

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

FRANCE PARENTE,	:	CIVIL ACTION
	:	
Plaintiff,	:	
	:	
v.	:	
	:	
AETNA LIFE INSURANCE COMPANY,	:	
	:	
Defendant.	:	NO. 99-5478

Reed, S.J.

June 19, 2001

MEMORANDUM

Now before the Court are the cross motions of plaintiff France Parente (Document No. 26) and defendant Aetna Life Insurance Company (“Aetna”) (Document No. 25) for summary judgment. Upon consideration of the motions, responses, and the memoranda and evidence submitted therewith, defendants’ motion will be granted and plaintiff’s motion will be denied.

Background

Plaintiff France Parente suffered from pain in her back, legs, and feet following a hysterectomy in January 1996. She was out of work for six months and received short-term disability benefits from her employer, Bell Atlantic, during that time. She then applied for long-term benefits under Bell Atlantic’s Long Term Disability Plan (“plan”). Following an examination by a neurologist who concluded there was no reason she could not return to work, plaintiff returned to her position at Bell Atlantic in July 1996. She continued to work through 1996 and 1997, but claims the pain and symptoms grew progressively worse over time. December 17, 1997 was the last day she worked at Bell Atlantic.

Plaintiff again applied for and received short-term benefits from Bell Atlantic and again

sought long-term benefits under the plan. Her claim for long-term benefits was denied, as was her appeal. Plaintiff then brought this suit under the Employee Retirement Income Security Act (“ERISA”), 29 U.S.C. §§ 1132 (a) (1) (B) and 1132 (a) (3), claiming that Bell Atlantic denied her benefits due under the plan and breached its fiduciary duty to her.¹ This Court has jurisdiction over this case under 28 U.S.C. § 1331, as it presents a question arising under federal law.

Summary Judgment Standard

Under Rule 56 (c) of the Federal Rules of Civil Procedure, “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law,” then a motion for summary judgment must be granted. The proper inquiry on a motion for summary judgment is “whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law.” Anderson v. Liberty Lobby, 477 U.S. 242, 251-52, 106 S. Ct. 2505 (1986). Furthermore, “summary judgment will not lie if the dispute about a material fact is ‘genuine,’ that is, if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.” Id. at 248.

The moving party “bears the initial responsibility of informing the district court of the basis for its motion and identifying those portions of ‘the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any,’ which it believes demonstrate the absence of a genuine issue of material fact.” Celotex Corp. v. Catrett, 477 U.S.

¹ This Court clarified plaintiff’s viable ERISA claims in a prior decision on a motion to dismiss under Rule 12 (b) (6) of the Federal Rules of Civil Procedure. See Parente v. Bell Atlantic – Pennsylvania, No. 99-5478, 2000 U.S. Dist. LEXIS 4851 (E.D. Pa. April 17, 2000)

317, 323, 106 S. Ct. 2548 (1986). The nonmoving party must then “go beyond the pleadings and by her own affidavits, or by the ‘depositions, answers to interrogatories, and admissions on file’ designate ‘specific facts showing that there is a genuine issue for trial.’” Id. at 324. On a motion for summary judgment, the facts should be reviewed in the light most favorable to the non-moving party. See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587, 106 S. Ct. 1348 (1986) (quoting United States v. Diebold, Inc., 369 U.S. 654, 655, 82 S. Ct. 993 (1962)).

On cross-motions for summary judgment, the court must determine separately on each party’s motion whether judgment may be entered in accordance with the summary judgment standard. See Sobczak v. JC Penny Life Ins. Co., No. 96-3924, 1997 U.S. Dist. LEXIS 1801, at *3 (E.D. Pa.) (citing 10A Charles Alan Wright, et al., Federal Practice and Procedure § 2720, at 23-25 (2d ed. 1983)), aff’d, 129 F.3d 1256 (3d Cir. 1997).

