SAMFIRU TUMARKIN LLP

# FAQ Guide for Heath Care Professionals and Your Interactions with Insurance Companies in Disability Claims

***If your patient needs to take a medical leave of absence from their employment, they may be entitled to Short- or Long-Term Disability Insurance Benefits. As their treating health care professional, you may need to interact with their insurance provider from time to time. You could be asked for your clinical notes and records and/or opinion(s) with regards to your patient's condition and ability to work. It is important that you understand how to deal with such requests in order to help your patients get the benefits they deserve.***

- ***What do insurers look for when they read your reports?***
  - ➢ First and foremost, it is important to understand that your patient's insurer will require medical support in order to assess their eligibility for disability benefits. They require this information both during the application for disability benefits, as well as while they are receiving benefits. Essentially the insurer is trying to determine if your patient is unable to work because of their disability.
  - ➢ The test for getting these benefits is nuanced and depends on where they are in the disability application process. That said, it boils down to proving to the insurer that your patient needs time off because they cannot perform their essential work duties. It is therefore imperative that your reports to the insurer explain in as much detail as possible the nature of your patient's disability (within the purview of your speciality) and why, in your opinion, your patient cannot work, at the present time.

- ***If you believe that your patient needs time off work because of their disability, what should you include in your report?***
  - ➢ You will need to ensure that you are providing adequate detail in any report that you submit to the insurance company. Lack of medical support is one of the most common reasons cited by insurers when they deny claims.
  - ➢ The below information is a good starting point of what you should include in your report:

- Your professional designation
- The length of time that you have been treating your patient
- Your patient's diagnosis or, if there is no formal diagnosis, a statement that your patient is disabled from working
- An explanation of your patients' symptoms/conditions that are disabling them from working
- If known, a prognosis. If there is no known prognosis, you can make note that your patient will continue to be evaluated every number of months (i.e., 6 months, 12 months, etc.), and that you will inform them of a prognosis once that becomes known

### *How do you provide the information to the insurance company, and can you get paid for your time in providing it?*

- If your patient provides the required authorization for you to communicate directly with their insurance company, the insurer will reach out to you when they need further records or documentation. You should generally be able to invoice the insurer directly for providing your records.
- If they do not provide an authorization, your patient will give you a form to sign, which you will send to the insurance company. In this situation, your patient will likely be required to pay for any documents/reports you provide.

### *What to do if your patient's insurer ignores your opinion that your patient can not work?*

- It is important to submit all medical reports and documentation to the insurance company, in writing. If your patient's insurer disregards your medical opinion and threatens your patient's benefits, your patient should contact us **ASAP** for assistance. Your patient should be able to follow your professional advice without fear of repercussion from the insurance company and should absolutely **NOT** be forced or pressured to return to work before they are ready. We help individuals in this situation frequently and often it is a matter of putting the insurer on notice of legal repercussions if they continue to disregard the treating health professional's opinion and advice with regards to the patient.

### *What to do if the insurer denies your patient's STD/LTD claim?*

- If your patient's claim has been denied for any reason, or if they are told that their benefits will stop at some point in the future (i.e. a precise date is given of when the benefits will terminate), your patient should reach out to us **ASAP** for assistance.
- Your patient will likely be told that they can submit an internal appeal directly to the insurance company and you may be asked to provide new and additional medical information in support of that appeal. We generally do not recommend that patients and their health care providers engage in this process. In our experience it frequently leads to immense frustrations and subsequent denials of benefits, all the while the patient is left without income and a feeling of hopelessness.
- Put simply, in our experience, these internal appeals rarely work. More often than not we see patients and their treating health care providers spend an inordinate amount of time trying to persuade the insurer to reverse their position on appeal, only to be rebuffed time and time again. We believe that this process is designed by insurers to frustrate claimants and their health care providers into giving up on benefits owed.
- Instead, we offer **free** consultations with regards to any aspect of a claimant's benefits claim or denial and we help individuals deal with insurers with the least amount of stress possible.

### *When does your patient need legal help?*

- The answer to this question is simple: when they feel that something is wrong with their disability claim, or whenever they simply have questions about the process itself of applying for benefits or managing their claim/interacting with their case manager.
- We are here to provide free advice and, when necessary, provide legal options for claimants who feel bullied and pressured, or who are denied their disability claims.
- Besides a formal denial of benefits, your patient may need legal help at various stages of the disability claim process. If at any point, your patient tells you their insurer is harassing them, making odd requests, threatening their monthly benefits, or anything that sets off that little red flag in the back of your (or their) mind, they (and you) can contact us for help and information.
- Insurance companies must abide by the rights and obligations set out in the insurance contract (the policy), and we can help make sure they are doing just that.

### *Can you, as a health care professional, reach out to us for advice and is that a breach of doctor-patient confidentiality?*

- We routinely speak with many health care professionals of diverse backgrounds with regards to both general information and advice, as well as regarding patient-specific

matters. If your questions to us are general and not patient-specific, then there should be no issues regarding breach of doctor-patient confidentiality. However, if you are seeking advice or information that is specific to one of your patients then we would urge you to obtain your patient's consent first (in writing), and ensure that you are acting within the prescribed guidelines of your professional organization. Typically, so long as the patient provides consent, we do not see an issue with discussing patient-specific matters.

***Questions? Concerns? Contact us!***

***Toll Free: 1-855-821-5900***
***Email: help@disabilityrights.ca***
***www.Disabilityrights.ca***
***or***
***Post your question and get an answer from one of our disability lawyers at www.MyDisabilityQuestions.com***

***FREE CONSULTATIONS***