

# Industry Trends Report

## FEATURED IN THIS ISSUE:

### Readiness with ICD-10

By **Vidya Dinamani**

Vice President Product Management & Marketing, Mitchell

By **Michele Hibbert-Iacobacci**

Vice President Information Management & Client Services, Mitchell





# Industry Trends Report

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### **About the Quarterly Feature author...**

#### **Vidya Dinamani**

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Vidya Dinamani joined Mitchell in 2011 and serves as Vice President of Product Management & Marketing for the company's Auto Casualty Solutions division, guiding the product roadmap for Decision Point®—Mitchell's medical claims billing solution that empowers claims handlers to accelerate appropriate decision making around medical bills related to liability claims. She has a passion for leading teams to create great customer experiences through creative data-driven solutions and services that connect people, processes and technology.



### **About the Quarterly Feature author...**

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Michele Iacobacci's responsibilities include managing the Health Information Management Group, Litigation Support and Professional Services. For the past 25 years, Ms. Iacobacci's focus has been working with major casualty insurers in implementing rules committees, quality assurance, risk management, compliance programs and review processes necessary in delivering objective bill review systems. Ms. Iacobacci is a Certified Clinical Coding Specialist (CCS-P), and a member of the American Health Information Management Association (AHIMA).

# Readiness with ICD-10

**Vidya Dinamani,**

VP, Product Management & Marketing, Mitchell

**By Michele Hibbert-Iacobacci,**

VP, Information Management & Support, Mitchell



It's official, ICD-10-CM and PCS will be implemented in the United States with dates of service effective 10/1/2014. In Property and Casualty this means all covered entities will be required to use ICD-10 code sets by that date for all inpatient and outpatient visits. Since all providers of healthcare are covered entities, all bills submitted are required by law (HIPAA) to use ICD-10. Both ICD-10-CM and PCS are used in the inpatient setting

(hospitals) whereas ICD-10-CM is used in the outpatient and professional services along with CPT (Level I of HCPCS). How many acronyms can we throw at you in one paragraph? Just to be clear:

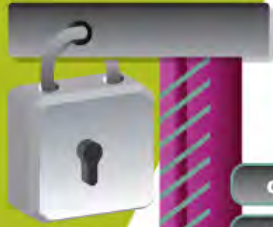
- ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification – replaces ICD-9-CM, volumes 1 and 2
- ICD-10-PCS – International Classification of Diseases, 10th Revision, Procedural Coding System – replaces ICD-9-CM, volume 3
- HCPCS - Healthcare Common Procedural Coding System contains 3 levels – CPT (Level I), National Codes developed by CMS (Level II), and Local Codes developed by local fiscal intermediaries (Level III).
- CPT – Current Procedural Terminology, 4th edition.
- HIPAA – Health Insurance Portability and Accountability Act.
- EHR – Electronic Health Records
- CAC – Computer assisted coding

***It's official, ICD-10-CM and PCS will be implemented in the United States with dates of service effective 10/1/2014.***

# ICD-10

# overview

### What happens if I do nothing?



- compliance
- DRG codes
- PIP fee schedules



### When will ICD-10 be required?\*



### What is the current state of insurer readiness?

**5%**  
of the P&C carriers  
are ready to test  
**ICD-10**



### What is ICD-10?



### Why is ICD-10 Important?



## Benefits

There is no option for submission of claims by the covered entity to not be compliant by October 1st 2014. The benefits of the new classification system to either the carrier or provider has been proven and documented. There are clear benefits to the provider, namely:

- Decrease administrative burden—less time for the provider staff in making copies and responding to requests for additional documentation.
- The new codes are so distinct with a focus on outcomes they provide a key concept in coordination of care.

- Competitive advantages in the ability to provide efficient billing and EHR access.

Highlights of some of the major benefits of the new classification to the P&C carrier are:

- Code descriptions provide documentation that was previously required in the form of reports from the provider. Less time requesting additional information.
- Bill review can be more black and white and less gray adding to straight through processing objectives.

- Understanding the encounters as to whether they are initial, subsequent or sequelae of an injury.
- New edits assist in identifying the site of injury and laterality notations.

## Challenges

The biggest challenge with the readiness of ICD-10 code set implementation is the coordination of all aspects of readiness. ICD-10 touches many areas of a provider and carriers business and the impact cannot be minimized. Creating a program around the multiple areas that utilize the code sets and building a program around the project to implement was to date the most valuable aspect of successful execution.

Providers may experience several different areas of issues during implementation that should be mitigated with proper management, these include:

- Payers may delay payments due to readiness issues, carriers need to be able to handle the costs associated with changes in accounts receivable timelines.
- Providers will most certainly take a productivity hit—this has been proven in many studies and observation of countries such as in the Canada implementation experience. The effect can be lowered by proper training, practice, implementation of EHR and the use of CAC software.

- ICD-10 code sets take knowledge to operate and apply successfully. Providers can experience office staff frustrations mixed with enthusiasm.
- Office and hospital staff will also likely be addressing issues caused by the payer not paying bills properly and these issues can be morale changers.

Carriers will not need all individuals who encounter the new code sets to be experts in coding, although it doesn't hurt to have a few key individuals with the skill set—they just need to make sure they understand how the code set is used. Some of the issues P&C carriers will have to resolve are:

- Changes in medical bill review edits. Because ICD-10 code sets are so detailed, there is more opportunity to either have more straight through processing or investigate more claims based on specific criteria. For example, ICD-10 codes can tell the carrier if treatment administered was the initial visit for the care or a subsequent visit. This will help with establishing causation and the start of a condition.
- Carriers will receive ICD-9 code sets even after the implementation date of October 1st 2014. This may be because the provider is not a covered entity under HIPAA or they have an exemption. Either way, carriers need to be versatile enough to handle both situations and pay bills appropriately.
- Did you miss an internal area that uses ICD-10 during your assessment phase? If so, just pick it up and make the fix. Have an expectation that there may be unknowns; it helps eliminate frustration with your teams.
- Carriers will need to understand any gaps in bill review systems after ICD-10 code set implementation. Some edits in bill review systems were done because ICD-9 was so non-specific it created more work to review the care.

### Are we ready?

A recent snapshot survey by Aloft Group, a Newburyport, Mass. healthcare branding and marketing firm, found that 74.6 percent of Respondents are 25 percent or less completed in the ICD-10 code set conversion. The biggest complaint or reason for not being farther along was time and limited financial resources (71 percent). Overall the majority felt they would meet the 10/1/2014 deadline (55.4 percent) and some were somewhat concerned (37.3 percent). 61

percent of Respondents felt one of the most important aspects of a system that uses ICD-10 was the ability to run dual reporting (ICD-9 and ICD-10) followed by assistance with a formalized training plan for user training and education to improve physician acclimation (57.7 percent).

### Best Practices

We've outlined some key areas to consider and be ready for with the ICD-10 changes. There are multiple guides for provider and

carrier available to guide through the multiple changes that are heading our way. Ask any vendor that integrates with your system and currently provides ICD-9 codes what they're doing to ensure readiness, and furthermore how they plan to connect all the various streams together to ensure a successful transition to this mandatory change.

