

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

DIANNE LeSUER

Plaintiff,

vs.

HCA INC., HCA INC. LONG TERM
DISABILITY PLAN; ITT HARTFORD;
DISABILITY INSURANCE
SPECIALISTS,

Defendants.

Case No. 3:07-cv-00230 TMB

ORDER

Re: Cross-motions for Summary Judgment

I. MOTION PRESENTED

At Docket 43, Plaintiff Dianne LeSuer (“LeSuer”) moves for judgment on the administrative record of her claim for long-term benefits under the Employee Retirement Income Security Act of 1974 (“ERISA”), 29 U.S.C. § 1001 *et seq.* At Docket 51, Defendant Disability Insurance Specialists (“DIS”) opposes the motion, and cross-moves for summary judgment pursuant to Federal Rule of Civil Procedure 56(c). At Docket 53, Defendant HCA, Inc. adopts the arguments set forth in DIS’s response and cross-motion.¹ Having carefully reviewed the parties’ briefing and the relevant portions of the administrative record, the Court hereby DENIES the Plaintiff’s motion and dismisses her complaint.

II. BACKGROUND

This action arises from the denial of LeSuer’s claim for long term disability (“LTD”) benefits under the HCA, Inc. Long Term Disability Plan (the “Plan”). The Plan provides 60 percent

¹ HCA argues separately that it is not liable under ERISA because it was not a fiduciary or administrator with authority to determine LeSuer’s eligibility for LTD benefits. Dkt. 53.

of monthly predisability earnings to participants who, following a five-month waiting period, are unable to earn more than 30 percent of their predisability earnings due solely to disease or injury.²

From February 1, 1995 through late January or early February 2000,³ LeSuer worked as a housekeeper for Alaska Regional Hospital, which is owned and operated by HCA. LeSuer participated in and was eligible for benefits under the Plan; she alleges that she became totally disabled and unable to work due to a back injury she suffered when she was caught between two elevator doors while working on July 19, 1999.⁴ After the injury, she worked sporadically until February 5, 2000⁵ and supplemented her income with paid medical leave and vacation time.⁶ After that date, she received paid time off or extended illness benefits from February 6, 2000 through March 4, 2000.⁷

On September 8, 1999, LeSuer saw Dr. Stan Smith at Health South Rehabilitation. According to a summary of LeSuer's medical records, Dr. Smith stated that he thought that she had "mild soft tissue injuries of her cervical, thoracic, and lumbar spine."⁸ He referred LeSuer to physical therapy with a diagnosis of "cervical thoracic and lumbar strain."⁹ An evaluation report from LeSuer's initial visit for physical therapy notes that she complained of disrupted sleep,

² DIS 002. The reference "DIS ____" refers to Disability Insurance Specialists' administrative record.

³ DIS 173, 448, 608.

⁴ DIS 192, 262. Plaintiff reported that the injury occurred when a set of elevator doors closed on the right side of her body. Plaintiff also notes that prior to the July 19, 1999 injury, she had a history of back problems dating to February 14, 1990 when she was involved in a motor vehicle accident. DIS 211-12.

⁵ LeSuer's last full day of work was January 21, 2000. On February 5, 2000, LeSuer clocked in, but worked for only a short period of time.

⁶ DIS 448.

⁷ DIS 447.

⁸ DIS 212.

⁹ DIS 130, 209.

difficulty raising her arms overhead, and an inability to lift more than 15 pounds with her right arm.¹⁰

LeSuer then underwent chiropractic treatments from January through March 2000. Brent Wells, her chiropractor, filled out a “Return to Work Recommendations” form on January 28, 2000 indicating LeSuer was totally incapacitated and would be reevaluated on January 31, 2000. He also signed an “Excuse Slip” on January 31, 2000 stating that she was unable to return to work due to “severe back pain” and should be excused through February 4, 2000.¹¹ On February 7, 2000, Wells signed another “Excuse Slip” clearing LeSuer to return to work with the caveat that she not lift more than 20 pounds.

Wells referred LeSuer for a spinal MRI, which indicated that LeSuer had “degenerative disc disease L4-5 and L5-S1 with mild disc bulging at both levels and medial tear of the annulus at both levels without disc herniation seen.”¹² On April 14, 2000, LeSuer was evaluated by another physical therapist to whom she reported that she had not noticed any benefit from her earlier physical therapy and chiropractic treatment. During this evaluation, LeSuer was found to have “75% loss of trunk flexion in the standing position,” muscle weakness, and positive indications of lower back pain.¹³

LeSuer then sought treatment from Dr. Nelly Bardman for hypertension and back pain. During a series of visits from June 9, 2000 through December 6, 2000, she complained of feeling tired, fatigued, weak, and suffering from chronic back pain.¹⁴ Another physician in the same practice, Dr. Irina Chernaya, later assessed LeSuer as having chronic back pain, degenerative joint

¹⁰ DIS 130.

¹¹ DIS 241, 335.

¹² DIS 138, 537.

¹³ DIS 81.

¹⁴ DIS 526-530.

disease, fibromyalgia, and hypertension.¹⁵ The doctors' patient notes indicate that on December 6, 2000, LeSuer declined additional therapy and sought another referral to a chiropractor.¹⁶

In January 2001, LeSuer began seeing a family practice physician, Dr. Olga I. Wasile, at Elmendorf Air Force base.¹⁷ Five months later, on June 11, 2001, Dr. Wasile wrote a memo stating that LeSuer suffers from chronic neck and back pain and depression, and that she "would probably have a difficult time as a housekeeper, because of the lifting and fairly severe physical demands."¹⁸ The following year, on April 8, 2002, Dr. Wasile completed a "Medical Examination & Capacity Form" for the state Division of Public Assistance indicating that LeSuer could not work part-time and that her medical condition would affect her ability to work for more than 12 months.¹⁹ She also checked boxes on the form indicating that LeSuer could lift and carry no more than 5 pounds on an occasional basis, and no weight on a frequent basis.²⁰ Wasile's opinions were echoed in a June 14, 2002 memo from Maj. Betty Smith, chief of the physical therapy element on Elmendorf, who wrote that:

1. Ms. Lesueur [sic] has been seen in physical therapy for her back pain since approximately July 1998. We have worked with her various exercise programs and modalities to control the pain. To date, all physical therapy treatments have been unsuccessful. With her limitations with standing, sitting, and walking and inability to lift more than a few pounds, it would be difficult for me to vision [sic] her being able to tolerate any kind of employment workload.
2. In conclusion, I support Dr. Wasile's recommendations for total and permanent disability rating . . .²¹

¹⁵ DIS 526. The records indicate Dr. Chernaya saw LeSuer during November and December 2000.

¹⁶ DIS 526.

¹⁷ DIS 341.

¹⁸ *Id.*

¹⁹ DIS 328-29.

²⁰ DIS 329.

²¹ DIS 337.

