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 during the last four years,

- 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, Burton vs. Mountain West Farm Bureau Mutual Insurance Co. in the state of Montana and in Arizona, Skene vs. State Farm. I have also offered an expert opinion and/or been deposed in the following individual lawsuits:

- AAA Nevada Insurance Company vs. Vinh Chau; Lang Chau; State of Nevada; United States District Court, District of Nevada; Case No. 2:08-cv-822-RJJ-LRL;
- AFO Imaging, Inc. as assignee of Bonhomme Debouquet, Ismene Menuir, Bictor Morgan, and Tingahar Taraba vs. Dairyland Insurance Company, State of Florida; In The Circuit Court of The Thirteenth Judicial Court, In and For Hillsborough County, Florida; Case No.: 08-CA-002771;
- Allstate Insurance Company And Allstate Indemnity Company, vs. Keith M. Stone, D.C.; Clinica Real, Llc; American Back Institute, Inc; John V. Stone; Darrel Schaeffer, D.C.; Edna Van Natta; And Patricia Rascon; Arizona In The United States District Court For The District Of Arizona; No. 07-1481-PHX-JAT
- Ambrose vs. Gary Coffey, et. al., State of California; United States District Court, Eastern District of California; No. CV-01664-LKK-GGH;

- 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;
- Allstate Insurance Company et al v. Michael Kent Plambeck, et al, Texas; United States District Court for the Northern District of Texas, Dallas Division; Civil Action No. 3:08CV-0388-M;
- Bane vs. State Farm Mutual Automobile Insurance Company, et al, Alabama; In the Circuit Court of Madison County, Alabama; Civil Action No. CV05-2334;
- Berry vs. Allstate Insurance Company, Michigan; United States District Court, Eastern District of Michigan, Southern Division; Case No. 2:07-CV-14627;
- 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;
- Brown vs. Property & Casualty Insurance Company of Hartford, Nevada; United States District Court, District of Nevada; Case No 2:07-CV-00998-LDG-RJJ;
- Burger vs. Allstate Insurance Company, Michigan; State of Michigan in the Circuit Court for the County of Wayne;
- Burton vs. Mountain West Farm Bureau Mutual Insurance Co. in the state of Montana; The United States District Court for the District of Montana Missoula Division, Cause No. CV 00-95-M-DWM;
- 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;
- Cincinnati Insurance Company v. State Farm Mutual Automobile Insurance Company, Ohio; United States District Court, northern District of Ohio, Eastern Division; Case No. 06CV3081;
- Cobb vs. Allstate Insurance Company, an Illinois corporation; Jim Biggs D/B/A Jim Biggs & Associates, State of Alabama;
- 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;
- Doan vs. Allstate Insurance Company, Michigan; United States district Court, Eastern District of Michigan, Southern Division; Case No. 5:07-cv-13957;
- 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;
- 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;
- Georgeff vs. Allstate Insurance Company, California; Superior court of the State of California for the Country of Ventura; Case No. SC044950;
- Goldstein vs. National Farmers Union, Montana; Montana Twelfth Judicial District Court, Hill County; Case No. DV-98-044;
- Hanley vs. Safeco, Montana; The United States District Court for the District of Montana Missoula Division; Case No. CV-01-217-M-DWM;
- Harry vs. State Farm Mutual Automobile Insurance Company, California; Superior Court of the State of California for the County of Orange, Central Justice Center; Case No. 00CC05795;
- Henke vs. State Farm Mutual Automobile Insurance Company, Washington; The Superior Court State of Washington for King County; Case No. 99-2-11808-7;
- Henry vs. Myers and State Farm Mutual Automobile Insurance Company, State of Indiana, County of Bartholomew, Bartholomew Circuit Court, Cause No: 03C01 0003 CT 556;
- 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;
- Hutt vs. State Farm Mutual Automobile Insurance Company, Pennsylvania; Court of Common Pleas, Philadelphia County; NO. 000176;
- Irene vs. Allstate Property and Casualty and Allstate Insurance Company, Colorado; In the United States District Court for the District of Colorado; Civil Action No. 08-cv-01265-RPM;
- 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);
- Jacqueline Adoski vs. American Family Mutual Insurance Company, a Wisconsin Corporation, Chloe Stewart, individually, State of Nevada, District Court Clark County, Nevada, Case number A532586, Dept. Number XXII;
- Jimkoski vs. State Farm Mutual Automobile Insurance Company, Michigan; The United States District Court for The Eastern District of Michigan, Southern Division; Case No. 02 CV 71701;
- Jon Hall, on behalf of himself and all others similarly situated vs. State Farm Mutual Automobile Insurance Company, Michigan: State of Michigan in the Circuit Court for the County of Macomb, Case No. 04-5356-CK;
- Joy vs. Allstate Indemnity Company; Washington; Superior Court, State of Washington, Spokane County; Case NO. 03-2-06286-8;
- Keegan vs. State Farm Mutual Automobile Insurance Company; State of Oklahoma; In The District Court of Jackson County, State of Oklahoma; Case No. CJ-07-567;
- Lawson, a legally incapacitated individual, by and through her guardian, Rebie Britton, and Rebie Britton, individually vs. Titan Insurance Company, Michigan; State of Michigan, The Circuit Court for The County of Wayne; Case No: 08- 116431 NF;
- Laurrance vs. Allstate, California; The United States District Court, Eastern District of California; Case No. CIV.S-00-1300 EJG GGH;
- 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;
- Mathis vs. State Farm Mutual Automobile Insurance Company, Washington, King County; US. District Court, Western District of Washington at Seattle; Case No. C97-1552 Z;
- McAllister vs. State Farm Mutual Automobile Insurance Company, Washington; Superior Court of Washington for Grays Harbor County; Case No. 92-2-01187-6;
- McGee vs. State Farm Mutual Automobile Insurance Company, Indiana; The Vanderburgh Superior Court, County of Vanderburgh; Case No. 82D03-0112-CT-4277;
- McLeod vs. State Farm Lloyds, Texas, The District Court of Travis County, Texas, 98th Judicial District, Cause No. GN204025;
- Mesa vs. State Farm Mutual Automobile Insurance Company, Wyoming; The District Court Eighth Judicial District; Case No. 13559;
- Mills vs. State Farm Mutual Automobile Insurance Company, Florida; In The Circuit Court, Eighth Judicial Circuit, In And For Alachua County, Florida; Civil No. 01-2007-CA-5039, Division J;
- Moceri vs. Auto Club Insurance Association, Michigan; State of Michigan, In the Circuit Court for the County of Macomb; Case No. 07-915;
- 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;
- Mulready vs. Allstate, Florida; The Circuit Court of the 12th Judicial Circuit in and for Sarasota County, Florida; Case No. 99-2496CA;
- Murphy vs. Swain and State Farm Mutual Automobile Insurance Company, Indiana; The Bartholomew Circuit Court, State of Indiana; Cause No. 03C01-0108-CT-1223;
- 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;
- Nicholson vs. State Farm Mutual Automobile Insurance Company, West Virginia; The Circuit Court of Monongalia County, West Virginia Division 1; Case No. 99-C-156;
- O'Reilly vs. State Farm Mutual Automobile Insurance Company, Washington; Superior Court of Washington for County of King; Case No. 00-2-11548-2KNT;
- Origel vs. Northwestern Insurance Company et al., California; United States District Court, Northern District of California; No. C05-04633 JCS;
- Pakenas, Guardian of Patti Rovers vs. State Farm Mutual Automobile Insurance Company, Michigan; United States District Court for the Eastern District of Michigan; Case No.: 05-CV60152;
- 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;
- Patti Murray, Guardian and Conservator for Nicholes Murray, an Incapacitated Individual v State Farm Mutual Automobile Insurance Company, Wayne County Circuit Court, Case No.: 00-13377-NF;
- Peter White vs. American Family Mutual Insurance Company, et al, Nevada; District Court Clark County Nevada, Case Number A499947 Dept. XIII;
- 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;
- Safeco vs. Allstate, Washington; Superior Court of Washington for King County; Case No. 01-2-07895-0 SEA;
- Samsel vs. Allstate Insurance Company; In The Superior Court for The State of Arizona, In and For the County of Pima; No. C-310775;
- Stacie Schmidt vs. Allstate Insurance Company and ABC Insurance Company, Wisconsin; State of Wisconsin, Circuit Court, Rock County; Case No. 08-CV-1626, Case Code: 30106;
- Schroeder vs. State Farm, Arizona; The Superior Court of the State of Arizona, in and for the County of Maricopa; No. CV2002-010179;
- Shortt vs. Progressive Express Insurance Company, Florida; In the County Court in and for Sarasota County, Florida;
- 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;
- Stimac vs. Horace Mann Insurance Company and David Hill; in The State of Michigan, The Circuit Court for The County of Genesee; Case No: 09-9926-NF;
- Taylor vs. Allstate, South Carolina; The United States District Court for the District of South Carolina, Florence Division; Case No. 4:01-997-22;
- The Cincinnati Insurance Company vs. State Farm Fire & Casualty Co., Ohio; United States District Court Northern District of Ohio, Eastern Division; Case No. 1:06CV3081;
- The People of The State of California vs. Wilmer Origel, Superior Court of California, County of San Joaquin; No SFO94494A;
- Therese Garon, Guardian and Conservator for Jessica Garon, an Incapacitated Individuals v A.C.I.A., Macomb County Circuit Court, Case No.: 03-3857-NO;
- Tonegatto, Personal Representative for the Estate of Kevin Tonegatto, Deceased v State Farm Mutual Automobile Insurance Company, Macomb County Circuit Court, Case No.: 02-4792-NF;
- Universal Health Group vs. Allstate Insurance Company, Michigan, United States District Court, Eastern District of Michigan, Southern Division; Case No: 2:09-CV-12524;
- Van Emon vs. State Farm Mutual Automobile Company, Michigan, United States District Court For the Eastern District of Michigan, Southern Division; Case No.: 05-CV-72638;
- 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;
- 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;

- White vs. Benjamin Rodriquez, Javier Rodriquez, American Family Mutual Insurance Company, Nevada; District Court, Clark County, Nevada; Case No. A499947, Department XVII;
- Whitman vs. Auto Club Insurance Association; State of Michigan, The 29th Circuit Court for The County of Gratiot/ Case No.: 05-9347-NO;
- Marlene Williams, Guardian and Conservator for Margarite Williams, an Incapacitated Individuals v State Farm Mutual Automobile Insurance Company, Macomb County Circuit Court, Case No.: 02-4791-NF;
- Wilson vs. State Farm Mutual Automobile Insurance Company, Indiana; The Vermillion Circuit Court Sitting in Newport, Indiana; Case No. 83C01-0003-CT-17.

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,
- ChiroCode Institute,
- 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,
- 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"
- "ATLA Audio Presentation",
- "Business Week",
- "CNN" News
- "King 5 News", Seattle, Washington,
- "Lawyers USA",
- "Lawyers' Weekly",
- "Massachusetts Trial News",
- "NBC Dateline",
- "NBC News Affiliate", Portland, Oregon",
- "Nevada Chiropractic Newsletter",
- "Newsweek",
- "Plaintiff", Journal of Consumer Attorneys Association for Northern Calif.,
- "Seattle Post Intelligencer",
- "The Advocate", Journal of Consumer Attorneys Association for So. Calif.,
- "The Los Angeles Times",
- "The Los Angeles Weekly",
- "The Medical-Legal News",
- "The Oregonian",
- "The Pinet Directory"
- "The Wall Street Journal",
- "The Washington Post",
- "US News and World Report",
- "United PolicyHolders of America"

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- Aetna (see also Travelers)
- Allstate, by 1997
- American National Property & Casualty - since January 1997 in 38 states
- American Family Group of Madison, Wis., since November 1996
- American States, 1994
- Arrow Claims Management, an affiliate of Arrowhead General Insurance Agency, August 1997
- Atlantic Mutual Insurance Co., 1999
- Axa Insurance LTD, 2001
- Bishopsgate Insurance, April 2000
- California State Automobile Association, October 2000
- Explorer Insurance Company, Burbank, California, December 1997
- Farmers Insurance Exchange, May 2000
- Federated Mutual Insurance Company, Owatonna, Minn., April 1998
- General Casualty Insurance Companies (Winterthur Swiss Insurance Group), July 1998
- Grange Mutual Casualty Companies, Columbus, Ohio (Dec 1998)
- Great American Insurance Company (American Financial Group, Inc., Cincinnati, Ohio), March 1998
- Hartford Financial Services, May 2000
- Highlands Insurance Group, 1999
- Horace Mann Educators Corporation, 1999
- Keystone Insurance Companies of Philadelphia
- Metropolitan Group, R.I.
- National Farmers Union Property and Casualty Company, 1999
- Norwich Union (UK)
- Motorists Mutual-American Hardware Insurance Group, Columbus, Ohio, December 1998
- Ohio Casualty Group of Insurance Companies, January 1998
- OneBeacon Insurance Group, 2001
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- Safeco
- State Auto Insurance Companies of Columbus, Ohio, September 1996
- St. Paul Fire and Marine Insurance Company
- 21st Century Industries, February, 1997
- Travelers/Aetna Property Casualty, September 1996
- United Services Automobile Association (USAA), February 1997
- United States Fidelity & Guaranty Company
- Utica Mutual Insurance Company, 1999
- Westfield Companies, August 2000
- Zurich Personal Insurance (Maryland Casualty Company - also underwrites through Assurance Company of America, Northern Insurance Company of New York, Valiant Insurance Company, Maryland Insurance Company, Maine Bonding and Casualty Company, National Standard Insurance Company and Maryland Lloyds), June 1998

DISABILITY & IMPAIRMENT

The AMA *Guides to the Evaluation of Permanent Impairment* (the *Guides*) provides a reference framework within which physicians may evaluate and report medical impairment and within which non-medical recipients of information about impairment may understand and make appropriate use of the medical information they receive.

The *Guides* makes the following point perfectly clear. "An individual who is 'impaired' is not necessarily 'disabled'. Impairment gives rise to disability only when the medical condition limits the individual's capacity to meet demands that pertain to nonmedical fields and activities. On the other hand, if the individual is able to meet a particular set of demands, the individual is *not* 'disabled' with respect to those demands, even though a medical evaluation may reveal impairment."

The *Guides* defines impairment and disability as follows:

IMPAIRMENT (AMA)
". . . an alteration of an individual's health status that is assessed by medical means . . . Simply stated, 'impairment' is what is wrong with the health of an individual."

Loss of use of, or derangement of any body part, system or function.

The extent to which an individual is impaired when compared to the average person of the same age and sex.

FUNCTIONAL IMPAIRMENT
Medical impairment, disability rating: expressed as a percentage, e.g., 15% to the body as a whole.

DISABILITY (AMA)
". . . an alteration of an individual's health status which is assessed by nonmedical means . . . Simply stated, 'disability' is the gap between what the individual can do and what the individual needs or wants to do."

Limiting loss or the absence of the capacity of an individual to meet personal (ADLs), social or occupational demands.

Generally applied to employment (work activities) which the individual can no longer perform either temporarily or permanently for a job he/she has been trained for in the current labor market in a defined geographic area.

FORMULATION OF AN IMPAIRMENT RATING

I. CLAIM CONSIDERATIONS

A. Source

1. AMA *Guides to the Evaluation of Permanent Disability - Fourth Edition*
2. Table(s) used should be identified
3. Spine impairment summary - apportionment considered?

B. Basis - paraspinal soft tissue trauma

1. Range of Motion (rigidity) should be measured by inclinometer; mean average of three consecutive measurements
2. Neurologic System
   a. loss of sensation
   b. loss of strength

C. Timing

1. Impairment should be evaluated **only** when the condition is stable after completion of all necessary medical, surgical, and rehabilitative treatment (maximum medical improvement)

DISABILITY AND IMPAIRMENT

IMPAIRMENT IS DETERMINED BY MEDICAL MEANS.

Major considerations in an examination by a health care provider in determining musculoligamentous injury are strength, range of motion and function. The rating is usually given with regards to the body as a whole. It is usually in the form of a percent (%). This rating should not be done until the person's condition has stabilized and not until the person has reached maximum medical improvement (MMI). If a rating is done before MMI has been achieved, the rating may be inaccurate, due to the fact that there is a possibility for further healing and improvement.

The provider should be able to provide documentation regarding the process through which the amount of impairment was determined. It should also be documented whether the impairment is temporary or permanent.

If an impairment rating is being provided by someone other than an MD, a check into your state regulations should be done to determine if the provider is within their scope of practice to give an impairment rating.

DISABILITY IS DETERMINED BY NON-MEDICAL MEANS.

DISABILITY is determined by comparing the impairment of the person, with the three (3) areas of demand.

These include:

1. Personal - this area includes personal hygiene, communications, meals, transportation, care of a home, and the basic activities of daily living.

2. Social - Social interaction, communication, and behavior (i.e., confused, agitated, socially unacceptable behavior).

3. Occupational - the ability or inability to perform work activities, which can be either temporary or permanent, for a job he/she has been trained, in the current labor market, in a defined geographic area.

In determining disability, a thorough survey should be performed of that person's job. By contacting the employer, information needed to accurately determine disability can be obtained.

Talk to the employer and request a complete job description. With the new American Disabilities Act, this information should be available in detail and include information regarding: lifting, bending, standing, sitting, and to what degree and for how many minutes or hours per day.

After the information has been obtained, it will then be given or sent to an Occupational or Rehabilitation therapist, who will study the information in the job description, possibly do a job analysis and compare it with the limitations and inabilities indicated by provider. This will enable the therapist to determine if the person is disabled and if so, to what degree. In order to make an accurate determination, a request for exact or specific limitations and inabilities may be needed from the provider.

QUESTIONS FOR THE ATTENDING PHYSICIAN CONCERNING DETERMINATION OF IMPAIRMENT

1. What specific reference resource do you use in making impairment ratings?

   NOTE: The most widely used is *The Guides to the Evaluation of Permanent Impairment* ("The Guides") published by the American Medical Association.

2. What training have you had in performing impairment ratings? Where and when taken?

3. When specifically was your rating performed on this patient? Was this patient receiving active care at that time?

   NOTE: An impairment rating should be performed at the point of maximum improvement (condition must be static and well stabilized).

4. What was your rating on this patient? On what specific elements was this rating based? What instruments were used to measure range of motion (flexion, extension, and rotation)?

   NOTE: An impairment rating for common musculoskeletal conditions should be made only on reduced range of motion (three repetitions should be done), reduced strength and/or loss of sensation. Pain in and of itself is not a basis for impairment.

5. Was apportionment a factor in the formulation of your rating? If so, please explain how your rating was apportioned?

6. In light of your rating, what specific physical activities can this patient not now perform that this patient could perform prior to the accident?

7. In your opinion, does this patient's residual functional impairment have any impact on this person's ability to perform his/her job duties? If so, how? If so, did you perform a functional capacity evaluation and/or job site survey?

Table 75. Whole-person Impairment Percents Due to Specific Spine Disorders.*

Disorder	% Impairment of the whole person		
	Cervical	Thoracic	Lumbar
I. Fractures:			
A. Compression of one vertebral body			
0%-25%	4	2	5
26%-50%	6	3	7
>50%	10	5	12
B. Fracture of posterior element (pedicle, lamina, articular process, transverse process)	4	2	5
Note: An impairment due to compression of a vertebra and one due to fracture of a posterior element are *combined* using the Combined Values Chart (p. 322). Fractures or compressions of several vertebrae are *combined* using the Combined Values Chart.			
C. Reduced dislocation of one vertebra.	5	3	6
If two or more vertebrae are dislocated and reduced, *combine* the estimates using the Combined Values Chart (p. 322).			
An unreduced dislocation causes impairment until it is reduced; the physician should then evaluate the impairment on the basis of the subject's condition with the dislocation reduced.			
If no reduction is possible, the physician should evaluate the impairment on the basis of the range of motion and the neurologic findings according to criteria in this chapter and the nervous system chapter.			
II. Intervertebral disk or other soft-tissue lesion			
A. Unoperated on, with no residual signs or symptoms	0	0	0
B. Unoperated on, stable, with medically documented injury, pain, and rigidity† associated with *none to minimal* degenerative changes on structural tests, such as those involving roentgenography or magnetic resonance imaging.	4	2	5
C. Unoperated on, stable, with medically documented injury, pain, and rigidity† associated with *moderate to severe* degenerative changes on structural tests; includes unoperated on herniated nucleus pulposus with or without radiculopathy	6	3	7
D. Surgically treated disk lesion without residual signs or symptoms; includes disk injection	7	4	8
E. Surgically treated disk lesion with residual, medically documented pain and rigidity	9	5	10
F. Multiple levels, with or without operations and with or without residual signs or symptoms	Add 1% per level		
G. Multiple operations *with* or without residual symptoms:			
1. Second operation	Add 2%		
2. Third or subsequent operation	Add 1% per operation		
III. Spondylolysis and spondylolisthesis, not operated on			
A. Spondylolysis or grade I (1%-25% slippage); or grade II (26%-50% slippage) spondylolisthesis, accompanied by medically documented injury that is stable, and medically documented pain and rigidity with or without muscle spasm	6	3	7
B. Grade III (51%-75% slippage) or grade IV (76%-100% slippage) spondylolisthesis, accompanied by medically documented injury that is stable and medically documented pain and rigidity with or without muscle spasm	8	4	9
IV. Spinal stenosis, segmental instability, spondylolisthesis, fracture, or dislocation, operated on			
A. Single-level decompression *without* spinal fusion and *without* residual signs or symptoms	7	4	8
B. Single-level decompression *with* residual signs or symptoms	9	5	10
C. Single-level spinal fusion with or without decompression *without* residual signs or symptoms	8	4	9
D. Single-level spinal fusion with or without decompression *with* residual signs or symptoms	10	5	12
E. Multiple levels, operated on, with residual, medically documented pain and rigidity with or without muscle spasm	Add 1% per level		
1. Second operation	Add 2%		
2. Third or subsequent operation	Add 1% per operation		

*Instructions:

1. Identify the most significant impairment of the primarily involved region.
2. The diagnosis-based impairment estimates and percents shown above should be combined with range of motion impairment estimates and with whole-person impairment estimates involving sensation, weakness, and conditions of the musculoskeletal, nervous, or other organ systems.
3. List the diagnosis-based, range of motion, and other whole-person impairment estimates on the Spine Impairment Summary Form (Fig. 80, p. 134).

†The words "with medically documented injury, pain, and rigidity" imply not only that an injury or illness has occurred, but also that the condition is stable, as shown by the evaluator's history, examination, and other data, and that a permanent impairment exists, which is at least partly due to the condition being evaluated and not only due to preexisting disease.

Figure 80. Spine Impairment Summary.

Name:_____ Soc. Sec. No.:_____ Date:_____

Impairment	Cervical or Cervicothoracic	Thoracic or Thoracolumbar	Lumbar or Lumbosacral
1. Injury Model impairment			
2. Range of Motion Model impairment a. Based on diagnosis (Table 64, pp. 85–86) b. Based on range of motion c. Neurologic system 1. Loss of sensation 2. Loss of strength			
3. Regional impairment totals Combine impairments in each column using the Combined Values Chart (p. 322).			
4. Total spine impairment (Combine regional impairments)			

Guides to the Evaluation of Permanent Impairment, American Medical Association, pgs. 90, 113, 116, 123, 127, 135, 231, copyright June 1993.

APPENDIX A

IMPAIRMENT - GLOSSARY OF TERMS

Activities of Daily Living (ADLs) - Include activities such as self care and personal hygiene, communication (e.g., use of the telephone), ambulation, travel, non-specialized hand activities, sexual function, sleep, and recreational activities.

In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness.

Apportionment - The determination of the degree (amount) to which each of various occupational or nonoccupational factors and/or prior injury has contributed to a documented impairment.

Clinical Evaluation - The collection of data by a physician for the purpose of determining the health status of an individual. The data include: information obtained by history; clinical findings obtained from a physical examination; laboratory tests including radiographs, electrocardiograms, blood tests, and other special tests and diagnostic procedures; measurements physiologic and psycho-physiologic functions.

Combined Value Chart - A system used to convert two or more impairments (which are determined separately) to the whole person.

Disability - Alteration of a patient's capacity to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements.

Disfigurement - An altered or abnormal appearance. It may involve an alteration of color, shape, or structure or a combination of these. Disfigurement may be a residual of an injury or disease, or it may accompany a recurrent or chronic disorder of function or disease. It may produce either social rejection, or impairment of self-image, with self-imposed isolation, alteration of lifestyle, or other changes in behavior.

Employability - The capacity of an individual to meet the demands of a job and the conditions of employment.

Evaluation or Rating of Disability - Nonmedical assessment of the degree to which an individual does or does not have the capacity to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements.

Evaluation or Rating of Impairment - Assessment of data collected during a clinical evaluation and the comparison of those data to the criteria contained in the *AMA Guides*.

Frequency and Intensity - The frequency and intensity of the occurrence of symptoms are graded as follows:

1. Frequency. When symptoms occur while awake:
   - a. intermittent -- less than 25 percent of the time when awake
   - b. occasional -- 25-50 percent of the time when awake
   - c. frequent -- 50-75 percent of the time when awake
   - d. constant -- 75-100 percent of the time when awake

2. Intensity. When the symptoms or signs:
   - a. minimal -- constitute an annoyance but cause no impairment in the performance of a particular activity
   - b. slight -- can be tolerated but would cause some impairment in the performance of an activity that precipitates the symptoms
   - c. moderate -- when the symptoms or signs would cause marked impairment in the performance of an activity
   - d. marked -- when the symptoms or signs preclude any activity that precipitates the symptoms or signs

Impairment - An alteration of an individual's physical health status that is *assessed by medical means* (i.e., by a physician).

Manual For Orthopaedic Surgeons in Evaluating of Permanent Physical Impairment **(AAOS Manual)** - First published in 1965, this manual provides an alternative to *The Guides*. Its scope is limited to the musculoskeletal system, and its use is generally considered supplemental to *The Guides*.

Maximum Medical Improvement (MMI) - The point in time when a permanent impairment rating can be assigned. The point of maximal recovery after every method of treatment has been employed and a reasonable period of time has elapsed to permit optimal regeneration and other physiological adjustments to occur. Also called maximum medical rehabilitation and/or permanent stationary status.

Medical Impairment - The loss of, loss of use of, or derangement of any body part, system, or function.

Pain - An unpleasant sensory and emotional experience associated with, or described in terms of actual or potential tissue damage and described in terms of such damage. Pain may be classified as acute, acute recurrent, or chronic.

Permanent Disability - Occurs when the degree of capacity becomes static or well stabilized and is not likely to increase in spite of continuing medical rehabilitative measures. Disability may be caused by medical or nonmedical factors.

Permanent Impairment - Impairment that has become static or well stabilized with or without medical treatment, or that is not likely to lessen despite medical treatment of the impairing condition.

Possibility and Probability - Nonspecific terms without true statistical or legal meanings. In workers' compensation, these terms may refer to the likelihood of less than 50 percent. *Possibility* sometimes is used to imply likelihood of less than 50 percent. *Probability* sometimes is used to imply a likelihood of greater than 50 percent.

Whole Person - Idea that percentage impairment can be expressed in different ways. Impairment of a specific body part can be expressed as percentages of impairment of that part, of an upper or lower extremity, or of the body as a whole. The latter is the "whole person," sometimes termed "whole body" or "whole man." For example, the amputation of all fingers except the thumb, at the metacarpophalangeal joints, equals 60 percent impairment of the hand, 54 percent impairment of the upper extremity, and 32 percent impairment of the whole person.

CLAIM COMPARISON ANALYSIS

Both Claimant A and Claimant B were involved in accidents during the same year when the at-fault insured party failed to stop and rear-ended A & B's vehicles. There are no contributing factors. Both at-fault parties have liability insurance policies of 25/50 with the same insurer.

	CLAIM A (with DOL)	**CLAIM B (without DOL)**
MEDICAL SPECIALS	$4,815.00	$12,752.00
INCOME LOSS	$350.00	None
PROPERTY DAMAGE	$2,946.00	$4,765.00
LIABILITY	Accepted	Accepted
Vehicle Photos	Stated Increase Value	Not Stated
Scene Photos	Stated Increase Value	Not Stated
Traffic Controls	Stated Increase Value	Not Stated
Weather	Stated Increase Value	Not Stated
Statement of Involved Parties	Stated Increase Value	Not Stated
Driver's Experience	Stated Increase Value	Not Stated
Alcohol/Drug Related	N/A	N/A
Speed	Stated Increase Value	Not Stated
Hit and Run	N/A	N/A
Vehicle Damage	Stated Increase Value	Not Stated
Ambulance	Stated Increase Value	Not Stated
Claim History	Stated Increase Value	Not Stated
INJURIES AND CODES	**851.4**	**784.0**
	922.1	**786.5**

	847.0	**723.1**
	847.1	**847.0**
	847.2	**847.1**
	739.1	**E829**
	739.2	
	739.3	
	839.00	
	839.21	
	839.4	
	728.4	
PRIOR SUBSEQUENT	None	None
HISTORY OF COMPLAINTS	Headaches	Pain
	Spasms	Radiculitis
	Radiating	Cervicalgia
	Range of Motion	Spasms
	Dizziness	
	Vision blurring	
	Disruption of sleep	
	Anxiety/Depression	
TREATMENT	Emergency Room Chiropractic	Emergency Room (2) MD Medication Pain Center
THERAPIES	Massage Therapy Self Exercise	Physical Therapy Hot & Cold Packs

	Hot & Cold Packs Bed Rest	
TESTS	Flexion/Extension X-rays	X-rays (Negative) Nerve Conduction MRI (Negative) C-scan Muscle Testing EKG
COMPLICATIONS	Pain Tingling	NOT STATED
PROGNOSIS	Ongoing Complaints and Treatment	Ongoing Complaints and Possible Surgery
IMPAIRMENT	22 to 26%	NOT STATED
MMI	CTL Vertebrae	YES
LOSS OF ENJOYMENT		
Work	YES	NOT STATED
Domestic	YES	NOT STATED
Household	YES	NOT STATED
Hobbies	YES	YES
DUTIES UNDER DURESS:		
Work	YES	YES
Domestic	YES	YES
Household	YES	NOT STATED
FUTURE MEDICAL EXPENSE	$1,500.00	Possible Surgery No Cost Stated
TRAVEL EXPENSES	$450.00	NOT STATED
ALL VALIDATED BY MD	YES	YES

Demand for Claimant A was completed in the format, sequence and terminology compatible with the insurance carrier's software. Claimant B's demand was done in the old style of a long discussion format.

SETTLEMENT VALUE	**$35 TO 65,000**	**$10 TO 15,000**

EXAMPLE DEMAND

Janice Doe
1506 Claim Drive
Claim Hill, Claim 11111

Settlement Demand

State Farm Mutual Insurance Company
P.O. Box 1111
Claim Hill, Claim 11111

7/30/2007

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

To Whom it may Concern:

This demand was prepared in an attempt to resolve my claim. This demand is not intended to be used in the current litigation in any fashion. This opportunity to settle the claim within the policy limits of your insured. I am aware of the TEACH program by which State Farm utilizes to evaluate claims and I have organized this demand so as to make that process as easy as possible.

I was involved in the automobile accident of August 10th, 2004 as the driver of my vehicle. I was travelling at about 20 mph after slowing down in traffic on the interstate for traffic ahead of me. Your client's vehicle rear-ended my vehicle. Your client's vehicle struck the trailer hitch of my vehicle transferring all the force of that impact directly through the under frame of my car and into the passenger compartment.

After the accident I experienced severe pain in my neck, mid-back, lower-back, left hip, right wrist and right lateral heel. These injuries were all expressed to and documented by Dr. Sam Feelgood, D.C. I continue to experience difficulty with several aspects of movement and will continue to seek treatment to alleviate this pain.

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

DOB: 9/28/1957
Gender: Female

I am Right-Handed.

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 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.

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. William Well, M.D. In his reading, Dr. Well 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. 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

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

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

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

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

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.

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 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:	$10,879.00
Mileage to and from physicians:	$1,799.88
House Cleaning:	$4,620.00
Future Medical:	$3,600.00
Future Income Loss:	$0.00
Total Medical Expenses:	$20,106.88

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, I will agree to release your policyholder in exchange for the payment of all available policy limits.

I am reserving 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 injuries and damages, however, I 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 me. All rights and defenses are reserved.

Please respond to the above requests and demand within 5 business days of your receipt of this demand.

Sincerely,

_____

Mrs. Janice Doe

Exhibit Listings:

EXAMPLE MEDICAL REPORT

SMITH MEDICAL CLINIC

DECEMBER 5, 2003

Bob Smith, MD
Smith Medical Clinic
1111 1st Street
Seattle, WA 98208

Masters Law Offices
John Masters, Attorney at Law
2222 2nd Street
Portland, OR 98344

Claim Number:	55-555-555
Your Client:	Jane Doe
Date of Loss:	January 01, 2001
Our patient:	Jane Doe

Dear John Masters:

Medical Report

The introductory paragraph should briefly introduce your patient's claim. State those physical conditions, which would assist the insurer in understanding the type and duration of treatment, which you have provided. Use this area to highlight the material aspects of your patient's treatment. State the improvement or lack of improvement, which was realized as a result of treatment provided.

Injured Party: Jane Doe DOB: 4-20-72 Sex: Female
Height: 5' 7" Weight: 145 lb

Medical specials: $5,000.00 Income Loss: $ Unknown
Property Damage: $3,000.00

Date of first Treatment: January 01, 2001

Injuries: Cervical, Thoracic, Lumber Sprain/Strain, Chest contusion

ICD9 Injury Codes: 875.6 748.6 745.3 959.3

CPT Treatment Codes: 9020590203 90215 90233 90245 90365 90425

Aggravation: Less than 24 months

Subsequent: None

The introductory paragraph should briefly introduce your patient's claim. State those physical conditions, which would assist the insurer in understanding the type and duration of treatment, which you have provided. Use this area to highlight the material aspects of your patient's treatment. State the improvement or lack of improvement, which was realized as a result of treatment provided.

Neck and Back Injuries:

Provider Name	# of Treatments	Last Tx Date	Prognosis
John Smith, DC	59	May 01, 2001	Complaints/treatment
Jane Frank, MD	3	May 01, 2001	Guarded
Jane Frank, MD	2	May 01, 2001	Complaints/treatment
Jane Frank, MD	554	May 01, 2001	Complaints/treatment
Jane Frank, MD	786	May 01, 2001	Complaints/treatment

History of Complaints:

Symptom	Duration	Physician	Date noted
Range of Motion	Unknown period	John Smith	May 01, 2001
Headaches	Unknown period	John Smith	May 01, 2001
Dizziness	Unknown period	John Smith	May 01, 2001
Spasms	Unknown period	John Smith	May 01, 2001
Visual Disturbance	Unknown period	John Smith	May 01, 2001
Radiating Pain	Unknown period	John Smith	May 01, 2001
TMJ	Unknown period	John Smith	May 01, 2001
Anxiety/Depression	Unknown period	John Smith	May 01, 2001

Depression/Anxiety or TMJ additional notation regarding treatment:

The introductory paragraph should briefly introduce your patient's claim. State those physical conditions, which would assist the insurer in understanding the type and duration of treatment, which you have provided. Use this area to highlight the material aspects of your patient's treatment. State the improvement or lack of improvement, which was realized as a result of treatment provided.

Other Injuries:

Diagnosis	Physician	Chart Date	Duration	Prognosis
Contusion	Jane Frank	May 01, 2001		Complaints/treatment
Contusion	Jane Frank	May 01, 2001	up to 1 month	Complaints/treatment
Contusion	Jane Frank	May 01, 2001	1 to 3 months	Complaints/treatment
Contusion	Jane Frank	May 01, 2001	3 to 6 months	Undetermined

Contusion	Jane Frank	May 01, 2001	6 to 12 months	Guarded
Contusion	Jane Frank	May 01, 2001	6 to 12 months	Undetermined

History of Treatment:

Type	Duration	Physician	Chart Date
Hospitalization	# of Times:	Dates:	Days: 27
ICU: No	1	May 01, 2001 – May 28, 2001	
Confined to Bed	Two weeks	Jane Frank	May 01, 2001
Immobilization:			
Corset	Six weeks	Jane Frank	May 01, 2001
Discogram	Number – 1	Jane Frank	May 01, 2001
Injections:			
Cortico-Steroid	Number - 1	Jane Frank	May 01, 2001
Tens at home	Weeks 8	Jane Frank	May 01, 2001
Home Traction	Weeks 5	Jane Frank	May 01, 2001
Physical Therapy:	Prolonged Regular	Jane Frank	May 01, 2001
Massage Therapy:	Prolonged Regular	Jane Frank	May 01, 2001
Acupuncture:	Short Intensive	Jane Frank	May 01, 2001
Self-Exercise:	Short Intensive	Jane Frank	May 01, 2001
Walking Aids			
Crutches	7 weeks	Jane Frank	May 01, 2001
Medication	Regular prolonged	Jane Frank	May 01, 2001
Delay Or Gaps in Treatment explained by:		Jane Frank	May 01, 2001
Duties under Duress			
	2 Weeks	Jane Frank	May 01, 2001
Number of Children	Ages:	Assistance	
3	2,7,12	Unpaid	
Loss Of Enjoyment:			
	2 Weeks	Jane Frank	May 01, 2001
Impairment:	Whole Body:	Physician	Chart Date
	15%	Jane Frank	May 01, 2001

Discussion of Future losses:

The introductory paragraph should briefly introduce your patient's claim. The introductory paragraph should briefly introduce your patient's claim. State those physical conditions, which would assist the insurer in understanding the type and duration of treatment, which you have provided. Use this area to highlight the material aspects of your patient's treatment. State the improvement or lack of improvement, which was realized as a result of treatment provided.

Future Medical:

Amount: $	Type:	Physician	Chart Date
5,000.00	Chiropractic	Jane Frank	May 01, 2001

Future Income:

Amount: $	Type:	Physician	Chart Date
6,000.00	Full time	Jane Frank	May 01, 2001

The introductory paragraph should briefly introduce your patient's claim. The introductory paragraph should briefly introduce your patient's claim. State those physical conditions, which would assist the insurer in understanding the type and duration of treatment, which you have provided. Use this area to highlight the material aspects of your patient's treatment. State the improvement or lack of improvement, which was realized as a result of treatment provided.

Sincerely,

Dr. Bob Smith

Cc: Mrs. Jane Doe

Exhibits Attached

6

MINOR IMPACT – LOW DAMAGE
Programs

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.

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

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.

Trainer's Guide: MIST Training

Note To Trainers: In addition to this trainer's guide, the MIST training module consists of the following parts:

- *MIST Training presentation* Provides an overview of the key findings that lead to the development of this generation of the MIST concept. Details the key strategies and lists the tactics and tools developed through which the MIST specialization will be accomplished. Lists the measures through which MIST performance will be tracked.
- *MIST Role Plays.* A MIST claim scenario including liability and loss facts, example evaluation, and worksheets for role plays of the recorded statements and the negotiation process. Use of Feedback sheets should be stressed in order to conduct a useful discussion of best practices.

Explain all parts of the training and how they will be used.

Guest speakers are encouraged in addition to these prepared Materials. They serve to promote greater understanding and generate questions and discussion on the key topics in this module. In addition, the change in tempo created by introducing speakers other than the trainer helps energize and engage the audience. Most important, however is the increased coordination of local resources and affected parties to assure the maximum success of the MIST program in your region. It is recommended that they speak towards the end of the general session.

Suggested Speakers are:

- *Local SIU Manager or Representative* to discuss the local file transfer guidelines, provide helpful hints for investigation and evaluation of evidence and to get consensus on disposition methods within the region.
- *Biomechanical engineer or expert* to explain basic biomechanical analysis and its application in evaluating and refuting injury allegations. They can also provide tips on what is required from claims representatives to facilitate the use of biomechanical analysis (e.g., photos, estimates, statements, medical review, etc.)
- *Managing Attorney or Supervisor from Staff Counsel* to speak on the partnership in file development between the claim office and starff counsel for selecting the appropriate disposition method: settlement, ADR or litigation.

Objectives of this Trainer's Guide:

- Provide background and additional help in making effective presentation of the MIST Training Module.
- Supplement training materials with points for reinforcement of slides.
- Provide basis for additional trainer's notes which can be included in the page by page notes.

Objectives of MIST Training:

Train MIST desk specialists in the tools and tactics to achieve the following objectives:

- improved investigation and verification of MIST claims
- more consistent and objective evaluations
- sound negotiating practices to reach the appropriate settlement
- litigation of all winnable cases which cannot be settled equitably

Participants:

MIST UCM's and MIST desk claims representatives, MCO management staff, Staff Counselors of MCO's

Preparation:

Trainers should feel comfortable with the training presentation, especially the case example and role plays. Suggested preparation tips:

- Spend time becoming familiar with presentation packet and appendix. A rule of thumb is to spend 2 hours studying and preparing for each hour of presentation.
- Practice speaking in front of a mirror making the points of each slide. Visualize making eye contact with your audience.
- Write additional examples or notes to yourself on your copy of the presentation or this trainers guide to remind you of what you want to say.
- Focus on the 2 or 3 main points of each slide and link them to the main objectives of the training.
- Visualize a high energy presentation that keeps your audience interested and engaged in the material they are learning.
- Try to keep the discussion on the agenda and on track. As facilitator of the discussion the participants look to you for leadership. Full attention of all participants is enhanced with appropriate breaks.
- Keep the big picture in mind and engage your audience with the benefits of the changes required. Given that 25% of cases of most MCO's are MIST, reducing loss cost from $5000 to $1500 creates tremendous bottom line impact.

Agenda Overview:

Subject	Description	Time	Materials[1]
1. Overview/Findings	Present basic findings leading to the MIST solution and highlight the five areas of improved execution addressed in this training document. Discuss Use of Case Example.	30 min.	• Objectives • Findings • Investigation, evaluation, negotiation, litigation, and settlement for improved MIST handling • File Transfer Criteria
2. File Selection Criteria/SIU	Permit discussion of local MIST file selection criteria, interface with SIU	30 min	• Guest Speaker materials
3. Investigation I	Present overview of tools for improved investigation of MIST cases.	30 min.	Investigation Guidelines, Guidelines for vehicle photos, Script: Recorded Statement from insured, Examples from Biomechanical Research, Guidelines for attorney meeting, Script: R/S from claimant, Guidelines for biomedical investigation, Vendor Catalog
4. Investigation I: Recorded Statement Role Plays (Insured)	Practice techniques for effective recording of statements for insured claimants.	30 min.	Role Play Scripts and Feedback Forms, Tape Recorder & Tapes
5. Investigation II: Recorded Statement Role Plays (Claimant)	Practice techniques for effective recording of statements for insured claimants.	1 hr.	Role Play Scripts and Feedback Forms, Tape Recorder & Tapes
6. Evaluation	Explain the use of Colossus and other tools for evaluation of MIST cases. Explain the offset that will usually be applied to MIST cases.	1 hr.	Example of Value Drivers and Liability Assessment Worksheet, Negotiation Strategy Worksheet, Base Values, Verdict Values
7. Negotiation	Discuss appropriate use of negotiation strategy for effective settlements. Role play negotiation discussion.	1 hr.	Negotiation Strategy Worksheet, Feedback Forms, Tape Recorder & Tapes
8. Litigation/Settlement	Explain tactics for trial of winnable cases and selection of the appropriate settlement method.	1 hr.	Trial Assessment Worksheet, Guidelines for Use of ADR/Litigation
9. Measurement	Explain key measures to be tracked and managed for MIST representatives and managers	15 min.	(none)
	Total Time (excluding breaks and lunch)	6 hrs. 15 min.	

[1] In addition to the MIST Training Presentation Packet

Page by Page Notes:

Page

0 **Title Page**

- Thank participants for attendance
- Introduce yourself and other trainers and guests by explaining any relevant experience

1 - 2 **Agenda**

- Present an overview of the topics to be covered (see above)

Training Objectives

3
- Explain the purpose of the training
- Point out that MIST specialization is a great opportunity to have impact within the MCO and for Allstate as a whole

4 **Findings (Tracker)**

5 **Findings**

- Discuss the origins of MIST process redesign
- Describe the vicious cycle that Allstate and the insurance industry in general are in. Until we can eliminate the incentive to pursue frivolous claims, loss cost will continue to rise, premiums will continue to increase, Allstate sales people will continue to struggle to sell to and the cycle will continue. By drawing the line on MIST cases of questionable credibility, we will pay only appropriate settlements and minimize any unfair gains currently reaped by attorneys and opportunists.

6 **Objectives of MIST Segment**

- Stress the benefits from specialization of the MIST class of claims

7 **File Selection Criteria**

- Transfer procedures for the local MCO should be explained

8 **File Selection Criteria: SIU**

- Be sure to invite a local representative of SIU to explain the roles and responsibilities of MIST and SIU in the local market
- SIU should handle all questionable or likely fraudulent cases up to their full capacity
- Any staged accidents, jump-ins or other clearly fraudulent cases are obviously SIU cases

9 **Tactics (Tracker)**

10 **Investigation: Overview**

- Main point: conduct the appropriate investigation to successfully settle or defend MIST cases.

11 **Investigation: Investigation Matrix**

- The investigation guidelines list required investigation procedures for MIST cases. For cases most likely to settle up front, the following are required:
  - Claimant Carrier Contact (to assure full disclosure of claimant information and coverages)
  - MBRS
  - Vehicle photo and PD estimate
  - Index bureau
  - Police Report
  - MAWA (standard form)
  - Claimant Recorded Statement (of all people in car, separately with precautions to prevent collaboration on stories)
- A recorded statement of the insured is recommended for settlements. Contact with the insured is required.
- A review of available biomechanical data is recommended for settlements or CWP's.
- The following practices are optional for settlement, but required if the case should be tried:
  - Medical History
  - Records Review
  - Biomechanical Analysis
  - Face to Face Claimant Recorded Statement
  - Insured Recorded Statement

  IMEs are required for threshold cases to be tried

12 **Investigation: Guidelines for Vehicle Photos**

- Stress the necessity for good photos to support the no/low injury case defense and potential biomechanical analysis. These photos might be used in settlement discussions to anchor case facts.
- Explain the need for objective photos from direct angles at eye level.
- Claims representatives must coordinate with drive-in or independent investigators as well as staff counsel to assure best practices are maintained as promptly as possible.

13 **Investigation: Recorded Statement from Insured**

- Self explanatory
- Introduce the role-playing exercise scenario and assign roles for claim representative and insured.
- Use Feedback templates to identify critical success factors for recorded statement taking.
- Mention necessity of probing adequately to assure witness credibility and avoid "cave-in"

14-15 **Investigation: Examples of Biomechanical Research**

- Use Examples from Biomechanical Research in conjunction with the Comparison of Damages, Speed and G-force as a negotiating tool.
- Data provided were developed by Minorpack (a biomechanical information vendor) through analysis of 6 example claims filed with Allstate in Southern California.
- Because vehicles are designed so that bumpers and other vehicle body parts absorb most of the force of impact, the force on passengers and drivers involved in accidents is actually quite low and comparable to other small impacts that people commonly experience.
- "G-force" is a measurement of the acceleration experienced by a mass. As we know from physics, F= ma. Force is measured by mass times acceleration. One "g" is equivalent to the acceleration rate of the earth, which is 9.8 m/sec/sec. Thus, the degree of force estimated in our hypothetical examples varies from 20% of the earth's acceleration to one and a half times this level. For reference as the maximum acceleration a human being would ever experience, a jet fighter pilot in excellent physical condition might experience 7 g's before the force of the acceleration would cause loss of consciousness.
- If you are considering the settlement for a minor impact case, the likelihood of serious injury occurring might be assessed by analyzing the force of impact. Furthermore, the comparisons made might aid in convincing a claimant of the weakness of their case.
- For example, suppose the insured was driving a 1987 Honda Accord and rear-ended a 1980 Mercury Bobcat at an estimated speed of 5 mph. The force experienced by the Mercury driver was approximately 0.6 g's according to Minorpack's analysis. One argument to the claimant might be presented as follows: "Admittedly, there was impact between the cars, and to the degree that our insured was liable, you should be compensated for any injuries sustained. Nevertheless, we estimate the force of impact was 0.6 g's, approximately the same degree of force as bumping into a parking curb @ 4 mph or rolling into a curb in neutral. How serious could injuries truly be under those circumstances?"
- The actual force experienced by accident victims depends on the vehicle designs as well as the speed and direction at which the vehicles were traveling at the time of impact. These examples may serve as effective general references in many cases. More precise and specific analysis of the force of impact should be pursued with the aid of biomechanical experts. Consult your vendor catalog if the claim warrants further research.
- Be sure to solicit questions regarding the biomechanical information since it may seem like mumbo-jumbo without clear explanation.

16 **Investigation: Guidelines for Attorney Meeting**

- Self explanatory
- Discuss purpose of Attorney/Rep meeting
  - Verify merits of case
  - Evaluate claimant as witness
  - Communicate negotiation position and influence settlement timing when appropriate.

17-18 **Investigation: Recorded Statement from Claimant**

- Same as 13
- All claimants should be interviewed independently to prevent collaboration.
- Note that the required contact method is face-to-face and MIST representatives should stress the necessity to assess liability and confirm loss facts and damages to continue processing claim.
- Attorney's may demand written statements. Offer to transcribe recorded statement for signature.

19 **Investigation: Guidelines for Biomechanical Investigation**

- Self explanatory
- Discuss range of biomechanical expert services
-

20-25 **Investigation: Vendor Catalog**

- This Vendor Catalog was developed by Dennis Elliott (San Fernando MCO) to serve as reference for hiring biomechanical experts, accident reconstructionists, etc. Each region should develop their own resource manual for hiring expert support.
- Table of Contents lists range of experts catalogued.
- Example page shows type of information available in this 100 page document.
- The entire Vendor Catalog should be available through your CCM. Retaining high cost consultants should be undertaken with consultation of UCM's and/or management team.

27-28 **Evaluation: Claim Diagnostic/Colossus**

- Factors such as the Colossus Value Drivers should be considered in adjusting the Colossus value calculated.
- Keep in mind that Colossus assumes that the injuries reported are credible, whereas investigation of some cases will indicate otherwise

29 **Evaluation: Base Values for MIST cases**

- Data from the local closed file surveys are shown in appendix pps. 18. This page shows historical information on the distribution of claims settlements for represented minor impact (generally PD <$1000) soft tissue cases.
- The "Base Value" for MIST settlements refers to the minimum level of likely settlement as represented by the historical settlement level for the lowest 10% of claims settled. (i.e. Of the claims reviewed in the closed file survey, 10% settled at or below this base value and 90% settled for more money than this value.)
- The "Median Value" is the $ settlement level below which 1/2 of all claims settled. (Half of all claims settled for more than this level.)
- While every case should be evaluated on its merits and adjustments in settlement value will often be required, the new evaluation approach should lead to more settlements in the base value range and fewer settlements greater than the historical median.

30-33 **Evaluation: Attorney & Provider Information Sheets**

- Information should be gathered on attorneys and providers involved in MIST cases and maintained in paper files until a computerized database can be developed.
- Prior to attorney discussions and negotiations, this information should be consulted to establish appropriate negotiation strategy.
- Longer term, computer based systems will be developed to insure easy access to this information.
- Note that no derogatory comments regarding attorneys or providers or anything that might be embarrassing to Allstate in court should be recorded on these files.

34-35 **Evaluation: Injury Description Sheets**

- Injury sheets are designed to aid the claims representative in identifying necessary and customary treatments for particular injuries.
- Will be augmented by Colossus on-line medical information.

36-38 Evaluation: Verdict Summaries & Trial Economics

- The verdict information presented is complied by Jury Verdict Research for verdicts across the country.
- The information included is specific to this region from 1990 to 1993 including MIST and non-MIST as well as defense verdicts.
- The message should be clear to claimants and lawyers considering taking claims to court that the majority of sprains & strains (even major impact accidents) settle for than $10,000. Based on typical trial time of 2 weeks (80 hrs.) and typical legal fees of $200 an hour and contingency fees of 40%, the attorney would not break even on fees compared to cost. For example:

  Cost in legal fees (80 hrs x $200/hr)= $16,000
  Contingency fees (@40% of 10,000)= $4,000
  Loss to attorney= -$12,000

- The claimant taking a case to litigation is most likely rolling the dice on a losing gamble.

39-41 Evaluation: Trial Assessment Worksheet

- The Trial Assessment Worksheet should be completed when a case is being considered for settlement. All of the factors impacting the favorability of the case should be assessed to determine our negotiating strength and willingness to litigate.

42 Evaluation: Negotiation Strategy Worksheet

- Self Explanatory
-

43 MIST Evaluation Overview

- MIST file evaluation revolves around two key decisions:
  1. whether the case has little enough merit to CWP
  2. if the case is to be settled for a nominal amount, how much adjustment to base value should be made
- These decisions should be based on the type of criteria listed on page 13
- In principle, the stronger our case would be in court, the less should be our settlement value

44-45 Evaluation: Factors for CWP vs. Nominal Amount

- Example factors to determine whether to CWP or settle for a nominal amount
- If a claimant is unwilling to accept what the claims rep determines is a fair offer and files suit, litigation should be pursued.
- Some example cases are listed to demonstrate our success in test sites.

46 Negotiation: Overview

- Stress the importance of appropriate investigation and evaluation to develop sound negotiation strategy.

52 Litigation: Overview

- Stress willingness to try questionable cases and commitment from house counsel
- When claimants' attorneys demand whether house counsel or external counsel will try, they may be trying to assess our commitment to try. Replies should stress capability to win based on case merits no matter who tries the case.

56 **Litigation: ADR/Litigation Guidelines**

- Self Explanatory
- War story: The Tustin office faced a MIST case with manipulation under anesthesia raising Medical Specials to $15,000. The claimant had been offered a nominal offer of $2000. The offer was withdrawn and house counsel prepared to litigate.

57 **Settlement: Overview**

- Stress necessity of choosing the appropriate settlement method for the case. Avoid ADR where favorable settlement is unlikely.

58 **Measurement (Tracker)**

59 **Measurement**

- Note differences in new measurement system compared to old focus on pending and closures.

MIST ROLE PLAYS

Refer to Tips for Role Plays

- Stress the goals of the Role Plays
  - Generate ideas for how best to handle interactions
  - Practice techniques to achieve objectives identified in Role-Play note-taking worksheets.
- Remind all participants to take notes on the FEEDBACK SHEETS provided and contribute to discussion of best practices.

CHIROPRACTIC CARE AND THE INSURANCE INDUSTRY HANDOUT

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

COLOSSUS RERU INJURIES 3-Jul-01 4:08pm

Please enter known injury codes and/or search commands. Press function key 1 for further help (including deleting codes).

Search Legend

AM = amputation	DL = dislocation	LA = lacerating, penetrating inj
CC = concussion	FR = fracture	LI = ligament, tendon damage
DP = disc injury	FD = fracture/dislocation	SF = superficial
CR = crush, extensive soft-tissue, de-gloving		SL = subluxation
CS = contusion, soft-tissue, whiplash		SP = sprain

ie. 'fr r leg' or 'fr r femur' for fractured right femur.

Input Codes and Searches (one per line)

7A01 Cervical - whiplash, musculoligamentous ONLY
7A02 Thoracolumbar - sprain/strain, musculoligamentous ONLY
A162 Soft-tissue at R ANKLE

PF1=Help 2=Backup 3=Exit 4=Refer 11=Facts 12=Comments Enter to Continue

Ver430f

EVENT #4: MANUAL EVALUATION (C1097/C1098) EXERCISE

Read the following scenario. Finish the partially completed manual evaluation form (found at the end of the scenario) based on the information provided in the scenario. Remember to complete all sections relevant to this case. Check your input against the fully completed example at the end of this exercise and complete a self sign-off.

