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United States District Court, D. Massachusetts.

Natalya PROHKOROVA, Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA, Defendant.

Civil Action No. 17-30064-MGM
|
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Attorneys and Law Firms

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MEMORANDUM AND ORDER REGARDING CROSS-MOTIONS FOR SUMMARY JUDGMENT

(Dkt. Nos. 40 and 43)

MASTROIANNI, U.S.D.J.

I. Introduction

***1** Natalya Prohkorova ("Plaintiff") brought this action against Unum Life Insurance Company of America ("Defendant"), challenging Defendant's denial of long-term disability ("LTD") benefits under the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 *et seq*. The parties have filed cross-motions for summary judgment. For the following reasons, the court concludes Defendant's decision to deny Plaintiff LTD benefits was flawed, such that it was arbitrary and capricious. The court will therefore grant Plaintiff's motion in part, deny Defendant's motion, and remand the matter to Defendant for further administrative proceedings.

II. Background

Plaintiff was born in Ukraine, where she attended medical school and began working as a pediatrician. (Administrative Record ("A.R.") at 1486-88.) She immigrated to the United States in 1989 along with her family. (*Id.* at 1489-90.) After learning English, Plaintiff studied for and passed the ECFMG Exam, a special exam for foreign medical students. (*Id.* at 1491-93.) Thereafter, Plaintiff completed a residency program at Mount Sinai Hospital and passed her board certification. (*Id.* at 1493-98.) In 2005, Plaintiff began practicing pediatrics at the Caring Health Center in Springfield, Massachusetts. (*Id.* at 1499.) As a result, Plaintiff received LTD coverage under an employee benefit plan provided by the Caring Health Center, which was funded by a policy issued by Defendant. (A.R., UA-POL at 1-31.) Defendant also served as the claims administrator. (*Id.*)

On January 2, 2007, Plaintiff bent over to reach for her purse and experienced abrupt back pain. (A.R. at 73, 142.) On January 8, 2007, Plaintiff had an MRI and began treating with Dr. Allen Kantrowitz, an attending neurosurgeon at Berkshire Medical Center. (*Id.* at 70.) The MRI revealed "a moderate size central disc herniation at T8-T9," which was "mildly deforming the ventral surface of the cord" and "slightly extruded behind the body of T8." (*Id.*) In a Consultation Report dated January 16, 2007, Dr. Kantrowitz stated that Plaintiff had an acute thoracic disc herniation at the T8-T9 level, along with symptoms "which clearly suggest there is a strong correlation with weight-bearing." (*Id.* at 73.) Dr. Kantrowitz believed there was "a potential threat to [Plaintiff's] thoracic spinal cord," found Plaintiff disabled, and ordered that she stay on bedrest. (*Id.*)[1]

***2** On May 15, 2007, Plaintiff filed a claim for LTD benefits with Defendant. (*Id.* at 58.) The policy defines disability as follows:

> You are disabled when Unum determines that:
>
> • you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
>
> • you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

(A.R., UA-POL at 15.) In addition, the policy states:

> You will continue to receive payments beyond 24 months if you are also:
>
> • working in any occupation and continue to have 20% or more loss in your indexed monthly earnings due to your sickness or injury; or
>
> • not working and, due to the same sickness or injury, are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

(*Id.*) On July 5, 2007, Defendant approved Plaintiff's claim and began paying disability benefits. (A.R. at 183-86.)[2]

On July 27, 2007, Dr. Peter G. Kouros, a medical consultant for Defendant, reported a review of Plaintiff's medical records. (*Id.* at 206-07.) Dr. Kouros concluded that "the medical and functional information in the file is consistent with the diagnosed thoracic disc herniation.... I believe it is medically reasonable to support the opinion of Dr. Kantrowitz that the Insured is presently precluded from performing her occupation." (*Id.* at 207.) Dr. Kouros also stated that "[r]esults of thoracic disc surgery are not as good as the results of cervical or lumbar disc surgery. There is a higher rate of permanent neurologic complication with surgery on the thoracic disc compared to cervical and lumbar discs, so the decision on surgical treatment should be deliberate." (*Id.* at 206-07.) Dr. Kouros's statement regarding treatment was consistent with Dr. Kantrowitz's conservative, nonsurgical approach, which included a TLSO back brace and over-the-counter pain medication. (*Id.* at 78, 141.) Both doctors, at least at the time, expected Plaintiff's condition to improve, and ultimately resolve, over time. (*Id.* at 73, 206.)

On September 18, 2007, Plaintiff had another MRI in an upright (weight-bearing) position. (*Id.* at 304.) Dr. Kantrowitz, after reviewing the MRI and evaluating Plaintiff, stated on December 1, 2007 that he believed Plaintiff was "having continuous progressive, albeit slow, improvement in her thoracic syndrome." (*Id.* at 305.) Dr. Kantrowitz also stated that he found Plaintiff "remains 100% disabled for work on a temporary basis. Her work responsibilities would involve working with young children who could start to fall from an examining table and therefore would demand immediate instantaneous response on the part of [Plaintiff] to catch such a child," which Dr. Kantrowitz found to be "an unacceptable risk." (*Id.*)

***3** In a July 13, 2008 Consultation Report, Dr. Kantrowitz described Plaintiff as having

> a clinically disabling syndrome with severe pain felt in a band-like distribution at a level corresponding to the lower thoracic segments. This disabling band-like pain is experienced when [Plaintiff] is upright for a period of time. It is relieved with recumbency [lying down]. The length of time before the onset of the pain with the upright position can be extended if [Plaintiff] wears her TLSO brace snugly fitted so as to engage her rib cage with close interference. Prolonged sitting also brings on the pain. Overall [Plaintiff] finds that she is able to remain in a weightbearing posture either standing or sitting for a longer period of time than she would have been able to several months ago. In other words, she is enjoying a small amount of subjective improvement.

