



## II. BACKGROUND

Sorensen worked as a department supervisor in Plymouth, Massachusetts, for Home Depot, which provided short-term disability (STD) and long-term (LTD) coverage through MetLife. Compl. ¶¶ 3, 4 (document # 1). The plan defines an employee as “fully disabled” and thus entitled to benefits if, due to injury or sickness, she is “under the regular care and attendance of a [d]octor” and is “unable to perform any of the material duties of [her] job.”<sup>3</sup> Claim File at 70-71 (document # 12).<sup>4</sup>

Sorensen claims she became disabled from performing her job by reason of severe depression on April 4, 2006. Compl. ¶ 9. She made a claim under the STD policy, which provided for a benefit at 66.67% of the employee’s base pay for up to twenty-four weeks with a two-week waiting period.<sup>5</sup> Claim File at 64. As reasons for ceasing to work, she listed “crying, so stressed out, financial problems, divorce.” Id. at 6; see also Def.’s Statement of Material Facts (“Def.’s Facts”) ¶ 5 (document # 19); Pl.’s Resp. to Def.’s Facts ¶ 5 (document # 22).

On May 5, 2006, soon after Sorensen filed for STD benefits, Clinic Director Rachel Novak called MetLife and stated that Sorensen was being seen twice a week for an hour, that her primary care physician had put her on antidepressants, and that she had anxiety and depression. Claim File 4-5. Mary Grosso, a licensed social worker, examined Sorensen on May 8, 2006, and

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<sup>3</sup> The parties do not dispute that Sorensen was under the regular care of a doctor.

<sup>4</sup> The Claim File is Bates stamped “MET” followed by five digits. For simplicity’s sake, I omit the Bates reference and superfluous digits throughout this opinion.

<sup>5</sup> Plaintiff’s complaint incorrectly states that the benefit runs for 26 weeks. See Compl. ¶ 7.

submitted documentation dated May 10, 2006,<sup>6</sup> noting that Sorensen was suffering from dysthymia<sup>7</sup> and anxiety and that Sorensen could return to work in mid to late summer 2006. Id. at 338-39. MetLife approved Sorensen's claim and provided her benefits in the amount of \$461.53 per month, but indicated that she would need to provide additional medical information if she continued to be disabled beyond May 31, 2006. See Compl. ¶ 10; Claim File at 322. Sorensen's social worker, Ms. Grosso, her psychiatrist, Dr. Ronal Russo, and her primary care physician, Dr. Jean Belkavich, provided additional records before May 31, 2006. Claim File at 314-39. MetLife extended Sorensen's claim, and requested additional medical records after her July 6, 2008, doctor's visit. Id. at 18.

#### **A. Termination of STD Claim**

On July 10, 2006, Sorensen's primary care physician, Dr. Brian McManus, sent a brief letter indicating that he had seen Sorensen on July 6 and that she needed to be out of work until her next appointment on September 15 due to "stress related issues." Id. at 312. Also on July 10, 2006, MetLife determined that the letter did not support an extension and requested further documentation from Dr. McManus, including (1) copies of his July 6, 2006, office visit notes and the most recent mental status exam, (2) specific restrictions/limitations preventing Sorensen from working, (3) a current and future treatment plan, (4) a list of medications, and (5) her estimated return-to-work date. Id. at 18-19. Dr. McManus sent the notes from Sorensen's visit but again

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<sup>6</sup> The fax from Mary Grosso was dated May 10, 2006 (Claim File at 337), but MetLife told Sorensen on May 17 that it had not yet received a fax. The fax in the Claim File was received on May 17 and reviewed on May 22. See id. at 13-14, 337.

<sup>7</sup> Merriam-Webster's Medical Dictionary defines dysthymia as "a mood disorder characterized by chronic mildly depressed or irritable mood often accompanied by other symptoms (as eating and sleeping disturbances, fatigue, and poor self-esteem)." Available at: <http://medical.merriam-webster.com/medical/dythymia>.

offered only a brief reply, noting simply that she could not return to work due to “anxiety, depression,” that she was undergoing psychological counseling, that she was taking Celexa, hydroxyzine, and Ambien, and that she could resume working in approximately one month. Id. at 307.

