IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

Pamela Spina,	)	
	)	
Plaintiff,	)	Case No. 1:10-CV-243
	)	
vs.	)	
	)	
CVS Long Term Disability, et al.,	)	
	)	
	)	
Defendants.	)	

O R D E R

This matter is before the Court on cross-motions for judgment on the administrative record filed by Defendant Hartford Life & Accident Insurance Company (Doc. No. 12) and Plaintiff Pamela Spina (Doc. No. 13). Additionally, Plaintiff has filed a motion for oral arguments (Doc. No. 18). For the reasons that follow, Plaintiff's motion for judgment on the administrative record is well-taken and is **GRANTED**; Defendant's motion for judgment on the administrative record is not well-taken and is **DENIED.** Plaintiff's motion for oral argument is **MOOT.** This case is **REMANDED** to the plan administrator with instructions to reinstate Plaintiff's long-term disability benefits as of July 21, 2009.

I. Background

Plaintiff Pamela Spina presents a claim against Defendants CVS Longterm Disability Plan ("the Plan") and Hartford Life & Accident Insurance Company ("Hartford") pursuant to the

Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), to review the plan administrator's decision terminating her long-term disability benefits from the Plan. Plaintiff contends that the plan administrator's determination that she is not disabled under the "any occupation" provision of the Plan was arbitrary and capricious because it was not the product of a deliberate principled reasoning process and because it was not supported by substantial evidence.

The Plan is an "employee welfare benefit plan" within the meaning of ERISA, 29 U.S.C. § 1002(1). Plaintiff was a participant in the Plan through her employment with CVS Corporation, where she was a customer call center supervisor.

In December 2006, Plaintiff was diagnosed with stage III stomach cancer. In January 2007, Plaintiff underwent a subtotal gastrectomy which involved removal of 75% of her stomach. AR764. This surgery included a Roux-en-Y gastrojejunostomy, which involves attaching the remainder of the stomach directly to the small intestine. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, at 76 (31st ed. 2007). Plaintiff developed significant post-operative complications - including an abscess and sepsis - which resulted in two additional surgeries and hospital stays. For some of this period, Plaintiff was in an induced coma and required the assistance of a ventilator. Once these complications were resolved, Plaintiff underwent a course

of chemotherapy and radiation treatments which was completed in the fall of 2007.

Plaintiff initially applied for and received short-term disability benefits. Hartford approved Plaintiff's claim for long-term disability benefits in June 2007 pursuant to the Plan's "own occupation" clause. AR 420-21. Under this provision, a plan participant is eligible for benefits if she is unable to perform the material duties of her regular occupation and is otherwise not gainfully employed. AR 421. After 24 months of payments under the "own occupation" clause, the terms of the "any occupation" clause come into effect. Under this provision, a plan participant is eligible for long-term disability benefits if she is unable to perform any occupation for which she is or may become qualified by education, training, or experience and is otherwise not gainfully employed. Id. In December 2008, Hartford sent Plaintiff a letter notifying her that it was commencing an investigation into whether she would be eligible to receive benefits under the "any occupation" clause after the expiration of her eligibility for benefits under the "own occupation" clause in June 2009. AR 355-56.

Although she was now cancer-free, from about December 2008 through about May 2009, Plaintiff's primary complaint post-surgery appeared to be chronic fatigue, which she thought might be a result of her radiation treatments. Plaintiff's treating

oncologist, Dr. Albers, documented these complaints in office notes from January and May of 2009. AR 640, 642. In January 2009, Dr. Albers completed and returned to Hartford a form indicating that Plaintiff had a fair prognosis for return to work due to chronic fatigue and abdominal pain. AR 348. In May 2009, Dr. Albers completed a second form for Hartford indicating that due to chronic fatigue, Plaintiff would not be able to work even in a sedentary position. AR 298. In June 2009, Hartford's claims examiner discussed Plaintiff's condition with Dr. Albers's nurse, who informed Hartford that Dr. Albers's office notes did not reflect the full extent of Plaintiff's impairment. The nurse advised Hartford that due to Plaintiff's stomach surgery, she was experiencing severe cramping and diarrhea immediately after eating. AR87. She also advised Hartford that due to her surgery, Plaintiff has malabsorption, meaning that she does not absorb the nutrients in the food she eats, and consequently experiences fatigue, Vitamin B12 deficiency, and iron loss. Id. The nurse also advised Hartford that in Dr. Albers's opinion, Plaintiff could not maintain a regular job. Id.

In July 2009, Hartford submitted Plaintiff's medical records to Dr. Nelson Chao, a physician board certified in internal medicine and oncology, for a review. In his report, Dr. Chao agreed with Plaintiff that her chemoradiation treatments could result in significant fatigue but then stated that "there

is no clinical finding that defines fatigue." AR 278. Dr. Chao concluded that since Plaintiff was disease free at the time, "there are no clinical findings at this time precluding the claimant from working in a sedentary capacity." Id.

