

UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF RHODE ISLAND

FRANCIS J. PERRY, III,  
Plaintiff,

v.

C.A. No. 14-276L

AETNA LIFE INSURANCE COMPANY,  
Defendant.

**MEMORANDUM AND ORDER**

RONALD R. LAGUEUX, SENIOR U.S. DISTRICT JUDGE.

This matter is before the Court on the parties' cross motions for summary judgment. The dispute results from Defendant's denial of Plaintiff's claim for long-term disability benefits, pursuant to a group insurance policy provided by Plaintiff's employer, Cox Enterprises, Inc., and administered by Defendant. The insurance policy is an employee benefit plan, governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001 et seq. The parties agree that Defendant is assigned discretionary responsibility and fiduciary authority to determine eligibility for benefits under the plan. For reasons explained below, the Court denies Plaintiff's motion for summary judgment, and instead grants judgment in favor of Defendant.

### Background

Plaintiff Francis J. Perry, III, is a middle-aged single, white male, who lives alone. Starting April 25, 2011, he worked at Cox Enterprises, Inc., ("Cox Cable") as a customer service representative. His duties included answering phone calls from customers who called with requests, complaints and problems concerning service and billing for cable television, internet and telephone services.

Plaintiff's life had been a difficult one, full of tragedy. When Plaintiff was a teenager, his seven-year-old brother died when struck by a car while Plaintiff was babysitting for him. Plaintiff's mother died soon after. Later in his life, he witnessed a terrible car accident. While working at Cox Cable, a co-worker with whom he had become friendly also died. This loss triggered memories of the earlier tragedies and Plaintiff began to suffer from panic attacks and nightmares. Dealing with occasionally angry Cox Cable customers exacerbated Plaintiff's anxiety. On August 23, 2012, Plaintiff suffered what he describes as "a meltdown" in the office - he walked off the job and has not returned.

According to the terms of the insurance policy, the Long Term Disability Flex Plan ("the Plan"), Plaintiff was not eligible for benefits until six months after his last day of work. To qualify for total disability benefits at this point, a

claimant must be unable to perform his or her own job. In April 2013, Plaintiff submitted his claim for benefits, asserting that he suffered from Post Traumatic Stress Disorder ("PTSD") and disabling anxiety. The claim was denied by Defendant in June 2013. Defendant's letter stated that "the clinical information submitted fails to support functional impairment from a psychological assessment from August 23, 2012 to present."

In the meanwhile, Plaintiff had also applied to the Social Security Administration for disability benefits, and was notified in June 2013 that he qualified for Social Security Disability Insurance ("SSDI").

Plaintiff appealed the denial of his insurance benefits, and was denied again in October 2013. In its letter to Plaintiff, Defendant explained that his file was reviewed by "an independent peer physician, who specializes in Psychology." In addition, "peer-to-peer teleconferences" took place with the Plaintiff's therapists. The letter continued:

After review of the aforementioned clinical information it has been determined there is a lack of medical evidence to support your inability to perform your own occupation. Clinical information reviewed noted you have PTSD. However, the records review for the time-period; under benefit, consideration (sic) did not denote findings of irritability, sleep disturbance and inability to concentrate. The records did not reveal you had any impairment in your cognitive functioning. The provided documentation did not contain specific examples of your behavior to collaborate (sic) you were

psychologically impaired from performing any particular task.

The letter also explained that Plaintiff's receipt of SSDI benefits was not given "significant weight" by Defendant, due to the differences in the regulations and criteria between the Plan and those of the Social Security Administration, as well as possible discrepancies in the material available to each entity.

Plaintiff next retained a lawyer who wrote to Defendant in November 2013 requesting that it reconsider its denial of benefits. Plaintiff's lawyer submitted additional medical records and stressed that the SSDI determination was "in and of itself, a conclusion that he is unable to perform his own occupation." Defendant responded on March 12, 2014, stating that it reviewed the additional clinical information but that it had not changed its earlier decision. The letter also explained that the appeal decision issued in October 2013 was "a final level appeal determination," and consequently, "we are not able to honor your request for another appeal review." This lawsuit ensued.

