

HOW TO WIN AGAINST WRONGFUL
DISABILITY INSURANCE DENIALS

THE
Disabled
DENTIST'S
GUIDE



Marc Whitehead, Esq.

The Disabled Dentist's Guide

How to Win Against Wrongful Disability Insurance Denials

First Edition

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DisabilityDenials.com

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Table of Contents

| | |
|---|----|
| Introduction | 1 |
| 1 Disability Claim Denials and the Dental Professional..... | 3 |
| 2 The Disability Insurance Industry..... | 6 |
| 3 Types of Coverage: Short-Term, Long-Term and Catastrophic Disability..... | 16 |
| 4 How Will Your Disability Benefits Be Paid?..... | 18 |
| 5 Exclusions and Limitations: Does Your Policy Cover Your Condition?..... | 20 |
| 6 Do You Have an Individual or a Group Disability Policy?.. | 22 |
| 7 Is Your Case Governed by Federal ERISA Law?..... | 27 |
| 8 ERISA (Group) Disability Claims vs. The Family Medical Leave Act..... | 31 |
| 9 Is Your Disability Case Governed by State Insurance Laws? (Non-ERISA)..... | 33 |
| 10 How to Begin Your Disability Insurance Claim..... | 36 |
| 11 What Do You Have to Prove to Win Your Disability Insurance Claim? | |
| 12 Proving Your Residual Functional Capacity (RFC)..... | 46 |

| | |
|---|----|
| 13 Why You Shouldn't Use the Insurance Company's Recommended Social Security Representative..... | 53 |
| 14 What Does an Attorney Do to Help You Win Your Claim?..... | 56 |
| 15 What if Your Disability Claim is Denied? The Administrative Appeal..... | 58 |
| 16 Do You Need an Attorney to Help With the Administrative Appeal?..... | 63 |
| 17 Insurance Company Tactics..... | 69 |
| 18 Filing an ERISA Lawsuit If My Administrative Appeal is Denied..... | 77 |
| 19 Filing a Lawsuit on a Private (Non-ERISA) Disability Insurance Claim..... | 82 |
| 20 The Importance of Attorney Representation During Your Lawsuit..... | 88 |
| 21 How Does an Attorney Get Paid?..... | 89 |
| 22 Choosing a Disability Insurance Attorney..... | 92 |
| 23 Conclusion..... | 95 |
| Disclaimer | 96 |
| Marc Whitehead Biography | 97 |

Introduction

Like most dentists, you purchased a long-term disability insurance policy to protect yourself and your family in the event you become disabled. As a high income professional, there is much at stake should you no longer be able to practice dentistry.

You've 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 dental specialty, and perhaps you are unable to work at all. You file a disability claim with your insurance carrier; yet you are stunned to learn that instead of honoring your policy, 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 Trend to Deny Dentists' Claims

The disability insurance industry resorts to many tactics based solely on financial gain. One trend is to deny high payout claims. Dollar wise, claim amounts in dentists' disability cases are substantial.

If an insurer has one hundred disability claims from dental professionals to pay on, and it succeeds at denying a third of them, that equates to millions of dollars they do not have to pay. Which is why many providers deny initial claims without fair cause, or inflict delays and frustration until you either just give up or give in to a lowball offer. Or, after you've been on claim for months, the insurer terminates coverage without warning.

From the insurance company's standpoint, they stand to profit by denying good claims in bad faith—even if they wind up in a court battle, even if they are forced to pay damages.

To this day, thousands of claimants have been left in financial ruin because of their own insurance company's broken promises. Even lawyers, if they

are not familiar with disability insurance law, do not realize what it takes to prove and win a claim; nor can they know the actions (or lack of actions) that negatively affect claims.

Do not give up on your claim, do not allow an insurer to under-settle your claim, without reading this book. The following chapters are designed to inform you about your disability policy and give you the best chance to fight back and prevail against the deck that has been stacked against you.

To your success,

Marc Whitehead, Esq.

1 Disability Claim Denials and the Dental Professional

Every dentist, whether in private practice or corporate dentistry, knows that survival requires careful financial planning. This planning involves purchasing disability insurance. If tragedy happens and you can no longer practice your dental specialty—or you can no longer earn a living in any capacity—long-term disability (LTD) insurance can help protect you and your family from dire economic loss.

1.1 Why Dentists' Disability Claims Are Unique

It takes a certain type of person to become a dental professional. In addition to intellect and expertise, dentists must have the drive and fortitude to withstand work-related health risks. Not only do they work with their minds, dentists also work with their hands and bodies. Unlike most other high income occupations, there is still a very physical component to the job.

Consequently, dentists are predisposed to a number of distinct occupational hazards. Due to the strenuous nature of their job, the physical aspect puts dentists at risk for disability.

Dentists persevere long hours of surgical maneuvers and routine procedures, enduring discomforts caused by muscle overuse and difficult, unnatural postures. They perform repetitive, forceful and prolonged exertions of the arms, wrists, hands, and fingers to manipulate precision instruments, often with sustained mechanical vibrations — all while staying highly focused.

Daily recurrence over the years can lead to disorders and diseases of the musculoskeletal system. Musculoskeletal disorders include a range of inflammatory and degenerative infirmities of muscles, bones, discs, joints, tendons, ligaments and nerves.

Disorders can result in debilitating pain, numbness and functional impairment affecting the neck, upper back, lower back, hip, shoulders, elbows, wrists, hands and fingers. Injuries can range from a mild decrease to the total loss of range of motion, grip strength, and coordination.

Other occupational hazards involve exposure to infections, radiation, and exposure to pathogens via splatter or percutaneous injury.

Dental professionals wisely plan ahead and purchase long term disability insurance as a form of income protection. They know that if suddenly faced with a disabling condition, they 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 dental practitioner's specific occupation, where even the slightest injury or illness can end a dentist's career.