<sup>1</sup>John DeGaspari, A Look at ICD-10 Readiness, Healthcare Informatics, March 1, 2013 <http://www.healthcare-informatics.com/blogs/john-degaspari/look-icd-10-readiness>



# Medical Price Index (MPI)

By Edward H. Olsen

DC, PCU, Senior Business Process Consultant, Mitchell



The National MPI experienced a 1.7% decrease in Q3 2011 that was followed by another decrease of 0.3%. By the close of 2012, National MPI was up 13% from the Q1 2006 benchmark.

A MPI comparison was made between fee schedule states and non-fee schedule states. The median index value for fee schedule states remains more consistent with the BLS CPI for all medical services than does the median value for non-fee

schedule states. Non-fee schedule states began to diverge from the BLS CPI for all medical service and the median value for fee schedule states in 2008.

## About the Medical Price Index

The Medical Price Index (MPI) was created by Mitchell's ClaimsLab™ to provide unique insight and analysis for casualty, auto and workers' compensation claims insurers. MPI monitors non-hospital facility charges for first party medical payments,

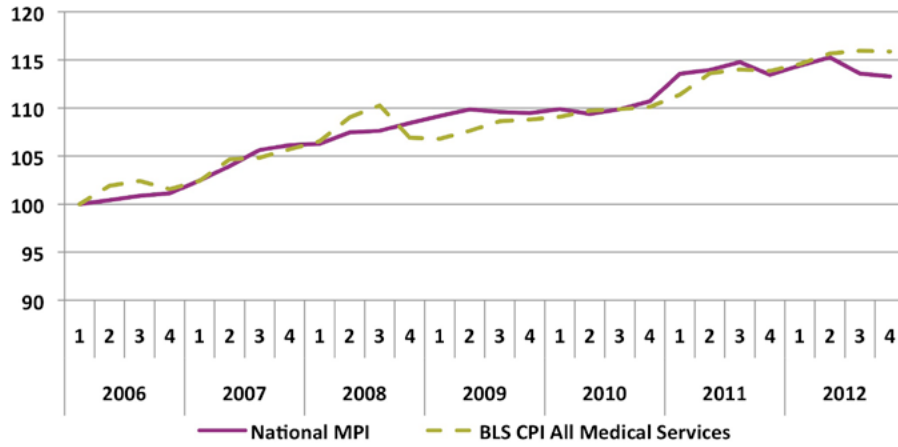
Personal Injury Protection (PIP) and Medical Payments Coverage (MPC).

Mitchell's MPI monitors pricing changes important to insurers' loss results. The index is constructed in a manner that allows easy comparison of the Auto Casualty, Workers' Compensation and Personal Health Insurance markets at a National,

*A MPI comparison was made between fee schedule states and non-fee schedule states.*

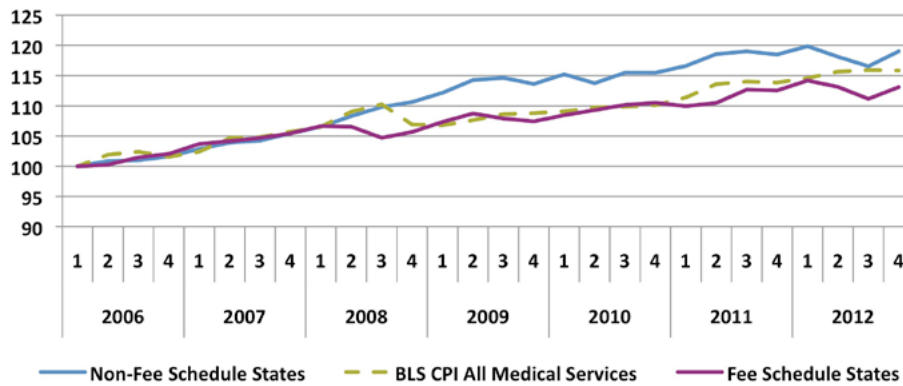
Regional and State level. While holding medical treatment utilization constant, MPI monitors the trend in medical charges by coverage state and medical service group so business leaders have a complete understanding of the pricing forces driving their overall costs.

Figure 1 – National MPI



Source: Bureau of Labor Statistics Consumer Price Index for All Urban Areas, All service types. Series Id: CUUR0000SA0

Figure 2 – MPI – Fee Schedule vs. Non-Fee Schedule



Source: Bureau of Labor Statistics Consumer Price Index for All Urban Areas, All service types. Series Id: CUUR0000SA0

[Click here to view Auto Physical Damage Edition](#)



# Hospital Emergency Room Cost Shifting

By Edward H. Olsen

DC, CPCU, Senior Business Process Consultant, Mitchell



Recently, *Time* magazine dedicated its entire feature section to an article on the high cost of medical care. This article explored why: 1) we spend twice as much on health care than most other developed countries and 2) we spend more on health care than the next ten highest spending countries combined. One answer the article offers is that health care is a seller's market with price having little to do with the cost of providing the service.

Mitchell ClaimsLab™ thought it would be interesting to take a look at its Auto Casualty Market data to determine if there are emerging trends in the hospital setting. The process started by first looking at the Mitchell Medical Price Index (MPI) that was developed to monitor charges incurred by the Auto Casualty insurance market for professional services. Since the MPI allows for analysis of specific service groups, this part of the investigation focused on emergency services

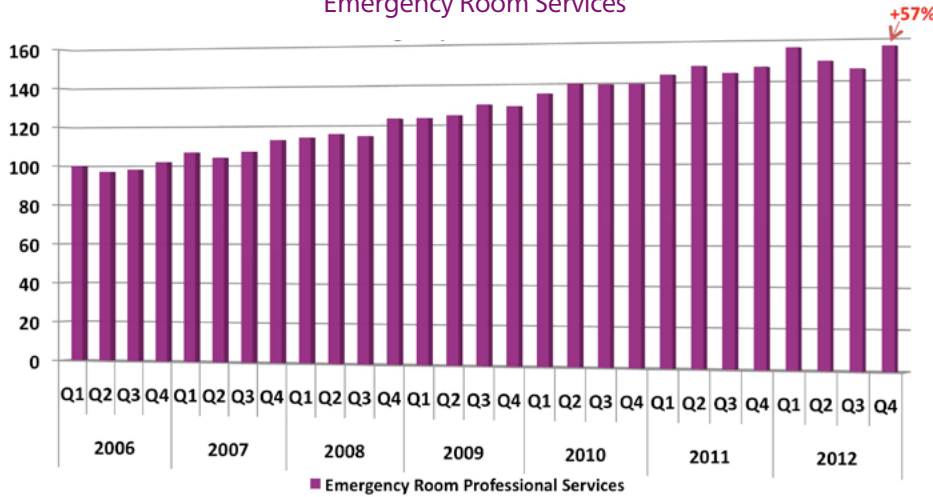
or the charges associated with the emergency room physician. Subsequently, we turned to the Medical Severity Index (MSI) to understand the trends associated with hospital facility charges.

