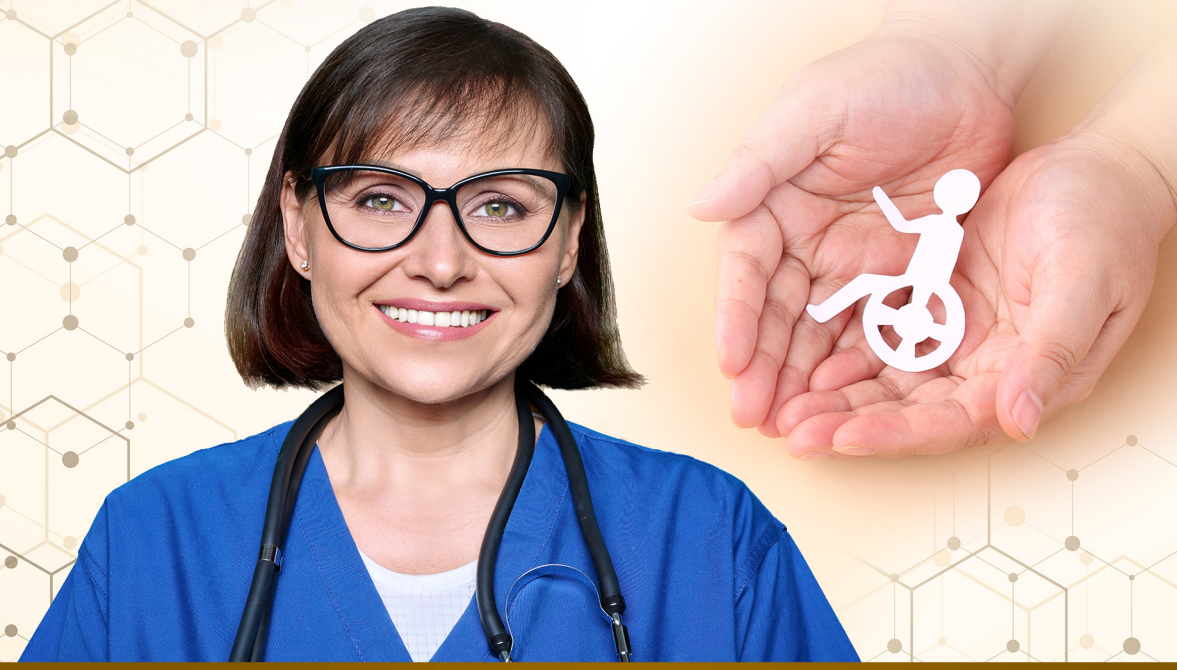
HOW TO WIN AGAINST WRONGFUL DISABILITY INSURANCE DENIALS

THE Disabled NURSES GUIDE



Marc Whitehead, Esq.

The Disabled Nurse's Guide

How to Win Against Wrongful Disability Insurance Denials

First Edition

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Introduction

It is said that disability is a destroyer of dreams. This often holds true for today's nursing professional. According to the U.S. Department of Labor, nurses are among the occupational groups most at risk for short- and long-term injuries nationwide.

If disability happens, most nurses trust that their employers' group disability plans will provide income replacement to help offset earnings loss. In addition, CRNAs and other advanced practice nurses may buy individual disability insurance coverage as primary or supplemental income protection. But what are your chances of actually getting these benefits when disability strikes?

The Trend to Deny Nurses' Claims

When we speak of being disabled, we mean any one of countless injuries or diseases that could prevent you from being able to perform your job in the future. In this light, now consider the nursing profession.

Health care is the U.S.'s largest employer. Nursing is the heart of health care, with over 4 million professionally active nurses. As a group, nurses have one of the most demanding jobs in the nation—physically, intellectually and emotionally. Financially, nursing careers provide healthy earnings, from middle to upper incomes.

For all these reasons, it is essential that nurses have disability insurance coverage. Yet these same facts often become the perfect storm for an insurance claim denial.

The insurance industry keeps close tabs on these statistics, so they can get their share of this thriving market. The same insurance companies who sell disability plans also decide whether to pay or deny those claims. It is a business practice to maximize profits.

An insurer may process hundreds of claims for disability benefits from LPNs, LVNs, RNs and APRNs nationwide. If it succeeds at denying even a third of them, that equates to millions of dollars they do not have to pay out. Which is why your insurance company may deny your initial claim

without fair cause, or delay resolving your claim until you either just give up in frustration, or give in to a lowball offer. You may even be on claim and receiving benefits for months, and the insurer can terminate 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, countless nurses have been left in financial ruin because of their insurance company's deceptive practices and broken promises.

Have you been denied your rightful benefits?

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, your claim for disability benefits as a nursing professional, 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 in the Nursing Profession

Nursing calls for individuals with special qualities and abilities. In addition to compassion and wit, nurses work with their hands and bodies. Due to the very physical component of their work, nurses must have the drive and fortitude to withstand all sorts of on-the-job hazards.

As an industry, nursing has the highest rate of nonfatal occupational injuries. Accordingly, nurses are at high risk of experiencing long term disability. Unfortunately, they are also at high risk of their insurance carriers denying their claims for disability benefits.

Insurance companies are known to use aggressive and unfair tactics in their quest to protect profits. Targeting the long term disability (LTD) claims of nurses for denial is a part of this strategy.

1.1 Why Nurses' Disability Claims Are Unique

Few people realize how physically demanding and even dangerous the nursing occupation is. Not many professions are as physically, mentally and emotionally rigorous as nursing.

As a result, nurses are predisposed to a number of distinct work-related injuries through overuse and accidents.

The Occupational Safety and Health Administration (OSHA) confirms that nurses face an especially high risk of experiencing musculoskeletal disorders (MSDs)—seven times higher than the risk faced by workers in other jobs, including construction.

After years in the field, many LPNs and RNs suffer debilitating and often career-ending MSDs from physical job demands.

The risk factors have been clearly identified. Repeated lifting and forceful movements associated with patient care activities—namely lifting, transferring and repositioning patients, as well as administering treatment or therapy—are common tasks that lead to injury.

For example, nurses frequently transfer patients from bed to chair, or wheelchair to bathtub. Critical care and ER nurses spend hours of many shifts doing the intense physical labor of chest compressions on a patient who may be 6 times his or her size.

Add to that, nurses frequently stand, walk, and even run for long periods of time, spending entire shifts on their feet. They continually twist their bodies and use their hands in repetitive handling of tools and equipment. Infirmities of muscles, bones, discs, joints, tendons, ligaments and nerves ensue. Symptoms include musculoskeletal pain and numbness. Functional impairment can range from a mild decrease to the total loss of range of motion, strength, and coordination.

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

Furthermore, nurses deal with violent, abusive and difficult patients. They are physically and verbally assaulted. They experience human bites and black eyes. They deal with pain and death and help families deal with pain and death.

Twelve-hour shifts often become 14 hours, with rarely a chance to sit or take a break. They multitask, and when chaos prevails they set priorities and manage accordingly. Work overload, sleep deprivation and stress threaten the health of nurses causing burnout and fatigue.

