

THE CFIDS ASSOCIATION OF AMERICA

# THE CFIDS CHRONICLE

Advocacy,  
information, research  
and encouragement  
for the CFIDS  
community

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**Want a  
fighting  
chance of  
winning your  
long-term  
disability  
claim?**

Information on  
how to dramatically  
increase the odds of  
filing a successful  
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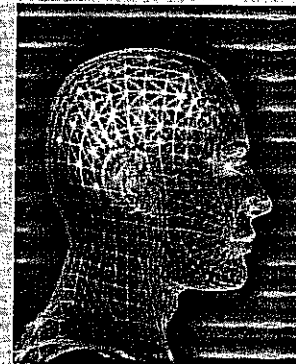
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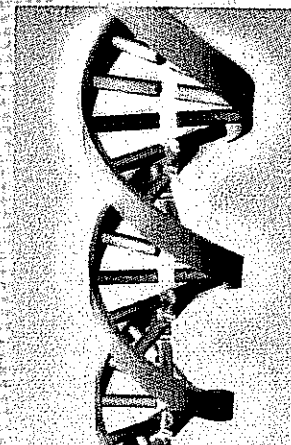
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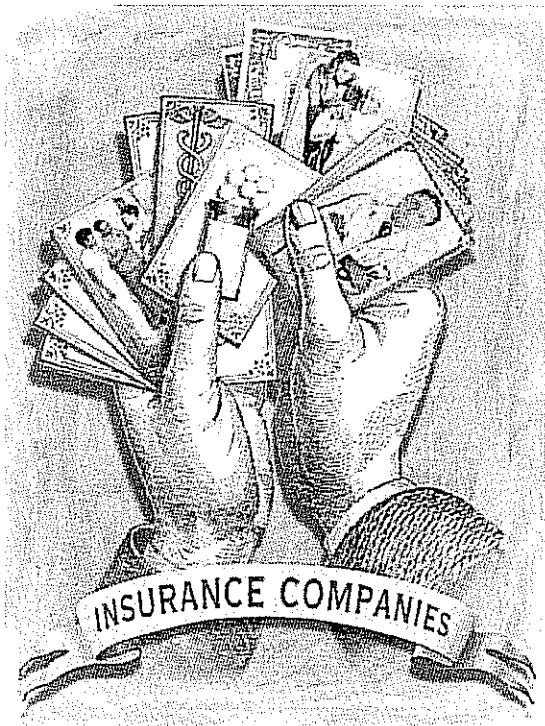
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Feel like you're playing a war game with your insurance company? Does it seem like they make all the rules and hold all the good cards? Learn how long-term disability claims are being examined by insurance companies and steps you can take to improve the odds that your claim will ultimately succeed.

BY JUSTIN FRANKEL AND JASON NEWFIELD,  
GUEST CONTRIBUTORS

## Finding Success in the Disability Wars

**D**iagnosing chronic fatigue immune dysfunction syndrome (CFIDS) and fibromyalgia (FM) is extremely difficult since most of the symptoms can't be objectively verified. Currently there's not a medical test available that will clearly diagnose either condition. Neither illness presents one single physical trait that can easily be recognized by a physician, and without a lesion or tumor to biopsy for a quick diagnosis, or a universally accepted lab test to rely on, physicians are often reluctant to diagnose these "invisible illnesses."

Similarly, insurers are often equally reluctant to treat these illnesses seriously, and they routinely use the lack of medical certainty about CFIDS and FM against patients who file disability claims. While this practice puts a greater burden on the patients to prove their cases, and it sometimes puts patients in

an adversarial relationship with their insurers, there are steps you can take to significantly enhance the chances of your claim being successful.

The purpose of this article is to provide individuals who suffer from CFIDS, fibromyalgia or other chronic illnesses with practical information to assist them in their pursuit of long-term disability benefits and to identify common problems that occur.

### Handling of claims by insurers

Unfortunately, individuals suffering from chronic illnesses are frequently surprised to find that their disability insurer refuses to approve their claim. Here are the most common positions taken by insurance companies when denying claims:

■ **Lack of objective evidence.** Insurance companies routinely delay or deny CFIDS

and FM claims because the claimant failed to provide objective evidence substantiating the disability, even though it's well known in the medical community that objective tests don't yet exist to confirm such conditions. Claims are delayed or denied while claimants attempt to develop support for their claims. Unfortunately, many treating physicians are either unwilling to assist the claimant or are unfamiliar with the insurers' claim requirements and don't adequately support the claim with the kind of information and documentation that is needed.

