California Senate Bill 1160—New Utilization Review Regulations Take Effect January 1, 2018

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Welcome to the Q4 edition of the mPower by Mitchell Casualty Industry Trends Report. At Mitchell, we’re passionate about how technology can deliver greater value to our customers. In previous issues, we’ve often shared insights into how cutting-edge technologies like artificial intelligence are transforming claims processes. This quarter, I explore how the Property & Casualty industry can use an existing technology, video chat, in new and innovative ways to enhance claims processes.

As part of our ongoing commitment to keep you informed about compliance issues, Vice President of Medical Management Services, Jackie Payne, and Director of Utilization Review, Suzette Price Doherty, take a look at the California Senate Bill (SB) 1160 changes and provisions related to utilization review (UR) that go into effect January 1, 2018. This portion of SB 1160 is intended to streamline the UR process and ensure injured workers receive timely and appropriate medical treatment. While SB 1160 is a California state bill, many other states are watching it closely. Based on the outcomes of this legislation, it may lead the way for other states to adopt similar measures.

This latest report is also packed full of other useful information and insights, including an article on forthcoming Current Procedural Terminology (CPT) code changes, as well as Mitchell’s own data, our Q3 2017 auto casualty and workers’ compensation Medical Price Indexes.

You can find these articles and many more on the mPower by Mitchell website, our latest resource for technology trends and industry insights. I encourage you to check back often.

Alex Sun | President and CEO | Mitchell
How Video Chat Is Enabling New Types of Interactions in the Claims Process

By Alex Sun | President & CEO, Mitchell

At a time when artificial intelligence-powered chatbots are making significant inroads in the insurance industry, another, more familiar technology is also gaining traction—video chat. When measured by the recent, rapid pace of technology advancement, video chat is a relatively “old” technology, but it’s enabling new types of personalized experiences, particularly in healthcare, and making its way into the claims process in new, innovative ways.
First, some background: Skype first launched video calls on Windows in 2006, but it wasn’t until 2010 that it was available on mobile, the same year Apple launched FaceTime on the iPhone 4. Interestingly, Facebook’s other messaging platform, WhatsApp, is the biggest messaging platform in the world, and they just rolled out video chat last year. In their first six months of service, 1.2 billion users in more than 180 countries spent more than 350 million minutes a day making more than 55 million video calls. If there were any question before, it’s abundantly clear that consumers are ready and willing to adopt the technology.

Video Chat Enables Virtual House Calls

The healthcare industry has aggressively adopted video chat in an effort to make care more accessible, less costly, and to deliver better outcomes. Telehealth companies like Doctor on Demand, Teledoc and MDLive are proliferating. According to the AMA, 70 percent of all healthcare visits could be done virtually. For workers’ compensation claims the number may even be higher since 75 to 78 percent of claims involve less complex injuries and illness relative to personal health.

Seven of 10 patients would prefer virtual care if given the option. Sixty percent of large, U.S. employers provide coverage for telemedicine consultations, including Mitchell. We offer this service to our employees through our healthcare plan.

Video Chat Goes Beyond the Office Visit

Office visits are not the only things that have gone digital. It’s being incorporated into other types of healthcare workflows. In Iowa, for example, a company called NuCara combines telepharmacy consultations with remote dispensing sites so people in rural areas can get easier access to their medications. Kmart Pharmacy plans to convert some of their traditional pharmacy with on-site pharmacists to a telepharmacy model. In early tests, customer feedback indicated that the video chat experience actually felt more personal.

Meanwhile, in an effort to reduce costly, unnecessary ambulance rides to the hospital, the city of Houston has implemented a program called Emergency Telehealth and Navigation (ETHAN).

7 of 10 patients would prefer virtual care if given the option.
ETHAN has resulted in an 80% reduction in unnecessary hospital transports.

ETHAN allows first responders to video chat with doctors who triage patients and determine if they need to be transported to the hospital or can be treated at the scene. The program has resulted in an 80 percent reduction in unnecessary hospital transports, reduced the time from evaluation to transport in actual emergencies, and in many cases, reduced the cost to patient from $2,200 to $220.

Video chat is also having an impact on the way physical therapy is delivered. One of the biggest challenges with physical therapy is getting people to comply with their prescribed exercise regimen at home, but tele-rehabilitation means a physical therapist can be right there in the room with the patient, providing encouragement, ensuring that the exercises are done correctly and for the proper length of time, and actually observing progress, or lack thereof.
The Best Technology Is the Right Technology to Meet the Need

According to a recent study by Tata Consultancy Services, the insurance industry is on the forefront of investing in artificial intelligence. While computer vision, machine learning natural language processing and other AI technologies hold incredible promise across the claims continuum, and we are exploring these here at Mitchell, it’s important to note that the best technology to solve a challenge, expedite a process or connect with a customer may not always be the most current or cutting edge technology. Sometimes an “old” technology applied in new ways can bring about better outcomes for both insurer and claimant.

Video Chat in the Claims Process

Insurers of all types are looking to video chat to streamline and personalize the claims process. Liberty Mutual offers a video chat service called RealTime Review™ that allows homeowners to connect with a claims representative via FaceTime or Skype to assess damages and initiate a claim. Allstate offers “Virtual Assist,” an app that lets repair facilities video chat with adjusters for approval of supplements. The app is unique in that it is staffed by trained adjusters who are available on demand, reducing the time for approval from days to minutes, and ultimately, accelerating the repair process.

