Litigating Subjective Disability Claims

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Here is what every attorney should know about disability income insurance cases involving self-reported conditions.

DISABILITY CLAIMS INVOLVING subjective (or "self-reported") conditions present unique problems. In the typical scenario, the condition that is alleged to have caused the disability cannot be confirmed by objective medical findings. Likewise, the symptoms related to that condition cannot be readily verified by standard medical tests or procedures. As a result, the objective medical data suggests that nothing is wrong, and the insured's own testimony may constitute the only evidence of the underlying disorder and related functional impairment.

To be certain, self-reported conditions can be real and often are very disabling. However, the insurer's difficulty in verifying the presence of

such conditions and the extent of the insured's functional impairment presents an enormous potential for fraud and abuse. At the same time, the number of disability claims based on self-reported conditions has increased dramatically over the last several years. CNA recently reported that, between 1991 and 1996, chronic fatigue syndrome claims increased more than 900 percent, FMS claims increased 254 percent, psychiatric-related claims increased 195 percent, and chronic pain claims increased as well. Susan C. Sendra, *Subjective Disabilities a Unique Challenge,* Business Insurance, Oct. 7, 1996, at 29. Disability insurers therefore have a compelling need for finding some way to distinguish legitimate disability claims based upon subjective disorders from those that are not.

Toward that end, some insurers have modified their disability insurance policies to include provisions that terminate any right to benefits for subjective or self-reported conditions after a certain time. Others have elected to insist that the insured present objective medical evidence to support a finding of total disability. However, the case law concerning such approaches to subjective disability claims is inconsistent and still developing. Disability insurers (and their litigation counsel) therefore must be prepared to evaluate subjective disability claims under a more traditional analysis that examines both the genuineness of the insured's reported condition and the impact that the condition allegedly has on the insured's functional capacity.

A GUIDE TO COMMON SELF-REPORTED CONDITIONS • Self-reported conditions come in all shapes and sizes. For example, experience has shown that between 20 percent and 40 percent of all back-related disability claims are self-reported with no objective evidence to substantiate the claimed disability. James R. McMullin, *Confronting the Back-Related DI Claims Challenge,* National Underwriter, Feb. 10, 1997, at 9. With increasing frequency, though, subjective disability claims involve a variety of other medical conditions with which practitioners may be less familiar. *See* Sendra, supra.

Understanding the nature of those self-reported conditions, their typical symptoms, and the manner in which they are diagnosed can be critical to any attorney defending a disability insurer in litigation that involves a subjective disability claim. An overview of two of the more common self-reported conditions follows.

CHRONIC FATIGUE SYNDROME • Chronic fatigue syndrome ("CFS") is a debilitating and complex disorder, characterized by profound fatigue that is not improved by bed rest and that may be worsened by physical or mental activity. By definition, persons with CFS must function at a substantially lower level of activity than they were capable of before the onset of illness. In addition, they must report various nonspecific symptoms, such as weakness, muscle pain, impaired memory or concentration, insomnia, and post-exertional fatigue lasting more than 24 hours.

Recent medical research suggests that patients with CFS show evidence of abnormalities in the brain and immune system. However, the cause or causes of CFS have not been identified, and no specific diagnostic tests are available. At the same time, many other illnesses produce the symptom of incapacitating fatigue. According to the U.S. Centers for Disease Control and Prevention, the "frequently treatable illnesses" that can cause fatigue include:

- Hypothyroidism;
- Sleep apnea and narcolepsy;
- Major depressive disorders;
- Chronic mononucleosis;
- Bipolar affective disorders;
- Schizophrenia;
- Eating disorders;
- Cancer;
- Autoimmune disease;
- Hormonal disorders;

- Subacute infections;
- Obesity;
- Alcohol or substance abuse; and
- Reactions to prescribed medications.

Care therefore must be taken to exclude other known (and treatable) conditions before diagnosing a patient to suffer from CFS. For that reason, CFS often is characterized as a "condition of exclusion." In other words, it usually is diagnosed by ruling out all other causes of the insured's reported symptoms.

Diagnostic Criteria

The U.S. Centers for Disease Control and Prevention first published a case definition of CFS in 1988. That definition was revised in 1994 to identify the following criteria for diagnosing CFS:

- Clinically evaluated, unexplained, persistent, or relapsing chronic fatigue that is of new or definite onset (i.e., has not been lifelong), is not the result of ongoing exertion; is not substantially alleviated by rest, and results in substantial reduction in previous levels of occupational, educational, social, or personal activities; and
- The concurrent occurrence of four or more of the following symptoms, all of which must have persisted or recurred during six or more consecutive months of illness and must not have predated the fatigue:

__ Self-reported impairment in short-term memory or concentration that is severe enough to cause substantial reduction in previous levels of occupational, educational, social, or personal activities;
__ Sore throat;
__ Tender cervical or axillary lymph nodes;
__ Muscle pain;
__ Multijoint pain without joint swelling or redness;
__ Headaches of a new type, pattern, or severity;
__ Unrefreshing sleep;
__ Postexertional malaise lasting more than 24 hours.

Routine Diagnostic Tests

As noted above, there is no specific diagnostic test for CFS. Indeed, CFS most often is diagnosed by ruling out the possibility of other explanations for the patient's symptoms. The U.S. Centers for Disease Control and Prevention therefore recommend obtaining a detailed medical history, performing a complete physical examination, conducting some form of mental status exam, and ordering a standard series of laboratory tests of the patient's blood and urine to help the physician identify other possible causes.

The number and type of tests performed varies from physician to physician. However, the following tests constitute a typical standard battery for the purpose of excluding other causes of fatiguing illness:

- Alanine aminotransferase ("ALT");
- Albumin;
- Alkaline phospohatase ("ALP");
- Blood urea nitrogen ("BUN");
- Calcium;
- Complete blood count;
- Creatinine;
- Electrolytes;
- Erythrocyte sedimentation rate ("ESR");
- Globulin;
- Glucose;
- Phosphorus;
- Thyroid stimulating hormone ("TSH");
- Total protein;
- Transferrin saturation; and
- Urinalysis.

Source: U.S. Centers for Disease Control and Prevention.

Activity Restrictions And Quality Of Life

To be diagnosed with CFS, an individual must show a prolonged (i.e., longer than six months) fatigue that is sufficient to produce a substantial reduction in his or her previous levels of occupational, educational, social, or personal activities. Numerous

studies have confirmed a substantial reduction in the functional capacities of patients suffering from CFS. *See, e.g.,* Komaroff, A.L., Fagioli, L.R., Doolittle, T.H., Gandek, B., Gleit, M.A., Guerriero, R.T., Kornish, R.J., Ware, N.C., Ware, J.E. & Bates, D.W., *Health Status In Patients With Chronic Fatigue Syndrome And In General Population And Disease Comparison Groups,* 101 American Journal of Medicine, 281-290; Buchwald, D., Pearlman, T., Umali, J., Schmaling, K., & Katon, W., *Functional Status In Patients With Chronic Fatigue Syndrome, Other Fatiguing Illnesses And Healthy Individuals,* 101 American Journal of Medicine 364-370 (1996); Wessely, S., Chalder, T., Hirsch, S., Wallace, P. & Wright, D. (1997); *The Prevalence And Morbidity Of Chronic Fatigue And Chronic Fatigue Syndrome: A Prospective Primary Care Study,* 87 American Journal of Public Health, 1449-1455 (1997). Significantly, the studies also have shown those reductions to be greater than those seen in patients who suffer from other chronic illnesses.

