Practice Tips...

Sizing up the *records review*

Robert Dawson

When you purchase automobile insurance and pay premiums for medical benefits coverage, you expect that the insurer will pay the reasonable expenses for medical treatment that was necessary because of the automobile collision. That's what the contract says and you expect that insurers will pay those bills without much resistance. However, at least one insurance company in this state is now making a practice of denying chiropractic bills based upon a "records review." Here is how State Farm Insurance Company goes about denying medical benefits owed to its insureds, and what you can do about it.

First, State Farm requests that your client's chiropractic physician provide a copy of his or her records. Next, State Farm will have those records reviewed by some person or company that reviews medical records. State Farm often uses Professional Evaluation Services (PES) to conduct these "records reviews." The reports by PES and the other companies typically say that a few chiropractic visits are okay but anything beyond that was no longer "necessary," or that the charges were "not reasonable."

The reports by these records review companies are typically not signed by a physician. These reports appear to come out on a pre-printed/computer generated document. The insured is not examined. Often the patient's treating physician is not contacted to discuss issues of concern. State Farm, in an effort to protect its own interests, at the expense of its insureds, uses these "records reviews" to deny first party medical benefits.

After receiving a copy of the "records review," State Farm writes to the insured's doctor stating:

Through analysis of your diagnostic workup and treatment plan by an independent medical consultant, it appears the level or amount of care provided (based on the diagnosis) was excessive. Based on this consultation, (copy enclosed), we enclose our draft in the amount of $_____ as full and final payment.

Thus, without having their insured examined, State Farm writes a nasty letter to the insured's physician stating that his or her treatment was unnecessary or overpriced. Now that's a letter that is likely to damage the physician-patient privilege.

Lastly, State Farm writes to the insured stating:

> Should Dr. X refuse to accept this payment and pursue any type of legal collection against you for the charges related to the bills in question, we will defend and indemnify you at our expense with an attorney of our selection.

Such actions are almost unbelievable. An insurance company refuses to pay benefits that the treating physician says are necessary, does so based on a "records review" by someone who never sees the patient, writes an insulting letter to the insured's doctor saying it won't pay any more benefits, and then offers to "protect" its insured, with an attorney of State Farm's choice, if the insured's doctor sues him or her!

There are a couple of things that you can do to discourage an insurer from wrongfully denying medical benefits that are owed to your client. You could note for arbitration what amounts are due to your client under his or her insurance contract. In most cases, the insurer will know that if you are serious enough to note the matter for arbitration then the benefits ought to be paid. The insurer will likely pay the benefits shortly after the matter has been noted. However, there are at least two drawbacks to noting the matter for arbitration. In a PIP setting your client may be compelled under his or her policy to pay the cost of one and one-half arbitrators. Also, relief in the arbitration proceeding is probably limited to the benefits actually due under the contract.

The second thing you can do is file a civil suit against the insurer who wrongfully fails to pay the medical benefits owed to its own insured. If the recovery were limited to the amount of benefits wrongfully withheld, then a civil suit would not be practical. However, it seems to me that you are entitled to recover treble damages, costs and attorney's fees, and the pain and suffering to the insured due to the failure to pay benefits when they were due.

In your civil suit, the first allegation would be that State Farm breached its contract because it failed to pay medical benefits that were owed under the contract. Although pain and suffering is not normally recoverable in a breach of contract action, the denial of medical benefits is one situation where it appears to be recoverable. In *Wilkins v. Grays Harbor Com. Hosp.*, 71 Wn.2d 178 (1967) the Court said:

> We are of the opinion that increased pain and suffering and detrimental changes in ones health are certainly a reasonable foreseeability from a breach of this medical service contract by denying treatment under it.

The *Wilkins* case is worth reading if only for the powerful language recognizing the justice in allowing a pain and suffering recovery where an insurer fails to pay first party medical benefits.

> We are of the opinion that the damages suffered here may be fairly said to have been within the contemplation of the parties when the contract was executed.
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> It is a well-known fact that as a rule these contracts are not entered into by the wealthy or well-to-do class of the community, but by that poorer class who seek thereby to provide themselves with medical or surgical assistance in case of sickness or accident, without resort to humiliating public or private charity. That a resort to such charity might result from a failure of defendant to keep its contract, was a contingency which would naturally be within the contemplation of both parties. That being compelled to resort to it for the meager assistance it usually affords would be a source of humiliation and mental anguish to a woman of average sensibilities, who for years had paid a monthly premium to avoid such a contingency, goes without saying.

Wilkins at 187. Plaintiff's counsel on the Wilkins case was John M. Darrah, now a judge of the King County Superior Court.

The civil suit could also allege a breach of the Consumer Protection Act. Insureds may bring a private action against their insurers for breach of the duty of good faith which insurers owe their insureds. Breach of the insurer's duty of good faith is a *per se* violation of the Consumer Protection Act. *Tank v. State Farm*, 105 Wn.2d 381, 394 (1986). Denial of medical benefits based on a "records review" would probably violate several WAC regulations defining unfair claims settlement practices, including:

> Refusing to pay claims without conducting a reasonable investigation.

> Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.
>
> Compelling insureds to institute or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.
>
> Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

WAC 284-30-330.

See *Escalante v. Sentry Insurance*, 49 Wn. App. 375 (1987) for a discussion of the private right of action an insured has against his or her insurer for a violation of the WAC regulations.

Once suit has been filed, the case can be prepared for mandatory arbitration with minimal effort. Often the letter State Farm has sent your client will make great exhibits. You will also need a letter from the client's treating physician stating that the charges were reasonable and that the treatment was necessary as a result of the accident.

I believe that arbitrators will be offended by the procedure State Farm uses to deny benefits to its insureds and will make reasonable mandatory arbitration awards. Furthermore, if the wrongful denial of benefits caused your client additional pain and suffering, hindered your client's recovery, or hurt your client's credit, then that might be a case to take to a jury.

Insurers owe a fiduciary duty to their insureds to pay first party medical benefits promptly and not use subterfuge to deny benefits that are owed. When medical benefits are denied it makes sense to question the denial and to provide the adjuster with reasonable documentation showing that the benefits should be paid. However, if an insurer continues to refuse to pay medical benefits that are owed under the policy, then consider filing suit or noting the matter for arbitration. This process of denying benefits based on a "records review" has got to stop and the way to stop it is to expose the practice for what it is and make the insurer pay the consequences of its wrongful actions.

Have a valuable "Practice Tip" that you would like to share with WSTLA members? Please call Bob Dawson (624-5000) with your thoughts. Remember, your practice tip may relate to substantive law, procedure, or law office management.

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