IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
ANDERSON DIVISION

Katherine Sudduth, Plaintiff, v. BlueCross BlueShield of Illinois, Defendant.	C.A. No. 8:14-04659-TMC **ORDER**

Pending before the court are the parties' cross-motions for judgment. (ECF Nos. 28 and 30). This case involves Plaintiff Katherine Sudduth's ("Sudduth") claims for health insurance coverage under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), and for attorney's fees pursuant to 29 U.S.C. § 1132(g). The disputes in this case center on Defendant BlueCross BlueShield of Illinois' ("BCBS") denial of health insurance coverage for a second series of intravenous immunoglobulin injections ("IVIG") ordered by her doctor following Sudduth's diagnosis of acute polyneuropathy Guillain-Barre Syndrome ("GBS").

I. Factual and Procedural Background

Sudduth's husband is employed at Timken Corporation, and Sudduth is provided health insurance coverage through her husband's employment by BCBS. On May 29, 2014, Sudduth was admitted to the Abbeville Area Medical Center and seen by Dr. Glenn Scott ("Dr. Scott"). From this encounter, Dr. Scott recorded the following regarding Sudduth:

> [A]cute onset of painless left lower extremity weakness. Given age, one would have to be concerned about potential demyelinating disorder such as MS. Stroke would also be in the differential. By report her CT scan of the brain was normal. At this juncture, we will arrange for an MRI of the brain with and without contrast enhancement. If these are non-diagnostic one would have to consider the

> possibility of an asymmetrical Guillain-Barre syndrome or the possibility of a variation of Charcot-Marie-Tooth disease the hereditary propensity of pressure palsies.

(ECF No. 29-2 at 19).

A little over a week later, on June 8, 2014, Dr. Scott saw Sudduth again, and concluded:

> This appears to be Guillain-Barre syndrome, which was somewhat asymmetrical from its onset. I recommend hospitalization for stabilization, intravenous immune globulin therapy, 400 mg/kg per day for 5 days and further diagnostic studies including a lumbar puncture.

(ECF No. 29-2 at 16-17). On that same day, Sudduth underwent a motor nerve conduction test, which demonstrated "Motor-Sensory Demyelinating Polyneuropathy Guillain-Barre Syndrome." (ECF No. 29-10 at 18).

On June 17, 2014, Sudduth was hospitalized at the Greenwood Regional Rehabilitation Hospital, and seen by Dr. Jonathan Hegler ("Dr. Hegler") with the primary diagnosis of acute polyneuropathy GBS. (ECF No. 29-10 at 48-52). During her admission, Dr. Hegler treated Sudduth with five doses of IVIG, which resulted in improvement of her strength. Upon discharge, Dr. Hegler concluded:

> HISTORY OF PRESENT ILLNESS: This is a 44-year-old white female with a history of hypertension, anxiety, depression, gastroparesis status post partial gastrectomy, that over a 2-week period developed progressive lower extremity weakness, ataxia, falls, and almost progressed to the point of upper extremity weakness and facial paralysis. Two weeks ago she fell while walking in the kitchen and noted that she had bilateral foot drop. That went away for about a week and then she fell face first in the dining room and was unable to even crawl to the phone 1 week ago. She went to the primary care physician about this. He did a nerve conduction test and she was found to have Guillain-Barre acute inflammatory demyelinating polyneuropathy. She was treated with IV corticosteroids to no avail and eventually started IVIG for a total of 5 doses, ending on Friday of last week. This is day 3 without IVIG. She has no history of strep throat, influenza, or influenza vaccination. Neurologic disorders do not run in the family, but her mother, has for some reason, lost the ability to walk. They have always blamed it on her morbid obesity, but they are not exactly sure why or what diagnosis has caused her to lose her ability to ambulate. Her strength has

