

No. 100272

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

At Charleston

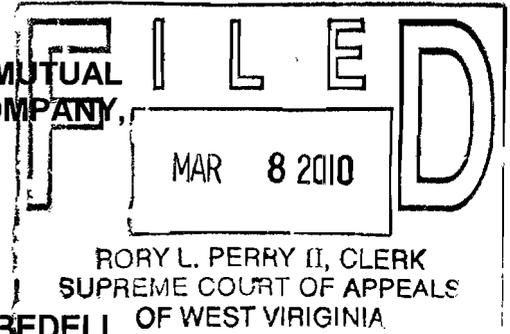
STATE EX REL. STATE FARM MUTUAL  
AUTOMOBILE INSURANCE COMPANY,

*Petitioner,*

v.

THE HONORABLE THOMAS A. BEDELL,  
Judge of the Circuit Court of Harrison County,  
West Virginia,

*Respondent.*



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*From the Circuit Court of  
Harrison County, West Virginia  
Civil Action No. 09-C-67-2*

**BRIEF OF AMICUS CURIAE NATIONAL INSURANCE CRIME BUREAU  
IN SUPPORT OF STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY'S  
PETITION FOR WRIT OF PROHIBITION**

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*Amicus Curiae* National Insurance Crime Bureau (“NICB”), by and through its attorneys, submits this brief in support of State Farm Mutual Automobile Insurance Company’s (“State Farm”) Petition for a Writ of Prohibition in the above-captioned proceeding and respectfully supports State Farm’s request that this Court issue a writ.

## I. INTRODUCTION

The protective order entered in this case, and similar orders that are increasingly being entered across West Virginia, are the best news that insurance fraudsters have had in a long time. Because of the enormous volume of casualty insurance claims that are filed across the country every day, and because criminals are adept at disguising their claims to look like routine and unobjectionable insurance claims, fraud detection and investigation requires patience, careful scrutiny and an analytical tool capable of processing information across millions of claims. In dealing with casualty claims, the most important such tool is the national claim database maintained by the Insurance Services Office, Inc. (“ISO”). Searches of this database, which are automatic when new claims are filed, are the primary source of red-flags indicating possible fraud. Once an insurer or NICB has been alerted of a possible incident of fraud, the information in insurers’ claim files, including medical records, medical bills and other such information becomes crucial to building a case that may eventually lead to prosecution.

The protective order entered in this case strikes at both of these antifraud tools. First, it could prevent insurers from reporting basic claim information to ISO and similar industry-wide antifraud databases or even into their own internal claim systems. Databases without information are useless and make it impossible to perform the pattern analysis that can reveal fraud in otherwise unremarkable cases. For example, ten similar claims alleging minor bodily injury submitted to different insurers under different names may not raise flags, but if a search of

the ISO database shows that all ten near-identical injuries occurred in the same month and involved persons living at the same address, insurers have a duty to investigate further.

Second, the protective order would strip claim files of the information that insurers and prosecutors need to build a fraud case. Protective orders like the one below generally require that medical records, medical invoices and related information must be removed from claim files after a claim is settled, or never be placed in the file in the first place. This means that, if that claim later turns out to be part of a pattern of fraud – which need not involve the claimant, but may implicate his or her medical provider – there is no realistic way for an insurer or NICB to go back and verify the charges, investigate the treatment or compare it with other cases of fraud. Without complete and accurate claim files, there can be no fraud investigations. And without investigations, there can be no criminal fraud cases. The result is that insurers' and NICB's antifraud programs will be drastically diminished, contrary to West Virginia law and overwhelming public interest. For this reason, NICB respectfully requests that this Court exercise its authority to stop the growth of overbroad and unnecessary protective orders like the one below.

## II. ARGUMENT

### A. **The Financial and Human Costs of Insurance Fraud**

Insurance fraud hurts all Americans, costing them billions of dollars a year. Although insurance fraud takes many forms, one of the most pernicious targets is casualty insurance that provides coverage for bodily injury under automobile and other liability insurance policies. Fraud against insurance companies may be based on false or exaggerated claims of liability or of unnecessary or overpriced medical treatment. Assertions of phony or unjustified treatment then support bogus claims for damages for pain and suffering. In the aggregate, all of these types of

fraud result in higher insurance premiums for consumers. Even more fundamentally, it corrupts key institutions, including the medical and legal professions, and our system of tort law.

