THE LAW OFFICE OF
NEAL H. SOBOL
A LAW CORPORATION

520 E. Broadway, Suite 201
Glendale, CA 91205
818-547-6650
www.NealSobol.com

DOCTOR NEWSLETTER NO. 13:

ARE YOUR CLAIMS ON THE DIARY MERRY-GO-ROUND?

Our office has learned, in relationships developed with insurance consultants, while prosecuting bad-faith litigation, how the claims process works at most of the larger insurance companies.

Our experience in handling these types of claims has given us a wealth of knowledge through discovery and research, in order to best assist our clients through the unfamiliar process of insurance claims.

DEPARTMENT OF INSURANCE REQUIREMENTS

All insurers doing business in the state of California are required to adhere to the Fair Claims Settlement Practices Regulations. The substance of these regulations has been in place for decades, while the most recent update to the regulations was made on August 30, 2006, and can be found in the California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, Section 2695, et seq.

Under 2695.7, every insurer shall immediately but in no event more than (40) calendar days accept, or deny the claim in whole or in part. If more time is required, written notice must be delivered every (30) days until a determination is made, or legal action is served.

COMPLIANT CLAIMS HANDLING

In order to fully comply with the aforementioned regulations, it is necessary that the adjuster regularly work the file, and make his or her conclusions in a timely manner, and communicate the same to the claimant, or his attorney, immediately. If unable to complete the investigation and accept or reject the claim within the first 40 calendar days following the loss, he or she must communicate what is further needed to do so, and continue delivering this written notice every 30 days.

Often times, the insurer sets unrealistic expectations about how many claims a given adjuster will be able to process, resulting in an adjuster that wants to "do the minimum" and end the day. This affects the claims of your patient and/or your claim, if benefits have been assigned, as illustrated below:

Let's assume that your unrepresented patient files a claim on January 1. For this illustration, let's also assume that the medical treatment has been completed and medical records and billing are all complete and "in hand."

The adjuster informs your patient that she will need to "do a thorough and complete investigation". On February 2, the adjuster sends a letter to your patient, which states in pertinent part, "investigation is continuing." Your patient calls for status on February 15 and the adjuster is not in. A voicemail message is left and a response is made to your patient on February 16 at your patient's work number, at 7:30 am, when the office is closed and a voicemail is left on a general delivery line, which never reaches your patient. On March 3, a letter is sent to your patient, indicating that "I am still waiting for your recorded interview, and have been unable to reach you".

This example can go on for as long as the claim itself, but you get the idea.

Typically, your patient will receive one call per month. In addition, the typical claims file will contain copies of written correspondence that may, or may not, have been sent out.

Once the adjuster documents that the call has been made, and the letter has been printed for the file, her work is done until the next month, in many cases.

We refer to this as the "diary merry go-round" as in many cases, the files are just pulled from their respective slot, handled for documentation purposes, then returned to their slot until they come back around the next month.

EFFECT OF CURRENT BUSINESS CLIMATE

In 2007, 21st Century Insurance laid off employees at its Woodland Hills Headquarters, only to be purchased by AIG, which sold 21st Century to Farmers on April 17, 2009 in a transaction expected to be approved by the state regulators by year's end. When the sale was announced, nearly 500 workers, or 7% of its staff were eliminated and the Long Beach office was closed.

In a media statement released by Mercury Insurance Group on March 9, 2009 a company-wide lay off resulted in the elimination of 363 positions, which from varying accounts, would result in a loss of 7-10% of its workforce.

Many adjusters are now faced with the very real possibility of losing their job, being forced into an early retirement, or having low morale due to having many of their benefits eliminated or reduced.

Even "good" adjusters that are concerned with seeing a fair and equitable resolution to their claims, are operating at a reduced performance level due to "inheriting" claims of their co-workers that have lost their jobs.

EFFECT OF COMPLAINT TO THE DEPARTMENT OF INSURANCE

It has often been the topic of discussion, exactly what effect will a department of insurance complaint have on a particular claim. In our experience, if a legally articulable set of facts can be presented to the department, at a minimum, an investigation will be undertaken, in which the insurer will have to provide access to the department for review of the claims file. If violations are discovered, this can lead to fines levied against the carrier. In future negotiations, the office that has a reputation for presenting successful complaints is virtually certain to have the claim handled differently than the office that either never raises the issues when present, or the office that habitually presents unsuccessful complaints, due to a misunderstanding of the regulations.

SOLUTION INVOLVES DEDICATED LEGAL REPRESENTATION

The best way to get your patients' claims off the "diary merry go-round" and to obtain a prompt, fair settlement, is to insist that your patients seek and obtain dedicated legal representation from an attorney you know and trust. Additionally, it is imperative that you assist your patients in securing representation by counsel that knows all aspects of personal injury claims, including the Fair Claims Settlement Practices Regulations, enforced by the California Department of Insurance.

At the Law Offices of Neal Sobol, we regularly follow up on our client's claims, so they are not placed in rotation, waiting until the adjuster has a free moment to look at the file, feels up to handling files on a given day, or is not himself looking for another job and preparing resumes. We pride ourselves on our success rate, and also with the speed and efficiency with which we are able to resolve our clients' claims, resulting in prompt payment for redress of injuries and treatment rendered.