

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS

HOUSTON DIVISION

COPELAND COLE,

CASE NO.: H-99-2185

Plaintiff,

v.

CONTINENTAL CASUALTY COMPANY,

Defendant.

**MEMORANDUM OF LAW IN SUPPORT OF
PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT**

I. Introduction

This suit arises out of a claim for group disability benefits pursuant to a group plan issued to Plaintiff, Copeland Cole, through his employer by the Defendant, Continental Casualty Company (hereinafter "CCC"). The plan is governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001, et seq. (ERISA). Mr. Cole is disabled from his former occupation due to the effects of Lyme Disease and Rocky Mountain Spotted Fever. CCC denied the claim without ever examining Mr. Cole by claiming that because he could do certain minimal activities which had no vocational significance, including getting married, he could necessarily perform all the substantial and material duties of his occupation. In addition, CCC ignored information submitted during the appeal process relating to the correct diagnosis of Mr. Cole's disability. Mr. Cole is entitled to receive all past due benefits (both short and long term), plus interest, costs, attorneys' fees and continued entitlement to monthly disability benefits.

II. Facts

Mr. Cole was employed by Cost Care, Inc.¹ in the Sales and Marketing Department as a Regional Sales Manager of employee benefits. His primary duties involved servicing existing accounts, prospecting for new accounts and completing reports. These duties required extensive travel to his existing and potential accounts, strong organizational skills and a thorough knowledge of all of the products of his own company as well as those of his competitors.

Through his employer, Mr. Cole was offered a group benefit plan which included disability benefits. The purpose of the disability plan was to provide Mr. Cole 70% of his weekly salary for the first twenty-six weeks and 60% of his monthly salary until age 65 in the event he became disabled and unable to work in his own occupation for the first twenty-four months and unable to work in any occupation thereafter. The Short Term Policy defines “total disability” in the following manner:

“‘Total Disability’ means that the Insured Employee, because of Injury of Sickness, is:

- (1) continuously unable to perform the substantial and material duties of the Insured Employee’s regular occupation;
- (2) under the regular care of a licensed physician other than the Insured Employee; and
- (3) not gainfully employed in any occupation for which the Insured is or becomes qualified by education, training or experience.”

Short Term Disability Plan, p. 4, bate stamp numbers 283-304² (attached as **Exhibit A**).

The Long Term Policy defines “total disability” as follows:

¹ Cost Care was purchased by UniCare in 1997.

² The bate stamp numbers are CCC’s internal numbers given to the administrative record and produced to the Plaintiff in discovery. Only the last three digits are used in this Memorandum.

“‘Total Disability’ means that, during the Elimination Period and the Insured Employee Occupation Period shown in Statement 4 of the Application, the Insured Employee, because of Injury or Sickness, is:

- (1) continuously unable to perform the substantial and material duties of the Insured Employee’s regular occupation;
- (2) under the regular care of a licensed physician other than the Insured Employee; and
- (3) not gainfully employed in any occupation for which the Insured Employee is or becomes qualified by education, training or experience.

After the Monthly Benefit has been payable for the Insured Employee Occupation Period shown in Statement 4 of the Application, ‘Total Disability’ means that, because of Injury or Sickness, the Insured Employee is:

- (1) continuously unable to engage in any occupation for which the Insured Employee is or becomes qualified by education, training or experience; and
- (2) under the regular care of a licensed physician other than the Insured Employee.”

Long Term Disability Plan, p. 4, bates stamp numbers 255-282 (attached as **Exhibit B**).

Beginning in 1993, Mr. Cole began feeling a variety of symptoms including, but not limited to, extreme fatigue, muscle and joint pain, lack of concentration, memory loss and sleep disturbances. In December 1995, these symptoms were diagnosed as Chronic Fatigue Immune Deficiency Syndrome (CFIDS). Mr. Cole continued to work, but his physical condition deteriorated rapidly forcing him to work fewer and fewer hours per day. Mr. Cole was finally forced to discontinue working completely as of May 9, 1997.

