TEN THINGS TO CONSIDER AND LOOK FOR IN THE HANDLING OF INSURANCE CLAIMS

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I. Introduction

I make my living as a trial attorney. Since beginning practice in 1985, I have had the privilege of representing insurance companies and your insureds in claim-related litigation. Beginning approximately ten years ago, my practice began to focus on defending insurance companies in regard to the investigation of claims and resulting bad faith litigation.

Although I enjoy greatly making my living in the courtroom, chances are most of you do not look at courtroom testimony as a "fun" or "rewarding" part of your employment. Because of that my goal is to review some key points to make certain our two professions do not "intersect" on a claim for which you are responsible.

It is often the most mundane and apparently simple of claims which results in bad faith litigation. Whether it is a property or a personal injury claim, and depending on the state you are in, either a first-party or third-party claim, literally any type of claim can result in an allegation of bad faith. Recent trends nationally have shown an increasing number of bad faith cases being filed against insurers and too often with resulting very high verdicts.

At the start of each trial we interview potential jurors to seat a fair and impartial jury. I routinely question jurors regarding their biases and prejudices toward insurance companies and am regularly assured they will treat my client "equally and fairly" as they would any other individual or corporation. I find this interesting because, after the trial is over and I have the opportunity to speak to the jurors, almost universally the jurors will make the following comment: "*I really never thought I could rule in favor of the insurance company, however, . . ".* The reality is our profession is not viewed favorably by those outside the insurance industry, and those are the exactly the same individuals who will serve on the jury deciding whether you handled the claim properly!

Perhaps even more importantly, however, is the analysis which has been done of cases where bad faith has been found and substantial damages awarded. Although there may be the exceptional case, in 99.9% of the cases which do result in substantial bad faith verdicts, there truly is no real evidence of intent or maliciousness on the part of the insurance company. Rather, a series of events, actions and, more often, inactions collide to create a situation where, at least in the mind of the jury, the claim was not handled properly, resulting in harm and ensuing damage to the claimant.

I have told my clients as well as the attorneys in our firm for many years, there no such thing as the "perfect" claim or lawsuit. Even in cases where we win at trial, we could still go back, review the file and find multiple things which should have been done better and mistakes which were made and never should have occurred. This is in the best of cases!

I also do not want to be demeaning to your profession or mine, however, the simple reality is it is not that difficult to handle a claim properly. As I often say, "We are not putting a man or woman on Mars." The problems which generally arise in the handling of claims are frequently very basic, and most claims professionals will tell you, had they simply stopped and taken the time to consider the claim, they would not only have realized but could have easily corrected the problem.

While it is true no two claims are alike, the following is a list of ten of the most frequent issues and problems which arise in the handling of claims. This list is not exhaustive, however, you should view it as a good foundation on which to build and improve your claims-handling skills.

It is my hope the information which follows will make you a better claims professional and allow you to provide better claims service to the persons who have placed their trust in you and your company.

II. The Top 10 Things to Consider As You Handle Claims:

1. Be Cautious of What You Write in the Claim File, Correspondence or Any Other Writing. Put Nothing in Writing You Would Not Be One Hundred Percent Proud to See Presented at Trial.

I place this item first for a very distinct reason. There is simply nothing which equals the importance of being cautious regarding your claim log or other communication entries. A good motto to adhere to in our business is: "Anything you write can and will be used against you!"

I urge the attorneys who work in our law firm to adhere to this same standard. The analogy I use is everything which you write, dictate or say should be viewed through a screen in your mind. That screen uses this filter: *"Would I be one hundred percent proud of what I am saying/writing if this is presented to a jury?"*

Our industry has changed dramatically with the advent of electronic communication. The use of email has dramatically accelerated the response time for most communications. Especially on a difficult claim, we no longer have the luxury of stopping, thinking and reflecting before writing a traditional letter or other communication to an insured, claimant or attorney. There are also times when the insured will intentionally try to set you up to evoke an angry response. Remember, email communications carry the same power and weight as any other type of written communication you may have with an insured.

You should assume everything you write or communicate regarding any claim is subject to be turned over in discovery if any litigation is instituted. Some states have even gone so far as to void any attorney-client privilege between an insurance company and its counsel when an allegation of bad faith is asserted. For that reason, literally every piece of information you write regarding an insured, their claim, or any aspect of the claims-handling process must be judged through the same filter of potentially being presented to a jury.

Before we leave this subject, this same standard also applies to oral communication, as well as written communication. Again, with the advent of advanced electronics, and depending upon the state you are in, the insured may well be within their rights to record every telephone communication and even personal meeting with you regarding their claim. Because of this, you should again assume everything you are saying to the insured

is in fact being recorded and the audiotape may well be introduced as evidence at a trial. In fact, depending upon the jurisdiction you are in, if the tape is being used for impeachment purposes only, you may not even learn you were recorded until you are confronted with the tape recording in cross-examination at trial.

The simple reality is you must be extremely cautious in all forms of communication with your insured, any witness, any agency personnel or anyone associated with your handling of any claim. Although this may appear to place a heavy burden upon you, the simple reality is you owe it to yourself, your company and your insureds at all times be professional, courteous and as correct as possible in all forms of communications. What justification could you ever provide to a jury regarding why any type of embarrassing, disparaging or insulting comments were made regarding a person or their claim at any time? Quite simply, even in the most complicated or difficult of claim, you still owe an absolute duty to the insured or claimant to treat them with the utmost courtesy, respect and dignity. More importantly, however, you owe it to yourself to not dishonor you or your profession by engaging in any type of communication of which you would not be one hundred percent proud.

2. Know Your Own Policy. Know What Coverage Applies, Conditions, Exclusions, Special Limits and the Effect of Any Endorsements.