Through it all, a nurse is required to use critical thinking skills, apply problem solving, and reach judgments. They must sustain their ability to communicate clearly. Doctors rely on the knowledge and observations of nurses to make decisions about patient care. Nurses catch potentially harmful mistakes made by doctors who don't know the patient as well as they do.

These things you personally know.

But most people outside the healthcare field don't think of nursing in this way. They envision nurses as checking vital signs, managing IVs, keeping patient charts and administering meds.

1.2 Why Nurses Were (and Still Are) Prime Targets for Insurance Denial

First: Insurance companies actively market to the nursing profession.

Unlike most people, disability insurance carriers are well aware that nursing is one of the highest ranking occupations for injury and illness in the United States. They know how important long term disability insurance is to nurses.

So they vigorously promote group disability plans to businesses that employ nurses: hospitals, clinics, nursing homes, outpatient care facilities, and other healthcare settings. Insurers also target nursing specialties such as CRNAs and NPs, as buyers of the more customized and costly individual disability policies.

Second: Insurers target the nurses they cover for denial.

What many insurers don't want you to realize is their endgame. Insurers make money when insureds and employers pay for coverage, and insurers lose money when they have to pay claims.

The majority of nurses' disability coverage is group disability insurance through their employer. Group plans are typically regulated by a statute known as The Employee Retirement Income Security Act of 1974, or ERISA.

Suffice it to say, ERISA is Federal legislation that has given disability insurance companies pretty much a free pass to deny good claims with little to no danger of penalty.

Hence, disability insurance carriers routinely target middle-to-high-end income claimants for denial—and nurses are at the top of the list.

1.3 The Harsh Reality of Many Valid Disability Claims

Your insurer is not always looking out for you. As you can see, disability insurance companies often give nurses a very hard time. Some insurers will

deny benefits despite clear evidence of disability.

The company that sold the group disability plan to your employing hospital or clinic is the same company that decides whether or not you get paid disability benefits.

Even if you purchased a disability policy specifically tailored to your occupation as a CRNA or other APRN, don't be surprised if your claim is denied. Insurance carriers frequently resort to delay tactics such as underpaying claims, unfairly terminating existing claims or other deceptive and wrongful behaviors to avoid paying your rightful benefits. Most nurses also tend to keep working through the pain—which ultimately works against them when battling an insurance company for disability benefits. Not all insurance companies are deceitful, and not every nurse's claim is creditable. But too many times, the reasons given for denied claims are unfair attempts to discourage and overwhelm you, so you give up and abandon your claim. That is unconscionable, and those insurers should be held accountable.

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

Written specifically for every nurse who has suffered a disability and now must suffer the insurance company—the chapters ahead will:

1. Clarify key features of your policy that you need to be aware of,
2. Explain why the process for you to obtain benefits is so difficult—even more so than it is for non-nursing 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 summary explains how the disability insurance industry has gotten into the shape it is in today. Although unwittingly, the nursing profession has played a major role. By sheer virtue of the numbers and risk factors, a significant segment of workers facing disability insurance claims were and will always be nurses.

2.1 Major Carriers

The largest and most infamous long term disability (LTD) insurance carrier is Unum. Other major companies with a large share of the disability market include Aetna, Ameritas, Assurity, Cigna, Colonial Life, Guardian, Liberty Mutual, Lincoln Financial, Mass Mutual, MetLife, Mutual of Omaha, New York Life, Northwestern Mutual, Penn Mutual, Principal, Prudential, The Hartford and The Standard, among others.

2.2 A Notorious History

Disability insurance was a fairly new concept when insurers began introducing it in the 1980s. It was also a fairly low-risk business. That is, before the rise of managed healthcare.

It is an interesting fact that the upsurge of nurses to attend universities, the explosion of graduate level education and advanced practice nursing, and the opening of the National Institute of Nursing Research, were all occurring coincidentally with the rising sales of disability insurance.

Individual Disability Insurance Policies Gain Momentum

In its heyday during the 1980s, the insurance industry recognized that there was a lucrative market in selling disability insurance policies to young, healthy professionals. These policies were designed to provide a financial safety net for high income earners in the event they became disabled and could not perform the duties of their own occupation.

Insurers stood to gain the most by selling individual policies as a form of income protection. These customized policies often had generous terms

with regard to the definition of total disability, lifetime payouts, and built-in cost-of-living adjustments.

Within the healthcare industry, prime consumers for such income protection were those with extensive licensing investments and higher annual incomes – such as physicians and nurses with advanced degrees.

Group Disability Claims Fall Prey to ERISA Law

A turning point for group disability plans came when Congress passed the Employee Retirement Income Security Act of 1974 (ERISA). This law was originally designed to protect workers' pension plans from abuse. But in 1986, the Supreme Court extended ERISA's scope to ALL employee benefit plans, including short-term and long-term disability.

ERISA law pre-empted (took over) all state laws on the subject of group disability benefits. From that moment on, any employee needing to dispute a denial of a group disability claim was now required to bring the claim to federal court.

But while ERISA may protect an employee's pension, it is a sweepingly unfair law when applied to an employee's group disability benefits. To this day, most LTD claims filed by nurses are through their employer's group benefits plan. This means their claims are subject to biased ERISA law that favors the insurer (not the claimant). ERISA basically robs claimants of vital legal rights and remedies that would normally protect them against wrongful denials.

We explain the lopsided regulations and often disastrous consequences of ERISA in Chapter 7.

Profits Drop for Insurance Companies

Insurers believed disability policies would make them money, but the benefits many of these policies promised proved to be too extensive (and too costly). In the late 1980s and into the 1990s, managed healthcare began to take hold and insurance companies began to experience serious financial loss.

At first, high returns on investments saved the insurers. But then disability policy customers began making more claims, and interest rates and investment returns started falling.

Something had to give, so the insurance companies decided to tighten up on their claims policies and procedures. They began looking for ways to deny disability claims and to cut off those claims that they had previously approved.

This approach enabled insurers to make money then, and continues to this day with many claims.

2.3 How Insurers Target Nurses for Claim Denial

Nursing professionals are easy targets for insurance companies to identify. A sales force can readily locate a hit list of LPNs, RNs, APRNs and others via their various specialty associations.

CRNAs, NPs, CNMs, CNS and other advanced practice nurses with individual disability policies are especially desirable denial targets because their claims have particularly high benefit amounts.

