ASISA Guidelines to the Management of Impairment Claims On Psychiatric Grounds

Third Edition

2017

ASSOCIATION OF SAVINGS & INVESTMENTS OF SOUTH AFRICA

Issued by the Medical and Underwriting Subcommittee of the Association of Savings and Investments of South Africa (ASISA)

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PREFACE TO THE THIRD EDITION

The need for a standardised approach to the assessment of patients with psychiatric disorders for medical disability was initially addressed in 1995 by a task-team comprising nominated psychiatrists from the South African Society of Psychiatrists and medical advisors of the Life Insurance Industry.

With the advent of time, the resulting Second Edition was drawn up by the participants, distributed widely for comments, and approved by the executive committee of the South African Society of Psychiatrists.

It was felt by the Life Insurance Industry, in light of significant developments in diagnosis, management and therefore outcomes of psychiatric patients, that the Guidelines required updating to include reference to new diagnostic tools and management techniques in order to be as fair as possible to all parties.

INTRODUCTION

Psychiatric causes of disability now comprise the largest proportion of disability claims admitted in the S.A. Insurance Industry.

Among these, mood disorders, anxiety and post-traumatic stress disorders are leading the diagnosis list. Work-related stress is invariably cited as a major contributing factor.

Psychiatrists are being put under increasing pressure to declare a patient disabled on psychiatric grounds. However, lack of a standard approach to dealing with these patients has led to frustration among treating professionals and the insurance industry. MUSC and a SASOP taskteam have compiled these peer-reviewed guideline, to aid the assessment and reporting on psychiatric disability.

The assessment of disability has become increasingly difficult due to:

- Inconsistencies in diagnosis, management and prognosis between medical professionals.
- Lack of objectivity in reports.
- Informing the patient they have a permanent condition before allowing sufficient time for the treatment plan to work.
- Inadequate treatment in terms of:
    - Dosages of medication either inappropriately low, excessive or mix of medications making it impossible for a patient to work.
    - Duration of any treatment modality whether medication or other.
    - Appropriateness of the treatment modalities applied (i.e. evidence-based best treatment approach).
    - Lack of referral to rehabilitation specialists (e.g. psychologists, occupational therapists.
    - Lack of return to work and vocational rehabilitation programs.
- Using work-related or psychosocial conditions as a reason for disability, when the claimant could function in another occupational environment.
- Affording extended time off work without adequate reason for doing so.

PURPOSE OF THIS DOCUMENT

The primary aim of all insurers is pay all valid claims, however this is becoming increasingly difficult for the reasons listed above. Psychiatric conditions by their nature can lend themselves to symptom-exaggeration by the claimant or sympathy by the treating psychiatrist. Therefore the aim of this document is to assist in identifying those people who should be paid their benefit for the right reasons.

This guideline will assist the understanding by the psychiatric community, as to what is expected from a psychiatric assessment and report and why the information is necessary:

- To standardise the psychiatric evaluation and report for a disability assessment, by providing a list of the minimum psychiatric information requirements necessary for a third party to make an informed decision on disability.

- To provide a guideline for insurance companies that allows for the application of a consistent approach to disability claims assessment on psychiatric grounds based on standardised reporting by treating and independent professionals.

- To assist psychiatrists in understanding the importance of assessing only the impact of the disorder on occupational and social functioning.

- Ultimately to:

    - Relieve pressure on the treating psychiatrist / patient relationship

    - Prevent patients from being labelled prematurely as disabled

    - Ensure that all parties are aware that insurance claims are dealt with according to the principles of Treating Customers Fairly.

    - Provide an opportunity for re-entry into the workplace; even after a period of prolonged disability, considering the negative impact of not working vs. the benefits of working.

ETHICAL GUIDELINES FOR THE INSURANCE INDUSTRY AND EMPLOYERS AND THE PRINCIPLES OF TREATING CUSTOMERS FAIRLY

In the South African Insurance Industry, which includes both private insurance policies and employee benefit schemes, on average 30% of all disability claims are due to psychiatric conditions. The extent of the problem necessitates a better understanding of psychiatric conditions by the uninformed, in order to ensure fair and equitable handling of these clients with the necessary dignity.