Similarly, LeSuer's mental health counselor, Sandy Bhargava, who first saw LeSuer on July 2002, concluded on October 8, 2002, that she was "totally disabled and permanently unable to perform work."²² Bhargava stated that her conclusion was based on LeSuer's "present emotional and psychological state," which included "severe depression" due to psychological and physiological pain.²³

LeSuer voluntarily resigned her job with HCA on September 2, 2002.²⁴ Based on the reports of her health care providers, the Social Security Administration found LeSuer to have been disabled as of November 5, 2002, and entitled to monthly disability benefits of \$731.00.²⁵

LeSuer first inquired about filing a claim for LTD benefits under the Plan on August 12, 2003 during a call to Aetna Life Ins. Co., the LTD claim administrator.²⁶ Aetna then contacted Integrated Disability Resources, Inc. ("IDR"), which it employed to administer disability income benefits,²⁷ and IDR sent a LTD claims package to HCA on August 15, 2003.²⁸ HCA returned this material to IDR on December 5, 2003.²⁹ In an "Employee's Statement" dated August 31, 2003, LeSuer stated that she was "[t]otally disabled and unable to work" due to a back injury and depression stemming from the July 19, 1999 elevator accident.³⁰

On July 20, 2004, IDR denied LeSuer's LTD claim on the ground that the medical records in her file did not support a level of disability "that would preclude [her] from performing the essential

²² DIS 353.

²³ *Id.*

²⁴ DIS 442.

²⁵ DIS 579.

²⁶ DIS 136, 447, 607.

²⁷ The transfer of claim administration responsibilities from Aetna to IDR occurred on January 2, 2001. DIS 136.

²⁸ DIS 604-05.

²⁹ DIS 575.

³⁰ DIS 580.

duties of [her] own occupation due to back pain.”³¹ IDR’s letter also noted that it did not receive notice of LeSuer’s claim until December 15, 2003 – more than two years after the policy’s deadline for filing a LTD claim.³² The letter quoted the policy as requiring LTD claims to be filed within 90 days after a five-month “waiting period” following the onset of a disability.³³ But the policy also provides that “[i]f, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will be accepted if you file as soon as possible; but not later than 1 year after the deadline unless you are legally incapacitated.”³⁴ Using January 21, 2000 as the date LeSuer was incapacitated, IDR calculated the LTD claim deadline as September 19, 2000 – or September 19, 2001 under the “not later than” one-year exception.³⁵ IDR’s letter also informed LeSuer that IDR would review “any additional information you wish to submit” and informed her of her right to appeal the denial of benefits by filing a written request for an appeal and review of her claim within 180 days.³⁶

On January 7, 2005, LeSuer wrote to IDR requesting an appeal of the denial of benefits.³⁷ With it, she enclosed a letter from Bhargava recommending her for permanent disability rating, the return-to-work recommendations from Wells, a medical exam and capacity form from Dr. Wasile, a “Notice of Award” from the Social Security Administration, and other documents.³⁸ IDR never responded to LeSuer’s appeal letter and went out of business in March 2006.³⁹ Defendant DIS took

³¹ DIS 140.

³² DIS 136-37.

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

³⁶ DIS 141.

³⁷ DIS 324.

³⁸ *Id.*

³⁹ DIS 69.

over administration of the claim, and on May 15, 2006 wrote to LeSuer stating that it had requested a medical review of her claim.⁴⁰ Later that month, on May 30, 2006, DIS denied LeSuer's appeal.⁴¹ After summarizing the medical evidence and other documents submitted by both LeSuer and her employer, DIS concluded that she was not "totally disabled for the policy's elimination period, February 5, 2000 to July 5, 2000" and thus did not qualify for LTD benefits.⁴² Specifically, DIS's own "medical review," conducted by Dr. Joseph Amato, found that "there was no true support objectively for an injury or disease" related to LeSuer's July 1999 injury that would have prevented her from performing her duties as a house keeper during the five-month waiting period.⁴³ DIS also found that the evidence did not support a restriction on lifting recommended by Wells.⁴⁴ The DIS letter further noted that LeSuer's claim was filed late, and stated that its "right to conduct a timely evaluation of your claim were prejudiced due to the late filing, as we had to evaluate the information on a retroactive basis."⁴⁵ Finally, the letter advised LeSuer that she had exhausted her administrative appeals, and had the right to bring a civil action under Section 502(a) of ERISA.

LeSuer initiated this action in federal district court on November 13, 2007. Her complaint seeks injunctive and declaratory relief, asserting that she is entitled to LTD benefits under the Plan from February 5, 2000 through the present and into the future so long as she is disabled, pursuant to 29 U.S.C. 1132(a)(1) and (3) and (d)(2).⁴⁶ LeSuer also seeks costs, interest and attorneys fees. DIS cross-moves for summary judgment, and costs and attorney's fees. In a separate brief, the HCA Defendants adopt the arguments set forth in DIS's Response / Opposition brief and argue separately that they should not be held liable under ERISA for any benefits owed to LeSuer.

⁴⁰ *Id.*

⁴¹ DIS 53-61.

⁴² DIS 60.

⁴³ DIS 63-64.

⁴⁴ *Id.*

⁴⁵ DIS 53.

⁴⁶ Dkt. 1, Pl.'s Compl. at 5.

III. DISCUSSION

A. Applicable Statute of Limitations

The Defendants argue that LeSuer's suit is untimely; in particular, they assert it is barred by contractual limitations contained in the Plan's Summary of Coverage ("Summary"), the Plan itself, and the Plan's Second Amendment, which became effective January 1, 2002.⁴⁷ LeSuer responds that her suit is timely if the Summary's three-year limitation period is construed together with the other time-limit provisions of the Plan and the "federal accrual rule."⁴⁸ Alternatively, LeSuer argues that both the Plan and the summary's limitations periods were unreasonable, and the Court should apply Alaska's three-year limitations period for breach-of-contract actions⁴⁹ from May 30, 2006, the date of DIS's final denial of LeSuer's administrative appeal.

ERISA does not provide a statute of limitations for suits brought under § 502 (a)(1)(B) to recover benefits, so courts must borrow the most closely analogous state limitations period.⁵⁰ The Ninth Circuit in *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Insurance Program* analogized ERISA disability claims with actions based on written contracts, and held that California's four-year statute of limitations period applied.⁵¹ The *Wetzel* court also held that "under federal law, an ERISA cause of action accrues either at the time benefits are actually denied, or when the insured has reason to know that the claim has been denied."⁵² In this case, which arose in Alaska, there is no dispute that the most analogous state statute is Alaska Statute 09.10.053, which requires that any action upon a contract be brought within three years. Applying *Wetzel's* accrual rule, LeSuer's claim began to accrue on May 30, 2006, the date of the final denial-of-

⁴⁷ Dkt. 51, Defs.' Resp. Br. at 37.

⁴⁸ Dkt. 67, Pl's. Reply Br. at 3.

⁴⁹ See Alaska Statute 09.10.053.

⁵⁰ *Wetzel*, 222 F.3d at 646.