(*Id.* at 398.) Dr. Kantrowitz further reported that Plaintiff "must be free to assume the recumbent position when the pain becomes severe. She should avoid prolonged standing and prolonged sitting. She is to avoid bending, twisting, and squatting, and she can lift no more than 10 pounds," but even that "must be done with meticulous attention to body mechanics." (*Id.* at 399.) In addition, Dr. Kantrowitz reiterated his finding of 100% disability from work, although he was "still optimistic that this status could change in the future, and therefore ... regard[ed] her 100% disability as a temporary condition." (*Id.*) Lastly, Dr. Kantrowitz repeated his prior assertion regarding the "unacceptable risk" of Plaintiff needing to "catch a falling child" as a pediatrician. (*Id.*)

On September 3, 2008, Defendant's vocational rehabilitation consultant, Kim S. Walker, confirmed her prior assessment —performed on June 21, 2007, as part of a "Team Based Approach roundtable"—that Plaintiff's occupation as a pediatrician "would require frequent stand[ing] and walk[ing]" along with lifting "up to 50 pounds." (*Id.* at 145, 173, 455.) Although the Dictionary of Occupational Titles ("DOT") and Enhanced Dictionary of Occupational Titles ("EDOT"), which are produced by the Department of Labor, classify pediatrician as requiring lifting of only 20 pounds, Ms. Walker stated, based on her "professional opinion and experience," "that pediatricians provide care and interact with children up to 18 which would require lifting beyond light." (*Id.*) Ms. Walker additionally found Plaintiff's occupation "would require bending [and] stooping to get down to [the] level of children." (*Id.*) Subsequently, both Dr. Kouros and Dr. Hugh P. Brown, medical consultants

for Defendant, described Plaintiff's occupation as "medium work" under the DOT and EDOT. (*Id.* at 490, 500.)[3]

***4** An October 18, 2008 MRI revealed a decrease in the size of the disc herniation, which was noted to be "compatible with the expected evolution" of the condition. (*Id.* at 651.) On November 21, 2008, Dr. James Greenspan conducted an independent medical examination ("IME") of Plaintiff at the direction of Defendant. (*Id.* at 602-605.)[4] Dr. Greenspan both examined Plaintiff and reviewed various medical records. (*Id.* at 602.) He opined that Plaintiff's "complaints and physical exam are reasonably consistent with a herniated disc in the mid to lower thoracic spine"; did not recommend a psychiatric evaluation in light of Plaintiff's "history, physical exam, and appropriate imaging studies that appear to correlate with a specific pathology"; and noted Plaintiff's "prognosis is guarded at best." (*Id.* 604-05.) Dr. Greenspan concluded that Plaintiff's "ability to perform work activities would be severely limited by her thoracic discomfort and issues involving her lower extremity" and, thus, there was "really no productive work that [Plaintiff] would be able to perform on a routine basis with her current level of disability." (*Id.* at 605.) A December 2, 2008 review by Dr. Kouros, Defendant's medical consultant, concluded that Plaintiff's restrictions and limitations were supported, as Dr. Greenspan's IME "appears valid and complete." (*Id.* at 607.)

In a December 27, 2008 Consultation Report, Dr. Kantrowitz reviewed the most recent MRI results,[5] which revealed "some continued time evolution as expected of the soft tissue components of the herniated [disc]" compared with prior MRIs. (*Id.* at 662.) Nevertheless, Dr. Kantrowitz found Plaintiff "is at maximum medical improvement. She has been plateaued with respect to her functional status." (*Id.* at 663.) Dr. Kantrowitz further concluded that Plaintiff, after having been temporarily disabled for nearly two years, was "now permanently disabled." (*Id.*)

On March 4, 2009, Defendant informed Plaintiff that it would be extending her LTD benefits beyond the initial 24 months and into the "any occupation" period of coverage: "Based on the facts of your claim, as well as our clinical review, we do not anticipate a change in your medical status and, therefore, have made the decision to extend our approval of your benefits." (*Id.* at 683.) Plaintiff's claim was transferred to Defendant's Extended Benefits Center unit, resulting in fewer reporting requirements. (*Id.*) For the next four years, Dr. Kantrowitz completed annual Disability Status Update forms and Plaintiff's condition remained essentially the same. (*Id.* at 723-26, 738-42, 766-70, 785-86.) As noted in an internal review, Defendant considered Plaintiff's claim "feasible for settlement consideration" in July of 2013. (*Id.* at 1742.) On December 6, 2013, Defendant prepared a present value of future benefits calculation of Plaintiff's LTD claim through August 5, 2027. (*Id.* at 845-46.) On December 10, 2013, however, Defendant deferred further settlement consideration pending "validation ... to obtain an update on [Plaintiff's] functional status." (*Id.* at 847.)