“According to a recent study by Tata Consultancy Services, the insurance industry is on the forefront of investing in artificial intelligence.”
The National CPI for All Services, as reported by the Bureau of Labor Statistics in November 2017 is 123.6, which reflects a 0.4 percent increase since Q2 2017. For the same period of time, Q2 2017 to Q3 2017, the National Auto Casualty MPI decreased 1.37 percent and as of November 2017, sits at 118.7. Since Q1 2006, the MPI has increased 18.2 percent while the National CPI for All Services increased 23.6 percent.

- Charges associated with physical medicine services remained virtually unchanged having experienced a 0.68 percent decrease from Q2 2017 to Q3 2017. Physical medicine has seen a 4.2 percent increase in unit charge since Q1 2006. Please recall that the physical medicine MPI is looking strictly at unit charge while holding utilization constant.

- The unit cost for major radiology services decreased 1.24 percent in Q3 2017 from Q2 2017 and as of November 2017, sits at 120.64.

- The unit charge for professional services in the emergency room decreased 1.4 percent in Q3 2017 compared to Q2 2017. Despite this minor correction, this service group has still experienced a 102.16 percent increase in unit charge since Q1 2006.

MPI remains 20.64 percent higher than its Q1 2006 benchmark unit charge.

- The unit cost for evaluation and management services experienced a 1.1 percent decrease in Q3 2017 when compared to its Q2 2017 result. Over the past year, comparing Q3 2016 results with Q3 2017 results, the unit charge associated with evaluation and management services has increased 4.28 percent. Since Q1 2006, evaluation and management services have seen unit charges increase 78.73 percent as reflected by the index value 178.73.

References:
Auto Casualty Medical Price Index

National MPI

Physical Medicine MPI

Major Radiology MPI

Evaluation & Management MPI

Emergency Room MPI
The National CPI for All Services, as reported by the Bureau of Labor Statistics, in November 2017, is 123.6, which reflects a 0.4 percent increase since Q2 2017. For the same period of time, Q2 2017 to Q3 2017, the National Workers’ Compensation MPI increased 2.3 percent and as of November 2017, sits at 113.03. Since Q1 2006, the MPI has increased 13.03 percent while the National CPI for All Services increased 23.6 percent.

- Charges associated with physical medicine services remained virtually unchanged having experienced a 2.22 percent increase in Q3 2016 from Q2 2017 that offset the 2.04 decrease seen between Q1 2017 and Q2 2017. Physical medicine has seen unit charge increase 8.3 percent since Q1 2006. Please recall that the physical medicine MPI is looking strictly at unit charge while holding utilization constant.

- In the workers’ compensation industry, major radiology services experienced a 2.45 percent decrease in Q3 2017 when compared to Q2 2017, remaining below the average unit charge seen by the industry in Q1 2006. Since Q1 2006, the unit charge of major radiology services billed on the Centers for Medicare & Medicaid Services (CMS) form have decreased 11 percent.

- The unit cost for evaluation and management services increased 9.2 percent in Q3 2017 when compared with its Q2 2017 result. Over the past year, comparing Q3 2016 results with Q3 2017 results, the unit charge associated with evaluation and management services has increased 21 percent. Since Q1 2006, evaluation and management services have seen unit charges increase 39.9 percent as reflected by the index value 139.9.

- The unit charge for professional services in the emergency room experienced a 5.07 percent increase in unit charge in Q3 2017 when compared to Q2 2017. This increase serves to offset the 5 percent decrease in unit charge experienced in Q2 2017. At the end of Q3 2017, index remains 72.9 percent higher than the Q1 2006 unit charge benchmark.
Workers' Compensation Medical Price Index

National MPI

Physical Medicine MPI

Major Radiology MPI

Evaluation & Management MPI

Emergency Room MPI
Audit, Audit, Audit: Why You Should Further Scrutinize Workers’ Compensation Bills

By Michael Parker | Senior Director, Product Management | Mitchell SmartPrice Solutions

"For most claims, there are a few key types of audits that help find billing inaccuracies and improve claim outcomes."

It’s very easy for payors to end up overpaying on medical bills. Auditing—a crucial but often forgotten or under-executed part of the claims process—can help payors identify questionable billing practices and prevent overpayment on workers’ compensation claims.

What is Auditing?

Auditing can take many shapes and forms but the essence of an audit is to review and verify that every line item is billed correctly and accurately. Since the complex factors to consider are numerous, it is important to employ clinical experts, sophisticated software systems, and robust industry data when performing the advanced auditing required.

For most claims, there are a few key types of audits that help find billing inaccuracies and improve claim outcomes.

Key Audit Types

Correctly Identifying Facility Type

Many states have adopted fee schedules that factor in the type of facility where services were performed in determining the price for services rendered. For example, the same procedure would cost a different price depending if it took place in an outpatient facility or ambulatory surgical center. It can be difficult to keep track of these complex, jurisdiction-based rules, so an auditing service can come in handy to accurately classify bills. In addition to helping pay the most accurate price on bills, accurately classifying facility type also helps with speeding up processing times, reducing the number of reconsiderations, cutting unnecessary processing costs and providing more precise bill routing and fee schedule application.
Validating DRG Groups

Many times, the difference between just one tier in a Diagnosis Related Group (DRG) is substantial—from $2,000 to $35,000 per code depending on the services billed and the difference in payment for what the provider reports and what service was actually performed. Validating the DRG pre-payment can mean big savings on a small amount of bills—alleviating reconsiderations and requests for refunds from providers and promoting accurate system routing and faster turn-times.

