2016 WL 11584226
Only the Westlaw citation is currently available.
United States District Court, N.D. Florida.

ROLAND BROWN, Plaintiff,
v.
UNITED OF OMAHA LIFE
INSURANCE COMPANY, Defendant.

Case No. 3:15-cv-00161-MCR-EMT
|
Filed 09/01/2016

ORDER

M. CASEY RODGERS CHIEF UNITED STATES DISTRICT JUDGE

***1** Before the court is Plaintiff Roland Brown's Motion for Summary Judgment, ECF No. 39, and Defendant United of Omaha Life Insurance Company's ("United") Motion for Judgment on the Administrative Record, or Alternatively, for Summary Judgment, ECF No. 43. Having full considered the matter, the court finds that Brown's Motion for Summary Judgment should be granted in part and denied in part, United's motion should be denied, and this matter should be remanded to the plan administrator for further proceedings. [1]

Brown worked as a lead bonding mechanic for Marianna Airmotive and was a participant in a United employee welfare benefits plan established by his employer. Under the plan, Brown had coverage for both short-term and long-term disability benefits, with United acting as the claim administrator for the plan. Under the policy, total disability is defined as follows: "Total Disability and Totally Disabled means that because of an injury or sickness, a significant change in [claimant's] mental or physical functional capacity has occurred in which [claimant is] prevented from performing all of the material duties of [his] regular occupation on a full-time basis." Further, the policy defines "Regular Occupation" as "the occupation [claimant is] routinely performing when [his] total or partial disability begins ...." The policy defines "Material Duties" as "the essential tasks, functions, and operations relating to an occupation .... One of the material duties of [claimant's] regular occupation is the ability to work for an employer on a full-time basis." Additionally, the policy has an "Examination" provision, stating that United "sometimes require[s] that a claimant be examined by a Physician or vocational rehabilitation expert of [its] choice. [United] will pay for these examinations. [United] will not require more than a reasonable number of examinations."

Brown was injured in an automobile accident in August of 2011. After the accident, he was seen by Dr. Robert Jensen, who diagnosed him with cervicalgia, lumbar discogenic and myofascial pain, possible cervical radiculopathy and sacroiliac joint dysfunction, mild right hip trochanteric hip bursitis, and an avulsion facture of the right elbow. Brown's right elbow problem was corrected with surgery soon after the accident, and his cervicalgia cleared up with conservative treatment and physical therapy. However, his low-back pain persisted, and Dr. Jenson ordered an MRI of his lumbar spine. Pursuant to the MRI, Dr. Jensen then diagnosed Brown with significant degenerative spondylosis at the L4-5 and lumbosacral levels with foraminal narrowing present at L4-5 and lumbosacral levels, and referred him to Dr. Mark Giovanni for a surgical evaluation.

***2** Dr. Giovanni initially recommended lumbar facet injections for Brown's pain. Brown underwent two such injections, but did not obtain lasting relief. Dr. Giovanni then recommended surgery, and on July 24, 2013, Brown underwent a lumbosacral fusion with posterior lateral interbody fusion and pedicle screw instrumentation with iliac crest bone grafting. After surgery, Brown claimed and was granted short-term disability benefits under the United policy.

On September 3, 2013, Dr. Giovanni saw Brown for a follow-up after surgery. Dr. Giovani concluded that the hardware components he had installed in Brown's back were well-seated and that there appeared to be no complications.

On September 4, 2013, Dr. Giovanni completed a short-term disability report for United. He noted that Brown had low back, bilateral hip, and leg pain. He further stated that Brown could return to light-duty work on March 3, 2014, provided that he did no lifting over ten pounds and avoided prolonged sitting, flexion or extension of the neck, bending, and wore a back brace.

On September 10, 2013, Dr. Giovanni completed a physician's order form for a semi-electric hospital bed to help Brown's pain, as well as to help him position himself in bed, and get in and out of bed. When asked to specify the duration that Brown would need the bed, Dr. Giovanni marked "lifetime."

On January 28, 2014, Brown reached the end of the short-term disability period under the United insurance policy. Thereafter, United informed Brown that he would be required to demonstrate his eligibility to continue receiving benefits under the long-term benefits provision.

On May 22, 2014, Dr. Jensen completed an attending physician's statement for United. In that statement, Dr. Jensen concluded that Brown had reached maximum medical improvement and that his prognosis for recovery, returning to light-duty work only, was fair. However, Dr. Jensen noted on the form that he had last seen Brown on May 9, 2013.