#### **Standard of Review**

Although the present matter reaches the Court on the parties' cross motions for summary judgment, the directives set forth in Fed. R. Civ. P. 56(a) are modified in ERISA cases. The First Circuit has stated that:

...in an ERISA case where review is based only on the administrative record before the plan administrator and is an ultimate conclusion as to disability to be drawn from the facts, summary judgment is simply a vehicle for deciding the issue. This means the non-moving party is not entitled to the usual inferences in its favor.

Orndorf v. Paul Revere Life Ins. Co., 404 F.3d 510, 517 (1st Cir. 2005).

Moreover, in ERISA cases, the Supreme Court has held that when a plan administrator exercises discretion in determining eligibility for benefits, as is the case herein, the plan administrator's decision will be reversed only if it is found by the court to be arbitrary and capricious. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). This standard is described by the Supreme Court as a deferential standard, intended to prevent or rectify an abuse of discretion by the fiduciary. Varity Corp. v. Howe, 516 U.S. 489, 514-515, (1996).

Under this standard, a reviewing court asks whether a plan administrator's determination is plausible in light of the record as a whole, or, put another way, whether the decision is supported by substantial evidence in the record.

Niebauer v. Crane & Co., Inc., 783 F.3d 914, 923 (1st Cir. 2015).

When making a claim to the plan administrator, it is the claimant's burden to establish disability. Dutkewych v. Standard Ins. Co., 781 F.3d 623, 634 n.7 (1st Cir. 2015). This Court's task is not to make a *de novo* review of Plaintiff's condition, but instead to review Defendant's decision and its reasonableness

in light of the material before it. When applying this standard, the Court must confine its review to the record that was before Defendant when it made its decision. Cook v. Liberty Life Assur. Co. of Boston, 320 F.3d 11, 19 (1st Cir. 2003); Vukic v. Melville Corp., 39 F. Supp. 2d 163, 166 (D.R.I. 1999).

### **Analysis**

#### ***The Plan's time frame***

Defendant asserts that Plaintiff failed to establish that he was disabled as of February 23, 2013, the eligibility date established in the Plan. Plaintiff argues that Defendant arbitrarily ignored evidence of his disability during the six-month waiting period between the day that he left his job and the start of the eligibility period. This dispute reflects a difference of perspective. Apparently, Defendant's interpretation is that the purpose of the Plan is to provide benefits to claimants who sustain a serious injury, or otherwise become disabled, and have not sufficiently recovered six months later to return to work. Plaintiff, on the other hand, claims that the stresses of his job at Cox Cable contributed to his becoming totally disabled and that, although those symptoms may have slightly improved by the end of the waiting period, they would be certain to return in full force if he returned to his job. Consequently, Plaintiff asserts that the period immediately after his departure from work provides the most relevant evidence

of his disability.

A second dispute between the parties concerns Defendant's refusal to consider materials presented to it subsequent to the denial of Plaintiff's appeal. While these materials were submitted to Defendant in connection with an untimely request for reconsideration, they included information and medical notes about Plaintiff for the pertinent time period. These disputes must be resolved through reference to the terms of the Plan and the Summary Plan Description ("SPD").

The Plan is clear that there is a six month waiting period between the onset of total disability and the commencement of benefits. The Plan states that it "will pay a Monthly Benefit for a period of total disability caused by a disease or accidental bodily injury. There is a waiting period of six months. (This is the length of time that must pass before benefits start.)" Administrative Record ("AR") 00007-8. The Plan goes on to explain that, "Your period of total disability ends on the first to occur of...[T]he date you fail to give proof that you are still totally disabled or comply with the Plan guidelines." Id. These terms operate to require that a claimant must be totally disabled from the start to the conclusion of the six-month waiting period, and that, most importantly, the claimant must still be totally disabled on the post-waiting-period eligibility date.

People do recover from serious, disabling injuries and illnesses. Although not always, medical treatment can result in the improvement and mitigation of a disability, including even mental illness. It is not unreasonable for Defendant to require that a claimant demonstrate a prolonged disability that continues to render the claimant unable to work six months after its onset. The Court is not unsympathetic to Plaintiff's assessment that his work exacerbated his mental health problems, but recognizes also that it is not unreasonable for Defendant to conclude that six months of rest and therapy had resulted in an improvement of Plaintiff's symptoms such that he could return to work.

