IN THE

# United States Court of Appeals for the Fourth Circuit

No. 03-2105

CONTINENTAL CASUALTY COMPANY,

*Appellant,*

v.

NEAL S. SMITH,

*Appellee.*

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND, NORTHERN DIVISION

## BRIEF OF APPELLANT, CONTINENTAL CASUALTY COMPANY


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Dated: November 10, 2003

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## I. STATEMENT OF SUBJECT MATTER AND APPELLATE JURISDICTION

Neal Smith ("Mr. Smith") filed a complaint against Continental Casualty Company ("Continental") in the United States District Court for the District of Maryland seeking benefits under an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The district court had subject matter jurisdiction under 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e). The district court granted, in part, Mr. Smith's motion for summary judgment and denied Continental's motion for summary judgment. (Joint Appendix ("J.A.") 39-40.) On September 3, 2003, Continental noted a timely appeal. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291.[1]

## II. STATEMENT OF ISSUES

A. Whether The District Court Erred By Relying On Social Security Precedent In Adjudicating An ERISA-Governed Disability Claim.

B. Whether The District Court Erred By Relying On Substantive Medical Evidence Never Presented Or Considered During the Disability Claim And Outside Of The Administrative Record.

C. Whether The District Court Erred By Intruding On Continental's Discretion To Interpret And Apply The ERISA Plan Terms.

[1] The district court denied Mr. Smith's motion for summary judgment with respect to Continental's denial of the "waiver of premium" coverage, and remanded that part of Mr. Smith's claim to Continental. (J.A. 39-40.) The district court's order was a final order because it disposed of all parties' claims.

## III. STATEMENT OF THE CASE

This appeal arises out of a claim for disability benefits filed by Mr. Smith under a group disability plan established or maintained by J.J. Haines & Company, Inc. After Continental denied Mr. Smith's claim and affirmed the denial on administrative appeal, Mr. Smith filed a complaint in the United States District Court for the District of Maryland seeking benefits under 29 U.S.C. § 1132(a)(1)(B).[2] The parties filed cross-motions for summary judgment. The district court granted, in part, Mr. Smith's motion for summary judgment and denied Continental's cross-motion for summary judgment. This appeal followed.

## IV. STATEMENT OF FACTS

### A. The Plan

Mr. Smith's employer, J.J. Haines & Company ("J.J. Haines"), established or maintained a "group disability plan." (J.A. 630.) The plan was administered by J.J. Haines as Plan Administrator through an insurance contract purchased from Continental. (*Id.*) Continental issued group long-term disability policy no. SR-83126022 (the "Plan") to J.J. Haines. (J.A. 610-632.) The persons eligible to participate in the Plan were "All full time Officers, Managers, Administrative or Sales working in the United States of America ...." (J.A. 614, 630.) Mr. Smith

[2] On preliminary motion, the district court dismissed Mr. Smith's breach of fiduciary duty claim. (*See* J.A. 2.) Mr. Smith has not filed a notice of appeal from that dismissal.

was an eligible and covered employee because he was a Vice President of Sales. (J.A. 566.)

Under the Plan terms, a covered person has a "disability" if he satisfies the "Occupation Qualifier,"[3] which provides:

> "*Disability*" means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:
>
> 1. continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*; and
>
> 2. not working for wages in any occupation for which *You* are or become qualified by education, training or experience.

(J.A. 617 (emphasis in original).) The Plan defines the "*Material and Substantial Duties*" of *Your Regular Occupation* to mean "the necessary functions of *Your Regular Occupation* which cannot be reasonably omitted or altered." (J.A. 629.)

The Proof of Disability section of the Plan requires an applicant for benefits to provide "[o]bjective medical findings which support *Your Disability*." (J.A. 625.) "Objective medical findings include but are not limited to tests, procedures,

[3] The definition of "disability" associated with the "Earnings Qualifier" is not at issue. (*See* J.A. 617.)

or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s)." (*Id.*)[4]

The Plan confers upon Continental "discretionary authority to determine ... eligibility for benefits and to interpret the terms and provisions" of the Plan. (J.A. 612.)

B. Mr. Smith's Claim For Plan Benefits

Mr. Smith submitted a claim for disability benefits under the Plan, seeking benefits as of February 23, 2001. (J.A. 569, 570.) The claim form included a Physician's Statement from Jon Lowe, M.D. ("Dr. Lowe"), and stated Mr. Smith suffered from degenerative disk and joint disease of the lumbar spine. (J.A. 570.) Dr. Lowe indicated Mr. Smith had undergone surgery on his back, physical therapy, and acupuncture treatment, but "doubted" further treatment would be required. (J.A. 570-571.) Dr. Lowe identified Mr. Smith's physical limitations as "can't stand or walk for more than 5 minutes" and "can't sit in a chair (without arm rest) for more than 10 minutes." (J.A. 571.) Dr. Lowe advised that Mr. Smith's

[4] The Plan's "Proof of Disability" section requires a claimant to submit, *inter alia*, proof: (i) of the date, cause, and prognosis of the disability; (ii) "that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor* ... whose specialty or expertise is the most appropriate for *Your* disability condition(s) according to *Generally Accepted Medical Practice*"; and (iii) of "[t]he extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*." (J.A. 625.)

symptoms first appeared in April 1995, but he was not advised to stop working until February 23, 2001. (J.A. 570.)

Mr. Smith's employer submitted an Employer's Statement and memorandum describing Mr. Smith's duties as Vice President of Sales. (J.A. 565-567.) Mr. Smith's job required him to "direct[] and coordinate[] activities of one or more divisions of the sales department and aid[] other administrative officers in formulating and administering organization policies by performing" certain "Essential Duties and Responsibilities" and "Supervisory Responsibilities." (J.A. 566.) His "role priorities" included strategic planning, sales growth, customer service, and problem resolution. (*Id.*) The "Physical Demands" of his job included frequent sitting, the ability to stand and walk, and extensive automobile travel. (J.A. 567.)

1. Mr. Smith's Medical History

In support of his claim, Mr. Smith submitted copies of correspondence between Clifford T. Solomon, M.D. ("Dr. Solomon") and various other physicians. (J.A. 574-607.) This correspondence reflected the course of Mr. Smith's medical condition between March 1997 and July 2000. (*Id.*)

In March 1997, Dr. Solomon diagnosed Mr. Smith with "significant" stenosis at certain points in his spine. (J.A. 607.) In May 1997, after Mr. Smith's first surgery, Dr. Solomon reported Mr. Smith was "clearly getting better." (J.A.

