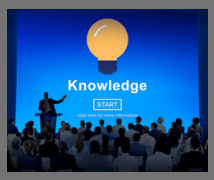
2016

INSURANCE CLAIMS PRACTICES, PROCEDURES AND SOFTWARE

Presented by:

James J. Mathis

Sponsored by:



MF University

I N D E X

R I S E O F C O L O S S U S

By James J. Mathis[1]

PREFACE

The business of insurance has been around for a very long time. The first contract of insurance I could find was signed in Genoa in circa 1347. Insurance contracts were entered into by individuals, either alone or in a group. They each wrote their name and the amount of risk they were willing to assume under the insurance proposal. In Babylonia, traders assumed the risks of the caravan trade through loans that were repaid after the goods had arrived safely—a practice resembling bottomry and given legal force in the Code of Hammurabi (c.2100 B.C.). Hence, the term Underwriter. In the United States. the history of insurance involves two principles: risk protection and capital accumulation. Originally, underwriters, usually merchants and real-estate men who could assess risk and estimate profitable premium rates, insured policyholders for lost cargoes and the destruction of buildings by fire. Risk is now calculated by professional actuaries using complex statistical techniques.

The *Merriam-Webster Dictionary* describes insurance as, "coverage by contract whereby one party undertakes to indemnify or guarantee another against loss by a specified contingency or peril." So the basis of insurance is "guarantee against loss". Insurance can be considered to be a transfer of a future risk in exchange for a paid premium. Each policyholder pays a premium to their selected insurer with the promise from the insurer that the future economic exposures up to an agreed limit from a covered loss will be assumed by the insurer with the exception of any deductible or co-payment previously stipulated in the insurance contract. Essentially, a transfer of risk is paid for by the policyholder and assumed by the insurer.

Payment for the assumed risk by the insurer on behalf of the policyholder can be separated into two types of claims. A **first** party claim involves those risks paid directly to the policyholder (or any other party considered a policyholder). For example, collision, comprehensive, MPC (Medical Payment Coverage), PIP (Personal Injury Protection), Uninsured and Underinsured losses would all be first party claims. **Third** party claims are those risks paid to a party who has suffered a loss which the policyholder may be found to be negligent in causing. Since, this represents an economic risk to the policyholder and assuming the policyholder has contracted with the insurer for *Liability coverage*, the insurer assumes the cost of that economic risk (including any cost of investigation, analysis, resolution and legal defense of the policyholder should litigation occur).

Most states hold that a fiduciary responsibility exists either implicitly or explicitly between the policyholder and the insurer. Almost all states have adopted the Fair Claims Act into their statutes defining what is required of the insurer in the handling of first party claims. Only a few states have adopted the Fair Claims Act in their statutes where the claim is handled by the insurer as a third party claim. Where a duty or fiduciary responsibility under the individual state's statutes has not been completed or has been violated, it could then be defined as an act of "Bad Faith" or "Breach of Contract". In some cases, this has led to a lawsuit brought by the policyholder against the insurer.

[1] CV of James J. Mathis is in the back of this handout.

When the risk or claim involves damages to a third party, not a policyholder, which the policyholder will be found responsible for, the insurer has a duty to assume the cost of those damages (up the limit of the coverage contracted by the policyholder). If the insurer fails to resolve the third party claim within the limits of the policy, when it had an opportunity to, the insurer can be found have failed its fiduciary responsibility, breached its contract and/or committed an act of bad faith. Under this circumstance the third party may filed a suit against the policyholder to recover all damages as a result of the policyholder's negligence. Should the lawsuit result in a judgement in excess of the policy limits, the policyholder can choose to assign to the third party the right to bring a lawsuit against the insurer for the breach of contract and/or the act of bad faith.

THE LEGAL ENVIRONMENT TODAY

Here is a general history of the environment, which exists between the legal community and the insurance industry. When an individual was involved in an accident where they were injured, they would seek medical treatment for their injuries (medical specials). They might lose some time from their employment as well (income loss or economic specials). They could also have future needs for medical treatment and possibly future periods of income loss. They might also have permanent impairment or disabilities.

When the treatment was completed and their injuries were resolved, they would approach the insurance company adjuster to settle their claim. The injured party might perform this through a retained attorney as well. The claim would be evaluated by the adjuster utilizing his/her experience, training, education, and common sense. The claim, which was evaluated, consisted of medical specials, economic specials (medical treatment costs and income loss) and "pain and suffering". "Pain and suffering" are dollars paid for the inconvenience of the accident, injuries and consequences of the accident. The adjuster would understand the inherent issues associated with these claims. A claim would result in a settlement of approximately three to four times specials. This meant that a claimant with $3,000.00 in specials would most likely receive a settlement offer from the insurance adjuster of $9,000.00 to $12,000.00. This is assuming there were no unusual circumstances involved in the claim.

At some point in the late 80's and during the early 90's, the insurance industry determined that there was an opportunity to realize a profit in their claims departments by paying less for claims. The fact became obvious that only a small percentage of any attorney's clients' claims could actually be taken to suit and ultimately to judgment. So, if an attorney had one hundred clients, the attorney could probably only file suit and pursue that suit to judgment on 2 to 5 of his clients' claims. This would mean at least 95 of the attorney's 100 clients' claims would be resolved at whatever settlement offer the insurer determined. Also, of the 2 to 5 claims taken to judgment, the insurer could very well succeed in realizing a judgment in its favor.

Therefore, the most financially successful strategy for the insurance industry was to simply low-ball every claim with the sole exception of those claims which might have obvious value in excess of the policy limits. Any claim which had the slightest defense available for the insurer (i.e. **MINOR IMPACT – low property repair estimates**, comparative negligence, contributory negligence, causation issues, excessive treatment billing, excessive treatment duration, frequency or type, questionable injury diagnosis, multiple defendants, etc.) would be evaluated at a low settlement value. After a delay from the time a demand was received from the attorney on behalf of a client, an unreasonably low offer (IFO – Initial First Offer) would usually be extended to resolve the claim. The attorney would either counter this or file a lawsuit. If the attorney countered the offer rather than filing a lawsuit, a second offer (only nominally increased from the

IFO) would be extended by the insurer as a final offer (FO – Final Offer). The insurer would also advise the attorney, that if the settlement offer was not acceptable, the attorney should file a lawsuit. Thereby, inviting litigation to be brought against its insured (considered to be a bad faith act in some states). Again, the insurer is playing the odds that the attorney would not be able to take the lawsuit to judgment.

If 80 percent of the claims presented to the insurer fell into the category of the claim as described in the previous paragraph, and if those same injured parties were willing to pay an attorney 33.3 percent of their settlement dollars to deal with the insurance industry for them, then why couldn't the insurance industry make the allegation that $6,000.00 inclusive of the specials was a fair settlement value of the claim? ($3,000.00 X 3 = $9,000.00; $9,000.00 X 33 1/3% = $3,000.00; $9,000.00—$3,000.00 = $6,000.00)

This analysis would lead to the insurance industry significantly reducing settlement offers to all parties. They determined only 20 percent of the public would actually retain an attorney. They assumed that of that 20 percent, 80 percent would settle for the claim in the insurance industry's range of settlement (Even at the new low figure). They anticipated that the percent of lawsuits would increase, but the cost to defend those was negligible compared to the profits generated by the decrease in claim dollars paid out. The net effect was significant on the bottom line profit realized by the insurance industry from the mid 1990s continuing through the present.

The case reserve[2] in 1990 for a soft tissue injury liability claim was approximately $15,800.00. The case reserve for the same type of injury in 2001 was approximately $5,800.00. This reduction in claim severity was a direct result of the changed process and programs such as "MIST", "Minor Impact" and "No Damage/No Injury". This $10,000.00 savings per claim has a direct impact the profits realized from the claim department. Considering that State Farm Claim Vice President[3] recently stated in deposition State Farm experiences 15,000 claim per day. While only thirty percent of this number would represent the number of automobile claims experiencing the decrease in claim severity, the number is still a staggering 5,000. Multiplying that number by the number of days in a year equals 1,825,000. Realizing a savings of $10,000.00 claim payout per claim, this would represent an annual savings of $1,825,000,000. This dollar amount of savings in claim payouts multiplied by the total number of insurers would be a staggering annual dollar figure not being paid out to the general public in reasonable settlements. It might be an eye opening exercise to have some economist actually extrapolate the direct and indirect economic impact on the public over the last fifteen years.

THE MEDICAL COMMUNITY ENVIRONMENT

The Insurance Industry claim handling culture went through a major transformation during the mid 1990's adopting the opinions and advice of McKinsey Consulting. This was accomplished by each individual insurer in conjunction with McKinsey Consulting (Arthur Anderson or Accenture as it is currently known, also contributed to some insurers' transformation) through the creation and implementation of the McKinsey "Business Process Improvement" (BPI) culture. This transformation of claim culture is evident in the McKinsey documents Allstate has produced in other cases across the country[4]. There no longer exists, if there ever did, a

[2] This is the amount of dollars set aside by the insurer in anticipating the amount to paid on this type claim at settlement. The figure is based on a three year historical severity realized by the insurer.

[3] Fowler vs. State Farm Mutual Automobile Insurance Company, Hawaii; The United States District Court For the District of Hawaii; Civil No. CV07 00071 SPK/KSC;

[4] (*See the listing of cases involving this issue as an endnote to this section)*

proprietary or confidential nature concerning these documents. Similarly, since Allstate has previously produced these same documents in their production as required by the courts in other litigation, it cannot now claim to this court that the requests would be overly burdensome or require unreasonable time to produce.

These Allstate/McKinsey and CCPR documents fully describe the current culture in the insurance industry including Allstate's culture, to target individual treating facilities or practitioners. The targeted facility would generally have a large patient count with a significant presence of minority patients. The target facility or practitioner would have a history of testifying on behalf of their patients' injuries. In most cases the targets have been well respected in the medical community in which they practice. These targeted facilities and practitioners would then find themselves the object of a SIU (Special Investigation Unit) or Fraud Unit intensive investigation during which time all payments to the facility would be put "on hold". The information that this facility or practitioner was identified as a target would be disseminated throughout the insurance industry, resulting in other insurers placing all payments "on hold". During this time of harassment by the insurance industry, naturally, patient numbers would dramatically reduce. Ultimately, an opportunity would be extended to the facility or practitioner to pay back disputed charges paid by the insurer or, in some cases, a suit against that facility or practitioner would be brought by the insurer alleging fraud. In other situations, a "Request for Prosecution" document is created and submitted to the local District Attorney's office for criminal prosecution[5].

This practice by the insurance industry has a direct impact on the entire medical community in the geographic area in which it is executed. The insurance industry experiences an even more extensive secondary benefit by other Chiropractic facilities or practitioners in the geographic region reducing the number of automobile patients accepted, reducing the duration, type or frequency of treatment to automobile patients and/or reducing the amount in which is billed for that treatment. The insurance industry has taken the next step with programs such as State Farm's "Minor Impact", Farmer's "No Damage, No Injury" and Allstate's "MIST (Minor Impact Soft Tissue), in which the insurer is stating that based on the small amount of property damage[6], there can be no injury and therefore, no treatment costs.

This culture is being driven by a very basic pursuit of profits by the insurance industry. Allstate receives tens of thousands claims presented to it each day. The current industry percentage of these claims which would involve "soft tissue" injuries varies between 85 and 90 percent. The most common treating facility or practitioner sought for the treatment of "soft tissue" injuries is Chiropractic. The current industry percentage of Chiropractic involvement in these types of claims is as high as 95%. Most of the injured parties have either PIP/MPC benefits available to pay for the treatment. A very significant number of the injured parties also have either third party claims against an insured negligent tortfeasor or a first party claim under their UM/UIM (Uninsured Motorist/Underinsured Motorist) coverages.

This reasonably reflects an enormous exposure to the insurance industry as first or third party claim severities as well as one of the most significant obstacles to the insurance industry's pursuit of profits. McKinsey introduced the simple concept of creating profits within the claim section of an insurer by simply utilizing those tools available to reduce or deny claim payments. By eliminating the Chiropractic diagnosis of injuries and complaints of injured the parties and reducing or eliminating entirely the medical cost of treatment to those individuals, claim

[5] The People of The State of California vs. Wilmer Origel, Superior Court of California, County of San Joaquin; No SFO94494A;

[6] Allstate's threshold was recently established at $1,500.00 or less in repair estimates to the vehicle.

severities would decrease dramatically. This decrease would be realized in the area of greatest exposure to the insurance industry (soft tissue claims). If an insurer is experiencing 16,000 claims a day, ninety five percent of ninety percent of that number is 13,680 claims.

When Allstate instituted this culture (McKinsey/CCPR/MIST) of attacking Chiropractic treatment and "soft tissue" injuries, it then realized a claim payout savings that is continuing to increase today. Almost all of the claim files which I reviewed in this matter involved property damage repair costs under $1,500.00. The average claim cost of $15,000 per claim experienced in 1990 through 2000 dropped by as much as two-thirds. A claim savings of $10,000.00 per claim multiplied by 13,680 claims represents $13,680,000.00 in claim payout savings (Profit) per year. As of 2000 the insurance industry began to experience a reduction of claim frequency (fewer claims were being reported or accepted) while the claim severity began to increase[7]. The reduction in frequency is in part due to safer vehicles and in part due to the insurance industry culture changes. The increase in severity is the motivator for the insurance industry's more aggressive change in claim culture (*State Farm Insurance Company's "Minor Impact Defense", Farmers Insurance Company's "No Damage No Injury" and Allstate Insurance Company's "MIST" Programs*) and its attack on the Chiropractic community.

ENDNOTE: LISTING OF APPLICABLE CASES

Allstate Ins. Co. v. Fields, 842 N.E.2d 804 (Ind. 2006)., Allstate Ins. Co. v. Fields, 831 N.E.2d 750 (Ind. 2005), Dale Deer vs. Allstate Insurance Company and Paul Jason Aldridge, In the Circuit Court of Jackson County, Missouri, at Independence, Case No. 0516-CV24031, *Hensel, Individually and as Class Representative vs. Allstate Insurance Company, Allstate Indemnity Company, Gary Davis and Tina Watts; Alaska; In the Superior Court for The State of Alaska, Third Judicial District; Case No. 3AN-02-7154 CI;; Martinez vs. Davis, New Mexico; The State of New Mexico, County of Bernalillo Second Judicial District Court; Case No. CV 99-07598; McCallum vs. Allstate Property and Casualty Insurance Company, Washington; In the Court of Appeals of The State of Washington, Division II; (Pierce Co. Superior Court No. 06-2-09493-5); Allstate vs. Scroghan, In The Court of Appeals of Indiana; No. 03A04-0410-CV-554, Camus vs. State Farm Mutual Automobile Insurance; Colorado; El Paso County, CO, District Court 4th JD; Case Number: 05CV404; Armisted, et al v. State Farm Mutual Automobile Insurance Company, Michigan; United States District Court, Eastern District of Michigan, Southern Division; Civil Action No. 07-10259; Simonsen vs. Allstate, Montana; The United States District Court for the District of Montana, Butte Division; CV-01-64-BU-DWM; Hutt vs. State Farm Mutual Automobile Insurance Company, Pennsylvania; Court of Common Pleas, Philadelphia County; NO. 000176; Berry vs. Allstate Insurance Company, Michigan; United States District Court, Eastern District of Michigan, Southern Division; Case No. 2:07-CV-14627; Burger vs. Allstate Insurance Company, Michigan; State of Michigan in the Circuit Court for the County of Wayne; Doan vs. Allstate Insurance Company, Michigan; United States district Court, Eastern District of Michigan, Southern Division; Case No. 5:07-cv-13957; Van Emon vs. State Farm Mutual Automobile Company, Michigan, Unites States District Court For the Eastern District of Michigan, Southern Division; Case No.: 05-CV-72638; State Farm Mutual Automobile Insurance Company and State Farm Fire and Casualty Company vs. Robert J. Cavoto, Jr., Fishbone Advertising, Inc. Cavoto Chiropractors, P.C., Margaret Fisher-Catrabone, Penn Center pain management, Inc., Tiprof, Inc. and International Health Alliance, Inc., Court of Common Pleas Delaware County, No. 05-10716; Lynch vs. State Farm Mutual Automobile Insurance Company, Nebraska; The District Court of Douglas County, Nebraska; Case No. DOC. 980 NO. 654; Hill vs. State Farm Mutual Automobile Insurance Company, Oklahoma; The United States District Court for The Western District of Oklahoma; Case No. CIV-00-1877-T; Sitton vs. State Farm, Washington; Superior Court of Washington for King County; Case No. 00-2-10013; Plateros vs. State Farm Mutual Automobile Insurance Company, Nevada; The Second Judicial District Court of the State of Nevada in and for The County of Washoe; Case No. CV98-07605; Quynh Truong, et al. vs. Allstate Insurance Company, et al., New Mexico; Watkins vs. State Farm Fire & Casualty Company, Oklahoma; In The District Court of Grady County, State of Oklahoma; Case No. CJ-2000-303; Hernandez v. Allstate Insurance Company, Washington; King County, Washington; Cause No. 05-2-005891-9 SEA; Hagar v. Allstate Insurance Company, Kentucky; Commonwealth of Kentucky, Fayette Circuit Court, Eighth Division; Civil Action No. 98-CI-2482; Ebbert vs. Liberty mutual Insurance, In The Circuit Court of Ohio County, West Virginia; Civil Action No.*

[7] ***"Trends in Auto Injury Claims, 2008 edition, "IRC (Insurance Research Council) reports falling claim frequency and rising claim severity."***

There were other opportunities for the insurance industry such as the following aspects discussed. However, nothing could compare to the enormity of the dollars contributed to the insurers' bottom line increase in profits previously discussed.

PROFIT IN A CLAIMS DEPARTMENT

1. SEARCH FOR PROFIT

Every company in every industry has as its primary goal to be profitable. The alternative would be to realize failure and ultimately dissolution. Even the self-proclaimed "Mutual" companies in the insurance industry recognize the importance of profitability. Their continued participation in the insurance market is dependent upon the pricing of their policies as compared to the other players in the market. However, the insurance company's pursuit of profits should

not overshadow the contractual responsibility it has to its insureds. When it does, the claims handling becomes tainted.

The options available for the insurance company to maximize its opportunities for profit are limited. As in other industries, the insurance company must either reduce their costs or increase their income. The following are some of the areas which all insurance companies consider in this pursuit.

a) OVERHEAD

Overhead for an insurance company consists of more than just the buildings, which house its operations. Although, this factor can be significant in the long run, it doesn't provide immediate availability of funds. Each company at one time in its history has attempted to reduce the number of real estate holdings it has dependent on the market prices of course as well as available opportunities for alternative investments or uses for the funds made liquid. However, in order to reduce this aspect of its overhead, it must be able to either reduce the number of its employees or have a realistic opportunity to consolidate the different functions of the company. It can effect the reduction or consolidation in any of its departments including claims. When the change is directed at the claims department, it will have a direct influence on the individual claim representatives' handling of claims.

b) CLAIMS

The cost of paying claims has always been a major area for the insurance industry in its pursuit of profit. Reducing the amount paid in a legitimate manner is reasonable on the surface. However, the temptation to focus on this area can be in direct conflict with the contractual agreement the insurer has with its insureds. It doesn't necessarily follow that it will occur. However, an overzealous manager or claim handler could be motivated by sources discussed later which would result in the insurer's interests having more significance than that of the insureds'. The insurance industry in the past has recognized the opportunity to utilize its training capabilities, new processes or procedures to have a direct impact in reducing the amount, which is paid out in claims.

c) INCREASE IN POLICY COUNT

In order for any insurer to continue to be successful in the industry, it must recognize the importance of growing its market share. Absent the growth of policies, the rising cost of insurance must be passed to the remaining policyholders. Of course, this has the adverse affect of increasing the premiums, which the insureds pay for the same benefits originally contracted for with the insurer. A substantial or constant increase in premiums will naturally force the policyholders to move to other insurers with lower premiums. Every insurer must balance its goal of reduction of claim cost with the exposure to losing policyholders. There is a marginal point which an insurer can exercise cost control measures in the handling of claims without losing more than a marginal amount number of policyholders. Similarly, the insurer through its agents and different media forums, risks the expenditure of advertising against the increase or retention of policyholders. It is expected the advertising would be factually correct and without misleading impressions of the contractual promises being made by the insurer. However, when the promises being marketed exceed the actual ones being kept in the day-to-day claim handling process, this is far from honest marketing.

d) INCREASE IN PREMIUMS

Another vehicle for increasing profits is to increase the premiums, which the insurer charges its insureds. Understandably, if the insurer can keep its costs from increasing or at least decrease the rise in increase and at the same time receive a higher premium from each of its insureds, it could recognize a significant increase in its profits. Premiums, in their simplest form, are a reflection of the history of companies' cost in paying and handling claims. If the insurer can reduce the cost of paying or handling claims, the premiums could be decreased or return a dividend. This would have a measurable impact on the market share of the insurer as well as the capability of retaining existing policyholders. Nothing sells better than selling for less.

e) INVESTMENTS

Most insurance companies are heavily dependent on the investments they have made. As funds become available they are invested incrementally throughout each day of the week. Naturally, this constant opportunity can only be realized if the company maximizes available funds. The reserve funds set aside in anticipation of claim payments become a tempting source of funds for the investments. Freeing up the funds frozen in the reserve account is the quickest and easiest way for an insurance company to have access for investments. This translates as a need for the company to close claims as soon as possible. There are many ways for the claims handlers to close claims. This also encourages the claims department to pay as little as possible for each claim.

Most insurance companies have some form of profit sharing program available for the personnel to participate in. These programs allow for the individual employee to participate in the profits generated by the company. The claim handlers have a direct incentive to reduce costs and close claims. When the company realizes a profit as a result of their claim handling procedures or their investment portfolio, there is less pressure on the claim department to reduce cost and close claims quicker. In contrast, when the market doesn't favor the investments made by the insurance company, even greater pressure is realized by the claims department to reduce the cost of claims and lower their pendings.

2. REDUCTION OF OVERHEAD

The insurance industry isn't different than any other industry. The pursuit of maximizing profits also includes the reduction of overhead. There are several aspects of the operation, which the insurance company can target for possible savings. These options have incrementally direct affect on each claim in some manner. Each of the insurers has the option of liquidating its physical holdings. However, in order to do that, it must analyze and make decisions regarding the following aspects of its business.

a) STAFFING

One of the largest areas of overhead for an insurance company is its personnel. The staffing includes underwriters, agents, support staff, estimators, claim handlers and management. Most insurance companies are reluctant to reduce their sales staff or the supporting personnel for them. These are the revenue generating members of the staff. The claims personnel don't generate revenue, though. In fact, most companies believe that with better procedures or processes, the claims staff can be reduced. Initiating new practices or programs designed or intended to streamline the claim handling process is anticipated to result in more claims being handled by fewer people. This can also develop an opportunity to release the higher salaried employees and either replace them or not. Either way, the company reduces its payroll.

b) PENDINGS

Prior to any consideration of a reduction of the personnel, an insurance company must acknowledge the size of its pending claims. The size of the individual claim inventories of the claim handlers has a direct relationship to the quality of service. Should the company reduce its personnel without initiating any process for the handling of the pending inventories, it would be reflected in the individual handling of each claim or lack thereof. Some companies have affected processes to handle claims in a more automated process. These processes do not allow for the same personal involvement of a decade ago.

These programs have received considerable criticism lately. Nevertheless, fewer decisions are required to be made by the claims staff. Fewer decision responsibilities means more claims can be handled by fewer claim personnel. Managing average pending claims is necessary in the pursuit of profits. The management of pendings can translate into pressure on the claims staff to close claims prematurely. Excessive focus by the company could stimulate the use of procedures or practices in a less than reasonable fashion. When a claim handler has goals on their individual performance reviews, this will encourage the handler to follow any company procedure or practice to be successful.

c) CONSOLIDATION

The next logical step for the insurance industry after manipulating its personnel and number of claims each can handle is to consolidate. It seems the industry vacillates over time between centralizing and decentralizing. I suspect this is a natural phenomenon of the balance between claim cost and policy count. When profit margins drop consolidation looks promising. When policy count drops and customer satisfaction dips below acceptable levels, decentralization looks promising. In order to consolidate the insurance industry relinquishes its ability to react to regional dynamics. Rather than handling each claim individually, it must accept the fact a great number of claims will be painted with the same brush. Using computerized programs for evaluation and medical management become the standards.

These practices establish an opportunity for the company to centralize the handling of large numbers of claims as groups. It might be argued that ultimately the cost savings of these practices could be reflected in lower premiums. The concept of lower premiums is great as long as it isn't your claim, which is receiving the cost saving practice applied to it. The opportunity to realize a dollar or two in premium dividends doesn't help pay for the hundreds or thousands of dollars in unpaid medical billings.

d) USE OF PROCESSES AND PROCEDURES

Claim inventories or pendings for claim handlers has risen over the years. Currently, the average pendings of a claim handler can only be managed through the use of processes and procedures designed by the home offices. The individual claim handler knows that if a claim doesn't go well, he won't be held accountable as long as the company's processes and procedures were followed. This practice becomes a crutch for the claim handler. It's easier to follow a company procedure than to practice pro-active handling. No decision is required of the claim handler if the processes are followed. The immediate manager will support the handler as long as the processes are followed. When the volume of claims in a claim handler's inventory reaches a level, the practices, which would allow for a denial or closure of a claim, are the only options available.

Medical cost management tools have become common in the industry both in first and third party claims. Computerized evaluation is another tool the insurance industry has accepted. Both these tools don't require decisions to be made by the claim handler. They are promoted by the insurance companies to their employees as the solution to the problems manifested by higher inventories and less experience. They protect the employee from any management criticism should the claim not go well. The insurance companies utilizing these tools see them as a viable and reasonable avenue in their quest for cutting costs. Insureds who find themselves involved as an object of one of these procedures have a difficult time accepting the justification of it.

Insureds have often paid premiums for many years. They didn't buy the policy many years earlier in order to be involved in an accident in which they would get injured and have an opportunity to be treated beyond the parameters of the insurance company's definition of reasonable or necessary. It's extremely sad when the insurance company chooses to punish its insureds for the treatment it has determined excessive according to their definition of the policy language.

3. AVOID LITIGATION

The cost of litigation can become an important factor in the process of cost reduction. There is a marginal point where the practices and procedures put into place result in an increase in law suits being filed either by third party claimants or first party insureds. An intelligent company will monitor this increase and weigh the cost against the benefits it is realizing by its practices. Some companies refuse to recognize that the increase in litigation cost may be a direct result of practices and/or procedures. Rather, they might feel the rise in cost is due to mismanaged attorney fees. Those companies have put into place a means or practice of having the legal fees reviewed by an outside source. Some of the other issues, which could affect the handling of claims after suit is filed, are listed below. Each of these factors can have a direct affect on the handling of an individual claim. However, this basic expense savings concept has been redefined and abandoned by the adoption of the "DOLF" program. This is explained in the section entitled "Legal Environment Today".

a) GROUP CLAIMS BY INJURY

There is a practice of grouping the claims with similar injuries. For example, all claims involving soft tissue injuries may be considered the same when referred to defense counsel. This could result in the handling of the claim taken out of the hands of the claim handler. The defense counsel now controls the handling. If the defense counsel is defending these on a cost and hourly basis, there may not be any motivation for the value to be re-analyzed. This also sets up an opportunity for the claim handler who at some point finds his inventory approaching unmanageable volume to stand on a single offer of settlement. This then forces the claim into litigation and off the adjuster's desk.

b) GROUP CLAIMS BY DOLLAR VALUE

Similarly, claims with approximately the same value range could realize the same treatment as above. Again, the result could be to reduce the number of claims in need of active handling by the claim handler. Recently, the trend has been to refer claims with a value under $25,000.00 and suit has been filed to those defense counsels offering a flat rate. This doesn't

motivate the defense counsel to discuss a change in value based on any material discovery with the claim handler.

This grouping could result in some claims with other than ordinary circumstances to be lost in the process. The result is abandonment of the claim handling process throughout the duration of the litigation process until either arbitration or trial. One major flaw in this practice for the insurance industry is an award in mandatory arbitration could set up a situation for the limits of the policy to be exceeded by attorney fees and costs should the award by appealed by the insurance company.

4. MOTIVATION

Claim handlers are no different than employees of other firms in other industries. They perform to the best of their ability in hopes of increasing their yearly income, possible opportunities for promotion and securing their future employment. Management in the insurance industry tracks their performance in several different areas. Two of the most objective means of tracking the claim handler's performance are average paid claims and average pending claims. From these statistical results the managers can determine which employees are handling the assigned claims appropriately and in accordance with the company's goals. Based on the employee's performance in these areas as well as others, the claim manager will rate the performance for merit increases or promotional opportunities.

a) MERIT REVIEWS

Merit reviews are traditionally completed on a quarterly basis. These reviews include many items including the claim handler's goals for the year in both average paid claims and average pendings. Some companies have removed the statistical references so as to avoid discovery should litigation occur. However, there are still the inferences to these statistical goals written into the review. In all instances I am familiar with, the statistical goals when not actually written into the review are discussed verbally between the manager and the claim handler. The manager has statistical goals, which are set in accordance with the section, region, state, or national goals of the company. The claim handler is expected to use those tools available through the processes and procedures developed by the company in achieving their goals.

