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February 16, 2007

VIA EXPRESS MAIL #XXXXXXX

We Cover You Claim Appeal Unit
We Cover You Life Insurance Company
PO Box 11111
We Cover You, PA 06104-1111

Re: Policy Holder: ICCF, Inc.
Claimant: Jane Doe
Policy No:

Gentlemen:

I represent Jane Doe with regard to her appeal of We Cover You Life Insurance Company's (hereinafter "We Cover You")'s denial of her claim for long term disability benefits under the referenced policy. In its August 24, 2006, letter, We Cover You notified Jane Doe of the denial of her claim advising that there is no objective testing to support her claim of functional impairment to sedentary job duties requiring cognitive skills. Based on a fair and impartial review of the claim file on appeal, We Cover You must reverse its decision denying Jane Doe LTD benefits, because its denial is not supported by substantial medical evidence.

SECTION I. STATEMENT OF CLAIM HISTORY

A. BACKGROUND AND NATURE OF JANE DOE'S DISABILITY:

Jane Doe was employed as a Receptionist with ICCF, Inc. On December 1, 2003, Jane Doe stopped working due to cognitive decline resulting from a brain injury sustained

in an October 18, 2002, fall. In addition to the brain injury, Jane Doe sustained multiple traumas in the fall, including injury to her left wrist and a cervical herniated disc. She was also involved in a subsequent automobile accident, further aggravating her injuries.

Following review of Jane Doe's claim application, We Cover You approved LTD benefits, and, after a 90 day elimination period, paid benefits from March 7, 2004, through August 24, 2006. Thereafter, on August 24, 2006, We Cover You issued a letter terminating Jane Doe's LTD benefits.

B. WE COVER YOU'S REASONS FOR TERMINATION OF BENEFITS:

We Cover You terminated benefits concluding that based on Jane Doe's medical information provided for review, her complaints have been subjective. Testing validated that she was motivated to exaggerate her problems. Therefore, a functional impairment to sedentary job duties requiring cognitive skills is not supported. We Cover You determined that the information in Jane Doe's file does not show that she is unable to perform the Essential Duties of her Own Occupation as a receptionist on a full time basis. In rendering its decision, We Cover You relied on the neuropsychological evaluation conducted by Dr. A, Ph.D.

During review of Jane Doe's file for continued benefits, Dr. A. performed an examination of Jane Doe on December 10, 2005, at We Cover You's request. Although Jane Doe passed 3 of the 5 tests administered for malingering, including the most sensitive malingering test, and although one of the failed tests has been rejected by a Florida Court as not being reliable or scientific, Dr. A. concluded that Jane Doe was probably malingering.

SECTION II: APPEAL

A. WE COVER YOU'S TERMINATION OF JANE DOE'S LTD BENEFITS IS ARBITRARY AND CAPRICIOUS AND MUST BE REVERSED.

1. From The Beginning Of Her Disability, Jane Doe's Condition Never Improved.

Benefits cannot be terminated without a change in status. In *McOsker v. Paul Revere Life Ins. Co.*, 279 F.3d 586, 589 (8th Cir. 2001), the Court held that unless information available to an insurer alters in some significant way, the previous payment of benefits is a circumstance that must weigh against the propriety of an insurer's decision to terminate those benefits. *See also* Norris v. City Bank, 308 F.3d 880 (8th Cir.

2002); *Walker v. Group Long-Term Disability Insurance*, 256 F.3d 835, 840 (8th Cir. 2001); *Connors v. Conn. General Life Ins. Company*, 272 F.3d 127 (2nd Cir. 2001); *Levinson v. Reliant Standard Ins. Co.*, 245 F.3d 1321, 1331 (11th Cir.2001); *Dishman v. UNUM*, 1997 U.S. Dist. LEXIS 22676 (C.D. Cal. 1997); *Hackner v. Long-Term Disability Plan for Employees of the HAVI Group LP*, 2003 WL22766067 (8th Cir. Nov. 17, 2003) (unpublished).

Jane Doe sustained a traumatic brain injury and multiple blunt traumas on October 18, 2002, when she fell down a flight of stairs. Immediately following the fall, she remained unconscious for several minutes. Emergency personnel air-lifted Jane Doe to Bayside Medical Center Emergency Room. In the Emergency Room, although alert and awake, Jane Doe could not recall the event and was somewhat repetitive and non focal. Hospital personnel admitted her for overnight observation.

Thereafter, she received follow up treatment with Dr. B., Dr. C., and Dr. D., and also underwent physical therapy. Upon completion of physical therapy, she returned to Dr. B., who noted that she was depressed due to the death of her grandmother. Dr. B. advised she may return to work, noting that she may have some discomfort which would resolve. On December 3, 2002, she returned to work for her employer in a limited capacity. However, as her symptoms progressed, Dr. B. documented significant back discomfort, pain on straight leg raise and palpable muscle spasms. On April 20, 2003, Dr. B. noted her "feelings of inability to work."

During her course of treatment with Dr. C., Jane Doe reported headaches and decreased memory. Therefore, he ordered an MRI scan of the brain. Jane Doe underwent the MRI scan of the brain on March 3, 2003, which revealed numerous punctate foci of increased T2 signal in the subcortical white matter, bilaterally. The radiologist interpreted these findings as probable ischemic changes.

Subsequently, on September 12, 2003, Dr. E., Psy.D., a clinical neuropsychologist, & Dr. F., Ph.D., a licensed psychologist, performed a comprehensive neuropsychological evaluation at the request of Dr. C. The purpose of the test was to assess her memory complaints. Jane Doe was administered a test sensitive to motivation to exaggerate cognitive and psychiatric symptoms. Performance – cognitive dissimulation indicated that she responded accurately and with optimal effort. The doctors' noted that she appeared to put forth her best effort throughout the evaluation and showed no signs of dissembling[1] on any of the tests.

[1] According to Dictionary.com, "Dissemble" is defined as (*transitive verb*): 1. To hide under a false appearance; to hide the truth or true nature of. 2. To put on the appearance of; to feign. *As an intransitive verb:* 1. To conceal

Jane Doe demonstrated difficulties with memory in several respects. On the WAIS-III Indices, her Working Memory Index was in the impaired range (WMI=65). She demonstrated brief auditory attention span in the borderline range, as she repeated 4 digits forward and 3 digits backward. She also obtained scores in the impaired range on tasks of divided attention/working memory. She also tested in the borderline and impaired ranges in verbal fluency for semantic and phonemic categories.

On testing of her executive abilities, Jane Doe demonstrated difficulty with higher level nonverbal reasoning, deductive reasoning, and conceptual formation. Although her overall performance was within normal limits (WCST categories completed-4, low average range), she made many perseverative[2] errors (6 percentile), and she was conceptually distracted (2-5 percentile). Further, although Jane Doe presented as an engaging, friendly woman, she readily became teary-eyed when she perceived she was performing poorly. On self-report screens of emotional and behavioral functioning (BDI-II; BAI), her response profile indicated mild levels of depression and anxiety.

Neurocognitive findings indicate that Jane Doe's overall intellectual functioning falls in the borderline/low average range, with equivalent verbal and nonverbal reasoning abilities. Psychological findings suggest that Jane Doe is experiencing mild to moderate levels of emotional turmoil, marked by somatic concerns, anxiety, depression, and relative social isolation. According to Dr. E. and Dr. F.' September 12, 2003, neuropsychological evaluation, it is likely that Jane Doe exhibits persisting cognitive and psychological difficulties as a result of the head injury she sustained in the October 2002 fall. Type of injury, medical records, and patient self report converge to suggest a classification within the severe end of the mild (i.e. complicated mild) severity classification. Additionally, the velocity of impact, alteration of consciousness, post-concussive symptoms, imaging findings, and the presence of post-traumatic amnesia are all consistent with a head injury in the severe end of the mild range.

Furthermore, Drs. E. and F. stated in their evaluation that they do not believe that Jane Doe's anxiety/depressive symptoms are the cause of her neuropsychological deficits. Overall, her performances were grossly within normal limits. Rather, her deficits were circumscribed to two domains: attentional abilities and executive functioning. In fact, both advised that the psychological distress currently experienced by her is similar to those

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the real fact, motives, intention, or sentiments under some pretense; to assume a false appearance; to act the hypocrite.

