Guidelines on Assessing Disability due to Cardiac Disease

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1. INTRODUCTION

1.1 Incidence and cost of disability due to cardiac disease

Over the past 3 years, cardiac diseases have accounted for between 16.9% and 18.9% of disability claims admitted in the insurance industry.

This not only contributed vast sums of money, but also contributed to the loss of skilled manpower to our economy.

1.2 Non-medical reasons for high claims incidence

It is clear that disability due to cardiac disease:

- is an important cause of disability worldwide;
- is increasing annually in terms of days off work, number of claims and monetary values of claim payouts, and
- is shifting to younger age groups as a cause of disability.

A number of non-medical reasons contribute to the above observations:

1.2.1 Employer anti-selection

For various economic reasons, employers often need to reduce staff volumes. If a disability claim is lodged, it will in most instances lead to:

- an image of a more sympathetic approach by the employer than would dismissal, and
- a better financial settlement for the employee than a retrenchment package.

In the group insurance business this often leads to employers encouraging disability applications in workers who, despite having a medical history, are still perfectly capable of working productively.

1.2.2 Lack of objectivity of medical reports

Clinical reports submitted to insurance companies for disability assessment very seldom contain any objective opinions or findings, and at most only convey the symptoms complex as described by the patient.

Unfortunately, this lack of objectivity leads to:

- unwarranted extended periods of absenteeism, and
- premature labelling of patients as permanently disabled.

This should be addressed by:

- obtaining independent opinions from specialists not involved in the treatment of the patient;
- requesting private specialists to assess and judge functional impairment only, and not disability, as discussed in more detail in Section 3; and
- a co-ordinated effort to find objective tools to quantify functional impairment.

1.2.3 Generous disability benefits

In South Africa this problem is compounded by lump sum disability payments, which act as an extra incentive for claimants to exaggerate illness behaviour and at the same time contribute to higher false rates of conservative treatment regimens.

The level of total insurance benefits, the viability of lump sum disability payments, and the possible downsizing of benefits payable in the case of subjective medical conditions should be critically reviewed by the insurance industry and the Compensation Commissioners.

1.2.4 Unfavourable workplace conditions

Unemployment has already been identified as being associated with job dissatisfaction, unpleasant work conditions or repetitive or menial job tasks, and this has been reported in the literature.

Recent legislation to force employers to accommodate patients with functional impairment, by facilitating reasonable adjustments of their working conditions as a compulsory measure prior to retiring them as medically unfit for employment, should be applied more vigorously by employers.

1.2.5 Poor claims investigations

Owing to market-related pressures, shortages of manpower and the costs involved, many insurance companies admit disability claims before proper claim investigations have been done. These include:

- obtaining second objective specialist opinions
- liaison with employers, and
- requesting video surveillance by private investigators in doubtful cases.

From the above it is clear that we are in dire need of a standardized approach for both the insurance industry and the medical profession, to obtain more objective assessments of the degree and prognosis of cardiac disease.

2. DRAFTING THE GUIDELINES

The high prevalence of ischaemic heart disease in South Africa has always necessitated a high level of co-operation and understanding between cardiologists and the insurance industry.

Effort ECGs are regularly being called for by insurance companies for both medical reasons, i.e. for medical or policy history purposes, and their requirements, i.e. when certain age and insured amount limits are exceeded.

However, over the past few years both private and academic cardiologists and the insurance industry have identified areas of concern where differences of opinion between the clinician and the insurance medical advisor have left a frustrated patient and client in the middle. These issues concerned both underwriting and claims assessment aspects.
3. IMPAIRMENT V. DISABILITY

It is vitally important for any doctor involved with a disability claim to distinguish between the concepts of impairment and disability.

It is harmful to the patient and to the economy of the country to label someone prematurely, and often on the basis of incorrect or insufficient information, as disabled. In most cases in which an applicant has been informed by his general practitioner or treating cardiologist that in their opinion he qualifies for a disability grant, these decisions will very seldom be reversed without great difficulty.

3.1 Impairment

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.

3.2 Disability

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

In practical terms, therefore, impairment assessment entails making a diagnosis and then determining on medical grounds which functions the person is still able to do and which he or she is not.

To assess disability, on the other hand, the extent of the person's impairment has to be judged in the context of the job description, the policy disability clause conditions, and personal factors such as education, experience, etc. (These matters will be discussed fully in section 4.)

