

[Attorney's Letterhead]

September 26, 2007

**BY OVERNIGHT MAIL AND
FACSIMILE (xxx) xxx-xxxx**

[EMPLOYER] [LTD] Quality Review Unit

P.O. Box xxxxx

[CITY, STATE] xxxxx-xxxx

Re: [EMPLOYER] Long Term Disability Plan for Management Employees
Claimant: [CLAIMANT]
Claim No.: xxxxxxxxxxx

Dear Sirs:

This firm represents the claimant, [CLAIMANT], in his appeal of the termination of his Long Term Disability (LTD) benefits by the [EMPLOYER] Long Term Disability Plan for Management Employees ([EMPLOYER] or the Plan). The Plan is administered by [TPA] who took over responsibility for this claim on December 18, 2006. [CLAIMANT] was notified of the termination of his LTD benefits effective May 1, 2007 in a May 11, 2007 letter to him. This correspondence, along with the enclosed attachments, constitutes [CLAIMANT]'s administrative appeal of the termination of his LTD benefits.

CLAIM HISTORY

[CLAIMANT] began to feel ill in early 2001. He began feeling a number of symptoms. However, fatigue and cognitive problems were the primary issues he was concerned about. He sought treatment with his primary care physician, [INITIAL PCP], who had [CLAIMANT] undergo numerous tests and therapies in order to determine the cause of his problems and try to alleviate them. After [INITIAL PCP] exhausted all avenues of treatment, [CLAIMANT] was referred to specialists including pulmonary, endocrinology, neurology, rheumatology, cardiology and other areas of medical expertise. Despite all of this medical treatment, [CLAIMANT]'s condition did not improve and in fact deteriorated.

In May 2003, [CLAIMANT] was forced to stop working in his management position with [EMPLOYER] due to his severe and ongoing symptoms. He submitted a claim for short term disability and began receiving benefits. In July 2003, he came under the care of [PCP-CFS EXPERT] who diagnosed him as suffering from Chronic Fatigue Syndrome. [CLAIMANT] was referred by [PCP-CFS EXPERT] for neuropsychological evaluation in 2003 because of his substantial cognitive complaints.

[EMPLOYER] had [CLAIMANT] undergo neuropsychological evaluations by two independent medical examiners in 2004 and 2005. Surveillance was also conducted upon [CLAIMANT]'s activities in 2005. Armed with this information, the Claims Administrator at the time, [INITIAL TPA], conducted periodic reviews of [CLAIMANT]'s claim and continued to

find him “disabled” under the [EMPLOYER] Long Term Disability Plan and continued to pay him benefits.

In December 2006, a new Claims Administrator, [TPA], took over administration of this disability plan. Shortly afterward, [TPA] hired a private investigator to conduct surveillance of [CLAIMANT]’s activities. [TPA] also had a “Physician Advisor” review the claim file. This doctor provided his opinion that nothing in the ‘current’ medical records objectively demonstrated an inability to return to work. [TPA] also concluded that the activities performed by [CLAIMANT] and shown on the surveillance video were inconsistent with his ‘alleged symptoms’. Based upon these opinions, an internal vocational assessment was conducted and it was determined that [CLAIMANT] could perform the duties of three positions. As a result, [TPA] terminated [CLAIMANT]’s long term disability benefits.

The claim file indicates that the “Physician Advisor” had [CLAIMANT]’s file for only a few hours to conduct his review of this medically complex claim. The claim file also indicated that the “Physician Advisor” only possessed medical records from [CLAIMANT]’s treating physician for a 10 month period, despite medical records having been provided to [EMPLOYER] for a period of at least 4 years. This 10 month file excerpt was almost exclusively routine office visit notes, without the benefit of extensive prior testing included. Also, the “Physician Advisor” did not have the 4 neuropsychological evaluations that [CLAIMANT] had undergone and submitted to the Plan previously. Likewise, the surveillance videos were not available for the “Physician Advisor” to review and he could only rely upon the investigation summaries to arrive at his expert opinion. Subsequently it was discovered that the “Physician Advisor” did not review many of these highly relevant materials because they were not in the claim file forwarded to him to review. It has also been discovered that these materials were not forwarded to the “Physician Advisor” in seeking his expert medical opinion because the new Claims Administrator, [TPA], did not possess these materials, at least not in any readable format. Apparently with the transition from [INITIAL TPA] to [TPA] as the claims administrator, the original file documents were put through an Optical Character Recognition (OCR) process which had extremely poor accuracy and yielded only snippets of information, with the remainder in a ‘TO CONVERT’ status. (Exhibit 26) Approximately 2 to 3 months **after** [TPA] informed [CLAIMANT] “that after a careful and thorough review” it was determined he did not qualify for payment of long term disability benefits, [TPA] first sought to obtain the claim file in legible format from its predecessor, [INITIAL TPA], which contained several years of medical records that the “Physician Advisor” was not privy to in arriving at his expert medical opinion.

Due to his ongoing “disability” and the improper handling of his claim, [CLAIMANT] submits this administrative appeal to reinstate his wrongfully terminated long term disability benefits.

[EMPLOYER] TERMINATION OF BENEFITS LETTER

In [EMPLOYER]’s May 11, 2007 letter, [CLAIMANT] was notified that his LTD benefits were being terminated on the basis that he no longer met the definite of “disability” as

defined by the [EMPLOYER] Long Term Disability Plan for Management Employees. More specifically, [EMPLOYER] indicated

Please be advised that after a careful and thorough review of your request for payment of long term disability (LTD) benefits, it has been determined you do not qualify for payment under the [EMPLOYER] Long Term Disability Plan for Management Employees. As a result, LTD benefits are denied effective May 1, 2007.

.....

Our determination to deny benefits is based on a review of medical documentation provided by [PCP-CFS EXPERT] on April 30, 2007 for the period from June 6, 2006 through April 29, 2007. We also considered the opinion of an IDSC Physician Advisor, as well as non-medical documentation of your activities.

.....

Clinical information does not document a severity of your condition(s) that supports your inability to perform any occupation as of May 1, 2007.

(See May 11, 2007 [EMPLOYER] letter to Claimant, pp. 1 and 3).

[EMPLOYER] sought to provide justification for its decision to terminate [CLAIMANT]'s LTD benefits. Among the points raised by [EMPLOYER] in its termination letter are the following:

- [PCP-CFS EXPERT]'s records showed you had periodic follow up visits for the listed diagnoses of fatigue, dysautonomia, and severe cognitive deficits. It is noted that you utilize a bi-pap machine due to obstructive sleep apnea, and you are prescribed Lunesta for insomnia with good results.
- In a letter dated December 22, 2006, [PCP-CFS EXPERT] informed you that updated ANSAR tested revealed that your autonomic nervous system was healthy and no additional intervention was warranted. In a letter to file dated April 29, 2007, [PCP-CFS EXPERT] stated that he considered you totally and permanently disabled, with major disabilities relating to profound fatigue, cognitive dysfunction, and chronic fibromyalgia pain. (*Id.*, pp.1-2).
- At the time of your last visit on April 10, 2007, you indicated you had been experiencing moderate symptoms of headaches, shortness of breath, rapid heartbeat; and severe symptoms of vision problems including light sensitivity, motion sickness, vertigo or poor balance, confusion/difficulty thinking, difficulty with concentration and/or reading, disorientation and various other cognitive deficits. There was no apparent limitation due to these severe alleged symptoms,

however, when you were observed on April 1, 2007, leaving your house mid-morning and driving from [HOME] 55 miles to Camden Yards stadium in Baltimore, MD, parking your vehicle and attending a Baltimore Orioles game. (*Id.*, p. 2).

- [PCP-CFS EXPERT]'s records from September 2006 through April 2007 indicate that during this period you reported similar physical and mental limitations resulting in severe functional impairments. Conversely, a review of your activities during this time frame showed that you were actively engaged in performing the duties of Director of Referees for the [YOUTH CLUB], and took on additional volunteering responsibilities as the League Director for the U-11 boy's house league. You have demonstrated the sustained ability to perform multiple administrative, organizational, and leadership duties over several months, with no objective medical evidence of deterioration of your physical and mental abilities in spite of the same subjective reports of fatigue, disorientation, confusion, memory and concentration problems.

Referees at the youth club level, indicated a broad scope of responsibilities including, but not limited to,

- Responsibility for administration and scheduling
- Establishes procedures for reporting and certifying games worked
- Coordinates with League of Directors to identify location and time of schedules games
- Enforcing policies of the youth club program, resolving all conflicts within the program
- Organizing and managing referee staff
- Evaluates referee performance after each game; ensures appropriate compensation
- Ensures that all referee reports have an adequate record of any incident, including names of referees and coaches, date and time of game, league, names and numbers of the player(s) involved, and the action taken.

As documented in the winter 2006-2007 [YOUTH CLUB] newsletter, you were presented with the [AWARD] in January 2007 as a result of your successful and significant volunteering activities. AS noted in your newsletter, "[CLAIMANT] has been in charge of our referee program for several years and he has made numerous contributions to the training, assignment, and overall supervision of the dozens of young men and women who referee in our younger house leagues. All of this work on [CLAIMANT]'s part is done behind the scenes, but [CLAIMANT] probably spends more time on [YOUTH CLUB] basketball matters than any of our volunteers and all of those contributions are greatly appreciated. Despite [CLAIMANT]'s huge commitment to the [YOUTH CLUB] basketball referee program, [CLAIMANT] once again stepped up the plate this season to volunteer to be the league director of the U-11 boys house

league....[YOUTH CLUB] basketball cannot function without loyal, hardworking volunteers like [CLAIMANT].” This information additionally rendered the degree of physical and mental impairment that you report as not fully credible, and it represents further support of your demonstrated ability to sustain work-like capacity both physically and cognitively. (*Id.*, pp. 2 – 3).

- We asked a Physician Advisor to review [PCP-CFS EXPERT]’s records and other non-medical information currently in your file. The Physician Advisor observed that you were reported to have chronic fatigue syndrome and positional hypotension. You alleged many symptoms and were judged by [PCP-CFS EXPERT] to be totally disabled because of these symptoms, but your physician found prognostication difficult. [PCP-CFS EXPERT]’s letter of April 29, 2007 cited a case definition that was used to define a study population and was reportedly not intended for use as diagnostic criteria. Your physician further noted that he considered your fatigue as disabling as other well-established disorders, but this was not based upon any objective medical data. And as noted by [PCP-CFS EXPERT], “Unfortunately, there are no clearly identifiable physical or laboratory markers to establish the diagnosis of this syndrome.” It was noted that observation of your activities showed you driving extensive distances, participating in sedentary activities, as well as continuing to participate in youth club activities in a position of responsibility with many sedentary activities requiring cognitive abilities. The Physician Advisor further noted that these activities were inconsistent with an inability to participate in sedentary activities in the workplace. In his opinion, there is insufficient objective medical findings in the medical and non-medical record to support an inability to perform sedentary activities as of May 1, 2007 and beyond. (*Id.*, p. 3),

- Based on your training, education, and experience, a transferable skills analysis completed by a certified rehabilitation consultant identified alternate sedentary occupations you are qualified to perform. These occupations included, but were not limited to:
 - Market Research Manager
 - Product Development Manager
 - Product Development Supervisor

The median wages for these occupations, specific to your labor market, provide median wages commensurate to 50% of your basic wage rate at the time Long Term Disability benefits commenced. (*Id.*).

Each of the above contentions raised by [EMPLOYER] is addressed fully below. Further, substantial additional medical and factual evidence is being provided with this letter in support of [CLAIMANT]’s administrative appeal. [CLAIMANT] and I believe that after you have reviewed the evidence and information set forth below, you will agree that he is indeed “disabled” based upon Chronic Fatigue Syndrome and other medical conditions, reinstate his LTD benefits and place him on continuing disability status.

In support of [CLAIMANT]'s appeal, I am enclosing the following:

- Exhibit 1: Affidavit of [PCP-CFS EXPERT], M.D.;
- Exhibit 1A: 2007 Tilt Table Test Results;
- Exhibit 1B: 2007 ANSAR Test Results;
- Exhibit 2: Curriculum Vitae of [PCP-CFS EXPERT], M.D.;
- Exhibit 3: Report of [NATIONALLY RECOGNIZED CFS EXPERT], M.D., dated September 5, 2007;
- Exhibit 3A: Office notes of [NATIONALLY RECOGNIZED CFS EXPERT], M.D. dated July 23, 2007;
- Exhibit 3B: 2007 CardioPulmonary Exercise Test Results;
- Exhibit 4: Curriculum Vitae of [NATIONALLY RECOGNIZED CFS EXPERT], M.D.;
- Exhibit 5: Report of Neuropsychological Evaluation of [2007 NEUROPSYCHOLOGIST], Ph.D.;
- Exhibit 5A: Curriculum Vitae of [2007 NEUROPSYCHOLOGIST], Ph.D.;
- Exhibit 6: Report of [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST], Ph.D., dated September 18, 2007;
- Exhibit 7: Curriculum Vitae of [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST], Ph.D.;
- Exhibit 8: Neuropsychological Evaluation of [2005 IME], Ph.D.;
- Exhibit 9: Neuropsychological Evaluation of [2004 IME], Ph.D.;
- Exhibit 10: 2004 Neuropsychological Evaluation of [INITIAL NEUROPSYCHOLOGIST], Ph.D.;
- Exhibit 11: 2003 Neuropsychological Evaluation of [INITIAL NEUROPSYCHOLOGIST], Ph.D.;

- Exhibit 12: Affidavit of [CLAIMANT]¹;
- Exhibit 13: Affidavit of [CLAIMANT'S BROTHER1], Esquire;
- Exhibit 14: Affidavit of [CLAIMANT'S BROTHER2], Esquire;
- Exhibit 15: Affidavit of [CLAIMANT'S SISTER], JD;
- Exhibit 15A: Email from [CLAIMANT] to [CLAIMANT'S SISTER], dated April 1, 2007
- Exhibit 16: Affidavit of [CLAIMANT'S FATHER], M.D.;
- Exhibit 17: Affidavit of [EXECUTIVE RECRUITER];
- Exhibit 18: Affidavit of [OTHER YOUTH CLUB COMMISSIONER], Esquire;
- Exhibit 19: Affidavit of [YOUTH CLUB MEMBER];
- Exhibit 20: Affidavit of [YOUTH CLUB COMMISSIONER], Esquire;
- Exhibit 21: Affidavit of [YOUTH CLUB REFEREE];
- Exhibit 21A: Affidavit of [YOUTH CLUB PRESIDENT];
- Exhibit 21B: Affidavit of [YOUTH CLUB VOLUNTEER];
- Exhibit 22: Medical Articles Regarding Chronic Fatigue Syndrome;
- Exhibit 23: Vocational Rehabilitation Report of National Rehabilitation Hospital and information regarding National Rehabilitation Hospital and [VOCATIONAL EXPERT], M.Ed., CRC;
- Exhibit 24: Summary of Objective Medical Evidence;
- Exhibit 25: Summary of Medical Expert Positions;

¹ [CLAIMANT]'s affidavit is the result of many months of collaborative effort by [CLAIMANT], his sister, [CLAIMANT'S SISTER], Esquire, and his brothers, [CLAIMANT'S BROTHER1], Esquire and [CLAIMANT'S BROTHER2], Esquire. (See, Exhibits 12 and 15). Undersigned counsel was also involved in its preparation. [CLAIMANT]'s brothers and sister are responsible the high quality of the content of the affidavit; [CLAIMANT] was the source of much of the factual content contained in the affidavit. Under no circumstances should [EMPLOYER] infer or determine that [CLAIMANT]'s affidavit is solely his work product because that is simply incorrect.

- Exhibit 26: Representative pages of [TPA] claim file demonstrating failure of Optical Character Recognition process to convert information to readable format.
- Exhibit 27: Statement of [CLAIMANT'S SON];
- Exhibit 27A: 2007 Baltimore Orioles Schedule and Press Releases;
- Exhibit 28: [TPA's PHYSICIAN ADVISOR] Website;
- Exhibit 29: [INITIAL TPA] Claim File Note: "NO DIRECT EMPLOYEE CONTACT";
- Exhibit 30: [TPA] LTD Case Manager II, [EMPLOYER] Job Listing;
- Exhibit 31: [TPA] request for claim file from [INITIAL TPA];
- Exhibit 32: 2004 Functional Capacity Evaluation;
- Exhibit 33: 2003 MLST Report;
- Exhibit 34: Karnofsky Performance Scale;

RELEVANT PLAN PROVISIONS

The sole basis for [EMPLOYER]'s decision to terminate [CLAIMANT]'s LTD benefits is its conclusion that [CLAIMANT] no longer meets the definition of "Disability" or "Disabled" under the Plan. There is no other basis identified by [EMPLOYER] in its May 11, 2007 for the termination of [CLAIMANT]'s benefits. Thus, the only relevant policy provision for purposes of this appeal is the definition of "Disability" or "Disabled". These terms are defined by the Plan as follows:

"Disability" or "Disabled" shall mean, for the one-year period commencing immediately after the 52 weeks of Sickness Disability Benefits have been paid, that the Eligible Employee is prevented by reason of such sickness or injury, other than accidental injury arising out of and in the course of employment of the Company, from engaging in his or her occupation or employment at the Company, for which the Eligible Employee is qualified, based on training, education or experience. Thereafter, an Eligible Employee shall continue to be considered as disabled under the Plan if, in the sole opinion of the Claims Administrator, the Eligible Employee is determined to be incapable of performing the requirements of any job for any employer (including non-[EMPLOYER] employment), (as management or occupational employee), for which the individual is qualified or may be reasonably become qualified by training,

education or experience, other than a job that pays less than 50 percent of the Eligible Employee's Eligible Pay that would have been in effect on the day preceding the day that the Eligible Employee's Sickness Disability Benefits ceased. ([EMPLOYER] Long Term Disability Plan for Management Employees, p. 2),

[TPA]'S FIDUCIARY DUTIES IMPOSED BY ERISA

[TPA], who is vested with the decision making authority to grant or deny claims, is an ERISA fiduciary based upon that fact. *Libby Owens Ford Company v. Blue Cross and Blue Shield Mutual of Ohio*, 982 F.2d 1031, *cert. denied*, 114 S.Ct. 72 (6th Cir. 1993). *See also, Vogel v. Independence Federal Savings Bank*, 728 F. Supp. 1210 (D.C. Md. 1990), *Simmons v. Willcox*, 911 F. 2d 1077 (5th Cir. 1990); *Drinkwater v. Metro Life Insurance Co.*, 846 F.2d 821, (1st Cir.), *cert. denied*, 488 U.S. 909 (1988); *PIA Michigan City, Inc. v. National Porges Radiator Corp.*, 789 F. Supp. 1421 (N.D. Ill. 1992); and *Toland v. McCarthy*, 499 F. Supp. 1183 (D.C. Mass. 1980).

