

**PRACTICAL CONSIDERATIONS IN DEFENDING  
MENTAL ILLNESS DISABILITY CLAIMS**

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Building a mental disability case can be a treacherous task. Neither the science nor the law is well settled, leaving many aspects ripe for litigation. Adding to the complexity are the jurisdictional differences that have emerged. Handling a mental disability claim, therefore, requires familiarity with relevant legal trends, a working knowledge of leading mental disability texts, and the willingness to carefully review mental health records.

This paper addresses four practical topics germane to the defense of mental disability claims. First, the paper provides an introduction to legal issues framing mental disability cases, including the difficulty of defining mental disorders. Second, the paper addresses the contents of a claim file for a mental disability claim. Third, the paper notes practical points gleaned from appropriate care cases in the mental disability arena. Finally, the paper reviews two specific issues concerning the defense of mental disability

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claims – namely, the development of objective evidence and the process of preparing for depositions in mental disability cases.

### I. LEGAL ISSUES FRAMING THE LITIGATION OF MENTAL ILLNESS DISABILITY CLAIMS<sup>1</sup>

One of the first issues framing the litigation is whether the claimed disability is a mental illness or mental disorder. If the policy’s definition of mental illness or mental disorder is clear, then this initial determination should be relatively straightforward. If, however, the policy or plan fails to define “mental disabilities,” or if the policy is vague or circular in its definition (*e.g.*, a “mental disability” is an illness or disorder that derives solely from a mental, non-physical condition), then consideration of the common law is necessary.

The federal law developing under the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. § 1001, *et seq.*, is instructive in this area. In the ERISA context, three trends have emerged in terms of how a court might differentiate between physical and mental disorders: (i) the “causes” approach; (ii) the “symptoms” approach; and (iii) the “treatment” approach. *See, e.g., Lynd v. Reliance Standard Life Ins. Co.*, 94 F.3d 979 (5<sup>th</sup> Cir. 1996); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9<sup>th</sup> Cir. 1990); *Blake v. Unionmutual Stock Life Ins. Co.*, 906 F.2d 1525 (11<sup>th</sup> Cir. 1990).

The causes approach analyzes whether the illness at issue has a physical (or “organic”) cause. *See, e.g., Kunin*, 910 F.2d at 538. Courts following this approach find it reasonable to define a mental disorder as a disorder that is the result of a traumatic

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<sup>1</sup> Although this paper sets forth several general points for consideration in the claims investigation process, it is not an exhaustive or exclusive list. Indeed, disability claims are inherently unique, and different claims call for different investigations.

experience, disturbing episode, or profound event, and is not a disorder that has an immediate physical, bodily cause. *See id.* An emotional disorder arising from the latent effects of having been abused as a child, for example, would constitute a mental disorder under the causes approach. *See id.* Insurers evaluating claims arising in jurisdictions that follow the causes approach, therefore, should be prepared to obtain evidence probative of the claimant's traumatic or disturbing life episodes.

Other courts, such as those following *Lynd v. Reliance Standard Life Insurance Co.*, 94 F.3d 979 (5<sup>th</sup> Cir. 1996), apply the symptoms approach. The symptoms approach focuses principally upon whether the manifestations of the infirmity (*i.e.*, the “symptoms”) would indicate the existence of a mental illness to a layperson. *See* 94 F.3d at 983-84. In *Lynd*, the Court of Appeals for the Fifth Circuit rejected the causes approach because it concluded that every disorder ultimately has at least some physical cause. *See id.* at 983 & n.5. The *Lynd* court also was persuaded by the Eighth Circuit's emphasis on the importance of the layperson's perspective. *See, e.g., id.* at 983 (quoting *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 154 (8<sup>th</sup> Cir. 1990)). Thus, the court reiterated *Brewer's* teaching that “[i]t would be improper and unfair to allow experts to define [ERISA plan] terms that were specifically written and targeted toward laypersons.” *Id.* Rather than concentrating on the life history of the claimant prior to the onset of illness, the evidence in jurisdictions following *Lynd* should focus on the claimant's post-illness behavior.

The “treatment” approach focuses on how the infirmity was treated by healthcare professionals. This, in *Blake v. Unionmutual Stock Life Insurance Co.*, 906 F.2d 1525

(11<sup>th</sup> Cir. 1990), the court concluded the claimant had a mental illness mainly because “[a]ll of the hospitalizations of Mrs. Blake were in psychiatric units. She was treated primarily by psychiatrists receiving well-recognized psychiatric treatment, including individual psychotherapy, psychoactive drug therapy, electroconvulsive therapy and participation in group sessions. To borrow from a euphuism, ‘if it looks like a duck, walks like a duck, quacks like a duck, then it’s probably a duck.’” *Id.* at 1530. In jurisdictions applying the treatment approach, therefore, the evidence should emphasize how the healthcare professionals responded to the claimant’s illness.

Understanding which approach (causes, symptoms, or treatment) the court will apply is important in determining whether an illness will be treated as a mental illness. This, of course, may guide the different inquiries that a claims examiner wishes to pursue. In turn, this may have an impact on the issues of appropriate care and duration of benefits.

