

2004

# Linda Malan Hilton v. Utah State Retirement Board, Long Term Disability Program : Brief of Appellant

Utah Court of Appeals

Follow this and additional works at: [https://digitalcommons.law.byu.edu/byu\\_ca2](https://digitalcommons.law.byu.edu/byu_ca2)



Part of the [Law Commons](#)

Original Brief Submitted to the Utah Court of Appeals; digitized by the Howard W. Hunter Law Library, J. Reuben Clark Law School, Brigham Young University, Provo, Utah; machine-generated OCR, may contain errors.

Loren M. Lambert; Arrow Legal Solutions Group; Attorney for Appellant.

David B. Hansen; Howard Phillips and Anderson; Attorney for Appellee.

---

## Recommended Citation

Brief of Appellant, *Hilton v. Utah State Retirement Board*, No. 20040950 (Utah Court of Appeals, 2004).  
[https://digitalcommons.law.byu.edu/byu\\_ca2/5342](https://digitalcommons.law.byu.edu/byu_ca2/5342)

This Brief of Appellant is brought to you for free and open access by BYU Law Digital Commons. It has been accepted for inclusion in Utah Court of Appeals Briefs by an authorized administrator of BYU Law Digital Commons. Policies regarding these Utah briefs are available at [http://digitalcommons.law.byu.edu/utah\\_court\\_briefs/policies.html](http://digitalcommons.law.byu.edu/utah_court_briefs/policies.html). Please contact the Repository Manager at [hunterlawlibrary@byu.edu](mailto:hunterlawlibrary@byu.edu) with questions or feedback.

---

IN THE UTAH COURT OF APPEALS

---

LINDA MALAN HILTON,

**BRIEF OF THE PETITIONER**

Appellant/Petitioner,

vs..

Case No. 20040950-CA

UTAH STATE RETIREMENT BOARD,  
LONG TERM DISABILITY PROGRAM,

Appellee/Respondent.

---

**AN APPEAL FROM A FORMAL AGENCY ADJUDICATION DENYING  
DISABILITY BENEFITS  
HEARING OFFICER JAMES L. BARKER, JR. PRESIDING**

---

David B. Hansen  
HOWARD PHILLIPS & ANDERSON  
Attorney for Respondent/Appellee  
560 East 200 South, Suite 300  
Salt Lake City, UT 84102

LOREN M. LAMBERT No. 5101  
ARROW LEGAL SOLUTIONS GROUP, PC  
Attorney for Petitioner/Appellant  
266 East 7200 South  
Midvale, Utah 84047  
Telephone 801-568-0041

**UTAH COURT OF APPEALS  
BRIEF**

**UTAH  
DOCUMENT  
KFU  
50**

**.A10  
DOCKET NO. 2004 0950-CA**

**FILED  
UTAH APPELLATE COURTS  
JAN 26 2005**

---

**IN THE UTAH COURT OF APPEALS**

---

LINDA MALAN HILTON,

**BRIEF OF THE PETITIONER**

Appellant/Petitioner,

vs..

Case No. 20040950-CA

UTAH STATE RETIREMENT BOARD,  
LONG TERM DISABILITY PROGRAM,

Appellee/Respondent.

---

**AN APPEAL FROM A FORMAL AGENCY ADJUDICATION DENYING  
DISABILITY BENEFITS  
HEARING OFFICER JAMES L. BARKER, JR. PRESIDING**

---

David B. Hansen  
HOWARD PHILLIPS & ANDERSON  
Attorney for Respondent/Appellee  
560 East 200 South, Suite 300  
Salt Lake City, UT 84102

LOREN M. LAMBERT No. 5101  
ARROW LEGAL SOLUTIONS GROUP, PC  
Attorney for Petitioner/Appellant  
266 East 7200 South  
Midvale, Utah 84047  
Telephone 801-568-0041

## PARTIES TO THE PROCEEDINGS BELOW

The caption of the case on appeal contains the names of all parties to the proceedings in the district court.

## TABLE OF CONTENTS

TABLE OF AUTHORITIES .....	ii
STATEMENT OF JURISDICTION .....	1
STATEMENT OF THE ISSUES AND STANDARD OF REVIEW .....	1
FIRST ISSUE ON APPEAL: Did the Hearing Officer (HO) Err by Concluding That There Was No Objective Evidence of Petitioner’s Disability, by Requiring an “Impairment Rating” and by Applying the Utah Worker’s Compensation Guidelines? .....	1
SECOND ISSUE ON APPEAL: To Prove the Severity of Petitioner’s Disability Did the Hearing Officer Err by Requiring Objective Evidence at the Exclusion of Subjective Evidence? .....	1
THIRD ISSUE ON APPEAL: Did the HO Err by Failing to Find Petitioner Disabled By Considering the Combined Effect of Petitioner’s Impairments and by Failing to Take into Consideration Petitioner’s SSA Determination? .....	1
FOURTH ISSUE ON APPEAL: Did the HO Err by Finding Dr. Knorpp’s Testimony to Be Credible and Persuasive? .....	2
FIFTH ISSUE ON APPEAL: Did the Hearing Officer Err by Failing to Draft Detailed Findings of Fact, Conclusions of Law and the Final Order? .....	2
CONSTITUTIONAL PROVISIONS, STATUTES, AND RULES .....	3
STATEMENT OF THE CASE .....	3
SUMMARY OF PROCEEDINGS BELOW .....	3
SUMMARY OF FACTS .....	6
SUMMARY OF ARGUMENTS .....	26
ARGUMENTS .....	28

I.	Did the Hearing Officer Err by Concluding That There Was No Objective Evidence of Petitioner’s Disability, by Requiring an “Impairment Rating” and by Applying the Utah Worker’s Compensation Guidelines? . . . . .	28
II.	To Prove the Severity of Petitioner’s Disability Did the Hearing Officer Err by Requiring Objective Evidence at the Exclusion of Subjective Evidence? . . .	34
III.	Did the Hearing Officer Err by Failing to Find Petitioner Disabled By Considering the Combined Effect of Petitioner’s Impairments and by Failing to Take into Consideration Petitioner’s SSA Determination? . . . . .	37
IV.	Did the Hearing Officer Err by Finding Dr. Knorpp’s Testimony to Be Credible and Persuasive? . . . . .	42
V.	Did the Hearing Officer Err by Failing to Draft Detailed Findings of Fact, Conclusions of Law and the Final Order? . . . . .	47
	CONCLUSION . . . . .	49
	CERTIFICATE OF SERVICE . . . . .	50
	ADDENDUM . . . . .	51

## TABLE OF AUTHORITIES

### CASES

<i>Alder v. Bayer Corporation</i> , 61 P.3d 1068, 1077-1078, footnotes 4, 6 (Utah 2002) .....	31
<i>Austin v. Continental Casualty Company</i> , 216 F.Supp.2d 515, 553, 555-556 (W.D.N.C. 2002) .....	41
<i>Foreman V. Foreman</i> , 176 P.2d 144 (Utah 1946) .....	5, 48
<i>Govindarajan v. FMC Corp.</i> , 932 F.2d 634, 637 (7 <sup>th</sup> Cir. 1991) .....	43
<i>Hyatt v. Sullivan</i> , 899 F.2d 329, 336 (4 <sup>th</sup> Cir. 1990) .....	35
<i>Industrial Power Contractors v. Industrial Comm.</i> , 32 P.2d 477 (Ut. Ct. App. 1992) .....	30
<i>Layton v. Heckler</i> , 726 F.2d 440, 442 (8 <sup>th</sup> Cir. 1984) .....	38
<i>Mickles v. Shalala</i> , 29 F.3d 998 (4 <sup>th</sup> Cir. 1994) .....	35
<i>Mitchell v. Schweiker</i> , 699 F.2d 185, 187 (4 <sup>th</sup> Cir. 1983) .....	38
<i>Morton v. State Tax Comm.</i> , 814 P.2d 581, 588-89 (Utah 1991) .....	1
<i>Sanderson v. Continental Casualty Corp.</i> , to 79 F.Supp. 2nd 466, 417, 473-476 (D. Del. 2003) .....	33
<i>State v. Rimmasch</i> , 775 P.2d 388 (Utah 1989) .....	47
<i>State v. Tucker</i> , 96 P.3d 368 (Ut. App. 2004) .....	30

**CONSTITUTIONAL STATUTES, PROVISIONS, AND RULES**

UCA § 34A-1-104 ..... 28

UCA § 34A-2-412 ..... 28

UCA § 49-21-102 ..... 3

UCA § 49-21-102(6) ..... 28, 32, 34, 35

UCA § 63-46b-8 (1) (b)(iii) ..... 30

UCA § 63-46b-8 (1) (c) ..... 30

UCA § 63-46b-10 (3) ..... 30

UCA § 63-46b-16 ..... 49



## **STATEMENT OF JURISDICTION**

This Court has jurisdiction under UCA § 63-46b-16 & 17, URAP Rule 14 and URAP Rule 4.

## **STATEMENT OF THE ISSUES & STANDARD OF REVIEW**

### **FIRST ISSUE ON APPEAL**

Issue. Did the Hearing Officer (HO) Err by Concluding That There Was No Objective Evidence of Petitioner's Disability, by Requiring an "Impairment Rating" and by Applying the Utah Worker's Compensation Guidelines?

Standard of Review. The Court of Appeals should review this issue under a de novo standard of review. See *Morton v. State Tax Comm.*, 814 P.2d 581, 588-89 (Utah 1991)

Citation to Record of Issue Preservation. Hearing Record (HR) 59:5-11, 69:9-21, 70:4-8, 71:2-9, 102:4-12, 233-241, 335, 339-347, 348-349, 358-359, 362-363.

### **SECOND ISSUE ON APPEAL**

Issue. To Prove the Severity of Petitioner's Disability Did the Hearing Officer Err by Requiring Objective Evidence at the Exclusion of Subjective Evidence?

Standard of Review. The Court of Appeals should review this issue under a de novo standard of review. See *Morton, supra*.

Citation to Record of Issue Preservation. HR 233-241, 335, 349-358.

### **THIRD ISSUE ON APPEAL**

Issue. Did the HO Err by Failing to Find Petitioner Disabled By Considering the Combined Effect of Petitioner's Impairments and by Failing to Take into Consideration Petitioner's SSA Determination?

Standard of Review. The Court of Appeals should review this issue under a De Novo standard of review. See *Morton, supra*.

Citation to Record of Issue Preservation. HR 337; Hearing Transcript (HT) 250:2-25, 251:1-16, 252:1-15, 265:6-16, 292:13-20, 293:14-25, 294, 295:1-2, 297:21-25, 298:1-6, 299:1-25, 303:5-25.

#### **FOURTH ISSUE ON APPEAL**

Issue. Did the HO Err by Finding Dr. Knorpp's Testimony to Be Credible and Persuasive?

Standard of Review. The Court of Appeals should review this issue under an intermediate abuse of discretion standard of review. See *Morton, supra*.

Citation to Record of Issue Preservation. HR 105:3-25, 106:1, 241-257, 347-348, 359-362.

#### **FIFTH ISSUE ON APPEAL**

Issue. Did the HO Err by Failing to Draft Detailed Findings of Fact, Conclusions of Law and the Final Order?

Standard of Review. The Court of Appeals should review this issue under an intermediate abuse of discretion standard of review. See *Morton, supra*.

Citation to Record of Issue Preservation. HR 336, 378-380.

#### **CONSTITUTIONAL PROVISIONS, STATUTES, AND RULES**

UCA 1953 Title 49-21-102 and the PEHP Pamphlet definition are of central importance to this case. UCA 1953 Title 49-21-102 indicates:

(6) “Objective medical impairment” means an impairment resulting from an . . . illness which is diagnosed by a physician and which is **based on accepted objective medical tests or findings** rather than subjective complaints.

