Maintaining Your Disability Claim

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April, 2011

Whether you are receiving disability benefits from Social Security, from private disability insurance, or from both, your medical condition will be periodically reviewed to see if you remain eligible to receive benefits, i.e., whether or not you still meet the plan's definition of disability and are entitled to have your benefits continued. This usually involves a review of your medical records and sometimes questionnaires to you and/or your physician.

Social Security

Social Security conducts *Continuing Disability Reviews* (CDR) beginning between two and seven years after the initial approval. They do this with both SSI and SSDI. This is in addition to the annual financial reviews they do with people collecting SSI. The time interval in the disability reviews is based on the likelihood of medical improvement. The initial Notice of Award letter will give an estimate when the first CDR can be expected.

However, due to reduced staffing and the large influx of disability claims, Social Security is lagging behind in these reviews, some are not being done at all, and most of those that are being sent are the short form reviews that require very little information, basically just checking to see that your condition has not improved.

While Social Security will sometimes determine a person is no longer disabled enough to receive benefits, it would only happen after a thorough review of current medical records. You will know if Social Security is looking that closely at your medical condition since they are required to obtain a medical release from you and would ask you to complete some questionnaires.

Although termination of benefits based simply on the medical record is not very common, it occasionally happens. Terminations are much more common because the claimant returned to work. However, should such a termination occur, you may elect to continue to receive benefits while you appeal the termination, however, you must agree to return any of the payments made after the termination letter, if your appeals are denied.

To help prevent loss of benefits you should continue to report all symptoms and problems to your treating doctors and make sure they put them in the record, as outlined below.

Disability insurance companies, on the other hand, conduct such reviews and attempt to terminate benefits much more frequently. It is not uncommon for a disability insurance company to terminate benefits, almost without notice, claiming that you no longer meet their definition of disability. Disability insurance companies appear to be conducting their reviews ever more frequently as

insurance carriers merge and as carriers contract out their disability claims to disability claims administrators who specialize in handling disability claims. These administrators sell their services to disability carriers by claiming that will save the carrier money in claims. Of course, they do that by terminating benefits as often as possible.

At the start of a disability claim, some insurance companies will ask for a brief update on your medical condition every month before the next month's payment is sent, although that is somewhat extreme. Many will obtain a physician's statement quarterly and review medical records less frequently. However, insurance companies cannot be counted on to adhere to any particular "schedule."

After two years of benefits, most disability policies shift the definition of disability from "your occupation" to "any occupation for which you are reasonably suited by education, training, or experience." That change almost always triggers a medical review and the most opportune time for them to attempt to terminate benefits.

Frequently, you, as the beneficiary, will not even be aware that the insurance company is reviewing your file. They will ask your physician to complete a form concerning your current medical condition or request updated medical records.

If you continue to be disabled and unable to return to work, it is important that you actively ensure that your records continue to reflect that fact. To accomplish this, there are several things you can do after your claim for benefits has been approved and before any claim review is initiated.

First, instruct all of your physicians to notify you any time they are contacted by the insurance company. Ask the doctor to put a note to that effect at the front of your medical file. Also request that he/she forward to you a copy of any questionnaire they complete from the insurance company. Depending on your physician, he/she may even ask for your input when completing a questionnaire.

You may also want to caution your physician to be wary of questionnaires that pretend to save the physician's "valuable time" by having her/him just check off some boxes. Such questionnaires usually don't give the physician enough choices to accurately describe your condition. Also, the insurance company will sometimes use the statement beside the checked box as if it were a statement actually made by your physician. *If your physician is willing, she/he should return such questionnaires without checking any boxes but attach, instead, a narrative letter which describes your current symptoms and condition and answers the questions asked on the form*.

Ask the physician to note or "explain" briefly in the medical record any laboratory findings that are "at normal levels" which an insurance company may use to try to claim you are no longer disabled. Insurance companies quickly forget that it is

the symptoms that prevent you from working, not the results of any specific lab test. A quick note on the lab results stating that symptoms have not changed although the lab numbers have will help avoid that. The physician might state something like “fatigue is still severe” on the sheet of “normal” lab results.

Also, you should not lose track of your symptoms. That may sound strange, but many people accommodate some symptoms so well and for so long that they forget they have the symptoms. Also, most people start feeling better when they leave work, especially after completing all the necessary paperwork and establishing eligibility for all the benefits to which they are entitled. However, some improvement in how you feel because your stress level is reduced is not the same as the elimination of all symptoms, or the ability to return to work. Your medical record must reflect that.

If, for the next six months, your doctor’s notes at each visit only say, “Pt. feeling better,” you can imagine what the insurance company will make of such statements. Perhaps, instead of the entry above, a more accurate assessment would be: “Pt. not as depressed, but fatigue still requires patient to take 2 or more naps daily.” Work with your doctor to make sure that the medical record accurately reflects your medical condition and your symptoms, not just your mood that day.

It is important, every time you visit the doctor, that she/he enters into the medical record a list of your symptoms and some estimate of their severity. Take a list of your symptoms and their severity with you. If the doctor is busy, he/she can simply attach them to the office notes. This should be done at every visit, even if the symptoms don’t change from one visit to the next.

One of the best tools for doing this is a Symptom Log or some type of written record in which you record what symptoms you have and when, how long they last, how severe they are, and, most importantly, their impact on your daily activities. You may want to enter items as they occur or once every few days or each week.

When you visit your doctor, be sure to take the log with you. That will give a quick summary of just how your medical condition has affected you since the last visit and can easily be photocopied and added to the medical record.

These recommendations are especially important for the beneficiary whose symptoms are primarily “subjective,” as insurance companies are reluctant to continue paying benefits solely because of symptoms that are “self-reported.” If your symptoms are fatigue, diminished mental acuity, pain, or other symptoms that aren’t easily measurable with a lab test, then you should make a special effort to see that a record of the continuation of these symptoms is regularly entered into your medical record.

Just because a disability policy agrees to pay benefits “until age 65” does not mean that they won’t try to stop paying much earlier if they believe the medical record doesn’t effectively support your claim to be still be totally disabled. Actively working to make sure that your medical records accurately reflect your medical condition and inability to work can save you unnecessary time, stress, and expense when your claim comes up for review.