What Can Plan Administrators Require?

Objective Versus Subjective Evidence in the ERISA Claims-Handling Process

By Amy L. Blaisdell and Daniel R. Ritter

It is perfectly lawful for ERISA claims administrators to require objective medical proof in support of claims for disability benefits, but take heed of the following lessons as you plan your defense strategy.

Disability claimants regularly take the position that certain difficult-to-diagnose conditions, such as fibromyalgia, chronic pain syndrome, fatigue, and post-concussive syndrome (to name a few), cannot be proven through objective medical evidence.

As such, they argue that it is unreasonable or arbitrary for an administrator of a disability plan governed by ERISA to require objective evidence of these disabling conditions. The notion that subjective symptoms must be given at least some level of consideration has gained traction in the federal courts over the last several years.

Consider This Case

You are defending the claim in this hypothetical:

> A 53-year-old electrical engineer who worked as a senior developer fell and struck his head at home. After the fall, he complained of difficulty concentrating, but he continued working.

A year later, he saw a neurologist for testing. The neurologist found him to be functioning in the "average range for verbal abilities and in the very superior range for visual-spatial skills." The neurologist also opined that the engineer had experienced a significant decline since the possible concussion and his symptoms, including physical, cognitive, and emotional and behavioral changes, were consistent with what is often seen in post-concussive syndrome.

After multiple declining performance reviews, the participant applied for disability benefits (at the urging of his supervisor), more than three years after the fall occurred. He claimed to be disabled due

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to post-concussive syndrome, reporting severe headaches and fatigue.

The claims administrator denied benefits, finding that the participant continued working for years after the incident, the *objective evidence* supported that he had normal verbal abilities and superior visual-spatial skills, and the participant's *subjective reports* of headaches and fatigue were insufficient to establish disability under the disability plan. The appeals administrator upheld the denial on appeal. The engineer filed suit, alleging wrongful denial of benefits under ERISA.

To state the obvious, if the plan or policy explicitly states that objective evidence of disability is required, then your odds of securing success for your client are categorically better.

Your client wants to know the likelihood of your success in defending the claim. The answer—of course—is, *it depends.* So, specifically, on what does your success as a defense lawyer in this case *depend*? This article discusses the lessons that emerge from a review of recent federal case law.

Lesson 1: Plan Language Matters

To state the obvious, if the plan or policy explicitly states that objective evidence of disability is required, then your odds of securing success for your client are categorically better. The fact that a disability plan did not expressly state that the participant was required to provide objective medical evidence was one of several reasons that caused the Tenth Circuit to affirm judgment in favor of the plaintiff in *McMillan v. AT&T Umbrella Benefit Plan No. 1,* 746 F. App'x 697, 698 (10th Cir. 2018). There, the court noted:

> With respect to proof, the Plan did not require objective evidence of disability; instead, it provided that the administrator could rely on information that "include[d], but [was] not limited to, medical, psychiatric or psychological opinion from the treating or reviewing Physician that [was] supported by diagnostic tools and examinations, which [were] performed in accordance with the generally accepted principals [*sic*] of the health care profession."

Id.

Notwithstanding, the claims administrator asked several reviewing physicians to opine whether there was objective medical evidence to support the existence of a disability. These reviewing physicians found no objective evidence to support the participant's claim of disability, and the claim was denied on that basis. The Tenth Circuit found the decision, which ignored subjective complaints about shortness of breath, to be arbitrary and capricious. *Id.* at 706.

In comparison, in *Conner v. Ascension Health and Sedgwick*, 2019 WL 7194762 (E.D. Mo. Dec. 26, 2019), the court affirmed the denial of disability benefits where the disability plan required the participant to provide "objective medical evidence" of disability.

The plaintiff, a nurse, had sustained injuries in a car accident and received benefits for the first twenty-four months under the "own occupation" standard of disability. After the first twenty-four months, she was required to provide objective medical evidence of a disability that prevented her from working in any occupation. She claimed to be experiencing ongoing pain and problems with concentration, fatigue, and cognition as a result of her medications. She relied, in large part, on her own subjective complaints of limitations.

