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JS-6

**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
SOUTHERN DIVISION**

DONALD DELANCEY,

Plaintiff,

v.

**LIBERTY LIFE ASSURANCE
COMPANY OF BOSTON,
AUTOMOBILE CLUB OF
SOUTHERN CALIFORNIA, CLUB
GROUP LONG-TERM DISABILITY
PLAN, and DOES 1 through 10,
inclusive,**

Defendants.

Case No.: SACV 15-02022-CJC(KESx)

MEMORANDUM OF DECISION

1 **I. INTRODUCTION**

2
3 Plaintiff Donald DeLancey worked as an IT Security Analyst for Automobile Club
4 of Southern California (“Auto Club”) until September 3, 2014, when he was hospitalized
5 for a suspected transient ischemia attack. (Dkt. 50-4 [Declaration of Heidi Jacques
6 (hereinafter “Jacques Decl.”) Ex. B (Administrative Record, hereinafter “AR”)] 909,
7 1924–30.) On January 10, 2015, DeLancey submitted a claim for long-term disability
8 (“LTD”) benefits under Auto Club’s Group Long-Term Disability Plan (the “Plan”) to
9 Liberty Life Assurance Company of Boston (“Liberty”). (AR 1–12.) Liberty is
10 responsible for administering and paying claims for LTD benefits under the Plan in
11 accordance with the Disability Income Policy (the “Policy”). Liberty denied DeLancey’s
12 claim on April 16, 2015, (AR 784), and affirmed the denial in response to DeLancey’s
13 appeal on November 18, 2015, (AR 21).

14
15 DeLancey brings this action under the Employee Retirement Income Security Act
16 of 1974 (“ERISA”), 29 U.S.C. §§ 1001 *et seq.*, challenging Liberty’s denial of LTD
17 benefits. After a bench trial on the administrative record, the Court finds that Liberty did
18 not abuse its discretion in denying DeLancey’s claim for LTD benefits.

19
20 **II. BACKGROUND**

21
22 **A. Relevant Terms and Conditions of the Policy**

23
24 The ERISA-governed LTD Plan in which DeLancey was enrolled through his
25 employment provides that a person is “disabled” if they meet the following definition:

- 26
27 i. If the Covered Person is eligible for the 6 Month Own Occupation
28 benefit, “**Disability**” or “**Disabled**” means during the Elimination
Period and the next 6 months of Disability the Covered Person is

1 unable to perform all of the material and substantial duties of his
2 occupation on an Active Employment basis because of an Injury or
3 Sickness; and

- 4 ii. After 6 months of benefits have been paid, the Covered Person is
5 unable to perform, with reasonable continuity, all of the material and
6 substantial duties of his own or any other occupation for which he is
7 or becomes reasonably fitted by training, education, experience, age,
8 and physical and mental capacity.

9 (Jacques Decl. Ex. A at 20 (emphasis in original).) The “Elimination Period” means “a
10 period of consecutive days of Disability for which no benefit is payable,” which “begins
11 on the first day of Disability.” (*Id.* at 21.) This is the greater of “the end of the Covered
12 Person’s Short Term Disability Benefits” or “26 weeks.” (*Id.* at 17.)

13 **B. Initial Hospitalization**

14
15 On September 3, 2014, DeLancey was admitted to the emergency room at Hoag
16 Hospital for a suspected transient ischemia attack (“TIA”), also known as a
17 “ministroke,”¹ after he noticed “onset of fatigue and right facial droop with drooling”
18 beginning around 9:30 a.m. while at work. (AR 901, 905.) He noted that he was
19 speaking slowly and said he felt “flushed and very tired.” (AR 905.) He also reported
20 that he had experienced a similar episode earlier that year in January. (*Id.*) At the time,
21 DeLancey was 60 years old. The emergency room doctors conducted a CT angiography
22 of his head and neck and concluded that it presented “no acute findings.” (*Id.*) A
23 neurologist also evaluated him and “felt that [DeLancey] was not a TPA² candidate.”
24 (*Id.*)

25
26
27
28

¹ See Dkt. 58 at 3 n.1.

² TPA is short for Tissue Plasminogen Activator, a medication used to treat a stroke that must be administered within several hours of the stroke to be effective. (See Dkt. 60 at 6, 6 n.2.)

1 DeLancey was then transferred to Kaiser Permanente Hospital (“Kaiser”) because
2 he presented with “slurred speech and aphasia.”³ (AR 901.) Dr. Juy Minh Le noted that
3 he had a “[p]ossible right lip droop” and his speech was “somewhat slow.” (AR 907.)
4 Dr. Le observed no other neurological abnormalities. (*Id.* (“CN II-XII otherwise grossly
5 intact, 5/5 strength in the upper and lower extremities. Sensation grossly intact. Rapid
6 finger movements intact. Finger to nose accurate. Babinski downgoing bilaterally.”).)
7 DeLancey was “[a]lert and oriented” and was experiencing “[n]o acute distress” but he
8 appeared tired and his face was flushed. (*Id.*)

9
10 The doctors at Kaiser performed an MRI and an echocardiogram, and both exams
11 tested negative for TIA. (AR 901; *see also* AR 920 (MRI presented “no acute
12 abnormality,” just “[m]ild periventricular white matter disease.”); AR 907 (EKG
13 presented “no acute ischemic findings.”) His CT angiogram was also normal. (AR 907
14 (“No acute intracranial abnormalities/enhancement. No significant perfusion
15 abnormalities. Unremarkable CT angio.”).) A speech pathologist, Kevin Schell, met
16 with him and found his speech, cognition, and behavior to be within normal limits. (AR
17 917.) Mr. Shell noted that he “did not seem aphasic during today’s session” and had
18 “[n]o slurred speech.” (*Id.*)

19
20 Upon discharge, Dr. Nam Quoc Le reported “this patient did NOT have a Stroke
21 during this hospital admission,” (AR 904 (emphasis in original)), and that he could return
22 to work in two days, (AR 903). Prior to discharge, Nurse Marcus Mercado also noted
23 that DeLancey had “no slurred speech.” (AR 921.) DeLancey was discharged the next
24 day and was never prescribed any stroke medication. (AR 901, 906.)

25
26
27
28 ³ Aphasia is a neurological condition involving impaired ability to communicate, speak, write, and understand language. (*See* Dkt. 56 n. 4.)

1 **C. Short Term Disability Claim**

2
3 DeLancey ceased working after his hospitalization on September 3 and 4, 2014,
4 and submitted a claim to Auto Club for short term disability (“STD”), which was
5 approved. (Dkt. 50-1 at 3; Dkt. 56 at 2.) Auto Club administers and sponsors its own
6 STD plan—Liberty had no involvement in Plaintiff’s STD claim and payment of
7 benefits. (Dkt. 56 at 2–3; Dkt. 60 at 2.) STD coverage ceased on March 8, 2015. (Dkt.
8 50-1 at 3.)

