

Docket No. 10-16035

In the
United States Court of Appeals
For the
Ninth Circuit

RICHARD KLUDKA,

Plaintiff-Appellant,

v.

QWEST DISABILITY PLAN,
QWEST COMMUNICATIONS INTERNATIONAL, INC.,
QWEST COMMUNICATIONS INTERNATIONAL INC. HEALTH INSURANCE PLAN,
and QWEST EMPLOYEE BENEFITS PLANS,

Defendants-Appellees.

*Appeal from a Decision of the United States District Court for Arizona (Phoenix)
No. 08-CV-01806 · Honorable David G. Campbell*

BRIEF OF APPELLANT

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I. STATEMENT OF JURISDICTION

This is a dispute over long-term disability benefits under ERISA. 29 U.S.C. § 1132.¹ The district court had federal question jurisdiction under 29 U.S.C. § 1132 and 28 U.S.C. § 1391. This Court has appellate jurisdiction under 28 U.S.C. § 1291 and Federal Rule of Appellate Procedure 3. On April 7, 2010, the district court entered final judgment.² Appellant Richard Kludka filed a timely Notice of Appeal.

II. STATEMENT OF ISSUES

Issue #1

In light of the factual differences, conflicts of interest and ERISA procedural irregularities Kludka alleges occurred in his claim, did the district court err in applying the "reasonable basis" standard of review in *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Plan*, 572 F.3d 727 (9th Cir. 2009) in concluding Qwest did not abuse its discretion rather than the more searching "combination of factors" approach required in *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343, 2351 (2008) and *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006)?

¹ R1. References to the Record ("R[#]") correspond to the Civil Docket index numbers. If included in the Excerpts of Record, they are designated "ER[#]."

² ER 1-22.

Issue #2

In light of the conflicts of interest and ERISA procedural irregularities Kludka alleges occurred in his claim, did he receive a full and fair review as required by ERISA, specifically, 29 U.S.C. § 1133(2)?

Issue #3

In light of the conflicts of interest and ERISA procedural irregularities Kludka alleges occurred in his claim and which precluded a full and fair review, did the district court err by not fully considering his extrinsic evidence pursuant to *Abatie*?

III. STATEMENT OF THE CASE

Kludka filed suit ³ against the Qwest Disability Plan, et. al. to enforce his ERISA rights and recover long term disability and other employee benefits which were terminated when the Qwest Disability Plan's (hereinafter "QDS") third party administrator, QDS found he was no longer disabled and terminated benefits. The district court allowed limited discovery, consistent with the judge's decision in *Wilcox v. Metro. Life Ins. Co.*, 2009 U.S. Dist. LEXIS 2977 (D. Ariz. 2009).

³ ER 455-463.

The parties filed cross motions for summary judgment with the court finding QDS's decision was supported by a reasonable basis and QDS did not abuse its discretion. As a result, the court granted Qwest's motion and denied Kludka's.⁴

IV. STATEMENT OF FACTS

Kludka is a fifty-four (54) year old male who worked for Qwest Communications, Inc. for 18 years. Kludka last worked as a Network Technician,⁵ before becoming disabled from engaging in any occupation on July 19, 1999, due to Anxiety with agoraphobia, a Major Depressive Disorder, Post Traumatic Stress⁶ and later, stress related to a heart attack which resulted in triple bypass surgery.⁷

Qwest found Kludka disabled on July, 19, 1999 and through 2006 it reviewed his claim on numerous occasions and found he continued to be disabled.⁸

Kludka's claim for Social Security disability benefits was approved on January 1, 2000 and he continues to receive those benefits through the date of this brief.⁹

Kludka's board certified treating psychiatrist, Shelley Doumani-Semino, M.D., and his therapist, licensed clinical social worker, Owen Golden, consistently

⁴ ER 2-22.

⁵ ER 218.

⁶ ER 390-391.

⁷ ER 219-372, 372-374.

⁸ ER 391.

⁹ ER 392.

completed Qwest Physicians forms and letters providing the information requested and opining Kludka was disabled.¹⁰

Qwest initially terminated Kludka's benefits on June 16, 2006 after finding he had provided objective medical information but it was not sufficient to substantiate his disability.¹¹ The denial was based on review of records by a physician retained by QDS, Kelly Clark, M.D. who believed Kludka could transition back to work.¹² Qwest also based the denial on a Transferable Skills Analysis which found jobs Kludka could perform.¹³

Kludka underwent an Independent Medical Examination with psychiatrist, Robert Bevan, M.D. on August 31, 2006 who concluded Kludka was unable to work full time at that time but would be able to make a gradual transition to work over a period of 60 to 120 days.¹⁴

Qwest reinstated Kludka's benefits following Dr. Bevan's examination before denying his claim on February 5, 2007 based on its conclusion Kludka's claim did not contain objective medical documentation.¹⁵

Kludka's medical records indicate his condition did not improve following Dr. Bevan's examination and his symptoms increased related to the fact his benefits

¹⁰ ER 219, 227-228, 230-232, 404-405, 406-407, 446.1-446.14.

¹¹ ER 446.17-446.21.

¹² ER 269-273.

¹³ ER 234-239.

¹⁴ ER 240-251.

¹⁵ ER 366-371.

were being terminated.¹⁶ After the termination of benefits, Dr. Semino and Mr. Golden submitted Qwest Physicians forms and letters providing the data asked for and Kludka's brother sent a letter all opining Kludka remained disabled.¹⁷

On September 20, 2007, the State of Arizona found Kludka Seriously Mentally Ill following an examination with a psychological professional and entitled to care.¹⁸

On October 9, 2007, Qwest made a final denial based on the medical records reviews of two (2) physicians, an internist Leonard Sonne, M.D., and psychiatrist Marcus, Goldman, M.D.¹⁹ Dr. Sonne concluded Kludka was disabled for a period of time following his triple bypass surgery but was able to engage in sedentary work and Dr. Goldman opined psychiatric functional incapacity could not be established.

On October 2, 2008 Kludka filed a complaint²⁰ alleging among other issues that he did not receive a full and fair review as required by ERISA. On November 13, 2009, undersigned counsel took the depositions of Qwest Disability Services

¹⁶ ER 426-439.

¹⁷ ER 217, 227-228, 406-407, 226.

¹⁸ ER 446.14-446.15.

¹⁹ ER 252-258, 259-265.

²⁰ ER 455-463.

claims managers who made the decisions, Ms. Susan Mackin and Ms. Rani Dodson.²¹

On April 2, 2010, the district court issued an Order granting Qwest's Motion for Summary Judgment finding that Qwest did not abuse its discretion in terminating benefits.²²

V. SUMMARY OF THE ARGUMENT

Summary judgment should be reversed because the district court erroneously applied the "reasonable basis" standard set forth in *Sznewajs* and did not apply a more searching combination of factors abuse of discretion review as required by *Glenn* and *Abatie* - this more searching review was warranted due to conflicts of interest and procedural irregularities Kludka identifies in his Argument that tainted the decision and resulted in the termination of his benefits.

Kludka did not receive a full and fair review as required by ERISA for numerous reasons, including inconsistent reasons provided for why his benefits were terminated and Qwest's erroneous interpretation of a plan term that resulted in a conclusion Kludka did not provide "Objective Medical Findings" when he did. Qwest compounded this error by failing to engage Kludka in a dialogue so he could perfect his claim.

²¹ ER 106-215.

²² ER 2-22.

Kludka was not afforded a full and fair review because his medical condition *deteriorated* after he underwent an Independent Medical Examination at Qwest's request and the reliable medical records and opinion evidence from his longtime treating medical professionals proved he remained disabled but this evidence was rejected without explanation due primarily to one-sided "pure paper reviews" from physicians retained by Qwest whose third party administrator then emphasized this evidence and de-emphasized all of Kludka's evidence.

Kludka argues numerous ERISA procedural irregularities indicate conflicts that resulted in the termination of his benefits and warrant a more searching combination of factors review required by *Glenn* and *Abatie* as well as consideration of his extrinsic evidence.

Kludka respectfully submits that if the district court engaged in a more searching review it should have concluded Qwest abused its discretion and Kludka did not receive a full and fair review and remained disabled.

VI STANDARD OF REVIEW

A district court's application of the appropriate standard of review for benefit decisions made by a plan administrator is *de novo*.²³ The district court applied the traditional abuse of discretion standard to Qwest's benefit

²³ *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 629 (9th Cir. 2009).

determination.²⁴ The standard of review for a district court's conclusions of law is *de novo* and clear error for a district court's finding of fact.²⁵

VII. ARGUMENT

A. *The "reasonable basis" standard applied by the district court was erroneous as Sznewajs is distinguishable factually and numerous conflicts of interest tainted the decision to terminate Kludka's benefits*

The district court found a structural conflict of interest did not exist in Kludka's case since Qwest self funded the Qwest Disability Plan (hereinafter the "Plan") at issue and Qwest hired a third party administrator, an unrelated entity named QDS, to review Kludka's claim and make the benefit decision.²⁶

Importantly, the district court found "no conflict of interest"²⁷ existed or tainted the decision terminating Kludka's disability benefits; consequently, the court failed to consider Kludka's extrinsic evidence proffered pursuant to *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006), regarding various conflicts and procedural irregularities he believed tainted the review and were responsible for the termination of benefits.

²⁴ ER 14.

²⁵ *Friedrich v. Intel Corp.*, 181 F.3d 1105, 1109 (9th Cir. 1999).

²⁶ ER 14.

²⁷ ER 14.

The court concluded the Plan contained discretionary language which was properly delegated to QDS,²⁸ and applied the standard of review in *Sznewajs v. U.S. Bancorp Amended & Restated Supplemental Plan*, 572 F.3d 727, 734 (9th Cir. 2009):

"Under the abuse of discretion standard, we must determine whether the plan administrator exercised its discretion reasonably. A plan administrator's decision to deny benefits must be upheld under the abuse of discretion standard if it is based upon a reasonable interpretation of the plan's terms and if it was made in good faith."

Kludka argues *Sznewajs* is irrelevant and factually distinguishable; the district court erred by applying minimal scrutiny and not engaging in a more searching abuse of discretion review where numerous factors and conflicts should have been considered pursuant to *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2343, 2351 (2008):

"We believe that *Firestone* means what the word 'factor' implies, namely, that when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one. This kind of review is no stranger to the judicial system. Not only trust law, but also administrative law, can ask judges to determine lawfulness by taking account of several different, often case-specific, factors, reaching a result by weighing all together."

²⁸ ER 9-14.