MPI provides insight at the national level as well as the individual state of jurisdiction. At the national level

***At the national level there has been a 57% increase in unit cost associated with the professional component of an emergency room visit.***

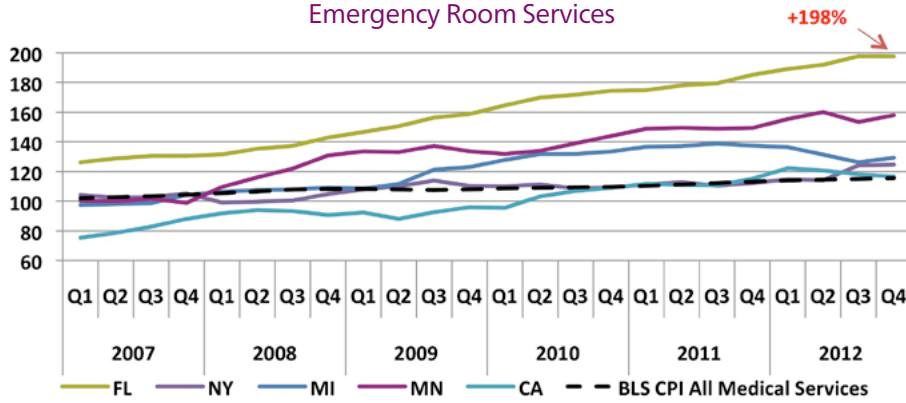
there has been a 57% increase in unit cost associated with the professional component of an emergency room visit. This equates to a 2% increase per quarter or 8% increase per year. Over the same period of time, the Bureau of Labor Statistics

### MPI–National Emergency Room Services



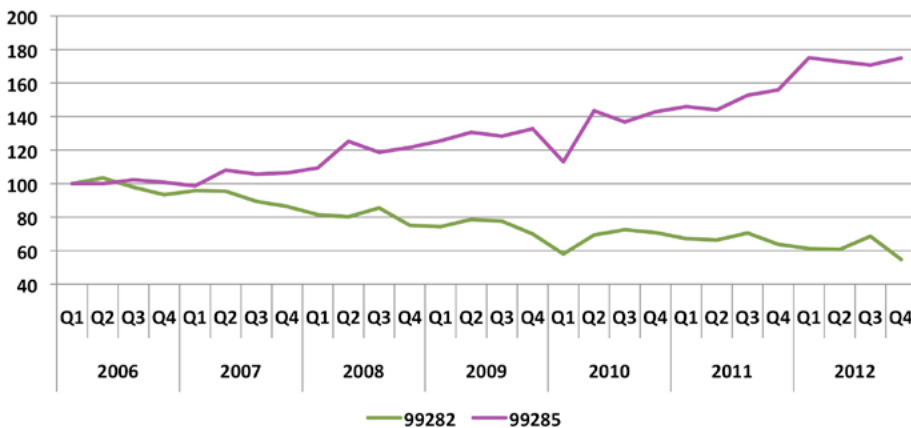
Graph 1: The graph above represents the National MPI for the professional component of emergency room services.

### MPI–State of Jurisdiction Emergency Room Services



Graph 2: The graph above represents a one year rolling average of the individual states MPI for emergency room services. (Source: Bureau of Labor Statistics Consumer Price Index for All Medical Services; series Id CUUR0000SA0)

### MPI–National Percent Contribution to Total Emergency Room Services

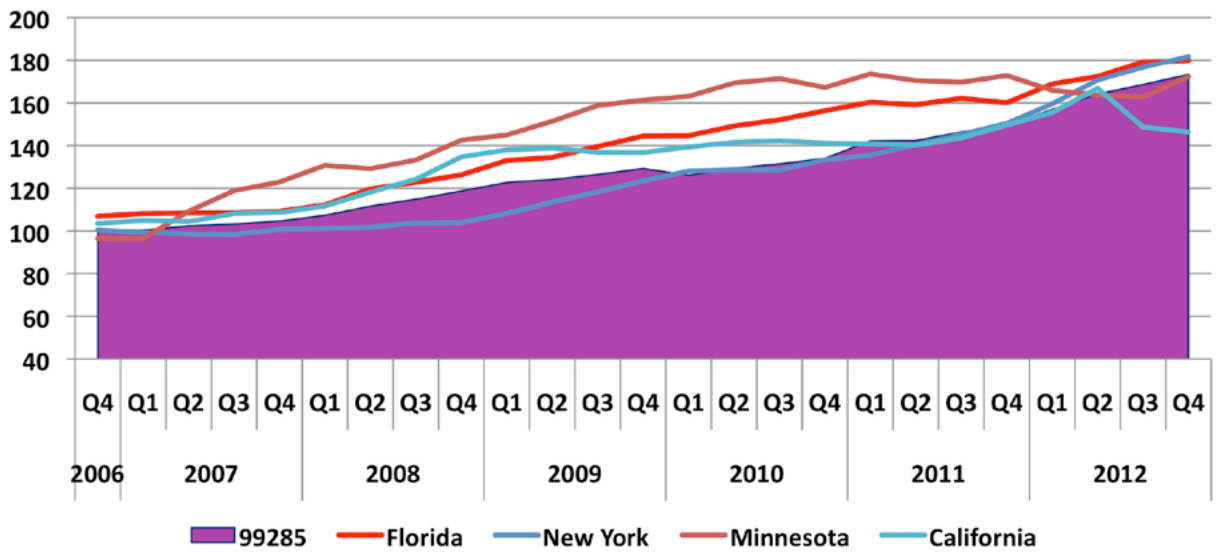


Graph 3: The graph above demonstrates the utilization trend recorded by the National MPI for the professional component of emergency room

(BLS) Consumer Price Index for All Medical Services experienced a 16% or an average 0.57% per quarter or 2.28% per year. However, the National level MPI only tells part of the story as not all states of jurisdiction are created equal. While all states examined experienced growth in excess of the BLS CPI for all medical services, Florida has seen their cost per unit nearly double.

