

Subjective Tension

By Jerel C. Dawson

It is important to be cognizant of the nature of the claimant's evidence in ERISA disability cases.

The Conundrum of Self-Reported Symptoms

Because disability insurance policies universally condition benefits on the insured's inability to work, a "medical diagnosis by itself does not establish a disability" under ERISA. *Jordan v. Northrop Grumman Corp.*, 370

F.3d 869, 880 (9th Cir. 2003).

As the Ninth Circuit observed in *Jordan*, medical treatises describe "medical conditions from amblyopia to zoologia that do not necessarily prevent people from working." *Id.* It is well known that many people with all manner of ailments are "able to work despite their conditions." *Id.*

Similarly, an ERISA disability is not established merely by the existence of pain (however persistent it may be) in the absence of proof that the pain actually precludes the claimant from working. *See Russell v. Paul Revere Life Ins. Co.*, 288 F.3d 78, 80-81 (3d Cir. 2002) (upholding denial of benefits where claimant undisputedly suffered from "chronic pain," but failed to show that it rendered him "totally disabled from performing his [occupational] duties").

Nevertheless, pain is a primary symptom (sometimes the only symptom) of many medical conditions. Plaintiffs in ERISA cases frequently claim to be disabled wholly or partially by pain, which a federal appeals court recently characterized as "inherently subjective" because it

"cannot be quantifiably measured." *Oliver v. Coca Cola Co.*, 497 F.3d 1181, 1196 (11th Cir. 2007). *See also Jewell v. Life Ins. Co. of N. Am.*, 508 F.3d 1303, 1315 (10th Cir. 2007) (pain is a "subjective matter which is not susceptible of objective measurement").

Several courts have therefore held that an ERISA insurer or claim administrator may not categorically reject subjective pain complaints as disability evidence, because if such rejection were permitted, then some pain-based conditions "could never be shown to be totally disabling." *Hawkins v. First Union Corp. LTD Plan*, 326 F.3d 914, 919 (7th Cir. 2003).

At the same time, however, the insurer of an ERISA plan has a "duty to all plan participants and beneficiaries to investigate claims and make sure to avoid paying benefits to claimants who are not entitled to receive them." *Davis v. Unum Life Ins. Co. of Am.*, 444 F.3d 569, 575 (7th Cir. 2006). If ERISA insurers were required to "accept all subjective complaints... without question," the insurers would soon be "paying virtually all claims," *Hufford v. Harris Corp.*, 322 F. Supp. 2d 1345, 1356 (M.D. Fla. 2004), including those filed by participants with only "subjective and effervescent symptomology." *Coffman v. Meropolitan Life Ins. Co.*, 217 F. Supp. 2d 715, 732 (S.D. W.Va.



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2002), *aff'd*, 77 Fed. Appx. 174 (4th Cir. Oct. 10, 2003).

In short, benefits cannot be payable simply on the say-so of the claimant, as this would make the denial of claims a virtual impossibility and bankrupt the secure employee benefit system intended by Congress when it enacted ERISA. Thus, objective evidence is necessary in order to “establish that the diagnosed disease, illness or condition results in an *actual* disability, not just a perceived one.” *Brucks v. Coca-Cola Co.*, 391 F. Supp. 2d 1193, 1205 (N.D. Ga. 2005) (emphasis added).

Due to the importance of “paying legitimate claims” while also “guarding the assets of the [plan] from improper claims,” *Coffman*, 217 F. Supp. 2d at 732, one of the most contentious and difficult areas of ERISA disability law concerns the degree of evidentiary weight to be accorded a claimant’s subjective descriptions of his or her own symptoms, particularly pain and fatigue.

Fibromyalgia and Chronic Fatigue Syndrome

The distinction between a medical diagnosis and a verifiable disability frequently arises in the context of claimants diagnosed with fibromyalgia or chronic fatigue syndrome (CFS), which are “not subject to objective verification” because they are not characterized by specifically identifiable medical abnormalities. *Denmark v. Liberty Life Assur. Co. of Boston*, 481 F.3d 16, 37 (1st Cir. 2007). Indeed, they are “only verifiable through patient self-report.” *Chronister v. Baptist Health*, 442 F.3d 648, 656 (8th Cir. 2006).

