RIEMER | HESS LLC
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Disability Benefit Appeals: *Proven Strategies and Case Study*

Long Term Disability

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You spent hours upon hours putting together and reviewing your disability application. You checked and re-checked it. You crossed your t's and dotted your i's. Both you and your doctor thought it would be approved without a problem. But, despite your best efforts and the support of your doctor, your claim was *denied*.

At first you were outraged. How could the insurance company make such a horrible mistake? Your anger, however, was soon replaced by worry. How are you supposed to support yourself without any income? You need your benefits, and you need them quickly.

Your first instinct is to send in a quick appeal and tell them what you think. They need to know you're not going to just sit here and take it.

But, sending in a quick, bare-bones appeal would be a big mistake. To be successful, appeals must be strategically planned and carefully thought out. Remember, you must convince the appeal adjuster that the claims adjuster (who she may eat lunch with), was wrong to deny your claim.

This isn't going to be easy. You need a new angle. Changing the claim dynamic is key.

What's worse, you usually only get one bite at the apple. You only may have *one* opportunity to appeal before lengthy and costly litigation becomes your only remaining option. Even more important, if litigation ultimately becomes necessary, how you appeal your denial could impact your chances of success in court. In many instances, a court only will consider evidence you submitted during the claim and appeal process. Therefore, if you do not submit a piece of evidence with your appeal, you may not be able to use it in court later. You need time to gather all relevant evidence and get additional testing if necessary.

Riemer Hess has helped hundreds of hardworking , disabled professionals and executives successfully appeal long term disability benefit denials for over 25 years. In fact, we win over 75% of the appeals we handle.

Over the past 25 years, we've honed a time-tested strategy designed to maximize the chances of winning your appeal and avoid the high cost and delay of litigation. Here are the pillars:

- **Preparing Your Appeal as if it were in Court.** When we prepare your appeal, we prepare it as if we were preparing a case for trial in court. In other words, we determine what we'll need in your claim file in order to prevail in court, and then submit it in support of your appeal. This better prepares your claim for a potential future litigation while also increasing your chances of approval on appeal. The result? The insurance company must take your appeal seriously. Indeed, in support of our appeals, we submit detailed letter briefs, which often are more than 30 pages in length.

- **Demanding & Reviewing Documents from the Insurance Company.** Before processing your appeal, we need to know the specific reasons why the insurance company denied your claim. To understand this, we send a detailed demand to the insurance company for the following documentation and information: 1) the LTD Plan or Policy; 2) the Summary Plan Description; 3) your claim file; 4) all documents relied on by the insurer in denying your claim, including, the reports of all medical and vocational reviewers; 5) audio or video tapes of you; 6) notes of any telephone conversations; 7) the insurer's internal guidelines; and 8) a more specific description of the reasons for denial along with any information the insurer perceives is missing from your claim.

  Once this information is received, we review it in detail. We spend a lot of time reviewing the insurance company's internal claim notes and reports from their



doctors and vocational experts. We note each time the insurer criticizes your evidence or indicates that certain evidence is missing to make sure all such criticism is addressed. We then assess what additional documentation would help support your appeal and begin obtaining that information.

- **Gathering All Supportive Evidence.** An appeal that merely tells the insurer you and/or your doctors disagree with the insurer's denial is probably a loser. To win your appeal, you must address the specific reasons behind the insurance company's denial. Doing so will require gathering additional medical and vocational evidence in further support of your claim. We will:
    - **Request Medical Records from Your Treating Doctors.** Your treatment notes will often corroborate your symptoms. However, all too often insurance companies neglect to obtain these notes prior to their denial.
    - **Recommend Additional Testing.** To provide more objective support for your claim and to effectively change the claim dynamic, we recommend additional testing. For example, if you suffer from cognitive deficits, we'll refer you to a neuropsychologist for neuropsychological testing to objectively verify your deficits. If you suffer from fatigue and/or pain, we'll refer you to a physical therapist to document your impaired functional capacity. We'll also refer you to a vocational expert to identify the material duties of your occupation and explain why your restrictions/limitations prevent you from working.
    - **Requesting Medical Reports.** Often, the opinions of the insurance company's doctors conflict with your treating physicians' opinions. To combat this, we'll request opinion letters and/or customized questionnaires designed to further document your disability and have your doctor provide specific opinions as to why your symptoms prevent you from working.



