

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS

HOUSTON DIVISION

COPELAND COLE,

CASE NO.: H-99-2185

Plaintiff,

v.

CONTINENTAL CASUALTY COMPANY,

Defendant.

PLAINTIFF'S REPLY AND INCORPORATED MOTION TO STRIKE
DEFENDANT'S UNTIMELY RESPONSE TO PLAINTIFF'S
MOTION FOR SUMMARY JUDGMENT

Plaintiff, Copeland Cole, by and through undersigned counsel, hereby files his Reply and Incorporated Motion to Strike Defendant's Untimely Response to Plaintiff's Motion for Summary Judgment against Defendant, Continental Casualty Company (hereinafter "CCC"), as follows:

I. Motion to Strike

CCC's Response to Mr. Cole's Motion for Summary Judgment can and should be quickly dispensed with because CCC's Response was untimely and no good cause reason was asserted for filing a late Response. The Response should be stricken as untimely and Mr. Cole's Motion for Summary Judgment should be granted since there was no proper opposition to his dispositive motion.

Mr. Cole mailed his Motion for Summary Judgment in this case to the Office of the Clerk of the Southern District of Texas on November 11, 1999¹. The clerk received

¹ This is the same day CCC was served by mail with a copy of the Motion.

and filed Plaintiff's Motion for Summary Judgment on November 12, 1999 making this the date of filing. Fed.R.Civ.P., Rule 5 (e). Pursuant to Southern District of Texas, Local Rule 6 (D):

“Opposed motions will be submitted to the judge twenty days from filing without notice from the clerk and without appearance by counsel.”

Id.

The date that the motion is submitted to the judge is the submission day. Southern District of Texas, Rule 6 (E)(1). The submission day for Mr. Cole's Motion for Summary Judgment was December 2, 1999. CCC was required to Respond to Mr. Cole's Motion for Summary Judgment on or before December 2, 1999. Id. “Failure to respond will be taken as a representation of no opposition.” Southern District of Texas, Rule 6 (E). CCC did not respond to Mr. Cole's Motion for Summary Judgment on or before December 2, 1999²; therefore, there was no proper and/or timely response to the motion which should be taken as a representation of no opposition. Any response after December 2, 1999 should be stricken as untimely and Mr. Cole's Motion for Summary Judgment should be granted due to CCC's failure to respond.

WHEREFORE, Plaintiff, Copeland Cole, respectfully requests this honorable Court enter an Order striking Defendant's untimely response to Plaintiff's Motion for Summary Judgment and granting Plaintiff's Motion for Summary Judgment due to Defendant's failure to respond as well as any additional and further relief this Court deems just and proper.

² Furthermore, CCC did not request additional time or even attempt to provide a showing of good cause.

II. Reply Introduction

In an abundance of caution and in the event that this Court denies the Motion to Strike, Mr. Cole implores this Court to exercise its discretionary authority and consider this Reply brief³. CCC has attempted in its Response to provide a rational basis for denying Mr. Cole's claim, but the Response fails to rebut or even address most of the arguments contained in the Motion for Summary Judgment.

As stated in the Motion for Summary Judgment, CCC improperly interpreted certain key plan terms, which was not fully rebutted in the Response and is one reason to find that CCC's decision was improper. CCC attempted in its Response to point to certain evidence that it has labeled as "concrete" to support its decision to deny Mr. Cole's claim. However, the evidence cited by CCC in its Response is ambiguous at best when read in tandem with the other records in the administrative file and cannot be used as a basis for denying Mr. Cole's claim. Furthermore, none of the evidence cited by CCC in its Response specifically addresses Mr. Cole's "bone crushing fatigue" which is one of the disabling causes of his Lyme disease. This is another reason to find that CCC's decision was improper. The final reason for determining that CCC's decision was improper is its failure to consider or rebut Dr. Gathe's diagnosis of Lyme disease and its effect on Mr. Cole⁴. This was also not adequately addressed in CCC's Response. The result of CCC's failure to respond to the majority of the Motion for Summary is that the information contained therein is true and accurate and CCC's decision was improper under ERISA.

