

# DISABILITY CLAIMS SOLUTIONS CLIENT NEWSLETTER MEDICAL ADVOCACY AND DISABILITY

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## Medical Advocacy—Good and Bad

By Linda Nee, BA, HIA, ALHC, DIA, DHP, CPM

The focus of October's newsletter is the importance of clear, frequent, written reporting of medical restrictions and limitations to any claim for disability benefits. In my experience, there is no such thing as a paid disability claim without the submission of frequent written support of all treating physicians, therapists, and counselors. The importance and urgency of this issue can make the difference between a claim that is paid or one that is denied.

Physicians today will tell you openly their business is treating patients, not filling out paperwork. Physicians report to DCS that up to 30% of physician patients require the completion of some sort of disability paperwork. When you consider the possibility that one patient might have worker's compensation, social security AND private disability, it amazes me physicians bother at all.

And they frequently don't. When one considers private disability has become a legal battleground, some physicians refuse to take patients requiring paperwork. It's just not worth the legal hassle. Physicians don't want to get involved, and consider it a waste of their valuable time.

Unfortunately, in some cases disability insureds are left with physicians who 1) do not take the time to complete forms and clearly write what they intend; 2) refuse to "go on the fence" with a specific diagnosis and medical restrictions and limitations; and 3) just give in to the insurance company's demands when vexatious requests to release patients to return to work are received.

Lyme Disease is a perfect example of physicians who frequently avoid the issue of identifying Lyme as a specific cause for disability. In 2006-2007 Lyme Disease was publicly denounced by the CDC as a long-term disabling disease particularly in the absence of positive Western Blot or CD-57 testing. According to the CDC, patients diagnosed with Lyme are cured after reasonable trials of antibiotics.

The position of the CDC literally split physicians into three camps of medical opinion. Conservatives favor and support the position of the CDC while the younger and more progressive docs still claim it is possible for Lyme bacteria to remain in the body after long periods of time. Still, a third group of physicians waffle when it comes to supporting a Lyme diagnosis at all.

### DCS Successes for October (so far)

1. 2- Individual Disability Claims Approved - Monarch and The Hartford
2. 1-Unum Reassessment Overturn
3. 2- Payment of Benefits previously withheld.
4. 2- IME issues resolves and successfully done.

By the way, this is certain death to any disability claim – a physician who can't, or won't make up his mind about what's wrong with you.

Bottom line, without the continued support of primary care physicians there can be no compensable disability claim. Out-of-work claimants must become experts in obtaining and keeping track of office treatment notes, lab reports, MRI's etc. in order to provide the disability insurer with never ending requests for updated medical information.

Further, claimants must also not "fall out of treatment." Even when your primary care physician tells you, "there is nothing more I can do for you", it is still necessary to consult with the physician on a regular basis and be prepared to produce medical records proving "appropriate and on-going regular care." Without sufficient medical records, there can be no paid benefits.

To further complicate matters, most employer sponsored ERISA policies have a provision which requires claimants to submit updated medical information within 30 days of its being requested. Failure to do so can result in a claim denial. IDI insureds must also submit monthly medical data.

Medical advocacy, or the lack of it, is extremely important in filing a disability claim.

Insureds should always seek physicians who are qualified in the specialty of their impairment with the highest credentials they can afford.

### What NOT to Tell Your Doctor

Physicians document visits with you and create what are called “office treatment notes (OVNs)” or simply “patient records.” This means anything said during an office consultation can potentially wind up in your patient file. Disability insurers have access to patient files (if you sign the required authorization) and therefore what you say to your doctor can be used to determine eligibility for disability benefits.

The number one most frequently used comment in patient files to deny a disability claim is **“Patient told me he is looking to retire and wants disability.”** Personally, I can understand the context of this statement, but in reality disability and retirement are two different things. Applications for disability benefits under the terms of a policy should never be used for retirement purposes. If the statement makes it into patient records, the insurance company will claim secondary gain issues. This is particularly relevant for IDI insureds.

Admittedly, the Internet is a great resource, but unfortunately some claimants spend a great deal of time researching their symptoms and then they tell their doctors what they have - a form of self-diagnosis. Unfortunately, some doctors take the path of least resistance and accept the patient’s diagnosis without any justification other than, **“my doctor told me 10 years ago I had Chronic Fatigue”**, or, **“I’ve suffered with fibromyalgia for the last 18 years”**, or, **“I have brain fog so it must be fibromyalgia”** etc.

Diagnoses based strictly on patient manipulation never work for disability, or if they do not for very long. It is extremely important to **allow the physician to make the final determination** for disability from his/her patient history and clinical treatment of you. Comments documented in patient records such as “patient claims she has chronic fatigue”, and “diagnosis is based on patient’s own self-report” are not credible in supporting a medical disability. **Patient self-diagnosis** is a definite future claim denial!

