The Disabled Doctor's Guide

FIGHT YOUR DISABILITY INSURANCE DENIAL AND WIN THE BENEFITS YOU HAVE PAID FOR!

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Disclaimer

INTRODUCTION

This book is designed to inform you about your disability policy and give you the best chance to prevail over the deck that has been stacked against you.

Like most physicians, dentists or other high-earning professionals, you purchased a long term disability insurance policy to protect your family and yourself in the event of total or partial disability. There is much at stake, should you find yourself no longer able to practice medicine.

You paid insurance premiums for years – a lot of money in return for the protection and peace of mind of knowing that disability income will be there to help support you when you need it.

Now, you have fallen ill or become injured to the point that you can no longer practice your medical specialty. Perhaps you are unable to work at all. As a matter of course, you file a disability claim with your insurance carrier. Yet instead of honoring your policy, you are stunned to learn that your insurance provider has denied your claim. Or perhaps your insurer is systematically stalling your claim decision, making it impossible to get benefits when you need them most.

The disability insurance industry resorts to many tactics based solely on financial motives. To this day, thousands of people that had paid their disability premiums for years have been left in financial ruin because of their own insurance company's broken promises.

Even lawyers who are not familiar with disability issues do not always understand what has to be proven in a disability claim.

To your success,

Marc Whitehead, Esq.

1. DISABILITY CLAIM DENIALS AND THE MEDICAL OR DENTAL PROFESSIONAL

If tragedy happens and you can no longer practice your medical or dental specialty – or you can no longer earn a living in any capacity – long term disability insurance (LTD) can help protect you and your family from dire economic loss.

Physicians and Dentists' Disability Claims Are Unique

Not only do medical specialists work with their minds, they also work with their hands and bodies. This is unique to medical professionals because, unlike most other high income earners, they still have a very physical component to their jobs.

It takes a certain type of person to become a medical professional. In addition to intellect and expertise, surgeons, dentists, chiropractors, and other practitioners must have the drive and fortitude to withstand copious pressures and repetitive physical movements.

They routinely muscle their way through long hours of surgeries, fending off discomforts caused by muscle overuse, unnatural postures, bending and standing in awkward positions to accomplish surgical maneuvers, routine procedures, spinal manipulations – all while remaining highly focused.

If suddenly faced with a disabling condition, these professionals may be forced to take a lesser position or actually give up their practice that took a lifetime to build.

These disability policies are costly. Most are highly customized to a doctor's specific occupation, where even the slightest injury or illness can end a doctor's career.

Consider the devastating economic loss to the disabled surgeon, dentist or chiropractor who once handled a high case-load of procedures such as vasectomies, colonoscopies, routine fillings or spinal manipulations, but due to a nerve injury to the hand or a degenerative disc, they no longer have the dexterity or strength to perform the procedures that are the lifeblood of their practice.

Financial and business losses increase exponentially when specialists such as orthopedists, cardiologists or orthodontists become disabled and can no longer work. Annual losses can be in the hundreds of thousands of dollars.

The Harsh Reality of Many Valid Disability Claims

Sadly, the insurer that sold your policy to you is not always looking out for you. Disability insurance companies often give doctors and dentists a very hard time.

Even if you purchased an LTD policy specifically tailored to your medical or dental practice, don't be surprised if your claim is denied. Insurance carriers frequently resort to exasperating delay tactics, such as underpaying claims, unfairly terminating existing claims, or practicing other deceptive and wrongful behaviors to avoid paying your rightful benefits.

If you have been denied LTD benefits, this book is for you.

Written for MDs, DOs, dentists, chiropractors, anesthesiologists, physician's assistants, nurses and every other medical professional who has suffered a disability and now must suffer the insurance company—the chapters ahead will allow you to:

1. Clarify key features of your policy that you need to be aware of.

2. Explain why the process for you to obtain LTD benefits is so difficult – even more so than it is for non-medical professionals.

3. Whether by appeal or lawsuit, explain what it takes to overturn a wrongfully denied claim.

4. You can fight back and win!

If you are considering filing a claim, are already on claim and benefits are being unfairly terminated, or your initial claim has been wrongly denied, you have remedies. For every "reason" the insurer uses to deny your valid claim, you may be able to respond in kind with a stronger legal argument.
Big insurance companies do not hold all the cards. Do not give up on the disability benefits you deserve.

2. THE DISABILITY INSURANCE INDUSTRY

The disability insurance market has changed dramatically over the past 35 years. Prior to the rise of managed health care, long term disability insurance was a fairly low-risk business. In the late 1980s and into the 1990s, managed healthcare began to take hold and insurance companies began to experience serious financial loss.

In its heyday during the 1980s, the insurance industry recognized that there was a lucrative market in selling disability insurance policies to young, healthy medical professionals. These policies were designed to insure doctors and dentists in the event that they became disabled and could not perform the duties of their **own occupation.**

These non-cancelable policies often had relatively generous terms with regard to the definition of disability, a lifetime payout, and a built-in cost of living adjustment.

Why Medical Professionals Were (and Still Are) Prime Targets

As high wage earners, doctors and dentists were an ideal niche group to market to. These were professionals who loved what they did, had devoted years of hard work, and invested serious money into their vocation. They were among America's highest income producers. Insurance carriers reckoned that, if a physician became disabled, he or she would be less inclined to quit working or shut down their practice.

Medical professionals have always been an easy target for insurance companies to identify. A sales force can readily locate a hit list of physicians, dentists, chiropractors, anesthesiologists, nurses and many other practitioners via their various specialty associations.

Insurance carriers stood to gain the most by selling individually purchased plans. Many medical practitioners invested in their own small businesses. LTD policies were marketed to them in the form of private, customized, high-premium plans, as opposed to less expensive group disability plans.

Eventually, the lucrative cash cow became a financial nightmare for disability insurance carriers such as Unum, Paul Revere, Provident Life and others. Poor underwriting of physician's LTD policies and underpricing in a competitive market led to a massive number of these policies being written on the expectation of substantial investment returns based on the high interest rates at the time.

By the 1990s, claims on these disability policies began to increase at the same time interest rates and investment returns began to drop.

Provident Life publicly admitted to the Securities and Exchange Commission that one of its principle solutions to cover its losses was to "improve its claims handling procedures" — a thinly veiled euphemism for increased claim terminations and denials.

Since insurance carriers could not control investment returns or the fact that their policyholders were aging and filing more claims, they did the only thing that was in their control: refuse to pay claims.

Cost Control though Claim Denial

The industry devised a series of resourceful measures designed to control the cost of paying claims and to justify or deny legitimate claims. These tactics included:

- Reclassifying a doctor's specialty as a generalist. For example: if you are a gastroenterologist and have lost certain motor skills, even though you can no longer perform colonoscopies, the insurer might state that you can still practice basic gastroenterology;
- Systematically searching for "misrepresentations" in the policy holder's initial applications;
- Requiring "objective" evidence of disability even though the policy didn't require it;
- Redefining a physician's or dentist's "own occupation";
- Offensively using the Employee Retirement Income Security Act (ERISA) preemption. ERISA is the federal law that governs group or employer-sponsored plans, which account for most disability claims in the U.S.;
- Use of biased insurance medical evaluation ands;
- Use of increased video surveillance.

The result of these "cost control" measures is that, to this day, thousands of individuals who had paid their disability premiums for years have been left in financial ruin because of their own insurance company's broken promises.

While the insurance carrier is happy for disabled claimants to represent themselves and will even state that they can "just send in a letter appealing their denial" – THIS IS A TRAP FOR THE UNWARY!

The Need for Experienced Legal Counsel

Because of the difficulties described above, it is critical that disabled medical professionals have an experienced ERISA attorney assist in the administrative appeal of their insurance denial.

Several respected federal judges have agreed about the disadvantages facing claimants representing themselves:

"In the Court's experience, [inexperienced] lawyers for ERISA claimants all too often do not appreciate the importance of getting all their evidence in the administrative record. Thus, it is not uncommon for ERISA claimants, when they get to court, to discover they cannot use what they think is critical evidence." Acree v. Hartford Life & Acc. Ins. Co.

"Having recognized the difficulties posed by Plaintiff's position [of having little or no evidence in the file], the Court also recognizes that ERISA claimants may not have the advantage of legal advice or favorable referrals before the administrative process is complete, placing such claimants at a distinct disadvantage if discovery is not permitted on judicial review. For ERISA claimants not able or aware enough to hire legal counsel before the administrative process is complete, they likely enter into judicial review facing a loaded deck—a deck loaded with the expert opinions of those hired by the plan administrator." Abromitis v. Cont'l Cas. Co./CNA Ins. Companies.

"A pro se ("do it yourself") claimant will be hopelessly outclassed [in an appeal to the disability insurance company] and will [likely] hit a brick wall each time." May v. AT&T Integrated Disability.

As explained later in this book, an administrative appeal of this type must include ALL the arguments, medical records, and other evidence that you want the insurance company to consider in re-evaluating your claim.

IT IS A TRAP TO ASSUME YOU CAN ADD ADDITIONAL EVIDENCE LATER. If you are unsuccessful in your appeal, the next step is to file a lawsuit in Federal Court. However, no new evidence is generally permitted in Federal Court.

"When reviewing a plan administrator's decision, even under a deferential standard, the district court is limited to the evidence that was before the plan administrator at the time of the decision." Rust v. Elec. Workers Local No. 26 Pension Trust Fund.

To make matters worse, the insurance company is usually afforded the "benefit of the doubt" in its decision-making:

"At its immovable core, the abuse of discretion standard requires a reviewing court to show enough deference to a primary decision-maker's judgment that the court does not reverse merely because it would have come to a different result in the first instance." Evans v. Eaton Corp. Long Term Disability Plan.

In Summary :

Your attorney must be experienced and well-versed in disability law and all types of LTD policies:

- Your policy may be a physicians' association group disability insurance plan (such as policies available to members of the American Medical Association.)
- If you purchased your insurance policy privately from a broker, your claim will be regulated under state insurance laws and subject to breach of contract, bad faith, and other causes of action. This is also known as a Non-ERISA policy.
- If your policy was obtained through an employer-sponsored group benefits plan, federal ERISA law prevails.
- Other insurance may play a role in your claim as well, such as Social Security Disability or worker's compensation.
- It is also important that your attorney fully understands the practices and strategies used by the various disability insurance companies.

3. TYPES OF COVERAGE: SHORT TERM, LONG TERM & CATASTROPHIC DISABILITY

Disability insurance is often offered and paid for, at least in part, by employers as a group benefit to employees. Private disability insurance can also be purchased directly from an insurance broker by an individual.

The language and provisions vary from policy to policy. For group employee coverage, the long term disability policy is the contract between a claimant's employer and the insurance company. It is essential that you get a copy of the policy from your employer's Human Resources department.

For an individually purchased policy, you would obtain a copy of your policy directly from the insurance company.

Short Term Disability (STD)

The purpose of Short Term Disability insurance ("STD") is to help replace lost wages when a disability keeps you from working for a limited span of time. STD benefits are paid anywhere from one week to six months, depending on your policy.

Generally, STD is paid for by your employer and is usually 100 percent of your salary. Because STD is usually paid by the employer and is for a limited amount of time, it can be easier to get approved for this type of benefit. Short term disability benefit claims are often the first step in the long term disability insurance claims process.

If a physician is disabled and cannot work at his own occupation, LTD benefits are generally paid for 24 months. After this "own occupation" period, the physician can potentially receive LTD benefits until age 65, if they continue to prove disability.

Long Term Disability (LTD)

The purpose of Long Term Disability Insurance ("LTD") insurance is to provide you with financial coverage in the event that an injury or an illness will prevent you from working for quite a long time, even permanently.

Most LTD policies have an "elimination" or waiting period. This means you must first apply for and receive all of the STD benefits available to you under your policy or satisfy a waiting period by being disabled for up to six months before you can even apply for LTD benefits.

For more about the "Own Occupation" standard see Chapter 12.

Catastrophic

A catastrophic policy is one that pays benefits only if a claimant is so severely impaired by accident or disease, that he or she cannot do even the most basic activities of daily living such as feeding, getting dressed or showering without assistance. The insurance company will often send a home health nurse to the claimant's home to confirm that he or she is disabled under this type of policy.