Claim No:	9080908903 TCR
Claimant:	Donna Peerhurt XX02
Limits:	$300.000 XX $1000 YY

On February 11, 1997, the insured, Cindy Smith, invited a co-worker, Donna Peerhurt, to her home. Cindy and Donna are both employed as typists at Largo Corporation, Inc. Cindy owns a large German shepherd she calls Bruno. Bruno is four years old and weighs ninety-five pounds. Bruno has never bitten anybody before, but he barks incessantly and has growled at strangers in the past. Cindy and Donna have known each other for several years, although Donna has never been to Cindy's home.

When Donna arrived at Cindy's home, Bruno barked as she approached the door. Cindy's twelve year old son, Biff, took Bruno by the collar and held him as Donna entered the house. Biff and Bruno were standing across the room from Donna, approximately twenty feet away.

Donna has always liked dogs and she asked Cindy if she could pet Bruno. By this time Bruno was staring at Donna and growling in a low rumble. Cindy suggested that it would be better if Donna waited for Bruno to become accustomed to her being there, but Donna insisted that dogs really liked her and asked Biff to let Bruno loose.

When Biff let the dog go, Bruno walked over to Donna and began sniffing around her feet. Donna put her right hand down and began to stroke Bruno's head. Bruno did appear to like Donna and let her pet him for several minutes, but when Donna put her left hand down to pet him with both hands, Bruno attacked Donna's left hand. Bruno's grip was so tight that it took Cindy and her husband, Cliff, to pry him loose.

The Smith's neighbor, Angela Mercy, was also there at the time. Angela was a witness to the entire incident. Angela also happened to be a nurse. She took one look at Donna's hand and told Cliff to call an ambulance. Donna was taken to Suburban Hospital where they found severe ligament and tendon damage in the hand. Emergency surgery was done by Dr. Handman. Donna was released that day, but was instructed to follow up with Dr. Sootsure, an orthopedic surgeon. Dr. Sootsure was impressed with the excellent job done by Dr. Handman. He instructed Donna to keep her hand wrapped for two weeks, then begin a course of hand therapy to help her regain strength and range of motion.

PAR - FULLY COMPLETED

INJURY EVALUATION WORKSHEET

CLAIM #/DESK LOCATION 208[illegible]8903 TCR DATE _____

COVERAGE

Insured _____ Policy Type 70 Coverage Involved/Limits _____
Excess/Coinsurance/Limits _____ Contribution Carrier/Limits _____

LIABILITY

Date of Loss _____ Loss Facts _____

LIABILITY ASSESSMENT SUMMARY

Factors	Insureds Liability: Decrease	No effect	Increase	Comment
Impact point on cars				
Scene pictures				
Traffic controls				
Witnesses, testimony				
Content of police report				
Alcohol/drugs involved				
Age of driver				
Aggravated liability				
Inconsistent statements				
Credibility of insured vs. claimants				
Contributing Factors, specify:				
Amount of PD				

Claimants Liability (A) _____ % Insureds Liability _____ %
Comments:

CLAIMANT INFORMATION

Claimant Status (Circle one) Driver Passenger Pedestrian CPL Other _____
Name _____ Clmt. # _____ Age 79
Pltf. Attorney _____ Def. Attorney _____
In Suit (Y/N) _____
Suit Segmentation Try _____
Liability _____
Damages _____
ADR _____
Settle _____
Current Demand: _____

DAMAGE ASSESSMENT SUMMARY

Factors	Impact on value: Decrease / No effect / Increase	Comment
Facts:		
Witnesses description of injury		
Seatbelt used		
Credibility:		
Claimant in ambulance		
Prior injuries to claimant		
Subsequent injuries		
Timing of medicals		
Inconsistent statements		
Claim history		
Treatment:		
Provider match with diagnosis		
Treatment match with diagnosis		
Damages:		
Impact on future ability to work		
Loss of enjoyment		
Our interpretation of MRIs		
Their interpretation of MRIs		
Results from other diagnostic tools		
Our Doctor's physicals/prognosis		
Their Doctor's physicals/prognosis		
Permanency		
Restraints or cast used		
Age specific injury complications		
Occupation specific injury comp.		
Probability of scar revisions		
Legal Considerations:		
Wrongful death statute		

MEDICAL SPECIALS

Provider	Dates of Service	# of Visits	Billed Amt.	Diag. Amt.	R&C Amt.
SUBURBAN E.R.	02/16/97	1	$ 595	$ 300	$ 595
DR. HANDAMANI	02/19/97	1	$ 200	$	$ 1200
DR. SCOTSURE	[illegible]	4	$ 270	$	$ 270
BILL [illegible]	[illegible]	48	$ 1980	$	$ 980
FINAL [illegible]	4/29/97		$ 225	$	$ 225
Rx			$ 90	$	$ 90
			$	$	$
			$	$	$
	Total	[illegible]	$ 3360	$ 300	$ 3460

(If applicable) No-Fault Threshold Met? (Y/N) N/A How Pierced? _____

WAGE LOSS

Employer _____ Occupation _____

Dates of Verified Absence [illegible] Disability Verified? ES Amt. of Wage Loss 3784

NEGOTIATION STRATEGY

Arguments in order of effectiveness	Our Position	Their Allegation	Our arguments to counter their allegation
Liability			
Damages			

AUTHORIZATION REQUEST

AMOUNT REQUESTED

Gross Amount $ 25000
Less Permissible Offsets $ —
BALANCE AMT. $ 25000

Less Clmts. Comparative Neg (If app)
OF ^ % X $ 25000 = $ 25000
(Balance Amt.)

NET AMOUNT $ 25000
LESS CONTRIBUTION $ —

AMOUNT REQUESTED $ 25000

AUTHORIZATION APPROVAL COMMENTS

Authority Granted - $ _____

Current Reserve $ 25000

Signed - Date -

Signed - Date -

Adjust Reserve to

EVALUATION CONSULTANT COMMENTS

Date evaluated: _____ Evaluation amount: _____

FULL COMPLETED EXAMPLE

INJURY EVALUATION WORKSHEET

CLAIM #/DESK LOCATION 90E 904403 TAR DATE 1/1/97

COVERAGE

Insured SMITH Policy Type 70 Coverage Involved/Limits XX/YY
Excess/Coinsurance/Limits NONE Contribution Carrier/Limits NO

LIABILITY

Date of Loss 12/11/97 Loss Facts INSURED'S DOG BIT CLAIMANT. CLAIMANT WAS A GUEST IN THE INSURED'S HOME.

LIABILITY ASSESSMENT SUMMARY

Factors	Insureds Liability: Decrease	No effect	Increase	Comment
Impact point on cars				N/A
Scene pictures				N/A
Traffic controls				N/A
Witnesses, testimony			X	DOG WAS PROVOKED BEFORE BITING
Content of police report				N/A
Alcohol/drugs involved				N/A
Age of driver				N/A
Aggravated liability				N/A
Inconsistent statements				N/A
Credibility of insured vs. claimants		X		
Contributing Factors, specify:				N/A
Amount of PD				N/A

Claimants Liability (A) 0 % Insureds Liability 100 %

Comments:
STRICT LIABILITY. INVESTIGATION SHOWS NO PROVOCATION.

CLAIMANT INFORMATION

Claimant Status (Circle one) Driver Passenger Pedestrian (CPL) Other
Name DONNA PEERHURT Clmt. # 02 Age 29
Pltf. Attorney WAISCH Def. Attorney NONE
In Suit (Y/N) N
Suit Segmentation Try
Liability
Damages
ADR
Settle
Current Demand: $100,000

DAMAGE ASSESSMENT SUMMARY

Factors	Impact on value: Decrease	No effect	Increase	Comment
Facts:				
Witnesses description of injury			X	DOES NOT WANT TO BE PRIED LOOSE
Seatbelt used				N/A
Credibility:				
Claimant in ambulance			X	
Prior injuries to claimant		X		
Subsequent injuries		X		
Timing of medicals		X		
Inconsistent statements		X		
Claim history		X		
Treatment:				
Provider match with diagnosis		X		
Treatment match with diagnosis		X		
Damages:				
Impact on future ability to work		X		
Loss of enjoyment		X		SOMETIMES COMPLAINS OF PAIN
Our interpretation of MRIs		X		BUT STILL IS PERFORMING AS
Their interpretation of MRIs		X		TYPIST
Results from other diagnostic tools		X		
Our Doctor's physicals/prognosis		X		
Their Doctor's physicals/prognosis			X	CLAIMANT DR. SAYS SHE MAY
Permanency		X		HAVE TO CHANGE JOBS SOMEDAY
Restraints or cast used				N/A
Age specific injury complications				N/A
Occupation specific injury comp.			X	POTENTIAL PROBLEMS WITH HAND
Probability of scar revisions			X	
Legal Considerations:				
Wrongful death statute				N/A
STRICT LIABILITY DOG BITE			X	

MEDICAL SPECIALS

Provider	Dates of Service	# of Visits	Billed Amt.	Diag. Amt.	R&C Amt.
SUBURBAN E.R.	02/11/97	1	$ 595	$ 300	$ 595
R. HANDMAN	02/11/97	1	$ 1200	$	$ 1200
DR. SCOTT SEE	02/11 02/26, 03/4, 3/24/97	4	$ 270	$	$ 270
ILL FCK-SESS PT	02/20/97 - 04/22/97	40	$ 2880	$	$ 1080
FINAL X-RAY INC	04/30/97		$ 225	$	$ 225
RX			$ 90	$	$ 90
			$	$	$
			$	$	$
	Total	54	$ 5260	$ 300	$ 3460

(If applicable) No-Fault Threshold Met? (Y/N) N/A How Pierced? _____

WAGE LOSS

Employer LARGO CORP. Occupation TYPIST

Dates of Verified Absence [illegible] Disability Verified? YES Amt. of Wage Loss 3784

NEGOTIATION STRATEGY

Arguments in order of effectiveness	Our Position	Their Allegation	Our arguments to counter their allegation
Liability	THE CLAIMANT ASSISTED ON PETTING THE DOG AFTER THE INSURED CAUTIONED HER.	THE INSURED ALLOWED HER 14 YEAR OLD SON TO LET THE DOG LOOSE.	THE CLAIMANT ASKED THE INSURED'S SON TO LET THE DOG LOOSE. THE CLAIMANT'S ACTIONS IN PETTING THE DOG MAY HAVE PROVOKED THE ATTACK.
Damages	GOOD [illegible] INJURY EXCESSIVE [illegible]	CLAIMANT MAY HAVE TO CHANGE JOBS. TREATING DOCTOR TREATED WITH THERAPY UNSIGHTLY SCAR	CLAIMANT HAS BEEN TREATED SINCE RETURNING TO WORK EXTRA PT WASN'T EFFECTIVE ACCORDING THE MEDICAL RECORDS SCARRING ON THE HAND

AUTHORIZATION REQUEST

AMOUNT REQUESTED

Gross Amount $ 25000
Less Permissible Offsets $ [illegible]
BALANCE AMT. $ [illegible]

Less Clmts. Comparative Neg (If app)
OF [illegible] % X $ [illegible] = $ [illegible]
(Balance Amt.)

NET AMOUNT $ [illegible]
LESS CONTRIBUTION $ —

AMOUNT REQUESTED $ [illegible]

AUTHORIZATION APPROVAL COMMENTS

Authority Granted - $ _____

Current Reserve $ 25000

Signed - _____ Date - _____

Signed - Your Name Date - today's date

Adjust Reserve to _____

EVALUATION CONSULTANT COMMENTS

Date evaluated: _____ Evaluation amount: _____

INJURY EVALUATION FORM

CLAIM #/DESK LOCATION _____ DATE _____

COVERAGE

Insured _____ Policy Type _____ Coverage Involved/Limits _____

Excess / Coinsurance / Limits _____ Contribution Carrier/Limits _____

LIABILITY

Date of Loss _____ Loss Facts _____

Aggravated Liability? _____ (e.g., DUI, Reckless Driving)

Claimant Status (Circle one) Driver Passenger Pedestrian CPL Other _____

	Insured Vehicle	Claimant Vehicle
Points of Impact		
Amount of PD	$	$

Witnesses (Y/N) _____

LIABILITY ANALYSIS

STRENGTHS	WEAKNESSES

Insured's Liability % | Claimant's Liability %

CLAIMANT INFORMATION

Name _____ Clmt. # _____ Age _____

Pltf. Attorney _____ In Suit (Y/N) _____ Def. Attorney _____

Diagnosis/Description of Injuries (describe in detail) _____

Diagnostic Testing/Results _____

Prognosis _____

I.M.E. Results _____

Pre-Existing Injury/Condition _____

(If applicable) No-Fault Threshold Met? (Y/N) _____ How Met? _____

COLOSSUS QUICK REFERENCE

PF Keys:

PF1 – Help screen(s)
PF 2 – Back up
PF 3 – Exit
PF 4 – Reference system (press "enter" to exit)
PF 5 – Date calculator, print, combine impairments
PF 6 – Unknown
PF 7 – Scroll back
PF 8 – Scroll forward
PF 11 – Facts screen (display only), peek (Colossus reporting)
PF 12 – Comments screen

Colossus Should Not Be Used For:

- Severe brain damage
- Dental trauma (except TMJ)
- Severe spinal cord damage involving paralysis
- Death
- Disfigurement
- Dog bite claims

Injury Codes:

AM – Amputation
CC – Concussion
DP – Disc injury - herniation, disc bulge, prolapse protrusion
CR – Crush, extensive soft tissue, degloving
CS – Contusion, soft tissue, whiplash, bruising hematoma
DL – Dislocation - displaced bones at a joint
FR – Fracture
FD – Fracture/dislocation - fracture at or near a dislocated joint
LA – Laceration, penetrating injury - requires sutures
LI – Ligament, tendon damage, cartilage - usually involves surgery
SF – Superficial – cuts, abrasions, scratches
SL – Subluxation – spine only, confirmed by X-ray
SP – Sprain

7A01 – Soft tissue injury to the neck
7A02 – Soft tissue injury to the back

Prognosis:

A. Resolution undetermined
B. No complaint (resolved)
C. Complaint, no more treatment
D. Complaint, further treatment
E. Complaint, guarded prognosis

On D.C. treatment claims, do not use "D" or "E"

Claim Data Screen:

DO NOT USE – Erases all prior data
USE/SHOW ANSWERS – Use to re-run a consultation; will show answers to *all* screens
USE/DO NOT SHOW ANSWERS – Will only show injury code screen, messages, & recommended range; "short-cut" to back up screen - use when you only have a couple of changes to make

Helpful Hints

1. Initial Treatment – The medical measures first taken to stabilize or treat an injury, i.e., E/R, first hospital admission (anything done until discharged), or at the first visit to the doctor
2. Subsequent Treatment – Any type of treatment that actually occurs after the release from the hospital or after the first doctor visit
3. Always look at your screen heading to ensure that your input is relating to the correct body part/injury or category
4. To delete an injury code, type "DDDD" over the injury code number and hit "enter"
5. MBRS reasonable and customary amounts should be entered under medicals incurred
6. MIST adjustments, Med Pay, where allowable, and Workers Compensation offsets should be taken under "reduction for other offsets"
7. If P.T. is prescribed by a M.D. or the Dr./staff does the P.T. themselves in their office, only the number of *office* visits should be included in the number of visits on the "Spine (Conservative) Treatment" screen; the P.T. treatments will be included in the history of therapy screen
8. D.C. visits and/or treatments will be included in the number of D.C. visits on the "Spine (Conservative) Treatment" screen
9. Wrist and knee braces should be inputted as "bandage/strapping" and comment made in the "comments" screen (PF 12)
10. Carpal Tunnel Syndrome should be inputted as peripheral nerve damage on the "Complications" screen (this will only be an option if there has been an injury to the wrist area)
11. When using "Back Up" (PF 2), you must *completely* finish the back up process before beginning another back up, i.e., do not back up while in the back up mode
12. To exit an *initial* consultation, use "Exit" (PF3)

If in the middle of a re-run of a consultation and you *have* made changes to the consultation, you would use PF3 and when prompted indicate yes to save answers. You do not have to "enter" all the way through the consultation to save any changes.

If in the middle of a re-run and you *have not* made any changes, you can exit by using the "Exit" key (PF3) say no to save answers.

Items Commonly Needed To Know For Colossus Input:

IMMOBILIZATION

- Corset
- Collar
- Neck brace
- Cast
- Splint/backslab
- sling
- Bandaging/strapping
- *On wrist or knee braces, use bandaging/strapping*

PRESCRIBED MEDICATION

- Short Term – Less than one month or one course of RX
- Prolonged Intermittent – Repeat RX at irregular intervals
- Prolonged regular use – Repeat RX at regular intervals

WALKING AIDS

- Crutches
- Wheelchairs
- Walking frame
- Walking stick/cane

FUTURE TREATMENT

- Possible – Less than 50%
- Probable – 50% to 75%
- Definite – Greater than 75%

SPINAL COMPLAINTS

- Headaches
- Muscle spasm
- Restriction of movement
- Dizziness
- Visual disturbance
- Radiating Pain – Numbness, tingling, etc.; through the extremities; must be medically documented
- Anxiety, Depression, Neurosis, etc. – Must be medically documented and treated for this

PERMANENT IMPAIRMENT

- Must be medically documented
- Will lead to "loss of enjoyment of life"
- Whole Person – Affects the whole person
- Whole Extremity – Relates to the entire limb
- Sub Parts – Relates to limited parts of the affected limb, e.g., wrist, elbow, ankle, foot, etc.

PHYSICAL THERAPY/EXERCISES

- Short-term, Self-exercise – Up to three months, e.g., home exercises
- Prolonged Self-exercise – More than three months
- Short-term P.T. – Up to three months, up to two times per week
- Short-term intensive P.T. – Up to three months, three times per week or more

Items Commonly Needed To Know For Colossus input, continued:

PRE-EXISTING CONDITION

- Treatment of Prior Condition to Accident – Diagnosed but not treating
- Actively Treating – Within one month's time
- Completed Treatment Within Last 24 Months
- Completed Treatment More Than 24 Months

DUTIES UNDER DURESS

Certain activities which were performed but were made more difficult than usual because of the injury and/or treatment.

Three requirements for Duties Under Duress to apply

- A claim must be made for such
- Must be medically documented
- Exacerbates the pain

Four types of duties under duress

- Work – Interferes with job duties
- Domestic (Cooking, cleaning, etc.): paid housekeeper hired, unpaid assistance (friends, relatives, etc.), I.D. spouse, number and ages of children
- Household (lawn-mowing, painting, etc.)
- Studies: type of studies involved (e.g., high school, college, trade school), full or part time student, how long did the injury interfere with the studies

LOSS OF ENJOYMENT OF LIFE

- Must have a permanent impairment
- Not an economic loss

Five types of loss of enjoyment of life:

- Work: full-time, part-time, casual, seasonal, not employed
- Domestic: cooking, cleaning, etc.
- Household (lawn-mowing, painting, etc.)
- Sport: Representative (selected to represent a geographic region, e.g., Davis Cup), Competitive (Played as a part of an organized competition, usually has some form of a governing body), Social (Recreational in nature)
- Hobbies (Crafts, gardening, sewing, etc.)

CLAIM DISSECTION SHEET

INSURED_____ CLAIM NUMBER_____

CLAIMANT_____ DOB_____ DOL_____ I/C#_____

FIRST TREATMENT DATE:___-___-___

INJURY	BODY PART	COMPLAINT	PROG	HISTORY / DATE	

COMPLAINT: SPASM - RADIATING PAIN - RESTRICTION OF MOTION - ANXIETY - HA - DIZZY - VISION
HISTORY OF TREATMENT: RX - IMMOBILIZER - PT - EXERCISE - TRACTION - MRI - C/SCAN
CONFINED TO BED - MYELOGRAM - DISCOGRAM - INJECTIONS #___

DUTIES UNDER DURESS:_____

GP/OP	1st Tx	Last Tx	Total Tx	PROGNOSIS
SPECIALIST				
CHIRO				
PT-LMT-ACUP			ST - STI - P - PI	
SELF			ST - P	

Prognosis codes: A = resolution undetermined B = no complaint (resolved)
C = complaint, no more TX D = complaint, further TX
E = complaint, guarded prognosis

MEDS_____ PROPERTY DAMAGE NEGLIGENCE ___%
OFFSET_____ I - $_____ IME DATE : __-__-__
WAGE_____ C- $_____ DR:_____
OFFSET_____ HOSPITAL____ ER ONLY___ PROGNOSIS _____

PRE-EXISTING INJURY - DESCRIPTION_____
_____Diagnosed but not treated _____Completed tx within last 24 months
_____Actively treating _____Completed tx more than 24 months ago

Comments:_____
_____

COLOSSUS DISSECTION
(OBJECTIVE AND NON-SPINAL SUBJECTIVE)

CLM # _____ D/L _____ CLMT NAME/# _____ DOB _____

INJURY # 1: _____ TREAT: _____ to _____ PROG: _____
A: underdetermined B: no treat/no complaint C: complaint/no treat D: more treat E: guarded

INITIAL TREATMENT (sutures, dress, immobilization, rx, surgery)	SUBSEQUENT TREATMENT (dress, rx, pt/exer, aspir, immob, inject, surg)	FUTURE TREATMENT (surgery, amputation, etc.)

INJURY # 2: _____ TREAT: _____ to _____ PROG: _____
A: underdetermined B: no treat/no complaint C: complaint/no treat D: more treat E: guarded

INITIAL TREATMENT (sutures, dress, immobilization, rx, surgery)	SUBSEQUENT TREATMENT (dress, rx, pt/exer, aspir, immob, inject, surg)	FUTURE TREATMENT (surgery, amputation, etc.)

COMPLICATIONS: _____

___ HOSPITALIZATION	___ # TIMES	___ # DAYS	___ ICU ___ # DAYS
___ IMMOBILIZATION	TYPE: _____		LENGTH: _____
___ WALKING AIDS	TYPE: _____		LENGTH: _____
___ PHYSICAL THERAPY	short	short intensive	prolonged prol. int.
___ MEDICATION	short	prol intermittent	prolonged regular
___ DUTIES UNDER DURESS: _____			
___ LOSS OF ENJOYMENT: _____			
___ IMPAIRMENT: _____			_____ %
___ IME: _____			pltf. defense prog: ___

MBRS INV.: _____
MBRS COV.: _____
MEDS ADJUSTED: _____
LIENS/SUBRO: _____

WAGE LOSS: _____
WAGE ADJUST: _____
WAGE EXPECTED: _____
OFFSET: _____
(% neg., primary/excess, etc.)

PD > $1000 yes or no Seatbelt yes or no

COMMENTS: _____

6/1/98

Dissection Sheet

Claim Number: _____ Insured: _____ Gender: _____

DOA: _____ DOB: _____ Claimant: _____ Economic Region: _____

Injury	Treatment	Dates	Prognosis	Other

Medicals: $_____ Settlement Amount: $_____

Wages: $_____ Represented (Y/N): _____

Negligence: _____

Contribution: _____

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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" (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" 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.

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

Claim Review Worksheet

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. <u>Other Issues</u>

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

PI Form Instruction and Use

Attorney Checklist:

Have your client complete as much as possible on this checklist with possibly the assistance of your paralegal prior to your meeting with the client. Then complete it while meeting with the client. Your paralegal will use this to begin entering the data into Demand Expert or Online Demand along with the Duties under Duress and Loss of Enjoyment of Life forms.

Letter of Representation:

Automatically created by Demand Online.

English and Spanish Cover Letters:

Automatically created by Demand Online.

Claim Information Form:

Automatically created by Demand Online.

Accident Worksheet:

This form can be used to acquire all the general and specific information regarding the accident your client was involved in. It can be jointly completed by you, your staff and the client.

Client Medical and Wage Authorization Forms:

These forms will be sent to physicians and employers of your clients to acquire necessary information.

Client General Request Letter:

Automatically created by Demand Online.

Client Reminder for Updates Letter:

Automatically created by Demand Online.

Client Questionnaires 1&2 Templates (English and Spanish):

These questionnaires should be completed by your clients for your use.

Duties under Duress and **Loss of Enjoyment of Life Worksheets:**

Have each client fill out and sign these forms on: (Retain a copy for the office.)

i. Initial visit

ii. Monthly re-exam
iii. Final exam

There are several to choose from (including Spanish and French versions. Use the one which best suits your needs.

Intake/Discharge Physician Form:

Doctor completes this form on the initial exam and updates it on the final exam for all clients.

☐ Range of Motion	First date noted: _____	Last date noted: _____
☐ Headaches	First date noted: _____	Last date noted: _____
☐ Spasms	First date noted: _____	Last date noted: _____
☐ Dizziness	First date noted: _____	Last date noted: _____
☐ Visual Disturbance	First date noted: _____	Last date noted: _____
☐ Sleep Disruption	First date noted: _____	Last date noted: _____
☐ Radiating	First date noted: _____	Last date noted: _____
☐ Anxiety/Depression	First date noted: _____	Last date noted: _____
☐ TMJ	First date noted: _____	Last date noted: _____
☐ Home Exercises	First date noted: _____	Last date noted: _____
☐ Bed Rest	First date noted: _____	Last date noted: _____
☐ Gym	First date noted: _____	Last date noted: _____
☐ Home Traction	First date noted: _____	Last date noted: _____
☐ Tens	First date noted: _____	Last date noted: _____

Pay Special Attention to the items which require MD determination or validation

Physician Request Form:

This is a preformatted letter to the medical doctor of your choosing who will be able to determine or validate the areas necessary for these value drivers to be accepted in the valuation of your clients' claims.

Physician Medical Log Form:

Automatically created by Demand Online. This is a listing of physicians, treatment billings to date, type of modalities.

Response to First Offer Template:

Automatically created by Demand Online. This should be sent to the insurer after you receive the first offer to your client's demand.

Negotiation Letters 1&2:

Automatically created by Demand Online. These should be sent to the insurer during the negotiation process.

Automatic Checklist:

Automatically created by Medical Report Expert, Demand Expert and Demand Online. This form provides a listing of possibly missed value drivers for the patients' and clients' claims.

Medical Timeline:

Automatically created by Medical Report Expert, Demand Expert and Demand Online.

Impairment Report Request to Physician Template:

This template provides a letter which can be customized in requesting medical information when the physician does not complete the "Intake/Discharge" form.

Client Letter Questionnaire Post Treatment Template:

This template provides a letter which can be customized in requesting medical information from the client.

UIM Preservation Template:

Body Shop Questionnaire:

Send this form to a credible body shop for completion when the damage to your client's vehicle is less than $1,500.00. You will use this in conjunction with the MIST write-up in addressing the issues which have caused your client's claim to be handled in the MIST or Minor Impact Units.

(*Also, see MIST paper in the User's Center at Sequoiavisions.com.*)

Physician Daily Exam Form:

This form provides a means for taking the initial intake of the patient and is compatible with both Medical Report and SOAP softwares.

Physician Soap Intake Form:

These forms are designed ease of input into the Soap Software. They are:

Soap Reference 1 & 2,
Soap Intake and
Soap Supplemental

Physician Response to Medical Billings Denial:

This is a multi-paragraphed template response. Simply eliminate the paragraphs which don't apply.

Code Sheet:

Use this ICD-9 code sheet to assist in your diagnosis of 'common personal injuries and symptoms. "Colossus" recognizes and gives value to each different documented injury. Appropriate diagnosis is required to support the doctor's treatment bill. Only ICD-9 codes on a HCFA-1500 are used for "Colossus" input.

*Note: Treatment bills not supported by ICD-9 codes will be reduced and considered for SIU referral.

Supplemental HCFA Form/Instruction:

Copy this template onto "HCFA forms" and use the "Supplemental HCFA form template" to place additional ICD-9 codes in cases where the doctor diagnoses more than 4 injuries on the PI patient. (e.g., if there are 12 diagnosed injuries on a PI patient, then the 1st HCFA would have diagnoses 1-4, and attached thereto would be 2 "Supplemental HCFA forms" containing patient ID info and diagnosis 5-12 – therefore, requiring 2 "Supplemental HCFA forms" attached to the billing.

*See Code Sheet "Note" above.

Additional instructions for Supplemental HCFA form:

1. This document should be placed in your copier to be copied. Place it face down with the circle and "supplement" indicating where the bottom of the page is.

2. Next, put blank HICFA forms into the location where you would normally put blank paper. You should determine how to place the blank forms in this location prior to making copies. You can do this by putting an X on the top of a blank piece of paper and running a copy. That will indicate how your copier moves the blank paper through your copier to make a copy. This will indicate how you should place the blank HICFA forms into the copier. (Either face up or down and which end should be up or down)

PRE-CHECK LISTING

Name of Client:		SSN:	
Date of Incident:	Police Dept	Ambulance	
Client's Insurer:		Phone:	
Claim Number:	MPC/PIP Limits	UIM/W Limits	
Employer/s:		Phone:	
First Date of Treatment:			
At Fault Insurer:		Phone:	
Claim Number:	Liability Limits	Umbrella	

Facts/Liability

Prior/Subsequent

Description	Physician	Last Date Treated	Proration

Injuries:

Description	Physician	Date	ICD-9

Monetary Damages:

Medical Expenses and Supplies:
Total Medical Costs:
Other Economic Expenses/Losses:
Income Loss:
Total Current:

Future Expenses:

Medical:

Description	Physician	Date

Economic:

Description	Physician	Date
Current Income Loss		
Future Income Loss		
Mileage to/from physicians _____ @ _____ cents per mile = _____		
Loss of Use and/or Rental		
Additional Property Costs		

Total:

Additional Comments:

Hospitalization/Surgery

	Description	Physician	Date	Duration
☐	Transfusion			
☐	Suturing			
☐	Oxygen			
☐	Catheter			
☐	Debridng			
☐	Bed Sores			
☐	Reduction	Open ☐	Closed ☐	
☐	Fixation	Internal ☐	External ☐	
☐	Removal of Apparatus			
Number of Days_____			Number of Times_____	

Physicians:

Name	Type	# of Treatments	Last Treatment Date	Billing
All Records Received				Y/N
Subtotal				

Impairment and Disability

% Whole body Impairment Rating: Body Part which has reached MMI _____	Physician:		Date:
Duties Under Duress:	Physician:		Date:
Work: ☐	School: ☐	Domestic Duties: ☐	Household Duties: ☐
Loss of Enjoyment:	Physician:		Date:
Domestic: ☐	Household: ☐	Hobbies: ☐	Sport: ☐
Sport Categories:			
Regionally Playing ☐	Competitive ☐	Social ☐	Original Sport ☐ Any ☐

Therapy

☐	Physical Therapy	Short Term/Prolonged	Regular/Intensive
☐	Massage Therapy	Short Term/Prolonged	Regular/Intensive
☐	HomeTraction/Exercise	Short Term/Prolonged	Regular/Intensive
☐	Bed Rest	Duration in weeks from date of accident _____	
☐	Tens		
☐	Gym		
☐	Other		

Treatment Coding:

Modality	Physician	Date	CPT

Testing:

Test:	Physician	Date	Positive/Negative

Symptoms:

	Description	Physician	Date	Duration
☐	Range of Motion			
☐	Headache			
☐	Spasm			
☐	Dizziness			
☐	Radiating Pain			
☐	Vision Disturbance			
☐	Sleep Disturbance			
☐	Depression			
☐	Anxiety			
☐	Post Concussion			
☐	TMJ			
Treatment Issue Drivers				
☐	Delay/Gap			
☐	Confined Bed			
☐	Immobilization			
Ace ☐	Sling ☐	Brace ☐	Cast ☐	Lumbar Support ☐
☐	Prescriptions	Short Term/Prolonged	Regular/Intensive	
☐	Tens			
☐	HomeTraction/Exercise			
☐	Bed Rest			
☐	Injections	Type _____	Number _____	
☐	Nursing Home			
☐	Walking Aids			
Crutches ☐	Cane ☐	Walker ☐	Wheelchair ☐	
☐	Arthroscopy			
☐	Dressings			
☐	Suturing			
☐	Internal Apparatus			
☐	External Apparatus			

ACCIDENT WORKSHEET

Today's Date: _____Referred by:_____

Date of Accident:_____Location of Accident:_____

Brief Description of How Accident Happened:_____

_____

_____

INJURED PARTY'S NAME:_____
"AT-FAULT" DRIVER'S NAME:_____
"AT-FAULT" OWNER'S NAME:_____

BRIEF DESCRIPTION OF INJURIES (Areas of Body That Are Sore):_____

_____

_____

CLIENT INFORMATION:

Injured Party _____ Date of Birth_____ Age____
Social Security #.: _____ E-Mail:_____
Address_____City/State:_____
Zip Code_____Phone_____(H)_____(Cell)_____(Wk)
Name/Address of Employer _____
Job Title/Description:_____

CLIENT'S SPOUSE / GUARDIAN INFORMATION:

Name of Spouse, Parent or Guardian_____(_____)
(Relationship)
Home Address (if differerent)_____
Social Security #.: _____ E-Mail:_____
Spouse's or Guardian'sEmployer _____Phone_____

CLIENT'S CHILDREN:

	Name	D.O.B. (Age)	School / Grade	Occupation
1.				
2.				
3.				
4.				

ACCIDENT INFORMATION:

Date of Accident _____Time _____Location: _____
_____Weather Conditions:_____
Lanes of Traffic in Each Direction _____ Divided Roadway? ☐ Yes ☐ No.
Road Conditions (Dry/Wet/Slippery)_____

Accident report made ☐ Yes ☐ No. If so, CCR#_____

Any Statements by "At Fault" Driver:_____

_____

Seat Belt worn ☐ Yes ☐ No Shoulder Harness worn ☐ Yes ☐ No

Were you: A Driver ☐ or A Passenger ☐ In Your Own Vehicle ☐ or In Another's Vehicle ☐ ? Or were you a Pedestrian ☐ ?

Names and Addresses of Witnesses to accident:

_____

_____

_____

_____

DEFENDANT INFORMATION:

Name of "At Fault" **Driver** _____
Address of "At Fault" **Driver**_____
Phone # of "At Fault" **Driver**_____(H)_____(Cell)_____(Wk)
"At Fault" **Driver's Insurance Company**_____**Policy #**_____
Claim # _____
Adjuster's Name, Address & Phone:_____

_____

Name of **Owner**(s) of "At Fault" Vehicle _____
Address of "At Fault" **Owner**(s)_____
Phone # of "At Fault" **Owner**(s)_____
"At Fault" **Owners' Insurance Company**_____**Policy #**_____
Claim # _____
Adjuster's Name & Phone:_____

INJURY INFORMATION:

Current Injuries	***Prior Injuries to Same Area From Any Source***	***Cause of Prior Injuries***
1.		
2.		
3.		
4.		
5.		

DID YOU GO TO THE EMERGENCY ROOM? ☐ Yes ☐ No

IF SO,WHEN? _____WHERE?_____

WERE YOU ADMITTED INTO THE HOSPITAL? ☐ Yes ☐ No

IF SO,WHEN? _____WHERE?_____

WHEN WERE YOU RELEASED? _____

NAME ALL DOCTORS SEEN FOR THIS ACCIDENT:

_____

_____

_____

PRIOR ACCIDENTS

WHEN	WHERE	WHAT INJURED?	TREATED BY?	DATE OF LAST TREATMENT	FULL OR PARTIAL RECOVERY?

CAR INSURANCE:

FOR EACH MOTOR VEHICLE YOU OWN:

Make & Model (Year)	Insurance Company	Policy #	Claim #	PIP?	Uninsured Motorist Coverage?

PIP Adjuster:_____**PIP Claim #:**_____**Phone #:**_____

IF YOU DO NOT OWN A MOTOR VEHICLE:

Does anyone else in household own motor vehicles? ☐ Yes ☐ No

How many vehicles? _____Describe:_____

FOR EACH MOTOR VEHICLE OWNED BY ANOTHER IN YOUR HOUSEHOLD:

Make & Model (Year)	Insurance Company	Policy #	Claim #	PIP?	Uninsured Motorist Coverage?

Whose vehicle were you driving? _____

Was this vehicle insured? If so, by whom_____
Named insured and policy # / claim #_____

HEALTH INSURANCE:

COMPANY	MEMBER NAME	I.D. #	GROUP #	HMO or PPO ?	PHONE #

CLIENT'S JOB INFORMATION:

Were you employed at time of accident? ☐ Yes ☐ No
Did you miss work? ☐ Yes ☐ No. If yes, how much? _____
Describe your duties _____
Rate Of Pay & How Paid (Hourly/Weekly/Monthly) _____
Were you on the job at time of accident? ☐ Yes ☐ No

VEHICLE DAMAGE INFORMATION:

How much damage to Vehicle you were in? _____
Was your Vehicle Towed? ☐ Yes ☐ No.
Name & Address of Where Towed:_____
Has it been repaired? ☐ Yes ☐ No. By whom ? _____
Were Photos Made? ☐ Yes ☐ No. By whom ? _____

PRIOR CLAIMS/LAWSUITS/WORKER COMPENSATION

Have you ever made a claim for damages? ☐ Yes ☐ No.
When, Where and for what injury or damage?_____
_____

Have you ever made a worker's compensation claim? ☐ Yes ☐ No
If yes, describe: _____

PLEASE PROVIDE ALL INSURANCE CARDS, DRIVER EXCHANGE INFO, ACCIDENT REPORT & DRIVER'S LICENSE FOR COPYING

Patient Name: _____ Date: _____/_____/2005

Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

N/A	Work	Reason for the difficulty	Duration
Job description: _____			
_____	Lifting	Increased Pain	_____
_____	Bending	Increased Pain	_____
_____	Sitting	Increased Pain	_____
_____	Walking	Increased Pain	_____
_____	Computer duties	Increased Pain	_____
Other: _____			

N/A	Studies/School	Reason for the difficulty	Duration
_____	Lifting	Increased Pain	_____
_____	Bending	Increased Pain	_____
_____	Sitting	Increased Pain	_____
_____	Walking	Increased Pain	_____
_____	Computer duties	Increased Pain	_____
_____	Studying		
Other: _____			

N/A	Domestic Duties	Reason for the difficulty	Duration
_____	Vacuuming	Increased Pain	_____
_____	Taking care of kids	Increased anxiety	_____
_____	Cleaning	Increased Pain	_____
_____	Preparing Meals	Increased Pain	_____
_____	Other: _____		

N/A	Household Duties	Reason for the difficulty	Duration
_____	Yardwork	Increased Pain	_____
_____	Transportation	Increased Pain/anxiety	_____
_____	Shopping	Increased Pain/anxiety	_____
_____	Taking out trash	Increased Pain	_____
_____	Other: _____		

Patient Name: _____ Date: _____/_____/2005

Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision?

Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your participation in any of the following areas:

N/A	Work	Reason for the difficulty	Duration
	Job description: _____		
_____	Lifting	Increased Pain	_____
_____	Bending	Increased Pain	_____
_____	Sitting	Increased Pain	_____
_____	Walking	Increased Pain	_____
_____	Computer duties	Increased Pain	_____
	Other: _____		

N/A	Studies/School	Reason for the difficulty	Duration
_____	Lifting	Increased Pain	_____
_____	Bending	Increased Pain	_____
_____	Sitting	Increased Pain	_____
_____	Walking	Increased Pain	_____
_____	Computer duties	Increased Pain	_____
_____	Studying		
	Other: _____		

N/A	Domestic Duties	Reason for the difficulty	Duration
_____	Vacuuming	Increased Pain	_____
_____	Taking care of kids	Increased anxiety	_____
_____	Cleaning	Increased Pain	_____
_____	Preparing Meals	Increased Pain	_____
_____	Other: _____		

N/A	Household Duties	Reason for the difficulty	Duration
_____	Yardwork	Increased Pain	_____
_____	Transportation	Increased Pain/anxiety	_____
_____	Shopping	Increased Pain/anxiety	_____
_____	Taking out trash	Increased Pain	_____
_____	Other: _____		

N/A	Sports	Reason for the difficulty	Duration
_____	Social	_____	_____
_____	Competitive	_____	_____
_____	Regional	_____	_____
_____	Other:		
_____		_____	_____

Nombre paciente: _____Fecha del : ___/_____/20___

Deberes bajo resumen de la compulsión

Termine el cuestionario siguiente como se relaciona con de cómo sus lesiones afectan su funcionamiento sus deberes de la vida y del trabajo. Ponga un cheque delante del cotidiano **deberes vivos que son dolorosos o difíciles para que usted se realice como resultado de lesiones** usted sostuvo en la colisión del vehículo de motor. Entonces marca de cheque la caja apropiada que señala la razón de la dificultad. Incluya esos deberes/responsabilidades que requieran que usted reduzca el tiempo que usted es capaz de realizarlas.
Descripción de las funciones :

_____

Trabajo	**Razón de la dificultad**
Elevación	□ Dolor creciente □ restricto del movimiento □Debilidad
Flexión	□ Dolor creciente □ restricto del movimiento □Debilidad
Sentada	□ Dolor creciente □ restricto del movimiento □Debilidad
El caminar	□ Dolor creciente □ restricto del movimiento □Debilidad
Deberes de la computadora	□ Dolor creciente □ restricto del movimiento □Fatiga
Otro: _____	□ Dolor creciente □ restricto del movimiento □Debilidad

Estudios/escuela	**Razón de la dificultad**
Elevación	□ Dolor creciente □ restricto del movimiento □Debilidad
Flexión	□ Dolor creciente □ restricto del movimiento □Debilidad
Sentada	□ Dolor creciente □ restricto del movimiento □Debilidad
El caminar	□ Dolor creciente □ restricto del movimiento □Debilidad
Deberes de la computadora	□ Dolor creciente □ restricto del movimiento □Fatiga
El estudiar del	□ Dolor creciente □ restricto del movimiento □Fatiga
Otro: _____	□ Dolor creciente □ restricto del movimiento □Debilidad

Deberes domésticos	**Razón de la dificultad**
El limpiar con la aspiradora	□ Dolor creciente □ restricto del movimiento □Fatiga
que toma el cuidado de cabritos	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga
Limpieza	□ Dolor creciente □ restricto del movimiento □Fatiga
que prepara comidas	□ Dolor creciente □ restricto del movimiento □Fatiga
otro: _____	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga

Deberes de la casa	**Razón de la dificultad**
Yardwork	□ Dolor creciente □ restricto del movimiento □Fatiga
Transporte	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga
Compras	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga
toma hacia fuera basura	□ Dolor creciente □ restricto del movimiento □Fatiga
otro: _____	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga

Nombre paciente: _____Fecha del : ___/_____/20___

Pérdida de resumen del disfrute

Termine el cuestionario siguiente como se relaciona con **actividades** (trabajo relacionado o de otra manera) **usted estaría normalmente el gozar** - pero sea **actualmente no gozando** como resultado de sus lesiones. Incluya todas las actividades que usted:

- la poder hace o se realiza no más, y/o
- no puede hacer o realizarse tan a menudo como usted hizo antes de su lesión

Description del trabajo _____

N/A	**Trabajo**	**Razón de la limitación**
	Elevación	□ Dolor creciente □ restricto del movimiento □Debilidad
	Flexión	□ Dolor creciente □ restricto del movimiento □Debilidad
	Sentada	□ Dolor creciente □ restricto del movimiento □Debilidad
	El caminar	□ Dolor creciente □ restricto del movimiento □Debilidad
	Deberes de la computadora	□ Dolor creciente □ restricto del movimiento □Fatiga
	Otro: _____	□ Dolor creciente □ restricto del movimiento □Debilidad

N/A	**Estudios/escuela**	**Razón de la limitación**
	Elevación	□ Dolor creciente □ restricto del movimiento □Debilidad
	Flexión	□ Dolor creciente □ restricto del movimiento □Debilidad
	Sentada	□ Dolor creciente □ restricto del movimiento □Debilidad
	El caminar	□ Dolor creciente □ restricto del movimiento □Debilidad
	Deberes de la computadora	□ Dolor creciente □ restricto del movimiento □Fatiga
	El estudiar del	□ Dolor creciente □ restricto del movimiento □Fatiga
	Otro: _____	□ Dolor creciente □ restricto del movimiento □Debilidad

Deberes domésticos	**Razón de la dificultad**
El limpiar con la aspiradora	□ Dolor creciente □ restricto del movimiento □Fatiga
que toma el cuidado de cabritos	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga
Limpieza	□ Dolor creciente □ restricto del movimiento □Fatiga
que prepara comidas	□ Dolor creciente □ restricto del movimiento □Fatiga
otro: _____	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga

Deberes de la casa	**Razón de la dificultad**
Yardwork	□ Dolor creciente □ restricto del movimiento □Fatiga
Transporte	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga
Compras	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga
toma hacia fuera basura	□ Dolor creciente □ restricto del movimiento □Fatiga
otro: _____	□ Dolor/ansiedad crecientes □ restricto del movimiento □Fatiga

Sports	**Razón de la dificultad**
Name Sport: _____	□ Dolor creciente □ restricto del movimiento □Debilidad

Pre-accident level of participation: □ Socially □ Competitively □ Professionally

Nom patient : Date de _____ : ___/_____/20___

Fonctions sous le résumé de coercition

Remplissez le questionnaire suivant comme il se relie derrière à la façon dont vos dommages affectent votre exécution vos fonctions de vie et de travail. Placez un contrôle devant le quotidien **fonctions vivantes qui sont douloureuses ou difficiles pour que vous exécutiez en raison des dommages** vous avez soutenu dans la collision de véhicule à moteur. Puis marque de contrôle la boîte appropriée indiquant la raison de la difficulté. Incluez ces fonctions/responsabilités qui exigent que vous réduisez le temps où vous êtes capable de les exécuter.

Description des fonctions : _____

Travail	**Raison de la difficulté**
Levager	□ Douleur accrue □ restreint de mouvement □Faiblesse
Recourbement	□ Douleur accrue □ restreint de mouvement □Faiblesse
Séancer	□ Douleur accrue □ restreint de mouvement □Faiblesse
Marcher	□ Douleur accrue □ restreint de mouvement □Faiblesse
Fonctions d'ordinateur	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre :	□ Douleur accrue □ restreint de mouvement □Faiblesse

Études/école	**Raison de la difficulté**
Levager	□ Douleur accrue □ restreint de mouvement □Faiblesse
Recourbement	□ Douleur accrue □ restreint de mouvement □Faiblesse
Séancer	□ Douleur accrue □ restreint de mouvement □Faiblesse
Marcher	□ Douleur accrue □ restreint de mouvement □Faiblesse
Fonctions d'ordinateur	□ Douleur accrue □ restreint de mouvement □ Faiblesse
Étudier	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre : _____	□ Douleur accrue □ restreint de mouvement □Faiblesse

Fonctions domestiques	**Raison de la difficulté**
Nettoyer à l'aspirateur	□ Douleur accrue □ restreint de mouvement □Faiblesse
Prenant soin des enfants	□ Douleur/inquiétude □ restreint de mouvement □Fatigue
Nettoyage	□ Douleur accrue □ restreint de mouvement □Faiblesse
Préparant des repas	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre : _____	□ Douleur/inquiétude □ restreint de mouvement □Fatigue

Fonctions de ménage	**Raison de la difficulté**
Yardwork	□ Douleur accrue □ restreint de mouvement □Faiblesse
Transport	□ Douleur/inquiétude □ restreint de mouvement □Fatigue
Achats	□ Douleur/inquiétude □ restreint de mouvement □Fatigue
Sortant le détritus	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre : _____	□ Douleur/inquiétude □ restreint de mouvement □Fatigue

Nom patient : Date de _____ : _____/_____/20___

Perte de résumé de plaisir

Remplissez le questionnaire suivant comme il se relie au **activités** (travail relié ou autrement) **vous normalement seriez apprécier** - mais soyez **n'appréciant actuellement pas** en raison de vos dommages.
Incluez toutes les activités qui vous :

- le bidon plus font ou n'exécutent, et/ou
- ne peut pas faire ou exécuter aussi souvent que vous avez fait avant vos dommages

Description_____ du travail

Travail	**Raison de la difficulté**
Levager	□ Douleur accrue □ restreint de mouvement □Faiblesse
Recourbement	□ Douleur accrue □ restreint de mouvement □Faiblesse
Séancer	□ Douleur accrue □ restreint de mouvement □Faiblesse
Marcher	□ Douleur accrue □ restreint de mouvement □Faiblesse
Fonctions d'ordinateur	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre :	□ Douleur accrue □ restreint de mouvement □Faiblesse

Études/école	**Raison de la difficulté**
Levager	□ Douleur accrue □ restreint de mouvement □Faiblesse
Recourbement	□ Douleur accrue □ restreint de mouvement □Faiblesse
Séancer	□ Douleur accrue □ restreint de mouvement □Faiblesse
Marcher	□ Douleur accrue □ restreint de mouvement □Faiblesse
Fonctions d'ordinateur	□ Douleur accrue □ restreint de mouvement □ Faiblesse
Étudier	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre : _____	□ Douleur accrue □ restreint de mouvement □Faiblesse

Fonctions domestiques	**Raison de la difficulté**
Nettoyer à l'aspirateur	□ Douleur accrue □ restreint de mouvement □Faiblesse
Prenant soin des enfants	□ Douleur/inquiétude □ restreint de mouvement □Fatigue
Nettoyage	□ Douleur accrue □ restreint de mouvement □Faiblesse
Préparant des repas	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre : _____	□ Douleur/inquiétude □ restreint de mouvement □Fatigue

Fonctions de ménage	**Raison de la difficulté**
Yardwork	□ Douleur accrue □ restreint de mouvement □Faiblesse
Transport	□ Douleur/inquiétude □ restreint de mouvement □Fatigue
Achats	□ Douleur/inquiétude □ restreint de mouvement □Fatigue
Sortant le détritus	□ Douleur accrue □ restreint de mouvement □Faiblesse
Autre : _____	□ Douleur/inquiétude □ restreint de mouvement □Fatigue

Sports	**Raison de la difficulté**
Name Sport: _____	□ Douleur/inquiétude □ restreint de mouvement □Fatigue

Please Print

Patient Information

Name _____ Date _____
Date of Birth _____ E-Mail Address _____
Street Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Occupation _____
Employer _____ Business Phone _____
Sex: □ Male □ Female Height _____ Weight _____
Are you: □ Married □ Single □ Domestic Partnership □ Divorced □ Separated □ Widowed
Spouses Name: _____ # of Children _____
Emergency Contact Name _____ Relationship _____
Contact Phone _____
Your Insurance Carrier _____ Claim Number _____
Other Party's Insurance Carrier _____ Claim Number _____
Name of Attorney _____ Phone Number _____
Do you have any special needs? _____
How did you hear about us? _____

Present Health

Please Complete Duties Under Duress and Loss of Enjoyment Worksheets

What are your health concerns? _____
_____
What are your goals coming in today? _____
_____
Who is your primary care provider? _____
Address _____
Phone _____
Please list any allergies you may have _____
_____
Please list any medications you are currently taking _____
Please list any supplements you are currently taking _____
_____
_____
Describe your current exercise regimen _____
_____
_____
Did you strike your head or any other part of your body in this accident? _____
_____

Medical History

Have you ever been treated by a: □ Chiropractor □ Naturopathic Doctor
□ Reflexologist □ Massage Therapist
□ Acupuncturist □ Other alternative practitioner

Family History

Check applicable	Father	Mother	Grandparent	Sibling	Other (Specify)
Anemia					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Epilepsy					
Psychological Disorder					
Asthma					
Hay fever, Hives					
Kidney Disease					
Glaucoma					
Tuberculosis					
Age at death					
General Health *(G=Good, P=Poor)*					

Personal History

As a child, did you have any of the following diseases?
□ Scarlet fever □ Rheumatic fever □ Diphtheria □ Mumps □ Measles □ German measles
□ Other _____
List hospitalizations or surgeries have you had with corresponding dates
_____
Have you ever been in an auto accident? _____ When? _____
List other injuries including falls and other traumas and when they occurred:
_____
Have you been diagnosed with any diseases or disorders and when? _____
_____

List childhood immunizations you received _____
Last Tetanus shot _____

Review of Symptoms

Weight _____ Weight 1 yr. ago _____ Max. Weight _____ When _____

Please Circle the appropriate letter next to each item based on the following:

Y= a condition you have now **N**= never had **P**= a condition you have had in past

Neck Pain	Y P N	Asthma	Y P N
Back Pain	Y P N	Bronchitis	Y P N
Lower Back Pain	Y P N	Pneumonia	Y P N
Extremity Pain	Y P N	Emphysema	Y P N
Chest Pain	Y P N	Difficulty Breathing	Y P N
Right/Left Arm Pain/ Tiingling	Y P N	Shortness of Breath	Y P N
Right/Left Leg Pain/Tingling	Y P N	Heart Disease	Y P N
Right/Left Foot Pain/Tingling	Y P N	Angina	Y P N
Right/Left Hand Pain/Tingling	Y P N	High Blood Pressure	Y P N
Fingers/Toes Pain/Tingling	Y P N	Fasciotomy	Y P N
Spasms	Y P N	Edema	Y P N
Dizziness	Y P N	Arthroplasty (prosthetic replacement)	
Vision Disturbance	Y P N		Y P N
Motion Restriction	Y P N	Nausea	Y P N
Radiating Symptom	Y P N	Vomiting	Y P N
Sleep Disruption	Y P N	Constipation	Y P N
Anxiety	Y P N	Blood in Stool	Y P N
Night Sweats	Y P N	Gas/Bloating	Y P N
Headaches	Y P N	Liver Disease	Y P N
Head Injury	Y P N	Hemorrhoids	Y P N
Impaired Vision	Y P N	Abdominal Pain	Y P N
Corrected Vision	Y P N	Peptic Ulcer	Y P N
Depression	Y P N	Gall Bladder Disease	Y P N
Tearing/Dryness	Y P N	Pain on Urination	Y P N
Double Vision	Y P N	Urinary Frequency	Y P N
Pallectomy	Y P N	Ligament or Tendon repair, not	
Cataracts	Y P N	arthroscopy, Arthrotomy	Y P N
Impaired Hearing	Y P N	Kidney Stones	Y P N
Ear Ringing	Y P N	Blood in Urine	Y P N
Earaches	Y P N	Joint Pain/Stiffness	Y P N
Frequent Colds	Y P N	Arthritis	Y P N
Sinusitis	Y P N	Broken Bones	Y P N
Postnasal Drip	Y P N	Muscle Spasms	Y P N
Change in Taste	Y P N	Deep Leg Pain	Y P N
Goiter	Y P N	Thrombophlebitis	Y P N
Cough	Y P N	Aspiration of Hematoma	Y P N
Sputum	Y P N	Fainting	Y P N
Spit up Blood	Y P N	Seizures	Y P N

Paralysis	Y	P	N
Muscle Weakness	Y	P	N
Numbness/Tingling	Y	P	N
Coordination Difficulties	Y	P	N
Depression	Y	P	N
Anxiety	Y	P	N
Mood Swings	Y	P	N
Memory Loss	Y	P	N
Drug/Alcohol Abuse	Y	P	N
Difficulty Sleeping	Y	P	N
Phobia	Y	P	N
Thyroid Problem	Y	P	N
Extremity Pain – Numbness	Y	P	N
Arthrotomy, Meniscectomy, cruciate	Y	P	N
Excessive Thirst	Y	P	N
Excessive Hunger	Y	P	N
Anemia	Y	P	N
Easy Bleeding	Y	P	N

Females Only

Age menses began			
Age menses ended			
Average cycle length			
Average bleeding length			
Spotting	Y	P	N
Irregular Cycles	Y	P	N
Painful Menses	Y	P	N
Birth Control	Y	P	N
Sexual Difficulties	Y	P	N
STD	Y	P	N
Breast Lumps	Y	P	N
Breast Pain	Y	P	N
Nipple Discharge	Y	P	N
PMS Symptoms	Y	P	N
Menopausal Symptoms	Y	P	N
Vaginal Dryness	Y	P	N
Vaginal Discharge/Sores	Y	P	N
Number of pregnancies			

Number of live births _____
Number of miscarriages _____

Males Only

Hernias	Y	P	N
Testicular Masses	Y	P	N
Testicular Pain	Y	P	N
Sexual Difficulties	Y	P	N
STD	Y	P	N
Penile Discharge/Sores	Y	P	N
Prostate Disease	Y	P	N

Are there any additional health concerns or questions you have?

