2022 WL 780724
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United States District Court, D. Massachusetts.

Mary MACNAUGHTON, M.D., Plaintiff,

v.

The PAUL REVERE LIFE INSURANCE COMPANY and Unum Group, Defendants.

CIVIL ACTION NO. 4:19-40016-TSH
|
Filed 03/07/2022

Synopsis

Background: Participant radiologist, who previously received long-term disability benefits following an eye injury, brought action against claims administrator of employer-sponsored long-term disability plan, challenging the termination of benefits under the plan. Parties cross-moved for summary judgment.

Holdings: The District Court, Timothy S. Hillman, D.J., held that:

[1] arbitrary, capricious, or abuse of discretion standard of review would be applied to parties' motions;

[2] administrator failed to provide full and fair review of claim to participant;

[3] participant was prejudiced by administrator's failure to provide full and fair review of claim; and

[4] appropriate remedy was remand to administrative stage.

Participant's motion granted and administrator's motion denied; remanded to administrative stage.

West Headnotes (7)

[1] **Federal Civil Procedure** Employees and Employment Discrimination, Actions Involving **Labor and Employment** Record on review

ERISA benefit-denial cases typically are adjudicated on the record compiled before the plan administrator; in such a case, a motion for summary judgment is simply a mechanism for positioning the case for disposition on the merits. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[2] **Labor and Employment** Standard and Scope of Review **Labor and Employment** Record on review

On summary judgment in an ERISA benefit-denial case, the district court's task is to evaluate the reasonableness of the administrative decision in view of the administrative record; in this sense, the district court sits more as an appellate tribunal than as a trial court. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[3] **Labor and Employment** Standard and Scope of Review

The standard of review of a ERISA benefit-denial case depends on whether the plan at issue grants discretion to the plan administrator to determine eligibility for benefits; if it does, the court must uphold the administrator's decision unless the decision is arbitrary, capricious, or an abuse of discretion, but if it does not, the court reviews the administrator's decision de novo. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[4] **Labor and Employment** Arbitrary and capricious **Labor and Employment** Abuse of discretion

District court would apply arbitrary, capricious, or abuse of discretion standard of review to parties' cross motions for summary judgment in long-term disability plan participant's challenge

to termination of benefits as records of participant's employer were sufficiently clear to grant ERISA plan administrator discretionary authority to determine eligibility for benefits; plan contained entire contract provision, which incorporated application of policyholder, employer's application included notice to participants, which stated that administrator had full, final, binding, and exclusive authority to determine eligibility for benefits, and summary plan description, sent to employer, stated that discretionary authority to make benefit determinations under plan was delegated to administrator. Employee Retirement Income Security Act of 1974, § 2 et seq., 29 U.S.C.A. § 1001 et seq.

[5] **Labor and Employment** Notice of Denial or Determination; Statement of Reasons

Labor and Employment Administrative Review

Administrator of ERISA long-term disability plan failed to provide full and fair review of claim to plan participant by not disclosing two medical opinions generated on participant's appeal from termination of benefits under plan, even though administrator promptly disclosed claim file as it stood at time of participant's request, where participant requested "entire claim file," including copies of any professional opinions rendered, after initial adverse determination, which required administrator to also disclose information generated on appeal, administrator failed to update disclosure with documents generated on appeal until after appeal was finalized, and undisclosed documents considered on appeal were file reviews by on-site physicians that opined that participant could return to work. Employee Retirement Income Security Act of 1974 § 503, 29 U.S.C.A. § 1133(2); 29 C.F.R. § 2569.503-1(h)(2)(iii).

[6] **Labor and Employment** Notice of Denial or Determination; Statement of Reasons

Labor and Employment Administrative Review

Participant in ERISA long-term disability plan, whose benefits were terminated, was prejudiced by plan administrator's failure to provide full and fair review of claim by not disclosing opinion rendered by on-site physician that opined participant could return to work, where administrator relied on physician opinion, which contained additional justifications from opinion of different doctor who rendered opinion for initial adverse determination, to uphold decision to terminate benefits, and administrator's failure to disclose physician's analysis prior to finalization of appeal prevented participant from rebutting physician's newly asserted justification as to participant's ability to return to work. Employee Retirement Income Security Act of 1974 § 503, 29 U.S.C.A. § 1133(2); 29 C.F.R. § 2569.503-1(h)(2)(iii).