2.4 Cost Control though Claim Denial

The disability insurance industry devised a series of shrewd measures designed to control the cost of paying claims and to justify or deny legitimate claims. Here is a list of just a few common tactics:

- Sniffing out "**misrepresentations**" in the policy holder's initial application (even though the claimant meant no untrue statement) – misrepresentation is generally due to an ambiguous question or lack of direction on the application form;
- **Separating impairments** (versus considering two or more impairments together, where the combined effects cause disability);
- Requiring "**objective evidence**" of a disability that is subjective in nature (for which no objective evidence exists);
- **Abuse of the Own Occupation clause.** Insurers misapply the policy's definition of "own occupation" to take advantage of the diverse sub-categories found within the nursing profession;

- **Misuse of the *Change of Definition Point***, when the "Own Occupation" definition changes (typically after 24 months) to "Any Occupation;"
- **Cherry-picking the facts** in an attempt to block a claim;
- Offensively using the **ERISA preemption**;
- Use of **biased medical and vocational evaluations** ordered by the insurance company to "stack the deck" against legitimately disabled nurse claimants;
- 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 advanced practice RN's specialty as a generalist**. For instance, if you are a nurse anesthetist and have lost certain motor skills due to Parkinson's, even though you can no longer administer anesthesia or monitor patients, the insurer would state that you can still practice as a nurse in a sedentary job.

2.5 ERISA Law Gets Amended. Will It Help?

Both Congress and the U.S. Department of Labor (DOL) have long recognized the need to fix ERISA-based group disability regulations. Even the Affordable Care Act enhanced the ERISA claims procedures for group health plans back in 2010 -- but not for group disability plans!

Finally, the 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." This became effective in April 2018. The regulations apply to disability benefit claims filed after April 1, 2018.

To strengthen consumer protection, the Final Rule amends how employee claims for benefits under 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 you must receive a clear explanation of:
1. Why your claim was denied,

2. Your rights to appeal a denial of a benefit claim,
3. Your rights to review and respond to new information developed by the plan during the course of an appeal, and
4. If all administrative appeals are denied, the insurance company must give a clear calendar date specifying by when a subsequent lawsuit must be filed.

Also, if the Plan fails to strictly adhere to all claims processing rules, you are then deemed to have exhausted the required administrative remedies and are free to file a lawsuit.

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 your case are reviewed as if for the first time.

The Final Rule also sets standards for the 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.

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

Since the new "Final Rule" was enacted, some disability insurers are attempting 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 nursing professionals under a group LTD plan have an experienced ERISA attorney assist in the administrative appeal of their insurance denial.

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.

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

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 governs your claim.
- If you purchased your insurance policy privately, your claim will be regulated under state insurance laws and subject to breach of contract, bad faith, and other causes of action that are more pro-claimant. These Non-ERISA 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 nursing association group disability insurance plan such as policies available to members of the American Association of Nurse Anesthetists (AANA) and Nurses Service Organization (NSO).
- 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.

Finally, make sure your attorney fully understands the practices and strategies used by these billion dollar 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 for LTD.

Short term disability 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 you are disabled and cannot work at your own occupation, LTD benefits are generally paid for 24 months. After this "own occupation" period, if you continue to prove disability, you can potentially receive LTD benefits until age 65.

A key factor in the own occupation provision is how the insurance company defines "disabled." At the 24-month point, group LTD plans typically change the own occupation definition of "disabled" to "any occupation" —meaning if you can work at any job, your benefits will be denied or terminated.

We explain more about how the "Own Occupation" standard affects claims under both group and individual disability policies in Chapters 13 and 14.

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 group disability policies pay 60 percent of your salary. If you work 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 you to work part-time or work at a lighter duty job when you are unable to work full time due to your disabling condition. A partial or residual disability benefit is payable if an impairment causes your income to fall below more than a certain percentage, usually 20 percent below your regular income. Generally, you will be making less money than if you worked full-time or full duty. The policy will require you to make a certain percentage less than your regular nurse's 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 you receive 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 LPN 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 LPN 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 your 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 nurses will apply for SSDI benefits around the same time they apply for LTD benefits. Included in the LTD application is a form you must sign specifying how you want the insurance company to "pay back" the SSDI offset. You can choose to have the carrier estimate how much your SSDI benefit will be. The insurance carrier will then "deduct" that estimate from your monthly LTD benefit.

Most claimants choose another option, which is to pay back the SSDI offset in a lump sum. In this case, you would receive the full LTD monthly benefit from the start. The problem is, since it can take as long as 18-24 months to receive an SSDI award, SSDI back benefits can add up to thousands of dollars. Once you receive the SSDI award and back benefits, the insurance company will want to recover the full amount of back benefits. **Because you have been unable to work and have been getting only 60 percent of their former salary, you may have had to use the SSDI back benefits to pay bills.**

If you 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 you "owe."

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 nurse hits the "any occupation" definition of disability at 24 months, because the insurance company may cut off benefits when the policy changes, leaving the nurse owing a large overpayment.

For more about the "Any Occupation" standard see Chapters 12.11 and 12.12.

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

5.1 Preexisting Condition Exclusion

Most policies have preexisting 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 you apply for LTD benefits less than a year after you sign up for the benefit, the insurance company will look at all your medical records and pharmacy records for the entire year plus the lookback period.

These exclusions are very, very broad. For example, an RN 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 RN to treat anxiety is now being prescribed to treat her muscle spasms. The insurance company will get the RN'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

Nursing 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 of narcotic pain medications as 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 directly, or you may be covered under a group disability insurance plan as a benefit of employment. Generally, If you are responsible for paying the premiums, then the disability insurance is not governed by ERISA. Sources of disability insurance include the following:

- 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 doctors, dentists, nurse anesthetists, and other advanced practice registered nurses, lawyers or CEOs often purchase this type of insurance as a form of income replacement in the event they become disabled. An individual policy may also be used to supplement a group disability policy.

- If your disability policy is paid for by or offered through your workplace as a benefit, you likely have a **group disability insurance policy**. Group coverage is by far the norm for most nurses.

- **Professional nursing associations** may offer group disability plans that may or may not be exempt from ERISA. For instance, with an American Association of Nurse Anesthetists membership, you might purchase **AANA Member Group Disability Income Insurance** either to stand on its own or to supplement your employer's group coverage, with own occupation benefits paid up to 10 years or to age 65. As of this writing, these disability plans are underwritten by New York Life Insurance Company for AANA members. If you are the purchaser of such a policy, a disability claim filed on that policy is likely not governed by ERISA law. Because it can be harder to decipher what laws are involved in various association disability plans, always ask your

insurer or an ERISA disability lawyer to be on the safe side.

- 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. Again, 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.

A quick look into case law shows how ambiguous policy language can work to the insurance company'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 available to you as a claimant are vastly different than if your policy is an ERISA-based group policy. ERISA law 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.

All leading to the question:

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 pay the premiums on your own private, individual, or family disability policy, then ERISA does not apply. A private (non-ERISA) policy would not be 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 to deny 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 gotten in the first place--and hopefully pay your attorney fees.

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

8 ERISA (Group) Disability Claims vs. The Family Medical Leave Act

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

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

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

Let's look at this in more detail.

8.1 What Is the FMLA?

The Family Medical Act was signed into law in 1993 and protects eligible employees who need to take 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, or individual, 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 Nurses

Individual disability insurance (IDI) policies for registered nurses who have specialized in advanced practice are written with specific features and/or supplemented by riders. The purpose is to protect the income level these health professionals have worked to achieve over many years. IDI policies can be very individualized and occupation-specific. Riders are purchased in addition to the base policy, significantly increasing the premiums. Examples might be:

- 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 "nurse anesthetist (CRNA)" or "psychiatric nurse practitioner" rather than "nurse" generally or someone who "practices nursing."
- 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 when employment with the sponsor company ends.

