

# **Functional Capacity Evaluations Should Not be Used to Assess the Sustained Vocational Abilities of Individuals Disabled from Chronic Fatigue Syndrome and Fibromyalgia**

**By: Barbara B. Comerford, Esq. and Richard Podell, M.D.**

**Barbara B. Comerford, Esq.  
Law Offices of Barbara B. Comerford  
392 Main Street  
Wyckoff, New Jersey 07481  
201-485-8806; email address:  
[bcomerfordesq@optonline.net](mailto:bcomerfordesq@optonline.net)  
Website: [www.tristatedisabilitylaw.com](http://www.tristatedisabilitylaw.com)**

**Richard Podell, MD, MPH Clinical Professor, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School (105 Morris Avenue, Springfield, NJ, tel. 973 218-9191;**

**Web address: [Dr. Podell.org](http://Dr.Podell.org)**

**(Dr. Podell's portion of the article is adapted from his lecture to the American Conference Institute's 10<sup>th</sup> National Advanced Forum on Resolving Disability Insurance Claims and Litigation, June 2007)**

Functional Capacity Evaluations (FCE) are commonly used by insurance carriers to assess a worker's ability to return to work following a period of disability. While there are a number of peer reviewed scientific studies which challenge the validity of the use of FCEs to assess a worker's ability to successfully return to work in general, this article is limited in its scope.

This article will address the use of FCEs in the context of ERISA long term disability insurance claims to measure the functional abilities of workers disabled from so called "subjective" illnesses such as chronic fatigue syndrome, fibromyalgia or other chronic pain impairments which are not documented by standard diagnostic techniques such as MRIs or x-rays.

ERISA is an acronym for the Employee Retirement Income Security Act of 1974. Except for those employers specifically excluded under ERISA Sec. 4(b), 29 U.S.C. Sec. 1003(b) (federal, state and local government employers) ERISA covers all employee benefit plans as defined in ERISA Sec. 3(3), 29 U.S.C. Sec. 1002(3) (2000).

Other than Social Security Disability benefits, which are paid from the Social Security Trust Fund from FICA payroll taxes, most disability insurance available to workers is provided by employers by virtue of ERISA.<sup>1</sup>

ERISA authorizes suits against fiduciaries and plan administrators in order to remedy a breach of fiduciary duty.<sup>2</sup> Participants in a plan covered by ERISA can file suit to recover benefits due under the terms of the plan, to enforce rights under the terms of the plan, or to clarify rights to future benefits under the plan.<sup>3</sup>

Moreover, Plan administrators are required to provide a clear accounting of why benefits were denied and a full and fair review of any denial of benefits.<sup>4</sup>

While the original ERISA legislation provided for judicial review of benefit denials, the standard of review was not addressed. The two standards of review which have developed are the “arbitrary and capricious” and the “de novo” standards.

The arbitrary and capricious standard imposes deference on the decision of the plan administrator and commonly by extension, the claims administrator. Under that standard of review, the Plan’s decision is not to be disturbed unless the plaintiff can demonstrate the denial was “without reason, unsupported by substantial evidence or erroneous as a matter of law.”<sup>5</sup>

Under the “*de novo*” standard of review, the Courts more consistently adhere to the protective purposes of ERISA to “promote the interests of employees and their beneficiaries in employee benefit plans.”<sup>6</sup>

The “*de novo*” standard exists where the Plan drafters exclude language granting discretion to the Plan decisionmakers.<sup>7</sup>

Not surprisingly, since the 1989 United States Supreme Court decision in **Bruch** created a loophole for Plan drafters to escape de novo review by utilizing language granting “discretion” to Plan fiduciaries in Plan documents, the professionals drafting such plans include such grants of discretion to avoid a *de novo* standard of review.

