

# Colossus:

## What Every Trial Lawyer Needs To Know

*by Dr. Aaron DeShaw, Esq.*

Personal injury lawyers should be aware that the insurance industry has at its disposal a number of computer programs intended to cut claims payments. Claim assessment software, including COLOSSUS, Claims Outcome Advisor (“COA”), Injury Claims Evaluations (“ICE”) and InjuryIQ evaluate bodily injury claims -- typically the largest expenditure of an insurance company. These software programs compute the general and, to some extent, the special damages of a claim. As bodily injury claims are typically dealt with by plaintiff lawyers, and the software programs act as cost containment measures to limit settlements, the programs’ purpose directly opposes plaintiff lawyers’ efforts. Insurers also employ the software to limit defense lawyers’ ability to negotiate cases prior to trial.

### What Is Colossus?

Colossus is the trade name for a software program owned by Computer Science Corporation (CSC), and licensed to individual insurers for use in evaluating bodily injury claims. In a press release dated June 27, 2001, CSC claimed that Colossus was being used by 34 insurers, representing 60% of all U.S. Direct Written Premiums for personal auto insurance.<sup>1</sup> In a CSC press release dated February 10, 2004, the number of major insurers noted as using Colossus had risen to 50 worldwide.<sup>2</sup> With the inclusion of COA, ICE and InjuryIQ, claims assessment software is utilized by 9 out of the top 10 insurers in the U.S. (#1 State Farm the notable exclusion), and at least 16 of the top 20. *As this cost-containment “tool” gains in popularity among insurers, lawyers must begin to understand 1) how claims assessment software evaluates cases and 2) how some settlement offers might not represent a good faith claim evaluation.*

The purpose of Colossus is to remove all individuality of a claim and simply break the claim down into factors which will be evaluated identically regardless of the insurer, the adjuster, or the claimant. Ken Williams, President of America’s Division of CSC’s Financial Services Group noted, “Colossus takes the guess work out of an historically subjective segment of the claims process, providing adjusters with a powerful tool for improving claims valuation consistency, increasing productivity and containing costs. Colossus sets the industry standard by basing pain

and suffering evaluations on the severity of actual injuries and provides claims professionals with a valuation range for each claim.”<sup>3</sup>

Unfortunately, correct evaluation would require that *all actual* injuries were entered into the program, which cannot occur when the injury at issue is not present among the injuries listed in Colossus. Even when the appropriate injury descriptions are available in Colossus, there is mounting evidence that proper entry of all correct injuries and factors — necessary for a good faith evaluation — is not occurring at some insurance companies licensing Colossus.

Why would an insurer use a computer-based system incapable of evaluating human pain and suffering caused by an injury? According to former adjusters, insurers implemented Colossus for claim consistency, with the expectation that all adjusters would duplicate the cost containment methods of the most conservative adjusters at the company. In fact, the initial programming of Colossus was commissioned to find ways of increasing insurer profits by reducing or containing claims payments – often referred to in the industry as “reducing severities” through non-rate action plans.

### **Understanding The Program**

According to the original programmers, Colossus was set up to calculate general/non-economic damages based upon the following four general categories:

1. Trauma (including all factors on diagnosis, prognosis, treatment, duration of symptoms, etc.)
2. Permanent Impairment
3. Disability (later changed to Duties Under Duress)
4. Loss of Enjoyment of Life

These general categories are broken down into approximately 600 injuries and 10,000 factors, which can range from the number of days in a hospital to the type of immobilization device used. In general, factors are provided value based upon the duration of symptoms, the type of treatments received, the frequency and duration of treatment, and the complications arising from the injuries. For an expansive list of injuries and factors, see *Colossus: What Every Trial Lawyer Needs to Know* at [www.colossusbooks.com](http://www.colossusbooks.com).

Colossus evaluates claims based upon a severity scale by providing “weight” to certain injuries and factors in the form of “severity points.” While some insurers have customized versions of Colossus, the number of severity points is apparently the same for every version of Colossus when it is delivered to insurers. A CSC executive previously testified that Colossus does not come with any set monetary values for the factors, and that the program’s monetary range for

the settlement offers is solely based upon the information fed into the systems by the insurer.<sup>4</sup> The insurer sets the amount of money that will be allocated per severity point in something called “benchmark tuning.” With some major insurers, the benchmark tuning session consisted of the company’s top 20-40 adjustors in a geographical region getting together to evaluate approximately 11 cases total. Once a consensus was reached by the adjustors as to a claim’s value, the decision would be recorded.<sup>5</sup> From that small amount of information, the insurer would extract the market value of all 10,000 factors in Colossus.

