

# Comments on *Colossus* and the use of “Adjusting Software” by U.S. Insurers

By Greg Samuels and Wyatt Pickett

Beginning in the early to mid 1990's, many insurers in the United States began using computerized claims adjusting software to assist them in keeping payouts on small to moderate personal injury claims more modest. CSC Corporation's *Colossus* program was the best-known, and most widely discussed, of the claim adjusting programs – but while some companies may use or have used other software, the principle behind the process is fundamentally similar regardless of the program used.

The program's purpose is to provide the insurance adjuster with a range of authority for non-pecuniary damage awards based on the severity of injuries and treatment history entered into the program's matrix. The adjuster inputs data from medical records, based on a coding system developed in conjunction with the software developer and the insurer. The insurer can calibrate the program to be stingy or more generous with certain types of treatment, certain elements of damages, and the like – again, a process which is unique to every insurer who uses the program. Once the data input is complete, the adjuster runs the program, and receives a range for what should be offered for the “pain & suffering” component of the claim.

Approximately two-thirds of U.S. insurers have utilized some type of claims adjusting software since the programs first gained wide acceptance in

the early 1990's. Since the companies don't widely advertise their use of these programs (often out of fear of increased exposure to bad faith litigation), much of the evolving knowledge about “who's using *Colossus*” and how it works is developed anecdotally, through discussion amongst plaintiff's lawyers in each individual U.S. jurisdiction who pass along tidbits gleaned from adjusters on their files, discovery in bad faith litigation which escaped protective orders, investor filings where the insurer may have “bragged” about using software to control claims costs and increase shareholder value, and the like.

A thorough discussion of *Colossus* and its uses is far beyond the scope of these materials, and would be best left to those few former insurance adjusters who have left their companies with information about the programs subsequently shared with the plaintiff's bar. What follows are a few tips, culled from our experience settling cases under the “computerized” regime in Washington State and elsewhere in the U.S., which may help you ensure that you maximize value when dealing with an adjuster whose offers are generated by a program rather than their own intuition and analysis.

**1) Claim Value is only enhanced through the input of objective data** – While the level of reliance upon software varies between those insurers

who use it, the upshot of computerized adjusting is to substitute intuitive analysis for raw data whenever possible. The average U.S. adjuster working for an insurer who uses claims analysis software will typically carry a load of anywhere between 200 and 350 open files at any given time. If you suspect that your client's claim will likely be evaluated by computer, it is imperative that you focus your settlement demand on drawing the adjuster's attention to those discrete items of evidence which are most likely to function as "value builders" for the claim within the framework of the program.

**2) Tell the Client's Story in Prose, not Poetry** – This suggestion follows logically from the reality expressed above. It does your client no good if your demand letter includes persuasive paragraphs on factors for which the software is not designed to evaluate. For example, severity of impact is typically not a "value builder" which *Colossus* or like programs are equipped to evaluate. While such evidence may assist you in getting out of an insurer's LVI regime, or might offer corroborating evidence as to the legitimacy of complaints, it's not likely to increase the value of the claim, no matter how persuasive and well-written the demand may be. With the case loads they typically carry, the adjusters will be scanning your demand for data to input – that's all.

**3) If it isn't in Chart Notes, it doesn't add Value – Encourage Clients to Tell Drs. Everything, Document all Symptoms and Segregate Complaints as much as possible** – Often tricky, I

know – especially when you get involved in the case a year or two post-MVA. The records often must speak for themselves, regardless of limitations. This suggestion is more for the clients who approach you early in the process, when there's still time for the client to assert control over this factor. Given the limitations of the insurer's computerized matrix, it's critical that each element which could serve as a "value builder" is segregated within the records to the maximum possible extent. E.g.: "shoulder pain radiating into neck" may end up getting input into the software as merely "shoulder pain". If the neck is affected, it's helpful if those symptoms can be segregated within the client's records as separate, discreet injuries. Encourage clients to identify each complaint to their treaters separately, rather than lumping complaints together. If all else fails, segregate the injuries yourself through the settlement demand text, and hope for the best.

**4) Clearly identify duration of treatment as evidenced in records --** Make it easy for the adjuster to determine the length of treatment and number of visits to each treater. Best approach is typically some sort of spread sheet, identifying each visit. In the U.S., the adjusters would be used to looking for bills to support each visit – thankfully, your client's MSP report can usually provide all the information you need on that score. The only downside to providing the MSP report is that it may not have dawned on the U.S. adjuster that a comprehensive printout summarizing your client's *pre-existing* treatment even exists, and could be

obtained by the defence through discovery. In cases where pre-existing injuries and their relationship to current complaints may be an issue of serious contention, you may reconsider whether providing the complete MSP report in settlement negotiations is your best strategy.