Understanding and Reviewing Implant Charges

Billing for implants is typically extremely vague, which frequently causes denials and long processing times. For example, you could get one line item for implants with 17 units billed for 17 different implants. That can make it very difficult for adjusters and bill reviewers to decipher, even with lots of documentation. A clinical review of implant invoices can alleviate these issues, reducing the chance of the claim coming back for re-review, cutting processing time and allowing for faster, more accurate payment.

Checking for Unbundled Charges

When a provider bills for a procedure, usually the cost of items like surgical trays or drugs that are specific to the procedure are actually included in the full price for the procedure itself. When a provider practices unbundling, they still charge the same price for the procedure, but they also list those additional items as line times—essentially asking for payment for supplies and drugs twice. It can be difficult to notice when this is happening, this is why it’s crucial to have a robust software system and clinical auditors that can identify these types of billing practices so they can help stifle overpayments and educate the provider on acceptable billing practices.

Conclusion

The many hidden complexities in medical billing make it difficult to ensure you’re not overpaying on workers’ compensation bills—from incorrect facility classification to unbundling. To combat questionable billing practices—whether they are intentional or unintentional—workers’ compensation payors need to add clinical auditing as a key component of their claims workflow.

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High Time for Change? Impact and Considerations for Medical Marijuana and Workers’ Compensation

By Mitch Freeman, Pharm.D. | Chief Clinical Officer | Mitchell Pharmacy Solutions
Michele Hibbert-Iacobacci, CCSP, OHCC | Vice President, Information Management and Support | Mitchell Casualty Solutions

"Several states have taken the lead in legalizing marijuana for both medicinal and recreational purposes, though the drug remains federally illegal."

Introduction
As the workers’ compensation industry battles the spread of opioid abuse in the United States, new methods for the treatment of pain have entered the conversation. Since the 1990’s, prescription opioid use and abuse have nearly quadrupled.¹ Today, one in four people receiving long-term opioid prescriptions becomes addicted² and around 91 Americans die from opioid-related drug overdoses every day.³ In 2016, the Center for Disease Control (CDC) released guidelines for prescribing opioids and in August 2017, the federal government declared a state of crisis in hopes of curtailing this widespread abuse. At the same time, the medical community is searching for alternative treatments for chronic pain, and many have turned their attention toward medical marijuana.

Some suggest that marijuana may be an effective alternative to opioids, with many medical benefits and fewer side effects. Several states have taken the lead in legalizing marijuana for both medicinal and recreational purposes, though the drug remains federally illegal. This legalization at the state level has many implications for the workers’ compensation industry. When faced with interstate commerce, vague state laws and the challenge of keeping a workforce safe, it is easy to see why marijuana has created such confusion among employers and insurers. Beyond the challenges of navigating the conflicting and often confusing rules at the state and federal levels, employers face issues with impairment on the job and insurers must consider options around reimbursement.
Impairment at Work

The use of marijuana can impair workers cognitively and physically, creating challenges in balance, coordination, and alertness. These impairments naturally lead to an increased risk of injury while on the job, especially in jobs that require physical and mental wellness, such as transportation or construction. As states continue to legalize marijuana both medically and recreationally, the likelihood of impairment and subsequent injuries occurring on the job increases.

Traditionally, employers have used drug tests to monitor employee health, but the challenge with marijuana is that the drug stays in the blood system for up to a month. Even if an employee may never have been intoxicated while at work, tests will still detect THC. Therefore, the employer cannot prove when the employee was intoxicated or if the marijuana was medicinal or recreational. As more states enact medical marijuana laws, employers must reconsider how to approach workplace rules regarding marijuana. Recent legislation and court rulings provide some direction, yet are conflicting from state to state.

States such as Florida and Colorado have upheld employers’ right to a zero-tolerance policy, giving businesses the right to terminate employees who use medical marijuana. Colorado additionally passed legislation that declares a 50 percent loss of wages or benefits if an employee is injured at work due to marijuana impairment. However, the recent ruling in Massachusetts’ Barbuto v. Advantage Sales and Marketing case questions whether employers can create a blanket zero-tolerance policy. The contrasting cases in Colorado and Massachusetts are summarized in the chart on next column.

<table>
<thead>
<tr>
<th>Case</th>
<th>State</th>
<th>Dispute</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Coats v. Dish Network</td>
<td>CO</td>
<td>Coats fired from Dish for using medical marijuana outside of work</td>
<td>Court upheld Dish’s decision to fire Coats</td>
</tr>
<tr>
<td>Barbuto v. Advantage Sales and Marketing</td>
<td>MA</td>
<td>Barbuto fired for testing positive for drug test based upon her use of medical marijuana</td>
<td>Court turned down Advantage’s defense that marijuana is federally illegal and said that Barbuto is protected under the Americans with Disabilities Act</td>
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These decisions make clear that businesses can no longer create blanket zero-tolerance policies, especially when operating across state lines.

Fourty-seven jurisdictions have laws that restrict workers’ compensation benefits if an employee is injured due to intoxication or drug use. Fourty of these are able to deny 100% of benefits. Nine states include in their medical marijuana laws provisions for anti-discrimination or reasonable accommodation. But it is unclear how to determine “intoxication.”

Recreational marijuana laws may also create difficulty for employers, as recent legislature in Maine shows. Because of the state’s legalization...
of recreational marijuana, employers cannot require drug tests for job applicants nor terminate employees for positive marijuana tests without proving impairment on the job. These various decisions create possible new precedents for other states to follow and new questions for employers to consider. Most importantly, employers must be cognizant of these changes and create new policies to keep their workplace safe.

