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## DOCTORS PAID TO AID IN DISABILITY DENIALS

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Every year, millions of Americans seeking to buy a safety net for their middle class lifestyles enroll in group disability insurance. If they fall sick or are injured badly enough that they can't work, the insurers promise to pay part of their salaries.

But legally denying these costly claims has proven remarkably easy for insurers. All they need is a single doctor's opinion that the insured is able to hold a job.

As a result, insurers hire a cadre of doctors to write reports on claims they don't want to pay.

These doctors are not required to see the patient. They can receive hundreds of assignments per year in repeat business from insurance companies. And they do not - unlike in many health insurance disputes - have to be part of an independent panel overseen by regulators.

The opinions of these insurance company-hired doctors carry more weight in court than those of the treating physicians, employers and Social Security Administration administrative law judges combined. That's because decades of high court decisions have nurtured an insurer-friendly playing field where the companies are free to deny any disability claim as long as they weren't "arbitrary or capricious" - in other words, as long as they have a reason. That has translated into big business for doctors like Harvard-trained psychiatrist Stephen Gerson.

Gerson, who declined to be interviewed, made well over \$1 million in four years writing reports part-time for several insurance companies and medical firms that arrange the reviews, court records show. Most of it, about \$900,000, came from a single insurer, Gerson revealed in a 2006 deposition.

"To work from home, in pajamas and some fancy slippers, denying legitimate claims by cherry-picking medical records is as low as it gets," said Frank Darras, an Ontario attorney who represents hundreds of group policyholders who were denied disability benefits.

The insurers dispute that, saying the reviews are fair, and meant only as protection from workers filing bogus claims or otherwise receiving benefits they're not owed.

"The physicians who conduct external file reviews... are independent of the carrier," said Whit Cornman, a spokesman for the trade group American Council of Life Insurance. "There is not a common practice of using captive physicians or physicians with a conflict of interest."

But insurers have fought tooth and nail to keep information about these doctors under wraps.

### **Documents Paint a Picture**

The Daily Journal reviewed dozens of court cases nationwide where federal judges have taken the rare step of allowing discovery. Those documents, including depositions and internal memos, painted a portrait of the role doctors and medical review companies play in claims denials.

Based on those records, here's how it works:

A worker who has paid for benefits files a claim. In most cases, the insurer will review it and pay.

Some cases - markedly those where the insured reports suffering from back, neck and spine injuries, chronic pain, and other "complex" symptoms - are denied, even if treating physicians and the Social Security Administration find them disabled.

If the worker appeals, the insurance company will send the files to what they call "independent" medical reviewers, a handful of specialized firms scattered across the country.

The firms that set up the reviews collect several millions of dollars a year, sometimes from a single insurer, and aggressively market their services.

These firms coach their doctors to never use the word "disabled" in reports and to use strict medical definitions they provide to determine a person's ability to work.

The doctors rarely examine the patients, but rather base their opinions on limited medical evidence selected by the firm. At times, they have no expertise in the field in which they give an opinion.

They are regularly paid more than \$100 per hour, often earning \$100,000 a year for part-time work. Some make all of their income from the insurance industry.

And a handful of these doctors, whose records were revealed in court documents, sided with the insurer in 90 to 95 percent of the cases.

### **Pushing Paper**

Joanna Morales, director of the Cancer Legal Resource Center at Loyola Law School, said the current system puts even people with legitimate claims at a steep disadvantage.

"You just have an insurance company looking at claims on paper and the average person is not getting the lengthy documentation from their doctors to make their case compelling," she said.

Because these policies are group benefits obtained through work, they are regulated by the Byzantine Employee Retirement Income Security Act.

Courts have ruled the law gives insured workers limited recourse against insurance companies, which have extraordinary preference in handling the appeals.

Despite a 2008 Supreme Court case, *Glenn v. Metropolitan Life Insurance Co.*, that suggested judges scrutinize an insurers' conflict of interest in denying claims, disabled workers encounter steep legal hurdles.

Mark D. DeBofsky, an appellate attorney for policyholders who teaches at the John Marshall School of Law in Chicago, said trial judges rarely look beyond the individual case to an insurer, or doctor's, pattern. Some circuits do not allow discovery into that behavior, he said.

A Daily Journal investigation that included a review of 576 federal lawsuits in California against the top insurers, found thousands of disabled Americans must sue for insurance benefits. In defending against those suits, the insurers typically hold up the opinions of contract doctors as evidence that the denial is legitimate.

Insurers have an obvious incentive to keep these claims down: Unlike medical leave or short-term benefits that are sometimes paid by employers, long-term disability costs the insurers directly. In some cases payments can span years, even decades.

At the same time, there are few disincentives for an insurer to stall expensive disability benefits because injured workers do not have a right to damages in court.

Dr. Suresh Mahawar, a practicing internist in Fremont, moonlights by reviewing disability cases for University Disability Consortium.

