

1 **BACKGROUND²**

2 **1. AT&T Disability Income Plan**

3
4 Plaintiff is a former employee of Pacific Bell Telephone
5 Company, where he was a manager with sedentary job duties. While
6 employed, Plaintiff participated in an employee welfare benefit
7 plan known as the "AT&T Income Disability Plan" (the "Plan").

8 The Plan was self-insured and administered by a third-party
9 claims administrator ("TPA"). It contained the following terms
10 relevant to the disposition of the parties' instant Motions:

11 "Total Disability" or "Totally Disabled" means, with
12 regard to Short Term Disability, that because of
13 illness or injury, an Employee is unable to perform all
14 of the essential functions of his job or another
available job assigned by the Participating Company
with the same full- or part-time classification for
which the Employee is qualified. Plan § 2.26.

15 "Injury" shall mean job and non-job related trauma or
16 damage to the physical person of an Employee medically
substantiated and treated by a Physician which renders
17 an Employee incapacitated from performing the duties of
any job assigned by the Participating Company. Plan
§ 2.12.

18
19 Upon the written request of a claimant or his duly
authorized representative, received by the Committee or
the Claims Administrator or the subcommittee to whom
20 claim review authority has been assigned not more than
sixty (60) days after the date of mailing or delivery
21 of written notice of denial of such claim, the
Committee or the Claims Administrator or the delegated
22 subcommittee, as applicable, is required to give such
claimant or his authorized representative a full and
23 fair review of the claim, the opportunity to review
pertinent documents, and the opportunity to submit to
24 the Committee or the Claims Administrator or the
delegated subcommittee, as applicable, issues and
25 comments in writing. Id. § 5.5.2(a).

26
27 ² The following recital of facts was primarily taken,
sometimes verbatim, from Plaintiff's Statement of Undisputed
28 Facts in Opposition to Defendants' Motion for Summary Judgment.
Additional facts derive from the administrative record.

1 Claim Decision-Making Authority: The Committee and each
2 Claims Administrator and each subcommittee to whom
3 claim determination or review authority has been
4 delegated shall have full and exclusive authority and
5 discretion to grant and deny claims under the Plan,
6 including the power to interpret the Plan and determine
7 the eligibility of any individual to participate in and
8 receive benefits under the Plan. The decision of the
9 Committee or a Claims Administrator or any
10 subcommittee, as applicable, on any claim, in
11 accordance with the claim procedures set forth in this
12 Subsection 5.5, shall be final and conclusive and shall
13 not be subject to further review. Id., § 5.5.4.

14 Information to be Furnished: Employees shall provide
15 the Claims Administrator, the Plan Administrator,
16 and/or the Participating Company with such information
17 and evidence, and shall sign such documents, as
18 reasonably may be requested from time to time, for the
19 purpose of administration of the Plan. Id. § 7.1.

20 Sedgwick Claims Management Services, Inc. ("Sedgwick"), was
21 the TPA for the Plan and had no role in the Plan's funding.
22 Sedgwick was not financially associated with the Plan and
23 received a flat fee for its services, without regard to whether
24 it approved or denied claims. Employees of Sedgwick compromised
25 both the AT&T Integrated Disability Service Center ("IDSC"), a
26 unit of Sedgwick, and the Quality Review Unit ("QRU") of IDSC.

27 Once a claim for STD benefits was initiated, Sedgwick
28 assigned to the claim a case manager responsible for determining
initial eligibility and for contacting the employee and/or his
treating doctors for necessary information. Sedgwick also
notified the employee as to whether his claim has been approved
or denied, and, if approved, for what period of time.

///

///

///

///

1 Based on the language of Plan § 7.1, Defendants contend it
2 was the employee's responsibility to ensure additional medical
3 information was provided, as necessary, to allow the case manager
4 to continue evaluating the STD benefits claim to determine
5 whether to authorize STD benefits for an extended period of time.

6 Participants that disagreed with the TPA's initial decision
7 regarding benefits had the option to file an appeal pursuant to
8 the methods and procedures provided in the Plan. Upon a written
9 appeal from denial of benefits, the Plan provided that the Claims
10 Administrator must give the claimant a full and fair review of
11 the claim, the opportunity to review pertinent documents, and the
12 opportunity to submit issues and comments in writing.

13 The QRU reviewed appeals filed under the Plan. It evaluated
14 those appeals based upon the information before the IDSC in
15 making the initial decision to deny the claim, the issues and
16 comments submitted by the participant employee, and such other
17 evidence as the QRU may independently have discovered. The QRU
18 was permitted to, and did, seek assistance from independent
19 medical advisors in analyzing medical evidence.

20
21 **2. Plaintiff's Original Claim**

22
23 On March 6, 2006, Plaintiff stopped reporting to work after
24 allegedly experiencing numbness in his feet. On March 13, 2006,
25 he submitted a claim to Sedgwick for STD benefits. IDSC
26 acknowledged receipt of his claim via written correspondence.

27 ///

28 ///

1 The initial letter to Plaintiff provided the paperwork required
2 for his claim and informed him that it was his responsibility to
3 provide the necessary medical documentation substantiating his
4 medical condition.

5 On March 21, 2006, IDSC sent Plaintiff a letter approving
6 his benefits request from March 13, 2006, through April 2, 2006.
7 However, on April 7, 2006, because no additional information had
8 been received to support continued benefits, IDSC notified
9 Plaintiff that his claim was denied effective April 3.

10 Subsequently, on April 11, 2006, IDSC received a faxed
11 "Initial Physician Statement," dated March 27, and completed by
12 Randall W. Armstrong, M.D., of Sacramento Knee & Sports Medicine,
13 describing Plaintiff's then-current functional limitations as
14 "can't bend/lift/stand." That same day, IDSC received a faxed
15 copy of an "Initial Consultation" letter, also dated March 27, in
16 which Dr. Armstrong recommended that Plaintiff undergo a CT
17 myelogram to determine whether he had a disc herniation.
18 Accordingly, on April 18, IDSC approved Plaintiff's claim for an
19 extension of STD benefits through April 23. Plaintiff was
20 subsequently approved for further extensions through July 23,
21 2006.

22 During the interim, Plaintiff had back surgery and, on
23 July 27, 2006, Greg Rountree, an IDSC Disability Specialist,
24 received from Plaintiff's treating physician, Dr. Gary A.
25 Schneiderman, a fax containing progress notes dated July 6 and
26 stating that Plaintiff's "pain has remitted, although he gets
27 some occasional pain in his back. His leg pain has remitted
28 completely.

1 He does have some persistent numbness that seems to radiate down
2 the posterior aspect of the leg, like his leg is dead." The
3 doctor elaborated, "He has excellent strength. Straight leg
4 raise is negative to 60 degrees. He has decreased sensation over
5 the dorsum of the left foot. The wound shows eschar in the
6 midline. No inflammation."

7 On July 28, 2006, Mr. Rountree sent Plaintiff a letter
8 notifying him that his claim for an extension of STD benefits had
9 been approved through August 27, 2006. In that letter,
10 Mr. Rountree explained to Plaintiff that if he was not
11 sufficiently recovered to resume his job duties at the end of the
12 approved period, updated medical information was due by
13 August 22, 2006.

