May v. AT & T Umbrella Benefit Plan No. 1: Independent Physician Reviews of the "Paper File" Under Fire

On August 25, 2014, the Ninth Circuit upheld a District Court decision that an ERISA administrator's denial of a short-term disability (STD) benefit claim may not be based solely on an independent physician's review of the "paper file." *May v. AT&T Umbrella Benefit Plan No. 1*, 2014 WL 4180224 (9th Cir. 2014). While the Ninth Circuit chose not to publish its decision, it may nonetheless be used as authority against ERISA plans and administrators and raises the specter that paper reviews may be considered *per se* arbitrary under certain conditions.

The procedural posture of this ERISA benefit case was not unique. The Plaintiff, Marcus May, was a retail sales consultant for AT & T Mobility. *May v. AT & T Umbrella Ben. Plan No.1*, 2012 WL 1997810, *2 (N.D.Cal. 2012). After experiencing severe knee pain, he went on leave and sought treatment. During the course of treatment, he submitted a claim for STD benefits and, for a period of time, received STD benefits until the plan denied further benefits. *Id.* at *3 – 8. He then filed an appeal with the claims administrator. *Id.* at *8.

As part of the appeal process, the claims administrator referred Mr. May's claim to Dr. William Andrews, board certified in orthopedic surgery, for an independent review. *Id.* at *9. Dr. Andrews did not perform a medical examination of Mr. May, nor did he or the plan request an in-person examination of Mr. May. *Id.* at *9 - 10. Instead, Dr. Andrews performed an independent medical review of the case notes, job description and medical records of the patient. *Id.* Following his review, Dr. Andrews concluded that the Plaintiff was not disabled from his regular job when disability benefits were discontinued, and therefore the Plan's decision to discontinue benefits was correct. *Id.* The plan argued that the treating physician's opinions were conclusory and based on subjective complaints rather than examinations or clinical findings. The MRI report showed no ligament tears or substantial damage to the knee and surgery was not recommended.

After its review of the administrative record, the District Court concluded that the Plan abused its discretion in the termination of benefits. *Id.* at *18. The court described the termination as "clearly erroneous because it was illogical and without support in inferences that may be drawn from facts in the record." *Id.* at *15. The court came to that conclusion because: 1) Mr. May was initially found to be disabled on the basis of his treating physician's reports documenting plaintiff's symptoms associated with knee pain, "and the updated medical records reflect that the plaintiff's symptoms remained unchanged"; 2) the only physician who conducted a paper review as part of the appeals process, Dr. Andrews, did not meaningfully address Mr. May's subjective complaints of pain and did not explain why he rejected the findings of the physicians who had examined plaintiff that plaintiff's pain was disabling; and 3) "in the face of what [the plan administrator] considered to be insufficient clinical findings supporting the conclusions of [Mr. May's] treating physicians, [the administrator] did not conduct its own examination, even though the plan allowed for such an exam." *Id.* at *15.

One East Washington Street, Suite 2400
Phoenix, Arizona 85004

The Ninth Circuit upheld the District Court's decision on the basis that the plan's reliance on Dr. Andrews' report was not "grounded in *any* reasonable basis," and as such, it was an abuse of discretion. *May*, 2014 WL 4180224 at *1. Both the District Court and the Ninth Circuit listed multiple reasons for why the plan's reliance on Dr. Andrews' independent medical review was in error:

- He relied only on the "paper file";
- He did not acknowledge the findings of the treating providers;
- He did not sufficiently explain why he disagreed with the MRI results, treating physicians' certificates and conclusions of all of the physicians and care providers who examined Mr. May;
- He did not speak to Mr. May's health care providers;
- He ignored Mr. May's subjective pain complaints;
- His review was cursory, at best; and
- Dr. Andrews did not examine Mr. May, in the face of insufficient medical evidence when the plan provided for such an examination.

ERISA plans and administrators should ensure that independent physician reviewers who evaluate benefit denial cases acknowledge the perceived shortcomings of the "paper file" and they must address the treating physicians' opinions and subjective complaints of the patient. An examination of the plan participant may also be a necessary step in order to further establish the reliability of the independent review. Without a thorough review of the participant's condition, through the medical records and otherwise, the plan risks an adverse result similar to the decision in *May v. AT & T Umbrella Benefit Plan No. 1*.

This document is intended to provide you with general information regarding May v. AT&T Umbrella Benefit Plan No. 1. *The contents of this document are not intended to provide specific legal advice. If you have any questions about the contents of this document or if you need legal advice as to an issue, please contact the attorneys listed or your regular Brownstein Hyatt Farber Schreck, LLP attorney. This communication may be considered advertising in some jurisdictions.*

John C. West
Shareholder
jwest@bhfs.com
T 602.382.4070

Shelley C. Nordling
Associate
snordling@bhfs.com
T 602.382.4074