

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

CASE NO.: 06-22025-CIV-LENARD/TORRES

RAFAEL RODRIGUEZ, JR.,

Plaintiff,

v.

THE PRUDENTIAL LIFE INSURANCE
COMPANY,

Defendant.

**PLAINTIFF’S MEMORANDUM OF LAW IN SUPPORT OF HIS
MOTION FOR SUMMARY JUDGMENT**

I. Introduction

Rafael Rodriguez, Jr. retired from the Air Force in 1997 and began working for APL Logistics America’s Ltd. (“APL”)¹ as a systems instructor. In this position, Mr. Rodriguez traveled the country and abroad to train APL personnel in the operation of computer systems and the handling of inventory, as well as provided technical support. In 2000, Rafael Rodriguez had his first episode of deep vein thrombosis and pulmonary embolism and his rare blood coagulation disorder was discovered. Mr. Rodriguez was out of work for a period of time. A Greenfield Filter was inserted in his heart and he was placed on a life long regimen of Coumadin. The Plaintiff chose to return to work and his employer accommodated him with a desk job as air travel put Mr. Rodriguez at risk for blood clots. Unfortunately, the Plaintiff was also plagued by back and leg pain, and an MRI in February of 2002 revealed degenerative disc disease with disc herniation. Such

¹ At this time, APL was GATX (General American Transportation) and was later bought by APL.

condition had an extremely harsh impact on the Plaintiff since his chronic Coumadin treatment precluded the typical invasive procedures that are used to relieve pain. The Plaintiff went out of work again at this time, fought his way back to his job a couple of months later, but was forced to cease work again in June of 2002. Rafael Rodriguez returned to work once again, but his lumbosacral pain, as complicated by his deep vein thrombosis/pulmonary embolus condition, exacerbated in October of 2002. Despite his physicians' recommendations otherwise, as explained by Dr. Florete and Dr. Harris in narratives submitted in support of the Mr. Rodriguez' disability, the Plaintiff did not want to stop working. Finally, in May of 2003, after a further deterioration in his condition despite aggressive treatment to relieve his pain including increases/changes in medications, steroid injections and walking devices, Mr. Rodriguez was forced by the combination of his disabling conditions as well as directed by his doctors to cease all work.

Instead of being commended for his work ethic and commitment to improving his condition and his pain, Prudential Life Insurance Company ("Prudential"), APL's long-term disability (LTD) carrier, used Rafael Rodriguez' persistence to remain in the work force against him, and denied his claim for LTD benefits based on the notion that if he could work after his degenerative disc disease was first diagnosed by MRI in February of 2002, he should be able to work with his conditions indefinitely. In supporting such argument, the Defendant also alleged that Mr. Rodriguez' condition remained the same since February of 2002, which is shocking considering the overwhelming amount of medical records in this nearly 1,000 page claim file that document, from October of 2002 through May of 2003, increases in pain and related procedures and changes in medication

that occurred as a result, as well as the deterioration in Mr. Rodriguez' ability to walk ultimately rendering him to a wheelchair. Such evidence also seriously undermines Prudential's other reason for its denial, the alleged lack of objective evidence.

II. Facts

Please refer to *Plaintiff's Statement of Undisputed Material Facts In Support of His Motion for Summary Judgment* being filed contemporaneously with this Memorandum.

III. Summary Judgment Standard and Argument

A moving party is entitled to summary judgment if the pleadings, affidavits and other supporting papers show there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R.Civ.P., 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322, 91 L.Ed. 2d 265, 106 S.Ct. 2548 (1986). "The burden of establishing the absence of a genuine issue of material fact is on the party seeking summary judgment." United of Omaha Life Ins. Co. v. Sun Life Ins. Co. of America, 894 F.2d 1555, 1557 (11th Cir. 1990)(citations omitted). Once this burden has been met, the adverse party must show there remains a genuine issue for trial. Fed.R.Civ.P., 56(e). "The court must view all evidence in the light most favorable to the non-movant and must resolve all reasonable doubts about the facts in favor of the non-movant." United of Omaha Life Ins. Co., 894 F.2d at 1558.

The Defendant, in advising this Court that the method in Curran v. Kemper Nat. Servs, 2005 WL 894840 (11th Cir. 2005) replaces the traditional Rule 56 standard for determining summary judgment in ERISA cases, is misleading in that Curran, as well as Crume v. MetLife, 417 F. Supp. 2d 1258 (M.D. Fla. 2006), applies only to cases where

the abuse of discretion standard is utilized by the Court, i.e. when the Court assesses the Defendant's "reasonableness". Curran, 2005 WL 894840 at *7. In this case, as is discussed *infra*, the appropriate standard is *de novo*.