The fiduciary responsibility provisions of ERISA provide as follows:

...a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and---

- (A) for the exclusive purpose of:
 - (i) providing benefits to participants and their beneficiaries; and
 - (ii) defraying reasonable expenses of administering the plan;
- (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;
-
- (D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and title IV. 29 U.S.C. § 1104.

An ERISA fiduciary duty is applicable as much to the handling of claims as to any other aspect of a fiduciary's conduct. *Russell v. Mutual Life Insurance Co.*, 722 F. 2d 482 (9th Cir. 1983), *reversed on other grounds*, 105 S. Ct. 3085, 473 U.S. 134; *Ogden v. Michigan Bell Telephone Co.*, 599 F. Supp. 961 (D. Mich. 1984). In fact, ERISA provides that a plan must provide for a meaningful claims review including the right to a full and fair review:

In accordance with regulations of the Secretary, every employee benefit plan shall-

- (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
- (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. 29 U.S.C. § 1133.

The failure of an employee benefit plan to provide adequate reasons for termination of a claim, or to afford a participant the right to a full and fair review, constitutes a violation of ERISA. *Weaver v. Phoenix Home Life Mutual Insurance Co.*, 990 F.2d 154 (4th Cir. 1993); *White v. Jacobs Engineering Group Long-term Disability Benefit Plan*, 986 F.2d 344 (9th Cir. 1989); *Short v. Central States, Southeast and Southwest Areas Pension Fund*, 729 F.2d 567 (8th Cir. 1984); *Wolfe v. J.C. Penney Co, Inc.*, 710 F.2d 388 (7th Cir. 1983); *Brown v. Retirement Committee of Briggs and Stratton Retirement Plan*, 577 F. Supp. 1073 (D. Wis. 1983); *Halpern v. W.W. Grainger, Inc.*, 962 F. 2d 685 (7th Cir. 1992). Assertions setting forth mere conclusions do not suffice to establish the basis for denial of a claim. (*Id.*).

It is within this legal framework that [TPA]'s termination of [CLAIMANT]'s benefits must be viewed. What is critical in this matter is that ERISA is designed to be administered in a manner not requiring constant involvement with the courts. As the Fourth Circuit has observed:

Congress intended that ERISA provide plan administrators and participants the opportunity and freedom to resolve internal disputes without necessarily having to resort to the expense and delay of the courts. *See, Berry v. Ciba-Geigy Corp.*, 761 F. 2d 1003, 1007 n. 4 (4th Cir. 1985); *Grossmuller v. International Union, United Auto., Aerospace and Agric. Implement Workers of Am.*, 715 F. 2d 853, 857 (3d Cir. 1983).

Given this goal, Congress assured plan participants of procedural fairness, by mandating that plan administrators provide a "full and fair review" of claims and the specific reasons for claim denials. In the words of the Third Circuit, "**full and fair review' must be construed** not only to allow a pension plan's trustees to operate claims procedures without the formality or limitations of adversarial proceedings but also **to protect a plan participant from arbitrary or unprincipled decision-making.**" *Grossmuller*, 715 F.2d at 857 (emphasis added).

Weaver v. Phoenix Home Life Mutual Insurance Co., 990 F. 2d 154 (4th Cir. 1993). In addition, federal regulations in effect at the time [CLAIMANT] filed his claim for disability benefits mandate that "every employee benefit plan shall establish and maintain reasonable claims procedures" and impose "certain minimum requirements" for claims procedures to be considered reasonable. 29 C. F. R. §2560.503-1.

These minimum requirements include the establishment of a procedure to review the denial or termination of a claim for benefits:

Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. 29 C. F. R. §2560-503-1(g)(1).

The fiduciary responsibility provisions of ERISA impose both a duty of loyalty and a duty of care. See, e.g., 29 U.S.C. Section 1106 (duty of loyalty); 29 U.S.C. Section 1104 (duty of care). If [TPA] intentionally violated the minimum requirements for reasonable claims procedures in order to frustrate [CLAIMANT]'s exercise of his rights under the benefit plan or in order to promote [TPA]'s own financial interests [or if its principal, [EMPLOYER]] to the detriment of the beneficiary, then [TPA] has breached the duty of loyalty it owed to [CLAIMANT]. If [TPA]'s wrongful termination of [CLAIMANT]'s benefits and its failure to provide a prompt, full and fair review of this termination resulted from lack of care, skill, or diligence, then [TPA] has breached the duty of care it owed to [CLAIMANT]. In either case, [TPA]'s actions constitute a violation of federal law and a breach of the fiduciary duty [TPA] owed [CLAIMANT].

[CLAIMANT] SUFFERS FROM CHRONIC FATIGUE SYNDROME AND OTHER MEDICAL CONDITIONS WHICH ARE WELL DOCUMENTED AND RENDER HIM DISABLED AS DEMONSTRATED BY THE EVIDENCE OF RECORD

The evidence of record overwhelmingly demonstrates that [CLAIMANT] suffers from significantly debilitating conditions as a result of a combination of Chronic Fatigue Syndrome, Dysautonomia, and Hypersomnia. Indeed, when [EMPLOYER] accepted his claim, it was accepted as a result of his disability from these conditions. Beyond the new evidence, both medical and factual, contained in this appeal, [CLAIMANT] incorporates by reference the medical records from his treating, evaluating and examining physicians contained in [EMPLOYER]'s claim file, including the Independent Medical Examinations of Drs. [2004 IME] and [2005 IME].

[CLAIMANT] and I believe that after a thorough review of the medical records of his treating physicians, combined with an understanding of Chronic Fatigue Syndrome, Dysautonomia, and Hypersomnia, the record clearly establishes that he does indeed continue to suffer from these illnesses to an extent that his medical condition renders him incapable of performing the requirements of any job for any employer for which he is qualified or may reasonably become qualified by training, education or experience, other than a job that pays less than 50 percent of the his Eligible Pay. As a result, [CLAIMANT] is "disabled" as defined by the [EMPLOYER] Long Term Disability Plan for Management Employees.

A. General Description of Chronic Fatigue Syndrome

Although [CLAIMANT] had not been fully diagnosed at the time he was forced to stop working because of his disability, his medical conditions was ultimately diagnosed as Chronic Fatigue Syndrome and several other medical conditions. These diagnoses were made by [PCP-

CFS EXPERT], M.D., an Internist in Reston, Virginia, who has provided medical care and treatment to [CLAIMANT] for his Chronic Fatigue Syndrome and to whom [CLAIMANT] was referred due to his substantial experience and expertise in this field.

Attached as Exhibit 22 to this appeal are several medical articles providing information regarding Chronic Fatigue Syndrome. In one publication from the Centers for Disease Control, ("CDC"), (*The Facts About Chronic Fatigue Syndrome*), the CDC states as follows:

Background

Chronic fatigue syndrome, or CFS, is a debilitating disorder characterized by profound tiredness or fatigue. Patients with CFS may become exhausted with only light physical exertion. They often must function at a level of activity substantially lower than their capacity before the onset of illness. In addition to these key defining characteristics, patients generally report various nonspecific symptoms, including weakness, muscle aches and pains, excessive sleep, malaise, fever sore throat, tender lymph nodes, impaired memory and/or mental concentration, insomnia, and depression. CFS can persist for years. (*Id.*,p.1)

What types of cognitive dysfunction are associated with CFS?

CFS patients commonly report one or more symptoms of cognitive dysfunction, including confusion, difficulty in concentration, impaired thinking, and forgetfulness. Patients often regard these symptoms among the most debilitating features of CFS. (*Id.* P.3).

Diagnosis of CFS

Can CFS be diagnosed by laboratory tests?

No diagnostic test exists for CFS. Currently, laboratory tests are useful solely to rule out other causes of fatigue. The same is true of serologic test for certain viruses. Numerous scientific reports have documented immunologic differences between groups of CFS patients and healthy controls, but differences are not observed consistently, and test results between individual patients and controls overlap considerably. In other words, the test values for a randomly chosen healthy person may both fall into the normal range for any of these tests.

How is CFS diagnosed?

CFS is currently diagnosed by a history of illness suggestive of CFS and through the systematic exclusion of other possible causes. A patient must first have profound fatigue for a minimum of 6 months. To complete the diagnosis, a physician must rule out the many clinically defined (and often

treatable) causes of chronic fatigue by using a panel of routine diagnostic tests. Consult Appendix A for specific example of illnesses that may cause severe fatigue. (*Id.*, p.7).

While there are no ‘laboratory markers’ for Chronic Fatigue Syndrome, it is nonetheless fully recognized by all medical and governmental agencies and is diagnosable by trained physicians. David S. Bell, M.D.² is one of the nation’s most recognized experts in CFS. His book “*The Doctor’s Guide to Chronic Fatigue Syndrome*” is an excellent resource for health professional and notes “CFIDS is a remarkably complex illness with myriad symptoms that partially resemble many other diseases. But the process of sorting through the symptoms and carefully looking for abnormalities on physical examination is no different from that of other illnesses. **Like other illnesses, the symptoms of CFIDS form a specific pattern that, combined with the characteristic physical examination, is diagnostic.**” (emphasis added)(*Id.*).

This is entirely analogous to many other illnesses such as Parkinson’s Disease, Multiple Sclerosis, and many other debilitating conditions. For example, the National Institutes of Health (NIH) notes “There are currently no blood or laboratory tests that have been proven to help in diagnosing sporadic PD. Therefore the diagnosis is based on medical history and a neurological examination.” (*Id.*)

It is also important to understand the unique characteristics of Chronic Fatigue Syndrome and keep those in consideration when doing a thorough and complete evaluation of conflicting information. Chronic Fatigue is widely known to be highly variable in the occurrence and severity of its symptoms. Dr. Bell also notes

One defining aspect of CFIDS is that with rest, many people feel relatively well, but symptoms flare up with exertion or activity. Some people with CFIDS will have three or four hours a day when they feel relatively well, most commonly in the afternoon, the ‘activity window.’ It is during this time that they can shop or do activities outside the house with less difficulty. The disability in CFIDS is not the same as in cancer or multiple sclerosis where performance level is constant during the day and constant from day to day. Any good measure of the disability status in this illness needs to take these variables into account.” (*Id.*).

² David S. Bell, M.D., is one of the world’s leading experts on Chronic Fatigue Syndrome (CFS), and is a pioneer in the diagnosis and treatment of CFS. Dr. Bell has taught at Harvard Medical School, and was a staff member of Cambridge Hospital. He serves on the Board of the International Association for Chronic Fatigue Syndrome/ME (IACFS/ME), and in recent years was appointed chair of the Chronic Fatigue Syndrome Advisory Committee, which advises the Secretary of Health and Human Services.

Renee Taylor, Ph.D., of the University of Illinois at Chicago, is one of the nation's leading scientific researchers of Chronic Fatigue Syndrome. In her book, "*A Clinician's Guide to Controversial Illnesses: Chronic Fatigue Syndrome, Fibromyalgia, Multiple Chemical Sensitivities*", Dr. Taylor states the following key points:

- Professionals working on behalf of individuals with CFS, FMS, and MCS should be aware of a number of shared challenges facing individuals with these conditions...[including] High variability of symptoms and impairments. These illnesses exhibit enormous fluctuations in symptom severity and level of impairment between and within individuals. (*Id.*).
- the enormous variation in symptom severity that can allow patients to be relatively functional for brief intervals yet severely impaired is very difficult for others to comprehend. Rather than viewing these fluctuations as a manifestation of a highly unpredictable and poorly understood condition, observers are more likely to believe that disability and functionality are voluntary choices made by the patient. (*Id.*).

[CLAIMANT] has been treated extensively by [PCP-CFS EXPERT] and has undergone a thorough medical evaluation spanning two days and a follow up with [NATIONALLY RECOGNIZED CFS EXPERT], M.D. Both of these physicians are leading figures in the diagnosis and treatment of patients suffering from Chronic Fatigue Syndrome. Both of these physicians have diagnosed [CLAIMANT] as suffering from Chronic Fatigue Syndrome to the degree he is not able to sustain employment of any sort.

B. General Description of Neurally Mediated Hypotension/Dysautonomia.

[PCP-CFS EXPERT] referred [CLAIMANT] to [CARDIOLOGIST], M.D., a cardiologist, for tilt table testing in October 2003. This testing diagnosed Neurally Mediated Hypotension and noted low blood volume. Understanding this medical condition is essential in arriving at a fully informed decision regarding [CLAIMANT]'s qualification for benefits under the [EMPLOYER] Plan.

Neurally Mediated Hypotension (NMH) is a specific type of Dysautonomia, which is a dysfunction of the Autonomic Nervous System (ANS). According to the National Dysautonomia Research Foundation (NDRF):

Our bodies have a complex task of maintaining a stable internal environment and respond appropriately to changes that take place in the external surroundings. This complex task is directed by the *Autonomic Nervous System*.

The autonomic nervous system manages most of our bodily systems, including the cardiovascular system, gastrointestinal, urinary and bowel

functions, temperature regulation, reproduction and our metabolic and endocrine systems. Additionally, this system is responsible for our reaction to stress - the flight or fight response.” (Exhibit 22)

When the autonomic nervous system malfunctions, it is known as Dysautonomia. Other terminology that is used includes Autonomic Dysfunction, Autonomic Failure and Autonomic Neuropathy.

For those afflicted with Dysautonomia, there is a range of symptoms that can vary. The prognosis may be one that calls for an abatement of symptoms, or an adjustment to living with a chronic impairment. The following statement, by Dr. David H.P. Streeten, provides an excellent summation of the impact of Dysautonomia:

While we are not constantly aware of the activity of the autonomic nervous system as we are of unusual sensory and motor events, the normal functioning of the autonomic nervous system day and night, from heart-beat to heart-beat, plays a largely unconscious but vital role in our livelihood. It is not surprising, therefore, that autonomic abnormalities, though they are usually more difficult to recognize than a severe pain, a sensory loss or paralysis of a limb, may be even more important in impairing the quality and even jeopardizing the continuation of life. (Id.)

The American Dysautonomia Institute describes the condition and its effects as:

The ANS is the part of the nervous system that controls all automatic bodily functions. Due to this disorder, the human body fails to properly regulate blood pressure, heart rate, temperature control, vascular constriction/dilation, and blood supply to the brain. The results are often unpredictable fainting, extremely low blood pressure, light-headedness, dizziness, problems concentrating (brain fog), headaches, fatigue, heart palpitations, exercise intolerance, insomnia, hot flashes, chills, weakness, seizures, pain, and disability.” (Id.)

[CLAIMANT] also identified [CLAIMANT] as having low blood volume. Dr. Bell notes in his article *Circulating Blood Volume*

If there is not enough blood in the system, circulation to certain organs, particularly the brain, could be impaired. If a normal person loses 40% of their blood volume in a car accident it is usually fatal. In CFS the loss is obviously not all at once, so it is not fatal. But it can cause problems in getting adequate oxygen to the brain, particularly if one is standing up. (Id.)

Two tilt table tests, 2003 and 2007, have proven the existence of this condition and the medical literature is quite clear on the effects it has those afflicted by Dysautonomia and Low Blood Volume. Additionally, the 2004 Functional Capacity Evaluation confirmed the

physiological impact on [CLAIMANT] in both active and sedentary situations. Two out of three ANSAR tests have shown abnormalities in his ANS. This condition is an important piece of the complex combination of issues which considerably contribute to the disabling condition of [CLAIMANT].

C. Sleep Disorder/Hypersomnia (Excessive Daytime Sleepiness).

[CLAIMANT] underwent a Multiple Sleep Latency Test (MSLT) in 2003 (Exhibit 33) because of complaints of overwhelming daytime sleepiness. This is just one of the myriad of symptoms that [CLAIMANT] has suffered from on a daily, ongoing basis since before he went out on disability in May 2003. As a result of his MSLT, [CLAIMANT] was diagnosed with Hypersomnia because of his excessive daytime sleepiness. An understanding of this component of [CLAIMANT]'s disability is also important in assessing his "disability" under the [EMPLOYER] Plan.

The National Institutes of Health (NIH) describes Hypersomnia as

characterized by recurrent episodes of excessive daytime sleepiness or prolonged nighttime sleep. Different from feeling tired due to lack of or interrupted sleep at night, persons with hypersomnia are compelled to nap repeatedly during the day, often at inappropriate times such as at work, during a meal, or in conversation. These daytime naps usually provide no relief from symptoms. Patients often have difficulty waking from a long sleep, and may feel disoriented. (Exhibit 22)

According to the American Academy of Sleep Medicine

The Multiple Sleep Latency Test (MSLT) is a nap study. It is used to see how quickly you fall asleep in quiet situations during the day. The MSLT is the standard way to measure your level of daytime sleepiness. Excessive sleepiness is when you are sleepy at a time and place when you should be awake and alert. It affects about 5% of the general population.

The study is based on the idea that you should fall asleep in a shorter amount of time as your feeling of sleepiness increases. The MSLT charts your brain waves and heartbeat and records your eye and chin movements.

The study also measures how quickly and how often you enter the rapid-eye-movement (REM) stage of sleep. Results of the nap study are routinely used to detect sleep disorders. (Exhibit 22).

This is objective medical evidence of [CLAIMANT]'s "alleged symptom" of fatigue and apparently was not considered in the determination to terminate [CLAIMANT]'s benefits. It is corroborated by observations from every medical professional that has examined [CLAIMANT], including those acting on behalf of [EMPLOYER].

This information is submitted to [EMPLOYER] in order to provide a general understanding of Chronic Fatigue Syndrome and the other medical conditions from which [CLAIMANT] suffers. Based upon the information contained in the CDC publication and other articles from well respected medical journals attached in Exhibit 22, along with the medical records of Drs. [PCP-CFS EXPERT], [INITIAL NEUROPSYCHOLOGIST], [2004 IME], and [2005 IME] contained in the [EMPLOYER] claim file, and the reports of Drs. [NATIONALLY RECOGNIZED CFS EXPERT], [2007 NEUROPSYCHOLOGIST] and [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] attached to this appeal, it is clear that [CLAIMANT] suffers from Chronic Fatigue Syndrome, Dysautonomia/NMH, Hypersomnia and neurocognitive dysfunction and that these medical conditions continue to prevent him from performing the duties of any gainful occupation. As a result, [EMPLOYER] should reverse its decision to terminate [CLAIMANT]'s benefits, reinstate his benefits from May 1, 2007, and place him on continued benefit payment status.

MEDICAL CARE AND TREATMENT PROVIDED TO [CLAIMANT]

Since the inception of his illness, [CLAIMANT] has been treated, examined or evaluated by a number of doctors including [PCP-CFS EXPERT], M.D., [NATIONALLY RECOGNIZED CFS EXPERT], M.D., [INITIAL NEUROPSYCHOLOGIST], Ph.D., [2004 IME], Ph.D., [2005 IME], Ph. D., and [2007 NEUROPSYCHOLOGIST], Ph.D. Review of the medical records and reports of these physicians, in light of the Centers for Disease Control (CDC) criteria to properly diagnose Chronic Fatigue Syndrome clearly establishes that [CLAIMANT] has been and continues to suffer from Chronic Fatigue Syndrome, NMH, and Hypersomnia to such a degree that his medical condition prevents him from performing the duties of any gainful employment. It is important to note that every medical professional that has examined [CLAIMANT] since 2003 has reached this conclusion. This includes the Independent Medical Examinations [EMPLOYER] has arranged and paid for. As a result, he "disabled" under the terms of the [EMPLOYER] LTD Plan.