- 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.
- Non-cancelable riders prevent the carrier from cancelling the policy (other than for non-payment or fraud.)
- Student loan protection riders offer additional protection to pay on student loan balances during times of disability.

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

With Individual disability insurance policies, you trade a higher level of benefit for a much higher premium. For more information about these customized policies and how insurance companies strive to deny IDI claims, please see Chapter 14.

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 nurses' 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, nurse-related disability claims to pay on, and it succeeds at denying 50 of them, it saves millions of dollars. 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

If you are applying under a group policy, you must request the claim forms for disability benefits from your employer's Human Resources department. For a privately purchased policy, claim forms will be available to you directly from the insurance provider.

You must also take an Attending Physicians Statement ("APS") form to your physician who will indicate that you are disabled or that the physician is keeping you off work.

Once the claim forms are completed, send all forms to the insurance carrier along with a list of all medical providers you see for treatment. Upon receipt of all the medical records, the insurance company will begin investigating the claim.

Most claimants do not realize that it is very hard to get the initial claim application done right.

It takes much more than your doctor's diagnosis and statement that you cannot work due to disability.

What is the real task of your LTD claim?

You know you are disabled and cannot work. Proving why the insurer should reach the same conclusion and agree to pay fair benefits is the real issue.

Be prepared for denial; approach your claim as though you'll have to prove it in court. The following tips show what it takes to level the playing field and prevail against an unreasonable insurance company.

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 how the policy's pre-existing condition exclusion applies in your case.

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 your 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 in which 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 pounds" 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 nurses' disability policies are written around the concepts of total disability and residual disability. These principles often play key roles in claims filed by LPNs, VPNs, RNs, and APRNs who literally use their hands and bodies while treating, repositioning and moving patients all day, as well as working with medical instruments and equipment.

Residual disability (or partial disability) is a definition of disability in which you are physically unable to perform some, but not all, of your regular job functions because of sickness or injury. This allows you to remain eligible for limited disability benefits while working in a limited capacity (working a lighter duty job or part time hours).

In many cases, disabled nurses are still able to function in their occupation in a general capacity. However, because of their specific disabilities, they can no longer lift patients, assist in the O.R. or delivery room, or perform other bedrock nursing procedures.

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 the physical component as well as any advanced practice nursing areas of expertise.

16. List medical providers and prescriptions.

It seems obvious that you should 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 medications 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 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, for example, if you leave your home to go to your doctor or the grocery store or walk down the driveway to take out the garbage. 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 for insurers 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 nurses. Even fewer attorneys are familiar with ERISA law.

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 Must You 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 regarding your LTD claim is specified 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 or not you will receive benefits. This often 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 insurer uses its 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 often state that your doctor's opinion is not supported by the medical records.

The Supreme Court has looked into this issue, which in the past was known as the "Treating Physician Rule." It was used by the Social Security Administration in its determinations of SSDI claims prior to March 27, 2017. The Rule stated if your treating doctor says you are disabled, that opinion is entitled to "great weight." The Supreme Court also decided that the rule did not apply in LTD determinations. In private and group LTD plans, the Supreme Court already held that your own doctor's opinion that you are disabled should be taken into account as merely "a factor" in the insurance company's determination of disability.

The SSA no longer gives "special consideration" to the opinion of a treating

doctor. This removal of the Treating Physician Rule may further embolden some insurance companies in their disregard of your doctor's opinion as a denial tactic.

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 nurse 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 require 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 an APRN's Disability Claim

Some advanced practice nurses' occupations are largely based on procedural services. Prime examples are CRNAs, who prepare and administer anesthesia to surgical patients all day. They manage the patient's blood pressure, heart rate and response to surgery, one patient at a time, procedure after procedure.

One strategy used by insurance carriers to deny claims filed by CRNAs is to classify their past work as a generalist, rather than as a specialist.

If the CRNA can no longer perform procedural anesthesiology and is suddenly forced to work on a far less specialized scale of nursing, by no means will he or she make the same kind of income as they would if they could administer anesthetics.

The insurance company will not take into account the loss of income that occurs when a CRNA or other APRN can no longer perform the specialty procedures of his or her practice. It is the nurse's burden to prove the economic component of his or her disability claim. Demonstrating a loss of earnings generally calls for objective supporting evidence from a vocational expert and economist.

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 (DOT), 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, ledgers or small tools or other objects. Example titles in the DOT for sedentary nursing positions are Admission Nurse, Nurse Consultant, and Director of Community Health Nursing.

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. Various nursing jobs and certified nursing specialties are considered light jobs. Example titles include Occupational Health Staff Nurse, Supervisor of Occupational Health Nursing, Instructor Nurse, CRNA and Nurse Practitioner. Other examples of a light job classification might be a cashier or security guard.

A medium job requires the ability to lift 50 pounds. In the company of commercial truck drivers and physical therapists, the majority of nursing jobs are considered medium jobs. Example titles in the DOT include Licensed Practice Nurse, General Duty Nurse, Nurse Midwife, or Head Nurse.

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.

NOTE: The DOT Has Not Been Updated Since 1991.

- Many nursing job definitions are in need of updating to reflect the actual occupational requirements.

- Specialized fields in the nursing profession have evolved since then, and therefore are not even listed in the Dictionary.

- You need to know how the DOT classified your job, and, where appropriate, you need to show how your true occupational duties differ from the job as described in the DOT

- Finally, beware of an insurer swapping your true job title with a mismatch from the DOT, as a basis to deny your claim.

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.

12.1 Exertional Classifications

RFC is expressed in terms of the exertional classifications of work. These classifications are described as sedentary, light, medium, heavy, or very heavy work. These terms generally have the same meaning as they have in the Dictionary of Occupational Titles.

12.2 Exertional Activities

Your RFC is viewed in terms of the seven primary strength, or exertional, activities of work, as follows:

Three work positions:

- Sitting
- Standing
- Walking

Four worker movements of objects:

- Lifting
- Carrying
- Pushing
- Pulling

12.3 Definition of Residual Functional Capacity

Residual Functional Capacity (RFC) is an evaluation of the most you can still do despite your physical or mental impairments.

In making this determination, the disability insurance carrier should

consider all of your relevant medical and non-medical evidence, including medical records, observations by examining physicians, evaluations of the medical evidence by non-examining physicians, and your testimony and the testimony others who have observed you.

12.4 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 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.

12.5 RFC: Requirement to Consider ALL Physical and Mental Impairments

In determining a disabled nurse'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 nurse can perform in a work setting.

The RFC examiner must consider all symptoms, including pain.

12.6 RFC: Requirement to Consider Effect of Mental Impairments

When mental impairments are claimed, the insurer 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, remember and carry out 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 from 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.