Following a field visit with Plaintiff on April 21, 2014, at which Plaintiff reported some minor improvement from the last field visit in 2008,[6] Defendant ordered that another IME be conducted. (*Id.* at 900, 1799.) On June 18, 2014, Dr. Brian Gordon performed an IME, which included both a review of the medical records and an examination of Plaintiff. (*Id.* at 1807-15.) Dr. Gordon noted that Plaintiff had "thoracic pain radiating into the chest region in a belt or band like distribution consistent with a thoracic radiculopathy." (*Id.* at 1813.) He noted: "The chronic pain that she is experiencing has been subjective in nature.... I do not find objective abnormalities attributable to thoracic pathology." (*Id.*) Dr. Gordon also noted, however, that "thoracic radiculopathy is often times difficult to truly document in terms of objective findings." (*Id.*) He continued:

> ***5** Unfortunately, I feel that this is a situation where [Plaintiff] is going to be complaining of chronic thoracic pain for an indefinite period of time. I find it interesting that [she] has not had any pain management treatments and my goal of obtaining an MRI would largely be predicated on attempting pain management modalities for [Plaintiff], possibly including injections and/or rhizotomies at a pain management specialist's discretion. I find it unlikely that there would be a surgical remedy for her. In terms of work restrictions, [Plaintiff] has exhibited significant pain behaviors in the office today and working as a pediatrician with these behaviors is likely to limit her effectiveness, regardless of whether her pain is organic; if she feels that she is unable to perform her tasks, she could place pediatric patients in jeopardy and as such, it is not likely that she could function as a pediatrician. Her oswestry disability index is quite high and when we see that, there is always ... the question of psychological overlay and in my opinion, a psychiatric examination would be appropriate.

(*Id.*)[7]

Dr. Gordon also wrote in his July 8, 2014 addendum to the IME report, in response to a question from

Defendant regarding "musculoskeletal activity restrictions," that because Plaintiff's complaints "were primarily subjective in nature with a paucity of objective findings," he thought it was important to obtain updated MRIs "before giving any definitive opinions regarding activity restrictions." (*Id.* at 1814-15.) Dr. Gordon wrote that he did "not see any absolute contra-indications to various activities," as he thought it was "reasonable for her to undertake activities without specific restriction based on her neurological findings." (*Id.* at 1815.) "[H]owever," Dr. Gordon reiterated, "if [Plaintiff] complains of persistent pain that we have no objective way to quantify, I cannot state that she should be compelled to pursue her duties as a pediatrician and potentially put patients at risk." (*Id.*)

On October 2, 2014, Dr. Joel Saks, a medical consultant for Defendant, reviewed Dr. Gordon's IME report and July 8, 2014 addendum. (*Id.* at 949-50.) Dr. Saks ordered thoracic and lumbar MRI studies and requested that they be performed on "a university based MRI such as may be found at Albany Medical Center." (*Id.* at 950.) On November 20, 2014, Plaintiff had weight-bearing and non-weight-bearing MRIs of her thoracic spine and lumbar spine, performed in Miami, Florida on a 3.0T Wide-Bore MRI machine pursuant to a prescription written by Dr. Kantrowitz ("Miami MRIs").[8] The following day, Plaintiff was examined by Dr. Kantrowitz, who noted "[t]he MRI demonstrates a moderate scoliotic curve in both thoracic and lumbar segments. At T8/9, [herniated nucleus pulposus] is demonstrated on the weight-bearing views" and "is readily identifiable." (*Id.* at 1854.) Dr. Kantrowitz concluded: "Updated MRI information consistent with previously proposed mechanisms of clinical syndrome of thoracic radiculopathy correlating weight-bearing position with onset of pain." (*Id.* at 1855.) He also found Plaintiff's "work status remains permanently disabled." (*Id.*; *see also id.* at 977-84.)

***6** On December 4, 2014, Plaintiff underwent additional non-weight-bearing MRIs of her thoracic and lumbar spine at St. Peter's Hospital in Albany, on a 1.5T MRI machine ("St. Peter's MRIs"), which is half as powerful as the 3.0T machines available at the Albany Medical Center and in Miami. (*Id.* at 1871-72; *see id.* at 1356.)[9] The St. Peter's MRI report noted "[t]here is no disc herniation" or "central canal stenosis," but only mild degenerative disc disease from T5 to T9. (*Id.* at 1871.) On January 6, 2015, Dr. Saks directed that the CD images of the St. Peter's MRIs and the reports be sent to Dr. Gordon, but that only copies of the reports of the Miami MRIs be sent to him. (*Id.* at 1885.)

On January 15, 2015, Dr. Gordon wrote another addendum to his IME report. (*Id.* at 1887-88.) Dr. Gordon reviewed the St. Peter's MRI images as well as the notes from Dr. Kantrowitz regarding the Miami MRIs, but he stated that he did "not have [the Miami MRI] films for review." (*Id.* at 1887.) In response to the question "does you musculoskeletal and neurologic evaluation of [Plaintiff] support a need for work activity restrictions," Dr. Gordon concluded:

> *According to the MRI's that I have visualized*, I do not see objective findings that would correlate with the patient's symptoms. I do not see a need for work activity restrictions *based on the films that I have visualized*, including the most recent MRI's performed at St. Peters or my neurologic evaluation. As I have previously indicated, the patient continues to complain of persistent pain that I have no way to objectively quantify. I can not state that she should be compelled to pursue her duties as a pediatrician if that potentially puts her patients at risk. In terms of objective findings for work activity restrictions based on radiographic and physical exam, I do not find any.

