MISTAKES OFTEN MADE BY PAIN PATIENTS APPLYING FOR PRIVATE DISABILITY BENEFITS

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BLINDLY ATTENDING AN INDEPENDENT MEDICAL EXAM

After submitting your claim, you may be asked to submit to an “independent” medical examination by someone chosen and paid for by your insurance carrier. Before submitting to an “independent” medical exam or any other exam, you must first ensure that your carrier has a right to conduct the exam per the policy language. For example, a psychologist, not a physician, conducts a neuropsychological exam over several days and the carrier to deny benefits often uses the subjective findings from such an exam. If your policy requires that you submit only to “medical exams” or exams “conducted by a physician,” there is certainly an argument that you need not submit to neuropsychological testing. Further, you may wish to be accompanied by an attorney or other legal or medical representatives who can monitor your “independent” medical exam.
Failing to Consult with a Disability Insurance Lawyer

Patients who are considering filing a claim for disability insurance benefits are advised to meet with an attorney experienced in the area before submitting a claim. Claim departments of insurance companies have one goal: to pay only those claims they absolutely have to pay. And unfortunately, some companies even take that one step further by designing their claims process to elicit information from insured’s that is then misconstrued and used to close the claim. Their friendliness is specifically designed to give you a false sense of security so you will share more information than you might otherwise, and their helpfulness is designed to get you to trust them so you won’t question the documentation they demand, all while studying you and your claim to figure out how best to reduce or close your claim as soon as possible. Claims examiners are on the payroll of the insurance company, meaning their employer’s instructions come first and foremost. All of the information you submit plus the additional information they’re able to obtain is examined and reviewed with their one goal in mind.

Misunderstanding the Definitions of “Disability” and “Occupation”

There is no such thing as a “standard” disability insurance policy, and the definition of “disability” can significantly vary.

Inadequate Documentation of the Claim Review Process

When submitting a claim and speaking with their carrier, it is important to take notes to assist them in remembering what was said in the event that their claim is denied. Patients should keep notes of all telephone conversations (including the date and time of the call, and what was said) and identify the person with whom they were speaking. Every conversation with the carrier should be confirmed in a letter sent by certified mail so that there are no misunderstandings. The “paper trail” may later be used as evidence to establish unreasonable treatment during the claim administration process.

Believing All Mental Conditions are Excluded or Subject to Limitations

Most disability insurance contracts differentiate between mental and physical disabilities. More recent policies cut off benefits for psychiatric conditions after two or three years. Insured’s often blindly accept their carrier’s decision to deny or limit benefits based on these conditions without considering numerous relevant factors, including whether there are any physical aspects to the mental condition, whether the mental condition has a biological/organic cause, or whether another, covered condition was the legal cause of the disability.
INADEQUATE COMMUNICATION WITH A TREATING PHYSICIAN
Insured’s should not discuss their claim or that they are considering filing for disability insurance benefits with their treatment provider until after you have had several visits. Physicians are often reluctant to support claims for benefits if they question the patients’ motivations. A physician who has treated you without success will likely be more willing to cooperate. It is also important that you communicate your symptoms and limitations to your treating physician in an organized and detailed manner so that all relevant information is recorded in your medical records, which your insurer will ultimately request. When finally speaking to your treating physician about your claim, you should ensure that your treating physician understands the definition of “disability” under the terms of the insurance policy, which can often be different than the definition as that word is normally used, so that he or she can accurately opine as to your ability to work.

QUANTIFYING YOUR TIME
You should be wary of insurance companies asking you to compartmentalize in percentages what your activities you engaged in pre- and post-disability. To the extent that there is any crossover, companies will often deny benefits or provide benefits for merely a residual disability. It is important that you broadly describe your important duties – rather than your incidental duties – so that your carrier has a clear understanding of the thrust of your occupation.

