

UNITED STATES DISTRICT COURT  
MIDDLE DISTRICT OF FLORIDA  
ORLANDO DIVISION

GAYLYN PHARR,

CASE NO. 6:03-CV-735-Orl-22KRS

Plaintiff,

v.

CONTINENTAL CASUALTY COMPANY,

Defendant.

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**PLAINTIFF'S RESPONSE TO DEFENDANT'S MEMORANDUM OF LAW IN  
SUPPORT OF MOTION FOR SUMMARY JUDGMENT**

**I. Introduction**

Insurance companies frequently use the truism, “diagnosis does not equal disability” as a defense to claims for disability benefits, as the real issue is whether the claimant has physical/mental restrictions or limitations that prevent her from performing her occupation. That is, insurance companies lean on such axiom when it serves them. Here, Continental Casualty Company (“CCC”) takes the opposite approach in justifying its denial of benefits, as its Motion for Summary Judgment and Incorporated Memorandum of Law (“Defendant’s Memorandum”) consists almost entirely of a list of negative test results and empty diagnoses from doctor to doctor<sup>1</sup>, in actuality confirming Chronic Fatigue Immune Dysfunction Syndrome (CFIDS) and fibromyalgia, diagnoses of exclusion, at every turn. Insurance companies additionally tend to find claims incredible when their insureds fail to heed their physicians’ referrals to specialists, but here where it suits CCC, it uses Gaylyn Pharr’s tenacity and commitment in determining the etiology of her symptoms against her. A mysterious etiology and the journey from specialist to

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<sup>1</sup> Such negative results were yielded before the identity of Gaylyn’s illness was determined, and as discussed *infra*, a profusion of test results confirming CFIDS and supporting Ms. Pharr’s physical and cognitive impairments followed thereafter and throughout treatment with Dr. Cheney and other specialists.

specialist until eventually all else is ruled out to explain for a set of defined symptoms that have been consistently experienced and documented is in fact a required practice in order to diagnose CFIDS. Such is the plight of a CFIDS patient. We know insurers are aware of the latter as it is common practice to criticize an insured's claim for CFIDS for lack of ruling out other illnesses.

Most irrelevant about Defendant's Memorandum, however, is its notation after every such specialist visit, between March 1998 and February 1999, of "no certification of disability." Gaylyn Pharr, in seeing such specialists, was in search for what was causing her devastating physical and cognitive decline, not to obtain a doctor's note that she could not work, especially before the Defendant initially denied her claim in June of 1999. Such was a journey to find out the cause of her debilitating symptoms, NOT a mission to be granted disability. Similarly, such specialists, who were so adamant in their search to uncover the symptoms' etiology, were not asked nor adequately informed enough about Gaylyn's occupation to report on her disability status.

Disability coverage denials of the type that Gaylyn Pharr has battled for almost five years now, occur frequently in the context of group disability policies, as illustrated by one of many courts, that when dealing with quite similar circumstances to the case at bar, refused to tolerate such callous claims behavior and wrote the following opinion:

Finally, every doctor who personally examined the plaintiff determined that she suffered from a severe case of fibromyalgia. None of these doctors concluded that Dorsey was capable of returning to her position as Director of Payroll Marketing. Notably the plaintiff also qualified for both short term disability benefits from another provider as well as social security benefits. In sum, every individual or organization that examined or reviewed the plaintiff's medical information found the plaintiff to be disabled - everyone except those individuals employed by Provident. . . The medical reviews conducted by Provident were incomplete and disregarded the substantial evidence of disability as submitted by plaintiff's treating physicians. The vocational consultant's evaluation inadequately assessed plaintiff's ability to return to her job. For these reasons, Provident's denial of plaintiff's benefits is simply not supported by reason. Even when viewed in the light most favorable to the defendant, Provident's denial of Dorsey's claim is arbitrary and

capricious, there is no genuine issue of material fact, and the plaintiff is entitled to judgment as a matter of law.

Dorsey v. Provident Life, 167 F. Supp. 2d 846, 856 – 857 (ED Pa. 2001).

## **II. Standard of Review**

Defendant, in its Memorandum, suggests that the applicable standard of review should be based on a provision contained in Continental Casualty Company's ("CCC") policy for The Martin Agency that went into affect in April of 1999, after Ms. Pharr became disabled and filed her claim. If an insurance company had the ability to alter a claimant's coverage, on which she relied when filing a claim, to its advantage, then benefits would never get paid. The courts recognize that "if [an] employer faced no limits on ability to change benefits for employees whose claim had already arisen, the coverage "could become all but nominal and make the promise of lifetime benefits illusory." Barker v. Ceridian Corp., 122 F.3d 628, 638 (8th Cir. 1997). *Accord*, Wulf v. Quantum Chemical Corp., 26 F.3d 1368, 1378 (6th Cir. 1994) (retroactively applying amendment that would reduce or delete benefits might render coverage illusory), quoting Edward W. Sparrow Hosp. Ass'n v. Industrial Welding, Inc., 1990 U.S. Dist. LEXIS 9194, 1990 WL 599020, \*7 (W.D. Mich. 1990) ("Once a participant became entitled to coverage under the then existing terms of the plan, it would be entirely illusory to allow [the employer] to essentially divest them of that right by retroactively deleting the benefit."); Edward W. Sparrow Hosp. Ass'n v. Industrial Welding, Inc., 1990 U.S. Dist. LEXIS 9194, 1990 WL 599020, (W.D. Mich. 1990); Bokunewicz v. Purolater Prods., Inc., 907 F.2d 1396, 1401 (3d Cir. 1990) (the right to disability benefits cannot be changed by amendment once a participant becomes disabled).