> improved. She is now able to ambulate with a rolling walker. She is moving the left leg very slowly, dragging it to some extent. She has some sensory disturbance to the lateral calves and the tops of her feet. She has delayed swallowing. She has to eat very slowly or she will choke. She has had double vision that is resolved and for the most part she feels significant improvement.
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> ASSESSMENT AND PLAN: Acute inflammatory demyelinating polyneuropathy (Guillain-Barre), status post 3 doses of IVIG, looks to be stable. Continue to monitor her closely with strength and reflex examinations on a daily basis. Anticipate a full resolution; however, we will continue to watch closely. We will need close communication with her neurologist, Dr. Schmitt and Dr. Glenn Scott, if this were to worsen. Continue with predisone 10 mg daily. We admitted her to the inpatient rehabilitation program, PT and OT to assess her and evaluate her for mobility and self-care. Speech therapy to evaluate her communication and swallowing. Probably needs to continue using a rolling walker with all ambulation. Global strengthening regimen necessitated and watch closely for any decompensation as there can be a relapse at 2-3 weeks. Prognosis for community discharge is excellent as she does appear to be responding to therapy. However, a relapse is still possible in 10%-25% of the cases. She will need fall precautions. She will be weightbearing as tolerated.
>
> Estimated length of stay, I think, is 7-10 days at this time. Functional goals include ambulating independently, transferring independently, toileting, bathing, feeding herself independently. . .

(ECF No. 29-10 at 48-51). Based on this discharge assessment, BCBS covered the five IVIG treatments that Sudduth received during her hospitalization finding that the sudden onset of her lower extremity weakness combined with her inability to stand or walk met the criteria set forth in its internal policy. (ECF No. 30 at 4-5).

Shortly thereafter, on June 25, 2014, Dr. Hegler saw Sudduth again, and noted:

> [s]he feels her therapy is doing much better. She still feels some weakness in her legs particularly her right leg. It gives out at times. She's making a significant amount of progress in her therapy. Modified independent with most of her ADLs. She did walk up to 600 feet. Still has some difficulty at times with weakness in her quadriceps muscle.

(ECF No. 29-10 at 54). A few days later, Dr. Cliff Monda ("Dr. Monda") saw Sudduth, and noted, "[s]he continued to have some swallowing difficulties. Was seen by speech therapy. This

did slowly improve . . . and by the time of discharge, her swallowing returned back to normal . . . She walked 600 feet on level surfaces without an assistive device." (ECF No. 29-10 at 27).

On June 30, 2014, Sudduth saw Dr. Scott again and his notes provide: "She was hospitalized and received intravenous immune globin as well as IV steroids. She is doing better. However, she has noticed now that she is fatigued and having some difficulties chewing and swallowing. She complains of some blurred vision. Lower extremity strength over all is improved." (ECF No. 29-2 at 14). Dr. Scott also raised the possibility for "a booster dose of intravenous immunoglobulin" if Sudduth is not better. (ECF No. 29-2 at 14). On July 7, 2014, Dr. Scott prescribed Gammagard IVIG for two days per month for three months, infused slowly over 6 hours. (ECF No. 29-2 at 13).

On July 9, 2014, Sudduth submitted a predetermination request for coverage of an additional three months of IVIG treatment. (ECF No. 29-2 at 12). On July 11, 2014, Dr. Ernest Kaminksi ("Dr. Kaminski"), a Medical Director for BCBS, reviewed the predetermination request to identify whether there was a medical necessity for such treatment. Dr. Kaminski determined that such treatment did not meet the requirements of BCBS's internal policy, and as a result, was not medically necessary and was not covered. (ECF No. 29-2 at 20). Based on Dr. Kaminski's determination, BCBS sent a letter to Sudduth and Dr. Scott advising that the IVIG treatments were not medically necessary and not covered under the plan. (ECF No. 24-2 at 20-22).

On August 6, 2014, Sudduth saw Dr. Scott again, at which time he conducted a physical examination and noted left side weakness, sensations intact to light touch, reflexes are symmetrical, coordination intact, full rapid alternating movements, and normal gait. (ECF No. 29-9 at 47-48). Dr. Scott recommended that Sudduth undergo additional IVIG treatment, which was administered to Sudduth on August 11, 2014, and August 12, 2014. (ECF No. 29-9 at 47-

48). In a letter to plaintiff's husband dated August 25, 2014, BCBS denied coverage for this treatment relying on its internal policy, and stating that the administration of IVIG purely for maintenance is not medically necessary and is not covered under the plan. (ECF No. 29-1 at 14-15). Despite this denial of coverage, Sudduth underwent another round of IVIG treatments on September 5, 2014, and September 6, 2014. On September 10, 2014, BCBS issued a letter denying coverage for this treatment. (ECF No. 29-1 at 16).