On July 31, 2014, United claim representative Joshua Pope terminated Brown's benefits. Pope later testified that he based his termination decision on his own evaluation of Brown's medical records, as well as evaluations of Brown's records by two in-house nurses. He concluded that Brown had not shown he was still disabled because the last doctor's statement confirming his condition was based on an exam that took place over a year earlier. Pope admitted, however, that Brown had explained to him that he was unable to afford further follow-up visits with his doctors because he did not have medical insurance. Pope also conceded that he knew Brown was still taking prescription pain medication and claimed to have significant pain. Further, one of the nurses who reviewed Brown's file, Beth Beumer-Anderson, recommended that Pope contact Dr. Giovanni to ask whether he still placed restrictions on Brown's work, whether Brown was taking any paid medication, and whether he was still in pain. However, Pope declined to investigate Brown's claim further by contacting Dr. Giovanni.

On October 14, 2014, Dr. Jensen completed a lumbar diagnosis related limited duty form, on which he specified that Brown could perform only sedentary work for a maximum of six hours per day. Dr. Jensen also completed a rehabilitation center referral form, on which he specified that Brown was suffering from loss of sensation, muscle weakness, muscular wasting, and pain and stiffness in his lumbar spine.

***3** On October 28, 2014, Brown was evaluated by physical therapist Susan Burke, who observed that Brown was experiencing mid-back pain, chronic low-back pain, limited functional mobility, reduced rotational mobility, and sleep disturbances, as well as neurological, motor, and sensory deficits at certain right and left hip flexion points. Burke marked Brown's pain as "constant" at a level of eight out of ten. She also noted that Brown could sit for one hour, stand for thirty minutes, and walk for ten to fifteen minutes.

On January 3, 2015, Brown presented to the emergency room at West Florida Hospital with complaints of severe, chronic back and hip pain. X-rays of his right hip were taken and revealed accelerated severe degenerative changes in the right hip and mild lateral subluxation and loss of femoral head sphericity, which the radiologist, Dr. Blunck, noted may reflect femoroacetabular impingement. Brown's discharge instructions stated that he should avoid bending, heavy lifting, prolonged sitting, and activities that aggravate his back pain.

On January 8, 2015, Dr. Jensen completed a second lumbar diagnosis related limited duty form on Brown, in which he specified that Brown could perform light-duty, sedentary work through April 8, 2015.

On January 12, 2015, Brown appealed United's denial of long-term benefits. Approximately two months later, on March 6, 2015, claim-representative Jake Smith rejected the appeal. Smith later testified that he based his decision on his own review of Brown's records as well as an outside records evaluation solicited from Dr. Charles Kershner. Dr. Kershner concluded as follows:

> [I]t should be noted the record is incomplete regarding [Brown's] follow-up and no x-ray report ever mentioned whether or not he had obtained a solid spinal fusion as a result of the attempted spinal fusion surgery [by Dr. Giovanni]. The diagnosis of severe degenerative arthritis of [Brown's]

> right hip [is substantiated by] the x-ray findings .... As noted ... there is insufficient information in the medical records to support limitation and restriction for the timeframe in question. There is also inadequate information in the medical record regarding [Brown's] right hip condition; the only medical information available is an x-ray finding indicating that he had severe arthritis .... There was no mention in the medical record as to what degree of impairment, if any, this caused. I am therefore unable to support any limitations and restrictions due to insufficient information available to me. There were no relevant records within the requested timeframe of [July 31, 2014] to the present. *In order to make an educated medical decision, [Brown] should have up-to-date routine x-rays and/or flexion extension x-rays and/or a CT of the spine to determine whether [he] has had a successful spinal fusion if he is continuing to complain of pain, as this would be the obvious cause.... The claimant has not had adequate follow up regarding his spinal fusion. There is no record as to whether the claimant ever obtained a solid fusion and therefore, what his current functional status is.... I saw no evidence of symptom magnification or exaggeration. The claimant's current condition is currently unknown and therefore, the claimant could have valid complaints.*

ECF No. 39-3, at 22-23(emphasis added). Smith testified that Brown had explained to him that he was unable to afford to see his doctors for further follow-up care because he did not have medical insurance. Smith declined to investigate Brown's claim further.

***4** Brown filed the instant action challenging United's denial of long-term disability benefits on December 4, 2013. The parties' respective motions for summary judgment are now before the court. In the Eleventh Circuit, courts employ a multi-step framework to review an ERISA plan administrator's benefits decision. *Blankenship v. Metro. Life Ins. Co.*, 644 F.3d 1350, 1354 (11th Cir. 2011). The steps are as follows:

> (1) Apply the de novo standard to determine whether the claim administrator's benefits-denial decision is "wrong" (i.e., the court disagrees with the administrator's decision); if it is not, then end the inquiry and affirm the decision.
>
> (2) If the administrator's decision in fact is "de novo wrong," then determine whether he was vested with discretion in reviewing claims; if not, end judicial inquiry and reverse the decision.
>
> (3) If the administrator's decision is "de novo wrong" and he was vested with discretion in reviewing claims, then determine whether "reasonable" grounds supported it (hence, review his decision under the more deferential arbitrary and capricious standard).
>
> (4) If no reasonable grounds exist, then end the inquiry and reverse the administrator's decision; if reasonable grounds do exist, then determine if he operated under a conflict of interest.
>
> (5) If there is no conflict, then end the inquiry and affirm the decision.
>
> (6) If there is a conflict, the conflict should merely be a factor for the court to take into account when determining whether an administrator's decision was arbitrary and capricious.