Medical Evaluations.

[PCP-CFS EXPERT], M.D.

[CLAIMANT] has been treating with [PCP-CFS EXPERT] since July 2003. (Exhibit 1). [PCP-CFS EXPERT] is a physician licensed to practice medicine in the Commonwealth of Virginia. He specializes in Internal Medicine and a significant portion of his practice concerns the proper evaluation and treatment of patients with Chronic Fatigue Syndrome (Exhibit 2). He is an Associate Clinical Professor of Healthcare Sciences at George Washington University. He has taught Attending Rounds for Georgetown University Internal Medicine Health Staff and is a Preceptor for Primary Care Apprenticeships for George Washington University School of Medicine. He has also published numerous articles in medical journals regarding Chronic Fatigue Syndrome and has lectured on this medical condition as well. (*Id.*).

The medical records of [PCP-CFS EXPERT] have been previously supplied to [EMPLOYER] and are not being reproduced here. His medical records dating from July 2003 to the present are replete with observations and findings that support the proper diagnosis of Chronic Fatigue Syndrome, Dysautonomia, and Hypersomnia concerning [CLAIMANT]. [PCP-CFS EXPERT]'s records reflect instances of profound fatigue, unrefreshing or non-restorative sleep, post-exertional malaise, orthostatic intolerance, the onset of new headaches, arthralgias, myalgias, sore throat and tender lymph nodes, cognitive problems, and sleep disorder/problems. These chronic and debilitating symptoms highly correlate to the major and minor criteria established by the CDC for the proper diagnosis of Chronic Fatigue Syndrome (Exhibit 1) and persist to date. [CLAIMANT] incorporates the affidavit of [PCP-CFS EXPERT], his medical records and the contents of the [EMPLOYER] claim file in support of his administrative appeal.

[PCP-CFS EXPERT] has submitted an affidavit in support of [CLAIMANT]'s current administrative appeal. (Exhibit 1) In his affidavit, [PCP-CFS EXPERT] sets forth [CLAIMANT]'s medical history, identifies his myriad of symptoms, the medical care and treatment provided to [CLAIMANT], and his diagnoses of Chronic Fatigue Syndrome, Dysautonomia, and Hypersomnia. He also addresses the substantial cognitive defects that he has personally observed in [CLAIMANT] and provides his opinion that he agrees with the findings of the various neuropsychological evaluations that [CLAIMANT] has undergone from 2003 through 2007. Among the other highly relevant matters addressed by [PCP-CFS EXPERT] in his affidavit are the following

- [CLAIMANT] presented with profound fatigue and complaints of unrefreshing or non-restorative sleep. In addition, he reported cognitive dysfunction including impaired memory and concentration which was confirmed by neuropsychological testing. He also has endured post-exertional malaise, the onset of new headaches, arthralgias, myalgias, sore throat and tender lymph nodes. Evidence of these symptoms is contained in his medical records. His medical history reflects that this constellation of symptoms arose after the onset of infection, and has persisted for more than six months. [CLAIMANT]'s substantial symptomatology and disabling affects meet the "working case definition" of Chronic Fatigue Syndrome and developed by the Centers for Disease Control (CDC) and as further defined in the March 1988 Annals of Internal Medicine, Holmes G.P. Kaplan J.E., Gantez, N.M., et al. and a subsequently modified in the December 15, 1994 Annals of Internal Medicine by Fukuda K., et al. Testing of [CLAIMANT]'s systems, including immune, cardiovascular, endocrine and neurologic, have all proven negative. Hence it is my clinical evaluation, based on years of study and hundreds of patients, that [CLAIMANT] does indeed suffer from CFS, which the Social Security Administration recognizes as a disabling illness and the Centers for Disease Control has designated as a legitimate clinical condition.
- Since my initial treatment of [CLAIMANT] in July 2003 and continuing until the present time, he has continued to exhibit numerous symptoms

including pronounced and extreme fatigue, which is exacerbated following physical activity.

- I concur with [NATIONALLY RECOGNIZED CFS EXPERT]'s assessment of [CLAIMANT]'s condition and inability to work. I also agree with [NATIONALLY RECOGNIZED CFS EXPERT]'s statement that [CLAIMANT] "is not capable of 'sustained ability to perform multiple administrative, organizational, and leadership duties' particularly of the complex and technical nature required by his managerial position at [EMPLOYER]."
- Throughout the period I have provided medical care and treatment to [CLAIMANT], he has reported substantial problems with memory and concentration. In fact, I have personally observed [CLAIMANT] on numerous occasions lose his train of thought, concentration and focus during office visits. He has exhibited problems with his memory during office visits as well, demonstrating difficulty recalling matters that he intended to bring to my attention. He also has shown a difficulty with word use, often grasping for words to express himself, and finding it very hard to pull the correct term from his mind. While these cognitive problems allow him such luxuries as purchasing gas, driving, and attending sporting events, they make it very difficult for [CLAIMANT] to function in a workplace setting.
- I agree with the relevant findings of these four psychologists that [CLAIMANT] continues to exhibit substantial cognitive deficits and is disabled from employment. Although I am not a psychologist, I am trained to look for and observe signs of decreased cognitive functioning in patients. That is a critical function of my physical examination of patients suffering from Chronic Fatigue Syndrome and I have personally observe such decreased cognitive functioning in [CLAIMANT] since I began treating him in July 2003 to date.
- [CLAIMANT] has undergone two vocational rehabilitation evaluations by the National Rehabilitation Hospital in Washington, D.C. . . . I have had the opportunity to review both of these reports and I agree with [VOCATIONAL EXPERT]'s opinion in both reports that [CLAIMANT] is unable to perform gainful employment. More specifically, in her 2007 report, [VOCATIONAL EXPERT] states that [CLAIMANT] is unable to perform the essential functions of his former job at [EMPLOYER] as well as the positions suggested in the Transferable Skills Assessment conducted by the disability insurer. Her thorough review of [CLAIMANT]'s medical history, including his substantial CFS symptoms (substantial fatigue, post-exertional malaise, memory impairment, decreased concentration, etc.), four neuropsychological evaluations (all

finding substantial cognitive problems), orthostatic intolerance, sleep disorder and other problems, demonstrate her understanding of CFS and how such problems lead to her fully supported opinion that the unpredictable and pervasive nature of [CLAIMANT]'s disability preclude him from maintaining any employment at the present time.

- I disagree with [EMPLOYER]'s conclusion that [CLAIMANT] is not disabled and that his activities are 'inconsistent' with his symptoms. In its May 11th letter, [EMPLOYER] states that ANSAR testing performed in December 2006 demonstrates that [CLAIMANT]'s autonomic nervous system (ANS) was healthy and therefore implies that this confirms its decision that he is not disabled. This implication is not only erroneous, it is contrary to the complete body of medical information and knowledge concerning Chronic Fatigue Syndrome. The ANS is the part of the nervous system that controls involuntary actions such as the beating of the heart or the widening of blood vessels. When something goes wrong with the ANS, serious problems can arise including blood pressure problems, heart problems, and trouble breathing and swallowing. Some ANS disorders get better when the underlying disease is treated. Often, however, there is no cure and in those cases, the treatment goal is to improve symptoms. This latter instance is the situation confronting [CLAIMANT] because there is no known cure for Chronic Fatigue Syndrome. The ANSAR test is not a diagnostic test that confirms or refutes a diagnosis of Chronic Fatigue Syndrome. Rather, it is a tool available to physicians in providing adequate medical care and treatment to patients suffering from Chronic Fatigue Syndrome. Further, the autonomic nervous system often fluctuates in patients suffering from Chronic Fatigue Syndrome. One day, a patient's ANS may be normal while the next day it may be abnormal. In [CLAIMANT]'s case, ANSAR testing prior to December 2006 demonstrated an abnormal ANS as did testing conducted in June 2007. My note to [CLAIMANT] regarding the December 2006 ANS performing properly was indicative of that point in time. Thus, [EMPLOYER]'s attempt to paint [CLAIMANT]'s ANS as having fully recovered in May 2007 is seriously flawed.
- . . . there are other objective indicators demonstrating [CLAIMANT]'s disabling condition. He has undergone tilt table testing on two occasions, in 2003 and 2007. In 2003, such testing caused [CLAIMANT] to faint after only 5 minutes. The 2007 test shows demonstrable syncope in 7 minutes. Both of these tests demonstrate severe orthostatic intolerance and ANS dysfunction. Further, blood pressure testing in my office during regularly scheduled appointments over the past year fluctuated markedly. For instance, in October 2006, April and May 2007, [CLAIMANT]'s blood pressure dropped upon standing but in June and December 2006, and February 2007, his blood pressure rose upon standing, demonstrating the variable and unpredictable nature of his syncope symptoms. Proper

evaluation of those medical records would have revealed this to the evaluating 'Physician Advisor'. Cardiopulmonary exercise testing conducted in July 2007 (Exhibit 3B) also demonstrates substantial limitations in [CLAIMANT]'s ability to return to work. The test results indicated that most of [CLAIMANT]'s cardiopulmonary values fell outside of the predicted ranges, suggesting an impairment of his work capacity that cannot be explained by de-conditioning alone, and also reflected an abnormal neuroendocrine response, further restricting his ability to work, especially under stress. Further complicating a possible return to work for [CLAIMANT] is his hypersomnia (excessive daytime sleepiness) that was confirmed by a daytime MSLT in 2003. This problem has persisted to date and compounds the effects of his other symptoms.

[PCP-CFS EXPERT] then summarized his opinion regarding [CLAIMANT]'s medical condition and ability to work. He stated

I have provided medical care and treatment to [CLAIMANT] since July 2003. I have attempted several therapies with [CLAIMANT] to help alleviate the severity of his symptoms and allow him to pursue more activities within his tolerance levels. I have adjusted medications as necessary in order assist in minimizing his symptoms. However, there has been no material improvement in his primary disabling conditions of fatigue and cognitive functioning. It is my medical opinion, which I hold to a reasonable degree of medical probability, [CLAIMANT] suffers from Chronic Fatigue Syndrome, Orthostatic Intolerance, Dysautonomia, and Sleep Disorder. His routine lab tests have been normal as expected. He has demonstrated positive tilt table testing in 2003, when he fainted after 5 minutes, and in 2007 that was positive for vasovagal/vasodepressive syncope. Four neurocognitive evaluations conducted between 2003 - 2007 have identified the presence of substantial cognitive problems with processing, concentration and memory, validating his subjective complaints as well as my personal observations. Cardiopulmonary exercise testing demonstrates significant impairment of work capacity that cannot be explained by de-conditioning alone. In summary, [CLAIMANT] is unable to engage in ongoing, regularly scheduled employment in his prior managerial position with [EMPLOYER], any of the three positions identified as suitable alternative employment in the May 11, 2007 [EMPLOYER] letter, or any other occupation requiring consistent and reliable attendance and performance. (Exhibit 1).

[PCP-CFS EXPERT] is of the opinion that [CLAIMANT] is disabled from all employment due to his debilitating and variable symptomatology. He suffers from Chronic Fatigue Syndrome, Dysautonomia, cognitive dysfunction, Hypersomnia and other symptoms that interfere with his ability to maintain a set schedule or perform the duties of employment for which he is reasonably qualified.

[NATIONALLY RECOGNIZED CFS EXPERT], M.D.

[CLAIMANT] has recently undergone an extensive medical evaluation by [NATIONALLY RECOGNIZED CFS EXPERT]. (Exhibit 3A). [NATIONALLY RECOGNIZED CFS EXPERT] is a nationally recognized medical expert in the field of diagnosing, evaluating and treating patients with Chronic Fatigue Syndrome. [NATIONALLY RECOGNIZED CFS EXPERT] is board certified in Internal Medicine, Pediatrics and as an Independent Medical Examiner. (Exhibit 4). He is a Fellow of the American Academy of Pediatrics, American Academy of Family Physicians and American Academy of Disability Evaluating Physicians (AADEP). (*Id.*). He was appointed by the Secretary of the U.S. Department of Health and Human Services to the Chronic Fatigue Syndrome Advisory Board and is and has been on the faculties of the medical schools at Duke University and the University of North Carolina. [NATIONALLY RECOGNIZED CFS EXPERT] has published numerous articles regarding Chronic Fatigue Syndrome in medical journals and textbooks as well as having presented numerous lectures on this topic. (*Id.*). It should be noted that **[NATIONALLY RECOGNIZED CFS EXPERT] is the co-author of the AADEP Position Paper on Chronic Fatigue Syndrome** by virtue of his extensive background in evaluating the illness. He is currently a Physician and Medical Director of the Hunter-Hopkins Center in Charlotte, North Carolina.

[NATIONALLY RECOGNIZED CFS EXPERT] conducted a thorough medical evaluation of [CLAIMANT] spanning two days and a follow up consultation. As a result of this medical examination, [NATIONALLY RECOGNIZED CFS EXPERT] prepared a report with his findings. (Exhibit 3). Based upon his physical examination of [CLAIMANT], his review of the medical records of [PCP-CFS EXPERT], four neurocognitive evaluations, a functional capacity evaluation from 2004, a 2003 tilt table test, a graded exercise test from 2003, and a copy of the [EMPLOYER] claim file, [NATIONALLY RECOGNIZED CFS EXPERT] diagnosed [CLAIMANT] as suffering from Chronic Fatigue Syndrome, Neurally Mediated Hypotension, Sleep Disorder, and Secondary Hypogonadism. (*Id.*). [NATIONALLY RECOGNIZED CFS EXPERT] rated [CLAIMANT] in the "Unable to Work" range in the oft used standard for rating disability, the Karnofsky Performance Scale (Exhibit 34).

[NATIONALLY RECOGNIZED CFS EXPERT] further opined that [CLAIMANT] met the Centers for Disease Control (CDC) and Canadian criteria for Chronic Fatigue Syndrome. He described Chronic Fatigue Syndrome as a disorder characterized by severe debilitating fatigue, recurrent flu-like symptoms, and neurocognitive symptoms such as difficulties with memory, concentration, comprehension, recall, calculation and expression. He also noted sleep disorder to be common and noted all of these symptoms are exacerbated by even minimal physical exertion or emotional stress, and that relapses may occur spontaneously. He indicated that although there is no treatment, rest and symptomatic therapies may palliate the symptoms. [NATIONALLY RECOGNIZED CFS EXPERT] also indicated that in [CLAIMANT]'s case, exclusionary studies, including those recommended by the CDC reveal no other plausible explanation for his symptoms. (Exhibit 3).

He found that [CLAIMANT]'s reports of being markedly impaired and unable to perform even sedentary work on a regular, sustained, or predictable basis, are supported by several objective findings including:

- At least 4 separate neuropsychological evaluations have concluded that [CLAIMANT] is markedly impaired and unable to maintain gainful full time employment.
- Passive tilt table testing demonstrated syncope after just 4 minutes of upright posture.
- Cardio-pulmonary exercise testing in July 2007 demonstrated a markedly reduced aerobic work capacity. Further, core temperature did not increase with maximal exertion, signifying an abnormal neuroendocrine response and inability to respond to physical or emotional stress.
- Graded exercise testing in July 2003 showed reduced aerobic capacity but not as poor as the July 2007 testing. Thus, the new study shows there has been significant deterioration in stamina and ability over the past 4 years.
- A Functional Capacity Exam in January 2004 demonstrated [CLAIMANT] could not physically meet the demand of his job and that he functioned at the "light demand level" at best. Although [NATIONALLY RECOGNIZED CFS EXPERT] opined that an FCE is not recommended for evaluation of CFS because (1) it measures mostly strength and range of motion; neither of which are generally affected by CFS; (2) it does not measure post-exertional malaise – the worsening of symptoms for days *after* the test; and (3) it does not measure the factors that most impair persons with CFS, namely fatigue, inability to perform on a regular or sustained basis, pain, or cognitive dysfunction. Nonetheless, [NATIONALLY RECOGNIZED CFS EXPERT] indicated that the FCE did confirm limitations and those limitations appear to be even higher in 2007 than they were in 2003.

(*Id.*).

[CLAIMANT] is able to perform limited physical activities, according to [NATIONALLY RECOGNIZED CFS EXPERT], such as tidy his home, feed the horses, even weed or garden a little (some of which is performed while sitting). He cautioned, however, that persons with CFS can typically exert for short periods as long as they balance such activity with rest. They can also pre-emptively rest in order to "store up energy" for exceptionally difficult or prolonged activity. Over-exertion will predictably trigger post-exertional malaise, which is an exacerbation of symptoms and debilitating fatigue that can last for hours to weeks. (*Id.*).

Based upon his comprehensive evaluation of [CLAIMANT] and his review of [CLAIMANT]'s complete medical history, [NATIONALLY RECOGNIZED CFS EXPERT] takes exception to [EMPLOYER]'s determination that [CLAIMANT] is capable of returning to full-time employment. He states decisively that [CLAIMANT] "is *not* capable of 'sustained ability to perform multiple administrative, organizational, and leadership duties' particularly of

the complex and technical nature required by his managerial position at [EMPLOYER].” (*Id.*). He goes on to note

In summary, [CLAIMANT] is markedly impaired by Chronic Fatigue Syndrome, orthostatic intolerance, and a sleep disorder. These disorders alone can cause significant disability, but the combination makes it unrealistic and unreasonable for [CLAIMANT] to perform even sedentary work on a regular and sustained basis. He is markedly impaired by weakness and fatigue after minimal every day activity; post-exertional malaise that may prostrate him for days; weakness and presyncope with prolonged sitting or standing; sleep disruption that leads to excessive daytime somnolence despite BiPAP therapy; and significant confusion and neurocognitive dysfunction including problems with memory, attention, reaction time processing speed, comprehension and calculation. He is also unable to maintain a set work schedule due to the unpredictable flares and the fluctuating nature of his illness.

[NATIONALLY RECOGNIZED CFS EXPERT] clearly addresses what [TPA] identifies as activities that are ‘inconsistent’ with [CLAIMANT]’s ‘alleged symptoms’. [CLAIMANT]’s pattern of extensive rest and occasional activity is entirely consistent with his symptoms in the context of the diagnosis of Chronic Fatigue Syndrome and the unique characteristics of that illness.

Thus, it is clear, based upon the medical examination and disability evaluation of [CLAIMANT] conducted by [NATIONALLY RECOGNIZED CFS EXPERT], [CLAIMANT] is incapable of performing the requirements of any job for any employer for which he is qualified or may be reasonably become qualified by training, education or experience. As a result, [CLAIMANT] is “disabled” under the [EMPLOYER] LTD Plan.