This court addressed the multi-factor approach in *Abatie*, 458 F.3d at 967:

"We read *Firestone* to require abuse of discretion review whenever an ERISA plan grants discretion to the plan administrator, but a review informed by the nature, extent, and effect on the decision-making process of *any conflict of interest that may appear in the record*. This standard applies to the kind of inherent conflict that exists when a plan administrator both administers the plan and funds it, as well as to other forms of conflict (emphasis added)."

1. Sznewajs is factually distinguishable

Sznewajs is distinguishable for several important reasons. First, the case involved an ERISA unfunded "top hat plan" maintained by an employer to provide deferred compensation for key management or highly compensated employees.

Sznewajs involved the plan administrator's interpretation of the word "retirement." The interpretation determined which beneficiary was entitled to a survivor's retirement benefit from the plan. The plan document did not expressly define the word "retirement" and this court found the wording to be a classic case of ambiguity and the administrator's interpretation was "reasonable" and in "good faith" based on the administrator's detailed six (6) page letter setting forth its interpretation, reasoning and decision, 572 F.3d at 735.

Critical to the instant case is that no conflict of interest was present in *Sznewajs* - the administrator's decision did not have a financial impact on the plan:

"But the specific decision in dispute here is not one which had a financial impact on the company. When the decision was made to reject Franciene's interpretation, the impact on the Plan was actuarially neutral. The present value of the anticipated benefits -- the amount of the Plan's liability -- was the same either way, because any difference between Virginia and Franciene was offset by the recalculation of the amount of the monthly payment. Replacement of Virginia with Franciene as the person identified as the potentially surviving spouse would not have exposed the company to any greater liability.

Franciene has not argued, let alone proven, that the Plan's adjudication of Franciene's claim was tainted by the self-interest of the company or the Plan, so there is no reason to review the Plan's decision with skepticism. We need not discount the amount of deference ordinarily owed to the administrator's decision in reviewing for an abuse of discretion."

Id. at 733-734.

In contrast, although not the classic *Glenn* structural conflict, a financial conflict of interest exists in Kludka's case because when QDS terminated benefits - the Plan saved *tens of thousands of dollars* it had already set aside in reserve. Kludka also lost health insurance coverage provided by Qwest and it also saved this money.²⁹ As of 2002, Qwest's records confirm it set aside \$67,359.65 in Kludka's claim.³⁰

²⁹ ER 398.

³⁰ ER 29, 392.

Unlike the plaintiff in *Sznewajs*, Kludka has consistently maintained that various conflicts of interest, financial and otherwise, resulted in the termination of his benefits.³¹

Sznewajs is also distinguishable because the issue was whether the plan administrator's interpretation of a word in its plan was "reasonable." To be sure, there is a significant factual difference between the instant case where an administrator with a fiduciary duty makes a decision regarding whether a beneficiary is disabled after reviewing hundreds of pages of evidence and the un-conflicted administrator in *Sznewajs* interpreting a word in its plan.

Sznewajs involved an un-conflicted administrator grappling with a unique set of facts, an ambiguous term requiring "interpretation" and whether its decision was made in good faith.

This court's reference to *McDonald v. Chevron Corp.* 203 F.3d 1099 (9th Cir. 2000) and similar cases, suggests *Sznewajs*' "reasonable basis standard" is more factually applicable to cases involving an un-conflicted administrator addressing ambiguity, interpretation of plan terms and whether its actions are *reasonable*, if so, "reasonable basis" review makes sense.

However, *Sznewajs*' holding did not contemplate the complex factual scenarios brought forth in *Glenn, Abatie* or the instant case:

³¹ ER 455-463.

"A plan administrator's decision to deny benefits must be upheld under the abuse of discretion standard if it is based upon a reasonable interpretation of the plan's terms and if it was made in good faith."

Sznewajs, 572 F.3d at 1113.

The instant case is also distinguishable from *Sznewajs* as addressed *infra*, because QDS terminated and repeatedly denied Kludka's benefits ³² after erroneously concluding he failed to provide objective medical findings which were sufficient to meet the Plan's definition and requirement of "Objective Medical Documentation."

Unlike *Sznewajs*, this term in the Qwest Plan is not ambiguous.

QDS's interpretation of that term in light of Kludka's evidence was totally unreasonable and inconsistent as it is clear Kludka and his medical professionals provided a *plethora* of objective medical evidence to support his psychiatric diagnoses and limitations.

Kludka's objective medical evidence and his medical professionals' opinions proved he met not only the Plan's requirement of "Objective Medical Documentation" ³³ but also its definition of disability. ³⁴

QDS's actions are distinguishable from *Sznewajs* in this critical regard; but for QDS's flawed review, Kludka's benefits should have never been terminated.

³² ER 366-371, 376-388, 446.17-446.21.

³³ ER 323.

³⁴ ER 320-321.

QDS's actions were not "reasonable" or in "good faith" because in total, the actions suggest numerous palpable conflicts tainted the review which precluded a full and fair review as required by ERISA, specifically 29 U.S.C. § 1133(2).

QDS's review was based on a litany of *Abatie* procedural irregularities³⁵ and when viewed through the skeptical lens of *Glenn*, it simply was not lawful or close to the court's requirement that QDS meet "higher than market place quality standards." 128 S. Ct. at 2350.

Sznewajs is also distinguishable because it involved a "top hat plan" which has features making it unique. This court noted as much by citing circuits who have carved out ERISA exemptions for these plans by applying *de novo* review regardless of discretionary language - this court decided against such a rule believing the standard of review is not outcome determinative:

"Both *Goldstein* and *Craig* emphasized, however, that application of a *de novo* standard of review did not materially change the outcome in either case, since ordinary contract principles require a reviewing court to give full effect to the entire pension plan, including any provisions granting the administrator discretionary interpretation."

Sznewajs, 572 F.3d at 734.

Importantly, this court noted:

"We do not believe, and have found no cases to suggest, that applying a different standard of review under these circumstances would lead to a materially different result. We conclude that importing "de novo"

³⁵ 458 F.3d at 972.

language into the standard of review simply because the plan involved is a top hat plan would create unnecessary confusion.

We will therefore continue to adhere to the framework established by the Supreme Court in *Firestone* and *MetLife* for all covered plans, top hat or otherwise. *Where, as here, there was no conflict of interest that tainted the Plan's determination, the Plan's decision should be upheld unless it constituted an abuse of discretion*" (emphasis added).

Id.

Kludka respectfully submits *Sznewajs'* "reasonable basis" standard was *dispositive* in his case and resulted in the district court applying a cursory review³⁶ involving minimal scrutiny in the face of numerous *Abatie* procedural irregularities and conflicts,³⁷ not addressing complex issues and instead looking for a "reasonable basis" to support the decision.

The district court erred in not applying *Glenn* and *Abatie's* more searching multi-factor abuse of discretion review with any conflict of interest, considered as only one factor of many.³⁸

Unlike the administrator in *Sznewajs*, QDS was not "interpreting" an ambiguous term - rather, it had an ERISA fiduciary duty to apply an unambiguous term correctly, evaluate evidence and determine whether Kludka met the definition of disability.

³⁶ ER 2-22.

³⁷ *Abatie*, 458 F.3d at 968-69, 972.

³⁸ ER 9-20.

Critically, as addressed *infra*, another distinguishable fact from *Sznewajs* is QDS *did misinterpret* the Plan's definition of "Objective Medical Documentation,"³⁹ *a term that is not ambiguous*. QDS's employees and the physicians QDS had review Kludka's records erroneously and repeatedly denied his claim⁴⁰ after determining his diagnoses and disability claim were not objectively documented and did not meet the Plan's objective medical documentation requirement.

2. *Glenn and Abatie provide the appropriate combination of factors approach required in abuse of discretion review*

In *Glenn*, the court concluded the insurance company's structural conflict of interest; *to wit*, it was responsible for making the benefit decision and paying the benefit was one factor, but alone was not dispositive to its finding that an abuse of discretion occurred. The court focused on numerous factors *other than Metlife's conflict*:

"The Court of Appeals' opinion in the present case illustrates the combination-of-factors method of review. The record says little about MetLife's efforts to assure accurate claims assessment. The Court of Appeals gave the conflict weight to some degree; its opinion suggests that, in context, the court would not have found the conflict alone determinative. *See* 461 F.3d at 666, 674. The court instead focused more heavily on other factors.

This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court in giving more weight to the conflict (because

³⁹ ER 323, 58.

⁴⁰ ER 366-371, 376-388, 446.17-446.21.

MetLife's seemingly inconsistent positions were both financially advantageous).

And the court furthermore observed that MetLife had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence. See *id.*, at 669-674.

All these serious concerns, taken together with some degree of conflicting interests on MetLife's part, led the court to set aside MetLife's discretionary decision. See *id.*, at 674-675. We can find nothing improper in the way in which the court conducted its review."

128 S. Ct. at 2352.

Regardless of whether a structural conflict of interest existed in Kludka's claim, *Glenn* sets forth exceptional standards QDS had to meet to satisfy ERISA's requirements but failed to do:

"For another, ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan, § 1104(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators "provide a 'full and fair review' of claim denials."

Id. at 2350.

Moreover, *Abatie* requires a reviewing court to consider *any conflict of interest* which may have influenced the decision - this includes ERISA procedural irregularities which precluded a full and fair review.

Kludka now addresses the numerous procedural irregularities that in total, indicate conflicts of interest tainted the decision to terminate his benefits.

B. A litany of ERISA and Abatie procedural violations indicative of conflict of interest precluded a full and fair review, were an abuse of discretion and precluded full development of the record and require consideration of extrinsic evidence

"What the district court is doing in an ERISA benefits denial case is making something akin to a credibility determination about the insurance company's or plan administrator's reason for denying coverage under a particular plan and a particular set of medical and other records. We believe that district courts are well equipped to consider the particulars of a conflict of interest, along with all the other facts and circumstances, to determine whether an abuse of discretion has occurred."

Abatie, 458 F.3d at 969.

The district court's application of the *Sznewajs*' "reasonable basis" standard⁴¹ was erroneous because while a *Glenn* or *Abatie* "structural conflict of interest" may not have existed, QDS's decision was based on many ERISA procedural violations indicative of conflict, but the court did not apply the scrutiny required by *Glenn* or *Abatie*.

Abatie requires a procedural irregularity to be weighed in abuse of discretion review:

"A procedural irregularity, like a conflict of interest, is a matter to be weighed in deciding whether an administrator's decision was an abuse of discretion."

⁴¹ ER 14, 21-22.

458 F.3d at 972.

Abatie catalogues various procedural ERISA violations which Kludka argues occurred and in combination, warrant heightened scrutiny:

"The level of skepticism with which a court views a conflicted administrator's decision may be low if a structural conflict of interest is unaccompanied, for example, by any evidence of malice, of self-dealing, or of a parsimonious claims-granting history.