One of the first things you learned in "Claims 101" is an insurance policy is a contract between the insured and the company, whereby coverages are provided, subject to certain provisions, exclusions and conditions. The reality as well is virtually no insured ever reviews all of the terms and conditions of their policy of insurance, especially before a claim arises. The expectation, however, is you as the claims professional will know all of the coverages, conditions and exclusions contained in the policy, as well as any endorsements added to the policy. In many states, you may even have the duty to make certain the insured is informed fully of all coverages which are available to them under their policy, including endorsements.

With more companies assigning responsibility to claims professionals on a multi-state basis, it has become more difficult in recent years for claims professionals to truly know and understand the multiple versions and types of policies which are issued. The desire to remain competitive in the insurance marketplace has also caused many companies to offer an increasing number of policies and endorsements. All of this has made the job of the claims professional much more difficult in knowing and fully understanding the terms and conditions of the insurance contract.

Nevertheless, you will be the one held to the highest degree of responsibility for knowing fully the terms and conditions of the policy of insurance. At deposition or jury trial, do you want to admit you handled, investigated and denied a claim without ever actually reviewing the terms and conditions of the specific policy issued to the insured? Many claims professionals simply rely on an "understanding" of what coverages the policies generally provide and adjust the claim accordingly. Even though you may have an excellent general understanding of the policy, even the most seasoned claims professional may still be unaware of a specific endorsement or revision in a policy which may dramatically affect the available coverages available to the insured.

Many bad faith verdicts have resulted from insurance companies failing to provide their insureds with notice of all coverages available after a loss, or the insurance company placing conditions, or demands, on the insured which are not specifically called for in the policy.

Even if you do have an excellent understanding of the policy, it still may not place you or your company in the best of lights before a jury when you testify you simply "relied on your understanding" of the policy, rather than actually reviewing the contract which was issued between your company and the insured whose claim you denied.

While it is true you cannot be expected to secure and read cover to cover a certified copy of every policy of insurance issued on every claim, especially on difficult claims you may well be in a situation where, to protect you and the company, you do need to request and review the policy and all applicable endorsements to make certain you do have a thorough and complete understanding of the contractual relationship between your company and the insured.

3. When You Have Reasonable Doubts Regarding Coverage, Issue a Reservation of Rights. The Reservation of Rights Must Be Prompt, Specific and Not General, and Should Cite Policy Language as Appropriate.

One of the frequent questions I am asked is when should a reservation of rights be issued? The answer is relatively simple and spans virtually every jurisdiction. *A reservation of rights should be issued on any claim immediately upon your reasonably believing coverage for the claim may be in doubt.*

The importance of a reservation of rights letter cannot be underestimated. Although I cannot verify its accuracy, I have heard repeatedly of a "rumored" case involving a multi-million dollar fire loss. The claim was denied as an act of arson. The defense attorney and the insurance company defended the case fully, feeling they had a very strong case for trial, and the plaintiff and their attorney had not developed much of a case to offset the extensive investigation by the insurance company. Allegedly, at the conclusion of the defendant's opening statement, the plaintiff's attorney approached the bench and requested a directed verdict. The basis for the directed verdict was the insurance company had never reserved its rights and under that state's law thereby waiving any basis to subsequently deny coverage. The court reviewed the law, entered judgment in favor of the plaintiff, and the remaining trial was then only to assess the additional amount of interest and extra-contractual damages owed.

Often confusion also arises between a reservation of rights and a non-waiver. A non-waiver is normally a document signed by the insured at an early phase of the claim advising the claim is being investigated and no policy conditions are being waived. It normally, however, does not contain nor cite specific policy language. In contract, the reservation of rights is normally a letter and is sent to the insured advising of the specific policy exclusions which may apply and unilaterally advising the insured, or claimant, there may be issues associated with coverage for the loss or claim. In some states, either of these documents may meet the requirements for a subsequent claim denial. If you do not know for certain, however, you are better served to either have both a signed non-

waiver and reservation of rights in your file to demonstrate your insured or claimant has been clearly notified of all possible issues regarding coverage.

Although you should check and verify the law in your particular state, most jurisdictions require the reservation of rights letter to be specific and not general. This means the letter must state specifically what sections or conditions of the policy are being invoked relative to the reservation of rights. For example, the letter cannot simply say, "*We are reserving all rights concerning your claim*." Although a sentence such as this may be contained in the conclusion of the reservation of rights letter, prior to that point the reservation of rights must specifically identify the claim is being investigated based upon intentional acts, failure to cooperate, a material misrepresentation, or whatever other basis or exclusion may apply.

Many jurisdictions will also require you to cite the specific policy language. Even if your state does not obligate you to do so, it is generally my recommendation the reservation of rights letter should include specific citations, where appropriate, to the sections of the policy which are being relied upon for the reservation of rights.

In like manner, the reservation of rights letter should also contain the specific section(s) of the policy setting forth the duties and responsibilities of the insured in the event of a loss. At the time you send the reservation of rights letter, your investigation of the claim is probably still ongoing, and you may not have even requested an examination under oath or specific documents from the insured. Including the duties and conditions of the policy in the reservation of rights letter, however, clearly sets forth and puts the insured on notice of what their duties and responsibilities are to move the investigation of the claim forward.

There are also two additional matters which are frequently overlooked in reservation of rights letters. First, many states do obligate you to contain specific fraud warning language in all communication regarding any claim. Even in states where this is mandatory, I frequently do not see this type of language included in the reservation of rights.