Where the “*de novo*” standard *is* utilized by a Court, it can examine the case anew, “conducting its own independent evaluation of the evidence in the administrative record” without giving deference to the decision of the plan administrator.<sup>8</sup>

---

<sup>1</sup> 101 Nw. U.L Rev. 1315 Spring 2007, John H. Langbein, Essay: TRUST AS REGULATORY LAW: THE UNUM/PROVIDENT SCANDAL AND JUDICIAL REVIEW OF BENEFIT DENIALS UNDER ERISA

<sup>2</sup> 29 U.S.C. § 1109

<sup>3</sup> 29 U.S.C. § 1132(a)(1)(B)

<sup>4</sup> 29 U.S.C. § 1133

<sup>5</sup> **Abnathya v. Hoffman-LaRoche, Inc.** 2 F3d 40, 45 (3<sup>rd</sup> Cir. 1993)

<sup>6</sup> **Mass. Mut. Life Ins. Co. v. Russell**, 473 U.S. 134, 148 (1985)

<sup>7</sup> **Firestone Tire & Rubber v. Bruch**, 489 U.S. 101, 109 S. Ct 948, 103 L.Ed 2d 80 (1989)

<sup>8</sup> **White v. Coblentz, Patch, Duffy & Bass, LLP Long T.**, 2007 U.S. Dist. LEXIS 36521 (May 2007)

Where a plan grants the administrator discretion, the Court will review the administrator's decision under the arbitrary and capricious standard of review. However, if a fiduciary operates under a "conflict of interest" that conflict must be 'weighed as a factor in determining whether there is an abuse of (that grant of) discretion.'" <sup>9</sup>

That "conflict of interest" analysis was explained by the Third Circuit Court of Appeals in **Pinto v. Reliance Standard Life Ins. Co**<sup>10</sup>

In **Pinto** the Court found that "when an insurer both funds and administers a plan, it operates under a conflict of interest justifying a heightened standard of review...the exact degree by which the review is heightened over the baseline of deferential arbitrary and capricious review is to be evaluated by a sliding scale, 'allowing each case to be examined on its facts...' Relevant factors include the 'sophistication of the parties, the information available to the parties and the exact financial arrangement between the insurer and the company.'" <sup>11</sup>

Following the ruling in **Pinto**, the Third Circuit in **Kosiba v. Merck., et al** interpreted the conflict language in **Pinto** to mean that even when there is no apparent financial conflict of interest, any procedural irregularities, bias or unfairness in the benefits determination process may be evidence of a conflict of interest sufficient to warrant a heightened arbitrary and capricious standard of review. <sup>12</sup>

Examples of procedural bias were provided by the Court in **Patton v. Continental** and include: 1) reliance on opinions of non-treating physicians over treating physicians without good reason (2) conducting a self serving review of the medical records (3) reliance on parts of a medical report favorable to its position and disregarding unfavorable parts (4) denying benefits based on inadequate information and lax investigatory procedures (5) ignoring recommendations of its own employees that benefits be granted or reinstated. <sup>13</sup>

It is within that legal framework that we examine whether the use of FCEs by long term disability insurance carriers to deny the claim of a worker disabled from a subjective illness (which is otherwise documented by substantial medical evidence) demonstrates the actions of a conflicted fiduciary who has abused her discretion where the plan has granted such discretion. As the **Havens** Court noted, a reviewing court must ascertain the level of heightened scrutiny to be applied in such a case, as well as the amount of deference the administrator's decision warrants in relation to the untoward influence resulting from the conflict.

---

<sup>9</sup> **Havens v. Cont'l Cas. Co., 186 Fed. Appx 207, 209 2006 U.S. App. LEXIS 14618 (3<sup>rd</sup> Cir 2006) citing Firestone Tire & Rubber v. Bruch, 489 U.S. 101, 109 quoting Restatement (Second) of Trusts §187, Comment d (1959)**

<sup>10</sup> **214 F3d 377 (3<sup>rd</sup> Cir. 2000)**

<sup>11</sup> **Id at 385**

<sup>12</sup> **384 F3d 58, 68 (3<sup>rd</sup> Cir. 2004)**

<sup>13</sup> **2005 U.S. Dist. LEXIS 5463 (D. NJ 2005)**

And in a case where discretion has not been granted, a reviewing Court must ascertain whether the basis for the denial was proper where the claim is otherwise supported by substantial medical evidence.