A court may weigh a conflict more heavily if, for example, the administrator provides inconsistent reasons for denial, *Lang*, 125 F.3d at 799; fails adequately to investigate a claim or ask the plaintiff for necessary evidence, *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463-64 (9th Cir. 1997); fails to credit a claimant's reliable evidence, *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003); or has repeatedly denied benefits to deserving participants by interpreting plan terms incorrectly or by making decisions against the weight of evidence in the record."

458 F.3d at 968-969.

By failing to properly scrutinize the QDS's procedural irregularities, the district court also failed to consider Kludka's extrinsic evidence in several important respects ⁴² regarding these irregularities, and his argument that QDS "outsourced" the ultimate decision to Reed Review Services (also known as Reliable Review Services) physicians retained by QDS who "recited and referenced" the existence of Kludka's medical evidence, but never considered the

⁴² ER 21.

significance of their content. QDS adopted the Reed physicians' opinions without question.

Kludka's extrinsic evidence, particularly the depositions of QDS claim managers, Ms. Rani Dodson and Ms. Susan Mackin ⁴³ connects the dots, explains why some irregularities occurred and *Abatie* allows consideration of this evidence:

"When a plan administrator has failed to follow a procedural requirement of ERISA, the court may have to consider evidence outside the administrative record. For example, if the administrator did not provide a full and fair hearing, as required by ERISA, 29 U.S.C. § 1133(2), the court must be in a position to assess the effect of that failure and, before it can do so, must permit the participant to present additional evidence."

458 F.3d 972-973.

C. Qwest and QDS's ERISA procedural violations precluded a full and fair review and were an abuse of discretion

1. Qwest and QDS provided inconsistent reasons why it denied Kludka's claim

"A court may weigh a conflict more heavily if, for example, the administrator provides inconsistent reasons for denial."

Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., 125 F.3d 794, 799 (9th Cir. 1997).

QDS initially denied Kludka's claim on June 22, 2006 ⁴⁴ after finding:

⁴³ ER 106-217.

⁴⁴ ER 446.17-446.21.

“Although objective medical information has been provided it is insufficient to substantiate Disability” (emphasis added).

In their final two (2) denials dated February 5, 2007⁴⁵ and October 9, 2007,⁴⁶ QDS changed course by concluding the claim did not contain objective medical findings:

“The medical information provided does not contain objective medical documentation to support both the medical condition and any actual limitation(s) caused by the medical condition” (emphasis added).

The first denial clearly states Kludka's primary psychiatric diagnoses of Anxiety and Major Depressive Disorders *are* objectively documented and the conclusion is consistent with the fact Qwest paid his claim due to these diagnoses for seven (7) years from 1999 to 2006.⁴⁷

Kludka remained disabled in June 2006 due to the same medical diagnoses and limitations that Qwest found persuasive in 1999 - nothing changed.

The June 22, 2006 denial confirming Kludka's claim was objectively documented is consistent with years of entries made in Qwest's case management system.

⁴⁵ ER 366.

⁴⁶ ER 376-377.

⁴⁷ ER 390.

A Qwest entry on June 13, 2005 notes Kludka's objective findings after review of a medical record from his longtime board certified treating psychiatrist, Shelley Doumani-Semino, M.D. (hereinafter Dr. Semino):

“Health Care Provider’s Statement of Disability Form rec’d from Dr. Doumani. Diagnosis listed as PTSD, panic disorder w/agoraphobia, depression major, recurrent. Dr. indicates patient is totally disabled from working sedentary and would not benefit from voc rehab.

Objective findings include: cannot tolerate stress without increase in panic attacks, until recently was restricted with regard to self care and ability to leave home...RTW (Return to Work) is not in the treatment goals. Condition in the last 6 months is improved, prognosis indicates permanent disability” (emphasis added).⁴⁸

A May 19, 2006 entry following receipt of a Qwest physician's form completed by Kludka's longtime treating therapist and licensed clinical social worker, Owen Golden, L.C.S.W. confirmed objective findings:

"Health Care Provider's Statement of Disability rec'd from Dr. Golden indicating a diagnosis of panic disorder and major depression. ***Objective findings state:*** limited ability to deal with minimal amount of stress, easily agitated and severe anxiety. Patient was hospitalized in 9-05 with TIA and severe anxiety....RTW is not in the treatment goals and progress in the last 6 months listed as unimproved" (emphasis added).⁴⁹

An entry on May 22, 2006, a month before the June 22, 2006 denial notes objective medical findings on Dr. Semino's Qwest form:

⁴⁸ ER 394.

⁴⁹ ER 396.

“major depression, PTSD, and generalized anxiety disorder. **Objective findings state:** inability to endure [sic] any degree of stress without increased panic attacks...RTW is not in treatment goals and progress in the last 6 months is listed as unimproved...GAF 55...concentration is overwhelmed by stress and interferes with concentration. Mood is anxious.”⁵⁰

The unreasonableness of QDS's conclusion in its denial letters dated February 5, 2007 and October 9, 2007 is obvious given that Kludka's medical records confirm he suffered from the same medical conditions and limitations throughout the duration of his claim.

For example, on January 11, 2007 on a *Qwest Health Care Provider's Statement of Disability*, Dr. Semino again advised Kludka's claim was objectively documented:

"please provide a brief statement of the objective medical and/or psychological findings supporting the disability:

"cannot tolerate stress of any kind - quickly becomes anxious and labile - poor coping skills - has some degree of agoraphobia"⁵¹

On September 18, 2007, after Kludka's claim was denied on February 5, 2007, Mr. Golden authored a narrative letter to QDS claim manager, Ms. Rani Dodson, which supported Kludka's claim and provided objective documentation:

"Over the course of Mr. Kludka's treatment, he has continued to struggle with moderate to severe anxiety and depression. He has shown extremely limited ability to deal with any stress, which will trigger either episodes of anxiety/panic or agitation or anger. **His**

⁵⁰ ER 396, 70.

⁵¹ ER 219.

anxiety/panic symptoms consist of panic attacks on a frequent basis, from five to seven times per week, nausea, light headedness/dizziness and fear of dying.

Of significant note is Mr. Kludka's fear of dying has intensified since his recent cardiac symptoms/surgery. *Mr. Kludka's symptoms of depression include low energy, poor motivation, severe feelings hopelessness and helplessness"* (emphasis added).⁵²

Simply put, Kludka's medical records and the opinions rendered by Dr. Semino and Mr. Golden before and after his claim was denied on June 22, 2006 were sufficient to show that Kludka's disabling medical conditions were as well documented in 2007 as they were in 1999 when Qwest initially approved his claim.

The inconsistent reasons QDS proffered for denying Kludka's claim that it was not objectively documented when it clearly was, as well as the fact the determination was against the weight of credible evidence in the record, is palpable evidence of an *Abatie* procedural irregularity, indicia of conflict and smacks of QDS combing for a reason to deny to Kludka's claim.

This procedural irregularity requires heightened scrutiny per *Lang* and *Abatie* and distinguishes Kludka's case from *Sznewajs* because QDS's inconsistent reasons for denying Kludka's claim were not based on a reasonable interpretation of the medical evidence or the Plan's term "Objective Medical Documentation."⁵³

⁵² ER 406-407.

⁵³ ER 323.

QDS's inconsistent reasons for denying Kludka's claim placed him in a position of being unrepresented and suffering from serious psychiatric limitations and now pitted against a multi-billion dollar company while trying to discern what needed to be submitted to meet the Plan's term of "Objective Medical Documentation." Indeed, Kludka needed QDS to be his fiduciary and engage him in a dialogue so he could perfect his claim; sadly, this never occurred.

2. *Kludka's claim contained Objective Medical Documentation, QDS's finding that it did not and its failure to engage him in a dialogue to perfect his claim was an abuse of discretion*

"We have also construed this regulation to require a plan administrator denying benefits in the first instance to notify the claimant not just of the opportunity for internal agency review of that decision but also of what additional information would be necessary "to perfect the claim."

Montour v. Hartford Life & Accident Inc. Co., 582 F.3d 933, 946 (9th Cir.

2009).

QDS's denials⁵⁴ based on a lack of objective medical findings failed to meet the notice requirements of ERISA, specifically, 29 C.F.R. § 2560.503-1(f)(2) & (3). Further, simply referencing "Objective Findings" as QDS did in one line, buried on page 5⁵⁵ of a denial with Kludka, who QDS knew had frequent concentration problems, fails to meet *Glenn's* "higher than market place quality standards" and is not sufficient notice of a critical element in his claim. Moreover,

⁵⁴ ER 366-371, 376-388.

⁵⁵ ER 370.

QDS's subsequent failure to engage Kludka in a dialogue regarding what objective medical findings were is a procedural irregularity, an abuse of discretion and led to a review which was neither full or fair.

QDS's denials based on an alleged lack of "objective medical evidence" are also a clear misinterpretation of how the Plan defines the term and this court found such flawed decision-making an abuse of discretion in *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1472-73 (9th Cir. 1993).

As referenced *supra*, Kludka's claim was repeatedly documented by objective medical findings but QDS in its February 5, 2007⁵⁶ and final denial on October 9, 2007⁵⁷ erroneously found it was not. Unlike the ambiguous term in *Sznewajs*, the term "Objective Medical Documentation"⁵⁸ in the Qwest Plan is clear:

"Objective Medical Documentation" means written documentation of observable, measurable and reproducible findings from examination and supporting laboratory or diagnostic tests, assessment or diagnostic formulation, such as, but not limited to, x-ray reports, elevated blood pressure readings, lab test results, functionality assessments, psychological testing, etc.

Incredibly, in its denial letters and communication with Kludka during appeal, QDS never communicated the Plan's definition to him, Dr. Semino or Mr. Golden. QDS's failure is factually similar to *Boyd v. Aetna Life Ins. Co.*, 438 F.

⁵⁶ ER 366-371.

⁵⁷ ER 376-388.

⁵⁸ ER 444.

Supp. 2d 1134, 1152 (C.D. Cal. 2006), where the court found the insurance company's failure to provide forms to allow a beneficiary to perfect a claim evidence of a serious conflict:

"Boyd argues that the most glaring example that Aetna's inherent conflict of interest became one of real substance in his case was that while it demanded 'objective proof of functional incapacity,' Aetna did not provide him any of the forms it had in its possession -- the MHPS form or the attending Physician Behavioral Health Statement form -- that would have relayed the very information they insisted his claim record lacked. Such 'procedural irregularities' in the claim administration process it is alleged should divest Aetna of any discretion. There is much to recommend for Boyd's position.