Another issue the courts have been called upon to resolve is the propriety of drawing a distinction between mental and physical disorders. If the policy or plan provides greater benefits for physical disorders than mental disorders, then this distinction in benefits may be challenged as invalid. In *Lewis v. Kmart*, 180 F.3d 166 (4<sup>th</sup> Cir. 1999), for example, Kmart’s disability plan “capped disability benefits for mental disabilities at two years, but only capped disability benefits for physical disabilities upon a participant turning age sixty-five.” 180 F.3d at 168. When the claims administrator classified Mr. Lewis’s condition as a mental disorder and capped his benefits, Mr. Lewis filed an action alleging the distinction between mental disability benefits and physical

disability benefits violated the Americans with Disabilities Act of 1990 (the “ADA”). *See id.*; *see also Ford v. Schering-Plough Corp.*, 145 F.3d 601 (3d Cir. 1998) (same); *Parker v. Metro. Life Ins. Co.*, 121 F.3d 1006 (6<sup>th</sup> Cir. 1997) (same).

In *Lewis*, the court ultimately concluded the ADA “does not require a long-term disability plan that is sponsored by a private employer to provide the same level of benefits for mental and physical disabilities.” 180 F.3d at 172. The court, therefore, ordered that judgment be entered in favor of Kmart. *See id.* The lesson here, however, is not simply the legitimacy of distinctions between mental and physical disorders, but that the claims administrator must be prepared to defend the decision to classify a claim as a mental disorder.

Although the common law poses restrictions on the decision-making authority of claims examiners in certain respects, recent cases have afforded claims examiners a higher degree of autonomy in rendering claims determinations. In *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 123 S. Ct. 1965 (2003), for example, the Supreme Court of the United States held that “courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant’s physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician’s evaluation.” 538 U.S. at 834. In so holding, the Supreme Court fortified the ability of claims administrators to make decisions unconstrained by the opinions of the claimant’s treating physician.

Following on the heels of *Nord*, the Court of Appeals for the Fourth Circuit confronted the question of whether Social Security rules apply to a fully insured ERISA

plan. *See Smith v. Cont'l Cas. Co.*, 369 F.3d 412 (4<sup>th</sup> Cir. 2004). In *Smith*, an insurer denied a claim for benefits based on lower back pain because the subjective complaints were not supported by objective medical findings. *See* 369 F.3d at 415-416. The district court opined, “[t]he evidentiary assessment of pain cannot reasonably differ whether a claimant seeks disability benefits under a private plan of insurance or under the public scheme of Social Security. Proof is proof.” *See id.* at 418. The district court entered judgment for the claimant relying on Social Security Ruling (“SSR”) 90-1p, which provided a standard for the evaluation of pain for purposes of Social Security disability determinations. *See id.* “Applying SSR 90-1p, the district court held that, ‘because a claimant need not present clinical or diagnostic evidence to support the severity of pain, a plan administrator cannot discount self-reports of disabling pain solely because the objective medical evidence does not fully support them.’” *Id.* at 418-419.

The Court of Appeals for the Fourth Circuit vacated the district court’s judgment. According to the Court of Appeals, “the district court in this case made the same error the Ninth Circuit made in *Black & Decker [v. Nord]* by equating the determination of disability under the Social Security regime with the determination of disability under the ERISA plan at issue.” *Id.* at 419.

As with the treating physician rule at issue in *Black & Decker*, the most recent version of the ERISA regulations was enacted long after SSR 90-1p was adopted, and the ERISA regulations do not reference the pain ruling. Moreover, ERISA does not mandate what benefits an employer must offer. ERISA benefits are a matter of contract. Accordingly, what qualifies as a disability for social security disability purposes does not necessarily qualify as a disability for purposes of an ERISA benefit plan – the benefits provided depend entirely on the language in the plan.

*Smith*, 369 F.3d at 415 at 420. Based on the holding and rationale of *Smith*, a benefits determination under an ERISA plan need not defer to either the process or outcome of a disability determination by Social Security. Although a claims administrator may want to know about the outcome of a Social Security disability claim for a variety of reasons, including setoff issues, the determination by Social Security is not outcome-determinative of the ERISA claim.

## II. FILE MANAGEMENT IN ANTICIPATION OF LITIGATION OF MENTAL ILLNESS DISABILITY CLAIMS

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### A. HIPAA And Uses And Disclosures Of Protected Health Information

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Although general rules applicable to all mental illness claims are difficult to articulate, an essential step in the claims process is obtaining all relevant medical records. Although this sounds simple, the reality of the process is far more complex.

As an initial matter, privacy laws affecting the propriety of disclosing health information have changed dramatically in recent years. In particular, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) created expansive civil and criminal healthcare laws designed, in part, to control the exchange of protected and individually identifiable health information.<sup>2</sup> Both HIPAA and its Privacy Rule<sup>3</sup> are

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<sup>2</sup> “Health information,” under HIPAA, means “any information, whether oral or recorded in any form or medium, that: (1) [i]s created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and (2) [r]elates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.” See 45 C.F.R. 160.103. “Individually identifiable health information” is information “that is a subset of health information, including demographic information collected from an individual, and: (1) [i]s created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse; and (2) [r]elates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an

broad in scope. Complying with the rules requires, for instance, (i) grappling with personnel and managerial issues; (ii) controlling paper and electronic flow of information; (iii) entering into agreements with business associates and trade partners; (iv) establishing company policies to keep protected health information private while allowing authorized access in appropriate circumstances; and (v) implementing a wide range of in-house “structural” and administrative requirements.