Neuropsychological Evaluations.

To date there have been five Neuropsychological Evaluations by four separate Neuropsychologists. Two of these have been Independent Medical Evaluations that have been arranged and paid for by [EMPLOYER]. Each of these evaluations have been consistent in their professional finding of a) the underlying issues affecting [CLAIMANT], b) the deterioration of his abilities over the course of the testing, c) the noticeable increase in fatigue over the course of the testing, d) the full level of effort he committed to the testing, e) ruling out malingering, and f) the debilitating condition of [CLAIMANT]. Each and every one of them has concluded that [CLAIMANT] is indeed unable to maintain an employment circumstance. As one of the [EMPLOYER] Neuropsychologists aptly stated, "his impaired concentration, poor and incapably compensated mode of behavior and thinking combine to make him a very poor candidate for any kind of work."

Additionally, we asked the nation's preeminent clinical Neuropsychologist specializing in the cognitive effects of Chronic Fatigue Syndrome to review these Neurocognitive Evaluations, as well as all other relevant information pertaining to this case. This review concluded that each of the Neurocognitive Evaluations were entirely consistent and that [CLAIMANT] is unable to sustain employment even in a sedentary situation.

[2007 NEUROPSYCHOLOGIST], Ph.D.

[2007 NEUROPSYCHOLOGIST] conducted a neuropsychological evaluation of [CLAIMANT] on May 29, 2007. He was referred to [2007 NEUROPSYCHOLOGIST] for further neuropsychological evaluation by his treating physician, [PCP-CFS EXPERT]. (Exhibit 5).

[2007 NEUROPSYCHOLOGIST] conducted a clinical interview and neuropsychological testing during her evaluation of [CLAIMANT]. Throughout the evaluation, [2007 NEUROPSYCHOLOGIST] observed that [CLAIMANT] appeared motivated to perform well and seemed to put forth good effort. Performance on effort indicators was within normal limits. However, his excessive fatigue was evident. [CLAIMANT] yawned frequently and stated that he actually fell asleep briefly during the 2 computerized tests. According to [CLAIMANT], this level of fatigue is typical for him. Thus, although he might be capable of better performance without fatigue, [2007 NEUROPSYCHOLOGIST] considered her current findings to be a valid representation of [CLAIMANT]'s typical cognitive functioning. (*Id.*).

It is clear from [2007 NEUROPSYCHOLOGIST]'s testing, as it was with the neuropsychological testing performed by Drs. [2005 IME], [2004 IME] and [INITIAL NEUROPSYCHOLOGIST], that [CLAIMANT] is a highly intelligent person. The fact that he suffers from Chronic Fatigue Syndrome has not diminished [CLAIMANT]'s intelligence. Rather, it has made it more difficult for [CLAIMANT] to use his intellect due to problems with memory, attention, processing speed and other cognitive factors. More specifically, [2007 NEUROPSYCHOLOGIST]'s testing showed demonstrable problems in the following areas

- His performance on measures of processing speed was with the average to low average range.
- Test results revealed impaired sustained attention. [CLAIMANT] committed 8 errors of omission (not responding when he was supposed to), which is markedly atypical for someone his age. He also demonstrated variability in his reaction time throughout the test. His performance suggests that he has difficulty sustaining his attention over time. In fact, [CLAIMANT] reported he had fallen asleep for a brief period.
- [CLAIMANT] performed within the average to low average range on WAIS-III measures of processing speed. In contrast, he performed within the impaired range on a timed measure of visual scanning and tracking.
- Although measuring within the high average range on the serial word-list learning test, when verbal information was provided within the context of a story, [CLAIMANT]'s ability to learn the information and recall it after a 4 hour delay was within the low average range.
- Test results for intact visual learning indicated over a 4 hour delay, [CLAIMANT] lost information he learned to such a degree he was impaired for someone of his age and education.
- His performance on a measure of word findings was marginal for someone his age and education.
- [CLAIMANT]'s responses on the personality assessment measure suggest that he attended appropriately to the items and responded consistently and in a forthright manner. Consistent with his report in the clinical interview, [CLAIMANT]'s personality profile does not suggest that he is suffering any significant symptoms of depression or anxiety and he does not appear to meet diagnostic criteria for a psychiatric disorder. (*Id.*).

Based upon her clinical interview and neuropsychological testing of [CLAIMANT], [2007 NEUROPSYCHOLOGIST] concluded that [CLAIMANT]'s premorbid intellectual level is estimated to be within the high average to superior range. She further concluded that neuropsychological test data suggest a decline from this level in sustained attention, processing speed, visual scanning/tracking, word finding, verbal fluency, mental flexibility, story learning and recall, visual memory, and mental flexibility. She further observed that research has shown that this pattern of performance is typical of individuals with Chronic Fatigue Syndrome. [2007 NEUROPSYCHOLOGIST] also noted, importantly, that

It is important to mention that the structured, controlled nature of the testing environment may have maximized [CLAIMANT]'s performance. In other words, he is likely to have more cognitive difficulties in "real-world" situations where he cannot always minimize the distractions, take frequent breaks, and work on just one task at a time. (*Id.*).

Relevant to this appeal, [2007 NEUROPSYCHOLOGIST] opined

1. [CLAIMANT]'s performance on the current evaluation, as well as his performance across the 4 prior neuropsychological evaluations, is entirely consistent with his diagnosis of Chronic Fatigue Syndrome. According to the Centers for Disease Control, their research has shown that "CFS can be as disabling as multiple sclerosis, lupus, rheumatoid arthritis, heart disease, end-stage renal disease, chronic obstructive pulmonary disease (COPD) and similar chronic conditions." In [CLAIMANT]'s case, the combination of his cognitive difficulties, fatigue, and other CFS symptoms precludes him from being able to maintain gainful employment.
2. At this time, there is no empirically based cure for CFS. Thus, although [CLAIMANT] might experience periods of improved function, it is not likely that he will recover and return to his baseline level of functioning. At this time, it is recommended that he continue to participate in meaningful activities in which he can control his level of involvement.
3. . . . [CLAIMANT] is encouraged to remain socially, mentally, and physically active to the extent that his CFS will allow.
4. . . . [CLAIMANT] is encouraged to minimize distractions when attempting complete cognitively demanding tasks. He should also attempt to focus on just one task at a time (i.e., avoid multi-tasking) and take frequent breaks to pace himself.
5. Given his variable performance on measures of learning and memory, [CLAIMANT] is encouraged to continue to write down important information to be remembered. Use of a daily planner or electronic organizer may be particularly helpful.
6. It is recommended that [CLAIMANT] participate in a feedback session to review the results of this evaluation in detail. (*Id.*).

In light of [2007 NEUROPSYCHOLOGIST]'s clinical interview and neuropsychological testing, it is clear that not only does [CLAIMANT]'s performance correlate highly with his diagnosis of Chronic Fatigue Syndrome, but as of the date of testing, May 29, 2007, this medical condition and its symptoms preclude him from performing the requirements of any job for any employer for which he is qualified or may be reasonably become qualified by training, education or experience. As a result, it can only be concluded that [CLAIMANT] is "disabled" as defined by the [EMPLOYER] LTD Plan.

[2005 IME], Ph.D.

As you are aware, [INITIAL TPA] had [CLAIMANT] undergo a neuropsychological evaluation in June 2005. This neuropsychological IME was performed by [2005 IME], Ph.D. Her report, which [INITIAL TPA] disability apparently received on June 27, 2005, is included in the claim file provided to undersigned counsel by [TPA].³ (Exhibit 8). [2005 IME]

³ The claim file initially provided to counsel for [CLAIMANT] did not include [2005 IME]' IME report. In fact, the claim file initially provided by [TPA] did not include any part of the claim file maintained by the prior Claims

conducted a comprehensive evaluation of [CLAIMANT] over a two day period. She noted that “the only difficulty in examining the patient proved not to be from any problem with articulation or extenuating circumstances, but instead seemed to arise from the patient’s persistent tiredness and fatigue.” [2005 IME] further indicated “he definitely appeared to give his best effort on all the procedures attempted. There was never any indication from the patient of any interfering factors that might bring into question the reliability of [CLAIMANT]’s overall results, and there was never any indication of any procedure being invalidated as a result of [CLAIMANT]’s thought, affect or behavior.” (*Id.*, p. 2).

Of relevant note in [2005 IME]’ results and interpretation, are the following:

- There was a very marked and salient discrepancy obtained between the patient’s functional efficiency with the tasks of the Wechsler requiring verbal, as appose to nonverbal, problem-solving ability. In this instance, this well represented by the patient’s obtained Verbal Scale IQ of 125 (95th percentile), compared to his Performance Scale IQ of 99 (47th percentile). (*Id.*, p. 3).
- The most profound deficiency seen on the Wechsler subtests affected the patient on the Perceptual Speed Index, where the patient’s Index Score of 71, places him at only the 3rd percentile. In this instance, these data seem to represent especially the patient’s very poor performance on procedures requiring visuo-symbolic motor speed and efficiency, as well as nonverbal cognitive fluency in the perceptual-motor sphere. (*Id.*, p.3).
- [CLAIMANT] also had difficulty with procedures requiring identification of isolated visual details. (*Id.*, p. 3).
- With regard to retention of information overall, the patient’s general pattern performance is considerably less proficient than the WAIS-III results just noted suggests. The principle measure of sustained memory skills on the WMS-III is the General Memory subtest. With composite index, the patient’s Index Score of 92 falls at only the 30th percentile compared to the normative standard. Thus, the patient’s retention of information is drastically less than we would anticipate, given [CLAIMANT]’s overall intellectual ability. Survey of the entire array of scores from the WMS-III indicates that the patient’s overall cognitive performance, as far as retention skills are

concerned, is roughly speaking in the low average range. (*Id.*, p.3).

- The chief areas reflecting some difficulty on the Halstead-Reitan proved to be with tasks requiring attention to auditory rhythmic patterns, as well as speed with the dominant (right) upper extremity. (*Id.*, p. 4).
- Aside from tiredness and fatigue, the patient does also complain on the Beck of concentration difficulties and loss of interest in general, but there is an absence of most of the indicators of significant depressive illnesses. The patient does show a marked alteration in certain vegetative signs, particularly increased sleep. (*Id.*, p. 5).
- The patient's self-report in this examination, especially on the Minnesota Multiphasic Personality Inventory-2, results are shown to be entirely psychometrically valid, with no effort on the patient's part to exaggerate symptoms whatsoever. (*Id.*, p. 6).

Thus, [2005 IME]' identifies significant cognitive dysfunction and difficulties that prevent [CLAIMANT] from performing any employment at all. In fact, in her diagnostic formulation, [2005 IME] notes:

- Current diagnostic assessment is entirely consistent, especially when taken in light of the history and previous examination finding--both those that are physical, and appear to be relevant, as well as those that are psychological and are definitely relevant. These indicate a principal diagnosis of Cognitive Disorder, not otherwise specified. The principle areas of dysfunction shown by the patient appear to be in the area of marked visual-motor difficulty and information processing speed and efficiency, with marked reduction also in the patient's retention skills and general perceptual-motor problem solving effectiveness. These results are entirely analogous, as this clinician views them with previous assessment indicators, and they suggest a very stable consistent pattern that is perhaps somewhat mildly progressive since the patient in certain regards seems to be declining in cognitive efficiency overall. (*Id.*, p. 6).

- On Axis III, the most obvious candidates for inclusion among the contributing health disorders, based on the existing records, are the patient's status as diagnosed Neurally Mediated Hypotension. (*Id.*, p. 7).

- With respect to Axis IV, which means the significance of psychosocial factors, I would rate these as a 3, meaning that the patient has suffered from some stress with respect to job-related adverse feedback as well as poor self-estimation of his own performance, and he has struggles with coincidental features of his health, which also constitutes something of a stressor. However, these do not appear in and of themselves major, though the impact on the patient's health and his anxiety problems may be somewhat greater. (*Id.*, p. 7).

- With respect to Axis V, global assessment of functioning, it appears that the patient performs most of the activities of daily living in his own behalf. However, I would rate his overall functioning as being much lower now than that given earlier by [2004 IME], which was a 60, and rate his current level of performance at approximately a 45, based on his global description to me of his functional effectiveness at this time. That is, the patient is markedly affected in a number of areas of his life by his Axis III Disorder, as well as his Axis I Disorder. (*Id.*, p. 7).

Thus, [2005 IME]' diagnosis of [CLAIMANT] is not only consistent with the previous diagnoses of Drs. [INITIAL NEUROPSYCHOLOGIST] and [2004 IME], but, in fact, shows increased deterioration in [CLAIMANT]'s functional effectiveness.

Finally, in regards to her conclusions and recommendations, [2005 IME] states as follows:

- This patient is significantly impaired in a number of areas of his life, and there appears to be no question whatsoever about the validity of the various diagnoses he has received. In fact, current examination documents fairly clearly what will be discussed below. (*Id.*, p.7).
- The principle disorder here is an underlying neurologic condition, presumably NMH and the residuals of this patient's previous neurologic surgery and the pituitary tumor, which are Axis III diagnoses and are not mental disorders as such. The patient does have various cognitive symptoms that I regard as severe, and he also appears to be functioning decreasingly well across time. Therefore, the latter part of the question, which has to do with the extent of the impairment, definitely should be answered as yes, meaning affirmatively that the patient is not going to be able, as he now functions, to conduct any meaningful employment. (*Id.*, p.7-8).
- From the examination results just reported, the patient's information processing speed, his capacity with tasks requiring timing and time limits, and the massive deficits in his general retention relative to his other skills are all hallmarks of his cognitive difficulties at this point.

Moreover, the evidence is that even since the fairly recent report by [2004 IME] in 2004, [CLAIMANT] is decreasing in his functioning at a fairly rapid pace. (*Id.*, p. 8)

- With the clinical course this patient exhibits now, there is no anticipation that [CLAIMANT] is going to return to full-time employment of any sort. To this writer's knowledge, NMH is a chronic and persistent condition, and no recovery is expected, unless the patient responds to stimulants, which is not the case here. In fact, [CLAIMANT] has utilized and continues to utilize to some extent a variety of psychotropics, as has been recommended concerning him by previous consultants, and all this intervention has been essentially to no avail. (*Id.*, p. 8).
- With respect to question number 4, the patient's "motivation to return to the work force" is only what is typical with individuals with this previous sound work history. That is, [CLAIMANT] reports that he wishes that he were productive and capable, but he recognizes accurately that his impaired concentration, poor and incapably compensated mode of behavior and thinking, combine to make him a very poor candidate for any kind of work. (*Id.*, p. 8).
- With respect to question number 5, whether the patient is currently in "appropriate treatment," I note in the first place that, at least to this writer's knowledge, there is no additional appropriate treatment. The patient remains in certain forms of treatment, but it should be emphasized that he does not for the most part exhibit a mental disorder in my opinion that is amenable to care. Instead, he exhibits sustained deficits that are basically neurologic in origin. While certain forms of cognitive rehabilitation, such as those recommended by [INITIAL NEUROPSYCHOLOGIS] and [2004 IME], might make the patient more comfortable with his current living circumstances, they are not going to habilitate or rehabilitate him, nor are they going to yield a changed result as far as employability is concerned. These are basically palliative treatments, not curative ones. (*Id.*, p. 8).
- The remarks about whether or not the patient is seeing a psychiatrist or any other kind of therapist is completely superfluous as to whether or not he has NMH or is the subject of residuals from a pair of additional neurologic difficulties...The idea that he is somehow the victim of a "psychiatric," functional, or emotionally driven condition alone is simply erroneous. I think the previous opinion of the consulting psychiatrist, Dr. Kenneth G. Busch, dated 5/27/04, is crystal clear on this topic as well. (*Id.*, pp. 8-9).

- We realize that there is a great deal of verbiage in the previous reports from [INITIAL NEUROPSYCHOLOGIST] and perhaps also [2004 IME] that can be construed as not merely reporting the results of their examinations, but commenting on the nature of the clinical presentation and in [INITIAL NEUROPSYCHOLOGIST]'s case, presenting a possible neuropsychologic rationale for the deficits observed. Although there is nothing in present findings or in present opinion to contradict any of this material from either of these two previous consultants, neither is there any basis in either set of statements for concluding that there is anything invalid about [CLAIMANT]'s illness, the marked and devastating impact it has had on him functionally, and the very doubtful and guarded prognosis that attends that condition. (*Id.*, p. 9).

Thus, it is crystal clear from [2005 IME]' report, including the findings and conclusions contained therein, that [CLAIMANT] is completely disabled from performing any type of employment on a full-time basis at this time and, most likely, in the future.

[2004 IME], Ph.D.

The prior Claims Administrator, [INITIAL TPA], also had [CLAIMANT] undergo a neuropsychological examination with [2004 IME], Ph.D., in May 2004. (Exhibit 9). [CLAIMANT] did undergo the cognitive rehabilitation recommended by [2004 IME] in his report. However, although initially of limited benefit, the cognitive rehabilitation provided by [2004 IME] did not provide any long term gain in [CLAIMANT]'s cognitive condition.

[2004 IME] makes a number of highly relevant findings in his report that are highly consistent with both [CLAIMANT]'s medical condition, Chronic Fatigue Syndrome, and his substantial cognitive problems. Among his findings are the following

- This overall pattern indicates great concentration difficulties associated with his medical condition. This is significant enough to keep him from effectively utilizing his cognitive and intellectual potential.
- There are not indications of malingering.
- There are great concentration difficulties, fatigue and other issues that combine to keep him from effectively tapping into this potential.
- However, his concentration difficulties combined with his worry and fatigue greatly impede [CLAIMANT] from being able to effectively encode information and this is at the root of his "functional" memory difficulties.

- There are indications of problems concentrating enough to produce memory problems.
- Neuropsychologically, due to significant concentration deficits he would not be able to work in his job capacity and complete his duties on a full time basis.
- With regard to returning to a work setting, [CLAIMANT] appears to be well motivated.
- There is great variability in performance. However, it is important to note that this is not due to malingering but is in fact common to his medical condition and his overall fatigue as the day progresses.
- **Yet, at the current level of poor concentration, he will not be able to function appropriately in his current work setting.**
- Continuing to be as active as possible and having a daily schedule and regimen will keep a depression from worsening. (*Id.*)

In his report, [2004 IME] found that “there is great variability in performance. However it is important to note that this is not due to malingering but is in fact common to his medical condition and his overall fatigue as the day progresses.” This statement by [2004 IME] concisely summarizes [CLAIMANT]’s medical condition and the fact that he never knows from one day to the next whether or not he will be bedridden or have a couple of good hours during the course of the day to accomplish tasks. It is this unreliability that further hinders his ability to carry out regular, sustained employment activity of any kind. All the physicians who have expressed an opinion regarding [CLAIMANT]’s work status have unanimously stated that he is incapable of performing any employment duties.

[INITIAL NEUROPSYCHOLOGIST], Ph.D.