Reimbursement

The morass of conflicting legislation and court rulings has also created confusion for insurers on whether to cover the costs of prescribed medical marijuana. Recent updates give an idea of where insurance coverage may be heading.

- New Mexico has led the way in outlining rules for medical marijuana coverage. In 2015, the state passed a law requiring insurers to reimburse employees for medical marijuana prescriptions related to a workers’ compensation claim.

The state has also seen three court rulings wherein medical marijuana was deemed “reasonable and necessary” for the workers injured on the job and had to be covered by workers’ compensation.

- In a recent ruling in New Jersey’s Watson v. 84 Lumber, the insurance company was also required to pay for an injured worker’s medical marijuana.

- Florida, on the other hand, passed legislation in 2017 stating that marijuana is not reimbursable.

Yet, the fact remains that marijuana is illegal federally. Despite the legislation moving forward at the state level, the federal government has the ultimate authority on the use of marijuana. This is
especially important for insurers and employers that operate across state lines. The decisions above may provide other states precedent in regards to coverage, but the current landscape of legislation means that all stakeholders must pay close attention to each state’s laws.

Challenges for Medical Marijuana’s Future in Pharmacy Management

Where does all of this leave us in the complicated and confusing world of medical marijuana? What are the implications for the workers’ compensation industry? The current challenge for payors as legalization moves forward is how to manage medical marijuana.

Pharmacy management today relies heavily on PBM systems to manage and monitor claims. These systems are highly automated and driven by multiple areas of standardization, from NDC drug codes to the transaction format. The coding is extremely specific, controls are put on claims in an automated fashion, and decisions follow formularies that are developed from state and federal guidelines.

With that said, the management of a drug that has no standardization is nearly impossible within a standardized system. Marijuana’s status as a Schedule I drug means there are no rules on standardization in the creation of medical marijuana drugs and no clinically based guidelines on prescribing. Because of this, the potency and dosage can vary drastically. For instance, recent years have seen a sizeable increase in THC levels, from around 4 percent in the 1990’s to around 12 percent in 2014, with some strands ranging up to 37 percent THC. Additionally, medicinal marijuana can come in various forms, intended to be applied topically, topical, smoked, or digested. No guidelines exist on what form is most appropriate for what ailment.

The variation in strengths and dosage forms combined with an absence of guidelines, make the evaluation of medical marijuana therapy for appropriateness extremely challenging. Until a standardized medication is created and approved by the FDA, it will be difficult for traditional PBM’s to effectively evaluate medical marijuana therapy.

With these points in mind, there are steps that payors can take now to stay at the forefront of medical marijuana management. Knowing that reimbursement is becoming more and more common, some insurance companies have taken steps to anticipate this change and develop

Until a standardized medication is created and approved by the FDA, it will be difficult for traditional PBM’s to effectively evaluate medical marijuana therapy.
flexible plans that allow for action on a state-by-state basis. Payors need to consider the regulatory and legal landscape in each state, as well as the patients on an individual basis. PBM systems will be useful in providing payors with medical history to determine if medical marijuana is appropriate, and understanding individual jurisdictional laws will be vital in determining if the claimant should be reimbursed. Although this is more complicated than creating a holistic policy, it will be necessary until such time that we see federal guidelines emerge.

The future of marijuana is sure to be complicated. Employers, physicians, pharmacists and insurers alike must continue to monitor the shifting landscape. As legalization and research moves forward, we will hopefully develop a clearer picture of the best uses and full range of side effects of this controversial treatment.

To learn more about this topic, please visit mitchell.com/mpower for the full white paper.

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10 Food and Drug Administration (FDA). “FDA and Marijuana” https://www.fda.gov/newsevents/publichealthfocus/ucm421163.htm
With an effective date of January 1, 2018 for California Senate Bill (SB) 1160 rapidly closing in, many stakeholders in our industry are continuing to analyze the kind of impact the bill may have for injured workers receiving quicker access to medical treatment, utilization review (UR) volumes, and controlled costs for those in our industry.

SB 1160, which Governor Jerry Brown signed in September of 2016, received the support from both labor representatives who advocated for injured workers getting appropriate care and quicker treatment, and business representatives who wanted to control costs. The principal changes are with utilization review and liens. The process of obtaining medical treatment is frequently seen as a driving factor in a claimant’s decision to seek treatment outside of their network, or employer-chosen physician. If an injured worker is being denied treatment, or is having their treatment delayed when following the rules for accessing workers’ compensation treatment, it may drive them to seek treatment from a source outside their network; typically hiring an attorney who then directs them outside of the employer-chosen physician,\(^1\) which can lead to extended medical liens and increased litigation costs. For these reasons, labor representatives were generally in favor of the bill because it promised to speed up the authorization process for injured workers receiving the care they needed during the first month of treatment. At the same time, business representatives by and large saw the benefit of the bill having the potential to keep an increased amount of claims out of litigation in the first month following a worker’s injury, and were too, in favor of passing of the bill.