Consider the devastating economic loss to the disabled dentist who once handled a high case-load of procedures – root canals, implants, routine fillings – 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 oral surgeons, periodontists, endodontists, prosthodontists or orthodontists become disabled and can no longer work. Annual losses can be in the hundreds of thousands of dollars.

1.2 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 dentists a very hard time.

Even if you purchased an LTD policy specifically tailored to your 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 other deceptive and wrongful behaviors to avoid paying your rightful benefits. Most dentists also tend to keep working through the pain—which ultimately works against them when battling an insurance company for disability benefits.

If you have been denied LTD benefits, or are thinking about filing a claim on your disability insurance policy, this book is for you.

Written specifically for every dentist 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-dental professionals,
- (3) Whether by appeal or lawsuit, explain what it takes to overturn a wrongfully denied claim.

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 following eye-opening account explains how the disability insurance industry has gotten into the shape it is in today. Although unwittingly, dental professionals played a salient role.

2.1 The Major Carriers

The largest and most infamous disability carrier is Unum. Unum came into being from a merger of Unum of Portland, Maine and Provident Life and Accident Insurance Company, which had previously acquired Paul Revere Insurance.

Other major companies with a large share of the disability market include Aetna, Ameritas, Cigna, Colonial Life, Guardian, Great-West, John Hancock, Liberty Mutual, Mass Mutual, MetLife, New York Life, Northwestern Mutual, Penn Mutual, Principal, Prudential, The Hartford and The Standard, among others.

2.2 A Notorious History

The disability insurance market has changed dramatically over the past 40 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 dental professionals. These policies were designed to provide a financial safety net for dentists in the event 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.

2.3 Why Dental Professionals Were (and Still Are) Prime Targets

As high wage earners, 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 dentist became disabled, he or she would be less inclined to quit working or shut down their practice.

Dental and medical professionals have always been easy targets for insurance companies to identify. A sales force can readily locate a hit list of dentists, dental hygienists, dental assistants, physicians, nurses and many other practitioners via their various specialty associations.

Insurance carriers stood to gain the most by selling individually purchased plans. Many dental 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 dentists' 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 policy holders were aging and filing more claims, they did the only thing that was in their control: refuse to pay claims.

2.4 Cost Control though Claim Denial

The disability insurance 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:

- Systematically searching for “misrepresentations” in the policy holder’s initial applications;
- Separating impairments (versus considering two or more impairments together, where the combined effects cause disability)
- Requiring “objective” evidence of disability even though the policy did not require it;
- Redefining a dentist’s “own occupation”;
- Cherry-picking the facts in an attempt to block a claim;
- Offensively using the Employee Retirement Income Security Act (ERISA) preemption. ERISA is the federal law that governs group or employer-sponsored disability insurance plans, which account for most disability claims in the U.S. Historically, ERISA leans in favor of the insurance company by denying claimants due process in claim disputes – often enabling insurers to get away with denying valid claims;
- Use of biased medical and vocational evaluations arranged by the insurance company;
- Use of increased video surveillance and hired private investigators;
- Disregarding the opinions of the claimant’s treating doctors;
- Accusing the claimant of malingering (faking or exaggerating disability for monetary gain)
- Reclassifying a dentist’s specialty as a generalist. For instance, if you are an endodontist and have lost certain motor skills, even though you can no longer perform root canals, the insurer would state that you can still practice as a general dentist

Example

Marie, an oral surgeon for 20 years, spends her days performing dental surgeries and extractions, implants, bone grafts, and restorative treatments. Her work requires hours of standing over patients in awkward postures while using manual dexterity and precision tools.

When Marie first started her practice, she purchased a long term disability policy with a rider covering her own occupation as a dentist.

For several years, Marie has suffered from degenerative disc disease. Now Marie realizes she is no longer able to perform the grueling surgeries and other specialty aspects of her profession. But she is used to calling the shots and is determined to remain active in her practice.

Marie turns over the surgical aspects of her practice to her associate – at least until she can get her back sorted out – and spends her work time scheduling appointments, counselling patients, advising staff, ordering supplies and other administrative duties. By temporarily abstaining from performing the skilled, specialty duties of her own occupation as a dentist, she is able to remain involved with her practice.

But the reality is, her back is not going to improve. She will learn in the months to come, after undergoing treatments and surgery, the damage and chronic pain will limit her everyday functionality.

Marie files a disability claim. Her insurance company denies her claim, stating that at the time her claim was filed, her job duties involved scheduling, counseling, ordering supplies and other administrative tasks (not skilled dentistry or surgery). The insurance company bases its decision on the fact that Marie would be able to perform similar duties in a low-impact, administrative job.

It is very common for many highly trained professionals disabled by chronic medical problems to want to remain active in their practice. To do so, they unwittingly shift their practice to offset their disability.

Insurance companies intently watch for this and other inadvertent missteps by high-payout claimants, as well as ways to “interpret” policy wording.

2.5 Congressional Hearings

On September 28, 2010, the Senate Finance Committee convened a hearing to examine the disability insurance industry and the difficulty that dentists and other policy holders have in winning benefits under the terms of their policy.

The hearing was entitled “Do Private Long-Term Disability Policies Provide the Protection They Promise?” The ultimate answer that became obvious was “NO!”

The hearing focused on whether claimants are being unfairly denied or terminated by their own insurance company because of aggressive use of ERISA. The hearing also examined claims handling abuse of discretion and the individual's limited appellate rights.

Senator Max Baucus said, “Abuses like these are not uncommon. Thousands of cases clog the district courts. Many claimants end up in desperate straits. Some lose their homes, their savings, and even their spouses or custody of their children. How do insurance companies get away with these abuses? Unfortunately, loopholes in the law permit them.”

However, before the committee could finish their work, the November 2010 Congressional elections brought about a change in the political party in power and with it a change in the leadership of the committee. Congress has not seriously looked at the problem since.

