Tackling Disability Defenses in TBI Cases

Don't let these seven common defense tactics derail your client's TBI claim.

By || **Jennifer Hess**

Defendants commonly raise several defenses in cases involving disability due to traumatic brain injuries (TBIs). These defenses range from characterizing the TBI as a mental illness, to labeling symptoms as subjective or atypical, to using substandard or inappropriate medical review.

Insights into these defenses are valuable for attorneys representing clients suffering from TBIs—whether in the long-term disability context, where I practice, or in other types of cases. Here are seven common defense strategies, together with effective cross-practice strategies to counter them.

1 Characterizing TBI Symptoms as Mental Illness

In my practice, I often come across long-term disability insurers that portray my client's TBI-related functional impairments as stemming from mental health conditions. This tactic is due to limitations for mental health conditions in disability policies—known as a "mental illness limitation"—usually capping benefits at 24 months. If successful, the tactic reduces long-term financial liability for insurers by limiting payments to a 24-month period instead of until the claimant's retirement age.[1] Understanding this defense narrative is key for attorneys in all practice areas when handling a TBI case—it can undermine all claims if not counteracted effectively.

To counter this defense, start by identifying objective physical abnormalities. Begin with concrete diagnostic results, such as abnormal neuroimaging. These are not typically linked to mental illness and can be reinforced by clinical symptoms such as impaired balance, altered vision, and more. Medical experts can correlate these markers to the TBI, making it difficult for insurers to misclassify the claim.

If cognitive impairments are present in your client, objective tests can help clarify their origins. A comprehensive neuropsychological evaluation can delineate whether these cognitive impairments are due to an organic brain injury or a mental health condition. Correlating the neuropsychological results with the results of the other objective tests can offer additional insights and solidify your case.

Also gather opinions on fatigue. In my experience, fatigue often is a gray area that long-term disability insurers capitalize on and attribute to mental health. Opinions from treating and consulting medical experts correlating the nature, duration, and frequency of fatigue to the TBI can counter this argument. Providing context, such as the client's prior activity levels, can also support your case.

Finally, clarify the timing and onset of your client's mental health symptoms. Did the mental health symptoms exist before but were not disabling, or did they emerge after the injury? Medical experts can help distinguish the timing and onset of these symptoms, which is vital for challenging the insurer.

For example, a provider can specify if depression is secondary to the TBI. If mental health symptoms such as depression were present before the TBI, have the treating psychiatrist or psychologist clarify how these symptoms did not previously impact your client's ability to function. They should detail the difference in your client's condition before and after the injury, highlighting the changes in clinical presentation.

Conversely, if the mental health symptoms emerged following the TBI, shift the focus more toward the input of the expert neurologists and neuropsychologists involved in the case. These experts should explain the nature of the symptoms and detail why the cognitive decline is consistent with TBI outcomes and not solely attributable to depression.

2 Defensive Neuropsychological Evaluations

I have often encountered long-term disability insurers that use defensive neuropsychological evaluations to save resources and support benefit denials.[2] These evaluations are typically less comprehensive than full neuropsychological tests and might contain unsupported conclusions—for example, that my client has no cognitive impairment or is malingering or exaggerating symptoms. It's necessary to recognize the limitations and biases of these evaluations to effectively challenge them across all TBI cases.

Keep in mind that while the insurers may label the evaluators as "independent," they often are selected and paid by the insurer under a contractual service agreement with no input from the claimant. This financial tie raises concerns about their objectivity. Spotlight this service agreement, together with compensation and review volume, to cast doubt on both the evaluator's neutrality and credibility.

I've also found in my long-term disability practice that defensive neuropsychological evaluations often omit crucial tests. Compare the tests given to more comprehensive ones a treating neuropsychologist or an independently vetted expert neuropsychologist might offer. This can expose selective testing that portrays your client negatively. It also weakens the reliability of evaluation findings and conclusions drawn from those findings.

Neuropsychological evaluations generate raw data, including test scores and responses. It's crucial for attorneys to not only obtain this raw data but to scrutinize it thoroughly with the help of an expert. By doing so, you can identify potential scoring errors, incomplete or missing pages, or instances where answers were altered, all of which may impact the reliability of the conclusions drawn in the report.

Enlist the help of a truly independent neuropsychologist expert who is skilled in analyzing such data to identify any contradictions between the raw data and the evaluator's conclusions. This examination helps strengthen your challenge to the report. For instance, defense reports might acknowledge certain cognitive deficits yet claim the deficits do not amount to actual impairment. Here, it is essential to highlight inconsistencies between the raw data and the report's conclusions to effectively challenge the evaluator's credibility.

