What to do when Your Disability is Denied AT&T Members

Category : Benefits
Published by Dave Skotarczyk [Dave Skotarczyk] on 2017/4/25

This package has been written by the CWA side of the Joint Benefit Forum as a way to help you perfect your disability claim. (Work Comp is not included in this guide)

Members are required to see a Doctor. The Doctor/Doctors must send in objective medical paperwork. The member must follow treatment advised or they will automatically be denied.

Members should explain to the Dr how important this paperwork is to not only their pay but their jobs and fax receipts should be kept.

Dr's should be willing to work with them and the Co on this paperwork, possible Doc to Doc conversations, or find new Dr's.

Under federal ERISA law employees have a right to appeal (directly to AT&T and/or their agent) within one hundred eighty (180) calendar days of their original denial without using or following these guidelines.

Following these guidelines, or using any process described below does not in any way prohibit AT&T from taking disciplinary action.

It is the employee's decision to return to work or not. Local Benefit Reps are prohibited from making medical of life decisions for their members. The Company can and has terminated for failure to return to work regardless of the treating Doctors opinion.

In the case of disciplinary action, please see your Local Union Representative within 45 calendar days.
(DO NOT wait until the last minute)

1. Disability is denied (first time/every time):
A)ASAP member must call the Local Benefit Representative (LBR). Local 4050 LBR Name Troy Smith or Dave Skotarczyk
TN# _248 968 0983____
B) FMLA should be requested.
2. As a member requesting help from the Local with your disability claim; you will be required to provide to your Local Benefit Rep the following within the above 15 calendar day time frame:
A) Completely filled out Intake form (provided by Local)
B) Signed Medical Release form (provided by Local)
C) All pertinent medical records from your treating physician. Included, but not limited to: all pertinent medical reports from treating physician or specialist, chart notes, operative reports, x-rays, lab tests, weight loss and time frame of and prescriptions.
If claim is mental health related: include mental status exams, comparable GAF scores. Axis rating

(DSM 4 or 5), or MMPI results, documented or observable behavior, ability to function, or inability to "do" activities or daily living).

The documentation from the Dr must be OBJECTIVE.

D) You should request copies of your SMAART case files. Case Worker: 1-866-276-2278.
E) The reason for DB should be linked to the member's job duties and/or inability to perform activities of Daily living.
F) Get all fax receipts [from Dr's office]. If doctor mails the Medical information have it sent return receipt requested.
G) Give LBR copies of all Co. communications and receipts of delivery.
H) Request (from the Co.) accommodations if desired and medically applicable.

Accommodations:
Must be proved necessary with objective medical documentation.
Restrictions must be temporary [6 months or less].
If members own Dr [or the Co] says the restrictions are permanent, the member will be put on Medical Priority Placement, required to test for other jobs that meet the restrictions and if none found will be terminated in 90 days.

NOTE:
Denial Reasons That Will Stay Denied

Member requested the DB [Dr sometimes say this in their notes]
Needed a vacation or funeral time [Travel is prohibited]
Needs to rest, put feet up or can't drive
Prescription change
Mad at supervisor, trouble at work with coworkers, can't make production
Working at other job/charity [paid or not]
Stressed out
Did not see a Dr
Never sent any paperwork in
Refused to follow treatment
Caught at beach/bar/party

Security Involvement [Benefit Fraud]
Security is looking for potential violations on both DB and FMLA.
It can be reported by another member, Dr office, supervisor or neighbor.
They are looking at patterns/repeaters [every summer, long weekends]
Looking for members doing thing inconsistent with reasons they are out. [Bars, beach, parties/Co or not, Union activities]

Remember Keep copies of:
All company correspondence
All doctor correspondence/documents
All receipts of faxes or mailed correspondence
Be sure to mail everything certified so that you get a receipt that the Company has received the information.

3. The LBR will investigate and attempt to gain benefit approval, but if still denied after 30 calendar days, will refer your claim to the State Benefit Rep, and file an appeal.

4. The State Benefit Rep has no power or authority to bargain or overturn decisions. They will attempt to gain approval or determine what if any other documentation is required to perfect the claim.
5. Company takes approximately 60-90 days to respond to the ERISA appeal.
6. All decisions will be sent to you via mail to the address you gave on the original intake form. It is your responsibility to notify us in writing of any address change during this process.

7. All communication will be in writing and should be certified in some manner to avoid lost files. Maintain copies of all certified receipts. Communication for which no certified receipt exists will be not honored.

8. If eligible, you may be entitled to FMLA treatment. See your local manager, human resource group or local benefit rep if you have concerns about entitlement.

9. The process is very time consuming- Be Patient.

10. Members are automatically paid for 3 weeks Db time even if no papers are sent in. If/when denied, the member has been paid for any of the denied time, they will be required to pay it back. [Remember the first 7 days of pay comes from the contract]

When Told To Return To Work Or Else
It is the member's decision to return to work or not.
The Co can and has terminated for failure to return to work regardless of their Dr's opinion or appeal.
The Local benefit Rep is prohibited from making medical or life decisions for members.
Appeals do not in any way prohibit SBC from taking disciplinary action.

Members have the right to appeal the Company's decision [directly to SBC and/or their agent] within one hundred and eighty [180] calendar days from their denial. If member does not want help from the Local Benefit Rep send appeal to:
ATT Integrated Disability Service Center
Quality Review Unit
P.O. Box 14626
Lexington, KY 40512-4626