606.) An April 1998 CT scan indicated Mr. Smith again suffered from severe stenosis and bulging disks. (J.A. 602, 605.) An April 1998 MRI confirmed the stenosis. (J.A. 602, 604.)

In August 1998, Randy F. Davis, M.D. ("Dr. Davis") found Mr. Smith had symmetric reflexes and no identifiable, specific motor weakness, even though a recent MRI and CT scan showed spinal stenosis and/or lateral disk herniation. (J.A. 602.) Dr. Davis observed that stenosis was the "most impressive finding." (*Id.*) A month later, in September 1998, Dr. Solomon found Mr. Smith had "severe congenital stenosis." (J.A. 601.) Mr. Smith underwent his second back surgery later that month. (J.A. 572.)

By November 1998, Dr. Solomon reported Mr. Smith was "walking much better." (J.A. 600.) In January 1999, a physical examination indicated symmetric reflexes, and X-ray testing revealed "excellent maintenance of alignment of the spine." (J.A. 599.) A June 1999 examination by Dr. Davis also indicated symmetric reflexes. (J.A. 597.) An MRI and CT scan in June 1999 again revealed stenosis. (J.A. 572, 598.) Dr. Davis believed the June 1999 testing revealed "broad-based dis[k] bulging," joints that looked "far from normal," and a "possibility of early lateral recessed stenosis." (J.A. 595.)

In July 1999, Dr. Solomon reported that Mr. Smith's condition had improved, but he was experiencing new pain. (J.A. 596.) Dr. Solomon also noted that Mr. Smith's pain emanated from "compressive effects" in his spine. (*Id.*)

Mr. Smith's February 2000 MRI revealed "[m]ulti level lateral dis[k] bulging," but the dimension of his lumbar spinal canal was within normal limits. (J.A. 585.) Shortly thereafter, in March 2000, Dr. Solomon noted Mr. Smith had injured himself while bending down to pick up an airplane ticket. (J.A. 584.) To alleviate Mr. Smith's pain, Dr. Solomon recommended selective nerve blocks and a visit with Brian S. Kahan, D.O. ("Dr. Kahan"). (*Id.*)

On March 2, 2000, Mr. Smith received "nerve blocks," which resulted in less than a 50% decrease in his symptoms. (J.A. 582.) On March 7, 2000, Dr. Solomon noted "marked degenerative changes" in Mr. Smith's lumbar spine. (J.A. 581.) Later that month, Dr. Solomon reported the MRI showed a bulging disk and moderate "neuroformamenal lateral recess stenosis", (J.A. 579), and that Mr. Smith had a "very classic symptom for a mechanical radicular pain." (J.A. 577.) Dr. Solomon recommended another surgical procedure "to free up" a nerve root. (*Id.*)

On May 3, 2000, Mr. Smith underwent his third back surgery. (J.A. 573.) Following the surgery, Dr. Solomon reported "the nerve roots looked very free" and Mr. Smith felt 50% better. (J.A. 575-576.) Dr. Solomon later noted the surgery was "not a cure-all, but [Mr. Smith would] make a huge step forward than

where he is right now." (J.A. 574.) Mr. Smith did not see Dr. Solomon for several months after July 11, 2000. (J.A. 553.)

### 2. The Initial Review And Denial Of Mr. Smith's Claim For Plan Benefits

On March 16, 2001, Continental interviewed Mr. Smith by telephone. (J.A. 553-555.) During the interview, Mr. Smith stated his condition had improved after his third surgery in May 2000, but declined again on January 17, 2001. (J.A. 553.) Thereafter, "if he walked too far, he couldn't do anything for 2-3 weeks afterwards." (*Id.*) Mr. Smith described his activities as including stretching, riding an exercise bicycle, and driving fifteen to twenty minutes at a time. (J.A. 554.)

On April 4, 2001, Mr. Smith's physical therapist told a vocational consultant with Continental that, when Mr. Smith was released from physical therapy, he "was ambulating with no problems and could stand up straight with no difficulties[,] … was doing well, and was given home exercises to perform." (J.A. 543.)

Continental sent Dr. Lowe a questionnaire asking whether he believed Mr. Smith would be able to perform work that allows him to control time spent sitting and standing. (*Id.*) Dr. Lowe responded Mr. Smith was "able to perform work which allows him to control the amount of sitting and standing he perform[s]." (*Id.*) Dr. Lowe also forwarded his most recent file notes. (J.A. 544-548.) Although Dr. Lowe's February 23, 2001 note confirmed his prior statement that

Mr. Smith "simply can not [sic] walk more than five minutes or sit longer than 10 minutes without excruciating pain in his back," Dr. Lowe further noted that treatment with Neurontin had "dramatically" helped Mr. Smith's sciatic radiating pain. (J.A. 546.)

Continental denied Mr. Smith's claim for disability benefits. (J.A. 540-542.) Continental noted that Mr. Smith's functional capabilities exceeded the physical demands of his job because, as Vice President of Sales, he had the flexibility to change positions as needed. (J.A. 541.) Continental cited Dr. Lowe's opinion that Mr. Smith was able to perform work that allowed him the flexibility to control the amount of his sitting and standing. (*Id.*) Continental acknowledged Mr. Smith's condition "may have exacerbations ... from time to time," but concluded that no medical evidence supported he was "continuously unable to perform the material and substantial duties" of his occupation under the Plan terms. (*Id.*)

C. The First Appeal

Mr. Smith appealed the denial decision and submitted additional medical records for Continental's consideration. (J.A. 465-523.) In a March 13, 2001 report submitted with the appeal, Dr. Solomon noted that Mr. Smith had "tremendous pan-stenosis of his whole lumbar spine." (J.A. 508.) Dr. Solomon also noted Mr. Smith was able to ride a recumbent bicycle for twenty-five minutes,

but his pain-free walking time decreased from eight to five minutes. (*Id.*) Dr. Solomon recommended not performing additional surgery. (*Id.*)

Mr. Smith also submitted a report from Dr. Kahan. (J.A. 501-503.) Dr. Kahan's findings from his physical examination of Mr. Smith included the following:

> Extremity: -e/c/c. Pulses intact. Tone normal. ROM normal, no atrophy, no deformities, skin normal, no erythema, no ecchymosis
>
> Neurologic: CN II-XII intact. PERLA. EOMI. MMT 5/5. Sensory intact. Muscle stretch reflexes equal and intact. Negative Babinski. Negative Hoffman's. Gait as above.
>
> Musculoskeletal:
> **Lumbar**:
> **ROM**: flexion: pain at end range, extension: pain at neutral, rotation: normal, sidebending: normal
>
> **Provocative Tests**: Hoovers: negative, SLR: negative, SRT: negative, Ober's: negative, Gaenslen: negative, Thomas: negative, Femoral Stretch Test: negative, FABER: negative, FABIR: negative, Bench: negative, Milgram's: negative, Wadell's: negative
>
> **Palpatory Findings**: Unremarkable

(J.A. 502.)

