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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	CV 14-9803 PSG (PJWx)	Date	August 25, 2015
Title	Felanie L. Yancy v. United of Omaha Life Insurance Company, *et al.*		

Present: The Honorable	Philip S. Gutierrez, United States District Judge	
Wendy Hernandez		Not Reported
Deputy Clerk		Court Reporter
Attorneys Present for Plaintiff(s):		Attorneys Present for Defendant(s):
Not Present		Not Present

Proceedings (In Chambers): **Order GRANTING Motion to Augment Administrative Record**

Before the Court is Plaintiff Felanie L. Yancy's ("Plaintiff") motion to augment the Administrative Record ("AR"). Dkt. # 27. The Court finds this matter appropriate for decision without oral argument. *See* Fed. R. Civ. P. 78(b); L.R. 7-18. After considering the arguments in the supporting and opposing papers, the Court GRANTS the motion.

I. Background

Defendant United of Omaha Life Insurance Company ("United") issued a group long term disability ("LTD") policy to Plaintiff's former employer, AeroVironment, Inc. ("AVI"). *See Compl.* ¶ 2.[1] The policy funds LTD benefits payable under the ERISA-governed plan at issue in this action ("the Plan"). *See* AR 1, 25.[2] Plaintiff was a participant in the Plan due to her employment with AVI as a software engineer. AR 2680.

In July 2013, Plaintiff submitted a claim for LTD benefits under the Plan, asserting that she was unable to work as of August 1, 2012 due to symptoms associated with lupus, migraines, and depression. *See* AR 2764; *Compl.* ¶ 17. With her claim form, Plaintiff submitted an Attending Physician's Statement from her psychiatrist, Dr. Mark Simonds, stating that her primary diagnoses were lupus and major depression. *See* AR 2773-74.

[1] Plaintiff initially brought this lawsuit against United and AVI, but voluntarily dismissed AVI on February 27, 2015. *See* Dkt. # 16.

[2] "AR" refers to the Administrative Record in this case. Relevant documents from the AR have been submitted by Plaintiff and United and are contained in Exhibit B to the Declaration of Corrinne Chandler Declaration and Exhibit A to the Declaration of Jake Smith. *See Chandler Decl.* ¶ 4; *Smith Decl.* ¶ 5.

In investigating Plaintiff's claim, United had two nurses review the medical records submitted by Plaintiff. *See Opp.* 5:1-7 (citing AR 2403-08, 2783-87). On September 2013, United denied Plaintiff's claim for LTD benefits. *See* AR 2307-13. The denial letter summarizes Plaintiff's medical records, as reviewed by the nurse medical consultants, and indicates the following grounds for denial:

> There was no evidence of testing to confirm Lupas [sic]. The file notes indicate you left work for stress. The exams noted to be within normal limits, no mini mental status exams or any evidence of cognitive and memory deficits. File notes you were pursuing another career in dentistry which is inconsistent with significant cognitive and memory or physical impairment. Your file does not indicate any evidence of exams of significant migraine headaches and intensity of headaches.
>
> In summary, the current available medical records fail to substantiate the need for restrictions and limitations that preclude you from performing the Material Duties of your Regular Occupation.

AR 2311-12.

In December 2013, in response to Plaintiff's request, United provided Plaintiff with a copy of her claim file. *See* AR 2215. A few months later, on March 24, 2014, Plaintiff timely administratively appealed the denial of her claim, submitting additional documents to United in support of her appeal. *See Compl.* ¶ 18; AR 2195-2208. Subsequently, Plaintiff supplemented her appellate submission with an August 1, 2014 neuropsychological report from Steven Castellon, Ph.D. ("Dr. Castellon"). *See* AR 304, 1632-50, 1661-79. In Dr. Castellon's report, he concluded that there was no evidence that Plaintiff attempted to feign or malinger cognitive deficits and that there was evidence that Plaintiff suffered from cognitive impairments. *Id.*