Courts have grappled with this assertion by insurance companies that they may alter their policies to retroactively apply to claims filed under the prior policy, and such courts have found

that the central question is whether such change has affected a claimant's "rights." Grosz-Solomon v. Paul Revere Life Ins. Co., 237 F.3d 1154, 1161 (9th Cir. 2001). Such notion leads us to Judge Posner's decision in Herzberger v. Standard Insurance Co., 205 F.3d 327 (7<sup>th</sup> Cir. 2000) in combination with the decisions that say in a *de novo* review a "wrong" leads to a judgment in the claimant's favor, but under an arbitrary and capricious review, the question is rather whether the decision process and final conclusion were reasoned and principled and based on substantial evidence when viewing the record as a whole, regardless of whether it is "wrong." Thus, such change in standard of review certainly affects Plaintiff's "rights" and does so in a way that decreases or completely eliminates benefits.

That said, to the extent the new 1999 policy would retroactively reduce the amount of benefits payable to an employee who became disabled prior to the acceptance and execution of the new policy, courts reject attempts to rewrite plans retroactively so as to change the amount or length of benefit payments or coverage to which an already-disabled employee is to receive under a plan until a specified date. Filipowicz v. American Stores Benefit Plans Committee, 56 F.3d 807 (7th Cir. 1995); Medina v. Time Ins. Co., 3 F. Supp. 2d 996 (S.D. Ind. 1998) (**a retroactive change in the effective date of the policy having the effect of denying the insured's benefits fell well outside any "discretionary" authority afforded a plan administrator under ERISA**); Prudential Ins. Co. of America v. Evergreen Oak Elec. Supply & Sales Co. Employee Benefit Plan, No. 92 C 7908, 1996 U.S. Dist. LEXIS 418, \*5-6 (N.D. Ill. January 17 1996); Brug v. Carpenters Pension Trust, 669 F.2d 570, 575-76 (9th Cir. 1982), *cert. denied*, 459 U.S. 861 (1982) (a provision of a plan providing disability benefits could not be rescinded for an employee who was already disabled and had filed a claim for benefits). *See also*, Algie v. RCA Global Communication, Inc., 891 F. Supp. 875, 884 (S.D.N.Y. 1994), *aff'd*,

60 F.3d 956 (2d Cir. 1995) ("Once a triggering event occurs that entitles the employee to a specified benefit, the employer . . . may not retroactively amend the plan to divest the plan participant of a payment that he was already entitled to receive."), *aff'd*, 60 F.3d 956 (2d Cir. 1995); Wheeler v. Dynamic Engineering, Inc., 62 F.3d 634 (4th Cir. 1995) (noting that "limits may exist on an employer's ability to rely on an amendment to deny coverage previously established"); Bartlett v. Martin Marietta Operations Support, Inc. Life Ins. Plan, 38 F.3d 514, 517 (10th Cir. 1994) ("Subsequent modifications to a plan through the drafting of a summary plan description do not [affect] the terms of the written plan in existence when the plaintiff's claim arose."). These courts recognize that it is important an employer be precluded from changing the terms of performance once a contract is no longer executory i.e., after the employee becomes disabled. Member Services Life Ins. Co. v. American Nat. Bank & Trust Co. of Sapulpa, 130 F.3d 950 (10th Cir. 1997) *cert. denied*, 523 U.S. 1139 (1998) (concluding that "post hoc amendment clearly cannot alter a plan provision in effect at the time performance under the plan became due").

Grosz-Solomon, where the central issue is whether a the change in the post-disability policy effects a claimant's rights, does not change this long-standing principle of law, nor does Smathers v. Multi-Tool, Inc., 298 F.3d 191, 194 (3d Cir. 2002) that reasoned that a post-disability discretionary grant was permitted because it did not change the coverage under the plan, or the substance of the plaintiff's benefits, or his entitlement to them, so there was no retroactive denial of "rights." Sapovits v. Fortis Benefits Ins. Co., 2002 U.S. Dist. LEXIS 24987 (E.D. Pa. Dec. 30, 2002). In the case at bar, such grant *does* change Plaintiff's *entitlement*, since in the Defendant's perception, it had leeway due to such discretionary policy provision to deny Ms. Pharr's claim, and any claim based on CFIDS or other illness where barriers exist to provide

objective proof of symptoms for that matter. On the other hand, if the plan lacked such discretionary language, the Defendant would see itself precluded from denying Ms. Pharr's disability claim and pay the Plaintiff her benefits based on her undisputed diagnoses and consistently reported debilitating symptoms, in the knowledge that a court would overturn its decision and possibly award attorney's fees to the claimant.