[7] **Labor and Employment** Remand to administrator

Appropriate remedy for ERISA plan administrator's failure to provide full and fair review of claim to plan participant by not disclosing two medical opinions generated on participant's appeal from termination of benefits under plan was remand to administrative stage to allow participant opportunity to respond to such opinions, as record from which to determine whether administrator's decision was arbitrary, capricious, or an abuse of discretion would be incomplete until participant was afforded benefit of full and fair review of her claim. Employee Retirement Income Security Act of 1974 § 503, 29 U.S.C.A. § 1133(2); 29 C.F.R. § 2569.503-1(h)(2)(iii).

Attorneys and Law Firms

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ORDER AND MEMORANDUM ON PARTIES' CROSS-MOTIONS FOR SUMMARY JUDGMENT (Docket Nos. 63 & 66)

HILLMAN, D.J.

***1** Plaintiff Mary MacNaughton worked as a diagnostic radiologist until 2007, when she suffered an eye injury following the birth of her twins. The plaintiff submitted a claim for disability benefits with defendants The Paul Revere Life Insurance Company and Unum Group, insurers of an employer-sponsored long-term disability plan in which the plaintiff participated. The defendants approved the plaintiff's claim and paid her benefits from 2007 to 2017.

In 2017, after the plaintiff's treating ophthalmologist retired and an independent medical examiner opined that the plaintiff could return to work, the defendants terminated the plaintiff's benefits. The plaintiff appealed. In upholding their termination, the defendants relied in part on analysis from one of their on-site physicians, who reviewed the plaintiff's medical records during the appeal. Although the plaintiff had requested her entire claim file, including "[a]ny professional opinions rendered in this claim," after the defendants' initial adverse benefit determination, the defendants did not disclose the on-site physician's analysis until after the appeal had been finalized.

In January 2019, the plaintiff commenced this action against the defendants to recover unpaid benefits. In December 2021, the parties cross-moved for summary judgment. Because the defendants did not disclose the on-site physician's analysis prior to rendering their final administrative decision, the plaintiff did not receive the "full and fair review" of her claim to which she was entitled. Accordingly, the Court ***grants*** summary judgment for the plaintiff, ***denies*** summary judgment for the defendants, and remands the case back to the administrative stage.

Background

In July 1998, the plaintiff began working as a physician radiologist at Alliance Radiology ("Alliance") in Overland Park, Kansas. Her work included reading radiographic images, including X-rays, CT scans, and MRIs. As part of her employment with Alliance, the plaintiff was offered coverage under a Long-Term Disability Plan ("the Plan"), insured by the defendants. The Plan provides benefits to individuals who are "totally disabled." The Plan defines "total disability" as, *inter alia*, being "unable to perform the important duties of [one's] own occupation on a Full-time or part-time basis because of an Injury or Sickness that started while insured under this Policy." The Plan defines a physician's "own occupation" as the physician's "specialty in the practice of medicine." The Plan does not define "important duties."

In 2007, while employed at Alliance, the plaintiff became pregnant with twins. On September 28, 2007, the plaintiff submitted a claim for disability benefits, listing the cause of her disability as pre-term labor. The plaintiff gave birth on October 17, 2007. In early November 2007, the plaintiff told the defendants that she had suffered complications from the birth. She stated that she had post-partum pre-eclampsia, had been in the hospital for eight days, and had blurred vision. While she had been told that blurred vision usually goes away, "obviously as a radiologist I can't work when I can't see."

***2** According to the defendants' evaluation of the plaintiff's "own occupation," the important duties of a radiologist include visual requirements of constant near acuity (clarity of vision at 20 inches or less), occasional accommodation (adjustment of lens of the eye to bring an object into sharp focus), and occasional color vision (ability to identify and distinguish colors). In addition, a radiologist must have an extremely high aptitude in "form perception," described as "the ability to perceive pertinent detail in objects or in pictorial or graphic material; the ability to make visual comparisons and discriminations and see slight differences in shapes and shadings of figures and widths and lengths of lines."

On November 26, 2007, the defendants approved the plaintiff's disability claim under the Plan. The letter approving the claim identified the plaintiff's maximum benefit as $10,000 per month. Over the ensuing ten years, the defendants paid the plaintiff $1,200,441.94 in benefits.[1]

1. Various Opinions

Over the years, doctors and consultants provided varying opinions concerning the plaintiff's medical condition and ability to work as a radiologist.

In November 2007, the plaintiff's treating ophthalmologist, Dr. Rolfe Becker, wrote that the plaintiff had correctable vision to 20/20 in her right eye and correctable vision to 20/25 in her left eye. Dr. Becker stated, "It is my impression that all of the findings are consistent with progressive improvement and no signs of any acute or regressive activity."