The Defendant's termination of Mr. Rodriguez' claim was wrong as a matter of law where it terminated the Plaintiff's LTD benefits based on the notion that a claimant is precluded from benefits if he works past the point when his condition materializes or exacerbates or when it is recommended by his physician that he cease work. Whatley v. CNA Insurance Companies, 189 F.3d 1310 (11th Cir. 1999) (court set aside the denial of LTD benefits to a plaintiff who suffered from a number of ailments, including kidney disease, kidney stones, and sleep apnea, but kept working until after the date he claimed he became disabled), Kirwan v. Marriott Corp., 10 F.3d 784 (11th Cir. 1994), Levinson v. Reliance Standard Life Ins. Co., 245 F.3d 1321, 1326 n.6 (11th Cir. 2001) ("We doubt that Levinson's status as a full-time employee constitutes evidence that he was able to perform the material duties of his occupation on a full-time basis."), Marecek v. Bellsouth Telecommunications, Inc., 49 F.3d 702, 706 (11th Cir. 1995) (When Ms. Marecek came back to work after a period of disability but could not handle it and quit, the court held that all she did was give it a go, "and her attempt to work does not forever bar her" from benefits), Godfrey v. BellSouth Telecommunications, Inc., 89 F.3d 755, 759 (11th Cir. 1996) ("with a dependent son, the plaintiff had no real choice other than to dope herself up with the medications that had been prescribed for her and get in the car, contrary to medical advice, drive herself to work, and then work while under the influence of a combination of very potent drugs").

Prudential's determination of Mr. Rodriguez' claim is also wrong as a matter of law where its denial was based on an alleged lack of objective medical evidence² in light of the overwhelming physical examinations and symptomatology that supported the consistent and unwavering opinions of the Plaintiff's primary care physician, pain management physician and consulting neurologist of the severity and complexity of Mr. Rodriguez' condition³, especially considering the very recent Eleventh Circuit opinion of Oliver v. Coca Cola, Nos. 05-16509 & 05-17072, U.S. App. LEXIS 20628 (11th Cir. Aug. 29, 2007).

We find that Coca Cola's denial of Oliver's LTD benefits claim was arbitrary and capricious, for a number of reasons. Coca Cola based its rejection of Oliver's claim on its contention that Oliver failed to provide "objective evidence" of his disability, stating that the "true organic etiology" of Oliver's pain had not been determined. R3-61, Exh. 30. Yet much medical evidence, especially as it relates to pain, is inherently "subjective" in that it cannot be quantifiably measured. Indeed, the only evidence of a qualifying disability may sometimes be the sort of evidence that Coca Cola and Broadspire characterize as "subjective," such as physical examinations and medical reports by physicians, as well as the patient's own reports of his symptoms.

Id. at. *34.

IV. Applicable ERISA Standard of Review: *De Novo*

The decision to deny benefits under an ERISA plan is evaluated under varying standards of review, depending on the express terms of the plan and factual circumstances of the case. The "default" standard is "*de novo*."

Consistent with established principles of trust law, we hold that a denial

² Plaintiff points out to this Court from a factual perspective that he did submit objective tests that were interpreted by his treating physician, pain management specialist as well as a consulting neurologist to reveal herniated discs, radiculopathy and neuropathy. However, Prudential's medical reviewers, an occupational specialist and a physician of unknown specialty, disagreed with such assessments and concluded the Plaintiff did not provide objective evidence that indicate these conditions or that would account for his severe pain or need for walking devices.

³ detailed in Plaintiff's Statement of Undisputed Material Facts and somewhat discussed *infra*.

of benefits challenged under §1132 (a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989); accord, Brown v. Blue Cross & Blue Shield, 898 F.2d 1556, 1559 (11th Cir. 1990).

The "burden of proving" that the plan contains the requisite discretionary authority is on the plan administrator and any "ambiguity in the wording of the policy should be resolved against [the insurer]". Kinstler v. First Reliance Standard Life Ins. Co., 181 F.3d 243, 252 (2nd Cir. 1999); accord, Kearney v. Standard Ins. Co., 175 F.3d 1084 (9th Cir. 1999). The terms of a plan that are required to provide discretionary authority to a plan administrator must be stated in "**express language**" that "is **unambiguous in its design** to grant discretion regarding entitlements to the fiduciary or administrator." Kirwan v. Marriott Corp., 10 F.3d 784, 789 (11th Cir. 1994)(emphasis added)(holding that the language: "the trustees have the final authority to determine all matters of eligibility for the payment of claims," is insufficient to grant discretionary authority to the administrator).