According to the Coalition Against Insurance Fraud (“Coalition”), insurance fraud “costs Americans at least \$80 billion a year, or nearly \$950 for each family.”<sup>1</sup> Automobile accident fraud is one of the most widespread and lucrative crimes in the United States. NICB receives reports of more than 80,000 questionable claims each year, about half of which are associated with automobile accidents. Automobile accident fraud has a significant impact on consumers. Based on data from the Insurance Research Council’s 2008 Study of Fraud and Buildup in Auto Injury Insurance Claims, approximately 20% of automobile bodily injury claims involve fraud or buildup, which is the practice of padding an otherwise legitimate claim.<sup>2</sup> According to the Insurance Research Council, fraud and buildup account for between 13 percent and 18 percent of total automobile bodily injury insurance payments, or approximately \$4.8 and \$6.8 billion each year. Notably, the 2008 figures from the Insurance Research Council show fraud and buildup to be on the rise compared to a similar study conducted in 2002.

This increase in automobile fraud is mirrored in NICB’s own statistics. Between 2002 and the first quarter of 2008, questionable claims reported to NICB relating to suspected staged automobile accidents increased by 65%, from 1,566 in 2002 to 2,592 in 2007. And, through the first quarter of 2008, the number of questionable claims relating to staged automobile accidents was projected to increase yet again, to more than 2,900 incidents. In all, insurers have submitted more than 13,000 questionable claims to NICB involving staged automobile accidents since

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<sup>1</sup> See Coalition Against Insurance Fraud, Consumer Information, Insurance Fraud Backgrounder *available at* [http://www.insurancefraud.org/fraud\\_backgrounder.htm](http://www.insurancefraud.org/fraud_backgrounder.htm).

<sup>2</sup> See Insurance Research Council, News Release, Fraud and Buildup Add 13 to 18 Percent in Excess Payments to Auto Injury Claims, Nov. 24, 2008, *available at* [http://www.aicpcu.org/irc/News/IRC\\_Fraud\\_NR.pdf](http://www.aicpcu.org/irc/News/IRC_Fraud_NR.pdf).

2002, representing hundreds of millions of dollars in possible fraudulent losses. And yet, most fraud likely goes undetected.

Insurance fraud is a serious problem in West Virginia. Although West Virginia is the thirty-seventh largest state by population, it ranked twentieth in the nation, according to NICB records, in terms of reports of suspected staged-accident insurance fraud in 2008. Just last week, on March 4, 2010, The Charleston Daily Mail reported that three people in north-central West Virginia were indicted on federal conspiracy and fraud charges, accused of defrauding insurance companies and doctors over a six-year period by staging accidents and faking injuries. The indictments were the result of a two-year state investigation, according to West Virginia Insurance Commissioner Jane Cline. The Charleston Daily Mail reported that Commissioner Cline said the trio staged at least 24 crashes, then tried to file false insurance claims, collecting \$150,000 in personal injury settlements and \$40,000 in unnecessary medical treatment from various providers. The Daily Mail article can be found at: [www.dailymail.com/News/statenews/201003040404](http://www.dailymail.com/News/statenews/201003040404).

Given the high incidence of insurance fraud in West Virginia, the threat that fraud poses both to individuals and to the insurance and health care systems is both real and serious. The West Virginia Insurance Commissioner has found that protective orders such as the one at issue here undercut efforts to detect and deter fraud. Recently, addressing the proliferation of requests for overbroad protective orders, the West Virginia Insurance Commissioner sent a letter to all insurers in this State, admonishing that: "[r]ecord retention is . . . an important tool in detecting fraudulent insurance claims. . . . Consistent maintenance of essential records by insurers is crucial to a comprehensive investigation of potentially fraudulent claims. Additionally, use of such claim information is necessary to protect the citizens of West Virginia from insurance

fraud." Informational Letter 172. (A copy of the Informational Letter is attached as Exhibit 1). As the Insurance Commissioner has recognized, moreover, the consequences of insurance fraud are serious. For instance, the Coalition identifies among the consequences of insurance fraud lost personal savings, dangers to personal health, unnecessarily high insurance premiums, increased cost of consumer goods, money lost by businesses, and lost jobs.<sup>3</sup>

**B. Anatomy of an Accident: How Automobile Accident Fraud Works**

As staggering as the financial costs of automobile insurance fraud are, however, the human cost can be even more serious. In addition to the significant additional premiums imposed by fraud, automobile accident fraud puts all drivers at risk.