This definition is exemplified in the PEHP’s definition of a medically determinable impairment.

*Medically determinable impairment* is defined as an impairment that results from anatomical, physiological, or psychological abnormalities **which can be shown by medically acceptable clinical and laboratory diagnostic techniques**. A physical or mental impairment **must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual’s statement of symptoms**.

### **STATEMENT OF THE CASE**

Petitioner seeks long-term disability benefits from the Public Employee’s Health Plan or “PEHP”. PEHP denied these benefits because the Appellee alleges Petitioner has not produced objective evidence that she has an impairment rating or is completely disabled. She appeals this denial of benefits.

### **SUMMARY OF PROCEEDINGS BELOW**

On May 6 and June 1, 2004, the Hearing Officer (HO), James Baker, heard Petitioner’s Request for Board Action on her claim for disability benefits. The HO, at the conclusion thereof, requested written closing arguments.

Based upon the issues raised by Appellee (HR 298-325) and, pursuant to Utah law and the PEHP policy, Petitioner asked in her closing arguments (HR 231-257, 329-373), among other issues, that the HO determine: (1) Whether there were objective clinical and laboratory diagnostic techniques, tests, findings and signs for Petitioner’s impairments, (2) Whether an “impairment rating” [v. impairment] is necessary to establish disability,

(3) Whether the severity of the disability must be established through objective medical evidence, (4) Whether the combined effect of Petitioner's medical impairments had been properly considered [including her severe sleep apnea and lumbar degenerative disc disease (DDD)], and (5) Whether the Utah 2002 [Worker's] Compensation Guides (the Guides), or any other guidelines were applicable to PEHP determinations.

After receiving the parties' closing arguments, the HO did not address Petitioner's specific requests but determined that, "The evidence presented by Petitioner consisted of her '**subjective complaints,' together with hearsay evidence** on the fact in dispute." He also ruled that, "**No admissible evidence was presented by Petitioner** on an impairment resulting from an injury or illness which was diagnosed by a physician based on accepted medical tests or findings." He further found that, "The evidence presented by Dr. Knorpp is credible and accepted." Denying her benefits, he requested that, "Counsel for the Respondent shall prepare an Order consistent with this decision." HR 374-375.

Upon receiving Appellee's prepared Order, the Petitioner, citing *Foreman V. Foreman*, 176 P.2d 144 (Utah 1946) objected stating:

The proposed Findings of Fact, Conclusions of Law and Order bear no relation to the "reasons the [HO] recited" in his decision and [the Decision] is therefore "not consistent with [the proposed] findings of fact, conclusions of law and order. This has the tendency to "cast doubt upon the foundation for those determinations." . . .

.. . . . Petitioner would urge [the HO] . . . to . . . make specific rulings as requested by Petitioner so that the issues have been properly ruled upon and so that Respondent's counsel does not appear to be the actual decision maker in this case...

"It is a simple matter to recite or write sufficient facts to support a decision once the decision is made, but the [HO's] process of determination to be a proper exercise of judgment for founding a question upon the merits should show an attempt to decide the issues of the case as presented, and should not be founded upon extraneous matters. " . . . This . . . will provide proper guidance in future cases and clarify the issues on appeal. HR 378-380.

Disregarding Petitioner's objection, the HO adopted Appellee's final Order

without revision. It contained some of the following statements:

Findings of Fact . . .

....

6. Both Petitioner and Dr. Beales testified that the worst conditions Petitioner suffers from are pain and fatigue. Dr. Beales testified, "There's no good objective measurement of pain, of fatigue. . ." Dr. Beales testified that he relied on Petitioner's self-reported symptoms in forming his opinion regarding Petitioner's disability. . . .

7. Dr. Beales . . . was not familiar with either the . . . AMA Guidelines or the Utah impairment Guidelines. . . . Dr. Beales did not provide any other guidelines or standards that could be used in making his determination on Petitioner's disability.

8. Dr. Beales failed to provide Petitioner with an impairment rating . . . Impairment ratings are the standard used in the medical community to determined disability.

9. Dr. Knorpp is board certified in physical medicine and rehabilitation. Dr. Knorpp is proficient with the AMA Guidelines and the Utah Impairment Guidelines . . . [B]ased upon these guidelines as well as the disability standard defined in Title 49 of the Utah Code, [Dr. Knorpp] could not find anything that could objectively show that Petitioner would qualify for an impairment that would lead to a disability.

....

Conclusions of Law . . .

....

9. Petitioner **failed to present any non-hearsay evidence** proving she suffered from and "objective impairment resulting from injury or illness based on accepted medical tests or findings." Although Petitioner provided evidence of diagnoses, Petitioner **failed to provide any evidence showing** that she was objectively impaired due and to these conditions."

....

11. Although it is not mandatory that a Petitioner use the AMA Guidelines and/or the Utah impairment Guidelines to prove impairment, a Petitioner must prove "objective medical impairment" through "accepted objective medical tests or findings." Since the AMA Guidelines and the Utah impairment Guidelines are the standards currently used by the medical community to determine impairment, these are reasonable guidelines to be used to determine the level of impairment.

12. **No evidence was presented** by Petitioner to indicate that she qualifies for an objective impairment rating pursuant to the AMA Guidelines, the Utah impairment Guidelines, or any other accepted objective criteria. . . HR 381-387.

This Order denied Petitioner's request for disability benefits. This appeal followed.

### **SUMMARY OF FACTS**

1. In October 2002, Petitioner, at age 55, after 25 years of employment as a Health Program Specialist left work due to disability. She was impaired by severe sleep apnea, Fibromyalgia Syndrome (FMS), Chronic Fatigue Syndrome (CFS), hypertension, heart valve disease, neuropathy and degenerative disc disease. These illnesses caused fatigue, chronic pain in her back, legs, neck, joints, sleepiness and memory loss. HR 8-16.

2. Petitioner's job was "sedentary." It required extensive expertise in State health-care programs, State and Federal laws, policies, rules and procedures, compiling, and analyzing and summarizing information regarding health services. It further required expertise in data entry, working with computer systems and the ability to deal with the public. It also required regular attendance and punctuality. HR 19-20.

3. On August 26, 2003 Petitioner requested Board Action on her request for Long Term Disability benefits. HR 6.

4. Appellee, supported by its expert witness, Dr. Scott Knorpp, has successfully argued that Petitioner is ineligible for benefits because: (1) there is no objective medical evidence that she has a disability, (2) there is no objective medical evidence that her disability meets the "total disability," standard (3) an "impairment rating" cannot be given to persons with FMS and CFS, (4) Petitioner does not have an "impairment rating," (5) without an "impairment rating" a person cannot be deemed disabled, (6) Petitioner's hearing evidence was hearsay, and (7) Dr. Knorpp's testimony was credible and

persuasive. HR 109-112, 298-325; Hearing Transcript (HT) 239:12-23.

### **Petitioner's Medical Documentation**

5. On May 6th and June 1st, 2004, the HO, James Baker, heard Petitioner's Request for Board Action. HR 144,156; HT 1, 207.

6. At the hearings, Petitioner submitted her medical records which were received without objection. HT 221 Exhibit B pp 00-191. The records indicated:

A. Dr. Lucinda Bateman's Office visit notes, on April 21, 2004 state:

1) **Fibromyalgia Syndrome . . . 12/18 tender points** on exam. . .

2) Lumbar degenerative disc disease. . .

. . . .

4) Baseline hypoxemia and there are **severe obstructive sleep apnea** seen on polysomnography in November of 2003. (HR 221 Exh. B p. 00)

B. M. Rosen, MD's Fatigue Clinic Consultation Report of 3/18/03 states:

PHYSICAL EXAMINATION:

. . . .

EXTREMITIES: . . . .

**50% loss of vibratory sensation loss in toes bilaterally.**

**TENDERPOINTS:** Occiput R-L, neck R-L, trapezius R-L, supraspinatus R-L, 2<sup>nd</sup> intercostal space R-L, lateral epicondyles R-L, L4-S1 R-L, buttock R-L, knees R-L (**18/18 tender points**) HR 221 Exh. B p. 14

C. The Central Ut. Med. Clinic's records by Lucia Altamirano on 11/20/02 state:

CONCLUSION: VERY MILD SENSORY **neuropathy** in the L. Peroneal nerve. . . . HR 221 Exh. B at pp. 38-39.

D. Michael Rosen, MD's Neurology Consultation on 11/6/02 from states:

SENSORY: There is a stocking and glove distribution **decreased perception of pinprick** or prominence in the lower extremities. . . **There is significant decreased vibratory sensation in the toes.** HR 221 Exh. B at pp. 45-46.

E. The Central Ut. Multi-Specialty Clinic's records on 11/6/02 indicate:

Results: **MPV - abnormal low.** HR 221 Exh. B at p. 47.

F. Pamela Vincent, MD's Multi-Specialty Clinic's records on 11/6/02 indicate:

REVIEW OF SYMPTOMS: . . . She has some **difficulty with sleep.** . . She has got **difficulty walking**, poor coordination, neck, back, leg left greater than right and arm pain. HR 221 Exh. B at p. 61

G. Michael S. Rosen, MD's Chart notes on 3/19/02 state:

. . .Still has the **multiple trigger points and tender spots to palpation.** HR 221 Exh. B at p. 104

H. Alta View Hospital's Intermountain Sleep Disorders Center's Final Report, on November 18, 2003, by John B. Krueger, M.D., F.C.C.P. states:

CONCLUSIONS:

1. Polysomnography revealed the presence of both mild to moderate alveolar hypoventilation . . . and **severe obstructive sleep apnea** . . . This resulted in moderately severe hypoxemia . . .

. . . .

3. **The abnormalities of sleep architecture and respiration**, as discussed above, **would account for clinical symptoms such as nonrestful sleep, daytime fatigue, and excessive daytime sleepiness.** HR 221 Exh. B at pp. 119-120.

I. The IHC Health Center - Sandy medical records note on 11/24/03 that:

Results of Baseline Sleep Study--Conclusion:

1. **Severe obstructive sleep apnea.**
2. Moderately **severe hypoxemia.** . . HR 221 Exh. B p. 125.

J. Dr. Lucinda Bateman's office notes on December 10, 2003 state:

4) L-spine **degenerative disc disease/ DJD/** moderate stenosis at L4-5 on L-spine MRI 3/03 with chronic back pain. HR 221 Exh. B at p. 130.



K. Ph.D Elaine Clark's Neuropsychological evaluation on 2/20/03 states:

#### CLINICAL IMPRESSIONS

....

**There is evidence from the current psychological testing that Mrs. Hilton's physical condition is being impacted by her psychological state, however, there is no indication that she is exaggerating her physical problems or malingering. . . . [T]here is evidence of significant visual memory problems, and some mild verbal learning and memory problems, there is no reason to believe that she could not do her work based on cognitive deficits alone. . . . If she is unable to work, this would have to be based on medical problems, not neurocognitive ones.** HR 221 Exh. B at pp. 135-136.

L. The Arthritis Clinic of Central Utah's medical records on 12/12/94 from

Richard A. Call, II, M.D., P.C. indicate:

**. . .Physical examination . . . multiple tender points over the areas traditionally associated with Fibromyalgia Syndrome.** HR 221 Exh. B at p. 146.