When the claim handler is on track with achieving the goals, the merit increase will be significantly greater than if the goals were not being met. In fact, if the goals are not being met, the claim handler can find himself in a precarious position until the situation improves. Should the claim handler exceed the goal of the company, he would receive an even greater merit rating or increase yearly salary. In order to achieve the goals as established by home office, the claim handler must pay special attention to the values paid in the handling of claims. Through this incentive program the company guarantees the procedures and practices it has developed are being followed in the line units.

b) PROMOTIONAL OPPORTUNITIES

Similar to the merit increases, the promotional opportunities are determined in part by the claim handler's success in achieving or exceeding the goals of the company. Some companies even have as their requisite for promotional opportunities that all candidates for promotion must have exceeded the goals. Throughout the career of the claim handler any opportunities offered will in part be based on the performance of the claim handler in following company procedures and the individual success in meeting or exceeding the goals. This isn't a

new concept nor is it isolated to the insurance industry. It makes sense, that the company would promote into management those individuals who will follow procedures and exceed the goals. Why would a company promote an employee who wouldn't follow procedures and ignore the goals of the company? That simply wouldn't make any sense at all.

As a result the individual claims handled by each of the claim handlers finds itself under this influence. The temptation to reduce claim payments in order to meet company goals can become overwhelming for the aspiring young claim handler. The tools provided by the company to assist the claim handler in achieving this success become the claim handler's best friend. The tools not only protect the claim handler, they provide an opportunity to realize exceeding success.

c) RECOGNITION

A claim handler's success does not stand-alone. This is traditionally recognized by the company in their internal publications or meetings. This exposure for the individual claim handler is an essential part in the path to success for him. It isn't necessary that the claim handler achieve this internal notoriety. However, it does expedite the opportunity for promotion. Visibility is important in a large company for the individual claim handler. If he is continually exceeding the goals of the company, he could find exposure, which would place him on a fast track for advancement.

This motivation is constant in the young claim handler's career. It does have a direct affect on each of the claims being handled by claim handler. Naturally, the claim handler would not want to receive complaints. This would be the wrong kind of exposure in his pursuit of a management position. However, if he is following the company procedures and processes, his claim average is dropping and his pending claim inventory is reducing, he could very well find the complaints are overlooked. This of course could have an adverse affect on the claims being handled by this individual. Nevertheless, the company has accepted the risk of losing some policyholders or possible litigation in the pursuit of their goals.

d) NO OWNERSHIP OF HANDLING

As a result of the procedures and processes developed by the company and the merit system, the individual claim handler is not taking ownership for the outcome of a particular claim. The claim is being handled as a group of claims by the claim handler. He is following the procedures provided by home office and he has been trained in. If the claim ends up in litigation as a result of denial of benefits or reduction of benefits owed, it isn't as a result of his handling. This is considered an acceptable risk and a part of doing business as an insurance company. The medical cost management procedures were followed by the claim handler. Therefore, he is protected from making decisions that could adversely affect his career. Or, the value was determined by the process available. The claim handler followed each of the approved steps in arriving at the authority level, which was offered. It isn't the fault of the claim handler if a number of his pending claims end up in litigation. It's a sign of the times.

5. SUMMARY

The individual claim is being affected by the insurance company's pursuit of profit. No one will argue that a company should pursue profit. The alternative would be ridiculous. However, pursuing profits should encompass first and foremost, the interests of the insureds being placed before those of the insurer. No insurer has the right to pursue its own interests at the cost of the

individual insured. Handling claims individually based on the dynamics of the individual claim will always be considered the only way to handle claims. When an insurance company consolidates its personnel and claims, the temptation to move away from the practice of handling one claim at a time can become too great. Sacrificing the individual attention a policyholder deserves for the sake of saving costs will ultimately have an adverse affect on all claims.

Some companies become so focused on saving every dollar of cost possible they overlook the opportunity to pay every dollar. The approach has changed from finding a way to pay a claim to one of finding a way to deny the claim. The procedures and practices developed by the company are focused on discovering those claims, which should be reduced or denied. When these procedures and practices are then a part of the merit review for the individual claim handler, they become the driving force in each claim. The individual accountability for the handling of the claim disappears.

Each claim is subject to the influences as addressed. At different times of the year the influences are more apparent. As a recording period ends or a performance rating nears, the affect of the system as established could manifest itself as less than good faith handling. Rather, it becomes more similar to tainted handling.

BACKGROUND HISTORY

The Insurance Industry claim handling culture went through a major transformation during the mid 1990's adopting the opinions and advice of McKinsey Consulting. This was accomplished by each individual insurer in conjunction with McKinsey Consulting (Arthur Anderson or Accenture as it is currently known, also contributed to some insurers' transformation) through the creation and implementation of the McKinsey "Business Process Improvement" (BPI) culture. This transformation of claim culture is evident in the McKinsey documents Allstate has produced in other cases across the country[8]. There no longer exists, if there ever did, a proprietary or confidential nature concerning these documents. Similarly, since Allstate has previously produced these same documents in their production as required by the courts in other litigation, it cannot now claim to this court that the requests would be overly burdensome or require unreasonable time to produce.

These Allstate/McKinsey and CCPR documents fully describe the current culture in the insurance industry including Allstate's culture, to target individual treating facilities or practitioners. The targeted facility would generally have a large patient count with a significant presence of minority patients. The target facility or practitioner would have a history of testifying on behalf of their patients' injuries. In most cases the targets have been well respected in the medical community in which they practice. These targeted facilities and practitioners would then find themselves the object of a SIU (Special Investigation Unit) or Fraud Unit intensive investigation during which time all payments to the facility would be put "on hold". The information that this facility or practitioner was identified as a target would be disseminated throughout the insurance industry, resulting in other insurers placing all payments "on hold". During this time of harassment by the insurance industry, naturally, patient numbers would dramatically reduce. Ultimately, an opportunity would be extended to the facility or practitioner to pay back disputed charges paid by the insurer or, in some cases, a suit against that facility or practitioner would be brought by the insurer alleging fraud. In other situations, a "Request for

[8] (***See the listing of cases involving this issue as an endnote to this section)***

Prosecution" document is created and submitted to the local District Attorney's office for criminal prosecution[9].

This practice by the insurance industry has a direct impact on the entire medical community in the geographic area in which it is executed. The insurance industry experiences an even more extensive secondary benefit by other Chiropractic facilities or practitioners in the geographic region reducing the number of automobile patients accepted, reducing the duration, type or frequency of treatment to automobile patients and/or reducing the amount in which is billed for that treatment. The insurance industry has taken the next step with programs such as State Farm's "Minor Impact", Farmer's "No Damage, No Injury" and Allstate's "MIST (Minor Impact Soft Tissue), in which the insurer is stating that based on the small amount of property damage[10], there can be no injury and therefore, no treatment costs.

This culture is being driven by a very basic pursuit of profits by the insurance industry. Allstate receives tens of thousands claims presented to it each day. The current industry percentage of these claims which would involve "soft tissue" injuries varies between 85 and 90 percent. The most common treating facility or practitioner sought for the treatment of "soft tissue" injuries is Chiropractic. The current industry percentage of Chiropractic involvement in these types of claims is as high as 95%. Most of the injured parties have either PIP/MPC benefits available to pay for the treatment. A very significant number of the injured parties also have either third party claims against an insured negligent tortfeasor or a first party claim under their UM/UIM (Uninsured Motorist/Underinsured Motorist) coverages.

This reasonably reflects an enormous exposure to the insurance industry as first or third party claim severities as well as one of the most significant obstacles to the insurance industry's pursuit of profits. McKinsey introduced the simple concept of creating profits within the claim section of an insurer by simply utilizing those tools available to reduce or deny claim payments. By eliminating the Chiropractic diagnosis of injuries and complaints of injured the parties and reducing or eliminating entirely the medical cost of treatment to those individuals, claim severities would decrease dramatically. This decrease would be realized in the area of greatest exposure to the insurance industry (soft tissue claims). If an insurer is experiencing 16,000 claims a day, ninety five percent of ninety percent of that number is 13,680 claims.

When Allstate instituted this culture (McKinsey/CCPR/MIST) of attacking Chiropractic treatment and "soft tissue" injuries, it then realized a claim payout savings that is continuing to increase today. Almost all of the claim files which I reviewed in this matter involved property damage repair costs under $1,500.00. The average claim cost of $15,000 per claim experienced in 1990 through 2000 dropped by as much as two-thirds. A claim savings of $10,000.00 per claim multiplied by 13,680 claims represents $13,680,000.00 in claim payout savings (Profit) per year. As of 2000 the insurance industry began to experience a reduction of claim frequency (fewer claims were being reported or accepted) while the claim severity began to increase[11]. The reduction in frequency is in part due to safer vehicles and in part due to the insurance industry culture changes. The increase in severity is the motivator for the insurance industry's more aggressive change in claim culture (*State Farm Insurance Company's "Minor Impact Defense", Farmers Insurance Company's "No Damage No Injury" and Allstate Insurance Company's "MIST" Programs*) and its attack on the Chiropractic community.

---

[9] The People of The State of California vs. Wilmer Origel, Superior Court of California, County of San Joaquin; No SFO94494A;

[10] Allstate's threshold was recently established at $1,500.00 or less in repair estimates to the vehicle.

[11] "*Trends in Auto Injury Claims, 2008 edition, "IRC (Insurance Research Council) reports falling claim frequency and rising claim severity."*

ENDNOTE:
LISTING OF CASES WHERE PRODUCTION OF DOCUMENTS ORDERED

Allstate Ins. Co. v. Fields, 842 N.E.2d 804 (Ind. 2006)., Allstate Ins. Co. v. Fields, 831 N.E.2d 750 (Ind. 2005), Dale Deer vs. Allstate Insurance Company and Paul Jason Aldridge, In the Circuit Court of Jackson County, Missouri, at Independence, Case No. 0516-CV24031, *Hensel, Individually and as Class Representative vs. Allstate Insurance Company, Allstate Indemnity Company, Gary Davis and Tina Watts; Alaska; In the Superior Court for The State of Alaska, Third Judicial District; Case No. 3AN-02-7154 CI;; Martinez vs. Davis, New Mexico; The State of New Mexico, County of Bernalillo Second Judicial District Court; Case No. CV 99-07598; McCallum vs. Allstate Property and Casualty Insurance Company, Washington; In the Court of Appeals of The State of Washington, Division II; (Pierce Co. Superior Court No. 06-2-09493-5); Allstate vs. Scroghan, In The Court of Appeals of Indiana; No. 03A04-0410-CV-554, Camus vs. State Farm Mutual Automobile Insurance; Colorado; El Paso County, CO, District Court 4th JD; Case Number: 05CV404; Armisted, et al v. State Farm Mutual Automobile Insurance Company, Michigan; United States District Court, Eastern District of Michigan, Southern Division; Civil Action No. 07-10259; Simonsen vs. Allstate, Montana; The United States District Court for the District of Montana, Butte Division; CV-01-64-BU-DWM; Hutt vs. State Farm Mutual Automobile Insurance Company, Pennsylvania; Court of Common Pleas, Philadelphia County; NO. 000176; Berry vs. Allstate Insurance Company, Michigan; United States District Court, Eastern District of Michigan, Southern Division; Case No. 2:07-CV-14627; Burger vs. Allstate Insurance Company, Michigan; State of Michigan in the Circuit Court for the County of Wayne; Doan vs. Allstate Insurance Company, Michigan; United States district Court, Eastern District of Michigan, Southern Division; Case No. 5:07-cv-13957; Van Emon vs. State Farm Mutual Automobile Company, Michigan, Unites States District Court For the Eastern District of Michigan, Southern Division; Case No.: 05-CV-72638; State Farm Mutual Automobile Insurance Company and State Farm Fire and Casualty Company vs. Robert J. Cavoto, Jr., Fishbone Advertising, Inc. Cavoto Chiropractors, P.C., Margaret Fisher-Catrabone, Penn Center pain management, Inc., Tiprof, Inc. and International Health Alliance, Inc., Court of Common Pleas Delaware County, No. 05-10716; Lynch vs. State Farm Mutual Automobile Insurance Company, Nebraska; The District Court of Douglas County, Nebraska; Case No. DOC. 980 NO. 654; Hill vs. State Farm Mutual Automobile Insurance Company, Oklahoma; The United States District Court for The Western District of Oklahoma; Case No. CIV-00-1877-T; Sitton vs. State Farm, Washington; Superior Court of Washington for King County; Case No. 00-2-10013; Plateros vs. State Farm Mutual Automobile Insurance Company, Nevada; The Second Judicial District Court of the State of Nevada in and for The County of Washoe; Case No. CV98-07605; Quynh Truong, et al. vs. Allstate Insurance Company, et al., New Mexico; Watkins vs. State Farm Fire & Casualty Company, Oklahoma; In The District Court of Grady County, State of Oklahoma; Case No. CJ-2000-303; Hernandez v. Allstate Insurance Company, Washington; King County, Washington; Cause No. 05-2-005891-9 SEA; Hagar v. Allstate Insurance Company, Kentucky; Commonwealth of Kentucky, Fayette Circuit Court, Eighth Division; Civil Action No. 98-CI-2482; Ebbert vs. Liberty mutual Insurance, In The Circuit Court of Ohio County, West Virginia; Civil Action No. 03-C-505; Hawkins v. Allstate Insurance Company, Supreme Court of Arizona, No.CV-86-0010-PR,* As amended March 4, 1987.

BUILDING THE CLAIM

The insurance industry spent little time training its claims adjusters (one to two days formal training). Colossus has over 10,720 value drivers, by the way. The insurance industry intentionally kept the claim personnel ignorant to all the specific manipulations of the Colossus program. The insurance industry was aware that their claims personnel would accept Colossus as a fair program for evaluating claims if they were less experienced and overworked. The average insurance adjuster has 200 injury claim files. This could represent as many as 300 injured parties, which require their claims be investigated and evaluated. The senior adjusters were encouraged to retire or find employment elsewhere.

The claims adjusters are required to complete a "dissection sheet" when reviewing the medical records. This same "dissection sheet" is then used to make all the entries into the Colossus program in evaluating a specific claim. The "dissection sheet" is intentionally vague and has very limited "value drivers" listed on it. There is one for "Neck and Back" soft tissue (Referred to as "Whiplash" injuries) and one for demonstrable injuries. The need for two forms was brought about because Colossus enters the information differently for soft tissue Neck and Back than it does for all other soft tissue injuries and demonstrable injuries.

The resulting affect of these changes in the insurance industry were claim payouts were reduced, claim costs reduced, profits increased, senior personnel replaced with novice claims employees and claim inventories were increased for each insurance adjuster. The insurance industry was extremely pleased. The layperson was being forced to accept lower settlements. But, as anticipated by the insurance industry, only 20% to 30% of the public injured claimants were retaining representation by a lawyer. Of the number of claims where lawyers were involved, 80% of those claims were resolved for the Colossus settlement figures. That meant that only 20% of the 20 to 30% claims where an attorney was involved ended up in trial. The program was a huge success for the insurance industry. As the economic trend in the late 90's allowed for huge profits to be realized on investments, the insurers were taking the new found profits and investing heavily. However, as the economic environment changed and the returns on investments dwindled in the recent past, the insurance industry has had to recover lost returns on investments. This has led to the insurance industry calibrating the value ranges of Colossus arbitrarily lower. Farmers has recently reduced all values straight across the entire injury claim spectrum by 20%.

The legal community did not understand the new program and still don't. They don't understand how to communicate with the adjuster because they don't understand how to communicate with Colossus. The insurance industry is taking advantage of this absence of communication to realize ongoing low claim payouts. The terminology is alien to the medical community as well as the legal community. Therefore the medical records are missing the documented value drivers necessary to participate in the Colossus value ranges. The legal community creates and delivers thirty, forty, fifty (and many) more page demand letters in their attempt to persuade larger settlements. However, these still don't respond to the Colossus computer program. It's as if the medical community is speaking one language; the legal community another; and the insurance industry still yet another. With the absence of communication the public community is truly the victim.

IMPLEMENTATION AND APPLICATION OF SOFTWARE

Colossus, Injury IQ, Decision Point and other evaluation software are computer systems for assessing general damages for bodily injury claims. While all adjusters have their own personal authority levels, they are required by specific guidelines to not deviate from the values arrived at through the use of these softwares. The settlement results of each adjuster, unit and region are tracked and deviations from the softwares' evaluations result in monetary and promotional opportunities lost for the individual adjuster. For the rest of this discussion, the use of Colossus will be in a generic sense so as to include all evaluation software and the State Farm manual evaluation program TEACH.

The evaluation of a claim begins with the receipt of documents, records and billings for medical treatment and wage loss. The information is separated and tabbed according to procedures by a processor. The packet of information is then turned over to another processor for input of medical billings into the MBRS (Medical Billing Review System), ADP, AIM or other similar automated billing review system. The billings must contain the date of service, amount of each modality, the ICD9 coding and the CPT code for each modality. The billing must contain the correct identity of the patient as well as the medical vendor. If the medical vendor is not one which is currently "on hold" due to an ongoing investigation by SIU (Special Investigation Unit

or Fraud Unit), the billings are reviewed for "reasonable and necessary" allowance. Once, this is completed, the packet is then given to the adjuster for input into Colossus.

The adjuster must now compare each billing to each record to confirm all records and billings are received prior to continuing with the Colossus. Once all the information is confirmed to be present, the adjuster reviews the records and determines the appropriate data to input into the Colossus evaluation. Significant responses may increase or decrease the value ultimately arrived at by Colossus.

Each of the entries by the adjuster is reviewed for its accuracy by the manager. This includes the amount of medical billing being accepted by the adjuster. The medical billing must have been entered into the medical review software program. After receiving the packet of records and billings back from the processor, the adjuster will electronically review the billings input. Each individual entry must be reviewed in this step prior to input into Colossus. The adjuster makes a decision to accept or deny those entries which the system has questions about. The entire billing must be verified at this step prior to the billing being accepted and processed for the next step. The adjuster must verify the reason for accepting any rejected billings by the system in a separate entry in the electronic claim file. Absent this explanation, the manager will not accept the Colossus for review and return it. . The adjuster must then make the corrections and corresponding entries in the claim file before returning the Colossus to the manager for a "revision".

Once the billings have passed this hurdle, they appear in the next review section of medical review program. Here, the adjuster once again reviews and determines the billings which will be accepted. This step allows the adjuster to independently opine which treatment dates or modalities may be reasonable or excessive. The adjuster will allow those treatments deemed reasonable and deny the others. This could result in denial of treatment dates during an accepted period of the treatment plan, denial of specific modalities found on any particular date, or the denial of treatment after a certain date. The adjuster may determine that after some date specific, the treatment was excessive. The manager may also make this determination (especially where a "mist" or minor impact claim is involved) and reduce the medical billings allowed. The adjuster may have reason to only accept some medical billings due to some pro-ration issue (another accident is involved) and thereby reduce the amount of the billings accepted. The manager may also make this determination and reduce the total amount of accepted billings. If it is determined the adjuster is "overriding" the "medical review program too often and accepting treatment or billings, this could be a performance issue for the adjuster.

Colossus requires the adjuster to identify specific factors which are documented in the medical records. It does this through a series of questions requesting either a "Yes or No" response or selection from a multiple choice listing. Most of the responses are entered by an "x" in the provided box. Colossus will then determine a range of value for the claim. The adjuster prints this result and attaches it to the claim file. The evaluation by Colossus and the file are then reviewed by the manager.

Knowing and understanding the process, programs and procedures which determine medical treatment and billings that are to be accepted is essential in today's dealings with the insurance industry. Absence of this knowledge will only produce frustration, anger, confusion and most importantly lack of payment or reimbursement for reasonable and necessary treatment.

FEEDING COLOSSUS

UNDERSTANDING THE EQUATION

Colossus is an equation without any human intuitive abilities. The process depends on the input of the claim handler alone. All information not included in the equation has no value. The equation is made of variables which are weighted depending on the injuries identified, treatment, duration of complaints, disability and impairment. The weighted values are determined by Insurance Industry during the process of tuning and calibration with the assistance of Accenture.

The claim representative is allowed to input those injuries, history of complaints and treatment regimen, which are documented in the treating records. The cost of the treatment is not a part of the equation other than as a one-time additive to the final authority. The Colossus equation is designed to establish general damages on top of the economic damages. Therefore, it is imperative each injury is input separately. For example, if the neck and back are indicated as being injured, the claim representative is allowed to enter cs neck and cs back. "Cs" refers to a contusion. If the claimant also complained of right shoulder injury in the emergency room, but the treating records subsequent to the emergency room did not support the shoulder injury, the claim representative is barred from inputting that additional injury. The result would be significant to the final value of the claim. In fact, the treatment provided to the neck and back could receive a decreasing weighted value the longer it continued. If the shoulder had been included as an injury in the treatment records, it would have created an opportunity for additional treatment to be allotted to it. This also would have increased the weight assigned to the extended care provided. The entire treatment period most likely would have been allowed at its full weighted value. Also, there would have been other subsequent areas in the equation, which would have increased the value due to the additional injury.

The Colossus equation is structured to react to each variable entered by the claim representative. Each variable entered by the claim representative sets in motion the opportunity for additional variables which the claim representative can respond to. The series of questions created by the additional variables from just one additional body part diagnosed as being injured adds to the overall value. The equation cannot be manipulated by the claim representative without the support of medical documentation. In the example above, the resulting value increase is significant and most likely is the difference between a low value range and a fair one.

Correct identification of all significant variables and their weighted milestones will directly affect the value of a claim. Medical and economic specials are added to the equation but do not become a weighted variable. These items do not affect the other variables within the equation. However, if the duration of medical treatment is not accepted, it will directly affect many variables in the equation as well as the weighted value of variables.

PROPER AND COMPLETE DIAGNOSIS

The initial records should reflect all complaints of the patient. A thorough examination should indicate all injuries as such. Recognizing an injury to one body part and commenting on the pain radiating into another, does not allow the claim representative to input the injury to the body part where the pain is radiating into. However, if the other body part is in fact injured, it should be documented as such. Taking a look again at the example above, if the neck and back are recognized as two separate injuries, each will receive its own weighted value. If the neck is diagnosed as an injury, but the back is mentioned only as a radiating symptom of the neck pain, the back will not be entered as a separate injury. Similarly, if the shoulder is only mentioned as having radiating pain without being diagnosed as a separate injury, it also, will not receive a

weighted value. This situation also disallows for any input, which would have been assigned to the separate injuries.

Colossus is structured to recognize only the diagnosed injuries found in the records of the patient or claimant. Absent a correct diagnosis for each injured body part the evaluation will be incomplete and of less value. Although, the equation does place some value on radiating symptoms, it is of far less value than what would have been assessed for a separate injury.

Recommendation: Diagnose all injuries as such and separately from each other injuries' symptoms.

DOCUMENTATION OF ALL SYMPTOMS

After the injuries are inputted by the claim representative, Colossus asks a series of questions associated with each injury. The corresponding input by the claim representative adds individual value amounts to the claim's general damage range. The following are those symptoms, which the claim representative is trained to search for in the records:

- Range of motion
- Stiffness
- Headaches
- Spasms
- Dizziness
- Visual Disturbance
- Sleep Disruption
- Radiating pain
- Anxiety/Depression (also recognized as a possible symptom of neck/back injuries) This recorded symptom would allow for additional questions, which could add to the general damage value of the claim.
- TMJ (also recognized as a possible symptom of neck/back injuries) This recorded symptom would allow for additional questions, which could add to the general damage value of the claim.

Each of the above symptoms must be documented in the treating records. It isn't necessary that they be included in each of the visiting records. However, some of these symptoms allow for additional input based on the length or severity of the symptoms. For example, dizziness, visual disturbance, anxiety or depression and TMJ allow for input associated with duration of symptoms, severity of symptoms and separate treatment modalities prescribed to each. Dizziness can be recognized as a form of Tinnitus. This would require the claim representative to indicate the length of time the symptom was experienced by the claimant/patient as well as additional treatment prescribed. Similarly, visual disturbance would require the claim representative to indicate the severity and length of complaint as well as other prescribed treatment. If anxiety or depression is indicated in the treatment records, it must be associated with a separate treatment regimen. This could be as simple as prescribed medication or exercises. It could also include counseling as a prescribed treatment. The severity of these symptoms and their duration should be documented in the chart notes.

Documentation of duration should be accurate so as to clearly reflect the impact the symptom is having on the claimant/patient. It isn't necessary that each date of treatment acknowledge the symptom. However, it might be accurate to do so. Nevertheless, the entire duration of the symptom should be reflected and clearly indicated in the chart notes. Certainly, one would

expect a diminished complaint throughout the treatment regimen. There should be clear documentation of when the symptom has subsided. This would allow for the claim representative to accurately reflect the duration of the symptom resulting in higher general damages. Accurate duration documentation also applies to injured body parts other than the neck and back. A question, which must be answered by the claim representative on injured body parts other than the neck and back, is the stabilization period for the injury as well as the final prognosis. The range of stabilization answers is as follows:

0 - Unknown period
1 - up to 1 month
2 - 1 to 3 months
3 - 3 to 6 months
4 - 6 to 12 months
5 - 12 to 18 months
6 - 18 to 24 months
7 - 24 to 36 months
8 - More than 36 months

Colossus will question a stabilization period it has been calibrated to recognize as longer than expected. For example, a slight contusion to the right shoulder with a stabilization period of 18 to 24 months might trigger a warning that the time frame for stabilization period is longer than what would be expected. However, if the records clearly reflect the ongoing complaint and treatment with progressive improvement, the input will be accepted.

TREATMENT PERIOD

The next input required of the claim representative is the treatment period represented by the treatment dates, treatment numbers, treating physician specialty and prognosis. Each must be accurately reflected in the records. Unlike other body part injuries, the neck and back require specific treatment dates. The duration of treatment is determined by entering the first and last date of treatment as well as the number of visits. Colossus treats chiropractic treatment differently than it does treatment provided by a medical doctor. The weight assigned to the duration and number of chiropractic treatment decreases the longer it occurs. However, if the treatment period by a chiropractor is sandwiched between medical doctor's visits, the weight is increased. The same affect is realized if the chiropractic treatment is punctuated with a visit to a specialist.

It is vitally important that any delay in seeking treatment or any gap in the treatment regimen is substantially explained in the records. Either of these situations unexplained would result in decreasing the weight of the treatment duration. If the records reflect the patient attempted to wait out the complaints for a short period of time, hoping the pain would subside, this would explain a delay. Likewise, if the patient attempted to mitigate their damages by attempting home exercises in lieu of formal treatment for a period of time, but subsequently found they had to return to treatment, the negative affect the gap would have on value would be eliminated.

Prognosis is another input required by the claim representative to input. The following are the different prognosis indicators allowed by the Colossus equation:

A - Undetermined
B - No treatment recommended/ no complaints
C - Complaints/ no treatment recommended

D - Complaints/ treatment recommended
E - Guarded

The only indicators of prognosis allowed for chiropractic treatment are A, B and C. Each of the indicators has an increasing weight on value. (A being the least and E being the highest) It is allowed to use the D indicator if documented by a medical doctor. This would be another reason to sandwich the chiropractic treatment between medical doctor visits.

COLOSSUS APPLICATION OF IMPAIRMENT AND DISABILITY RATINGS

COLOSSUS = "A knowledge-based system for assessing general damages for bodily injury claims."

COLOSSUS assigns general damage values within four categories – each comprised of many elements. These categories are:

- Trauma (pain and suffering)]
- Permanent Impairment
- Disability (performing "Duties Under Duress")
- Loss of Enjoyment of Life

Permanent Impairment is one of the two most powerful factors driving value of a claim. (The other factor is the actual injury code itself).

Permanent Impairment

Permanent Impairment is defined as:

- A permanent medical condition resulting from trauma or work related disease or illness.

- A deviation from normal function of a body part or an organ system.
- Something the body or body part can no longer perform normally.

How **does Permanent Impairment differ from Disability?**

- Disability is how the impairment affects and changes the person's ability to perform personal, social, or employment demands.
- Impairment is a medical assessment.
- Disability is a non-medical assessment.

COLOSSUS is **not capable** of establishing an impairment rating. Only qualified medical physicians can assess impairment ratings.

COLOSSUS is **not capable** of assessing brain damage, spinal cord injuries, or skin impairments. (Disfigurement is entered in an area on COLOSSUS separate from impairment.) The only head injury impairments, which may be entered to COLOSSUS are related to sight, hearing, equilibrium, air passage, or mastication.

COLOSSUS **applies general damage compensation** for impairment based on the following information that an adjuster enters into COLOSSUS after the medical documentation which supports these findings are identified on the claim:

- The **body part or system impaired**
- The degree **(amount) of impairment** assigned by the medical examiner

As part of their COLOSSUS training, adjusters are advised, "Impairment ratings must be **AMA** (American Medical Association) **derived**, **medically documented**, and the **patient is permanent and stationary**.

PERMANENT IMPAIRMENT CAN ONLY BE ENTERED IN THE COLOSSUS EVALUATION WHEN THE INJURY HAS BECOME **STABLE AND/OR STATIC**.

- Stable: Stopped receiving treatment
- Static: When a period of time has passed since treatment has stopped and the condition of the injury has not improved.

Adjusters are further advised to enter permanent impairment to the evaluation when documentation supports that it is related to the accident, the physician and the claimant are credible, the nature and severity of the impact and other factors provided supports its inclusion.

How the degree of Impairment is determined:

Although medical professionals have indicated degrees of impairment by both subjective and objective terms, many medical groups are trying to establish measurement and classification of permanent impairments on a more objective basis. Of the two most widely used classification methods, it is the ratings of the (AMA) American Medical Association's *Guides to the Evaluation of Permanent Impairment* that seems to be the guideline used in COLOSSUS.