**A. Even if the 1999 Plan Applied to Ms. Pharr's Claim in Conjunction With the 1993 Policy, the Appropriate Standard of Review Would Be Heightened Arbitrary and Capricious.**

Regardless of whether this Court deems the policy that became effective after Ms. Pharr made her claim for benefits applicable, the standard of review is modified abuse of discretion due to the inherent conflict in CCC's role as decision-maker and payer of claims.<sup>2</sup>

Language in an ERISA policy that confers discretion on the insurer to interpret entitlement to benefits dictates that courts review such interpretation for an abuse of discretion, unless a conflict of interest is present.<sup>3</sup>

It is quite clear from the Plan documents that CCC underwrites The Martin Agency's long-term disability benefits. However, CCC also makes determinations as to whether claimants are disabled. The Defendant's dual role creates a clear conflict of interest in that it both determines and pays long-term disability benefits.

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<sup>2</sup> The proper standard of review of defendant insurer's denial of plaintiff's LTD claim was for "modified" abuse of discretion, because defendant was both insurer and plan administrator with discretion under the plan to deny claims. Noting the conflict of interest, the court held that it would review the decision by applying a conflict of interest factor in which the deference accorded the decision varied inversely with defendant's profit incentive. Russell v. UNUM Life, 40 F. Supp. 2d 747 (D. S.C. 1999).

<sup>3</sup> "A determination that the arbitrary and capricious standard applies does not end the court's inquiry with respect to the appropriate standard of review, however, because the concept of arbitrary and capricious must be 'contextually tailored.' Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1564 (11<sup>th</sup> Cir. 1990). The Eleventh Circuit has identified a range of deference to be applied to an administrator's decision with a 'disinterested, impartial decisionmaker deserving the greatest deference' and fiduciaries with a serious conflict of interest being given slight, or even no deference, so that 'the decision, if wrong may be unreasonable.' Id." Vann v. National Rural Electric Cooperative Assoc. Retirement and Security Program, 978 F. Supp. 1025, 1039, 1048 (M.D. Ala. 1997).

The beneficiary need only show that the fiduciary allowed himself to be placed in a position where his personal interest might conflict with the interest of the beneficiary. It is unnecessary to show that the fiduciary succumbed to this temptation, that he acted in bad faith, that he gained an advantage, fair or unfair, that the beneficiary was harmed. Indeed, the law presumes that the fiduciary acted disloyally, and inquiry into such matters is foreclosed. Its sole purpose is prophylactic... In other words, one reason for limiting the deference when the fiduciary suffers a conflict of interest is to discourage arrangements where a conflict arises.

Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1565 (11<sup>th</sup> Cir. 1990)(citations omitted).

Stated another way, where a conflict of interest exists for the administrator, the arbitrary and capricious standard is still applicable, but the conflict of interest must be weighed as a “factor in determining whether there is an abuse of discretion.” Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989). That is, the review in such cases is still “for an abuse of discretion, but it is less deferential.” Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130 (9th Cir. 2001)(vacated on other grounds). “[A] fiduciary operating under a conflict of interest may be entitled to review by the arbitrary and capricious standard for its discretionary decisions as provided in the ERISA plan documents, but the degree of deference actually exercised in application of the standard will be significantly diminished.” Brown, 898 F.2d at 1568. *See also*, Florence Nightingale v. Blue Cross/Blue Shield of Alabama, 41 F.3d 1476,1481 (11<sup>th</sup> Cir. 1995) (The arbitrary and capricious deference is diminished if the claims administrator was acting under a conflict of interest); Sahlie v. Nolen, 984 F. Supp.1389, 1401 (M.D. Ala 1997).

Fiduciary conflicts of interests are most clearly found when, as in the case before us, an insurer administers its own plan. In Brown, 898 F.2d 1556, an insurance company not only insured the plan benefits, but it also had the right to interpret the plan and make final determinations as to eligibility for benefits. The Eleventh Circuit deemed this an “inherent

conflict between the roles assumed,” as benefits denied to plan participants and beneficiaries would be retained by the insurer. Conversely, when the insurer determined that benefits were payable, the funds came out of the insurer’s own assets. Thus, the Eleventh Circuit determined that the insurance company’s “fiduciary role lies in perpetual conflict with its profit-making role as a business.” Brown, 898 F.2d at 1561. The Brown court reasoned that, “when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs ‘direct, immediate expense as a result of benefit determinations favorable to plan participants.’” Id. at 1561. More recently, the Eleventh Circuit has clarified its position, stating that an inherent or apparent conflict is presumed to be an actual conflict of interest, because “a conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries.” Adams v. Thiokol Corp., 231 F.3d 837, 842 (11th Cir. 2000).

Such an assessment led the Eleventh Circuit to derive a burden-shifting process, whereby due to such inherent conflict, the burden shifts to the fiduciary to demonstrate that its interpretations and determinations were not tainted by self-interest.<sup>4</sup> The first step in reviewing the interpretations and decisions of a fiduciary with an inherent conflict of interest is for the district court to make a *de novo* review of the interpretations and decisions, in order to determine whether they were legally “correct” (*i.e.* what the court would have done) under the relevant plan provisions. Brown, 898 F.2d at 1566, n.12. In that vein, in conducting a *de novo* review, this court can properly consider information not contained in the record. *See* Kirwan v. Marriott Corp., 10 F.3d 784 (11th Cir. 1994)(“a district court conducting a *de novo* review of an Administrator’s benefits determination is not limited to the facts available to the Administrator at

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<sup>4</sup> Such analysis is also known as the Presumptively Void Approach, first established by Eleventh Circuit, and now followed by the Fourth, Fifth and Eighth Circuits.

the time of the determination”; Luby v. Teamsters Health, Welfare and Pension Trust Funds, 944 F.2d 1176 (3d Cir. 1991). If the fiduciary’s interpretations and decisions are legally correct, the district court need not consider the fiduciary’s self-interest, and the fiduciary’s interpretation or decision will be upheld. Brown, 898 F.2d at 1566, n.12. If the Plan Administrator’s interpretations or decisions were legally “wrong” (i.e. not what the court would have done), the next step would be for the district court to consider whether the interpretations or decisions were “wrong, but apparently reasonable.” See Brown, 898 F.2d at 1566-67. If the fiduciary made decisions that were "wrong" and "unreasonable" then the decisions must be reversed by the court, as being “arbitrary and capricious.” However, if the decisions were “wrong, but apparently reasonable,” the analysis must continue further, as detailed *infra*.

