Translating disability insurance issues for the treating doctor

An otherwise supportive treating physician can become a real liability to his patient when he does not understand how the insurer will try to use him as a pawn to deny benefits

By Rebecca Grey

A very sick young man contacted my office. He'd had a back fusion which failed, and he was on a raft of narcotic pain medications. His back condition was exacerbated by an arthritic knee, which made walking difficult and which made his back condition snowball. As much as he wanted to, there was no way he could perform his job as a bank vice president. Unfortunately, a rushed and misguided doctor who had been contacted by his disability insurance company ruined his chance for the benefits he clearly deserved by completing a form which said he was capable of "sedentary work" even though the physician agreed he could never work full-time in any real-world job for which he was qualified.

Another potential client's surgeon was so confident he could correct his patient's foot injury that even though she was too disabled to bear weight on the foot, he completed an insurance company form declaring the client could return to work within weeks. When the surgery was a failure, the insurance company used the doctor's declaration to deny the patient's claim for benefits. The doctor refused to respond to her requests to correct his record.

A third doctor who was supportive of her patient explained that she did not want to complete her disability paperwork because she thought the patient could try to return to some type of part-time work with accommodations and to complete a form saying otherwise would be counter-therapeutic.

There will always be physicians who are unwilling or unable to support claims of disability. But, supportive doctors need not make these mistakes. A physician's refusal to accurately document medically demonstrable impairments can have devastating financial consequences for claimants who require medical certification in order to receive the benefits for which they paid premiums. This, in turn, can seriously jeopardize their own patient's ability to take care of themselves, to afford medical care and to focus on the rehabilitation and healing process.

For the most part, however, a little education and support can persuade your client's treating doctors to provide critical corroboration for their disability claims.

Acknowledging therapeutic tension

Your client's doctor's prime directive is to heal the patient; to return the patient to the highest possible level of function and health. The client, too, wants to get better and wants the physician to improve her health and functionality. Asking a physician to document a disabled patient's inability to work raises real tensions both for the treater and the client. This is one reason it can be difficult to get the doctor to articulate in necessarily excruciating detail how injured or sick your client really is, the potential long-term nature of impairment, and the inability to work.

Insurance companies cleverly exploit this conundrum. Even those practicing physicians who are skeptical of insurance companies often underestimate how shamelessly dishonest some disability insurance companies are. Innocent medical notations are frequently manipulated and miscast, taken out of context, and cherry-picked by the insurer, rendering a well-meaning treating physician an inadvertent pawn in a denial machine. Physicians sometimes fail to recognize that insurance companies use deliberate trickery in order to get the doctor to say something the company can use to support a denial or termination of benefits.

However, by communicating with your clients and their physicians, disability advocates can and must facilitate the treating physician's detailed and unequivocal support for disability.

Definition of "disability"

Dishonest disability insurance companies rarely, if ever, properly define the terms used when requesting a medical opinion. Instead, the company will ask the physician about a patient's "restrictions and limitations," their ability to perform a "sedentary occupation," or "work activity," whatever *that* means. The company will improperly reduce a real-world professional occupation to an incomplete checklist of the basic physical demands of

the job, like lifting 10 pounds, pushing and pulling, or reaching.

These are traps for the unwary doctor. The insurance company is using these undefined terms – terms which are never part of an actual disability insurance policy – to make a determination about whether or not a person is disabled. Faced with these vague inquiries, the treating doctor should be aware that the insurance companies *can* and *will* use any ambiguities in their favor.

Many people, not just doctors, misunderstand the meaning of "total disability." There may be a perception that a person must be unable to work *at all*. Some doctors may presume that work could be part-time, or could accommodate the patient's disability. Some doctors may discount the impact of pain or the side effects of medication. Some doctors are under the false impression that if a patient can perform some of her duties, but not all of them, then she cannot be "totally disabled."

Doctors of disabled patients will benefit from understanding a few things about disability insurance. First, some policies insure against disability from a person's "own occupation." If an OB/GYN can no longer deliver babies or perform obstetrical surgery because of a hand injury, but she can earn as much money teaching medicine and consulting patients, she would still be entitled to benefits under an "own occupation" policy. A second definition of disability insures against disability from "any occupation." However, *any* occupation does not mean *own* occupation.

California law provides a mandatory definition of disability in both the "own occupation" and "any occupation" contexts, *regardless of the definition provided in the policy.* For "own occupation policies" this means that a claimant is eligible for benefits if she is unable to perform the substantial and material duties of her own occupation in the usual and customary way with reasonable continuity.