The business of insurance carriers is to insure uncertainty using evidence-based scientific measurement criteria. The aim is to pay all legitimate claims as speedily and expeditiously as possible. The basic ethical guidelines and principles governing this are in accordance with the principles of Treating Customers Fairly (TCF), which are:

- Transparency
- Equity
- Fairness
- Consistency
- Objectivity

Patients suffering from mental illness should be treated with the same respect and dignity as those with a medical condition. These diagnoses carry the risks of morbidity and mortality as does many serious medical conditions. Psychiatric conditions should not be treated differently from any other medical condition in terms of policy benefits design, underwriting practices, claims protocols and other insurance practices.

Confidentiality of the contents of psychiatric reports are of paramount importance. Both employers and insurance carriers must take every precaution to safeguard this confidentiality. In addition, the source/author of any psychiatric report should be protected as far as possible.Psychiatric reports may only be disclosed to any third party with the consent of the client.

When second objective psychiatric opinions are sought, the client should clearly be informed that this is not because his treating psychiatrist is not being regarded as an expert, but because it is in practice impossible to divorce the two roles of therapist and objective adjudicator. Therefore, a second,

independent opinion is necessary in conditions where the symptomatology and impairment are of a subjective nature. This practice is in accordance with international practice.

Clients will benefit from sound advice and financial planning by a qualified financial advisor, prior to starting a process of boarding or medical incapacitation. Many patients have been disillusioned by the limited buying power of a lump sum payout, which ultimately contributes to the worsening of their psychiatric condition through financial despair.

Insurance Carriers specifically:

- The benefits, limitations and exclusions of all risk products sold to clients should be explained in clear and understandable terms prior to them accepting the contract. Transparency should be practised pro-actively, not reactively. Particular attention should be given to people insured through group policies.
- In dealing with disability claims, communication with the claimant can solve many misperceptions. Clear and precise reasons for declining or postponing claims should be given in laymen terms.
- When it is proven that sales intermediaries have misrepresented products at sales stages, appropriate remedial and punitive measures should be taken by the insurer involved.

Employer specifically

- Vigorous attempts should be made to reasonable accommodate the employee with psychiatric impairment within the workplace, prior to ddeclaring a person mediclly incapacitated. This may imply reasonable alternative placement or adjustment of job requirements or working hours to assist the employee in remaining at work.
- Sickleave, or temporary part-time work, should be made available to encourage employees to comply with psychotherapy programmes, psychiatric rehabilitation protocols etc. This will ensure better outcomes of treatment regimes and a higher return to the work place.
- It is unethical for an employer to counsel and encourage employees regarding increased benefits for a disability claim as compared to a retrenchment package. Employees are often disillusioned in this way when a disability claim is unsuccessful.
- Employees should discuss the benefits of their policies and the financial implications of such a decision as well as the work implications with their employers, brokers and/or insurance company prior to requesting their doctor, clinical psychologist or psychiatrist to start the process.

DEFINING IMPAIRMENT AND DISABILITY

It is vitally important in the context of insurance disability claims to distinguish between the concepts of impairment and disability.

Disability is the alteration of capability to meet personal, social or occupational demands due to impairment and is assessed by non-medical means.

Impairment is the alteration of normal functional capacity due to a disease, and is assessed by medical means after a diagnosis has been established, and appropriate and optimal treatment applied.

In practical terms, therefore, **impairment** assessment entails examining the diagnosis and current and future treatment options before determining on medical grounds which functions the person is still able to do and which not. Occupational therapists are the well positioned to assess functional impairment in mentally ill patients through functional capacity assessments and hence play an important role prior to taking a final decision regarding extent of impairment.

To assess **disability** on the other hand entails assessing the extent of the person's impairment needs in conjunction with their job description, **policy disability clause conditions** and personal factors such as education and experience. To assess disability means determining the extent to which the client's impairment affects the ability to execute personal, social or occupational activities in the context of the definition in the contract. In the context of disability Insurance, activities most often relate to the occupational duties performed by the client prior to the impairment.

By understanding the difference between impairment and disability, it should be clear why a doctor or other health practitioner can only express an opinion regarding functional impairment, and not disability. From the above, it is clear that the general practitioner or psychiatrist treating the patient is *usually* in no position to express an opinion on disability as the **policy disability clause conditions** are a vital part of the assessment.

Psychiatry, like most medical specialities, is not an exact science. However especially in psychiatry one often finds different opinions regarding diagnosis and treatment approach for the same impairment. This will inevitably lead to different opinions regarding disability.

The evidence from the treating psychiatrist is part of the assessment but might not be sufficient to make a decision regarding disability.

An independent psychiatrist will be asked to review the case and give an objective opinion on the **impairment and treatment**. The name of an independent psychiatrist will be provided for an assessment. He/she will be provided with the necessary consent and all relevant documents and information relating to the claimant's personal details and medical and psychiatric reports.

