PERSONAL INJURY PROTECTION:

A Review of the Medical Billing Process Under the KY PIP System

Kentucky Department of Insurance

October 23, 2018

PIP SYSTEM OVERVIEW

- Personal Injury Protection or "PIP"
  - Commonly known as: "no-fault", "basic protection insurance", "basic reparation benefits".
- What is PIP?
  - No-fault automobile insurance that covers specific expenses resulting from accidents arising out the maintenance or use of an automobile.
    - Baseline amount of $10,000 with option to purchase additional benefits in $10,000 increments.
    - Pays for medical expenses, funeral expenses, wage loss, survivor benefits, and the cost of rehabilitation.
  - Alternative to the tort system
    - By accepting PIP coverage, an individual gives up the right to sue UNLESS:
      - Medical expenses exceed one thousand dollars ($1,000);
      - Injury resulting in whole or in part permanent disfigurement;
      - Injury resulting in a fracture to a bone, a compound, a comminuted, displaced or compressed fracture;
      - Injury resulting in a loss of a body member;
      - Permanent injury within reasonable medical probability; or
      - Permanent loss of bodily function or death.
  - Kentucky is a choice state
    - Individuals may reject no-fault coverage.
  - Medical bills are presumed reasonable. Limited ability to challenge based on reasonableness and necessity.

INTRODUCTION TO THE STUDY

- 2018 General Assembly passage of HB 464
  - DOI required to perform "a comparison study of billing rates for medical bills submitted by providers to reparation obligors pursuant to KRS 304.39-020(5)(a)."
  - Primary discussion throughout the 2018 General Assembly concerned PIP medical billing and PIP fraud.
- DOI charge:
  - Review and compare the medical billing rates in the PIP system with other fee schedules.
- DOI Study Issues:
  - Data- What data do we need and where to get it from to effectively compare?
  - Process – What is the best way to get the data, and form for analysis?

DOI PROCESS

- Consideration of Third Party Data Sources
  - Eliminated due to breadth of data set and potential confusion.
- Internal decision made to sample insurance companies for PIP data
  - Survey request was sent to five insurance companies in this market. Request information on process, data intake, and data storage.
  - Must have captured the relevant data for comparison (CPT Codes, ICD, Modifiers, Provider information, Billed Charge, Allowed Amounts)
- Receive responses
  - PIP medical billing processes differ by company.
    - Internal processing with very limited reductions to the billed.
      - Not much data retained in easily accessible/transferable manner for study purposes.
    - External use of 3rd party vendors
      - Insurance company transfers varying degrees of responsibility to 3rd party vendors for payment of bills.
      - Medical bills are repriced based on provider contracts of the 3rd party vendor.

DOI PROCESS

- Data Request
  - Kentucky Workers' Compensation Fee Schedule ("WCFS") is based primarily on applicable CPT Codes.
  - DOI must request medical billing that captures, at minimum, the CPT coding for comparison.
  - Helpful to use insurer company data that uses re-pricing. In the end, DOI would have billed amount, allowed amount, and the WCFS rate.
  - Request data from three insurance companies of all medical bills submitted and processed in 2017 for PIP claims.
- Data Submitted
  - Receive responses to request in August, September, and October.
  - Approximately 600,328 individual transactions.
  - Approximately $140,483,820 in billed charges.
  - Approximately $107,914,238 in allowed charges.
- Data Refinement
  - DOI had to refine the data to take into account various limitations
    - Units for some CPT codes
    - Usage of modifiers
    - Hospital and non-hospital transactions
    - PIP limits
- Organization and Analysis
  - KY Department of Insurance Market Conduct Division was instrumental in the data request, organization, and analysis processes.

