INSURANCE COMPANY EVALUATION OF BODILY INJURY CLAIMS

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Insurance companies have certain criteria that they use with which to evaluate bodily injury claims, whether arising out of a motor vehicle accident case, a slip and fall accident, or some other liability event involving their insured causing injury to a victim.

Attorneys representing injury victims must learn to recognize those criteria in order to best serve their clientele, and must be adept at distinguishing their client's case from that of other injury claimants in order to make the best presentation of their client's claim and thereby distinguish them from the rest of the "pack".

A Bit of History: Representing the personal injury victim of today is a different proposition than what it was for attorneys ten years ago.

Insurance companies several years ago would tend to evaluate cases on an "actuarial basis", meaning that the cost of defense was a factor that would often go into their evaluation. In other words, if negotiation became stalled, then the attorney representing the injury victim was often able to persuade the carrier to see things more their way in making a favorable offer, given the amount of defense costs that the carrier was sure to incur should the case be litigated, and when there was never any assurance that a judge or jury would necessarily see things from the carrier's more conservative perspective.

In order to avoid litigation costs, most carriers at that time would also be willing to submit the case to arbitration in order to resolve it, whereby a neutral trier of fact like an impartial attorney or a retired judge would hear the case in an informal evidentiary hearing, and then render an award. This was especially useful in smaller personal injury cases, where the injury involved sprains and strains (often referred to as "soft-tissue" cases), as opposed to more dramatic or catastrophic injuries. Because this was more cost efficient and quicker to schedule than a formal jury trial, both the insurance company and the injury victim and their attorney would benefit by using such a procedure.

But as the years went by, insurance companies began to change their method of evaluating and settling personal injury cases. The biggest reason for this was probably the evolution of public perception regarding personal injury victims, the civil justice system, and attorneys who represent personal injury victims.

Over the past ten years, the public has been bombarded with various ballot initiatives regarding automobile insurance and liability insurance that have been the subject of contentious elections in which insurance money has attempted to rewrite existing law on joint and several liability, attorney's fees, and other aspects of the civil justice system. While most of the insurance sponsored initiatives have met defeat, the propaganda associated with the initiatives has left a residual taint on the mind set of those members of the public who end up sitting on juries.

This indoctrinated mind set believes that there are too many personal injury lawsuits being filed, that the filing of such lawsuits drives up insurance rates, that juries are awarding outrageous sums of money on frivolous cases, that people claim "whiplash" to try and get rich, and that lawyers are the root of the problem. While it is beyond the scope of this article to refute these myths (and myths they are), except to state that the number of lawsuits for personal injury has steadfastly declined on a per capita basis

over the past ten years, the damage has been done and many people in the jury pools are openly hostile to personal injury plaintiffs and their attorneys.

The public's general dislike of attorneys has not been helped in recent years either, what with the legal circus surrounding the criminal and civil prosecution of certain high profile cases, and the publicity surrounding certain unusual jury verdicts, such as the "infamous" McDonald's coffee burn case. The general public has been misled to believe that juries are giving away the farm to undeserving injury victims on completely non-meritorious and frivolous cases. While this misconception is due to the public accepting media reports at face value on cases where the public was not privy to the actual evidence in the case being publicized, and where the more mundane cases do not receive any publicity whatsoever, it is a public perception problem that has tainted the mind set of many of those members of the public who end up sitting as jurors.

Insurance companies are well aware of this, and they now exploit it. Arbitration, especially on smaller injury cases, is no longer routinely accepted or acquiesced in by most insurance carriers. Instead, they will insist on a jury trial, even if the costs of same may outweigh the reasonable value of the case or the carrier's costs of defense for defense counsel and related litigation expenses.

The stated goal of many insurance companies is to make the handling of personal injury claims by plaintiff attorneys, especially in the smaller cases, to be financially unattractive. They do this by offering less than what is reasonable, and then by insisting on a three or four day jury trial should their "magnanimous" offer be refused. As the costs of putting on a jury trial for even a small injury case may end up being as much as a third of what the case may be realistically worth, this often gives some attorneys representing injury victims a financial disincentive to take the case further.

