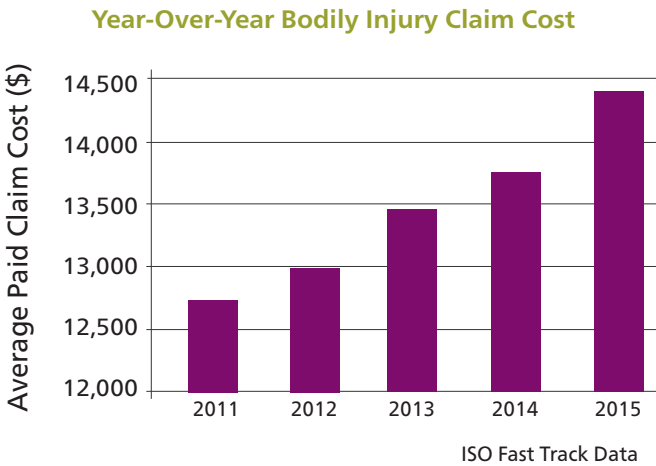
casualty market, an insurance company can't afford to leave these costly problems unaddressed.

Though there are many issues that arise while adjudicating third party claims and demands, three major problems stand out across the industry—the rising cost of third party claims, inconsistent evaluation and claim settlements, and a new generation of adjusters.

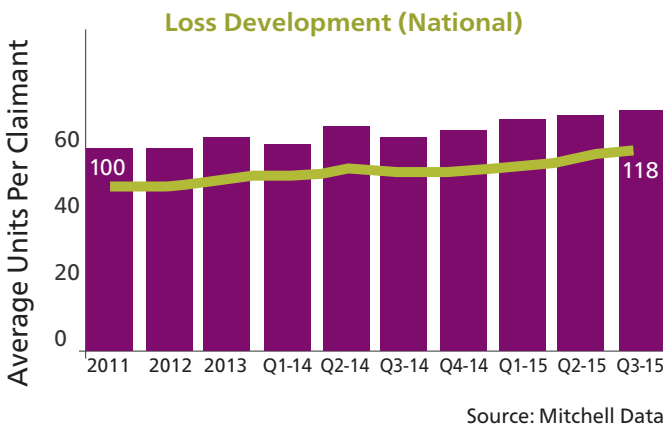
Breaking Down the Three Biggest Industry Challenges

Challenge 1: Rising Cost of Third Party Claims

One of the biggest obstacles the industry is facing is rising claim costs which are directly related to increased medical specials. Since 2011, the average bodily injury claim cost for third party medical specials has increased about 12 percent.



In fact, when we look more closely at the numbers behind these increases, we see that average utilization, or the frequency of using medical services, has also increased by 18 percent during the same period according to Mitchell data.



Causes and Effects

The cause of the rising costs can't be attributed to just one single factor, such as inflation. Medical specials on third party auto claims are rising due to

A partner that offers an integrated solution set is a great choice, since the integration ensures that no parts of the process get lost.

a few complex reasons that fall into three categories: provider-related trends, fraud and adjuster struggles.

Provider-Related Trends

Many of the cost drivers of third party claims are centered on issues related to provider visits and treatments. There's the new trend of claimants visiting providers more frequently than before, and the overall length of time taken to treat injuries is increasing as well. In addition to more frequent visits, there has also been an increase in providers using costly procedures, like more expensive imaging procedures, such as MRI or CT scans, to diagnose injuries. Not only are injuries becoming more expensive to diagnose, but some have also become more expensive to treat.

Providers have been diagnosing more serious injuries more frequently as well. For example, since 2011, there’s been a 34 percent increase in average charge per claimant with nerve or disk injuries while the frequency of this type of injury has increased about 18 percent. One reason for the increase in treatment costs is that providers are now using surgeries and injections as treatment more often than other, less expensive options.

Different areas of the country are currently seeing recommended surgeries as a more common part of third party demands, though this isn’t due to new technology or surgical procedures that help with auto injuries. This is coupled with a trend of increased use of surgeries as standard practice and increased tolerance in certain venues. Not only are all of these different factors driving third party claim costs on their own, but on top of that, providers are charging auto carriers at a higher rate than they are charging other payors. This is most likely occurring because third party insurers don’t have access to networks with lower contracted rates like other payors, including Medicare and group health.

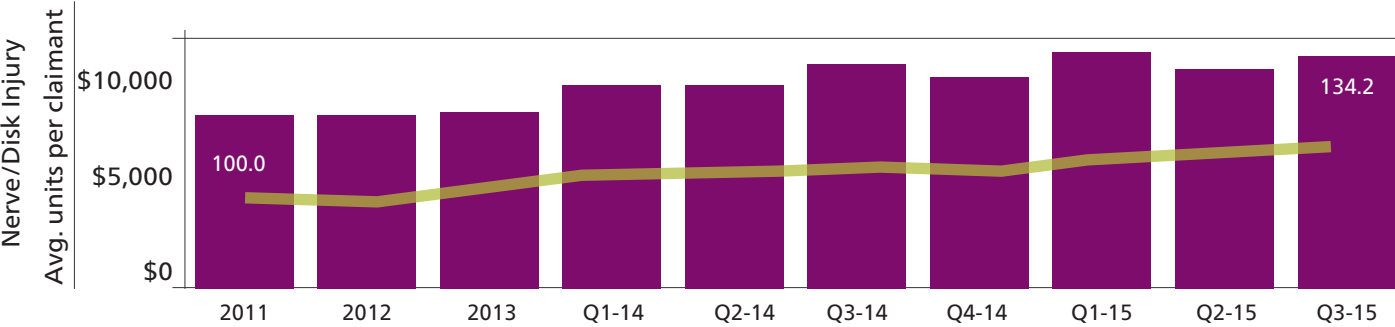
Cases of Fraud

Fraud is another leading driver of rising third party claims. There are a couple of different categories of fraud to look out for. First, there is a trend of providers not only treating pre-existing conditions

that are unrelated to the third party claim, but also using more expensive procedures, like surgeries or nerve treatments to do so.

Second, some attorney-represented claims are falling victim to “the build-up model,” which is a term used to describe what happens when attorneys direct treatment in a particular (self-serving) way. For example, an attorney could refer a claimant to a medical provider who he has a relationship with. Though that claimant was initially diagnosed at the hospital with a soft tissue problem, they might end up getting treated for it at the chiropractor who refers them to an expensive orthopedist. The orthopedist then recommends injections or surgery for this minor injury even though such treatment recommendation deviates from the standard of care. This recommendation then increases the value of the demand request, so the attorney ends up asking the insurance company for more money even before the procedure occurs. Many times, the claimant doesn’t end up getting the surgery, resulting in pure profit for the attorney and claimant and causing the insurance company to pay much more than the fair price for that claim. Only a small percentage of claims might result from attorneys participating in the build-up model, but when they do, the results can be extremely costly for insurance companies.

Loss Development—Nerve/Disk Injuries (National)



Adjuster Struggles Inside the Claims Process

Finally, there are a few factors affecting third party claim costs that are within the insurance company's claims process itself. Claims with attorney representation pose additional challenges for adjusters. There is a general consensus among carriers that the number of represented claims is growing, which is concerning because attorney represented claims are much more complex than unrepresented claims, since attorney representation adds in an extra step of negotiation. Further complicating this aspect of third party claims is that adjusters often have to deal with daunting demand packages. The demands that are presented are frequently disorganized, include poor-quality images and duplicate billings. Adjusters are typically already extremely busy. With a lot of work on their plate, it is difficult for them to find the time required to sort through demand packages and organize them in the best way so that they can negotiate the claims to the fairest price. Disorganized demands already make negotiations and the third party claim process a pain point for adjusters. But to make that even worse, recently, negotiation training has fallen by the wayside at many insurance companies. As a result, adjusters aren't trained to consistently use the best practices to negotiate with attorneys on demands, leading to less successful negotiations—which means insurance companies are more frequently overpaying on third party claims.

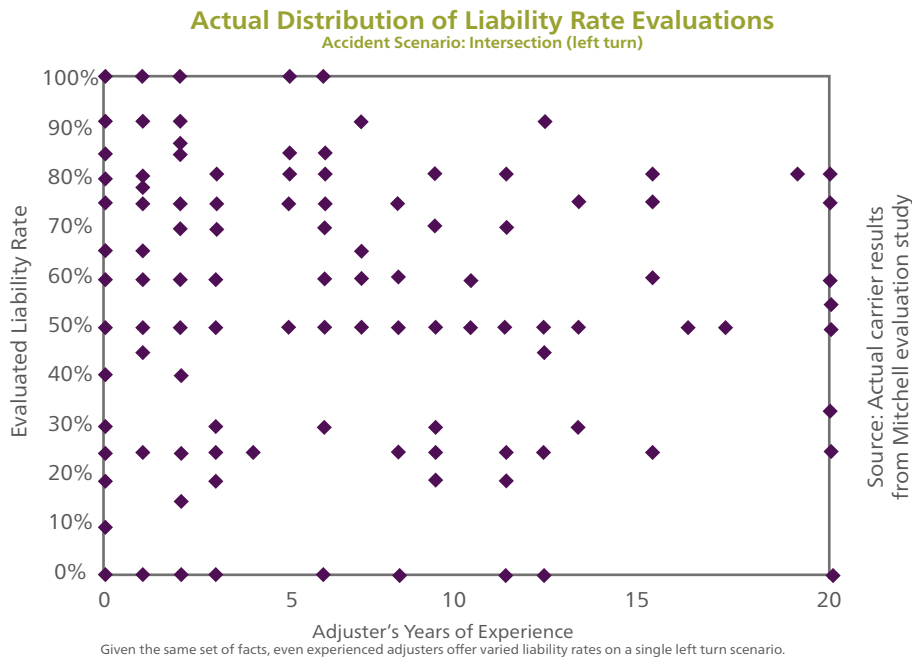
About the Quarterly Feature author...



By Norman Tyrrell

Director of Product Management,
Mitchell Casualty Solutions Group

Norman Tyrrell is Director of Product Management for Mitchell's Casualty Solutions Group. In this role Norman directs the product management and strategic planning activities for the company's Auto Casualty Solutions division leading a passionate team of product professionals focused on delivering smart technology, deep industry expertise, and the broadest range of solutions to Mitchell customers. As an experienced product and technology executive, Norman brings to Mitchell more than 20 years' business and product management expertise across a variety of markets and industries. Prior to joining Mitchell, Norman served in multiple capacities at Qualcomm, a leader in mobile communications technology, across product management, technical marketing, and global business development. Norman also has previous leadership roles in marketing and product management within the enterprise software and enterprise communications industries and has broad international experience including spending five years in Japan. Norman holds an MBA from the Thunderbird School of Global Management and an undergraduate degree in Physics from St. John's University.



