

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

Jerry Whitley, as Personal Representative of the Estate of Carol Whitley,	)	
	)	
Plaintiff,	)	C/A NO. 3:06-257-CMC
	)	
v.	)	<b>OPINION AND ORDER</b>
	)	
Carolina Care Plan, Inc.,	)	
	)	
Defendant.	)	
_____	)	

Through this action, Plaintiff, Jerry Whitley (“Mr. Whitley” or “Plaintiff”) seeks a determination that Defendant, Carolina Care Plan, Inc. (“Plan”), abused its discretion when it denied his deceased wife’s claim for coverage of certain medical procedures. The matter is currently before the court on Mr. Whitley’s motion to strike the declaration of the Plan’s medical director, Edward D. Hutt, M.D. (“Dr. Hutt”), Dkt No. 26, as well as for a decision on the merits based on the parties’ written submissions. *See* Dkt No. 9 (Joint Certification agreeing to resolution based on the joint stipulation and cross memoranda for judgment).

The parties filed cross-memoranda in support of judgment on September 29, 2006, and October 2, 2006. Dkt No 24 & 25.<sup>1</sup> Both filed responsive memoranda (“Replies”) on October 10, 2006. Dkt No. 27 & 28. In addition, on October 3, 2006, Mr. Whitley filed a motion to strike the declaration of Dr. Hutt, which the Plan relied on in its memorandum in support of judgment. Dkt No. 26. The Plan filed an opposition to the motion to strike on October 20, 2006. Dkt No. 29. Finally, Plaintiffs filed a notice of supplemental authority on October 23, 2006. Dkt No. 30.

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<sup>1</sup> The substantive memoranda rely on the extensive evidentiary record filed on August 29, 2006, as Dkt No. 14-17. This administrative record is sequentially numbered and is referred to herein with the prefix “AR” followed by page number(s) (*e.g.*, AR pp. 1-25).

For the reasons set forth below, the court strikes the affidavit of Dr. Hutt. The court further finds that the Plan abused its discretion in denying benefits. The court, therefore, finds that Plaintiff is entitled to judgment in his favor on the claim for benefits. The court will defer entry of judgment, and resolution of Plaintiff's request for attorneys' fees, to allow Plaintiff to address the Fourth Circuit's recent decision relating to the same. *See Carolina Care Plan, Inc., v. McKenzie*, Slip Op. No. 05-2060 (4th Cir. October 23, 2006). Briefing on this issue shall be as set forth at the conclusion of this order.

#### **APPLICABLE LAW AND STANDARD OF REVIEW**

It is undisputed that the benefits at issue are provided under an employee benefit plan governed by the Employee Retirement Income and Security Act, 29 U.S.C. § 1001 *et seq.* ("ERISA"). Mr. Whitley's claim for benefits is, therefore, pursued solely under 29 U.S.C. § 1132(a)(1)(B).

It is also undisputed that the Plan's benefits determination is subject to a modified abuse of discretion standard of review. *See, e.g.*, Dkt No. 25 at 5-6 (Plan's memorandum); *McKenzie*, Slip Op. at 5-7. Under the basic abuse of discretion standard of review, the court is required to uphold the administrator's decision if it is reasonable, even if the court would have come to a different conclusion had it considered the matter independently. *See Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). A decision is reasonable if it is "the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." *Id.* at 232 (quoting *Brogan v. Holland*, 105 F.3d 158, 161 (4th Cir. 1997)).

The modified abuse of discretion standard of review applies when the decision-maker is operating under a conflict of interest, such as when a for-profit insurance company is both the funder

and decision-maker. See *McKenzie*, Slip Op. at 5-7 (finding standard applicable even where relatively minor expense is involved). Under this standard, the court reduces the degree of deference to the extent necessary to neutralize any untoward influence resulting from the conflict of interest. *Id.*, Slip Op. at 5.

Numerous factors are considered in “determining the reasonableness of a fiduciary’s discretionary decision.” *Booth*, 201 F.3d at 342-43. These include:

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

*Id.* See also *McKenzie*, Slip Op. at 6-7 (quoting same).

As these criteria reveal, the plan language is the starting point. *Id.* (“[a]s with any interpretation of a contractual trust document, we begin by examining the language of the Plan”). This is because “ERISA demands adherence to the clear language of the employee benefit plan.” *White v. Provident Life Accident Ins. Co.*, 114 F.3d 26, 28 (4th Cir. 1997). “When an ERISA plan vests discretion in an administrator who also insures the plan, reasonable exercise of that discretion requires that the administrator construe plan ambiguities against the party who drafted the plan.” *McKenzie*, Slip Op. at 9.