9
10 **D. Medical Appointments Prior to Claim Submission**

11
12 On September 8, 2014, four days after DeLancey was discharged from the hospital,
13 he met with primary care physician Dr. Terry Chan and reported that he felt “sluggish,”
14 had “trouble finding words and typing,” experienced “stress at work,” and felt he “can’t
15 work due to dysarthria⁴ and aphasia and typing difficulties.” (AR 994.) DeLancey’s
16 neurological tests that day showed no abnormalities, (AR 997 (“He is alert and oriented
17 to person, place, and time. He has normal reflexes. No cranial nerved deficit. Gait
18 normal. Coordination normal. GCS score is 15.”)), but he tested positive for depression,
19 (AR 996, 997).

20
21 DeLancey then met with a speech and language pathologist, Jaclyn Rooney, on
22 September 12, 2014. (AR 1044.) He expressed concerns about “slow speech and
23 difficulty finding words,” that he was “very sleepy and his eyes are ‘heavy,’”
24 and that he had “trouble speaking during a lengthy period of time.” (*Id.*) He compared
25 himself to the “‘Old Man from the Carol Barnett Show’” and noted increased difficulty in
26 following directions. (AR 1044–45.) He also reported being “very stressed” during the
27

28 ⁴ Dysarthria is a neurological condition involving difficulty controlling the muscles used in speech, often
characterized by slurred or slow speech that can be difficult to understand. (*See* Dkt. 56 n.5.)

1 time of his suspected TIA. (AR 1045.) Ms. Rooney conducted a cognitive-linguistic
2 evaluation and found no impairment in DeLancey's orientation and awareness,
3 immediate memory, recent memory, long-term memory, thought organization, reading
4 and visual processing, and writing. (AR 1045.) Only his auditory "Processing and
5 Comprehension" and "Logic, Reasoning, and Inference" assessments were low (60% and
6 37%, respectively). (*Id.*) His informal language screening test similarly indicated no
7 impairment in auditory comprehension, commands, and verbal expression, except in the
8 sub-categories of complicated "Body Part Commands" (40%) and "Responsive Naming"
9 (60%). (AR 1046.) Ms. Rooney concluded that he presented with "mild aphasia and
10 dysarthria secondary to a transient ischemic attack" because his speech was
11 "characterized by reduced rate and loudness, and word-finding difficulties." (AR 1049.)
12

13 On September 15, 2014, DeLancey met with a social worker, Rebecca Anne Hall,
14 who reported that DeLancey suffered from "work stress." (AR 1052.) She noted that on
15 the day DeLancey experienced the suspected TIA, he was scheduled for a performance
16 review at work. (*Id.*) Several days before the scheduled performance review, a
17 supervisor warned him that his review "may not be positive," and if it was not, he may be
18 "let go from his job." (*Id.*) Ms. Hall noted that "since [the] most recent TIA [DeLancey]
19 has experienced poor concentration, poor attention to details, slow speech and fatigue
20 daily." (*Id.*) She arrived at "no diagnosis" and concluded that DeLancey had
21 "occupational problems" and "other psychosocial and environmental problems." (AR
22 1056.)
23

24 DeLancey met with Ms. Rooney for a follow up speech therapy appointment on
25 September 25, 2014. (AR 1110.) Ms. Rooney again evaluated him and determined that
26 according to "standard assessments" DeLancey "presents with attention, memory,
27 executive functions, language, and [his] visuospatial skills are within normal limits when
28 compared to adults his age." (AR 1115.) She also noted that the "[r]esults from informal

1 assessments should be interpreted with caution as [DeLancey] has also been diagnosed
2 with Acute Stress disorder by Dr. Chan and signs of depression. Motivation and
3 performance may hinder his overall performance at this time.” (*Id.*)
4

5 Four days later, on September 29, 2014, DeLancey met with Dr. Terry Thay-Lun
6 Chan and reported symptoms of “heart flutter,” speech delay, delayed walking, and
7 lightheadedness. (AR 1143.) Dr. Chan found that he had no impairment in his memory,
8 affect, and judgment. (AR 1146.) Dr. Chan observed signs of dysarthria, organic brain
9 syndrome, and history of transient ischemia attack, but noted that there was “possibly
10 some psychiatric component to this.” (*Id.*) At a follow up appointment in January 2015,
11 however, he abandoned his “organic brain syndrome” diagnosis. (AR 1793.)
12

13 On October 6, 2014, DeLancey met with psychiatrist Dr. Pranav Vinaykant Shah,
14 who conducted Global Assessment of Functioning (“GAF”) testing, which demonstrated
15 “[m]ild symptoms (e.g. depressed mood and mild insomnia) OR [s]ome difficulty in
16 social, occupational, or school functioning; [that DeLancey h]as meaningful social
17 relationships; [and that he is g]enerally functioning pretty well.” (AR 1177 (emphasis in
18 original).) Dr. Shah concluded that he had “mild depressive symptoms” for the last few
19 months and diagnosed him with “unspecified” depression. (AR 1176, 1177.)
20

21 DeLancey then met with Ms. Rooney for his third speech therapy session on
22 October 8, 2014. (AR 1218.) At that meeting, Ms. Rooney noted that his “articulation
23 was accurate and he was 100% intelligible during conversational speech.” (*Id.*) She
24 found him to present with “attention, memory, executive functions, and visuospatial skills
25 within functional limits when compared to individuals his age,” and “minimal
26 dysarthria.” (AR 1219.) At follow up sessions on November 18, 2014, and December 2,
27 2014, she reported that he no longer had dysarthria. (AR 1437, 1567.) At a final meeting
28 on December 17, 2014, Ms. Rooney determined that DeLancey had satisfied his test

1 objectives, had “mild cognitive deficits,” and required no further speech therapy but
2 could schedule a follow up appointment in one month if he desired. (AR 1601–02.)
3

4 On October 30, 2014, DeLancey met with a physical therapist, Mr. Bryan Rilea,
5 due to “fatigue with walking and mobility throughout his day.” (AR 1348.) Mr. Rilea
6 tested him and found most of his movement to be normal or within functional limits but
7 that his gait demonstrated a “left lateral shift of hips with left LE SLS phases of gait” and
8 his posture demonstrated “forward head, rounded shoulders, increased thoracic kyphosis
9 and increased cervical lordosis, increased PPT and decreased lumbar lordosis.” (AR
10 1349, 1351.) Mr. Rilea gave him light therapeutic exercises including “sit to stands,” a
11 walking program, and “alternating finger tips touching” exercises. (AR 1351.)
12 DeLancey also met with Mr. Rilea on November 20, 2014, when he was given a few
13 additional exercises, (AR 1451–55), and again on December 18, 2014, when Mr. Rilea
14 concluded that his goals were achieved and discharged him from therapy, (AR 1617–21).
15

16 On November 21, 2014, DeLancey met with Dr. Tracy Chaffee for a psychiatric
17 evaluation. (AR 1480.) She diagnosed him with depressive disorder and insomnia, and
18 she recommended supportive counseling. (*Id.*) On November 26, 2014, DeLancey again
19 met with Dr. Chan who noted that his neurological assessments were normal and
20 suspected DeLancey had “some anxiety about going back to work soon.” (AR 1520.)
21