Beyond the Privacy Rule’s administrative and structural requirements, the Rule sets forth specific standards addressing the uses and disclosures of protected health information. Permitted uses and disclosures are organized under six broad categories. *See* 45 C.F.R. § 164.502. Thus, in general, entities regulated by HIPAA are permitted to use or disclose protected health information:

- (1) to the individual to whom the information pertains;
- (2) for treatment, payment or healthcare operations, pursuant to the standards articulated in 45 C.F.R. § 164.506;
- (3) incident to a permitted use or disclosure, provided that appropriate administrative, technical, and physical safeguards are in place to protect the privacy of protected health information, and provided that the regulated entity complies with the “minimum necessary” standard set forth in § 164.502 (b) and implicated by § 164.514 (d);

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individual; and (i) [t]hat identifies the individual; or (ii) [w]ith respect to which there is a reasonable basis to believe the information can be used to identify the individual.” *See id.* Although certain health records are excluded from its definition, “protected health information” generally means “individually identifiable health information” that is (i) transmitted by electronic media; (ii) maintained in electronic media; or (iii) transmitted or maintained in any other form or medium. *See id.*

<sup>3</sup> The term “Privacy Rule,” as discussed in this paper, is over-inclusive and refers to both the substantive and procedural aspects of the Rule. As used here, the term includes not only the privacy standards pertaining to individually identifiable health information (*i.e.*, 45 C.F.R. §§ 164.500 – 164.534), but also the more general administrative requirements applying to the privacy standards and other HIPAA laws (*i.e.*, 45 C.F.R. §§ 160.101 – 160.572).

- (4) pursuant to a valid authorization under § 164.508, which requires the individual's authorization to allow disclosures of psychotherapy notes or for marketing purposes;
- (5) pursuant to an agreement under, or as otherwise permitted by, § 164.510, which affords individuals the opportunity to agree or object to certain disclosures; and
- (6) in specific situations, including disclosures: (i) required by law or for law enforcement purposes; (ii) in connection with public health or health oversight activities; (iii) in situations concerning a victim of abuse, neglect, or domestic violence; (iv) in situations involving a coroner's examination or organ donations; (v) in connection with judicial or administrative proceedings; (vi) for research purposes; (vii) to avert a serious threat to health or safety; (viii) for specialized government functions; (ix) in connection with workers' compensation; (x) in association with certain fundraising or underwriting activities; or (xi) in connection with the creation of limited data sets. Each of these permitted disclosures are described and regulated by rules set forth in 45 C.F.R. § 164.512 and § 164.514.

*See, generally*, 45 C.F.R. § 164.502(a).

One of the most important aspects of the Privacy Rule, regardless of the nature of the disclosure, is the "minimum necessary" standard. Although certain exceptions apply, the general rule provides that "[w]hen using or disclosing protected health information, or when requesting protected health information from another covered entity, a covered entity must make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request." 45 C.F.R. § 164.502 (b) (articulating the rule and its exceptions). As a general rule, therefore, it would be prudent to apply the minimum necessary standard when seeking a disclosure that could run afoul of the Privacy Rule.

Navigating through HIPAA is only one part of the process of obtaining mental healthcare records. Many states also attach additional statutory or regulatory prohibitions and prerequisites to the disclosure of medical information. Maryland, for example, by statute, prohibits disclosure of a patient's mental health records in response to a subpoena or discovery request unless a copy of the subpoena or discovery request is served on the person whose records are being sought and the subpoena is accompanied by a certificate sent by certified mail to the person whose records are being sought containing certain specified information, including:

- (a) notice that the person's records are being sought;
- (b) notice of the legal provisions under which disclosure is being sought; and
- (c) notice of the procedures for filing a motion to quash or for seeking a protective order.<sup>4</sup>

Moreover, with respect to mental health records, even if all of the statutory procedures are followed, Maryland still does not permit wholesale disclosure of the records. Rather, the healthcare provider must disclose only those portions of the records "relevant to the purpose for which disclosure is sought."<sup>5</sup> This, of course, opens the door for collateral litigation over what is "relevant to the purpose for which disclosure is sought."

#### B. The Process Of Gathering Relevant Medical Records

The process of gathering the medical records should begin with the treating physician and any other providers identified on the claim form. Once the initial records are obtained, they should be reviewed to determine if they are complete and if the

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<sup>4</sup> See Md. Code Ann., Health-Gen. §§ 4-306(b)(6); 4-307(k)(1)(v).

