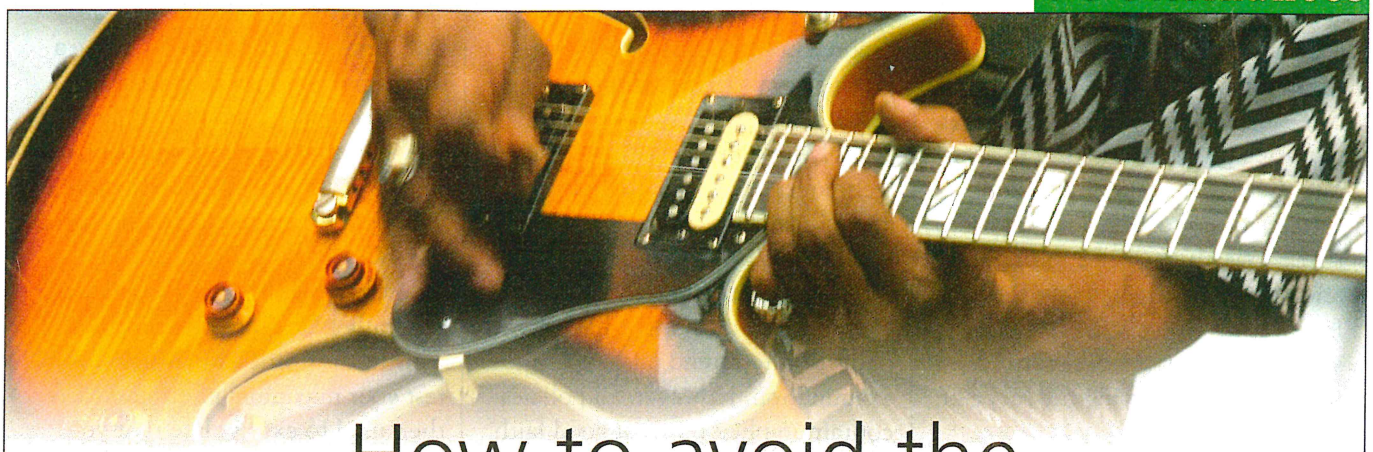

How to avoid the disability-claims blues

BY JUSTIN C. FRANKEL, ESQ.

Will the disability insurance policy you bought protect your income if you are no longer able to perform chiropractic adjustments? Maybe. Maybe not.

Insurers pay disability claims only according to the terms of the policy. This fact is so important that before you buy a policy you should carefully analyze it. You want to make sure you understand such clauses that concern:

- Elimination periods (waiting period before benefits will be paid),
- The definition of disability (these terms vary greatly among policies), and
- Other potential issues, such as eligibility for partial disability, rights of the insurer to contest representations on the application, and the rights and scope of any examination by the insurer.

If you have cause to file a disability claim under your policy, here are some tips:

1. Understand the policy's definition of disability. And do it in the language the insurer will understand and accept.

It is not uncommon, for instance, for a policy to define "disabled" as the "inability to perform the material and substantial duties of your occupation." Carefully articulate how your disability prevents you from performing your material and substantial duties.

2. Talk with your medical doctor. Address your impending claim with your treating physician. The doctor is an important player in the claim, because the insurer will access the doctor to verify the disability.

An unsupportive doctor will sink a claim. Tell your doctor the restrictions and limitations that you face due to the symptoms or conditions of your disability.

For example: A herniated disc is a condition; being unable to bend over or lift resistance are restrictions. The insurer does not care about the condition. What it addresses are the limitations in functional ability to work.

Many medical doctors do not understand the insurance policy definition of disability. Getting the doctor to understand the policy definition is crucial.

3. Carefully complete the claim kit. Once the insurer is notified of a claim, you will receive a claim kit of forms to complete. The kit usually includes a claimant statement, attending physician statement, and an authorization form to be returned to the insurer.

Each of these forms has its own potential for disaster and must be approached cautiously and methodically.

- *Claimant statement.* The claimant statement usually seeks a variety of information about the claimant's condition(s), the onset of the condition(s), the restrictions and limitations resulting from the condition(s), and work information, including occupational duties.

Often, you are asked to provide an exhaustive list of what you do in your job, listed in order of importance, or defined by the amount of time dedicated to each task or duty.

The insurer will seek to determine if you can still perform any of the tasks or duties. If so, it will try to settle the claim by paying a partial disability.

- *Physician's statement.* This form seeks medical information from the treating physician. Because the statement may fail to document the disability sufficiently, it may be helpful to supplement the formal statement with a physician's narrative that addresses

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areas not covered in the formal statement.