Colossus: A more insidious development in insurance company claim evaluations has been the development and widespread use of Colossus and other computer software programs that evaluate the claim based on certain computer input data, taking the human evaluation largely out of the picture. It is still a subject of debate in some legal circles as to what criteria the computer software specifically relies on in making these calculations, but it is supposed that its data base rests on what juries are doing with regard to certain cases. When the data on a particular claim is inputted into the program to obtain a valuation, the presence (or absence) of certain "red flags" will then dictate the amount of the resultant evaluation of the claim, and what the offer in response to a settlement demand will be.

Red Flags: Insurance carriers have certain criteria they use as the earmark of a disputed claim (by definition, all claims are essentially "disputed"), if certain facts are present in it. These can include the following:
Initial Delay In Treatment: If the injury victim delays too long in seeking medical treatment, then the carrier will use it to argue that the claimant was not injured at all or was not hurt that bad. Many soft-tissue injury victims, unless they are hauled away by an ambulance from the scene, are hesitant to see a health care provider immediately, due to lack of medical insurance, uncertainty as to how the medical treatment and expenses are going to be treated or accepted by the adverse carrier, lack of transportation due to their vehicle being repaired or totaled, difficulty in getting off of work to see a

health care provider, or various other sundry reasons. The longer the delay, the more of an issue it will become in the carrier's assessment of the claim.

Gap In Treatment: Even if the victim sees a health care provider soon after the accident, if they are prescribed further treatment or evaluation and then fail to follow-through on it, only to resume after some delayed period of time, then the carrier will argue that the gap is evidence of lack of injury or evidence of unnecessary treatment being obtained solely to "build up the claim". Again, gaps can occur for legitimate reasons just as a delay in initial treatment can be explainable, but it is an argument that the carrier will seize on in any given case.

Lack of Significant Property Damage: If a motor vehicle accident is involved, the lack of significant damage to the victim's vehicle will give the carrier the opportunity to argue to both the victim's lawyer, and to a jury if necessary, that if the car wasn't damaged that bad that the claimant can't be hurt or hurt that bad. These cases are often known in legal circles as MIST cases: "Minor Impact Soft Tissue" claims. Many carriers are openly hostile to MIST claims and assign them to their fraud units as suspected bogus claims.

While studies have shown that people can be hurt in motor vehicle collisions where the property damage is minimal or even non-existent, this is an argument that can prove especially persuasive to a jury, especially when the defense attorney blows the property damage photographs up to the size of a small billboard and uses them as trial exhibits in front of a jury.

This argument can be countered in some cases, however, by taking into account the damage to the other vehicle, the claimant's propensity to injury given their age or a pre-existing problem or injury, by the claimant's body posture positioning at the time of impact, or by the findings of the treating physician when taken in context with the patient's overall medical history.

Excessive Diagnostic Testing Without Positive Findings: Diagnostic testing that is out of proportion to the amount of conservative therapy being received, or which is medically repetitive or not called for given the clinical presentation of the patient, is usually given short shift by most carriers, and is difficult to justify in a claim. MRI scans, CT scans, bone scans, nerve conduction studies (NCS), and electromyograms (EMG) are expensive and are touted by some medical practitioners as substantiation of a soft tissue injury claim. While some of these tests may be helpful in the diagnosis of a suspected nerve root irritation caused by a bulging disc or a bone spur, such testing is expensive and the results can sometimes be highly debatable in a court of law, especially in regard to the NCS and the EMG.
The injury victim is helped by such testing when it is cautiously prescribed by a prudent practitioner who seeks to confirm the presence of a more serious cause of the patient's problem, as opposed to being prescribed by a practitioner who is more interested in diagnostic support for their clinical diagnosis of a soft-tissue type of injury.
While the client and their physician should have the final say as to what testing will be done, the attorney should appropriately advise the client and their health care provider of the significance, or lack thereof, as to any proposed testing. Any testing which has been done and which has yielded findings which may or may not support the injury being presented in the claim, must also be recognized by the attorney and explained to the client as well, not to mention to the adverse carrier.

Excessive Charges For Examination or Therapy: As opposed to buying a car or haggling over a used sofa at a neighborhood garage sale, most consumers do not debate what they are being charged for when it comes to medical care. Some medical practitioners who have practices based primarily on treating accident or work injury victims will often charge exorbitant fees for examination or therapy that are difficult to justify in making a claim, as the claimant always has the legal burden of proving that their medical treatment and related charges are "necessary and reasonable" for the care and treatment of their injuries.