In December 2007, Dr. Thomas Whittaker, a neuro ophthalmologist at the University of Kansas, examined the plaintiff and confirmed the following diagnoses: (1) recent history of eclampsia with subsequent visual loss; (2) convergence insufficiency exotropia; (3) optic nerve hemi hypoplasia, OU; (4) gliosis and regressed optic nerve head edema in both eyes; and (5) residual small paracentral visual field defect in the left eye.

In March 2008, Dr. Marilyn Kay noted that the plaintiff's ophthalmologic records did not indicate that the plaintiff had any difficulty seeing from her right eye.[2] Dr. Kay opined that the plaintiff, if appropriately corrected, "should not have any difficulty functioning in her job as a radiologist."

In August 2008, Dr. John Taylor found that the plaintiff had "a mild residual optic neuropathy in the left eye evidenced by a left afferent pupillary defect, subjective blurring of vision in the left eye, and a previously abnormal VER response in the left eye."[3] Dr. Taylor explained that the plaintiff "has residual uncorrectable vision loss in the left eye, with acuity corrected to 20/25 -1 right eye and 20/30 -2 left eye." He specifically noted that the plaintiff does not have "normal central vision." Dr. Taylor opined that the plaintiff's visual impairment restricted her ability to work as a radiologist.[4]

***3** In December 2008, one of the defendants' vocational rehabilitation consultants reviewed the plaintiff's occupation as a radiologist and was "not able to find any possible visual accommodations which might enable [the plaintiff] to return to work in her own occupation."

In February 2009, Dr. Carrie Lehr, the plaintiff's treating internist[5] indicated that the plaintiff remained unable to perform duties of a radiologist (specifically, reading X-rays) because of vision loss due to hypertensive retinal vascular damage that occurred during pre-eclampsia.

On February 11, 2010, Dr. Sabrina Hammond, one of the defendants' on-site physicians, reviewed the plaintiff's file and found it unclear why the plaintiff was restricted from working as a radiologist. Dr. Hammond contacted Dr. Becker, who stated that the plaintiff could not return to work as a radiologist due to her inability to focus clearly with her left eye. Dr. Becker stated that the plaintiff's vision would not improve, but rather, it could get worse. Dr. Becker also noted that the plaintiff was "a liability to her radiologist group." When asked whether the plaintiff's inability to return to work was mainly about professional liability, Dr. Becker reportedly answered affirmatively, stating that "it would be different if she was an independent radiologist."

On February 25, 2010, Dr. Shatz, a board-certified ophthalmologist, conducted a "Designated Medical Officer" review of the plaintiff's file, at the defendants' request. Dr. Shatz opined that, "[g]iven normal acuity in the right eye and near normal vision in the left eye, it is unclear to this reviewer why [the plaintiff] would be unable to perform as a radiologist." Dr. Shatz explained that "[u]nder binocular viewing conditions, the [plaintiff's] vision is essentially normal," and that "[m]ild visual impairment of the left eye should have negligible impact on her ability to function as a diagnostic radiologist." While the "impairment of the left eye may reduce the speed at which [the plaintiff] can interpret images," it was "unclear why the accuracy of interpretation would be impacted." Dr. Shatz pointed to studies noting that many practicing radiologists have worse than 20/20 vision.

In April 2010, the defendants performed another occupational assessment of the plaintiff; this time, the assessment concluded that plaintiff's restrictions and limitations did not exceed the occupation demands of a radiologist. Thus, the defendants terminated benefits.

In June 2010, Dr. Becker diagnosed the plaintiff with convergence insufficiency. He found that the plaintiff's "field of vision defect has worsened, particularly obstructing near vision." He further noted that the plaintiff's "muscle balance (convergence insufficiency and exotropia) has increased over time which makes focusing impossible, particularly at close range."

In September 2010, after reviewing Dr. Becker's updated diagnosis, Dr. Shatz updated her opinion, concluding that the plaintiff's mild impairment of visual acuity in her left eye "combined with the convergence insufficiency" could

"compromise her ability to read and review diagnostic imaging studies." Accordingly, the defendants reinstated benefits, with back-pay.

***4** From 2010 through 2017, Dr. Becker continued to support the plaintiff's disability, noting that the plaintiff was "unable to perform required duties as radiologist due to decreased [visual acuity] in left eye[,] diplopia and convergence problem causing binocular [visual acuity]."

