From DENIED to APPROVED

How to file a great ERISA

Long Term Disability Administrative Appeal

without making common mistakes that destroy good claims

APPROVED

A Former Insurance Company Attorney Guides You

Price McNamara, Esq

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Without Making Common Mistakes That Destroy Good Claims

By Former Insurance Company Attorney,
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To Those Stuck In an ERISA Insurance Claim Battle—PERSEVERE!

You're likely shocked by the insurance company's unfair denial or termination of disability benefits you paid for, need and deserve. And it's at a time of family crisis and tremendous emotional and financial distress.

Your own doctors clearly say you're disabled, but the insurance company hires doctors you've never even seen from out of state to say you're not.

You didn't ask for this. Now you're involuntarily thrust into our confusing legal world of insurance policy definitions, administrative appeals and federal "ERISA" law. You're anxious to get the next steps right without guessing. Unless someone's been in your shoes, they can't truly understand. But persevere, you CAN overturn a denial.

On a Personal Note

Before losing my own brother, then my father and sister after long, disabling illnesses just a few months apart, I never truly understood the place you're in. It literally brought home to me the dramatic impact that receiving (or not receiving) the benefits you paid for and now need can have on your life—when you need to focus on family and healing. That experience drives the way I view my clients and my work, and I will never forget it.

Working Directly for Insurance Companies Taught Me and Inspired Me to Guide Disabled Claimants to Justice

The first several years of my career were spent representing insurance companies at a big law firm. I helped them figure out how to avoid or minimize payments to injured and disabled claimants. After a while it became apparent that most people working for the insurance companies felt pressured to derail and deny even legitimate claims. The work was not fulfilling. I finally quit.

But everything happens for a reason. In my mind, NOTHING can replace the value of that insurance company insider insight, and now using what I learned there, in my mission of guiding disabled claimants and other attorneys in ERISA long term disability claims for the past 25 years.

I've come to find this area of practice so motivating and challenging that I finally decided to phase out of my only other area of practice of 25 years, representing victims of serious personal injury, to focus exclusively on ERISA litigation.

The Focus, Purpose and Ultimate Goal of This Guide

An ERISA long term disability claim has three important phases. The initial application phase, the administrative appeal phase and the litigation/court phase. Each phase has complexities of its own.

This guide focuses on the administrative appeal phase, which comes after the insurance company first denies a claim.

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The administrative appeal phase, more than anything else, determines the outcome of an ERISA claim. It's your greatest opportunity for winning if handled properly. **But it's also where most tactical mistakes are made.** These mistakes can be avoided by better understanding the ERISA process.

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The purpose of this guide is to explain to the unfamiliar claimant (or attorney), step-by-step, how to avoid common mistakes and properly handle the critical administrative appeal process after a denial of ERISA long term disability benefits. Getting it right is crucial to best chances for success, not only on administrative appeal, but also in federal court if the disability insurance company denies the claim again on administrative appeal.

The ultimate goal of this guide is to avoid unnecessary losses of benefits for well- deserving people. It's meant to be practical, so legalese is absent.

Attorneys who practice in the fields of Social Security Disability, worker's compensation, personal injury, successions-estate planning, family law and other areas of law will often refer people fighting long term disability insurance claims to me. They prefer not to "dabble" in the occasional unfamiliar ERISA claims that come their way. ERISA claims are complex, and few attorneys focus on representing claimants in this area of law.

I sometimes help other attorneys who do want to handle the occasional ERISA long term disability administrative

appeal or lawsuit themselves, and want to learn more about this complex area of law, but need some help getting up to speed. In addition to talking them through the process, I always give them a copy of this guide as a reference to help them get it right.

Finally, I get calls directly from disabled individuals who have either received denials of their long term disability claims from the insurance company, or the insurance company terminates their benefits after paying them for some period of time. Some are seeking help filing an administrative appeal. Others have already filed their administrative appeals, have been denied at that level as well, and are now needing to file suit in federal court. This guide helps them better understand the process we follow when fighting the insurance company.

We guide disabled people, and attorneys who represent them, at all stages of the process. Discussing these unique claims, the specifics of cases and ideas for building the strongest possible case on administrative appeal and in court is never work for me. It's energizing. I'm forever grateful for the opportunity to use what I've learned through representing insurance companies, to now help stop insurance company abuse and help families reverse unfair denials of insurance benefits they paid for, need and deserve.

