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FRANKEL & NEWFIELD, P.C. is a boutique law firm focusing on assisting individuals with long term disability claims, and individuals whose long term disability claims have been wrongfully denied or terminated. Our experience in recognizing issues before they become problems has helped guide many claimants through this difficult process at a time in their lives when they most need the benefits of the protections they purchased.

Welcome to “**LTD Management**,” Frankel & Newfield, P.C.’s quarterly newsletter for the Firm’s clients and professionals who routinely consult with the Firm, updating them on our practice, as well as important new developments in the law of disability insurance.

Firm Updates

Justin Frankel, Esq. recently lectured to a group of attorneys on disability insurance matters, addressing claim issues and concerns as well as issues concerning the types of coverages available for income protection.

Frankel & Newfield recently sponsored a booth at the Physician’s Expo, where it provided a free evaluation of existing disability coverages and answered questions about policy and claim issues.

Frankel & Newfield continues to contribute to medical journals with advice and insight on disability claim issues, including Podiatry Management, and Chiropractic Economics.

New York Declares Discretionary Clauses in Insurance Policies Violative of Law

Recently, the New York Insurance Department issued a policy statement indicating that policies of disability insurance containing “discretionary clauses” were illegal and violative of law. These discretionary clauses in insurance policies permitted insurers unrestricted authority to determine eligibility for benefits and to interpret terms and provisions in insurance policies. This change is significant in the law concerning group insurance policies - policies that are often held by doctors working as employees at hospitals (a discussion of group policies is contained in our prior Newsletter, Volume II, No.2.). The Insurance Department determined that the discretionary provisions encouraged misrepresentation, or were unjust, unfair, inequitable, misleading and deceptive, and thus violated the law. What this means is that the insurance companies will now be compelled to act more reasonably and fairly when reviewing disability claims, since their conduct will be subject to a heightened degree of scrutiny.

During 2005, Frankel & Newfield lobbied state and federal officials in support of this change in law.

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In our efforts, we urged New York to follow several other states in restricting insurers' discretion, and provided commentary to numerous media outlets concerning the impact of the Insurance Department's position.

We expect that this change in the law will have tremendous impact on claimant's rights during the disability process.

Disability Q&A

During the course of regular consultations with physicians seeking to file disability claims or who have questions regarding their existing coverage, we have seen a variety of issues raised.

One question that has recently predominated is whether an insured with a disabling condition, who suffered a decline in income from his practice for a year or 18 months, can file a claim for disability back dated to the time in which the income declined. The answer is largely dependent upon the policy language, but the main issue to be considered in this analysis relates to not if the claim can be back dated, but how far back it can be back dated. Most policies require an insured to provide "proof of loss" - with time periods for such proof as short as 30 days or as long as 6 months after the commencement of the disability.

An insured who has a disabling condition, and who suffered a loss of income often does not appreciate the policy provision for "residual" or "partial" disability, and thus fails to realize that benefits could be payable for the period with the loss of income. That period could also be utilized in many cases to satisfy the elimination period (the period which must be satisfied before any benefits are payable).

Thus, if an insured has a disabling condition that has caused a decline in income, most of the policies would permit recovery for partial disability for that period of time.

The only remaining question is whether the insurance company will argue that the notice of claim was someone too late - a position that is tenuous and unlikely to succeed.

Most residual disability policies permit an insured to determine "Prior Monthly Income" based upon a choice of earnings, ranging from the best two consecutive years of the 5 years prior to disability, to the best calendar year of the 3 years prior to disability, permitting an insured to initially evaluate and determine the greatest base income to utilize for pursuing a residual disability claim.

Residual disability claims present the greatest challenge for claimants, since the issues involve financial evaluations in addition to the usual occupational and medical issues. Careful consideration must be given to best strategize such a claim prior to filing.

Practical Concerns-A Case Study

A significant issue being seen with greater regularity in disability claims of medical professionals is whether a disabling condition is appropriately classified as a sickness or an injury.

The issue is of tremendous import, since most private insurance policies differentiate on the maximum benefit period between sickness and injury. Disabilities resulting from a sickness are generally limited to a pay period of benefits until Age 65, while many policies afford lifetime benefits for a disability as a result of injury. And contrary to popular belief, several conditions fall into a gray area leading to disputes with the insurer on the maximum benefit period.

An example is carpal tunnel syndrome, a condition many surgeons could become afflicted with, due to the repetitive nature of their work. Insurers argue that this condition is a sickness, because it happens over time, because no one incident led to the disability, and perhaps even because one could argue that it is an "occupational disease: process, that is akin to traditional sicknesses.

The argument advocated by good counsel, (and well received by several courts) is that the condition is an injury - notwithstanding the fact that there is no one single and specific onset. The argument is that the condition was the result of repeated insults (accidents/injuries) and thus, was an unintended result of intentional behavior. Several courts throughout the country have addressed the issues - and have utilized a variety of legal concepts to reach decisions. The driving force behind the courts' decisions, however, has been the "reasonable expectations" of the insured. Thus, if a claim should arise from a repetitive type condition, careful thought must be given to how to frame responses to the insurer, who will likely look to develop claim responses that could lead to finding an insured disabled from sickness, rather than injury, and greatly shortchange benefit payments.

For more disability claim concerns/mistakes, go to our web site, at www.longtermdisabilityclaim.com, or www.frankelnewfield.com and click to Disability FAQs.

Recent Decisions on Disability Cases

There have been a number of interesting decisions from the Courts that decide disability claims. There are also a few trends that we have noticed from the recent cases that have been decided.

One court recently held that an insurer acted in an arbitrary and capricious manner when it had the claimant's medicals reviewed by a doctor, but not an examination of the claimant directly. The Court held that the insurer's paid doctors "strained" to reach conclusions that were largely unsupported.

Another recent case took issue with the lack of independence of the IME doctor employed by the insurer. The Court noted that where the doctor relied so heavily upon the insurer for income, and did such a great volume of work with the insurer, the lack of impartiality had to impact the process.

Courts have continued to be troubled by claimants whose activity levels were inconsistent with reported activities. These claimants whose alleged conditions have been refuted or called into question by other materials developed during the insurer's investigation, such as surveillance of the claimant engaging in certain activity, the insurers have continued to succeed in having the courts uphold these claim terminations.

An appellate court reversed the decision of a federal judge that had dismissed a disability case, where the lower court dismissed the action finding appropriate the application of a pre-existing coverage issues. The appellate court held that the insurer could not avoid coverage based upon the pre-existing condition limitation in the policy. IN that case, the insured had received medical care during the relevant "look back" period for pre-existing analysis, but the treatment was for an undiagnosed condition. When the condition was later diagnosed, the insurer attempted to apply the pre-existing limitation, and denied coverage. Finding it improper to apply the pre-existing to an undiagnosed condition, the court reinstated the claim and permitted the insured to seek recovery.

Recently, a court chastised the insurer for failing to properly consider the job duties of the claimant, instead opting to consider a generic occupational title, in contravention of the policy terms. This inappropriate occupational analysis carried through the claim consideration, including the medical personnel review of the claim, leading to a flawed review process. The court thus held that such conduct was arbitrary and capricious.

The information provided in this publication is intended to be for informational purposes only. It is not intended, nor should it be used, as a substitute for legal advice or opinion which can only be rendered when related to a specific fact situation, and on an individual basis.

If you would like to read any of our prior Newsletters, you can either request a copy or view them online at www.longtermdisabilityclaim.com

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