

## **A Medico-Legal Approach to Subjective Pain Testimony in Disability Adjudication**

Applying for Social Security Disability benefits is a tedious and frustrating process, evidenced by the high rates of successful appeals. While 38% of applicants who meet the technical requirements for the Social Security Administration's (SSA) programs are initially approved for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI), an additional 53% of those who appeal their denial are ultimately granted benefits.<sup>1</sup> The hearing with an administrative law judge (ALJ) is a pivotal point in the appeal process, and for most applicants, it is the last realistic opportunity of approval. Beyond this stage, the chances of success diminish drastically, with only about 1% of cases approved at the Appeals Council level.<sup>2</sup> Given that ALJ hearings typically occur two years after the initial application,<sup>3</sup> this stage is critical in determining the final outcome of disability claims.

A deeper examination into the ALJ decision-making process reveals discrepancies in how subjective evidence like pain testimony is considered. While objective medical evidence like laboratory results and imaging studies is straightforward and less contentious, evaluating subjective reports of pain and symptoms presents significant challenges. Despite some improvements in how the SSA directs ALJs to handle such testimony, subjective evidence continues to be undervalued or discredited. The fact that 35% of those denied by ALJs proceed to appeal, with 12% of these cases remanded back for reconsideration,<sup>1</sup> highlights the need for a medico-legal collaborative approach to better manage and assess subjective pain testimony in disability adjudication.

### **BACKGROUND**

#### *The Rise of Subjective Pain Data Collection*

In the 1990s, there was growing awareness of the under-treatment of chronic pain, both for malignant and nonmalignant conditions. Labeled as a "serious public health problem," this prompted advocacy and policy initiatives aimed at improving pain assessment, reporting, and management.<sup>4</sup> The American Pain Society (APS) introduced the concept of pain as the "fifth vital sign"<sup>5</sup> in 1995, urging clinicians to treat pain with the same importance as other vital signs. This momentum continued in 2001 when Congress passed HR 3244, declaring it as the "Decade of Pain Control and Research."<sup>6</sup> The Joint Commission reinforced this movement by mandating routine pain assessment and documentation in clinical settings,<sup>7</sup> leading to the widespread use of standardized pain scales. The scales most commonly leveraged were unidimensional methods like the Visual Analog Scale (marking pain on a scale of "no pain" to "worst imaginable pain") and the Numeric Rating Scale (scale of 0-10).<sup>8</sup>

While these efforts attempted to enhance patient care, they also highlighted the inherent subjectivity of pain assessment. The complex, multidimensional nature of pain involves sensory, emotional, cognitive and social components.<sup>9</sup> Compared to other vital signs, pain measurement cannot be directly quantified and subsequently validated. Despite this, the shift towards the aggressive assessment and treatment of pain played a role in the overprescription of opioids; patient satisfaction metrics being tied to pain relief, as well as external factors like pushes by pharmaceutical companies, placed pressure on clinicians to more strongly resolve the pain through stronger pain medications.<sup>10</sup>

In response to the opioid crisis, American Medical Association (AMA) recommended rolling back on pain being used as a "fifth vital sign" in the clinical setting.<sup>11</sup> While this led to reduced emphasis on mandatory pain score collection from healthcare organizations, it did not

affect the use of the subjective numeric pain scales for pain assessment as they are still extensively used today. Methods like incorporating more qualitative assessments have been implemented, but still don't take away from the subjective nature of these data in addition to general pain testimony. While the ambiguity behind these pain assessment methodologies pose their own medical hardships for providers, it also promotes the improper handling of this data in the legal setting, particularly in determining disability eligibility.

### *Handling of Pain Testimony in Disability Adjudication*

The subjective nature of pain makes it a frequent point of contention in disability appeals. Since pain cannot be directly measured, ALJs need to properly balance and combine claimant testimony with objective medical evidence. Briefly, the five-step process for determining disability eligibility include if the individual 1) is currently employed/engaging in substantial activity; 2) has a severe impairment; 3) has an impairment that meets/medically equals the ones specified in regulations; 4) can conduct past relevant work; and 5) has the ability to perform any work in the national economy.<sup>12</sup> Subjective pain testimony is crucial in proving claims at several of these steps, yet it is frequently dismissed or discounted by ALJs, denying many claimants the benefits they seek.