Hartford also obtained an employability analysis report from an internal vocational expert in July 2009. AR 259-260. Based on Dr. Chao's opinion that Plaintiff can perform sedentary work, the vocational expert concluded that because of her education, training and experience, she is able to perform the jobs of customer complaint service supervisor, skip tracer, claims clerk, and routing clerk and that these jobs exist in this region in reasonable numbers. Id. at 260.

Thus, based on the review of the medical evidence submitted, but principally it appears on the opinions of Dr. Chao and the vocational expert, Hartford terminated Plaintiff's long-term disability benefits effective July 21, 2009. AR 133-134.

Plaintiff filed a timely administrative appeal from the termination of her benefits. In contrast to chronic fatigue, Plaintiff's appeal focused on "dumping syndrome" and she submitted additional medical evidence in support of that theory of disability. According to the Mayo Clinic's website, the pertinent portions of which are including in the administrative record, "dumping syndrome":

> is a group of symptoms most likely to develop most if you've had surgery to remove all or part of your

> stomach, or if your stomach has been surgically bypassed to help lose weight. Also called rapid gastric emptying, dumping syndrome occurs when the undigested contents of your stomach are transported or "dumped" into your small intestine too rapidly. Common symptoms include abdominal cramps and nausea.

AR 797. The Mayo Clinic went on to explain that when symptoms of dumping syndrome occur within 15 to 30 minutes after a meal, the symptoms may include nausea, vomiting, abdominal pain or cramps, diarrhea, dizziness or lightheadedness, bloating or belching, fatigue, and heart palpitations. AR 797-98. The additional information submitted by Plaintiff in her appeal also included a report and opinion from her gastroenterologist, Dr. Peck, medical records from Dr. Peck, additional medical records from Dr. Albers, medical records related to her surgeries and chemoradiation treatment, medical records from her family physician, Dr. Pastor, a video statement of Plaintiff and her husband, a report from her own vocational expert, Mark Pinti, and two articles on dumping syndrome, which included the Mayo Clinic report just cited. AR 527-535.

In his report, dated January 5, 2010, Dr. Peck recounted his course of treating Plaintiff for various gastric issues through the discovery of and her treatment for stomach cancer. Dr. Peck also stated that in the course of treating Plaintiff after her surgery, he received office notes from Dr. Albers from May 2009 indicating that Plaintiff was experiencing rapid transit with abdominal cramping. He also noted that in

September 2009, Dr. Albers documented that Plaintiff was reporting symptoms consistent with dumping syndrome. AR 536-538.

Dr. Peck also examined Plaintiff in September 2009 and concluded that Plaintiff was exhibiting symptoms of "early dumping syndrome," which means that the symptoms occur shortly after she eats. AR 538; AR 803. Dr. Peck recommended that Plaintiff follow up with a dietician to help manage her symptoms. AR 538.

Dr. Peck then provided his opinion on the effects of dumping syndrome on Plaintiff and her prospects for returning to work:

> Dumping syndrome is a group of symptoms that usually develops after surgery to remove all or part of the stomach. This condition is also known as "rapid gastric emptying." The most common symptoms include abdominal cramps and nausea. Other symptoms can include diarrhea, bloating, and fatigue. Additionally, in severe cases, weakness, dizziness, and lightheadedness or "flushing" can be present. Many times these patients experience anxiety and nervousness as well as heart palpitations and confusion.
>
> The mechanism involved in dumping syndrome involves the movement of ingested food into the small intestine more quickly than normal. The acceleration is most often associated with surgery. There is a correlation between the more stomach removed or bypassed and the severity of the syndrome. Unfortunately, <u>with Mrs. Spina having lost three quarters of her stomach, the syndrome is "severe" in her case and is likely to be a chronic disorder.</u>
>
> She was referred to a dietician for help in managing her symptoms by changing her eating habits. Frequently, these patients are advised not to drink with the ingestion of food and to be mindful of the

> ingestion of juices or foods that have high sugar contents or food items that contain fructose.
>
> Presently, I believe the pain and discomfort associated with this condition can be described as moderate. That is to say that the pain can be tolerated but would cause an impediment in the performance of normal activities. In addition, in my clinical experience, I would say that Mrs. Spina's attention and concentration are frequently effected [sic] by the symptoms and side effects of dumping syndrome.
>
> Presently, I would indicate that Mrs. Spina's prognosis is guarded. As we move forward from this point, we must be very concerned about Mrs. Spina's weight loss and her ability to comfortably take nutrition. Because the "dumping syndrome" is chronic, it is unlikely that she will recover from it.
>
> Although this syndrome has no specific limitations on sitting, standing and walking, it should be noted that the process involves a variety of symptoms which would remove Mrs. Spina from a vocational setting anywhere between thirty-five to forty-five minutes for unscheduled diarrhea/bathroom events. In fact, some of the diarrhea type events can become so unpredictable that it may not be realistic that Mrs. Spina would be able to return to a work environment after concluding such an event.
>
> Because of the side effects of dizziness, lightheadedness, and fatigue, I believe that Mrs. Spina would not posses a minimum level of attention and concentration that would allow her to participate in a daily work environment.
>
> Mrs. Spina is a very good candidate for disability. I am presently unaware of any work environment that she would be able to participate in a sustained manner.