**5) Intersperse GP/ specialist visits with chiro, acupuncture, alternative medicine, etc. to Enhance the Value Accorded these Treatments --** We can assert from personal experience that adjusting software gives higher value to a claim dominated by *active* therapy, like physio, as opposed to *passive* modalities such as chiropractic care. *Colossus* is harshest on those claimants whose presentation suggests the typical “whiplash” complaints and treatment (diffuse STI to the neck/back, with a heavy component of chiropractic care). Anything you can do to frame your client’s claim in a way that takes them out of that paradigm will increase value.

As a general rule, our experience has been that Canadian plaintiffs are more likely than their U.S. counterparts to try therapies beyond the traditional “physio vs. chiro” approaches. If you represent a claimant whose treatment includes significant use of acupuncture, traditional Chinese medicine, or other alternative modes of therapy, you will pose a real challenge for the *Colossus*-bound adjuster. It may be beneficial to express your concerns with the adjuster up front, and try to divine whether the claim’s unique presentation takes you entirely out of the software regime (good) or whether alternative therapies

are given any credit as “value builders” in the analysis (bad). A significant segment of adjusters are willing to admit the limitations of the program, and offer comments which may hint at the best way to proceed.

In any event, anecdotal reports suggest that “second tier” therapies of any kind may receive enhanced value when they are “bracketed” by visits to an M.D. or a specialist.

**6) Provide clear evidence of prognosis/permanence of any disability**

**7) Identify factors in history of treatment (meds, traction, MRI, injections) --** Adjusting software is generally equipped to consider the use of devices such as cervical collars and TENS units, as well as the use of trigger point injections and the duration/type of certain types of medications. As with the treatment history, breaking these items out in a spreadsheet with clearly marked durations of use, supported by the records if possible, is the best approach.

**8) Comparative jury verdicts irrelevant --** The reason for this is that software was created, in large part, to reduce insurer payouts for non-pecs, which were often calculated as a rough multiple of treatment expenses. Under a *Colossus*-type regime, the software analyses type and duration of treatment to determine how much to offer...typically, medical expenses don’t factor into the equation of determining what the non-pec authority will be.

With insurers NOT utilizing software-based analysis, the typical comparative jury verdicts approach commonly used in BC may be worthwhile...another good reason to know which regime you labour under *before* drafting your demand.

**9) Talk with the adjuster – are they bound by range, can they consider other factors, have all relevant “value drivers” been included. Do they have room to move?** -- You may be surprised how much information you can glean from certain adjusters. Some will offer no insight whatsoever into the “behind the scenes” processes at work. Others, resentful of the loss of analytical control over their caseload that the software programs have brought about, are remarkably cynical about *Colossus*. They may be even more open in discussing the regime they work under with the rare Canadian lawyer they see than they would with one of their “usual suspects” from their local plaintiff’s bar, who may have multiple open files with the adjuster at any given time, or a reputation that precedes him. Use typical XFD strategy – be friendly, ask questions, and get them talking. You may get some helpful hints on how to further enhance the claim’s value.

**10) Mediation unlikely to increase settlement authority** -- Few of you would get to this stage *without* filing suit and involving a U.S. lawyer...but it’s worth knowing that if authority has been determined by computer, mediation, pre-trial settlement conferences and the like are not likely to squeeze any additional funds out of the insurer. Some judges in

Washington State are becoming very frustrated with this latter development, especially in cases where PTC’s are mandated by court rule and the parties are expected to appear in good faith.

**11) Adjusters not generally allowed to consider litigation expenses – but “fees to winner” regime might work in your favour, or get you out of Colossus entirely** -- Typically, decisions about the balance between settlement and litigation costs are made at a corporate level far removed from the front-line adjuster, and as such, curry little favour in settlement talks. However, since virtually no U.S. jurisdictions follow the “loser pays” rule for costs and disbursements, this would certainly be an issue you might want to hammer home in cases involving a U.S. defendant, a B.C. accident, and no serious dispute as to liability. The possibility of facing a prevailing party costs award which exceeds the value of the underlying claim is simply not in the contemplation of the U.S. insurer or adjuster. Use this factor to your advantage in negotiation – it may take your claim out of the software loop.

**12) Software frequently recalibrated – if it’s been months/years since last evaluation, ask to have it re-examined. You’ll always get the higher figure.**

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