"When Boyd made his claim for long-term disability benefits, Aetna was also required to provide him '[s]pecific reference to the pertinent plan provisions on which the denial is based,' and '[a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.' 29 C.F.R. § 2560.503-1(f)(2) & (3)."

Id. at 1155-1156.

Kludka's medical diagnoses and limitations were repeatedly objectively documented for seven (7) years by Dr. Semino⁵⁹ and Mr. Golden⁶⁰ and Qwest accepted these records.

⁵⁹ ER 408-409, 410-411, 412-13, 414-415, 416-417, 418-419, 420-421, 422-423, 424-425, 426-427, 428-429, 430-431, 432-433, 434-435 (Dr. Semino's records).

⁶⁰ ER 436, 437, 438, 439 (Mr. Golden's records).

In fact, on August 29, 2007,⁶¹ in Dr. Semino's last medical record before QDS's final denial, she notes a plethora of medical findings which met the Plan's definition:

“since last seen in March has had a lot of medical problems....had MI in May and then a quadruple bypass a few days later - was diagnosed with COPD (Chronic Obstructive Pulmonary Disease) and uses supplemental O2 in the evening and if he has to go out ...still has not done sleep apnea test...he says he has high anxiety and sleeps many hours per day...*anxiety is rated 8.5/10; more depressed at 10/10...energy is low...concentration is poor...has a hard time looking after mail and responsibility – easily frustrated...says he has called 13 attorneys but cannot find someone to take up his disability dispute because he cannot afford to pay them...worries that his house will be foreclosed to cover his medical bills...says he has panic attacks 3 times per day...cannot afford therapy...concentration impaired...insight judgment fair...GAF 50*”⁶² (emphasis added).

Dr. Semino and Mr. Golden for many years completed Qwest physician forms confirming Kludka was disabled and the form required each to set forth "objective medical/psychological" findings which "supported the disability."⁶³

On September 18, 2007, Kludka's brother sent a letter to QDS explaining that due to Kludka's medical problems, "Now, he can barely get out of bed...he is a

⁶¹ ER 434-435.

⁶² ER 70, An *Axis V GAF Score of “50”* translates into *Serious symptoms* (e.g., suicidal ideation, *severe* obsessional rituals, frequent shoplifting) OR any *serious impairment* in social, occupational or school functioning (e.g., no friends, unable to keep a job)(emphasis added). American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Page 32, Fourth Edition. Washington, D.C., American Psychiatric Association, 1994.

⁶³ ER 227-228, 229-230, 231-232, 405, 446.2-446.14.

shadow of his former self...and cannot focus long enough to understand the schematics." ⁶⁴

As addressed *infra*, Dr. Semino's and Mr. Golden's reliable opinion evidence was "referenced" but never considered by QDS's or its physicians on appeal.

QDS's February 5, 2007 denial left an unrepresented Kludka trying to determine exactly what was "Objective Medical Documentation?"

Further, QDS *never provided* Kludka with the Plan's definition of "Objective Medical Documentation" ⁶⁵ to assist him.

If QDS believed Kludka's claim was not objectively documented; notwithstanding the fact *for years Qwest accepted* Dr. Semino's and Mr. Golden's objective evidence ⁶⁶ provided on Qwest forms which suddenly was not sufficient - QDS had a fiduciary duty to meet "higher than market place standards" pursuant to *Glenn* by resending its forms to Dr. Semino and Mr. Golden and/or to ask QDS psychiatrist Dr. Goldman ⁶⁷ who reviewed Kludka's claim on appeal to personally contact them to obtain this critical evidence - but this never happened.

In *Boyd* the failure to provide forms to allow a beneficiary to perfect a claim was evidence of a serious conflict:

⁶⁴ ER 226.

⁶⁵ ER 366-371, 376-388.

⁶⁶ ER 227-232, 405, 446.2-446.14.

⁶⁷ ER 259-265.

"If a plan administrator has possession of a document that the claimant does not have equal or superior access to, the administrator does not produce that document, and the document could have altered the administrator's decision, then the failure to produce such documentation is evidence of a serious conflict of interest.

This is precisely what took place in this case. Aetna had in its possession forms -- forms which Boyd did not have access to -- that it could have sent to Boyd's physicians that would have provided Aetna the objective medical evidence regarding Boyd's functional abilities that it so insisted upon during the claim process. Yet Aetna never provided those forms to Boyd's physicians even though it was part of Aetna's custom and practice to do so."

Boyd, 438 F. Supp. 2d at 1155.

If QDS believed Kludka's claim was not documented by objective medical findings, it had a fiduciary duty and this court required QDS to engage him in a dialogue so he could perfect his claim - but QDS never did.

The unreasonableness of QDS's denial for this reason is illustrated by the Rule 30(b)(6) deposition of QDS claims manager Ms. Susan Mackin, who admitted after reviewing several of Dr. Semino's records during deposition that they contained objective medical findings.⁶⁸

QDS claims manager, Ms. Rani Dodson, who wrote the final denial letter on February 5, 2007, was asked during her deposition if she knew how the Plan defined "Objective Medical Findings," she testified "No."⁶⁹ If Ms. Dodson did not

⁶⁸ ER 136-144, 60-62.

⁶⁹ ER 196, 64.

know how the Plan defined "Objective Medical Documentation" - *how would a disabled Kludka with psychiatric limitations figure it out?*

To his credit, Kludka tried but nobody listened - in his appeal letter to QDS on September 18, 2007, he provided a summary of his medical records which documented the severity of his symptoms but even then, *he made it clear he did not understand what objective medical evidence was in a cry for help:*

"As a patient I do not have the ability to self diagnosis [sic] or understand medical terminology" (emphasis added).⁷⁰

Unfortunately, Kludka's letter was never addressed by QDS.⁷¹

QDS claim management entries confirm nobody communicated with Kludka regarding what objective medical evidence he needed to submit. Ms. Mackin testified she told Kludka that "treatment notes from his providers" would be considered objective evidence - but clearly this did not occur⁷² and Ms. Dodson testified she spoke with Kludka during appeal on ten (10) different occasions but never discussed objective medical findings.⁷³

How in the world can this type of review be "reasonable" in light of *Glenn* and *Abatie*?

⁷⁰ ER 223.

⁷¹ ER 222-225.

⁷² ER 148.

⁷³ ER 181-182, 186, 195-196.

QDS's actions and inaction, in total, violated ERISA, 29 C.F.R. § 2560.503-1(f) and this court's holding in *Booton v. Lockheed Medical Benefit Plan*, 110 F.3d 1461, 1465 (9th Cir. 1997) which required more be done to assist Kludka; heightened *Glenn* and *Abatie* scrutiny should be applied as a result:

"If the plan is unable to make a rational decision on the basis of the materials submitted by the claimant, it must explain what else it needs. *Id.*

If ERISA plan administrators want to enjoy the deference to which they are statutorily entitled, they must comply with these simple, common-sense requirements embodied in the regulations and our caselaw. The plan here did not." ⁷⁴

3. *Kludka's reliable evidence was never considered by QDS and its decision to terminate benefits was against the weight of the evidence*

"Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician."

Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (U.S. 2003).

In *Abatie*, this court held a conflict should be weighed more heavily if a Plan Administrator, "...fails to credit a claimant's reliable evidence" or makes "decisions against the weight of the evidence." 458 F.3d at 968.

Kludka's medical professionals had consistently treated him for many years including, board certified psychiatrist, Dr. Semino (*treated Kludka since November*

⁷⁴ See *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863 (9th Cir. 2008).

3, 2003) and therapist, Mr. Golden (*treated him since October 20, 2003*). Over many years on QDS treating physician forms, Dr. Semino and Mr. Golden *consistently* opined Kludka was disabled from engaging in any occupation.⁷⁵

On January 11, 2007, just weeks before Kludka's benefits were denied on February 5, 2007, Dr. Semino completed two (2) QDS physician forms⁷⁶ opining Kludka was "disabled from any occupation" that he "cannot tolerate stress of any kind - quickly becomes anxious and labile, poor coping skills - has some degree of agoraphobia," and progress was "unimproved."

Dr. Semino confirmed Kludka's ability to sustain concentration, focus and complete tasks in a work environment was "poor - overwhelmed by anxiety," Kludka was "irritable," there was "no evidence of secondary gain" and he was taking Cymbalta and Clonazepam on a daily basis for his psychiatric symptoms.

QDS reviewing psychiatrist, Kelly Clark, M.D., spoke with Dr. Semino on January 29, 2007, three (3) weeks after Dr. Semino completed her form;⁷⁷ incredibly, Dr. Clark never explained why he disagreed with Dr. Semino that Kludka was disabled and failed to reference her January 11, 2007 forms.

QDS, in its February 5, 2007 denial letter completely failed to address Dr. Semino's opinions and in its final denial dated October 9, 2007, which is a

⁷⁵ ER 219-221, 404, 406-407, 446.2-446.14.

⁷⁶ ER 219, 227-228.

⁷⁷ ER 266-268, 369.

regurgitation of the facts provided in the February 5, 2007 denial, "references" but never states what weight Dr. Semino's opinions were given, why they were unreliable or rejected.⁷⁸

On September 18, 2007, Mr. Golden submitted a detailed narrative letter⁷⁹ to Ms. Dodson and opined Kludka was "permanently disabled due to his psychiatric symptoms" and "returning to work was not a goal of treatment," that his "fear of dying had intensified since his recent cardiac symptoms/surgery" and Kludka's symptoms of "depression" include "low energy, poor motivation, severe feelings of hopelessness and helplessness."⁸⁰

Mr. Golden offered to discuss Kludka's case *but nobody called him*.

The same day, Kludka appealed the denial of his benefits and provided a four (4) page summary of his medical records and symptoms which disabled him and asked QDS to "consider this appeal expeditiously as possible since my condition continues to worsen with the added causes of stress"⁸¹ and to call if there were any questions.

In QDS's final denial on October 9, 2007⁸² it never referenced Kludka's letter; neither did QDS reviewing psychiatrist, Marcus Goldman, M.D., who

⁷⁸ ER 377.

⁷⁹ ER 406-407.

⁸⁰ ER 406.

⁸¹ ER 222-225.

⁸² ER 376-388.

reviewed Kludka's case on October 3, 2007⁸³ and *nobody contacted Kludka beforehand.*⁸⁴

Kludka also submitted a September 20, 2007 letter⁸⁵ from the State of Arizona which had a psychological professional evaluate him and following examination, found him *Seriously Mentally Ill* and entitled to mental health care. Neither QDS, in its final denial or Dr. Goldman referenced the State of Arizona's finding in his review of the records even though it occurred *just weeks prior.*

QDS and its physicians' one-sided review, which completely failed to consider reliable evidence⁸⁶ from Kludka's medical professionals violated ERISA's requirement pursuant to 29 C.F.R. § 2560.503-1(h)(2)(iv) that all evidence be considered and this is an *Abatie* procedural irregularity evidencing conflict tainted the decision.