[2] According to Dictionary.com, "perseverate" is defined as: to repeat something insistently or redundantly.

symptoms reported by persons that experience Persistent Post Concussive Syndrome. These symptoms include depression, anxiety, irritability, indifference, and apathy.

On September 17, 2003, Dr. G., Jane Doe's primary care physician who treated her anxiety and depression, noted that Jane Doe recently underwent neuropsychological testing which showed anxiety disorder and postconcussional disorder. Dr. G. expressed concern that some of Jane Doe's memory and concentration problems could also be related to use of Topamax. Therefore, he discontinued her Topamax and increased her Effexor. During Jane Doe's October 13, 2003, visit, Dr. G. noted that at one time he recommended she discontinue taking Topamax because of some memory impairment and confusion. However, Jane Doe's headaches recurred and her neurologist told her to restart it.

At her November 3, 2003, appointment with Dr. D., Jane Doe reported complaints of daily headaches, significant photo and phonophobia and not sleeping well due to anxiety and neck and back pain. On December 1, 2003, Dr. D. noted that she had been reprimanded at her job due to poor job performance. He also noted that Jane Doe had some issues with staff, felt harassed, and that her feelings of persecution contributed to her level of stress. Because he felt this affected Jane Doe's job performance, Dr. D. recommended a period of short term disability (STD).

On December 16, 2003, Dr. D. noted that since her last visit Jane Doe gave up her apartment and briefly moved back in with her abusive former boyfriend; however, he again became abusive and she moved back out. Dr. D. also noted that Jane Doe still felt significant stress and reported lots of cognitive dysfunction, difficulty with concentration, problems in math and recently missed a flight because she forgot the time of her flight. Dr. D. felt Jane Doe's symptoms worsened in the last 4-6 months and he referred her to a psychiatrist.

In addressing Jane Doe's work status on January 13, 2004, Dr. D. advised that she was not able to work due to frequent headache and concomitant problems with concentration, attention and headache. On February 9, 2004, Dr. D. documented that Jane Doe still experienced significant difficulty with day to day activities and did not appear to be at a functional status that would allow her to reenter the work force. On March 11, 2004, Dr. D. documented Jane Doe's report of being terminated. On September 20, 2004, Dr. D. completed an Attending Physician Statement certifying that Jane Doe is unable to work due to inability to focus and attend to task due to her headaches and mood dysfunction. He indicated that she cannot perform computer work or anything that requires significant planning or attention.

Sherry F. performed a claim's review on behalf of We Cover You on June 23, 2004. She advised that the "prior NCM assessment of 3/19/04 & 4/27/04, in my opinion is unchanged and claimant is incapable of performing fulltime work at this time. Medical evidence presented by Dr. D. and Dr. G. supports claimant's functional impairment. MD states she is too symptomatic with mood symptoms and too compromised by cognitive difficulties d/t post concussion syndrome/ post traumatic cognitive function d/t falling with head injury 2 years ago."

In her September 17, 2004, addendum, Sherry F. stated that "the current medical continues to support loss of functionality that would preclude claimant from performing a fulltime sedentary job as a receptionist". Ms. F. went on to state that Claimant has "history of (h/o) post concussion syndrome with significant problems – traumatic cognitive function, depression, migraines, anxiety disorder, C3 radiculopathy."

There was no significant change in Jane Doe's condition to support a termination of benefits. While Jane Doe's condition may have waxed and waned following the date of her injury, she experienced no improvement in her physical condition or cognitive functioning at any time after We Cover You's September 17, 2004, review which concluded that benefits were payable. None of the medical records or any other records support a change or improvement in Jane Doe's memory, fatigue, headaches or difficulty with multitasking or functional limitations to warrant termination of benefits.

2. **We Cover You's Denial Is Not Supported by Substantial Medical Evidence**

In order to render a decision to deny disability benefits, We Cover You's determination must be supported by substantial medical evidence. Jane Doe contends that We Cover You's denial is not supported by substantial medical evidence.

A plan administrator must base its decision to terminate disability benefits on substantial evidence. *Roig v. Limited Long-Term Disability Program*, 2001 U.S. App. LEXIS 30157, *9 (5th Cir. Oct. 9, 2001) (unpublished) ("There is no substantial evidence in the record to support the Plan's conclusion that Roig was not under a doctor's care and able to perform her job.") (emphasis supplied). A plan administrator must also base its factual determinations on substantial evidence. *Robinson v. Aetna Life Ins. Co.*, 443 F.3d 389, 395-96 (5th Cir. 2006) ("Under the Plan as interpreted by Aetna, the record would have to reveal some concrete evidence that driving was not an essential task required of employees in positions comparable to Robinson's job in the general economy. The record does not contain such concrete evidence.") (footnote omitted and emphasis supplied).

Dramse v. Delta Family-Care Disability &Survivorship Plan, 2006 U.S. Dist. LEXIS 57364, *18 n.12 (N.D. Tex. Aug. 16, 2006) (Lynn, J.) (". . . the Court finds that the record does not clearly support the administrator's factual finding that Plaintiff was not psychologically unable to work. . . ."). "To support an administrator's decision, the Court must find substantial evidence supporting the administrator's decision. *Ellis v. Liberty Life Assur. Co. of Boston,* 394 F.3d 262, 273 (5 Cir. 2004), *cert. denied*, 545 th U.S. 1128 (2005). *See Meditrust Fin. Servs. Corp. v.Sterling Chems., Inc.*, 168 F.3d 211, 215 (5th Cir. 1999) ("When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, we affirm an administrator's decision if it is supported by substantial evidence."). "Substantial evidence is 'more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Ellis*, 394 F.3d at 273 (footnote omitted)."

During the course of Jane Doe's September 12, 2003, neuropsychological evaluation, Drs. E. and F. noted that Jane Doe's current medical complaints included memory difficulties and symptoms of depression and anxiety. Moreover, Dr. D. advised that her memory problems had been most prominent at work, as Jane Doe reported that she forgets what she previously learned, cannot find information quickly in the company's manuals, and has difficulty with multistep directions. Dr. D. also noted that she had trouble sequencing information and deciding what is most important versus least important. She becomes easily confused and frustrated. She also reported word retrieval problems. Jane Doe reported that her memory-related problems significantly affect her abilities at work, heightened her stress levels and that she had recently failed an important test at her work. Her depressive and anxiety-related symptomatology includes sleep difficulties, subjective feelings of depression, increased crying, and feelings of being overwhelmed.

Jane Doe's post traumatic complaints are consistent with her injury. "The basic mechanism of injury in concussion is a blow to the head that delivers acceleration/deceleration forces to the brain with a transient impairment of consciousness for which the patient is afterward amnesic."[3] The most common post concussional symptoms include poor concentration, memory loss, anxiety, depression, irritability, headaches, dizziness, sleep disturbance, fatigue, and diplopia. *Id.* "Acceleration/deceleration forces [of cerebral insult] are thought to cause strains and distortions within the brain resulting in the shearing or stretching of nerve fibers with subsequent diffuse axonal damage." As is the case with Jane Doe, "[n]euroimaging studies

[3] Philip G. Gasquoine, Ph.D., *Postconcussion Symptoms*, Neuropsychology Review, Vol. 7 (June 1997.), which states: In determining accurate pre-injury levels of functioning, studies have shown that while the severity of post traumatic complaints (PTC) declines during the first three months, the prevalence of having any complaints six months after the trauma is still estimated to be 20-80%

of such structural changes after mild head injury are typically negative." *Id.* The persistence of neuropsychological impairment beyond one month after mild head injury may only be apparent under conditions of stress, although this may simply reflect limitations in the sensitivity of current neuropsychological assessment techniques and difficulties.

Here, Jane Doe's memory problems became most prominent at work. She experienced difficulty finding information quickly in the company's manuals and with multistep directions as well as trouble sequencing information and deciding what is most important versus least important. She experienced confusion and frustration and reported word retrieval problems. Finally, Jane Doe indicated that her memory-related problems significantly affected her abilities at work and heightened her stress levels.