2.6 U.S. Department of Labor Issues New ERISA Disability Claims Regulations

In due course, the U.S. Department of Labor (DOL) completed a review of ERISA-based disability cases dating from 2000. The result was the issuance of an update to ERISA procedural requirements, a.k.a. the “Final Rule,” which became effective in April 2018. The regulations will apply to disability benefits claims filed after April 1, 2018.

To strengthen consumer protection, the Final Rule amends how employee claims for benefits from their workplace disability insurance plans are

administered. The goal is to cut down on disability claim disputes and lawsuits by improving fairness and transparency in the insurance industry's administration of claims.

The new rule states, for example, that claimants must receive a clear explanation of (1) why their claim was denied, (2) their rights to appeal a denial of a benefit claim, and (3) their rights to review and respond to new information developed by the plan during the course of an appeal.

If plans fail to strictly adhere to all claims processing rules, the claimant is deemed to have exhausted their administrative remedies and is free to seek judicial review.

In some cases where an insurer failed to strictly adhere to the regulations, the court may elect to substitute a **de novo** review—in which all issues in the claimant's case are reviewed as if for the first time.

The Final Rule also sets standards for impartiality of individuals involved in claims determinations. The rule requires that a claims adjudicator could not be hired, fired, promoted, or compensated based on the likelihood of supporting the denial of disability benefits.

DOL acknowledges that ERISA rules have been inadequate from a claimant's standpoint. As the Federal Register states in the Final Rule,

“

“...[group] disability cases dominate the ERISA litigation landscape today. ...Insurers and plans looking to contain disability benefit costs may be motivated to aggressively dispute disability claims. Concerns exist regarding conflicts of interest impairing the objectivity and fairness of the process for deciding claims for group health benefits.”

Though long overdue, the DOL's effort to protect consumers and reduce the number of disability claim disputes is commendable. It is a first step

to holding wrongful disability insurers accountable. A combination of time, new court decisions and fresh case law will tell whether the new regulations will have the intended effect.

2.7 The Need for Experienced Legal Counsel Is As Strong as Ever

As some disability insurers attempt to improve their claims handling behavior, others continue their old habits, concocting new denial tactics and seeking fresh ways to minimize these new risks and associated costs. With so much at stake, it is critical that disabled dental professionals under a group LTD plan have an experienced ERISA attorney assist in the administrative appeal of their insurance denial.

Insurance carriers are 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!*

And it is not just us who say that; several respected federal judges have agreed:

“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**

Even with the Final Rule protections, ERISA claim appeals remain complex. As explained further in this book, an administrative appeal of this type must include ALL the arguments, medical records, and other pivotal 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:

- If your policy was obtained through an employer-sponsored group benefits plan, federal ERISA law usually prevails.
- 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. Also known as Non-ERISA policies, these policies

are also referred to as individual disability insurance, private disability insurance, and disability income (DI) protection.

- You may have supplemented a group (ERISA-based) plan with an additional individual disability policy as added income protection;
- Your policy may be a dental association group disability insurance plan (such as policies available to members of the American Dental Association.)
- You may have a form of hybrid policy, for example one that combines own-occupation coverage with any-occupation coverage.
- Other insurance may play a role in your claim as well, such as Social Security Disability Insurance (SSDI) 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 in the contract 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.

3.1 Short-Term Disability (STD)

The purpose of short-term disability (STD) insurance 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 STD than LTD. Short term disability benefit claims are often the first step in the long term disability insurance claims process.

3.2 Long-Term Disability (LTD)

The purpose of long-term disability (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.

If a dentist is disabled and cannot work at his or her own occupation, LTD benefits are generally paid for 24 months. After this “own occupation” period, the dentist can potentially receive LTD benefits until age 65, if he or she continues to prove disability.

For more about the “Own Occupation” standard see Chapter 12.9.

3.3 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?

4.1 Salary Percentage

The majority of policies pay 60 percent of a disabled 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.

4.2 Partial or Residual Disability

Some policies allow dental professionals to work part-time or work at a lighter duty job when 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 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 10.1 (Tip #15).

4.3 The Social Security Offset

Most policies have a Social Security offset. This means if a claimant receives a monthly Social Security Disability Insurance (SSDI) benefit, the amount of the SSDI check is "subtracted" from the monthly LTD check. For example, if a disabled orthodontist receives an LTD check for \$2,000 a month and then begins to receive an SSDI 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 SSDI and \$1,000 from LTD. Some policies even allow the SSDI benefit paid to a claimant for his or her minor children to be taken as an offset.

4.4 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.

4.5 The Problem of Overpayments

Many disabled dentists apply for SSDI benefits around the same time they apply for LTD benefits. Included in the LTD application is a form claimants must sign specifying how they want the insurance company to “pay back” the SSDI offset. A claimant can choose to have the carrier estimate how much their SSDI 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 SSDI 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 SSDI award, SSDI back benefits can add up to several thousand dollars. Once the claimant receives the SSDI 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 SSDI back benefits to pay bills.

If the disabled dentist 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 SSDI offsets that the dentist “owes.”

In addition, most ERISA plans require an assessment, usually after 24 months, to determine whether the claimant can perform “any occupation.” So this problem is compounded when the SSDI award arrives just as the dentist hits the “any occupation” definition of disability at 24 months, because the insurance company may cut off benefits when the policy changes, leaving the dentist owing a large overpayment.

For more about the “Any Occupation” standard see Chapters 12.10 and 12.11.

5 Exclusions and Limitations: Does Your Policy Cover Your Condition?

5.1 Pre-Existing Condition Exclusion

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

5.2 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.

5.3 Depression Secondary to Chronic Pain

Dental 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.

5.4 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.

5.5 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?