³ "The Court may in its discretion . . . permit additional authority or supporting material." Southern District of Texas, Local Rule 6 (I).

III. The Decision Cannot be Upheld Because of CCC's Improper Plan Interpretation

In its Response, CCC goes to great lengths to give its version of the factual history of this case in an attempt to divert the Court's attention. The fourteen pages of the Response devoted to the factual history of Mr. Cole's claim have no bearing on whether CCC's decision was proper. As pointed out in the Motion for Summary Judgment, CCC's interpretation of the plan was improper and is reason enough to determine that its decision to deny benefits was unlawful.

In the Fifth Circuit, plan interpretations are reviewed under the *de novo* standard of review. Pierre v. Connecticut General Life Ins. Co., 932 F.2d 1552 (5th Cir. 1991)(citing, Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989)). This is the standard of review that Mr. Cole stated was the proper standard of review in this case⁵. CCC's assertion that "Plaintiff fails to mention the proper standard of review in the Fifth Circuit⁶" is patently false.

The Motion for Summary Judgment listed multiple examples of CCC's improper plan interpretation, any one of which can be used by itself to find the decision arbitrary and capricious⁷.

"Pan American claims that its decision to deny the claims submitted by Burks-Farber as not 'customary and reasonable' was a determination of fact. This assertion is clearly in error: a determination of whether a claim is customary and reasonable" is an interpretation of a term within the plan. Thus, under the rationale in Pierre, the standard of review is determined according to Bruch."

Gulf South Medical and Surgical Institute v. Pan American Life Ins. Co., 1992 U.S. Dist. LEXIS 15272, *7 (E.D. La. October 6, 1992)⁸.

⁴ Other than to have a non-medically trained individual completely dismiss this key evidence of disability.

⁵ Memorandum of Law in Support of Plaintiff's Motion for Summary Judgment, p. 10.

⁶ Defendant's Response to Plaintiff's Motion for Summary Judgment, p. 15.

⁷ It is not even necessary in this case to find that the decision is arbitrary and capricious because the correct standard of review is *de novo*. However, even under the more deferential standard of review, CCC's decision cannot be upheld.

Mr. Cole pointed to the record to show where CCC used the wrong interpretation of occupation with respect to Mr. Cole's claim⁹, specifically, the use of "any" occupation as opposed to "own" occupation. Mr. Cole also pointed out in the record CCC's insertion of an additional requirement for eligibility¹⁰, the requirement that an impairment be "severe." Mr. Cole pointed out another instance where CCC did not properly interpret the plan by giving the term "disabled"¹¹ an overly restrictive interpretation¹². The adjuster was looking for "an inable [sic] to function"¹³ which is not a requirement for eligibility in the plan. Mr. Cole even showed in the record where one of CCC's paid doctors used a definition of disability¹⁴ that was not present in the plan¹⁵.

The *only* argument raised in opposition to Mr. Cole's evidence of CCC's improper plan interpretation was a brief statement: "However, if Plaintiff had added the paragraph immediately following the paragraph he quoted from the letter, it would be clear that Defendant was using the correct definition of 'Total Disability' in denying Plaintiff's claim¹⁶." This statement was followed by a quote from the denial letter.

Contrary to CCC's self-serving assertion otherwise, it is clear that CCC did not use the correct definition of total disability. CCC makes no attempt to distinguish between the very different definitions of "any occupation" and "own occupation" in its denial letter which shows that it does not make any conceptual distinction between the

⁸ The full case is attached as **Exhibit A**.

⁹ Memorandum of Law in Support of Plaintiff's Motion for Summary Judgment, p. 11.

¹⁰ *Id.*

¹¹ This term is used interchangeably with the terms "disability", "totally disabled" and "total disability".

¹² *Id.*

¹³ *Id.*, p. 12 and Exhibit U.

¹⁴ The definition used was: "Disability is the limiting loss or absence of the capacity of an individual to meet personal, social or occupational demands or to meet statutory or regulatory requirements." *Id.* at fn. 16.

¹⁵ *Id.*, p. 7, 12.