22 On December 2, 2014, DeLancey saw an occupational therapist, Ms. Mary Recker,
23 for “difficulty picking things up.” (AR 1541–45.) She found most of his functions to be
24 normal but noted “functional impairments” in his right hand and gave him corresponding
25 exercises. (*Id.*) He met with Ms. Michelle Woo, another occupational therapist, on
26 December 16, 2014, and January 5, 2015, for follow up appointments where he
27 demonstrated “slight gains” in strength and overall “fair+ to good functional use” of his
28

1 right upper extremity. (AR 1582, 1727.) DeLancey also told Ms. Woo that he had been
2 working on the computer, but that fatigue limited his time on the computer. (AR 1727.)
3

4 DeLancey saw a neurologist, Dr. Erika Pietzsch, on December 23, 2014, and
5 reported concern about memory loss and “[r]esidual speech and hand deficits.” (AR
6 1643.) Dr. Pietzsch noted that she “[s]uspect[ed] some psychosomatic component” to his
7 symptoms. (*Id.*) She reviewed DeLancey’s medical records and reported that he was
8 initially “diagnosed with possible ischemic, however his MRI was negative for stroke.”
9 (AR 1643–45.) She reported that his Carotid Ultrasound showed “no evidence of
10 hemodynamically significant stenosis.” (AR 1645.) She conducted neurological exams
11 and memory tests that showed normal results and determined that DeLancey had
12 “nonspecific subjective cognitive problems” and a “moderate amount of chronic small
13 vessel disease,” but that there was “no specific neurological condition to be diagnosed.”
14 (AR 1644.) In her assessment she called the September 2014 incident as a “questionable
15 ischemic event.” (*Id.*) However, DeLancey requested a neuropsychological evaluation,
16 so she approved one. (*Id.*)
17

18 On January 29, 2015, DeLancey met with Dr. Priscilla Armstrong for a
19 neuropsychological assessment. He reported that he was performing all activities of daily
20 living (“ADLs”) and was able to drive, but experienced “ongoing mental confusion and
21 fatigue for which he requires a nap daily.” (AR 1769). She tested his intelligence,
22 attention and concentration, visuospatial skills, verbal memory, nonverbal/visual
23 memory, language, executive functioning, and motor skills, which encompassed
24 approximately 24 sub-categories. (AR 1768–69.) He tested in the average or high
25 average range for his age in all categories, except for the following five sub-categories:
26 visual skills (13th percentile), basic attention (16th percentile), visual processing speed
27 (<1st percentile), attention and sequencing (14th percentile), and dexterity and speed in
28 his right hand (18th percentile). (*Id.*) She noted that with regard to his impairments in

1 visual processing speed, “it should be noted that he had difficulty with visual scanning
2 and finding items, thus his score was negatively impacted by visual skills rather than a
3 true processing speed issue.” (AR 1768.) She noted that this impairment also affected
4 his attention and sequencing score. (AR 1769.) She concluded that his current
5 “neuropsychological assessment revealed average range intellectual functioning,” that he
6 presented with a “generally intact neurocognitive profile,” that his “cognitive skills are
7 generally within normal limits,” and that he did not meet the criteria for dementia. (*Id.*)
8 She also noted that his “low average scores with motor speed and visual scanning are
9 likely a result of possible CVA.⁵” (*Id.*)

11 **E. Long Term Disability Claim**

12
13 On January 10, 2015, DeLancey submitted a claim for LTD benefits to Liberty.
14 (AR 1–12.) Liberty sent his file to a licensed and Board Certified psychologist, Dr.
15 Timothy Belliveau, for review. (AR 862, 878.) Dr. Belliveau reviewed DeLancey’s
16 entire medical record and concluded that it “provides insufficient support for the presence
17 of dementia due to stroke . . . or the presence of mild cognitive impairment due to
18 stroke,” but that it does “provide reasonable support for the presence of mild depressive
19 symptoms.” (AR 870.) He reviewed and summarized the file in detail, (AR 870–78),
20 and found “insufficient support for the presence of impairment in [DeLancey’s]
21 emotional, psychological, or cognitive functioning that would preclude his ability to
22 resume his occupational functioning at any time beyond the 01/29/15 neuropsychological
23 examination.” (AR 870.)

24
25 Liberty also sent Plaintiff’s file to Dr. David Houghton, a Board Certified
26 physician in internal medicine, for an assessment. (AR 863.) Dr. Houghton reviewed the
27

28 ⁵ CVA is short for “cerebrovascular accident,” or a stroke. (*See* Dkt. 56 at 1 n.1.)

1 entire file and concluded that the medical evidence only supported conditions of
2 hypertension, depressive disorder, and urolithiasis. (AR 863–64.) He reported that
3 “diagnostic tests and physical exams have not demonstrated any abnormalities that might
4 provide a basis for [DeLancey’s] symptoms” and that “[n]o restrictions or limitations are
5 supported outside of psychiatric issues.” (*Id.*)

6
7 On March 31, 2015, Ms. Jeannie Swanson, a case manager at Liberty,
8 recommended denying the claim. (AR 8.) Her manager, Juanita Chandra, recommended
9 contacting DeLancey’s treating physicians before making a final decision, (*id.*), so Ms.
10 Swanson sent Dr. Belliveau and Dr. Houghton’s reports to Dr. Armstrong and to Kaiser
11 and asked for a review the assessments, including any disagreements they might have.
12 (AR 823.) Kaiser, responding on behalf of itself and Dr. Armstrong, indicated that
13 “providers will not review any independent medical reviews produced for the purpose of
14 disability benefits determination.” (AR 789.)

15
16 Rebecca Moody, another case manager for Liberty, also reviewed DeLancey’s file
17 and recommended denying the claim, and Robert Digiandomencio, her manager, agreed.
18 (AR 7.) On April 16, 2015, Ms. Moody sent a letter to DeLancey, notifying him that his
19 claim had been denied. (AR 784.) The denial letter quoted Dr. Belliveau and Dr.
20 Houghton’s findings, as well as Kaiser’s decision not to review those reports, and then
21 explained that “[b]ased on the medical documentation received in relation to the
22 requirements of your occupation, you do not meet the definition of disability outlined [in
23 the Policy].” (AR 786.) The letter also notified DeLancey of the appeal process, which
24 required him to submit any additional medical records in support of his appeal. (*Id.*)

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1 **F. Appeal of Claim Denial**

2
3 On August 18, 2015, DeLancey’s attorney sent Liberty a letter to appeal the denial
4 of LTD benefits⁶ but failed to include any supporting documentation. (AR 724.) His
5 attorney sent a follow up letter on September 21, 2015, stating that he would submit
6 additional documentation in support of the appeal, (AR 677), which Liberty received on
7 September 23 and 29, 2015, (AR 84–673).

8
9 On March 25, 2015, DeLancey met with Dr. Chan and reported speech problems.
10 (AR 525.) Dr. Chan noted that his physical and neurological exams were normal, but that
11 his speech skills were “poor” had and “plateaued” and he was “unable to perform
12 requested duties per his job.” (AR 528.) On March 27, 2016, Dr. Chan reported, “In my
13 opinion, the patient currently cannot perform the duties of his prior position at the Auto
14 Club (IT specialist). It requires too much high level thinking, cognitive reasoning, and
15 interpersonal communication. He would do very poorly and will likely make many
16 mistakes at work. If there is a position for him at the Auto Club that does not require the
17 above listed duties, he may be able to work in that position Therefore he can go back
18 to work with accommodations since we do not expect [him] ever to recover those
19 functions and abilities.” (AR 593.)

