Disability Insurance and the Physician Practice: A Primer for Physicians and Office Managers

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While your office may be familiar with all of the ins and outs of health insurance, disability insurance claims are complex and difficult to navigate, often deliberately so. When the unthinkable occurs and a claim must be filed, physicians are all too frequently stymied by the response of the insurance company to their claim. This article will provide fundamental information for the physician who needs to file a claim as well the practitioner who comes across a long-term disability insurance claim in his or her practice.

Key words: Long-term-disability insurance; partial disability; full disability; independent medical examinations; functional capacity evaluations; definition of disability; restrictions and limitations; occupational duties.

Disability insurance is a unique area, different from all other insurance practices. While your office may be familiar with all of the ins and outs of health insurance, disability insurance claims are complex and difficult to navigate, often deliberately so. For the physician, long-term-disability insurance is a necessity. But when the unthinkable occurs, and a claim must be filed, physicians are all too frequently stymied by the response of the insurance company to their claim. This article will provide fundamental information for the physician who needs to file a claim, as well the practitioner who comes across one of these claims in his or her practice. The article will address the process of filing a claim for disability benefits, the issues that often arise in the claims process, and the potential problems that must be avoided to successfully maintain a claim for disability benefits.

FILING A CLAIM: LAYING THE FOUNDATION PROPERLY

Every claim for disability benefits is guided by the actual terms of the policy. Careful analysis of the governing policy is critical because each insurer has policy language on myriad issues that can vary greatly among policies.

The treating physician plays a critical role in the claim's success or failure.

It is also vital to discuss an impending claim with the treating doctor because a nonsupportive doctor or one with no knowledge of the disability insurance claims process can hurt the likelihood of success of a claim. The importance of working with a treating physician who appreciates the contractual issues and how they integrate with the medical issues cannot be overstated.

Restrictions and limitations of occupational duties must be outlined in medical records.

The treating physician must be able to clearly relate not only symptoms but restrictions and limitations of occupational duties that have been created as a result of the disability. A neurosurgeon with a back injury who can no longer perform surgery does not present a clear enough picture for an insurance company reviewing a claim. A clear definition of the neurosurgeon's professional tasks—standing for extended periods of time while performing intricate

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surgery that demands exactitude and precision—must become part of the physician's narrative to address areas that the physician statement may not cover to the degree required for a disability claim to be successfully filed.

It is important to understand that it is not the diagnosis that makes a person disabled, but the *restrictions and limitations* that the condition creates for a claimant.

WHAT HAPPENS AFTER THE INSURER IS NOTIFIED OF THE CLAIM

Once the insurance company receives the claim, it will contact the claimant and provide the forms that are required. These include a claimant statement, attending physician statement, and an authorization form permitting access to health, financial and occupational materials from third parties. There is legal significance to every single item being sought by the insurance carrier, and there are consequences relating to the information supplied or withheld.

The insurance carrier is likely to request financial records from the physician personally and from the practice itself, requesting everything from basic bookkeeping records to complex 401(k) statements and more. The insurance company is evaluating not just the physician's income and assets, but the contribution the physician makes to the practice and the value of the practice. This is an unsettling request for practitioners who are used to running their professional practice without prying eyes. Providing this information correctly requires a cautious and methodical approach.

The claimant statement seeks to understand the claimant's condition(s), the restrictions and limitations resulting from the condition(s), and work information, including all occupational duties. A claimant and the attending physician must be extremely conscious of how to respond to this request. Policy definitions should be integrated into the response.

A claimant will be asked to provide a list of job duties, listed in order of importance, or defined by the amount of time spent on each task. An innocent and honest mention that the claimant handles certain administrative functions like opening the mail or dealing with equipment or medical supply vendors could significantly undermine a claim. The insurance company will use this information to argue that the claimant is only partially disabled, rather than totally disabled, if he or she retains the capacity to perform these administrative functions.

COMMONLY USED EVALUATION METHODS

Disability insurance companies use several methods to evaluate and investigate claims, including IMEs (independent medical examinations), FCEs (functional capacity evaluations), peer reviews, field investigations, and surveillance.