Analysis

Both parties agree that this Court must apply an arbitrary and capricious standard of review to Aetna’s decision to deny plaintiff benefits. I concur with the parties and the well-reasoned analysis of the magistrate judge who, in the course of resolving a discovery dispute, concluded that the arbitrary and capricious standard of review applies here. See Parente v. Aetna Life Ins. Co., No. 99-5478, 2001 U.S. Dist. LEXIS 1919, at *4-7 (E.D. Pa. Jan. 25, 2001). Thus, I will review the decision of Aetna, the plan administrator, under an “abuse of discretion” or “arbitrary and capricious” standard,² and its decision to deny benefits “will not be disturbed if

² “The ‘arbitrary and capricious’ standard is essentially the same as an ‘abuse of discretion’ standard” Mitchell v. Eastman Kodak Co., 910 F. Supp. 1044, 1047 (M.D. Pa. 1995), aff’d, 113 F.3d 433 (3d Cir. 1997).

reasonable.” Mitchell v. Eastman Kodak Co., 113 F.3d 433, 437 (3d Cir. 1997) (quoting Firestone, 489 U.S. at 111).³ Under the arbitrary capricious standard, a plan administrator’s decision “should be upheld even if the court disagrees with it, so long as the interpretation is rationally related to a valid plan purpose and not contrary to the plain language of the plan.” Moats v. United Mine Workers Health and Retirement Funds, 981 F.2d 685, 688 (3d Cir. 1992) (quoting Gaines v Amalgamated Ins. Fund, 753 F.2d 288, 289 (3d Cir. 1985)).

The reasonableness of Aetna’s decision turns on its interpretation of the plan language in light of the facts and evidence in the administrative record. The relevant language here is the plan’s definition of disability:

Disabled during the two-year period beginning on the first day of the Waiting period shall mean the inability of an Employee, because of a significant adverse change in the Employee’s physical or mental condition due to sickness or injury documented by objective medical evidence, to perform the material duties of his/her occupation, as assigned to the Employee immediately before the sickness or injury; or while unable to perform the material duties of his own occupation, is performing at least of one of the material duties of any occupation on a part-time or full-time basis and has lost at least 20 percent of his indexed predisability earnings to a disabling condition.

(Bell Atlantic Long-Term Disability Plan for Management Employees, dated Jan. 1, 1998, at LTD-00007.) The key element of the plan’s definition of disability in this case is the requirement that an employee show through objective medical evidence that she is unable to perform the material duties of her occupation.

First, then, I must examine the reasons provided by Aetna for denying plaintiff long-term benefits. Aetna set forth its reasons in a letter dated September 21, 1998. (Letter from Jennifer L. Bell, dated Sept. 29, 1998, at CLAIM-00036.) The letter discussed the physician statement of

³ I note that the decision of the Court of Appeals for the Third Circuit in Pinto v. Reliance Std. Life Ins. Co., 214 F.3d 377 (3d Cir. 2000), under which a heightened arbitrary and capricious standard must apply when the administrator also funds the plan, is not implicated here, because Aetna is merely the claims administrator and does not fund the plan.

Dr. Rosemarie Leuzzi, a physician specializing in internal medicine, who concluded that plaintiff suffered from lumbar neuropathy, reflex weakness and chronic pain. The letter also referenced medical records from chiropractor Irene Ryan, including an electromyographic (EMG) examination report showing acute denervation of paraspinal muscles, and the results of a magnetic resonance imaging (MRI) scan indicating degenerative disc disease and a mild disc bulge. Also discussed in the letter were the medical records of Dr. Hope Victor, a psychologist, who treated plaintiff with relaxation and imagery therapy. The letter also discussed the results of two independent medical examinations, conducted by two different neurologists; Dr. Steven Mandel, who concluded in his report that he could see no reason why plaintiff could not return to work, and Dr. James D. Nelson who likewise observed that there was no reason she could not go back to work without restrictions. The letter concluded by informing plaintiff that plaintiff's claim was denied because the medical record did not demonstrate that she was totally disabled from performing the material duties of her occupation.

Plaintiff appealed the denial. Aetna scheduled another independent medical examination for plaintiff with another neurologist, Dr. William F. Bonner, who reviewed all the medical records from other physicians who had seen plaintiff and examined plaintiff himself. Dr. Bonner concluded that plaintiff did not suffer from a femoral neuropathy or disc herniations. He suggested a functional capacity evaluation and a repeat EMG. Aetna then scheduled and plaintiff took part in a functional capacity evaluation, and upon reviewing its results, Dr. Bonner wrote that his review of the functional capacity evaluation had not changed his opinion, and again suggested a repeat EMG examination. (Letter from William F. Bonner, dated May 21, 1999, at APPEAL-00061.) Aetna did not seek a repeat EMG examination.