Proof of regular and on-going care does not include **“call-in office visits.”** Patient records containing an excess of telephone consultations are considered a “red flag”. Phone calls to request prescription refills are ok, but there are no substitutes for in-house office visits and consultative sessions.

Finally, if you have a claim for disability be honest with your physician and don’t be overly optimistic about how you feel. If you don’t feel well, don’t say that you do. Many disability claims have been denied because of the comment **“patient says he is doing much better!”**



For claimants who have taken cardiac stress tests, exercise capacity is frequently reported in metabolic equivalents of task (METs). METs indicate units equivalent to the use of oxygen while sitting. An exercise capacity of 5 METs or less is generally associated with a poor prognosis in patients younger than 65. METs are frequently used by disability insurers as proof of physical work capacity.

**Just a reminder - the DCS office closes at 5 p.m. EST. If you are in a different time zone and need to get in touch with me after 5 p.m., please send an email to let me know you have an urgent matter to discuss that cannot wait until the next day. I'll get right back.**

**Thanks!**

### Objective Medical Evidence Standard

**Objective medical evidence is by definition any test, x-ray, imaging, lab report, or proof, relied upon by your doctor, in rendering a final diagnosis and assessment of disease.**

The problem is that for many types of disease, there are no known medically accepted “objective tests” which prove you have what your doctor says you have. For diseases such as fibromyalgia and chronic pain, a “clinical diagnosis” is made by the physician based on your medical history and his/her previous treatment and consultation with you. To some extent the physician relies on how you describe your symptoms; therefore, in part, the diagnosis of chronic pain, for example, is based entirely on what YOU tell your physician.

Disability insurers have a big problem paying on claims for which a “clinical diagnosis” has been made because there is no medical proof of your symptoms other than what you report to your doctor yourself, or your doctor’s expertise in assessing clinical patient history.

In addition, the insurance company assumes your physician advocates for you and your disability by exaggerating restrictions and limitations to support your disability rather than releasing you to return to work in some capacity. Although there is some truth to the fact that physicians advocate disability for their patients, there is also some truth in the fact that for some types of disease, “clinical diagnoses” are medically accepted by the medical community and CDC.

Interestingly, most disability policies do not require the application of the “objective evidence standard” as proof of disability. This standard is adopted for internal review by the disability insurer because it is advantageous for them to do so, and results in the denial of more claims.

Look through your records and notice how many times “objective evidence” may be mentioned in letters and communications. You may be a bit surprised.

## **Medical Evidence as Proof of Claim and Why Claims are Denied**

Sue Ellen has been receiving monthly disability payments from Prudential for the last 18 months. The insurance company requested an “updated medical report” from her physician, Dr. Robinson. On the Attending Physician’s Statement, Dr. Robinson wrote on the form in the box asking for “Restrictions and Limitations”,

“Patient is totally and permanently disabled.”

Prudential’s claims specialist was somewhat miffed when she received the APS back from Dr. Robinson. In order to pay Sue Ellen’s claim beyond 24 months, she needed to confirm “medical restrictions and limitations precluding work capacity.” Dr. Robinson was sent a second request asking specifically for medical restrictions and limitations. Dr. Robinson responded,

“Patient is totally and permanently disabled.”

This time Prudential’s claims specialist sent Dr. Robinson a faxed narrative (third request) asking for specific restrictions and limitations “describing why your patient cannot work.” Dr. Robinson responded,

“ In my opinion patient cannot work as she is totally and permanently disabled.”

Two weeks later Prudential denied Sue Ellen’s claim with the statement,

“There is no (objective) medical evidence to support restrictions and limitations which are precluding you from returning to work in your own, or another occupation.”

I can’t tell you how many times this same scenario has happened to claimants insured by companies such as Unum, Aetna, Reliance Standard, Prudential, and The Hartford. It’s like clock work! Doctor’s Response = Claim Denial. This is, without a doubt, an unfortunate miscommunication between a treating physician and the insurance company. There is also another problem with this type of response.

The “Definition of Disability” in any policy consists of two parts: 1) you are not able to perform the material and substantial duties of your occupation, and 2) you are receiving treatment from a qualified physician. Therefore, the two parts to compensable disability are your occupation, and your medical condition. In order for the insurance company to approve benefits and pay your claim, it must be provided with “medical restrictions and limitations” describing why you can’t work in either your own occupation, or any occupation in which you have training, education, or experience.