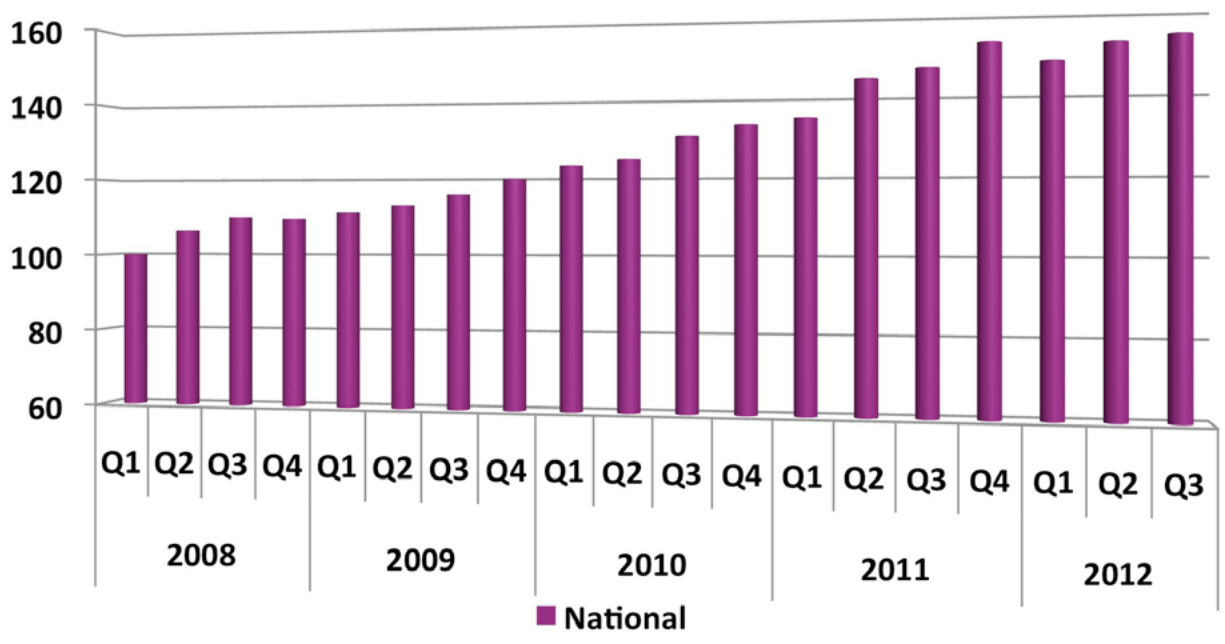
The emergency room service group of MPI is made up of the most frequently encountered emergency room evaluation and management procedure codes. The drill down capability of MPI allowed for the identification of each procedure codes percent contribution to the emergency room service group over time. At a national level, the Auto Casualty Market has experienced a 47% decrease in utilization of 99282 (emergency room visit involving medical decision making of low complexity) and a 75% increase in utilization of 99285 (emergency room visit involving medical decision making of high complexity). This trend was not unique to the national result and was in fact consistent with the results seen for each state of jurisdiction investigated. This finding suggests that either: 1) injury severity is dramatically increasing or 2) up-coding of services is taking place as part of the seller's market described in the *Time* article.

### MPI-National 99285 Utilization Trend



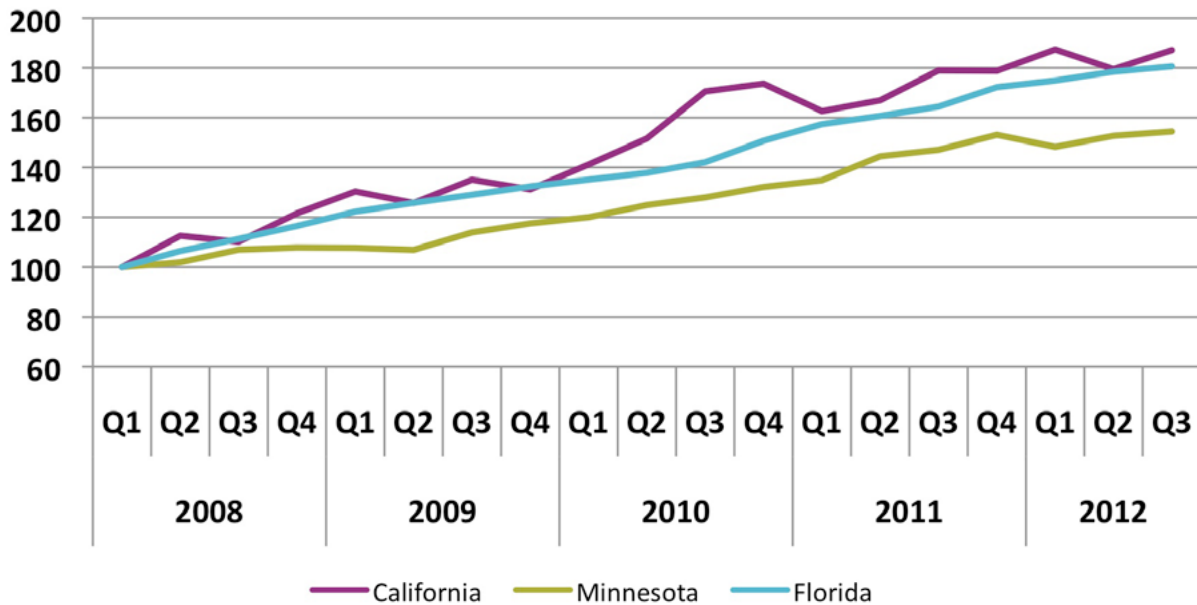
Graph 4: The graph above demonstrates the utilization trend of emergency room visits requiring decision making of high complexity.

### MSI-Facility Emergency Room Charged per Claimant



Graph 5: The graph above represents the median charge per claimant recorded by MSI for states of jurisdiction making up the auto casualty market.

## MSI–Facility Emergency Room Charged per Claimant



Graph 6: The graph above represents the charge per claimant specific to UB forms and emergency service revenue codes recorded by MSI.

The hospital facility emergency room charge experience is similar to what is unfolding above with emergency room professional fees. Mitchell ClaimsLab utilized the MSI to uncover the trends seen on hospital facility bills for emergency room visits. MSI reports on the total claimant’s history from date of loss to current on a quarterly basis and breaks down the results to bill form type and service group. For this investigation, the results were limited to the UB billing form (facility) and revenue codes specific to emergency room service. While this is not an exact comparison with the MPI results it provides valuable insight into the current state of hospital facility charges.

The charge per claimant for emergency room services in a hospital facility since Q1 2008, as reported by MSI, demonstrates a 55% increase at a national level which equates to an 11% increase per year. MSI found similar results in each state investigated. The three states demonstrating the largest increase in charge per claimant since Q1 2008 are Florida (+81%), California (+87%) and Minnesota (+54%). An interesting note is that the increases in Florida, California and Minnesota occurred while utilization remained virtually unchanged. When charge per claimant increases and utilization remains constant a factor of the unit cost must be at work (i.e. up-coding). Looking to the procedure codes billed in conjunction with

