THE PERSONAL INJURY PLAYBOOK

Clinic Manager's Edition

Running a Compliant, Profitable PI Clinic

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THE PERSONAL INJURY PLAYBOOK: CLINIC MANAGER'S EDITION

Running a Compliant, Profitable PI Clinic

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Introduction: How to Use This Book

This book is written for the person who runs the floor of a personal injury practice — the office manager, practice administrator, or operations lead responsible for keeping intake, scheduling, billing, and compliance running smoothly in a clinic that treats patients whose care is tied to litigation. If that's your role, whether you came to it from a clinical background, a general medical practice management background, or straight into PI work with no prior frame of reference, this book is meant to give you both the reasoning and the practical tools to do it well.

Why This Book Exists

A personal injury practice looks like any other medical clinic from the outside, but as Chapter 1 explains in detail, it runs on a different operating model underneath — litigation timelines instead of purely clinical ones, deferred lien-based revenue instead of near-term insurance payment, and an attorney relationship that touches nearly every operational decision a standard practice never has to consider. Most clinic managers learn this the hard way, through accumulated experience and the occasional costly mistake. This book exists to shorten that learning curve by laying out, systematically, what's actually different about PI practice management and what a well-run practice does about it.

How the Book Is Organized

The book moves through six parts, each building on the one before it. Part I establishes the structural differences that make PI practice its own discipline — the operating model, the attorney-client-provider triangle, the lien-based revenue model, and the staffing implications that follow. Part II covers intake and case onboarding, since the first 48 hours of a case set the trajectory for everything that follows. Part III covers the daily operational work of managing a case through treatment — scheduling, documentation, multi-provider coordination, and the recurring challenge of gaps in care. Part IV turns to the financial mechanics of the business: liens, billing, pre-settlement funding, and settlement disbursement.

Part V addresses compliance and legal exposure — documentation that withstands deposition, records requests and subpoenas, and how to work with SIU investigators and auditors. Part VI closes with growth and systems: scaling across multiple locations, technology, and building the operations manual that turns everything in this book into your own practice's daily standard.

Each chapter follows the same basic shape: an explanation of why the topic matters specifically in a PI context, practical guidance for handling it well, and — where useful — a table, diagram, or worked example illustrating the point concretely. Many chapters also include an AMA-style reference list, since a meaningful share of this book's guidance rests on sourced legal, regulatory, and industry material rather than opinion alone, and you may want to trace a specific claim back to its source.

Using the Appendices

The appendices at the back of this book are meant to be used, not just read. They include ready-to-adapt checklists, worksheets, and log templates covering intake, LOP review, referral vetting, fraud documentation, treatment gap monitoring, lien tracking, settlement readiness, subpoena response, audit response, compliance self-assessment, and new-location readiness. Photocopy them, rebuild them in your own practice management software, or use them as the starting skeleton for the operations manual Chapter 25 describes — whatever gets them into daily use rather than sitting unused in the back of a book.

A Note on Scope

This book is not a substitute for legal, compliance, or financial advice specific to your practice and your state. Lien law, HIPAA's application to specific disclosure scenarios, and insurance regulation all vary by jurisdiction and change over time. Where this book describes a legal standard or regulatory requirement, treat it as a starting orientation for a conversation with your practice's own qualified counsel, not as a final answer for your specific situation.

A Companion Series

This book is part of The Injury Playbook Library's broader Personal Injury Playbook series, alongside the Medical Practice Edition — written for the clinical and compliance decisions providers make — and the forthcoming Case Manager's Edition and Paralegal Edition, covering the medical-legal case management role and the law-firm side of PI litigation, respectively. Each book in the series can stand alone, but readers managing a practice that touches all of these functions may find real value in the full set. See About the Series at the back of this book for more detail.