⁸³ ER 259-265.

⁸⁴ ER 205.

⁸⁵ ER 446.15-446.16.

⁸⁶ *See Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 695 (7th Cir.1992), "...in making such a determination, the administrator must weigh the evidence for and against, and within reasonable limits, the reasons for rejecting evidence must be articulated if there is to be meaningful appellate review" and *Hackett v. Xerox Corp.*, 315 F.3d 771, 775 (7th Cir. 2003), "There was no weighing of the evidence for and against, and there were no articulated reasons given for Xerox's rejection of the evidence that Hackett was unable to work."

4. ***QDS's termination of benefits after finding Kludka disabled for 7 years was an abuse of discretion because his medical condition deteriorated rather than improved***

The Eighth Circuit in *McOsker v. Paul Revere Life Insur. Co.*, 279 F.3d 586, 589 (8th Cir. 2002), held “...but unless information available to an insurer alters in some significant way, the previous payment of benefits is a circumstance that must weigh against the propriety of an insurer's decision to discontinue those payments.”

QDS's termination of Kludka's benefits must be weighed against Qwest's finding him disabled in 1999 and consistently reviewing the claim paying benefits for over seven (7) years. QDS's decision must be weighed against the opinions of his longtime treating medical professionals, Dr. Semino and Mr. Golden, who knew him best and consistently opined he was disabled from engaging in any occupation. ***Did Kludka's medical condition really improve allowing a return to work where he could earn 60% of his pre-disability income?***⁸⁷

QDS initially terminated Kludka's benefits following a psychiatric Independent Medical Examination (IME) performed by Robert Bevan, M.D. on August 31, 2006, who essentially opined Kludka was unable to work at the time of the examination but could make a gradual return to work.⁸⁸ Dr. Bevan rated

⁸⁷ ER 320-321.

⁸⁸ ER 240-251.

Kludka's overall level of psychological functioning at "**61**" on a scale of 0 to 100 which indicated "some mild symptoms."⁸⁹

Dr. Bevan's opinion Kludka could gradually return to work over a period of months was mere speculation:

“Mr. Kludka does perform a full range of activities of daily living, provides childcare for his daughter, and leaves the home to visit his daughter, grocery shop, and attend appointments with care providers, although he would prefer to avoid leaving home.

Therefore, in my opinion, Mr. Kludka's degree of disability is mild. He displayed no undo objective signs of anxiety during my one-hour and 45 minute interview, and did not appear unduly anxious when I monitored his progress on the MMPI-2 for over an hour following that Interview. He was able to travel six to eight miles by automobile for this evaluation.

In my opinion, Mr. Kludka could work two hours daily currently, and as his avoidance of leaving home diminishes, **he could presumably** increase his hours back to full-time without restriction” (emphasis added).

QDS's eventual termination of Kludka's benefits based on Dr. Bevan's speculation was unreasonable based on Kludka's deteriorating condition following the IME and because speculation is insufficient as noted in *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 170-171 (6th Cir. 2003):

"The mere possibility that a participant in an ERISA plan might be able to return to some type of gainful employment, in light of overwhelming evidence to the contrary, is an insufficient basis upon

⁸⁹ ER 70, An *Axis V GAF Score of "61"* translates into *Some Mild symptoms* (emphasis added). American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Page 32, Fourth Edition. Washington, D.C., American Psychiatric Association, 1994.

which to support a plan administrator's decision to deny that participant's claim for LTD benefits."

QDS's reliance on Dr. Bevan's IME is more unreasonable given the overwhelming evidence that Kludka's condition deteriorated after the IME.

After initially terminating benefits on June 22, 2006⁹⁰ before Dr. Bevan's examination, QDS concluded Kludka remained disabled following the IME because Dr. Bevan opined he remained disabled, needed additional care and time to make a gradual transition to work.⁹¹

The *McOsker* and *McDonald* question is whether Kludka's medical condition improved following Dr. Bevan's IME?

After the IME and learning his benefits were being terminated, Kludka's records confirm his anxiety and depression skyrocketed and his overall ability to function *deteriorated significantly* from the IME in August 2006 through QDS's final denial on October 9, 2007 - this deterioration never allowed him to return to work or attend vocational rehabilitation. However, QDS ignored Kludka's marked deterioration; a deterioration Dr. Bevan did not anticipate which rendered his IME opinions irrelevant.

⁹⁰ ER 446.17-446.21.

⁹¹ ER 251 and ER 82-84, Qwest's answers in its Requests to Admit.

For example, during Kludka's very next visit with Dr. Semino on November 6, 2006,⁹² two (2) months following Dr. Bevan's IME, she documented Kludka was having:

"daily panic attacks" and rated both his anxiety and depression at *"10/10"* was *"in bed a lot of the day"* and *"felt worse than when he first came to see me."*

Dr. Semino rated his *Axis V GAF Score at "50"* indicating *serious* psychological limitations⁹³ - confirming Kludka's overall level of psychological functioning *had plummeted* in just over two (2) months since the IME.

Dr. Semino's subsequent visits from January 15, 2007 through QDS's final denial confirm Kludka's GAF Scores never rose above *"50:"*⁹⁴

"feel[sic] pent up frustration needs to release it, screams into a pillow...concentration is poor...energy level is poor...judgment and insight are fair."⁹⁵

Kludka's psychiatric decline continued on his next visit with Dr. Semino on February 26, 2007, weeks after QDS's February 5, 2007 denial and six (6) months after the IME; it was obvious Kludka was not coping with the termination of benefits:

⁹² ER 426-427.

⁹³ ER 70.

⁹⁴ ER 426-427, 428-429, 430-431, 432-433, 434-435

⁹⁵ ER 428-429.

"Qwest disability has termed him...says he cannot work because he is too anxious (cannot concentrate, panics and shakes)...concentration impaired...judgment/insight impaired...GAF 50." ⁹⁶

On March 19, 2007, Kludka's psychiatric condition declined further on his next visit with Dr. Semino:

“is very angry-palpitations are constant-says that his doctor is Dr. Charles Abrams wants to know if it is psychological before he runs tests...nothing he does is enough...has not been seeing his therapist because he cannot afford it...did not go for sleep study test...has a lot of stress in his life...loss of disability...divorced his grandchildren...depressed anxious...concentration impaired...judgment fair...insight fair...Axis IV Severe...reiterated that I am not in favor with his having a hand gun because of his intense anger...GAF 50” (emphasis added). ⁹⁷

On August 29, 2007, Kludka's last visit with Dr. Semino before QDS's final denial, she notes he recently suffered a heart attack, underwent triple bypass surgery, ⁹⁸ was diagnosed with Chronic Obstructive Pulmonary Disease (COPD), was using oxygen at night as well as to leave his house, was *suffering three (3) panic attacks daily* and could not afford an attorney for his claim:

“since last seen has had a lot of medical problems...had an MI and a bypass a few days later... - was diagnosed with COPD (Chronic Obstructive Pulmonary Disease) and uses supplemental O2 in the evening and if he has to go out ...still has not done sleep apnea test...he says he has high anxiety and sleeps many hours per day...anxiety is rated 8.5/10; more depressed at 10/10...energy is

⁹⁶ ER 430-431.

⁹⁷ ER 432-433.

⁹⁸ ER 372-374.

low...concentration is poor...has a hard time looking after mail and responsibility – easily frustrated...⁹⁹

...says he has called 13 attorneys but can't afford to pay an attorney to take up his disability dispute...worries that his house will be foreclosed to cover his medical bills...says he has panic attacks 3 times per day...cannot afford therapy...concentration impaired...insight judgment fair...GAF 50.”

Mr. Golden's records also document Kludka's deterioration.¹⁰⁰ On September 18, 2007, only weeks before QDS's final denial, he confirmed Kludka's condition had not improved:¹⁰¹

“During his course of treatment, Mr. Kludka's symptoms have precluded him the opportunity to return to employment on any level. ***Given this, the topic of returning to work has not been addressed in his treatment, nor was it a goal of his treatment.***

It is my opinion Mr. Kludka is permanently disabled due to his psychiatric symptoms. I hope you find these comments helpful. If can offer any additional information or assistance, please feel free to contact me at 602 997-6635” (emphasis added).¹⁰²

Mr. Golden provided ample *objective medical evidence* Kludka was disabled due to his psychiatric condition and the impact the heart attack had on his ability to function:

"Over the course of Mr. Kludka's treatment, he has continued to struggle with moderate to severe anxiety and depression. He has

⁹⁹ ER 434-435.

¹⁰⁰ ER 436-439.

¹⁰¹ ER 406-407.

¹⁰² ER 406-407.

shown extremely limited ability to deal with any stress, which will trigger either episodes of anxiety/panic or agitation and anger.

His anxiety/panic symptoms consist of panic attacks on a frequent basis, from five to seven times per week. Mr. Kludka endorses symptoms including sweating, chest pain, palpations, nausea, light headedness dizziness and fear of dying.

Of significant note is Mr. Kludka's fear of dying has intensified since his recent cardiac symptoms/surgery.

Mr. Kludka's symptoms of depression include low energy, poor motivation, severe feelings of hopelessness and helplessness.

He denies suicidal ideation. His daily functioning is very limited as well. He is socially withdrawn and isolated with the exception of attending church services.

He will sleep as much as 15 hours a day.

He complains of impaired concentration and memory. His daily activities include household chores and yard maintenance and watching television" (emphasis added).

As addressed *infra*, incredibly, QDS "listed" Mr. Golden's letter as a piece of evidence in Kludka's claim but neither QDS or reviewing psychiatrist Dr. Goldman ever addressed why it was unreliable or explained why it was rejected without comment.¹⁰³

A wider longitudinal view of Kludka's psychiatric care from 2004 through QDS's final denial in October 2007 confirms his condition *only deteriorated*, particularly after the IME - QDS and its physicians had these records which makes the termination even more unreasonable and unlawful.

¹⁰³ ER 259-265, 376-388.

For example, Dr. Semino's records reveal Kludka's GAF Score was "60" indicating only "moderate" symptoms in 2004 and 2005¹⁰⁴ when Qwest consistently found Kludka disabled and paid him. However, Dr. Semino reduced Kludka's GAF Score to "55"¹⁰⁵ three (3) months before his claim was denied in June 2006.

Kludka's level of psychiatric functioning as measured by his Axis V GAF Score *was lower in 2007* when QDS made its final denial on October 9, 2007 than during the period of 2004 through 2006 when it found he was disabled.