The symptoms of fibromyalgia, which include “pain all over” and fatigue, are “entirely subjective,” and there are “no laboratory tests for [their] presence or severity.” *Brown v. Continental Cas. Co.*, 348 F. Supp. 2d 358, 360 (E.D. Pa. 2004). Not surprisingly, then, courts have “often struggled with the role of objective evidence in fibromyalgia cases,” *Patrick v. Hartford Life and Acc. Ins. Co.*, 543 F. Supp. 2d 770, 777 (W.D. Mich. 2008), as well as cases involving CFS and chronic pain generally.

Treating Physicians

Complicating matters further is the role of plaintiffs’ treating physicians, whose medical opinions on behalf of their patients often comprise a disability claimant’s best

evidence. In 2003, the Supreme Court held that claim administrators are not required to “accord special weight to the opinions of a claimant’s physician.” *Black & Decker Disab. Plan v. Nord*, 538 U.S. 822, 834 (2003).

Nor can courts impose on administrators any “burden of explanation when they credit reliable evidence that conflicts with a treating physician’s evaluation.” *Id.* At the same time, however, courts cannot “arbitrarily refuse to credit a claimant’s reliable evidence, including the opinions of a treating physician.” *Id.*

As the Court made clear in *Nord*, the touchstone of the ERISA evidentiary inquiry is reliability. But how reliable is a treating physician’s opinion that his or her patient cannot work if the opinion is based on the patient’s subjective self-reports to the physician? Physicians, in providing medical care, typically “accept at face value what their patients tell them about their symptoms.” *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 409 (7th Cir. 2004).

An ERISA claim administrator, by contrast, must “consider the possibility that applicants are exaggerating in an effort to win benefits,” or, alternatively, that they may be “sincere hypochondriacs” who are “not at serious medical risk.” *Leipzig*, 362 F.3d at 409. Therefore, although “acceptance of a plaintiff’s subjective complaints” is generally “required of treating physicians” in rendering care, it is “by no means required of [an] administrator” in determining whether a claimant has established contractual entitlement to benefits under an ERISA plan. *Maniatty v. UnumProvident Corp.*, 218 F. Supp. 2d 500, 504 (S.D.N.Y. 2002), *aff'd*, 62 Fed. Appx. 413, 2003 WL 21105390 (2d Cir., May 15, 2003).

The Crucial Distinction

Case law demonstrates the continuing struggles of courts to define the role of subjectively perceived pain and fatigue in disability evaluation, and to determine whether and to what extent insurers may insist upon objective corroborating evidence. The Eleventh Circuit’s decision in *Oliver* illustrates a crucial distinction that should guide insurers and administrators in evaluating the need for objective evidence to substantiate a given claim.

In *Oliver*, the claimant experienced chronic neck and back pain due to an auto

accident. His treating physicians diagnosed chronic pain syndrome and fibromyalgia, and supported his claim of disability. The administrator had the medical records reviewed by a consulting physician, who indicated that the claimant’s pain lacked a “true organic etiology” and that the claim was supported only by the “patient’s own subjective complaints.” *Oliver*, 497 F.3d at 1191. Benefits were thus denied on the ground that there was “no objective evidence to support [the claimant’s] subjective complaints.” *Id.*

The Eleventh Circuit observed that in view of the intrinsically subjective nature of pain, the “only evidence” of a disability in some cases will consist of “physical examinations and medical reports by [treating] physicians, as well as the patient’s own reports of his symptoms.” *Id.* at 1196. Finding it “unclear what additional ‘objective’ evidence of his pain [the claimant] could have provided,” *id.* at 1197, the appeals court affirmed the district court’s decision for the claimant.