Challenge 2: Claim Evaluation Inconsistency

Third party auto claims are different than first party claims since there aren't as many defined standards of payment and because claims are typically settled in chunks instead of by individual medical bills. Because of this and a lack of fee schedules in third party, it's tough to get every adjuster to consistently come up with accurate values across similar claims. Inconsistency stems from two major areas: liability assessment and injury evaluation.

Liability Assessment

Without any tools in place, adjusters frequently use different methods to assess liability. In a customer study, Mitchell documented this adjuster inconsistency in assessing liability third party claims. A variety of adjusters from a specific carrier, with experience ranging from zero to 15+ years, were given the same set of facts for an accident involving a left turn at an intersection and asked to

perform a liability assessment. Though they were given the same information, the liability rates the adjusters came up with were different across the board. Even the group of adjusters in the category of 15+ years of experience category came up with different answers than each other. This variation demonstrates the major consistency problem adjusters are facing when assessing liability — even with years of training and practice, adjusters struggle to settle claims consistently with their peers. Inconsistent claims adjusting means insurers are either frequently overpaying or underpaying on claims. While paying more than the accurate price is obviously problematic for insurers, underpaying can result in litigation that often ends up unnecessarily driving up settlement costs.

The root cause of this problem stems from a few different areas. One reason for inconsistency could be that while the company's methods and liability assessment techniques are documented, they might not be fully integrated within the claim system or

adjuster computing workspace. An example of what this gap might look like is a series of Post-it Notes explaining the procedure around the adjuster's desk. If companies don't have their adjusting requirements integrated into their third party claims adjusting process, then it's easy for one adjuster to forget to make certain changes or interpret guidelines in a different way than the next adjuster.

Injury Evaluation

Another reason for inconsistency is that injuries are being evaluated by adjusters who aren't using tools to support them in the process. Many times, the threshold of how much money an adjuster can spend on a claim, which is determined by a supervisor, shapes the way an adjuster looks at a claim. In this scenario, adjusters may try to keep their settlements under that threshold, and decide to cut or allow medical treatments only based on keeping the cost under that number instead of evaluating based on best practices. Since there are usually multiple different supervisors at one company, there can be a wide distribution of all of the payouts with a wide gap between the lowest and highest payouts. This gap could lead to increased litigation for insurance companies.

Challenge 3: A New Generation of Adjusters

The consistency problem insurers are facing in the third party market could get a lot worse if companies aren't prepared. About 25 percent of insurance industry professionals are slated to retire by the year 2018, meaning thousands of the industry's most senior adjusters will walk out the door, taking their industry knowledge and expertise with them. This will be felt more profoundly in third party claims departments since adjuster knowledge is key to reaching accurate settlements

and succeeding in negotiations. When many experienced employees leave, companies will have to train many new, younger adjusters which will take time. Third party claims are complicated, and it could take a while for employees who are new to the industry to become experts at their jobs. This could leave insurers with sub-optimal settlements on claims for years.

Another factor with the more experienced generation retiring and the new generation entering into the industry is that younger employees are generally more tech savvy. The millennial generation, defined as people born from the early 1980s until about the year 2000, is entering the workforce and bringing their love for technology with them. In fact, a study by the U.S. Chamber of Commerce Foundation found that compared to older generations, millennials are 2.5 times more likely to try out new technologies as early adopters. Millennials are also more likely to use the internet. Millennials want to use the latest and greatest technology to help them get their jobs done efficiently, which contrasts with much of the older generation's unwillingness to try out new platforms and solutions.

The Solution

To combat these three major issues facing the third party market, it is critical to provide adjusters with expert decision support tools to help them make the best decisions when evaluating third party demands and negotiating settlements. By providing adjusters with a third party solution suite that comes filled with comprehensive, integrated expert technology and services, insurance companies can start to see improved outcomes and more consistent settlements.

Here is an example of a recommended suite of third party tools: medical bill review, liability and injury evaluation, general damages assessment, claims process services, demand package management, medical professional review and direct-to-provider negotiation services. This combination of technology and services covers all of the most important areas of third party claims, allowing insurance companies to increase efficiency and combat rising costs, reduce claim evaluation inconsistency, and the aging workforce.

Rising Costs of Third Party Claims

Specifically, in order for insurance companies to combat rising costs based on provider-related charges, they should make sure their bill review process includes benchmarking. By comparing provider charges on auto casualty claims to provider charges for the same treatment in other areas like workers' compensation or group health, insurance companies can be more confident that they are paying the fairest price on claims—instead of a price that was inflated just because the injury happened in an auto accident.

Another important tool to have in an insurance company's third party toolkit is medical review services. Medical reviewers help verify that insurers are only paying for injuries related to the accident and also aren't overpaying for treatments. This service can help protect the insurance company from fraud and help identify "the build-up model" as well. For example, a charge might show up on a bill for a treatment on a patient's shoulder. When a nurse or other medical professional reviews the record, they might realize that based on their professional opinion, the accident wasn't the cause for the patient's shoulder injury, and then the nurse can alert the adjuster. In order to get the most value out of a medical professional's recommendations,

this medical review process should be linked with the rest of the company's solutions. This way, it's easy to make sure no recommendations are lost or diminished. This helps insurance carriers contain costs by making sure they only pay for treatments the patient actually needs and for injuries that are related to the accident, helping protect them from fraud.

Insurance companies should also make sure to provide adjusters with tools to assist them as they negotiate with attorneys. In order to reach the most accurate settlement, adjusters have to successfully negotiate with attorneys, which can be a complicated and difficult process. That's why it's valuable to have solutions that provide an organized set of facts to help with the negotiation process. This not only helps drive consistency across adjusters, but also empowers adjusters to negotiate the specific facts of the case, not just a dollar figure. By using medical reviewers, adjusters are assured of having a strong, evidence-based foundation when discussing the merits of their settlement offer.

Another great way to improve negotiations is to provide adjusters with liability and general assessment tools that empower them to settle the claim at the precise amount of liability and negotiate more successfully. These types of solutions provide organized information that can help adjusters explain their decisions to attorneys so that they are completely prepared for the negotiation process. This helps adjusters better explain the investigation and liability assessment process and ultimately results in more consistent, accurate settlements on third party claims.

Inconsistent Claim Evaluation

An efficient way to improve assessment and settlement consistency throughout the claims organization is to take the time to build the company's strategy into an easy-to-operationalize knowledgebase. A liability assessment and injury evaluation tool can help an insurance carrier improve consistency and manage costs from settling too high or too low by integrating and distributing the company's knowledge base into adjusters' daily workflows. A tool that also comes with reporting capabilities can help an insurance company address any problems with inconsistency or overpayment right away instead of waiting a year or two to finally notice that their severity is trending upward. This can help save companies from overpaying or underpaying on settlements over a long period of time.

Another area a robust software solution can help insurers improve outcomes is in liability assessment. Without a robust solution, carriers typically have a low rate of claims that are approved for shared liability, meaning they are missing an opportunity for cost containment in situations where liability is shared. A liability assessment tool can help companies improve their approved liability averages while also increasing their shared liability averages across the board. This helps enable consistency in liability evaluation which improves accuracy, helps manage costs and improves third party outcomes.

[View the Auto Physical Damage Edition](#)



A good solution can also enable adjuster independence while providing guidance to them where needed. If a company can prove its methodology and can show that it has paid the same price on similar claims on every instance, they can have a better chance of winning any lawsuits that could come their way. By using an assessment and evaluation solution correctly, companies can see major improvements in consistency and optimize their medical spend.

A New Generation of Adjusters

One of the most helpful pieces of a third party solution suite to ease the human resource transition is a liability and injury assessment tool that incorporates the best practices and knowledge that retiring adjusters will be taking with them. By capturing the company's knowledge and culture within its workflow, companies can easily apply it across the organization even after all of its most experienced adjusters have retired. One example of what to build in to the software system is the best practices that their adjusters are using in the field to negotiate with attorneys.

With the millennial generation entering the workplace and naturally taking to new technology, now is the time to start considering how using more of the latest technology in the claims process can improve outcomes. By implementing advanced software solutions that will help adjusters learn and do their jobs quicker and more efficiently, companies can better match the millennial desire for using technology at work. For example, in assessing third party claims, new adjusters need to learn the best practices for negotiating with attorneys. A great way to assist them is to use a technology solution that's integrated with the investigation and liability process, which simplifies the most important negotiation points into a table or list.

By implementing friendly, effective and easy-to-use software solutions, companies can attract more of the technology-loving millennial generation to fill the gap it will be facing in a few years.

Conclusion

Choosing to work with an experienced partner that offers a complete, integrated suite of products and services specifically targeted to the unique needs of the third party market is an easy way for insurance companies to manage all of the knowledge and tools adjusters need to successfully settle claims and manage costs. A partner that offers an integrated solution set is a great choice, since the integration ensures that no parts of the process get lost. When adjusters are empowered to make great decisions and their claims management system works seamlessly with bill review, medical review, liability assessment and all of the other steps in the claim life cycle, the insurer can consistently pay the most accurate price on claims.

5 Ways to Use Visual Reporting Effectively to Improve Claim Outcomes

By Shahin Hatamian

VP Product Management & Strategy, Mitchell Casualty Solutions Group

Visual reporting lets insurance companies understand areas of their performance that might have taken weeks to uncover in a spreadsheet.



Insurance carriers who aren't looking at visual performance reports on a regular basis could be missing out on major opportunities to improve their operations and to move toward more standardized and efficient processes.

Visual reporting lets insurance companies understand areas of their performance that might have taken weeks to uncover in a spreadsheet, making it easier for them to know where they are having successes and where they need to improve. Here are some tips for using visual reports successfully when it comes to measuring claims operations performance:

1) Pinpoint outliers and identify red flags

Visual reporting, when used effectively, helps insurance companies quickly and easily make informed decisions and changes to correct issues plaguing their bill review process. Monitoring specific red flags in the bill review process is the first step to making important changes. For example, a visual report can help pinpoint with a simple click of the mouse in which counties in Michigan a company is paying more than the industry average for neck sprain treatments. This way, the company can focus in on this specific outlier to understand why it is happening and then work to make improvements in that category.