⁵¹ *Wetzel v. Lou Ehlers Cadillac Group Long Term Disability Insurance Program*, 222 F.3d 643, 646 (9th Cir. 2000).

⁵² *Id.* (citations omitted).

benefits letter from DIS. Prior to this point, LeSuer could have reasonably believed her claim had not been finally denied. LeSuer's action, filed in November 2007, was thus filed within Alaska's three-year statutory limitations period.

The next issue is whether LeSuer's action is contractually barred – as the Defendants assert it is – by the various limitations provisions in the Plan, Summary, and Second Amendment. Courts have traditionally held that “in the absence of a controlling statute to the contrary, a provision in a contract may validly limit, between the parties, the time for bringing an action on such contract to a period less than that prescribed in the general statute of limitations, provided that the shorter period itself shall be reasonable.”⁵³ The Ninth Circuit has not squarely addressed whether a contractual provision may validly shorten the limitations period for bringing an ERISA lawsuit. However, the Ninth Circuit has suggested that shorter time limits in a policy could be enforceable.⁵⁴ Several district courts within the Ninth Circuit have followed this approach,⁵⁵ as have the Seventh and Eleventh circuits.⁵⁶ In *Wetzel*, the Ninth Circuit concluded that California's four-year statute of limitations for contract actions applied to ERISA claims, and found that the plaintiff's claim fell within that period. The court then asked “whether *Wetzel*'s action [was] contractually barred by the limitations provision in the policy.”⁵⁷ The relevant provision required that an action to recover benefits had to be commenced “within three years after the time written proof of loss [was]

⁵³ *Order of United Commercial Travelers v. Wolfe*, 331 U.S. 586, 608 (1947).

⁵⁴ *See Wetzel*, 222 F.3d at 646; *Mogck v. Unum Life Ins. Co. of America*, 292 F.3d 1025, 1028-29 (9th Cir. 2002).

⁵⁵ *See Sousa ex rel. Will of v. Unilab Corp. Class II (Non-Exempt) Members Group Benefit Plan*, 252 F.Supp.2d 1046, 1057 (E.D. Calif. 2002); *Scharff v. Raytheon Co. Short Term Disability Plan*, 2007 WL 2947566 (C.D. Cal. 2007).

⁵⁶ *See Northlake Regional Med. Ctr. v. Waffle House Sys. Employee Benefit Plan*, 160 F.3d 1301 (11th Cir. 1998) (holding that contract limitations in ERISA plans are enforceable provided they are reasonable and finding 90 day period reasonable and enforceable); *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869 (7th Cir. 1997) (upholding the plan's three-year limitations period instead of state's six-year breach of contract period).

⁵⁷ *Id.* at 650.

required.”⁵⁸ The Ninth Circuit ultimately remanded the case to the district court because the record lacked sufficient information to determine when proof of loss was decided. However, the Ninth Circuit’s focus on the contractual limitations period – after finding that the action was not barred by the four-year statute of limitations – can be interpreted as an indication that the applicable statute of limitations may be modified by the terms of an ERISA-governed policy. The Court adopts this approach.

Here, the Summary, Plan and Second Amendment contain different time limits for filing a civil lawsuit challenging a denial of benefits. The Summary states that: “No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.”⁵⁹ Separately, it defines the “waiting period” as the first five months of a disability,⁶⁰ and states that:

The deadline for filing a claim for benefits is 90 days after the end of the waiting period. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will be accepted if you file as soon as possible, but not later than 1 year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.⁶¹

The Plan, under “Limitation on Lawsuits,” states:

- b. No court action can be maintained against the Plan, the Plan Administrator, the Company, an Affiliated Facility or any fiduciary until the claim procedures set forth in Section 8.01 and 8.01 [sic] have been exhausted
- c. No court action may be maintained against the Plan, the Plan Administrator, the Company, an Affiliated Facility or any other fiduciary after one (1) year following the date on which the claim was originally filed with the Organization.⁶²

And, finally, the Second Amendment, under the heading “Rights After Appeal,” provides:

If the Participant is dissatisfied with the Insurer’s review of the decision, the Participant has the right to file suit in a federal or state court, which suit must be filed within twelve (12) calendar months immediately following the date of the insurer’s decision of the appeal. No action may be brought for benefits provided by this Plan or to enforce any rights hereunder until after a claim has been submitted to and

⁵⁸ *Id.*

⁵⁹ DIS 019.

⁶⁰ DIS 002.

⁶¹ DIS 018.

⁶² DIS 681.

determined by the Insurer and all appeal rights under the Plan have been exhausted. This means that all claims under this Plan must be appealed under this Plan before any suit for benefits may be filed by the Participant in federal or state court.⁶³

In addition to deciding which, if any, of these limitation periods is reasonable, the Court must first consider whether a contractual limitation period may not only shorten the time for filing suit, but also change the event that triggers the accrual of a claim. Under the Summary limitation period, the clock starts running once the deadline for filing a claim has passed, which is eight months after an alleged disability began. Under the Plan limitation period, the time period runs from the date a participant first files a disability claim. Plaintiff contends that limitation periods beginning before a claim has been fully denied are unreasonable and, thus, unenforceable. The Defendants simply argue that all of the contractual provisions should be enforced, but do not address the Plan's inconsistencies or when a claim accrues.

In *Wetzel*, the Ninth Circuit held that “under federal law, an ERISA cause of action accrues either at the time benefits are actually denied, or when the insured has reason to know that the claim has been denied.”⁶⁴ On this point, the court cited with approval its earlier decision in *Price v. Provident Life & Accident Ins. Co.*, in which the Ninth Circuit rejected the defendant's contention that, under the ERISA-governed contract, the limitations period began to run from the deadline for submitting proof of loss.⁶⁵ The contract in question required proof of loss to be submitted within 90 days of a purported loss. “‘Because the cause of action is federal,’ ” the court stated, “‘[] federal law determines the time at which the case of action accrues,’ and ‘that time is when the plaintiff knows or has reason to know of the injury that is the basis of the action.’”⁶⁶ More recently, the Ninth Circuit affirmed the “federal accrual rule” in *Chuck v. Hewlett Packard Co.*, stating: “Federal law . . . governs the issue of when a cause of action accrues and thereby triggers the start of the limitations

⁶³ DIS 693-94.

⁶⁴ *Wetzel*, 222 F.3d at 649.

⁶⁵ *Price v. Provident Life & Accident Ins. Co.*, 2 F.3d 986, 988 (9th Cir. 1993).