After remanding the case to the claims administrator to consider the effects of the plaintiff's medication on her cognition and an overhead-reaching restriction, the court affirmed the denial of benefits. The court noted:

> In this case, Sedgwick gave detailed reasons for denying Plaintiff's [long-term disability] claim, clearly pointed to the basis for its decision, and noted Plaintiff's lack of objective support for her claimed disability. Upon consideration of the record before it, the Court cannot say that Sedgwick abused its discretion in denying the Plaintiff's claim for… benefits. The denial of benefits based upon lack of objective evidence of Plaintiff's disability is not unreasonable.

Id. at 28. *See also Powers-Taylor v. Ascension Health, Inc.*, 2019 U.S. Dist. Lexis 104973, *25 (June 24, 2019) (affirming the denial of benefits based on the reviewing physicians' observation that the plaintiff failed to submit objective evidence, leaving the plaintiff's subjective complaints as evidence of her ailments) (citing *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793, 799 (8th Cir. 2002) (holding that providing only subjective medical opinions, which were unsupported by objective medical evidence, did not suffice to prove a claim for benefits)).

Practically speaking, there are many plans that do not *expressly state* that they require *objective medical evidence* to support a finding of disability under the plan. Some courts have not been bothered by the absence of express language in the plan.

For example, in *Christmas v. Sun Life Assurance Co. of Canada*, 2018 WL 6592090, at *7 (D. Conn. Dec. 14, 2018), the court rejected the participant's argument that objective proof of disability was not specified as a requirement under the plan and therefore could not be a basis for the denial. But the court noted that "it is not unreasonable for ERISA plan administrators to accord weight to objective evidence that a claimant's medical ailments are debilitating in order to guard against fraudulent of [sic] unsupported claims of disability." *Id.* (*quoting Hobson v. Metro. Life Ins. Co.*, 574 F.3d 75, 88 (2d Cir. 2009)). So, the plan administrators were "entitled to require Plan participants to submit objective medial evidence to support a claim of total disability." *Id.*

Nevertheless, when the disability plan does not expressly state that the participant must provide objective medical evidence, it is prudent to focus the court on other plan provisions that give the administrator the authority to construe and interpret the plan and determine whether proof of disability is sufficient.

For example, in *Prezioso v. Prudential Ins. Co. of Am.,* 748 F.3d 797 (8th Cir. 2014), the Eighth Circuit discussed the long-term

disability plan's definition of disability. The plan did not expressly require objective medical evidence, but it did expressly state that Prudential, in considering a claim for benefits, "may request… proof of continuing disability, satisfactory to Prudential." *Id.* at 803. Furthermore, the long-term disability plan's summary plan description stated that Prudential "has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits" and that Prudential's decisions "shall not be overturned unless arbitrary and capricious." *Id.*

Relying on this language, the Eighth Circuit affirmed Prudential's decision to deny benefits. The Eighth Circuit noted that Prudential's expert concluded that the participant's subjective reports of continuously disabling pain were not supported by the objective medical evidence. *Id.* at 806. The Eighth Circuit further explained, "[p]articularly in a case like this involving a claim of total disability based primarily on the claimant's subjective complaints of pain, '[w]here there is a conflict of opinion, the plan administrator does not abuse his discretion in finding that the employee is not disabled.'" *Id.* at 807 (quoting *Clapp v. Citibank, N.A. Disability Plan* (501), 262 F.3d 820, 829 (8th Cir. 2001).

Lesson 2: Unreliable or Conflicting Subjective Reports Can Bolster Your Case

Even if the disability plan expressly requires the participant to provide objective medical evidence to substantiate a finding of disability, you still are not guaranteed success. In preparing your motion for judgment on the administrative record, you should highlight portions of the administrative record demonstrating that the claims administrator *considered* the *subjective complaints,* but found them to be *unreliable or in conflict with objective medical evidence*. This is important because no matter how clear you find the language of the plan to be, the court may disagree. Furthermore, even when the plan language is clear, several courts have held that a disability plan administrator *must* still consider subjective reports.