Without visual reporting, the company might have noticed an increase in spending via their spreadsheet report, but might not have been able to realize that specific treatment in that specific region was the problem. With visual reports, companies can easily and quickly zero in on the anomalies or flags and start asking the right questions to improve performance in those areas.

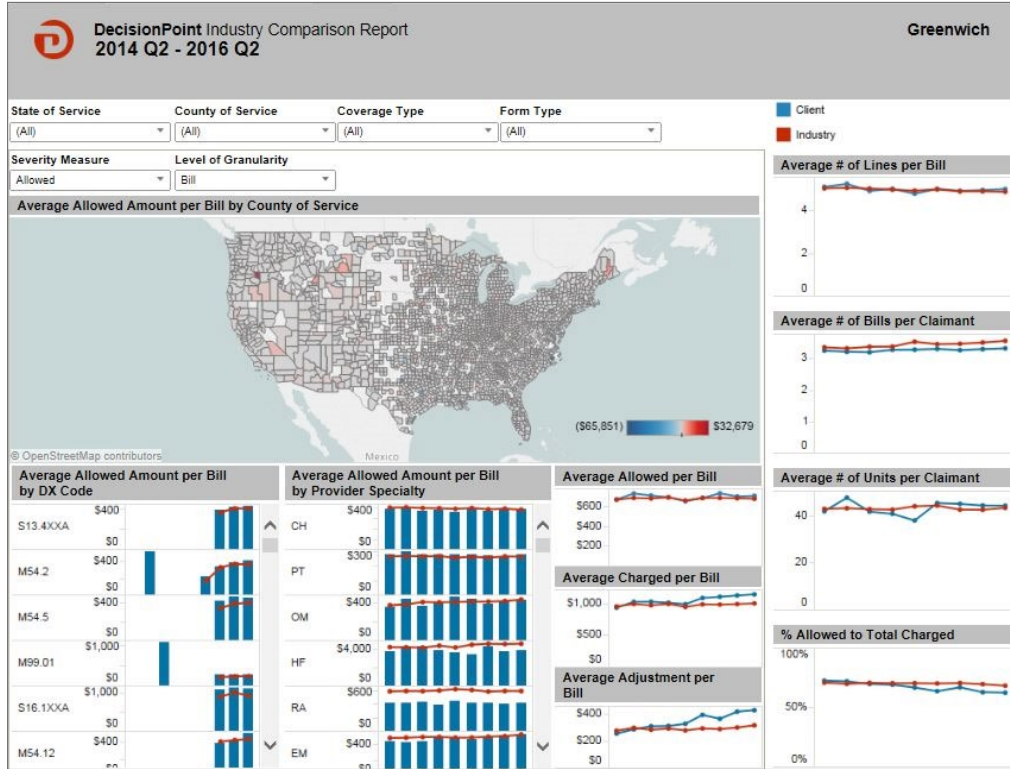
2) Interact with the report to dig deeper into the most important data

With a spreadsheet, companies have to balance robust performance reporting against the amount of employee time it would take to generate and find patterns in that data. But with visual reporting, companies are able to easily change and modify filters to quickly view that data, eliminating manual processes. Visual reporting allows for more flexibility in the types and groupings of data that are available for review. It also allows companies to focus in on the areas that specifically match their business needs, making it easier to look at relevant data that can help make significant improvements in business

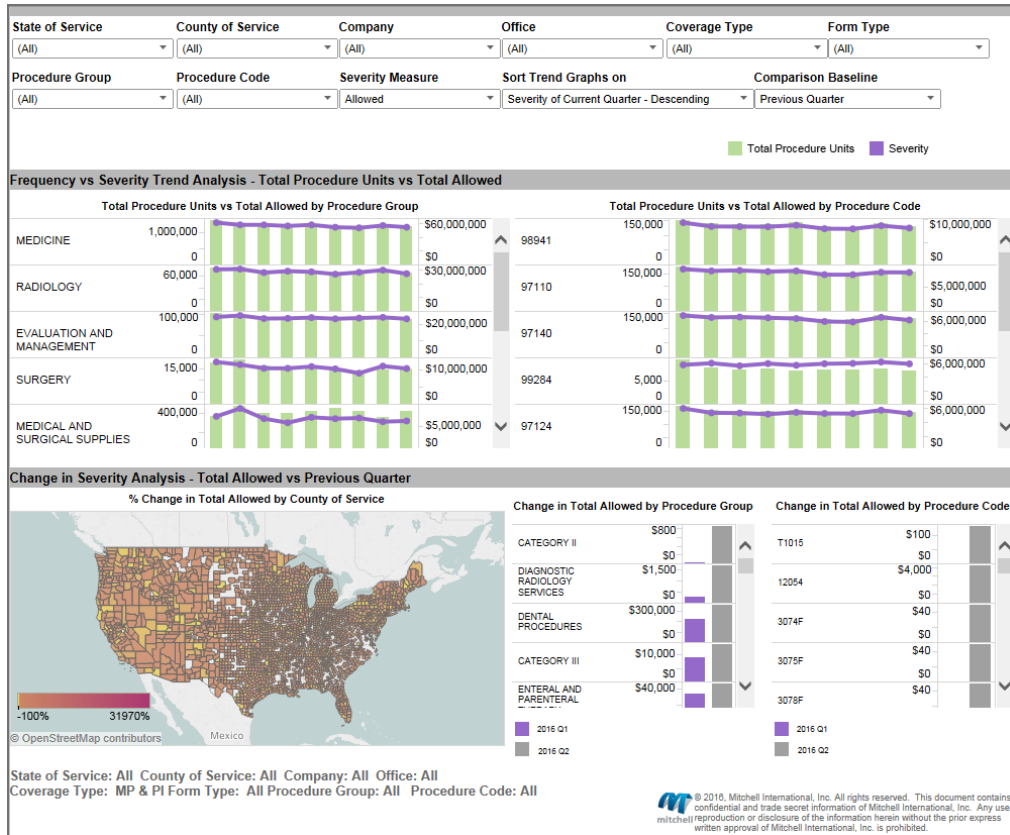
With visual reports, companies can easily and quickly zero in on the anomalies or flags and start asking the right questions to improve performance in those areas.

processes. For example, if a company is interested in which types of adjustments their adjusters are making to bills, visual reporting provides easy access to view a general breakdown of those adjustments. A company can also easily drill down on this data —to look at adjustments in specific states or lines of insurance, like workers’ compensation or third or first party auto casualty. The interactive filtering capabilities within a visual report help companies simply view the exact data they are looking for without spending a large amount of time sorting through all of the information.





Mitchell's DecisionPoint® Bill Review platform allows companies to compare their performance to the industry in various categories and different locations around the country to help pinpoint potential problem areas.



Visual reporting can help companies focus in on specific areas of the operations to determine where to focus in on for improvement. For example, this Procedure Code Analysis report lets companies analyze frequency and severity trends by procedure group.

3) Use industry comparison data to your advantage

A robust reporting solution should provide the ability to compare one company's performance to the industry based on a robust set of industry data. Carriers are always looking to improve accuracy and consistency, and an industry comparison report allows them to get closer to achieving those goals. By understanding, for example, the percentage allowed to total charged compared to the industry average for this statistic, insurance carriers can know if they are consistently paying the fairest price on medical charges. Comparing performance to the industry is a great tool to help carriers manage their medical costs and focus on specific regions or counties where they are paying more than the industry average price, allowing them to be better prepared to remedy the situation.

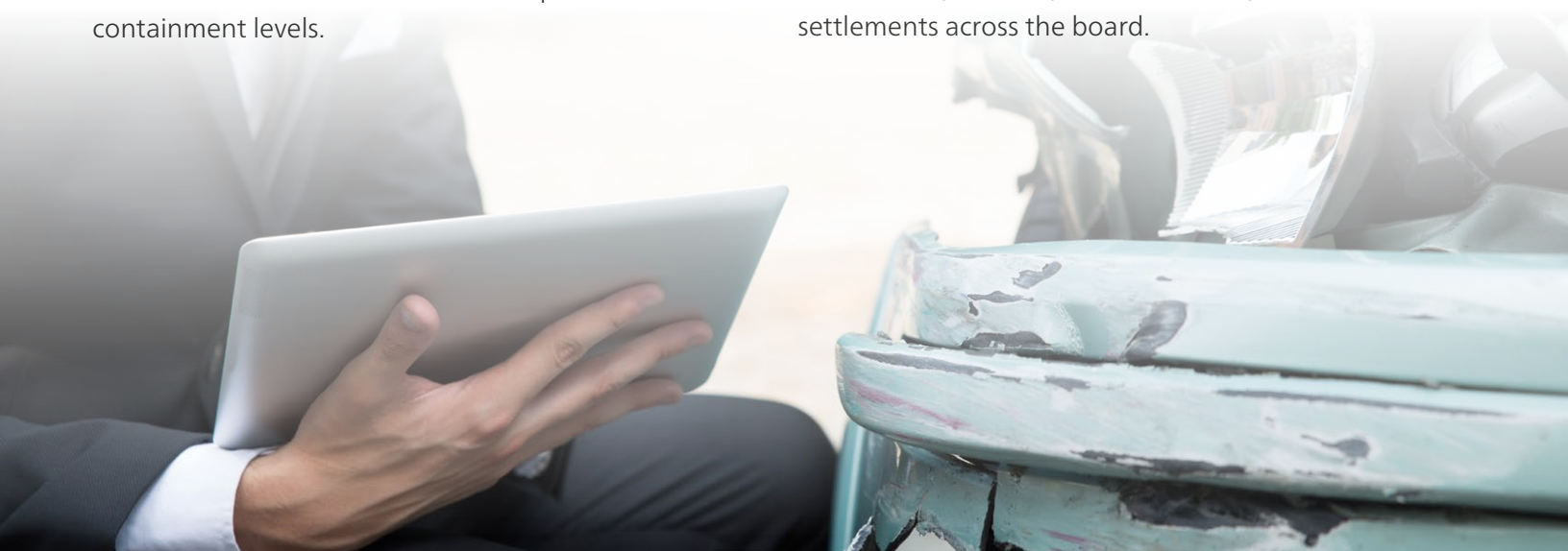
4) Assess provider network performance

Understanding which provider networks are performing best in each state and on each type of bill is a key piece of information to have. If an insurance company has a deep understanding of which networks are performing best in certain situations, they are better prepared to optimize their cost containment stacking to achieve better outcomes. For example, if a company views a report and learns that negotiation services are outperforming a specific network in a certain state, they are able to readjust the position of their solutions within their stack to reach optimal cost containment levels.