Methods used in the **AMA Impairment Rating System:**

The five impairment-rating methods COLOSSUS accepts:

- **Amputation:** Removal of body limb or appendage resulting in complete loss of amputated body part function.
- **Ankylosis**: Immobility of stiffness of a joint due to injury, disease, or surgery. Under this method, the impairment rating assessed can range from a joint position which causes the least amount of impairment - to a severe change in position, which creates an inability of that joint to function that would be similar to a loss of function occurring from an amputation.
- **Diagnosis-Based Estimates (DBE)**: Diagnosis based estimates mostly are used for lower extremity impairments. (This would include specific fractures and deformities), various surgical procedures and some ligament instabilities.

- **Diagnosis-Related Estimates (DRE)**: This involves assigning the patient to an impairment category based on either the injury suffered or objective findings, which would include:

  - Muscle Spasm
  - Neurological changes (motor loss/anatomic sensory loss)
  - Observed asymmetric loss of motion
  - Observed changes on imaging studies that correlate to clinical findings
  - Observed evidence of loss of structural integrity on lateral flexion/extension x-rays
  - Loss of bladder and bowel functions
  - Long tract signs

- Range of Motion (ROM): Joints have different types/ranges of motion and each needs to perform normally – any restriction/impairment of one movement type will often affect another type of movement.

AMA Range of Motion Impairment Rating Method: Restriction in movement/function of a body part = A percentage of function lost.

0% = Normal use of body part

100% = Total loss of function/movement.

The AMA Guides also provide a system for translating impairment of a portion of a limb into impairment for the entire limb and a resulting impairment of the whole body. For example:

- 40% impairment of a thumb =
- 16% impairment of the hand =
- 14% impairment of the arm =
- 8% whole person impairment

For permanent impairment rating purposes, the musculosketal system is divided into four units:

Spine, Pelvis, Upper Extremity (arm), Lower Extremity (leg). Specific techniques are used to determine the permanent joint impairment rating based on the affected area/body part. Each

range of motion is rated separately, and then indicated in degrees of range of motion. (50% flexion, 30% extension).

How does COLOSSUS consider **Pre-existing Impairments**?

COLOSSUS will evaluate the difference between the pre-existing impairment percent and the current impairment percent. There are two impairment screens in the COLOSSUS evaluation that allows the adjuster to enter the percentage of impairment for both the pre-existing and for the current.

If there is a pre-existing impairment and no current impairment, the same percent is entered in both screens, and COLOSSUS compares them. Since there would be no difference between the two impairment percents, COLOSSUS will determine that no new impairment has occurred.

If there is a pre-existing plus an impairment from the current injury, when COLOSSUS compares the two impairment percents, it will subtract the current impairment percent from the pre-existing one and use the difference between the two percents to assess the impairment.

How does COLOSSUS view **Future Treatment and Impairment**?

COLOSSUS does consider in its assessment future treatment that could cause impairment. For it to be considered, the **need for future treatment must be documented in the medical reports**. Secondly, the future treatment is considered in one of three categories based on the probability of it occurring:

Possible:	0-49%	possibility of occurring
Probable:	50-75%	possibility of occurring
Definite:	76-100%	possibility of occurring

Please note that COLOSSUS will automatically **include only the *probable* and *definite* future treatments** into its calculations.

Loss of Enjoyment of Life is considered a permanent loss. The loss of enjoyment of life valuation screens appears in a COLOSSUS consultation only in cases of impairment and only after a certain threshold is passed. That threshold is determined by the COLOSSUS program. Generally, Loss of Enjoyment value screens can only be accessed in COLOSSUS if a "whole person impairment of 2% or more" is input in the evaluation.

There **must** be a **claim allegation of loss of enjoyment of life** for it to be considered. Specification must be made as to which phase of life is the subject of this type of claim. Choices are work, hobbies, domestic duties (outside the house), and household duties (inside the house). Additionally, there must be explicit statements in the medical records about the loss of enjoyment.
Points to consider under claims for Loss of Enjoyment are:

- Loss of Enjoyment of Work: Reason for the loss must be stated.
- Loss of Status within the organization
- Loss of Job Security
- Loss of promotional prospects
- Difficulty in performing duties

- Reduced quality of work

COLOSSUS is considering lost **enjoyment** of work not economic loss. For example, a K-9 police officer whose injuries and impairment have relegated her to desk duty following the accident could be considered to have lost certain portions of her previous position, which were enjoyable to her. She may claim loss of enjoyment of outdoor lifestyle, working with her K-9, etc.

- **Loss of Enjoyment of Domestic Duties**: This refers to a claim by someone who enjoys maintaining the home, and is unable to do because of her impairment. It does not pertain to the claimant being unable to perform the domestic duty to maintain the home.

- **Loss of Enjoyment of Household Duties**: Similar to domestic duties above but pertaining to duties outside of the home (gardening, mowing, house painting, etc.)

- **Loss of Enjoyment of Hobbies**: If making a claim for loss of income from a hobby (sewing, crafts, etc), be sure to include a claim for the person's loss of enjoyment of that hobby.

- **Loss of Enjoyment of Sport**: Claims for loss of enjoyment in this category are somewhat more complex. Consideration must be taken for the activity level pre-accident compared to post-accident restrictions. Pre-accident, did the claimant participate in sports on a social, competitive, or regionally recognized level? Post-accident, is the level of sport that the claimant is now playing best described as: regionally playing, competitive, social, cannot play original sport, or cannot play any sport?

- If the individual played multiple sports, for COLOSSUS valuation purposes, consider only the sport that has suffered the greatest impact.

HISTORY OF TREATMENT

Treatment by LMT's, MT's or LPT's is inputted differently than either chiropractic or medical doctor visits. The indicators for duration of treatment for these providers are as follows:

- Short — less than 90 days
- Short Intensive — less than 90 days and more than 2 times/week
- Prolonged — longer than 90 days
- Prolonged Intensive — longer than 90 days and more than 2 times/week

Each of these indicators has an increasing weight in determining the value of the claim. If there is no final medical doctor visit when the therapy is completed, it is allowed to use the last therapy visit as a medical doctor visit. This increases the value of the claim. However, it would also depend on the final prognosis as well.

The same indicators for duration are used in describing home exercise programs. Therefore, it's very important to document the period of time which the patient/claimant is performing home exercises.

The following are additional indicators of the history of treatment required by Colossus:

- Medication
- Home Traction
- Tens
- Injections
- MRI
- Discogram
- Myelogram
- Immobilization
- Confined to bed or Bed Rest
- Hospitalization

Each of these allow for additional weighted value to be added to the final range of authority for the claim. Each has additional questions, which must be answered by the claim representative.

Medication must be prescribed in the chart notes. Duration is determined to be either short term or long term. Short term is less than 30 days. As expected long term has a greater affect on value than short term.

Home traction must be documented in the chart notes that it is prescribed and the duration required.

Prescription or use of a Tens unit must be documented in the chart notes. It can be at home or provided in office. The duration must be documented in the charts.

Injections must be described as to type and number in the chart notes. The number and type have an affect on value.

MRI, Discogram and Myelogram must also be documented in the chart notes. Each has an incremental affect on the value of the claim.

Immobilization must be documented in the records as well as the type. Whether it is a collar or lumbar support, each has a direct weighted impact on value. Duration is also important to value and must be documented in the charts.

Confined to bed must be documented in the records as well as the duration. This has a substantial affect on the value of the claim.

ADDITIONAL FACTORS

There are three additional factors, which have a significant weighted affect on the general damage portion of a claim. It's surprising how few medical facilities document these two issues.

- Duties Under Duress
- Loss of Enjoyment of Life
- Impairment

Duties under duress is an area, which is designed to acknowledge the day to day living duties, which become painful or difficult as a result of the injuries. These could be the household responsibilities of the housewife, the responsibilities of the husband or other household or work

responsibilities performed by the patient/claimant. If the injuries are such that complaints arise from vacuuming, picking up the children, dusting, making dinner or other domestic responsibilities, these should be documented in the chart notes. It's not necessary that a prescription be made for the patient to refrain from these duties. Documenting the difficulty and reason for the difficulty in performing the duties is all that is needed. The duration is also necessary to add value to the claim. This has to be clearly acknowledged in the charts. It may be necessary for the patient/client to go to work for whatever reason. But, if the responsibilities at work are difficult or painful, this adds value to the claim. Of course the duration of the duress is significant to value as well.

Loss of Enjoyment of Life encompasses the areas of life, which the patient/claimant normally would have enjoyed had they not been injured. This includes athletics, vacationing, entertainment and socializing. It allows that the activity be informal and amateur, competitive, semi-professional and professional. It should be clearly documented in the charts as to the activities and the duration. This could be documented in the original questionnaire completed by the patient/claimant and subsequently documented in the chart notes as to duration. This area has a significant affect on the value of the claim.

Impairment rating is allowed when indicated by a medical doctor. It must be based on test results and based on AMA guidelines. This is a very heavily weighted factor in the value of a claim. However, the question for an impairment rating will not be asked if the prognosis is either an A or a B. (See above for prognosis definition) Impairment ratings must be in whole person. The age of the person is also significant to the severity of the impairment and the weight allowed towards general damage value.

CONCLUSION

The impact records have on the final authority of a claim is of more importance than any demand package put together by an attorney. Claim representatives do not read most packages. There is so little information, which is provided in them, which can be inputted into the Colossus equation. As indicated above, the specific value drivers, their duration, their severity and the correct identification of their application is what has weighted value in a Colossus evaluation. Colossus rates claims on a severity scale by assigning severity points to various factors about the case. The insurance industry claims, in this way it evaluates each case individually. Each individual insurer defines how these severity points should be converted into dollars for various geographic locations or economic regions. This conversion is based on the best claim experts in the company determining the market values for various types of claims in each region. Primarily, the industry has relied on the history of judgments to determine these numbers.

All injuries have an injury profile, which defines Colossus expectations and assumptions about that injury and assigns a base severity rating. Absent accurate information in the chart notes, the severity rating for an individual claim would not reflect a reasonable value. This base profile rating provides Colossus with a starting point for valuing the injury. During the consultation, Colossus questions the claim representative about different aspects of the case and, depending on the answers derived from the chart notes and records as well as their impact on severity, adjusts the base profile rating up and/or down.

PREPARING THE DEMAND AND NEGOTIATION

- The demand is not a snapshot taken at the end of your client's treatment period.
- Demand preparation begins when your client walks into your office.
- Make sure you acquire all the relevant information concerning the injuries. Each injury should be reflected in the medical records by an individual ICD9 code.
- Document all the symptoms based on your knowledge of "value drivers" and their associated impacts on your client's pain, treatment, complications, impact on life, duties under duress, loss of enjoyment and future costs and treatment.
- The keys to a successful negotiation process are:

    - Information
    - Preparation
    - Communication
    - Anticipation
    - Persistence

- Information
    - The more informed you are about your client's condition and the valuation methods used by the Insurance Industry, the more effective your negotiations will be.
    - The earlier you acquire information, the better you will be suited to dealing with creation and presentation of the demand.

- Preparation
    - Begin preparing your demand immediately and continue the process throughout your client's claim.
    - Be prepared to present your demand in the format the adjuster will need.
    - Know your client's claim better than the adjuster will know it.

- Communication
    - Communicate with your client how different value drivers are considered by the Insurance Industry.
    - Make sure your client is fully communicating with their treating physician.

- Be sure to communicate with the adjuster when the claim is becoming more severe.
- Present your demand to the adjuster in the format they need to input the claim so as to maximize value.
- Use the terms and significant value drivers which are common language to the adjuster.
- Solicit the highest offer from the adjuster after submitting your demand.

- Anticipation
  - Remember the first offer will most likely be 80% of the full authority extended on your client's claim.
  - Follow this offer up with a letter requesting the adjuster document in writing which value drivers were accepted or used in arriving at the value.
  - Don't argue the points at this juncture.
  - After you have received the written confirmation of which value drivers were used, make a counter demand to the first offer.
  - The adjuster will now extend a counter offer which will be the full extent of the authority based on value drivers used.
  - You can do the math to determine this.

- Persistence
  - Now that you have 100% of the full authority as an offer, you can begin a written discussion as to why not all the value drivers were used in arriving at full value of your client's claim.
  - If the value drivers were not accepted because additional information is needed, you can provide that to the adjuster
  - You have a right to know why valid value drivers were not used.
  - If there isn't a valid reason, ask to speak to a manager.
  - Once you have satisfied the requirements necessary for the "not used" value drivers to be used, request that a new and fair offer be extended.
  - Now that you've received a fairer offer, you can decide whether to take the next step or accept it.
  - It is possible that if a lawsuit is to be filed, there exists a window to increase the offer another $2500 to $3000.
  - When a lawsuit is filed on a claim with a value of less than $25,000.00, the claim file is "Dolfed". This term applies to a suit which the defense counsel has contracted a flat rate to defend. Once, the suit is sent to the defense, they receive the contract price whenever it settles.
  - This means that if the claim settles the day after it's referred to the "contracted" defense counsel, the insurer will pay the defense counsel the full contract rate. Since these rates run from $2500 to $3000, there is a window for you to negotiate for a portion of that amount.
  - This strategy will work best when dealing with a manager. However, in some instances you might find success increasing the offer by the "contracted" rate when dealing with the adjuster. After all, he will have to spend the money if you serve his insured.

- The Insurance Industry trains its employees that:
  - They control the money
  - Money represents power
  - Power is in the ability to control

    - If you lose control, stall and delay
    - Negotiate so as to reduce the expectations of the attorney

- Know when to negotiate
- Most of the larger insurers, at the corporate level, are not as concerned about the amount of a single settlement as they are concerned of creating bad law and adverse media exposure.
- Know when to negotiate
- Know who you're negotiating with
- Be realistic about the acceptable range of settlement
- Be persistent in discovery, but don't get lost
- Nothing should be given up without getting something in return
- Staying firm at an unrealistic settlement demand could cost your client a very reasonable settlement
- Understand the how the Insurance Industry and your role has changed

  Adapt to the change
- However, recognize when your client's rights and contractual privileges are being trampled on.

PRESENTATION

The claim should be presented in such a fashion as to allow the adjuster evaluating it to understand clearly what injuries were involved. This should be concise and based on exactly what is diagnosed in the records. All the economic specials should be listed clearly with an accurate total.

DOCUMENTATION

All supporting billings should be attached in the same order as the listing and in a separate section. The listing of medical specials should match the actual billings. Matching records for each date should support the billing dates. If there is a loss of income, all documentation should be included. Normally, this would include the amount of the income loss, a statement from the treating physician for the dates of wage loss and a statement from the employer confirming the loss for each date. If there are prescriptions, travel costs or other economic losses, these should be supported by physician records, receipts and other reliable documentation.

UNDERSTANDING THE PROCESS

Not all insurance companies use the same process. Some use evaluation forms necessary for file documentation and internal reviews. These forms are structured to allow the adjuster to enter the economic damages, diagnosed injuries, treating physicians, treatment modalities, negligence, decision and arguments or brief discussion of claim. These types of evaluation formats sometimes have pre-determined ranges of values based on severity of impact or other factors. Some allow for the adjuster to establish the range of value within which he/she will negotiate the claim. Other companies use electronic formats for evaluation of claims. These formats are calibrated on a periodic basis so as to reflect the changing claim environment. Those companies, which have been involved in the use of this type of format for sometime, have developed a form for soft tissue injury claims and one for objective injury claims. The adjuster completes an

analysis of the claim using a form, which will allow the adjuster to input the necessary information. The electronic evaluation process asks specific questions based on the responses and ultimately provides a range of general damage values. Traditionally, the adjuster then has only the authority, which is determined by this process. There may be another step added to this process by some companies to insure correct information was inputted.

COORDINATING DEMAND TO PROCESS

Understanding which process is being used to determine the value of your client's claim is essential. Absent this understanding, your demand may not address the specific areas, which would be value drivers. However, knowing which process is being used provides for clearer insight as to how to construct the demand so as to maximize the range of value for settlement. This allows the adjuster to increase the authority, which he/she has to negotiate settlement of the claim. Demands should be formatted to fit the different processes currently being used in the insurance industry today. The current electronic process for evaluation of claims has specific value drivers imbedded within the equation for general damages. Clearly pointing out these value drivers and the supporting medical chart entries provides for a maximum claim value range. The economic losses do not affect the range of general damages. They are simply an addition to the general damage range.

INITIAL OFFER

RESPONSE TO INITIAL OFFER

After the claim has been evaluated most companies are encouraging at least one initial offer. This is usually 85% of the top value of the range of authority for the claim. So, if the initial offer is $8,500.00 inclusive that would indicate to you the top value in the range of authority for the claim is $10,000.00 inclusive. I suggest that you confirm whether there is room to move or if that is all the authority the adjuster has to settle the claim. This is a difficult question for the adjuster to respond to. He/she will respond there is room to move or there is additional authority if in fact that is the case. Rarely, will they respond that is the top and final offer. They do not want to be accused of not fairly and reasonably negotiating the claim. Therefore, you now know there are additional monies to be negotiated for and you have a good idea of what the top end of the range is. The next series of questions to be asked are what specials were accepted, what injuries were evaluated, what symptoms or history of complaints were used as well as any other value drivers in determining the value. I don't suggest presenting any arguments at this time. Give yourself the opportunity to take this information and develop item-by-item arguments and foundation.

CLEAR COMMUNICATION

This is very necessary in the final outcome of getting all the authority allowed by the process being used. Document the responses to each of the items (amount of medical specials, income loss, injuries diagnosed, history of complaints, etc.). Confirm these responses in writing to the adjuster as well as the offer presented. Be specific as to the amount of specials allowed, the value drivers allowed and amount of general damages as relayed to you by the adjuster. This will cement the specifics, which can then be used during the next discussion with the adjuster.

WHAT WASN'T CONSIDERED

If you are fortunate enough to know which process is being used and have a good understanding of the process, documenting which value drivers were not allowed is essential. Again, I wouldn't bring up verbal arguments at this time to each of the value drivers not allowed. However, in the confirming letter you send to the adjuster as pointed out above, state the value drivers not allowed which were indicated to you by the adjuster. Be specific and list incrementally each of the items allowed and disallowed. This letter will then be a basis for you to assure all value is being accredited to your client's claim.

ADDITIONAL CONSIDERATIONS

Now, that you have a listing of the economic specials, diagnosed injuries, duration of treatment, treating physicians, treatment gaps or treatment delays (these are negative value drivers) and any other considerations for value, you can list those medical specials, diagnosed injuries or other value drivers not accepted and specifically state where in the records they would be supported. Having this information and the initial offer from the adjuster places you in the position of knowing how to increase the top end of the adjuster's authority range. Keep in mind; the adjuster wants to settle this claim as much if not more than you do. Just as you might find yourself caught between negotiating with the adjuster for more money on one side and explaining to your client why they might need to adjust their demand downward on the other side, the adjuster is in a similar position with his/her management. The difference being, the adjuster may have as many as 300 claim files and is being paid on salary. Understanding the time constraints of the adjuster in the handling of each claim might provide you with the ability to assist them in getting your client more money.

FORMATTING ADDITIONAL INFORMATION TO EVALUATION PROCESS

The next step I would suggest is to list each of the items not included in the evaluation or not allowed. This should be done concisely and organized so as to be very clear to the adjuster. For example, list an injury not allowed such as shoulder contusion. Then, indicate exactly where in the medical chart notes the diagnosis for this injury was documented by the treating physician. Suppose in the first conversation with the adjuster, he/she advised that only the contusions to the neck and back were allowed as diagnosed injuries. In reviewing the records now, you find in the emergency records the record of left shoulder contusion. You could make the following entry on your itemized list: (Contusion Left Shoulder- Dr. Mathis 09-20-2001 chart note - Patient complains of sore neck, lower back and left shoulder. The left shoulder shows bruising and has limited range of movement.) By completing this listing of value drivers, you will be in a position to increase the value range. This will be very easy for the adjuster to resubmit a revision of the evaluation and secure additional authority at a later date.

FINAL OFFER

CONFIRMING ALL FACTORS WERE CONSIDERED

Calling the adjuster back with a counter offer and once again confirming the items on your list will in most cases elicit a top offer from the adjuster and cement those factors he/she considered in arriving at that figure. Confirm this is the top offer and that it was based on the factors as previously discussed. This will set up the next call, which will be based on the list you have completed after the first call. The adjuster is now locked into a value based on the value drivers you have confirmed in writing. There will be no misunderstanding at a later date. This is important in the process. I would not recommend verbally addressing those items, which you can now identify which could be used in determining value but were not. The adjuster cannot

move above the top value of a claim in most instances. In order for the adjuster to increase the range of value, he/she must complete a resubmission for additional authority. I would recommend after receiving the top offer from the adjuster, a letter be sent with a final counter offer and specifically stating each item not allowed and where it is supported in the medical records. This will allow the adjuster to easily complete the resubmission and support additional authority. I would recommend once again this be done concisely and organized as the previous example indicated.

UNDERSTANDING WHICH FACTORS ARE NOT VALUE DRIVERS

A very important factor in this process is understanding the items which are value drivers and which aren't. It wouldn't do any good to list and document items, which wouldn't have any affect on the value range. For example, severity of impact is not necessarily a value driver (unless the claim is being handled as a minor impact). In most electronic processes there is no opportunity to input severity of damage. However, this doesn't mean that indicating the accident was a "T-bone" type accident wouldn't support a left shoulder injury, which may not have been allowed in the original evaluation. Note that the left shoulder injury in most cases would still need to be acknowledged somewhere in the medical chart notes. If you're not sure, don't be afraid to ask the adjuster. He/she may tell you. After all, it will assist them in getting one more claim settled and off their inventory. There are also several other resources available now for the different processes being used by the insurance industry. Take advantage of these.

WOULD ADDITIONAL DOCUMENTATION INCREASE VALUE

Don't be afraid to ask the adjuster if some form of additional documentation would assist in allowing for a value driver. It could be there is a valid impairment rating. But, the treating physician never addressed this other than to state there were ongoing limitations, which may not resolve. Requesting the treating physician to state the impairment rating based on AMA guidelines for the whole body has a significant impact on value. This is only one example of additional information, which could be very relevant to increasing the value range.

MEDIATION

In most instances, once the top offer has been made and there are no other indicators, which the adjuster can input to increase the value of the claim, mediation will not have any affect on the value. Absent the required value drivers, the value will remain the same. In those instances where the claim is being evaluated with other than an electronic process, the mediation avenue could be very affective. With these claims, the severity of impact, age of your client or other issues could very well result in a higher offer. Presented through the mediator, the adjuster is provided with the documentation, which he/she may otherwise have been unaware of. This might result in an agreeable settlement. Remember, in most instances, the final offer from you in the mediation should include that your share of the mediation be paid by the insurance carrier. This cost is paid separately and does not require additional authority to be requested by the adjuster.

FILING SUIT MAY NOT INCREASE VALUE

In discussing most soft tissue injuries, filing a lawsuit will not automatically increase the value of the claim. Most adjusters have been taken out of the loop where allocated costs are concerned.

They are told the cost of litigation is not a consideration for increased offers. Most insurance companies have moved to a flat rate defense. In most instances where the injuries are soft tissue in nature and the claim has a limited value, the adjuster is no longer involved. It becomes even more difficult at that point to return to the issue of value drivers, which might affect the top value. However, it's not impossibility. Reviewing the same issues with the defense counsel, which have been outlined above, could result in the same positive result even before the first deposition is taken. This is assuming they haven't already been addressed with the adjuster prior to suit being filed.

OTHER OUTSIDE FACTORS

END OF MONTH/QUARTER/YEAR-END

At the end of certain periods there is always a push to reduce inventories. It is possible to take advantage of these periods. Assuming your demand has already been presented, it would be very strategic to keep in mind the cycle, which may be ending in the near future. Timing your final counter offer with specific value drivers addressed two or three weeks prior to the end of one of these cycles could result if a quicker and higher offer. Of course, this would depend on the complexity of the claim and the clarity and accuracy of your final counter. Nevertheless, being aware of these timing issues could be very affective.

MERIT, PERFORMANCE REVIEWS AND PROMOTIONAL OPPORTUNITIES AFFECT VALUE

Merit increases are determined based on performance, which is monitored throughout the year. The possibility for achieving "Meets", "Exceeds" or "Exceptional" merit ratings are standard throughout the industry. Each company differs only slightly when making determinations on merit increases for their claims personnel.

Although severity is only one category in the equation to determine which rating the claims person will be awarded, it is significant in that it is one indicator which is tracked monthly in almost all institutions. This reflects in an ongoing attitude between management and the claims personnel. Imagine yourself as a manager with goals determined by your superiors and with little control for you to have a direct impact on achieving those. You would find yourself monitoring the monthly results of each of your claims personnel for their successes or failures to assist in the satisfaction of those goals. You would out of necessity utilize any and all available tools to stimulate or motivate your personnel.

You might practice positive reinforcement, negative reinforcement, ongoing emphasis on training, demands for established practices and procedures to be adhered to, contests or whatever other tools provided to you through your training when becoming a manager. You would definitely see the monthly reports and quarterly reviews as an effective vehicle to assist you in the management of your personnel. These would definitely provide you with a gauge of comparison among the different personnel you manage. They would also provide a most reliable stimulator throughout the year. You would have the capability of assessing the actual accomplishments of each claims person on a monthly basis. Thereby, realizing quickly which of the claims person you manage is failing to contribute to the satisfaction of the goals, which you are held accountable for.

Therefore, you establish with your claims people the urgency to evaluate and settle claims within a range of values not to exceed the goal on average. This reflects on each individual claim so as to encourage the largest number of evaluations and settlements to be less than the average claim paid or severity average. It doesn't take a large number of severe injuries exhausting the liability policy limits to budge the average paid claim or average severity above the goal.

The same philosophy and company practices apply when pendings or claim inventories are reviewed on a monthly basis. The company wants to reduce the number of claims open. This in return reduces the amount of dollars, which are held in reserve for those claims. When fewer dollars are tied up in reserves, more investment earnings are realized. This can also be realized through the reserving process for each claim as well. Claims handlers are encouraged to properly evaluate claims early on. This results in proper reserves and avoids excess reserve dollars being tied up.

Although, the insurance industry argues that each claim is independently reviewed and valued, it continues to monitor average severity. This is a contradiction in the simplest of terms. If each claim were evaluated and settled in a vacuum of all other claims, then the average claim value and the attention paid to that figure would be insignificant. Any reference to an average severity or claim value would never reach the front line managers or claims personnel. What would be the relevance of identifying this figure to the front line people? What would be the anticipated reaction of the front line personnel?

There is a reason for tracking of this number at an executive level. It's understood that forecasts for funds needed to pay future claims would have impact on premiums charged the general public. Each insurance company in the market today has realized the importance of being competitively priced. This pricing would naturally reflect the cost of claims. Throughout the industry it has become even more competitive where pricing their product is concerned. Each company attempts to under price their competitor. This is a very strong stimulant for the executive office to then relay their expectations of the claims departments to reduce their averages.

This state of urgency can be even more obvious towards the end of each quarter and the end of the year. If, the individual claims person, unit, section or region has had a good average up to the end of a particular cycle; it will then do whatever it can to carry over larger claims into the next cycle period. If, the individual claims person, unit, section or region has had a poor average (represented by higher than goal average); it might attempt to resolve any and all larger claims within the present cycle. This would allow for a clean slate for the next cycle and explanation would be more acceptable for the failure to achieve company goal. It would also provide a possible for comparison as to how improved the following cycles are.

I realize this is probably more "behind the scene" information than you might feel is relevant to the evaluation to one claim. However, it is in this environment of ongoing pressure, which the claims person is evaluating each claim individually. The implication being, no claim is evaluated or settled in a vacuum. The temptation to take advantage of the possibility of including a settlement of a smaller claim in any cycle can be overwhelming for the front line manager and claims person. This can be attested to by those instances when a claim is severely under evaluated. This, of course, results in those offers, which appear ridiculously low.

In general, though, the result of these tools used to monitor the performance of claims personnel is seen in evaluations and settlements in the lower end of acceptable claim values.

HOW LONG SINCE CLAIM WAS INITIALLY EVALUATED

It was stated earlier that electronic processes for evaluation are calibrated on a periodic basis. If it has been a while since any evaluation was completed on the claim, a re-evaluation could result in a significant higher amount. This often occurs when your client has been negotiating directly with the insurance company without success. Although, there may not be any new information, which would impact the claim, the periodic calibration of the process could. Don't be afraid to ask when the claim was last evaluated. If there has been a significant time lapse, ask for a re-evaluation. This is a very simple process.

SMALL LIMITS

In those instances where the policy limits are low, it might have an impact on increasing the value of the claim. The insurance industry is becoming more aware of the exposure to excess awards as a result of the costs and fees of plaintiff counsel after an arbitration award is de novo is taken. They are more amenable to open up negotiations in these instances and place additional monies on the claim. This avoids the risk of not bettering the arbitration award and then realizing an excess possibility due to fees and costs. This potential risk could be a value driver even before arbitration or suit is filed if presented appropriately to the adjuster. Of course there would also have to be a claim value in a range that could realistically have this situation occur.

