

Common Fatal Mistakes in Doctor's and Dentist's Disability Insurance Claims – Asset Protection

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I don't sell insurance, but part of the education I provide all clients is the value and limits of the policies they have in place. I have previously covered the use of various kinds of insurance as an "asset class", as a risk hedge and even as an alternative to cash. One form of insurance protects one of your most valuable assets, your income, in the form of disability insurance. One of the legal professionals on my short list of regular resources is Attorney Edward Comitz, the guy I call when a carrier is not paying my client what they are owed (bad faith). I asked Ed to share some insights and help educate us on how those exposures occur, and how they can be addressed. – Ike Devji, J.D.



**Why Is It So Hard to Collect on My Disability Insurance Policy?
Avoiding Mistakes When Filing a Claim**

Attorney Edward Comitz

“I retired early because I had Multiple Sclerosis (MS) and could no longer work. Since retiring, my health insurance denied me critical medication and my disability insurance told me that I am no longer disabled. . . . I face a daily battle with my insurance companies.”

Former hospital CEO, William Blaine of Minnesota on *The Oprah Winfrey Show*, September 2007

Throughout the 1980's and early 1990's, disability insurance companies aggressively marketed and sold policies known as “own-occupation” or “occupational” disability policies to dentists and other health care professionals. Common wisdom and actuarial knowledge demonstrated that doctors would be less likely to stop working due to physical limitations, even severe limitations, since they had already invested years into their education and training, enjoyed working and were earning high salaries. Accordingly, most of the older policies sold ten or more years ago contain favorable coverage provisions.

The older insurance policies were typically available to doctors without the requirement of long applications, detailed medical histories or medical testing. The benefits of these policies included, among other things: (1) occupation-specific coverage; (2) no mental health exclusions or limitations; (3) lifetime benefits instead of benefits payable to age 65; (4) cost of living increases; (5) benefits not offset from other income sources; and (6) no limits or relaxed limits on maximum coverage amounts, among many other things. Of all the bells and whistles, the key marketing hallmark of these liberalized policies was to allow full payment of disability benefits if the doctor became disabled from his or her “own occupation,” regardless of whether he or she was able to work in another occupation. This allowed specialists to receive full disability benefits even if they could work, and did work, in another occupation or specialty. Allowing doctors to double dip was the most attractive feature of the older policies and a key component to the insurance companies marketing campaigns.

Although the insurance companies projected high interest rates would continue, they actually plummeted in the late 1990's, coinciding with the emergence of managed care. Many doctors grew frustrated and refused to work through their physical limitations, opting instead to make legitimate claims for disability benefits on policies that were equal to, or greater than, their modified salaries. This led to a deluge of claims submitted by physicians and dentists, leading to an acute lack of profitability within the disability insurance industry.

To counteract this “problem” that the insurance industry created, carriers began to focus on claim administration, hyper-scrutinizing the terms of their policies and any claims made thereunder, and utilizing novel, creative and often improper methods to justify the denial or termination of legitimate claims. Despite the obligation to honor their commitments, many disability insurance companies banked on doctors being unaware of the favorable language contained in their policies, including the details of their own-occupation coverage.

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This type of gamesmanship was the hallmark of many companies in the 1990's and early 2000's. The practices were so egregious that they began receiving media attention, including segments on NBC's *Dateline* and CBS' *60 Minutes*. As a result of continuing media pressure, insurance commissioners began cracking down. UnumProvident Corporation became the prime target of repeated investigations by insurance regulators, resulting in a Multistate Market Conduct Examination Report identifying serious areas of concern, including: excessive reliance on in-house medical professionals, unfair construction of attending physician or IME reports, failure to evaluate the totality of the claimant's medical condition, and placement of an inappropriately high burden on claimants to justify their eligibility for benefits.

After several years of investigation and negotiation, UnumProvident Corporation entered into regulatory settlement agreements with the insurance commissioners of all 50 states, agreeing to promptly, fairly and objectively investigate all claims on a going forward basis. Although the media interest has considerably waned, large numbers of dentists and other health care professionals continue to file legitimate claims that remain a huge liability for the industry. Accordingly, dentists and other health care professionals still have difficulty collecting benefits, notwithstanding any lip service paid to the industry's supposedly reformed practices. This is particularly true now, in light of down economy and increasing financial pressures experienced by the disability insurance industry.

Today, doctors and dentists are simply not purchasing disability insurance coverage as they did in the past, in part due to pricing, and in part due to the fact that the policies now sold cannot come close to providing the coverage found in the past. In turn, premiums received by insurance companies cannot be reinvested in the stock market and real estate holdings to meet overhead. Many disability insurance companies are merging, vanishing and feeling pressure to release reserves just to stay afloat, and this has unfortunately materially affected claimants. With nowhere to turn, except to cut costs, insurance companies are now fighting just to survive.