Second, almost every jurisdiction has enacted laws regarding the duty of an insurance company to turn over to law enforcement, fire investigation agencies and the state department of insurance any file records which are requested of the insurance company. I am frequently asked by insurance companies whether there is a duty to advise the insured information they provide may be turned over to a governmental agency. Although most state laws do not specifically address this issue, I am not aware of any state which would prohibit you from including language in the reservation of rights letter notifying the insured, if so requested, your company may be obligated to turn over your claim file records to any appropriate state agency which may request the documentation. In fact, it is generally a good idea to include a specific citation to the state statute obligating you to disclose information or turn over documents. You need not reprint the entire statute in your letter, however, making reference to the specific state law then allows the insured to research the law further should they so desire. What you want to avoid is a situation where the insured alleges, after they have even been criminally charged, your company breached its duty to notify the insured of the "risk" of having information turned over regarding their claim by not notifying them in advance.

Reservation of rights letters are an extremely important way of notifying the insured the company is conducting a thorough and complete investigation of their claim and coverage has not yet been determined. Equally, the reservation of rights letter can be an important tool in protecting you and your company from potential exposure to bad faith or extra-contractual damages, should litigation regarding the claim arise. The best advice I can give you is to view the reservation of rights letter as a way to fully inform your insured while also providing you, as the claims professional, with a shield and protection, so you can clearly testify the insured was properly notified of the problems and issues associated with their claim in the early stages of the investigation.

4. Failure to Secure All Pertinent Documents and Records to Analyze the Claim.

There has probably never been an era where more information and documentation regarding a claimant, their claim's history and other relevant information is available. Equally, however, there has never been a period in time where there have been more restrictions on securing private information, due to HIPPA and other related federal and state legislation.

The job of the claims professional is to secure all of the relevant information and documentation regarding the claim but to do so in a proper and legal manner. The single best tool available to you for this is a signed authorization which contains all appropriate language of your jurisdiction for disclosure of the records and documents you will need to investigate the claim fully.

Most insurance companies take the necessary steps to make certain authorizations are drafted properly and are in compliance with state and federal law. The problem more often is the failure of the claims-handler to properly use the authorization to secure relevant information and documentation, please consider the following as brief highlights.

In bodily injury claims, it is important to secure <u>all</u> relevant medical information concerning the subject injury which is being claimed and any prior claims of injury or relevant medical conditions. Determining what is relevant medical information becomes more difficult. Most jurisdictions have now adopted rather broad legislation for claims-handling procedures which does permit you to inquire into a person's prior medical history and medical conditions, provided you can establish some relationship to the injury currently being claimed. Frequently, however, you will not know whether such information exists until you have the opportunity to review virtually <u>all</u> medical information. Since this can be a daunting task, the issue becomes: "Where do I begin?"

One of the best sources for information is a person's primary care or family physician. You will generally find this is the doctor who has the most complete and thorough medical history regarding the patient. Although medical insurance is beginning to change, in the era in which a family or primary care physician had to make any referral to a specialist these records were even more valuable in establishing the medical history of the patient. Now you have to work harder and locate more records to find the relevant information.

Although I frequently view very thorough recorded statements taken by claims professionals, even in claims where there is obviously a bodily injury being claimed the interviewer will often ask about the injury in question and treatment for that injury but will not ask about any preexisting medical problems, or similar injuries in the past. This type of questioning can lead to extremely important information and documents which can then be used to establish a baseline from which to determine the true extent of any "new" injury being claimed. You will never be able to do this, however, until you ask about what medical conditions, injuries or treatments the person has sought or received in the past.

One of the other issues which can be difficult in securing medical records, especially with chiropractic physicians, is often a person who treated at the same clinic for many years will have a "new" file established after an auto accident or other injury. Oftentimes you have to go to great lengths and make multiple requests to secure the earlier medical records, since some medical offices will only provide you with the specific file which they created from the date of the accident or injury forward. If you do not, however, get all of the medical records, then chances are the truly relevant information you are seeking will never be discovered.

Another issue in reviewing medical records is, when you request the entirety of a patient's file, one item you will virtually never receive is a copy of the file jacket itself which contains the records. Remember on your own doctor visits oftentimes the doctor will make his or her personal notes on the file jacket. We have even had to occasionally send a representative from our firm to the doctor's office to personally review and copy file jacket information.

Another frequently overlooked "gold mine" for information is to review carefully nurses' notes. This applies equally when you are examining emergency room records or hospital records for inpatient or outpatient services. It is absolutely surprising the information and detail which will often be recorded in nurses' notes and overlooked in physicians' notations. We have had cases over the years where nurses' notes have also reflected statements made by the patient regarding the occurrence of an accident or an event and implicating their own responsibility or liability for the occurrence. Oftentimes as well key information regarding prior medical histories and even notations of the person meeting with their attorney in the emergency or hospital room only hours after an accident will all be recorded in these notes. Too often nurses' notes are overlooked and can be a wealth of information in proper claims investigation.

Other information to consider when reviewing medical records is to check for medications the person is taking at time of admission or treatment. If you find a person advises their medical provider they are taking muscle relaxants or pain medication and later, in deposition or examination under oath testimony, they deny any type of preexisting medical condition, then you know something is amiss. In like manner, also carefully review medical records for drug screens or alcohol testing, as this too may lead to pertinent information. In severe injury or claimed brain injury cases also check to see if a "Glasgow Coma Scale" test was performed. This is a widely accepted test which gave be of great value in assessing whether any actual traumatic brain injury event occurred as later claimed.

In addition to reviewing medical records, medical billing statements should also not be considered at "face value" and must carefully be considered as part of any claim investigation. A number of years ago, I was asked to review a claim for an insurance carrier as part of a training program. A number of experienced claim professionals were given the same file and asked to review and evaluate the claim. This was an actual case, and the medical records and billing statements were the same ones actually submitted by the plaintiff's attorney to the carrier. Based upon seven thousand dollars of medical expenses, the range of "settlement value" generally spanned from fifteen to twenty-two thousand dollars. When prodded, this experienced group of claims handlers admitted they based their settlement evaluation on the medical expenses. When they were shown a detailed breakout of the billing, however, everyone overlooked the fact the "carryover" or "past-due" amounts for each of the billing statements had been added collectively by plaintiff's counsel to the claimed "total" amount of medical expenes. In like manner, also, treatment had been included on the billing statements for a wholly unrelated heart condition for which the plaintiff had returned to the same medical facility for evaluation of chest pains. No one was alleging this was related to the accident. The case that everyone evaluated based upon seven thousand dollars of medical expenses actually had only twenty-three hundred dollars of truly incurred medical expenses. Needless to say the evaluations dropped dramatically.