Since he could no longer work, Mr. Cole applied for the disability benefits promised under the terms of the CCC plan³. Mr. Cole’s treating physician, Patricia D. Salvato, M.D., provided CCC with medical documentation of Mr. Cole’s disability and his functional limitations. Dr. Salvato’s conclusions were ignored by CCC and her records were sent by CCC to Dr. Al Ziffer for review. Dr. Ziffer never spoke to or consulted with Dr. Salvato concerning any of her treatment records or opinion of Mr.

Cole. Dr. Ziffer also never examined, spoke to or even met Mr. Cole. Instead, his opinion was based on a cursory examination of certain records that were submitted to him by CCC. This necessarily led to numerous erroneous interpretations of the records and Mr. Cole's condition. Dr. Ziffer's ultimate conclusion was that Mr. Cole was not disabled because:

“When he plays golf and softball weekly, why cannot he do extremely sedentary work? It is my opinion that he could.”

Dr. Ziffer's report, bate stamp numbers 094-096 (attached as **Exhibit D**).

In effect, Dr. Ziffer's report came to several conclusions that were unsupported by the records provided. Dr. Ziffer concluded that Mr. Cole's occupation was “extremely sedentary work.⁴” Mr. Cole's position required extensive travel which takes this job out of the extremely sedentary category⁵. Dr. Ziffer concluded that Mr. Cole played golf weekly⁶. Mr. Cole actually stated that he did not play golf any longer⁷. What he did do, when he was not too fatigued, was hit golf balls on the driving range for approximately one hour per week. Dr. Ziffer equated playing a weekly, fifty minute softball game with being able to work on a full time basis⁸. This does not make logical sense because it has no vocational significance. How does activity for fifty minutes per week transform into the capability of activity for forty hours per week? Mr. Cole is not bedridden, nor is he required to be to receive benefits.

³ The initial claim form, bate stamp number 055, with a certification of disability from Dr. Salvato is attached as **Exhibit C**.

⁴ Id.

⁵ Mr. Cole's job description, bate stamp numbers 051-053, attached as **Exhibit E**.

⁶ See, Exhibit D.

⁷ See, July 11, 1997 letter from Mr. Cole, bate stamp numbers 078-079, attached as **Exhibit F**.

⁸ In his follow up report, bate stamp numbers 100-101, attached as **Exhibit G**, Dr. Ziffer also finds it significant that Mr. Cole is able to cook, shop and do laundry. Dr. Ziffer seems to equate any activity at all with being able work full time, which is not a requirement of the plan.

CCC used this report in conjunction with a definition of disability not present in the plan as the basis for denying Mr. Cole's claim.

“Based on the medical records contained in our file at the present time, there are no findings of any **severe** anatomical, physiological or psychological abnormality which could reasonably be expected to produce impairment. We recognize that your condition may impose minimal limits; however, there is no evidence to demonstrate these limits would preclude you from performing the duties of **any** occupation.”

Denial letter, bate stamp numbers 111-112 (emphasis added)(attached as **Exhibit H**).

This letter requires Mr. Cole to be suffering from a “severe” abnormality in order to receive benefits. This requirement is not present in the disability plan⁹. In addition, the letter requires Mr. Cole to be unable to perform the duties of “any occupation.” Mr. Cole only needs to be unable to perform the duties of his own occupation during the first twenty-four months in order to receive benefits¹⁰.

Mr. Cole appealed the decision denying his benefits¹¹ and submitted additional medical information in support of his claim. Mr. Cole submitted a report from Larry Pollock, Ph.D. diagnosing Mr. Cole as suffering from Organic Brain Syndrome and a Major Depressive Disorder, in addition to CFIDS¹². Dr. Pollock further opined that:

“Based on his cognitive and emotional difficulties, he is unable to maintain full-time competitive employment.”

Id at bate stamp 125.

⁹ See, Exhibits A and B.

¹⁰ Id.

¹¹ The October 27, 1997 letter appealing the denial of benefits is attached as **Exhibit I**. This letter does not have bate stamp numbers because it mysteriously does not appear in the administrative record. It is acknowledged in the administrative record that the letter was received by CCC. See, bate stamp number 232, attached as **Exhibit J**.