A layperson with no psychological training could have determined simply by looking at Kludka's GAF Scores that his psychological functioning deteriorated from QDS's initial denial in June 2006 through October 9, 2007; however, during her deposition Ms. Dodson testified she was not familiar with the abbreviation "DSM" and did not know what an Axis V GAF Score was and had no training on it.¹⁰⁶

A fiduciary meeting *Glenn's* "higher than market place quality standards" should have asked Dr. Bevan to review Kludka's medical records or examine him a second time since Dr. Bevan knew Kludka's condition at the time of appeal - 14 months had passed since the IME.

¹⁰⁴ ER 408-409, 410-411, 412-413, 414-415, 416-417, 418-419, 420-421, 422-423.

¹⁰⁵ ER 424-425.

¹⁰⁶ ER 210.

Instead, QDS relied on a one-sided, selective, flawed medical records only review by Dr. Goldman who never examined Kludka and never addressed any of Kludka's evidence or why it was summarily dismissed.¹⁰⁷

In its final denial, QDS unreasonably terminated Kludka's benefits after relying in part on Dr. Bevan's IME opinion¹⁰⁸ even though the IME was 14 months earlier and the weight of the evidence made it clear Dr. Bevan was wrong about a gradual return to work. Incredibly, in discovery, QDS admitted that after obtaining his IME report, it never again contacted Dr. Bevan.¹⁰⁹

Given QDS's rejection of and failure to credit any of Kludka's reliable, overwhelming evidence from his longtime treating psychiatric professionals (*critically, they were only professionals to personally examine Kludka for the 14 months following Dr. Bevan's IME and before the final denial on October 2007*), that his condition deteriorated following the IME; a full and fair review, *Glenn and Abatie*¹¹⁰ required QDS to investigate further by obtaining a second IME. The pressing need for obtaining a second IME in Kludka's case was expressed in *Sheehan v. Metro. Life Ins. Co.*, 368 F. Supp. 2d 228, 255 (S.D.N.Y. 2005):

¹⁰⁷ ER 259-265.

¹⁰⁸ ER 376, 379-380, 382.

¹⁰⁹ ER 83.

¹¹⁰ *Abatie*, 458 F.3d at 968.

“Courts discount the opinions of psychiatrists who have never seen the patient for obvious reasons. Unlike cardiologists or orthopedists, who can formulate medical opinions based upon objective findings derived from objective clinical tests, the psychiatrist typically treats his patient's subjective symptoms: in Sheehan's case, as described by Dr. Prati, depression, fear of death, and anxiety, among others. Physicians do not diagnose or evaluate these different conditions in the same way.”

QDS's failure to obtain a second IME is an *Abatie* failure to investigate.

Given the complexity of Kludka's condition, which now included a heart attack and surgery since the IME, QDS's reliance on a superficial medical records only review by Dr. Goldman raises serious questions about the thoroughness of its denial particularly since it failed to credit any of Kludka's evidence and did not contact Kludka, Dr. Semino or Mr. Golden for clarification.

Simply put, this court required QDS to investigate further than simply obtaining a medical records only review as set forth in *Montour v. Hartford Life & Accident Ins. Co.*, 582 F.3d 933, 944 (9th Cir. 2009):

"Another factor is Hartford's decision to conduct a 'pure paper' review in this case, that is, to hire doctors to review Montour's files rather than to conduct an in-person medical evaluation of him."

5. ***QDS's termination was based on an unlawful review which included Dr. Bevan's outdated IME, a flawed vocational report and medical records only reviews which emphasized QDS's evidence while ignoring Kludka's***

In *Glenn*, 128 S. Ct. at 2351-2352, the court found an insurance company's emphasis on certain reports while de-emphasizing other reports, coupled with the

fact its reviewing medical professionals failed to review all the evidence to be indicia of conflict and sufficient facts to warrant an abuse of discretion:

"The Court of Appeals' opinion in the present case illustrates the combination-of-factors method of review...The court instead focused more heavily on other factors...the court furthermore observed that MetLife had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence."

a. QDS violated Glenn and ERISA because Dr. Bevan and QDS's vocational professional did not review all of Kludka's evidence

QDS denied Kludka's claim on February 5, 2007¹¹¹ and October 9, 2007 based in part on Dr. Bevan's IME and a vocational report. Dr. Bevan's only involvement in Kludka's claim was the IME on August 31, 2006¹¹² - an incredible 404 days before QDS rendered its final denial on October 9, 2007.¹¹³ QDS admitted under oath in discovery that it never again contacted Dr. Bevan after the IME.¹¹⁴

It is obvious then that Dr. Bevan never reviewed all of Kludka's medical evidence, including the records documenting his deterioration for the ensuing 14 months following Dr. Bevan's IME - not Dr. Semino or Mr. Golden's records or those showing Kludka suffered a heart attack and underwent triple bypass surgery.

¹¹¹ ER 366, 368-370, 377, 379, 381.

¹¹² ER 240-251.

¹¹³ ER 376-388.

¹¹⁴ ER 83.

Thus, when QDS relied in part on Dr. Bevan's IME report to deny Kludka's claim in its final denial on October 9, 2007,¹¹⁵ QDS violated *Glenn's* requirement that its medical professionals be provided with and review all the evidence.

Similarly, QDS relied on a Transferable Skills Analysis performed by a company named Genex, dated June 13, 2006¹¹⁶ that was performed before QDS initially denied Kludka's claim on June 22, 2006.¹¹⁷ Notwithstanding the fact Kludka's medical care and claim continued for another *16 months* after the report, QDS never obtained an updated vocational report or asked Genex to review those updated medical records or opinions from Dr. Semino, Mr. Golden or to consider how cardiac and psychiatrically related stress had impacted Kludka's ability to perform the jobs indentified in its June 13, 2006 report.

On October 9, 2007 when QDS again denied the claim based in part on Genex's June 13, 2006 report - the decision was based on evidence *474 days old*. Consequently, QDS unreasonably violated *Glenn* as it is clear Genex did not review any of Kludka's evidence which followed after June 2006.

Closer scrutiny of the Genex report also suggests *Glenn* unreasonableness. First, Genex was never aware Kludka underwent an IME with Dr. Bevan two (2) months after the report was generated. Second, Genex ignored the obvious fact

¹¹⁵ ER 377, 379.

¹¹⁶ ER 234-239.

¹¹⁷ ER 446.17-446.21.

that Kludka had not worked for seven (7) years from 1999 to 2006 - Qwest was Kludka's only employer for 18 years and he worked in a technical field as a Network Technician.¹¹⁸

Importantly, pursuant to the Qwest Plan, Kludka had to be able to earn 60% of his pre-disability income for QDS to terminate benefits.¹¹⁹

After not working and using *any skills for seven (7) years*, it was completely unreasonable to assume Kludka could make a quick return to work within months to a skilled or semi-skilled job. However, this is the assumption Genex made in finding jobs Kludka could perform.¹²⁰

Although Genex never reviewed Dr. Bevan's IME report, even Dr. Bevan believed the best case scenario was Kludka needed to begin on a part time basis - only 2 hours of work per day, and then make a transition to full time over a period of four (4) months.¹²¹ Genex's marching orders from QDS were to consider only the opinions of QDS medical records reviewer, psychiatrist Kelly Clark, M.D.¹²² and QDS's first denial on June 22, 2006 confirms only Dr. Clark's opinions were considered.¹²³

¹¹⁸ ER 235.

¹¹⁹ ER 320-321.

¹²⁰ ER 236-239.

¹²¹ ER 251.

¹²² ER 269-273.

¹²³ ER 446.17-446.21.

Implausibly and unreasonably, Genex found several jobs, including Data Communications Technician and Cable Splicer, two very complex jobs with Specific Vocational Preparation (SVP) times of 7, meaning a person would require *a minimum of 2 to 4 years to learn them proficiently.*^{124 125} Two other jobs Genex found, Mail Handler and Mail Carrier, have SVP's of 4, indicating it would take a person up to six (6) months to learn.

The two remaining jobs, Meter Reader and Maintenance Service Dispatcher are SVP's of 3, meaning it would take a person up to three (3) months to learn them.

The Meter Reader and Maintenance Service Dispatcher require contact with the public and necessarily involve occupational stress that Dr. Semino and Mr. Golden's records in 2006, 2007, and their QDS forms completed just a month before the Genex report make clear Kludka could not engage in.

Kludka was not "any person," he was almost 50 years old, had not worked in over 7 years, and if job skills remained - they were seriously diminished, eroded and outdated like today's long term unemployed workers.

¹²⁴ ER 236, 238.

¹²⁵ Dictionary of Occupational Titles, *Appendix C: Components of the Definition Trailer*, "Specific Vocational Preparation," http://www.occupationalinfo.org/appendxc_1.html (2003).

Moreover, given his psychiatric limitations - how marketable could Kludka's job skills be since he had not worked since 1999? Genex did not address and QDS did not question these common sense occupational issues when it relied on Genex's report in every denial - simply stated, the jobs identified were not viable.

Genex's report and QDS's reliance on it was unreasonable in several respects; first, it failed to reference, let alone consider reliable evidence and opinions rendered *less than a month* prior from Dr. Semino or Mr. Golden that Kludka was disabled from engaging in any occupation and could not tolerate any stress.¹²⁶

For example, Genex never considered Dr. Semino's QDS Physician's form completed on May 18, 2006 where she informed QDS that Kludka could not concentrate, focus or complete tasks in a work environment and was "overwhelmed by stress - interferes with concentration"¹²⁷ and had an "inability to endure any degree of stress without an increase in panic attacks."¹²⁸

Genex also failed to consider Mr. Golden's similar opinions in his QDS Physician's form dated May 17, 2006 where he confirmed Kludka had a "limited ability to deal with minimal amount of stress" and was "unimproved."¹²⁹

¹²⁶ ER 230, 232, 404, 446.2-446.14

¹²⁷ ER 446.11.

¹²⁸ ER 446.9.

¹²⁹ ER 446.5.

Genex's report, which defies common sense, used "best case scenario" assumptions which were unreasonable and unsubstantiated while failing to consider any of Kludka's evidence of disability. QDS's actions in basing the denial on a report riddled with error is similar to what occurred in *Montour*; it is also evidence of a procedural irregularity and an inadequate *Abatie* investigation:

"Thus, there is a common theme, both in Hartford's communications with Plaintiff and in the assessments of those professionals Hartford hired to evaluate Plaintiff's condition, of presenting evidence of capability in the best possible light, while failing to subject evidence of capability to the same skepticism and rigorous analysis applied to evidence of disability."