You should carefully consider, when reviewing medical records, whether the appropriate CPT codes have been utilized for the services rendered. Although frequently such detailed questioning will be done by your legal counsel, make certain your defense counsel is properly questioning the claimant and inquiring about such "mundane" facts as the length of time actually spent during the initial evaluation of the patient or whether the initial evaluation was done by a physician's or chiropractic assistant or by the doctor personally. Also, information regarding the duration and who actually treated the patient on follow-up visits can be extremely important. Certain modalities, especially of a chiropractic nature, may frequently be "upcoded" and you should inquire fully of the claimant regarding the exact type, duration and administration of the treatments received. Some carriers have found it useful to use "flash cards" showing different modality treatments to ask the person whether, or not, they actually remember receiving the type of treatment shown on the card.

Also do not overlook the value of documentary evidence in property claims. With the ease of computers, an increasing number of claims are being paid where absolutely false or modified receipts are being submitted. It is very easy, using computer programs, to create what appear to be sales receipts or scan legitimate receipts and change purchase prices or quantities of items purchased. These trends are occurring with such increasing frequency it is extremely alarming. One of the most abused areas in property claims is on replacement cost coverage. In the past few years we have seen an explosion of claims where expensive items are allegedly lost and, after the ACV is paid, a replacement cost claim is submitted and paid. What actually occurred, however, is the insured either simply ordered the item and then canceled the order or picked up the item and returned the item very shortly thereafter, with no intention of ever actually replacing the item. Most insurance policies are vague or silent regarding how long a person must retain an item to claim replacement cost value. Most state laws regarding insurance fraud, however, do not look favorably upon an insured simply acquiring an item and returning it

within hours or days, solely for the purpose of insurance gain. One of the things we have recommended to a number of our clients is to require submission of original receipts for RCV purposes or to advise the insured, as part of the RCV claim, your company reserves the right to come in at any time and request verification and inspection of the items for which replacement cost coverage has been paid.

Before we leave the subject of documentation, I would be remiss to not point out one of the most valuable tools for searching of information, and that is simply "GOOGLE." We have turned up invaluable information through simply doing personal Google searches and Google searches of other relationships regarding claims of both a personal injury and property nature. Just a few examples of claims which have been successfully investigated through a "Google" search include locating an appraisal company out of Australia which would appraise any item of jewelry for a flat fee of twenty dollars U.S. and would then issue the appraisal, never having seen the actual item. We were also able to locate online photographs of an attorney's office and chiropractic clinic which were located in the same physical building. This relationship had not been identified previously by the insurer. On a theft claim, we were also able to establish a very expensive men's watch which was claimed to have been purchased more than a year before in Chicago, and subsequently stolen several months later was not even introduced into the marketplace by the manufacturer until about two weeks before the alleged theft occurred.

With the age of the computer now fully upon us and the amount of data and information which is available online growing rapidly, the use of "Google" and other search engines will continue to be an extremely important resource for claims investigation well into the future.

5. Failure to Use Sworn Statements in Proof of Loss Correctly

When I lecture on this topic, I frequently ask claims professionals: "When do you actually have a claim to adjust?" I will get many answers, ranging from when the call center receives the first call, to when the company actually assigns the claim to the appropriate handler. Unfortunately, none of these questions are "legally" correct, even though you do owe a duty to the insured to "handle" their claim from the first notice of any loss being reported, from a purely legal perspective, however, the first time you actually have a claim is when the insured signs, under oath, a sworn statement in proof of loss, setting forth the type of claim they are making, the basic information regarding the date and time of the loss, and the amount they are claiming under their policy.

Each company has differing rules, standards and guidelines relative to the use of proofs of loss. The proof of loss, however, is an extremely important tool when used appropriately by an insurer. The proof of loss is a fully appropriate way for an insurer to compel the insured to attest under oath to the occurrence of the loss and the amount they are claiming under the policy. Especially in claims where you believe insurance fraud may be an issue, requesting a proof of loss to be completed promptly and fully should be a part of any thorough investigation.

Another issue which frequently occurs regarding handling of proofs of loss is what is to be done with the proof once it is received. Although you do need to be acquainted with the laws of your particular jurisdiction, in most states an insurer has three options regarding a proof of loss:

- The insurer may ACCEPT THE PROOF OF LOSS, meaning the claim will be honored and paid.

- The insurer may REJECT THE PROOF OF LOSS, provided the proof of loss is materially deficient. The issue of what is "materially deficient" causes great frustration for many claims-handlers. Failure of an insured to include information such as the policy number, claim number or other basic information is not sufficient grounds for the insurer to reject the proof of loss. To properly reject a proof of loss, the insurer must establish the proof fails to provide the insurer with material information which is relevant to the investigation of the claim and which the insurer cannot determine or locate on its own. For example, material omissions on a proof of loss would include the failure to state the amount being claimed or to do so in a manner so vague it is meaningless, by using such terms as "unknown" or "ongoing" or "to be determined." Material omissions in the proof of loss could also include failure to disclose any lien-holders or others who may have any material interest in the property, either by way of co-ownership or a lien-holder status. Also, failing to have all necessary insureds sign the proof of loss in the presence of a notary may also be a material reason for rejection. Remember, even if only one spouse is the named insured on the policy, through marriage, in virtually every jurisdiction, a husband or wife are equally an insured under the policy and should also be required to sign a sworn statement in proof of loss.