Any feedback would be much appreciated, and as always, feel free to contact me if you wish to discuss anything about ERISA law and process in general, or the specifics of your case and ideas for making it as strong as possible. Email me at price@jpricemcnamara.com.

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Why Does Federal Erisa Law Apply to Most Long Term Disability Claims Filed In the U.S., and Why Does It Matter?

The vast majority of long term disability insurance claims in the U.S., 80% or so, are governed by the federal ERISA (Employee Retirement Income Security Act of 1974) statute. With a few exceptions, ERISA governs all long term disability claims involving insurance policies or plans which form part of employee benefits package.

Yet handling an ERISA long term disability insurance claim, from the administrative appeal to the federal court lawsuit, is a complex minefield for the unfamiliar. Everything about it is different. Disability insurance companies and their attorneys know and understand how to use ERISA's complexities to their advantage. But claimants, and often their attorneys, typically don't until it's too late.

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Unfortunately, most claimants file administrative appeals unrepresented, or represented by attorneys unfamiliar with ERISA law. The result is often the permanent loss of a benefits claim that could, and should have been successful. Understanding the following will help to avoid unnecessary losses.

What Makes the Administrative Appeal In an ERISA Long Term Disability Claim So Critical? Can't I Always File Suit and Get Serious About Building a Case Later if the Administrative Appeal Is Denied?

The simple answer is "no", and comes as a surprise to many after it's too late.

What makes the administrative appeal so critical, is that the federal judge in the ERISA lawsuit that follows, cannot consider any evidence that was not made part of the administrative record during the administrative appeal process. So the administrative appeal phase is your only chance to gather, create and build the best evidence to support your case later in court. The evidence you submit during the administrative appeal process becomes part of that record that the court can later consider. Whatever case you build (or don't) is carved in stone before you ever file suit.

That the administrative appeal makes or breaks your case cannot be overstated. It is during this process, before a lawsuit can even be filed, that most claimants lose without realizing it.

A brief overview of the life of an ERISA long term disability claim, and how it's so different, underscores the importance of the administrative appeal for the success of the claim.

What Is So Different About an ERISA Long Term Disability Case?

The process starts when someone becomes disabled from working, files an initial application or claim for long term

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disability insurance benefits, usually without attorney assistance, and receives a written denial of their claim by the disability insurance company.

Disability insurance policies purchased by individuals on their own, independent of their employment (most are not), are not governed by ERISA. For individual disability insurance policies not governed by ERISA, if the insurer denies the claim, the claimant can go directly to state court and file a lawsuit. No "administrative appeal" to the insurance company is required, and there is no requirement that the lawsuit be filed in federal court. Normal state court procedure, including all typical discovery methods are available. The claimant has the right to a jury trial, and all parties can introduce traditional evidence, including live witness testimony. Bad faith penalty remedies are available under state law that are unavailable under federal ERISA law. Typical litigation.

However, if the claim is governed by ERISA, as most are, a mandatory administrative appeal process is required by ERISA before a claimant can file suit to challenge a denial of benefits. The claimant must file the administrative appeal with the same insurance company that denied the claim. Then that same insurance company, which also must pay benefits if it reverses itself, decides whether or not to reverse itself and pay benefits—crazy but true.

If the insurance company again denies benefits following a timely administrative appeal (a very common outcome), the claimant can only then file a lawsuit, which must be filed in federal court. State court is without jurisdiction.

WARNING 1: The deadline for filing an administrative appeal on a denied long term disability claim is 180 days from the date of the written denial. Missing an administrative appeal deadline is as fatal to a claim as the passing of a statute of limitations with very few exceptions. Missing it means the claim is over, and the denial cannot be challenged.

If the insurance company again denies benefits following a timely administrative appeal (a very common outcome), the claimant can only then file a lawsuit, which must be filed in federal court. State court is without jurisdiction.

While beyond the scope of this guide, which focuses on the administrative appeal, a bit about the lawsuit that follows helps highlight the importance of the administrative appeal. An ERISA long term disability lawsuit in federal court is different from others. It doesn't follow the typical federal procedural path. Most federal district courts use special scheduling orders tailored specifically to the unique way ERISA cases reach court resolution.

