

# DISABILITY CLAIM DENIED: JUSTLY OR UNJUSTLY?

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**KEY WORDS**

**Insurance claims  
Denied disability claims**

It is a fact that disability income insurance claims submitted by dentists (and other professionals) have increased dramatically over the last several years along with a disproportionate number of inappropriate denials. The claims departments of too many insurance companies have been told to “tighten-up.” Claims that once would have been paid are routinely being denied because of industry trends, misunderstandings, and consumer lack of knowledge and inability to contest. This article will discuss those claims that have been inappropriately denied and how one can go about getting them reversed. Comments will also be made on those that should have justifiably been denied because the claim was invalid or fraudulent.

**REASONS WHY A CLAIM CAN BE DENIED**

An insurance claim can be denied because (1) the elimination period had not been satisfied due to an inadequate number of days of disability, or the days of disability were not consecutive; (2) the benefit period had expired; (3) the definitions, terms, and conditions for benefits to be paid had not been satisfied, for example, total or residual disability; and (4) renewability.

From these, there is one major reason for a claim denial: satisfying the definitions of total disability, some of which are the following (the easiest one to satisfy has been listed first):

- Own occupation (own-occ). This definition allows payment to be made

as long as the claimant cannot do the substantial and material duties of his or her occupation, even if the insured is working elsewhere, so long as it is at another occupation. This is the most desirable of all definitions. Note that some carriers offer an own-occ specialty letter for this definition (for example, the claimant cannot do oral surgery but can still practice as a dentist or teach). If the claimant can still do all or most of the duties of his or her occupation, but is earning less money because of a disability and has a residual disability benefit, then he or she will be paid as if it were a loss of earnings policy (see below). This is especially useful when the dentist or surgeon has a bad back and can only work every other day while recuperating.

- Own occupation, but not gainfully employed elsewhere. A policy with this definition pays benefits if the claimant cannot do the substantial and material duties of his or her occupation and is not working elsewhere. Working or not then becomes the choice of the claimant. If he or she does decide to work in another occupation (for example, teaching), or is not totally disabled but working in his or her occupation, and has a residual benefit option, the claimant is considered residually disabled and will be paid as if it was a loss of income policy (see below).
- Own occupation (for a period of time), thereafter, unable or not working elsewhere. This is an example of a split definition that gives own-occ

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(see above) for a period of time, usually 2–5 years. Then the definition changes to not working or unable to work elsewhere (education, training, experience, and sometimes prior economic status become factors in determining when someone is unable to work). This is one of the least desirable definitions and gives the carrier some control in minimizing the impact of the claim. Again, residual or loss of income might factor in.

- Loss of earnings. This definition or type of policy has been around for a long time, but recently more and more carriers have chosen to stipulate this definition in lieu of any of the above own-occ definitions. Loss of earnings is the same as a residual/proportionate benefit. For example, if a claimant has a 30% loss of income while disabled and under the care of a physician, he or she will be paid 30% of the monthly benefit. While this type of policy does pay proportionately, it should be noted that a claimant will start off with an initial income loss of 40–50%, since participation tables only allow approximately 50–60% of predisability income (depending on the income level of the insured, their occupation/duties, and when the policy was issued) to be covered. Higher issue limits are usually available if the premium is employer paid; however, benefits then become taxable and a 1099 form will be sent to the IRS by the insurance company.

Another major reason for claims denial has to do with misstatements and/or omissions made on the application by the claimant. In some cases, they have been unintentional due to the poor wording of the questions. It has been said many times that the claim starts with the application. When this happens, who is at fault? Is it the carrier for poorly constructing the questions, or is it the fault of the dentist or his agent who intentionally withholds information that could have a

negative impact the underwriter's decision whether or not to issue a policy without exclusions for pre-existing conditions?