¹² The August 19, 1997 report, bate stamp numbers 119-126, is attached as **Exhibit K**.

Mr. Cole also submitted an additional report from Dr. Salvato¹³ wherein she stated:

“He continues to experience debilitating symptoms, the worst being his bone-crushing fatigue and diminished cognitive functioning. His health status continues to compromise his ability to be gainfully employed.”

Id., p. 4.

CCC sent Mr. Cole’s file to two doctors to review, but did not have Mr. Cole examined by anyone. Gary Friedman, M.D. sent CCC two different reports. The first report, dated November 14, 1997, goes to great lengths to dispute the methodology used by Mr. Cole’s treating physicians to diagnose him¹⁴. However, this report does not conclude that Mr. Cole could work or even address whether or not he has any specific limitations. The report only gives CCC a reason to dispute the diagnosis.

“In view of these facts I believe that your company would be on solid ground in disputing the diagnosis of chronic fatigue syndrome and raising question [sic] concerning the presence of and organic brain syndrome. I would defer to a psychologist concerning the diagnosis of the depressive reaction but if it is present, it certainly warrants medical therapy.”

Id. at bate stamp number 214.

Dr. Friedman did specifically caution CCC about taking any further action without investigating further and did not rule out a diagnosis of CFIDS in the future.

“Based on the above, it is my opinion that a diagnosis of chronic fatigue syndrome cannot be rendered *at this time* in the case of Mr. G. Copeland Cole. I would also seriously question a diagnosis of organic brain syndrome in this case. In addition, it is my opinion that there are sufficient discrepancies within the medical records that the methodology or basis for arriving at the diagnosis of chronic fatigue syndrome *merits further investigation* by CNA *prior to taking final action on this claim.*”

Id. at bate stamp number 209 (emphasis added).

¹³ This report, attached as **Exhibit L**, also does not appear in the administrative record, but it is also referenced in Exhibit J.

¹⁴ The November 14, 1997 report, bate stamp numbers 208-214, is attached as **Exhibit M**.

Ten days later, on November 24, 1997, Dr. Friedman filed a supplemental report at the request of CCC¹⁵. Using a different, more stringent definition of disability¹⁶, Dr. Friedman opined that Mr. Cole was not disabled based on his interpretation of Mr. Cole's activities as reported in different records. For example, Dr. Friedman concluded that "[c]learly he can meet personal and social demands" because "I note that he apparently has met, courted and married his present spouse during the course of time when he has been reportedly ill¹⁷." Dr. Friedman also stepped out of his purported role as an independent records examiner and stepped into the role of advocate and legal counselor for CCC when he stated:

"All of this data should be presented to your legal counsel for their consideration prior to taking any action in Mr. Cole's claim."

Id at bate stamp number 238.

CCC also sent Mr. Cole's records to Charles Paskewicz, Ph.D. for a psychological review¹⁸. Dr. Paskewicz concluded that Mr. Cole was not disabled because he scored well on the IQ tests performed by Dr. Pollock, so this would prevent him from having a psychological problem that would interfere with working¹⁹.

CCC completely disregarded the findings and conclusions of Mr. Cole's treating physicians²⁰. Without further investigating his claim or physically examining Mr. Cole, CCC denied Mr. Cole's appeal based on the paper reviews of Dr. Friedman and Dr. Paskewicz.

¹⁵ The November 24, 1997 report, bate stamp numbers 236-238, is attached as **Exhibit N**.

¹⁶ "Disability is the limiting loss or absence of the capacity of an individual to meet personal, social or occupational demands or to meet statutory or regulatory requirements." Id at bate stamp number 236.

¹⁷ Id at bate stamp number 237.

¹⁸ The November 19, 1997 report, bate stamp numbers 228-230, is attached as **Exhibit O**.

¹⁹ Does this mean that intelligent people cannot suffer from psychological problems?

²⁰ The December 18, 1997 appeal denial letter, bate stamp numbers 243-245, is attached as **Exhibit P**.

