Guidelines
to the
Management of Disability
Claims
on
Psychiatric Grounds

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1. INTRODUCTION

Applications for disability claims have been increasing steadily over recent years in South Africa. Although we have the highest incidence of ischaemic heart disease in the world, it only features as the third most common cause for disability in our country. Following musculoskeletal claims (mostly back problems), the second largest group of claims are due to psychiatric diagnoses. Among these, depression, anxiety and post-traumatic stress disorders are heading the DSM IV diagnosis list.

Privately practising psychiatrists are increasingly put under more pressure to declare a growing number of patients medically disabled. However, lack of a standard procedure on how to deal with these cases has led to frustration among many professionals.

The need for guidelines on how to approach psychiatric disability claims in a practical and consistent way has been expressed for some time now by all the parties involved, i.e private psychiatrists and insurance companies as well as employers and patients.

Currently, the main problems with psychiatric claims include the following:

(i) Inconsistency of approach between medical professionals.
(ii) Lack of objectivity in reports.
(iii) Inadequate treatment, in terms of:
   • Duration of treatment
   • Dosages of medication
   • Treatment modalities (inpatient treatment, ECT).
(iv) Specific work-related conditions sometimes mean that the patient could function in another occupational environment.

In order to address the above problems, a forum was set up consisting of:

• Medical advisors from insurance companies
• A group of psychiatrists representing the Society of Psychiatrists of SA
• Claims assessors from insurance companies and international re-insurance companies.

This document is a summary of the proceedings and decisions made at this forum.

2. PURPOSE OF THIS DOCUMENT

The panel of professionals present at the two-day forum attempted to find solutions to the problem areas discussed in Section 1, with the following goals in mind:

(i) To attempt to provide a practical and consistent approach to disability claims on psychiatric grounds, by both the doctors and the insurance companies involved.

(ii) To standardise a psychiatric evaluation and the psychiatric report for disability assessment, providing a list of minimum psychiatric data necessary for a third party to make an informed decision on disability.

(iii) To compile guidelines for assessing specific disorders, in order to assist professionals in assessing the validity of specific claims.

3. IMPAIRMENT V. DISABILITY

It is usually important for every person involved with a disability claim to distinguish between the concept of impairment and that of disability.

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

By understanding the difference between impairment and incapacity, it should be clear why the treating doctor can only express his opinion regarding functional impairment, and not disability.

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.

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 not.

To认定 disability, on the other hand, the extent of the person’s impairment has to be judged in conjunction with his job description, his policy disability clause conditions, and personal factors such as education, experience, etc. These matters will be fully discussed in Section 4.

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.

From the above, it is clear that the general practitioner or psychiatrist treating the patient is in no position to express an opinion on disability.
Although he is fully informed on the medical condition, he usually has no information on:
- The patient's working history, previous occupations, qualifications, experience
- The relevant job description applicable to
- The policy conditions.

It is therefore important that the doctor involved:
- Only supplies the insurer/employer with detailed medical information – see 6.5.
- Expresses his opinion only on functional impairment due to the disease.
- 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 more important goals:
- The pressure will be taken off the treating doctor by moving the disability decision making to the insurer.
- The patient will not be labelled as being disabled prematurely, only to find out at a later stage that the application has been unsuccessful owing to other factors, e.g. policy clause conditions which were not met.

3.3 Minimum format for medical report

This is discussed in section 6.3.

4. ASSESSING DISABILITY

Definition

Disability is the alteration of capability to meet personal, social or occupational demands due to an impairment.

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

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

4.1 Claimant
Factors that need to be considered include:
- gender and age
- experience and qualifications
- income
- previous occupations.

4.2 Job description
Generally, occupations can be classified into the following categories:
- manual
- sedentary
- supervisory
- mixed
- managerial
- specialised.

4.3 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

(i) 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 to some degree of impairment.

(ii) Own/similar occupation
A claim is considered when a claimant is unfit to do his own job, and will also not be fit to perform any other occupation which may be reasonably expected of him to follow, taking into account his education, training and experience.

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

(iii) Any occupation
This is a very cheap 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

(i) Total and permanent disability
Here the disease has to be optimally treated and still leave 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 ability to work constantly; diseases which are treatable (e.g. hypertension) and periodic in nature (e.g. epilepsy) therefore do not qualify as causes for disability in this category.
(hi) **Total disability**

In this category a monthly income is provided and periodic medical review is required to determine sustained disability. Temporary disability due to treatable or episodic types of diagnoses (e.g. depressive episode) 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
- The extent to which a claimant can be expected to undergo treatment and/or surgery for a medical condition by his employer or the insurer.

