A Higher Bar for Quality Under ERISA's New Rule: The Importance of Medical Evaluations & Clinical Reviews in Disability Insurance

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Types of Disability Insurance Policies Affected
Long-term disability (LTD)
Short-term disability (STD)
Disability income
Accidental death and dismemberment
Waiver of premium
Life insurance that has a provision for disability

Today, a primary concern of executives at disability insurance carriers is compliance with updates to the Employee Retirement Income Security Act (ERISA), which went into effect April 1, 2018.

The final rule aims to strengthen consumer protections for private-sector employees making claims for benefits from their disability insurance plans. Now, under Section 503 of ERISA, there are fuller protections to ensure disability claimants receive an accurate and fair review. The rule aims to help individuals who might otherwise have been unduly denied benefits and, consequently, would have suffered financial and emotional hardship.

In this paper, we outline some of the key requirements under ERISA's final rule and discuss how quality medical evaluations and clinical reviews — coordinated by a sophisticated managed care vendor — can help insurance companies and employers comply with new requirements.

Overview of ERISA Final Regulation

The final rule amends the Department of Labor's current regulations around the claim procedures outlined in Section 503 of ERISA, which generally requires insurance carriers and employee benefit plans to provide the claimant with a full and impartial review of the claim, and written notice when a claim has been denied.

The new procedural protections and consumer safeguards strive to shield claimants from any conflicts of interest, provide increased transparency into the claims process, and ensure claimants have the opportunity to respond to evidence and reasoning behind a decision.

Let's first review the requirements of the final rule — and then examine how quality medical evaluations and clinical reviews can serve as vital tools helping to meet new requirements in processing claims, denials, and appeals.

Key Components of the ERISA Final Rule

To comply with new ERISA requirements, organizations must partner with a quality managed care vendor that can provide the clinical and vocational expertise to navigate the complex issues that arise in disability determinations.

Basic Disclosure Requirements. Denial notices must now contain a more complete discussion of why a plan denied a claim and the standards used in arriving at this decision.

Right to Receive Claim File and Internal Protocols. Benefit denial notices must include a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents; this includes reports from medical evaluations and clinical reviews. Denial notices must include the internal rules, guidelines, protocols, standards, or other criteria that the plan used to arrive at a decision to deny the claim.

Right to Review and Respond to New Information Before Final Decision. Claimants must be given notice and fair opportunity to respond to new or additional evidence or rationales for denying a claim before a final decision is made.

Avoiding Conflicts of Interest. Plans must ensure that disability benefit claims and appeals are adjudicated in a manner designed to uphold the independence and impartiality of the parties involved in making the decision. For example, a claims adjudicator, medical or vocational expert cannot be hired, terminated, or compensated based on the likelihood of that person denying a disability benefit claim.

Deemed Exhaustion of the Claims and Appeal Process. If plans adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan, and the claim or appeal is deemed denied. The claimant may then pursue his or her claim in federal court.

Certain Coverage Rescissions Are Adverse Benefit Determinations Subject to Claims Procedural Protections. Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (e.g. errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the plan's appeals process.

Notice Written in a Culturally and Linguistically Appropriate Manner. The final rule requires that benefit denial notices be provided in a culturally and linguistically appropriate manner in certain situations. Specifically, if a disability claimant's address is in a county where 10% or more of the population is literate in the same non-English language. In such situations, benefit notices must include a prominent statement in the relevant non-English language regarding the availability of language services.

A Quality Managed Care Vendor: In-depth & Multi-faceted Expertise

Disability insurance companies need to process claims, in accordance with the requirements outlined above, while also adhering to the contractual language within their own policies.

For example, a disability policy might specify a "threshold" of disability that claimants must meet in order to qualify for benefits. The policy might say employees must be unable to perform "any occupation," a higher threshold to meet the definition of disability. Or, the policy might say individuals have to be unable to perform their "own occupation," a lower threshold to meet the definition of disability.

To comply with regulatory and unique policy requirements, carriers must have within their wheelhouse of service providers a quality managed care vendor that can provide clinical and vocational expertise to navigate the complex medical and functionality issues that arise in disability determinations.

This is particularly important as there are several different types of medical evaluations and clinical reviews available, and various instances when the need for these services may arise in the disability claims process. We'll outline the various types of evaluations and reviews and discuss factors that constitute "quality" in these services.