"Contrary to the argument of the insurance company that discretionary authority can be implied from the plan, the circuit courts which have found that particular ERISA plans granted discretion to plan administrators or fiduciaries, in cases decided after Firestone, have uniformly rested this finding upon **express language** of the ERISA plan before them. Indeed, this court has recently stated that the 'discretionary authority' to which Firestone refers must be '**expressly give[n]**' by the plan. Guy v. Southeastern Iron Workers' Welfare Fund, 877 F.2d 37, 38-39 (11th Cir. 1989)(finding requisite grant of discretionary authority where plan stated 'full and exclusive authority to determine all questions of coverage and eligibility' as well as 'full power to construe the provisions of [the] Trust' belonged to trustees); see also, Batchelor v. Int'l Broth. Of Elec. Workers Local 861 Pension & Retirement Fund, 877 F.2d 441, 443 (5th Cir. 1989)(grant of discretion found when plan stated 'full and exclusive authority to determine all questions of coverage and eligibility . . . [and] full power to construe the provisions' of the plan belonged to trustees); Boyd v. Trustees of United Mine

Workers Health & Retirement Funds, 873 F.2d 57, 59 (4th Cir. 1989)(discretion found where plan expressly gave trustees power of 'full and final determination as to all issues concerning eligibility for benefits' and 'authorized [them] to promulgate rules and regulations to implement th[e] Plan'); Lowry v. Bankers Life & Cas. Retirement Plan, 871 F.2d 522, 524 (5th Cir. 1989)(plan's language that committee had authority to 'interpret and construe' plan and 'to determine all questions of eligibility and status under the Plan' constituted grant of discretionary authority"; Bali v. Blue Cross & Blue Shield Association, 873 F.2d 1043, 1047 (7th Cir. 1989)."

Moon v. American Home Assurance Co., 888 F.2d 86, 88-89 (11th Cir. 1989)(emphasis added).

The APL Logistic America's Ltd. Plan ("the Plan") contains no discretionary language.⁴ Unlike most other group insurance plans, there is no provision dedicated for the purpose of conferring discretion nor is there any discretionary language contained in the Plan's proof of loss provision. Instead Defendant relies on four words contained in the Plan's definition of disability, that being, "You are disabled *when Prudential determines that...*"⁵ in its position that the Plan confers discretion on Prudential and thus that this Court should review its determination regarding Mr. Rodriguez under an arbitrary and capricious standard of review.⁶ The Defendant relies on the Newell v. Prudential, 725 F. Supp. 1233, 1242 (N.D. Ga. 1989), *affirmed*, 904 F.2d 644, 650 (11th Cir. 1990), in its argument that the Plan contains discretionary language. In that case, the Plan stated, that "hospital services...will be considered 'needed' only to the extent that Prudential determines them to be (a)related to the treatment of the sickness..." Id. at 1242. However, Calmbacher v. Prudential, 392 F. Supp. 2d 1364 (M.D. Fla. 2005), that

⁴ See the Plan documents located in the Claim File at 0001-0214.

⁵ See the Plan's entire definition of disability in paragraph 4 of the Plaintiff's Statement of Undisputed Material Facts (hereinafter "Plaintiff's Facts").

⁶ See pages 18-20 of the Defendant's Memorandum of Law in Support of its Motion for Summary Judgment (hereinafter "Defendant's Memorandum")

involved the exact language at issue in the case at bar, distinguished Newell⁷ which was relied upon by Prudential in that case, and held that the subject language did not confer discretion. “The language of the Policy permits Prudential to ‘determine’ benefits. It does not, however, contain language mandating that Prudential's decision is "final and conclusive" as there was in the policy in Jett and Paramore.” Id. at 1369. Calmbacher relied upon Eleventh Circuit precedent, most of which was decided more recently than Newell, namely, Shaw v. Connecticut General Life Ins. Co., 353 F.3d 1276 (11th Cir. 2003) (finding deference because the Summary Plan Description contained an express grant of discretion to the insurance company), Kirwan, 10 F.3d at 789 (the language in the plan fell short of an express grant of authority where the plan provided that the administrator would determine whether a benefit was properly payable, but there was no "no grant of discretion to accompany this mandatory function.") Jett v. Blue Cross & Blue Shield, 890 F.2d 1137, 1139 (11th Cir. 1989) (the plan expressly permitted the administrator to "make[] reasonable determinations in the administration of the [plan] ...such determinations shall be final and conclusive." and further provided that the administrator/insurance company "has the exclusive right to interpret the provisions of this Plan, so its decision is conclusive and binding."), and Paramore v. Delta Air Lines, 129 F.3d 1446, 1450 (11th Cir. 1997) (not only did the plan contain mandatory language that disability benefits "shall be determined" by the administrator, but the plan also expressly bestowed the authority "to interpret" the plan and decide all questions of eligibility, with its interpretation to be "final and conclusive.”) The Calmbacher court

⁷ The Court stated, “In Newell, the Court construed a different aspect of an employee welfare benefit plan written by Prudential, one involving hospital care coverage. The district court found that to the extent the Plan gave Prudential the right to determine the necessary length of hospital stays and the services and supplies “needed”, sufficient discretion had been delegated to invoke the deferential arbitrary and capricious review standard.” Calmbacher v. Prudential, 392 F. Supp. 2d 1367, fn 5 (M.D. Fla. 2005)

also held, “Finally, the lack of the type, level, and sufficiency of proof required to be submitted by the employee indicates no express grant of authority to Prudential.”

Calmbacher, 392 F. Supp. 2d at 1369.

Thus Defendant’s Plan documents do not contain express language, unambiguous in its design, or *any language for that matter* to give Prudential discretionary authority to determine eligibility for benefits or to interpret the terms of the plan.