He nearly never disagrees with the insurer.

In 202 cases he was assigned to review for The Hartford Financial Services Group between 2005 and 2007, court records show he only found nine people who were so sick or injured they could not return to work.

When a physician to one of those other 193 people insisted his patient was permanently disabled, Mahawar replied that he believes anybody can work a desk job regardless of reported pain and physical limitations, court records show.

A judge said Mahawar's opinion that an employee with a severe spinal injury could return to work should be viewed with "commensurate skepticism." The judge ordered the insurer pay the claim.

In a statement to the Daily Journal, Mahawar said his medical opinions should not be equated with siding with the insurer. "How the insurance carrier may translate my findings into claims related decisions is decided solely by them," he said.

Federal judges have repeatedly shot down reports by Dr. Amy Hopkins, who was paid \$493,832 for file reviews for just one firm from 2001 to 2004 - nearly two-thirds of her income, according to court records.

Opinions provided by Hopkins, an occupational medicine specialist based in Guilford, Connecticut, have been challenged in about 20 lawsuits since 2003.

In 2004, a federal judge in Pennsylvania described Hopkins' work as a "pick and choose approach" that ignored evidence and "completely mischaracterized" a treating physician's notes in order to deny a claim.

In several reports, Hopkins uses the exact same language to explain why different patients suffering from different diseases were not so disabled they couldn't hold a job.

For example, Hopkins routinely stated in her reports that whatever the insured was suffering from "is not necessarily, in and of itself, a disabling disorder."

A skeptical U.S. District Court Judge Claudia Wilken dismissed Hopkins saying: "A suggestion that it is possible that plaintiff is not disabled is not the same as evidence that she is not."

Hopkins, contacted while vacationing out of the country, refused to discuss her work.

Dr. J. Mark Melhorn, president of the American Academy of Disability Evaluating Physicians, which offers certification for medical reviewers, said he believes that biased doctors are the exception. "My hope would be that the system is designed in such a way that those individuals can be identified."

Melhorn said the on-paper medical reviews are only one part of a extensive process that gives claims an unbiased look.

"It is not a perfect system but it is reasonably fair, and there are levels of appeal," he said.

### **Repeat Business**

Financially speaking, the firms that arrange reviews for insurance companies are hardly independent: they rely heavily on repeat business.

Details about those business arrangements are rarely disclosed. In court cases where information is revealed, the money earned from a single insurer can be staggering.

"They get more business if they deny more," said Bryan Liang, executive director of the Institute of Health Law Studies at the California Western School of Law in San Diego.

Liang, who studies health coverage issues, said the close ties between physician reviewers and the insurers lead to "egregious" denials. He said policyholders can't get a truly independent review because they are one-time players while insurers are repeat customers.

The Hartford alone paid University Disability Consortium, more than \$13 million between 2002 and 2007 for 10,000 reviews. The insurer provided about 75 percent of the firm's income in 2006, according to court records.

The firms aren't shy about negotiating bulk business. For instance, UDC's rate was \$300 an hour initially. But company president, Jonathan Peter Strang said in a deposition that he dropped the price to \$225 for The Hartford in a "volume discount type arrangement" for nearly double the number of reviews.

Strang runs UDC out of his \$1.2 million six-bedroom Victorian house in a Boston suburb, according to public records. He farms the work out to about 100 physicians from different specialties.

Among them is Gerson, the psychiatrist who made a million dollars doing part-time reviews.

Gerson was also sometimes paid directly by the insurance companies. In 2005, while Prudential Insurance was paying him \$250,000 a year to conduct reviews, he told Prudential claims managers how to successfully deny a claim for a woman with a brain tumor, according to court records.

A Prudential claims worker made notes of the conversation.

"If we consider this a gray area claim and we wanted to be sure [Dr. Gerson] would suggest either surveillance or having [the patient] sit for an extended period with a neuropsychologist," among other tests.

But, the worker continued, "if we do, we run the risk that they will find a doctor who is an advocate," Gerson warned, according to the notes. "[Gerson] said he will not put these suggestions in the report... From the information he has [the patient] is not impaired."

Gerson, who currently performs medical reviews as an independent contractor, refused to comment on that case.

UDC's Strang said his insurance company clients don't reward his firm and those like it on how often they back a denial. "We don't get report cards, there are no quotas," he said.

Doctors like Gerson can be good umpires because they don't form personal relationships with the workers, he added. "Attending doctors can be too close to patients who say they can't [work], so they accept it at face value."

### **Altered Report**

Gulf War veteran Terry Hall, left his desk job in 2001 when chronic back pain and spine surgeries made sitting excruciatingly painful.

The disability insurance he'd paid for covered part of his salary at first. The plan cut off his benefits in June 2004 after an independent firm called MLS Inc. decided Hall was not disabled after all.