On September 23, 2014, Sudduth saw Dr. Scott again at which time he noted mild left upper end lower extremity weakness, sensations intact to light touch, reflexes symmetrical, coordination intact, full rapid alternating movements, and mildly uncoordinated gait. (ECF No. 30 at 8). On October 9, 2014, Dr. Scott issued another order for IVIG treatments. Sudduth subsequently received IVIG treatment on October 13, 2014, October 14, 2015, and November 13, 2014, which BCBS again denied coverage for stating that IVIG treatments are not a medical necessity and relying on its internal policy. (ECF No. 29-1 at 17). Following BCBS' denial of coverage, Sudduth appealed, and requested a complete copy of every document upon which the denial was based, including the entire claim file and any and all plan documents, internal guidelines or regulations, or any pertinent information pursuant to 29 U.S.C. §§ 1132(d), 1133, 2560.503-1(h). (ECF No. 29-1 at 1-2). BCBS failed to respond to the appeal, and Sudduth filed this lawsuit.

The court thereafter granted a consent motion to stay the case allowing Sudduth to submit additional evidence and for BCBS to complete another review. Following the additional submission of evidence by Sudduth, BCBS had a peer review completed by Dr. LeForce. Dr. LeForce, without addressing the new evidence submitted by Sudduth, determined that Sudduth did not meet the internal policy criteria for IVIG treatment, and he raised for the first time that "the diagnosis of CIDP requires specific findings on nerve conduction settings and these findings

were not provided." (ECF No. 29-11 at 91-92). BCBS upheld its original denial based on Dr. LeForce's opinion. (EFC No. 29-12 at 1-3). Sudduth submitted additional evidence for consideration, including the following statement from Dr. Scott detailing his treatment of Sudduth:

> 4. Ms. Sudduth presented in late May of 2014 with lower extremity weakness and numbness. She first noticed it when her left foot would not work. I saw her again on June 9, 2014 and her right side had become profoundly weak as well. She could wiggle her toes but she could not walk. She had numbness and deadness in her bilateral legs. On June 30, 2014 I believed that she had Guillain-Barre syndrome and noted that she was very fatigued and was having difficulty chewing and swallowing, displaying rapid deterioration of acute symptoms. She had undergone an intravenous immunoglobulin and IV steroid treatment. Her lower extremity strength was improved, but she was continuing to have deteriorating symptoms and was still unable to walk. I prescribed IVIG treatments for Ms. Sudduth starting in July 2014 through November 13, 2014. It is my understanding that Ms. Sudduth's insurer has denied benefits for those treatments claiming that they are not medically necessary. It was medically necessary for Ms. Sudduth to be treated with IVIG treatments from August 11, 2014 until November 13, 2014.
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> 5. It is paramount to realize that without the medically necessary IVIG treatments for Guillain-Barre syndrome from August 11, 2014 until November 13, 2014, Ms. Sudduth would likely have become even worse. To have not prescribed her with the IVIG treatments would have posed a significant risk to her life and health. The clinical information documented Guillain-Barre syndrome that required IVIG treatments as the appropriate level of care.
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> 6. The IVIG treatments prescribed by me were made in accordance to accepted standards of medical practice. Ms. Sudduth was rapidly losing the ability to ambulate, was unable to ambulate for 10 meters, and was suffering rapid deterioration with acute symptoms.
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> 7. [Dr. Scott sets forth the plan's definition of medical necessity, as well as BCBS' internal policy, as set forth *infra*.]
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> 8. I am certain, to a reasonable degree of medical certainty, that the treatment I prescribed for Ms. Sudduth meets the above definition of medical necessity and the guideline for approval of the IVIG treatment. I am confident that my treatments improved Ms. Sudduth's condition and the treatment was the best way to obtain such positive results. I am hopeful that Ms. Sudduth will never have a relapse but it is always possible with Guillain-Barre syndrome. The IVIG treatment was consistent with the symptoms, diagnosis, and treatment for Guillain-Barre syndrome, and was appropriate with regards to the standards of good medical practice, was not primarily for the convenience of the patient,

> myself, or any other provider, and was the most appropriate service that could be provided to the patient. Further, the treatment was provided because Ms. Sudduth was having rapid deterioration with acute symptoms for less than two weeks, was suffering from rapid deterioration of her ability to ambulate, and was unable to ambulate independently for ten meters. While her condition improved when she was receiving IVIG treatment, if I had stopped the treatment, it is probable that her condition would have rapidly deteriorated and she would have lost any improvements from the IVIG treatments. I believe that the IVIG treatments were medically necessary under the above definition and guideline.