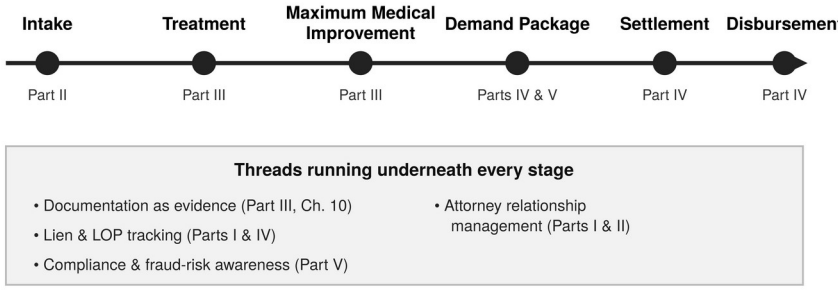

Figure 0.1 — The PI Case Lifecycle and Where This Book Covers It

PART I: THE PI PRACTICE OPERATING MODEL

Chapter 1: How PI Practices Differ from Standard Medical Practices

If you have managed a general medical practice — internal medicine, family practice, an urgent care, even a busy orthopedic clinic — you already know how to run an office. You know scheduling, you know insurance verification, you know how to keep a provider's calendar full and a front desk running smoothly. None of that experience is wasted in a personal injury practice. But it is not sufficient either, and the gap between "runs a medical office well" and "runs a PI practice well" is where a lot of otherwise capable managers get into trouble.

A personal injury practice looks like a medical clinic. It has exam rooms, a front desk, a billing department, and providers who see patients. But underneath that familiar shape is a different business model entirely — one built around litigation timelines instead of treatment timelines, liens instead of copays, and a second client sitting just off-stage who never sets foot in your building but who drives nearly every operational decision you make: the patient's attorney.

This chapter lays out the structural differences that make PI practice management its own discipline. Everything else in this book — staffing, intake, billing, compliance — builds on these distinctions.

The Litigation Timeline Runs the Clinical Timeline

In a standard practice, treatment ends when the patient is better, or when they stop needing care, or when insurance stops authorizing visits. The clock is clinical.

In a PI practice, the clock is legal. Your patient's treatment plan does not exist in isolation — it exists as evidence in a case that will eventually be settled or litigated. The statute of

limitations sets an outer boundary on when a claim can be filed at all, and timely evaluation is part of what preserves that claim.[1] The attorney's strategy for building a demand package shapes when treatment needs to reach "maximum medical improvement" so a settlement demand can be sent. Gaps in treatment, whether from a missed appointment or a lapse in care, do not just create a clinical problem — they create a documentation problem that opposing counsel or an adjuster will use to argue the injury wasn't serious or wasn't caused by the incident in question.[2]

This means your office is managing two calendars at once: the clinical calendar and the legal calendar. A clinic manager who only tracks the first will regularly get blindsided by attorney requests for records "by Friday," or by a case that stalls out because treatment dragged on for a year with no clear endpoint.

Revenue Model: Liens Instead of Copays

In a standard practice, revenue comes from a predictable mix of insurance reimbursement and copays, collected at or near the time of service. In a PI practice, a substantial share of revenue is deferred — often for months or years — through medical liens, where the practice treats the patient without upfront payment in exchange for a right to be paid out of any eventual settlement.[3]

This reshapes the financial character of the practice. Cash flow is lumpy instead of steady. Billing isn't just posting payments and chasing denials — it's tracking open lien balances across dozens or hundreds of active cases, each attached to a case that may settle, may go to trial, or may stall for years. And the practice carries real financial risk on cases that don't resolve favorably: a case can be lost, a settlement can come in far lower than the value of care provided, or a patient can be dropped by their attorney mid-treatment. Managers coming from a copay-driven world often underestimate how much this reshapes cash reserves and even which new patients the practice can afford to accept.

Third Stakeholder: The Attorney

In most medical practices, the relationship is bilateral: patient and provider. In a PI practice, there is a third party embedded in nearly every interaction — the patient's attorney — and managing that relationship well is one of the most important, least clinical skills a PI office manager develops. The patient remains the practice's patient in every professional and ethical sense; the attorney is a key stakeholder, a referral source, and an authorized recipient of information once proper authorization is on file — not someone to whom the practice owes the clinical duties it owes the patient.

Attorneys refer patients, which makes the referral relationship itself a business-development function your practice depends on.[4] Attorneys request records, updates, and narrative reports on their own timeline, which means your practice needs a system for producing accurate documentation quickly without disrupting clinical operations. Attorneys also have their own incentives, which can create pressure — subtle or explicit — around how records are worded or treatment plans extended. Navigating that pressure without compromising clinical integrity is a skill this book returns to repeatedly.

