

# **The Role of the Medical Director in Claims Review**

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Medical Directors may be called on to do any of the following in their companies:

- Give an opinion, from a medical perspective, as to whether the death of an insured was accidental and qualifies for Accidental Death Benefits (ADB) under the terms of the contract.
- Review additional information uncovered after the date of the application or contract to determine whether such information would have made a difference in the original underwriting decision.
- Review claims that occur within the contestable period of a life insurance contract.
- Review Disability Income (DI) claims or Waiver of Premium (WP) claims
- Review claims with regard to suicide as the cause of death.
- Testify in court or via deposition as a representative of the company or as an expert witness.
- Evaluate employee disability and Worker's Compensation claims.
- Consult on Family Medical Leave Act (FLMA) and Americans with Disabilities Act (ADA) questions.
- Assess Long Term Care (LTC), Health Insurance and Critical Illness Claims.

The goal of claims review is to fulfill the contract the company made with an individual insured or an employer and to pay claims properly. To accomplish this, it is necessary to ensure that claims that should not be paid under the terms of the contract are, in fact, not paid, thus ensuring that there are sufficient financial resources to cover the vast majority of claims that are legitimate and should be paid.

- In 1999, fraud cost the insurance industry a total of \$96.2 billion, of which life and disability insurance fraud totaled \$12.3 billion. (According to Conning and Company study)
- An estimated 10 to 25 percent of all insurance claims are fraudulent. (Insurance Information Institute) They cost Americans about \$30 billion each year and add \$200 to \$300 to total insurance premiums for the average household. (National Crime Insurance Bureau)
- In a 2000 poll, 24 percent of Americans said it is all right to overstate insurance claims to make up for the premiums they have paid in the past, down 12 percentage points from the 36 percent who thought this behavior was acceptable in 1997. (Insurance Research Council)
- The five common types of fraud are misrepresentation of disability; unreported income; unreported return to work; unreported death and check fraud; and misrepresentation of medical treatment. (GBD's Special Investigation Unit, The Hartford)

## Evaluation of Claims

**General:** Experienced Medical Directors approach claims systematically to make sure that everything is addressed. This is like the approach that is taught for reading a chest x-ray or doing a complete physical. The review components include:

**Legal Considerations:** While the medical director is not responsible for interpretation of the law, there generally is little tolerance for ignorance of the law. In most companies, the claims personnel have direct responsibility for being aware of applicable state and federal law as well as contractual clauses as they relate to the claim in question. Nonetheless, the Medical Director must be aware of laws and contract provisions that are directly applicable to the case being reviewed. In general, the law supersedes the contract and the contract supersedes "desires/wishes" and opinion. If the Medical Director or claims personnel do not understand what is applicable, it is wise to consult with your company's legal counsel.

**Medical vs. Contractual, Fact vs. Opinion:** It is useful to differentiate between the medical (evaluation of disability) and the contractual (Is the claim covered by the contract?) The medical director needs to separate medical fact and medical opinion from legal fact and contractual language. It is also helpful as a consultant to be very clear about the type of comment being made. When stating an opinion, it is useful to note the basis for the opinion. Is it an expert opinion based on one's training and background or an opinion based on a review of the literature, consultation with other doctors or other types of resources? The same holds true when making statements of fact.

## Evaluation of Disability Claims

Medical directors often participate in the evaluation of disability for:

- Disability Income Insurance
- Waiver of Premium benefit

It is possible for a claimant to qualify by contract for DI but not WP because of contract definition changes for these coverages.

Additionally, evaluating employee disability and related issues may be a responsibility of the medical director. (These areas will not be directly addressed in this document.)

- Worker's Compensation
- FMLA
- Americans with Disability Act

## The Disability Claim – Two Main Decisions

### Is the covered person disabled?

**Current loss or level of function:** This is determined by assessing the insured's current level of function or degree of loss of function. All available information should be used. For example:

- Cardiac stress test will give exercise tolerance in METS. Cardiac rehabilitation will give detailed description of level of function.
- Physical therapy notes can be very helpful for musculoskeletal disorders.
- Attending physician medical records are useful in several ways: the attending physician's diagnoses, treatment plan and prognosis should be documented and supported by the medical records.