In contrast, research concerning the impact of CFS on an individual's employment and work activities has been less conclusive. At best, that research shows only that unemployment is higher among people suffering from CFS. For example, one study suggests that between 25 and 50 percent of CFS sufferers are unable to maintain previously held employment and that those who do maintain their employment report decreased work performance. Bombardier, C.H. & Buchwald, D. *Chronic Fatigue, Chronic Fatigue Syndrome, And Fibromyalgia: Disability And Health-Care Use,* 34 Medical Care 924-930 (1996).

Treatment Options

Despite intensive research, little is definitely known about the causes or mechanisms of CFS. As a result, even less is known about how to treat CFS effectively. *See, e.g.,* Wilson, A., Hickie, I., Lloyd, A. & Wakefield, D., *The Treatment of Chronic Fatigue Syndrome: Science and Speculation,* 96 American Journal of Medicine 544-550 (1994); Blondel-Hill, E. & Shafran, S.D., *Treatment of the Chronic Fatigue Syndrome: A Review and Practical Guide,* 46 Drugs 639-651 (1993).

Most medical reviewers therefore recommend symptomatic treatment, simple advice on lifestyle management and the avoidance of factors that may exacerbate disability, and other forms of "good clinical care." *See, e.g.,* Wilson, A., et al., supra, at p. 548; Blondel-Hill, E., et al., supra, at p. 649; Epstein, K.R., *The Chronically Fatigued Patient,* 79 Medical Clinics of North America 315-327 (1995); Fukuda, K. & Gantz, N.M., *Management Strategies for Chronic Fatigue Syndrome,* 12 Federal Practitioner 12-27 (July 1995); Sharpe, M. *Chronic Fatigue Syndrome,* 19 The Psychiatric Clinics of North America 549-573 (1996). Similarly, the National Institute of Allergy and Infectious Diseases Information for Physicians ("NIAID") offers the following treatment principles for sufferers of CFS:

- Establish therapeutic alliance with patient;
- Dispel misinformation about the disease;
- Use a medical team approach;
- Prescribe symptomatic treatments;
- Urge stress reduction;
- Introduce slowly graduated exercise;
- Suggest rehabilitation therapy to develop energy conservation techniques;
- Schedule regular follow-up visits; and
- Give emotional support.

National Institute of Allergy and Infectious Diseases, *Chronic Fatigue Syndrome: Information for Physicians,* U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health (1996).

Long-Term Prognosis

It is generally recognized that the long-term course for persons suffering from CFS is unpredictable. *See* Hinds, G.M.E. & McCluskey, D.R., *A Retrospective Study of Chronic Fatigue Syndrome,* Proc. 23 Royal College of Physicians 10-14 (1993); Peterson, P.K., Schenck, Cc.H. & Sherman, R., 74 *Chronic Fa-*

tigue Syndrome in Minnesota, Minnesota Medicine 21-26 (1994); Vercoulen, J.H.M.M., Swanink, C.M.A., Fennis, J.F.M., Galama, J.M.D., van der Meer, J.W.M. & Bleijenberg, G., *Prognosis in Chronic Fatigue Syndrome: A Prospective Study on the Natural Course*, Journal of Neurology, 60 Neurosurgery, and Psychiatry 489-494 (1996); Clark, M.A., Katon, W., Russo, J., Kith, P., Sintay, M. & Buchwald, D., *Chronic Fatigue: Risk factors for Symptom Persistence in a 2 ½ Year Follow-Up Study*, 98 American Journal of Medicine 187-195 (1995); Wilson, A., Hickie, I., Lloyd, A., Hadzi-Pavlovic, D., Boughton, C., Dwyer, J. & Wakefield, D., *Longitudinal Study of Outcome of Chronic Fatigue Syndrome*, 308 British Medical Journal 756-759 (1994); Bonner, D., Ron, M., Chalder, T., Butler, S. & Wessely, S., *Chronic Fatigue Syndrome: A Follow Up Study*, 57 Journal of Neurology, Neurosurgery, and Psychiatry 617-621 (1994). According to these studies, between 37 and 80 percent of CFS sufferers show no signs of recovery. In contrast, only slightly more than eight percent of all the CFS sufferers in those studies experienced a complete recovery.

Predictors Of Long-Term Impairment

Numerous recent medical studies have attempted to identify common characteristics that distinguish CFS sufferers who have experienced a complete recovery from those who have not. At best, those studies document statistical trends and tendencies, without suggesting that individuals with a particular factor are more or less prone to a good prognosis or recovery from CFS. Nevertheless, the statistics produced by those studies do associate the following factors with a long-term impairment from CFS:

- Previous psychiatric disorder. Bonner, D., et al., supra; Wilson, A., et al., supra; Clark, M.A., et al., supra;
- Greater number of somatic symptoms. Bonner, D., et al., supra; Clark, M.A., et al., supra; Vercoulen, J.H.M.M., et al., supra;
- Greater severity of symptoms. Bonner, D., et al., supra; Vercoulen, J.H.M.M., supra;
- Longer duration of illness. Clark, M.A., et al., supra; Vercoulen, J.H.M.M., et al., supra;
- Older age. *Id.*; and
- Poor initial response to treatment. Bonner, D., supra.

FIBROMYALGIA SYNDROME • Fibromyalgia syndrome ("FMS") is a chronic disorder characterized by widespread musculoskeletal pain, fatigue, and multiple tender points. "Tender points" refers to tenderness in precise, localized areas, particularly in the neck, spine, shoulders, and hips. People with FMS also may experience sleep disturbances, morning stiffness, irritable bowel syndrome, anxiety, and other symptoms.

FMS is not a muscle condition. Instead, it is a dysfunction of informational substances such as neurotransmitters, hormones, peptides, and other biochemical messengers which regulate and run the systems of the body and mind. Because it causes hypersensitivity to all sorts of stimuli, FMS can amplify pain. Many FMS patients also have memory and cognitive impairments. Devin J. Starlanyl & Mary Ellen Copeland *Fibromyalgia and Chronic Myofascial Pain Syndrome: A Survival Manual* (2d ed. 2001).

The cause of FMS is unknown. However, researchers have offered several theories about the causes of this disorder. Some, for example, believe that FMS can be caused by an injury or trauma that affects the central nervous system. Greenfield, S. et al., *Reactive Fibromyalgia Syndrome*, 35 Arthritis & Rheumatism 678-681 (1992); see also, Buskila, D. et al. *Increased Rates of Fibromyalgia Following Cervical Spine Injury*, 40 Arthritis and Rheumatism (1997); *cf.*, Wolfe, F. *The Fibromyalgia Syndrome: A Consensus Report on Fibromyalgia and Disability*, 23 The Journal of Rheumatology 534-539 (1996). Others believe that FMS is associated with changes in muscle metabolism, such as decreased blood flow, that cause

fatigue and decreased strength. Still others believe the syndrome may be triggered by an infectious agent, such as a virus in susceptible people. However, no such agent has ever been identified.