In March 2003, 71-year old Alice Ross was on her way to visit her daughter in Floral Park, New York when her Buick was rammed from behind by another car carrying three men. The collision forced Ms. Ross off the road and into a tree, killing her. It was a particularly tragic example of a callous form of insurance fraud in which the perpetrators intentionally cause accidents using unwitting and insured victims like Ms. Ross.<sup>4</sup> After the accident, the three men were taken to a nearby medical center where they feigned an assortment of neck, back and other injuries in order to collect insurance for phony injury claims.

Two of the men later admitted they were recruited by the third man to participate in the accident that killed Ms. Ross. One was charged with manslaughter, criminally negligent homicide and fraud. The other was charged with forgery, criminal possession of a forged instrument and hindering prosecution.

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<sup>3</sup> See Coalition Against Insurance Fraud, Consumer Information, Insurance Fraud Backgrounder, *available at* [http://www.insurancefraud.org/fraud\\_backgrounder.htm](http://www.insurancefraud.org/fraud_backgrounder.htm).

<sup>4</sup> See also N.Y. State Ins. Dep't, June 26, 2005, Three More Insurers Reducing New York Auto Rates, *available at* <http://www.ins.state.ny.us/press/2005/p0506271.htm>.

The increase in the number of deliberate automobile accidents in recent years is accompanied by an increase in their recklessness. Improved efforts by law enforcement to detect such accidents and greater involvement by organized crime have lead to more aggressive and more dangerous accident schemes.

Automobile accident fraud can take several forms, including so-called “paper accidents,” “staged accidents” and “caused accidents,” as well as faked injuries in the context of genuine accidents that resulted only in property damage. “Paper accidents” are accidents that did not actually occur and include fake hit and runs in which a perpetrator drives an already damaged car to a public place and reports being the victim of a hit and run accident. “Staged accidents” are real accidents that are orchestrated among all of the participants in the accident. The most dangerous crime, however, is a staged accident involving an innocent party, sometimes called a “caused accident.” As in the Alice Ross case, caused accidents usually occur in slow moving traffic as the perpetrators do not want to suffer actual injury, but can nonetheless result in real injuries or even death to the unsuspecting victims.

Caused accidents can be as basic as a simple rear-end or highly choreographed. The most elaborate cases can involve multiple vehicles, the first of which makes a sudden move that forces the unwitting target to make a sudden accident-preventing stop or swerve, only to collide with a second perpetrator’s car, while the first perpetrator speeds off. In such accidents, the second perpetrator appears as an innocent victim of the target’s unpredictable driving.

Caused accident rings usually target new, rental or commercial vehicles because of the likelihood that these vehicles are insured. Women driving alone and senior citizens are particularly favored targets as they are perceived to be less confrontational and less likely to cause problems for the perpetrators.

Although some auto accident fraud is carried out by small time operators, increasingly the most insidious fraud across the United States is carried out by well-organized rings involving not only the principal actors in the accident itself but hundreds of secondary participants, medical clinics, lawyers and body shops, in many cases owned or controlled by organized crime. The largest of these organized crime rings generate tens of millions of dollars in fraudulent insurance payouts.

The main players in an organized accident ring are the accident participants, the witnesses, the cappers, health care providers, body shops and attorneys. Accident participants are recruited by a capper for a fee and are often connected to the other participants in the scheme as friends, family members or co-workers. The participants report fake or exaggerated injuries and are directed to participating medical providers who cooperate in reporting fraudulent bodily injury claims. The capper is the director of the scheme at the street level. It is the capper's job to recruit participants and witnesses. Witnesses are positioned near the accident site and are paid to support the participant's account of the accident and contradict an innocent victim's testimony. The capper directs the "victims" to participating medical providers who prescribe or report expensive phony or non-existent treatment that is then billed to the victim's insurance company. The capper coordinates the "story" of the accident by providing scripts to each of the participants including diagrams, names, seating positions, injuries and symptoms. After the accident occurs, the capper "sells" it to a medical clinic. Cappers can be paid a flat rate per referral or a percentage of the final insurance settlement.