The insurer has a contractual right to compel a claimant to undergo an IME; and in most circumstances, a claimant has the obligation to attend an examination. However, every policy must be read to have implied terms of good faith and fair dealing guiding the process. Our firm now has a case pending in Federal Court in which the judge has agreed with our questioning of the independent nature of the doctor conducting the IME—when the doctor has been hired and is being compensated by the insurance company, an inherent conflict of interest may exist that must be taken into consideration. However, for the most part, the IME is assumed to be a reasonably fair process. What is not acceptable is for an insurer to require a claimant to undergo invasive testing or to require a claimant to travel a significant distance to have an examination performed.

An FCE provides a completely different scenario. In direct contrast to the IME, the FCE is not generally included in the insurance contract. This test, which is controversial even in the physical therapy community, is utilized by insurers to test a claimant's maximal effort. Data are then extrapolated to determine whether the individual can work full time on a sustained basis. Exerting maximal effort often puts a disabled person at risk for further injury. There are numerous grounds upon which claimants are advised to refuse to attend or participate in an FCE, and claimants must be vigilant about asserting their right to refuse this test.

Disability insurance companies often use in-house medical staff to contact a claimant's treating physician to discuss the claimant's condition, restrictions, and limitations. In essence, the insurer's medical staff is seeking to develop evidence from the treating physician that will demonstrate that the claimant is not disabled, regardless of the claimant's own attending physician's certification of disability. Often, the insurer sends a letter to the attending physician "confirming" a conversation and stating that absent a fast response, the physician accepts the statement in the letter. The content of the letter, however, either distorts the facts or casts them in an unfavorable light. Because the attending physician is busy and responding to this letter may not be his or her first order of business, the insurance company deems the lack of response or delayed response to be an affirmation that the attending physician agrees with the statement. This is often the first reason given for a denial or termination of a claim.

Once a claim has been filed, evidence gathering begins.

To combat this particular problem, it is wise to restrict the insurer from direct access to the treating physician by telephone; rather, all inquiries should either be directed to go through counsel or in writing to the attending physician. This prevents the insurance company from attempting to miscast information, distort facts, or otherwise pursue the development of erroneous information.

When an insurance company conducts a peer review of the claim, it relies on a non-examining physician to address a claimant's functional abilities. This has many inherent problems, largely because it precludes the claimant from receiving a fully appropriate evaluation of the claim. Even when an outside, truly independent physician conducts the review, it is difficult for the non-examining physician to conduct a review on the limitations and restrictions of a physician relying solely on the medical records. Claimants must ensure that their treating physician provides well-developed, highly organized, and clear office notes and/or narrative reports to support claims of disability.

Field investigations are commonly used methods employed by insurance companies for claims by medical professionals. An investigator will stop by at the office or home, unannounced, with a goal of ascertaining the claimant's activity level, determine whether the claimant is working in another capacity, or develop other information to be used by the insurance company. Caution must always be used by claimants speaking directly to the insurance company and its representatives. Providing interviews should be done only on the claimant's terms, with witnesses, possibly recorded to avoid any distortions.

Surveillance is commonly used in cases with conditions that are considered subjective or for which objective support exists but is not truly indicative of the restrictions or limitations. It is commonly used in high-benefit claims, as is frequently the case with privately owned disability policies. The insurance company is willing to make significant investments to terminate or deny potentially expensive claims. Claimants must be mindful of their activities as well as statements made to the insurer about daily activities while in the claims process, as well as when claims are being paid. Regular visits to the gym, for example, even when prescribed by a physician, will be questioned. Inconsistencies can be fatal to a claim.

Long-term disability claims are vastly different than health insurance claims, and must be treated as such.

Insurance companies that oversold long-term disability insurance policies decades ago never anticipated that many physicians would make claims on the policies. As a result, insurance companies seek to minimize their exposure by making the process of navigating a disability insurance claim difficult. The result is unfortunate for the practitioner who does not have the experience and knowledge to successfully bring a claim, or the attending physician who does not understand the importance of outlining limitations and restrictions with great specificity. A well-educated claimant who understands the process will be more likely to succeed than one who considers a disability insurance claim to be similar to any other insurance claim—rife with moving parts and paperwork, but essentially manageable. The disability insurance claim is different and must be treated as such. ■