On July 20, 2006, MetLife sent Sorensen a letter notifying her of its decision to terminate her claim as of July 6 due to lack of detailed medical information, including but not limited to a mental status examination, a global assessment of functioning, a psychiatric evaluation, a current cognitive functioning evaluation, a report on the degree of depression (using, for example, a Beck’s Depression Inventory), a copy of her treatment plan, and progress notes from a therapist or psychiatrist. Id. at 22. The letter also advised her of her right to appeal. Id. at 21-22.

**B. Sorensen’s Initial Appeal**

On July 24, 2006, Sorensen called MetLife and explained that she had “all that information,” referring to the documentation listed in the insurer’s July 20 letter, and that “if she knew she could of [sic] had it sent in.” Sorensen then requested to speak with the claims representative. Id. at 22-23. According to MetLife, Sorensen told the claims representative that she was seeing a therapist; that she was “dealing with an ex-husband and a sick child”; that she was “being harassed by a manager while at work”; and that she was “unable to return to work and needs to re-think whether this job was a good fit working for this manager.” Id. At 23. She also commented that the “manager wants [her] to change and [she] is not able to change at this point in [her] life.” Id. Her social worker, Ms. Grosso, told the claims representative on July 25, 2006, that Sorensen was “going through a divorce and is moving and having to sell [her] home,” “anxious and depressed,” and “having problems with her children.” Ms. Grosso also stated that

Sorensen “has many problems preventing [her] from [returning to work].” Id. At Ms. Grosso’s request, the claims representative faxed a list of medical documentation necessary for Sorensen to receive an extension of STD benefits. See id. at 23, 305. In response, on August 9, 2006, Ms. Grosso faxed MetLife various notes, an assessment of functioning, and a treatment plan indicating that Sorensen had experienced little change in her condition. See id. at 285-304.

On August 14, MetLife notified Sorensen that it had received the additional information but that she had to request an appeal for this information to be reviewed. Id. at 284. She immediately requested review, which MetLife accepted as a timely appeal. Id. at 282-83.

**C. First Independent Physician Consultant Review, August 31, 2006**

On August 23, MetLife forwarded its claims materials to an independent physician reviewer, board-certified psychiatrist Dr. Mark Schroeder, with the following instructions:

PROVIDER, ON ALL CLAIMS PLEASE INCLUDE IN YOUR IMPRESSION, THE FOLLOWING:

Metlife’s focus is on defining our claimant’s level of functionality and abilities. Please define the claimant’s current level of functionality based on your review of all material provided, medical documentation and/or physical examination according to DOT physical demands.

Additional questions to be addressed by the provider:

A. Does the medical information support psychiatric limitations beyond July 6, 2006?

B. If the answer to A is yes, please explain specifically how the medical information supports psychiatric impairment, and what specific limitations does the claimant have?

C. If the answer to A is no, please explain specifically why the medical information does not support psychiatric cognitive impairments?

Id. at 280-81.

On August 31, 2006, Dr. Schroeder reported that the record was insufficient to establish psychiatric impairment and associated limitations beyond July 6, 2006. He stated that the record noted “milder symptoms of tearfulness, anxiety and irritability, but did not document more severe psychiatric symptoms, such as suicidal or homicidal thoughts with intent or plan, psychotic or manic symptoms, panic attacks with agoraphobia, morbid guilt, profound lethargy, which may be more reliably associated with impairment.” Id. at 272-78. Dr. Schroeder added that, based on the July 24, 2006, conversation between Sorensen and the claims representative, the continued absence “may be due, at least in part, to avoidance of a job perceived as stressful or a poor fit.” Id. at 278

**D. Further Review, October 9 & 31, 2006, and Denial of Appeal**

Subsequent to this initial report, Sorensen’s psychotherapist, Dr. Timothy Goguen, submitted records documenting her weekly visits from July 24 through September 19, 2006. Id. at 261-67. Dr. Schroeder reported on October 9, 2006, that these records were also insufficient to establish disability beyond July 6. Id. at 226. MetLife forwarded Dr. Schroeder’s reports to Dr. Ronal Russo (Sorensen’s psychiatrist) and Dr. Goguen on October 18, but neither physician responded. Id. at 202. Dr. McManus then submitted additional records, which Dr. Schroeder reported on October 31, 2006, were also insufficient to establish psychiatric limitations beyond July 6, 2006. Id. at 186. MetLife ultimately denied Sorensen’s appeal on November 28, 2006. Compl. ¶ 12; Claim File at 170.