From the above, it is clear that the general practitioner or cardiologist treating the patient is in no position to express an opinion on disability. Although he is fully informed on the medical condition, he does not have information on:

- the patient's working history, previous occupations, qualifications and experience
- the relevant job description applicable, and
- the policy conditions.

It is therefore important that the doctor involved:

- only supplies the insurer/employer with detailed medical information
- expresses his opinion only on functional impairment due to the disease, and
- informs the patient that the disability decision is not made by him, but by a panel of experts of the employers/insurers.

By doing this, we will achieve two important goals:

- the pressure will be taken off the treating doctor by...
moving the disability decision making to the insurer, and
- the patient will not be prematurely labelled as disabled, only to find out at a later stage that the application had been unsuccessful owing to other factors, e.g. policy clause conditions that were not met.

3.3 The Labour Relations Act, 1995

According to our new Labour Relations Act, an employer may not dismiss an employee on the grounds of ill health unless he adheres to the ‘Code of Good Practice’ as detailed in Schedule 8 of the Act.

According to this code, a dismissal may be deemed unfair if the following steps were not followed by the employer:
- A proper objective assessment of the employee’s incapacity and his ability/ability to perform his work.
- If the employee is not capable:
  (a) the extent to which he/she is still able to perform the work,
  (b) the extent to which the employee’s work conditions may be adapted to accommodate his functional impairment, or
  (c) failing the above, the availability of any suitable alternative work.
- In certain kinds of incapacity, counselling and rehabilitation should be considered by the employer. If an employer did not follow the above code of good conduct, he could be charged with unfair labour practice by the employer.

In practical terms, this means that the treating doctor and insurance company can demand a written statement from the employer, clearly outlining the steps taken by the employer to adapt the work conditions and/or job description to accommodate the impaired employee, as well as reasons for the failure thereof, before final boarding is recommended.

4. ASSESSING DISABILITY

**Disability is the alteration of capability to meet personal social or vocational demands arising from an impairment.**

Disability assessment is a legal and not a medical decision, taken by a panel of experts including a
- medical doctor
- legal advisor, and
- claims consultant.

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

4.1 Claimant
- gender and age
- experience and qualifications
- income, and
- previous occupations.

4.2 Job description

Generally, occupations can be classified into the following categories:
- manual
- operative
- clerical
- supervisor in clerical field
- technical
- supervisor in technical field
- managerial
- specialised, and
- mixed.

In the case of a disability claim on cardiac grounds, the percentage of time spent supervising, sitting down, standing or doing manual labour should be specified by the employer.

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4.3 Disability clause conditions

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

4.3.1 According to type of work

4.3.1.1 Own occupation

A claim is considered when a claimant cannot do his own specific job, done immediately before disability. This is a more expensive type of disability cover and is usually sold to professional people. In these cases the exact job description of each claimant is evaluated in terms of his or her medical impairment.

4.3.1.2 Own/similar occupation

A claim is considered when a claimant is unfit to do his or her own occupation, and will also not be fit to perform a similar occupation which he or she may reasonably be expected to follow, taking into account education, training and experience.

In practice these are the claims which lead most to misunderstanding and unhappiness. Usually the doctor declares the claimant unfit for the job he or she is currently doing, but the insurer, although agreeing on that point, has to decline the claim in terms of the clause conditions, whereby the claimant may still be able to do an alternative occupation.

4.3.1.3 Any occupation

This is a cheap type of disability cover with a very wide policy definition, and 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 simple tasks like access control to buildings/venues, selling tickets, etc.

4.3.2 According to duration of disability

4.3.2.1 Total and permanent disability

Here the disease has to be optimally treated and still result in impairment to such a degree that the person is totally and permanently unfit to work. The impairment must be irreversible and must permanently prevent the patient from working; diseases that are treatable (e.g. hypertension) or periodic in nature (e.g. epilepsy) therefore do not qualify as causes for disability in this category.

4.3.2.2 Partial disability

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

Two other concepts need to be discussed in this context:

- the unavailability of alternative employment posts, and
- the criteria to which a claimant can be expected to undergo treatment and/or surgery for a medical condition by his employer or the insurer.

4.4 Availability of employment

It is important to realise that disability insurance only insures the ability to work, and not the availability of alternative employment or the ability to continue to work. The employer very often uses the latter as a reason for medical boarding, e.g. where a patient may be unfit to continue with his or her physical work and an alternative sedentary position is not available.