<sup>5</sup> See Md. Code Ann., Health-Gen. § 4-307(c).

claimant was seen by or referred to any other healthcare providers. Many physicians fail to provide prescription records as part of their medical records. The records should be reviewed to make certain the prescription records are included. A family physician, perhaps an internist, may have provided initial care for a mental illness before referring the claimant to a specialist. Thus, the records from any initial treating provider should be obtained. The medical records should be reviewed to see what treatments and medications were prescribed. Consideration should be given to requesting records from the pharmacy and any psychotherapist.

Contacting and obtaining records from any health insurer involved in the care and treatment of the mental healthcare claimant can be important. Assuming the insured does not provide this information on the claim form, it can be requested or may be discernable from a review of the treating provider's records. The health insurers' records may reveal additional providers or the reasons for selection of a particular provider or treatment. In addition, the treating provider may have provided information to the health insurer that is not reflected in the medical records. Frequently, for example, insurers conduct medical necessity reviews and/or reviews associated with inpatient care and treatment. Statements and information provided by the treating provider to a health insurer should be reviewed to see if a consistent picture emerges concerning the claimant's condition. Another point to consider in reviewing the health insurer's records is whether the treatment and condition codes employed by the treating provider are consistent with the reported disabling condition and treatment regimen.

### C. Internal Review Of The Medical Records

Once the complete medical records are obtained, review of the records by an appropriate healthcare provider is often worthwhile. If the resources are available internally, then this probably is an appropriate use of those resources. Initial input by a qualified medical provider may include inquiries concerning (i) whether the diagnosis is supported by the information contained in the medical records; (ii) whether the initial treatment was appropriate for the disabling condition; (iii) whether the treatment plan (assuming one exists) is appropriate for the disabling condition and is being followed; (iv) whether, if no treatment plan exists, the provider should have such a plan at this time; (v) whether any other appropriate treatments should be considered; (vi) whether referral for an IME would be beneficial in evaluating the claim or condition; (vii) what type of IME provider is recommended; (viii) whether any further testing is appropriate or necessary to evaluate the claim or condition; and (ix) whether the restrictions and limitations appear consistent with the findings in the medical records.

### D. The IME Process

Depending on the findings and advice received from the initial provider review, consideration should be given to the possibility of pursuing an IME. Although most policies allow an insurer to require the insured to submit to an IME, an IME is not necessary or appropriate in all cases. Based on the “bad faith” law in some states, some insurers may adopt a strategy of requiring all mental healthcare claimants to submit to an IME because the properly performed IME should limit the risk and exposure associated with claims for “bad faith.” See *Phelps v. Provident Life & Acc. Ins. Co.*, 60 F. Supp. 2d

1014, 1021-24 (C.D. Cal. 1999) (insurer's reliance on three separate IMEs before terminating benefits was not bad faith); *Walsh v. Provident Mut. Life Ins. Co. of Phila.*, No. CV 98-10602, 1999 WL 511928, \*5 (C.D. Cal. 1999); *Seidman v. Minn. Mut. Life Ins. Co.*, 40 F. Supp. 2d 590, 594 (E.D. Pa. 1997).

An IME can be particularly helpful in an ERISA case. As the court in *Laser v. Provident Life & Accident Insurance Co.*, 211 F. Supp. 2d 645 (D. Md. 2002), recognized, the "independent" nature of an IME can assuage an allegation that the plan administrator's decision was driven by conflict of interest. *See* 211 F. Supp. 2d at 650 ("Although independent reviews of medical evidence and independent examination of claimants are not required, both are common in ERISA cases. They can prove especially significant in cases in which the plan administrator is operating under a conflict of interest or rejects a treating doctor's opinion ...."). An IME in an ERISA case also can balance a suspect report submitted by a claimant's treating physician. *See, e.g., Smith v. UNUM Life Ins. Co. of Am.*, 305 F.3d 789, 795 (8<sup>th</sup> Cir. 2002) (approving plan administrator's reliance on an independent examining physician's opinion rather than the opinions of two treating physicians); *House v. Paul Revere Life Ins. Co.*, 241 F.3d 1045, 1048 (8<sup>th</sup> Cir. 2001) ("If Paul Revere was dissatisfied with the medical evidence submitted [by the treating physician], it was entitled to require House to submit to an independent medical examination. Had it done so, Paul Revere would have been entitled to discount [the treating physician's] opinion entirely in favor of a contrary opinion produced by the independent examiner.").

Assuming the insurer decides to pursue an IME, then consideration should be given to what type of healthcare provider is needed to perform the IME, what questions or concerns should be submitted to the IME provider, and whether to ask the IME provider to perform non-invasive testing. In many mental illness disability claims, such as clinical depression claims, the IME provider should be board certified in psychiatry. Common inquiries to the IME provider include: (i) whether the symptoms observed by the IME provider are consistent with the symptoms reported in the medical records; (ii) whether the diagnosis is consistent with the symptoms observed; (iii) whether the insured has any restrictions or limitations; (iv) the precise nature of any restrictions or limitations; (v) whether the treatment to date is appropriate; (vi) whether the treatment plan, if any, is appropriate, or what the treatment plan should be; (vii) what, if any, additional testing should be considered or performed to fully evaluate the condition and/or the severity of the condition; and (viii) the prognosis for the insured's recovery from the condition, both in terms of the likelihood of recovery and a timetable for recovery.