Therefore, if a denial in either of the above contexts is based on the results of an FCE in a case where such an evaluation is not a scientific measure of a worker's functional abilities, theoretically, practically and legally such a denial should not stand.

Much of the research on the use of FCE testing has demonstrated that, in many contexts, it is of questionable value, at best. When we limit our focus to the so-called subjective conditions-- chronic fatigue syndrome and fibromyalgia, the evidence justifies a much more negative view.

For chronic fatigue syndrome and fibromyalgia the FCE is a demonstrably false and invalid test, with no credible support whatsoever in the medical or scientific literature. In short, it is "junk science"

What empirical scientific evidence underlies the FCE's claim that measuring hand strength, squatting, balancing and similar activities over a few hours has any relevance to whether a person can in fact work eight hours a day and 40 hours a week, on an on-going basis?

To formally test this crucial question we ran a computer-assisted search of the National Library of Medicine medical literature data base, Entrez PubMed. PubMed contains more than fifteen million health journal articles. It contains essentially all English Language medical publications since 1966, and also a large number of foreign language publications.

Based on the National Library of Medicine's data base there are no published controlled studies at all that support the validity of any currently standard FCE protocol as applied to chronic fatigue syndrome or fibromyalgia. By "no publications", this means literally zero--not one or two publications, but literally zero.

On March 16, 2008 we submitted the keywords: *functional capacity evaluation, FCE, fibromyalgia* and chronic fatigue syndrome.

The keywords fibromyalgia and functional capacity evaluation or FCE identified three single references. However, based on the abstracts of these articles--which are available on line-- neither article assessed the clinical relevance or validity of the FCE as a tool for evaluating FMS disability.

While not evaluating the validity of any specific FCE protocols one article did provide this warning:

"...the evaluation of work capacity requires a rigorous approach, which adopts an integrative bio-psycho-social model...The object of this article is to highlight some difficulties related to the coexistence of medical and legal logics which can sometimes be divergent."

(Perdrix J, Fibromyalgia: how to appreciate work capacity Rev Med Suisse 2007 June 20; 3(116) 1585-7)

A search using the keywords chronic fatigue syndrome and functional capacity evaluation or FCE disclosed six articles. None of these articles provided evidence to support the validity of the FCE for patients with CFS. Indeed, their conclusions tended toward the contrary.

For example consider Van Houdenhove B, Verheyen L, Paradaens K et. Al. Rehabilitation of decreased motor performance in patients with chronic fatigue syndrome: should we treat low effort capacity or reduced effort tolerance:

“This new Heuristic framework may inform future research aimed at disentangling the complex determination of impaired motor performance in CFS, as well as studies aimed at customizing treatment to different subtypes of patients.”

For Example consider Ross SD, Estok RP, Frame D, Stone LR, Ludensky V, Levine CB. Disability and chronic fatigue syndrome: a focus on function Arch Intern Med. 2004 May 24;164(10):1098-107.

Their conclusion states:

*For questions of disability and employment in CFS, the limitations inherent in the current literature are extensive. Methodologically rigorous, longitudinal, and interventional studies are needed to determine baseline characteristics that are associated with the inability to work... Simple and consistent evaluations of functional capacity in patients with CFS are needed.*

For example consider Nijs J De Meirleir K Wolfs S, Duquet W Disability Evaluation in chronic fatigue syndrome: association between exercise capacity and activity limitations/participation restrictions Clin Rehabil. 2004 Mar; 18(2):139-48.