(*Id.* at 1888 (emphasis added).)

Following another review by Dr. Saks on January 21, 2015, Defendant ordered that an independent psychiatric evaluation of Plaintiff be conducted by Dr. Stephen Rappaport. (*Id.* at 993-34, 1033-35.) On April 9, 2015, Dr. Rappaport, after examining Plaintiff and reviewing her medical records, wrote in a Psychiatric Evaluation: "My diagnostic impression is not indicative of any psychiatric condition at this time." (*Id.* at 1040.) Rather, according to Dr. Rappaport, "[i]t appears that [Plaintiff's] chronic pain is a direct result of the injury she sustained in January 2007." (*Id.* at 1041.)

On May 1, 2015, Defendant notified Plaintiff that it had terminated her LTD benefits as of that date. (*Id.* at 1051-57.) Defendant's termination letter noted, among other reasons, that Plaintiff's report of spending "the majority of your time in bed or in a recliner since January of 2007 is inconsistent with your ability to maintain muscle mass and weight, with no other apparent decline in your health that would be expected with your reported level of inactivity over 8 years"; questioned why Plaintiff "would not seek treatment from a local provider," in light of the long and difficult travel to Florida to see Dr. Kantrowitz; and noted that Plaintiff, during her 2014 IME, "exhibited inconsistencies during muscle strength testing that was indicative of variable effort." (*Id.* at 1053.) In addition, Defendant relied on the December 4, 2014 St. Peter's MRIs:

***7** Our physician, board certified in orthopedic surgery, noted that the December 4, 2014 study, thoracic MRI shows no findings of stenosis or nerve root compression that would be consistent with thoracic radiculopathy or local thoracic pain. Compared with the thoracic MRI done on October 8, 2008, the size of the thoracic disc herniation had decreased so that on the December 4, 2014 study, there is no longer any disc herniation seen. Other findings were noted to be mild and age appropriate.

(*Id.* at 1053-54.) Significantly, other than noting that Plaintiff also had MRIs conducted on November 20, 2014, Defendant did not discuss the results of the Miami MRIs. (*Id.*) Defendant concluded that "the information in your claim file does not support that you are precluded from performing your regular occupation" and, as a result, Plaintiff no longer met the definition of disability under her LTD policy. (*Id.* at 1054.)

On December 11, 2015, Plaintiff submitted her administrative appeal of Defendant's decision to terminate her LTD benefits. (*Id.* at 1171-1218.) Plaintiff argued that Dr. Gordon's January 15, 2015 addendum to the IME report was flawed because his opinion was limited to the MRI films he "visualized," which did not include the Miami MRIs showing the continued presence of the disc herniation. (*Id.* at 1198-1201.) Plaintiff also argued Defendant had failed to provide a reasonable explanation (or any explanation) for disregarding Dr. Kantrowitz's opinion regarding Plaintiff's condition. (*Id.* at 1202-03.) In addition, Plaintiff provided Defendant with Dr. Kantrowitz's opinion regarding the St. Peter's MRIs, which Dr. Kantrowitz read as showing a herniated disc. (*Id.* at 1283.) Plaintiff also provided the opinions of two other neurosurgeons, Dr. Christopher H. Comey and Dr. Khalid M. Abbed, both of whom, in September of 2015, agreed with Dr. Kantrowitz's findings of a disc herniation based on the Miami MRIs. (*Id.* at 1299, 1311-14.)[10] Lastly, Plaintiff argued her credibility, as demonstrated in multiple interviews and extensive surveillance, supported her claim for LTD benefits. (*Id.* at 1206-11.)

In response to Plaintiff's appeal, Defendant had its in-house consultant, Dr. Charles Sternbergh, conduct a written review. (*Id.* at 1743.) On January 13, 2016, Dr. Sternbergh wrote that the Miami MRIs demonstrate "continued presence of disc protrusion at T8-9"; he did not mention the St. Peter's MRIs. (*Id.* at 1745; *see also id.* at 1746 ("Serial imaging of the herniated disc at T8-9 do not demonstrate resolution of the herniated disc, but there are no progressive degenerative changes.").) Nevertheless, Dr. Sternbergh concluded: "After review of all available medical records, it is my opinion that claimant could sustain light physical demand work activities with occasional lifting of 20 pounds, frequent sitting, and occasional standing or walking. Claimant would be allowed to change position every hour if needed between sitting, standing, or walking." (*Id.* at 1745.) Dr. Sternbergh also stated: "Claimant's reports of being able to sustain brief and minimal physical activities do not correlate with continued imaging, and expected pain improvement after a thoracic herniated disc." (*Id.* at 1746; *see also id.* ("After review of all medical information since 2007, complaints of impairment are in excess of medical abnormalities, with consideration of the natural history of a herniated thoracic disc.").) Dr. Sternbergh noted that Plaintiff "has had no evidence of muscle atrophy, contractures, or skin breakdown in spite of related history of virtual bedrest from 2007 to the present one" and that "[a]fter 8 years, it would be reasonable for her to lift 20 pounds occasionally, sitting frequently, and stand or walk occasionally." (*Id.*)