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), as well as disability income (DI) protection. 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 dentists, physicians, 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 (paid for) by or offered through your workplace, you likely have a group disability insurance policy. Employer-sponsored group coverage for dental professionals is becoming increasingly common as corporate dentistry becomes more widespread.
- Professional dental associations offer group disability plans that may or may not be exempt from ERISA. For instance, with an American Dental Association (ADA) membership, you have the right to buy your disability policy. For decades, and as of this writing, Great West has been the recommended carrier that sells both short and long-term disability policies through the ADA. If you are the purchaser of such a policy, a disability claim filed on that policy is likely not governed by ERISA law.
- You may supplement an employer-sponsored (ERISA-based) group policy with an individual policy or with an association disability plan. This can provide you with coverage that is more

specific to your occupation, may be portable, and may increase your overall benefit. However, be aware of important caveats and nuances in the law when dealing with group association policies and an ERISA-based group policy from your employer.

Example

The following case summarizes an unfortunate situation in which a dentist, Robert Fleisher, had coverage from two different disability insurance plans: one from a professional association, the American Association of Endodontics (AAE), and a separate group policy offered through his employer. However, when the time came to file for benefits, the employer-sponsored plan chose to offset (reduce) its benefit payment amount by subtracting the \$ amount Fleisher received under the supplemental AAE plan. Fleisher challenged the offset on appeal. The court ruled that the AAE policy was a permissible offset, drastically reducing Fleisher's anticipated benefits.

Fleisher v. Standard Ins.Co., 2012 U.S.App.LEXIS 9907 (3d Cir. May 17, 2012):

During the course of his career as an endodontist, Robert Fleisher obtained LTD insurance coverage under two separate policies.

In July 1979, Fleisher obtained coverage under a policy issued by North American to the American Association of Endodontics ("AAE"), of which Fleisher was a member. The North American Policy provides for LTD benefits of \$1,500 per month.

In August 2002, Fleisher became eligible for LTD insurance coverage under a group policy issued by Standard Insurance Company to his employer, Endodontics, Ltd., P.C. The LTD coverage offered by Fleisher's employer is an employee benefit governed by ERISA. The Standard Policy provides for monthly

LTD benefits equal to a percentage of the plan participant's pre-disability earnings, which in Fleisher's case was a maximum of "\$10,000 before reduction by Deductible Income."

In January 2008, Fleisher became disabled and claimed LTD benefits under both the Standard and the North American policies. Shortly after Fleisher began collecting under both policies, Standard reduced his monthly benefits from \$10,000 to \$8,500 based on its determination that the North American Policy constitutes "another group insurance coverage," and that the \$1,500 in benefits he receives under it is therefore "Deductible Income." Fleisher filed an administrative appeal of Standard's decision, arguing that the North American Policy qualifies as an individual disability insurance policy, and therefore is not subject to deduction.

By letter dated July 11, 2008, Standard rejected Fleisher's appeal and continued making the deduction.

On May 26, 2010 Fleisher filed a Complaint in the United States District Court for the District of New Jersey, asserting individual and class claims for wrongful denial of benefits under ERISA, along with various state law claims.

It all came down to the Court's interpretation and understanding of the language and provisions of each policy.

The District Court recognized, and the parties do not dispute, that the term "group insurance" is ambiguous. The Court consulted various insurance law treatises and found that insurers use the term "group insurance" to refer to "at least two subsets of collective insurance products," including "true group insurance" and "franchise insurance."

The Court explained a basic difference between the two:

Group insurance is an arrangement by which a single insurance policy is issued to a central entity—commonly an employer, association, or union—for coverage of the individual members of the group.

Franchise insurance is a variation on group insurance, in which all members of the group receive individual policies. The District Court also identified other distinguishing features of the two types of group policies.

The Court acknowledged Fleisher's argument that the Policy "bears certain features characteristic of individual insurance policies," but concluded that the Policy can nonetheless be "reasonably characterized as a franchise policy." (A.19). On this basis, the Court dismissed Fleisher's § 502(a)(1)(B) claim.

Fleisher challenged this conclusion on appeal with various arguments including § 502(a)(3) and claims for breaches of fiduciary duty and contract. In the end, the Court also dismissed Fleisher's additional challenges, concluding that Standard's conduct was not improper.

You can see how the differences in the types of disability policies, and the source of each policy, are important. The laws governing each are quite different, and will affect your claim in a big way.

A quick look into case law shows how ambiguous policy language can work to the insurer's advantage. This is not by accident. Insurers do all they can to minimize their liabilities, and that includes writing and selling policies that you would view favorably – but as soon as you need benefits, the insurer's real interpretation of provisions may come as a shock.

Always consult a qualified attorney to be certain of what type of policy you have, and what your legal rights are.

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. Individual policies (private policies) are contracts between you and the insurance company. Policy disputes and claim denials are regulated by 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 paid for by your employer, a whole different set of laws apply. These are the 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?

7.1 What Is ERISA?

As stated earlier, 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 available to the beneficiaries of these Plans.

29 U.S.C. § 1003(a) provides that ERISA applies to employee benefit plans established or maintained :

- (1) by an employer engaged in commerce or in any industry or activity affecting commerce; or
- (2) by an employee organization representing employees engaged in commerce or in any industry or activity affecting commerce; or
- (3) by both.

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.

7.2 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.

7.3 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: These are voluntary plans where the employer contributed nothing to the plan and merely acted as a “pass-through.” These plans 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.

7.4 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
- **Limited ERISA Remedies:** Under ERISA you can only sue for what the insurance carrier should have paid you in the first place, and your ability to recover attorney fee reimbursement is difficult at best. 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 where 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. [Note that, under the new Final Rule for ERISA claims, if the insurance provider disputes your own medical or vocational experts, they are required under the new rule to include a more complete discussion of why they denied a claim and the standards it used in making the decision.]
 - **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.