⁶⁶ *Id.* (quoting *Northern Cal. Retail Clerks Unions v. Jumbo Markets, Inc.*, 906 F.2d 1371, 1372 (9th Cir. 1990)).

period.”⁶⁷ The Court thus concludes that the limitation periods in the Summary and Plan are unenforceable because, under both, the time period for filing suit begins before the Plan’s internal review process has been completed and a claim fully denied.⁶⁸

This leaves the limitation period in the Plan’s Second Amendment. Unlike the time limits in the Summary and Plan, the Second Amendment’s limitation period incorporates the federal rule of accrual, but imposes a one-year limit on filing suit. LeSuer argues the Second Amendment is inapplicable for three reasons: 1) it conflicts with the other limitation periods in the Plan and Plan Summary, and inconsistencies within a plan must be construed in a participant’s favor; 2) the Second Amendment was adopted after LeSuer resigned from her job, and thus she was given no notice of the change in the limitations period; 3) Plan provisions addressing retroactive amendments prevent the Second Amendment from barring her claim. In their response brief, the Defendants note that the Second Amendment became effective, retroactively, on January 1, 2002 – before LeSuer filed her claim – and that the amendment actually extended the time to file suit. They note, too, that it is nearly identical to a limitation period found to be enforceable in *Scharff v. Raytheon Co. Short Term Disability Plan*.⁶⁹ The Defendants’ also point out that under the Second Amendment, LeSuer’s suit was filed approximately six months late; DIS’s final denial letter was dated May 30, 2006, but her federal suit was not filed until November 13, 2007.

As an initial matter, the Court finds that the Second Amendment’s one-year contractual period may be enforceable, based on the Ninth Circuit’s analysis in *Wetzel*. The Court therefore turns to LeSuer’s arguments against enforcement of the limitation. It is well established that conflicts or inconsistencies between provisions of a master plan document and a plan summary must

⁶⁷ *Chuck v. Hewlett Packard Co.*, 455 F.3d 1026, 1031 (9th Cir. 2006) (citing *Wetzel*, 222 F.3d at 646).

⁶⁸ The Plaintiff invites the Court to combine the SPD’s three-year limitation period with the federal accrual rule The Court declines to follow this approach. The three-year limitation period is tied to the trigger . . . Plaintiff cites no authority for this mish-mash approach.

⁶⁹ 2007 WL 2947566 (C.D. Cal. 2007).

be construed in favor of an employee or claimant.⁷⁰ Assuming that the Summary and Plan contain enforceable limitations periods, this rule favors the limitations period in the Second Amendment over the others. Under the Second Amendment's limitation period, the time for filing a civil lawsuit does not begin to run until the plan administrator's review of a claim is complete. But under the Summary and Plan limitation periods, an employee could be barred from seeking redress in the courts before the internal review procedure is complete. This is illustrated by the deadlines for filing suit under each of the limitation periods. According to the Defendants, the Summary limitations period barred LeSuer's suit after September 19, 2004; the Plan barred it after December 14, 2004; and the Second Amendment barred it after November 13, 2007. Therefore, even if the Court were to construe the Second Amendment as the applicable limitation period, Plaintiff's suit would still be barred by the time limit.

Plaintiff's argument regarding provisions on retroactive amendments fails as well. Sections 6.01 and 6.02 of the Plan state:

6.01 Amendment of Plan.

The Board, through action of its own or through its duly designated officer, reserves the right at any time, and from time to time, without prior notice to or the consent of any Affiliated Facility or any Participant, to modify, alter or amend the Plan, in whole or in part, effective as of a specified date. Any amendment to the Plan shall be documented in writing. No amendment shall have the effect of denying to any Participant a claim for benefits which has been incurred prior to or on such amendment date or denying benefits properly payable under the Plan for events that occurred prior to or on such amendment date.

6.02 Retroactive Amendment.

Subject to the foregoing limitations, any amendment may be made retroactively which, in the judgment of the Company, is necessary or advisable provided that such retroactive amendment does not deprive a Participant, without his consent, of a right to receive benefits which have already vested in such Participant, except such modification or amendment as shall be necessary to comply with any laws or regulations of the United States or of any state.⁷¹

Plaintiff's Reply brief appears to suggest that the Second Amendment would deny her claim, in violation of these plan provisions. The Court disagrees. Section 6.01 protects claims already "incurred" from being denied retroactively, while Section 6.02 protects participants from being

⁷⁰ *Bergt v. Re. Plan for Pilots Employed by MarkAir, Inc.*, 293 F.3d 1139, 1144-46 (9th Cir. 2002).

⁷¹ DIS 676.

“deprived” of rights that have “already vested.” While neither section defines “incurred” or “vested,” the Second Amendment did not bar LeSuer from filing her initial claim, or from having it reviewed administratively. Indeed, DIS issued its final denial of her claim in March 2006 – long after the amendment was adopted and took effect.

LeSuer’s argument regarding notice, however, has merit. She relies on *Chappel v. Laboratory Corp. of America*, in which the Ninth Circuit held that a failure to notify a participant of a mandatory arbitration clause and a 60-day deadline for seeking arbitration after the denial of a claim constituted a breach of a plan administrator’s fiduciary duty.⁷² The court noted that although neither ERISA’s statutory provisions nor implementing regulations required such a disclosure, “[a]n ERISA fiduciary is nonetheless constrained by its duty to ‘discharge [its] duties with respect to a plan solely in the interest of the participants and beneficiaries.’”⁷³ LeSuer also cites *Solien v. Raytheon Long Term Disability Plan*, in which the district court, relying on the principles espoused in *Chappel*, concluded that regulations establishing the minimum requirements for claims procedures used by ERISA-governed plans require “clear written notice to the claimant of the time limit for filing a civil ERISA case, especially when the time limit is established by the Plan.”⁷⁴ Accordingly, the court permitted the plaintiff to file a late appeal of the denial of her LTD benefits claim and construed it as timely. In doing so, the *Solien* court relied on § 502(a)(3) of ERISA, which provides for individualized equitable relief.

The Court finds the reasoning of *Chappel* and *Solien* to be persuasive, and concludes that the Defendants may not rely on the Second Amendment’s one-year limitations period due to the lack of “clear written notice” regarding the one-year time limit. As the *Solien* court noted, ERISA’s statutory and regulatory framework does not explicitly require a plan administrator to inform a participant of the time limit to file a lawsuit in the final denial letter; nor is a plan administrator required to provide a participant with a copy of the master plan document or subsequent amendments. But a plan summary is the “ ‘statutorily established means of informing participants of

⁷² *Chappel v. Laboratory Corp. of America*, 232 F.3d 719, 726-727 (9th Cir. 2000).

⁷³ *Id.* at 726 (quoting 29 U.S.C. § 1104(a)).

⁷⁴ *Solien v. Raytheon Long Term Disability Plan*, 2008 WL 2323915 (D. Ariz. 2008).

the terms of the plan and its benefits,’ and the employee’s primary source of information regarding employment benefits.’⁷⁵ And as the Ninth Circuit noted in *Chappel*, it would have been a simple matter for DIS to have mentioned the one-year time limit for filing suit in its final denial letter. It also would have been a simple matter to have included the one-year limit in the Plan Summary, the only document the Plan is required to furnish participants, and the document on which participants typically rely for information about the Plan. Because of the potential for confusion given the conflicting limitations periods, and the difficulty of determining the applicability of the one-year period from the Second Amendment, the Court concludes LeSuer received inadequate notice of this contractual requirement. As the *Solien* court stated: “In cases of inadequate notice, the usual remedy is to allow the plaintiff to file a late appeal and to construe it as timely.”⁷⁶ The court adopts this remedy, and construes LeSuer’s suit as timely under Alaska’s three-year statute of limitations.