CONCLUSION

This is a personal opinion. As I am no longer an employee of an insurance company, I certainly cannot speak on their behalf. It is my belief the majority of claims presented to insurance companies could result in higher values. It is also my experience almost all adjusters try their very best in dealing with large inventories and cumbersome processes. One of my superiors once advised me when I was first promoted into management with State Farm, "Don't ever be so procedurally correct as to be practically stupid." I have seen the insurance industry in their attempt to reduce overhead costs, severity costs and litigation costs move into an environment of increased procedural requirements for their employees. This appears to have resulted in an increase in the number of claims each adjuster is responsible for. It has also created a great deal more procedures, which must be adhered to by the adjuster. Some of these procedures seem to have removed the adjuster as an experienced professional from the handling of the claim.

These frontline technicians honestly want to perform at the highest level possible. Given an opportunity and an environment of cooperation with the legal community, each of them would be able to do just that. Adjusters are required to work within the system of the company with which they are employed. It is not a choice for any of them to step outside the processes or procedures as required by their employer. I might suggest working with the adjusters, assisting them in their responsibilities of these processes and understanding the specific requirements of the evaluation system would be without question a positive outcome for all.

PROGRAM FOR EVALUATION

Demand Online® The First Computerized Claims Processing System For Attorneys. The Insurance Industry Has Been Using It For Decades, Now You Can Too. Create Demand Letters, Negotiation Letters And Most Importantly Find Out The Settlement Value Range Before Talking To The Insurance Carrier.

SOME OF THE FUNCTIONS INCLUDED IN THE "DEMAND ONLINE®":

- **Automatically Creates Your Clients' Demands Compatible With Insurance Industry Software**
- **Web-Based System (Access System Anywhere)**
- **Automatically Determines Settlement Value Range**
- **Automatically Creates Claim Label & Summary For Printout**
- **Automatically Creates Negotiation Letters**
- **Automatically Creates Timeline Of Significant Claim Drivers**
- **Automatically Creates Listing Of Possible Overlooked Or Missing Drivers**
- **Automatically Remembers Names, Addresses, Dates From Demand To Demand**
- **Automatically Networked With Our Medical Customers**
- **Compatible With Our Medical Software**
- **Capable Importing The Medical Data Of Your Client From Our Medical Customers' Software**
- **Client Listing With Search & Sort Functions By Client, Insurance, Statute, Date, Etc.**
- **Pre-Formatted Paragraphs, Discussions And Statements**
- **Code Express Icd-9 & Cpt Search Built-In Function For Accurate Coding**
- **Built-In Injury Listing For Quick Workup Of Injuries**
- **Built-In Duties Under Duress And Loss Of Enjoyment Checklists**
- **Built-In Medical Expense Summation**
- **Built-In Mileage Calculator**
- **Built-In Liability Checklist**
- **Free Client Worksheets To Match Insurance Industry Software**
- **Automatically Tracks Last Time Claim Was Worked And By Who**
- **Free Upgrades**
- **Free Training**
- **Free Tech Support**
- **Free Networking Support**
- **Free Review And Re-Write Of Demands**
- **Pre-Formatted Response Letters To Low Offers, Reductions, Denials, Ime's And Reviews**
- **Free Individual Client Claim Consultation**
- **Built In Analysis Of Missing Information And Listing Of Overlooked Drivers**
- **Built-In Dictionary**
- **Built-In Library And Storage For Legal/Medical Discussions**

The attorneys open the program in preparing a demand letter for damages to the insurance company. Once the program is opened, it leads the attorney through the medical records. As the attorney is responding to each question, his cursor is in the corresponding window. There is an informational window on the top of each screen, which describes what information is being requested. There are help buttons in each section and on each screen, which describe the value drivers and how to increase each of their values.

When the last piece of information is entered, the attorney can press the "Create Demand" button. This transforms the data entered into text format so that the demand can then be placed on any text editor (i.e. Word, Word Perfect, Correl, etc.) The demand is then ready to be printed and mailed to the insurance company for evaluation and settlement. The demand is saved in the attorney's client folder as a text file and as a data file. This allows the attorney to continue to edit or supplement the demand at any time. However, it is not recommended that the demand creation utilizing "Demand Expert" program begin until all medical and economic documentation has been gathered.

"Demand Expert" and "Medical Report Expert" are excellent educational tools for the legal and medical community as well as their clients and patients. For the first time, there exists a window of opportunity. The legal community has a unique opportunity to actively participate in the evaluation process of their client's claims regardless of which system is being used. It's as if the lawyer is sitting next to the adjuster prompting him to enter the correct information as well as the complete information.

The program does this by asking specific questions beginning with:

1. The general information:
    a. Where the demand is to be sent,
    b. Letterhead information, who is sending the demand
    c. Claim specific identification
        i. General description of the claim/accident
        ii. Discussion on Liability
    d. Facts of accident
    e. Including aggravated liability issues
    f. Multiple defendants
    g. Contributory negligence
    h. Comparative negligence
        i. More specific information on client and claim
    i. Age
    j. Weight
    k. Height
    l. Medical specials
    m. Economic specials
    n. Vehicle damage
2. Identification of Injuries with ICD9 coding
3. Prior or Subsequent injuries or events
    a. Include paragraph for discussion to include
        i. Delay in seeking treatment
        ii. Gaps in treatment

iii. Prior treatment stopped before this accident
iv. Treatment overlaps and pro-ration

v. Then Treatment details for Contusion treatment details (Neck and Back only – this is cervical, thoracic and lumbar regions) they are entered separately into the Insurance Industries computer program, Colossus separately from all other injuries' details. The necessary information needed in this sections is as follows:

b. Identify Neck (cervical) and/or Back (thoracic and lumbar)
c. Physician name
d. Type of physician
e. Last date of treatment
f. Number of treatment dates
g. Final prognosis
h. Discussion option available to support prognosis

4. (Note therapies are not entered yet – physical therapy, massage therapy, acupuncture, water therapy, self-exercise and medication details are all entered in a different section for Neck and Back soft tissue injuries. Therapy treatment for all other injuries is entered in the specific section of each of those injuries.

5. The next section is all the symptoms associated with the Neck and Back only. These are called value drivers. The specific symptoms allowed by Colossus are listed and there are additional increasing indicators allowed in drop down windows for some.

6. There is a section allowed for discussion of certain of the value drivers such as TMJ, Anxiety/Depression and any complications not normally associated with Neck and Back contusions.

7. (Injuries to the Neck and Back such as bulges, prolapses, herniations and fractures are treated in separate sections each as if they are other injuries. A claimant can have soft tissue injuries as well as each of these. They are not considered in this section of demand letter because Colossus deals with them separately.

8. The next section is for all other injuries. Identification of each injury with the name of the physician, type of physician, chart date where indicated, last date of treatment, number of treatments and final prognosis. This would include the following types of injuries available in this basic program:

a. Sprain/Strain cervical, thoracic and/or lumbar
b. Subluxation
c. Prolapse cervical, thoracic and/or lumbar
d. Bulge cervical, thoracic and/or lumbar
e. Herniation cervical, thoracic and/or lumbar
f. Dislocation cervical, thoracic and/or lumbar
g. Fracture cervical, thoracic and/or lumbar
h. Superficial Injuries all other body parts
i. Contusions all other body parts
j. Sprain/Strain all other body parts
k. Fracture all other body parts

l. Dislocation all other body parts
m. Ligament injuries – usually associated with joints
n. Laceration all other body parts
o. Penetrating wounds all other body parts
p. Crush wounds all other body parts
q. Amputation all other body parts
r. Concussion
s. Lastly, dental injuries

    i. Each of these injuries would have there own specific treatment details different from each other and different from the Neck and Back contusion treatment details. (See listing for each)

    ii. Each of these injuries would have specific complaints or symptoms, which would be different from Neck and Back contusion. (See listing for each)

    iii. Each of these could have complications associated individually and a paragraph option needs to be available.

    iv. The next section should deal with the therapies. Since these are entered differently into Colossus.

t. Name of physician or clinic
u. Duration
v. Frequency of treatments

9. This next section should include all the details of the dental injuries. Colossus does not allow dental injuries to be entered. Therefore, a separate section should include all the treating details including physician name, number of treatments, last chart date, prognosis.

10. There should be a window for discussion offered here to allow the attorney to discuss the value of the dental trauma. This will allow the insurance adjuster to enter a dollar figure for compensation.

    i. The next section should deal with testing as this is entered separately into Colossus

b. There are specific tests allowed

    i. X-rays
    ii. MRI
    iii. Cat scan
    iv. Myelogram
    v. Discogram

    vi. The next section would deal with disabilities. The disabilities and associated affects need to be documented by chart note dates and physician names.

c. Loss of enjoyment
d. Duties under duress

11. The next section should deal with impairments.

    a. Physician name
    b. Chart note date where this occurs
    c. AMA % (whole body)

12. This section is for any disfigurement, which resulted from the injuries. The section should include:

    a. Physician's name
    b. Type of physician
    c. Chart date or medical report date supporting
    d. Date of photograph
    e. Amount of compensation demanded
    f. Future treatment necessary – Yes or No

        i. See Future losses

13. A paragraph window should be offered if any of the previous sections were part of the injuries' records. This allows for additional supporting arguments for the insurance company to include these into their evaluation of the claim.

14. A section for Income loss should include the following:

    a. Name of physician
    b. Type of physician
    c. Last date of treatment
    d. Duration of disability from employment
    e. Name of employer
    f. Discussion window for explanation or variation

15. Future losses (Income and Medical costs) are the second to last section. This should include the following:

    a. Name of physician
    b. Type of physician
    c. Last treatment date recorded in charts
    d. Prognosis
    e. Future treatment needed
    f. Dollar amount of future treatment
    g. Dollar amount of future wage loss

16. There should be a listing of all medical billings and their amounts

17. There needs to be a final discussion window to allow the attorney to bring the claim demand together. Here he'll list the total of medical expenses, total income loss, overall summary of the claim, brief reference to liability, disabilities, impairment, prognosis,

complications, scarring, future medical treatment, and future income loss. He should close with his demand for settlement in this final paragraph.

NON-COLOSSUS CLAIM

The non-Colossus claim would include the following types of injuries as experienced by your client:

1. Severe brain damage.
2. Death.
3. Severe spinal cord trauma.
4. Dental trauma (Other than TMJ or TMD).
5. Dog bites.
6. Disfigurement (Although, if there are associated claims allowable for Colossus, the disfigurement amount can be added once it has been determined). This has become significant in recent years. Connective tissue claims which have pinched or compromised nerves due to ligament, tendon damage result of atrophy of muscles associated with the pinched nerves. The atrophy can be documented by monthly measurements by the treating physician.
7. Loss of consortium (Although, if there are associated claims allowable for Colossus, the loss of consortium amount can be added once it has been determined. Typically, no loss of consortium amount will be added if the underlying claim is valued at less than $50,000.00. Then, the loss of consortium claim is usually determined to be 5 to 10% of the underlying claim).
8. Emotional Distress claims.
9. Negligent Infliction of Emotional Distress.
10. Disability claims.
11. Claims for gross negligence factors (i.e. Driving under the influence, excessive speed, racing, driving without a license, etc.) Although, if there are associated other claims available for Colossus, the amount for these types of claims can be added once it has been determined. Amounts for these types of claims will be entered as a dollar figure to be added to the Colossus value range. It is best to provide jury verdicts which would be similar to these claims.

The type of demand created for the claims which have no associative Colossus type injuries will resemble the old form of demand. The following factors should be considered and addressed in separate paragraphs, if they are relevant.

1. Introductory paragraph.

    a. Provide an overview of the claim include the injuries descriptions as well as onset of injury and initial treatment sought.

    b. Be brief, but also, be thorough. If there is ongoing symptoms and treatment, state that briefly. This can be handled more thoroughly in later paragraphs.

    c. Provide a brief, but accurate description of your client (age, height, weight, in school, working, retired, etc.). This is an opportunity to influence the value of the injuries and symptoms based on the affect they would have on similar victims. If there are some special or unique attributes of your client which may have been directly affected by the injuries, this would be a great place to lay that foundation. For example, your client may have been a model prior to the incident. Now, the disfigurement as a result of the dog bite will affect future earning capacity. Your client may have been a minor and due to the dog bite, the minor has had behavioral problems (anger, tension, bed-wetting, nightmares, etc.).

2. The next paragraph should confirm liability agreements or address the issues which need to be presented in order to reach an agreement of negligence. If liability has been agreed to previous to the presentation of the demand (the most favorable position to be in, at this time), then a simple sentence stating that "liability has been determined and we are in agreement that my client has no negligence for the damages sustained in this incident".

3. The next paragraph should clearly state each injury and the treatment which was provided. The treatment can be a listing of medical providers, last date of treatment, prognosis and dollar amount of treatment billing.

4. The next paragraph should address the symptoms as well as any testing which occurred to support the treatment (duration, type and frequency). This paragraph should include the significant issues which needed both active and passive treatment modalities. This paragraph should include any issues which rose as a result of the injuries which may be contested by the insurer. For example, if there was psychological counseling necessary due to the injuries or disfigurement, that should be addressed here. It would be appropriate to quote the physicians who have addressed these issues in their reports.

5. The next paragraph should address the impairment rating which was determined by a doctor as a result of the injuries. This paragraph should also discuss each of the factors normally found in Duties under Duress and Loss of Enjoyment sections of the Colossus type claims.

6. The next paragraph should address the need for future treatment determined medically necessary on a "Probable" or "Definite" basis. It is appropriate to quote directly from the physicians' reports. Include in this section the necessary information for future need for plastic reconstruction as well as the cost of this. Future medical costs, including surgeries, should be projected in a single figure, not a range. If you provide range, the amount included in the settlement value range will be the lowest figure of the range you have provided here.

7. The next paragraph should address any past, current and future income loss. This would also be the appropriate paragraph to address issues such as loss of education, need to attend summer school to catch up, need to retake a year of education, loss of scholarships (scholastic or athletic). Any other issues which could be considered by a jury in arriving at a judgment for your client, which haven't already been discussed should be addressed in this paragraph.

8. This section of the demand should be a listing of all current medical and income loss, future medical and income loss, amount for disfigurement, aggravating factors, etc. A total should be shown for the damages which a jury would be instructed to consider in arriving at a judgment.

9. Finally, this paragraph should briefly summarize the claim, ongoing issues which will be realized by your client, a summary of the medical costs and income loss, a summation of future medical costs and income loss as well as the total amount you are presently demanding on behalf of your client. If there is an emotional distress claim you are presenting on behalf of your client's spouse, parents or children, address that in a brief paragraph prior to this one and include the case law or statutes you are relying upon in arriving at a total figure for that claim. Then, include only the amount for the claim in this paragraph.

10. You should request that the insurer request permission from their policyholder to release the policy limit information to you. Absent this information, you will probably want to demand the policy limits.

    Your attachments should include:

    1. All medical records

    a. Separate these by physician

    2. All medical billing statements

    a. Separate these by physician

    3. All income loss documentation

    4. Medical reports for future plastic surgery, reconstruction, etc.

    5. All police or investigation reports

    6. Quality photos, especially if there is a disfigurement claim.

    7. Physical capacity reports

    8. Economic reports

    9. Work hardening reports

    10. Disability reports

    11. Jury verdicts

        a. If there are multiple injuries, separate verdicts by injury type.

When submitting this demand, be sure to protect all possible sources of insurance coverage (PUP, PLUP, Umbrella, UIM and commercial policies of co-defendants as well as any other

resource for policy dollars. Look at the entirety of the claim and how it occurred to make sure that you have identified all possible defendants with any negligence.

INSURANCE INDUSTRY APPLICATION OF COLOSSUS

Colossus is a computer system for assessing general damages for bodily injury claims. It is acclaimed to have the capacity to train the user in assessing common law damages while honing the skills of even the most experienced claims assessor. While Allstate adjusters have their own personal authority levels, they are required by specific guidelines to not deviate from the values arrived at through the use of Colossus. The settlement results of each adjuster, unit and region are tracked and deviations from Colossus evaluations result in monetary and promotional opportunities lost.

In addition to assessing claims, Colossus is presented to adjusters as having the ability to explain trauma-related medical terms, provide basic anatomy and physiology descriptions of the human body, highlight inadequate evidence of a claim, and warn of any exaggeration or inconsistencies - particularly in non-demonstrable injuries such as whiplash. Colossus evaluation will result in a printout of all features of a particular claim. This summary represents an instant overview of the claim to the adjuster, assisting defense counsel as well in interrogation and defense to litigation.

Colossus has limitations where severe brain damage, death, severe spinal cord trauma, dental trauma (except for TMJ), dog bites or disfigurement are present. Colossus is dependent upon the data captured and entered by the individual adjuster. This data is reviewed and corrected by a manager. The manager after careful review of entered data according to specific guidelines and sometimes personal opinion will extend settlement authority to the adjuster. The authority for an individual claim cannot be exceeded without an exhaustive explanation as to why this occurred. Should an adjuster be found to have more than two claims where management extended authority is exceeded, this option would be considered a trend. Where a trend is recognized in the settlements of any adjuster, the ability to use personal discretion in exceeding management authority will be taken away for a period of time for as long as six months to a year.

Settlements and their percentage to Colossus evaluations are tracked on a weekly, monthly, quarterly and annual basis. Quarterly and annual monetary incentives are offered to the individual, unit and region for maintaining settlements less than the regional goals of the company. These incentives can be thousands of dollars to the region to spend on the employees of the unit or region. Awards are given based in part on the history of an individual who maintains a low percentage rate to Colossus evaluations. During individual annual performance salary reviews the percentage rate of an individual adjuster becomes part of the merit decision-making process. An adjuster who has had more than 100% adherence to Colossus values could realize a smaller merit increase in salary base pay.

Each adjuster is required to participate in some form of training in the use and preparation of a Colossus evaluation. Training consists of from one to three-day workshop as well as a part of Home Office courses. All the training classes stress the requirement to not deviate from the precise procedures for reviewing medical and wage loss records and billings, interpretation of these records and billings, and finally, precisely required insertion of the data into the Colossus equation for final evaluation of the claim.

The evaluation of a claim begins with the receipt of documents, records and billings for medical treatment and wage loss. This information is required to be complete with very little latitude

allowed for any missing record. The information is separated and tabbed according to procedures by a processor. The packet of information is then turned over to another processor for input of medical billings into the MBRS (Medical Billing Review System), ADP, AIM or other similar automated billing review system. It is also possible that the medical chart notes and billings will be submitted to a contracted vendor to determine which treatment or billings may be denied. The billings must contain the date of service, amount of each modality, the ICD9 coding and the CPT code for each modality. The billing must contain the correct identity of the patient as well as the medical vendor. If the medical vendor is not one, which is currently "on hold" due to an ongoing investigation by SIU (Special Investigation Unit or Fraud Unit), the billings are reviewed for "reasonable and necessary" allowance. Once, this is completed, the packet is then given to the adjuster for input into Colossus.

The adjuster must now compare each billing to each record to confirm its corresponding match and to the demand from the plaintiff attorney. The adjuster must confirm all records and billings are received prior to continuing with the Colossus. Until such time as all records and billings, the adjuster in almost all but the rarest of occasions is barred from requesting management authority by completing the Colossus. Once all the information is confirmed to be present, the adjuster reviews the records and determines the appropriate data to input into the Colossus evaluation. This is done with the assistance of a "dissection sheet". The dissection sheet corresponds to the questions requiring response by Colossus in order to arrive at a particular value. Significant responses may increase or decrease the value ultimately arrived at by Colossus. At times these responses may be subjective in how the records were interpreted. It is the management's interpretation, which is final. As an example: the adjuster may interpret a record to indicate an individual suffered a shoulder injury. The manager may interpret the record to mean only that the cervical pain "radiates" into the shoulder. This is significant because Colossus is now reduced to allowing authority for only the neck injury. The shoulder injury is removed and no longer provides any settlement authority. The neck injury will increase with the symptom of "radiation". However, the increase is very insignificant when compared to the level of authority provided for an additional shoulder injury.

Each of the entries by the adjuster is reviewed for its accuracy by the manager. This includes the amount of medical billing being accepted by the adjuster. The medical billing must have been entered into the medical review software program and reviewed twice by the adjuster before the total amount can be considered by Colossus. After receiving the packet of records and billings back from the processor, the adjuster will electronically review the billings input. Each individual entry must be reviewed in this step prior to input into Colossus. The adjuster makes a decision to accept or deny those entries, which the system has, questions about. The entire billing must be verified at this step prior to the billing being accepted and processed for the next step. The adjuster must verify the reason for accepting any rejected billings by the system in a separate entry in the electronic claim file. Absent this explanation, the manager will not accept the Colossus for review and return it to the adjuster. The adjuster must then make the corrections and corresponding entries in the claim file before returning the Colossus to the manager for a "revision".

Once the billings have passed this hurdle, they appear in the next review section of medical review program. Here, the adjuster once again reviews and determines the billings which will be accepted. This step allows the adjuster to independently opine which treatment dates or modalities may be reasonable or excessive. The adjuster will allow those treatments deemed reasonable and deny the others. This could result in denial of treatment dates during an accepted period of the treatment plan, denial of specific modalities found on any particular date, or the denial of treatment after a certain date. The adjuster may determine that after some date specific,

the treatment was excessive. The manager may also make this determination (especially where a "mist" or minor impact claim is involved) and reduce the medical billings allowed. The adjuster may have reason to only accept some medical billings due to some pro-ration issue (another accident is involved) and thereby reduce the amount of the billings accepted. The manager may also make this determination and reduce the total amount of accepted billings. If it is determined the adjuster is "overriding" the "medical review program too often and accepting treatment or billings, this could be a performance issue for the adjuster.

Colossus evaluation is divided into two basic forms. The standard "whiplash" type injuries evaluation uses a dissection form, which allows for the traditional findings in records and billings. The "demonstrable" type injuries require a different dissection form. Each dissection form is designed to assist the adjuster with the requested input by Colossus in arriving at an evaluation. The forms deny individual knowledge or experience when evaluating a claim. The attempt is to uniformly assess injury claim values in a specific geographic area. Thereby, removing the ability of an adjuster to increase or decrease a value based on specific knowledge of the dynamics of a particular claim, claimant, or attorney involved. Supposedly, this represents the benefit of the value of the claim not being dependent upon the experience, prejudice or personal opinion of the adjuster. It would no longer matter what experience level the adjuster is. All values would be consistent.

Colossus requires the adjuster to identify specific factors, which are documented in the medical records. It does this through a series of questions requesting either a "Yes or No" response or selection from a multiple-choice listing. Most of the responses are entered by an "x" in the provided box. The medical billings and loss of use expected are the only sections which allow numerical input other than those requesting time responses or responses to "how many".

Colossus will then determine a range of value for the claim. The adjuster prints this result and attaches it to the claim file. The evaluation by Colossus and the file are then reviewed by the manager. The manager does one of the following actions:

- Extends settlement authority
- Returns the Colossus to the adjuster for a revision due to errors or disagreement with the inputted data
- Returns the Colossus to the adjuster for additional information missing from the demand (i.e. records or billings, prior records)
- Requests a verbal discussion with the adjuster for clarification
- Then extends settlement authority
- Or returns for revision
- Or returns with request for additional records, billings or other information

Each revision demanded by the manager of an adjuster is tracked. A revision will count against the adjuster when their individual performance review is completed for merit consideration. When additional information is later determined by the adjuster to be relevant to the claim value, the Colossus is redone and "resubmitted" to the management. These additional requests for authority are also tracked for the adjuster and the manager. They are considered as a negative action and could result in having an affect on any merit consideration. A large number of Colossus are returned for revisions based solely on the personal opinion of the manager in the area of type of treatment, length of treatment, number of treatments during any period of time and disagreement with the accepted diagnosed injuries by the adjuster.

Knowing and understanding the process, programs and procedures that determine medical treatment and billings that are to be accepted is essential in today's dealings with the insurance industry. Absence of this knowledge will only produce frustration, anger, confusion and most importantly lack of payment or reimbursement for reasonable and necessary treatment.

Beyond the issues of shop ownership and control, the cash out program, the ADCP control of preferred/select one/PRO Shop/participating vendor program, and the estimatic policy of "Write only what you can see". Although, each of those procedures assist not only in securing the claim into the MIST programs, but, also significantly increase the net capturing as much as 90 percent more claims which would never meet the procedural requirements for a MIST claim.
There are three major formal programs currently in use throughout all insurers:

- MIST (Minor Impact Soft Tissue),
- "No damage, No injury", and
- State Farm's "Minor Impact Program"

The other insurers each have derivative programs based on these three successful ones. State Farm was the first to have a formal procedure for the handling of these types of accidents. "Minor Impact Program" was designed to identify, manipulate and control these claims all the way to jury verdict. Let me know if you'd like to see the outline of this I participated in creating in 1990. The subsequent and most attacked program was Allstate's MIST program formally instituted in 1993 and created by Kathy Hale of the Seattle Allstate MCO. Farmers followed trend with the "No Damage, No injury" program.

The programs were designed to weed out the easiest claims to dissuade at the onset of the claim. The programs are specifically tied to the SIU units of each insurer. For instance, a minor impact claim for Allstate receives 40 automatic points towards a SIU referral. 100 points is all you need to transfer the claim off your desk, out of your inventory and into the SIU unit. Of course, this also increases your opportunity to receive a bonus of $250.00 each quarter if you transfer 6 claims into the SIU. Another quick note: An adjuster receives increased performance points for each "Cash Out" completed in each quarter. An estimator receives performance points as well if the "Cash Out" is completed by them in the field. One more quick note: Each insurer has a program called the "Early Bird" or "Less than 30" or "Early Settlement" contests. These programs allow for bonuses to the adjuster who has the largest number of settlements within 30 days following the new assignment of a claim. They are designed for BI (Bodily Injury) claims. The easiest claims to be successful settling within the 30 day period are the minor impact claims. I'm sure you've seen Allstate's Quick Settlement Evaluation Guide. These claim settlements occur when the MIST duty adjuster meets with the claimant of a minor impact and settles the claim for less than established amounts on the QSEG or when the State Farm adjuster settles them for under $1,000.00. There's more, but I wanted you to understand the motivation for settlement of the initial adjuster handling this claim.

Although these programs were instituted some time ago, they were most successful because of the greed, avarice and laziness of the medical and legal communities. I'm definitely not saying the programs are ethical in any way. However, they only succeeded because no one really objected to them. Very few people outside the insurance industry even knew about them. But, it was the attitude of the medical and legal communities which allowed these programs to become so successful. Let me explain. Picture the Personal Injury legal community in which you practice. OK, now, remove from that community the 5 percent top law firms or attorneys whom you know are most ethical. (The ones, who are not practicing law for the 33.3 percent fee.) (The ones who would fight the fight for the client because it’s the right thing to do.)

Now, picture just one law firm in the remaining community. He or she is in the office on a Friday around 3pm and the receptionist notifies them an unscheduled possibly new client has just walked into the office. The attorney goes out to meet with the client. The questions are asked

which would define the possible claim. What happened—the client was rear ended while stopped at a stop sign. Was the other party insured—Yes, Allstate. Were you injured—Yes, whiplash. Have you seen a doctor—Yes a Chiropractor—one I've seen before. Has the property damage been resolved—Yes, I already got a check for $385.00, or $585.00 or any amount under $1,000.00. I'm sure you can picture what this attorney is about to say to this prospective client. The client states that the repairs haven't been done and asks if the attorney would like to see the damage. The attorney asks the client if he/she has approached the insurer concerning the injury claim. The client states that the insurer told him/her, they would give him $250.00 for his injury claim. This attorney politely advises the client, "I can't take your case. You might try the attorney in the next office, next street or next block."

The client may go to the Chiropractor first to seek treatment. The same questions come up and unless the client is in good standing with the Chiropractor or is associated with an attorney the Chiropractor has worked with, the Chiropractor will make a similar referral.

This scenario is not unusual or uncommon. In fact, it has become the norm in today's world. This has been going on since early to mid 90's and has provided the success of these programs. It has become reality because both the attorney and the Chiropractor are aware that almost certainly; they will not be successful in getting recovery from the insurer. I've heard some courageous but misguided attorneys state that they'd take on these types of cases and would file suit immediately. Most of those claims fail long before they reach a jury. Even those that do reach a jury rarely are successful. At least, they're not successful enough to substantiate the cost, energy, time and ultimate economic disaster which results. A few (very few—maybe as few as ten throughout the country) succeed in a successful jury award. The communities where juries are picked from have been persuaded through intelligent marketing by the insurance industry to believe that whiplash is not an injury, Chiropractors are witch doctors practicing black magic and plaintiff attorneys are greedy and unethical. That it is these minor impact soft tissue claims which drive the cost of insurance up. Of course, it's these ten successes which everyone talks about. Almost all fail. However, more success would be realized if the legal community was more familiar with partial summary judgment motions for the medical costs and how that affects the DOLF and GateKeeper programs. But, that's another whole discussion.

So, the programs were successful from the onset. Now, it was obvious to the insurance industry it simply had to cast a larger net. This is exactly what they did. Just when you think the explanation to the situation is simple, the insurance carriers complicate it. That's because there is more profit to be made if you cast a larger net and catch more claimants trapped in it. To enlarge the net, the insurance carriers had to establish either a wider parameter to include more claimants or avoid the holes which some claimants may be slipping out of the net. If they broadened the thresholds (such as including claims with $2,000.00 in property damage), it might result in a significant negative affect on the success of these claims. So, the answer is simple from a business perspective. Simply transform the $2,000 to $3,000 claims into $1,000 claims. That way the net is larger, but the risks don't change. Success can be realized in a larger number of claims. Even more importantly, the medical and legal communities will support this type of increase rather than if the insurance industry began including the $2,000 to $3,000 claims. In fact, the success will be guaranteed because of the way those two communities refuse to take on these claims.