In conducting a *de novo* review, aside from standing in the shoes of the Defendant without according its decision deference, the district court is not limited to the information available to the plan administrator at the time of the coverage determination.

Kirwan v. Marriot Corporation, 10 F.3d 784 at 789-790 (11th Cir. 1994), Moon v.

American Home Assurance Company, 888 F.2d 86, 89 (11th Cir. 1989), Grant v.

Provident Life and Grant v. Provident Life & Accident Insurance Company, 2001 U.S.

Dist. LEXIS 21557 (S.D. Fla. June 27, 2001).

A. Alternatively, the Heightened Scrutiny Standard Applies

If this Court finds discretionary language in the Plan, the heightened arbitrary and capricious standard of review would be applicable to Defendant’s claim decision. It is quite clear from the Plan documents that Defendant Prudential underwrites APL’s long-term disability benefits. However, Defendant also makes determinations as to whether claimants are disabled. The Defendant’s dual role creates a clear conflict of interest in that it both determines and pays long-term disability benefits.

Fiduciary conflicts of interests are most clearly found when, as in the case before us, an insurer administers its own plan. In Brown, 898 F.2d 1556, an insurance company not only insured the plan benefits, but it also had the right to interpret the plan and make

final determinations as to eligibility for benefits. The Eleventh Circuit deemed this an “inherent conflict between the roles assumed,” as benefits denied to plan participants and beneficiaries would be retained by the insurer. Conversely, when the insurer determined that benefits were payable, the funds came out of the insurer’s own assets. Thus, the Eleventh Circuit determined that the insurance company’s “fiduciary role lies in perpetual conflict with its profit-making role as a business.” Brown, 898 F.2d at 1561. The Brown court reasoned that, “when an insurance company serves as ERISA fiduciary to a plan composed solely of a policy or contract issued by that company, it is exercising discretion over a situation for which it incurs 'direct, immediate expense as a result of benefit determinations favorable to plan participants.'" Id. at 1561. More recently, the Eleventh Circuit has clarified its position, stating that an inherent or apparent conflict is presumed to be an actual conflict of interest, because “a conflicted fiduciary may favor, consciously or unconsciously, its interests over the interests of the plan beneficiaries.” Adams v. Thiokol Corp., 231 F.3d 837, 842 (11th Cir. 2000).

Where a conflict of interest exists for the administrator, the arbitrary and capricious standard is still applicable, but the conflict of interest must be weighed as a “factor in determining whether there is an abuse of discretion.” Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed. 2d 80 (1989). That is, the review in such cases is still “for an abuse of discretion, but it is less deferential.” Regula v. Delta Family-Care Disability Survivorship Plan, 266 F.3d 1130 (9th Cir. 2001)(vacated on other grounds). “[A] fiduciary operating under a conflict of interest may be entitled to review by the arbitrary and capricious standard for its discretionary decisions as provided in the ERISA plan documents, but the degree of deference actually

exercised in application of the standard will be significantly diminished." Brown, 898 F.2d at 1568. *See also*, Florence Nightingale v. Blue Cross/Blue Shield of Alabama, 41 F.3d 1476,1481 (11th Cir. 1995) (The arbitrary and capricious deference is diminished if the claims administrator was acting under a conflict of interest); Sahlie v. Nolen, 984 F. Supp.1389, 1401 (M.D. Ala 1997).

Although Defendant states in its Memorandum that the Newell Court found that, "Prudential had the full authority to determine eligibility for benefits..."⁸, the Eleventh Circuit held that Prudential's conflict of interest warranted the heightened standard. "Prudential stands in a position identical to that of Blue Cross in *Brown*. The district court erred in holding that this case did not warrant increased examination for abuse of discretion." Newell, 904 F. 2d at 650.

The first step in reviewing the interpretations and decisions of a fiduciary with an inherent conflict of interest is for the district court to make a *de novo* review of the interpretations and decisions, in order to determine whether they were legally "correct" (*i.e.* what the court would have done) under the relevant plan provisions. Brown, 898 F.2d at 1566, n.12. If the fiduciary's interpretations and decisions are legally correct, the district court need not consider the fiduciary's self-interest, and the fiduciary's interpretation or decision will be upheld. Brown, 898 F.2d at 1566, n.12. If the Plan Administrator's interpretations or decisions were legally "wrong" (*i.e.* not what the court would have done), the next step would be for the district court to consider whether the interpretations or decisions were "wrong, but apparently reasonable." *See* Brown, 898 F.2d at 1566-67. If the fiduciary made decisions that were "wrong" and "unreasonable" then the decisions must be reversed by the court, as being "arbitrary and capricious."

⁸ See Defendant's Memorandum at page 20.

However, if the decisions were “wrong, but apparently reasonable,” the analysis must continue further.