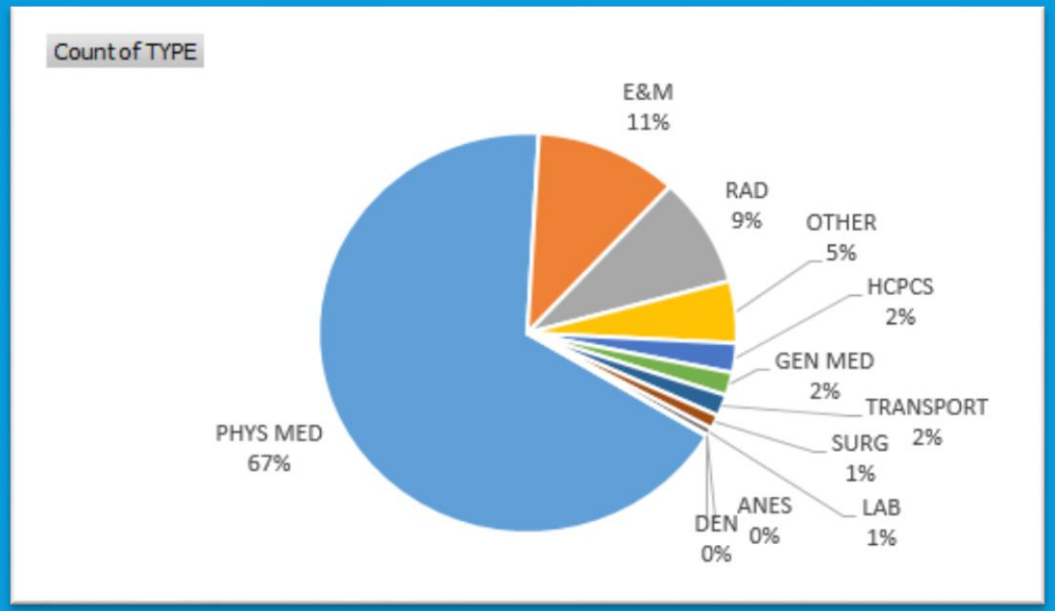
PIP MEDICAL DATA COMPARISON

- Two Primary Components:
  - Frequency
    - Determine the codes that were billed most often in the PIP system.
    - Helps show who is using the system most frequently.
    - Also may help determine the best potential comparison for the amounts billed.
  - Amount
    - Review and compare the amounts billed in comparison to different fee schedules

FREQUENCY

- Data Refinement
  - Non-Hospital
  - Non-Unit CPT Codes
  - Organization by WCFS Section tabs (10 different sections)
- Aggregate Totals:

PHYS MED	246,552
E&M	40,496
RAD	32,558
OTHER	18,363
HCPCS	8,707
GEN MED	6,820
TRANSPORT	6,356
SURG	4,155
LAB	2,285
ANES	167
DEN	79
Grand Total	**366,538**