Some companies then took the values provided by their top adjustors and cut them before creating the Colossus baseline. In doing so, the insurer knowingly pays claimants less than the claim’s worth as determined by the company’s most conservative adjustors. According to former adjustors involved in the initial implementation of Colossus, some insurance companies arbitrarily cut the value of all claims by a percentage (ranging from 5-20%) from the values provided by their best adjustors.<sup>6 7 8</sup> This meant that these insurers knowingly underpaid UM/UIM claims by that percentage.<sup>9 10 11</sup> Another significant problem resulted when some major insurers originally tuned Colossus: they intentionally excluded all cases which were “clear policy limits cases,” all cases worth more than \$50,000, all stacking UM/UIM policies and all litigation cases.<sup>12 13 14</sup> Some insurers excluded all claims where there were “external factors” such as excessive speed, drunk driving, hit and run, etc., from the baseline. The exclusion of all high claims likely resulted in a baseline value notably lower than the insurer’s actual baseline.

From this baseline, claim value is then calculated by Colossus based upon the claim factors. The program provides a “Colossus High” and a “Colossus Low” value for the adjustor. Some licensing insurance companies instituted policies of requiring adjustors, and even defense counsel, to not exceed the Colossus High during settlement negotiations or even mediation.

As noted above, Colossus uses approximately 600 injuries and 10,000 factors in determining case value of a claim. Claims Outcome Advisor, ICE and Injury IQ use more injuries than Colossus but use similar factors or rules in order to determine case value. My research suggests that the following factors are likely considered by Colossus:

### **Doctor as Factor**

While all claims will be devalued due to the above-benchmark tuning bias (explained above), resolving a claim short of trial is dependent upon two main factors: the physician’s ability to chart the factors of value to Colossus, and the lawyer’s specific formatting of the demand letter. As a general consideration, physicians are the single most important aspect of a Colossus case. *The healthcare provider’s records are the only source of information that adjustors are allowed to enter into Colossus, other than their own personal observations of the claimant.*

The most valuable factors considered by Colossus are the injuries or diagnoses. The physicians involved in a case must convert all subjective and objective findings into an appropriate diagnosis in order for the injury to be entered into Colossus. In response to the entry of these diagnoses into Colossus, screens seeking additional information will “pop up” for the adjuster. Some of these questions may seek data on the type of doctors seen, the number of treatments and the duration of treatment. Further questions may address hospitalizations, surgery characteristics or procedures, injury complications, immobilization devices prescribed, therapies used, and a long list of other factors. In the case of soft tissue claims, the system will track the presence and duration of some subjective symptoms associated with spinal injuries.

The only factors available in a Colossus evaluation are those which are opened by the entry of triggering factors such as diagnoses. It is for this reason that a full and complete list of diagnoses must be noted on every client by their physicians. Unless the doctor provides adequate chart notes detailing injuries, treatment, complications and other factors, the client cannot get a full settlement evaluation on the case. This is why it is important that the doctors providing treatment for traumatic injuries understand claims assessment software. (See *Colossus: What Every Physician Needs To Know* at [www.colossusbooks.com](http://www.colossusbooks.com))

Physicians themselves are considered a factor in claim evaluation. Physicians are categorized according to their degree designation or their activities in a case. Three categories of physician in Colossus include: D.C. (Doctor of Chiropractic); M.D. (Doctor of Medicine) and Medical Specialist. The types of doctors considered specialists by most licensing insurers include the following: orthopedic surgeons, neurosurgeons, neurologists, psychiatrists and psychologists.

### **Attorney as Factor**

Historically, legal representation had a positive impact on the Colossus evaluation; today, however, it appears to have no value. The devaluation likely stems from a failure of the plaintiff's bar to appropriately litigate cases and dispute Colossus values.

Clients won't receive optimal claim evaluations if a doctor fails to document factors of value; the same situation holds true for claim value if the lawyer fails to make the necessary claims in the demand letter. Some insurers licensing Colossus have instituted policies that require the lawyer to make a specific claim in order for certain valuable factors to be entered to the claimant's credit. As an example, even where the client's physician has noted the disability or loss of enjoyment of life, it will not be entered into Colossus (at some insurers) unless the lawyer makes a specific claim for this loss.