Through his attorney, Mr. Cole responded to the appeal denial letter²¹. Mr. Cole pointed out the faulty reasoning the denial was based on. In addition, Mr. Cole forwarded a report from Joseph C. Gathe, Jr., M.D. which correctly diagnosed Mr. Cole as suffering from Lyme disease and Rocky Mountain Spotted fever²². Lyme disease is a well-known disease that causes the type of debilitating fatigue and cognitive difficulties Mr. Cole had been complaining of. This new information was completely ignored by CCC because the diagnosis was not made until after Mr. Cole had applied for disability²³.

CCC never bothered to physically examine Mr. Cole and it did not possess any medical evidence contrary to a finding of disability. Mr. Cole's claim was denied because CCC completely discounted Mr. Cole's treating physicians conclusions while giving complete deference to its non-examining physicians and using a more stringent definition of disability not present in the plan²⁴. This finding is contrary to the terms of the disability plan and violative of the applicable law. This suit was commenced to recover the benefits promised to Mr. Cole under the terms of the CCC plan.

III. Summary Judgment Standard

A moving party is entitled to summary judgment if the pleadings, affidavits and other supporting papers show there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R.Civ.P., 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322, 91 L.Ed. 2d 265, 106 S.Ct. 2548 (1986). "The burden of establishing the absence of a genuine issue of material fact is on the party seeking summary judgment." United of Omaha Life Ins. Co. v. Sun Life Ins. Co. of America, 894 F.2d

²¹ The March 9, 1998 letter, bate stamp numbers 250-252, is attached as **Exhibit Q**.

²² The January 20, 1998 report, bate stamp number 249, is attached as **Exhibit R**.

²³ The March 24, 1998 final denial letter, bate stamp number 253, is attached as **Exhibit S**.

1555, 1557 (11th Cir. 1990)(citations omitted). Once this burden has been met, the adverse party must show there remains a genuine issue for trial. Fed.R.Civ.P., 56(e). “The court must view all evidence in the light most favorable to the non-movant and must resolve all reasonable doubts about the facts in favor of the non-movant.” United of Omaha Life Ins. Co., 894 F.2d at 1558.

A genuine issue of material fact exists when “the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” Anderson v. Liberty Lobby Inc., 477 U.S. 242, 248, 91 L.Ed. 2d 202, 106 S.Ct. 2505 (1986). “The mere existence of a scintilla of evidence in support of the [nonmoving party’s] position will be insufficient; there must be evidence on which the jury could reasonably find for the [nonmoving party].” Id at 252. “ If a review of the evidence presented reveals that the non-movant has failed to produce evidence sufficient to support a jury verdict in his favor, then summary judgment should be granted.” United of Omaha Life Ins. Co., 994 F.2d at 1558.

IV. ERISA Standard of Review

The basis of Ms. Cole’s claim is a denial of disability benefits pursuant to a group disability insurance plan, governed by 29 U.S.C. § 1001, et seq. (ERISA). The decision to deny benefits under an ERISA plan is evaluated under varying standards of review, depending on the express terms of the plan and factual circumstances of the case.

“Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132 (a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”

²⁴ This fact is significant because the Social Security Administration has found Mr. Cole to be totally disabled from any occupation based on the same information submitted to CCC.

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989); accord, Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1559 (11th Cir. 1990).

There is no language in either the short term plan or the long term plan granting discretionary authority to CCC to determine eligibility for benefits or to construe the terms of the plans²⁵. Therefore, the proper standard of review in this case is *de novo*. It is the Court's function to review the evidence submitted to CCC and determine whether CCC's decision to deny benefits was right or wrong based on the information submitted.

V. CCC's Improper Plan Interpretation

When interpreting the terms of the short and long term plans, CCC, as an ERISA fiduciary, is required to "discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries²⁶" . . . "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims²⁷." To determine whether a fiduciary has properly discharged its fiduciary duties and permissibly interpreted the provisions of a plan, the first step is to look at the express language contained in the plan.

