Disability Claims Solutions Client Newsletter Employee and Insured Protections

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Disability Claims Solutions, 60 Hicks Rd, West Newfield, ME 04095
http://www.disabilityclaimssolutions.com lindanee@metrocast.net
(207) 793-4593 Fax (207) 793-2006

Protected by *What?*

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

On occasion, individual insureds and claimants are so concerned with the complex process of applying for disability that federal protections from The Family & Medical Leave Act (FMLA), Americans with Disabilities Act (ADA) and Worker's Compensation (WC) are lost in the maze of paperwork and employer demands to "fill this out" and "fill that out."

Even when the employer-provided FMLA forms are handed to an employee requesting leave, it is doubtful most really understand what protection he/she actually has, or more specifically the limitations of any *presumed* protection.

Therefore, I thought it might be a good idea to hit the highlights of FMLA, ADA, and Worker's Compensation in this issue of the DCS Newsletter. With the exception of Worker's Comp, most attorneys I've spoken to afford little to no protection from the ADA and FMLA.

To illustrate, ADA laws require employers to make "reasonable accommodations" for disabled workers, but also allows employers to decide what "reasonable" means. Frankly, in my experience most employers fail to "knock themselves out" accommodating an employee who returns to work after a lengthy LTD claim. In reality most ADA litigation is less than successful and attorneys avoid ADA litigation except for unusual circumstances, and "a hell of a good case."

On the other hand, I find our legal system doesn't push hard enough on employers to commit to FMLA. Nevertheless, most employers in today's workforce have integrated sick leave plans and short-term disability with FMLA. Of course, its to their advantage to do so since once an employee's sick leave and 12 weeks of FMLA are exhausted, the employer can then terminate the employee and stop paying all benefits – including health insurance. All this with the government's blessing.

In the past, many employers continued to pay life and health premiums for employees out on disability from 6-12 months. Now FMLA allows employers to terminate the employee and their benefits after only 12 weeks. What a deal!

Humor.....Acronyms- The Latest

BHNC (Big Hat No Cattle) Cowboy parlance for someone who is all talk and no action.

MEGO (My Eyes Glazed Over) A sign of extreme boredom.

PURE (Previously Undiscovered Recruiting Error) A new employee who isn't working out as well as expected. Looked good on paper, though.

WIIFM (What's In It For Me?) Used by PR people, but typical for today's ethics behavior.

On the other hand Workers Compensation laws are designed to ensure employees who are injured or disabled on the job are provided with fixed monetary awards, eliminating the need for litigation. Like ERISA, Workers Comp laws often have one intent, with completely opposite results.

It is now more normal for Workers Compensation claims/settlements to go court after long battles with IMEs and local appeal boards. About half of the states do not allow laypersons to represent claimants and attorney fees are either limited by statute or become liens against awards. In California, for example, laypersons are allowed to represent claimants, but are not allowed to collect a fee for representation. Clearly, persons injured on the job are afforded little to no representation or support.

"So what's the big deal?", you might ask. Well, a DCS client was recently forced out on disability by a state university because the so-called ADA Committee decided they would no longer "accommodate" the employee's part-time job. Another physician client's employer filed a Worker's Comp claim on behalf of the employee knowing full well the doc was insured under a non-occupation STD policy which does not pay benefits when a WC claim is filed. Still, another new client was not asked to file for FMLA and was terminated after 4 weeks.

Given the environment in which disabled persons are forced to manage disability claims these days, little protection is better than no protection. Disability Claims Solutions believes that knowledge is power when it comes to protecting rights under the terms of any disability policy as well as other protections afforded under the law.

Know your rights and stay on top to prevent hitting rock bottom during a period of unexpected disability.

Workers' Compensation – Then and Now

Wally Stringer was a 23-year old cinder block worker at a local block company in St. Louis, Missouri. On May 8, 1930, he lost his footing and fell into the heavy machinery severing his right arm above the brachial region and also suffered a compound fracture of the left leg with extensive rupturing of the muscles and nerve damage to the left crural region.

Upon admission, Mr. Stringer was immediately taken to emergency surgery where he sustained amputation of the right arm, permanent loss of the use of the right leg distal to the knee. He also sustained permanent partial loss of bowel function.