20
21 DeLancey resumed physical therapy with Mr. Rilea on April 17, 2015, upon
22 referral by Dr. Chan due to his reported “unsteady gait.” (AR 581.) Mr. Rilea’s
23 examination revealed substantially the same results as his prior visits and he gave him a
24 similar light treatment plan of therapeutic exercises. (AR 582–84.) DeLancey met with
25 Mr. Rilea on May 15, 2015 (AR 581), but did not attend his follow up appointment on
26

27
28 ⁶ The letter also purported to appeal Liberty’s denial of STD benefits, (AR 724), but DeLancey never
submitted a claim for STD benefits to Liberty—his STD benefits were granted and administered
independently by Auto Club, (AR 22).

1 June 30, 2015, because his wife had broken her arm and he was taking care of her, so he
2 was discharged, (AR 585.)
3

4 On July 29, 2015, DeLancey saw Dr. Chan again. (AR 617.) He reported that his
5 motor skills were improving but his speech issues were the same. (*Id.*) Dr. Chan noted
6 that he “[a]dvised that eventually [DeLancey] will need to return to work with modified
7 restrictions. But given [his] anger issues [it] may not be prudent to have [him] near the
8 public.” (AR 618.) Dr. Chan repeated this opinion at another appointment on August 26,
9 2015, noting that possible work restrictions could include “limited person to person
10 contact, no or limited computer usage, avoidance of higher level functions at work, [and]
11 limited time at work with breaks to avoid frustration.” (AR 634.)
12

13 In March, May, and July 2015, DeLancey also met with Dr. Chaffee for
14 counseling. (AR 512, 575, 625.) He reported frustration with memory and in July he
15 reported “bouts of yelling, hitting [him]self on the head, and clearing the counter of glass
16 condiment bottles,” (AR 625), which became “less frequent” in September, (AR 176).
17 He also saw Ms. Rooney again for speech therapy and reported speech problems. (AR
18 171.) On September 12, 2015, she conducted an updated assessment, finding that he
19 performed at 100% in most categories, 75% in “Recent Memory” and 80% in “Mental
20 manipulation 5 words.” (*Id.*) She concluded that he “presents with mild cognitive
21 deficits as a result of a stroke. Areas of difficulty are reported in daily memory and
22 function.” (*Id.*)
23

24 On April 24, 2015, DeLancey returned for additional occupational therapy with
25 Ms. Woo due to his inability to remember day to day information and resulting
26 frustration. (AR 553.) She encouraged writing daily as an exercise and recommended a
27 “community resource on Cognitive day program at High Hopes Costa Mesa.” (*Id.*) She
28 also noted “good to normal strength” in his right upper extremity. (*Id.*)

1 On May 27, 2015, he returned to neurologist Dr. Pietzsch. (AR 599.) She
2 reviewed his tests, which were “within normal limits test results” with “some deficits.”
3 (*Id.*) “His MRI brain showed moderate amount of small vessel disease. It is possible that
4 those spots interrupt his cognitive function, but it is impossible to test At this point
5 patient has non-specific cognitive deficits, which do not meet criteria for dementia.” (*Id.*)
6 She prescribed Aricept, a medication used to treat Alzheimer’s disease, for a brief period
7 at DeLancey’s request. (AR 23, 31, 54, 600–04; Dkt. 56 at 18.)

8
9 On October 9, 2015, Liberty received a copy of a form that DeLancey’s attorneys
10 had prepared and sent to Dr. Chan. (AR 75–78.) The form contained the *attorney’s*
11 summary of DeLancey’s medical history and presented questions to Dr. Chan. (*Id.*) For
12 example, it listed DeLancey’s symptoms such as facial droop, drooling, and dysarthria,
13 and asked Dr. Chan to check a box indicating whether such symptoms were
14 “neurological” or “psychological.” (*Id.*) Dr. Chan indicated through check marks that all
15 the symptoms were “neurological.” (AR 77.) It also asked, “In your professional
16 opinion, taking into account his medical findings, job description, and definition of LTD,
17 is Mr. DeLancey disabled?” under which Dr. Chan checked a box for “yes.” (AR 78.) In
18 a follow up question (“If your answer is YES, then is Mr. DeLancey’s disability
19 neurological or psychological?”) Dr. Chan checked the box for “neurological.” (*Id.*)
20 DeLancey’s attorneys also provided Liberty with a letter from Dr. Chan excusing
21 DeLancey from jury duty. (AR 79.)

22 23 **G. Liberty Investigation of Appeal**

24
25 Liberty forwarded Plaintiff’s file, including the new documents submitted on
26 appeal, to two additional, independent physicians—Dr. Rajat Gupta, Board Certified in
27 Neurology, Pain Medicine, and Headache Medicine, and Dr. David Yuppa, Board
28 Certified in psychiatry and psychosomatic medicine. (AR 28–33, 47–52.)

1
2 On October 22, 2015, at Liberty’s request, Dr. Gupta conferred with DeLancey’s
3 treating neurologist, Dr. Pietzch, who stated that his neurological exams and MRI were
4 negative for stroke and that neuropsychological testing in January 2015 showed that he
5 had “average intelligence and generally intact cognitive functioning.” (AR 54.) Dr.
6 Pietzch repeated that she is of the opinion that DeLancey has “no significant
7 demonstrable deficits to either physical and/or cognitive functioning.” (*Id.*)
8

9 On October 28, 2015, Dr. Gupta reported that the record “supports the following
10 diagnoses: hypertension, hyperlipidemia, chronic small vessel ischemic disease, and
11 depression. A diagnosis of TIA is also suspected, but not confirmed The
12 preponderance of the evidence in the available medical record, spanning from the time of
13 hospital discharge on 9/04/14 to the present, supports that the claimant had an absence of
14 any significant residuals from the suspected TIA—in both physical capabilities as well as
15 cognitive and/or language functions. Therefore, there is no impairment supported for any
16 of the time periods in question.” (AR 51.) Dr. Gupta also disagreed with Dr. Chan’s
17 findings as follows:
18

19 The claimant’s PCP, Dr. Chan, has supported his patient’s
20 allegations of being impaired, but this support is based
21 primarily on the claimant’s self-reported symptoms. He does
22 not provide objective support for his opinions. In fact, the
23 overwhelming amount of objective evidence in the record
24 supports that there is no significant presence of neurocognitive
25 dysfunction. Dr. Chan’s latest progress notes on 7/29/15 and
26 8/26/15 actually seem to implicate psychiatric issues as the
27 major hurdle in his patient returning to work—such as his easy
28 frustration and angry outbursts.

Whether there is significant impairment from a psychiatric
perspective would be best determined by a reviewer within the
mental health specialty.