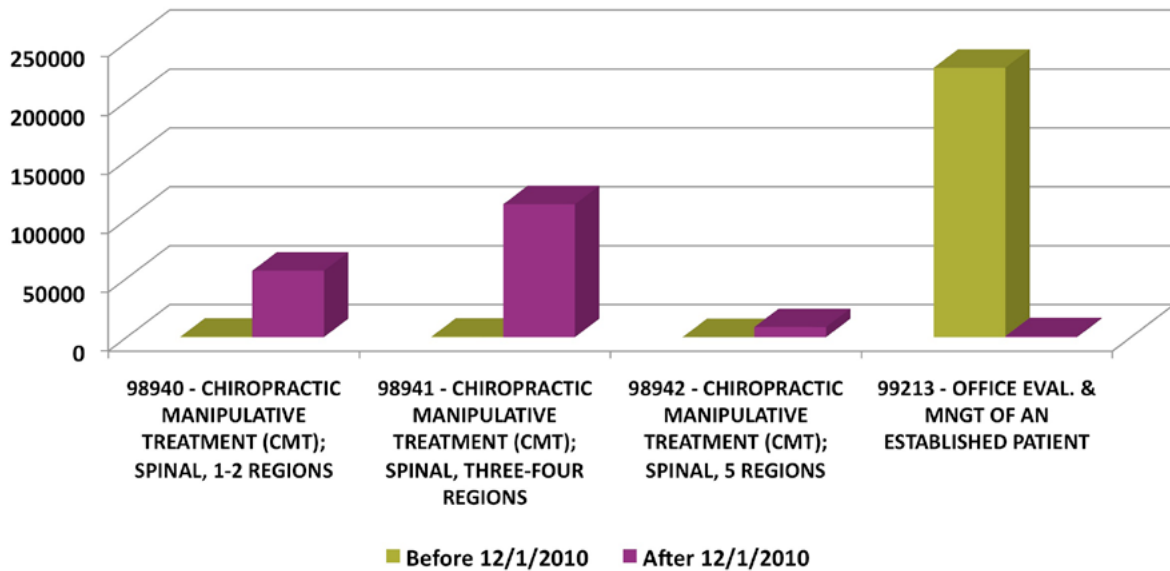
emergency revenue codes you see the same pattern emerging with fewer 99282 (low complexity decision making) and more 99284 and 99285 (moderate to high complexity decision making). While utilization of 99285 is up nearly 20% since Q1 2008, 99284 demonstrated more consistent growth and is up 93%.

While additional research will be needed to fully delineate whether the seller’s market with fees having little to do with the cost of service, as described in the *Time* magazine article, is at work in the Auto Casualty Market the early findings suggest it is. Mitchell ClaimsLab will continue to investigate hospital service utilization and its relationship to reported injury severity.

# Data Insights

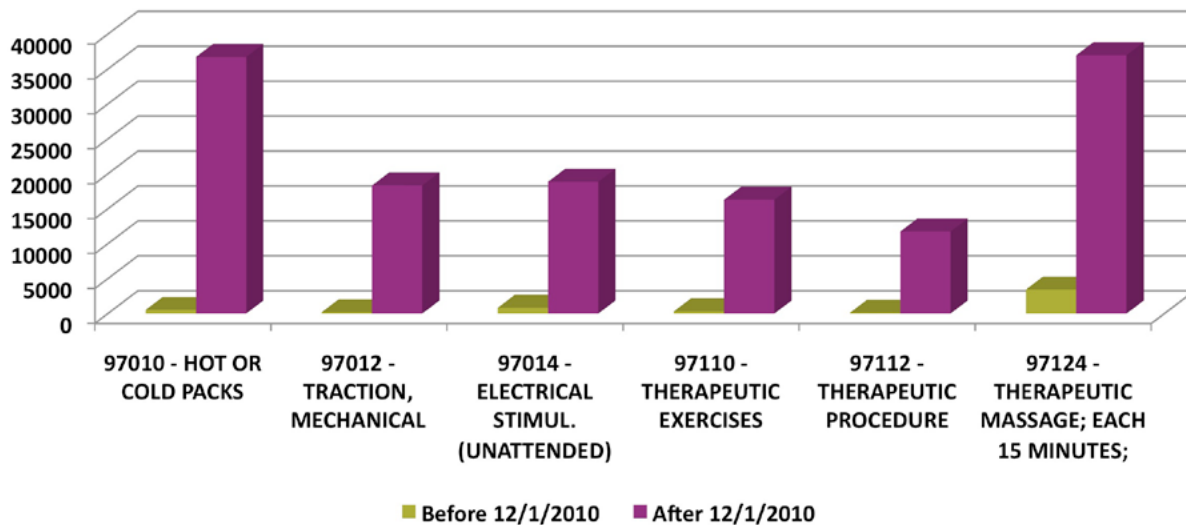
The New York Fee schedule update of December 2010 prompted chiropractors to abandon use of 99213 to identify all services performed on a single date of service. Chiropractors replaced 99213 with chiropractic manipulation focusing mostly with treatment to 3-4 regions.

## Chiropractic Utilization of CMT and E&M Before and After Fee Schedule Update



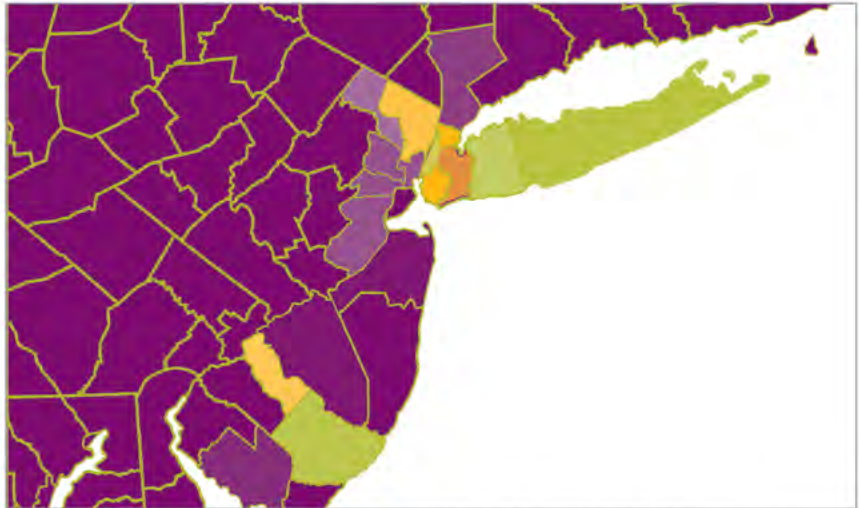
New York chiropractors also moved toward using various physical medicine modality procedure codes after the fee schedule update of December 2010. Here are the procedure codes most frequently utilized by chiropractors.

## Chiropractic Utilization of Physical Modalities Before and After Fee Schedule Update



Procedure Map

Procedure - 99244 OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION:...  
Form Type: CMS\_1500



This sheet represents 15 months (10/01/2010 - 12/31/2011) of data from all Mitchell Insurers



MedRadat - Procedures - All:  
Created by eo96951  
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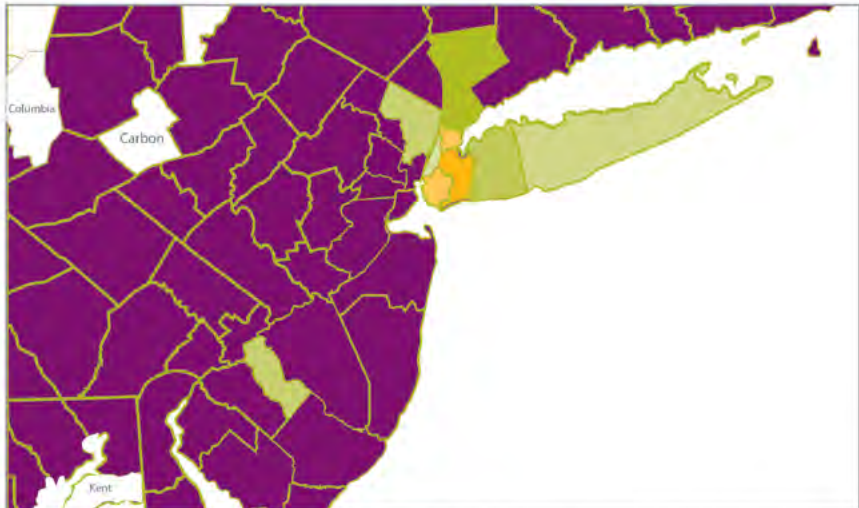
Disclaimer

Data Source

The New York metropolitan area accounts for 37% of claimants nationwide in need of an office consultation with decision making of moderate complexity (99244) and 34% of claimant in need of an office consultation with decision making of high complexity (99245). You may recall that an office consultation code is used when a provider's opinion or expertise is sought by another provider or appropriate referring source.