- **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. However, in most claims brought under ERISA, you must prove that the insurance carrier “abused its discretion” when it denied your claim. Abuse of discretion is a tough standard requiring you to show that the insurance company had “no reasonable basis” for denying your claim. An example might be if you have three doctors that say you are disabled and the insurance company only has one doctor that says you are not. The insurance company would argue that they have a “reasonable basis” to deny your claim based on their one doctor, in spite of your three.

Claimants under ERISA plans aren't eligible for the above protections, because 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 received 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.

8.1 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.

8.2 Which Employers Must Offer Family Medical Leave?

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.

8.3 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 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.

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.

9.1 Riders and Occupational-Specific Policies for Dentists

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

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

For example:

- **Own-Occupation:** occupation-specific coverage where 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 “oral and maxillofacial surgeon (OMS)” or “prosthodontist” rather than “dentist” or “practicing dentistry.”

- There are no limitations or exclusions on benefits payable for disabilities caused by mental disorders
- Individual policies are portable, whereas most group LTD policies end with employment.
- Partial and Total disability benefits can cover you until age 65, or for life.
- Cost of living increases are covered.
- Optional graded lifetime benefits beyond a certain age.
- Recovery benefit 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 dentist's disability claim with additional scrutiny due to the added language of any riders attached to the claim.

9.2 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 non-ERISA dentists' 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.

If a carrier has 100 individually owned, dentist-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. 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.

10.1 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 policies totally exclude 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 Insurance benefits.

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 SSDI 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 essential 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.

10. Pick your onset of disability date.

When filing for disability, you will be required to state the date that you became disabled. This can be important for many reasons. First, it can matter if there is a question of a pre-existing exclusion. Second, it can matter to avoid certain limitations and exclusions in the policy. Third, the onset of disability date must be alleged to be during a period while insurance coverage is in effect. If it is possible to time your claim for disability, it is best to have an experienced attorney look at these issues before you make your disability claim.

11. Make a working copy of your application.

The application you submit should be neat, clean, and present a well-reasoned theory of disability. It may be necessary to do several versions of the application before it is perfect.

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 dentists' disability policies are written around the concepts of total disability and residual disability. These principles play a huge role in claims filed by oral surgeons, periodontists, endodontists and other dental practitioners who literally use their hands and bodies while bending over patients all day.

In many cases, disabled dentists are still able to function in their “dental practice” in a general capacity. However, because of their specific disabilities, they can no longer practice surgeries or other bedrock dental procedures.

Imagine an oral and maxillofacial surgeon's shock when the insurer denies his disability claim because the insurer says he can still be a general dentist, but not an OMS. The insurer does not consider the disparity in income. It is up to the disabled dentist 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 60–80% 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 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 that he needs to take that call.

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

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.

21. Consult with experienced disability attorneys.

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

These are complex matters which require representation from a lawyer that 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.

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.

11 What Do You Have to Prove to Win Your Disability Insurance Claim?

11.1 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.” 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**.

11.2 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.

11.3 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 dentist 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.

This issue is addressed in part by the 2018 ERISA Final Rule. The rule's expanded disclosure requirements requires insurers to discuss their basis for disagreeing with a disability determination made by the Social Security Administration.

11.4 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.

11.5 Proving the Economics of a Dentist's Disability Claim

Often a dentist's practice is largely based on procedural services – minor or routine dental surgeries such as extractions, root canals, and implants.

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

For example, a general dentist might not practice complex surgeries. The reality is most dentists also do root canals, which is a form of surgery and is responsible for a vast portion of their income. If the dentist can no longer perform root canals and is suddenly forced to work on a far more diminished scale of hands-on dentistry, by no means will he or she make

the same kind of income as they would if they could perform routine surgical procedures.

The insurance company will not take into account the loss of income that occurs when a dentist is no longer able to perform the specialty procedures of his or her practice. It is the claimant's burden to prove the economic component of his or her disability claim. This generally entails bringing in a vocational expert and economist to prove loss of earnings.

11.6 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 plus derive skills 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.

11.7 Your Residual Functional Capacity (RFC)

A claimant's RFC is based on the physical level of work a person can perform. The Dictionary of Occupational Titles, provided by the U.S. Department of Labor, and The Social Security Administration define work as:

- Sedentary
- Light
- Medium
- Heavy
- Very Heavy

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.

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 a cashier or security guard.

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

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

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

Because proving what your RFC currently is and what may be expected from you in the future are both critical factors in your disability claim, this book devotes the following chapter to understanding your RFC.

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.

12.1 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

12.2 Definition of Residual Functional Capacity

Residual Functional Capacity (RFC) is what the disabled dentist 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 dentist

and others who have observed him or her.

12.3 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.

12.4 RFC: Requirement to Consider ALL Physical and Mental Impairments

In determining a disabled dentist's RFC, the disability claims examiner should consider all competent medical evidence, and after taking into account all impairments, assess the physical and mental activities that the dentist can perform in a work setting.

The RFC examiner must consider all symptoms, including pain.

12.5 RFC: Requirement to Consider Effect of Mental Impairments

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.

12.6 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.

12.7 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 regimens of such impairments. A disabled dental professional should consider having a vocational expert evaluate his or her impairment-related to excessive absenteeism.

12.8 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 dental and medical professionals are classified as 7, 8 and 9.

12.9 “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: Eloise is a practicing periodontist of 30 years. She has developed radiculopathy, the pinching of a nerve root in the spinal column. Eloise no longer has the stamina nor is she able to assume the postures required to treat her patients. Because of that impairment, she cannot perform the daily duties of her own occupation.

Example 2: Joe is a prosthodontist diagnosed with Parkinson's disease. He is losing the ability to perform the essential tasks and duties of his own specialty practice. Prosthodontistry falls within the Light job class and is considered skilled work requiring years of training and education. Although the claimant 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.

12.10 “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.

12.11 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 off 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 to 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. 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 SSDI representative. The hook is that the SSDI 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 whatever back benefits are truly owed to the insurance company.

