UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
GREENVILLE DIVISION

Wanda Stacy, Plaintiff, v. Verizon Wireless Managed Short Term Disability Plan, Defendant.	)	C/A No.:6:06-cv-3506-GRA **ORDER** (Written Opinion)

This matter comes before the Court on Wanda Stacy's (Plaintiff's) October 30, 2006 complaint alleging an entitlement to Short Term Disability (STD) benefits under the STD component of the Defendant Verizon Wireless Disability Plan (Plan), pursuant to 29 U.S.C. § 1132(a)(1)(B), and attorneys' fees and costs pursuant to 29 U.S.C. § 1132(g). The Plan is regulated by the Employee Retirement Income Security Act (ERISA); therefore, this Court entered a specialized case management order on December 21, 2006. The parties subsequently filed a joint stipulation on April 20, 2007.

Joint Stipulation

The parties' joint stipulation narrowed the issues for the Court to decide. The parties stipulated that the plaintiff only seeks STD benefits under the Plan pursuant to 29 U.S.C. § 1132(a)(1)(B), and attorneys' fees and costs pursuant to 29 U.S.C. § 1132(g). They also agreed that the plaintiff has exhausted all necessary administrative

remedies under the Plan and that the administrative record was filed with the joint stipulation. The parties agreed that the appropriate standard of review is an abuse of discretion standard. And they stipulated that the issue for this Court to resolve is "whether MetLife abused its discretion under the Plan in denying Plaintiff's claim for STD benefits." *Joint Stip.* at ¶ 7. They agree that the Court may resolve this issue based solely on the joint stipulation—including the administrative record, the parties memoranda, and exhibits attached thereto—without the need for a hearing. As all memoranda have been filed, this matter is now ready for disposition.

Facts

At the time of the claim, Plaintiff worked as a customer service representative for Verizon Wireless, the sponsor of the defendant plan. Her job entailed assisting customers using a phone and a computer, sitting at a desk.

On December 9, 2005, the Plaintiff missed work because she was experiencing debilitating pain in her neck and left arm. On December 12, 2005, Plaintiff filed a claim with the Plan for short term disability benefits. MetLife, the defendant plan's administrator, responded on that day and requested supporting documentation, as required by the plan language. The plan provides that:

> An employee is considered disabled under the STD component of the Managed Disability Plan when the employee is absent from work for at least 8 full consecutive calendar days beginning with and including your first day absent from work because of a medical condition for which there is objective medical evidence that the employee cannot perform the *Essential Functions* of his or her job at Verizon Wireless.

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> **Note:** Objective medical evidence is not a physician's note stating that the employee should not work. Rather, the determination as to whether the employee has submitted objective medical evidence sufficient to establish entitlement to STD benefits shall be made by MetLife in its sole discretion. In making this determination, MetLife shall consider all documents submitted by the employee and his/her *Physician(s)*, as well as any other *Relevant Documents* MetLife deems necessary in its sole discretion, including but not limited to, any reviews or examinations conducted by Physician(s) employed or engaged by MetLife.

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> **Essential Functions** — Functions normally required for the performance of a job or occupation and which cannot be reasonably omitted or modified. MetLife will consider you able to perform *Essential Functions* if you are working or have the capacity to perform such *Essential Functions* at least 37.5 hours per week.

Admin. Rec. at STA # 0008 & 0039.

Specifically, MetLife requested that the plaintiff provide: names and dosages of all current medications; functional abilities; notes, diagnostic test results, and reports from her two most recent visits with her physician; and an expected return-to-work date. *Id.* at STA # 0263. MetLife informed the plaintiff that she had to provide this information by December 26, 2005, or her claim would be dismissed. *Id.*

Though it appears that the plaintiff sent the necessary documentation into MetLife on December 26, 2005, MetLife responded on December 27, 2005, stating, "Since we have not received the requested information by December 26, 2005[,] your

claim is denied." *Id.* at STA # 0228. The plaintiff immediately appealed. The plaintiff submitted additional medical records with her appeal. And, in an attempt to keep MetLife abreast of her progress, Plaintiff further supplemented her record on appeal with notes from her physical therapist detailing her progress on January 20, 2006.