**The diagnosis, prognosis and anticipated duration of the disability** are often determined with the same information. For example:

- The diagnosis may be the primary determinant: complications of end stage renal disease: recovery unlikely without transplant. Coronary artery disease with successful intervention: recovery likely and duration of disability may be weeks or months.

**Maximal medical improvement is not usually an endpoint** for assessment of a DI claim. For example:

- An individual frequently can perform their own or any occupation before full recovery.

### Is the disability a covered claim under the terms of the contract?

**The contract defines what is a covered claim.** Once the insured's level of function is established, the next decision is whether the person meets the criteria for disability under the terms of the contract. The same individual may be disabled under one contract and not under another. Contract provisions that may be applicable:

- **Own occupation vs. any occupation** (See definitions). The actual requirements of the job and/or occupation in question need to be understood to accurately assess the issue of disability.
- Result of an **accident/injury** vs. result of a **disease/illness**. Many contracts have different coverage for disability due to an accident vs. disability due to an illness. The concept of proximate cause may be important if there has been an accident. For example, a person with diabetes strikes their foot against a doorframe, injures a toe, and eventually has the toe removed surgically. In a case such as this, the Medical Director may be asked to determine if the claim

(surgical removal of the toe) and any associated disability is the result of an injury/accident or the result of the underlying disease (diabetes).

- **Definition of Blindness:** Medical Directors often assess claims for blindness. One needs to know if the contract explicitly defines blindness. If it does not, a standard must be determined with the claims area and legal counsel. There are various definitions of blindness. There may be applicable state law. Once the definition of blindness is established, it is straightforward for the Medical Director to review the visual evaluation and assess the claim. For guidance one may look to the Social Security Administration's definition of legally blind is quoted at <http://www.ssa.gov/pubs/10052.html#1075347> and the publication is at <http://www.ssa.gov/pubs/10052.html>: "...What Do We Mean By "Blind"? We consider you to be legally blind under Social Security rules if your vision cannot be corrected to better than 20/200 in your better eye or if your visual field is 20 degrees or less, even with a corrective lens. Many people who meet the legal definition of blindness still have some sight and may be able to read large print and get around without a cane or a guide dog...."

## **Rescission of Contract for Disability Claims**

The contestable period is the period of time during which a company may contest the validity of the insurance contract based upon fraud or misrepresentation in the application. A policy is typically contested if information is uncovered which would have led to a different offer or no offer had it been known by the insurer at the time of the original contract offer. The purpose of the period is to allow an insurance company to rescind the contract for cause.

### **Contestable Period**

- The contestable period for Disability Insurance (DI) is affected by contract language and applicable laws. Each company's legal counsel should be consulted to determine the time limit for a given contract.
- If a claim is investigated and there is evidence that the insured withheld information that would have led the company to issue a contract other than as applied for (e.g. rated policy), postponed the application or declined coverage, the company may bring an action to rescind (nullify or revoke) the policy. It is very important to review all pertinent information in the file, especially the application and medical exam. The way a question is worded on the application or examination form may make a difference when deciding whether or not information was deliberately withheld or misrepresented.
- If rescinded, premiums are refunded. Since the contract was not valid, no benefit is paid.
- Sometimes information comes to the attention of the company in ways other than a death claim during the contestable period, e.g. an application for another product or waiver of premium claim. A similar investigation, triggered by one of these, may be done. A decision to rescind the contract may also be made in this situation.

## **Fraud**

- Fraud is another reason for contract rescission. Fraud is the deliberate effort to provide false information to the insurance company with the intent of deceiving the company. (Examples include having another person take the medical exam or provide body fluid specimens for analysis.) If fraud is involved in the procurement of a disability policy in some states the contestability period may extend beyond two years.

## **Burden of Proof**

Typically, the burden of proof for a new disability income or waiver of premium claim falls on the claimant but it can be on the insurer. No claim is presumed to exist without sufficient proof of the claim.