B. Standard of Review

Given this, the Court turns next to the question of the appropriate standard of review. LeSuer contends that the Court should apply a de novo standard of review or, alternatively, an abuse of discretion standard with heightened scrutiny. The Defendants argue that the Court should review the rejection of LeSuer’s claims only for abuse of discretion.

A claim for benefits under 29 U.S.C. § 1132(a) is to be reviewed 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.⁷⁷ For a plan to alter the standard of review, it must unambiguously provide discretion to the administrator.⁷⁸ The Supreme Court has suggested that a plan grants discretion if the administrator has the “power to construe disputed or doubtful terms” in

⁷⁵ *Bergt*, 293 F.3d at 1143.

⁷⁶ *Solien*, 2008 WL 2323915 *8; see also *White v. Jacobs Eng’g Group Long Term Disability Benefit Plan*, 896 F.2d 344, 350-51 (9th Cir. 1990).

⁷⁷ *Bendixen v. Standard Ins. Co.*, 185 F.3d 939, 942 (9th Cir. 1999) (citations omitted).

⁷⁸ *Abatie, v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963 (9th Cir. 2006).

the plan.⁷⁹ Following this approach, the Ninth Circuit has held that wording that grants the power to interpret plan terms and make final benefits determinations confers discretion on the administrator.⁸⁰

If the language of the plan unambiguously confers discretionary authority, the court reviews the administrator's decision for "abuse of discretion."⁸¹ The abuse of discretion standard is a deferential one. An ERISA claim administrator's determination must be upheld unless the court finds that the claim administrator abused its discretion by: (1) rendering decisions without any explanation; (2) construing provisions of the plan in a way that conflicts with the plain language of the plan; or (3) relying on clearly erroneous findings of fact in making benefit determinations.⁸² The Ninth Circuit "will uphold the decision of an ERISA plan administrator 'if it is based upon a reasonable interpretation of the plan's terms and was made in good faith.'"⁸³ Where there is relevant evidence in the administrative record "that reasonable minds might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence," the decision must be upheld.⁸⁴

Here, LeSuer acknowledges that the Summary provided discretionary authority to Aetna with the following language:

For the purpose of section 503 of Title I of [ERISA], Aetna is a fiduciary with complete authority to review all denied claims for benefits under this policy. This includes, but is not limited to, the denial of certification of the medical necessity of

⁷⁹ *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

⁸⁰ *Abatie*, 458 F.3d at 963, citing *Bergt*, 293 F.3d at 1142.

⁸¹ *Bendixen*, 185 F.3d at 942 ("Where the decision to grant or deny benefits is reviewed for abuse of discretion, a motion for summary judgment is merely the conduit to bring the legal question before the district court and the usual tests of summary judgment, such as whether a genuine dispute of material fact exists, do not apply.")

⁸² *See Bendixen*, 185 F.3d at 944.

⁸³ *Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1178 (9th Cir. 2005) (quoting *Estate of Shockley v. Alyeska Pipeline Serv. Co.*, 130 F.3d 403, 405 (9th Cir. 1997)).

⁸⁴ *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1473 (9th Cir. 1993) ("In the ERISA context, even decisions directly contrary to evidence in the record do not necessarily amount to an abuse of discretion."); *Gilbrook v. City of Westminster*, 177 F.3d 839, 856 (9th Cir. 1999).

hospital or medical treatment. In exercising such fiduciary responsibility, Aetna shall have discretionary authority to:
determine whether and to what extent employees and beneficiaries are entitled to benefits; and
construe any disputed or doubtful terms of this policy.
Aetna shall be deemed to have properly exercised such authority unless Aetna abuses its discretion by acting arbitrarily and capriciously.⁸⁵

This language unequivocally gives Aetna the “power to construe disputed or doubtful terms” and to make final determinations on benefits claims. However, LeSuer contends that this discretionary authority does not extend to Aetna’s designees, IDR and DIS, because those entities are not mentioned in the Plan documents, and therefore de novo review should be applied. LeSuer also argues that the Court should apply a stricter version of the abuse-of-discretion standard of review identified in *Abatie v. Alta Health & Life Ins. Co.*⁸⁶ because IDR’s and DIS’s decisions were “subject to review and countermanding by Aetna,” and therefore a conflict of interest existed. Finally, LeSuer contends that de novo review is warranted because of “the long delay attending a decision on LeSuer’s appeal.”⁸⁷

On the first issue, the Defendants note that the Plan explicitly states that an insurance company providing benefits under the plan “shall be the ‘named fiduciary’ and claims administrator responsible for administering and controlling such Coverage Documents, with all the power and discretion afforded the Plan Administrator as described below.”⁸⁸ The Plan further states that the administrator’s authority includes the power:

to allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.⁸⁹

While the delegation of authority to IDR and DIS is not included in Plan documents, the Defendants have submitted, as exhibits to their response brief and cross-motion, copies of a “Claim Reserve

⁸⁵ DIS 038. *See also* DIS 671.

⁸⁶ 458 F.3d 955 (9th Cir. 2006).

⁸⁷ Dkt. 44, Pl.’s Mot. for Summ. J. at 12.

⁸⁸ DIS 671.

⁸⁹ DIS 672.

Assignment Agreement,” (“Agreement”) between Aetna and ReliaStar Life Insurance Co., under which Aetna delegates its administrative power and responsibilities to ReliaStar.⁹⁰ The Agreement, in turn, gives Reliastar express authority to “appoint a properly licensed third party administrator or insurer (the “Administrator”) acceptable to Ceding Company to adjudicate such claims.”⁹¹ The Agreement explicitly names “IDR as the Administrator,”⁹² and Amendment No. 1 to the Agreement expressly names DIS as the new Administrator, following the demise of IDR.⁹³ The Agreement took effect December 1, 2000, and Amendment No. 1 took effect March 11, 2006. The terms of the Plan are therefore satisfied.

In connection with this, LeSuer objects to the Court’s consideration of the Claim Reserve Assignment Agreement on the grounds that an affidavit submitted with it “provides no basis for verifying the documents,” and because the agreement contains redactions and omissions.⁹⁴ The Court concludes these objections are without merit. LeSuer had an opportunity to respond to the exhibits in her reply brief, and the affidavit from Ryan J. Burt, counsel for DIS, is sufficient to authenticate the “Claim Reserve Assignment Agreement.”⁹⁵ In addition, the limited redactions in the Agreement are irrelevant to LeSuer’s claims and do not affect the Agreement’s admissibility. The Court therefore finds that discretionary authority was properly conferred on DIS as the third-party administrator, and thus the abuse of discretion standard applies.