Soon after Dr. Bonner sent his May 21, 1999 letter, Aetna informed plaintiff that her appeal was denied. (Letter from Ann-Marie Deluco, dated June 10, 1999, APPEAL-00012.) The letter referenced the opinions of Dr. Bonner and his impressions of the functional capacity evaluation in concluding that plaintiff was not totally disabled. (Id.)

I cannot conclude on this record that Aetna was unreasonable, arbitrary, or capricious in concluding that plaintiff had not produced sufficient objective evidence that she was unable to perform the material duties of her occupation. Aetna relied on the conclusions of three different physicians who conducted three separate independent medical examinations; two concluded that plaintiff was physically able to return to her job, and one which found objective evidence of a disability lacking. Those physicians each reviewed the medical records of plaintiff's treating physicians and conducted their own independent examinations of plaintiff in coming to their conclusions. There is no indication that those physicians overlooked compelling objective medical evidence of a disability nor is there persuasive evidence that Aetna's conclusion was based on an unreasonable interpretation of the Plan's definition of total disability. Rather, Aetna's conclusion appears to be grounded in the medical record and supported by reasonable medical opinions.

The decision of the Court of Appeals for the Third Circuit in Abnathya v. Hoffmann-La Roche Inc., 2 F.3d 40 (3d Cir. 1993), is instructive. There, plaintiff developed severe pain in her neck, shoulders, arms, hands and legs from having to sit for long periods of time. She received long-term benefits for a time, until they were discontinued upon a subsequent review of her disability after four year because two independent medical examiners concluded that she was not totally disabled and that she could do work of a sedentary nature. See id. at 43-44. Plaintiff

appealed, pointing to her treating physician's belief that she was totally disabled, but the plan upheld its decision to discontinue benefits. See id. at 44. Reversing the decision of the district court, the court of appeals concluded that the plan's decision to discontinue plaintiff's long-term disability benefits was neither arbitrary nor capricious. "[The plan administrator's] reliance on two independent evaluations, both of which came to the same conclusion that Abnathya was able to perform gainful employment, where the plan did not require a second evaluation, was clearly not unreasonable." Id. at 47.

The similarities between Abnathya and the instant case are striking; plaintiffs with pain, holding primarily sedentary jobs, and multiple independent medical examiners who concluded the plaintiffs were not disabled. In the instant case, the evidence relied upon by the administrator is even more compelling; three independent medical evaluators could not conclude that plaintiff was totally disabled. Abnathya clearly indicates that Aetna's decision to deny benefits here was not unreasonable.

Plaintiff argues that Aetna ignored or gave short shrift to evidence that tended to show that she was totally disabled. Plaintiff points to a letter sent by Dr. Leuzzi after plaintiff's claim was denied stating the opinion that plaintiff could not return to work (Letter from Dr. Rosemarie A. Leuzzi, date Oct. 23, 1998, at CLAIM-00194); however, Aetna's denial letter makes it clear that the records of Dr. Leuzzi were reviewed by Aetna and Dr. Nelson and did not persuasively support a finding of total disability. Plaintiff also points to the report of an independent medical evaluation ordered to investigate plaintiff's short-term disability claim, in which the neurologist, Dr. Robert D. Aiken, concluded that plaintiff was "incapable of returning to work in her previous capacity." (Plaintiff's Exh. E, Letter from Robert D. Aiken, dated May 29, 1998, at 3.) However,

in that same letter, Aiken concluded that plaintiff “may be capable of sedentary work, that involves no lifting and does not require frequent changes in position, that is, from sitting to standing or standing to sitting.” (Id.) Aetna concluded that plaintiff’s job was “mostly sedentary,” and there is insufficient evidence on this record to indicate that that conclusion was unreasonable. Thus, Dr. Aiken’s report, which was considered by Dr. Bonner during plaintiff’s second independent medical examination, is not enough evidence to show that Aetna was unreasonable in concluding that plaintiff was not totally disabled.

Plaintiff also maintains that Aetna ignored the records produced by Dr. Robert Winer, her treating neurologist. While Aetna did not explicitly mention Dr. Winer’s records in its communications with plaintiff, the records are unquestionably part of the administrative record and thus presumptively were reviewed by Aetna. Furthermore, Dr. Winer’s records merely describe her treatment regimen and do not conclusively demonstrate that plaintiff was totally disabled. Therefore, I cannot conclude that Dr. Winer’s records, even if they were overlooked by Aetna, create a genuine issue of material fact as to the reasonableness of Aetna’s decision to deny plaintiff benefits.