❑ **Skepticism about the existence of these conditions.** This skepticism causes many claims to be delayed or denied. This can result in instances of secondary depression for patients, which sometimes leads insurers to conclude that the claimant's condition is actually psychological, not physical.

❑ **Self-reported illness.** Some insurers deny claims because of the subjective, self-reported nature of many symptoms related to CFIDS and FM. Some policies actually require objective support for the disabling condition, while other policies limit benefit periods for self-reported claims, essentially treating those suffering from CFIDS or FM differently than other claimants.

❑ **Mental condition.** Many medical professionals and insurance companies attribute the complaints and symptoms to psychological or psychiatric disorders, or worse, to malingering. Claimants are left with delayed or denied claims. When coverage is provided, insurance companies often limit benefits to two years under a "mental or nervous" limitation clause in the policy.

### Claim requirements for CFIDS and FM patients

To be entitled to disability benefits, a claimant suffering from CFIDS or fibromyalgia must

## DID YOU KNOW?

❑ According to the U.S. Census Bureau, Americans have a one in five chance of becoming disabled. One out of every seven workers will suffer a disability lasting five or more years before age 65. Given these statistics, insurance companies are highly motivated to find ways to deny claims. Perseverance is essential to winning your claim.

❑ According to researchers at the CDC, 25 percent of Americans with CFIDS are unemployed due to the illness. The 2004 study also showed that those who continued to work lost one-third of their annual income to reduced hours and other factors related to CFIDS.

❑ Many long-term disability (LTD) claims are governed by a federal statute called ERISA (Employee Retirement Income Security Act). Don't be fooled by the name. The statute was designed to protect the integrity of pension plans, but it offers more protection to insurers than employees and can make winning a LTD claim difficult. It's advisable to work with an experienced attorney on such claims.

❑ When you interview attorneys to see who will best represent you, ask if you can get punitive damages. If they say yes, they doesn't know ERISA law. If your long-term disability claim falls under ERISA, you're not entitled to a jury trial, you can't make a bad-faith claim, and no punitive damages can be awarded. You can, however, receive back benefits and may also get attorney fees and costs associated with your claim.

demonstrate that as a result of injury or sickness, you are "disabled" as that term is defined in the policy. It is therefore critical to understand what the definition of disability is in your policy. Although the terms vary among policies, there are generally two different definitions:

❑ **Own occupation.** Here, disability is defined as the inability to perform the material and substantial duties of your "own occupation," even under the regular care of a physician. Insurance companies will also define an individual's own occupation as how the job is performed in the national economy as opposed to how you actually perform your own job.

❑ **Any occupation.** Usually after 24 or 36 months of disability, policies routinely change the definition of disability to a less restrictive definition. Instead of determining whether you can perform your own occupa-

tion, the policy changes to an analysis of whether you can perform "any occupation" for which you are reasonably qualified by education, training and experience. Insurance companies often perform a vocational analysis to determine if you're capable of performing any job in the economy, even if no job is actually available.

### Claim considerations

So how do you ever win a claim when the insurance companies have so many weapons in their arsenal? Fortunately, there are effective and proactive steps you can take to increase your chances for success.

When you're preparing to file a long-term disability claim for benefits, you must review and analyze (or have a professional review and analyze) the policy to understand what the insurer actually requires from you in order to issue benefits.

## FIVE COMMON LONG-TERM DISABILITY CLAIM MINEFIELDS

... and what you can do to avoid them



**Submitting a long-term disability insurance claim form or giving an interview to the insurer without fully understanding the significance of the statements you make.**

Insurance companies are very skillful at utilizing your own claim form to deny a claim. A dentist with CFIDS may answer a question about the activities she performs in her job with, "I perform chair dentistry, I sometimes assist the other dentists in their procedures, and I submit insurance claims and pay bills." The problem is that the insurer can then deem this dentist only residually or partially disabled because she can perform administrative functions as well as be a "dental assistant."



**Not working with your attending physicians so they fully understand the definition of disability contained in your long-term disability insurance policy.**

Even physicians who support your claim need guidance on the terms and conditions of your policy. You should get a copy of your medical records and review them carefully. Then set up an appointment with your physicians to explain the definition of disability contained in your policy and ensure that both your medical records and the report they submit detail how your illness restricts or limits your ability to perform the material duties of your occupation. Make sure you include all your health care providers in this process, including rehabilitation counselors, exercise physiologists and any others who are familiar with the functional limitations you experience.



**Attending an Independent Medical Examination or Functional Capacity Evaluation at the request of the insurer without preparing for it.**

Appear at IMEs and FCEs only after significant negotiations with the insurer regarding the examiner, the testing to be conducted and the scope of the examination. In addition, have a third person appear at these examinations with you to record events.