- The burden of proof for claimants who have no reasonable anticipation of recovery or improvement in function, e.g. blindness, will almost invariably be on the payer.
- Other claimants who have a reasonable anticipation of recovery in the future, e.g. lumbar disk herniation, generally are required to give evidence if the duration of their disability exceeds that which can be reasonably anticipated.
- When the claimant has been covered for the disability for a long time, the burden of proof can shift to the payer to support a decision to no longer pay the claim. This may be avoided by setting a finite duration of claim payment (at the time of the initial decision). This duration of claim payment should be reasonable and based on the same information used to determine that the claim is covered under the contract. Coverage beyond the stated duration then requires evidence of continued disability. While this requirement for evidence of continued disability must be reasonable, the burden of proof will more likely rest with the claimant than with the company.

## Utilizing Independent Medical Examiners (IME)

It is often necessary to use the services of IMEs to determine functional level or disability. Generally the IME is considered an agent of your company. Since it is difficult to argue against your agent's conclusions, your company will be constrained with the IME's opinion. It is important that communication with the IME be very clear on the following:

- Should the IME evaluate the disability solely with reference to the insured's level of function?
- Should the IME also determine whether the claim is covered under the terms of the contract? While this appears to be unwise, it is frequently what is done when the IME is simply requested to determine if the claimant is disabled. For example, the IME may do an excellent evaluation and estimation of level of function, but if the IME assumes incorrectly that the disability coverage is for "own occupation" while it is actually for "any occupation", they may incorrectly determine that the claim is covered under the contract when it is not. The company will then have the additional burden of clarifying the IME's error.
- Generally an IME with the same specialty as the treating physician is used. For example, if the claimant were being treated by a neurosurgeon for back pain, the IME ideally would also be a neurosurgeon. An exception to this rule is when the treating physician is clearly in an inappropriate or less than ideal specialty. Selection criteria for an IME provider include their credentials, experience and credibility that are most suited to the medical basis for the claim.
- The request for evaluation to the IME should be worded very clearly. In general, the company wants to reserve the right to decide whether or not the insured is disabled under the terms of the contract. It is important to be explicit and succinct. Is a general evaluation of the level of disability wanted? If a determination of disability under the terms of the contract is desired, then the exact contract wording or an explicit definition of disability must be included. (How can the IME determine if the claimant is disabled under the terms of the contract if he/she does not know the terms of the contract?) If the contract wording (quoted exactly, not paraphrased) is not used, it is essential to use a definition on which agreement has been reached with the claims and legal areas. If the definition of disability under the terms of the contract is not correct in the document sent to the IME, not only does one get an opinion by the IME based on incorrect information, but also the contractual relationship with the claimant may also effectively be changed.

In addition to using an IME to determine the extent of functional impairment and/or appropriate limitations/restrictions, some additional reasons for seeking IMEs include:

- Presence of contradictory medical assessments in a claim file.
- A concern regarding nature/adequacy of care/treatment (i.e., need to demonstrate "appropriate" care or attempt to encourage a redirection to more appropriate care)
- Situations where impairment appears to be significant in the record but the cause is obscure or undiscovered

## Evaluation of Death Claims

In addition to the general claim review concepts already reviewed, there are some unique aspects of death claim review.

**Contestable Period:** Most life insurance contracts specify a period of time, often two years, during which the insurance company may contest the validity of the contract. The purpose of the contestable period is to allow an insurer to rescind a contract for fraud or misrepresentation.