The role of the treating psychiatrist

The role of the treating psychiatrist is to diagnose, treat and manage the condition, and thereby manage any impairment.

Although the treating psychiatrist may be fully informed and provide expert information on the medical condition, especially important is understanding and reporting the following:

- The patient's working history, previous occupations, qualifications, and experience
- The relevant job description and
- Current or recent occupational functioning.

It is therefore important that the treating psychiatrist:

- Supplies the Insurer with detailed medical information related to the history and clinical condition as above.
- Expresses an opinion only on functional impairment due to the disease. This opinion should be made with the input from a formal functional capacity assessment that has been done by an occupational therapist.
- Informs the patient that the disability decision is made by a panel of experts appointed by the Insurer, and refers to the ability to perform occupational duties or activities of daily living specifically.
- Does not provide an opinion on the current level of perceived disability to the patient. This is particularly important where long term sick leave is being granted.

By doing this the following goals will be achieved by all parties:

- The therapeutic relationship is not jeopardised through the involvement of the treating Psychiatrist in the disability decision-making process.

- The pressure is therefore taken off the treating doctor by moving the disability decision-making to the insurer.

- The patient will not be assumed as being disabled by either himself or the treating psychiatrist prematurely.

- It is important to understand that this approach not only applies to psychiatric conditions, but also to any other condition that may lead to disability.

The role of the independent psychiatrists

These are independent psychiatrists who have an interest in disability claim work and assessment of psychiatric impairment and who can provide sufficiently detailed independent reports for an insurer to assist them in making appropriate decisions regarding disability. They are familiar with insurance terminology and requirements for accurate reporting. They have no affiliations with the insurance Industry and therefore provide objective external opinions.

The independent psychiatrist will follow the guidelines as set out for the primary treating psychiatrist, in compiling a full clinical report. It may also be necessary for this independent psychiatrist to liaise with the treating psychiatrist to obtain additional information if required. There may also be discussion with the medical advisor of the insurance company.

At all times there should be an open line for discussion between the medical advisors and the independent psychiatrists, and in some of the more difficult cases a third opinion may even be sought.

The role of the occupational therapists and psychologists are of great value in assisting making a final decision. However it must be emphasized that no one party's input is of greater value than another and all the information received is used in context.

Importance of not prematurely recommending disability

It is harmful to a client to prematurely label him/her as disabled. From an insurance perspective this is important as all treatment options and avenues must have been pursued before this label can be applied by a treating practitioner.

- When an applicant has been informed by their doctor that they qualify for a disability benefit, it may result in a mind-set that may be to the detriment of the future well-being of the applicant.

This may then be very difficult to change, which will likely hinder the outcome of any attempts at rehabilitation or return to work.

- The outcome of psychiatric treatment has been proven to be better where a patient has the view that return to work is the expected outcome, or that the patient remains employed where possible.

- An applicant must be given the opportunity to be rehabilitated back into gainful employment before the label of disability is applied.

- A person in receipt of disability benefits is often unable to obtain further disability cover or life insurance.

- A person who has been labelled as “disabled” will find it difficult to gain future employment.

- People in receipt of disability benefits may find that they suffer from further psychosocial issues such as financial difficulties and marital problems due to not working

- People in receipt of benefits may increasingly succumb to poor lifestyle habits such as increased smoking, poor eating habits and consequent weight gain.

ASSESSING DISABILITY

Equality Act

The Equality Act of 2001 prohibits any person from unfairly discriminating against another person on one or more of the grounds in terms of subsection (3). These include, inter alia, gender, age, race, religion, disability and others. Furthermore, alleged discrimination will be deemed as unfair unless the Respondent proves it to be fair.

In the area of disability evaluation, this act in practice will imply the following :

- That all guidelines and criteria for disability assessment are evidence-based.
- That claims assessment is done fairly, objectively and consistently.
- That each individual claim is assessed on its own merit, and that no diagnosis will be handled with a broad-brush approach.