The 1991 ruling by the 11th Circuit Court of Appeals set the precedent that a claimant's subjective pain testimony cannot be dismissed solely due to a lack of objective medical evidence and requires a thorough evaluation of its credibility before being dismissed.<sup>13</sup> Additionally, ALJ's must consider subjective evidence of pain when determining an individual's disabled status under 42 USCS § 1382c(a)(3)(c).<sup>14</sup> But while the court cannot discredit pain complaints due to a lack of objective medical evidence, the court is not required to give every statement of pain full credit and validation.<sup>14</sup> However, it has been established multiple times that it is "improper as a matter of law for an ALJ to discredit excess pain testimony solely on the ground that it is not fully corroborated by objective medical findings."<sup>15</sup> And when done so, the ALJ has to provide "specific, clear, and convincing reasons" for discrediting a claimant's symptom testimony if there is no evidence of malingering.<sup>16</sup>

Despite this, most of the appeals against the ALJ rulings have been concerning the improper, vague, or invalid discounting of claimant's pain testimony. In the recent case of *Ferguson v. O'Malley* before the 9th Circuit Court of Appeals, the panel found that the ALJ had erred in dismissing the claimant's headache testimony based solely on perceived inconsistencies with their daily activities. Furthermore, the Commissioner's insistence on objective medical evidence to establish headache severity was rejected by the court, underscoring the challenges of relying solely on objective measures for inherently subjective conditions.<sup>17</sup> This is one of many cases where the claimant successfully challenged the ALJ's decision for failing to provide clear and convincing reasons for rejecting the subjective pain testimony.<sup>16,18,19,20</sup> Beyond merely discrediting this testimony, the subjectivity of pain and lack of standardization has been misused in cases like where a ALJ leveraged a pain scale that was "clearly designed to elicit reported pain scores significantly lower than those that claimants would normally give when asked to rate their pain by their physician."<sup>21</sup>

This is not to say that ALJs always lack specific reasons for discrediting pain testimony. Appeals against ALJ denials of disability benefits have frequently demonstrated that ALJs can appropriately discount a claimant's subjective testimony after a thorough evaluation of medical records, test results, activity levels, appointment attendance, treatments,<sup>22</sup> pain reports,<sup>23</sup> etc.. However, conducting this holistic analysis of medical evidence to properly justify discrediting

subjective claims is challenging, especially for individuals without a medical background. Methods to streamline this process for ALJ's include incorporating more objective pain measurement methodologies, such as functional magnetic resonance imaging (fMRI),<sup>24</sup> though this remains a developing area of research and is not yet reliable or accurate enough for widespread use. Other approaches include updates to the Social Security Ruling: the SSR 16-3p supersedes the SSR 96-7p in clarifying subjective testimony as credible and focusing more on considering "whether an individual's statements about the intensity, persistence, and limiting effects of his or her symptoms are consistent with..." a claimant's daily activities, treatment efficacy, and laboratory findings.<sup>25</sup> This focus on consistency is also seen in attorneys' recommendations for plaintiff's to maintain detailed pain journals or calendars.<sup>26</sup>

However, shifting the emphasis to consistency does not resolve the fundamental issue of properly handling the subjectivity in pain claims and reported pain scores. Inconsistencies at any stage of testimony—including reported symptoms, following up on treatment, or internal contradictions—can significantly impact the ALJ's perception of the claimant's credibility and often lead to discredited testimony.<sup>27</sup> For instance, even when a claimant used a pain calendar documenting over 30 numeric pain scores across 1.5 years, the ALJ deemed the plaintiff's claims inconsistent and discounted their testimony.<sup>28</sup> The variability of pain scores, influenced by minor environmental changes<sup>29</sup> and the inherent difficulties in expressing and recalling traumatic pain experiences,<sup>8</sup> makes consistency an insufficient metric for evaluating subjective testimony. These challenges disproportionately affect marginalized communities, who may lack access to healthcare providers conducting consistent pain assessments,<sup>23</sup> refuse treatment due to personal, financial, or mental burdens,<sup>15</sup> or simply lack the resources to establish a consistent record. As a result, the recent updates to how subjective pain testimony is considered in disability evaluations have not fully addressed the ambiguity in how this evidence is utilized by ALJs. Therefore, a combination of medical and legal interventions is necessary to improve the process of validating subjective pain evidence and to support ALJs in making fair and informed decisions.