Utilization Review: Removal of Prospective Review

SB 1160 focuses primarily on provisions related to workers’ compensation UR and liens; with one of the most interesting provisions being that medical treatment for injured workers will not be subject to prospective review in the first 30 days following the date of injury. The intent behind this was to streamline the UR process and guarantee that...
injured workers received timely and appropriate medical treatment.\textsuperscript{i}

There are however, a few exceptions to the prospective UR ban; and several requirements and notes to keep in mind below:

- The treating providers must render treatment consistent with the medical treatment utilization schedule (MTUS), including the new \textbf{California drug formulary}, in order to be exempt from utilization review within the first 30 days following an injury—or risk being removed as the predesignated treating physician, employer-selected physician or member of the MPN or HCO.

- According to Labor Code Section 6409, employer chosen physicians treating injured workers must file a complete request for authorization with the Division of Workers’ Compensation (DWC)\textsuperscript{iii} and the employer, or if insured, with the employer’s insurer within five days following an initial visit and evaluation, including a treatment plan. 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.

- There remains a list of treatments that are still subject to utilization review. The services listed out below still require physicians to file a complete request for authorization and receive prior approval. They are: surgical procedures, non-formulary medications, psychological treatment, home health, electro-diagnostic studies, imaging studies and durable medical equipment.\textsuperscript{iv}

- To avoid liens related to delivery of medical care in the first 30 days of the claim, employers and insurers can retrospectively review treatment delivered within the first 30 days of the claim action to remove physicians from treating workers if they are not compliant with the MTUS and American College of Occupational and Environmental Medicine (ACOEM) guidelines—a reactive and complicated effort that may further disrupt and delay resolution of the claim.

It is too soon to measure the effectiveness of these actions and whether or not they will achieve the intended outcomes of SB 1160: reduced cost and faster access to better treatment.
An Example of How SB 1160 Impacts a Carrier’s UR Program

Analysis of a large insurance carrier with a robust UR program allowing adjusters to rapidly approve the initial treatments following a claim, found many treatments occurring in the first 30 days of network-enrolled claims that will require preauthorization by means of the SB 1160 guidelines. Among the treatments provided within the first 30 days of a claim, the SB 1160 preauthorization requirements resulted in a 3 percent increase in overall UR volume related to treatments that would require UR that would have before been approved by the adjuster.

A separate, yet positive finding for this carrier, was that approximately 16 percent of the treatment requests within the first 30 days of the claim that had been managed at the adjuster level would no longer require approval prior to the claimant receiving treatment, giving claims administrators the opportunity to focus on other activities that would have positive impacts on the claim outcomes.

Based on our findings, this carrier could expect to see a 13 percent decrease in the total number of requests for authorization that would have required authorization prior to the claimant receiving treatment. Reviews by physicians are expected to have limited impact from SB 1160, with only a 1 percent potential change identified on analysis.

The use of UR programs that meet the new standards established by SB 1160 in mid-2018, including accreditation and UR data reporting requirements, will also require some planning for carrier and claims administrators who have internal processes for review of treatment request. All of these items are significant factors for an insurer establishing their 2018 goals and objectives.

Illustrating a few Claim Scenarios

Our findings definitely indicate that SB 1160 appears to have the potential for the positive impacts intended—faster access to care and reducing liens. The following claim scenarios and stories are to help provide an illustration of what you can potentially expect from SB 1160.

Take Jim, a 47-year-old male mechanic, who experiences a workplace injury on January 2, 2018. He was working on a car in the auto shop at his job when a tire explodes and punctures his arm causing injuries to his left arm and hand. His employer calls an ambulance and Jim is taken to the closest Emergency Room for treatment.

Jim suffered several fractured fingers, and is fortunate to able to be stabilized and treated. He is sent home with a referral to see an orthopedist, and to use anti-inflammatories and ice for pain. After taking the necessary steps with his employer to access his workers’ compensation network, Jim finds an orthopedist, and makes an appointment the next day.

The orthopedist files a first report of injury (FROI), indicating Jim’s treatment plan will include surgery, medications, bracing and occupational therapy.
Mike Loader reported an injury with his employer the same day. It had been an especially busy holiday season on the docks, and as he was bending down to lift a box, he felt a pull in his back. As the day went on the pull progressed to pain, and he told his employer he had injured himself. Mike’s employer sends him to the local occupational medicine clinic they use for work injuries. Mike is examined, and the clinical provider files a FROI five days later with a treatment plan indicating they expect Mike needing rest, medications, a brace and physical therapy to recover from his injury.

Both Jim and Mike are able to quickly access care within their employer or carrier-selected providers. Just like before SB 1160, Jim’s emergency room treatment did not require authorization. Jim’s network orthopedist, being well versed on SB 1160 changes and recognizing Jim’s recovery requires early intervention, submits a preauthorization request for the surgery and the braces planned to be used to improve Jim’s recovery. Mike’s provider takes a bit more time to file his treatment plan, but because none of the treatments he recommends require preauthorization, Mike is able to start physical therapy at the occupational medicine clinic three days after first being seen. Both injured workers are able to access medical treatment quickly, but before SB 1160, Mike might have had to wait 5 days to 14 days to get approval for physical therapy. Some carriers would have had the adjuster approve Mike’s initial treatment prior to SB 1160, and some would have had a UR agent review the treatment. With SB 1160, Mike does not need to wait for approval because he is treating with the provider his employer directed him to.

Jim, on the other hand, will still need to wait for preauthorization before he can have the surgery needed to fix his fractured fingers, regardless of being within the first 30 days of his injury and being treated in his employer’s network. To make matters worse, the anti-inflammatories and ice he had been given were not doing much to control the pain and swelling in his injured hand while he waited to get the treatment he needed. Several of Jim’s friends suggested he go see a different doctor or perhaps the attorney who helped them with their claim a few years back. It’s this access to care scenario that has been identified as contributing to the current lien issue in California. Although it’s only been a few days since Jim was injured and he has gotten medical treatment; the anxiety of a work injury, the potential loss of financial stability and waiting to get treatment the doctor said he
needed in order to have use of his hand back might send Jim looking for an attorney to get him the treatment he needs—putting Jim’s claim in a lien scenario.

