

When Disability Insurance Says You're No Longer Disabled

By Jacques Chambers, CLU

If you are collecting disability benefits from an insurance company, your medical records will be periodically reviewed to see if you remain disabled and eligible for benefits. It appears to be increasingly common for insurance companies to attempt to terminate benefits, claiming the disability is no longer severe enough to prevent employment. This seems to occur most frequently after two years of receiving benefits, when the definition of total disability normally is narrowed.

Although it will never be more than an educated guess, many believe that since insurance companies specialize in numbers and statistics, they use it to their advantage. They probably know that if they cancel 1,000 disability claims, a certain percentage, probably a large one, will not contest the termination. The money saved by those canceled claims more than covers anything they spend fighting the appeals of those who contest the decision. It is in your best interest to always appeal a denial or termination of disability benefits.

So, what do you do? Of course, you can always accept their decision and let the benefits end, which is what they hope you will do, but it is not recommended. You should consider appealing the termination of LTD benefits.

Some may suggest that you get an attorney and sue. However, most policies require you to use all internal appeal procedures before initiating any legal action. You don't necessarily need to hire an attorney to handle this first level of appeal. Many attorneys would prefer to wait until the appeal reaches the level of a lawsuit. But with a little preparation and time, you can handle the first level of appeal yourself, and you quite possibly will win your case there.

Assuming that you and your doctors believe you are still unable to work, a little time and effort on the initial appeal may get your benefits restored without the expense and stress of finding an attorney. Plus, a well-prepared appeal lets the insurance company know that you do not intend to give up your benefits without a fight.

The insurance company letter terminating your benefits will usually tell you three things that are important to your appeal:

1. It will give the provision of the policy under which they are terminating your benefits; if they are claiming you are no longer disabled this will usually be the contract definition of disability;
2. the letter will also list the reasons that they believe you no longer meet that definition; usually this will focus on isolated statements made by your medical providers and "normal" results of lab tests that rarely have anything to do directly with the symptoms you have; and,
3. the letter will give you directions on appealing the termination. It will usually be from 60 to 180 days from the date of the termination letter. Note the deadline for submission on your calendar and prepare your appeal with that deadline in mind. Be accurate; if it is 180, count out 180 days on the calendar, don't use six months.

If your disability insurance comes through a prior employer, it comes under a federal law called ERISA which gives you certain rights. Primarily, it means you do have 180 days to file the appeal. It also gives you an absolute right to see your entire claim file.

The first thing you should do in preparing your appeal is to write the insurance company and ask for a complete copy of your claim file. You are entitled to this if it comes under ERISA and under many state laws. Having their file will help you prepare a more accurate and thorough appeal. If your deadline is less than 180 days, you should also request an extension of the appeal deadline, so that you will “have adequate time to review the claim file and prepare the appeal.” Do not assume they will grant the request, however. Send the letter with proof of receipt, and keep a copy. It is also recommended that you call to confirm its receipt. If they refuse your request, it will help in later appeals.

The next step is to take a copy of the termination letter to each of your doctors. Ask them to write a letter refuting the insurance company’s statements. Ideally, the doctor should take each statement the insurance company lists as evidence that you are not disabled and show medically how it has no direct connection with your disabling symptoms. For example, when the primary disabling symptom is fatigue, the insurance company will often say things such as “your HCV is in remission,” or “your liver function tests were all in the normal range,” or “the results of the urinalysis were normal.” None of these statements mean a thing about whether or not you have fatigue or how severe it is, but the insurance company will treat it as proof. Your physician should refute each such statement. Each physician’s letter should be several pages long.

After the claim file arrives and while your physicians are preparing their letters, you should review the claim file. The claim file should contain not only your medical records, but also internal memos and consultants’ analyses of your claim. It should also include all claim forms you submitted as well as forms completed by your doctors. Have a highlighter and tabs or clips handy to mark the pages and statements that support your claim.

If you don’t get your claim file you should go through copies of your medical records and look for statements of symptoms and comments by physicians that support your disability claim.

Within these documents, you will often find statements, especially in the medical records, about symptoms that the insurance company has ignored in the termination letter. For example, one termination letter cited a claimant’s ability to perform a treadmill EKG as proof there was no fatigue. Yet, the EKG report noted that patient had to terminate the test “due to fatigue,” which was not mentioned in the termination letter. Identify and highlight or tag each statement so you can refer to it when you write your appeal letter.

If your symptoms are primarily “subjective” or “self-reported,” you may also want to collect articles that illustrate such symptoms are common with your diagnosis. For example, there are many articles available on this site as well as others on the web that document the presence of severe fatigue with HCV and that the level of fatigue appears to have no connection to liver function numbers or other test results.

Once you have received your doctors' letters, and any articles you plan to submit, you are ready to write your cover letter. This letter will pull together all the documents you are sending plus it should provide a point-by-point summary of why you are still disabled according to the contract definition. It is usually a good idea to get a copy of each of your doctors' CV's (curriculum vitae, sort of a resumé) and include them with the appeal, especially if your doctor specializes in treating HCV.

Allow plenty of time to write the letter and come back to review it after a day or two. Ideally, the letter should be several pages long, often between seven and ten pages. It is not an easy letter to write, especially if you are dealing with "brain fog." You may want to enlist the assistance of a partner or friend to assist you.

Start the letter with a simple statement that you disagree with the termination of your benefits and that the appeal will show that you are still disabled and eligible for benefits. Also, so the quality of the appeal letter will not be used against you, be sure to note how many hours it took to write, how many drafts you had to make and that you had to have assistance with it.

Summarize the symptoms and side-effects of medications that impair your ability to work. If your termination letter was like most, they rarely if ever even mentioned the symptoms you have. Remind them why you can't work.

When listing your symptoms, cite any documentation that confirms the presence of those symptoms. For example, when listing joint pain, you may want to note that your physician recorded this complaint in the office notes on: January 15, March 2, April 12, and May 27, and quote any pertinent statements. For example: "On June 22, Dr. Watson noted, 'pt has pain when lifting arm.'"

Whether it is statements from your medical records, from other documents in the claim file, comments from the physicians' letters, or statements from medical articles, you should not just refer to them. Quote the actual statement in the appeal letter. You should not expect the reviewer to actually follow-up and read them, especially with articles you attach. Quote pertinent phrases from them right in your letter, and give the source of the quote and put a note saying "See attached."

When speaking about fatigue, when possible, use adjectives to describe it, such as severe, debilitating, etc. There is a big difference between the fatigue the claim reviewer feels on Friday afternoons and the fatigue you are experiencing that forces you to cancel plans and stay in bed. Make sure that difference is clear in your letter.

Next you should address the statements in the termination letter and explain why they do not show that you are able to work. Here you will probably want to quote liberally from your physicians' letters. If they are good letters, you may just want to refer to them and leave it at that. The reviewers will read those. If the letters don't clearly rebut the insurance company's statements, you will need to spend time doing so, statement by statement.

Raise all issues you find; do not skimp or rely on just one argument. Show all medical support for your position and question all of their positions that you can. The more you

mention in this appeal, the better your chances with this and with future appeals if they come.

In closing your letter, state clearly that you believe this appeal shows you still qualify for benefits and that you are sure they will agree once they review the material you have submitted.

Finally, just to let them know that you are not giving up, and add that should they choose to deny you again, you will request a full explanation of why they do not believe you have the symptoms severely enough to prevent you from working. Also, ask for their consulting physician's CV.

You may also want to ask them to explain specific points if they deny the appeal. For example, you may want to ask: "Please explain and show documentation of how normal liver function proves that I have no fatigue."