Under the weight of increasing financial pressure, insurance companies have more incentive than ever to deny or terminate legitimate claims. Claims of dentists and other health care professionals are exceedingly expensive to pay, which has resulted in the resurgence of more stealth, hard-ball claim administration. Increasingly, insurers are closely scrutinizing claims and passing the claim administration function on to third-party vendors who specialize in "getting results" that can increase the insurance carrier's bottom line.

The administration of high-dollar claims is now a billion dollar business, with insurers and third-party administrators lobbing a seemingly endless barrage of anti-coverage grenades on claimants, including: video surveillance of their activities; unannounced field interviews and investigations; inaccurately reported attending physician interviews; vocational rehabilitation testing; in-house medical evaluations; "independent" medical exams; medical "interventions" and micro-management of medical care; financial and insurance billing audits; re-evaluation of answers on application forms; investigations of prior litigation and board complaints; and investigations of circumstances surrounding practice sales, among other things.

The disability insurance industry has become unrelenting, with the knowledge that the denial or termination of a single professional's claim can save hundreds of thousands of dollars, if not more. Therefore, at this time more than ever, dentists must familiarize themselves with their policies and the claim process, and continue paying premiums on any liberalized policies that they may have purchased in the past. Because claims filed by dentist and other health care professionals are particularly scrutinized, it is critical that the following mistakes are not made during the claim process:

Mistake # 1 Failing to Consult With Counsel

If you are considering filing a claim for disability insurance benefits, it is advisable that you meet with an attorney experienced in the area before submitting your claim for payment. Disability provisions vary greatly in the language used, and coverage is often circumscribed and restricted by qualifying words and phrases. Accordingly, each policy of insurance must be individually reviewed to determine whether a particular claim is covered and, if so, how that claim is best presented to ensure payment.

Mistake # 2 Misunderstanding The Definitions Of "Disability" And "Occupation"

Because there is no such thing as a "standard" disability insurance policy, the definitions of "disability" can significantly vary. The central issue in many cases is the definition of "total disability," which could variously mean that the insured cannot perform "all" or "every" duty of his or her occupation, or the "substantial and material duties" of his or her occupation. Similarly, the term "occupation" may be specifically defined in the policy, *e.g.*, "oral surgeon," or as the claimant's specific occupational duties immediately prior to the time that disability benefits are sought. In the latter situation, if a dentist reduces his or her hours in the months preceding claim filing, the carrier may consider his or her occupation to be part-time rather than full-time. Similarly, the term "occupation" may be comprised not only of the duties of a doctor's specialty, but also significant travel time, teaching engagements or other areas in which he or she spends time or draws revenue. For example, your "occupation" may be defined as "endodontist/professor/business owner," in which case you may not be "totally disabled" if you can still teach or perform management functions.

Mistake # 3 Inadequate Documentation

When submitting a claim and speaking with your insurance company, it is important to take notes to assist you in remembering what was said in the event that your claim is denied or terminated. Keep notes of all telephone conversations, including the date and time of the call, what was said, and identifying the person with whom you were speaking. Every conversation with the carrier should be confirmed in a letter sent by certified mail so that there are no misunderstandings. The "paper trail" may later be used as evidence to establish unreasonable treatment during the claim administration process.

Mistake # 4 Blindly Attending An Independent Medical Exam

After submitting your claim, you may be asked to submit to an “independent” medical examination by someone chosen and paid for by your insurance carrier. You may also be asked to undergo exams by someone other than a physician. Before submitting to an “independent” medical exam or any other exam or evaluation, you must first ensure that your carrier has a right to conduct the exam per the policy language. For example, a neuropsychological exam is conducted over several days by a psychologist, not a physician, and the subjective findings from such an exam are often used by the carrier to deny benefits. If your policy requires that you submit only to “medical exams” or exams “conducted by a physician,” there is certainly an argument that you need not submit to neuropsychological testing. Further, you may wish to be accompanied by an attorney or other legal or medical representatives who can monitor your “independent” medical exam. Other considerations include receiving the examiner’s *curriculum vitae* in advance; limiting the scope of the exam to ensure that no diagnostic test which is painful, protracted or intrusive will be performed; having the exam videotaped or audio-taped; and receiving a copy of all notes and materials generated.