(ECF No. 29-13 at 18-20). BCBS again upheld its decision denying benefits. (ECF No. 29-12 at 1-6).

II. Standard of Review

Before addressing the merits, the court must resolve the parties' dispute over the appropriate standard of review. Selecting the appropriate standard of review turns on the extent of power vested in the plan administrator. It is well-settled that a denial of benefits under § 1132(a)(1)(B) is to be reviewed de novo in the district court unless "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan," in which case the standard of review is abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *see also Feder v. Paul Revere Life Ins. Co.*, 228 F.3d 518, 522–23 (4th Cir. 2009) (abuse of discretion review warranted only when plan "vest[s] in its administrators discretion either to settle disputed eligibility question or construe doubtful provisions of the Plan.").

Although no specific phrases or terms are required in a plan to confer this discretionary authority, the plan's intention to do so "must be clear." *Gallagher v. Reliance Standard Life Ins. Co.*, 305 F.3d 264, 268 (4th Cir. 2002); *Feder*, 228 F.3d at 522 ("[I]f the terms of a plan indicate a clear intention to delegate final authority to determine eligibility to the plan administrator, then this Court will recognize discretionary authority by implication."). Any ambiguity in an ERISA plan "is construed against the drafter of the plan, and it is construed in accordance with the reasonable expectations of the insured." *Gallagher*, 305 F.3d at 269 (citing *Bynum v. Cigna Healthcare, Inc.*, 287 F.3d 305, 313–14 (4th Cir. 2002). Put simply, if a plan does not clearly grant discretion to interpret the plan, no deference is owed to the plan administrator's decision and the standard of review is de novo. *See id.*

Here, the "General Limitations" section of the plan provides, in pertinent part:

> Although your medical plan covers most types of medical care, there are expenses for which you and your dependents are not covered . . . . Listed below are some of the more common expenses/services that are not covered by the plan. However, excluded benefits are not limited to those listed. *The claims fiduciary makes the final determination on all benefit coverages.*
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> . . .
>
> - services, treatment, drugs, or devices that are not necessary for treatment of an injury or illness . . .
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> - services, treatments, drugs, or devices not necessary according to

accepted standards of medical practice.

(ECF No. 29-11 at 109-110) (emphasis added). Both parties agree that BCBS based its decision to deny coverage on its determination that the treatment was not medically necessary - the parties, of course, dispute whether that determination was a correct one. The court finds that the language in the policy granted discretion to the claims fiduciary to determine whether treatment is medically necessary. Accordingly, the court finds that the standard of review is abuse of discretion.1

III. Discussion

Next, the court must determine whether BCBS abused its discretion when it denied Sudduth coverage for the IVIG treatments administered from August 2014 to November 2014.

Under the abuse of discretion standard, the court will uphold the administrator's decision so long as it was reasonable. *Ellis v. Metro. Life. Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). *See also Booth v. Wal-Mart Stores, Inc. Assocs Health & Welfare Plan*, 201 F.3d 335, 344 (4th Cir. 2000) (holding that even when an ERISA plan gives an administrator broad discretion to interpret plan language, the court "will enforce the administrator's decisions only if they are reasonable"). To find the decision reasonable, the court must find that it resulted from a "deliberate, principled reasoning process." *Guthrie v. Nat'l Rural Elec. Coop. Assoc. Long Term Disability Plan*, 509 F.3d 644, 651 (4th Cir. 2007). In assessing reasonableness, the court is guided by eight nonexclusive factors:

> (1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan; (5) whether the decisionmaking process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have.

Champion v. Black & Decker Inc., 550 F.3d 353, 359 (4th Cir. 2008) (quoting *Booth*, 201 F.3d at 342-43)). "All eight *Booth* factors need not be," and may not be, "in play" in a given case.2

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[1] The plan does not appear to give the claims fiduciary discretion to interpret the policy. The court need not decide whether the failure to include that language is determinative, because, as stated below, the court finds that BCBS abused its discretion.