The administrator in *Oliver* argued that the district court had overlooked a “fine, but important distinction”—namely, that the administrator had required “objective medical evidence of his claimed inability to perform his job, not of the etiology of his pain.” *Id.* at 1197 n.5. Noting the administrator’s earlier emphasis on the absence of a “true organic etiology of the pain,” the Eleventh Circuit rejected the administrator’s claim that it had focused merely on the claimant’s work capacity. But the distinction between an etiology or diagnosis on the one hand, and the claimant’s ability or inability to work on the other, is vital.

The difference was described with concision in *Boardman v. Prudential Ins. Co. of Am.*, 337 F.3d 9, 16 n.5 (1st Cir. 2003), where the claimant was diagnosed with fibromyalgia and CFS (the two conditions are closely related). As the court acknowledged, the insurer was “willing to accept that [claimant] suffered from the illnesses she reported to her doctors,” and had not required her to “present objective evidence to establish her illnesses.” *Id.* at 16 n.5. Instead, the insurer required objective evidence that her illnesses “rendered her unable to work.” *Id.*

Holding that the insurer acted appropriately, the First Circuit observed that “while



the diagnoses of chronic fatigue syndrome and fibromyalgia may not lend themselves to objective clinical findings, the physical limitations imposed by the symptoms of such limitations do lend themselves to objective analysis.” *Id.* In other words, irrespective of the subjective nature of the allegedly disabling condition, an insurer is allowed to require “objective evidence that

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the plaintiff is unable to work.” *Denmark*, 481 F.3d at 37.

When ERISA disability insurers require objective evidence to substantiate claims involving subjective diagnoses or symptoms, it is thus important that they make clear that the evidence sought concerns the claimant’s functional capacity rather than the existence of the symptoms or their underlying medical cause. See *Pralutsky v. Metropolitan Life Ins. Co.*, 435 F.3d 833, 839 (8th Cir. 2006) (upholding administrator’s requirement of “clinical and objective evidence” where administrator sought “substantiation of the extent of [claimant’s] disability” and not an “impossible level of objective proof that she suffered from fibromyalgia”).

The state of ERISA law with regard to the “distinction between subjective and objective evidence of symptoms such as pain and fatigue” was summarized and discussed in *Williams v. Aetna Life Ins. Co.*, 509 F.3d 317 (7th Cir. 2007). The plaintiff in *Williams* claimed to be disabled by CFS, arguing that “because fatigue is inherently subjective,” the insurer “acted improperly when it denied [the] claim on the basis of a lack of objective support in the record.” *Id.* at 322.

Citing *Hawkins*, *Boardman*, *Denmark*, and *Pralutsky*, the Seventh Circuit held that the subjective nature of pain and fatigue “does not bar reviewers from requiring accurate documentation from a treating physician that the claimant’s subjective symptoms of pain or fatigue limit his func-

tional abilities in the workplace.” *Id.* at 323. As the court noted, however, such documentation must be accurate and complete—in *Williams*, the claimant’s physician submitted a “residual functional capacity questionnaire” that “could have provided sufficient evidence that [the claimant’s] functional abilities were limited by his subjective symptoms of fatigue,” except that the physician answered many of the questions with “unknown” or “untested.” *Id.*

Objective Measures

While a number of courts have agreed that elusive maladies such as fibromyalgia, CFS, and chronic pain may be objectively measured in terms of the physical or functional limitations caused, the nature and sufficiency of such measurements remain problematic. Some courts have specifically endorsed functional capacity evaluations (FCE) as the “best means of assessing an individual’s functional level.” *Fick v. Metropolitan Life Ins. Co.*, 347 F. Supp. 1271, 1280 (S.D. Fla. 2004). FCEs are used to “define an individual’s functional abilities or limitations” through a series of tests that may include “musculoskeletal screening, endurance/aerobic capacity evaluation, dynamic lift testing, positional tolerance testing, and other functional and strength testing.” *Stiltz v. Metropolitan Life Ins. Co.*, 2006 WL 2534406, *12 (N.D. Ga., Aug. 30, 2006).