**Availability of employment**

It is important to realise that disability insurance only insures one's ability to work, and not the availability of alternative employment. The employer very often uses this as a reason for medical branding, e.g. where a patient may be unable to continue with his physical work and alternative sedentary work is not available.

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

**Reasonable medical treatment**

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

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

As an example, it would be reasonable to expect a depressed patient to be compliant with various courses of medical treatment and psychotherapy, but one would not be able to enforce ECT on a patient who has made an informed decision not to undergo ECT.

4.4 **Medical condition**

The medical condition will be assessed by the medical advisor according to the information as described in section 5.3. It is therefore important to supply as much medical information as possible in order to be able to make an informed decision.

5. **PRACTICAL PROTOCOL FOR PSYCHIATRIC DISABILITY APPLICATIONS**

During the two-day forum on psychiatric disability claims, the delegates reached consensus on opinion on certain fundamental principles, as well as a suggested practical flow diagram on approaching these cases.

5.1 **Fundamental principles**

Certain fundamental principles discussed and accepted as basic criteria should be distributed to and adhered to by each and every doctor, psychologist or psychiatrist dealing with psychiatric disability applications.

**These are:**

I. **All disability claims on psychiatric grounds should be assessed and treated by a psychiatrist.**

Hereby we do not mean to undervalue the important work done by general practitioners and/or clinical psychologists, but the forum felt unanimously that a psychiatric condition severe enough to warrant permanent disability should at least have been optimally treated by a registered psychiatrist.

II. **Psychiatrists should express their professional opinion only on functional impairment, and not on disability.**

Please refer to section 3 of this document for a more detailed discussion on this recommendation.

III. **Confidentiality of medical reports should be maintained at all times.**

In view of the sensitive nature of some of the psychiatric reports and the individual's rights in terms of the new Bill of Rights, medical reports should be mailed or faxed directly to the Medical Officer only of the insurance company or employer involved. If an employer does not employ a medical officer, the psychiatrist should liaise with the personnel department involved, determine which insurance company does the group insurance scheme for the employer, and forward the medical report to the medical officer involved.

Under no circumstances should any medical reports be handed over to any intermediary party, e.g. a broker manager at work personnel department, etc.

5.2 **Practical approach to claims**

The accompanying flow diagram (5.3, p. 5) acts as a summary of a practical approach which should be followed by treating psychiatrists and insurance companies in order to:

- Obtain objective reports
- Provide detailed information
- Make a fair decision on quality information
- Be consistent in approach to psychiatric disability applications.

From the included protocol, the following points need further discussion.

5.2.1 As stated under fundamental principles (section 5.1), a claim on psychiatric grounds should at least be handled through a psychiatrist.
5.3 PROTOCOL for psychiatric disability claims assessment

5.2.1

Claimant

Employer

GP

Psychologist

5.2.2

Psychiatrist

Psychiatric evaluation

DSM IV diagnosis

Full clinical report

Confidentiality

Insurance Company Medical Advisor

Assessment

5.2.3

Claimant

Job description

Policy conditions

Medical condition

Doubtful cases

Clear-cut cases

5.2.4

All available reports

Network psychiatrists 2nd and 3rd opinions

Open line discussion

Insurance Company Medical Advisor

5.2.5

Final decision

Claim admitted/rejected

Liaise with treating psychiatrist

Additional investigations required
This means that the patient can arrive at the psychiatrist either:
- On his own (which should be the exception), or
- Referred by his employer, general practitioner or clinical psychologist.

It is vitally important that the employee, general practitioner and psychologist supply the psychiatrist with all relevant information regarding the start, severity and course of the disease applicable and treatment instituted.

5.2.2 The psychiatrist should:
- Review all medical documentation available
- Obtain all relevant collateral information involved
- Do a full standard psychiatric evaluation
- Make a diagnosis based on DSM IV guidelines, and
- Compile a complete clinical report, supplying the maximum detail on the topics discussed in Section 6.3.

It is vital that the psychiatrist informs the claimant that.

The final decision on disability lies with the insurance company and not with the private doctor or specialist.

By referring to the criteria (Section 6), the psychiatrist will be able to get a good indication of how the insurance industry will approach a disability claim with a similar diagnosis.

The psychiatrist can then use his own judgement, in cases where it is obvious from the criteria that the claim will not be admitted, and either:
- Inform the patient as such and continue with an adequate treatment regime, or
- Forward the documentation for the insurance company to make the final decision and communicate with the claimant.

Because of the importance of confidentiality of medical reports, the relevant documents should be furnished directly to the medical advisor of the company involved. Please refer to Section 5.1 in this regard.