Despite this medically documented evidence, We Cover You terminated benefits on the opinions Dr. A. expressed in his report. However, Dr. A.'s report does not provide substantial medical evidence to support the administrator's determination that Jane Doe is capable of performing the material and substantial duties of her occupation as a receptionist, because he relied on testing that is not scientific and has been rejected by a Florida Court.

a. "FAKE BAD SCALE" IS NOT SCIENTIFIC AND IS NOT A RELIABLE INDICATOR OF MALINGERING –

During the course of We Cover You's review of Jane Doe's file for continued benefits, Dr. A., Ph.D, conducted a neuropsychological examination of Jane Doe at We Cover You's request. As part of his evaluation, he administered several cognitive symptom validity tests. Although Jane Doe passed the Word Memory Test, Test of memory Malingering (Trail 1 and Trail 2), and the forced Choice subtest of the California Verbal Learning Test –II (CVLT), Dr. A., determined Jane Doe's effort and motivation were suspect due to her performance on the Fake Bad Scale (FBS) and the Reliable Digit Span.

Dr. A.'s impression was "probable malingering" of neurocognitive dysfunction due to substantial external incentive, failure on a cognitive effort test (RDS=6), and gross inconsistency between probable pre-morbid status and performance on task sensitive to pre-morbid functioning. He also advised that the result of the psychological portion of the test also indicates probable malingering due to a "severely elevated Fake Bad Scale (FBS score=28)". Therefore, he advised that her current cognitive functioning cannot be validly determined due to probable malingering of neurocognitive dysfunction

Dr. A. places great significance on the *Fake Bad Scale*. He claims Ms. Doe's FBS scale is "severely elevated" when, in fact, the cut off is 26, and she scored a 28, a mere two questions above the cut off scale.

A review of the questions that make up the Scale which gives rise to points in malingering are questions that individuals with concussion and with Post-Concussive Syndrome would be expected to endorse; however, when the Fake Bad Scale is used this results in points towards malingering. For example, Jane Doe gets a point towards malingering for having headaches, having sleep disturbance, having a hard time keeping her mind on a task, feeling like she is going to pieces, having difficulty concentrating, becoming tired quickly. Inexplicably, she even gets a point towards malingering if she wears glasses![4] As a result, a patient with post concussive syndrome type symptoms would, by definition, almost never pass the Fake Bad Scale.

Question 264 illustrates another inherent fault with this scale. If the patient answers true to this question, she gets a point towards malingering on the F scale, which is the "malingering" scale of the MMPI-II itself[5]. If the patient answers false, she gets a point towards malingering on the Fake Bad Scale[6]. Therefore, regardless of whether the patient answers this question, true or false, she still gets a point towards being dishonest and malingering. There is no way she can win. It is no accident that the questions he chose are questions individuals with depression, anxiety and/or brain damage, would likely endorse.

What is important to realize is that in this instance, the "Fake Bad Scale" is being applied to the MMPI-II. However, Dr. H., one of the creators of the MMPI-II, authored an article entitled "The construct validity of Lees-Haley Fake Bad Scale, Does this scale measure somatic malingering and feigned emotional distress?[7]". In that article, Dr. H. criticized the use of the fake bad scale on the MMPI -II because it (the "Fake Bad Scale")

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[4] Brain Injury/Professional, Vol. 2, Issue 1, Controversies in Neuropsychology, Dorothy Sims, Esq., page 36, wherein examples of questions of the Fake Bad Scale are given.

[5] Minnesota Multiphasic Personality Inventory 2, MMPI-2, User's Guide, The Minnesota Report, James N. Butcher.

[6] The construct validity of the Lees-Haley Fake Bad Scale, Does this scale measure somatic malingering and feigned emotional distress?

[7] Dr. H. criticized this scale because (page 41) the FBS appears to over predict malingering in clinical and forensic samples. He further states (page 42) "the analysis presented in this study shows that the FBS is *not psychometrically sound* measure of somatic malingering but more associated with the expression of psychopathology in which physical symptoms are experienced. Moreover, the FBS is not likely to meet legal criteria in forensic cases because of lack of empirical validity and the low level of professional acceptance of it as a measure of malingering." The FBS…greatly overestimates malingering in individual's genuine psychiatric and psychological distress." (page 45).

was originally published in a pay journal[8]. In other words, Dr. I. had to actually pay the journal to publish the article rather than having it published in the standard peer review journal. Using the fake bad scale in this manner fails *Frye* and *Daubert* standards[9] because it is not scientifically reproducible. Why? Because as can be seen from Dr. Paul Lee-Haley's article, his 'N' (normative) number was unacceptably low and at no time could Dr. Paul Lee-Haley explain how he determined the original group that he decided are malingerers, were, in fact, malingerers[10].

Dr. Lee-Haley's 'N' sample is very constricted and population based - always on patients he selected and whom he alone decided were malingering. Therefore, this experiment cannot be reconstructed. This is one of the reasons that a Florida court has rejected the "Fake Bad Scale" as not being scientifically reproducible and refused to allow testimony with regard to its usage[11]. Furthermore, Dr. H., when asked questions regarding the MMPI stated, "Consequently people with physical problems or somatoform disorder are likely to be viewed by the FBS as malingering. ***The FBS is used mostly by defense oriented forensic psychologists because of the likelihood of finding malingering*.**"[12]

Perhaps what is most alarming about the "Fake Bad Scale" is that this test finds women to be malingerers at a greater rate than convicted felons[13]. This test is so sexist it even gives a woman a point as malingerer if she answers truthfully that she has hot flashes![14] Therefore, to apply this scale to a woman is inappropriate. However, should one want to argue that a female was a malingerer and be assured of a very high probability

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[8] Trial Excerpt of Vadergracht v. Progressive Express, et al., 3/9/05, page 15, line 12, which states, "I think I published way back a report that there was a payment involved, but also I got reprints along with it."
[9] *Forensic Applications of the MMPI-2*, Yossef S. Ben-Porath, John R. Graham, Gordon C. N. Hall, Richard D. Hirschman, Maria S. Zaragoza, Editors, Applied Psychology: Volume 2, Individual, Social, and Community Issues, pgs. 21-22.
[10] *Effort has a greater effect on test scores than severe brain injury in compensation claimants*, Brain Injury, 2001 Dec; 15(12):1045-60, P. Green, Rohling, ML, Lees-Haley, PR, Allen, LM 3rd.
[11] Trial Excerpt of Vandergracht v. Progressive Express, et al., 3/9/05, page 31, line 23-25; page 32, lines 1-6 which states, "This is my ruling on the very narrow issue which was raised as to whether or not he would be permitted to testify as to the Lees-Haley Fake Bad Scale. Although the Court would be compelled to conclude based upon the expert's affidavit and testimony that facially he has demonstrated that the Lees-Haley Scale meets the requirements of Frey, when a qualitative analysis is undertaken, a contrary result is dictated."
[12] MMPI-2/MMPI-A Research Project, stating "The FBS is used mostly by defense oriented forensic psychologist because of the likelihood of finding "malingering." "
[13] The construct validity of the Lees-Haley Fake Bad Scale, Does this scale measure somatic malingering and feigned emotional distress?, page 481, which states, "The highest malingering classification was for the women in the personal injury sample (37.9%), while the lowest was among male prison inmates (2.3%). Compared to men, almost twice as many women were classified as "malingerers." "
[14] The construct validity of the Lees-Haley Fake Bad Scale, Does this scale measure somatic malingering and feigned emotional distress?, page 475, which states, "44 - Once a week or oftener I suddenly feel hot all over, for no real reason."

that any female taking the test would be called a malingerer, the fake bad scale is the test to give.

In light of the fact that at the time the tests were administered, Jane Doe was in her early fifties, had hot flashes, and wore glasses, if she admitted these in the test when questioned about hot flashes and glasses she would have received two points for malingering! In fact, if she had lied about those two questions and lied about her headaches, she would have passed the test of malingering. In other words, she would have been found not to be a liar if she had, in fact, lied on this test (three points would have put her in the passing range).

Because the "Fake Bad Scale" is not scientifically reproducible, not reliable and has been rejected by a Florida Court, Dr. A.'s reliance on the Lees-Haley Fake Bad Scale is unsound and does not provide substantial medical evidence on which an opinion can be rendered. Therefore, We Cover You's reliance on an evaluation which places such heavy emphasis on the FBS is an abuse of discretion and must be reversed.

