LONG TERM DISABILITY INSURANCE CLAIMS

How To Prepare Your First Administrative Appeal

Remarks to the National Organization of Social Security Claimants Representatives NOSSCR
San Francisco, California, October, 2009
by Pamela I. Atkins, Esq.

The disability application and all supporting evidence will be scrutinized by insurance claims personnel trained to find weaknesses that can be used to delay, deny or limit policy benefits. Careful preparation in the early stages of an STD/LTD claim is essential and can help avoid common mistakes. Take your time and go through each step of the process slowly, and ask for guidance from experienced practitioners. Unfortunately, too many individual with legitimate disability claims and lawyers new to the litigation of LTD claims wait too long to seek advice from experienced legal counsel and the strengths and weaknesses in the initial application and appeals process can have a major impact on the outcome of a claim. A clear example is the *Townsend* case we litigated for a social security attorney where the district court judge refused to consider an affidavit of a doctor (which refuted documentation in the claim file as to substance of a phone conversation between the doctor and the in house medical reviewer), first submitted by us at the district court level because the conversation it addressed was referenced frequently in the denial letter and should have been addressed by the claimant at the time of the denial since she had the opportunity to do so. *See Townsend v. Delta*, materials attached.

Obtaining experienced legal advice early in the process can help to overcome many of the bases the LTD carrier will employ to attempt to defeat the claim.

A claimant's rights and obligations under their Short Term and Long Term Disability insurance policies are governed by the terms of the STD and LTD agreements. Not all contracts are identical. For instance, there may be important differences in the definition of disability; the term of disability; whether there are limitations on disability caused by mental illness, etc...

The most important determination with regard to a Disability Income policy is whether or not it is governed by a federal law called the Employee Retirement Income Security Act (ERISA). The transformation of a disability insurance policy into an

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ERISA plan occurs when the insurance is provided as an employee benefit. Be advised that many times policies which were never meant to be part of an employee benefit plan are, in fact, interpreted as such, and ERISA is applied. ERISA is a strong shield for the insurer in employee benefits litigation.

The primary purpose of ERISA was the protection of plan participants; however, the application of ERISA has not carried this purpose to fruition.

The ERISA statute provides in pertinent part:

> [E]very employee benefit plan shall--
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair hearing by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133 (1988). Accordingly, ERISA requires that "Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained...." 29 C.F.R. § 2560.503-1(f)(g).

Courts have noted that "these procedural guidelines are at the foundation of ERISA" because Congress intended that ERISA provide plan administrators and participants the opportunity and freedom to resolve internal disputes without necessarily having to resort to the expense and delay of the courts. Unfortunately, the ERISA statute has become an effective shield for the insurance companies to deny valid claims without fear of incurring bad faith and punitive damages for their actions. Generally, the outcome of litigation on an LTD claim governed by ERISA is that the insurance company is forced to pay the past due benefits, and at the court's discretion interest on the past due benefits and the attorney fees and costs on a claim that was improperly denied. Therefore, it is extremely important that a claim be properly presented from the date of initial application with the strongest evidence possible.

Under policies governed by ERISA, the insurance company really has an incentive to deny the claim and take their chances in court. That is why insurance

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companies have gone so far as to even establish special tasks forces to promote the identification of policies which may be covered by ERISA and to initiate active measures to get new and existing policies covered by ERISA. A now well circulated "Privileged Provident Internal Memorandum" from the IDC (Individual Disability Group) stated:

> The advantages of ERISA coverage in litigious situations are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of the benefits in question, and claims administrators may receive a deferential standard of review. The economic impact on Provident from having policies covered by ERISA could be significant. As an example, Glenn Felton identified 12 claim situations where we settled for 7.8 million in the aggregate. If these 12 cases had been covered by ERISA, our liability would have been between zero and $0.5 million.

Because ERISA provides a shield to the insurance company, many companies take an aggressive approach to claims even in the face of strong medical evidence, particularly if their own medical reviewers in house or third party medical vendors have provide a medical opinion supporting a denial.

Disability Income policies (DI) which are not part of en employee benefit plan are commonly underwritten for white collar workers who are concerned that a disability may drastically reduce or eliminate current income. An application is completed providing medical history for at least the past five years, employment background and income for the past three years, and other documentation to assess the risk to the insurance company. The premiums paid for individual policies are typically very high and well in excess of those paid for group coverage. Most DI policies, as differentiated from group policies, do not offset for Workers' Compensation or Social Security benefits. Underwriting guidelines during the 80s until mid-90s, allowed insurance companies to cover significant high percentage of gross income. There is very aggressive risk management now so applicants are lucky to get 50%. Policies written in most states must abide by certain minimum standards delineated by state insurance laws. They typically have a two-year incontestability clause. That means that if the claimant made a material misrepresentation or omissions of fact on the initial application, the company would still be liable for payment, so long as the claim is made at least two years from the date of issuance. However, companies seek to get around the incontestability clause by claiming that the misrepresentations are fraudulent which gives a longer statute of limitations.

