IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

NEUROCARE, INC., and BARBARA WHITMORE,

Plaintiffs,

v.

PRINCIPAL LIFE INSURANCE COMPANY; ECONOMICAL AIR SERVICE COMPANY INC., and ECONOMICAL AIR SERVICE MEDICAL BENEFITS PLAN,

Defendants.
_____/

No. C 98-0195 MJJ

ORDER RE. STANDARD OF REVIEW AND GRANTING PARTIAL SUMMARY JUDGMENT

INTRODUCTION

Before the Court is a motion for summary judgment on an ERISA claim brought by Barbara Whitmore and Neurocare, the clinic which provided Whitmore with outpatient therapy services for six months in 1993 after Whitmore had surgery to remove a brain tumor. Most of the services provided by Neurocare were subsequently denied coverage by Principal, Whitmore's ERISA plan administrator. Whitmore and Neurocare now seek summary judgment on claim one of their complaint (entitlement to coverage), as well as attorneys' fees and costs. For the reasons outlined in this memorandum and order, the Court finds that an abuse of discretion standard applies in its review of the administrative record, and that Whitmore meets that standard as a matter of law.

FACTUAL BACKGROUND

Plaintiff Barbara Whitmore ("Whitmore"), a former employee of defendant Economical Air Service Company, Inc. ("EASCO"), is a named beneficiary of the Economical Air Service Medical Benefits Plan ("the Plan") which EASCO purchased from Principal.

In November 1992, Whitmore was diagnosed with a brain tumor and underwent surgery to have it removed. After her surgery, Whitmore "was left with significant cognitive, speech, physical and other neurological deficits that required rehabilitation in a post-acute facility." While her discharge summary, written by Dr. George Koenig, indicated that acute rehabilitation was not necessary, that summary also indicated that "[i]n reality what we wished to do was transfer [Whitmore] to the Extended Care Unit", but that Whitmore had refused this placement. Schaap Decl., Exh. H at 2. After an irregular EEG result in February 1993 indicated that Whitmore had some post-operative problems, Whitmore received outpatient rehabilitation services from Neurocare from April through October, 1993 upon the written recommendation of another treating physician, Dr. Richard Gravina.

As a result of her treatment from Neurocare, Whitmore incurred medical expenses in the amount of $35,320.00, which were submitted to Principal for payment. Two Principal employees reviewed Whitmore's claim, which included the written submission of Drs. Koenig and Gravina. *See* Schaap Decl., Exh. K (evaluation of Lohrenz, Sept. 29, 1993), Exh. L (evaluation of Christopher, Nov. 5, 1993). Principal denied coverage for Whitmore's claim in an Explanation of Benefits dated December 2, 1993. The stated basis for the denial was that Whitmore's treatment from Neurocare had not been substantiated as medically necessary. Principal's denial cited Koenig's written initial belief that acute rehabilitation was not necessary, but not Dr. Gravina's recommendation or Dr. Koenig's preference, expressed in the same letter, that Whitmore receive post-operative extended care.

In 1994, Neurocare's claims processing agent, Claims Management, Inc. ("CMI"), appealed the denial of benefits. A recommendation by a third, reviewing physician, Dr. Radecki, was submitted. Schaap Decl., Exh. C. After a second review by two other Principal employees, neither of whom were doctors (see Schaap Decl., Exh. M (evaluation of Eckard, Oct. 3, 1994), Exh. N

(evaluation of Gates, Oct. 5, 1994)), Principal wrote CMI on December 1, 1994 affirming in part[1] the denial of the claim, stating that it did not consider Whitmore's treatment to be "necessary and appropriate." In addition, Principal cited to an exclusion in the policy for "confinement, treatment, or service for educational or training problems, learning disorders, marital counseling or social counseling . . . ."