- The final option available to an insurer, which is used in most claims where an investigation is under way, is to ADVISE THE INSURED THE PROOF OF LOSS IS BEING HELD PENDING COMPLETION OF THE INVESTIGATION. This option allows the insurer to move forward with the investigation of the claim while not accepting or rejecting the proof of loss. Remember, if the proof of loss is materially deficient it should be rejected, and when a properly submitted proof of loss is resubmitted you may, at that time, elect to hold the proof pending completion of the investigation. By invoking this third option, you are telling your insured the proof of loss is proper in its form but your company is requiring further time to investigate the claim before a final decision to deny or pay the claim is made.

In virtually every jurisdiction, you will be under a time limit to properly respond to the proof of loss. If you advise the insured the proof is being held pending further investigation you may also be under a duty to provide timely updates on the claim and investigation to your insured. These time limits may be a set number of days or may be as vague as "reasonable." Nevertheless, and even if your state does not mandate reports, you do owe a contractual duty to your insured to promptly notify them whether their proof of loss is being accepted, rejected, or held pending completion of the investigation and to update them appropriately and regularly

regarding their claim and the investigation which you are conducting.. It is never wise to wait until the last minute to advise the insured of this information, and you should make a prompt decision regarding the proof of loss and advise the insured as soon as practicable as to what position the company will be taking regarding the proof as submitted.

6. Overlooking or Not Looking For Patterns of Fraudulent Claim Activity

You will never notice connections in fraudulent claim activity unless you take the time and effort to "connect the dots." You would be shocked at the amount of fraudulent and questionable claims which probably pass right over your desktop daily without your ever noticing. One of the largest fraudulent insurance activities taking place in the country today is a multi-state chain of chiropractic clinics. This organization telemarkets not-at-fault drivers and passengers targeting specifically lower-income persons involved in relatively minor accidents. These individuals are telemarketed and offered a "free" exam, with the caller oftentimes misrepresenting the call is being made on behalf of "the insurance company." Once at the clinic, these individuals are then told they need legal representation and are steered to a law firm which is also tied to the clinic organization. These clinics do not run up large bills or even over treat. In fact virtually every patient receives the same eight to ten weeks of treatment and is discharged, with approximately $3,200-3,500 of chiropractic expenses being billed. Since these are normally clear liability cases, the claims-handlers are more than happy to settle these claims for what they believe to be a "good" settlement value, often between $7,500 -10,000. No doubt some of the people treated may in fact have been injured however most of these claims probably never would have even been brought in the first place if the telemarketing and combined chiropractic/legal steering of the claimant did not occur. Literally millions of dollars each year are funneled from insurance carriers to this organization, and other similar types of operations throughout the United States. The claim you are thinking was an "excellent" settlement may well have been entirely fraudulent.

The question becomes how do you "link" these types of patters of fraudulent claim activity. Although there are a number of ways to do so, they do require diligent effort on your part. Here are just a few "pointers" to look for in trying to identify patterns of fraudulent claim activity:

- When you take a recorded statement ask the claimant whether they have received solicitation calls from any medical provider and, if so, ask them which provider and what they were told and if they were offered any type of incentive for treatment.

- Ask the claimant if they actually saw and met the physician or chiropractor and who administered any treatments they received. We recently uncovered a medical/chiropractic clinic relationship where the M.D. was referring his "patients" to the clinic, however, the doctor was in another city and the "patients" would call from his local "office" (next door the chiropractic clinic) and he would diagnose them over the phone and being in need of a chiropractic referral.

- Carefully watch for the same or similar addresses of law firms and medical providers. If you see mailings or addresses from the same or very similar addresses, this probably warrants further investigation or an SIU referral.

- Although it is increasingly hard to do so in the era of scanned mail, check return envelopes to determine whether billing statements, medical reports, and even attorney demand packages are actually coming from the city where the clinic or lawyer is located. We have literally found multiple cases where medical reports, billing statements and attorney demand packages are being forwarded from a completely different state. Often you will find these documents are prepared through processing services affiliated with chiropractic or medical clinics.

- Ask the claimant whether they were made any promises or representations by the medical provider regarding who would be responsible for medical payments or any type of free examinations, x-rays, or other treatments. Then compare what you are told by the claimant with the billing records which are submitted.

- Check the licensing of clinics and other medical providers. In one state, recently, it was discovered a chiropractic clinic had been billing for services for several years, and insurers had paid hundreds of thousands of dollars on claims, only to learn the clinic was not properly licensed.

- Although it may simply be a coincidence, you should monitor to determine whether you are routinely seeing the same lawyer and medical provider on multiple claims. If so, this may warrant further investigation of the relationship between the medical provider and the attorney or law firm.

- Look carefully for treatment patterns. For example, if multiple passengers from the same family are making claims, is everyone treated on the same dates, for the same duration and all for identical injuries? Especially with persons of differing ages such "cookie cutter" treatment is rarely warranted.

- You should also carefully look at referrals between various medical providers. Although referrals for specific services are routine and often necessary, if you are seeing regular billings for referrals on virtually every claim to the same specialist or clinic, then this may demonstrate a pattern of activity which warrants further investigation. Also watch for increase charges for "outside" readings of x-rays, scans or other services.

- Many of the same issues and concerns regarding medical and chiropractic clinics also apply to body shops. Look carefully at estimates, and make certain all body shop repairs are supported by actual evidence of damage, whether substantiated through police reports and photographs or personal inspections.

The key to determining whether a pattern of fraudulent claim activity is taking place requires you to look more broadly than at one single claim. Patterns do not emerge from

one claim but through repeated activities which you can identify, linking various claims over a period of months or even years. The best way to analyze whether a pattern of activity is taking place is to first make a mental note of repeated patterns which you think you are beginning to see, relative to claims crossing your desk. Once you have made a mental note of a certain number of claims, then start logging those claims and keeping track of the relationships which you suspect exist. At the appropriate time, you will then know whether to move forward or to refer the matter for further investigation to the appropriate department or special investigations unit within your company.