For example, in the case of the engineer discussed in the introduction of this article, the court noted, "Plan administrators may not dismiss evidence merely because it is subjective, but must meaningfully address why reported symptoms either false or exaggerated or do not impede a claimant's ability to work." *Ampe v. Prudential Ins. Co. of Am.*, 2018 WL 5045184, at *6 (D. Mass. Oct. 17, 2018). In *Ampe*, the court remanded the case to the administrator to conduct "a more considered examination of the medical evidence…." *Id.* at *6.

Likewise, courts in the Second Circuit have noted, "It has long been the law of this Circuit that 'the subjective element of pain is an important factor to be considered in determining disability.'" *Khan v. Provident Life & Accident Ins. Co.*, 386 F. Supp. 3d 251 (W.D.N.Y. 2019) (quoting *Connors v. Connecticut Gen. Life Ins. Co.*, 272 F.3d 127, 136–37 (2d Cir. 2001). *See also Miles v. Principal Life Ins. Co.*, 720 F.3d 472, 476 (2d Cir. 2013) (quoting *Thurber v. Aetna Life Ins. Co.*, 712 F.3d 654, 660 (2d Cir. 2013))("[A] reviewing court is obliged to determine whether a plan administrator has given 'sufficient attention to [the claimant's] subjective complaints… before determining that they were not supported by objective evidence.'") (alterations in quote).

In *Khan,* the court further noted, "Fatigue is likewise the type of symptom that may not be discounted simply because the amount of fatigue an individual's experiences is subjective in nature." *Id.* at 277. *See also Spears v. Liberty Life. Assurance Co. of Boston*, 2019 WL 4766253, at *40 (D. Conn. Sept. 30, 2019) (finding that the determination on remand was arbitrary where the reviewing doctors "completely discount[ed] [the] [plaintiff's] subjective symptoms, simply because they are 'self-reported'.").

Although many courts impose a requirement to "consider" subjective evidence, most do not require deference to the subjective reports. For example, the Fifth Circuit has explained, "ERISA requires that all evidence 'actually be taken into account in an administrator's determination.'" *Spenrath v. Guardian Life Ins. Co. of Am.*, 564 F. App'x 93, 98 (5th Cir. 2014) (quoting *Love v. Dell, Inc.*, 551 F.3d 333, 337 (5th Cir. 2008)). However, the Fifth Circuit upheld the denial of benefits finding, "Guardian did not fail to credit the evidence the [plaintiff] provided; instead, it concluded that that evidence was not sufficient." *Id.*

However, in a rather surprising decision, the Sixth Circuit reversed the lower court's decision that had granted summary judgment to the Eaton Corporation Disability Plan. The Sixth Circuit found that the plan, which expressly required objective medical evidence of disability, did not give enough consideration to the plaintiff's subjective reports. *Outward v. Eaton Corp. Disability Plan for U.S. Employees*, 2020 WL 1514852, at *18 (6th Cir. Mar. 30, 2020).

In that case, the plaintiff was an engineer. After she suffered a miscarriage in August 2011, her physical condition reportedly began to deteriorate to the extent that she claimed to be unable to work by December 2011. By May 2012, she reported that her "energy level continued to deteriorate over time," and she was diagnosed with sinusitis, pneumonia, pleuritis of the chest wall, Epstein-Barr virus, immunodeficiency, pernicious anemia, dysautonomia, and three bulging discs. *Id.* at 1. The plan expressly stated:

> Objective findings of a disability are necessary to substantiate the period of time your health care practitioner indicates you are disabled. Objective findings are those that can be observed by your health care practitioner through objective means, not from your description of the symptoms. Objective findings include:
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> - Physical examination findings (functional impairments/capacity)
> - Diagnostic test results/imaging studies;
> - Diagnoses;
> - X-ray results;
> - Observation of anatomical, physiological or psychological abnormalities; and
> - Medications and/or treatment plan.

Notwithstanding this provision, the Sixth Circuit found the denial of benefits to be arbitrary and capricious because it did not give weight to the plaintiff's subjective reports. The court noted:

> [W]hen evaluating whether disabling conditions are present and whether certain treatments are appropriate, the information provided by a patient is of the utmost importance and relevance in determining the *quality* of any sup-

porting documentation. Thus, although subjective complaints, by themselves, cannot support a finding of disability, such complaints that form the rationale for objective medical testing and treatment should be given credence.