In August 2017, Dr. Tony Smith, a physician for the defendants, questioned whether the plaintiff could perform the occupational demands of a radiologist with one eye.[6] The defendants contacted Dr. Becker but learned that he had retired; Dr. Christopher Pole had taken over his practice. The defendants' call notes indicate that Dr. Pole was not comfortable providing an opinion on the plaintiff's "work or work capacity from a vision/ophthalmology standpoint." In a letter sent to the defendants, however, Dr. Pole noted that the plaintiff "may have trouble doing her work tasks due to her diagnosis." Dr. Pole further stated that "vision is a subjective sense and convergence insufficiency and ischemic retinopathy could cause difficulty with full time near work including diplopia while not patching." Dr. Pole noted that the plaintiff "claims to have attempted patching within the last 3 years and feels she cannot see well enough to perform her tasks required at near as a radiologist."

In November 2017, the plaintiff underwent an independent medical examination, at the defendants' request. Dr. Michael Rosenberg, the examiner, reported that the plaintiff's vision was correctable to 20/20 in each eye, with "an acuity that would allow any person the ability to easily see details of a radiologic study viewed on a normal computer screen let alone the larger screens used in radiology departments." Dr. Rosenberg also reported that the plaintiff had normal color vision and the ability to use both eyes together without double vision.[7] Dr. Rosenberg opined that, while there was reasonable evidence supporting a diagnosis of convergence insufficiency, the plaintiff "is capable of performing full time work as a Radiologist from a vision standpoint, without restriction."[8]

2. Termination Decision

In December 2017, following Dr. Rosenberg's examination, the defendants terminated the plaintiff's benefits. The termination letter explained the defendants' decision as follows. The plaintiff had reported that she "did not really have any restrictions or limitations in any of [her] activities;" she provides care for her three children, volunteers at their school, performs household chores, drives, and works part-time at a radiology clinic. After "attempt[ing] a phone consultation with Dr. Becker," the defendants learned that Dr. Becker had retired and that his replacement, Dr. Pole, "was not conformable giving an opinion related to work and/or work capacity from a vision/ophthalmology standpoint." The plaintiff completed an independent medical examination; Dr. Rosenberg opined that "without a doubt" the plaintiff could perform full-time work as a radiologist.

***5** On February 21, 2018, plaintiff's counsel wrote to the defendants, requesting the plaintiff's "*entire* claim file." (emphasis is original). Plaintiff's counsel specifically requested "[a]ny professional opinions rendered in this claim." On February 23, 2018, the defendants provided the plaintiff a copy of the claim file.

3. Appeal

In August 2018, the plaintiff appealed the termination decision. She submitted records and a sworn statement from her new treating physician, Dr. Keith Warren, whom she had begun seeing in April 2018. Dr. Warren diagnosed the plaintiff with ischemic optic neuropathy in her left eye and found that she had been misdiagnosed with convergence insufficiency. Dr. Warren explained that his testing demonstrated that the plaintiff had a pupillary response abnormality, a visual field deficit adjacent to the optic nerve consistent with loss of blood supply to that nerve, and a left eye that was unable to conduct electricity as well as her right eye. Dr. Warren posited that Dr. Rosenberg misdiagnosed the plaintiff's condition by failing to identify permanent damage to her optic nerve. He stated that, contrary to Dr. Rosenberg's findings, the plaintiff was not correctable to 20/20 in each eye; in fact, she had reduced vision of 20/40 in her left eye. Dr. Warren opined that the plaintiff could not perform full-time work as a radiologist from a vision standpoint.

4. Final Decision

The defendants referred the plaintiff's file to an on-site physician, Dr. Richard Eisenberg. Dr. Eisenberg opined that the records did not support the plaintiff's purported

restrictions and limitations in her occupation as a radiologist. He opined that the plaintiff's visual acuity in her right eye would allow her to perform the duties of a radiologist, positing that "the right eye alone is sufficient to perform the visual duties of the [plaintiff's] occupation, as the reading of two-dimensional films does not require stereopsis." He also opined that there was sufficient retention of function in the plaintiff's left eye such that the plaintiff was not impaired. Dr. Eisenberg noted that the "presence of normal stereoscopic vision on more than one occasion by two examiners (Dr. Rosenberg and Dr. Taylor) indicates that the left eye, despite the evidence of optic nerve compromise, had recovered a significant amount of function."

Dr. Eisenberg also noted deficiencies in Dr. Rosenberg's report. According to Dr. Eisenberg, Dr. Rosenberg had not adequately recognized the presence of a persistent optic neuropathy in the plaintiff's left eye. In addition, Dr. Rosenberg had not recognized the presence of a mild relative afferent pupillary defect in the plaintiff's left eye, a defect documented by several other examiners.