Diagnostic Criteria

Many physicians will diagnose a patient as having FMS if the patient's medical history includes chronic, widespread pain that has persisted for more than three months. However, many of the symptoms associated with FMS mimic the symptoms of other disorders. The American College of Rheumatology ("ACR") therefore has developed a more precise set of diagnostic criteria for FMS that includes:

- A history of widespread pain in the left side of the body, the right side of the body, above the waist and below the waist (all four areas must be involved); and
- Pain, on digital palpation, in at least 11 of the following 18 sites:

__ Occiput: bilateral, at the suboccipital muscle insertions;

__ Low Cervical: bilateral, at the anterior aspects of the intertransverse spaces at C5-C7;

__ Trapezius: bilateral, at the midpoint of the upper border;

__ Supraspinatus: bilateral, at origins, above the scapula spine near the medial border;

__ Second rib: bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces;

__ Lateral epicondyle: bilateral, 2 cm distal to the epicondyles;

__ Gluteal: bilateral, in upper outer quadrants of buttocks in anterior fold of muscle;

__ Greater trochanter: bilateral, posterior to the trochanteric prominence;

__ Knee: bilateral, at the medial fat pad proximal to the joint line.

See illustration 1. Wolfe, F. et al., *The American College of Rheumatology Criteria for the Classification of Fibromyalgia.* Report of the Multicenter Criteria Committee, 33 Arthritis and Rheumatism 160-163 (1990).

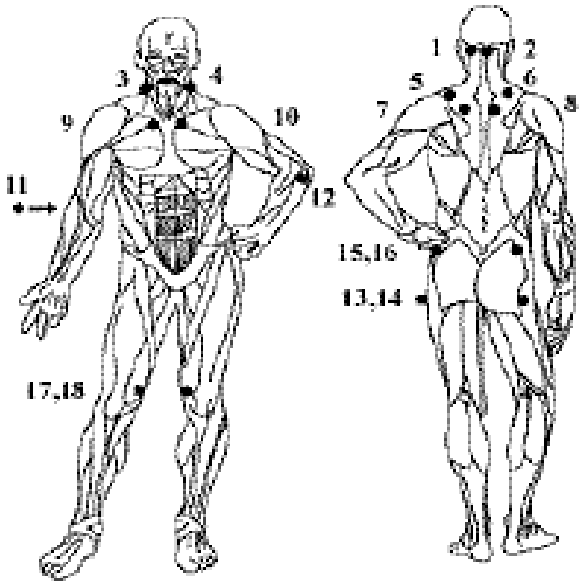

Figure 1: Pain sites, fibromyalgia diagnosis

Common Symptoms

Most patients with FMS report that they ache all over and that their muscles feel like they have been pulled or overworked. However, FMS patients also exhibit numerous other symptoms, including:

- Fatigue. This symptom can be mild in some patients and incapacitating in others. It often is described as "brain fatigue," meaning the patient feels totally drained of energy. Patients sometimes describe the symptom as feeling like their arms and legs are tied to concrete blocks;
- Sleep disorders. Most FMS patients have an associated sleep disorder called alpha-EEG anomaly, during which their deep level (or stage 4) sleep is constantly interrupted by bursts of awake-like brain activity. Some FMS patients have other sleep disorders, such as sleep myoclonus or PLMS (nighttime jerking of the arms and legs), restless leg syndrome, and bruxism;
- Irritable bowel syndrome. Between 40 and 70 percent of FMS patients frequently experience

constipation, diarrhea, frequent abdominal pain, abdominal gas, and nausea;

- Chronic headaches. Approximately half of all FMS patients experience recurrent migraine or tension-type headaches;
- Temporomandibular joint dysfunction syndrome ("TMJ"). By some accounts, as many as 90 percent of FMS patients have jaw and facial tenderness that could produce at least intermittent symptoms of TMJ;
- Multiple chemical sensitivity syndrome ("MCSS"). About half of all FMS patients report heightened sensitivities to odors, noise, bright lights, medications, and various foods.

Most FMS patients also have memory and cognitive impairments. As a result, doctors often refer FMS patients to psychologists or psychiatrists. However, recent studies have shown that FMS patients have no more of an abnormal psychology than arthritis patients.

The severity of the symptoms associated with FMS varies by patient. They also may become aggravated (or lessened) by changes in weather, environments, hormonal fluctuations, stress, depression, anxiety, and over-exertion. More importantly, a FMS patient may be able to perform certain tasks on any given day, then require several days of rest to "recover" from that activity. The unpredictability of symptoms, their changing severity, and the adverse effects of environmental changes, therefore can affect an FMS patient's ability to maintain employment and perform other daily activities on an ongoing basis.

Common Treatments

At present, there is no known cure for FMS. Because deep level (stage 4) sleep is crucial for many body functions, such as tissue repair, antibody production, and perhaps even the regulation of various neurotransmitters, hormones, and immune system chemicals, the sleep disorders that frequently occur in FMS and chronic fatigue patients are thought to be a major contributing factor to the symptoms of this condition. Traditional treatments for FMS therefore are geared toward improving the quality of the patient's sleep, as well as reducing pain.

Medicines that boost the body's level of serotonin and norepinephrine—neurotransmitters that modulate sleep, pain, and immune system function—are commonly prescribed. Examples of drugs in this category would include Elavil, Flexeril, Sinequan, Paxil, Serzone, Xanax, and Klonopin. In addition, nonsteroidal, anti-inflammatory drugs like ibuprofen may also be beneficial. Nevertheless, most patients will probably need to use other treatment methods as well, such as trigger point injections with lidocaine, physical therapy, acupuncture, acupressure, relaxation techniques, osteopathic manipulation, chiropractic care, therapeutic massage, or a gentle exercise program.

Prognosis

Long-term follow-up studies on FMS have shown that it is chronic, but that the symptoms usually wax and wane. For that reason, the impact that FMS can have on the ability to work in a full-time job (or engage in other daily activities) differs among patients. *See, e.g.*, Waylonis, G., et al. *A Profile of Fibromyalgia in Occupational Environments,* 73 American Journal of Phys. Medicine Rehabilitation 112-115 (1994). Overall, some studies have shown that FMS can be as disabling as rheumatoid arthritis. Although preliminary follow-up studies suggest that as many as 40 percent may significantly improve, it appears that few people with FMS will ever completely recover.

EVALUATING THE INSURED'S PROOF OF SICKNESS • As a general rule, each party in a lawsuit has the burden of proving the existence (or nonexistence) of every fact that is essential to the claim or defense he or she is asserting. With regard to claims for insurance coverage, it therefore is axiomatic that the insured has the burden of estab-

lishing that the occurrence which forms the basis of the coverage claim falls within the basic scope of insurance coverage. *See, e.g., Weil v. Federal Kemper Life Assurance Co.* 866 P.2d 774, 788 (Cal. 1994).

The typical disability income insurance policy provides for benefits only if the insured's disability is attributable to some "sickness" or "injury." Consequently, the insured cannot establish his or her eligibility for benefits without offering some proof of the sickness or injury to which he or she attributes the alleged disability.

By nature of the conditions, it often is extremely difficult for an insured to prove that he or she suffers from CFS or FMS. Simply stated, there is no single diagnostic test for either condition. Recognizing that fact, some courts have elected to require lesser proof of the insured's sickness. However, other courts have been persuaded that the absence of a definitive diagnosis is enough to justify the denial of a claim for disability benefits.

Must The Insured Have A Definitive Diagnosis?