***8** On January 19, 2016, a new occupational assessment was performed by Richard Byard, another vocational rehabilitation consultant for Defendant. (*Id.* at 1752.) Mr. Byard stated that, despite the prior occupational assessments performed in 2007 and 2008 finding Plaintiff's occupation required lifting up to 50 pounds and frequent standing and walking, her occupation actually required lifting of only 20 pounds and occasional standing and walking. (*Id.* at 1754.) Mr. Byard relied on the DOT and EDOT listings for pediatrician, which stated that the pediatrician occupation "is one that is performed at a 'Light" level of physical exertion" as defined by the DOT. (*Id.*) In addition, Mr. Byard stated the contrary conclusion in the prior occupational assessments "was reached without any corroborative data or support from established vocational resources." (*Id.*) Accordingly, Mr. Byard found, in light of Dr. Sternbergh's conclusion regarding Plaintiff's restrictions and limitations, that "the physical demands of [Plaintiff's] own occupation would not exceed her stated level of work capacity." (*Id.*) Moreover, Mr. Byard declined to assess Plaintiff's "capacity to perform alternative occupations," given that she could perform her own occupation of pediatrician. (*Id.*)

On January 26, 2016, Defendant denied Plaintiff's administrative appeal. (*Id.* at 1762.) Defendant primarily relied on Dr. Sternbergh's opinion and the updated occupational assessment. (*Id.* at 1764-65.) Defendant also noted that because Plaintiff "did not have any MRI findings that were consistent with her pain complaints, it is our opinion

that she is capable of performing the duties of her occupation as of May 1, 2015." (*Id.* at 1766.) Defendant further stated that Plaintiff's "updated medical documentation" indicated "she has improved and is capable of returning to work in her occupation at the present time." (*Id.*) In addition, Defendant noted Plaintiff "uses no analgesics except ibuprofen and has not been under any significant pain management program," questioned why Plaintiff "would continue to make [the trip to Florida to see Dr. Kantrowitz] if the level of her discomfort was not bearable," and listed the total amount of benefits paid to Plaintiff under the LTD policy. (*Id.* at 1764, 1767.)

III. Standard of Review

As the parties agree, the LTD policy at issue here provides Defendant with discretionary authority to determine benefit eligibility. (A.R., UA-POL at 11.) Accordingly, a deferential standard of review applies, under which the administrator's decision will be upheld unless it is "arbitrary, capricious, or an abuse of discretion." *Ortega-Candelaria v. Johnson & Johnson*, 755 F.3d 13, 20 (1st Cir. 2014) (quoting *Cusson v. Liberty Life Assur. Co. of Bos.*, 592 F.3d 215, 224 (1st Cir. 2010)); *see also Colby v. Union Sec. Ins. Co. & Mgmt. Co. for Merrimack Anesthesia Assocs. Long Term Disability Plan*, 705 F.3d 58, 61 (1st Cir. 2013) (explaining that, in the ERISA context, the phrases "abuse of discretion" and "arbitrary and capricious" are "equivalent"). "Whatever label is applied, the relevant standard asks whether a plan administrator's determination 'is plausible in light of the record as a whole, or, put another way, whether the decision is support be substantial evidence in the record.' " *Colby*, 705 F.3d at 61 (quoting *Leahy v. Raytheon Co.*, 315 F.3d 11, 17 (1st Cir. 2002)). While this standard is deferential, it does not mean "no review at all." *Id.* at 62. "In short," the plan administrator's decisions "must be reasonable." *Id.*

"It also bears emphasis that this standard of review, which concerns a fiduciary element of the role of an ERISA plan administrator, must reflect the relevant principles of trust law, rather than the law of contracts." *D & H Therapy Assocs., LLC v. Bos. Mut. Life Ins. Co.*, 640 F.3d 27, 37 (1st Cir. 2011); *see also Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008) (explaining that "ERISA imposes higher-than-marketplace quality standard on insurers," under which a plan administrator must " 'discharge [its] duties' in respect to discretionary claims processing 'solely in the interests of the participants and beneficiaries' of the plan" (quoting 29 U.S.C. § 1104(a)(1))). In this regard, the First Circuit recently framed the inquiry as follows: "To what extent has [Defendant] conducted itself as a true fiduciary attempting to fairly decide a claim, letting the chips fall as they may?" *Lavery v. Restoration Hardware Long Term Disability Benefits Plan*, 937 F.3d 71, 79 (1st Cir. 2019). "To the extent [Defendant] has not so conducted itself in deciding [Plaintiff's] claim," the First Circuit explained it "would tend to move in the direction of viewing its decision as arbitrary and capricious rather than fair and reasoned." *Id.*

***9** Moreover, as the parties also acknowledge, the fact that Defendant was "in the position of both adjudicating claims and paying awarded benefits" means it had a structural conflict of interest. *Denmark v. Liberty Life Assur. Co. of Boston*, 566 F.3d 1, 7 (1st Cir. 2009) (citing *Glenn*, 554 U.S. at 112-14). Although such a conflict does not change the standard of review to *de novo*, it is "one factor among many that a reviewing judge must take into account." *Glenn*, 554 U.S. at 116. Accordingly, a structural conflict of interest should be considered in the same way as other, "often case specific, factors" are weighed: "any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance." *Id.* at 117. The Supreme Court has explained that a "conflict of interest ... should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision." *Id.* Another important factor recognized by the Supreme Court in *Glenn*, to be weighed alongside a conflict of interest, was "procedural unreasonableness." *Id.* at 118; *see Lavery*, 937 F.3d at 78.[11]

IV. Analysis

The court concludes, after a review of the administrative record as a whole and considering the parties' arguments in support of their cross-motions, that Defendant's decision to terminate Plaintiff's LTD benefits resulted from a flawed process and was not the product of reasonable decision making. Moreover, as will be described, Defendant's procedural errors, shifting rationales, and missing explanations suggest its structural conflict of interest played a role in its decision. Accordingly, the court concludes Defendant's decision was arbitrary and capricious and not consistent with the actions of a true fiduciary.