_____
_____
_____
_____
_____
_____
_____

Please describe a poor experience with a health practitioner you have had in the past.

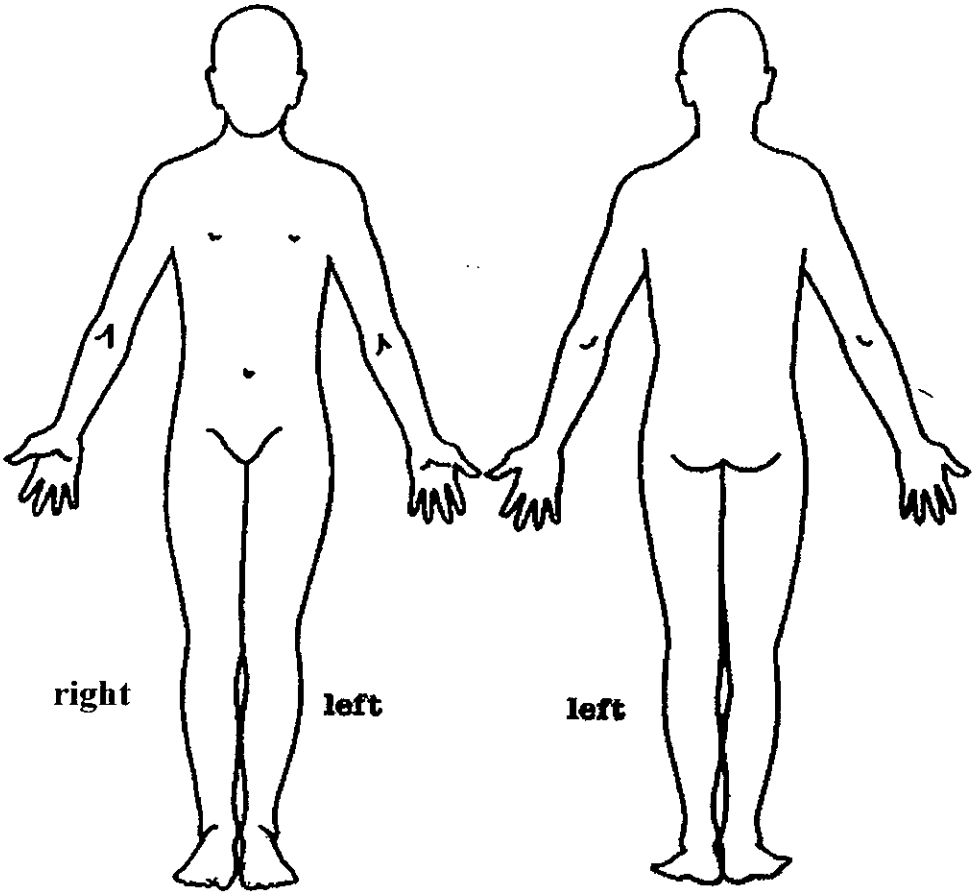
_____
_____
_____
_____
_____

Please describe a good experience with a health practitioner you have had in the past.

_____
_____
_____
_____

Use the pictures below to indicate your problem areas. Use the appropriate symbol to indicate numbness, pins & needles, burning, stiffness, aching, or stabbing pain.

Numbness: □	Pins & Needles: .-.	Aching pain: ±
Stabbing pain: ↑	Burning: #	Stiffness: u



Please rate your discomfort on a scale of 1-10.
(1= mild pain, 10=the worse pain you've ever felt).

	Location	Pain rating
1.	_____	
2.	_____	
3.	_____	

PHYSICIAN PORTION ONLY

List all ICD-9 codes diagnosed: _____

_____

List all CPT codes used: _____

_____

Total number of treatment dates: ____ Last treatment date: _____

Has whiplash (Subluxation) injuries been identified as well as individual Cervical, Thoracic and Lumbar Sprain/Strain, Ligamentous, Prolapse, Bulge, Protrusion, Herniation, Dislocation or Fracture?

If so, enter whiplash (Subluxation) into **NECK and BACK** section.
Enter each individual body part injury separately into **OTHER INJURIES** including Sprains/Strains.

Which of the following items were identified throughout the treatment:
(Last date noted could be the last treatment date or today and ongoing on the date of this report)

	Initial Date Noted	Last Date Noted
☐ Range of Motion	_____	_____
☐ Headaches	_____	_____
☐ Spasms	_____	_____
☐ Dizziness	_____	_____
☐ Visual Disturbance	_____	_____
☐ Sleep Disruption	_____	_____
☐ Radiating	_____	_____
☐ Anxiety/Depression	_____	_____
☐ TMJ	_____	_____
☐ Home Exercises	_____	_____
☐ Bed Rest	_____	_____
☐ Gym	_____	_____
☐ Home Traction	_____	_____
☐ Tens	_____	_____

All ITEMS BELOW MUST BE VALIDATED BY A MEDICAL DOCTOR

Determine future treatment determined necessary as either Probable (51 to 75% medically certain of it occurring) or Definite (76 to 100% medically certain.)
Number of treatments over next:
6 months _____ 12 months _____ 18 months _____ 24 months _____
Total cost of expected treatment _____

Is your final prognosis, "Ongoing Complaints with Ongoing Treatment: ☐Yes ☐No
Ongoing treatment would include both Passive and Active Treatments.

Indicate which body part has reached MMI: _____
% Whole Body Impairment Rating: _____

Duties Under Duress:

Work ☐ Study ☐ Domestic Duties ☐ Household Duties ☐ Hobbies ☐

Loss of Enjoyment:

Work ☐ Study ☐ Domestic Duties ☐ Household Duties ☐ Hobbies ☐ Sport ☐

Sport Categories: Regionally Playing ☐ Competitive ☐ Social ☐ Any ☐

ignature of Physician_____ Date Completed_____

[redacted]
Attorney at Law
Your street
Your town, state and zip

Tel [redacted]
Fax [redacted]

Date

[redacted] M.D.
Pain and Rehabilitation Center
Street.
City, State and zip

Re: Name: [redacted]
Address:
Birth Date:
SS#:

Dear Dr. _____:

This ratings appointment has been scheduled for [redacted]

Enclosed please find my prepayment of $400.00 and CLIENT NAME's medical records. I have notified my client that on the date of his rating appointment, he will need to hand-carry any film of his injury (x-rays and MRI results).

I have attached the ICD-9 codes and police report. Please address the following:

1. In your opinion, has the treatment provided been reasonable and necessary as well as appropriately charged?
2. Impairment ratings with comprehensive total whole body percentage based on 5th edition AMA Guidelines.
3. Specific body part which has reached MMI.
4. Duties under duress and loss enjoyment of life. (Summaries attached)
5. Would you determine there are ongoing complaints and continuing treatment needed?
6. Future medical care (not palliative) that is probable or definite. Please include amount, duration, and frequency.
7. Risk factors if any. (e.g. Degenerative Disc Disease, Arthritis, Future risk of injury, Seizure from head injury)
8. If there is pre-existing injury then determine if it was exacerbated by the present accident. Also please prorate the impairment rating between multiple accidents.
9. Do you recommend home exercise, bed rest, abstinence of any activity? If so, provide duration, type, and frequency.

10. Any complications that have arisen from the accident. (e.g. necrosis, delayed bony union, delayed wound healing, osteomyelitis, peripheral nerve injury, pulmonary embolism, thrombosis, fat embolism, wound infections or ulcerations.)
11. Any permanent disabilities (e.g. lifting restrictions, sit/stand)
12. If you find an injury not previously diagnosed, please provide the ICD-9 code.
13. If patient suffers depression, anxiety, or loss of sleep, please address it.
14. Please document if client complains of spasms, headaches, radiating pain, TMJ or visual disturbances.
15. Which of the following complaints were experienced during treatment and which continue:

During Treatment	Continue at Present
❑	☐ Range of Motion
❑	☐ Headaches
❑	☐ Spasms
❑	☐ Dizziness
❑	☐ Visual Disturbance
❑	☐ Sleep Disruption
❑	☐ Radiating
❑	☐ Anxiety/Depression
❑	☐ TMJ

In addition to these standard requests, Please address the following case specific issues:

[redacted]

Please call with any questions or concerns.

Very truly yours,

[redacted]

Please Answer Every Question

Body Shop Questionnaire

Client:_____ Date:_____

Make/Model_____ Your estimate of Repair_____

1. Please include frame time cost and OEM parts in the estimate. You may do an alternative estimate for non OEM parts.

$_____

2. Did the rear bumper absorbers move more than one inch? If so, how many inches? This should be memorialized with a 35mm photograph, if possible.

Yes_____ How many inches?_____ No_____

3. Did rear bumper absorbers not move at all and is there rust or other buildup visible on the absorber armature? (This should be memorialized with a 35mm photograph if possible.)

Yes_____ No_____ 35mm available?_____

4. Was this a submarine style accident? In other words, was there undercarriage damage but little visible damage to the unibody of the vehicle?

Yes_____ No_____

5. Are more than two hours of frame repair time required? (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.)

Yes_____ No_____

6. Does the damage travel 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.)

Yes_____ No_____ 35mm available?_____

7. Is there significant prior damage to the same impact area of the vehicle?

Yes_____ No_____

8. Please note if this is not a unibody vehicle.

Yes_____ No_____

9. Please note if the vehicle had an attached item; which would eliminate the effectiveness of the unibody and/or low impact bumper. (This is often seen when the 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.)

Yes_____ No_____

If yes what is the item?_____

10. Were seatbelts and seatbelt locking mechanisms checked for replacement?

Yes_____ No_____

11. If so, which ones?_____

12. Were the driver or passenger seat mounts damaged? Or were any of the seats knocked off their mounts?

Yes_____ No_____

13. If so, which one?_____

14. Was the headrest for either the driver or passenger seat damaged?

Yes_____ No_____

15. If so, which one?_____

Printed Name:_____

Signature:_____

Phone #_____

Medical Report Checklist

Patient Details

1. Name of Injured patient:_____
2. Date of Birth:_____
3. Gender:_____
4. Height:_____
5. Weight:_____
6. Dominate Hand:_____
7. Address:_____

Insurer/Attorney details

1. Insurer/Firm name:_____
2. Address:_____
3. Adjuster/Attorney name:_____

Additional Details

1. Patient number:_____
2. Name of Insured:_____
3. Date of Loss:_____
4. Date of first treatment:_____
5. Medical Specials:_____
6. Income Loss:_____
7. Claim Status:_____
8. Medical Assistant:_____

Physicians

1. Physicians Name:_____
2. Physician Type:_____
3. Billed Amount:_____
4. All records received: Yes / No
5. Treating Physician: Yes / No

Injuries

List Injuries

1. _____
2. _____
3. _____
4. _____
13. _____
14. _____
15. _____
16. _____

5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____

Complaints:
- ☐ Range of motion Physician:_____ Date:_____
- ☐ Headaches Physician:_____ Date:_____
- ☐ Dizziness Physician:_____ Date:_____
- ☐ Spasms Physician:_____ Date:_____
- ☐ Visual Disturbance Physician:_____ Date:_____
- ☐ Radiating Pain Physician:_____ Date:_____
- ☐ TMJ Physician:_____ Date:_____
- ☐ Anxiety/Depression Physician:_____ Date:_____
- ☐ Sleep Disturbance Physician:_____ Date:_____

Treatments:
- ☐ Pool Therapy or Hubbard tank with therapeutic exercises, initial 30 mins.
- ☐ Arthrodesis
- ☐ Plastic Surgery
- ☐ Physical medicine treatment to one area, individual instruction
- ☐ Injections
- ☐ Physical medicine treatment to one area, joint mobilization
- ☐ Elec. Stimulation (manual)
- ☐ Electrical Stimulation
- ☐ Myofacial Release
- ☐ Walking Aids
- ☐ Whirlpool
- ☐ Reduction
- ☐ Unlisted Procedure (specify)
- ☐ Meniscectomy through arthroscope
- ☐ Delay or Gaps in Treatment
- ☐ Transfusion
- ☐ Physical medicine treatment to one area, taping
- ☐ Ultrasound
- ☐ Tens (at home)
- ☐ Vasopneumatic devices
- ☐ Patient education (organized group instruction programs (two to five patients)
- ☐ Manual Traction

☐ Myofacial release/soft tissue mobilization, one or more regions
☐ Surgery
☐ Paraffin bath
☐ Bed Rest

☐ Removal of internal fixation
☐ Debridement
☐ Extremity Adjustment
☐ Fasciotomy
☐ Arthroscopy
☐ Unlisted Modality (specify)
☐ Ultraviolet
☐ Ligament or Tendon repair, not arthroscopy, Arthrotomy
☐ Work hardening/conditioning, initial 2 hours (Prior authorization required)
☐ Diathermy
☐ Iontophonaia
☐ Arthrotomy, Meniscectomy, cruciate
☐ Aspiration of Hematoma
☐ Bone Graft
☐ Physical medicine treatment to one area, soft tissue mobilization
☐ Microwave
☐ Release of adhesions
☐ Other Chiropractic Treatment
☐ Chiropractic Manipulation
☐ Catheter
☐ Kinetic activities, one each, initial 30 mins
☐ Perctaneous insertion of intra-medullary nail (femur only)
☐ Immobilization
☐ Duties Under Duress
☐ Mechanical Traction
☐ Arthroplasty (prosthetic replacement)
☐ Training in activities of daily living, initial 30 mins
☐ Elec. Stimulation (unattended)
☐ Loss of Enjoyment
☐ Infrared
☐ Hospitalization
☐ Contrast Bath
☐ Functional Activities
☐ Traction
☐ Traction Manual
☐ Massage

☐ Therapeutic Exercises
☐ Pallectomy
☐ Confined To Bed
☐ Other Significant Treatments
☐ Suturing
☐ Home Traction
☐ Prescribed Medication
☐ Neuromuscular reeducation
☐ Traction Mechanical
☐ Nursing/Convalescent Home
☐ Individualized procedure requiring the application of computer assisted equipment
☐ Dressings
☐ Oxygen
☐ Gait Training
☐ Orthotics training (bracing, splinting) upper/lower extremity, initial 30 mins
☐ Hot or Cold packs

Physician:_____ Chart Date:_____

Therapy

☐ Physical Therapy
☐ Massage Therapy
☐ Acupuncture
☐ Self-Exercise
☐ Gym
☐ Exercise Rehabilitation
☐ Bed Rest

Physician:_____ Chart Date:_____

Testing

☐ X-Ray
☐ MRI
☐ Cat Scan
☐ Discogram
☐ Myelogram
☐ Ultrasound
☐ Other:_____

Physician:_____ Chart Date:_____

Medical Supplies

Item: _____ Cost: _____

_____ _____
_____ _____
_____ _____
_____ _____

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Impairment

Physician:_____ Chart Date:_____

Whole Body%:_____ Body Part:_____

Disfigurement

Physician:_____ Chart Date:_____

Depression

Physician:_____ Chart Date:_____

TMJ

Physician:_____ Chart Date:_____

Income Loss

1. Physician Name: _____
2. Last Chart Date: _____
3. Employer Type: _____
4. Future Time off: _____
5. Employer: _____
6. Duration: _____
7. Loss Amount: _____

Future Medical

1. Physician Name: _____
2. Last Chart Date: _____
3. Treatment/s: _____
4. Amount: _____

Letter Details

Introductory Paragraph:

Closing Paragraph:

Daily Exam Form

Date	Time of Arrival	Patient Name"	DOB:	Age:	
Name of Insurer:		Temperature_____ Respiration____ Height_____ Weight_____			

Lungs Clear to Auscultation or Abnormality	L/R/B Handed L ☐ R☐ B☐	Pain Level: 1 2 3 4 5 6 7 8 9 10 Frequency 1 2 3 4 5 6 7 8 9 10	Pulse _____ Regular Dysrhythmic Blood Pressure Right/Left _____/_____

Injuries

Injury/Description **See common Code Listing**	**Date**	**ICD-9**

CERVICAL RANGE OF MOTION PAIN/LEVEL

Flexion _____/60_____
Extension _____/75_____
Rt Lat. Flex _____/45_____
Rt Lat. Flex _____/45_____
Rt. Rot. _____/80_____
Lt. Rot _____/80_____

Impairment

% Whole Body Impairment Rating: ☐Yes ☐No	Date:
Duties Under Duress:	Date:

Work ☐ Hobbies ☐ Domestic Duties ☐ Household Duties☐

Loss of Enjoyment: Date:

Ceraniocervical Functional Maneuver (Hyperextension/Rotation @ 10 seconds)	Abdomen No masses, tenderness, rigidity or Bruit Apparent Abnormality

Domestic Duties ☐ Household Duties ☐ Hobbies ☐ Sport ☐ Work / Study ☐

Sport Categories: Regionally Playing ☐ Competitive ☐ Social ☐ Any ☐

Symptoms

ROM ☐	Headache ☐	Spasm ☐	Dizziness ☐	Radiating Pain ☐	Pain Scale

Visual Disturbance ☐	Sleep Disturbance ☐	Depression ☐ Anxiety ☐	Post Concussion ☐ TMJ ☐

Treatment Issues: ☐ Delay/Gap ☐ Confined to bed ☐ Immobilization ☐

LEVEL	PAIN L	PAIN R	SPASM L	SPASM R	EDEMA L	EDEMA R
OCC						
C1						
C2						
C3						
C4						
C5						
C6						
C7						
T1						
T2						
T3						
T4						
T5						
T6						
T7						
T8						
T9						
T10						
T11						
T12						
L1						
L2						
L3						
L4						
L5						
SAC						
S-I						
CC						

Documentation

Description:	Physician:	Date:	Duration:

**CERVICAL / THORACIC ORTHOPEDIC
All + findings must describe location radiation of provoked pain, and intensity on a 1-10 scale

	Location	Radiates to	Intensity							
Cerv. Comp					Adsons					
Max. Comp					Halsted					
Cerv. Dist.					Wrights					
Shld. Dep.					Edens					
					Valsalva					

Continuing or Future Treatment Plan:

_____

_____

Cranial Nerves

1 Smell	N	A
2 Accomodate/light	N	A
3,4,6 Eye Movement	N	A
5 Sensation/Wink	N	A
7 Smile/Taste	N	A
8 Auditory/Balance	N	A
9 Gag Taste	N	A
10 Voice/Swallow	N	A
11 Shoulder Shrug	N	A
12 Tongue Move	N	A

Sensory Pinwheel Testing N=Normal A=Abnormal D=Decreased I=Increased

	Right	Left
C5	N-A-D-I	N-A-D-I
C6	N-A-D-I	N-A-D-I
C7	N-A-D-I	N-A-D-I
C8	N-A-D-I	N-A-D-I
T1	N-A-D-I	N-A-D-I
L2	N-A-D-I	N-A-D-I
L3	N-A-D-I	N-A-D-I
L5	N-A-D-I	N-A-D-I
S1	N-A-D-I	N-A-D-I

Grip Strength Dominant Hand Right Left
R_____L_____ R_____L_____
R_____L_____

Rombergs Test Normal Abnormal
Hoffmans Sign Absent Right Left Present Right Left

Plantar Response	Downgoing	Absent	Upgoing
Right	R	R	R
Left	L	L	L

Kemps

	Right	Left
Full & Pain Free		
To right-Pain	Positive	Negative
Back		
Right Leg		
Left Leg		
To Left Pain		
Back		
Right Leg		
Left Leg		

Cerebeller Function
Gait Normal_____ Dystaxia_____
Rapidly Alternating Movements

	Quickly & Accurately	Clumsily	Unable to Perform
Right	R	R	R
Left	L	L	L

Heel to Shin	Quickly & Accurately	Clumsily	Unable to Perform
Right	R	R	R
Left	L	L	L

Deep Tendon Reflexes

	R	L
Biceps C5	0-1-2-3-4	0-1-2-3-4
BrachioRad C6	0-1-2-3-4	0-1-2-3-4
Triceps C7	0-1-2-3-4	0-1-2-3-4
Patellar L4	0-1-2-3-4	0-1-2-3-4
Achilles S1	0-1-2-3-4	0-1-2-3-4

Muscle Strength: 0=None 1=trace 2=poor 3=fair 4=good 5=normal

	Right	L
Deltoid C5	0-1-2-3-4-5	0-1-2-3-4-5
Biceps C5/6	0-1-2-3-4-5	0-1-2-3-4-5
Triceps C7/8	0-1-2-3-4-5	0-1-2-3-4-5
Wrist Flexion C7	0-1-2-3-4-5	0-1-2-3-4-5
Wrist Extension C6	0-1-2-3-4-5	0-1-2-3-4-5
Finger Flexion C8	0-1-2-3-4-5	0-1-2-3-4-5
Interossei T1	0-1-2-3-4-5	0-1-2-3-4-5

Lower Extremity Motor Function

	Right	Left
Hip Flexion L2/L3	0-1-2-3-4-5	0-1-2-3-4-5
Leg Extension L3/L4	0-1-2-3-4-5	0-1-2-3-4-5
Foot Dorsi-Flexion L4/L5	0-1-2-3-4-5	0-1-2-3-4-5
Great Toe Dorsi-Flex L5	0-1-2-3-4-5	0-1-2-3-4-5
Hip Extension L4/L5	0-1-2-3-4-5	0-1-2-3-4-5
Knee Flexion L5/S1	0-1-2-3-4-5	0-1-2-3-4-5
Foot plantor-flexion S1/S2	0-1-2-3-4-5	0-1-2-3-4-5
Foot Eversion S1	0-1-2-3-4-5	0-1-2-3-4-5

		Postive	Negative
Heal Walk L4/L5	Right	R	R
	Left	L	L
Toe Walk S1/S2	Right	R	R
	Left	L	L

Straight Leg	N P	0-1-2-3-4-5	_____R C L_____
Well Leg	N P	0-1-2-3-4-5	_____R C L_____
Brag/Fajers	N P	0-1-2-3-4-5	_____R C L_____
Bilat Raise	N P	0-1-2-3-4-5	_____R C L_____
Sign of 4	N P	0-1-2-3-4-5	_____R C L_____
Lindner's	N P	0-1-2-3-4-5	_____R C L_____
Mannkopf's	N P	0-1-2-3-4-5	_____R C L_____

Fabre Patrick + -- Nachlas +-- Elys +-- Hibbs+--

Recommended Management, Adjustments, Ice, moist heat, intersegmental mobilization, mechanical traction, massage, ultrasound, other
Supportive Exercise Program
Cervical, lumbar, scoiliosis, spinal rehabilitation

All general measures associated with condition have been reviewed

Potential risks have been described and patient has acknowledged their understanding of them.

Your Name:					
Your Address:		Your Insurance:		Limit:	
		Address:			
Phone #:		Phone #:		Claim #:	
Your Attorney:		Other Insurance:		Limit:	
		Address:			
Phone #:		Phone #:		Claim #:	

Prior/Subsequent Injuries (Injuries you had before or after your accident):		
	Last date you treated or had complaints:	
	Last date you treated or had complaints:	
	Last date you treated or had complaints:	
	Last date you treated or had complaints:	
	Last date you treated or had complaints:	

Current Injuries:	Pain Scale 1-10	When/Amount of time felt

Were you a pedestrian? _____ Were you on a bicycle? _____ Were you on a motorcycle? _____

Were you the driver or passenger in auto? _____ Were there other passengers in your vehicle? ____
Were you wearing a seatbelt? _____ What was your speed at time of collision?_____
What side of vehicle was impacted?_____ Make of your vehicle?_____
Have you experienced any of the following? Loss of Consciousness _____ Sleep Disruption _____
Dizziness _____ Blurred Vision _____ Anxiety/Depression _____ Stiffness _____ Spasms _____
Does it hurt to bend, stoop or lay down?_____ How often do you experience this? _____
Have you completed the DUD/LOE worksheets? _____ Are you currently working or in School? _____
Are you married? _____ Do you have children? _____ How many and their ages: _____

Patient Signature: _____ Date: _____

1a. Chiropractic

1 Bed rest
2 Contrast Bath
3 Diathermy
4 Elec. Stimulation (Manual)
5 Elec. Stimulation (Unattended)
6 Functional Activities
7 Gait Training
8 Hot or Cold Packs
9 Individualized Procedure
10 Infrared
11 Iontophonaia
12 Kinetic Activities
13 Massage
14 Microwave
15 Myofacial Release
16 Neuromuscular release
17 Orthotics Training
18 Paraffin Bath
19 Patient Education
20 Physical Medicine (Individual Instruction)
21 Physical Medicine (Joint Mobilization)
22 Physical Medicine (soft Tissue Mobilization)
23 Physical Medicine (taping)
24 Pool Therapy
25 Therapeutic Exercises
26 Traction Manual
27 Traction Mechanical
28 Training in activities
29 Ultrasound
30 Ultraviolet
31 Unlisted Modality
32 Unlisted Procedure
33 Vasopneumatic Devices
34 Whirlpool
35 Work Hardening

1b. Complaints

1 Range of Motion
2 Headaches
3 Dizziness
4 Spasms
5 Visual Disturbance
6 Radiating Pain
7 TMJ
8 Anxiety/Depression
9 Sleep Disturbance

1c. Treatments

1 Arthrodesis
2 Arthroplasty
3 Arthroscopy
4 Arthrotomy, Meniscectomy, Cruciate
5 Aspiration of Hematoma
6 Bone Graft
7 Catheter
8 Chiropractic Manipulation
9 Confined to bed
10 Debridement
11 Dressings
12 DUD: Work
13 DUD: Hobbies
14 DUD: Domestic Duties
15 DUD: Household Duties
16 Electrical Stimulation
17 Extremity Adjustment
18 Fasciotomy
19 Home Traction
20 Hospitalization
21 Injections
22 Ligament or Tendon repair
23 LOE: Work/Study
24 LOE: Hobbies
25 LOE: Domestic Duties
26 LOE: Household Duties
27 LOE: Sports
28 Manual Traction
29 Mechanical Traction
30 Meniscectomy
31 Myofacial Release
32 Nursing/Convalescent Home
33 Other Chiropractic Treatments
34 Other Significant Treatments
35 Oxygen
36 Pallectomy
37 Perctaneous insertion
38 Plastic Surgery
39 Prescribed Medication
40 Reduction
41 Release of Adhesions
42 Removal of Internal Fixations
43 Surgery
44 Suturing
45 Tens (At Home)
46 Traction
47 Transfusions
48 Walking Aids

1d. Therapies

1 Physical Therapy
2 Massage Therapy
3 Acupuncture
4 Self-Exercise
5 Gym
6 Exercise Rehabilitation
7 Bed Rest

1e. Testing

1 X-ray
2 MRI
3 Cat Scan
4 Discogram
5 Myelogram
6 Ultrasound
7 Other

1f. Complications

1 Wound Infections/Ulceration
2 Delayed Wound Healing
3 Delayed Bony Union
4 Non-Union
5 Thrombosis
6 Pulmonary Embolism
7 Fat Embolism
8 Avascular Necrosis
9 Peripheral Nerve Injury
10 Osteomyelits

INTAKE/SUPPLEMENTAL SOAP WORKSHEET

A. Patient Name: _____ Physician: _____ Today's Date: ___/___/_____ **(Select "Add")**

1. INJURY/DETAILS No Change☐
Add Injury_____

a. **Chiropractic** No Change☐
Add Chiropractic_____

b. **Complaints** No Change☐
Add Complaints_____

c. **Treatments** No Change☐
Add Treatments_____

d. **Therapies** No Change☐
Add Therapies_____

e. **Testing** No Change☐
Add Testing_____

f. **Complications** No Change☐
Add Complications_____

g. **Other** No Change☐
Add Other_____

2. SUBJECTIVE No Change☐
a. **Accident Details**_____

b. **Symptoms** No Change☐

c. **Symptoms Details** No Change☐ Intensity/Frequency
_____ /
_____ /
_____ /

Aggravated When _____ Relived When_____
Quality of Pain_____ Affected by Time_____
d. **Other Symptoms** No Change☐
Radiating Pain_____ Radiating to_____
Other Symptoms_____

e. **Duties Under Duress** No Change☐
Work_____ Domestic_____
Study_____ Household_____

f. **Loss of Enjoyment** No Change☐
Work_____ Domestic_____
School_____ Sports_____
Hobbies_____ Factors _____
Notes_____

3. OBJECTIVE No Change☐
Was E/M Exam Preformed Y / N
a. **Range of Motion** _____
b. **Muscle Weakness** Upper_____ Lower_____
c. **Dermatomal Sensation** _____
d. **Muscle Spasms** _____
e. **Vertebral Subluxations**_____
f. **Other Subluxations**_____
Notes_____

4. ASSESSMENT No Change☐
a. Notes_____

5. PLAN No Change☐
a. Plan Options

b. X-Rays Taken☐ Ordered☐

c. Discharge Plan/Notes No Change☐

Notes No Change☐

2b. Symptoms

a. Occipital Headaches
b. Frontal Headaches
c. Right Temporal Headaches
d. Left Temporal Headaches
e. Dizziness
f. Range of Motion
g. Muscle Spasms
h. Visual Disturbance
i. Sleep Disturbance
j. Radiating Pain
k. TMJ
l. Anxiety/ Depression
m. Left Jaw Pain
n. Right Jaw Pain
o. Neck Pain
p. Upper Back Pain
q. Middle Back Pain
r. Low Back Pain
s. Left Shoulder Pain
t. Right Shoulder Pain
u. Left Elbow Pain
v. Right Elbow Pain
w. Left Wrist Pain
x. Right Wrist Pain
y. Left Hip Pain
z. Right Hip Pain
aa. Left Knee Pain
bb. Right Knee Pain
cc. Left Ankle Pain
dd. Right Ankle Pain

2d. Other Symptoms

a. Burning
b. Numbness
c. Pain
d. Tingling
e. Weakness

Radiating to:

a. Left Arm
b. Right Arm
c. Left Forearm
d. Right forearm
e. Left hand
f. Right hand
g. Left thigh
h. Right thigh
i. Left leg
j. Right leg
k. Left foot
l. Right foot
m. Left hip
n. Right hip
o. Left shoulder area
p. Right shoulder area
q. Posterior Cervical musculature
r. Thoracic paraspinal musculature
s. Right gluteal musculature
t. Left gluteal musculature

Other symptoms

a. Anxiety
b. Depression
c. Fatigue
d. Sleep Disturbance
e. Stress at home
f. Stress at work
g. Visual Disturbance

3a. Range of Motion

f. Cervical Extension
g. Cervical Flexion
h. Cervical Left lateral Flexion
i. Cervical Right lateral Flexion
j. Cervical Left Rotation
k. Cervical right Rotation
l. Dorsolumbar Left Rotation
m. Dorsolumbar Right Rotation
n. Lumbar Extension
o. Lumbar Flexion
p. Lumbar left Lateral Flexion
q. Lumbar Right Lateral Flexion

3b. Muscle Weakness (upper)

a. Left shoulder Abductors
b. Right Shoulder Abductors
c. Left shoulder Flexors
d. Right Shoulder Flexors
e. Left Shoulder Lateral Rotators
f. Right Shoulder Lateral Rotators
g. Left Elbow Flexors
h. Right Elbow Flexors
i. Left Elbow Extensors
j. Right Elbow Extensors
k. Left Finger Flexors
l. Right Finger Flexors
m. Left Finger Abductors
n. Right Finger Abductors

3b. Lower Extremities

a. Left Hip Flexors
b. Right Hip Flexors
c. Left Hip Abductors
d. Right Hip Abductors
e. Left Hip Extensors
f. Right Hip Extensors
g. Left Knee Flexors
h. Right Knee Flexors
i. Left Knee Extensors
j. Right Knee Extensors

3d. Muscle Spasms

a. Left Suboccipital Muscle
b. Right Suboccipital Muscle
c. Left Trapezius Muscle
d. Right Trapezius Muscle
e. Left levator Scapulae Muscle
f. Right levator Scapulae Muscle
g. Left Rhomboid Muscle
h. Right Rhomboid Mucsle
i. Left supraspinatus Muscle
j. Right supraspinatus Muscle
k. left Subscapularis Muscle
l. Right Subscapularis Muscle
m. Left Erector Spinae Muscle
n. Right Erector Spinae Muscle
o. Left Piriformis Muscle
p. Right Piriformis Muscle
q. Left SCM
r. Right SCM
s. Longus Colli
t. Scalenes
u. Right Sacrospinalis
v. Left Sacrospinalis
w. Right Quadratus Lumborum
x. Left Quadratus Lumborum
y. Right Iliopsoas
z. Left Iliopsoas

4a. Assessment

a. Guarded
b. Improving
c. Regressed
d. No Change
e. Exacerbated
f. Static
g. Stationary
h. Refer to Working Diagnosis

5a. Plan Options

a. Acupuncture
b. Cervical Collar
c. Cervical Pillow
d. Chiropractic Adjustments
e. Cold Pack
f. Comparative Muscle Testing
g. Dual Inclinometers
h. E/M Exam
i. Electrical Stimulation
j. Home Exercises
k. Hot Pack
l. Low Level Laser
m. Manual Therapy
n. Neuromuscular Re-education
o. Refer to Current Treatment Plan
p. Refer to Updated treatment plan
q. Therapeutic Exercise
r. Traction
s. Treatment plan
t. Ultrasound

5b. X-rays

a. AP Lateral Cervical
b. AP Lower Cervical
c. AP Lumbar
d. AP Open Mouth
e. AP Thoracic
f. Cervical Extension
g. Cervical Flexion
h. L5 Spot
i. Lateral lumbar
j. Lateral Thoracic
k. Left Cervical Oblique
l. Right Cervical Oblique
m. Lumbar Extension
n. Lumbar Flexion

5c. Discharge Plan

o. Releasing patient from care
p. Continues to experience decreased symptoms
q. Patient has reached MMI at body part/s: _____
r. Continue to require active care
s. Patient will require future passive treatment intermittently

CHIROPRACTIC CLINIC

1100 Street, Suite 110
Well Towne, Florida 99999
DR. FEELGOOD

Date

Re: Patient Name
Chart: Patient Chart Number

Appropriate Name
Insurance Company Name
Insurance Company Address
Insurance Co. State, Zip

Re: Medical Treatment Billings

Dear, (Appropriate Name):

Your letter dated _____ unilaterally reduced the amount of our medical services and charges. The explanations you provided for the reductions did not state which medical treatise, medical literature, medical professional or medical facility you relied upon. Your denial of benefits stated the following:

"EXCEEDS FREQUENCY" –

Please provide the medical foundation which would establish allowable frequency for your policyholder PATIENT NAME. If you used the services of a peer review, please state the name of the physician, the physician's credentials and the report completed by this individual. If you used an external and independent paper review service, please provide the name of this vendor, its credentials, the reviewer's name and credentials as well as the specific report produced. If you used a computerized or schedule of allowable fees, please provide the name of this system or schedule, the basis upon which the determination was made as well as a printout of its review and summary. If any of your sources for this medical determination were based upon a survey, please provide that survey including its date of origin, the vendor which produced this survey, the areas of medical practice which were covered by the survey, the individuals who participated in the accumulation of data for the survey, the modalities which were addressed by the survey and its functional capacity for manipulation. If your medical determination was made by a medical physician other than a chiropractic, please provide the name and specific practice that person is certified and accredited in. If the medical determination for this denial was made by a non-medical or non-practicing physician, please state that

person's name, education, degree, certifications and accreditations which would qualify in making this denial. If this medical determination was made by an employee of your company or a claim representative, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial.

"AMOUNT ALLOWED IS BASED ON PROVIDER'S GEOGRAPHIC AREA" –

Please provide the medical foundation which would establish allowable frequency for your policyholder PATIENT NAME. If you used the services of a peer review, please state the name of the physician, the physician's credentials and the report completed by this individual. If you used an external and independent paper review service, please provide the name of this vendor, its credentials, the reviewer's name and credentials as well as the specific report produced. If you used a computerized or schedule of allowable fees, please provide the name of this system or schedule, the basis upon which the determination was made as well as a printout of its review and summary. If any of your sources for this medical determination were based upon a survey, please provide that survey including its date of origin, the vendor which produced this survey, the areas of medical practice which were covered by the survey, the individuals who participated in the accumulation of data for the survey, the modalities which were addressed by the survey and its functional capacity for manipulation. If your medical determination was made by a medical physician other than a chiropractic, please provide the name and specific practice that person is certified and accredited in. If the medical determination for this denial was made by a non-medical or non-practicing physician, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial. If this medical determination was made by an employee of your company or a claim representative, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial.

"ONLY 3 MODALITIES ALLOWED PER OFFICE VISIT." –

Please provide the medical foundation which would establish allowable frequency for your policyholder PATIENT NAME. If you used the services of a peer review, please state the name of the physician, the physician's credentials and the report completed by this individual. If you used an external and independent paper review service, please provide the name of this vendor, its credentials, the reviewer's name and credentials as well as the specific report produced. If you used a computerized or schedule of allowable fees, please provide the name of this system or schedule, the basis upon which the determination was made as well as a printout of its review and summary. If any of your sources for this medical determination were based upon a survey, please provide that survey including its date of origin, the vendor which produced this survey, the areas of medical practice which were covered by the survey, the individuals who participated in the accumulation of data for the survey, the modalities which were addressed by the survey and its functional capacity for manipulation. If your medical determination was made by a medical physician other than a chiropractic, please provide the name and specific practice that person is certified and accredited in. If the medical determination for this denial was made by a non-medical or non-practicing physician, please state that

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"ALLOWED 1 AREA" –

Please provide the medical foundation which would establish allowable frequency for your policyholder PATIENT NAME. If you used the services of a peer review, please state the name of the physician, the physician's credentials and the report completed by this individual. If you used an external and independent paper review service, please provide the name of this vendor, its credentials, the reviewer's name and credentials as well as the specific report produced. If you used a computerized or schedule of allowable fees, please provide the name of this system or schedule, the basis upon which the determination was made as well as a printout of its review and summary. If any of your sources for this medical determination were based upon a survey, please provide that survey including its date of origin, the vendor which produced this survey, the areas of medical practice which were covered by the survey, the individuals who participated in the accumulation of data for the survey, the modalities which were addressed by the survey and its functional capacity for manipulation. If your medical determination was made by a medical physician other than a chiropractic, please provide the name and specific practice that person is certified and accredited in. If the medical determination for this denial was made by a non-medical or non-practicing physician, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial. If this medical determination was made by an employee of your company or a claim representative, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial.

"ALL TREATMENT DENIED DUE TO EXCEEDING FREQUENCY" –

Please provide the medical foundation which would establish allowable frequency for your policyholder PATIENT NAME. If you used the services of a peer review, please state the name of the physician, the physician's credentials and the report completed by this individual. If you used an external and independent paper review service, please provide the name of this vendor, its credentials, the reviewer's name and credentials as well as the specific report produced. If you used a computerized or schedule of allowable fees, please provide the name of this system or schedule, the basis upon which the determination was made as well as a printout of its review and summary. If any of your sources for this medical determination were based upon a survey, please provide that survey including its date of origin, the vendor which produced this survey, the areas of medical practice which were covered by the survey, the individuals who participated in the accumulation of data for the survey, the modalities which were addressed by the survey and its functional capacity for manipulation. If your medical determination was made by a medical physician other than a chiropractic, please provide the name and specific practice that person is certified and accredited in. If the medical determination for this denial was made by a non-medical or non-practicing physician, please state that

person's name, education, degree, certifications and accreditations which would qualify in making this denial. If this medical determination was made by an employee of your company or a claim representative, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial.

"ALL TREATMENT DENIED DUE TO DURATION" –

Please provide the medical foundation which would establish allowable frequency for your policyholder PATIENT NAME. If you used the services of a peer review, please state the name of the physician, the physician's credentials and the report completed by this individual. If you used an external and independent paper review service, please provide the name of this vendor, its credentials, the reviewer's name and credentials as well as the specific report produced. If you used a computerized or schedule of allowable fees, please provide the name of this system or schedule, the basis upon which the determination was made as well as a printout of its review and summary. If any of your sources for this medical determination were based upon a survey, please provide that survey including its date of origin, the vendor which produced this survey, the areas of medical practice which were covered by the survey, the individuals who participated in the accumulation of data for the survey, the modalities which were addressed by the survey and its functional capacity for manipulation. If your medical determination was made by a medical physician other than a chiropractic, please provide the name and specific practice that person is certified and accredited in. If the medical determination for this denial was made by a non-medical or non-practicing physician, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial. If this medical determination was made by an employee of your company or a claim representative, please state that person's name, education, degree, certifications and accreditations which would qualify in making this denial.

If these medical determinations were made with the use of MBRS (Medical Billing Review System), a computerized program known to be used by Allstate countrywide, please provide the complete printout of the Q codes upon which this computer program relied. Also, provide the complete medical reasoning this computerized program used in arriving at this medical determination regarding PATIENT NAME's individual injuries as diagnosed, her stated symptoms as described in the daily chart notes and her specific age, weight, height, build and ethnicity. Please provide the specific medical, physics or bio-dynamic analysis which this computer program relied upon in association with the individual dynamics (i.e. type of accident, make, model and type of all vehicles, number of vehicles involved, speed of all vehicles, braking distance prior to impact, amount of damage to all vehicles, severity of impact to all vehicles, direction of impact to PATIENT NAME's vehicle, location of impact to each vehicle, position of PATIENT NAME in the vehicle, position of headrest, type of safety restraint system in use at the time of impact. Please provide the computerized medical methodology in arriving at the denials of treatment or billing associated with PATIENT NAME's injuries as caused by this accident. Please provide the specific medical foundation which this computer program relied upon in denial of medical treatment and medical billings in the consideration of the

prior medical history of PATIENT NAME, time of day or evening, previous activity to the accident occurrence and PATIENT NAME's physical condition prior to this accident.

Please respond to this request for clarification and medical reasoning for your unilateral denial of benefits and payment for medical treatment provided to your policyholder and our patient, PATIENT within 15 days of your receipt.
In the absence of an adequate response from you to the concerns raised in this letter, you will be exposing your policyholder, PATIENT NAME, to possible litigation and economic risk. Your medically unsupported denials represent a re-victimization of PATIENT NAME. This type of claim practice has been investigated and exposed by the Florida Department of Insurance Regulation (DIR) as egregious activity [1]. Allstate's refusal to produce the very documents establishing this claim practice trend in Florida has lead to the Florida DIR revoking Allstate's license to do business in that state. In *Deer vs. Allstate* [2], Allstate was sanctioned $25,000.00 per day for its contempt in refusing to produce these claim practices documents as ordered by the court.

This letter is also being sent to the Department of Insurance for their consideration of what has become a claim practice trend for Allstate. The Attorney General's office will also receive a copy of this letter.

Sincerely,

Dr. Feelgood, D.C.

Cc: PATIENT NAME, Insurance Commissioner, State Attorney General

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[1] **Allstate Floridian Insurance Company, et al., vs. Office of Insurance Regulation, Case No.: 1D08-275, Lower Case No.: 91774-07; In the District Court of Appeal, First District State of Florida.**

[2] **Deer vs. Allstate, case number: 0516-CV24031; In the Circuit Court of Jackson County, Missouri at Independence**

Common Injury Codes (ICD-9)

(common to whiplash injuries highlighted)

Neck and back Section:

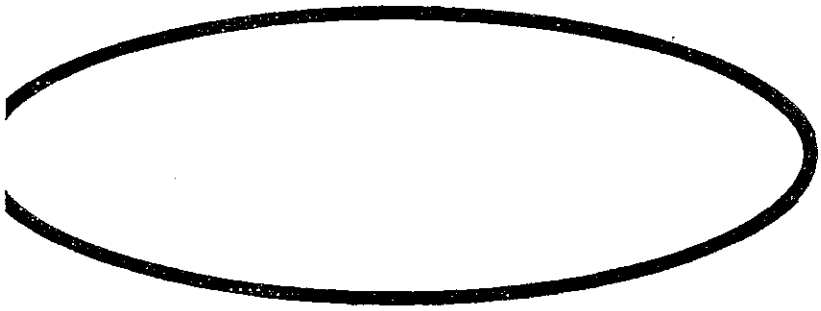
839.0:	Closed dislocation cervical vertebra
839.2	Closed dislocation thoracic and lumbar
839.4	Closed dislocation other vertebra
739.1:	Nonallopathic lesion cervical
739.2:	Nonallopathic lesion thoracic
739.3:	Nonallopathic lesion lumbar
739.4:	Nonallopathic lesion sacral
739.5:	Nonallopathic lesion pelvic

Other Injuries Section (Including the Cervical, Thoracic and Lumbar Regions):

524.60:	Temporomandibular joint disorders (unspecified) (Common to all injuries) (Characterized by pain, clicking, grinding, muscle tenderness, stiffness of jaw)
722.0	Cervical Disc Displacement
722.11	Thoracic Disc Displacement
722.10	Lumbar Disc Displacement
726.12:	Bicipital Tenosynovits (characterized by pain over anterior aspect of shoulder)
726.5:	Enthesopathy of Hip Region (inflammation: Gluteal, Posas, or Trochanteric Tendinitis)
728.4:	Laxity of Ligament (Specify region – Cervical, Thoracic, Lumbar)
840.9:	Sprains and strains of Shoulder and Upper arm (Unspecified Site)
841.9:	Sprains and strains of Elbow and Forearm (Unspecified Site)
842.00:	Sprains and strains of Wrist (Unspecified Site)
842.10:	Sprains and strains of Hand (Unspecified Site)
843.9:	Sprains and strains of Hip and Thigh (Unspecified Site)
844.9:	Sprains and strains of knee and Leg (Unspecified Site)
845.00:	Sprains and strains of Ankle (Unspecified Site)
845.10:	Sprains and strains of Foot (Unspecified Site)
846.9:	Sprains and strains of Sacroiliac Region (Unspecified Site)
847.0:	Sprains and strains of Cervical
847.1:	Sprains and strains of Thoracic
847.2:	Sprains and strains of Lumbar
847.3:	Sprains and strains of Sacrum
847.4:	Sprains and strains of Coccyx
848.1:	Sprains and strains of Jaw (joint) (ligament) (ill-defined)
848.5:	Sprains and strains of Pelvic (ill-defined)
851.4	Cerebel Contusion w/out open wound
851.42	Cerebel Contusion w/ brief coma
910.8	Superficial Head Injury
920:	Contusion of Face, Scalp, and Neck
922.1:	Contusion of Chest wall
922.2:	Contusion of Abdominal wall (Flank) (Groin)
924.00:	Contusion of Thigh
924.01:	Contusion of Hip

Common History of Complaints and Symptoms:

307.81:	Tension headache	(Common to all injuries)
308.0:	Predominant disturbance of emotions (Anxiety, Panic State)	(Common to all injuries)
524.60	Temporomandibular joint disorders (unspecified)	(Common to all injuries)
780.5:	Sleep disturbance (unspecified)	(Common to all injuries)
728.85:	Spasm of muscle	(Common to all injuries)
724.6:	Disorders of the Sacrum (Ankylosis: immobility due to injury, Instability)	
719.46:	Pain in joint; lower leg	
719.46:	Pain in joint; shoulder region	
729.5:	Pain in limb (soft tissue disorder)	
780.4:	Dizziness and giddiness	
780.79:	Other malaise and fatigue (Lethargy, Tiredness)	
782.0:	Disturbance of skin sensation	
784.0:	Headache (Facial pain, Pain in head)	
786.50:	Chest pain (unspecified)	



Supplement

Letters To Insurers – First Party

1. Assume they are a fiduciary who will honor the insured's reasonable requests.

2. Request equal footing.
   (1) Results of investigations and tests.
   (2) Copies of statements and reports.
   (3) Claim file/reports and recommendations.
   (4) Custody of evidence from scene.
   (5) Claim manuals and other internal guidelines.
   (6) Training materials.

3. How can I remedy any mistakes or form of my proof?

4. Please send specific amounts for specific needs.

5. Please provide your plan for any further investigation activities.
   (1) Why is each step required?

6. Please provide your timetable to accomplish what you intend to do.

7. Please provide the name, address, and telephone number of every person from the President to the clerks who have authority or responsibility for the handling of <u>any</u> aspect of this claim, regardless of how minute.

We're counting on you to investigate and communicate everything we will need to know to get every possible benefit of this policy. Will you?

No threats, "bad faith" postures, whining, bluffing, or overstatement.

RELATEDNESS
(QP, QR)

The audit system classifies all ICD-9 (diagnosis) and CPT (procedure codes) as Class I, II, and III.

Since CLASS I codes (both ICD-9 and CPT) are USUALLY considered related to injuries sustained in a motor vehicle accident, they automatically pass through the system until frequency and/or duration occur.

The CLASS II diagnosis codes are "flagged" since these can sometimes be aggravated by injuries (i.e. hypertension).

The CLASS III diagnoses are mainly congenital or acquired conditions such as cancer of heart disease, and are considered by the audit to be unrelated to an MVA.

CPT codes are linked to diagnosis for reimbursement considerations. All CLASS I's will pass through if matched. If a CLASS II or III CPT is linked to a CLASS I, ICD9, the procedure will flag for review.

Depending on the flagged issue, a variety of records may be necessary to make a decision.

SURGICAL PROCEDURES
(Codes QF; QH)

The CPT codes for all but very minor surgical procedures are flagged for review. The reasons that these procedures are evaluated include:

Causal Relationship to the Motor Vehicle Accident

Once these two issues have been established, the operative report is scrutinized to:

- Ascertain if services are coded correctly. For instance, many CPT codes are inclusive of more than one procedure and to report more than one is a practice known as "unbundling".
- Verify that all services billed were actually performed.
- Verify the presence of an assistant surgeon, if billed.

Anesthesia bills are evaluated only if the surgery is considered appropriate. When the surgical procedure is accepted, the appropriate value is applied.

- All anesthesia bills must contain the appropriate CPT code and anesthesia time in minutes.

DOCUMENTS REQUIRED

- Emergency room report
- Daily notes of the attending physician prior to surgery
- Operative report
- Anesthesia records

UNUSUAL SERVICES MODIFIER
(Code QQ)

Modifier 22 is used when the service provided is greater than usually required for the listed procedure. In order to ascertain if additional reimbursement should be made, the medical office records for that particular date of service should accurately reflect why the modifiers were used. The use of this modifier, alone, does not warrant additional reimbursement.

Modifiers should not be used with Evaluation and Management codes for office visits, since 1995 CPT specifically describes the level of service and the length of time that the physician is to spend "face to face" with a patient.

Modifiers with 1995 Physical Therapy codes are usually inappropriate. The 1995 edition of CPT requires time units for reimbursement for most physical therapy procedures.

RECORDS REQUIRED

- The records of the provider to justify the need for the extended, decreased, or additional services.

FEE ADJUSTMENT CODES FOR ADDITIONAL MODIFIERS

26 - Professional Component of (AP)
27 - Technical Component (AT)
50 - Bilateral Procedure (A7)
51 - Multiple Procedures (A8, A9)
80 - Assistant Surgeon (A2)

ELECTRODIAGNOSTIC STUDIES
(Code QD)

One of the most abused areas of billing in the casualty arena is the use of electrodiagnostic studies. There are a variety of tests, the most common of which are:

EMG (electromyogram)

NCV (nerve conduction velocity) - Motor and Sensory

H and F Reflexes

SSEP (Somatosensory Evoked Potentials)

EEG (Electroencephalogram)

AER, VER (Auditory and Visual Evoked Potentials)

Surface EMG

IN MOST CASES THESE TESTS ARE NOT MEDICALLY NECESSARY FOR THE TREATMENT AND EVALUATION OF SOFT TISSUE INJURY

A very useful guide for proper use of these tests is the American Association of Electrodiagnostic Medicine Guidelines in Electrodiagnostic Medicine. These guidelines require, among other things, that the testing be performed or supervised by a physician trained in electrodiagnostic medicine. Additionally, the electrodiagnostic medicine consultant usually performs a physical examination (paying particular attention to the neuromuscular system) and prepares a written report which includes the indications for the studies and description of the findings.

RECORDS REQUIRED

- Daily office records of the referring/treating physician
- Consultation report in compliance with AAEM Guidelines

1996 CPT contains significant changes in electrodiagnostic testing codes. New codes have been added and others changed:

- Codes 95880 - 95883: have been deleted
- Code 95900 - NCV: was allowed for each nerve. Now defines as, "each nerve, any/all site(s) along the nerve; motor without F-wave study."
- Code 95903 - NCV: motor with F-wave
- Code 95904 - NCV: sensory only
- Code 95925 - SSEP: upper limbs
- Code 95926 - SSEP: lower limbs
- Code 95927 - SSEP: trunk or head

Please note there continues to be no specific code for surface EMGs. Proper coding for this procedure would be an unlisted code, such as 95999.

PSYCHIATRIC SERVICES
(Code QK)

Psychiatric testing, evaluation and management codes, and therapy sessions are flagged for review.

Records are reviewed for the following:

- A demonstrated causal relationship to the accident itself.
- Any referral from a medical provider.
- Treatment which is related to the diagnosis.

DOCUMENTS REQUIRED

- All treatment records from referring physician.
- All psychiatric/psychological test results.
- All daily psychiatric/psychological records.
- Treatment plan with goals for care.

BIOFEEDBACK
(Audit Codes T3; T4; F7; PB)

Relaxation technique used to teach control of stress. Should generally not be administered absent a course of more conservative treatment (e.g four weeks).

DOCUMENTS REQUIRED

- All treatment records from referring physician.
- All physical therapy records.
- All daily psychiatric records.
- Treatment plan with goals and response to care.

AMBULANCE TRANSPORT (QA) AND EMERGENCY ROOM (QE)

While the audit allows transport by an ambulance and emergency room treatment within the first 24 hours after the motor vehicle accident, there are occasions when these services are billed after that point in time. When bills are presented for a later date of service, it is necessary to make sure that the services were for injuries sustained in the accident.

RECORDS REQUESTED

- The ambulance report.
- Initial emergency room records.
- The emergency room record for the date in question.
- Any other physician notes that may be available between the accident and the dates of service in question.

THERAPEUTIC TRIGGER POINT INJECTIONS (QI)

Trigger points are points in the body that, when stimulated, cause a sudden pain in a specific area. They can appear anywhere in the body, do not show up on regular tests, and may go unrecognized because of referred pain. These usually occur:

- In a chronic pain situation (myofascial pain syndrome).
- After surgery, particularly laminectomy.

Trigger point injections consist of a mixture of a local anesthetic solution (lidocaine) and a cortisone preparation (dexamethasone, celestone). Multiple areas of the body can be injected during one setting. The need for these injections must always be related to injuries sustained in the accident.

RECORDS REQUIRED

- Records immediately subsequent to the accident.
- Daily office records of the treating physician.
- Results of any previous injections to indicate effectiveness.

TREATMENT LAPSE OF MORE THAN THREE MONTHS (QL)

When there is a gap in care of more than three months, it is important to causally relate the need for continued care to the accident in question. Many things, like activities of daily living, and/or additional injuries may be contributing to the continued complaints.