In *Yeager v. Reliance Standard Life Insurance Company,* 88 F.3d 376 (6th Cir. 1996), an industrial nurse filed a claim for disability benefits under a group plan issued by Reliance Standard, claiming that she was disabled as a result of FMS, chronic low back pain, arthritis, fatigue, and carpal tunnel syndrome. Three of her treating physicians supported her claim for benefits by offering opinions that she was not capable of performing the material duties of her occupation. All three physicians also identified FMS as the "probable diagnosis" of her condition. However, they each acknowledged an absence of objective findings to support the insured's subjective complaints, and none of them definitively diagnosed her to be suffering from FMS.

The insurer denied the claim for benefits because there was insufficient proof that the insured was totally disabled within the meaning of the policy. In the subsequent lawsuit, the court reasoned that:

"The Plan required plaintiff to submit satisfactory proof that she could not perform the material duties of her regular occupation, and defendant had received no medical evidence of any physical condition or anatomic abnormality that would cause plaintiff to be totally disabled. The disabling condition on which plaintiff based her claim for disability benefits is FMS, but no doctor ever actually definitively diagnosed plaintiff as having this condition…. In the absence of any definite anatomic explanation of plaintiff's symptoms, we cannot find that the administrator's decision to deny benefits was arbitrary and capricious."

Id. at 381-382. The *Yeager* court therefore found the lack of a definitive diagnosis of the insured's condition to be fatal to her claim, even though three of her treating physicians had agreed that she was totally disabled. *See also, Ellis v. Metropolitan Life Insurance Co.,* 126 F.3d 228 (4th Cir. 1997) (despite primary treating physician's diagnosis of somatic dysfunction, denial of claim was not arbitrary and capricious when all treating physicians were unable to arrive at a consensus on a diagnosis of the claimant's condition).

Other cases involving challenges to the insured's proof of an underlying sickness have produced similar results. *See, e.g., Steinmann v. Long-Term Disability Plan of the May Department Stores Co.,* 863 F. Supp. 994 (E.D. Mo. 1994) (summary judgment proper in absence of objective evidence supporting a diagnosis of chemical sensitivity that would form a basis of total disability); *Donato v. Metropolitan Life Insurance Company,* 19 F.3d 375 (7th Cir. 1994) (claim denial neither arbitrary nor capricious when disability attributed to alleged chemical hypersensitivity identified by questionable medical theory and suspect medical evaluation, testing, and documentation). However, the notion that insureds must present objective medical evidence of the sickness allegedly causing the disability has not been univer-

sally accepted. At least one court has reasoned that requiring the insured to present objective medical evidence of a sickness is consistent with the goal of providing disability benefits only to those individuals who "truly merit such benefits." *Davis v. U.S. West Inc.*, 1996 WL 673148 at *12 (D. Neb. Sept. 26,1996), *aff'd without opinion*, 141 F.3d 1167 (8th Cir. 1998). Other courts have reasoned that "medical conditions that do not give rise to hard laboratory facts or data may still be cognizable claims." *Duncan v. Continental Casualty Co.*, 1997 WL88374 at *5 (N.D.Cal. 1997). The prevailing view therefore appears to be that, when the underlying sickness is universally recognized as being severely disabling but has no known etiology, "it would defeat the legitimate expectations of [plan participants] to require those with [the condition] to make a showing of such etiology a condition of eligibility for LTD benefits." *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 443 (3d Cir. 1997) (arbitrary and capricious to deny benefit claim for a lack of clinical evidence regarding the etiology of the insured's CFS); *see also, Clausen v. Standard Insurance Company*, 961 F. Supp. 1446, 1456 (D. Colo. 1997) ("Standard's attempt to ignore the CFS diagnosis of Clausen's treating physicians and to require, instead, that Clausen provide 'objective' evidence of a distinct 'physical disease' runs afoul of established law in this circuit."); *Duncan*, supra, at *5 ("Continental may not deny Duncan's claim because her physician cannot provide physiological proof where the physical condition is such that physiological proof is not available").

Indeed, the majority of courts now consider it unreasonable for an insurer to require objective medical evidence of a condition such as CFS or FMS that cannot be verified through objective laboratory testing. Illustrative cases include:

- *Welch v. Unum Life Ins. Co. of Am.*, 382 F.3d 1078, 1087 (10th Cir. 2004) (summarizing decisions from different Circuits recognizing that conditions such as FMS and CFS are disabling conditions that are not subject to objective tests to conclusively confirm the disease);
- *Denmark v. Liberty Life Assurance Co. of Boston*, 481 F.3d 16, 37 (1st Cir. 2007) (district court correctly found that FMS is a condition that is not subject to objective verification);
- *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 872 (9th Cir. 2004) ("[F]ibromyalgia's cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective");
- *Green-Younger v. Barnhart*, 335 F.3d 99, 108 (2d Cir. 2003) (noting that a growing number of courts recognize that FMS is a disabling condition that is not subject to objective testing to confirm diagnosis of the impairment);
- *McPhaul v. Board of Comm'rs of Madison County*, 226 F.3d 558, 562 (7th Cir. 2000), *cert denied*, 532 U.S. 921 (2001) (there is no known cause or cure for FMS, and the symptoms are entirely subjective);
- *Boardman v. Prudential Ins. Co. of Am.*, 337 F.3d 9, 16 n.5 (1st Cir. 2003) (CFS and FMS do not lend themselves to objective testing);
- *Cook v. Liberty Life Assurance Co.*, 320 F.3d 11, 21 (1st Cir. 2003) (unreasonable for insurer to require claimant to provide "clinical objective" evidence to establish that she was suffering from CFS);
- *Burchill v. Unum Life Ins. Co. of Am.*, 327 F. Supp.2d 41, 51 (D. Me. 2004) (requiring standard of proof of CFS effectively eliminates possibility that claimant with CFS can establish eligibility for disability benefits).

Importantly, however, a few courts have concluded that conditions such as FMS is diagnosable and suffers from such can be diagnosed objectively. Illustrative cases include the following:

- *Russell v. UNUM Life Ins. Co. of Am.*, 40 F. Supp.2d 747, 751 (D.S.C. 1999) (concluding that courts and the medical community both

are aware that FMS is a "diagnosable condition" that physicians "can look to objective factors to diagnose");

- *Hawkins v. First Union Corp. Long-Term Disability Plan,* 326 F.3d 914, 919 (7th Cir. 2003) (noting that FMS can be diagnosed "more or less objectively by the 18-point test," but acknowledging that "the amount of pain and fatigue that a particular case of it produces cannot be");
- *Brenner v. Hartford Life & Accident Ins. Co.,* 2001 WL 224826, at *4 (D. Md. Feb. 23, 2001) ("Both objective and subjective evidence may be used to establish a diagnosis of FMS, with greater deference accorded to the evaluation of the treating physician");
- *Brosnahan v. Barnhart,* 336 F.3d 671, 678 (8th Cir. 2003) (claimant's testimony and reports to the Social Security Administration were "supported by objective medical evidence of fibromyalgia").

Whether a claimant may be required to offer objective medical evidence to support a diagnosis of FMS or CFS therefore is likely to depend as much on the jurisdiction in which the dispute is litigated as the particular facts that are specific to the claim.