ERISA has its own statutory venue rules. The way the statute of limitations is determined is complicated and depends upon a number of factors. Discovery is restricted, really almost non-existent. The parties have no right to a jury trial. No witness testimony is presented. The Federal Rules of Evidence don't apply as they normally would. The only "trial" at all is a trial on briefs referencing the administrative record filed with the court, either on cross-motions for summary judgment or simply motions for judgment on the administrative record.

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The court reviews a denial under an "abuse of discretion" standard, requiring it to give great deference to the financially-conflicted insurance company's decision. Courts have even upheld the insurance company's administrative appeal decision while expressly stating that it is contrary to how the court would have ruled independently on the evidence.

Choice of venue and choice of law considerations are critical because they can impact the standard of review, as some states have laws prohibiting "abuse of discretion" review, and such laws apply in ERISA cases. Most of the governing substantive law is either ERISA specific or federal common law jurisprudence, with much disagreement on many issues among and even within federal jurisdictions.

WARNING 2: But most important, and most pertinent to the impact of the administrative appeal, **the federal judge in an ERISA lawsuit cannot consider any evidence that was not made part of the administrative record, during the administrative appeal process, before suit is filed.**

But most important, and most pertinent to the impact of the administrative appeal, **the federal judge in an ERISA lawsuit cannot consider any evidence that was not made part of the administrative record, during the administrative appeal process, before suit is filed.**

The insurance companies and their attorneys know this. Most claimants and many attorneys don't. So most claimants and many attorneys file "administrative appeals", but submit no supporting evidence beyond medical records. They basically argue how impossible it is for the claimant to work, and how unfair the denial is after they paid policy premiums

for years. This does absolutely nothing to help their claim. It wastes the best and only opportunity to build the best case for reversal either on administrative appeal or in court if the insurer denies the claim again.

A Process to Build a Strong ERISA Long Term Disability Administrative Appeal

Beginning with the potential end in mind (federal court), you want to use the administrative appeal process to gather, create and introduce all available supporting evidence into the administrative record. Any evidence you submit to the insurance company in the process becomes part of that record. That record is ultimately filed into the court record if a lawsuit becomes necessary, and forms the only evidence the court can consider.

So where to start?

The process we follow, described on the following pages, will help guide you to develop the nuts and bolts of a strong, well-supported administrative appeal.

Analyze the Insurance Company's Denial Letters

We analyze the reasons given by the insurance company for denying the claim. This serves as our primary roadmap for what and where our focus needs to be.

Analyze the Long Term Disability Insurance Company's Claim File or Administrative Record

The insurance company is required to provide upon written request, and free of charge, its entire claim file/administrative

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record. It's typically over a thousand pages long. We review every page, and we always find information there helpful to the case. It consists of all medical and other evidence the insurer gathered earlier in the process through authorizations signed by the claimant, through private investigation, including surveillance video. It also includes the insurance company's own consulting medical, vocational rehabilitation and other expert opinions and reports. The insurance company is required to include all evidence generated in connection with the claim whether or not the insurance company relied upon it to support the denial.

Much more is contained in that record than is mentioned in the insurance company's denial letters. We often find evidence that directly contradicts the insurance company's denial, or a lack of evidence to support a reasons it gave to support a denial.

We have even found evidence that the insurance company's own expert directly contradicted a denial of benefits. In fact, the federal Fifth Circuit Court of Appeals awarded benefits in one client's case, finding that the insurance company **illegally withheld from my client** its own expert's report, which directly contradicted the denial of benefits. This underscores the importance of reading every page of the administrative record. Without reviewing every page of that 1000 plus page record to find the buried report, our client would not have received the benefits she needed and deserved. It also shows the importance of never giving up, as the win came as a reversal of a district court ruling that the insurance company did not have to pay.

We also need to determine what supportive medical or other available evidence we deem important is not in the record,

as well as what evidence we need to contradict the opinions of medical, vocational rehabilitation and other experts the insurance company hired to support its denial. All such additional evidence we can gather must be included as part of our appeal. That way it becomes part of the administrative record which can later be considered by the court if the claim is denied on administrative appeal.

Analyze the Long Term Disability Insurance Policy, Plan and Summary Plan Description

If you don't have these documents, you can request them directly from the insurance company or the ERISA Plan Administrator.

We look at the policy definition of disability. The definition can vary from policy to policy. This definition drives what the claimant must prove to be considered disabled under the policy.