Defendant argues that it was not an abuse of discretion for it "to review Plaintiff's LTD claim for the period of time for which he was actually eligible for benefits (i.e., starting from February 23, 2013)." In fact, according to the terms of the Plan, Defendant would have to find that Plaintiff was totally disabled not only throughout the waiting period, but also at its conclusion. It appears that Defendant confined its assessment to the conclusion of the waiting period. Nonetheless, because the burden was on Plaintiff to prove that he was totally disabled as of February 23, 2013, the Court concludes that it was not unreasonable for Defendant to focus its review of Plaintiff's medical condition at the point of eligibility.

After Plaintiff's claim had been denied, and the denial

appealed and denied again, Plaintiff hired a lawyer who, on November 21, 2013, wrote to Defendant requesting reconsideration of his claim. In the letter, Plaintiff's counsel argued that Defendant had given insufficient weight to the Social Security Administration's determination that Plaintiff was entitled to disability benefits. He also provided additional medical records obtained from Plaintiff's therapist, covering the period July 2012 through October 2013, which, in his words, show that Plaintiff "was having disabling panic attacks after the period of February 23, 2013 and that these continue today." According to Plaintiff, these medical records included a September 2013 treatment note, the contents of which had been discussed in a telephone call between Plaintiff's therapist and Defendant's independent medical examiner that same month. However, the actual treatment note was never submitted to Defendant with Plaintiff's initial claim or on appeal.

Plaintiff received no reply to his November 2013 reconsideration request and he wrote again in February 2014. Defendant responded in March 2014, stating that the additional clinical information was reviewed, but that the decision of October 1, 2013, was unchanged. The letter went on to explain that "The appeal decision rendered on your client's claim was a final level appeal determination. As such, he does not have another appeal available to him. Therefore, we are not able to

honor your request for another appeal review." The letter included guidance concerning Plaintiff's right to bring a civil action under ERISA.

Plaintiff objects, now, to Defendant's refusal to consider this latterly-submitted treatment note as part of the administrative record. This treatment note was submitted to Defendant at the end of November 2013, approximately two months after Defendant denied Plaintiff's appeal. This material is properly excluded from the administrative record, which consists exclusively of the material available to Defendant at the time it rendered its decisions. The First Circuit has stated, "In reviewing an ERISA determination for arbitrariness, we and the overwhelming majority of other circuits have held that there is a strong presumption that the required deferential review of a plan administrator's benefits decision should be limited to the evidentiary record presented to the administrator." Lopes v. Metropolitan Life Ins. Co., 332 F.3d 1, 5 (1st Cir. 2003); see also Cook v. Liberty Life, 320 F.3d at 19. In accordance with these First Circuit rulings, this Court holds that Defendant was not arbitrary or capricious in its refusal to reconsider the denial of Plaintiff's appeal when presented with additional medical records in November 2013.

As for the Social Security Administration's decision to provide Plaintiff with SSDI benefits, the First Circuit has been

clear and consistent that "benefits eligibility determinations by the Social Security Administration are not binding on disability insurers." Cook v. Liberty Life, 320 F.3d at 16 n.5.

Consequently, it was no abuse of discretion for Defendant to accord the Social Security determination lesser weight than other factors.

### ***The Administrative Record***

Plaintiff contests Defendant's conclusion that he presented insufficient medical evidence to support his claim of total disability. The administrative record is extensive and full of varying medical evaluations, from various providers, covering a period from before Plaintiff left his employment at Cox Cable up through and after Defendant's denial of his appeal. Moreover, the administrative record consists mostly of hard-to-read handwritten medical notes. If that were not challenging enough, the records are very poorly reproduced, ordered randomly, with many redundant copies of the same records.<sup>1</sup> The Court has reviewed the medical evidence, concentrating on those records cited by Plaintiff in his memorandum supporting his motion for summary judgment, as those records are presumably most at odds with Defendant's finding that Plaintiff is not totally disabled.