Similarly, the failure by many lawyers to recognize the presence of a client's ratable permanent impairment is a major problem. Failure to obtain an expert opinion on the client's permanent impairment leaves a substantial amount of money on the table. If lawyers' demands

fail to note permanent impairment ratings or exclude claims for disability and loss of enjoyment of life (when applicable), the demands will lack three of the top five most important factors in Colossus. For this reason, lawyers must learn the requirements of a demand letter formatted for claims assessment software. To effectively report the client's injuries to ensure appropriate compensation, consider this: Colossus is a computer program and the more information correctly conveyed, of value to the system, the more the client's case is worth. The problem then is in knowing exactly how the Colossus system is providing value.

### **Case Value In Colossus**

#### **A. Injuries / Diagnoses**

Historically, Colossus has not used the same injury coding system as physicians, referred to as the International Classification of Disease ("ICD") codes. The ICD system presently used by the physicians in the US contains approximately 14,000 diagnoses. By contrast, Colossus has historically contained 600 diagnoses. These have been broken down into the following general categories:

Amputation

Concussion

Crush, Extensive Soft Tissue, Degloving

Contusion, Soft-tissue, Whiplash

Disc Injury

Dislocation

Fracture/Dislocation

Fracture

Lacerating, Penetrating Injury

Ligament, Tendon Damage

Superficial Injuries

Subluxation

Sprain

By contrast, other claims assessment software, most notably Claims Outcome Advisor, uses the ICD-9 codes, which prevent adjusters from reclassifying the physician's diagnoses prior to entry into the system. There is some question presently whether a new version of Colossus uses the ICD system to differentiate between different severities of the same variety of diagnosis.

An actual use of the ICD codes for the evaluation allows for differentiation between different severities of similar types of injuries. Consider the concussion diagnosis codes where one code (850.0) signals a concussion with no loss of consciousness, whereas another code (850.3) denotes

a concussion with a substantial loss of consciousness. Historically, Colossus would be unable to differentiate the two as it was limited to a single concussion injury code. Instead, unconsciousness is considered a *complication* of a head injury in Colossus (rather than the injury itself) and is incapable of being differentiated between a very short loss of consciousness, and one that lasts more than 24 hours. This differs from the ICD system, which provides different injury codes for a short loss of consciousness (850.1) to an extended loss of consciousness with residual cognitive alteration (850.4). Similarly, Colossus has been unable to provide different values to a fracture where there is a low likelihood of permanency (i.e. a fracture of the shaft of the femur) from one where there is a high likelihood of permanency (i.e. a fracture of the head of the femur.) Moreover, the entire area of strains/sprains is considered differently by Colossus than the medical field. The difference between the 600 Colossus codes and the 14,000 diagnosis codes used by physicians has also resulted in cases where an injury was simply excluded from consideration because it didn't fit within the Colossus system.

## **B. Complaints**

Colossus divides injury cases into two categories: demonstrable and non-demonstrable/soft tissue. The non-demonstrable cases are actually dealt with in a subsection of the Colossus program referred to as the "Whiplash System," and the value of factors noted in such a case are calculated differently than the factors in a demonstrable injury case.

In addition to the injuries themselves which will be things like "sprain/strain" injuries to the cervical or "thoracolumbar" regions, chiropractic subluxations, and disc bulges, there are a number of soft tissue injury signs and symptoms that are given value in Colossus. In Colossus, these signs and symptoms are called "Complaints," which include the following: headaches, muscle spasms, restriction of movement, radiating pain and depression. Each of the complaints associated with a soft tissue injury (if present) should be listed in the attorney's demand report, along with the provider who saw the client for the condition, the type of provider and the duration of the complaint. Since duration of a complaint and the underlying injury are determinant factors in case value, it is important that the client's healthcare providers perform regular re-examinations and symptom reviews. Without known injury and complaint duration, the program will provide less value for the claimant's injuries.

## **C. Treatment**

In Colossus, all treatment is characterized as one of the following varieties: *Initial*, *Subsequent*, or *Future*. If an injury entered into Colossus is one in which "initial treatment" is expected, additional windows will pop up requesting what the initial treatment was for that

particular injury. The conditions typically believed to require initial treatment are demonstrable injuries. Since non-demonstrable/whiplash diagnoses do not have initial treatment windows, such cases will automatically have less opportunity to be evaluated in a high range.