Some courts have found FCEs to be decisive evidence in fibromyalgia/CFS cases. See *Fitzpatrick v. Bayer Corp.*, 2008 WL 169318, *14 (S.D.N.Y., Jan. 17, 2008) (upholding termination of benefits and ruling that FCE was a “reasonable method of ascertaining the extent of Plaintiff’s disability” from CFS). But the FCE has also been described as a mere “test of strength” which can “neither prove nor disprove claims of disabling pain.” *Brown*, 348 F. Supp. 2d at 367.

Administrative reliance on an FCE was criticized on another ground in *Manning v. Johnson & Johnson Pension Committee*, 504 F. Supp. 2d 1293 (M.D. Fla. 2007), with the court finding that the plaintiff’s FCE “primarily assessed her ability to perform certain motor functions on a short or intermittent basis, rather than continuously through an eight hour day.” *Id.* at 1304. Therefore, the court reasoned, it was improper for the administrator to conclude, based on the “dubious FCE findings,” that

the plaintiff was “capable of sedentary work for eight hours per day.” *Id.*

When a claim administrator initially denies or terminates benefits on the ground that objective evidence is lacking, the administrator can help its cause by giving the claimant a fair opportunity to correct the deficiency in the claimant’s administrative appeal. (Under ERISA, any plan participant who is denied benefits must be afforded an appeal with the opportunity to submit additional medical information to substantiate the claimed disability.) In some cases, as indicated in *Williams*, a requirement of objective evidence can be satisfied by specific information from treating physicians that clearly goes beyond mere recitation of their patients’ subjective complaints. If such information is provided, it can be evaluated for its sufficiency, and if it is not provided, the insurer’s good faith effort to obtain it will assure the court of the thoroughness of the claim review and the reasonableness of the decision.

When the Eighth Circuit upheld the benefits decision in *Pralutsky*, for example, the court emphasized that this was “not a case in which MetLife unreasonably expected [claimant] to guess what evidence would satisfy the plan administrator.” *Pralutsky*, 435 F.3d at 840. Instead, the insurer “specifically identified and requested additional clinical evidence supporting the severity of [claimant’s] condition.” *Id.*

During the administrative appeal process, the insurer wrote to the claimant and advised her to provide “treatment records from her treating physicians that indicate her current treating diagnosis, restrictions and limitations... ongoing current treatment plans, and clinical findings and rationale to support her disability claim.” *Id.* The insurer also took the extra step of contacting the claimant’s treating physicians directly and supplying them with forms to “indicate more specifically the nature and severity of [claimant’s] limitations.” *Id.* But the requested information was not forthcoming; instead, the insurer received only letters from the physicians “largely repeating [claimant’s] subjective complaints.” *Id.* at 841.

Because the claimant and her physicians “failed to provide the requested objective evidence that might have substantiated her inability to work,” the court held that the

insurer's denial of benefits comported with its "obligation to protect the plan's trust property by ensuring that disability claims are substantiated." *Id.* See also *Williams*, 509 F.3d at 323 (noting with approval that insurer's denial letters "clearly explained" the need for "specific data" reflecting the claimant's "functional impairment"). In *Lamanna v. Special Agents Mut. Ben. Ass'n*, 2008 WL 622743 (W.D. Pa., March 6, 2008), by contrast, the court found that the administrator wrongfully denied benefits on the ground that there was "no objective evidence" demonstrating that the plaintiff's "fatigue and pain" were disabling, where the administrator had "refused to advise Plaintiff before that time what evidence would be persuasive." *Id.* at *31.

Judicial Acceptance of Subjective Complaints

While some courts take a relatively dim view of subjective evidence, others hold that a claimant's subjective complaints may constitute "legally sufficient evidence of disability" if the complaints are "credible." *Krizek v. CIGNA Group Ins.*, 345 F.3d 91, 101-02 (2d Cir. 2003) (vacating judgment for insurer because district court categorically dismissed subjective complaints as *per se* insufficient). This raises the question of how the credibility of a claimant's subjective complaints is to be determined.