4. HOW WILL YOUR DISABILITY BENEFITS BE PAID?

The majority of policies pay 60 percent of a disabled doctor's or dentist's salary. If he or she works on a commission or other non-salaried basis, the insurance company will use a calculation described in the policy to arrive at a benefit amount.

Partial or Residual Disability

Some policies allow medical professionals to work part-time or work at a lighter duty job because they are unable to work full time due to their medical impairment. A partial or residual disability benefit is payable if an impairment causes a physician's or dentist's income to fall below more than a certain percentage, usually 20 percent below their regular income.

Generally, the claimant will be making less money than if they worked full-time or full duty. The policy will require the claimant to make a certain percentage less than their regular salary.

For more about Residual (Partial) Disability see Chapter 10.

The Social Security Offset

Most policies have a Social Security offset. This means if a claimant receives a monthly Social Security Disability (SSD) benefit, the amount of the SSD check is "subtracted" from the monthly LTD check.

For example, if a disabled surgeon receives a LTD check for $2,000 a month and then begins to receive a SSD check for $1,000, the insurance carrier will reduce the amount of the LTD check to $1,000. The claimant still receives a total of $2,000 a month, but $1,000 from SSD and $1,000 from LTD. Some policies even allow the SSD benefit paid to a claimant for his or her minor children to be taken as an offset.

Other Possible Offsets

Every policy is different, but other possible offsets are worker's compensation benefits, certain retirement or retirement disability benefits, settlements from lawsuits, and state disability benefits. In the event that the total of the offsets is higher than the monthly LTD benefit amount, most policies have a minimum payment of at least $100 per month or in some cases, 10 percent of the monthly LTD benefit.

The Problem of Overpayments

Many disabled physicians and dentists apply for SSD benefits around the same time they apply for LTD benefits. Included in the paperwork for the LTD application, there is a form they must sign that tells the insurance company how they will "pay back" the SSD offset. A claimant can choose to have the carrier estimate how much their SSD benefit will be. The insurance carrier will then "deduct" that estimate from the claimant's monthly LTD benefit.

Most claimants choose another option, which is to pay back the SSD offset in a lump sum, so that the claimant will receive the full LTD monthly benefit. Because it can take as long as 18-24 months to receive an SSD award, SSD back benefits can add up to several thousand dollars.

Once the claimant receives the SSD award and back benefits, the insurance company will want to recover the full amount of back benefits. Because they have been unable to work and have been getting only 60 percent of their former salary, many claimants spend their SSD back benefits to pay bills.

If the disabled physician cannot pay back the full amount in a lump sum, sometimes the insurance company will hold back the entire LTD monthly benefit towards the amount of SSD offsets that the physician "owes." This problem is compounded when the SSD award arrives just as the physician hits the "any occupation" definition of disability at 24 months, because the insurance company may cut off benefits when the policy changes, leaving the physician owing a large overpayment.

For more about the "Any Occupation" standard see Chapter 12.

5. EXCLUSIONS AND LIMITATIONS: DOES YOUR POLICY COVER YOUR CONDITION?

It is very important to make sure the insurance carrier does not mischaracterize your physical disability as mental.

Pre-existing Condition Exclusion

Most policies have pre-existing condition exclusions – guidelines that prevent someone from receiving benefits if certain illnesses or injuries occurred in the past. These exclusions usually kick in when a doctor or dentist has been eligible for benefits for less than a year, but sometimes the stated period is two years.

Besides the pre-existing condition period of a year, there is also a "lookback" period, usually the three months prior to filing for disability benefits. In a nutshell, if a doctor applies for LTD benefits less than a year after he or she signs up for the benefit, the insurance company will look at all the medical records and pharmacy records for the entire year plus the lookback period.

These exclusions are very, very broad. For example, an orthodontist may have been prescribed a medication for the treatment of anxiety during the look back period. Later, she develops a back problem with muscle spasms. The same medication that was prescribed to the orthodontist to treat anxiety is now being prescribed to treat her muscle spasms. The insurance company will get the orthodontist's pharmacy records and claim that she was being treated for muscle spasms because she took the medication. The insurance company will then refuse to pay benefits based on the pre-existing condition exclusion.

Mental Health Limitation

Most policies have a 24 month mental health limitation. This means that benefits for mental health conditions such as depression, anxiety or bipolar disorder will only be paid for 24 months.
Medical professionals may develop depression secondary to chronic pain. The insurance company may try to classify the impairment as mental, so that benefits will be paid for only 24 months. The insurance company may also try to classify a cognitive problem or side effects from narcotic pain medications as a mental impairment.

Self-Reported Symptoms Limitation

Disability insurance companies are always looking for ways to reduce their liability. One way is to continually ask for "objective evidence." Objective evidence usually refers to diagnostic tests like MRIs or X-rays.

Unfortunately, some symptoms, like pain, and some diseases, like fibromyalgia and chronic fatigue, do not show up on any "objective" tests. These symptoms are diagnosed by the doctor based on examination and patient reports. Examples of these conditions include: Chronic Pain, Fibromyalgia, and Chronic Fatigue Syndrome.

Non-Exertional Limitations

Non-exertional limitations are also largely self-reported and therefore, ignored for the most part by the insurance company. Examples include fatigue, intellectual and cognitive limitations, headache, memory loss, and medication side effects.

6. DO YOU HAVE AN INDIVIDUAL OR A GROUP DISABILITY POLICY?

Why is this difference important?

If you have an individual policy, the remedies that are available to you, as a claimant, are vastly different than if your policy is a group policy.

Many factors affect the course of your LTD claim. First and foremost is where your policy came from.

As mentioned earlier, you can purchase disability insurance coverage on your own behalf, or you may be covered under a group disability insurance plan as a benefit of employment.

- Coverage purchased on your own behalf is referred to as privately purchased disability insurance, or individual disability insurance (IDI). It is NOT part of an employer's group insurance plan. Rather, it is a private form of insurance that is underwritten for an individual consumer. Many professionals in specialty occupations such as physicians, dentists, lawyers, CEOs, and others purchase this type of insurance as a form of income replacement in the event they become disabled by illness or injury. An individual policy may also be used to supplement a group disability policy.

- If your disability policy is sponsored by or offered through your workplace, you likely have a group disability insurance policy.

Individual policies are regulated under state insurance laws regarding bad faith and contract law. These laws are designed to protect the insured and beneficiaries from unfair practices by insurers.

If you have a group policy through your employer, a whole different set of laws apply. These are complex federal (not state) laws known by the acronym "ERISA."

Unfortunately, ERISA law protects and favors insurance companies, not disabled claimants. ERISA gives insurance companies many outlets to delay or deny a valid disability insurance claim. Insurers face no real penalties for denying ERISA claims. With nothing to lose, they often use this to their advantage to unfairly avoid paying out disability benefits.

7. IS YOUR CASE GOVERNED BY FEDERAL ERISA LAW?

ERISA stands for the Employee Retirement Income Security Act of 1974. ERISA is a federal law that regulates the handling of Employee Benefit Plans and the remedies of the beneficiaries of these Plans. ERISA applies to all employees benefit plans established or maintained by an employer engaged in commerce or by an employee organization representing employees engaged in commerce.

Practically all long-term disability group plans offered by an employer are governed by ERISA.

If you are challenging a disability denial under an ERISA governed plan or policy, you must bring the claim according to ERISA regulations and procedures. You must appeal the denial to the same insurance company that denied the claim.
Since ERISA claims are based on federal law, the law and procedures are generally the same in all 50 states. All state law remedies are preempted, meaning they do not apply to an ERISA claim.

ERISA Does Not Apply to Privately Purchased Insurance
If you purchase your own private, individual, or family disability policy, then ERISA does not apply. To be clear, it must not be a policy obtained through your employer sponsored group benefits plan.

Possible Exceptions to ERISA

- Government employees: Government plans are excluded from ERISA coverage. This generally includes federal, state, and local governments including school districts and public universities.
- Church Plans: Employees of qualifying religious institutions such as a church, synagogue, or mosque are generally exempt from ERISA.
- Self-Employed Individuals: Self-employed individuals are not governed by ERISA if only the individual and their family are covered.
- Some Partnerships: Similarly, partners in a partnership with a plan that only covers partners, but no employees is not an ERISA governed plan.
- Pass Through Plans: Voluntary Plans where the employer contributed nothing to the plan and merely acted as a "pass-through" are exempt from ERISA if all requirements are met. These are extremely rare as the LTD carriers generally require employer contributions to set up the plan for the express purpose of receiving ERISA protection.

Protections ERISA Plans Don't Have

Why is ERISA favorable to the insurance company? Supposedly, ERISA was enacted to protect people who get their health insurance through employer-provided plans. But anyone who has spent time working on these types of long term disability cases knows that the reality is less about protecting you and more about keeping insurers from losing money.

The following explains exactly what protections you lose when you have a disability plan covered by ERISA laws.

ERISA Offers No State Protections: In NON-ERISA claims, depending on the state you live in, there are a wide variety of things that you can do to keep your insurer honest and fight back against illegal practices designed to keep you from getting the benefits you deserve. These state protections may include suing for:

- Emotional distress
- Consequential (or special) damages
- Loss of credit claims
- Prejudgment interest for breach of contract
- Tortious interference with contract
- Statutory insurance violation claims
- Deceptive trade acts or unfair practices
- Bad faith
- Punitive damages
- Mandatory attorney fee reimbursement

Under ERISA, you can only sue for what the insurance carrier should have paid you in the first place. Your ability to recover attorney fee reimbursement is difficult at best.

- **Limited ERISA Remedies:** As you might imagine, under a system in which the worst that could happen to the insurance company is that they have to pay the original claim and nothing else, the insurance companies are emboldened and do not fear denying claims as they see fit.

- **No Right to Jury Trial:** Also, you have no right to a jury trial to decide your claim. Juries are the great equalizer in the civil justice system. Insurance companies are wary of them. In an ERISA case, the insurance company doesn't have to worry about a jury holding them accountable.

- **No Treating Physician Rule:** Unlike a Social Security Disability claim in which the SSA must respect the opinions of your own doctor, in an ERISA disability insurance claim, the insurance company can ignore your own doctor's opinions and rely on their own doctor's opinions as they see fit.
- **Little Government Regulation:** There is little guidance in the law as to how the insurance policy must be written. As a result, the insurance carriers are free to write the policy as they wish. Competition from other companies is their greatest incentive to write any provisions favorable to the claimant.

In most claims brought under ERISA, you must prove that the insurance carrier "Abused Its Discretion" when it denied your claim. This is a tough standard requiring you to show the insurance company had "No Reasonable Basis" for denying your claim.

- **Plaintiff Must Prove the Insurance Company "Abused Its Discretion":** In a disability insurance claim brought under state law, you only have to prove it is "more likely than not" that you are disabled. This is a tough standard requiring you to show the insurance company had "No Reasonable Basis" for denying your claim. An example might be if you had three doctors that said you were disabled and the insurance company only had one doctor that said you were not. The insurance company would argue that they had a "reasonable basis" to deny your claim based on their one doctor, in spite of your three.

Those under ERISA plans aren't eligible for any of this, because all state law procedures and remedies are preempted by ERISA.
To put it bluntly, you are prevented from pursuing state law remedies. You won't even be able to go to a state court. Instead, you will be sent to a federal courtroom and the best outcome you can hope to receive is that the judge will make your insurer honor the policy by providing you with benefits you should have gotten in the first place – and hopefully pay your attorney fees.

Doesn't sound fair, does it? Unfortunately, it's the law that we have to live under until enough people push for change.

8. ERISA (GROUP) DISABILITY CLAIMS VS. THE FAMILY MEDICAL LEAVE ACT

There can be confusion between short term disability (STD) insurance and the Family Medical Leave Act (FMLA). Both deal with temporary disability. If you are suddenly unable to work due to a disability, you may wonder what rights you have to disability benefits and whether you'll still have a job if you are able to continue working in the future.

The short answer is:

Short term disability insurance is a paid benefit offered by some employers. It is not mandatory under any federal act. The insurance company does nothing to protect jobs. If a claim is approved, STD **replaces a portion of your income.**

Family Medical Leave Act (FMLA) applies to the entire USA. It is a federal **job protection program** that offers limited protection to employees. It is not the insurance company and does not entitle a disabled worker to any monetary benefits.