Fortunately, the adjuster working Jim’s claim had more time to address this; as she no longer receives as many adjuster approvals for her new claims since SB 1160 went into effect. Jim’s adjuster is able to get the authorization request for Jim’s surgery to the UR agent as soon as she receives it and asks for expedited review. Jim’s surgery gets approved the next day and the adjuster also assigns a nurse case manager to help Jim with his surgery experience. Jim’s nurse case manager helps get his surgery scheduled, prepares him for what to expect and makes sure the brace his doctor ordered gets delivered. The nurse case manager also made sure Jim’s post-operative medicine got submitted for preauthorization early, because the opiate prescribed requires pre-authorization under the new SB 1160 formulary. Jim’s employer understands the dangerous outcomes opiate use can have, and when Jim’s prescription is received for preauthorization they activate their opiate program to ensure the medicine meets guideline recommendations and educate Jim about the negative impacts opiates can have on his health and recovery. Jim’s surgery is completed and he goes home with everything he needs for his recovery.

Meanwhile, Mike has been very compliant with completing his treatment so he can get back to work. After his first few visits of physical therapy, Mike realized he was experiencing more pain rather than positive outcomes, and he had his doubts. His employer was great about putting him on modified duty at a desk and the occupational medicine clinic decided that when he wasn’t getting better after the first few visits of therapy that they would increase the frequency and add some massages. He is still within the first 30 days of his injury and the occupational medicine clinic knows that physical therapy no longer requires preauthorization under SB 1160. Unfortunately, by the time Mike’s adjuster receives the bills, Mike has had 18 physical therapy sessions with mostly
passive treatment that won’t get him ready for working on the docks again. Now that SB 1160 took away preauthorization on some treatments he is worried about the reserves he set based on the FROI, and quickly sends Mike’s bills for retrospective review to see if the occupational medicine clinic is staying within the treatment guidelines for Mike’s lumbar strain. All he can do now is make the occupational clinic get preauthorization for any further treatment on Mike’s claim, if the retrospective review shows the treatment did not meet guidelines. Mike’s employer really likes the occupational medicine clinic that is close to their shop and it has hours that work for their employees. The adjuster hopes SB 1160 won’t cause problems with his customer and wonders what might happen if this clinic has a pattern of treating outside the guidelines and has to be removed from the network.

Conclusion

Time will tell whether the changes SB 1160 made in the beginning of these two claim scenarios will result in the outcomes that the bill’s supporters fought for. As Mitchell moves forward implementing SB 1160, we will continue to monitor how best we can combat challenges while continuing to deliver improved outcomes.

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2 http://www.csim.org/?page=SB1160
3 http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB1160
Sometimes the most innocuous conversations with family, friends and coworkers can lead to a major finding for medical billing fraud. Take the example of simply talking to your coworker in the next cube about a suspicious provider billing situation. To your surprise, you find out your co-worker is having the same suspicion about the same provider on other auto first party claims. What ends up happening is a pervasive situation of intentional fraud uncovered by one conversation. These kinds of conversations are exactly what led to identifying "Global Surgical Package Fraudulent" billing scenarios.

What is the Global Surgical Package?
Understanding what the Global Surgical Package concept is and how these procedures are presented in billing is an important aspect in finding this type of fraud. The global surgical package, also called ‘global surgery’ and sometimes ‘global surgical period,’ is a single payment for all care associated with a surgical procedure. It includes all necessary services normally furnished by a surgeon before, during and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by a surgeon or by members of the same physician group with the same specialty.
The global surgical package includes a global follow-up period whereby follow-up care is not to be billed. This means that any follow-up office visits performed during the global follow-up period should not be billed or reimbursed separately. The length of the global follow-up period is specific to each surgical procedure code and varies according to the severity of the surgery and its level of complexity. There are three time periods used by Medicare to define for how long a global follow-up should be applied; and most timelines including the rules, have been adopted as a standard by most payors. The three time periods are outlined below:

- Zero days—for procedures like endoscopies
- 10 days—minor procedures
- 90 days—major procedures

The zero, 10 and 90-day timelines are an important factor of the global surgical package where the provider is unable to charge for certain services as they are included in the price paid for the surgical procedure itself. For our discussion, we will use the most complex global surgical package—90 days. In actuality, the 90-day global surgical timeline, is really 92 days. This is because it includes specific charges the day prior to surgery, the day of surgery, and 90 days after the surgical procedure is performed. The following services are included in the 92-day timeline:

- Intra-operative procedures
- Additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery

- Post-surgical pain management by the surgeon
- Supplies, except for those identified as exclusions
- Miscellaneous services such as: dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes

Knowing what is included in the global surgical package is key to finding billings that are not supposed to be charged for by the provider.
Identifying a Claim’s Potential for Fraud

Discussing medical billing concerns with family, friends and coworkers have the potential of driving an investigation further into data, and in the following case, it did. The conversation in this scenario involved an experienced insurer, who we will call Joe, and a family member of his who recently underwent surgery. Knowing that he has extensive background in medical coding, the family member, who we will call Jane, asked Joe a question regarding her healthcare bill.