**CONCLUSIONS:** These results suggest a moderate association between exercise capacity and activity limitations/participation restrictions in patients with CFS. **The observed correlations lack strength to predict activity limitations/participation restriction based on exercise capacity parameters...**

For example consider Barrows, D, Functional capacity evaluations of persons with chronic fatigue immune dysfunction system (Am J Occup Ther. 1995 Apr; 49(4):327-37.:

Abstract: Chronic Fatigue Immune Dysfunction Syndrome (CFIDS) is estimated to affect 2 to 5 million people in the United States. Despite its high incidence, persons with CFIDS have been neglected by the medical community mainly because there is no singular confirming diagnostic test or proven effective treatment. The CFIDS population is incorrectly stereotyped as upper-middle-class, white, female hypochondriacs;

consequently, symptoms often are belittled or ignored. **In reality, CFIDS is a severe medical condition that affects women, men, and children of any race and often causes long-term or total disability. The results of a modified functional capacity evaluation developed by the author and completed on 86 persons with CFIDS between 1988 and 1990 confirm that this population has severe physical and cognitive disabilities that affect their professional, familial, and social lives.**

Please note, this study used the authors' own unique and newly formulated FCE protocol. They did not attempt to evaluate any of the FCE protocols that are currently in use. Nor did they attempt to validate their own protocol against a "gold standard" of actual work-place performance.

For example, consider Morriss, R et. al. Exploring the validity of the Chalder Fatigue scale in chronic fatigue syndrome *Psychosom Res.* 1998 Nov; 45(5):411-7.)

The Chalder fatigue scale is widely used to measure physical and mental fatigue... We examined the constructs of the 14-item fatigue scale in a sample of 136 chronic fatigue syndrome patients... There were four factors of fatigue explaining 67% of the total variance. Factor 1 was correlated with subjective everyday cognitive difficulties, concentration difficulties, and a deficit in paired associate learning. Factor 2 was correlated with difficulties in maintaining sleep. Factor 3 was inversely correlated with grip strength, peak VO<sub>2</sub>, peak heart rate, and peak functional work capacity. Factor 4 was correlated with interview and self-rated measures of depression. The results support the validity of mental and physical fatigue subscales and the dropping of the "loss of interest" item in the 11-item version of the fatigue scale

This study did not address standard FCE protocols or attempt to validate their use.

The sixth study in the National Library of Medicine data base was a clinical trial for treating chronic fatigue syndrome with an antiviral medicine. It was not relevant to any current FCE protocols.

In addition, in a summary of FCE research studies discussed in the *Journal of Physical Therapy* by Dr. David Fishbain, M.D, who himself has conducted studies on the reliability of FCEs, he noted that the scientific studies "could not predict actual return to work without taking pain into account...(the study) again points to the limitations of functional capacity testing for predicting whether the patient with chronic pain will or will not be able to function at some job...."<sup>14</sup>

And in yet another study, on the general application of FCE testing, researchers at the University of Alberta concluded that "contrary to functional capacity evaluation theory, better functional capacity evaluation performance as indicated by a lower number of failed tasks was associated with higher risk of recurrence. The validity of functional capacity evaluation's purported ability to identify claimant's who are 'safe' to return to work is therefore questionable at best."

---

<sup>14</sup> *Phys Ther.* Vol 80, No 1, January 2000, pp-110-112

Therefore, so far as can be determined from the published medical literature, there are no published studies that even attempt to validate any of the currently used FCE protocols with regard to their validity for predicting disability among persons with FMS or CFS. Indeed, much of the scientific research raises serious questions about the use of FCEs in general.

The lack of empirical scientific or medical support for FCE should not surprise us because, as now constructed, FCE protocols lack “face validity”. They are asking the wrong questions. They look in the wrong place.

The scientific research overwhelmingly demonstrates the inherent deficiencies in FCE evaluations most notably vis-à-vis CFS and FMS patients.

First, standard FCE testing measures physical abilities. It ordinarily occurs over the course of a few hours on one day, two at most. If an individual complains of pain, the examiner subjectively concludes that the person is self limiting. If the person finishes the tasks, despite pain and other complaints, in an effort to fully cooperate, that individual is falsely deemed to have the ability to work commensurate with the tasks completed during testing: lifting, carrying, pushing, pulling, gripping and grasping etc.. Therefore, such test results, which are based on an individual’s ability to complete the tasks over a limited period of time, are extrapolated to formulate a false conclusion: that the worker has demonstrated the ability to work at sustained vocational level (sedentary, medium, light, heavy, very heavy) 8 hours a day, five days a week.