#### CLAIMS THAT HAVE BEEN INAPPROPRIATELY DENIED

Over the last several years, I have either testified for or have prepared written opinions on claims that were initially denied by the carrier. Some of these denials were based on what seemed to be straightforward and uncomplicated reasons. Others, because of the contract's language and integrating benefits, riders, exclusions, etc., were more convoluted. One claim that comes to mind, which incidentally was straightforward and governed by clear contract language, was submitted by a dentist. He was unaware that the policy had lapsed, and consequently the claims department denied the claim for this reason. What, therefore, was the basis for an appeal? On closer scrutiny, the contract clearly stated that any policy change must be submitted in writing. In this case, the dentist's agent had verbally made the change, and thus the submitted change accepted by the carrier was incorrect. Why then did the carrier continue to deny the claim? That was for the carrier's attorney to justify. The carrier had no basis (except wanting to escape the liability of a very rich contract). Ultimately the policy was reinstated and the claimant was fully paid.

The most common denial has to do with a total disability claim. In one particular case, the agent's client who did oral surgery as part of his duties had purchased a policy after reading the agent's brochure, which had printed on it "your own-occupation/specialty." After the policy was issued, the insured asked the carrier to issue a specialty letter based on the fact that he wanted his subspecialty as an oral surgeon to become part of the own-occ definition for total disability. This subspecialty request was, according to the plaintiff, clearly stipulated to the agent at the time of policy delivery. A spe-

cialty letter finally was issued; however, it only made mention of dentistry. When the dentist complained to the agent that his specialty as an oral surgeon was not addressed, he was told not to worry. To further compound the problem, the policy only had total disability benefits (that is, it was missing some important options, such as residual disability). A year later a claim was submitted and was paid even though the dentist was back to work (but not doing oral surgery). The dentist's claim finally came to an end. Time went by and a new claim for disability benefits was submitted. This time it was denied. The carrier stated that his claim did not satisfy the definition for total disability (remember that the subspecialty was not mentioned in the letter). So far the carrier was correct; however, it was pointed out that since such an issue of subspecialty had been made, the carrier had an obligation to mention in a specialty letter reply that the subspecialty had to be one that was recognized by the American Dental Association. This case is still pending.

One other interesting example has to do with a dentist who submitted a claim based on her group long-term disability certificate. She was paid \$6000 per month, and after 24 months these benefits stopped even though the policy's benefit period clearly stated that benefits were payable to age 65. In this case, the carrier invoked a split definition for total disability (see "Own-occupation, thereafter unable to work elsewhere" above). The claim was rejected because of the carrier's inability to fully comprehend its own split definition for total disability (which also included prior economic status). The claimant found it difficult to find work elsewhere because she had been making over \$200,000 a year prior to her claim. She sued and won.

#### WHAT HAPPENS WHEN A CLAIM IS SUBMITTED FOR PAYMENT?

After the claim is reviewed for completeness, the file is pulled and the initial application is compared with the

information on the claim form for possible inconsistencies. To further verify the claim, an attending physician's statement will be ordered. Other documentation to support the claim, such as tax returns, will also be ordered. Underwriting once again takes place to determine if the claim is valid, and to assist with this determination the carrier might use Certified Public Accountants, psychiatrists, independent medical examinations, etc. If the claim is valid, payment will follow. If it is not because of the terms of the policy (for example, an elimination period), correspondence will address those issues. If the claim is invalid because of major omissions on the application, and it is within the contestability period, the policy will usually be rescinded and all premiums from the policy's inception will be refunded. If the claim is invalid and it is past the incontestability period, it might be paid unless the carrier strongly feels there was intent to commit fraud; then rescission/denial will also take place. Fraud is hard to prove, but the courts have recently become more lenient in favor of the carriers. In any event, if it is a valid long-term claim or a short-term claim with a high monthly benefit, expect surveillance and/or a possible buyout of the claim. Many carriers have developed a system to wear down claimants by overwhelming them with paperwork and a series of complex requirements that would frustrate a saint.

#### WHAT FEATURES TO LOOK FOR TO MINIMIZE CLAIM PROBLEMS

Obviously, an important feature of each policy is to have the best definition for total disability. Not all carriers use the same definition for a particular occupation. Seek a variety of carriers. Some other features of importance fall into the policy's terms and conditions, such as the elimination period. Try to get a policy that states the days of disability need not be consecutive. By doing so, the disability can be one that is a "stop and go" type, which is better than one that states the days of dis-

ability must be consecutive in order to count toward the elimination period. Another good feature will state that both residual and/or total disability days will both count toward satisfying the elimination period. Most carriers allow this, but some require that in order for them to count, a period of total disability must first precede a residual benefit. Policies that have many of these features are referred to as "claims-driven" policies, which are preferable to "contract-driven" policies that protect the carrier rather than the claimant.