Dr. A. also failed to acknowledge that elevations in F scale also are found in individuals who have significant psychopathology[15]. In other words, he leaps to a malingering conclusion, but fails to admit that it is also an indication of significant psychopathology. If, in fact, Jane Doe was having a panic attack (she would certainly know more than the Doctor), it is no wonder she endorsed the symptoms. Further, she has a known history of physical abuse and suicide attempt (following the injury, she briefly moved back in with her abusive former boyfriend who again physically abused her, and Dr. B. noted that she was depressed due to the death of her grandmother). Because Jane Doe's significant psychopathology provides a reasonable explanation for the elevation in Jane Doe's F scale other than malingering, Dr. A.'s failure to report this is an indication of bias against Jane Doe.

Furthermore, it is inappropriate to conclude exaggeration or malingering based on the Fake Bad Scale because MMPI-II is not a test created to rule out or determine the existence or significance of a brain injury or determine malingering, it is a *personality* inventory. (Minnesota Multiphasic *Personality* Inventory -2)

[15] The construct validity of the Lees-Haley Fake Bad Scale, Does this scale measure somatic malingering and feigned emotional distress?, page 482, which states, "Further, mental health patients who have psychologically based disorders or have a chronic medical condition are likely to have high FBS scores."

Clearly, regardless of how one answers the question, one can have, and also not have, a brain injury. Nothing in the MMPI-II test permits one to conclude if someone has brain damage, and if so, to what extent. It asks questions as referenced above, and regardless of the answer, one can be brain damaged.

The National Academy of Neuropsychology code of ethics specifically states that a doctor cannot use measures of *personality* inventory and apply them to claim of malingering for cognitive effort.[16] The reverse is true as well. This is precisely what Dr. A. has done. Dr. A. seeks to use the Fake Bad Scale which consists of certain questions from the MMPI-II, a *personality* inventory, to conclude cognitive malingering.

b. FAKE BAD SCALE WAS CREATED BY A DEFENSE EXPERT

Dr. Paul Lees-Haley, the doctor who created the "Fake Bad Scale", derives essentially all of his income from the defense.[17] He created his test by sitting down with the MMPI-II, a 567 true false personality inventory, and pulled certain questions from it to form the fake bad scale. He decided, on his own, that if certain questions were answered TRUE and certain other questions were answered FALSE, then he could conclude the person answering the question was malingering.

Dr. Lees-Haley has admitted that the bulk of his practice is "almost all defense" [18] and his pre-written report already reflects it is the defense who hired him and his charges are as high as $25,000.00[19], [20]. Further, Dr. Lees-Haley, the creator of the Lees-Haley Fake Bad Scale, admitted in deposition when caught, that he himself probably lied to the patient when he was hired by the defense on two separate occasions when administering the test[21].

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[16] Symptom validity assessment: Practice issues and medical necessity, NAN Policy & Planning Committee. Accepted 28 February 2005, page 419.

[17] Deposition of Dr. Lee Haley, Trotter v. Washington Group International, Inc., et al, August 19, 2004, page 93, lines 2 – 6, which states: "Q. . . . Is it safe to say that by the time you testify in trial your bill could well exceed $25,000? A. I would think it probably could. I don't know the total but yes, it probably could."

[18] Deposition of Dr. Lee Haley, taken 8/19/04, page 37, line 7-12, which states, " . . . And I don't know by specific memory but I would assume that the referrals he made to me would have been either all defense or almost all defense, except for the ones that were treating referrals."

[19] Deposition of Dr. Lee Haley, taken 8/19/04, page 93, lines 2-6, which states, "Q. . . . Is it safe to say that by the time you testify in trial your bill could well exceed $25,000? A. I would think it probably could. I don't know the total but yes, it probably could."

[20] Brain Injury/Professional, Vol. 2, Issue 1, Controversies in Neuropsychology, Dorothy Sims, Esq., page 36.

[21] Deposition of Dr. Lee Haley, taken 8/19/04, page 317, lines 11 – 16, which states: "Q. That's actually a lie, isn't it, Doctor? It's not a -- they're not difficult and in fact they're not a memory test. They're a test to see if they're malingering; and to give the test, it requires you to lie to the patient? A. Well, yeah, that's probably fair."

Therefore, relying upon such a test by an individual with a complete defense bias (Dr. Lees-Haley could not name a single case in which he had been retained by the plaintiff in years), and in which he himself was found to be dishonest, constitutes an abuse of discretion and should be reversed.

c. RELIABLE DIGIT SPAN

The only other test given upon which Dr. A. relies for his conclusion of malingering is the Reliable Digit Span ("RDS"). While he also references the "Slick Criteria" no court in Florida has adopted this "criteria."

It is important to note that the Reliable Digit Span actually was *never* created as a malingering test, but was, in fact, a part of the Wechsler Adult Intelligence Scale designed to determine whether or not the individual has deficits in her IQ which, clearly, brain injury can cause. That being the case, to administer brain injury tests where a brain injured patient should and does do poorly and then claim that doing poorly signifies malingering constitutes an inappropriate use of the test. It is no wonder that this test is used because it has a high sensitivity of 62%, meaning essentially it is just better than flipping a coin in terms of accuracy, and "has an unacceptably high false positive rate."[22] Above seven is a passing score. With a score of 6, Dr. A. fails to point out that Jane Doe was only two questions away from "passing" this malingering test. Considering that Jane Doe answered thousands of questions for the evaluation, to call her a malingerer based on two answers, is inappropriate.

By letter of December 22, 2006, we requested that We Cover You provide the raw data from Jane Doe's testing in order to perfect her appeal. In spite of our specific request, on February 13, 2007, We Cover You advised our office by telephone that no such raw data was contained within the administrative claims file. We Cover You made no effort to obtain the raw data from their agent even though the APA and HIPAA laws require it be released[23]. Thus, we cannot discuss the contents of the raw data, nor can we

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[22] *Sensitivity and specificity of various digit span scores in the detection of suspect effort*, Babikian T, A. KB, Lu P, Arnold G., Department of Psychology, Loma Linda University, Loma Linda, CA, USA, which states: "The RDS recommended cutoff of < or = 7 resulted in a sensitivity of 62% but with an unacceptably high false positive rate (23%); . . ."

[23] *Bulletin 98-001, Florida Department of Insurance*, which states: "Since the federal act contains a provision which supercedes conflicting state law, the following Florida Statutes are subject to preemption.; *Ethical Principles of Psychologist and Code of Conduct,* 2002, Section 9.04 Release of Test Data (a), which states: The term *test data* refers to raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during an examination. Those portions of test materials that include client/patient responses are included in the definition of *test data*. Pursuant to a client/patient release, psychologists must provide test data to the client/patient or other persons identified in the release."

verify that any of the test data is actually Jane Doe's, nor can we verify that there were no scoring errors.

Arguably, there exist no norms for any malingering tests, because none of the tests contain actual malingerers in the normative sample, and there is no way to know how a true malingerer will behave. In fact, according to medical literature, individuals who are told to pretend to behave in a manner they believe a malingerer would act, actually answer questions quite differently from true malingerers[24]. Therefore, the two tests selected by Dr. A. to determine malingering are questionable at best and can in no way rule out brain injury. Additionally, one has been rejected by a Florida Court. The fact that Dr. A. could not validate Jane Doe's cognitive deficit is not the equivalent of the absence of cognitive deficit. As such, Dr. A.'s opinion does not provide substantial medical evidence that Jane Doe has no cognitive deficits. Therefore, We Cover You's reliance on his report is arbitrary and capricious and must be reversed.

d. JANE DOE PASSED THE MORE RELIABLE VALIDITY MEASURES

On the cognitive symptom validity testing, Jane Doe passed three of the four symptom validity measures (Word Memory test, CVLT-II Forced Choice, and Test of Memory Malingering). On the forced choice component Jane Doe scored a 16 over 16, which is a perfect score, indicating *no* malingering. She also passed the three trials of the word memory test and the two trials of the test of memory malingering, missing only one question in the first trial and getting a perfect score on the second. It is also of importance to note that passed the Word Memory test is a highly sensitive symptom validity measure[25]. In a previous deposition Dr. A. agreed that this is the most sensitive symptom validity measure[26]. Jane Doe passed those tests which are actually *created* for the purpose of determining malingering brain, and yet Dr. A. concludes she is exaggerating.