During the appeal process, United had Plaintiff undergo an Independent Medical Examination ("IME") conducted by neuropsychologist Charles Furst, Ph.D. ("Dr. Furst"), and Dr. Furst produced a report that summarized and commented on other medical records related to Plaintiff (including Dr. Castellon's report) and presented his own findings. *See* AR 1299-1320. Contrary to Dr. Castellon's conclusion, Dr. Furst's report concludes that his testing produced "no objective evidence of any neurocognitive neurobehavioral restriction or impairment for [Plaintiff]." AR 1319. Dr. Furst acknowledges this finding is inconsistent with Dr. Castellon's finding of cognitive impairment. AR 1318. Rather than reconciling the discrepancy between the two reports, Dr. Furst challenges Dr. Castellon's findings, stating that Dr. Castellon's tests had "a lower degree of sensitivity (ability to detect malingering)" and Plaintiff "may have detected the purpose of these measures when they were administered by Dr. Castellon." *Id.* Dr. Furst's

own performance-validity testing indicated "embellishment of cognitive dysfunction" which invalidated his "contemporaneously administered neurocognitive tests." *Id.* Thus, based on this "very clear evidence of embellishment in [his] own battery" of tests, Dr. Furst reported that he had "no objective evidence of any neurocognitive or neurobehavioral restriction or impairment for [Plaintiff]." AR 1319. Plaintiff requested the opportunity to review and respond to Dr. Furst's report during the appeal process on two occasions, *see* AR 805, 1331, but United did not provide Plaintiff with the report until it had completed its appellate review.

On December 17, 2014, United upheld its initial determination to deny Plaintiff's LTD benefits claim. AR 1291-96; *Compl.* ¶ 19. In this appellate determination letter, United stated that its "medical review [of Plaintiff] has determined that [she] would not be restricted from performing the Material Duties of her Regular Occupation due to cognitive deficits." AR 1295. When United sent this December 17, 2014 letter upholding the benefits denial to Plaintiff's attorney, United included a copy of Dr. Furst's report. *See Smith Decl.* ¶ 8.

Less than a week later, Plaintiff filed this lawsuit challenging United's denial of LTD benefits. *See* Dkt. # 1. Subsequently, Dr. Castellon prepared a rebuttal report commenting on Dr. Furst's findings and responding to Dr. Furst's criticism of his testing methods. *See Chandler Decl.*, Ex. A ["Castellon Rebuttal Report"]. Dr. Castellon concludes that "there is nothing that I've read from Dr. Furst's report that would change my opinion that, at the time that [Plaintiff] was evaluated by me (June, 2014), she provided sufficient test-taking effort and nonetheless showed detectable areas of cognitive deficit . . .. " *Id.* at 3.

In this motion, Plaintiff seeks to augment the Administrative Record with the Castellon Rebuttal Report. *See* Dkt. # 27.

II. Legal Standard

A. Supplementing the Administrative Record

Generally, ERISA cases are reviewed and decided on the basis of the record that was before the claims or plan administrator. *See Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090-91 (9th Cir. 1999). "[T]he record that was before the administrator furnishes the primary basis for review" and "'[i]n most cases' only the evidence that was before the plan administrator should be considered." *Id.* (quoting *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 944 (9th Cir. 1995)). "[A] district court should not take additional evidence merely because someone at a later time comes up with new evidence that was not presented to the plan administrator." *Mongeluzo*, 46 F.3d at 944.

However, this general rule is not absolute. For example, the Ninth Circuit has held that "[w]hen a plan administrator has failed to follow a procedural requirement of ERISA, the court may have to consider evidence outside the administrative record." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 972-73 (9th Cir. 2006) (en banc). "[W]hen an administrator has engaged in a procedural irregularity that has affected the administrative review, the district court should 'reconsider [the denial of benefits] after [the plan participant] has been given the opportunity to submit additional evidence.'" *Id.* at 973 (quoting *VanderKlok v. Provident Life & Accident Ins. Co.*, 956 F.2d 610, 617 (6th Cir. 1992)). "Even when procedural irregularities are smaller . . . and abuse of discretion review applies, the court may take additional evidence when the irregularities have prevented full development of the administration record. In that way the court may, in essence, recreate what the administrative record would have been had the procedure been correct." *Id.*; *see also Pac. Shores Hosp. v. United Behavioral Health*, 764 F.3d 1030, 1041 (9th Cir. 2014).