Defendant's initial decision to terminate Plaintiff's LTD benefits, in May of 2015, relied in large part on the IME

addendum written by Dr. Gordon on January 15, 2015 and Dr. Saks' interpretation of the addendum. Dr. Gordon's conclusion in his addendum, however, was explicitly limited to the MRI films he "visualized," namely, the St. Peter's MRI films:

> *According to the MRI's that I have visualized*, I do not see objective findings that would correlate with the patient's symptoms. I do not see a need for work activity restrictions *based on the films that I have visualized*, including the most recent MRI's performed at St. Peters or my neurologic evaluation.

(A.R. at 1888 (emphasis added).) Because Dr. Saks only ordered that the St. Peter's MRI films be sent to Dr. Gordon, and not the Miami MRI films, Dr. Gordon's ultimate conclusion in his IME addendum did not take into consideration the Miami MRIs, which clearly showed the continued presence of Plaintiff's herniated disc. Moreover, despite Dr. Saks' request that the MRIs be performed on "a university based MRI such as may be found at Albany Medical Center," (*id.* at 950), the St. Peter's MRIs were performed on an inferior 1.5T MRI machine at St. Peter's hospital in Albany, whereas the Miami MRIs were performed on a 3.0T Wide-Bore MRI machine, the same type of advanced equipment available at Albany Medical Center.[12] These circumstances demonstrate a significant evidentiary flaw in Defendant's initial termination decision. In addition, the fact that Dr. Saks and Defendant relied on Dr. Gordon's flawed conclusion "brings into question the integrity of [Defendant's] decision-making process in this case." *Buffonge v. Prudential Ins. Co. of America*, 426 F.3d 20, 29 (1st Cir. 2005); *see also id.* at 30 ("Prudential's willingness to rely on a report it knew or should have known to be misleading, and its mischaracterization of the conclusions of Dr. Jacques, raises concerns about the fairness of its decision-making process.").

***10** Then, following Plaintiff's administrative appeal, Defendant abandoned its reliance on the St. Peter's MRIs and the purported resolution of Plaintiff's disc herniation. Instead, relying on Dr. Sternbergh's written review, Defendant concluded Plaintiff "could sustain light physical demand work with occasional lifting of 20 pounds, frequent sitting, and occasional standing or walking." (A.R. at 1764.) Dr. Sternbergh, however, provided only minimal explanation for this conclusion. Despite acknowledging the "continued presence of disc protrusion at T8-9," Dr. Sternbergh stated Plaintiff's "reports of being able to sustain brief and minimal physical activities do not correlate with continued imaging," without explaining why. (*Id.* at 1745-46.) He also noted Plaintiff's complaints were inconsistent with "expected pain improvement after a thoracic herniated disc" and "the natural history of a herniated thoracic disc," (*id.* at 1746), but the record does indicate Plaintiff reported some improvement in her pain and functioning, just not to the level determined by Defendant as permitting a return to work. *Cf. Elliot v. Metro. Life Ins. Co.*, 473 F.3d 613, 620 (6th Cir. 2006) (" 'Getting better,' without more, does not equal 'able to work.' "). In addition, Dr. Sternbergh cited a lack of "evidence of muscle atrophy, contractures, or skin breakdown in spite of related history of virtual bedrest from 2007 to the present one," (*id.*), but, as Plaintiff argues, no examining physician opined as to any inconsistency between these examination findings (or lack thereof) and her reported level of activity. Dr. Sternbergh's statements, the court concludes, do not provide a sufficiently reasoned basis for Defendant's termination decision.

Importantly, neither Dr. Sternbergh nor Defendant provided any reason for rejecting the opinion of Dr. Kantrowitz, who consistently opined that Plaintiff could not return to work. In *Santana-Diaz v. Metro. Life Ins. Co.*, 919 F.3d 691, 696 (1st Cir. 2019), the First Circuit quoted favorably the following statement: "While plan administrators do not owe any special deference to the opinions of treating physicians ... they may not simply ignore their medical conclusions or dismiss those conclusions without explanation." *Love v. Nat'l City Corp. Welfare Benefits Plan*, 574 F.3d 392, 397 (7th Cir. 2009); *see also Ortega-Candelaria v. Johnson & Johnson*, 755 F.3d 13, 20 (1st Cir. 2014) ("[A] plan administrator 'may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician' ...." (quoting *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003))); *Elliot*, 473 F.3d at 620 ("Generally speaking, a plan may not reject summarily the opinions of a treating physician, but must instead give reasons for adopting an alternative opinion."); *Doe v. Unum Life Ins. Co. of America*, 35 F. Supp. 3d 182, 190 (D. Mass. 2014) ("A plan administrator may not simply ignore medical or vocational evidence which contradicts its conclusion."). Defendant's failure to provide an explanation for rejecting Dr. Kantrowitz's opinions "lends force to the conclusion that [it] acted arbitrarily and capriciously," *Elliot*, 473 F.3d at 620, and suggests it "cherry-picked evidence it preferred while ignoring significant contrary evidence," *Santana-Diaz*, 919 F.3d at 695.