This is exactly where the "Cash Out", "Early Bird Settlement" and "Write **Only** What You Can See" programs become so effective. Beginning with the "Write **Only** What You Can See" program, the insurer can capture a greater number of damaged vehicles into the net. By keeping the estimate less than $1000, a claimant is now exposed to the "Cash Out" and "Early Bird

Settlement" programs. How is the claimant to know if there is damage that is hidden? How would secondary damage or other significant and necessary repairs become a part of the claimant's knowledge base? After all, isn't the claimant dealing with "The Good Neighbor"? State Farm insures two out of five cars on the road today. In many instances, the claimant is also insured with State Farm.

By writing **Only** what can be seen, quite a bit of necessary repair costs are overlooked. Secondary damage hidden behind the unibody structure cannot be written on an estimate. If the car is not put up on a hoist so that the undercarriage can be seen, no repair estimate will be written for that damage. Often, estimates are written to include aftermarket parts rather than OEM parts. This procedure is extremely cost saving for the insurer. In fact, an estimator will have his performance rating directly affected depending on the percentage of estimates written with aftermarket parts. Another significant safety issue never written on any estimate by any insurer is for certified inspection by a qualified technician of the safety belts or locking devices unless there is visible damage. This is truly a significant omission on the part of insurers and is a direct violation of the policyholder's contract as well as intentionally not making all necessary repairs on the damaged claimant vehicle.

All vehicles from the early 90's include specific directions in the vehicle's "Owner's Manual" found in the glove box of every car, addressing the seat belts and locking devices. It will be stated in these manuals that the seat belt locking device is designed for one use only. This means that once, an accident has occurred, the seat belt locking device will not function properly again. The manuals go on to say that it doesn't matter whether the seat belt is being worn or not. Once, the vehicle has been involved in an accident it simply will not perform as it was initially designed. In fact, the seat belt locking device could fail in the next accident so as to allow more significant injuries including death. Of the vehicles on the road today, 60 percent state in the "Owner's Manual" that the seat belt locking device must be replaced, period. This means every seat belt locking device in the vehicle, not just the one being worn at the time of the impact. The remaining 40 percent of vehicles on the road today state in the "Owner's Manual" that all seat belt locking devices in the vehicle including those not being worn at the time of the accident must be inspected by a certified and qualified technician to assure future adequate and safe function. (I would encourage you to check your vehicle's "Owner's Manual" and be familiar with its service requirements on this issue.)

All insurers are aware of this issue. At State Farm, we received the engineering reports of several vehicle manufacturers on this issue. However, at State Farm, in an "R&R" publication (State Farm internal property damage estimatic publication provided to Estimating Superintendents and executives only.) it states that we are aware of this opinion. However, we have decided to do our own testing before we initiate any response to this safety issue. In a subsequent "R&R" publication, it was stated that the company would continue with its internal procedure of testing seat belt safety in the following manner by its own estimators not certified or qualified technicians:

- Observe the belt for any tears or stretch marks.
- Observe any direct damage to the casing for the locking device.
- Jerk on the belt to assure that it locks (This should be done while the vehicle is moving and has achieved at least 10 mph)

I'm sure you're aware that none of the estimators took each and every vehicle out for a test run so that while they were driving the estimator could jump from seat belt to seat belt jerking on it. Also, there are no tools to remove the covering of the seat belt locking device so as to inspect the

locking devices of each belt. Even if we did have the tools, what were we supposed to be looking at? No estimator or Re-inspector has ever been certified as a qualified technician in this area. I know there are none employed at any body shop either. These individuals are employed only at a few select vehicle dealers. Since, the insurance industry won't pay for the procedure; there is no motivation for the expense and time to be assumed by any body shop. Even if the insured, claimant or shop were to request payment, the insurer will advise them in writing that it is not their procedure to pay for this inspection unless damage is found that can be directly related to the accident in question. Of course, if a body shop requests payment, it would have to be on a supplement and that brings us back to the issues of shop ownership and control, the cash out program, the ADCP control of preferred/select-one/PRO Shop/participating vendor program, and the estimatic policy of "Write only what you can see".

Supplements are exactly what they imply. When a shop is working off an estimate written by an insurer or even off their own written estimate, if there are additional repair issues or costs, the shop will send those over to the insurer for approval and payment on a supplement. All shops working within any of the programs established by the insurance industry must agree to repair all vehicles according to the written estimates or by pre-approved supplement. The insurer controls the payment and authority to grant repairs beyond the initial estimate. If a shop does not get pre-approval, it will not be paid for the repairs (with some exceptions). An estimator's performance rating will be directly affected by the number of supplements submitted on estimates written by him/her. This is almost in direct opposition to "Write Only What You Can See". Therefore, the estimator is highly motivated to encourage "Cash Outs". The estimator works directly with the shops and closely monitors the number of supplements requested by a shop. A shop can be removed from the approved vendor listing or preferred vendor listing if it has too many supplement requests or supplement requests which are not allowed. The outcome is obvious. Shops don't write for seat belt or locking device inspection. Few shops are even aware of vehicle owner's manual requirements in this area. But, one thing each and every body shop is aware of, their economic livelihood is dependent on each insurer's referrals and payments.

WHAT TO DO

If you are aware that your client's claim is being handled by a MIST (Minor Injury Soft Tissue) or Low Damage or Minor Damage adjuster, you should identify why the claim should not be handled in this procedure based on the following issues. You will need to know who these adjusters are in your area and for each company. The window of time which exists for you to have the claim transferred back into the normal population of claim handling is within the first 30 to 45 days of the notice of claim or within 30 to 45 days after the insurer has received your letter of representation. Therefore, if at all possible have as many of the following points addressed in your first correspondence to the insurer for best results.

The minor impact adjuster has extensive responsibilities required in the investigation and handling of these claims. If at all possible, they will appreciate the opportunity to transfer the claim from their desk and back into the normal population of claims. However, they will only be motivated to do so if they haven't already invested a great deal of time completing the required steps of investigation associated with these types of claims. They will also need as much assistance from you in identifying as many of the following points which exist in order to receive permission from their supervisor to transfer the claim.

POINTS OR ISSUES

1. The target vehicle has greater than $1,000.00 in repair costs. Repair costs may differ from repair estimates. Get multiple repair estimates to include frame time cost and OEM parts.

2. The bullet vehicle has greater than $1,000.00 in repair costs. Repair costs may differ from repair estimates. Get multiple repair estimates to include frame time cost and OEM parts.

3. The target vehicle's rear bumper absorbers have moved more than one inch. This should be memorialized with a 35mm photograph if possible.

4. The target vehicle's rear bumper absorbers have not moved at all and there is rust visible on the absorber armature. This should be memorialized with a 35mm photograph if possible.

5. The bullet vehicle submarined the target vehicle resulting in undercarriage damage but little visible damage to the unibody of the target vehicle.

6. The target vehicle requires greater than two hours of frame repair time. If at all possible, also document this with a certified frame inspection. Often times this is overlooked when the insurance carrier completes the estimate. They are taught to write only what can be seen. They are also taught to attempt a "Cash Out" settlement if at all possible and receive bonuses for doing so.

7. The bullet vehicle requires greater than two hours of frame repair time. If at all possible, also document this with a certified frame inspection. Often times this is overlooked when the insurance carrier completes the estimate. They are taught to write only what can be seen. They are also taught to attempt a "Cash Out" settlement if at all possible and receive bonuses for doing so.

8. The damage to the target vehicle travels beyond the rear wheel well. This should be documented by a 35mm photograph taken along the side of the vehicle. Often times this is overlooked when the insurance carrier completes the estimate. They are taught to write only what can be seen. They are also taught to attempt a "Cash Out" settlement if at all possible and receive bonuses for doing so.

9. Negligence is being disputed. This will not remove the claim from a minor impact program. However, it will assist in the determination to transfer it if other issues are present.

10. Multiple cars were involved in the accident. A police report will substantiate this. This is particularly effective when there are other vehicles with significant damage.

11. There are statements or facts, which support that there were multiple impacts to the target vehicle. This can be evidenced by statements from the drivers of either vehicles or their passengers or witnesses.

12. There is significant prior damage to the same impact area of the target vehicle.

13. The target vehicle was not a unibody vehicle.

14. The target vehicle has an attached item, which would eliminate the effectiveness of the unibody and/or low impact bumper. This is often seen when the target vehicle has a trailer hitch directly mounted onto the frame of the vehicle. Also, watch for items such as bicycle carriers, wheelchair lifts or other such devices, which would eliminate the functionality of the low impact bumper or unibody structure.

15. The bullet vehicle has an attached item, which would eliminate the effectiveness of the unibody and/or low impact bumper. It may also occur when there is a winch mounted on the front of the bullet vehicle. Also, watch for items such as bicycle carriers, wheelchair lifts or other such devices, which would eliminate the functionality of the low impact bumper or unibody structure.

16. The accident involves aggravated liability on the part of the bullet vehicle. This is evidenced by the police report documenting the insured left the scene of the accident, that alcohol was involved, that speed was involved, etc.

17. The target or bullet vehicles have injured parties who have demonstrable injuries.

18. The target vehicle injured party (your client) has suffered a subsequent demonstrable injury.

The "Target" vehicle is the one that was struck. The "Bullet" vehicle is the one that struck the target vehicle.

A REVIEW OF THE LITERATURE REFUTING THE CONCEPT OF MINOR IMPACT SOFT TISSUE INJURY (M.I.S.T.)

Christopher J. Centeno, M.D.
Michael Freeman, PhD, M.P.H., D.C.
Whitney L. Elkins, M.P.H.

Short Title: Refuting the M.I.S.T Concept

Address for Correspondence:
The Spinal Injury Foundation
c/o The Centeno Clinic
11080 Circle Point Road, Suite 140
Westminster, CO 80020 USA
Phone: 303-429-6448 x119
Fax: 303-429-6373
Email: centenooffice@centenoclinic.com

M.I.S.T. is a acronym that stands for Minor Impact Soft-Tissue. The concept refers to the claim that low damage impacts cannot be associated with significant injuries. The literature concerning late whiplash is reviewed. This review focuses on medical research which refutes the M.I.S.T. concept.

Background: Minor Impact Soft Tissue is a concept that seeks to identify late whiplash as a psychosocial phenomenon. However, the medical literature in this area has not been systematically reviewed since the Quebec Task Force in 1995.

Objectives: To review the medical literature which claims that late whiplash is an organic phenomenon causing significant disability.

Methods: The medical literature was reviewed in a narrative format.

Results: There are a significant number of studies which refute the M.I.S.T. concept.

Conclusions: A review of the literature does not support the validity of M.I.S.T. In the mid nineteen nineties, the U.S. automobile insurance industry launched a new concept in claims handling called M.I.S.T., an acronym for Minor Impact Soft Tissue. The theory behind this claims stance was that it was virtually impossible to sustain a permanent or serious injury in a low damage car crash. As a result, these claims should be handled differently. This new concept has expanded to almost all major U.S. insurers, yet little has been published regarding its scientific validity. For many patients with objective physical exam findings but little automobile property damage, this policy has led to loss of insurance coverage for their injuries.

The Medical Literature Concerning Minor Impacts

Early studies suggested that the g-forces involved in low damage crashes were comparable to those commonly seen with normal everyday activities of daily living.[1] This concept was driven home by the Quebec Task Force in 1995.[2] This report seemed to demonstrate that whiplash was a short lived and self-limited condition that didn't require more than supportive care. In addition, other similar reports suggested that late whiplash didn't exist in countries where there is no legal system to recover damages. [3] In addition, more recent studies performed in Saskatchewan suggested that when the ability to sue for pain and suffering was removed, the duration of the insurance claim for medical coverage was reduced.[4] Based on this information, it would then seem reasonable that insurers would adopt the M.I.S.T. policy. However, since multimillion dollar decisions relay on this policy, the validity of the research in support of M.I.S.T. must be vetted.

Freeman was the first to point out that many of the studies refuting the existence of late whiplash had very poor methodology.[5] This author also published a research critique of the Quebec Task Force and the Saskatchewan study.[6] [7] which demonstrated that this research also suffered

from flaws in methodology. As a result, the conclusions of these studies were called into question. In light of this information, the foundation for the M.I.S.T. needs further investigation.

The Literature Linking Low Damage High Energy Crashes to Serious Injury

A major building block of the foundation for M.I.S.T. relies on the concept that vehicle damage and occupant damage must be closely linked. Said another way, there must be a linear relationship between how hard a vehicle is struck (delta V or change in velocity) and serious injury rates. However, as a research question this phenomenon is very difficult to study. Up until recently, staged crashes were the only way any information regarding delta V and injury rates could be gleaned. However, staged crashes are specifically designed not to injure the participants. Therefore, staged crashes are a poor place to study injury rates.

The advancement in technology has provided an opportunity for these questions to be answered in a real world crash setting. Krafft has now studied the relationship between real world delta V as measured by "Black Boxes" installed inside many vehicles and chronic injuries.[8] While one would expect a linear relationship, none was found. For instance, chronic injury rates at delta V's of 5-10 km/h were twice that of 10-15 km/h! In addition, again chronic injury rates at 15-20 km/h were twice the rates seen at 20-25 km/h delta V's. These rates likely relate to the stiffness and elasticity of the vehicle and the complex interplay of seat design, occupant mass, occupant position, and vehicle dynamics. In addition, Krafft also discovered a much higher AIS 1 (WAD II or WAD III) chronic injury rate in the presence of a tow-hitch. This external factor hints at a list of complex kinematics that the M.I.S.T. program does not utilize to determine injury risk. Finally, in the same study, Krafft also concluded, "The two crashes which resulted in long-term disabling neck injuries had the highest peak acceleration (15 and 13 x g), but not the highest change of velocity." This is again very concerning for the M.I.S.T. methodology, as it demonstrates serious neck injury resulting from high peak accelerations in high energy, but low damage and low delta V settings. Brault et al produced similar findings when investigating rear end collisions.[9] Their conclusions are also concerning for M.I.S.T.: "Objective clinical deficits consistent with whiplash associated disorders (WAD) were measured in both men and women subjects at both 4 km/h and 8 km/h. At 4 km/h, the duration of symptoms experienced by women was significantly longer when compared with that in men ($p < .05$). There were no significant differences in the presence and severity of WAD between men and women at 4 km/h and 8 km/h or in the duration of WAD at 8 km/h. There was also no significant difference in the presence, severity, and duration of WAD between 4 km/h and 8 km/h. No preimpact measures were predictive of WAD." In summary, Brault again concluded that trying to tie delta V to injury rates didn't work. Siegmund again echoed the same findings while trying to create a model of rear end crash dynamics and long-term injury risk.[10] Again, there was no connection between delta V and injury risk. Finally, Davis in a meta-analysis of the medical literature on delta-V and long-term injury risk reached the same conclusion.[11]

Why is this uncoupling of crash damage and long-term injury rates occurring? Some clues can be found in studies presented at international congresses that show that vehicle stiffness has increased to reduce property damage in low speed crashes. However, the vehicle is only one parameter. Much more attention recently has been paid to seat back design in rear end crashes. Viano has concluded that one reason whiplash injuries are increasing is that seats have been made stiffer to avoid rearward occupant ejection in a seat back failure.[12] As seats are made stiffer, the shear forces (NIC) on the neck increase. In addition, newer studies by the same author suggest that for females, a lower relative mass as compared to seat back stiffness may play a role in serious neck injury at low speeds.[13] Head restraint characteristics are also likely involved.

Clearly, the lack of a direct link between delta V and long-term AIS 1 neck injury rates calls into question the validity of a no damage, no injury policy.

The Literature that Defines Late Whiplash as a Serious Medical Condition

If late whiplash is a short-term mild muscle pull that should always resolve on its own with only supportive care, then the M.I.S.T. policy would again seem reasonable. However, if data exists that this injury is more serious, then again M.I.S.T. would be called into question.

The early medical literature for late whiplash is clearly supportive of a M.I.S.T. policy. The focus was on a muscle strain and possibly a ligament sprain. Hence the name sprain-strain was commonly used. Compared to other muscle strains such as a hamstrings injury, whiplash seemed to have an excessively long recovery time that could only be explained by psychological problems.[15-22] In addition, at that time, little was known about the central nervous system and pain and spinal ligament injuries that did not require surgery.

However, in the last decade, much been learned about what is injured in late whiplash patients. As a result, the landscape has been significantly altered. What we would previously call a "soft-tissue" injury has now been redefined into numerous injury categories.

Seminal studies by Taylor and Twomey demonstrated that serious spinal injuries could be detected on cadaver dissection.[23-25] These patients had all died of other causes such as blunt abdominal trauma, yet many seemed to have very serious spinal injuries. These injuries included bleeding into the dorsal root ganglia, small fractures of the facet joints, bleeding into the facet joints, and other injuries. While these insults could be easily detected on dissection, they couldn't be detected on more advanced imaging.

In-vitro studies by Grauer and Panjabi were also telling. In simulated low speed rear end collisions, they demonstrated facet joint spearing in the cervical spine as well as significant ligament stretch injury to the anterior longitudinal ligament and facet joint capsules.[26-28] Other authors have now confirmed these findings and added to the database of significant joint and ligament injuries that occur at low speeds.[29, 30] In addition, these findings have also been confirmed in live volunteers in simulated low speed crash tests.[31] If the cervical facet joints were injured, then clinical studies would have to confirm that these joints were pain generators in a late whiplash population. Indeed, numerous studies have now confirmed that when these joints are anesthetized and treated, both short-term and long-term relief is the result.[32-35] In addition, when double blinded prevalence studies are reported, approximately 50% of patients with late whiplash have been found with injured neck joints.[36]

More recently, central sensitization has been the focus of late whiplash research. The early studies above demonstrating injury to the dorsal root ganglion as well as crash research by Svensson showing injury to the same structure, has moved researchers to take a closer look at neurologic injury.[37-40] It has been noted by numerous researchers that late whiplash patients have different sensory thresholds than normal controls.[41-46] These patients show increased sensitivity to a variety of stimuli including pressure, light vibration, heat and cold, not only in the neck but also in body areas remote to the site of pain such as the front of the shin. This means that they feel things differently than someone with a normal sensory system. Importantly in those patients who fail to recover following injury, these sensory changes have been shown to be present from very soon after injury. As outlined above, the prevailing opinion in that this is due to sensitization of the central nervous system. For instance, recent research has correlated elevated levels of a protein only released in CNS injury with more severely injured whiplash

patients.[47] However, more surprising is that serum muscle injury markers are not elevated in whiplash patients, indicating that the muscle strain part of the whiplash theory espoused early on is likely not valid.[48]

Finally, as above, investigators over the last decade have reported that serious ligament injury is likely one cause of late whiplash injury. MRI indicators of upper cervical ligament injuries in the alar, transverse ligament, posterior atlanto-occipital membrane and tectorial membranes have been found in late whiplash patients but not in controls.[49-52] In addition, significant lower cervical ligament injury has also been reported by multiple authors both in vitro cadaver studies and in real world imaging studies.[29, 53-58] From all of the above evidence it can be seen that, at least in some patients, whiplash is a complex, multifaceted condition that requires a suitable classification system to address these complexities.

Long-term Prognosis for Late Whiplash Injury

If late whiplash is more than a muscle pull or mild sprain, then are these problems minor "soft-tissue" injuries or do they have a major functional impact?

Berglund has looked at this issue in a large epidemiologic study where several hundred patients who sought specialist care for a rear end crash were compared to several thousand people not exposed to such a crash. Seven years after the crash, there was a 160%-370% increased risk for headache, thoracic and low back pain, as well as for fatigue, sleep disturbances and ill health.[59] The same type of investigation found a threefold increased risk for neck and shoulder pain seven years after a rear end crash exposure.[60] In addition, Squires reported on a group followed for 15.5 years.[61] 70% of these patients continued to report symptoms related to the original crash. Between years 10 and 15.5, 18% had improved, while 28% had worsened and 54% had stayed the same. Finally, Bunketorp conducted a similar investigation seventeen years after a crash.[62] She found that when patients who sought specialty care for injuries reported in an ER were compared to patients also seen in the ER but with no MVC related complaints, that the disability rate in the injury group was 30-35% while the non-injury group reported an injury rate of only 6%.

Is M.I.S.T. Still Scientifically Viable?

While many authors have published studies that would seem to support the M.I.S.T. hypothesis, the vast majority of work published in the last 10 years would not support M.I.S.T. Assuming an insurer must take the position that policyholder must at all times be given the benefit of the doubt; the M.I.S.T. program does not have overwhelming scientific support. We would argue that its time to retire M.I.S.T. in favor of a research based severity indexing approach that allows insurers to better allocate resources.

1. Allen, M.E., et al., *Acceleration perturbations of daily living. A comparison to 'whiplash'.* Spine, 1994. 19(11): p. 1285-90.

2. Spitzer, W.O., et al., *Scientific monograph of the Quebec Task Force on Whiplash-Associated Disorders: redefining "whiplash" and its management.* Spine, 1995. 20(8 Suppl): p. 1S-73S.

3. Schrader, H., et al., *Natural evolution of late whiplash syndrome outside the medicolegal context.* Lancet, 1996. 347(9010): p. 1207-11.4. Cassidy, J.D., et al., *Effect of eliminating compensation for pain and suffering on the outcome of insurance claims for whiplash injury.* N Engl J Med, 2000. 342(16): p. 1179-86.

5. Freeman, M.D., et al., *A review and methodologic critique of the literature refuting whiplash syndrome.* Spine, 1999. 24(1): p. 86-96.

6. Freeman, M.D., A.C. Croft, and A.M. Rossignol, *"Whiplash associated disorders: redefining whiplash and its management" by the Quebec Task Force. A critical evaluation.* Spine, 1998. 23(9): p. 1043-9.

7. Freeman, M.D. and A.M. Rossignol, *Effect of eliminating compensation for pain and suffering on the outcome of insurance claims.* N Engl J Med, 2000. 343(15): p. 1118-9; author reply 1120.

8. Krafft, M., et al., *How crash severity in rear impacts influences short- and long-term consequences to the neck.* Accid Anal Prev, 2000. 32(2): p. 187-95.

9. Brault, J.R., et al., *Clinical response of human subjects to rear-end automobile collisions.* Arch Phys Med Rehabil, 1998. 79(1): p. 72-80.

10. Siegmund, G.P., J.R. Brault, and J.B. Wheeler, *The relationship between clinical and kinematic responses from human subject testing in rear-end automobile collisions.* Accid Anal Prev, 2000. 32(2): p. 207-17.
11. Davis, C.G., *Rear-end impacts: vehicle and occupant response.* J Manipulative Physiol Ther, 1998. 21(9): p. 629-39.
12. Viano, D.C., *Seat properties affecting neck responses in rear crashes: a reason why whiplash has increased.* Traffic Inj Prev, 2003. 4(3): p. 214-27. 13. Viano, D.C., *Seat influences on female neck responses in rear crashes: a reason why women have higher whiplash rates.* Traffic Inj Prev, 2003. 4(3): p. 228-39.
14. Tencer, A.F., S. Mirza, and K. Bensel, *The response of human volunteers to rear-end impacts: the effect of head restraint properties.* Spine, 2001. 26(22): p. 2432-40; discussion 2441-2.
15. Young, W.H., Jr. and J.H. Masterson, *Psychology, organicity, and "whiplash".* South Med J, 1962. 55: p. 689-93.
16. Fujinami, S., *[A study on the treatment-resistant whiplash injuries with special reference to psychosocial aspect].* Seishin Shinkeigaku Zasshi, 1971. 73(1): p. 1-26.
17. Schild, R. and C. Bloch, *[Problem patient in rheumatology].* Schweiz Med Wochenschr, 1971. 101(8): p. 299-303.
18. Hinoki, M., et al., *"Neurotic vertigo" from the standpoint of neurotology.* Agressologie, 1978. 19(4): p. 269-86.
19. Roy, R., *Many faces of depression in patients with chronic pain.* Int J Psychiatry Med, 1982. 12(2): p. 109-19.
20. Mendelson, G., *Follow-up studies of personal injury litigants.* Int J Law Psychiatry, 1984. 7(2): p. 179-88.
21. Merskey, H., *Psychiatry and the cervical sprain syndrome.* Can Med Assoc J, 1984. 130(9): p. 1119-21.
22. Merskey, H., *The importance of hysteria.* Br J Psychiatry, 1986. 149: p. 23-8. 23. Twomey, L.T., J.R. Taylor, and M.M. Taylor, *Unsuspected damage to lumbar zygapophyseal (facet) joints after motor-vehicle accidents.* Med J Aust, 1989. 151(4): p. 210-2, 215-7.
24. Taylor, J.R., L.T. Twomey, and B.A. Kakulas, *Dorsal root ganglion injuries in 109 blunt trauma fatalities.* Injury, 1998. 29(5): p. 335-9.
25. Taylor, J.R. and L.T. Twomey, *Acute injuries to cervical joints. An autopsy study of neck sprain.* Spine, 1993. 18(9): p. 1115-22.
26. Grauer, J.N., et al., *Whiplash produces an S-shaped curvature of the neck with hyperextension at lower levels.* Spine, 1997. 22(21): p. 2489-94.
27. Panjabi, M.M., et al., *Mechanism of whiplash injury.* Clin Biomech (Bristol, Avon), 1998. 13(4-5): p. 239-249.
28. Panjabi, M.M., et al., *Capsular ligament stretches during in vitro whiplash simulations.* J Spinal Disord, 1998. 11(3): p. 227-32.
29. Yoganandan, N., F.A. Pintar, and J.F. Cusick, *Biomechanical analyses of whiplash injuries using an experimental model.* Accid Anal Prev, 2002. 34(5): p. 663-71.
30. Yoganandan, N., F.A. Pintar, and M. Klienberger, *Cervical spine vertebral and facet joint kinematics under whiplash.* J Biomech Eng, 1998. 120(2): p. 305-7.
31. Kaneoka, K., et al., *Motion analysis of cervical vertebrae during whiplash loading.* Spine, 1999. 24(8): p. 763-9; discussion 770.
32. Barnsley, L., S. Lord, and N. Bogduk, *Whiplash injury.* Pain, 1994. 58(3): p. 283-307. 33. Lord, S.M., et al., *Percutaneous radio-frequency neurotomy for chronic cervical zygapophyseal-joint pain.* N Engl J Med, 1996. 335(23): p. 1721-6.
34. Bogduk, N. and R. Teasell, *Whiplash: the evidence for an organic etiology.* Arch Neurol, 2000. 57(4): p. 590-1.
35. McDonald, G.J., S.M. Lord, and N. Bogduk, *Long-term follow-up of patients treated with cervical radiofrequency neurotomy for chronic neck pain.* Neurosurgery, 1999. 45(1): p. 61-7; discussion 67-8.
36. Lord, S.M., et al., *Chronic cervical zygapophysial joint pain after whiplash. A placebo-controlled prevalence study.* Spine, 1996. 21(15): p. 1737-44; discussion 1744-5.
37. Svensson, M.Y., et al., *Neck injuries in car collisions--a review covering a possible injury mechanism and the development of a new rear-impact dummy.* Accid Anal Prev, 2000. 32(2): p. 167-75.
38. Svensson, M.Y., et al., *[Nerve cell damages in whiplash injuries. Animal experimental studies].* Orthopade, 1998. 27(12): p. 820-6.
39. Ortengren, T., et al., *Membrane leakage in spinal ganglion nerve cells induced by experimental whiplash extension motion: a study in pigs.* J Neurotrauma, 1996. 13(3): p. 171-80.
40. Eichberger, A., et al., *Pressure measurements in the spinal canal of post-mortem human subjects during rear-end impact and correlation of results to the neck injury criterion.* Accid Anal Prev, 2000. 32(2): p. 251-60.
41. Moog, M., et al., *The late whiplash syndrome: a psychophysical study.* Eur J Pain, 2002. 6(4): p. 283-94.
42. Sterling, M., J. Treleaven, and G. Jull, *Responses to a clinical test of mechanical provocation of nerve tissue in whiplash associated disorder.* Man Ther, 2002. 7(2): p. 89-94.
43. Sterling, M., et al., *Sensory hypersensitivity occurs soon after whiplash injury and is associated with poor recovery.* Pain, 2003. 104(3): p. 509-17.
44. Sterling, M., *A proposed new classification system for whiplash associated disorders-implications for assessment and management.* Man Ther, 2004. 9(2): p. 60-70.
45. Sterling, M., et al., *Characterization of acute whiplash-associated disorders.* Spine, 2004. 29(2): p. 182-8.
46. Curatolo, M., et al., *Central hypersensitivity in chronic pain after whiplash injury.* Clin J Pain, 2001. 17(4): p. 306-15.
47. Guez, M., et al., *Nervous tissue damage markers in cerebrospinal fluid after cervical spine injuries and whiplash trauma.* J Neurotrauma, 2003. 20(9): p. 853-8.
48. Scott, S. and P.L. Sanderson, *Whiplash: a biochemical study of muscle injury.* Eur Spine J, 2002. 11(4): p. 389-92.
49. Krakenes, J., et al., *MRI assessment of the alar ligaments in the late stage of whiplash injury--a study of structural abnormalities and observer agreement.* Neuroradiology, 2002. 44(7): p. 617-24.
50. Krakenes, J., et al., *MRI of the tectorial and posterior atlanto-occipital membranes in the late stage of whiplash injury.* Neuroradiology, 2003. 45(9): p. 585-91.
51. Krakenes, J., et al., *MR analysis of the transverse ligament in the late stage of whiplash injury.* Acta Radiol, 2003. 44(6): p. 637-44.
52. Krakenes, J., et al., *MRI of the posterior tectorial and atlanto-occipital membranes in the late stage of whiplash injury.* Neuroradiology, 2004. 46(2): p. 167-8.
53. Dvorak, J., et al., *Clinical validation of functional flexion/extension radiographs of the cervical spine.* Spine, 1993. 18(1): p. 120-7.
54. Griffiths, H.J., et al., *Hyperextension strain or "whiplash" injuries to the cervical spine.* Skeletal Radiol, 1995. 24(4): p. 263-6.
55. Kristjansson, E., et al., *Increased sagittal plane segmental motion in the lower cervical spine in women with chronic whiplash-associated disorders, grades I-II: a case-control study using a new measurement protocol.* Spine, 2003. 28(19): p. 2215-21.
56. Stemper, B.D., N. Yoganandan, and F.A. Pintar, *Gender dependent cervical spine segmental kinematics during whiplash.* J Biomech, 2003. 36(9): p. 1281-9.
57. Stemper, B.D., N. Yoganandan, and F.A. Pintar, *Intervertebral rotations as a function of rear impact loading.* Biomed Sci Instrum, 2002. 38: p. 227-31.
58. Yoganandan, N., et al., *Whiplash injury determination with conventional spine imaging and cryomicrotomy.* Spine, 2001. 26(22): p. 2443-8.
59. Berglund, A., et al., *The association between exposure to a rear-end collision and future health complaints.* J Clin Epidemiol, 2001. 54(8): p. 851-6.
60. Berglund, A., et al., *The association between exposure to a rear-end collision and future neck or shoulder pain: a cohort study.* J Clin Epidemiol, 2000. 53(11): p. 1089-94.