#### **Medical Evidence v. Dr. Knorpp's Testimony**

7. At the hearing, Appellee's expert witness, Dr. Knorpp stated that he is certified by the American Academy of Disability Evaluating Physicians, (AADEP), a "sub-specialty board" of physicians. Dr. Knorpp averred that his AADEP membership grants him an exclusive expertise to determine impairment ratings and disability. He further indicated that AADEP is authoritative and that he adheres to its directives. HT p. 67:11-18, 139:8-18.

8. AADEP indicates that:

"Impairment ratings [for people with CFS] cannot be determined with any single tool . . . At present, impairment ratings are best done based upon daily living

activity rating scales in the *AMA Guides to the Evaluation of Permanent Impairment* (4<sup>th</sup> Edition). HR 173–1st ¶ after heading “Impairment Rating.”

9. AADEP indicates that: “Impairment assessment in **Fibromyalgia** is difficult, but possible when appropriate comprehensive evaluations are performed.” HR 182.

10. The Social Security Administration (SSA) states that:

CFS, when accompanied by appropriate medical signs or laboratory findings, is a medically determinable impairment that can be the basis for finding of disability,” [and appropriate medical signs and laboratory findings include,] **persistent, reproducible muscle tenderness on repeated examinations, including the presence of positive tender points, . . . Abnormal exercise stress tests or abnormal sleep studies,” . . . [and psychological problems,] documented by mental status examination or psychological testing**, such findings constitute medical signs or (in the case of psychological testing) laboratory findings that established the presence of the medical determinable impairment. HR 221 Exh. B pp. 168-671.

11. The SSA also states that:

[T]here is considerable overlap of symptoms between CFS and FMS, but individuals with CFS who have tender points have a medically determinable impairment. Individuals with impairments who fulfill the **American College of Rheumatology criteria for FMS (which includes a minimum number of tender points)** may also fulfill the criteria for CFS. HR 221 Exh. B p 175 note 3.

12. Contrary to AADEP and the SSA, Dr. Knorpp testified that regardless of the medical information, a person diagnosed with FMS and/or CFS can never be granted an “impairment rating” or be deemed to be disabled. HT 102:19-25, 103:1-7, 113:13-17, 120:1-19, 125:5-13, 220, 221:1-6, 276:23-25, 277:1-22. He also stated, “even if [Petitioner] met all the criteria for fibromyalgia syndrome, I would not be able to declare

her disabled based on the current criteria established for this condition.” HT 116:17-20.

13. Contrary to AADEP and the SSA, Dr. Knorpp asserts that there are no signs, tests or findings to objectively establish FMS and CFS as an impairment or disability. HT 114:23-25, 115:1-2, 125:5-17, 129:16-22.<sup>1</sup>

14. Consistent with AADEP and the SSA, Dr. Beales testified that an FMS or CFS caused impairment or disability may be objectively verified through medical tests, laboratory findings, medical signs, diagnostic studies, neuro-psychometric tests, and other objective medical findings that establish the existence of these illnesses. HT 25-26, 315:16-25, 316.

15. To evaluate CFS caused “impairment ratings” and disability AADEP states:

**...[Sleep studies] are valid as investigational tools and specifically for sleep disorders. In patients who report cognitive defects as a cause of disability, appropriate psychometric testing is recommended to better objectify the presence or absence of cognitive impairment and the type and severity of any cognitive impairments detected. . . . If the sleep disorder is diagnosed, then Table 6 in Chapter 4 may be used [to evaluate the impairment].”**

16. Also, in AADEP’s “Fibromyalgia: Impairment and Disability Issues,” it states:

**... The examiner must also elicit information concerning pain – including sites, duration, severity and precipitating factors. Similar inquiries should be directed toward other fibromyalgia symptoms, including fatigue, sleep disturbance, headaches, irritable bowel syndrome, cognitive difficulties and psychological disturbance. . . .** HR 184

---

<sup>1</sup> On HT 131:16-18 Dr. Knorpp does admit that the Social Security Administration did accurately identify the clinically accepted signs but he contradicts this admission in other portions of his testimony.

17. Contrary to AADEP and the SSA, Dr. Knorpp disregarded Petitioner's abnormal sleep study as an objective finding for Petitioner's FMS and CFS, did not use "Table 6 in Chapter 4" and failed to document Petitioner's symptom reports. When pressed, he admitted that abnormal sleep studies were an objective anomaly that consistently coincided with FMS and CFS. HT 252:3-25, 253, 254, 255:1-11, 296:19-24.

18. Consistent with AADEP and the SSA, Dr. Beales testified that sleep studies objectively measure this FMS and CFS caused impairment. HT 318:21-25, 319:1-14.

19. Contrary to AADEP and the SSA, Dr. Knorpp disregarded Petitioner's abnormal psychiatric testing as an objective sign consistent with Petitioner's FMS and CFS. HT 292:13-20.

20. Consistent with AADEP and the SSA, Dr. Beales testified that Petitioner's psychiatric testing objectively evidenced this FMS and CFS caused impairment to her memory and psychological functioning. HT 322:1-7.

21. The AADEP's "Fibromyalgia: Impairment and Disability Issues," states:

Persons being evaluated for impairment related to fibromyalgia should receive a thorough physical examination. . . The examiner should palpate the tender point sites, examine for the presence of trigger points, perform a detailed peripheral joint examination, and examine carefully the back and neck. In the classic definition of a trigger point, **a trigger point is an area in an abnormal muscle which, when palpated, is severely tender, has a band-line or ropy feel to it, twitches, and causes pain in a site distant from the patient's pain complaint.** HR 183-184.

22. Contrary to the SSA and AADEPs' directives, Dr. Knorpp asserts that trigger

point examinations are useless and disregarded the findings of Petitioner's treating physicians Dr. Bateman, Dr. Call and Dr. Rosen. As to Dr. Beales, he stated, ". . . I don't recognize [Dr. Beales] opinion as being tenable or valid based on lack of qualifications." HT 104:25, 105:1-2, 132:7-13:23-24, 233:8-20, 235:5-10, 302:19-21.

23. When evaluating persons claiming disability due to CFS, AADEP directs:

The physician examining a patient with chronic fatigue needs to take a detailed history as to onset and the relationship to any other conditions that may cause fatigue. . . there should be a description of the severity of the fatigue. A detailed description of the examinee's loss of function, activities of daily living and self care, and activities of work would need to be recorded, as well as the frequency and duration of the complaints. . . This type of history is necessary in order to determine if the examinee can perform the essential functions of a job and sustain a work pace consistent with the employment. The history of work problems and stress should be recorded as well as the reasons for leaving work. . . HT 172.

24. Contrary AADEP, Dr. Knorpp investigated the effect Petitioner's impairments had on her work activities to see if she could **"perform the essential functions of a job and sustain a work pace consistent with the employment."** HT 239:5-11.

25. To evaluate FMS caused disabilities, AADEP also directs:

. . . There may need to be more than one examination to complete the history because of the waxing and waning of symptoms [of CFS]. . . HR 172.

. . . .

**. . . [A] proper evaluation [of FMS] may take 'hours if not days,' requires 'review of all available medical records and diagnostic studies,' and may require contact with previous health professionals, family and close contacts, and imaging studies.** HR 184. (Citing the AMA Guides)

26. To evaluate CFS and FMS impairments, the SSA also recommends

interviewing neighbors, friends, relatives, clergy, past employers, and follow-ups with treating physicians and other medical providers. HR 221 Exh. B pp 174-175.

27. Contrary to AADEP's directives, Dr. Knorpp only met with the Petitioner for 45 minutes, did not speak with any of the Petitioner's family members, acquaintances, or physicians. HT 307:8-13. Moreover, Dr. Knorpp made no "review of all available medical records and diagnostic studies." HT 230:15-18. Dr. Knorpp stated:

I don't have Dr. Call's reports. I only have one report from Dr. Bateman, March 18<sup>th</sup> which postdates my evaluation. I didn't have all the records from all the physicians that you're talking about. . . ." HT 13:20-25. **I had just a smidgeon of records.** HT 136:7-8.

28. Also, aware that Petitioner had hypertension and heart valve disease, Dr. Knorpp stated: "I did not have any medical records to corroborate that," and contrary to AADEP's directives, he did not obtain these medical records. HT p 99:23-24, 249:19-25.

29. Citing the AMA Guides, regarding **Functional Capacity Evaluation** (FCEs) and range of motion tests in evaluating CFS patients, AADEP:

. . . Functional Capacity Evaluations (FCE) may give a picture of the physical and muscular condition of the CFS patient at the time of the examination, **but since the condition of these patients varies from day to day, the FCE tests would also not be recommended as a diagnostic tool for CFS patients** . . . HR 172.

. . . .

. . . **Functional Capacity Evaluation, which includes exercise studies, would also not appear to be helpful for impairment ratings** due to the day-to-day variations noted and the usually normal muscle strength in CFS patients. . .

. . . .

**Musculoskeletal ratings are not relevant since there is no apparent musculoskeletal basis for limitation in the CFS patient.** . . . (Emphasis added).

HR 173.

....

Since **symptom severity** in **fibromyalgia** is typically based on self-report, **the examiner should quantify** self-reported severity regarding functional ability, fatigue, sleep disturbance, and pain **through the use of validated assessment instruments**. **Assessment instruments that have been useful in chronic pain evaluations include the Oswestry Disability Index, McGill Pain Questionnaire, and the Pain Disability Index, among others.** HR 184.

30. To evaluate persons with CFS, the *AMA Guides (4<sup>th</sup> Edition)*, recommend that the evaluator conduct brain imaging techniques, treadmill testing, use daily living activity rating scales and quality of life measurement studies. HR 172-173.

31. Contrary to AADEP and the *AMA Guides (4<sup>th</sup> Edition)*, in evaluating Petitioner, Dr. Knorpp did not use the “Oswestry Disability Index, McGill Pain Questionnaire, the Pain Disability Index,” treadmill exercise testing, or quality of life measurement studies, but instead conducted an FCE and range of motion exams. HT 82-85, 290:21-25, 291, 292:1-12.

32. Dr. Knorpp, asserting legislative applicability, used the Utah Impairment Guides (the Guides) promulgated to establish “impairment ratings” for Worker’s Compensation benefits to evaluate Petitioner. HT 103:8-25, 104:1-14, 128:1-6.

33. The Center of Disease Control (CDC) CFS Case definition states:

Recent longitudinal studies suggest that some persons affected by the Chronic Fatigue Syndrome improve with time but that most remain functionally impaired for several years. HR 221 Exh. B p. 178.

34. Contrarily, Dr. Knorpp testified that:

**All the literature** regarding chronic pain disorders including the literature for [FMS] and [CFS], is that these people are really best served by maintaining functional lives rather than sitting at home; [p 100, lines 14-18].

....

The best medical science today would say that Mrs. Malan should continue functioning and should continue working even if she has this disorder. [page 116, lines 15-22].

35. Consistent with medical literature, Dr. Beales stated that persons with FMS and CFS often do not recover, grow progressively worse and are more severely disabled than persons with HIV, lupus or rheumatoid arthritis. HT 331:16-20, 333, 334:1-6.

36. Dr. Knorpp has never diagnosed, treated, nor provided rehabilitation services to persons with FMS and CFS. HT 138:6-25, 139:1-8, 217:22-25, 218:1-25. He does not do evaluations for FMS and admitted he has no expertise on FMS and CFS. HT 223:22-25, 224:1-13, 251:16-18.

### **Scientific Support For CFS and FS**

37. In *Arthritis & Rheumatism*, Vol. 46, No. 5, May 2002, *Impaired Growth Hormone Secretion in Fibromyalgia Patients*, submitted by Dr. Knorpp, it states:

*Conclusion:* Three new findings are reported: 1) FM patients have a reduced GH response to exercise, 2) pyridostigmine reverses this impaired response, and 3) defective GH secretion in FM can occur in patients with normal IGF-1 levels. HR 203.