Dr. Eisenberg also disagreed with certain of Dr. Warren's findings, noting that "the reduced visual acuity of 20/40 in the left eye on Dr. Warren's examination [from April 2018] is not consistently corroborated; and, in fact, is reported as 20/25 -1 OS on his repeat exam [from June 2018]. Multiple other examiners found corrected vision in the left eye to be consistently in the 20/25 – 20/30 range."

Following Dr. Eisenberg's review, the plaintiff's file was passed to another of the defendants' on-site physicians, Dr. Scott Norris. Deferring to Dr. Rosenberg and Dr. Eisenberg regarding the plaintiff's visual conditions, Dr. Norris opined that no non-ophthalmologic conditions rendered the plaintiff unable to work as a radiologist.

***6** On September 20, 2018, the defendants upheld their termination decision. The letter on the decision noted that the plaintiff's medical records "document the presence of normal stereoscopic vision on multiple occasions, which indicates that her left eye has recovered a significant amount of function despite evidence supporting optic nerve compromise." The letter continued, "Our ophthalmologist [Dr. Eisenberg] concluded [the plaintiff] would be capable of performing the visual demands of her occupation as a radiologist ... based on the vision in her right eye alone, as the reading of two-dimensional films would not require stereopsis." Finally, the letter stated that "our ophthalmologist determined the visual field defect in [the plaintiff's] left eye would not result in a deficit in both eyes since the full visual field in her right eye would fill any diminished area in her left."

On September 25, 2018, plaintiff's counsel requested an updated copy of the plaintiff's file, again requested any "professional opinions rendered in this claim." The defendants complied.

5. Lawsuit

In January 2019, the plaintiff filed suit. The plaintiff alleges that the defendants unlawfully terminated benefits due to her under the Plan. *See* 29 U.S.C. § 1132(a)(1)(B). In December 2021, the parties cross-moved for summary judgment. The defendants argue that their termination decision is supported by substantial evidence, and, under an arbitrary and capricious standard of review, must be affirmed. The plaintiff disagrees, both with respect to the reasonableness of the decision and the standard of review. The plaintiff additionally argues that the defendants committed a procedural error by failing to disclose reports from Dr. Eisenberg and Dr. Norris before rendering their final decision.

Legal Standard

[1] **[2]** "ERISA benefit-denial cases typically are adjudicated on the record compiled before the plan administrator." *Denmark v. Liberty Life Assur. Co.*, 566 F.3d 1, 10 (1st Cir. 2009). In such a case, a "motion for summary judgment is simply a mechanism for positioning" the case for disposition on the merits. *See Stephanie C. v. Blue Cross Blue Shield of Mass. HMO Blue, Inc.*, 852 F.3d 105, 110 (1st Cir. 2017). The district court's task is to evaluate the reasonableness of the administrative decision in view of the administrative record. *See Leahy v. Raytheon Co.*, 315 F.3d 11, 18 (1st Cir. 2002). In this sense, the district court "sits more as an appellate tribunal than as a trial court." *Id.*

[3] The standard of review depends on whether the plan at issue grants discretion to the plan administrator to determine eligibility for benefits. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). If it does, the court must uphold the administrator's decision unless the decision is arbitrary, capricious, or an abuse of discretion. *See Ortega-Candelaria v. Johnson &*

Johnson, 755 F.3d 13, 20 (1st Cir. 2014). If it does not, the court reviews the administrator's decision de novo. *See Firestone*, 489 U.S. at 115, 109 S.Ct. 948.

[4] Here, the parties disagree over the applicable standard of review: the defendants contend that the arbitrary and capricious standard applies; the plaintiff contends that review is de novo. The defendants have the better argument. The Plan contains an "entire contract" provision, which states, "The entire contract is made up of this Policy, the application of the policyholder, applications of the Participating Employers, and application by each Employee." In turn, Alliance's application includes a "notice to applicants" section, which states, "The Paul Revere Life Insurance Company, as claims administrator, has the *full, final, binding and exclusive authority* to determine eligibility for benefits and to interpret the policy under the plan as may be necessary in order to make claims determinations." (emphasis in original). In addition, a Booklet Certificate concerning the Plan (otherwise known as a Summary Plan Description, or "SPD") states, "The Plan, acting through the Plan Administrator, delegates to The Paul Revere, and its affiliate UnumProvident Corporation discretionary authority to make benefit determinations under the Plan." The language in the application and the SPD is sufficiently clear to grant the defendants discretionary authority to determine eligibility for benefits. *See Medina v. Metro. Life Ins. Co.*, 588 F.3d 41, 45 n.2 (1st Cir. 2009); *Gannon v. Metro. Life Ins. Co.*, 360 F.3d 211, 213, n.1 (1st Cir. 2004). The plaintiff does not contend otherwise.