Additionally, I recommend ensuring that your expert and the legal team discuss not just the data included in

the report but also what was omitted. Information that appears in the raw data but is left out of the evaluator's report can be particularly telling.

3 Defensive Non-Examining Peer Reviewers

In my practice, it is not uncommon for insurer-selected physicians to conduct exams. However, *non-examining* medical peer reviews by doctors that long-term disability insurers employ are far more prevalent.[3] Almost *every* disability claim will be reviewed by at least three non-examining reviewers. I have seen as many as eight. These doctors review a high volume of files annually, raising questions about the thoroughness and potential bias of each review.

In personal injury contexts, these reviews wouldn't even meet the *Daubert* standard for admissibility of expert witness testimony. This standard requires that the methodology underlying the testimony must be scientifically valid and applicable to the facts of the case. Non-examining peer reviews often lack direct examination and an objective basis in individual case nuances, undermining their scientific validity.

These non-examining reviewers often comment on subjective symptoms, such as pain and fatigue, that they have not directly observed in a clinical setting. This lack of direct evaluation can lead to significant misunderstandings about the nature of your client's condition, especially when these symptoms are predominantly subjective. In the context of disability claims, insurers' reliance on conclusions drawn by non-examining reviewers has been consistently undermined in court.[4]

In my experience, reviewers working for insurers are usually biased. Many reviewers are in-house and salaried by the insurer. Address this inherent bias. Seek discovery related to their compensation and review statistics. Examine the volume of reviews conducted. Dive into compensation structures, including how promotions or career advancements are linked to claim outcomes. Scrutinize performance evaluations. Additionally, assess the frequency of court challenges against the reviewer's opinions, analyze error rates, and review outcomes to identify patterns that may indicate biased assessments or inconsistencies in their reviews.

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Also highlight any deficiencies in the quality of the review. Non-examining reviewers often work with incomplete files, leading to factual errors and internal inconsistencies. Spotlighting these deficiencies can undermine their reliability, complementing the above strategies.

4 The "Subjective Symptom" Defense Narrative

Defendants often use the "subjective symptom" narrative in TBI cases.[5] They argue that symptoms such as headaches, memory problems, and mood changes that your client reported are subjective and cannot be objectively measured. In long-term disability cases, insurers use this to deny benefits. This defense may also apply in long-term disability cases if the policy limits benefits for "subjective symptoms."

To successfully counter this defense and enhance your client's credibility, present medical documentation to establish a clear link between the reported symptoms and the TBI. Objective tests such as advanced neuroimaging and neuropsychological evaluations can provide strong evidence.

I also recommend highlighting your client's consistent reporting of symptoms over time and how these symptoms affect their daily life, employment, and social activities. This demonstrates the real-world impact. In addition, emphasize evidence of your client's ongoing treatment efforts, including medical appointments, therapies, and medications.

Finally, keep in mind when handling insurance cases that some jurisdictions bar "subjective symptom" limitations.[6] Be sure to check the relevant state laws.

5 The "Atypical Progression" Defense Narrative

Another common defense tactic in TBI cases is the "atypical progression" narrative.[7] Defendants label a claim as "atypical" when symptoms don't follow the expected recovery pattern, aiming to cast doubt on its validity.

The best way to offset this narrative is by presenting strong medical documentation of persistent objective abnormalities. This should include your client's diagnostic tests, clinical findings upon examination, and objective evaluations, such as neuropsychological or vestibular evaluations. By showcasing these persistent objective abnormalities, you can demonstrate that the symptoms are not up for debate and that they simply exist, irrespective of what is considered a typical progression.

TBI specialists can offer invaluable

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medical opinions that debunk the "atypical" narrative. Their extensive training and experience lend them the authority to explain why a particular case may not follow the typical trajectory.

Also look at research from reputable medical journals or renowned experts that can help establish that prolonged or worsening TBI symptoms are not outliers but well-documented phenomena. This evidence-based approach can make it difficult for insurers to dismiss the case based on their own preconceived ideas of what constitutes a typical TBI case.

Additionally, look for cases discussing "atypical" presentation in TBI claims to bolster your argument. By citing such cases, you add substantial weight to your claim, potentially discouraging defendants from sticking with their "atypical" argument.