14 On August 24, having received no further medical information
15 regarding Plaintiff's condition, Mr. Rountree called
16 Dr. Schneiderman's office and left a message requesting updated
17 work status, including any restrictions and exam findings to
18 support those restrictions. That same day, Mr. Rountree left a
19 message for Plaintiff stating that his benefits approval would
20 expire on August 27, and that updated medical information was
21 needed to support an extension.

22 On August 25, Mr. Rountree received a voicemail from
23 Dr. Schneiderman's office stating that Plaintiff's last visit
24 with Dr. Schneiderman had been on August 22, and that, on August
25 28 or 29, a dictation would be available, but would have to be
26 requested from the medical records department.

27 ///

28 ///

1 Plaintiff also left a message for Mr. Rountree indicating that
2 medical records from Dr. Schneiderman's office would not be
3 available until August 30.

4 On August 28, Mr. Rountree called Dr. Schneiderman's medical
5 records department and left a message requesting the dictation
6 from August 22. The next day, Mr. Rountree called Plaintiff to
7 advise that no medical records had been received.

8 Finally, on August 30, 2006, Mr. Rountree sent Plaintiff a
9 letter notifying him that "after a careful and thorough review of
10 [his] request for further payment of short term disability
11 benefits..., it ha[d] been determined that [his] claim [did] not
12 qualify for payment." Mr. Rountree provided those portions of
13 the plan defining "total disability" and requiring employees to
14 provide information and evidence as requested. The IDSC employee
15 then stated that, because "[n]o additional information ha[d] been
16 received to support continued disability benefits beyond August
17 26, 2006," STD benefits were denied effective August 28.
18 Mr. Rountree advised Plaintiff that if he disagreed with the
19 determination, he could appeal to the QRU. He also provided
20 Plaintiff with the procedures to do so.

21 In that communication, Mr. Rountree made clear that "[i]n
22 order to determine ongoing disability, AT&T Integrated Disability
23 Service Center [would] need clear medical evidence that
24 support[ed] a severe functional impairment or limitation that
25 would give credence to [Plaintiff's] functional inability to
26 perform [his] job or alternative job duties available to [him]."

27 ///

28 ///

1 Mr. Rountree advised that "[t]his information may be included in
2 the following: chart or progress notes, specialist's evaluations,
3 physical therapy notes, diagnostic test results, operative
4 report(s), or any other medical information [Plaintiff felt]
5 support[ed] [his] inability to work."

6 Lastly, Mr. Rountree explained, "You shall be provided, upon
7 written request and free of charge, reasonable access to, and
8 copies of, all documents, records, and other information relevant
9 to your claim for benefits. ¶ 'Please note that your file may be
10 supplemented after we respond to your request for relevant
11 documents and such further information will be provided to you
12 upon your future request(s).'

13 Plaintiff subsequently submitted additional medical
14 information to Mr. Rountree, including Dr. Schneiderman's
15 August 22, 2006, progress notes, which stated, "His exam shows
16 wound is well-healed. Straight leg raise is negative. Good
17 strength...Follow-up in six weeks after concluding therapy. He
18 remains temporary disabled until October 15, 2006." Plaintiff
19 later faxed a "Physical Capacities Evaluation - Sedentary" form
20 completed by Dr. Schneiderman, as well as the doctor's progress
21 notes from September 21, 2006, which stated that "[o]n exam
22 today, he appears to have good strength. Straight leg raise
23 causes back pain, but no radicular symptoms...The patient has had
24 a substantial flare in his back pain after undergoing physical
25 therapy. He does not have radicular symptoms at this time."

26 ///

27 ///

28 ///

1 After each communication, Mr. Rountree sent Plaintiff a letter
2 informing him that the information received did not alter the
3 previous denial decision, and that, to have such information
4 considered, Plaintiff was required to submit an appeal to the
5 QRU.

6
7 **3. Plaintiff's Appeal to the QRU**
8

9 On November 15, 2006, Plaintiff filed a written appeal with
10 the QRU, and, on November 19, 2006, Mr. Rountree received a
11 letter dated November 3, from Phillip A. Cooke, Plaintiff's
12 counsel, requesting Plaintiff's entire disability file.

13 On December 1, 2006, after at least two unsuccessful
14 attempts to contact Mr. Cooke, Stephen Austin, an IDSC Disability
15 Specialist, reached Plaintiff's counsel by phone and informed him
16 regarding the appeal process and the finality of any decision.
17 Mr. Austin also inquired as to whether all medical information
18 had been submitted. Mr. Cooke responded that he intended to
19 review Plaintiff's file "before stating whether all medical has
20 been submitted," but that he "[did] believe all medical has been
21 submitted up to this point."

22 Several days later, on December 6, Mr. Austin spoke to
23 Valerie at Mr. Cooke's office to follow-up as to whether
24 Plaintiff planned to submit any additional medical information
25 and to inquire as to whether Plaintiff wished to toll his appeal.

26 ///

27 ///

28 ///

1 That same day, Mr. Austin received a fax from Mr. Cooke stating
2 that Plaintiff had seen Dr. Schneiderman on November 14, and was
3 waiting to be scheduled for a functional capacity evaluation
4 ("FCE"). Nevertheless, according to Mr. Cooke, Plaintiff did not
5 wish to delay the appeal by waiting for the results of that FCE.

6 On December 8, 2006, Valerie at Mr. Cooke's office again
7 confirmed in a telephone conversation with Mr. Austin that "they
8 [were] not submitting any additional medical documentation," that
9 the QRU has all the information relating to Plaintiff, and that
10 the QRU could proceed with the appeal.

11 On December 14, 2006, IDSC sent Mr. Cooke the requested copy
12 of Plaintiff's claim file.

13 On December 28, 2006, Mr. Austin left a message for Valerie
14 at Mr. Cooke's office to confirm once again that Plaintiff did
15 not want to toll his appeal in order to include Plaintiff's "op
16 report." Later that same day, Mr. Austin spoke with Valerie, who
17 informed him not to toll the appeal, but that she would contact
18 him the following day if she learned otherwise. Neither party
19 alleges Plaintiff made any later attempts to toll the appeal or
20 to submit additional medical information.

21 The QRU subsequently sought medical evaluations of
22 Plaintiff's claim from independent physician advisors.

23 On January 3, 2007, a physician board certified in Physical
24 Medicine and Rehabilitation, Dr. Saad M. Al-Shathir, M.D.,
25 completed a report for QRU, in which he concluded that "Mr. Alvis
26 is not disabled from his regular job as of 8/28/06 through
27 present."

28 ///

1 Dr. Al-Shathir further determined, "[t]here are no clinical
2 findings contained in the record provided that would impact his
3 ability to function in his sedentary job." Additionally, Dr. Al-
4 Shathir stated, "There are no documented disabling objective
5 findings. On 8/22/06 his straight leg-raising test is negative
6 with good strength. On 9/21/06 it is documented that he has some
7 residual low back pain is insignificant since he is over all
8 definitely improved and therapy was put on hold. It is not clear
9 what the purpose or goals of therapy since he has no functional
10 loss or documented inability to perform job duties to unable to
11 function in any capacity." Finally, Dr. Al-Shathir explained
12 that Plaintiff had an "uncomplicated lumber diskectomy with no
13 documented loss of function, loss of ROM or neurological deficit.
14 On 7/5/06 it is documented that his back pain is remitted
15 completely. The reported PT, which eased his back pain, is put
16 on hold. There is no documented clinical abnormality after
17 8/28/06 that would impact his ability to do sedentary job."