- A death claim occurring during the contestable period is always investigated. If the investigation uncovers evidence that the insured withheld information that would have led the company to issue a contract other than as applied for (e.g. rated policy), postponed the application or declined coverage, the company may bring an action to rescind (nullify or revoke) the policy. It is very important to review all pertinent information in the file, especially the application and medical exam. The way a question is worded on the application or examination form may make a difference when deciding whether or not information was withheld or misrepresented.
- If rescinded, premiums are refunded less any policy loans. Since the contract was not valid, no death benefit is paid.
- Contracts often have a clause that deals with misstatement of age or sex or use of products that contain nicotine (aka "smoking habits"). These clauses allow the insurer to pay benefits according to the amount of insurance the premiums would have purchased at the insured's correct age, sex or nicotine use status. The insurance company can enforce these clauses beyond the two-year incontestable period because the company is adjusting the death benefit and not rescinding the contract.
- Sometimes information comes to the attention of the company in ways other than a death claim during the contestable period, e.g. an application for another product, a disability income or waiver of premium claim. Assuming that compliance with privacy laws is maintained, a similar investigation, triggered by one of these, may be done. A decision to rescind the contract may also be made in this situation.
- Fraud is another reason for contract rescission. Fraud is the deliberate effort to provide false information to the insurance company with the intent of deceiving the company. (Examples include having another person take the medical exam or provide body fluid specimens for analysis or falsifying a death certificate.) Many state laws address the time frame during which fraud can be used as a reason for contract rescission on life insurance, allowing it only within the 2-year contestable period.

**Suicide Clause:** Many life insurance contracts exclude death by suicide as a covered event during the first one or two years of the contract, depending upon the policy form or state in which the policy was sold.

- In most states, there is a presumption against suicide as a cause of death so the burden of proof rests with the insurer.
- The contract usually excludes death by suicide whether the insured was sane or insane at the time. If the contract does not state this, there are two parts to the death claim decision: 1) Was the person sane or not at the time of death? 2) Was the death a result of suicide?
- Suicide generally is understood to include some element of willful intent to kill oneself. One test of intent would be to consider whether or not a sane and reasonable person could have foreseen that death was a likely result of an action and could have prevented it.
- Knowledge of toxicology may be very helpful in assessing results of tests done before and after death.
- Despite clear contract language, courts have often overturned company decisions on suicide as the cause of death.
- It is important to note that the purpose of the suicide clause is to prevent anti-selection. Once the exclusion period is over, suicide as the cause of death is a covered event.

**Accidental Death Benefit (ADB):** Also called “double indemnity”, this benefit is often sold as a rider on a life insurance policy.

- If death is the result of a covered accident, the death benefit paid is in addition to the face amount of the policy and may equal or exceed the face amount by two or more times.
- The contract may stipulate a maximum time frame that can separate the accident and the death for this benefit to be considered. For example, a person was in an auto accident, suffered a fracture of the femur and one year later died of a pulmonary embolus. If the contract limit was 6 months, ADB would not be paid. Alternatively, if the person was in an auto accident, suffered a fracture of the femur and 5 days later died of a pulmonary fat embolus, the 6 month time frame would be met and ADB would be paid. The person, whose injuries sustained in the accident were directly linked to death, would be considered to have died as a result of the accident under the concept of **proximate cause**.

## Glossary

**Accident vs. Illness:** Many disability insurance policies have different benefits dependent on the cause of the disability, accident vs. illness.

**Accidental Death Benefit (ADB):** A rider on a policy that increases the death benefit (often doubles it) of a policy if the insured's death is the result of an accident. There is usually contract language that defines accident and there is often a limit on the length of time (90 days is common) that separates the accident from the actual death.

**Change in Health Statement:** At the time of policy delivery, the insured may be required to sign a document, that becomes part of the policy, which states that there has been no material change in their health since the time of application. If there has been a change, and if it materially affects the underwriting of the policy, the company may move to rescind, offer at a different premium or not place the policy.

### **Claims**

- **Conflicting:** Two or more parties make claim for the same benefit, e.g. 2 people make a claim on a life insurance policy, each believing that he/she is the valid beneficiary
- **Mistaken:** A claimant makes a claim in error, e.g. a person who is unaware that the policy is no longer in effect makes a claim on a life insurance policy

**Common Disaster:** When the insured and the primary beneficiary die in a common disaster, a decision must be made as to how to then disperse the death benefit (e.g. who died first?). Many policies have a common disaster clause and several states have statutes that deal with this.

**Contestable Period:** This is the period of time during which a company may contest the validity of the insurance contract based upon a misrepresentation in the application. A policy is typically contested if information is uncovered which would have led to a different offer had it been known by the insurer at the time of the original contract offer. After the contestable period has elapsed, there are very few things on which the company could base a decision to not pay a benefit.