***7** Rather, the plaintiff asserts that she was not given appropriate notice of the grant of discretion because she was not given a copy of either the application or the SPD prior to this litigation. The plaintiff relies on *Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.*, 813 F.3d 420, 427-29 (1st Cir. 2016), in which the First Circuit held that a financing agreement between an employer and a claims administrator could not be used to grant discretionary authority to the claims administrator because the financing agreement had not been "seasonably disseminated" to the employees against whom enforcement was sought. The plaintiff's reliance is misplaced.

Here, the application was explicitly referenced in the Plan itself, and the defendants sent Alliance a copy of the application in January 1999, requesting that Alliance keep a copy of the application in its files. The plaintiff was both an employee and a part-owner of Alliance. The application, therefore, would have been available for the plaintiff to review.

As to the SPD, an Unum billing coordinator declared, in reference to a discovery dispute earlier in this case, that the SPD would have been sent to Alliance on or about June 1, 2005 (when it became operative), per Unum's usual and customary business practices. Although there is no indication in the record that Alliance delivered the SPD to the plaintiff, the plaintiff was on notice, through the Plan, that the SPD existed. The Plan states that the defendants will "issue certificates of insurance for each insured Employee," which are "delivered to the Employer to be given to the Employee." As with the application, even if Alliance did not deliver a copy of the SPD to the plaintiff, the SPD would have been available for the plaintiff to review.

Both the application and the SPD were disseminated to Alliance, and, through the Plan, the plaintiff was appropriately notified that both documents existed in connection with the Plan. Thus, the plaintiff was provided with sufficient notice of the Plan's grant of discretionary authority. Accordingly, the applicable standard of review is arbitrary, capricious, or abuse of discretion.

Discussion

1. Full and Fair Review

[5] The plaintiff argues that the defendants failed to provide her with a "full and fair review" her claim. Following *Jette v. United of Omaha Life Ins. Co.*, 18 F.4th 18 (1st Cir. 2021), the plaintiff contends that the defendants violated 29 C.F.R. § 2569.503-1(h)(2)(iii) by not timely disclosing two medical opinions generated on appeal -- those of Dr. Eisenberg and Dr. Norris.

An employee benefit plan under ERISA must "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133(2). A "full and fair review" means the claimant has, "upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." 29 C.F.R. § 2569.503-1(h)(2)(iii).

In *Jette*, 18 F.4th at 24, an employee appealed an adverse benefit determination and requested that the claim administrator "promptly disclose any new medical opinions generated during the appeal process." In response, the administrator refused to disclose a new report until after the appeal had been finalized. *See id.* The First Circuit held that the administrator's failure to disclose the report violated the employee's right to a full and fair review of her claim. *See id.* at 29. The court determined that, upon the claimant's request "after the initial adverse determination," the administrator had to disclose relevant documents generated on appeal. *See id.* The court reasoned that the language of 29 C.F.R. § 2569.503-1(h)(2)(iii) is not limited to information relevant to the initial adverse determination, but rather, encompasses information relevant to the appeal. *See id.* at 28. Moreover, consistent with the policy of judicial review confined to an administrative record, claimants at the administrative stage "must be allowed to engage in a meaningful dialogue regarding the denial of benefits." *Id.* at 29.

***8** Here, after the initial adverse determination, plaintiff's counsel wrote to the defendants, requesting the plaintiff's "*entire* claim file," including a copy of "[a]ny professional opinions rendered in this claim." This request was sufficient to require the defendants to disclose information generated on appeal, not just information relevant to the initial adverse determination. While the defendants promptly disclosed the claim file as it stood at the time of the request, the defendants did not update their disclosure with documents generated in response to the plaintiff's appeal until after the appeal decision was finalized and the plaintiff re-requested documents.