Id. at 18. Again, this case is somewhat surprising for the Sixth Circuit, which is generally defense friendly when it comes to ERISA denial of benefit reviews.

Less surprising is that the Ninth Circuit has also taken a firm stance that subjective complaints of conditions, such as pain, must be considered.

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For example, in *Cruz-Baca v. Edison Int'l Long-Term Disability Plan*, 708 F. App'x 313, 315 (9th Cir. 2017), the court found that it was arbitrary and capricious for the long-term disability plan's reviewing physician to fail to discuss and consider the plaintiff's subjective complaints of pain as evidence of her chronic pain syndrome. The court noted that this was particularly true, given that the doctor observed the plaintiff exhibiting pain symptoms during an independent medical evaluation and had also considered her long history of chronic pain. The court further noted that it "has previously held that 'conditioning an award on the existence of evidence that cannot exist is arbitrary and capricious.'" *Id.* (quoting *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 678 (9th Cir. 2011)).

As a result of decisions such as *Cruz-Baca*, plan participants in the Ninth Circuit regularly rely on their own subjective reports of conditions to establish the existence of disability. For example, in *Shaikh v. Aetna Life Ins. Co.*, 2020 WL 1430496 (N.D. Cal. Mar. 24, 2020), the court granted the plaintiff's motion for judgment and denied the defendant's cross-motion for judgment. The court noted that it was "of particular importance" that Aetna "has essentially disregarded Shaikh's complaints of severe pain, which… have persisted over an extended period of time." *Id.* at 3.

But, a recent case from the U.S. District Court of the District of Arizona highlights that all hope is not lost in the Ninth Circuit. In *Woolsey v. Aetna Life Ins. Co.*, 2020 WL 1083932 (D. Ariz. Mar. 6, 2020), the court rejected the plaintiff's argument that Aetna discredited the plaintiff's subjective complaints. The court discussed at length the fact that Aetna did not ignore the plaintiff's subjective complaints, but rather, "Aetna's denial cites observational evidence inconsistent with Plaintiff's subjective reports." *Id.* at 9. The court further quoted from one of the letters in Aetna's file stating, "While we do not deny that you may be experiencing some complications from your physical and nervous conditions, we need to determine[] if they rise to the level of severity which[] prevented you from performing the material duties of your own occupation as a Financial Advisor." *Id.* (alteration in original).

Lesson 3: Focus on the Lack of Impairment Evidence, Rather than the Diagnosis

Several courts have held that a plan or claims administrator does not abuse its discretion by making a reasonable request for some objective verification of the *functional limitations* imposed by a medical or psychological condition, even where the underlying condition is difficult to diagnose.

For example, the First Circuit has held that it is unreasonable to require objective evidence supporting a *diagnosis* such as fibromyalgia that inherently evades objective verification. *Cook v. Liberty Life Assurance Co.*, 320 F.3d 11, 21 (1st Cir. 2003). However, the First Circuit has also held that an ERISA plan may require objective medical evidence that supports the *inability to work* due to "the physical limitations imposed by the symptoms of such illnesses…." *Boardman v. Prudential Inc. Co. of Am.*, 337 F.3d 9, 16 n.5 (1st Cir. 2003).

In *Shahgholi v. Aetna Inc. Long Term Disability Benefits Plan,* 2018 WL 4177934, at *10 (S.D.N.Y. Aug. 30, 2018), the court also interpreted the law of the Second Circuit to draw the crucial distinction as between objective proof of the underlying condition and objective proof of *functional impairment*. In *Shahgholi*, the plaintiff argued that the law of the Second Circuit required the administrator to consider her subjective complaints. The court rejected this argument, finding that the claim had been denied because the participant had not adduced sufficient evidence of her inability to do her job duties: "What was lacking, in other words, was not 'objective proof of tinnitus … but objective proof of *functional impairment*.'" *Id.* at 10 (citation omitted).

