Bringing Down Barriers to Care and Ensuring Access to Injured Patients by Dr. Arthur C. Croft

According to David Berardinelli, author of From Good Hands to Boxing Gloves: The Darker Side of Insurance, Allstate's strategy is to apply the "three Ds" principle to hang on to money that should otherwise be used to reasonably settle claims. The three Ds are delay, deny and defend.1 If you are homeless because of a hurricane (as many who were insured by Allstate during Katrina still are), paying your existing mortgage plus renting a temporary home, things gets desperate pretty quickly. The insurer conjures up excuse after excuse to delay settling claims.

After about four months, people are quite desperate, and much more inclined to accept a meager offer. For those who won't, the second phase is denial: It's not covered by your policy, it's not our fault, etc. For those who refuse to give up and take the claim to the next level by hiring a lawyer, the proverbial "good hands" become boxing gloves, and the legal defense begins.

In motor-vehicle claims, the number-one approach, which is used industry-wide these days, is to deny the claim right from the start. Usually this comes in the form of a letter from the claims agent to the claimant that explains, in essence, "According to our investigation, this was a very low-speed collision in which an injury would have been very unlikely. Therefore, we are not authorizing any further payment of medical bills in this claim." The subtext of the letter is, "Sue us."

Insurers know this initial letter will discourage a substantial proportion of claimants from pursuing any claim. That will translate into a savings of many millions of dollars every year for the company. Unfortunately, this very often means injured parties won't get the medical attention they need and will have an increased chance of becoming one of the approximately 1.5 million people injured each year who develop chronic pain.

As advocates of public health and the welfare of victims, we should all be concerned whenever a systematic barrier to health care access exists. This also, of course, limits our access to this important patient demographic. Fortunately, there are simple ways to circumvent these problems, and I'll offer them in basic format here.

It is first important to understand that in most instances the insurer's "investigation" in the early stage consists of nothing more than looking at the claimant's vehicle property damage. If it does not exceed a certain dollar amount, the case is considered "soft fraud." This investigation is purely the work of the claims agent at the lowest rung of the claims process ladder and does not involve the collaborative work of accident reconstructionists, biomechanical experts or physicians.

Because the insurer is obligated by law in most states to provide a "reasonable dispute of facts," they are probably already pushing the envelope of "good faith" with this disingenuous denial of services. An arbitrary agent-level decision will not usually form the basis for a reasonable dispute of facts. The dispute of facts should be based on an independent examination or some other formal investigation of facts. Most states require this dispute to be made in writing within a specified period after receiving the claim (e.g., 30 days). Doctors are certainly within their right, as are patients, to call the insurer and demand this written explanation of the true basis of the denial.

It is also important to restate something about which I have written many times. The insurer's reliance on property damage as a proxy for injury probability or injury seriousness, and therefore as a gauge for the need for medical care, is completely devoid of any scientific

underpinning. It lacks criterion validity, as our meta-analysis of crash epidemiology literature showed a few years ago.2 (If you would like a free copy of this paper, please e-mail me: info@srisd.com.) Thus, an arbitrary property-damage threshold also will not constitute a reasonable dispute of facts. This is not really a fact unknown to insurers: the Insurance Institute for Highway Safety, which routinely tests the head restraints of production cars in order to rate their safety, sponsored a study that actually showed that the largest group of whiplash patients investigated by them were in crashes characterized as no-damage.3

The obverse of the standard defense argument is that human-subject crash tests have established a crash speed threshold, below which injuries are not likely to occur. This is generally taken to be a speed change, or delta V, of 5 mph. This is a subject I have also explored in previous columns, but the two points to remember here are these: None of the authors of any of these studies has actually made any such claim; and the Helsinki Declaration explicitly prevents the kind of human subject research that would necessarily lead to the establishment or validation of the maximum corridors (i.e., tolerance) of trauma, since one would necessarily have to produce injuries in the exploration process.

As with any kind of experiment, it is impossible to replicate the myriad of human risk factors and crash conditions in a laboratory experiment using only a few cars and a handful of healthy, (mostly) male volunteers. While important for understanding biomechanical and other features of a crash, these crash test studies do lack external validity when it comes to risk.

Some crash test studies have reported short-term symptoms. None ever reported long-term neck symptoms, of course, but none of them ever formally followed the volunteers long-term. On the other hand, none of them reported significant property damage, either, so in any real-world collision in which there is property damage beyond scratches, this human crash-test literature is not relevant anyway.

The most reliable data for developing criteria for considering risk thresholds (to the extent they are attainable) come from clinical and epidemiological reports of real-world crash injuries. Interestingly, paired comparison studies in which two or more people in the same vehicle are followed after the crash demonstrate that human variables (age, sex, history of neck pain, etc.) are more deterministic vis-a-vis whiplash injury risk than the crash speed or property damage.4 This kind of data provide much higher criterion validity than experimental crash tests.

When a series of these real-world crashes involving injured people in cars equipped with accelerometers were investigated, the mean crash delta V in the rear-impact crash variety was found to be 5.1 mph.5 This one study single-handedly invalidates the common misperception that "most people will not be injured in a rear impact crash if the delta V is 5 mph or below." Assuming the cases were distributed under a normal (bell-shaped) curve, approximately half are injured below this 5 mph "threshold."

In the derivation of crash speeds, these special accelerometer-derived speed studies do not suffer from the usual uncertainty induced when employing traditional accident-reconstruction methods. It is also worth pointing out that in the many crash tests conducted at the Spine Research Institute of San Diego between 1999 and 2006, we virtually never found structural property damage when the crash delta V was under 7 mph. Thus, it is clear that, as the IIHS found earlier, a large proportion of whiplash injuries can and do occur in no-damage crashes.

The most recent important papers on this subject were published last fall by Bartsch, et al.6,7 They very meticulously reconstructed a series of more than 90 crashes occurring here in the U.S. using the most reliable techniques of accident reconstruction. They also examined the corresponding medical records from treating doctors with DC, DO or MD degrees. They reported that the mean delta V for the vehicle of the rear-struck victims was only 3.97 mph.

This represents the most sophisticated analysis of U.S. data and, once again, establishes the fact that property damage is not a reliable proxy for injury risk.

All of this peer-reviewed, scientific research undermines the common defense arguments in low-velocity, rear-impact injury claims. In short, the claims are entirely without any scientific merit. The fact that they are commonly effective in litigation is merely a reflection of the extent to which unopposed junk science can succeed in our judicial system. Other than junk science and editorial opinions, the defense generally has no foundational scientific literature to support its contentions.

This understanding can be helpful in dealing with denial-of-service disputes. As insurers' arguments lose their underpinning, their motivations become increasingly transparent, and, if they remain intransigent, it would certainly appear that they are no longer dealing in good faith. While some states, such as California, have done away with third-party bad-faith suits, this still has a tendency to make insurers uncomfortable. This information is also, of course, extremely important in litigated cases, even for patients who might wish to take an insurer to small claims court to recover medical expenses. Doctors can assist their patients in preparing for such claims by providing this information and/or narrative reports and medical records. This has been quite successful in my experience.

References

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