In other words, your physicians must “connect the dots” between your medical restrictions and limitations and your job or occupation. Without these two components, the insurance company may not pay your claim. The insurance company JUST WON’T GET IT. And, after asking for the information several times, a claim denial is almost certain.

Here are several suggestions if you are just starting the disability claim process, or you have been asked to provide medical updates to your insurance company. DCS clients have some help in this regard, but for those of you who are not a current client you may benefit from the information as well.

1. Find physicians who are willing to complete disability forms for you on a regular basis. If your doctor frowns every time you bring in a disability form, chances are he’s not going to take the time to communicate what he means. In order for your claim to be paid you need physicians who are willing to complete forms. Find them. They’re out there. Physical Therapists and Pain Management professionals typically do not fill out disability forms. Move on.
2. Provide your doctor with a copy of your job description. Physicians are not mind readers and often do not have the time to query you about your job. Physicians often do not know how important your job duties are to writing good restrictions and limitations. Many insurance forms now ask the physician if they’ve reviewed information about your job. Make sure your physician “connects the dots” between your job or occupational duties and why you can’t do them. If he/she does not do this the insurance company will keep making vexatious requests for information.
3. Be open and honest with your doctor about why you can’t work and discuss your disability claim with all of your physicians. If it looks as though the physicians are not going to be supportive.....find other doctors. Your disability claim won’t be paid for long if your physician: 1) expresses his distaste for filling out forms 2) gives the forms to his business manager to fill out, or 3) rushes through them during an office visit. Sometimes physicians charge an extra fee for completing forms. This is well worth the extra cost.
4. Tell your doctor how important it will be for him/her to communicate accurately and completely about your reasons for not being able to work, as well as his treatment plan.

5. Don't let the insurance company request "office treatment notes" directly from your physicians. Always ask your physicians to notify you when they get requests for patient notes, and obtain them yourself. Make a copy before sending to the insurance company. This way, you know what the insurance company has and does not have for records.
6. If you have lost access to all health care and can't afford treatment, seek assistance from your local hospital or Human Resources Department. Most hospitals offer free-clinics and low cost medical care to those who have no other access to treatment. Apply for Medicaid in your state. If you qualify, your medical costs can be significantly covered. Always ask for help. Unfortunately, I've seen cases where claimants are forced to stop seeking treatment and lose their disability claim because of lack of medical documentation and treatment. Keep seeking assistance until you find the medical help you need to substantiate your claim for benefits including making application for Social Security Disability Income benefits.
7. Your disability specialist will most likely call to ask you about your medical condition. Questions about your restrictions and limitations are best deferred to your physicians. Don't try to answer medical questions you don't know the answer to. Do you know the difference between a restriction and a limitation? If not, you shouldn't try to answer the question when your disability insurer asks. Defer to people who know.
8. Ask your physicians up front how they intend to handle requests for information and updates from your insurance company. Some doctors are now asking insurance companies to submit their inquiries in writing. This is the method we prefer at DCS. Insurance companies often do not accurately document doc-to-doc calls to physicians.
9. Do not sign open-ended Authorizations to obtain medical information. At DCS we have physician specific authorizations which preserve records as Protected Health Information ("PHI") under HIPAA. This is especially true for mental health records.

### **Editorial from your Consultant**

We hope our focus on medical documentation and its importance to any disability claim has been helpful to you. The bottom line here is that there is no such thing as a compensable disability claim without proof of documented regular and on-going medical treatment by a qualified physician.

I know people hate it when I tell them disability policies are two party contracts – the insured has some rights, AND the disability insurer has some rights. Access to, and the right to obtain updated medical information is a right given to all disability insurers under the terms of the policy. In order to receive monthly benefits under the policy all insureds have an obligation to remain in regular and appropriate care and submit proof of that care when requested to do so.

Having said that, DCS prefers that we, or our clients maintain control of the process rather than allowing the disability insurer to chase down patient medical records, or have doc-to-doc calls with treating physicians. Disability insurers frequently do not accurately document phone calls with physicians.

On occasion, clients who come to DCS have often "dropped out of medical care", or are in consultation with inappropriate specialists relative to the claimed disability. It is extremely important for the insured to manage their medical care, not only for their general health and well being, but also to meet the conditions contained in their disability policy and avoid future financial challenges.

If you take anything with you from the October issue of our newsletter, it should be that medical documentation of a claimed disability is essential to any compensable disability claim. Insureds need to seek out primary care physicians who are willing to take the time to fully diagnose and document on-going treatment. Physicians who cannot, or won't make a clear diagnosis cannot be used for disability purposes. Move on. Find other doctors.

As always, if you have any questions concerning this topic, please feel free to contact us. I'm planning a special edition of the newsletter addressing social security, offsets and repayments – a tall subject, so stay tuned. Linda