18 That same day, Dr. Michael J. Chmell, M.D., a licensed
19 orthopedic surgeon, also completed a report for QRU, similarly
20 concluding that "[t]his employee is not disabled from his regular
21 job from 8/28/06 through the present." Dr. Chmell determined
22 that there were "no clinical findings contained within the
23 medical record, which would impact upon the employee's ability to
24 function as of the date in question." Additionally, he stated
25 that "the patient has no documented objective findings and in
26 fact has documented normal neurologic status with no evidence of
27 recurrent radiculopathy.

28 ///

1 It is also documented that his physician has instituted
2 restrictions due to his symptomatology rather than any objective
3 findings."

4 According to Dr. Chmell, a review of the medical records
5 revealed that Plaintiff's pain and his inability to perform his
6 regular job were based on his subjective statements, and not
7 supported by objective findings. Dr. Chmell also determined the
8 office notes from Dr. Schneiderman did not provide objective
9 documentation of a functional impairment severe enough to
10 preclude Plaintiff's return to work. Dr. Chmell noted that
11 Dr. Schneiderman provided no rationale for the selection of an
12 October 15, 2006, return to work date, and he determined the
13 restriction and return to work day were selected on a "pure
14 arbitrary basis."

15 Dr. Chmell went on to conclude that the restrictions of
16 "sitting, standing, or walking for only 10 minutes at a time,"
17 were also arbitrary. He stated, "There is no documentation of a
18 functional impairment, which would cause the patient to be only
19 able to sit, stand or walk for 10 minutes at a time. No
20 objective testing is provided to support these restrictions nor
21 is there anything in the peer reviewed orthopedic or spine
22 literature, which would suggest the need for such restrictions
23 now three months following uncomplicated discectomy. These
24 restrictions illustrate the arbitrary nature by which this
25 patient's restrictions are given largely related to subjective
26 assessment of his pain and subjective assessment of functionality
27 rather than any objective findings."

28 ///

1 Dr. Chmell made similar conclusions regarding the
2 restrictions of "keyboarding, utilizing the upper extremities
3 only rarely and reaching with the upper extremities never." The
4 doctor noted, "There is no documentation at any point in the
5 medical record of any type of upper extremity impairment, which
6 would necessitate upper extremity restrictions."

7 Thus, Dr. Chmell concluded, "As of 8/22/06, the patient is
8 documented as having undergone a successful L5-S1 discectomy
9 without complications. The patient is noted to have a healed
10 incision with straight leg raising and good strength with no
11 neurologic deficit and no evidence of recurrent radiculopathy.
12 These findings support intact functionality sufficient enough to
13 return to work duties on a full-time basis."

14 After reviewing the file, including the medical evaluations,
15 Mr. Austin sent Plaintiff a letter informing him that his request
16 for appeal had been reviewed and that the decision to deny
17 benefits upheld. In that letter, Mr. Austin explained that in
18 making its determination the QRU reviewed all of the material
19 submitted by Plaintiff, all of the information that IDSC had
20 regarding the denial of STD benefits, additional documents
21 submitted during the pendency of his appeal, and the reports of
22 independent physician advisors. According to Mr. Austin's
23 letter, the determination to uphold the denial of benefits was
24 made because Plaintiff's condition did not meet the Plan's
25 definition of "total disability" with regard to STD.

26 ///

27 ///

28 ///

1 **4. Procedural History of the Litigation in this Court**

2
3 Plaintiff filed this action in Yuba County Superior Court on
4 April 17, 2007, and Defendants timely removed to this Court on
5 May 24, 2007, pursuant to 28 U.S.C. § 1331.

6 On May 9, 2008, the Court issued a Pretrial Scheduling Order
7 (“PTSO”) stating, “This case will be governed by ERISA,
8 therefore, all evidence for trial will be limited to the
9 administrative record. The parties may move to admit evidence
10 outside the administrative record.” Additionally, the Court
11 ordered that all dispositive motions were to be heard by
12 December 8, 2008, and stated, “This Status Order will become
13 final without further order of the Court unless objections are
14 filed within seven (7) court days of service of this Order.”

15 Plaintiff objected to the PTSO on grounds unrelated to the
16 present Motions, and the Court subsequently issued an Amended
17 PTSO leaving the aforementioned directives unchanged.

18 On October 28, 2008, citing calendar conflicts, the parties
19 filed a Joint Stipulation to Extend Time for Hearings on Motions
20 from December 8, 2008, to January 23, 2009, which this Court
21 approved on October 30, 2008.

22 On November 26, 2008, Plaintiff propounded upon Defendants
23 Interrogatories, Requests for Production of Documents, and a
24 Notice to Take the Deposition of Defendants’ Person Most
25 Knowledgeable. Defendants objected to each discovery request on
26 the grounds that evidence was limited to the administrative
27 record, and, thus, on December 30, 2008, Plaintiff filed the
28 instant Motion to Clarify or Amend the Pretrial Order.

1 Shortly thereafter, on January 9, 2009, Defendants filed their
2 Motion for Summary Judgment. Hearing on these Motions was
3 scheduled on February 6, 2009, and both were submitted without
4 oral argument. The Court will now address each Motion in turn.

5
6 **ANALYSIS**

7 **I. AMEND/CLARIFY PTSO**

8
9 Plaintiff seeks to clarify or amend the PTSO as to his ERISA
10 claims to permit discovery and the admission of evidence outside
11 of the administrative record. According to Plaintiff, discovery
12 is necessary to determine the existence of any conflicts of
13 interest or procedural irregularities that would inform the
14 standard of review applicable to, *inter alia*, Defendants' instant
15 Motion for Summary Judgment.

16 To the extent Plaintiff seeks to clarify the PTSO, his
17 Motion is denied. The Court twice stated, "This case is governed
18 by ERISA, therefore, all evidence for trial will be limited to
19 the administrative record. The parties may move to admit
20 evidence outside the administrative record." PTSO, 2:2-4;
21 Amended PTSO, 1:25-27. These limitations are unambiguous.
22 Consequently, no further clarification is necessary.

23 Additionally, no good cause having been shown, Plaintiff's
24 Motion to Amend the PTSO is denied as well. The Court is
25 normally required to enter a pretrial scheduling order within 120
26 days of the filing of the complaint. Fed. R. Civ. P. 16(b). The
27 scheduling order "controls the subsequent course of the action"
28 unless modified by the Court. Fed. R. Civ. P. 16(e).