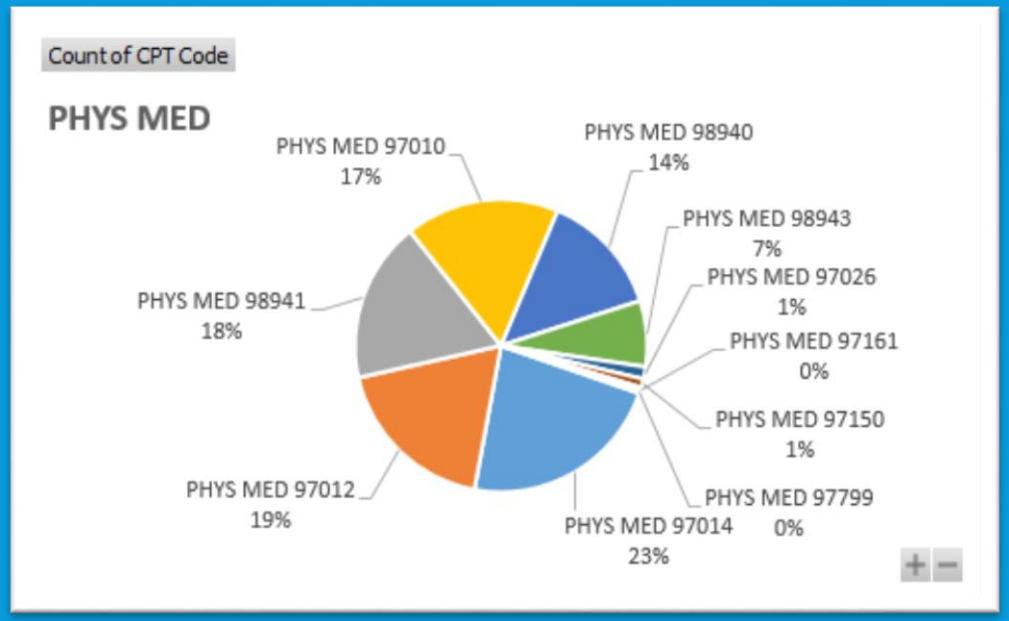


FREQUENCY

- Physical Medicine is the most frequently billed section.
- Physical Medicine, E&M, and Radiology codes comprise 87% of total non-hospital, non-unit codes.
- Top Five Billed Codes:

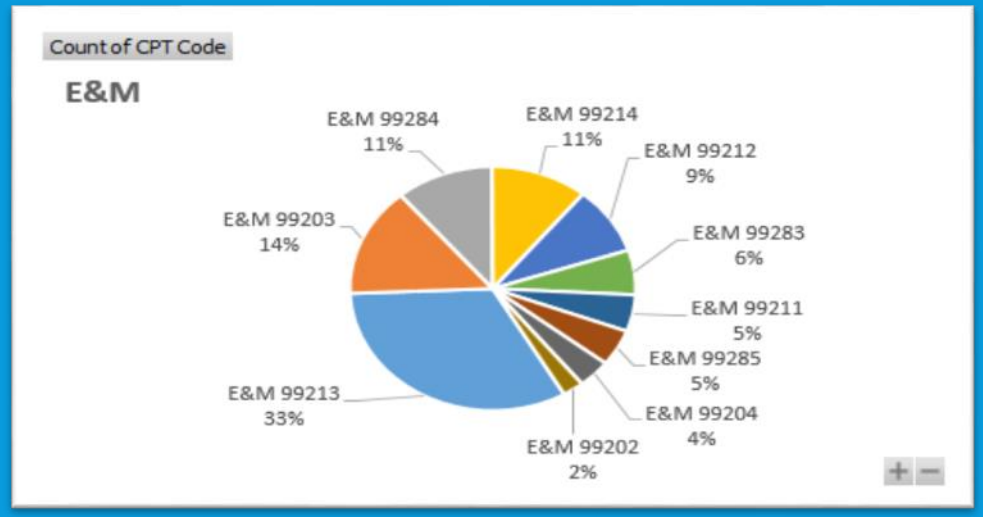
CPT Code	Number of Transactions	CPT Code Description
97014	55,068	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97012	45,127	Application of a modality to 1 or more areas; traction, mechanical
98941	43,256	Chiropractic manipulative treatment (cmt); spinal, 3-4 regions
97010	41,513	Application of a modality to 1 or more areas; hot or cold packs
98940	33,302	Chiropractic manipulative treatment (cmt); spinal, 1-2 regions