## **MEDICO-LEGAL POLICY RECOMMENDATION & IMPLEMENTATION**

### *Coalition-Driven Strategies for Improved Understanding of Pain Assessment Inconsistencies*

The first component of the proposed policy is a push for improved pain management and documentation in clinical settings, particularly when inconsistencies arise between reported pain and objective medical evidence. Providers should develop a more comprehensive pain assessment history for patients by incorporating both self-reported and objective evaluations. This can include psychosomatic assessments or consultations with clinical psychologists and psychiatrists, or the use of standardized tools the Symptom Checklist-90-R (SCL-90-R) for more equitable assessment options tailored to the resources available in the care setting. Generally, having providers establish baseline pain scores and track trends overtime allows for more coherent narratives of a patient's pain experience and stronger pain testimony to be considered by the ALJ. By supporting potential claimant's in building a long-term record within the clinical setting, this approach can help patients establish greater consistency in their cases, reducing the amount of subjectivity in their pain testimony. Collecting and reporting this more nuanced understanding of the patient's condition over time provides valuable, accurate insights that can be effectively used in disability hearings.

As seen during the initial shift toward enhanced pain management, major healthcare organizations like APS and the Joint Commission wield significant influence in leading change. Ideally also with the backing of the AMA and SSA, this implementation strategy involves

developing a coalition of advocacy groups, medical associations, and legal stakeholders that support more comprehensive and consistent pain assessment protocols, particularly for individuals with inconsistencies in their medical presentation and reported pain presentation. One plausible way this coalition can make an impact is through the standardized, nationwide Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.<sup>30</sup> Developed by the Center for Medicare & Medicaid Services (CMS), HCAHPS is mandatory for hospitals receiving Medicare funding in order to meet the requirements of the Hospital Inpatient Quality Reporting (IQR) Program.<sup>31</sup> With the revision of pain-related questions on the HCAHPS survey away from assessing pain relief and more toward quality of communication about pain,<sup>32</sup> it is possible that with enough leverage, this coalition may be able to negotiate with CMS for additional pain consideration metrics on the survey. These metrics would focus more on the thoroughness and satisfaction of pain assessments, potentially surrounding discussions of trends in pain overtime as well as psychological considerations following pain evaluations. This approach is not only a cost-effective way to encourage healthcare institutions to adopt more holistic pain assessment protocols—particularly to secure their Medicare funding—but it would also result in more comprehensive, consistent medical records that better align with patients' subjective pain testimony, ensuring fairer consideration by ALJs.

#### *Pilot Program for Integrating Mandated Pain Specialists in ALJ Adjudication*

The second policy component is the integration of licensed pain/symptom specialists into the disability determination process. With expertise in pain management, psychosomatic medicine, and symptom evaluation, these agents would serve alongside the ALJ as more objective evaluators of the claimants' subjective pain reports. Their involvement would be mandated in cases where chronic pain is the primary claim without clear objective evidence. While ALJ's sometimes leverage agents like general psychological experts to determine if an impairment could reasonably produce specific symptoms, these specialists would be experts in the holistic and comprehensive analysis of the subjective pain data. While consistency is still a consideration, the specialists will have more specialized training in differentiating the subjective parts of the testimony from general malingering.

Given the resource-intensive nature of this strategy, the initial implementation of this policy component would begin as a pilot program in states with high rates of disability appeals, particularly those with a significant number of successful ALJ appeals or repeated instances of ALJs improperly discrediting subjective pain testimony. The SSA would collaborate with the American Board of Pain Medicine and the American Psychological Association (APA) to develop a comprehensive certification program for state-level pain/symptom specialists. The training curriculum would cover areas like the best practices for evaluating subjective pain, legal considerations of disability claims, use of multimodal tools for comprehensive pain assessments, and how to properly provide evidence-based testimony to the ALJs. The panels would operate under the SSA, offering standardized assessments of the subjective pain testimony that ALJs would be required to consider and detail in their rulings. If the pilot program is successful in lowering appeal rates and improving the consistency of disability determinations, the policy should be formalized within the Social Security Administration's Hearings, Appeals, and Litigation Law Manual (HALLEX).<sup>33</sup> A new rule would mandate the consultation of these certified pain/symptom specialists in hearings involving extensive and inconsistent subjective testimony, providing a consistent national framework for ALJs. This initiative would streamline the adjudication process, ensure fairer consideration of subjective pain claims, and bridge the gap

between clinical evaluation and legal judgment, ultimately reducing the number of appeals and fostering more accurate disability determinations.