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DI policy language varies from one company to the next. Of interest is that the major insurers have been consolidating so that there will be fewer DI policies in the future. For example, Equitable's DI division was bought by Paul Revere, whose DI division was then purchased by Provident Life, who has since merged with UNUM Life to become UNUMProvident which is now called UNUM Group.

While the laws governing an insured's rights under a policy are greatly affected whether or not ERISA applies, many of the same tactics in administering the claims are utilized. The length of this talk is not conducive to separate detailed discussions regarding the tricks of the trade in private vs. group policies and in policies subject to ERISA vs. policies governed by contract and state law. Therefore, our presentation will focus exclusively on ERISA.

The first step in LTD representation is to obtain a copy of the complete STD and LTD policies read them thoroughly before applying for benefits or if time allows before initiating the appeal or suit. The plan administrator who is typically also the employer and plan sponsor must provide a copy of the plan document and SPD to you under ERISA within 30 days when it is requested in writing. Note: pamphlets that describe the benefits may not be the actually Plan or the SPD.

Understand all terms used in the policy, including: disability, covered employment, exclusion or elimination period, pre-existing condition, special limitations for certain conditions and proof of claim. Insurers sometimes distinguish between a claimant being disabled from his or her job (the position held with the employer); being disabled from his or her "own occupation" (similar work done for another employer); and being disabled from "any occupation" for which you are reasonably qualified. Read the insurer's own "definitions" published in their reports. What do they mean by preexisting conditions? If they were not diagnosed prior to the disability and the claimant was not treated for them, they probably do not qualify as preexisting, but read the policy.

It is important that you also note all time limits that apply to eligibility: i.e. the elimination period, providing proof of claim, appealing denials, exhaustion of any administrative remedies and filing a lawsuit. Observe these matters carefully. Note how many hours per week the claimant must be working to be covered and whether the claimant must be totally or partially disabled to be eligible. If the claimant reduces her work hours due to illness, be sure to document the date the claimant left full-time employment and obtain a letter from the doctor clarifying that the reduction in hours was for medical reasons. When was the onset of disability? Did the claimant change

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his or her job prior to application such that the carrier can argue not disabled from current job. Is the claimant dually employed (performing two functions: i.e., surgeon and office manager)?

Work closely with the treating doctor(s) to provide the strongest possible evidence in support of the claim. It is imperative that the claimant seeks treatment on a regular basis, in order to obtain detailed and up-to-date medical records from the treating physicians. Medical reports submitted with the applications or appeals should include the following: a strong statement confirming the diagnosis and the claimant's inability to work; a detailed application of current criteria and medical history to support the diagnosis; documentation of all physical signs, abnormal lab tests and other objective evidence of illness; a statement that the claimant is totally disabled and unable to do any kind of work, if applicable; a detailed explanation of how the claimant specific symptoms limit or preclude any work activity; results of functional capacity or exercise tolerance tests, if possible, to support the inability to work; and objective evidence that all other possible causes for the symptoms have been carefully excluded (lab tests, reports from specialists, etc.). Throughout the claim, be prepared to provide ongoing documentation of all signs and symptoms that support the claimant's diagnosis and inability to work. The claimant's doctor may be asked to submit additional information, including office notes and written reports.

Be aware of two-year limitations. Many policies contain two-year limitations for mental illness and nervous conditions. Beware of "cause or contributed to by" language. The insurer may look for reasons to classify the claimant as mentally ill in order to limit benefits. If symptoms of depression or anxiety must be documented, be sure the doctor clarifies that they are secondary to the illness and did not exist before. Many new and renewal policies also include two-year limitations for "chronic fatigue conditions," "allergies to chemicals or the environment" and "self-reported" symptoms such as "chronic fatigue" and "muscle pain" which can not be confirmed by objective laboratory testing. Many policies now require "objective evidence" of the impairment.

Maintain a chronological file of all documentation and correspondence related to the claim, including the initial application; information from the employer and physician's statement; all medical information submitted; all letters from you, the claimant, and the insurer; and any supplemental forms completed. Review this file frequently to catch and clarify any details you may have missed, and note patterns of delays or denials. The claimant is legally entitled to copies of everything your insurer has in the file, including internal memos, reports from independent medical examinations required by the insurer and any surveillance videos the insurer has ordered from private investigators.