In February 1995, in response to a third request for review of the denial, one of the initial evaluators revisited the file. Schaap Decl., Exh. O (evaluation of Lohrenz, Feb. 25, 1995). Lohrenz' comments include the following excerpt: "Based on review of file, no add'l information has been provided to warrant add'l benefits. Although it appears the insrd bnftd from svcs provided by NeuroCare, bnfts are not payable since the focus of therapy was community reentry, and adaptive skills. The svcs do not meet our policy def of medically nec care." *Id.* By the time of Lohrenz' second review, Whitmore had submitted the opinion of yet another treating physician, neuropsychologist Dr. Neil Hersch. Schaap Decl., Exh. B. Principal's senior consultant Sherry Ferry summarized the history of Whitmore's claim process in a letter to CMI, dated June 6, 1995. "It remains our position that the evidence included in the medical records provided by NeuroCare Inc. supports the conclusions made that these claims fall within the policy limitation for Medically Necessary Care and educational and/or training problems." Ferry Decl. Exh. D at 0066-67. Ferry also points CMI to a specific alleged deficiency in the claim. "If you have any information that supports Barbara Whitmore's fine motor skills and range of motion in the upper extremities, that her speech was impaired and not at 100% intelligibility and the physical therapy was needed beyond June 22, 1993 [the cutoff date for Principal's agreed coverage after reconsideration], please include that information in your request for review." *Id.*

In 1994 and 1995, CMI also requested in writing on three different occasions that Principal send to CMI a copy of Whitmore's benefit booklet so that CMI could understand the nature and extent of Whitmore's coverage under the Plan. Principal failed to comply fully with CMI's request.

---

[1]Principal did reconsider its ruling as to the first two months of Neurocare treatment (late April-late June, 1994), and provided payment in part, leaving $30,686.08 as the unpaid balance.

In May 1997, Whitmore and Neurocare[2] instituted this action against Principal and EASCO in the District of Utah. The matter was transferred to this Court on convenience grounds. Plaintiffs' Second Amended Complaint asserts three claims against defendants Principal and EASCO: (1) recovery of plan benefits under 29 U.S.C. section 1132(a)(1)(B); recovery of statutory sanctions for failure to provide the Plan's operating documents in violation of 29 U.S.C. sections 1021, 1024, and 1132(c)(1); and (3) violation of 29 U.S.C. section 1133.

On December 8, 1998, the Court granted Principal's motion for summary adjudication on the second cause of action, finding that Principal was not the "plan" or "plan administrator" within the meaning of ERISA.

LEGAL ANALYSIS

I. Summary Judgment Standard

Summary judgment is appropriate if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). The moving party bears the initial burden of establishing that there is no genuine issue of material fact. *Id.*; *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986).

After the moving party makes a properly supported motion, the responding party must present specific facts showing that contradiction is possible. *British Airways Board v. Boeing Co.*, 585 F.2d 946, 950-52 (9th Cir. 1978), *cert. denied*, 440 U.S. 981 (1979). It is not enough for the responding party to point to the mere allegations or denials contained in the pleadings. Instead, it must set forth, by affidavit or other admissible evidence, specific facts demonstrating the existence of an actual issue for trial. The evidence must be more than a mere "scintilla"; the responding party must show that the trier of fact could reasonably find in its favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986). Accordingly, summary judgment should be granted "[i]f the evidence is merely colorable . . . or is not significantly probative." *Eisenberg v. Insurance Co. of North America*, 815 F.2d 1285,

---

[2]Principal takes issue with plaintiffs' concurrent standing in this matter, apparently questioning Neurocare's rights to be a plaintiff. However, an assignment of ERISA right to reimbursement is permitted by the statute. *Misic v. Building Services Welfare & Trust*, 789 F.2d 1374, 1377 (9th Cir. 1986). Plaintiffs are referred to collectively as "Whitmore" in this memorandum.

1288 (9th Cir. 1987). In reviewing a motion for summary judgment, the court must take the responding party's evidence as true and all inferences are to be drawn in its favor. *Id.* at 1289.