Dr. Kahan described Mr. Smith's pain as "7/10" and his "functional rating" as "34/40." (J.A. 501.) Dr. Kahan opined that Mr. Smith suffered from lumbar radiculopathy and post-lumbar laminectomy syndrome. (J.A. 502.) Dr. Kahan

recommended home exercises, a possible corticosteroid injection, and, potentially, spinal cord stimulators. (*Id.*) He further recommended that Mr. Smith "[c]ontinue short-term disability." (*Id.*) Mr. Smith saw Dr. Kahan again on April 25, 2001. (J.A. 499.) Although Mr. Smith had altered his medication regimen, Mr. Smith "only fe[lt] a little bit better." (*Id.*)

Mr. Smith's appeal also included reports from William Launder, M.D. ("Dr. Launder"), an orthopedic surgeon, (J.A. 486-493), and Martin Kranitz ("Mr. Kranitz"), a vocational consultant, (J.A. 481-485), both of whom first examined Mr. Smith after Continental denied his claim, and from Frederick T. Sutter, M.D. ("Dr. Sutter"), who had not examined Mr. Smith in several years. (J.A. 496-497.)

On July 2, 2001, Dr. Launder, in answers to interrogatories from Mr. Smith's counsel, identified Mr. Smith's diagnosis as failed back syndrome. (J.A. 384, 486.) Dr. Launder opined that Mr. Smith had mild limb atrophy, no muscle spasm, no muscle weakness, no sensory loss, and no reflex loss. (J.A. 487.) Dr. Launder found Mr. Smith could sit and stand on a continuous basis for less than thirty minutes before experiencing interruption due to feeling pain, and would not be able to "alternate between sitting and standing on a continuous basis throughout an eight hour workday with customary breaks without experiencing interruption due to pain." (J.A. 488.) According to Dr. Launder, Mr. Smith could not walk continuously without experiencing pain, but required less than five minutes' rest to

relieve the pain. (J.A. 488-489.) Dr. Launder's answers to the interrogatories from Mr. Smith's counsel concluded with the opinion that "the objective medical findings show a medically determinable condition or conditions which could reasonably be expected to produce the degree of pain described to [him] by [Mr. Smith] …." (J.A. 492.)

In a July 19, 2001 report to Mr. Smith's counsel, Mr. Kranitz concluded Mr. Smith was not capable of performing "competitive employment which requires consistent and ongoing work activities in the range of 35-40 hours per week." (J.A. 481, 485.) Mr. Kranitz based his findings on Mr. Smith's "difficulties with walking, standing and sitting," the 36% decrease in production described by Dr. Launder, and his understanding that Mr. Smith "ha[d] to lay down 75 percent of the day[.]" (J.A. 485.)

Dr. Sutter conducted an evaluation of Mr. Smith on June 11, 2001. (J.A. 496.) Dr. Sutter noted Mr. Smith had advanced lumbar spondylosis at multiple levels, as well as posterior element spondylosis and scoliosis. (J.A. 496.) Although Dr. Sutter noted Mr. Smith's belief that he would have to lie down for significant lengths of time due to his inability to stand or move around for periods longer than ten to fifteen minutes, Dr. Sutter declined to determine disability and referred the question of Mr. Smith's disability to another physician, stating, "[r]egarding a disability evaluation, it would be best if a local physician, Dr. Kevin

Hanley, saw him ..., as he has the greatest expertise in this area." (J.A. 496-497.) Dr. Sutter also noted Mr. Smith was no longer seeing Dr. Kahan. (J.A. 496.)

Continental construed Mr. Smith's letter and submissions as both a request for reconsideration by its Claims Unit and for review by its Appeals Committee. (J.A. 464.) Continental's Claims Unit sustained its initial denial. (*Id.*) Continental forwarded Mr. Smith's file to the Appeals Committee. (*Id.*)

On August 28, 2001, Mr. Smith's counsel submitted another report of Dr. Launder from the same July 2, 2001 examination, but this time under the label "Independent Medical Evaluation." (J.A. 383-386.) Although Dr. Launder reported the same findings, he further opined that "[t]he patient has reached maximum medical improvement and is completely disabled permanently from now onwards. His treatment has been exemplary, but unfortunately he has been unable to gain complete relief." (J.A. 386.)

D. Remand For Further Investigation

Continental's Appeals Committee remanded his file to the Claims Unit for further investigation. (J.A. 382.) Continental agreed to pay benefits while further reviewing Mr. Smith's claim. (J.A. 349-350.)

1. The Independent Review By Dr. Soriano

Continental forwarded Mr. Smith's claim file to Elite Physicians for an independent assessment of Mr. Smith's test results, functional ability, and duration

of disability, if confirmed. (J.A. 44, 46.) Marc Soriano, M.D. ("Dr. Soriano"), a board certified neurological surgeon and neurovascular fellow, reviewed Mr. Smith's medical records and conducted an interview of Dr. Solomon. (J.A. 335-339.)

Dr. Soriano noted "the primary diagnosis affecting Mr. Smith's ability to work is complaints of pain." (J.A. 336.) Dr. Soriano opined that Dr. Launder's evaluation and diagnosis of failed back syndrome were supported by a "paucity of clinical findings" and "based on self-reported complaints only." (*Id.*)

Dr. Soriano recognized Mr. Smith was mildly impaired, had limited range of motion due to the surgeries, and had specific limitations including lifting no more than 35 pounds on a frequent basis and avoiding lifting heavier objects. (J.A. 337.) Dr. Soriano also acknowledged Mr. Smith would need to be allowed to change positions frequently, and avoid sitting or standing for periods of time over 1-2 hours. (*Id.*) Dr. Soriano concluded, however, that Mr. Smith's self-reported complaints exceeded the clinical findings and a diagnosis of total impairment was unreasonable based on the self-reported complaints. (*Id.*) Dr. Soriano noted that Mr. Smith had "normal neurological exams, stable x-rays and has negative straight leg raising sign, no spasm and only a patient-controlled diminished range of motion is not reason enough to support a diagnosis of total disability." (*Id.*)

Dr. Soriano also based his opinions on a telephone interview with Dr. Solomon. During the interview, Dr. Solomon conceded, "Mr. Smith's complaints were excessive and often did not correspond well to [his] clinical X-ray findings or neurological exam." (*Id.*) Dr. Solomon noted it was "odd" that "despite Mr. Smith's complaints of pain on multiple occasions, he was making trips out of the country on a frequent basis." Dr. Solomon agreed "there were no significant physical findings, either neurologically or on an orthopedic basis, and ... that Mr. Smith was probably not totally disabled ...." (*Id.*)