In an organized accident ring, medical providers pay for referrals from cappers or the capper may work directly for the medical provider. The medical provider can either falsify billing for unnecessary treatments or visits or, in some cases, the medical provider is a shell

operation that does not actually employ any medical personnel and is used only as a billing source. Most injuries reported in these schemes are soft-tissue injuries because such injuries are difficult to diagnose, subjective in nature and not necessarily susceptible to physical examination or testing. A fraudulent clinic can then pad medical bills with excessively long treatment periods or by billing for numerous expensive tests, which are often administered by unqualified personnel or not at all. As long as the total cost of treatment is not noticeably excessive, it is very difficult to detect a fraudulent claim in isolation from the minimal information in the paper record required to substantiate the claim.

Medical clinics often work in tandem with attorneys who represent the claimants and submit the claim to the insurance companies. Claims are supported by fraudulent “special damages” in the form of medical bills but are asserted for multiples of the “specials” supposedly to compensate for nonexistent pain and suffering. Attorneys involved in fraudulent claims are careful to keep the total claim value low and often push for quick settlements to avoid investigations that might uncover irregularities in the accident itself or the subsequent medical treatment. Most individual claims fall in the \$5,000 to \$15,000 range. The goal is to make the fraudulent claims look routine, relatively modest and appropriate for quick settlement without careful scrutiny.

### **C. How Insurers, NICB and Law Enforcement Work Together to Detect Fraud**

The claims departments of insurance companies are the front line of defense against insurance and health care fraud. Indeed, it is not an exaggeration to say that, without the data shared by insurers with national indexing bureaus, including ISO, insurance fraud could not be identified efficiently by insurers, NICB or law enforcement agencies. Moreover, without the

information retained in insurers' claim files, insurance fraud could not be investigated or prosecuted effectively once it has been identified.

Automobile accident rings are usually detected by investigations that begin when an insurer spots suspicious circumstances regarding a single claim (perhaps reflecting sloppy mistakes by the perpetrators of fraud) or detects an anomalous pattern in the claims it receives over the course of several months or years involving the same participants, medical providers or attorneys. In this process, the ISO database is an essential tool for linking common participants across multiple claims. The ISO database is the property and casualty insurance industry's "All Claims Database," which is utilized by thousands of insurers, state workers compensation insurance funds, self-insureds, third-party administrators, state governmental insurance fraud bureaus, other law-enforcement agencies and NICB, all of which are actively involved in investigation and prosecution of insurance fraud.

As described on ISO's website, ISO's ClaimSearch<sup>®</sup> software "help[s] investigators find and visually represent hidden relationships, such as parties linked to multiple addresses, telephone numbers, vehicles, or claims. Such relationships can be the fingerprint of fraud."<sup>5</sup> In addition to NICB, ISO's services are used by "thousands of insurers (more than 93 percent of the property/casualty insurance industry by premium volume), 25 state workers compensation insurance funds, 636 self-insureds, 452 third-party administrators (TPAs), several state fraud bureaus, and many law-enforcement agencies involved in investigation and prosecution of insurance fraud."<sup>6</sup>

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<sup>5</sup> ISO, Claims Information and Tools to Fight Fraud, *available at* <http://www.iso.com/About-ISO/ISO-Services-for-Property-Casualty-Insurance/Claims-Information-and-Tools-to-Fight-Fraud.html>.

<sup>6</sup> ISO, ISO ClaimSearch – Facts and Figures, *available at* <http://www.iso.com/Products/ISO-ClaimSearch/ISO-ClaimSearch-Facts-and-Figures.html>