DOCUMENTS REQUIRED

- Emergency room records.
- Daily treatment records of all providers who treated from the accident and prior to the gap.
- All x-ray and diagnostic test results.
- All daily treatment records of the provider delivering services after the gap.
- All consultant evaluations.

SUPPLIES/ DME/ ORTHOTICS/ PROSTHETICS
(QS and QJ)

The audit flags all of the above if the charge is greater than $25.00, for review. This review is necessary since there is no code to identify supplies other that 99070, and supplies can be costly. While HCPCS and Medicare do have some fees assigned to medications and supplies, the list in incomplete.

DEFINITIONS

SUPPLIES - any type of equipment issued for a patient to aid in healing. These may include cervical collars, back supports, crutches, canes, ace bandages, hot packs, ice bags, etc.

DME (Durable Medical Equipment) - these include wheelchairs, patient beds, commode chairs, overhead traction on beds, etc.

ORTHOTICS - devices used to assist in posturing such as lifts on shoes, some braces, corrective shoes, etc.

PROSTHETICS - these include artificial limbs and devices that are permanent in nature, such as some bracing.

RECORDS REQUIRED

- Identification of the supply.
- Manufacturer's description for unusual items.
- Documentation to support how this supply will aid in the recovery process.

FREQUENCY AND DURATION OF PHYSICAL THERAPY AND MANIPULATION (F1, F4, F5, F6, F8, FB, FD, FH, FP, FW, T1, T2)

The need to evaluate the frequency and duration of the physical therapy is imperative to utilization review and medical cost containment. Fee schedules or screens are of limited effectiveness if health care providers are able to "recoup their fees" by treating more frequently, or for a longer period of time. However, more is not necessarily better.

DOCUMENTS REQUIRED

- Emergency room records if applicable.
- Initial evaluation, subsequent re-evaluations and all daily treatment records of the provider of review.
- Any diagnostic tests that may be applicable.

TMJ
(QP)

TMJ is a CLASS II diagnosis, therefore care will flag if it is the only diagnosis. Treatment can be costly and can ultimately result in a surgical procedure. Much of TMJ is not traumatic, and the relationship between TMJ and whiplash injuries is controversial.

RECORDS REQUIRED

- Emergency room records.
- All evaluations and daily treatment records of treating physician.
- All evaluations and daily treatment of dentist involved.
- Prior dental records if available.

TENS/PENS AND SUPPLIES
(Codes QT, QS)

The use of transcutaneous/percutaneous electrical nerve stimulators and accompanying supplies are flagged for review, because their efficacy is controversial and they can be costly. The medical necessity must be questioned if:

- They are rented or purchased without an adequate trial in a clinical setting.
- Rental or purchase occurs within the acute phase of injury.
- Both clinical and home use are being delivered simultaneously.

RECORDS REQUESTED

- All evaluations of treating physician.
- Initial evaluation, subsequent evaluation, and all daily progress records of physical therapist.
- Evidence of the usefulness of this modality identified in the clinic and after one month rental.

THERMOGRAPHY
(Codes QO; AE; NT)

- Approved by MBRS only in Florida, New York, and New Jersey.
- Other areas will be denied.

LEVELS OF SERVICE

Three Key Components

- History
- Examination
- Medical Decision Making

Each component must be evaluated separately for its complexity and documentation.

SELECTING A LEVEL OF SERVICE

(E/M GUIDELINES)

- ## History: Four levels of complexity

  - *Problem Focused:* chief complaint; brief history of present illness or problem.

  - *Expanded Problem Focused:* chief complaint; brief history of present illness; problem pertinent system review.

  - *Detailed:* chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history *directly related to the patient's problems.*

  - *Comprehensive*: chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history.

- ## Examination: Four levels of complexity

  - *Problem Focused:* a limited examination of the affected body area or organ system.

  - *Expanded Problem Focused:* a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

  - *Detailed:* an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

  - *Comprehensive:* a general multi-system examination or a complete examination of a single organ system. **Note:** The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.

- ## Medical Decision Making - Four levels

  - *Straight Forward*
    1) Minimal Diagnosis
    2) Minimal complexity or data to review
    3) Minimal risk or complications

  - *Low Complexity*
    1) Limited Diagnosis
    2) Limited or data to review
    3) Low risk of complications
    4) Morbidity or mortality

  - *Moderate Complexity*
    1) Multiple Diagnosis
    2) Moderate data to review
    3) Moderate risk of complications
    4) Morbidity or mortality

  - *High Complexity*
    1) Extensive Diagnosis
    2) Extensive data to review
    3) High risk of complications
    4) Morbidity or mortality

- For new patient codes, all three components must meet or exceed the stated requirements.
- For established patient codes, two of the three components must be meet or exceed the stated requirements.
- In soft tissue injury:
    - Number of diagnosis - depends on initial evaluations, but usually sprains, strains, contusions, and fractures.
    - Number and complexity of medical records - usually only the ER records. Rarely have any other provider's records.
    - Diagnostic tests for analysis - usually only x-rays from the hospital; possibly lab work.
    - Risk of significant complications - morbidity or mortality; minimal to low

IMPACT AND INJURY CAUSATION ANALYSIS

A process of automobile accident investigation designed to determine whether the impact forces as documented could have reasonably resulted in the injuries claimed.

COULD THIS VEHICLE COLLISION HAVE CAUSED THIS INJURY?

I. ACCIDENT RECONSTRUCTION

- A. Sources of Information
  - 1. Vehicle inspection
    - a. Photographs
  - 2. Site/scene investigation
  - 3. Witness statements and drawings
  - 4. Police reports
  - 5. Fire department
  - 6. News media reports
  - 7. Weather reports
- B. Vehicle Characteristics
  - 1. Repair estimates
  - 2. Manufacturer's specifications
    - a. Make/model/weight
    - b. Bumper types/height
    - c. Center of gravity
    - d. Modifications
- C. Exterior of Vehicles
  - 1. Driveable?
  - 2. Nature of Impact -- front, rear end, lateral, rollover
  - 3. Structural Intrusion/crush
    - a. Frame damage
    - b. Suspension damage
    - c. Bumper energy absorption
  - 4. Principle Direction of Force (PDOF)
- D. Interior of Vehicles
  - 1. Evidence of occupant physical contact
  - 2. "Loading" marks on vehicle restraint system

3. "Trip" Mechanisms (air bags)
4. Child restraint systems

E. Site/Scene Exam
1. Skid/gouge marks
2. Other physical evidence

F. Conclusions
1. Orientation of injured occupant
2. Closing speed of vehicle(s) at contact
3. Principal Direction of Force (PDOF)

II. INJURY RECONSTRUCTION

A. Sources of Information
1. Physician Reports / Office Notes
2. X-rays / CT Scans / MRI Scans
3. EMS / ambulance reports
4. Emergency room reports
5. Witness statements
6. Police reports

B. Pre-Accident Medical Profile of Injury Victim
1. Sources of Information
   a. Family medical records
   b. Specialist records
   c. Employer records
   d. Military records
   e. School records

C. Indications for Independent Medical Examination
1. Closing speed low / minimal damage to vehicles
2. PDOF not consistent with mechanics of injury as described. The occupant will move (or be "thrown") toward the PDOF.
3. Speed at impact indicates questionable injury
4. Strain/sprain injuries which do not resolve in 4-6 weeks
   KEY: No positive neurological signs.
5. Diagnosis, prognosis, treatment plan change
6. "Doctor Shopping" by the patient
7. Pre-existing injury involved

III. USE OF INJURY CAUSATION CONSULTANT

A. Information Needs - Minimum
   1. Police / Accident Reports
   2. Make, model, year of vehicle(s)
   3. Use of restraint system
   4. Post accident photographs of vehicle(s)
   5. Damage repair estimates of vehicle(s)
   6. All available pre-accident and post-accident medical records
   7. Radiological films / scans

B. Additional Information If Available
   1. IME Report(s)
   2. Witness / insured / claimant statement
   3. Scene / site photographs
   4. Your conclusions / questions

The more information you can provide, the more definitive the consultant's report will be.

APPENDIX A

VEHICLE PHOTOGRAPHY GUIDE

1. Photograph the full side views of the vehicle.

2. Photograph the full front and rear views of the vehicle.

3. Photograph oblique views from each corner; the views should be taken from a distance such that a side and front/rear are both visible in the view.

4. Photograph each side of the vehicle as viewed from the front and rear right along the edge of the vehicle.

5. Photograph the front and rear of the vehicle as viewed from each side, right along the edge.

6. Photograph the seating arrangement in the interior of the vehicle with the doors open. Of particular significance, is the seat in which the injured party was sitting. In addition, photographs of the seat back and/or headrest would be beneficial, particularly with a tape measure indicating the height of the head rest relative to the seat.

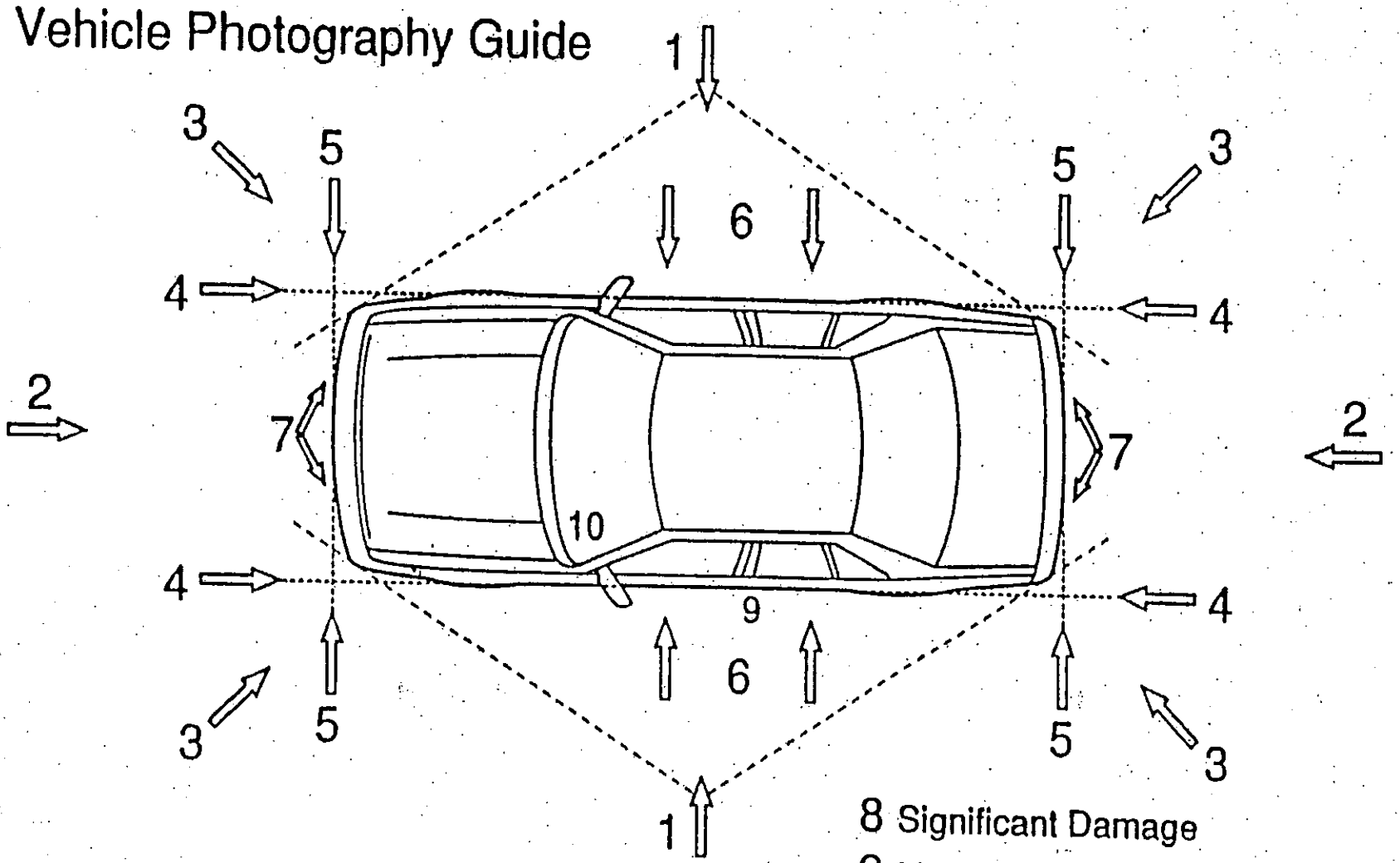
7. Photograph underneath the bumpers to show the energy absorbing mechanisms on each side of the front and rear bumpers.

8. Photograph close-up views of any significant damage, especially if it has not been photographed in another shot.

9. Photograph the manufacturer's plate. This is typically found on the inside of the driver's side door.

10. Photograph the Vehicle Identification Number (VIN) plate. This is typically found on the driver's side dashboard.

Vehicle Photography Guide



8 Significant Damage
9 Manufacturer's Plate
10 VIN Plate

ABUSE (BUILD-UP) DISTINGUISHED FROM FRAUD

ABUSE (BUILD-UP)

"The term *ABUSE* describes incidents or practices of providers, physicians, or suppliers of services and equipment which, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the program, improper payment, or payment for services which fail to meet professionally recognized standards of care, or which are medically unnecessary." *(Medicare Definition)*

EXAMPLES

1. Overutilization of medical and health care services.

2. Excessive charges for services or supplies.

3. Claims for services not medically necessary, or not medically necessary to the extent rendered (e.g., a battery of diagnostic tests is given where, based on diagnosis, only a few are needed).

4. Improper billing practices which include:
   - Unbundling
   - Upcoding
   - Exploding
   - Failing to provide full details (i.e., leaves off the diagnosis code for routine physical exam, or other service unrelated to the MVA)

5. Using different fee schedules for different patients.

Although these types of practices may initially be categorized as abusive in nature, under certain circumstances, they may develop into fraud.

ABUSE (BUILD-UP) DISTINGUISHED FROM FRAUD

FRAUD

"*FRAUD* is an intentional deception or misrepresentation which the individual makes, knowing it to be false and that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent kind of fraud arises from a false statement or misrepresentation which is material to entitlement or payment under the Medicare program. The violator may be a participating provider, a supplier of durable medical equipment, a beneficiary, or some other person or business entity." *(Medicare Definition)*

EXAMPLES

1. Billing for services or supplies that were not provided. This includes billings for "no shows".

2. Soliciting, offering, or receiving a kickback, bribe, or rebate, e.g., paying for a referral of patients.

3. Provider completion of Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider.

4. False representation with respect to the nature of services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services, etc.

5. Claims for noncovered services billed as covered services, e.g., routine foot care billed as a more involved form of foot care to obtain payment, or acupuncture billed as a chiropractic subluxation

6. Claims involving collusion between a provider and a beneficiary, or between a supplier and a provider resulting in higher costs or charges.

7. Use of another person's name and policy number in obtaining medical care.

8. Alteration of claims history records to generate fraudulent payments.

9. False provider disclosures of ownership in a clinical laboratory.

10. Split billing schemes (e.g., billing procedures over a period of days when all treatment occurred during one visit).

11. Collusion between a provider and a claims employee where the claim is assigned. (If the provider deliberately overbilled for services, adjustments could be generated with little awareness on the part of the insured.)

12. A claims employee acting on his/her own behalf where the claim is unassigned. (Through manipulation of insured's address or the claims history record, a claim employee could generate adjustment payments against many beneficiary records and cause payments to be mailed to an address known only to him/her.)

13. Deliberate duplicate billing.

SECOND-OPINION EXAMINATION STEPS

1. Contact the patient to discuss status.
2. Obtain medical records.
3. Schedule exam.
4. Notify patient regarding time and place of exam.
5. Send all medical records to second-opinion doctor or clinic.
6. Advise agent.

UPON RECEIPT OF THE EXAM REPORT

1. Discuss report findings with supervisor.
2. Contact patient to advise of report findings. Send copy of report to patient.
3. Promptly pay bills that have been held pending receipt of the exam report.
4. Consider further bills based upon report conclusions.
5. Submit rebuttals immediately to second-opinion physician.

RECORDS REVIEW STEPS

1. Contact the patient to discuss status.
2. Contact the medical provider to discuss treatment plan.
3. Obtain medical records.
4. Advise patient of review.
5. Submit records to reviewer.
6. Advise agent.

UPON RECEIPT OF REVIEW FINDINGS

1. Discuss review findings with supervisor.
2. Contact patient to advise of review findings.
3. Make payment, as recommended by the review.
4. Provide written confirmation of review findings to patient and medical providers.
5. Submit rebuttals immediately to reviewer.

STEPS FOR ARRANGING A SECOND-OPINION EXAM

1. Contact the patient to discuss their current status. Ask the patient about their current condition. Is treatment providing any benefit at this time? How often are they recieving treatment? Is the injury condition continuing to improve? Advise the patient that we are considering a second-opinion examination, and we will be checking back within a set time period (within 30 days). If the patient is represented by an attorney and communication has been restricted, contact the attorney directly to discuss the patient's status.

Remember that this should not be confrontational. We should be expressing concern for the patient, and a desire to assist them in achieving pre-accident status. Avoid words that create unnecessary anxiety, such as "independent medical exam", "cut-off", or "unreasonable".

If the patient is uncertain or unclear about their condition, contact the primary medical provider (M.D., Chiropractor) to discuss the patient's treatment plan. Advise the doctor that we are considering a second-opinion exam, and we will be checking back within a certain time frame (within 30 days).

2. Obtain current medical records. Make certain that a current medical authorization is in the claim file. If the authorization has expired, obtain an updated authorization immediately from the patient. Make certain the authorization is valid for all medical providers the patient is seeing.

Records may be obtained directly from the medical provider's office, or through a copy service, such as Medrecs. A sample copy service request form is attached (Example #1). When requesting medical records, be sure to send a photocopy of a valid medical authorization form.

If an attorney has revoked the medical authorization, request records through the attorney's office.

3. Remember to follow-up with the patient or doctor within 30 days, as discussed in item #1. If a second opinion exam is to be scheduled, check with the patient to determine any schedule restrictions. Contact the clinic that will perform the exam (such as OMAC or MCN), and provide their scheduling department with the necessary information. Also provide the clinic with the specialty of the physician needed (Neurologist, Orthopedist, etc.). The clinic will schedule a time, usually during the initial telephone conversation.

4. Contact the patient (or their attorney) to advise them of the time and place of the exam. Follow-up in writing. Examples #2 and #3 contain pattern letters that provide notice of the exam.

5. Send all medical records to the second-opinion doctor or clinic, along with a cover letter. Example #4 contains a typical cover letter. Be sure to list any specific concerns that the examining doctor should address. The exam report should indicate if the patient requires further medical treatment , and if so, the nature and duration of the treatment should be listed. If disability is involved, be sure to ask the examining doctor for an evaluation of the patient's ability to work.

6. Advise the insured's agent of the pending exam.

AFTER RECEIVING THE SECOND-OPINION REPORT

1. Upon receipt of the report, discuss the findings and conclusions with your supervisor. Remember to look for the specific information requested from the examining physician (see item #5 above).

2. Contact the patient and advise them of the report findings, as discussed with your supervisor. If the patient is represented by an attorney, contact the attorney to discuss this. Confirm the discussion by letter (Example #8), and send a copy of the exam report.

3. Steps #1 and #2 should be done within the day the report is received, if possible. If the patient (or attorney) cannot be contacted on the same day, the letter contained in Example #9 should be sent out, along with a copy of the exam report.

4. Any medical bills held pending receipt of the exam report should be paid promptly.

5. Medical bills received after notification of the exam findings to the patient (or attorney) should be considered based upon the recommendations of the report. If the patient's physicians or attorney submits a rebuttal, it should immediately be submitted to the second-opinion physician to determine any changes to the original report. Written notification to the party that sent the rebuttal and the patient should be sent, stating the information has been forwarded to the second opinion doctor.

6. When the second-opinion physician's response to a rebuttal is received, discuss the findings with your supervisor, and provide prompt notification to the patient (or attorney), and the party the submitted the rebuttal. A copy of the second-opinion physician's response should be sent with the notification.

UR/AUDIT/IME INDICATORS

UTILIZATION REVIEW AND AUDIT

- Charges exceed usual, reasonable, customary for the geographic area
- Multiple diagnoses with questionable causation from trauma
- Diagnostic (ICD-9-CM) and/or procedural (CPT-4) codes missing or unclear...
- "Unbundled" charges (i.e., fragmenting)
- Treatment is excessive based on diagnosis and level of service required to treat injury
- Questionable diagnostic procedures/treatment
- Charges for postoperative care
- Hospital confinement is excessive for injury sustained (use LOS Guide)
- Treatment could have been provided on an outpatient basis - Was confinement necessary?

  Was the patient ambulatory?
  Medications (I.V. & I.M. v Oral)?
  Home health care considered?
  Hospitalized for physical therapy?

- Admitted on Friday or Saturday for elective procedure(s) or treatment
- Discharged on a Monday
- Excessive diagnostic studies - repeat studies on same day
- Treatment with physical therapist and chiropractor on same day
- Room and board charges for both the first and last day of admission

- Ancillary charges do not appear in line with the room and board charges

  Too low - just in for a rest?
  Too high - Overcharged? Excessive lab? Excessive diagnostics? Excessive medication? Duplication of diagnostics?

- Two or more surgical procedures performed during one hospitalization

- Extensive charges for blood, plasma and/or solutions

- Set up charges on emergency room bills

- ICU care needed for injury as diagnosed?

INDEPENDENT MEDICAL EXAM

- The treating provider refuses or cannot provide "reasonable proof" of the necessity and reasonableness of treatment

- Soft tissue injury (with migrating injuries) resulting from a minor or no impact accident

- The treating provider will not or cannot provide a treatment plan with a prognosis

- The patient is showing no signs of improvement based on the clinical records

- The diagnosis, prognosis, treatment plan, attending physician or medication changes during treatment

- The schedule of treatments does not change, i.e., three times per week continues throughout the treatment

- The medical records indicate subjective signs only - no objective signs of injury

- Impairment being claimed from a minor injury

UTILIZATION REVIEW

The Severity of Illness or Injury
Equals
The Intensity of Services Provided

The first step in utilization review is understanding the injury as it relates to the accident and auto damage. A proper bill with a clear description of the injury and the services rendered should be consistent with information received in conversations with the injured party. Additional information may be needed from medical records and talking with medical providers. Many questions should be answered before involving a utilization review specialist (vendor or IME provider). This preliminary work must be done in order to determine the necessity for obtaining the services of a consulting firm to review the medical records and treatment or examine the patient.

Utilization Review

1. Documentation of causal relationship. Could the impact as reported and documented have caused the injury?

2. Are the services appropriate to the type of injury?

3. Is the level of service appropriate based on the reported injury and its severity, i.e., inpatient hospital care for soft tissue injury?

4. Is the duration of services and treatment reasonable for the stated injury?

5. Do charges fall within the usual, reasonable and customary range for the geographic area where they are provided?

VENDOR SERVICES

Audits

A review conducted to determine whether products or services billed to the patient were provided.

Audits can be done in several ways:

1. *Pre-screen* A review performed at the claim office or the vendor's office to examine charges which may be inconsistent with the type of treatment provided. Questions may be resolved at this level or may lead to a more in depth review.

2. *Off-site* A review performed at the vendor firm's office after securing a complete copy of the medical provider's records. A copy service may be employed to obtain records or a claim representative can secure the records for the vendor.

3. *On-site* A review performed at the site where services were rendered, the hospital or medical provider's office. The vendor will compare the charges with the information found in the hospital or office records to determine if the services were provided in accordance with the bill.

We must be specific about the information we want the vendor to review. The dollar amount ***should not*** be the deciding factor. Many emergency room bills include charges for setups not used while services provided were minimal. We choose the files to be audited.

Three Types of Utilization Review

1. **Prospective**
   The proposed treatment plan is evaluated prior to services being rendered, i.e., a second surgical opinion done with records and/or examination of the patient might follow a proposal made for surgery on the temporomandibular joints.

2. **Concurrent**
   The treatment plan is evaluated and approved as treatment is provided.

3. **Retrospective**

Review is done after treatment has been completed. It is necessary to have all medical records in our possession before employing the vendor.

Independent Medical Examinations

A physical examination is done by a medical provider, preferably of a similar discipline, to determine the current status of the injured person.

Timing is crucial in obtaining an IME. An early IME is helpful in verifying the injury when consistency of the injury to the accident is an issue. A late IME is most helpful for objective injuries, i.e., following a healed fracture and physical therapy. Impairment ratings are done at this time.

Be specific about the information you are seeking from the medical expert examining the patient.

Provide the examiner with all available medical records, x-rays, and diagnostic test reports. (Photographs of the vehicle damage should also be provided.)

Vendor services should only be utilized when it has been determined that the necessary function cannot be accomplished by the claim representative or expediter.

Appendix A

MBRS's Frequency and Duration Guidelines

JJM-2941-A

Overview

This appendix offers an expanded explanation of MBRS's frequency and duration guidelines for manipulation therapy, physical therapy and biofeedback. If treatment exceeds these guidelines, a careful review of the medical records is recommended. These records should include the treatment plan, progress notes including all evaluations and diagnostic testing, and all objective findings to determine if the circumstances of the particular case support the additional care.

Manipulation Therapy Guidelines

Weekly Frequency Guidelines for Manipulation

Weekly frequency refers to the number of dates of service within a 7-day period.

For treatment beginning **during the acute phase**, manipulation therapy should be considered appropriate if it employs a pattern of not more than:

- 5 sessions per week during weeks 1–3,
- 3 sessions per week during week 4,
- 2 sessions per week during weeks 5–8,
- 1 session per week during weeks 9–12, and
- 1 session every 14 days during weeks 13–16.

If treatment begins **after the third week from the date of loss**, manipulation therapy should be considered appropriate if it employs a pattern of not more than:

- 3 sessions per week during weeks 1–4,
- 2 sessions per week during weeks 5–8,
- 1 sessions per week during weeks 9–12, and
- 1 session every 14 days during weeks 13–16.

The total number of manipulation therapy sessions (total frequency) should not exceed 26 sessions over a 16-week period.

If frequency is exceeded **during any given week**, or if more than 26 dates of service are billed within the 16-week period, MBRS recommends denial of the item and Reason Code **FW** is generated: *Service or procedure exceeds frequency guidelines from the initial date of service. Further reimbursement is suspended pending submission of all records including patient history, evaluations, test results, progress notes, and treatment plans.*

JJM - 2942 - A

Daily Frequency Guidelines for Manipulation

Daily frequency refers to the number of services provided on a single day. For manipulative care, daily frequency is equal to the number of diagnoses indicated on the provider's bill that correspond to separate body regions. MBRS recognizes 12 distinct body regions:

- Jaw/Head
- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Pelvic/Sacro-Iliac/Coccyx (Spine)
- Sternum/Ribs/Thyroid
- Shoulder/Upper Arms
- Elbow/Forearm
- Wrist/Hand
- Hip/Thigh
- Knee/Leg
- Ankle/Foot

Note that unspecified diagnosis codes (such as 848.9—specified strain/sprain) are not specific to a distinct body region when determining the appropriate number of manipulation treatments in a day (or session).

If CPT codes 98925–98929 are billed by a provider, MBRS verifies that the appropriate number of body regions are represented by ICD-9 codes. If the level of service is not substantiated by the submitted diagnosis(es), MBRS prices the manipulation at a reduced level of service, reflective of a manipulation involving fewer body regions. Reason Code **A43** is generated: *The level of service is not substantiated by the submitted diagnosis(es). Charge exceeds the reasonable amount for the reduced level of service for the region where the service was provided.*

Similarly, if an osteopath bills CPT codes 98925–98929, MBRS also verifies that the level of service is supported by the number of diagnosis(es) submitted on the bill. Reason Code **A37** is generated if the level of service is priced at a level that involves fewer body regions: *This osteopathic manipulation level of service is not substantiated by the number of body regions indicated in the diagnosis(es) submitted. Charge exceeds the reasonable amount for the reduced level of service.*

If there are no applicable diagnosis codes present on a bill or the diagnosis codes are not specific enough, Reason Code **U1** is generated: *The diagnosis(es) submitted is not specific enough to support treatment provided. Please re-submit bill with a more specific diagnosis to support manipulation services.*

JJM-2943-A

Cumulative Reasonable Fee Calculation

NOTE: The following is only applicable if a chiropractor is billing with manipulation codes 97260, 97261 and/or office visits. The cumulative fee is NOT applied for CPT codes 98940–98943.

After daily frequency checks have ensured that the manipulation therapy is appropriate, the services are calculated to determine the daily reasonable fee (applies to chiropractic specialty only). The initial office visit, or an office visit with "25" modifier, is not calculated into the total fee.

A regional manipulation is considered a physician service. For an established patient, a brief pre-manipulation evaluation is considered to be part of the manipulation treatment. Therefore, an office visit and a regional manipulation, except for the initial office visit, are not allowed on the same day for chiropractors.

The cumulative reasonable fee can be greater than the charge for a single regional manipulation. In this case, the remaining payment will "spill over" into office visits or additional manipulations. Therefore, it may appear that these services are being reimbursed.

Once the cumulative reasonable fee is calculated, payments are distributed in the following order:

97260	Regional manipulation
97261	Supplemental manipulations
Office Visits	For chiropractic specialty

Duration Guidelines for Manipulation

If manipulation therapy extends beyond 112 days (16 weeks) from the date of initial treatment, or treatment is not completed within 365 days from the date of loss, Reason Code **T1** is generated: *Manipulation therapy exceeds expected duration for the diagnosis indicated. Further reimbursement is suspended pending submission of all records including patient history, evaluations, test results, progress notes, and treatment plan.*

Physical Therapy Guidelines

The *Physicians' Current Procedural Terminology* divides CPT codes into modalities (any physical agent applied to produce therapeutic changes to biologic tissue) and therapeutic procedures (a manner of effecting change through the application of clinical skills and/or services that attempt to improve functionality). The modalities are further divided into those that are supervised (do not require direct patient contact by the provider) and those that need constant attendance (require direct patient contact by the provider).

Supervised modality CPT codes include application to "one or more areas." Accordingly, each code is reportable only once per visit.

Constant attendance modality CPT codes include the application to "one or more areas," but are assigned in fifteen-minute time intervals.

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Therapeutic procedure codes are billed in time increments, not per body region.

Per Medicare, hot and cold packs are not reimbursable.

Weekly Frequency Guidelines for Physical Therapy

Weekly frequency refers to the number of dates of service within a 7-day period.

The majority of patients with soft tissue injuries recover completely within a short period of time. Physical therapy treatment should therefore be considered appropriate if it employs a pattern of not more than:

- 5 sessions per week during the acute period (weeks 1–3), and
- 3 sessions per week during weeks 4–10.

The total number of physical therapy sessions should not exceed 30 sessions over the 10-week period (total frequency).

The count for weekly and total frequency guidelines starts over again if a surgery occurs (surgeries that are starred in the CPT manual are considered "minor" and do not reset the count for frequency). Total frequency guidelines are bypassed for fracture/dislocation diagnoses.

If weekly frequency is exceeded, or more than 30 sessions are billed within the 10-week period, MBRS recommends denial of the item and Reason Code **FP** is generated: *Service or procedure exceeds frequency guidelines from the initial date of service. Further reimbursement is suspended pending submission of all records including patient history, evaluations, test results, progress notes, and treatment plans.*

Daily Frequency Guidelines for Physical Therapy

Daily frequency refers to the number of services provided on a single day.

In order to determine the appropriate number of treatments that should be allowed on a given day, MBRS performs a series of audit checks dependent upon the CPT code that was billed. Physical therapy treatments are examined for the checks listed below.

Duplicate Services

MBRS first flags physical therapy procedures that have the same physiological end-points. For example, if a provider bills hot packs and infrared on the same date of service, Reason Code **F3** is generated: *Multiple physical therapy treatments on the same date of service which have the same physiological end-points are inappropriate and not reimbursable.*

 JJM-2945-A

.dditional Time-Units

For services that have a primary code with a time element and a secondary code with additional time elements, MBRS limits the number of additional units allowed for physical therapy. Reason Code **F8** is generated if additional units are not appropriate: *Item exceeds the allowable additional time-units per day and is not reimbursable.*

MBRS also ensures that additional time-units are not allowed when there is not a corresponding primary code. If this occurs, Reason Code **FA** is generated: *An additional time-unit is not allowable in the absence of a reimbursed corresponding primary code.*

Relatedness

MBRS verifies that the diagnosis code(s) on the bill are appropriate with regard to physical therapy services. If the diagnosis(es) are not appropriate for physical therapy services, or cannot be mapped to a specific body region, Reason Code **U3** is generated: *The diagnosis(es) submitted is not specific enough to support treatment provided. Please re-submit bill with a more specific diagnosis to support physical therapy services.*

Daily Allowance

aily frequency is determined for physical therapy and muscle testing services. Procedures are divided into six groups, each of which has a different allowance. Some of these allowances depend upon number of body regions represented by ICD-9 codes, some allow only one per day regardless of body regions. Four of the groups have 15-minute time units assigned to them and have limits of time units per modality or procedure.

The applicable CPT codes for physical therapy are divided into groups:

- **Group One**. One physical therapy code is allowed per day regardless of the number of diagnoses that are listed on the bill. If any of these codes exceed the daily allowance, Reason Code **FD** is generated: *Per CPT-4, this code is reportable only once per patient visit.*
- **Group Two**. One physical therapy code is allowed per body region. If a bill is submitted with diagnoses that that represent three distinct body regions, the provider can be reimbursed for up to three physical therapy procedures of the same service. However, if only one region is represented in the diagnoses, only one physical therapy procedure is allowed and the other two procedures listed generate Reason Code **FH**: *The physical therapy procedure exceeds the daily allowance for the body regions indicated by the diagnosis(es) submitted.*

Note: The remaining physical therapy groups are billable in 15-minute time increments.

- **Group Three**. No more than two units (30 minutes) of the same CPT code are billed on the same date of service, otherwise Reason Code **TD3** is generated: *Total time reported exceeds allowance of 30 minutes for a passive modality. Please submit all records including patient history, evaluations, test results, progress notes, and treatment plans.*

 JJM-2946-A

STEPS FOR ARRANGING A RECORDS REVIEW

1. Contact the patient to discuss their current status. Ask the patient about their current medical condition. Is treatment providing any benefit at this time? How often are they recieving treatment? Is the injury condition continuing to improve?

2. Contact the medical provider(s). Ask for detailed information regarding the treatment plan. Specifically, when is the patient expected to reach pre-injury condition? What additional treatment is projected for the patient? Let the medical provider know that we are considering a review.

3. Obtain current medical records. Make certain a current medical authorization is in the claim file. If the authorization has expired, obtain an updated medical authorization immediately from the patient. Make certain the authorization is valid for all of the medical providers the patient is seeing.

Records may be obtained directly from the medical provider's office, or through a copy service, such as Medrecs. A sample copy service request form is attached. (Example #1. When requesting medical records, be sure to send a photocopy of a valid medical authorization form.

If an attorney has revoked the medical authorization, request records through the attorney's office.

3. If the level of treatment is continuing, and a review is necessary, advise the patient of the review. If the insured is represented, advise their attorney. Provide notice to all of the medical providers of the review - this should be done in writing. Example # 5 provides written notice to the medical providers of the review, and Example #6 provides written notice to the patient. Be sure that telephone contact is followed by notice in writing.

4. Submit the medical records for review to the review service. Example #7 contains the notice to be sent to the reviewer.

AFTER RECEIVING THE REVIEW FINDINGS

1. Upon receipt of the review findings, discuss the report and conclusions with your supervisor. Remember to look for the specific information requested from the reviewer.

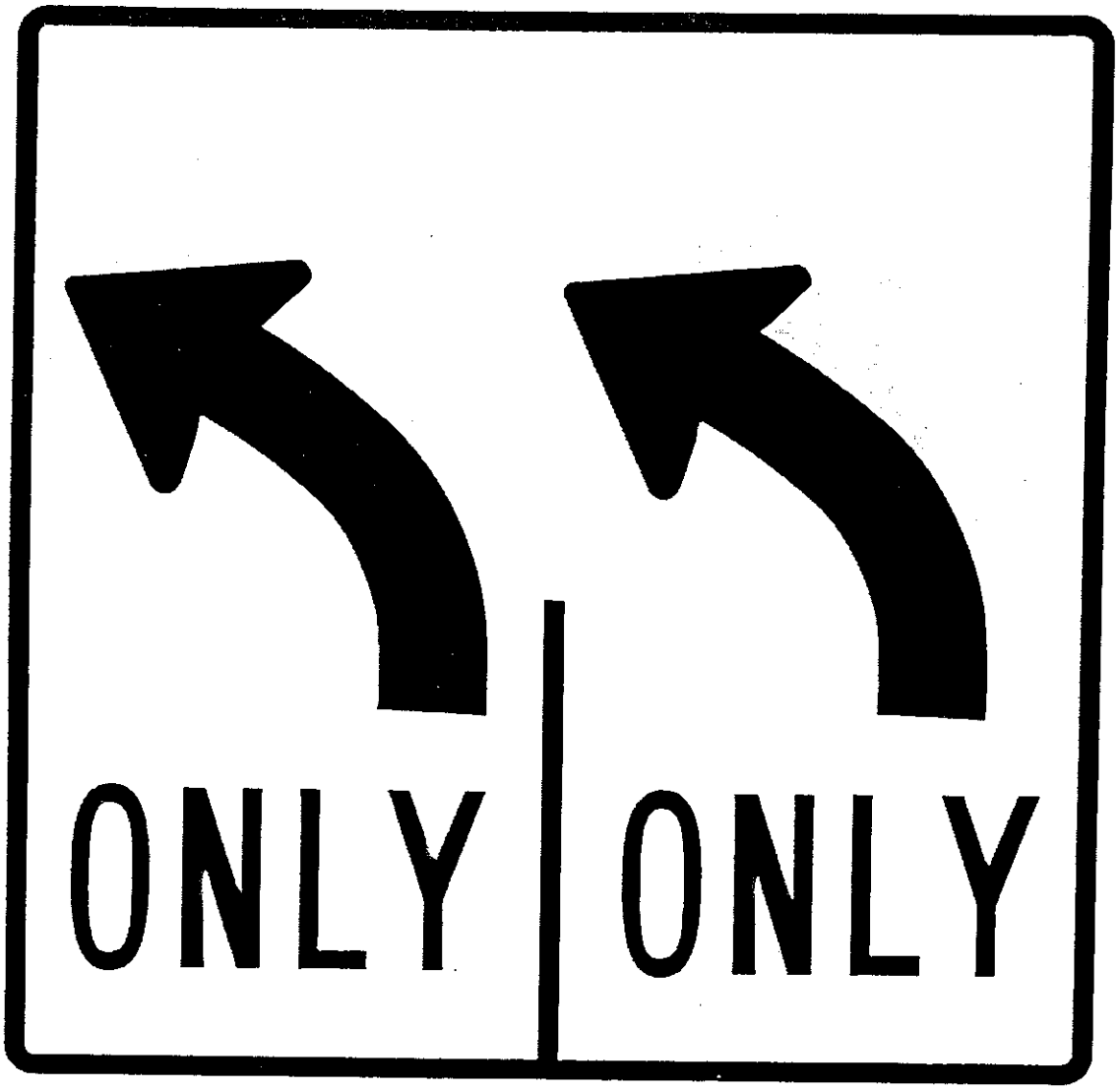
2. Contact the patient and advise them of the report findings, as discussed with your supervisor. If the patient is represented by an attorney, contact the attorney to discuss this.

3. Prompt payment should be made, as recommended in the review.

4. Written confirmation of the review should be sent to the patient (or attorney), and all medical providers involved. A copy of the review findings should be sent.

5. Any rebuttals received should be immediately forwarded to the reviewer to determine any changes in the original recommendations. Written notification to the party that sent the rebuttal and the patient should be sent, stating the information has been forwarded to the reviewer.

6. When the reviewer's response to a rebuttal is received, discuss the findings with your supervisor, and provide prompt notification to the patient (or attorney), and the party that submitted the rebuttal.



Auto fraud could be just around the corner.

You're in a double left-hand turn lane and you get hit by the guy driving next to you. But he swears you crossed into his lane and hit him. Be aware. Not all accidents are accidental. To help protect yourself from this, and many other types of auto fraud, see your Allstate Agent for a brochure or call toll free 1-888-ALLSFTY. **Being in good hands is the only place to be.**

Allstate®
You're in good hands.

C3617

Total points (in pencil) _____ Date score reaches 100+ _____

Claim No. _____

SIU CASUALTY TRANSFER GUIDE

(CIRCLE ALL POINTS THAT APPLY)

100 INSURED REPORTS ACCIDENT DID NOT HAPPEN

100 INFORMANT NOTIFIES ALLSTATE OF SUSPECTED FRAUD

100 UNEXPLAINED INCONSISTENT DAMAGES

* SEVERITY OF IMPACT (MINOR TO ONE-MAJOR TO ANOTHER)
* LOCATION (POINTS OF IMPACT)

100 SYSTEM INFORMATION INDICATIVE OF SUSPECTED FRAUD

* PARTY TO LOSS INVOLVED IN PRIOR NICB REFERRAL
* INSURED/CLAIMANT HAD PRIOR ALLSTATE CLAIM HISTORY THAT WARRANTS FURTHER INVESTIGATION BY THE SIU

100 INDICATION THAT ACCIDENT WAS A SET-UP

* STAGED ACCIDENT
* JUMP-IN
* SUSPICIOUS HIT AND RUN

TREATMENT MAY NOT HAVE OCCURRED. INDICATION THAT CLAIMANT DID NOT RECEIVE ALL OF THE TREATMENT DESCRIBED IN THE SPECIALS

30 CLAIM REPORTED 20 DAYS OR MORE AFTER DATE OF LOSS

20 MINOR IMPACT (GENERALLY LESS THAN $1000 DAMAGE ON ANY VEHICLE)

40 CLAIMANT HAD A BI CLAIM INVOLVING MORE THAN EMERGENCY ROOM TREATMENT (WITHIN THE PAST 3 YEARS OR SUBSEQUENT TO THE LOSS)

10 LOSS WITHIN FIRST 90 DAYS OF NEW POLICY (FIRST TIME ALLSTATE AUTO POLICYHOLDER)

MULTIPLE CLAIMANTS

30 THERE ARE MULTIPLE INJURED CLAIMANTS

50 UNRELATED CLAIMANTS HAVE SAME DOCTOR AND SAME ATTORNEY
25 UNRELATED CLAIMANTS HAVE SAME DOCTOR BUT NOT SAME ATTORNEY
25 UNRELATED CLAIMANTS HAVE SAME ATTORNEY BUT NOT SAME DOCTOR

SELECT ONE

TREATMENT

30 TREATMENT STARTED MORE THAN 15 DAYS FROM DATE OF LOSS (EXCLUDING ANY INITIAL EMERGENCY ROOM TREATMENT)

OTHER REASONS (DISCUSS WITH SIU REP AND/OR UCM)

(FILE QUALIFIES AS A REFERRAL WHEN TRANSFER GUIDE TOTALS 100 POINTS OR MORE)

JOB AID

SIU MEASUREMENTS

PURPOSE: To maximize the use of lists and current diagnostic tools to identify adverse trends and to create action plan to exceed SIU goals.

TOOLS:

List C180 - MCO Casualty Referral Summary Report
List C176 - SIU Item/Claimant Closures
Casualty Transfer Guide Review (Scorecard)

ANALYSIS:

List C180 - MCO Casualty Referral Summary Report

* Monthly Casualty SIU referral volume by MCO.
* List tracks number of Casualty files transferred, files returned from the SIU unassigned and net files assigned to SIU reps from each MCO.
* High number of unassigned files reflects compliance issue in transfer guide scoring or "false positives."
* List also compares net Casualty referral percent to SIU with established baseline for each MCO.
* Report should be used to evaluate whether scorecard is utilized properly, MCO is focused on fraud identification, and whether fraud activity in the market is changing.
  - Baseline variance percent should be evaluated to identify trends by MCO and overall CSA trends.

List C176 - SIU Item/Claimant Closures

* Item/claimant closures in the SIU by desk location, unit, office and CSA.
* List tracks total and average loss and expense payments in the SIU, and compares total dollars paid with MCO severity based on injury type and attorney representation.
* SIU dollars not paid should be evaluated to determine overall impact of SIU operations.

Scorecard

* Conduct management reviews to ensure complaince with SIU transfer process:
  - Spotcheck random sampling of open/closed AA/BB files to determine if transfer guide is complete.
  - As part of pending BI preferred file reviews, conduct review of fraud indicators identified to evaluate accuracy of scoring.
  - Review files investigated in the SIU and returned to the MCO to evaluate whether transfer guide is identifying appropriate files for specific investigation.

Video Surveillance of Allegedly Disabled Claimants

The compensation of disabled individuals is calculated using a graduated scale based upon the claimant's level of disability. Inherent in this system is a temptation for the claimant to exaggerate their alleged disability in order to receive a greater level of compensation.

Bodily injury claims, whether you are self-insured or not, can severely impact the bottom line of any organization either through direct benefit payments or increased insurance premiums.

One way to verify whether or not a claimant is as disabled as alleged is through the use of video surveillance. This is a legal, cost-effective means by which an employer or claims handler can improve their bottom line. This strategy involves covertly observing and videotaping a claimant and then comparing the claimant's videotaped activity to their allegations of disability.

The following is a guide to controlling video surveillance operations. It includes selecting candidates for surveillance, controlling costs, conducting surveillance legally, and using videotapes as evidence. This guide is for all levels of claims handlers as well as attorneys and risk managers.

Identifying A Malingerer

Claims handlers are often kept in the dark as to the extent of a claimant's disability. In some cases, surveillance may provide evidence that a claimant is malingering, while other times it may help confirm the disability. When considering the use of surveillance, refer to the following indicators to identify the likely candidates.

RED FLAGS:

FLAG 1: Claimant can never be directly reached at home. usually by phone other parties always answer for clmt

FLAG 2: Injury coincides with reduction of work force.

FLAG 3: Leads from co-workers or neighbors.

FLAG 4: Rehab reports indicate a healthy-looking claimant.

FLAG 5: No organic basis for disability.

FLAG 6: Claimant receives mail at a post office box and will not divulge the residence address.

FLAG 7: Claimant has a history of self-employment.

FLAG 8: Claimant has relocated. / PO Box — Rural Rt

FLAG 9: Excessive or premature demands for compensation.

FLAG 10: Disability beyond that normally associated with claimed injury.

FLAG 11: Claimant has a history of malingering.

FLAG 12: "Dueling Doctors." One says the claimant is disabled, the other says not.

JOB AID – SIU CASUALTY MEASUREMENTS

PURPOSE: Maximize the use of SIU-CDS reports to:

Measure SIU referral and claim handling results.
Identify adverse trends.
Create action plans to achieve optimum SIU results.

TOOLS:
List C176 - SIU Item/Claimant Closures
List C180 - MCO Casualty Referral Summary
List C181 - Casualty Scorecard Detail Report
List C182 - SIU Files Referred/Not Referred/Unassigned/Returned Detail Report
List C183 - SIU Files Assigned/Returned Detail Report

LIST C176 - SIU ITEM/CLAIMANT CLOSURES

- Lists item/claimant closures by desk, unit, office location and CSA.
- Reports all AA/SS item claimants closed in the SIU. In losses where a claim was denied or compromised due to the fraud issue, report will compare the SIU paid loss and expenses for these item/claimants with the MCO YTD severity's based on file segmentation.
- SIU Payment Rate, or percentage of MCO total baseline paid, is also calculated for month and year to date. The lower the percentage, the higher the number of SIU CWP's, the greater the difference in average payments between the SIU and MCO based on segmentation, or a combination of both.
- Item/claimants closed in the SIU not included in the above calculation are deemed legitimate. These display on the bottom of the report and should be reviewed to evaluate SIU reporting accuracy.
- SIU dollars not paid should be evaluated to determine overall impact of the SIU casualty operation.

LIST C180 - MCO CASUALTY REFERRAL SUMMARY

- Reports monthly casualty SIU referral volume by the MCO.
- List tracks number of casualty files transferred, files returned from the SIU unassigned, and the net files assigned to SIU reps from each MCO.
- List also compares net casualty referrals with established MCO baselines and reports variances.
- Report should be used to evaluate MCO performance in fraud identification in meeting or exceeding SIU referral goals, and also to determine whether SIU transfer guidelines are followed.

LIST C181 - CASUALTY SCORECARD DETAIL REPORT

- List broken into three sections. Reports casualty scorecard activity for each MCO.
- C181A - Listing of AA/SS claims 90 days or less that remain unscored. Once the claim appears three times on the list, it will drop off.
- C181B - Displays AA/SS claims opened 6 months or less and not updated. Claims opened 60 days or less and not updated in one month will display on the list. Claims between 60 - 180 days old will appear on the list if the scorecard is not updated in two months.
- C181C - Displays AA/SS claims that reach 80 point scorecard total but less than 100 points. Claims will remain on the list for three months and will drop off.
- Report should be used as a tool to evaluate scorecard compliance and to identify potential SIU referrals.
- Summaries for C181A and C181B found at the end of each category will report percent of opens scored and percent of open claims reviewed by MCO and CSA.

LIST C182 - SIU FILES REFERRED/NOT REFERRED/UNASSIGNED/RETURNED DETAIL REPORT

- List reports all AA/SS claims assigned into the SIU.
- Replaces manual SIU transfer log maintained in the MCO.
- For each MCO desk location, list tracks claims referred, not referred, unassigned, or returned monthly.
- Due to the volume of claims, totaling by desk is only calculated year to date. The list does total month and year to date by MCO and CSA.
- List should be used to evaluate individual claim rep performance in referring claims to the SIU, and to measure claim rep compliance in following the scorecard transfer process.

LIST C183 - SIU FILES ASSIGNED/RETURNED DETAIL REPORT

- Reports all AA/SS claims assigned into the SIU. For each SIU desk location, report lists any claims that were assigned, transferred, resolved or returned to MCO during the reporting period.
- List replaces manual SIU log.
- List also calculates the percentage of assigned claims that were returned from the SIU to the MCO following investigation. This percentage should be tracked closely to evaluate effectiveness of SIU, measure compliance in following SIU file handling requirements, and to gauge accuracy of scorecard in identifying potential fraud.

RULES OF THE ROAD

1. Must treat its policyholder's interests with equal regard as it does its own interests. This is not an adversarial or competitive process.

2. Insurance company should assist the policyholder with the claim.

3. Insurance company must disclose to its insured all benefits, coverages and time limits that may apply to the claim.

4. Insurance company must conduct a full, fair and prompt investigation of the claim at its own expense.

5. Insurance company must fully, fairly and promptly evaluate and adjust the claim.

6. Company must pay all amounts not in dispute within 30 days.

7. Company may not deny a claim or any part of a claim based upon insufficient information, speculation or biased information.

8. If there is a full or partial claim denial, the insurance company must give a written explanation, pointing to facts and policy provisions supporting the denial.

9. Company may not misrepresent facts or policy provisions.

10. Company may not make unreasonably low settlement offers.

11. Company must give claimant written update on status of claim every 30 days, including a description of what is needed to finalize the claim.

12. Company may not conceal or fail to disclose how it interprets its policy or how it handles similarly-situated claims.

G. Robert Mecherle — Claims Vice President

"Let there be no doubt that our goal is to give the best, most efficient, and most profitable claim service in the industry."

GENERIC CLAIM PRACTICES DISCOVERY LIST

Compiled by
Gary T. Fye

1. **Complete paper and electronic claim files: home office, regional, and local (including "field" files).**
   (1) Reports and correspondence
   (2) Memos of any type, i.e. telephone slips, inter office communications, handwritten notes, etc.
   (3) Tapes - Video and Audio
   (4) Photographs - original negatives
   (5) Instructions regarding investigation, coverage questions, etc.
   (6) Statistical documents and draft copies
   (7) Copy file jacket (Note: Examine original files for authenticity or evidence of alterations)

2. **Testimony and statements of client and any witnesses.**
   (1) Transcripts - Handwritten or typed
   (2) Original tapes
   (3) Contemporaneous notes

3. **Claims Manuals - printed and electronic**
   (1) Property loss handling procedures
   (2) Liability claim handling procedures
   (3) Supervisor's and manager's manuals
   (4) Data processing/systems manuals (intranet & e-mail methods)
   (5) S.I.U. manuals, fraud/arson procedures
   (6) "Historical" copies and procedures to retain them

4. **Information on the handling adjusters and supervisors.**
   (1) Job descriptions
   (2) Original application for employment
   (3) Annual performance evaluations

(4) History of salary and promotions/demotions
(5) Educational records (including company courses)
    (a) Curriculum (taped or written) used for these courses
(6) Letters of commendation or complaint
(7) Memberships in professional organizations, codes of ethics

5. **Personnel or "H.R." (Human Resources) manuals.**
   (1) Job descriptions
   (2) Salary grade classifications
   (3) Criteria for promotion/demotion
   (4) Performance evaluations and activity reviews
   (5) Performance-based compensation plans
   (6) Incentive programs and retirement funds
   (7) Profit sharing and stock ownership

6. **Documents which show the legal history of the claim.**
   (1) Legal opinions prior to the date of denial
   (2) Legal analysis of programmatical issues prior to loss
   (3) Correspondence to/from counsel

7. **Reports, correspondence, and materials provided by "outside" investigators.**
   (1) Confidential reports
   (2) Surveillance tapes (audio or video)
   (3) Investigations to determine level of disability
   (4) Time logs
   (5) List of investigators used for similar claims

8. **Reports, correspondence, and materials provided by Experts.**
   (1) Test results
   (2) Tapes (video or audio)
   (3) List of experts used for similar claims
   (4) Surveys/research

9. **Loss reserve history.**
   (1) Original reserves and all changes
   (2) Methods and criteria for setting reserves

10. **Reinsurance, facultative or treaty.**
   (1) Reinsurance policies and treaties
   (2) Reinsurance claim and reporting instructions
   (3) "Loss pooling" agreements
   (4) Documents concerning the acquisition, negotiation, and drafting of the agreements
      (a) including bills, payments, claims, inspections, or other

11. **Programs to control claim costs (indemnity and allocated/unallocated).**
   (1) Medical cost containment
   (2) Medical management/utilization review
   (3) Captive or favored contractors or shops
   (4) Fee and price guides
   (5) Approved vendor lists

12. **Videotaped, recorded, or written training materials:**
   (1) Property loss adjusting
   (2) Fire or accident investigation
   (3) Liability claims handling
   (4) Disputed claims
   (5) Fraud & arson detection, S.I.U. operations
   (6) Hiring outside experts or investigators
   (7) Coverage interpretation
   (8) Medical training

13. **Employee Handbook.**
   (1) Orientation manual or booklet
   (2) Benefits and disability plans
   (3) Profit-sharing, stock ownership, and incentive plans
   (4) Company philosophies and policies

(5) Code of conduct

(6) Confidentiality agreement

14. Newsletters - paper and electronic.

(1) Company-wide

(2) Regional and local

(3) Video-conferences and video magazines

(4) Claims

(5) "Sales", or agency

15. Quality control audits or surveys.

(1) Home office or regional audits

(2) Manuals or guidelines for audits

(3) Claim handling quality criteria

16. Records of public complaints.

17. Other files: loss or claim litigation and bad faith.

18. Forms, publications and manuals for the claims staff.

(1) Index, catalog or inventory of available materials

(2) Bulletins, memoranda, etc. not part of the "official" manuals used to convey instructions from management to claim handlers

19. Guides for letter writing or correspondence.

(1) Index of form letters

(2) E-mail program and manual

20. Description of the data processing equipment

(1) Language of "expert" systems (artificial intelligence/core skills)

(2) Programs for specific losses

(a) Bulletins and manuals explaining the capabilities of the programs

(b) Orientation bulletins or manuals

(3) Location of data "centers"

21. **Corporate operating authority.**
    (1) Articles of Incorporation
    (2) Certificate of Authority

22. **Information on the organization and officers.**
    (1) Diagram or chart of the claim department "chain of command"
    (2) Company structure by line and levels of authority
    (3) Manuals or bulletins on management reports and operations displays

23. **Annual reports**
    (1) 10K and 10Q reports to the S.E.C.
    (2) Reports to shareholders
    (3) Reports to regulators/insurance departments

24. **Advertising or promotional materials.**
    (1) 5 video ads displayed in area prior to loss
    (2) 5 audio ads displayed in area prior to loss
    (3) 5 print ads displayed in area prior to loss

25. **Archives or records storage.**
    (1) Bulletins or manuals on records retention and destruction
    (2) Index of retained materials, including instructions for
    (3) Documents which explain archives or records storage centers
    (4) Location of historical material

26. **Loss control, engineering, or risk inspection services.**
    (1) "Inspections" of risk subject

27. **Agency manuals**
    (1) Service instructions for premiums, claims handling, communications, handling of complaints and disputed claims, etc.
    (2) Training for the sale of policies

28. **Seating plan of local claims department.**

29. **"Claim Committee" procedures.**
    (1) Names of the committee members
    (2) Reports issued by the committee on this case
    (3) Documentation of "committee" deliberations

30. **Trade organizations of which the company is a member or subscriber.**
    (1) Dates such associations began
    (2) Codes of ethics and by-laws

31. **Underwriting files on the property and insured.**
    (1) Inspection reports
    (2) Any manuals governing underwriting or rating

32. **Corporate liability insurance for E & O or bad faith.**
    (1) Copies of the policies
    (2) Reports and correspondence to insurers
    (3) Investigation and adjustment files

33. **Any separate file on the claim which deals with "fieldwork", salvage, accounting, subrogation, cause and origin investigation, or any other subject.**

34. **Home Office or Regional conferences - syllabus and tapes.**
    (1) "Binders", course materials, audio/video tapes

35. **Insurer's philosophies on:**
    (1) Claims handling policies
    (2) Providing service to policyholders
    (3) Good/bad faith claim handling
    (4) Extra-contractual damages and suits
    (5) Compliance with unfair claim practices statutes
    (6) Wrongful claims handling

36. Speech transcripts
   (1) Executive officers
   (2) Claims officers
   (3) "House" counsel

37. Prior Depositions and Affidavits
   (1) Adjusters and supervisors
   (2) Company officers

DOCUMENT HANDLING GUIDELINES

1. Document copies should be unstapled, unperforated, unbound, and should be separated by colored paper (slip sheets) to facilitate recopying. A sheet of explanation can be placed on each section of documents to minimize confusion about the identity of documents.