2. <u>The Termination Of Benefits</u>

Continental informed Mr. Smith that benefits were being terminated. (J.A. 330-331.) Continental explained that Mr. Smith's records did not demonstrate a functional impairment that would prevent him from performing the duties of his occupation, and his physical restrictions could easily be accommodated based upon his job description. (*Id.*) Continental forwarded Mr. Smith's claim file to the Appeals Committee for final review. (*Id.*)

E. <u>The Second Appeal</u>

Mr. Smith submitted additional materials for consideration on appeal, including a functional capacity evaluation performed by P. Steven Macedo, M.D., and Eric Meyer, D.O. (J.A. 272-274.) Drs. Macedo and Meyer concluded, based upon a "job strength analysis," that Mr. Smith could perform "light duty" work as

described by the Department of Labor, but "in view of his dynamic functional deficits, his functional capacity was below the sedentary work threshold." (J.A. 274.) Mr. Smith's counsel also provided a copy of the decision regarding Mr. Smith's application for social security disability benefits. (J.A. 284-290.) Finally, Mr. Smith's counsel submitted a statement by Dr. Solomon that: "I have not examined Neal Smith since 6/11/01 and cannot render any opinion concerning his condition or functional capacity after that date." (J.A. 271.)

F. The Final Decision

On May 2, 2002, Continental issued a final decision affirming the denial of disability benefits. (J.A. 250-254.) Continental acknowledged Mr. Smith had back pain and longstanding difficulties associated with back pain, but "the information presented does not support a functional loss that would preclude him from performing the full duties of his regular occupation." (J.A. 253.) Continental explained the "primary limiting factor" affecting Mr. Smith was his pain complaints, which "are disproportionate when compared to the diagnostic and physical findings presented." (*Id.*)

## V. SUMMARY OF ARGUMENT

The district court erred by importing the Social Security ruling from *Hyatt v. Sullivan*, 899 F.2d 329 (4th Cir. 1990), into this ERISA-governed disability claim.

The district court's reliance on *Hyatt* is contrary to the Supreme Court's decision in *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003).

The district court further erred by not adhering to the Supreme Court's decision in *Nord* in two other significant respects. First, the district court adopted a new version of the treating physician rule, holding that pain medications prescribed by "treating physicians" are "objective evidence of disabling pain." (J.A. 28.) Second, the district court violated *Nord* and the plan terms by shifting to Continental the burden of proving through "substantial evidence" that the pain complaints were "exaggerated." (J.A. 18.)

The district court also erred by relying on a news release as substantive medical evidence that there is a "physiological basis for individual differences in pain sensitivity." (*Id.*) This medical evidence was never presented to or considered by Continental during the claims process. Indeed, neither the news release nor the underlying study were part of the administrative record. *See Sheppard & Enoch Pratt Hosp., Inc. v. Travelers Ins. Co.*, 32 F.3d 120 (4th Cir. 1994).

The district court erred by relying on the news release and underlying study because the study is not "proof" of the proposition cited. This small study of hand-picked, healthy subjects, failed to adhere to well-established principles of scientific methodology and utterly fails to meet the threshold criteria for reliability and

relevance established in *Daubert v. Merrell-Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993).

Finally, viewed from the proper perspective, Continental's decision to deny Mr. Smith's claim was reasonable, followed a deliberate review process, and was supported by substantial evidence, including evidence from one of the treating physicians. Continental, therefore, did not abuse its discretion in denying Mr. Smith's claim. For the reasons stated above and more fully discussed below, the Court should vacate the district court's order.

## VI. STANDARDS OF REVIEW

A district court's grant of summary judgment is reviewed *de novo*, employing the same legal standards applied by the district court. *Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 268 (4th Cir. 2002). Summary judgment is appropriate when "there is no genuine issue as to any material fact and … the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c).

If an ERISA benefit plan gives an administrator discretionary authority to determine eligibility for benefits or to construe plan terms, then the standard of review is the abuse of discretion standard. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *Sargent v. Holland,* 114 F.3d 33, 35 (4th Cir. 1997). Under the abuse of discretion standard, a federal court's ability to review

the decisions of the administrator is "significantly limited," *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 605 (4th Cir. 1999), and "will not be disturbed if [it is] reasonable." *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 787 (4th Cir. 1995). The administrator's decision is reasonable if it "is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Id.* at 788 (citation omitted).

Where an ERISA plan fiduciary both administers and pays claims, the deference afforded the fiduciary's decisions is reduced to the degree necessary to neutralize any untoward influence resulting from the conflict. *See Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997). Under this "modified" abuse of discretion standard, the administrator's decision still should be upheld if it was "reasonable," *Bernstein*, 70 F.3d at 787-88, but the court should weigh the conflict of interest as a factor in analyzing the reasonableness of the decision. *Id.*; *see also Ellis,* 126 F.3d at 233 ("in no case does the court deviate from the abuse of discretion standard").

## VII. ARGUMENT

### A. ERISA Disability Claims Are Governed By ERISA, Regulations Promulgated Pursuant To ERISA, And The ERISA Plan Terms, Not By The Social Security Act, Social Security Regulations, Or Cases Interpreting Social Security Regulations

ERISA is a "comprehensive and reticulated statute" that delegates to the Department of Labor the authority to adopt regulations. *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (quoting *Nachman Corp. v. Pension Benefit Guar. Corp.*, 446 U.S. 359, 361 (1980)); *see also* 29 U.S.C. § 1135. Although the Secretary of Labor has adopted ERISA regulations pursuant to this delegation of authority, the Secretary of Labor has never adopted Social Security Ruling ("SSR") 90-1p, or any comparable decision-making rule, for purposes of ERISA claims. *See* 65 Fed. Reg. 70265 (November 21, 2000). Still further, although Congress undoubtedly anticipated a federal common law of ERISA, "the scope of permissible innovation is narrower in areas where other federal actors are engaged." *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1970-71 (2003).