II. ERISA Standard of Review

The United States Supreme Court has held that the default standard of review for ERISA denial of benefits claims is *de novo*, "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire v. Bruch*, 489 U.S. 101, 115 (1989). Where the plan reserves discretion, an abuse of discretion standard is the appropriate standard of review. *Id.*

The relevant policy language reserves discretion for Principal. The Benefit Booklet defines "Medically Necessary Care" as follows: "Medically Necessary Care means any confinement, treatment or service that is prescribed by a Physician and considered by Us to be: (1) necessary and appropriate; and (2) nonexperimental or non-investigational and not in conflict with accepted medical standards." Schaap Decl., Exh. D at 86. "Us" is defined as Principal. *Id.* at 89. Whitmore cites to several cases where more vaguely worded policy language was at issue. In those cases, consistent with *Firestone Tire*, the courts applied the *de novo* review standard in evaluating the benefits at issue. For example, in *Kearney v. Standard Insurance Co.*, 175 F.3d 1084 (9th Cir. 1999), the policy language at issue provided that disability benefits would be paid "upon receipt of satisfactory written proof that you have become disabled." Despite the passive nature of that important sentence, the insurer argued that inclusion of the term "satisfactory" implied discretion in the insurer to make the evaluation, and that an abuse of discretion standard was warranted. The *en banc* panel disagreed, finding at least three plausible constructions of the disputed language, chose the one most favorable to the insured (i.e. an objective standard). The court thus employed a *de novo* review standard.

The type of definitional ambiguity in *Kearney* is absent from the EASCO plan. Unlike *Kearney*, the policy language here does reserve discretion for the plan, by defining medically necessary care as treatment "considered by Us . . . to be necessary and appropriate". In other words, the standard for providing care is defined, as well as the arbiter of that standard (*i.e.*, "Us"). While the latitude afforded reservations of discretion in policy language is narrow, the language here is the type of reservation of discretion that meets the *Firestone Tire* test. Therefore, the Court finds

that an abuse of discretion standard is appropriate.[3]

III. Scope of Review

The Ninth Circuit has held that it is an abuse of discretion "to make a decision without any explanation, or in a way that conflicts with the plain language of the plan, or that is based on clearly erroneous findings of fact." *Snow v. Standard Insurance Co.*, 87 F.3d 327, 331 (9th Cir. 1996)(quoting *Atwood v. Newmont Gold Co., Inc.*, 45 F.3d 1317, 1323-24 (9th Cir. 1995)). On this question, the parties debate the proper scope of the Court's review under 29 U.S.C. 1132(a)(1)(B), and therefore what if any evidence extrinsic to the administrative record is properly considered. However, it is clear that no evidence outside the administrative record is to be considered when an abuse of discretion standard is employed. *Taft v. Equitable Life Assurance Soc'y.*, 9 F.3d 1469, 1472 (9th Cir. 1994)("Permitting a district court to examine evidence outside the administrative record would open the door to the anomalous conclusion that a plan administrator abused its discretion by failing to consider evidence not before it.")[4]

While the parties dispute the question, it is on this record something of an academic point because plaintiffs have not come forth with any extrinsic evidence necessary to refute, or demonstrate the clear erroneousness of Principal's decision. All the information which plaintiffs contend gives rise to an abuse of discretion (namely the doctors' recommendations and the policy and procedure manuals) is already a part of the record before the Court. In fact, the only clearly extrinsic submission by either party is the declaration of Dr. Raymond Webster, submitted by Principal. Because the Court finds that an abuse of discretion standard applies, it will not consider the Webster declaration in

---

[3]The Court declines Whitmore's invitation to dilute the abuse of discretion standard for alleged fiduciary violations by Principal in administration. This standard obtains where "material, probative evidence" showing that self-interest caused a breach of the fiduciary obligation. *Bendixen v. Standard Ins. Co.*, 1999 WL 556938 (9th Cir., Aug. 2, 1999). Because the Court finds that Principal's review fails an unadulterated abuse of discretion standard, it does not reach the question as to whether the requisite showing under *Bendixen* is met.

[4]Even under a *de novo* standard, extrinsic information can be considered only in the limited circumstance where additional evidence is necessary to conduct an adequate *de novo* review of the record. *See, e.g., Mongelouzo v. Baxter Travenol*, 46 F.3d 938 (9th Cir. 1995).

its review.[5]

IV. Administrative Process

Whitmore makes a three-pronged substantive attack on Principal's administrative handling of the Neurocare claim. They are: (1) the absence of any peer review (*i.e.* review by actual doctors) of Whitmore's claim before denial and of proper deference to the treating physicians' opinions; (2) the quotation of one doctor's discharge notes as the sole basis for refuting other doctors' recommendations of coverage, where the notes read in totality seem ambiguous at best; and (3) that claim language not defined in the plan itself was not construed in a manner resolving all ambiguities in favor of Whitmore. Each of these issues resonates in Ninth Circuit law, and each is addressed in turn below.

