

Best Risk Management Practices What is Claim Cost Containment?

By Therese Gentile and Elaine Hughes

Cost containment practices used from the very beginning of a claim enable the Claims Examiner to make informed decisions throughout the life of the claim. Following is an example of one such claim cost containment and risk management strategy.

Interviews with the claimant, employer and physician(s) are priceless tools that are performed by both in-house personnel and outside resources. This approach helps the Claims Examiner assess the approximate duration of the claim by getting a global perspective of the claimant's disability, and builds rapport with the claimant to promote good communication throughout the life of the claim. The claimant (employee) interview needs to be conversational, like touching base with Aunt Molly to get an update of her medical condition.

For example:

Good morning, Ms. Smith. I am calling in reference to your disability claim. I understand that you have stopped working because of your arthritis; is that correct? How are you feeling today? I see that Dr. Epstein determined that you are not able to work. How long have you been seeing Dr. Epstein? How often do you see him? Has your arthritis changed your life at home? Oh, I didn't realize that you had such difficulty walking. Oh, we didn't know you have also been diagnosed with peripheral neuropathy. When was that condition diagnosed? How does it affect your daily life?...

It is important to ask the claimant what it is about their job they cannot do. This line of questioning brings forth details of the job or occupation that may not be identified in a written job description. It will tell you more about the physical demands required of her when performing her job responsibilities. Do her medical complaints correlate with her reported dysfunction? Does all of this make sense? You now have information to bring to your conversations with both the employer and the attending physician(s).

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Cost Containment Strategies:

A Medical Record/Peer Review is like watching a movie. It helps to define a beginning and an end. Medical record reviews will reveal patterns, assist with determining the direction of a file and place the file into perspective.

Vocational Intervention Assessment is an effective cost containment tool when utilized as soon as the claimant is deemed able to work any occupation. Vocational Intervention/Assessment is of great value when reviewing files for "test change." A Vocational Specialist with comprehensive knowledge of return to work strategies not only saves the employer money, but also reduces overall claims overhead. Fewer claims come into litigation, less time is lost and second medical opinions result in lower claim cost.

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Custom Disability Solutions Rolls Out Its LTD Conversion Product

We are pleased to announce the roll out of our LTD conversion insurance offering. It is available to our client companies and their customers. We understand the challenges employees often face when transitioning from one job to another, and the consequences they may face for failing to maintain disability coverage. We developed our LTD conversion insurance product to meet the needs of these employees and their families.

Conversion insurance allows an employee who terminates employment in specific situations to convert their group LTD coverage, provided by their former employer, to a "new" conversion coverage plan. LTD conversion coverage is intended to be a "transition" LTD plan for terminating employees who have no other LTD coverage option at the time of termination. The LTD conversion plan coverage lasts for one (1) year.

Reliance Standard Life Insurance Company (RSL) provides the insurance coverage for this offering, and will manage conversion certificate issuance, billing, premium collection, and conversion claim administration. CDS provides conversion administration support to its clients, their policyholders and employees. Our administrative support include distribution of conversion enrollment kits to clients, screening initial applications, answering questions from clients and their policyholders and employees about the conversion offering, and coordinating with RSL as needed.

The conversion coverage is an especially valuable benefit for those employees who may take some time in transitioning from one employer to another. As long as a person meets the eligibility requirements and applies within thirty-one (31) days of termination of coverage under their prior employer's group LTD policy, the conversion application cannot be declined. Conversion insurance coverage is not available in certain states. ■



What is Claim Cost Containment *(continued from first page)*

Your call to the employer should confirm how long the claimant was an employee of the company. Did anything about her job change recently, i.e., electronic equipment brought into the office workflow, a change in supervision, a new co-worker, and/or stoppage of company flex-time or other company benefits? At this time, you can clarify the physical demands of Ms. Smith's occupation. It is also appropriate to ask the employer if they have observed the difficulty Ms. Smith was having with her job. Did she miss time from work due to her medical condition? Did they have to accommodate her in any way prior to her going out on disability? Are they willing to accommodate her disability for a period of time when her medical condition changes?

You now have information to use in your call to the attending physician to get specific medical data pertinent to the file. From your discussion with the claimant, you know you need to see x-rays and other diagnostic test results; office visit notes from one year prior to her disability; medication prescribed for this period of time; and referral information to any other physicians.

This three-point contact cost containment tool has served to: (1) build rapport and set expectations with the claimant (2) provide clarification and agreement on the physical demands of Ms. Smith's job, and whether the employer is willing to accommodate her (3) provide pertinent medical data from which to make a judgment on the approximate duration of the claim, on what treatment is required, and if there will be ongoing restrictions and limitations.

If the above simple strategy is not used, you may experience the following scenario:

Ms. Smith, a 51-year-old female conveyor belt assembler, has filed a claim reporting that she is no longer able to stand to do her work for a full day, and her doctor has noted that she is unable to work. The diagnosis is advanced osteoarthritis.

Insurance Company A receives Ms. Smith's claim. The Claims

Examiner speaks to a representative of the employer and determines that Ms. Smith is eligible for benefits. The Claims Examiner sends the claimant a letter advising that the claim has been received and benefits are pending investigation. A request for medical records also is faxed to the doctor's office requesting the information be provided within two weeks.

At the end of the second week, a second notice is faxed requesting medical records. The doctor is asked again to respond in two weeks.

At the end of the fourth week, another notice is sent to the physician marked "Third Notice". At the same time, a second form letter is sent to the claimant indicating that her doctor has been asked three times to provide medical records and has not done so to date. If he does not respond in two weeks, her claim may result in denial due to no ongoing proof of loss. The claimant calls her doctor asking why they have not complied with the request for medical records. The doctor's office indicates they never received any request.

The Claims Examiner has no information with which to make a claims determination. The physician's office is angry at the insurance company because the office is made to appear inept in the eyes of the patient. The claimant is untrusting of the insurance company and is in fear that her benefits will not be approved. The claim started on a bad note; the claimant has no idea what to expect from the insurance company and does not know what is expected of her. The insurance company does not have adequate information from the employer, and the attending physician's office has no idea what is expected from them. The claim investigation has been delayed and more than likely will progress on an adversarial basis.

If this case would go to litigation would the insurance company's workflow have complied with ERISA guidelines? I think you already know the answer. ■

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Strategies *(continued from first page)*

Social Security Intervention and expertise need to come into play early in the disability in order to reduce reserves and lessen benefit overpayments.

Independent Medical Examinations are a useful objective tool in assessing and documenting actual visual findings or the lack of findings. The IME will assist in determining where the claimant is at the time of the examination, and is similar to taking a snap-shot in the middle of a movie.

Functional Capacity Evaluations provide the clearest understanding of the obstacles, complaints, impairments and medical limitations in a particular situation.

Examination Under Oath is an effective tool when the claim file contains many contradictions, and when the Claims Examiner had a difficult time obtaining the medical, financial or employment data needed to make a decision for ongoing benefits. ■



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