6 Treatment Notes Versus Treating Opinions

In handling long-term disability cases, I've found that insurers often insist on strict alignment between medical records and physician opinions to undermine TBI claims. However, this tactic is unrealistic due to the differing purposes of these documents.[8] Successfully challenging this approach not only impacts the immediate case but also can set a broader precedent, weakening defendants' reliance on this tactic across various types of disability and injury cases.

Stressing the specialist's expertise can invalidate the defendant's focus on medical record consistency. TBI specialists, for example, have a wealth of expertise in diagnosing and treating complex neurological conditions. Their in-depth knowledge allows them to make nuanced judgments that may not be immediately apparent in medical records.

Encourage treating physicians to articulate their reasoning comprehensively. This can provide a much-needed bridge between medical records and specialist evaluations, negating the claims of inconsistency.

In addition, enlighten the insurer, court, and any mediator about the intended use of medical records. These documents are for clinical use and are not designed to stand alone in, for instance, disability evaluations. In my practice, I use this distinction to help invalidate the insurer's argument.

Consider incorporating additional types of evidence, such as testimonies, therapy notes, or journals. These can paint a fuller picture of your client's condition. I have found this makes it difficult for an insurer to base its denial solely on the issue of medical record consistency.

7 Surveillance Footage

In TBI cases, defendants may use surveillance to challenge your client's reported limitations. In insurance cases, the aim is to deny or terminate benefits.[9] This is particularly impactful when symptoms are often invisible and variable. Understanding the role of surveillance is vital for ensuring your client's credibility and for anticipating defense tactics.

Start by assessing the legitimacy of the surveillance footage. I've encountered long-term disability carriers that have misidentified claimants. Also note the context and emphasize variability. Surveillance footage seldom captures fluctuating or invisible TBI symptoms, such as headaches or mental fog, that may be debilitating for your client. Emphasize that the footage might capture a good day but is not indicative of your client's overall condition. In addition, address any time gaps. Surveillance does not capture the entire day or all the TBI symptoms experienced throughout it.

Always validate the activities observed in the surveillance footage with medical evidence. Get medical experts to confirm the limitations and variable symptoms your client experiences, even if not apparent in the footage. Check for bias, professional qualifications of investigators, and whether the TBI symptoms were correctly interpreted. In complex cases, consult surveillance experts to identify loopholes and inconsistencies in the methods used.

Additionally, be vigilant for any signs that the defendants might have altered or edited the surveillance footage to misrepresent the claimant's condition. Ensure that any discrepancies or signs of manipulation are thoroughly investigated and documented to challenge the credibility of the evidence presented. Hiring a surveillance expert can help with this.

Confronting TBI-related defenses requires a collaborative approach. Successfully challenging defense tactics benefits not only your client but also the broader TBI-related disabilities community by shaping future cases. T

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Notes

1. *See, e.g.*, *Aucoin v. LifeMap Assurance Co.*, 2023 WL 5836035, at *5 (W.D. La. Sept. 8, 2023); *Goodman v. First Unum Life Ins. Co.*, 2023 WL 3224481, at *6, 11 (W.D. Wash. May 3, 2023); *Lewis v. First Unum Life Ins. Co. of Am.*, 2023 WL 2687284, at *23 (D. Conn. Mar. 29, 2023); *Proctor v. Unum Life Ins. Co. of Am.*, 2022 WL 4585278, at *8–10, 14–15 (D. Minn. Sept. 29, 2022); *Brooks v. Hartford Life & Accident Ins. Co.*, 525 F. Supp. 3d 687, 695, 699–700, 702–03 (E.D. Va. 2021), *vacated in part*, 2021 WL 9958667 (E.D. Va. Apr. 5, 2021), *and aff'd*, 2022 WL 2800813 (4th Cir. July 18, 2022); *Meyer v. Unum Life Ins. Co. of Am.*, 2021 WL 1102443, at *13 (C.D. Cal. Mar. 23, 2021); *Twigg v. Reliastar Life Ins. Co.*, 2020 WL 5819547, at *5–6, 11 (W.D. Ky. Sept. 11, 2020); *Ampe v. Prudential Ins. Co. of Am.*, 2018 WL 5045184, at *5 (D. Mass. Oct. 17,

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2018); *Pagendarm v. Life Ins. Co. of N. Am.*, 2017 WL 6405617, at *2 (N.D. Cal. Dec. 15, 2017); *Horn v. Life Ins. Co. of N. Am.*, 2015 WL 4477039, at *8 (E.D. Pa. July 22, 2015); *Atkins v. Guardian Life Ins. Co. of Am.*, 969 F. Supp. 2d 788, 794–95 (E.D. Ky. 2013); *Henarie v. Prudential Ins. Co. of Am.*, 2013 WL 2359009, at *2 (D. Or. May 29, 2013); *White v. Prudential Ins. Co. of Am.*, 908 F. Supp. 2d 618, 635–36 (E.D. Pa. 2012).