#### WHAT THE POLICYHOLDER'S AGENT CAN DO TO HELP THE INSURED PREVENT OR MINIMIZE THE CHANCE OF A DENIED CLAIM

Some critical areas of the application that affect a claim and could be inadvertently answered incorrectly, or dishonestly, have to do with (1) occupation/duties, (2) health, (3) income, and (4) other pertinent facts such as avocation. Some of the honest mistakes made by the applicant might be overlooked after 2 years, as is previously mentioned in the contract's incontestability clause. What is not overlooked, however, are fraudulent misstatements or omissions regarding health or income. With the same view in mind, the agent's role in completing the application is important. Did the agent record all answers exactly as they were answered, or was there some hidden agenda or motive for writing them down in such a way that the policy would be issued as "applied for" (without a rating or an exclusion)? Did the agent really do the proposed insured a favor, or were these omissions for the agent's own gain? What can the agent and the proposed insured person do to minimize these problems?

The policyholder's agent should do the following to help minimize the chance of a denied claim:

1. Answer all questions honestly and completely.

2. Restate the question if it is not clear the first time.
3. Repeat the question if the answer appears shaky.
4. Explain the penalty for fraud.
5. Verify all of the answers and information on the application before signing it.

#### WHY ARE DENIED CLAIMS INCREASING?

Over the last several years, the ratio of subjective claims, such as mental/nervous, soft tissue (for example, back injuries), chronic fatigue syndrome, etc., versus nonsubjective claims (broken arm, heart attack, etc.) have dramatically increased to a point where the industry is no longer operating in the black. To stop this financial hemorrhaging, carriers have taken a number of steps both for the long- and short-term. For the long-term, some carriers have redesigned their policies to limit the benefit period of subjective claims, changed occupation classifications, and revised rates, especially for women. For the short-term, carriers have decided to be paranoid by overreacting and refusing to pay many of these subjective claims.

#### WHAT IS THE BEST WAY TO HANDLE A CONFLICT?

The following steps will help if a conflict arises:

1. Cooperate fully with all requests made by the claims adjuster.
2. Request a full explanation of all negative responses and the basis for such responses.
3. Request that a review be made by the adjuster's supervisor to verify that inexperience or bias did not affect his or her decision.
4. Ascertain whether or not the carrier is acting in bad faith.
5. Establish that the investigation was proper. An improper investigation or one that results in bad faith can be explained as a flawed or incomplete investigation (an adjuster must

investigate to support the insured's claim); failure to objectively evaluate the claim, ignore the evidence in the file, or make the file biased; unduly restrictive policy interpretation; purposeful delay or dilatory claim handling; and/or an unreasonable investigation (deceptive investigating and harassment) that can result in a countersuit with a tort invasion of privacy.

#### **WHAT A CLAIMS CONSULTANT WILL DO PRIOR TO A CLAIM SUBMISSION**

Before a claim submission, a consultant will review all policies and associated correspondence including, but not limited to, the application; review all medical reports; assist in the completion of the claim form, espe-

cially the section that has to do with predisability duties and related issues; determine the benefits (for example, is it a residual or a total disability claim, and if it is total, how to interpret the definition, especially if it is a split definition); offer guidance on what to expect during an independent medical exam or some other type of visit; and provide explanations on policy limitations, exclusions, definitions, terms, and conditions.

If all else fails, seek professional assistance from either an attorney or an expert witness/consultant who specializes in these matters, and perhaps punitive damages will also be awarded. Punitive damages might be awarded if punitive damages address egre-

gious conduct such as intentional wrong doing or a circumstance of aggravation. Please note that proof of bad faith is not in and of itself a cause for punitive damages.

#### **CONCLUSION**

Inappropriate denials must be prevented so that litigation is only for acts of bad faith on the part of the carrier and fraud on the part of the claimant. If the current method of disputing inappropriately denied claims continues, then in most cases the insurance company, with its deep pockets, will surely win. It has been the experience of skilled consultants that there are carriers who habitually take this approach and who excessively deny legitimate claims.