¹⁶ Defendant's Response to Plaintiff's Motion for Summary Judgment, p. 7.

two terms. This fact proves that CCC could not have used the correct definition of total disability.

Furthermore, the quote highlights CCC's requirement not present in the plan that there be "severe anatomical, physiological or psychological abnormality which could reasonably be expected to produce impairment¹⁷." Since CCC did not dispute Mr. Cole's allegation that the use of the additional term "severe" led to an "unreasonable interpretation¹⁸," this allegation must be taken as true resulting in the conclusion that the denial of Mr. Cole's benefits is contrary to law. CCC also did not dispute Mr. Cole's allegations that both it and its paid doctor used an "unreasonable and overly restrictive interpretation.¹⁹" These unrefuted allegations must also be taken as true and provide two other independent reasons for finding that CCC's denial of benefits to Mr. Cole is contrary to law under either the less deferential *de novo* standard of review²⁰ or the most deferential arbitrary and capricious standard of review.

¹⁷ Id.

¹⁸ Memorandum of Law in Support of Plaintiff's Motion for Summary Judgment, p. 12.

¹⁹ Id.

²⁰ This is the proper standard of review in this case. Plaintiff agrees with Defendant that under the *de novo* standard of review, certain evidence not contained in the administrative record may be relevant. See, Wildburv. Arco Chemical Co., 974 F.2d 631, 638 (5th Cir. 1992). However, in this case, no further evidence is necessary because the interpretations given by CCC and the additional requirements inserted by CCC were in direct conflict to the express terms of the plan. "[T]here is no evidence, which was not presented to the administrator that is now available, that bears on the administrator's interpretation of the policy." Southern Farm Bureau Life Ins. Co. v. Moore, 993 F.2d 98, 102, fn 7 (5th Cir. 1993). The only other evidence that could possibly be relevant to this case at all would be the introduction of the Social Security decision. Any inferences of a lack of good faith is an additional factor that may become relevant. Wildbur, 974 F.2d at 638. The Social Security Administration determined that Mr. Cole was totally disabled from any occupation, a more restrictive standard than present in the plan at issue, based upon the same information CCC determined did not support a finding of total disability. The fact that an independent agency made a different decision (which is a plan interpretation subject to *de novo* review) is evidence that CCC's decision was made in bad faith. Sweatman v. Commercial Union Ins. Co., 39 F.3d 594, fn 10 (5th Cir. 1994)("ultimate conclusions are reviewed *de novo* while underlying facts are reviewed for clear error").

IV. The Facts Do Not Support a Denial

CCC's decision to deny benefits to Mr. Cole cannot be upheld because of its unlawful plan interpretation. This makes a factual inquiry unnecessary and irrelevant. However, CCC's decision cannot be upheld under even the most strained review of the facts. According to CCC, "Defendant had 'concrete evidence' on which it based its denial of Plaintiff's disability claim²¹." As will be shown *infra*, when CCC's "concrete evidence" is analyzed in tandem with the entire record, CCC's "concrete evidence" begins to crumble and this crumbling evidence is not strong enough to support its decision to deny benefits. Its concrete fails inspection.

The first step in analyzing eligibility for a claim is to make a reasonable and impartial determination of the facts underlying a claim. Pierre, 932 F.2d at 1557, 1562. Factual determinations are reviewed under the arbitrary and capricious standard of review. Id at 1562. The second step is to "determine whether those facts constitute a claim to be honored under the terms of the plan." Id at 1557. This determination is reviewed under the *de novo* standard of review in this case, as discussed *supra*.

Mr. Cole is disabled because of extreme fatigue and cognitive problems that prevent him from working. At the beginning of its Response, CCC focuses this Court's attention on a review of information that it states does not support Mr. Cole's claim of cognitive difficulties. CCC references Dr. Ziffer's follow-up report²² and his notes on a conversation with Mr. Cole's treating physician²³, Dr. Salvato, to somehow show that it

²¹ Defendant's Response to Plaintiff's Motion for Summary Judgment, p. 24.

²² This was attached to the Memorandum of Law in Support of Plaintiff's Motion for Summary Judgment as Exhibit G.