As the above review of current scientific research studies reveal, there is no scientific or medical basis in the published literature that supports the validity of the FCE’s central extrapolations particularly in CFS and FMS cases. Lacking such scientific or medical bases, extrapolating out from a few hours activities to 40 hours a week is unsound and unreasonable.

Secondly, most of the FCE testing fails to simulate the precise job duties a worker must perform in her own occupation.

Third, FCE evaluators often subjectively determine when a person is “self limiting.” While there are some testers who monitor pulse rates, blood pressure etc., to determine whether complaints of pain are consistent with such measures, there are physicians who have noted that a worker’s use of pain and other medication could well impact such readings. As the above review of FCE research demonstrates, a tester’s subjective conclusions concerning “self limiting” behavior of the test taker raise serious questions about the reliability of the test results. Moreover, these “real time” measures completely fail to assess the dramatic functional declines which occur in the post exertional crash stage.

These FCE deficiencies are apparent. However, use of FCE results is even more egregious when used to measure function in workers disabled from CFS and FMS where the level of function fluctuates from one day to the next. A review of the diagnostic criteria for CFS and FMS is therefore in order.

As Dr. Podell, M.D recently noted in an online article,<sup>15</sup>

“Fibromyalgia’s (FMS) defining symptom is wide spread chronic pain. Symptoms by definition are meant to be ‘subjective.’ They must therefore be based on a patient’s self report. Thus the criteria that define the illness requires that we depend on the patient’s self reports...The American College of Rheumatology Criteria for the diagnosis of fibromyalgia requires one ‘subjective’ along with one...(semi objective) element. That is the patient must complain of chronic wide spread pain affecting all 4 quadrants of the body and also report abnormal pain over at least 11 of 18 predesignated sites (known as tender points) when a standard quantifiable degree of pressure is applied to these sites.”

Chronic Fatigue Syndrome (CFS) is a self reported illness as well. The international definition of Chronic Fatigue Syndrome was established in 1994. This revision of the 1988 Centers for Disease Control case definition remains the currently the accepted research definition, also known as the Fukuda definition, and was based on the presence of the following:

1. Clinically evaluated, unexplained, persistent or relapsing chronic fatigue that is of new or definite onset (has not been lifelong); is not the result of ongoing exertion; is not substantially alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities
2. The concurrent occurrence of four or more of the following symptoms, all of which must have persisted or recurred during 6 or more consecutive months of illness and must not have predated the fatigue:
  - a. Self-reported impairment in short-term memory or concentration severe enough to cause substantial reduction in previous levels of occupational, educational, social, or personal activities
  - b. Tender cervical or axillary lymph nodes
  - c. Muscle pain, multijoint pain without joint swelling or redness
  - d. Headaches of a new type, pattern, or severity
  - e. Unrefreshing sleep
  - f. Postexertional malaise lasting more than 24 hours<sup>16</sup>

These illnesses often result in “good days” and “bad days” which occur on an unpredictable basis.

As a result, an individual disabled from these impairments might have the ability to function sufficiently to perform a couple of activities on a particularly good day, but might then crash for days thereafter where they can barely get out of bed.<sup>17</sup>

---

<sup>15</sup> Spring 2006 Pro Health Immune Support.com: Fibromyalgia, chronic fatigue syndrome, and disability evaluation 3/6/06 adopted from a Paper presented to the American Conference Disability Institute on the same topic

<sup>16</sup> Fukuda, K., Straus, S.E, Hickie, I., Sharpe, M.C, Dobbins, J.G. & Komaroff, A., (1994) The Chronic Fatigue Syndrome: A comprehensive approach to its definition and study. *Annals of Internal Medicine*, 121 (12) :953-959

<sup>17</sup> **“A Consensus Manual for the Primary Care and Management of Chronic Fatigue Syndrome”**, Academy of Medicine of New Jersey, University of Medicine and Dentistry of New Jersey, New Jersey Department of Health & Senior Services 2002

The most crucial difference between the clinical patterns of Fibromyalgia and Chronic Fatigue Syndrome and those of many other illnesses is the delayed post-exertional flare-up phenomenon that typically occurs because of physical effort.