38. In *Subspecialty Clinics: Physical Medicine and Rehabilitation, Tension Myalgia as a Diagnosis at the Mayo Clinic and its Relationship to . . . Fibromyalgia . . .*, Jeffrey M. Hompson, M.D., submitted by Dr. Knorpp, it states:



## CONCLUSION

**Effective treatment necessitates recognition of the disorder by a clinician,** acceptance of the diagnosis by the patient, and institution of intensive treatment including elimination of contributing factors, reduction of pain and muscle over activity, correction of motor dysfunction, restoration of an adequate level of fitness, and judicious use of medications. HR 168.

39. In the *Arthritis & Rheumatism*, Volume 50, Issue 2, Published Online,

February 2004, submitted by Dr. Knorpp, it states:

Pain in other idiopathic chronic pain conditions, such as . . . fibromyalgia syndrome (FMS) appears to result from abnormalities in pain processing rather than from damage or inflammation of peripheral structures.

. . . .

Functional imaging studies in chronic pain states that are characterized by hyperalgesia/allodynia have corroborated patients' self-reports of mechanical hyperalgesia [i.e. pain in response to normally nonpainful stimuli], **identifying objective evidence** of augmented responses to pressure stimuli (such as in the viscera and periphery in . . . FMS, respectively). HR 211.

40. Contrary to medical authority, Dr. Knorpp stated, "[M]y understanding is that there is no science to support the existence of the disease. HT 119:15-17.

## Pain, CFS and FMS

41. The *Cleveland Journal of Medicine*, Vol 68, #10, Oct. 2001, ". . . *Treating the Biologic Basis of Fibromyalgia* . . . ," submitted by Dr. Knorpp, states:

Recent data shows that the emphasis on tender points as indicating tenderness in discrete regions of the body does not adequately define the pain that people with fibromyalgia feel. **Rather, people with fibromyalgia are more sensitive to pain throughout their entire body.**

. . . .

. . . Some current theories suggest fibromyalgia . . . [is] due to:

- A low threshold of pain and heightened perception of internal and external

stimuli.

....

- Hyporeactivity of both the hypothalamic-pituitary-adrenal axis and the autonomic nervous system, with attenuated response to stressors. . .

- Lack of sleep . . . HR 158, 159

42. The Arthritis & Rheumatism, Vol 46, #5, May 2002, pp 1333-1343, “*Imaging*

*Evidence of Augmented Pain Processing in [FMS]*,”submitted by Dr. Knorpp, states:

*Conclusion:* The fact that comparable subjectively painful conditions resulted in activation patterns that were similar in patients and controls, whereas similar pressures resulted in no common regions of activation and greater effects in patients, **supports the hypothesis that FM is characterized by cortical or subcortical augmentation of pain processing.**

....

**Results:** FM patients displayed significantly lower pressure pain thresholds at the left thumbnail compared with those displayed by control subjects . . .

....

**Discussion:** **In FM patients, application of mild pressure produced subjective pain reports and cerebral responses that were qualitatively and quantitatively similar to many of the effects produced by application of at least twice the pressure in control subjects.** HR 192, 195, 198.

43. Contrary to the authority he submitted, Dr. Knorpp disregarded Petitioner’s reports of hypersensitivity to touch and the pain it caused. He stated:

Q. Were you aware that patients with fibromyalgia, chronic fatigue can often have great sensitivity to touch of their skin?

A. I’m aware of reports to that effect, yes. As a physician looking at non-noxious pain stimuli, **I have a different criteria.**

Q. Are you aware that some patients with fibromyalgia, chronic fatigue find it painful to take a shower?

A. I’ve never had that kind of information before, no.

Q. Are you aware that some patients with fibromyalgia, chronic fatigue find it painful to be touched or hugged or caressed?

Q. Were you aware of that?

A. No, I wasn't. HT 78:1-17, 84:21-24, 136:19-23, 137:14-25, 138:1-6.

44. Consistent with the medical literature, Dr. Beales testified that persons with FMS and CFS can be very sensitive to even light touch. HT 317:9-25, 318:1-20.

45. Dr. Knorpp also stated, "We don't disbelieve they have pain, we don't have any disease to explain their disorder so if we don't have any disease to treat, then we probably shouldn't treat them as if they can't do something . . ." HT 141:23-25, 142:1-2.

46. On all evaluations, Dr. Knorpp disregards reports of pain. HT 273:10-25, 274-276, 278.

#### **Dr. Knorpp, Biased Activist or Independent Evaluator?**

47. Dr. Knorpp only does evaluations for insurance companies. HT 112:10-15, 237:24-25.

48. Dr. Knorpp testified, "If there's a disconnect between a desire to return to work and an inability to return to work, I have to bridge that gap." HT 80:19-23.

49. Dr. Knorpp alleged that you cannot have a disability without an impairment and an, "Impairment' is defined as the loss of function of or deranged function of a body part, an organ or an organ system." HT 68:1-19, 69:9-12.

50. Dr. Knorpp admitted that a person can have an "impairment" and yet not qualify for an "impairment rating." HT 289:15-22. He begrudgingly admitted that AMA Impairment Guides (Chap. 18) indicate that pain syndromes from nonarticular disorders

(such as FMS and CFS) can cause disability. HT 266:20-23.

51. Dr. Knorpp only evaluated Petitioner's FMS and did not consider in isolation or in combination the effect of Petitioner's other medical impairments including her sleep apnea, hypertension, heart disease, DDD<sup>2</sup>, psychological deficits, neuropathy, etc. HT 250:2-25, 251:1-16, 252:1-15, 265:6-16, 292:13-20, 293:14-25, 294, 295:1-2, 297:21-25, 298:1-6, 299:1-25, 303:5-25.

52. Dr. Knorpp was asked:

Q. . . .[Y]ou just evaluated [Petitioner] based upon the narrow information you were given, the smidgen of medical records and the fibromyalgia and chronic fatigue, correct? You didn't look at anything else, correct? . . .

A. That's correct. HT 285:10-17.

53. Dr. Knorpp was asked:

Q. And you don't know how severe her degenerative disc disease is because you didn't look at it?

A. No, I didn't evaluate it for (inaudible) disease. HT 295:19-21.

54. Dr. Knorpp was asked:

Q. Would obstructive sleep apnea indicate and arrangement [sic-derangement] of the body part, system or organ?

A. I think it would. I'm not an expert in sleep disorders, so you'd have to ask a sleep specialist in that regard.

Q. So you don't know if there is a derangement to a bodily part, organ, or system that is causing her sleep apnea because you didn't look at that, correct?

A. No, I did not. HT 295:25, 296:1-9.

---

<sup>2</sup> Interestingly, Dr. Knorpp compares DDD with gray hair and tries to argue they are the same- this demonstrates his irrationality. HT 293:14-25, 293, 294:1-2

55. Dr. Knorpp was asked:

Q. . . . Have you read the report by Dr. Elaine Clark?

A. No, I have not. HT 303:21-22.

56. Dr. Knorpp testified:

. . . [Petitioner's] fingernails were cosmetically dressed, and I indicate that because people . . . who are in a significant degree of body pain for whatever reason, . . . usually don't waste time getting their fingernails dressed." HT 86:17-21.

57. In summation that Petitioner was not disabled, Dr. Knorpp stated: "Sir, we don't determine whether someone is so ill they can't work. We use the guides, we use the impairment ratings to determine a number." HT 129:1-3.

58. Dr. Knorpp testified that to work, Petitioner would need her employer to accommodate her. HT 122:5-6.

59. Petitioner's employer could not accommodate her. HT 146-161, 165-171.

**Dr. Landon Beales Testimony.**

60. Dr. Beales has practiced medicine for 35 years. HT 14:11. Since the late 1980s he has become an FMS and CFS expert. On a yearly basis he attends national, international, and statewide conferences on FMS and CFS. He has often been a featured speaker therein and is one of only a handful of experts in Utah on FMS and CFS. Over the past 15 years he has treated more than 3000 individuals with CFS and FMS. He is familiar with the CDC diagnoses criteria for these illnesses and is knowledgeable about assessing FMS and CFS caused disabilities. HT 16:22-25, 17-24.

61. Consistent with AADEP, Dr. Beales indicated that Dr. Knorpp's FCE and other orthopedic exams performed on Petitioner were useless in evaluating her impairments. HT 26:21-25.

62. After examining Petitioner, reviewing her medical records, laboratory work, and imaging studies, Dr. Beales opined that based upon objective testing, including the fact that several reputable doctors had verified the existence of tender points consistent with CFS and FMS, Petitioner had FMS, CFS, aortic insufficiency, severe sleep apnea, DDD, and visual memory problems as shown by the neuro-psychometric testing. He further opined that because of her severe symptoms she would be unable to work on a consistent basis. HT 27-29, 32:14-25, 33:16-25, 34:1-17.

63. On cross-examination, Dr. Beales admitted pain and credibility cannot be objectively measured and that he could not parrot the legal standards for disability. Also he admitted that he did not use nor was he familiar with the Utah Guides. He further admitted that he is not board certified. HT 49-60.

#### **Petitioner and Her Witnesses' Testimonies**

64. Petitioner testified that she is a high school graduate with two years of college. She started working for the State of Utah on April 1, 1979 until October 1, 2002. She perceived herself as a very good and respectable worker who had strived for excellence while working for the State of Utah. She first became ill in 1990 and her illness slowly

worsened. She was unable to sleep, had widespread pain and fatigue, and difficulties concentrating. To maintain her employment she first cut out all non-work related activities. During the last year of employment she had frequent absences, tardies and had to take frequent naps during the day, started making errors in her work and fell behind in her duties. On her way to work she fell asleep several times, almost wrecking. At first her employer tried to accommodate her but she was finally terminated because her illness prevented her from accomplishing the necessary duties of her employment. HT 146-161, 165-171.

65. Petitioner indicated that Dr. Knorpp treated her rudely and scolded her when she explained she could not wear undergarments or tight clothing because they caused pain. She also indicated that he would get angry and raise his voice with her. She further indicated she almost fell because of his insistence that she keep her eyes closed during one of his orthopedic balance tests. HT 162-163.

66. Debbie Ward and Ashley Ward both testified about their observations that Petitioner's condition had become progressively debilitating until she has become almost a complete recluse and had to rely upon the assistance of others for her activities of daily living. HT 189-194.

67. Petitioner was found disabled by the SSA . Dr. Knorpp nor the HO took this into consideration. HT 304:2-25, 305:1-9.

## **SUMMARY OF ARGUMENTS**

The Appellee and the HO denied Petitioner long-term disability benefits because they alleged she produced no objective evidence that she has an “impairment rating.” Petitioner’s “impairments” are fibromyalgia syndrome (FMS), chronic fatigue syndrome (CFS), severe sleep apnea, degenerative disc disease (DDD), hypertension, heart disease and neuropathy. These impairments have caused her to have, severe pain, severe fatigue sleepiness and cognitive deficits. Her medical records contain findings, signs and test results from a sleep study, imaging studies of her spine, several clinical tender point exams and psychological testing. These results are objective evidence of her impairments. These results and her subjective testimony about her impairments’ effects upon physiology demonstrate that she is totally disabled.

However, the HO disregarded all of her evidence, including her medical records and expert witness testimony, as hearsay and as subjective. The HO found the appellant’s expert witness--whose testimony contradicted the treating physicians and medical authorities and who violated his own credentialing organization’s directives, to be reliable. The HO further ruled that without objective evidence of an “impairment rating,” she was not disabled.