"A key principle guiding our resolution of the Retirees' claim is that we must look to the plain language of the [] plan to determine whether the Trustees' interpretation of that plan is 'arbitrary and capricious.' We have consistently explained that 'trustees abuse their discretion if they . . . construe provisions of [a] plan in a way that clearly conflicts with the plain language of the plan.'"

Canseco v. Construction Laborers Pension Trust, 93 F.3d 600, 606 (9th Cir. 1996)(citations omitted).

²⁵ See, CCC Short Term Plan, Exhibit A and CCC Long Term Plan, Exhibit B.

²⁶ 29 U.S.C. § 1104 (a)(1).

²⁷ 29 U.S.C. § 1104 (a)(1)(B).

The short and long term plans specifically set forth the requirements Mr. Cole needed to meet in order to receive benefits. When Mr. Cole's benefits were denied, he only needed to be disabled from his own occupation in order to be eligible for benefits²⁸. CCC ignored the terms of its own plan by determining Mr. Cole's eligibility for benefits under the more stringent "any occupation" provision which requires that he be disabled from performing the duties of any occupation as opposed to his own occupation²⁹. CCC construed a provision of its plan in a way that clearly conflicted with the plain language of the plan. By doing so, CCC's actions were arbitrary and capricious and its decision cannot be upheld even under the most deferential arbitrary and capricious standard. Canseco, 93 F.3d at 606.

In addition to using the wrong definition of occupation to determine eligibility, CCC inserted additional requirements for eligibility. Based on CCC's denial letter³⁰, Mr. Cole would only be eligible for benefits if he was suffering from a "severe anatomical, physiological or psychological abnormality which could reasonably be expected to produced impairment³¹." Nowhere in either the short term or long term plans is there a requirement for an impairment to be "severe" as a condition for eligibility.

"A second interpretive principle guiding our analysis is that pension plan trustees or administrators may not construe a plan so as to impose an additional requirement for eligibility that clashes with the terms of the plan. Lower federal courts have held that where plan trustees 'impose a standard [of eligibility for pension plan benefits] not required by the pension plan itself,' that action 'results in an unwarranted and arbitrary construction of the plan'.

...

²⁸ See, Exhibits A and B, discussed, *supra*.

²⁹ See, Exhibit H, discussed, *supra*. Also see, bate stamp number 063, attached as **Exhibit T** ("Any Occ Assessment").

³⁰ Exhibit H, discussed, *supra*.

³¹ *Id.*

Recently, in Saffle, we extended this principle to disability benefits. In Saffle, a plan administrator denied an employee long-term benefits for ‘total disability.’ The administrator concluded that the employee did not satisfy the definition of ‘total disability’ because medical reports concluded the employee could return to work if her job was modified to allow her to perform exclusively sedentary work. On appeal, we rejected the administrator’s interpretation of the disability plan in part because the administrator construed the plan to prohibit benefits if the employee was able to continue working with ‘accommodations.’ Such an interpretation, we concluded, would operate to ‘impose [] a new requirement for coverage’: it would require the claimant to show that accommodations were futile. We rejected this implied additional term, explaining that a ‘[plan] administrator lacks discretion to rewrite the plan.’”

Canseco, 93 F.3d at 608-9 (citations omitted).

The insertion of the additional “severe” requirement to determine eligibility led to an unreasonable interpretation of the term “disabled”, effectively making both the short and long term plans meaningless except for extreme cases of complete mental or physical incapacity³². This unreasonable and overly restrictive interpretation is evident by both Dr. Friedman’s definition of disability (“absence of the capacity . . .”)³³ and CCC’s adjuster’s definition of disability.

“Please note we are rev’ing [sic] for creditability [sic] an inable [sic] to function (impairments diagnosis is not the basic issue with type of condition, functionality is the issue).”

Bate stamp number 054, attached as **Exhibit U** (emphasis in original).