*Initial treatment* is the treatment rendered on the first hospital/ER visit, or if no hospital/ER visit took place, on the first visit to a physician's office. Initial treatment is more significantly weighted than subsequent treatment, thereby providing more value in a claim. The initial treatment screen will provide the adjustor the expected varieties of initial treatment for the specific diagnosis. When demonstrable injuries do exist in a case, additional screens will pop up after the initial treatment screens, then asking about *subsequent treatment*. Subsequent treatment occurs after the first ER/doctor's visit through the period when the patient is declared medically stationary or at Maximum Medical Improvement ("MMI"). Subsequent treatment makes up the bulk of treatment and includes treatment of both demonstrable and non-demonstrable claims within Colossus. Valuation of subsequent treatment hinges on the treating healthcare providers, details of number of treatments and the last date of treatment. Some immobilization methods are considered as subsequent treatment, along with a very narrow list of home treatments consisting of the use of TENS, bed rest, home traction and home exercises.

Potential complications of certain injuries or treatment methods will pop up with certain entries. If there is a complication which is allowed in Colossus, the adjustor then enters the treatment methods employed to deal with the complication and the outcome. *Future treatment* is defined as all treatment expected to be "medically probable" (51% or greater likelihood) which is directly related to the collision or a complication of the collision. It is at the adjustor's discretion whether to enter this, and at some insurers only future treatment prescriptions by an M.D. are considered.

A single injury can lead to the notation of many "factors" in a claim, including all of the injuries, the treatment varieties, injury complications and treatment for complications. According to the lead programmers of Colossus, an average case will require the adjustor to answer around 40 questions; in the most complex case, adjustors may provide up to 700 different answers.

A form called a dissection sheet is used by many insurers licensing Colossus. The dissection sheet is a 1-2 page form that contains approximately 60 factors out of the 10,000 available in Colossus. Dissection sheets allowed adjustors to enter pertinent Colossus factors on paper — for later entry into the Colossus program. Dissection sheets are not nearly as complex, detailed or interactive as the Colossus program itself, and inherently may lead to a failure to provide all relevant case facts to the Colossus program.

## **D. Prognosis**

Prognosis is another large value driver in Colossus. Prognosis should be given by the physician for *each area injured*. One problem: the program does not use the typical medical prognoses such as Excellent, Good, Fair, Guarded, Poor, etc. Instead, Colossus has its own categories and an adjustor must re-characterize the physician's prognosis. The Colossus categories focus on whether there are remaining complaints and whether treatment is or is not required.

## **E. Disability**

Disability defined by Colossus is considered in different terms/methods than those used by physicians. While the medical community will look to the job description, the client's physical capacity testing and clinical forms such as the Roland Morris, Oswestry, or Neck Disability Indices, Colossus uses a completely different system called Duties Under Duress, which is one of the top five most valuable factors. Adjustors at some insurers are instructed that three things must occur in order to enter Duties Under Duress in Colossus:

1. The injured party must actually do one of the accepted activities while in pain;
2. The physician must appropriately chart the injured party's performance while in pain; and
3. The lawyer must specifically make the claim for the Duties Under Duress.

This is one of several claims that must be specifically made by the lawyer in the demand in order for it to be counted.<sup>15</sup> If the attorney fails to make the claim, it will not be provided value although the client actually sustained the loss and a physician noted it.

The accepted activities qualifying for a Duties Under Duress claim are as follows: work, domestic (inside the home), household (outside the home) and educational/studies. Each of these categories has subsections providing more factors per Duties Under Duress category.

## **F. Permanent Impairment**

Permanent impairment is the second most valuable factor in a claim, following only the injuries themselves. Colossus is presently set up to calculate values based upon the findings of a Whole Person Permanent Impairment under *The AMA Guides to the Evaluation of Permanent Impairment 5<sup>th</sup> Edition*. Failure to obtain appropriate value in a case often stems from not obtaining an AMA impairment rating.

As an example, the value of a 10% whole person impairment of a 50-year old male alone should provide a value ranging from approximately \$8,000 to \$42,000, depending upon the other

factors involved in a claim. When combined with the Duties Under Duress and Loss of Enjoyment claims that often accompany a 10% impairment, this could be up to \$20,000 more. These values are dependent upon the individual insurer and the geographical location of the claim. However, this example illustrates why lawyers must fully understand Colossus in order to maximize claim values.

### **Writing An Exceptional Colossus Demand Letter**

The days when a 3/4 page demand letter was acceptable are over. In fact, they were over in the mid 1990s starting when Allstate implemented Colossus, which may explain why case settlement averages have been going down in the past 10 years. To reverse this trend at law firms, attorneys need to start writing demand letters capable of obtaining full value for every case handled. This requires a very different kind of format for cases involving insurers who use claims assessment software.