As to the conflict-of-interest claim, the Ninth Circuit in *Abatie* explained that “the existence of a conflict of interest is relevant to how a court conducts abuse of discretion review.”⁹⁶ In particular, the court noted that “ ‘if a benefit plan gives discretion to an administrator or fiduciary who is

⁹⁰ See Dkt. 51, Ex. 2 at 9-22..

⁹¹ Dkt. 51, Ex. 2 at 11.

⁹² *Id.*

⁹³ *Id.* at 21.

⁹⁴ Dkt. 67, Pl.’s Reply Br. at 7.

⁹⁵ Dkt. 51, Ex. 1.

⁹⁶ *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d at 965

operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion.”⁹⁷ Here, Amendment No. 1 states that ReliaStar “shall be responsible for the actions” of the third-party administrator, and that the third-party administrator “shall be acting on behalf of [ReliaStar], and [ReliaStar] shall be responsible for any actions or omissions of” the third-party administrator.⁹⁸ The Court does not read this language as eroding DIS’s authority to “adjudicate” benefits claims, and therefore does not find a structural conflict of interest of the type warned against in *Abatie*. But assuming *arguendo* that this language did give rise to some form of a conflict, the Court’s review would be enhanced by only a low level of skepticism because LeSuer has provided no evidence of “malice, of self-dealing, or of a parsimonious claims-granting history.”⁹⁹

LeSuer’s third argument on the standard of review lacks merit as well. Citing *Abatie*, she argues that de novo review is warranted because more than 14 months elapsed before DIS issued a final decision on her appeal. LeSuer notes that in a letter dated January 21, 2005, IDR acknowledged receipt of her appeal letter and supporting documentation, and stated that “Under ERISA guidelines, we have 45 days from the receipt of your appeal to advise you of our final claim determination.”¹⁰⁰ DIS issued the final denial of her appeal on May 30, 2006. LeSuer suggests this delay was a “flagrant” or “wholesale” violation of ERISA procedural rules, justifying de novo review.

The Defendants acknowledge that ERISA regulations include deadlines for notifying claimants of decisions regarding their claims. Specifically, 29 C.F.R. § 2560.503-1(f)(3) provides that if a claim is wholly or partially denied, the plan administrator shall notify the claimant within a “reasonable period of time” but not later than 90 days after receiving the claim, unless the plan

⁹⁷ *Id.* (quoting *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (internal citation omitted)).

⁹⁸ Dkt. 51, Ex. 2 at 13.

⁹⁹ *Abatie*, 458 F.3d at 968-69 (internal citations omitted).

¹⁰⁰ DIS 424.

administrator determines that an extension of time is needed.¹⁰¹ Any extension is limited to an additional 90 days, and notice of the extension “shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.” The regulations further specify that if a plan fails to follow the requirements of the regulation:

[A] claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.¹⁰²

The Defendants contend that the Ninth Circuit’s opinion in *Gatti v. Reliance Standard Life Ins. Co.*¹⁰³ established that a failure to issue a benefit decision within the regulatory time limits does not justify application of the de novo standard of review.

In *Abatie*, the Ninth Circuit recognized that procedural irregularities can be so substantial as to alter the standard of review. “When an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well, we review de novo the administrator’s decision to deny benefits. We do so because . . . a plan administrator’s decision is entitled to deference only when the administrator exercises discretion that the plan grants as a matter of contract.”¹⁰⁴ But the court also noted that a “procedural irregularity in processing an ERISA claim does not usually justify de novo review.”¹⁰⁵ Like a conflict of interest, a procedural irregularity, is a matter to be weighed in deciding whether an administrator’s decision was an abuse of discretion.¹⁰⁶ The *Abatie* court further directed that:

¹⁰¹ 29 C.F.R. § 2560.503-1(f)(3).

¹⁰² 29 C.F.R. § 2560.503-1(l).

¹⁰³ 415 F.3d 978 (9th Cir. 2005).

¹⁰⁴ *Abatie*, 458 F.3d at 971.

¹⁰⁵ *Id.* at 972.

¹⁰⁶ *Id.*

“Lesser irregularities . . . do not remove the decision from abuse of discretion review, but rather should be factored into the calculus of whether the administrator abused its discretion.”¹⁰⁷

In *Gatti*, the Ninth Circuit found that the district court erred in applying de novo review because Reliance, which provided LTD benefits for an employer, took 177 days to reaffirm its earlier denial of a claimant’s benefits, and then took another 279 days to again reaffirm its decision after the claimant submitted additional evidence.¹⁰⁸ The district court based its decision on an older version of ERISA regulations that required administrators to issue a decision on a benefits claim within 60 days, or 120 days under certain circumstances.¹⁰⁹ The regulations also provided that if a decision was not made within the time limits, the claim was to be “deemed denied” on review. The Ninth Circuit rejected *Gatti*’s suggestion that once a benefits administrator violated the regulation’s time limit, the “deemed denied” language cut off the administrator’s discretion and made de novo review appropriate.¹¹⁰ Instead, the Ninth Circuit interpreted the “deemed denied” language as merely a safeguard guaranteeing a claimant a final decision that could be appealed in court. The Ninth Circuit found further support for this interpretation in the deletion of the “deemed denied” language when the regulations were amended in 2000. The current version of the regulations – the ones at issue here – do not include this language.

Here, the elapse of 14 months before DIS rendered a final decision on LeSuer’s administrative appeal certainly constitutes a procedural irregularity. But given the analysis in *Gatti*, the Court finds that this delay does not justify the imposition of de novo review. The Court does, however, factor the delay into its decision on whether the Defendants abused their discretion.

C. Does the Rejection of LeSuer’s Claim Constitute an Abuse of Discretion?

LeSuer argues that even if abuse of discretion is the appropriate standard of review, she is entitled to benefits based on the medical evidence and procedural irregularities, including a “faulty review process,” a lack of opportunity to comment on the medical reviews conducted by IDR and

¹⁰⁷ *Id.* at 959.

¹⁰⁸ *Gatti*, 415 F.3d at 981.

¹⁰⁹ *Id.* at 981-82 (citing 29 C.F.R. § 2560.503-1(h) (1998)).

¹¹⁰ *Id.* at 983.

DIS, and an alleged failure to advise her, in lay terms, of the type of evidence she could submit in support her claim. The Defendants counter that the denial of benefits was not an abuse of discretion because LeSuer failed to show that she was unable to perform her job for the first five months after she allegedly became disabled, as required by the Plan.