"Why have I been billed for all of my follow-up visits, yet not once seen a bill for my surgical procedure come in?"

This question sent red flags to Joe, who then asked Jane if the provider was paid for the follow-up visits. Jane responded, "Yes." Jane had a spinal fusion that fell into the 90-day global surgical package. Confused as to why Jane had been billed having not surpassed the 90-day post-operative timeline parameter, Joe escalated questions and prompted an investigation into auto claims at his own employer. He was determined to see how prevalent billing for follow-up visits before the surgical procedure was billed out of their own payment system.

A conversation like this encountered by someone less familiar with correct coding may have been dismissed as nothing more than a quirk in the provider’s workflow. Luckily, Joe had many years of experience with medical coding and healthcare and was able to initiate a detailed investigation of claims data. What he found was that this kind of fraudulent practice had been occurring with the same provider for several years without any indication.

Unlike workers’ compensation claims, the majority of auto casualty claims are paid retrospectively, and procedures are often not managed in pre-authorization—with the exception of New Jersey. Receiving follow-up office visit codes (99211, 99212, 99213, 99214, 99215) is not unusual and would essentially go under the radar as long as there is a compensable injury. Had the provider billed in a manner consistent with date of service, most bill review systems would recognize that a surgery was performed and that a global surgical package and follow-up billings would be applied. However, when the provider submits bills for payment out of date of service order, this indication becomes much more difficult. Even though the dates preceded the follow-up visits, billing the surgery after the follow-up visits would lead an insurer to pay for these visits separately. Providers that bill auto claims and “hold” the surgical procedure bill until after the follow-up period, should be reviewed.

Just when you think you have heard it all, think again. When it comes to potential manipulation of billing codes, the scenarios are endless. Something as innocent as a simple conversation with a family member can cause a review of data that may prove to be a fraudulent scenario. If recognizing this issue is not in a bill review system today, it will be tomorrow. To mitigate in the meantime, data queries can be written to look for these types of scenarios to initiate an investigation.
A new year means new Current Procedural Terminology (CPT) code changes! There are a total of 314 code changes in the 2018 code set, and with 2018 just around the corner, it’s time to start thinking about how these changes will impact the casualty industry. After an intensive review of the new CPT code book, we’ve identified a few items that may be of interest to your business and could impact the casualty industry in the coming year. Keep these in mind as you review the new CPT code book:

- Revised description to Surface Neurostimulator CPT code 64550
- New addition of the Proprietary Laboratory Analysis (PLA) codes
- Changes to codes related to Orthotic and Prosthetic Management and Training
- Removal of Development of Cognitive Skills CPT code 97532

"The jury is still out on how the inclusion of these codes will affect reimbursement."
The inclusion of this example may not seem like much at first glance, but it could lead to some confusion in practice. From a coding perspective, it is important to know that though transcutaneous electrical nerve stimulation (TENS) is provided as an example, the intent of this code does not include the actual modality or performance of nerve stimulation. Electrical nerve stimulation is appropriately reported with either of the following modality codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97014</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (unattended)</td>
</tr>
<tr>
<td>97032</td>
<td>Application of a modality to 1 or more areas; electrical stimulation (manual); each 15 minutes</td>
</tr>
</tbody>
</table>

The American Medical Association (AMA) describes code 64550 as a service “in which electrodes are placed on the skin by the physician, and the patient takes the unit home.” Electrical stimulation is done at home, with the patient operating the unit.

**Revision to CPT® Code 64550**

A new parenthetical note has been added to the guidelines for code 64450:

<table>
<thead>
<tr>
<th>▲ Revised Code</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲ 64550</td>
<td>Application of surface (transcutaneous neurostimulator (eg. TENS unit)</td>
<td></td>
</tr>
</tbody>
</table>

The jury is still out on how the inclusion of these codes will affect reimbursement. Though CMS is expected to release pricing for diagnostic tests as they usually do, the degree to which insurers will allow reimbursement for these rapidly issued codes remains to be seen. It’s possible that it may be easier to process claims for these tests, especially for those tests that already have a Medicare coverage determination. However, it could also allow for abuse. For example, if the codes show up in the Medicare fee schedule, some payors may default to automatic reimbursement.

**New Proprietary Laboratory Analysis (PLA) Codes**

One of the biggest additions to the 2018 book is an entirely new section called for the Proprietary Laboratory Analysis (PLA) codes. In June 2016, under the umbrella of the Protecting Access to Medicare Act (2014), the Centers for Medicare & Medicaid Services (CMS) released the Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule. This rule requires Healthcare Common Procedure Coding System (HCPCS) codes to identify new advanced diagnostic laboratory tests (ADLTs) and clinical diagnostic tests (CDLTs) that are cleared or approved by the FDA if an applicable CPT (HCPCS Level I) code does not exist.

Shortly thereafter, in response to these coding requirements, the AMA CPT Editorial Panel approved and finalized the new PLA section. These codes were introduced with the CPT 2017 code set. However, there was no dedicated section in the code book at that time. Instead, the AMA released quarterly updates to the PLA list of codes throughout 2017. The quarterly release of new codes will continue through 2018 as they are approved by the AMA CPT Proprietary Laboratory Analyses Technical Advisory Group (PLA-TAG).