²³ CCC implies on p.5 of its Response that Plaintiff's counsel erred by stating that Dr. Ziffer had not consulted with Dr. Salvato. A thorough reading of the passage referred to reveals that Dr. Ziffer had not consulted with Dr. Salvato as of July 16, 1997, which is the date of the report Plaintiff's counsel was referencing.

was reasonable in concluding in the denial letter that the evidence did not support a finding of cognitive dysfunction²⁴. **What is lacking in these three pages of discussion is anywhere in the record where his disabling fatigue is discussed or challenged.** The reason is that it does not exist.

CCC then goes into a discussion of why it believes that it was reasonable in relying on its other paid doctors who did not find Mr. Cole disabled from his cognitive difficulties²⁵. Again, CCC does not ever discuss, challenge or refute the fatigue aspect of Mr. Cole's disability. Mr. Cole's statement of Daily Activities and attached letter²⁶ are unrefuted evidence of his disabling fatigue. Mr. Cole's statements are supported by Dr. Salvato: "He continues to experience debilitating symptoms, the worst being his **bone-crushing fatigue** . . ."²⁷,

CCC's factual determinations regarding Mr. Cole's claim only focused on his cognitive difficulties which is only a portion of his disabling conditions. CCC failed to even make a factual determination regarding the effect of Mr. Cole's fatigue²⁸. This makes it unnecessary to specifically respond to the arguments regarding his cognitive difficulties²⁹. CCC's factual determinations were arbitrary and capricious because his fatigue was ignored.

²⁴ Defendant's Response to Plaintiff's Motion for Summary Judgment, p. 5-8.

²⁵ Id, p. 8-13.

²⁶ Id, Exhibits C and D respectively.

²⁷ Id, Exhibit L (emphasis added).

²⁸ Although not raised in the Response, the record does imply that CCC determined that Mr. Cole's fatigue did not prevent him from working because he could occasionally play a 50 minute softball game or hit golf balls. However, this determination would be an arbitrary and capricious factual determination because it is completely unreasonable to equate an occasional 50 minute activity with consistently being able to perform an occupation 8 hours per day and 40 hours per week.

²⁹ At best, CCC only has information from non-treating physicians that conflicts with information from treating physicians. Mr. Cole provided authority for the treating physician rule in his initial brief which will not be restated here. CCC's reference to Meditrust Financial Services Corp. v. The Sterling Chemicals, Inc., 168 F.3d 211 (5th Cir. 1999) is misplaced because the review there was only upheld because the plaintiff there failed to "point to any authority" to support its position. Id at 215. Such is not

V. There was No Evidence to Rebut Dr. Gathe's Conclusions

The final piece of evidence submitted by Mr. Cole was Dr. Gathe's report diagnosing him with Lyme disease and Rocky Mountain Spotted Fever and certifying him to be disabled based on "severe fatigue, cognitive deficit, and disseminated joint pain³⁰." CCC implied in its Response that it was proper to disregard this information because Dr. Gathe did not perform his tests until after Mr. Cole's claim was denied and did not provide information that linked this information to his condition at the time of the denial³¹.

CCC fails to mention that the determination that the information contained in Dr. Gathe's report could be disregarded was made by the adjuster. CCC also fails to mention that it is common knowledge that Lyme disease causes the fatigue, cognitive problems and joint pain Mr. Cole complained about³². CCC's adjuster had no medical training, yet had the audacity to, in effect, overrule the conclusions of a medical doctor. This fact alone makes her conclusion arbitrary and capricious. Even a cursory knowledge of medicine will inform someone that the fact that an actual diagnosis is not made until

the case here. In fact, further authority appears in Gulf South Medical and Surgical Institute v. Pan American Life Ins. Co., *supra*: "[T]he mere fact that Pan American hired a consultant to assist in its review of the claims will not shield it from reversal."

The Fifth Circuit has neither approved nor disapproved the treating physician rule. Salley v. E.I. DuPont de Nemours & Co., 966 F.2d 1011, 1016 (5th Cir. 1992). The Salley Court seemed to leaning against approving the rule in that case because the treating physician would directly benefit financially if the procedure was determined to be medically necessary because the operation would not occur otherwise. There is no potential financial gain by the treating physician in a disability case and CCC suffers from an inherent conflict of interest as an insurance company paying claims out of its operating resources. See, Wildbur, *supra*. Therefore, the treating physician rule should be followed in this case.