- This is frequently 2 years on life insurance contracts.
- The contestable period for Disability Insurance (DI) is affected by contract language and applicable laws. Each company's legal counsel should be consulted to determine the time limit on for a given contract.

**Disability:** The inability to engage in the major duties of an individual's occupation.

- **Own Occupation:** the inability to engage in the major duties of one's primary occupation.
- **Any occupation:** the inability to engage in the major duties of one's own occupation and/or any occupation for which the individual is reasonably suited by their education, training or experience. In addition, there is usually consideration given to a generally equivalent income level when making this determination.

**Elimination Period:** In disability and long term care insurance, there is generally a waiting period prior to becoming eligible for benefits.

**Estopped:** The definition of estopped is to be prevented from doing something. E.g. a company may be estopped from refusing to pay benefits on a policy if, at the time of the inception of the contract, the company had information regarding the possible existence of a condition that would have made a difference in the underwriting of the case and chose not to pursue it at the time.

**Exclusions:** Conditions that are not covered under the contract. These are usually in the form of riders. E.g. excluding disability income coverage for any medical condition involving the back when an applicant has a history of lumbar disc surgery.

**Fraud:** The deliberate attempt to provide false information with the intent of deceiving the company. For example having another person provide body fluid specimens for analysis and passing it off as one's own.

**Functional Capacity:** The actual ability of an individual to perform a task.

**Interpleader:** A legal proceeding sought by an insurer when two or more persons claim entitlement to the policy proceeds. The company knows that the benefit is payable. In an interpleader action, the insurer turns the policy proceeds over to the court and the court in turn decides who is rightfully entitled to the funds. This remedy allows the company to avoid the risk of having to pay the claim twice. The court's decision discharges the insurer from further liability.

**Long Term Disability (LTD):** Disability insurance where coverage begins after an elimination period (often 60-90 days to one year or longer). Most contracts have a two year period of coverage for own occupation disability followed by a "change of definition" to any occupation for which they are suited by training education or experience. LTD may be individual or employer provided.

**Misrepresentation (Material):** Providing false information or withholding information that is relevant to an insurance company's underwriting decision.

**Misstatement of Age or Sex Or Use Of Products That Contain Nicotine:** A provision in some policies in which it is spelled out how a company would deal financially with misstatement of age or sex or use of products that contain nicotine (aka "smoking habits") by the insured. Often, the death benefit is adjusted based on the true status of the insured.

**Necessary to Care and Treatment:** A determination that a given treatment or procedure is/is not needed in the care and treatment of a given condition.

**Over-Utilization:** A determination that a given service or treatment has been used more than is the necessary.

**Pre-existing Condition:** A condition that existed prior to the inception of the contract. In some cases, there may be no coverage for the condition or a certain period of time may have to pass after the insurance is in force before a claim for a pre-existing condition would be covered. Some contracts have no exclusions for pre-existing conditions.

**Proximate Cause:** The initial event in a chain of events that leads to an end. In life insurance, an event that eventually leads to the death of the insured. E.g. death due to a pulmonary embolus resulting from a fractured femur sustained in an automobile accident. In DI, an event which may determine whether benefits are payable under the accident or illness provisions of the contract.

**Rescission:** The procedure by which a contract is nullified and taken back. Rescission is usually due to discovery of material misrepresentation on the application or a change in the health of the insured between application and inception of the contract. E.g. discovery that the insured was diagnosed with cancer prior to the date of the application.

**Short Term Disability (STD):** Disability insurance where coverage begins after a short elimination period (5-10 days is common). STD usually requires the person to be disabled for his or her **own occupation** and is usually employer provided.

**Suicide Clause:** Usually contract language that excludes from coverage a death that results from suicide during the first one or two years of a contract.

**Waiver of Premium (WP):** A benefit in which payment of the premium is waived if the owner becomes totally disabled during the life of the contract. It is generally underwritten similarly to disability coverage.

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