2. *See, e.g.*, *Rhodes v. First Reliance Std. Life Ins. Co.*, 670 F. Supp. 3d 119, 122 (S.D.N.Y. 2023); *Kopesky v. Aetna Life Ins. Co.*, 2022 WL 2304505, at *2 (E.D. Wis. June 27, 2022); *Twigg*, 2020 WL 5819547, at *5; *Anyanwu v. Ascension Health*, 2019 WL 2211057, at *11 (E.D. Mo. May 22, 2019); *Oster v. Std. Ins. Co.*, 759 F. Supp. 2d 1172, 1180–81 (N.D. Cal. 2011).
3. *See, e.g.*, *Quigley v. Unum Life Ins. Co. of Am.*, 2023 WL 6387021, at *2 (S.D.N.Y. Sept. 29, 2023); *Goodman*, 2023 WL 3224481, at *9–10; *Lewis*, 2023 WL 2687284, at *34; *Meyer*, 2021 WL 1102443, at *19–23; *Bethany Coleman-Fire v. Standard Ins. Co.*, 2019 WL 2011039, at *6, 8 (D. Or. May 7, 2019); *Ampe*, 2018 WL 5045184, at *5; *Mendez v. FedEx Express*, 2016 WL 4429598, at *5 (E.D. Mich. Aug. 22, 2016); *Henarie*, 2013 WL 2359009, at *6.
4. *See, e.g.*, *Chicco v. First Unum Life Ins. Co.*, 2022 WL621985, at 4 (S.D.N.Y. Mar. 3, 2022) (for "a disability claim based on complaints of pain . . . it is also significant that none of First Unum's physicians personally examined [plaintiff]"); *Khan v. Provident Life & Acc. Ins. Co.*, 386 F. Supp. 3d 251, 278–79 (W.D.N.Y. 2019) (because a claimant's disability was "based in large part on his subjective sensations of fatigue and pain," Provident's reliance on non-examining reviewers raised "questions about the thoroughness and accuracy of the benefits determination"); *Johnson v. Guardian Life Ins. Co. of Am.*, 2017 WL 4870909, at *16–17 (D. Conn. Oct. 27, 2017); *Diamond v. Reliance Std. Life Ins.*, 672 F. Supp. 2d 530, 537 (S.D.N.Y. 2009) ("especially when the chief symptoms of the illnesses are subjective . . . due weight should be given to the treating physician's findings").
5. *See, e.g.*, *Aucoin*, 2023 WL 5836035, at *2; *Shimomura v. Unum Life Ins. Co. of Am.*, 2023 WL 5042930, at *17 (D. Or. July 3, 2023); *Goodman*, 2023 WL 3224481, at *11; *Lewis*, 2023 WL 2687284, at *26; *Proctor*, 2022 WL 4585278, at *6, 10, 14–15; *Brooks*, 525 F. Supp. 3d at 697.
6. *See, e.g.*, N.Y. Comp. Codes R. & Regs. 11 §52.16(c) (2018).
7. *See, e.g.*, *Shimomura*, 2023 WL 5042930, at *9, 13, 18; *Goodman*, 2023 WL 3224481, at *7; *Lewis*, 2023 WL 2687284, at *20; *Brooks*, 525 F. Supp. 3d at 695; *Proctor*, 2022 WL 4585278, at *6, 8; *Meyer*, 2021 WL 1102443, at *7, 12, 14; *Jennifer L. v. United of Omaha Life Ins. Co.*, 2020 WL 5659483, at *3–4, 7 (D. Utah Sept. 23, 2020); *Bethany Coleman-Fire*, 2019 WL 2011039, at *11; *Anyanwu*, 2019 WL 2211057, at *12; *Landeck v. Unum Life Ins. Co. of Am.*, 2018 WL 11472373, at *8 (N.D. Cal. Oct. 15, 2018).
8. *See, e.g.*, *Goodman*, 2023 WL 3224481, at *7; *Proctor*, 2022 WL 4585278, at *6; *Brooks*, 525 F. Supp. 3d at 697, 702.
9. *See, e.g.*, *Cohen v. Aetna Life Ins. Co.*, 2020 WL 4283959, at *8 (C.D. Cal. July 27, 2020); *Henarie*, 2013 WL 2359009, at *9.