1 (AR 52.)
2

3 On November 16, 2015, Dr. Yuppa reported that “the medical evidence does not
4 support the claimant’s complaints of cognitive impairment. Neuropsychological testing
5 was generally within normal limits, and neither Dr. Chaffee nor Dr. Shah documented
6 any clinical evidence of the claimant’s reports of cognitive abnormalities.” (AR 33.) He
7 also stated the clinical evidence “does not corroborate the claimant’s reports of symptoms
8 or support the presence of an impairing degree of symptomatology.” (*Id.*)
9

10 **H. Additional Medical Records from New Doctors** 11

12 In late October 2015, DeLancey’s attorneys provided Liberty with additional
13 records. (AR 56, 59.) DeLancey’s attorney had prepared another form (nearly identical
14 to the one sent to Dr. Chan) and sent it to Dr. Phillip O’Carroll. Dr. O’Carroll saw
15 DeLancey on September 22, 2015. (AR 63.) Dr. O’Carroll checked the boxes on the
16 form indicating that DeLancey’s symptoms were neurological rather than psychological
17 and that he had a neurological disability. (AR 60–62.) On another form prepared by
18 DeLancey’s attorneys, Dr. O’Carroll indicated that DeLancey had suffered a TIA and
19 diagnosed him with “cognitive impairment.” (AR 63.) Dr. O’Carroll indicated that
20 DeLancey would have difficulty with low or moderate stress work because of “cognitive
21 impairment” due to “possible stroke/TIA.” (AR 64.) The report included no diagnostic
22 evidence or test results, nor did it indicate which, if any, medical records he relied on.
23

24 DeLancey’s attorneys also provided Liberty with a pre-prepared “Psychological
25 Opinion” form filled out by Dr. Joshua Matthews. Dr. Matthews checked boxes on the
26 form indicating that DeLancey can understand and carry out short instructions but that he
27 cannot maintain focus and concentration, sustain an ordinary routine, complete a normal
28 workday, deal with work stress, work independently, troubleshoot IT problems, or sit for

1 eight hours a day to do IT security reports. (AR 57.) He also checked boxes indicating
2 that with difficulty DeLancey could get along with coworkers, handle instructions and
3 respond appropriately to supervisors, and deal with stress of skilled work requiring
4 critical thinking and judgment. (*Id.*) Like Dr. O’Carroll’s form, this report included no
5 diagnostic evidence or test results, nor did it indicate which, if any, medical records he
6 relied on.

8 **I. Liberty Upholds Denial of Benefits**

9
10 On November 18, 2015, after conducting an independent review of the entire claim
11 file and rebuttal evidence, including the reports from Dr. O’Carroll and Dr. Matthews,
12 Heidi Jacques, an Appeal Review Consultant for Liberty, prepared and sent a letter
13 affirming the denial of benefits. (AR 21–26.) The letter included a summary of all new
14 rebuttal evidence as well as the independent reviews of Dr. Yuppa and Dr. Gupta. (*Id.*)
15 In the letter Liberty acknowledged that DeLancey “may experience some symptoms
16 associated with his condition.” (*Id.*) However, it concluded that “the available
17 information does not contain physical, neurologic, neuropsychologic or mental status
18 exam findings, diagnostic test results, or other forms of medical documentation that
19 reasonably correlate with Mr. DeLancey’s subjective complaints and to support that his
20 symptoms were of such severity that they resulted in restrictions or limitations rendering
21 him unable to perform the duties of his occupation throughout and beyond the Policy’s
22 elimination (waiting) period.” (AR 25.) Liberty maintained that DeLancey had not
23 adequately demonstrated disability. (*Id.*)

24
25 //

26 //

27 //

28 //

1 **III. DISCUSSION**

2
3 **A. Standard of Review**

4
5 The parties dispute the applicable standard of review. (*See* Dkt. 56 at 3; Dkt. 60 at
6 14.) Although de novo review is the default standard, where a plan confers
7 “discretionary authority as a matter of contractual agreement, then the standard of review
8 shifts to abuse of discretion.” *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 963
9 (9th Cir. 2006). To trigger the deferential standard, a plan must “unambiguously provide
10 discretion to the administrator” but no particular “magic words” are necessary. *Id.* Here,
11 the Plan states “Liberty shall possess the authority, in its sole discretion, to construe the
12 terms of this policy and to determine benefit eligibility hereunder. Liberty’s decisions
13 regarding construction of the terms of this policy and benefit eligibility shall be
14 conclusive and binding.” (Jacques Decl. Ex. A at 40.) This language unambiguously
15 provides discretion to the Plan Administrator, so Defendants correctly assert that the
16 abuse of discretion standard applies. *See Pannebecker v. Liberty Life Assur. Co. of*
17 *Boston*, 542 F.3d 1213, 1217 (9th Cir. 2008) (“The Plan here was a discretion-granting
18 one, as it stated that Liberty ‘shall possess the authority, in its sole discretion, to construe
19 the terms of this policy and to determine benefit eligibility thereunder.’”); *see also*
20 *Abatie*, 458 F.3d 963 (A plan stating that “[t]he *responsibility for full and final*
21 *determinations of eligibility for benefits; interpretation of terms; determinations of*
22 *claims; and appeals of claims denied in whole or in part under the HFLAC Group [Home*
23 *Life] policy rests exclusively with HFLAC” triggered the abuse of discretion standard.*
24 (emphasis in original)).

25
26 Under the deferential abuse of discretion standard, “a plan administrator’s decision
27 will not be disturbed if reasonable. This reasonableness standard requires deference to
28 the administrator’s benefits decision unless it is (1) illogical, (2) implausible, or (3)

1 without support in inferences that may be drawn from the facts in the record.” *Stephan v.*
2 *Unum Life Ins. Co. of Am.*, 697 F.3d 917, 929 (9th Cir. 2012) (internal quotation marks
3 and citations omitted). A district court may only review the administrative record when
4 considering whether a plan administrator abused its discretion. *Abatie*, 458 F.3d at 969–
5 70. However, evidence outside the administrative record that was before the Plan
6 Administrator can be considered to evaluate the effect of a conflict of interest on the
7 decision making process.⁷ *Id.*

8

9 **B. Conflict of Interest**

10

11 When an insurer acts as both the plan fiduciary and the funding source for benefits,
12 an inherent structural conflict of interest exists. *Abatie*, 458 F.3d at 965 (citing *Tremain*
13 *v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999)). The presence of a conflict of
14 interest merely contributes to the district court’s decision of “how much or how little to
15 credit the plan administrator’s reason for denying insurance coverage.” *Id.* at 968. If a
16 structural conflict is unaccompanied by evidence of “malice, of self-dealing, or of a
17 parsimonious claims-granting history,” its effect on the district court’s analysis may be
18 slight. *Id.* If, however, “the administrator provides inconsistent reasons for denial, fails
19 adequately to investigate a claim or ask the plaintiff for necessary evidence, fails to credit
20 a claimant’s reliable evidence, or has repeatedly denied benefits to deserving participants

21

22 ⁷ Defendants move to strike numerous portions of Plaintiff’s briefing on the grounds that it references
23 and relies on material outside the Administrative Record—namely, declarations of DeLancey, Dr. Chan,
24 and the briefs previously filed in this case. (Dkt. 64.) DeLancey objects on the grounds that such
25 evidence may be considered to determine the standard of review, (Dkt. 65 at 2–3), but the evidence in
26 question is irrelevant to the standard of review in this case, (*see infra*, n.8). DeLancey also argues that
27 he has good cause to introduce such evidence because he did not have a prior opportunity to respond to
28 the Liberty’s assessment of certain rebuttal evidence and “attacks” of his credibility. (*Id.* at 4–6.) This
is also unavailing, since Liberty afforded DeLancey numerous opportunities to submit rebuttal evidence,
of which he took advantage. Furthermore, much of the evidence that he wanted to “respond” to was
evidence that *he* submitted, such as reports from Dr. Chan. (*See id.*) That he did not like the way
Liberty characterized such evidence is not grounds to introduce evidence outside the Administrative
Record. Accordingly, the Court hereby GRANTS the motion to strike.