Dr. A. claims that Jane Doe is malingering despite the fact that she passed the above mentioned test and almost passed the Reliable Digit Span. Skeptically, one can argue that Dr. A. kept giving Jane Doe malingering tests, until he could *ignore* those she passed and rely only upon the test he claims she failed. Continuing to give malingering tests to someone who:

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[24] *Traumatic Brain Injury Litigation Group Newsletter, Spring 2006*, Myths of Malingering, Dorothy Sims, Esq., page 40.
[25] Letter to Dorothy Sims, Esq. from Dr. F., Ph.D., dated 2/2/07.
[26] Dr. A. IME report, MD in a Box, Volume 11, P 1017.

a. Doesn't want to be there
b. Doesn't trust the doctor (and with good reason)
c. Is hungry, anxious and depressed
d. Is taking medication that interferes with concentration
e. is brain damaged

and then claim poor results on a test requiring concentration resulting in a diagnosis of malingering is absurd. Therefore, the opinion expressed by Dr. A. is not scientifically sound, is unreliable and does not provide substantial medical evidence. Since We Cover You's denial is not supported by substantial medical evidence, it is an abuse of discretion and must be reversed.

3. <u>Dr. A.'s Own Test Result Is Consistent With Brain Injury</u>

As previously stated, Jane Doe was diagnosed with Post-Concussion Syndrome by her treating physician, Dr. D. The most commonly reported symptoms of Post-Concussion Syndrome include:

- Attention deficits, difficulty sustaining mental effort;
- Fatigue and tiredness;
- Impulsivity, irritability;
- Low frustration threshold;
- Temper outbursts and changes in mood;
- Learning and memory problems;
- Impaired planning and problem solving;
- Inflexibility, concrete thinking;
- Lack of initiative;
- Dissociation between thought and action;
- Communication difficulties;
- Socially inappropriate behaviors;
- Self-centeredness and lack of insight;
- Poor self-awareness;
- Impaired balance;
- Dizziness and headaches; and
- Personality changes.

Often despite several of these chronic symptoms, there is no evidence of brain abnormality from conventional structural neuroimaging tests, such as CT scans and MRIs. Consequently the person can be labeled a "hot head" with a "short fuse" or as

having either a mood disorder or anger problem, or as having a personality or psychological disorder[27].

The fact that these complaints seem to contradict the "negative" medical findings has often generated controversy as to whether post-concussion syndrome has an organic or psychological basis. However, over the past 30 years, evidence for an organic (brain based) etiology (original cause) of post-concussion syndrome has accumulated through studies of cerebral blood flow, neuropsychological deficits, evoked potential recordings, PET, SPECT, MRI and quantitative EEG or QEEG. **Id.**

The presence of white matter evident in Jane Doe's March 3, 2003, MRI of the brain provides evidence of one of many organic features of post-concussion syndrome. It is indicative of cellular damage and metabolic abnormalities in patients with mild head injury and normal MRI scan within the first few weeks of injury[28]. Dr. K's editorial also indicates that around 8% of patients have significant symptoms at 1 year and in some cases these symptoms are permanent. Other evidence suggestive of organic factors includes the following: slower recovery with increased age (cut-off at around 40 years); poorer outcome and a cumulative effect of previous and successive mild head injuries; and poorer outcome with a history of alcohol or substance misuse. **Id.** Jane Doe was XX years old at the time that she sustained the fall, and had a history of alcohol and substance misuse. Furthermore, there is a higher prevalence of post-concussion syndrome in women, which is in line with a prevalence of psychopathological presentations in women. **Id.**

Dr. A. cannot claim that Jane Doe does not have brain damage because he is not a medical doctor, and the MRI shows brain damage. His inability to determine cognitive impairment does not mean that cognitive impairment does not exist. Furthermore, his scores on the cognitive test that were created to determine the existence of brain damage show her to be in the severely impaired range, and she passes the majority of the malingering scales. Interestingly enough, Dr. A. does not identify a single answer or a single symptom that Jane Doe exaggerated or malingered. Rather, he just seeks to paint her with the brush of being untruthful when he, himself, left out important data that supports her claim.

Dr. A. leaves out the fact that Jane Doe has an elevated SC scale of 82 in the MMPI, which has been associated with traumatic brain injury. In other words, individuals score high on the schizophrenic scale because the schizophrenic scale has

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[27] Behavioural Neuropathy Clinic, Post-Concussion Syndrome.
[28] Nigel S. King, ClinPsyD., Post-concussion syndrome: clarity amid the controversy? *British Journal of Psychiatry, Editorial* , October 2003.

many of the concentration questions loaded in the MMPI-II[29]. There is also a large split between the plaintiff's verbal v performance IQ. Almost an entire standard deviation and a split such as that is also an indication of a traumatic brain injury. Again, Dr. A. chose to leave that out of his report as well.

It is interesting to note that the PK scale of the MMPI-II, known as the post traumatic scale, is elevated at 72. Dr. A. failed to mention this in his report. Dr. A. administered none of the standard Post-Traumatic Stress Disorder tests even though Jane Doe suffered a traumatic experience and the only component of a test referencing Post-Traumatic Stress Disorder is elevated.

It is also important to point out the Grooved Peg Board is claimed by Dr. A. to be in the *borderline* range. This is simply patently false. Borderline performance being in the bottom 3rd percent and 5th percent and 10th percent respectively is not borderline, but significantly impaired. That means out of 100 people in a room, there are only 2 people taking this test who would have done more poorly than our client. To call it "borderline range" is a complete misstatement of the facts.

Dr. A. did *not* conduct physical examination because he is not a medical doctor. He states that Jane Doe has intact visual fields and hearing functions; however, he is not licensed to test these conditions, nor does he indicate what, in fact, her vision is, nor does he indicate what her actual hearing is. According to the medical record, on April 2, 2004, Dr. J., M.D. (E.N.T.) evaluated Jane Doe at the request of Dr. g. for complaint of hearing loss ever since she suffered the fall on October 18, 2002. Dr. J. noted that she reported that she misses words or misinterprets them, since then also has some chronic dizziness, some memory loss and confusion. His assessment was that she had abnormal auditory perception, and closed head injury with post-concussion syndrome. However, this report was not listed among the records reviewed by We Cover You prior to termination of her benefits. Further, during Dr. A.'s evaluation, Jane Doe had to have test instructions repeated. Since Dr. A. conducted no hearing test, it appears that he simply talked to her and assumed she could hear fine, contrary to the medical records.

Likewise, Dr. A. doesn't indicate anywhere how he tested Jane Doe's visual fields, nor did he indicate whether he tested any of the twelve cranial nerves which can be damaged in a brain injury. The medical records do contain reference to Jane Doe's

[29] Traumatic Brain Injury, Methods for Clinical and Forensic Neuropsychiatric Assessment, Robert P. Granacher, page 231; MMPI, MMPI, James N. Butcher and Carolyn L. Williams, page 86; The Evaluation and Treatment of Mild Traumatic Brain Injury, Nils R. Varney, Richard J. Roberts, page 297; Fourth Edition, Neuropsychological Assessment, Muriel D. Lezak, et al., page 749.

complaint of photophobia, yet, without a physical examination, Dr. A. concludes intact visual fields.

Dr. A. makes conclusory statements such as concussions/mild brain injury not *typically* associated with reduction in intelligence. However, there is no indication that Jane Doe's brain injury was, in fact, "mild." She lost consciousness, has an abnormal MRI of the brain and was amnesic to the event when she arrived at the Emergency Room. Clearly, the brain damage she sustained is legitimate, valid, and Dr. A.'s own test results find her in the significantly impaired range. It must, however, be pointed out that an individual does not need to lose consciousness to have brain injury; yet, in this case, Jane Doe's injury was so severe she did lose consciousness. Her problems of headaches, blurred vision, susceptible of being lost, and being irritable are all typical brain injury symptoms. As reflected in "Hope Through Research"[30], published by the U.S. Government, CDC, many of her symptoms are similar to those symptoms tabled in the Hope Through Research article.