**E. Reopened Appeal and Final Consultant Review, March 29, 2007**

On January 2, 2007, Sorensen’s attorney requested that her appeal be reopened and that she be permitted to offer additional evidence. Claim File at 169. MetLife agreed and Sorensen

submitted records from Ms. Grosso from February 2006 through August 2, 2006, along with a copy of her Home Depot job description. Id. at 114-67. On March 29, 2007, Dr. Schroeder again concluded that the evidence did not demonstrate psychiatric impairment beyond July 6, 2006, by means of “specific, detailed, consistent and objective mental health information.” Id. at 105-08. Metlife communicated this information to Sorensen’s counsel on April 3, 2007, ending her reopened appeal. Id. at 101-02.

**F. Appeal for Judicial Review**

Sorensen now seeks judicial review under 29 U.S.C. § 1132(a)(1)(B), which permits a participant in an insurance plan governed by ERISA to recover benefits due under the terms of the plan. She contends that the decision to terminate her STD benefits was arbitrary and capricious, not supported by substantial evidence, motivated by a conflict of interest, contrary to the substantial medical and vocation evidence of the record, a breach of the defendant’s contractual obligations, and otherwise unreasonable. Compl. ¶ 15. She seeks payment under the STD policy for the fourteen weeks beginning July 6, 2008 (\$6,461.42) and payment under the LTD policy for fourteen weeks following the exhaustion of the STD benefits through January 7, 2007 (\$5,740).

The plaintiff and defendant have filed cross-motions for judgment on the administrative record (documents ## 13, 17). Sorensen’s motion for judgment, however, does not advance a claim for LTD benefits. She asks that judgment be entered as to liability for STD benefits from July 6, 2006, to October 19, 2006, and that, since the record does not disclose when or whether Sorensen returned to work at a less demanding job, a hearing be held later to determine the amount of benefits due.<sup>8</sup> Pl.’s Mem. at 16.

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<sup>8</sup> According to her complaint, Sorensen obtained subsequent employment on January 8, 2007. Compl. ¶ 14.

### **III. DISCUSSION**

#### **A. Standard of Review**

Where a plan participant challenges an administrator's decision to deny benefits under 29 U.S.C. § 1132(a), a court reviews that decision de novo "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). If the plan gives discretion to the administrator or fiduciary, the court applies an arbitrary and capricious standard of review. See id.; Brigham v. Sun Life of Can., 317 F.3d 72, 81 (1st Cir. 2003). In July 2008, the Supreme Court re-examined the standard of review in an ERISA denial of disability benefits case and held that where the administrator/fiduciary has a potential conflict of interest in exercising its discretion -- i.e., the payer of a potential claim also has the discretion to approve or deny the claim -- the review does not change to de novo, but the court should weigh the conflict of interest as a factor in determining whether there has been an abuse of discretion. Metro. Life Ins. Co. et al. v. Glenn, 128 S. Ct. 2343, 2350 (2008).<sup>9</sup>

#### **B. MetLife Is a Fiduciary**

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<sup>9</sup> The Court explained that the weight of this factor is highly dependent on the individual facts of a given case. For instance, the conflict of interest "should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration," and it would "prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy." Glenn, 128 S. Ct. at 2351. The Court affirmed the Sixth Circuit's ruling in favor of Glenn because the court of appeals gave weight to the conflict alongside other evidence that MetLife took inconsistent positions when financially advantageous, emphasized some medical reports over others, and failed to provide the independent vocational and medical experts with all relevant evidence. Id. at 2352.