None of this makes the attorney relationship adversarial by default — most are professional and straightforward, and a strong referral relationship built on reliable documentation is one of the most valuable assets a PI practice has. But it is a stakeholder a standard medical office simply doesn't have to account for.

Documentation as Evidence, Not Just Record

Every medical practice knows documentation matters. In a PI practice, documentation carries a second, higher-stakes purpose: it is evidence. The chart note isn't just the internal record of what happened in the exam room — it's the artifact read by an adjuster deciding whether to pay a claim, cited in a demand letter, and scrutinized in deposition.[5]

This changes what "good documentation" means operationally. A causation statement that's clinically obvious

to the provider still needs to be explicitly written down, because nobody outside the exam room can be trusted to infer it. A gap in treatment needs a documented reason, because an unexplained gap becomes a defense talking point. Objective findings need consistent recording across visits, because inconsistency becomes an argument that the injury isn't real. None of this is about overstating an injury — it's about making sure the true clinical picture is fully captured, because in litigation, undocumented care is often treated as care that didn't happen.

Staffing Implications

Because of all this, PI practices need roles a standard practice often doesn't carry at all. Case managers or care coordinators who track compliance and communicate with attorneys are common in PI and rare elsewhere.[6] Billing staff need working knowledge of lien law, not just insurance coding. Front desk staff need scripts for attorney calls and records requests. Whoever manages intake needs a screening process attuned to PI-specific fraud risk. This book treats staffing as a recurring theme rather than a single chapter, because nearly every operational decision touches who is responsible for tracking it.

Compliance and Liability Exposure

Finally, PI practices carry compliance exposure beyond standard HIPAA and billing compliance. A revenue model built on referral relationships and deferred lien payment sits closer to regulatory scrutiny around fee-splitting and improper inducement.[7] Patients involved in litigation make the practice more likely to face subpoenas, records requests, and occasionally insurance SIU inquiries.[8] And because documentation functions as legal evidence, errors carry legal as well as clinical consequences.

This isn't a warning that PI practice is inherently risky — most PI practices operate well within good clinical and legal bounds, serving patients who genuinely need care after another party's negligence. But the compliance margin for error is narrower, and a manager who understands why is far

better equipped to make good judgment calls when a situation doesn't fit neatly into an existing policy.

Table 1.1 — Standard Practice vs. PI Practice

Dimension	Standard Practice	PI Practice
Revenue timing	Collected at or near time of service	Often deferred months to years via liens
Who the client is	Patient only	Patient only; attorney is a key third-party stakeholder
Purpose of documentation	Clinical record	Clinical record and legal evidence
Primary compliance exposure	HIPAA, billing accuracy	HIPAA, billing accuracy, referral/inducement rules, subpoena exposure
Key staffing need	Front desk, billing, clinical staff	Above, plus treatment compliance coordinator and lien-literate billing

A Day in the Life: Where the Differences Actually Show Up

It can help to walk through how these five structural differences surface in a single ordinary day, rather than treating them as abstractions.

The morning starts with a scheduling review. In a standard practice, the front desk is mainly checking for gaps to fill and confirming insurance is active. In a PI practice, the same review also flags which patients are drifting off their treatment cadence, because a widening gap between visits is quietly becoming a documentation problem before anyone has consciously decided anything is wrong. A new patient arrives, referred the day before by a local attorney's office after a rear-end collision. The intake conversation looks the same as any new patient conversation on the surface, but

underneath it, staff are also capturing an exact timeline, screening for red flags, and confirming what payment source will apply — because this file will eventually be read by people who were never in the room.

By mid-morning, a call comes in from a paralegal at a referring firm asking for a status update on a patient's treatment. In a standard practice, this call wouldn't exist — there's no third party checking in on a patient's progress. Here, staff need to know, immediately and without hesitation, whether a signed authorization is on file before saying anything beyond confirming the patient is a current patient. The provider, meanwhile, is finishing a visit note for a different patient whose case is approaching maximum medical improvement, and is more deliberate than usual about tying the day's findings back to the original mechanism of injury, because this note may be one of the last before the file moves toward a demand package.