**Not hiring an attorney who is experienced in disability insurance litigation.**

Only a small number of attorneys in the U.S. understand how to handle disability cases. Litigating such claims is very different from handling other contract claims. Interview candidates by phone or in person before hiring a lawyer, and check out the firm's website.



**Failing to engage counsel early enough in the claims process to avoid costly delays.**

Effective assistance of counsel at the outset of a long-term disability claim can prevent delays in claims processing. Insurers rely on the relative inexperience of claimants to manipulate and delay the claims process. An experienced attorney can work with your physicians to get needed documentation, negotiate the terms of an IME or FCE with your insurer, help you understand your policy, file your claim and handle an appeal if your claim is initially denied.

For instance, careful attention must be paid to the material and substantial duties of your occupation, and thought must be given to articulating how you are unable to perform such duties. Having a disorder or syndrome does not make you disabled under a policy of insurance; rather, the symptoms, restrictions and limitations of the disorder or syndrome determine disability.

When you experience chronic pain, concentration difficulties and chronic fatigue, those symptoms are likely to limit you in the performance of many occupational duties. You must have your treating physician address these symptoms and relate them to employment. It's absolutely essential to work with your doctor and make sure your medical records reflect how you are disabled in terms that relate to the language of your policy. That's why knowing your policy is so important.

The insurer may take the position that the pain is self-limiting, but not objectively verified, that the concentration difficulties are not supported by neuropsychological testing or that the fatigue is not disabling. Consequently, it's imperative that you provide as much support for the limitations as possible. To do this effectively, you can maintain a journal or diary of activities, describe your physical condition after engaging in various activities, and address the lack of functionality you experience. This may constitute some supportive evidence for the restrictions and limitations you are claiming.

### Avoiding potential claim investigation minefields

There are several common tools utilized by insurance companies to verify disability either before your claim is approved or to deny continuing coverage at some point after

you have begun receiving benefits. Each of these techniques poses potential problems for CFIDS and fibromyalgia claimants. Contractual support for many of these tools may be buried in your insurance policy. However, any request by an insurer to invoke any contractual rights must be balanced with a reasonableness standard.

■ **Independent Medical Examination (IME).** 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's safe to assume that objectivity can be questioned. Claimants faced with an IME must arm themselves for battle. You should bring a witness, request to videotape the examination and request the insurer to demonstrate the validity and/or necessity of the testing.

When an insurer exercises a contractual right to an examination, a claimant usually has the obligation to attend an examination. However, in any policy there are implied terms of good faith and fair dealing which 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 significant distance to have an examination performed, or it may be unreasonable to schedule an examination on two days' notice. You do have some control over the process.

■ **Functional Capacity Evaluation (FCE).** An FCE is an entirely different scenario. An FCE is not generally contractually required, but insurers nonetheless act as if it's mandated. This test is utilized by insurers to test your maximal effort, which can then be used to extrapolate that you can work full time on a sustained basis due to your ability to perform a myriad of tests one time. The results are inherently unreliable,

and the tests lack validity.

■ **Peer reviews.** An insurer peer review of the claim relies upon a non-examining physician to address a claimant's functional abilities. This has inherent problems, because it precludes you from receiving an appropriate evaluation of the claim. Even when an outside physician is used, it's difficult for a doctor who has never examined you to opine properly on your restrictions and limitations from just a review of the records. Thus, you must ensure that your own treating physician provides well-developed, organized office notes and narrative reports to support your claim.

■ **Field investigations.** Field investigations are common in subjective complaint claims. An investigator will often stop by unannounced to speak to the claimant. The investigator wants to ascertain your activity level, determine whether you are working in another interest, or gather other information to be used by the insurer. Caution should always be used when speaking to your insurance company or their investigator. Remember that the investigator is not on a social call.

As noted above, insurers are supposed to adhere to a reasonableness standard, so you should feel free to advise an investigator who shows up unannounced that the timing isn't convenient and that while you are willing to meet with the investigator, it must be a scheduled visit.

■ **Surveillance.** Surveillance is a common technique used by insurers in CFIDS and FM cases because of the subjective, self-reported nature of these illnesses. It's also 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 statements made to the insurer about their daily activities. Inconsistencies can be fatal to a claim, and the expression "a picture is worth a thousand words" holds true with regard to surveillance.

We hope that this article has provided helpful information to guide you in filing long-term disability claims and in navigating the minefields in the claim process. In a future article, we will provide more in-depth information regarding treatment by the courts on specific cases and issues that commonly arise in disability claims based on CFIDS or fibromyalgia. ■

#### About the authors

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