7. Avoid Delays in Moving the Claim Investigation or Decision Forward Promptly

As an attorney who handles bad faith cases, I can tell you the single biggest problem causing bad faith verdicts against insurance carriers is the failure to properly move the claim investigation and decision forward promptly. The reality is most American consumers do not look favorably upon our profession, as most have had some type of negative experience with an insurance carrier. A jury simply does not care how many job changes or claim reassignments may have taken place and whether, or not, the company was "justified" in assigning four new adjusters to a file during the course of an investigation. In virtually every case, no matter how strong the evidence may be against the insured, the attorney will argue vehemently in front of the jury about the repeated delays and long periods of inaction by the insurance carrier leading up to the denial of the claim. Sadly, these are "bullets" which most insurance companies and their employees allow to be placed in the "gun" to be fired at them at trial.

Although I may not have heard every single one of them, I have certainly heard plenty of excuses for not moving a claim investigation forward more promptly. None of them ultimately have any merit before a jury. In deciding whether a claim is moving forward promptly enough, you can use a very simple test, which is simply this: *"If this claim involved a close loved one of mine and was being handled by another insurance company, would I believe that company was treating my loved one well and handling their claim promptly?"* If you simply keep this standard in mind, you will generally have no trouble moving a claim forward expeditiously.

Many times the delays in the claim-handling truly are the fault of the insured and not the fault of you or your company. What may surprise you is, unless you have documented your claim file very well, even these delays will still be used again you at trial. If you have not recorded fully in the file and in written communications with the insured the delays are at their request or due to their inaction, then you have not created an appropriate "paper trail" to establish to the jury you were attempting to move the claim forward promptly but the inaction of the insured prohibited you from doing so.

If you are faced with a claim where the insured is delaying the claim, you need to communicate that in writing to the insured. Remind them you are still awaiting key documents and you have sent letters on multiple prior dates (you should list the dates) detailing the records and documents which are needed to fully consider their claim. If the insured is taking an extended vacation and has requested an extension to submit their proof of loss or other key information, then by all means grant them that request, but document in writing the request is being made by them and your company is "pleased" to

provide them this courtesy so long as they understand this may delay the final decision regarding their claim. The important thing is you have created written communication, which allows your defense counsel to then create a timeline to show the jury where your actions did not cause any delays in the claim investigation, but instead you documented your file fully as to why the actions of the insured led to any delays in reaching the final decision regarding the claim.

As a final note on this topic, there are an increasing number of court decisions from around the United States which are holding an insurer may still be liable for bad faith even when the claim is paid. The vast majority of these decisions are based upon the fact the insurer failed to promptly conduct the investigation of the claim, and even though the claim was ultimately paid, the insured is entitled to bad faith damages due to the delay in the claims-handling process and the delay in the insured receiving the benefits of the insurance policy to which they were entitled.

I anticipate the issue of the prompt handling of claim investigations will be an increasingly important factor in bad faith litigation in the years to come.

8. Failure to Secure Proper Expert Witness Assistance

When used effectively, the appropriate expert witness can be the deciding factor as to whether a claim denial was proper. More frighteningly, however, retention of the wrong expert can be the factor which leads to a multi-million dollar bad faith judgment against your company.

Whether you are retaining an independent medical expert, an origin and cause investigator, a forensic accountant or any other of the myriad of experts which are called upon in the insurance industry, the important thing is you must have absolute trust and confidence in the expert you retain.

Although there may be the "unique" claim, requiring specialized expert services, most of the experts you will retain are of the type and nature which are routinely encountered in the handling of insurance claims, whether of a bodily injury or property nature. For these experts, if you are searching to find an expert to hire after the loss has occurred, then you are already probably "behind the eight ball." The time to be searching for, interviewing, screening and testing the reliability of expert witnesses is not after the claim has arisen but months or years before.

It should probably not be the job of the front-line claims-handler to interview and prescreen experts. Someone in the company, however, must take responsibility for this task and make certain the company's approved listing of experts is reviewed and updated on a regular basis. Too often experts are retained simply because they knew someone many years ago and the company has been "comfortable" using that expert ever since.

The expert your company retains does not need to be the highest-charging expert in his or her field of expertise but certainly should be among the best qualified. Do not ever be afraid to ask very pointed and probing questions regarding your expert's education, training and prior litigation, deposition and trial testimony. Your career future may

ultimately rest upon whether the expert you retain on a claim accurately represented their credentials and experience to you or your company.

There are far too many "horror" stories regarding experts who do not actually possess the degrees or educational training they represent, or who may have serious personal or professional matters in their background which will negatively impact upon their credibility as an expert witness, but here is yet one more:

I was recently assigned a file from an insurer involving a house fire. The claim had been investigated, denied and litigation instituted when I was retained to represent the company. Rather than simply "accept" the fact the company hired a competent expert, we undertook an investigation which uncovered two court opinions in which the expert's opinion had been severely criticized and struck as unreliable. What made matters worse is the plaintiff's attorney in our case had actually retained the expert in one of those cases and was obviously well aware of the weaknesses in this person's background. Furthermore, we uncovered another lawsuit which had been filed only approximately six months before by the same insurance carrier who had retained our services, suing this expert witness and his company, through their national subrogation counsel, for allegedly negligently destroying evidence in a subrogation case. When the claims-handler and myself met with the expert, we did not disclose to him, initially, the investigation we had undertaken regarding his background. Even when asked about prior dealings with the same plaintiff's attorney who would be opposing him in this case, the expert advised he had been contacted by that attorney on one occasion but refused to work with him. It was only when the court decision striking his testimony was slid across the table to the expert, that the expert finally "came clean" and admitted he must have "forgotten" about the prior case!