## **CONCLUSION**

No matter how advanced technological and multimodal assessment methods become, pain will always remain an inherently subjective experience. While this can be frustrating, the complexity that underlies that seemingly simple 0-10 pain scale is something to appreciate. It is extremely important to understand that the true challenge is not to eliminate the subjectivity of pain, but to develop better frameworks for the consideration and validation of subjective pain testimony.

The process of obtaining approval for SSDI and/or SSI benefits is already extensive and restrictive, underscoring the need for methods that streamline the fair evaluation of subjective pain testimony. The proposed policy recommendations include methods addressing this at both the clinical and legal levels, aiming to provide more thorough and equitable consideration of pain reports. While this policy focuses on improving the disability eligibility process, it is also important to acknowledge the broader implications of subjective pain data. Subjective pain data can also be ambiguously interpreted in situations such as pharmaceutical companies exploiting flexible pain scales to present more favorable drug efficacy results,<sup>34</sup> the use of pain testimony to assess the current and future impact of personal injuries, and identifying unmet gaps in care within medical malpractice claims.

Ultimately, subjective pain testimony is a critical component of the disability eligibility process that must be handled properly. To achieve this, comprehensive medical and legal frameworks are needed to ensure that these data are given fair consideration without marginalizing already vulnerable communities. These policy recommendations help facilitate a compassionate system that recognizes the complexities of pain and the needs of those who suffer from it.

## REFERENCES

1. What is the approval rate for Social Security Disability Benefits? (2023, January 12). USAFacts. <https://usafacts.org/data-projects/disability-benefit-process>
2. Zayat, T. (n.d.). SOCIAL SECURITY DISABILITY INSURANCE PROGRAM WORKER EXPERIENCE ACTUARIAL STUDY NO. 123. Retrieved November 13, 2024, from [https://www.ssa.gov/OACT/NOTES/pdf\\_studies/study123.pdf](https://www.ssa.gov/OACT/NOTES/pdf_studies/study123.pdf)
3. Hearing Office Average Processing Time Ranking Report | Public Data Files. (n.d.). Wwww.ssa.gov. [https://www.ssa.gov/appeals/DataSets/05\\_Average\\_Processing\\_Time\\_Report.html](https://www.ssa.gov/appeals/DataSets/05_Average_Processing_Time_Report.html)
4. S. Rept. 106-299 - THE PAIN RELIEF PROMOTION ACT. (2024). Congress.gov. <https://www.congress.gov/congressional-report/106th-congress/senate-report/299/1>
5. Scher, C., Meador, L., Van Cleave, J. H., & Reid, M. C. (2018). Moving Beyond Pain as the Fifth Vital Sign and Patient Satisfaction Scores to Improve Pain Care in the 21st Century. *Pain Management Nursing*, 19(2), 125–129. <https://doi.org/10.1016/j.pmn.2017.10.010>
6. congress.gov. (2019). H.R.3244 - 106th Congress (1999-2000): Victims of Trafficking and Violence Protection Act of 2000. Congress.gov. <https://www.congress.gov/bill/106th-congress/house-bill/3244>
7. Berry, P. H., & Dahl, J. L. (2000). The new JCAHO pain standards: Implications for pain management nurses. *Pain Management Nursing*, 1(1), 3–12. <https://doi.org/10.1053/jpmn.2000.5833>
8. 2 LAWYERS' GUIDE TO MEDICAL PROOF § 212.02 (2024)
9. Williams, A. C. de C., & Craig, K. D. (2016). Updating the definition of pain. *PAIN*, 157(11), 2420–2423. <https://doi.org/10.1097/j.pain.0000000000000613>
10. Morone, N. E., & Weiner, D. K. (2013). Pain as the Fifth Vital Sign: Exposing the Vital Need for Pain Education. *Clinical Therapeutics*, 35(11), 1728–1732. <https://doi.org/10.1016/j.clinthera.2013.10.001>
11. The opioid epidemic and emerging public health policy priorities. (n.d.). American Medical Association. <https://www.ama-assn.org/delivering-care/overdose-epidemic/opioid-epidemic-and-emerging-public-health-policy-priorities>
12. 20 C.F.R. § 404.1520
13. *Holt v. Sullivan*, 921 F.2d 1221 (11th Cir. 1991)
14. 42 U.S.C.S. § 1382c
15. *Havens v. Kijakazi*, No. 21-35022, 2022 U.S. App. LEXIS 16270 (9th Cir. June 13, 2022)
16. *Garrison v. Colvin*, 759 F.3d 995 (9th Cir. 2014)
17. *Ferguson v. O'Malley*, 95 F.4th 1194 (9th Cir. 2024)
18. *Kelly D. v. O'Malley*, No. 8:22-cv-01406-SP, 2024 U.S. Dist. LEXIS 54078 (C.D. Cal. Mar. 26, 2024)
19. *Karasek v. Astrue*, No. CIV A 1:08CV208-CSC, 2009 WL 692191, at \*1 (M.D. Ala. Mar. 13, 2009)
20. *Theresa M. K. v. Comm'r, Soc. Sec. Admin.*, No. 1:18-CV-01221-MK, 2019 WL 2550317, at \*1 (D. Or. June 20, 2019)