5.2.3 The insurance company will assess the disability claim as described in Section 4, and will then be in a position to either:
- Make a final decision, and proceed to admit or reject the claim, or
- Call for another expert opinion, in cases where doubt may still exist.

5.2.4 In these doubtful cases, one of the network psychiatrists will be asked to review the case and give his objective opinion on the impairment only.

The network psychiatrist will be provided, with the necessary consent, with all relevant documents and information relating to:
- The claimant and personal detail
- Full job description
- The policy wording, conditions and amounts of compensation involved
- All relevant medical and psychiatric reports.

The network psychiatrist should then follow the guidelines as set out for the primary treating psychiatrist, as set out in Section 5.2.2. In compiling a full clinical report. He will in most cases also liaise with the treating psychiatrist and obtain additional investigations if required, after discussion with and obtaining approval from the medical advisor of the insurance company.

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

5.2.5 After all the above reports, the insurance company should be able to reach a final decision and finalise the claim.

5.4 Who are the network psychiatrists?

This is not a predetermined list of selected psychiatrists, as the terminology may indicate, but rather a process of natural selection by both the private psychiatrists and the insurance companies. Most insurance companies already know which psychiatrists are interested in doing disability claim work, and which ones deliver objective reports of good quality. The list of these names can be expanded at any time, and any private psychiatrist interested in doing this type of work is invited to contact the medical advisor of any one of the insurance companies.

5.5 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 the general practitioner, clinical psychologist and first report of his psychiatrist.

Should the insurance company regard the information as inadequate, the claimant should still be accountable 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, psychologist or psychiatrist for the initial medical documentation, and the insurance companies pay the network psychiatrists.

5.6 Tariff structure

The fee for psychiatrists dealing with disability claims, and who are approached by the insurance companies for expert opinions, will be negotiated on an hourly basis with the Society of Psychiatrists of SA and updated yearly.
6. CRITERIA FOR ASSESSING PSYCHIATRIC DISORDERS

6.1 Some basic principles
While there will always be individuals who disagree with criteria laid down, we feel that these are based on current knowledge and sound clinical judgement. They are intended to assist the psychiatrist, who is often placed in a difficult situation when having to assess patients for disability claims.

These guidelines are intended on the one hand to prevent premature and incorrect decisions being made concerning permanent occupational impairment, and on the other to ensure that genuinely impaired patients are not disadvantaged. We believe that this is the best way of safeguarding the rights of psychiatric patients.

No specific psychiatric disorder is in itself an indication for permanent disability. Degrees of functional impairment vary widely among individuals, and among all the psychiatric disorders.

Decisions regarding the irreversibility of impairment cannot be made hastily. A condition can only be declared non-responsive after optimal treatment has been applied — i.e. sufficiently high dosages of medication for a long enough period of time. Treatment applied need to be those generally recognised as appropriate for the psychiatric disorder in question. (NB: Sleep therapy is not a generally accepted form of treatment for any psychiatric disorder). Patient compliance is also important — a patient who does not keep psychotherapy appointments, or who does not take medication regularly, cannot be said to be non-responsive to treatment.

The psychiatrist should never lead a patient to believe that he or she will be declared permanently medically unfit on the basis of a psychiatric report. Remember — the psychiatrist's job is to assess the degree of impairment and to indicate whether this is permanent or not — the medical assessors of the insurance company take the actual decision regarding disability.

Whenever possible collateral information should be obtained before making any long-term and permanent disability on psychiatric grounds. This is particularly so when disability is claimed due purely to subjective symptoms and reactions.

6.2 The psychiatric assessment
The psychiatric assessment should include:
- A full psychiatric history and mental status examination
- Collateral information — from family, employee, or any other appropriate sources
- Penusal of previous medical documentation
- Appropriate special investigations.

6.3 The psychiatric report
The psychiatric report should include:
- Date of onset of the disorder
- Precipitating factors
- Course
- Severity of symptoms
- Perpetuating factors
- Special investigations
- Diagnosis according to DSM or ICD criteria
- Treatment applied:
  - Medication — specify: drugs used, dosage, compliance
  - Psychotherapy — specify: type, frequency, duration, compliance
- Hospitalisation (or reasons why not)
- Other
  - Response to treatment
  - Complications
  - Impact on occupational and social functioning
  - Prognosis

6.4 Specific disorders commonly leading to disability claims

Major depressive disorder
Remember: In the majority of cases of major depressive disorder there is a complete remission of symptoms, and functioning returns to the pre-morbid level. There are, however, a significant minority who do have residual symptoms that may persist for months to years. The degree and duration of impairment vary widely.

The disorder can be specified as chronic only after full criteria have been met continuously for at least the past 2 years.