When a claim is filed with an insurer, the insurer transmits certain specified fields of information (which does not include confidential medical records or medical information) to ISO for inclusion in its system. The ISO ClaimSearch system then searches existing information in the system for matches in fields including name, address, Social Security number (SSN), vehicle identification number (VIN), driver's license number, tax identification number (TIN), or other parties to the loss. Insurers can thus quickly identify basic information about other claims filed by the same individuals or businesses (either as claimants or insureds). The report that is sent back to the insurer is called a "match report." A match report is the first line of defense against fraud as it may indicate whether any of the parties reported have been involved in prior cases of fraud or merely similar claims that have not to date been established as fraud. Approximately 50,000 new claims are entered into the database every day and the ISO ClaimSearch product is the only way that insurers and NICB can tap into this ever-expanding resource. Accordingly, NICB has long identified this sharing of information thorough a centralized claim reporting system as having the greatest impact in the identification and investigation of insurance fraud ring activity. *NICB is, therefore, extremely concerned that protective orders of the kind entered in this and similar cases, would preclude an insurer from entering information about a covered claim into this vital database.*

When a claim adjuster or specialized claims examiner receives a match report, he or she uses the information provided in the original claim and in the ISO match report to look for red flags that indicate the possible presence of fraud. Among the many possible red flags are:

- claims are only for soft-tissue injuries are claimed;
- multiple claimants all have the same soft-tissue injury claims;

- otherwise unconnected claimants used the same doctor or medical clinic who is not their regular physician;
- minimal damage to a vehicle or a very low-speed accident accompanied by significant bodily injury claims;
- a medical provider has a history of billing for a disproportionate number of expensive treatments and tests;
- multiple unrelated claimants from different claims list the same address;
- unrelated parties have the same legal representative;
- claimants were referred to a medical provider or lawyer at the scene of the accident;
- claimants refuse on-the-scene treatment;
- numerous claims connect the same attorney, medical provider and/or body shop;
- multiple claimants use exactly the same words in describing the accident; and
- the same attorney is involved at a very early stage in several apparently unrelated incidents involving accidents that fit the description of a staged accident;

If a new claim, or any of the claims with which it is matched through ISO, raises the possibility of fraud, the insurer's SIU will usually perform a more detailed investigation of the claim. The investigation may involve interviewing the claimant, witnesses and medical providers or requesting further supporting documentation about the nature of the accident, vehicle damage, injuries, diagnoses and treatment plans. If, after investigating a claim, the insurer believes that the claim is fraudulent, it may pursue legal action, report it to law enforcement or refer it to NICB to undertake a broader investigation into the parties involved in the claim.

When NICB receives a referral from an insurer, it runs its own search of the claim against the ISO database and against its own historical databases to identify other possible fraudulent

claims involving the same parties. NICB may then reach out to other insurers that, according to these databases, have dealt with the same parties. *The protective order in this case, however, would preclude other affected insurers, NICB or law enforcement from examining the covered files should they become relevant to an investigation.* If warranted by its file review, NICB may also conduct a field investigation of the parties involved using its experienced staff, who have extensive law enforcement investigative experience. If NICB assembles enough data to support a criminal prosecution, it turns that evidence over to law enforcement for further investigation or prosecution. NICB's investigations, with the cooperation of insurers, have resulted in many convictions and successful civil actions for insurance fraud.

**D. Protective Orders Like the One Below Are Fatal to Fraud Detection and Prosecution**

Protective orders like the one in this case, which are increasingly being sought, undercut the ability of NICB and law enforcement agencies to prosecute fraud effectively and thereby rein in the out-of-control costs of insurance and health care fraud. As such orders become more prevalent, the damage to the anti-fraud efforts will continue to grow until it reaches a tipping point where law enforcement action becomes realistically unsustainable.

A fraud identification system such as ISO ClaimSearch is only as effective as the information in the system. Similarly, when an insurer cooperates with a fraud investigation or prosecution, its assistance is only as valuable as the evidence it is able to produce from its claim files to document the fraud. Because it is impossible to predict what information and which claims may be relevant in future fraud investigations, the success of any fraud-detection system, including the ISO database and insurers' own claim files, relies on the inclusion of as much claim information as possible. This point cannot be overstated. On their face, individual fraudulent claims usually appear unremarkable, by careful design. A report of a side-swipe in

which a driver and a passenger each allege soft-tissue damage for which each is compensated for \$10,000 may have no obvious indicators of fraud by itself. But if a search of the ISO database shows that the medical provider, the attorney or the participants themselves appear to be involved in a disproportionate number of such cases, each with very similar facts, a pattern meriting scrutiny may begin to emerge.