PHYSICAL MEDICINE FREQUENCY



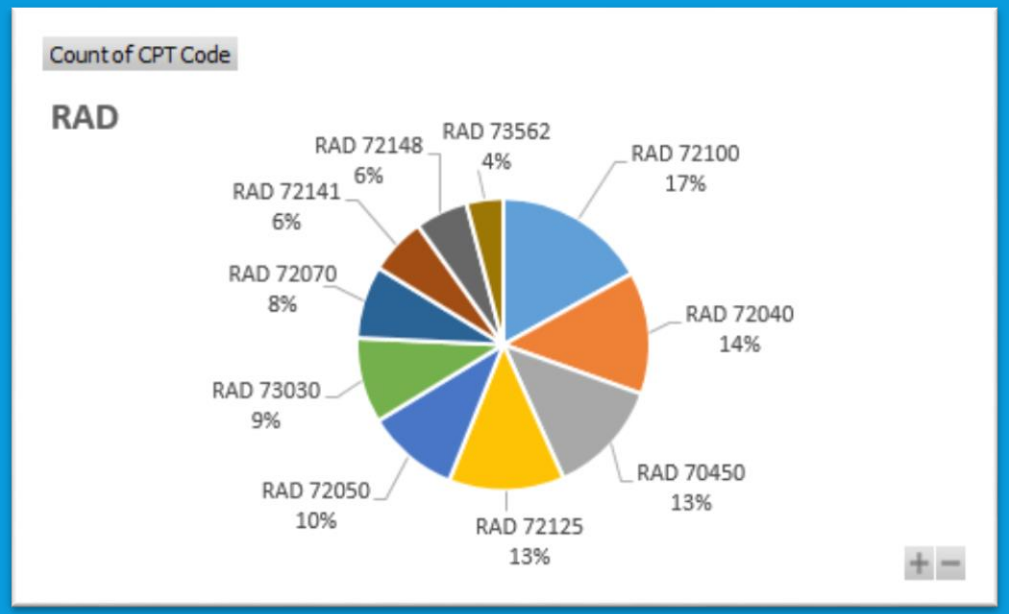
CPT Code	Description	Count
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	55,068
97012	Application of a modality to 1 or more areas; traction, mechanical	45,127
98941	Chiropractic manipulative treatment (cmt); spinal, 3-4 regions	43,256
97010	Application of a modality to 1 or more areas; hot or cold packs	41,513
98940	Chiropractic manipulative treatment (cmt); spinal, 1-2 regions	33,302
98943	Chiropractic manipulative treatment (cmt); extraspinal, 1 or more regions	17,668
97026	Application of a modality to 1 or more areas; infrared	3,285
97150	Therapeutic procedure(s), group (2 or more individuals)	2,306
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	909
97799	Unlisted physical medicine/rehabilitation service or procedure	698
Grand Total		**243,132**

EVALUATION AND MANAGEMENT FREQUENCY



CPT Code	Description	Count
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components. Typically, 15 minutes are spent face-to-face with the patient and/or family.	12,457
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: Typically, 30 minutes are spent face-to-face with the patient and/or family.	5,524
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.	4,203
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	4,179
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	3,436
99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history. Usually, the presenting problem(s) are of moderate severity.	2,253
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	1,861
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.	1,835
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	1,434
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	908
Grand Total		**38,090**

RADIOLOGY FREQUENCY



CPT Code	Description	Count
72100	Radiologic examination, spine, lumbosacral; 2 or 3 views	3,042
72040	Radiologic examination, spine, cervical; 2 or 3 views	2,438
70450	Computed tomography, head or brain; without contrast material	2,300
72125	Computed tomography, cervical spine; without contrast material	2,296
72050	Radiologic examination, spine, cervical; 4 or 5 views	1,842
73030	Radiologic examination, shoulder; complete, minimum of 2 views	1,697
72070	Radiologic examination, spine; thoracic, 2 views	1,449
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material	1,136
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material	1,045
73562	Radiologic examination, knee; 3 views	733
Grand Total		**17,978**

FREQUENCY OBSERVATIONS

- Vast majority of claims come from three sections of the WCFS
- Providers billing in these areas:
  - Chiropractors
  - Physical Therapists
  - "Spine and Rehab" Facilities – Multi-use facility
  - Limited amount of general practitioners
- Geographic Location:
  - The bills primarily originate from Jefferson County
  - Other notable locations include Hardin County, Laurel County, Perry County

