Helping Patients With Insurance Claims: Doctoring With A Difference

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Introduction

There can be but few physicians remaining these days who have not been approached by their patients, their patients' lawyers, insurers, or benefits agencies such as the Canada Pension Plan, to address requests for information, documentation and assessments concerning disability.

This article is directed primarily to medical professionals. The opinions expressed are those of a lawyer practicing almost exclusively in the area of injury and disability law, representing claimants. The article will focus on the role of physicians in the injury and disability claims process, and how physicians might best view and carry out certain administrative and professional responsibilities toward their patients in a medical-legal or benefits-based setting. Much of what is said regarding physicians, however, may apply equally to other health disciplines which also become involved in the claims process, such as therapists and rehabilitation specialists.

Physicians are Central in the Claims Universe

The injury and disability claims field is "physician-centric". To the extent that an individual's entitlement to compensation of benefits is dependant upon confirmation of injury or medical disability – as is normally the case – it is the physician whose information and opinion has the potential to steer the ultimate direction of the claim. Whether a motor vehicle injury claimant "suffers a substantial inability to perform the essential tasks of her employment' as a condition to receiving no-fault income replacement benefits under the Statutory Accident Benefits Schedule, is a determination made largely on the basis of the available medical evidence. Whether a long-term disability benefits claimant "is in a continuous state of incapacity due to illness which prevents him from performing the essential duties of his own occupation" as a condition to receiving "own-occupation" benefits under a typical LTD policy, is a determination made largely on the basis of the available medical evidence. Whether a Canada Pension Plan claimant suffers from a "severe and prolonged disability" as a condition to receiving CPP disability benefits, is a determination made largely on the basis of the available medical evidence. While other types of evidence may also be necessary to support a claim, such as current employment information, the central issue usually seems to involve the proof of disability

Understanding and Supporting Patients' Claims

To a patient who has suffered injury or disability and the consequent impairment of lifestyle or income security, her benefit claim is one of the most important things in her life at that time. She is in pain, feeling emotionally frustrated and financially insecure, possibly getting the "run-around" from her insurer or a benefits agency, and the last thing she needs to hear is the insurance claims handler telling her that her own physician has either failed to respond to requests for information or has responded in such a way that the insurer is compelled to deny the claim.

When asked by a patient, insurer or agency for information concerning the patient - such as the completion of a medical questionnaire, disability certificate or narrative report - the physician should understand the importance hi providing a prompt, fair and thoughtful response. Before responding, however, it is important that the physician also have some understanding of the particular disability criteria involved, be it the criteria for LTD entitlement, CPP entitlement, or otherwise. The criteria can usually be obtained by simply asking the patient (or her lawyer) to provide, for example, a copy of the insurer's definition of "disability" or "totally disabled" that will invariably be found in the LTD benefits booklet or contract, or a copy of the Canada Pension disability benefits brochure (which is also readily available online at the Human Resources Development Canada website).

It is also important for the physician to understand the patient's occupational demands. A physician cannot possibly certify whether the patient is or is not totally disabled from performing her essential job functions, if the physician has little or no understanding of the patient's job description, requirements and demands. Taking a little time with a patient (or employer) to discuss these matters will go a long way toward promoting a greater understanding of whether or why the patient is unable to return to work, or to engage in certain activities, or to function without modifications to the home or work environment. In that way, the likelihood of fair and accurate medical reporting to the party responsible for the benefits determination is bound to be enhanced.

Similarly, an early, "rosy" prognosis is a formula for potential disaster for the patient's claim if, in fact, it should turn out that the patient is legitimately continuing to experience disabling symptoms well beyond the prognosticated period of recovery. I cannot overstate the frequency with which an insurer has "reminded" counsel that his client's own physician stated in the Disability Certificate that, within the specified number of months, the patient would make a complete recovery or be capable of returning to unrestricted employment. I can only conclude in such cases that the physician, while perhaps well-intentioned and obviously optimistic, was unduly myopic or naive about how a claims handler would seize upon the early prognosis and turn it against the patient-claimant. It may be fairer and in the patient's interests, particularly when

reporting at the initial stages of the claim, for the physician in making the requested prognosis, to avoid expressions of undue optimism. This can be done by frankly indicating, for example, that the prognosis is currently "guarded", or that it is simply "too early" to provide a fair and realistic prognosis, as the case may be, at least until such time as a more definitive statement regarding the patient's future course can fairly and reliably be made.