Let's look at this in more detail.

What Is the FMLA?

The Family Medical Act was signed into law in 1993 and protects eligible employees who need to take an unpaid leave due to a family or medical emergency. The FMLA states that eligible employees can take up to 12 weeks of **unpaid leave** in the course of a year and, after they've used up their 12 weeks of leave, still return to the same or an equivalent job with their employer.

During this time, the employee will continue to receive the same group health benefits that their employer would have offered them if they had been working during this time. Unfortunately, if the employee is absent for longer than 12 weeks, the employer can legally terminate them.

In order to be protected under the FMLA, employees must:

- Have worked for their current employer for at least 12 months;
- Have worked at least 1,250 hours for that employer in the past 12 months; and
- Work at a location where the employer has at least 50 employees within a 75 mile radius.

Not all employers are legally obligated to offer family medical leave. All public sector agencies, no matter what the size, must comply with the FMLA, but only private sector organizations with 50 or more employees who work at least 20 weeks out of the year are required to offer the same leave. That means that employees of small, private workplaces are not protected by the FMLA.

Who Is Eligible for Family Medical Leave?

Even if your employer is covered by the FMLA, there are some reasons why you might be ineligible for family medical leave.

In addition to the limited time frame and specific eligibility requirements, one problem that many employees encounter with the FMLA is the lack of support they receive from their employer during their leave of absence. Many employees who file for both family medical leave and short term disability benefits will receive the medical leave (because their employer is legally obligated to give it to them) but will be denied short term disability benefits.

9. IS YOUR DISABILITY CASE GOVERNED BY STATE INSURANCE LAW? (NON-ERISA)

Private long term disability policies are contracts between you and the insurance company. As such, these policies and claim denials are governed by state contract and bad faith law.
If an insurance company denies your claim for long term disability benefits, you can appeal the decision. This is your right, and the insurer must allow you recourse to a full and fair review of a denied claim. But be aware, this appeal is often nothing more than an internal review with the same insurance carrier that denied the claim in the first place.

When an acceptable settlement with an insurance company cannot be reached, bad faith insurance claim litigation becomes necessary. Litigation of private policies are held in state or federal court before a jury of your peers, and the laws that govern these claims vary by state.

Riders and Occupational-Specific Policies for Physicians

Individual disability insurance policies for medical professionals are often written with specific features or supplemented by riders. The purpose is to protect the income level that doctors and dentists have worked hard to achieve over many years.

Medical specialists are able to create very individualized and occupation-specific policies. Riders are purchased in addition to the base policy, significantly increasing the premiums.

If a carrier has 100 individually owned, physician-related disability claims to pay on, and it succeeds at denying 50 of them, that equates to millions of dollars they do not have to pay.

For example,

- Own-Occupation: This is occupation-specific coverage in which you have a rider saying that the definition of disability is your specific occupation or sub-specialty rather than the broader definition of "other occupation" or "any occupation." For instance, your occupation is defined as "neurosurgeon" or "cardiologist" rather than "physician" or "practicing medicine."
- There are no limitations or exclusions on benefits payable for disabilities caused by mental disorders.
- Policies are portable, whereas most LTD policies end with employment.
- Partial and Total disability benefits can cover you until age 65 or for life.
- Cost of living increases.
- Optional graded lifetime benefits beyond a certain age.
- Recovery benefits up to the benefit period through a Residual Disability Rider.

Most group plans or base individual policies will not have these added features. Ultimately, this means an insurer may evaluate a physician's disability claim with additional scrutiny due to the added language of any riders attached to the claim.

The Campaign to Deny Legitimate Claims Continues

You can bet that many insurers inspect each claim against the language and terms of the policy in order to find ways to deny benefits. Dollar wise, claim amounts in physicians' disability cases are considerable. From the insurance carrier's standpoint, even if they wind up in a court battle, even if they are forced to pay damages, it is to their overall financial gain to deny good claims in bad faith.

They would much rather risk being challenged by denying the claim, causing delays until the policy owner gives up, or otherwise significantly underpaying or shortening the benefit coverage they have to pay out.

The following chapters explain how to take control and fight back against both an ERISA and non-ERISA claim denial.

10. HOW TO BEGIN YOUR DISABILITY INSURANCE CLAIM

A claimant under a group policy must request the forms for disability benefits from their Human Resources department of their employer. For a privately purchased policy, claim forms will be available to the policyholder directly from the insurance provider.
The claimant must also take an Attending Physicians Statement ("APS") form to a physician who will indicate that the claimant is disabled or that the physician is keeping the claimant off work.
Once the forms are completed, they are sent to the insurance carrier along with a list of all medical providers the claimant sees for treatment.
Once the insurance carrier receives all the medical records, it will begin investigating the claim.

Tips to Help You Win Disability Benefits on Your Initial Application

1. Understand the structure of your policy.
Most policies have a 3-6 month Short Term Disability policy for which you must initially submit an application. Once this is exhausted, you must reapply for the Long Term Disability portion of the plan. The initial term of the LTD plan, usually 24 months, is referred to as the "Own Occupation" portion of the plan. After that term has expired, to continue benefits, you must meet the tougher "Any Occupation" definition of disability to continue to receive benefits.
Most policies naturally terminate at your retirement age, either age 65 or your full Social Security Retirement Age.

2. Understand the interaction between your short term & long term policies.
Many Long Term policies require that you exhaust all short term benefits to be considered to have met the "elimination period" that is required before long term disability benefits will be paid. In short, denial of the short term disability benefits will prevent the payment of long term benefits.

3. Look at the Pre-Existing Condition provisions in the policy.
If you have been covered under a policy for only a short period of time, usually less than one year, the policy will have a "lookback period" in which the insurance carrier will look for pre-existing conditions. It is important to plan for this possibility before filing your disability application as the timing of the claim could be of great importance in the application of the policy's pre-existing condition exclusion.

4. Know what medical conditions are excluded or have limited benefits.
Most policies limit or totally exclude the payment of benefits for certain types of medical conditions. It is common for disability policies to limit benefits to only

24 months for disability based on mental conditions, soft tissue injuries, fibromyalgia or other conditions that are based on self-reported symptoms. Most exclude totally any benefits based on injuries that occurred while the claimant was in the act of a felony. It is important in filling out the initial application to avoid basing the claim for disability on these limited or excluded conditions if at all possible.

5. Understand "Other" income offsets in the policy.

Most policies will offset or subtract from your monthly insurance benefits "other" income that you may be entitled to from other sources. Most frequently this means your Social Security Disability benefits but can also include early retirement or pension benefits. It may be worth considering deferral of retirement or pension benefits, if possible. This does not include Social Security Disability benefits. See below.

6. Prepare to file for Social Security Disability.

Practically all disability insurance policies require you to file for Social Security Disability benefits within 12 months of disability. The reason is obvious: The insurance company gets to offset or subtract the SSD benefits from what they owe you.

7. Review policy for how it defines your salary vs. bonus.

Most policies base your monthly benefits on your base salary and not bonuses or commissions. This varies greatly from policy to policy, but you need to understand how salary, bonuses, and commissions are defined and calculated if your income is based on them.

8. Review your medical records and get your doctor on your side.

You must have good medical documentation of your diagnosed medical conditions AND opinion evidence from your doctors as to your functional limitations that naturally develop from these conditions. Your doctor will need to fill out forms and be interviewed on multiple occasions to support your disability claim.

9.Write down your job description and compare it to your employers' version of your job description.

During the initial "own occupation" term of your disability claim, it is critical that you have a written job description that describes all physical, mental, and travel requirements of your "own" job. Sometimes your employer's version does not match what you really do. It is critical to the success of your claim that your doctor's description of your functional limitations clearly shows that when matched with your accurate job description, you can no longer do that job.

12. Focus your application on your medical conditions and functional limitations that are not subject to limitations, exclusions or pre-existing limitation exclusions.

The reasons should be obvious, but you want to make sure you maximize your chances of success, so don't blow it in the application.

13. Never use absolutes to describe your limitations.

When describing your physical limitations, don't use absolutes like "always" and "never." Statements like "I can never lift 10 lbs." or "I always require a cane to walk" can easily be contradicted. Instead use words like "frequently, sometimes, occasionally or seldom." Once you are contradicted, either in your own medical records or on video, you are branded a liar and nothing you say will be believed. This is a favorite insurance company tactic.

14. Beware of vague or misleading questions in your application or activity log.

A big problem with many disability insurance applications is that some questions unfairly assume facts that aren't true or only give the applicant multiple choice answers that all lead to an unfair result. A prime example that is often seen is asking the claimant what level of activity they are capable of and giving the following choices; heavy, medium, light or sedentary. The result is that any answer they choose can result in a denial of their claim. To be fair, the question should have included the ability to choose "none of the above."

15. Understand Total vs. Residual (Partial) Disability.

Many physicians' and dentists' disability policies are written around the concepts of total disability and residual disability. These principles play a huge role in claims filed by surgeons, dentists, chiropractors, and other practitioners who literally use their hands and bend over patients all day.

In many cases, a disabled doctor or dentist is still able to practice his or her "medical practice" in a general capacity. However, because of their specific disabilities, they can no longer practice surgeries or other bedrock medical procedures.

Imagine an orthopedic surgeon's shock when the insurer denies his disability claim because the insurer says he can still be a general orthopedic, but not an orthopedic surgeon. The insurer does not consider the disparity in income. ***It is up to the disabled doctor to prove the economic component of his disability claim. This often means bringing in a vocational expert and economist to prove the loss of earnings component.***

Most policies will provide definitions of Total and Residual or Partial disability and the requirements of both. If you think you may be able to work part-time and plan on filing for partial disability, you need to look at the mathematical formulas and limits very carefully.

Residual disability policies are often structured where, if you cannot make at least 60 to 80% of your former salary, you can get residual disability. This is primarily because of the reduction in income due to the loss of that key component of your job, which is the surgery component.

16. List medical providers and prescriptions.

It seems obvious that you need to provide an accurate list of your medical providers, but you also need to verify their contact information. If your medical providers have moved or changed phone numbers and cannot be contacted directly by your insurance company, they will be treated as if they don't exist. It is also important to provide a complete list of your prescription medication and the side effects of each medication.

17. Warn your doctors they may be getting calls from insurance company doctors.

You must prepare your doctors for the requests that the disability insurance carrier is about to make. Often, they will require your doctor to fill out monthly disability forms. One missed form can lead to a claim denial. The insurance carrier will also want to talk directly to your doctor. Explain to him how important it is that he take that call.

IMPORTANT! Understand that you have the right to refuse an unannounced visit and ask them to schedule a time that is convenient for you.

18. Be prepared for video surveillance and unannounced home visits.

A favorite tactic of disability insurance carriers is hidden video surveillance, especially if you are going to your doctor or going to the grocery store. They are trying to catch you doing something that you stated in your application that you can't do. Also, the carriers will send their claims investigators to your home unannounced to interview while you are off guard.

19. Be prepared to comply with strange and difficult requests.

A common tactic is to ask for documents or forms to be filled out over and over again, hoping you will trip up. Be consistent and vigilant in keeping up with their multiple requests for the same information.

20. Observe all deadlines to the letter.

You must file your application for disability within certain time deadlines laid out within your policy. If your application is denied or you are cut off, you usually have 180 days to appeal. If your appeal is denied, you have a limited amount of time to file your lawsuit that can vary from state to state or could be limited under the terms of the policy.

It is advisable to consult with an experienced disability insurance lawyer before filing your application. It is a must to consult with one before filing your appeal of a denied claim.

21. Consult with experienced disability attorneys.

Few attorneys are able to effectively deal with disability insurance denials of claims by physicians and dentists. Even fewer attorneys are familiar with ERISA law.

These are complex matters that require representation from a lawyer who knows how billion dollar insurance companies operate, is proficient in state and ERISA insurance law, and knows what is required to successfully overturn a claim denial.

11. WHAT DO YOU HAVE TO PROVE TO WIN YOUR DISABILITY INSURANCE CLAIM?

The insurance company defines disability, interprets the terms in their definition, and decides whether a claimant is disabled or not. The insurance company decides whether or not a claimant will receive benefits. This creates an inherent financial conflict of interest.