To be eligible for LTD benefits under the Plan, a participant's "period of disability" must "continue[] during and past the waiting period."¹¹¹ An individual is deemed to be disabled if, during the period which ends after the first 24 months that benefits are payable, she is "not able, solely because of injury or disease, to perform the material duties of [her] own occupation; except that if [she] start[s] work at a reasonable occupation [she] will no longer be deemed disabled."¹¹² A "period of disability" starts on the first day the participant is disabled as a direct result of a significant change in her physical or mental condition, while covered by the Plan. Conversely, the "period of disability" ends on the first date a participant is no longer disabled.¹¹³ Here, DIS identified February 5, 2000 as the first day of LeSuer's purported disability.¹¹⁴ Therefore, the five-month elimination period extended from February 5, 2000 to July 5, 2000.¹¹⁵

Having reviewed the evidence submitted by LeSuer and HCA in connection with her claim, and the reasons given by IDR and DIS for rejecting her claim, the Court concludes that the denial of LeSuer's claim was not an abuse of discretion. Specifically, the Court finds there is relevant evidence in the record that "reasonable minds" might accept as supporting the denial of benefits, although it is "possible to draw two inconsistent conclusions from the evidence."¹¹⁶ Therefore, the denial of her claim must be upheld.

¹¹¹ DIS 008.

¹¹² DIS 007.

¹¹³ DIS 0008.

¹¹⁴ DIS 053. This determination was based on payroll records showing LeSuer worked less than a half-day on February 5, 2000, and did not work after this date.

¹¹⁵ DIS 054.

¹¹⁶ *Taft*, 9 F.3d at 1473 ("In the ERISA context, even decisions directly contrary to evidence in the record do not necessarily amount to an abuse of discretion."); *Gilbrook*, 177 F.3d at 856.

LeSuer asserts that she was disabled due to two conditions: a back injury and depression.¹¹⁷ The strongest evidence supporting her claim are the medical records from her chiropractor, Brent Wells; Dr. Nelly Bardman, who saw LeSuer at least five times during May, June, and July 2000; and Maj. Betty Smith, a physical therapist at Elmendorf Air Force base, where LeSuer sought treatment for her back pain. The evidence from Wells includes two forms signed in late January 2000 indicating LeSuer was “totally incapacitated.”¹¹⁸ In early February, however, Wells filled out another form, an “Excuse Slip,” releasing LeSuer to return to work on the condition that she not lift more than 20 pounds.¹¹⁹ Along with these forms, LeSuer submitted a one-page summary of an MRI performed on February 14, 2000, which found evidence of degenerative disc disease at L4-5 and L5-S1, with “mild disc bulging at both levels and medial tear of the annulus at both levels without disc herniation seen.”¹²⁰

Dr. Bardman’s notes describe LeSuer’s July 1999 elevator accident at Alaska Regional Hospital, in which a set of elevator doors closed on her back. In May 2000, Dr. Bardman assessed LeSuer as suffering from “fatigue / lack of energy,” hypertension, and “[c]hronic low back pain,” for which she was prescribed the drugs Relafen and Baclofen.¹²¹ On June 9, 2000, LeSuer returned for a follow-up visit and reported that the Relafen had helped her back pain “somewhat.” Under “History,” Dr. Bardman’s notes state that: “[LeSuer] also complained of feeling tired and fatigued. She has generalized weakness. She hasn’t been working for the last six months because she didn’t have the strength to work.”¹²² During this visit, Dr. Bardman spoke with LeSuer about “her possible depression,” and suggested that taking drugs to treat depression might “significantly improve her

¹¹⁷ DIS 580.

¹¹⁸ DIS 334-35.

¹¹⁹ DIS 240.

¹²⁰ DIS 537.

¹²¹ DIS 530.

¹²² DIS 530.

pain sensation.”¹²³ In response to this, LeSuer agreed to try another drug, Celexa, for three weeks. On June 30, LeSuer reported that she “could not tolerate Celexa” and that the Relafen was not helping her backpain. She was assessed as having “[c]hronic fatigue syndrome / chronic pain syndrome – this may be related to depression.”¹²⁴ The notes indicate that Bardman gave LeSuer samples of a new drug, Wellbutrin, to try. On July 21, 2000, during a follow-up visit, LeSuer reported that both her fatigue and back pain had improved somewhat. She was then given a prescription for Baclofen and Relfen, and referred for an orthopedic consult.¹²⁵

The evidence from Maj. Betty Smith, chief of the physical therapy unit at Elmendorf, consists of a single, one-page memorandum dated June 14, 2002. It states that LeSuer “has been seen in physical therapy for her back pain since approximately July 1998.” It continues:

1. We have worked with her with various exercise programs and modalities to control the pain. To date, all physical therapy treatments have been unsuccessful. With her limitations with standing, sitting, and walking and inability to lift more than a few pounds, it would be difficult for me to envision [sic] her being able to tolerate any kind of employment workload.
2. In conclusion, I support Dr. Wasile’s recommendations for total and permanent disability rating . . .¹²⁶

Defendants dismiss LeSuer’s evidence as vague and lacking in specific support for her disability claim. In particular, they note that the record contains no support for Wells’s conclusion that LeSuer was “totally incapacitated” in late January 2000, but ready to return to work two weeks later, albeit with the weight-lifting restriction. They note, too, that LeSuer did not submit any information from her health care providers discussing the relevance of the MRI results, or whether

¹²³ DIS 529.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ DIS 337. Although this memo was written long after the end of the five-month waiting period for disability, it can be read as covering the waiting period because of the reference to 1998. By contrast, the records of Dr. Olga Wasile, a family practice physician at Elmendorf, do not support LeSuer’s claim because Dr. Wasile did not begin treating her until January 2001, six months after the end of the waiting period. DIS 112.

degenerative disc disease rendered her disabled in the context of her job at the hospital.¹²⁷ Finally, they point out that although Plaintiff submitted documents from three medical doctors, none of the documents offers a cogent explanation of how LeSuer's back pain and possible depression left her unable to perform her job at the hospital.

Defendants point to records from two other medical providers, Dr. Stan Smith and Dr. Shawn Hadley, both of whom examined LeSuer during the five-month waiting period and whose evaluations were considered by DIS's medical reviewer, Dr. Joseph Amato. As noted above, LeSuer saw Dr. Smith on September 8, 1999 for back pain.¹²⁸ It is unclear whether the administrative record includes copies of medical records from Dr. Smith; neither party has pointed to any. Defendants rely, instead, on medical records summary compiled by Dr. Hadley, who examined LeSuer on March 21, 2000 at the request of HCA's workers compensation carrier.¹²⁹ Hadley's summary states that LeSuer contacted the office of Dr. Smith, her primary care physician, at the end of July for an appointment in connection with neck and back pain, but was told the earliest she could see him was September.¹³⁰ When LeSuer finally saw Dr. Smith in September, he diagnosed her as having mild, soft tissue injuries of her cervical, thoracic, and lumbar spine.¹³¹ Hadley's summary also quotes Smith's notes as stating:

Whether or not this is residual from her old injuries or new with the onset of her crush injury six weeks ago, I don't know. Seems kind of funny she would delay it this long. I suspect there may be some magnification of symptoms with the stress with her supervisor, she states she is not very happy with her employment because of recent on-the-job difficulties.¹³²

Smith referred LeSuer for physical therapy, but did not limit her job activities or find her disabled.¹³³

¹²⁷ Dkt. 51, Resp. Br. at 14; DIS 62.

¹²⁸ DIS 212.