As mentioned above, these services are important in light of the new ERISA rule, as carriers cannot arbitrarily deny disability benefits — or even appear to do so. As a result, there are risks associated with relying solely on in-house staff to conduct evaluations and reviews. This type of practice may be interpreted as having a greater potential to generate biased results. Chosen providers must not have a conflict of interest or a financial incentive to arrive at a certain medical opinion or impairment conclusion.

Medical Evaluations & Clinical Review for Disability Carriers

- Nurse clinical reviews
- Peer reviews
- Independent medical evaluations
- Fitness-for-duty examinations
- Functional capacity evaluations

When partnering with a quality managed care vendor, carriers receive assistance in upholding the rigid protocols and guidelines required to ensure fairness and impartiality. Oftentimes, carriers also set up distinctive claims procedures in order to adhere with applicable regulations. Consequently, the partner must be able to customize its workflow and technology to be in sync with these protocols.

Clinical & Medical Expertise to Confirm and Evaluate Disability

When individuals request benefits for a physical or mental condition, insurance companies have the right to investigate and confirm the diagnosis and extent of disability, as part of their claim-determination process. Almost every policy contains such a clause, allowing the insurer to request a medical evaluation or clinical review to confirm coverage.

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And now under the ERISA rule, such determinations cannot be or seem to be arbitrary. Instead, only expert physicians and clinicians with the right expertise can be utilized to evaluate the extent to which a medical condition will restrict a person's ability to work. To ensure a quality assessment, leaders at insurance companies are increasingly leveraging a managed care partner that can provide the right types of evaluations and reviews.

A quality partner has fostered relationships with a broad pool of medical experts. The vendor partner will evaluate physicians to make sure they are skilled in performing these exams and reviews, remain in active practice, and have unrestricted credentials related to medical licensure and medical board certifications. The partner is familiar with the physicians' areas of specialty, board certifications and expertise related to body parts, and works with these physicians to ensure they're adhering to all of the right protocols.

In addition, a vendor partner should have expertise in behavioral as well as physical health. There are numerous mental disorders that can qualify an individual for disability benefits. Currently, about a third of the disability claims submitted to the Social Security Administration involve diagnoses for mental disorders. In some cases, it can be difficult to prove mental impairment, as symptoms and signs are subjective in nature. Another challenge is there's a cultural bias against mental disorders. Any prejudice against these conditions can be combatted with a psychological fitness-for-duty exam, which we discuss later in this paper.

With many different types of medical evaluations and clinical reviews, a managed care partner can assist in the various instances when these services may be needed in the disability claims process.

Let's review the types of medical reviews and evaluations critical to the disability claims-determination process:

Nurse Clinical Review

To assess a claimant's condition, disability associates at the carrier may request a nurse clinical review. These are file-based reviews. Nurses analyze the claimant's medical records to look for evidence that confirms functionality, restrictions or limitations. They may contact the attending physicians to obtain additional clinical information or to clarify issues on the case. In some situations, nurses may feel the opinion expressed in the file isn't supported by evidence-based medicine. If that's the case, a peer review may be requested.

Peer Reviews (with and without peer-to-peer contact)

A peer review is also a paper-based review similar to a nurse clinical review, except it's performed by a physician who has credentials at least equivalent to those of the attending physician. In some cases, the peer reviewer may have the added prestige of working at a teaching hospital or having written industry papers.

In some cases, a peer review may require a "peer to peer" consultation. This type of peer contact must be authorized by the insurance company. When approved, peer-to-peer conversations can provide a valuable perspective for both the peer reviewer and attending physician.

At the end of the review, the peer physician will offer a medical opinion as to the extent of the claimant's restrictions and limitations. In some cases, the peer physician may conclude that "no restrictions or limitations" exist. In every review, there is documented clinical reasoning, upon which the carrier can base its decision to either deny or accept the claim.

Independent Medical Evaluation (IME)

IMEs are used to answer similar questions as peer reviews; the primary difference is an in-person medical examination takes place in addition to a review of the medical records. For IMEs, it's critical that the managed care partner have an extensive nationwide network of examining physicians because these medical experts and specialists must be available in specific geographic areas.

Fitness-for-Duty Examination

Since fitness-for-duty (FFD) exams are job-related, it typically falls within the domain of the employer to order them, but a quality

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managed care partner – working with an insurance carrier – may also suggest that one is needed.

