

# DISABILITY CLAIMS SOLUTIONS CLIENT NEWSLETTER PHYSICIAN'S EDITION

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## Primary Care Physicians – Salute!

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

Although treating physicians are crucial to the disability claims process most doctors view the tedious and often burdensome task of filling out disability forms as a waste of their valuable time. That's not to say that physicians do not try to communicate their recommendations, but in a busy environment of patient care and hospital rounds there is often little time to be thorough and do a good job. As a result, disability forms are most often handed off to office managers who know less about writing medical restrictions and limitations than do the actual physicians. This is a claim denial waiting to happen!

Primarily, physicians are in the business of patient care, not filling out disability forms. Potentially, one patient can present three different groups of forms for certification: private disability, workers compensation and/or social security. In addition, from the physician's perspective vexatious calls from patient insurance companies is a waste of staff, time, and office overhead.

The fact that physicians continue to allow themselves to be harassed by disability insurers is indeed amazing. As far as I'm able to discern approximately 30-40 percent of physician's practices can consist of patients with some sort of disability paper requirement. No wonder actual office notes are short and non-descriptive since physicians may spend half of an office visit filling out a disability form!

One primary care physician recently remarked to me, "If I'd known Patient X was going to be such a bother I never would have taken her on as a patient!" This comment came as the result of a psychiatrist receiving one of Unum's 10 page Psychiatric Assessment forms to complete. My response was, "Make sure you bill Unum a completion fee for the form in addition to your normal hourly rate." Still, Unum doesn't get the message.

Disability insurers can actually "wear down" a treating physician by contacting him/her frequently in writing or by phone. Sometimes, physicians will actually become so fatigued and frustrated with insurance calls they will release the patient to work by agreeing with the disability insurer, just to get the insurer to go away and not call the office anymore. Other physicians tell their patients to find treatment elsewhere when the burden of paperwork goes over the top. Sometimes, it's just not worth the hassle to the physician.

### Assignment of Proper ICD-9 Codes

Most disability forms ask for properly assigned ICD-9 codes. The only way to accurately communicate actual diagnoses for the patient is to provide an ICD-9 code assignment for both Primary and Secondary causes of disability. Since most physicians won't know the ICD-9 classification from memory, the disability form may require asking the office manager to provide the codes from billing or patient software. For therapist and psychiatrists a complete Axis I-V assignment from the DSM-IV is crucial to reporting R&Ls for mental patients. ICD-9 code assignment is one of the many variables used in determining financial reserves.

In recent years physicians have also been sending patients packing when it becomes apparent they may be called to testify in a deposition, or become a patient witness in a lawsuit. Doctors prefer the parties to "play nice", but that's not always possible when it comes to disability claims. Physicians generally do not like to be challenged on the witness stand unless they're in the business of giving expert testimony. Who does?

Another area of frustration for physicians is that even when they do a great job communicating restrictions and limitations for patients, the disability insurer completely disregards their opinions and denies the claim anyway. This has got to be one of the most frustrating aspects of patient care for physicians. Imagine, an eminently qualified specialist in his field supposedly topped by an insurance paid Internist with no clinical history with the patient. I understand completely why physicians quickly become frustrated with the disability claims process.

Finally, there's the long list of doctors who work for the defense (the insurance company) as IME physicians and write documentation in favor of claim denials. This places patient primary care physicians in a position of having to defend their original evaluation when in reality the insurance IME will be the deciding factor as to whether the patient can work or not. Patients often come back to their physicians crying and pleading for help when insurance IME physicians "rubber stamp" denial decisions already made by business interests. What a mess.

Therefore, this issue is about the many, many loyal and enduring physicians who continue to provide medical restrictions and limitations to disability insurers on behalf of patients. They are truly – the good guys.

## ***“The Treating Physician Rule” – A Disaster for ERISA Claims***

*Originally, the “treating physician rule” was developed by the Court of Appeals as a means of controlling disability determinations by administrative law judges under the Social Security Act. Simply put, the rule stated the following:*

*“ When the patient’s health is in question, an insurer should give greater weight to the opinion of a physician who has examined the patient than to the opinion of a physician who has not examined the patient and whose opinion is based solely on a review of the examining physician’s notes or reports. “*

*However, in May 2003, in a much anticipated Supreme Court Decision (Black & Decker Disability Plan v. Nord, No. 02-469, 2003 WL 21210418) the court held that plan administrators need not accord special deference to the opinions of claimants’ treating physicians.*

*This decision is significant in that it lays to rest any notion that the “treating physician rule” be incorporated into ERISA. The Supreme Court unanimously held that plan administrators are not obliged to accord special weight to the opinions of treating physicians, and while the insurance company may not arbitrarily refuse to consider a claimant’s reliable evidence, they do not have a duty of explanation when insurance credible evidence conflicts with that of a treating physician.*