In *Killebrew v. Prudential Ins. Co. of Am.*, 723 F. App'x 133, 136 (3d Cir. 2018), the Third Circuit considered whether the lower court properly granted summary judgment in favor of Prudential and against a plan participant who had been diagnosed with multiple sclerosis. The Third Circuit found that there were general factual disputes over whether there was evidence to support *limitations due to the plaintiff's complaints of fatigue*, given the subjective nature of fatigue. The Third Circuit vacated in part and remanded in part to consider three procedural issues: whether it was arbitrary and capricious for Prudential (1) to decide not to conduct an independent evaluation, (2) to rely on its medical experts' conclusions that were contrary to the plaintiff's treating physicians' opinions, and (3) to reject her complaints of fatigue and pain.

The Fifth Circuit also has held that it is entirely permissible to demand evidence of functional impairment caused by a condition that evades diagnosis. In *Anderson v. Cytec*, 619 F.3d 505 (5th Cir. 2010), the Fifth Circuit held that the plan administrator did not abuse its discretion by relying on the independent experts' opinion that the plaintiff had not offered objective clinical proof showing the functional effect of his post-traumatic stress disorder. *Id.* at 513. The Fifth Circuit further explained, "Without some objective measure of [the] [plaintiff's] functional limitations, Cytec had no way to determine whether his concentration was impaired to the point that he could not perform his job or 'any similar occupation which his Employer may provide.'" *Id.* at 514.

Several district courts in the Fifth Circuit have followed suit. For example, in *Burrell v. Metropolitan Life Ins. Co.*, 2020 WL 532934 (W.D. Tex. 2020), the magistrate judge considered the parties' cross-motions for summary judgment in a case in which the participant was a former billing analyst with Deloitte who claimed to have ceased working due to a myriad of health conditions, including chronic fatigue syndrome, fibromyalgia, myalgia/mitosis, Epstein-Barr virus, and joint pain. The court reviewed MetLife's decision for an abuse of discretion and noted:

> A plan administrator does not abuse its discretion when it relies on an independent expert's opinion that a claimant has not offered objective clinical proof of functional limitations that indicate a disability.… Although a claims administrator may consider a claimant's subjective complaints in its claim determination, it is not required to do so.

Id. at 11 (citing *Spenrath*, 564 F. App'x at 98).

The court further noted, "For a condition such as chronic fatigue syndrome, which may be difficult to diagnose definitively, a claimant may use objective clinical evidence of functional limitations to demonstrate difficulty working." *Id.* The magistrate judge recommended that summary judgment be entered in MetLife's favor on the long-term disability benefits claim, and the district judge adopted this recommendation.

Similarly, in *Hernandez v. Life Ins. Co. of N.A.*, 2020 WL 1557802 (W.D. Tex. Apr. 1, 2020), the plaintiff was a service supervisor who claimed disability based on reported mental health issues of anxiety and depression. The plaintiff argued that the claims administrator erred by ignoring his subjective symptoms and demanding objective evidence to establish his impairments when such objective tests either did not exist or could have been ordered by the defendants but were not. The magistrate judge rejected these arguments, again relying on *Spenrath* to explain, "The Fifth Circuit has 'never… held' that a claims administrator is required to discuss every piece of evidence it considered in reaching its conclusion." *Id.* at 8. The magistrate recommended that the denial of benefits be affirmed. The district judge adopted the recommendation.

The Seventh Circuit has also expressed concern over the distinction between subjective and objective evidence of symptoms such as fatigue and pain. *Hawkins v. First Union Corp. Long Term Disability Plan*, 326 F.3d 914, 916–19 (7th Cir. 2003) (finding that the plan had acted arbitrarily and capriciously largely because it based its denial of benefits on its medical consultant's belief that a claimant could never be found to be disabled due to fibromyalgia because the amount of pain an individual experiences is subjective in nature). *See also Mathews v. Northwest Mutual Life Ins. Co.*, 2019 WL 5578333, at *10 (W.D. Wis. Oct. 29, 2019) (awarding short-term disability benefits and finding that the lack of objective MRI findings was not sufficient to overcome the plaintiff's already diagnosed myofascial pain disorder). But, as explained, by the Seventh Circuit, "[a] distinction exists… between the amount of fatigue or pain an individual experiences, which as *Hawkins* notes is entirely subjective, and how much an individual's degree of pain or fatigue limits his functional capabilities, which can be objectively measured." *Williams v. Aetna Life Ins. Co.,* 509 F.3d 317 (7th Cir. 2007).