1 by interpreting plan terms incorrectly or by making decisions against the weight of
2 evidence in the record,” the district court may weigh the presence of a conflict more
3 heavily. *Id.* at 968–69 (internal citations omitted).

4
5 Even if the plan presents these more serious conflicts, the standard of review
6 remains abuse of discretion. *Id.* 968–69. “[T]he existence of a conflict [is] a factor to be
7 weighed, adjusting the weight given that factor based on the degree to which the conflict
8 appears improperly to have influenced a plan administrator’s decision.” *Montour v.*
9 *Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 631 (9th Cir. 2009). Additional factors to
10 be considered in determining whether a plan administrator or fiduciary abused its
11 discretion include “the quality and quantity of the medical evidence, whether the plan
12 administrator subjected the claimant to an in-person medical evaluation or relied instead
13 on a paper review of the claimant’s existing medical records, whether the administrator
14 provided its independent experts with all of the relevant evidence, and whether the
15 administrator considered a contrary SSA disability determination, if any.” *Id.* (internal
16 quotation marks omitted).

17
18 As Liberty concedes, it has a conflict because it both funds and decides LTD
19 benefit claims under the Plan. (Dkt. 60 at 14.) However, the effect of Liberty’s conflict
20 on the Court’s analysis is slight. *See Abatie*, 458 F.3d at 968. DeLancey has offered no
21 real evidence “of malice, of self-dealing, or of a parsimonious claims-granting history.”
22 *Id.* at 968.

23
24 DeLancey provides a laundry-list of criticisms in an attempt to show that the
25 conflict improperly impacted Liberty’s decision.⁸ DeLancey contends that Liberty
26

27 ⁸ At the hearing, DeLancey’s attorneys argued that many of his criticisms also support de novo review.
28 While the Court finds that none of DeLancey’s criticisms have merit, even if they did, the standard of
review would still be abuse of discretion. *Abatie*, 458 F.3d at 968–69.

1 looked for and manufactured reasons to deny his claim and ignored or “cherry picked”
2 critical evidence.⁹ (Dkt. 56 at 5–6, 13, 22; Dkt. 58 at 7–10, 13, 14, 16, 20.) To the
3 contrary, the record shows that Liberty *twice* conducted a thorough, independent, good-
4 faith review of DeLancey’s claim, which entailed an analysis of over 1,900 pages in
5 medical records. (AR 21–26, 784–87.) It requested peer reviews from four experienced,
6 Board Certified specialists in psychology, psychiatry, neurology, and internal medicine.
7 (AR 28–33, 47–52, 870–78, 863–64.) Each of these reviewing physicians conducted a
8 full review of the medical record and the neurologist consulted for the appeal, Dr. Gupta,
9 conferred with DeLancey’s treating neurologist, Dr. Pietzsch, prior to making his final
10 assessment. (AR 54.) Liberty also attempted to obtain Kaiser doctors’ review of such
11 reports and invited their criticisms, but Kaiser declined to do so as a matter of policy.
12 (AR 789, 823.) The Court finds no evidence that Liberty ever withheld information or
13 records from any of the reviewing physicians. Liberty even permitted DeLancey extra
14 time to produce medical records on multiple occasions after his appeal letter failed to
15 attach any evidence. (AR 56, 59, 84–673, 677, 724). DeLancey points out that Liberty
16 did not provide him with Dr. Gupta and Dr. Yuppa’s reports until after the final appeal
17 letter was issued. (Dkt. 56 at 8, Dkt. 58 at 11.) This is immaterial, however, since
18 DeLancey points to no authority requiring such disclosure *before* Liberty has finished
19 conducting its review.

20
21 DeLancey also notes that the doctors conducting the peer reviews did not
22 personally examine him. (Dkt. 56 at 7; Dkt. 58 at 9.) In this case, such in-person

23
24 ⁹ DeLancey often references two different standards of disability—whether a claimant is unable to
25 perform his “own occupation,” or whether he is unable to perform “any occupation.” (See Dkt. 56 at 6–
26 9, 21, 25; Dkt. 58 at 10, 12, 25.) He claims, without support, that Liberty disregarded evidence relating
27 to both standards. (See *id.*) In doing so, he misreads the definition of disability under the Plan. The
28 Plan provides that “Disability” or “Disabled” means “during the Elimination Period and the next 6
months of Disability the Covered Person is unable to perform all of the material and substantial duties of
his occupation on an Active Employment basis because of an Injury or Sickness.” (Jacques Decl. Ex. A
at 20 (emphasis added).) Only *after* receiving benefits for six months, which was not the case here, does
the Plan consider whether the claimant can perform any occupation. (See *id.*)

1 review was unnecessary. *Cf. Montour*, 588 F.3d at 634 (finding that the insurer’s failure
2 to conduct an in-person medical evaluation raised questions as to the reliability of the
3 insurer’s decision where it was not clear that the insurer presented the reviewing
4 physicians with all relevant evidence). Not only did the reviewing physicians have
5 DeLancey’s complete and voluminous medical records, which they referenced in great
6 detail in their own reports, but, as explained in greater detail below, they largely *agreed*
7 with the analysis of the treating physicians who actually undertook neurological exams,
8 CT scans, and MRIs of DeLancey. (*See* AR 28–33, 47–52, 863–64, 870–78, 901–07,
9 920, 1643–44.)

10
11 DeLancey claims that Liberty ignored evidence that Auto Club had approved his
12 short-term disability claim. (Dkt. 58 at 6, 9–10.) Such evidence, however, is irrelevant.
13 The Auto Club’s determination is not medical evidence—it is a separate and non-binding
14 conclusion reached by a different agency.

15
16 DeLancey contends that Liberty did not engage in the requisite “meaningful
17 dialogue” with him by failing to explain what additional information was required to
18 support his claim. (Dkt. 56 at 8; Dkt. 58 at 11.) DeLancey misunderstands this
19 requirement. The Ninth Circuit has held that “[i]f benefits are denied in whole or in part,
20 the reason for the denial must be stated in reasonably clear language, with specific
21 reference to the plan provisions that form the basis for the denial; if the plan
22 administrators believe that more information is needed to make a reasoned decision, they
23 must ask for it.” *Booton v. Lockheed Med. Ben. Plan*, 110 F.3d 1461, 1463 (9th Cir.
24 1997). Here, Liberty did not believe that more information was needed—it determined
25 that he was *not* disabled, so its explanation of the grounds for the denial and its invitation
26 to DeLancey to submit whatever records he thought would be helpful on appeal was
27 sufficient. (AR 786.)