Id. at 1355.

Brown argues that United's denial of his claim was both de novo wrong and arbitrary and capricious, because, inter alia, it failed to conduct an adequate investigation of his claim by failing to require an independent medical examination. Specifically, Brown contends that United claim-representatives Pope and Smith both ignored the advice of their own medical consultants stating that such additional inquiry into Brown's condition was warranted in order to determine whether he was disabled. In response, United contends that Pope and Smith's actions in having Brown's paper medical records reviewed by its own doctor and nurses was a sufficient investigation into

Brown's claim. Additionally, United argues that Pope and Smith had no legal obligation to investigate his claims further, and that Brown had the burden to prove he was disabled under the policy.

The court recognizes, as United points out, that in some circumstances a claims representative may rely on the written reports of consultants who have conducted a paper review of a claimant's medical records to determine whether a claimant is disabled. *See, e.g.*, *Howard v. Hartford Life & Acc. Ins. Co.*, 929 F. Supp. 2d 1264, 1297 (M.D. Fla. 2013), *aff'd* 563 F. App'x 658 (11th Cir. 2014). Likewise, it is true that in a lawsuit challenging an insurer's decision to deny disability benefits, the burden is on the claimant to prove he is disabled. *See Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir. 1998). However, United misconstrues its obligation toward Brown when initially determining his eligibility for benefits. "ERISA imposes higher-than-marketplace quality standards on insurers." *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008). "It sets forth a special standard of care upon a plan administrator, namely, that the administrator 'discharge [its] duties' in respect to discretionary claims processing 'solely in the interests of the participants and beneficiaries' of the plan ...." *Id.* (first alteration in original) (quoting 29 U.S.C. § 1104(a)(1)). ERISA "simultaneously underscores the particular importance of accurate claims processing by insisting that administrators 'provide a "full and fair review" of claim denials ....' " *Id.* (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989)).

***5** In the instant case, the court finds that United failed to discharge its duty under ERISA to provide a full, fair, and accurate review of Brown's claim when it neglected to require an independent medical examination. Though Brown's medical records may have been somewhat sparse, they plainly show that he had significant injuries to both his back and hip. His back problem was so serious that after epidural injections failed to alleviate his pain, Brown underwent spinal fusion surgery that prevented him from performing even light-duty work for a full six months.[2] And records from Brown's physical therapist show that he reported back pain at a level of eight out of ten and had notable mobility deficits at fifteen months out from surgery, during the time between United's initial claim denial and Brown's appeal. Further, Brown's medical records from that same period show that he was admitted to the emergency room with complaints of chronic pain and diagnosed with severe degenerative changes in his right hip. At minimum, these records suggest that there is a reasonable likelihood that Brown was disabled and unable to perform all the material duties of his occupation as a lead bonding mechanic for an aircraft maintenance company.[3]

Even assuming, for the sake of argument, a reasonable likelihood that Brown was disabled was insufficient to warrant an independent medical examination, two additional factors show that United failed discharge its duty under ERISA to provide Brown with a full, fair, and accurate review. First, it appears that any lack of documentation of Brown's physical limitations was not due to his unwillingness to comply with the requirements of the claims process, or his doctor's unwillingness to provide a supportive diagnosis,[4] but rather due to the simple reality that Brown's lack of medical insurance left him unable to afford regular visits to his doctors.[5] A benefits plan such as the one at issue here is designed for the express purpose of protecting a beneficiary from poverty in the event that he is unable to work due to injury. It would be a bitter irony if ERISA permitted a plan administrator to deny coverage due to lack of supporting medical records where an injured claimant's inability to work has left him too poor to see a doctor to obtain such records.[6] Second, and perhaps most tellingly, United's own nurse and doctor confirmed on review of the records Brown did provide that more information from doctors in direct contact with Brown was necessary to make an accurate determination regarding the extent of his disability. Specifically, United's nurse Beth Beumer-Anderson recommended that United contact Brown's surgeon Dr. Giovanni to determine whether he still placed restrictions on Brown's work, whether Brown was taking any paid medication, and whether Brown was still in pain. Moreover, United's doctor Charles Kershner explicitly concluded:

> In order to make an educated medical decision, [Brown] should have up-to-date routine x-rays and/or flexion extension x-rays and/or a CT of the spine to determine whether [he] has had a successful spinal fusion if he is continuing to complain of pain, as this would

> be the obvious cause.... I saw no evidence of symptom magnification or exaggeration.... [T]he claimant could have valid complaints.