The HO erred in determining what constitutes “objective evidence” and “impairment,” under Utah law. The HO erred in rejecting Petitioner’s sleep apnea



testing, clinical tender point exams, imaging studies, psychological testing, and medical history as hearsay and as subjective evidence. He also erred in accepting Dr. Knorpp's testimony as reliable. Petitioner's evidence was sufficiently objective and it should have been considered along with her subjective testimony regarding her pain, fatigue, and mental difficulties and their effect upon her functionality and activities. Had her evidence been properly considered the HO would have found that the combined effect of Petitioner's impairments rendered her completely disabled.

### **ARGUMENTS**

#### **I. Did the Hearing Officer Err by Concluding That There Was No Objective Evidence of Petitioner's Disability, by Requiring an "Impairment Rating" and by Applying the Utah Worker's Compensation Guidelines?**

To qualify for benefits Petitioner must have a "medically determinable impairment." The PEHP DISABILITY BENEFITS PAMPHLET, page 2 states:

*Medically determinable impairment* is . . . an impairment that results from anatomical, physiological, or psychological abnormalities **which can be shown by medically acceptable clinical and laboratory diagnostic techniques.** A physical or mental impairment **must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual's statement of symptoms.**

UCA §49-21-102(6) states: "Objective medical impairment" means an impairment resulting from an . . . illness which is . . . **based on accepted objective medical tests or findings** rather than subjective complaints.

#### **A. "Impairment" vs. "Impairment Rating"**

Pursuant to UCA § 34A-1-104 and 34A-2-412, the Industrial Commission

promulgated Utah's 2002 Impairment Guides [the Guides] for calculating "Impairment ratings" to calculate worker's compensation partial disability and total disability benefits. HR 372. The Guides prohibit "impairment ratings" for FMS and CFS. This prohibition is logical because worker's compensation benefits are paid when a work-place accident causes an illness or injury and it is unclear what specifically causes FMS and CFS.

Pursuant to UCA § 49-21-102, eligibility for PEHP disability benefits is not predicated upon proving causation nor having an "impairment rating." Therefore the Guides have no application here. Despite this, Appellee and its expert witness Dr. Knorpp applied the Guides to evaluate Petitioner's claim for disability. They argued that to be disabled Petitioner must have an "impairment rating," and since the Guides prohibit such a rating for FMS and CFS Petitioner is ineligible for benefits. The HO agreed, and adopting Appellee's Findings of Fact and Conclusions of Law, he found;

Dr. Beales failed to provide Petitioner with **an impairment rating** . . . .  
**No evidence was presented** by Petitioner to indicate that she qualifies for an  
**objective impairment rating** . . . HR 381-387

Although the HO temporized by adopting Appellee's language that, "it is not mandatory . . . [to] use the AMA Guidelines and/or the [Guide] to prove" impairment, they were nevertheless used to deny Petitioner's claim because she did not "qualif[y] for an . . . impairment rating." This was error. All that is required is that she have an "impairment," "from anatomical, physiological, or psychological abnormalities." Indeed, Dr. Knorpp admitted that a person can have an "impairment" and yet not qualify for a

“impairment rating.” HT 289:15-22.

## **B. Objective Evidence of an “Impairment” vs. Hearsay and Subjective Evidence**

UCA § 63-46b-8 (1) (c) provides that the HO may not exclude hearsay evidence. UCA § 63-46b-10 (3) provides, however, that no finding of fact that is contested may be based solely on hearsay evidence unless that evidence is admissible under the URE. Pursuant thereto the HO determined, “The evidence presented by Petitioner consisted of her ‘**subjective complaints,**’ **together with hearsay evidence** on the fact in dispute.” He also found that, “**No evidence was presented** by Petitioner to indicate that she qualifies for an objective impairment . . . . HR 381-387. This is false.

UCA § 63-46b-8(1) (b)(iii) states that the HO, “may receive documentary evidence in the form of a copy or excerpt if the copy or excerpt contains all pertinent portions of the original document.” Moreover, in *Industrial Power Contractors v. Industrial Comm.*, 32 P.2d 477 (Ut. Ct. App. 1992), the Court held that pursuant to URE Rule 803(4) medical records are admissible as an exception to the hearsay rule as follows:

Statements made for purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception . or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment. . . . (notations by treating physicians on hospital records carry "sufficient guarantees of trustworthiness to render them admissible in evidence). (Citations omitted.)

Hence, Petitioner’s medical records, received into evidence without objection, are not hearsay. In *State v. Tucker*, 96 P.3d 368 (Ut. App. 2004), the Court held that:

Under [URE Rule 703] an expert witness may offer an opinion based on facts and data made known to him outside of trial. Such information need not be admissible in evidence so long as it is "of a type reasonably relied upon by experts in the particular field in forming opinions. (Citations omitted.)

Furthermore, URE Rule 702, states:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise.”.

Dr. Beales also provided expert witness testimony he based upon Petitioner’s medical records, medical authorities, the SSA disability determination, his clinical observations and Petitioner’s statements to him. This information is “of a type reasonably relied upon by experts in the particular field in forming opinions.” His testimony was also not “hearsay.” Moreover, in *Alder v. Bayer Corporation*, 61 P.3d 1068, 1077-1078, footnotes 4, 6 (Utah 2002), the Utah Supreme Court found that CFS and FMS as objective cognizable illnesses that are “more than merely subjective,” and fully recognized by the medical community as disabling

The HO’s holding that Petitioner’s medical records and expert witness testimony, “consisted of her ‘subjective complaints,’ together with hearsay” was error.

### **C. What is the Objective Evidence of Petitioner’s Impairments?**

Dr. Knorpp testified that there are no objective markers for CFS and FMS. The HO agreed, finding that, “Petitioner **failed to present any non-hearsay evidence** proving she suffered from an ‘objective impairment resulting from injury or illness based on accepted medical tests or findings.’” HR 381-387. This is not true.

Dr. Knorpp stated that, “Impairment is defined as the loss of function of or deranged function of a body part, an organ or an organ system.” HT 68:1-19. The PEHP PAMPHLET and UCA § 49-21-102(6) states that objective evidence of impairment consist of signs, symptoms, and laboratory findings revealed by medically acceptable

clinical and laboratory diagnostic techniques and tests.

Contrary to the HO's finding that "Dr. Beales did not provide any other guidelines or standards that could be used in making his determination on Petitioner's disability," Petitioner provided the SSA and AADEP's guidelines delineating the medically acceptable clinical and laboratory diagnostic techniques and tests with their resultant signs, symptoms, and laboratory findings to establish an impairment based on CFS and FMS. AADEP and the SSA—again contrary Dr. Knorpp's representation--indicate, "when accompanied by appropriate medical signs or laboratory findings, [CFS and FMS are] medically determinable impairment[s] that can be the basis for finding of disability."

To do this AADEP and SSA recommend sleep studies, psychological testing and tender point exams (which were done for Petitioner). Contrary to Appellee's arguments, tender point exams, when performed by experienced physicians, are medically accepted clinical exams that produce objective signs. AADEP states:

The examiner should palpate the tender point sites, examine for the presence of trigger points, perform a detailed peripheral joint examination, and examine carefully the back and neck. In the classic definition of a trigger point, **a trigger point is an area in an abnormal muscle which, when palpated, is severely tender, has a band-line or ropy feel to it, twitches, and causes pain in a site distant from the patient's pain complaint.** HR 183-184.

In *Sanderson v. Continental Casualty Corp.*, to 79 F.Supp. 2nd 466, 417, 473-476 (D. Del. 2003) cited as persuasive authority, the court determined that a denial of disability benefits was arbitrary and capricious for a plaintiff who had rheumatoid arthritis and FMS. The plaintiff's expert witness stated, "the most remarkable aspect of her musculoskeletal examination is her extreme tenderness not only to the joint areas but in the soft tissue areas as well. She is tender to even very light palpitations in the soft tissue

areas. The court then reasoned:

[T]he court need not accept the decision if the administrator uses a self-serving approach to the evidence that selectively relies upon the evidence that supports a denial of benefits, but rejects the evidence that supports the granting of benefits.”

.....

While there is no objective “laboratory marker” for fibromyalgia, these doctors made their diagnosis based on diagnostic criteria, specifically the location of tender points, which are widely used by doctors. . . . Moreover, and Dr. Newman’s October 6, 2000 letter, he specifically noted that: I think a reasonable second diagnosis is fibromyalgia. She certainly seems to have this syndrome on the basis of **sleep disturbance, chronic fatigue**, . . . and symmetric tender points. All in all, I think she has a severe disability due to these about problems.

.....

There is also evidence in the record that Continental was less than forthcoming with the evidence it chose to consider. . . such selective parsing of medical information with no explanation can only be described as suspect.

The [SSA] disability regulations require that subjective complaints of pain be given great weight as long as there is objective evidence of some condition that could reasonably produce such pain. In the present case there is objective medical evidence of fibromyalgia in the form of Sanderson’s examining physician reports. While there is no “objective laboratory marker” for fibromyalgia, the illness is clinically diagnosed through a standardly accepted test in the practice of medicine—the trigger or tender point test. P 476.

Hence, Petitioner’s “medically acceptable clinical and laboratory diagnostic techniques and tests” and their results are as follows. Her repeated clinical tender point exams all verify the existence of tender points consistent findings for CFS and FMS. Petitioner’s imaging studies show DDD, her Polysomnography (Sleep study) shows moderately severe hypoxemia and severe obstructive sleep apnea, and neurological testing has shown mild sensory neuropathy in the L. Peroneal nerve with a 50% loss of vibratory sensation loss in toes bilaterally. Finally her neuropsychological evaluation and testing has shown “significant visual memory problems, and some mild verbal learning and memory problems.” Summary of Facts (SOF), ¶ 6.

Given these are the objective signs, symptoms, and laboratory findings resulting from anatomical, physiological, and psychological abnormalities or “impairments,” it was error to disregard them as either subjective or hearsay.

**II. To Prove the Severity of Petitioner’s Disability Did the Hearing Officer Err by Requiring Objective Evidence at the Exclusion of Subjective Evidence?**

The HO ruled that not only must the existence of an impairment be established through objective evidence, but the impairments’ severity must likewise be founded on objective evidence. This is not the law. UCA § 49-21-102(6) and the PEHP PAMPHLET only mandate that the impairment’s existence be shown by more than the individual’s subjective statements. Hence, the claimant’s subjective statements are probative in proving her impairments’ severity and their resultant disability.

**A. Pain, Fatigue and Cognitive Deficits**

The HO disregarded Petitioner and Dr. Beales’ testimonies about Petitioner’s pain and fatigue because it cannot be objectively proven. However, it is the symptoms of an illness or injury that are disabling. If the law bars consideration of the subjective testimony thereon, regardless of their impairments, most persons would be unable to prove eligibility for disability benefits. The proper statutory interpretation of UCA § 49-21-102(6) is that once objective evidence, coupled with subjective evidence has shown the existence of an impairment, then the severity of the impairment’s symptoms may also be founded on subjective testimony. This rationale is followed by the Federal Courts in interpreting similar statutory and policy language.

In *Mickles v. Shalala*, 29 F.3d 998 (4<sup>th</sup> Cir. 1994) the court stated, “The only fair manner to weigh a subjective complaint of pain is to examine how the pain affects the

routines of life.” And in *Hyatt v. Sullivan*, 899 F.2d 329, 336 (4<sup>th</sup> Cir. 1990) it was held that:

Once an underlying physical or mental impairment that could reasonably be expected to cause pain is shown by medically accepted objective evidence, such as clinical or laboratory diagnostic techniques, the adjudicator must evaluate the disabling effects of a disability claimant’s pain, even though its intensity or severity is shown only by subjective evidence. If an underlying impairment is capable of causing pain is shown, subjective evidence of the pain, its intensity or degree, can, by itself, support a finding of disability. Objective medical evidence of pain, its intensity or degree (i.e., manifestations of the functional effects of pain such as deteriorating nerve or muscle tissue, muscle spasm, or sensory or motor disruption), is available, should be obtained and considered. Because pain is not readily susceptible of objective proof, however, the absence of objective medical evidence of the intensity, severity, degree or functional effect of pain is not determinative.