Medical Experts And The Need For An IME

In *Gawrysh v. CNA Insurance Company,* 8 F. Supp. 2d 791 (N.D. Ill. 1998), the insured described herself as suffering from chronic fatigue, sinus problems, severe headaches, and depression. Her primary treating physician offered that she suffered from CFS and other infirmities, including sinusitis with intractable headache, recurrent sinus infections, and bronchitis. After obtaining the insured's medical records, the insurer's claim specialist found that the insured's maladies did not meet the diagnostic criteria for CFS. The claim specialist therefore denied the insured's claim for benefits because there was no objective medical documentation to support her claim of disability.

When reviewing that claims specialist's decision, the court first noted that diagnosing CFS is "not a simple matter." It then explained that no single test for the diagnosis of CFS exists and that the formal diagnostic criteria require physicians to rule out other clinically defined causes of chronic fatigue by using a variety of tests. On the facts before it, the court found the evidence to indicate that the insured's symptoms were "debilitating and were consistent with CFS." The court commented that: "[r]ather than punishing [the insured] for the inability of medicine to specifically pinpoint the cause of her debilitating fatigue, C.N.A. should have hired experts or used its own doctors to examine [the insured] to determine the cause and degree of her fatigue." *Id.* at 794.

Significantly, the insurer in *Gawrysh* never had outside experts examine the insured or make any effort to establish the severity and cause of her fatigue. Instead, it utilized only a claims specialist who had no apparent medical training or experience. The court therefore held that the insurer's denial of the insured's benefit claim had been arbitrary and capricious.

In contrast, the insurer in *Greene v. Metropolitan Life Insurance Company,* 924 F. Supp. 351 (D.R.I. 1996), collected the medical records regarding an insured who claimed to suffer from CFS and forwarded them to an outside medical consultant for review. Ultimately, that medical consultant concluded that the available information did not allow for an independent confirmation of the CFS diagnosis. The lawsuit that followed the insurer's denial of the benefit claim therefore presented a classic "battle of the experts." Stated differently, the court was being asked to decide whether to believe the insured's doctor (who diagnosed CFS) or the insurer's medical consultant (who found no support for that diagnosis). In the end, though, the court found that the "arbitrary and capricious" standard of review prescribed by ERISA (*see Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989)) prevented

it from "injecting its own judgment into the case to vacate a claim fiduciary's prior determination." *Greene,* supra, 924 F. Supp. at 360.

Despite the outcome in *Greene,* it is clear that hiring a medical expert to review the available records or examine the insured who attributes disability to a self-reported condition is not always enough—even in an ERISA case in which the claim review fiduciary has discretion. In *Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan,* 971 F. Supp. 1310 (C.D.Cal. 1997), for example, the insured sought disability benefits after her rheumatologist diagnosed her to be suffering from "profound fibromyalgia." In response, the plan had the insured examined by an internist who found no objective evidence to substantiate her reported symptoms. The plan then denied the claim for benefits, and the insured filed suit.

Unlike the court in *Greene,* the *Monroe* court held that the plan's claims decision had been arbitrary and capricious. In part, the court based its decision on the presence of some objective evidence supporting the claim of FMS (i.e., an abnormal sleep study and record of certain trigger points). However, the court also was persuaded by the plan's failure to have the insured examined by a rheumatologist, as well as the fact that the plan's physician was not a "fibromyalgia expert." *Id.* at 1315.

ASSESSING THE INSURED'S FUNCTIONAL CAPACITY • Under the terms of most disability income insurance policies, the insured cannot establish a "total disability" simply by presenting evidence that he or she has a sickness or suffered some injury. Rather, the terms of most disability income insurance policies define the phrase "totally disabled" to mean that, due to "injuries" or "sickness," the insured has an incapacity to perform the substantial or material duties of an "occupation." To establish a total disability within the meaning of such policies, the insured therefore must establish both a sickness (or injury) and a resulting incapacity to perform the substantial or material duties of an occupation.

For that reason, most policies can be said to prescribe a functional test for determining whether the insured is "totally disabled." Under such a functional test, the Ninth Circuit, in *Matthews v. Shalala,* 10 F.3d 678 (9th Cir. 1993), explained that "[t]he mere existence of an impairment is insufficient proof of a disability…. A claimant bears the burden of proving that an impairment is disabling." *Id.* at 680. Accordingly, proof of a sickness or injury alone is not enough. Rather, "the focus of the analysis is on the degree to which the physical impairment has hindered a worker's earning capacity." *State Industrial Ins. System v. Bokelman,* 946 P.2d 179, 182 (Nev. 1997).

Numerous cases involving disabilities attributed to self-reported conditions recognize that concept. *See, e.g., Greene,* supra, 924 F. Supp. at 360 ("…whether or not Greene could perform her job duties was the relevant question in determining her eligibility under the disability plan, not simply being diagnosed with CFS"); *Renfro v. UNUM Life Insurance Company of America,* 920 F. Supp. 831, 839 (E.D. Tenn. 1996) ("…the issue before the plan administrator was, as it is before this court, whether any condition or combination of conditions suffered by the [claimant] is disabling within the meaning of the applicable plan language. A list of diagnosed conditions, standing alone, does not satisfy the burden of making such a showing of disability"). Thus far, though, the reported cases show little agreement as to the type and character of evidence necessary to show that a self-reported condition is, in fact, disabling.

In an unreported decision, the court in *Duncan,* supra, considered the disability benefit claim of an insured who had been diagnosed with FMS. The insurer had denied the claim because there was no objective medical evidence of a condition severe enough to have caused a disability. When reviewing that decision de novo, the court first noted that the

policy made no reference to the "objective medical evidence" described in the insured's denial letter. It then concluded that, unless the requirement of "objective medical evidence" was made "clear, plain and conspicuous enough [in the policy] to negate laymen objectively reasonable expectations of coverage," the insurer's claim decision could not be sustained under any standard of review. *Id.* at *4.

In a slightly different context, the court in *Sansevera v. E.I. Du Pont De Nemours & Co., Inc.* 859 F. Supp. 106 (S.D.N.Y. 1994), reached a similar conclusion. In that case, the plan denied a claim for long-term disability benefits because the insured failed to provide objective medical evidence that he was permanently incapacitated by CFS. However, the court found the plan's requirement that the applicant demonstrate with medical certainty that a disability will be permanent to be unreasonable when:

"...[As] is especially true in the case of an applicant diagnosed with CFS…there is currently no method of determining whether a person will ever recover from CFS, nor is there any treatment that has been proven effective in overcoming this illness. Because Sansevera has been suffering from CFS since February of 1990 and has not shown any sign of improvement, it is unreasonable to deny him benefits simply because he cannot prove with medical certainty that he will never recover."

Id. at 114-115. About two and a half years later—in a case involving the very same long-term disability plan—the District Court of New Jersey reached the opposite conclusion. Specifically, the court in *Pokol v. E.I. Du Pont De Nemours & Co., Inc.*, 963 F. Supp. 1361 (D.N.J. 1997), held that, because the plan expressly gave the administrator discretionary authority to construe its terms and conditions, it was neither irrational nor unreasonable for the administrator to interpret the language "satisfactory medical evidence" to require "objective medical evidence." *Id.* at 1372.