*This decision represented a decided blow to ERISA claimants since STD/LTD policies already contained unfair “discretionary clauses” giving Plan Administrators full discretion to administer and review claims as they saw fit. While ERISA statutes require “full and fair” review of claims including full disclosure and communication of the ‘specific reasons’ for benefit denials, the statutes do not require Plan Administrators to give more weight to the opinions of treating physicians over other evidence obtained by the disability insurer (such as IMEs).*

*Not surprisingly, after the Ninth Circuit decision disability insurers quickly moved away from requiring a “consensus of medical opinion” to using “just their opinion” in making disability claim decisions, particularly in the ERISA group. Hundreds of on-staff insurance physician consultants were hired by disability insurers for the purpose of “rubber stamping” claims denials previously approved by internal business managers. After all, if the denial looks good on paper, it will probably withstand an*



Physicians do not have to participate in doc-to-doc calls from representatives of insurance companies. Simply tell the insurance company it is your policy to answer questions submitted to you in writing. This way your responses won’t be misinterpreted or documented and a clear record can be produced. In general, it is not a good idea for physicians to give phone interviews to disability insurers.

*an ERISA appeal. Money well spent.*

*If primary care physicians ever wondered how an insurance company can get away with completely disregarding their opinions concerning the treatment and care of patients, this is it – the disability insurer is under no lawful duty to place more weight on medical opinions obtained as a result of actual physical examination, consultation, or clinical history. Although attorneys and consultants continue to argue the “reasonableness” of the treating physician rule, the courts have no license to order the application of a treating physician rule to employee benefit claims made under ERISA.*

*The vacating of the “treating physician’s rule in combination with “discretionary clauses” allows any disability insurer to determine, define, and implement what it determines to be “full and fair” assessment of claims. In a nutshell.....the claimant doesn’t have a chance!*

*It is interesting the justification of vacating the “treating physician rule” was that the Supreme Court felt...” ERISA was best serviced by preserving the flexible claims processing consistent with prudent administration.” Of course, who determines what is “prudent administration?” The disability insurer, of course. There’s that fox in the hen house again!*

*Therefore, from a treating physician’s perspective “what’s the point?” A physician might say, “It doesn’t make any difference if I spend 10 minutes or two hours filling out my patient’s forms. My opinions won’t be considered anyway.”*

*But, all is not lost. There is a point with a preponderance of medical evidence provided by the claimant suggesting the disability insurer is abusing their contract discretion by denying a claim in an arbitrary and capricious manner. Many ERISA cases are won using this very important defense on behalf of the claimant.*

*Admittedly though, it’s frustrating for physicians to continually be disregarded by insurance physician consultants who have no clinical history with the patient.*

## **The Golden Rule- Writing Clear Medical Restrictions and Limitations For Patients**

### **Editorial by Linda Nee**

All disability insurers review eligibility for benefits by evaluating medical “restrictions and limitations.” (R&Ls) By definition, “restrictions” are those work duties the insured may not ever do, and “limitations” are work duties the insured may perform, but only to a limited extent. The key phrase in this definition is “work duties” since all disability restrictions and limitations represent qualifications, and or limitations relating to actual material and substantial duties, or regular occupational tasks. Therefore, it is impossible for a physician to write accurate R&Ls without reviewing the patient’s Job Description or having specific knowledge of actual work duties performed. Restrictions and Limitations must always relate to actual job duties.

I wish I had a dollar for every time I’ve read R&Ls stating, “Patient is totally disabled.” Although this statement indicates the patient’s condition relative to maximum medical improvement (MMI), the statement is not useful in describing why the patient can’t perform certain occupational tasks for medical reasons. For example, if an Administrative Assistant is diagnosed with Carpal Tunnel, medical restrictions may be written, **“Patient is restricted from repetitive keyboarding and use of right and left fingers, hands and wrists for fine manipulation and repetitive function.”** On the other hand the physician may decide to just limit the patient by writing, **“Patient is limited to repetitive keyboarding not > 10-15 minutes with frequent intermittent breaks of hands and fingers. Patient is further limited in her ability to lift > 5 lbs. occasionally.”** Restrictions, therefore by definition are specific work tasks the patient may never do, and limitations are work tasks the patient may do, but only to a limited extent. **“ It is impossible to write clear and effective Restrictions and Limitations for disability purposes without knowledge of the patient’s actual work or occupational duties. Physicians should ask for a copy of the patient’s job description before filling out forms.**

The task of reporting clear and specific R&Ls for mental and nervous disorders is much more complicated since therapists and mental health providers should always communicate to the insurer: 1) both primary and secondary diagnoses from the DSM-IV, 2) Axis I-V diagnoses and 3) a current global assessment of functioning (GAF score) and GAF within the last year. Insurance companies are not able to assess the extent of mental and nervous disability without the above in addition to specific restrictions and limitations. The rules are the same as above in writing good, clear R&Ls from therapy notes and sessions.