Even if a court finds Defendant’s denial wrong but reasonable, the burden shifts to the Defendant to prove that its interpretation of the policy and medical evidence was not tainted by self-interest, *based on a benefit conferred to the plan participants/beneficiaries as a class.* Lee v. Blue Cross/ Blue Shield of Alabama, 10 F.3d 1547 (11th Cir. 1994). Such notion could not possibly be proven by the Defendant where benefits are funded by the insurer who determines the claims as well, as it is disingenuous for the Defendant to assert that participants and beneficiaries benefit from such an arrangement.

V. **It Was Arbitrary and Capricious for Prudential to Rely On Its Own Internal Medical Review⁹ and Occupational Specialist Over the Opinions of the Non-Treating Consulting Neurologist with Regard to the Plaintiff’s Back/Leg/Knee Conditions and the Plaintiff’s Treating Physicians with Regard to Plaintiff’s Coumadin-Related Restrictions.**

Notwithstanding the standard of review that this Court applies to the Defendant’s determination of Mr. Rodriguez’ claim, Defendant’s actions were blatantly arbitrary and capricious when it chose to adopt its consulting occupational specialist’s paper medical

⁹ This section will focus on Dr. Heaney’s medical file review only, as the actual internal medical review report of Dr. Richard Day is not contained in the file and only appears in the context of Defendant’s SOAP notes. As such, Dr. Day’s qualifications, board certifications if any, or documents reviewed cannot be discerned. As explained in Plaintiff’s Facts, footnote 87, such information, including the actual medical report, has been requested in Plaintiff’s Request for Production to which the Defendant has responded, “To the extent that any such document exist, produced as part of Prudential’s initial disclosures.” For purposes of this section, however, assuming that Dr. Day does not possess the particular areas of expertise necessary to evaluate the Plaintiff’s condition, Plaintiff’s position on Defendant’s arbitrary and capricious adoption of Dr. Heaney’s conclusions applies to Dr. Day’s conclusions as well. As the Court will notice, Dr. Day’s conclusions, that were rendered before Dr. Heaney reviewed the file, are almost identical to Dr. Heaney’s and include but are not limited to: (1) MRI only shows degenerative changes that would be common for someone of the Plaintiff’s age; (2) It is routine that people are able to have invasive procedures while being anticoagulated; and (3) there is no limitation based on the history of deep vein thrombosis and pulmonary embolism (which obviously misses the mark with regard to why this condition contributes to Mr. Rodriguez’ inability to work.)

review¹⁰ over the opinions of Mr. Rodriguez' treating physician, pain management physician, and neurologist with whom he consulted on two occasions. While it may be the law that the treating physician is not "automatically" accorded special weight, it is well-established that, "Plan Administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." See Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003). Of course, the credibility and qualifications of disagreeing physicians must be considered when determining whose conclusion is more accurate. Id.

Dr. Deborah Heaney is board certified in occupational medicine.¹¹ She has no other apparent training or expertise in neurology, orthopedics, cardiology, pain management, internal medicine or any other area of medicine. Courts have recognized that the failure to incorporate medical expertise appropriate to the circumstances renders subsequent denials arbitrary and capricious. Calvert v. Firststar Finance, Inc., 409 F.3d 286, 295-6 (6th Cir. 2005), Kunin v. Benefit Trust Life, 910 F.2d 534, 538 (9th Cir. 1990) (no indication in the record that the doctors with whom the medical director consulted had any significant experience with or particular expertise concerning autism) Zavora v. Paul Revere 145 F.3d 1118, 1122-1123 (9th Cir. 1998) (improper to have relied on a physician without relevant expertise instead of ophthalmologist regarding a thorn injury to the eye); Moreover, Dr. Heaney's purpose in her occupation, is not to treat patients as she has no practice, but to safely return employees to work as soon as possible

¹⁰ "[File review] is a factor to be considered in reviewing the propriety of an administrator's decision regarding benefits: We regard [the plan administrator's] decision to conduct a file review rather than a physical exam as just one more factor to consider in our overall assessment of whether Liberty acted in an arbitrary and capricious fashion." Evans v. Unumprovident Corp., ---F.3d---, 2006 WL 146194, *9 (6th Cir. Jan. 20, 2006)

¹¹ Please refer to footnote 87 and paragraph 63 of Plaintiff's Facts.

after an illness or injury.¹² The Supreme Court has stated, “Physicians repeatedly retained by benefit plans may have an incentive to make a finding of ‘not disabled’ in order to save their employers money and preserve their own consulting arrangements.” Nord, 538 U.S. at 832 (citations and quotations omitted). Thus Dr. Heaney’s conclusions with regard to Mr. Rodriguez’s specific back condition as interpreted by MRI and physical examination must be called into question, especially when they are in direct conflict with the consistent opinions of the Plaintiff’s treating physicians and a consulting neurologist, who has no significant relationship with the Plaintiff.