Most policies have variations of two definitions for disability.

Typically, for the first 24 months, a claimant only has to be unable to perform their "own occupation." *The definition of "own occupation" is found in the policy. Usually it will state that the definition is based on how the job is performed in the national economy as defined by the Dictionary of Occupational Titles, not how the claimant actually performs his or her own occupation.*

In most policies, after 24 months, a claimant must prove that he or she cannot perform "any occupation." Usually the definition includes "any occupation" that the claimant can perform based on his or her education, background and skills.

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The "any occupation" standard often also includes a salary percentage requirement. This provision means that the company cannot deny benefits on the basis that the claimant can perform the duties of any job, at any wage. Instead, to support a denial, the insurance company must identify occupations that will pay the claimant usually at least 80 percent (typically) of their pre-disability income.

In many cases, the disability insurance company will pay benefits for the first 24 month "own occupation" period, then terminate benefits under the "any occupation" provision. This triggers the start of the administrative process the same as an initial claim denial.

In many cases, the disability insurance company will pay benefits for the first 24 month "own occupation" period, then terminate benefits under the "any occupation" provision.

We also analyze all other insurance policy language (it differs from company to company and policy to policy), as well as the ERISA Plan itself and the Summary Plan Description. We regularly find helpful contradictions and technical violations in these documents. We also regularly find provisions that contradict the insurance company's stated reasons for denying a claim.

We sometimes find that the insurance company wrongfully denies a claim based on policy language of an older or newer version of the policy that doesn't even apply to your case. Or, we may find that the insurance company is seeking to use an unfavorable policy amendment that doesn't apply to the case to wrongfully deny the claim.

In some cases we find that a provision the insurance company is using to deny a claim is ambiguous, or contradicted by other policy or plan provisions, making the denial legally unenforceable.

The entire insurance policy, ERISA Plan and Summary Plan Description should be read carefully to determine any provisions that undermine the insurance company's claim denial.

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Perform a Client Interview and Gather Other Basic Information

We interview our clients to determine details about medical history and treatment, educational background, former work history, occupational duties at the time of disability and the nature of the disability. This lets us get to know them better and gives us our foundation to build upon. We determine all medical history and explore what family members, coworkers or friends can provide affidavits describing their observations of the claimant's mental or physical manifestations of disability.

We then schedule interviews with those people to prepare the appropriate affidavits. A claimant's affidavit is prepared, describing in detail the nature, intensity, frequency and duration of all pain, physical restrictions and limitations, all mental or physical effects of any prescribed medication, how all of these things affect physical functioning, concentration, memory, the need for breaks or rest, etc. Corroborating

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affidavits are prepared for family members, coworkers or friends noting their observations. The more detail the better.

We get the claimant's official written job description from the employer's human resources department and include in the affidavit the client's comments on whether the job in actual practice is different, and if so, how. If the insurance company claim file contains surveillance, we have the client comment on that as well and include it in the affidavit.

Gather and Analyze Medical Records to See How Well They Support the Claim for Disability and Supplement Where Needed

Medical records are always important in a long term disability claim. We gather, review, study and summarize the relevant medical records, physician reports, diagnostic studies, etc. Here, we look for areas of potential strengths, weaknesses or the absence of evidence needed for claim support. The focus is to determine where we need to build evidence that supports disability as defined in the policy, and addresses the reasons the insurance company gives to support its denial of benefits.

When Physicians write their reports, they are not necessarily attempting to cover all information in the kind of detail needed to support a disability claim. They often rely on computer programs when preparing their notes that simply do not have fields concerning the evidence necessary to support a claim. So the support needed may be weak or

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absent. They often don't state any opinions specifying physical restrictions in enough detail. The insurance companies then cite "lack of evidence" to support the disability. That evidence may in reality exist, but is just not stated in the records in the kind of detail necessary. Insurance companies know this and exploit it. Sometimes the records contain plain errors that hurt the claim. These need correcting.

Whatever the weakness or absence of evidence or error in the medical records might be, we do everything we can to correct it.

Wherever we find weaknesses, the absence of important evidence or errors in the medical records, we correct the problems using a number of different approaches depending on the case at hand.