Assisting Patients by Challenging Insurer Medicals

Automobile and disability insurers are in the business of assessing injury and disability claims. Once we understand that insurers are commercial entities that are driven by profit, are accountable to their shareholders, and maximize dividends by concerning themselves with ratios between claim pay-outs and premium dollars, then we understand that insurers may be approaching the assessment of disability differently than perhaps would the claimant's own physicians.

A common practice of insurers in a given claim is to arrange one or more medical assessments by practitioners of their choosing. Insurers like to refer to these undertakings as "Independent Medical Assessments". Whenever someone has to remind me that they are "independent" by labeling themselves as such, I become naturally curious if not skeptical. In any event, decisions to accept or deny claims are often made on the basis of these assessments. A claim denial that follows such an assessment may lead the claimant to consult with her physician, her lawyer, or both. I would actively encourage any physician who questions the report made by the insurer's medical advisors to unhesitatingly respond in kind, either by forwarding to the insurer a reasoned, narrative report identifying the specific areas of concern, inaccuracy or disagreement, or by referring the patient to an appropriate specialist who may be better positioned to address or challenge the medical findings or conclusions made on behalf of the insurer.

Similarly, situations may arise where the insurer is seeking to have the claimant submit to excessive assessments or to be placed in a program of rehabilitation that, in the opinion of the claimant's primary physicians or other health practitioners, is inconsistent with the therapeutic regime or goals that have been clinically established for the patient. In such cases, the physician is well within her rights - some might say duty-bound - to intervene in the process, with the assistance of the patient's counsel if necessary, by informing the insurer of any potential harm or regressive effects that the insurer's proposed plan may precipitate. The patient's physician, rather than the insurer, should be exercising the ultimate authority to control the course of rehabilitation. Such intervention will not only help maintain a workable balance between the various interests; it will go a long way toward reaffirming the patient's trust and confidence in his physician that portends a more successful medical and insurance outcome.

Cooperation with Counsel

Cooperation between a client's physician and lawyer is essential to the advancement of the claim. In my own practice experience, difficulties in dealing with physicians who have assessed or treated my clients are generally rare. Most respond reasonably promptly to requests for clinical notes, records and narrative reports. On occasion, however, requests may go unanswered, which could have unfortunate result of delaying the processing of the client's benefits claim. In most such cases, polite reminders and follow-up correspondence will usually suffice. In others, further inducements may be required, including advising the physician of the adverse impact her conduct may be having on the patient's claim or advising of the patient's option of involving the professions' regulatory body. None of this, of course, should have to be necessary.

Counsel's requests for information may also be met with the physician's demand for advance payment of her invoice. While such a demand is permissible, the patient (who often is not able to work and earn income because of the very injury or disability that brought her to the physician in the first place) may not be financially able to pay for the documents requested. Although some physicians are amenable to working out satisfactory payment arrangements, including accepting a written undertaking that guarantees payment by an agreed date or out of the proceeds of the settlement of the patient's insurance claim, others insist upon immediate payment from the lawyer or patient. Supporting a patient in his claim should encompass a level of financial cooperation from the physician that facilitates the advancement of the claim and lessens the patient's anguish. Physicians should appreciate that lawyers practicing in the personal injury and disability field frequently refrain from charging their clients fees until the claim is settled, in recognition that to do otherwise would place too difficult a financial burden on the client.

Summary and Conclusion

- The old adage "an ounce of prevention is worth a pound of cure" applies as much to insurance and benefits claims practices as to health maintenance practices. The prevention element, directed to helping the patient avoid an undue denial of benefits, is in ensuring that the patient's claim-related needs are addressed effectively by: promptly responding to requests for medical information and other documentation in support of patients' claims;
- rendering reports and disability certificates to insurers that are useful to the assessment of claim, in that they are fair, realistic in their recovery and return-to-work prognostications, and based upon an understanding of the patient's occupational demands and limitations

- ensuring that statements made about the patient's functional capacities address the specific disability criteria in issue;
- challenging insurer proposals for treatment and rehabilitation that are viewed as inconsistent with the primary therapeutic goals set for the patient;
- making appropriate specialist referrals where necessary; and
- being flexible and making allowances for the patient's inability to pay up-front for services relating to her benefits claim.

The stress and anxiety that is eliminated when the claims process operates smoothly because the above-noted considerations are kept in mind, may have the tangential effect of speeding the recovery process and restoring the patient's function even sooner than anticipated.

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