Sorensen concedes that the MetLife STD Plan (the “Plan”) grants discretionary authority to the Plan administrator and other fiduciaries.<sup>10</sup> See Pl.’s Statement of Facts at 2 (document # 15). However, she points out that the Plan identifies Home Depot, Inc. as the administrator and does not designate MetLife, either expressly or by implication, as a fiduciary. Pl.’s Mem. at 4. On this reading, MetLife is merely the insurer. Sorensen recognizes that the Home Depot employee handbook contains language to the contrary -- stating that “the Plan Administrator (or, for the fully insured benefits, the insurance carrier) has the full power and authority in its absolute discretion to determine all questions of eligibility for and entitlement to benefits, and to interpret and construe the terms of the plan,” Claim File at 701 -- but she argues that it cannot confer the requisite authority on MetLife. Pl.’s Mem. at 4. She contends that under the reasoning of Firestone, whether “the exercise of a power is permissive or mandatory depends on the terms of the trust.” Here, the trust is arguably the certified benefit plan; as the handbook is not part of the plan, it cannot granting any additional authority to MetLife. Id.

Defendant MetLife offers three responses. First, it argues that it is a fiduciary because it serves the functions of a fiduciary as defined in ERISA, 29 U.S.C. § 1002(21)(A) (defining a plan fiduciary to include a person who has authority and control over the management of the plan, the disposition of plan assets, and the administration of the plan). Second, it argues that it is a fiduciary under 29 U.S.C. § 1102(a)(2), which provides that a “named fiduciary” may be named in the plan instrument or may be identified as a fiduciary by the employer pursuant to a procedure

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<sup>10</sup> The relevant language states: “In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.” Claim File at 92 (document # 12).

specified in the plan. MetLife claims it is identified as a plan fiduciary by the claims procedures set forth in the Plan. Def.'s Resp. to Pl.'s Facts at 3 (document # 18) (citing Claim File at 81, 91). Third, Defendant argues that the Home Depot employee handbook contains the Summary Plan Description, Claim File at 701, which is part of the Plan and which expressly identifies MetLife as a plan fiduciary. Def.'s Resp. at 4 (document # 18). MetLife argues that because it is a fiduciary, it has been granted discretionary authority in both the certified plan documents, Claim File at 92, and in the Employee Handbook/Summary Plan Description, id. at 701.

Since the defendant's first argument clearly establishes that MetLife is a fiduciary with discretionary authority, it is unnecessary to address the others.<sup>11</sup> As I explained in Bendaoud v. Hodgson, 578 F. Supp. 2d 257 (D. Mass. 2008), "[w]hether a party is an ERISA fiduciary is a functional, fact-bound question." Id. at 275 (citing 29 U.S.C. § 1002(21)(A)); accord. Briscoe v. Fine, 444 F.3d 478, 486 (6th Cir. 2006) ("Whether a person or entity qualifies as a fiduciary is . . . a mixed question of law and fact. . . ."). Moreover, "[p]arties who are not named fiduciaries may nevertheless be liable if they have sufficient responsibility to meet the statutory definition of a fiduciary." Bendaoud, 578 F. Supp. 2d at 275. A person or entity is a fiduciary with respect to a plan to the extent (1) it exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (2) it renders investment advice for a fee or other compensation, direct or

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<sup>11</sup> The defendant's contention that it is a named fiduciary would also likely resolve this issue. It appears that the Home Depot Employee Handbook contains the categories of information required by § 102(b) of ERISA (29 U.S.C.A. § 10229(b)) and its corresponding Department of Labor regulation (29 CFR § 2520.102-3), and thus it constitutes a summary plan description ("SPD"). Courts have traditionally given substantial deference to terms set forth in the SPD, finding for instance that the terms of an SPD control over conflicting terms in the master benefit plan. See Gentile v. John Hancock, 951 F. Supp. 281 (D. Mass. 1997). Even if MetLife were not clearly a fiduciary under the functional analysis above, the terms of the SPD should therefore be given substantial deference, including language which states that "[t]he insurer . . . is the Named Fiduciary for decisions on claims and appeals." Claim File at 704 (document # 12).

indirect, with respect to any monies or other property of such plan, or has any authority or responsibility to do so, or (3) it has any discretionary authority or discretionary responsibility in the administration of such plan. See 29 U.S.C. § 1002(21)(A).

Regardless of the contested terms of the Plan that grant discretionary authority to “fiduciaries” without listing MetLife among them, Claim File at 92, the claims procedure sections of the Plan clearly grant discretionary control directly to MetLife to make claim determinations. After defining “we,” “us,” and “our” to mean MetLife, id. at 68, the Claims Procedure section requires that

[w]ritten notice of a claim must be given to us. . . . When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. . . . Proof must be satisfactory to us . . . . If the written proof of a claim a) has been made on time; and b) is satisfactory to us; we will pay the accrued benefits.