On January 23, 2006, Dr. Vernon Mark, a physician MetLife procured to review the plaintiff's record, found that "As long as this woman's job responsibilities are limited to her sedentary occupation, with a soft cervical collar and appropriate medication, she *could* continue working at her job." *Id.* at STA # 0207. It does not appear that Dr. Mark considered the plaintiff's January 20, 2006 information in reaching this decision. Upon this recommendation, MetLife denied the plaintiff's claim. Plaintiff then retained counsel to handle her final appeal.

Throughout February MetLife and Plaintiff's counsel, Robert Hoskins, exchanged letters. Hoskins initially asked MetLife to refrain from rendering a final decision until he could provide MetLife with additional information. MetLife responded positively by setting a deadline of February 28, 2006 for Hoskins to submit further records on behalf of the plaintiff. Hoskins wrote back and insisted that this deadline was not reasonable for two reasons: (1) MetLife had not produced its record on appeal to the plaintiff yet; and (2) it would take more than two weeks to obtain the necessary information from the different physicians involved in the plaintiff's treatment. Though MetLife did not respond, it did provide Hoskins with its record on appeal on March 8, 2006, a week after its deadline.

On May 3, 2006, before the plaintiff submitted any additional information, Dr. Mark reviewed the plaintiff's record again. It appears the only additional information Dr. Mark considered in rendering his second opinion was the information the plaintiff submitted to MetLife on January 20, 2006. Unsurprisingly, Dr. Mark's opinion remained the same. Relying on Dr. Mark's opinion, MetLife rendered its final decision on May 4, 2006. MetLife cited the sedentary nature of the plaintiff's job to find that the "objective information does not offer specific impairments of such a severity as to preclude [the plaintiff] from performing her normal job duties, on a full time basis, as of December 10, 2005. Therefore, the initial claims decision was appropriate." *Id.* at STA # 0189.

Hoskins wrote MetLife on May 11, 2006, to request that it revoke its May 4, 2006 decision because Hoskins had yet to submit the plaintiff's additional medical records. Hoskins noted that typically MetLife gives claimants 180 days to supplement their record before rendering a decision. MetLife did not respond. On October 5, 2006, Hoskins submitted the additional information to MetLife. MetLife did not respond. On October 30, 2006, Plaintiff filed suit in the court of common pleas in South Carolina; on December 13, 2006, the plaintiff's suit was removed to this Court.

Standard of Review

The parties agree and Fourth Circuit precedent dictates that this Court should review the MetLife's decision to deny coverage for an abuse of discretion. *Joint Stip.* at ¶ 3; *Eckelberry v. Reliastar Life Ins. Co.*, 469 F.3d 340, 343 (4th Cir. 2006).

"Under this deferential standard, the administrator or fiduciary's decision will not be disturbed if it is reasonable, even if this court would have come to a different conclusion independently." *Ellis v. Met. Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). "Such a decision is reasonable if it is 'the result of a deliberate, principled reasoning process and if it is supported by substantial evidence.'" *Id.* (quoting *Brogan v. Holland*, 105 F.3d 158, 161 (4th Cir. 1997)). And, "Substantial evidence is the quantum and quality of relevant evidence that is more than a scintilla but less than a preponderance and that a reasoning mind would accept as sufficient to support a particular conclusion." *Donnell v. Met. Life Ins. Co.*, 165 Fed. Appx. 288, 295 (4th Cir. 2006) (internal quotations omitted). Though the parties agree on the standard of review, they hotly contest the evidence that this Court may review in determining whether MetLife abused its discretion.

Scope of Review

The parties dispute whether this Court may consider the plaintiff's October 5, 2006 Addendum (October 2006 Addendum)—comprising, "additional medical records of the [physical therapist], Dr. Nelson, Dr. Tollison, Dr. Mittal, Dr. Cunningham, and an affidavit signed by Dr. Nelson"—to determine whether MetLife abused its discretion. *Pl's Mem. in Sup. of Judg.* at 6. Plaintiff argues that this Court should consider the October 2006 Addendum because MetLife agreed it would not make a final decision until the plaintiff could submit additional information. Defendant argues that MetLife did not need to consider the October 2006 Addendum because it was

submitted five months after MetLife's final decision. The Court must first determine whether it can properly consider the contents of October 2006 Addendum before it reviews MetLife's decision.