Being believed by one's treating physicians is certainly a threshold test, but is it enough? In some cases, courts have ruled that a claimant's subjective complaints, if deemed to be credible by his or her treating doctors, suffice to establish disability in the absence of contrary evidence sufficient to undermine the credibility of the complaints. See *Fiedor v. Qwest Disab. Plan*, 498 F. Supp. 2d 1221, 1235 (D. Minn. 2007) (ruling for plaintiff and criticizing administrator for "rejecting [claimant's] subjective complaints" while "pointing to no contrary evidence"); *Payzant v. Unum Life Ins. Co. of Am.*, 402 F. Supp. 2d 1053, 1064 (D. Minn. 2005) (ruling that insurer's requirement of objective evidence was a "procedural irregularity" when the claimant's "subjective complaints are not contradicted by or inconsistent with other record evidence").

One of the most liberal, and in some ways troubling, appellate decisions in recent years with respect to crediting a

claimant's subjective self-reports was *Diaz v. Prudential Ins. Co. of Am.*, 499 F.3d 640 (7th Cir. 2007). The claimant in *Diaz*, a computer analyst, experienced persistent lower back pain due to diagnosed conditions of degenerative disc disease and lumbar radiculopathy. After undergoing an apparently successful spine surgery, the claimant "continued to experience varying levels of pain in his back and legs" and ultimately "concluded that he could not return to work." *Id.* at 641-42.

Although the claimant's disability benefits application was supported by "several doctors' notes expressing the opinion that his condition prevented him from sitting for more than fifteen to twenty minutes at a stretch," his claim was denied because a consulting physician retained by the insurer concluded that the medical records did not establish a disability. *Id.* at 642. The district court, finding that the plaintiff had no "reliable proof" of disability, entered summary judgment for the insurer.

When the *Diaz* case was appealed to the Seventh Circuit, the appellate panel held that the district court had given inadequate consideration to the plaintiff's "own accounts of his pain." *Diaz*, 499 F.3d at 641. In a key passage, the court discussed the plaintiff's self-reported pain this way:

[T]he record contains a great deal of evidence about Diaz's subjective assessment of his pain.... Diaz's testimony offers more than a long series of complaints spoken across the breakfast table. It demonstrates the kind of "long history of treatment" that we have found relevant in the past in comparable circumstances:

What is significant is the improbability that [the claimant] would have undergone the pain-treatment procedures that she did, which included not only heavy doses of such strong drugs such as Vicodin, Toradol, Demerol, and even morphine, but also the surgical implantation in her spine of a catheter and a spinal-cord stimulator, merely in order to strengthen the credibility of her complaints of pain and so increase her chances of obtaining disability benefits....

Carradine v. Barnhart, 360 F.3d 751, 755 (7th Cir. 2004). Taken in the light

most favorable to the plaintiff, the evidence of Diaz's repeated attempts to seek treatment for his condition supports an inference that his pain, though hard to explain by reference to physical symptoms, was disabling.

499 F.3d at 646.

From a disability defense perspective, this is quite problematic. The notion that

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a disability may be inferred merely from a claimant's efforts to seek treatment does not seem tenable, as millions of people regularly seek treatment without being disabled. Many also take narcotic pain medications without being disabled. See, e.g., *Tuttle v. Standard Ins. Co.*, 459 F. Supp. 2d 1063, 1065 (W.D. Wash. 2006) (plaintiff found not disabled despite taking "narcotic pain medications").

Noting that the plaintiff's treating physicians did not doubt the veracity of his subjective complaints, the *Diaz* court went on to opine that:

This medical evidence supports Diaz's claim that he was disabled by the pain. We have drawn inferences from the fact that trained medical professionals responded to a claimant's call for help in the past, commenting on the "improbability that [plaintiff] is a good enough actress to fool a host of doctors and emergency-room medical personnel into thinking she suffers extreme pain; and the (perhaps lesser) improbability that that this host of medical workers would prescribe drugs and other treatment for her if they thought she were faking her symptoms." *Carradine*, 360 F.3d at 755.

Diaz, 499 F.3d at 647. This part of the decision ignores the basic reality that treating physicians are not, for the most part, in the business of viewing their patients' symptoms with skepticism and detecting fakery.