Dr. A. also failed to address the effects that medications such as Topamax and Xanax, which cause psychomotor retardation, have on her ability to perform effort tests. On February 2, 2007, Dr. F. prepared a response to Dr. A.'s report, wherein she pointed out Jane Doe's long-time use of Xanax and Topamax, both of which have research-proven deleterious cognitive effects. She points out that had Jane Doe taken Xanax the morning of the evaluation with Dr. A., or even the night before, that could have had a profound impact on her performance[31]. Dr. F. provides specific central nervous systems effects from use of Topamax which would have adversely affected Jane Doe's performance during her evaluation with Dr. A.. **Id.** Thus, there was a pharmacological reason for Jane Doe's poor performance which Dr. A. failed to consider when he concluded that she was malingering.

Dr. A. also failed to admit that an individual with pre-existing psychiatric problems will fare much worse from a brain injury than those without[32], and failed to admit her MRI is consistent with brain damage. Dr. A. is not licensed or trained to testify as to the cause of brain damage in Florida Courts[33]. Thus, he must rely on the

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[30] Traumatic Brain Injury, Hope Through Research, National Institute of Neurological Disorders and Stroke, National Institutes of Health, page 3.
[31] Letter from Nancy Parsons, PhD. To Dorothy Sims, Esq., dated February 2, 2007.
[32] Psychiatric illness following traumatic brain injury in an adult health maintenance organization population, Arch. Gen Psychiatry, 2004 Jan; 61 (1):53-61, which states, "Persons with mild TBI and prior psychiatric illness had evidence of persisting psychiatric illness. CONCLUSIONS: Both moderate to severe and mild TBI are associated with an increased risk of subsequent psychiatric illness.
[33] Grenitz v. Jacob Thomas Tomlian, 858 So.2d 999; 2003 Fla. LEXIS 925; Fla. L. Weekly S 433.

findings of the diagnostic studies and medical doctors. Jane Doe has an abnormal MRI with changes in the white matter consistent with traumatic brain injury.[34]

Jane Doe's functioning is in the significantly impaired range. Dr. A. failed to discuss the effect of medications, pain, headaches, sleep disturbances, depression and anxiety on effort tests. Jane Doe admitted that "I don't like these tests" and "it is times like these that I feel like lashing out" per Dr. A.'s report. This irritability can also interfere with focus and concentration. She also has panic attacks, and she advised Dr. A. that she felt like she was having a panic attack. Further, no one told Jane Doe that she would be taking complicated tests with thousands of questions, and that it would take all day; thus, she brought no money with her for lunch and had difficulty concentrating as the day went on due to resulting hunger. Jane Doe was angry, hungry, frustrated and anxious. There is NO evidence that doing poorly on these tests under those conditions constitute malingering. Jane Doe has cognitive deficits due to her brain injury, and nothing in Dr. A.'s report refutes that. Therefore, We Cover You's denial is not supported by substantial medical evidence.

4. Co-Worker Corroborates Evidence

The only individual to whom Dr. A. spoke, clearly confirmed the presence of cognitive deficits. Jane Doe's former co-worker, Ms. B. L., describes the many changes she observed in Jane Doe's struggle to continue working after the injury. Ms. L. states that when she first began to work for the employer, Jane Doe was helpful in teaching her insurance rules, procedures and aspects of her job. However, since the fall Ms. L. noted that Jane Doe exhibited memory loss, mental slowing, headaches and difficulty with multi tasking. Ms. L. stated that she noticed no improvement in Jane Doe's status since her fall in October 2002. Ms. L.'s comments and observation are consistent with symptoms of cognitive deficits caused by brain injury and the reports contained in the medical records. Yet, Dr. A. chose to discount them, advising that he suspects Ms. L.'s impressions reflect Jane Doe's depression and anxiety rather than neurological disturbance.

Dr. A. refuses to diagnose cognitive disorder by:

a. Ignoring his own test results.
b. Relying on tests that were never created to determine the existence of traumatic brain injury.

[34] Applied Neurology, The Behavioral Neurology of White Matter: Diagnosis of Major Disorders and Syndromes, which states, "Traumatic brain injury (TBI) qualifies as a white mater disorder because of the ubiquitous lesion, known as diffuse axonal injury, in the white matter of TOC patients.

c. Completely ignoring a validly administered MRI which reflects brain damage regardless of the cause.
d. Ignoring the observation of B. L., the only person who observed Jane Doe in the work setting before and after the trauma.

As for We Cover You's suggestion that Dr. A.'s medical review was independent, it remains to be seen what discovery of We Cover You's Form 1099s issued to Dr. A. / Psyche Bar will reveal about their alleged "independence". We Cover You paid him $4,750 for his opinion in this case. In a previous deposition Dr. A. testified to being a consultant for Urban Life Disability Company once per week at that time. It remains to be seen how often Dr. A./Psyche Bar is a consultant for We Cover You. Further, while testifying about his credentials, Dr. A. stated that his Ph.D was in neuropsychology. However upon further questioning, he admitted, in fact, that his degree was not in neuropsychology but, clinical psychology[35].

Because the brain injury and the medications used for treatment of her brain injury caused cognitive slowing, Jane Doe was unable to perform the material and substantial duties of her occupation and is totally disabled within the meaning of the policy. Furthermore, the neuropsychological evaluation provided objective documentation of deficits in her executive functions and significant memory impairment. Therefore, there is competent substantial evidence to support Jane Doe's inability to perform the material and substantial duties of her occupation and We Cover You's decision to deny Jane Doe's LTD benefits must be reversed.

B. JANE DOE IS UNABLE TO PERFORM THE MATERIAL AND SUBSTANTIAL DUTIES OF HER REGULAR OCCUPATION.

Basic contract law and ERISA require that a determination with respect to the entitlement of benefits must be analyzed under the terms of the subject Benefits Plan. An insurer may not impose conditions on the payment of benefits which are not clearly stated in the plan. The insurer, in assuming the duties of Plan administrator, takes on a fiduciary role with the attendant duties to ensure that Plan beneficiaries receive the benefits under the Plan to which they are entitled. Thus on this appeal, the reviewer's allegiance to the beneficiary and to fulfilling the purpose of the Plan must prevail over any allegiance held to the insurance company.

1. Policy Requirements

[35] Deposition of James R. A., Ph. D, Stasio v. McManaway, taken 2/2/05, page 31, lines 13-17, which states: "A. My PH.D was in neuropsychology. Do you want to know my dissertation topic? Q. Well no, what does the Ph.D., what does your degree read? A. It's a – I have a Ph.D in clinical psychology."

Jane Doe's LTD policy pays benefits under either an occupation test or an earnings test. Jane Doe is currently under the regular occupation of the occupation test. She is entitled to benefits during the first thirty sixty (36) months if injury or sickness cause physical ***or*** mental impairment to such degree of severity that she is continuously unable to perform the Material and Substantial Duties of her regular occupation.

> Regular occupation is defined in the policy as the occupation that you were performing for income or wages on your date of disability. It is not limited to the specific position you had with your employer.

Further, the policy provides that proof of loss must be by objective medical findings. Objective medical findings include, but are not limited to, tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).

Where, as here, a claim has been approved for the payment of benefits the policy nevertheless provides that the insurer may, from time to time, require proof that the disability is continuing. That provision, which applies to this review, states:

Continuing Proof of Disability
You may be asked to submit proof that you continue to be disabled and are continuing to receive Appropriate and Regular Care of a Doctor. Request of this nature will only be as often as we feel reasonably necessary. . . .

This obligation to provide current documentation applies to the beneficiary who is already receiving benefits and is distinct from a separate provision which states the requirements for filing a notice of claim of disability and submitting "proof of loss." There is no requirement in the policy that a beneficiary who has been approved as disabled must submit on a review for continuing benefits the ten items required for a "proof of loss" determination. More specifically, there is no policy requirement that additional "objective medical findings" be included in response to a request for continuing proof of disability.