Under the "any occupation" definition, total disability means the claimant, "is prevented from working with reasonable continuity in his customary occupation ... or ... another occupation in which he could reasonably be expected to perform satisfactorily in light of his age, education, training, experience, station in life, physical and mental capacity. (*Moore v. American United Life Ins. Co.* (1984) 150 Cal.App.3d 610, 618.)

> '(T)otal disability' does not signify an absolute state of helplessness but means such a disability as renders the insured unable to perform the substantial and material acts necessary to the prosecution of a business or occupation in the usual or customary way. Recovery is not precluded ... because the insured is able to perform sporadic tasks, or give attention to simple or inconsequential details incident to the conduct of business ...

(*Erreca v. Western States Life Ins. Co*. (1942) 19 Cal.2d 388, 396.)

It is important for the patient and the patient's advocate to explain the correct standard for disability to the treating physician. It is helpful for the treater to understand the duties of the patient's occupation and how the physical problems interfere with their performance.

Doctors also need to understand the difference between the definition of disability applied by the Social Security Administration, and private or work-provided disability policies. SSDI benefits require that the patient be precluded from any substantial gainful work activity for a minimum of 12 months. Vocational realities, whether or not the patient would qualify for work they could physically do, are not a factor.

In contrast, the California definition, which applies to private and work-provided disability claims, adds several factors to the analysis. First, an alternative occupation must reflect the insured's, "station in life." In other words, a disabled surgeon cannot be denied benefits just because he could be a receptionist. The claimant must be able to perform the important duties of the job in the *usual and customary way*. Thus, for example, if a salesperson's occupation requires in-person sales meetings, an insured cannot be denied benefits because he can conduct meetings by phone. The claimant must be able to do the job "with reasonable continuity." Thus, if a dentist with wrist problems can perform 12 procedures one day, but is too sore the following day to perform any, the dentist is precluded from performing with reasonable continuity.

Moreover, California disability policies require the insurer to consider the "real world employment marketplace" when making a disability determination. This means assessing the actual employment prospects of the insured, not "some fanciful or imaginary occupation in which there is no likelihood of anyone employing the insured." (*Moore*, at 629.) For example, a school principal who has been on disability for over a decade is not likely to be a competitive job applicant for any occupation for which she is qualified.

Don't allow the literal terms of the policy to mislead your client's doctors. Total disability from any occupation is a nuanced creature of California common law. Doctors should understand that disability insurance companies have every incentive to keep them in the dark about those nuances and will seize upon any medical misstep to create a plausible reason to deny or terminate disability claims.

The tricks of the trade

In addition to providing undefined terms, dishonest insurance companies use a bevvy of tricks to gather misleading information from treating physicians. Here are just a few sad tunes from the well-worn insurance denial playbook.

- ***The misleading "summary"***

Insurance companies frequently request medical opinions in response to activity depicted on *sub rosa* surveillance of the client. There is nothing wrong with

this practice when done honestly. However, dishonest companies will purport to "summarize" what is depicted in a manner that exaggerates physical ability and downplay or ignore evidence supporting disability. One client with severe thoracic outlet syndrome was secretly filmed going grocery shopping. The summary of the surveillance sent her to doctors for comment described her as lifting, loading, and unloading several heavy bags of groceries with "fluid motions and no apparent distress." They described her lifting a full bag of soil while "gardening" and digging a hole in the garden with a shovel.

However the actual videotape showed that at the grocery store she was wearing a shoulder brace. She had an attendant load her car for her. She visibly winced in pain getting in the car, where she used a special pillow on her lap to support her arms. Once home, she carefully carried one bag at a time with both hands into her house. Once home, she moved a nearly empty bag of dirt to a small mole hole where she filled it with a small trowel and went inside.

The company's misleading summary was followed by a list of physical restrictions and limitations defining a sedentary occupation and asked if the patient could perform these. Relying upon the false descriptions of her activity, the physical checked that she could even though she contemporaneously documented that the claimant was totally disabled from her occupation as a nurse. The insurance company terminated her benefits.

This conduct is intended to divide the doctor and patient and to create suspicion in the physician's mind, exactly what the covenant of good faith and fair dealing prohibits.

Insurance companies also "summarize" other medical findings, either by different treating physicians or their own paid medical consultants. These summaries can also be subject to highly misleading cherry-picking designed to bias the doctor. For example, where a client suffered a severe pain flare sending her to bed for two days, but was able to get out of bed when the flare resolved, a dishonest insurance company might simply tell the treating doctor, "her orthopedist said her pain had improved and was resolved."

Physicians should take insurance company representations about any medical records or activity with a heaping tablespoon of salt. The best practice is for the treater to review the actual records of any relevant care providers and to discuss the relevant data with the patient before responding.