For example, when a person with angina, a lumbar disc or emphysema pushes past their limits, the increase in symptoms typically occurs during the period of exertion. We call this an immediate or acute exertional flare-up. Symptoms increase during the exertion and decrease rapidly once the activity is stopped.

In an observed setting such as a Functional Capacity Evaluation, subjects report increased symptoms in real time. The observer may observe signs of distress and/or objective changes on vital signs, ability to bend over, strength, EKG, oxygen saturation, etc.

In CFS and fibromyalgia the typical clinical pattern is very different. The patient might or might not have increased symptoms during the exertion, but whether they do or do not, their symptoms of fatigue, pain, poor concentration, etc. typically flare some hours or even a day or two later. We call this the delayed post-exertional flare-up phenomenon.

The flare up of pain and/or fatigue typically lasts 24 hours or more. The longer or more often the patient tries to push through, the worse and the longer the flare-up.

In an FCE setting, the subject might appear to be okay at the end of the session, but might then “crash” hours later or the next day. They might then remain more symptomatic for 24 hours or more. Unless, the post-exertional flare-up phenomenon is sought out by the observer, the observer will necessarily be unaware of the negative consequences of the activity session.

This fact alone negates the validity of current FCE protocols. Current protocols do not seek out or attempt to recognize the delayed post-exertional flare-up. Yet a key issue in deciding whether or not a patient is disabled is whether they are, in fact, telling the truth—that modest activity increases symptoms not necessarily during the exertion but hours or a day later.

In principle the truth or falsity of these claims could be objectively determined e.g. by testimony of persons who are familiar with the patient’s usual patterns of activity; by prolonged (and fairly interpreted) video surveillance; by a patient’s wearing a simple device that measures activity (e.g. a pedometer).

The post-exertional flare-up phenomenon is well known to physicians who specialize in treating chronic fatigue syndrome and/or fibromyalgia patients and has been measured in research studies. Reference: Kaufman K and Goodnick P, Depression, Chronic Fatigue Syndrome, and Fibromyalgia: An Update, *Journal of Chronic Fatigue Syndrome*, 2006; 13:77-106.

(This phenomenon is analogous to the delayed post-exertional pain and fatigue that can often be seen among healthy persons who do “eccentric contraction” muscle exercises at levels higher than usual. However, most likely, the mechanisms are different.)

A second aspect of the post exertional flare-up phenomenon is that its severity and duration both tend to increase with repeated attempts to exceed the patient’s limits.

Thus a fibromyalgia or chronic fatigue syndrome patient who pushes beyond their limits for 4 or 6 hours on one single day may have some degree of flare-up the next day. But if that same individual repeats the same activity for two days in a row, the symptom flare-up would typically be more severe and the duration of flare-up would typically be longer. All the more so if that activity were to continue to be pushed through e.g. for five days in a row—as in a work week.

The take home lesson here is that an individual who can perform at a relatively high level for just a few hours might or might not have the reserve and stamina to maintain that level of performance on a regular basis day after day and week after week. One subject can; another cannot. But, limited short term observations cannot tell us which is which.

Once again, it must be emphasized that the FCE extrapolation is not valid for these critical reasons: It lacks face validity, because the FCE fails to evaluate precisely the main reason that persons with CFS/FMS claims prevent them from working. (Their most frequent reason for not being able to work is that prolonged exertion over one or several days is likely to cause their symptoms to flare up severely over the next days, and to remain worse for an extended period of time.).