As is noted below, the claim reviewer erroneously applied this requirement to their review of Jane Doe's file. An insurer cannot add restrictions to the policy or burden a Plan beneficiary with additional obligations not set forth in the policy. The policy limitation is that "objective" medical findings must be submitted as one part of the "proof of loss". The policy does not require "objective medical findings" in response to an inquiry for continuing proof of disability. The requirement for such findings is one of the

items that must be submitted on the initial claim of disability as part of the written proof of loss. It was an error for the reviewer to make this a requirement for continuing proof of disability when there is no such requirement set forth in the policy. Despite the clear policy language the claims reviewer states that the denial is based upon lack of "objective testing to support her claim of functional impairment".

Not only did the reviewers here erroneously apply a requirement for objective evidence in this review for continuing disability, but they completely ignored the definition of that phrase contained in the proof of loss provision. The provision specifically defines "objective findings" very broadly, to include but not be limited to *"tests, procedures, or clinical examinations standardly accepted in the practice of medicine*" for the particular disabling condition. Nowhere does the reviewer or the insurer's medical advisors raise any objections to the standards of practice employed by Jane Doe's treating physicians.

All of Jane Doe's physicians based their evaluations and opinions upon clinical examinations of Jane Doe, as well as tests and procedures, standard to the medical community for such evaluations. Therefore, their opinions are rendered based upon "objective medical findings." The record is replete with objective findings, from MRIs, laboratory findings, reports of physical examinations, results of cognitive testing, prescribed medications, and prescribed treatments. These findings support the findings of Jane Doe's underlying impairments. Furthermore, it is arbitrary and unfounded for the reviewers not to consider Jane Doe's subjective reporting of the disabling pain associated with the impairments which she suffers. The fact that Jane Doe is on many strong medications for pain is objective evidence that she is indeed chronically disabled and that her subjective complaints should be credited. [*See* *Flanigan v. Liberty Live Assur. Co. of Boston*, 277 F. Supp. 2d 840, 844 (S.D. Ohio 2003); *Carradine v. Barnhard*, 360 F.3d 751, 753, 755 (7th Cir. 2004) ("medical science confirms that pain can be severe and *disabling* even in the absence of 'objective' medical findings" and the pain treatment prescribed provides 'objective' evidence of significant, disabling pain.] Once an impairment has been properly diagnosed, "pain caused by the impairment may be found disabling even though the impairment "ordinarily does not cause severe, disabling pain." [*See* *Marcus v. Califano*, 615 F.2d 23, 28 (2d Cir. 1979).] It is ironic that the insurers' reviewers criticize Jane Doe's continuing proof of disability for a lack of "objective medical findings," when (a) the policy has no such requirement, (b) numerous examples of objective findings -- as that term is specifically defined by the policy with respect to a filing of a proof of loss -- were included in Jane Doe's proof of continuing disability. In fact, it is clear that the reviewer and medical consultant have performed a biased and

totally subjective review of the claim file, completely ignoring the objective findings of disability abundantly set out in support of Jane Doe's claim.

2. <u>Occupational Review</u>

Jane Doe's regular occupation was as a receptionist for ICCF, Inc. On the date of her disability, Jane Doe was working as a receptionist in a modified duty position. (modification here)

There was no Job Description contained in the administrative record provided by We Cover You. However, the Dictionary of Occupational Titles (DOT) provides standardized occupational information of how jobs are performed in the majority of industries across the Country. It provides that receptionist (DOT:219.367-038) lists the strength requirement at light physical demand level. Similarly, O*Net (43-9041.02) provides that receptionist require the following abilities: manual dexterity; arm hand steadiness; finger dexterity; static strength; dynamic strength; extent flexibility and trunk strength.

Further, according to the DOT, a receptionist requires the ability to compile and summarize pertinent data onto underwriting worksheets, consult manuals to determine rate classifications and assigns rates to pending applications, using adding machine and corresponds with or telephones field personnel to inform them of underwriting actions taken and maintains related files. Further, the Reasoning Development required for a receptionist is level three (3). Level 3 requires the ability to apply commonsense understanding to carry out instructions furnished in writing, oral or diagramic form and deal with problems involving several concrete variables.

Although Jane Doe returned to work for her employer, she was unable to continuously perform the material and substantial duties of her regular occupation. Her memory problems became most prominent at work. She experienced difficulty finding information quickly in the company's manuals and with multistep directions as well as trouble sequencing information and deciding what is most important versus least important. She experienced confusion and frustration and reported word retrieval problems.

Because Jane Doe's occupation required her to deal with problems, compile and summarize data and explain information, and Jane Doe became anxious and began crying when she made mistakes during testing and her ability to recall was impaired, she could

not be expected to problem solve or accurately summarize and explain information to other personnel or customers. Since there is objective documentation of cognitive impairment in her ability to do work activities and the material duties of her occupation require cognitive functioning, Jane Doe is unable to perform the material duties of her regular occupation and is totally disabled within the meaning of the policy.

Moreover, Jane Doe is unable to perform the physical aspects of her job as well. On April 15, 2004, Jane Doe was examined by Dr. D., who noted that she reported that her hand and arms were going numb when she sleeps. Dr. D. felt that was indicative of transient compression radiculitis. An MRI of the cervical spine, performed on April 29, 2004, showed a left sided herniated disc arising at C2-3 accompanied by bony overgrowth. There was also mild left neural foraminal narrowing. On May 27, 2004, Dr. D. advised that the finding was likely to cause some radicular impingement. He noted that Jane Doe continued to experience pain in left side of her neck and shoulder, and daily headache. Dr. D.'s assessment time was cervical (C-3) radiculopathy, migraine and headaches and cervicogenic pain related to C-3.

On June 23, 2004, Jane Doe was involved in an auto accident in Sunshine in which she was side-swiped at an intersection, resulting in aggravation of her symptoms. When she returned to Dr. D. on July 12, 2004, he noted worsening of her pain complaints due to the accident. Dr. D. also noted that the pain affected her sleep and added to her depression. His assessment included migraine headache; occipital neuralgia; depression and cervical strain. There is no indication that We Cover You considered her physical abilities prior to termination of benefits.

3. Compelling Financial Necessity

Continuing to work after injury is not inconsistent with brain damage, especially when considering the fact she was doing poorly and ultimately could no longer work. Rather, poor job performance due to cognitive deficits resulting in her losing her job is consistent with brain injury.[36] Neither is working inconsistent with total disability where one is working out of compelling financial necessity.

Because of her financial obligations, Ms. Jane Doe had no alternative but to push and push until she could no longer endure the mental and physical exertion necessary to continue working. Immediately after Dr. D. placed her on

[36] Special Report, Damage to the Frontal Lobes Can Affect a Person's Ability to 'Stay on the Job', which states, "A new study sheds light on why brain injury patients have difficulty performing tasks consistently – a necessary requirement for holding a job." "Our study has shown that damaging certain areas of the frontal lobes can impair our ability to perform consistently – a key requisite for holding a job."

disability, because of financial necessity Jane Doe moved in with her abusive former boyfriend. However, because he again abused her, she moved out. During the time of her disability, Jane Doe's car was repossessed due to non-payment and on several occasions, Dr. D. documented Jane Doe's inability to pay for her much needed medications.

Courts who have addressed this issue in prior cases concur. In Whatley v. CNA Insurance Co., 189 F.3d 1310, 1314 (11th Cir. 1999), citing Kirwan v. Marriott Corp., 10 F 3d 784 (11th Cir. 1994), the Court stated:

> We similarly disagree with the district court's conclusion that appellant could not have been totally disabled if he was able to come to work, perform some of the tasks assigned and collect a paycheck. We find our decision in Kirwan v. Marriott Corp., 10 F.3d 784 (11th Cir. 1994), particularly instructive.

See also Perlman v. Swiss Bank Long Term Disability Plan, 195 F.3d 975, 983 (7th Cir. 1999):

> Some disabled people manage to work for months, if not years, only as a result of superhuman effort, which cannot be sustained. Reality eventually prevails, however, and limitations that have been present all along overtake even the most determined effort to keep working.

This was also cited in Bowman v. Reliance Standard, 2003 U.S.Dist. LEXIS 4398 (N.D.Ill. 3/21/03, which held, this portion of the Perlman decision speaks volumes, and lends more support to plaintiff's entitlement to disability benefits than it does to defendant's denial of those benefits.@ Id. *23-24.