AR 538-539 (emphasis added).

The additional office notes from Dr. Albers reflect that Plaintiff's first complaints about dumping syndrome symptoms

occurred in May 2009, as Dr. Peck's summary indicated. AR 612.

In September 2009, Dr. Albers recorded that:

> She also has difficulty with symptoms that are consistent with dumping. She has early transit of undigested food and then has to spend the next 30 minutes in the bathroom after taking a few bites. This seems to all settle down and she can eventually get enough intake in. She will take an Imodium only if going out and avoid eating [sic]. She has not taken any scheduled anti-diarrheals or bowel antimotility agents.

AR 614.

Plaintiff also had an office visit with Dr. Peck in September 2009. Dr. Peck's notes report that:

> Her biggest problem is what appears to be early dumping syndrome. About 15 minutes after eating she will have abdominal cramping and then multiple episodes of diarrhea. She will have flushing. She will have some dizziness. She will not feel like she has to lie down. She is trying to eat small meals everyday [sic]. She is watching her simple sugars. She is not drinking with solid meals. She says it does not bother her too much when she is at home but it makes quite an impedance when she goes out to dinner.

AR 616. Dr. Peck's assessment and plan was as follows:

> Abdominal cramping and diarrhea. The symptoms are suggestive of early dumping syndrome. <u>What we will do is have her see a dietician again to go over the things she can do from a dietary standpoint to improve things. If not we will try some octreotide 50 mcg b.i.d subcu 30 minutes before meals to see if that improves her symptoms.</u>

<u>Id.</u> (emphasis added).

Plaintiff's video statement is about 20 minutes in length and in it she explains among other things how dumping syndrome affects her daily activities. In brief, Plaintiff

explains that she has to eat five or six small meals a day of a quarter cup or less of food. Immediately after eating, she must lie down for approximately 30 minutes. After lying down, Plaintiff's abdominal and diarrheal symptoms commence and she will be in the bathroom anywhere from 30 minutes to two hours. Plaintiff's husband also provided a brief statement, but the upshot of both of their statements is that dumping syndrome essentially renders Plaintiff homebound.

Finally, Plaintiff's vocational expert, Mark Pinti, provided to Hartford an opinion which states that "Mrs. Spina's graphic depiction of her struggles with 'dumping syndrome' and its attendant effects, as well as Dr. Peck's explanation of the cause and effects of 'dumping syndrome' or ARDS, paint a picture of an individual who spends most of her day in pain, discomfort and taking frequent, unscheduled bathroom breaks followed by the need for extended periods of rest. There is no way an individual with those constraints could perform any work at any level of exertion." AR 795.

In February 2010, Hartford submitted Plaintiff's records, including the new evidence she produced in her appeal, to Dr. Vinayek, a board certified internist with a subspeciality in gastroenterology, and Dr. Marciniak, an internist with a subspeciality in oncology, for a file review and opinion. AR 173-180. Dr. Vinayek and Dr. Marciniak work for the same peer

review company. Both of their reports were provided in March 2010.

Dr. Vinayek stated that he spoke with Dr. Peck, who recounted Plaintiff's gastric surgery and post-operative complications, and her symptoms of dumping syndrome. Dr. Vinayek wrote that "[d]ue to all of these symptoms, Dr. Peck is not sure if the claimant would be able to work in any capacity in a meaningful way." AR 173. Dr. Vinayek reported that he spoke with Dr. Marciniak, who stated that from an oncology perspective, Plaintiff should be able to work in a sedentary capacity since she is cancer-free. Id. Dr. Vinayek summarized Plaintiff's video statement and her other medical records. AR 173-174. Dr. Vinayek concluded his report by providing his opinion as to Plaintiff's capacity to return to work:

> Based on all of the medical records reviewed and my discussion with Dr. Peck as well as MES reviewer Dr. Marciniak, it is my opinion that the claimant is capable of functioning full time in a sedentary to light physical demand level as of 7/21/09.
>
> The claimant has dumping syndrome which can be managed with small meals and antidiarrheal and antispasmodics. Even though she complains of frequent bouts of diarrhea, there is no clinical evidence in the medical records to support the severity of the complaint. The claimant has not required hospitalization for dehydration, electrolyte imbalance, etc. in 2009, and she has not been on any pain medications for abdominal pain. Though it is noted that she has a poor nutritional status, there is no documentation in the medical records to support this. There is no mention that has [sic] lost weight as a result of poor oral intake or persistent diarrhea.