5) Review categories you couldn't easily uncover in a spreadsheet

In addition to focusing in on areas that a company already knows aligns with its business needs, insurance carriers can identify completely different categories that they had not previously considered. The beauty of a visual reporting tool is that a company can spend minimal time gathering information about different areas of their performance that they wouldn't have assessed otherwise. For example, a company could more easily identify a procedure code that's trending upward that they might not have looked at otherwise. Many companies only look at the top-10 or top-20 procedure codes, but visual reports can give companies more insight into other procedure codes as well so they can catch those that are trending up before they become a problem—a statistic that would be much more difficult for someone looking at the raw data to recognize. New insight into different areas, like less-costly procedure codes, can help companies make informed and precise decisions. Companies should use the knowledge to their advantage to identify areas of improvement which are highlighted in the visual reports.

By using visual reports to review claims processing performance, insurance carriers can easily ask the right questions and get on the right path to improving accuracy and consistency of claim settlements across the board.



Understanding SB1160— New California Utilization Review Requirements

By Jackie Payne

Vice President, Medical Management Services, Mitchell Casualty Solutions Group

The workers' compensation industry in California has been seeking managed care cost containment and faster delivery of medically necessary care.



In the scant months leading up to its signature by California Governor, Jerry Brown, SB1160 gained a tremendous amount of attention from those in the California workers' compensation industry. This bill, which was signed into law on Sept. 30, 2016, speaks to persistent delays and denials of medical care for injured workers, contains reforms that could considerably impact workers' compensation programs and influence utilization review requirements nationwide.

The excerpts pulled below from SB1160 Sec. 4.5, are just a handful of utilization review (UR) provisions addressed by the legislature. Based on the highlighted language below, we can expect to see many UR entities in the next year making modifications to their current operations to ensure they are compliant with the new requirements:

- Prospective review of medical treatment will not be required with certain exceptions in the first 30 days following the date of injury occurring on or after Jan. 1, 2018.
- The employer or utilization review entity conducting UR on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a UR physician reviewer based on the number of modification or denial decisions made.
- Prospective decisions regarding requests for medications covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. There is no extension of the turnaround time to 14 calendar days.

- A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review service, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria.

So what does this mean for workers' compensation programs in California? To understand that, we need to look at the various stakeholders that will be impacted by these new changes.

Various Stakeholders

Injured Worker

The bill, effective for work injuries occurring on or after Jan. 1, 2018, focuses on reducing treatment delays for injured workers during the first 30 days following the date of injury. During this 30-day treatment window in an accepted workers' compensation claim, an injured worker, assuming that they are being treated by a medical provider network (MPN) or health care organization (HCO) doctor or another employer-directed doctor/facility, can get the care they need without being subject to "prospective" utilization review — which can result in denial of care when it is most needed. This bill continues the effort to ensure that injured workers are being put on the right path to recovery as quickly as possible.

Treating Providers

Treating physicians are required to follow rules adopted by the administrative director of the Division of Workers' Compensation (DWC) for submitting requests for authorization for medical treatment with supporting documentation to the claims administrator for the employer, insurer or other entity. These rules are meant to help ensure that requests

for authorization of treatment will be directed to the appropriate entity to ensure timely processing of the request.

Only treatments consistent with the medical treatment utilization schedule (MTUS) are exempt from utilization review in the first 30 days following an injury, and treating physicians must render treatment consistent with the MTUS, including the drug formulary, to avoid being removed as the predesignated treating physician, employer-selected physician or member of the MPN or HCO, or be subjected to prospective review of all further treatment rendered.

Payor

Electronic reporting of utilization review is mandated under this law, requiring that claims administrators route all UR data to the Division of Workers' Compensation for increased monitoring. The DWC can also review the financial contracts between the employer, UR entity and UR physician reviewers.

The new law also prohibits insurers and third party administrators (TPAs) from referring UR services to an entity in which the insurer or TPA has a financial interest unless the insurer/TPA discloses the name of the UR entity and the insurer or TPA's financial interest in the entity to the employer and the DWC.

UR Entities

The bill calls for greater oversight over UR entities by requiring that UR plans that address modification or denial of treatment requests be approved by the DWC and accredited by an independent nonprofit organization by July 1, 2018. Many smaller UR entities who are not currently accredited will have to decide whether to go through the accreditation process or only issue UR authorization decisions.

The new statutes should have only minor effects to those UR entities that have practiced in compliance previously. For others, it may end up that these smaller entities will instead choose to partner with other UR entities that are already accredited to avoid operational setbacks.

Industry as a Whole

The workers' compensation industry in California has been seeking managed care cost containment and faster delivery of medically necessary care. SB1160 certainly has the potential to help with both. However, it also puts payors and UR entities in the position of retrospectively monitoring the delivery of treatment and potentially disrupting that treatment well after the development of a physician-patient relationship. Another factor to consider is the necessity for the provider community to understand the requirements for treating workers' compensation patients as well as the MTUS treatments recommended for the patient's injury. Educating the provider community has been a barrier in prior DWC regulatory changes and payors and UR entities have had to take over that burden, often at the expense of timely delivery of care.

While the changes made by SB1160 removes potential delays in seeking needed treatment and increases the potential for delivery of consistent, medically necessary care for injured workers, the impact on the MPN, HCO and employer-chosen physician groups could be significant. And as we remove barriers for the injured worker to have access to treatment with limited preauthorization requirements, payors risk losing the managed care cost containment benefits SB1160 brings through increased medical costs in the first 30 days after the injury and extension of the overall claim resolution timeframe due to disruption in the physician-patient relationship. UR Entities and TPAs may be scrambling to meet the accreditation requirements and find innovative solutions to balance the impact of SB1160 on their customers claim cost. Here at Mitchell, our workers' compensation Utilization Management program has been accredited by URAC since 2009. We will continue to monitor the impacts of SB1160 to continue empowering better outcomes for injured workers, payors and the broader workers' compensation industry.



The Compliance Corner

By Michele Hibbert-Iacobacci, OHCC, CCSP

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



In 2019, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be introduced requiring new quality measurements.

Understanding MACRA — Medicare Access and CHIP Reauthorization Act of 2015, in Relation to the Property and Casualty Industry

A change is in the wind, or more like a tornado, when it comes to new healthcare reforms, particularly on the payment side. In 2019, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) will be introduced requiring new quality measurements. In a “be careful what you wish for” scenario, MACRA was put in place after physician groups pushed back on the Sustainable Growth Rate (SGR) formula which lowered payments from Medicare to physicians.

Since the SGR method of paying physicians is being eliminated, MACRA will be implementing a new payment framework that is based on the quality of care provided to a patient rather than the quantity of care. MACRA consists of two separate payment programs; Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). As if we didn’t need more acronyms, these programs are loaded with new definitions and more acronyms that will eventually roll off the tongue as part of the new health world terminology in the United States.

Some definitions before moving on to how the components of MACRA are combined. They are:

- Physician Quality Reporting System (PQRS)—A reporting system developed by the Center for

Medicare/Medicaid Services (CMS) to encourage physicians/practices to report quality. This reporting allows providers to quantify how often they are meeting quality metrics. Starting in 2015, providers who did not report these metrics were paid less than those that did through the fee for service schedule (CMS, 2016).

- Value Modifier (VM or Value-based Payment Modifier) — This modifier is an indicator to CMS the physician/practices quality of care rating during a performance period of reporting PQRS. This modifier indicates adjustments to payments made to the providers who perform under the Medicare Physician Fee Schedule (PFS). This modifier is connected to the provider’s Tax Identification Number (TIN) to be applied to individual physicians and practices (CMS, 2016). This program was being phased in starting in 2015. In 2017, the adjustment will apply to solo

practitioners and physicians in groups of two or more and, in 2018, all physicians will be included with the addition of physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists who are solo or in groups of two or more. The performance is rated on what occurred for these providers going back two years (CMS, 2016).

- Medicare Electronic Health Record (EHR) — Requirements were established for the capture of clinical data which included providing patients with EHRs. In the second phase, the quality improvement was focused on the point of care and the exchange of information (CMS, 2016). The incentive programs were established as part of the American Recovery and Reinvestment Act of 2009 (ARRA) enacted Feb. 17, 2009.



- Eligible Professionals (EPs)—Applies to individual EPs, groups of EPs or virtual groups. The provider types these new quality programs apply to are: physicians, physician assistants, certified registered nurse anesthetists, nurse practitioners, clinical nurse specialists and groups that include these professionals. After 2021 the CMS can add additional EPs. Those that are excluded are qualifying Alternative Payment Model (APM) participants; partial qualifying APM participants; and low volume threshold exclusions (CMS, 2015).

The first model is the MIPS model which combines the PQRS, VM and EHR incentive programs into one single program for the EPs effective in 2019. The measurements will consist of quality, resource use, clinical practice improvements and use of EHR technology. The second model is the APM which from 2019–2024 may pay some participating health care providers one lump sum based on either the covered life or case type (e.g., hip replacement). These lump sum models are intriguing for P&C

when we conceptualize the course of care for a workers’ compensation injury or auto accident and the possibilities of moving away from fee for service. This is the main reason we are keeping track of these new models as they can be “bell weathers” for future payments through the healthcare continuum.

The American Medical Association (AMA) has been involved in encouraging physicians who are willing to spend the time to develop APMs and work with the system. In addition, they are supporting:

- Identifying opportunities to remove barriers in our existing payment systems in the performance of quality of care
- Identifying unintended consequences of APMs and monitoring the performance
- Maintaining a vigilant and constant attention to realizing the benefits to patients
- Focusing on improving care outcomes for patients, while at the same time achieving savings for payers (AMA, 2016)





Lastly, the payment models and initiatives for quality of care, MACRA contains the “Social Security Number Removal Initiative”. This initiative requires SSNs be removed from all Medicare cards.

So what does this really mean for P&C medical payments? To understand that, we simply need to look at how Medicare affected P&C with just a fee schedule. If we think that value based healthcare is the silver bullet in the payment of medical payments, we need to think again. We still have state laws to contend with and adoption of models and policies. P&C is risky business, not likely where we will attempt to try these new models until we can understand the benefit. Providers are consolidating, physicians are retiring at higher numbers and they’re really not that enthusiastic for these changes, according to the 2016 Survey of America’s Physicians: Practice Patterns and Perspectives which surveyed over 17,236 physicians (The Physicians Foundation by Merritt Hawkins, 2016). These new models could affect change in P&C specifically in negotiating BI claims. As we did with fee schedule adoption in P&C, the results of the new models will need to be evaluated over time.