1. Absence of Practitioners in Review Process And Insufficient Deference to Treating Physician's Opinion

In denying Whitmore's claim initially and in two subsequent rounds of appeals, Principal never submitted her claim to a doctor. Instead, Principal's employee claim analysts (two of whom were registered nurses) found that the treating physicians' recommendations did not provide for medically necessary care. The Ninth Circuit recently held that an insurer abused its discretion in overruling a treating physician's diagnosis where (1) the insurer's physician was not an expert in the relevant field; (2) the insurer did not consult with the treating physician; and (3) the insurer did not examine the plaintiff. *Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d 1118 (9th Cir. 1998). *See also Isabel v. Hartford Life*, 1999 WL 38854 (N.D. Cal. 1999)(applying *Zavora* to remand case where no independent examination conducted and treating physician's opinion overruled). The Ninth Circuit's holding in *Zavora* dictates that a similar conclusion obtain here, where the undisputed evidence establishes that Principal, in rejecting Whitmore's claim, failed to contact any of her treating or reviewing physicians to evaluate her claim and did not have her examined. Thus the facts here present an even clearer abuse of discretion than in *Zavora*, since (prior to Dr. Webster's eleventh-hour submission) Principal had no physician involvement in either a reviewing or treating capacity.

Whitmore also argues that Principal's failure to provide a practitioner's review was violative

---

[5]Similarly, the Court will not consider manuals and guidelines not part of the contemporaneous administrative record.

of industry standards, citing to the rules of URAC, an industry accreditation commission. However, Principal points out that it was not a member of URAC until 1994, so its review of 1993 claims would not govern. The Court finds resort the URAC guidelines unnecessary to resolve the issue in any event, given the clarity of the record under governing law.

2. Substantial Evidence to Deny Claim

Under Ninth Circuit law, it is the insurer's duty to obtain all evidence necessary to make an informed decision on a claim. *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 538 (9th Cir. 1990). Ninth Circuit law emphasizes deference to a treating physician's opinions. *Andrews v. Shalala*, 53 F.3d 1035, 1041 (9th Cir. 1995). More weight is accorded to the treating physician's opinion than that of a non-examining physician. 20 CFR 416.927(d)(1). Further, a treating physician's opinion may be controverted by the factfinder only for clear and convincing reasons. *Andrews*, 53 F.3d at 1041. Following the logic of *Andrews*, Judge Smith in *Isabel v. Hartford Life Ins. Co.* held that the opinion of a non-examining physician cannot, by itself, constitute substantial evidence to overturn the opinion of either an examining or treating physician. *Isabel*, 1999 WL 38854 at *3. Judge Smith's conclusion is amply supported by Ninth Circuit case law finding an abuse of discretion where a non-expert's opinion provided the basis for denial of coverage. *Zavora*, 145 F.3d at 1123.[6] As Whitmore points out, if *Andrews* provides that a treating physician must be given more weight than a non-treating physician, this principle is *a fortiori* stronger where, as here, a non-treating non-physicians attempt to trump the opinion of multiple treating and reviewing physicians.

Principal seeks to introduce the declaration of its in-house medical director, Dr. Raymond Webster, to refute the contentions of Whitmore's treating physicians and bolster Principal's own review. As discussed *supra*, this analysis is a day late and a dollar short. Webster's own declaration, in attempting to defend the denial of claims by arguing that rehabilitative services were believed not necessary, actually raises salient questions which Principal did not seek to answer in its review. *See* Webster Decl., ¶ 10 ("Only Dr. Koenig knows whether or not the extended care facility was going to allow for acute rehabilitation.") Principal presents no evidence that it either attempted to contact Dr.

---

[6] The factual record here is even stronger than that in *Zavora*. This record does not reflect a battle of the physicians: the record is bereft of a physician, treating or reviewing, on Principal's side of the ledger during the administrative process itself.