The Missouri Workers' Compensation Commission determined Wally's worker status to be permanent partial disability (PPD) and awarded him payment of 66 2/3% of his average wage. He was paid $23.07 per week for a maximum of 400 weeks, or $6,152. Wally appealed the decision, although the workers' compensation court ruled in denial of additional funds or medical care stating that the injured worker was subsequently engaged in gainful employment. (the selling of eggs)

In evaluating this case in today's terms, Wally would have received comprehensive adult and rehabilitative care. He would have received care from a team of physician specialists, including a general surgeon, an orthopedic surgeon, a vascular surgeon, a gastroenterologist, a proctologist, a psychiatrist and potentially a physiatrist.

He could also have been assigned to a physical therapist and may even have received orthotics and prosthetics, DME equipment, ambulation aids, assistive living devices, home modifications, bath assists, compression therapy, skin integrity surfaces, and adaptive driving equipment. Finally, he would have been a candidate for vocational testing, employment evaluation, retraining and ergonomic restructuring for potential reemployment at the cinder block company.

The Workers' Compensation representative who evaluated this case study would like for you to know the case "clearly demonstrates that while the current health care system is often convoluted, expensive and duplicative, it has dramatically improved in 80 years." This patient survived in spite of the health care system of 1930, not because of it. One could probably say the same about today, wouldn't you think?

Disability benefits are taxable to the extent the employer pays the premium. If you have an IDI policy and paid 100% of the premium, then your benefits are not taxable. However, if your employer paid the premium, or if you paid the premium with before-tax dollars, your benefits are wholly taxable. If your employer paid 60% of the premium and you paid 40% by payroll deduction, then your benefits are 60% taxable. It's that time of year again!

What is FMLA?

The Family & Medical Leave Act (FMLA allows individuals who have been employed for at least 12 months (and worked at least 1,250 hours) to take unpaid leave of up to 12 weeks in any 12 month period for the birth or adoption of a child, to care for a family member, or if the employee themselves has a serious health condition. You are an "eligible" worker if your employer employs 50 or more employees within 75 miles of the worksite. The 12 months of employment do not need to be consecutive. Also, full-time teachers are eligible for FMLA even though they might not work 1,250 hours in a year.

Under FMLA, the employee is entitled to have their benefits maintained, but any premiums usually paid by the employee must also be paid during the leave. The employee also has the right to return to the same or equivalent position, pay, and benefits at the conclusion of the leave.

An employer is allowed to ask the employee periodically to report their intentions to return to work. If an employee informs the employer they do not intend to return to work, the employer may immediately terminate the employee and end the FMLA.

In order to be eligible for FMLA, the employee must have a condition that causes him/her to be unable to perform their essential job function. Ordinary illnesses do not qualify for FMLA such as the common cold, flu, ear aches, upset stomach, headaches and routine denial care. Substance abuse is covered, but only if the employee is seeking treatment.

Every employer covered by FMLA must post and keep posted a notice outlining the Act's provision.

When Enough "Proof of Claim" Still Isn't Enough.....And Why..... Editorial by Linda Nee

Disability Claims Solutions supports the notion that our client insureds have a duty to submit any proof of loss clearly required by policy provisions as proof of claim. In the 960 Series Individual Disability Income Policy issued by The Paul Revere Life Insurance Company (and managed by Unum Group), it states the following:

"**WRITTEN PROOF OF LOSS**"

Written proof of loss must be sent to Us within 90 days after the end of a period for which You are claiming benefits. If that is not reasonably possible, Your claim will not be affected. But, unless you are legally incapacitated, written proof must be given within one year.

We can also require reasonable proof from You of Your:
a. Prior Earnings; and
b. Monthly Earnings for the month for which Disability is claimed.

This may include personal and business tax returns, financial statements, accountant's statement or other proof acceptable to Us. We can have an audit performed as often as is reasonably required while Your claim is continuing. Such an audit will be at Our expense."

While no one disputes the insured's duty to provide proof of earnings information, P&Ls, and expense summaries, the above provision does not require the insured to specifically submit detailed proof of material and substantial duties. The policy simply says, "**Your Occupation**" means the occupation in which You are regularly engaged at the time You become Disabled."

The problem is that the above provision haunts the insured with wording "other proof acceptable to Us" which gives Unum complete authority to decide what is, and what isn't "acceptable" as proof of claim. The above policy wording is a death march since it gives "discretionary authority" to Unum and its claims managers to decide what it needs to establish eligibility for benefits. Of course, we all know what happens when the fox sits comfortably in a hen house. Let me give you a few examples.

