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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.

The Disability Claim Process

Once the insurer is notified of a claim, a claim kit or forms are provided to the claimant for completion. These materials usually include a claimant statement, attending physician statement, and an authorization form to be returned to the insurer. Each of these items has its own potential for problems for the claimant and, thus, must be approached cautiously and methodically.

The claimant statement usually seeks a variety of information about the claimant's condition(s), the onset of the condition(s), the restrictions and limitations resulting from the condition(s), and work information, including occupational duties. Often, a claimant is asked to provide an exhaustive list of what he/she does at their job, listed in order of importance, or defined by the amount of time dedicated to each task or duty. The insurer will take this information and seek to determine if ANY of the tasks/duties can still be performed. If so, welcome to the land of partial/residual disability.

To prevent this, one must anticipate the question and develop an appropriate response.

The physician statement seeks medical information from the treating physician. Unless the physician is supportive and a strong advocate, many times the physician statement fails to properly document the disability sufficiently to qualify for benefits. At **Frankel & Newfield, P.C.**, we often secure a physician narrative to address areas that the physician statement may not cover.

The authorization is used by the insurer to access information about the claimant. Often, it is a wide ranging, overreaching authorization, allowing the insurer access to financial information and other information that is irrelevant to the claim. At **Frankel & Newfield, P.C.**, we counsel all clients to substantially restrict access to such materials, and to modify the scope of any authorization. An insurer will often complain that it unreasonably restricts their ability to render a claim decision. We believe that it is a ploy and we NEVER allow such unfettered access without good justification.

These various claim requirements could prove dangerous to a naive claimant. While the insurers are generally entitled to certain information to substantiate a claim, it has been our experience that unrepresented claimants are thoroughly disadvantaged when navigating the claim process.

Insurers' Investigative Tools

During the course of a claim, insurers utilize a myriad of tools to investigate the validity of the claimant's condition and other aspects of the claim. Much of the investigation is used by the insurer in an effort to deny or terminate claims.

Common tools utilized by the insurer in the course of their "verification" of one's disability include IME's (Independent Medical Examinations), FCE's (Functional Capacity Evaluations), field investigations and/or surveillance. Each of these techniques pose potential problems for claimants.

Where an insurer exercises a contractual right to an examination, a claimant has the obligation to attend an examination. However, in every policy, there are implied terms of good faith and fair dealing which guide the process. Thus, it may be unreasonable for an insurer to require a claimant to undergo invasive testing by the insurer's doctor, or it may be improper to require a claimant to travel significant distance to have an examination performed. In any event, the IME is actually a PME (Paid Medical Examination), and the results are often skewed as such. If the PME physician is being paid by the insurer, it is safe to assume that their objectivity can be questioned. Thus, a claimant faced with an IME must arm themselves for battle. At **Frankel & Newfield, P.C.**, we counsel clients to bring a witness, to request to videotape the examination and we request that the insurer provide certain pre-testing responses to various inquiries, so we can determine the validity and/or necessity of the testing.

An FCE is an entirely different scenario. In our opinion, an FCE is not generally contractually required and we object to the insurer's request on that ground. This test is utilized by insurers to test one's maximal effort, which is then used to extrapolate that one can work full time on a sustained basis due to the ability to do a myriad of tests one time. The results are inherently unreliable and the tests lack validity.

Nonetheless, if compelled to attend under penalty of breach of the policy and denial or termination of benefits, we recommend that the same issues raised for PME's guide the claimant.

Field investigations are common in disability claims by medical professionals. An investigator will often stop by unannounced to speak to the claimant. Often, the investigator seeks to ascertain the claimant's activity level, determine whether the claimant is working in another interest, or to develop other information to be used by the insurer. Caution should always be used when speaking to the insurer or its investigator. At **Frankel & Newfield, P.C.**, our clients do not meet with field investigators without our presence, and we demand a jointly drafted statement addressing the meeting with the investigator to protect our client's interests.

Surveillance is a common technique used by insurers in cases where claimants allege disability based upon either subjective type conditions or where the objective support exists but is not truly indicative of the restrictions or limitations, or where the insurer believes the claimant is exaggerating. It is also commonly used in high benefit claims, where the insurer is willing to invest significant money to terminate or deny a potentially expensive claim. Claimants must be wary not only of their activity levels while on claim (including going to the gym - even if physician prescribed), but of the statements made to the insurer about their daily activities. Inconsistencies can be fatal to a claim, as the expression a picture is worth a thousand words holds true with regard to surveillance.

These are the most popular techniques and tools employed by the insurers when investigating a claim. At **Frankel & Newfield, P.C.**, our experience guides clients through the process and helps to avoid the numerous pitfalls that can arise during a claim, jeopardizing one's benefits.

Recent Decisions on LTD Cases

Court permits Frankel & Newfield, P.C. to conduct discovery into insurer's alleged conflict of interest

In its relentless pursuit of client's rights, a federal judge recently permitted discovery by our firm to develop evidence as to whether the insurer acted under a conflict of interest in terminating a claim for long term disability benefits.

We successfully argued that such evidence was relevant to the court's review of the claim decision, because where the insurer both decides the claim and funds the claim, it is financially motivated to deny or terminate claims. Thus, discovery of this conflict is significant to addressing the handling of the claim and attacking the claim decision.

Court holds that insurers' "pick and choose" approach to review of medical records was arbitrary and capricious

A court recently decided in a disability action that the insurer refused to credit the opinion of the claimant's treating physician and other reliable documentation in favor of its selective review of material favorable to its decision. The court held that the insurer's inherent conflict of interest as claims payor and claim decider weighed into its decision to terminate benefits.

Court holds that insurer hired IME report lacks credibility

A court determined that it was improper for the insurer to require objective support for a claim where the disabling condition could not be supported by objective findings. The court held that self-reported symptoms could support a claim for disability in situations where objective testing does not exist to determine the existence of the condition.

Policy Definitions at a Glance

Disability insurance policies have a number of important terms, many of which have legal significance and are only appreciated after the claim process has begun. We hope to offer some insight into these policy terms to educate our readers before a claim arises.

Own Occupation: "Disability" is defined as the inability to perform the material and substantial duties of **your occupation**. Significant to this evaluation is that the determination of your occupation is what you were doing at the time you became disabled, NOT what your policy application stated was your occupation.

Any Occupation: Usually after 24 or 36 months of disability, policies modify the definition of disability to a less restrictive definition. Instead of whether the claimant can perform their "own occupation," the policy changes to an analysis of whether the claimant can "perform "any" occupation for which they are reasonably qualified by education, training and experience. To analyze this, insurance companies no often perform a vocational analysis to determine if the insured is capable of performing any job in the economy, even if no job is actually available. Some policies also take age and/or prior earnings into account when addressing this definition of disability.

Residual Disability: Some policies provide for a claimant to secure a portion of the benefit if they are unable to perform one or more of the material and substantial duties of an occupation. In these cases, the insurer will engage in a financial investigation to evaluate the loss in income, which determines the percentage amount of the monthly benefit. Insurers often attempt to determine that a medical professional claimant is only residually disabled, even when the claim is for total disability, finding that the insured can perform administrative functions in a practice setting. Thus, careful consideration must be given to developing an occupational description at the outset of a claim.