Among the undisclosed documents considered by the defendants on appeal were file reviews by Dr. Eisenberg and Dr. Norris. Dr. Eisenberg opined that the plaintiff could return to work as a radiologist because "the right eye alone is sufficient to perform the visual duties of the [plaintiff's] occupation, as the reading of two-dimensional films does not require stereopsis." Dr. Norris opined that no non-ophthalmologic conditions prevented the plaintiff from returning to work as a radiologist. Those documents were relevant to the plaintiff's claim, and, because the plaintiff had requested a copy of "[a]ny professional opinion[ ] rendered in [her] claim," the defendants were required to disclose them. Thus, the defendants did not provide the plaintiff with a "full and fair review" or her claim, as set forth in 29 C.F.R. § 2569.503-1(h)(2)(iii).

2. Prejudice

[6] The plaintiff was prejudiced by the defendants' error, at least with respect to Dr. Eisenberg's opinion.[9] The defendants' termination decision rested in part on Dr. Rosenberg's opinion that the plaintiff had correctable 20/20 vision in both eyes and could use both eyes together without double vision. On appeal, Dr. Warren criticized Dr. Rosenberg's finding that the plaintiff had correctable 20/20 vision in both eyes. Dr. Eisenberg, in his review of the plaintiff's medical records, agreed with some of Dr. Warren's criticisms. Accordingly, Dr. Eisenberg offered his own, additional justifications for concluding that the plaintiff could return to work as a radiologist. Specifically, Dr. Eisenberg opined that the plaintiff could use her right eye alone "because the reading of two-dimensional films does not require stereopsis." The defendants relied on this opinion in upholding their decision.

The plaintiff makes clear in her summary judgment papers that she disagrees with Dr. Eisenberg's opinion that she can work as a radiologist using only her right eye. Yet, because the defendants did not disclose Dr. Eisenberg's analysis prior to rendering their final decision, the plaintiff was not able to rebut Dr. Eisenberg's analysis in the administrative record. Accordingly, the plaintiff was prejudiced.

3. Remedy

[7] The Court is confronted with an incomplete record from which to determine whether the defendants' decision was arbitrary, capricious, or an abuse of discretion.[10] Accordingly, the appropriate remedy is a remand to the administrative stage. *See Jette*, 18 F.4th at 33; *Estate of Chambers v. Blue Cross & Blue Shield of Mass., Inc.*, 2021 WL 4079794, at *5 (D. Mass. Sept. 8, 2021). There, the plaintiff will have an opportunity to respond to Dr. Eisenberg's analysis on the administrative record, after which the defendants will make a new determination based on that supplemental record. In the end, the plaintiff will have been afforded "the benefit of a full and fair review." *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1035 (9th Cir. 2006) (quoting *Syed v. Hercules Inc.*, 214 F.3d 155, 162 (3d Cir. 2000)).

Conclusion

9** For the reasons stated, the plaintiff's motion for summary judgment (Docket No. 66) is ***granted, the defendants' motion for summary judgment (Docket No. 63) is ***denied***, and the case is remanded to the administrative stage.

SO ORDERED.

All Citations

--- F.Supp.3d ----, 2022 WL 780724

Footnotes

1 The defendants briefly terminated the plaintiff's benefits in April 2010, but upon receiving updated information from the plaintiff's treating ophthalmologist, the defendants reinstated benefits in October 2010, with back-pay.

2 Dr. Kay reviewed the plaintiff's records on behalf of Northwestern Mutual Life Insurance Company ("Northwestern Mutual"), an insurer from which the plaintiff also sought disability benefits.

3 Dr. Taylor conducted an independent medical examination of the plaintiff, at Northwestern Mutual's request.

4 In response to the question whether the plaintiff was "capable of reading 2-dimensional films/screens with monocular vision," Dr. Taylor responded that the plaintiff "told me that she feels uncomfortable reading two dimensional radiologic studies at this time because of the residual visual loss in her left eye, and I personally feel that this leads to as of yet unaddressed issues concerning [the plaintiff's] performance as a radiologist from a professional liability standpoint." Dr. Taylor added that "if [the plaintiff] feels that she would be indefensible in a situation of professional liability malpractice action, this would be a major functional 'road block' in her ability to work as a radiologist."

5 The plaintiff had been diagnosed with breast cancer and was undergoing treatment.

6 In June 2017, the plaintiff had reported that while her vision was still blurred, "there are not R & L's [restrictions and limitations] really."

7 The defendants contracted with a company called Dane Street to arrange the independent medical examination. Dane Street indicated that it could not immediately locate a doctor to conduct the examination within 200 miles of the plaintiff's home in Kansas. Dr. Taylor was identified as a possibility, but, according to notes in the administrative record, he declined.