It should be clear to the Court, especially upon an initial *de novo* review, that the Defendant’s review of Gaylyn Pharr’s disability claim ignored all consistent and credible medical documentation and opinions including those from the most prestigious in the medical community, and was “wrong,” “unreasonable” and thus arbitrary and capricious. CCC’s entire claims process was replete with conflicts of interest and improper motivations. For instance, the identification of CFIDS, a diagnosis of exclusion, required Ms. Pharr to visit physicians of many specialties to rule out particular disorders, and although an insurance company typically refuses to accept a CFIDS diagnosis when the latter practice of undergoing a barrage of tests with various medical professionals is not followed, here CCC uses such actions against Ms. Pharr, making her out to be a patient with no real ailment in a desperate search for a medical problem. In addition, CCC completely discredited Gaylyn, a former Vice President with an excellent track record who was forced to leave her career at the top of her game. Even with the knowledge of the latter, CCC did not conduct a functional capacity evaluation, or any personal exam for that

matter, probably because the Defendant feared the results considering the amount of Gaylyn's benefits and her young age and thus its significant liability on the Plaintiff's claim. CCC's reviewing physician mocked the notion of full and fair review by selectively reviewing the available information and omitting any documentation of the Plaintiff's cognitive and most disabling impairments with regard to her occupation<sup>5</sup> as well as the most objectively conclusive evidence with regard to physical restrictions and limitations – the bicycle ergometry test, and by completely discounting all Ms. Pharr's symptoms regardless of the consistency with which they were recorded. This Court should thus consider the conflict resulting from CCC's roles of both determining and paying such benefits in light of its obstinate claims handling and its inquiry should end at a finding that the Defendant's decision was wrong and unreasonable.

However, even if this Court finds CCC's denial wrong but reasonable, the burden shifts to the Defendant to prove that his or her interpretation of the policy and medical evidence was not tainted by self-interest, *based on a benefit conferred to the plan participants/beneficiaries as a class*. Lee v. Blue Cross/ Blue Shield of Alabama, 10 F.3d 1547 (11<sup>th</sup> Cir. 1994). Such notion could not possibly be proven by the Defendant where benefits are funded by the insurer who determines the claims as well, as it is disingenuous for the Defendant to assert that participants and beneficiaries benefit from such an arrangement. After finding such burden is not met by the Defendant, this Court should rule in Ms. Pharr's favor.

As discussed *infra*, Gaylyn Pharr's claim withstands even a strict arbitrary and capricious standard of review in that CCC's decision was both wrong and unreasonable and furthermore, under such a review, this Court can properly consider particular information not contained in the Defendant's administrative record. *See* Barnett v. Metropolitan Life Ins. Co., 32 F.3d 413 (9<sup>th</sup>

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<sup>5</sup> The results of a QEEG dated March 12, 2000 attached as Exhibit 6 provides objective support for Ms. Pharr's reported cognitive impairments. As discussed *infra*, this Court has discretion in conducting its initial de novo review to consider the post-denial information.

Cir. 1994) (abuse of discretion review) where the Ninth Circuit permitted discovery and admission of evidence *not contained in the record but related to* the evidence in the record.

While the Defendant argues that under an abuse of discretion review, *only the papers it places in its file* can be considered by the Court in assessing whether its decision was arbitrary and capricious, there are exceptions to this rule. Such exceptions to the rule include explanation of medical terms that are contained in the Record, such as explanation of various tests and definitions of conditions. *See e.g., O'Sullivan v. Metropolitan Life Ins. Co.*, 114 F. Supp. 2d 303, 310 (D.C. NJ 2000) citing to *Vega v. Nat. Life Ins. Servs., Inc.*, 188 F.3d 287, 299 (5<sup>th</sup> Cir. 1999) and *Est. of Bratton v. Nat'l Union Fire Ins. Co.*, 215 F.3d 516, 521 (5<sup>th</sup> Cir. 2000).

Similarly, the district court in *Sluiter v. Blue Cross & Blue Shield*, 979 F. Supp. 1131 (E.D. MICH 1997), a case in which the administrator was granted discretion, in responding to the Defendant's argument that the Court's review was limited to same evidence submitted to the plan administrator at the time of its decision, the court explained that:

As a preliminary matter, even under the rule urged by Blue Cross, the Court's limitation would still include evidence that was available to the insurance company at the time of its decision. . . . **Data published in medical journals or made available to Blue Cross before the time that the administrator denied coverage was "available" to Blue Cross.** Whether the administrator chose not to consider the information, was unaware of the information, or refused to research to find the information is immaterial. The information contained in those reports was available, and therefore, this Court may properly consider it . . .