Plaintiff argues that Aetna failed to give appropriate consideration to the fact that Dr. Bonner’s independent medical examination of plaintiff and the functional capacity evaluation he ordered were essentially inconclusive. On his initial examination of her, Dr. Bonner observed that “she has significant changes on the manual muscle exam which were not reproduced during the functional observation of her which do not correlate to any diagnostic testing results that I have nor to any specific nerve root pathologies which she may suffer from.” (Letter from Dr. William F. Bonner, dated Mar. 31, 1999, at APPEAL-00057.) He recommended both a

functional capacity evaluation and a repeat EMG. After reviewing the results of the functional capacity evaluation, Dr. Bonner noted that while “plaintiff’s actual abilities cannot be accurately determined as a result of this [functional capacity] evaluation,” his “examination does not objectively document pathologies, rather inconsistencies in regard to dynamic and static lifting.” (Letter from Dr. William F. Bonner, dated May 21, 1999, at APPEAL-00061.) I cannot conclude that Aetna was unreasonable in concluding from Dr. Bonner’s reports that plaintiff had not demonstrated that she was totally disabled. Dr. Bonner stated that his examination had not “objectively document[ed]” a disability and that “inconsistencies” abounded in the results of his examination. Aetna reasonably could have found on the basis of these reports that plaintiff had not met her burden under the plan of producing objective evidence that she could not perform the material duties of her occupation. An inconclusive result works against plaintiff under the terms of the plan, because she – not Aetna – bears the burden of demonstrating her disability. Particularly in light of the other independent medical examinations indicating that plaintiff was not disabled, I conclude that the Dr. Bonner report and functional capacity evaluation could not possibly render Aetna’s decision to deny benefits unreasonable in the eyes of a reasonable jury.⁴

Plaintiff also contends that Aetna failed to consider whether she was mentally disabled. However, the initial documents related to plaintiff’s long-term disability claim focused on plaintiff’s physical capabilities, and even the initial attending physician’s statement from plaintiff’s psychologist states in the section entitled to “Mental/Nervous Impairment” stated “n/a

⁴ The fact that Aetna did not follow Dr. Bonner’s recommendation of seeking another EMG examination does not undermine the reasonableness of Aetna’s decision to deny plaintiff benefits. Plaintiff had already had two EMG examinations that did not conclusively establish a disability. And again, in light of the other evidence upon which Aetna relied in concluding that plaintiff was not totally disabled, I conclude that a reasonable jury could not find that the failure to secure a third EMG examination was unreasonable.

Limitations and impairment are physical, not mental.” (LTD/PTD Attending Physician’s Statement of Dr. Hope R. Victor, dated May 27, 1998, at CLAIM-00005.) Thus, from the outset of plaintiff’s claim, there was no indication that she was asserting that a mental disability had rendered her totally unable to do her job. Second, the only objective medical evidence regarding her mental condition came from Dr. Hope R. Victor, plaintiff’s treating clinical psychologist. (Medical Records of Dr. Hope R. Victor Re: France Parente, CLAIM-00284-307.) My review of Dr. Victor’s notes concerning plaintiff’s treatment leads me to the conclusion that Aetna was not unreasonable in finding that plaintiff suffered no mental condition that rendered her permanently disabled, as most of the notes were related to plaintiff’s efforts to deal psychologically with her physical pain and limitations.

Plaintiff also points out that defendants failed to reference all of the medical records from all of the physicians who treated or evaluated plaintiff, and did not address the conclusions of some medical professionals that she was unable to perform in her position at Bell Atlantic. As noted by the Court of Appeals for the Fourth Circuit, “it is not an abuse of discretion for a plan fiduciary to deny . . . benefits where conflicting medical reports were presented.” Elliott v. Sara Lee Corp., 190 F.3d 601, 606 (4th Cir. 1999) (citing Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 234 (4th Cir. 1997) (finding no abuse of discretion in denial of benefits where beneficiary’s primary medical provider’s finding of disability conflicted with reports of independent medical panel)). Even reading the conflicting evidence on this record in plaintiff’s favor, I cannot conclude that Aetna’s failure to conclude that plaintiff was disabled was unreasonable.