The MRI Results: In an attending physician statement dated June 12, 2003, Dr. Harris, Mr. Rodriguez primary care physician, supplied Mr. Rodriguez’ February 26, 2002 MRI results as evidence of herniated discs.¹³ The October 1, 2003 lumbar spine MRI impression was dessication of the L4-5 disk with concentric annular bulge and small right paracentral disk protrusion and desiccation of the L5-S1 disk with mild concentric annular bulge.¹⁴ After reviewing Mr. Rodriguez’ MRI findings, the assessment of Dennis Dewey, M.D., consulting neurologist, was lumbar radiculopathy and neuropathy.¹⁵ Dr. Florete, in a letter dated December 8, 2003, noted the October 2003 MRI to reveal disc degeneration with moderate disc herniation at L4-5 touching thecal sac¹⁶. The SSA opinion states, “The claimant has a well documented history of lumbar disc disease with documented dessication of the L4-L5 disc with noted disc protrusion...confirmed by...MRI from February 2002.”¹⁷ Dr. Heaney’s opinion, even after reviewing the

¹² See Exhibit A of Plaintiff’s Facts.

¹³ Claim File at 0806, 0808.

¹⁴ Claim File at 0645.

¹⁵ Claim File at 0654.

¹⁶ Claim File at 0674.

¹⁷ Claim File at 0261.

aforementioned interpretations and despite her having any apparent expertise in neurology, was that were only age-appropriate degenerative changes on 2 disk levels, that such findings were not a cause for severe back pain, and that there was no evidence of radiculopathy or neuropathy.

The physical exam assessments are numerous and detailed in Plaintiff's Statement of Undisputed Material Facts, and include degenerative disk disease, myofascial pain, arthropathy, neuropathy, radiculopathy, severe lumbosacral pain, recommendations for steroid injections and facet block injections, restrictions of being unable to sit or stand for even short periods of time, the need for walking devices, prescriptions for narcotic and non-narcotic medications, and unwavering opinions from the Plaintiff's treating physicians that he cannot work. Dr. Dewey, who is not one of Mr. Rodriguez' treating physicians and thus not vulnerable to an attack by the Defendant that he harbors bias, found upon physical exam, back and neck pain, chronic low back pain, neuropathy, lumbar radiculopathy, and that the Plaintiff could sit for less than thirty minutes, and recommended Neurontin.¹⁸ Yet Dr. Heaney's opinion, without examining Mr. Rodriguez and without any apparent expertise in orthopedics or neurology, was that there was no evidence of radiculopathy or neuropathy and that the only impairment noted was pain which is unlikely to be severe and disabling. She also found no explanation as to why Mr. Rodriguez would need walking aids. She found the Plaintiff had restrictions of no lifting over 20 pounds, that he needs to sit/stand as needed and can only perform limited bending and twisting. Dr. Heaney concluded that nothing in the medical records from May 2003 supported disability.¹⁹ It is of note that much of Dr. Heaney's opinion

¹⁸ Claim File at 0642 and 0654.

¹⁹ Claim File at 0260.

centered on an allegation of lack of objective medical evidence. *See Oliver v. Coca Cola*, Nos. 05-16509 & 05-17072, U.S. App. LEXIS 20628 (11th Cir. Aug. 29, 2007) , Menard v. Hartford, Menard v. Hartford, Case No. 6:05-cv-1145-Orl-31DAB, 2006 U.S. Dist. LEXIS 78767 (M.D. Fla. Feb. 23, 2007) (Judge Presnell discussed the importance of the Plaintiff's subjective complaints and refused to discount the same in favor of the Defendant's medical consultant's opinion without good reason: "Under such circumstances, this Court will not credit the opinions of Hartford's chosen physicians over the subjective complaints of the Plaintiff with regard to his own pain, and the assessment of his chosen Physician.") Id. at 20. The Defendant's reliance on Dr. Heaney's conclusion with regard to Mr. Rodriguez' restrictions and limitations attributable to his back condition, in light of Dr. Heaney's lack of specific expertise and the weight of the evidence in its record, constitutes an abuse of discretion.

Dr. Heaney's conclusions with regard to Mr. Rodriguez' Coumadin usage is even more shocking. Dr. Heaney disagreed with the unanimous opinions of the Plaintiff's treating physicians about the risks inherent in taking the Plaintiff off of his Coumadin treatment in order to perform invasive treatments to relieve Mr. Rodriguez' pain. The record is clear that the Plaintiff's physicians considered the same on numerous occasions and that Mr. Rodriguez' cardiologist was consulted and thus had input in the ultimate decision. On February 7, 2003, the Institute of Pain Management advised the Plaintiff to check with his cardiologist to see if he could stop Coumadin for a few days to perform an interventional procedure on his thoracic/lumbar area.²⁰ On July 11, 2003 the Institute of Pain Management recommended a consultation with Mr. Rodriguez' cardiologist to see if it was possible to take him off Coumadin for five days in order to give him facet