1 Orders entered before the final pretrial conference may be
2 modified upon a showing of "good cause."

3 Rule 16(b)'s "good cause" standard primarily considers the
4 diligence of the party seeking the amendment. Johnson v. Mammoth
5 Recreations, 975 F. 2d 604, 609 (9th Cir. 1992). The district
6 court may modify the pretrial schedule "if it cannot reasonably
7 be met despite the diligence of the party seeking the extension."
8 Fed. R. Civ. P. 16 advisory committee's notes (1983 amendment);
9 Id. Moreover, carelessness is not compatible with a finding of
10 diligence and offers no reason for a grant of relief. Id.
11 Although the existence or degree of prejudice to the party
12 opposing the modification might supply additional reasons to deny
13 a motion, the focus of the inquiry is upon the moving party's
14 reasons for seeking modification. If that party was not
15 diligent, the inquiry should end. Id.

16 Plaintiff failed to exercise the requisite diligence in
17 seeking to amend the PTSO. While Plaintiff objected to the
18 original order on unrelated grounds, no further objections were
19 had, and the Amended PTSO became final seven court days following
20 service of the second order. Thus, Plaintiff twice relinquished
21 opportunities to object to the limiting provision, and also
22 failed, at any time prior to his December 30, 2008, Motion to
23 Clarify or Amend, to move to admit additional evidence.

24 ///

25 ///

26 ///

27 ///

28 ///

1 Instead, Plaintiff waited until November 26, 2008, to begin
2 to pursue discovery and then waited an additional month to file
3 any motion before this Court. Notably, had the parties not
4 stipulated to continue the December 8, 2008, deadline for hearing
5 dispositive motions, Plaintiff's November and December discovery
6 attempts would clearly have been untimely. Consequently, the
7 Court finds that by waiting to pursue his current request until
8 December 30, 2008, months after the issuance of the Amended PTSO
9 and just shy of the continued motion hearing deadline, Plaintiff
10 did not exercise the diligence necessary to now justify such
11 amendment.

12 Furthermore, even if Plaintiff was able to show the
13 requisite diligence, he makes only speculative claims that the
14 additional evidence "will help the court determine what the test
15 for review of the administrative record is, will help the court
16 determine whether there are potential conflicts of interest, and
17 may shed light on what is in the administrative record." Motion
18 to Clarify/Amend, 4:6-10. Plaintiff further claims that "[t]he
19 Motion for Summary Judgment raises several red flags of conflict
20 of interest and bias which should be explored." Reply in Support
21 of Motion to Clarify or Amend, 1:26-27.

22 Plaintiff specifically alleges that "[i]t is unknown whether
23 the 'flat fee' [paid to Sedgwick] [was] significant enough to
24 influence decision-making." Id., 2:3-4. Plaintiff also
25 questions whether various supervisory relationships may have
26 created conflicts and claims the independent medical reviews may
27 be the result of bias.

28 ///

1 Finally, Plaintiff contends that additional discovery might
2 evidence whether Defendants properly filed the bylaws and
3 regulations adopted for the enforcement of the plan. Plaintiff's
4 speculation is simply insufficient to justify amendment of the
5 PISO at this time.³ Thus, Plaintiff's Motion to Clarify or Amend
6 is hereby denied.

7
8 **II. DEFENDANTS' MOTION FOR SUMMARY JUDGMENT**

9
10 Defendants move for summary judgment, or in the alternative,
11 summary adjudication, as to each of Plaintiff's causes of action.
12 In evaluating Defendants' Motion, the Court will determine
13 whether Sedgwick abused its discretion when it upheld the denial
14 of Plaintiff's claim for STD benefits, whether Plaintiff's state
15 law claims are preempted by ERISA, and whether Plaintiff is
16 barred from seeking extra-contractual damages in an ERISA case.

17
18 ³ See Gough v. Pacific Telesis Group Comprehensive
19 Disability Benefits Plan, 2007 WL 4531695, *1 (E.D. Cal. 2007)
20 ("There is no evidence that any exercise of discretion in the
21 decision-making process below was tainted by a conflict of
22 interest. Plaintiff's arguments in this regard are purely
23 speculative. Therefore, Plaintiff's request for additional
24 discovery regarding potential conflicts of interest is denied.");
25 see also Bartholomew v. UNUM Life Insurance Co., 579 F. Supp. 2d
26 1339, 1342 (W.D. Wash. 2008) ("Further damaging Plaintiff's
27 position here is that in the final analysis her discovery request
28 is little more than a fishing expedition. There are no
allegations of actual conflicts or irregularities in her
proceedings, and Plaintiff's position boils down to 'because
Abatie permits the court to consider information outside the
record if there is evidence of conflict of interest, I should be
permitted to engage in wide-ranging discovery to find evidence of
such a conflict.' This is an unwarranted expansion of the Abatie
rationale, and Plaintiff presents no case support for it.
Furthermore, the request flies in the face of the principles of
streamlining and efficiency that underlie the ERISA statutory
scheme.").

1 **A. Whether Sedgwick Abused Its Discretion in Denying**
2 **Plaintiff's Claim for STD Benefits**

3
4 "A denial of benefits challenged under 29 U.S.C.
5 § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless
6 the benefit plan gives the administrator or fiduciary
7 discretionary authority to determine eligibility for benefits or
8 to construe the terms of the plan. Where the plan vests such
9 discretionary authority in the administrator or fiduciary, the
10 Court reviews the denial of benefits under the Plan for an abuse
11 of discretion. However, in order for the abuse of discretion
12 standard to apply, the Plan must unambiguously grant discretion."
13 Frost v. Metropolitan Life Ins. Co., 470 F. Supp. 2d 1101, 1107
14 (C.D. Cal. 2007) (internal quotations and citations omitted).

15 In this case, it is undisputed that the Plan unambiguously
16 vests discretionary authority in the Claims Administrator such
17 that application of the abuse of discretion standard is
18 appropriate. However, the existence of a conflict of interest or
19 procedural irregularity may alter the lens through which the
20 Court evaluates the instant decision to deny benefits. Abatie v.
21 Alta Health & Life Ins. Co., 458 F.3d 955, 970-971 (9th Cir.
22 2006).

23 As previously discussed, Plaintiff's supposition that there
24 may have been either a conflict or procedural irregularity is
25 merely speculative. Indeed, the record is devoid of facts
26 supporting the conclusion that a conflict of interest informed
27 the decision-making in this case.

28 ///

1 Furthermore, the Court is able to discern from Plaintiff's
2 interpretation of the relevant facts the potential existence of
3 only two alleged procedural irregularities.⁴ Specifically,
4 Plaintiff's Opposition can be construed to allege: 1) that
5 Defendants' ultimate decision to uphold the denial of STD
6 benefits was based on reasons not provided in the original August
7 30, 2006, denial; and 2) that Sedgwick did not provide him with
8 unambiguous notice of the reasons for the August decision.

9 First, Plaintiff appears to argue that he was initially
10 denied benefits for failing to timely provide medical records,
11 but that the decision to uphold the denial of his claim was based
12 on a subsequent determination that he was no longer totally
13 disabled. "When an administrator tacks on a new reason for
14 denying benefits in a final decision, thereby precluding the plan
15 participant from responding to that rationale for denial at the
16 administrative level, the administrator violates ERISA's
17 procedures." *Abatie*, 458 F.3d at 974. However, in his
18 August 30, 2006, correspondence, Mr. Rountree made clear that,
19 based on the records in Plaintiff's file, Plaintiff was no longer
20 considered totally disabled under the Plan. Plaintiff was
21 thereafter put on notice that specific medical information
22 establishing his disabled status was required, and that
23 requirement remained consistent throughout the duration of his
24 appeal.