³⁰ Defendant's Response to Plaintiff's Motion for Summary Judgment, Exhibit Q.

³¹ *Id.*, p. 14, 22.

³² There is also support of a very real and very serious illness in the record. *Id.*, Exhibit F. On May 19, 1997, Dr. Salvato noted that Mr. Cole's natural killer T-cell level was 153. The lower limit of normal is 418. Dr. Ziffer mentioned this fact, but never even attempted to explain it away. *Id.* The T-cells are the body's natural defense mechanisms and a low T-cell count is indicative of serious problems, including these symptoms described by Mr. Cole. Usually, the T-cell level is only this low in patients who are in the final stages of AIDS. It was not reasonable for a non-medically trained adjuster to disregard important information.

several months later does not mean someone cannot suffer from its effects prior to the diagnosis. Basic logic also supports this fact. CCC had no rational reason to ignore this information.

“[I]f a decision is supported by substantial evidence and is not erroneous as a matter of law, it is not arbitrary and capricious.”

Wildbur, 974 F.2d at 637, fn 12. Accord, Meditrust, 168 F.3d at 215 (“we affirm an administrator’s decision if it is supported by substantial evidence”).

Not only was there no substantial evidence that Dr. Gathe’s information was irrelevant to Mr. Cole’s claim, there was no evidence other than the suspicion of a non-medically trained adjuster. If a non-medically trained person is allowed to disregard the conclusions of a treating physician, then an ERISA administrator’s could never be improper. As in Vega v. National Life Ins. Services, Inc., 188 F.3d 287 (5th Cir. 1999), there was “simply no competent evidence³³” to support CCC’s denial other than the “unsupported suspicions³⁴” of the adjuster that this information had no bearing on his claim at the time of denial. The adjuster, at the very least, had an obligation to make his decision base on all the available evidence. The adjuster here did not even have the most recent records which were Dr. Gathe’s records. Instead, the records were summarily determined to be irrelevant to the claim.

“At the very least, however, administrators relying on hospital records obviously must review the most recent records.”

Salley, 966 F.2d at 1016.

VI. Conclusion

CCC’s decision to deny benefits to Mr. Cole cannot be upheld for three major reasons. First, several of its plan interpretations were contrary to law. Any one of these

³³ Id at 301.

improper plan interpretations is reason enough to overturn its denial of benefits. Second, CCC's factual determinations were arbitrary and capricious because it did not address a major effect of Mr. Cole's disability. The final reason for overturning this decision is due to its complete disregard of the information regarding Lyme disease. Any one of these reasons is a basis to overturn the decision, the combination of the three causes is absolute proof that CCC's decision was unlawful.

What is evident from the record is that CCC simply sat back and attempted to play defense with the medical information submitted by shutting it down. All CCC did was have the medical information sent for review so it would have a basis to determine that "the information submitted does not support a finding of total disability." None of the reviewing physicians or CCC itself even acknowledged that there was anything wrong with Mr. Cole despite the records to the contrary. CCC's defense, as shown *supra*, was not effective and contrary to the role of an ERISA fiduciary.

It is not the role of an administrator to sit back and wait for information, then, after it is submitted, attempt to pick it apart piece by piece without providing another diagnosis, requesting further information or examining the patient. An ERISA fiduciary is required to act solely in the interests of the plan participants and beneficiaries and must necessarily do more than distrust the veracity of all claims submitted. Mr. Cole is entitled to all past due benefits, plus interest, costs and a decree ordering CCC to continue payment of his benefits.

³⁴ Id at 302.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

WE HEREBY CERTIFY that a true and correct copy of the foregoing was faxed/mailed this ____ day of December, 1999 to: James J. McConn, Jr., Esq., Hays, McConn, Rice & Pickering, 400 Two Allen Center, 1200 Smith Street, Houston, Texas 77002.

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