Koenig or any of Whitmore's treating physicians, examined Whitmore in-house, or assigned any physician with expertise in the relevant fields (as opposed to expertise in claim processing).[7] Under *Zavora*, the Court's mandate on such a record is clear. Principal relies on *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1473 (9th Cir. 1994) for the proposition that evidence in the record contradictory to a denial of coverage does not alone amount to an abuse of discretion showing. The record does not present so difficult an issue. While *Taft* sets forth an appropriate guideline for the exercise of the Court's discretion in some cases, *Taft* simply does not read on this factual record. The facts on this record are stark: not a single doctor employed or retained by Principal either reviewed the record or examined Whitmore, and not a single Principal employee even placed a phone call to any of Whitmore's treating or reviewing physicians before denying her the coverage they recommended as medically necessary.

3. Interpretation of Undefined Language

Any ambiguities in claim language relevant to the determination of entitlement to ERISA benefits must be resolved in favor of the insured. *Kunin*, 910 F.2d at 539. Principal refers to the policy exclusion for "educational or training problems" as the basis for denial of the bulk of Whitmore's claims. This language is not defined by the policy. Therefore, as a practical matter Whitmore cannot make a principled counterargument to the denial, because no common template for discussion was established. The Ferry letter suggests that Whitmore's fine motor skills, which were within "normal ranges" at the time rehabilitation began, excluded her from coverage by putting any rehabilitation into the "educational or training" realm. This exacerbates the ambiguity, because the normal ranges also go undefined by the plan. This failure to affirmatively define the term upon which denial hinges is damaging to Principal. *See Kunin*, 910 F.2d at 541 (failure to define term "mental illness" termed "fatal to the insurer's attempt to limit payment.") The only unambiguous conclusion to be drawn is that the terms were construed to Whitmore's detriment, and that runs afoul of *Kunin*.

---

[7] Even the cases Principal cites confirm this fundamental distinction in ERISA law. *In Meditrust Financial Corp. v. Sterling*, a Fifth Circuit case affirming denial of coverage which Principal claims to be "strikingly similar" to the case at bar, the insurer's denial was made on the basis of medical records by doctors. 168 F.3d 211, 214 (5th Cir. 1999). Thus, *Meditrust* does not help Principal.

While the Court relies primarily on the absence of independent practitioner review of Whitmore's claim in reaching its conclusion that an abuse of discretion occurred, it notes that the failure to construe disputed and undefined terms in favor of Whitmore would provide an independent basis for reaching the Court's conclusion.

V. Attorneys' Fees

29 U.S.C. 1132(g) provides a fee-shifting provision for any participant, beneficiary or fiduciary on an ERISA claim. The Ninth Circuit utilizes a five-part equitable test for assessing whether attorneys' fees should be awarded. *Hummell v. Rykoff & Co.*, 634 F.2d 446 (9th Cir. 1980). The *Hummell* factors are: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions. *Id.* at 453.

Whitmore's request for attorneys' fees is premature, as the motion before the Court does not dispose of the case. Even with the disposition of this motion, the third cause of action would remain for trial. The merits of this remaining claim would necessarily impact on the *Hummell* analysis, particularly the first, fourth and fifth factors. Accordingly, the Court DENIES WITHOUT PREJUDICE Whitmore's request for attorneys' fees.

CONCLUSION

Whitmore has made a strong showing under *Zavora* that Principal abused its discretion in denying her claim. Principal's reliance on one selected excerpt of a treating physician's written analysis to trump other treating and reviewing physicians' recommendations (not to mention the first physician's overall recommendation in context), is not permissible on the record before the Court. An examination of the record demonstrates no in-house examination of Whitmore, no physician review of her claim, and not even a telephone call to attempt to resolve what even Principal's own in-house medical director now identifies in retrospect as an ambiguity on the written record. Simply

relying on that is a clear abuse of discretion. The Court therefore GRANTS Whitmore's motion for partial summary judgment as to her first claim, and DENIES WITHOUT PREJUDICE as premature Whitmore's request for attorneys' fees. A further case management conference is hereby scheduled in this case for November 2, 1999 at 2:00 p.m. The trial date currently set for November 8, 1999 is vacated.

IT IS SO ORDERED.

Dated: 9/29/99

MARTIN J. JENKINS
UNITED STATES DISTRICT JUDGE

United States District Court
For the Northern District of California