The Definition of Disability

There is no one legal definition of disability. Every insurance company, the Social Security Administration, and the Veterans Administration all have different definitions.

The definition of disability is explained in the policy. Usually, it is something along the lines of "Due to sickness or injury the employee is unable to perform the material and substantial duties of his or her own occupation."

Your Doctor Says You Are Disabled! Why Doesn't That Matter to the Insurance Company?

The insurance company determines whether or not you are approved or denied benefits. The insurer uses their own employees, either a nurse or an in-house doctor to review your medical records. Many times, these in-house consultants will have an opinion that is different than your treating doctor. The insurance company will state that your doctor's opinion is not supported by the medical records.

The Supreme Court has looked at this issue and decided that the "Treating Physician Rule" used by the Social Security Administration, does not apply in LTD determinations.

The Treating Physician Rule states if your treating doctor says you are disabled, that opinion is entitled to "great weight." In private and group LTD plans, the Supreme Court has held that your own doctor's opinion that you are disabled should be taken into account as "a factor" in the insurance company's determination of disability.

Social Security Says You Are Disabled! Isn't That Enough?

For a person under 50 years old, Social Security's definition of disability is actually a tougher standard than an LTD definition because a doctor, dentist, chiropractor, or other medical professional must be unable to work at any occupation available in the national economy. But because Social Security has slightly different rules for disability, the insurance company will ignore an award of benefits by Social Security by stating that the rules are different.

The insurance company will not take into account the loss of income that occurs when a doctor or dentist is no longer able to perform the specialty procedures of his or her practice.

But the Insurance Company Helped Me Get Social Security Disability

The insurance company is more than happy to help you get Social Security benefits because this helps the insurer financially. The insurance company contracts with another company that will represent you before the Social Security Administration. Your insurance company will reduce your LTD monthly benefit by the amount that you receive from Social Security and will demand that you "pay back" the insurance company the back benefits you received from Social Security.

Proving the Economics of a Physician's Disability Claim

Often a doctor's or dentist's practice is largely based on procedural services – minor surgical procedures such as endoscopies, eye laser treatments, routine dental surgery or skin biopsies.

One strategy used by insurance carriers to deny claims filed by medical professionals is to classify a doctor's or dentist's past work as a generalist, rather than a specialist.

For example, a "general" urologist might not practice surgery. The reality is most urologists also do vasectomies, which is a form of surgery and is responsible for a vast portion of their income. If the physician can no longer perform vasectomies, and is suddenly forced to work as a general urologist, by no means will he or she make the same kind of income as they would if they could perform vasectomies.

Vocational Review by the Insurance Company

If the insurance company finds a claimant "not disabled," they will often perform a cursory "vocational review."

The vocational analyst will take the restrictions the insurance company decides you have and the skills the vocational analyst derives from your past work history and come up with a list of jobs that you can perform. The vocational analyst will state that these jobs are available in your region and that the job will pay usually at least 60-80 percent of your pre-disability earnings.

These reviews are often flawed and make unreasonable suggestions for occupations.

Your Residual Functional Capacity (RFC)

A claimant's RFC is based on what physical level work a person can perform. The Dictionary of Occupational Titles and The Social Security Administration define work as:

Sedentary

A sedentary job is like an office job, where a claimant sits up to six hours a day, stands or walks up to two hours a day and lifts and carries up to 10 pounds, like files or small objects.

Light

A light job requires that a person be able to stand or walk up to six hours per day, frequently lift and carry 10 pounds and/or occasionally lift and carry 20 pounds. A majority of medical and dental professions and specialties are considered light jobs. Other examples of a light job classification might be cashier or security guard.

Medium

A medium job, like a nurse or commercial truck driver, requires the ability to lift 50 pounds;

Heavy

Heavy work, like construction, requires the ability to lift 100 pounds

Very heavy

Very heavy work requires the ability to lift more than 100 pounds.

12. PROVING YOUR RESIDUAL FUNCTIONAL CAPACITY (RFC)

Your RFC is the maximum remaining ability you have to do sustained work activities in an ordinary work setting on a regular and continuing basis. A regular and continuing basis means work done for eight hours a day, for five days a week, or an equivalent schedule.

Your RFC is expressed in terms of the exertional classifications of work. These classifications are described as sedentary, light, medium, heavy, or very heavy work.

Exertional Activities

Your RFC must be understood in terms of the seven primary strength, or exertional activities of work. These consist of **three work positions** and **four worker movements of objects**, as follows:

Three work positions:
- Sitting
- Standing
- Walking

Four worker movements of objects:
- Lifting
- Carrying
- Pushing
- Pulling

Definition of Residual Functional Capacity

Residual Functional Capacity (RFC) is what the disabled physician can still do despite his or her physical or mental impairments. In making this determination, the disability insurance carrier should consider all relevant medical and non-medical evidence, including medical records, observations by examining physicians, evaluations of the medical evidence by non-examining physicians, and the testimony of the disabled physician and others who have observed him or her.

RFC Levels

Each of the five exertional RFC levels – sedentary, light, medium, heavy, and very heavy – is defined in terms of the degree that the seven primary strength demands of jobs are required.

To illustrate this, the degree that the seven primary strength demands are required is set out below:

SEDENTARY WORK

- Sitting should generally total approximately six hours of an 8-hour workday.
- Periods of standing or walking should generally total no more than 2 hours of an 8-hour workday.
- Lifting no more than 10 pounds at a time.
- Occasionally lifting or carrying articles like docket files, ledgers and small tools.
- The term "occasionally" means occurring from very little up to one-third of the time.

LIGHT WORK

- Requires standing or walking off and on, for a total of approximately six hours in an 8- hour workday.
- May involve sitting most of the time, but with some pushing and pulling of arm-hand or leg-foot controls which require greater exertion than in sedentary work.
- Lifting no more than 20 pounds at a time.
- Frequent lifting or carrying of objects weighing up to 10 pounds.
- The term "frequent" means occurring from one-third to two-thirds of the time.
- If someone can do light work, he or she also can do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods.

MEDIUM WORK

- Requires standing or walking off and on, for a total of approximately six hours in an 8- hour workday.
- As in light work, sitting may occur intermittently during the remaining time.
- Lifting no more than 50 pounds at a time.
- Frequent lifting or carrying of objects weighing up to 25 pounds.
- The term "frequent" means occurring from one-third to two-thirds of the time.
- If someone can do medium work, he or she also can do light and sedentary work.

HEAVY WORK

- Requires standing or walking off and on, for a total of approximately six hours in an 8- hour workday.
- Lifting objects weighing no more than 100 pounds at a time.
- Frequent lifting or carrying of objects weighing up to 50 pounds.
- If someone can do heavy work, he or she also can do medium, light, and sedentary work.

VERY HEAVY WORK

- Requires standing or walking off and on, for a total of approximately six hours in an 8- hour workday.
- Lifting objects weighing more than 100 pounds at a time.
- Frequent lifting or carrying of objects weighing 50 pounds or more.
- If someone can do very heavy work, SSA determines that he or she also can do heavy, medium, light, and sedentary work.

RFC: Requirement to Consider ALL Physical and Mental Impairments

In determining a disabled doctor's or dentist's RFC, the disability insurance carrier should consider all competent medical evidence. The determination of RFC includes a consideration of all symptoms, including pain.
When mental impairments are alleged, the carrier should determine whether these impairments further limit the exertional tasks the claimant is deemed capable of handling. The evaluation of RFC in claimants with mental disorders includes consideration of the ability to understand, to carry out, and remember instructions to respond appropriately to supervision, coworkers, and customary work pressures in a work setting.

Evidence needed for making this determination includes:

- History, findings, and observations from medical sources (including psychological test results) regarding the presence, frequency and intensity of hallucinations, delusions or paranoid tendencies; depression or elation; confusion or disorientation; conversion symptoms or phobias; psychophysiological symptoms; withdrawn or bizarre behavior; anxiety or tension.
- Reports of the individual's activities of daily living and work activity, as well as testimony of third parties about the individual's performance and behavior.
- Quality of daily activities, both in occupational and social spheres.
- Ability to sustain activities, interests, and relate to others over a period of time. The frequency, appropriateness, and independence of the activities must also be considered.
- Level of intellectual functioning.
- Ability to function in a work-like situation.

RFC: Requirement to Consider Non-Medical Evidence

Non-medical evidence may be 'vital' in assessing the functional limitations of a mental impairment. Such sources explicitly include social workers and family members. The courts have noted that '[i]nformation concerning an individual's performance in any work setting (including sheltered work and volunteer or competitive work) . . . may be pertinent in assessing the individual's ability to function in a competitive work environment.'

Relevant evidence in assessing RFC includes subjective reports of pain testified to by the claimant—in addition to medical facts, diagnoses and medical opinions based on such facts.

Absenteeism and Its Effect on the Ability to Work

The disability insurance carrier should consider (1) the fact that a claimant would be absent from the workplace an inordinate amount of time due to physical or mental impairments, and
(2) the treatment regiments of such impairments. A disabled medical professional should consider having a vocational expert evaluate his or her impairment-related to excessive absenteeism.

Your Skill Level

Skill levels are also defined by the Dictionary of Occupational Titles, based somewhat on how long it takes a person to learn a skill.

- Unskilled or semi-skilled jobs, rated at skill level 1, 2, or 3, take less than 30 days to learn;
- Skilled jobs are rated at 4, 5 and 6;
- Very skilled jobs are 7, 8 and 9.

The majority of all highly trained health care professionals are classified as 7, 8 and 9.

The definition of "own occupation" is found in the policy.

Often it will state that the definition is based on how the job is performed in the national economy as defined by the Dictionary of Occupational Titles, not how the claimant actually performs his or her own occupation.

"Own Occupation" Standard Usually Limited to the first 24 Months

For the first 24 months or as defined in the policy, a claimant only has to be unable to perform their "own occupation."

Example 1: Nursing is a Medium occupation. If the claimant was working as a nurse but has a medical impairment, for example, a back problem, and is restricted to only lifting 20 pounds because of that impairment, the claimant would not be able to perform his or her own occupation.

Example 2: Claimant is a neurosurgeon diagnosed with Parkinson's disease. He is losing the ability to perform the essential tasks and duties of his own specialty practice. Neurosurgery falls within the Light job class and is considered skilled work requiring years of training and education. Although the surgeon may still be able to lift 20 pounds and stand for 6 hours, tremors, weakness, and the loss of fine dexterity must be taken into account as rendering him disabled from his own occupation.

The definition of "own occupation" is found in the policy. Often it will state that the definition is based on how the job is performed in the national economy as defined by the Dictionary of Occupational Titles, not how the claimant actually performs his or her own occupation.

"Any Occupation" Standard

After 24 months, a claimant must prove that he or she cannot perform "any occupation." Usually the definition includes "any occupation" that the claimant can perform based on his or her education, background and skills.

- **Benefits Usually Paid Up to Retirement Age:** If a claimant can continue to prove ongoing disability, benefits are usually paid through age 65, depending on the policy.
- **Special Rules if Disability Occurs After Age 60:** If a claimant's disability begins after age 60, benefits are paid according to a schedule in the policy. Depending on the age of the claimant, benefits will be paid for a maximum number of months. For example, a claimant who becomes disabled at age 63 would get 36 months; age 64, 30 months.

Salary Percentage Requirement under the "Any Occupation" Standard

The "any occupation" standard usually includes a salary percentage requirement. This provision in the policy is the requirement that your insurance company can't just say that you qualify for any job, at any wage and deny you disability benefits based on that. In other words, the insurance company must find occupations that will pay the claimant usually at least 80 percent of their pre-disability income.

13. WHY YOU SHOULDN'T USE THE INSURANCE COMPANY'S RECOMMENDED SOCIAL SECURITY REPRESENTATIVE

Frequently your insurance company will recommend one of several different companies that will represent you on your Social Security Disability claim. This is not done out of the goodness of their heart. They have a financial motive for you to win Social Security Disability benefits AND they have an incentive to keep tabs on you and your social security case.

They accomplish both of these agendas if they can control who you choose to represent you before the Social Security Administration. Many people don't realize it, but the disability insurance plan not only gives the insurance company the right to offset (subtract) your Social Security benefits from what the insurance company owes you now, but the insurance company also wants to recover your past benefits for their own use.