Montour, 582 F.3d at 944.

b. QDS's review violated Glenn and circuit law because it was based on and emphasized one sided, biased medical records only reviews by QDS's medical professionals who de-emphasized Kludka's evidence and failed to consider the combination of his medical conditions and his subjective complaints

Glenn's holding makes it clear that since Dr. Bevan and Genex were not provided with and did not review all the evidence¹³⁰ in Kludka's claim, it was unreasonable for QDS to rely on this evidence in its final denial. After disposing of this evidence, QDS's review and final denial was based solely on medical records only reviews from psychiatrist, Dr. Goldman and internist, Dr. Sonne.

¹³⁰ *Glenn*, 128 S. Ct. at 2351-2352.

As noted in *Montour*,¹³¹ QDS's actions in relying on a "pure paper" medical records only review raises questions regarding the thoroughness and accuracy of its decision. Moreover, a plain read of Drs. Goldman¹³² and Sonne's¹³³ reports illustrate bias and the type of selective, one sided "pure paper review" which favors the insurance company or administrator and which *Glenn* and circuit courts have frequently rejected.

“A plan administrator abuses its discretion when it ignores relevant evidence.” *Willcox v. Liberty Life Assur. Co.*, 552 F.3d 693, 701 (8th Cir. 2009).

Neither QDS or Dr. Goldman considered Kludka's evidence of disability. First, QDS did not ask Dr. Goldman to contact either Kludka, Dr. Semino or Mr. Golden. Dr. Goldman's report consists of *two (2) paragraphs of actual analysis*¹³⁴ and in those paragraphs he ignores and never analyzes any of Kludka's evidence from Dr. Semino, Mr. Golden or their medical records cited in this brief which document that Kludka's condition deteriorated following Dr. Bevan's IME. Dr. Goldman's flawed analysis violates *Willcox* and ERISA's requirement that all of Kludka's evidence be reviewed as part of a full and fair review pursuant to 29 C.F.R. § 2560.503-1(h)(2)(iv).

¹³¹ *Montour*, 582 F.3d at 944.

¹³² ER 259-265.

¹³³ ER 252-258, 98-104.

¹³⁴ ER 265.

Instead, Dr. Goldman embarks on a mission to take out Kludka's claim with biased, unexplained conclusions such as, "the claimant has grown accustomed to not working, not due to severe psychopathology, but rather due to simply ""not working,"" "The information is largely subjective and self reported," "It is not at all clear what this claimant does on a daily basis." ¹³⁵

As addressed *supra*, the absurdity of Dr. Goldman's review, his reasoning and biased opinions are laid bare by Dr. Semino and Mr. Golden's records ¹³⁶ for the year before Kludka's benefits were terminated, which document his deterioration as well as their opinions on QDS physician forms ¹³⁷ which provided objective evidence of why he was disabled. In addition, the State of Arizona found Kludka *Seriously Mentally Ill* which qualified him for psychiatric care only two (2) weeks before Dr. Goldman reviewed Kludka's claim. ¹³⁸

Dr. Goldman's flawed conclusion that Kludka's claim consisted of "largely subjective and self reported" is eviscerated by the fact Qwest and QDS sent Dr. Semino and Mr. Golden its own physician's forms for years, which specifically requested - *and they consistently provided* - objective findings of Kludka's psychiatric diagnoses and his limitations.

¹³⁵ ER 265.

¹³⁶ ER 219, 230, 232, 404-405, 426-427, 428-429, 430-431, 432-433, 434-435, 436-439.

¹³⁷ ER 446.2-446.14.

¹³⁸ ER 446.15-446.16.

Specifically, Dr. Semino completed Qwest forms setting forth objective evidence of Kludka's disability on June 18, 2004,¹³⁹ June 8, 2005,¹⁴⁰ May 18, 2006.¹⁴¹ Similarly, Mr. Golden completed the Qwest forms providing objective evidence on June 7, 2004,¹⁴² June 6, 2005,¹⁴³ May 17, 2006,¹⁴⁴ and December 28, 2006.¹⁴⁵ Qwest accepted Dr. Semino and Mr. Golden's opinions during this time and paid Kludka's claim.

If Dr. Goldman or QDS believed Kludka's claim was not perfected or documented by objective evidence, QDS had a fiduciary duty to engage him in a dialogue but failed to do so. *Montour*, 582 F.3d at 946. QDS and Dr. Goldman also had a duty to consider Kludka's subjective symptoms of disability, particularly since his claim was primarily psychiatric, since so many complaints can be subjective, but they failed to do so. In *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 873 (9th Cir. 2008) this court held:

"If MetLife is turning down Saffon's application for benefits based on Saffon's failure to produce evidence that simply is not available, that too may bear on the degree of deference the district court shall accord MetLife's decision and on its ultimate determination as to whether Saffon is disabled."

¹³⁹ ER 230.

¹⁴⁰ ER 446.12.

¹⁴¹ ER 446.9.

¹⁴² ER 232.

¹⁴³ ER 446.2

¹⁴⁴ ER 446.5.

¹⁴⁵ ER 405.

Ms. Dodson testified she "did not" consider Kludka's subjective complaints, this failure precluded full development of the claim.¹⁴⁶

Dr. Goldman failed to reference any of Dr. Semino or Mr. Golden's forms in his cursory two (2) paragraph "Assessment/Rationale."¹⁴⁷ Dr. Goldman's selective review failed to credit literally any of Kludka's evidence and his conclusion was against the weight of reliable evidence and as a result, an *Abatie* procedural violation, 458 F.3d at 972-973.

Dr. Goldman also failed to reference or explain the significance in Dr. Semino's medical records that Kludka consistently had serious psychiatric limitations as reflected in a ***GAF Score of 50*** on every visit after Dr. Bevan's IME to the final QDS denial.¹⁴⁸

On September 18, 2007 in two (2) separate letters to QDS, Kludka and Mr. Golden made it clear that after Kludka suffered a heart attack which led to triple bypass surgery only five (5) months after QDS terminated benefits, Kludka was struggling to function due to a combination of medical problems; *to wit*, the increased anxiety and panic attacks caused by his cardiac problems:

"All of my assessments undoubtedly outline the severity of my condition. I feel it was a direct result of the added stress of increased

¹⁴⁶ ER 204.

¹⁴⁷ ER 265.

¹⁴⁸ ER 426-427, 428-429, 430-431, 432-433, 434-435.

financial and medical difficulties that caused the stress related my severe heart attack in May of 2007." ¹⁴⁹

Mr. Golden confirmed the tremendous impact the combination of cardiac and anxiety symptoms were having, "Of significant note is Mr. Kludka's fear of dying has intensified since his recent cardiac symptoms/surgery." ¹⁵⁰

QDS's failure to consider the *aggregate or combined impact* Kludka's heart attack, ensuing triple bypass, cardiac symptoms, stress and fear of death precluded a full and fair review. ¹⁵¹ Ms. Dodson testified QDS did not consider the combined impact and never asked its physicians to consider it, this precluded full development of Kludka's claim. ¹⁵²

Against this evidence, *Abatie* ¹⁵³ required an adequate review and other circuit courts require QDS and Dr. Goldman to do more to survive judicial scrutiny. The court in *Glenn v. MetLife (Metro. Life Ins. Co.)*, 461 F.3d 660, 666 (6th Cir. 2006) held:

"The arbitrary-and-capricious standard . . . does not require us merely to rubber stamp the administrator's decision."

¹⁴⁹ ER 225.

¹⁵⁰ ER 406-407.

¹⁵¹ See *Kalish v. Liberty Mutual/Liberty Life Assur.Co. of Boston*, 419 F.3d 501 (6th Cir. 2005)(plan faulted for failure to consider co-morbid depression).

¹⁵² ER 211-212.

¹⁵³ 458 F.3d at 968.

However, the analysis applied by the district court was unfortunately exactly that - a rubber stamp of QDS's flawed review.¹⁵⁴

Dr. Goldman's one-sided review demands higher scrutiny, the type applied by the court in *Metro. Life Ins. Co. v. Conger*, 474 F.3d 258, 265 (6th Cir. 2007):

"Here, the administrator, in reviewing the insured's medical records, focused on slivers of information that could be read to support a denial of coverage and ignored - without explanation - a wealth of evidence that directly contradicted its basis for denying coverage. Such a decision-making process is not deliberate or principled, and the explanation provided was far from reasoned, as it failed to address any of the contrary evidence."

In *Norris v. Citibank, N.A. Disability Plan (501)*, 308 F.3d 880, 885 (8th Cir. 2002), the court held a plan administrator abused its discretion in part by failing to "address the extensive medical evidence relating to [the claimant's] disability or the consistent conclusions of her doctors and various [plan administrator] personnel that she could not work."¹⁵⁵

QDS and Dr. Goldman's failure to address any of Kludka's evidence was an abuse of discretion in *Love v. Nat'l City Corp. Welfare Benefits Plan*, 574 F.3d 392, 398 (7th Cir. 2009):

"While plan administrators do not owe any special deference to the opinions of treating physicians, see *Nord*, 538 U.S. at 834, they may

¹⁵⁴ ER 14-22.

¹⁵⁵ See also *Calvert v. Firststar Fin. Inc.*, 409 F.3d 286, 296 (6th Cir. 2005)(abuse of discretion when administrator relies on opinion of physician who fails to explain basis for rejecting other physicians' conclusions).

not simply ignore their medical conclusions or dismiss those conclusions without explanation."

The court found the same in *Majeski v. Metro. Life Ins. Co.*, 590 F.3d 478, 484 (7th Cir. 2009):

"By ignoring Majeski's key medical evidence, MetLife can hardly be said to have afforded her an opportunity for full and fair review, and its failure to address that evidence in its determination surely constitutes an absence of reasoning. *Love* goes further and unambiguously requires plan administrator to 'address any reliable, contrary evidence submitted by the claimant.'"

In the face of the numerous conflicts of interest in Kludka's claim, Dr. Goldman's review and QDS's decision to not obtain a second IME given the deterioration in Kludka's condition, the combination of his medical problems including stress,¹⁵⁶ or simply the chasm between Dr. Goldman, Dr. Semino and Mr. Golden's opinions, QDS's review is not sufficient to meet the *Montour* "modicum of evidence" requirement. 582 F.3d at 936.

Incredibly, notwithstanding Dr. Goldman's flawed review, QDS claims manager Ms. Rani Dodson emphasized and wholeheartedly accepted his opinions in QDS's final denial on October 9, 2007. As addressed *infra*, Ms. Dodson's deposition testimony¹⁵⁷ provides compelling conflict evidence with regard to why QDS never considered Kludka's evidence.

¹⁵⁶ See *Glenn*, 461 F.3d at 673 (finding failure to consider insured's stress arbitrary).

¹⁵⁷ ER 174-213.