Other courts have employed similar reasoning to uphold an insurer's denial of a subjective disability claim for a lack of objective medical evidence about the insured's functional capacity:

- *Finster v. Metropolitan Life Insurance Co.,* 927 F. Supp. 201 (N.D. Tex. 1996) (summary judgment granted to insurer because plaintiff did not provide objective medical evidence that reported back pain was disabling);
- *Conley v. Pitney Bowes, Inc.*, 978 F. Supp. 892 (E.D. Mo. 1997), *aff'd*, 176 F.3d 1044 (8th Cir. 1999), *cert. denied*, 528 U.S. 1136 (2000) judgment for insurer after trial because plaintiff's complaints of subjective back pain not supported by objective medical findings);
- *Pralutsky v. Metropolitan Life Ins. Co.*, 435 F.3d 833, 839-40 (8th Cir. 2006), *cert. denied*, 127 S.Ct. 264 (2006) (plaintiff failed to establish disability because record did not contain objective medical evidence of significant impairment);
- *Johnson v. Metropolitan Life Ins. Co.*, 437 F.3d 809, 814 (8th Cir. 2006) (claimant with FMS only offered subjective, uncorroborated complaints of pain and the objective evidence failed to functional impairment);
- *Stiltz v. Metropolitan Life Ins. Co.*, 2006 WL 2534406 (N.D. Ga. Aug. 30, 2006) (same), *aff'd by Stiltz v. Metropolitan Life Ins. Co.,* 2007 WL 1600036 (11th Cir. June 5, 2007).

In *Brucks v. Coca-Cola Company*, 391 F. Supp.2d 1193, 1205 (N.D. Ga. 2005), the court more fully explained that:

"The requirement that a plaintiff submit objective evidence of the impact of a diagnosed disease, illness or other condition is logical and necessary…. The objective-evidence requirement promotes integrity in the application of the law. It assures claimants are treated fairly and with parity by providing that coverage decisions are not based on varying subjective expressions by claimants of a disease, illness or condition with which they have been diagnosed. That is, it requires claimants to establish that the diagnosed disease, illness or condition results in an actual disability, not just a perceived

one. The requirement of objective evidence also promotes integrity by assuring there is corroboration for the claimant's subjective complaints, thus deterring embellished allegations of the effect of the diagnosed malady as well as deterring fraud in the claims process."
Id. at 1205. At the same time, though, other courts continue to reason that a lack of objective medical evidence to prove the insured's functional impairment "cannot constitute substantial evidence that [the insured] was not disabled." *Clausen,* supra, 961 F. Supp. at 1457, *citing Sisco v. U.S. Department of Health and Human Services,* 10 F.3d 739 (10th Cir. 1993).

Collectively, then, the cases involving subjective disability claims suggest that the required proof and likely outcome can be as dependent upon the choice of forum as any differences in the facts or available evidence. Nevertheless, the prevailing view appears to allow insurers to require objective evidence of a functional impairment, even when objective medical evidence cannot establish the insured's underlying medical condition.

STRATEGIES AND PRACTICAL TIPS • Subjective disability claimants often are confident of their eligibility for benefits because of either the apparent certainty with which their conditions have been diagnosed or the severity of the symptoms which they attribute to those conditions. All too frequently, however, subjective disability claimants fail to recognize the need to establish both the sickness from which they suffer and their related functional impairments.

In the end, the party who examines those issues first usually has a tremendous advantage. Indeed, an appreciation for the differences between those issues (and the evidence required with respect to them both) can create several opportunities for a favorable resolution of disability cases that involve self-reported conditions.

Make No Claims Decision Without Medical Review Or An IME

For reasons discussed earlier, an insurer's failure to retain an expert to review the insured's medical records or have the insured examined by a qualified medical practitioner can prompt the finder of fact to conclude that its denial of a subjective disability claim was arbitrary and capricious. *See, Garwysh,* supra. In contrast, an insurer's reliance on the opinions of qualified experts can demonstrate that its claims decision was reasonable, even when the insured's treating physicians disagree with those experts. *See Greene,* supra, 924 F. Supp. at 360. Insurers therefore should defer any decision on a subjective disability claim until the insured's medical records have been reviewed or the insured has been examined by a qualified medical expert.

In that regard, care must be taken to select appropriate medical experts. *See Monroe,* supra. Those experts also should be asked to comment separately on the genuineness of the insured's underlying condition and his or her functional capacity. Doing so could reveal that the insured's self-reported condition escapes a definitive diagnosis. *See, Yeager,* supra, 88 F.3d 376 (6th Cir. 1996). It also could enable the insurer to enhance its position before the jury by permitting it to acknowledge the insured's self-reported condition as genuine while, at the same time, challenging only the level of functional impairment related to that condition.

Verify That The Insured Received Proper Medical Treatment

Many policies define "total disability" as a functional incapacity which is caused by a condition for which the insured is receiving appropriate medical care. As the court in *Kottle v. Provident Life and Accident Insurance Company,* 775 So.2d 64 (La. App. 2 Cir., 2000), explained, the primary purpose of requiring proof of appropriate medical care "is to insure proper treatment so as to shorten the period of disability."

Although the medical experts in *Kottle* differed in their diagnoses of the insured's condition (i.e., panic disorder, anxiety disorder, agoraphobia, ADNOS or OCD), the court noted that they all agreed that "the 'gold standard' of treatment" for the insured's condition was "a combination of drug therapy and psychotherapy or cognitive therapy." In an appropriate case, then, evidence that the insured had received none of those forms of treatment could be offered to prove the insured did not receive appropriate medical care (and therefore was not totally disabled).

In other words, evidence that the insured did not receive medical care that is appropriate to his or her self-reported condition therefore can significantly affect the benefits that must be paid. For that reason, a thorough understanding of the diagnostic criteria and accepted treatment options for any self-reported condition can be invaluable.

Consider Whether The Self-Reported Condition Involves A Mental Disorder

Many policies contain significant limitations or exclusions for disabilities that involve a mental disorder or illness. The nature of the condition producing the insured's self-reported symptoms therefore can have an important impact on the insurer's liability under the policy.

Unfortunately, the task of determining whether a self-reported condition involves a mental disorder or illness is not always simple. In fact, some conditions may appear to be physiologically based but, in actuality, be more properly classified as mental disorders or diseases. *See, e.g., Elam v. First Unum Life Insurance Company,* 32 S.W. 3d 486 (Ark. Ct. App., 2000), *rev'd,* 57 S.W. 3d 165 (Ark. 2001) (bipolar disorder). Insurers therefore should carefully consider consulting a medical expert before asserting that a limitation or exclusion for disabilities involving a mental disorder or illness applies to a self-reported condition.

Obtain A Functional Capacity Evaluation

A functional capacity evaluation (or "FCE") is a tool for identifying "an individual's functional abilities or limitations in the context of safe, productive work tasks." *Bressmer v. Federal Express Corp.,* 2000 WL 637069, at *1 n.1 (2d Cir. 2000), *quoting* Phyllis M. King, et al., *A Critical Review of Functional Capacity Evaluations,* 78 Physical Therapy 852, 853 (August 1998). In essence, it involves a series of test activities that are designed "to measure whether an individual has the ability to meet the required job demands." *Id.* Unlike an independent medical exam, then, an FCE can provide an objective measure of a claimant's functional capacity. In turn, an FCE often is considered the "best means of assessing an individual's functional level." *Fick v. Metropolitan Life Ins. Co.,* 347 F. Supp.2d 1271, 1280 (S.D. Fla. 2004), *citing Lake v. Hartford Life & Accident Ins. Co.,* 320 F. Supp.2d 1240, 1249 (M.D. Fla. 2004).