As the Seventh Circuit itself recognized in *Leipzig*, physicians ordinarily accept their patients' self-reported symptoms at "face value." *Leipzig*, 362 F.3d at 409. The fact that a physician does not call his or her patient a liar is hardly proof that the patient is medically incapable of working, or that the patient's subjective perceptions are necessarily accurate.

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Diaz appears to rely on an artificial dichotomy, assuming that a claimant who describes severe pain or fatigue is either "faking" or "disabled," when in fact there is a wide spectrum of possibilities between those two extremes. One is that the claimant is a "sincere hypochondriac," *Leipzig* at 409; another is that the claimant is genuinely experiencing real symptoms that simply may not be quite severe enough to preclude him or her from working in a relatively undemanding job.

Video Documentation

With a number of courts showing increasing willingness to credit subjective complaints in the absence of a compelling reason to reject them, ERISA claim administrators should have procedures in place for testing the veracity of claimants' self-reports in situations where the evidence of disability is largely subjective. Video surveillance, conducted by a licensed investigator retained as a third-party vendor, is a cost-effective and under-utilized tool that can assist insurers and courts by furnishing objective documentation of disparities between a claimant's subjectively reported limitations and his or her actual capabilities.

When surveillance video documents activities that are inconsistent with the claimant's self-reports, the administrator has "good reason for not giving significant

weight to Plaintiff's subjective complaints," as well as good reason to be skeptical of medical opinions that are "based on those subjective complaints." *Giertz-Richardson v. Hartford Life and Acc. Ins. Co.*, 536 F. Supp. 2d 1280, 1292 (M.D. Fla. 2008). For an illustration of how this works, we turn again to the Seventh Circuit.

The claimant in *Mote v. Aetna Life Ins. Co.*, 502 F.3d 601 (7th Cir 2007), was allegedly disabled by fibromyalgia and chronic back pain. Her treating physicians opined, based largely on her subjective complaints, that she was incapable of almost any activity, including driving, and would likely not "ever work again." *Id.* at 604.

A reviewing medical consultant agreed, advising that "absent information... to the contrary, her subjective musculoskeletal symptoms are of such severity as to be totally medically limiting." *Id.* However, the same consultant was later provided with surveillance video obtained by the insurer's investigator, showing the claimant "running errands, driving an elderly relative to doctors' appointments, and loading groceries into her car." *Id.* at 605. After viewing the video, the consultant changed his opinion and no longer concurred with the treating physicians' "assessments of severity" and "medically limiting conclusions." *Id.*

After benefits were terminated and the district court ruled in favor of the insurer, the claimant appealed to the Seventh Circuit, arguing that the insurer had wrongly relied on the video and the modified opinion of the consultant rather than on the claimant's subjective complaints and the opinions of her treating physicians. Ruling that the insurer had weighed the evidence correctly, the appeals court emphasized that while the claimant's treating physician had opined that she "cannot operate a motor vehicle," the video showed her "doing just that." *Id.* at 609.

The same treating physician had advised that the claimant "could never climb, crawl, kneel, move repeatedly or stoop," but the video "show[ed] her kneeling, moving repeatedly, and stooping." *Id.* In short, the video documented the claimant "engaging in many of the activities that she claimed to be unable to accomplish." *Id.* The court also found that the reviewing consultant was "justified in altering his opinion... after viewing the videotapes," because the activ-

ities seen on the video were "exactly the type of additional, contrary evidence upon which he conditioned his original opinion [that the claimant was disabled based on her subjective complaints]." *Id.*

The appellate panel in *Mote* was divided, with the dissenting judge arguing that the surveillance video showed only "light physical activities" of relatively brief duration, which failed to demonstrate the claimant's ability to "manage full-time employment." *Mote*, 502 F.3d at 614. But the majority opinion is representative of an emerging prevailing view that where a claim depends on subjective evidence, surveillance video need not show the claimant performing actual work tasks, or sustained activity sufficient to approximate the demands of full-time employment, if the video provides an objective basis for rejecting the claimant's self-reported limitations.