ECF No. 39-3, at 22-23. Nevertheless, United ignored even the advice of their own consultants and declined to inquire further into Brown's condition by requiring an independent medical examination. The court finds that United's denial of Brown's claim in such a manner deprived him of a full, fair, and accurate review, *see Glenn*, 554 U.S.at 115, and was both de novo wrong and arbitrary and capricious. *See Capone v. Aetna Life Ins. Co.*, 592 F.3d 1189, 1199 (11th Cir. 2010) (holding failure to fully investigate claim before denying benefits was de novo wrong);[7] *Acree v. Hartford Life & Acc. Ins. Co.*, 917 F. Supp. 2d 1296, 1321 (M.D. Ga. 2013) (remanding plaintiff's claim to plan administrator for reconsideration because administrator failed to conduct full and fair review).[8]

***6** However, courts generally should not resolve the ultimate question of a claimant's eligibility for benefits on the basis of evidence never presented to the claim administrator, but should instead remand to the administrator for a new determination. *See Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137, 1140 (11th Cir. 1989). Therefore, the court finds that this case should be remanded to United's claim representatives for a new determination regarding Brown's eligibility for benefits.

Accordingly:

1. Plaintiff Roland Brown's Motion for Summary Judgment, ECF No. 39, is **GRANTED in part**—to the extent that it seeks to overturn United's denial of benefits as arbitrary and capricious; and **DENIED in part**—to the extent that it asks this court to determine that Brown should ultimately be granted benefits.

2. Defendant United of Omaha Life Insurance Company's Motion for Judgment on the Administrative Record, or Alternatively, for Summary Judgment, ECF No. 43, and Motion in Limine, ECF No. 47, are **DENIED**.

3. The case is **REMANDED** to the plan administrator for further proceedings necessary to conduct a full and fair review after obtaining an independent medical examination.

4. The Clerk is directed to close the file for administrative purposes and reopen it on notice that Plaintiff seeks review of the plan administrator's final determination.

DONE AND ORDERED on this 1st day of September, 2016.

All Citations

Slip Copy, 2016 WL 11584226

Footnotes

1 Also pending is United's Motion in Limine. ECF No. 47. To the extent United seeks to exclude consideration of certain social security documents, the court finds that this point is moot because the court does not rely on these documents in its present decision. To the extent that United seeks to exclude the deposition transcripts of claim representatives Joshua Pope and Jacob Smith, their testimony is within the scope of the court's discovery order, *see* Final Scheduling Order, ECF No. 11, and is necessary to determine whether the administrator fulfilled its duties. Therefore, United's Motion in Limine will be denied.

2 Dr. Giovanni performed Brown's surgery in July of 2014. Dr. Giovanni's last note regarding Brown's restrictions stated he could return to light-duty work in March of 2014.

3 Brown's occupation was classified by United as “medium duty,” meaning that it required the ability to exert twenty to fifty pounds of force occasionally and ten to twenty-five pounds of force frequently.

4 For instance, it appears that Dr. Jensen was so convinced of Brown's disability that he was willing to complete forms documenting Brown's ongoing limitations long after the last time he personally examined him.

5 United does not dispute, and there is no evidence in the record to contradict, the veracity of Brown's assertion to Pope and Smith that his lack of medical insurance left him unable to afford to see his doctors.

6 After reviewing the depositions of Pope and Smith, the court is left with the distinct impression that it seems unlikely they would use an independent medical examination unless necessary to *dispute* a claimant's evidence of disability, not to garner support for a claim.

7 The court in *Capone* did not go beyond the de novo inquiry, because it concluded that the trial court based its decision exclusively on de novo grounds. *See id* at 1196.

8 In *Acree*, the court noted that in the Eleventh Circuit there is no clear precedent regarding how a procedural violation of ERISA such as a failure to properly investigate before denying benefits should be reviewed. *See id.* at 1305. Based in part on the reasoning of the Sixth Circuit *in Kent v. United of Omaha Life Ins. Co.*, 96 F.3d 803, 806 (6th Cir.1996), the *Acree* court declined to employ the customary six-step arbitrary and capricious review for benefits denials, and simply reviewed the procedural violation de novo. *See Acree*, 917 F. Supp. 2d at 1305. Though the court has adhered to the six-step framework in this case, the result would be no different had Brown's failure to investigate the claim been reviewed separately.

End of Document