With respect to disability assessment, however, the availability of another job within the company or in the open labour market, is irrelevant in terms of the policy contract.

4.5 Reasonable medical treatment

The extent to which an employer or insurer can insist that the claimant must undergo certain medical treatment or surgical procedures mainly depends on:

- the risk attached to such treatment
- the degree of success which can be guaranteed by undergoing such treatment, and
- what the average reasonable patient with a similar condition would be prepared to undergo.

4.6 Medical condition

The medical condition will be assessed by the medical advisor according to the information as described in section 5.4. It is therefore important to supply as much medical information as possible in order to be able to make an informed decision.

5. ASSESSING CARDIAC FUNCTIONAL IMPAIRMENT: A PRACTICAL GUIDELINE FOR THE CLINICIAN

Having accepted the fact that functional impairment and disability are two distinct entities (Section 4), it is clear that the medical doctor should rely on a thorough and objective evaluation of the patient’s limitation in function, and refrains from expressing an opinion on disability.

This evaluation should include:

5.1 A complete systematic cardiological examination of the patient. Other systemic conditions which may contribute to the patient’s current cardiac limitations, should be determined and mentioned in the final report.

5.2 Certain routine special investigations needed, as well as additional special investigations as indicated by specified criteria. More details are described below.

5.3 Categorisation of functional impairment according to guidelines and parameters provided.
5.1 Complete cardiological examination

The aim of this document is not to teach clinicians clinical medicine, as we know that all specialists are well able to do a thorough clinical examination.

It is important to document any abnormal findings during the assessment, which should include:

- a comprehensive clinical history, and
- a systematic clinical examination, with the emphasis on the cardiovascular system.

Careful consideration should be given to the correlation between symptoms and pathology identified, and any discrepancies should be elaborated upon in the final report.

If the cardiologist finds any indication for an evaluation by a psychologist/psychiatrist and/or occupational therapist, this should be recommended in the report for the relevant company to arrange.

5.2 Special investigations

When a patient presents for assessment of cardiac impairment for the first time, it is important to realise that the onus, and therefore the responsibility for the costs involved, is on the claimant to prove significant permanent impairment, after a proper clinical diagnosis has been established and fair and proper treatment instated.

Therefore, when an insurance company refers the patient for a second objective opinion, the basic special investigations to quantify functional impairment should already have been done, and made available to the examining network doctor.

The forum delegates agreed that the following investigations should be available for all cardiological evaluations:

- chest X-ray
- Bruce protocol (or similar) effort ECG, and
- 2D echocardiogram.

The insurance company involved should therefore ensure that the network doctor is supplied with the results of the above investigations, failing which the cardiologist may obtain these without prior permission from the insurance company.

Any additional investigations that may be indicated should be authorised by the insurance company involved.

5.2.1 Lung function

Lung function tests are indicated when there is normal cardiac function (i.e. left ventricular ejection fraction (LVEF) > 45%) in the presence of severe symptoms of functional impairment (e.g. New York Heart Association NYHA grade II or III). They are also indicated in the patient with a low-voltage ECG with right axis deviation. Metacholine challenge should be included if the patient or family has a history of atopy or asthma.

5.2.2 Doppler studies

Valvular heart disease is common in South Africa. While its quantification has improved dramatically as echo and diagnostically techniques have become more refined, little information is available on the insurance aspects of this condition. These patients may be physically impaired not just due to the primary valvular involvement, but also due to pulmonary hypertension or arrhythmias.

For insurance purposes valve areas of > 1.2 cm2 in the aortic position and 1.5 cm2 in the mitral position are generally regarded as mild. However, the degree of regurgitation is frequently as important a factor in determining functional capacity, and should be assessed equally carefully.

Doppler assessment is indicated in all cases where impairment due to valvular heart disease is suspected, with measurement of diastolic flow patterns and pulmonary pressure.

5.2.3 Effort ECG

The end-point of any exercise regimen when doing an effort ECG is based on the patient’s subjective clinical symptoms (tiredness, palpitations, shortness of breath, tired legs). This could lead to deceptively low target workloads (metabolic equivalents (METs), Bruce stage) achieved, especially if there is a substantial financial incentive for being declared disabled.

It is therefore vital that the cardiologist records blood pressure and pulse rate responses at each stage of the exercise protocol in order to verify patient cooperation and motivation.