25 ///

26
27 ⁴ In arguing that the denial of benefits was unfair or
28 unjust, Plaintiff seems to have stumbled upon potential legal
arguments, despite his complete failure to cite to any applicable
legal authority in his Opposition.

1 Therefore, this Court finds that Plaintiff's STD benefits were
2 denied both in August, 2006, and January, 2007, because the QRU
3 determined the evidence in the record did not support a finding
4 that he was "totally disabled" as required by the Plan.

5 Plaintiff next argues that the TPA's August denial letter
6 and its subsequent correspondence were ambiguous, making it
7 impossible for Plaintiff to determine whether his claim was
8 denied because he was untimely in submitting medical records or
9 because the medical records were insufficient. "If benefits are
10 denied in whole or in part, the reason for the denial must be
11 stated in reasonably clear language, with specific reference to
12 the plan provisions that form the basis for the denial; if the
13 plan administrators believe that more information is needed to
14 make a reasoned decision, they must ask for it." *Booton v.*
15 *Lockheed Medical Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997).
16 "[A] meaningful dialogue between ERISA plan administrators and
17 their beneficiaries" is required. *Id.* Sedgwick here made
18 numerous attempts to engage in such a dialogue.

19 In his August letter Mr. Rountree stated, in pertinent part,
20 "Please be advised that after a careful and thorough review of
21 your request for further payment of short term disability
22 benefits under the AT&T Disability Income Plan, it has been
23 determined that your claim does not qualify for payment. As a
24 result, benefits are denied effective 8/28/06 through your return
25 to work date." AR 0222.

26 ///

27 ///

28 ///

1 Mr. Rountree then provided the Plan definition of "Total
2 Disability" and confirmed that he had received information
3 evidencing Plaintiff's total disability through the period ending
4 August 27, but had yet to receive any information indicating
5 Plaintiff remained so disabled thereafter. Finally, Mr. Rountree
6 further advised Plaintiff:

7 In order to determine ongoing disability, AT&T
8 Integrated Disability Service Center will need clear
9 medical evidence that supports a severe functional
10 impairment or limitation that would give credence to
11 your functional inability to perform your job or
12 alternate job duties available to you. This
13 information may be included in the following: chart or
14 progress notes, specialist's evaluations, physical
15 therapy notes, diagnostic test results, operative
16 report(s), or any other medical information you feel
17 supports your inability to work.

18 AR 0223.

19 Accordingly, this Court finds that Mr. Rountree's
20 communication clearly stated the reason for denial of Plaintiff's
21 benefits, specifically that the record did not support the
22 finding that Plaintiff remained "totally disabled."

23 This Court's conclusion is bolstered by the fact that, prior
24 to issuance of the August denial letter, Plaintiff was already on
25 notice that his claim had been approved only through August 23.
26 Indeed, Plaintiff had received written correspondence to that
27 effect, and, before his claim was formerly denied, Mr. Rountree
28 made numerous additional attempts to reach both Plaintiff and
29 Plaintiff's treating physician to allow them to supplement the
30 record. Only when no such evidence was forthcoming, did
31 Mr. Rountree deny Plaintiff's claim.

32 ///

33 ///

1 Plaintiff subsequently submitted additional information to
2 Mr. Rountree on several occasions in September and October. Each
3 time, Mr. Rountree notified Plaintiff that the after-filed
4 information did not change his decision, and that, should
5 Plaintiff wish to have that information considered, he needed to
6 file an appeal with the QRU.

7 After Plaintiff finally filed his appeal, Mr. Austin, from
8 the QRU, also contacted Plaintiff's counsel on numerous occasions
9 to inquire as to whether Plaintiff would be submitting additional
10 medical information. Plaintiff was also given the opportunity to
11 toll his appeal while he gathered such evidence, but he
12 affirmatively rejected such an option, choosing to submit his
13 claim on the existing record instead.⁵

14 This Court finds the above correspondence sufficient to
15 qualify as meaningful dialogue. Consequently, no procedural
16 irregularity will affect the applicable standard of review, and
17 the Court will review the denial of Plaintiff's claim for an
18 abuse of discretion, affording great deference to the decision of
19 the Claims Administrator.

20 ///

21 ///

22 ///

23 ///

24
25 ⁵ Plaintiff contends he would have chosen differently had he
26 been privy to the evaluations of Sedgwick's independent medical
27 advisors. However, as discussed below, Sedgwick operated well
28 within its discretion to seek medical review of the record before
reaching its conclusion to uphold denial of benefits, and
Plaintiff was not legally entitled to review those documents
prior to a decision being rendered.

1 "An ERISA fiduciary is obligated to guard the assets of the
2 Plan from improper claims, as well as to pay legitimate claims.
3 [The] deferential [abuse of discretion] standard of review
4 furthers a primary goal of ERISA, which endeavors to provide a
5 method for workers and beneficiaries to resolve disputes over
6 benefits inexpensively and expeditiously." Boyd v. Bert
7 Bell/Pete Rozelle NFL Players Retirement Plan, 410 F.3d 1173,
8 1178 (9th Cir. 2005) (internal citations and quotations omitted).
9 Thus, "[a]n ERISA administrator abuses its discretion only if it
10 (1) renders a decision without explanation, (2) construes
11 provisions of the plan in a way that conflicts with the plain
12 language of the plan, or (3) relies on clearly erroneous findings
13 of fact." Id. (internal citations and quotations omitted).

14
15 **1. Defendants Did Not Render a Decision Without**
16 **Explanation**

17 Plaintiff does not argue that his claim was denied without
18 reason. To the extent Plaintiff claims ambiguity in the
19 communications he received during the claim and appeal process,
20 his argument has already been rejected. Thus, this Court finds
21 that Sedgwick did not abuse its discretion by rendering a
22 decision without explanation in either its August 30, 2006, or
23 January 3, 2007, correspondence.

24 ///

25 ///

26 ///

27 ///

28 ///

1 **2. Defendants Did Not Construe the Plan in a Manner**
2 **that Conflicts with its Plain Language**

3 Plaintiff's Opposition can feasibly be construed to make two
4 arguments regarding Defendants' allegedly improper interpretation
5 of the Plan. First, Plaintiff appears to argue that, absent
6 appropriate notice to him, Defendants improperly relied on a lack
7 of objective findings in the record to deny him STD benefits.
8 Plaintiff also contends that, contrary to Plan requirements,
9 Sedgwick failed to allow him adequate opportunity to rebut the
10 conclusions of its independent medical advisors.

11 To the extent Plaintiff argues that Sedgwick acted contrary
12 to the plain language of the Plan by denying Plaintiff's claim
13 for STD benefits due, in part, to a lack of objective findings
14 indicating his inability to work, his argument must fail.
15 Sedgwick did not evaluate the evidence in the record in a manner
16 contrary to the Plan terms.