QDS also relied on a medical records review¹⁵⁸ by internist, Leonard Sonne, M.D., who evaluated Kludka's cardiac and pulmonary diagnoses. Kludka submitted an affidavit signed by Dr. Sonne¹⁵⁹ on March 10, 2006 in another ERISA disability case titled *Ferree v. Life Insurance Company of North America*, Case No. 1:05-cv-2266-WSD, which suggests that as of that time, he was frequently retained by the disability insurance industry.

Dr. Sonne's affidavit confirms that as of 2002 he derived 20-30% of his annual income from performing medical reviews like the one performed in Kludka's case. Dr. Sonne confirmed that in an average month he completed forty (40) peer reviews and *the most he performed in one (1) month was 400*.¹⁶⁰

Given the Supreme Court's concern regarding bias of reviewing physicians as set forth in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832 (U.S. 2003), and this district court's limited discovery,¹⁶¹ Dr. Sonne's affidavit suggested *some indicia of conflict* that should have given rise to modest increased scrutiny. However, the court dismissed the affidavit and criticized Kludka for not providing more evidence of conflict when the court did not permit the same.¹⁶²

¹⁵⁸ ER 98-104.

¹⁵⁹ ER 99-104.

¹⁶⁰ ER 101.

¹⁶¹ See *Wilcox v. Metro. Life Ins. Co.*, 2009 U.S. Dist. LEXIS 2977 (D. Ariz. 2009) and Kludka's discovery and Qwest's Answers, Objections thereto, ER 91-97.

¹⁶² ER 13 and discovery order in footnote 162.

Following Kludka's triple bypass, Dr. Sonne found he was disabled ¹⁶³ for a period of time, from May 11, 2007 through May 18, 2007, May 24, 2007 through May 27, 2007 and through July 1, 2007 for recuperation; ¹⁶⁴ notwithstanding, Dr. Sonne's opinion, *QDS never stated if it accepted the opinion* or what weight, if any, it was given. Instead, QDS concluded in its final denial, "In light of the above your Long-Term Disability benefits remain denied from 02/01/2007 forward." ¹⁶⁵

Courts have found an administrator's failure to accept or follow its own physician's opinions/recommendations, as appears to have occurred in Kludka's claim, an abuse of discretion and indicia of conflict of interest. ¹⁶⁶

Dr. Sonne's report confirms he failed to consider the combined impact of Kludka's physical and psychiatric symptoms, including stress, would have on his ability to work following surgery. ¹⁶⁷

¹⁶³ ER 257.

¹⁶⁴ ER 257. Dr. Sonne's report may contain a typo, he opined "For recuperation time until 6/1/07..." This timeframe is not possible because the surgery occurred on *May 12, 2007*. Kludka assumes Dr. Sonne meant July 1, 2007.

¹⁶⁵ ER 388.

¹⁶⁶ See *Platt v. Walgreen Income Prot. Plan For Store Managers*, 455 F. Supp. 2d 734, 746-747 (M.D. Tenn. 2006); *Giannone v. Metropolitan Life Insur. Co.*, 311 F. Supp. 2d 168, *178 (D. Mass. 2004); *Chan v. Hartford Life Ins. Co.*, 2004 U.S. Dist. LEXIS 17962, *28 (S.D.N.Y. Sept. 8, 2004).

¹⁶⁷ ER 252-258.

c. Dr. Clark's multiple reviews precluded a full and fair review and violated the spirit of 29 C.F.R. § 2560.503-1(h)(3)(v)

QDS retained psychiatrist, Kelly Clark, M.D., on two (2) separate occasions to review Kludka's claim. In Dr. Clark's first review on June 10, 2006,¹⁶⁸ he opined Kludka could make a graduated return to work. QDS internal records on June 21, 2006, July 20, 2006 and August 21, 2006 confirm it denied Kludka's claim based on Dr. Clark's opinion¹⁶⁹ and QDS issued a written decision denying the claim on June 16, 2006.¹⁷⁰

Kludka never appealed the denial because he underwent the IME with Dr. Bevan; QDS records on September 18, 2006 confirm it reinstated benefits but only *through December 31, 2006*; however, this remained an adverse decision as it terminated benefits as of a date certain.¹⁷¹ On January 30, 2007, QDS again had Dr. Clark's review of the claim which led to the denial on February 5, 2007 - not surprisingly, Dr. Clark agreed with his first opinion.¹⁷² The simple fact is Dr. Clark reviewed Kludka's claim on two (2) separate occasions, both directly led to the denial of benefits.

Dr. Clark's reviews were referenced by QDS and tainted *every decision*;¹⁷³ for this reason his involvement at a minimum violated the spirit of 29 C.F.R. § 2560.503-1(h)(3)(v) and did not meet *Glenn's* "higher than market place quality standards" and QDS should have had another physician review the claim before the

¹⁶⁸ ER 269-273.

¹⁶⁹ ER 397-398.

¹⁷⁰ ER 446.17-446.21.

¹⁷¹ ER 398.

¹⁷² ER 266-268.

¹⁷³ ER 446.17-446.21, 366-371 and 376-388.

February 2007 denial. QDS's failure warrants consideration of *Abatie* extrinsic evidence.¹⁷⁴

6. ***QDS's numerous procedural irregularities precluded full development of Kludka's claim which he believes is due to conflicts of interest, pursuant to Abatie this court should consider his extrinsic evidence which connects the dots***

Kludka alleged in his complaint and argued before the district court that various conflicts of interests resulted in the termination of his benefits.¹⁷⁵ Kludka maintains these procedural irregularities precluded full development of his claim and *Abatie*¹⁷⁶ allows consideration of extrinsic evidence.

As referenced, Kludka's extrinsic evidence in part includes the depositions of QDS claim managers, Ms. Susan Mackin and Ms. Rani Dodson¹⁷⁷ who managed his claim as well as evidence regarding Pressley Reed, M.D., founder of Reed Review Services (aka Reliable Review Services), the company QDS hired to review Kludka's medical records.¹⁷⁸

As referenced *supra*, QDS completely failed to consider any of Kludka's evidence on appeal and instead wholeheartedly adopted the opinions of its medical records reviewers - Ms. Dodson's deposition testimony explains why.

¹⁷⁴ See *Pitts v. Prudential Inc. Co. of Am.*, 534 F.Supp. 779, 790 (S.D. Ohio 2008).

¹⁷⁵ ER 455-463, 18-22.

¹⁷⁶ *Abatie*, 458 F.3d at 973.

¹⁷⁷ ER 106-215.

¹⁷⁸ ER 24.1-24.15.

Ms Dodson testified that although she talked to Kludka on ten (10) different occasions she never discussed the need for him to provide “Objective Medical Findings”¹⁷⁹ and did not know how the Qwest Plan defined “Objective Medical Findings.”¹⁸⁰

Ms. Dodson testified she was instructed to rely on the "physician making the decision"¹⁸¹ and when asked what evidence she considered in Kludka's appeal she stated "I used the appeal or the reviews from Reliable,"¹⁸² and “relied 100% on the opinions of the peer review physicians.”¹⁸³ Ms. Dodson also testified, “I do not review the medical” and when Reed sends a claim for a peer medical review, “we pay them to review that information and make a decision,” and the practice at her company is to trust the Reliable physicians made the right decision.¹⁸⁴

Ms. Dodson testified she never questioned the independence of Reed's doctors and did not know whether any procedure was in place to check their opinions.¹⁸⁵

With regard to Kludka's review, Ms. Dodson testified she “would basically take the information from the physician review and put it into the document [i.e.

¹⁷⁹ ER 181-182, 186.

¹⁸⁰ ER 195-196.

¹⁸¹ ER 189.

¹⁸² ER 189.

¹⁸³ ER 191.

¹⁸⁴ ER 196-197.

¹⁸⁵ ER 189.

denial]”¹⁸⁶ and Kludka's final decision was based on “both physician reviews came back saying he was not disabled” and she “emphasized” the peer reports.¹⁸⁷

Ms. Dodson was asked if the final denial drew upon earlier denials and the only new information gathered during Kludka’s appeal were the peer reviews and she testified “Yes.”¹⁸⁸

Ms. Dodson’s testimony provides compelling evidence of an ERISA procedural irregularity that tainted the decision.

Most troubling is Qwest never proffered any *Glenn*¹⁸⁹ evidence regarding procedures to ensure accuracy of its decisions; Qwest objected to providing this evidence in discovery¹⁹⁰ and the Professional Services Agreement¹⁹¹ between Qwest and QDS related solely to business performance measures.

Kludka also offered extrinsic evidence regarding Presley Reed, M.D., who founded Reed, later renamed Reliable Review Services and who was Editor in Chief of a book named *The Medical Disability Advisor* and allegedly made comments at a conference in London, England on February 12, 2005, regarding his view of disability that, if true, including the diagnosis of depression, may raise

¹⁸⁶ ER 198.

¹⁸⁷ ER 191.

¹⁸⁸ ER 211.

¹⁸⁹ 128 S. Ct. at 2351.

¹⁹⁰ ER 95.

¹⁹¹ ER 274-311.

questions about his or his company's ability to impartially evaluate disability claims and the independence of QDS reviewing physicians and their reports.¹⁹²

Kludka's extrinsic evidence raises legitimate questions as to conflict and procedural irregularities he believes in part, resulted in the decision to terminate his benefits and may offer an explanation for why QDS and the Reed physicians provided such one sided reviews; *Abatie* allows consideration of Kludka's extrinsic evidence.

VIII. CONCLUSION WITH RELIEF SOUGHT

For all the foregoing reasons, QDS did not provide a full and fair review as required by ERISA and it abused any discretion afforded by the Qwest Plan.

Kludka respectfully asks this court to reverse the district court's denial of his motion for summary judgment and to grant his appeal.

Kludka also respectfully requests an award of pre-judgment interest on any benefits due in addition to an order awarding his reasonable attorney's fees pursuant to 29 U.S.C. § 1132(g) and costs incurred.

Respectfully Submitted,

Dated: January 5, 2011

By: /s/Scott E. Davis
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Attorney for Appellant,
Richard Kludka

¹⁹² ER 24.2-24.15

CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the type-volume limitation set forth in Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure. This brief uses a proportional typeface and 14-point font, and contains 13,991 words.

Respectfully Submitted,

Dated: January 5, 2011

By: /s/Scott E. Davis
Scott E. Davis, Esq.
SCOTT E. DAVIS, P.C.
Attorney for Appellant,
Richard Kludka

STATEMENT OF RELATED CASES

Appellant is unaware of any related case pending before this Court within the meaning of Circuit Rule 28-2.6

CERTIFICATE OF SERVICE

I hereby certify that on January 5, 2011 I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ Chris Avery