It has been objectively shown that Petitioner has FMS and CFS and DDD. These illnesses are known to cause pain and fatigue. It has also been shown she has severe sleep apnea. Her treating physician stated:

The abnormalities of sleep architecture and respiration, as discussed above, **would account for clinical symptoms such as nonrestful sleep, daytime fatigue, and excessive daytime sleepiness.** HR 221 Exh. B at pp. 119-120.

Hence, since the medical evidence objectively established the existence of these impairments—FMS, CFS, DDD and Severe Sleep Apnea--and since these impairments **“would account for clinical symptoms such as nonrestful sleep, daytime fatigue, . . . excessive daytime sleepiness”** and pain, Petitioner’s subjective testimony about the effects of these symptoms on her ability to function and work should have been considered by the HO.

Psychological testing has also objectively indicated that Petitioner has, “significant visual memory problems, and some mild verbal learning and memory problems.” SOF ¶



6(K). Hence, since the medical evidence objectively established the existence of these cognitive impairments--and since they “would account for clinical symptoms such as” her forgetfulness and cognitive errors at work, Petitioner’s subjective testimony about the effects that this impairment has on her ability to function at work should have been considered by the HO. It was therefore error to disregard Petitioner’s subjective testimony about the debilitating symptoms of her impairments.

**III. Did the Hearing Officer Err by Failing to Find Petitioner Disabled By Considering the Combined Effect of Petitioner’s Impairments and by Failing to Take into Consideration Petitioner’s SSA Determination?**

The PEHP DISABILITY BENEFITS PAMPHLET, page 2 states:

Total Disability: Defined as the complete inability due to . . . impairment to engage in the employee’s regular occupation during the elimination period and the first 24 months of disability. Thereafter, *total disability* means the complete inability, based solely on impairment, to engage in any gainful occupation which is reasonable, considering the employee’s education, training, and experience. . .

Appellee argues that no evidence demonstrates that Petitioner’s physical impairments would prevent her from performing her sedentary employment. Moreover, the Appellee argued that Petitioner’s cognitive or mental impairments were not sufficiently severe to prevent her from working. While it is true that Petitioner has no “impairment rating,” nor any anatomical limitations such as range of motion losses, and it may also be true that her impairments when viewed in isolation to each other would not appear to cause disability, the combined effect of her impairments are disabling.

During cross examination Dr. Knorpp admitted that he did not consider how Petitioner’s cognitive deficits, DDD, neuropathy, or severe sleep apnea affected her ability to work. As a consequence the Appellee’s did not submit any testimony on the

combined effect of her impairments. Dr. Beales and Petitioner did.

In *Layton v. Heckler*, 726 F.2d 440, 442 (8<sup>th</sup> Cir. 1984) the Federal Appellate Court held,

For each illness standing alone, measured in the abstract, may not be disabling. But disability claimants are not to be evaluated as having several hypothetical and isolated illnesses. These claimants are real people and are entitled to have their disability measured in terms of total psychological well-being.

Moreover, the Guides, if applicable, state that “the attending physician is deemed the person most knowledgeable regarding the condition, progress and final status of the injured employee.” HR 373. The Guides therefore grant controlling weight to treating physicians over the testimony of Dr. Knorpp. Regarding treating physicians, in *Mitchell v. Schweiker*, 699 F.2d 185, 187 (4<sup>th</sup> Cir. 1983) this Federal Appellate Court held that the opinions and diagnosis of the treating an examining doctors constitute a major part of the proof to be considered in a disability case and may not be discounted.

Treating physician Dr. Vincent indicated that Petitioner has difficulty sleeping, has difficulty walking, poor coordination, difficulty with sleep, and neck, back, leg . . . and arm pain.

Treating physician Dr. Bateman stated at HR 221, Exh. B p 11, in her FATIGUE CLINIC CONSULTATION REPORT that:

On a good day. . . by 4 p.m. she is so tired that she needs a rest for about an hour. . . she cannot walk around a lot, sit in car and drive a long time, stay out late, be around people who are negative and can’t do a lot or she will be in bed for the next few days. On a bad day she can talk on the phone, have hot baths, take naps and look at a magazine. She cannot bend over, lift or push things, walk, think clear, sleep, concentrate, focus on one thing or lift her arms to do her hair.

Dr. Beales stated:

**... [Petitioner] has significant visual memory problems ... shown by the neuro-psychometric testing and would present a significant detriment to her adequate functioning in ... not [being] able to read and remember.**

[Petitioner] can't read policies and remember them. [Petitioner] can't read clients documented problems and remember them ... HT 28:14-21

....

... [Petitioner] would not be able to remember things consistently and reliably particularly with the visual memory impairment that has been objectively demonstrated. ... [Petitioner] would be distracted all the time because of her pain, ... tiredness and fatigue and having to take three or four naps [a] day. ... HT 33:24-25, 34:1-11.

Petitioner gave extensive testimony. Petitioner is age 57. She has two years of college. She worked for the state of Utah since April 1, 1979 to October 1, 2002, for a total of over 20 years. During those years she was a, "very good, respectable worker," who "completed things on time," did what she was asked to do, was well-trained, sociable, and was admired by her clients and coworkers. She started experiencing difficulties with her health in 1990. She had symptoms of severe fatigue, pain, and memory problems. At that time she started eliminating all unnecessary activities from her life except for work. HT 146-149.

Because of her symptoms, she could not work without many absences and while at work she committed errors and had to take frequent rest breaks. She also stated that because of fatigue she has fallen asleep at the wheel several times. She testified that her employer attempted to accommodate her by allowing her to take work home and to take rest breaks but this was unsuccessful. While at work she couldn't sit at her desk because of pain. She would forget her computer password. She had to take frequent naps during the day and was often tardy and absent. HT 150-155.

In regards thereto she stated:

I would come in late. I was reprimanded a couple or three times by my supervisor. . . I would [to take naps] but it just became worse. It was just more of the pain and more of needing to rest more than what I was getting. HT 151:22-25, 152:1-3.

....

A year before that I could have at least one or two days that **I could function and then toward the end in 2002, I had no days.** . . I was missing a lot of work . . . my supervisor . . . suggested at that time to make up hours to come into work for the State on the weekends. **So I did that for a full year** . . . [E]ven then, . . . it would be hard . . . my work was getting so behind. So after doing that for a full year . . . working every weekend, I became considerably more ill. . . I was ill and it's a hard thing to tell yourself that . . . you just can't do the things that you used to. HT 153:19-25, 154:1-10.

She was able to sustain her employment until her health problems grew progressively worse until leaving and filing for disability. HT 146-150. Currently Petitioner's family has to take care of her and she is constantly in pain. Sometimes she can't sleep for consecutive days, and even when she does she is not rested. Because she falls she has trouble showering, she often can't do her own hair or nails and cannot pay bills because of errors. It is painful for her to wear undergarments or tight clothing. HT 156-159.

Even Dr. Knorpp begrudgingly admitted that the Petitioner had "low back pain" [HT 86:9], and ". . .some routine osteo-arthritis changes in the digital joints [HT 86:24-25]." He indirectly acknowledged that to work Petitioner would need an accommodation from her employer. [HT 122:5-6]. Because she had too many absences and was making too many mistakes, Petitioner testified that her employer could not make any additional accommodations for her.

Petitioner presented this same evidence to the SSA who found her to be totally disabled. In *Austin v. Continental Casualty Company*, 216 F.Supp.2d 515, 553, 555-556 (W.D.N.C. 2002), provided as persuasive authority, the plaintiff, found disabled by the

court, was diagnosed with cervical arthritis with a component of **fibromyalgia**. The medical evidence indicated that the plaintiff's disease made it very difficult for her to sit for very long periods of time and she could not raise her hands above her head, lift, nor perform rapid movements of the upper extremities. The evidence also indicated that the plaintiff could not concentrate on tasks, maintain pace or persistence, maintain attendance and punctuality, carry out tasks in a timely manner, and complete a work day or work week without an unreasonable number of breaks related to her symptoms.

Plaintiff also had a favorable Social Security Determination granting her federal disability benefits. Nevertheless, as in this case, the defendant determined that plaintiff Austin could work at a sedentary job. .

In regards thereto, the *Austin* at 556, court stated that:

[T]he . . . record . . . indicate[s] that plaintiff's application for Social Security disability benefits was granted. This court has earlier held that the plan administrator is not bound by such a decision; however, the information is relevant because . . . the standards applied by the [SSA] in determining whether an applicant retains the . . . capacity to perform any gainful employment are at least as restricted as the plan standards in this case. . . Even though a plan administrator need not give deference to, or even consider, the ultimate vocational determination of the [SSA], failing to do so would be at the administrator's peril. Although those determinations are not infallible, federal courts are keenly aware of the close scrutiny which claims for Social Security disability receive.

It was error to disregard the SSA's findings and to fail to consider the effect of the combination of Petitioner's medical impairments.

#### **IV. Did the Hearing Officer Err by Finding Dr. Knorpp's Testimony to Be Credible and Persuasive?**

The Petitioner acknowledges that Dr. Knorpp's credentials qualify him as an expert witness. However, all the medical authority, including that from AADEP the

organization that certified Dr. Knorpp, demonstrates that his evaluation of Petitioner was unreliable.

Dr. Knorpp states that impairment ratings cannot be given to persons with CFS or FMS. He therefore concludes that they can never be found to be disabled. The CDC, Mayo Clinic, SSA and AADEP state otherwise. Dr. Knorpp spent 45 minutes with Petitioner. AADEP indicates that a proper evaluation may take “hours if not days.” It directs that while refraining from orthopedic exams, that physicians evaluating persons with CFS or FMS should review all available medical records, take a detailed history as to onset and the relationship to any other conditions that may have caused fatigue, provide a description of the severity of the fatigue, provide a detailed description of the examinee’s loss of function, activities of daily living and self care, and activities of work as well as the frequency and duration of the complaints. It states that all other conditions should be excluded and treated. SOF §§ 8-10, 12, 23, 25, 33, 38, 43, 47.

*Govindarajan v. FMC Corp.*, 932 F.2d 634, 637 (7<sup>th</sup> Cir. 1991) the plaintiff sought long-term disability benefits because of a back injury. While doing so he obtained a favorable judgment from the SSA that granted him Social Security benefits. The plaintiff was granted short-term disability benefits but denied long-term disability benefits by the defendant. Both the District Court and the appellate court found under any standard of review that benefits had been arbitrarily denied. The Court found that the defendant failed to review the entire medical file in assessing the plaintiff’s claim for benefits. Consequently, the appellate court agreed with the District Court that the defendant’s selective review of the medical evidence and its completely erroneous assertion that there

was no physical cause for the subjective symptoms of pain renders his decision not only unreasonable but arbitrary and capricious.

AADEP and the SSA direct that evaluating physicians should conduct tender point exams, sleep studies, treadmill exercise testing, tilt table testing, psychological testing, spinal imaging studies and brain imaging studies. To “quantify self-reported severity regarding functional ability, fatigue, sleep disturbance, and pain” “the examiner **should**” use the daily living activity rating scales in the *AMA Guides to the Evaluation of Permanent Impairment (4<sup>th</sup> Edition)*, quality of life measurement studies, Oswestry Disability Index, McGill Pain Questionnaire, and the Pain Disability Index, among others. They also recommend contact with previous health professionals, family and close contacts. SOF §§ 10, 29, 30.