Not only is this an indicator to the carrier that the provider is jacking up the bill to promote the value of the claim, it is also a smoking gun that the provider's practice specifically caters to accident victims, such that the provider's diagnosis and prognosis may be given lesser credence as opposed to the findings of a more mainstream provider whose practice is not based primarily on treating people who just happen to have a legal claim.
As a general rule, the greater the amount of medical bills, the more the claim may be theoretically worth. Carriers know this and therefore always challenge the amount or extent of the bills. Unreasonable bills can actually detract from the value of the claim, and the attorney needs to recognize what is reasonable and what is not.
The attorney needs to let their client know what their provider is charging them as the claim progresses, so there are no surprises at the end of the road. Excessive charges may (or may not) be negotiable by the attorney at the conclusion of the claim. The attorney also needs to know about the credibility of certain providers in the medical community in the context of support of a client's legal claim.

Multiple Accidents in a Certain Period of Time: Nobody asks to get hurt, but some people seem to have a greater inadvertent talent than others in sustaining multiple injuries from different causes over a given period of time. When this happens, it gives the carrier the argument that the injury involved in the claim is really due to some other accident.

It is up to the victim's attorney in such circumstances to communicate with the victim's physician to ascertain the difference between the different injury events and/or how one injury may have been made worse by a subsequent accident, and then have the physician reduce his findings to a report that can beused to evaluate the case and educate the carrier as to the merits of that particular claim.

Carriers have access to insurance company indices, which can alert them to other claims being made by any one person in the past. Multiple claims may sometimes be viewed with suspicion as being indicative of a "professional claimant". The attorney must be able to put his client's accident history into context for the benefit of the adverse carrier, and full disclosure of the medical history is always the better route to take in order to avoid a credibility attack on the client.

Pre-existing Conditions: Similar to the multiple accident claimant, is the accident victim who because of a congenital problem, their age, or a prior accident have a pre-existing similar problem for which they have previously sought medical attention for. Some victims may have even been treating for the prior problem right up until the time of the accident which is the subject of their claim. While the adverse carrier is not responsible for the prior condition or injury, it is responsible under the law for any

aggravation of that condition that the negligence of their insured causes. There is even a court approved jury instruction on this issue.

Again, it is the responsibility of the victim's attorney to discuss these issues with the treating physician and to have their opinion reduced to a report, so that the aggravation problem or the peculiar nature of the injury resulting from the accident can be put into a proper medical-legal context and the claim successfully resolved.

Retaining an Attorney: The experience and skill of a seasoned personal injury attorney is the injury victim's best hope of a successful resolution of their claim. Part of this experience is being able to recognize red flags and putting them into context with the adverse carrier; the attorney having a credible reputation in the legal community with claims adjusters; and the attorney instilling in clients a conservative and realistic expectation of what can and cannot be accomplished for them in the representation of their claim.

Accident victims should not be afraid to question an attorney whom they are considering to retain about their expertise, their jury trial experience, the number of similar cases that they have handled, and how they would propose to resolve their claim. Beware of attorneys who promise the moon, who predict potential values on the claim at the very outset without recourse to all of the client's medical records, or who are evasive in responding to inquiries about their experience level. Nobody deserves to be a victim twice.

ACTUAL QUOTES FROM TEXAS LEGAL PROCEEDINGS

Attorney: Are you a U.S. citizen?
Defendant: No, Ma'am.
Attorney: Where were you born?
Defendant: Texas.

Attorney: Isn't it a fact that ["blah, blah, blah"]?
Defendant: Yes, absolutely. But you can't prove it.

Attorney: On the day of the accident, were you intoxicated?
Defendant: No, I definitely was not.
Attorney: Had you drinking at all that day?
Defendant: I had a few beers is all.
Attorney: How many beers did you consume?
Defendant: About thirty.
Attorney: If you were not drunk after that much beer, how would you define drunk?
Defendant: Drunk is when you fall down and can't get up.

Defendant in an auto case: I had been driving my car for 40 years when I fell asleep at the wheel and the accident occurred.

Attorney: Mr. Jones, why do you continue to refuse to pay any child support?

Defendant: I ain't sending her nothin' so long as she's shackin' up with guy named Frank or Sam or whatever his name is.
Attorney: Did you know that she is having a tough time making ends meet, even with HUD paying half her rent?
Defendant: Who?
Attorney: HUD.
Defendant: I didn't even know about him. Why's he paying her rent?
Attorney: I think you're thinking of Paul Newman in the movie Hud.