21. *Cook v. Comm'r of Soc. Sec.*, No. 1:19-CV-1068, 2020 WL 7253307, at \*1 (S.D. Ohio Dec. 10, 2020), report and recommendation adopted, No. 1:19-CV-1068, 2021 WL 22522 (S.D. Ohio Jan. 4, 2021)
22. *LeBert v. O'Malley*, No. 23-35301, 2024 U.S. App. LEXIS 11859 (9th Cir. May 16, 2024)
23. *Singletary v. Kijakazi*, No. 7:20-CV-00229-M, 2023 WL 2302000, at \*1 (E.D.N.C. Mar. 1, 2023)
24. Nature. (2015, February 25). Neuroscience in Court: The Painful Truth. Center for Law, Brain & Behavior. <https://clbb.mgh.harvard.edu/naturepainfeature/>
25. SSR 16-3p. (2016). Ssa.gov.  
[https://www.ssa.gov/OP\\_Home/rulings/di/01/SSR2016-03-di-01.html#FNR2](https://www.ssa.gov/OP_Home/rulings/di/01/SSR2016-03-di-01.html#FNR2)
26. James Publishing, Inc., *How Insurance Companies Settle Cases*, 27 Edition Chapter 7 Settlement Negotiations & Compromises
27. *Maria G.H. v. O'Malley*, No. 2:23-cv-04698-MAA, 2024 U.S. Dist. LEXIS 114715 (C.D. Cal. June 28, 2024)
28. *Boyd v. Astrue*, No. 3:10-CV-105-J-JRK, 2011 WL 1259795, at \*1 (M.D. Fla. Mar. 31, 2011)
29. ARTICLE: THE CULTURE WAR OVER GIRLS' SPORTS: UNDERSTANDING THE ARGUMENT FOR TRANSGENDER GIRLS' INCLUSION, 67 Vill. L. Rev. 717
30. Centers for Medicare & Medicaid Services. (2023, September 6). HCAHPS: Patients' perspectives of care survey . Cms.gov.  
<https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/hcahps-patients-perspectives-care-survey>
31. Centers for Medicare & Medicaid Services. (2023b, September 6). Hospital Inpatient Quality Reporting Program | CMS. Wwww.cms.gov.  
<https://www.cms.gov/medicare/quality/initiatives/hospital-quality-initiative/inpatient-reporting-program>
32. CMS Removes Pain Management Questions from HCAHPS Survey. (n.d.). Wwww.asahq.org.  
<https://www.asahq.org/advocacy-and-asapac/fda-and-washington-alerts/washington-alerts/2016/11/cms-removes-pain-management-questions-from-hcahps-survey>
33. SSA, O. (n.d.). Hearings, Appeals, and Litigation Law Manual. Wwww.ssa.gov.  
[https://www.ssa.gov/OP\\_Home/hallex/hallex.html](https://www.ssa.gov/OP_Home/hallex/hallex.html)
34. *Depomed, Inc. v. Banner Pharmacaps Inc.*, No. CIV.A. 13-04542 JLL, 2015 WL 1421836, at \*1 (D.N.J. Mar. 26, 2015)