Industry Trends Report

FEATURED IN THIS ISSUE:

ICD-10—How is the Casualty Industry Measuring Up?

By Michele Hibbert-Iacobacci, CCSP, CMCO
Vice President, Information Management & Support, Mitchell Casualty Solutions
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ICD-10’s Impact

Welcome to the Q1 Edition of the 2016 Casualty Mitchell Industry Trends Report. In this issue, we take a step back and look at the progress that has been made since transitioning to the ICD-10 code set in October and what that means for the industry.

In our feature article on page 4, ICD-10 – How is the Casualty Industry Measuring Up, author Michele Hibbert-Iacobacci shares Key Performance Indicators (KPIs) that our team has identified regarding adoption statistics and the areas where ICD-10 can address issues in medical bill review applications that insurers currently rely on for objective review. Michele explains how the need for KPIs is vital to understanding the benefits and workflow changes for efficiency planning and what we should be focusing on for increasing claim efficiency.

Finally, as you may have heard, we have expanded our pharmacy solutions through the acquisition of Jordan Reses and introduced ScriptAdvisor as the new name for our pharmacy benefit management solution. We are excited about this recent acquisition and ensuring that we are continuing to bring value to you through our network of products and services. As we prepare to celebrate our 70th anniversary this year, it is an exciting start for all of us here at Mitchell and we appreciate you being part of our story. I look forward to sharing more news with you in future issues and thank you for your continued readership of the Industry Trends Report.

Alex Sun
President and CEO
Mitchell
ICD-10—How is the Casualty Industry Measuring Up?

By Michele Hibbert-Iacobacci, CCSP, CMCO
Vice President, Information Management & Support, Mitchell Casualty Solutions

The Property & Casualty (P&C) industry experienced a big change on October 1, 2015—the implementation of ICD-10 codes, after multiple delays. The use of ICD-10 provides greater specificity, expanded medical terminology and insight into medical procedures, due to the expanded set of codes that are now available for providers. ICD-10 diagnosis codes are utilized by all medical providers for communicating with payers. One method that can be used to evaluate the impact of ICD-10 is through the use of Key Performance Indicators (KPIs), which provide insight into the adoption and value of the classification system. Creation of KPIs specifically for the adoption of ICD-10 provides the P&C industry measurable means for monitoring status of implementation.

Mitchell has been working diligently to adopt and review KPIs for the ICD-10 transition for our customers and the industry. Since Mitchell is a bill review technology provider, our customers are

ICD-10 diagnosis codes are utilized by all medical providers for communicating with payers.
interested not only in adoption statistics but also the areas where ICD-10 can address issues in the medical bill review applications insurers rely on for objective review.

Adoption statistics from Mitchell data for providers’ billing in casualty calculated the last week of 2015 were at 91.1 percent and cumulative since implementation of ICD-10 was 86.4 percent. Our industry’s expectation three months post implementation was 80% provider adherence. The casualty industry is progressing above expectations from a provider adoption perspective. We are even reviewing bills from Puerto Rican car accident victim cases that are coming in with ICD-10 codes.

From a state perspective, end of 2015 statistics demonstrate eleven states were below the 80 percent adoption expectation, but not far behind with the lowest adoption rate at 72 percent. Since we are reviewing data week by week, the standings for the individual states have changed dependent upon the providers who are billing and the amount of workers compensation and auto accidents dates of service that have occurred during the timeframe we are reviewing. The providers billing ICD-9 in the
eleven states below 80 percent adoption only represent 7 percent of the providers nationwide.

From a provider “Specialty” analysis, our data is demonstrating for those providers still using ICD-9: 37 percent are Chiropractic Specialist, 12 percent are General Practice, 10 percent are physical therapists and 5 percent are massage therapists. These four specialties represent 65 percent of the providers still using ICD-9 in P&C. We have seen a vast improvement in these and other specialties over time but it does demonstrate where the focus areas should be from an education perspective.

Interesting coding scenarios we have observed have demonstrated the use of partial codes like V99. XXXA for “Unspecified transport accident, initial encounter” without providing any codes to describe the patient’s injuries. We are also seeing more codes billed for an encounter than would be necessary, whereby some providers may be using the General Equivalency Mapping (GEMs) for literal translations from ICD-9 to ICD-10.