If an IME is performed, the IME provider should be advised to submit a complete written report. The IME provider's report should state what records were reviewed, what information was considered, what testing was performed, the findings from the examination, and detailed answers to the questions posed by the insurer.

An issue arising from time to time in the IME process is whether the insured may require videotaping, audiotaping, and/or the presence of a spouse or family member at the IME. Although contractually the insurer appears to have no obligation to consider –much

less consent to – such requirements, many insurers will defer to the IME provider.<sup>6</sup> In the mental healthcare field, however, the risk of coaching and/or otherwise interfering with the examination process is particularly high. For this reason, many mental healthcare professionals will not permit the presence of these external variables. If this issue becomes contentious, then one way to defuse a potential conflict is to point out that the IME provider should be permitted to examine the insured under the same conditions extant during the treating provider’s examination. Thus, if the treating provider did not videotape, audiotape, and/or involve other persons in the examination process, then allowing such intrusions into the IME process is illogical and unfair.

Assuming the IME confirms the diagnosis of mental illness, the restrictions and limitations, the appropriateness of the treatment, and that no further testing or inquiry is necessary, approval of the claim may be appropriate.<sup>7</sup> If, however, the IME report conflicts with the treating provider’s findings, then this conflict requires consideration and resolution.

Some insurers will send the IME report to the treating provider and ask for his or her input on the nature of the disagreement. In some instances, an insurer may have the IME provider call the treating provider to discuss their respective findings. In still other circumstances, an in-house medical consultant may review the IME report and contact

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<sup>6</sup> Although the typical contract language concerning an IME does not suggest any right on the part of an insured to impose conditions on submission, if the matter is in litigation, recording, videotaping, or the attendance of others at the IME, if unobtrusive, may be permitted. *Rachel-Smith v. FTData, Inc.*, 247 F. Supp. 2d 734, 739 (D. Md. 2003) (defendant sought sanctions for plaintiff’s failure to submit to IME, despite prior court order resolving dispute over tape recording of IME, which permitted recording so long as it did not “materially interfere with the examination”); *U.S. Sec. Ins. Co. v. Climino*, 754 So. 2d 697 (Fla. 2000) (holding videographer could videotape IME and attorney could be present at IME); *Kleine v. Fred Meyer, Inc.*, 855 P.2d 881 (Idaho Ct. App. 1992) (court ordered IME could be videotaped if prior arrangements were made with the doctor).

<sup>7</sup> Given the limited scope of this paper, this assumes all other policy requirements are satisfied.

the treating provider. Regardless of whether the initial contact with the treating provider is through an IME provider or in-house medical consultant, a contemporaneous memorandum should be prepared summarizing the conversation. The insurer generally has no affirmative duty to contact the treating provider or provide the IME report to the treating provider. *See, e.g., DiCamillo v. Liberty Life Assur. Co.*, 287 F. Supp. 2d 616 (D. Md. 2003) (defendant insurer voluntarily sent the results of the IME and videotape surveillance to the insured's primary treating physician of record seeking review and comment).

An insurer can legitimately proceed to adjudicate the claim without further input from the treating provider. *See DiCamillo*, 287 F. Supp. 2d at 623-24 (defendant insurer's denial of benefits was not arbitrary, even where its decision was made without the input of any of plaintiff's treating physicians); *Wilczynski v. Kemper Nat. Ins. Companies*, 998 F. Supp. 931 (N.D. Ill. 1998), *aff'd* 178 F.3d 933 (7<sup>th</sup> Cir. Ill. 1999). Assuming the claim is not governed by ERISA, and the insurer does not wish to contact the treating physician again, then another option for the insurer is to refer the matter back to the provider that conducted the prior paper review to seek further input and guidance. Depending on the nature of the response from this provider, the insurer may decide whether to deny the claim.

### III. "APPROPRIATE CARE" ISSUES IN MENTAL ILLNESS DISABILITY CLAIMS

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Given current uncertainties regarding diagnosis and treatment of mental disorders, one issue that arises in mental disability cases is whether the claimant received the proper

treatment. The issue generally arises from policy language requiring the insured to receive “appropriate care.”

In *Doe v. Provident Life & Accident Insurance Co.*, No. 96-3951, 1997 U.S. Dist. LEXIS 20770 (E.D. Pa. Dec. 30, 1997), John Doe, an attorney, claimed disability due to a psychiatric condition and coronary artery disease. *See* 1997 U.S. Dist. LEXIS at \*12. He sought benefits, *inter alia*, under two policies requiring him to show he was “receiving care by a Physician which is appropriate for the condition.” *See id.* at \*4. Once his claims were denied, Doe filed a breach of contract action that ultimately reached a jury trial. *See id.* at \*3-4. After a three-week trial and five days of deliberation, the jury found that Doe had not “receiv[ed] care by a Physician which is appropriate for the condition.” *Id.* at \*7.