[2]The third and seventh factors set forth in *Booth* involve the adequacy of the materials considered to make the decision and the degree to which they support it and any external standard relevant to the exercise of discretion. 201 F.3d 342-43. The parties did not address

Helton v. AT&T, Inc., 709 F.3d 343, 357 (4th Cir. 2013). In general, a reviewing court should not find an abuse of discretion where the plan administrator's decision is reasonable, "even if the court itself would have reached a different conclusion." *Booth*, 201 F.3d at 340. A plan administrator's decision is reasonable as long as the denial of benefits results from "a deliberate, principled reasoning process" and "is supported by substantial evidence." *Williams v. Metro. Life Ins. Co.*, 609 F.3d 622, 630 (4th Cir. 2010). Substantial evidence, which "consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance," is evidence that "a reasoning mind would accept as sufficient to support a particular conclusion." *Whitley v. Hartford Life & Accident Ins. Co.*, 262 F. App'x 546, 551 (4th Cir. 2008) (quoting *Laws v. Celebrezze*, 368 F.2d 640, 642 (4th Cir. 1966)) (internal quotation marks omitted).

Sudduth argues that the medical record satisfies the plan description and definitions of "medical necessity" such that the court could reach no other conclusion that BCBS abused its discretion. (ECF No. 28 at 17-19). Sudduth contends that the decisions were "moving targets" with BCBS changing its justification for denial during the appeals process, and referencing inapplicable provisions, making it so the court must conclude that BCBS did not provide a careful, considered, and meaningful administrative review. (ECF No. 28 at 19-23).

BCBS argues that it did not abuse its discretion because it correctly applied its plan and policies. (ECF No. 30 at 12-15). BCBS claims that the policy did not provide for "maintenance treatment" for GBS. (ECF No. 30 at 13-15).

As to the first two factors cited in *Booth*, the court finds that the language of the plan and the respective policies do not support BCBS's position and show that BCBS failed to exercise its discretion reasonably. "The award of benefits under any ERISA plan is governed in the first

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these factors in their brief, and the court finds them to be unnecessary for the analysis of this case.

instance by the language of the plan itself." *Lockhart v. United Mine Workers of Am. 1974 Pension Trust*, 5 F.3d 74, 78 (4th Cir. 1993). It appears from the documents filed with the court that a goal of the plan is to ensure that the care an insured receives is the most appropriate and cost-effective care. (ECF No. 29-6, at 2). The plan does not establish specific criteria for a plan participant to be entitled to IVIG treatments for GBS. Rather, the plan description includes the following guidance:

> The plan provides coverage as defined herein for covered expenses only when medically necessary and ordered or supplied by a physician unless otherwise specified. A covered expense is medically necessary when:
>
> - Consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury;
> - Appropriate with regard to the standards of good medical practice;
> - Not primarily for the convenience of the patient, the physician or other provider;
> - The most appropriate supplies or services that can be provided safely to the patient. For inpatients, it means that the patient's symptoms or condition requires that the services or supplies cannot be provided safely on an outpatient basis.

(ECF No. 29-11 at 101). According to the internal policy available on its website, IVIG treatments may be medically necessary "when standard intervention, treatment, and/or therapy has failed, become intolerable, and/or is contraindicated for any of the following off-label indications when the listed criteria are met." (ECF No. 24-8 at 193). The internal policy also states that IVIG treatments are medically necessary for patients diagnosed with GBS if they demonstrate one or more of the following:

- Rapid deterioration with acute symptoms for less than two weeks; OR
- Rapidly deteriorating ability to ambulate; OR
- Unable to ambulate independently for ten meters; OR
- Deteriorating pulmonary function tests.

(ECF No. 29-11 at 4).

As to the fourth *Booth* factor, the record reflects BCBS's interpretations of the Plan were

not consistent with the provisions of the Plan. No one disputes that Sudduth suffered from GBS and received treatment for that syndrome in June 2014. Both parties agree that Sudduth initially met the plan definition and the policy definition for insurance coverage. Where the dispute arises is whether the additional treatment, ordered by Sudduth's treating physician, on July 7, 2014, meets this definition.