5.3 Categorisation of functional impairment parameters

Different degrees of impairment will produce different levels of disability, which should be assessed within the framework of the patient’s job description and the disability clause specifications.

Sections 4.2 and 4.3 deal with the classification of jobs and different types of disability clauses.

In this section we have attempted to quantify impairment, categorise it and link it to the level of physical effort required in a specific occupation.

5.3.1 Assessment of functional impairment

Quantification of functional impairment is fraught with apparent discrepancies. Frequently the physician’s assessment of functional capacity or a patient’s ability to perform his duties is not in line with what the body of objective data from invasive and non-invasive tests performed, such as the LVEF, wedge pressure or echo mea-
measurements, would suggest. This makes objective assessment of the patient's right to claim disability extremely difficult.

If, for instance, the claim is genuine and founded upon the fact that the claimant truly finds it impossible to perform his or her duties, even after a maximal effort to return to work, it is surely fair to grant it promptly. However, if the claim reflects underlying depression or a perceived inability to return to work stemming from emotional inability to come to grips with the disease, a caution is indicated. The prospects of a comfortable early retirement or being able to start a new career are clearly not grounds for granting disability. In this case, the outcome of a set of guidelines for disability should be to address the underlying misconception and to encourage the claimant to return to a productive life. The reality is that few patients who do receive disability are emotionally stable and well adapted after a number of years.

The questions we need to address are whether the functional assessment is fair both to the claimant, who indeed has a right to compensation if his or her quality of life is severely impaired, and to the company, which needs to restrict such payments to those who are truly in need of them.

There are three grounds that could be considered for disability:

5.3.1.1 Objective severe impairment of cardiac function:
- impaired LV EF as assessed by 2-D echo, MUGA or angiography
- impaired functional capacity, i.e. high NYHA functional class
- disabling (life-threatening) arrhythmias, and
- refractory angina in patients not amenable to corrective procedures.

5.3.1.2 Non-suitability for current work (client-work mismatch):
- insomia, depression, e.g. traffic controller, air traffic controller, bus or taxi driver, machine operator, etc.
- physically demanding profession, e.g. artisan, and
- emotionally demanding profession, e.g. actor, teacher.

5.3.1.3 Increased mortality:
- widespread atherosclerotic disease, i.e. multiple myocardial infarctions in the presence of peripheral vascular disease, bruits or claudication
- repetitive life-threatening arrhythmias, e.g. recurrent ventricular tachycardia or syncope due to arrhythmias that cannot be corrected
- end-stage valvular disease, and
- cor pulmonale or irreversable pulmonary hypertension.

Cardiac evaluation

The following parameters of risk assessment have been found to identify patients at high risk:

- **LV EF** is the widely accepted single indicator of future cardiac prognosis. There does not seem to be a magic cut-off point (e.g. 35%), but there is a progression as the LV EF decreases. LV end-diastolic volume (or volume index) is an additional factor that may be considered, but is less sensitive.

- **NYHA functional class**. This is a widely used assessment, it is an additional and independent predictor of mortality and prognosis. However, it depends on the patient's perception and therefore tends to be subjective.

- **Stress exercise capacity**: This does not give much additional data, but it is a better predictor of mortality than NYHA class. The two measurements used are an exercise duration in excess of 4 minutes, and a pulse rate increase of > 30 beats per minute.

- **Exercise capacity**: The ability to perform in excess of 10 METS confers an excellent risk in any population group (once stage 1 = 3 METS, stage II = 10 METS). Exercise capacity may also be expressed as maximal oxygen uptake (VO2), but these evaluations are not easily available and are therefore unlikely to find wide application.

- **Pulmonary congestion**: X-rays are readily available and give valuable information. The predictive value is enhanced if the findings are graded as follows:
  0 = no pulmonary congestion
  1 = congestion of the upper lobes
  2 = interstitial oedema (retropleural), perivascular or subpleural.
  3 = alveolar oedema.

- **Biochemical evaluation**. Raised urea and creatinine values and a sodium level below 135 mmol/l were all associated with increased mortality.

- **Furosemide dose**: Use of more than 80 mg furosemide (Lasix) per day identifies patients at high risk.

- **Hypertension**. A systolic BP below 90 mmHg is associated with a decreased mortality.