Fundamental principles

1) In all instances, the onus is firstly on the client to prove their claim for disability to the Insurer. Therefore, the conditions defined in the policy document regarding the terms of the contract, the requirements for the claim to be assessed and other parameters are vital to understanding the claims process. Sufficient evidence must be provided by the client for the insurer to make a fair assessment.
2) All disability claims on psychiatric grounds will only be considered following diagnosis and adequate treatment by a psychiatrist. The client must also be actively participating in and compliant with a prescribed treatment plan.
3) Disability assessment is a **legal** and **not** a medical decision and is based on the terms of the contract that the client enters into with the Insurer. Typically, such a contract will consider, include or refer to the following:
    - The existence of a diagnosed medical condition.
    - The deferred or waiting period. (The Deferred Period is the period that has to elapse during which the Life Insured is continuously unable to perform his/her duties and a claim can only be considered thereafter.)
    - The definition of Occupational Disability which may differ between Insurers.

- Any applicable limitations and / or exclusions applicable to that policy or contract. This may have been applied individually at underwriting stage to the contract or be a standard exclusion. The policyholder should be aware of this benefit limitation or exclusion clause from their policy document.

Practice applied by the Life Insurer

At any insurer, a disability claim is assessed by evaluating the following four criteria:

i. Specific claimant particulars

ii. Job description or occupational duties performed by the claimant prior to the onset of the illness

iii. Disability clause conditions contained in the contract

iv. Medical condition and reasonable medical treatment.

1) Claimant particulars

Factors that may be considered include:

- Age
- Experience, level of education and qualifications
- Previous earnings / income
- Previous occupations.

2) Job description

The occupation for which the claimant is covered by insurance will be specified in the contract. This may be for specific or non-specific occupations. It is important that the claimant is aware of this occupation when they claim to ensure they are eligible to claim for that condition. If in doubt their financial advisor or insurer would be able to assist.

3) Disability clause conditions

Precise disability clause wordings differ from insurer to insurer, but generally the following types of disability cover are offered:

(a) According to type of work

(ai) Own occupation

A claim is considered when a claimant cannot do their own specifically named occupation as per the contract. This is a more expensive type of disability cover and is usually sold to professional clients or people with specific occupations. In these cases the exact job description is evaluated in terms of the medical impairment.

(aii) Own / similar occupation

A claim is considered when a claimant is unfit to do their own specific occupation, but could perform an alternative occupation which may be reasonably expected of them to follow, taking into account their education, training and experience.

In practice these are the claims which most often lead to misunderstanding and unhappiness. Claimants can be found unfit for their specific occupation, but the insurer, although agreeing on that aspect, declines the claim in terms of the clause conditions whereby the claimant may still be able to do an **alternative** occupation.

(aiii) Any occupation

This is an inexpensive type of disability cover with a very wide policy definition, and therefore the degree of disability has to be very high to qualify for a claim.

Here qualifications, experience, income, etc. are irrelevant, and the claimant literally has to be unable to do **any** work, i.e. even being unable to perform simple tasks like access control to buildings / venues, selling tickets, etc.

(b) According to type of disability

(bi) **Total and permanent disability**

Here the disease has to be optimally treated and still have resultant impairment to such a degree that the person is **totally** and **permanently** unfit to work. It means that the impairment must be **irreversible** and must prohibit the person's ability to work **continuously;** diseases which are treatable and episodic in nature therefore do not qualify as causes for disability in this category. The patient must have reached a stage of maximal medical improvement of their condition, having allowed sufficient time on an accepted treatment protocol to allow for this. Maximal medical improvement is reached when no further improvement is expected over the next 12 months

(bii) **Temporary disability**

In this category a monthly income is provided temporarily, and periodic medical review is required to determine sustained disability. Temporary disability due to treatable or episodic disorders (e.g. depressive episode) may qualify for a claim provided the other parameters of disability assessment are met.

4) **Medical condition and reasonable medical treatment.**

a) Work Stress and psychiatric diagnoses.

Work stress is not considered a psychiatric diagnosis on its own. Should a claimant present with this as the major reason for claim, they would be advised of alternative work opportunities, work grading, work rehabilitation and other measures before being considered disabled.

Should this be a precipitating factor contributing to a psychiatric diagnosis, then it is expected that the treating practitioner will have a plan to assist the claimant to manage either the stress or the work situation.

b) Availability of employment

The unavailability of alternative employment does **not** constitute disability. An employer may use this as a reason for 'medical boarding' or declaring a person 'medically incapacitated', e.g. where a patient may be unfit to continue in the specific stressful

environment and less stressful alternative work with is not available. In these circumstances, the onus is on the claimant to find alternative employment or adjust with stress management as this is not classified as disablement. With respect to disability assessment, the lack of availability of another job within the company or in the open labour market is irrelevant in terms of the policy contract. The policy insures one's ability to earn an income by working, not the availability of work.