17 "ERISA rules of construction govern the interpretation of
18 the term 'total disability.' Accordingly, the burden of proof is
19 on the insured to show that [he] is totally disabled under the
20 Policy definition." Seleine v. Fluor Corp. Long-Term Disability
21 Plan, --- F. Supp. 2d ----, 2009 WL 377131, at *10 (C.D. Cal.).
22 Because the Plan defines "total disability" as an illness or
23 injury coupled with a consequent inability to work, Plaintiff's
24 burden here encompasses two distinct prongs.

25 ///

26 ///

27 ///

28 ///

1 Typically, "[a] plan administrator cannot exclude a claim
2 for lack of objective medical evidence unless the objective
3 medical evidence standard was made clear, plain and conspicuous
4 enough in the policy to negate layman plaintiff's objectively
5 reasonable expectations of coverage." Moody v. Liberty Life
6 Assurance Co. of Boston, --- F. Supp. 2d ----, 2009 WL 192889, at
7 *7 (N.D. Cal.) (internal citations and quotations omitted).
8 Nevertheless, "an administrator is not prohibited from taking
9 into account the fact that there is a lack of objective
10 evidence."⁶ Id. Furthermore, "numerous Courts have concluded
11 that an administrator does not abuse its discretion by requiring
12 objective evidence of an inability to function in the workplace."
13 Seleine, 2009 WL 377131 at *12 (citations omitted). Accordingly,
14 this Court holds that Sedgwick operated well within the
15 discretion granted to it under the Plan when it based denial of
16 Plaintiff's claim, at least in part, on a lack of objective
17 evidence supporting his claim of his total disability.

18 Plaintiff's related argument that the TPA failed to provide
19 him proper notice of its intent to rely on objective findings, or
20 a lack thereof, similarly fails. Sedgwick notified Plaintiff on
21 numerous occasions that additional evidence of his continued
22 disability was required.

23 ///

24
25 ⁶ Accurately described, Sedgwick in this case merely took
26 into account the fact that the record was devoid of objective
27 evidence supporting Plaintiff's disabled status. In fact,
28 objective evidence did exist, but that evidence pointed toward a
finding that Plaintiff was capable of returning to work. Thus,
it was quite proper for the TPA to consider the lack of any
contradictory objective evidence in reaching its conclusion.

1 First, the Plan itself provided Plaintiff notice that his
2 claim must be medically substantiated and that he was required to
3 submit evidence supporting that claim. See Plan § 2.12 (injury
4 defined as "job and non-job related trauma or damage to the
5 physical person of an Employee medically substantiated and
6 treated by a Physician which renders an Employee
7 incapacitated..."); see also Plan § 7.1 ("Employees shall provide
8 the Claims Administrator, the Plan Administrator, and/or the
9 Participating Company with such information and evidence, and
10 shall sign such documents, as reasonably may be requested from
11 time to time, for the purpose of administration of the Plan.").

12 Furthermore, in the very first correspondence from IDSC to
13 Mr. Alvis, the TPA representative stated, "To qualify for benefit
14 payments under the AT&T disability plans, your medical condition
15 should involve a sickness or injury, supported by medical
16 documentation that prevents you from performing the duties of
17 your job with or without reasonable accommodations." AR 0095.

18 In that letter, IDSC further informed Mr. Alvis as follows:

19 It is your responsibility to sign the Authorization to
20 Release Medical Information form and to provide that
21 authorization form with the Instructions to the
22 Physician, the Initial Physician Statement and the
23 enclosed self-addressed envelope to your physician. It
24 is important that both you and your treatment provider
25 understand that these forms, along with chart notes,
26 diagnostic test results, hospital summaries, etc.
27 specifically related to the reason of your absence
28 should be returned regardless of the length of your
disability. It is critical that your physician
demonstrates by his/her observations and clinical
findings that you are unable to perform your work with
or without accommodations. This is the information,
which will allow the case manager to make a
determination of your eligibility for benefit payments
under the AT&T Disability Plans.

...

1 If the medical documentation received from your
2 treatment provider does not contain information that
3 establishes that your condition prevents you from
4 performing the duties of your job with or without
reasonable accommodations, your claim will not qualify
for benefit payments under the AT&T disability plans.

5 AR 0095-0096.

6 Numerous of Defendants' subsequent communications to
7 Plaintiff, including the August 30 denial of benefits dated, also
8 contained instructions that "[i]n order to determine ongoing
9 disability, AT&T Integrated Disability Service Center will need
10 clear medical evidence that supports a severe functional
11 impairment or limitation that would give credence to your
12 functional inability to perform your job or alternate job duties
13 available to you. This information may be included in the
14 following: chart or progress notes, specialist's evaluations,
15 physical therapy notes, diagnostic test results, operative
16 report(s), or any other medical information you feel supports
17 your inability to work." AR 0223. Thus, on multiple occasions,
18 Plaintiff received actual notice that further approval of
19 benefits was contingent upon the provision of evidence
20 sufficiently supporting his treating physician's conclusion that
21 Plaintiff was physically unable to work. Any attempt to argue
22 otherwise is rejected, and this Court finds Sedgwick did not
23 improperly interpret applicable evidentiary requirements contrary
24 to Plan provisions.

25 ///

26 ///

27 ///

28 ///

1 Plaintiff finally challenges, as contrary to the terms of
2 the Plan, his inability during the appeal process, to rebut the
3 conclusions of Defendants' independent medical advisors.
4 Plaintiff's argument is based on the premise that, after he
5 determined not to submit any further evidence, Defendants
6 continued to supplement the administrative record without notice
7 to him. Plaintiff bases his argument on Plan language stating:

8 Upon the written request of a claimant or his duly
9 authorized representative, received by the Committee or
10 the Claims Administrator or the subcommittee to whom
11 claim review authority has been assigned not more than
12 sixty (60) days after the date of mailing or delivery
13 of written notice of denial of such claim, the
14 Committee or the Claims Administrator or the delegated
15 subcommittee, as applicable, is required to give such
16 claimant or his authorized representative a full and
17 fair review of the claim, the opportunity to review
18 pertinent documents, and the opportunity to submit to
19 the Committee or the Claims Administrator or the
20 delegated subcommittee, as applicable, issues and
21 comments in writing. Plan § 5.5.2(a).

22 According to Plaintiff, he was not afforded the opportunity to
23 review pertinent documents because he was not provided the
24 independent physicians' reports prior to the QRU rendering its
25 decision. Plaintiff's argument must fail.

26 In Silver v. Executive Car Leasing Long-Term Disability
27 Plan, a plaintiff similarly argued that the administrator
28 "unfairly kept the record open for itself after closing the
29 record to him." 466 F.3d 727, 732 n.2 (9th Cir. 2006). The Ninth
30 Circuit stated:

31 ///

32 ///

33 ///

34 ///

1 [T]here is no other way that [the administrator] could
2 have addressed [the claimant's] appeal except by
3 waiting until he had submitted all of his material.
4 Simply put, in order for [the administrator] to
5 evaluate [the claimant's] administrative appeal fairly,
6 it *had* to wait until [the claimant] had submitted all
7 of his materials; for [the administrator] to do
8 otherwise would either undermine [the claimant's]
9 ability to present all of his supporting information or
10 lead to an interminable back-and-forth between the plan
11 administrator and the claimant. Further, the paperwork
12 generated by [the administrator] in the course of its
13 review was fully disclosed to [the claimant] during
14 trial at the district court, at which point [the
15 claimant] had ample opportunity to respond.