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• Adjustments/Denials—Are they increasing or decreasing? Our expectation is that the change will be neutral. It will be important to understand the trends in this area for process improvement and to create a dynamic review process.

• Duplicate Bills—Are carriers receiving more duplicate bills because they are paying the claims slower? Paying claims slower costs money and is inefficient for carriers and providers. Monitoring of payment timelines will assist in process improvement.

• Claim Open Timeframe—Are claims staying open longer? Claims that stay open longer cost insurance companies money. Identifying process improvements for the workflow associated with claim open timelines can help control expenses.

• Severity—ICD-10 is a comprehensive classification system with new medical terminology. Are we seeing “severity rise” from the comprehensive nature of ICD-10 and/or are more codes being utilized?

• Case Mix Changes—Are we seeing varying degrees of change in the way injuries are being described and presented for payment? These changes can have a domino effect, especially if carriers are using predictive analytics upon first notice of loss to assist in triaging claims.
This list of KPIs is not all inclusive but it does give a good basis for top focus areas for the KPI monitoring. It has been our experience since the October 1, 2015 implementation of ICD-10 that the early results are better than expected. We also know the focus for the casualty market should not be on the transitional aspects to ICD-10, rather the value it can bring to our industry in communicating information and aiding carriers to pay what is owed on claims more efficiently.

By Michele Hibbert-Iacobacci, CMCO, CCSP
Vice President, Information Management & Support, Mitchell

As Vice President, Information Management and Support for Mitchell’s Casualty Solutions, her responsibilities include Health Information Management, Regulatory Compliance, Professional Services, Litigation Support, and Consultant to Advanced Analytics & Consulting. For the past 25 years, Ms. Iacobacci’s focus has been on working with major casualty insurers implementing rules committees, quality assurance, risk management, compliance programs and review processes necessary in delivering objective bill review systems. Ms. Iacobacci is a Certified Clinical Coding Specialist (CCS-P), and a member of the American Health Information Management Association (AHIMA).
For the second straight quarter, the National CPI for All Services—as reported by the Bureau of Labor Statistics—increased. In Q3 2015, CPI increased 0.65%. Medical CPI, as reported by Mitchell’s Medical Price Index for first party medical claims has decreased 1.6% over the past two quarters. Even with these two consecutive quarters demonstrating declines in medical CPI, medical CPI remains 17% higher than that reported in Q1 2006. The rise in Medical CPI experienced in the auto casualty market since Q1 2006 is equivalent to 0.44% increase each quarter or 1.75% increase each year. For the same period of time the National CPI for All Services increased 0.5% each quarter or 2% per year. (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)

- Charges associated with physical medicine services have experienced a decrease for the second consecutive quarter. In Q3 2015, the medical CPI associated with physical medicine had decreased nearly 1.0%. This decrease brings the total units cost change for physical medicine since Q1 2006 to 3.02%.
- The unit cost for Major radiology services continued to trend downward in Q3 2015, decreasing 1.23%.
- The unit cost for evaluation & management services decreased 0.7% in Q3 2015. This change has had little impact on the overall trend in unit cost associated with evaluation & management services. Since Q1 2006, evaluation & management services have experienced a 72% increase in unit charge.
- The unit charge for professional services in the emergency room remained virtually unchanged leaving its total increase since Q1 2006 at 80%.
Medical Price Index

**National MPI**

![Graph of National MPI]

**Evaluation & Management MPI**

![Graph of Evaluation & Management MPI]

**Emergency Room MPI**

![Graph of Emergency Room MPI]

**Major Radiology MPI**

![Graph of Major Radiology MPI]

**Physical Medicine MPI**

![Graph of Physical Medicine MPI]
We took a look at the 1st party bill review data associated with emergency room services to identify industry trends. Georgia was interesting in that cost and utilization increased at nearly identical rates. The graph depicts actual average charges experienced in Georgia on a per claimant basis. The increase in average charge per claimant from $3,028 in 2012 to $4,457 in Q3 2015 represents a 47% increase.

Not only is the increase in average charge per claimant one of the highest in the country, the fact that it is matched both by average allowed per claimant and units per claimant is unique. Most, if not all other states of jurisdiction, see average allowed per claimant expand at a slower rate than charge per claimant.