• *Authorization form.* The insurer uses the authorization form to access information about the claimant. Insurers often request authorization that allows them access to financial and other information that is irrelevant to the claim. You can substantially restrict access to such materials by modifying the scope of any authorization.

THE INVESTIGATION

After receiving your completed claim kit, the insurer next begins its investigation of your claim. The nature of the claim (whether it is physical or mental, or is the result of sickness or injury) in part dictates the manner of the investigation.

Common tools utilized by the insurer in the course of its verification of your disability include the use of independent medical examinations (IMEs), functional capacity evaluations (FCEs), peer reviews, field investigations, and possibly surveillance. Each of these techniques poses potential problems for claimants.

• **IME.** When an insurer exercises a contractual right to an examination, a claimant has the obligation to attend an examination. However, all policies contain implied terms of good faith and fair dealing to guide the process.

Thus, it may be unreasonable for an insurer to require you to undergo invasive testing by the insurer's doctor, or it may be improper to require you to travel a significant distance to have an examination performed.

In any event, the IME is actually a paid medical exam-ination (PME), and the results are often skewed toward the payer — the insurance company. If you must undergo an IME, arm yourself for battle. Bring a witness; request to videotape the examination; and ask the insurer to provide certain pre-testing responses to various inquiries, to determine the validity and/or necessity of the testing.

• **FCE.** An FCE is an entirely different situation. An FCE may not generally be required by contract. This test is utilized by insurers to test your maximum effort, which is then used to extrapolate that you can work full-time on a sustained basis because you have the ability to do a number of tests one time.

The results are inherently unreliable and the tests lack validity. Nonetheless, if compelled to attend under penalty of breach of the policy, follow the same procedures as you would in an IME.

• **Peer review.** When an insurer conducts a peer review of the claim, it relies upon a non-examining

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Take care in defining your job

How you describe your job in a disability claim can significantly affect the outcome of your claim and can mean the difference between being compensated for total disability instead of a partial disability. *For example:*

A self-employed chiropractor is likely to do more than simply perform procedures on patients. Some chiropractors in this scenario may also handle the insurance and billing aspect of the practice.

In those situations, the insurer may argue that a chiropractor who is unable to perform the *physical* functions due to injury or sickness can still do the administrative duties. Or, the company may claim that you can still make diagnoses even if you cannot physically treat patients.

By claiming that administrative duties and diagnosing are material, the insurer may attempt to create a claim for *partial* disability rather than *total* disability.

To anticipate and combat this approach effectively, your claim should emphasize that as a chiropractor, your core duty is the physical, hands-on treatment of the patient.

However, in the situation in which a chiropractor owns the practice and has several other chiropractors working at the practice, the situation is likely to be less favorable. The insurer can effectively argue that administrative duties, including managing the practice and its employees, comprise the chiropractor's material duties.

If a claim is settled as a partial disability as opposed to a total disability, a financial analysis is permitted and loss of income must be shown. In a total-disability claim, loss of income is irrelevant. CE

physician to address a claimant's functional abilities. This precludes the claimant from receiving an appropriate evaluation of the claim.

Even when an outside physician is used, it is difficult for the non-examining physician to opine properly on the restrictions and limitations other than from a review of the records. Your best defense is a great offense: Make sure that your treating physician provides well developed, organized office notes and narrative reports to support the claim.

• **Field investigations.** Field investigations are common in claims made by medical professionals. An investigator will often stop by unannounced to speak to the claimant. Often, the investigator seeks to ascertain the claimant's activity level, determine

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whether the claimant is working in another interest, or to develop other information to be used by the insurer. You should always be cautious when talking with an insurer or its investigator.

• **Surveillance.** Surveillance is a common technique used by insurers when claimants allege disability based upon either subjective conditions or objective support that is not truly indicative of the restrictions or limitations.

Surveillance is also commonly used in high benefit claims, in which the insurer is willing to invest money to deny a potentially expensive claim. Claimants must be wary not only of their activity levels (including going to the gym — even if your physician prescribed it), but also of the statements made to the insurer about their daily activities. Inconsistencies can be fatal to a claim, as the expression "a picture is worth a thousand words" holds true with regard to surveillance.

While these are some of the common issues faced by claimants in the process of applying for and receiving disability benefits, a number of other issues are also commonly seen. Should a claim issue arise, view it from a cynical perspective and try to anticipate the impact of any statements provided or information conveyed.

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