To be certain, several courts have found the results of an FCE to be highly persuasive evidence that a claimant with a self-reported condition retained the ability to perform the essential functions of his or her job. *Donnell v. Metropolitan Life Ins. Co.,* 165 Fed. Appx. 288, 295, 296 (4th Cir. 2006); *see also, Wise v. Hartford Life & Accident Ins. Co.,* 403 F. Supp.2d 1266, 1277-78 (N.D. Ga. 2005). Nevertheless, other courts have been reluctant to accept FCE's findings in cases involving an insured with FMS, reasoning that it cannot provide a true picture of an illness marked by variable symptoms and cannot prove or disprove a claim of disabling pain. *See, e.g., Brown v. Continental Casualty Co.,* 348 F. Supp.2d 358, 367-68 (E.D. Pa. 2004); *Dorsey v. Provident Life & Accident Ins. Co.,* 167 F. Supp.2d 846, 856 (E.D. Pa. 2001). Regardless of the view held in any particular jurisdiction, then, insurers should consider obtaining a functional capacity evaluation before finalizing any adverse claim decision.

Consider Surveillance Of The Insured's Daily Activities

Clandestine surveillance can be useful in verifying the candor with which an insured reports the symptoms and level of functional impairment associated with a self-reported condition. However, it often is expensive to surveil an insured's daily activities. As a result, many insurers reserve the use of clandestine surveillance to larger claims that involve a disability that the insured attributes to a subjective disorder.

To the extent it produces evidence that the insured has engaged in daily activities that are inconsistent with his or her reports to the insurer, surveillance can severely damage the insured's credibility at trial. When those inconsistencies are substantial, skilled defense attorneys also can use scenes from a surveillance videotape to secure important admissions from the insured's treating physicians. However, the full utility of surveillance videotapes can unwittingly be lost without advance planning by the insurer's trial counsel.

Specifically, Rule 26 of the Federal Rules of Civil Procedure mandates that the parties to federal litigation produce all "tangible things" that are relevant to disputed facts alleged with particularity in the pleadings. Fed. R. Civ. P. 26(a)(1)(A). Rule 26 also stays all formal discovery until after the "meet and confer" session, which must precede those disclosures by no more than 14 days. Fed. R. Civ. P. 26(d). The disclosure provisions in Rule 26 therefore operate to require that insurers which have conducted clandestine surveillance as a part of their claims investigation produce any videotapes from that surveillance before conducting any discovery.

That circumstance can substantially limit the utility of surveillance videotapes. For example, a disability claimant who receives copies of videotapes with the insurer's initial disclosures can examine them to learn what the insurer knows about the activities in which he or she has engaged. Armed with that information, the disability claimant can carefully tailor his or her deposition testimony to support the alleged disability without contradicting the activities recorded on videotape. In turn, that deposition testimony can reduce the videotapes to a mere record of the claimant's ability to perform activities that bear no relationship to the disability the claimant describes in deposition.

Several published federal rules decisions recognize this problem and provide a solution. *See, Forbes v. Hawaiian Tug and Barge Corp.,* 125 F.R.D. 505 (D. Haw. 1989); *Daniels v. National Railroad Passenger Corp.,* 110 F.R.D. 160 (S.D.N.Y. 1986); *Martin v. Long Island Rail Road Co.,* 63 F.R.D. 53 (E.D. N.Y. 1974); *Snead v. American Export-Isbrandtsen Lines, Inc.*, 59 F.R.D. 148 (E.D. Pa. 1973). In each of those cases, the court acknowledges that allowing the claimant to view the videotapes before testifying in deposition could affect the substance of his or her deposition testimony. To guard against that result, they uniformly conclude that the defense "must be given an opportunity to depose the plaintiff fully as to his injuries, their effects, and his present disabilities" before even the existence of the surveillance videotapes is disclosed. *Snead,* supra, 59 F.R.D. at 151.

Insurers who have made an investment in videotaped surveillance to investigate a disputed disability claim therefore should consider making an ex parte motion—without notice to the claimant—for a protective order that allows them to omit the videotapes from their initial disclosures and defer producing them until after the claimant has testified in deposition. Without such an order, the impeachment value of surveillance videotapes can be irretrievably lost, and the true nature of the claimant's alleged disability can become elusive.

An additional consideration regarding videotaped surveillance which seems obvious (but often may be overlooked) is that the insurer should provide the videotape to its expert or otherwise ensure that a record of the surveillance becomes part of the claim file. Indeed, the insurer in an ERISA case must make certain that any videotaped surveillance

that is favorable becomes part of the administrative record. Otherwise, the insurer will be precluded from using evidence of the surveillance at trial, even if the insured's observed activities clearly contradict his or her professed level of functional incapacity. *See, e.g., Opeta v. Northwest Airlines Pension Plan for Contract Employees*, 484 F.3d 1211, 1219 (9th Cir. 2007).

Conduct The Insured's Deposition Early In The Lawsuit

In most cases, it is best to conduct the insured's deposition during the earliest stages of discovery. Delays allow the insured and his or her attorney more time to consider the facts, research the proof that must be made to prevail at trial, and become more "educated" about the potentially dispositive issues.

During the insured's deposition, the insurer's attorney should authenticate as many of the claim forms, written communications, and other documents (such as attending physician statements) as he or she can. Naturally, the authentication of those documents will assist the insurer when it sets out to prepare a motion for summary judgment. At the same time, though, many of the documents in the insurer's claim file will include statements the insured made about his or her condition, the symptoms related to that condition, and the activities in which he or she engaged on a daily basis. Reviewing those documents with the insured will invite him or her to verify the severity of the subjective disorder and resulting level of functional impairment.

The insurer's attorney also can use the review of those documents as an opportunity to establish other important facts. For example, it can be used to ask the insured to confirm the presence (or absence) of those symptoms which are necessary to meet the diagnostic criteria for the self-reported condition. It also can solicit damaging testimony about the insured's daily activities that are inconsistent with those captured on videotape by a surveillance team, as well as admissions about the insured's functional capacity which are consistent with the demands of the occupation in question.

Cross-Examine The Treating Doctors In Deposition

After developing a full evidentiary record of the insured's reported symptoms and actual level of functioning, the insurer's attorney should depose each of the insured's treating physicians. At a minimum, those depositions should be used to establish the limits of each physician's expertise. However, the focus of those depositions should otherwise be kept on the certainty with which the physician diagnosed the insured's condition and the facts upon which each physician based his or her assessment of the insured's functional capacity.

The decision in *Renfro v. UNUM Life Insurance Co. of America*, 920 F. Supp. 831 (E.D. Tenn. 1996), provides an excellent illustration of one insurer's successful use of that strategy. In that case, the claimant initially filed a claim due to major depression. After the policy's two-year benefit period for mental-nervous conditions expired, she asserted that she remained totally disabled from multiple causes.

The insured supported her claim for benefits with a variety of medical evidence. For example, the report from her allergist indicated that she was very sensitive to certain chemicals. Based upon that report, the insured's treating internist concluded that the insured's allergies and asthma made her sensitive to perfume and other materials common in the workplace and therefore unable to work. *Id.* at 834. In addition, the insured's chiropractor and physical therapist both reported that the insured suffered from arthralgias, myalgias, weakness, and other medical problems that contributed to her inability to work. After reviewing the insured's medical records, though, the insurer found nothing from a physical standpoint to support her claim of disability. The insured thereafter consulted a pulmonologist, who reported that her breathing difficulties

were neither psychological nor the product of malingering. *Id.* at 835.