Making these findings even more interesting is that the average charge per claimant encountered on the CMS form type has only increased 4% since 2012. The graph here demonstrates that the average charge per claimant has increased from $579 in 2012 to $606 in Q3 2015, suggesting that the majority of emergency room cost increases are due to facility cost increases.

The most dramatic increases associated with facility bills involve two classes of service: evaluation & management and radiology. Here are two examples of the +30% increases in average allowed per claimant seen on facility bills for evaluation & management and radiology services. It is worth noting that each of these service classes experienced little change in average units per claimant indicating that the increased cost was due to an increase in the unit price charged by Georgia facilities.
Data Insights

Charge per claimant

Industry allowed per claimant index

Industry charge per claimant index

Industry units per claimant index

CMS Results

Procedure Code: UB Results

Procedure Code: UB Results

99284-evaluation & management

72125 cervical CT scan
Compliance in the Property & Casualty Insurance world can be a challenging endeavor, due to the ever-changing regulatory environment. At Mitchell, we recognize these challenges and provide updates and insight throughout the year. Here’s a quick recap of some recent changes in the regulatory compliance arena:

**Florida**
On October 7, 2015, the U.S. District Court for the Southern District of Florida issued a judgment regarding air ambulance services in Bailey v. Rocky Mountain Holdings and found that state regulations are not preempted by federal legislations (Airline Deregulation Act).

Click Here for More Info

**New York—Auto**

New York Published Proposed Rule Making for the Ambulatory Surgery Fee Schedule

In the September 16, 2015 edition of the State Register, the state posted the proposed rule making notification for the permanent rules for the Ambulatory Surgery Fee Schedule.

The state accepted comments on the proposed changes up until November 1, 2015. Information regarding the proposed changes have been included below. [Excerpt from New York web site Emergency Adoption and Proposed Rulemaking, Amending Part 329 of 12 NYCRR]

“Attached is an emergency adoption and proposed rulemaking amending Part 329 of 12 NYCRR. The regulations amend the Ambulatory Surgery Fee Schedule and will go into effect on October 1, 2015. The Notice of Emergency Adoption and Proposed Rule Making will be/was published in the September 16, 2015, edition of the State Register. Comments on the proposed rule will be accepted for 45 days. Please send questions or comments on the proposed regulation to:
New York—Workers’ Compensation
Medical Portal First Phase
Available
On December 16, 2015, the state updated its web site to now include access to the Medical Portal. The portal currently contains an overview of the new process, news, webinars and presentations, as well as an email address for questions. The first phase will allow the electronic submission of C-4 AUTH, MG-p1, and MG-2. In the next several weeks, the state will be holding one hour webinars to demo the portal and its use. To access information on how to register for the webinars and information on the Medical portal please use the links provided below.

Overviews Click Here
Webinars Click Here

Alaska
State of Alaska Department of Labor and Workforce Development Workers’ Compensation Board Meeting
Date: September 17, 2015
By: Shonni Burnside
On September 17, 2015, the state conducted a full public board meeting to discuss various agenda items, one of which was the proposed fee schedule update. At the meeting, they gave the public the opportunity to make comments on the proposed fee schedule, which had a tentative effective date of December 1, 2015. However, prior to the public meeting, the fee schedule proposal had been withdrawn as it had not been officially approved by the Alaska Workers’ Compensation Board. The state did, however, accept comments on whether the proposal should be approved and made available for public comment. Currently there are many parties that have voiced opposition to what had been proposed. Two of the biggest issues were the ambulance fee schedule and the lack of an outpatient fee schedule. The board will have to approve or deny the request for the proposal of a new fee schedule. If approved, the schedule will need to go through the appropriate rulemaking process and then again be opened up for public comment. Regulatory Affairs will continue to monitor this closely and advise of any additional changes in future communications.