Due to changes in HIPAA regulations, most mental health providers do not provide copies of actual psychotherapy notes to outside third-parties such as insurance companies. In fact, DCS strongly recommends the insured protect actual psychotherapy notes as Protected Health Information (“PHI”) allowed under HIPAA. Still, disability insurers will harass mental health providers for actual psychotherapy notes in an effort to engage in what is called “snatching”. The practice of “snatching” is when an insurance medical resource (RN or physician) selectively chooses to interpret or “snatch” key phrases commonly found in therapy notes ( or office notes) favorable to the insurance company at the expense of ignoring all else written favorable to the insured.

For example, a typical psychotherapy note might say, “Patient presents today and appears to be much better. We talked about her going back to work at some point and she told me she could probably try right now. Upon further examination and discussion, however, patient became very tearful and experienced a panic attack. Started patient on trial of Paxil in combination with previous Xanax. Will see patient in two weeks.” **Surprisingly, the insurance company will say this note indicates the insured is able to return to work and will actually quote the office note “she could probably try right now” in the denial letter.** Actually, this office note indicates the insured is still having panic attacks and is still receiving bi-monthly care. This is the primary reason why psychotherapy notes should never be released to any disability insurer. Disability insurers “snatch” what they need to support a denial, and ignore everything else.

The best way for mental health providers to communicate with a disability insurer on behalf of a patient is to complete the rather lengthy Psychiatric Assessment Form provided, and charge the insurance company an appropriate fee.

Physicians are also frequently contacted by the disability insurer to give telephone interviews called doc-to-doc calls. The insurance company arranges a date and time for a telephone call with the insured's physician. **Doc-to-doc calls have a very specific intended purpose – to convince, coerce and persuade Attending Physicians to accept the opinion of the insurance company that the insured can be immediately returned to work.** After the phone interview, the disability insurer usually follows-up with a “this-is-what-we-discussed” letter and the AP is asked to sign if he/she agrees to the written assessment of the conversation.

The problem with this strategy is that when the fax or letter arrives, the Attending Physician is otherwise engaged in his/her busy office, neglects to read the letter in its entirety, endorses the letter and sends it back to the insurance company. I have read perhaps a thousand or so of these so-called “confirmation letters”, and guess what? Very rarely do they accurately document the assessment, words, or recommendations given by the treating physician on a doc-to-doc call. Some physicians don't even realize they've released their patient to work until the patient arrives in the office completely in tears. When this happens the physician cannot “explain it away” and the damage is impossible to repair.

**This is an area in which treating physicians really need to be careful.** The only way to be absolutely clear in communicating with a disability insurer is to insist all questions be submitted to the physician in writing. This way, the physician AND the patient are protected from insurance “snatching” or interpretations of what a “physician really means” in recommending disability or communicating full or part-time return to work. It should be noted by physicians that all of the above are deliberate strategies on behalf of disability insurers and do not occur by accident. It's by deliberate design that Unum hires on-staff physicians who can communicate to management how best to “get over on” other physicians.

Finally, the old adage about “can't read physician's writing” is also used to the advantage of the disability insurer. Unum Life, for example, used to do the right thing and return illegible office notes to the physician for transcribing. At least a reasonable effort was made to completely understand what the office notes said before making a liability determination on the claim. But alas, UnumProvident's position was, “well, we asked for the notes, but we couldn't read them, so we're going to deny the claim anyway.” Many denial letters actually say, “your physician's notes were not readable therefore we have no alternative but to deny your claim for failure to provide proof of claim.” Unum Group follows the UnumProvident philosophy.

It is very important, then, that physician notes can at least be read by any outside person. I realize some physicians are very territorial about their office notes and use symbols and abbreviations known only to them. The off-shoot of that is that the notes won't be useful to a patient and the business manager may have to dedicate some time to deciphering if requested by the insurance company. End result? The patient will present in tears telling the physician his/her claim was denied because the insurance company couldn't read the office notes. Here we go again.....a situation nearly impossible to reverse.

Writing medical restrictions and limitations for private insurance is very different from certifying a percentage of total body disability such as Workers' Comp physicians do. Unfortunately, private disability insurers can't use a “25% total body disability rating” since private benefits are not based on percentage certifications. It's not useful information.

Whether physicians want to participate in the system of medical disability claim review or not, the reality is, they ARE part of the system and are greatly depended upon to communicate R&Ls to insurance companies. If this task is not done well, the result is an unfair claim denial to a patient who is already ill and not feeling their best. The results can be devastating. What is particularly bad is that once a physician submits inaccurate statements or incomplete recommendations to a disability insurer, there is no opportunity for rehabilitation. The physician can talk himself until he is blue in the face, but the disability insurer will always ask the question, “why are you changing your mind now?” It just doesn't work. Patient restrictions and limitations need to be written thoroughly and accurately first time around. All patients truly appreciate a physician who takes the time to do a good job with disability forms.