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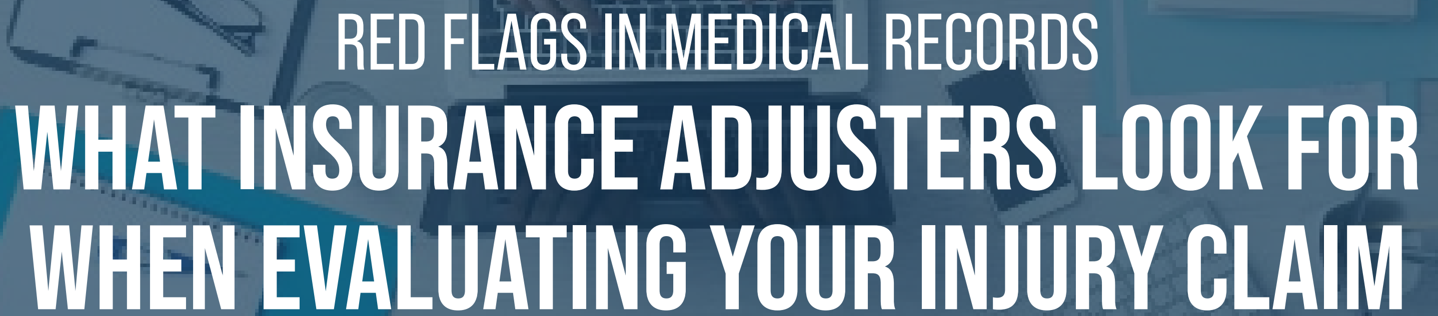

RED FLAGS IN MEDICAL RECORDS

WHAT INSURANCE ADJUSTERS LOOK FOR WHEN EVALUATING YOUR INJURY CLAIM

Many insurance companies have departments dedicated to investigating injury claims for their validity. Insurance investigators often become suspicious when there's something about the claim that "doesn't seem right" under the facts and circumstances presented. If this happens, it may prompt a further inquiry into your claim.

As a personal injury claimant, it's always in your interest to avoid having your case marked for such an inquiry … even if your claim is 100% genuine. If the insurance company's investigation results in the discovery of something problematic about your claim, rest assured this will be brought to the attention of the court at an appropriate time. This could result in you having to provide an explanation or clarification to clear up the issue, which can in turn have the effect of delaying or prolonging your case.

Fortunately, most claims are not subjected to this rigorous kind of investigation. In fact, your claim probably won't receive any unwanted special attention from an insurer unless one or more of these "red flags" are present:

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1. A LACK OF MEDICAL TREATMENT IMMEDIATELY FOLLOWING THE ACCIDENT

From the perspective of an insurer, one of the most glaring red flags in a claimant's medical records is the absence of any emergency medical treatment. How badly could you be injured, after all, if you didn't need to go to the hospital immediately after your accident? Even more troubling is the claimant who sought no treatment whatsoever for several days following the accident. At a minimum, your medical file should contain some proof of treatment in the first few days following the incident in question -- even if it was by your own primary care physician.

2. AN INCONSISTENT COURSE OF MEDICAL TREATMENT

A similar but slightly different red flag is an inconsistent pattern of medical treatment. Inexplicable delays or gaps between medical appointments can be a cause for concern. Injured claimants have a duty under the law to mitigate damages as much as possible. In other words, you will be expected to take all reasonable steps to minimize the effects and consequences of your injuries by pursuing the fastest possible recovery.

The mitigation rule also applies to lost wages; you're expected to return to work as soon as you're reasonably capable of doing so. If you fail to do this, expect the defendant to bring this to the judge's attention in an attempt to reduce your lost wages claim.

3. A DECISION TO FOREGO NEEDED SURGERY

In some injury cases, the claimant's physical condition as a result of the subject accident is such that her physician may recommend surgery as the best course of action for remedying the problem in the long run. Of course, the decision whether to undergo such surgery is for the claimant to make.

However, it's important to understand that her decision to decline such surgery can and probably will have an impact on her claim for damages. Simply put, the law does not allow one to recover damages for the consequences of an injury that can reasonably be addressed through a standard low-risk surgical procedure. An injury cannot be deemed "permanent" for purposes of damages if there's a strong probability that the surgical procedure would have remedied the condition completely.

The test in such situations is whether a reasonable person under similar circumstances with knowledge of the risks involved would have elected to undergo the procedure. If the answer to this question is yes, then the claimant's decision to avoid surgery will make it significantly harder to recover consequential damages based on the alleged "permanency" or long-term impact of the injury.

Factors such as a high risk of complication, further injury, and/or death as a result of the procedure are given special weight when determining if the claimant's decision was reasonable. A surgery that would be unusually invasive in nature may be viewed as a procedure that a reasonable person would hesitate to undergo. In such a situation, the claimant might still be able to recover damages for long-term consequential impacts.

On the other hand, a relatively straightforward procedure that has been performed successfully over the course of several years with a high success rate may be viewed as something reasonable people would go forward with. In cases where the claimant makes a claim for lost future earnings, the court will usually consider the probability of whether the surgery would have allowed the claimant to continue his career (or return to work sooner than he/she would have been able to without the surgery).

4. TREATMENT FROM PLAINTIFF-FRIENDLY MEDICAL PROVIDERS

There are some medical providers who are notorious for their "plaintiff-friendly" reputations. Insurance companies know who these medical providers are. They often have close working relationships with personal injury attorneys, who may refer their clients to the medical provider on a regular basis.

If your attorney and/or doctor have such a reputation, there's a strong possibility that the defendant's lawyer will explore this issue during your deposition. For example, counsel may ask what prompted you to begin seeing a particular doctor or attending physical therapy at a particular clinic. If the truth is that you went to that medical provider based on the direct advice you received from your attorney, you have no choice but to acknowledge this.

This testimony can have a negative impact on your case and prompt further scrutiny or investigation into your claim by the insurance company. An example of such further investigation would be the insurance company requesting that you undergo an independent medical examination.

5. A COURSE OF TREATMENT THAT CONSISTS ENTIRELY OF ALTERNATIVE MEDICINE

While complementary and alternative forms of medicine have gained more acceptance over the years, insurance adjusters still view such treatment as a sign that an injury may not be serious. Adjusters are particularly skeptical when it comes to claims involving soft-tissue injuries. The problem with soft tissue claims is that while the claimant may have subjective complaints of pain and discomfort, such complaints can't be substantiated through objective medical tests.

6. A CLAIMANT WHO IS DIFFICULT TO REACH

There will be instances following your accident in which the insurance company adjuster will try to contact you regarding your claim. In the insurance company's eyes, it shouldn't be all that difficult to reach you. After all, you probably spend most of your time at home since you're injured and can't go to work or move around too much right? Claimants who never seem to be around to answer telephone calls from an insurance adjuster get noticed very quickly.

7. AN IMMEDIATE NOTICE OF LEGAL REPRESENTATION

Following an accident, if an injured party ends up hiring an attorney, the first thing that attorney will do is send the insurance company a notification letter explaining that the injured party has retained the attorney's services to pursue the claim. This is standard protocol. However, problems sometimes arise in situations where the insurance company receives a notification letter from an attorney so quickly after an accident that it comes across as suspicious. Similarly, concerns will arise if the initial correspondence from your attorney is dated the same date as your injury. Whether fair or not, the fact remains that insurance adjusters will always be on the lookout for accident victims who seem to exhibit a little too much savvy when it comes to pursuing an injury claim.