AMOUNT COMPARISON - AGGREGATE

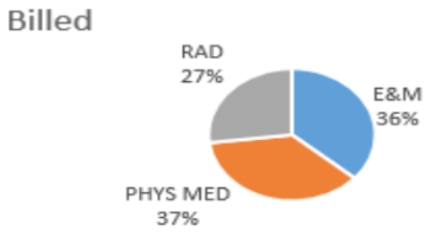
- Two Data Sets
  - Aggregate
    - Limited comparison due to data limitations (i.e., unit codes, modifiers, allowed amounts, exhaustion of PIP). Can't get an accurate comparison to the WCFS.
    - Non-Hospital
      - 514,944 Non-Hospital Medical Transactions
      - $103,824,627 in billed charges
      - $85,703,222 in allowed charges
    - Non-Hospital, Non-Unit
      - 366,538 non-hospital, non-unit transactions
      - $46,769,826 in billed charges
      - $38,537,629 in allowed charges

AMOUNT COMPARISON- REFINED

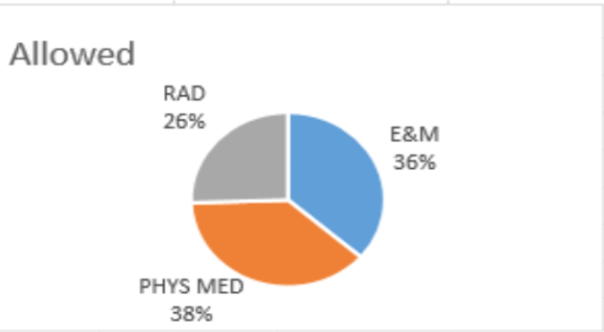
- Data refined to non-unit transactions to allow for consistent comparison between billed charge, allowed amount, and the WCFS.
  - Example of charges not considered- Transportation with mileage codes and Physical Medicine application codes in 15 minute increments.
- Further refined data to the three most frequently billed WCFS sections.
- Total population – 319,606 of the 366,358 claims.
- Calculate:
  - The billed amount for each section;
  - The allowed amount for each section;
  - The amount compensable under the WCFS;
  - A comparison of the reductions.

AMOUNT COMPARISON- REFINED

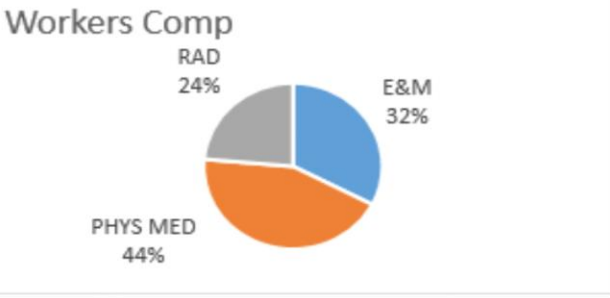
Billed	
E&M	11,817,270.59
PHYS MED	11,867,570.08
RAD	8,726,889.33
Total	32,411,730.00



Allowed	
E&M	10,452,557.93
PHYS MED	10,937,942.21
RAD	7,327,940.07
Total	28,718,440.21

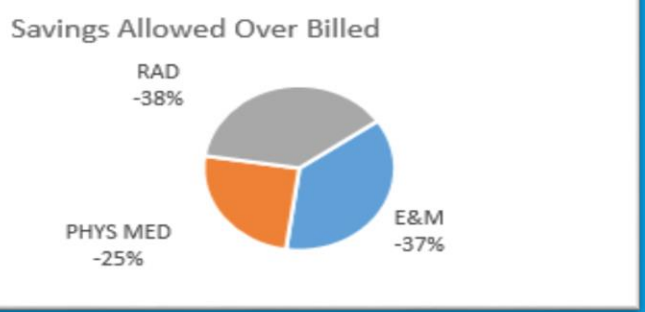


Workers Comp	
E&M	6,413,916.62
PHYS MED	8,611,007.68
RAD	4,646,387.76
Total	19,671,312.06