Using their recommended representatives (usually they are not even attorneys) allows them to track your progress with the SSA and swoop in and take any back benefits you recover.
Sometimes you owe it, sometimes you don't.

For example: You file a claim for long term disability. Your policy also requires that you apply for SSD. Once you are approved for SSD benefits, this creates an overpayment, and you are obligated to reimburse the insurance company from the back benefits of any SSD award.

In any event, it creates an obvious conflict of interest between yourself and their recommended representative. One of the most notorious suspects brags on its website about how much money it recovers for the insurance company, not what it recovers for you. The insurance carrier will offer an illusory incentive to convince an unsuspecting disability claimant to use their recommended SSD representative. The hook is that the SSD rep will help the claimant get Social Security Disability benefits free of charge, because the LTD insurer will cover the costs.

In reality, the claimant must turn over all back benefits to the insurance company anyway. Nothing is gained, and the claimant is not in control of what back benefits are truly owed to the insurance company.

Remember our discussion in Chapter 4 about The Social Security Offset and The Problem of Overpayments. If the insurance company is supposed to pay you $3,000 per month, and you also win Social Security Disability that pays you $2,000.00 per month, the LTD insurance company now only has to pay you $1,000.00 per month.

IMPORTANT! be aware of Social Security Disability "firms" recommended by your insurance company. Their purpose is to collect your back due benefits to reimburse your insurance company.

That is the financial incentive for the LTD insurance company to talk you into using their handpicked SSD representative. These SSD representatives are working for the insurance company, not you. Their business is to facilitate the insurance company's collection of overpayment.

So the first thing your insurance company does is to solicit you to sign up with their recommended SSD representative to handle your SSD claim. Your insurance provider tells you they will pay the representative, making this is free service to you. This deceptive tactic has you thinking that you are saving money and will be taken care of as far as receiving your SSD benefits.

As discussed in detail below, when SSD representatives access your claim, your private or confidential disability information is not treated confidentially – to the extent that the SSD representative will share your Social Security Disability information with the LTD insurance company, who may then find ways to use this information to undermine your LTD claim.

Why Do I Need Attorney-Client Privilege with an SSDI Claim?

Many disabled doctors and dentists apply for group or individual long term disability benefits in addition to their Social Security Disability. Here is the problem: Some Social Security advocates who are not attorneys specialize in getting their referrals from LTD insurance carriers.

LTD insurance carriers team up with non-lawyer advocates because, since they are not attorneys, there is no attorney-client privilege and the advocate can tell everything they know about your case to the LTD carrier. In other words the advocate's loyalty is to the LTD insurance company, not the SSD claimant.

This is an obvious conflict of interest. A dedicated Social Security Disability attorney is your loyal advocate who is going to watch out for you and protect your best interests 100% of the time.

Only an attorney can provide advice on the law. Moreover, many general practice attorneys who do not specialize in Social Security Disability law are unwilling to appeal claims to federal court because it requires particular expertise, time, and resources.

Why Is Representation in Federal Court So Important?

If your claim is denied during the administrative appeal, your last resort is appealing to the federal courts. Non-attorney advocates or representatives cannot appeal denied SSDI claims to federal court. Their ability ends with answering questions concerning administration policies and procedures.

Why Is Attorney Accountability So Important?

Attorneys are bound by the ethical rules of the legal profession and are subject to the discipline of the courts and bar authorities. The rules of professional conduct obligate lawyers to zealously and competently represent their clients, charge only reasonable out-of-pocket costs, and maintain good communication with the client to keep them informed on the status of claim. A lawyer is never allowed to represent a client if the representation involves a concurrent conflict of interest.

If your case has been mishandled or your lawyer has violated any rules of professional conduct, you can file a grievance with their state bar. Non-attorney advocates or representatives are not members of, nor regulated by, state bars and are not subject to the same disciplinary measures as attorneys.

14. WHAT DOES AN ATTORNEY DO TO HELP YOU WIN YOUR CLAIM?

Every client is different and has different needs, but below are just some of the things an experienced attorney may do to help you with your disability insurance claim:

- Aid you in filling out all insurance company forms correctly and without inadvertently saying things that damage your claim;
- Evaluate your insurance policy and advise you on its meaning, the law and your options;
- Review your medical records and make suggestions for any additional testing required to prove your case;
- Supplement your claim file with additional medical records and testing;
- Obtain your complete claim file from the Insurance Company pursuant to Federal ERISA statutes;
- Obtain medical reports and opinion evidence regarding your disability;
- Consult with qualified Vocational Experts to get opinion evidence rebutting an insurance company's denial;
- Obtain and develop evidence regarding your "Residual Functional Capacity" that is the key to your disability claim;
- Develop evidence to rebut surveillance video;
- Develop evidence impeaching the credibility of the insurance company's doctors and vocational experts;
- Quickly and effectively file your administrative appeal when necessary;
- Correctly calculate your benefits;
- File a legal brief arguing the legal, medical and vocational issues in your case;
- File a lawsuit in Federal Court if necessary;
- Conduct discovery in the Federal Court case, such as filing interrogatories and requests for production, as needed, as well as taking all necessary depositions;
- Respond to Motions for Summary Judgment and trying your lawsuit;
- Most importantly, let the insurance company know that they cannot run over you!!!

15. WHAT IF YOUR DISABILITY CLAIM IS DENIED? THE ADMINISTRATIVE APPEAL

The basic process is:

- You file a claim for disability;
- If the insurance carrier denies you, generally you have 180 days to respond;
- You go through an internal administrative appeals process; and
- After that, if you are still denied, you have the right to file a lawsuit against the insurer

After the claim is filed, the insurance carrier will either grant the claim or deny the claim. If the claim is granted, the insurance company will begin to pay monthly benefits.

If the claim is denied, the claimant will receive a "denial letter." This letter is very important because it will list what evidence the insurance company reviewed when making its decision, and who reviewed the evidence – such as an in-house Nurse Case Manager, a doctor hired as a consultant or only non-medical reviewers such as a Senior Claims Adjuster.

The denial letter should state the reasons the claim was denied and what medical evidence the claimant needs to prove disability. The denial letter also gives important information for an appeal, including where and when the appeal must be received.

Time Limits for Filing Your Appeal

The denial letter will give the time limits for filing the appeal. If the policy is an ERISA-governed group benefit, the appeal deadline is 180 days. Most non-ERISA policies also give the claimant 180 days to appeal.

In every case, it is very important to read the denial letter carefully, so no deadlines are missed. If an appeal deadline is missed, the claimant is unable to appeal. If the claimant does not "exhaust" or use all appeals available, the claimant will not be able to file a lawsuit.

The Administrative Appeal Procedure – What You Need to Know

Filing a long term disability claim and receiving benefits is not an overnight process, and the administrative appeal procedure alone can take up to a year.

The process is basically the same for both ERISA and non-ERISA regulated claims. Because ERISA regulations must be followed to the letter, and because so many claims fall under ERISA, insurance companies tend to keep the same administrative appeals process and procedures in place for all claims.

The following explains in greater detail what anyone filing an ERISA claim should know about the administrative appeal process and the statute of limitations.

Under federal law, a claimant cannot bring a claim under judicial review until an internal review is carried out. This internal review, or pre-suit administrative appeals procedure, begins when a claimant submits their proof of loss. At that point, the Plan (i.e., the insurance company) has a set amount of time to carry out an internal review before the claim is taken to a judicial court. How does this work?

- The Plan has 45 days from initial application to determine that benefits are not a medical necessity to the claimant or that the claimant is not eligible for benefits for any other reason.
- The Plan may use two 30 day extensions based on elements outside of their control, such as a claimant's failure to submit documents necessary to make a decision based on their claim.
- The claimant must appeal a denial of their claim within 180 days of that denial.
- The Plan has 45 days to resolve any appeal with one 45 day extension.

The Statute of Limitations for Civil Action

Physicians whose initial claim was denied and then denied again on appeal need to pay close attention to the timeline for filing a lawsuit, because the statute of limitations for civil actions in ERISA cases has recently changed.

Statute 502 (a)(1)(b) requires that a claimant exhaust the internal review process before bringing their case under judicial review. ERISA does not provide a statute of limitations for actions under 502 (a)(1)(b), but a specific ERISA plan may have a limitation provision that goes into effect as soon as an individual files their claim.

Previously, the federal courts had been divided on whether an ERISA plan limitation provision is enforceable during the internal review process. Since the internal review process can take a year or more, it may use up a substantial amount of the claimant's limited time to file a lawsuit. In 2013, the Supreme Court resolved this issue by ruling that a contractual statute of limitation on an ERISA plan is enforceable, and the statute of limitations can begin to run from the time an individual files their claim and is not tolled during the administrative appeals process. Most policies have a three year contractual statute of limitations period but many are as short as one year and some shorter than that.

If you are worried that the Plan is dragging out the ERISA administrative appeal procedure or otherwise trying to stop you from filing a lawsuit within the applicable limitations period, you should meet with an experienced ERISA attorney as soon as possible.

Mistakes That Even Lawyers Make

Lawyers who are not familiar with disability issues do not always understand what has to be proven. These lawyers may argue that because the claimant's doctor or Social Security has found the claimant disabled, the insurance carrier "must" find the claimant disabled. Although these are factors to consider and do support disability, these two factors alone do not prove disability to the insurance carrier.

Some lawyers may not understand the difference between "own occupation" and "any occupation," or the subtle differences in each carrier's definition of "disabled." Inexperienced lawyers may argue the medical diagnosis, which does nothing to help prove disability.
Especially in cases where a disabled individual is a doctor, dentist or other skilled medical professional, one way the attorney must combat an insurance company's denial tactics is by unequivocally proving the economics of their client's case.

What Happens If I Refuse to Be Examined?

Because the disability policy is a contract, all contractual obligations must be followed. If the policy indicates that the insurer has a right to have the claimant examined, that is a contractual obligation. If you refuse to be examined, benefits can be terminated.

What Happens If You Win Your Administrative Appeal?
If you win the administrative appeal, you will receive back benefits (monthly benefits from the date benefits were cut-off) and be put "back on claim." You will begin to receive monthly disability benefit payments. You will still need to adhere to all contractual obligations and will need to continue to send in updated medical records and Attending Physician Statements to prove on-going disability.

16. DO YOU NEED AN ATTORNEY TO HELP WITH THE ADMINISTRATIVE APPEAL?

An experienced attorney will perform many tasks on appeal, including:

- Writing an appeal letter that addresses each of the carrier's allegations;
- Contacting and obtaining expert opinions;
- Sending a claimant out for a functional capacity exam or other medical exam;
- Obtaining updated medical records; and
- Carefully go through the claims file to see if the insurance carrier followed the proper procedures in handling your claim.

Often they will write a one-paragraph appeal stating "I appeal your decision. Please reconsider." This approach rarely succeeds.

A disability lawyer will help you gather all necessary documentation, prepare and file a proper conclusive appeal, talk with your doctors, obtain statements from witnesses, consult with qualified vocational experts, and use the latest science and technology to investigate and build the details of your case.

Loading the Record

Many times, the medical record itself is not enough to fully support an administrative appeal. How the medical evidence is presented and expressed, or how an injury or illness has been detailed and explained is what really makes a difference.

During the administrative appeal process, medical records, medical literature and articles, doctor's opinions, letters from friends or employers, photographs, and all other types of evidence that document your impairments can be submitted and made part of the "record."

Once all appeals allowed under the policy (usually one or two) are "exhausted," the "record" is closed. There is case law that indicates that more material can be added to the record before a lawsuit is filed, but usually once all appeals are exhausted, the carrier will send any newly submitted evidence back.

In ERISA cases, after a lawsuit is filed, nothing else can be added to the record. That is why it is so important to fully load the record during the appeals process. An experienced attorney will understand the importance and ensure that the record is loaded.

Obtaining Vocational Expert Opinions

The correct and effective use of a Vocational Expert's testimony and written assessment is critical to both support your appeal and to disprove opposing testimony from the insurance company.

Vocational experts are sometimes called "jobs experts" or "VEs" for short. VEs usually have a master's degree or a Ph.D. in a field such as Vocational Rehabilitation or Vocational Counseling. Using a disabled physician's Residual Functional Capacity (RFC), taking into consideration all of physician's restrictions and limitations caused by his or her medical impairments, and the physician's age, education, background, work experience and skills, the VE can form an expert opinion on what jobs the disabled physician may be able to perform. The VE could also come to the conclusion that there are no jobs available in the national or regional economy that the physician can perform.