CCC’s interpretation of the Plan is similar to the case of Helms v. Monsanto Co., Inc., 728 F.2d 1416 (11th Cir. 1984). Helms applied for disability benefits under a group plan which defined disability as being unable to engage in any occupation or employment for remuneration or profit. His benefits were denied because an “independent medical

³² “An interpretation which gives a reasonable, lawful and effective meaning to all the terms is preferred to an interpretation which leaves a part unreasonable, unlawful, or of no effect.” Meredith v. Allsteel, Inc., 11 F.3d 1354, 1358 (7th Cir. 1993).

³³ See, footnote 16, *supra*.

examiner” determined that, although he believed Helms was disabled, he could not say that anybody was disabled under the definition provided. This is exactly what has occurred in Mr. Cole’s case. In Helms, the court overturned the decision denying benefits under an arbitrary and capricious standard.

“Common knowledge of the occupations in the lives of men and women teach us that there is scarcely any kind of disability that prevents them from following some vocation or other, except in cases of complete mental incapacity. Although the achievements of disabled persons have been remarkable, we will not adopt a strict, literal construction of such a provision which would deny benefits to the disabled if he should engage in some minimal occupation, such as selling peanuts or pencils, which would yield only a pittance. The insured is not to be deemed ‘able’ merely because it is shown that he could perform some task.

...

To bar recovery, under the provisions of the [plan], the earnings possible must approach the dignity of a livelihood. Mr. Helms is required to show physical inability to follow any occupation from which he could earn a reasonably substantial income rising to the dignity of an income or livelihood, even though the income is not as much as he earned before the disability."

Id at 1421-22.

CCC’s improper interpretation of the terms of the plans make its actions arbitrary and capricious under the most deferential standard of review. Its decision denying benefits to Mr. Cole must be reversed.

VI. CCC’s Failure to Conduct a Full and Fair Review

CCC has an obligation to conduct a full and fair review of every claim submitted to it³⁴. CCC has a duty to consider the medical information “in tandem” and render a decision based on all the information. Paramore v. Delta Air Lines, Inc., 129 F.3d 1446, 1452 (11th Cir. 1997).

“[The plan administrator’s] selective review of the medical evidence and its completely erroneous assertion that there was no physical cause for the

³⁴ 29 U.S.C. § 1133; ERISA § 503.

subjective symptoms of pain renders its decision not only unreasonable but arbitrary and capricious.”

Govindarajan v. FMC Corp., 932 F.2d 634, 637 (7th Cir. 1991).

Mr. Cole submitted medical reports from three different doctors who all agreed that he was completely disabled from any occupation due to severe fatigue and cognitive difficulties. Dr. Salvato diagnosed him as suffering from Chronic Fatigue Immune Deficiency Syndrome. Dr. Pollock diagnosed him as suffering from Organic Brain Syndrome and Major Depression. Dr. Gathe diagnosed him as suffering from Lyme disease and Rocky Mountain Spotted Fever³⁵. CCC’s paid non-examining physicians never gave him a diagnosis nor did they dispute that he had impairments. They only disputed the severity of the impairments based on their interpretation of what was written on paper. Although Mr. Cole’s actual diagnosis was not the same from his treating physicians, the impairments were the same. Every physician who actually met and examined him agreed that he had debilitating fatigue and cognitive problems that prevented him from working. The cause of Mr. Cole’s conditions does not matter, only the conditions causing his disability matter.

“We find that defendant’s denial was arbitrary and capricious because administrators and fiduciaries are prohibited from adding a term or extra requirement into an insurance policy that is not expressly part of it. This action alone would support a finding that a fiduciary has acted arbitrarily and capriciously. Here, the SPD nowhere provides that employees must submit objective medical evidence in support of their claims. Despite defendant’s assertions that plaintiff bore the burden of demonstrating a link between stress and aneurysm formation and/or rupture, **the SPD does not require employees to provide information on the cause of their disabling conditions. Instead, plaintiff submitted what was required of him under the SPD – proof of his disability – by providing copies of his medical records, his medical history, and three doctors’ opinions stating that he is disabled.** Thus, it was unreasonable for defendant to interpret the SPD as requiring plaintiff or plaintiff’s treating physicians to

³⁵ Mr. Cole assumes that this is the correct diagnosis because it has been confirmed with objective tests.

provide MetLife with published studies, articles, or texts showing a connection between stress and plaintiff's condition."