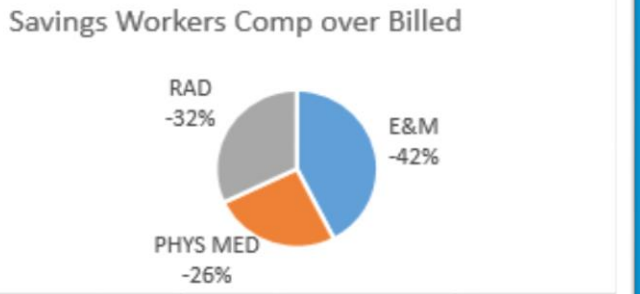


AMOUNT COMPARISON - REFINED

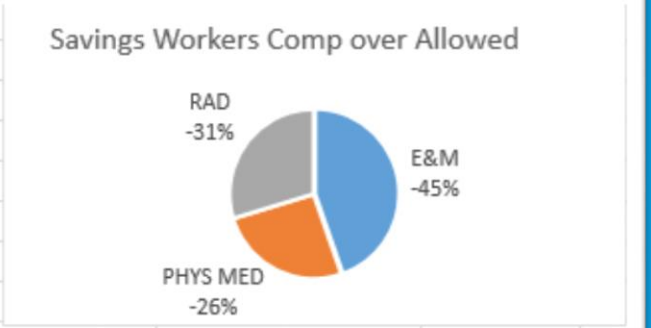
Savings Billed to Allowed	
E&M	(1,364,712.66)
PHYS MED	(929,627.87)
RAD	(1,398,949.26)
Total	(3,693,289.79)



Savings Billed to Workers Comp	
E&M	(5,403,353.97)
PHYS MED	(3,256,562.40)
RAD	(4,080,501.57)
Total	(12,740,417.94)



Savings Allowed to Workers Comp	
E&M	(4,038,641.31)
PHYS MED	(2,326,934.53)
RAD	(2,681,552.31)
Total	(9,047,128.15)



Theme: The physical medicine represents the vast majority of billed codes, but they are less expensive on average and the reduction in allowed and the WCFS is less than the other, less frequently billed codes.

AMOUNT COMPARISON – CPT CODES

- Code Review and Comparison
  - Determine the potential reduction and impact based on review of CPT in each section. Data suggests a greater reduction in less frequently billed, but higher value transactions.
- Physical Medicine
  - CPT Code 97014 (electrical stimulation) was billed 55,054 times, excluding limited outliers.
  - The total amount billed by providers was $2,194,885 for an average of $39.87 per transaction.
  - The total amount allowed by insurers was $2,012,637 for an average of $36.56 per transaction.
  - The total amount under the WCFS was $1,376,350.
  - The total amount saved between the billed amount and WCFS is $818,535.
  - 11,025 transactions were at or below the WCFS rate of $25.00.
  - 44,029 transactions were above the WCFS rate of $25.00.
  - The range of billed charges was $10 to $150.

AMOUNT COMPARISON- CPT CODES

- Evaluation & Management
  - CPT Code 99213 (most often billed E&M code, 2 or 3 key findings) was billed 12,453 times, excluding outliers.
  - The total amount billed by providers was $1,998,154 for an average of $160.46 per transaction.
  - The total amount allowed by insurers was $1,722,858 for an average of $138.50 per transaction.
  - The total amount under the WCFS was $1,419,642.
  - The total amount saved between the billed amount and WCFS is $578,512.
  - 4,606 transactions were at or below the WCFS rate of $114.00.
  - 7,847 transaction were above the WCFS rate of $114.00.
  - The range of billed charges was $20 to $679.

AMOUNT COMPARISON – CPT CODES

- Radiology
  - CPT Code 72148 (MRI of the lumbar spine, without contrast)
    - CPT Code 72148 (Modifiers 26/TC/59)
      - This code as modified was billed 197 times.
      - The total billed by providers was $86,200 for an average of $437 per transaction.
      - The total allowed by insurers was $63,555 for an average of $322 per transaction.
      - The total amount under the WCFS is $24,924 at the WCFS rate of $126.56.
      - The total savings from the billed to WCFS is $61,276.
    - CPT Code 72148 (No Modifier)
      - This code was billed 846 times.
      - The total billed by providers was $1,437,708 for an average of $1,699 per transaction.
      - The total allowed by insurers was $1,233,452 for an average of $1,457 per transaction.
      - The total amount under the WCFS is $823,344 at the WCFS rate of $973.22.
      - The total savings from billed to WCFS is $614,364.
  - The total savings in this code from billed charge to WCFS is $675,640.