Lastly, *after* Dr. Sternbergh provided his opinion regarding Plaintiff's ability to lift up to 20 pounds and occasionally stand or walk, Defendant reversed its earlier occupational assessments—which found Plaintiff's occupation entailed "medium work," requiring frequent standing and walking and lifting up to 50 pounds—and determined Plaintiff's occupation actually entailed "light work" with lifting of only 20 pounds and occasional standing or walking. Not only does that reversal appear to be arbitrary and designed to align with Dr. Sternbergh's conclusions, it also violated ERISA regulations which require plan administrators to provide claimants with a reasonable opportunity to respond to new or additional rationales for denying claims. *See* 29 C.F.R. § 2560.503-1(h)(4)(ii) ("[B]efore the plan can issue an adverse benefit determination on review on a disability benefit claim on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date."). As Plaintiff had no reason to focus on this issue in her administrative appeal, she likely was prejudiced by this procedural violation. *See Lavery*, 937 F.3d at 82-83. Moreover, contrary to the statement made in the January 19, 2016 occupation assessment, Plaintiff's "job description information" in the record was consistent with the initial occupational assessments, not the subsequent reversal. (A.R. at 44-45, 65, 1754.) The initial occupational assessments were also consistent with Plaintiff's testimony during a Statement Under Oath on December 3, 2015, which Defendant declined to attend, regarding the unpredictable nature of a pediatric physical exam and the need to lift children, which testimony itself was consistent with statements made by Dr. Kantrowitz. (*Id.* at 73, 315, 399, 1500-01.)

***11** Defendant argues that, contrary to the earlier occupational assessments, the January 19, 2016 occupational assessment did not focus on "the specific duties [Plaintiff] engaged in at the job she had last worked in 2007, but rather as a pediatrician in general," due to the LTD policy's change from "own occupation" to "any occupation" after 24 months. (Dkt. No. 51 at 18.) The court, however, agrees with Plaintiff that "[t]his is an argument that had been 'conjured up in litigation.' " (Dkt. No. 53 at 18 (quoting *Scibelli v. Prudential Ins. Co. of Am.*, 666 F.3d 32, 41 (1st Cir. 2012)).) Both the January 19, 2016 occupational assessment and Defendant's appeal termination decision only assessed Plaintiff's ability to return to her "own occupation." (A.R. at 1754, 1766.) Moreover, Plaintiff is correct that "[t]here is no evidence that the prior vocational assessments pertained to a 'specific job' of pediatrician that differed from the 'general occupation of pediatrician' as argued by [Defendant]." (Dkt. No. 53 at 18.)[13]

This chronology—an initial determination based on a purported resolution of the herniated disk, then a different determination on appeal relying on a brand-new occupational assessment aligning with Dr. Sternbergh's conclusions regarding Plaintiff's restrictions and limitations—demonstrates "something of a hunt for a reason to deny [Plaintiff's] claim." *Lavery*, 937 F.3d at 79. It also suggests that Defendant's "structural conflict of interest ... play[ed] a role in its handling of [Plaintiff's] benefits claim," by indicating that it was "behaving like a conflicted party intent on advocating for a desired result." *Id.* at 79, 80. As was true in *Lavery*, "[c]umulatively, the foregoing record of internally inconsistent positions, changing rationales, missing explanations, and regulatory violations paints a picture that starts to look quite like the 'procedural unreasonableness' cited by *Glenn* as an important factor for [this court's] consideration." *Id.* at 80. "Taking all of this together," this court concludes that Defendant's denial of Plaintiff's claim "was less the decision of a reasoned fiduciary and more the product of an arbitrary attempt to justify a preferred result, and so [Defendant's] decision is not entitled to deference." *Id.* at 80-81.

Having concluded that Defendant's LTD termination decision does not survive the arbitrary and capricious standard of review, the court next must determine the appropriate remedy. Plaintiff argues the court should award retroactive benefits. The First Circuit has explained that "[a] retroactive benefits reinstatement is appropriate in ERISA cases where there is no record evidence to support a denial of benefits." *Id.* at 83. The court concludes, by the slightest of margins, this is not such a case. The record is not so one-sided that the court can be sure Plaintiff "was denied benefits to which [s]he was clearly entitled." *Buffonge*, 426 F.3d at 31. Rather, "[t]he problem is with the integrity of [Defendant's] decision-making process" and, thus, "[t]he appropriate response is to let [Plaintiff] have the benefit of an untainted process." *Id.*; *see also Maher v. Massachusetts Gen. Hosp. Long Term Disability Plan*, 665 F.3d 289, 295 (1st Cir. 2011) ("We cannot say with assurance that the MGH Plan denied Maher benefits to which she was entitled, but even according deference we are also not confident that its analysis has fully justified its decision."). Accordingly, the court concludes this matter

should be remanded to Defendant "to conduct such further review and provide such further explanation and information as it sees fit, providing [Plaintiff] a fair opportunity to respond to any such supplementation of the administrative record." *Maher*, 665 F.3d at 295.

V. Conclusion

***12** For these reasons, the court ALLOWS, in part, Plaintiff's Motion for Summary Judgment (Dkt. No. 40), DENIES Defendant's Motion for Summary Judgment (Dkt. No. 43), and hereby REMANDS THIS MATTER TO DEFENDANT for proceedings consistent with this memorandum and opinion. This case may now be closed.