In *Anyanwu v. Ascension Health,* 2019 U.S. Dist. Lexis 86006, at *62–64 (E.D. Mo. May 22, 2019), the district court granted summary judgment in favor of the defendant where the plaintiff failed to provide objective evidence of functional impairment. The court relied on the Eighth Circuit precedent, explaining as follows:

> Plaintiff also suggests [the claims administrator] denied her [long-term disability] benefits because she produced no objective medical evidence, or Proof as defined under the Plan, in support of any mental impairment or disability.… Even if that was Defendant's position, that position is not erroneous under the law. *See Cooper v. Metro. Life Ins. Co.*, 862 F.3d 654, 662 (8th Cir. 2017) (citations omitted) (holding "it is generally 'not unreasonable for a plan administrator to deny benefits upon a lack of objective medical evidence"); *Hunt v. Metro. Life Ins. Co.*, 425 F.3d 489, 490–91 (8th Cir. 2005) (upholding decision to deny [long-term disability] benefits based on lack of objective evidence when the plaintiff self-reported complaints of mental confusion, anxiety, and depression and treating physician opined the plaintiff was totally disabled based on diagnosis, but reviewing physicians gave contrary opinions).
>
> However, that is not Defendant's position. Instead, Defendant contends that while the general categories of evidence in Plaintiff's records may constitute objective medical evidence, "Plaintiff did not provide objective medical evidence that, in the discretion of Sedgwick, *substantiated the existence of a Disability as defined in the Plan."*… *Cf. Cooper*, 862 F.3d at 654 (citation omitted) (holding it is "especially" reasonable for a plan administrator to rely on a lack of objective indicia of disability to the exclusion of subjective indicia when the plan administrator's "purpose is to substantiate the extent of disability rather than to question the diagnosis."). Defendant contends Plaintiff's own subjective, self-reported symptoms do not justify overturning Sedgwick's decision because Sedgwick reasonably considered Plaintiff's treating and reviewing physicians' opinions that her symptoms were overstated or exaggerated based on validity testing.… The Court agrees.

As is reflected above, the Eighth Circuit generally takes the position that objective medical evidence may be required. However, the claims administrator should focus on whether there is objective evidence of the inability to work, as opposed to objective medical evidence of a specific diagnosis. Furthermore, as will be discussed in the final section, the participant's credibility can also be an important consideration in the defense.

Lesson 4: Consider Credibility and Whether to Use It

As noted above, several courts have focused on the importance of making "a credibility determination" when it comes to certain difficult to diagnose conditions, such as fibromyalgia, where "the claimant's subjective, uncorroborated complaints of pain constitute the only evidence of the ailment's severity." *See, e.g., Meraou v. Williams Co. Long Term Disability Plan*, 221 F. App'x 696, 705 (10th Cir. 2007). In *Johnson v. Life Ins. Co. of North Am.*, 2017 WL 4180328 (D. Colo. Sept. 21, 2017), the court extended the same concept to trigemi-

nal neuralgia and found that the claims administrator's decision to deny benefits based on a finding that the plaintiff's "symptoms were significantly exaggerated and self-reports of pain were inconsistent with clinical findings" was erroneous.

As has the Tenth Circuit, the Eleventh Circuit has noted that when it comes to certain "subjective" diagnoses, "credibility determinations are critical to claims of impairment." *Howard v. Hartford Life and Acc. Ins. Co.*, 563 F. App'x 658, 663 (11th Cir. 2014). In that case, the plaintiff who was 5'6" and weighted over 300 pounds, had primary diagnoses of lupus, fibromyalgia, and severe joint pain, as well as secondary diagnoses of depression, short-term memory loss, and asthma. She was approved for long-term disability benefits.

The court noted that the denial of benefits was not based on inappropriate treatment; instead, it was based on the fact that the administrator believed that the plaintiff could perform her own duties.