Although normally decisions from the United States Supreme Court do not directly impact insurance law issues, there are two cases which are an extreme exception. These are the 1993 case of *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, followed by the 1999 case of *Kumho Tire Co. v. Carmichael*. These cases dramatically limited expert witness testimony in all courts in the United States. Although these decisions have been the law of the United States for more than a decade, I am still surprised at the number of expert witnesses who do not truly understand the depth and importance of these court decisions. Under the *Daubert* and *Kumho Tire Co.* cases, a trial judge has the duty to be the "gatekeeper" to determine whether the opinions of the expert are in fact reliable before that expert may testify. These court decisions affect every type of expert witness testimony. Under the *Daubert* test, a judge is required to determine the following regarding any expert testimony:

- Is the testimony directly relevant to the facts and circumstances of the case?
- Is the opinion the expert is to give reliable and based upon accepted scientific method?
- Is the testimony being offered by the expert subject to empirical testing which can verify its accuracy and prove it is not simply based upon opinion?

- Can the expert show the opinions being given in court have been subjected to peer-review and are accepted through professional and industry publications?

- Is there a known or potential error rate regarding the opinions or standards used for testing by the expert?

- Can the expert establish the opinions or techniques utilized to reach their opinion are generally accepted standards within the scientific community of their particular area of expertise?

It is also important you very clearly advise your expert witness from the start you are seeking nothing more than his or her completely accurate and truthful opinion regarding the claim. As an attorney handling these types of cases for insurance companies, I frequently encounter experts who later will tell me they had doubts or reservations about their opinion but were afraid to tell the insurance company of those concerns for fear they would lose future business. No one wins in this type of situation. If you are denying a claim based upon false or inaccurate information from your expert, then your insured is being treated improperly and is being denied benefits they are entitled to under the insurance contract. If your company is denying the claim based upon false or inaccurate opinions you are also acting in bad faith. It will not be sufficient to later try to tell a judge or jury the expert was "mistaken" since, under most state laws, the expert will be deemed to have been acting as your "agent" in conducting his or her investigation.

Finally, the expert does not win either, since if this information does come out ultimately in a trial, it will probably be the end of his or her professional career.

The important thing is to simply establish right up front the scope of the expert's area of retention and the fact you want the expert to render an opinion in that area only and based upon nothing more than an honest opinion based upon scientific fact and evidence.

Before leaving the area of expert witnesses, let me comment upon one other issue. I do not personally care whether the expert you retain is the best orthopedic surgeon within five hundred miles, writes the best origin and cause investigation report or has conducted fifty prior investigations for your company. As a trial attorney, what is most important to me, behind the credibility and reliability of the expert, is the ability of that expert to effectively communicate his or her opinions to the jury. You may have an expert who writes the best report, has the best credentials or performs services for a very reasonable fee however, if that person cannot withstand vigorous cross-examination in a deposition or cannot effectively communicate their opinions to a jury this expert is of zero value when the case ultimately goes to a jury trial.

This brings me to my final point. One of the most overlooked areas of inquiry regarding expert witnesses is probably right under your nose. Whether it is your house counsel or outside-retained defense counsel, contact your attorneys and ask them to give you honest and frank evaluations of expert witnesses before you retain their services. Most experienced insurance attorneys will speak honestly with you and advise you of their opinions regarding whether an expert witness truly has the ability and skill to effectively communicate their opinions in deposition and trial testimony.

9. Sending the File to Defense Counsel (Whether House Counsel or Outside Counsel) Does Not Mean You Can "Wipe Your Hands" of the File

Far too many times I hear from claims professionals they no longer have to "worry" about a file because it is in litigation and has now been sent "to counsel." While it is true it is my job, as your defense counsel, to take control of the litigation and make certain the file is handled properly, it may surprise you to find in my opinion you still play a very distinct role in managing and directing that file. And I am not referring to some type of claim litigation guidelines but instead to the real and practical handling of that file to successful conclusion.

Your defense counsel brings specific skills, knowledge and expertise to the case. A properly trained defense attorney will focus his or her attention upon the ultimate resolution of that case by way of settlement, arbitration or jury trial and will concentrate their efforts upon moving the case in that direction as promptly as possible.

The reality, however, is you handle and oversee many more claim files than any of your defense counsel will ever see as litigation files. An experienced insurance attorney should be able to provide you keen insight into the local jurisdiction, jury pool and local judges. All of those factors may well contribute to what amounts to a reasonable settlement or evaluation of the risk of the case if you do elect to go all the way through a jury trial. Nevertheless, you as the claims professional have the unique background of having handled and settled far more claims and are probably the best person to determine a reasonable range of settlement to place upon a file. In fact, you may actually have much more experience in negotiating and settling cases with the opposing counsel than does your defense counsel.

Remember, too, your future career may rise and fall upon the outcome of the case you have assigned to defense counsel. If you have carefully selected defense counsel, that attorney should have the interest of your insured, your company and you at the forefront at all times. Sadly, however, as in every other aspect of life, this does not automatically ring true for every defense lawyer. Defense lawyers make mistakes and can be misguided by everything from a personal dislike of opposing counsel or a party to trying to create billable hours on a file which should be resolved and not litigated further. In short, you do not want your career improperly tied to a defense attorney who may not be thinking as clearly as he or she should be or be handling the file in a correct manner. It is for this reason the file must remain under your jurisdiction and control at all times.