#### 1. The District Court Erred By Relying On *Hyatt* And Ignoring The Supreme Court's Decision In *Nord*

The primary authority relied upon by the district court for its adoption of the SSR is *Hyatt v. Sullivan*, 899 F.2d 329 (4th Cir. 1990). In *Hyatt*, the district court

determined that SSR 82-58 violated Fourth Circuit law because objective evidence of pain's intensity or degree is not required to support a Social Security disability claim. *Hyatt v. Heckler*, 711 F. Supp. 837, 840-42 (W.D.N.C. 1989) (citing, *inter alia*, *Myers v. Califano*, 611 F.2d 980, 983 (4th Cir. 1980) (Secretary must evaluate the disabling effects of a disability claimant's pain even though the intensity of the pain is shown only by subjective evidence)). The district court ordered the Secretary of Health and Human Services to distribute a new "Social Security Ruling for Review of North Carolina Disability Claims Based on Pain as a Disabling Condition" to all administrative law judges hearing Social Security cases in North Carolina. *Id.* at 843-45. The new SSR was attached as Exhibit A to the district court's opinion. *Id.* at 844-47 (exhibit A).

On appeal, this Court affirmed, finding SSR 82-58 violated Fourth Circuit law. *Hyatt v. Sullivan*, 899 F.2d at 329 (citations omitted). This Court further approved the proposed new SSR, later promulgated as SSR 90-1p, *see* 55 Fed. Reg. 31898 (August 6, 1990), and quoted it, with one word changed, *en haec verba*. 899 F.2d at 337 n.9.

In pertinent part, the language this Court reiterated, which is now set forth in SSR 90-1p, and which the district court in *Smith* adopted for ERISA disability claims, is as follows:

> Once an underlying physical or mental impairment that could reasonably be expected to cause pain is shown by

> medically acceptable 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 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 motory disruption), if 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.

*Hyatt v. Sullivan*, 899 F.2d at 337; *see also* J.A. 19-20; SSR 90-1p (current version at Notice of Social Security Ruling 95-5p, 60 Fed. Reg. 55406 (Oct. 31, 1995)). By engrafting this Social Security rule upon ERISA, the district court violated the principles established in and the reasoning articulated by the Supreme Court in *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003).

In *Nord v. Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002), the Ninth Circuit Court of Appeals reversed a plan administrator's disability determination based on the so-called "treating physician rule."[5] *Id.* at 829-30 (citing *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130

[5] The treating physician rule affords special deference to the opinions of a claimant's treating physician and imposes a burden of explanation on administrative law judges when they reject a treating physician's opinion. *See Nord*, 123 S. Ct. at 1969; 20 C.F.R. § 404.1527(d) (2003).

(9th Cir. 2001)). According to the Ninth Circuit's decision in *Regula*, the treating physician rule, which by regulation was applicable to Social Security cases, should apply to private ERISA benefit plans because of "common sense as well as consistency in [judicial] review of benefits protected by federal law." *Regula*, 266 F.3d at 1139.

In *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003), the Supreme Court rejected the Ninth Circuit's attempt to read the treating physician rule from Social Security disability regulations into ERISA disability claims. The Supreme Court's decision rested on several key distinctions between the Social Security and ERISA statutory schemes.

First, the Supreme Court recognized that, although ERISA empowered the Secretary of Labor to prescribe necessary and appropriate regulations, the Secretary of Labor, unlike the Commissioner of Social Security, had not adopted regulations concerning a treating physician rule. 123 S. Ct. at 1970-71. Indeed, the Court noted the most recent version of ERISA regulations was issued long after the Social Security Administration promulgated the treating physician rule. *Id.* at 1970.

Second, the Supreme Court observed that the "question whether a treating physician rule would 'increas[e] the accuracy of disability determinations' under ERISA Plans, as the Ninth Circuit believed it would ... moreover, seems to us one

the Legislature or superintending administrative agency is best positioned to address." *Id.* at 1971 (citation omitted). The Court questioned whether opinions of treating physicians warrant greater credit than the opinions of plan consultants, but noted the issue "might be aided by empirical investigation of the kind courts are ill equipped to conduct." *Id.*

Finally, and of "prime importance," the Supreme Court recognized "critical differences between the Social Security disability program and ERISA benefit plans." *Id.* The Social Security Commissioner published detailed regulations governing benefits determinations "to foster uniformity and regularity" and based upon "[p]resumptions ... that 'grow out of the need to administer a large benefits system efficiently.'" *Id.* (citing *Cleveland v. Policy Mgmt. Sys. Corp.*, 526 U.S. 795, 803 (1999)). In contrast to this "uniform set of federal criteria" against which an adjudicator measures entitlement to Social Security benefits, the validity of a claim under ERISA turns, in large part, on the interpretation of terms in a particular plan. *Id.* (citing *Firestone Tire*, 489 U.S. at 115). The Supreme Court deferred to the Secretary of Labor's view that ERISA is "best served" by allowing plan administrators "the greatest flexibility possible ... for operating claims processing systems consistent with the prudent administration of a plan." *Id.* at 1972 (citation omitted.)

The district court's decision violates the precise holding of and the reasoning in *Nord* in several respects. First, as in *Nord*, the Secretary of Labor has not enacted a regulation applicable to ERISA plans codifying SSR 90-1p. Notably, like *Nord*, the most recent version of the Secretary of Labor's ERISA regulations was adopted more than ten years after SSR 90-1p was adopted. *Compare* Notice of Social Security Ruling, 55 Fed. Reg. 31898 (August 6, 1990) *with* Notice of Final Regulations, 65 Fed. Reg. 70265 (November 21, 2000). The Secretary of Labor's decision not to enact a similar decision-making rule for ERISA, after being on public notice of SSR 90-1p for over ten years, is ample evidence that the Secretary never intended SSR 90-1p to apply to ERISA plans.

Second, as in *Nord*, the question of whether to apply a universal and uniform rule for analysis of disability claims based on pain to all ERISA plans, regardless of differences in plan terms and design, is a decision best left to the Legislature or the Secretary of Labor. Notably, neither has adopted the rule espoused by the district court.

Further, as in *Nord*, the district court adopted a decision-making rule without any "empirical" evidence that the rule would yield more accurate disability determinations. *Nord*, 123 S. Ct. at 1971. For the same reasons noted in *Nord*, this Court should refuse to presume the credibility of a claimant who complains of

disabling pain. Indeed, such claimants may have more powerful "incentives" than the treating physicians discussed in *Nord*.