Some policies' definition of disabled include that the physician is disabled if he or she cannot find work that pays a certain percentage of their pre-disability income, usually around 60 to 80 percent. A VE researches the local job market and wages and is able to form an opinion on whether or not there are jobs that the disabled physician can perform and still meet the salary percentage.

An example would be an orthopedic surgeon who performed skilled surgical procedures requiring fine dexterity and the ability to stand and bend over patients for hours, and now can only do sedentary work. It is quite likely any sedentary job will not pay enough to reach the salary requirement. The disabled surgeon would meet the policy definition of disabled because the VE found that there are no jobs that the claimant could perform that pay 80 percent of his or her salary.

Obtaining Medical Expert Opinions

In the same way that the VE reviews the record and forms an expert opinion, an independent medical expert can review all the medical records and form an opinion about a disabled doctor's or dentist's RFC. Sometimes the medical expert will also examine the claimant and include those findings in the report.
A claimant may need a medical expert opinion if there are not very many records or if the records don't accurately reflect the claimant's condition.
Rebutting Insurance Company Distortions and Mischaracterizing of the Evidence
The insurance companies claim adjusters focus only on the evidence that supports a denial and ignores evidence that supports disability. This is called "cherry-picking" the record.

For example, a claimant's physician may write a letter that states that their patient is disabled due to pain and can no longer work, but on another form may indicate that their patient could sit for eight hours a day. The insurance company will ignore the "disabled" letter and state that the physician has released the claimant to work in a sedentary position because the claimant can sit for eight hours.

A good lawyer knows this is going on and will ensure the proper evidence and expert testimony is in place if the insurance company cherry picks the facts in an attempt to block your claim.

Rebutting In-House Medical Reviews

The insurance company often has nurses and doctors on staff who review medical records. A seasoned attorney will effectively argue against the insurance company's in-house medical reviews and any misuse or misrepresentation of the evidence by the insurer.

17. INSURANCE COMPANY TACTICS

Insurance companies can use video surveillance as evidence to terminate benefits even when the record as a whole supports a finding of disabled."

Separating Impairments during the Review

Many physicians have more than one medical impairment. It may be the combination of impairments that renders them disabled. However, during a file review, the hired doctors will focus on each impairment individually and find that the physician is not disabled based on that one impairment.

It is not unusual for the insurance company to send the file out to several doctors, each with a different "specialty." When a physician's impairments are separated out, the reviews do not reflect a true picture of the physician's condition. The physician ends up with several expert opinions saying he is not disabled—but those experts have not even seen the totality of the conditions the physician is actually faced with.

Video Surveillance

The administration of high-end disability claims is a billion dollar business, with insurance carriers hiring private investigators to covertly film disabled medical professionals as they go about their day.

Some insurance companies make a habit of videotaping claimants after they have received benefits for a year or two. The insurance company will claim that there are "red flags" that indicate a doctor or dentist may be working or be capable of working, so an "investigation" is necessary. Often, the only activity that is "caught on tape" is a claimant going to a doctor's appointment, going to the pharmacy or driving through a fast food chain.

The insurance company will always claim that a claimant is capable of more activity than originally reported because he or she was "able to enter and exit a motor vehicle unaided," "use a cell phone," and "walk about in a non-guarded fashion." Later, a representative of the insurance company will visit the disabled doctor for an "interview" and show them the footage.

This can be intimidating to a claimant. Then the insurance company will use the video surveillance as evidence to terminate benefits even when the record as a whole supports a finding of disabled.

Disability Insurance Companies Watch You

There's absolutely nothing in your policy that gives your insurance company the right to hire a private investigator to watch you and record your daily activities, but that hasn't stopped most of them from doing it more and more in recent years.

The idea is that by following beneficiaries around and watching them closely, they'll catch people in the act of doing something they shouldn't be able to do based on their condition and have a valid reason to deny your claim or stop payments.

Supposedly, it's a way to cut down on fraud, but all too often it results in the insurance companies or the investigators they hire using shady practices to make it look like claimants are behaving badly when the truth is something completely different.

So, how do you fight back against these tactics and make sure you get the long term disability benefits you need?

What To Do When Surveillance Costs You Benefits?

The way surveillance works in a disability insurance denial is that insurance companies will send video recordings and the investigator's written report to the independent medical examiner treating you. They want to bias the doctor against you and get him to ask leading questions and look for specific things, so it's important that you know how to deal with this kind of evidence.

Watch the footage. You should be allowed to look at the footage yourself so that you can see how you're being represented and explain anything that appears to hurt your claim. Often, things will be taken out of context and may even be edited to make you look worse, so you need to know what you're dealing with.

Read the reports. Investigators are supposed to simply report the facts, but quite frequently their reports are riddled with editorializing comments designed to turn the doctor against you. It's not even out of the question for investigators to turn in reports that barely seem to match the actual video footage.
Learn what the claims person used. Far too often, the claims person deciding your fate doesn't even bother to watch the actual video footage because that takes up too much time. Instead, they simply read investigators' reports. But as mentioned above, quite often the reports are incredibly editorialized and exaggerate what's in the videos. A good disability attorney will then use this to argue that they didn't consider all the evidence when denying your claim.

Until disability laws are changed to prevent spying, this is the only recourse claimants really have.

A CASE STUDY: Disabled dentist is denied benefits when insurer "cherry-picks" the medical record based on 5 minutes of video surveillance

The insurance carrier terminated disability benefits for our client, a dentist who suffered serious back and shoulder pain as well as psychiatric impairments. Our client's impairments were fully documented medically and vocationally.

The insurer's decision to terminate benefits was based largely on 5 minutes of video surveillance. Our client was videoed driving, walking, lifting bags, shopping and standing. Specifically, she exits her vehicle and walks to the mailbox. She pulls the trash can from the street to the side of the residence. She sorts mail. Our client did not exceed her stated limitations, and the surveillance video accurately reflected our client's functional capacity as reported to the insurer.

The insurance company's reviewer stated that he could medically evaluate our clients from a short video. Moreover, the video observations constituted the insurer's only attempt to evaluate our client's physical and mental capabilities rather than requesting an independent medical evaluation.

The insurer also compelled our client to engage in a cold-call interview. The insurer relied on the interviewer's observations that our client "showed no signs of any difficulty moving around." Such conduct and emphasis on misconstrued statements fails to constitute substantial evidence that our client is totally disabled from work.

We appealed the insurer's decision under the premise that its emphasis on misconstrued statements and a brief video is largely conjecture and has the overwhelming appearance of "cherry-picking" the medical record to present our client's disabilities in a misleading way, rather than a principled assessment of our client's functional abilities and medical impairments.

Our appeal was firmly based on our medical and vocational findings and supported by case law. Our appeal also contended that the insurer's conduct constituted unfair and deceptive acts and practices as well as misrepresentation. The insurance company engaged in:

- Breach of Duty of Good Faith and Fair Dealing,
- Breach of Contract,
- Violations of State Insurance Code, and
- Violations of Deceptive Trade Practices Act.

What Is Non-Compliance?

If a disabled physician refuses treatment or does not take medication as directed by their doctor, that claimant is "non-compliant."
When the insurer attempts to use your refusal as a tactic to deny a valid claim, a good lawyer will apply the law to protect you and help you prove your decision or action was based on reasonable and valid grounds. There is a difference between a disabled dentist or doctor choosing to not undergo a surgery because of possible adverse outcomes or not being able to pay for medication, and non-compliance.

Functional Capacity Exam

A Functional Capacity Exam ("FCE") is a series of physical tests given to determine a claimant's RFC. These are standardized tests given by a physical therapist over about a 3-4 hour period in a gym-like setting. The claimant walks on a treadmill, lifts and carries cardboard boxes and goes through a series of different postures, like squatting and crawling. The physical therapist observes and analyzes the claimant's physical abilities to sit, stand, walk, lift and carry.
These tests are designed to surmise the claimant's maximum RFC in the work environment. However, 3-4 hours of activity can't really reflect how well a disabled doctor, dentist, chiropractor or other medical specialist would do eight hours a day, day after day, week after week.

The FCE can be a confusing and painful process for a disabled claimant. When conducted improperly, the FCE can produce unreliable data that can actually be used against a claimant to challenge the statements of the treating doctor. Insurance companies often write their policies to force a disabled medical professional to endure an FCE.

What Is Malingering?

Malingering means that a person deliberately pretends to have a disability in order to avoid working and to gain financial benefits. Another term used by insurance companies is "symptom exaggeration."

The insurance company will state that the disabled doctor's symptoms do not correlate to "objective evidence," so he or she must be exaggerating the pain or other symptoms.
One of the tests performed at a FCE is a grip strength test where the claimant squeezes a handle rapidly, alternating hands. In claimants with normal or weak grips, the test results tproduce a bell shaped curve. The thought behind this test is that it is difficult to consciously control how hard a person grips the handle in a rapidly alternating exchange.

If the results are not bell-shaped, the individual will be accused of faking their hand strength. Most importantly, the insurance company will then claim that the claimant was malingering on all the tests and therefore, even if the FCE shows that the claimant has a very low RFC, the insurance company will say the FCE results are not valid. However, scientific study of these tests on people with carpal tunnel syndrome show that these tests are really not reliable to distinguish true or faked hand weakness.

Non-Medical Problems at Work

Insurance companies sometimes make the claim that you are not really ill and that you "just want a lifestyle change." The insurance company will ask if you ever had any problems at work with supervisor or co-workers. This is an attempt by the company to characterize symptoms as "job stress."

Discounting the Opinions of Treating Physicians (Relying Solely on In-House Medical Reviews)

An award of LTD benefits relies heavily on the evaluation of your medical condition. The extent to which an impairment prevents you from performing the material duties of your own occupation is paramount. Your treating physician's medical opinion is an essential part of confirming the extent of your disability.

Insurance carriers may attempt to disregard or override the opinion of your doctor(s), and instead provide conflicting medical opinions using their own in-house physicians. Even though your treating doctor advised you to file for disability, has provided medical evidence that you are disabled and has continued providing your care and treatment – many insurers discount all of it and rely solely on their in-house doctor's medical review.

A CASE STUDY: Ophthalmologist is denied benefits when insurer discounts treating doctor's opinion

Dr. L is an ophthalmologist who suffered from both physical and mental impairments. In 2000, Dr. L filed a claim for disability with his insurer. Short-term disability benefits were granted. Dr. L then filed for long-term disability benefits with the same insurer, who initially granted the LTD benefits.

Sometime later, the insurer terminated the LTD benefits. Dr. L was notified that he had 180 days to appeal this decision.

Dr. L requested an administrative review of the denial. As allowed in the Plan, an administrative appeal was timely submitted with additional information including medical records showing that he was totally disabled from performing both his own occupation and any other occupation as defined by the Plan.

Dr. L suffers from degenerative and traumatic injuries and impairments, including radicular pain, hearing loss, disc herniation and severe back pain. Dr. L's medications had caused additional side effects in the form of sedation and cognitive difficulties.

Dr. L's treating physicians have carefully documented all symptoms with medical facts.
The insurance company did not budge. It affirmed its original decision to deny benefits, and also stated that Dr. L had exhausted his administrative remedies.

With this final denial, the insurer blatantly discounted the opinions of Dr. L's treating physicians. It also discounted the documented limitations from which he suffers, including the effects of Dr. L's impairments on his ability to engage in work activities.

The next action is to reverse the denial in a lawsuit against the insurance company on three counts:

- Breach of contract,
- Bad Faith / Vexatious Refusal to Pay, and
- Breach of Fiduciary Duty.

Insurance companies will always protect their own interests, which often means that they plan to discount and ignore your own doctor's medical opinions—regardless of the legitimacy of your claim.

[Note, if long-term disability benefits are granted, the insurer will have had to pay a monthly benefit of just over $20k a month for the length of Dr. L's life.]

Because of the high worth of these disability claims, medical professionals must be ever vigilant in protecting themselves.

An experienced insurance lawyer will anticipate this behavior, and will outmaneuver such conduct with the strategic and meticulous preparation and presentation of medical and vocational evidence.