Accordingly, I conclude that there is no genuine issue of material fact as to plaintiff’s § 1132 (a) (1) (B) claim, defendant’s motion for summary judgment on that claim will be granted,

and plaintiff's motion for summary judgment will be denied.

Plaintiff also claims that Aetna breached its fiduciary duty in violation of 29 U.S.C. § 1132 (a) (3) by denying her claim despite the fact that its independent examiner, Dr. Bonner, suggested further diagnostic testing and by relying on the functional evaluation to deny benefits when the results were inconclusive. Plaintiff argues, "There is no authority requiring this Court to use an arbitrary and capricious standard of review regarding plaintiff's claim for breach of fiduciary duty." *Au contraire*. The Court of Appeals for the Third Circuit has clearly indicated that the arbitrary and capricious standard applies to claims of a breach of fiduciary duty under ERISA. See Northeast Dept. ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229, 764 F.2d 147 (3d Cir. 1985) ("This court has held that a decision of trustees denying benefits to participants or beneficiaries meets the requirements of § 1104 [which sets forth fiduciary duties of plan trustees] unless that decision is arbitrary and capricious.") (citations omitted). I discussed under plaintiff's § 1132 (a) (1) (B) claim Aetna's conduct with respect to Dr. Bonner's examination and the functional capacity evaluation and concluded that its conduct was neither arbitrary nor capricious, and reach the same conclusion under her § 1132 (a) (3) claim.

Plaintiff's assertion that Aetna violated ERISA by failing to comply with the procedural requirements of the plan cannot prevail. Plaintiff's claim that the resolution of her appeal was delayed beyond the 60-day time frame set forth in the plan does not establish a breach of fiduciary duty. The record indicates that a lengthy period of time passed while Aetna considered plaintiff's appeal because Aetna was attempting to gather more information through an additional independent medical examination and functional capacity evaluation. Thus, the delay worked in

plaintiff's favor, because it provided her additional opportunities that were not required under the plan to demonstrate her disability. I conclude that a reasonable jury could not find that Aetna's delay in resolving plaintiff's appeal was a breach of fiduciary duty.

Plaintiff's claim that Aetna did not abide by the procedures set forth in the administrative services agreement between Bell Atlantic and Aetna is inapposite, because the administrative services agreement is not the plan, and it is the fiduciary duties set forth under the *plan* that control the outcome of a § 1132 (a) (3) claim. Even if the administrative services agreement did control here, I conclude that there is insufficient evidence on this record for a reasonable jury to find that Aetna violated the fiduciary standard set forth in 29 U.S.C. § 1104. Likewise, plaintiff's general averments that Aetna did not keep her fully informed are not supported by the record; the Court of Appeals for the Third Circuit has held that "substantive remedies are generally not available for violations of ERISA's reporting and disclosure requirements" except "where the plaintiff can demonstrate the presence of 'extraordinary circumstances.'" Ackerman v. Warnaco, Inc., 55 F.3d 117, 124 (3d Cir. 1995). I conclude that no extraordinary circumstances are present here.

Therefore, defendant's motion for summary judgment will be granted on plaintiff's § 1132 (a) (3) claim, and plaintiff's motion for summary judgment will be denied.

An appropriate Order follows.

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

FRANCE PARENTE,	:	CIVIL ACTION
	:	
Plaintiff,	:	
	:	
v.	:	
	:	
AETNA LIFE INSURANCE COMPANY,	:	
	:	
Defendant.	:	NO. 99-5478

ORDER

AND NOW, this 19th day of June, 2001, upon consideration of the motion of defendant Aetna Life Insurance Company for summary judgment (Document No. 25) and the motion of plaintiff France Parente for summary judgment (Document No. 26), the memoranda and evidence submitted therewith, as well as the entire record, pursuant to Rule 56 of the Federal Rules of Civil Procedure, and having concluded for the reasons set forth in the foregoing memorandum that there is no genuine issue of material fact and that defendant are entitled to judgment as a matter of law, **IT IS HEREBY ORDERED** that motion of defendant for summary judgment is **GRANTED** and the motion of plaintiff for summary judgment is **DENIED**.

JUDGMENT is hereby **ENTERED** in favor of defendant Aetna Life Insurance Company and against plaintiff France Parente.

LOWELL A. REED, JR., S.J.