Third, as in *Nord*, the district court's decision fails to account for the differences between ERISA plans and Social Security disability claims. Although Social Security claims are administered through a uniform nationwide system, ERISA claims are handled individually and with wide variance among employers and plan terms.[6]

Although the district court may have believed that "[p]roof is proof," ERISA is not Social Security. Notably, the district court's "proof is proof" rationale is remarkably similar to the Ninth Circuit's "common sense and consistency" rationale for the now rejected "treating physician rule." *Compare* (J.A. 18-19) *with Regula*, 266 F.3d at 1139. Neither the "proof is proof" nor the "common sense and consistency" rationale is sufficient to sustain the district court's decision. This Court has repeatedly recognized that proof sufficient to sustain a right to recover Social Security disability benefits is not proof of an improper denial of disability

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[6] The other authorities cited by the district court in its *Hyatt* analysis are equally inapposite. Four of the cases are Social Security cases that pre-date *Nord*. *O'Donnell v. Barnhart*, 318 F.3d 811 (8th Cir. 2003); *Light v. Soc. Sec. Admin.*, 119 F.3d 789 (9th Cir. 1997); *Cotton v. Bowen*, 799 F.2d 1403 (9th Cir. 1986); *Mickles v. Shalala*, 29 F.3d 918 (4th Cir. 1994). The remaining three cases are ERISA cases, but likewise pre-date *Nord*. *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914 (7th Cir. 2003); *Willis v. Baxter Int'l, Inc.*, 175 F. Supp. 2d 819 (W.D.N.C. 2001); *Palmer v. Univ. Med. Grp.*, 994 F. Supp. 1221 (D. Or. 1998), *abrogated on other grounds*, *Hensley v. N.W. Permanente P.C. Retirement Plan & Trust*, 258 F.3d 986 (9th Cir. 2001).

benefits under an ERISA plan. *See Gallagher*, 305 F.3d at 275; *Elliott*, 190 F.3d at 607.

2. The District Court's New Version Of The Treating Physician Rule Is Contrary To The Supreme Court's Decision In *Nord*

The district court's decision violates *Nord* in at least one other significant respect. The district court noted that Mr. Smith's treating physicians prescribed various medications. (J.A. 26-27.) The district court accused Continental of ignoring the medications prescribed and characterized the medication regimen as "'objective evidence' of disabling pain." (J.A. 26, 28.) The district court reasoned that if treating physicians prescribe pain medications, then the medications are "tantamount to 'objective evidence' of disabling pain." (J.A. 26-28.)

The district court's analysis of Mr. Smith's medication regime is a new twist on the now-rejected treating physician rule. The mere fact that a treating physician prescribed a pain medication is not "objective evidence of disabling pain." (*See* J.A. 625 (Plan definition of "objective medical findings").) Indeed, a physician's decision to prescribe medications in response to unsubstantiated subjective complaints is not objective proof of anything.[7]

The district court's new version of the treating physician rule would allow a disability claimant to subjectively create "objective evidence of disabling pain" by

[7] This evidence may be relevant, however, to whether the individual is receiving appropriate treatment or treatment from a physician. (J.A. 625.)

simply complaining to his or her treating physician until he or she received higher doses or more significant pain medications. The increased or different medications, although not supported by any objective measure, then become the "objective evidence of disabling pain." This crediting of the "treating physicians" through their medications violates *Nord*, which specifically held "treating physicians" are not entitled to special deference. *See Nord*, 123 S. Ct. at 1972.

By considering the medication regimen as "tantamount to objective evidence of disabling pain" (J.A. 28) and requiring "substantial evidence" (J.A. 18) to rebut it, the district court gave greater weight to the opinions of the "treating physicians" simply because they prescribed pain medications. This new twist on the treating physician rule cannot pass muster post-*Nord*.

#### 3. The District Court Imposed A Burden Of Proof On Continental Prohibited By *Nord* And Contrary To The ERISA Plan Terms

The district court found that, "[w]ithout objective medical proof to verify the intensity and severity of the pain that Mr. Smith reported, Continental Casualty simply disbelieved him." (J.A. 17-18.) The district court held "Continental Casualty abused its discretion ... [by] discredit[ing] Mr. Smith without substantial evidence that he was exaggerating." (J.A. 18, 34.)

Applying the *Hyatt* analysis, the district court found (1) "all the objective evidence indicates that Mr. Smith has a physical impairment that could cause

pain"; and (2) although "[a]lmost no such evidence substantiates the intensity of the pain that Mr. Smith said he was feeling," Continental "offer[ed] no evidence impeaching the veracity of Mr. Smith's account [of his pain]." (J.A. 21-22.) The district court, therefore, concluded Continental did not provide "objective medical proof" refuting Mr. Smith's disability and "abused its discretion ... [by] discredit[ing] Mr. Smith without substantial evidence that he was exaggerating." (J.A. 18, 34.)

The district court violated *Nord* by requiring Continental to prove by "substantial evidence" and "objective medical proof" that Mr. Smith's subjective complaints were exaggerated. *Nord,* 123 S. Ct. at 1972. The district court's imposition of a "discrete burden" on Continental to refute "specially weighted" evidence is anathema to the Supreme Court's decision in *Nord*.

The district court also abandoned the Plan terms by requiring Continental to provide "objective medical proof" that Mr. Smith's pain was not genuine, rather than requiring Mr. Smith to provide "objective medical findings" supporting his disability. Moreover, by shifting the burden to Continental to refute the "intensity and severity" of this "objective evidence of disabling pain," the Court improperly altered the ERISA plan terms. The Plan's "Proof of Disability" required Mr. Smith to provide the proof of loss though "[o]bjective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests,

procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s)." (J.A. 625.) By adding "pain medications" as a new "objective medical finding," the district court effectively altered the Plan terms. (*Compare* J.A. 28 *with* J.A. 625.)

Neither this Court nor other courts in this circuit has approved burden shifting in an ERISA case. *See, e.g., Elliott*, 190 F.3d at 608 (a plan administrator owes no duty to obtain evidence supporting the participant's claim for benefits); *Berry v. Ciba-Geigy Corp.*, 761 F.2d 1003, 1008 (4th Cir. 1985) (same). Moreover, this Court has recognized that a lack of objective medical evidence supporting a claimant's disability is sufficient grounds for a denial of benefits. *See Lown v. Cont'l Cas. Co.*, 238 F.3d 543, 549 (4th Cir. 2001) (district court properly sustained denial of ERISA benefits where "no objective medical test confirmed [her] disability" due to chronic fatigue and pain).

The United States District Court for the District of West Virginia, in a decision recently affirmed by this Court, explained that a plan's objective evidence requirement comports with a plan administrator's duty under ERISA to protect plan assets:

> [If objective medical evidence of disability were not required] LTD benefits would be payable to any participant with subjective and effervescent symptomology simply because the symptoms were first passed through the intermediate step of self-reporting to a medical professional. If that were so, Defendants would

> be greatly hampered in exercising their fiduciary role of carefully scrutinizing self-reporting, preventing malingering, and consequently "'guard[ing] the assets of the trust from improper claims, as well as ... pay[ing] legitimate claims.'"