Typically FCE protocols make no attempt to assess the status of patients during the days after repeated increased activity. The FCE does not even seek to address the central component of why most persons with severe CFS/FMS claim as the reason they cannot work. For that reason alone, current FCE protocols lack even face validity. That there is no empirical medical or scientific justification for using FCE protocols to predict long term ability to work—that simply compounds the error.

However, there is an objective basis for judging the credibility of the patient’s self-report and how, in fact, they live their lives. What is objective is the paper trail of medical records, the medical opinion of physicians, appropriate surveillance records and other information that increases or decreases confidence that the self-reports are accurate. This requires interpreting the data as it applies for each specific claimant.

Therefore, using the results of an FCE administered over the course of a few hours on one or two days is hardly appropriate in cases such as this. Moreover, surveillance conducted over a few hours or days is unreliable for the same reasons.

In the context of an ERISA LTD case, there are a few ways to challenge the use of such “evidence.” In discussing the improper denial of benefits to an ERISA LTD claimant, the Third Circuit in Havens utilized the Rules of Evidence to dismiss the conclusions made by the insurer’s vocational expert. The Court held, “It is not rationale to defer to such experts in the absence of a threshold indication that their conclusions, in the words of Federal Rules of Evidence 702, are the product of ‘reliable principles and methods...applied...reliably to the facts of the case.’”<sup>18</sup>

The same rationale used by the Havens Court in looking for guidance from FRE 702 could be utilized in a case where an insurer orders an FCE in an FMS or CFS case. By definition, these illnesses result in functional variations from one day to the next for those who suffer from them. Therefore, measuring a claimant’s level of function on a “good day” creates an illusory impression of the claimant’s overall functional abilities. Therefore, it would hardly be rationale to defer to such test results in the “absence of a threshold indication that such conclusions “are the product of reliable principles and methods...applied...reliably to the facts of the case.”

It would be the equivalent of an insurer arguing that a normal MRI of the brain be considered a “reliable method...applied...reliably to the facts of the case” where the person claimed disability from a leg amputation.

To utilize the results of an FCE test administered for a few hours over a day or two to deny ERISA LTD benefits to a worker disabled from chronic fatigue syndrome and fibromyalgia should automatically raise the specter of a conflicted fiduciary and cause a Court to employ a heightened level of scrutiny. As was noted above, these illnesses result in dramatic functional fluctuations from one day to the next, and cause those who suffer from them to experience “good days” and “bad days.”

On good days, such individuals can perform some activities, on bad days they are often bedridden. So by definition, someone suffering from CFS or FMS is experiencing a “good day” or two when she is well enough to appear for FCE testing. Whatever abilities she may demonstrate during such testing is hardly indicative of her sustained work abilities, particularly since individuals who suffer from these illnesses experience “post exertional” malaise (see the Fukuda definition above) in the aftermath of any activity. And as was noted above, the problem of post exertional crashes is that, over time, the more post exertional crashes a patient suffers, the more debilitating the symptoms become.

Therefore, someone disabled with severe CFS who accepts as true FCE results that she could work at a sustained vocational level and attempts a return to work based on those findings, might well suffer a debilitating cycle of working and crashing causing a much more incapacitating form of the illness. Therefore the industry wide practice of using FCEs in such cases is more than a harmless exercise in an effort to fit a square peg into a round hole. In CFS cases, it can exacerbate already devastating symptoms over the short run, and cause even more debilitating symptoms over the long term if successfully used to reintroduce such a person back into the workforce.

---

<sup>18</sup> Havens v. Cont’l Cas. Co., 186 Fed. Appx 207 at 210 citing FRE 702

As noted in Appleman's treatise, "the insured is considered to be disabled where it is impossible for him to work without hazarding his health..."In fact, this proposition is sufficiently well settled that in many jurisdictions it travels under the name of the "common care and prudence rule."<sup>19</sup> Forcing a worker disabled from these conditions to undergo FCE testing at all violates such principles. Utilizing FCE test results to compel such individuals to return to work is even more egregious.