18. FILING AN ERISA LAWSUIT IF MY ADMINISTRATIVE APPEAL IS DENIED

Who Can Sue?

Any plan beneficiary or participant may bring suit to enforce their rights under the plan or policy. This generally means the disabled individual but in some cases could be a spouse, an estate or an heir.

Who Do You Sue?

Typically in a disability claim, the suit is brought against the Plan or the Plan Fiduciaries, often called the Plan Administrator. Frequently, the plan administrator is the underwriting insurance company. Hence, the reason we generally refer to the insurance company throughout this book when we are speaking about the Plan. Occasionally, but not often, the proper defendant is the claimant's employer. The test is who had the authority under the plan to grant or deny the disability claim.

ERISA states you may file your lawsuit in one of four places:

- Where the Plan is administered;
- Where the breach occurred;
- Where the defendant resides; or
- Where a defendant may be found.

Where Can I File My Lawsuit?

The plaintiff's choice of venue is given great deference by the courts. In benefit denial cases, the courts generally conclude that the breach of contract occurs where the benefits are to be received. Practically speaking, this means you may file your lawsuit where you live or expect your benefit checks to be delivered. You may file an ERISA case in either state or federal court, but invariably the defendant will remove (transfer) your case to federal court based on federal issue jurisdiction.

What Remedies Can I Sue For?

Under ERISA, you may sue to "recover benefits due under the terms of the plan, to enforce rights under the terms of the plan, or to clarify rights to future benefits under the terms of the plan." The only relief available is to require the plan to pay what it was required to pay in the

first place, including an award for retroactive benefits. No extra contractual compensatory damages or punitive damages are allowed. You may also seek a declaration of a right to future benefits or an injunction preventing a future denial of benefits.

IMPORTANT! Your lawsuit must be filed prior to the expiration of the appropriate statute of limitations or your claim is lost forever. This is an absolute. One day late and your claim is gone, PERMANENTLY

How Long Do I Have to Sue?

All potential claims for which a lawsuit could be filed have deadlines for filing suit. These deadlines are known as the "Statute of Limitations."

Oddly, ERISA provides for no statute of limitations directly, so instead you must look to each individual state for the appropriate deadline. Most courts apply a breach of contract statute of limitations to a benefit denial claim under ERISA. In Texas, for example, the deadline would be four years from the date of breach or denial. This varies from state to state. However, the insurance plan or policy may shorten the deadline pursuant to the terms of the plan. It is vital that you check your plan documents for any pending deadlines. Many plans shorten the deadline to three years from the date proof of disability must be provided. Some plans have much shorter deadlines.

IMPORTANT! Remember, only the evidence submitted during your administrative appeal can be used during your federal lawsuit. If you don't do an excellent job developing your evidence at this point, you probably won't have much of a chance in Court!

Do I Have to Exhaust My Administrative Appeals Before I Can Sue?

In one word, Yes! ERISA regulations require that all Employee Benefit Plans have an Internal Administrative Appeal or claims procedure. The courts have interpreted this to mean that it is mandatory that you go through with an Administrative Appeal and "Exhaust" your administrative remedies before you have a right to file a lawsuit. **YOU CANNOT SKIP THIS STEP!** If you do you will lose your right to file your lawsuit.

The denial of a disability claim must be done in writing. Generally the last paragraph or two of the denial letter spells out the deadline for filing the administrative appeal. Usually the deadline is 180 days from the date of the denial letter.

What Do I Have To Prove?

Winning your lawsuit requires much more than simply proving you are disabled. You must prove that the insurance company that denied your disability claim "abused their discretion" in denying your claim based on the evidence available to them at the time they made their final decision to deny the claim. That is why it is so important that your case is properly developed during the administrative appeal.

Experienced ERISA attorneys know that it is critical to the litigation to prove both a structural conflict of interest and an individual conflict of interest that is present with the insurance company and its decision makers. The odd procedure set up under ERISA allows the insurance company to decide if they have to pay the claim, assuming that their financial self-interest won't outweigh their fiduciary duty to do the right thing.

In previously litigated cases, it has also been discovered that insurance carriers sometimes create financial incentives for their own doctors, vocational experts and decision makers to keep claims cost down. These inherent conflicts of interest must be demonstrated to the court when litigating these cases. Doing so can cause the court to use a more favorable "sliding scale" when deciding these cases.

Some states are beginning to attempt to remove or void language in insurance contracts that give the insurance carrier complete "discretion" in deciding claims. If this trend continues and is upheld by the federal courts, it would ease the claimant's burden of proof before the federal court. This will vary from state to state and is another reason to consult an experienced ERISA attorney early in the process.

What Are the Possible Outcomes?

When litigating an ERISA disability claim, the mostly likely outcomes, depending on the strength of your case are:

- **Settlement:** It may be possible to negotiate a "buyout" with the insurance carrier to settle the claim and surrender the policy.
- **Motion for Summary Judgment:** The case could be decided for or against you based on a Motion for Summary Judgment filed either by yourself (through your attorney) or by the insurance carrier. A motion for summary judgment is filed by either party when they believe the case could be decided by the judge "as a matter of law" without the need for a trial. Remember, there is no opportunity to submit new evidence to the court; therefore, the only thing the judge needs to consider to decide the motion for summary judgment is the evidence already submitted (referred to as the administrative record).
- **Bench Trial:** The judge could decide to have a bench trial. Since there is no right to a jury trial, the case would be tried to the judge at the "bench." The judge would indicate what issues were not decided on the motions for summary judgment and that would dictate what live testimony may be needed for the judge to decide the remaining issues.
- **Remand for Another Administrative Appeal:** The judge could order the case remanded back for another administrative appeal to develop the case further.

One thing to remember is that if a judge rules in your favor, he or she only has the power to order the insurance company to pay you the back benefits you are owed and to start your monthly benefits from this point forward. The insurance company has the right to require you to continue to demonstrate that you are disabled per the policy definition and could conceivably cut you off again in the future. The judge may award you some attorney fees as well.

19. FILING A LAWSUIT ON A PRIVATE (NON-ERISA) DISABILITY INSURANCE CLAIM

Pro Tip
Give your insurance company every opportunity to do the right thing and put it in writing.

If you purchased your own private policy and you believe your carrier has wrongly denied your claim, you have far more legal recourse than claims subject to ERISA law.

A lawsuit against an insurer for privately purchased LTD insurance is governed by state laws. You are entitled to all procedural rights and remedies available to you in your state – just like you would under your privately purchased homeowner's or life insurance policies. You will retain the right to a jury trial and the right to present evidence and cross-examine any witnesses testifying for the insurance company.

If you have a private disability plan, you will be treated much better by your insurance company. Since these cases are based on the individual state law that applies to the particular policy, we would have to write 50 different books to cover the topic. As such, we only discuss the topic generally.

In cases where an insurance carrier has denied a claim, most states have multiple remedies available if litigation is necessary. What applies to all state law claims is that you should endeavor to

Many states require that you put your grievances in writing and establish a certain amount of time that must be given for the insurance company to comply. If the insurance company fails to comply with your requests by the statutory deadlines, you probably have many extra contractual remedies available to you that you would not be available if your case was ERISA preempted.

These contractual remedies include causes of action for:

- Breach of contract
- Bad faith
- Punitive damages
- Mental anguish or consequential damages
- Loss of credit
- Deceptive Trade Practice Act damages
- Insurance Code Violations
- Attorney fees.

In a lawsuit seeking private LTD benefits, you also have rights that are not available under ERISA law:

- You are allowed a trial by jury,
- You may engage in discovery of relevant evidence from the insurance carrier, and
- You may cross-examine any witnesses the insurance company puts on the stand to testify against you.

Breach of Contract of a Private Disability Insurance Claim

Under a breach of contract claim, your attorney must prove that the insurance provider fundamentally violated the insurance policy by failing to acknowledge your disability in accordance with the terms of the policy.

Breach of contract lawsuits are often focused on the language in the policy to establish what obligations each party had, and whether the parties met those obligations. Your attorney will strive to compel the insurance company to pay compensatory damages (the value for the actual denied benefits and any incidental damages.)

Bad Faith in Private Disability Insurance Claims

Did the insurance company breach the covenant of good faith and fair dealing by denying your claim?

Did the insurer willfully act with the intent to cause harm, or intentionally ignore the risk of causing harm?

If there was no reasonable basis for the denial under the policy, the insurance company breached the insurance contract in an act of "bad faith."

Some common indicators of bad faith actions are when an insurance company

- misrepresents the provision and coverage in the policy
- does not acknowledge your claim or reply to you promptly upon notification of a claim
- does not investigate your claim promptly and thoroughly
- tries to make you settle your claim for much less than it is worth
- alters any part of the policy without your knowledge
- denies your claim without explanation
- delays or denies payment without a reasonable basis
- applies unreasonable misinterpretations of policy language

Verdicts of bad faith insurance may result in the award of monthly disability benefits, plus punitive damages, together with litigation costs and attorneys' fees. The jury will consider the amount of harm caused, motive, and other factors of the case.

Meticulous preparation and understanding the methods used by powerful insurance firms is the key to success. If you have such a claim, bringing in an experienced attorney early will help you "set up" your case for a good result down the road.

CASE STUDY: A Urologist's Non-Erisa Claim Denial

The following is an ongoing case in which big insurance fails to honor a privately purchased disability insurance policy with the disabled policy owner.

The Claimant

Dr. S, a 67 year old urologic surgeon, filed a disability claim with his insurance company Unum. He has been a covered beneficiary since 1990 under an individually purchased disability income policy for business overhead expense.

Dr. S became disabled in 2012 due to injuries to his left hand. Surgery was required to repair a fracture of the proximal pole of the left scaphoid bone. Dr. S. now suffers from multiple medical conditions resulting in both exertional and non-exertional impairments. He suffers from the loss of his pre-surgery dexterity in his left hand, and requires ongoing pain management.

His multiple impairments have resulted in restrictions in activity, have severely limited his range of motion, and significantly curtailed his ability to engage in any form of exertional activity. Dr.
S. suffers from chronic pain and discomfort. His medications cause additional side effects in the form of sedation and cognitive difficulties.

The Insurance Company

The defendant in this case is Unum Life Insurance Company of America (Unum) who denied Dr. S's claim and gave him 180 days to appeal the decision.

In its denial, Unum discounted the opinions of Dr. L's treating physicians, and discounted documented limitations from which Dr. S suffers, including the documented effects of Dr. S's impairments on his ability to engage in work activities.

If granted, the plan would pay monthly benefits of $14,000.00.

Administrative Appeal

Dr. S filed an administrative appeal perfected with additional information including medical records to show that he is partially disabled from doing the work of his occupation as defined by the Plan. The administrative record fully documents the aforementioned impairments and their symptoms, which preclude Dr. S's ability to perform any work activities on a consistent basis. As such, Dr. S has been and remains disabled per the terms of the Plan and has sought disability benefits as stated in the plan. However, after exhausting his administrative remedies, Unum persists in denying Dr. S his rightfully owed disability benefits.

Allegations of Wrongful Denials of Disability Benefits

Dr. S's final option is to file a lawsuit against Unum in state or federal court under the following allegations:

Breach of Contract: Unum's conduct constitutes a breach of the policy, and has failed to perform its obligations under the contract by failing to pay Dr. S's properly submitted and payable claim.

Breach of Duty of Good Faith and Fair Dealing: Unum breached its duty of good faith and fair dealing, and has thus failed to execute a prompt, fair and equitable settlement of a claim with respect to which Unum's liability has remained consistently clear.

Insurance Code and DTPA Violations: Unum has violated both the Texas Insurance Code and The Texas Deceptive Trade Practices Act sections and articles by:

- misrepresenting the of benefits and advantages of the policy
- placing before the public materials containing untrue, deceptive or misleading assertions, representations or statement regarding the policy
- engaging in unfair settlement practices
- misrepresenting the terms of the policy
- representing that services had characteristics, uses and befits that they did not have
- representing that an agreement conferred or involved rights, remedies or obligations which it did not have
- failing to disclose information concerning services which was known at the time of the transaction where the failure to disclose such information was intended to induce Dr. S into a transaction into which Dr. S would not have entered had the information been disclosed

20. THE IMPORTANCE OF ATTORNEY REPRESENTATION DURING YOUR LAWSUIT

Whether you are a cardiologist, anesthesiologist, surgeon or a dentist, your disability policy likely falls in the "high dollar" category – one that would be quite beneficial for the insurance carrier to deny and not have to pay.