> Despite the above, the claimant does have classic symptoms of dumping syndrome with abdominal pain, diarrhea, flushing and dizziness and tachycardia which her Gastroenterologist has observed. He has recommended dietary recommendations, small meals, antispasmodics and antidiarrheals, which are controlling her symptoms of diarrhea and abdominal pain, but not the dizziness, flushing and palpitations. The claimant also has surgical scars from three previous surgeries which would prevent her from lifting heavy objects. However, she is able to lift/carry 20 pounds occasionally and ten pounds frequently. She is able to sit without restrictions and can stand/walk up to 6 hours in an 8 hour day.

AR 175.

Dr. Marciniak, as already indicated, stated that Plaintiff did not have any impediments to returning to work from an oncology standpoint. He also agreed with the diagnosis of dumping syndrome but did not find that it prevents Plaintiff from returning to work:

> The claimant was complaining of symptoms of dumping syndrome and fatigue. I spoke with Dr. Albers, the claimant's oncologist. She confirmed that the claimant has no evidence of recurrent disease. Dr. Albers stated that she has not been primarily responsible for evaluating and treating the symptoms of the claimant's dumping syndrome, and deferred this to the claimant's gastroenterologist. Dr. Albers stated that she did not become aware of the severity of the claimant's problems with dumping syndrome until the issue of continued long-term disability came up.
>
> The claimant's complaints related to dumping syndrome are subjective. She has not recently demonstrated any weight loss. Her weight on 10/09/08 when evaluated by Dr. Albers was 143, when evaluated by Dr. Albers on 5/19/09 was 142, and when evaluated by Dr. Allan Peck on 9/21/09 she again weighed 143. There is no evidence for malnutrition. Her BMI is 25.7, which is borderline overweight. She was evaluated by Dr. Peck on 9/21/09, he described the dumping syndrome as "early," and

> wrote, "She says it does not bother her too much when she is at home . . ." This contrasts significantly with the comments made by the claimant in her videotaped statement.
>
> The dumping syndrome is a complication of the claimant's surgery, and the evaluation of the degree of limitation imposed by the dumping syndrome has been assessed separately by the MES gastroenterology reviewer.

AR 180.

Earlier in his report, Dr. Marciniak summarized his conversation with Dr. Vinayek about Plaintiff's case:

> Dr. Vinayek discussed that the complaints of dumping syndrome were subjective; there were no objective findings of weight loss or malnutrition documented. This can be observed in severe cases of dumping syndrome. Dr. Vinayek relayed that he had spoken with the claimant's gastroenterologist, <u>who did not recall if the claimant had failed any pharmacologic interventions for dumping syndrome</u>. Dr. Vinayek related that the dumping syndrome also was only a subjective complaint of the claimant, <u>in the opinion of the treating gastroenterologist</u>.
>
> We discussed how the dumping syndrome would impair the claimant's ability to work. We agreed that the claimant would be able to perform full-time light work, <u>as long as she was provided ready access to toilet facilities as needed.</u>

AR 176-77 (emphasis added).

On March 22, 2010, Hartford issued a decision upholding the termination of Plaintiff's long-term disability benefits. AR 122-126. In reaching this conclusion, Hartford's claims administrator rejected Dr. Peck's opinion and relied principally on the reports of Dr. Vinayek and Dr. Marciniak stating that

Plaintiff's symptoms of dumping syndrome would not preclude her from working:

> Dr. Peck was not sure of Ms. Spina's ability to work, Dr. Albers was not aware of the dumping syndrome until letter [sic] were requested in support of Long Term Disability were received, all three reviewing physicians, Dr. Choa [sic], Dr. Vinayek, and Dr. Marciniak are of the opinion that Ms. Spina is capable of performing at minimum sedentary work activity and which sedentary jobs were identified previously by the Rehabilitation Case Manager.
>
> Further, Ms. Spina has self reported complaints of dumping syndrome however has not presented with any weight loss, dehydration, electrolyte imbalance and/or malnutrition which demonstrates the severity of her complaints are not supported by clinical evidence. The weight of the evidence does not support functional restrictions/limitations that would preclude Ms. Spina from work activity. Therefore, there will be no further benefits payable.

AR 126 (emphasis added).

Following the denial of her appeal, Plaintiff filed a timely complaint for review of the plan administrator's decision pursuant to 29 U.S.C. § 1132(a)(1)(B). The parties have filed cross-motions for judgment on the administrative record which are now ready for disposition. Additionally, Plaintiff filed a motion to present oral argument on the issues before the Court.

II. Standard of Review

Plaintiff filed suit pursuant to ERISA, 29 U.S.C. § 1132(a)(1)(B), to review the plan administrator's decision denying her claim for long-term disability benefits. The parties agree that the plan document gives the plan administrator

complete discretion to make determinations concerning eligibility for plan benefits. Doc. No. 12, at 2; Doc. No. 13, at 17-18. Accordingly, the arbitrary and capricious standard of review applies to this Court's review of the plan administrator's decision denying Plaintiff's claim. Yeager v. Reliance Std. Life Ins. Co., 88 F.3d 376, 380 (6th Cir. 1996).

