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ABOUT OUR FIRM

Eric Buchanan & Associates, PLLC is a full-service disability benefits, employee benefits, and insurance law firm. The attorneys at our firm have helped thousands of disabled people who have been denied social security disability benefits, ERISA LTD benefits, health insurance, life insurance and other ERISA employee benefits, as well as private disability and health insurance benefits.

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SUBJECTIVE SYMPTOM LIMITATIONS IN LONG TERM DISABILITY INSURANCE POLICIES BY: R. SCOTT WILSON

Most practitioners are familiar with the "mental and nervous" limitation present in most long term disability insurance policies. A provision limiting how long benefits can be paid for a psychiatric condition—most commonly two years—is near ubiquitous. However, there are other limitations provisions that can crop up, limiting payment for certain medical conditions, and transform what looks at first blush to be an extremely valuable claim into one that is virtually worthless.

The most common of these is a "subjective symptom" limitation. This limitation appears designed to limit insurance company exposure to medical conditions like fibromyalgia and chronic fatigue syndrome. However, depending on how they are drafted, such limitations clauses can catch any number of other medical conditions in their net. They can also fail to catch those medical conditions the limitations clauses seem most designed to address.

We see two main types of subjective symptoms limitation: firstly, one based upon the diagnosis of diagnostic criteria of a particular medical condition; secondly, one based upon the symptoms produced by the medical condition.

Diagnosis/Diagnostic Criteria-Based Limitations Clauses

The easiest way to draft a clause limiting payment for certain medical conditions would seem to be to identify the condition(s) by name, and on occasion we do see such provisions. However, there is often a fine line between one diagnosis and another, and diagnoses may change over time: for example, the fibromyalgia patient who, at varying times and with varying doctors, also carries diagnoses of Sjogren's Syndrome, undifferentiated connective tissue disorder, or even lupus.

As a result, it is more common to see the limitations clause drafted in terms of diagnostic criteria, rather than diagnosis. The "neuromusculoskeletal limitation" from a MetLife policy is a good example:

> Monthly benefits are limited to 24 months during your lifetime if you are Disabled due to a:
> . . . .
> Neuromusculoskeletal and soft tissue disorder including, but not limited to, any disease or disorder to the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, *unless the Disability has objective evidence of*:
> a. seropositive arthritis;
> b. spinal tumors, malignancy, or vascular malformations;
> c. radiculopathies;
> d. myelopathies;
> e. traumatic spinal cord necrosis; or
> f. musculopathies

Radiculopathies, musculopathies, and the other listed items are then further defined in the policy. For example, "radiculopathies" are defined as "disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology." "Musculopathies" are defined as "disease of muscle fibers, supported by pathological findings on biopsy or electromyography (EMG)."

The method for dealing with such a limitations provision is obvious: the claimant and representative must simply show that the diagnostic criteria are met; if the diagnostic criteria cannot be met, there is no other way around the limitation.

However, there are a few important points to keep in mind. Firstly, medical records are written for doctors, not to document disability claims, and can be made more confusing by terms of art and medical synonyms. Reference to a medical treatise can help explain how the medical data show that the required diagnostic criteria are met. Better yet, if the case is sufficiently large to justify the expense, a sworn statement from the treating specialist explaining, for example, how radiculopathy works from an anatomic perspective, and how it was diagnosed in this particular client/patient, can be invaluable.

Secondly, a precise parsing of the policy language can important. In the same neuromusculoskeletal limitation above, musculopathies are required to be demonstrated by biopsy or EMG, but radiculopathies require only "clinical findings" of nerve pathology. So a claimant could meet the requirements of this particular policy on the basis of radiculopathy diagnosed on physical exam, while a different policy might require EMG evidence.

Thirdly, this should demonstrate the necessity for reviewing the policy, in detail, at the beginning of the claim. Not doing so risks emphasizing aspects of a claimant's condition that might be subject to a limitation on how long benefits can be paid. And if specific tests are required to establish diagnostic criteria, the claimant may better be able to afford those tests earlier in the case, before health insurance lapses or savings are exhausted.

Symptom-Based Limitations Clauses

The other method used by insurers for limiting payment to more subjective illnesses is the symptoms-based limitations clause. A common Unum policy provision limits payment of benefits for "disabilities, due to a sickness or injury, which are primarily based on self-reported symptoms" to a specified number of months, most often 24. "Self-reported symptoms" are then defined as "manifestations of your condition which you tell your doctor such as pain or fatigue that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine."

At first blush, this language is astonishingly broad. After all, with the exception of paralysis and amputation, virtually all disabilities result from pain or fatigue (or shortness of breath) preventing the claimant from engaging in or sustaining a particular activity. Fortunately, experience shows that, the better the source of the pain (or fatigue) is objectively, anatomically explained, the less courts are willing to use this policy language to deny recovery. And surprisingly, this can even be true where the medical condition in question is fibromyalgia or another largely subjective condition. *E.g.*, *Welch v. Unum Life Ins. Co. of America*, 382 F.3d 1078 (10th Cir. 2004) (declining to allow Unum to invoke this language to limit payments of benefits or fibromyalgia so long as the diagnosis was made properly in accordance with appropriate clinical findings).

A second way of avoiding the impact of this limitations clause is to find a way of measuring the impact of the symptom in question: after all, on its face, the limitation applies only to manifestations of the condition that "are not verifiable using tests." To that end, a functional capacities evaluation can both demonstrate disability, and do so in an objective manner that avoids the impact of the subjective symptoms limitation. The Sixth Circuit has held that "while the diagnos[is] of ... fibromyalgia may not lend [itself] to objective clinical findings, the physical limitations imposed by the symptoms of such illness[ ] do lend themselves to objective analysis. One method of objective proof of disability, for instance, is a functional capacity evaluation, a 'reliable and objective method of gauging' the extent one can complete work-related tasks." *Huffaker v. Metropolitan Life Ins. Co*., 271 Fed.Appx. 493 (6th Cir. 2008).

A limitations clause restricting the length of time for which benefits are payable to disfavored medical condition—whether that limitation is based upon diagnostic criteria or the nature of the symptoms caused by the condition—is almost never a good thing for claimants. Particularly under the arbitrary and capricious standard of review, it is one more way for the insurer's denial of benefits to be deemed "reasonable." However, particularly when the limitations clause is identified as a potential stumbling block early in the case, there are both evidence- and argument-based paths around the limitation.

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