61. Squires, B., M.F. Gargan, and G.C. Bannister, *Soft-tissue injuries of the cervical spine. 15-year follow-up.* J Bone Joint Surg Br, 1996. 78(6): p. 955-7.
62. Bunketorp, L., L. Nordholm, and J. Carlsson, *A descriptive analysis of disorders in patients 17 years following motor vehicle accidents.* Eur Spine J, 2002. 11(3): p. 227-34.

CHIROPRACTIC CARE AND THE INSURANCE INDUSTRY QUICK GUIDE

The insurance industry has aggressively revolutionized its practices and procedures over the last two decades. This revolution has adopted the use of computer programs (Colossus, Decision Point, ICE, AIM, ADP, MBRS, Med-Data and Mitchell Medical Expert), which allow the insurance industry to reduce the payout of claims. It has also had a direct impact on:

1. The number of claim files each insurer's employees can handle,
2. What amount of training is needed for the claim handlers to be most effective in reducing the claim payout?
3. Reducing the number of experienced and higher salaried employees,
4. Eliminating individual analysis by a claim handler based on experience and intelligence,
5. Standardizing the process by which each claim is reviewed and processed.
6. Increasing the profits of each insurer by the reduction of both first party and third party severity payments.

Unfortunately, the Chiropractic community has, to a great degree, assisted the insurance industry in its success. During the last two decades, the insurance industry has capitalized on the unreadable and inaccurate chart notes produced by Chiropractors. This alone has allowed the insurance industry to attack treatment duration, type and frequency of all Chiropractic physicians. In the absence of accurate and proper documented patient daily chart notes, the Chiropractic community is finding itself receiving less than full reimbursement for their patient treatment. The Chiropractor of today is forced to accept a reduced payment from the insurers on first party claims. The Chiropractor of today is repeatedly asked to accept a discounted payment from the attorney representing the patient on a third party claim because the claim settlement payment was significantly less than expected.

Is it any wonder that this is occurring to Chiropractors more so than any other rehabilitating physician? The answer to this question is, NO. Consider for just a moment what percentage of claims presented to the insurance industry are "soft tissue". Some insurers claim over 80% percent of all claims are "soft tissue". This huge body of "soft tissue" claims is more often than not receiving treatment from Chiropractors. Again, most insurers recognize the Chiropractic involvement in treating these types of claims exceeds 80%. This natural progression of type of claims, number of claims and treating physician for these claims has been the impetus to the insurance industry's focus on Chiropractic treatment costs. By reducing the cost of Chiropractic treatment costs, the insurance industry has and will continue to realize immeasurable reduction of claim payout and increased profits.

The focus of the insurance industry will not diminish in the future. In fact, with the introduction of computer programs capable of making claim decisions that reduce Chiropractic treatment costs and subsequently, third party claim settlement costs, the insurance industry is motivated to become even more aggressive in the future. Until such time as the Chiropractic community begins to adopt some very simple practices, it will continue to be the victim of this trend.

The solution is now available for the Chiropractor to address and realize full reimbursement of patient treatment. It begins with proper daily chart note recording. It would help a great deal if this was also readable. The eight most important issues in any claim for the insurance industry are the following:

1. Correct use of ICD-9 and CPT codes,
2. Proper identification of injuries,
3. Identification of **all** injuries (even those the physician isn't treating),
4. Correct documentation of all symptomology,
5. Manifestations (Duties under Duress and Loss of Enjoyment,
6. Accurate prognosis with consideration for **active** as well as passive treatment,
7. Documentation of daily **active** as well as passive treatment,
8. Probable or Definite determination of future treatment,
9. Documentation of specific body part reaching MMI
10. Determination of impairment ratings.

Some of this information the insurance industry requires to be validated by a medical doctor. Unfortunately, the insurance industry currently places more credibility in medical doctors than Chiropractors. This isn't a medical fact. It's a fact of the insurance industry's procedures, practices and training. Fighting that battle today won't reflect a full payment of treatment tomorrow. Not that the battle isn't worth fighting, it just won't realize an immediate success.

The solution also involves the Chiropractor understanding the insurance industry's accepted computer program terminology, injury definition, acceptable symptomology, prognosis and manifestations. There are points assessed to each aspect of these categories which allow the insurance industry's programs to accept or deny payment and credibility of Chiropractic treatment in determining claim value. This information can be acquired by extensive investigation and education by the individual Chiropractor. However, it would be unlikely the Chiropractor would ever realize complete knowledge absent being employed in the insurance industry. The answers can also be found in software currently available to the Chiropractic community. The only software which enables the Chiropractor full knowledge and user friendly access to this information is sold by Sequoia Visions, Inc. Of course, being owner and president of Sequoia Visions, Inc., might influence my preference of software.

In an attempt to educate and assist the Chiropractic community, I have created a "Quick Review" of issues to consider when completing daily chart notes. I was also limited in the amount of space allotted to this endeavor. Subsequently, the following listing developed specifically for this article. I hope that you find it both educational and surprisingly succinct. I would strongly recommend that each Chiropractor include the issues as presented on this listing in daily practice and patient recording. The result will be amazingly successful each Chiropractor who does.

Thank you for inviting me to address some of the obstacles Chiropractors are facing today. I would be happy to provide more information in future articles. More information on these issues and the Sequoia Vision's software may be found at www.SequoiaVisions.com.

QUICK REVIEW

1. Remember to put **all correct** CPT and ICD-9 codes in your records.

    - Identification of all injuries (Even those not being treated within your scope of practice) is necessary for acceptance of all treatment (duration, type and frequency);
    - Number and type of injuries drive the program;
    - Use of "Initial report" or supplemental HCFFA forms to include all injuries should be normal course of business with first submission of billings;
    - Values are assigned to the injuries, symptomology, treatment, prognosis, manifestations, impairment and the specific future treatments needs of the patient;
    - Injury diagnoses without treatment carry little value. However, it often does support further duration, frequency and/or type of treatment;

2. Document on an ongoing basis Duties under duress manifestations which result from ongoing complaints while activities continue to be performed in the areas of work, study, domestic or household.

- These are specific terms which trigger points and value in the systems being utilized by the insurance Industry.

3. Document on an ongoing basis all information about additional manifestations due to Loss of enjoyment of work, study, domestic and household activities as well as sporting opportunities. Sporting activities must be additionally separated out into as many 5 sub categories.

   - These are specific terms which trigger points and value in the systems being utilized by the insurance Industry.

4. Remember if isn't in your notes, as far as the insurance industry is concerned, it didn't happen.

   - Often, what is missing from treating physician daily notes are the end dates of symptoms and active treatment being performed by the patient (example of active treatment would be home exercise or home traction).

5. Always document all of the objective findings on each treatment date.

   - The insurance programs work based upon the last treatment date that the objective symptom is recorded in the physician's daily records. This is very similar to how these programs use the last date of recorded symptomology and manifestation.

6. Type of care is entered into the insurance programs based on type of treatment being provided. The care may be entered into these programs based on the CPT and description of care in the daily chart notes.

   - Chiropractic office visits and manipulations are entered as a chiropractic treatment date. When there are therapies such as massage therapy, exercise, or physical therapy being provided and documented (even if there is no charge for the correctly identified treatment), this allows for additional entries into the insurance programs as additional treatment dates or duration depending on the CPT code and description. This includes active treatment being performed by the patient at home.

7. Follow chiropractic standards on evaluations, re-evaluations and scope of treatment.

   - Failure to follow recommended procedures and guidelines could have adverse effect on the duration, frequency and type of treatment accepted as reasonable and necessary. In some cases, it may be cause for referral of the claim to the SIU or fraud units of the insurer.

8. Impairment and disability must be detailed in the chart notes, final prognosis and final report. This determination, unfortunately, will only be accepted by most insurers if it has been determined or validated by an MD.

   - Use the AMA Guides to the Evaluation of Permanent Impairment will assure that the information is entered into the program.
   - Use one of the five accepted final prognosis accepted by the insurers.

- Recognize that if active treatment is being recommended after final release of your patient, that ongoing complaints (such as continued range of motion deficiencies, stiffness, etc.) must be documented.
- Recognize that if it is being recommended that the patient continue to exercise, stretch, participate in a gym program or other active treatment performed after the patient's release from your passive care, that this represents ongoing treatment.

9. Note secondary or conflicting conditions in the records.

   - The insurance industry programs may add substantial points for pre-existing conditions that are exacerbated or aggravated by the accident depending on proper documentation at the earliest date.

   - Similarly proper and accurate documentation in the daily chart notes regarding subsequent events of injury may increase point assessment by the insurance industry.

   - Delay in seeking treatment may increase acceptance of duration, type and frequency of treatment allowed by the insurance industry if documented properly. Delays in seeking treatment may be viewed as a responsible attempt by the patient to mitigate their treatment costs and ethically avoid passive treatment by participating in active treatment of their injuries and symptoms.

   - Gaps in treatment may also be recognized as an attempt to mitigate medical costs by your patient. If properly documented in a similar manner as in a delay, these periods of absence of passive treatment may justify not just a substantial foundation for a return to passive treatment, but they may also support complete duration, frequency and type of treatment after the gap has occurred.

HOW TO PREPARE A CLAIM FOR EVALUATION

If you are just beginning to approach a patient/client's claim for the purpose of creating a medical report or demand letter, you may find the process a bit overwhelming. However, it doesn't need to be. In fact, the process can be simple and quick without the frustration you might normally experience. Here are some very simple techniques which could help you survive this adventure.

First, let's divide the types of individuals we have currently in our population base into two groups. There are those who retained your services prior to you using this newly learned process (Oldies). Then, there are those clients who retained you after you began using the new process and software, "Medical Report Expert" or "Demand Expert" or "Demand Online" (Newbies).

Now wasn't that simple?

Since we have two distinct groups now, we can address each one separately. The difference is significant between the two groups. The Oldies haven't completed a "pre-checklist or intake form or the DUD/LOE form. This group may not have been managed as carefully as the Newbies, either. Whereas, the Newbies have completed both forms when they first came

into your office and you have been more sensitive to the different aspects of their claims, such as the "value drivers".

Let's address the Newbies first. By starting with this group, when we later address the Oldies, we'll discover how easy the entire population of clients can be brought up to speed. Newbies are those clients who have walked into your offices since you have begun to really understand the process. You've already installed the software, "Medical Report Expert", "Demand Online" or "Demand Expert" and are actively utilizing the forms.

When the Newbie arrives for his/her appointment, your CA, paralegal or assistant should have him/her complete the initial "Intake" or "Pre-checklist" form as well as the "DUD/LOE" form. There are several different "DUD/LOE" forms in the "Users' Center" on the Sequoia website. You can travel to the center by entering your id and password after selecting the button, "Users' Center". On the right hand side of this page, you'll find the four different forms as well as the "Pre-checklist form" and others. All documents and forms on this page are free to download by utilizing the id "alpine" and password "forest". They are in a Word document format. Once you have downloaded the forms, you want or need, onto your desktop, you can then place them anywhere in your computer it's convenient for you to find them later.

Since these documents are in Word format, you will be able to change and customize them to suit your needs. You can print them out as you need them or have an available supply already printed and ready for your clients as they flood into your office.

Your paralegal or assistant should assist the client in understanding some of the terms or questions on these forms. However, we recommend that the client fill the forms out in their own hand. Especially, the DUD/LOE form should be completed in the patient/client's handwriting. The reason for this is simple. The patient/client, after completing the forms and after you've made a copy of these for your records, should take the form to their representing attorney or treating physician, whichever may be the case. This assures that a record of this information exists in the file of the attorney or treating physician for later use. Should it be discovered at a later date, there is no misunderstanding as to who completed the forms.

The information taken in the intake/pre-checklist forms should be immediately entered into the software programs. By doing this your medical report or demand letter is almost completed. When the treatment regimen is through, you simply enter the new "Last Date Noted" from the medical chart notes in order to establish duration. If, during the course of treatment there are new diagnoses, symptoms of complaints, tests, therapies or other drivers, simply update the data in the software with that date.

Here are some very simple points to remember when finalizing the claim:

1. All injuries must be diagnosed correctly and have the correct ICD-9 codes assigned.
2. All symptoms must be documented throughout the claim. Especially on the last office visit date. Use of the correct terminology is adamant.
3. Recognition of possible Anxiety/Depression and TMJ in the medical records is very important.
4. All treatment for the injuries and complaints must be documented. Especially the active treatments such as: home exercises, home stretching, home traction and other activities performed by the patient outside the medical clinic.
5. Address any prior, subsequent, delay in seeking treatment or gaps in treatment.

6. All injuries must have a final prognosis. Remember, if there are any ongoing complaints or restriction at the end of the passive treatment and active treatment is recommended for the patient, the correct prognosis is: Ongoing complaints, Continuing Treatment.
7. Future treatment should be in the form of specific recommendations for duration and cost.
8. The medical probability of future treatment necessary for the cost to be included in the claim evaluation must be either "Probable" or "Definite".
9. Each patient must have a specific body part to have reached MMI with treatment either in a static or stable description. A patient who is medically documented as having achieved whole body MMI will not receive credit for any future treatment.
10. All Duties under Duress and Loss of Enjoyment factors must be documented in the medical records and appear in the demand letter.
11. An impairment rating of at least 2% whole body is the threshold for the value screens to be opened for DUD and LOE.
12. Each of the above aspects should be **validated** or determined by a medical doctor.

CLAIM REVIEW WORKSHEET

Here is a simple outline for collecting information to input into Demand Expert and Demand Online as well as Medical Report Expert:

Review the client's chart notes and billing forms to identify the following information:

1. **Injuries**

    a. ICD-9 codes
    b. Description

    Number of codes should match number of descriptions. Identify individual injuries NOT injured body regions. For example in the Cervical, Thoracic and Lumbar body regions there are the following body parts:

        i. Vertebral
        ii. Muscle
        iii. Ligament
        iv. Tendon
        v. Nerve

    While the Cervical, Thoracic and Lumbar subluxation or Whiplash injuries will be addressed in the "Neck and Back" section of the program, injuries to the muscles,

ligaments and tendons will be addressed individually in the "Other Injury" section of the program. Also, in skeletal section of the neck and back individual injuries will be identified by specific vertebral and type. For example, the following injuries at each level are separately addressed in the program:

i. Prolapse
ii. Bulge
iii. Herniation
iv. Dislocation
v. Fracture

2. Treatment

a. CPT codes
b. Description

List each treatment type and enter only once.
Match each billing date with its specific chart note.

c. Identify Last Treatment Date Provided and by which Physician
d. Identify all Hospital Dates Including ER
    i. Count Number of Visits
        1. ER counts as One Day MD and Hospital
    ii. Count Number of Nights for Each Stay

3. History of Complaints (Symptoms)

a. Identify all symptoms which are common to all injuries
b. Identify those symptoms which are specific to certain injuries only
c. Identify Last Date Each Symptom was stated in Chart Notes
d. List Physician who made Last Notation

4. Physician or Facility Name and Type

a. Identify Name of Each Facility
b. Identify Total amount of charges for Each
c. Identify Last Date of Treatment for Each
d. Identify Total Number of Treatment Dates for Each
e. Identify When a Physician can be Identified as different Type
    i. Any Kind of Therapy Provided
    ii. MD or DO Providing DC or Therapy Modalities

5. Body Part which has reached MMI

a. Which specific body part can be determined to have reached MMI
b. Do Not Identify an Entire Region if it can be avoided

6. Impairment Rating

a. Must be Provided by MD Utilizing AMA 5th Edition Guideline
b. What is the final Prognosis

i. Ongoing Complaints, Continuing Treatment?
    1. Active and/or Passive
ii. Guarded?

7. Duties Under Duress

a. Have Worksheet Completed by Client and Included in Physician's Charts
b. Confirm Employer Records also Support
c. May also need statements from:
    i. Coworkers
    ii. Family
    iii. Friends
    iv. Neighbors
    v. Billings from Paid Assistance
d. Number and Ages of Children

8. Loss of Enjoyment

a. Have Worksheet Completed by Client and Included in Physician's Charts
b. Confirm Employer Records also Support
c. May also need statements from:
    i. Coworkers
    ii. Family
    iii. Friends
    iv. Neighbors
    v. Billings from Paid Assistance
d. Number and Ages of Children

9. Medical Costs and Probability

a. Current Medical Costs
b. Future Medical Costs
    i. Type of Treatment
    ii. Duration
    iii. Probability
        1. Probable
        2. Definite

10. Income Loss

a. Current Income Loss
b. Future Income Loss
    i. Supported by Probability of Future Medical Treatment
    ii. Employer's Statement
    iii. Projected Amount

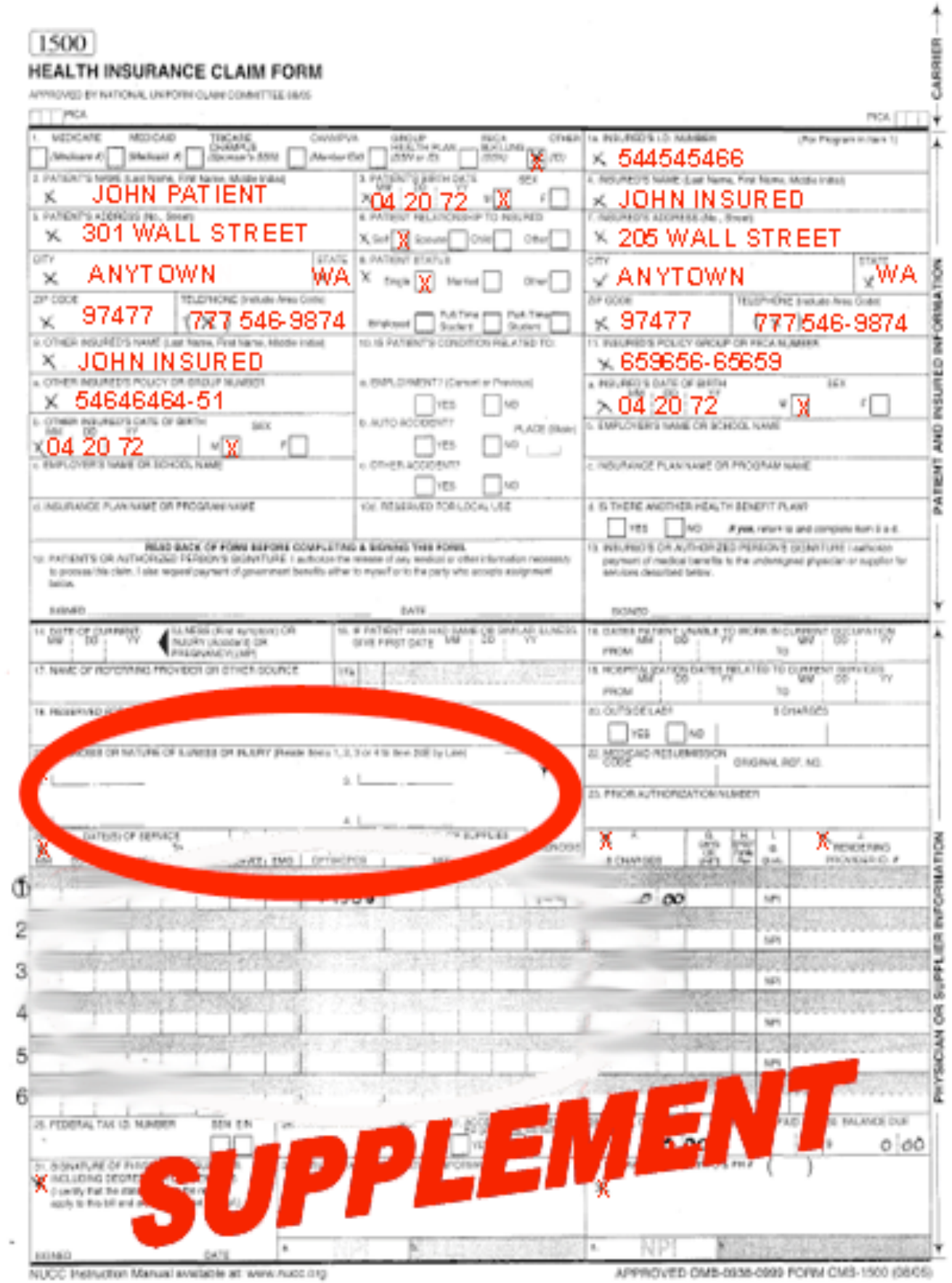
11. Other Issues

a. Aggravated Liability
b. Loss of Consortium
c. Scarring or Deformity

i. List Cases from Juryverdicts.com

d. Emotional Distress
e. Mileage Expense (Use Mileage Calculator in Program)
    i. Number of Miles from Each Provider to Client's Home
    ii. Number of Visits to Each Provider
f. Property Damage
    i. Additional Damage
    ii. Lost or Damaged Articles
    iii. Rental or Loss of Use Funds
    iv. Divinization
    v. Seatbelt Retraction
        1. Inspection
        2. Replacement

One final note to remember, the HCFA forms do not allow all injuries to be included on one form. It is appropriate to include a Supplemental HCFA form with the identification of additional injuries. The template for this form can be found on the website, ***Sequoiavisions.com***. The "Supplemental" form should be included with the first and final submission of billings, medical report or demand letter.


1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05
PICA
1. MEDICARE MEDICAID TRICARE CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
1a. INSURED'S I.D. NUMBER
544545466
2. PATIENT'S NAME
JOHN PATIENT
3. PATIENT'S BIRTH DATE SEX
04 20 72 M
4. INSURED'S NAME
JOHN INSURED
5. PATIENT'S ADDRESS
301 WALL STREET
6. PATIENT RELATIONSHIP TO INSURED
Self
7. INSURED'S ADDRESS
205 WALL STREET
CITY
ANYTOWN
STATE
WA
8. PATIENT STATUS
Single
CITY
ANYTOWN
STATE
WA
ZIP CODE
97477
TELEPHONE
777 546-9874
ZIP CODE
97477
TELEPHONE
777 546-9874
9. OTHER INSURED'S NAME
JOHN INSURED
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
659656-65659
a. OTHER INSURED'S POLICY OR GROUP NUMBER
54646464-51
a. EMPLOYMENT? (Current or Previous)
a. INSURED'S DATE OF BIRTH SEX
04 20 72 M
b. OTHER INSURED'S DATE OF BIRTH SEX
04 20 72 M
b. AUTO ACCIDENT?
PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT?
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED
DATE
SIGNED
14. DATE OF CURRENT
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED
20. OUTSIDE LAB?
$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
22. MEDICAID RESUBMISSION
ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE
B. PLACE OF SERVICE
C. EMG
D. PROCEDURES, SERVICES, OR SUPPLIES
E. DIAGNOSIS POINTER
F. $ CHARGES
G. DAYS OR UNITS
H. EPSDT Family Plan
I. ID. QUAL.
J. RENDERING PROVIDER ID. #
1
2
3
4
5
6
NPI
25. FEDERAL TAX I.D. NUMBER
SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT?
28. TOTAL CHARGE
29. AMOUNT PAID
30. BALANCE DUE
0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
I certify that the statements on the reverse apply to this bill and are made a part thereof.
32. SERVICE FACILITY LOCATION INFORMATION
33. BILLING PROVIDER INFO & PH #
SIGNED
DATE
a.
b.
a. NPI
b.
SUPPLEMENT
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION
NUCC Instruction Manual available at: www.nucc.org
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

DOG BITE SCARRING OR DEFORMATION DEMAND PREPARATION

Individual - Age, gender, social status, social activities, appearance and employment
Actual injuries - bite penetration and subsequent other objective or subjective injuries
Symptoms or recorded complaints - including emotional and psychological
Complications - non healing or infection
Scarring - Size, appearance, location, future concerns and need for future attention. A good photo of the scarring is necessary. Also, see factors under "Individual".

Social effects of a disfiguring injury

Without intending it, people may cause a disfigured dog bite victim to feel humiliated and discriminated against. An unmarried person may have trouble getting dates. Consider these shameful, true stories from the actual case files of attorney Kenneth Phillips:

- A prominent scientist had an ugly scar on her wrist from a dog's teeth; she repeatedly was asked whether she had tried to slit her wrists.

- An attractive lady was bit in the face and the end of her nose was ripped away; she reported that men were less attracted to her, even after reconstructive surgeries.

In our society, good-looking people have more friends, get more invitations and are treated better than those who are disfigured. Disfigured victims are unjustly required to endure stares, painful questions and social discrimination.

Medical cost - current and future - Future revisions of the scar should be projected in dollar costs.
Income Loss - current and future
Impairment - not normally considered in dog bites
Impact on life in general - Also, see factors under "Individual".

If so, this needs to be worked up as to future treatment.

FEAR OF DOGS AND THE OUTDOORS

One of the most painful effects of a dog bite can be the resulting morbid fear of dogs. A victim frequently is a dog lover; after being attacked, however, he or she no longer feels comfortable around dogs, and thereby can no longer enjoy the companionship of "man's best friend."

This may interfere with friendships and the quality of life. For example, a woman who lived in the countryside found that she no longer could take walks because she feared being attacked. This left her a "shut-in" for a period of months.

The emotional reactions of children who are the victims of, or witnesses to, dog attacks include fear, depression, withdrawal and anger. These problems can occur immediately or sometime after the tragic event. Many such children will develop post traumatic stress disorder ("PTSD") and/or other persistent problems."

Trauma" includes emotional as well as physical experiences and injuries. Emotional injuries are essentially a normal response to an extreme event. Emotional injury involves the creation of

emotional memories, which arise through a long lasting effect on structures deep within the brain. The more direct exposure to the traumatic event, the higher the risk for emotional harm.

The "undifferentiated thinking" of children frequently leads them to derive "wrong" conclusions from traumatic events. A child, especially a very young one, attempts to read the environment in order to enhance his comfort and further survival. A traumatic event like a dog bite is often misunderstood as a statement about life in general, that it is uncertain, painful and precarious. Furthermore, such an event might be internalised as a statement about the child himself, that he is somehow "bad" and even responsible for not only his physical pain but even the emotional pain suffered by his parents as a result of the dog attack. These psychic wounds may become significant determinants of the adult personality, so that the dog attack truly affects the child victim for life.

Either being exposed to violence within the home for an extended period of time or exposure to a one-time event like an attack by a dog can cause PTSD in a child. Some scientists believe that younger children are more likely to develop the disorder than older ones. PTSD can develop at any age, including in childhood. Symptoms typically begin within 3 months of a traumatic event, although occasionally they do not begin until years later. Once PTSD occurs, the severity and duration of the illness varies. Some people recover within 6 months, while others suffer much longer.

Emotional reactions to trauma may appear immediately after the dramatic event or days and even weeks later. Rates of PTSD identified in child and adult survivors of violence and disasters vary widely. For example, estimates range from 2% after a natural disaster (tornado), 28% after an episode of terrorism (mass shooting), and 29% after a plane crash. The disorder may arise weeks or months after the traumatic event.

Children and adolescents exposed to a dramatic events frequently lose trust in adults and have fear that the event may occur again. Other reactions vary according to age:

- For children five years of age and younger, typical reactions may include a fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Parents may also noticed children returning to behaviours exhibited at earlier ages (these are called regressive behaviours), such as thumb-sucking, bedwetting, and fear of darkness. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event.

- Children six to eleven years old may show extreme withdrawal, disruptive behaviour, and/or inability to pay attention. Regressive behaviours, nightmares, sleep problems, irrational fears, inability or refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. Also, the child may complain of stomach aches or other bodily symptoms that have no medical basis. School work often suffers. Depression, anxiety, feelings of guilt and emotional numbing or "flatness" are often present as well.