### **MOTION TO STRIKE**

The motion to strike relates to the sworn declaration of Dr. Hutt, who serves as the Plan’s Medical Director. Hutt Decl. ¶ 1. Dr. Hutt asserts that he is “familiar with the decision to deny the

claim . . . because [he] reviewed the claim at the time it was made.” Hutt Decl. ¶ 2. He then explains the Plan’s reliance on the HAYES rating system<sup>2</sup> to deny Mr. Whitley’s claim as experimental, investigational or unproven. Hutt Decl. ¶ 3-5 & 9. He also provides his interpretation of the evidence and explains that the initial denial was based on his own application of the HAYES rating system to this interpretation. Hutt. Decl. at 6-7.

In addition, Dr. Hutt addresses why he believes the two independent reviews obtained by the Plan (both favorable to coverage of the claim) should not result in a ruling in Mr. Whitley’s favor. Dr. Hutt asserts that both reviews are irrelevant as they addressed only whether the treatment was “medically appropriate,” not whether it fell within the Plan’s Experimental Exclusion. This characterization of the two reports is incorrect as one of the two was obtained by the Plan for the sole and express purpose of addressing whether the service fell within the Experimental Exclusion. In concluding that the treatment at issue did not fall within this exclusion, this review (referred to in the remainder of the order as the “Peer Review”) addressed each of the relevant Plan criteria. The other review was obtained as part of a transplant evaluation (referred to herein as the “URN-Review” or “URN Specialized Physician Review”). In concluding that Mrs. Whitley was not a good transplant candidate at the time of the review, the URN-Reviewer also addressed some of the criteria relevant to application of the Plan’s Experimental Exclusion.

Thus, neither report was limited to the question of “medical appropriateness” of the treatment and both bear directly on the Experimental Exclusion. Dr. Hutt does not otherwise address these

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<sup>2</sup> As discussed in the remainder of this order, the Plan has consistently relied on a rating from Winifred S. HAYES, Inc., as its basis for denying the claim as experimental, investigational or unproven. The particular report relied on was published in February 2003 and was obtained by the Plan in October 2004 from the HAYES website. The published report is referred to herein as the “HAYES Report.” The rating in that report is referred to as the “HAYES Rating.”

independent reviews on their merits. Dr. Hutt's attempt to discount these reports would, therefore, bear little weight even if his declaration was considered.<sup>3</sup>

In any case, nothing in Dr. Hutt's declaration explains what information was provided to and considered by the third-level grievance panel. This is the body which rendered the Plan's final decision. While there is strong evidence that this body, as well as the panel before it, may have deferred unduly to Dr. Hutt's opinion, it remains that: (1) it is the decision of the final grievance panel which is actually at issue; and (2) nothing in Dr. Hutt's declaration aids the court in understanding what information that panel considered.<sup>4</sup>

Dr. Hutt's declaration is dated October 2, 2006. The final denial letter was written, and the record closed, almost a year earlier on October 28, 2005. Thus, Dr. Hutt's declaration clearly is not part of the record relied on by the Plan in making its benefit decision. Rather, it seeks to explain that decision with information not contained in the record.

There is no suggestion that the Plan advised Mr. Whitley of its intent to rely on such a declaration before it was filed with the Plan's memorandum in support of judgment. Indeed, all evidence is to the contrary as evidenced by the parties' July 26, 2006 Joint Certification which

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<sup>3</sup> The Plan asserts in its opening memorandum that, in reaching "his" decision to deny benefits, "Dr. Hutt reviewed and especially relied on" thirteen specifically listed excerpts from a URN-Specialized Physician Review and abstracts culled from a HAYES research update (discussed *infra* as "HAYES Update"). Dkt 25 at 13-15. Dr. Hutt's declaration contains no statements which would support either assertion. Hutt does not, in fact, even refer to the HAYES research update or the abstracts contained therein. His only reference to the URN-Specialized Physician Review is the cursory discounting of it as discussed above.