c) **Reasonable medical treatment** is defined as that which a patient has been advised to undergo or it would be reasonable to expect the patient to undergo in order to improve the condition. Refusal to undergo reasonable treatment means the claimant cannot be assessed for maximal improvement and therefore the permanence of the condition is uncertain. Temporary disability benefits might still be assessed but participation in a claim management protocol or rehabilitation process may be implemented to assist the recovery process. It is understood that the duration of impairment for different diagnoses may vary but permanence of the impairment can only be assumed after all reasonable treatment avenues have been pursued.

d) The medical condition will be assessed by the insurer according to the information as described above. It is therefore important to supply **as much psychiatric information as possible** in order for the insurer to assess the claim correctly. It is vital that the psychiatrist informs the claimant that the final decision on disability lies with the insurance company and not with the treating doctor.

Being declared medically boarded or medically incapacitated to continue working by an employer or permanently disabled by one insurance company does not imply that all the patient's disability policies will be paid out. This is due to the differing terms of the contracts between the insurers covering these scenarios.

The onus is not on the treating psychiatrist to interpret the details of the insurance contract. In case of uncertainty on the side of the patient, he/she should be advised to obtain full details from the insurance company or an accredited independent financial advisor.

PRACTICAL APPROACH TO CLAIMS

The accompanying flow diagram at the end of this section acts as a summary of a practical approach which should be followed by psychiatrists and insurance companies in order to:

- Ensure objective reports to provide sufficient detailed information for the claimant to prove their claim.
- Make a fair decision assuming sufficient information has been received
- Be consistent in the approach to psychiatric claim applications.

First line evidence (to be provided by the claimant):

- Completed, insurer specific claim form
- Information regarding qualifications and occupational history.
- Vocational analysis including the following:
    - Job description with details regarding the duties performed by the client on a daily basis.
    - Work environment and circumstances in which duties are performed.
    - Productivity reports and other collateral information by the employer.
    - Annual and sick leave records.
- Detailed medical evidence supplied by the treating Psychiatrist

Second line evidence <u>may</u> include any of the following (<u>to be obtained by the insurer if indicated</u>):

- Additional information or clarification of existing information provided by the treating psychiatrist as referred to in the point above.
- Assessment and/ or review by an Independent Psychiatrist and/ or other health professionals.
- Functional Capacity Evaluation by an Occupational Therapist
- Any further information or clarification of existing information that may be deemed necessary such as worksite visit.

Assessment process

Refer to the flow diagram of the process.

- The assessment process is a dynamic and interactive one that requires analysis of data from various sources which includes many role players and stakeholders. The claim may be assessed by a Medical advisor, a Legal advisor as well as the Claims assessor.

The final outcome of the assessment process in the event of a valid claim may be any one of the following:

- In the case of a lump sum benefit, a once-off payment.
- In the case of an income replacement benefit (regular benefit payments), review and management on an on-going basis.

The purpose of these reviews is as follows:

- Determination of the on-going validity of the benefit
- Implementation and monitoring of active case management strategies.
- Case management is aimed at achieving return to work.
- Case Management strategies may involve the treating psychiatrist and psychologist.
- Treatment programs may include both pharmacological and supportive therapies.
- Compliance is monitored closely.
- Return to work can be either in full capacity or in a graded fashion with job accommodation in consultation with employer, partners or other relevant stakeholders

Who pays for the clinical reports?

The initial onus to prove disability lies with the claimant. Therefore the claimant should be liable for the accounts of all first line evidence as above.

The insurance company will be liable for second line evidence as above.

In practical terms this means that the claimant pays the general practitioner, psychologist or psychiatrist for the initial medical documentation, and the insurance companies may pay for further documentation.

Tariff structure

The fee for Psychiatrists dealing with disability claims will be negotiated with each individual insurance company.

Compensation for Occupational Injuries and Diseases Act 130 of 1993

Disability assessment by the Compensation Commissioner is conducted according to the rules and regulations of the Compensation for Occupational Injuries and Diseases Act (COIDA) and these are different from the criteria applied by pension funds and the insurance industry in general.

Thus, medical boarding, even on the grounds of a condition such as Post Traumatic Stress Disorder, does not necessarily imply that the patient is entitled to additional awards under COIDA or vice versa.

Doctors advising patients thus on medical disability should first consult the law and the regulations on the specific procedures to follow as these can be different to other claims. The regulations attached to this law are amended from time to time.

FLOW DIAGRAM