IGNORING THE POSSIBILITY OF SURVEILLANCE
Insurers are likely to videotape or photograph patients who have filed for disability insurance benefits; the insurance company will be watching your activities. If you do things your doctor said you shouldn’t do, it might look like you are trying to cheat the insurer. If the insurance company sends you an activity log to complete, that only confirms that you are being watched. Follow your doctor’s instructions carefully. Patients who engage in any activities that they claimed they could not perform and are caught on tape are likely to have their benefits denied and the contract could be terminated.

Also, the total value of your benefit payments plays a major role in the likelihood of surveillance. The amount of reserves set for a claimant’s disability benefits must justify the cost of the surveillance. The cost of each surveillance operation varies, but surveillance costs usually range from $2,000 – $5,000. This means that relatively high-value claims are more likely to be subject to surveillance than low-value claims.

Anytime claimants meet with or talk to a claims examiner or field rep, they’re essentially under surveillance. If a claims examiner asks to meet in your home, they are trained (and expected) to inspect the surroundings to see if there are any inconsistencies from the story of your claim. Insurance companies hire experienced investigators and train them further on how to write reports to be used in disability claims.
For example, if you have a bad back and had to fire your housekeeper due to financial concerns, the investigator will make sure to note the immaculate condition of the exterior and interior of your house in his or her report, which can then become the basis of assumptions – that you must be able to clean and repair your home. Or, if you sit for an extended period of time to talk with the field rep in spite of being in pain, the field report will include such observations that you are able to sit and work for extended periods of time despite whatever documentation was already provided.

**BLINDLY ACCEPTING THAT SUBJECTIVELY DIAGNOSED CONDITIONS ARE NOT COVERED**

Disability insurers often deny benefits by insisting that the insured’s subjective symptoms do not provide objective, verifiable evidence of disability. In many cases, there is no provision or contractual requirement mandating that the insured submit objective evidence of disability. Therefore, the insured may be able to secure benefits with ample evidence bearing on the extent and severity of his or her limitations, which is far more important than providing a definitive diagnosis.

**TOSSING OUT THE DISABILITY INSURANCE APPLICATION, POLICY, AND CLAIMS DOCUMENTS**

From the time of application forward, patients should keep copies of everything (including notes from meetings with the insurer’s sales representative or agent, the policy application and the policy itself). If the sales representative provided a letter or a verbal representation that the patient jotted down, those notes can go a long way if the insurer says that the policy says something different.

**ASSUMING THAT YOU HAVE ENOUGH EVIDENCE FOR YOUR CLAIM IF YOUR EMPLOYER SAYS YOU ARE TOO SICK TO WORK**

The insurance company, not your employer, will be paying your long-term disability benefits. Assuming that your employer’s opinion regarding your ability to work is sufficient to qualify for benefits is a big mistake. The insurer will decide when you meet the legal definition of disability under the terms of the policy.

**RELYING SOLELY ON THE ADVICE OF YOUR HUMAN RESOURCES DEPARTMENT**

While human resources personnel might mean well when giving you advice, they are not trained in interpreting insurance policies, and they have no influence over the insurers for the most part. Taking action to obtain long-term disability benefits will be up to you.
Your doctor must answer certain questions on the insurance company forms. But don’t leave it at that — you may need further explanation or information to prove your disability. Sit down with your physician and explain the terms of your disability insurance policy. Request that your doctor complete a report that fully explains how your sickness or condition is preventing you from performing the substantial and material duties of your occupation. Even if your doctor charges you for such a report, it is well worth the money.

Most newer disability policies have a 12 or 24-month cap on benefits from mental and nervous conditions. Insurance companies are looking to reclassify claims because of this limitation. By reclassifying claims that may have started out a physical disability to a mental and nervous disability claim the insurance companies are able to reduce their liability. This issue relates to the last point: your doctor must be very specific in describing your symptoms and functional capacity. Many people try and work with chronic pain from back problems, but this pain may become unbearable and cause them to become depressed. If an insured files a disability claim in this scenario, the claim should be pursued for the back problems and chronic pain condition, which may not have a benefit limitation, in addition to the depression.