Doe filed a post-trial motion seizing on the obvious issue: what does “appropriate” mean in the context of policy language requiring “care ... which is appropriate for the condition”? *See id.* at \*11-12. Specifically, Doe maintained the court erred in instructing the jury that “appropriate” means “suitable under the circumstances. It does not mean perfect care, or best possible care.” *See id.* at \*14. According to Doe, “the policy language does not impose a duty on the insured to ensure that his treating physician achieves a certain level of performance,” but rather “the policy language is satisfied if he received psychiatric care for his psychiatric condition and cardiac care for his coronary artery disease.” *Id.* at \*12.

Refusing to “torture” the policy language to create ambiguity, the court’s response was a simple one – a review of the dictionary. *See id.* at \*13. According to the court’s

reading of Webster's Third New International Dictionary, "appropriate" meant "specifically suitable," "fit," or "proper." *See id.* at \*14 n.4. The court found no error in the instruction and denied Doe's post-trial motion because the jury instruction mirrored the dictionary definition. *See id.* at \*15. This appropriate care case teaches the value of simplicity. Torturing policy language to suit a particular situation is often an ineffective strategy.

A second issue reflected in *Doe* also arises with regularity in appropriate care cases. Once the parties and the Court settle on a definition of the word "appropriate," the question becomes whether the claimant, in fact, received the appropriate care. *Doe* provides a good example of an effective use of expert witnesses in evaluating the quality of the claimant's treatment. In *Doe*, three expert witnesses testified on behalf of the insurer, and all questioned the treatment rendered by Doe's treating physician. *See id.* at \*16-17. When the dust settled, the list of deficiencies in Doe's treatment was lengthy and the appropriateness of Doe's treatment was seriously questioned. The deficiencies identified by the experts included: (i) lack of a treatment plan; (ii) lack of a vigorous effort to enable a return to work; (iii) premature discontinuance of antipsychotic medications; (iv) allowing a six-week hiatus between office visits; (v) the diagnostic formulation was in error; and (vi) failure to offer an optimal range of available psychological or psychiatric treatments. *See id.* at \*17-18.

A more recent case also highlights appropriate care issues in the mental disability context. In *Gough v. Metropolitan Life Insurance Co.*, No. 3:03-0158, 2003 U.S. Dist. Lexis 25252 (M.D. Tenn. Nov. 21, 2003), Jeffery Gough sought long-term disability

benefits based on symptoms arising from a temporal lobe epilepsy. *See* 2003 U.S. Dist. Lexis at \*2. Mr. Gough’s plan required him to demonstrate he was “receiving Appropriate Care and Treatment from a Doctor on a continuing basis” and provide “Proof that [he was] under the Appropriate Care of a Doctor throughout [his] Disability.” *Id.* at \*10, 12. The insurer provided Mr. Gough long-term disability benefits throughout the duration of the plan’s 24-month “own occupation” period, in part because Mr. Gough underwent an inferior frontal gyrectomy and lobotomy and an operation to place electrodes in his brain. *See id.* at \*2, 14. The insurer terminated Mr. Gough’s benefits shortly after the “own occupation” period ended, however, in part because Mr. Gough could not show he was receiving appropriate care for symptoms purportedly arising from the temporal lobe epilepsy. *See id.* at \*39.

Among other interesting features of *Gough* was the court’s reliance on the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (“DSM”). In fact, the court granted Mr. Gough’s request that it take judicial notice of a particular version of the text, entitled the Diagnostic and Statistical Manual of Mental Disorders Revised Text (4<sup>th</sup> ed. 2000) (“DSM-IV-TR”). *See id.* at \*8-9. Upon review of Mr. Gough’s request, the court noted that “the Sixth Circuit Court of Appeals has taken judicial notice of the [DSM] as an appropriate standard for diagnosing mental disorders.” *See id.* at \*6 (citation omitted). Although the court acknowledged the insurer’s argument that it is not a court’s role to diagnose medical conditions, the court nonetheless took judicial notice of the contents of DSM-IV-TR for purposes of

adjudicating the parties' cross-motions for judgment on the administrative record. *See id.* at \*7-8.

Cases such as *Gough* teach the importance of having a thorough working knowledge of the DSM. Indeed, as demonstrated by *Gough*, regardless of whether an insurer relied on the DSM, *see id.* at \*7 n.3 (insurer did not rely on the DSM-IV-TR), a court may rely on it as the "appropriate standard for diagnosing mental disorders." Thus, rather than being caught off-guard with a court's or claimant's reliance on the DSM, an evaluation of a mental disability claim should include a review and analysis of the pertinent section(s) of the DSM.

*Gough* also raises an interesting aspect of the requirement that a claimant receive appropriate care for the claimed condition. If a policy contains an appropriate care requirement and a claimant makes an effort to satisfy the requirement, the file should contain a variety of reports indicating both what the appropriate care should be and whether the claimant received it. In *Gough*, for instance, "[a]lthough several doctors referred Plaintiff for psychiatric evaluation and management, Plaintiff evidently did not follow-up on these referrals ...." *Id.* at \*38. Thus, although the nature of care that would be appropriate was made clear by physician referrals, plaintiff's lack of follow-through resulted in there being "no record of him receiving ... medical care and treatment for a psychiatric disorder or condition." *Id.*

One argument sometimes advanced is that the claimant failed to receive appropriate care because he or she is so severely mentally disabled that he or she is unable to appreciate the need for treatment. Given the current state of psychiatric care

and treatment, however, the factual possibility of this case is rare. On the off chance a particular claim may fall within this slim minority, however, a claims examiner may want to review the activities of a claimant along with any restrictions or limitations to see if any such claim could even be asserted.