AMOUNT COMPARISON – CPT CODES

- The lumbar MRI code was billed 1.89% (1,093 v. 55,054) of the physical medicine code (electrical stimulation).
- Using the fee schedule on the less frequently billed code represents 83% of the reduction in the most frequently billed code.
- Fee schedule has a greater impact on less frequently billed codes but higher per transaction cost.

OTHER STATES

- Review of cost containment measures in other no-fault states:
  - Hawaii
    - Fee schedule and treatment guidelines
    - HRS 431:10C-308.5
  - Pennsylvania
    - Fee schedule and peer review system
    - 75 Pa. C.S.A. 1712
  - New York
    - Fee Schedule in 1977.
    - Article 51, Section 5108
  - New Jersey
    - Fee schedule
    - N.J.A.C. 11:3-29.1
- Proposed but not enacted in Michigan and Minnesota.

DOI PIP FRAUD REVIEW

- The Kentucky Department of Insurance places great value on our Division of Insurance Fraud Investigation.
- Since PIP fraud is a related concern, internal review of fraud referrals below:

YEAR		TOTAL FRAUD REFERRALS		AUTO/PIP REFERRALS	% of Total Fraud Referrals		JEFFERSON CO PIP Referral	% of PIP Referrals		Health Care Provider Referrals	% of Auto/PIP Referrals
2006		741		187	25%		77	41%		41	21%
2007		733		188	25%		72	38%		21	11%
2008		1,025		274	26%		109	39%		22	8%
2009		1,048		262	25%		130	49%		38	14%
2010		965		358	37%		223	62%		45	12%
2011		1,066		560	52%		353	63%		111	19%
2012		1,914		1,243	64%		851	68%		340	27%
2013		1,687		1,062	62%		1,005	94%		298	28%
2014		1,677		1,106	65%		694	62%		235	21%
2015		1,870		1,371	73%		904	65%		449	32%
2016		1,720		1,199	69%		710	59%		360	30%
2017		1,854		1,096	59%		755	69%		442	40%

DOI PIP FRAUD REVIEW

- Health Care Provider Fraud Common Referrals:
  - Excessive treatment;
  - Billing for services not rendered;
  - Duplicate billing for same services;
  - Illegal solicitation/cappers; and
  - Unqualified or unlicensed person to perform billing.
- Example
  - 2016J00737 – Questionable MRI billing. The records indicate an MRI was taken at a facility/provider that does not have an MRI machine. MRI re-read indicated the images were of moderately poor quality and the exam quality prevents detailed analysis of the report. Records review indicated the MRI referral was not reasonable, and indicates the referral for pain management was not supported by the notes.

CONCLUSION

- Update to Report:
  - DOI continues to review a substantial amount of data, and will update the report with a comparison of hospital specific transactions.
- Overall:
  - PIP is a beneficial system, and serves to streamline the process of receiving necessary medical treatment following an accident.
- PIP medical bill process varies by insurer.
- The medical bills submitted in the PIP system vary widely in amounts between providers for the same service.
- Certain codes make up the majority of transactions.
- The KY Workers' Compensation Fee Schedule would reduce the amounts payable in the system, and have a greater impact on the higher dollar transactions.
- DOI welcomes the opportunity to answer questions, continue the receipt and review of PIP data in the future, and provide updates on the system.

QUESTIONS AND THANK YOU

- Questions
  - You may contact me with questions at Patrick.oconnor@ky.gov
- Thank You
  - DOI Market Conduct personnel:
    - Russ Hamblen, Patrick Smith, James Axman helped greatly in the data request, organization, and analysis.
  - Participating Insurers:
    - Kentucky Farm Bureau
    - State Farm
    - Allstate
    - USAA
    - Nationwide
    - Kentucky National