Id. at 1139.

### III. **CCC's Erroneous Interpretation of the Medical Evidence: Its Misunderstanding of CFIDS and Fibromyalgia and its Inappropriate Insistence on the Lack of Objective Evidence**

Defendant repeatedly notes in its Memorandum that Gaylyn Pharr was treated by a variety of medical professions and subjected to a litany of tests, most of which performed before the diagnosis of CFIDS came up negative. The latter only highlights the appropriateness and

accuracy of Ms. Pharr's diagnosis of CFIDS. As discussed *infra*, such physical exams and lab tests are necessary to rule out other various disorders with similar symptoms such as mononucleosis, multiple sclerosis, Lyme Disease, post-polio syndrome and autoimmune diseases such as Lupus.<sup>6</sup> Defendant's failure to understand the latter and that CFIDS can only be diagnosed by excluding known etiologies of symptoms is illustrated by the following statement in its Memorandum: "Dr. Cheney performed an extensive battery of physical and laboratory tests on Plaintiff. Essentially, all of these tests, as reported by Dr. Cheney, were normal.

*Nevertheless*, Dr. Cheney opined that Plaintiff met the Centers for Disease Control (CDC) definition for chronic fatigue syndrome. At that time he recommended that Plaintiff take a leave of absence from work for one (1) year. . . Again, despite the plethora of medical tests in Plaintiff's past that revealed normal physical and laboratory findings, Dr. Cheney again diagnosed Plaintiff with chronic fatigue syndrome." Defendant's Memorandum, p. 14-17. (emphasis supplied).<sup>7</sup>

Using the same line of reasoning, the Defendant in its Memorandum highlights the absence of objective medical tests contained in Ms. Pharr's record despite the fact that the lack thereof is a characteristic of CFIDS and fibromyalgia, conditions that are undeniably known to

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<sup>6</sup> "CFIDS is often misdiagnosed because it is frequently unrecognized and can resemble other disorders including mononucleosis, multiple sclerosis (MS), fibromyalgia (FM), Lyme Disease, post-polio syndrome and autoimmune diseases such as Lupus. . .diagnosing CFIDS requires a thorough medical history, physical and mental status examinations and laboratory tests to identify underlying or contributing conditions that require treatment " Introducing CFIDS, published by CFIDS Association of America, (citing Annals of Internal Medicine, December 15, 1994.)

<sup>7</sup> In actuality, the Centers for Disease Control's requirements for CFIDS are as follows:

1. Clinically evaluated, unexplained persistent or relapsing chronic fatigue that is of new or definite onset (i.e. not lifelong), is not the result of ongoing exertion, is not substantially alleviated by rest, and results in substantial reduction in previous levels of occupation, educational, social or personal activities.
2. The concurrent occurrence of four or more of the following symptoms: substantial impairment in short-term memory or concentration; sore throat; tender lymph nodes; muscle pain; multi-joint pain *without joint swelling or redness*<sup>7</sup>, headaches of a new type, pattern or severity; unrefreshing sleep; and post-exertional malaise existing more than 24 hours. These symptoms must have persisted or recurred during six or more consecutive months of illness and must have not predated the fatigue.

Introducing CFIDS, a pamphlet about CFIDS published by THE CFIDS Association of America.

be disabling. More importantly, CCC's Memorandum makes clear by quoting its denial letters as well as its medical reviewer's report, that such lack of objective evidence tests was the reason that CCC denied the Defendant's claim. Such admission allows this Court quite easily to enter a decision in Plaintiff's favor:

The Liberty analyst handling Cook's claim concluded that there were no "clinical objective findings to support the fibromyalgia or chronic fatigue syndrome" diagnoses. She added that Dr. Blackwood's assessment of Cook's condition appeared "to be based on just [Cook's] subjective complaints." . . . Liberty sought evidence from tests that were independent of Cook's reporting of her symptoms. In many instances, such a requirement would be justified. However, as we have recognized, "diagnosing CFS is not sport for the short-winded." *Rose v. Shalala*, 34 F.3d 13, 18 (1<sup>st</sup> Cir. 1994). "There is no 'dipstick' laboratory test for chronic fatigue syndrome." *Sisco v. HHS*, 10 F.3d 739, 744 (10th Cir. 1993). See also *Vega v. Comm. of Social Security*, 265 F.3d 1214, 1219 (11th Cir. 2001) ("We note that the Social Security Administration recently concluded that there are no specific laboratory findings that are widely accepted as being associated with CFS."). **Given the nature of Cook's disease, it was not reasonable for Liberty to expect her to provide convincing "clinical objective" evidence that she was suffering from CFS.** See *Mitchell*, 113 F.3d at 443 ("It would defeat the legitimate expectations of participants in the [] Plan to require those with CFS to make a showing of clinical evidence of such etiology as a condition of eligibility for LTD benefits.").

*Cook v. Liberty Life Assurance Co.*, 320 F.3d 11, \*25-\*26 (1st Cir.2003). The Courts are clear that where a claimant's condition does not lend its self easily to objective verification, such as in cases of pain, the claimant's subjective reports must be considered.