- **Endothelin-1 levels**. This radio-immunoassay (RIA) is available commercially, and seems to identify patients at high risk of sudden death (23% v. 4%). It is the most potent vasoconstrictor known, and is significantly associated with outcome. As an indication of endothelial activation, it may become the gold standard of identification of patients at high risk.

- **Autonomic function**: Baroreceptor sensitivity and heart rate variability reflect the loss of the protective parasympathetic tone, and have been studied extensively, especially in the post-infarction population. Difficulty in execution, difficulty in interpretation and lack of standards, prohibit the widespread use of these techniques.

- **Ventricular late potentials**: These reflect the electrophysiological substrate for re-entrant ventricular arrhythmias. The negative predictive values attained in studies of 90%, which is reasonable.
positive predictive accuracy remains poor, in the order of 29%, which severely limits their practicality in selecting the high-risk patient.

5.3.2 Proposed guidelines for disability allowance by insurance companies

The Forum proposed the following classification of subnormal functional parameters.

5.3.2.1 Category 1. Fit for physical work
- LVEF greater than 45%
- Bruce stage II, or 10 METS
- normal chest X-rays, and
- NYHA class II.

5.3.2.2 Category 2. Unfit for physical work but fit for sedentary work
- LVEF 40 - 45%
- Bruce stage II, or 8 METS
- grade I changes on chest X-ray, and
- NYHA class II.

5.3.2.3 Category 3. Unfit for any work
- LVEF less than 40%
- Bruce stage I, or 5 METS
- furosemide 80 mg/day
- NYHA class III
- biochemical changes (sodium, urea, creatinine), and
- cachexia.

Summary

In cases where the objective evaluation does not satisfy the criteria, evaluation by a psychologist and an in-depth evaluation of the patient's personal profile may be indicated. In some cases periodic re-evaluation may be necessary with proof that the suggestions of the practising cardiologist have been adhered to (e.g. invasive cardiac procedures, cardiac rehabilitation, blood pressure control, adequate anticoagulation if indicated and adherence to treatment regimens). Delayed and partial payments over an extended period of time may have a considerable impact on the opportunistic use of these facilities.

5.4 Format of clinical report

As a general rule, insurance companies are doing away with questionnaire type forms to be completed by the examining doctor.

The following format was accepted as being adequate to provide sufficient data to enable a third party to make an informed decision on a patient whom he/she has not clinically examined. It is recommended that all network cardiologists comply with this format for clinical reports.

The role of cardiac risk factors

Although it is generally accepted that cardiac risk factors worsen the prognosis of the disease, this cannot play a
The claimant's GP or cardiologist should therefore inform the patient:

- that their reports will only be used as background information.
- that they will not express an opinion on disability resulting from the cardiac disease, but only provide clinical detail on functional impairment.
- that the final decision on disability lies with insurance companies' disability assessment panels or that of the employer, and
- that in some exceptional cases an independent specialist will do a functional impairment assessment and a full clinical examination.

By doing this, we will be achieving our goals:

- relieving patient pressure from the doctor by moving the final decision-making process to the insurance company or employer, and
- obtaining more objective reports by not involving a treating doctor in their assessment.

The same principles as outlined above should be applied in compiling reports for employers on behalf of patients who want to be boarded. Those employers who do not employ a team to do the disability assessment could easily outsource this function to institutions that are general and experienced in doing so, like insurance companies.

6.2 Flow diagram for assessment

Fig. 1 summarises the practical approach to objective assessment of impairment due to cardiac disease. For optimal uniformity, the implementation of this protocol by employers and insurance industry should be encouraged.

In order to enable this model to function adequately, the different role players in the chain of disability assessment will need to change and standardise their roles in the following ways.

6.2.1 The general practitioner and cardiologist

Both the primary care and specialist care clinicians should:

- refrain from providing recommendations or opinions on the degree of disability of the patient.
- only supply full clinical data on the patient's problems, addressing the issues listed in the form of a clinical report in Section 5.4, and
- also inform the patient that the final decision will be taken by a disability assessment panel of the employer or insurer.

6.2.2 The employer

The employer should:

- Conform to the statutory regulations of the new Labour Relations Act. This implies workplace adaptations to suit the functional impairment of the employee, failing which alternative placement in the
workplace must be considered.

- Supply full details of all adaptations and alternative placements attempted and reason why it did not succeed.
- Supply a detailed job description of the employee. This must include average percentage time spent per day sitting, standing, walking, bending. Physical work should be described in detail.