Due to his ongoing substantial cognitive difficulties, [CLAIMANT] was referred for neuropsychological examination and underwent an evaluation with [INITIAL NEUROPSYCHOLOGIST], Ph.D.

[INITIAL NEUROPSYCHOLOGIST] actually performed two evaluations of [CLAIMANT], the first in August 2003 and a follow-up in May 2004. (Exhibits 10 and 11). In his 2003 report, [INITIAL NEUROPSYCHOLOGIST] noted “(t)he Neurocognitive disturbance [CLAIMANT] presents follows a well defined and empirically well supported model ... concerning different memory disordered syndromes in relation to prefrontal CNS related impairments versus impairments of the hippocampalo and para-hippocampal structures.” (Exhibit 11). Based upon his neuropsychological testing and clinical interview of

[CLAIMANT], [INITIAL NEUROPSYCHOLOGIST] concluded that [CLAIMANT] “really is cognitively unable to sustain an employment circumstance.” (*Id.*).

In his May 2004 report concerning his follow up evaluation of [CLAIMANT], [INITIAL NEUROPSYCHOLOGIST] stated “(t)here really is an enduring and disabling neurocognitive deficit affecting this gentleman.” (Exhibit 10). He went on to indicate “(t)he amnesia features, the difficulties with the sequential planning of intention and the difficulty with the relevant implementation of intention into action programs follow concisely with the characterization of the dys-executive syndrome.” (*Id.*). [INITIAL NEUROPSYCHOLOGIST] then opined that “[CLAIMANT] is unable to function in an employment context.” (*Id.*).

As in the case of all of the other evaluating clinical Neuropsychologists, [INITIAL NEUROPSYCHOLOGIST] is of the opinion that [CLAIMANT]’s demonstrated cognitive deficiencies rendered him unable to engage in the performance of the duties required in any regular, sustained employment. Although his opinion was the first opinion provided by any psychologist regarding [CLAIMANT]’s inability to work due to his objectively identifiable cognitive deficiencies, [INITIAL NEUROPSYCHOLOGIST]’s conclusion has been repeatedly confirmed by the evaluations of Drs. [2004 IME], [2005 IME] and [2007 NEUROPSYCHOLOGIST], and is as relevant today as it was when first provided in 2003.

[NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST], Ph.D.

A review of the reports of all evaluating Clinical Psychologists was undertaken by [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST], Ph.D.⁴ [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] is nationally recognized as a leading researcher on cognitive and behavioral aspects of chronic pain and persistent fatigue. She is a member of the Board of the International Association of Chronic Fatigue Syndrome and has served on major committee assignments regarding Chronic Fatigue Syndrome with the National Institutes of Health. She has published books and articles regarding the cognitive issues related to Chronic Fatigue Syndrome in numerous well-respected medical journals. (Exhibit 7).

[NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] reviewed the reports of Drs. [2007 NEUROPSYCHOLOGIST], [2005 IME], [2004 IME] and [INITIAL NEUROPSYCHOLOGIST]. She also reviewed [CLAIMANT]’s medical records, volunteer information, surveillance summaries from the claim file, and notes prepared by [CLAIMANT]. Based upon her review of this substantial amount of information as well as her expertise in evaluating cognitive function in patients with persistent fatigue and pain conditions such as Chronic Fatigue Syndrome, [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] provided her opinion regarding [CLAIMANT]’s current cognitive status. (Exhibit 6).

⁴ [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] is not related in any way whatsoever to the claimant, [CLAIMANT]. They have no previous relationship and their only current relationship consists of [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST]’s review of the previous neuropsychological evaluations and her report that was prepared for this appeal.

[NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] reported the following salient findings from the neuropsychological evaluations provided to [CLAIMANT]

- [CLAIMANT]'s scores on the WAIS-III indices point to a superior ability when required to comprehend and use verbal information under **untimed** conditions. Working memory, the ability to hold information briefly online for further use appears to be in the average range, a relative weakness for [CLAIMANT]. Likewise, when reported, processing speed was in the average range, again a significant weakness within the context of [CLAIMANT]'s overall intellectual functioning.
- It appears that [CLAIMANT]'s ability to sustain attention is poor, working memory is within the average range (a relative weakness), and information processing speed is slow. However, from the data provided it seems that when challenged, [CLAIMANT] "rises to the occasion" performing better on tasks that are more effortful.
- [CLAIMANT]'s memory performance was variable. While list learning was in the high average range, retention and spontaneous recall especially of complex visual information suffered. Based on WMS III general memory indices provided, memory performance was consistent with overall intellectual function in 5/2004, but significantly decreased when reassess in 6/2005. (*Id.*).

As a result of her review, [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] expressed her opinion that [CLAIMANT]'s memory seems to have significantly deteriorated over time. She attributed this marked deterioration to contributing factors, including poor sustained attention and slowed information processing speed affecting encoding and retention of information. [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] further opined that "(c)ombined the decrement in these high level cognitive functions will preclude [CLAIMANT] with certainty from working in the fast paced and challenging environment he left at [EMPLOYER]. It is unlikely, that [CLAIMANT] will be successful when required to follow complex conversations or detailed program development plans. Importantly however, the cognitive decrements observed will also impact on his performance in a slow moving, sedentary environment." (*Id.*). After providing examples of sedentary occupations [CLAIMANT] would have difficulty performing, [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST] stated

While these examples may sound extreme, many CFS patients encounter these difficulties every day making it impossible for many to function in any working environment. [CLAIMANT]'s cognitive profile is entirely consistent with that observed in the majority of patients with CFS. Most patients are yearning to remain productive members of society and often try "extra hard" to accomplish cognitive tasks, previously easily completed, but now complex and challenging. This effort often leads to significant post-exertional fatigue, a major issue for many CFS patients, rendering the patient housebound for days afterward.

Finally, based on my reading of the neuropsychological reports provided to me, all examiners agree that [CLAIMANT] has difficulties in the areas outline above. It appears unreasonable and ill advised to subject [CLAIMANT] to additional neuropsychological testing to look for evidence that might contradict the professional opinion of four independent clinical neuropsychologists, two of whom were conducting independent medical examinations. (*Id.*).

It is thus abundantly clear that [CLAIMANT] is incapable of performing not only the duties of his prior managerial position with [EMPLOYER] but also the duties of a Market Research Manager, Product Development Manager, and Product Development Supervisor that [TPA] contends he is capable of performing. In fact, based upon the findings of the four independent clinical Neuropsychologists who have evaluated [CLAIMANT] to date, and as confirmed by [NATIONALLY RECOGNIZED CFS NEUROPSYCHOLOGIST], he is also incapable of performing any sedentary positions, such as data entry or receptionist in slow moving work environments, due to his substantial cognitive deficiencies.

**THE REASONS PROVIDED BY [EMPLOYER] TO TERMINATE [CLAIMANT]'S
LONG TERM DISABILITY BENEFITS ARE ERRONEOUS AND CONTRARY TO THE
OVERWHELMING AND UNREBUTTED EVIDENCE OF RECORD**

**[CLAIMANT]'s Volunteer and Other Activities Are Not Only Consistent With The
Diagnosis Of Chronic Fatigue Syndrome But Also Were Recommended By His and
[EMPLOYER]'s Own Medical Experts**

[EMPLOYER]'s decision to terminate [CLAIMANT]'s long term disability benefits is based, in large part, upon its videotaped surveillance which showed [CLAIMANT] driving his vehicle to Baltimore to attend a function at Camden Yards and upon [CLAIMANT]'s volunteer activities as a Director of Referees and referee for the [YOUTH CLUB]. [EMPLOYER] explicitly states that activities observed during surveillance and [CLAIMANT]'s volunteer activities are 'inconsistent' with [CLAIMANT]'s 'alleged symptoms' and infers that [CLAIMANT] is sufficiently recovered from his Chronic Fatigue Syndrome and therefore his medical condition poses no obstacle to his return to full time employment. [EMPLOYER]'s inference is not supported by the generally accepted medical evidence that activity, both mental and physical, is not only beneficial to patients suffering from Chronic Fatigue Syndrome but is necessary to prevent 'deconditioning' as well as psychiatric conditions such as depression from worsening their condition. These activities are not 'inconsistent' with his condition and definitely not evidence that the condition has resolved. In fact, each examining expert, including those working on [EMPLOYER]'s behalf, has recommended that [CLAIMANT] keep as active as possible within the bounds of his illness.

The Centers for Disease Control (CDC) is very clear on maintaining activity levels while suffering from Chronic Fatigue Syndrome explaining that it is "*important not to avoid activity and*

exercise altogether. Such avoidance leads to serious deconditioning and can actually worsen other symptoms.” They note that “CFS patients must learn to pace activities” and that “The goal is to balance rest and activity to avoid both deconditioning from lack of activity and flare-ups of illness due to overexertion.” (Exhibit 22).

The following discussion addresses each of those activities [TPA] maintains is ‘inconsistent’ with [CLAIMANT]’s ‘alleged symptoms’ in detail as well as in context with the medical knowledge surrounding the diagnoses [CLAIMANT] has received due to overwhelming objective medical evidence.

VOLUNTEER ACTIVITIES IRRESPONSIBLY ANALYZED BY [TPA]

[CLAIMANT]’s volunteer activities with the [YOUTH CLUB] do not rise to the level of activity that a reasonable person could conclude to be evidence of his ability to carry on full-time, regularly scheduled employment. As noted in his affidavit, this activity took only 5 to 10 hours per week and was performed by [CLAIMANT] in short periods over the course of the entire week as he was available to. The positions were not demanding and the position of director of referees for [YOUTH CLUB] performed only a few of the many duties described in the list [TPA] used for analysis. Attached as Exhibits 20 through 21B are affidavits from individuals associated with the [YOUTH CLUB] attesting to the time and duty demands placed upon [CLAIMANT] by these positions as well as his ability to perform such duties. Clearly, a reasonable person could not contend, based upon this unrebutted evidence, that this volunteer activity supports the conclusion that [CLAIMANT] is capable of “the sustained ability to perform multiple administrative, organizational, and leadership duties” as contended by [TPA].

Other [YOUTH CLUB] representatives have also submitted affidavits noting that the other activities [CLAIMANT] was involved in were also minimally challenging. (Exhibits 21A and 21B). [YOUTH CLUB VOLUNTEER] testifies that the role of a league director, after some about 10 hours over two months of pre-season organization, this role requires less than an hour a week during the season and his coaching requires about 2 ½ hours per week. (Exhibit 21B). [YOUTH CLUB REFEREE] testifies that during her refereeing activities with [CLAIMANT] he often appeared fatigued and confused to the point that time outs were extended and she would have to work extra hard to compensate for his health issues. (Exhibit 21). All [YOUTH CLUB] individuals also commented on occasional confusion with either too many or not enough referees showing up. (Exhibits 20 through 21B).

Also attached is an affidavit of [YOUTH CLUB COMMISSIONER], the Basketball Commissioner for [OTHER YOUTH CLUB] in Virginia, the local basketball league that [TPA] took the “director of referees” position off of the internet and used the duties of that position as a basis for terminating [CLAIMANT]’s long term disability benefits. (Exhibit 18). [YOUTH CLUB COMMISSIONER] testifies that not only does the [OTHER YOUTH CLUB] director of referees not actually perform many of those duties, that person requires only 5 hours per week on a sporadic basis as her schedule allows to perform her duties. This is confirmed in the affidavit of [DIRECTOR OF REFEREES], the director of referees for [OTHER YOUTH CLUB], who has a full time job as an office manager. (Exhibit 19). An analysis of the two organizations reveals that [OTHER YOUTH CLUB] is much larger than [YOUTH CLUB] with 50% more

games each week and more than double the number of referees. [CLAIMANT]'s [OTHER YOUTH CLUB] counterpart is paid \$2,500 for the season, while [CLAIMANT] performs his activity on a strictly volunteer basis. Both [OTHER YOUTH CLUB OFFICIALS] confirm that this role described in the document [TPA] used as the basis for their decision making requires only basic organizational and administrative skills. [OTHER YOUTH CLUB COMMISSIONER] specifically notes that "No analytical, management, or leadership skills whatsoever are required" in the duties of the director of referees of [OTHER YOUTH CLUB].

Furthermore, both [OTHER YOUTH CLUB COMMISSIONER] and [YOUTH CLUB COMMISSIONER] are attorneys who testify in their affidavits that no one contacted them on behalf of [EMPLOYER] in order to ascertain the duties of the position, the level of effort required, or the skill sets required to fulfill this role.

[YOUTH CLUB COMMISSIONER] addressed the award given to [CLAIMANT] by stating

"Regarding the [AWARD] that [CLAIMANT] received this past January, the primary reason he received the award was because, by virtue of not being employed, he was flexible and could help out a few hours more per week than most of my other volunteers that had full time jobs. This assistance was very valuable to the organization, although the activities he assisted with did not require a significant amount of time or more than clerical skill sets. [CLAIMANT] was certainly a deserving recipient, but it is important to recognize that this volunteer position with no set schedule and primarily clerical skill sets is in no way comparable to any full or part time employment in hours worked or skills required. Basically, he provided a few more hours a week than other volunteers and had been volunteering for several years. I spread this award around and it was [CLAIMANT]'s turn." (Exhibit 20).

Simply put, no one from [EMPLOYER] or [TPA], or anyone acting on their behalf, performed any reasonable level of due diligence which would support any reasoned analysis to determine the true nature of [CLAIMANT]'s volunteer activities for [YOUTH CLUB] relative to his 'alleged symptoms'. Essentially the case manager grabbed a few things off the internet, made assumptions to meet her goals then made subjective conclusions based on those erroneous assumptions.

[CLAIMANT] has always cleared these activities with his physicians, including those contracted to [EMPLOYER]. In fact, [CLAIMANT] included his role at the time with [YOUTH CLUB] in his initial application for LTD benefits when the claims were administrated by [INITIAL TPA]. His physicians encouraged such activities to the extent [CLAIMANT] was able and [2004 IME], one of the Neuropsychologists retained by [EMPLOYER], even stated that [CLAIMANT] should be "Continuing to be as active as possible and having a daily schedule and regimen will keep a depression from worsening." (Exhibit 9). [CLAIMANT] was following the directive of the [EMPLOYER] contracted expert who considered these volunteer activities when

doing his reasoned analysis concluding in his expert opinion that [CLAIMANT] was not employable.

SURVEILLANCE ACTUALLY SUPPORTS [CLAIMANT]'S 'ALLEGED SYMPTOMS'

[TPA] hired a private investigator to conduct surveillance of [CLAIMANT] in March and April 2007. The video provided by [TPA] was taken during a three day period. The total amount of time videoing [CLAIMANT] over this entire three day period is 17 minutes and 34 seconds of video (11 minutes and 8 seconds of which was actually of someone other than [CLAIMANT]). It is neither compelling nor demonstrative evidence of [CLAIMANT]'s ability to perform sustained, full-time employment.

On the first day, he is briefly seen exiting his house in his bathrobe. On the third day, he is seen briefly driving his daughter one mile to school. On neither day is he observed at any other time. On the middle day, [CLAIMANT] attended a baseball team 'Fanfest' with his son, driving 57 miles, going 'across state lines'. This activity was misrepresented by both the investigator and by the [TPA] Claims Manager.⁵

[CLAIMANT] described the events of that day in his attached affidavit (Exhibit 12) as follows:

Understanding the nature of my illness, it is clear that this is not in the least bit 'inconsistent' with my complaints. To begin with, I rested the entire day before to have enough energy for the trip. The day after was spent recovering from the trip. In addition, during the trip I got confused finding the parking lot, found a spot at the event to sit and rest (often napping) while my son participated in the event, and upon returning that afternoon, went straight to bed (see attached email exchange with my sister). This behavior is *entirely* consistent with the nature of my symptoms in context with my illness.

[CLAIMANT]'s son discusses this in his statement (Exhibit 27):

My dad has been taking me to Orioles games since I was five years old, 1995. Although he has taken me up there very often, he got confused and missed the turn in for the parking lot. We ended up going into the city and

⁵ [CLAIMANT] did not attend a Baltimore Orioles baseball game as [EMPLOYER] contends in its May 11, 2007 letter. The event was the annual Orioles FanFest, which had been rescheduled from an earlier date. This is an important distinction given the nature of the two types of events, at the Fanfest, [CLAIMANT] was able to find an isolated place to sit, often napping, while his son attended to the activities at the event. The Orioles did not play their first game of the 2007 Major League Baseball season until April 2, 2007. (Exhibit 12A). This is just one simple example of the numerous factual inaccuracies relied upon by the case manager to attain her pre-determined objective of terminating [CLAIMANT]'s long term disability benefits.

finding our way back to the parking lot. He then turned into the wrong parking lot and finally realized how to get to the right one.

When we arrived, we parked close to the stadium, and walked around for a while. Whenever he had the opportunity, he found a seat and rested while I looked around the various events. We ate at one of the restaurants in the stadium and while I stood on line for player autographs, he sat where there were various speaker presentations. It was clear when I returned that he had been napping.

When we returned, my father went straight to bed and I don't recall seeing him again until the next day. (Exhibit 27).

The following email exchange took place that afternoon between [CLAIMANT] and his sister upon returning from the event:

Dot – Thanks so much for the stuff you have sent.... I just got in from being out with Robert all day and am exhausted... I'll have to look at it once I wake up from the nap that I'm about to collapse into....(Exhibit 15A)

The 'header' information from this email is attached to prove the authenticity of the date and time sent. (*Id.*).

The above evidence confirms the severity of [CLAIMANT]'s symptoms and that despite having to deal with the responsibilities of being a father from time to time, he has to deal with the need for significant rest prior to and post-exertional malaise after something as simple as being out of the house for several hours doing a sedentary activity with his son. This demonstrates quite clearly the severity of [CLAIMANT]'s symptoms from Chronic Fatigue Syndrome.

[NATIONALLY RECOGNIZED CFS EXPERT] also weighed in on the surveillance video and its lack of relevance. He stated in his report:

Surveillance of [CLAIMANT] was obtained April 30-May 2, 2007⁶, and is purported to show 'normal work ability.' In fact, this surveillance only showed that [CLAIMANT] had one exceptional day during which he drove to Baltimore and sat to watch an Oriole's fanfest, which did not require concentration, exertion, or participation. The same surveillance confirmed that he was inactive the day before (pre-emptive rest) and inactive the day after (post-exertional malaise). (Exhibit 3).

6



[CLAIMANT] has never claimed that he is an invalid or that he can do nothing at all. In fact, he tries to do everything he possibly can, sometimes to his detriment. He openly disclosed these activities on his initial LTD application and discussed them with the [EMPLOYER] IME medical experts. However, due to the complications of his symptoms from Chronic Fatigue Syndrome, Dysautonomia, and Hypersomnia, he is no longer physically capable of performing sustained physical activity over numerous hours, days, weeks and months. In fact, there is nothing in the video or the [TPA] claim file that would demonstrate [CLAIMANT] could carry out sustained physical activity over these periods of time.