The condition can only be regarded as refractory after optimal treatment has failed. Optimal treatment comprises:
- Adequate dosage (close to the manufacturer's recommended maximum dose, or the highest dose that the patient can tolerate) of different classes of antidepressants, for an extended period of time (e.g. 6 weeks each)
- Electroconvulsive therapy is safe and effective in refractory depression. If not applied for this disorder, reasons should be given why not.
- Patients with refractory depression almost invariably require hospitalisation at some stage.
- Periods of hospitalisation should be specified.
- If the patient was not hospitalised, reasons should be given why not.
- Psychotherapy is usually indicated as adjunctive treatment in refractory depression. Patients need to be compliant.

Suicidal ideation as such is not an indication of medical disability.

Dysthymic disorder
Although this disorder follows a chronic course and is often not dramatically responsive to treat
ment, the degree of associated impairment is usually not sufficient to cause permanent occupational disability.

**Adjustment disorder**

Again, the degree of impairment is usually not severe enough to consider permanent disability. When symptoms related to stress are more severe or protracted, the patient will usually meet criteria for a major depressive disorder or another psychiatric disorder, and the guidelines for that disorder will then apply.

**Post-traumatic stress disorder**

This has become one of the most common diagnoses given for patients applying for medical disability in South Africa. There have been several cases of patients grossly misrepresenting the severity of stressors to which they were allegedly exposed, as well as the symptoms of this disorder. The diagnosis is often applied, both by laypeople and professionals.

For these reasons, psychiatrists should adhere strictly to the criteria as laid down for this diagnosis. Note that criterion A (2) of the DSM-IV requires that the person’s response to the initial traumatic event involves intense fear, helplessness, or horror. In patients presenting for the first time years after the traumatic event, this criterion should be enquired after.

**Remember:** Post-traumatic stress disorder usually resolves with time, so the majority of patients should not come into consideration for permanent occupational disability. Duration of the symptoms varies, with complete recovery occurring within 3 months in approximately half the cases. For the rest, various degrees of persistence of symptoms occur. Approximately 10% remain unchanged or become worse.

Treatment options are: Pharmacotherapy (antidepressants), individual psychotherapy (especially behavioural, cognitive, crisis intervention and psychodynamic), and group therapy (mutual self-help and family).

An extended period or appropriate treatment is necessary before the condition can be regarded as permanent. It is not usually possible to declare an individual treatment-resistant after only a few months of treatment.

The return of the patient to a work situation where he or she is exposed to danger, or is reminded of past traumatic events, can often exacerbate the condition. However, this does not preclude the patient from working in different environments, where these factors are not present.

**Other anxiety disorders**

Panic disorder with agoraphobia, social phobia and generalised anxiety disorder are often associated with avoidant behaviour to such an extent that significant impairment of occupational and social functioning occurs.

However, once again these disorders often respond favourably to treatment, so that optimal treatment needs to be applied for an extended period before the condition can be considered irreversible.

**Obsessive compulsive disorder:** Although sometimes severely incapacitating, modern treatment (in the form of anti-obsessional drugs such as clomipramine and fluoxetine together with specific behavioural therapy techniques) often provides effective relief.

**Psychotic disorders**

Schizophrenia, bipolar disorder, schizoaffective disorder, delusional disorder, psychotic disorder due to a general medical condition; substance-induced psychosis. These conditions are usually associated with severe functional impairment during psychotic episodes. Any decision regarding permanent disability should, however, be delayed until optimal recovery has taken place. Factors such as the presence of residual symptoms, degree of insight, nature of employment and likelihood of relapse need to be considered when assessing long-term impairment.

**Cognitive disorders**

Dementia, amnestic disorder and personality change due to a general medical condition. It is essential that these patients undergo full assessment. This should include the appropriate special investigations, including neuroradiological (CT or MRI scan) and neuropsychological testing.

In the case of brain injury, a sufficient period of time should be allowed for recovery to occur. This may be 2 years or more.

**Personality disorders**

On their own, these are not usually regarded as indicating permanent occupational impairment.

**Chronic fatigue syndrome**

Because this is not a psychiatric disorder, psychiatrists should not be primarily involved in assessment of impairment. However, depression is often present, and the opinion of a psychiatrist may be sought.

**Epilepsy**

Again, this is not a psychiatric disorder. Psychiatric grounds for disability may, however, arise if psychiatric sequelae (e.g. psychiatric disorder or cognitive disorder) were to occur.

The psychiatric disorders discussed above are those most commonly considered for medical disability. Many other disorders may, however, be associated with protracted functional impairment. In these cases, adherence to the general guidelines as set out above is advised.