B. ERISA's Procedural Requirements

Under ERISA, "[a]n administrator must provide a plan participant with adequate notice of the reasons for denial, 29 U.S.C. § 1133(a), and must provide a 'full and fair review' of the participant's claim, id. § 1133(2)[.]" *Abatie*, 458 F.3d at 974; *see also Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011) ("the statute entitles the claimant to 'full and fair' review of a denial") (citing 29 U.S.C. § 1133). The regulations governing "full and fair review" provide that claimants shall be provided with "reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." 29 C.F.R. § 2560.503-1(h)(2)(iii). A document is "relevant" to a claim if it was: (1) "relied upon in making the benefit determination"; (2) "submitted, considered, or generated in the course of making a benefit determination"; (3) "[d]emonstrates compliance with the administrative processes and safeguards required" by ERISA; or (4) "constitutes a statement of policy or guidance with respect to the plan concerning the denied . . . benefit[.]" *Id.* § 2560.503-1(m)(8).

III. Discussion

Plaintiff asserts that United's failure to provide Plaintiff with Dr. Furst's report during the administrative appeal process violated the procedural requirements of ERISA. Accordingly, Plaintiff contends that the Court should augment the Administrative Record with the Castellon Rebuttal Report, in order to recreate how the Administrative Record would have appeared absent the procedural violation. *See Mot.* 6:22-26. United counters that it did not commit a procedural violation. *See Opp.* 1:10-16. United argues that ERISA procedures did not require it to provide Plaintiff with Dr. Furst's IME report prior to issuing its decision on Plaintiff's administrative appeal. *Id.* at 1:10-16, 8:22-27. Thus, the determinative issue in this motion is whether United

violated ERISA-mandated procedures by failing to provide Plaintiff with Dr. Furst's report during the administrative appeal process.

In its argument against augmenting the record, United distinguishes between documents generated and considered when making the initial claim determination and those generated and considered when making the final appellate determination. United contends that while ERISA and its regulations required United to provide Plaintiff with documents created and relied on during its initial claim determination (the initial denial issued in September 2013), "there is no mandate that the claims administrator provide documents generated *during the appeal* [] prior to the appeals decision." *See Opp.* 9:3-9 (emphasis added). This distinction is not an unreasonable interpretation of the ERISA regulations describing the documents that a plan must provide to claimants in order to afford them "full and fair review" of denied claims. *See* 29 U.S.C. § 1133(2). The applicable regulations state that claimants should have access to "relevant" documents when appealing adverse benefit determinations, 29 C.F.R. § 2560.503-1(h)(2)(iii), and "relevant" documents are those that were relied on, submitted, considered or generated in the course of making a "benefit determination," *see id.* § 2560.503-1(m)(8)(i)-(ii). To interpret "benefit determination" as a reference to the initial benefit determination only, not the initial determination and the subsequent decision to uphold the determination on appeal, is not contrary to the plain language of the regulation. However, the Court cannot interpret the regulation in this way because the Ninth Circuit implicitly held otherwise in its decision in *Salomaa*. *See Salomaa*, 642 F.3d at 679-80; *Reply* 3:21-4:17.

In *Salomaa*, the claim manager first denied the plaintiff's claim for LTD benefits relying on the review and written opinion of a consulting physician. *Id.* at 669-70. The plaintiff administratively appealed and the appeals claim manager affirmed the denial in a letter that quoted from another file review that it had obtained from a consulting physician. *Id.* at 671-72. The Ninth Circuit observed that "[t]his consulting physician's report, like the previous one, was not provided to [Plaintiff's] lawyer." *Id.* Thus, two undisclosed physician reports were at issue in the case – one reviewed during the initial benefits determination and the other reviewed during the administrative appeal. On this record, after citing 29 C.F.R. § 2560.503-1(h)(2)(iii), the Ninth Circuit ruled that "[t]he review was not 'fair,' as the [ERISA] statute requires, because the plan did not give [Plaintiff] and his attorney and physicians access to the two medical reports of its own physicians on which it relies[.]" *Id.* at 679. "The plan evidently based its denial in large part on review of [Plaintiff's] file by two physicians, one for the first denial, another for the final denial . . . [y]et the plan failed to furnish their letters to [Plaintiff] or his lawyer." *Id.* at 680. The Ninth Circuit explained that "[h]ad the plan met its duty of providing copies of its physicians' evaluations, then [Plaintiff's] treating physicians could have provided such comments and performed such additional examinations and tests as might be appropriate" to support Plaintiff's claim. *Id.* Thus, the Circuit concluded that "[b]y denying [Plaintiff] the

disclosure and fair opportunity for comment, the plan denied him the statutory obligation of a fair review procedure." *Id.*