Procedure Map

Procedure - 99245 OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION:...  
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MedRadat - Procedures - All:  
Created by eo96951  
on 2013-03-22 08:36:52.8050

Disclaimer

Data Source

# Technology Impact: Customer Feedback Leads to New Claimant Treatment Guide Updates

By Vidya Dinamani

Vice President Product Management & Marketing, Mitchell

By Chris Williamson

Product Manager, Auto Casualty Solutions Mitchell



Solving important customer problems is what product teams care about. Our commitment at Mitchell is to partner with customers to continually learn what key issues they face. One thing that we've continued to hear is that New Jersey is a complicated state to do business in for Insurance Carriers.

The New Jersey Automobile Insurance Cost Reduction Act of 1998 (AICRA) requires notification of planned medical procedures and treatments. Carriers need to ensure

that these plans are authorized and subsequently used as directed. This pre-certification process has been supported by Mitchell's Decision Point® product and integrated Claimant Treatment Guide (CTG) module for many years. However, actively listening to customers is how great product teams make their products better. Mitchell learned that there were several areas that could be improved to make CTG easier to use, and produce even better results.

The first step was to learn from customers using CTG, understand what was going well, and which specific areas customers were looking to improve. Customers explained that it took extra time when they needed to go back and forth between screens. They found it hard to locate certain information when talking to providers. Listening to customers certainly makes an impression—but the breakthrough came when our product teams watched customers use precious minutes in locat-

ing the right information. Sitting side-by-side customers accelerated the product team to make breakthroughs in layout, interaction and design. The team then quickly prototyped multiple new product screens, and went back to the customers they had observed in order to get their early feedback. This ongoing interaction enabled customer feedback to be part of the way the teams developed new features. There were multiple, fast iterations that allowed the team to quickly narrow in on the best solution.

One example of an area that has significantly improved ease of use is the CTG Ledger. This new feature provides an instant view into how a claimant's CTG penalties have affected received bills. Before the introduction of this view the adjuster would have to review information within a bill and then navigate to the CTG Module to evaluate which pre-certification or IME record applied the action. The new CTG Ledger eliminates the need to navigate between individual bills and CTG. Powerful filters also allow a user to zero in on specific pre-certs or penalties.

There are multiple new features as part of this key redesign including: a new Pre-Certification Interface, improved Voluntary Utilization Network (VUN) penalties, ability to evaluate and take action on Phar-

macy Bill Lines, and the CTG Ledger (described earlier). Combining technical know-how and customer feedback to help solve customer issues is the best way to produce software that makes a real impact.



# The Compliance Corner



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 PIP

There has been a challenge to the adoption of H.B. 119, a bill that would make changes to PIP rules and medical payments.

On December 13, 2012, a judge rejected the request by medical providers for an injunction. An article in the Tampa Bay Business Journal regarding this injunction can be found at [here](#).

Florida auto PIP stakeholders are battling over the rules that were enacted by HB 119 last year. A judge issued an injunction to stop certain provisions of the bill; however, an appeals court placed a "stay" on that injunction until such time as the courts make a final decision on the validity of HB 119.

## New Jersey

A stay against the fee schedule was requested by the following entities: the New Jersey Healthcare Coalition, the Alliance for Quality Care, Inc., the New Jersey Association of ASCs, the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey Orthopedic Association, and the New Jersey Society of Anesthesiologists. However, the request for the stay has been denied and the fee schedule is to move forward as adopted. The order that relates to the PIP fee schedule states the following:

*Excerpt from: Department of Banking and Insurance - Orders 2012*

*"In sum, Movants have failed to demonstrate by clear and convincing evidence any of the four prerequisites it was their burden to establish in order for a stay to be granted. Consequently, for all the foregoing reasons, the application for a stay must be, and is hereby, DENIED.*

*IT IS SO ORDERED this 23rd day of November, 2012. Kenneth E."*

The order denying the stay can be found at [here](#).

The state released Advisory Bulletin #36 regarding changes to statistical data reporting sanctions. The state requires that carriers in New Jersey

provide Unit Statistical Reports and has now imposed monetary fines for delinquent reports or reports with greater than 10% errors. The bulletin also indicates the additional data field requirements. [Learn More](#)

### New York

Amendment to Rules Regarding Requests for Verification

The state adopted the Fourth Amendment to Regulation 68-C (11NYCRR 65-3), effective April 1, 2013. The amendment added two new sections about the rules that apply to the request for verification of medical treatment and lost earnings.

[Learn More](#)

### Changes to the NF-10 Form

The state adopted changes to the NF-10 form, effective March 1, 2013. The updates consist of language referencing the department's new name and other minor changes. The new denial of claim form can be accessed on the [state's web site](#).

### CMS, FR, and OIG Announcements

This section highlights some of the publications posted by the Centers for Medicare and Medicaid Services (CMS), the Federal Register (FR), and the Office of the Inspector General (OIG) throughout the month. Since these entities publish continually, not all documents are included here.

### Cens for Medicare and Medicaid Services

February 15, 2013

- Transmittal 2660/Change Request 8211 was posted regarding "Health-care Provider Taxonomy Codes Update, April 2013." [Download Here](#)
- Transmittal 1193/Change Request 7910 was posted regarding "Standardizing the Standard - Phase 1" (related to the use of CARCs and RARCs).

[Download Here](#)

- Transmittal 2659/Change Request 8163 was posted regarding "Instructions for Downloading the Medicare ZIP Code File for July 2013."

[Download Here](#)

February 6, 2013

- Transmittal 2653/Change Request 8191 was posted regarding "Summary of Policies in the CY 2013 Medicare Physician Fee Schedule (MPFS) Final Rule and the Telehealth Originating Site Facility Fee Payment Amount."