The insurer next conducted an IME that produced a finding that the insured's asthma was, at best, mild. The IME doctor further offered that the insured's sensitivity to chemicals could be controlled with the aggressive use of an anti-inflammatory drug. *Id.* at 836. He also suggested that her alleged disability was functional (i.e., the product of secondary gain), rather than the result of a true asthma condition. *Id.* at 837. The insurer therefore denied the benefit claim.

In the ensuing ERISA lawsuit, the court examined the insurer's claims decision under the de novo standard of review. *Id.* at 838. It commenced its analysis by noting that the treating psychiatrist had only provided evidence of the insured's mental disability and had disclaimed any expertise concerning allergies. It then noted that the treating allergist had diagnosed several conditions, but had not attributed the insured's disability to any of them. The court next dismissed the opinions of the insured's chiropractor and physical therapist because neither of them had the expertise to diagnose an infectious or environmental illness. In cases involving Social Security benefits, the Ninth Circuit has unambiguously held that a chiropractor is "not considered an acceptable medical source…. Although a claimant is free to offer chiropractic evidence to help the Secretary understand his inability to work,…there is no requirement that the Secretary accept or specifically refute such evidence." *Bunnell v. Sullivan*, 912 F.2d 1149, 1152 (9th Cir. 1990), *rev'd on other grounds*, 947 F.2d 341 (9th Cir. 1991) (en banc); *see also*, 20 C.F.R. §404.1513(a) and (e) (distinguishing between "acceptable medical sources" and "other sources," and listing chiropractors under "other sources"). As a result, the treating internist's opinion (attributing the alleged disability to "very, very severe asthma") was the only competent medical evidence to support the disability claim.

After isolating the court's attention on the internist's opinion, the insurer offered evidence of clinical tests that contradicted the internist's opinion. It also demonstrated that the insured's own allergist did not suggest that allergies contributed to her disabilities. The court therefore upheld the insurer's denial of the benefit claim. *Renfro*, supra, 920 F. Supp. at 838.

In most cases, treating physicians also will acknowledge that their assessment of the insured's functional capacity was based largely on the insured's subjective complaints. Insurers who possess compelling surveillance videotapes therefore should consider asking the treating physicians to view those videotapes during deposition, then soliciting either an admission that the insured's functional capacity may be greater than reported or at least a concession that their assessment of the insured's functional capacity is based on incomplete information.

Moving For Summary Judgment

Through the use of qualified medical experts, IMEs, surveillance, and effective cross-examination, disability insurers and their attorneys often can assemble a wealth of evidence to refute the insured's claim that a self-reported condition is disabling. Accordingly, the mere fact that the insured has made subjective complaints of a disabling sickness or injury should not dissuade the insurer from filing a motion for summary judgment.

To be certain, the insured's subjective complaints may ultimately reflect on his or her motivation to return to work. However, the credibility of those complaints is immaterial to a motion for summary judgment in a subjective disability case. Specifically, the policy's definition of "total disability" usually provides for an objective test that focuses on the insured's ability to return to some form of gainful employment. The central issue therefore is one that requires medical evidence, rather than an insured's subjective, unqualified opinion.

In most cases, the subjective disability claimant lacks sufficient medical expertise to offer an opinion about his or her functional capacity. For that reason, the insured's subjective complaints should have no bearing on his or her eligibility for benefits. Stated differently, the insured's subjective complaints of a self-reported condition or disabling symptoms cannot constitute substantial evidence that the underlying condition is, in fact, disabling. Instead, the resolution of that issue must turn on medical evidence developed from a variety of other sources. A plaintiff must come forward with sufficient competent evidence to find permanent disability. *See, e.g.*, *Nevada Industrial Commission v. Hildebrand*, 675 P.2d 401, 404 (Nev. 1984) ("Hildebrand could not, by her own assertion of substantial limitation, show a…permanent total disability"); *see also, Chappaz v. Golden Nugget,* 822 P.2d 1114, 1118 (Nev. 1991) (competent medical authority is required to establish that an injured worker is unable to return to his pre-injury employment).

Trial Tactics

Subjective disability claims often involve a complex set of medical opinions about conditions with which most jurors have little experience. When preparing to try a case involving a subjective disability claim, the primary goal of the insurer's attorney therefore should be to simplify that evidence so that the jury can more readily apply it to the applicable legal standards.

A significant portion of that work must be completed before trial actually begins. For example, the insurer's attorney should consider filing pretrial motions to exclude the opinions of any treating physician who lacks the expertise necessary to diagnose the insured's self-reported condition or assess his or her functional capacity. Doing so will minimize the amount of testimony the jury hears about the various maladies from which the insured may suffer. It also should limit the insured's evidence at trial to the competent medical evidence required to sustain his or her burden of proof.

Of course, the insurer has no reason to expect a favorable outcome at trial unless it has assembled medical evidence of its own to suggest either that the insured's self-reported condition is not genuine or that the insured's functional capacity is not sufficiently impaired. However, its trial counsel should seize every opportunity to establish common ground between its medical experts and the insured's treating physicians, so that the points of dispute (and issues to be resolved by the jury) are more clearly defined.

In most cases, insurers who have retained qualified medical experts and allowed them to perform appropriate tests to comprehensively examine the nature and extent of the insured's alleged disability can rely on the testimony of those experts to demonstrate that their opinions are more compelling than those of the insured's treating physicians. The insurer's ability to make that showing also can be enhanced by evidence (such as excerpts from surveillance videotapes) that directly contradicts the insured's subjective complaints. Indeed, the treating physicians' opinions often are based on those subjective complaints. As a result, evidence that the insured is capable of tasks he or she told doctors were impossible to perform can undermine the foundation of the treating physicians' opinions.

Absent compelling evidence, though, insurers must be careful not to ask that the jury decide whether the insured's subjective complaints are credible. Rather, they should explain why the evidence that contradicts those subjective complaints is more reliable, then ask that the jury consider only the competent evidence of the insured's functional capacity. Otherwise, jurors may presume the insurer believes the insured to be a liar and reach a decision for reasons unrelated to the evidence presented at trial.

CONCLUSION • Although the case law involving subjective disability claims is largely unsettled, several decisions hold promise for an analytical approach that will assist insurers in exposing fraudulent claims. Specifically, some cases hold that the insured must present evidence of a definitive diagnosis regarding his or her self-reported condition, and others suggest that objective medical evidence is required to establish the condition and related functional impairment. For now, though, an insurer's ability to use those decisions to achieve favorable outcomes appears to be more a matter of forum selection than anything else.

As a result, disability insurers and their trial counsel should stick to the basics and apply more traditional principles of insurance coverage analysis to disability claims that involve self-reported conditions. In particular, they should develop an evidentiary record concerning the sickness or injury to which the insured attributes his or her disability, then insist that the insured meet his or her burden of proving that sickness or injury exists. They also should develop an evidentiary record concerning the insured's functional capacity and use it to challenge the insured's proof of functional impairment.

Insurers who opt not to assemble that evidence are left to make claims decisions on the basis of conclusory opinions by medical professionals who often believe either that self-reported conditions do not exist or are not disabling. In the end, though, the party that assembles evidence to support the medical experts' opinions will prevail. Disability insurers who remain focused on the need for that evidence during the claims administration and litigation stage of subjective disability claims therefore fare much better than those who do not.