The courts have addressed this issue in cases such as *Irwin v. Shalala*, 840 F. Supp. 751 (D. Or. 1993), where the Federal Court stated:

a disability claimant need not vegetate in a dark room in order to be deemed eligible for benefits nor should an otherwise eligible claimant be penalized for attempting to maintain some sort of normalcy in her life and a modicum of independence ..**The critical issue in a disability case is the claimant's capacity for work activity on a regular and continuous, ongoing basis.** (emphasis added).

The *Irwin* Court went on to note:

One of the more perplexing aspects of CFS is that sufferers often report that their condition varies considerably from day to day. One day they can function reasonably well while on another day they may be unable to get out of bed.

Likewise, in *Cohen v. Secretary of H.H.S.*, 964 F.2d 524 (6th Cir. 1992), a case in which the plaintiff was a CFS patient who finished one year of Law School in three years, the court saw her activity as a tribute to her courage and determination in refusing to surrender to the debilitating affects of her illness. The court went on to acknowledge that

“CFS is characterized by exacerbations and remissions which are unpredictable in nature and which make sustained work activity virtually impossible”

The lack of compelling evidence in the video is clear on its face and has been commented upon by [CLAIMANT]'s physicians. For example, in his affidavit, [PCP-CFS EXPERT] states

I have had the opportunity to review two CD ROMs containing surveillance videos taken of [CLAIMANT] and corresponding reports by a private investigators apparently hired by the disability insurer. The most recent video was taken on March 31, April 1 and April 2, 2007. The March 31 surveillance is mainly of someone other than [CLAIMANT]. [CLAIMANT] shows up

briefly in his robe, picking up what I understand to be his cat. Likewise, there is nothing extraordinary in the April 2 surveillance. On April 1, [CLAIMANT] is shown getting into a car with a young man who I understand is his son. [CLAIMANT]'s son gets gas for his car, [CLAIMANT] presumably pays for it and then drives to Camden Yards in Baltimore to attend some event. I do not see anything extraordinary in this surveillance either. [CLAIMANT] appears to have driven his car some 50 to 60 miles. Occasional trips by persons suffering from Chronic Fatigue Syndrome are not contraindicated for medical reasons and taken in context with his pre and post driving activities (extensive resting) are in no way 'inconsistent' with his symptoms. (Likewise, [CLAIMANT]'s trips to New York and North Carolina to visit family are not prohibited by his CFS or the severity of his symptoms, so long as his travel is planned to accommodate his symptoms, as necessary. Further, [CLAIMANT] reported that he only engaged in limited activities during these visits and had to rest in bed for substantial periods of time while away.). Rather, I encourage patients to get out of their house and to travel occasionally but remind them not to overdue it because that could exacerbate their symptoms and could cause their medical condition to deteriorate further. Although it is not shown on the video, I am advised that he became somewhat disoriented upon arriving in Baltimore, drove past the ballpark, became confused and somewhat lost, but ultimately found the ballpark again. In light of the fact that [CLAIMANT] has driven to this ballpark a number of times over the years, his actions are entirely consistent with someone suffering from the characteristic symptoms of Chronic Fatigue Syndrome. He apparently rested the day before and the day after his trip to Baltimore, based upon the lack of any substantial videotaped activity on either of those days, and attended a sedentary event that expended his energy reserves. I saw nothing on the surveillance video that is inconsistent with either his symptoms or the nature of the diagnoses he has received and they in no way alter my opinions regarding [CLAIMANT]'s disabled status or his inability to work on either a part-time or full-time, regular and ongoing basis. The surveillance video demonstrates nothing of substance to show [CLAIMANT] was at that time or any other time since 2003 capable of working a regularly scheduled, ongoing job on either a part-time or full-time basis. I have also reviewed a second CD ROM containing surveillance of [CLAIMANT] in May and June 2005. Since [CLAIMANT] received disability benefits during this period of time and the disability insurer apparently saw no reason based upon the contents of this video to terminate his benefits, it appears to me that it is irrelevant and I will not address the specifics contained in it. I do note that I saw nothing extraordinary in that surveillance that would be either inconsistent with his diagnosed condition of Chronic Fatigue Syndrome or his inability to work on either a part-time or full-time, regular and ongoing basis. There is nothing contained in either of these two surveillance videos that would alter my opinion that [CLAIMANT] is and has been since 2003 disabled from performing the requirements of any job on either a part-time or full-time, regular and ongoing basis. (Exhibit 1).

[NATIONALLY RECOGNIZED CFS EXPERT] also commented on the earlier surveillance [INITIAL TPA] had placed [CLAIMANT] on in 2005

Similarly, surveillance on May 9-15 and May 31-June 2, 2005 did not demonstrate any activities beyond the ability of a person disabled by CFS/ME, and it is absurd of [INTERNAL PHYSICIAN] to conclude that it would require a 'higher level' of cognitive functioning to drive in familiar areas, make a couple of routine purchases, pump gas, and wash a windshield. (Exhibit 3).

[CLAIMANT] remarked upon the video surveillance as well and limitations he faced due to his illness, indicating

Regarding the surveillance [TPA] had me under for three days, two of the days I was observed leaving the house once each day for very brief periods (the first in my bathrobe retrieving my cat from a neighbor's yard, the second driving my daughter one mile to school). On the middle day, I was observed driving my son 57 miles to a baseball event. [TPA] has turned this into my ability to 'drive extensive distances' and stating that it is "inconsistent" with my "alleged" complaints. They also stated that I showed no limitations. This is in fact not inconsistent with my complaints, especially in context of the diagnosis I have received, and there were in fact several limitations during this drive. This will be fully explained later in this statement. These were limitations that an investigator is in no way capable of recognizing, nor did he attempt to. Furthermore, per the claim file, the case manager did not even review the video of me when translating the investigator's notes of my activities into her subjective and invalid conclusions. We know this because when my attorney requested the video, the claim file shows that the case manager at that point had to request it from the Investigative firm as it had not been previously sent to her. When we did receive the video, it was of such poor quality it was hard to make out much detail at all. (Exhibit 12).

The surveillance videotape is episodic in nature, totaling less than 68 minutes over the total of twelve days [CLAIMANT] was under surveillance. In fact, nine of the total twelve days [CLAIMANT] was under surveillance, he did little more than conduct routine activities such as drive his daughter to her nearby school, walk the dog a couple of times, and was rarely seen to leave his residence otherwise. The other three days he ventured out for family commitments and the evidence shows that upon returning home was not seen again. This is evidence of 'post-exertional malaise' and is one of the defining symptomatic criteria of Chronic Fatigue Syndrome.

The surveillance not only does nothing to demonstrate [CLAIMANT]'s ability to carry out sustained employment over a period of days, weeks, months or years but with responsible reasoning, it actually confirms his complaints. It is irresponsible and unprofessional to attempt to portray [CLAIMANT] as malingering and exaggerating his symptoms by not assessing the

surveillance in it's totality and choosing only to 'cherry pick' one event, not understanding it in context and ignoring it's impact on him.⁷

There is absolutely nothing in the twelve days of surveillance to contradict [CLAIMANT]'s 'alleged' medical condition or prove he possesses the ability to perform sustained, full-time employment, especially in light of the substantial medical documentation evidencing the chronic, disabling condition of [CLAIMANT] by physicians who have treated him over the course of years and see [CLAIMANT]'s good and bad days. As a result, the videotape is not persuasive evidence of [CLAIMANT]'s true capability to work on a full-time basis and, properly analyzed in context of the diagnoses he has received, it clearly supports his 'alleged symptoms'.

MEDICAL PUBLICATIONS ADDRESSING ACTIVITY AND CHRONIC FATIGUE SYNDROME

Despite [TPA]'s claims that [CLAIMANT]'s volunteer and other activities are inconsistent with his medical condition, medical literature suggests just the opposite. Attached as Exhibit 22 to this appeal are several medical articles providing information regarding the beneficial nature although not curative, of regular exercise and other activities for persons suffering from Chronic Fatigue Syndrome.

Activity should include both physical and mental exercise and lack thereof is detrimental both physically and psychologically. Sachi Thanawala and Dr. Renee R. Taylor state in their research published in the May, 2007 Journal of Chronic Fatigue Syndrome:

“Research has been conducted to study the influence of coping on the physical, social, and psychological well being of people with CFS. Strategies such as avoidance/escape, denial, mental and behavioral disengagement, information seeking, and accommodating to illness have been reported to be associated either with greater levels of fatigue, impairment, or other psychosocial issues in CFS. In contrast, maintaining activity, positive reappraisal, and seeking social support were associated with lower levels of impairment and greater psychological well being.”(Exhibit 22) (References omitted)

In their article “Pain and Fatigue” in the Handbook of Chronic Fatigue Syndrome (Jason, Fennell, Taylor), Drs. Dennis Turk and Beatrice Ellis note:

A common feature of both CFS and FMS is physical deconditioning. Thus, exercise to improve endurance and flexibility is appropriate for both

⁷ Each of the 4 Neuropsychologists who have comprehensively evaluated [CLAIMANT], including the 2 hired by [EMPLOYER] to conduct Independent Medical Examinations, have specifically found that he is **not** malingering, has substantial cognitive problems, and is unable to work. (Exhibits 5, 8, 9, 10 and 11). Likewise, the expert who reviewed all of these reports and test results agreed with these unbiased assessments. (Exhibit 6). Thus, there exists only unanimous evidence that [CLAIMANT]'s substantial cognitive impairments prevent him from engaging in full time, gainful employment.

pain and fatigue. There may be both direct and indirect benefits of exercise. Direct benefits might include increased production of endorphins with a concomitant reduction in pain. There may also be indirect benefits from an increased perception of control that counteracts the sense of helplessness commonly observed in patients and thereby restores their morale. (Exhibit 22)

Also in this definitive book on Chronic Fatigue Syndrome, Dittner and Chandler note in their article "Measuring Symptoms and Fatigue Severity":

Physiological, immunological, neuroendocrine, and sleep and mood changes can all result from inactivity. In fact, physical changes can be seen in normal volunteers after only a week of inactivity. There is also evidence that mental inactivity can lead to symptoms such as the mental deficits seen in CFS. Other consequences of inactivity include reduced visual acuity and heat and cold intolerance. Again, inactivity is itself a consequence of many illnesses, but its role in perpetuating the condition should also be considered. (*Id.*) (References omitted).

While addressing inactivity as a potential cause for some CFS symptoms, this statement primarily points out that inactivity, both physical and mental, can make CFS symptoms worse. [CLAIMANT], like all CFS patients must be diligent in performing enough physical and mental activity as their individual condition allows in order to avoid a downward spiral of mental and physical deconditioning.

Other articles attached in Exhibit 22 also demonstrate the benefit that Chronic Fatigue sufferers obtain from regular exercise. This is exactly what [CLAIMANT] was doing when [EMPLOYER] hired a private investigator to conduct surveillance of [CLAIMANT]. He was not doing anything out of the norm for Chronic Fatigue patients, including driving. Rather, [CLAIMANT] was following the recommendations of his treating physician and acting in accordance with the findings of accepted practice as demonstrated by the medical literature. The inference arrived that by [EMPLOYER] in its termination notice is irrational and not supported by current medical practice and literature.

Each of the physicians who have commented on this issue have indicated that [CLAIMANT]'s actions are not inconsistent with his CFS and in fact either were recommended to him to perform or are activities that he should be performing. For instance, [PCP-CFS EXPERT] states

Initially, at the onset of his illness, [CLAIMANT] was incapable of performing any physical activity for more than minimal periods of time and then would be required to have periods of bed rest, often prolonged. The length of this bed rest depended upon the amount of activity [CLAIMANT] performed. Over time, [CLAIMANT] has lost weight, approximately 40 pounds, and has sought to inject forms of light physical activity within his capabilities into his daily routine. He began walking

and performing light refereeing duties at a local youth basketball league. He informed me of his activities and I encouraged him to exercise as regularly as his condition allowed but cautioned him not to overdue it because that could exacerbate his symptoms and could cause his medical condition to deteriorate further. He has kept me informed of both his progress and his setbacks in this area. In fact, published medical literature on the effect of regular exercise for patients suffering from Chronic Fatigue Syndrome indicates that it can be beneficial for patients although it is not a cure for their medical condition. Vol. 102, The American Journal of Medicine, p. 357, Freeman, R. and Komaroff, A. (April 1997). (Exhibit 1).

[PCP-CFS EXPERT] went on to address [CLAIMANT]'s volunteering as a referee in a local youth basketball league, stating

He has also volunteered, on a limited basis, as a director of referees for the youth basketball league. These volunteer activities average approximately 5 – 7 hours per week. While these volunteer activities are helpful for his overall medical condition, they are substantially less demanding than his management position at [EMPLOYER] or the other employment positions identified by [EMPLOYER], but are not an indication of a current ability to work on either a part-time or full-time, regular and ongoing basis. Rather, his volunteerism is indicative of the type of person [CLAIMANT] is. He has demonstrated a clear desire to improve his medical condition throughout his course of treatment with me. He has been willing to participate in all suggested modes of treatment, including extensive and difficult treatment for Lyme's disease. He has been diligent in complying with medical advice in his attempts to regain his health. (Exhibit 1)

Likewise, [NATIONALLY RECOGNIZED CFS EXPERT] expressed his opinion regarding [CLAIMANT] volunteering as a basketball referee and as a "director of referees." [NATIONALLY RECOGNIZED CFS EXPERT] stated

He has been able to referee some basketball games, which requires a fairly limited output of energy. This is not inconsistent with his illness, may require "payback" in terms of a flare, and some physical activity is encouraged by physicians and the medical literature as beneficial in CFS. (Exhibit 3).

[NATIONALLY RECOGNIZED CFS EXPERT] went on

He has volunteered as the "director of referees" for his son's basketball league in Virginia, which required about 5 to 7 hours of sedentary work per week. This was divided up in small amounts of work each day. Even then he would make significant errors like sending three referees to the same

game. He primarily developed and promulgated work schedules, which work was done from home, at his leisure, over short periods of time daily.

Persons with CFS/ME can typically exert for short periods as long as they balance such activity with rest. They can also pre-emptively rest in order to “store up energy” for exceptionally difficult or prolonged activity. Over-exertion will predictably trigger post-exertional malaise, which is an exacerbation of symptoms and debilitating fatigue that can last for hours to weeks. (Id.).

Nothing in [NATIONALLY RECOGNIZED CFS EXPERT]’s report indicates that this is inconsistent with [CLAIMANT]’s CFS. In fact, [NATIONALLY RECOGNIZED CFS EXPERT] is fully supportive of [CLAIMANT]’s efforts, so long as he does not over exert himself. Similarly, [2007 NEUROPSYCHOLOGIST] concurred with this assessment, advising that [CLAIMANT] can successfully engage in his volunteer work for the [YOUTH CLUB] so long as he is allowed to pace himself appropriately. (Exhibit 5).

Clearly, based upon both the medical literature and the recommendations of his physicians, [CLAIMANT]’s volunteer activities as a referee and “director of referees” and other activities of daily living such as driving, going to the store, and even attending a sedentary baseball event are clearly within the limitations imposed by his various diagnosed conditions. These activities cannot be rationally construed as rising to the level of ability of being able to sustain a full time employment circumstance, especially in a cognitively challenging environment. The cognitive level required to drive, even in the strictest states, is far below the cognitive level of functionality required to work at the level the LTD plan calls for.

This is also true for all the other activities [CLAIMANT] is engaged in, which are essentially basic living activities. These include cooking, helping his children, minor chores around the farm such as feeding the horses, and even travel. In the claim file the case manager specifically mentions this as a contradiction to his symptoms. In fact, disabled and handicapped people are able to travel with appropriate planning and accommodation. Exhibit 22 includes a document from the website www.cfidselfhelp.org outlining steps persons with CFS should take in order to travel. As [CLAIMANT] points out:

Travel is ***not*** inconsistent with my symptoms or illness. It ***is*** ‘difficult’, but ***not*** impossible or even ‘inconsistent’. I rest prior to and after a travel day and I give myself plenty of time in case I have cognitive boo-boos or need to stop to rest. I travel only occasionally, and often see handicapped or otherwise disabled people doing the same. (Exhibit 12).

The Medical and Claims Review Conducted by [TPA] Was Cursory and Incomplete In Violation of Its Fiduciary Duties Imposed by ERISA .

[TPA] has breached its fiduciary duties under ERISA, and most likely, its internal rules guidelines, protocol or other similar criterion in its administration of [CLAIMANT]'s claim.⁸ This began with its inappropriate contact of a claimant with legal representation and continues to the time of this appeal in their refusal to turn over key documents that are relevant to the claim.⁹

[CLAIMANT] has been represented by this law firm since he first applied for Long Term Disability in 2004. [INITIAL TPA] was careful not to communicate directly with [CLAIMANT] and even had a page in the claim file with very large font indicating that there was to be "NO DIRECT EMPLOYEE CONTACT; CONTACT ATTY" followed by my complete contact information. (Exhibit 29). The necessary authorization was in the file and available to the case manager, unless the case manager either did not have it or ignored it. The former is further indication that the claim file was not properly or fully transferred to [TPA] during the administrative switch from [INITIAL TPA]. The latter of course would simply be unethical.

⁸ A request to [TPA] for "copies of . . . [all] internal rules, guidelines, protocol or other similar criterion relied on in denying [[CLAIMANT]'s disability] claim" was made by counsel on or about July 31, 2007 and renewed on September 24, 2007. Counsel is still awaiting receipt of these documents. However, it is inconceivable that such policies would allow [TPA] to engage in the review of partial medical documentation and ignore substantial evidence in reviewing a claim for ongoing disability benefits.

⁹ [TPA] has continually been remiss in providing the documentation requested by counsel in a timely fashion and as required to be produced by ERISA and its implementing regulations. Multiple requests for the **complete and correct claim file** have been made and it appears documentation from the MetLife claim file has not yet been produced. Also, despite the clear direction from U.S. Department of Labor regulations requiring [TPA], as Claims Administrator, to provide the plan documents since it relied upon those documents in reaching its decision to terminate [CLAIMANT]'s benefits, 29 C.F.R. § 2560.503-1, [TPA] ignored counsel's requests and refused to provide such documents. Rather, [TPA] would only refer counsel elsewhere for copies of the plan documents and persisted in its wrongful conduct after counsel advised [TPA] that the **wrong plan documents** had been produced. Currently, [TPA] has failed to provide the internal rules, etc. requested by counsel. [TPA]'s complete disregard of its obligations to produce such documents under ERISA continues its pattern and practice of breaching its fiduciary duties throughout the administration of [CLAIMANT]'s claim.