- Adolescents 12 to 17 years old may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school

avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some children and adolescents will have prolonged problems after a traumatic event. These potentially chronic conditions include depression and prolonged grief. Another serious and potentially long-lasting problem is post-traumatic stress disorder (PTSD). This condition is diagnosed when the following symptoms have been present for longer than one month:

- Re-experiencing the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma.

- Routine avoidance of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future).

- Increased sleep disturbances, irritability, poor concentration, startle reaction and regressive behaviour.

PTSD may resolve without treatment, but some form of therapy by a mental health professional is often required in order for healing to occur. Fortunately, it is more common for a traumatized child or adolescent to have some of the symptoms of PTSD than to develop the full-blown disorder.

People with PTSD are treated with specialized forms of psychotherapy and sometimes with medications or a combination of the two. One of the forms of psychotherapy shown to be effective is cognitive/behavioural therapy, or CBT. In CBT, the patient is taught methods of overcoming anxiety or depression and modifying undesirable behaviours such as avoidance. The therapist helps the patient examine and re-evaluate beliefs that are interfering with healing, such as the belief that the traumatic event will happen again. Children who undergo CBT are taught to avoid "catastrophizing." For example, they are reassured that dark clouds do not necessarily mean another hurricane, that the fact that someone is angry doesn't necessarily mean that another shooting is imminent, etc.

Play therapy and art therapy also can help younger children to remember the traumatic event safely and express their feelings about it. Other forms of psychotherapy that have been found to help persons with PTSD include group and exposure therapy.
A reasonable period of time for treatment of PTSD is 6 to 12 weeks with occasional follow-up sessions, but treatment may be longer depending on a patient's particular circumstances.
Research has shown that support from family and friends can be an important part of recovery and that involving people in group discussion very soon after a catastrophic event may reduce some of the symptoms of PTSD.

There has been a good deal of research on the use of medications for adults with PTSD, including research on the formation of emotionally charged memories and medications that may help to block the development of symptoms. Medications appear to be useful in reducing overwhelming symptoms of arousal (such as sleep disturbances and an exaggerated startle reflex), intrusive thoughts, and avoidance; reducing accompanying conditions such as depression and panic; and improving impulse control and related behavioural problems. Research is just beginning on the use of medications to treat PTSD in children and adolescents.
There is preliminary evidence that psychotherapy focused on trauma and grief, in combination with selected medications, can be effective in alleviating PTSD symptoms and accompanying depression.

More medication treatment research is needed to increase our knowledge of how best to treat children who have PTSD.

Parents' responses to a violent event or disaster strongly influence their children's ability to recover. This is particularly true for mothers of young children. If the mother is depressed or highly anxious, she may need to get emotional support or counselling in order to be able to help her child.

PTSD is often accompanied by depression. In a group of teenage. Depression must be treated along with PTSD in these instances, and early treatment is best.

IMPAIRMENT & DUD/LOE

I would strongly recommend that before you submit a demand, you find an MD to determine the AMA impairment rating. If you submit this impairment determined by a DC and not an MD, it will not be accepted AND none of the DUD or LOE factors will be included in the evaluation as a result

of this. We have posted several physicians throughout the country on our website who understand and can determine impairments.

YOU NEED AN IMPAIRMENT RATING OF AT LEAST 2% WHOLE BODY, IN ORDER TO GET THE DISABILITIES ENTERED INTO COLOSSUS. Soft tissue whiplash type injuries typically bring in impairments in the range of 5 to 8%. Ligament Laxity (728.4) will bring a 25 to 35% whole body impairment.

IF NO PHYSICIAN HAS PROVIDED AN IMPAIRMENT - CONSIDER: IMPAIRMENT

In regards to permanent impairment assessment, it must be performed in accordance with the AMA *Guides to the Evaluation of Permanent Impairment*, Fifth Edition. Adequate information is provided in the medical records to analyze this case and provides the needed data for the rating criteria in the Fifth Edition. The *Guides* state, "**If the clinical findings are fully described, any knowledgeable observer may check the findings with the *Guides* criteria"**.

Therefore, after review of the medical documentation to include any and all diagnostic testing, the most recent patient visit with Dr. _____ it can be determined that the following **whole person permanent impairment rating of 8%** as it relates to the AMA *Guides to the Evaluation of Permanent Impairment,* Fifth Edition would be medically correct.

THE FOLLOWING FACTORS MUST BE DOCUMENTED BY YOUR CLIENT/PATIENT

DUTIES UNDER DURESS:

Work
Study
Domestic
Household

Due to:

Difficulty with Stability/Mobility
Difficulty with Postural Difficulties
Difficulty with Dexterity
Fatigue
Anxiety/Depression
Reduced Concentration
Pain (must interfere with work or studying capacity)

These Duties under Duress factors (choose) - are ongoing
- have been experienced since the incident
- were experienced for __ weeks
__ months

LOSS OF ENJOYMENT

Work

_____Loss of Status within the organization
Loss of Job Security
Loss of promotional prospects
Difficulty in performing duties
Reduced quality of work

Other

School

Loss of Attending class
Loss of Attending functions
Loss of Gym class
Loss of studying
Other

Domestic

Loss of Interior Cleaning
Loss of Interior Maintaining
Loss of Interior Preparing meals
Loss of Attending to spouse
Loss of Attending to children
Loss of Interior Decorating
Loss of Entertaining
Loss of Pet Care
Other

Household

Loss of Exterior Cleaning
Loss of Exterior Landscaping
Loss of Exterior Maintenance
Loss of Exterior Decorating
Loss of Pet Care
Other

Hobbies

Sports

Pre-incident level:

Played Socially
Played Competitive
Played Regionally

Current level:

Cannot play regionally
Cannot play competitive,
Cannot play social,
Cannot play original sport
Cannot play any sport

These Loss of Life Enjoyment factors
- are ongoing
- have been experienced since incident
- were experienced for __ weeks
__ months

S E Q U O I A V I S I O N S

2 0 5 S C O T C H P I N E R D . R E N O , N E V A D A 8 9 5 1 1

Visit our webpage at www.SequoiaVisions.com

Sales and Technical Number (888) 737-8642

Facsimile Number (775) 849-8423

Name:
Email (For future notice of upgrades) :
Shipping Address:

City, State and Zip code:
Phone Number:

LEGAL

Purchase Registration and License for **"ONLINE DEMAND"** $ 900.00
(Includes up to additional 2 paralegal only workstations)
One year contract required with licensing for a monthly fee of $79.00 charged to your credit card.

Additional Attorney Workstation - $29.00 each per month **Quantity** _____ _____
(Includes up to additional 2 paralegal only workstations)

MEDICAL

Purchase Medical Suite** 2,400.00
** (Includes Medical Report Expert, SOAP program and both CPT and ICD-9 Code Express)
Additional Workstations (**More than one physician user** – 100.00 per month) Quantity _____ _____

Additional Workstations Medical Suite, Billing and Scheduling (250.00 each) Quantity _____ _____

TWO DAY RENO WORKSHOP WITH CERTIFICATION

Purchase Registration*** Quantity _____ 2,500.00
*** (Discount of $500.00 if software has been purchased) Quantity _____ 2,000.00

Sequoia Visions Colossus Seminar Workbook and/or Power Point.
Level I ($200.00 no/ppt) Level II ($400.00 no/ppt) Level I&II ($500.00 no/ppt) Powerpoint ($150.00) _____

SEQUOIA PREFERRED NETWORK MEMBERSHIP

Sequoia Preferred Network (Choose the level you want ~ See explanation in Network Section at our website)
Silver ($50.00) Gold ($100.00) Platinum ($200.00) Enter amount here: _____

Add Shipping and handling per order (No Shipping and Handling charges for Network or Online Demand) 15.00
Total Purchase $ _____

SELECT TYPE OF CREDIT CARD: (CHECK ONE)

___Visa ___MasterCard ___American Express
Name on Credit Card if Different than above_____
Card Number: _____ (Please Print Clearly) Card verification #:_____
Date of Expiration: _____/_____ (Month/Year)

This order form can be faxed directly to Sequoia Visions, Inc. at (775) 849-8423
MAKE CHECKS PAYABLE TO SEQUOIA VISIONS, INC.
205 SCOTCH PINE RD. RENO, NEVADA 89511

JAMES J. MATHIS

205 Scotch Pine Road **Reno, Nevada 89511** **(775) 849-8400**

I have extensive professional experience in the Insurance Industry, as an expert consultant on insurance claim handling issues, and as a speaker for Trial Lawyers' Associations and Medical Associations. As owner of Sequoia Visions, Inc., I have designed and created innovative software for the Legal and Medical Communities to address the ongoing changes and demands of the Insurance Industry. I have lectured at numerous workshops and seminars in the following areas: Claim Practices, Evaluation and Negotiation, Medical Claim Documentation and Presentation, General Claim Processing and Handling.

I have specific knowledge of Insurance Industry processes, procedures, manuals, memos, literature, claim handling practices, advertisements, electronic systems, computer maintained data, computer retrieval reporting, personnel guides, training guides and literature, trial defenses and discovery preparation.

I have assisted in the discovery process for law firms dealing with issues of bad faith, extra-contractual, breach of contract and consumer violation lawsuits. This is due to my extensive experience in varied positions in the insurance industry as well as management positions while employed with All Insurance and ongoing review of insurance procedures, processes, literature and claim files in my capacity as a consultant.

ACHIEVEMENTS WHILE EMPLOYED IN THE INSURANCE INDUSTRY

CREATED, DEVELOPED AND IMPLEMENTED a program concept designed to solve two major problems, service to customers and the relative costs. Presented findings and the complete plans for a centralized department designed to improve service, decrease cost per claim, cost of handling and reserves cost. The result was a charter to implement the plan.

EXCEPTIONALLY SUCCESSFUL as an insurance company representative speaking to internal departments, individual members and groups in the medical and legal communities. In this position I was designated company expert and administrator in suits against the company including class action litigation involving first party benefits within the state of Washington.

HIRED, TRAINED and MANAGED a new department of 5 supervisors, 5 attorney negotiators, 22 medical claim examiners and 12 support personnel. As a result, this new cohesive and efficient department was able to successfully process approximately 15,000 claims annually and over 1,500 pieces of mail daily. Previous positions as superintendent in casualty and property also required I hire and train personnel in those areas, including third party claims, UIM and UM claims, first party property claims, estimators and field inspectors.

CONCEPTUALIZED, ORGANIZED and AUTHORED an operational guide for an innovative department consisting of new and creative processes, procedures and formats. This expanded my responsibility to provide continual internal auditing and external troubleshooting combined with published instructional articles and motivational seminars.

EXPERIENCE

Mathis Insurance Consulting, Inc.	Owner and President
Sequoia Visions, Inc.	Owner and President
National Claims Services, Inc.	Owner and President
Allstate Insurance	Senior Staff Adjuster Litigation and Attorney Negotiator
State Farm Insurance	Superintendent, Consolidated Claims
	Superintendent, Metro Property, Casualty and Litigation
	Resident Superintendent, Casualty and Property
	Claim Representative, Life, Casualty and Property
University of Oregon	Research Assistant

Mathis Farms Owner/Operator

EDUCATION

Bachelor Degree	University of Oregon, Eugene, OR
Associate of Arts	Lane Community College, Eugene, OR
AIC	Insurance Institute of America
Two Parts CPCU	Insurance Institute of America
ICAR certified (all parts)	ICAR

STATE FARM INSURANCE COMPANY

Negotiation Skills for the Claims Professional (Certified)	State Farm Insurance Company
Superintendent School	State Farm Insurance Company
Casualty Supervision	State Farm Insurance Company
Property Supervision	State Farm Insurance Company
Management (Parts I, II, III)	State Farm Insurance Company
Claims School	State Farm Insurance Company
BCC (Parts I, II, III, IV)	State Farm Insurance Company
Bodily Injury School	State Farm Insurance Company
Negotiation Skills for the Claims Professional Facilitator	State Farm Insurance Company
Personnel Management School	State Farm Insurance Company

ALLSTATE INSURANCE COMPANY

CCPR Workshops and Training	Allstate Insurance Company
MBRS Workshops and Training	Allstate Insurance Company
Casualty Skills Workshop	Allstate Insurance Company
P-CCSO Workshops and Training	Allstate Insurance Company
MIST Workshops and Training	Allstate Insurance Company
Colossus and Evaluation Training	Allstate Insurance Company
Claim Portfolio Workshops and Training	Allstate Insurance Company
Liability Investigation Matrix Workshop	Allstate Insurance Company
Damage Investigation Matrix Workshop	Allstate Insurance Company
MIST Investigation Matrix Workshop	Allstate Insurance Company
CDS Best Practices Training	Allstate Insurance Company
Claim Performance Measurement System	Allstate Insurance Company
Allstate Profit Sharing Enhancement	Allstate Insurance Company

TESTIMONY AND PRESENTATIONS

I have been retained as an expert and consultant throughout the country to review the uniform claim handling practices and procedures of the Insurance Industry. I am paid $300.00 per hour as a consultant and $100.00 per hour for travel time not including costs. I am paid $300.00 per hour for deposition and testimony with an additional one-time charge of $500.00 if the deposition is video-taped. This has resulted in my review of more than 7,500 insurance claim files. I have testified in the following lawsuits:

- Bien Aime vs. State Farm Mutual Automobile Insurance Company, Florida; Circuit Court of the 17th Judicial Circuit, Broward County, Florida; Case No. 95-008749-25;
- Boll vs. State Farm Mutual Automobile Insurance Company in the state of Idaho; The District Court of the Fifth Judicial District, State of Idaho, County of Twin Falls; Case No. CV-97-4624;

- Holderness vs. State Farm Mutual Automobile Insurance Company in the state of Alaska; Superior Court, Alaska, Third Judicial District at Anchorage; Case No. 3AN-94-9277 CI;
- Mesa vs. State Farm Mutual Automobile Insurance Company, Wyoming; The District Court Eighth Judicial District; Case No. 13559;
- Morgan vs. State Farm Mutual Automobile Insurance Company, Louisiana; Twenty-Second Judicial District Court, Parish of St. Tammany, State of Louisiana; Case No. 99-10917;
- Robinson vs. State Farm Mutual Automobile Insurance Company, Idaho; The District Court of the Fourth Judicial District of the State of Idaho, in and for the County of Ada; Case No. CV OC 94-98099D;
- Schroeder vs. State Farm Mutual Automobile Insurance Company, Arizona; The Superior Court of the State of Arizona, in and for the County of Maricopa; No. CV2002-010179;
- The People of The State of California vs. Wilmer Origel, Superior Court of California, County of San Joaquin; No SFO94494A;
- Vittorio vs. Grange Insurance Companies; The Court of Common Pleas, Franklin County, Ohio; Case No. 03CVC-04-3849;
- Waddell vs. Allstate, Montana; United States Federal Court, Montana; Case No. CV-99-65-BU-CCI;

I have been deposed in class action lawsuits in the state of Washington, Crannell vs. State Farm, Van Noy vs. State Farm and Sitton vs. State Farm, in Nebraska, Lynch vs. State Farm, Oklahoma, Burton vs. Mountain West Farm Bureau Mutual Insurance Co. in the state of Montana and in Arizona, Skene vs. State Farm, in California, Watts vs. Allstate. I have also been deposed or provided a written opinion in the following lawsuits.

- Allstate Insurance Company ET AL. vs. Michael Kent Plambeck, D.C., ET AL; Texas, United States District Court for the Northern District of Texas, Dallas Division; Civil Action No 3:08CV-0388-BD;
- Adams vs. State Farm Mutual Automobile Insurance Company, State of Michigan in the Circuit Court for the County of Kent Civil Division, Case No. 02-08360-NF;
- Barerra vs. Western United dba AAA Nevada Insurance Company, a California Corporation; Case No. 2:09-cv-02289-ECR-PAL; filed in United States District Court, District of Nevada.
- Bien Aime vs. State Farm, Florida; Circuit Court of the 17th Judicial Circuit, Broward County, Florida; Case No. 95-008749-25;
- Blair vs. Allstate, California; Superior Court of California, County of San Francisco; Case No. 313720;
- Boe vs. Allstate, Washington; Superior Court of Washington for King County, Case No. 01-2-19280-9SEA;
- Boll vs. State Farm Mutual Automobile Insurance Company in the state of Idaho; The District Court of the Fifth Judicial District, State of Idaho, County of Twin Falls; Case No. CV-97-4624;
- Brewer vs. State Farm Mutual Automobile Insurance Company in the state of Indiana; Superior Court of Indiana, County of Bartholomew, Case No. 03C01-9912-CT-1795;
- Carlson vs. Progressive Insurance Company; in The Superior Court of the State of Washington, In and For the county of King; Case No. 08-2-23495-9 SEA;

- Carlson vs. State Farm Mutual Automobile Insurance Company in the state of Montana; The Montana Eighth Judicial Court, Cascade County, Case No. BDV-00-140;
- Crannell and Tesfamariam vs. State Farm Mutual Automobile Insurance Company, State of Washington, In The Superior Court Of The State Of Washington For King County, NO. 92-2-264433-1;
- Crump vs. State Farm Mutual Automobile Insurance Company, Michigan; Circuit Court, State of Michigan, County of Genesee; Case No. 02-72839-NF;
- Dunn vs. State Farm Mutual Insurance Company, Michigan; State of Michigan In The Circuit Court For The County of Wayne; Case 2:08-cv-12831;
- Elizabeth Ann Pakenas, Guardian of Patti Rogers vs. State Farm Mutual Automobile Insurance Company, United States District Court, Eastern District of Michigan, Southern Division; Case NO: 05 CV60152;
- Feldotto vs. State Farm Mutual Automobile Insurance Company, Colorado; District Court, Douglas County, State of Colorado; Case No. 01 CV 480;
- Foltz vs. State Farm Mutual Automobile Insurance Company, Oregon; United States Court of Appeals for the Ninth Circuit; Case No. CV-94-06293-MRH;
- Furrier vs. Allstate Property And Casualty Insurance Company, State Of Arizona; In The Superior Court Of The State Of Arizona, In And For The County Of Maricopa; No. Cv2009-003464;
- Henke vs. State Farm Mutual Automobile Insurance Company, Washington; The Superior Court State of Washington for King County; Case No. 99-2-11808-7;
- Hill vs. State Farm Mutual Automobile Insurance Company, Oklahoma; The United States District Court for The Western District of Oklahoma; Case No. CIV-00-1877-T;
- Holderness vs. State Farm Mutual Automobile Insurance Company in the state of Alaska; Superior Court, Alaska, 3rd Judicial District at Anchorage; Case No.3AN-94-9277 CI;
- Isham vs. Hitchman, Jean-Charles, State Farm Mutual Automobile insurance Company, Griffin Insurance Agency, Inc., Progressive Express Insurance Co., and Gibbs, P.A., Florida; In The Circuit Court for Broward County, Florida, General Jurisdiction Division; Case No.: 02-16942 CA CE (04);
- Joy vs. Allstate Indemnity Company; Washington; Superior Court, State of Washington, Spokane County; Case NO. 03-2-06286-8;
- Lehman vs. State Farm Mutual Automobile Insurance Company, Washington; The Superior Court State of Washington for King County; Case No. 00-2-26450-0 SEA;
- Liebig v. State Farm Mutual Automobile Insurance Com., Indiana; Cause No. 53C04-0502-CT-00339;
- Lynch vs. State Farm Mutual Automobile Insurance Company, Nebraska; The District Court of Douglas County, Nebraska; Case No. DOC. 980 NO. 654;
- Martinez vs. Davis, New Mexico; The State of New Mexico, County of Bernalillo Second Judicial District Court; Case No. CV 99-07598;
- McAllister vs. State Farm Mutual Automobile Insurance Company, Washington; Superior Court of Washington for Grays Harbor County; Case No. 92-2-01187-6;
- Mesa vs. State Farm Mutual Automobile Insurance Company, Wyoming; The District Court Eighth Judicial District; Case No. 13559;
- Morgan vs. State Farm Mutual Automobile Insurance Company, Louisiana; Twenty-Second Judicial District Court, Parish of St. Tammany, State of Louisiana; Case No. 99-10917;

- Nettles and Czarnedki et. al. v. Allstate Insurance Company, Illinois; In The Circuit Court of Cook County, Illinois County Department, Chancery Division; Case No, 02 CH 14426;
- O'Reilly vs. State Farm Mutual Automobile Insurance Company, Washington; Superior Court of Washington for County of King; Case No. 00-2-11548-2KNT;
- Passy-Fontes vs. State Farm Mutual Automobile Insurance Company, California; Superior Court of the State of California for the County of San Bernardino Central District; Case No. SCVSS74793;
- Plateros vs. State Farm Mutual Automobile Insurance Company, Nevada; The Second Judicial District Court of the State of Nevada in and for The County of Washoe; Case No. CV98-07605;
- Rel vs. State Farm Mutual Automobile Insurance Company, New Mexico, The United States District Court for The District of New Mexico; Case No. CIV-04-0033 ACT/RLP;
- Reyher vs. State Farm Mutual Automobile Insurance Company, Colorado; District Court, County of Otero, State of Colorado; Case No. 03 CV 18;
- Robinson vs. State Farm Mutual Automobile Insurance Company, Idaho; The District Court of the Fourth Judicial District of the State of Idaho, in and for the County of Ada; Case No. CV OC 94-98099D;
- Schroeder vs. State Farm, Arizona; The Superior Court of the State of Arizona, in and for the County of Maricopa; No. CV2002-010179;
- Simonsen vs. Allstate, Montana; The United States District Court for the District of Montana, Butte Division; CV-01-64-BU-DWM;
- Sitton vs. State Farm, Washington; Superior Court of Washington for King County; Case No. 00-2-10013;
- State Farm Mutual Automobile Insurance Company and State Farm Fire and Casualty Company vs. Robert J. Brown, Spectrum DX services, Inc. and Gary M. Weiss; Florida; United States District Court Middle District of Florida Orlando Division; No. 03 CV 3936;
- The People of The State of California vs. Wilmer Origel, Superior Court of California, County of San Joaquin; No SFO94494A;
- Van Noy vs. State Farm Mutual Automobile Insurance Company, Washington; The Superior Court of the State of Washington, The County of King; Case No. 94-2-17363-4;
- Waddell vs. Allstate, Montana; United States Federal Court, Montana; Case No. CV-99-65-BU-CCI;
- White vs. Benjamin Rodriquez, Javier Rodriquez, American Family Mutual Insurance Company, Nevada; District Court, Clark County, Nevada; Case No. A499947, Department XVII;

Prior to those lawsuits, I was designated as a company representative in the class action, Cranell v. State Farm, Washington and testified on behalf of State Farm in single lawsuits brought against them by their insureds. I am sought as a speaker, at workshops, seminars and educational forums. Included with these presentations is my authored handout exceeding 100 pages. The following is a listing of those functions:

- Alaska Trial Lawyers Association,
- Alabama Trial Lawyers Association,
- Arizona Trial Lawyers Association,
- Arkansas Trial Lawyers Association,

- Association of Trial Attorneys of America,
- Brain Injury Association of Michigan,
- California Bar Association,
- California Advocacy Association of San Diego,
- California Chiropractic Association,
- Colorado Trial Lawyers Association,
- Colorado Chiropractic Association,
- Delaware Trial Lawyers Association,
- Florida Trial Lawyers Association,
- Florida Chiropractic Association,
- Georgia Paralegal Association,
- Indiana Trial Lawyers Association,
- International Chiropractic Association,
- Kansas Association of Trial Attorneys,
- Kansas Chiropractic Association,
- Kentucky Academy of Trial Lawyers,
- Louisiana Trial Lawyers Association,
- Massachusetts Association of Trial Attorneys,
- Michigan Trial Lawyers Association,
- Michigan Chiropractic Association,
- Mississippi Trial Lawyers Association,
- Missouri Trial Lawyers Association,
- Nevada Trial Lawyers Association,
- Nevada Bar Association,
- New Jersey Trial Lawyers Association,
- New Mexico Trial Lawyers Association,
- North Carolina Academy of Trial Lawyers,
- Ohio Academy of Trial Lawyers,
- Ontario Trial Lawyers Association, Canada,
- Oregon Chiropractic Association,
- Oregon Trial Lawyers Association,
- Rhode Island Association of Trail Attorneys,
- San Diego Consumer Advocate Association,
- Santa Clara County Trial Lawyers Association,
- Spokane WA Chiropractic Association,
- Southern California Advocate Association,
- Southern California Physician Network,
- Utah Association of Chiropractic Physicians,
- Vermont Association for Justice,
- Washington State Chiropractic Association,
- Washington Association of Independent Medical Examiners,
- Washington Trial Lawyers Association,
- West Virginia Trial Lawyers Association,

In addition to the written opinions, affidavits and declarations provided in the above listed cases, I have been interviewed, quoted, video-taped, or provided written articles on Insurance Industry policies, practices and procedures in the following:

- "American Chiropractic Magazine" - Article
- "ATLA Audio Presentation", - Lecture
- "Business Week", - Interview
- "CNN" News - Interview
- "King 5 News", Seattle, Washington, - Interview
- "Lawyers USA", - Article
- "Lawyers' Weekly", - Interview
- "Massachusetts Trial News", - Interview
- "NBC Dateline", - Interview
- "NBC News Affiliate", Portland, Oregon", - Interview
- "Nevada Chiropractic Newsletter", - Article
- "Newsweek", - Interview
- "Plaintiff", Journal Of Consumer Attorneys Association For Northern Calif., - Article
- "Seattle Post Intelligencer", - Interview
- "The Advocate", Journal Of Consumer Attorneys Association For So. Calif., - Article
- "The Los Angeles Times", - Interview
- "The Los Angeles Weekly", - Interview
- "The Medical-Legal News", - Article
- "The Oregonian", - Interview
- "The Pinet Directory" - Article
- "The Wall Street Journal", - Interview
- "The Washington Post", - Interview
- "US News And World Report", - Interview
- "United Policyholders Of America" - Article
- Co-authored "Minor Impact Soft Tissue" - Book

NOTES

NOTES

LAW OFFICES OF JUSTICE JONES

Justice Jones, Attorney at Law
1506 Claim Drive
Claim Hill, Claim 11111

SAMPLE SETTLEMENT DEMAND

Mutual Insurance Company 7/30/2007
Attn: Jay Paycheck
P.O. Box 1111
Claim Hill, Claim 11111

Claim No: 44-444-4444
Your Insured: Mr. And Mrs. Insured
Date of Loss: 8/10/2004
Claimant: Janice Doe

Dear Mr. Paycheck:

This demand is prepared in an attempt to resolve my client's claim. This demand is not intended to be used in future litigation. This is an opportunity for your company to settle my client's claim within the policy limits of your insured. I am aware of the computerized programs which your company utilizes to evaluate claims and I have organized this demand so as to make that process as easy as possible.

My client was involved in the automobile accident of 8/10/2004 with your insured. After the accident my client experienced severe pain in their neck, mid-back, lower-back, and chest. My client was examined at the accident scene and transported to the emergency room by ambulance. These injuries were all expressed to and documented by Dr. Sam Feelgood, D.C.

The following aspects of my client's claim were gathered from the medical records for your convenience in evaluating my client's claim for settlement.

DOB: 9/28/1957 I am Right-Handed.
Gender: Female

Medical Specials: $10,879.00

Date of First Treatment: 8/10/2004

INJURIES:

Neck and Back, Disc Bulges at L5-S1, C4-5, C5-6, and C6-7, Left Hip Contusion, Cervical, Lumbar Sprain/Strains

LIABILITY:

Liability is not an issue at this time and will have no affect on the settlement value of my client's claim. If this is not correct, please inform me immediately.

ICD9 Injury Codes: 359.3, 729.1, 799.1, 799.4
CPT Treatment Codes: 97010, 97014, 97012, 98941, 98942, 97032

PRIOR/SUBSEQUENT INJURIES:

Degenerative Disc Disease existed prior to this accident. However, there were no existing complaints or symptoms being experienced prior to this accident. There was no treatment being provided for this condition. This condition is only relevant in that, the injuries caused by this accident took longer to heal and the complaints directly related to the injuries caused by this accident were more severe as a result of the Degenerative Disc Disease.

SURPRISE IMPACT

According to Mertz and Patrick, the unaware occupant is at greater risk of injury. *(Mertz JH, Patrick LM. Investigation of the Kinematics and kinetics of whiplash. 1967; SAE 670919.)*

Our client stated that he was wearing his safety belts (lap and shoulder harness) at the time of the accident.