12.7 RFC: Requirement to Consider Non-Medical Evidence

Non-medical evidence can be vital in assessing the functional limitations of 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.

12.8 Absenteeism and Its Effect on the Ability to Work

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

12.9 Your Skill Level

Skill levels are also defined by the Dictionary of Occupational Titles (DOT), 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.

Nursing occupations are classified ranging across skill levels 6, 7 and 8.

Again we emphasize the out-of-date nature of the DOT. Its database excludes many of the newer occupational titles of nursing specialties, let alone up-to-date job descriptions throughout the vast nursing industry.

Insurance companies will take advantage of these discrepancies; meanwhile, the uninitiated claimant has no idea of this underhanded practice, much less how to fight it.

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

For the first 24 months or as defined in the policy, you only have to be unable to perform your "own occupation."

Example 1: Eloise is an ICU nurse of 20 years. Her job is listed in the DOT as having a medium strength rating. 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 maneuver, lift and transfer her patients. Because her impairment limits her ability to lift, walk and stand, she cannot perform the daily duties of her own occupation.

Example 2: Joe is a neonatal nurse practitioner diagnosed with Parkinson's disease. He is losing the ability to perform the essential tasks and duties of his own occupation. His nursing duties fall within the light strength rating and his skill level is considered highly skilled work requiring years of training and education. Although Joe 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.

12.11 "Any Occupation" Standard

After 24 months, you must prove that you are unable to work in "any occupation." Usually, the policy definition includes "any occupation" that a claimant can perform based on his or her education, background and skills.

- **Benefits Usually Paid Up to Retirement Age:** If you 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 your disability begins after age 60, benefits are paid according to a schedule in the policy. Depending on your age, benefits will be paid for a maximum number of months. For example, if you become disabled at age 63 you would get 36 months; age 64, 30 months.

12.12 Salary Percentage Requirement under the "Any Occupation" Standard

The "any occupation" standard usually includes a salary percentage requirement. This favorable provision in a 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, under this provision, the insurance company must find occupations that will pay you usually at least 80 percent of your pre-disability income. Otherwise, you are disabled.

13 The Impact of "Own Occupation" and "Any Occupation" in a Nurse's ERISA-based Claim

Throughout this book, you see mention of Own Occupation and Any Occupation. These occupational standards are perhaps the most important components towards winning the disability benefits you deserve.

Disability policies, whether group or individual, provide definitions of the occupational standard that you must meet in order to obtain benefits.

We refer to these as the Own Occupation (Own Occ) standard and the Any Occupation (Any Occ) standard. Whatever your policy states are what you must adhere to and prove in your claim for disability benefits.

As stated earlier, the majority of LTD claims submitted by nurses are group claims where the disability insurance was provided by or through the employer. These claims are governed by ERISA law.

This chapter explains the basics of:

- How your group disability policy defines disability: Own Occupation vs. Any Occupation, and
- How insurance companies may try to spin or exploit these definitions to justify claim denial or termination.

13.1 Own Occupation in Group (ERISA) Plans

Actually, group long-term disability plans are most often hybrid plans that combine **own-occupation** and **any occupation** provisions.

Group policies typically start with a definition of your own occupation. The own occ provision lasts 24 months (or less), and benefits are payable if you cannot perform your regular occupation or a similar one.

Here is a typical group "Own Occ" definition of Total Disability:

> You will be considered totally disabled if you are unable to perform the material and substantial duties of your own occupation due to accident or sickness. You must be under the regular care of

> a physician to be considered totally disabled. This definition is applicable during the first two years of disability after the elimination period has been satisfied. Your "own occupation" is that which you were performing on the day before the total disability began.

Generally, if you cannot do any of the duties the insurance company considers "material," then you are totally disabled. If you can do some of the duties or all of the duties but for less than full-time you are considered partially or residually disabled.

13.2 Any Occupation in Group (ERISA) Policies

Next, your policy will define the **"Any Occ" definition of Total Disability,** such as this one:

After 24 months, you will be considered totally disabled if you are unable to perform the material duties of any occupation, require a physician's care and are not engaged in any job for wage or profit. "Any occupation" is an occupation which fits you by education, training, or experience. (Or, some group plans define Any Occ as any occupation which is performed in the national economy.)

Notice how the definition of disability shifts to "Any Occupation" at the two-year mark. From this point forward you only get benefits if you can prove you are disabled from doing any job – a much harder undertaking.

The broader any occupation provision places you at a huge disadvantage. The burden is on you to prove that you cannot perform any job you are reasonably qualified to do. Plus, you have to prove this to the company that denied the claim to begin with.

13.3 How Insurers Abuse the Own Occ Provision to Deny Group LTD Claims

Recall how diverse the nursing industry is. Nursing occupations occur in various settings with different levels of skill and duties.

Claims handlers capitalize on this. They will often stretch "own

occupation" to imply the disabled nurse can take on another nursing job—one that might be more sedentary, or otherwise less "demanding"—simply because they hold the same (or higher) licensure.

Example: "Nurses Can Do All, Be All" Tactic (Misinterpreting Material Duties)

A home health gerontology RN of 20 years, Anne recently had hip surgery, which ultimately rendered her disabled. She submits a disability claim to her employing hospital system's group benefits plan.

The insurance company does a paper review of Anne's claim. It contracts a third-party doctor to review the medical evidence and records and to provide an opinion of Anne's ability to work. The company also hires an investigator to surveille Anne over several months. They deny her claim, saying she is not disabled because (they find) she is able to do similar "lighter, more sedentary" nursing duties.

This is a common ploy to deny claims outright, during the first 24 months of the own occ definition, regardless of the evidence submitted by Anne and her treating doctors.

In this case, the insurer ignores, among other things, the frequency of travel and the amount of walking, standing, and strength required in Anne's job as a home health RN, where she visits and treats various geriatric patients in their home settings on a daily basis.

The policy instructed the insurer to consider the duties of Anne's own occupation, as the work she was doing immediately before the onset of disability. But with no penalties in ERISA law for doing the wrong thing, this insurance company felt no incentive to do the right thing.

The insurer unreasonably interprets the "material duties" of Anne's occupation—by deciding that there are other desk-based nursing jobs she could step right into. The insurer finds that Anne is not totally disabled under the Own Occ standard.

And with the right piece of surveillance tape (and other tactics), they expect to discourage Anne from challenging the denial.

13.4 The Top 5 "Own Occupation" Denial Tactics with Nurses' Group LTD Claims

- Claims adjusters won't hesitate to interpret or redefine your own occupation broadly—as nursing might be performed generally in the national economy. E.g., a claimant who is a PICU travel nurse can fill the role of a telephone triage nurse, and therefore is not disabled.
- Insurance carriers will deny your claim because you have transferable skills (skills you have as a nurse that will transfer to similar or related jobs).
- Insurers will rely on the results of their own Independent Medical Exams and Functional Capacity Exams to deny benefits, using their biased data to override your doctors' findings—thus deciding you are vocationally able to work in your own occupation.
- Insurers will selectively focus on parts of your job ("nursing" generally) that you can still perform, even if those duties do not fit your true own occupational duties.
- Adjusters selectively or inappropriately apply the Department of Labor's Dictionary of Occupational Titles and the O*Net database in a way to support a denial.