Recently, Unum used the above policy wording "other proof acceptable to Us" to claim the insured must meet with a field representative even when the policy contains no specific provision requiring the insured to do that. Another Unum representative (different client) used the same policy provision to defend sending out a field representative to go into a client physician's office, download CPT codes and have complete access to the physicians patient and billing records. On this one, we said, "Enough is Enough!" What about HIPAA and Protected Health Information ("PHI)? Confidentiality? Patient Privacy?

A Unum claim manager also recently demanded a physician provide her with all their payroll records including dates of hire of all past and present employees. At this point I asked her if Unum HR would be able to provide me with all of the payroll records of her staff. She said she didn't think so.

Unum also interprets the "other proof acceptable to Us" wording to force physicians and dentists to provide CPT and ADA codes broken down by month, on an Excel Spreadsheet with specific headings, and in a Unum designed format. Unum informs the physician they MUST submit the information in this format so that "resources" can adequately interpret the information. Some physicians and dentists can access their CPT or ADA codes this way, others can't, but that's not the point.

One computer system administrator told me the physician would need to spend an additional $15,000 to upgrade his patient billing system in order to be able to provide CPT codes in a format demanded by Unum. When DCS informed Unum our physician couldn't provide what he didn't have, Unum threatened to send out a field representative to "get the information for us" from the physician's computer. This is when *I* said, "I don't think so." The claims representative immediately responded, "But, we are entitled to "other proof acceptable to Us."

Yes, it is a decisive victory when state insurance regulators invalidate or outlaw discretionary clauses, finding such provisions also violate specific state insurance laws. We applaud those changes. However, who's watching the battlefield of endless indoctrinated Unum claims representatives and managers when they continually make out-of-contract demands which are, to use one of their terms, *overly burdensome* to the insured.

Now that the fiasco of the multistate reassessment has ended, and Unum is informing federal and state regulators "they're the good guys now", it appears to me litigating attorneys are dropping the ball by not challenging Unum's persistent out-of-contract requests as they have in the past. Out-of-contract conduct is basically a "breach of contract", and as far as I know, still against the law.

Litigating attorneys need to take "second looks" at claims review abuse and out-of-contract demands. For example, the above provision actually requires the insured to submit proof of loss within 90 days, but then states, "If that is not reasonably possible, Your claim will not be affected." How is it possible then, for Unum to claim the insured "prejudiced" its investigation and deny the claim after 90 days? The provision says, "Your claim will not be affected", but most Unum representatives will include the standard legal "prejudice" wording after 90 days. *Why?*

Again, while no one disputes the insured's duty to provide proof of loss as it is written in the disability policy, it is also unreasonable for Unum to demand information "acceptable to Us" and engage in out-of-contract underwriting in order to establish eligibility for benefits. Either it's in the contract policy, or it isn't.

We are of the opinion IDI insureds are not required to obtain, create, purchase, or otherwise pay for proof of loss requests which are clearly being made outside of policy provisions. Unum, and other disability insurers need to be challenged to the point where they are forced to adjudicate policy provisions as they are written, not "make them up as you go along." In point of fact, contracts "say themselves" and therefore the wording of such should be enforced as it is written in the contract policy.

Unum and other disability insurers like to play the numbers – it's profitable. While it is probable Unum's management no longer supports sanitizing claim files, it is the observation of this consultant that under new leadership the company re-manoeuvered its claims review strategies directing "interpretations" of policy provisions – a much more difficult situation to win in court. *And who can fight a breach of contract in the rank and file process of making application for benefits?*

In my book when an organization waddles like a duck, quacks like a duck, and acts like a duck, it IS a duck. Unum certainly isn't "one of the good guys", they've only become smarter, and a bit more clever at requiring more and more "proof of claim" in an effort to withhold and/or delay otherwise compensable claims. Requiring the insured to submit proof of claim he/she never had access to, or never had, or has to pay money to get is no doubt a very profitable strategy. However, DCS continues to maintain our position that insureds are required to submit "proof of loss" as it is written in the contract policy – nothing more and nothing less. In those states where discretionary provisions are still in effect, we maintain the "proof acceptable to us" should be reasonable and relative in importance to the claim decision. Anything outside of these parameters is an illegal breach of contract.