Id. at 81-82. Additionally, the “Claims Information” section of the Plan states that “the claimant must report the [disability] claim to MetLife. . . . MetLife will review your claim and notify you of its decision to approve or deny your claim.” Id. at 91. Finally, the Plan states that if a claimant chooses to appeal a denial by MetLife,

MetLife will conduct a full and fair review of your claim . . . . The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim. . . . MetLife will notify you in writing of its final decision . . . . If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied.

Id. at 92. This broad discretionary control over the determination of disability claims, and thus the disposition of the assets of the plan, renders MetLife a fiduciary under the functional analysis called for by 29 U.S.C. § 1002(21)(A).

Since MetLife is a fiduciary to whom “the benefit plan gives . . . discretionary authority to determine eligibility for benefits or to construe the terms of the plan,” Firestone Tire, 489 U.S. at 115, Sorensen is not entitled to de novo review of MetLife’s denial of her disability claim. Instead, I apply “arbitrary and capricious” review, considering as one factor the conflict of interest in MetLife’s dual role as claims adjudicator and payer. See Glenn, 128 S. Ct. at 2350.

### **C. Review of Disability Denial**

To withstand arbitrary and capricious review, a denial of disability benefits must have been based on substantial evidence, meaning evidence that is “reasonably sufficient” to support the claims administrator’s decision. Gannon v. Metro. Life Ins. Co., 360 F.3d 211, 213 (1st Cir. 2004). This is a deferential standard of review; the court may not substitute its own judgment for that of the administrator. See Terry v. Bayer Corp., 145 F.3d 28, 40 (1st Cir. 1998).

In the instant case, MetLife afforded Sorensen ample opportunity to establish her disability, evaluated all the evidence provided by her and her treating professionals, and ultimately denied her benefits application. It based its decision on two main grounds: First, its view that Sorensen lacked specific objective evidence that she could not do her job, and second, Dr. Schroeder’s repeated judgment to the same effect. In its initial letter terminating Sorensen’s benefits, MetLife explained that it was “unable to make a claim determination beyond July 6, 2006,” because she and her doctors had not submitted critical medical information, including objective exam results, a specific psychiatric evaluation, and her physicians’ assessment of the degree of her depression. Claim File at 96. Sorensen appealed and submitted further documentation, but MetLife again denied her claim based on Dr. Schroeder’s opinion that the evidence did not support a medical condition severe enough to warrant benefits. Four times he

considered supplemental filings, concluding that these “generally noted more general and less-severe symptoms of anxiety, depression and emotional distress, and did not demonstrate the presence of psychiatric impairment that would have precluded the employee from working by means of specific, detailed, consistent, and objective mental health information beyond 7/6/06.” Id. at 108.

Sorensen raises the following three arguments for why MetLife lacked a sufficient basis for its decision to deny her benefits: (1) all medical personnel who treated her agreed that she was disabled, and it was arbitrary for MetLife to rely on a reviewing physician’s judgment to the contrary; (2) Dr. Schroeder failed to analyze her ability to do her specific job, as required under the plan; and (3) Dr. Schroeder applied an overly exacting standard for psychiatric impairment. I find that none of these points undermines the reasonableness of MetLife’s ultimate conclusion.

Sorensen’s first argument emphasizes that “[a]ll of [her] treating doctors and mental health counselors agree . . . that she was disabled for a return to work to her regular job.” Pl.’s Mem. at 7 (document # 14). To begin, while her clinicians agreed on her diagnosis, only two of them found that she could not go to work. Ms. Grosso, her social worker, diagnosed her with dysthymic disorder and anxiety disorder, and believed that Sorensen could not return to work till mid to late summer 2006. Dr. McManus also found depression and anxiety disorder; on July 6, 2006, he wrote a note explaining to her employers that she needed to be out until September 15, 2006, “due to stress-related issues.” Claim File at 307, 310. Dr. Russo, her psychiatrist, diagnosed her with probable dysthymic disorder, an adjustment disorder, depression, and anxiety, id. at 320, but nowhere do his notes reflect a belief that she could not do her job. Dr. Goguen,

her psychotherapist, diagnosed her with depression, id. at 266; while he acknowledged Dr. McManus's note, he himself never concluded she could not work.