It is So Ordered.

All Citations

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Footnotes

1 Dr. Kantrowitz, in subsequent reports, noted diagnoses of both disc herniation at T8-T9, also known as thoracic herniated nucleus pulposus T8-T9, as well as thoracic radiculopathy, a related condition caused by compression on the nerve root of the thoracic spine and resulting in radiating pain to the front of the body. (*See id.* at 79, 1364.) Dr. Kantrowitz also discussed possible lumbar radiculopathy, or nerve root compression of the lower spine, in connection with Plaintiff's complaints of sensations in her legs, although he noted the cause of Plaintiff's leg symptoms was less clear. (*See id.* at 78.)

2 In the letter notifying Plaintiff of its approval of her claim, Defendant stated: "Although we are approving benefits at this time, you must continue to meet the definition of disability in your policy in order to qualify for ongoing benefits. Periodically, we may request additional medical and/or vocational information to support the continuation of your disability benefits." (*Id.* at 185.)

3 These findings regarding Plaintiff's occupation were consistent with Plaintiff's Job Description at Caring Health Center and a Physician Questionnaire, provided to Defendant when Plaintiff applied for LTD benefits. (*Id.* 44-45, 65.) The findings were also consistent with statements made by Dr. Kantrowitz regarding the risks of Plaintiff returning to work as pediatrician in light of her back condition, as well as Plaintiff's testimony during a Statement Under Oath on December 3, 2015. (*Id.* at 73, 315, 399, 500-01.)

4 That same day and the following day, Defendant, via a third-party company, attempted fifteen hours of surveillance on Plaintiff but did not observe her. (*Id.* at 593.)

5 The results of this MRI, conducted in October of 2008, were not reviewed by Dr. Greenspan in conjunction with the IME, but Defendant subsequently sent it to him and asked whether the results changed his assessment. (*Id.* at 669.) Dr. Greenspan responded that, after reviewing the October of 2008 MRI results, "I have no changes to make based on [MRI] reports." (*Id.* at 770.)

6 Specifically, Plaintiff explained during the interview that "the difference between 2008 and [2014] is that she can now get up and walk for anywhere between 1 and 2 hours." (*Id.* at 900.) The Personal Visit Report also noted Plaintiff's description of being "nearly completely dependent on family for daily needs and support," her use of a stair lift because "she is not physically capable of walking up and down the two section stairwell" at her home, and the same "constant band like tightness around her chest" especially when she is active, along with a "constant base line pain level 5/6 out of 10" and pain of 10 out of 10 "[w]ith activity and weight bearing." (*Id.* at 900, 902-03.) Plaintiff also explained that because Dr. Kantrowitz relocated to Florida, she was driven down to see him once a year, a trip she described as "horrible"; Plaintiff would lie "down in the car either in the front seat with the seat all the way down or she [would] lie[ ] down on her stomach in the back seat." (*Id.* at 903.) In addition, the Personal Visit Report noted that surveillance of Plaintiff was again attempted on February 11 and 12, 2014, but she was not observed. (*Id.* at 899.)

7 Defendant conducted surveillance on Plaintiff on the day of the IME. (*Id.* at 1818-19.) Dr. Gordon was provided a video of Plaintiff leaving the IME and wrote an addendum to his IME report on July 8, 2014. (*Id.* at 1814.) He noted that Plaintiff was walking slowing, holding on to another individual's arm, entered a car, and appeared to sit in a reclining position. (*Id.*)

8 The 3.0T Wide-Bore Miami MRIs were performed on the same type of advanced equipment available at Albany Medical Center, as requested by Dr. Saks. (*See id.* at 1356.) These advanced MRI machines, the most powerful available, are especially helpful in scanning the spine, due to the clearer images. (*See id.* at 1356-60, 1428-66.)

9 The reason Plaintiff had a second set of MRIs taken at St. Peter's Hospital was because there was some initial confusion as to whether the Miami MRIs were done in both the weight-bearing and non-weight-bearing positions. (*See, e.g., id.* at 1873-74.) Dr. Gordon wanted non-weight-bearing MRIs taken in order to compare with prior non-weight-bearing MRIs taken in 2007 and 2008. (*Id.* at 1880.) Dr. Saks eventually acknowledged that the Miami MRIs did include non-weight-bearing MRIs. (*Id.* at 1874.)

10 In fact, Dr. Abbed read the Miami MRI films as showing a loss of cerebral spinal fluid and suspected a "possible ventral dural defect and cord herniation at T8-T9 level." (*Id.* at 1312.)

11 Although the parties have filed cross-motions for summary judgment, "motions for summary judgment in this context are nothing more than vehicles for teeing up ERISA cases for decision on the administrative record" and, as such, "[t]he burdens and presumptions normally attendant to summary judgment practice do not apply." *Stephanie C. v. Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.*, 813 F.3d 420, 425 n.2 (1st Cir. 2016).

12 It should also be noted that Dr. Kantrowitz, upon reviewing the St. Peter's MRI films, found those films also showed the continued presence of the herniated disc. (*Id.* at 1283.)

13 On remand, of course, Defendant may assess, if appropriate, Plaintiff's ability to work in a different occupation, given the policy's change to "any occupation" after 24 months. Defendant, however, has not yet conducted such an assessment, but has only focused on Plaintiff's "own occupation" of pediatrician.

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