13.5 How Do Insurers Abuse the Any Occ Provision to Deny Group LTD Claims?

In group claims, it is an all-too-common strategy for an insurer to award disability benefits initially, only to discontinue benefits later. The insurance company will terminate benefits by claiming you are able to return to work in any occupation which fits you by education, training, or experience that is not as physically demanding.

Example: "Pay Now, Terminate Later" Tactic (The Switch from Own Occ to Any Occ)

Henry was an LPN at a surgery center and stopped working due to degenerative disc disease. He filed a claim for LTD benefits and was initially approved. The insurer agreed he could not perform the duties of his own occupation.

After paying Henry benefits under the own-occ standard for 24 months, the insurer now cuts off his benefits on the basis that he is not disabled from performing the material duties of any occupation.

As it so often happens, the insurance carrier decides that Henry is able to work in a sedentary occupation, even if it is part-time work, with suggestions that Henry is qualified to work as a medical records technician, blood bank booking clerk, data entry clerk, or appointment manager.

And especially with the switch to Any Occupation, the policy likely **has no income qualifier** in the Any Occ definition—giving the insurer loose rein.

The occupation of nursing is specialized. Most of these professionals work only in medical settings, deal one to one with patients, and their experience is with diverse illnesses, conditions, and injuries.

Contrary to what insurance companies would have you believe, most nurses are not office workers. Many have no word processing skills, have never dealt with reports, handled administrative matters, or served as clerks. For a nurse who is immersed in patient care, medication dosage, medical devices, bedside manner, pain management, anesthesia, ER, OR, delivery room or hospice, to say he or she should be proficient in keyboarding or office administration is flawed thinking.

13.6 How do you combat the misuse of own occ and any occ standards?

Because you're dealing with a law that often turns a blind eye towards an insurer's claims handling misconduct, working with an attorney who understands group plans and the ERISA process is your best hope for fair treatment. Chapter 16 explains how sound legal counsel can help you win the fight.

Next:

CRNAs and others in very specialized nursing careers can make $200,000 a year or more. This may call for a different level of insurance coverage

known as Individual Disability Income (IDI) protection. This type of disability claim has an entirely different set of laws under which you can fight back when your insurer acts in bad faith.

14 APRNs with Individual Disability Income (IDI) Policies

So far, we have discussed how insurance companies abuse aspects of the tough ERISA law that regulates group disability claims.

Now we shift focus to registered nurses who are denied benefits under their individual disability income (IDI) policies. These claim disputes are controlled by state contract and insurance laws (not ERISA).

14.1 Who Might Have IDI Policies and How Are they Different?

IDI policies are a logical investment for registered nurses with advanced practice certification, degrees and licensing, often listed as an advanced practice nurse (APN) or advanced practice registered nurse (APRN). Certifications include: certified registered nurse anesthetist (CRNA), certified nurse practitioner (CNP), certified nurse midwife (CNM), and clinical nurse specialist (CNS), as well as psychiatric mental health advanced practice registered nurse (PMH-APRN), and certified pediatric nurse practitioner (CPNP).

These and other APRNs have made a considerable investment in their careers, with incomes high enough to protect by paying monthly premiums out of pocket.

They choose to purchase individual disability income coverage for better financial protection. In stark contrast to group plans, individual policies have nothing to do with groups of employees, and everything to do with protecting you exclusively.

IDI policies are very versatile. You can "stack" coverage provisions tailored to your situation. You buy add-on protections (riders) such as an Own Occupation definition that states your occupation is limited to a single medical specialty, or unlimited mental/nervous coverage, or make your coverage portable if you change jobs. Each add-on rider for enhanced coverage substantially increases the policy's cost.

With IDI policies, the own occupation provision is legally defined with much more clarity regarding the nurse's specialty field, as follows:

14.2 Levels of "Own Occupation" in IDI Policies

With customized IDI coverage, you pay for a better definition of "Own Occupation" with the fewest gaps in coverage. For example:

• A true own-occupation policy pays out if you can't do your specific job, even if you're able to do other work; i.e., you may work in another job and still get disability benefits under the policy. Some policies refer to this as "Specialty Own Occ" with language that further defines and narrows what your full time specialty occupation is.

For example, your IDI policy's definition of own occupation is Certified Registered Nurse Anesthetist (instead of "nurse" or "nursing"). You are insured if you become disabled and cannot perform the specific duties of a CRNA. One day you're in a car accident, and you permanently injure the ulnar nerve of your scope-holding hand. Because you can no longer perform endotracheal intubation, you no longer have a clinical practice. Under this policy, benefits will be paid, even if you decide to continue working in another capacity.

• Modified own occupation policies often let you receive benefits if you can't do your own job plus you are not working anywhere else.

• Hybrid own-occupation and any occupation policies combine own occ and any occ provisions (and are therefore the least expensive IDI policies).

But there is the fly in the ointment: when reviewing nurses' disability claims, in particular, a favorite denial strategy of insurers is to exploit the own occupation definition.

14.3 How Insurers Abuse the "Own Occ" Provision in Nurses' IDI Claims

The diversity of occupations throughout the nursing industry adds a unique element to disability claims. Nursing is comprised of a multitude of sub-categories— more than most professions.

Levels of nursing go much more in-depth than LPN and RN. Branches of the profession range from nurse educators and family health to geriatric, clinical studies, research, pediatrics, oncology or obstetrics.

This unique diversity is something many insurers will attempt to exploit under state contract and insurance laws.

14.4 The Top 6 "Own Occupation" Denial Tactics with Nurses' IDI Claims

- IDI insurance carriers routinely **redefine or "misinterpret" the own occ definition** in the policy to argue their basis that nurses have multiple occupations such as administrator, directors, educators, or consultants. They will continue to deny on the premise that you do not understand your policy's own occupation definition and to not have the understanding to manage a successful claim.

- Insurers may try to **classify your work as a generalist**, rather than as a specialist. Imagine a CRNA's shock when the insurer denies her disability claim because the insurer alleges she can still work as a general nurse. The insurer does not consider the disparity in income. It is up to the disabled nurse to prove the economic component of her disability claim. This often entails working with a vocational expert and economist to prove the loss of earnings component.

- Insurers will try to **ignore or invalidate your treating doctor's opinion**, and displace it with opposing medical opinions from their own physicians. So you must fully develop your claim to prove how deeply your condition prevents you from doing the material duties of your own occupation. This is key.

- An extension of the above item, your insurance company will require you to attend an **Independent Medical Exam (IME) and Functional Capacity Exams** with experts contracted by the insurer. Often biased against you, their expert medical and vocational opinions will focus on providing "evidence" that you are capable of performing your own occupation.