The Sixth Circuit has described at length the parameters of the arbitrary and capricious standard of review:

> This standard is the least demanding form of judicial review of administrative action. When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary and capricious. Consequently, a decision will be upheld if it is the result of a deliberate principled reasoning process, and if it is supported by substantial evidence. The ultimate issue in an ERISA denial of benefits case is not whether discrete acts by the plan administrator are arbitrary and capricious but whether its ultimate decision denying benefits was arbitrary and capricious.
>
> While the arbitrary and capricious standard is deferential, it is not, however, without some teeth. Merely because our review must be deferential does not mean our review must also be inconsequential. While a benefits plan may vest discretion in the plan administrator, the federal courts do not sit in review of the administrator's decisions only for the purpose of rubber stamping those decisions. The obligation under ERISA to review the administrative record in order to determine whether the plan administrator acted arbitrarily and capriciously inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues.
>
> We have recognized that a conflict of interest exists when the insurer both decides whether the employee is eligible for benefits and pays those benefits. In this case, because defendant maintains such a dual role, the potential for self-interested decision-making is

> evident. However, this conflict of interest does not displace the arbitrary and capricious standard of review; rather, it is a factor that we consider when determining whether the administrator's decision to deny benefits was arbitrary and capricious. The reviewing court looks to see if there is evidence that the conflict in any way influenced the plan administrator's decision.
>
> Finally, absent a procedural challenge to the plan administrator's decision, this Court's review is limited to the administrative record of the benefit determination.

Evans v. UnumProvident Corp., 434 F.3d 866, 875 (6th Cir. 2006) (internal citations, quotation marks, and brackets omitted).

III. Analysis

Because the focus of Plaintiff's disability claim shifted from chronic fatigue during the initial review to dumping syndrome during the appeal, the Court's review of the plan administrator's decision will focus on the final decision upholding the termination of her benefits. As stated, in upholding the decision to terminate Plaintiff's disability benefits, the plan administrator relied heavily on the opinions of Dr. Vinayek and Dr. Marciniak. Although the arbitrary and capricious standard is highly deferential, the Court is persuaded on review that the reports of Dr. Vinayek and Dr. Marciniak, as well as the opinion of the plan administrator, contain significant misstatements, misinterpretations, and omissions of the relevant medical evidence such that the plan administrator's

decision cannot be considered the product of a deliberate principled reasoning process.

The Court initially notes that Dr. Peck, Dr. Vinayek, and Dr. Marciniak all agree that Plaintiff suffers from symptoms consistent with dumping syndrome. They simply disagree about the limitations this syndrome imposes on Plaintiff's ability to resume working. In turn, this assessment turns in large part on Plaintiff's credibility, but not entirely so.

First, in rejecting Plaintiff's claims concerning the severity of the diarrhea she experiences, Dr. Vinayek stated that her claims were not supported by objective medical evidence. Specifically, Dr. Vinayek concluded that Plaintiff's dumping syndrome was not severe because she had not been hospitalized for dehydration or electrolyte imbalance due to diarrhea. AR 175. The Court is unsure from Dr. Vinayek's report why Plaintiff's diarrhea has to reach the point where she is hospitalized before it can be considered "severe" but in concluding that the severity of this symptom is not supported by objective clinical evidence, Dr. Vinayek overlooked or ignored what seems to be the most important objective evidence supporting her claim - Plaintiff had 75% of her stomach removed during surgery. Nowhere in his report does Dr. Vinayek address this fact nor does he address Dr. Peck's opinion that Plaintiff's dumping syndrome is severe because she had a significant portion of her stomach removed. AR 539; see,

e.g., Calvert v. Firstar Fin., Inc., 409 F.3d 286, 297 (6th Cir. 2005) (holding that plan administrator's reliance on reviewing physician's opinion to terminate benefits was arbitrary and capricious where reviewing physician "never address[ed] head-on and seemed to ignore" the contrary opinions of treating physicians).

Second, in a related error, Dr. Vinayek commented that Dr. Peck recommended dietary modifications, small meals, and antispasmodics and antidiarrheal agents "which are controlling" Plaintiff's abdominal pains and diarrhea symptoms. AR 175 (emphasis added). This, however, is a flat misstatement of the medical records. While Dr. Peck did recommend these modifications, there are no notations or statements by Dr. Peck in the records that these measures have been successful and in fact "are controlling" Plaintiff's symptoms. Dr. Vinayek certainly cites none in his report. In fact, the only medical evidence on this topic is Dr. Peck's office note from September 2009 in which he refers Plaintiff to a dietician "to go over things she can do from a dietary standpoint to improve things." AR727. Further according to the note, if dietary changes were unsuccessful, then Dr. Peck would prescribe an antidiarrheal agent (octreotide). AR 727. In other words, Dr. Peck's office notes indicate a plan to treat Plaintiff's symptoms, but do not

indicate that the plan was successful, as Dr. Vinayek's report incorrectly states.