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If the insurer offers a cash settlement in exchange for relinquishing the claimant's rights to future benefits, insist on being allowed time to review the offer in written form to weigh its merits and obtain qualified advice before signing away the claimant's rights. Many offers are ridiculously low, never put in writing, or withdrawn after a short time. The entitlement to other employee benefits such as medical insurance and pension credits may be linked to receipt and entitlement of LTD benefits. If so, these benefits disappear if you settle the LTD claim—be careful. Many times they are move valuable than the actual LTD benefit application of an SSDI offset. Currently we are litigating a case for just the pension freeze and medical benefits valued at about 350,000 while the LTD after offset is only $179.00 per month.

Be sure to appeal denials within the stated time limit. Draft the appeal highlighting the strengths of the medical evidence, weaknesses in the insurer's denial and citing relevant sections of ERISA and other applicable laws and cases. Remember that insurers do not care about the pain and hardships claimants must endure - they are only interested in the relevant facts of the case. But write the appeal as if you are writing for the court later and be certain your appeal includes everything you would need to prove the case in court. Once the final appeal is denied the record is CLOSED!

Strengthen your case by providing additional medical evidence when you appeal a denial; relevant articles published in peer-reviewed medical journals can be used to support your evidence and submit such evidence when applicable. Also consider obtaining functional capacity evaluations or vocational appraisals by persons trained to assess the claimant's ability to work full or part time. Any of these strategies will also strengthen initial applications for benefits.

Be prepared for independent medical examinations (IMEs) by doctors paid by the insurer to evaluate the disability. Some insurers go out of their way to schedule IMEs with cynics who do not recognize the disability as a valid diagnosis and many times IMEs are purposely scheduled with doctors through third party vendors who do volumes of this type of work and may not have experience in the specialty for the type of impairment alleged. Try to find out about an IME examiner's experience and attitudes toward disability and how much of their work is for insurance companies. Have the claimant bring an observer or tape recorder to the examination. Make certain the claimant avoids appearing antagonistic, but have the claimant prepared to document any irregularities in the examination or indications of obvious bias by the examiner.

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Expect difficulties after the first two years of the claim. Many insurers try to limit their liability to a maximum of two years of benefits. After two years, depending on the contract the insured may need to prove disability from any occupation to be eligible for further benefits. Also be prepared for increased frequency of IMEs, home visits, or surveillance.

Document everything. Remember, the insurer's profits are related to the amount of premiums taken in relative to claims paid out. Companies bank on "meltdown" and you do not have to see "The Rainmaker" to understand that the unstated culture of every insurance company encourages the earliest possible resolution of every claim. Case workers will say "no and bye bye" wherever they can and hope that you will stay. Do not give up.

Under most group polices, as compared to individual disability policies, the LTD benefit is the maximum amount the claimant can receive from all employment-related sources. For example, any additional income received from part-time work, short-term disability, state disability, workers' compensation, Social Security and some retirement plans can and will be deducted from the benefit amount. If the claimant receives back payments from SSDI while receiving LTD payments, the claimant may owe all or part of this to the LTD carrier. If other family members receive benefits due to the claimant's illness, depending upon the provisions in the LTD contract, the carrier may seek to include all dependent's benefits in the offset calculation. Determine what percentage of the premium (if any) is paid by the employer; the same percentage of any benefits paid to the claimant will be considered taxable income by the IRS.

Even though most group LTD contracts provides for a Social Security offset, it is generally to the claimant's advantage to apply and seek approval for Social Security disability for the following reasons:

1. Most LTD policies do not offset Social Security's annual cost of living increases (COLA). In addition, some policies only offset only individual Social Security benefits and not family's Social Security benefits and many policies have a minimum benefit payment that is not offset by Social Security.

2. Receipt of Social Security disability benefits for all years prior to retirement age "freezes" those years for the purpose of calculating the retirement benefits amount. Therefore, lack of earnings covered by

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Social Security during the period of disability will not adversely affect the amount of the claimant's retirement check. In this way, Social Security retirement and survivor's benefits are usually protected, so the claimant is not penalized for lost work due to his/her disability if the claimant applies and is awarded a period of disability from Social Security.

3. Many LTD policies limit benefits to 24 months or less. For example, some policies limit payment of benefits to 24 months if your disability is due to mental health problems, whereas Social Security does not discriminate between mental or physical limitations. Some policies may also require the claimant to obtain Social Security within a certain time frame or the claimant will lose entitlement to LTD benefits. In this case, winning a Social Security claim is very important. In addition, if the carrier terminates the benefits for any reason, however wrong, the claimant will still have a Social Security benefit to fall back on until you can obtain reinstatement of the LTD benefits.