#### IV. ADDITIONAL CONCERNS IN DEFENDING MENTAL HEALTH DISABILITY CLAIMS

Disability claims based on mental disorders, to a large extent, are based on self-reporting by the insured. Although objective evidence of the condition may never exist, objective evidence that the condition is not as serious or disabling as the claimant contends may exist. Objective evidence, when it is available, also can be particularly helpful in assessing the veracity of the self-reports. As the United States District Court for the District of West Virginia, in a decision affirmed by the Court of Appeals for the Fourth Circuit, explained:

[If objective medical evidence of disability were not required] LTD benefits would be payable to any participant with subjective and effervescent symptomology simply because the symptoms were first passed through the intermediate step of self-reporting to a medical professional. If that were so, Defendants would be greatly hampered in exercising their fiduciary role of carefully scrutinizing self-reporting, preventing malingering, and consequently “guard[ing] the assets of the trust from improper claims, as well as ... pay[ing] legitimate claims.”

*Coffman v. Metro. Life Ins. Co.*, 217 F. Supp. 2d 715, 732 (S.D.W. Va. 2002) (ERISA plan’s objective evidence requirement comports with a plan administrator’s duty under ERISA to protect plan assets), *aff’d*, No. 02-2128, 2003 WL 22293610 (4<sup>th</sup> Cir. Oct. 7, 2003).

A. Developing Objective Evidence Concerning The Severity Of The Mental Condition

One way to begin developing evidence in a mental disability claim is to focus on the tasks the insured claims he or she is no longer able to perform and try to develop evidence to the contrary. In a clinical depression claim, for example, a professional may claim she is no longer able to concentrate and, therefore, cannot attend to her profession. In defense of this claim, inquiry can be made about activities the insured has engaged in since leaving her practice. The insured may reveal, for example, that she has taken up writing short stories in order to occupy her newfound free time. Further inquiry may reveal that, not only was the insured writing short stories, but she was taking writing classes and winning awards for her writing. Ultimately, the point can be made that the insured's ability to perform at such a high level is anathema to her claimed inability to concentrate.

Another way to attempt to obtain objective evidence is through psychological and neuro-psychological testing. *See Tarsio v. Provident Ins. Co.*, 108 F. Supp. 2d 397, 402 (D.N.J. 2000) (suggestion from psychological testing that symptoms of depression were being exaggerated justified granting summary judgment on bad faith claims); *Michael v. Trustmark Ins. Co.*, 16 Mass. L. Rptr. 245 (Mass. Super. 2003). Although some may squabble over the value of this testing, a complete work-up from both a psychological and neuro-psychological testing perspective, generally speaking, is quite valuable. The costs of retaining two qualified experts and performing all of this testing can be substantial. Thus, care should be exercised in deciding whether to pursue this option.

Although drawing a line between the psychological and neuropsychological world is difficult, a leading neuropsychologist explained the difference as follows: (a) psychologists study behavioral and emotional functioning; (b) neuropsychologists study brain function and attempt to assess cognitive skills, including memory, attention, and executive functioning skills. Thus, the more the claim is focused on the inability of the insured to perform cognitive functioning associated with his or her occupation, the more likely it is that neuropsychological testing will prove valuable.

Assuming you decide to pursue testing, what can you expect? Some of the common psychological tests administered include the Minnesota Multi-Phasic Personality Inventory (MMPI), the Symptom Checklist 90 Revised, the Beck Inventory, the Brief Intelligence Test, the Digit Span Test, the Trailmaking Test, and the Depression Scale. In terms of neuropsychological testing, a common battery of tests is referred to as the Halstead-Reitan battery. This battery of tests consists of approximately nineteen different tests and takes several hours to administer.

#### B. Deposition Preparation

In real estate, the three most important words are location, location, and location; in depositing a mental healthcare professional, the three most important words are preparation, preparation, and preparation. If the questioner does not know more than the “expert/provider” knows concerning the claimant’s condition, activities, medical records, test results, tests not performed, and care and treatment administered, then the deposition is lost before it is begun.

Proper preparation begins with a thorough understanding of the medical records, treatment provided, treatment options available, testing performed and not performed, activities of the insured, IME report, and reasons for the differences in views between the IME provider and the treating provider; a thorough knowledge of any articles published by the provider; and, as previously indicated, a complete working knowledge of the pertinent section(s) of the DSM. Absent this base of knowledge, the examiner is unlikely to create any grounds for questioning the accuracy of the various opinions to be expressed by a treating provider.

A key part of the examination of the treating provider is to commit him or her to the universe of what constitutes his or her records. In addition, the examiner will want to have the provider acknowledge that it is his or her practice to maintain complete and accurate medical records and that the records for this particular person are complete and accurate.

If a mental health claim is particularly complex, consider retaining a consulting expert separate and apart from your testifying expert. This person will not have to be disclosed in discovery and will not be open to deposition. This individual will be able to have candid and open discussions concerning the case and the opinions held by various individuals.