It is also important you understand you are the person who retains ultimate responsibility for your files, you should never simply assume because the case is assigned to counsel that attorney knows what the correct course of action may be. You are the claims professional and have handled far more claims, and know your business far better, than most of the attorneys to whom you will assign claims. The attorney, in a true partnership, however, should work with you fully and bring to the case his or her distinct knowledge of the law, opposing counsel and the local court system. Although you should hopefully never be in an adversarial situation with your defense counsel, do not ever be afraid to ask questions, challenge their opinions or advice and do not ever move forward in any direction in handling of litigation until you as the claims professional are

personally satisfied you understand and support fully the course of action you are embarking upon on behalf of your company or your insured.

Do not ever be intimidated or assume your defense counsel knows more than you do. You have every right to expect your defense counsel to be able to explain and meet fully your level of satisfaction regarding what is being done on the file at all times and why. In like manner, your defense counsel also owes you the courtesy of communicating with you regularly and promptly regarding any file. In our firm, we have a policy requiring our attorneys to return every call every business day. This includes if the call is returned after hours and a message is left, advising the claims professional we will call him or her back the following day. One of the primary complaints I hear from claims professionals is their counsel not communicating with them clearly or returning their calls promptly. If that occurs, you have every right to notify your defense counsel, or his or her supervisor, you are dissatisfied with the services you are receiving and expect more prompt communication in the future. If this does not occur, then it is probably time to seek out your immediate supervisor and advise them of a potential need to make a change in your defense counsel selection.

When a claims professional and defense attorney work cooperatively, depending upon whether it is a first- or third-party claim, the best interest of the insured or the company should always guide the process and, at least from my years of experience, it has been an enjoyable and rewarding opportunity to work together toward a successful resolution of the litigated file. The best cases are not ones where either the claims professional or the defense counsel is "in charge" but rather those claims where, working cooperatively and communicating effectively as a team, the claims professional and defense counsel are at all times working toward the appropriate and most prompt avenue for the litigation to either be resolved or moved promptly toward trial.

10. Do Not Have An Inordinate Fear of Giving Deposition or Trial Testimony

In your career as a claims professional, there will be times when you are called upon to give deposition or jury trial testimony. This should not be viewed by you as a "horrifying" experience. Remember at all times you are a professional who has received the utmost and best of training from your company to handle the type of claims you handle and on which you are being questioned. Remember as well, the attorney who is questioning you regarding your handling of the claim probably never worked for an insurance company, never adjusted a claim in his or her life, and is probably more afraid of you than you are of them. Most trial attorneys are very good at "bluffing" and through trying to intimidate you or confuse you with questioning they may actually be covering up their own lack of actual knowledge and understanding of the claims-handling process and what you take for granted in the day-in and day-out handling of claims.

Although much can be said about preparing for and giving of deposition and trial testimony, the key points to remember, however, are simply the following:

- Before you give any testimony, make certain you review all of the logs, notes, correspondence and communications associated with the claim upon which you are giving testimony.

- Never give any deposition or trial testimony without first meeting with your defense counsel and making certain you understand fully the anticipated scope of questioning and have been updated fully regarding the status of the claim or litigation. Do not accept the fact your defense counsel is "too busy" or such a meeting is "not necessary." This meeting should occur at least several days before the taking of your testimony, and I would not recommend you agree to have this meeting immediately before the giving of your deposition or trial testimony as this does not afford you the opportunity to fully digest and prepare for the proper giving of your testimony.

- The most "superhuman" thing you have to do in deposition or trial testimony is to listen better than you have ever listened at any other point in your life. It is absolutely imperative you listen to the question being asked of you carefully and intently. You should never answer the question until you understand that question to your satisfaction fully. I advise witnesses I simply do not care if they have to ask the plaintiff's attorney to repeat or rephrase the question five or ten times, as it is the job of the attorney asking the question to make certain the question is asked clearly and unambiguously.

- Remember your job in the deposition is simply to answer the questions which are asked of you. You are not there with the burden of "winning the case" on your shoulders or to convince the opposing attorney their client's case lacks merit. Instead, your job is simply to listen intently to the question being asked of you and answer that question fully with any relevant explanation which may be required. All too often, I see depositions go "off track" when the claims professional tries to explain or give more information than was actually asked of them in the specific question. In like manner, I have also seen claims professionals, when a very poorly worded question is asked, reform the question in their own minds, thinking "I know what he really wants to ask me is..." The witness then goes on to provide information which may well be accurate and correct regarding the claim, but in so doing they have volunteered information to the opposing counsel which he or she did not even ask in the specific question. What you have just done is probably expanded your deposition by one to two hours of what will now be new questioning which the other attorney never even intended to ask you in the first place!

I have also frequently heard claims professionals talk about a deposition as if it is nothing more than a "dry run" from which they can correct any future problems at trial. This is an extremely inaccurate view of deposition testimony. In actuality, a deposition is virtually no different from your trial testimony, with the exception we do not have a judge and jury sitting in the room. In a deposition, everything you say is being taken down by the court reporter and may be used fully in a trial (subject to certain pretrial rulings), including for purposes of impeaching your testimony. You should never view a deposition as a "dry run" or "rehearsal". Instead, whether you are giving deposition or trial testimony, it is your duty, in conjunction with your defense counsel, to make certain you are fully informed regarding all relevant facts of the case and are fully and completely prepared for the giving of your testimony.

III. Conclusion

The profession you have selected is one in which not only your company but, more importantly, your insureds place great trust in you and your abilities and skills to handle a claim.

Whether we are focusing on the "Ten Things" to consider as you handle claims or "One Hundred Things" to consider, the basic premise remains the same. You have selected a profession which requires you to be detail-oriented and at all times make certain you are considering a myriad of factors which may affect the claim you are handling or investigating. The work we are called to do collectively is extremely important. It requires every day for us to give our best, to consider these ten factors, as well as many others which will occur to you in your career, to endeavor to make certain at all times each claim is being handled with the utmost of professionalism and promptness. Our work should always be centered toward the goal of making certain the correct decision is made regarding how the claim is to be handled, denied, settled or ultimately taken through jury trial.