The denial of benefits stems from an apparent conflation over the policy language by BCBS and its claims officials throughout this dispute. For example, in its brief, BCBS argues "the Medical Policy specifically states that use of IVIG treatment is not approved for 'maintenance' purposes with respect to Myasthenia." (ECF No. 30 at 15). However, a careful review of the documents shows that this IVIG treatment was not ordered for Myasthenia, but it was instead ordered to treat Sudduth's GBS. (ECF No. 29-2 at 13-19). BCBC denied her coverage for two reasons: first, the IVIG was not medically necessary as to GBS, and second, to the extent her condition was Myasthenia Gravis, the policy specifically excludes coverage for maintenance. (ECF No. 29-2 at 20).

Even if BCBS did not abuse its discretion in finding that the IVIG treatments were for "maintenance," BCBS abused its discretion in finding that its plan and policy prohibit IVIG treatment for GBS maintenance. BCBS appears to read into its policy a clause against maintenance. In the section of the policy discussing whether IVIG is medically necessary for Myasthenia Gravis, the policy specifically provides: "Does not include use of IVIG for maintenance." (ECF No. 29-11 at 5-6). Certainly, its use of this language shows that BCBS knew how to outline a coverage restriction based on maintenance. However, the policy does not use similar language as to IVIG treatment for GBS; instead, the policy provides that IVIG "may be considered medically necessary" for "Patients who have one or more of the following: Rapid deterioration with acute symptoms for less than two weeks; OR Rapidly deteriorating ability to

ambulate; OR Unable to ambulate independently for ten meters; OR Deteriorating pulmonary function tests." (ECF No. 29-11 at 4). Given that BCBS included a prohibition against maintenance coverage as to Myasthenia Gravis but did not do so as to GBS, the policy can only be read so as not to prohibit coverage for maintenance for GBS.

Moreover, even if the court could read a prohibition against maintenance into the GBS portion, neither the policy nor the plan defines "maintenance" such that the court could find that BCBS acted reasonably in applying that definition to these facts. The plan references maintenance three times when discussing medical treatment and the references are to chiropractors, occupational and physical therapists, and custodial care. (ECF No. 29-11 at 105, 111, 114).

When interpreting the terms of a contract, the court uses "both state law and general contract law principles." *Johnson v. Am. United Life Ins. Co.*, 716 F.3d 813, 819 (4th Cir. 2013). "A paramount principle of contract law requires us to enforce the terms of an ERISA insurance plan according to 'the plan's plain language in its ordinary sense' that is, according to the 'literal and natural meaning' of the Plan's language." *Id.* at 819-20 (quoting *United McGill Corp. v. Stinnett*, 154 F.3d 168, 171 (4th Cir. 1998); *Wheeler v. Dynamic Eng'g, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995)). This requires the court "to consider 'what a reasonable person in the position of the participant would have understood those terms to mean.'" *Id.* at 820 (quoting *LaAsmar v. Phelps Dodge Corp. Life Acc. Death & Dep. Life Ins. Plan*, 605 F.3d 789, 801 (10th Cir. 2010)).

In addition,

> ERISA plans, like contracts, are to be construed as a whole. Courts must look at the ERISA plan as a whole and determine the provision's meaning in the context of the entire agreement. And, because contracts are construed as a whole, courts should seek to give effect to every provision in an ERISA plan, avoiding any interpretation that renders a particular provision superfluous or meaningless.

Id. (internal quotation marks and citations omitted).

When construing the contract as a whole, the court finds the fiduciary abused its discretion by interpreting a prohibition of continued treatment into its guidelines for IVIG treatment for GBS. When a contract includes a restriction in one portion, but not in another, the contract must be interpreted such that the writer made the conscientious decision not to include that provision in the latter clause. BCBS cannot remedy its failure to include the language against maintenance through interpretation. Otherwise, the language in the Myasthenia section would be rendered superfluous. In sum, no reasonable person would have concluded based on the language of the policy and the diagnoses of Sudduth that she did not meet the criteria as set forth in the policy. Therefore, in weighing the *Booth* factors cited above, the court finds that BCBS acted unreasonably.

Turning to the fifth *Booth* factor, BCBS has also committed various other mistakes throughout the administrative review, such that the decision making process was not principled and reasoned.