In *Sheppard & Enoch Pratt Hospital, Inc. v. Travelers Ins. Co.*, the plaintiff argued that, regardless of the standard of review, the district court "erred by refusing to consider evidence that was not before [the administrator] when it made its decision." 32 F.3d 120, 124 (4th Cir. 1994). The *Sheppard* court relied a prior Fourth Circuit case, *Berry v. Ciba-Geigy*, 761 F.2d 1003 (4th Cir. 1985), and found that:

> We continue to adhere to the view expressed in *Berry* that an assessment of the reasonableness of the administrator's decision must be based on the facts known to it at the time. Thus, although it may be appropriate for a court conducting a *de novo* review of a plan administrator's action to consider evidence that was not taken into account by the administrator, the contrary approach should be followed when conducting a review under either an arbitrary and capricious standard or under the abuse of discretion standard.

Id. at 125. The *Sheppard* court was clear: when reviewing an administrator's denial under an abuse of discretion standard, a district court may only consider documents, reports, and other items that the administrator considered, nothing more. *Id.* But, the *Sheppard* court did not stop there.

The court then considered the plaintiff's argument that the administrator lacked adequate information to make a reasonable decision. *Id.* The court hearkened back to *Berry* to note that:

> "If the court believe[s] the administrator lacked adequate evidence, the proper course [is] to remand to the trustees for a new determination . . . not to bring additional evidence before the district court." *Berry*, 761 F.2d at 1007 (internal quotation and citations omitted). The district court's decision to remand *vel non* will not be disturbed in the absence of an abuse of discretion.

Id. The Fourth Circuit then upheld the district court's decision to refuse to hear evidence that the administrator did not consider and its decision not to remand to the administrator. *Id.*

This Court finds that MetLife lacked adequate evidence to render a reasonable decision for two reasons. First, the information that MetLife relied upon was inadequate because it did not sufficiently reflect the plaintiff's extensive medical history. The plaintiff alleges that the neck and arm pain that led her to file her claim is merely another episode in her lengthy medical history that includes "epilepsy, sleep disorders, bilateral cervical stenosis at C3-4, left cervical stenosis at C5-6, and possible dis protrusion at C5-6." *Pl's Mem. in Support of Judg.* at 1. The October 2006 Addendum contains extensive details about how the plaintiff's medical history relates to her claim, information necessary for an adequate decision.

Second, the record the administrator relied upon to make the decision was inadequate because both litigants intended the record to be supplemented before a final decision was made. The plaintiff made it clear that she did not want MetLife to render a final decision until she supplemented the record; MetLife made it clear that it would delay its decision, beyond its initial deadline of February 28, 2006, until the

plaintiff could refer to the administrative record to supply it with additional information. It appears as though MetLife rendered its May 4, 2006 decision under the mistaken belief that the plaintiff's January 20, 2006 addendum was all of the additional information the plaintiff sought to provide. This Court will not allow this misunderstanding to preclude the intention expressed and implied by both parties for MetLife to consider additional information in rendering its final decision.

Plaintiff also argues in the alternative that, regardless of failing to review the October 2006 Addendum, MetLife abused its discretion by denying coverage based on the record it actually reviewed. However, Plaintiff supports this argument by citing to information within the October 2006 Addendum. As mentioned *supra*, this Court cannot consider any information in the October 2006 Addendum when reviewing an administrator's decision for an abuse of discretion. This Court can only determine whether MetLife abused its discretion by failing to adequately take into account specific evidence from the October 2006 Addendum after the administrator considers the October 2006 Addendum on remand.

Conclusion

When applying an abuse of discretion standard, this Court may only consider the materials the administrator reviewed in making its decision. For the reasons aforementioned, this Court holds that the administrator of the defendant Plan did not have adequate information to render a decision and, therefore, remands this case back

to the administrator with instructions to consider the October 2006 Addendum and issue a new decision.

IT IS THEREFORE SO ORDERED THAT this matter be remanded back to MetLife with specific instructions to consider the plaintiff's October 2006 Addendum in reaching a new determination whether the plaintiff is entitled to the STD benefits she seeks within sixty (60) days from the entry of this Order.

IT IS SO ORDERED.

G. ROSS ANDERSON, JR.
UNITED STATES DISTRICT JUDGE

January 16, 2008
Anderson, South Carolina