Mabry v. Travelers, 193 F.2d 497 (5th Cir. 1952):

> Pinched by poverty, beset by adversity, driven by necessity, one may work to keep the wolf away from the door though not physically able to work.

Hawkins v. First Union Corp. LTD Plan, 326 F.3d 914 (7th Cir. 2003) (noting working full-time and disability can be logically compatible where the employee continues to work and finally gives up although his condition had not worsened).

Therefore, because she continued to work despite considerable pain and limitations, due to her considerable financial obligations, and out of compelling

necessity, Jane Doe should not be penalized by We Cover You by denying her long term disability benefits.

For the foregoing reasons, there was substantial medical evidence to support Jane Doe's claim for disability benefits, and her inability to perform the material and essential functions of her job, and We Cover You's decision to deny her claim should be overturned. Accordingly, we demand an immediate reinstatement of benefits plus interest payable at the rate of 11% in accordance with 55.03 FS (2007), as well as attorney's fees in accordance with Parke v. First Reliance Standard Life Insurance Co., 2002 U.S.Dist. Lexis 18762 (D. Minn. 9/25/02) which upheld an award of fees for time spent in appealing the insurer's decision.

We hereby request that We Cover You Life Insurance Company immediately issue payment of benefits and mail payment of back benefits interest and attorney's fees to the order of Jane Doe and the undersigned to the address above and to continue making ongoing payments in like manner. Nonetheless, we reserve the right to submit further medical and other evidence until We Cover You Life Insurance Company begins paying benefits. So that we may submit evidence that We Cover You Life Insurance Company will find valuable, please identify with specificity the records or other information required for We Cover You Life Insurance Company to confirm Jane Doe's ongoing disability and eligibility for benefits and state why the information (records) is needed (as required by state and federal law).

SECTION III: RECORDS

For the purposes of this request please consider the word records to be defined as follows: all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, computer information, information stored on disks, (CD ROM/hard/floppy), tape or electronically, or other materials regardless of physical form or characteristics.

In order to assist Jane Doe in perfecting her appeal and confirming entitlement to ongoing disability benefits, we request that you please provide us with the following:

1. Pursuant to the Department of Labor Regulations governing ERISA Claims Procedures, 29 CFR - Chapter XXV Part 2560, '2560.503-1, we are also writing at this time to request that you provide us as soon as practicable with copies of the complete and entire administrative record that has been amassed or compiled to date by We Cover You Life Insurance Company with respect to Jane Doe's claim for long term disability benefits. *See* '2560.503-1(h)(2)(iii) (AProvide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and

other information relevant to the claimant's claim for benefits@). The administrative record should also include copies of any internal rules, guidelines, protocols, or other similar criterions that We Cover You Life Insurance Company relied upon in making its adverse determination. *See* '2560.503-1(g)(1)(v)(A) (AIf an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request).

2. A complete copy of the plan or policy. Note: It is my experience that the plan or policy often defines the complete plan or policy to include the complete policy, the summary booklet (summary plan description), the application, the declaration sheets, amendments and endorsements. Please be advised that I am requesting the entire contract as that term is defined by the policy or plan documents.

3. Your complete claims file and/or all non-privileged documents in your claims file.

4. Please provide copies of all documents, records, or other information relevant to Jane Doe's claim for benefits. For purposes of this request please reference the definition of records set forth above. Please consider a document, records or other information to be considered relevant, if the documents, records, or other information:

a) were relied upon in making the benefit determination;

b) were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

c) demonstrated compliance with the administrative processes and safeguards required pursuant to the ERISA Act; or

d) constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit without regard to whether such advice or statement was relied upon in making the benefit determination.

5. In addition to requesting documents listed above, I would like for you to please confirm whether it is your contention that the coverage provided to Jane Doe is

pursuant to an ERISA plan or an insurance policy. In the event that you contend that the coverage is pursuant to an ERISA plan, please provide any and all evidence that the insurance is pursuant to an ERISA plan including but not limited to a copy of the application and all plan documents. Furthermore, I request that you please provide a written denial which conforms with the ERISA regulations and which provides the following: the specific reason or reasons for denial with reference to those policy provisions on which the denial is based; a description of any additional material or information necessary to complete the claim and an explanation of why the material or information is necessary.

6. Please provide a complete copy of any and all records prepared by any and all medical consultants, and/or any individual in contract with medical consultants relied upon by you in reaching your determination to deny benefits.

7. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the adverse determination please provide the specific rule, guideline, protocol, or other similar criteria used by you. If no internal rule, guideline, protocol, or other similar criteria was relied upon in making the adverse determination, please so indicate.

8. If a national or industry rule, guideline, protocol, or other similar criteria was relied upon in making the adverse determination please provide the specific national or industry rule, guideline, protocol, or other similar criteria used by you. If no national or industry rule, guideline, protocol, or other similar criteria was relied upon in making the adverse determination, please so indicate.

9. A copy of the claims procedures which contain the administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

10. A complete copy of all claims procedures utilized by you in making claims determinations with respect to Long Term Disability claims for Jane Doe's disability.

11. A printout of any computer/screen claims procedures or guidelines utilized by you in determining whether to deny a claim for disability benefits.

SECTION IV: AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

You will find enclosed with this letter an Authorization for Release of Protected Health Information (PHI). In providing this authorization, Jane Doe is revoking any and all previously signed authorizations. The authorization permits you full access to Jane Doe's medical and other records. It does not provide access to medical providers for conversations, nor does it permit direct written communication with medical or other providers, unless our office is conferenced in on any phone or in-person office conference or copied with any letters or written requests. However, we wish to assure you that we are not trying to prevent contact with medical providers. Rather, we simply request that any and all written and oral communication between We Cover You Life Insurance Company, its agents or assigns, be coordinated through the office of Sims, Stakenborg & Henry, P.A.' s undersigned attorney, Claudeth J. Henry, Esq. This arrangement simply permits Jane Doe's attorney to be present during, but not interfere with communication between the Plan, Employer, claims administrator, etc., and Jane Doe's medical providers and other individuals who may possess information relevant to Jane Doe's claim. We hope that the presence of Jane Doe's attorney will prevent fraud, dissemination of misinformation, or mis-communication that may prejudice Jane Doe's claim. Should you have any questions concerning this procedure please do not hesitate to call or write. If you contend that this procedure in any way conflicts with the Plan provision(s), please identify and quote the relevant provision(s) and we will make other arrangements that fit within the Plan (as well as state and federal law) while protecting Jane Doe's interests.

SECTION V: MEDICAL CONSULTANTS AND REVIEWERS

It is commonplace for a claimant's medical records to be reviewed by consulting physicians to assist insurance companies in making their determination to either award or deny disability benefits. In the event that We Cover You Life Insurance Company has, intends to, or does submit Jane Doe's medical records to any medical consultant(s) or reviewer(s), we formally request that we be provided with the identities of any consulting physicians, or reviewer together with copies of their respective Curriculum Vitae or similar credentials detailing their board-certifications, and with the identity of the specific file records or other information forwarded by We Cover You Life Insurance Company to each of these consulting physicians or reviewer for their respective review. *See* '2560.503-1(h)(3)(iv) (Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination). Additionally, we request an opportunity to answer any questions raised by any medical consultant(s) or reviewer(s) and to respond to any potential reason(s) for denial, if any, raised for the first time by any medical consultant(s) and/or

reviewer(s) before such denial is formally made by We Cover You Life Insurance Company.

Jane Doe hereby makes a continuing request to be provided copies of all new and additional documents and information developed or generated by We Cover You Life Insurance Company or by any person or entity acting on its behalf or at its direction, that is either added to the Administrative Record, or reviewed and considered as part of Jane Doe's appeal. Jane Doe also requests a reasonable opportunity after the provision of such documents to file an appropriate response as part of this appeal.

As above, please provide the identity and contact information for the Plan Administrator immediately. Thank you for your attention to this matter.

Sincerely,
Sims, Stakenborg & Henry, PA

Claudeth J. Henry
For the Firm

CJH/dmb
Enclosures

cc: Ms. Jane Doe