*Coffman v. Metro. Life Ins. Co.*, 217 F. Supp. 2d 715, 732 (S.D.W. Va. 2002) (citations omitted), *aff'd*, No. 02-2128, 2003 WL 22293610 (4th Cir. Oct. 7, 2003) (petition for rehearing filed).

In contravention of *Nord*, the district court required Continental to accord special weight to Mr. Smith's subjective complaints of pain and provide substantial evidence that his complaints were exaggerated. This shifted the burden of proof to Continental to disprove Mr. Smith's disability. Under well-established Fourth Circuit law, as well as the Plan terms, Continental properly relied upon the lack of objective medical evidence supporting Mr. Smith's disability for its decision to deny benefits.

## B. The District Court Erred By Relying On Substantive Medical Evidence That Was Never Presented Or Considered During The Claim Review Process

### 1. The District Court Should Not Have Considered Substantive Medical Evidence Outside The Administrative Record

The district court relied on a June 24, 2003 news release for the proposition that there is "a physiological basis for individual differences in pain sensitivity." (J.A. 18.) The news release cited by the district court was "*Brain Imaging*

*Confirms that People Feel Pain Differently, Report Researchers at Wake Forest University Baptist Medical Center*, Wake Forest University Baptist Medical Center News Release, *at* http://www.wfubmc.edu/news_sys/fullstory.php? articleid=4241 (June 24, 2003) (the "News Release"). (*Id.*)

Neither the News Release nor the recent study by Robert C. Coghill, Ph.D. (the "Coghill Study") cited therein was presented or considered during the claims process or otherwise made a part of the administrative record. Indeed, the Coghill Study was not published, and the News Release was not issued, until more than a year after Continental issued its final claims decision in May 2002. (*See* J.A. 250.) The district court, therefore, erred by relying on the News Release and the purported results of the Coghill Study. *See Sheppard & Enoch Pratt Hosp.*, 32 F.3d at 124-25 (district court properly refused to consider materials relied upon by treating physician and treating physician's affidavit when those materials were not before administrator); *Berry*, 761 F.2d at 1007 (district court erred in admitting treating physician's "after-the-fact testimony").

"[W]hen a district court reviews a plan administrator's decision under a deferential standard, the district court is limited to the evidence that was before the plan administrator at the time of the decision." *Bernstein*, 70 F.3d at 788. *See also Elliott*, 190 F.3d at 608. "[A]lthough it may be appropriate for a court conducting a *de novo* review of a plan administrator's action to consider evidence that was not

taken into account by the administrator, the contrary approach should be followed when conducting a review under ... the abuse of discretion standard." *Sheppard & Enoch Pratt Hosp.*, 32 F.3d at 125. Under the abuse of discretion standard, "an assessment of the reasonableness of the administrator's decision must be based on the facts known to it at the time." *Id.*; *see also Elliott*, 190 F.3d at 608 (same). Indeed, "[t]o review *de novo* all the evidence trustees *might* have considered is to transfer the administration of benefit and pension plans from their designated fiduciaries to the federal bench. Such substitution of authority is plainly what the formulated standards in [ERISA] are intended to prevent." *Berry*, 761 F.2d at 1007 (emphasis in original).

The district court relied upon the News Release as substantive medical evidence because it is the only authority cited for the proposition that there is "a physiological basis for individual differences in pain sensitivity."[8] (*See* J.A. 18.) This "physiological basis for individual difference in pain sensitivity," in turn, is the predicate for the district court's entire analysis of disabling pain. Absent this medical predicate, however, the district court's opinion is completely unfounded.

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[8] Although the district court also cited the Black Knight's traumatic amputation of both arms as "just a flesh wound," (J.A. 18 (citing *Monty Python and The Holy Grail*)), Continental seriously doubts the district court intended this as substantive medical evidence. Regardless of the severity of his pain, however, the Black Knight would have suffered a "Presumptive Disability" and been entitled to 46 months of benefits under the terms of the Plan. (J.A. 624.) Thus, the district court's analogy is inapposite.

Although citation to generally accepted medical authorities, such as the Physicians' Desk Reference, may be permissible and appropriate for background information, reliance on studies that are not part of the administrative record for substantive points of medical evidence, as here, is improper and inconsistent with ERISA. Indeed, neither Continental nor its medical expert ever considered this "new" substantive medical evidence. As noted more fully by the discussion below, Continental's medical expert may have found the study unreliable, flawed science, or, perhaps, inapplicable to Mr. Smith. The district court, of course, never considered any of these points because Continental had no opportunity to raise them.

2. The News Release And Coghill Study Relied Upon By The District Court Are Unreliable

In the Coghill Study, magnetic resonance imaging was used to assess responses in brain function to heat stimulus in seventeen healthy people. (*See* News Release, p. 1.) According to the News Release, the Coghill Study "confirm[s] that self-reports of pain intensity are highly related to brain activation and that self-reports should guide treatment of pain." (*Id.*) To the district court, the theory presented in the Coghill Study confirmed the genuineness of Mr. Smith's complaints of pain and required Continental to overcome that presumption of genuineness with objective medical proof. (*See* J.A. 18-20.)

The methodology of the Coghill Study falls far short of fundamental principles of scientific testing. The study involved a small, homogenous group of seventeen normal, healthy persons. Robert Coghill, John G. McHaffie & Ye-Fen Yen, *Neural Correlates of Interindividual Differences in the Subjective Experience of Pain*, 100 Proceedings of the Nat'l Acad. of Sciences, 8538-42 (2003). The study did not incorporate bias controls or utilize randomization techniques such as single or double blinding in order to reduce predispositions to certain results. *Compare id.*, p. 8538, *with* 63 Fed. Reg. 49583, 49587-88 (September 16, 1998) (guidance from the Department of Health and Human Services states that blinding and randomization are the "most important design techniques for avoiding bias in clinical trials"). The study also did not employ a control group, introduce a placebo, or take into consideration other variables, such as individual differences in sensitivity to heat. *Compare Coghill, McHaffie & Yen*, at 8538-39 *with* Notice, 63 Fed. Reg. 49583, 49595; *see also* ClinicalTrials.gov, A Service of the National Institutes of Health, *An Introduction to Clinical Trials,* at http://www.clinicaltrials.gov/ct/info/whatis (last visited October 28, 2003). The study simply relied upon subjective reports of pain (heat) intensity, which was the very fact sought to be proved. *See Coghill, McHaffie & Yen*, at 8538.

Moreover, as the district court acknowledged, the Coghill Study represents "recent scientific research" that "uncovered" a physiological basis for pain. (J.A.