Octreotide is indicated to suppress severe diarrhea and flushing associated with carcinoid tumors and profuse watery diarrhea associated with peptide tumors. PHYSICIANS' DESK REFERENCE, at 2304-05 (58th ed. 2004). Carcinoid tumors occur in the gastrointestinal tract, including the stomach. STEDMAN'S MEDICAL DICTIONARY, at 1653 (25th ed. 1990). Dr. Peck's prescriptive choice for addressing Plaintiff's symptoms indicates a severe a case of dumping syndrome. Dr. Vinayek, however, ignored or overlooked that Dr. Peck's intended course of treatment indicated a severe case of dumping syndrome. Compare with White v. Sun Life Assur. Co. of Canada, 488 F.3d 240, 255-56 (4th Cir. 2007) (plan administrator's decision denying benefits was arbitrary and capricious because it ignored treating physicians' decisions that treatment with painkillers was necessary to ease claimant's pain and because plan administrator did not refer Court to any treating physician who stated that the pain medication was unnecessary or that the pain itself was imagined).

Additionally, even if Dr. Peck's records indicated that the dietary modifications and antidiarrheal agents were controlling Plaintiff's dumping syndrome, Dr. Vinayek explicitly recognized that these measures were not controlling her dizziness, flushing, and palpitations. AR 175. Dr. Vinayek

failed, however, to consider and address whether these other symptoms would impair Plaintiff's ability to work. Moreover, Dr. Vinayek again ignored or overlooked Dr. Peck's opinion that the dizziness, lightheadedness, and fatigue would impair Plaintiff's attention and concentration to the point of precluding work. AR 539.

Dr. Marciniak's report contains equally troubling misstatements, misinterpretations, inconsistencies, and omissions.

First, Dr. Marciniak states that Dr. Vinayek informed him that Dr. Peck could not recall if Plaintiff had failed any pharmacological interventions for dumping syndrome. AR 176-77. Dr. Vinayek's summary of his conversation with Dr. Peck, however, does not include any reference to a discussion of the success or failure of any pharmacological interventions. As just discussed, Dr. Peck expressed a plan to start treatment with octreotide if dietary modifications were unsuccessful but there is no indication that they were even implemented, much less successful. Moreover, Dr. Peck's disability opinion letter post-dates the plan to treat Plaintiff with octreotide, which should have been an indication that such measures had not in fact been successful. Finally, one of the medical articles Plaintiff provided to Hartford states that the "long-term efficacy of octreotide is much less favorable." AR 807. In other words, even short-term

success treating Plaintiff's symptoms with octreotide may not translate into a pharmacological intervention which would permit her to return to work. Neither Dr. Vinayek nor Dr. Marciniak commented on this shortcoming of octreotide.

Dr. Marciniak reported that Dr. Vinayek told him that Plaintiff's dumping syndrome "was only a subjective complaint in the opinion of the treating gastroenterologist." AR 177. The comment that Dr. Peck stated to Dr. Vinayek that Plaintiff's claim of dumping syndrome was "only a subjective complaint" is troubling. Again, Dr. Vinayek's summary of his conversation does not mention that Dr. Peck made this statement. More importantly, Dr. Vinayek's report that Dr. Peck stated that dumping syndrome was "only a subjective complaint" suggests that Dr. Peck found Plaintiff to be a less than credible patient when his disability opinion clearly indicates the opposite. Dr. Vinayek thus gave Dr. Marciniak a false impression of the treating physician's assessment of Plaintiff's credibility, which could only have made it easier for Dr. Marciniak to conclude that Plaintiff is not disabled from dumping syndrome.

Dr. Marciniak stated that he and Dr. Vinayek agreed that Plaintiff can perform full-time light work so long as she has ready access to toilet facilities if needed. AR 177. As indicated by Dr. Peck, however, dumping syndrome requires Plaintiff to experience extended "diarrhea/bathroom events," and

there is no indication in the record that there are any jobs that Plaintiff can perform that provide such toilet access. AR 262-274 (descriptions of jobs Plaintiff can perform according to Hartford's vocational expert).

Dr. Marciniak also discounted Plaintiff's credibility because her video testimony conflicted with her statement to Dr. Peck that dumping syndrome does not bother her too much at home. AR 180. Dr. Marciniak's observation misses the point, however. The issue is how dumping syndrome affects Plaintiff's ability to work, not how it affects her at home. Plaintiff's ability to function with dumping syndrome adequately at home is not inconsistent with an inability to work because of dumping syndrome. As stated earlier, in the video, Plaintiff and her husband both stated that she has essentially been rendered homebound by dumping syndrome. In fact, in the same office note cited by Dr. Marciniak, Dr. Peck stated that Plaintiff told him that dumping syndrome "makes quite an impedance when she goes out to dinner." AR 727. Additionally, Dr. Albers also informed Hartford that her notes do not reflect the seriousness of Plaintiff's impairment and that she is "pretty much housebound." AR 87.