2. Photos should include "proof sheets" showing sequence of original negatives; one set of slides for use at trial; and adequate sets of 4" x 6" glossy prints. Enlargements are not needed, but should be on glossy paper if provided. Grainy-surfaced papers are hard to magnify and don't produce good copy negatives.

3. Photos should be from original negatives to assure sharp resolution and good color balance.

Ways to Take Advantage of Defense Noncompliance

Motion for Appointment of Discovery Master
Motion to Amend Case Schedule
Motion to Amend Discovery Deadlines
Motion to Compel Discovery
Motion to Compel Discovery Conference
Motion to Compel Deposition/Discovery at Defense Expense
Motion for Continuance of Trial Date
Motion for Leave to Name Additional Rebuttal Witnesses
Motion *in Limine*
Motion to Limit Testimony for Failure to Make Full/Timely Discovery
Motion for New Trial
Motion for New Trial at Defense Expense
Motion to Strike Affirmative Defense
Motion to Strike Answer and for Entry of Order of Default
Motion to Strike Proposed Exhibit
Motion to Strike Witness
Motion for Sanctions and Terms
Motion for Terms

Analytic Steps for Proceeding with a Motion After Noncompliance Occurs

1. Plan with full knowledge of current case law.

2. Know your judge.

3. Identify the appropriate motion to bring.

4. Carefully limit the issues the motion presents.

5. Plan when to bring the appropriate motion.

6. Fully support motion with facts, exhibits, declarations, the case schedule, your multiple letters requesting compliance, defense refusal to meet pursuant to CR 26(i) preventing your client from being able to set a discovery motion which the Court may entertain, leading to further delays.

APPENDIX G

7. Be sure that the violations are prolonged, repeated, intentional and in violation of both the Civil Rules and the Case Schedule.

8. Be thoughtful and present other less severe sanctions which might be imposed and explaining why the Court should consider and reject them as inadequate to right the prejudice to your client and the judicial system.

9. Be sure that your client is in compliance with the Civil Rules and the Case Schedule.

10. Provide a good explanation of the prejudice your client suffers because of the violations.

11. Provide a good analysis of the prejudice the judicial system will suffer due to the violations.

12. Provide a good brief on the law regarding the basics of discovery as well as reviewing the cases applying to violations of the applicable Case Schedule and the particular Civil Rules violated as well as reviewing *Rivers, Burnett* and other cases on sanctions.

13. Make your motion and supporting materials easy to read and refer back and forth within. Three ring binder presentation with side tabs are encouraged to make it easier for the assigned Judge/Judicial Assistant to digest.

14. Be sure to comply with all local rules on Case Schedule, motions, and limitations for pleadings. [Move for relief in writing and timely if necessary.]

15. Be sure that your motion, if dispositive, is brought within the time frame for dispositive motions under your Case Schedule.

16. Prove your client is in compliance with the Case Schedule and in discovery or prove how the client's inability to comply was the result of the defense noncompliance.

Presume You Are Guilty When Presenting the Motion

Presume that the Court will be evaluating your and your client's compliance as well as the defense' compliance in discovery and with the Case Schedule in every case. Assume that the scrutiny on your client will be heightened when your client moves for relief for defense violations.

In your motion, provide proof in the form of exhibits/affidavits/declarations of your client's compliance as well as your multiple attempts to avoid the need for the motion by trying to cajole defense compliance/discovery.

One solution to this problem is to document everything that is done both to be in compliance and to obtain compliance regarding both discovery and the Case Schedule. Paper what ever you do, *e.g.* phone calls, email, faxes, letters. Get all your deliveries done by a messenger service with a copy received stamp on both the messenger slip and the accompanying extra copy of the face sheet of the delivered item.

Timing of Motions for Discovery & Sanctions

Advantage to an early motion is that you may obtain the compliance/discovery needed and may prevent the prejudice to your client.

Disadvantage to the early motion is that the Court may view it as premature and reject later requests for sanctions for noncompliance.

Solution to this disadvantage is to utilize as many avenues as you can as early as you can to obtain the compliance/discovery.

Advantage to the later motion is that you will not be accused of moving prematurely and your client's prejudice may now be irremedial by lesser sanctions.

Disadvantage of the later motion is that you may be accused of laying in wait to spring this matter on the defense when it has no option to rectify the prejudice, unfairly snookering them into serious sanctions territory without giving them fair notice of the problems your client has from discovery.

Solution: Send repeated letters requesting compliance all along. Send repeated letters requesting defense counsel to meet with you pursuant to CR 26(i) so you can either (1) resolve the discovery/compliance problem or (2) move to compel and/or for sanctions.

Examination of Claim Handlers

JOB

Sympathetic, hard-working claims handler

(Are you taught to . . .? Is part of your training . . .? Avoid <u>duty</u> questions)

I. INVESTIGATE (Verification Phase)

1. Coverage
2. Liability
   a) Prompt, thorough, fair
   b) Facts for coverage
   c) Know right from wrong
   d) Grant benefit of doubt to insured
   e) Handle case on its merits, objective
   f) Utmost good faith
   g) No such thing as a "favorable" fact
   h) Rules of the road, no secrets
   i) No outcome orientation
   j) No conflict of interest
   k) Document everything

II. EVALUATE (Quantification Phase)

1. Without regard to limits
2. Reserve: probable ultimate payment
3. Indemnity – making "whole"
   a) See list above
   b) UM – same value as BI
   c) Medical claims
      (1) Medical expenses
      (2) Future medical
      (3) Wage loss
      (4) Earnings
      (5) Inconvenience
      (6) Pain and suffering
      (7) Consortium
4. No "discounts"
5. Effect of internal incentives
6. Disclose range of values
   (1) Knowledgeable
   (2) Objective, fair

III. SETTLE, ACCEPT, OR REJECT

1. Indemnity
2. Declaratory relief
3. Informal reformation
4. Do the "right" thing
5. No hidden agenda
6. No undisclosed incentives
7. No dirty tricks
8. Full measure

Claim denials have consequences far beyond this claim. Should allow insured to withdraw before "branding" with a denial letter.

____

Signature?

WRONG

Same claims handler

(If you didn't do your job, would that be wrong?)

I. AGREE

Duty questions now come in

1. Common law
2. Statutory
3. Regulations (D.O.I.)
4. Industry standards
5. Internal standards
6. Assumed duties
7. Trade organizations
8. Codes of ethics
9. "Social contract"

II. AGREE

Wrong to break

1. Promise
2. Commitment
3. Contract

People who have loss or injury aren't at their best. Mistreating them is abusive. They are financially and emotionally vulnerable.

III. AGREE

____

Signature?

BAD FAITH

Stern, authoritarian supervisor

(Argumentative examination: You didn't investigate properly, did you?)

I. DENY

No criticisms or notes in the file.
No critical letters or reviews for adjusters

II. DENY

Not an experimental way to handle
Meets all company standards

"Did you read the file? Is it OK with you? *In fact, you'd do it the same way again, wouldn't you?"*

III. DENY

Point by best point, establish wrongful handling

____

Signature?

SOFT TISSUE INJURY DEPOSITION QUESTIONS

Approximately 80% of claims in MVAs are a result of soft tissue injury. In treating this problem the patient may see a number of different practitioners including physical therapists, chiropractors, and orthopedic surgeons as well as their primary care physician. In many cases the claimant still complains of soft tissue pain years after the injury. X rays and MRI findings are often non diagnostic.

Evaluations by independent medical examiners are often requested. Such individuals (often orthopedic surgeons) will often declare that soft tissue injuries all resolve within a few weeks. The following questions may be used to clarify his/her opinions as well as his/her education, training, and potential biases.

1. What medical school did you graduate from?

This will come from his/her résumé which should be reviewed prior to the deposition.

2. What is your specialty?

Most of these individuals are orthopedic surgeons.

3. Are you board-certified in the specialty?

He/she will say yes.

4. Do you have any subspecialties? What ones?

Most likely the answer will be no.

5. Why is an important to be board-certified?

A board certified individual has completed the necessary training and examinations and is fully qualified to practice the specialty.

6. So, in other words, it does not make sense for a person who is not board-certified in orthopedic surgery to practice orthopedic surgery or to give opinions regarding orthopedic surgical cases?

This is a leading question. This question will be used demonstrate later that since the issue in this case is chronic pain and not orthopedic surgery the opinions of the medical expert are suspect.

7. Is evaluation and treatment of chronic pain part of the program of orthopedic surgery residencies?

These residencies focus on teaching the resident to operate. They do not focus on treat of inoperable pain problems.

8. What is the major problem in this case?

Chronic spine pain.

9. Do you treat patients who have chronic pain?

He/she may treat some patients who have chronic pain due to osteoarthritis and osteoporosis. It would be useful to see if he has any patients will have problems of secondary to injuries and ask him how many patients he treats who have this problem.

10. Have you ever given anyone in impairment rating for a soft tissue injury case in your life?

He may say no. Also important to ask if he has done evaluations for plaintiffs.

11. Does the AMA guides give impairment ratings for soft tissue injuries?

If he says no, refer to table 75 of the fourth edition of the AMA guides and table ____ of the fifth edition which very clearly state that a person has a impairment rating as a result of a soft tissue injury with no or minimal degenerative changes on x-ray.

12 .Are you board certified in pain?

He will say no. It is important to review his résumé before coming to the deposition.

13. Which boards certify physicians in the subspecialty of pain?

There are a number of medical boards which certify doctors in pain.

The American Board of Anesthesiology and the American Board of Neurology and Psychiatry offer subspecialty certifications in pain medicine. These are ABMS boards.

The American Board of Pain Medicine also offers a certification in this field. This board is not an ABMS board but is considered as being the equivalent of an ABMS board by a number of states.

The American Board of Pain Management is a non-ABMS board which offers certification by examination to pain practitioners.

14. Are you certified by any of these organizations?

No.

15. Do you believe that this claimant has chronic pain?

No.

16. If there is no problem why has this claimant seen all these doctors and had all this treatment?

If the doctor says that the problem is all in the claimant's head, please ask what training the doctor has had in psychology or psychiatry. Has he completed any coursework, etc?

17 .How do you measure chronic pain?

Pain is called the 5th vital sign. This is a subjective parameter. Recent research has confirmed that surface EMG testing is an objective marker of the pain complaint. (See enclosed paper by Geisser et al)

18. Which organizations certify doctors in impairment evaluation?

There are no ABMS boards which certify physicians in disability or impairment evaluation. The American Board of Independent Medical Examiners is the board which comes closest to requirements of an ABMS board. To become certified by this board the applicant must complete educational requirements and a four-hour examination.

Some medical experts will claim that they are board-certified by the American Academy of Disability Evaluating Physicians or other organizations. It will be good to ask exactly how he came to be certified by this organization which does not certify doctors. Was there an examination? Was it a take home exam? Was the examination monitored by an independent agency? The certifying examination which ABIME gives is 4 hours long and has 125 questions. Its content is continually reviewed by HUMRO, an independent agency.

19. What medical journals do you read on a regular basis?

20. Are you aware of any medical journals which specialize in disability or impairment evaluation?

Disability Medicine published by ABIME is the major journal in disability and impairment evaluation.

21. Do you read any medical journals which specialize in disability or impairment evaluation?

He will say no.

22. How many medical articles have you reviewed on the subject of disability or impairment evaluation?

23. Which textbooks have you read on disability and impairment evaluation?

24. Have you taken any courses on impairment evaluation?

This is an important question. Medical experts might not have taken any courses at all in this area. These should be listed on his résumé.

25. Have you attended any courses or conferences or conventions in the field of pain evaluation?

26. Have you published any articles in the peer-reviewed medical literature on pain evaluation?

Almost certainly he will answer no.

27. Are you a faculty member of any medical college?

28. Can we agree that it is very important for a physician to keep up with the medical literature?

Yes. This question will lead into the fact that the doctor has not been keeping up with the pain and impairment medicine literature.

29. Do you keep up with the latest in the medical literature?

Yes.

30. What would you think of a doctor who failed to keep up with the medical literature?

Another leading question.

31. In your report you opine the Surface EMG is a useless technology. What is the basis for your belief for this statement?

Most likely he will say that this is generally regarded as a technology which is not reliable. He may refer to some studies written by Dr. Haig and Dr. Pullman. (These are attached.) The studies were written before 2000 and it is probable that he has not reviewed the most recent literature which was published in November of 2005.

32. What is the American Academy of Electrodiagnostic Medicine?

33. Who is the author of the study on which the opinions of the AAEM were based?

Andy Haig et al.

34. You refer to the review article by Dr. Pullman et al. published in 2000. In this article how many research studies on low back pain did they actually look at to come to their conclusions?

4

35. Is the University of Michigan a reputable institution?

Yes.

36. Would you consider research coming out of the University of Michigan reputable research?

Yes.

37. Who is in the third author of the meta-analysis on surface EMG which was published in the Journal of Pain in November of 2005?

Andy Haig of the University of Michigan

38. What are the conclusions from this study?

The answer is in the abstract of the paper which is attached. Bottom line: SEMG discriminates low back pain patients from controls.

39. How many research studies on low back pain did they review to come to their conclusions?

About 50

40. In your report you say that most tissue injuries resolve after six weeks. What is the basis of this opinion? Can you show me an article in the peer reviewed medical literature which substantiates this observation?

Most likely he will say that this is generally recognized. There are no medical studies which corroborate this opinion scientifically to my knowledge, however. There is evidence that 90% of people will have low back pain 10 years after a motor vehicle accident.

41. Who is Dr. X?

This would be any primary care physician or specialist who has been treating the claimant for the pain problem. The medical expert has stated in his report that problem has completely resolved after eight weeks so the issue is why all these doctors continuing to treat this patient?

42. Is he a reputable medical practitioner?

Obviously yes.

43. I am confused, if there is nothing wrong with her, why is Dr. X. treating her with injection therapy? Should Dr. X. be reported to the medical board for excessive and/or inappropriate treatment?

This question is just meant to irritate the doctor.

44. What is botulinum toxin?

45. What are the medical uses for botulinum toxin?

46. Why is Dr. X considering treating Mrs. when this medication is so dangerous?

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

SCOTT DOAN,

Plaintiff,

Case No.: 07-13957
Hon. John Corbett O'Meara
Mag. Paul J. Komives

v

ALLSTATE INSURANCE COMPANY,

Defendant.

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PLAINTIFF'S FIRST REQUEST FOR ADMISSIONS TO DEFENDANT ALLSTATE INSURANCE COMPANY, DATED FEBRUARY 11, 2008

NOW COMES Plaintiff by and through his attorneys, Law Offices of Paul Zebrowski & Associates, and hereby submits the following First Request for Admissions to Defendant, Dated February 11, 2008, pursuant to Rule 36 the Federal Rules of Civil Procedure:

1. Admit that Allstate claims adjusters must fully explain to their policyholders, any and all benefits available to them under the policy.

Response:

2. Admit Allstate Insurance Company must be fair in its investigation of the facts in each of its policyholders' claims.

Response:

3. Admit Allstate must conduct a quick and prompt investigation of each of its policyholders' claims.

Response:

4. Admit Allstate must not pay less than what is owed for each claim submitted and/or incurred.

Response:

5. Admit Allstate claims adjusters must answer any and all questions pertaining to coverages or benefits made by its policyholders or on their behalf.

Response:

6. Admit that once it is determined that a benefit is owed and not in dispute under the Allstate policy to a policyholder the payment should be made by Allstate within a reasonably prompt period of time including while litigation is ongoing.

Response:

7. Admit it would be improper for Allstate Insurance to set goals for its employees to reduce the payment of claims under no-fault first party coverages.

Response:

8. Admit Allstate Insurance Company implements a desk level Claim Performance Measurement System (CPMS).

Response:

9. Admit Allstate Insurance Company uses the Claim Performance Measurement System (CPMS) as a tool for performance management.

Response:

10. Admit the Claim Core Process Redesign allows Allstate to take an objective look at how it handles claims.

Response:

11. Admit one of the goals of the Claim Core Process Redesign is so that Allstate can and should manage specific components of severity to provide greater financial support to the company.

Response:

12. Admit that the Claim Core Process Redesign allows Allstate to realize that the

way it approaches claimants and develops relationships will significantly alter representation rates and contribute to lower severities.

Response:

13. Admit that the Claim Core Process Redesign directly impacts the manner in which claims adjusters have handled Scott Doan's claim.

Response:

14. Admit that Allstate used the services of McKinsey Consulting, Inc. in association with Allstate's claim handling in the creation of Allstate's CCPR (Claim Core Process Redesign.

Response:

15. Admit that Allstate has maintained documents in association with their retention and association with McKinsey Consulting, Inc.

Response:

16. Admit that McKinsey Consulting, Inc. was used by other insurers including competitors of Allstate.

Response:

17. Admit that documents concerning Allstate's CCPR program has been produced for public records.

Response:

18. Admit that Allstate has referred to its claim department as a profit center.

Response:

19. Admit that one of the initiatives of Allstate's CCPR program was to focus on increasing profits.

Response:

20. Admit that Allstate has tracked the increased profits generated by the implementation of the CCPR program.

Response:

21. Admit that Allstate in the handling of claims in the state of Michigan must abide by the Michigan statutes.

Response:

22. Admit that Allstate has been sanctioned as much as $25,000.00 per day for its refusal to produce documents ordered by a court.

Response:

23. Admit that Allstate has had its certificate of authority to sell insurance in the state of Florida for its refusal to produce documents subpoenaed by Florida's Office of Insurance Regulation.

Response:

24. If the answers to 21 and/or 22 are in the positive, admit that Allstate has continued in the same claim practice processes and procedures in spite of admissions 21 and 22 stated above.

Response:

25. If the answers to 21 and/or 22 are in the positive, admit that Allstate has no

intention of changing its claim practice processes and procedures as a result of the admissions 21 and 22 stated above.

Response:

26. Admit that Allstate never changed its claim practice processes and procedures as a result of any court order or judgment involving Allstate as a defendant or plaintiff.

27. **Response:**

28. If the answer to 25 is negative, state the specific case(s) in which the order or judgment was rendered.

Response:

29. If the answer to 25 is negative, state the specific changes which Allstate instituted into its claim practice processes and/or procedures and the date of implementation.

Response:

30. Admit that Allstate determines the annual increase or increase for its employee's salary based on the CCPR guidelines.

Response:

31. Admit that Allstate advertises that its policyholders are in "Good Hands" when a claim is presented by the policyholder to Allstate for handling and payment.

Response:

32. Admit that Allstate's CCPR program was implemented in its claim operations throughout the United States including the state of Michigan.

Response:

33. Admit that Allstate's CCPR program is required procedure for all claim personnel throughout the United States including the state of Michigan.

Response:

34. Admit that there exists an implied fiduciary responsibility contained within the Allstate policy in the state of Michigan

Response:

35. Admit that Allstate should never adopt a claim practice process or procedure in its claim handling which has been determined to be fraudulent, deceptive and/or in violation of Michigan statutes.

Response:

Respectfully submitted,

Paul A. Zebrowski (P44427)
Thomas A. Biscup (P40380)
Attorneys for Plaintiff
45581 Village Blvd.
Shelby Twp., MI 48315
(586) 566-7266

Dated: February 11, 2008

CERTIFICATE OF SERVICE

I hereby certify that, on February 11, 2008 a copy of the foregoing Plaintiff's First Request for Production of Documents to Defendant, Dated February 11, 2008 by first class mail via United State Postal Service to:

Donald C. Brownell
1450 W. Long Lake Rd., Ste. 100
Troy, MI 48098-6330

_____
Lisa Chambers

SECTION I – TOOLS OF THE TRADE
Daily Practice and Use Documents (Including prior versions, drafts, notes, change memos, critiques distribution procedures and field requests for changes)
A. The work of Investigation, Evaluation and Settlement of claims.
1. Auto Policy Manual I
2. Casualty Hub Training
3. Unrepresented Process Training Book I
4. Expert Consultant Reference Catalog
5. Guiding Principles for Customer Care and Satisfaction.
6. Human Resources Policy Statements Manual
7. Medical Bill Review System Users Manual
8. MBRS Quick Reference Manual
9. Operations Manual
10. Continuum Colossus Training Manual, User Manual and Reporting Manual
11. All documentation pertaining to Allstate's enhancement/changes to Colossus Training.
12. SAR/Claims a la Carte Instructions/Manual (Note: SAR = Statistics and Research).
13. LRS Manual (Loss Report System)
14. Anti-trust Compliance Guidelines
15. Security Administration Manual
16. All Best Practices Guides
17. C3249 Best Practices Guide
18. All Allstate Service or Quality Pledges
19. Brochure C 2896 - "Important Things You Should Know in Case of a Loss"
20. All documentation of Loss or Severity Control Initiatives
21. All MCO (Market Claim Office) Trainer Guides
22. All training material and manuals dealing with the Moment of Truth Process
23. SIU Casualty Best Practices Guide (Note: SIU = Special Investigation Unit)
24. All Unit Meeting Guides since 1990
25. Claim Management Education Series (Video Training)
26. Progress Development Summaries on <u>all</u> adjusters, supervisors, and managers in the region which contains the Albuquerque MCO since 1990.
27. Performance Review forms on <u>all</u> adjusters, supervisors, and managers in the region which contains the Albuquerque MCO since 1990.
28. The Prescription History (Note: This is the education and training record of those who complete the ***prescribed*** training) on <u>all</u> adjusters, supervisors, and managers in the region which contains the Albuquerque MCO since 1990.
29. All documents pertaining to the Quarterly Leadership Measurement System
30. All "Upper Communication Process" Guidelines and use manuals
31. All Employee Opinion Surveys (of management or processes)
32. Progressive Discipline System guidelines or manual.
33. All Claim Bulletins issued since 1990 nationally.
34. All Claim Bulletins from before 1990 retained for use or reference.
35. *"Allstate Now"* since 1985
36. Allstate's Regional and National newsletters since 1985

37. All Codes of Ethics or conduct in use since 1985.
38. All Secrecy or confidentiality agreements used since 1985.
39. All Software licensing agreements since 1990
40. All Intellectual property/copyright protection agreements of any type entered into by Allstate since 1985
41. An Organization chart of the Home Office, the Region which contains the Albuquerque MCO, and the Albuquerque MCO
42. P-CCSO National Claim Training Center index or catalog of training courses.
43. P-CCSO National Claim Training Center index or catalogue of audio/visual materials.
44. P-CCSO National Claim Training Center roster of employees and past employees since 1990
45. Bodily Injury Evaluation training for claims handler. This request is to include all historical and present training and guideline material dealing with the subject of evaluating the bodily injury claims of both 1st and 3rd party claimants. It is a request to broadly encompass everything Allstate could conceivably produce showing how it instructs employees to deal with the injury claims of the insuring public.
46. Negotiation training materials since 1990, including but not limited to *"Negotiation Skills"*, *"Negotiation Strategies"*, and other such courses.
47. Any training or documents concerning "Management by Statistics"
48. All CSC or Continuum Colossus vendor promotional materials, including the 36 page full-color brochure mentioned in a recent article published by Insure.com. This request is meant to include all promises, inducements, presentations, power-point displays, order forms, licensing and use information or any other preliminary materials exchanged between vendor and vendee.
49. All documents that reflect Allstate's knowledge of and training for the use of Colossus, including but not limited to, the training manual, the user's manual, and other such material.
50. Allstate's documentation and protocols for establishing Colossus baseline values and of the company's knowledge of both the methods and values involved.
51. Invoices for the use of Colossus since 1990. This request includes evidence of payments and tax identification number printouts for any vendor who received payment for Allstate's use of Colossus.
52. Vendor contracts of any nature concerning the use of Colossus since 1990.
53. All opinion and feasibility memos, letters and analyses concerning Allstate's decision to implement Colossus. This request includes all legal opinions.
54. Allstate's measurement of the effectiveness of using Colossus, including all analysis.
55. All correspondence, training, communications, and technical materials not covered in the above requests concerning Allstate's use of Colossus and relations with either users, vendors, auditors, regulators, or any other person or entity.
56. Documents which list Allstate's use of Colossus by Country, Region, State, numerically, monetarily, or in any other way.
57. Documents Allstate believes are relevant to the claim practices, systems and techniques that are the subject of this suit.
SECTION II – EVIDENCE OF CORPORATE PURPOSE AND INTENT.
58. All depositions of Home Office level employees since 1990.

59. All depositions of any employees since 1990 which involve the Claim Core Process Redesign
60. All depositions of any employees since 1990 which involve Colossus
61. All manuals, guidelines, menus and user instructions for the Claims Legal computer, and for any computer named "Henry"
62. All documents pertaining to JoAnn Lowe.
63. All documents pertaining to California Insurance Commissioner Quackenbush, including the files concerning Allstate's donations to foundations as an alternative to being fined for improper claim practices.
64. All documents dealing with Allstate's response to the Market Conduct Examination(s) in California and the remedial steps Allstate took as a result.
65. All documents dealing with Allstate's response to Market Conduct Examinations in any state since 1990 and the remedial steps Allstate took or has taken as a result.
66. All documents dealing with Allstate's response to the Market Conduct Examination(s) in Virginia and the remedial steps Allstate took as a result.
67. All documents dealing with Allstate's response to the Market Conduct Examination(s) in Ohio and the remedial steps Allstate took as a result.
68. All documents dealing with Allstate's response to the Market Conduct Examination(s) in any Southwestern state, including Colorado, and the remedial steps Allstate took as a result.
69. All management studies, analyses and reports or "Blue Books" or any other writings, tapes or communications to Allstate or its subsidiaries and management by Frost & Sullivan, Bain & Company, McKinsey & Company, CCC, Automated Data Processing (ADP), Computer Sciences Corporation, Continuum, PMSC, or similar vendor.
70. All proposals, purchase orders, projects outlines or contracts between Allstate or its subsidiaries and management and Frost & Sullivan, Bain & Company, McKinsey & Company, CCC, Automated Data Processing (ADP), Computer Sciences Corporation, Continuum, PMSC, or similar vendor.
71. All tax identification number printouts for Frost & Sullivan, Bain & Company, McKinsey & Company, CCC, Automated Data Processing (ADP), Computer Sciences Corporation, Continuum, PMSC, or similar vendor.
72. All management studies, analyses and reports or "Blue Books" or any other writings, tapes or communications from Allstate or its subsidiaries and management to Frost & Sullivan, Bain & Company, McKinsey & Company, CCC, Automated Data Processing (ADP), Computer Sciences Corporation, Continuum, PMSC, or similar vendor.
73. All management studies, analyses and reports or "Blue Books" or any other writings, tapes or communications by Frost & Sullivan, Bain & Company, McKinsey & Company, CCC, Automated Data Processing (ADP), Computer Sciences Corporation, Continuum, PMSC, or similar vendor which in any way is related to the loss control, severity control, severity reduction, claim cost, loss or severity measurement initiatives referred to in Allstate's Annual Reports to shareholders from 1985 to the present.
74. Annual reports to Shareholders since 1985
75. Annual reports to Insurance Departments since 1985
76. 10K and 10Q Reports to the Securities and Exchange Commission or Internal Revenue Service since 1985 with exhibits and attachments.

77. Executive Salary disclosures to the Nebraska and New York Insurance Departments since 1985
78. Documents to illustrate the number of Allstate employees participating in the company's "profit-sharing" plan.
79. Identity of any "secret" settlements since 1990.
80. Allstate secrecy or confidentiality agreements for use since 1990.
81. Manuals, guidelines or instructions for enforcing secret settlements and confidentiality agreements.
82. All Customer Satisfaction Survey results since 1990
83. CCPR Telephone surveys
84. CCPR closed file surveys
85. Claimant Focus Group Videos: Attorney Section, Contact
86. All versions of Claim Core Process Redesign Training Manuals since 1990.
87. Allstate's file on International Executive Technology, Inc. or similar or related companies.
88. Allstate's investigation file on allegations that it was influenced by or affiliated with the Church of Scientology or International Executive Technology, Inc.
89. Allstate's file on Donald Pearson, International Executive Technology, Inc., or any person or organization affiliated with Mr. Pearson.
90. Any documents in Allstate's possession, including depositions and legal analyses, dealing with Mr. Pearson, International Executive Technology, Inc., his training company, or Allstate's personnel who attended or saw Scientology-related training material or material by International Executive Technology, Inc.
91. Quality Control or Audit guidelines, manuals, organization charts or rosters.
92. Any guidelines and manuals that deal with boycotting, price-fixing, anti-trust compliance, the McCarren-Ferguson Act, and unification of techniques among purported competitors.
93. Complete files on all cases since 1985 where any of the behaviors set forth above in Request No. 92 have been complained about.
94. Notice and correspondence of any governmental or regulatory action such as Show Cause, Cease & Desist, Market Conduct Exam, Bar Association complaint pending since 1990.
95. SAR (Statistics and Research) training, manuals, guidelines, menu, applications, and user instructions.
96. Management Information System and SAR training and use materials.
97. Management Seminars and Workshops – Instructor Guides, Materials, Work papers, displays, summaries, and exhibits since 1990.
98. All Basic claim training course materials not produced in response to other requests hereinabove.
99. All Intermediate claim training course materials not produced in response to other requests hereinabove
100. All Advanced claim training materials not produced in response to other requests hereinabove
101. SIU training materials of every level
102. MIST (Minor Impact, Soft Tissue) training materials at every level and of every type.
103. Goal Attainment training material for claim department employees and managers at every level

104. Effective Measurement for Outflows or Outcomes training for claim department employees and managers at every level
105. *Management By Statistics* training for claims department employees.
106. '*Town meeting*' summaries since 1990 (Note: *Town meeting* is Allstate's term for internal gatherings for the purpose of employees conferring with timely events with management.
107. All "*Executive Newswire*" communications since 1990
108. All CD-ROM training materials for claims handlers since 1990.
109. All *Strategic Leadership Seminar* materials since 1990
110. All *Transition to Management* course materials since 1990
111. All *Leadership in Action* course materials since 1990
112. All *Managing the Business* course materials since 1990
113. All *Financial Overview* course materials since 1990
114. All Corrective Action Committee Memoranda
115. All Monthly Debrief Reports for the Albuquerque MCO
116. All CCPR Tracking Reports since 1993 for any geographic area or region
117. All C170 series and C180 series reports, including C186 reports for any geographic area or region
118. All Documents Allstate believes are relevant to show the company's motives for the development of its systems, their redesign, and implementation.
SECTION III – EVIDENCE OF THE RESULTS OF IMPLEMENTATION OF WRONGFUL CLAIM PRACTICES
119. All documents which illustrate the number of Allstate employees participating in the company's "profit-sharing" plan.
120. All documents which illustrate the number of Allstate *claim handling and supervisory* employees participating in the company's "profit-sharing" plan.
121. All documents dealing with Allstate's Performance Bonus Plan for P-CCSO employees.
122. Any document dealing with incentives for claim handlers, performance-based compensation in claims, performance enhancement techniques, or similar influences for salary increase or promotional consideration.
123. All reports of the Audit Committee of Allstate's Board of Directors since 1985.
124. All Compliance programs and reports to the Board of Directors since 1985
125. All internal audit reports relating to any class action litigation involving Allstate since 1985
126. All internal audit reports about Northridge Earthquake claims and the aftermath up to and including the resignation of the California Insurance Commissioner for allegedly entering highly questionable financial transactions with Allstate and other insurers.
127. All internal audit reports about aftermarket parts litigation which includes allegations of fraud in the use of other than OEM (Original Equipment Manufacturer) parts.
128. All internal audit reports about Allstate's use of the *Customer Service Pledge*, the *Quality Service Pledge*, and any similar program.
129. All internal audit reports since 1985 about claims that Allstate engaged in unauthorized practice of law.
130. All internal audit reports about litigation against the company and its effect of the

company's financial well-being.
131. Roster of the Corporate Internal Audit Department.
132. The report of the independent consultant hired by Allstate to review Allstate's catastrophe handling as required by a settlement of the Northridge Earthquake class action.
133. Evidence of Allstate's establishment of a charitable foundation for consumer protection and education as required by a settlement of the Northridge Earthquake class action.
134. Any and all reports and correspondence of any sort to any insurer of Allstate's Director's and Officer's liability since 1990.
135. All evidence of communications within Allstate's claim organization following and pertaining to news reports in Smart Money, Forbes, Wall Street Journal, 60 Minutes, 20/20, KING-TV in Seattle, NBC Dateline, or other media attempts to report on the company's claim practices.
136. All evidence of communications within Allstate's claim organization following and pertaining to verdicts or settlements in *Cassim v. Allstate (CA), Coffey v. Allstate (TX), Campbell v. State Farm (UT), Robinson v. State Farm (ID), Nordhoff Townhomes v. Truck Insurance (CA), Martinez v. Allstate (NM), Frimodig v. Allstate (MT), Jackson v. Allstate*

June 12, 1995

QUESTIONS & ANSWERS FROM DCS CONFERENCE
JUNE 5-9, 1995

1. *Is it safe to assume no CORs until ACE project concluded?*

   Yes. The ACE follow-up activities may take the place of traditional CORs.

2. *Who is the ACE manager?*

   Region decides who the ACE manager will be. DCSs, PD superintendents, CLC, claim representatives, management--all may serve.

3. *At what point do we phase out McKinsey group?*

   Phase out after Florida and Missouri.

4. *Does team stay the same over the 18 months to two years?*

   Manager, DCS, and superintendent full 18 months to two years. Others, seven months or so.

5. *What happens to ACE team members after two years?*

   In previous processes, the primary team have typically been promoted or reutilized within the region.

6. *As a region prepares, what out-of-region training is needed?*

   DCS and superintendent may have many months commitment.

7. *Have we found any situations where we are paying too little?*

   Some, usually isolated, except R-1.

8. *Is ACE done on regional or divisional basis?*

   Region study. Results broken down to division level.

9. *Does team stay in region more, move around region?*

CONFIDENTIAL
Subject to
Protective Order

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

SCOTT DOAN,

Plaintiff,

Case No.: 07-13957
Hon. John Corbett O'Meara
Mag. Paul J. Komives

v

ALLSTATE INSURANCE COMPANY,

Defendant.

PAUL A. ZEBROWSKI (P44427)

THOMAS A. BISCUP (P40380)

Attorneys for Plaintiff

45581 Village Blvd.

Shelby Twp., MI 48315

(586) 566-7266

DONALD C. BROWNELL (P48848)

VANDEVEER GARZIA, P.C.

Attorney for Defendant

1450 W. Long Lake Rd., Ste. 100

Troy, MI 48098-6330

(248) 312-2800

PLAINTIFF'S FIRST REQUEST FOR PRODUCTION OF DOCUMENTS TO DEFENDANT ALLSTATE INSURANCE COMPANY, DATED FEBRUARY 11, 2008

NOW COMES Plaintiff by and through his attorneys, Law Offices of Paul Zebrowski & Associates, and hereby submits the following First Request for Production of Documents to Defendant, Dated February 11, 2008, pursuant to Rule 34 the Federal Rules of Civil Procedure:

1. Produce an entire copy of Plaintiff's claim file, including but not limited to: the entire adjusters log and/or claim notes of any and all claims adjusters and/or any and all other representatives on behalf of Defendant, the Claims Portfolio, HUB, LRS screens, CDS screens, and ADS screens.

2. Produce a copy of any and all policies and procedures which Defendant, through its employees, agents, assigns and/or adjusters rely upon in the evaluation and determination of payment or non-payment of Plaintiff's benefits.

3. Produce a copy of any and all reports, correspondence or written documentation of any kind sent to or received from the Michigan Catastrophic Claims Association regarding Plaintiff's first party No-Fault claim.

4. Produce the entire and complete "certified copy" of the Plaintiff's insurance policy which was in effect for personal injury protection benefits on the date of this accident including any endorsements and amendments to said policy.

5. Produce a hard copy of any and all e-mails as well as any and all written reports, correspondence or written documents sent between adjusters, representatives, personnel or any other individual whoever participated in any way in handling the claim of Plaintiff.

6. Produce a copy of any and all documents showing the original reserve set on this matter along with any and all changes made (pertaining to Plaintiff) and adjustments made to date.

7. Produce a copy of any and all documentation, manuals, policies, procedures, or any other materials Defendant relied upon in order to make a determination as to what bills of Plaintiff's would be reasonable and necessary and which ones fall outside the area of reasonable and necessary or customary charges.

8. Produce a copy of the payment ledger relative to this claim from the date of the accident to the present.

9. Produce a copy of any and all No-Fault Manuals and/or policies and procedures which apply to Michigan No-Fault claim handling, originating from or used by Allstate Insurance Company.

10. Produce a copy of any and all documents reflecting the claim handlers' roles in handling injury or medical claims with respect to first party no-fault benefits and Defendant, Allstate's contractual obligations to its insureds.

11. Produce a copy of any and all documents reflecting the steps the claims handler must go through in order obtain information from one of Allstate's insured's treating physician(s).

12. Produce a copy of any and all reports, notes, memorandum, correspondence, video tapes, a duplicate of any DVD's, VHS tapes, mini-dv's, duplicates of any still pictures including but not limited to any digital pictures, 35 mm, and the like as it relates to any surveillance of the Plaintiff and/or Plaintiff's family conducted by the Defendant at any time before, during, and after the pendency of Plaintiff's claim with Defendant.

13. Produce a copy of any and all documents or any other tangible evidence which would support Allstate's position that Scott Doan would be entitled to anything less than the reasonable market rate charged by an agency for attendant care/nursing care services.

14. Produce a copy of any and all memos, emails, directives, workshops, modules, meeting notes, pamphlets, seminars, or any other written documentation or tangible evidence including any and all electronic evidence which addresses attendant care services describing the manner in which Allstate adjusters are to handle attendant care claims.

15. Produce a copy of *Guiding Principles for Customer Care.*

16. Produce a copy of *Allstate Best Practices Guide: Identifying and Handling Potentially Fraudulent First Party Casualty Claims.*

17. Produce a copy of the *Claim Policy, Practices, and Procedure Manuals (CPPP Manual)* on handling claims in general.

18. Produce a copy of the *Claim Policy, Practices, and Procedure Manuals (CPPP Manual)* on handling no-fault claims.

19. Produce a copy of the *CCPR: Claim Core Process Redesign, Implementation*

Training Manual in each of its generations including any and all updates over the years...

20. Produce a copy of the *CCPR II: Claim Core Process Redesign, Implementation Training Manual* in each of its generations including any and all updates over the years.

21. Produce a copy of Allstate's *"Quality Service Pledge"* in every generation in which it exists.

22. Produce a copy of the *Medical Management (MBRS) Reference Guide.*

23. Produce a copy of the *Allstate Code of Ethics.*

24. Produce a copy of the *Allstate Code of Ethics Manual.*

25. Produce a copy of the *Allstate Code of Ethics Manual II.*

26. Produce a copy of the Performance Development Summaries ("PDS") for each of the following employees who have been assigned to handle Mr. Doan's' Allstate claim:

27. Produce a copy of the Skills Management System ("SMS") for each of the following employees who have been assigned to handle Mr. Doan's' Allstate claim:

28. Produce a copy of all "Allstate Now" from 1995 through the present.

29. Produce a copy of Allstate's "Quality Service Pledge".

30. Produce Allstate's P-CCSO 1997 "Guide to Recognition", "Demonstrating the Difference".

31. Produce a copy of the ----------, Michigan MCO Goals.

32. Produce a copy of Allstate's "Acclaim" from 1995 through the present.

33. Produce a copy of Allstate's "Moment of Truth" ("MOT") program and formatted letters.

34. Produce a copy of Allstate's video "Magical Medical Mystery Show".

35. Produce a copy of Allstate's video "Ethics in the P-CCSO Workplace".

36. Produce a copy of Allstate's video "Role of the Plaintiff Attorney".

37. Produce a copy of each specific document Allstate is relying upon in their decision to withhold benefit payments from Mr. Doan.

38. Produce a copy of all Allstate documents reflecting the utilization of MBRS on Mr. Doan's Allstate claim.

39. Produce a copy of Allstate's "Auto Policy Manual I".

40. Produce a copy of Allstate's "Casualty Hub Training" Manual.

41. Produce a copy of Allstate's "Expert Consultant Reference Catalog".

42. Produce a copy of Allstate's Guiding Principles for Customer Care and Satisfaction".

43. Produce a copy of Allstate's "Medical Bill Review System Users' Manual".

44. Produce a copy of Allstate's "Operation Manual".

45. Produce a copy of Allstate's "SAR/Claims a la Carte Instructions/Manual.

46. Produce a copy of Allstate's "LRS Manual".

47. Produce a copy of Allstate's "Best Practices Guides".

48. Produce a copy of Allstate's documentation of "Loss or Severity Control Initiatives".

49. Produce a copy of Allstate's "SIU Casualty Best Practices Guide".

50. Produce a copy of Allstate's "Unit Meeting Guides".

51. Produce a copy of Allstate's "Claim Management Education Series".

52. Produce a copy of Allstate's "Quarterly Leadership Measurement System".

53. Produce a copy of all documents pertaining to Allstate's "Upper Communication Process" Guidelines and use Manuals.

54. Produce a copy of all documents pertaining to Allstate's "Claim Bulletins" since 1995.

55. Produce a copy of all documents pertaining to Allstate's "P-CCSO National Claim Training Center" index or catalog of training courses including all audio/visual materials.

56. Produce a copy of all documents pertaining to Allstate's "Negotiation Skills" and/or "Negotiation Strategies".

57. Produce a copy of all Allstate's depositions of Home Office level employees since 1995.

58. Produce a copy of all Allstate's depositions of any employees which involve the "Claim Core Process Redesign" since 1995.

59. Produce a copy of all Allstate's 10k and 10Q Reports to the Securities and Exchange Commission or Internal Revenue Service since 1995 with exhibits and attachments.

60. Produce a copy of all Allstate's "Profit and Sharing" program.

61. Produce a copy of all Allstate's "SIU" training materials.

62. Produce a copy of all Allstate's "Basic Claim Training Course".

63. Produce a copy of all Allstate's "Tech Core" Training Manuals.

64. Produce a copy of all Allstate's "Management By Statistics" Training Manuals for claims department employees.

65. Produce a copy of all Allstate's "Executive Newswire" since 1995.

66. Produce a copy of all Allstate's "Strategic leadership Seminar" materials since 1995.

67. Produce a copy of all Allstate's "Leadership in Action" course materials since 1995.

68. Produce a copy of all Allstate's "Managing the Business" course materials since 1995.

69. Produce a copy of all Allstate's "Financial Overview" course materials since 1995.

70. Produce a copy of all Allstate's "CCPR Tracking Reports" for Michigan since 1995.

71. Produce a copy of all Allstate's "Performance Bonus Plan"

72. Produce a copy of all Allstate's "Customer Service Pledge" and "Quality Service Pledge"

73. Produce a copy of any and all job descriptions of each position held by each individual who has ever had any contact, input, or has been involved in the handling of Plaintiff's claim.

74. Produce a copy of the personnel file(s) of each and every adjusters, supervisors, and any other employee that had any dealings whatsoever with Plaintiff's claim. (When producing the personnel file(s), personal information may be redacted, i.e., social security number, home address, any second home address, name of spouse and any children.)

Respectfully submitted,

Paul A. Zebrowski (P44427)
Thomas A. Biscup (P40380)

Attorneys for Plaintiff
45581 Village Blvd.
Shelby Twp., MI 48315
(586) 566-7266

Dated: February 11, 2008

CERTIFICATE OF SERVICE

I hereby certify that, on February 11, 2008 a copy of the foregoing Plaintiff's First Request for Production of Documents to Defendant, Dated February 11, 2008 by first class mail via United State Postal Service to:

Donald C. Brownell
1450 W. Long Lake Rd., Ste. 100
Troy, MI 48098-6330

_____
Lisa Chambers

EDELSTEIN & STEINBERG, LLP
BY: MICHAEL R. LOGUE, ESQUIRE
Identification No.: 75675
230 South Broad Street, Suite 900
Philadelphia, PA 19102
(215)893-9311
E&S File No. 130.060

Attorney for Defendants,

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY AND STATE FARM FIRE AND CASUALTY COMPANY V. ROBERT J. CAVOTO, JR., FISHBONE ADVERTISING, INC. CAVOTO CHIROPRACTORS, P.C., MARGARET FISHER-CATRAMBONE, PENN CENTER PAIN MANAGEMENT, INC., TIPROF, INC. AND INTERNATIONAL HEALTH ALLIANCE, INC.	COURT OF COMMON PLEAS DELAWARE COUNTY CIVIL ACTION NO. 05-10716

MOTION FOR SANCTIONS

Defendants, by and through their undersigned counsel, bring this Motion for Sanctions as follows:

FACTUAL/PROCEDURAL BACKGROUND

1. Plaintiffs have brought this lawsuit against the Defendants, under the guise of seeking declaratory relief from this Court. Attached for the Court's convenience and ease of reference is a copy of Plaintiffs' Amended Complaint. (Exhibit "A")

2. Although the Plaintiffs have paid, and continue to pay, first party claims for medical benefits that are submitted to them by the Defendants, they contend that they should be relieved of their statutory and contractual obligations to do so as a result of the Defendants' alleged unlawful conduct. (Exhibit "A")

3. Plaintiffs additionally seek an award of an money damages from the Defendants, although the Plaintiffs have **never** specified the amount of damages to which

they claim to be entitled. (Exhibit "A")

4. Defendants deny that their conduct is or has ever been unlawful, and to that end, have filed with this Court's express permission an Amended Answer with New Matter and Counterclaim, a copy of which is attached for ease of reference as Exhibit "B" hereto.

5. Importantly, Defendants have pleaded in their New Matter affirmative defenses, as well as in their Counterclaim, that this lawsuit has been brought by the Plaintiffs for bad faith and unlawful purposes. Specifically, that Plaintiffs have brought and are utilizing this lawsuit as a pretext to evade their statutory and contractual obligations to make payments on the claims that are submitted to them by the Defendants. (Exhibit "B")

6. Defendants in short have pleaded that Plaintiffs have brought this lawsuit for improper purposes, rather than to obtain the relief that the Plaintiffs purportedly seek. (Exhibit "B")

PLAINTIFFS' REFUSAL TO PRODUCE MEANINGFUL DISCOVERY

7. Although the Defendants have served interrogatories, as well as a formal document request, upon the Plaintiffs, and have supplemented their formal document request with several supplemental requests, Plaintiffs have refused to produce any meaningful discovery to date. To the contrary, Plaintiffs have invariably refused to produce any discovery whatsoever, on the grounds that the discovery sought is not relevant, or otherwise objectionable. This is evidenced by the documents that are attached as Exhibit "C" hereto, which include Plaintiffs' answers to Defendants' Second Supplemental Request for Production of Documents, wherein Plaintiffs object to every single document Request. By way of further information, Plaintiffs are refusing to answer the informal document requests that Defendants recently served, on the theory that Defendants are precluded from informally supplementing their formal discovery requests. Defendants anticipate that a separate Motion will be filed to address Plaintiffs' refusal to answer

their informal document requests.

8. To date, the only "discovery" of any **potential** substance that has been produced by the Plaintiffs has been the deposition testimony of State Farm representative Austin Bowles, who verified Plaintiffs' Amended Complaint. (Exhibit "A")

9. Mr. Bowles in reality knew nothing about this case at the time he took his verification, as evidenced by the following exchange which took place at his deposition:

> Q: Who knows the basis for the factual allegations in [Plaintiffs'] Amended Complaint?
>
> A: I don't know.
>
> (Deposition of Austin Bowles, p. 67, lines 13-18)

10. Since the undersigned's law firm assumed the representation of all Defendants in June of last year, the Plaintiffs have produced absolutely **no** documents in response to Defendants' discovery requests.

DISCOVERY ORDERS ENTERED AGAINST THE PLAINTIFFS

10. To insure that they are adequately prepared for trial, as well as to level the playing field with regard to discovery, Defendants moved to compel certain documents from the Plaintiffs that are critical to Defendants' affirmative defenses and Counterclaim. Additionally, Defendants requested that the Plaintiffs be ordered to produce certain State Farm representatives for deposition. Upon reviewing Defendants' Motion to Compel, as well as Plaintiffs' opposition to same, this Court granted Defendants' Motion by Order dated September 28, 2007. A copy of said Order is attached as Exhibit "D" hereto.

11. Rather than comply with this Court's Order, Plaintiffs moved for reconsideration of same. After having reconsidered its Order of 9/28/07, this Court denied Plaintiffs' Motion by Order

dated January 14, 2008. (Exhibit "E")

12. On several occasions defense counsel has written to Plaintiffs' counsel to inquire as to whether Plaintiffs intend to comply with this Court's Orders of 9/28/07 and 1/14/08. (Exhibit "F")

13. Additionally, the undersigned spoke with Mr. Castagna on or about January 16, 2008, during which conversation he posed the same question.

14. Despite this, Plaintiffs have refused to **definitively** state that they will comply with their Court-ordered discovery obligations. To the contrary, on January 29, 2008, that is, two weeks **after** the entry of this Court's Order of 1/14/08, Plaintiffs' counsel wrote to Jay Edelstein, Esquire, of the undersigned's office the following letter, a copy of which is attached as Exhibit "G" to this Motion:

Dear Mr. Edelstein:

Please note that Plaintiffs are **attempting, to the extent they are able**, to comply with the Court's Order and **any responsive, non-privileged documents that will be produced will be done** so only under the protection of a strict Confidentiality Agreement entered by the Court.

I ask that you confirm your willingness to enter into such an agreement in writing. At that time, we will endeavor, to draft an appropriate agreement for your review.

I look forward to hearing from you in the very near future.

Very truly yours,

Cy Goldberg

(Emphasis added)

15. In a subsequent telephone conversation with Mr. Edelstein, Plaintiffs' counsel reiterated his "demand" for a confidentiality agreement, despite the fact that Defendants are under no obligation to enter into one. Moreover, neither the Order of 9/28/07 nor the Order of 1/14/08 state that Plaintiffs are entitled to a confidentiality agreement. Mr. Edelstein has nevertheless agreed to review, but not be bound by, any proposed confidentiality agreement that Plaintiffs' counsel prepares.

14. As of the time that this Motion was filed and served, defense counsel has not received a proposed confidentiality agreement from Plaintiffs' counsel.

COURT-IMPOSED DEADLINES AND URGENCY OF DISCOVERY SOUGHT

15. At the present time, the Court-imposed discovery cut-off date is April 1, 2008.

16. At the present time, trial in this matter is scheduled for September 2, 2008. This is a firm date.

17. Although time runs critically short with regard to completing discovery, Plaintiffs have yet to produce **a single document** in response to this Court's Orders of 9/28/07 and 1/14/08.

18. Moreover, although Plaintiffs' counsel has contacted the undersigned for the purpose of scheduling the depositions of State Farm representatives, defense counsel is at a loss as to which representatives should be deposed, inasmuch as Plaintiffs have produced no discovery which might shed light on who at State Farm is a decision-maker with regard to the Defendants and/or this case.

19. Based on Plaintiffs' conduct to date in this case, as well as in cases involving similar subject matter from other jurisdictions, Defendants have no confidence that Plaintiffs intend to comply with this Court's Orders.

20. This Court may take judicial notice that in a written opinion from the United States

District Court for the Eastern District of Michigan, that Court upheld Orders for sanctions against State Farm Automobile Insurance Company, one of the Plaintiffs in this case. A copy of the Court's decision in the *Van Eamon v. State Farm* matter, Docket No. 5-CV-72638, is attached as Exhibit "H" hereto.

21. In that case, as in this one, Plaintiffs sought discovery of documents relating to State Farm's "Advancing Claims Excellence" (ACE) program, which according to the Van Eamons, provides State Farm employees with "strong incentives for the deliberate or negligent underpayment of claims", for the purpose of obtaining "huge savings in claims costs." (Exhibit "H", p. 3)

22. In finding that the ACE documents were discoverable, the Magistrate Judge held that the Van Eamons were entitled to obtain them, in view of their potential relevance and application to the claims that were in dispute. (Exhibit "H", pp.3-4)

23. Although State Farm moved for reconsideration of the Magistrate's Order, on October 18, 2007, the Magistrate Judge affirmed that the ACE documents must be produced. Subsequently, State Farm violated that Order by refusing to produce the ACE documents. (Exhibit "H", p.4)

24. In his Order of 10/18/07, the Magistrate Judge sanctioned State Farm for failing to produce various documents that it had been under an obligation to produce since 2006. (Exhibit "H", pp.8-10)

25. The Court in *Van Eamon* notes that the Magistrate Judge expressed "frustration" with State Farm's discovery tactics, as a result of which he convened a hearing "in order to save my own sanity - as much as anything else in this case." (Exhibit "H", p.9)

26. In upholding the sanctions against State Farm, the *Van Eamon* Court initially cited to NHL v. Met. Hockey Club, Inc., 427 U.S. 639, in which the United States Supreme Court upheld

a dismissal of the Complaint due to Plaintiff's "bad faith" refusal to comply with Court-ordered discovery obligations. (Exhibit "H", p.10)

27. The *Van Eamon* Court then noted that State Farm had violated a three separate discovery Orders:

> The same could be said in the instant case. Defendant refused to produce documents despite three court orders requiring it to do so ... **If this Court declined to uphold the discovery sanctions imposed by Magistrate Judge Scheer, it would be giving State Farm a license to withhold responsive documents without fear of reprisal. State Farm cannot claim that its conduct was not "willful" when it ignored three orders of the Court to produce specific documents ...**
>
> (Exhibit "H", pp.11-12) (Emphasis added)

28. The Plaintiff complained in *Van Eamon* that State Farm's repeated violations of the Court's Orders had hampered her preparations for trial and unfairly prejudiced her. (Exhibit "H", p.12)

29. Unfortunately, the Defendants in this case find themselves in the exact same predicament, as it is now February 2008 and Plaintiffs have yet to provide **any** of the discovery that they are under a Court Order to produce.