In the afternoon, billing flags a lien-based case where the patient's attorney has gone quiet for two months. This isn't unusual — cases stall for all kinds of ordinary reasons — but it's exactly the kind of open balance that Chapter 15 will describe as needing active monitoring rather than being left to age quietly. Nobody in the practice is doing anything dramatically different from what a well-run medical office does every day. What's different is that PI introduces a second audience — the eventual reader of the file — into decisions that would otherwise be purely clinical or administrative, and a good PI clinic manager has trained staff to feel that second audience's presence without needing to be reminded of it constantly.

This is really the heart of what makes PI practice management its own discipline: not that the individual tasks are unfamiliar, but that almost every task now carries a second layer of purpose. Recognizing that layer, and building habits and systems around it, is what the rest of this book is about.

Metrics That Signal Whether Your Practice Has Made the Shift

It's worth having a small set of concrete indicators that tell you, honestly, whether your practice has actually internalized the differences this chapter describes, rather than assuming that reading and agreeing with the chapter is the same as operating differently day to day.

A useful first indicator is how quickly staff can answer a basic question about any given PI patient's payment source and case status without pulling the file — if front desk or billing staff routinely have to go dig for this information for cases they should know well, that's a sign the "second calendar" this chapter described isn't yet part of daily awareness. A second indicator is how often your practice discovers a documentation gap only when an attorney's office asks a pointed question, rather than catching it internally first — reactive discovery suggests the documentation-as-evidence mindset hasn't fully taken hold yet. A third is simply asking new staff, a few weeks into their role, to explain in their own words why PI intake is handled differently than standard intake; a confident, specific answer is a good sign the training has actually landed, while a vague or purely procedural answer suggests the underlying reasoning hasn't been transmitted, even if the checklist itself is being followed.

Recognizing the Structural Differences During Onboarding

When you bring on a new office manager, biller, or front desk lead who has only worked in standard medical practices, it's worth building a short, deliberate onboarding conversation around the five structural differences in this chapter, rather than assuming they'll absorb the distinction gradually through exposure.

A useful exercise is walking a new hire through one real (de-identified) case file from open to close, pausing at each point where a PI-specific consideration entered the picture — the causation language in the first note, the LOP sitting in the billing file instead of an insurance card, the attorney's status update request, the eventual settlement disbursement. Seeing these five differences show up concretely in a single file does more to build real understanding than describing

them abstractly in a training manual. New hires who've only ever worked with copay-and-insurance patients often need to unlearn a few instincts — treating a missed appointment as purely a scheduling inconvenience, or treating a request for records as routine regardless of who's asking — and a guided walkthrough surfaces exactly where those instincts need adjusting.

What This Means for You

Every chapter that follows builds from these five structural differences: the litigation timeline, the lien-based revenue model, the attorney as a key third-party stakeholder, documentation as evidence, and the staffing and compliance implications that follow from all of it.

References

1. GoSuits. Carrollton Medical Visit Checklist After an Injury. Updated January 14, 2026. Accessed July 11, 2026. https://gosuits.com/knowledge-base/carrollton-medical-visit-checklist-injury/

2. Georgia Disability Lawyer. How Do Gaps in Treatment Affect Injury Cases? Updated May 27, 2025. Accessed July 11, 2026. https://georgiadisabilitylawyer.com/blog/how-do-gaps-in-treatment-affect-injury-cases/

3. Quilia. Medical Liens in Personal Injury: How They Work. Accessed July 11, 2026. https://www.quilia.com/glossary/medical-lien/

4. New York Spine Institute. How to Refer Your Legal Clients to Doctors. Updated March 8, 2026. Accessed July 11, 2026. https://www.nyspine.com/blog/how-to-refer-your-legal-clients-to-doctors/

5. Horn Wright, LLP. What Medical Records Matter Most in a Personal Injury Case? Updated March 14, 2026. Accessed July 11, 2026. https://www.hornwright.com/bronx/personal-injury/what-medical-records-matter-most-in-a-personal-i/

6. Quilia. Personal Injury Case Manager Job Description. Updated April 3, 2026. Accessed July 11, 2026.

https://www.quilia.com/articles/what-does-a-personal-injury-case-manager-do/

7. Office of Inspector General, US Department of Health and Human Services. Fraud & Abuse Laws. Accessed July 11, 2026. https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

8. IX Legal Personal Injury. What is a Special Investigations Unit? Updated March 10, 2026. Accessed July 11, 2026. https://www.ix-legal.com/blog/2023/november/what-is-a-special-investigations-unit-/