For example, you file a claim for long term disability. Your policy also requires that you apply for SSDI. Once you are approved for SSDI

benefits, this creates an overpayment, and you are obligated to reimburse the insurance company from the back benefits of any SSDI award.

Remember our discussion in Chapter 4.3 about The Social Security Offset and Chapter 4.5, 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.

That is the financial incentive for the LTD insurance company to talk you into using their handpicked SSDI representative. These SSDI 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 SSDI representative to handle your SSDI claim. Your insurance provider tells you they will pay the representative, making this a 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 SSDI benefits.

As discussed in detail below, when SSDI representatives access your claim, your private or confidential disability information is not treated confidentially—to the extent that the SSDI 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.

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

Many disabled 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 SSDI claimant.

So 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.

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.

13.2 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.

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.

13.3 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 the 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 saying inadvertent 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

15.1 The Denial Letter

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.

15.2 Time Limits for Filing Your Appeal

The denial letter will give the time limits for filing the appeal. If the policy is a group benefit to employees and therefore governed by ERISA, 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.

15.3 The Administrative Appeal Procedure – What You Need to Know

There is a great deal of work to be done. 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 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; you must pursue and exhaust the appeal procedures before you can file suit;
- After that, if you are still denied, you have the right to file a lawsuit against the insurer.

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** to make an adverse benefit determination (i.e. 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**.

15.4 The Statute of Limitations for Civil Action

Under the new ERISA Final Rule, the applicable Statute of Limitations must be disclosed with a reasonable calendar date. This rule is meant to rectify past situations in which contractual limitations could literally expire before the review was concluded, completely undermining legitimate claims.

A dentist whose initial claim was denied and then denied again on appeal needs to pay close attention to the timeline for filing a lawsuit, because the statute of limitations for civil actions requires that a claimant exhaust the internal review process before bringing their case under judicial review.

Historically, ERISA did 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.

In the past, 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 often used 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 could 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.

The Final Rule changes this. As of April 2018, the U.S. Department of Labor says that a limitation time-period **shorter than a year after the final claims decision** does not allow a reasonable period after the conclusion of

the appeal in which to bring a lawsuit and is accordingly unenforceable.

Additionally, “plans that offer appeals or dispute resolution beyond what is contemplated in the claims procedure regulations **must agree to toll the limitations provision during that time.**”

Still, in the short time the Final Rule has been issued, some insurers continue to do less than what is required, by making statements such as the limitations period expires “one year from the date of the denial.” This is not in compliance with the rule; insurers must state the actual date.

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.

15.5 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 dentist, doctor 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. (See 11.5 – Proving the Economics of a Dentist’s Disability Claim).

15.6 Are “Independent Medical Exams” Really Independent?

Often the insurance company will send the record out for an Independent Medical Review. However, these reviews are anything but independent. The insurance companies contract with other companies that have many doctors working for them who perform these reviews. Most of these doctors do not see patients anymore because they receive a large income from doing these file reviews. The medical review companies advertise on their websites that they can help disability insurers keep costs down. That is because these doctors rarely find a claimant disabled.

15.7 What Happens If You 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.

15.8 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?

16.1 The Importance of Representation During the Administrative Appeal

Many dental professionals decide to appeal the insurance carrier's denial on their own. Often they will write a one-paragraph appeal stating "I appeal your decision. Please reconsider." This approach rarely succeeds.

Because you are in no condition to work, 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.

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.

16.2 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 insurer 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.

16.3 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 by 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 dentist's Residual Functional Capacity (RFC), taking into consideration all restrictions and limitations caused by his or her medical impairments, and the dentist's age, education, background, work experience and skills, the VE can form an expert opinion on which jobs the disabled dentist 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 dentist can perform.

Some policy definitions of disabled include that the dentist 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 dentist can perform and still meet the salary percentage. An example would be an oral surgeon who performed skilled surgical procedures requiring finger dexterity, control precision,

arm-hand steadiness and the ability to stand and bend over patients for hours, and now can only do basic sedentary work. It is quite likely any sedentary job will not pay enough to reach the salary requirement. The disabled oral 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.

16.4 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 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.

16.5 Rebutting Insurance Company Distortions and Mischaracterizing of the Evidence

Some insurance company claims 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.

16.6 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.

16.7 Case Study: Hartford LTD Denial Reversed for Dentist

Founded 200 years ago, The Hartford Financial Services is one of the largest insurance companies in the United States and is a leading carrier of short term and long-term disability insurance.

Recently, we represented a dentist from Texas with severe back and spinal issues, lumbar spondylolisthesis, and a complete shoulder replacement in her appeal of Hartford's decision to deny her claim for long term disability benefits.

There was no real justification for the denial she received. The insurance company failed to take into account the substantial and ongoing medical limitations of our client's physical impairments. They also ignored the severe impairments caused by our client's necessary medications.

Hartford LTD Denial Appealed by Marc Whitehead & Associates

The Hartford claimed that there was not enough medical evidence to justify disability, so we began our appeal by explaining the disabilities our client faced every day and how these disabilities keep her from being able to continue her dental career.

In an extensive appeal, we explained how our client's medical records continually document that she has multiple physical problems that prevent her from maintaining the positional requirements of a dentist, specifically bending, stooping, crouching and constant use of her upper bilateral extremities including her shoulders, arms, and hands.

Certainly, our client could not perform the substantial duties of her own occupation as a dentist or any of the other similar skilled positions offered by Hartford. This is particularly true in light of our client's documented reduced problem solving skills, an executive skill crucial to a person working in any aspect of the medical field.

Due to these limitations, there would be no possibility of our client being able to perform her own occupation. In our use of comprehensive medical documentation, our appeal was able to prove that the denial of ongoing long term disability benefits was incorrect.