30. With the discovery end date (4/1/08) and trial date (9/2/08) fast approaching, Defendants could very well find themselves irreparably prejudiced in their preparations for trial, unless **meaningful** sanctions are immediately imposed upon the Plaintiffs for their failure to abide by their Court-ordered discovery obligations.

31. In this case, Plaintiffs are both multi-billion dollar insurance companies, as evidenced by the marketing materials that they post on State Farm's website, a sample of which is attached as Exhibit "I" hereto ("Fast Facts about State Farm"). This Court may take notice that State Farm boasts on its website of having over 76 **million** policyholders in this country and Canada.

32. Clearly, a lump sum monetary sanction of a few hundred or even a few thousand dollars will not deter the Plaintiffs in any way.

33. To insure that this Court's authority is not flouted, and that the Defendants will not be unfairly prejudiced in their trial preparations, it is respectfully submitted that the following **meaningful sanctions** be imposed until such time as Plaintiffs purge themselves of contempt:

a. Monetary sanctions of $1,000.00 per day to be paid to the Defendants for each day the Plaintiffs are in contempt of Court;

b. A counsel fee of $1,500.00, to be paid by the Plaintiffs to defense counsel as reimbursement for the cost of preparing and filing this Motion;

c. In the event the Plaintiffs remain in violation of this Court's discovery Orders for more than ten (10) days following the entry of an Order for Sanctions, this Court will impose additional sanctions upon further Motion by the Defendants.

34. A proposed form of Order is attached hereto.

WHEREFORE, Defendants respectfully request that their Motion for Sanctions be granted.

RESPECTFULLY SUBMITTED,

EDELSTEIN & STEINBERG, LLP

BY: _____
MICHAEL R. LOGUE, ESQUIRE
ATTORNEY FOR DEFENDANTS

DATE: _____

EDELSTEIN & STEINBERG, LLP
BY: MICHAEL R. LOGUE, ESQUIRE
Identification No.: 75675
230 South Broad Street, Suite 900
Philadelphia, PA 19102
(215)893-9311
E&S File No. 130.060

Attorney for Defendants

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY AND STATE FARM FIRE AND CASUALTY COMPANY V. ROBERT J. CAVOTO, JR., FISHBONE ADVERTISING, INC. CAVOTO CHIROPRACTORS, P.C., MARGARET FISHER-CATRAMBONE, PENN CENTER PAIN MANAGEMENT, INC., TIPROF, INC. AND INTERNATIONAL HEALTH ALLIANCE, INC.	COURT OF COMMON PLEAS DELAWARE COUNTY CIVIL ACTION NO. 05-10716

MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR SANCTIONS

Pa.R.C.P. 4019 states in relevant part as follows:

(a)(1) The Court may, on motion, make an appropriate order if:

* * *

(viii) a party or person ... fails to make discovery **or to obey an order of court respecting discovery**.

(Emphasis added)

Sub-section (c) of Rule 4019 goes on to state that:

The Court, when acting under subdivision (a) of this rule, may make:

* * *

(2) an order refusing to allow the disobedient party to support or oppose designated claims or defenses, or prohibiting such party from introducing in evidence designated documents, things or testimony, ...;

(3) an order striking out pleadings or parts thereof, or staying further proceedings until the order is obeyed, or entering a judgment of non pros or by default against the disobedient party ...;

(4) an order imposing punishment for contempt ...;

(5) such order with regard to the failure to make discovery as is just.

Likewise, sub-section (g)(1) of Rule 4019 authorizes the Court to impose sanctions as

follows:

> Except as otherwise provided in these rules, if following the refusal, objection or failure of a party or person to comply with any provision of this chapter, the court, after opportunity for hearing, enters an order compelling compliance and the order is not obeyed, the court on a subsequent motion for sanctions may, if the motion is granted, require the party ... whose conduct necessitated the motions or the party or attorney advising such conduct or both of them to pay to the moving party the reasonable expenses, including attorney's fees, incurred in obtaining the order of compliance and the order of sanctions, unless the court finds that the opposition to the motion was substantially justified or that other circumstances make an award of expenses just.

Respectfully, an award of sanctions against the Plaintiffs is amply justified in this case, as they have offered nothing more than a vague assurance that they **might** comply with this Court's discovery Orders, but **only if** the Defendants agree to the entry of a "strict" confidentiality agreement. Despite the fact that the Plaintiffs did not ask for, and this Court did not enter, a confidentiality order, defense counsel nevertheless agreed as a professional courtesy to review any confidentiality proposals submitted by the Plaintiffs.

Importantly, as of the date of this Motion's filing, Plaintiffs' counsel has not submitted a proposed agreement for defense counsel's review, despite his representation that he would do so. The only logical conclusion that may be drawn from this omission is that Plaintiffs' counsel and his clients are attempting to lull the Defendants into inaction by falsely representing that they will attempt to comply with this Court's Orders. Actions speak louder than words, however, and in this case, Plaintiffs have made **no** attempt to fulfill their discovery obligations. That is to say, they have produced none of the documents that this Court has ordered them to supply to the Defendants, although more than three weeks have passed since the entry of the Court's Order of January 14th. Under these circumstances, sanctions are unquestionably warranted.

In view of the fact that sanctions are warranted in accordance with Rule 4019, the only

remaining question is what type of sanctions are to be imposed. Unfortunately, Defendants have no confidence that the Plaintiffs will comply with the Orders of this Court, in view of their conduct to date, which includes a refusal to supply any discovery of meaningful substance. Furthermore, the Plaintiffs have a documented history of refusing to supply Court-Ordered discovery, as witnessed by their conduct in *Van Eamon*. Significantly, State Farm was sanctioned in *Van Eamon* for having disobeyed **three** separate Court Orders concerning discovery. While that matter was venued in federal court and involved questions of Michigan law, it is nevertheless illustrative of the discovery tactics that the Plaintiffs employ. Defendants anticipate a similar response from the Plaintiffs here.

To prevent this from happening, this Court must impose sanctions that will have a **meaningful** effect upon the Plaintiffs. That is to say, the sanctions must be of such severity that they will deter the Plaintiffs from persisting in their refusal to abide by this Court's Orders. It is respectfully suggested that the sanctions requested herein are entirely appropriate, in view of Plaintiffs' conduct, as well as their financial status as multi-billion dollar insurance companies. Unfortunately, sanctions of a less harsh nature will have no deterrent effect, as the Plaintiffs will easily be easily to absorb them as a so-called "business cost."

Based on the foregoing, it is respectfully asked that Defendants' Motion for Sanctions be granted. A proposed form of Order is attached hereto.

WHEREFORE, Defendants respectfully request that their Motion for Sanctions be granted.

RESPECTFULLY SUBMITTED,

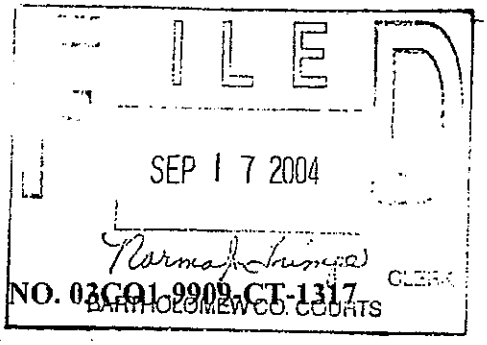
EDELSTEIN & STEINBERG, LLP

BY: _____
MICHAEL R. LOGUE, ESQUIRE
ATTORNEY FOR DEFENDANTS

DATE: _____

IN THE BARTHOLOMEW CIRCUIT COURT

STATE OF INDIANA



TIM L. SCROGHAN,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	**CAUSE NO. 03C01-9909-CT-1317**
	)	
MICHELLE R. WADE and	)	
ALLSTATE INSURANCE COMPANY,	)	
	)	
Defendants.	)	

ORDER
RELATIVE TO PLAINTIFF'S MOTION FOR SANCTIONS
FILED JANUARY 14, 2004
(NOTEBOOK 18)
(PLAINTIFF'S SUBMISSION)

Comes now the Court, having reviewed Plaintiff's Motion for Sanctions, Allstate's reply thereto, and having reviewed the findings and recommendations of the Special Master, now finds the following:

1. On January 31, 2002, the Plaintiff, by counsel, served Defendant, Allstate Insurance Company, with his first Request For Production. Among the documents requested were the entire paper and electronic claim files (RFP 1, 12, 13, 16 & 38); all documents relating to computer programs utilized by Allstate in evaluating/processing Plaintiff's claims including, but not limited to, Colossus/CSC, ADP and MBRS documents (RFP 30); all documents relating/evidencing Allstate's design to control claim costs, e.g. McKinsey & Company documents (RFP 21); all documents pertaining to employment compensation information on the

Allstate adjusters and supervisors handling of Plaintiff's claims, including Performance Development Summaries ("PDS") (RFP 14); all salary/compensation and personnel manuals/documents relating to performance and compensation (RFP 15); all training materials including manuals (RFP 22); all publications and newsletters (RFP 24); all organizational documents (RFP 32); all documents pertaining to archives and records storage/retention (RFP 35); all documents relating to prior bad faith claims and lawsuits filed against Allstate in Indiana from 1994-97 (RFP 6); and all documents pertaining to prior depositions and affidavits in bad faith litigation against Allstate in Indiana from 1994-97 (RFP 43).

2. Prior to responding to said discovery, Allstate moved for a protective order claiming that all documents requested were proprietary, trade secret and/or confidential.

3. On April 23, 2002, this Court denied Allstate's Request for Protective Order.

4. On May 6, 2002, Allstate responded to the aforementioned discovery requests. Allstate alleged that it had produced its entire claim file but for all privileged documents listed in its Document & Privilege Log. Allstate objected to the production of all the other aforementioned requests on the basis of relevancy.

5. On July 5, 2002, Scroghan moved to compel the production of all of the documents responsive to the aforementioned requests.

6. On February 18, 2003, this Court conducted a hearing regarding Plaintiff's Motion To Compel. At said hearing, this Court warned that it "would start giving sanctions" for discovery abuses.

7. On February 26, 2003, this Court entered its "Order Regarding Scroghan's Motion To Compel Discovery which was filed on July 31, 2002." This Court found: "It is apparent from

a review of this matter that Allstate has been stonewalling Scroghan as it relates to the production of documents requested." This Court further found that Allstate had not produced the entire claim file as alleged.

8. This Court's discovery order compelled Allstate to produce all of the aforementioned documents by March 15, 2003 (RFP 30); April 1, 2003 (RFP 14, 15, 21, 22, 24, 32 & 35); and May 15, 2003 (RFP 6 and 43), respectively. This Court limited the scope of the documents to be produced pursuant to RFP 6 & 43 for uninsured motorist claims/lawsuits in Indiana alleging bad faith against Allstate from 1994-1997.

9. On March 27, 2003 this Court denied Allstate's motion to reconsider its request for a protective order.

10. On April 2, 2003 this Court denied Allstate's certification for an interlocutory appeal pursuant to Indiana Appellate Rule 14(B).

11. Allstate intentionally refused to produce all of the aforementioned documents on the dates compelled by this Court.

a) With respect to all documents responsive to RFP 30, i.e. computer programs utilized by Allstate, including, but not limited to Colossus/CSC, ADP & MBRS documents, Allstate failed to produce any documents responsive to said request from March 17, 2003 to date.

b) With respect to all documents responsive to RFP 21, including all documents relating/evidencing Allstate's design to control claim costs, e.g. McKinsey & Company Documents, Allstate claimed, after a diligent search and reasonable inquiry, Allstate had no documents responsive to said request. Allstate made such an assertion after the Trial Court compelled the production of said documents and after having sought and been denied a protective order for the very same McKinsey documents based upon their value to Allstate for redefining the game of claims adjusting/processing for Allstate, thereby conceding the relevancy and discoverability of said documents. Finally, on June 11, 2003, Allstate filed its Response To Plaintiff's Motion For Sanctions acknowledging that the Trial Court ordered Allstate to produce "cost control" documents generated by McKinsey & Company in its February 26, 2003 Discovery Order. To date, Allstate has failed to produce any documents responsive to RFP 21.

c) With respect to RFP 14, 22 and 35, Allstate claimed either that it had or may have documents responsive to each of said requests, but defiantly refused to produce said documents on the following basis:

> Allstate reiterates its objection to the production of these documents based on its position that such production should be made only pursuant to Protective Order. Allstate is currently appealing the Court's denial of its request for a protective order, and as such, Allstate will defer production of such protected documents that it believes should be protected by the request for protective order until it has exhausted all avenues of appeal.

Allstate made no attempt to identify each document so withheld, or identify the nature of the privilege allegedly protecting each such document withheld. *See e.g.* ***Peterson v. U.S. Reduction Co.***, 547 N.E.2d 860, 862 (Ind. App. 1989). More importantly, the Trial Court had previously denied Allstate's Motion for Protective Order regarding these documents on April 23, 2002, and Allstate has failed to produce any of the requested documents. With respect to RFP 22, Allstate has only produced two (2) training manuals to date, a PP&C Manual and P-CCSO Claims Manual, despite evidence that many more training materials exists. (See Plaintiff's Motions to Compel Relating To His Third, Fifth, Sixth and Seventh Requests For Production.)

d) With respect to RFP 15 and 24, Allstate attempted to comply but its production was defective in the following respects:

(a) Request No. 15: Allstate produced two (2) Human Resource Policy Guide manuals, one commencing on Bates-stamped page 02323, and one commencing on Bates-stamped page 02548. With respect to the first manual, pages 2-20, 2-21, 3-18, 3-19, 3-20 and 3-21 were not produced. Pages *i*, 2-15, 2-17, 3-1, 3-13 and 3-14 of the second manual were not produced. Allstate also produced MCM-CDM-Incentive Compensation Plan documents responsive to this request, but omitted Bates-stamped pages 02834 through 02838.

(b) Request No. 24: With respect to Allstate publications, Allstate failed to produce all *CCPR News* and *Allstate Now* publications for the applicable time frame. Also, Allstate failed to produce any *Acclaim* publications for the applicable time frame.

e) With respect to RFP 6 and 43, all documents relating to prior bad faith claims and lawsuits filed in Indiana against Allstate from 1994-97, including employee affidavits and depositions, Allstate has failed to produce any of said documents from May 15, 2003 to date.

12. As Allstate refused to produce the documents on the dates compelled by this Court's Discovery Order, Plaintiff filed additional motions to compel and motions for sanctions

for Allstate's intentional willful and unjustified non-compliance with this Court's Discovery Order. (See Notebooks 5, 9, & 12). (See also paragraph 8 above).

13. On March 27, 2003, Allstate filed a notice of appeal of this Court's discovery order with respect to Requests No. 6 and 43, only. Allstate claimed the right to seek an interlocutory appeal as of right under: 1) Indiana Appellate Rule 14 (A)(1), pertaining to the payment of money; 2) Rule 14(A)(3) dealing with orders compelling the production of certain documents; and/or 3) the holding in ***State v. Hogan***, 582 N.E. 2d 824 (Ind. 1991). Alternatively, Allstate requested the Appellate Court exercise its discretion to entertain an appeal pursuant to Indiana Appellate Rule 66(B).

14. Pursuant to Indiana Appellate Rule 36(B), the Plaintiff moved to dismiss Allstate's appeal based on a lack of jurisdiction.

15. On May 28, 2003, the Appellate Court denied Plaintiff's motion to dismiss appeal. Further, at the request of Allstate, the Appellate Court stayed the entire discovery order entered by this Court on February 26, 2003, even though an appeal was taken on Requests No. 6 & 43, only. Further, the stay was granted only after Allstate had already failed and refused to produce many of the documents as previously compelled by this Court.

16. Subsequently, the Special Master conducted hearings on Notebooks 5, 9, and 12 relative to Allstate's discovery abuses. The Special Master was reluctant to make recommendations and findings and/or enter sanctions due to the Appellate Court stay. However, the Special Master warned that Allstate would face severe sanctions when and if the stay was lifted.

17. Further, the Special Master was reluctant to rule on the discoverability and/or release of *in camera* documents (i.e. Notebook 3 relating to RFP 1, 12, 13, 16 and 38) until the

Appellate Court stay was lifted.

18. On January 8, 2004, the Appellate Court unanimously dismissed Allstate's appeal due to a lack of jurisdiction.

19. On January 14, 2004, Plaintiff filed his Motion For Sanctions herein for Allstate's refusal to comply with this Court's Discovery Order of February 26, 2003. (See also Notebooks 5, 9, & 12).

20. On March 10, 2004, the Appellate Court denied Allstate's Petition for Rehearing.

21. On June 18, 2004, the Indiana Supreme Court unanimously denied Allstate's Petition for Transfer. The Supreme Court further certified the Appellate Court decision. As a matter of law, the Appellate Court stay of the Trial Court's February 26, 2003 Discovery Order was lifted. The Circuit Court of Bartholomew County resumed jurisdiction of this case on July 27, 2004.

22. To date, Allstate has failed to comply with this Court's Discovery Order. Further, on September 2, 2003, Allstate filed its Motion to Reconsider, wherein Allstate stated it will not comply with said Order.

THE COURT NOW FINDS THE FOLLOWING:

(a) Allstate's non-compliance involves requests that were not the subject of its purported appeal. To date, Allstate has failed to produce the compelled documents.

(b) With respect to Allstate's failure and refusal to produce all documents responsive to RFP 30 as compelled by this Court by March 15, 2003; RFP 14, 15, 21, 22, 24 and 35 as compelled by this Court by April 1,2003; and RFP 6 and 43 as compelled by this Court on May 15, 2003; and every day

thereafter:

(1) Allstate's failure and refusal to respond has been willful;

(2) Allstate's failure and refusal to respond has been intentional;

(3) Allstate's failure and refusal to respond has been disobedient;

(4) Allstate's failure and refusal to respond resulted in delay;

(5) Allstate's failure and refusal to respond occurred after this Court had given Allstate additional time to respond;

(6) Allstate's failure and refusal to respond occurred after this Court had forewarned Allstate that discovery abuses would be sanctioned; and

(7) Allstate's failure and refusal to respond constitutes post-suit litigation evidencing Allstate's continuing bad faith pursuant to ***Gooch v. State Farm Mut. Auto. Ins. Co.***, 712 N.E. 2d 38, 41 (Ind. App. 1999), *reh'g denied, trans. denied.*

(c) Defiantly, Allstate has refused to produce to its insured all the documents necessary to prosecute his claim. Allstate has taken such a stance, despite its obligation of good faith and fair dealing owed its insured and prior Court orders to do so.

(d) Indiana law provides that T.R. 37 sanctions serve three (3) discernable purposes. First, they aid in securing compliance with discovery requests and orders. Second, they ensure that a party will not profit from its failure to comply. Finally, they have a general deterrent effect helping to assure future compliance. ***State v. Wilbur***, 471 N.E. 2d 14, 17 (Ind. App. 1984),

reh'g denied [citing ***Cine Forty-Second St. Theatre v. Allied Artists***, (2d Cir. 1979) 602 F 2d 1062, 1066]. (Emphasis added).

(e) Indiana law further provides that the trial court's discretion in the selection of an appropriate sanction is almost without limitation. *See e.g.* ***Nyby v. Waste Management, Inc.***, 725 N.E.2d 905,915 (Ind. App. 2000). Such sanctions include: the imposition of monetary sanctions, fines and/or penalties; the exclusion of evidence, witnesses and/or testimony; the striking of court pleadings and/or defenses; and/or the entry of a default judgment or dismissal.

(f) It is inferred that the documents unlawfully withheld by Allstate in violation of this Court's Discovery Order would have been unfavorable to Allstate's case. *See* ***Cahoon v. Cummins***, 734 N.E. 2d 535, 545 (Ind. 2000).

(g) Allstate's refusal to produce the compelled documents supports the presumption that said refusal "was...but an admission of the want of merit in its asserted defense in this case," i.e. a good faith dispute as to the value of Scroghan's claims. *See e.g.*, ***Bankmark of Florida v. Star Fin. Card***, 679 N.E. 2d 973, 977 (Ind. Ct. App. 1997).

(h) Allstate is the nation's second largest automobile insurer, and Allstate is a seasoned and experienced national litigator. Allstate has repeatedly argued that the cost of partially complying with this Court's discovery order relative to RFP 6 and 43, alone, will cost approximately $12 million. Discovery sanctions must make sure that the offending party will not profit from its actions. It is suggested that Allstate will profit from its willful,

intentional and unjustified non-compliance if sanctioned in an amount less than the cost of compliance. Moreover, Allstate has failed to comply with the entire Discovery Order compelling production even though its purported appeal sought review of RFP 6 and 43, only.

IT IS, THEREFORE, ORDERED, ADJUDGED AND DECREED that Allstate be sanctioned accordingly by this Court pursuant to T.R. 37 for its willful non-compliance with this Court's Discovery Order dated February 26, 2003, relative to:

(a) RFP 30, all documents relating to computer programs used by Allstate, including but not limited to, all Colossus/CSC, ADP and MBRS documents;

(b) RFP 21, all documents relating/evidencing Allstate's design to control claim costs, including, but not limited to, the McKinsey & Company documents;

(c) RFP 14, all documents pertaining to employment compensation information on the Allstate's adjusters and supervisors handling Plaintiff's claims, including, but not limited to, Performance Development Summaries ("PDS");

(d) RFP 22, all training materials, including manuals;

(e) RFP 15, including pages 2-20, 2-21, 3-18, 3-10, 3-20 and 3-21 of the Human Resource Policy Guide Manual beginning on Bates-stamped page 02323, pages i, 2-15, 2-17, 3-1, 3-13 and 3-14 of the Human Resource Policy Guide Manual beginning on Bates-stamped page 02548, and MCM-CDM-Incentive Compensation Plan documents Bates-stamped pages 02834 through 02838), if not previously produced in Allstate's recent supplemental responses;

(f) RFP 24 (a) - (d), including all *Acclaim, CCPR News and Allstate Now* publications for the applicable time frame, if not previously produced in Allstate's recent supplemental responses;

(g) RFP 6, all documents relating to prior bad faith claims and lawsuits filed in Indiana against Allstate from 1994-97;

(h) RFP 43, all documents pertaining to prior depositions and affidavits of Allstate personnel in bad faith litigation against Allstate in Indiana from 1994-97.

That Allstate is ordered to produce said documents, without the benefit of a protective order, as a part of any sanctions imposed by this Court consistent with the Discovery Order entered on February 26, 2003.

That Allstate is ordered to comply with this order by November 23, 2004.

For its willful non-compliance, the Court imposes the following sanctions pursuant the Special Master's Recommendations and Findings and pursuant to T.R. 37:

That Allstate be sanctioned to pay the amount of Ten Thousand Dollars ($10,000.00).

SO ORDERED THIS 17 **DAY OF** September**, 2004.**

Stephen R. Heimann, Judge
Bartholomew Circuit Court

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IN THE
COURT OF APPEALS OF INDIANA

ALLSTATE INSURANCE COMPANY,	)	
	)	
Appellant-Defendant,	)	
	)	
vs.	)	No. 03A04-0410-CV-554
	)	
TIM L. SCROGHAN,	)	
	)	
Appellee-Plaintiff.	)	

APPEAL FROM THE BARTHOLOMEW CIRCUIT COURT
The Honorable Stephen R. Heimann, Judge
Cause No. 03C01-9909-CT-1317

July 25, 2006

OPINION – FOR PUBLICATION

KIRSCH, Chief Judge

Allstate Insurance Company ("Allstate") appeals the trial court's imposition of sanctions for its violation of a discovery order and for its failure to properly designate its Ind. Trial Rule 30(B)(6) representatives. On appeal, Allstate raises the following restated issues:

I. Whether this court has jurisdiction to review the propriety of the trial court's Order Regarding Scroghan's Motion to Compel Discovery Which Was Filed on July 31, 2002 (the "Discovery Order").

II. Whether the discovery sought by Scroghan is relevant to his bad faith claim.

III. Whether the discovery is unduly burdensome, such that it violates Allstate's right to due process (or at least requires some sort of equitable discovery limit).

IV. Whether the information sought by Scroghan through discovery should be considered trade secrets, confidential or proprietary, thus warranting a protective order.

V. Whether the trial court was correct in sanctioning Allstate for violating the Discovery Order and for failing to properly designate its T.R. 30(B)(6) representatives.

We affirm in part and reverse in part.[1]

FACTS AND PROCEDURAL HISTORY

This appeal involves a hotly contested battle over discovery sought in the course of a bad faith claim brought against Allstate for allegedly refusing or delaying payment on an uninsured motorist claim. Tim L. Scroghan brought the bad faith claim (along with breach of

[1] We held oral argument on this case on January 24, 2006 at the Krannert Graduate School of Management at Purdue University. We commend counsel on the quality of their oral and written advocacy, and we thank our host for its hospitality.

contract and punitive damages claims) after being injured in an automobile accident on October 10, 1997. At the time of the accident, Scroghan was insured by Allstate. His policy provided for coverage of property damage, medical payments, uninsured motorist, and bodily injury with a limit on liability of $50,000 per person. The trial court bifurcated Scroghan's claims into two trials -- one on the breach of contract claim and one on the bad faith and punitive damages claims. This appeal covers only the discovery pursued in the latter case.

Following the conclusion of the case involving the breach of contract claim, Scroghan served Allstate with his first Request for Production ("RFP"), which encompassed requests for

> The entire paper and electronic claim files ([Requests] 1, 12, 13, 16 & 38); all documents relating to computer programs utilized by Allstate in evaluating/processing [Scroghan's] claims including, but not limited to, Colossus/CSC, ADP and MBRS documents ([Request] 30); all documents relating/evidencing Allstate's design to control claim costs, e.g. McKinsey & Company documents ([Request] 21); all documents pertaining to employment compensation information on the Allstate's adjusters and supervisors handling [Scroghan's] claims, including Performance Development Summaries ("PDS") ([Request] 14); all salary/compensation and personnel manuals/documents relating to performance and compensation ([Request] 15); all training materials, including manuals ([Request] 22); all publication and newsletters ([Request] 24); all organizational documents ([Request] 32); all documents pertaining to archives and records storage/retention ([Request] 35); all documents relating to prior bad faith claims and lawsuits filed against Allstate ([Request] 6); and all documents pertaining to prior depositions and affidavits in bad faith litigation against Allstate ([Request] 43).

Appellant's Reply in Support of Motion to Accept Jurisdiction of Interlocutory Appeal, Ex. 8 at 1-2. After receiving this RFP, Allstate moved for a protective order, which was denied by the trial court on April 23, 2002 on the grounds that Allstate's motion was "general in nature and did not make an attempt to show what items should be held as confidential . . . ."

Appellant's App. at 926. On May 6, 2002, Allstate responded to Scroghan's RFP by producing some responsive documents and also objecting to some of the requests on the grounds of relevance or by claiming attorney-client privilege or work product. *Id.* at 343-89. Scroghan then moved to compel discovery, and a hearing was held on the motion on February 18, 2003.

On February 26, 2003, the trial court issued its Discovery Order, finding that "Allstate has been stonewalling Scroghan as it relates to the production of documents requested." *Id.* at 928. The court also determined that Scroghan's RFP requests 6 and 43[2] were unduly burdensome and, therefore, limited the scope of the requests to those documents relating to Indiana uninsured motorist claims against Allstate, which alleged bad faith from 1994 through 1997. The court further ordered Allstate to provide the documents that it was claiming to be privileged to the court for an *in camera* review. The court also denied Allstate's renewed motion for a protective order.

Allstate requested that the court stay enforcement of its Discovery Order and reconsider the denial of its protective order, both of which were denied on March 27, 2003. Allstate filed a Notice of Appeal on the same day, along with a Motion for Certification of

[2] Specifically, Scroghan's request 6 sought: "All documents relating to bad faith claims or lawsuits filed against defendant, Allstate Insurance Company, arising out of uninsured claims initiated by Allstate's own insureds since 1990." *Appellant's App.* at 930. Request 43 sought: "All documents pertaining to prior depositions and affidavits, including bad faith claim litigation, since 1990 of Allstate's: (a) Adjusters and supervisors; and (b) Company officers." *Id.*

Interlocutory Appeal of the Discovery Order. Both were denied.[3] Allstate served its responses to Scroghan's first RFP as ordered by the trial court in the Discovery Order. However, Allstate continued to refuse to produce certain documents responsive to the RFP, stating,

> Allstate reiterates its objection to the production of these documents based on its position that such production should be made only pursuant to a Protective Order . . . Allstate will defer production of such protected documents that it believes should be protected by the request for a protective order until it has exhausted all avenues of appeal

Id. at 1335. This response prompted Scroghan to file another Motion to Compel regarding the first RFP and to also file a Motion for Sanctions.

On April 21, 2003, Scroghan filed another Motion to Compel, this time in regards to Allstate's responses to his third set of interrogatories. Specifically, Scroghan requested that the court compel Allstate to designate its T.R. 30(B)(6) corporate representatives with the most knowledge regarding thirty-two specified areas of inquiry.

On May 28, 2003, we stayed enforcement of the Discovery Order pending Allstate's appeal. This, however, did not stem the flow of filings before the trial court. During the stay, Scroghan continued to request documents and send interrogatories, and Allstate continued to refuse to answer and to object to his requests on various grounds. More

[3] Allstate attempted to pursue its appeal of the Discovery Order even after the trial court's denial of its motion for an interlocutory appeal. This appeal was ultimately dismissed due to a lack of jurisdiction. *Allstate Ins. Co. v. Scroghan*, 801 N.E.2d 191 (2004), *trans. denied.*

significantly, also during the stay, the trial court appointed a Special Master,[4] pursuant to T.R. 53, for the sole purpose of sorting through the numerous discovery disputes. The Special Master held several hearings on discovery, but did not make final recommendations due to the stay.

Once the appeal was dismissed and our Supreme Court denied transfer, the Special Master again held a two-day hearing on Scroghan's various motions to compel regarding his fifth, sixth, and seventh RFPs and his fifth and sixth sets of interrogatories, as well as on Allstate's motion to reconsider and its motion for a protective order, and finally, *in camera* production. Following the hearing, the Special Master issued a series of recommendations to the trial court regarding the various issues. The trial court adopted those findings in their entirety and issued several orders based on the Special Master's recommendations. The court sanctioned Allstate and ordered it to pay $3,500 for failing to comply with the trial court's order that it appropriately designate its T.R. 30(B)(6) representatives without evasion or ambiguity. The court ordered Allstate to produce documents responsive to Scroghan's fifth, sixth, and seventh RFPs and to respond to Scroghan's fifth and sixth sets of interrogatories without protective orders. Finally, the court dismissed Allstate's motion to again reconsider its ruling on the Discovery Order and sanctioned Allstate and ordered it to pay $10,000 for failing to comply with the Discovery Order. There were also several orders issued after the Special Master's *in camera* review of certain documents, which were determined to be privileged or trade secrets.

[4] The trial court appointed the Honorable John L. Price as Special Master. Judge Price died on October 29, 2005, following a long and distinguished career as judge, lawyer, teacher and community leader.

Allstate then appealed the trial court's order sanctioning it under Ind. Appellate Rule 14(A), which allows an interlocutory appeal as of right of orders requiring the payment of money. Additionally, Allstate requested that the trial court certify the discovery orders issued on September 20, 2004, which address Scroghan's fifth, sixth and seventh RFPs (the "RFP Orders") and to his fifth and sixth sets of interrogatories (the "Interrogatory Order") and Allstate's request for a protective order. The trial court certified all requested interlocutory orders for appeal, and we accepted jurisdiction.

DISCUSSION AND DECISION

A trial court is accorded broad discretion in ruling on issues of discovery, and an appellate court will interfere only when the appealing party can show an abuse of that discretion. *Vernon v. The Kroger Co.*, 712 N.E.2d 976, 982 (Ind. 1999). A trial court is also accorded broad discretion in determining appropriate sanctions for a party failing to comply with a trial court's discovery order. *Id.* A ruling will be reversed only when the trial court reached a conclusion against the logic and natural inferences to be drawn from the facts and circumstances before the court. *Burr v. United Farm Bureau Mut. Ins. Co.*, 560 N.E.2d 1250, 1253-54 (Ind. Ct. App. 1990). The reviewing court determines whether the evidence serves as a rational basis for the trial court's decision but may not reweigh the evidence or assess the credibility of witnesses. *Id.*

I. Jurisdiction

Through its appeal of the trial court's imposition of sanctions, Allstate also requests

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His integrity, humanity, intellect and humor will be missed by his colleagues in the bench and bar and by the citizenry of this State. All here join us in commemorating a life well-lived.

that we review the underlying Discovery Order. Scroghan contends that we do not have jurisdiction to review the Discovery Order because the trial court refused to certify it for interlocutory appeal. He further argues that we should not consider the Discovery Order because Allstate intentionally engaged in misconduct, i.e., failing to comply with the trial court's Discovery Order in the hopes of being monetarily sanctioned, thus allowing an interlocutory appeal as of right. Although Scroghan does concede that Allstate obtained an interlocutory appeal as of right when it was sanctioned for noncompliance with the Discovery Order, he maintains that the propriety of that order is a distinct and severable issue from the propriety of the imposition of sanctions. We disagree.

While we do not condone the practice of intentionally violating discovery orders to obtain appellate review of those orders, we recognize that such a practice can act as an important "safety valve," which relieves parties from generally non-appealable discovery orders. *Marrese v. Am. Acad. of Orthopaedic Surgeons*, 726 F.2d 1150, 1157 (7th Cir. 1984), *rev'd on other grounds*, 470 U.S. 373 (1985). While finding no Indiana case law that specifically discusses the propriety of this method of obtaining review, we note that the Seventh Circuit has explained it well:

> Confining the right to get appellate review of discovery orders to cases where the party against whom the order was directed cared enough to incur a sanction for contempt is a crude but serviceable method, well established in case law, of identifying the most burdensome discovery orders and in effect waiving the finality requirement for them.

Id. Therefore, while we certainly do not encourage parties to intentionally violate a discovery order so as to be sanctioned and thus obtain an interlocutory appeal as of right, we can see the narrow situations, such as this one, where such a strategy may be utilized. A

party in Allstate's position has few options since complying with the court's discovery order, proceeding through a trial, and ultimately winning on appeal would be a hollow victory indeed when the information sought to be protected would then already have been disclosed. In such situations, if a party is willing to incur possibly serious sanctions to obtain review of a discovery order, then the option should be available. This court has jurisdiction to review the Discovery Order.

II. Relevance of Discovery Requests

Next, Allstate contends that Scroghan's requested discovery is not relevant to his bad faith claim. The relevance of discovery requests is primarily governed by T.R. 26(B)(1), which states:

> Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject-matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or the claim or defense of any other party, including the existence, description, nature, custody, condition and location of any books, documents, or other tangible things and the identity and location of persons having knowledge of any discoverable matter. It is not ground for objection that the information sought will be inadmissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

In addition, generally, Indiana's discovery rules were designed to allow a liberal discovery process that would provide parties with information essential to the litigation of the issues and to promote settlement. *Rivers v. Methodist Hosp., Inc.*, 654 N.E.2d 811, 813 (Ind. Ct. App. 1995).

Here, Scroghan is seeking a wide variety of corporate information from Allstate on the grounds that "the best way to understand why and how Allstate acted as it did in Scroghan's case is to understand the corporate mentality underlying the conduct of the individuals

involved in his claim." *Appellant's App.* at 43. Allstate argues that such information is irrelevant to his bad faith claim because its general business practices and motivations are not at issue; only its behavior regarding Scroghan's claim is at issue. Faced with such extensive requests, it is possible that another court may have exercised its discretion differently. However, because of the fact-sensitive nature of discovery matters, the trial court's ruling here is cloaked with a strong presumption of correctness on appeal. *Brown v. Dobbs*, 691 N.E.2d 907, 909 (Ind. Ct. App. 1998). Given that our discovery rules were drafted to allow a liberal discovery process, we cannot say that the trial court abused its discretion by finding the "information sought to be reasonably calculated to lead to the discovery of admissible evidence." T.R. 26(B)(1).

III. Discovery Requests Unduly Burdensome

Scroghan's original Request 6 sought: "All documents relating to bad faith claims or lawsuits filed against defendant, Allstate Insurance Company, arising out of uninsured claims initiated by Allstate's own insureds since 1990." *Appellant's App.* at 930. Request 43 sought: "All documents pertaining to prior depositions and affidavits, including bad faith claim litigation, since 1990 of Allstate re (a) Adjusters and supervisors; and (b) Company officers." *Id.* The trial court previously limited Requests 6 and 43 to just those documents, depositions, and affidavits relating to Indiana uninsured motorist claims against Allstate, which allege bad faith from 1994 through 1997. Allstate contends that Scroghan's Requests 6 and 43, even as limited by the trial court, are unduly burdensome and too expensive for it to produce.

Our Supreme Court has previously stated "discovery should go forward, but, if challenged, a balance must be struck between the need for the information and the burden of supplying it." *WTHR-TV v. State of Indiana*, 693 N.E.2d 1, 6 (Ind. 1998).

The trial court determined that Scroghan's original requests were burdensome and thus, has already limited them to only those claims involving Indiana uninsured motorists from 1994 through 1997. Just as trial courts act as gatekeepers regarding the admission of expert opinion testimony, so too do they act in such a fashion in adjudging discovery disputes. *See Clark v. Sports*, 777 N.E.2d 1166, 1170 (Ind. Ct. App. 2002) (trial court considered gatekeeper for expert opinion evidence). Here, the trial court's actions in limiting Scroghan's discovery requests rather than finding them overly burdensome strikes the kind of discovery balance contemplated by our Supreme Court in *WTHR-TV*. *WTHR-TV*, 693 N.E.2d at 6. The trial court acted within its discretion in this regard.

IV Protective Order

Allstate next argues that the trial court abused its discretion in not granting its request for a protective order because the documents sought by Scroghan are either trade secrets or confidential in nature.

T.R. 26(C) provides that a trial court may, for good cause shown, take measures to limit discovery to protect a party from annoyance, embarrassment, oppression, or undue burden or expense. *Munsell v. Hewlett*, 776 N.E.2d 1272, 1277 (Ind. Ct. App. 2002). Two such measures involve issuing a protective order that the requested discovery may only be had on specified terms and conditions, or that a trade secret or other confidential research, development, or commercial information not be disclosed or be disclosed only in a

designated way. T.R. 26(C)(2). T.R. 26(C) also allows a trial court to impose certain conditions upon discovery, upon a showing of good cause, when a party from whom discovery is sought requests judicial protection from perceived abuse of the discovery process. *Wright v. Mount Vernon Daycare/Preschool*, 831 N.E.2d 158, 163 (Ind. Ct. App. 2005).

Although the trial court denied Allstate's overall request for a protective order, it also reviewed certain documents *in camera* and determined those to be trade secrets. Allstate continues to claim that other documents requested by Scroghan also require protection. The specific documents claimed as trade secrets include the Colossus materials (Request 30) and the McKinsey documents (Request 21).[5] The Colossus materials mainly include Allstate's computer program used to assist personnel in evaluating claims and the manuals explaining how the program works. The McKinsey documents encompass materials created in connection with Allstate's hiring of a management consulting firm (McKinsey & Co.) to

[5] The owner of the Colossus software, Computer Services Corporation ("CSC"), sought to intervene in the trial proceeding, ostensibly to protect its program from disclosure to competitors. The trial court denied both CSC's motion to intervene and Allstate's motion for a protective order.

create and implement its Claim Core Process Redesign ("CCPR"), which included various cost control measures aimed at reducing the amount paid out on claims. Allstate also claims the following documents are confidential and also should have been granted a protective order: all documents pertaining to compensation information on the Allstate employees involved with Scroghan's claim (Request 14), all manuals and documents relating to performance, evaluation and compensation, incentive programs, and retirement funds (Request 15), all cost control manuals and procedures (Request 21), and all training materials and manuals (Request 22).

Here, we find that the trial court did abuse its discretion in denying Allstate's requests for a protective order. The aim of discovery is to provide parties with evidence for use in their present case. *See* Discovery, T.R. 26.3(1) (discovery available regarding matters involved in pending action). Scroghan has made no showing that discovery under a protective order would be detrimental in this case, but discovery without a protective order could be detrimental to Allstate. Therefore, the trial court abused its discretion in not granting Allstate's request for a protective order.

V. Sanctions

Lastly, Allstate argues that because the Discovery Order is unreasonable, the trial court abused its discretion in imposing sanctions against Allstate for its failure to: (1) comply with the Discovery Order; and 2) properly designate its T.R. 30(B)(6) corporate representatives. We disagree.

After considering that Allstate failed to completely respond to Scroghan's first RFP, essentially ignored Scroghan's informal attempts at obtaining discovery, failed to comply

with the trial court's order compelling discovery, and also necessitated many hours of hearings before the court and the Special Master, the trial court followed the recommendations of the Special Master and sanctioned Allstate $10,000 for disobeying its Discovery Order.

The proceedings leading up to the issuance of sanctions for Allstate's failure to properly designate its T.R. 30(B)(6) corporate representatives were lengthy. T.R. 30(B)(6) states, in relevant part:

> A party may in his notice name as the deponent an organization, including without limitation a governmental organization, or a partnership and designate with reasonable particularity the matters on which examination is requested. The organization so named shall designate one or more officers, directors, or managing agents, executive officers, or other persons duly authorized and consenting to testify on its behalf."

Initially, in response to Scroghan's Third Set of Interrogatories, Allstate responded that "Allstate would consult with counsel and, subject to that consultation, would probably produce Nancy Brechbuhl . . ." *Appellee's App.* at 3217. This response is just one example of the general manner in which Allstate responded to Scroghan's interrogatories. After the trial court granted Scroghan's motion to compel Allstate to designate, without evasion and ambiguity, its T.R. 30(B)(6) representatives for thirty-two areas of inquiry, Allstate filed its amended responses to Scroghan's Third Set of Interrogatories and responded with the exact same language: "Allstate would consult with counsel and, subject to that consultation, would probably produce Nancy Brechbuhl . . . ." *Id.* at 3252-3313. The Special Master also heard argument on the issue and recommended that the trial court sanction Allstate for its evasive answers. The trial court then sanctioned Allstate $3,500.

Based on the evasive nature of Allstate's evasive tactics in responding to Scroghan's discovery requests, we find that the trial court was *well* within its discretion to order both of these defendants monetary sanctions. Such evasion could easily have warranted more significant monetary sanctions.

VI. Conclusion

In conclusion, we affirm the trial court's ruling that Scroghan's requested discovery is relevant to the subject matter of the pending action and is not unduly burdensome. We reverse the trial court's order denying Allstate's request for a protective order and remand with instructions to enter a protective order that provides the following:

> 1. Plaintiffs and their counsel will return all material and all copies of material produced by Defendant in connection with this matter, and all copies made of such material, at the conclusion of this action, including those given to co-counsel to the Plaintiffs' counsel, legal assistants and secretaries or other support personnel necessary for the litigation of this action, the Court Reporter(s) in this action, and witnesses or prospective witnesses (including designated expert witnesses and consultants employed by parties or the counsel for the parties).
>
> 2. Plaintiffs and their counsel will not copy any material produced by Defendant in response to discovery requests in this matter, except for use in this case, and all copies shall be treated in the same manner as documents produced by Defendant or Plaintiffs' response to Plaintiffs' requests for production.
>
> 3. Plaintiffs and their counsel will not use any such material or copies of material received or obtained from Defendant during the course of this action in any other case, action or proceeding.
>
> 4. Plaintiffs will not distribute any material or copies of material received or obtained from Defendant during the course of this action to any other person, organization or entity of any type during the course of this action, or after conclusion of this action, except for the parties to this action, the Court and the Court's personnel, the counsel for the parties for this action (including such counsel's co-counsel, legal assistants and secretaries or other support

personnel necessary for the litigation of this action), the Court Reporter(s) in this action, and witnesses or prospective witnesses (including designated expert witnesses and consultants employed by parties or the counsel for the parties) necessary to prosecute the action or defend matters in the action.

5. Plaintiffs shall not make public or disclose to any other person or entity or organization of any kind any of the information contained in any of the materials or copies of materials received or obtained from Defendant during the course of this action except that such materials or copies of materials during the litigation of this action may be used for or in an appeal, except for the parties to this action, their counsel, the counsel's personnel, the counsel to the parties for this action (including such counsel's co-counsel, legal assistants and secretaries or other support personnel as necessary for the litigation of this action), the Court Reporter(s) in this action, and witness or prospective witnesses (including designated expert witnesses and consultants employed by parties or the counsel for the parties) necessary to prosecute the action or defend matters in the action.

6. All materials and copies of material that Plaintiffs receive from Defendant as responses to discovery in this matter shall be deemed to be confidential documents without the necessity of a "confidential" marking on any such materials.

Appellant's Appendix at 253-54.

Finally, we affirm the trial court's order imposing sanctions for Allstate's evasion.

Affirmed in part, reversed in part, and remanded with instructions.

NAJAM, J., and CRONE, J., concur.

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY AND STATE FARM FIRE AND CASUALTY COMPANY V. ROBERT J. CAVOTO, JR., FISHBONE ADVERTISING, INC. CAVOTO CHIROPRACTORS, P.C., MARGARET FISHER-CATRAMBONE, PENN CENTER PAIN MANAGEMENT, INC., TIPROF, INC. AND INTERNATIONAL HEALTH ALLIANCE, INC.	COURT OF COMMON PLEAS DELAWARE COUNTY CIVIL ACTION NO. 05-10716

ORDER

AND NOW, this _____ day of _____, 2008, upon consideration of Defendants' Motion for Sanctions, and any response thereto, it is hereby ORDERED and DECREED that Defendants' Motion is GRANTED.

IT IS FURTHER ORDERED that sanctions are imposed upon the Plaintiffs as follows for having disobeyed this Court's Orders of September 28, 2007, and January 14, 2008:

1. Plaintiffs shall pay a monetary sanction of one-thousand dollars ($1,000.00) per day to the Defendants until such time as they have fully complied with the aforementioned Orders;
2. Plaintiffs shall pay a counsel fee of one-thousand and five-hundred dollars ($1,500.00) to defense counsel as reimbursement for the cost of preparing and filing Defendants' Motion for Sanctions; and
3. In the event Plaintiffs remain in default of their Court-ordered discovery obligations for more than ten (10) days from the date of this Order, this Court will

impose additional sanctions upon the Plaintiffs upon further Motion by the defense.

BY THE COURT:

_____

J.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

BRANDI VAN EMON,

Plaintiff,

vs.

Case No. 5-CV-72638

HON. GEORGE CARAM STEEH

STATE FARM MUTUAL AUTOMOBILE INSURANCE, COMPANY,

Defendant.

ORDER AFFIRMING MAGISTRATE JUDGE'S ORDERS AND GRANTING DEFENDANT'S MOTIONS FOR STAYS

This lawsuit arises out of an automobile accident which rendered plaintiff Brandi Van Emon a paraplegic. She brought this suit against State Farm Mutual Automobile Insurance, Company (State Farm) for breach of contract seeking personal protection insurance (PIP) benefits under Michigan's No-Fault Act, MCL § 500.3142 and tort claims of silent fraud, fraud/misrepresentation, negligence and intentional infliction of emotional distress.[1] Now before the court are two appeals of orders entered by Magistrate Judge Scheer. Both underlying orders were entered on October 18, 2007. The two orders involve different discovery disputes. The first order is an order denying in part and granting in part defendant State Farm's motion for reconsideration. This matter involves State Farm's failure to produce discovery relating to the Advancing Claims Excellence (ACE) program. The request for ACE documents was made in plaintiff's fourth request for production of documents dated November 10, 2006. The second order involves a different discovery dispute - defendant's

failure to respond to plaintiff's first set of interrogatories and first set of production requests dated January 26, 2007. In that order, Magistrate Judge Scheer entered sanctions of $44,000 for State Farm's late production of 2,000 papers in response to interrogatories and document requests. In addition to its two appeals, State Farm also has filed two "emergency" motions to stay compliance pending its appeals here. A hearing was held on December 20, 2007. From the bench, this court granted the emergency motions to stay compliance pending a decision on the appeals.

STANDARD OF LAW

The court reviews the nondispositive orders of Magistrate Judge Scheer under the "clearly erroneous or contrary to law" standard. Fed. R. Civ. P. 72(a); 28 U.S.C. § 636(b)(1)(A). "A finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." U.S. v. U.S. Gypsum Co., 333 U.S. 364, 395 (1948). In reviewing whether the Magistrate Judge erred in awarding sanctions, this court applies the "abuse of discretion" standard. See Nelson v. Tennessee Gas Pipeline Co., 243 F.3d 244, 248 (6th Cir. 2001), cert. denied, 534 U.S. 822 (2001); Haworth, Inc. v. Herman Miller, Inc., 162 F.R.D. 289, 291 (W.D. Mich. 1995).

BACKGROUND

Plaintiff Brandi VanEmon was involved in an automobile accident in January 1989 whereby she suffered a closed head injury rendering her a paraplegic. She brought this lawsuit against defendant State Farm for breach of contract seeking personal protection insurance (PIP) benefits under the No Fault Act. She also alleges several tort claims, including (1) silent fraud, (2) fraud/misrepresentation, (3) negligence, and (4) intentional infliction of emotional distress. Defendant filed a motion to dismiss[2] claiming that none of plaintiff's claims, other than the breach of contract count, could be maintained because the Michigan No-Fault Act

provided the exclusive remedy. In this court's January 26, 2007 order, all of plaintiff's tort claims survived dismissal except for the silent fraud claim to the extent that it relied "on an insurer's alleged duty to disclose under the UTPA or the insurer-insured relationship." The court granted plaintiff leave to file a third amended complaint to replead the fraud claim with appropriate specificity. Plaintiff has not filed a third amended complaint. On May 31, 2007, this court dismissed the silent fraud claim without prejudice for plaintiff's failure to replead it.

DISCUSSION

A. Order denying motion for reconsideration

On November 10, 2006, plaintiff served defendant with its fourth request for production of all documents regarding the Advancing Claims Excellence (ACE) program. ACE was an internal review of catastrophic claims handling procedures based on a survey of randomly selected closed claims files involving benefits pay outs of less than $250,000. According to plaintiff, the purpose of the ACE program was to "obtain huge savings in claims costs" which provided "strong incentives for the deliberate or negligent underpayment of claims." Defendant sought a protective order

[2]This court converted defendant's motion for summary judgment to a motion to dismiss for failure to state a claim.

barring the production of the ACE documents on the grounds that the documents are irrelevant and unsupportive of plaintiff's silent fraud and misrepresentation claim. Magistrate Judge Scheer ordered defendant to produce some of the documents for in camera review. Upon review, Magistrate Judge Scheer denied defendant's motion for a protective order. In his written order dated March 26, 2007, Judge Scheer explained:

> My in camera review of documents submitted by Defendant indicates that the ACE program led to the development of "initiatives" to render the handling of loss claims by State Farm employees more efficient and less costly for the defendant. The documents further indicate that many of the initiatives have been implemented by Defendant in its Michigan operations. While my in

camera review does not confirm whether claims handling policies implemented as a consequence of the ACE initiatives were applied to Plaintiff's case, that question is the proper subject of discovery.

Defendant then filed a motion for reconsideration of the March 26, 2007 order. In its motion, defendant argued that the ACE documents are not pertinent in time to plaintiff's PIP claim, but that plaintiff is merely on a "fishing expedition." Defendant relies on the Michigan Court of Appeals decision in Grant v. AAA, Mich./Wisc. Ins., 272 Mich. App. 142 (2006), leave denied, 477 Mich. 1043 (2007)[3] for the proposition that the "one-year back" rule, MCL § 500.3145 limits plaintiff's claim to losses occurring on or after July, 2004.[4] This court rejected those arguments in its May 31, 2007 order denying defendant's motion to dismiss pursuant to new precedent.

[3]Defendant also cites to Grant v. AAA, Mich./Wisc. Ins., 266 Mich. App. 597 (2005) (holding that MCPA claim is preempted by no-fault claim so "one-year back" rule applies limiting plaintiff's claim).

[4]On April 2, 2007, defendant renewed its motion to dismiss based on the Grant case. This court denied the motion, holding that Grant did not affect the court's denial of defendant's motion for summary judgment entered on January 26, 2007.

On October 18, 2007,[5] Magistrate Judge Scheer entered his order granting in part and denying in part defendant's motion for reconsideration. In that order, he required defendant to produce all of the ACE documents discussed in the court's March 26, 2007 order no later than November 15, 2007. Defendant is now in default of that order. That order also included a protective order requiring that plaintiff may only use the documents for the prosecution of this case. Defendant has filed objections to the order granting in part and denying in part defendant's motion for reconsideration. In its objections, defendant argues again that the ACE program is irrelevant. It accuses plaintiff of using the ACE discovery to "accumulate discovery relative to an as yet unrealized institutional case against State Farm." In other words, defendant claims that plaintiff is preparing a class action lawsuit.

Defendant claims that any discovery with respect to the ACE program is irrelevant.

Defendant explains that the ACE program consists of an internal review of randomly selected closed files with a total benefit payout of less than $250,000. According to defendant, the ACE project does not refer to plaintiff's claim. State Farm accuses plaintiff of improperly using the ACE program documents, not for this plaintiff's case, but in an attempt to create a class action lawsuit.

State Farm relies on the unpublished decision of Crump v. State Farm Mut. Auto. Ins. Co., No. 256558, 2005 WL 3303978 (Mich. App. Dec. 6, 2005) to support its claim that the ACE documents are not the proper subject of discovery. In that case, like the instant action, plaintiff was seriously injured in a motor vehicle accident and brought suit

[5]This is the date docketed, although October 18, 2007 was a Saturday. 5

against State Farm for breach of the insurance contract claim for its alleged failure to pay adequate benefits. Id. at 1. During discovery, State Farm produced the ACE documents but sought a protective order preventing plaintiff from using the ACE documents at trial. Id. The court granted the protective order on the grounds that the ACE documents were privileged as self-evaluative audits under MCL § 500.221. Plaintiff then sought leave to bring an interlocutory appeal of the order barring the ACE documents from trial, but opposed a stay of the trial pending the appeal. Id. Instead, plaintiff chose to proceed to trial without the ACE documents. Id.

On appeal, the Court of Appeals held that plaintiff had waived any claim of prejudice regarding those documents by opposing a stay and insisting on going to trial without the ACE documents. Id. State Farm cites to a footnote in Crump, in which the Court of Appeals noted that the ACE project was little more than documents 'created during an internal review of State Farm's catastrophic claims handling procedures for purely business reasons: to improve employee efficiency and cost-effectiveness.'" Id. at 1, fn2.