The predetermination decision, dated July 14, 2014, based its decision on Sudduth not meeting the requirements for IVIG for GBS or Myasthenia. (ECF No. 29-2 at 20-22). On August 25, 2014, Sudduth's husband received a letter indicating that IVIG was not approved for lack of medical necessity. (ECF No. 29-1 at 14). The reasoning was "Chronic debilitating disease in spite of treatment with cholinesterase inhibitors, and/or complications from or failure of steroids and/or azathioprine for Myasthenia, does not include use of IVIG for maintenance." (ECF No. 29-1 at 14). Absent from this decision is any justification based on GBS, the syndrome Sudduth suffered from. The denial letter from September 10, 2014, stated the same justification for denying benefits. (ECF No. 29-1 at 16). The decision letter from November 20, 2014, provided a different justification, which was that the IVIG treatment lacked medical necessity because of "[c]hronic debilitating disease in spite of treatment with cholinesterase

inhibitors, and/or complications from a failure of steroids and/or azathio." (ECF No. 29-1 at 17). Outside of the predetermination decision, the denial letters did not reference Sudduth's medical condition, GBS, or the applicable provisions for denial.

Sudduth appealed the denial of benefits on October 6, 2014. (ECF No. 29-1 at 1). Although BCBS policy provides for a written decision with sixty days, BCBS failed to respond to the appeal. After the lawsuit was filed, BCBS submitted Sudduth's claim for a peer review report with Dr. LeForce. (ECF No. 29-11 at 91–92). Dr. LeForce determined that:

> The member has received IVIG for a diagnosis of Guillain-Barre syndrome and chronic inflammatory demyelinating polyneuropathy (CIDP) but no formal nerve conduction study report is provided. The diagnosis of CIDP requires specific findings on nerve conduction studies and these findings are not provided. Since the diagnostic criteria for this diagnosis are not met, she does not meet the Medical Policy criteria for treatment with IVIG.

(ECF No. 29-11 at 91). This peer review study provides merely three sentences of justification for why BCBS properly denied the claim. And in these three sentences, Dr. LeForce focuses on the wrong condition. Although the report provides that the "diagnosis of CIDP requires specific findings on nerve conduct studies," the report provides no information about why the IVIG should be denied for GBS, Sudduth's primary condition. Moreover, BCBS states that the "medical records are clear that [Sudduth] was never actually diagnosed with CIPD." (ECF No. 30 at 15). In addition, as Sudduth indicates, Dr. Scott completed a nerve conduction study on Sudduth. (ECF No. 29-10 at 18). The report provides no reason why this study is insufficient.

To propound these errors, BCBS upheld its decision on March 5, 2015, based on the reasoning set forth by Dr. LeForce. (ECF No. 29-13 at 8-9). BCBS provided essentially the same justification as set forth in Dr. LeForce's determination, namely that no formal nerve conduction studies have been provided and a diagnosis of CIDP requires one. (ECF No. 29-13 at 9).

Thereafter, Sudduth submitted a statement of Dr. Scott on July 30, 2015, which outlined his reasons for ordering the IVIG treatment. (ECF No. 29-13 at 18-20). This thorough opinion provided his belief of the medical necessity of the IVIG treatment and how Sudduth met the standards as set forth in the policy.

BCBS upheld its original decision in two letters issued on October 12, 2015, and October 21, 2015. (ECF No. 29-12 at 1-6). The October 12th letter provided the following reason for denying coverage: "The nerve conduction studies provided are limited and are insufficient to make the diagnosis of Guillain Barre syndrome or CIDP. There is no documentation of temporal dispersion and no f-waves are documented. The electrodiagnostic studies provided are insufficient for the diagnosis of an inflammatory demyelinating neuropathy. The use of IVIG is not supported for the treatment of other types of neuropathy." (ECF No. 29-12 at 2). The October 21st letter provided the same justification. (ECF No. 29-12 at 5).

As noted, BCBS has not adequately explained the references to inapplicable provisions of the Plan, inconsistent reasons for denial of coverage, and lack of specific coverage regarding Sudduth's diagnosed condition.