"Mr. Hall would be capable of performing work within the restrictions outlined," the doctor's report prepared by MLS said. "Mr. Hall would be most suited for sedentary work."

Hall, 39, was shocked the insurance-company hired doctor - who had actually examined him - said he could work.

It turns out, so was the doctor.

When Dr. James Templin compared his own notes against the official copy that MLS sent to the insurance company, he did not recognize entire sentences.

He had come to the opposite conclusion about the patient. "I am unable at this time based on Mr. Hall's presentation and examination, to identify any work position which I believe he could return to," his own notes stated.

Templin was so horrified he sent his original notes to Hall, who sued MLS for allegedly tampering with the medical report during transcription in order to deny his claim.

MLS, a Michigan-based firm that describes itself as a national leader in independent medical assessments, performs on-paper reviews and exams for dozens of insurance companies, including Liberty Life Insurance Co. and CIGNA and large employers like General Motors Corp.

The president of the family-run company said in a deposition it was common for the company to cut and paste doctor's signatures from drafts to final versions. But he denied MLS added new sentences.

"They forged my name and they admitted to it," Templin said in an interview. "They can do anything they want... it is nearly fool proof because doctors always dictate straight into their system."

MLS sued Templin in federal court for breach of contract, saying their agreement forbade him from sharing his findings with a patient. MLS lost.

The company settled with Hall privately.

MLS is not the only firm that makes doctors dictate reports by phone to be transcribed.

According to Dr. Philip Marion, a rehabilitation specialist at Georgetown University who has reviewed disability cases for years, it's even common for firms to add details to reports.

The firms also control the medical evidence, he stated in a deposition. In some cases, Marion said he gave opinions based on incomplete records - unaware of additional surgeries or new injuries for instance.

Marion, who declined to comment for this story, estimated in court records that he found patients unable to work in only 5 to 10 percent of the cases he reviewed.

### **Hiding the Numbers**

Track records like Marion's are a smoking gun that can prove illegitimate denials, many trial lawyers said.

Attorneys who take group disability insurance cases are increasingly fighting for the companies to release those records in individual disputes.

Insurers counter that the numbers aren't relevant - or are proprietary information.

When a judge does allow discovery, the insurers often respond by settling the case or rendering it moot by reversing the denial and paying the claim.

In April, a federal judge in Northern California railed at an insurer's defense lawyers, infuriated by attempts to stall discovery in a lawsuit brought by a 65-year-old man suffering from diabetes, a heart condition and partial blindness who was denied disability benefits.

"I have gone overboard to try to accommodate you and your foot dragging," U.S. District Judge William Alsup told Metropolitan Life Insurance Co.'s lawyers, according to court transcripts.

Alsup demanded MetLife show how frequently Network Medical Review reviewers sided with the insurer to see if the company used "gimmicks" to justify not paying disabled people. He threatened MetLife's lawyers with contempt of court if they did not produce the records within 24 hours.

"We are at the end of this," Alsup said from the bench. "It's going to be public record. Its going to be out there for every other lawyer in California to see."

That weekend, MetLife decided to start sending the monthly checks it had withheld from David Walker, instead of letting the case proceed.

"They didn't settle it, they paid it," complained Glenn Kantor, a Northridge attorney who represented Walker.

Other lawsuits in recent years have uncovered a close relationship between MetLife and NMR, with annual payments in the millions and growing. In 2005, MetLife paid NMR more than \$2 million for thousands of reviews, court records show. But the total number of denials based on the firm's opinions remain elusive.

Liang, at the California Western School of Law, said he believed federal courts would increasingly allow discovery and evidence showing so-called independent doctors have a conflict of interest.

Liang said a better fix would be to have regulators assign the reviews rather than the insurers or middle-men firms.

"What we should be doing is putting the review decisions in the hands of a truly independent panel where the private insurers would just put money into one pot and then let the [reviewers] make a binding decision," Liang said.

Doing so could require legislation in Washington. Under the current system, insurers are free not only to hire who they want, but also to ignore the opinions of their own reviewers, as they did in the case of Marianne Wible.

The 56-year-old nurse for The Boeing Company suffered from Lupus for 11 years before the chronic disease, which wreaks havoc on the joints, blood and kidneys, made work impossible.

Her doctor, a Lupus specialist, told her she was disabled and needed to stop working.

Aetna did not want to pay the claim. It sent her to be examined by a medical expert of its choosing. That doctor also found her disabled.

Aetna still was not convinced. It sent her file to Dr. Emil Bardana Jr. in Oregon, who was not board-certified in rheumatology. He "completely disagreed" with her treating physicians. "There are no medical records available to verify her diagnosis," Bardana wrote in his review.

The insurer refused to comment on the case citing privacy laws, but court records show Aetna seized on Bardana's report, dropping Wible's coverage in August 2003. She appealed the decision.

While she awaited Aetna's response, Wible died.

The cause of death, according to the coroner's death certificate: "complications from Lupus."

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