- Insurance companies know just how effective visual evidence is; **through surveillance,** they hope to capture you in activities that can prove you can do the physical activities needed in your "own occupation." They may take hours of digital surveillance to get that perfect five minutes where you are getting in and out of a car, picking up your 4-year-old, or walking in the park.

- Many advanced practice nurses **tend to keep working through their illness or injury.** This can work against you in IDI claims, even if you purchased a policy written to your true own occupation as a CRNA or other advanced practice. Insurers are looking for any reasons that indicate you are capable of working at your own occupation.

14.5 IDI Claim Denial: More Risk for the Insurer, but Higher Payout

Insurers use a host of tactics to deny valid benefits under IDI policies. From an insurer's standpoint, a nurse's ERISA claim is easier to deny and get away with unscathed. But a nurse's IDI claim is a more profitable target. If they can succeed at avoiding years of much bigger payouts, it is worth the risk.

Yet when fighting wrongful IDI claim denials, you have state laws on your side. Many legal remedies come into play which are not allowed under ERISA. Causes of action in IDI litigation generally state bad faith and breach of contract, as well as filing for misrepresentation, negligence and other state law causes of action.

15 Why You Shouldn't Use the Insurance Company's Recommended Social Security Representative

Your insurance company will likely recommend one of several 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 a false incentive to convince you to use their recommended SSDI representative. The hook is that the SSDI rep will help you get Social Security Disability benefits free of charge because the LTD insurer will cover the costs.

In reality, you must turn over all back benefits to the insurance company anyway. Nothing is gained, and you are not in control of whatever back benefits you truly owe 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, Section 4.3 about The Social Security Offset and Section 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 aid 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 is 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 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.

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

Many disabled nurses 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.

Insurance companies team up with non-lawyer advocates because 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.

15.2 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.

15.3 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.

16 What Does an Attorney Do to Help You Win Your Claim?

Countless traps must be overcome when filing initial claims and appealing a denied claim. If the claim is denied, the greatest danger of all is failing to develop the administrative record during the appeals process – which can undermine future litigation of your case.
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 making inadvertent statements or mistakes 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!!!

17 What If Your Disability Claim Is Denied? The Administrative Appeal

If your insurer denies your initial claim for LTD benefits, you must not give up! It is through the appeals process that many claimants finally receive their benefits.

17.1 The Denial Letter

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

If the claim is denied, you will receive a "denial letter." This letter is very important because it lists what files and 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 you need to prove disability. The denial letter also gives important information for an appeal, including where and when the appeal must be received.

17.2 Time Limits for Filing Your Appeal

The denial letter will give the time frame 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 claimants 180 days to appeal.

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

17.3 The Administrative Appeal Procedure – What You Need to Know

There is a great deal of work to be done. Appealing a long term disability claim 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 as directed in the denial letter; 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 you or that you are 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 your failure to submit documents necessary for the insurer to make a decision based on your claim.
- You must appeal a denial of your claim within **180 days** of that denial.
- The Plan has 45 days to resolve any appeal with one **45 day extension**.

17.4 Statute of Limitations: Your Insurer Must Specify Your Time Limit to File a Lawsuit

In Chapter 2, section 2.5, we summarized the 2018 ERISA "Final Rule" set forth by DOL updating ERISA disability rules to better protect disabled claimants.

One of the most important changes requires that insurers provide an explanation and a reasonable date specifying any deadline to take a case to court. This is to be specified in the letter of denial or termination, clearly stating the calendar date on which any applicable contractual limitations period for filing a lawsuit expires.

This rule is meant to rectify past situations in which contractual limitations could literally expire before the review was concluded, completely undermining legitimate claims. Insurers have historically used the complexities of calculating a Plan's limitation periods for filing administrative appeals or for filing a lawsuit as a preferred tactic to mislead or overwhelm claimants.

Still, any nurse whose initial claim was initially denied and then denied again on appeal needs to pay close attention to the timeline for filing a lawsuit. In the short time the Final Rule has been issued, many 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 and is meant to cause confusion; 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.

17.5 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 CRNA or other advanced practice nurse, 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 an APRN's Disability Claim).

17.6 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.

17.7 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.

17.8 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.

18 Do You Need an Attorney to Help With the Administrative Appeal?

Perhaps the greatest danger with an unrepresented disability appeal is the failure to develop the administrative record. This can cause irreparable harm for future litigation. In most ERISA cases that go to trial, the administrative record is the only evidence a Judge can consider – new evidence is seldom allowed and the record is closed beyond that point.

This chapter shows how claims are immensely strengthened when an experienced disability lawyer strategically develops the administrative record during the appeals process.

18.1 The Importance of Representation during the Administrative Appeal

Many nurses and other healthcare professionals decide to appeal the insurance carrier's denial on their own. Often they will write a one-paragraph appeal letter stating "I appeal your decision. Please reconsider." Others submit only minimum information in support of their claims, omitting crucial evidence. These approaches rarely succeed, as claimants are naive of insurers who are waiting for them to make these and other mistakes.

Because you are in no condition to work, a disability lawyer will help you gather all necessary documentation and prepare and file a well-drafted, conclusive appeal. Your attorney will talk with your doctors, obtain statements from crucial witnesses, consult with qualified vocational and economic experts, and use the latest science and technology to investigate and build the details of your case.

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

- Rebutting each of the insurance carrier's allegations for denial, point by point;
- Contacting and obtaining expert opinions;

- Sending you for a functional capacity exam or medical evaluation;
- Obtaining updated medical records; and
- Carefully reviewing your claim file to see if the insurance carrier followed the proper procedures in handling your claim.

18.2 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, and showing how your condition affects your life 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 how your impairments affect you on a daily basis can be submitted and made part of the "record."

In ERSIA cases, after a lawsuit is filed, nothing else can be added to 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 refuse any newly submitted evidence.

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 with competent, relevant evidence.

18.3 Obtaining Vocational Expert Opinions

Effective use of your own vocational expert's testimony and written assessment is critical to support your appeal and to disprove opposing testimony by the insurance company.

Vocational experts are sometimes called "VEs" or "jobs experts" 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 nurse's Residual

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

As mentioned earlier, some policy definitions of disabled include a salary percentage provision. This states that you are disabled if you cannot find work that pays a certain percentage of your 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 you can perform and still meet the salary percentage.

> **Example:** Jack is an ICU registered nurse. His daily care of patients requires (aside from his medical qualifications) long hours of standing, walking, sometimes running, lifting and moving patients, and moving equipment. Due to a severe knee impairment, Jack is now capable of sedentary work only. It is quite likely any sedentary or light-duty job for which he may reasonably become qualified based on education, training or experience will not pay enough to reach the salary requirement. Jack would meet the policy definition of disabled because the VE found that there are no jobs that he could perform that pay 80 percent of his pre-disability salary.

18.4 Obtaining Medical Expert Opinions

In the same way a VE reviews your record and forms an expert opinion, an independent medical expert (ME) can review all your medical records and form an opinion about your RFC. Sometimes the medical expert will also examine you in person and include those findings in the report. You may need a ME's opinion if there are not very many medical records or if the existing records don't accurately reflect your condition.