The holding of Crump is inapplicable here. In Crump, unlike the present matter, State Farm produced the ACE documents during discovery. Only after conducting an in camera review of the documents did the trial court rule that the ACE documents were barred from admission at trial because the documents at issue were privileged. The trial court did not rule on the relevance of the ACE documents. Our case, by contrast, regards discovery of the ACE documents, not trial production. As Magistrate Judge Scheer noted in his order requiring that the ACE documents be produced, only upon review can a determination of relevance be made. Magistrate Judge Scheer explained that whether or not the ACE initiatives were applied to plaintiff's case is a proper subject of discovery.

Defendant also relies on the Grant case for the proposition that the "one-year back" rule limits discovery to the period of time beginning on July of 2004 and since the ACE documents were created well prior to July of 2004, they are not discoverable. In its January 26, 2007 order denying defendant's motion to dismiss, this court considered and rejected defendant's argument that the "one-year back" rule applied to plaintiff's tort claims. In that order, this court explained that the "one-year back" rule was limited to recovery of no-fault insurance benefits only and did not bar plaintiff's claims of silent fraud, fraud/misrepresentation, negligence, intentional infliction of emotional distress, or violations of the UTPA.

Plaintiff responds that defendant's objections are untimely because defendant did not file objections to the March 26, 2007 order. Plaintiff's timeliness argument lacks merit as defendant timely moved for reconsideration of the March 26, 2007 order on April 5, 2007. In its motion for reconsideration, State Farm argued that new precedent existed, namely Grant v. AAA, Mich./Wisc., Inc., 272 Mich. App. 142 (2006), leave denied, 477 Mich. 1043 (2007) which limited plaintiff's claim to the one year period prior to the filing of the case which would be July, 2004. On October 18, 2007, Magistrate Judge Scheer granted in part and denied in

part defendant's motion for reconsideration. Defendant timely filed objections to that order. Given this scenario, the allegation of timeliness lacks merit.

Second, plaintiff argues that Magistrate Judge Scheer's order granting in part and denying in part defendant's motion for reconsideration is not "clearly erroneous." Plaintiff maintains the ACE documents are relevant with respect to its tort claims as they may show that defendant implemented programs that "could provide strong incentives for the deliberate or negligent underpayment of claims, for the withholding of benefit information." Furthermore, plaintiff claims the ACE documents might be relevant with respect to its Consumer Protection Act claim because it "relates to the incentive for the failure to effectuate prompt, fair, and equitable settlements and the substantial underpayment of claims."

Defendant's main argument in favor of its objections to Magistrate Judge Scheer's October 18, 2007 order regarding the motion for reconsideration is that the Grant case bars the tort actions under the "one-year back" rule. This court rejected that argument twice already, first, in the denial of defendant's motion to dismiss on January 26, 2007 and secondly, in the denial of defendant's motion to dismiss pursuant to new precedent dated May 31, 2007. Under these facts, defendant has failed to show that Magistrate Judge Scheer's order was clearly erroneous or contrary to law. For this reason, this court shall affirm Magistrate Judge Scheer's order denying in part and granting in part State Farm's motion for reconsideration.

B. Order Imposing Sanctions

On October 18, 2007, Magistrate Judge Scheer entered an order imposing sanctions on the defendant. The sanctions include $40,800 for 136 documents produced late at a cost of $300 per document, and $4,000 for four documents which it failed to produce under a claim of privilege. These sanctions are to be paid to the plaintiff as attorney fees. These fines were ordered to be paid within ten business days of the entry of the order, in other words, on

or before October 31, 2007. The parties agreed to extend the date for compliance to November 9, 2007. The order further requires defendant to produce another nine documents.[6] For each document produced voluntarily, the fine is $600. If defendant feels the documents are privileged, defendant may produce the documents for the court to review. If the court finds that a document is discoverable, defendant is fined $2,000 per document. The court further ruled that defendant must pay reasonable attorney fees and costs incurred by plaintiff's counsel in connection with the supplemental motion to compel and for sanctions.

The October 18, 2007 order imposing sanctions stems back to defendant's failure to respond to plaintiff's first set of interrogatories and first document production request which were served on January 27, 2006. Those requests involve training materials for State Farm claims representatives and claim handling policies and manuals, among other things. When State Farm failed to respond to the discovery requests, plaintiff filed a motion to compel on March 31, 2006. State Farm filed a response on April 13, 2006. State Farm claims that plaintiff sought production of documents that it had already provided to plaintiff's counsel in other cases over a period of ten years. Defendant claims it offered to "authenticate" all of the documents already in plaintiff's possession that would be responsive. On April 27, 2006, Magistrate Judge Scheer ordered defendant to provide answers and responsive documents no later than May 18, 2006. He also ordered defendant to pay $750 in attorney fees to plaintiff which State Farm paid three weeks late. He also ruled that defendant had waived all

[6]These include, among other things, the entire Auto Claim Manual General Information Section, Medical Payment Coverage, Auto Claims Manual Memos, General Claims Memos, and Auto Claims - Records Mgt Manual.

objections except for privilege and required that defendant set forth the elements and facts of each privilege claimed.

The parties met again for a hearing on May 23, 2006. At that time, defendant produced

nearly 200 documents on the courthouse steps. At the May 23, 2006 hearing, Magistrate Judge Scheer noted that he could not determine if State Farm had violated the order, but if it had, he would recommend striking defendant's answer. On June 20, 2006, Magistrate Judge Scheer entered a stipulated order requiring that defendant respond to plaintiff's first set of interrogatories dated January 27, 2006 and respond to her first request for production of documents dated January 27, 2006. Plaintiff claims that defendant still did not comply so plaintiff filed a supplemental motion to compel and for sanctions. In that motion, plaintiff claimed that State Farm had "produced only 218 pages of the no-fault manuals, policies and procedures; that Defendant had failed to provide all attendant care tools regarding attendant care rates in the state of Michigan; and that Defendant had failed to produce all responsive, non-privileged documents, including claim committee reports and large loss PIP surveys."

Defendant's position was that it had produced all of the requested materials with respect to the no-fault portions of the Claim Manual and that "to the extent that Plaintiff had documents from other cases that we had not provided, Defendant would review said documents and authenticate same if able." Defendant claims it made this peculiar offer not to obfuscate its duty to provide discovery, but because, as a practical matter, over the course of time, not all documents had been maintained. Defendant also claims confusion as to what documents were required to be produced.

Magistrate Judge Scheer heard argument on September 28, 2006. On October 18, 2006, he ruled that plaintiff's counsel should produce a list of the documents received from the defendant in other litigation in response to similar document requests and ordered defendant to produce responsive documents. Once again, defendant stood by its earlier limited response and produced nothing new. Magistrate Judge Scheer then scheduled another hearing for December 7, 2006.

On December 7, 2006, Magistrate Judge Scheer heard argument. On January 3,

2007, Magistrate Judge Scheer scheduled an evidentiary hearing to determine defendant's compliance with the courts prior orders of April 27, 2006, June 20, 2006, and October 17, 2006 - all of which addressed the first interrogatories and first requests to produce dated January 27, 2006. His order cautioned State Farm that "the Court shall sanction Defendant for each document that the Court finds was properly requested and not produced." The hearing was adjourned to February 12, 2007. On February 9, 2007, State Farm produced over 2,000 pages of documents. At the hearing, Magistrate Judge Scheer imposed sanctions for responsive documents produced late. On May 1, 2007, he held another hearing over the proposed order to impose sanctions whereby he expressed his frustration with the defendant:

> You had opportunity after opportunity to identify and produce these documents and then on the eve of the grand hearing - that I called and set in order to save my own sanity - as much as anything in this case, the documents were somehow produced, and I sanctioned them, and I stick to that.

Magistrate Judge Scheer carefully reviewed the documents and found that 136 documents were produced late that were responsive. His order, dated October 18, 2007, imposed a fine of $300 on each of the 136 documents in question and another $4,000 for four documents whereby defendant waived its claim of privilege because the defense was raised for the first time on February 9, 2007. Magistrate Judge Scheer entered the order imposing sanctions on October 18, 2007.

Defendant has filed objections to Magistrate Judge Scheer's order imposing sanctions.[1] In its objections, it contends that the documents are not relevant and were not

willfully withheld. It asks that this court stay the imposition of sanctions pending the trial of this case and/or a ruling on a subsequent motion for summary judgment.[8] Defendant claims that plaintiff admitted the documents were irrelevant in Basirico v. State Farm, No. 95-74691 (E.D. Mich.) - another case assigned to this court.[9] Defendant claims that it made a good faith effort to comply with plaintiff's demands. It also claims that its failure to produce documents -- which it alleges are irrelevant – cannot be the foundation for sanctions.

Plaintiff responds that discovery sanctions are authorized under Fed. R. Civ. P. 37(b)(2). Under Rule 37(b)(2), where a party refuses to comply with an order to provide discovery, the court "may make such orders in regard to the failure as are just." Rule 37(b)(2)(B) allows the court to treat the failure to obey an order as "a contempt of court" and Rule 37(b)(2)(E) further provides that the court may order the party failing to obey the order "to pay the reasonable expenses, including attorney's fees, caused by the failure." In National Hockey League v. Metropolitan Hockey Club, Inc., 427 U.S. 639,

[7]Defendant filed its objections on November 1, 2007 after receiving an extension for compliance with the order from the plaintiff until November 9, 2007.

[8]The dispositive motion cut-off date is January 7, 2008 and the discovery cut-off date is April 4, 2008.

[9]Plaintiff's counsel is the same in the Basirico case as here. Magistrate Judge Morgan is handling the discovery disputes in that matter.

643 (1976), the court upheld the outright dismissal of plaintiff's antitrust action where the plaintiff "in bad faith" refused to timely answer written interrogatories as ordered by the court. The court explained that such an extreme sanction as dismissal was warranted not merely to penalize the plaintiff, "but to deter those who might be tempted to such conduct in the absence of such a deterrent." Id.

The same could be said in the instant case. Defendant refused to provide documents despite three court orders requiring it to do so. Defendant was on sufficient notice as to the

discovery sought since plaintiff's counsel could identify specific documents produced in other litigation that it was requesting. Given that State Farm is involved in related breach of contract claims involving the same training materials albeit different plaintiffs, including another lawsuit pending in this very court, (see Basirico v. State Farm, No. 95-74691 (E.D. Mich. 1995)), makes the deterrent factor compelling. If this court declined to uphold the discovery sanctions levied by Magistrate Judge Scheer, it would be giving State Farm a license to withhold responsive documents without fear of reprisal. State Farm cannot claim that its conduct was not "willful" when it ignored three orders of the court to produce specific documents which were identified by name. Plaintiff's counsel was able to identify the documents because they were aware of their production in other lawsuits.

Plaintiff claims that defendant's failure to comply with discovery requests for over two years has hampered her prosecution of the case and prejudiced her. The May, 2008 trial date is fast approaching and plaintiff needs discovery to progress. Plaintiff points out that Magistrate Judge Scheer entered lesser sanctions before entering the more weighty fines at issue now. For example, in April, 2006, Judge Scheer ordered sanctions of $750 which defendant paid late and after doing so, still continued to withhold documents. Plaintiff claims the record, taken as a whole, supports the imposition of sanctions. Because the training materials at issue might be relevant to plaintiff's tort claims, it appears that Magistrate Judge Scheer's order imposing sanctions does not amount to an abuse of discretion, and therefore, should be affirmed.

C. Defendant's motions to stay

Defendant has filed two "emergency" motions to stay both orders of Magistrate Judge Scheer entered on October 18, 2007 - (1) the order granting in part and denying in part defendant's motion for reconsideration and (2) the order imposing sanctions. This court granted those motions from the bench.

CONCLUSION

For the reasons stated above, this court AFFIRMS both orders of Magistrate Judge Scheer dated October 18, 2007 - (1) the order granting plaintiff's renewed motion for sanctions and to compel (docket entry 166), and (2) the order granting in part and denying in part defendant's motion for reconsideration (docket entry 167).

IT IS FURTHER ORDERED that defendant's appeals (docket entries 170 and 174) hereby are DENIED. IT IS FURTHER ORDERED that defendant's motions to stay (docket entries 177 and 178) hereby are GRANTED. IT IS FURTHER ORDERED that defendant comply with the orders hereby affirmed within twenty-one days of the entry of this order.

Dated: January 24, 2008

s/George Caram Steeh GEORGE CARAM STEEH
UNITED STATES DISTRICT JUDGE

CERTIFICATE OF SERVICE

Copies of this Order were served upon attorneys of record on January 24, 2008, by electronic and/or ordinary mail.

s/Josephine Chaffee
Deputy Clerk

IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT INDEPENDENCE

DALE DEER and
TERRI DEER,

Plaintiffs,

vs.

ALLSTATE INSURANCE COMPANY,

Defendant,

and

PAUL JASON ALDRIDGE,

Defendant/Cross-Claimant.

Case No. 0516-CV24031

SD

ORDER

On July 2, 2007, the parties appeared before the Court for a Show-Cause hearing set by Court Order of June 14, 2007. The plaintiffs, Dale and Terri Deer, appeared through counsel Dirk Vandever. Defendant, Allstate Insurance Company ("Allstate"), appeared through its counsel, Paul Hasty. Co-defendant, Paul Jason Aldridge ("Aldridge"), appeared through counsel, Steve Garner, Andrew Gelbach, and Jeff Bauer.

No evidence was adduced by the parties, although counsel stipulated that the Court had previously entered discovery Orders with which Allstate had not complied. Allstate presented no evidence as to why it failed to produce such documents.

The procedural history underlying the show-cause order is as follows:

1. Aldridge filed a motion for additional sanctions for failure to comply with the Court's latest discovery order and suggestions in support on May 25, 2007. Aldridge then filed an alternative motion for contempt against Allstate for failure to comply with

the Court's discovery orders. This motion was accompanied by suggestions in support, and was filed May 31, 2007.

2. On June 14, 2007, this Court faxed an Order to Show Cause to all parties. The show-cause hearing was ordered to take place on July 2, 2007, at 1:30 p.m.

3. Having established the procedural history, the Court's findings at the hearing were as follows:

   a. Allstate filed no response or suggestions to either Aldridge's Motion For Additional Sanctions or Aldridge's Motion For Civil Contempt;

   b. Allstate presented no evidence for consideration at the Show-Cause hearing July 2, 2007. Specifically, Allstate presented no affidavits and called no witnesses to provide testimony.

   c. Allstate currently stands in violation of two separate Orders of the Court, wherein Allstate was ordered to respond to discovery, in particular Interrogatories and Requests For Production.

   d. A prima facie case for civil contempt against Allstate for violation of the Court's two Orders has been shown. Allstate has offered no evidence to show either an inability to produce the documents, or that its ongoing violation of this Court's Orders is not an act of contumacy. Allstate has in fact presented no evidence to either excuse or justify its continuing violations of this Court's Orders.

4. Based on the foregoing findings, the Court hereby finds defendant, Allstate Insurance Company, in Contempt of Court.

5. Having found defendant, Allstate Insurance Company, in Contempt of two separate Orders of the Court and having found that defendant, Allstate Insurance Company, has not attempted to provide any evidence to explain, justify, or excuse its refusal to honor two separate Court Orders, Defendant, Allstate Insurance Company, is ordered to pay to Defendant/Cross Claimant, Aldridge, the sum of Twenty Five Thousand Dollars ($25,000) per day, beginning Friday, September 14, 2007. The Twenty Five Thousand Dollar ($25,000) per day contempt Order will continue each and every day Defendant Allstate Insurance Company is in Contempt of the Court's Orders, and shall end when Defendant Allstate Insurance Company purges itself of its Contempt by complying completely and fully with the Court's prior Orders of February 27, 2007 and May 11, 2007, by producing all discovery Ordered.

6. If Allstate has not complied by fully and completely responding to the discovery as previously ordered by the Court by September 28, 2007, the Court will entertain additional motions concerning the appropriate penalty in this case.

7. In making this Order, the Court cautions Defendant, Allstate Insurance Company, that it cannot and will not tolerate a party intentionally ignoring its Orders and, should Allstate not respond to the Orders and further hearing be required, the Court upon motion will consider additional and/or more severe penalties to ensure compliance.

IT IS SO ORDERED.

MICHAEL W. MANNERS
JUDGE, DIVISION 2

Dated: Sept. 12, 2007

FLORIDA INSURANCE COMMISSIONER SUSPENDS ALLSTATE INSURANCE CO.

Wednesday, January 16, 2008

TALLAHASSEE, Fla. - Florida Insurance Commissioner Kevin McCarty today announced that he is suspending the certificate of authority of Allstate Companies to write new insurance in Florida until they fully comply with the subpoenas served Oct. 16 by the Office of Insurance Regulation (Office).

Today's decision by the commissioner follows Tuesday's action when he abruptly halted the scheduled two-day hearing into the Allstate Companies' reinsurance program, their relationships with risk modeling companies, insurance rating organizations and insurance trade associations. "In view of Allstate's ongoing, blatant disregard of our subpoenas, I have little choice but to take an action that will send a clear message about how seriously I am taking this issue," said Commissioner McCarty. "Suspending their certificate of authority to write new business in our state should make my point.

"If Allstate is willing to pay $25,000 per day in fines to a Missouri court for its ongoing failure to provide similar documents, it's obvious to me that it will

take more than a monetary sanction to get them to comply with our subpoenas."

Allstate was to have provided all appropriate company documents related to the above topics at or before Tuesday's hearing, but failed to do so. Instead, the Office received 51 pages of objections to the subpoenas.

The suspension applies to Allstate Insurance Co., Allstate Indemnity Co. and Allstate Property and Casualty Co., and it only suspends the companies from writing new business in Florida.

Existing policyholders will not be affected. Allstate must continue to service them and the companies must make all required statutory filings including, but not limited to, audited annual financial statements, quarterly financial statements and rate filings.

"The duration of the suspension is up to them," added McCarty. "It will be lifted when I am satisfied that we have received each and every document we need to properly investigate the important issues before us.

"It continues to trouble me that Allstate has not complied with our subpoenas and is not willing to explain to us their relationships with rating agencies, modeling companies and trade groups and how these relationships might have influenced the huge rate increases they have requested. This clearly cannot be in the best interests of Florida consumers."

This is the first time the Office has suspended a company for failure to "freely" provide documents as required by Florida law.

A copy of the subpoena is available to review.

Allstate Floridian Indemnity and Allstate Floridian Insurance Company have requested rate increases of 28.3 percent and 41.9 percent respectively. Encompass Floridian Indemnity requested a 38.4 percent increase, and Encompass Floridian Insurance Company requested a 39.7 percent increase.

About the Florida Office of Insurance Regulation
The Florida Office of Insurance Regulation (Office) has primary responsibility for regulation, compliance and enforcement of statutes related to the business

of insurance and the monitoring of industry markets. Business units within the Office are organized based on regulatory expertise and include the areas of life and health, property and casualty, specialty lines and other regulated insurance entities. It is within the Office that the mission of public protection is implemented through regulatory oversight of insurance company solvency, policy forms and rates, market conduct performance and new company entrants to the Florida market.

For more information about the Office, please visit www.floir.com. If you would like to review and compare homeowners insurance rates in Florida, go to www.shopandcomparerates.com.

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAII

NANCY M. FOWLER, as Guardian of The Person and Property of SKIPP VAN FOWLER, an Incapacitated person, Plaintiff, vs. STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, an Illinois Corporation, Defendant.	CIVIL NO. CV07-00071 SPK/KSC DECLARATION OF JAMES J. MATHIS

PRELIMINARY DECLARATION OF JAMES J. MATHIS

I, James J. Mathis, pursuant to 28 U.S.C.A. Section 1746, hereby declare as follows:

1. That, I am over the age of 18, competent to testify herein, and make this declaration based upon personal knowledge.

2. That, I am a former employee of State Farm Insurance, having been an employee from January 1987 through November 30, 1994. During the course of my tenure with State Farm Insurance I rose through the ranks from my initial position as Claims Representative, to eventually management positions including Superintendent of Claims having responsibility for claims supervisors, representatives, estimators, MPC/PIP expeditors and support staff who handled both first and third party claims presented to State Farm. In my position as Claims Superintendent, I had responsibility to interview, hire and train new candidates as well as employees already employed by State Farm and supervise their workload throughout the workday. (*See CV of James Mathis, Attached as Exhibit One*)

3. That, I have reviewed large portions of the State Farm claim file for Skipp Van Fowler including, but, not limited to the claim activity log, claim committee reports, Serious Injury Case Follow-up Reports, Status Reports, correspondence, office memos. medical records, medical reports, medical billings, and other material.

4. That, I have reviewed the depositions[1] of the following persons produced to me:

1) Cindy Stowe, RN;
2) Vanessa Leimomi Crawford, rough draft summary only;
3) Casey Dean Dunhill, rough draft summary only;
4) Jubal Wade Cheek, rough draft summary only;
5) Psalm Autumn Lambeth, rough draft summary only;
6) Brenda B. Weeks, rough draft summary only;
7) Richard Miller, M.D., rough draft summary only;
8) Lisa Joy Fujikawa, rough draft summary only;
9) Joy Ann Wall, rough draft summary only;
10) Sheila June Winters, rough draft summary only;

[1] **Some of the depositions were just completed the day before this declaration and, therefore, I was provided only a rough summary of each of these. These have been marked accordingly.**

5. That, I have reviewed the following documents provided to me in this matter:

1) State Farm Claim File for Fowler;
2) State Farm Mutual Car Policy;
3) Complaint and Demand for Jury Trial;
4) Answer to Complaint and Affirmative Defenses;
5) Order Setting Rule 16 Scheduling Conference ;
6) Report of Rule 26 Conference ;
7) Defendant's Scheduling Conference Statement;
8) Plaintiff's Scheduling Conference Statement ;
9) Order Granting Pro Hac Vice ;
10) Plaintiff's Supplemental Initial Disclosures;
11) Defendant's First Request to Produce;
12) Plaintiff's Response to Defendant's First Request to Produce;
13) Defendant's First Set of Interrogatories to Plaintiff;
14) Plaintiff's Answers to Defendant's First Set of Interrogatories;
15) Defendant's Second Set of Interrogatories;
16) Plaintiff's Responses to Defendant's Second Set of Interrogatories;
17) Defendant's First Request for Admissions directed to Plaintiff;
18) Plaintiff's Responses to Defendant's First Request for Admissions;
19) Defendant's Rule 26 Disclosures;
20) Plaintiff's First Request to Produce Documents;
21) Response to Plaintiff's First Request to Produce Documents;
22) Plaintiff's Second Request for Production of Documents to Defendant;
23) Plaintiff's Third Request for Production of Documents to Defendant;
24) Plaintiff's Motion for Preliminary Injunction; and Memorandum in Support of Motion;
25) Defendant's Memorandum in Opposition to Plaintiff's Motion for Preliminary Injunction;
26) Plaintiff's Reply Memorandum in Support of Motion for Preliminary Injunction;
27) Notice of Plaintiff's Withdrawal of Motion for Preliminary Injunction;
28) Plaintiff's ExParte Motion to Seal the Complaint, Motion for Preliminary Injunction and all Related Pleadings;
29) Defendant's Motion to Allow Richard Grover, Jr., Esq. and Robert Johnson, Esq. to Appear Pro Hac Vice;
30) Release Agreement (1987), attached as exhibit B to the Motion for Preliminary Injunction;
31) MCCA Documents Volume I;
32) MCCA Documents Volume II;
33) MCCA Documents Volume III;
34) MCCA Documents Volume IV;
35) MCCA Documents Volume V;
36) MCCA Documents Volume VI;

37) MCCA Documents Volume VII;
38) MCCA Documents Volume VIII;
39) MCCA Documents Volume IX;
40) Pac Blu Records;
41) Ridgemoor Case Management Records Volume I;
42) Ridgemoor Case Management Records Volume II;
43) Ridgemoor Case Management Records Volume III;
44) Ridgemoor Case Management Records Volume IV;
45) Ridgemoor Case Management Records Volume V;
46) Ridgemoor Case Management Records Volume VI;
47) Declaration of Nancy Fowler;
48) Declaration of Patricia Patrick, M.D.;
49) Declaration of Robert Sloan, M.D.;
50) Declaration of Richard Miller Regarding Plaintiff's Motion for Preliminary Injunction;
51) Affidavit of Robert Johnson Support of Opposition to Motion for Preliminary Injunction;
52) Karen Klemme R.N.'s Report I;
53) Karen Klemme R.N.'s Report II;
54) Karen Klemme R.N.'s Report III;
55) Karen Klemme R.N.'s Report IV;
56) Hawaii's Revised Statute, Part IV, UNFAIR COMPETITION AND DECEPTIVE ACTS OR PRACTICES

6. That, I have reviewed the medical opinions, statements, comments or letters from the following physicians or medical facilities:

1) Home Care for U LLC
2) Andrew H. Eaton, LPN
3) Ellen F. Gavin, RN
4) Patricia A. McCarthy, RN
5) Joy A. Wall, RN
6) Brenda B. Weeks
7) Barbara Nasco
8) Cindy Stowe, RN, BSN, CRRN,CCM,CBIT,CLCP
9) Arlene Buklarewicz, RN, CCM
10) Frank Aragon RN, Primary Caregiver/Coordinator for Mr. Fowler
11) Jacqueline Ahn, RN
12) Angela Reisener, Occupational Therapist
13) Diane Goulet, Occupational Therapist
14) Seila June, Music Therapist
15) Frank Fowler, RN
16) Dr. Patricia Patrick, Psychiatrist
17) Richard Miller, MD, PCP Primary Care Physician

18) Diane/Dinah Bukowski, MD Pulmonary
19) Dr. Simpson/Ross, Pulmonologist
20) Peter Mazzie-Patrick, Physical Conditioning
21) Dr. Burr-Ross, MD
22) Dr. Salzburg, Physiatry Consultation
23) Muareen M. Toal, DMD
24) Declaration of Robert Sloan, M.D.;
25) Declaration of Patricia Patrick, M.D.;
26) Pac Blu Records;
27) Ridgemoor Case Management Records Volume I;
28) Ridgemoor Case Management Records Volume II;
29) Ridgemoor Case Management Records Volume III;
30) Ridgemoor Case Management Records Volume IV;
31) Ridgemoor Case Management Records Volume V;
32) Ridgemoor Case Management Records Volume VI;
33) Karen Klemme R.N.'s Report I;
34) Karen Klemme R.N.'s Report II;
35) Karen Klemme R.N.'s Report III;
36) Karen Klemme R.N.'s Report IV;
37) MCCA Documents Volume I;
38) MCCA Documents Volume II;
39) MCCA Documents Volume III;
40) MCCA Documents Volume IV;
41) MCCA Documents Volume V;
42) MCCA Documents Volume VI;
43) MCCA Documents Volume VII;
44) MCCA Documents Volume VIII;
45) MCCA Documents Volume IX;
46) List is not complete

7. That, in the formulation of my opinions I have reviewed other publications such as, "*Aggressive Good Faith and Successful Claims Handling*", "*Liability Claim Concepts and Practices*", "*Insurance Contract Analysis*", "*Insurance Perspectives*", and "*Casualty Claim Practice*".[2]

[2] The Insurance Institute of America (IIA) requires the studying of "Aggressive Good Faith and Successful Claims Handling" by Willis Park Rokes, "Liability Claim Concepts and Practices" by Robert J Prahl and Stephen M. Utrata, "Insurance Contract Analysis" by Eric A. Wiening and Donald S. Malecki, "Insurance Perspectives" by Robert J. Gibbons, George E. Rejda and Michael W. Elliott, and "Casualty Claim Practice" by James H. Donaldson in order to achieve the different IIA designations. This designation and others offered by the Insurance Institute of America have become a standard in the insurance industry. With a few exceptions, all State Farm employees hold either the AIC designation or CPCU or both. I have the AIC designation and Steve Strzelec, another

In his book, Mr. Rokes states, "In every contract there is an implied covenant of good faith and fair dealing that neither party will do anything which impairs the right of the other to receive the benefits of the agreement. This principle is applicable to policies of insurance." This is actually a quote taken from John H. Holmes' book, "*Excess Liability for Bad Faith, or Is There More To It?*" Mr. Rokes continues with his explanation of Fiduciary Responsibility, "The nature of the insurance contract, where the insured turns over his or her financial interests to the insurance company, dictates that the insurer has no right to sacrifice those of the insured in order to save money. The relationship between the insured and the insurer under the contract closely approximates that of principal and agent, or beneficiary and trustee, and indeed, some courts have held that the insurer occupies a fiduciary position."

8. Mr. Rokes emphasizes the significance of record keeping and good faith claim handling on page 88 of his book. "All of the record keeping requirements that now confront insurance companies mean that there will be written reports of all complaints. Most likely the adjuster involved will also be identified; in the event that a lawsuit or a complaint from the state insurance department results, you will definitely be involved. This has rather serious ramifications for the adjuster, because it puts you in the spotlight. Consequently, you should strive to act responsibly, documenting and controlling your file to demonstrate conscientious, prudent, and good-faith handling."

9. That, as a preliminary opinion, I have determined the following points based on my review of the previously listed documents and my expertise, training and condition is either directly related to the injuries he received in the accident of February 24th, 1985. These injuries require 24 hour one on one nursing care in order for his well-being and continued

expert involved in this matter holds the CLU and CPCU designations.

survival. The afflictions and conditions as a result of his injuries include:

1. His inability to swallow, which causes frequent aspiration of saliva that must be immediately suctioned out of his mouth and/or his open tracheotomy by a nurse to avoid choking;
2. He must be fed intravenously though a "J-Tube", though which he also receives medication. This must be monitored by a nurse.
3. His temperature must be monitored in connection with the feeding and medication.
4. His lack of mobility requires nurse assistance to move him manually by specialized equipment, and/or by wheelchair.
5. His frequent episodes of voluntary and involuntary muscle movements place him in danger of injury himself.

b. That State Farm is obligated to pay Skipp Van Fowler's treatment costs under the settlement agreement entered into on May 14th, 1987 by all parties. State Farm's original obligation prior to the settlement arose from its policy of insurance covering the car in which Skipp Van Fowler was a passenger. State Farm's obligation under the settlement agreement includes his and his family's choice for him to remain at home and not be institutionalized by State Farm.

c. That, State Farm has breached its contract by not continuing to pay for the reasonably necessary care required by Skipp Van Fowler.

d. That, State Farm from 1985 until June of 2006 had determined the care

Skipp Van Fowler was receiving in home and around the clock at a cost of $33,000.00 was reasonably necessary.

e. That, State Farm unilaterally determined it could reduce the cost of Skipp Van Fowler's claim by removing him from his family home and institutionalizing him, or alternatively pay a bare institutional care rate for his nursing care, a rate that was grossly inadequate and would force him into an institution. Based on this decision, State Farm notified Nancy Fowler that commencing in September, 2006 it was going to only pay $18,000.00 per month for Skipp Van Fowler's nursing care **and** medical supply expenses; State Farm would reimburse a maximum of $10,000.00 per month of his reasonably necessary nursing care costs.

f. That, State Farm made this decision without conducting a thorough investigation into the medical facilities available to match Skipp Van Fowler's medical requirements.

g. That, State Farm, prior to this decision, had a thoroughly investigated and competent report by Arlene Bukiarewicz, RN, which stated that State Farm should not only maintain the level of services that it was currently paying for, but, also increase services to include certain types of therapy State Farm had previously denied.

h. That, State Farm chose to ignore its chosen case manager, Ms. Bukiarewicz and, in fact, terminated her services as an independent case manager.

i. That, State Farm has not replaced Ms. Bukiarewicz as an independent case

manager.

j. That, State Farm has made the decision to reduce the benefits paid for the reasonable and necessary treatment required by Skipp Van Fowler solely to reduce the claim cost.

k. That, State Farm's decision was maintained in spite of the contradicting medical opinions of Skipp Van Fowler's treating physicians and absent any supporting medical opinions.

l. That, State Farm has made a medical determination to only pay for $10,000.00 per month for home nursing care and up to $8,000.00 for medical supplies.

m. That, State Farm has acted wantonly, oppressively, or with such malice as implies a spirit of mischief or criminal indifference to civil obligations.

n. That, State Farm currently has no reasonable foundation for the continued denial of benefits for medical treatment to Skipp Van Fowler and should be required to immediately reinstate all benefit payments at least to those which it paid prior to June of 2006.

o. That, there exists in the State Farm claim file the appropriate and necessary medical documentation to pay these benefits to Skipp Van Fowler.

p. That, the delay in decision making and subsequent denial of benefits to Skipp Van Fowler found in the claim file are identical in practice to the thousands of State Farm claim files I have reviewed.

q. That, State Farm has violated Hawaii's Unfair Competition and Deceptive

Acts or Practices[3].

[3] PART IV. UNFAIR COMPETITION AND DECEPTIVE ACTS OR PRACTICES

§435E-41 Unfair methods of competition and deceptive acts or practices. The following are unfair methods of competition and deceptive acts or practices with respect to cooperative corporations or interindemnity arrangements under this chapter:

(1) Making any false or misleading statement as to, or issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any interindemnity arrangement or the benefits or advantages promised thereby, or making any misleading representation or any misrepresentation as to the financial condition of an interindemnity arrangement, or making any misrepresentation to any participating member for the purpose of inducing or tending to induce the member to lapse, forfeit, or surrender his or her rights to indemnification under the interindemnity arrangement. It shall be a false or misleading statement to state or represent that a cooperative corporation or interindemnity arrangement is or constitutes "insurance" or an "insurance company" or an "insurance policy".

(2) Making or disseminating or causing to be made or disseminated before the public in this State, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any statement containing any assertion, representation, or statement with respect to such cooperative corporations or interindemnity arrangements, or with respect to any person in the conduct of such cooperative corporations or interindemnity arrangements, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading. It shall be a false or misleading statement to state or represent that a cooperative corporation or interindemnity arrangement is or constitutes "insurance" or an "insurance company" or an "insurance policy".

(3) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in an unreasonable restraint of, or monopoly in, such cooperative corporations or interindemnity arrangements.

(4) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, or delivered to any person, or placed before the public any false statement of financial conditions of such a cooperative corporation or interindemnity arrangement with intent to deceive.

(5) Making any false entry in any book, report, or statement of such a cooperative corporation or interindemnity arrangement with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such a cooperative corporation or interindemnity arrangement is required by law to report or who has authority by law to examine into its conditions or into any of its affairs, or, with like intent, wilfully omitting to make a true entry of any material fact pertaining to a cooperative corporation or interindemnity arrangement in any book, report, or statement of a cooperative corporation or interindemnity arrangement.

(6) Making or disseminating, or causing to be made or disseminated, before the public in this State, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that such a cooperative corporation or interindemnity arrangement is insured against insolvency, or otherwise protected by law.

r. That, Nancy M. Fowler was forced to file this lawsuit so as to recover the policy benefits owed to Skipp Van Fowler as stated in the State Farm policy and the settlement agreement.

s. That, State Farm must either pay the benefits of Skipp Van Fowler' policy or provide a reasonable, legal and moral explanation for the denial of those benefits in a timely fashion. Skipp Van Fowler has not received either in this case.

10. State Farm's dramatic decrease in payment for medical care was in conscious disregard of Skipp Van Fowler's health and well-being. Therefore it would be reasonable for the Plaintiffs to seek damage awards for both the bad faith actions of State Farm and the emotional distress this has caused.

11. That, as a Claims Superintendent, I was also responsible for making decisions on coverage, liability, value, procedures and processes. I was also responsible for supervision of the defense of lawsuits against the company involving bad faith in the handling of claims. PIP is the acronym for personal injury protection and MPC is the acronym for medical pay coverage. All involve first party benefits owed to the insured for injuries under the State Farm Policies.

12. That, as a Claims Superintendent, I had responsibility for the training of State Farm

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(7) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:
(A) Misrepresenting to claimants pertinent facts or provisions relating to any coverage at issue.
(B) Failing to acknowledge and act promptly upon communications with respect to claims arising under such interindemnity arrangements.
(C) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under such interindemnity arrangement.
(D) Failing to affirm or deny coverage of claims within a reasonable time after proof of claim requirements have been completed and submitted by the participating member.

personnel in the handling of PIP and MPC claims. This responsibility included reviewing thousands of claims each year to assure the handling complied with State Farm Corporate practices and procedures. I was also required to introduce new procedures as defined and distributed by State Farm Corporate to all employees. This training followed the specific format as outlined in the "Education and Training Guideline" provided by State Farm Corporate. I adhered to the practices and procedures for handling all claims as found in the "General Claims Memo" manual, "Superintendent's Manual" and "Claims Procedural Guide". Each of these manuals was provided to me from State Farm Corporate. I am aware there was a 13-week pre-claims school program as well as a 13-week post-claims school program. Adjusters were required to complete these programs and obtain verification of completion from the immediate superintendent, divisional superintendent and the divisional manager. New employees were required to complete the Basic Claims Courses. I was also requested to provide and train all employees in Washington in the State Farm Corporate Program, "Negotiation Skills for the Claims Professional". This was a formatted course in the instruction of negotiating claims for first and third parties. It emphasized the philosophy of negotiating from a position of strength. It utilized the fact that, as claims people we hold the power in our ability to write the check. This is even more evident in the handling of PIP claims such as Skipp Van Fowler's and is discussed later in this opinion. The philosophy was premised on the understanding that insureds naturally have a reluctance to engage as an adversary with their own insurance company. The implication that the more paid on this particular claim results in the higher the cost of insurance for all policyholders is more significant in PIP claims. Insureds have a natural trust in their own insurance company to deal with them with the highest good faith actions. I was trained in the use and application of

"PP&R" as a means of evaluation of performance for State Farm Personnel. I am familiar with the use of "Quarterly Reports" as a substitute for "PP&R"s where State Farm Management is concerned. I am aware that the "PP&R" was replaced by the "QPR" (Quarterly Performance Review as discussed in the "Advancing Claims Excellence" claim procedural documents) and, currently, by the "EPR" (Employee Performance Review).

13. That, throughout the course of my tenure with State Farm, I had the opportunity to travel to different states and review claim operations in those states. Ultimately, I was asked to create and head up a centralized unit for the PIP and MPC claims in the State of Washington consolidating all the PIP and MPC claims handled throughout the State of Washington into one area. This included the out of state policies being serviced in Washington. As part of my duties I also had occasion to research how State Farm conducted claims handling procedures and practices uniformly all across the country.

14. That, I received considerable training during my tenure at State Farm. When I first started as a Claims Representative I went to several workshops before I had the opportunity to go back to a formalized claims school at the State Farm home office in Bloomington, Illinois. I attended a three-week claims school at the home office. I continually participated in other training workshops and seminars through the formal training program outlined in the State Farm education and training manuals. I later attended State Farm Claims Management School, also at the home office in Bloomington, Illinois, where I was taught the State Farm philosophy and State Farm management tools. After attending the home office management school, I then went through a regional office management program for State Farm. Throughout my tenure, I also participated in workshops and seminars to supplement my training.

15. That, I was also responsible for training other employees through workshops and seminars. I am aware that State Farm's policies and procedures for adjustment and handling of claims are implemented on a national, regional and local level in a uniform manner. This includes State Farm's nationwide and universal use of **PP&R's (Performance, Planning and Review), QPR's (Quality Performance Review), EPR'S (Employee Performance Review)[4] and Quarterly Reports as a means of performance rating** across the country. I have experience, while employed with State Farm, discussions with other State Farm employees on this issue. Since leaving State Farm, I have reviewed State Farm employees' PP&R's, QPR's, EPR's and Quarterly Reports involved with other bad-faith lawsuits filed against them. I have found these to be **uniform** in their structure and completion throughout the country. All policies and procedures originate from the State Farm's home office.

21. That, at the regional level, different workshops and programs would be conducted for State Farm Management. There were also managers' workshops and managers' meetings at the section level, which were required attendance. There were formalized programs and newly hired employee orientation required through regional office. **Local claims offices were not permitted to adopt policies or procedures for the handling of claims that were contrary to national or regional policies.** There was a precise program for training that was disseminated from State Farm Corporate Headquarters to local management, which we were strictly required to follow.

22. That, at the regional level, different workshops and programs would be conducted for

3 The current performance program for State Farm employees and the one in place at the time of this loss is the EPR. This was preceded by the QPR which in turn was preceded by the PP&R. The EPR includes a section for review of the employee's contribution to the economic success of State Farm.

State Farm Management. There were managers' workshops and managers' meetings we would attend regularly. There were formalized programs and newly hired employee orientation required through regional office. Local claims offices were not permitted to adopt policies or procedures for the handling of claims that were contrary to national or regional policies. There was a precise program for training that was disseminated from State Farm Corporate Headquarters to local management, which we were strictly required to follow. This training was specific to the handling of Personal Injury Claims as well as well as the use of Medical Cost Management tools such as IME's and paper reviews to deny policyholder benefits such as is the case for Skipp Van Fowler.

23. That, State Farm adjusters and management personnel regularly rely on and refer to the claims manuals provided by home office. There were also additional training tools available at Home Office and listed in the "Claims Video Library". I am aware that a "Claims Supervision Manual" was used for instruction and reference of all employees. These materials would refer to the handling of claims, coverages (including UIM), liability and injuries. The manuals were not unique to either Washington or the Northwest Region, but to my knowledge were used throughout the nation, including Michigan. Other publications such as "Obiter Dictum" and "Medi-Claims" were also suggested reading for all employees involved in the handling of automobile accidents, injuries, treatment, treatment modalities, reviewing processes, and anything that had to do with injury claims. Independent Medical Examinations and Paper Reviews were two additional tools expressly encouraged to be used in order to reduce the average paid amount of first and third party claims. State Farm Corporate determined the selection of the vendor or physician to perform these services for State Farm. The vendor listing is now available to all State Farm employees via State Farm's intranet. The continued

relationship with State Farm would be dependent upon the percentage of reduction produced by their involvement in the claim handling. If State Farm did not realize a significant reduction of billed amounts for treatment provided to insureds or a significant percentage of the ongoing treatment cutoffs recommended by a vendor, the field offices would be directed to discontinue use of that vendor.

24. That, during the course of my tenure at State Farm, I was aware that job performance and promotional opportunities would be evaluated in part based upon statistical performances produced both in average paid claims as well as the average percentage of claims pending. Such evaluations would also encompass adherence to the philosophies of State Farm. Management was given specific goals and objectives in the form of quarterly reports, which would include these average claim values and pendings. In my experience with State Farm, regular circulars and reports were put out by each region, including each unit's performance on claims in the different coverages in terms of both average paid and average pendings. These reports were used as a motivational vehicle to encourage the use of tools such as IME's, paper reviews, retrospective reviews, retroactive reviews, billing audits and utilization reviews in the handling of first and third party injury claims.

25. That, I became intimately involved with cost containment measures implemented by State Farm during my tenure with the company. I am aware there are numerous manuals, guidelines and memoranda that were regularly disseminated among State Farm claims centers uniformly throughout the nation.

26. That, I am aware of the current program adopted by State Farm across the country to encourage the awareness of claim severity and require adoption of the use of those tools provided by State Farm corporate to reduce the "Quality Differential". "Quality Differential"

is defined by State Farm in the ACE program as the opportunities lost to reduce severity in claims including PIP/MPC claims. Recent Discovery in Plateros vs. State Farm (CV98-07605) in Reno, Nevada has developed documents, which substantiate State Farm's commitment to the use of this program nationwide so as to realize substantial increase in profits by cutting cost through medical claim cost management. ACE is an acronym for Advancing Claim Excellence. It is a result of the uniform change in State Farm's intensity in reducing its costs based on regional, state and nationwide surveys. The program was designed by State Farm corporate to produce a profit from the claim department and is required to be followed specifically by each of the regions and states. This program directly controls the handling of each claim across the nation for State Farm. Adoption of the program began in the northeast United States in 1994. By 1998 it had been inserted into the claim practices throughout the nation.

27. That, I am aware of the process by which the performance of each State Farm individual involved in the handling or decision making of this claim was reviewed. The performance review process includes analyzing how the performance of the individual in the handling of each claim adheres to the initiatives as outlined in A.C.E. (Advancing Claims Excellence). These initiatives include the contribution of the employee to the company's economic success based on the individual's claim handling performance in each specific claim, including the subject claim. A.C.E. has established the areas of opportunity for profiting in the claims department through a C.F.R. (Closed File Review). This opportunity is then expanded in the A.C.E. procedural program by identifying the means by which this profit can be achieved and the tools which should be used by the individual claim handler in order to achieve it. Through a process of subsequent claim file review areas of improvement and additional training needs are identified. These areas are then communicated to the individual employee through the

A.C.E. process entitled Q.A.R. (Quality Assurance Review).

Q.A.R. incorporates the individual claim handling review results for each claim handler into the individual's performance analysis and rating through the QPR (Quarterly Performance Review) and EPR (Employee Performance Review). The employee's individual annual salary adjustment is then determined according to the analysis of the employee's performance. For example, if the claim file review and overall claim average cost (including salvage profit or loss) has contributed to State Farm's economic success, then the employee would receive an increase in their annual salary. The opposite would also be true.

It is through these performance analysis tools (PPR, QPR and EPR), State Farm can closely monitor the outcome of each claim and the performance of each individual in the claim department. Thereby, State Farm, as a corporation, is able to hold the employee accountable to achieving the A.C.E. goals of profitability in each of the areas of the claim department and claim handling process.

The PP&R was the precursor to the QPR and the EPR. While this particular process was not used during the period of A.C.E., it is important to understand the premise upon which the performance evaluation processes, QPR and EPR, are based. However, the PP&R was used during the largest portion of the handling of this claim. The PP&R included statistical and dollar goals of each claim handler in each area of claim handling. This practice of including specific statistical percentages and dollar goals was abandoned by State Farm in order to avoid discovery. While the statistical percentages and dollar goals are still tracked in terms of "Average Paid" and "Average Expense" and "Average Cost" analyses, these reports are used as a reference in the performance process and only vague statements appear on the performance review processes such as the QPR and EPR. These vague references are found in

the section entitled, "Employee's contribution to the company's economic success.

The State Farm claim employee is held accountable to control the costs of a claim such as medical expenses, household services, attendant care, income loss, and funeral costs. However, the more significant performance indicator for a claim employee in Personal Injury Claims is the cost of medical expenses. This is a powerful motivator for each employee to follow the State Farm procedure and process for claim handling as opposed to what might be legally, ethically or morally correct.

28. That, I am familiar with State Farm's procedures and practices in determining its goals in each of the coverages provided within the State Farm policy including PIP. These goals were determined by State Farm Corporate with the recommendations from each of the Regional Vice Presidents. The goals were then conveyed to the Claims Managers, Division Managers and Claims Superintendents through the use of "Quarterly Reports". Ultimately, each claims handler was held accountable to these goals. In 1991, after an adverse discovery of the PP&R review process in Alaska, State Farm Corporate informed all managers to no longer state specific numbers or percentages on the PP&R so as to avoid discovery in future lawsuits. Instead, these goals were to be discussed with each individual handler during the quarterly and annual merit review sessions. Goals were established for an entire year. At the end of each quarter, each superintendent would report the actual statistical performances in relation to these goals. Naturally, the expectation was to meet or exceed the goal in each category. In my experience with State Farm, these goals were traditionally below the actual results for the previous year. I am familiar with goals being established for PIP average severity and PIP average pendings. The actual results for each State Farm unit, section, region and state would be published and distributed on a monthly basis to all State Farm Management.

29. That, I am also aware of the "Incentive and Thrift" program, which matched the employee's contribution at a percentage rate dependent upon the company's annual profit or loss results. "Savings and Thrift" is State Farm's profit-sharing program for its employees. When profit is realized in the claim department at the end of the year, this profit is shared with the individual employees who have contributed to the economic success of State Farm. The State Farm employee is allowed to invest up to 6% of their annual salary into this program. If there is a profitable balance in the claims department, then, State Farm will match this 6% investment at different levels. The matching ratio depends on the amount of profit realized. While I was employed with State Farm, I saw a matching ratio as high as 4 times by State Farm. This matching investment contribution by State Farm is compounded by the rate of return State Farm realizes in the investment vehicles as well. Again, while I was employed with State Farm, I saw a rate of return as high as 14% on my investments with them.

For a claim handler or manager in the claim department, this is a major economic motivator to contribute to the economic success of the company. If a State Farm employee's annual salary is $50,000.00, that employee could invest $3,000.00 into this program. In a profitable year, State Farm could match up to 4 times that investment or another $12,000.00 would be invested by the company in the employees investment account. This represents a $16,000.00 investment with a rate of return as high as 14%. For an employee earning $50,000.00 a year, this would be an impossible investment without State Farm's program.

However, because this program is so very lucrative, it provides a motivator so strong that a claim handler is blindly persuaded to follow the State Farm procedures and processes while ignoring what might be illegal, unethical or immoral. It is through these processes and programs; State Farm establishes the environment to aggressively reduce each claim so as to be

recognized by a superior for merit increases and/or promotion. It is a driving force within each State Farm employee to reduce their respective average paid claims and average pending percentages. The aggressive pursuit to find a reason to deny Skipp Van Fowler' claims for necessary medical treatment found in the State Farm claim file is evidence of this exact influence.

30. That, I am aware State Farm designs its procedures and practices on a national scale and insists they contain the elements of "time and measurability". This constant and continued practice provides management control of every small segment of State Farm's huge financial empire. It was obvious in my review of the State Farm claim file for Skipp Van Fowler that through the Claim Committee Reports and Serious Injury Reports, State Farm corporate was making the significant claim handling decisions on Skipp Van Fowler' claim. Additionally, this evidences the organizational influence, which State Farm's executive and general claims department has with each individual claim experience. These procedures and practices exemplified by the documents produced to date establish the undeniable evidence of State Farm's conduct in continuing to deny benefits needed by Skipp Van Fowler and which State Farm has sole control and possession.

That, based on my experience, education and training with State Farm and Allstate as well as the aforementioned review of documents involved in this issue produced to date, I have found State Farm to have not handled Skipp Van Fowler's claim in good faith. In the handling of Skipp Van Fowler's claim, the contractual benefits available under the settlement agreement were reduced without documented and practical claim reasoning. State Farm is motivated by selfish purpose and a desire to protect its own interest at the expense of its insured.

31. That, State Farm has and is placing the financial interest of itself above that of its insured.

State Farm used its position of apparent authority over Skipp Van Fowler in order to affect his interests and expectations of benefit payment. This has become routine claim practice for State Farm in dealing with its insureds as evidenced by one of its many training programs, "Negotiations for the Claims Professional". The instructions in this course are self evident of this abusive relationship. Some quotes directly from the course are, "It's often said that we negotiate from a position of strength.", "Power is the ability to control.", "We need to be aware of the power we have.", "The public recognizes the innate power of the insurance company and responds instinctively to its dicta, just, as it does a "stop sign".", S(he) who has control of the dollars is in a position of power.", "Reward and punish – The claim rep has the power to pay or deny.", and finally, "If you are in a position of power, use it! If you are in a position of no power, delay." I could find no reason not to continue the benefit payments at least at the rate before they were reduced for the treatment to Skipp Van Fowler at the present time.

32. That, as a former manager and company representative for State Farm, I am familiar with the documents being requested by the plaintiff as well as State Farm's corporate policy and directive to deny and/or evade discovery in lawsuits against the company. Any such requests were closely tracked and routed to specific management personnel in the regional office as well as State Farm home office. Based upon my education, training and experience with State Farm, I know that such evasive discovery tactics are encouraged, and actually taught to employees, particularly management personnel, in the defense of bad faith claims such as the case at hand.

33. That, I am aware State Farm through its counsel denies the existence of many documents or denies the documents relevance. Such representation is false, deceptive and misleading. As

a former manager and company named representative in lawsuits including class actions against State Farm, I am aware of the training, education and expectations to resist any and all discovery attempts. This is nothing short of intentional harassment of the plaintiff and post litigation bad faith. These attempts recently led to sanctions being awarded against State Farm in both, Plateros vs. State Farm (CV98-07605) in Reno, Nevada and Marten vs. State Farm (334545) in Tucson, Arizona.

34. That, it is my experience the expectation of State Farm Corporate was to encourage payment as little as possible in the handling of all claims. Their motto "We pay every dollar we owe, but not one dollar more" is typical of the underlying attitude throughout State Farm personnel. It was significant to realize even a moderate savings on each claim settled. State Farm is the largest personal lines auto insurer in the world. A savings of one or two thousand dollars on each claim would realize a national yearly profit in the billions for State Farm. I am familiar with State Farm's philosophy, that the occasional incidental loss it experiences by an adverse judgment against it does not outweigh the economic benefits of continuing with its philosophy and bad faith claims handling practices in the same fashion across the country. Until such time that a judgment matches or exceeds the continuing annual benefits of this practice, State Farm will not change.

35. That, the victims of accidents such as Skipp Van Fowler need and rely on the benefits of their insurance policy as well as the superior knowledge of their insurance company during the claim process more than at any other time. During this process the insured victims are emotionally and financially vulnerable. It is hard to imagine a more economically abusive and morally egregious conduct than a corporation using programs to exploit the claim transaction and to delay or attempt to intimidate by refusing to honor in good faith the contract with their

insureds so as to enrich the insurer. State Farm's incentive schemes, practices and procedures, do exactly that.

36. That, I have been retained as an expert and consultant throughout the country to review the ongoing uniform claim handling practices and procedures of State Farm. 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 to be video taped. This has led to my review of thousands of State Farm claim files as well as their unchanged and universal claim practices.

I declare under penalty of perjury that the foregoing is true and correct to the best of my information and belief.

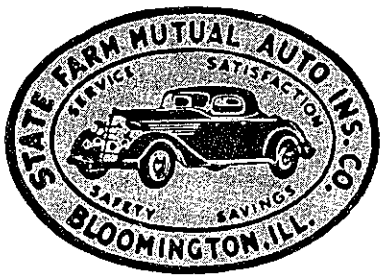
James J. Mathis
203 Scotch Pine Road
Reno, Nevada 89511
(775) 849-8400

Sworn to and subscribed
before me this 11th day of January, 2008.

Notary Public for the State of Nevada

Residing at Reno, Nevada
My commission expires: 05-19-2008

JODY CHAN
Notary Public – State of Nevada
Appointment Recorded in Washoe County
My Appointment Expires 5-19-2008
04-89069-2



Auto Claims Continuing Education

Certificate of Completion is Awarded to

for the successful completion of the

Negotiating Skills For The Claims Professional

Trainer's Signature
date

Instructions: Original to Employee
1. Copy to Division Shield
2. Copy to Regional Office Personnel Sheild

Printed in U.S.A.
161-5409

Do

Slide No. 29
Take Control

Slide — Blank

Pad
Power

Slide No. 30
There's no such thing as . . .

Slide — Blank

Say

It's often said that we negotiate from a position of strength. Control flows out of our power position — not bombast.

Power is the ability to control.

I read this statement somewhere, and I wonder how you react to it?

Suggested responses:

- It's only in the head of the person to whom you relate
- Power doesn't last for any extended period of time
- Power is mysterious
- Power seems to derive from a lot of externals

You can never foretell what any one individual will do, but you can predict, with surprising accuracy what the average Attorney will do.

Do

Pad
80/20
Pareto

Slide No. 31
Indicia

Say

Has anyone heard of the 80/20 rule?

A man by the name of Pareto propounded the rule that says:

- 80% of sales come from 20% of salesmen
- 80% of sales come from 20% of the customers
- 80% of value is in 20% of inventory
- 80% of action occurs in the last 20% of the time available

Since negotiation is an art form **not** a science — we play percentages.

You should be able to predict reaction and outcome with over 80% accuracy.

We need to be aware of the power we have.

- Legitimacy — The public recognizes the innate power of the insurance company and responds instinctively to its dicta, just as it does with a "Stop" sign.
- Questioner — the person doing the questioning relegates to himself automatic power.
- Position — s(he) who has control of the dollars is in a position of power!