For instance, we may need to get detailed input from treating Physicians, as well as other medical experts as needed for the particular case. We may need to ask treating Physicians to address certain issues not previously addressed specifically and in detail in a report. We may need to push to have certain medical diagnostic tests run to offer unequivocal proof of the existence of a disabling condition. We may need a physician to address in writing the disabling side effects of prescribed medications not previously addressed. In some cases we may need to retain additional Physicians of various specialties to provide an opinion.

We sometimes meet face-to-face with treating Physicians to determine their opinions on relevant details. We sometimes ask them to write a report addressing whether the claimant's

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affidavit (attached to the report) is consistent with what the physician would expect given the medical condition at hand, or whether any surveillance affects his or her opinion regarding disability. Whatever the weakness or absence of evidence or error in the medical records might be, we do everything we can to correct it.

Decide What Additional Evidence May Be Helpful

At this point, we determine what, if any additional medical or other forms of evidence not forming part of the administrative record might be helpful to support the case. This varies from case to case, but may include a functional capacity evaluation as evidence of the claimant's physical restrictions, further medical diagnostic studies to provide objective evidence of a disabling medical condition, additional affidavits of the claimant, family members or coworkers regarding any important new issues discovered but not addressed in their initial affidavits.

An expert vocational rehabilitation evaluation is sometimes warranted to rebut an insurance company's similar expert's opinion regarding a claimant's ability to perform a certain occupation, or what Dictionary of Occupational Titles occupation best resembles the client's actual job, or what items the insurance company's expert failed to consider.

Conduct Legal Research

We conduct nationwide computer research, combing for judicial opinions factually similar or otherwise supportive of the claim and our legal arguments. We save these so we can later cite to them and quote portions of them to support our

arguments to the insurance company, and later to the court if necessary.

Construct the Best Argument

We then again analyze and dismantle the reasons given by the insurance company for denying the claim. We do this by using everything helpful we find from all of the above efforts, and assemble it into a concise, impactful argument. It's a blended argument of our strongest facts, woven together with our strongest legal arguments, citing supporting court cases found in our research, relevant policy provisions, the administrative record we received from the insurance company and all new evidence we've gathered. The administrative appeal is constructed much like a legal brief filed in court, tailored to follow the same pattern the court will use to analyze the case. The insurance companies will know you have built a solid case for court if they again deny the claim.

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Final Review

Before we submit our administrative appeal argument and supporting evidence to the insurance company (which will ultimately be our argument to the court), we examine our argument again in detail to determine whether it triggers ideas for any additional evidence which may be supportive.

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Submit the Best Argument and Await a Decision

After we feel that we've left no stone unturned, and have crafted our very best arguments in favor of the claim, we submit our administrative appeal, along with all new supporting documentation that was not already part of the original administrative record, to the insurance company.

The insurance company now has 45 days to render a decision, with one 45 day extension which it commonly takes, giving the claimant a written decision with reasons.

If the insurance company reverses its denial, great! Make sure they calculate benefits and any offsets accurately and for the full period of back pay owed.

If it doesn't, your efforts and argument will still be useful in the lawsuit that follows. Be sure to request an updated copy of the administrative record and make sure it includes all of the evidence you submitted. This will help to avoid a later argument in court about the completeness of the administrative record to be considered by the judge.

Concluding Message

Hopefully you've found this guide practical and useful. Any feedback would be much appreciated, and as always, feel free to contact me if you wish to discuss anything about this area of law in general or the specifics of your client's case and ideas for making it as strong as possible.

Email me at price@jpricemcnamara.com or send me a message at jpricemcnamara.com.

I'm always also happy to share federal district court or appellate court forms, pleadings, briefing (we've addressed every issue you can imagine) or thoughts involving the litigation/court phase of ERISA claims as well.

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Disclaimer

This book is not legal advice. I can offer suggestions and identify some common traps and mistakes to avoid, but please do not construe anything in this book to be legal advice about your case, as each case is different. An attorney can give you quality legal advice only when he or she fully understands the facts involved in your case.

Price McNamara Biography

Published Books

- *Finally! Hire the Right Attorney (and Avoid the Wrong Ones) With Confidence!*
- *Seven Deadly Sins That Will Destroy Your Legitimate Personal Injury Claim*
- *How to File a Great ERISA Long Term Disability Administrative Appeal Without Making Common Mistakes That Destroy Good Claims.*

Awards

- Holds Martindale-Hubbell® highest possible attorney peer review rating of "AV" ("Highest Level of Professional Excellence and Ethical Standards. Very High to Preeminent").
- Holds 10/10 AVVO attorney rating.
- Named "Top Attorney for Burn, Brain and Closed Head Injuries" by *New Orleans Magazine*.
- A+ Better Business Bureau Rating.