1 DeLancey also argues that Liberty shifted its reasons to deny benefits and “tacked
2 on” new bases for the denial in its denial of the appeal, including that DeLancey did not
3 complete the Elimination Period. (Dkt. 56 at 14; Dkt. 58 at 14, 15.) This is false. In the
4 denial of his appeal, Liberty simply considered new evidence, much of which *DeLancey*
5 had provided, in reaching the *same* conclusion that he did not meet the Plan’s definition
6 of a disabled person. (AR 25 (“[T]he available information does not contain physical,
7 neurologic, neuropsychologic or mental status exam findings, diagnostic test results or
8 other forms of medical documentation that reasonably correlate with Mr. DeLancey’s
9 subjective complaints and to support that his symptoms were of such severity that they
10 resulted in restrictions or limitations rendering him unable to perform the duties of his
11 occupation throughout and beyond the Policy’s elimination (waiting) period. Having
12 carefully considered all of the information submitted in support of Mr. DeLancey’s claim,
13 our position remains that proof of his disability in accordance with the policy provisions
14 has not been provided.”); AR 786 (“Based on the medical documentation received in
15 relation to the requirements of your occupation, you do not meet the definition of
16 disability.”).)

17
18 DeLancey claims that Liberty unfairly demanded objective evidence for subjective
19 symptoms. (Dkt. 56 at 10; Dkt. 58 at 12.) This similarly mischaracterizes the record. As
20 laid out in further detail below, Liberty did not base its denial solely on the fact that most
21 of the evidence favorable to DeLancey was subjective self-reporting. Rather, it observed
22 that the majority of objective evidence *conflicted* with DeLancey’s claim of being
23 disabled.¹⁰

24
25
26
27
28 ¹⁰ For the same reason, DeLancey’s argument that Liberty ignored the “Non-Verifiable” Symptoms
clause in the Plan because it insisted on objective evidence and ignored self-reported symptoms is
unavailing. (Dkt. 56 at 9–10; Dkt. 58 at 12.)

1 DeLancey also argues that Liberty mischaracterized his job as sedentary while his
2 job also involved cognitive skills. (Dkt. 56 at 12; Dkt. 58 at 13.) A sedentary job and a
3 job involving cognitive skills are not mutually exclusive, so this characterization is not
4 incorrect. Here, Auto Club provided Liberty with a report describing DeLancey’s job as
5 “primarily an office job” that required him to sit at a desk and use a computer
6 approximately 98% of the time to protect Auto Club’s computer systems from intentional
7 or inadvertent access or destruction. (AR 1924–26.) In any event, this distinction is of
8 little consequence because Liberty’s denial relies primarily on evidence in the medical
9 record showing that DeLancey did not suffer from a degree of *cognitive* impairment that
10 would render him unable to perform at his job. Finally, DeLancey also argues that
11 Liberty mischaracterized his condition as psychological or psychiatric. (Dkt. 56 at 11;
12 Dkt. 58 at 13.) In actuality, as described further below, this characterization was made by
13 some of the treating *and* reviewing medical professionals. (AR 52, 1146, 1480, 1176,
14 1177.) And even if this description was incorrect, the record nevertheless supports
15 Liberty’s conclusion that DeLancey was not disabled, as outlined further below.

16
17 Simply put, there is no evidence that Liberty’s conflict of interest impacted its
18 decision, so the impact of the conflict on the Court’s analysis remains slight.

19 20 **C. Reasonableness of Liberty’s Denial**

21
22 Liberty’s decision denying DeLancey LTD benefits was sufficiently supported by
23 the substantial evidence before it. Liberty reasonably concluded that the extensive
24 medical records rule out a TIA or other neurological (or psychological) event that
25 rendered him “unable to perform *all* of the material and substantial duties of his
26 occupation on an Active Employment basis because of an Injury or Sickness,” as required
27 by the Plan. (Jacques Decl. Ex. A at 20 (emphasis added).)

1 The doctors who first evaluated DeLancey on the day of the suspected TIA decided
2 that he was not a “candidate” for medication used to treat a TIA or stroke. (AR 905.)
3 His CT angiogram, MRI, and echocardiogram from that day were also all negative for
4 stroke, (AR 901, 905), and his neurological exams similarly showed no abnormalities,
5 (AR 907). He was discharged from the hospital after the treating physician, Dr. Le,
6 affirmatively concluded that he had not had a stroke and did not give him any stroke
7 medication. (AR 904.) DeLancey’s sweeping assertion that all treating and examining
8 doctors diagnosed him with CVA/TIA is false. (*See* Dkt. 56 at 2.) That his doctors met
9 with him before and after the hospitalization because of suspected CVA/TIA or other
10 ischemic event does not mean that they went on to diagnose him with one—in fact, his
11 treating physicians ruled out such a diagnosis, and Dr. Gupta, a neurologist, concurred in
12 this assessment in his peer review. (AR 47–52.) Although DeLancey’s MRI did present
13 “[m]ild periventricular white matter disease,” (AR 920), this does not prove neurological
14 impairment. DeLancey’s earlier MRI from January 2014 also showed mild
15 periventricular white matter disease, (AR 871), but his self-reported symptoms did not
16 begin until the suspected TIA incident in September of that year. DeLancey’s own
17 treating neurologist, Dr. Pietzsch, reviewed the MRI results after his hospitalization and
18 confirmed that DeLancey had “no specific neurological condition to be diagnosed.” (AR
19 599, 1644.) And as Dr. Gupta explained, “even if a vascular etiology is presumed, there
20 is no indication that this led to any permanent infarction in the brain.” (AR 50.)

21
22 The record also supports Liberty’s finding that even after the suspected TIA,
23 DeLancey did not suffer cognitive impairment that would render him unable to perform
24 the functions of his job. The speech pathologist who saw him when he was initially
25 hospitalized found his speech, cognition, and behavior to be within normal limits. (AR
26 917.) DeLancey continued to report symptoms including trouble finding words,
27 dysarthria, and aphasia in his follow up appointments after he was discharged from the
28 hospital, but his neurological exams were consistently normal. (*See, e.g.*, AR 528, 997,

1 1520, 1644.) While Ms. Rooney’s observations during speech therapy could support
2 Plaintiff’s subjective reports of his symptoms, they are insufficient to counter the
3 extensive neurological evidence in the record and her own assessments that he was
4 generally functioning well compared to others his age—and in any event, her
5 observations do not support a finding of disability because she concluded that his
6 reported symptoms had *resolved* by December 2014. (AR 1437, 1567, 1601, 1602.) His
7 physical and occupational therapists similarly observed that he was generally functioning
8 well for his age group and eventually discharged him. (AR 1541–45, 1582, 1727, 1348–
9 51, 1617–21.) DeLancey points to the number of medical professionals who took note of
10 DeLancey’s subjective reports of his own symptoms, (*see* Dkt. 56 at 16–21), but, as the
11 record demonstrates, his reports conflicted with these same professionals’ *own*
12 assessments. (*See* AR 28–33, 47–52, 863–64, 870–78, 901–07, 920, 1643–44.) Nor did
13 Liberty ignore evidence of DeLancey’s own comments to his doctors and therapists in
14 reaching its decision. (*See* AR 25 (“[W]e do acknowledge that Mr. DeLancey may
15 experience some symptoms associated with his condition.”)).