Reversal of Hartford LTD Denial Aided by Social Security Disability Decision

Before Hartford denied our client's LTD benefits, The Social Security Administration had already agreed that our client is disabled from any occupation at any level and granted her Social Security disability benefits. Even knowing this, Hartford continued to deny our client's LTD benefits by stating that she can perform the duties of light sedentary occupation.

Rather than require that a claimant be unable to perform the material duties of his or her own occupation, the Social Security Act requires that a claimant for disability benefits be unable to perform the material duties of any occupation for which he is reasonably suited.

This means literally any occupation existing in significant numbers in the national economy and within the claimant's functional capacity. In our client's case, this Social Security disability award proved that our client was incapable of any work within her field of education.

In our appeal, we stated that due to the Social Security Administration approval of disability benefits, Hartford cannot claim, with enough evidence, that our client was not disabled.

By exhaustively researching all medical documentation, we were able to create a substantial argument against The Hartford's LTD denial of our client's claim for benefits.

Hartford LTD Denial Incorrectly Relied on Paid Consultants Findings

Hartford relied on the opinions of a paid consultant's review regarding our client's physical abilities without adequate consideration of her non-exertional limitations. Our appeal showed in great detail how the review and vocational analysis failed to take into account the significant functional limitations of our client's physical and cognitive impairments and how these severely impair her ability to perform the duties of a dentist. Hartford's medical reviewers did not assess our client's ability to perform a highly skilled light occupation, rather they merely adopted her physician's notation of the ability to occasionally lift 20 pounds, even though her medical records indicate that she still experiences pain after her shoulder

replacement and lumbar limitations.

By not examining our client's full client medical record file, Hartford did not see our client's disability in full. They merely cherry picked the medical documentation that they and the paid consultant felt disproved disability.

By explaining each medical issue that our client has, our appeal provided a 360 degree view of our client's ongoing disability. By doing this, we were able to show that the Hartford LTD denial of disability benefits was unfounded.

Strategies an experienced attorney will use to improve your chances of winning your claim:

- Loading the Record
- Obtaining Vocational Expert Opinions
- Obtaining Medical Expert Opinions
- Rebutting Insurance Company Distortions and Mischaracterizing of the Evidence
- Rebutting In-House Medical Reviews

17 Insurance Company Tactics

17.1 Separating Impairments During the Review

Many dentists 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 dentist 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 dentist’s impairments are separated out, the reviews do not reflect a true picture of the dentist’s condition. The dentist ends up with several expert opinions saying he or she is not disabled—but those experts have not even seen the totality of the conditions the dentist is actually faced with.

17.2 Video Surveillance

The administration of high-end disability claims is a billion dollar business, with insurance carriers hiring private investigators to covertly film disabled dental 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 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 dentist for an “interview” and show them the footage.

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

17.2.1 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 claimants around and watching them closely, an insurer will catch people in the act of doing something they shouldn't be able to do based on their condition, and thus have a valid reason to deny the 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?

17.2.2 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 independent medical examiner 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 I 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 did not 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 trashcan 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 fail 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.

17.3 Functional Capacity Exam

A Functional Capacity Exam ("FCE") is a series of physical tests given to determine a claimant's RFC. Using a series of tasks, the IME doctor will examine the functional capacity at which you are able to work. 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. Along with testing your ability to stand for long periods, exert force, and show upper extremity strength, critical to dentists is FCE testing to determine pinch strength, hand grip strength, fine manipulation, and dexterity.

These rigorous tests are designed to surmise the claimant's maximum RFC in the work environment. Results are reviewed against the Dictionary of

Occupational Titles levels of work activity: sedentary, light, medium, heavy and very heavy. However, 3-4 hours of activity can't really reflect how well a disabled dentist would do eight hours a day, day after day, week after week.

Always seek legal advice when your insurance provider wants to send you for a Functional Capacity Exam.

Used correctly, the FCE can provide valuable support to a disability claim. However, beware the FCE that is required by the insurance company. 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 disabled dental professionals to endure an FCE.

17.4 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 dentist's symptoms do not correlate to "objective evidence," so he or she must be exaggerating the pain or other symptoms.

17.5 Malingering Because of "Grip Strength" Test

One of the tests performed during the FCE of dental professionals is a grip strength test where the claimant squeezes a handle rapidly, alternating hands. In claimants with normal or weak grips, the test results produce 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.

17.6 What Is Non-Compliance?

If a disabled dentist 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 choosing to not undergo a surgery because of possible adverse outcomes, or not taking medication to avoid prohibitive side effects, and non-compliance.

17.7 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 supervisors or co-workers. This is an attempt by the company to characterize symptoms as “job stress.”

17.8 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.

The following is an example case in which a dentist is denied benefits when the insurer discounts the treating doctor's opinion.

Dr. Benson is a pediatric dentist who suffered from both physical and mental impairments. In 2000, Dr. Benson filed a claim for disability with his insurer. Short-term disability benefits were granted. Dr. Benson 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. Benson was notified that he had 180 days to appeal this decision.

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

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

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. Benson's life.]

Because of the high worth of these disability claims, dental 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.

The insurance companies have denial tactics of their own. These can include:

Separating impairments during the review

Video Surveillance

Functional Capacity Exam

Malingering Because of "Grip Strength" Test

Non-Compliance

Non-Medical Problems at Work

Discounting the Opinions of Treating Physicians

18 Filing an ERISA Lawsuit If My Administrative Appeal Is Denied

18.1 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.

18.2 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.

18.3 Where Can I File My Lawsuit?

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

1. Where the Plan is administered;
2. Where the breach occurred;
3. Where the defendant resides; or
4. Where a defendant may be found.

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.

18.4 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.

18.5 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.” 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.

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.

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

In most cases, 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.

With the issuance of the ERISA Final Rule, exceptions to this may occur if and when the insurer fails to comply with the claims procedure requirements.

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. 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!