Moreover, Dr. Schroeder explained in detail why he did not consider these diagnoses sufficient to sustain a claim for disability. He acknowledged that Ms. Grosso identified "many problems preventing [Sorensen] from returning to work," but noted that she did not specify the nature of those problems. Id. at 274. Ms. Grosso recorded the presence of symptoms, but she neither specified their "nature, intensity, frequency, or duration," nor explained how they affected Sorensen's daily activities. Id. at 107. Moreover, Ms. Grosso's findings were based primarily on Sorensen's self-reports, not objective evidence such as an exam or diagnostic assessment. Id. Likewise, he found that Dr. McManus recorded Sorensen's vague report of stress-related symptoms but failed to "document how severe the symptoms were, how often they occurred, how long they lasted, what triggered them, what means the employee used to control them and how successful she was in this, and how they affected the employee's ability to function." Id. at 276. Dr. Goguen, meanwhile, did not specify any impairment to Sorensen's daily activities and in fact noted conduct -- trying to buy a house -- that Dr. Schroeder considered inconsistent with an incapacitating mental disorder. Id. at 227. And while Dr. Russo noted symptoms of tearfulness and depression, he also noted characteristics suggesting lack of disability, including the fact that she was well groomed, had a full range of affect, and had intact cognitive function and judgment. Id. at 275. In sum, Dr. Schroeder concluded that "[t]he providers did not give a specific reason why the employee could not work as a department supervisor beyond 7/6/06." Id. at 277.

Schroeder also relied on his review of MetLife's direct interviews of Sorensen. He noted that on May 10, 2006, she reported that she routinely accomplished life's daily tasks, including

preparing meals, doing laundry, leaving the home, shopping for groceries, seeing family and friends, maintaining good hygiene, and caring for her children. Id. at 275. On July 24, 2006, Sorensen said she was being harassed by a manager at work and needed “to rethink if this job is a good fit working for this manager.” Id. at 276. On this basis, Dr. Schroeder suggested that “the employee’s continued absence of work may be due, at least in part, to avoidance of a job perceived as stressful or a poor fit.” Id. at 278.

While I might not have evaluated Sorensen’s medical record in the same way, I cannot say that Dr. Schroeder’s analysis is unreasonable. His emphasis on the generality of the providers’ diagnoses is well founded, especially in light of MetLife’s attempts to obtain further details from them. On July 10, 2006, the insurer explained to Dr. McManus that it required “detailed medical documentation to support [Sorensen’s] inability to return to work.” Id. at 307. On a form asking for “specific restrictions and limitations” preventing her return, he then listed unhelpfully, “anxiety, depression.” Id. Similarly, MetLife forwarded Dr. Schroeder’s first two reports to Drs. Russo and Goguen on October 18, 2006, for review and comment, but received no response from either. Defs.’ Mem. at 13-14 (document # 17).

The law permits a plan administrator to rely on the opinions of a non-examining, reviewing doctor like Dr. Schroeder, see Tsoulas v. Liberty Life Assurance Co. 454 F.3d 69, 81-82 (1st Cir. 2006), and does not require that the opinions of treating physicians be given special weight, see Leahy v. Raytheon Co., 315 F.3d 11, 20 (1st Cir. 2002). To the extent that the reviewing and treating physicians offer conflicting opinions, the plan administrator has the discretionary right to choose between them, so long as its decision is reasonable. See Vlass v. Raytheon Employees Disability Trust, 244 F.3d 27, 32 (1st Cir. 2001). In light of the above

discussed facts, MetLife's reliance on Dr. Schroeder's reports over those of Sorensen's clinicians was valid.