An experienced disability lawyer is well aware of all the tactics an insurance company uses during the administrative appeal process to turn down a claim. Many of these tactics have been litigated in prior lawsuits. A good attorney researches case law in a claimant's jurisdiction and uses that law to support legal argument to persuade the judge that the insurance company made the wrong decision in finding the claimant not disabled.

Remember, in long term disability lawsuits under ERISA, there is no jury trial, only a trial before a judge, called a bench trial. The judge reviews written legal arguments to make a decision. It is important to have an attorney knowledgeable in the appropriate case law during the lawsuit. An attorney understands the strengths and weaknesses of a case and may be able to negotiate a cash settlement on behalf of the claimant before it is necessary to present an argument to a judge.

21. HOW DOES AN ATTORNEY GET PAID?

There are a number of ways to hire an attorney. They range from a traditional hourly basis, to a pure contingency fee arrangement in which the attorney is compensated from the proceeds of the case and the disabled claimant does not owe attorney fees unless the claim is successfully resolved, or some combination of both.

The difference generally boils down to who is taking the risk of whether a recovery is made: the client or their attorney. If you hire an attorney on an hourly basis, you are taking all the risk of an unfavorable outcome. In other words the claimant has to pay attorney fees whether they win or not. Under a contingency fee arrangement, the risk of not getting paid shifts to your attorney. In other words, the attorney will not get paid if the claim is not successful.

Most claimants, including medical professionals, hire their lawyer on a contingent fee basis. Generally speaking, an attorney expects to get compensated more for doing contingency fee work because the attorney is assuming a risk that they will not get paid at all.

Can I Get My Attorney Fees Paid by the Defendant?

In the case of ERISA lawsuits, the answer is "Maybe, but it is difficult." Generally speaking, attorney fees are not recoverable in most causes of action without an explicit statute authorizing it.

ERISA does allow for recovery of attorney fees but only at the "discretion" of the judge. In other words, it is not mandatory that the judge award attorney fees, and the judge also has the discretion to award what he thinks is reasonable, not necessarily what you have to pay.

This is especially evident given that most claimants hire their attorney on a contingent fee basis, but the judge can only award fees based on a reasonable hourly rate. Also, the judge will not award attorney fees based on work done during the administrative appeal even though the claimant still has to pay them. In short, ERISA strikes again. Call your Congressman! Seriously, only they can fix this!

Conversely, a lawsuit against an insurer for privately purchased LTD insurance is governed by state laws. In these cases, the prevailing disabled claimant is generally entitled to recover attorney fees from the insurance company.

ERISA Statute: How Fee Awards Are Calculated

While it's notoriously difficult to get the other side to pay for your attorney fees in an ERISA lawsuit, that doesn't mean it's impossible. Some judges are more willing to engage in this practice, and a few even follow the rule present in other types of cases (but missing in ERISA) that the winning party deserves to have the losing side pay. Because of this, it is useful to talk about how the actual amount of your monetary award is calculated.

The Lodestar Method and How It Works

The Lodestar method is a method adopted for calculating attorneys' fees where the court multiplies a reasonable hourly rate by a reasonable number of hours expended. To get the lodestar figure, the district court has to look at 12 lodestar factors.

1. How much time and labor was involved.
2. How unique and/or difficult the questions raised in the case were.
3. How skilled the attorneys needed to be to handle the case.
4. How much work the attorneys gave up by taking this case.
5. The amount of the attorneys' typical fee.
6. Whether the fee is contingent or fixed.
7. Time limitations present – imposed either by circumstances or the client.
8. The overall amount involved and what was obtained.
9. The attorneys' ability, reputation, and experience.
10. The case's "undesirability."
11. How long the attorneys have been working with the client.
12. How much was awarded in similar cases.

By making determinations about all of those factors as required by the ERISA statute, the judge should be able to come up with an appropriate award amount. Of course, that doesn't mean everyone involved will agree with it, but it is the way long term disability cases work, and hopefully knowing all of the 12 factors involved will give you a better idea of what may happen in your case.

22. CHOOSING A DISABILITY INSURANCE ATTORNEY

Statistics show that claimants can double their chances of winning their disability claim if they have an experienced attorney. Picking the right attorney for your disability claim could be one of the most important decisions you'll ever make. ERISA disability law can be complex.Knowing how to deal with medical experts, vocational experts, insurance company tactics, ERISA regulations and the federal judicial system is essential to writing a thorough and decisive appeal that will compel a powerful insurance company to reverse a claim denial and pay a claim.The following are things you should know about any attorney before you hire them:

What Are the Attorney's Qualifications?

First you want to know if the lawyer is qualified, so ask:

Are they a licensed attorney? This may sound like a silly question, but you do not have to be a licensed attorney to handle administrative appeals under ERISA regulations – and there are in fact some people out there who will handle your administrative appeal for a fee. They can handle administrative reviews but cannot take your case to federal court if necessary.

How many years of experience do they have handling ERISA based disability insurance claims? Again, this area of law is complex so you want someone with experience – but dig a little deeper than just years of experience.

How many individually owned disability cases have they handled? Look for an attorney who has built a reputation on assisting medical professionals, CEOs, key executives and other high wage earning individuals with their private disability insurance claims. The legal counsel you hire should have authoritative knowledge and years of experience negotiating and litigating these claims.

Is disability law the main focus of their practice? Many attorneys are general practitioners that handle many areas of law such as wills, probate, family law, criminal matters as well as some insurance claims work. You get the picture — jack of all trades, master of none. ERISA claims are complex and require an ERISA specialist. Bad faith insurance and breach of contract issues demand an insurance attorney's expertise of the law and the insurance industry.

Another good question to ask is if they have written on the subject, and if so, will they share this material with you? Often times experienced attorneys will have written papers, articles, editorials or books on their area of expertise. These can demonstrate an in depth knowledge about the subject. Many times good attorneys will put this material on their websites so you can check it out in advance. They may also post videos, blogs or other materials that can be helpful.

Research the Attorney's Reputation

Once you have established that an attorney has the necessary experience, you want to explore their reputation. Go to the internet and see if they have any reviews on Google, Yahoo or Yelp. Don't be scared by an occasional negative review; not every claimant wins, and sometimes they take it out on their lawyer. But look for patterns or trends in the reviews.

Next, go to Martindale.com and check out their attorney ratings. Martindale.com is the gold standard for lawyer ratings as it has been around in one form or another for over 140 years.

Martindale conducts peer review surveys, asking lawyers to rate other lawyers anonymously. The areas surveyed are a lawyer's legal knowledge, analytical capabilities, judgment, communication ability and legal experience. Lawyers are then rated on a 5 point scale. Lawyers that rate 4.5 or above are designated with an AV Preeminent rating, which is the best rating possible. Those from 3.0-4.4 are designated BV Distinguished and below that are designated as Peer Review Rated.

Another good source is to go to Avvo.com and check out their AVVO rating and reviews. AVVO does a great job of rating lawyers on a 10 point scale, weighing an attorney's experience, industry recognition and professional conduct. Former clients and other lawyers can leave reviews at AVVO as well.

Super Lawyers is another ratings service of outstanding lawyers by practice area for those lawyers that have achieved a high degree of peer recognition and professional achievement. Go to Superlawyers.com to find out if a particular lawyer has been designated a "Super Lawyer." Finally, you could ask about their honors, recognitions, and organizational memberships.

23. CONCLUSION

Disability insurance claims are governed by a complex set of laws and procedures. These laws are full of traps for the unwary, even attorneys who are not experienced in ERISA law or insurance bad faith. Doctors, dentists, even attorneys make the mistake of thinking they can handle the administrative appeal themselves and then hire a disability insurance lawyer if they lose and have to file a lawsuit. This is totally backwards thinking.

Recently, I had a client come to me with such a claim. He said, "Don't worry about the administrative appeal, I filed it myself. I just need you to file my lawsuit."

It turns out he filed a one page letter asking the insurance company to reconsider because he "really was disabled." He was astonished to learn that this one page letter was the only evidence the judge could consider in his case other than what the insurance company chose to include when they denied him. In other words, he had blown any chance to present his case in court. Don't let this happen to you. If you don't call us, call someone.

ABOUT MARC WHITEHEAD

Marc Whitehead & Associates, Attorneys at Law is a disability law firm based in Houston, Texas, that serves clients across the nation.

Marc Stanley Whitehead is the founding partner of Marc Whitehead & Associates, Attorneys at Law, LLP which was established in 1992 in Houston, Texas. Born in Memphis, Tennessee, Marc was raised in Normangee, Texas. He graduated in 1985 from Normangee High School as class valedictorian.

Marc attended Texas A&M University where he graduated in 1989 with a Bachelor of Business Administration in Finance. Marc attended the University Of Houston Law Center and received his law degree (J.D.) in 1992, graduating in the top quarter of his class. He was admitted to the State Bar of Texas in 1992. He is also admitted to practice before all U.S. Federal District Courts in Texas, the U.S. Court of Appeals-Fifth Circuit and the U.S. Court of Appeals for Veterans Claims.

Marc's areas of practice include personal injury and wrongful death, social security disability, long-term disability insurance denials, employee benefit denials, ERISA litigation and insurance claims and pharmaceutical and medical device litigation.

He is also a former adjunct professor of Law at the University Of Houston Law Center teaching Civil Trial Advocacy. He has also been an instructor for the National Institute of Trial Advocacy teaching Civil Trial Advocacy and an instructor for the National Business Institute teaching Social Security Disability Law.

Marc is board certified in Personal Injury Trial Law by the Texas Board of Legal Specialization and in Social Security Disability Law by the National Board of Trial Advocacy.

Professional Activities & Associations

President – Houston Trial Lawyers Association (2009-2010)
Board of Directors – Houston Trial Lawyers Association
Board of Directors – Texas Trial Lawyers Association
Texas Trial Lawyers Board of Advocates (1999-2001)
HBA Social Security Section Chairman (2004-2005)

Member:

- Association of Civil Trial and Appellate Specialists
- National Organization of Social Security Claims Representatives
- American Association of JusticeTexas Aggie Bar Association
- Houston Volunteer Lawyers Association
- College of the State Bar of Texas
- Houston Bar Association

Honors & Awards

- AV Rated by Martindale Hubble
- 10.0 AVVO Rating
- Rated by Super Lawyers
- Top 100 Trial Lawyers in Texas by National Trial Lawyers Association

Books and Publications

Published Books:

- The Disabled Doctor's Guide: Fight Your Disability Insurance Denial and Win the Benefits You Have Paid For!
- The Social Security Disability Puzzle: How to Fit the Pieces Together and Win Your Claim;
- Disability Insurance Policies: How to Unravel the Mystery and Prove Your Claim
- Veterans Disability Claims: Strategies for a Winning Campaign
- Car & Truck Crashes: 10 Secrets Victims Should Know to Protect Their Rights
- Transvaginal Mesh Lawsuits: What You Need to Know If You Have Suffered Harm from Vaginal Mesh Implants
- The Fall of Testosterone: How a Vaunted "Low T" Therapy Has Backfired and Put Millions of Men at Risk for Heart Problems and Stroke
- The Xarelto Disaster: How Johnson & Johnson Failed to Warn Consumers of Deadly Internal Bleeding Risks
- The Zofran Tragedy: Marketing Anti-Nausea Drug "Off-Label" to Pregnant Women Linked to Birth Defects
- Risperdal: The Shocking Truth – Marketing Fraud Adds Up to Billion$… While Boys & Young Men are Irreparably Harmed
- Viagra: The Unvarnished Truth – The Link between the Deadly Skin Cancer Melanoma and Viagra
- The Life Insurance Claims Kit: What To Do If Your Life Insurance Benefits Are Denied

Published Articles

- Tort Reform As It Relates to Strict Products Liability
- A Lawyer's Guide for Determining Eligibility of Social Security Disability Claimants
- Nuts & Bolts of Social Security Disability Law
- The Five Step Sequential Evaluation Process Used in Determining Disability For Social Security Claimant

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