¹²⁹ Dkt. 67, Reply Br. at 11; Dkt. 51, Resp. Br. at 14; *see* DIS 208.

¹³⁰ DIS 208.

¹³¹ DIS 212.

¹³² *Id.*

¹³³ DIS 130.

During Dr. Hadley's evaluation of LeSuer, she complained of frequent headaches and of pain in her neck, upper right arm, mid back, and lower back. With regard to the latter, Hadley's notes state: "She reports that she is never without low-back pain."¹³⁴ As part of the exam, LeSuer was asked about her employment. Dr. Hadley's notes state LeSuer reported that things were going "real fine" until she made a sexual harassment complaint against a supervisor. She also voiced uncertainty about returning to work at the hospital, but indicated that she felt capable of working.¹³⁵ During the exam, Dr. Hadley also observed that LeSuer "moves quite fluidly and normally." Dr. Hadley did find a moderate restriction in LeSuer's cervical range of motion, but also wrote that "rotation is noted to be better when not formally observed."¹³⁶ But she also found that the range of motion for LeSuer's lumbar spine was "poor."¹³⁷ Relying on her observations and LeSuer's previous medical records, Dr. Hadley diagnosed LeSuer as having chronic pain syndrome, "with evidence of symptom magnification and psychological factors affecting [her] physical condition," and age-related degenerative changes in the cervical and lumbar spine.¹³⁸ She further concluded that the degenerative changes to her spine did "not appear to be related to any specific injury," and expressed skepticism about LeSuer's complaints of pain, concluding that:

[LeSuer] has basically a normal physical examination; in fact, she moves about quite normally. She has multiple, rather bizarre pain complaints that do not fit any specific medical diagnosis. This lends support to the opinion that there are significant psychological factors affecting her presentation. There may be secondary gain issues as well, with respect to impaired employer-employee relations and questionable motivation to return to full-time employment, particularly since she has applied for Social Security disability.¹³⁹

With regard to LeSuer's July 1999 elevator injury, Dr. Hadley opined that her "current complaints" were not "reasonably related" to the incident, nor supported by objective findings. She

¹³⁴ DIS 209.

¹³⁵ DIS 210.

¹³⁶ DIS 211.

¹³⁷ *Id.*

¹³⁸ DIS 312.

¹³⁹ *Id.*

further concluded that no additional treatment or diagnostic studies were needed in connection with the July 1999 incident, and she flatly denied the possibility that the July 1999 elevator incident could have aggravated a preexisting condition in LeSuer.¹⁴⁰

LeSuer argues that Dr. Hadley's conclusions should be given little weight because her "opinions were primarily focused on whether the July 1999 work related accident had caused disability and not the questions posed by her LTD claim [non-work related disability]."

As noted above, the Court finds that the relevant evidence in the administrative record supports two reasonable, yet inconsistent, conclusions. While Wells's "total disability" and weight-lifting restriction lack support in the record, the notes from LeSuer's appointments with Dr. Bardman clearly suggest she was suffering significant back pain in the spring of 2000, along with fatigue and possible depression. That Bardman did not explicitly find LeSuer disabled, or unable to perform her job, does not negate her reports of chronic back pain.

Yet the record also supports DIS's affirmation of the denial of LeSuer's claim. In his summary and recommendation, DIS's medical reviewer, Dr. Amato, relies heavily on Dr. Smith's findings of only mild, soft tissue injuries, and Dr. Hadley's conclusion that LeSuer's physical exam was "essentially within normal limits" and that her complaints of pain were possibly magnified by psychological factors.¹⁴¹ Dr. Amato also cast Dr. Bardman's clinical notes in a different light from LeSuer. According to Dr. Amato's review, Dr. Bardman's notes suggest that LeSuer's primary complaints were of fatigue and low energy, with an additional diagnosis of depression. Dr. Amato concluded that there was no "true support objectively for an injury or disease of the back . . . to produce any restrictions or limitations in this individual's ability to perform the essential duties of her occupation" during the five-month waiting period.¹⁴² In sum, Dr. Amato found no support in the medical records for Wells's disability determination and lifting restriction, nor for LeSuer's claim that she was disabled and unable to perform her job due to depression. Because DIS did not render

¹⁴⁰ DIS 214.

¹⁴¹ DIS 65.

¹⁴² DIS 066-067.

its decision without an explanation, did not construe provisions in a way that conflicts with the plain language of the plan, and did not rely on clearly erroneous facts, its decision must be upheld.

Finally, the Court addresses LeSuer's claims of procedural irregularities during the claim review process. She contends that DIS and IDR used a "faulty review process," apparently because Dr. Amato did not review additional records from Dr. Wasile and two mental health therapists, Sandy Bhargava and Vicki Heinz. But as the Defendants point out, the Plan required LeSuer to establish that she was disabled during the five-month waiting period, which ended July 5, 2000. If she cannot do this, documents relating to later time periods are irrelevant. Here, the record indicates that Dr. Wasile did not begin treating LeSuer until January 2001,¹⁴³ that Bhargava did not begin treating LeSuer until July 2002, and that Heinz met with LeSuer on May 10, 2002. All of these dates are beyond the waiting period, and thus DIS's failure to consider them was not an abuse of discretion. LeSuer also claims that she was never given an opportunity to comment on the medical reviews conducted by IDR and DIS. But she cites no authority for this, and the Court is not aware of any statutory or regulatory requirement that, apart from filing an administrative appeal, a claimant must be allowed to comment on a plan administrator's medical review. Finally, LeSuer claims she was never advised in "laypersons terms" of the type of evidence she could supply in support of her claim. This is not true. IDR's initial denial of her claim, dated July 20, 2004, informed LeSuer that it would review "any additional information you wish to submit" and proceeded to list specific types of documents, including medical reports, diagnostic studies, "documentation showing why you are not capable of working at any reasonable occupation," and any determination on a Social Security disability application.¹⁴⁴

In sum, the Court concludes that LeSuer failed to establish that she was disabled during the five-month waiting period and, thus, DIS's denial of LeSuer's claim for benefits was not an abuse of discretion.¹⁴⁵

¹⁴³ DIS 112.

¹⁴⁴ DIS 140.

¹⁴⁵ Given the dismissal of LeSuer's complaint, the Court does not reach the issue of whether HCA, Inc. and HCA, Inc. Long Term Disability Plan are proper parties to LeSuer's suit and could be

V. CONCLUSION

For the reasons stated above, the Plaintiff's complaint is dismissed with prejudice. The Court DENIES her motion at Docket 44 and GRANTS the Defendants' cross-motion for summary judgment at Docket 51. The Defendants' request for costs and attorney's fees was not adequately briefed, and may be addressed in a separate motion.

Dated at Anchorage, Alaska, this 31st day of March 2009.

/s/ Timothy Burgess
Timothy M. Burgess
United States District Judge

held liable for the denial of LeSuer's claim. See Dkt. 53, HCA Defs.' Resp. Br. 1-3.