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International Classification of Diseases, 10th Revision-Clinical Modification and Procedural Coding System (ICD-10-CM/PCS) Update

ICD-10-Clinical Modification (CM) and Procedural Coding System (PCS) has over 5,000 changes and/or additions in fiscal year 2017. The information was released in June 2016 for fiscal year beginning Oct. 10, 2016. The effective date of Oct. 1 for these new revisions applies to all sectors of health payment, including Property and Casualty (P&C) where ICD-10 is specifically adopted. Mitchell has been working to implement all of the new changes within our databases to be on time for usage by our customers.

The significant number of new codes being added are due for a freeze on updates to ICD-10 codes before the Oct. 1, 2015 implementation date, caused by an overlap of ICD-9 expiration.

On June 2, 2016, the Centers for Medicare and Medicaid Services (CMS) released the PCS (procedure) codes. The PCS codes are used by hospitals to report procedures performed on inpatient admissions.

Summary of updates for PCS (Procedure) Codes are:

- 3,836 New/Added
- 12 Deleted
- 491 Revised

The new codes are found in the Medical and Surgical, Administration, Measurement and Monitoring and New Technology sections.

On June 24, 2016 the Centers for Disease Control and Prevention released the CM (Diagnosis) codes. The CM codes are used for all bill types reporting diagnoses (CMS/UB).

Summary of updates for CM (Diagnosis) Codes are:

- 2,305 new/added
- 212 deleted
- 551 revised

The following is a brief synopsis of additions and changes throughout the code set that are relevant to the Property & Casualty industry. Mitchell has observed many changes to the code sets we frequently use in P&C.

- **Chapter 6** (Diseases of the Nervous System) include carpal tunnel disorder and various lesions of specific nerves.
- **Chapter 13** (Diseases of the Musculoskeletal System and Connective Tissue) added pain in joints of the hand, more specificity to temporomandibular joints, cervical disc disorders at specific levels, atypical femoral fractures and periprosthetic fractures.
- **Chapter 19** (Injuries, Poisoning and Certain Other Consequences of External Causes) made significant additions regarding fractures to bones of skull and foot.
- **Chapter 20** (External Causes of Morbidity) updated some of the vehicular accident codes and added contact with paper or sharp objects and overexertion external cause codes.

The final code updates and addendum were posted to the links below:

- PCS (Procedure) www.cms.gov/Medicare/Coding/ICD10/index.html
- CM (Diagnosis) www.cdc.gov/nchs/icd/icd10cm.htm, www.cms.gov/Medicare/Coding/ICD10/index.html

Coding and Reporting

The ICD-10-CM Official Guidelines for Coding and Reporting has been updated for FY 2017. These guidelines have been approved by the

four organizations that make up the cooperating parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), Center for Medicare and Medicaid (CMS), and National Center for Health Statistics (NCHS), www.cdc.gov/nchs/data/icd/10cmguidelines_2017_final.pdf

Managing New York Durable Medical Equipment in P&C

Recently, Mitchell's Internal Regulatory Committee was called to research and provide factual information on the proper billing and payment of Durable Medical Equipment (DME) charges under New York Workers' Compensation fee schedule for both auto and workers' compensation claims. In researching, we found several references that should help customers with their claims.

To set the background, New York State Workers' Compensation Board (NY WCB) had previously adopted the NYS Medicaid fees and rules governing DME payments. Per an email response provided to Mitchell from the NY WCB on March 20, 2013:

"For DME items that do not have an MRA, the rental fee is calculated at 1/6th of the equipment provider's acquisition cost. The total accumulated monthly rental charges may not exceed the actual purchase price of the item. If the item is eventually purchased, all accumulated monthly rental payments including Medicare and other third party payments will be applied to the total purchase price of the item. Where there is prolonged need for a piece of DME and purchase is either undesirable or unavailable, rental terms will be set by the DOH Medical Director."

New York Workers' Compensation fee schedule adopted the New York State Medicaid fee schedule for DME under Part 442 of Title 12 NYCRR, section 442.2. Previously, the rules of NYS Medicaid, including the reference to allowing 1/6th the purchase price on rental charges were also adopted. However, per notification in April 2009 the following change was made:

"Note: The Medicaid provider manual for durable medical equipment and the policy guidance do not apply to workers' compensation except to the extent such documents contain the Medicaid durable medical equipment fee schedule. Application of the durable medical fee schedule is based on Workers' Compensation statute, rules and regulations in addition to the durable medical equipment fee schedule. Only the Board in the exercise of its adjudicatory function is authorized to determine entitlement to benefits based on the specific facts of a given claim and the application of the law to those facts. No-Fault cases may be subject to differing interpretations. For information regarding No-Fault Insurance, contact NYS Department of Financial Services at dfs.ny.gov" (New York Workers' Compensation Board)

As stated, the updated DME fee schedule under 442.2 no longer follows the Medicaid guidelines (NYS Medicaid Program Durable Equipment Manual Policy Guidelines Version 2009-2) when the DME code is not in the fee schedule. Therefore, pricing for DME codes not listed would be considered "By Report" and payable at carrier's discretion.

Data Insights

By Ed Olsen

Sr. Business Process Consultant, Mitchell Casualty Solutions Group



Since the emergency room bill is one of the earliest bills presented, we can take a look at results based on loss year and immediately start to see differences state by state.

In previous editions of the Industry Trends Report we reviewed the top 10 procedure codes used in various states of jurisdiction for the automobile insurance marketplace. What we discovered was that the top 10 medical service codes served as a fingerprint for each state revealing how providers avail themselves to various medical services to a greater or lesser extent based on jurisdiction. For example, in the Pacific Northwest, the top 10 procedure codes represented nearly 50 percent of the total charges, while in New York, the top 10 procedure codes only represented 10 percent of the total charges. Additionally, the Pacific Northwest top 10 consisted purely of physical medicine services while the New York top 10 included both physical medicine and advanced diagnostic imaging services.

In this edition of the Industry Trends Report, we are going to look at the use of diagnosis codes in the emergency room and throughout the entire first party automobile insurance claim lifecycle to determine if it too serves as a state's fingerprint.

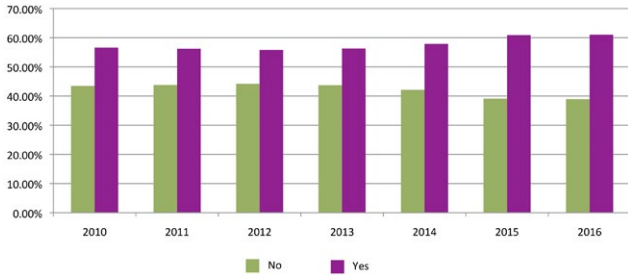
It is worth noting that not all states are created equal when it comes to available policy limits and there is potential for these limitations to mitigate the use of more extensive injury diagnoses. However, the diagnosis assigned at the emergency room is rarely impacted by this factor as it is typically one of the earliest bills presented on a claim. Since the emergency room bill is one of the earliest bills presented, we can take a look at results based on loss year and immediately start to see differences state by state.

In Michigan, with unlimited personal injury protection (PIP), there is a fairly consistent split between those seeking emergency room treatment and those who do not, with approximately 42 percent choosing not to go to the emergency room while 58 percent decide to visit the emergency room. Comparing Michigan’s result with either Texas or Florida we can see pretty remarkable differences as it relates to the single decision of whether or not to treat in the emergency room. In Texas, approximately 80 percent of claimants do not treat in the emergency room while in Florida the percent of claimants choosing not to go the emergency room has been steadily declining to its current state that closely approximates Michigan’s result with approximately 46 percent of claimants opting to not treat in the emergency room.

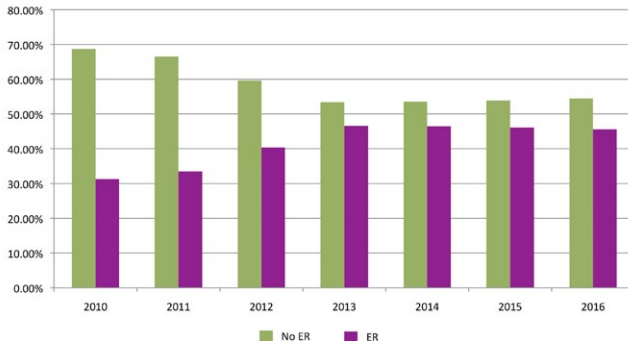
By scoring and categorizing every diagnosis as either a non-traumatic, soft tissue, nerve and/or intervertebral disk, fracture and/or dislocation and head injury, each medical bill processed and every claimant can be categorized according to their worst diagnosis. Upon investigating the worst diagnosis assigned to each individual claimant by the doctors that examined and billed for services rendered in the emergency room we start to see similarities emerge. For instance, it is readily apparent that in Florida and Texas the majority of claimants have a soft tissue sprain and/or strain injury as their worst diagnosis. The next factor observed is that claimants with fractures and/or dislocation injuries make up the second largest group of claimants treated in the emergency room. The final two factors involve claimants with nerve and intervertebral disk injuries (IVD) and head injuries (i.e. concussions, traumatic brain injury). The trend observed for both of these diagnosis categories is interesting — in both Texas and Florida the percent of claimants leaving the emergency room with some type of head injury

diagnosis started to increase in 2015 while the percent of claimants leaving the emergency room with a nerve or disk injury has remained relatively consistent at approximately two percent.

