What You Need to Know About Filing a Claim for Disability Benefits–Part 1

How you handle this process will affect your benefits.

By Jason Newfield, Esq.

In past articles in Podiatry Management by Dr. Daniel Lefkowitz, readers have been educated about the need for disability insurance, the benefits of having this valuable protection, and the likelihood of becoming disabled during their working career. This article will explain the process of filing of claim for disability benefits, the issues that sometimes arise in the claim process, and potential problems that must be avoided in order to successfully maintain a claim for disability benefits.

In my practice, which focuses on private and group disability claims, I see a myriad of claim issues that laypersons would never think about in their everyday practice, nor would such issues become relevant to non-lawyer professionals until the time that the insurance company raises the issue during the claim process. Thus, this article is intended to act as a word of caution to many, to guide some in their practice, and as information for others.

Preparing to File a Claim

First, each claim for disability benefits under the terms of a policy of insurance is guided by the actual terms of the policy. This is important because a first step in filing a claim must be to review and analyze (or have a professional review and analyze) the policy. The policy will dictate issues such as the elimination period (waiting period before benefits will be paid), the definition of disability (these terms vary greatly among policies), and other potential issues, such as partial disability, rights of the insurer to contest representations, and rights and scope of any examination by the insurer.

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Once the policy is thoroughly reviewed, a claimant must be keen as to what the insurer is actually seeking, or what is required from a claimant in order to issue benefits. For instance, where a policy defines disabled as the "inability to perform the material and substantial duties of your occupation," careful attention must be paid by the claimant to what are the material and substantial duties of the occupation, and thought must be given to articulating how one's disability prevents one from performing such material and substantial duties.

For example, a self-employed podiatrist in a practice by him/herself is likely to do more than simply perform procedures upon patients. Some podiatrists in this scenario may actually handle the insurance aspect of the practice. In those situations, it is likely that the insurer will seek to argue that the podiatrist, unable to perform the physical functions due to injury or sickness, can still do the administrative duties. Or the insurer may claim that you can still make diagnoses even if you cannot physically treat patients. They may claim that administrative duties are material, and that diagnosing is material, and attempt to create a claim for partial disability rather than total disability. To effectively combat this anticipated approach, being able to argue that as a podiatrist, the core duty is the treatment of the patient, will support the claim.

In the situation, however, where a podiatrist owns the practice and has several other podiatrists working at the practice, the situation is likely to be less favorable. There, it can be argued that the administrative duties comprise material duties, including managing the practice and its employees.

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If a claim becomes partial as opposed to total, a financial analysis is permitted and loss of income must be shown, whereas in the total claim, loss of income is irrelevant.

Your Treating Physician

The other significant step in the pre-filing process of a claim is to address your impending claim with your doctor. The treating physician is an important player in the claim, because the insurer will access the doctor, whether through records or otherwise, and an unsupportive doctor will sink a claim. Thus, it is important to relate to the treating physician not only symptoms but restrictions and limitations that one faces due to the symptoms or conditions. For example, having 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.

Having your treating physician understand the definition of disability in your policy is of paramount significance. Many doctors hear the term disabled and think that one can only be disabled if confined to a wheelchair, not appreciating that a contract has a definition of the term that governs the claim. Making the doctor understand the policy definition is crucial. Having the doctor provide objective support for the claim is helpful but not mandatory. Clinical findings are sometimes the only support one has (coupled with subjective complaints).

Complying with the Insurer's Claim Requirements

Once the insurer is notified of a claim, a claim kit or forms will be provided to the claimant for completion. These usually include 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.

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, a claimant is asked to provide an exhaustive list of what he/she does at work, listed in order of importance, or defined by the amount of time dedicated to each task or duty. The insurer will take this information and seek to determine if ANY of the tasks/duties can still be performed. If so, welcome to the land of partial disability. To prevent this, one must anticipate the question and develop an appropriate response.

The physician statement seeks medical information from the treating physician. The physician should be supportive and a strong advocate. Many times the physician statement fails to properly document the disability sufficiently to qualify for benefits. You should secure a physician narrative to address areas that the physician statement may not cover.

The authorization is used by the insurer to access information about the claimant. Often, it is a wide ranging, overreaching authorization, allowing the insurer access to financial information and other information that is irrelevant to the claim. I counsel all clients to substantially restrict access to such ma-

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terials, and to modify the scope of any authorization. An insurer will often complain that it unreasonably restricts their ability to render a claim decision. This is a ploy and you should never allow such unfettered access to your records without good justification.

The Insurer's Investigation of the Claim

After receiving your completed claim kit, the insurer next begins its own investigation of your claim. The nature of the claim, whether physical or mental, or whether it is the result of sickness or injury, will in part dictate the manner of the investigation. Common tools utilized by the insurer in the course of their "verification" of one's disability include the use of IME's (independent medical examinations), FCE's (functional capacity evaluations), peer reviews, field investigations, and/or surveillance. Each of these techniques pose potential problems for claimants.

Where an insurer exercises a contractual right to an examination, a claimant has the obligation to attend an examination. In any policy, however, there are implied terms of good faith and fair dealing which guide the process. Thus, it may be unreasonable for an insurer to require a claimant to undergo invasive testing by the insurer's doctor, or it may be improper to require a claimant to travel significant distance to have an examination performed. In any event, the IME is actually a PME (paid medical examination), and the results are often skewed as such.

If the PME physician is being paid by the insurer, it is safe to assume questionable objectivity. Thus, a claimant faced with an IME must be armed for battle. Clients should be counseled to bring a witness, to request to videotape the examination, and to request that the insurer provide certain pre-testing responses to various inquiries, so the validity and/or necessity of the testing can be determined.

Functional Capacity Evaluations

An FCE is an entirely different scenario. An FCE is not generally contractually required and you should object to the insurer's request on those grounds. This test is utilized by insurers to test one's maximal effort. The results are then used to extrapolate that one can work full-time on a sustained basis as exemplified by the ability to perform a myriad 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, I recommend that you raise the same issues raised for PME's guide the claimant.

When an insurer conducts a peer review of the claim, it relies upon a non-examining physician to address a claimant's functional abilities. This has inherent problems, because it precludes the claimant from receiving an appropriate evaluation of the claim. Even where 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. Thus, claimants must ensure that their treating physicians provide well developed, organized office notes and/or narrative reports to support the claim.

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Field Investigations

Field investigations are common in claims 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 whether the claimant is working in another interest, or to develop other information to be used by the insurer. Caution should always be used when speaking to the insurer or its investigator.

Surveillance is a common technique used by insurers in cases where claimants allege disability based upon either subjective type conditions or where the objective support exists, but is not truly indicative of the restrictions or limitations. It is also commonly used in high benefit claims, where the insurer is willing to invest significant money to terminate or deny a potentially expensive claim. Claimants must be wary not only of their activity levels while on claim (including going to the gym—even if physician prescribed), but 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, there are a number of other issues that are commonly seen. We will address some of the other issues and offer further illustrations in future articles about the claim process. In the interim, 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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