18.6 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.

19 Insurance Company Tactics

While the insurance companies' strategies to deny legitimate claims for benefits are well known to our attorneys, each denied claim comes as a shock to disabled claimants and policyholders. This chapter illustrates just a few tactics routinely practiced by insurers to watch for.

19.1 Separating Impairments during the Review

Many nurses have more than one medical impairment, and it may be the combination of impairments that render them disabled. However, during a file review, the insurance company's hired doctors will focus on each impairment individually and find that the nurse is not disabled based on that one impairment.

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

19.2 Video Surveillance

The administration of disability claims is a billion dollar business. It is quite common for insurance carriers to hire private investigators to covertly film disabled nursing professionals who have applied for disability benefits 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 nurse 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 nurse for an "interview" and show them the footage. This is quite intimidating to any 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.

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?

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 often their reports are filled with commentary designed to turn the 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 evidence the claim examiner actually used. Far too often, the claims handler deciding your fate doesn't even bother to watch the actual video footage because that takes up too much time. Instead, they simply read investigators' reports. But as mentioned above, quite often the reports are incredibly editorialized and exaggerate what's in the videos. A good disability attorney will then use this to argue that they 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.

19.3 Functional Capacity Exam

A Functional Capacity Exam (FCE) is a battery of physical tests given to determine your Residual Functional Capacity, or RFC (see Chapter 12). 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 and lower extremity strength, a critical component in a nurse's claim 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 cannot possibly reflect how well a disabled nurse 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 exam 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 nurses to endure an FCE.

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

19.5 Malingering Because of "Grip Strength" Test

One of the tests performed during the FCE of nursing 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 carpel tunnel syndrome show that these tests are really not reliable to distinguish true or faked hand weakness.
You must anticipate and be prepared to refute allegations of malingering from the outset of your case.

19.6 What is Non-Compliance?

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

19.7 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."

19.8 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 as a nurse 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.

20 Filing an ERISA Lawsuit If My Administrative Appeal Is Denied

20.1 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.

20.2 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.

20.3 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.

20.4 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.

20.5 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 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 contractual limitations and deadlines. Many plans shorten the deadline to three years from the date for which proof of disability must be provided. Some plans have much shorter deadlines.

(Also see: Chapter 17.4, Statute of Limitations: Your Insurer Must Specify Your Time Limit to File a Lawsuit.)

20.6 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!

20.7 What Do I Have To Prove?

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

Abuse of Discretion

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.

Judicial Review / De Novo Review

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 (the judge gives your case a fresh look) 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.

20.8 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 generally 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.

21 Filing a Lawsuit on a Private (Non-ERISA Disability Insurance Claim

If you privately purchased your own policy and believe your carrier has wrongly denied your claim, you have far more legal recourse than claims subject to ERISA law. Private disability insurance policies are fundamentally insurance "contracts."

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.

21.1 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.)

21.2 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.

22 The Importance of Attorney Representation during Your Lawsuit

Marketing disability insurance to nurses is big business. While issuing disability insurance plans is profitable, paying out on these policies is not.

Whether you are an LPN, RN or APRN, your disability policy likely falls in the "upper middle-to high income" range. Add to that, there are over four million nurses working in the one profession that boasts the highest rate of nonfatal occupational injuries. It would be quite beneficial for the insurance carrier to collect premiums while denying claims and not having 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.

Below is a study of a typical disability case we handled, where the insurance carrier, The Standard, not only discounted the treating physician's opinion, they did not examine our client and made no attempt to contact our claimant's doctors.

Case Study: The Standard LTD Denial Reversed for Nurse Practitioner

Recently, our firm represented a nurse practitioner who is a cancer survivor. Our client suffers from fatigue, cognitive impairment, neuropathy, and hearing impairments caused by her cancer treatment. Carpel tunnel and neuropathy limit the use of her hands. She faces many obstacles including balance problems, difficulties with fine motor skills, and is prone to

dropping items.

Our client is fully supported by her health care providers and treating physicians, all of whom corroborate that these side effects are common in cancer survivors.

Our client filed a disability claim with her insurance carrier, The Standard. However, the insurer ignored the opinions of our client's treating physicians. The Standard's medical reviewers did not bother to examine our client nor did they speak with her doctors. Not surprisingly, The Standard found our client had no problems and could return to her work.

By researching and applying case law, we were able to win our client's case and recover benefits. We successfully argued that The Standard wrongfully denied benefits by failing to consider our client's inability to work continuously:

1) While there may be times when a person is capable of working, reliability and consistency are necessary, as cited in Peterson v. Federal Express Corp. Long Term Disability Plan:

> *"Finally, the court notes that a total-disability determination cannot reasonably hinge on whether an employee is minimally capable, on a good day, at the right hour, of fulfilling her job duties in barely tolerable fashion. Qualification for employment requires an ability to work effectively and to be reliable."*
> *— Peterson v. Federal Express Corp. Long Term Disability Plan, U.S.Dist. LEXIS 41590 (D. Ariz. 2007)*

2) The nature of our client's occupation as a nurse practitioner would adversely affect her future health, as cited in Shipp v. Provident Life Acc. Ins. Co. that holds that if a claimant's job poses a threat to safety, an insurer must consider that fact:

> *"Because [the insurer's] clinical reviewers appear to have ignored the overall effect [the claimant's] occupation might have on a person's health, the court finds that [the plan administrator's] decision may have been incorrect."*
> *— Shipp v.provident Life Acc. Ins. Co., 214 F.Supp.2d 1241 (M.D. Ala. 2002)*

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.

23 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 on 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 nurses 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.

23.1 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.

23.2 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.

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.

24 Choosing a Disability Insurance Attorney

24.1 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.

Knowing how to deal with medical experts, vocational experts, insurance company tactics, ERISA regulations, state insurance statutes, 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:

24.2 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? Look for an attorney who has built his or her reputation on assisting LPNs, LVNs, RNs and APNRs with ERISA-based group claims. Again, this area of law is complex so you want someone with experience and also the resources and background to prevail. Dig a little deeper than just years of experience.

How many individually owned disability cases have they handled? Look

as well for an attorney who has built his or her reputation on assisting CRNAs, APRNs, physicians, dentists, CEOs, key executives and other high wage earning individuals with their private disability insurance claims. The legal counsel you hire should have authoritative knowledge and years of experience negotiating and litigating these claims.

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 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.

24.3 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.

25 Conclusion

Disability Insurance claims are governed by a complex set of laws and procedures. These laws are full of traps for the unwary, including lawyers who have no experience in ERISA law or insurance bad faith. Nurses, 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 the denial 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.

You should always consult with an attorney directly before making legal decisions concerning your own unique legal issues. The offer of the information in this book does not create an attorney/client relationship. An attorney/client relationship with this law firm can only be formed by executing a written contract with Marc Whitehead or his firm that is signed by the client and a representative of the firm.

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 veterans' disability compensation, Social Security disability, long-term disability insurance 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 Mess 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