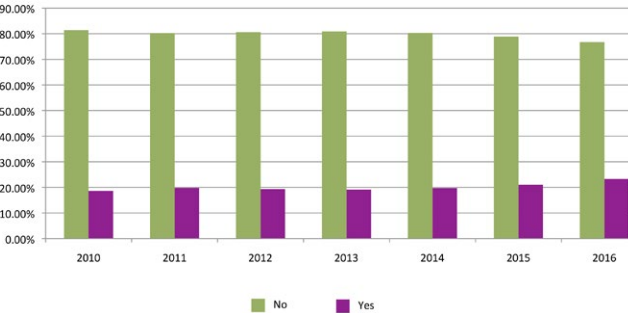
Michigan Claimants Seeking Emergency Room Treatment



Florida Claimants Seeking Emergency Room Treatment



Texas Claimants Seeking Emergency Room Treatment



By continually monitoring a claimant’s diagnosis progression after they leave the emergency room we find that both Florida and Texas see a marked increase in the number of claimants diagnosed with nerve and IVD injuries. In Florida, while only 1.5 percent of claimants leave the emergency room with a nerve or IVD injury, a full 20 percent of claimants who sought emergency room treatment ultimately end up with a nerve related injury diagnosis. Texas sees a similar phenomenon with two percent of claimants leaving the emergency room with a nerve related injury and approximately nine percent of these claimants ultimately being diagnosed with a nerve or IVD injury. An interesting side note is that the progression to a nerve or IVD injury occurs earlier in the claim life cycle in Florida than in Texas as reflected by the marked decrease in Texas claimants seen in loss year 2016 and the consistent nature of Florida’s result throughout all periods.

Looking a little deeper and considering all claimants, whether they visited the emergency room or not, we see that even a greater percentage of claimants ultimately end up with a nerve or IVD related injury. If we compare claimants who visited the emergency room with those who did not, we find that in 20 percent of Florida claimants who visited the emergency room and 40 percent of those claimants that never treated in the emergency room are ultimately diagnosed with nerve or IVD injury. For those Florida claimants never treated in

the emergency room the percent of claimants with nerve and IVD related injuries has been gradually increasing, and starting with loss year 2013, the percent of claimants with nerve or IVD related injuries actually surpassed the percent of claimants with soft tissue injuries. The average charge per claimant in Florida for nerve and disk injured claimants has remained consistently higher than soft tissue injury claimants and the gap is getting wider. While nerve injury related treatment in 2011 was 20 percent higher than soft tissue injury treatment, by 2014 nerve related treatment was twice that of soft tissue claims in Florida. In Texas the average charge per claimant has remained a fairly constant—56 percent higher for nerve and IVD related treatment when compared to soft tissue injury treatment.

It should not be a surprise that treatment for nerve and IVD related injuries has a higher average charge per claimant as they may require more advanced and costly diagnostic testing and/or surgeries. What is at least intriguing is the number of claimants having never sought emergency room treatment who are ultimately diagnosed with nerve related injuries. This should not be interpreted to mean that nerve and IVD injuries in claimants that never treated in the emergency room are not possible. What it should be interpreted to mean is that review of medical documentation is essential to the determination of medical necessity and causal relationship.



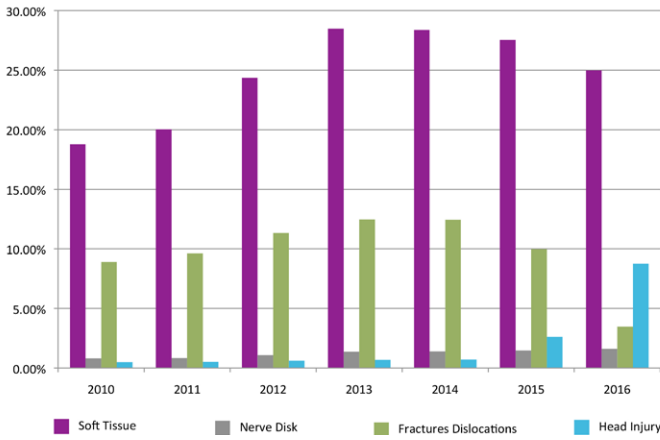
Florida Claimants with Nerve/Disk Injuries



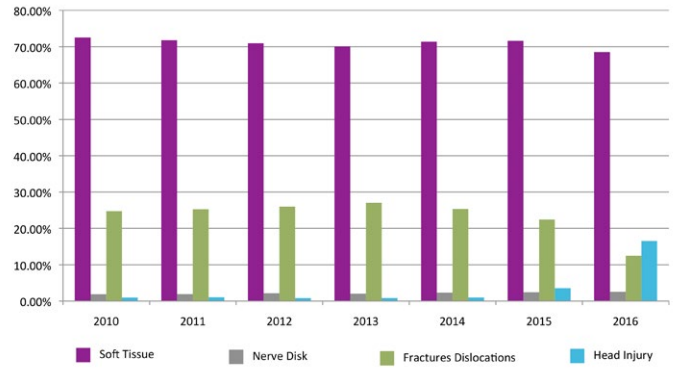
Texas Claimants with Nerve/Disk Injuries



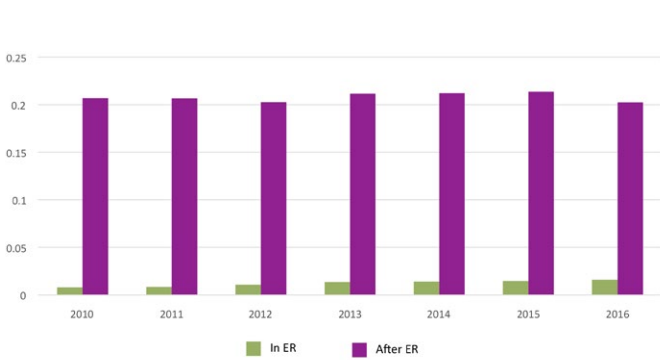
Florida ER Claimants Worst Diagnosis



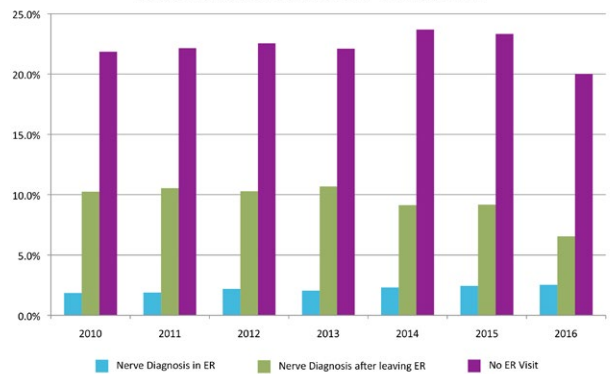
Texas ER Claimants Worst Diagnosis



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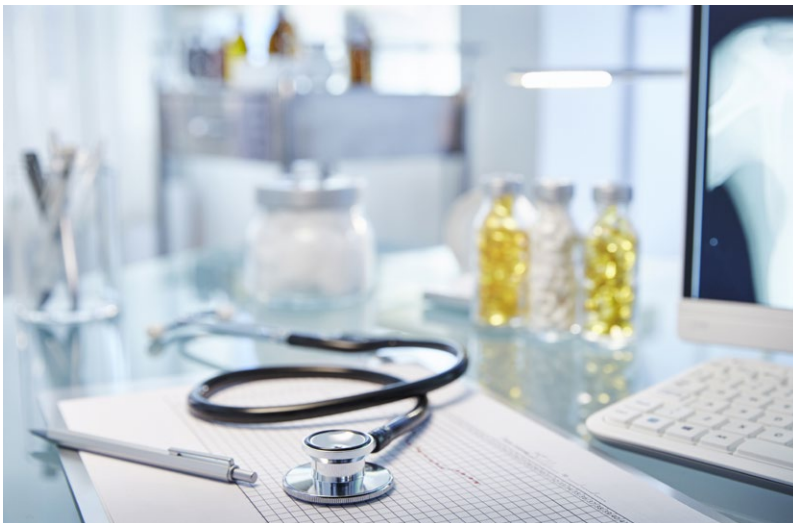
Texas ER Claimants with Nerve/Disk Injuries



Auto Casualty Medical Price Index

By Ed Olsen

Sr. Business Process Consultant, Mitchell Casualty Solutions Group



Charges associated with physical medicine services experienced a 2.15 percent increase in Q2 2016 from Q1 2016.

The National CPI for All Services, as reported by the Bureau of Labor Statistics, is presently 119.68, which is up 0.35 percent in Q2 2016 since Q1 2016. For the same period of time, Q1 2016 to Q2 2016, the National Auto Casualty MPI increased by 2.56 percent and presently sits at 121.54. Since Q1 2006, the MPI has increased 21.54 percent while the National CPI for All Services increased 19.68 percent.

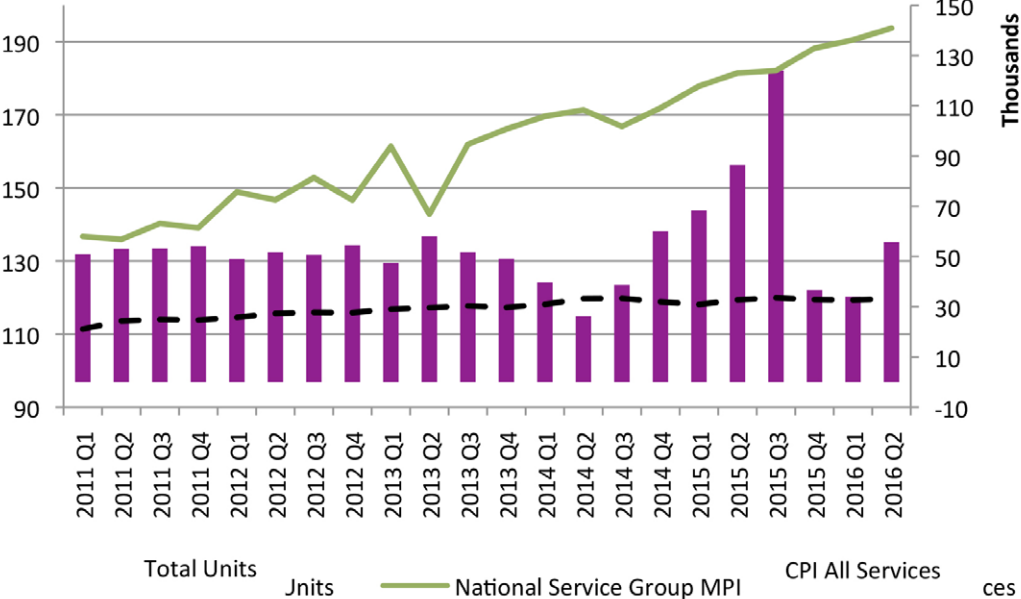
- Charges associated with physical medicine services experienced a 2.15 percent increase in Q2 2016 from Q1 2016. This increase brings the total unit cost change for physical medicine since Q1 2006 to 6.3 percent, significantly below the National CPI for All Services reported by the Bureau of Labor Statistics. Recall that the physical medicine MPI is looking strictly at unit charge while holding utilization constant. No significant changes in technology to deliver physical medicine services have been discovered that might influence the unit charge of these services.