²⁰ See October 31, 2003 narrative from Institute of Pain Management

injections.²¹ Subsequently on August 8, 2003, the recommendation of the Institute of Pain Management was to not take any risk to stop Coumadin because of Mr. Rodriguez' rare blood disorder.²² On October 3, 2003, the Institute of Pain Management notes document that Mr. Rodriguez was seeking help from a local neurologist and considering having major surgery to his lower back but noted that that since the Plaintiff's arrival to pain management, any intervention has been disallowed by chronic Coumadin use.²³ On October 31, 2003, the Institute of Pain Management noted it was not able to proceed with any lumbar intervention because of Coumadin.²⁴ On December 8, 2003, Dr. Florete stated, "Again, I do not want to take a chance to stop his Coumadin where it would lead into another blood clot in his lower leg which could be potentially lethal."²⁵ Obviously, the opinion of Mr. Rodriguez' cardiologist was considered and it was ultimately believed that stopping Coumadin would be too risky and that it could result in paralysis and even death.²⁶ Interestingly, Dr. Heaney felt otherwise, even without examining Mr. Rodriguez or knowing the particulars of his cardiac condition or having any sort of apparent training in cardiology. After Dr. Heaney rendered her opinion, and there was disagreement in the record as to the risks of taking the Plaintiff off Coumadin, albeit with the weight of the evidence indicating that such treatment option would present a significant risk, Prudential could have easily consulted with the Plaintiff's cardiologist, or with its own cardiologist on this issue. Yet there is not one record from any cardiologist Defendant's entire file. Woo v. Deluxe Corp., 144 F.3d 1157, 1161(8th Cir.1998)

²¹ Claim File at 0622.

²² Claim File at 0634.

²³ Claim File at 0649.

²⁴ Claim File at 0661.

²⁵ Claim File at 0674.

²⁶ See Dr. Florete's December 8, 2003 letter. Claim File at 0674.

(concluding that the insurer's failure to have an expert review a claim based on a rare disease was evidence of failure "to use proper judgment or thoroughly investigate [the claim]"). The complications that Coumadin presented with regard to Mr. Rodriguez inability to undergo typical invasive treatment to relieve his pain were and are quite central to his disability. Thus the failure of the Defendant to investigate this issue and simply adopt the opinion of its hired paper reviewer is blatant arbitrary and capricious behavior. An improper motive sufficient to set aside a fiduciary's decision may be inferred from the fiduciary's failure to investigate or to interpret honestly evidence that greatly preponderates in one direction. Brown v. Blue Cross & Blue Shield of Alabama, Inc., 898 F.2d 1556, 1566 n. 11 (11th Cir. 1990) See also Shannon v. Jack Eckerd Corp., 113 F.3d 208, 212 (11th Cir.1997) (accepting the bald assertions of its medical advisors without examining their underlying bases, and failing to obtain additional relevant information is arbitrary and capricious.), Brock v. Walton, 794 F.2d 586 (11th Cir. 1986) (fiduciary's duty to investigate is a key facet of prudence), Kunin, 910 F.2d at 538 (abuse of discretion to deny without obtaining relevant information); Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461,1463-64 (9th Cir. 1997) (Burden on administrator to obtain confirmatory, necessary and easily obtainable information), Teeter v. Supplemental Pension Plan of Consol. Rail Corp., 705 F. Supp. 1089, 1095 (E.D. Pa. 1989) (holding that fiduciary has an affirmative responsibility to gather information that bears on the claim and is reasonably available and failure to do so is reversible error), Peterson v. Continental Casualty Co., 116 F.Supp.2d 532, 540 (S.D.N.Y. 2000) (failure to clarify disputed issues of fact and/or uncritically accepting the opinions of own consultants was arbitrary and capricious).

VI. Other Arbitrary and Capricious Aspects of Prudential's Determination

- A. Prudential's determination that Mr. Rodriguez was not disabled because he worked after his condition commenced is unreasonable and based on fallacious reasoning.

As illustrated *supra* by the Eleventh Circuit precedent cited, such notion is wrong as a matter of law. However, Prudential's reasoning is also flawed from a factual perspective. Defendant repeatedly made the determination that Mr. Rodriguez could work with his condition since he allegedly worked for over a year after his back condition was diagnosed in February of 2002.²⁷ Such statement is erroneous and fails to acknowledge that Mr. Rodriguez was in and out of work throughout the year of 2002, which is evident from the Defendant's own file.²⁸

- B. Prudential's based its denial in part on the allegation that in August of 2003, Mr. Rodriguez realized that prayer and meditation took away all of his pain.

Defendant's SOAP notes from November 26, 2003 state that, "In addition, records document ee was able to cease meds w/out w/drawal symptoms and found that daily prayer and meditation was helpful...Plan: Disallow LTD"²⁹ The same reasoning is mentioned in Defendant's' denial letters.³⁰ The notes fail to mention that although on this one particular August 8, 2003 visit, the Plaintiff felt that meditation and prayer had improved his condition, he returned a couple of weeks later to Dr. Harris with severe back and leg pain, and throughout September and October experienced severe pain in is head, neck, shoulders, knees and back, requested new type of medications, was referred to a neurologist and neurosurgeon and for facet joint procedures and needed a cane for

²⁷ See one instance in Defendant's November 26, 2003 denial letter in the Claim File at 0909-0913.