### ***Dr. John Machata***

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<sup>1</sup> Many of the records submitted by Defendant are date-stamped August 16, 2023.

Plaintiff's primary care physician is Dr. John Machata. He treated Plaintiff while he worked at Cox Cable, and, as revealed by the records, saw him frequently, as much as once a week, in the ensuing couple of years. Dr. Machata noted that Plaintiff was on medical leave following his departure from Cox Cable, and he filled out the necessary paperwork for Plaintiff to receive temporary disability insurance. Dr. Machata diagnosed Plaintiff with these medical issues (coded for insurance purposes): abdominal pain; reflux esophagitis; diverticulitis of colon; mixed hyperlipidemia; pain in joint involving lower leg; iron deficiency; insomnia; obesity; hypertension and major depressive disorder recurrent episode. Dr. Machata's notes consistently describe Plaintiff as "Well nourished and well developed in no acute distress. Obese. Affect is normal and appropriate." Dr. Machata consistently noted Plaintiff's anxiety, and prescribed anti-anxiety medication, as well as medication for his other conditions.

On October 30, 2012, Plaintiff complained he had had a panic attack while out for a walk the previous week. He reported that he was seeing a therapist, social worker David Swain, and that he (that is, Plaintiff) suspected he was experiencing PTSD. At this appointment, Dr. Machata noted "Anxiety is extreme. Patient is having panic manifesting as neurologic symptoms affecting sympathetic and parasympathetic control of urine. Continue PTSD

specific treatment with David Swain." AR at 00438. Soon after, Dr. Machata recommended that Plaintiff seek a psychiatric evaluation. On March 20, 2013, Dr. Machata noted that Plaintiff had broken his toe, and that Plaintiff felt like he was "in the midst of a negative spiral." AR at 00426. Dr. Machata again filled out the paperwork to authorize Plaintiff being out of work from March 5, 2013, to April 5, 2013.

***David Swain***

In his memorandum, Plaintiff next calls the Court's attention to four pages of treatment notes from David Swain who was counseling Plaintiff at the time he stopped working. There is no indication that Swain had any medical expertise or training in psychology. These treatment notes were unavailable to Defendant when it made its two determinations about Plaintiff's condition. The notes begin in August 2012, when Plaintiff reported panic attacks triggered by leaving the house. He and Swain discussed techniques to manage these episodes, as well as Plaintiff's medication regimen. Plaintiff cancelled several appointments in September, once explaining that he was having difficulty leaving his house. In October 2012, Plaintiff reported that he was sleeping poorly and had low energy. The frequency of his panic attacks were decreasing, but he attributed that to the fact that he was staying in his house and avoiding triggers. As the month progressed, Plaintiff reported further

alleviation of his anxiety symptoms, but increased depression and lethargy. Swain suggested that Plaintiff see a psychiatric specialist who could prescribe and adjust medications. Although Plaintiff continued to cancel appointments with some frequency, he explained that it was because he was often engaged in caring for his father. He also reported that he didn't have panic attacks when he was taking his father to his appointments, because at those times he had a sense of purpose.

As the therapy continued into 2013, Swain and Plaintiff discussed his difficult upbringing, the death of his brother and the more recent death of his co-worker. In March 2013, Plaintiff reported having another panic attack when out with friends, forcing him to leave the social event. As these notes conclude, Plaintiff continued to complain of depression, a lack of purpose to his life, and the demands placed on him by his father. On May 30, 2013, Swain filled out a questionnaire for Defendant, checking off that Plaintiff was currently unable to work, but was projected to return to work in six months.

***Adele Palazzo***

Plaintiff went to see psychiatric nurse Adele Palazzo for evaluation and treatment in December 2012. Between then and August 2013, Palazzo worked to determine the best course of psychiatric medication with the fewest side effects. In February 2013, Palazzo noted Plaintiff's "Mood is more depressed with

diminished energy and motivation. Feels that his mood is dark." AR at 00300. In June, Palazzo noted, "His mood is changeable and when depressed, he isolates and spends the day in bed." AR at 298. In July, Palazzo recorded that Plaintiff "Has had some improvement in his mood. Reports decreased mood lability with some increase in energy and brighter affect." AR at 00296. By August, Palazzo's final treatment record noted that Plaintiff's mood had continued to improve and that his "thinking is clearer and his affect is bright. Still has fatigue and daytime sleepiness. Discussed memory issues which are long standing." AR at 294. In the questionnaire Palazzo submitted to Defendant, she described Plaintiff as suffering from "Acute Depression," and checked yes to the question "Have you recommended that your patient stay home from work on disability?" As a start date for the diagnosis, she chose the date Plaintiff was referred to her, December 5, 2012, with the end date left blank.