[Read More](#)

- Transmittal 2657/Change Request 7900 was posted regarding "Expansion of Medicare Telehealth Services for CY2013." [Learn More](#)

### Federal Register

February 6, 2013

- HHS proposed rules related to cer-

tain preventative services under the Affordable Care Act. [Read More](#)

### CMS, FR, and OIG Announcements

This section highlights some of the publications posted by the Centers for Medicare and Medicaid Services (CMS), the Federal Register (FR), and the Office of the Inspector General (OIG) throughout the month. Since these entities publish continually, not all documents are included here.

### Office of the Inspector General

February 20, 2013

- OIG posted a report regarding "Part B Payments for Drugs Infused Through Durable Medical Equipment." [Read More](#)

# What's That Injury Really Worth?

*Investigating Auto Bodily Injury Claims*

By Christopher Tidball



*Originally published in  
Property Casualty 360 – Feb. 12, 2013*

*Like liability, the path of least resistance often yields the wrong answer, as claimed injuries are not always related to the accident.*

We see it time and time again: Stacks of papers piling up on claims adjusters' desks in the form of bodily injury (BI) demands from attorneys for injuries supposedly sustained as the result of an auto accident. Of course, the attorney's client is never at fault, and most certainly the alleged injuries are always the result of your insured's negligence. Sound familiar?

Like a game of cat and mouse, some attorneys will try to take

advantage of busy adjusters to maximize settlements for their clients, at times garnering far more than the claim may actually be worth. It should be said, however, that the tables can be turned, as attorneys are equally as busy, often necessitating the use of associates, or negotiators, to push through an even greater volume of work. Fortunately, this latter bit of information can be of invaluable assistance when evaluating and negotiating injury claims.

The truth of the matter is that attorneys get paid based upon how much they collect. Their contingency fee is often one third of the settlement value, and perhaps 40 percent if a lawsuit is filed. The same cannot be said of adjusters, whose obligation is to conduct a thorough investigation in order to arrive at a fair value based upon the facts and evidence presented. Herein lies the challenge for organizations trying to intersect accuracy with perfection.

## **Core Claims Skills**

As is so often the case, success stems from a fundamental execu-

tion of basic blocking and tackling of claims skills. While there are many important aspects to a claims investigation, the two most critical are liability and damages, as the claim would not exist without both.

**Liability** – Which driver was at-fault for the accident? There are only three possible outcomes: a.) the insured was at fault; b.) another party was at fault; or c.) there was shared fault among two or more parties. Far too often claims adjusters select either option “A” or “B.” Meanwhile juries, more often than not, choose “C” and apportion liability accordingly.

**Damages** – What were the economic and non-economic losses from the accident? Again, there are three possible outcomes:

1. There are damages and they are related to the accident.
2. There are no damages.
3. There are damages, but some or all of them are unrelated to the accident.

Like liability, the path of least resistance often yields the wrong answer, as claimed injuries are not always related to the accident. The challenge to insurers is ensuring that both liability and damages are investigated concurrently. Commonly one or both are either

overlooked or incomplete, thereby adversely impacting outcomes. Consider that, on average, comparative negligence by insurers nationwide is assessed on somewhere between 3 and 5 percent of all claims. Let’s also consider the fact that research on jury verdicts indicates that around 55 percent of all claims adjudicated involve scenarios other than clear liability. These may include intersection accidents, sideswipes, slip-and-fall accidents, and liquor liability. In other words, myriad opportunities exist to improve basic blocking and tackling skills in the comparative negligence arena.

[Click here to read more](#)



# Getting The #1 Seed for Your Claims Organization

By Christopher Tidball



*Originally published in*

*Property Casualty 360 – Mar. 20, 2013*

*As office pools are forming, now is a great time to indulge in this exercise by turning it into a life lesson to better your own claims organization.*

March Madness is upon us with a flurry of activity as millions complete their NCAA brackets. Who will be the national champion? Will there be a Cinderella story? With 68 teams vying for the title, it is anyone's guess, and far from predictable.

So why is it that this particular sporting event is so hard to predict? Perhaps it is because of the high level of talent that permeates NCAA basketball. Players and coaches execute with precision and perfection in one

of the fastest sports around. At the end of the day, the execution of fundamental skills will ultimately prevail in this championship, as is the case in claims handling.

As office pools are forming, now is a great time to indulge in this exercise by turning it into a life lesson to better your own claims organization. What makes Louisville a number one seed? What makes Davidson a great choice for an upset pick? Can San Diego State leverage the elite talent

of Jamal Franklin to be Cinderella? These, and many other questions, will be answered over the next couple of weeks.

March Madness provides a lot of lessons that we can take to the boardroom. It is the ultimate test of teamwork, perseverance and coaching. These are fundamental lessons that many claims organizations can use to build upon.

One of the most interesting aspects of March Madness is that it brings

together diverse styles of play, reflecting that there is more than one way to skin a cat. Fifth-seeded Wisconsin is anything but a fast team, leveraging the clock with perhaps the slowest offense in the tournament, while 8th seeded Pitt simply tears apart opponents with their aggressive play. Of course, there is Gonzaga, once a Cinderella, now the number one seed. Different styles, different players, different philosophies that all win games.

At the heart of hoops is a rather simplistic game with very basic tenets that form the foundation. So too is this true in our organizations, where claims share the common foundation of liability and damages. How we attack the claim is a different matter. The key to success in both worlds is consistency. We must develop our playbook and then consistently execute.

[Read more](#)



# Celent Defines Five Tiers of Data Capability

By Staff Writer



*Originally published in  
Property Casualty 360 – Feb. 19, 2013*

In its new report on Big Data, the research and consulting firm Celent has defined five tiers of data capability: Spectator, Experimenter, Practitioner, Innovator, and Scientist. Using these tiers, Celent suggests that an organization can understand where it is in terms of Big Data capability, but perhaps more importantly where it should be.

The report, *Big Data: A Guide to Where You Should Be, Even If You Don't Know Where You Are*, was

written with a focus on insurance, banking, and securities.

“Celent does not advocate that all companies should aspire to be at the bleeding edge of big data,” says Craig Beattie, senior analyst with Celent’s insurance group and coauthor of the report. “The goal of this report is to help financial institutions understand what their level of investment should be strategically, and how to get there.”

## Among the findings of the report are:

- There is no shortage of assertions around the power of Big Data to transform the enterprise. There is similarly no shortage of arguments for the obsolescence of most of today’s technology infrastructures, since most lack the latest Big Data technologies. Beyond the hype, however, lies a compelling reality: as consumers become increasingly digitally driven, the manner in which financial services are delivered will change inexorably.
- Big Data, when sensibly integrated with core, channel, and decision support systems, and directed from an enterprise perspective, holds the promise for enabling the survival of financial service companies within this epic transformation.

[Click here](#) to read more

# Mitchell Announces New Collision Analytics Program



Originally published in  
*Claims Journal* – Feb. 11, 2013

*These claims are characterized near exclusively by a pain management course of care versus traditional medical interventions.*

Mitchell, a provider of technology, connectivity and information solutions to the property/casualty claims and collision repair industries, announced the initial results of a new data analysis program specifically focused on understanding the vehicle and collision factors that impact injury patterns in motor vehicle accidents.