Dr. Beecher's [Provident's medical reviewer] cursory report did not discuss the significance of plaintiff's irritable bowel syndrome, migraine headaches, and major depression - all symptoms that support a diagnosis of fibromyalgia. In her report Dr. Beecher gave no explanation for her rejection of Dr. Chesner's diagnosis and only referred to the plaintiff's lack of laboratory abnormalities. However, there is no test that can be performed to confirm the diagnosis since fibromyalgia only manifests itself through clinical symptoms."

*Dorsey*, 167 F. Supp. 2d at 855; See also *Palmer v. Standard Ins. Group*, 994 F. Supp. 1221, 1233-1234 (C.D. Or. 1998); *Marcus v. Califano*, 615 F. 2d 23, 27 (2nd Cir. 1979) ("The subjective evidence of appellant's pain, based on her own testimony and the medical reports of examining physicians is more than ample to establish her disability, if believed."); *Rivera v.*

Schweiker, 717 F. 2d 719, 724 (2nd Cir. 1983) (citing plaintiff's frequent complaints to his wife and neighbors of headaches and neck pain as "overwhelming, substantial" evidence of extent of functionality.); Aponte v. Sec'y of Dept Health & Human Svs., 728 F. 2d 588, 592 (2nd Cir. 1984) (Function of the fact finder is to appraise credibility of claimant's pain complaints and fact finder cannot dismiss such complaints as legally insufficient evidence of disability.) In Connors v. Connecticut General, 272 F.3d 127 (2d Cir. 2001), the Court went even further and held that the determination that subjective complaints are not sufficient to establish a claim for disability, is a question of law and thus must be reviewed by a district court *de novo*.

[T]he District Court erred in discounting Connors's complaints of pain as merely "subjective." Connors II, 2000 U.S. Dist. LEXIS 12962, 2000 WL 1279790, at \*1. It has long been the law of this Circuit that "the subjective element of pain is an important factor to be considered in determining disability." Mimms v. Heckler, 750 F.2d 180, 185 (2d Cir. 1984) . . .it cannot dismiss complaints of pain as legally insufficient evidence of disability, see Rivera v. Schweiker, 717 F.2d 719, 724 (2d Cir. 1983) . . . A district court's finding that a complaint of pain is not credible is a finding of fact subject to review for clear error. A determination that such a complaint is legally insufficient, however, is a conclusion of law subject to review *de novo*. . . We vacate the judgment and remand for reconsideration to the extent that the District Court failed to consider Connors's complaints of pain because it found that such complaints could not be considered evidence of disability.

Id. at 137-137.

It is even more unreasonable for an insurer to require objective medical evidence, no matter the condition, when no such requirement exists in the policy. Blau v. Del Monte Corp., 748 F. 2d 1384, 1354-1355 (9th Cir. 1984); Saffle v. Sierra Power Pacific Co., 9 F. 3d 600, 608 (9th Cir. 1996) (A plan administrator may not interpret a plan so as to "impose a new requirement for coverage" as the administrator "lacks discretion to rewrite the plan"; Canesco v. So. California Construction, 93 F. 3d 600 (9th Cir. 1996).

The Defendant further finds a lack of objective evidence where none exists. With regard to CFIDS, please see the attached summary of objective findings of Dr. Cheney's December

1998 physical examination, records review and laboratory testing, as well as his July 1999 laboratory testing reflecting a complete contradiction to CCC's allegations of a lack of objective support of Ms. Pharr's restrictions and limitations related to CFIDS.<sup>8</sup> Also, attached as **Exhibit 5** is Ms. Pharr's appeal letter to the Social Security Administration, that has already found her disabled from her regular occupation since January 1999 and any occupation since December 2000, that discusses medical records demonstrating concurring objective support for disability that occurred both before and after CCC's final denial.<sup>9</sup>

With regard to the Plaintiff's diagnosis of fibromyalgia<sup>10</sup>, it is interesting that Defendant's Memorandum states, "During the September 8<sup>th</sup> exam, Dr. Zashin reported Plaintiff's temperature at 97.9° and an otherwise normal examination, except for myofascial trigger points in areas characteristic of for fibromyalgia," thereby diminishing such medical finding as is attempted throughout such Memorandum. However, the courts among the circuits have not only recognized such illness as disabling<sup>11</sup> *but have recognized establishment by the medical community that such condition is objectively diagnosable by trigger point tests, and further that fibromyalgia claims supported by such trigger points are not precluded by self-reported symptom limitations in policies.* Russell v. UNUM Life, 40 F. Supp. 2d 747 (D. S.C. 1999); Morgan v UNUM, 2002 U.S. Dist.LEXIS 17663; McCardle v. UNUM Life, 2001 U.S. Dist. LEXIS 20541; Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., 125 F.3d 794, 799; Godfrey v. Bellsouth Telecoms, 89 F.3d 755, 758. To discount such trigger

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<sup>8</sup> Such summary is attached as **Exhibit 2** and clarifies/summarizes objective evidence previously submitted to CCC.

<sup>9</sup> As discussed *infra*, this Court has discretion in conducting its initial de novo review to consider the post-denial information.

<sup>10</sup> "Fibromyalgia is a type of muscular or soft-tissue rheumatism that affects principally muscles and their attachment to bones, but which is also commonly accompanied by fatigue, sleep disturbances, lack of concentration, changes in mood or thinking, anxiety and depression." Lang v. Long-term Disability Plan of Sponsor Applied Remote Tech., Inc., 125 F.3d 794, 796 (9th Cir 1997) (citing The Arthritis Foundation, Fibromyalgia, Arthritis Foundation Pamphlet at 1, 5 (1992)).