The critical point is that each claim in an insurance fraud scheme that is unearthed by such investigations, when viewed in isolation, looks routine and innocuous. Indeed, the success of these criminal schemes is dependent on the fraudulent claims passing muster as legitimate when processed individually by insurance claim adjusters. The detection and investigation of criminal insurance fraud enterprises, therefore, depends almost entirely on the aggregation of large volumes of data about apparently unremarkable claims that did not raise suspicion at the time they were submitted.

Insurers must analyze tens of thousands of such claims in order to identify troubling circumstances from among thousands of facially indistinguishable valid claims. By spotting patterns that may not be coincidental across numerous claims, interviewing multiple health care providers, claimants and other participants, looking for the innocent dupe or the weak link in a scheme, and by painstaking, detailed analysis of claim information in files that did not initially seem suspicious, insurance fraud cases are developed and evidence is mustered to build a case against a criminal fraud ring. For this reason, every time a protective order prevents an insurer from contributing the necessary, non-confidential information to support a claim into the ISO database or requires an insurer to return or destroy information from a claim file, essential data is lost and future attempts to identify patterns or perform fraud investigations will be that much

harder. The prevalence of such orders is increasing. If protective orders like the one in this case become the norm, then fraud identification becomes virtually impossible.

As demonstrated above, without the information provided by insurance companies to the ISO system and retained by insurers in their claim files, important investigations of insurance fraud would not be possible. NICB, therefore, urges this Court to reject the protective order below.

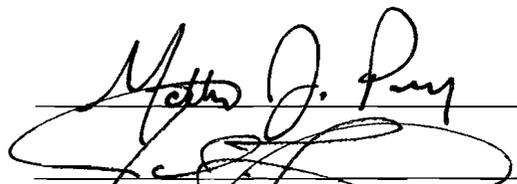
## II. CONCLUSION

For the reasons set forth above and in the Brief of Petitioner State Farm, this Court should issue a rule to show cause and thereafter grant a writ of prohibition against enforcement of the February 11, 2010 Order of the Circuit Court of Harrison County, West Virginia.

Respectfully submitted,

Dated: March 8, 2010

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**CERTIFICATE OF SERVICE**

I, James D. Lamp, counsel for Amicus Curiae, National Insurance Crime Bureau, hereby certify that I served a true copy of the foregoing Brief of Amicus Curiae National Insurance crime Bureau in Support of State Farm Mutual Automobile Insurance Company's Petition for Writ of Prohibition upon the following individuals, by placing the same in the U.S. Mail, First Class, postage prepaid, on this the 8th day of March, 2010:

The Honorable Thomas A. Bedell  
CIRCUIT COURT OF HARRISON COUNTY  
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Joseph Shaffer, Esquire  
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A handwritten signature in black ink, appearing to read 'J. D. Lamp', is written over a horizontal line. The signature is stylized with large loops and a long horizontal stroke at the end.



September 2009

WEST VIRGINIA INFORMATIONAL LETTER

NO. 172

**TO: All Insurance Companies Licensed to do Business in the State of West Virginia**

**RE: Record Retention Requirement**

This Informational Letter is intended to remind insurers of their obligation to properly document claim files to ensure that the Offices of the Insurance Commissioner (“OIC”) can conduct a complete and thorough review of the subject claim by permitting the OIC to fully assess the subject insurer’s claim adjusting or processing methods. 114 CSR 15 provides, in relevant part:

4.2. For the purpose of examination, analysis and review activities conducted pursuant to W. Va. Code § 33-2-9 or this rule, an insurer or related entity licensed to do business in this state shall maintain its books, records and documents in a manner so that the commissioner can readily ascertain during an examination the insurer’s compliance with the insurance laws and rules of this state, the standards outlined in the NAIC Financial Conditions Examiner Handbook, and with the standards outlined in the NAIC Market Regulation Handbook, including, but not limited to, company operations and management, policyholder service, marketing, producer licensing, underwriting, rating, complaint/grievance handling, and claims practices.

\* \* \* \* \*

b. All insurer records within the scope of this rule must be retained for the lesser of:

1. The current calendar year plus five (5) calendar years;
2. From the closing date of the period of review for the most recent examination by the commissioner; or
3. A period otherwise specified by statute as the examination cycle for the insurer.

c. The producer of record shall maintain a file for each policy sold, and the file shall contain all work papers and written communications in his or her possession pertaining to the policy documented therein. These records shall be retained for the current calendar year plus additional years as set forth in subdivision b of this subsection.