Michigan
On December 15, 2015, a revised summary of SB 313 was completed. This bill was originally introduced on May 5, 2015. If adopted, this bill would change the insurance code to reflect the following:

- Require a person who rendered treatment for automobile accident injuries covered by auto insurance to be reimbursed a reasonable amount that could not exceed what the person customarily was reimbursed for similar products or services.
- Prohibit a person who rendered treatment to an individual injured in an automobile accident from seeking reimbursement in an amount that exceeded the amount the person customarily was paid for rendering similar treatment of injuries that were not connected with a motor vehicle.
- Prohibit a treatment rendered who was paid by a provider of health and accident coverage that was coordinated with an automobile insurance policy from seeking reimbursement from the automobile insurer in an amount that exceeded what the person previously was paid for similar treatment by the provider of health and accident coverage.
- Prohibit a health insurance policy or a health maintenance organization (HMO) contract from denying or limiting health coverage to an insured or enrollee solely because he or she suffered accidental bodily injury in connection with a motor vehicle or was eligible for personal protection insurance benefits under an automobile insurance policy.”

Click here to view this bill
Insurance fraud is a growing global phenomenon. In the United States alone, it is estimated that insurance fraud is an $80 billion dollar industry, second only to narcotics trafficking. Not surprisingly the two are often connected. According to the Coalition Against Insurance Fraud (the Coalition), there has been an increase in organized transnational crime rings using insurance fraud as a vehicle to fund illegal activities. Compounding matters, it appears that terrorists are also capitalizing on these crimes to make a quick profit.

Read More
The connection between drugs and insurance fraud has long been established. Now there is a growing body of evidence adding terrorism to this criminal trifecta.

According to Judicial Watch, Mexican drug cartels are smuggling foreigners, including members of ISIS, from countries with terrorist links into a small, rural Texas town near El Paso, and they’re using remote farm roads—rather than interstates—to elude the Border Patrol and other law enforcement barriers according to sources on both sides of the borders, including the Texas Department of Public Safety.

Compounding matters, it appears that terrorists are also capitalizing on these crimes to make a quick profit.
Claims organizations are faced with settling claims accurately and fairly, all while maintaining customer satisfaction. There are a variety of factors that can impact claims outcomes—in particular, treatment types. Investigation into the most frequently used codes (based on total allowed amount) experienced by the auto casualty insurance marketplace can provide valuable insight for claims organizations and investigators.

Read More
Current Events

ICD-10 Versus States’ Rights

By Michele Hibbert-Iacobacci, Tina Greene

From: ICD-10 Monitor
Publish Date: November 17, 2015

ICD10monitor’s Talk Ten Tuesdays, a national radio news broadcast, featured Michele Hibbert-Iacobacci and Tina Greene on 11/17/15.

ICD10monitor’s Talk Ten Tuesdays, a national radio news broadcast, featured Michele Hibbert-Iacobacci and Tina Greene on 11/17/15 discussing the latest with ICD-10 and the workers’ compensation and property casualty markets.

Access Podcasts
A Focused Approach to Leveraging Big Data for Workers’ Comp

Contributor: Vidya Dinamani

From www.propertycasualty360.com
Publish Date: October 30, 2015

One of the ever-present challenges facing the Workers’ Compensation industry is managing and making sense of the massive and growing amounts of information generated throughout the bill review process. This challenge increases daily with the introduction of new publicly available data resources, cheaper ways to store all this information and new tools that enable new different ways to manipulate information. The vast potential created by new tools and more resources creates a great need to make sense of and efficiently leverage big data.

Read More
Recent ICD-10 end-to-end testing conducted by CMS and the American Medical Association yielded an 87 percent claim acceptance rate. This means that of the 29,286 test claims received, only 25,646 were accepted. Imagine thousands of claims denied due to providers submitting improper codes, stalling the bill review process and creating pain for everyone involved.
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

ICBC Selects Mitchell International as Strategic Material Damage Solution Provider
Mitchell enters into long-term agreement with Insurance Company of British Columbia (ICBC) to serve as their new material damage solution provider.

CIECA Award Winners Announced
The Collision Industry Electronic Commerce Association (CIECA) board of trustees announces the winners of the 2015 Electronic Commerce awards.

Get Your Auto Claims Down to Size
Edward Olsen analyzes the top 10 procedure codes to fine-tune claims organizations.

How to Avoid an ICD-10 Claims Disaster
Michele Hibbert-Iacobacci shares steps that providers can take to ease the transition to ICD-10 and improve the overall billing experience.

A Focused Approach to Leveraging Big Data for Workers’ Comp
Vidya Dinamani discusses a three-pronged approach to leveraging big data in workers’ compensation.

For More Mitchell News:
Press Releases  Mitchell International  Mitchell_Intl  MitchellRepair  Mitchell Claims
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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