• ***The peer-to-peer call***

Another way disreputable disability insurance companies manipulate the treating physician opinion is through the so-called "peer-to-peer" call. These calls usually take place after a so-called "round table" meeting on the file. A round table is a meeting attended by the claim representative, the supervisor, a department head, the in-house medical and vocational staff assigned to the claim and sometimes a legal representative. The point of these meetings is to discuss how to terminate a particular claim.

In a peer-to-peer, after the round table discussion of "claim direction" or "target resolution," the company's in-house medical consultant will contact the doctor's office to discuss the claimant's disability. The insurance company physician will invariably highlight any perceived weaknesses in the claim for benefits with seemingly innocent questions in an attempt to get the treating physician to confirm them. For example, in a case where there is little to no objective evidence, such as in a back pain or migraine headache case, the company physician will lead the treater to confirm that the level of disability is based solely on the claimant's "self-report." Or in a case where severe symptoms are caused by an unknown or unusual etiology, the company physician will confirm the lack of certainty of the cause of the condition. The insurance company doctor will confirm "normal test results" even where the tests are not diagnostic for the patient's condition.

Good claims-handling practice requires the company to send any summary of the peer-to-peer to the physician for confirmation. It is surprising in how many cases the company doctor baldly misstates the substance of the conversation, which is then summarized in writing and included in the claim file where subsequent reviewers rely on those misstatements in making claims' determinations.

It is important during these calls for our clients' doctors to be as clear and unequivocal about the level of impairment, including detailed narrative descriptions of the symptoms and how they preclude meaningful work activity. Treating doctors should be aware that many disability insurance companies seeking information from them are not in fact searching for the truth, but are simply searching for information which can be spun into fodder for a denial.

Remember, these opinions are not ultimately for a physician, but need only sound medically scientific in the event the termination or denial is challenged in litigation. Indeed, the Ninth Circuit has expressly chastised an insurance company for "fooling someone unfamiliar with the medical terms with irrelevant medical mumbo jumbo [which] violates the statutory duty to write a denial in a manner calculated to be understood by the claimant." (*Salomaa v. Honda Long Term Disability Plan* (9th Cir. 2011) 642 F.3d 666, 680 (internal quotations omitted).)

How to help the treating doctor

It's important to acknowledge the frustration felt by physicians faced with reams of disability insurance paperwork, repeat requests, lengthy forms for seemingly irrelevant information and constant bombardment from insurance companies

(and from their own patients' lawyers). Doctors did not go through all that education to check dozens of boxes about whether a patient can lift 10 pounds frequently, sometimes or not at all.

The skeptical practitioner might even suspect that insurance companies deliberately hassle doctors who support disability claims with excessively lengthy and frequent requests for information, medical records, phone consultations and multi-page functional capacity forms.

There are things patients and advocates can do to support treating physicians.

• **Bill them:** Doctors who are asked to complete lengthy forms or write narratives can and should be encouraged to bill insurance companies who are requesting this time. Most insurance companies will compensate for physician time.

• **Annotate:** Doctors should resist being restrained by insurance forms and checkboxes when conveying information. Narrative descriptions and real-world variations are important. For example, when asked how long during a workday a claimant can sit and stand, a physician can add a brief notation that sitting in excess of 20 minutes exacerbates pain.

If a form fails to address the intellectual demands of a job, and the person has cognitive symptoms, a physician can add, "Patient cannot sustain concentration sufficient to work an eight-hour day in a professional setting."

• **Patients working with their doctors:** Doctors and patients can work together to accurately complete relevant forms. For example, when asked for a detailed functional capacity assessment, the patient should make an appointment to update the doctor on the condition while they complete the form together. Then the doctor and her staff have a baseline template he or she can use for future requests.

• **Pay them:** Finally, when a narrative response or explanation is important to a disability claim, the patient should be prepared to pay the physician for the time to create it. These reports take time away from the physician's practice and, despite high hourly rates that most doctors demand, the return on investment can be tremendous.

The disability claimant, advocate and treating physician are in a symbiotic relationship. We need medical support, our clients need their benefits and their doctors have an interest in the patient obtaining deserved benefits to avoid financial and potentially medical catastrophe. Supportive physicians are the lynchpin to a successful disability claim. In most cases they simply need the information and support to empower them to help.


Grey

Rebecca Grey is the founder of The Grey Law Firm, PC *which is exclusively dedicated to advocating on behalf of insurance policyholders in disability, life, health, long-term care and property insurance disputes. For over 15 years, she has represented individuals with private insurance policies, as well as those governed by ERISA, in all stages of the insurance process, from the initial claims, administrative appeals, litigation, mediation, trial and appeal.*