Most disability policies have clauses that differentiates between total and residual disability. Without going into too much detail in this overview, a disability claim is usually considered a total disability if the insured is unable to perform material and substantial duties. The claim is considered a residual (or partial) disability if the insured is able to perform some of their material and substantial duties. Insurance companies like to look past the required duties and jump to the income of the insured in order to back into a residual claim, when the job duties almost always guide this decision. No matter your current income level, if you cannot perform the material and substantial job duties, you are considered to be totally disabled in most policies.

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Successful people are rightfully proud of their career achievements and enjoy what they do for a living, so it makes sense that they wouldn’t want to stop working. In the long run, this decision can end up hurting a disability claim. Many policies require an insured to be under the regular care of a physician and have reduced or stopped working to qualify as the date of disability, not necessarily when the insured began to suffer from his or her restrictions and limitations. If you have been reducing your job responsibilities prior to filing a claim, your material and substantial duties at the time of disability may have been simplified and reduced, making your disability claim that much more difficult to prove. Likewise, if you’ve become disabled and don’t file your claim, there may be restrictions and deadlines that hurt your claim. It is important to seek medical care as soon as you’re suffering work restrictions and limitations and to prudently decide when and how to file your disability claim.

NOT REALIZING THE EFFECTS OF SOCIAL MEDIA

Social media has become such an important factor in claim investigations and many people like to portray a “second” life on social media networks with their friends. These sites are the only places many disabled insured’s can feel normal and like a regular part of society. However, insurance companies may not look at it this way. If you are active in groups or forums that support activities that your restrictions and limitations indicate that you can’t do, the insurance company may try and use this against your claim. It’s important to remember that insurance company investigators can find everything about you on the Internet, and it’s next to impossible to completely remove something once it’s out on the Web.

WAITING TOO LONG TO SEEK A DIAGNOSIS AND FILE A CLAIM

Successful people are rightfully proud of their career achievements and enjoy what they do for a living, so it makes sense that they wouldn’t want to stop working. In the long run, this decision can end up hurting a disability claim. Many policies require an insured to be under the regular care of a physician and have reduced or stopped working to qualify as the date of disability, not necessarily when the insured began to suffer from his or her restrictions and limitations. If you have been reducing your job responsibilities prior to filing a claim, your material and substantial duties at the time of disability may have been simplified and reduced, making your disability claim that much more difficult to prove. Likewise, if you’ve become disabled and don’t file your claim, there may be restrictions and deadlines that hurt your claim. It is important to seek medical care as soon as you’re suffering work restrictions and limitations and to prudently decide when and how to file your disability claim.
TRUSTING THE INSURANCE COMPANY TO BE FAIR AND DO THE RIGHT THING

Insurance companies will tout how quick and easy their claims process is when you are purchasing a policy from them or even when you request claim forms. But this process becomes anything but quick and easy as the claim process unfolds. Under the guise of trying to prevent fraud and maintain “integrity,” insurance companies teach their claims examiners to behave like your friend and convince you that they are on your side, when these statements are carefully scripted to gain your trust and make you slip up into saying something they can use against you and your disability claim. Claims examiners and their managers earn bonuses based on achieving certain claim ratios, so it is misleading to say they aren’t biased when their compensation depends on how many claims are paid or denied. It’s important to have an expert help you with your claim, someone you know is on your side and help you every step along the claim review process.

PRESCRIPTION DRUG ABUSE AND THE EFFECT ON DISABILITY CLAIMS

Medications have been responsible for the improved quality of life for many sick and disabled individuals, many of whom receive disability benefits from both the Social Security administration and private disability insurers. Some patients may develop life-long dependencies to many of these drugs. When claimants become addicted to the medications they’re using to control their disability or disease, their claims for disability benefits can become much more difficult and challenging, subject to multiple delays or denials. Insurance companies often defend against disability claims involving drug dependence in two ways: asserting that the disability is only a “legal disability” or that the disability is intentionally self-inflicted. These are both causes of disability that have been increasingly excluded from insurance coverage. Legal disability can loosely be defined as an inability to work in an occupation due to legal or license restrictions, rather than a factual disability.