18.7 What Do I Have To Prove?

Winning your lawsuit requires much more than simply proving you are disabled.

In typical ERISA cases, where the insurance company has granted itself discretionary authority, the standard under which the court reviews the claim is abuse of discretion. This means 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. That is why it is so important that your case is properly developed during the administrative appeal.

The abuse of discretion standard exists because trust principles are basic elements to ERISA. This law is founded on the premise that a fiduciary acts to safeguard and maximize the goals and intent of the insurance plan and the beneficiaries over which it is entrusted. But the truth is, in ERISA disability claims, most fiduciaries are not conventional trustees; instead, they are incentivized, profit-seeking insurance companies, plans, and outsourced administrators. This is another aspect of the ERISA disability debacle the DOL has taken steps to mitigate.

Consequently, under new ERISA Final Rule, for claims filed after April 2018, you may also have further protections:

- In cases where the insurer absolutely violates ERISA's claims handling regulations, you are deemed to have exhausted your

- administrative remedies and are free to seek judicial review.
- You may be able to lawfully proceed to court to pursue your claim and the court may review the claim de novo without deference to the insurance company's decision to deny.

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.

18.8 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 "buy out" 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 before a 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.
- **Compliance and Possible De Novo Review:** As mentioned regarding the 2018 ERISA disability claims regulations, there may be cases in which the insurer failed to strictly adhere to all ERISA procedural requirements when processing a disability claim (except for some minor oversights). Such neglect may now trigger your right to file a lawsuit in court under section 502(a) of ERISA, even before the plan’s procedures are exhausted. In that case, a court may not give special deference to the plan’s decision but may find it appropriate to review the dispute de novo, in which all issues of your case are reviewed as if for the first time. Discovery may be allowed to examine whether procedural violations affect the standard of review.
- **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

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.

Good for you 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 **give your insurance company every opportunity to do the right thing and put it in writing.**

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 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 important 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.

19.1 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.)

19.2 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.

19.3 Example of a Dentist's Non-ERISA Claim Denial

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

The Claimant

Dr. Brown, a 67-year-old oral surgeon practicing in Texas, filed a disability claim with his insurance provider, ACME. He has been a covered beneficiary since 1998 under an individually purchased disability income policy for business overhead expense.

Dr. Brown became disabled in 2015 due to injuries to his hand. Surgery was required to repair fractured phalanges of the thumb and two fingers of his right hand. Dr. Brown 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 right 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. Brown 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 ACME Corporation who denied Dr. Brown's claim and gave him 180 days to appeal the decision.

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

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

The Administrative Appeal

Dr. Brown filed an administrative appeal perfected with additional information including medical records and vocational evidence 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. Brown's ability to perform any work activities on a consistent basis. As such, Dr. Brown 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, ACME persists in denying the good doctor his rightfully owed disability benefits.

Allegations of Wrongful Denials of Disability Benefits

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

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

Breach of Duty of Good Faith and Fair Dealing: ACME 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 ACME's liability has remained consistently clear.

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

- misrepresenting the 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 benefits 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. Brown into a transaction into which he would not have entered had the information been disclosed.

20 The Importance of Attorney Representation during Your Lawsuit

Marketing disability insurance to dentists is big business. While issuing disability insurance plans is profitable, paying out on these policies is not. Whether you are an orthodontist, endodontist or a general 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.

Many insurance companies resort to every strategy, tactic, and angle at their disposal that will allow them to deny or terminate a legitimate claim. Their hope is that eventually you give up and abandon the claim, or otherwise fail in your efforts to appeal the claim.

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 the 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 a written legal argument, called a **Motion for Summary Judgment**, 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** where 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 arraignment, 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 dental 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.

21.1 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.

21.2 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.

21.2.1 The Lodestar Method and How It Works

The Lodestar method is a process 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

22.1 What Questions Should You Ask Before Hiring a Disability 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 will 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:

22.2 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 his or her reputation on assisting dentists, as well as physicians, CEOs, key executives and other high wage earning individuals with their private disability insurance claims. The legal counsel

your hire should have authoritative knowledge and years of experience negotiating and litigating these claims.

A related question is whether or not disability law is 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.

22.3 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 rating 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.

Hopefully, I have given you something to think about in your search for an excellent ERISA disability insurance lawyer.

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. Dentists, doctors, 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.

Disclaimer

This book is authored by Marc Whitehead, an attorney, whose principal office is located in Houston, Texas. The information provided is for general informational purposes only and is not a substitute for professional legal advice based on your individual circumstances. Laws change frequently and may have changed since this book was authored, therefore Marc Whitehead cannot warrant that all representations are correct.

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Marc Whitehead Biography



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

American Association for Justice-Leader Forum Member
AAJ Risperdal Litigation Group Member
AAJ Xarelto Litigation Group Member
AAJ Transvaginal Mesh Litigation Group Member
AAJ Toxic, Environmental, and Pharmaceutical Torts Section

Houston Trial Lawyers Association
President (2009-10)
President Elect (2008-2009)
Secretary/Treasurer (2007-08)
Vice-President (1999-2007)
Texas Trial Lawyers Association
Board Member (1997-Present)
Board of Advocates (1999-2001)
HBA Social Security Section Chairman (2004-2005)

Memberships and Honors

Association of Civil Trial and Appellate Specialists
National Organization of Social Security Claims Representatives
College of the State Bar of Texas
Houston Bar Association
National Organization of Veterans Advocates
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 Dentist's Guide: How to Win Against Wrongful Disability Insurance Denials
- The Complete Guide to Winning Disability Claims
- 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
 - Denied Disability by Unum: How to Fight Back and Prove Your Claim
 - Denied Disability by Aetna: How to Fight Back and Prove Your Claim
 - Denied Disability by Liberty Mutual: Your Battle Plan for Winning Disability Insurance Benefits
 - 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 Claimants