<sup>11</sup> Godfrey v. BellSouth Telecomm., Inc., 89 F.3d 755, 759-60 (11th Cir. 1996)("fibromyalgia can be severely disabling and can only be diagnosed by an examination of the patient.")

points in the case at bar is even more unreasonable where there is no limitation for self-reported symptoms. In a more recent fibromyalgia case where the abuse of discretion standard was conceded, the Court granted summary judgment against Continental Casualty Company due to its firm rejection of CCC's effort to require "objective evidence" of the extent of disability. The opinion also dictates that carriers must base decisions on what is in the claims file not what is not in the claims file. Conrad v. Continental Casualty Co., 232 F. Supp. 2d 600 (E.D. N.C. 2002).

**IV. Defendant's Erroneous Description of Gaylyn Pharr's Occupation and its Wrongful Determination that She Was Able to Return to Work as Vice President/Associate Media Director**

Defendant in its Memorandum asserts that Ms. Pharr's occupation can be classified as sedentary or light<sup>12</sup> based on a generic Position Description provided by The Martin Agency that highlights the purpose, major duties, and standard of performance of the position, without discussing any specific physical or mental tasks of such occupation. Defendant's Administrative Record attached to its Memorandum, CNA0645. For instance, such document, in laying out the major duties, states the goals of the position each beginning with "develop" or "contribute," rather than the specific actions necessary in order to meet such goals. Such document is clearly not informative when it comes to assessing the physical classification of Gaylyn's position. The Plaintiff provided in her Memorandum several other job descriptions and testimonials concerning Ms. Pharr's position<sup>13</sup> that on the contrary provide a basis to assess its physical demands. Specifically, it is noted in such documents that Gaylyn's position required 30% travel and giving presentations and seminars. The courts have been intolerant of insurance companies who refuse to consider the real and specific nature of one's occupation, namely where such occupation includes travel. In Dorsey, 167 F. Supp. 2d 846, the Court held that regardless of

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<sup>12</sup> Note that while CCC provides both these classifications, it later concludes that the Plaintiff was required to prove in her claim that she was unable to perform sedentary occupations in the general economy.

<sup>13</sup> See Exhibits A and B attached to Plaintiff's Memorandum.

whether the insured could perform light work, the evidence clearly indicated that she could not return to her job, which was the standard for benefits:

Based on Dorsey's functional capacity evaluation, Pam Perdue, the consultant, concluded that Dorsey had the physical capacity to return to her job. However, Perdue never evaluated Dorsey's *actual* job description and requirements. **Even though Provident was aware that Dorsey's job required traveling, the vocational consultant never addressed this issue. . .** In light of the inadequate review, the consultant's conclusion that the plaintiff could return to work is unreasonable.

Id. at 855-856.

V. **Defendant's Memorandum Completely Omits Plaintiff's Most Objectively Conclusive Evidence Concerning Restrictions and Limitations, the Bicycle Ergometry Test**<sup>14</sup>.

The Defendant's Memorandum does not address the failure of its medical reviewer, Eugene Truchelut, to mention, consider or review the Bicycle Ergometry with Gas Analysis Test<sup>15</sup> report that details many laboratory findings and concludes, "**Taken together these abnormalities suggest a significant impairment of work capacity which cannot be explained merely on the basis of deconditioning . . . These findings are comparable with the observations of other investigators and are likely to cause severe functional capacity difficulties for Ms. Pharr.**" The omission of this report, along with the failure to find any credibility or consider Gaylyn's subjective complaints or cognitive impairments, displays not only bias on the part of CCC's medical reviewer and conflict of interest on the part of the Defendant, but reflects the essence of arbitrary and capricious behavior. In fact, Defendant omitted such report from its Memorandum. "When Dr. Beecher reviewed Dorsey's claim on appeal, she cited some of the plaintiff's medical records but failed to address the evidence supporting Dorsey's contention that she was disabled." Dorsey, 167 F. Supp. 2d at 855 (finding

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<sup>14</sup> An article that discusses the significance of Bicycle Ergometry testing for CFIDS patients is attached as **Exhibit 3**.

<sup>15</sup> Attached as Exhibit D to Plaintiff's Memorandum.

medical reviewer's report unreasonable and thus resulting in an arbitrary and capricious determination).

**VI. Plaintiff's Response to CCC's Inaccuracies/Falsehoods Concerning Ms. Pharr's Medical Treatment and Documentation**

Defendant alleges in its Memorandum that Dr. Cheney is a "self-reported" CFIDS specialist. Such unsubstantiated dig at Dr. Cheney's credibility is ludicrous; one can do a simple Google search to learn of Dr. Cheney's notoriety in the CFIDS medical community. In addition, please see the attached CV (**Exhibit 1**) that details Dr. Cheney's published accomplishments.<sup>16</sup>

Defendant's statement on page 13 concerning Dr. Zeller is completely false in that Dr. Zeller *did not* refuse to order additional tests or prescriptions, but told Gaylyn she had CFIDS. Upon hearing the latter, Ms. Pharr made the decision not to continue treatment with Zeller, but to find through research the best CFIDS physician available, which ended up being Dr. Cheney. In addition, with regard to Dr. Zashin's notes, Defendant's Memorandum mentions that on August 12, 1998, Ms. Pharr, not Dr. Zashin, was considering temporarily disability, but conveniently omits from a later office visit, September 22, 1998, that Zashin concludes that Gaylyn should only work half days.<sup>17</sup>