If the insurer has not already conducted an IME, then consideration should be given to conducting an examination pursuant to the applicable rules. *See, e.g., Fed. R. Civ. P. 35.* Assuming such an examination is to be conducted, careful consideration should be given to both the qualifications of the person retained and their independence

from the insurer and/or insurer's counsel. A good place to search for highly qualified and independent experts is at the various teaching hospitals around the country.

In an effort to persuade the fact-finder that the opinion of the IME provider is correct, consider how the IME examiner's qualifications, conduct, and/or information may be differentiated from those of the treating provider(s). The IME examiner, for example, may have performed more complete testing than the treating physician or may have reviewed information not available to the treating physician.

Another option in evaluating mental disorder claims is surveillance of the insured. Although surveillance in mental disability claims lacks some of the intrinsic value extant in surveillance of a physical disability claimant, it nonetheless may be valuable in cases where the insured claims his or her condition impairs his or her ability to interact with the world. If surveillance demonstrates routine and normal interactions between the claimant and the world, then the process of disproving the insured's alleged limitations has begun.

In examining a treating provider, generally the best place to start is his or her curriculum vitae. Many physicians and attorneys provide these routinely in an effort to avoid extensive time spent in depositions questioning the treating providers about their background. Although accepting a proffer of a curriculum vitae presents no problem, examination concerning the curriculum vitae and what it means still may be appropriate and necessary. Depending on the nature and extent of the curriculum vitae, it may suffice to simply inquire of the treating provider whether the curriculum vitae provided to you is complete and accurate. With this admission, assuming the information on the curriculum

vitae is clear and understandable, no further inquiry is necessary. If anything on the curriculum vitae is unclear, however, this is the time for clarification.

Generally speaking, cross-examining the treating provider in deposition is not particularly helpful. Consider cross-examination questions, however, if (1) committing the provider to a particular answer is important because, given time, he may come up with a better answer; or (2) the deposition goal is to posture the case for settlement. If the treating provider “expert” becomes worthless as a result of the deposition, then the settlement value should drop substantially.

Frequently, a mental healthcare patient may have seen many healthcare providers. Some of the providers may not agree that the insured either has the condition or is disabled. These providers should be sought out and deposed. Consideration also should be given to creating conflict among the providers on different test results and/or diagnoses. The more conflict created among treating providers, the greater chance there is that a jury may question the legitimacy of the claim.

Claimants often advance the argument that the treating provider should be believed because he or she has seen the claimant for the longest period of time or the most number of times. Highlighting how and why the IME provider reached a different conclusion may overcome the superficial appeal of this argument. Indeed, consideration should be given to asking the IME provider if certain findings would change over time or if the patient was seen more than once. The answer often is no. This line of questioning, of course, suggests that the number of times the patient was seen is less important. Another way to demonstrate that the IME provider is correct is to show that the test

results of the IME provider are similar to or the same as the test results obtained by the treating provider. This again suggests that the difference is not one of time or frequency, but of more subjective interpretation.

Another way to confront the treating provider is to turn the tables. The treating provider may have continued a course of treatment for some time that appears to have been ineffective and may have failed to have considered alternative treatments. Stated differently, the competence of the treating provider to treat the condition may be put into question. This is a particularly effective strategy if the disability policy has an appropriate care clause and the IME provider will testify that the treatment regime was inappropriate.

The proposition that a particular person was an unbiased treating physician also may be open to doubt and challenge. If, for example, the insured consulted his lawyer before seeing a particular physician, and this particular physician was not referred by another healthcare provider, then the “treating provider” may be someone with whom the claimant’s lawyer has a close working relationship. This relationship should, of course, be fair game in attacking the objectivity of the physician as well as the characterization of “treating physician.”

The treating provider also may have a substantial interest in finding the insured disabled in order to earn fees for continuing treatment and billing the health insurer. The treating provider also may receive separate and additional consideration for time spent testifying, which may be at higher rates than those charged for office time. This again suggests financial motive. Consideration should be given to demonstrating that, had the

treating provider found the insured fit to return to work and discharged the insured from his or her care, then several thousand dollars in billings associated with weekly treatments would have disappeared. On top of that, the point can be made that the physician also is being paid for time spent testifying in court, which similarly would disappear if the insured went back to work. In sum, the treating provider may have a powerful financial incentive for confirming disability.

Consider locating deposition testimony by the treating provider in other cases. Various associations maintain databases on experts. If the expert is local, other attorneys may be a source of information. Ask for prior opinions and transcripts in discovery. The prior deposition transcripts should be searched for medical or analytical inconsistencies.

#### V. CONCLUSION

Successful defense of mental health disability claims requires knowledge of the mental health condition(s) at issue, detailed understanding of the mental healthcare process, knowledge of the pertinent medical records, knowledge of the appropriate course of treatment of the mental condition(s) at issue, careful compliance with applicable state and federal law, and a willingness to work hard to lay the foundation for use of information properly gathered during the claim and discovery process. Although defense of mental health disability claims is never easy, the diligent practitioner often is the successful practitioner.