Again, Dr. Knorpp did none of these things. Dr. Knorpp did conduct an orthopedic FCE and range of motion exam which is contraindicated by AADEP. He also applied the Guides which are inapplicable to this case. Dr. Knorpp had only a “smidgeon” of the medical records. He knew Petitioner had a history of hypertension and the heart valve disease, but took no action to evaluate these conditions or to secure the medical records thereon. He did not consider the effect Petitioner’s severe sleep apnea, her DDD, her neuropathy or her cognitive deficits had upon her overall functionality. Nor did he speak with any of the Petitioner’s family members, acquaintances, or doctors. SOF §§ 27, 28, 31, 51-55.

Even the Guides, which are inapplicable to this case, state the following:

The history should be based primarily on the individual's own statements rather than secondhand information. The physician should consider information from

sources, including medical records . . . . It is not appropriate to question the individual's integrity. HR 373.

Despite the Guides, the SSA and AADEPs' directives to consult with treating physicians, he denigrated the trigger point findings of Dr. Beales and of the Petitioner's treating physicians Dr. Bateman, Dr. Call and Dr. Rosen. Dr. Knorpp further disregarded with the SSA's policies and its determination that Petitioner is disabled. SOF §§ 22, 67.

Dr. Knorpp has never diagnosed, treated, nor provided rehabilitation services for any patient with CFS and FMS. HT p. to 17:22 –25, to 18:1–12. Dr. Knorpp has never done a tender point examination for FMS or CFS. HT 23:22 –25, 224: 1 –13. Dr. Knorpp only works for insurance companies. Contrary to medical literature cited above in the Arthritis & Rheumatism Journal, The Cleveland Clinic Journal of Medicine, he has stated that there “no science to support the existence of the disease.”<sup>3</sup> Dr. Knorpp discounted Petitioner's reports of hypersensitivity to touch because he was unaware that patients with FMS and CFS often have great sensitivity to touch. SOF § 43.

Dr. Knorpp also stated, contrary to the medical science, “We don't disbelieve they have pain, we don't have any disease to explain their disorder so if we don't have any disease to treat, then we probably shouldn't treat them as if they can't do something or they shouldn't do something.” SOF § 44. Dr. Knorpp also testified that, “All the literature regarding chronic pain disorders including the literature for [FMS] and [CFS] is that these people are really best served by maintaining functional lives rather than sitting at home. The best medical science today would say that Mrs. Malan should continue

---

<sup>3</sup> While it is true that it cannot be determined what specifically causes CFS and FMS, it is not correct that there is no scientific evidence of these illnesses' existence.



functioning and should continue working even if she has this disorder.” SOF § 34. This is not true.

The CDC CFS Case definition states, “Recent longitudinal studies suggest that some persons affected by the [CFS] improve with time but that most remain functionally impaired for several years.” HR 221 Exh. B p. 178. The CDC Clinical Course of CFS states, “Some patients recover completely with time, and some grow progressively worse.” HR 246.

Dr. Knorpp’s bias was displayed when he took issue with the Petitioner painting her fingernails stating, “. . .her fingernails were cosmetically dressed, and I indicate that because people . . . who are in a significant degree of body pain . . . usually don’t waste time getting their fingernails dressed.” HT 86:17-21. Dr. Knorpp is an activist who expels the ill into the wilderness to die because, “if there’s a disconnect between a desire to return to work and an inability to return to work, I have to bridge that gap.” HT 80:19-23.

Dr. Beales’ testimony was consistent with the medical literature. It is conceded that Dr. Beales is unable to parrot the statutory disability standards and is not board certified. Unlike Dr. Knorpp, Dr. Beales reviewed all of Petitioner’s medical records, conducted a thorough history, examined her, gave weight to her treating physicians’ findings and considered the combined effect of all of her impairments. Also, consistent with AADEP, he attested that the FCE and orthopedic exams are ineffectual in evaluating her impairments due to CFS and FMS. SOF ¶¶ 60-63.

Dr. Beales has practiced internal medicine for 35 years, seven of these years at the

Brigham Young University's Health Center. Since 1980 he has become completely familiar with the leading scientific research on FMS and CFS, has treated approximately 3,000 patients with these conditions, and has followed many of these patients during the course of their illnesses. HT 11-20.

In conclusion, the superficiality and bias of Dr. Knorpp's expertise is not only exemplified by his failure to follow the directives of his own certifying organization, AADEP, but was exemplified by his rude behavior with Petitioner and is summed up by his comment: "Sir, we don't determine whether someone is so ill they can't work. We use the guides, we use the **impairment ratings** to determine a number." Hence, Dr. Knorpp used Guides that have no application to the Petitioner to deem her ineligible for an "impairment rating" and to be therefore ineligible for disability benefits.

Pursuant to *State v. Rimmasch*, 775 P.2d 388 (Utah 1989) Dr. Knorpp's testimony was scientifically unreliable and should have been stricken because he did not follow accepted scientifically valid methodology noted above in arriving at his opinions and because even if Dr. Knorpp did employ scientifically valid methodology he did not properly apply that methodology in alleging that Petitioner did have an impairment and was therefore not totally disabled. It was error for the HO to "accept" Dr. Knorpp's testimony as credible and to disregard Dr. Beales' experience-based expertise.

**V. Did the Hearing Officer Err by Failing to Draft Detailed Findings of Fact, Conclusions of Law and the Final Order?**

Based upon Appellee's arguments, Petitioner requested that the HO resolve several specific issues. The HO then issued a "Decision." In it he determined that all of Petitioner's evidence consisted of "subjective complaints" together with hearsay, there

was no admissible evidence showing an impairment, and Dr. Knorpp's testimony was credible and "accepted." It did not address the following issues: (1) Whether an "impairment rating" was necessary to establish disability, (2) Whether the severity of the disability must be established through objective medical evidence, (3) Whether the combined effect of Petitioner's medical impairments had been properly considered [including her severe sleep apnea and lumbar DDD], and (4) Whether the Utah 2002 [Worker's] Compensation Guides, or any other guidelines where applicable to PEHP determinations. (HR 231-257, 329-373)

In *Foreman V. Foreman*, 176 P.2d 144 (Utah 1946) the court held that when a trial renders a decision, its Findings of Fact, Conclusions of Law and Order should be consistent with its initial decision. Otherwise, this has the tendency to "cast doubt upon the foundation for those determinations." Also, UCA § 63-46b-10 requires the HO to issue an order that includes a statement of his Findings of Fact and Conclusions of Law and the reasons for his decision. The HO did not do this. The Appellee did. Granted, it is a common practice to have counsel prepare such orders. However the orders are required to be consistent with the adjudicator's Decision.

Here, the HO's threadbare "Decision" bears no resemblance to the final Order's Findings of Facts ¶¶3,4,5,6,7,8,9, 11, 12 and Conclusions of Law" ¶¶ 2; 3, 4,5,6,9 (second sentence), 11, 12. Other than ignoring all of Petitioner's evidence as "subjective" and hearsay, finding Dr. Knorpp credible, and ruling against Petitioner, it is unclear if the HO engaged in any deliberations and made decisions based thereon. This makes it difficult to review his final Order. Moreover, the Agency/Appellee selects, hires and retains the HO.

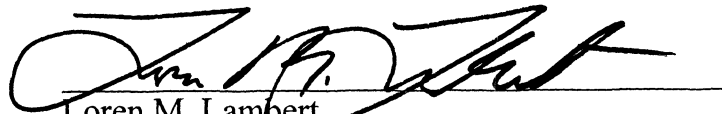
In his tenure with the Agency, the HO has never ruled in favor of a claimant. HR 263-297. While this is not evidence of bias, under the circumstances of this case, it creates the inference that the Appellee really determined this case. It was error for the HO to do this.

### CONCLUSION

In conclusion, it is respectfully requested that pursuant to UCA § 63-46b-16 the HO's and Agency's Decision and Order be stricken and that the Agency be ordered to pay Petitioner her disability benefits action. This should be done because Petitioner has been substantially prejudiced because the HO did not decide all of the issues before him, erroneously interpreted the law regarding impairments, erroneously applied the evidentiary hearsay rules, failed to follow prescribed procedure in making proper Findings of Fact and Conclusions of Law, his Decision and Order are not supported by substantial evidence when viewed in light of the whole record before the court, and the HO abused his discretion and acted in an arbitrary and capricious manner.

Dated: January 25, 2005.

Arrow Legal Solutions Group, PC

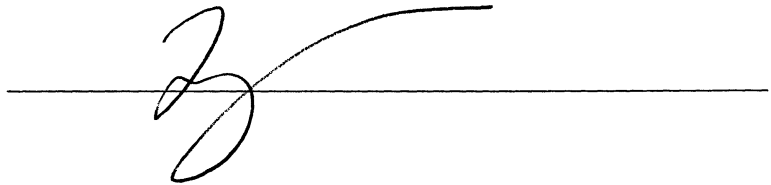
  
Loren M. Lambert  
Attorney for Petitioner

CERTIFICATE OF MAILING

I certify that I mailed two true and correct copies of the foregoing document on

1-26-05, postage prepaid to:

David B. Hansen  
Counsel for Respondent/Appellee  
560 East 200 South, Suite 300  
Salt Lake City, UT 84102

A handwritten signature, appearing to be "DBH", is written over a horizontal line. The signature is in black ink and is stylized.

# **ADDENDUM**

**A. DECISION**

**B. ORDER**

## A. DECISION

---

**BEFORE THE UTAH STATE RETIREMENT BOARD**

---

**LINDA MALEN HILTON:**

<b>v.                    Petitioner,</b>	:	<b>DECISION</b>
	:	
	:	
<b>UTAH STATE RETIREMENT BOARD,</b>	:	<b>File #: 03-16D</b>
<b>LONG TERM DISABILITY PROGRAM,</b>	:	
	:	
<b>Respondent.</b>	:	
	:	

---

**ISSUE**

1.     The issue presented is whether, by applicable law, the petitioner is entitled to permanent and total Long Term Disability benefits.

**APPLICABLE LAW**

2.     Section §49-11-13(2) of the Utah Code provides:  
  
      The hearing officer shall:
  - a.     Be hired by the executive director after consultation with the Board;
  - b.     Follow the procedures of Title 63, Chapter 46 b, Administrative Procedure Act, except as specifically modified by this Title.
3.     Section §49-11-613(4), Utah Code, provides:  
  
      The moving party in any proceeding brought under this section shall have the burden of proof.
4.     Section §63-166-8(c), Utah Code, provides:  
  
      The presiding officer may not exclude evidence only because it is hearsay.



5. Section §63-46(b) – (3)(10), Utah Code, provides:

No finding of fact that was contested may be based solely on hearsay evidence unless that evidence is admissible under the Utah Rules of Evidence.

6. Section §49-21-102(6) Utah Code provides:

“Objective Medical Impairment” means an impairment resulting from an injury or illness which is diagnosed by a physician and which is based on accepted medical tests or findings rather than subjective complaints.


### **EVIDENCE**

7. The evidence presented by Petitioner consisted of her “subjective complaints,” together with hearsay evidence on the fact in dispute.
8. No admissible evidence was presented by petitioner on an impairment resulting from an injury or illness which was diagnosed by a physician based on accepted medical tests or findings.
9. The evidence presented by Dr. Knorpp is credible and accepted.
10. Under the evidence, Petitioner is not entitled to permanent Long Term Disability benefits.