The sixth *Booth* factor involves consideration of whether the decision was consistent with the procedural and substantive requirements of ERISA. The principal object of ERISA is to protect plan participants and beneficiaries. *Boggs v. Boggs*, 520 U.S. 833, 845 (1997). ERISA affords a reasonable opportunity to any participant whose claim for benefits has been denied a full and fair review by the plan fiduciary. 29 U.S.C. § 1133(2). The court finds the history of denials, based on focusing on incorrect diagnoses and failing to consider important records and documents, shows that BCBS did not render its decision on a principled or reasoned basis.

In addition, the eighth *Booth* Factor involves consideration of the fiduciary's motives and any conflict of interest it may have. A conflict of interest exists when the administrator has a

"dual role," such that it "both determines whether an employee is eligible for benefits and pays benefits out of its own pocket." *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 108 (2008).

> The conflict of interest here . . . should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including but not limited to, cases where an insurance company administrator has a history of biased claims administration. It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits.

Id. at 117-18. In this case, BCBS determined both the eligibility of benefits and it had the obligation to pay any benefits out of its own pocket. Here, neither party briefed the weight, if any, the court should afford to this factor.

While a conflict of interest arguably exists, there is no evidence, or even a permissible inference drawn from the evidence, suggesting that BCBS improperly denied Sudduth's claim, or that the denial was based on a desire to materially benefit the company, in direct contravention of BCBS's fiduciary responsibilities. Therefore, ultimately, "[n]o weight is given to a conflict in the absence of any evidence that the conflict actually affected the administrator's decision." *Durakovic v. Building Serv. 32 BJ Pension Fund*, 609 F.3d 133, 140 (2nd Cir. 2010). The Fourth Circuit has held that a conflict of interest may be a "tiebreaker when the other factors are closely balanced." *Champion v. Black & Decker, Inc.*, 550 F.3d 353, 362 (4th Cir. 2008) (citing *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 117 (2008)). Here, however, "the factors are not closely balanced."

Moreover, as other courts have noted, a decision to award at least some benefits rather than deny benefits entirely "manifest[s] an approach demonstrating an unbiased interest that favor[s the claim applicant], making the conflict factor less important (perhaps to the vanishing

point)." *Champion v. Black & Decker (U.S.) Inc*., 550 F.3d 353, 362 (4th Cir. 2008) (internal quotations and citation omitted).

In sum, examining the *Booth* factors in light of the evidence leads the court to conclude that BCBS abused its discretion and acted unreasonably in denying Sudduth's claims. When a plan administrator has abused its discretion, a district court may either reverse the decision or remand it to the administrator for further review. *See DuPerry v. Life Ins. of North America*, 632 F.3d 860, 875-76 (4th Cir. 2011). "[R]emand is not required, particularly in cases in which evidence shows that the administrator abused its discretion." *Helton v. AT & T Inc.*, 709 F.3d 343, 360 (4th Cir. 2013); *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154, 159 (4th Cir. 1993) ("[A] remand for further action is unnecessary here because the evidence clearly shows that [the administrator] abused its discretion."). As the court finds BCBS abused its discretion, the court declines to remand the case.

IV. Attorney's Fees and Costs

Sudduth has requested attorneys' fees and costs pursuant to 29 U.S.C. § 1132(g). Section 1132(g) states in part that "[i]n any action under this subchapter . . . by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1). The Fourth Circuit has adopted a five-factor test to guide courts in determining whether an attorney's fee award is warranted under ERISA. The five factors are: (1) degree of opposing parties' culpability or bad faith; (2) ability of opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions. *Quesinberry v. Life Ins. Co. of N. America*, 987 F.2d 1017, 1029 (4th Cir. 1993). The court has not been provided with sufficient information to address this issue. Accordingly, the court, in its discretion, is denying the request for attorney's fees without prejudice at this time.

V. Conclusion

Accordingly, based on the foregoing, the denial of benefits is **REVERSED** and judgment is **GRANTED** to Plaintiff Sudduth.

The request for attorney's fees and costs is **DENIED** without prejudice. The court shall retain jurisdiction in this matter to address this issue on proper motion, as well as any disputes concerning implementation of this order. Any motion for fees or costs shall be filed within thirty days from the date this order is filed.

IT IS SO ORDERED.

s/ Timothy M. Cain
United States District Judge

March 20, 2017
Anderson, South Carolina