The jury is still out on how the inclusion of these codes will affect reimbursement. Though CMS is expected to release pricing for diagnostic tests as they usually do, the degree to which insurers will allow reimbursement for these rapidly issued codes remains to be seen. It’s possible that it may be easier to process claims for these tests, especially for those tests that already have a Medicare coverage determination. However, it could also allow for abuse. For example, if the codes show up in the Medicare fee schedule, some payors may default to automatic reimbursement.
which is not always appropriate. At this point, it is anybody’s guess as to how (and the extent to which) these codes will be reimbursed. Time will tell.

Pertinent Changes in Orthotic and Prosthetic Management and Training

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97760</td>
<td>Orthotic(s) management and training (including assessment and fitting when not otherwise reported, upper extremity(ies), lower extremity(ies) and or trunk, initial orthotic(s) encounter, each 15 minutes</td>
</tr>
<tr>
<td>97761</td>
<td>Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes</td>
</tr>
<tr>
<td>97763</td>
<td>Orthotic(s) /prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies) and/or trunk, subsequent orthotic(s)/ prosthetic(s) encounter, each 15 minutes (Do not report 97763 in conjunction with 97760, 97761)</td>
</tr>
</tbody>
</table>

CPT® code 97762 has been deleted and replaced with the new code, 97763

The new format for these codes aligns with the AMA’s movement-toward more specificity. Similar to last year’s physical therapy and occupational therapy evaluation codes, these codes have the “look and feel” of evaluation and management codes since these visits can be reported as initial versus subsequent visits. Because the new subsequent visit code, 97763, is reported for either orthotic or prosthetic management, it is considered mutually exclusive to both 97760 and/or 97761, hence the parenthetical guideline.

Removal of Development of Cognitive Skills CPT code 97532

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes</td>
</tr>
</tbody>
</table>

CPT code 97532 has been deleted: Users are now instructed to report CPT code 97127

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97127</td>
<td>Therapeutic interventions that focus on cognitive function (eg. attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg. managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact (Report 97127 only once per day)</td>
</tr>
</tbody>
</table>

The previous code, 97532, was a time-based code, reported in increments of 15 minutes. In contrast, the new code, 97127 is now reported only once per day—meaning that even if the therapeutic interventions or strategies are provided during separate encounters during the day, this code is still reported no more than once per day. Since the new code is not time-based, from a coding perspective that means that a one-to-one crosswalk between deleted code 97532 and the new code 97127 is inappropriate.

A complete listing of code additions, deletions and revisions is available in the AMA CPT 2018 code book under Appendix B.

References:
2 American Medical Association CPT Knowledge Base Electronic Inquiry #1419, July 27, 2006
5 https://www.ama-assn.org/practice-management/cpt-pla-codes
Tina Queen, a product manager at Mitchell, was recently honored with the NextGen Award, which recognizes professionals under the age of 40 who are making an impact on the workers’ compensation industry. Tina Queen has been active in the IAIABC since 2006 and has been the IAIABC Claims Committee Chair since 2012. Most recently, Tina lead the Claims Committee in development and publication of the Claims Release 3.1 standard.
Claims adjusters are extremely busy—with many assigned more than 100 claims per month. But most adjusters are working on more than just adjusting the claims assigned to them and are frequently assigned other tasks. Unfortunately, over-worked adjusters who are asked to complete additional work beyond their core duties tend to be less productive, effective and accurate than if they were only working on the claims assigned to them.
To process claims smoothly, effectively and efficiently, it is important to focus on collecting and analyzing the right data from the start.

If you head on a road trip without first considering traffic reports, weather forecasts or recommendations from travel websites, you could end up stuck in a traffic jam, caught in a thunderstorm or visiting some place you didn’t intend to along the way. Similarly, processing an auto insurance claim without collecting and considering key data and analytics, asking the right questions and using the right tools early on, can send the claim down a path filled with wasted time, extraneous expenses and a lot of headaches.

To process claims smoothly, effectively and efficiently, it is important to focus on collecting and analyzing the right data from the start—good data upfront supports good decision making throughout the claim lifecycle, ultimately enabling better auto insurance claim results.
Mitchell and One Call Care Management (One Call) work collaboratively to offer an extensive suite of programs and services that enable streamlined cost containment solutions tailored to the needs of the workers’ compensation industry.

One Call provides consistent connections to care through outcomes-based provider networks while leveraging in-house expertise in high-end diagnostics, physical therapy, transportation, language services, home care, durable medical equipment (DME), dental specialty services and complex care management.

As a result of partnering for many years, Mitchell and One Call have developed a strong understanding of each other’s businesses. The relationship has expanded to include shared claim feeds, data analytics and eBilling in deployments—resulting in greater value for our customers. Through Mitchell and One Call, customers can extend their network offering to include the following (among others):

- One Call DME Retro
- One Call Home Health Retro
- One Call Diagnostic Retro
- One Call Physical Therapy Retro

Together, One Call and Mitchell focus on providing the best solutions for customers while continuing to explore alternative solutions and next generation programs that will deliver optimal outcomes in the future. We look forward to continue enhancing cost containment programs for our customers and, with One Call, provide leading network solutions for the workers’ compensation industry.
Mitchell empowers clients to achieve measurably better outcomes. Providing unparalleled breadth of technology, connectivity and information solutions to the Property & Casualty claims and Collision Repair industries, Mitchell is uniquely able to simplify and accelerate the claims management and collision repair processes.

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

For more information on Mitchell, visit www.mitchell.com.
The Industry Trends Report is a quarterly snapshot of the auto physical damage collision and casualty industries. Just inside—the economy, industry highlights, plus illuminating statistics and more. Stay informed of 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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casualtysolutions@mitchell.com