*Medications.* Defendant's Memorandum states that Trazodone is prescribed as an anti-depressant. Although it's original use years ago was to treat anti-depression, Trazedone is now prescribed as a mild sleep aid. Gaylyn currently takes Trazodone and Doxepin at very low doses at night to alleviate her unrestful sleep, as non-REM sleep is chronic in CFIDs patients. CCC's Memorandum is also confusing as to the reason Ms. Pharr was prescribed Neurontin, as it

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<sup>16</sup> As noted in O'Sullivan and Sluiter, *infra*, even under an arbitrary and capricious review, this Court is permitted to review this document and any referenced relevant publications, as such information was available to CCC at the time of Ms. Pharr's claim.

<sup>17</sup> Note that even such partial preclusion from work back in 1998 lends itself to a finding of disability under the Plan, since once cannot perform the occupation of departmental Vice President when working half days.

mentions such prescription in the context of her fatigue. Dr. Cheney along with most CFIDS doctors, prescribe low daily doses of Neurontin as a brain protectant to reduce the high level of hypothalamus damage suffered by CFIDS patients.

Throughout CCC's Memorandum, it mentions Gaylyn's self-reported abnormal body temperature and the subsequent normal findings at physician visits. In actuality, Dr. Haron, infectious disease specialist, had Gaylyn chart her temperatures over several weeks<sup>18</sup>, and such chart that reflects a recurring fever is contained in Defendant's administrative record. Also, Dr. Haron documented persistent fever for the past 7 ½ weeks and that her temperature on that day was 99.6° in her May 5, 1998 office visit<sup>19</sup>, a temperature of 99° and that her fever continued in her May 12, 1998 office note<sup>20</sup>, and that gastroenterologist Dr. Stevens reported she had fever, abdominal discomfort and diarrhea in her July 14, 1998 visit<sup>21</sup>. Yet, Defendant omits all such documentation as well as Dr. Haron's impression of "persistent fever with fatigue," on July 14, 1998 and mentions only the documentation of depression in such note.

Defendant's Memorandum mentions the alteration of diarrhea and constipation that plagued Gaylyn. For this Court's clarification, Irritable Bowel Syndrome is a recurring and remittent disease that includes diarrhea, constipation and other dysfunction of the bowels.<sup>22</sup>

Defendant's Memorandum downplays the importance of herbs and supplements as well as fish oil and garlic prescribed to Gaylyn, as well as questions their efficacy: "Glucosamine has not been evaluated by the FDA for safety, effectiveness, or purity. There have been instances

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<sup>18</sup> Attached as Exhibit 4 is a partial documentation of temperatures from May 7 to May 12, 1998.

<sup>19</sup> Defendant's Administrative Record CNA0586.

<sup>20</sup> Defendant's Administrative Record CNA0177.

<sup>21</sup> Defendant's Administrative Record CNA0183.

<sup>22</sup> "Irritable bowel syndrome (IBS) is a disorder that interferes with the normal functions of the large intestine (colon). It is characterized by a group of symptoms--crampy abdominal pain, bloating, constipation, and diarrhea." [WebMDHealth](http://WebMDHealth.com), [www.webmd.com](http://www.webmd.com)

where herbal/ health supplements have been sold which were contaminated with toxic metals or other drugs.” Defendant’s Memorandum, p. 18, fn. Since CFIDS is an autoimmune disease, the body’s dysfunction creates extreme deficiencies in many different vitamins and supplements necessitating supplementation to replace what the body does not have/makes on a daily basis.

## **VII. Conclusion**

Defendant’s Memorandum offers no genuine issue of fact to preclude summary judgment in Gaylyn Pharr’s favor. The only evidence Defendant asserts against Ms. Pharr’s debilitating restrictions and limitations is the *absence* of evidence, which fails for several reasons. First, the courts have precluded insurers from denying claims on the lack of objective evidence when the condition in question does not lend itself to a “dipstick laboratory test” that can confirm such condition, and admonish disability carriers from discounting subjective symptoms when credible, specifically for CFIDS and fibromyalgia, *even when there is a self-reported symptom limitation*, as is not the case here. Further, the Defendant cannot create an absence of objective results where none exists by simply ignoring them – objective testing appropriate for CFIDS exists here in abundance.

CCC additionally repeatedly misspeaks about office notes, and mischaracterizes Gaylyn’s occupation as Vice President/Associate Media Director where her time was spent traveling, giving presentations and meeting immediate deadlines, duties that are very well established in the record. An arbitrary and capricious standard of review cannot shield CCC from liability in this case – in fact such standard may work in Plaintiff’s favor due to CCC’s selective review and unsubstantiated conclusions.

*Respectfully Submitted,*

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**CERTIFICATE OF SERVICE**

WE HEREBY CERTIFY that a true and correct copy of the foregoing has been served via U.S. mail this \_\_\_\_th day of February, 2004 to: Gregory P. McMahon, Esq., MARCUS, McMAHON & MYERS PL, The Citrus Center, 255 S. Orange Avenue, Suite 1250, Orlando, FL 32801, facsimile: (407) 447-2551.

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