While the legal profession has historically used narrative-style demand letters to convey claims, much of the information provided in such a demand letter has no value in Colossus. Adjustors look almost entirely to the medical records for the information required by Colossus. But things can be missed, which is made more likely by the use of the dissection sheets. Unprotected documents reflecting adjustor accuracy in evaluating Colossus claims suggest that the percentage of accurately evaluated claims is quite low at some insurers. In fact, one major insurer has set a goal that the evaluations only need to be 85-90% accurate, and sent memos that the insurer believes this to be an unrealistically high goal. As a result, lawyers educated about Colossus have now started formatting demand letters containing the applicable Colossus factors supported by the medical records, so that the adjustor does not miss any factors in the case.

Injuries are tracked as to the duration, the treatment varieties, complications, prognosis and then the duties under duress, permanent impairment and loss of enjoyment of life involved in the claim. Demand letters should set forth this information in tables and in the order required for entry into Colossus. Adjustors should be able to take the demand letter and enter the information directly into Colossus, relying upon the records to substantiate the demand letter.

### **The Future of Colossus**

With some insurers saving up to \$200 million per year using Colossus, it is unlikely that the use of claims assessment software will go away. As a result, lawyers must be familiarized with the nuances of the software program, and thereafter implement specific demand letter procedures to obtain full case value.

There are cases where Colossus will not appropriately evaluate claim value. There are other cases where an individual insurer's use of Colossus will undervalue the claim and force litigation.

After reviewing Farmers Insurance's use of the program, Federal Court Judge Robert E. Jones opined, "Colossus is a waste of time and money (over \$10 million per year), and is more of a colossal failure than of any realistic pragmatic assistance. Results from demonstrations reproduced in this court were patently erroneous, under-evaluating FIE's exposure and increasing the risk of unnecessary litigation."<sup>16</sup> In the cases where the program does not appropriately evaluate the claim, attorneys need to take the cases to trial.

*Article compiled from "Colossus: What Every Trial Lawyer Needs To Know," by Siren Publishing, 2004 (www.colossusbooks.com). Author Dr. Aaron DeShaw, Esq. is a Portland, OR attorney and nationally known speaker, who specializes on Colossus issues. For more information, contact Aaron DeShaw at www.doctorlawyer.net*

**(Endnotes)**

<sup>1</sup> CSC Press Release of June 27, 2001, "CSC Expands Cost Containment Solutions For Claims and Legal Expenses," at [www.csc.com](http://www.csc.com)

<sup>2</sup> [www.csc.com](http://www.csc.com)

<sup>3</sup> [www.csc.com](http://www.csc.com)

<sup>4</sup> *Scrogan v. Wade and Allstate Ins. Co.*, Bartholomew Circuit Court, State of Indiana, Case No. 03C01-9909-CT-1317 Testimony of Steve Hancock, Director of Financial Services Group at CSC.

<sup>5</sup> Wilke, M., Electronic Marvels at State Farm

<sup>6</sup> Robert Dietz & Christine Klein at WSTLA CLE The Rise of Colossus, November 22, 2002

<sup>7</sup> James Mathis at WSTLA CLE The Rise of Colossus, November 22, 2002

<sup>8</sup> Declaration of Robert Dietz, No. 1, *Farmers Insurance Exchange v. Robert Dietz & Christine Klein*, Superior Court of the State of Washington for Snohomish County, Case 02 2 10109 5 (2002)

<sup>9</sup> Robert Dietz & Christine Klein at WSTLA CLE The Rise of Colossus, November 22, 2002

<sup>10</sup> James Mathis at WSTLA CLE The Rise of Colossus, November 22, 2002

<sup>11</sup> Declaration of Robert Dietz, No. 1, *Farmers Insurance Exchange v. Robert Dietz & Christine Klein*, Superior Court of the State of Washington for Snohomish County, Case 02 2 10109 5 (2002)

<sup>12</sup> Robert Dietz & Christine Klein at WSTLA CLE The Rise of Colossus, November 22, 2002

<sup>13</sup> James Mathis at WSTLA CLE The Rise of Colossus, November 22, 2002

<sup>14</sup> Guidera, Jr. “Colossus at the Accident Scene: Software of Insurers Spurs Suits – Insurers Use Program to Calculate Payout for Injuries, But Many Claim It Is Misused,” *The Wall Street Journal*, January 2, 2002

<sup>15</sup> Robert Dietz & Christine Klein at WSTLA CLE The Rise of Colossus, November 22, 2002

<sup>16</sup> *In Re Farmers Insurance Exchange Claims Representatives’ Overtime Pay Litigation*, United States District Court for the District of Oregon MDL Docket No. 33-1439, Findings of Fact p. 39-41.