Sorensen's second argument is that Dr. Schroeder's analysis was unreasonable because it failed to take into account the specific interpersonal, motivational, and organizational requirements of the plaintiff's actual job. In effect, the claim is that he failed to apply the proper legal standard: Under the terms of the plan, Sorensen is disabled if she is unable to perform her own job; she need not show that she is incapable of doing any work at all. In his reports, Dr. Schroeder summarized Sorensen's duties as "managing all aspects of the store's operation and profitability." Claim File at 273. This is accurate, but Sorensen claims that he should have used the more detailed job description Home Depot issued to her, which lists among her responsibilities "delighting our customers each and every day" and "making the shopping experience exciting and fun." Pl.'s Reply Mem. at 6-7 & n.4 (document # 21). Had he measured her tearfulness, anxiety, and irritability against those duties, she insists, he would have had to find her disabled. Id.

I disagree. For one thing, these responsibilities appear in a three-page document that lists dozens of qualities, many of them as general customer service goals and company priorities rather than necessary characteristics of the store manager. For another, Dr. Schroeder received this job description and presumably reviewed it.<sup>12</sup> More importantly, his report demonstrates on its face that he understood the proper standard. It states, "Disability Definition is own job." Claim File at 273. He did not compare her symptoms to her specific job requirements; but then, the crux of his reports was not that Sorensen unequivocally was not disabled, but rather that the medical

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<sup>12</sup> Plaintiff questions whether the job description was ever conveyed to Dr. Schroeder. Pl.'s Mem. at 12. Defendant notes, however, that all files including the job descriptions were submitted to Dr. Schroeder electronically. Def.'s Mem. at 17. The record does appear to indicate that the files were sent electronically. Claim File at 109 (noting "scan only - med/voc").

evidence was insufficient to establish her disability. Given that the burden rests on the claimant to prove entitlement to benefits, see, e.g., Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan, 402 F.3d 67, 77 (1st Cir. 2005), the failure to specifically reference her job duties in his analysis was not unreasonable.

Sorensen's final argument is that Dr. Schroeder applied an unduly strict standard in finding that she had not established her disability. He remarked that Sorensen's medical records "did not document more severe psychiatric symptoms, such as suicidal or homicidal thoughts with intent or plan, psychotic or manic symptoms, panic attacks with agoraphobia, morbid guilt, profound lethargy." Claim File at 277. Sorensen points to this language as further evidence that Dr. Schroeder applied an "any job" as opposed to "own job" standard. As explained, that notion is contradicted by his clear articulation of the correct standard elsewhere in the reports. In addition, these are not the only examples Dr. Schroeder cited as concrete indications of disability. He also suggested "disorganized thought, impaired perception of reality, measured cognitive deficits, markedly slowed or agitated behavior, disturbed speech or communication or poor hygiene" as "more reliably associated with impairment" than Sorensen's vaguely described symptoms.<sup>13</sup> Id. at 277. The reviewing physician's demonstrable intent was to highlight the inadequacy of Sorensen's diagnoses. To be sure, some of the conditions he cited are extremely severe, but it is not the role of the courts to determine how thoroughly one's mental health need deteriorate to amount to disability. The inquiry, rather, is whether a plan administrator has sufficient grounds for its decision to deny benefits. In the instant case, the generality of the treating physicians'

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<sup>13</sup> Sorensen notes that Dr. Schroeder mischaracterized the record, as Ms. Grosso expressly found that Sorensen displayed extreme impairment as to her general physical health and moderate impairment as to her personal hygiene, bathing, and ability to concentrate. Pl.'s Mem. at 11 (document # 14) (citing Claim File at 241). However, MetLife explains that this record of impairment was not a clinical determination by Ms. Grosso, but a self-report by Sorensen. Def.'s Mem. at 14 n.8 (document # 17).

notes and the detail of Dr. Schroeder's reports compel me to answer that question in the affirmative.

**IV. CONCLUSION**

As explained above, because MetLife had discretion in administering the plan, deferential review is appropriate. On the record before me, MetLife's decision to deny continuing benefits to Sorensen was not arbitrary and capricious. The case is sufficiently clear that MetLife's potential conflict of interest does not change the analysis, and indeed no evidence has been put forth as to the extent of that conflict. Plaintiff's Motion for Judgment on the Pleadings (**document # 13**) is **DENIED**, and Defendant's Cross-Motion for Judgment on the Record (**document # 17**) is **GRANTED**.

Judgment for Defendant.

**SO ORDERED.**

**Date: March 31, 2009**

*/s/ Nancy Gertner*  
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**NANCY GERTNER, U.S.D.C.**