These opinion letters also can refute the findings and conclusions of the insurance company's doctor(s) and address the concerns raised by the insurance company in its denial letter.

- **Obtain Client Affidavits and Witness Statement.** It's much more difficult to deny your appeal when the insurance company sees you as a living, breathing individual, rather than just another claim number. We, therefore, will work with you to prepare a detailed affidavit describing the duties of your job; your symptoms; and why your symptoms prevent you from working. The affidavit makes your case come alive. It lets the reader know who you are, and how your symptoms have affected your life – both at home and at work.

  In addition to your affidavit, statements from people with first-hand knowledge of your struggles can help document your impairment. So, we'll assist you in obtaining corroborating statements from family, friends and coworkers who have observed and witnessed your disabling symptoms.

- **Score any Surveillance Videotapes.** If the insurance company obtained video surveillance of you, we'll spend time "scoring" the video. By scoring the video, we can attack the surveillance by putting it in perspective. We add up all the time on the video when you are shown walking, standing, sitting, etc. We then show the combined amount is nothing compared to the actual time of the surveillance – which helps prove the surveillance is insufficient to contradict your claim of disability.



- **Preparing Your Administrative Appeal Letter.** Insurers must understand why their decision was wrong. A simple letter stating, "I hereby appeal the denial of my LTD claim" won't cut it. Our disability lawyers prepare a very comprehensive appeal letter: (1) arguing why you are totally disabled under the definition of disability in the policy; and (2) attacking the reasons for the denial mentioned by the insurer. We treat your appeal as if it were litigating a case in court – with the goal of submitting papers that are persuasive, awe-inspiring, and leave the impression you are ready, willing and able to litigate, if necessary.

  As we explain why you're totally disabled, we'll present your medical and vocational evidence, highlighting why you are unable to perform the specific duties of your job (or any occupation). We'll also spend a lot of time and effort developing and explaining your disability narrative. We want the insurer to understand who you are as a person – e.g., that you are a hard worker who is not content falling back on disability benefits, but rather your biggest desire is to get better so you could return to work.

- **Submitting Your Administrative Appeal to the Insurance Company.** It's important to submit your evidence to the insurance company in an organized, coherent manner. Once the administrative appeal letter is complete, we'll prepare an appendix consisting of the additional medical and vocational evidence we have gathered. We'll organize and number the records for identification purposes. We'll then submit your completed appeal to the insurer.

  In doing so, we'll ensure your appeal is submitted in a timely fashion. An insurance company likely will reject your appeal even if it is submitted just one day late. Worse yet, if you don't file a timely appeal, you could be barred from filing a lawsuit to recover your benefits.



- **Complying with Additional Requests & Ensuring a Timely Decision is Made**. The insurance company may require additional information even after your appeal is submitted. For example, the insurer may request copies of certain medical records it believes are missing from the file. The insurer also may order you to attend an Independent Medical Evaluation ("IME") if the insurer perceives a conflict between the opinions of your treating doctor and the insurer's doctor. If this happens, we'll help you every step of the way. We'll contact your doctor and obtain the requested documentation, and prepare you for what to expect at the IME. The disability lawyers at our firm will negotiate with the insurer to help ensure these examinations and evaluations are reasonable and convenient to you. If necessary, we'll also arrange for a nurse to be present at the examination to record what happens and to keep the insurer honest.

  Even if the insurer requests additional information, the insurer still must issue an appeal decision within a certain time-frame (e.g., within 45 or 90 days) if your claim is governed by ERISA. We'll keep track of the insurance company's deadline, and follow-up when necessary to ensure the insurer issues a decision in a timely fashion. After all, the longer it takes to make a decision, the longer you are without your LTD benefits.

We'll keep you updated by phone and email every step of the way. You'll also have 24/7 access to your very own secure Client Portal, where you can check on our progress and get copies of your documents.

To learn more about how our personalized strategy has helped other disabled professionals and executives, read the case study on the next page.



