Chronicle Issues
Research Review Issues
CFIDSLink E-newsletter
Reprint Policies

RETURN TO TABLE OF CONTENTS

Spring 2001

What to Do when Your Disability Benefits Are Denied

By Scott M. Reimer, Esq.

Becoming disabled has a huge impact on your financial future. In the winter issue of the Chronicle, attorney Scott Riemer explained in his article, "What to Do if You Become Disabled," your legal rights before you leave a job because of a disability. In this second article, Riemer provides common sense tips on what to do if your disability claim is denied.Disability benefits are often denied at a time when you are least able to handle it emotionally. Not only are you learning to cope with the limitations of chronic fatigue and immune dysfunction syndrome (CFIDS), you now have to deal with a depersonalized bureaucracy on an issue central to your financial security.

If your disability benefits are denied, understanding the appeals process and knowing what your rights are and what steps you can take are paramount to successfully overturning a denial.

The appeals process

All employer-provided disability plans have an appeal procedure. The first step when a claim is denied is to exhaust all internal administrative appeals. If you complete this procedure and your appeal is denied, you then have the option of suing an insurer. Appeals should be taken very seriously. Not only could the insurer reverse the denial, but the appeal presents a valuable opportunity for you to create a strong case should a lawsuit be necessary. Conversely, if you don't create a solid case during the appeals process, you could fail in a future lawsuit.

Before beginning the appeals process, understand your rights. Under the Employee Retirement Income Security Act (ERISA), you are entitled to a full and fair review of your claim, and you must be told in writing: (a) the specific reason for the denial; (b) the plan provision(s) on which the denial is based; (c) any additional material and information that is needed before the insurer will pay the claim and an explanation of why this is needed; and (d) the steps that must be taken to appeal the denial. If your denial letter fails to tell you any of this, your ERISA rights have been violated.

If your denial letter doesn't satisfy these requirements, send a letter to the insurance company noting the deficiencies. Note the date that an appeal must be sent to them. Many courts enforce these deadlines, so a timely appeal is very important.

If the denial letter specifies that your records were reviewed by a doctor on behalf of the insurer, include in your letter a request for the doctor's report and any other information they may have relied on in denying your benefits. In addition, if you have not already done so, request copies of the plan or policy.

Show the denial letter to your doctor and have him or her prepare a report addressing every concern in the denial letter. Gather all medical evidence supporting your claim, including your doctor's notes from office appointments or other medical records. Also include literature on CFIDS to support your case.

Frequent denial reasons

The following are among the most common reasons insurers will deny benefits:

"There is no objective evidence in support of total disability." Denial for this reason is very common in CFIDS cases. If your denial letter says this, check the language

of your policy or plan. If the plan doesn't require objective evidence in support of disability, some courts will rule that this is not sufficient reason for a denial.

Ensure that your doctor's letter describes any objective evidence establishing your disability. At the very least, your doctor should include a statement on whether your symptoms are consistent with your diagnosis.

"We have spoken with your doctor and he agrees with us." If your denial letter says that the insurer spoke with your doctor, who agrees with them, check with your doctor. Often, it is just not true. If this case, have the doctor write a letter to correct the record. Sometimes your doctor's records do contain information that could damage your case, so reviewing them before they are sent to the insurer is best. You can them ask your doctor to revise or qualify the report. If the records have already been sent to the insurer and the damage is already done, ask your doctor to write a letter explaining away the damaging information or to explain how you are disabled despite the information.

"Your job was sedentary and you are not disabled from performing sedentary work." It is hard to quantify fatigue and pain. Therefore, insurers will often say your job didn't involve much physical activity and that despite your fatigue and pain you can perform your duties. Obtain a letter from your doctor stating that you cannot work even in a sedentary job. In some cases, a description of your duties from your employer can show that your duties weren't sedentary or that considerable cognitive abilities were required, which have since diminished.

"We had your records reviewed by Doctor X. Dr. X says you are not disabled." Request a copy of Dr. X's report and have your doctor contest it. You could argue that your condition cannot be evaluated without a physical examination, but this sets you up for an independent physical examination. Be sure to assess the risks and benefits of such an evaluation.

"You are no longer disabled." Insurers periodically review the cases of individuals receiving benefits. You have the right to appeal this denial just as you did during the initial application for benefits. These discontinuations often can be refuted by demonstrating that your condition has not improved.

Once you have responded to the denial of benefits, gather all evidence in support of your claim, including a report from your doctor and any relevant medical records. Send a letter to the insurer stating why their decision was not in accordance with the evidence.

The insurer's response

If benefits are still denied after appeal, you may want to consult a disability attorney to determine if you have a reasonable chance of collecting disability benefits if you sue the insurer.

In some instances, the insurer will offer a lump sum settlement or the option of participating in a rehabilitation program. Think long and hard before you agree to either of these. The insurer would not be offering them to you unless the company believed it was in its best interest.

Lump sum payments. In exchange for a release of all legal rights under the policy, insurers may offer you a lump sum cash amount. The pros of a cash settlement are that you will have cash now, which could help you get through a trying time. You also will not have to worry about an insurance company constantly monitoring your progress, requesting that you provide periodic reports, and/or submit to physical examinations.

The downside of lump sum settlements are that they are almost always significantly less than the present value of your benefits, so you would be wise to consult an attorney to determine if the settlement is fair.

Rehabilitation programs. Insurance companies adopt rehabilitation programs to minimize the benefits they pay. They are not for your benefit. Rehabilitation programs

may sound very appealing, because no one wants to be disabled with CFIDS, however, they can be a Trojan horse. We had a client who expressed interest in such a program. Once he did, the insurer told him that he must be able to work. The insurer then subjected him to a functional capacity evaluation and discontinued his benefits—without him ever participating in the program.

There is much you can do to ensure your financial future, but by far the most important is just being cognizant of the process.

Scott M. Riemer is an attorney specializing in long-term disability litigation. He may be reached at 212-297-0700 or by writing to 60 East 42nd Street, 47th Floor, New York, NY 10017. His e-mail address is riemer@scottriemer.com.