\* \* \* \* \*

Page 1 of 3



4.4. Claim files shall be maintained as follows:

a. A claim file and accompanying records shall be maintained for the calendar year in which the claim is closed plus additional years as set forth in subdivision b, subsection 4.2 of this section. The claim file shall be maintained so as to show clearly the inception, handling and disposition of each claim. The claim files shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed. A claim file shall, at a minimum, include the following items:

1. For property and casualty: the file or files containing the notice of claim, claim forms, proof of loss or other form of claim submission, settlement demands, accident reports, police reports, adjustors' logs, claim investigation documentation, inspection reports, supporting bills, estimates and valuation worksheets, medical records, correspondence to and from insureds and claimants or their representatives, notes, contracts, declaration pages, certificates evidencing coverage under a group contract, endorsements or riders, work papers, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, payment or denial of the claim, copies of claim checks or drafts, or check numbers and amounts, releases, all applicable notices, correspondence used for determining and concluding claim payments or denials, subrogation and salvage documentation, any other documentation created and maintained in a paper or electronic format, necessary to support claim handling activity, and any claim manuals or other information necessary for reviewing the claim;

2. For life and annuity: the file or files containing the notice of claim, claim forms, proofs of loss, medical records, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, claim handling logs, copies of checks or drafts, check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity; and

3. For health: the file or files containing the notice of claim, claim forms, medical records, bills, electronically submitted bills, proofs of loss, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, health facility pre-admission certification or utilization review documentation, claim handling logs, copies of explanation of benefit statements, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, copies of checks or drafts, or check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

It is further noted that 114 CSR § 14-3 requires the retention of all notes and work papers concerning a claim in such detail that pertinent events and the dates of such events can be reconstructed. A violation of this provision can result in a finding by the OIC that the insurer transacted insurance in an illegal, improper or unjust manner and, accordingly, the OIC may refuse to renew, or may revoke or suspend the license of the insurer or, in lieu thereof, the OIC may order the insurer to pay a penalty set by statute. *See* 114 CSR § 14-10.

Moreover, insurers are required to provide the OIC with a complete copy of the claim file as part of an administrative proceeding involving the claim. If a violation is found, the OIC may request complete copies of other claim files from the insurer to determine whether the violation is occurring with such frequency as to constitute a general business practice, thus potentially triggering a violation of W. Va. Code § 33-11-4(9). Accordingly, the claim files must contain all of the insurer's documentation and records in order for the OIC to make an accurate assessment of whether a violation occurred with the initial claim at issue and, if so, whether a general business practice is prevalent.

Record retention is also an important tool in detecting fraudulent insurance claims. Insurance fraud is a serious and growing problem, which has been conservatively estimated as accounting for ten percent (10%) of the cost of insurance premiums. Consistent maintenance of essential claim records by insurers is crucial to a comprehensive investigation of potentially fraudulent claims. Additionally, use of such claim information is necessary to protect the citizens of West Virginia from insurance fraud.

The OIC has recently become aware that certain first and third party claimants involved in litigation concerning their respective claims have requested that the court order pertinent medical documentation to be destroyed or returned by the insurer at the conclusion of the litigation. The OIC is charged with ensuring the orderly, fair and consistent application of laws enacted by the Legislature to protect the state's consumers of insurance products and services. To that end, the Legislature has given the OIC broad authority to conduct market conduct reviews of insurer claim files on a targeted or periodic basis. Such reviews include, as set forth above, a detailed assessment of all relevant claim records maintained by insurers. The applicable insurance laws and rules demand consistent and comprehensive maintenance of all essential claim records by insurers to ensure that the laws protecting consumers of this state are being followed and that claims are being properly resolved. If records necessary for an adequate market conduct review are missing, the OIC will be substantially hindered in carrying out its legislative mandate and thus may subject insurers to penalties.

If you have a question concerning this Informational Letter, please e-mail your question to [Informational.Letters@wvinsurance.gov](mailto:Informational.Letters@wvinsurance.gov) or call (304) 558-0401.

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