Durr v. Metropolitan Life Ins. Co., 15 F.Supp 2d 205, 212 (D. Conn. 1998)(citations omitted)(emphasis added); accord, Mitchell v. Eastman Kodak Co., 113 F.3d 433, 443 (3rd Cir. 1997)(**a claimant does not have to provide clinical evidence of the etiology of the condition that renders him disabled because it is not a requirement of the plan**).

CCC did not even bother to respond or attempt to refute Dr. Gathe's report concerning the diagnosis of Lyme disease and Rocky Mountain Spotted Fever other than to state that this diagnosis at this point in time could have no bearing on his disability status despite the fact the symptoms of Lyme disease and CFIDS are virtually indistinguishable. Ignoring a key piece of medical evidence is inconsistent with the concept of a full and fair review and yet another reason to find CCC's decision unreasonable.

"There is nothing in the decision itself to indicate that the Administrative Committee in fact examined the record in its entirety. No mention is made of the supplemental medical opinions, Mr. Todorowski's report, or the favorable decision of the Social Security Administration, finding Plaintiff completely disabled, within the meaning of the Social Security Act, as of June 1994. By relying only on 'the original' medical record and Dr. Deutsch's report, the Administrative Committee acted arbitrarily.

. . .

By failing to address this un rebutted opinion or refute it in any way, the Administrative Committee acted unreasonably."

Lozada v. Delta Family-Care Disability and Survivorship Plan, 1998 U.S. Dist. LEXIS 11290, *10-11 (M.D. Fla. 1998)(emphasis added)³⁶.

An ERISA plan administrator is required to have some medical information in its possession that supports a denial of a claim before it can actually deny the claim. CCC did not have any contrary medical evidence to support its denial. CCC failed to conduct a full and fair review and its decision cannot be upheld.

³⁶ The full case is attached as **Exhibit V**.

“Plainly put, we will not countenance a denial of a claim solely because an administrator suspects something may be awry. Although we owe deference to an administrator’s reasoned decision, we owe no deference to the administrator’s unsupported suspicions. **Without some concrete evidence in the administrative record that supports the denial of the claim, we must find the administrator abused its discretion.**”

Vega v. National Life Ins. Services, Inc., 188 F.3d 287, 1999 U.S. App. LEXIS 20894, *46 (5th Cir. September 1, 1999)(emphasis added); accord, Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Auto Ins. Co., 463 U.S. 29, 43, 103 S.Ct. 2856, 77 L.Ed. 2d 443 (1983) (a decision is arbitrary and capricious if the decision-maker "entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before [it], or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise").

VII. The Treating Physician Rule

Part of the obligation to conduct a full and fair review is the concept of the treating physician rule. An ERISA plan administrator is required to give deference to the conclusions of a treating physician.

“Cases in this circuit distinguish among the opinions of three types of physicians: (1) those who treat the claimant (treating physicians); (2) those who examine but do not treat the claimant (examining physicians); and (3) those who neither examine nor treat the claimant (nonexamining physicians). As a general rule, more weight should be given to the opinion of a treating source than to the opinion of doctors who do not treat the claimant. At least where the treating doctor’s opinion is not contradicted by another doctor, it may be rejected only for ‘clear and convincing’ reasons. We have also held that ‘clear and convincing’ reasons are required to reject the treating doctor’s ultimate conclusions. Even if the treating doctor’s opinion is contradicted by another doctor, the Commissioner may not reject this opinion without providing ‘specific and legitimate reasons’ supported by substantial evidence in the record for so doing.”

Lester v. Chater, 81 F.3d 821, 830 (9th Cir. 1995)(citations omitted)³⁷.