Do

Say

- Knowledge — the claim rep who has the superior knowledge of:

  - the law
  - details of the accident
  - coverage
  - Attorney "leaks"
  - verdict range
  - experience

  possesses the greater power.

- Time — It's always a power advantage to choose the precise time for interaction and negotiation because preparation is strength.
- Silence — when we are interacting, prolonged silence on the part of one of the parties, will make the other real nervous!
- Competition — the claim rep can derive power by a subtle reminder how "other" Attorneys operate. The need to belong is very strong.
- Reward and punish — The claim rep has the power to pay or deny.
- Effort — energy and action are the vestments of power.
- Personal Ambition — It cannot be masked, and it signals a drive that translates into power.
- Negotiating Skills — Attorneys will attempt to take more negotiation liberties with the unskilled.

Do

Slide — Blank

Pad
Power Principles

Pad
Process

Pad
Expectations

Say

Here are some power principles that will work for you most of the time:

- If you are in a position of power, **use it!**
- If you are in a position of **no** power, delay.
- Power and expectation erode with time.

The process of negotiation is as follows:

- There is an exchange of information
- The development of expectations
- Agreement on settlement

Attorneys usually have a well-developed set of expectations that they bring to every negotiation. The satisfaction of these needs is vital:

Some of the more common ones:

The need to:

- Feel Competent
- Avoid Risk
- Look Good
- Relieved from Detail
- Get it Over With
- Considered Fair

NEGOTIATIONS

Negotiating basics

Negotiations are about POWER and using power effectively. Power or the perception of power is what keeps a negotiation in some form of balance. In negotiations, only the perception of power is important because for power to be effective, it must be recognized by the other party. Simply put, power is the ability to influence the behavior of others. Therefore, nonexistent power can become real power when the other side perceives power.

Defined

What are negotiations? In its simplest form it is simply a discussion of the value of a claim with both sides having input and a view to reaching an agreement.

Methods

Face to face negotiations have long been considered the most effective way to negotiate a settlement. In face-to-face negotiations individual personalities can and do have an impact on the proceedings and can influence the final settlement. Personal contact has many advantages.

1. See each other eye to eye – many times a person is quite different in person then they seem over the phone or in letter.
2. A chance to see the other side's file.
3. See the other side's office – idea of prosperity, work organization, etc.

4. Build rapport with office staff – may become "in" more often when you call
5. Able to watch reaction to discussion – pick up non-verbal clues
6. Gives other side a chance to size you up
7. Gives other side a chance to see how "big" your file is.

Telephone negotiations have become more routine as insurers centralize in cost cutting moves. You lose many of the benefits of face-to-face contact, but can be effective if you take the time to establish a working relationship.

Written communications should be used to exchange information and confirm conversations, not negotiate.

Remember, communication is:

7% actual words

38% vocal

55% facial

4 Keys to Success

1. Have a negotiating plan specific to the case and the parties involved. Take into account your analysis of the facts, liability and damages. The adjuster must determine a settlement range with a top settlement amount and a beginning offer. The claimant must

have a settlement range with a bottom dollar figure. In each case the people involved and the issues are different. Every negotiation is unique to itself and as negotiations progress flexibility is critical to success. If you remain rigid and follow the same course that was successful in the past, you run the risk of becoming predictable.

2. Know your strengths and weaknesses. Knowledge is always your greatest asset. The side that knows the case best has the upper hand in negotiations. Your investigation of the facts, including discovery; your detailed legal analysis; and a proper evaluation will reveal the strengths and weaknesses of the case. This should be the source of power to use when appropriate in the negotiation.

3. Always be a good listener. Do not allow yourself to get so caught up in presenting your side of the case that you fail to hear what the other side is saying. Many times the other side will concede a point. If your response is not timely, you cannot take advantage of the power that comes with the concession and it will be played without impacting the bottom line.

4. Use time to your advantage. Understand the other side is using time to their advantage, it is up to you to know what they are doing and why. Many times you can turn this around to your advantage once you understand what is going on.

Have a Plan

An adjuster who is very good at investigating and evaluating a claim is not necessarily good at negotiating a settlement. A very good trial attorney is not automatically a good negotiator. Insurance companies have recognized this for many years and have included in their claim handling training various seminars and training modules on negotiating. The evaluation forms most insurers use today have incorporated many aspects of a negotiating plan within the evaluation. Successful negotiations are usually the result of a detailed negotiation plan. To develop a plan it is easiest to begin at the end and work forward. Ask yourself:

A. How do we want this to end? That is, what do we really want out of this case? What is the base dollar amount or other outcome we are willing to settle for?

B. How can we reach this goal? What steps do we need to take to end at the desired outcome? What are the strengths of our case? What are their strengths? Timing? Who goes first? How should negotiations take place?

At this point it is a good strategy to put yourself in the shoes of the other side. Argue their case. What key points would you focus on? How strong is their position? What are the weaknesses to your case and how would they capitalize on them. How could you minimize their strengths? Now go back and reconsider your evaluation and rethink your negotiation plan.

Review handouts A). Negotiation Plan sample, and B). Evaluation Sheet sample

Strengths and Weaknesses

Make a detailed listing of strengths and weaknesses to your case. During discovery you have become exceptionally aware of the strengths and weaknesses. This includes many factors in addition to the facts, legal analysis and evaluation of damages. It includes the subjective issues such as impression of witnesses, what was not said, knowledge and skill on other side, and experience with other side. Strengths are a source of power in negotiations. Knowing your weaknesses can be equal power. On occasion cases unravel and it appears there is little going in your favor. The list of weaknesses seems to overpower the strengths. The earlier you recognize this, the more power you have because you will not have to react to moves by the other side.

Identifying the other side's weaknesses is included in your strengths as they are sources of power. So, your weaknesses become sources of power for the other side. There are ways to minimize that power.

1. Balance a weakness with a strength. If you have identified a strength that counters a weakness, save it for that purpose.

2. If you are certain the other side has identified or will identify a weakness, acknowledge it first. This allows you to control the timing and minimize the effect.

3. Identify the weakness with your initial settlement offer. Include it as a reason for your value.

Three important basics about power.

1.) There is a cost associated with using power. Most cards can only be played once effectively. Never reveal or use your power too early.

2.) While you always have more power then you think, it is always limited. Revisit the case from end to end, something is missed every time. Power is also dependent on time.

3.) Never assume the other side knows all their strengths or your weaknesses.

Listen

Listening is the easiest skill to ignore. Everyone believes they are a good listener. Most of us believe we can listen effectively and multi-task at the same time. This is simply false. Effective listening is a learned skill that requires thought and practice. Many times it is very difficult to listen to just one complete thought. By the fifth word or so we have already decided what is being said and are starting to formulate a response. For example, the other side may say they have hit their bottom line, but also hint there is still room for discussion. It would be a huge mistake to make decisions based only on the first part of the comment. During negotiations, this mistake concedes power. Make it a habit to put other things aside both mentally and physically before any conversation begins. In some cases one side may find itself well into detailed negotiations before they recognize the process has even started.

Take good notes and recap discussions in detail. Never rely on your memory. Even the best memory will erode quickly, losing important details.

Time

Time can be a negotiators best friend or worse enemy. If used effectively, time is a source of power and one of the strongest tools. Time will build or erode power and it will change expectations.

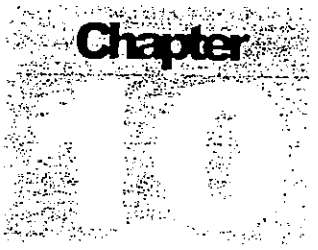
The "big" question about timing is when to start negotiations. The negotiating process begins with the initial contact. While the investigation is just beginning and the facts are being sorted out, the negotiation process has begun. Rapport is being established and a search has begun for common ground. Getting the other side to agree on any point or identifying common ground early can change the overall power equation.

Use time limits and deadlines to your advantage. Respect, but do not be intimidated by deadlines imposed by the other side. When using deadlines, give a reason for the time limit so it does not appear arbitrary. It is most effective to give the other side adequate time to digest and come to grips with the information. There must be time for thought and adjustment if an adjustment is to take place.

The opposite is also true. Give yourself time to think about what the other side is presenting. What are the merits? Are they presenting a new argument or restating the same points over and over? Is a point being conceded or an earlier point being conceded again?

Timing also includes the pace of negotiations, when to use the strengths you have identified, and when to concede the weaknesses. It is usually very effective to negotiate

issues and concede dollars. The amount of money needs to correspond to the importance of the issue. To concede a large sum for a minor issue can create an expectation for conceding a larges amount for a more important issue. Do not allow yourself to be backed into a corner. It is acceptable to backtrack and take back a prior concession or to readdress a prior point. It is important to keep track of the negotiation process in both issues and concessions.



Letter A

Letter A - is a form letter which would be sent to the insurer after receiving the initial offer in response to the demand the attorney has sent. It pulls all the relevant data from the demand including a listing of each value driver presented in the demand. It solicits from the insurer an acknowledgment of which value drivers were accepted, rejected or needed additional information. The letter should be sent after the first offer and before any negotiation occurs. This creates the foundation for Letter B to be successful in maximizing the ultimate settlement amount of their clients' claims.

See the following for an example of this letter

Letter A Sample

Your Letter Head Here

June 5th, 2002

John Smith
Allfarm Insurance Company
1111 First Street
Seattle, Washington 11111

Claim Number:	55-5555-555
Your Insured:	Bob Brown
Date of Loss:	January 01, 2001
Our Client:	Mrs. Jane Doe

Dear John Smith:

Thank you for the offer you recently extended to settle the claim of my client, name of client. This offer is presently being considered. I'll respond as soon as I have had the opportunity to discuss this with my client.

In order for my client to make an intelligent decision on whether to accept your offer, there are a few questions I would like you to provide answers to.

Please request permission from your insured to release to my client the limits available under the policy or policies, which apply to the damages of this claim. When requesting this information from your insured, include the policy limits of any duplicate/co-insured policies and/or any umbrella policies as well.

Please advise if there was any reduction in your evaluation of my client's claim for negligence or if there is any contribution you are seeking from a third party.

Please advise which of the following aspects were not taken into consideration in the evaluation process of my client's claim. If there was additional information necessary prior to your acceptance of any aspect, please indicate that as well. Simply check the box next to the appropriate item, sign and date this letter and return it to my attention.

There is a box available for the adjuster to check

- ☐ Accepted
- ☐ Not Accepted
- ☐ Need additional information

Please identify information needed on the bottom of this letter

(The items below will be automatically pulled from the demand you previously prepared and the above check boxes will appear next to each)

Listing of Injuries with ICD-9 codes

Listing of Treating Physicians
- Name of physician
- Number of treatments
- Treatment through last treatment date
- Prognosis

Total of Medical billings

Total Income loss

Listing of all value drivers entered in the "Demand Expert" demand
- Be sure to include scarring, disability, impairment rating

Listing of future medical billings

Listing of future income loss

Please identify the additional information needed:

_____

_____

_____
Signature of adjuster

_____
Date completed and returned

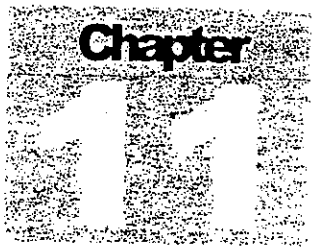
Thank you for taking the time in assisting my client and me in understanding the offer you have extended. We will be in a position to respond to this offer once we have received your response to this letter.

If you have any questions, please feel free to contact me directly.

Sincerely,

James Attorney

Cc: Mrs. Jane Doe



Letter B

Letter B - is a form letter which would be sent to the insurer after sending Letter A and after receiving the "TOP" or "Final" offer from the insurer. No actual negotiation should occur in the time period following the insurer's response to Letter A and this letter other than a counter offer in response to the insurer's first offer. After receiving the "TOP" offer, Letter B refers back to the insurer's response to Letter A by addressing each of the value drivers which were indicated as rejected or which needed additional information. This allows that the top authority for the claim is tendered before the attorney begins to negotiate the additional value which would be represented by the value drivers not accepted. In turn, this will increase the settlement value of the claim by as much as 50% more.

See the following for an example of this letter

Letter B Sample

Your Letter Head Here

July 5th, 2002

John Smith
Allfarm Insurance Company
1111 First Street
Seattle, Washington 11111

Claim Number:	55-5555-555
Your Insured:	Bob Brown
Date of Loss:	January 01, 2001
Our Client:	Mrs. Jane Doe

Dear John Smith:

Thank you for the latest offer you recently extended to settle the claim of my client, name of client. My client respectfully rejects this offer. In an attempt to resolve this claim without having to file a lawsuit, I am countering this offer with a demand for settlement in the amount of $_____.

Once again, I am requesting you seek the permission of your insured to release to my client the limits available under the policy or policies, which apply to the damages of this claim. When requesting this information from your insured, include the policy limits of any duplicate/co-insured policies and/or any umbrella policies as well.

In your response to my letter dated **(enter date of Form letter A)**, you stated the following aspects of my client's claim were not taken into consideration in arriving at your evaluation because there were either missing documentation or additional support needed. I have attached that documentation to this letter and request you resubmit the evaluation including those aspects for additional authority to resolve this claim.

I have also attached the specific medical records and highlighted for your convenience the supporting portions for the following value drivers, which you omitted in previous evaluation of my client's claim.

Please include these value drivers in the revision of your request for authority as well. If you are still unwilling to include these in your evaluation of my client's claim, please provide to my client a reasonable explanation.

(A paragraph will be inserted here, which you can respond to any discussion of negligence, contribution, etc.)

Listing of value drivers, which were checked by the adjuster in the response to Form letter A.

Thank you for your professional attention to this matter. Please contact me as soon as possible with your response to my client's counter demand. If you have any questions, please feel free to contact me directly.

Sincerely,

Sincerely,

James Attorney

Cc: Adjuster's Supervisor ***(If necessary)***

Cc: Mrs. Jane Doe

Enclosures:

Listing of supporting attachments

NERVES OF STEEL: WHAT TO DO WHEN THE OFFER IS ALMOST ENOUGH -- BUT NOT QUITE

Prepared for WSTLA seminar on "Negotiation."
Seattle, Washington. October 17, 2001.
Eugene M. Moen
Chemnick, Moen & Greenstreet

-- Know your true bottom line, vs. the goal you want to achieve, and make sure the client agrees with your figures. Consider the verdict range, the settlement range, and what you will recommend to the client as a final figure. Don't play it by ear during the mediation or negotiation; know your figures well enough that you can respond within those figures and project confidence.

-- Think in advance -- to yourself -- of what adjustments you might be wiling to make, including attorneys fees, to enable a settlement to occur. Distasteful, but sometimes practical.

-- Assess the risks of losing on liability, because that is the major factor in deciding whether to hold out for more money.

The other side is making the same assessment. If you are confident about proving liability, and think the other side is erring in their assessment, that can give you the confidence to reject their "last and best" offer. Conveying your confidence may also cause the defense to re-assess the liability risks. One author on negotiating said that the number one rule for success is "The projection of awesome power and the will to use it." Note he said "projection," not "actual." "Perception" is the mirror image of "projection," and in negotiating, perception is everything, and reality counts for little. How you project your confidence in your case -- and how the other side perceives it -- is the key to achieving your settlement goal.

-- **Ask yourself: how risk-averse am I in terms of losing at trial, and how risk-averse is my client?** You are better able to afford the risk than your client, because you have other cases. The ideal client is one who is able and willing to take risks, but that is often not the case. You may want to convince the other side that your client is perfectly wiling -- and even eager -- to roll the dice at trial, but you have to be realistic as to whether the client can afford to do that. In a good cop/bad cop

approach, sometimes your client can be the bad cop. That allows you to be conciliatory, but to say "my client is adamant about receiving 'x' amount in settlement or he wants to have his day in court."

-- Try to "read" from the mediator's comments how firm the defense is on their final figure. Sometimes the mediator has a good sense, but is honor-bound not to communicate it. But there are many forms of communication. If you know your mediator well from previous experience, that helps. I don't know anything about these new MVA carriers tactics, i.e., Pemco's "full and final" program, so nothing I say is applicable to those situations.

-- What is your reputation as an attorney for taking risks and backing up your position? If you don't have a track record of taking chances, it's more difficult to convince the other side you will walk away from their final offer and go to trial.

-- If you are rejecting the defense "final" offer, never acknowledge that it is their final offer; simply treat it as just another offer in the negotiations. In your written response, say that you appreciate the factors that went into their latest offer,

but point out the things they are missing or undervaluing.

-- **Do not ask for more time to consider the defense's "last and final" offer, because the implication is that you acknowledge that this is their best offer, and the only issue is whether you will take it.** Never agree to arbitrary deadlines: "This offer is open for 48 hours only and then it's off the table." If that type of deadline is made, simply reject it and say you will take as much time as needed to formulate a response to their offer.

-- **"Needs" approach vs. "value" approach.** Needs almost always can be met with less money than value of the case, so the defense will fixate on needs. It also allows them to appear sympathetic to your client and want to help them. In that case, you will want to emphasize verdict potential. However, needs may be most important for the client. If liability is problematic, then meeting those needs may be the actual goal of settlement. If the "last and best" offer doesn't adequately meet the client's financial needs, that can then be a basis for holding out for more. In effect, you are telling the defense "your offer cannot be accepted by the client because it does not meet the basic

needs resulting from the injury/illness."

-- **Consider face saving approaches.** If other information can be disclosed or other discovery completed, then the defense can re-evaluate its position. Either side can paint itself into a corner, and it's difficult to change that position unless new information comes up that allows it. "A change in circumstances" is a useful device for backing off a final figure. This cuts both ways, and may be a means for the plaintiff to retract a rejection of the defense offer. There is also the "I've used all my authority" position often taken by defense negotiators. Whether true or not, graciously granting the defense time to go back to the "home office" may be a face-saving way out of their position.

-- **If you take a hard-line position on a higher amount, and walk, be prepared to back it up.** If you fold, you are creating a history that may work against you in the future. But it is the client's call, and sometimes sleeping on it overnight changes the client's perspective. You always have to be prepared to swallow some pride if the client tells you to accept the defense last offer, even if you walked out of the mediation

or negotiation saying it was inadequate.

-- If you make a "last and final" counter-offer, unless you are confident about the mediator's ability to convey that, ask to have a face-to-face meeting with the other side, or their attorney, to communicate your figure and explain the rationale for it. Your sincerity and believability may be the key factor in convincing them you are serious. If they don't think you're serious, they'll just wait for you to accept their final offer. Remember that the defense will pay money to you only if they think you have a good case AND are perfectly willing to go to trial to prove it. Remember "The projection of awesome power and the will to use it."

-- If the differences are not large between the defense final offer and your counter-offer, consider the "split the difference approach." That allows a conciliatory and cooperative approach rather than an adversarial one: "Let's each give a little to achieve a settlement."

-- If the difference between what they offer and what you want is relatively small, try to get the defense to pay the costs of mediation or, if a minor plaintiff is involved, the costs of the

guardian ad litem fees (which can turn out to be substantial). We have also found in some medical negligence cases that, even though the defense may have tapped out the authority given to them by their claims committee, they can pay your expert or discovery costs that have not yet been paid, because those funds come from a different accounting fund.

-- **If you decide to terminate the mediation or negotiation when the defense final offer is not enough, don't do so in anger or pique.** Explain to the other side that their assessment of risk and verdict potential is not accurate, and that you and your client see the case differently. I find that the "agree to disagree" approach sometimes works effectively. Take a very confident approach, and simply say "it appears we have honest differences about valuation of this case, and perhaps the best approach is to just let the jury decide." At that point, don't argue the merits or the facts of the case and express complete willingness to submit the disagreement to a jury as a reasonable means of resolving the differences. Your willingness to accept the risks of trial will often be contrasted with the queasiness of adjusters in letting a jury decide.

Insurance adjusters do not like risks. If they think you tolerate risks -- or even thrive on them -- you have a big advantage in negotiating.

NEGOTIATION

Friday, October 19, 2001 • Washington State Convention & Trade Center • Seattle
Chairpersons: Kimberly Gaddis Weyer & Michael J. McKasy

MICHAEL J. MCKASY is a partner in the law firm of Troup, Christnacht, Ladenburg, McKasy & Durkin, Inc., P.S., in Tacoma. His areas of specialty have included products liability, auto negligence, medical malpractice, real estate and domestic relations.

He is a member of the Washington State Bar Association, American Bar Association, ATLA, and Washington State Trial Lawyers Association, and has served as an arbitrator in Pierce County. He is a past Chairman of the WSBA Public Relations Committee and Past-President of the Tacoma-Pierce County Bar Association. He also chaired WSTLA's Family Law Section in 1990 and 1991.

Mr. McKasy received his J.D. degree in 1976 from Seattle University and B.A. and B.S. degrees in mathematics and education, respectively, from the University of Minnesota.

Mr. McKasy was selected as a "superlawyer" by Washington Law & Politics in 2000 and 2001.

Mike McKasy

EARLY MEDIATION

Michael J. McKasy

Early resolution of a conflict is usually beneficial on many fronts–practically, emotionally and financially. Consequently, an effort to schedule mediation should usually be made as soon as possible. The timing of the mediation, however, depends on a case by case analysis and involves consideration of numerous factors.

No case is "perfect" for mediation, but every case is at least a candidate. The timing and approach to mediation are items for the attorney to determine for the benefit of the client.

1. SCHEDULING FACTORS

1.1 TYPE OF CASE

The nature of the case may determine when the time is ripe for mediation.

A personal injury case may have elements and concerns quite different from another case such as a dissolution, commercial contract, landlord/tenant, or intellectual property.

1.2 COURT SELECTION

The selection of the court may dictate when mediation will take place at the very latest.

A superior court case will probably not have a specific time line for mediation, but could well have a settlement conference requirement as part of the case schedule. If mediation has not been accomplished by that time, an effort to do so may be done independently or possibly in lieu of the court settlement conference.

County district courts, such as in Pierce County, may have their own requirement for mediation which is provided by the court and free of charge.

Federal district court requires a CR 39.1 mediation conference before the case goes to trial.

RCW 7.70.100 requires mandatory mediation for all causes of action for damages arising from injury occurring as a result of health care.

1.3 STATUS OF DISCOVERY

In order to make an informed and proper valuation of your case, the bulk of discovery should be completed prior to mediation.

Usually the case just gets better as discovery continues. However, there are always exceptions and you know you case better than anyone. Maybe it would be beneficial to mediate before all discovery is complete if there are facts you know exist that hurt your case and have not yet been discovered.

You can minimize your discovery costs with early mediation, but your opposition usually won't agree to the process unless discovery is completed or you have made such full disclosure of all facts and documents that your opposition feels fully informed.

1.4 COST OF PROCESS

Encourage early mediation as a way to reduce litigation costs. Also, see if you can find an attractive forum that will keep the mediation cost at a minimum–either by court-provided mediation or with a mediator in whom you are confident that has reduced or minimal administration expenses.

Some cases may be so complex that the costlier mediation services may be necessary; or the other party may insist upon that venue. If so, still strive for early mediation but request your opposition to pay those costs as part of the final agreement.

1.5 "VALUE ADDED" CASE

Early mediation may be driven by the fact that your opposition sees a real benefit to immediate resolution. This occurs in the personal injury case that may have sensitive facts that add to the value of the case. Likewise, the dissolution case may be ripe for early mediation based upon the other party's anxiety to finalize the divorce and start a new ("greener grass") relationship. That anxiety can be brokered into a more favorable distribution of assets for your client.

1.6 MULTIPLE PARTY CASE

Two or more defendants often put up a misdirected defense where neither

one will blink first. Early mediation will put an end to such a case which will otherwise drag on indefinitely.

1.7 MULTIPLE CLAIMS

Your client with two accidents, each defendant blaming the other, may find quick and immediate resolution by early mediation of both claims.

1.8 ELDERLY/INFIRM CLIENT

Your client's age or physical condition may dictate that mediation be pursued as soon as possible. If the client is infirm or has a serious illness in remission, pursue mediation as soon as possible before you just end up with an estate.

1.9 CLIENT "EMERGENCY"

Often the client will push you for immediate resolution of a case: the personal injury client with creditors at the door; the dissolution client wanting to move or start a new relationship; the commercial client that is about to go out of business. All of these may insist upon an early effort for mediation.

1.10 LIMITED COVERAGE

If insurance coverage is limited, the specter of protracted litigation only serves to increase costs and decrease the client's recovery. Early recognition of low limits can dictate immediate mediation if your limits demand is rejected.

1.11 NO RESPONSE

When communication breaks down or the other side just appears too busy to move your claim or demand, then mediation at an early date will focus attention on your case and bring that response you are looking for.

1.12 DIFFICULT ADJUSTER/ATTORNEY

Frustration with a difficult adjuster or attorney may require mediation as soon as possible. Let the mediator communicate with this difficult person if you have not had success.

1.13 CLIENT CONTROL PROBLEMS

If your client's demands seem impossible or unreasonable, then an early mediation may help to present reality to your client and assist in the resolution of the claim.

1.14 ONGOING RELATIONSHIP OF PARTIES

Some disputes involve parties that will have ongoing relationships in the future. In order to foster and promote those relationships and to keep them free of conflict, an early mediation may be helpful and in fact mandatory.

1.15 FAIR AND FINAL OFFER

There are insurance companies making "fair and final" offers before any litigation or discovery is commenced. These companies then maintain that they will not vary that offer once it has been made. Is mediation viable in that setting?

1.16 WASTE OF TIME

We have all had cases where we have been told or can easily see that no amount of mediation or negotiation will affect the polarization of the parties and a mediation session would be a "waste of time." I tend to still push for resolution in these cases; at the very least the process helps you to prepare your case and at the most you may settle the case.

1.17 STATUS OF LIENS/SUBROGATION AND COSTS

Your client will want to know the bottom line net for any mediated settlement. Check prior to mediation to determine not only your costs and outstanding medical bills, but also the nature and extent of any liens or subrogation claims; determine if they can be compromised or reduced to your client's benefit. Entering a mediation without that information can only lead to possible later client dissatisfaction when the numbers change in the future.

1.18 STATUS OF MEDICAL TREATMENT

Early mediation certainly isn't advised if the client's medical condition is not fixed and stable. Questions as to future treatment or surgery and concern over the residual condition postoperatively will serve to really complicate the mediation procedure and put you at risk for settling short.

2. HOW TO APPROACH MEDIATION

2.1 POSITIVE

An antagonistic attitude will serve to defeat the mediation process. Keep a positive attitude and be nice to the adjuster and defense attorney. If your client sees a positive approach, the client will adopt the same attitude. However, if you are confrontational and insulting, you make the process more difficult and less likely to succeed.

2.2 INFORMAL

Everyone benefits from an informal atmosphere. Rather than the confined and foreign atmosphere of the courtroom, participants will benefit from an informal, friendly, and comfortable setting.

a. RELAXED

The mediation process benefits from a relaxed atmosphere. Many mediators resort to providing snacks and beverages to make the parties feel more social and relaxed.

b. OPEN-MINDED

Parties should be open-minded and receptive to different approaches to settlement. That may include conceding some points in order to gain others, or entertaining certain options such as annuities.

2.3 BOTH SIDES HAVE AUTHORITY

Nothing is more frustrating or unproductive than to have one of the parties unavailable for a mediation. Equally frustrating is having a party either without authority to proceed with the mediation or unable to get enough authority *at that time* to settle.

2.5 SIGN OF WEAKNESS? WHO BLINKS FIRST?

Are you hesitant to suggest mediation? Is it a sign of weakness? Typically, the other side welcomes the invitation to mediation. To refuse is simply an indication that one doesn't care about one's client or the client's financial situation. Don't view the suggestion as being a sign of weakness.

a. DOCUMENT THE SUGGESTION

In making a prelitigation settlement demand, include the suggestion of possible mediation. Let the adjuster know that you are willing to consider that early on as a means of resolution. The adjuster will remember that willingness later on if the case gets heated up in litigation and may then take you up on the suggestion that was first documented at an early stage in the adjuster's file.

b. DIVISION OF COST

You know you will be asked to initially agree to split the cost of the mediation with the other party or parties. Rather than make a big issue of that initially, it is better to start with that agreement but then later try to include your cost of mediation as a finishing touch to the final settlement figure.

c. SELECTION OF MEDIATOR

Make sure you know the background of your mediator. Call other attorneys for input if you are not familiar with the proposed mediator. Find out the areas of practice and associations the mediator may have had with other attorneys to the case. Some people resist the selection of a defense attorney as a mediator; however, I feel it may offer some benefits. The defense attorney speaks the same language as the adjuster and also knows some unique ways to pull money from various sources the other side may have.

d. DOCUMENT THE DECISION

Avoid later confusion: make sure the mediator documents not only the settlement agreement but also the payment of mediation costs; have all parties sign the agreement.

2.6 OPEN-ENDED MEDIATION

Sometimes the mediation just cannot be finalized and more information or time may be needed. A number of mediators successfully follow up on the parties and later settle the case. That result requires, however, not only a very talented mediator, but also a very persistent and dedicated one.

2.7 WIN-WIN APPROACH

The approach that all parties to a mediation will buy off on is that the

object is to have a situation where all parties "win" and there isn't an adversarial contest with a winner and a loser. The mere fact that all the parties can assist in crafting a settlement that all feel comfortable with is a tremendous "win" and far more satisfying than having a third party (judge or jury) over whom you have no control make a decision in which everyone feels like a "loser" and has no input.

2.8 INPUT AND INVOLVEMENT OF MEDIATOR IN CLIENT DISCUSSIONS

There are times when you approach the mediator and involve him or her directly in conferences and deliberations with your client. I like to do that if I want independent input from the mediator to comment on my negotiation strategy or approach. Often times the mediator has an idea of just how far the other side may go and, even if the mediator can't disclose those conversations, it may help to have the mediator assist in your discussions with your client.

2.9 BABY STEPS OR BIG STEPS

During mediation, you may make "baby steps" or "big steps" in terms of your movement in dollar amounts. I think the size of the move conveys a message and, certainly, if the other side continues to make baby steps in value changes, then you surely don't want to take big steps and drastically alter the course of the negotiation.

2.10 CONDITIONAL OFFER APPROACH

I have been involved in mediations where one side will make a "conditional offer," i.e., "I will go to $175,000 if the other side will go to $125,000." Interestingly enough, I have seen that work; it doesn't resolve the case yet but it keeps both sides on track. If the other side won't go to the requested figure, you back up to where you originally were.

2.11 NONECONOMIC TERMS

On occasion, a client will want certain terms of settlement that are not financial. The most common request seems to be for an "apology" from the other side for some wrong. While heartfelt, such a request usually isn't practical. However, other terms may be. Settlement could be conditioned upon changing a dangerous condition, such as carpeting a slippery floor, or

maybe actually modifiying a dangerous machine or product so that no one else is similarly injured. Some requests may not have great monetary value, but they may go a long way towards making the client feel that a claim has accomplished something purposeful in addition to monetary damages.

2.12 DO YOU NEED AN OPENING STATEMENT/SESSION? DOES THE CLIENT SPEAK?

While a joint opening session is almost always advisable so the parties actually see each other eye to eye, it is not mandatory that an opening statement be made. Usually you have already made a written settlement demand to the other side that outlines your position and demand, so it is a waste of time to repeat it all. A reference to the demand and an update on the status of negotiations is all that is usually necessary.

If there is a powerful video or other evidence to show the mediator, the opening session is the right time. A client generally should not be put on the spot to make comments that could turn out to be misunderstood or harmful. You can underscore the points the client wants emphasized. Certainly in the closed sessions the client can speak and vent to the mediator.

2.13 ADDITIONAL ADVOCATES; GUARDIAN AD LITEM

You may have an additional advocate to assist the mediation process. A settlement guardian ad litem can be appointed in advance of the mediation process to review the case and actually participate in the mediation process. Although that may seem costly, the guardian ad litem is going to have to review the file in depth to make a report anyway, so the mediation process helps get that preparation started.

2.14 "TAG TEAM" APPROACH

An effective negotiation technique is always the "tag team" approach using the good attorney/bad attorney dynamics. If the size of the case warrants it, then two attorneys can effectively take opposing personalities in the negotiations on behalf of the plaintiff: one is the cooperative negotiator and the other is the caustic litigator who is going to win the case and feels the settlement process is a waste of time.

Often the "team" really does have those actual sentiments, and the combination of views and approaches can spur the mediator and the process on. I remember the mediator in a case who felt deadlocked and I reminded him that his reputation was his ability to settle the large, complex

cases and that was why we were there. He seemed to be re-energized and attacked the mediation with new vigor and eventually got the case resolved.

2.15 A 'UNIFORM' APPROACH?

The final draft of the Uniform Mediation Act was adopted by the National Conference of Commissioners on Uniform State Laws in August 2001. It is to be presented to the American Bar Association for adoption in February of 2002. You may review the latest draft online at www.mediate.com/articles/umajune01draft.cfm. Although very general in its content, the greater concern of reviewers is that the open and fluid dynamics of the mediation process may be restricted by codification.

3. CONCLUSION

Consider all of the factors before deciding the right time to mediate your case. Be open to alternative approaches to mediation; try to be creative and come up with a result that everyone will feel is a "win-win" solution.

NEGOTIATION

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MICHAEL E. WITHEY has been with the Seattle firm Stritmatter Kessler Whelan Withey Coluccio since 1997. From 1983 to 1997 he was a partner in the Seattle firm Schroeter, Goldmark & Bender specializing in toxic tort and human rights litigation. He was lead counsel in *Estate of Domingo, et al. v. Ferdinand E. Marcos, et al.* (U.S.D. Ct. Western District of Washington) in a wrongful death action brought by the estates of two anti-Marcos union organizers against Ferdinand and Imelda Marcos. The case resulted in multi-million dollar verdicts against the Estate of Ferdinand Marcos and Imelda Marcos (by jury) and against pro-Marcos defendants (ruling by judge 1989).

Mike's recent cases include as co-counsel on *Smith v. Behr Process Corporation*, a class action brought by customers whose homes experienced excessive mildew growth after applying Behr finishes, which resulted in a default judgment for deliberate discovery violations and a jury award for the entire class estimated at more that $50 million. He has successfully settled or tried cases involving faulty fall protection programs, toxic mold growth, products liability, and class actions.

Mike is the former President of the Trial Lawyers for Public Justice, was awarded WSTLA's Trial Lawyer of the Year Award in 1991 and the TLPJ's Public Justice Achievement awards in 1991 and 1992. He is a member of DART and ABOTA. He has conducted over 25 focus groups and speaks frequently about jury issues at trial lawyers organizations and ATLA conventions.

Michael Withey

GARNERING MOMENTUM, CONVEYING VALUE AND TRIAL READINESS

Strategic Use of Demonstrative Evidence in Mediation

October 2001

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INTRODUCTION

Strategic use of demonstrative evidence in mediation depends upon a trial lawyer's objective assessment of (a) the strengths and weaknesses of the factual and legal case; (b) the degree of readiness of the defense team to settle; (c) the degree of persuasion needed to successfully resolve the case.

Demonstrative evidence should not be used in every mediation. However, the effective use of trial-ready demonstrative evidence can assist plaintiffs' trial counsel in successfully resolving cases. Demonstrative evidence can be the most effective method of demonstrating the strengths of the liability, causation or damages case. The use of demonstrative evidence in mediation demonstrates trial readiness, can garner momentum within the mediation process and convey the human values underlying your case.

Many mediations fail because defense and insurance adjusters either do not understand or appreciate the strength of your case. In those circumstances, demonstrative evidence can be effective.

When to present demonstrative evidence is a tactical question. If sufficient time does not exist to present this evidence in opening statement in a joint session, consider scheduling an hour

or two on the day before the mediation in order to educate the defense team and insurance adjusters about the strength of your case.

I. UNDERSTANDING THE PERSUASIVE POWER OF DEMONSTRATIVE EVIDENCE

Effective use of demonstrative evidence requires an understanding of human psychology and how to enhance rather than reduce the effectiveness of demonstrative evidence. Juror researchers and human psychologists agree that a method of presentation dramatically affects the retention of information both in the short and long term. When our grammar school teachers taught us to "show and tell" they realized that effective teaching methods enhance the retention of the information conveyed over merely telling (verbal) or even merely showing (visual).

There is a hierarchy that applies to the speed and order in which human perceive and thus understand information. The first is color – it is the first thing people see. Second are pictures, followed by shapes, and then text. Spoken words are fifth in line. While this hierarchy suggests that demonstratives should be used, it also suggests what should be included in demonstratives.

Demonstrative evidence, whether in the form of PowerPoint presentations, videotapes, story boards, charts, animation, still photography, etc., should play upon this hierarchy of persuasion. Color will be the first thing your audience sees on a demonstrative. This can be both positive and negative. Color is used to focus jurors on what you want the jurors to see that can be useful. However, color also can distract jurors from the point you want to drive home. Jurors will also remember pictures because they can communicate the information without words and create emotional responses. Texts should accompany, where appropriate, both color pictures and shapes in order to explain and highlight certain key aspects of the demonstrative evidence.

There are many errors that reduce the effectiveness of demonstratives. The most frequent is data density or "clutter", including charts that include large amounts of data or too many

words. Another is "chart junk," which refers to the use of design elements that have nothing to do with communicating the point or the purpose of the demonstrative evidence. Naked charts fail to utilize text in order to provide direction to the audience. An audience without direction may create his or her own reason or explanation for an unlabeled exhibit. Authenticity is another prime requirement. Demonstrative evidence that present medical models, computer graphics, or timeline charts that appear to be the creation of the plaintiffs' lawyer's optimistic imagination should be discouraged. Instead, produce actual copies of the medical chart and then highlight the text in order to create greater authenticity. Make sure your medical or scientific demonstrative evidence are cross examination "expert proof."

II. EXAMPLES OF DEMONSTRATIVE EVIDENCE FOR USE IN MEDIATION

Like an opening statement at trial, effective use of demonstrative evidence in mediation can enhance the value of your case, demonstrate trial readiness and garner momentum toward a positive outcome. Unless strongly discouraged by the mediator, you should insist upon an opening statement which allows effective use of your demonstrative evidence that is trial ready. Providing videos and PowerPoint presentations in the mediation memorandum may also be useful in order to allow time for the defense to digest and understand the importance of the demonstrative evidence you are presenting. Videos can be particularly valuable to share with the defense prior to the day of the mediation. PowerPoint presentations are more effective when giving an opening statement rather than to be viewed by the defense without proper direction through verbal input.

Large blow-up charts are also effective for mediation purposes. They will be present within the mediation room during the opening statement. They are a reminder to the defense that this is the chart that the jurors will be seeing throughout the trial.

The opening statement presentation should be short and simple. It should not rehash issues that were covered in the mediation materials, if provided to the defense. The purpose is to persuade through visuals not verbiage. Saving the best visuals for the opening statement during mediation (rather than providing it to the defense beforehand) is an effective way of garnering momentum within the mediation process.

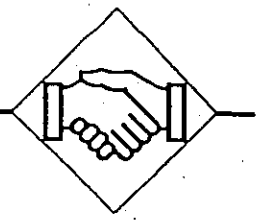
Involve the mediator in your decision to utilize demonstratives. Indicate in your letter to the mediator your desire to have a brief opening statement and provide the demonstrative evidence to the mediator. The mediator is part of the audience you are seeking to persuade. Don't neglect his or her practice in mediations.

Finally, garnering momentum is important because you want to, as much as possible, stay in control of the mediation process. An effective presentation puts the spotlight on your case, the evidence of defendant's wrongdoing, and the damages suffered by your client. An effective opening statement, supplemented by demonstrative evidence, can resolve questions in the insurance adjuster's mind about liability, causation or damages. It can rebut the best of the defense arguments against significant settlement value in the case. It will demonstrate your command of the facts and the law. It will prove that you are ready for trial and have a strong case for jury appeal. Rarely will defense attorneys have much to say in opening statement that can be as effective as a well-prepared opening statement by plaintiffs' attorneys armed with effective demonstrative evidence.

III. EXAMPLES OF THE USE OF DEMONSTRATIVE EVIDENCE AT MEDIATION

The presenter will show both PowerPoint and video examples of effective use of demonstrative evidence at mediations. The following graphics were used in a mediation

memorandum in a recently mediated case involving a worker who was seriously injured in a chemical gas explosion.

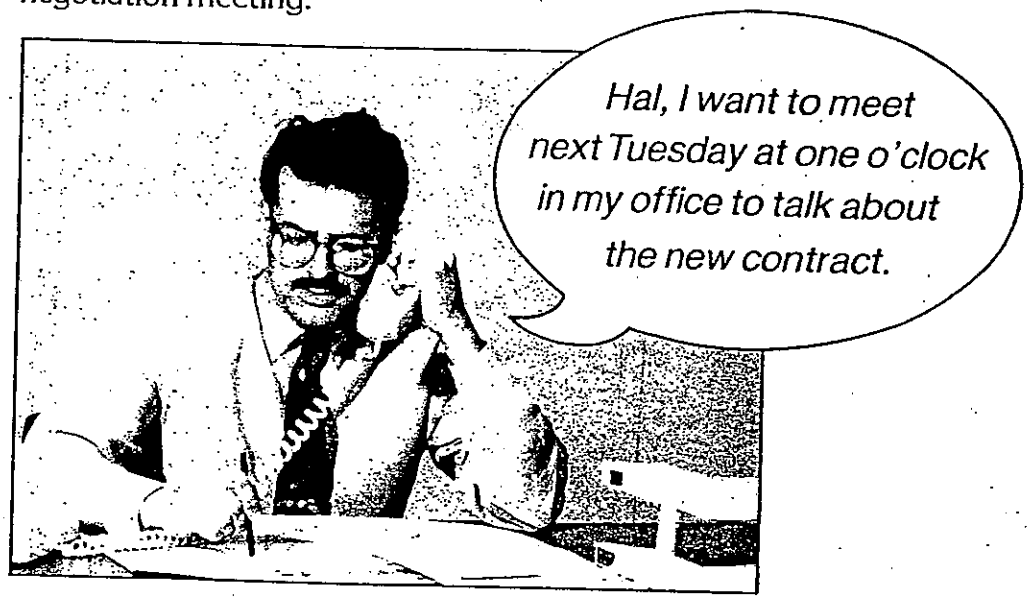


Tips for Establishing and Maintaining the Right Climate

1. Initial Contact

Set up the initial meeting using a friendly but professional tone. Make sure the arrangements – time, date, location – are agreeable to both parties.

This is an illustration of the wrong way to establish initial contact and set up a negotiation meeting.



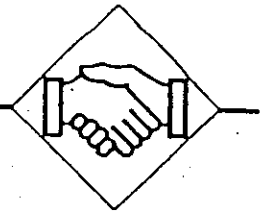
INSTRUCTIONS:

Describe a better way to establish initial contact with the other party.

"_____

_____

_____"



2. The Negotiation Site

The location can be an important factor in negotiations. There are basically three choices: your location, the other side's location, or a neutral location.

Each location has advantages and disadvantages. Your site would probably be considered the most desirable location to meet. It gives you the extra edge of being in familiar surroundings and having all of your resources within easy reach. A disadvantage is having to contend with more distractions. A neutral location provides more of a distraction-free environment. A disadvantage is that it may prolong negotiations if either side does not have the authority to make certain decisions on the spot. Meeting at the other side's location is the third option. An advantage of this would be that it allows you to withdraw if negotiations are not proceeding the way you want them to. A disadvantage is that it puts the other side into a "power" position.

As a general rule, in a buying/selling situation, negotiations should take place at the seller's location when the business is of a personal nature and at the buyer's location when the business involves commercial or job-related dealings.

INSTRUCTIONS:

For each of the following negotiation situations, decide where you feel the negotiation should take place. Mark an "H" for your location, an "A" for the other side's location, or an "N" for a neutral location.

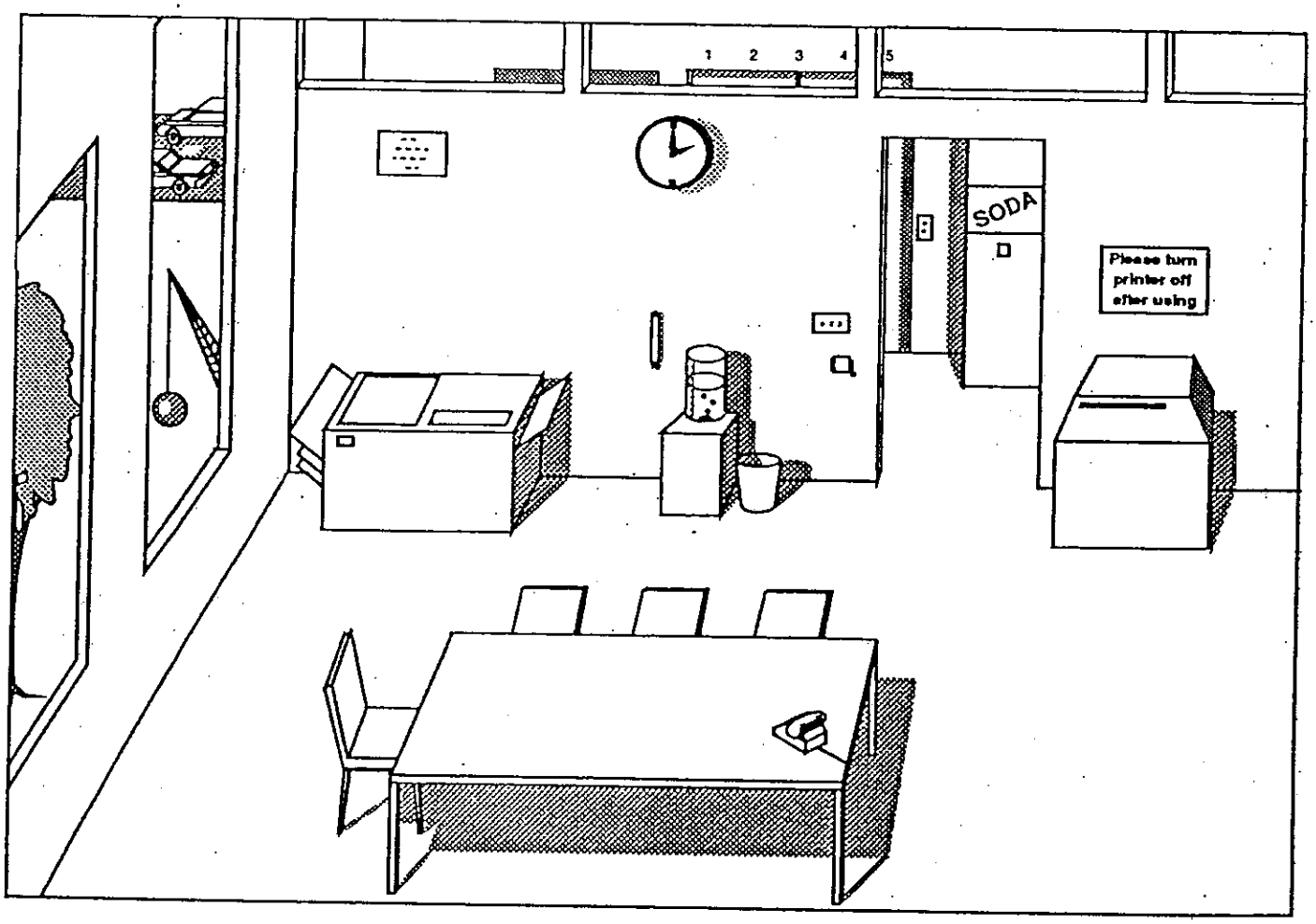
_____ 1. You are a claim representative negotiating a claim settlement with a policyholder.
_____ 2. You are negotiating to have aluminum siding put on your home.
_____ 3. You are negotiating to buy a new car.
_____ 4. You are negotiating to buy a packaged "Customer Service" course for our company from a vendor.
_____ 5. You are negotiating a project completion date with another department.
_____ 6. You are a claim representative negotiating a liability settlement with a lawyer.
_____ 7. You are in charge of purchasing new computer terminals.
_____ 8. You are a diplomat negotiating an arms limitation agreement with another country.
_____ 9. You are negotiating the transfer date of an employee who is leaving your unit.
_____ 10. You are negotiating to purchase a house.

3. Characteristics of the Room

The characteristics of the meeting room can have an impact on the negotiations. The size of the room, lighting, color, temperature, and ventilation are all important considerations. A meeting room which is too large reduces feelings of intimacy and openness. Smaller spaces encourage participation and communication. Inadequate lighting and dull wall colors have a negative impact. Adequate air conditioning and smoke exhaust systems are essential in establishing and maintaining a pleasant environment. Also, the room should be in a location that is as distraction-free as possible. A location in or near high people traffic areas or in which street noises or construction work can be heard would not be a good place to try to negotiate.

INSTRUCTIONS:

There are at least ten things in this negotiation room that could cause distractions. Name as many as you can.



4. Punctuality

Be on time for the negotiation. This shows that you have respect for the other people involved and take them seriously.

QUESTION:

Which negotiator would you prefer to negotiate with?

1

2

3

4

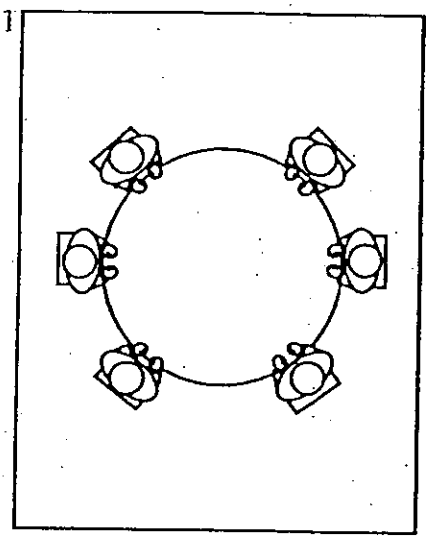
5. Seating

Seating arrangements can either help or hinder the climate established at a negotiation. Two negotiating teams may arrange themselves directly across from each other as if they are preparing for a competitive game. To create an atmosphere that is less tense, participants from each side could sit next to each other. This seating mix creates a feeling of friendliness and cooperation. The most effective seating arrangement is either a round or oval table.

QUESTION:

Which are desirable seating arrangements for a negotiation meeting?

1



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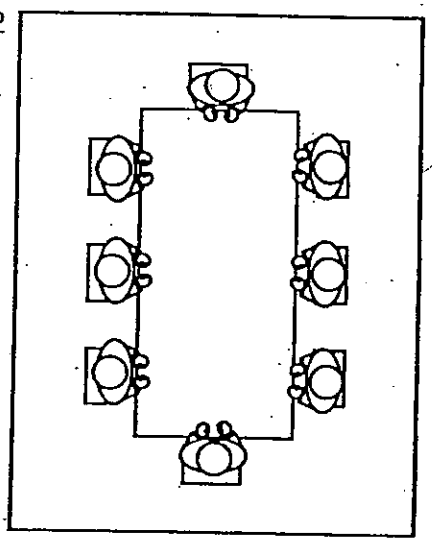

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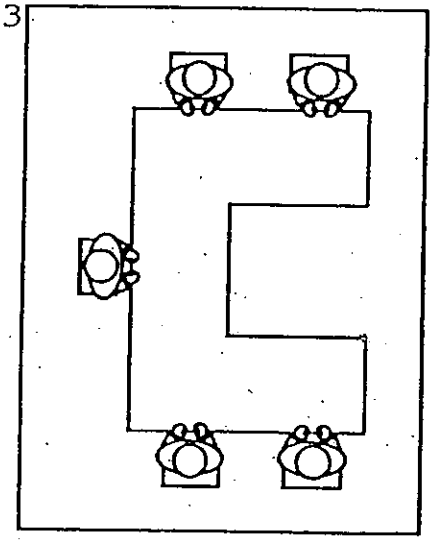

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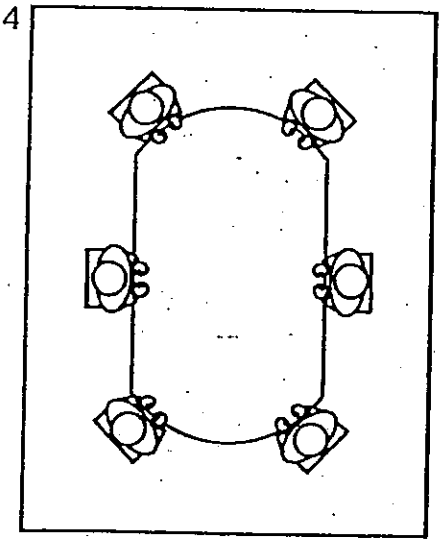


6. Appearance

Formality of dress depends on the negotiation situation. However, regardless of the situation, appearance communicates one of the first messages that the other side will receive from you. Generally, if you are a person that is neat, clean, and well-groomed, then you are more apt to make a positive first impression.

QUESTION:

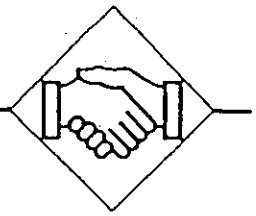
Who would you prefer to negotiate with?

1

2

3

4



7. Tone

Strive for a friendly tone. Maintain a professional tone in business negotiations, but try empathizing and agreeing with the other side when you can. Treat others like you would want to be treated. People do not like to be treated rudely or without respect. Often they react in the same way that they are being treated. The way you treat other people will probably set the tone for how they treat you.

INSTRUCTIONS:

Circle the words/actions that you feel promote a positive negotiation climate. Cross out those that could cause a negative climate and leave the rest unmarked.

PERSUADE ORDER MANIPULATE PUSHY

ENCOURAGE THREATEN INFLEXIBLE

COLD DEMAND SUPPORT SLICK

REQUEST SYMPATHIZE FRIENDLY

WARM EXPLAIN INTIMIDATE BLAME

ABRUPT CAUTIOUS BUSINESS-LIKE

ACCUSE HELP EMOTIONLESS GIVING

8. Be Alert for Signals

Listen and watch for clues regarding the other side's reactions during the negotiation. Be alert for nonverbal body language such as facial expressions, posture, and gestures which may signal acceptance or rejection. Often nonverbal clues convey the deep-down emotions and true reactions that people have towards the message that you are sending.

INSTRUCTIONS:

What nonverbal message is being conveyed in each of the following?

1

2

3

4

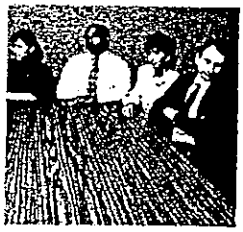
5

6

7

8

9.



10

11

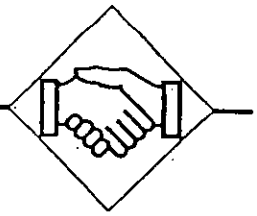
12

9. Listen Actively

It is very important for you to show that you are interested in what other people are saying. You can do this by maintaining eye contact, nodding or smiling when in agreement, writing down key points, and paraphrasing when possible. Too often in a negotiation situation, each side is only interested in what their side is saying. They are so preoccupied with achieving what they want that they do not even listen to the other side. This will usually result in a negotiation stalemate.

INSTRUCTIONS:

Name five ways this man is showing he is actively listening.



10. Time Schedule

It would be wise to establish planned lunch and regular breaks at the beginning of a negotiation session. This will help keep the participants "fresh" and avoid hurt feelings if someone feels like he/she is being cut-off because someone else must leave the room. Arrangements for refreshments to be brought in should be made.

EXERCISE

You are going to be involved in a negotiation involving the proposed construction of a regional airport. The negotiation starts at 9:00 a.m. tommorrow. Outline a time schedule to be followed for tommorrow's session (briefly describe the activity in each time slot).