***Jack Demick***

Finally, on August 7, 2013, Plaintiff was referred to Jack Demick, described as a "Licensed Psychologist Provider," for a psychological and neurological evaluation "for diagnostic clarification for treatment recommendations." Demick noted that Plaintiff "was pleasant throughout, and presented as an extremely likeable individual." AR at 370. Demick's Summary and Recommendations included the following assessment:

Frank is a 44-year old man who is experiencing symptoms consistent with Bipolar Disorder (e.g., unstable moods, irritability, impulsivity, cognitive regression) superimposed on ADHD. Further, his unresolved family-of-origin issues appeared very much alive so that, given his pervasive inner turmoil, he is unable to trust and develop any relationships whatsoever, including romantic ones. Further, there was evidence that he often uses reaction formation, denial, obsessive-compulsivity, and even Asperger's symptomatology to ward off his pan anxiety that most likely has taken the form of a PTSD. Most probably an underachiever in life, Frank's ongoing weight issues may be a way for him to distance himself from others. Nonetheless, Frank's prognosis is guardedly favorable insofar as he presented himself as a likeable individual with a strong desire to make himself better.

AR at 00376. Among his recommendations, Demick included: "in light of the findings concerning aspects of his IQ and ongoing underachievement, Frank should consider the implications of this for future vocational and/or other training if he wishes to do everything possible to lead a normal life." AR at 00376.

***Lawrence Burstein***

When it received Plaintiff's appeal, Defendant obtained the services of an independent medical examiner, Lawrence Burstein, who holds a Ph.D. in psychology. Burstein conducted a review of Plaintiff's medical records, and telephone interviews with Swain and Palazzo. According to Burstein, Palazzo explained that "she based her opinion about the claimant's functioning primarily on the claimant's complaints. She stated that the claimant appeared tired and that he could be lethargic, but she did not have any specific findings to support that the claimant would have been

impaired during the period under review." AR at 00267. Burstein set forth his conversation with Swain as follows:

Mr. Swain stated that the claimant had severe symptoms of panic at times and the claimant had to leave his office on occasion when he became too upset. However, after some discussion of these events, it was established that they occurred prior to the period under review, not during the period under review. I asked if there were any occupational tasks that the claimant was impaired from. The claimant complained of angry customers, but Mr. Swain was unable to indicate anything he actually observed of the claimant's behavior, during the period under review, to support that the claimant would have been impaired from a psychological perspective.

AR at 00267. Burstein concluded that "the available information does not contain findings to support impairment in the claimant's psychological functioning during the period in question." AR at 00268.

#### ***Defendant's decision***

The foregoing medical profiles led Defendant to deny Plaintiff's initial claim for benefits, as well as his appeal, based on its determination that there was a lack of medical evidence to demonstrate that Plaintiff was unable to perform his job at Cox Cable. The Court cannot say that this conclusion is implausible in light of the record. Plaintiff is clearly a troubled man, but dealing with some depression, regret about life's choices, questioning one's sense of purpose, are all part of the human condition. Following his "meltdown" on August 23, 2012, Plaintiff clearly found some assistance in his months of

therapy and pharmaceutical treatment, bringing him to a point several months later where it was not an abuse of Defendant's discretion to determine that he was well enough to try working again.

**Conclusion**

For the reasons set forth above, Plaintiff's motion for summary judgment is denied, and Defendant's motion for summary judgment is granted. The Clerk shall enter judgment for Defendant on Plaintiff's Complaint forthwith. It is so ordered.

/s/Ronald R. Laqueux  
Ronald R. Laqueux  
Senior United States District Judge  
September 17, 2015