"According to Allen, Barnes and Bowidala, shoulder belts are very effective at saving lives in auto accidents, but there is some evidence that they can actually cause more damage in a rear end collision. Because the body is held in place, the neck suffers worse hyperflexion. The cervical spine may also undergo a twisting motion from the head restraint, causing a more complex injury." *(Allen MJ, Barnes MR, Bodiwala GG. The effect of a seat belt legislation on the injuries sustained by car occupants. Injury: The British Journal of Accident Surgery 1985; 16; 471-476)*

NECK AND BACK INJURIES

Provider	# of Tx	Last Tx Date	Prognosis
Dr. John Doe	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. John Doe	7/19/2007
Anxiety/Depression	Dr. John Doe	7/19/2007
Dizziness	Dr. John Doe	7/19/2007
Headaches	Dr. John Doe	7/19/2007
Spasms	Dr. John Doe	7/19/2007
Visual Disturbance	Dr. John Doe	7/19/2007
Radiating Pain	Dr. John Doe	7/19/2007
Sleep Disruption	Dr. John Doe	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. John Doe	7/19/2007
Acupuncture	Prolonged Regular	Dr. John Doe	8/12/2006
Bed Rest	Prolonged Regular	Dr. John Doe	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

OTHER INJURIES

CERVICAL SPRAIN/STRAIN

Provider	# of Tx	Last Tx Date	Prognosis
Dr. John Doe	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. John Doe	7/19/2007
Anxiety/Depression	Dr. John Doe	7/19/2007
Dizziness	Dr. John Doe	7/19/2007
Headaches	Dr. John Doe	7/19/2007
Spasms	Dr. John Doe	7/19/2007
Visual Disturbance	Dr. John Doe	7/19/2007
Radiating Pain	Dr. John Doe	7/19/2007
Sleep Disruption	Dr. John Doe	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. John Doe	7/19/2007
Acupuncture	Prolonged Regular	Dr. John Doe	8/12/2006
Bed Rest	Prolonged Regular	Dr. John Doe	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

LUMBAR SPRAIN/STRAIN

Provider	# of Tx	Last Tx Date	Prognosis
Dr. John Doe	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted

Range of Motion	Dr. John Doe	7/19/2007
Anxiety/Depression	Dr. John Doe	7/19/2007
Dizziness	Dr. John Doe	7/19/2007
Headaches	Dr. John Doe	7/19/2007
Spasms	Dr. John Doe	7/19/2007
Visual Disturbance	Dr. John Doe	7/19/2007
Radiating Pain	Dr. John Doe	7/19/2007
Sleep Disruption	Dr. John Doe	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. John Doe	7/19/2007
Acupuncture	Prolonged Regular	Dr. John Doe	8/12/2006
Bed Rest	Prolonged Regular	Dr. John Doe	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

The following injuries were documented on the MRI's which occurred on July 19th, 2005 and read by Dr. Sam Feelgood, M.D. In his reading, Dr. Sam Feelgood states under Findings:

L5-S1: Degenerative signal loss is present in the disc. Mild to moderate, 2-3 mm, central and bilateral paracentral posterior disc bulge. Minimal posterior osteophytosis. Minor bilateral articular facet hypertrophy. Minor central stenosis. Moderate bilateral neural foraminal narrowing.

C4-5: Degenerative loss of signal and height is present in the disc. Mild to moderate, 2-3 mm, posterior annular disc bulge. Minor posterior osteophytosis. Mild to moderate bilateral uncovertebral joint hypertrophy. Mild to moderate central stenosis and bilateral neural foraminal narrowing.

C5-6: Minimal posterior annular disc bulge without osteophytosis. Minor bilateral uncovertebral joint hypertrophy. Minor central stenosis and bilateral neural foraminal narrowing.

C6-7: Degenerative loss of signal and height is present in the disc. Mild to moderate, 2-3 mm, posterior annular disc bulge. Minor posterior osteophytosis. Mild to moderate bilateral uncovertebral joint hypertrophy. Moderate central stenosis and bilateral neural foraminal narrowing.

Conclusion: Spondylotic change at L4-5, L5-S1, C4-5, C5-6, and C6-7.

L5-S1

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. William Well, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. John Doe	7/19/2007
Anxiety/Depression	Dr. John Doe	7/19/2007
Dizziness	Dr. John Doe	7/19/2007
Headaches	Dr. John Doe	7/19/2007
Spasms	Dr. John Doe	7/19/2007
Visual Disturbance	Dr. John Doe	7/19/2007
Radiating Pain	Dr. John Doe	7/19/2007
Sleep Disruption	Dr. John Doe	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. John Doe	7/19/2007
Acupuncture	Prolonged Regular	Dr. John Doe	8/12/2006
Bed Rest	Prolonged Regular	Dr. John Doe	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

C4-5

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. William Well, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. John Doe	7/19/2007
Anxiety/Depression	Dr. John Doe	7/19/2007
Dizziness	Dr. John Doe	7/19/2007
Headaches	Dr. John Doe	7/19/2007
Spasms	Dr. John Doe	7/19/2007
Visual Disturbance	Dr. John Doe	7/19/2007
Radiating Pain	Dr. John Doe	7/19/2007
Sleep Disruption	Dr. John Doe	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. John Doe	7/19/2007
Acupuncture	Prolonged Regular	Dr. John Doe	8/12/2006

Bed Rest	Prolonged Regular	Dr. John Doe	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

C5-6

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. Sam Feelgood, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. John Doe	7/19/2007
Anxiety/Depression	Dr. John Doe	7/19/2007
Dizziness	Dr. John Doe	7/19/2007
Headaches	Dr. John Doe	7/19/2007
Spasms	Dr. John Doe	7/19/2007
Visual Disturbance	Dr. John Doe	7/19/2007
Radiating Pain	Dr. John Doe	7/19/2007
Sleep Disruption	Dr. John Doe	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. John Doe	7/19/2007
Acupuncture	Prolonged Regular	Dr. John Doe	8/12/2006
Bed Rest	Prolonged Regular	Dr. John Doe	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

C6-7

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. William Well, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted

Range of Motion	Dr. John Doe	7/19/2007
Anxiety/Depression	Dr. John Doe	7/19/2007
Dizziness	Dr. John Doe	7/19/2007
Headaches	Dr. John Doe	7/19/2007
Spasms	Dr. John Doe	7/19/2007
Visual Disturbance	Dr. John Doe	7/19/2007
Radiating Pain	Dr. John Doe	7/19/2007
Sleep Disruption	Dr. John Doe	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. John Doe	7/19/2007
Acupuncture	Prolonged Regular	Dr. John Doe	8/12/2006
Bed Rest	Prolonged Regular	Dr. John Doe	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

LEFT HIP

Injury Type: Contusion
Duration: 1 to 3 months
Prognosis: Undetermined

Physician: Dr. John Doe
Last Date Noted: 7/19/2007

Physician: Dr. Sam Feelgood
Last Date Noted: 8/10/2004

Anxiety/Depression

Physician: Dr. John Doe
Duration: Undetermined
Chart Date: 7/19/2007
Treatment(s): Exercise

FREQUENCY, TIMING, AND COURSE OF DEPRESSIVE SYMPTOMOTOLOGY AFTER WHIPLASH.

Carroll LJ, Cassidy JD, Cote P.Department of Public Health Sciences, University of Alberta,Edmonton, Alberta, Canada. lcarroll@ualberta.ca

STUDY DESIGN: Population-based incidence cohort. OBJECTIVE: To report the incidence, timing, and course of depressive symptoms after whiplash.

SUMMARY OF BACKGROUND DATA: Evidence is conflicting about the frequency, time of onset, and course of depressive symptoms after whiplash. METHODS: Adults making an insurance claim or seeking health care for traffic-related whiplash were followed by telephone interview at 6 weeks, and 3, 6, 9, and 12 months post-injury. Depressive symptoms were assessed at baseline and at each follow-up. RESULTS: Of the 5,211 subjects reporting no pre-injury mental health problems, 42.3% (95% confidence interval, 40.9-43.6) developed depressive symptoms within 6 weeks of the injury, with subsequent onset in 17.8% (95% confidence interval, 16.5-19.2). Depressive symptoms were recurrent or persistent in 37.6% of those with early post-injury onset. Pre-injury mental health problems increased the risk of later onset depressive symptoms and of a recurrent or persistent course of early onset depressive symptoms.

CONCLUSIONS:

Depressive symptomotology after whiplash is common, occurs early after the injury, and is often persistent or recurrent. This suggests that, like neck pain and headache, depressed symptomotology is part of the cluster of acute whiplash symptoms. Clinicians should be aware of both physical and psychological injuries after traffic collisions.

PMID: 16845342 [PubMed - indexed for MEDLINE]

IMPAIRMENT

Physician	Chart Date	Whole Body %	Body Part
Dr. John Doe	7/19/2007	26	Cervical, Thoracic, Lumbar vertebra

DUTIES UNDER DURESS

Hobbies
Work
Domestic Duties
Household Duties

Physician	Chart Date
Dr. John Doe	7/19/2007

Dr. Doe documented the following statements of my client:

"Extended sitting or attending computer classes cause radiating pain from my low back and pain as well as stiffness in my neck. It resolves into rigid and stiffness, restricted movement, which never seems to go away. Vacuuming increases low back pain. I have difficulty preparing larger meals such as Thanksgiving and Christmas. I have had to hire a person to help with heaving cleaning throughout the home. Yard work increases neck and low back pain. Transporting my family increases numbness in my hands and they go to sleep. While standing in the checkout line during shopping my pain increases and I experience dizziness and nausea. When I awake in the morning my arms are numb."

LOSS OF ENJOYMENT OF LIFE

Domestic Duties

Household Duties
Hobbies
Work\Study
Sports

My client stated the following in Dr. Doe's records:

"I have had to limit my relationship with my husband as this causes pain in my lower back to increase. I am unable to participate in recreational activities with my children because it will increase my pain. I was not able to participate with my children in rafting, attending amusement parks or water parks. I could not enjoy dancing with my husband or playing volleyball with my family. I have been reduced to a spectator.

While in school, drafting and drawing would increase the pain in my upper back and neck. I have stopped doing a lot of activities such as dancing, driving and sewing because it increases my pain. My husband is legally blind and I am responsible for all the driving in our family of 4 children."

Physician	**Chart Date**
Dr. John Doe	7/19/2007

DISABILITY

Dr. Sam Feelgood, D.C. in his report of August 01, 2005, he states the following:

"...Her injuries are permanent in nature and she has been given the following restrictions to avoid an aggravation of her condition:

1. no lifting over 15lbs
2. no repeated overhead lifting or working with the arms in an outstretched position
3. no sitting or standing for over 30 minutes at a time without changing positions and taking a break
4. no repeated bending and twisting at the waist

She will need to receive treatment over the next three year period on a prn basis to control her symptoms and exacerbations which are likely to occur. Approximate treatment will cost $60.00 per visit for therapies and spinal adjustments at an estimated 15-20 visits yearly, $900-1,200 per year.

Physician	**Chart Date**
Dr. Sam Feelgood	8/1/2005

CURRENT MEDICAL EXPENSES

Exercise Program		$792.00
Dr. John Doe, DC	Physician	$4,845.00
BioImaging, MD	Physician	$1,960.00
Dr. Sam Feelgood, DC	Physician	$3,132.00
Natural Oasis Spa, TH	Physician	$150.00
Total Physician Expenses		$10,879.00

FUTURE MEDICAL EXPENSES

My client stated that he felt pain immediately after the accident.

"A study by Radanov found that patients who reported pain immediately after their accidents were more likely to have pain at two years post-injury. It is generally recognized that patients with immediate symptoms are at a higher risk of long-term pain from whiplash." *(Radanov, BP, Sturzenegger M, De Stefano G. Long-term outcome after whiplash injury. A two-year follow-up considering the features of injury mechanisms and somatic, radiologic and psychosocial findings. Medicine 1995; 74(5): 281-476.)*

Dr. Sam Feelgood, D.C. in his report of August 01, 2005, states the following:

"...Her injuries are permanent in nature and she has been given the following restrictions to avoid an aggravation of her condition:

1. no lifting over 15lbs
2. no repeated overhead lifting or working with the arms in an outstretched position
3. no sitting or standing for over 30 minutes at a time without changing positions and taking a break
4. no repeated bending and twisting at the waist

She will need to receive treatment over the next three year period on a prn basis to control her symptoms and exacerbations which are likely to occur. Approximate treatment will cost $60.00 per visit for therapies and spinal adjustments at an estimated 15-20 visits yearly, $900-1,200 per year.

Future Treatment	Future Cost	Physician	Chart Date
Chiropractic and Therapy	$3,600.00	Dr. Sam Feelgood	8/1/2005

Total Future Medical Costs: $3,600.00

MILEAGE

Mileage to/from Physicians

Mileage for all 121 visits is based on 35 miles round-trip. The total miles driven for medical treatment equals 4,235. This figure multiplied times the federal mileage rate of $.425 per mile equals $1,799.88.

EXPENSES SUMMARY

Physician Expenses:	$10,087.00
Mileage to and from physicians:	$1,799.88
House Cleaning:	$4,620.00
Future Medical:	$3,600.00
Future Income Loss:	*Undetermined*
Total Medical Expenses:	$20,106.88

On behalf of my client, I am asking that you request permission from your policyholder to release all information concerning all policies and their respective limits which would be available to satisfy the

damages of this claim. In consideration of current medical specials, current income loss, ongoing disabilities which will constitute future medical expenses and income loss, my client has agreed to release your policyholder in exchange for the payment of all available policy limits.

My client reserves all rights and defenses known or unknown that arise at either law or equity. The above claim for bodily injury and damages has been submitted with the current knowledge of my client's injuries and damages, however, we reserve the right to supplement or amend either the claim for liability or damages. No comment action or inaction should be construed as to waive, alter, or modify any rights and or defenses possessed by my client. All rights and defenses are reserved.

Please respond to the above requests and demand within 10 business days of your receipt of this demand.

Sincerely,

_____
Justice Jones, Attorney at Law

EXHIBIT LISTINGS:

Medical Reports
Medical Records
Medical Billings
DUD/LOE Worksheets

F e e l g o o d M e d i c a l C l i n i c

Dr. Sam Feelgood, D.C.
1111 Getwell Drive
Anywhere, State 2222

SAMPLE MEDICAL REPORT

LAW OFFICES OF JUSTICE JONES
Justice Jones, Attorney at Law
1506 Claim Drive
Claim Hill, Claim 11111

Claim No: 44-444-4444
Your Client: Janice Doe
Date of Loss: 8/10/2004
My Patient: Janice Doe

Dear Mr. Jones:

My patient was involved in the automobile accident of 8/10/2004. After the accident my patient experienced severe pain in her neck, mid-back, lower-back, and chest. My patient was examined at the accident scene and transported to the emergency room by ambulance. Ms. Doe came into my clinic for her visit on August 10th, 2004.These injuries were all expressed to me and documented in my medical records attached for your review.

The following aspects of my patient's claim were gathered from the medical records for your convenience.

DOB: 9/28/1957 I am Right-Handed.
Gender: Female

Medical Specials: $10,087.00
Future Medical Costs: $3,600.00

Date of First Treatment: 8/10/2004

INJURIES:

Neck and Back, Disc Bulges at L5-S1, C4-5, C5-6, and C6-7, Left Hip Contusion, Cervical, Lumbar Sprain/Strains

ICD9 Injury Codes: 739.1, 739.2, 739.3, 839.0, 839.2, 839.4, 847.0, 847.1, 847.2, 728.4 (Cervical, Thoracic and Lumbar areas), 359.3, 729.1, 799.1, 799.4, 307.81, 308.0, 780.5, 728.85, 780.4, 780.79, 782.0

CPT Treatment Codes: 97010, 97014, 97012, 98941, 98942, 97032

PRIOR/SUBSEQUENT INJURIES:

Degenerative Disc Disease existed prior to this accident. However, there were no existing complaints or symptoms being experienced prior to this accident. There was no treatment being provided for this condition. This condition is only relevant in that, the injuries caused by this accident took longer to heal and the complaints directly related to the injuries caused by this accident were more severe as a result of the Degenerative Disc Disease.

SURPRISE IMPACT

According to Mertz and Patrick, the unaware occupant is at greater risk of injury. *(Mertz JH, Patrick LM. Investigation of the Kinematics and kinetics of whiplash. 1967; SAE 670919.)*

Our patient stated that she was wearing her safety belts (lap and shoulder harness) at the time of the accident.

"According to Allen, Barnes and Bowidala, shoulder belts are very effective at saving lives in auto accidents, but there is some evidence that they can actually cause more damage in a rear end collision. Because the body is held in place, the neck suffers worse hyperflexion. The cervical

spine may also undergo a twisting motion from the head restraint, causing a more complex injury." [12]

NECK AND BACK INJURIES

Provider	# of Tx	Last Tx Date	Prognosis
Dr. John Smith, MD	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

OTHER INJURIES

CERVICAL SPRAIN/STRAIN

Provider	# of Tx	Last Tx Date	Prognosis
Dr. Sam Feelgood, DC	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007

[12] **Allen MJ, Barnes MR, Bodiwala GG. The effect of a seat belt legislation on the injuries sustained by car occupants. Injury: The British Journal of Accident Surgery 1985; 16; 471-476**

Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

THORACIC SPRIAN/STRAIN

Provider	# of Tx	Last Tx Date	Prognosis
Dr. Sam Feelgood, DC	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

LUMBAR SPRAIN/STRAIN

Provider	# of Tx	Last Tx Date	Prognosis
Dr. Sam Feelgood, DC	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

CERVICAL LIGAMENT LAXITY

Provider	# of Tx	Last Tx Date	Prognosis
Dr. Sam Feelgood, DC	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007

Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

THORACIC LIGAMENT LAXITY

Provider	# of Tx	Last Tx Date	Prognosis
Dr. John Smith, MD	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

LUMBAR LIGAMENT LAXITY

Provider	# of Tx	Last Tx Date	Prognosis
Dr. John Smith, MD	79	8/5/2006	Complaints/treatment recommended
Dr. Sam Feelgood	42	7/22/2005	Complaints/treatment recommended

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

The following injuries were documented on the MRI's which occurred on July 19th, 2005 and read by Dr. John Smith, MD. In his reading, Dr. Smith states under Findings:

L5-S1: Degenerative signal loss is present in the disc. Mild to moderate, 2-3 mm, central and bilateral paracentral posterior disc bulge. Minimal posterior osteophytosis. Minor bilateral articular facet hypertrophy. Minor central stenosis. Moderate bilateral neural foraminal narrowing.

C4-5: Degenerative loss of signal and height is present in the disc. Mild to moderate, 2-3 mm, posterior annular disc bulge. Minor posterior osteophytosis. Mild to moderate bilateral uncovertebral joint hypertrophy. Mild to moderate central stenosis and bilateral neural foraminal narrowing.

C5-6: Minimal posterior annular disc bulge without osteophytosis. Minor bilateral uncovertebral joint hypertrophy. Minor central stenosis and bilateral neural foraminal narrowing.

C6-7: Degenerative loss of signal and height is present in the disc. Mild to moderate, 2-3 mm, posterior annular disc bulge. Minor posterior osteophytosis. Mild to moderate bilateral uncovertebral joint hypertrophy. Moderate central stenosis and bilateral neural foraminal narrowing.

Conclusion: Spondylotic change at L4-5, L5-S1, C4-5, C5-6, and C6-7.

L5-S1

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. William Well, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

C4-5

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. William Well, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007

Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

C5-6

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. Sam Feelgood, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted

MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

C6-7

Injury Type:	Disc Injury - bulge
Duration:	25 to 36 months
Prognosis:	Complaints/treatment recommended
Physician:	Dr. William Well, M.D., BioImaging
Last Date Noted:	7/19/2005

History of Complaints:

Symptom	Physician	Date Noted
Range of Motion	Dr. Sam Feelgood, DC	7/19/2007
Anxiety/Depression	Dr. Sam Feelgood, DC	7/19/2007
Dizziness	Dr. Sam Feelgood, DC	7/19/2007
Headaches	Dr. Sam Feelgood, DC	7/19/2007
Spasms	Dr. Sam Feelgood, DC	7/19/2007
Visual Disturbance	Dr. Sam Feelgood, DC	7/19/2007
Radiating Pain	Dr. Sam Feelgood, DC	7/19/2007
Sleep Disruption	Dr. Sam Feelgood, DC	7/19/2007

Therapies:

Therapy	Duration	Physician	Last Date Noted
Massage Therapy	Short-Term	Natural Oasis Spa	12/10/2004
Self-Exercise	Prolonged Regular	Dr. Sam Feelgood, DC, MD	7/19/2007
Acupuncture	Prolonged Regular	Dr. Sam Feelgood, DC, MD	8/12/2006
Bed Rest	Prolonged Regular	Dr. Sam Feelgood, DC, MD	8/12/2006

Testing:

Test Type	Test Result	Physician	Date Noted
MRI	Positive	BioImaging	7/19/2005
X-Ray	Positive	Dr. Sam Feelgood	8/10/2004

LEFT HIP

Injury Type:	Contusion
Duration:	1 to 3 months
Prognosis:	Undetermined
Physician:	Dr. Sam Feelgood, DC, MD
Last Date Noted:	7/19/2007
Physician:	Dr. Sam Feelgood
Last Date Noted:	8/10/2004

Anxiety/Depression

Physician: Dr. John Smith, MD
Duration: Undetermined
Chart Date: 7/19/2007
Treatment(s): Exercise

FREQUENCY, TIMING, AND COURSE OF DEPRESSIVE SYMPTOMOTOLOGY AFTER WHIPLASH.[13]

STUDY DESIGN: Population-based incidence cohort. OBJECTIVE: To report the incidence, timing, and course of depressive symptoms after whiplash.

SUMMARY OF BACKGROUND DATA: Evidence is conflicting about the frequency, time of onset, and course of depressive symptoms after whiplash. METHODS: Adults making an insurance claim or seeking health care for traffic-related whiplash were followed by telephone interview at 6 weeks, and 3, 6, 9, and 12 months post-injury. Depressive symptoms were assessed at baseline and at each follow-up. RESULTS: Of the 5,211 subjects reporting no pre-injury mental health problems, 42.3% (95% confidence interval, 40.9-43.6) developed depressive symptoms within 6 weeks of the injury, with subsequent onset in 17.8% (95% confidence interval, 16.5-19.2). Depressive symptoms were recurrent or persistent in 37.6% of those with early post-injury onset. Pre-injury mental health problems increased the risk of later onset depressive symptoms and of a recurrent or persistent course of early onset depressive symptoms.

CONCLUSIONS:

Depressive symptomotology after whiplash is common, occurs early after the injury, and is often persistent or recurrent. This suggests that, like neck pain and headache, depressed symptomotology is part of the cluster of acute whiplash symptoms. Clinicians should be aware of both physical and psychological injuries after traffic collisions.

IMPAIRMENT

Physician	Chart Date	Whole Body %	Body Part
Dr. John Smith	7/19/2007	26	Cervical, Thoracic, Lumbar vertebra

DUTIES UNDER DURESS

Hobbies
Work
Domestic Duties
Household Duties

Physician	Chart Date
Dr. John Smith	7/19/2007

I have documented the following patient comments:

[13] **Carroll LJ, Cassidy JD, Cote P.Department of Public Health Sciences, University of Alberta,Edmonton, Alberta, Canada. PMID: 16845342 [PubMed - indexed for MEDLINE]**

“Extended sitting or attending computer classes cause radiating pain from my low back and pain as well as stiffness in my neck. It resolves into rigid and stiffness, restricted movement, which never seems to go away. Vacuuming increases low back pain. I have difficulty preparing larger meals such as Thanksgiving and Christmas. I have had to hire a person to help with heaving cleaning throughout the home. Yard work increases neck and low back pain. Transporting my family increases numbness in my hands and they go to sleep. While standing in the checkout line during shopping my pain increases and I experience dizziness and nausea. When I awake in the morning my arms are numb.”

LOSS OF ENJOYMENT OF LIFE

Domestic Duties
Household Duties
Hobbies
Work\Study
Sports

My patient stated the following:

“I have had to limit my relationship with my husband as this causes pain in my lower back to increase. I am unable to participate in recreational activities with my children because it will increase my pain. I was not able to participate with my children in rafting, attending amusement parks or water parks. I could not enjoy dancing with my husband or playing volleyball with my family. I have been reduced to a spectator.

While in school, drafting and drawing would increase the pain in my upper back and neck. I have stopped doing a lot of activities such as dancing, driving and sewing because it increases my pain. My husband is legally blind and I am responsible for all the driving in our family of 4 children.”

Physician	**Chart Date**
Dr. John Smith	7/19/2007

DISABILITY

On August 01, 2005, I documented the following regarding my patient:

"...Her injuries are permanent in nature and she has been given the following restrictions to avoid an aggravation of her condition:

5. no lifting over 15lbs
6. no repeated overhead lifting or working with the arms in an outstretched position
7. no sitting or standing for over 30 minutes at a time without changing positions and taking a break
8. no repeated bending and twisting at the waist

She will need to receive treatment over the next three year period on a prn basis to control her symptoms and exacerbations which are likely to occur. Approximate treatment will cost $60.00 per visit for therapies and spinal adjustments at an estimated 15-20 visits yearly, $900-1,200 per year.”

Physician	Chart Date
Dr. Sam Feelgood	8/1/2005

CURRENT MEDICAL EXPENSES

Exercise Program		$792.00
Dr. John Smith, MD	Physician	$4,845.00
BioImaging, MD	Physician	$1,960.00
Dr. Sam Feelgood, DC	Physician	$3,132.00
Natural Oasis Spa, TH	Physician	$150.00
Total Physician Expenses		$10,879.00

FUTURE MEDICAL EXPENSES

My patient stated that she felt pain immediately after the accident.

"A study by Radanov found that patients who reported pain immediately after their accidents were more likely to have pain at two years post-injury. It is generally recognized that patients with immediate symptoms are at a higher risk of long-term pain from whiplash."[14]

On August 01, 2005, I documented the following regarding my patient:

"...Her injuries are permanent in nature and she has been given the following restrictions to avoid an aggravation of her condition:

5. no lifting over 15lbs
6. no repeated overhead lifting or working with the arms in an outstretched position
7. no sitting or standing for over 30 minutes at a time without changing positions and taking a break
8. no repeated bending and twisting at the waist

She will need to receive treatment over the next two year period on a prn basis to control her symptoms and exacerbations which are likely to occur. Approximate treatment will cost $60.00 per visit for therapies and spinal adjustments at an estimated 15-20 visits yearly, $900-1,200 per year.

Future Treatment	Future Cost	Physician	Chart Date
Chiropractic and Therapy	$3,600.00	Dr. Sam Feelgood	8/1/2005

Total Future Medical Costs: $3,600.00

EXPENSES SUMMARY

Physician Expenses:	$10,087.00
Future Medical:	$3,600.00
Total Medical Expenses:	$13,687.00

All injuries as documented are a direct result of this accident. Treatment will continue for Ms. Doe

[14] **Radanov, BP, Sturzenegger M, De Stefano G. Long-term outcome after whiplash injury. A two-year follow-up considering the features of injury mechanisms and somatic, radiologic and psychosocial findings. Medicine 1995; 74(5): 281-476.**

on an as needed basis as stated above. If there is a claim any of the medical treatment was unnecessary or any of the bills were unreasonable, please request in writing specific identification which bills are in dispute and the factual basis for this dispute. If there is a dispute by a qualified expert opinion from a doctor willing to testify, then please provide me with a copy of the report. If not then please confirm in writing that the bills are disputed by an adjuster and not a qualified medical professional.

If you do not respond in writing to this request, I will assume the amount of medical bills associated with the duration, type and frequency of the necessary treatment is not in dispute.

Please respond to the above requests and Medical Report within 10 business days of your receipt of this Medical Report.

Sincerely,

_____

Dr. Sam Feelgood, D.C.

ATTACHMENT LISTINGS:

Medical Reports
Medical Records
Medical Billings

PERSONAL INJURY UNIVERSITY SYLLABUS

Attorneys/Physicians

Breakfast Networking and Registration 7-8

1. Seminar Sponsor/Vender Introduction	- Dr. DeGaetano	30 mins	8-8:30
2. Guest Speaker	– Guest	1 hour	8:30-9:30
3. History of Insurance Claim Practices	- Mathis	1 hour	9:30-10:30
4. Break		**15 minutes**	**10:30-10:45**
5. Claim Practices and Software	- Mathis	1 ¼ hour	10:45- 12:00
6. Lunch		**1 hour**	**12:00-1:00**
7. Impairment -	- Ciello/Mathis	1 ½ hour	1:00-2:30
8. DUD/LOE	- Mathis	30 minutes	2:30-3:00
9. Break		**15 minutes**	**3:00-3:15**
10. Minor Impact	- Mathis	30 minutes	3:15-3:45
11. SIU (Fraud Department)	- Mathis	30 minutes	3:45-4:15
12. PI University	- DeGaetano	45 minutes	4:15-5:00
	CLE/CME time		**7.25 hours**
Optional Panel Q&A			**1hour**

Attendee Evaluation Form

Thank you for attending this seminar. Please complete this form and hand it in at the back of the room or leave it on the table where you are sitting. We sincerely appreciate your participation.

I attended the seminar and overall I found it to:

(1=Strongly Agree; 2=Agree; 3=Disagree; 4=Strongly Disagree)

	Strongly Agree			Strongly Disagree
Have a suitable program	1	2	3	4
Have good speakers	1	2	3	4
Be in a good location	1	2	3	4
Be well organized	1	2	3	4

Specific Comments:

How valuable were these parts of the program to you?

(1=Quite valuable; 2=Valuable; 3=Somewhat valuable; 4=Not at all; N/A=Not applicable)

	Quite Valuable			Not at all	
Keynote Speaker	1	2	3	4	N/A
Invited Speaker	1	2	3	4	N/A
Other Speaker	1	2	3	4	N/A

The seminar was on Friday. For future conferences, would you prefer?

[ ] Weekend (Saturday [ ] Midweek pattern
(e.g. Monday-Wednesday)

How would you rate the seminar manual provided?

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

How would you rate the vendors present at the seminar?

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

How would you rate the _____ Hotel as the site for the seminar?

[ ] Excellent [ ] Good [ ] Fair [ ] Poor

Would you attend a future seminar on this topic?

[ ] Yes [ ] No

Please feel free to provide additional comments on the reverse of this form. Thank you for your time.