18.) Due to its infancy, size, and dimension, the Coghill Study would qualify, at most, as a Phase I clinical trial. The study could not qualify as a Phase II or Phase III clinical trial for the simple reason that its subjects were too few and were healthy individuals who did not suffer from any medical condition.[9]

Still further, the Coghill Study fails to meet the threshold requirements of reliability and relevance set forth in *Daubert v. Merrell-Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). The study fails the reliability test because its hypothesis (i) has not been tested, (ii) has not been subjected to peer review,[10] (iii) has no known or potential rate of error in relation to large populations, and (iv) has not been accepted within the relevant scientific community.[11] *Aldridge v. Goodyear Tire & Rubber Co.*, 34 F. Supp. 2d 1010, 1023 (D. Md. 1999), *vacated on other grounds*, 223 F.3d 263 (4th Cir. 2000).

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[9] "In Phase I trials, researchers test a new drug or treatment in a small group of people (20-80) for the first time to evaluate its safety, determine a safe dosage range, and identify side effects. In Phase II trials, the study drug or treatment is given to a larger group of people (100-300) to see if it is effective and to further evaluate its safety. In Phase III trials, the study drug or treatment is given to large groups of people (1,000-3,000) to confirm its effectiveness, monitor side effects, compare it to commonly used treatments, and collect information that will allow the drug or treatment to be used safely." ClinicalTrials.gov, A Service of the National Institutes of Health, *An Introduction to Clinical Trials, at* http://www.clinicaltrials.gov/ct/info/whatis (last visited October 28, 2003).

[10] Although the article was subject to peer review, the article does not indicate whether the study itself was subject to any peer review.

[11] Although the online version of the News Release was issued during the week of June 23, 2003, the journal article was not published in hardbound form until July 8, 2003. *Coghill, McHaffie & Yen*, at 8538.

The Coghill Study also has limited, if any, relevance to Mr. Smith. The study purports to measure simulated pain, not pain resulting from a medical condition. *Coghill, McHaffie & Yen*, at 8540-41. The study did not attempt to account for other factors affecting self-reported pain, such as financial motive. *Id.* Further, Mr. Smith, who is 59 years old, is not within the age range of the sample group in the Coghill Study, which was comprised of individuals 21 to 40 years of age, with a mean age of 26. (*Compare* J.A. 569 with *Coghill, McHaffie & Yen*, at 8540.) Finally, Mr. Smith did not undergo the same MRI testing described in the Coghill Study. *Coghill, McHaffie & Yen*, at 8540-41. Thus, whether Mr. Smith would have the same increased brain activity as the test subjects is unknown.

### C. The Decision To Deny Benefits Was Supported By Substantial Evidence, And The District Court's Determination To The Contrary Was Based On A Usurpation Of The Powers And Duties Delegated To Continental

Under the abuse of discretion standard, an ERISA plan administrator's decision will not be disturbed if it is "reasonable," even if a court reviewing the decision would have reached a different conclusion. *Ellis*, 126 F.3d at 232. A decision is reasonable if it is "the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Id.* (quoting *Brogan v. Holland*, 105 F.3d 158, 161 (4th Cir. 1997)).

Continental's review of Mr. Smith's claim consisted of evaluating numerous medical records and test results, obtaining the opinions of his treating physicians, reviewing numerous additional materials submitted by Mr. Smith's counsel and the physicians retained by Mr. Smith's counsel, and referring Mr. Smith's claim to a neurosurgeon for independent medical review. Continental conducted two full appeals in the process of considering Mr. Smith's claim. The first appeal was actually successful, in part, because Continental released certain benefits and conducted a further investigation. Only after the conclusion of the second appeal did Continental finally deny Mr. Smith's claim. This process was reasonable, followed a deliberate review process, and was supported by substantial evidence.

Notably, during the second appeal of Mr. Smith's claim, Mr. Smith had abandoned all of his treating providers and was relying solely on his counsel-inspired experts, Drs. Launder, Macedo, and Meyer and Mr. Kranitz. Although counsel also submitted a report from Dr. Sutter, Dr. Sutter specifically eschewed any opinion on disability, deferring to Dr. Hanley. (J.A. 497.) Continental never received any information from Dr. Hanley.

Moreover, Dr. Sutter noted that Mr. Smith was no longer seeing Dr. Kahan, which is understandable due to the fact that Dr. Kahan's findings on examination were not supportive of Mr. Smith's claim. (*See* J.A. 496, 502.) Dr. Lowe likewise

became a non-participant in the claim process after answering Continental's questionnaire in a fashion that was unfavorable to Mr. Smith. (*See* J.A. 543.)

Finally, although Dr. Solomon saw Mr. Smith for several years leading up to his disability, the opinions he expressed during the claim process supported Continental's decision. When Mr. Smith's counsel sought to obtain some limiting statement from Dr. Solomon, the only statement he could obtain was that Dr. Solomon was not familiar with Mr. Smith's condition after June 11, 2001. (J.A. 271.) This, however, is a non-issue because Mr. Smith's date of disability was four months earlier, February 23, 2001. (J.A. 570.) Moreover, no evidence was ever offered of any change in condition after June 11, 2001.

In sum, the administrative review process was not marked by any unfairness or procedural irregularities. Continental engaged in substantial efforts to obtain information, evaluate the information received, and conduct a full and fair review of Mr. Smith's claim. Continental's determination was reasonable, followed a deliberate review process, and was supported by substantial evidence.

## VIII. CONCLUSION

For the foregoing reasons, Continental Casualty Company respectfully requests that this Court vacate the district court's August 4, 2003 order granting Mr. Smith's motion for summary judgment and direct the entry of a judgment in favor of Continental based on its cross-motion for summary judgment.

Respectfully submitted,

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Dated: February 21, 2007

## CERTIFICATE OF COMPLIANCE WITH TYPE-VOLUME LIMITATION, TYPEFACE REQUIREMENTS, AND TYPE STYLE REQUIREMENTS

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because the brief contains 8,240 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B).
2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because the brief has been prepared using a proportionately spaced typeface, Microsoft Word 2000 in 14-point Times New Roman.

## STATEMENT PURSUANT TO FED. R. APP. P. 34 AND LOCAL RULE 34(a) REQUESTING ORAL ARGUMENT

Oral argument should be heard in this appeal because this case presents a matter of first impression. This Court has not yet addressed or applied the Supreme Court's decision in *Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965 (2003). Moreover, the *Nord* decision and its relationship with existing Fourth Circuit Social Security law are important. Continental Casualty Company respectfully submits the decisional process would significantly benefit from oral argument.

## CERTIFICATE OF SERVICE

I HEREBY CERTIFY that, on this 10th day of November, 2003, two copies of Continental Casualty Company's Brief to the United States Court of Appeals for the Fourth Circuit were sent by Federal Express to:

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