³⁷ Cases construing Social Security disability provisions should be used as guidance in ERISA cases. Helms v. Monsanto Co., Inc., 728 F.2d 1416, 1420 (11th Cir. 1984); Pierce v. American Waterworks Co., 683 F.Supp. 996, 1000 (W.D. Pa. 1988)(relying in part on Social Security Administration’s determination of disability in finding administrator’s decision arbitrary and capricious). Also see, Isabel v. Hartford Life and Accident Ins. Co., 1999 U.S. LEXIS 824, *6-7 (N.D. CA January 29, 1999)(“As a general matter, the opinion of a treating physician is accorded more weight than that of a non-treating physician. . . . In addition, the opinion of a non-examining physician cannot, by itself, constitute substantial evidence to

CCC did not have Mr. Cole examined by a physician. In Godfrey v. Bellsouth Telecommunications, Inc., 89 F.3d 755 (11th Cir. 1996), the failure of the administrator to physically examine the plan participant was held to be arbitrary and capricious because “fibromyalgia can be severely disabling and can only be diagnosed by an examination of the patient.” Id at 758³⁸. The Eighth Circuit has also held that it is arbitrary and capricious to rely on a reviewing physician’s opinion over the treating physician’s opinion. Donaho v. FMC Corp., 74 F.3d 894, 901 (8th Cir. 1996)(“where the reviewing physician’s conclusions are contradicted by an examining physician and two treating physicians, reliance on the reviewing physician’s conclusions ‘seems especially misplaced’ and constitutes an abuse of discretion”). CCC’s paid non-examining physicians provided no support for the denial and their conclusions were contradicted by three treating physicians. CCC had no medical evidence to contradict the conclusions of Mr. Cole’s treating physicians. This decision cannot be upheld.

“Specifically, the claim file does not contain any evidence showing that plaintiff is not disabled. Nor is there any evidence demonstrating that stress would not cause plaintiff to develop aneurysms or that stress would not prohibit plaintiff from performing his job duties.”

Durr, 15 F.Supp. at 214.

VIII. Conclusion

CCC’s decision to deny Mr. Cole’s benefits was not only wrong, but unreasonable. CCC improperly interpreted the terms of the plan. Furthermore, it never

overturn the opinion of either an examining physician or a treating physician. In rejecting Dr. Neuwelt’s diagnosis, neither Hartford’s in-house nurse nor Dr. Kozin ever personally examined plaintiff. Further, Hartford later declined to have plaintiff looked at by a physician of its own choosing. . . . Dr. Lifshay’s report thus amounts to an uncontradicted opinion which may be rejected only for ‘clear and convincing’ reasons.) (the full case is attached as **Exhibit W**).

³⁸ Also see, Zervos v. Solo Cup Co., 520 N.E. 2d 823, 826 (Ill. App. 1987)(the decision was arbitrary and capricious where the recommendation of the treating physician was not followed and the fiduciary ignored the doctor’s evaluation and asserted its own independent judgment of the medical records).

had Mr. Cole examined by a physician and completely ignored or disregarded any medical information that did not support its position and/or offered an explanation for its decision that ran counter to the evidence before it. The significance of this fact is evident because the doctors CCC employed to determine that Mr. Cole was not disabled found little wrong with him despite the fact that Lyme disease causes all the symptoms complained about. CCC's conclusions appear to have even less validity given the fact that the Social Security Administration determined Mr. Cole to be totally disabled from any occupation. CCC's actions reject any possible excuse. Mr. Cole is due his full benefits in accordance with both the short and long term plans plus interest, costs, attorney's fees and a decree ordering CCC to continue paying Mr. Cole his benefits through age sixty-five.

Respectfully Submitted,

THE WAGAR LAW FIRM
Kirk W.B. Wagar, Esq.
John P. Murray, Esq.
3250 Mary Street, Suite 207
Coconut Grove, FL 33133
305-443-7772

BY: _____
KIRK W.B. WAGAR
Fla. Bar No.: 994936

and

THE WEST LAW FIRM
S. Scott West, Esq.
1600 Highway Six, Suite 450
Sugar Land, TX 77478
281-277-1500

Co-Counsel

CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was mailed this ____ day of November, 1999 to: James J. McConn, Jr., Esq., Hays, McConn, Rice & Pickering, 400 Two Allen Center, 1200 Smith Street, Houston, Texas 77002.

Respectfully Submitted,

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