4. The claimant will become eligible for Medicare after entitlement to Social Security Disability benefits for 24 months. If the claimant is uninsurable, this entitlement sometimes is more important than the monthly benefit amount from Social Security. In addition, if the claimant is receiving insurance under COBRA, the COBRA benefits will only last, at most, for 29 months following the COBRA entitlement. Therefore, after 29 months of COBRA, Medicare might be the only medical coverage you can obtain.

5. Entitlement to Social Security disability within the claimant's original eighteen (18) months of coverage under a COBRA insurance plan finding the individual disabled within the first 60 days of COBRA entitlement will allow the claimant to extend his/her COBRA coverage to twenty-nine (29) months.

6. The claimant's Social Security payments may be tax free depending on the claimant's other income, whereas, the claimant=s LTD benefits may be taxable, partially taxable or not taxable depending on who paid the premiums and whether they were paid with after tax dollars.

The application for Social Security raises some important considerations. *While it is generally the case that the claimant is better off applying for Social Security, many circumstances may prove to be an exception to the general rule.*

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Health insurance coverage and tax consequences must be examined. Furthermore, a Social Security application can be both a sword and a shield to both the claimant and the insurance company. An integrated plan must be made regarding when and how to apply for SSDI benefits.

The attorney must undertake a detailed case analysis to develop a strategy for decision making and pre-empt the expected review which will be employed by the carrier. The following is a list, in no specific order, based on this attorney's experience of the most often employed tactics/arguments by carriers which cause very legitimate claims to be denied and upheld following appeal:

- denial issued with no statement of the specific reasons for the denial
- changing basis for denial; follow the bouncing ball
- benefits are paid conditionally or with reservation of rights and threat of recovery against claimant
- assertion of requirements that appear no place in the policy-imposing new terms
- not disabled within the Elimination Period
- onset of disability did not occur while policy was in force
- "Not under the regular care of physician," or "wrong type of care" or "no in-person treatment"
- no "objective evidence of disability"
- "symptoms are merely self –reported" no objective evidence of the degree and frequency of the symptoms – OFTEN seen in MS cases
- condition is amenable to treatment and claimant is not compliant or can work with treatment, medications etc...
- prescription/pharmacy records "do not support amount of medication claimant reports taking" or "document that claimant averages X pills per day which would not cause symptoms alleged" or "do not document any changes in medications or dosages to support claimant's alleged worsening of condition"
- disable due to mental/ nervous and 24 month provision is invoked
- not a true disability, but a personality trait not amenable to treatment
- not disable from "own occupation" only disabled from job as they performed it
- can do all the "material duties" of occupation or job
- occupation or job "at time of disability" – claimant modified the occupation and kept working or just supervised and waited to file
- claimant was "dually employed as Y & Z" and can perform the material duties of occupation or job Z even though cannot perform Y

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- "misrepresentation by claimant" of income, job description or medical history or failure to disclose excessive disability coverage
- condition did not "first manifest" "while policy was in force"
- failure to provide "timely notice" of claim as specified
- review by their VE questions what are true "material duties of job or occupation," "what is job or occupation"
- review by their experts who question severity of symptoms, claimant's motivation, credibility or establish disability as of onset date that precludes benefits
- IME wrong specialty
- review by doctors who are given incomplete and limited information or asked only to answer specific, misleading questions
- claimant worked previously with impairment and no change in condition is supported by objective medical evidence in record
- denial issued without addressing all impairments or evidence in support of disability or on basis of wrong standard or standard not set out in policy
- denial based on spying: surveillance denials, claimant was seen or recorded...; visit by field representatives to claimant's home documented...; credit card charges showed frequent trips out of town (you can fly, you can work denial)
- SS games: client not found disabled by SS; client's SS decision states that most significant impairment is X and we only cover Z or coverage for X is limited to 24 months; non-examining, non-treating State Agency doctor agrees with assessment of insurance company; found disabled by SS but SS had different or incomplete information - not reliable determination.
- ERISA applies
- failure to exhaust administrative remedies
- improper jurisdiction or forum
- differential standard of review applies
- evidence documenting disability should not be considered because the court should consider only the evidence presented to plan administrator
- application defective

More than 100,000 disability claims are filled each year. That number is increasing by close to 20% yearly as are the millions of dollars spent on settlement and attorney's fees. In this complex, ever evolving, high stakes area, no one involved can afford not to have an up to date, in-depth understanding of the legal and medical issues. **Our power point presentation will guide you through *How to Prepare Your First Administrative Appeal*.****

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