16 Id. (emphasis in original). Plaintiff cites no contrary
17 authority supporting his proposition that Defendants were
18 required to provide their independent reviewing physician's
19 reports to Plaintiff prior to rendering the decision on his
20 appeal.⁷

21 Plaintiff likewise points to no authority, and no logical
22 interpretation of the Plan, supporting a more general conclusion
23 that, since a copy of his file had previously been provided to
24 him, Defendants were required to send him each and every
25 additional entry or document generated during the ongoing claims
26 review.

27 ///

28 ///

///

///

25 ⁷ Plaintiff also implies that the TPA's physicians should
26 have examined Plaintiff or sought additional information from
27 Plaintiff's physician. However, "there is no statutory or other
28 requirement that [the Claims Administrator's] consultants must
examine Plaintiff or consult with Plaintiff's treating physicians
prior to rendering their opinions." Frost, 470 F. Supp. 2d. at
1108.

1 Not only would that be impractical, but, under the terms of the
2 Plan and as Plaintiff was informed throughout the process,
3 Plaintiff was himself required to request pertinent documents,
4 and was not entitled to assume Defendants would automatically
5 update him on any regular basis.⁸ Accordingly, for the above
6 reasons, the Court finds that Sedgwick did not improperly
7 supplement the administrative record contrary to the terms of the
8 Plan.

9 Thus, all arguments that Sedgwick construed the Plan in a
10 manner that conflicted with its plain language are rejected, and
11 the Court finds no abuse of discretion on this ground.

12
13 **3. Defendants Did Not Deny Plaintiff's Claim for**
14 **Benefits Based on Clearly Erroneous Findings of**
15 **Fact**

16 The crux of the parties' dispute ultimately turns on the
17 determination of whether the TPA's decision was clearly
18 erroneous. "Trust principles make a deferential standard of
19 review appropriate when a trustee exercises discretionary
20 authority."

21 ///

22
23 ⁸ On numerous occasions, Plaintiff was provided actual
24 notice that the administrative record could be supplemented after
25 the date a copy was issued to him. Specifically, in his
26 August 30, 2006, letter, and those issued thereafter,
27 Mr. Rountree stated, "You shall be provided, upon written request
28 and free of charge, reasonable access to, and copies of, all
documents, records, and other information relevant to your claim
for benefits. ¶ 'Please note that your file may be supplemented
after we respond to your request for relevant documents and such
further information will be provided to you upon your future
request(s).'" AR 0223.

1 Jordan v. Northrop Grumman Corp. Welfare Benefit Plan, 370 F.3d
2 869, 879 (9th Cir. 2004), quoting Firestone Tire and Rubber Co.
3 v. Bruch, 489 U.S. 101, 111 (1989). "Deferential review, of
4 course, does not mean no review. If the administrator's decision
5 is arbitrary, ...the administrator's decision fails the 'fair
6 review' requirement of the statute. But as long as the record
7 demonstrates that there is a reasonable basis for concluding that
8 the medical condition was not disabling, the decision cannot be
9 characterized as arbitrary, and [the Court] must defer to the
10 decision of the plan administrator." Id.

11 In Jordan, as here, "[t]he administrator...had conflicting
12 reports from [Plaintiff's] treating physician and [Defendants']
13 reviewing physicians. This is typical of the evidence used in
14 disability determinations. Reasonable people can disagree on
15 whether [Plaintiff] was 'disabled' for purposes of the ERISA
16 plan. Because that is so, the administrator cannot be
17 characterized as acting arbitrarily in taking the view that [he]
18 was not." Id. at 880.

19 "Without taking upon [itself] the judgment of [Plaintiff's]
20 disability, [the Court] must nonetheless look to the record to
21 determine whether there is a reasonable basis for the
22 administrator's conclusion that [Plaintiff] was not disabled."
23 Id. "A finding is clearly erroneous when although there is
24 evidence to support it, the reviewing body on the entire evidence
25 is left with the definite and firm conviction that a mistake has
26 been committed. [The Court] will uphold the decision of an ERISA
27 plan administrator 'if it is based upon a reasonable
28 interpretation of the plan's terms and was made in good faith.'"

1 Boyd, 410 F.3d at 1178, quoting Estate of Shockley v. Alyeska
2 Pipeline Serv. Co., 130 F.3d 403, 405 (9th Cir. 1997). Based on
3 the evidence before it, this Court is left with no conviction
4 that a mistake was made here.

5 First, as a threshold matter, Plaintiff never makes the
6 claim that no reasonable basis exists to support Sedgwick's
7 decision. Instead, Plaintiff simply seems to seek *de novo* review
8 of a benefits determination with which he disagrees. Plaintiff
9 argues that:

10 It is noted that Plaintiff first went off work with
11 substantial symptoms of pain. His original x-ray was
12 negative. However upon appropriate further testing, it
13 was established that there was not only good reason for
14 the pain, but a surgical lesion that could be helped.
15 Thus, the pain that Plaintiff was complaining of had
16 been born out by objective tests. The Plaintiff's
17 complaints of pain which were subjective were verified
18 by objective evidence. Further, the applicant had
19 objective evidence showing the need for surgery
20 including neurological changes, weakness, numbness, and
21 radicular pain. There is nothing in the record to
22 reflect that the applicant was feigning an illness or
23 genuinely did not suffer the pain described.

24 ...

25 [F]urther close review of the medical reports used to
26 decide the appeal reflect that they were not objective
27 and omitted significant findings. This was a repeat
28 surgery or second surgery at the same level, which
means more scar tissue and a much higher risk for
increasing long-term pain and a failed back syndrome.

29 Opposition, 4:20-5:17. According to this and Plaintiff's other
30 arguments, he disagrees with the evaluations performed by the
31 independent medical advisors and the decision reached by the QRU.
32 Nevertheless, as stated above, even if reasonable people could
33 disagree as to whether Plaintiff was disabled, such disagreement
34 is insufficient to constitute an abuse of discretion.

1 Notably, in reaching his conclusion as to his own level of
2 disability, Plaintiff relies primarily on those portions of the
3 administrative record that Defendants actually used to originally
4 grant Plaintiff's claim through most of 2006. However, the issue
5 before the IDSC and the QRU on August 30, 2006, and thereafter,
6 was not whether Plaintiff had been injured at some prior time.
7 Rather, after the approval of Plaintiff's benefits claim expired
8 at the end of August, both the IDSC and the QRU reviewed the
9 record to determine whether Plaintiff had adequately supported
10 his claim that he continued to remain so disabled. Both units
11 determined he had not. While the prior reports are informative
12 as to the injury Plaintiff originally sustained, they are not
13 indicative of his capabilities at the end of August.

14 To the contrary, though "[t]he medical information indicated
15 that [Plaintiff] received treatment for back pain with radiation
16 status post diskectomy," the QRU apparently relied more heavily
17 on other evidence, such as later evaluations, that concluded none
18 of the documented findings were "so severe as to prevent
19 [Plaintiff] from performing the duties of [his] job...with or
20 without reasonable accommodation from August 28, 2006 through to
21 [his] return to work." AR 0403-0404.