Moreover, because the scientific research confirms individuals suffering from these illnesses cannot predict what their level of function will be from one day to the next it simply defies reason to demand that such a person submit to such an exam.

In an recent unpublished New Jersey Federal District Court decision, **Lyon v. Kimberly Clark Corp. Pension Plan**, Judge Kugler citing **Holzschuh v. Unum Life Ins. Co. of Am.**, concluded that a Pension Committee's final denial of Ms. Lyon's claim for permanent disability from a variety of musculoskeletal impairments based in part on her failure to submit to a functional capacity evaluation was arbitrary and capricious noting that such a finding improperly required her to satisfy conditions which were not part of the policy.<sup>20</sup>

Therefore, one could well argue, that where the policy is silent on whether a claimant is required to undergo a functional capacity evaluation to support the functional limitations alleged, failure to submit to such an evaluation should not result in a denial of benefits. Indeed, under the above ruling it is arbitrary and capricious for an insurer to deny or terminate benefits if such a claimant refuses to undergo a functional capacity evaluation.

A federal District Court in the Northern District of Georgia, in denying the motion for summary judgment sought by Hartford, the long term disability insurance carrier which had denied a claimant with fibromyalgia based on the results of a functional capacity evaluation, held, "Such tests have at times been described by courts in this Circuit as 'the best means of assessing an individual's function level.'...Nevertheless, the evidence before the Court suggests that, in this instance, the reliability of the evaluation in assessing Plaintiff's disability status is open to debate. The third-party service provider that performed the evaluation (selected by Hartford) appears to have been a physical therapist. While such a professional is typically well-suited to conducting evaluations of a patient's physical capacity, and extrapolating therefrom what tasks the individual is capable of performing, the inherent nature of Plaintiff's disease (as described by her doctors) is prone to unpredictable and frequent remission and relapse...(see exhibits regarding the waxing and waning course of the disease and plaintiff's deteriorating condition immediately following the

---

<sup>19</sup> E.L Kellett, Annotation, **Continuation of Work as Affecting Finding of Total or Permanent Disability within Insurance Coverage**, 24 **A.L.R 3<sup>rd</sup> 8 Sec. 3(a)**

<sup>20</sup> **2007 U.S. Dist. LEXIS 46424 (D. N.J. June 2007) citing Holzschuh v. Unum Life Ins. Co. of Am., 2002 U.S. Dist. LEXIS 13205, No. 03-1035, 2002 WL 1609983, at 6, 8 (E.D. Pa. July 18, 2002)**

evaluation)...(her doctor) stated, “By definition, fibromyalgia leaves a patient with episodes of ...unstable... physical capabilities...”<sup>21</sup>

In **Stup v. Unum Life Insurance Company of America**<sup>22</sup> the Fourth Circuit expressed concern about the validity of FCE testing and the long term disability insurance carrier’s reliance on the FCE results in denying benefits. The Court was not persuaded that extrapolating test results from two and a half hours of testing to measure sustained work abilities in an 8 hour work day was valid.

In conclusion, the value of functional capacity evaluations to determine a worker’s ability to return to work is questionable at best. However, use of the FCE to deny ERISA LTD benefits to a worker disabled from chronic fatigue syndrome and fibromyalgia is at a minimum evidence of a conflicted fiduciary in that such testing has no evidential value, and in general it lacks all indicia of reliability in such a context. The reliability problems inherent in FCEs which include failure to reproduce all work demands, physical and mental; inability to accurately measure sustained work abilities, and the subjective input of those administering the tests are considerable. But the extrapolation of such test results to establish sustained work ability lacks all facial validity when an individual’s disability causes unpredictable, dramatic functional fluctuations from one day to the next.

---

<sup>21</sup> **Wise v. Hartford Life & Accident Ins. Co., 360 F. Supp. 2d 1310; 2005 U.S. Dist. LEXIS 8916 (D. N.Ga. 2005)**  
<sup>22</sup> **390 F.3d 301 (4<sup>th</sup> Cir. 2004)**