Memberships

- Louisiana Association for Justice
- American Association for Justice
- North American Brain Injury Society
- National Spinal Cord Injury Association

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Education

1995 Masters Law Degree, LL. M Energy and Environment Tulane Law School, New Orleans, Louisiana.

1990 Law Degree, Loyola Law School, New Orleans, Louisiana.

1987 Bachelor of Arts Degree, School of Business Administration, Finance Concentration (with Honors), Loyola University, New Orleans, Louisiana.

1983 Licensed Single-Engine Land and Sea Plane Pilot, Airtaix School of Aviation, New Orleans, Louisiana.

1982 Graduate, Jesuit High School.

Work History

Law Offices of J Price McNamara, Baton Rouge (Headquarters) and Metairie, Louisiana 1995 to present. Main practice focusing on representing people wrongfully denied long-term disability insurance, life insurance and accidental death insurance benefits, with special focus on ERISA claims and lawsuits.

Jefferson Parish District Attorney's Office, Felony Trial Division Prosecutor, Gretna, Louisiana 1995-1997 Responsible for prosecuting all division felony crimes including drug offenses, child molestation, theft, burglary, robbery, fraud, rape and murder.

Law Office of Hailey, McNamara, Hall, Larmann & Papale, Metairie, Louisiana 1991-1995

Insurance company attorney handling federal and state court defense of insurance companies.

Honorable John M. Shaw, Chief Judge, United States District Court, Western District of Louisiana, Lafayette, Louisiana. 1990-1991. Law Clerk to Federal Judge for civil and criminal dockets.

Court Admissions

Supreme Court for the State of Louisiana, admitted to practice law in all Louisiana State Courts, 1990.

Supreme Court for the State of Texas, admitted to practice law in all Texas State Courts, 2013.

United States District Courts for the Eastern District of Louisiana, 1990.

United States District Courts for the Middle District of Louisiana, 1990.

United States District Courts for the Western District of Louisiana, 1990.

United States District Courts for the Eastern District of Texas, 2013.

United States District Courts for the Middle District of Texas, 2013.

United States District Courts for the Western District of Texas, 2013.

United States District Courts for the Southern District of Texas, 2013.

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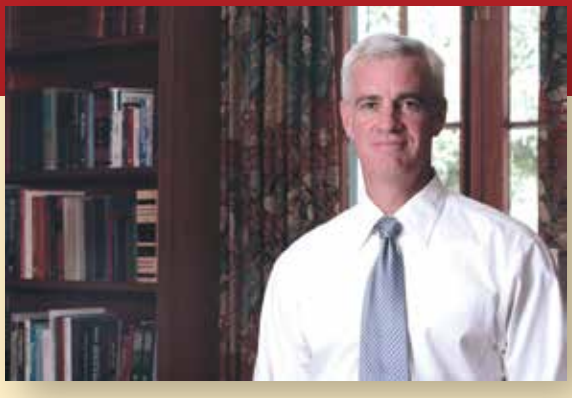
United States District Courts for the Northern District of Texas, 2013.

United States Court of Appeals, Fifth Circuit, 1990.

Bar Admissions

Louisiana State Bar Association—1990 (In good standing)
Texas State Bar Association—2013 (In good standing)



Price McNamara began his law practice in 1991 at a large Louisiana law firm representing insurance companies.

He then stopped representing insurers to serve two years representing the State of Louisiana as a state felony division prosecutor.

In 1995, Mr. McNamara founded McNamara Law Offices. With offices in Louisiana and Texas, he now puts his experience to work representing people across the U.S. who are wrongfully denied long-term disability insurance, life insurance and accidental death insurance benefits, with special focus on ERISA claims and lawsuits.

He is a member of the Louisiana and Texas bars, and lives in Baton Rouge, Louisiana with his wife and their three children.

Finally! This book makes the confusing Administrative Appeal process easy to understand and navigate... I highly recommend it to anyone fighting an insurance denial!

Sara B.

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For more information, go to **jpricemcnamara.com**