

Colossus and Medical Management

This newsletter, and the next several newsletters, will be devoted to Colossus and other computer programs with similar purposes. These applications are essentially claim and settlement valuation programs used by over 70% of the insurance industry. With industry acceptance continuing to grow, it is essential that physicians and attorneys become familiar with their assessment logic and protocols. It is only through an understanding of the programs expectations that we can communicate effectively with the insurance industry personnel and help them fairly evaluate your client's injuries.

The content for these newsletters comes from many resources but primarily from a book published by Siren Publishing. The book, titled [Colossus: What Every Physician Needs to Know](#), was written by Aaron C. DeShaw who is both an attorney and physician. The second release of this book is 465 pages versus 160 pages in the first edition published just a few years earlier. This demonstrates the tremendous increase in data available to fully appreciate the impact of Colossus and similar programs.

During a recent presentation I was challenged by the audience regarding the information presented and its legal interpretation. While giving my opinion as a physician, I unfortunately upset some of my attorney audience. Therefore, as a disclaimer, I must stipulate that I am not an expert in Colossus. However, I have read many articles and books on the subject because the information helps me understand the importance of what we do as physicians in the context of what you need as attorneys. I have pre-digested the information and present it to you from the perspective of clinically active physician. Please accept the information in this context and use it as intended.

Disclaimers out of the way, let me sum up Colossus in one word **PACKAGING**. No matter what data you have and regardless of the many considerations that need to be assessed, the packaging of the information specifically for the program is the least common denominator. Even the best case in the world along with good liability, great coverage, significant injuries and a great plaintiff will be compromised if not presented in a manner consistent with the data entry requirement of the programs

What do I mean by packaging? Simply the method and manner in which the providers offer the clinical information and the way the attorney organizes it in the demand package. I want to emphasize that by packaging properly; I do not mean misrepresenting the data in an inaccurate or fallacious manner. The data is composed of the facts but the packaging will determine its impact on the computerized valuation

Let me explain further. In a later newsletter I will be discussing some of the specific factors (a.k.a. rules and attributes) that the computer analyzes. For now, lets just say that each of these factors is important and needs to be entered into the program. The method that is used to enter data into the computer follows its own logic and is frequently time limited and time dependent. The logic plays a role because by answering one question correctly a whole different group of screens and questions become available.

If the trigger question never gets answered properly then the entire follow-up questioning will never be considered. Obviously, the solution is to package the information so it is easily extracted in an orderly manner. Also, because the programs will time out after a specified time, the data needs to be organized before beginning the data entry. Otherwise, the program shuts down and supervisor authorization is required to re-enter the data. The adjuster or the adjuster's assistant is charged with compiling the data from the doctors' reports and the attorney's demand package into an organized "dissection" sheet. Generally, the dissection sheet has approximately 60 different items that can be entered. These 60 items are extracted by people who probably don't understand the medical terminology very well and are under the pressure of production quotas. The ease in which the data can be extracted and entered into the dissection sheet (and later the program) will determine the quality and quantity of data extracted. The easier the data is presented to the carrier the more likely it will be entered into the computer.

Doctors reports and notes that do not address the specific areas considered by Colossus will be a detriment to the valuation of the case. Equally important, if the data is in the report or notes but difficult to find it may be overlooked and never considered. With this in mind, it is important to have an understanding of those factors considered in Colossus and how they need to be presented so that the doctors can report or "package" the facts in the format required.

Before discussing the details I have gathered regarding the factors and triggers, it is important to understand some general facts about colossus and it's competitor programs including Claims Outcome Advisor by Insurance Services Office (ISO), Insurance Claims Evaluation by Automatic Data Processing and InjuryIQ by ClaimIQ.

Colossus is the dominant software used to value bodily injury claims. Between Colossus and its competitors approximately 70% of all bodily injury claims are valued by computer program. The purpose for implementing these programs was to remove emotions out of the claims valuation process. Colossus is presently owned by Computer Sciences Corporation (CSC). CSC is one of the world's largest software support companies with approximately 35,000 employees worldwide. Colossus was originally developed in Australia (1988) for the purpose of cost containment. After several iterations it was adopted in the United States by Allstate in 1993. Since then, it has been reported that some insurers spend \$30 million to implement Colossus plus \$10 million per year for licensing. Even with the tremendous costs of implementation and licensing some insurers claim to save 100 million annually. These savings come from your client's settlements resulting reduced net proceeds to your client, lower attorney fees and doctor fee reductions. The savings also result in better earnings for the insurance company and its stockholders.

How fair are these programs in valuing bodily injury?

Let's start with the concept of the dissection sheet. As I wrote earlier, the dissection sheets used by the adjusters have approximately 60 factors. However, some programs have up to 600 diagnosis and 10,000

factors that can be considered. While the 60 factors may be significant, not considering 9940 possible factors can only lead towards undervaluation of the claims.

The largest value allowed for the original Colossus program in 1983 was \$274,000 for Quadriplegia. For those unfamiliar with the diagnosis, Quadriplegia is a condition whereby the patient is paralyzed in all four limbs from the neck down. Therefore, under the worst case scenario this would be the highest value allowed by the adjuster. It is interesting to note that these programs were developed with the MIST case in mind. In other words, while the highest benchmark value is for a Quadriplegia, that diagnosis would not even be considered using the program. Do you think that might skew the values slightly? Also, from my reading it was suggested that the \$274,000 value was never upgraded since 1983 and it was based upon the Australian dollars not the US dollar.

Medical bills are reduced to what the program considers usual, customary and reasonable (UCR) for the geographic region. In addition to the UCR reduction, the services considered are dependent on the program's end-user defined parameters. As an example, chiropractic and physical therapy services are considered by some carriers program versions only if provided within the first 8 weeks and under 22-24 visits. Additionally, treatments provided after a gap in care are not considered by some programs. One program considers a 5 day gap in care a termination of necessary treatment. If everything is perfect and the fees are considered reasonable, within acceptable time frame and without gaps in care, there is one last reduction. This reduction lacks any basis in science. This reduction is the consideration of only 80% of the approved medical specials. In other words, if your client received \$2500 of appropriate care medical care based upon the program's criteria (impossible if you ask me), the considered medical specials would only be \$2,000. This built in 20% reduction has no basis and is an absolute bias

I'm running out of space and have much more to share. In the next several newsletters I will provide details about the factors, rules and attributes to help you help your doctors and staff to better package the information. I will also discuss some of the tips we have learned to assist in better reporting and documentation so that the information is easily extracted and better communicated. If you have any comments or suggestions for the upcoming newsletters I am open to suggestions. I am also available for constructive criticism regarding the newsletter and its content. I only ask that you don't shoot the messenger and allow me a modicum of editorializing.