22 Similarly, while the QRU was privy to post-surgery
23 subjective physical complaints Plaintiff made to his treating
24 physician, it also had before it additional documentation
25 indicating that, on August 22, 2006, Plaintiff's straight leg
26 raise test was negative with good strength.

27 ///

28 ///

1 He had residual pain in his lower back that Sedgwick's medical
2 examiner determined was "insignificant since he [was] over all
3 definitely improved and therapy was put on hold." AR 0282.
4 Plaintiff had no documented loss of function and both his back
5 and leg pain were remitted. Thus, not only were objective
6 findings of total disability lacking, but the clinical evidence
7 in the record actually indicated, *inter alia*, that Plaintiff had
8 "documented normal neurologic status with no evidence of
9 recurrent radiculopathy." AR 0285. Accordingly, while Plaintiff
10 did claim to continue to experience some pain, Sedgwick operated
11 well within its grant of discretion to reasonably weigh the
12 evidence and to reach a conclusion that Plaintiff was no longer
13 disabled.

14 Consistent with its conviction that there was no abuse of
15 discretion by the Claims Administrator, the Court is compelled to
16 point out that, to a great extent, Plaintiff's current claims
17 boil down to an expression of his disagreement with the TPA's
18 refusal to afford greater deference to his treating physician's
19 conclusions regarding his level of disability than to other
20 evidence. However, Plaintiff's position is contrary to the law.

21 "Plan administrators...may not arbitrarily refuse to credit
22 a claimant's reliable evidence, including the opinions of a
23 treating physician. But...courts have no warrant to require
24 administrators automatically to accord special weight to the
25 opinions of a claimant's physician; nor may courts impose on plan
26 administrators a discrete burden of explanation when they credit
27 reliable evidence that conflicts with a treating physician's
28 evaluation."

1 Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003).
2 In fact "[u]nder ERISA, an administrator is not free to accept a
3 conclusion in a medical report without considering whether that
4 conclusion follows logically from the underlying medical
5 evidence...[a claims administrator is] duty bound to conduct its
6 independent investigation of [Plaintiff's] disability claim."
7 Seleine, 2009 WL 377131 at *12.

8 In this case, based in part on the evaluations of the
9 independent medical examiners, the Claims Administrator
10 determined that the conclusion reached by Plaintiff's treating
11 physician was not supported by the objective findings. The
12 Claims Administrator appropriately refused to accept such a
13 conclusion without independently examining the underlying
14 evidence. It was not only proper, but necessary in order to
15 fulfill its obligations, for the TPA to do so.

16 Finally, it is of no small import that the records of
17 Plaintiff's treating physician on which Plaintiff would have the
18 TPA rely are largely no more than a reiteration of Plaintiff's
19 subjective complaints. Plaintiff's allegations are not medical
20 "findings." See Id. ("[Plaintiff's] attempts to elevate these
21 notes of a patient's self-report to the status of "findings" is
22 inappropriate. Doctors have an affirmative obligation to record
23 the symptoms complained of by their patients...[T]hese complaints
24 were subject to verification by objective medical evidence. [The
25 Administrator] was under no obligation to accept them at face
26 value."). Thus, the QRU was not required to accept Plaintiff's
27 own description of his pain or limitation as binding.

28 ///

1 Quite the opposite, Defendants were under an obligation to
2 provide full and fair review of Plaintiff's claims, which
3 included enlisting the advice of independent physicians to
4 evaluate all of the evidence in the record.

5 In conclusion, though Plaintiff may have a plausible
6 argument that reasonable people could disagree as to whether or
7 not he was "totally disabled" in August 2006, that is not the
8 standard by which this Court is bound. Instead, this Court finds
9 the denial of benefits in this case was based on a good faith and
10 reasonable interpretation of the evidence. Thus, Sedgwick did
11 not abuse its discretion.

12 In sum, the record simply does not support the conclusion
13 that Defendants "rendered a decision without explanation,
14 construed provisions of the plan in a way that conflicts with the
15 plain language of the plan, or relied on clearly erroneous
16 findings of fact." Consequently, Defendants' Motion for Summary
17 Judgment as to Plaintiff's ERISA claims is granted.

18
19 **B. Whether Plaintiff's Claims for Breach of Contract and**
20 **Breach of the Implied Covenant of Good Faith and Fair**
21 **Dealing Are Preempted by ERISA**

22 Defendants argue that Plaintiff's common law claims cannot
23 survive the instant Motion because those claims are preempted by
24 ERISA.⁹

25 ///

26 _____
27 ⁹ The Court's remaining discussion is subject to traditional
28 summary judgment analysis. However, because only purely legal
issues remain, no further elaboration on that legal standard is
required.

1 Section 514(a) of ERISA provides, "Except as provided in
2 subsection (b) of this section, the provisions of this subchapter
3 and subchapter III of this chapter shall supersede any and all
4 State laws insofar as they may now or hereafter relate to any
5 employee benefit plan described in section 1003(a) of this title
6 and not exempt under section 1003(b) of this title." 29 U.S.C.
7 § 1144(a). To the extent Plaintiff raises breach of contract or
8 tort claims in his First Amended Complaint, it is undisputed that
9 those claims are preempted by ERISA because they "relate to" an
10 employee benefit plan. See Pilot Life Ins. Co. v. Dedeaux, 481
11 U.S. 41, 48 (1987) (noting that "[t]he common law causes of
12 action raised in [plaintiff's] complaint, each based on alleged
13 improper processing of a claim for benefits under an employee
14 benefit plan, undoubtedly meet the criteria for pre-emption under
15 § 514(a)."), overruled on other grounds by Kentucky Ass'n of
16 Health Plans, Inc. v. Miller, 538 U.S. 329 (2003). Accordingly,
17 Defendants' Motion for Summary Judgment as to Plaintiff's state
18 law claims is granted.

19
20 **C. Whether Plaintiff is Barred from Seeking Extra-**
21 **Contractual or Compensatory Damages in an ERISA case**

22 Defendants contend that Plaintiff is unable to recover
23 punitive damages or damages for emotional distress in this ERISA
24 action. Because the Court has already disposed of all of
25 Plaintiff's causes of action, Defendants' Motion for Summary
26 Adjudication as to these remedies is denied as moot.

27 ///

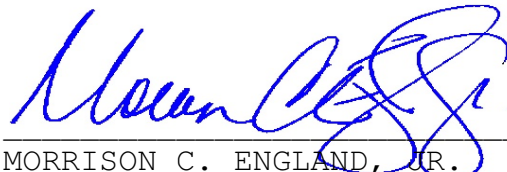
28 ///

CONCLUSION

Plaintiff's Motion to Clarify or Amend the P.T.S.O. is DENIED. Defendants' Motion for Summary Judgment is GRANTED, and the Clerk of the Court is directed to close the file.

IT IS SO ORDERED.

Dated: April 14, 2009



MORRISON C. ENGLAND, JR.
UNITED STATES DISTRICT JUDGE

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28