Insurance Physicians Practice Voodoo Insurance Medicine by Linda Nee

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There's an old saying, "If someone can't do their job, they should teach." Insurance companies typically hire physicians, who for whatever reason, can no longer perform clinically but want plush jobs paying big money. Insurance medicine, including IME physicians is a multi-billion dollar a year industry. Once employed or retained by any disability insurer to review claims physician's ethics of "do no harm" goes out the window and is immediately replaced with "do as much harm as you can."

Although insurance physicians hired directly, or working for third-party facilities, lack actual recent clinical experience and practice they do lend their "board certified" certifications to the illusion their opinions and documentations are credible. It is also true insurers "buy" the credentials of its internal physician consultants to the tune of $125,000+ per year in salary with an option of receiving up to 30% in yearly incentive bonuses for supporting management's agenda to deny claims.

Insurance medicine is an entirely different expertise from medical patient diagnosis and treatment since insurance physicians conduct only "paper reviews" and have no actual medical treatment history with insureds that submit claims. Clearly, those physicians practicing insurance medicine for pay have no patients other than the corporation itself.

In addition, the objective of practicing insurance medicine is to "assist disability insurers achieve annual targeted financial goals" rather than identifying and treating disease. A second objective is to provide through written reports and documentation, the "illusion" of credibility about whether insureds can work or not.

From the thousands of medical reviews I've read over 25 years on both sides of the claim fence the following appear to be clear objectives of all insurance-paid physicians:

1. Obtaining paper reviews only for the purpose of discrediting all medical restrictions and limitations provided by treating physicians not paid for by the insurance company.

2. Document medical standards, which support the insurer's agenda to not pay claims rather than current medical diagnostic criteria recommended by the AMA.

3. Engage in doc-to-doc calls for the purpose of intimidation and persuasion to obtain a work release or buy-in from the treating physician agreeing to a return to work even when the patient would not be able to sustain work at any level.

4. "Snatch" key phrases from patient medical notes that support the insurer's position of denying claims at the expense of all else contained within the records.

5. Document and support insurers' Quality Compliance Department's directives as to language and content of written medical reports and documentation for the purpose of guaranteeing appeal upholds and state and federal regulatory scrutiny.

6. Support claim denials by rendering reports and documentation which make the non-payment of benefits "look good" as if the denial was the "absolute correct" decision.

Clearly, insurance physicians appear to take no pride is accurately diagnosing disease, but rather choose to do the bidding of the company paying their salary. Each physician has his/her price for leaving the standards of traditional medical practice behind from "do no harm" to "do as much harm as you can."

A good case in point recently, is a female physician client who was diagnosed with 1) herniated disks with spondylitic changes with encroachment, 2) spinal stenosis, 3) angular bulging disk, 4) reversed curvature suggesting muscle spasm, and thoracic spondylosis. In addition, the insured will require surgery on both of her knees in the future.

In addition, this insured as offered a lump sum settlement by her insurer in 2006 – an offer she turned down because the offer represented less than 53% of the net present value at the time.

As part of her company's current agenda to "go get all the claims in the EDU and deny them" this unfortunate insured is again targeted for "risk management". A doc-to-doc call was made to the treating physician by phone and was told in addition to her other diagnoses that she is unable to do more than occasional fine manipulation with the hands.

Several weeks after the doc-to-doc call, the insured received notice her insurer scheduled an IME. Just how much medical evidence is needed in order for insurance companies to pay claims these days?

Years ago an insurance physician claimed an HIV insured with a T-cell count of 200 could return to work full-time. It's unclear where that medical standard came from since upon investigation DCS, Inc. learned a T-cell count of 500 was considered to be functional for an HIV patient and that counts as low as 200 placed the patient at risk for severe bacterial infections. If this isn't voodoo medicine I don't know what is.

Yet, false information about surveillance was communicated to a treating physician that was falsely accusing the insured of activity including trips to Toronto when the insured didn't even have a passport. Insurance physicians do not follow-up on information they are given and therefore support management's agenda unintentionally, or as some would say, blindly.

Working for the insurance industry as a medical physician consultant does not come without a price. My observations are that it is similar to working for the mafia – once in, you either support the agenda to deny claims, or you're out.

Some time ago, DCS Inc. was contacted by a former Unum Medical Director, terminated because he refused to change the wording of his reports to comply with what Quality Compliance wanted him to do. His descriptions of what Unum's management did to him prior to termination are pretty scary including humiliating him in front of peers.

In the end, any insurance company's internal physician reports, which have nothing to do with the practice of medicine, or the identification of reasonable restrictions preventing insureds from returning to work, misrepresent and distort functional capacity for profitability at the expense of insureds. As "reborn company hacks" they review medical records with a deliberate prejudice to comply with management's profit targets even though their recommendations could cause harm or even death to insureds.

Another good example of the potential harm documented by Unum physicians is the pattern of practice of denying addicted anesthesiologist claims by alleging these physicians could return to the surgical arena where drugs are readily available. It's no wonder the rates for remission are lower in this specialty since anesthesiologists are forced back to work prematurely by Unum physicians. Other insurance companies do basically the same thing.

Bottom line, insurance physicians practice "paper medicine" because they either are incapable of practicing on their own, or choose the cushy life behind a desk at the behest of insurance management. These physicians sell-out their medical licenses and credentials to the highest bidder, and quickly learn the "lingo" of disability insurance - their opinions becoming a "turkey shoot" to Unum insureds.

What attracts physicians to the insurance industry are commonalities of self-interest. Companies use their credentials to bolster the notion of credibility, while at the same time physicians use insurers to provide better than average salaries and benefits when actual medical practice isn't an option.

In the end, insurance physicians do not practice medicine in the traditional sense, but rather use their education and experience to further the agenda of the insurance industry for money.

One has only to wonder what goes through the mind of an insurance physician when it's clear their documentation isn't medically sound and is destined to cause future harm to someone. Does sending an insured neonatologist with HIV back into the NICU after suffering three heart attacks and having 5 stents placed actually make sense? Would you want your newborn infant cared for by a physician who isn't physically able to be there when you need him?

We can only hope as educators and consultants in the insurance industry that we can open the eyes of insureds and claimants to one of the most popular and profitable insurance medical scams in the United States.

IME physicians earn in excess of what they would ordinarily make running their own medical practices, while internal insurance physicians crank out thousands of voodoo medical reports intended to deny more and more legitimate claims.

Perhaps we should start asking physicians what it takes to sell out their personal integrity and medical licenses to insurance companies who use them to better their profitability. I wonder what their responses will be.