In a related vein, in arguing that Plaintiff is not disabled from working due to dumping syndrome, Hartford relies on a questionnaire she completed in which she indicated she can

perform the activity of “voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.” Doc. No. 12, at 8; AR 340. Plaintiff has never claimed, as far as the Court can tell, that she is disabled because she cannot control her bowel movements or that she cannot maintain personal hygiene due to dumping syndrome. The problem with dumping syndrome is severalfold, but with respect to toileting, the primary issue is the frequency and duration of her bathroom events, not her inability to control those functions. Therefore, Plaintiff’s response to this question does not undermine her disability claim.

The Court recognizes that both Dr. Vinayek and Dr. Marciniak observed that Plaintiff has not lost any weight, which would be an indication of a severe case of dumping syndrome even according to the literature supplied to Hartford by Plaintiff. AR 805. As already stated, however, neither of these doctors addressed the one significant finding that supports a conclusion that Plaintiff’s dumping syndrome is severe - the loss of 75% of her stomach, nor did they address the other symptoms of dumping syndrome that Dr. Peck indicated impair her ability to work. Therefore, their reliance on the absence of weight loss to discount the severity of Plaintiff’s dumping syndrome was unreasonable. Consequently, the plan administrator’s reliance on the reports of Dr. Vinayek and Dr. Marciniak to terminate

Plaintiff's disability benefits was arbitrary and capricious. See Kalish v. Liberty Mut./Liberty Life Assur. Co. of Boston, 419 F.3d 501, 510-11 (6th Cir. 2005) (plan administrator's decision denying plaintiff's claim for disability benefits was arbitrary and capricious where it relied on flawed and inadequate report of independent file reviewer); see also Bennett v. Kemper Nat. Serv., Inc., 514 F.3d 547, 556 (6th Cir. 2008) ("We are also troubled by Broadspire's reliance on file reviews that imply that Bennett is not credible, when in fact, no one who actually examined Bennett reached that conclusion.").

Because of the plan administrator's heavy reliance on the reports of Drs. Vinayek and Marciniak, the flaws in those documents naturally carried over into the written decision. For instance, the plan administrator stated that Plaintiff's complaints of severe dumping syndrome are not supported by objective clinical evidence, such as weight loss and electrolyte imbalance, but ignored the most critical objective fact - the loss of most of Plaintiff's stomach - and failed to note Dr. Peck's opinion that this would produce a severe case of dumping syndrome. Similarly, the plan administrator did not address Dr. Peck's opinion that Plaintiff's attention and concentration would be impaired by dumping syndrome.

The plan administrator also appears to have made important credibility judgments about Plaintiff without obtaining

an independent physical examination. In her decision, the plan administrator stated that, according to Dr. Vinayek's report, Dr. Albers stated that she was not aware that Plaintiff's dumping syndrome became an issue until she received requests for letters to support this claim. AR 126. The plan administrator's specific mention of this comment by Dr. Albers seems, in the Court's opinion, to be a finding or suggestion that Dr. Albers believed that the severity of Plaintiff's dumping syndrome is overstated, and that, therefore, she is malingering, or at least less than credible, by claiming disability based on dumping syndrome. In reaching this apparent conclusion, however, the plan administrator did not refer to or address Dr. Albers's earlier statements that Plaintiff's condition is worse than reflected in her office notes. Nor did the plan administrator refer to or address Dr. Albers's office note of September 9, 2009 in which she stated that "[Plaintiff's] quality of life seems very much impacted by her bowel syndrome and fatigue." AR 638. Thus, the record reflects that Dr. Albers found Plaintiff's complaints to be credible and that the plan administrator relied on a single comment by Dr. Albers, perhaps taken out of context, to make an adverse determination about Plaintiff's credibility. This was arbitrary and capricious. See Helfman v. GE Group Life Assur. Co., 573 F.3d 383, 395-96 (6th Cir. 2009)("[W]here an administrator exercises its discretion to conduct a file review,

credibility determinations made without the benefit of a physical examination support a conclusion that the decision was arbitrary.").