According to Keith Peterson, Ph.D., vice president of Advanced Analytics and Consulting, "An early

finding is that that low impact, rear point of impact claims generate 2 to 3 times the amount of medical services and last roughly 30 percent longer when they occur in Florida versus other states. And, these claims are characterized near exclusively by a pain management course of care versus traditional medical interventions."

[Click here](#) to read more

# P&C Summary

By **Sandra Piccillo**

Senior Marketing Manager, Auto Casualty Solutions Mitchell



*Attendees were able to see firsthand how Mitchell is working to achieve its vision to be the leading trusted strategic technology partner to the property and casualty claims industry*

Mitchell held its annual Property & Casualty Conference on April 9 & 10, 2013 at the Rancho Las Palmas Resort in Rancho Mirage, CA. The conference is a unique opportunity for P&C claims executives to gain insights, ideas, and perspectives on new claims approaches and cutting-edge technologies for claims acceleration and business trends affecting our industry.

Guest speakers included Shawn Achor, the 2013 P&C Keynote Speak-

er. Shawn is a best-selling author of 'The Happiness Advantage,' and he addressed the importance of happiness and Positive Psychology in our business and personal lives during his presentation to the attendees.

In addition, we also welcomed Bryant Walker Smith, who spoke at the general session on Wednesday.

Bryant is a Fellow at the Center for Automotive Research at Stanford and discussed the industry, legal,

and cultural impact of driverless technology implementation.

Some of the session highlights included:

## **Product Innovations in 1st and 3rd Party Claims**

Upcoming product innovations were highlighted in this session. A deeper dive into third party claims processes and the unique drivers that have resulted in innovative solutions designed for practical, stream-

lined, and optimized third party claims productivity were featured.

Attendees were able to see first-hand how Mitchell is working to achieve its vision to be the leading trusted strategic technology partner to the property and casualty claims industry, and to have the broadest array of deeply effective solutions that simplify and optimize the claims process. Upcoming product innovations were highlighted in this session.

### **Regulatory Compliance Trends in Review and Healthcare**

Another important industry topic is regulatory compliance and Michele Hibbert-Iacobacci presented insight and analysis into these trends. The session explored what drives our healthcare model and what is being done to combat irrational medical billing and payment systems. The session presentation focused on battleground states, the largest challenges, and described alternative methodologies to learn if they would be viable options in the industry.

Simple regulatory change can affect patient care positively or negatively, thus bringing into question the value of healthcare. Why is healthcare purchased differently than other services we buy? Would

you buy a car that needed more than four wheels and required an oil change every twenty miles?

Would you pay twice the market value for that car? These topics were reviewed by Michele Hibbert-Iacobacci, with data analysis and insights highlighted for session attendees.

### **Out-of-Network Negotiations:**

#### **Keys to Building a Competitive Medical Cost Containment Program Workers' Compensation Solutions / Auto Casualty Solutions Joint Session**

Medical cost inflation continues to be the primary challenge for claims executives in auto and workers' compensation. Even with a robust voluntary network program in place, 50-75% of medical charges may fall outside the scope of your networks. Greg Gaughan discussed the evolution of out-of-network negotiations (OON), and the value of OON in a comprehensive medical cost containment program. During the session, a deeper dive was taken into the following areas:

- Key differences between the various solutions in the market
- Tips for finding the right fit for your business model

- Critical workflow issues and best practices to consider when implementing a solution

The conference was a great opportunity for P&C claims executives to discover the latest trends, connect with each other and gain new insights into technology solutions for the industry.



**mitchell**

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Mitchell, founded in 1946 and headquartered in San Diego, California, is a leading provider of technology, connectivity and information solutions to the Property & Casualty Claims and Collision Repair industries. The company's comprehensive solution portfolio streamlines the entire auto physical damage, bodily injury and workers' compensation claims processes. Mitchell processes over 50 million transactions annually for over 300 insurance companies/claims payers and over 30,000 collision repair facilities throughout North America to enhance partner productivity, profitability, and customer satisfaction.

From the moment policyholders notify their insurance companies of a vehicle claim, Mitchell's robust solutions take action, transforming the entire claims and repair cycle into a streamlined, end-to-

end process using intuitive tools, data-driven software and shared workspaces that deliver a much improved and efficient experience. From initial damage appraisal to helping collision repairers safely and efficiently return vehicles to pre-accident condition, insurers and collision repair businesses depend on Mitchell to deliver cost savings to their organizations and pleasant and timely claims settlement to their customers.

Mitchell also has a 20-year track record of delivering solutions to help Auto Insurance Carriers and Workers' Compensation Claims Payers evaluate and settle their medical claims faster and more accurately. With an unmatched breadth of medical data and decision support experience, Mitchell offers a variety of technology, database, and service solutions that enable its clients to control costs

and improve consistency throughout the claims process.

Mitchell is a privately-held company, owned primarily by the Aurora Capital Group. Aurora Capital is a Los Angeles-based investment firm formed in 1991 that acquires and builds companies in partnership with operating management. The firm currently manages approximately \$2 billion in capital and is committed to investing in companies with unique, defensible market positions. Aurora is dedicated to generating long-term value principally through investing the time and resources necessary to enhance the fundamentals of each of its businesses.

For more information on Mitchell, visit [www.mitchell.com](http://www.mitchell.com).

For more information on Aurora Capital, please visit its website: [www.auroracap.com](http://www.auroracap.com).

# Mitchell In the News



## Analytics Program Compares Collisions, Injury Outcomes

Mitchell, a leading provider of technology, connectivity and information solutions to the U.S. property/casualty claims and collision repair industries, has released the initial results of a unique new data analysis program specifically focused on understanding the vehicle and collision factors that impact injury patterns in motor vehicle accidents. [Read More](#)



## Mitchell Showing Positive Results with National Impact Injury Database

Mitchell announces the initial results of their new data analysis program specifically focused on understanding the vehicle and collision factors that impact injury patterns in motor vehicle accidents. Mitchell provides technology, connectivity, and information solutions to the property & casualty claims and collision repair industries, [Read More](#)



## Mitchell Makes Predictions for Collision Repair Industry in 2013

Mitchell International has released some of its predictions for the collision repair industry for 2013, and they include a decrease in recycled parts prices and increases in average cost to repair collision damage and average hourly labor rate. [Read More](#)



## Auto-Owners to Implement Mitchell's WorkCenter Total Loss Solution

Auto-Owners Insurance has signed a multi-year partnership agreement with Mitchell to deploy its WorkCenter Total Loss solution to enhance customer satisfaction.

The solution produced accurate valuations, increased first-call settlement rates and overall consumer satisfaction with the total loss claims process, during testing in three states. [Read More](#)



## Mitchell Releases Shop-Insurer Communication Tool

Mitchell International on Monday announced the launch of a new product designed to streamline communications between auto insurers and collision repair shops. The tool, called RepairCenter Connect, allows any collision repair shop either inside or outside of a direct repair program (DRP) network to receive appraisal assignments from insurance companies. [Read More](#)



# Industry Trends Report

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 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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