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

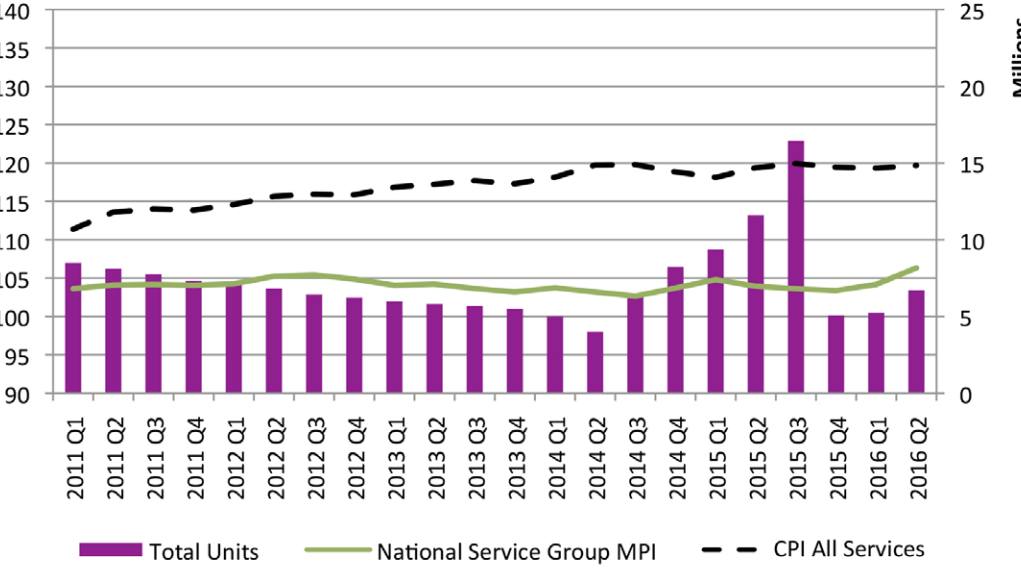
- The unit cost for major radiology services increased 3.35 percent in Q2 2016 from Q1 2016 and presently sits at 127.65. Despite this increase, MPI for major radiology services remains 1.1 percent below the service groups high of 128.75 experienced in Q4 2013.
- The unit cost for evaluation and management services increased 3.87 percent in Q2 2016 when compared with its Q1 2016 result. Since Q1 2006 evaluation and management services have seen unit charge increase 78.9 percent as reflected by the index value 178.9. In the first two quarters of 2016, the index for evaluation and management services has increased 6.5 points.
- The unit charge for professional services in the emergency room continues to rise. In Q2 2016, professional services in the emergency room experienced a 3.22 percent increase since Q1 2016. Since Q1 2006, this service group has experienced a 93.75 percent increase in the unit charge of professional emergency room evaluation and management services. In the first two quarters of 2016, the index for professional services in the emergency room has increased 5.5 points.



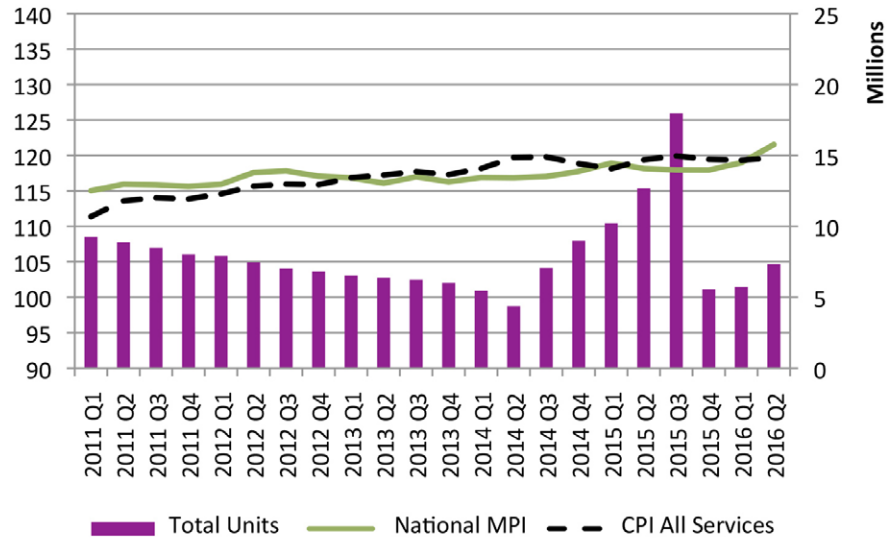
Emergency Room MPI



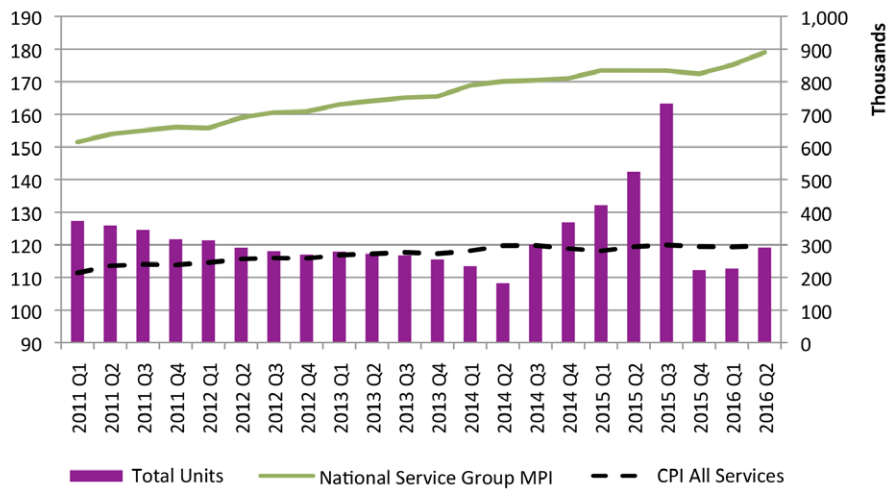
Physical Medicine MPI



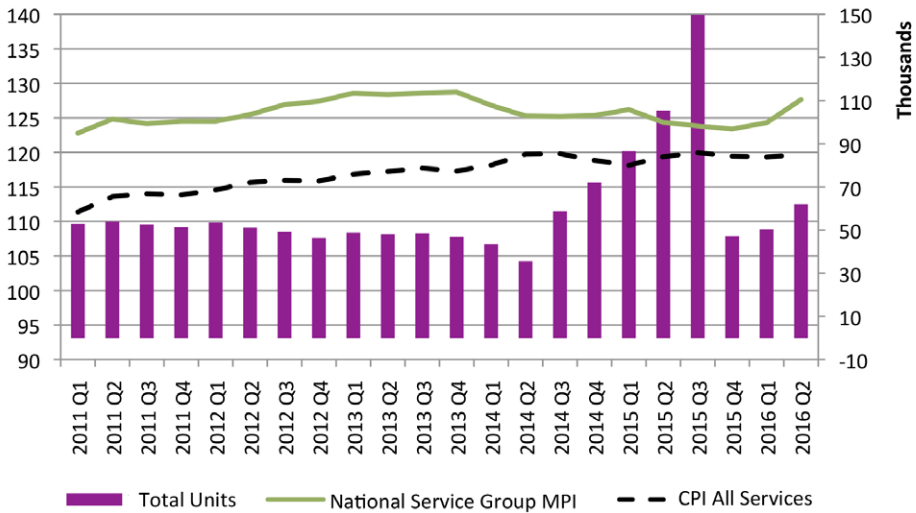
National MPI



Evaluation & Management MPI



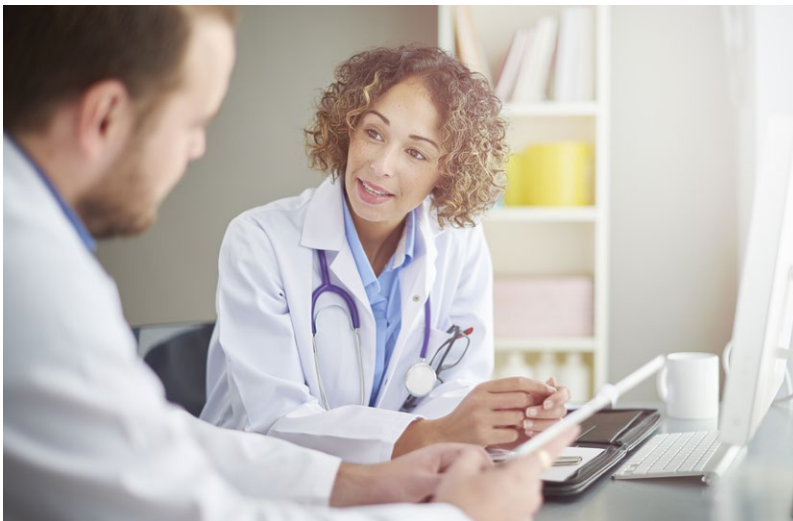
Major Radiology MPI



Workers' Compensation Medical Price Index

By Ed Olsen

Sr. Business Process Consultant, Mitchell Casualty Solutions Group



In the first two quarters of 2016, the MPI for physical medicine services has increased 4.6 percent.

The National CPI for All Services, as reported by the Bureau of Labor Statistics, is presently 119.68 which is up 0.35 percent in Q2 2016 since Q1 2016. For the same period of time, Q1 2016 to Q2 2016, the National Workers' Compensation MPI is virtually unchanged and presently sits at 112.33. Since Q1 2006, the National Workers' Compensation MPI has increased 12.33 percent while the National CPI for All Services increased 19.68 percent.