Hartford later conducted sixty hours of surveillance over a six-day period. This showed the plaintiff running errands for extended periods of time, driving approximately 248 miles in one day, driving her daughter to and from school, sitting in her car for thirty-three minutes, carrying groceries, and walking with and without her cane. A Hartford investigator also interviewed the plaintiff, and she reiterated that she was precluded from working due to severe pain, she had chronic fatigue, she was not able to sit for more than an hour, and she could standard and walk for five to ten minutes and could drive for only thirty minutes or less, and not father than twenty miles. She claimed to use her cane 90 percent of the time. Based on the totality of the evidence, Hartford denied the claim.

The district court entered judgment in favor of Hartford, and the Eleventh Circuit affirmed, finding that the plaintiff's credibility was "seriously called into question by the surveillance video which shows her engaging in activities grossly inconsistent with her description of her abilities, and in stark contrast to her own treating physicians' assessments, which were based on… subjective complaints." *Id.* (quoting *Howard v. Hartford Life & Acc. Ins. Co.*, 929 F. Supp. 2d 1264, 1300 (M.D. Fla. 2013)).

While credibility attacks can work well when they are well researched and thoroughly documented in the file, they can backfire when they are not. Courts have reacted negatively to challenges to the credibility of a plan participant where that was not the reason for the underlying denial or benefits, or where the claims administrator could have done more to flesh out credibility but chose not to do so.

For example, in *Lowe v. United of Omaha Life Ins. Co.*, No. 2020 WL 1921444 (S.D. Ohio Jan. 10, 2020), the plan participant, a building services supervisor, reported that she suffered from multiple health conditions, including, among others, morbid obesity, osteoarthritis of her knees and ankles, chronic pain, and swelling of her feet. She sought disability benefits after she suffered a torn tendon and arch collapse in one of her feet. The court found that the decision to deny benefits was arbitrary and capricious. Among other reasons, the court noted, "Even if Defendant had terminated Plaintiff's benefits because her treating physicians' opinions were based on Plaintiff's subjective complaints, such a decision would be arbitrary and capricious where Defendant had the opportunity to, but did not, examine Plaintiff to test her credibility." *Id.* at 12.

Similarly, in *Tiedel v. Reliance Standard Life Ins. Co.*, 2020 WL 1872348 (W.D. Mich. Apr. 15, 2020), the court reviewed the decision to deny benefits to a flight engineer who had been in a plane crash years earlier and who had been diagnosed with hepatitis C, likely contracted when he received blood transfusions after the accident. After receiving benefits under the "own occupation" standard for a recurrence of hepatitis C, benefits were denied based on a conclusion that he was not disabled to such an extent that he could not work in any occupation. The court reviewed the decision to deny benefits under the de novo standard, finding it to be erroneous. The court rejected the reliance on reviewing physicians who made credibility determinations in assessing the plaintiff's subjective complaints, which the court found to conflict with other medical evidence.

Finally, in *Krystofiak v. Boston Mutual Life Ins. Co.*, 424 F. Supp. 3d 446, 453 (D. Md. 2019), the court rejected an argument that the plaintiff's treatment in the form of opioids should be taken into consideration in disqualifying her from benefits. The court noted that the denial of benefits was not based on inappropriate treatment; instead, it was based on the fact that the administrator believed that the plaintiff could perform her own duties.

Final Practice Pointers

In summary, there are many factors that come into play in assessing whether a court is likely to defer to an administrator's denial of benefits for lack of objective medical evidence. The reality is that some jurisdictions are more receptive to requiring objective medical evidence than others. But, as this article demonstrates, there are ways that you can organize your defense to increase your likelihood of success on the merits.

First, focus on the most helpful language in the plan, which gives your client discretion to require proof to its satisfaction of a disabling condition.

Second, highlight evidence in the record that demonstrates that subjective evidence was considered, even if was ultimately found to be insufficient.

Third, focus not on the plaintiff's diagnosis of particular conditions, but rather on whether the participant has carried *his or her burden* of proving that he or she suffers from a *functional impairment* that precludes him or her from working.

Finally, *carefully* consider the *role of credibility* in your arguments. Do not be quick to call into question the plaintiff's credibility if that issue has not been thoroughly vetted in the underlying administrative record. On the other hand, if it has been thoroughly developed in the record and contributed to the decision to deny benefits, then weave the theme into your arguments. FD