### **PROCEDURE**

11. Counsel for the Respondent shall prepare an Order consistent with this decision. This hearing will be final when that Order is approved and adopted by the undersigned.

Dated this 14 day of September, 2004.

  
James L. Barker, Jr., Administrative Hearing Officer

**CERTIFICATE OF MAILING**

I hereby certify that on this, 14 day of September 2004, I mailed a true and correct copy of the above **Decision**, postage prepaid, to the following:

Loren Lambert  
Arrow Legal Services  
266 East 7200 South  
Midvale, UT 84047

David B. Hansen  
Howard, Phillips & Andersen  
560 East 200 South #300  
Salt Lake City, UT 84102

  
\_\_\_\_\_  
Debbie Buck

## **B. ORDER**

---

**BEFORE THE UTAH STATE RETIREMENT BOARD**

---

**LINDA MALAN HILTON,**

**Petitioner,**

**v.**

**UTAH STATE RETIREMENT BOARD,  
LONG TERM DISABILITY PROGRAM,**

**Respondent.**

:  
:  
:  
:  
:  
:  
:  
:  
:  
:  
:

**ORDER**

**File #: 03-16D**

---

A hearing was held on May 6<sup>th</sup> and June 1<sup>st</sup>, 2004, before the Adjudicative Hearing Officer on Petitioner's Request for Board Action. The Petitioner was represented by Loren Lambert. The Board was represented by David B. Hansen. Based upon the evidence in this matter and the legal memoranda submitted, the Adjudicative Hearing Officer makes the following Findings of Fact, Conclusions of Law and Order.

**FINDINGS OF FACT**

1. Petitioner worked as an employee of the State of Utah as a Health Program Specialist II. See, Petitioner's Hearing Exhibit B-15, at 166.

2. Petitioner testified that her last day of work with the State of Utah as a Health Program Specialist II was October 1, 2002. See, Hearing Transcript [Hereinafter “TR”]173:13-15.

3. Petitioner presented into evidence a job description from the State of Utah which indicates that her position as a Health Program Specialist II was a sedentary position. See, Petitioner’s Exhibit B-15. The physical demands of this position consisted primarily of sitting and included some walking, standing, bending, and carrying light items. See, Id. at 166-167.

4. The LTD Program denied Petitioner’s application for a two-year own occupation long-term disability benefit because she failed to show she suffers from an objective medical impairment preventing her from performing her regular occupation.

5. At the hearing, Petitioner’s expert witness, Dr. Landon Beales, testified that there are tests which might provide some objective markers for identifying fibromyalgia and chronic fatigue syndrome, but that most of these tests have not been performed on Petitioner. See, TR. 343:16-25, 344:1-25 (Dr. Beals cannot remember if MRI was performed on Petitioner), 345:1-25, 346:1-25(no testing done on Petitioner’s anti-viral pathways), 347:1-25(neuropsychological exam done, but no reason why Petitioner cannot work based on cognitive problems), 348:1-25(did not see lab work to see if blood tests were done to test growth hormone secretion or adrenal hormone measurements), 351:13-25, 352:1-25, 353:1-25(no tilt table test performed), 354:1-25, 355: 1-3(no ultrasound performed on nasal cavity).

6. Both Petitioner and Dr. Beales testified that the worst conditions Petitioner suffers from are pain and fatigue. See, TR. 21:17-18, 22:7, 18-23, 177: 11-25, 178:1-13. Dr. Beales testified, “There’s no good objective measurement of pain, of fatigue . . .,” TR 360:12-13. Dr.

Beales testified that he relied on Petitioner's self-reported symptoms in forming his opinion regarding Petitioner's disability due to pain and fatigue. . . TR. 60: 1-7.

7. Dr. Beales testified that he was not familiar with either the American Medical Association Guides to the Evaluation of Permanent Impairment ("AMA Guidelines") or the Utah Impairment Guidelines. See, TR. 59:15-19, 60: 8-10. Dr. Beales did not provide any other guidelines or standards that could be used in making his determination on Petitioner's disability.

8. Dr. Beales failed to provide Petitioner with an impairment rating using any accepted objective criteria, such as the AMA or Utah Impairment Guidelines. Impairment ratings are the standard used in the medical community to determine disability. See, TR. 60: 1-7.

9. Dr. Knorpp is board certified in physical medicine and rehabilitation. See, Respondent's Hearing Exhibit 1. Dr. Knorpp is proficient with the AMA Guidelines and the Utah Impairment Guidelines in determining medical impairment and disability. See, TR. 65:15-16. Dr. Knorpp testified that the AMA guidelines have been supplemented with the Utah Impairment Guidelines in Utah to establish disability due to pain and fatigue. See, TR. 70:13-24. Dr. Knorpp testified that based upon these guidelines as well as the disability standard defined in Title 49 of the Utah Code, he could not find anything that could objectively show that Petitioner would qualify for an impairment that would lead to a disability. See, TR. 105:18-21, 25, 106:1.

10. Dr. Scott Knorpp's testimony concerning Petitioner's alleged impairment and disability was credible and persuasive. Dr. Knorpp affirmatively testified that Petitioner did not meet the definition of "total disability," under the definition in Utah Code Ann. § 49-21-102(11). See, TR. 105:18-21, 25, 106:1.

11. Petitioner submitted into evidence a Neuropsychological Evaluation performed on Petitioner on February 20, 2003, by Dr. Elaine Clark, a licensed psychologist. See, Petitioner's

Exhibit B-11. Dr. Clark concluded, “this evaluation failed to provide any evidence that would suggest Mrs. Hilton is disabled from work for psychological or cognitive reasons.” Id. at 135-136.

12. The Hearing Officer reviewed and considered all of Petitioner’s medical records in making this determination and Order.

### CONCLUSIONS OF LAW

1. Petitioner’s claim appealed the LTD Program’s denial of a two-year long-term disability benefit.

2. Pursuant to Utah Code Ann. § 49-11-613(2), “the hearing officer shall be hired by the executive director after consultation with the Board and shall follow the procedures of Title 63, Chapter 46B, Administrative Procedures Act, except as specifically modified by this Title.” No evidence was presented which shows the Board failed to follow any of its procedures in conducting this hearing.

3. Petitioner proved no bias in these proceedings. The procedure for administrative hearings has been determined by statute and upheld by Utah Courts.

4. Petitioner proved no bias on the part of the hearing officer in these proceedings. Evidence of previous decisions by a hearing officer does not create bias. See, Prickett v. Amoco Oil Co., 31 Fed.Appx. 608, 611 (10<sup>th</sup> Cir. 2002) (finding that, a judge enjoys a presumption of honesty and integrity which is rebutted only by a showing of “some substantial countervailing reason to conclude that a decision maker is actually biased with respect to factual issues being adjudicated.”).

5. Pursuant to Utah Code Ann. § 49-11-613(4), “the moving party in any proceeding brought under this section shall bear the burden of proof.” Here, as it was in Murphy, the Court



of Appeals held, “the plain language of section 49-1-610(4)<sup>1</sup> clearly imposes the burden of proof on (Petitioner) to demonstrate that she has a ‘total disability.’” Murphy v. Utah State Ret. Bd., 2004 Ut. App. 109, at 2. In long-term disability cases, Petitioner bears the burden to prove she meets the criteria under Title 49, Chapter 21 to be eligible for a long-term disability benefit.

6. Pursuant to Utah Code Ann. §63-46b-8(c), in administrative hearings, the hearing officer “may not exclude evidence only because it is hearsay.” However, hearsay evidence cannot be the sole basis for a contested finding of fact unless that evidence is admissible under the Utah Rules of Evidence. Utah Code Ann. §63-46b-10(3).

7. “Total disability” is defined in Utah Code Ann. § 49-21-102(11)(a) as “the complete inability, due to objective medical impairment, whether physical or mental, to engage in the eligible employee’s regular occupation during the elimination period and the first 24 months of disability benefits.”

8. Pursuant to Utah Code Ann. §49-21-102(6), “Objective medical impairment,” is defined as “an impairment resulting from an injury or illness which is diagnosed by a physician and which is based on accepted objective medical tests or findings rather than subjective complaints.”

9. Petitioner failed to present any non-hearsay evidence proving she suffered from any “objective medical impairment” resulting from an injury or illness based on accepted medical tests or findings. Although Petitioner provided evidence of diagnoses, Petitioner failed to provide any evidence showing that she was objectively impaired due to these conditions.

---

<sup>1</sup> U.C.A. § 49-1-610 was renumbered in 2002. It now appears as U.C.A. § 49-11-613.

10. Because Petitioner failed to provide any objective medical impairment, Petitioner does not meet the statutory standard of “total disability,” and does not qualify for long-term disability benefits.

11. Although it is not mandatory that a petitioner use the AMA Guidelines and/or the Utah Impairment Guidelines to prove impairment, a petitioner must prove “objective medical impairment” through “accepted objective medical tests or findings.” Since the AMA Guidelines and the Utah Impairment Guidelines are the standards currently used by the medical community to determine impairment, these are reasonable guidelines to be used to determine the level of impairment.

12. No evidence was presented by Petitioner to indicate that she qualifies for an objective impairment rating pursuant to the AMA Guidelines, the Utah Impairment Guidelines, or any other accepted objective criteria.

### **ORDER**

IT IS HEREBY ORDERED that Petitioner’s appeal for two-year own occupation long-term disability benefits is denied.

### **BOARD RECONSIDERATION**

Within ten (10) days of a Board order, any party may file a written request for reconsideration stating the specific grounds upon which relief is requested as set forth in Utah Code Ann. §49-11-613. This filing for reconsideration is not a prerequisite for seeking judicial review of the order on review. The request for reconsideration shall be filed with the Board and one copy sent by mail to each person making the request. The Board chairman or executive

director shall issue a written order granting or denying the request within twenty (20) days of receipt. If no order is issued within twenty (20) days, the request is denied.

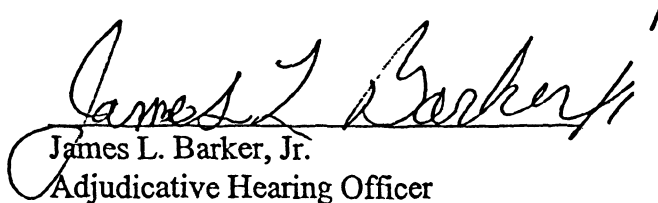
### JUDICIAL REVIEW

If Petitioner is aggrieved with the final Board order, she may seek a judicial review within thirty (30) days after the date that the order constituting final Board action is issued. Petitioner shall name the Board and all other appropriate parties as respondents. The Utah Court of Appeals has jurisdiction to review all final Board actions resulting from formal proceedings. All petitioners shall follow the procedures established in Utah Code Ann. § 63-46b-17.

---

APPROVED AS TO FORM


DATED this 15 day of October, 2004.

  
James L. Barker, Jr.  
Adjudicative Hearing Officer

The foregoing Findings of Fact, Conclusions of Law, and Order of Denial of the Adjudicative Hearing Officer is hereby adopted as the order of the Utah State Retirement Board.

Dated this 21 day of October, 2004.

UTAH STATE RETIREMENT BOARD

BY   
John Lunt, Board President

**CERTIFICATE OF MAILING**

I hereby certify that on this the 25 day of October, 2004, I mailed a true and correct copy of the above Order, postage pre-paid, to the following:

Loren Lambert  
Arrow Legal Solutions, LLC  
266 East 7200 South  
Midvale, UT 84047

David B. Hansen  
Howard, Phillips & Andersen  
560 East 200 South, Suite 300  
Salt Lake City, Utah 84102

  
\_\_\_\_\_  
~~Renee Jensen~~