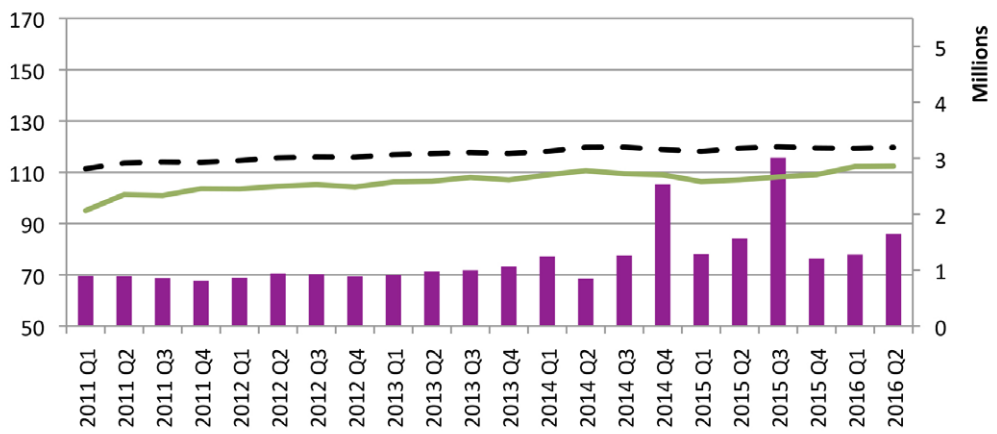
- Charges associated with physical medicine services experienced a 0.82 percent increase since Q2 2016. This increase brings the total unit cost change for physical medicine since Q1 2006 to 7.45 percent, significantly below the National CPI for All Services reported by the Bureau of Labor Statistics. In the first two quarters of 2016, the MPI for physical medicine services has increased 4.6 percent. Recall that the physical medicine MPI is looking strictly at unit charge while holding utilization constant. No significant changes in technology to deliver physical medicine services have been discovered that might influence the unit charge of these services.

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

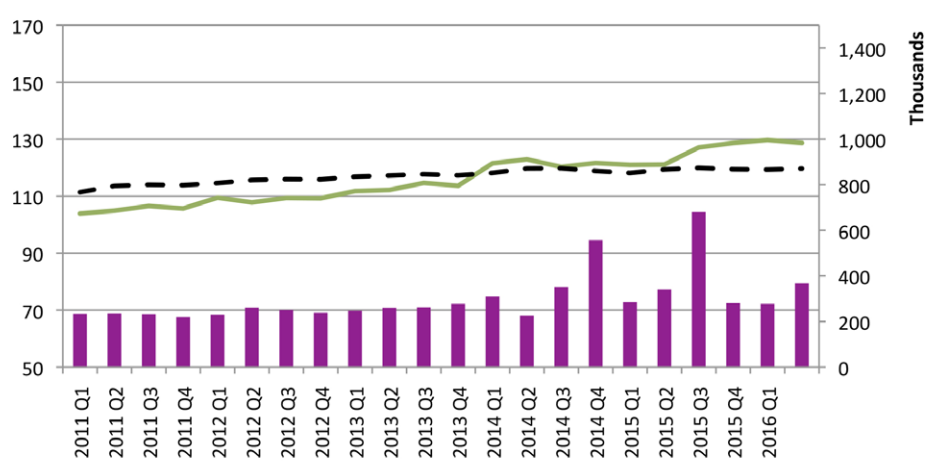
- While the unit cost for major radiology services experienced by the workers' compensation industry has increased 2.05 percent in Q2 2016, when compared to Q1 2016, it remains virtually unchanged since Q1 2006. This service groups current index value of 100.4 indicates the unit charge has increased 0.4 percent since Q1 2006.
- The unit cost for evaluation and management services decreased 1.04 percent in Q2 2016 bringing the workers compensation index to 128.69. The 1.04 percent increase experienced in Q2 2016 essentially eliminated the 1.07 percent decrease experienced in Q1 2016. Since Q1 2006, evaluation and management unit charge has increased 28.69.
- Since Q1 2016, the unit charge of professional services performed in the emergency room setting has increased 15.57 percent. This increase brings the MPI to 168.1 which reflects a 68.1 percent increase in the unit charge since Q1 2006. In the previous edition of ITR we reported a 3.16 percent improvement in unit charge for the period Q4 2015 to Q1 2016 and indicated that we believed it to be a temporary improvement. The current reporting periods' result supports that conclusion.



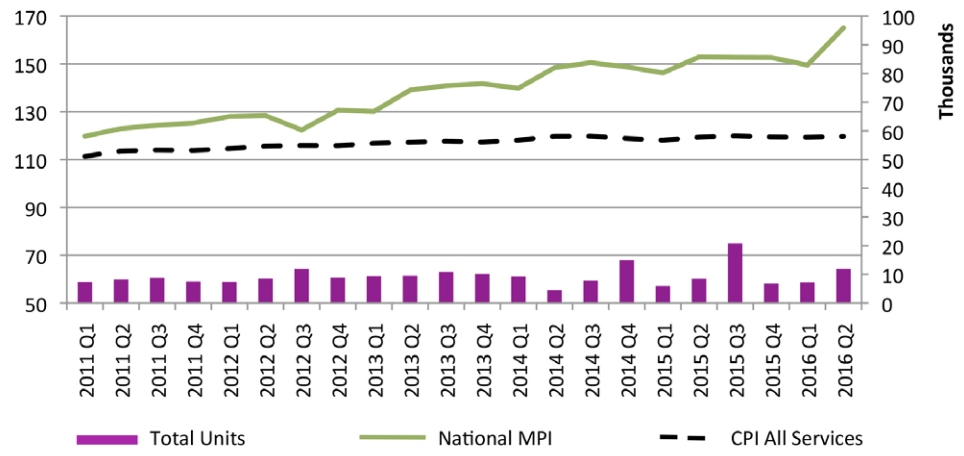
National MPI



Evaluation & Management MPI

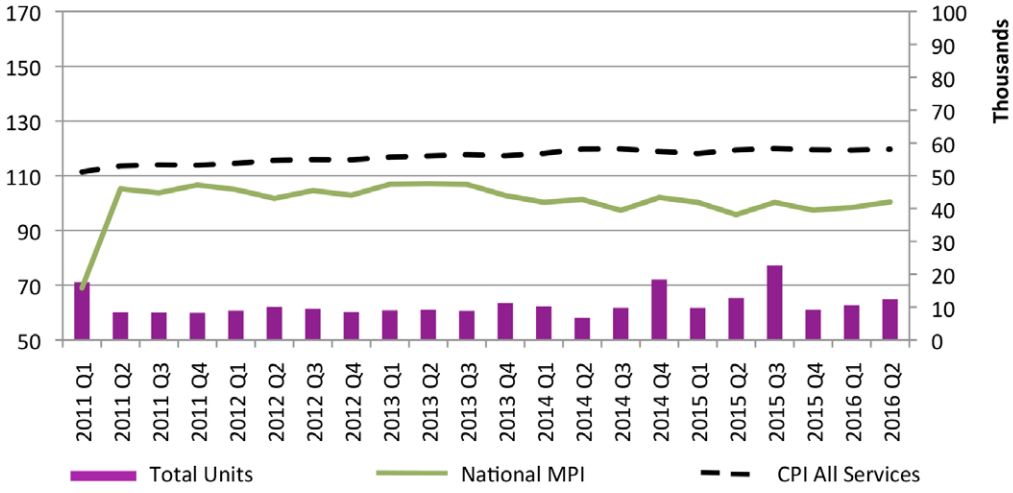


Emergency Room MPI

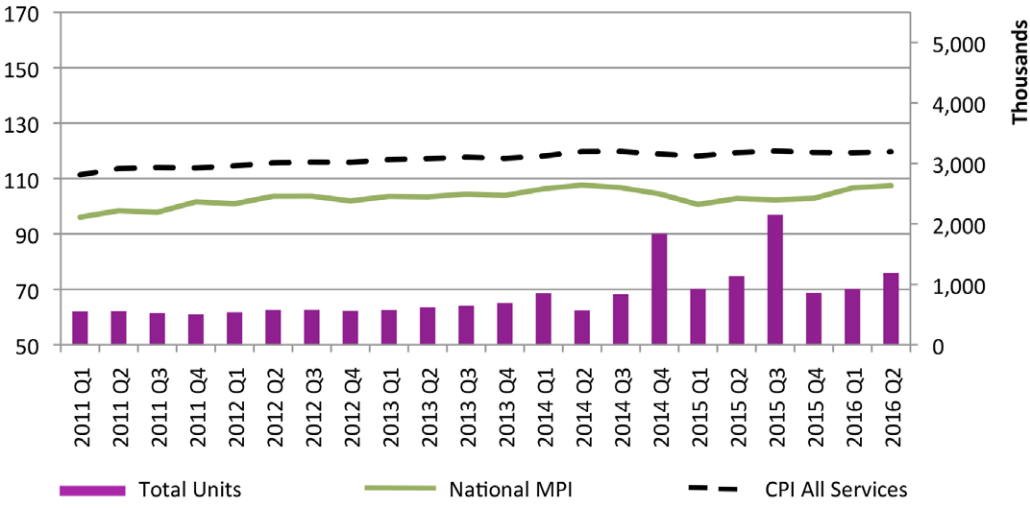


█ Total Units
 — National MPI
 - - - CPI All Services

Major Radiology MPI



Physical Medicine MPI



Partner Spotlight—Adva-Net



Adva-Net has access to over 23,000 contracted in-network providers and locations.

Nearly \$1.2 billion is spent annually on pain management services within the workers' compensation industry. To address the increasing demand for cost containment solutions in the market, Mitchell is pleased to announce the addition of Adva-Net to its portfolio of Strategic Partners.

Adva-Net has access to over 23,000 contracted in-network providers and locations. The specialty solution generates new and enhanced penetration and savings through a custom EDI bridge within Mitchell's SmartAdvisor® bill review platform. Adva-Net's expansive network provides negotiated rates for all facets of comprehensive pain management treatment, including evaluations, injections, physical and behavioral rehabilitation, drug screening and addiction recovery. The prospective and

retrospective application of Adva-Net's provider agreements, coupled with its expansive network, creates the opportunity to generate substantial savings on specialty pain management bills.

Read more about Mitchell and Adva-Net's partnership in the official [Mitchell press release](#).



About Mitchell



mitchell

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San Diego, CA 92122**



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



Mitchell Acquires Qmedtrix

Mitchell announced the acquisition of Qmedtrix, a provider of speciality bill review and strategic negotiations to the workers' compensation and auto casualty markets.

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Mitchell to Acquire Integrated Prescription Solutions

Mitchell announced it has acquired the assets of Integrated Prescription Solutions, a pharmacy benefit management (PBM) company for the workers' compensation industry.

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Mitchell Adds Adva-Net to Portfolio of Provider Network Solutions

Mitchell announces the addition of Adva-Net as a new strategic partner to SmartAdvisor.

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7 steps to paying the right amount for bodily injury claims

Chris Tidball looks at the factors that have contributed to the rise in bodily injury claims and the steps adjusters should take while investigating them.

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Around the P&C insurance industry: September 28, 2016

Mitchell announces enhancements to the DecisionPoint medical bill review solution for first- and third-party auto casualty markets.

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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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