6.2.3 The patient

The patient must complete the claim application form (obtained from the insurance company or employer), which should include details such as personal information, qualifications, previous experience and occupation.

6.2.4 The insurance company or employer

Insurance companies and employers should standardise their administrative claims management, which should include:

- Changing the current system whereby each company supplies its own question-and-answer forms to the examining doctor, to a clinical report provided by the doctor according to the minimum format described in Section 5.4. Supplying the examining doctor with this minimum format as a checklist could minimise the need for communication.
- Obtaining the clinical reports from the GP and treating surgeon. The job description and adaptation report from the employer and the claim application from the claimant, and making this available to the network doctor, should such an independent opinion be indicated.
- Making their expertise and infrastructure in assessing disability claims available to employers who do not employ medical advisors or who do not have the facilities to assess disability effectively. Through timeous and correct handling of claims at employer level, a great many invalid claims will be prevented from filtering through to insurance companies, which will ultimately benefit the economy and productivity of our country.
- Better training in and understanding of the products by insurance agents, in order to be able to explain the conditions of the policy contract to the client in a more meaningful manner.
- Rewriting of policy contracts in user-friendly terminology aimed at the man in the street.

6.2.5 The network doctor

This section on objective assessment of functional impairment has been dealt with comprehensively in Section 5.

6.2.6 Paramedical reports

The occupational therapists and biokineticists, when involved, should also limit their clinical reports to objective assessment of limitation in functional ability, besides their normal reports on job description after workplace assessment, functional rehabilitation suggestions, etc.

6.3 Who are the network doctors?

6.3.1 This committee is not a predetermined list of selected cardiologists, as the terminology may indicate, but rather a process of natural selection by cardiologists and insurance companies. The list of these names can be expanded at any time and any private cardiologist interested in doing this type of work is invited to contact the medical advice of any one of the insurance companies.

6.4 Who pays for the clinical reports?

The initial onus to prove disability lies with the claimant. The claimant should therefore be liable for the costs of the general practitioner or cardiologist.

Should the insurance company regard the information as insufficient, then the claimant should still be responsible for any additional information.

However, when the insurance company needs to obtain another opinion, this should be done at the company’s expense.

In practical terms this means that the claimant pays the general practitioner and the physician treating him for the initial medical documentation, and the insurance companies pay the network doctors.

Fee structure for Network cardiologists

The LOA realises that meeting the above requirements will need time, effort and intellectual input. For this reason the consultation fee suggested should be fair and adequate.

In order to remove the incentive to do special investigations for reasons other than pure clinical indications, the fees for Bruce ECGs and echocardiograms have been reduced. This should rather be seen as a package together with the consultation, which in total still represents adequate fee for service.

Based on a 1-hour appointment, the suggested fees (VAT included) are:

- Consultation and report: R 920
- Bruce protocol effort ECG: R 100
- Echocardiogram (2D & Doppler): R 220
- Total package (when requested): R 1 305

The fees will be adjusted annually in January by the same percentage increase as the LOA/SAMA fee increase of insurance tariffs.

It is, however, important to distinguish between the following:

- An ordinary report as the treating specialist, for which item number 1.8.1, 1.8.2, 5.2.1, 1.1.1, 2.1 or 5.1 should be charged. Refer to p. 175, Section VIII a — d of the 1999 Guideline to Fees for Medical Services (SA Medical Association). This is usually done on one’s own patient.
- A network doctor report for which the above new
fee will be paid. This entails perusing all available documentation of other treating doctors, a full examination, a report according to the agreed format, and a second objective opinion on functional impairment. This is usually done on someone who is not one’s own patient to obtain a second opinion.

Therefore a doctor who is approached by his own patient for a disability application may not apply the above Network fees, which are only applicable when the company requests a second opinion.

6.5 Confidentiality

Reports obtained from the Network doctors in this protocol are requested and paid for by the insurance company involved and therefore legally remain the property of the relevant company.

Confidentiality of the medical information contained in these reports is of paramount importance to the insurance industry, lest they lose the objectivity of the medical examiner. If disclosure of medical information is requested at any stage owing to a dispute, the written consent of the clinician involved will first be obtained, failing which only a summarised extract from the report will be supplied without revealing names.

7. APPENDICES

Addendum 1.
Insurance medical advisors

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone numbers</th>
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Fig. 1. Flow diagram objective assessment of disability due to cardiac disease.