CASE STUDY: "VICTORIOUS" VINCENT

Vincent is 40-year-old investment banker at a major financial institution. About 6 months ago, Vincent suffered a stroke which led to severe left sided weakness and problems with attention, concentration, and memory. Despite intensive physical and occupational therapy, Vincent's symptoms became progressively worse over time.

Knowing he was covered under a group long term disability insurance policy offered by his employer, Vincent filed a claim for benefits. He completed and submitted the insurer's application forms along with his medical records and an Attending Physician Statement completed by his treating neurologist. Vincent was confident the medical documentation and his doctor's statements would convince the insurance company he was disabled. Unfortunately, Vincent's claim was denied. He was shocked. Upon review of the denial letter, Vincent realized he needed assistance if he wanted to have any chance of success on appeal.

Vincent decided to call Riemer Hess **to see how they could help.**

Riemer Hess took the time to listen to Vincent and understand his symptoms and the reasons why he was unable to perform the duties of his position as an investment banker. Vincent explained his left-sided weakness made it difficult for him to type on a computer quickly and accurately. He also explained how his cognitive decline made it impossible for him to focus and concentrate in a fast-paced, distracting work environment.

Understanding the nature of Vincent's disability and the reasons he was unable to continue working in his occupation, Riemer Hess formulated a clear strategy to win Vincent's appeal .



The strategy included:

1. Notifying the insurer we represent Vincent and requesting a copy of his claim file along with all documents relevant to the decision-making process;
2. Reviewing, in detail, Vincent's claim file to determine the exact reasons for the denial of his LTD claim and any documentation the insurer alleged was missing;
3. Requesting and obtaining updated medical records and opinion letters from Vincent's treating doctors;
4. Strengthening the evidence by scheduling Vincent to undergo a neuropsychological evaluation to objectively demonstrate his cognitive limitations and a functional capacity evaluation to objectively demonstrate his physical limitations;
5. Referring Vincent to a vocational expert to document his job duties and explain how his restrictions and limitations prevent him from working;
6. Preparing a detailed administrative appeal letter explaining why Vincent is disabled and why the insurer's determination and reasoning is incorrect;
7. Organizing the additional medical and vocational information into an organized, numbered appendix to submit with the administrative appeal letter; and
8. Submitting the completed appeal package to the insurer prior to the appeal deadline.

With a plan in place, Riemer Hess **sprang into action.**

First, Riemer Hess requested Vincent's claim file from the insurance company. Upon receipt, we reviewed the file in detail and determined Vincent's claim was denied because the insurer's doctor claimed there was a lack of objective evidence to document Vincent's cognitive and physical restrictions and limitations. We also determined the insurer's vocational consultant mischaracterized the duties associated with Vincent's occupation as an investment banker.

Knowing the reasons for the denial, Riemer Hess requested updated medical records and opinion letters from Vincent's treating neurologist. Then, Riemer Hess scheduled Vincent to undergo both a neuropsychological evaluation and a functional capacity evaluation to objectively measure and demonstrate his limitations. As the appointments approached, Riemer Hess told Vincent exactly what to expect so he felt comfortable and confident

during the testing. Once the respective reports were received, Riemer Hess reviewed the results to ensure they were supportive. The firm then referred Vincent to a vocational expert, and provided the expert with everything she needed to conduct her review.

Once Riemer Hess received all supportive documentation, it prepared and submitted a comprehensive administrative appeal letter addressing why Vincent is disabled, as well as the inconsistencies/misconceptions found in the insurer's denial letter.

Upon receipt of the appeal, the insurance company requested the raw data from Vincent's neuropsychological evaluation. Riemer Hess immediately contacted the neuropsychologist to ensure he would send the information directly to the insurer's doctor. Within 45-days of the submission, the insurer reversed its claims decision and approved Vincent's appeal.

Vincent was so relieved. No longer did he have to worry about supporting himself and his family. Finally, Vincent could rest and focus on his treatment.



Need help with your appeal?
Call us at 212.297.0700

Riemer Hess is a firm of disability attorneys based in New York City. The Firm's practice focuses exclusively on long term disability claims, appeals, and litigation. For over 25 years, we have built a thriving practice and national reputation on our unwavering commitment to protecting and fighting for people with disabilities. We have obtained tens of millions of dollars in benefits, settlements and judgments.

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