Finally, the plan administrator's decision takes out of context or misinterprets a statement made by Dr. Peck in denying Plaintiff's claim. The plan administrator wrote that "Dr. Peck was unsure of Plaintiff's ability to work[.]" AR 126. The plan administrator apparently cited this comment as an indication that Dr. Peck was equivocal about her capacity to work and, thus, that her treating physician did not support her claim. This, however, is the full statement reported by Dr. Vinayek in his summary of his conversation with Dr. Peck: "Due to all of these symptoms [of dumping syndrome], Dr. Peck is not sure if the claimant would be able to work in any capacity in a meaningful way." AR 173. Although Dr. Peck supposedly stated that he was "unsure" if Plaintiff could return to work, clearly what he was conveying to Dr. Vinayek was that in his opinion it was improbable that Plaintiff would ever be able to work again. This is the only reasonable interpretation of this comment, particularly in light of the fact that just six weeks before his conversation, Dr. Peck issued a written opinion stating that Plaintiff is disabled by dumping syndrome. In the face of Dr. Peck's written opinion, the plan administrator's selective quotation of this single comment, taken out of context, was arbitrary and capricious. See Glenn v.

MetLife, 461 F.3d 660, 672 (6th Cir. 2006) (holding that plan administrator's reliance on treating physician's responses to a "check-off" disability form and his brief assessment on a functional capacity form was arbitrary and capricious where "that information was in direct conflict both with his earlier assessments and with every detailed written explanation that he gave concerning [plaintiff's] disability."). Indeed, the plan administrator's selective reliance on comments by Dr. Albers and Dr. Peck, as reported by Dr. Vinayek (whose reliability as an accurate historian appears to be questionable) suggests "cherry-picking" the medical record to support denying Plaintiff's claim. This was also arbitrary and capricious. Metropolitan Life Ins. Co. v. Conger, 474 F.3d 258, 265 (6th Cir. 2007) (plan administrator's decision is arbitrary and capricious if it is based on a selective review of the administrative record to justify a decision to terminate coverage).

Accordingly, for all of the above reasons, the Court concludes that the plan administrator's decision to terminate Plaintiff's long-term disability benefits was not the product of a deliberate principled reasoning process and, therefore, was arbitrary and capricious. Given that conclusion, the Court need not consider whether the plan administrator's decision was influenced by a conflict of interest or whether the plan administrator failed to give appropriate consideration to the

Social Security Administration's determination that Plaintiff is disabled. Elliott v. Metropolitan Life Ins. Co., 473 F.3d 613, 621 (6th Cir. 2006). Accordingly, the plan administrator's decision must be reversed.

The only remaining issue is Plaintiff's remedy. The district court may remand the case with instructions to award the plaintiff benefits retroactively if the record clearly demonstrates that she is entitled to them. Cooper v. Life Ins. Co. of North Am., 486 F.3d 157, 171 (6th Cir. 2007). Otherwise, the appropriate remedy is to remand the case to the plan administrator with instructions to conduct a proper review of the medical evidence. Id. In making this decision, however, the Court cautioned that:

> Plan administrators should not be given two bites at the proverbial apple where the claimant is clearly entitled to disability benefits. They need to properly and fairly evaluate the claim the first time around; otherwise they take the risk of not getting a second chance, except in cases where the adequacy of claimant's proof is reasonably debatable.

Id. at 172.

In this case, the Court finds that proof of Plaintiff's disability is clear, and that, therefore, the appropriate remedy is to remand the case to the plan administrator with instructions to reinstate her long-term disability benefits, retroactive to July 21, 2009, the original date of termination of benefits. Plaintiff has adduced objective evidence that her dumping

syndrome is as severe as claimed, namely, the removal of 75% of her stomach. Dr. Peck provided an unequivocal opinion that Plaintiff would be unable to work because of dumping syndrome, in particular because of the frequency and duration of her bathroom events and the dizziness, lightheadedness, and fatigue it causes. While Dr. Albers did not provide an opinion as to whether Plaintiff is disabled by dumping syndrome, she has consistently maintained that Plaintiff is disabled by fatigue. Thus, her opinion, while not dispositive, supports Dr. Peck's opinion that Plaintiff is disabled by the symptoms produced by dumping syndrome, one of which is fatigue.

On the other hand, the reports provided to Hartford by Drs. Vinayek and Marciniak are significantly flawed for the reasons discussed by the Court. Most notably, however, they failed to address Dr. Peck's opinion that Plaintiff's dumping syndrome is severe because of the large portion of her stomach that was removed during surgery. Moreover, despite the concession that octreotide was not controlling Plaintiff's dizziness and lightheadedness, Dr. Vinayek did not rebut and in fact failed to address Dr. Peck's opinion that these symptoms would impair Plaintiff's attention and concentration, and thus, preclude her from working.

Conclusion

Accordingly, for all of the above reasons, Plaintiff's motion for judgment on the administrative record is well-taken and is **GRANTED**; Hartford's motion for judgment on the administrative record is not well-taken and is **DENIED.** Plaintiff's motion for oral argument is **MOOT.** This matter is **REMANDED** to the plan administrator with instructions to award Plaintiff long-term disability benefits retroactive to July 21, 2009.

IT IS SO ORDERED.

Date March 2, 2011

s/Sandra S. Beckwith
Sandra S. Beckwith
Senior United States District Judge