16
17 Four separate doctors also conducted a peer review of DeLancey’s medical records
18 at Liberty’s request and confirmed that there was insufficient evidence to support a
19 finding that DeLancey suffered cognitive impairments that would render him unable to
20 perform his work duties.¹¹ (AR 28–33, 47–52, 870–78, 863–64.) Most significantly, Dr.
21 Gupta, the neurologist, conferred with DeLancey’s treating neurologist *and*
22 independently reviewed the medical record before coming to his own conclusion. (AR
23 51, 54.) These numerous assessments provide more than a reasonable basis for Liberty’s
24 determination.

25
26
27 ¹¹ DeLancey briefly questions whether Dr. Houghton and Dr. Belliveau had appropriate expertise and
28 training because Dr. Houghton practices internal medicine and pediatrics and Dr. Belliveau is a non-
physician. (Dkt. 58 at 10.) The Court has reviewed their credentials, (*see* Dkt. 60-4; Dkt. 60-5), and
finds them well qualified for the purposes of their assessments in this case.

1 DeLancey relies heavily on the opinion of Dr. Chan, (*see* Dkt. 56 at 16–17; Dkt. 58
2 at 16, 20), who believed that DeLancey could not perform his job duties, (AR 528, 593,
3 634). However, Dr. Chan’s reports are far less credible because he never based his
4 conclusions on conclusive testing or neurological evidence—he relied on the subjective
5 reports of DeLancey that actually conflict with the substantial weight of the medical
6 records and with most of the other doctors’ findings. As Dr. Gupta noted, “the
7 overwhelming amount of objective evidence in the record supports that there is no
8 significant presence of neurocognitive dysfunction. Dr. Chan’s latest progress notes on
9 7/29/15 and 8/26/15 actually seem to implicate psychiatric issues as the major hurdle in
10 his patient returning to work—such as his easy frustration and angry outbursts.” (AR
11 52.) Dr. Shah confirmed that DeLancey had depressive symptoms, (AR 1176, 1177), and
12 Dr. Chaffee also diagnosed him with depressive disorder, (AR 1480). Dr. Chan’s
13 conclusions are undermined by his own diagnosis that DeLancey had acute stress
14 disorder, (AR 1115), his observation that there was “possibly some psychiatric
15 component to [his symptoms],” (AR 1146), and the fact that he later abandoned his
16 diagnosis of “organic brain syndrome,” (AR 1793). Dr. Chan’s later assessments are
17 even less credible because he simply checked boxes on forms that DeLancey’s own
18 attorney had prepared and asked him to fill out. (AR 75–78.) Thus, it was reasonable for
19 Liberty to give more weight to the assessments of Dr. Pietzsch, Dr. Gupta, and Dr. Le,
20 and the evidence from speech therapy, occupational therapy, and physical therapy
21 showing that his symptoms had largely resolved and he was within functional limits for
22 his age.

23
24 DeLancey also places considerable weight on the “raw scores” Dr. Armstrong
25 observed. (Dkt. 56 at 13, 20; Dkt. 58 at 3, 11, 17, 18, 19.) However, only five of the
26 approximately twenty-four categories Dr. Armstrong tested revealed low scores, and she
27 noted that two of them were likely the result of his visual impairment, (AR 1768–69),
28 which is consistent with reports that DeLancey wears corrective lenses, (AR 871, 1023,

1 1031). Dr. Armstrong failed to acknowledge that DeLancey wears corrective lenses or a
2 hearing aid, which could have further impacted her results. (AR 871.) In any event, Dr.
3 Armstrong concluded that DeLancey’s “neuropsychological assessment revealed average
4 range intellectual functioning” and that he presented with a “generally intact
5 neurocognitive profile.” (AR 1769.) Dr. Houghton reviewed Dr. Armstrong’s
6 assessments and reported that “[e]ven with the assumption that the obtained exam results
7 are valid indices of the claimant’s neuropsychological status, the obtained test data
8 provide insufficient support for the presence of cognitive impairment due to a
9 neurological disorder. The test results show intact general intellectual functioning, high
10 average verbal and language-based reasoning abilities, average processing speed, average
11 visual-spatial and constructional abilities, average verbal memory, and average to high
12 average visual memory.” (AR 872.)

13
14 Finally, the reports from Dr. Phillip O’Carroll and Dr. Matthews are not
15 persuasive. Both doctors saw DeLancey for the *first* time over a year after the suspected
16 TIA incident and they were specifically retained by DeLancey’s attorney—they were not
17 DeLancey’s treating physicians. (AR 57, 60–64.) They only met with DeLancey once
18 and were asked to answer a specific set of pointed questions. (*See id.*) Unlike the four
19 peer reviewers Liberty consulted, it is also unclear whether Dr. O’Carroll or Dr.
20 Matthews had access to his full medical record and if so whether they reviewed the
21 record or simply relied on DeLancey’s attorneys’ medical summary.¹²

22
23 Considering all of this evidence together, the Court finds that Liberty did not abuse
24 its discretion in deciding to deny DeLancey LTD benefits. Liberty properly considered

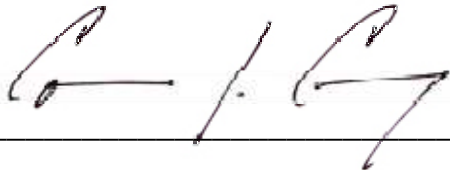
25
26 ¹² DeLancey’s meeting with the social worker demonstrated that he experienced the suspected TIA the
27 same day he was scheduled for a work performance evaluation. (AR 1052.) He had been previously
28 warned that the evaluation might not be positive, and if so, he could be fired. (*Id.*) This evidence does
not constitute an attack DeLancey’s character or credibility, (*see* Dkt. 58 at 22), but rather provides a
credible alternative explanation for DeLancey’s symptoms and is corroborated by the numerous reports
of work stress in the medical records. (*See, e.g.*, AR 1115, 1045, 1052, 1520.)

1 all the evidence before it, including DeLancey's subjective evidence. However, because
2 his subjective evidence conflicts with the majority of objective evidence of his medical
3 history and cognitive capabilities, the Court cannot say that Liberty's decision was
4 illogical, implausible, or unsupported by the nearly 2,000 page medical record.

5
6 **IV. CONCLUSION**

7
8 Liberty's decision to deny DeLancey long-term disability benefits was not an
9 abuse of discretion. Accordingly, the Court affirms Liberty's denial of benefits.

10
11
12 DATED: January 13, 2017

13 
14 _____
15 CORMAC J. CARNEY
16 UNITED STATES DISTRICT JUDGE
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