²⁸ See Defendant's SOAP notes that discuss Mr. Rodriguez' out of work history in the Claim File at 0828, as well as Mr. Rodriguez' approved leave under FMLA in the Claim File at 0447.

²⁹ Claim File 0667-1669.

³⁰ See Defendant's November 26, 2003 denial letter in the Claim File at 0909-0913.

balance. Specifically, on August 22, 2003, Dr. Harris noted that Mr. Rodriguez was still in severe pain³¹ and extended his disability certification another thirty days.³² On September 22, 2003, Dr. Harris again documented severe back and leg pain,³³ and extended Mr. Rodriguez' work excusal another thirty days.³⁴ A summary from the Institute of Pain Management dated October 31, 2003 similarly recounted that on August 8, the Plaintiff was happy that he was able to stop certain drugs, but on October 3 he came back with severe pain and requested new type of medications for his lower back, was experiencing severe burning across his lower back, and that he was referred to a neurologist and neurosurgeon for his myofascial pain in neck, shoulders, back, and facet symptoms of his lower back.³⁵ As detailed in Plaintiff's Facts, Mr. Rodriguez' condition only worsened from that point in time.

C. Defendant did not apply the information revealed in its vocational assessment to its analysis of Mr. Rodriguez' Claim.

Prudential completed an internal vocational assessment on Mr. Rodriguez' position of Help Desk Specialist.³⁶ The assessment found that Mr. Rodriguez' occupation required him to occasionally lift, carry, push and pull up to ten pounds, frequently use his upper extremities for reaching, handling and fingering and occasionally stand or walk during the course of the day. However, nothing was done with this information. There is no indication these requirements were assessed in the context of Mr. Rodriguez' restrictions and limitations. For example, even Dr. Heaney 's restrictions for Mr. Rodriguez included limited twisting and bending, which would be difficult in a

³¹ Claim File at 0636.

³² Claim File at 0637.

³³ Claim File at 0639.

³⁴ Claim File at 0640.

³⁵ Claim File at 0741.

³⁶ Claim File at 0856.

job that required frequent use of the upper extremities for reaching and handling. In fact, a PT Clinician that disallowed benefits, after an “AP” approved Mr. Rodriguez’ claim earlier that day³⁷, noted that the Plaintiff had pain on hyperextension (bending back) and lateral bending (to side) but that such motions were not performed during his workday.³⁸

VII. Conclusion

The claim file in this case presents a man who did not want to stop working. After being in and out of the hospital for episodes of deep vein thrombosis and pulmonary embolism, he requested a sedentary job from his employer. After being in and out of work for severe back and leg pain, as complicated by his Coumadin treatment, he returned to his job. In May of 2003, however, he reached a new low in his medical condition, and the claim file is filled with frequent doctor visits documenting increased breakthrough pain, injections in his knee, changes in medications, and the start of his treatment with a pain management clinic during that exact time period. Still, Prudential attempted to avoid liability for this claim based on the notion that Mr. Rodriguez worked after his conditions materialized. The Eleventh Circuit has said it will not penalize employees for attempting to stay at work with their illnesses or injuries. Prudential has employed several tactics in Mr. Rodriguez’ claim that illustrate bad insurance practice and arbitrary and capricious behavior precluded by the Eleventh Circuit, namely, failure to gather all relevant information and fully investigate a claim, for example, with regard to the Plaintiff’s Coumadin-related restrictions; arbitrarily discounting treating and other physicians’ opinions in favor of unqualified paid medical reviewers; selective review of evidence, for example, with regard to the one occasion where Mr. Rodriguez felt better

³⁷ Claim File at 0834.

³⁸ Claim File at 0836.

due to positive thought in August of 2003; and the dismissal of credible reports of pain and physical exam findings.

Irrespective of the standard of review employed by this Court, Prudential's behavior toward Rafael Rodriguez cannot be tolerated.

WHEREFORE, Rafael Rodriguez, Jr., respectfully requests that this Court reverse the Defendant's determination of his disability claim, and award him his past due benefits plus interest as well as his attorney's fees and costs associated with this litigation.

Respectfully submitted,

WAGAR FEIT PA
Attorneys for Plaintiff
3250 Mary Street, Suite 302
Coconut Grove, FL 33133
305-443-7772
305-443-1969 – fax

BY: /s/ Carrie Feit
CARRIE J. FEIT
FL Bar No. 470066
cfeit228@bellsouth.net

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 7th day of September, 2007, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF. I also certify that the foregoing document is being served this day on counsel for Defendant, Clifford L. Rostin, Esq., Wilson, Elser, Moskowitz, Edelman & Dicker LLP, 3800 Bank of America Tower, 100 Southeast Second Street, Miami, FL 33131 via transmission of Notices of Electronic Filing generated by CM/ECF or in some other authorized manner for those counsel or parties who are not authorized to receive electronically Notices of Electronic Filing.

BY: /s/ Carrie Feit
CARRIE J. FEIT
FL Bar No. 470066
cfeit228@bellsouth.net