In light of the Ninth Circuit's ruling that failure to provide a claimant with a physician's report generated during the administrative appeal process violates ERISA's "full and fair review" disclosure requirements, this Court cannot draw the distinction between the initial and appellate determination documents that United proffers. United mentions *Salomaa*, but ignores the portions of the decision that contradict its position. *See Opp.* 14:24-15:3. United explains that the review in *Salomaa* was not "fair" as required by ERISA regulations because "the administrator 'gave shifting and inconsistent reasons' for the denial of an LTD claim[.]" *Id.* (citing *Salomaa*, 642 F.3d at 679. This statement is accurate but incomplete. The Ninth Circuit was clear that "[t]he review was not 'fair,' as the statute requires, because the plan did not give [Plaintiff] and his attorney and physicians access to the two medical reports of its own physicians upon which it relied, among other reasons." *Salomaa*, 642 F.3d at 679. United's attempt to limit the holding of the case to one of those "other reasons" is not persuasive.

United also supports its argument with non-binding case law that this Court cannot rely on to overcome the ruling in *Salomaa*. *See Reply* 7:11-8:14. First, United cites two out-of-circuit cases that conflict with the Ninth Circuit's decision. *See Opp.* 9:10-10:22 (citing *Metzger v. Unum Life Ins. Co. of Am.*, 476 F.3d 1161, 1166 (10th Cir. 2007); *Midgett v. Washington Group Int'l Long Term Disability Plan*, 561 F.3d 887, 895 (8th Cir. 2009)). Further, United supports its interpretation of ERISA's procedural requirements with citation to six California district court decisions. *See id.* 10:23-11:28, 14:1-10. Although no district court authority could trump the *Salomaa* holding, these cases have additional deficiencies, as highlighted by Plaintiff. *See Reply* 7:14-8:14. Four of the cases pre-date *Salomaa*. *Id.* 7:14-17. The remaining cases are *Montoya v. Reliance Standard Life Ins. Co.*, No. 14-cv-2740-WHO, 2015 WL 1056560 (N.D. Cal. Mar. 10, 2015) and *Langlois v. Metropolitan Life Ins. Co.*, No. 11-cv-3472 RMW, 2012 WL 1910020 (N.D. Cal. May 12, 2012). *Montoya* is factually analogous and supports United's position, but the *Montoya* court did not mention *Salomaa* in its analysis and, as the plaintiff failed to raise the case in its briefing, the court may have been unaware of the conflicting Ninth Circuit authority when issuing its decision. *See Supp. Chandler Decl.*, Ex. B. *Langlois* does not address an analogous procedural violation because it was the insurer who sought to augment the record and the insurer had "explicitly invited" the claimant to review and respond to the proposed supplemental reports, but the claimant refused. *Langlois*, 2012 WL 1910020 at *11.

Under binding Ninth Circuit authority, the failure to provide a claimant with a physician's report relied on during the administrative appeal of a denied benefits claim violates ERISA's guarantee for "full and fair review" of a denied claim. *See Salomaa*, 642 F.3d at 679-80; 29 U.S.C. § 1133(2). In upholding its denial of Plaintiff's claim for LTD benefits, United stated

that it used Dr. Furst's neuropsychological evaluation to make its determination and summarized the report in four paragraphs. *See* AR 1292-94. Because the record reflects that United considered and even relied on Dr. Furst's report in making its appellate determination to uphold the claim denial, United violated ERISA's procedural requirements when it failed to make the report available to Plaintiff for review and comment during the appeals process. *See* 29 C.F.R. §§ 2560.503-1(h)(2)(iii), 2560.503-1(m)(8)(i)-(ii).

When an administrator commits a procedural irregularity, it is appropriate for the district court to give the claimant the opportunity to submit additional evidence to "recreate what the administrative record would have been had the procedure been correct." *Abatie*, 458 F.3d at 973; *see also Pac. Shores Hosp.*, 764 F.3d at 1041. If Plaintiff had the opportunity to review Dr. Furst's report during the administrative process, as required by the Ninth Circuit's interpretation of ERISA and its regulations, Plaintiff could have submitted the Castellon Rebuttal Report during that process and it would have been a part of the Administrative Record. Accordingly, to remedy the procedural error, the Court GRANTS Plaintiff's request to augment the Administrative Record with the Castellon Rebuttal Report.

IV. Conclusion

For the foregoing reasons, the Court GRANTS the motion to augment the Administrative Record.

IT IS SO ORDERED.