<sup>4</sup> As discussed in the remainder of this order, it is clear that Dr. Hutt made the decision to deny the first-level appeal and had direct input as to the second. As to the third-level appeal, the evidence of his input is less direct. Nonetheless, his opinion as to the controlling nature of the HAYES Rating was provided to the third-level grievance panel in a manner which likely had a strong, if not determinative, influence on the outcome of the final appeal.

provided the following assurances:

- a. The parties certify that they conferred on July 25, 2006 with respect to the matters contained in the Specialized Case Management Order.
- b. There are currently no issues raised by the Joint Stipulation on which the parties are not in agreement.
- c. *No parties object to the procedure for disposition of the action proposed by the Joint Stipulation.*
- d. *The parties confirm that they exchanged all documents on which any party intends to rely for resolution of the action.*

Dkt No. 9 (Joint Certification – emphasis added). The procedure to which the parties indicated agreement is set forth, in part, below:

5. If the matter is not resolved by mediation, the parties shall, within sixty (60) days after the conference addressed in Paragraph 2 above, file cross-memoranda in support of judgment with respect to all benefits claims governed by ERISA. The Joint Stipulation shall be filed at the same time. Each party shall have five (5) days thereafter to file an optional reply. These memoranda should follow the form of Local Rule 7.05. *All references in memoranda shall be to the consecutively-numbered page of the attachments to the Joint Stipulation.* In its discretion, the court may order a hearing. Unless so ordered, the court will decide the ERISA benefits issues upon the record before it without a hearing. Motions for summary judgment need not be filed. *Any party objecting to the court disposing of the case on the Joint Stipulation must file an objection with or prior to the filing of the joint certification required by Paragraph 2 of this order.*

Dkt No. 7 (original emphasis deleted – above emphasis added).

The parties, thereafter, filed their joint stipulation (with attached administrative record) on August 29, 2006. Dkt No. 14-17. This extensive record does not include Dr. Hutt's declaration which, as noted above, was not prepared until over a month after the administrative record was compiled and exchanged and long after the Plan's final denial of Plaintiff's claim. Thus, Dr. Hutt's declaration is clearly not part of the administrative record to which the parties agreed to limit their reliance in their July 2006 joint certification.

As suggested above, the critical difficulty with consideration of Dr. Hutt's declaration is that it is not a part of the administrative record. While supplementation of the record might, in some instances, be appropriate, it would only be appropriate if proper notice was given of the intent to rely on the additional evidence. Under the procedures of this court, that notice should have been given prior to the filing of the Joint Certification which occurred on July 26, 2006.

Had the Plan provided notice of its intent to rely on testimony of Dr. Hutt, the court would first have determined whether to allow that testimony. If the court determined that such testimony should be allowed, it would likely have allowed Plaintiff to depose Dr. Hutt as to his full role in the decision-making process. That deposition might, in turn, have led to the deposition of other Plan representatives to test the veracity of Dr. Hutt's testimony.

To the extent any of these depositions related to communications with third parties, the court would, upon request, have considered whether to allow Plaintiffs to designate opposing witnesses to address the same communications. Likewise, to the extent the testimony was in the nature of expert witness testimony (the reasonableness of relying on the HAYES Rating), a counter-expert would most likely have been allowed. In addition, the usual expert witness disclosure requirements would have applied.

None of the decisions detailed above was ever made because the Plan gave no notice of its intent to rely on Dr. Hutt's testimony until his declaration was filed with Defendant's memorandum in support of judgment.<sup>5</sup> Under these circumstances, it would be decidedly unfair to allow the Plan to rely on Dr. Hutt's declaration.

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<sup>5</sup> In opposing to the motion to strike, the Plan refers to several cases which have allowed expansion of the record under relatively unusual circumstances. Nothing in the Plan's memorandum, however, supports allowing such expansion *when not timely sought*. Under the procedures applied in this district, that would be no later than upon the filing of the joint stipulation.

For all of the reasons set forth above, the court grants Mr. Whitley's motion to strike Dr. Hutt's declaration.

### **DECISION OF THE COURT ON SUBSTANTIVE CLAIMS**

After examining the administrative record, joint stipulation, and parties' memoranda, the court enters the following Findings of Fact and Conclusions of Law pursuant to Rule 52(a) of the Federal Rules of Civil Procedure. To the extent that any findings of fact represent conclusions of law, or vice-versa, they shall be so regarded.

### **FINDINGS OF FACT**

#### **OVERVIEW**

The claims at issue in this action involve implantation of a left ventricle assist device (LVAD). This implantation was performed at Duke University Medical Center ("Duke") on October 11, 2004, and resulted in charges in the amount of \$369,775.75.