CASE MANAGER'S INAPPROPRIATE HANDLING OF THE CLAIM

In addition to her inappropriate contact with [CLAIMANT] and other details of which will be discussed further, the case manager mishandled this case from the very beginning. To begin with, it is obvious by simple review that the claim file she was dealing with was not in an appropriate condition to be performing a responsible analysis on. The file was apparently scanned in and put through an Optical Character Recognition (OCR) process. OCR software processes the scanned image, which is essentially a series of pixels, and translates that into a recognized character. This process has many inherent limitations, especially with documents that have been copied or faxed, not fed cleanly through the machine, or handwritten. In this case, the resulting file the case manager was working from was often full of mere snippets of sentences, and replete with entries of 'TO CONVERT'. In whole, it is almost impossible to follow many the documents which make up the file, even if there is a relatively high conversion rate on an individual document. No original documents were included. We know this as fact as when we objected and requested the original documents, the claim file indicates that [TPA] had to request them from [INITIAL TPA] (Exhibit 31) and a substantially larger claim file was produced.

[CLAIMANT]'s complete claim file goes back to 2004 and includes a tremendous amount of material, including almost all his primary physician's records, numerous testing results supporting the validity of his 'alleged symptoms', his initial application, internal [INITIAL TPA] notes of previous reviews and surveillance reports, and internal [INITIAL TPA] physician reports. This information should have been carefully evaluated when making a reasoned assessment of [CLAIMANT]'s disability status.

There are only two possibilities; either [TPA] did not possess this information or [TPA] did not consider it in their determination. Either case is inappropriate and establishes a clear and incontrovertible breach of [TPA]'s fiduciary duties imposed by ERISA. Further, [TPA]'s actions under either possibility is a cause of great concern regarding [TPA]'s intent concerning [CLAIMANT]'s claim for ongoing disability benefits.

Lacking legible documentation of [CLAIMANT]'s case, the case manager relied solely on information she gathered through internet searches, limited surveillance activity, and ten months of notes from [PCP-CFS EXPERT], [CLAIMANT]'s primary care physician. Both the acquisition and analysis of each of these was seriously flawed.

Although I have already discussed in detail the volunteer information gathered via the internet and the surveillance activity from the perspective of [CLAIMANT]'s illness, they also need to be examined from the perspective of how the claim was handled by [TPA].

The volunteer activity, which had been clearly noted a) on [CLAIMANT]'s initial application for LTD, b) [PCP-CFS EXPERT]'s medical records, and c) [2004 IME]'s IME Neuropsychological Evaluation report, was discovered by the case manager via an internet search using [CLAIMANT]'s cell phone number. This information was quickly supported by the discovery of a list of responsibilities for the position that was posted online by another youth recreation league. While it is totally appropriate for the case manager to 'discover' and evaluate activities such as this, she clearly displayed her intent in quickly terminating this claim by her lack

of interest in obtaining a full understanding of the level of effort and types of skills required in [CLAIMANT]'s performance of these activities. At no time did the case manager contact [CLAIMANT], his counsel, or anyone from [YOUTH CLUB] to discuss these issues. It was inexcusable to make such a serious determination without a full and reasoned evaluation of **all** the facts, not just the ones that are convenient to a desired outcome. The reality of [CLAIMANT]'s participation, regardless of the praise an appreciative benefactor of that activity has levied upon him, are well documented to be a) inconsequential in terms of relative time and skill levels, b) therapeutic for his condition, and c) recommended by both his and [EMPLOYER]'s medical professionals due to the potentially worsening of his condition by not engaging in such activities. The case manager made no effort whatsoever to obtain information such as this which is necessary for a thorough and reasoned analysis of [CLAIMANT]'s volunteer activity as it relates to his disabling condition. She simply made invalid conclusions based on incomplete and misleading information. She then provided this biased presentation to the "Physician Advisor", her manager, and others involved in the claim. For her to state "(t)his information additionally rendered the degree of physical and mental impairment that you report as not fully credible, and it represents further support of your demonstrated ability to sustain work-like capacity both physically and cognitively" is incredulous given the shoddy investigation into this claim before terminating [CLAIMANT]'s benefits.¹⁰

The surveillance was equally mishandled. The claim file clearly shows that the case manager not only did not even fully evaluate the surveillance activities, but she failed miserably in assessing them in context of [CLAIMANT]'s diagnosed medical conditions.. The claim file shows that the case manager received a surveillance report of [CLAIMANT]'s activities, but did not receive the videos. In addition to not reviewing [CLAIMANT]'s activities herself, she relied solely on the investigative notes. These notes were simple statement of facts, there were no representations regarding [CLAIMANT]'s apparent health, his behavior, or anything else related to his disability. Presumably this is because as a private investigator he has no medical or psychological qualifications to allow him to so. Nonetheless, without viewing the video and armed only with notes of minimal activity, the case manager confidently stated that [CLAIMANT] showed "no apparent limitation due to these severe alleged symptoms, however, when you were observed on April 1, 2007, leaving your house midmorning and driving from Fairfax, VA 55 miles to Camden Yards stadium in Baltimore, MD, parking your vehicle and attending a Baltimore Orioles game." It was simply impossible for her to judge if there were any 'apparent limitations' or not from the evidence the claim file proves she was limited to. Furthermore, as [CLAIMANT] points out, he faced substantial limitations from his day:

To begin with, I rested the entire day before to have enough energy for the trip. The day after was spent recovering from the trip. In addition, during

¹⁰ Counsel for [CLAIMANT] has been handling ERISA disability matters for more than 15 years and has **never** encountered a benefit termination that has been administered in such an arbitrary and capricious manner. Not only did the case manager, "Physician Advisor" and "Job Accommodation Specialist" fail to review **most** of [CLAIMANT]'s medical records that had already been provided to [EMPLOYER], but then to question [CLAIMANT]'s credibility based upon such an incomplete review is absolutely intolerable. Had there not been the requirement to exhaust administrative remedies under ERISA, counsel would have filed suit in the United States District Court shortly after receiving the claim file and learning of [TPA]'s transgressions. Further, but for the good nature of [CLAIMANT], counsel would have immediately filed complaints with the United States Department of Labor and Virginia Insurance Commission concerning [EMPLOYER]'s specious conduct in this matter.

the trip I got confused finding the parking lot, found a spot at the event to sit and rest (often napping) while my son participated in the event, and upon returning that afternoon, went straight to bed (see attached email exchange with my sister). (Exhibit 12).

[CLAIMANT]'s limitations are real and verifiable, and just a small sampling of the issues he faces on a daily basis. For the case manager to have drawn her insupportable conclusions based on such limited information is further evidence of her rush to a preconceived conclusion.

Furthermore, as a nurse, the case manager should have evaluated these activities in the context of the diagnoses given to [CLAIMANT]. Theoretically her background includes an understanding of this process as well as the ability to research issues such as those presented by [CLAIMANT]'s claim. Extensive discussion concerning the medical implications of [CLAIMANT]'s activities during this surveillance as well as true experts' opinions on these matters have been provided earlier in this letter. All current medical knowledge and literature is at odds with the case manager's evaluation of [CLAIMANT]'s activities with regards to Chronic Fatigue Syndrome. Once again, as [NATIONALLY RECOGNIZED CFS EXPERT] described it "surveillance confirmed that he was inactive the day before (pre-emptive rest) and inactive the day after (post-exertional malaise)."

The claim file shows that the case manager at [INITIAL TPA], when confronted in 2006 with activities which appeared in 'inconsistent' with [CLAIMANT]'s condition took the appropriate step of forwarding their concerns to [PCP-CFS EXPERT] for his commentary and opinion given that he is both a recognized expert in Chronic Fatigue Syndrome and had been [CLAIMANT]'s treating physician for over three years at that point. Although [PCP-CFS EXPERT] did not have the opportunity to respond, for whatever reason, this nonetheless demonstrated good faith and appropriate handling of the claim. The [TPA] case manager, however, took no such similar and responsible action. This is further evidence that she was not interested in gathering all relevant opinion on the matter, just those which supported her interests.

The level of information the case manager provided both the "Physician Advisor" and the "Job Accommodation Specialist" is astonishingly inadequate. According to the claim file, the "Physician Advisor" was limited to the following information:

- o Statement and medical file provided by [PCP-CFS EXPERT]. Medical file requested by [EMPLOYER], and provided by [PCP-CFS EXPERT], was for the 'review period' of June 2006-April 2007. These were primarily routine office visits as he evaluated antibiotic therapy on potential Lyme disease.
- o Request to Dr. [TPA PHYSICIAN ADVISOR] referred to a 2005 IME report, however this was not in the file provided by [EMPLOYER] to undersigned counsel when the record was requested.
- o Information and subjective conclusions on [CLAIMANT]'s volunteer activities.

- o Surveillance report and subjective conclusions on [CLAIMANT]'s surveillance.

Substantial information was *not* provided to the "Physician Advisor" for his review and opinion regarding [CLAIMANT]'s medical and cognitive conditions and his ability to return to work. Among the highly relevant evidence already in the claim file but not given to [TPA PHYSICIAN ADVISOR] include:

- o At least three Neurocognitive Evaluations, including 2 IMEs, all of which were very detailed in their evaluations of [CLAIMANT]'s cognitive functioning and clearly stating his inability to perform in a work environment.
- o 2003 MSLT ruling out narcolepsy but diagnosing 'Excessive Daytime Sleepiness'.
- o 2004 Functional Capacity Evaluation stating "Unpredictability of the patient's heart rate and blood pressure response to activity, whether sedentary or active affects his endurance, his ability to complete tasks, and his ability to perform consistently to a significant extent. This will undoubtedly have serious impact on his ability to return to competitive employment."
- o Positive 2003 Tilt-Table test in which [CLAIMANT] fainted between 4-5 minutes.
- o Notes of extensive testing from 2002-2006 from a variety of specialists.

This is an enormous amount of information and its omission cannot be justified in any reasoned analysis of the case. It is not possible that the "Physician Advisor" saw any of these necessary medical and vocational records in any legible format as they were not in the file I initially requested after [CLAIMANT]'s termination and only in the claims administrator's possession after we requested full file, which was then requested from by the case manager from [INITIAL TPA] (Exhibit 31).

Information provided to the "Job Accommodation Specialist" was even more anemic:

- o Summary of Physician Advisor's deficient review that "evidence in the file is consistent with EE's ability to perform sedentary work activity; cognitive impairments are not objectively supported."
- o "General job description for Director of Referees at the youth club level" and information on award received for volunteer activity. We have shown this 'job description' to be completely unrelated to [CLAIMANT]'s actual volunteer activities.
- o "Gainful wage as \$nn.nn per hour in a 40-hour workweek."

Once again, and unlike the responsible manner [INITIAL TPA] handled the Transferable Skills Assessment, the case manager failed to provide any information regarding [CLAIMANT]'s documented cognitive difficulties. This "oversight" is inexcusable and amounts to a clear breach of [TPA]'s fiduciary duty under ERISA.

Other issues which raise significant concern with the case manager's handling of [CLAIMANT]'s claim include her handling of his request for plan guidelines regarding travel, her intentional misdirection of the request for his completion of an Activities of Daily Living request, her deception regarding the surveillance, and her continued insistence to discuss the claim decision with him even after [CLAIMANT] made it clear to her that he was represented by counsel and that counsel's release was in the claim file.

In early February, 2007, [CLAIMANT] received a newsletter reminding anyone on LTD of the need to notify their case manager of any planned travel and that such travel required approval by [EMPLOYER] IDSC in advance. This was totally contrary to [CLAIMANT]'s understanding of the Plan so on February 13, 2007 he inquired about this requirement. According to the claim file entries, three days later, the case manager called and informed [CLAIMANT] that "I reviewed his LTD plan document and SPD and could not find anything indicating that he could not travel." Approximately a week later, on February 22, case manager did a review of the plans and noted "as it pertains to this EE – EE is TCVTDIPLD50 – he would be covered under the DIP Plan." She then called [CLAIMANT] to inform him "when we last spoke I gave him incorrect information – after addtl investigation, it has been confirmed that he falls under the DIP plan (NIN 78-7281)" and yes, this Plan does have a provision indication that he cannot travel without the permission of CM. According to the claim file, on March 8, the case manager entered "***** Reviewed plan with Team Lead *****" and the "*** EE IS NOT COVERED UNDER DIP, BUT UNDER LTD PLAN FOR MANAGEMENT EMPLOYEES". That same day, [CLAIMANT] called to inform case manager that he reviewed his LTD plan and confirmed that there was no mention of travel notification. Case manager confirmed that she had given him incorrect information in the February 22nd call and that he is not on the DIP plan. She noted "I told EE I'd send him written confirmation of the plan under which he is covered – not a problem". Despite her promise to send a [CLAIMANT] a letter confirming the status of his plan, one did not materialize and [CLAIMANT] called back on both March 20 and March 22. The case manager returned his call on March 22 and left him a voice mail informing him that that they had been discussing the situation with her manager and "was told that addtl checking will be needed". An entry in the file later that day stated "FU on travel ltr from EE next week". It was not for another week and a half, on April 7, 2007 that case manager finally "Reviewed EE's ltr with LTD Mgr, EE's request for written confirmation of the Plan under which he is covered. Per Mgr, ok to provide confirmation in writing to EE that he is covered under the T-Mgmt Plan." On April 9 she received final approval from the "BUM", presumably the Business Unit Manager, to inform [CLAIMANT] in writing of the travel notification requirements.

This is an incredible amount of time simply to verify which plan [CLAIMANT] is covered under. [INITIAL TPA] was aware of it continuously during their management of his claim, and presumably it is one of the first things, along with validation of attorney representation, that a case manager should familiarize herself with. That it took almost two months, from February 13 to April 9, to confirm and communicate with [CLAIMANT] exactly which plan they believed he was covered under is inexcusable.

Perhaps the most obvious example of the case manager's disinterest in giving [CLAIMANT] a full and fair evaluation is her handling of the request for his completion of the "Activities of Daily Living" (ADL) questionnaire required by [TPA] in their review of the case. As

he had not received confirmation of travel notice requirements, [CLAIMANT] had sent [TPA] a letter notifying them of travel to see his family in North Carolina for two weeks beginning April 16. In a phone call with the case manager on April 4, as documented in the claim file, [CLAIMANT] informed her that the trip would be extended an additional week in order to see a physician in the area. This would put his trip out until at least May 7. On April 18, two days after she knew [CLAIMANT]'s trip commenced, the case manager sent the ADL to his home address, knowing he would not be there for almost three weeks. Her claim file entry noted "1st req to EE for completion of ADL/Voc Qx, reply req'd by 5/8/07" That date she also sent a request via fax to [PCP-CFS EXPERT] for his records. Despite the fact that she was able to contact [PCP-CFS EXPERT]'s office twice (April 19 and April 25), not once did she follow up with [CLAIMANT] or myself to confirm that he had received it and remind him of its due date of May 8.¹¹ [CLAIMANT] had provided her with his contact information in North Carolina. On May 9, absent any input from [CLAIMANT], the case manager called him to inform him that his benefits were terminated. [CLAIMANT] protested that she not discuss this with him but with me, his attorney. She insisted that in order to do that there would need to be a release in the file, further indication that she did not have the necessary claim file to perform her role as case manager in a responsible manner.

The case manager was even incapable of correctly documenting facts, for example, she notes that [CLAIMANT] was taking Lunesta for insomnia. The fact is, [CLAIMANT] does not have insomnia, has never complained of it, and it is not mentioned anywhere in the medical records or any other document provided to [EMPLOYER]. Insomnia was not the medical reason for his Lunesta prescription. While irrelevant to any of the medical or legal issues relating to his claim, this does however illustrate the case manager's propensity to make statements which have no basis in fact and can thus only be the product of confusion, her imagination, or poor analysis; none of which are acceptable under any circumstances. This is just one of many such examples. The claim file is replete with errors and omissions, misrepresentations and mischaracterizations, and inflammatory comments clearly indicating the case manager's intent relative to this claim and the ultimate outcome of [CLAIMANT]'s disability benefits. It is not a surprise to find in it's advertising for this position of case manager, [TPA] states the position requires "**Excellent** oral and written communication skills", "**Excellent** interpersonal skills", "**Excellent** negotiation skills", "**Strong** organizational skills", yet [TPA] requires merely "**Good** analytical and interpretive skills". These are the posted requirements for the Case Manager, Case Manager II, and Case Manager III positions specifically for [EMPLOYER] as the client (Exhibit 30) While we are not sure that even this lowered standard was met by this case manager, it is interesting where [TPA] has placed it's priorities in case manager hiring.

In the case manager's defense, we note with interest the unusual timestamps and activity in the claim file including as late as almost 11PM and weekend meetings. It is entirely possible that [TPA] has overextended and overburdened their case manager's workload and they are unable to perform competent levels of analysis. Combined with [TPA]'s rumored policy of

¹¹ Furthermore, given the controlling direction in the claim file that there should be no contact directly with [CLAIMANT] but only with his counsel, it is inexplicable why the case manager failed to send the ADL to counsel as [INITIAL TPA] had done previously. A more skeptical person may conclude that [TPA] had pre-designed plans to terminate [CLAIMANT]'s LTD benefits as soon as possible and therefore did not bother to waste the time to fully review his claim file. At the present time, counsel will refrain from drawing any conclusions.

giving bonuses for terminating claims, it is easy to see how the case manager might have performed in a manner wholly inconsistent with her ERISA imposed fiduciary obligations.

THE PHYSICIAN ADVISOR'S REVIEW OF [CLAIMANT]'S CLAIM WAS INADEQUATE

The cursory nature of the physician's review for a claim this complex is simply inexcusable, regardless of the fact that the case manager provided such a limited amount of information. The claim file timestamps show the physician, Dr. David L Hinkamp, had the case in his possession for only a matter of hours during which he performed and documented his evaluation.

In his very brief report, Dr. Hinkamp, referring to surveillance of [CLAIMANT] driving and to volunteer activities, definitely stated "These activities are inconsistent with an inability to participate in sedentary activities in the workplace." Additionally he noted that "There are insufficient objective medical findings to support an inability to perform sedentary activities during the review period 5/1/07-ongoing." We have clearly established in this letter that both these assertions are a significant departure from the truth.

There are significant issues with the manner in which Dr. Hinkamp performed his review, these include, but are not limited to:

- o His failure to review the entire medical file and to look beyond basic "routine follow-up" office visit notes.
- o His failure to discuss the 2005 IME Neuropsychological Evaluation indicating significant cognitive issues.
- o His blind acceptance of the case manager's subjective, and incorrect, conclusions of both surveillance and volunteer activities.
- o His lack of reference to the 2004 Functional Capacity Evaluation
- o He missed and misinterpreted information in [PCP-CFS EXPERT]'s records, for example, did not note the variability of [CLAIMANT]'s blood pressure from laying to standing over the course of the 'review period' notes indicating continued ANS dysfunction.
- o He spent only a few hours (at most) on this highly complex case and failed to review years of evidence.
- o The case manager clearly pointed out that during the surveillance "2 out of the 3 days EE did not leave his residence; however, on Sunday 4/1/07, EE was observed to drive approx 57 miles across state lines to Baltimore, MD to attend a baseball game. No other activity of significance was obtained during the other two days of surveillance." Dr. Hinkamp apparently failed to recognize that apparently two out of three days [CLAIMANT] was too ill to leave the house. Possibly he thought that the cognitive and physical skills required to go "across state lines" was somehow indicative of the ability to hold down a full time technical managerial position.