Mistake # 5 Believing All Mental Conditions Are Excluded Or Subject To Limitations

Most disability insurance contracts differentiate between mental and physical disabilities. More recent policies cut off benefits for psychiatric conditions after two or three years. Insureds often blindly accept their carrier’s decision to deny or limit benefits based on these conditions without considering numerous relevant factors, including whether there are any physical aspects to the mental condition, whether the mental condition has a biological/organic cause, or whether another, covered condition was the legal cause of the disability. Without exploring these issues in detail, claimants often blindly accept that certain conditions are limited or excluded from coverage when in fact they are not.

Mistake # 6 Inadequate Communication With Treating Physician

You should not discuss your claim or that you are considering filing for disability insurance benefits with your treatment provider until after you have had several visits. Physicians are often reluctant to support claims for benefits if they question your motivations. A physician who has treated you without success will likely be more willing to cooperate. It is also important that you communicate your symptoms and limitations to your treating physician in an organized and detailed manner so that all relevant information is recorded in your medical records, which your insurer will ultimately request. When you finally speak to your physician about your claim, ensure that he or she understands the definition of “disability” under your policy, so that he or she can accurately opine as to your inability to work.

Mistake # 7 Quantifying Your Time

You should be wary of insurance companies asking you to compartmentalize in percentages what your activities you engaged in pre- and post-disability. To the extent that there is any cross-over, companies will often deny benefits or provide benefits for merely a residual disability. It is important that you broadly describe your *important* duties – rather than your incidental duties – so that your carrier has a clear understanding of the thrust of your

occupation. For example, in response to a question about principal duties and the percentage of time spent at each duty, a dentist may be better off stating “100% clinical dentistry” rather than compartmentalizing each and every incidental task (*e.g.*, patient intake, supervising staff, charting) into discrete percentages. The reason is your insurer may erroneously consider an incidental task a “principal duty,” and therefore downgrade the amount of your benefits. For example, where a dentist has duties as a businessperson (*i.e.*, supervising staff, overseeing payroll), the insurance company may argue that the disabled dentist can still manage his or her practice and is therefore partially disabled only.

Mistake # 8 Ignoring The Possibility of Surveillance

Once you file for disability insurance benefits, you will likely be videotaped or photographed by your insurance company at some point in time. If you are engaging in any activities that you claimed you could not perform, and that is caught on tape, your benefits will likely be denied and your contract could be terminated.

Mistake # 9 Blindly Accepting That Subjectively Diagnosed Conditions Are Not Covered

Disability insurance carriers often deny benefits by insisting that the claimant’s subjective symptoms do not provide objective, verifiable evidence of disability. In many cases, there is no provision or contractual requirement mandating that the insured submit objective evidence of disability. Therefore, from the insured’s perspective, these insurance companies are merely trying to save money by generously interpreting policy language in favor of a claim termination. Notwithstanding the subjective nature of a particular condition, the insured may be able to secure benefits with ample evidence bearing on the extent and severity of his or her limitations, which is far more important than providing a definitive diagnosis.

Mistake # 10 Tossing Out Your Application, Policy And Claims Documents

From the time of application forward, you should keep copies of everything (including your notes from meeting with the insurer’s sales representative or agent, the policy application and the policy itself). If the sales representative provided you with a letter or a verbal representation that you jotted down, your notes can go a long way if the insurer says that the policy says something different. Similarly, information that you provided on your application may have a bearing on your reasonable expectations at the time of purchase.

Insurance companies are vigilant in protecting their own interests, which often means not paying claims. Medical professionals must be even more vigilant in protecting themselves.

***Edward O. Comitz, Esq.** heads the health care and disability insurance practice at the Scottsdale-based law firm, Comitz | Beethe, earning a national reputation for prosecuting claims on behalf of individuals based on fraud and unfair practices in the insurance and health care industries. Mr. Comitz has extensive experience in disability insurance coverage and bad faith litigation, representing dentists, physicians and other professionals in reversing denials of their

disability claims, principally in federal courts. He can be reached at ecomitz@cobelaw.com, (480) 998-7800, or please visit his website at www.disabilitycounsel.net

About Asset Protection Attorney Ike Devji



Ike Devji and his professional partners bring over a century of combined experience to identifying and creating monolithic barriers against the things, people and events that pose threats to the wealth of those he serves.

Ike Devji has personally practiced from Phoenix, Arizona for eight years as an Asset Protection only lawyer with a national client base of thousands of clients representing nearly \$6 Billion in personal assets.

Mr. Devji is the former managing attorney of the United States' largest Asset Protection only law firm, Lodmell & Lodmell, P.C and is currently of-Counsel with the firm. Ike helps protect clients in all 50 states and a dozen plus foreign countries in the area of Asset Protection.

Ike has personally designed and executed north of 500 comprehensive Asset Protection plans for clients in the seven to nine figure net worth range and those on their way to accumulating significant wealth.