Since these exams determine if an employee is able to meet the minimum requirements to complete a job safely and effectively, they help to minimize the risk of injury or re-aggravation of the impairment, thereby saving the employer and carrier significant costs. As such, it is in everyone's interest to move forward with this type of exam if it's believed that a particular employee may be unable to meet the demands of a job. A quality managed care partner can help to determine whether an FFD exam or a functional capacity evaluation is needed – or if both may be required. Functional capacity evaluations are discussed in the next section.

As previously noted, psychological FFD evaluations may be required if it's suspected that certain employees have observable behaviors, mental health disorders, or stress reactions that may cause or contribute to behavioral health problems, substandard performance or other factors that jeopardize the health and safety of themselves or other workers. A psychological FFD will determine if these individuals are psychologically capable of performing their job, and if not, what measures, if any, are recommended.

After performing an FFD exam, it may be found that certain employees have not recovered adequately from their impairments to be able to return to work and to perform their job functions safely. Before making such a determination, the employer should carefully review the FFD assessment, meet with the employee, and engage in an interactive dialogue, as it might be possible to make an accommodation.

A quality partner can assist and support with the interactive dialogue and accommodation process. However, we'll hold off on discussing these concerns in a future paper that outlines the clinical and vocational services that employers need for their internal disability management process.

Functional Capacity Evaluation

A functional capacity evaluation (FCE) is a set of tests that help determine a claimant's physical capabilities. The FCE compares the individual's health, body functions and structures to the demands of potential jobs and work environments. In essence, an FCE's primary purpose is to evaluate the claimant's ability to participate in work, although other activities of daily living that support work performance may also be evaluated.

Functional job descriptions are sometimes pertinent when performing these exams, as they can help customize the evaluation.

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Testing might evaluate a claimant's ability to meet a specific level of physical activity, or an ability to perform certain work tasks, such as lifting or carrying a 50-pound object. An FCE can also evaluate the person's ability to tolerate certain activities, such as sitting and standing for specific periods of time. Pain levels while performing certain tasks may be monitored. With so many factors to evaluate, an FCE can take up to 4 to 6 hours.

A quality managed care vendor will have relationships with highly qualified FCE practitioners. Occupational and physical therapists are often used, as they're highly skilled in assessing a person's physical capabilities.

Additional Criteria to Look For in a Managed Care Vendor

- Ability to meet information security requirements around HIPAA, PHI & PII
- SOC 2 Type II certification
- Sophisticated IT capabilities including online portals, interactive dashboards and stewardship reports

Meeting a Higher Bar for Quality Under ERISA

Clinical and vocational expertise have always been important in the disability space, but the bar has risen under the new ERISA rule. As a result, insurance companies must pay greater attention to the managed care vendors with whom they partner.

Sophisticated partners have evolved to meet ERISA's new procedural protections and consumer safeguards — providing an even greater level of clinical excellence. Within this new regulatory environment, many insurers are moving from a strategy of using unsophisticated vendors to relying on preferred best-in-class partners that have extensive reach, a team of medical and vocational experts, as well as demonstrated capabilities in clinical coordination, quality assurance, streamlined workflow, and advanced technology.

Companies — like Genex Services — have structured their enterprise to ensure fair, credible and unbiased processes that withstand the scrutiny of ERISA regulators, other agencies, and judicial systems. Vendor partners like Genex are the conduit to getting potentially impaired workers matched to the best, most qualified physicians, nurses, and other specialists — resulting in resolute disability claims decisions.

About the Authors

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About Genex Services, LLC

Genex's Disability and Absence Management Services (www.genexservices.com/disability) is a national provider of managed care and vocational services to the disability and leave management industry. Genex serves the top underwriters of disability insurance, third-party administrators and a significant number of Fortune 500 employers. The company's specialized disability expertise helps mitigate the challenges of compliance, high disability costs, lack of resources, and legal expenses. Our in-house disability experts provide comprehensive services throughout disability, FMLA, and ADAAA environments, including medical evaluations and clinical reviews, vocational expertise, ADAAA accommodation reviews, and Social Security services. Genex's integrated Absence Management Services help administrators and employers achieve better FMLA and ADAAA outcomes and enable faster and sustained return to work.

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