- o His very superficial analysis and commentary with absolutely no reference to [CLAIMANT]'s level of cognitive functioning or his documented fatigue levels.
- o He has no apparent expertise in Chronic Fatigue Syndrome and the nuances of its debilitating conditions. This is evidenced by his commentary and acceptance of minimal information, mostly irrelevant. His published background includes no activities related to CFS in any way.
- o He made no effort to contact [PCP-CFS EXPERT] or other consulting experts for further clarification.

In short, the "Physician Advisor" reviewed a minimal amount of medical records, made no effort to conduct any further inquiry or investigation, and blindly accepted the case manager's unsupported conclusions without question. Certainly this is not the type of "full and fair review" of a claim that Congress envisioned when it drafted ERISA.

It is interesting to note Dr. Hinkamp's substantial expertise in "Health in the Arts" and his active participation in orchestras and other arts related organizations. However, it is also noted that Dr. Hinkamp not only has no published works relating [CLAIMANT]'s debilitating conditions, they are not at all mentioned in any way in any of his website presence (Exhibit 28) or related papers. It will also be interesting to discover his compensation arrangements with [TPA] and what medical expertise he does possess.

Perhaps had Dr. Hinkamp consulted with his colleague at the University of Illinois at Chicago, Dr. Renee Taylor, where they are on faculty together, his feedback to [EMPLOYER] would not only have been more thoughtful and reasoned, it might have actually generated a valid report.

In addition to being on the Advisory Editorial Board of the Journal of Chronic Fatigue Syndrome (CFS), Dr. Hinkamp's colleague, Dr. Taylor, is a member of American Psychological Association, American Association for Chronic Fatigue Syndrome, and the American Occupational Therapy Association. Dr. Taylor has published dozens of highly regarded research papers and published many books on CFS and has been awarded millions of dollars in research grants by National Institutes of Health (NIH) and other organizations specifically to expand the scientific understanding of CFS.

If Dr. Hinkamp truly wanted to understand what he perceived as 'inconsistencies' between [CLAIMANT]'s activities, the severity of his 'alleged symptoms', and the comments and analysis of the treating and evaluating physicians that actually examined [CLAIMANT] and understand this illness, he should have consulted his colleague's vast knowledge base. At the very least, Dr. Hinkamp should have referred to Dr. Taylor's book "*A Clinician's Guide to Controversial Illnesses: Chronic Fatigue Syndrome, Fibromyalgia, Multiple Chemical Sensitivities*".

In particular, Dr. Hinkamp notes that [CLAIMANT]'s driving and volunteer activities are inconsistent with the severity of the symptoms being complained of. Yet, on the very first page

of her book, Dr. Taylor notes that “Professionals working on behalf of individuals with CFS, FMS, and MCS should be aware of a number of shared challenges facing individuals with these conditions...[including] High variability of symptoms and impairments. These illnesses exhibit enormous fluctuations in symptom severity and level of impairment between and within individuals.” (Exhibit 22).

Dr. Taylor goes on to state that “the enormous variation in symptom severity that can allow patients to be relatively functional for brief intervals yet severely impaired is very difficult for others to comprehend. Rather than viewing these fluctuations as a manifestation of a highly unpredictable and poorly understood condition, observers are more likely to believe that disability and functionality are voluntary choices made by the patient.” (*Id.*).

In and of themselves, these understandings by members of the community actually familiar with CFS goes a long way in explaining why observations made by unqualified investigators and grainy video of [CLAIMANT] performing basic functions of life are in fact *not* inconsistent with his severely debilitating fatigue and cognitive problems. A vast majority of the time he was under surveillance, [CLAIMANT] did not leave his house. He attempted to perform the activities he was able to when he was able to. He rested a great deal of the rest of the time. The claim file shows that Dr. Hinkamp did not even review these videos. In fact, he couldn't have viewed them had he wished to do so since [TPA] was not in possession of the videos at the time of his review.

The roads and stores are full of people that are capable of navigating traffic but not capable of performing cognitively in a technical/managerial position. To assume that just because [CLAIMANT] drives as he feels he is able to in no way proves, suggests, or even implies that he is able to perform on a sustainable and reliable basis at the cognitive level his plan calls for.

In addition, in the Spring 2004 issue of the CFIDS Chronicle, Dr. Taylor addresses the very need [CLAIMANT] has in his performing what volunteer work he could as his illness would allow. In that article she states “*Because CFIDS is a chronic condition, it puts stress on everyone involved, not just the patient. The most common form of anger I see is the anger that emerges from disappointment and losses associated with interpersonal relationships.*” She goes on to note “*anger turned inward is one of the most undesirable and dangerous forms of anger because it is so closely tied to self-worth and identity. When I see a patient who is demoralized, anxious, sad, apathetic or hopeless about recovery, I usually find that the patient is experiencing a great deal of internalized anger.*” (Exhibit 22)

It is well established in the medical and psychological communities, and has been already discussed at length, that not keeping one's body and mind active leads to atrophy, depression, and other problems that not only inhibit improvement, but contribute to physical and mental deconditioning, making the patient worse. Certainly Dr. Hinkamp does not dispute this. If he does, he would be the only medical professional we have been able to identify on record as doing so. [CLAIMANT] needed to contribute in a meaningful way to his community as much for therapeutic reasons as anything. That he saved his energy throughout the week to perform five

to ten hours per week of volunteer work on a sporadic basis is not only not ‘inconsistent’ with his complaints, it is medically advised.

Finally, Dr. Taylor points out very clearly that “Chronic Fatigue syndrome has been recognized as a disability by Social Security, and confirmed as a legitimate clinical entity by the U.S. Centers for Disease Control and Prevention. Numerous results from biomedical studies have also confirmed its medical legitimacy and significance as a public health concern.”

We hope in the future that Dr. Hinkamp, when evaluating cases that are outside his area of “Health in the Arts” expertise, he will perform at least rudimentary research on the illness, particularly when a nationally recognized research expert in the field is only an internal phone extension away. Claimants need such minimal effort; ERISA demands it – and more.

The medical review conducted for [TPA] was wholly deficient and invalid. It should be given absolutely no weight at all in the determination of [CLAIMANT]’s disability status.

[EMPLOYER] should be aware of cases in the federal circuit governing [CLAIMANT]’s ERISA claim, such as *Dunbar v. Orbital Sciences Corporation*, 265 F. Supp. 2d. 572 (D. Md. 2003) In this very analogous case, the court held that the insurer could not ignore the opinions of the treating physicians on a condition that could be disabling while relying solely on their own consultant's opinion that the claimant was not disabled. The treating physicians' opinions were supported by diagnostic objective neuropsychological tests that had been performed on the claimant concerning his alleged cognitive impairments.

Of even greater consideration by [EMPLOYER] should be *Stup v. UNUM Life Insurance Co.*, 390 F. 3d 301 (4th Cir. 2004). In *Stup supra*, there was a conflict between the treating physician and an in-house physician for UNUM as to whether or not the claimant was still disabled under the terms of the long-term disability policy. Judge Motz held that an insurer such as UNUM had failed to adhere to the substantiality requirement by arbitrarily disregarding Stup's reliable evidence including the opinion of her treating physician, relying instead on ambiguous and insubstantial evidence favoring UNUM's own economic self-interest. It is thus UNUM not Stup, that has failed to follow an instruction of the Nord Court, i.e. **that "plan administrators may not arbitrarily refuse to credit a claimant's reliable evidence including the opinions of the treating physician. (Emphasis added).** In *Stup*, unlike Nord, the only evidence to refute the opinions of the treating physician was a functional capacity evaluation that was ambiguous in terms of whether or not the claimant was capable of performing sedentary work.

In [CLAIMANT]’s case, Dr. Hinkamp relied on “ambiguous and insubstantial evidence” consisting of an inappropriate and invalid list of responsibilities and surveillance which (a) showed nothing beyond the normal limits of someone with CFS and (b) was incomplete and missed reporting several relevant limitations. Additionally, Dr. Hinkamp apparently ignored the independent medical evaluations and conclusions from the Plan’s previous administrator and failed to consider [CLAIMANT]’s complete medical condition, both physical and cognitive, by failing to review more than 3 years of medical records.

THE TRANSFERABLE SKILLS ASSESSMENT WAS BASED ON MINIMAL DATA

The Job Accommodation Specialist failed to consider [CLAIMANT]'s cognitive condition and its impact on any potential positions.¹² By way of comparison with effective practice, her [INITIAL TPA] counterpart was diligent during her 2006 Transferable Skills Assessment in attempting to fully understand [CLAIMANT]'s condition, physical and cognitive, so a reasoned determination for employability could be made. After discussing the case with [INITIAL TPA]'s consulting Neuropsychologist, it was noted that due to "unclear identification of specific cognitive restrictions and limitations, VRC is unable to identify gainful occupations for which he [[CLAIMANT]] would be qualified."¹³

Conversely, a thorough review of all aspects of [CLAIMANT]'s condition was performed at the National Rehabilitation Hospital by their Vocational Rehabilitation Coordinator, [VOCATIONAL EXPERT], M.Ed., CRC. [VOCATIONAL EXPERT] had access to all records and evaluated all Neuropsychological Evaluations, Physician's reports, Surveillance Reports, [TPA]'s termination rationale, [YOUTH CLUB] volunteer information, and affidavits of many interested parties. As a result of extensive evaluation, [VOCATIONAL EXPERT]'s very comprehensive seven page report concluded:

As a VR counselor, my job is to focus on a person's residual strengths and abilities and then assist them in determining feasible vocational goals and return to work. It is the exception to find that return to work is not an attainable goal, especially for someone like [CLAIMANT] who has a college degree and management experience. Based upon review of all the information listed above, return to work is not a feasible goal. The standard must be applied is the ability to return to work in any occupation with a comparable gainful wage. Due to the established cognitive limitations as noted throughout this report, he is unable to perform in any job that requires planning, dealing with people, and making judgments and decisions. In addition, he is unable to perform in any role in a consistent, reliable or sustained level. (Exhibit 23)

In addition to this formal evaluation, [EXECUTIVE RECRUITER], an executive technical recruiter who has known [CLAIMANT] for almost 25 years testifies in his attached affidavit that:

His [[CLAIMANT]'s] illness has significantly and noticeably affected his ability to perform at this level any longer. His decreased mental processing speed and memory, along with his obvious fatigue would make it impossible to place [CLAIMANT] in a position at this time. (Exhibit 17)

¹² In fact, the Job Accommodation Specialist failed to identify the requirements of the three positions it is contended [CLAIMANT] can perform. Of course, had she set out the requirements of these positions, it would have been abundantly clear that [CLAIMANT] was incapable of performing the requirements of any of these positions.

¹³ There is not a single piece of evidence in the claim file that remotely suggests any improvement in [CLAIMANT]'s cognitive condition that would explain the change in his vocational capability as determined by [TPA] in 2007.

[EXECUTIVE RECRUITER] goes on to describe in detail the realities of the current IT market and the types of positions [EMPLOYER] proposed for [CLAIMANT]. [EXECUTIVE RECRUITER] concludes:

Quite frankly, it would not be ethical for me or anyone else to attempt to place [CLAIMANT] with a client, especially in positions proposed by [EMPLOYER], given what is known, and I have observed, to be his medical and technological condition. (Id.).

I am sure you will agree that a thorough and comprehensive vocational assessment will lead any reasonable Vocational Counselor to the conclusion that [CLAIMANT] is simply unable to be placed in any position requiring either high levels of cognitive functioning or sustainable levels of commitment.

[TPA]'S POSITION THAT THERE IS NO OBJECTIVE MEDICAL EVIDENCE IS NOT ONLY INCORRECT, IT IS TOTALLY IRRELEVANT

In its May 11, 2007 letter advising [CLAIMANT] of its decision to terminate his long term disability benefits, [TPA] and its "Physician Advisor" repeatedly make reference to the lack of objective medical evidence to support [CLAIMANT]'s ongoing entitlement to benefits.

However, [TPA]'s position regarding Objective Medical Evidence is totally irrelevant. As noted previously, there is no objective medical test to confirm the diagnosis of Chronic Fatigue Syndrome. Rather, the diagnosis is arrived at based upon the presence of numerous symptoms and the lack of any other medical reason for such symptoms. As has been fully demonstrated previously, [CLAIMANT] meets the diagnostic criteria established by the Centers for Disease Control and the medical community for Chronic Fatigue Syndrome. Thus, there are no objective medical test results that can be presented to [TPA] to 'prove' [CLAIMANT] suffers from Chronic Fatigue Syndrome. If there were no such objective medical evidence, there is no basis to dispute that [CLAIMANT] suffers from Chronic Fatigue Syndrome and that its effects have been so debilitating to him that he has been unable to work since May 2003 and has been receiving benefits since that time.

The [EMPLOYER] LTD Plan does not require "objective" evidence and in fact, [CLAIMANT]'s disabling medical condition, Chronic Fatigue Syndrome, is universally acknowledged by the medical community **not** to have objective medical findings. Thus, [TPA] is requiring [CLAIMANT] to provide medical evidence that (a) is not required by the long term disability plan, and (b) that is impossible to provide as universally acknowledged by the general medical community. As a result, [EMPLOYER]'s imposition of additional terms and requirements that **cannot be provided** under current medical science is a breach of its fiduciary duty under ERISA. *Mitchell v. Eastman Kodak*, 113 F.3d 433 (3rd Cir. 1997).

Beyond the above, the undisputed medical evidence of record clearly demonstrates the presence of **other** objective medical evidence that supports the both the diagnosis of Chronic

Fatigue Syndrome and the severity of [CLAIMANT]'s disabling conditions. This evidence includes, but is not limited to

- Five Neuropsychological Evaluations – 2007, 2005, 2004 (2), & 2003
- Two Tilt Table Tests – 2003 & 2007
- Functional Capacity Evaluation – 2004 (Exhibit 32)
- Cardiopulmonary Stress Test – 2007 (Exhibit 3B)
- MSLT – 2003 (Exhibit 33)

Further summation of these, including performing physician/facility and comments can be found in Exhibit 24. All this evidence does not 'prove' [CLAIMANT] suffers from Chronic Fatigue Syndrome, as there is no such 'proof' available in medical science today. This evidence, however, does prove beyond any doubt, reasonable or otherwise, that [CLAIMANT] does suffer from a constellation of symptoms to such a degree that he is unable to sustain full time employment of any sort.

The medical experts that have evaluated this evidence, or subsets thereof, are outlined in Exhibit 25. In summary, the experts supporting the severity of [CLAIMANT]'s 'alleged symptoms' and his inability to sustain meaningful employment includes:

- Two widely recognized experts in Chronic Fatigue Syndrome, both of whom have extensively evaluated [CLAIMANT], one over the period of four years, One of these is also it should be noted that the co-author of the American Academy of Disability Evaluating Physicians *Position Paper on Chronic Fatigue Syndrome*.
- Seven Neuropsychologists, including
 - Four who have personally tested [CLAIMANT], two of whom were under contract to [EMPLOYER],
 - Two internal [EMPLOYER] consulting Neuropsychologists
 - One nationally renowned researcher on the cognitive and behavioral aspects of chronic pain and persistent fatigue
- Two Vocational Rehabilitation experts, including one working for [EMPLOYER].

In addition to establishing the disabling nature of [CLAIMANT]'s condition, those experts that have been involved since the termination of [CLAIMANT]'s benefits have all testified that his volunteer and other activities are in no way 'inconsistent' with the severity of his condition and in fact are recommended to prevent further mental and physical deconditioning.

Experts not supporting the severity of [CLAIMANT]'s 'alleged symptoms' and his inability to sustain meaningful employment includes:

- o Two Occupational Medicine specialists, one of whom only had a small subset of relevant information and spent only a few hours on the case, and the other who had the audacity to refer to looking under the hood of a car for a moment as "performing car maintenance" and comparing the ability to buy donuts and gas as evidence that [CLAIMANT] is capable of performing a cognitively challenging full time position.
- o One "Job Accommodation Specialist" who was primary guideline was "[CLAIMANT] is capable of sedentary work" and was given no further information regarding [CLAIMANT]'s cognitive dysfunctionality.

There is no evidence whatsoever to indicate these two Occupational Medicine physicians followed the guidelines of the American Academy of Disability Evaluating Physicians (AADEP) or those outlined in the American Medical Association Guides to the Evaluation of Permanent Impairment ("AMA Guides") as they relate to Chronic Fatigue Syndrome.

CONCLUSION

The overwhelming evidence of record demonstrates that [CLAIMANT] has a "disability" under the [EMPLOYER] Long Term Disability Plan and is entitled to the reinstatement of his benefits. [CLAIMANT] has met the criteria required under the Plan for the receipt of benefits. He has been at all times under the regular care of a doctor. He has demonstrated the onset date of his disability and its cause (i.e., Chronic Fatigue Syndrome, Neurally Mediated Hypotension, Hypersomnia, sleep disorder, cognitive dysfunction, and other symptoms that interfere with his ability to maintain a set schedule or perform the duties of employment for which he is reasonably qualified). The reports of four Clinical Psychologists establish the numerous cognitive deficiencies from which he suffers. The evidence also shows, despite [EMPLOYER]'s inference to the contrary, the volunteer and physical activities that [CLAIMANT] performs are consistent with the activity levels of other Chronic Fatigue Syndrome patients and does not establish that he has recovered from his disability. Rather, it is evidence that he is following the advice of his physicians to engage in reasonable physical and mental activity but the beneficial nature of this activity is not a cure, and does not lead to the irrational conclusion that he can engage in full time employment as [EMPLOYER] has determined.

Apart from the overwhelming objective medical evidence, extensive and comprehensive evaluation and assessment of numerous experts specializing in [CLAIMANT]'s condition, and definitive medical literature, **for [EMPLOYER] to uphold the termination of [CLAIMANT]'s benefits, it will be contradicting four of its own contracted Medical Experts and one of its own Vocational Experts. Under such circumstances ERISA does not allow a claims administrator to "cherry pick" the evidence, accepting only evidence that supports its financial interests while at the same time completely disregarding the overpowering evidence of record that fully**

supports a participant's claim. If [EMPLOYER] takes this route, it will have clearly violated its fiduciary obligations under ERISA.

The decision to terminate [CLAIMANT]'s long term disability benefits must be reversed and [CLAIMANT] should be determined to be "disabled" under the terms of the [EMPLOYER] Long Term Disability Plan. [CLAIMANT]'s long term disability benefits should be reinstated from the date of termination and he should be placed on payment status for ongoing long term disability benefits. [CLAIMANT] and I look forward to receipt of your correspondence agreeing that he is entitled to both past due long term disability benefits and ongoing disability benefits.

Thank you for your attention to this matter.

Very truly yours,

[ATTORNEY'S FIRM], P.C.

[ATTORNEY]

cc: [CLAIMANT]