The patient, Carol Whitley ("Mrs. Whitley" or "member"), is now deceased.<sup>6</sup> The claim is, therefore, pursued on behalf of Mrs. Whitley's estate by the estate's personal representative, Jerry Whitley ("Mr. Whitley").

The final denial was based on two related grounds, both of which are advanced as denial reasons in this action. First, the Plan maintained that "LVAD *for destination therapy* was considered by [the HAYES rating system] to be experimental at the time of the service." The Plan, therefore, denied coverage under a plan exclusion for experimental, investigational, or unproven services ("Experimental Exclusion"). AR p. 3 (emphasis added). Second, the Plan maintained that it was

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<sup>6</sup> The Plan uses the term "member," rather than the ERISA terms "participant" or "beneficiary" to refer to Mrs. Whitley and to other individuals covered under its policies. The court will use the same terminology in this order.

not informed of the intent to implant an LVAD *for destination therapy* until after the procedure was completed. The Plan concedes, however, that it had approved other significant heart treatment, apparently including high-risk bypass surgery and preparation for a possible heart transplant. AR p. 3 (December 14, 2005 letter from Plan summarizing reasons for denial—emphasis added).<sup>7</sup>

The purpose of the implant (“for destination therapy”) was critical to the denial.<sup>8</sup> This is because use for other purposes (*e.g.*, “as bridge to transplant”) would not have been considered experimental, investigational, or unproven under the HAYES Report on which the Plan relied. *See supra* n. 2 and *infra* at 19 (explaining HAYES Report).

The HAYES Report on which the Plan relied was published in February 2003, nineteen to twenty months before Mrs. Whitley’s surgery. At some point between Mrs. Whitley’s surgery and December 14, 2005, a period of seventeen months, the published HAYES Rating was changed. *See* AR p. 3 (December 14, 2005 letter from Plan representative conceding that, as of that date, “LVAD for destination therapy is no longer considered experimental or investigational by Hayes”). Neither party has provided the court with the date of that change. The record is also silent as to what studies or other evidence was considered by HAYES when it ultimately did change the relevant rating.

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<sup>7</sup> The Plan has consistently relied on the Experimental Exclusion in its various denials. Its reliance on the alleged lack of notice has been sporadic.

<sup>8</sup> The term “destination therapy” refers to implantation of the LVAD as a permanent treatment which, according to the literature, may extend life by several years before a new implant is needed. “Bridge to transplant,” by contrast, refers to implantation only pending an intended heart transplant. The line between the two goals of treatment is not, however, always clear. This is because a patient who is not a transplant candidate due to correctable or controllable conditions (*e.g.*, obesity and diabetes), may become a transplant candidate after implantation of the LVAD.

## RELEVANT PLAN TERMS

1. **Notice Term.** The Plan provides as follows regarding notification for services received from Network Providers such as Duke.<sup>9</sup>

### Notification Requirements

We require notification before you receive certain Covered Health Services. In general, Network providers are responsible for notifying us before they provide these services to you. Your Provider cannot bill you for these services if they fail to notify Us.

AR pp. 874-75.

After noting the member's duty to provide notice before receiving certain health services from non-Network Providers, the Plan document encourages confirmation that "services from non-Network Providers" are covered "because in some instances, certain procedures may not meet the definition of a Covered Health Service and are therefore excluded" or may fall within an exclusion such as the "Experimental, Investigational or Unproven Services exclusion." *Id.*

### 2. **Coverage of Transplant Services**<sup>10</sup>

The Plan document provides that it covers "Transplantation Services" as follows:

Covered Health Services for the following organ and tissue transplants when ordered by a Network Physician. Transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant

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<sup>9</sup> It is undisputed that Duke is a network provider. Thus, if denial rested solely on a failure of notification, the real parties in interest might be Duke and the Plan, rather than Mr. Whitley and the Plan, because Duke would be precluded from charging Mrs. Whitley or her estate for the service. The denial, however, rested on dual grounds. In any case, the Plan does not challenge Mr. Whitley's standing as the real party-in-interest.

<sup>10</sup> The transplant provisions are relevant because Mrs. Whitley was transferred to Duke because she was under consideration for a heart transplant. *See* AR p. 27 (October 4, 2004 letter to MUSC). Her initial care at Duke was, therefore, reviewed under the provisions applicable to transplant candidates.