8 Although the defendants had not previously provided Dr. Rosenberg with their determined visual requirements for the occupation of radiologist (constant near acuity, occasional accommodation, occasional color vision, and an extremely high aptitude in form perception), the defendants followed up with Dr. Rosenberg after his report. In response to the defendants' follow-up question whether the plaintiff would be able to meet those requirements, Dr. Rosenberg responded, "Absolutely able to perform which was in my report."

9 Because the plaintiff does not contend that any non-ophthalmologic conditions prevent her from working as a radiologist, the Court discerns no prejudice from the defendants' non-disclosure of Dr. Norris's opinion.

10 This is not a case where the plaintiff was so clearly denied benefits to which she was entitled, such that no remand is necessary. *See* *McDonough v. Aetna Life Ins. Co.*, 783 F.3d 374, 382 n.6 (1st Cir. 2015).

Table of Authorities (13)

Treatment	Referenced Title	Type	Depth	Quoted	Page Number
Cited	**1. Chuck v. Hewlett Packard Co.** 455 F.3d 1026, 9th Cir.(Or.), 2006 LABOR AND EMPLOYMENT - Benefit Plans. Plan's material violation of claims procedures militates strongly against running of limitations period against claimant.	Case			8
Cited	**2. Denmark v. Liberty Life Assur. Co. of Boston** 566 F.3d 1, 1st Cir.(Mass.), 2009 LABOR AND EMPLOYMENT - Benefit Plans. Remand was appropriate so that district court could reconsider benefits denial in light of Glenn.	Case			6
Mentioned	**3. Estate of Chambers v. Blue Cross and Blue Shield of Massachusetts, Inc.** 2021 WL 4079794, D.Mass., 2021 The Estate of Paul Nelson Chambers brings this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 et seq., seeking to recover long-term...	Case			8
Cited	**4. Firestone Tire and Rubber Co. v. Bruch** 109 S.Ct. 948, U.S.Pa., 1989 Former employees who were terminated by employer and hired by successor corporation immediately upon sale of employer's plant brought action for alleged violations of Employee...	Case			6+
Mentioned	**5. Gannon v. Metropolitan Life Ins. Co.** 360 F.3d 211, 1st Cir.(Mass.), 2004 LABOR AND EMPLOYMENT - Benefit Plans. Benefit plan's disability insurer reasonably found non-disability despite treating physicians' opinions.	Case			6
Discussed	**6. Jette v. United of Omaha Life Insurance Company** 18 F.4th 18, 1st Cir.(Mass.), 2021 LABOR AND EMPLOYMENT — Benefit Plans. ERISA claims administrator deprived participant of full and fair review of her claim by not disclosing IME to plan participant upon request.	Case			7+
Cited	**7. Leahy v. Raytheon Co.** 315 F.3d 11, 1st Cir.(Mass.), 2002 INSURANCE - Disability. Arbitrary and capricious standard applied on appeal in action challenging ERISA determination.	Case			6+

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Cited	**8. McDonough v. Aetna Life Ins. Co.** 783 F.3d 374, 1st Cir.(Mass.), 2015 LABOR AND EMPLOYMENT - Benefit Plans. Claims administrator was arbitrary and capricious under ERISA in terminating long-term disability benefits.	Case			8
Cited	**9. Medina v. Metropolitan Life Ins. Co.** 588 F.3d 41, 1st Cir.(Puerto Rico), 2009 LABOR AND EMPLOYMENT - Benefit Plans. ERISA plan administrator's denial of short term disability benefits was supported by substantial evidence.	Case			6
Cited	**10. Ortega-Candelaria v. Johnson & Johnson** 755 F.3d 13, 1st Cir.(Puerto Rico), 2014 LABOR AND EMPLOYMENT - Benefit Plans. Administrator was not arbitrary and capricious in denying participant benefits upon finding participant was uncooperative during exam.	Case			6
Cited	**11. Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.** 852 F.3d 105, 1st Cir.(Mass.), 2017 LABOR AND EMPLOYMENT — Benefit Plans. Denial of coverage for housing and treatment of son at residential private school treatment center was warranted under ERISA.	Case		”	6
Cited	**12. Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.** 813 F.3d 420, 1st Cir.(Mass.), 2016 LABOR AND EMPLOYMENT - Benefit Plans. Phraseology used in certificate was insufficiently distinct to constitute clear grant of discretionary decisionmaking authority.	Case			7
Mentioned	**13. Syed v. Hercules Inc.** 214 F.3d 155, 3rd Cir.(Del.), 2000 LABOR AND EMPLOYMENT - Benefit Plans. One year limitations period for work related claims applied to claim for benefits under ERISA.	Case			8