In *Cusumano v. Continental Cas. Co.*, 2008 WL 1711405 (M.D. Fla., Apr. 10, 2008), the court recognized that "a great deal of the evidence is based on subjective reports of pain by the Plaintiff." *Id.* at *8. The plaintiff claimed to be disabled by severe chronic pain in his left foot, resulting from a past fracture injury and multiple surgeries. In obtaining benefits, the plaintiff reported that he walked with a limp, could not stand for more than five minutes without experiencing unbearable pain, could ascend and descend stairs only with pain, and had difficulty getting in and out of cars. Echoing the plaintiff's subjective complaints, his treating physician stated that he "could not drive or weight bear for even short periods." *Id.* at 9.

The insurer terminated benefits based primarily on a surveillance video. Although the footage was only 15 minutes in duration, it showed the plaintiff walking without a limp, moving about normally, standing for more than five minutes with no visible difficulty, ascending and descending stairs with no visible difficulty, using his left foot to stomp and break down cardboard boxes, driving, and entering and exiting his car with no apparent problem.

Emphasizing the plaintiff's failure to "satisfactorily explain the discrepancy between what he said he could do and what he was seen doing in the video," the court upheld the termination of benefits based on the "objective evidence" from

the surveillance. *Id.* at *8. See also *Larson v. Old Dominion Freight Line, Inc.*, 481 F. Supp. 2d 451, 460 (M.D.N.C. 2007) (where plaintiff was filmed performing yard work “far beyond what he claimed he could perform,” administrator correctly found that the video “cast doubt on the credibility of the Plaintiff’s subjective reports of pain to his treating physician”); *Kiloh v. Hartford Life Ins. Co.*, 2005 WL 2105957, *12 (M.D. Fla., Aug. 31, 2005) (although plaintiff argued that his activities on surveillance video were “completely unrelated” to the demands of his occupation and therefore irrelevant, the court ruled that the video was “objective evidence that Plaintiff’s physical capabilities exceeded that which he reported to his doctors”).

A Note about Social Security Disability Law

In giving weight to plaintiff’s subjective complaints in *Diaz*, the Seventh Circuit relied heavily on the *Carradine* decision, which was a Social Security disability benefits case. That reliance indicates that the *Diaz* panel was influenced, arguably improperly, by the law governing Social Security disability determinations, which

differs from ERISA law with respect to subjective evidence.

The coexistence of two bodies of federal common law concerned with disability evaluation—one arising under the Social Security Act and the other under ERISA—has caused considerable difficulty in the courts. In *Nord*, the Supreme Court recognized “critical differences between the Social Security disability program and ERISA benefit plans” in deciding that ERISA administrators could not be compelled to accord automatic deference to treating physician opinions in the manner required of Social Security disability evaluators. *Nord*, 538 U.S. at 832–33.

In Social Security hearings, the claimant’s subjective testimony is considered presumptively credible; a Social Security administrative law judge (ALJ) is not permitted to reject subjective complaints without making an “express credibility determination explaining the reasons for discrediting the complaints.” *Wagner v. Astrue*, 499 F.3d 842, 851 (8th Cir. 2007). If the ALJ’s reasons are not “clear and convincing,” the denial of Social Security benefits may be reversed. *Shafer v. Astrue*, 518 F.3d 1067, 1072 (9th Cir. 2008). Not surpris-

ingly, claimants in ERISA cases frequently try to import Social Security law principles, and insurers should be vigilant in resisting those efforts based on the “critical differences” emphasized in *Nord*.

Conclusion

When insurers are evaluating disability claims or deciding whether to continue paying benefits, it is important to be cognizant of the subjective component of the claimant’s disability evidence. If an insurer believes that objective support for a claim is lacking, it should advise the claimant of the deficiency and give him or her a fair opportunity to supply the needed evidence before making a final decision.

In seeking objective verification of disability, insurers should take care to focus their inquiry on objective evidence of a claimant’s functional limitations, and should avoid insisting on objective substantiation of inherently subjective diagnoses. Functional capacity evaluations and video surveillance are two valuable tools for obtaining objective evidence to test the accuracy of the claimant’s subjective self-reports, as well as the validity of treating physicians’ opinions. 