IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JEFFREY MARION,	)	
	)	Civil Action
Plaintiff	)	No. 05-CV-01288
	)	
vs.	)	
	)	
THE AGERE SYSTEMS, INC. SICKNESS AND ACCIDENT DISABILITY BENEFIT PLAN FOR OCCUPATIONAL EMPLOYEES,	)	
	)	
Defendant	)	

O R D E R

NOW, this 26th day of March, 2008, upon consideration of Plaintiff's Second Motion for Summary Judgment filed June 29, 2007; upon consideration of the Cross-Motion for Summary Judgment of Defendant The Agere Systems Inc. Sickness and Accident Disability Benefit for Occupational Employees filed July 27, 2007; upon consideration of Plaintiff's Answer to Defendants' Motion for Summary Judgment, which answer was filed August 13, 2007; upon consideration of the briefs of the parties; after oral argument conducted September 18, 2007 before the undersigned; and for the reasons expressed in the accompanying Memorandum,

IT IS ORDERED that Plaintiff's Second Motion for Summary Judgment filed June 29, 2007 is denied.

IT IS FURTHER ORDERED that the Cross-Motion for Summary Judgment of Defendant The Agere Systems Inc. Sickness and Accident Disability Benefit for Occupational Employees filed July 27, 2007 is granted.

IT IS FURTHER ORDERED that judgment is entered in favor of defendant The Agere Systems Inc. Sickness and Accident Disability Benefit for Occupational Employees, and against plaintiff Jeffrey Marion.

IT IS FURTHER ORDERED that the Clerk of Court shall marked this case closed for statistical purposes.

BY THE COURT:

/s/ James Knoll Gardner
James Knoll Gardner
United States District Judge

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Defendant	)	

* * *

APPEARANCES:

DAVID L. DERATZIAN, ESQUIRE
On behalf of Plaintiff

WILLIAM K. KENNEDY, II, ESQUIRE
On behalf of Defendant

* * *

M E M O R A N D U M

JAMES KNOLL GARDNER,
United States District Judge

This matter is before the court on the parties' cross-motions for summary judgment. On June 29, 2007, Plaintiff's Second Motion for Summary Judgment ("plaintiff's motion") was filed. On July 27, 2007, the Cross-Motion for Summary Judgment of Defendant The Agere Systems Inc. Sickness and Accident Disability Benefit for Occupational Employees ("defendant's motion") was filed. On August 13, 2007, Plaintiff's Answer to

Defendants' Motion for Summary Judgment was filed. For the reasons that follow, I grant defendant's motion and deny plaintiff's motion, and enter judgment in favor of defendant and against plaintiff.

JURISDICTION AND VENUE

This court has jurisdiction over this matter pursuant to § 502(e)(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(e)(1), and 28 U.S.C. § 1331. Venue is proper pursuant to 28 U.S.C. § 1391(b) because the events giving rise to plaintiff's claims allegedly occurred in Allentown, Pennsylvania, which is located within this judicial district.

PROCEDURAL HISTORY

Plaintiff initiated this action on March 21, 2005 by filing a three-count Complaint against Kemper National Services, Inc. and Kemper Insurance Companies (collectively "Kemper"). The Complaint sought declaratory judgment declaring that Kemper's denial of plaintiff's long-term disability benefits was arbitrary and capricious, and that plaintiff was indeed entitled to benefits; alleged a breach of contract for termination of plaintiff's disability benefits; and alleged that Kemper's action in denying plaintiff's benefits was in bad faith.

On April 22, 2005, plaintiff filed an Amended Complaint naming his employer, Agere Systems, Inc., in addition to Kemper.

In his Amended Complaint, plaintiff alleged the same three counts against both defendants. By leave of court, plaintiff filed a Second Amended Complaint on July 11, 2005. The Second Amended Complaint names two additional defendants, the Agere Systems Inc. Sickness and Accident Disability Benefit Plan for Occupational Employees ("Plan") and the Agere Systems Inc. Long Term Disability Plan for Occupational Employees ("Long Term Plan"). The Second Amended Complaint contains one count, requesting declaratory judgment declaring that defendants' denial of plaintiff's benefits was arbitrary and capricious in violation of ERISA.

On March 15, 2006, Plaintiff's Motion for Summary Judgment and the Motion of Defendants Agere Systems Inc., Sickness and Accident Disability Benefit Plan for Occupational Employees, The Agere Systems Inc. Long Term Disability Plan for Occupational Employees, Agere Systems Inc., Kemper National Services, Inc., and Kemper Insurance Companies for Summary Judgment were filed. On April 25, 2006, I heard oral argument on the motions for summary judgment.

At oral argument, plaintiff made an oral motion to dismiss certain defendants. By Order dated April 25, 2006, I granted plaintiff's oral motion and dismissed all claims against Kemper, Agere Systems, Inc., and the Long Term Plan. Accordingly, the only remaining defendant is The Agere Systems,

Inc. (short-term) Plan.

By Order dated March 29, 2007, I denied defendants' motion for summary judgment. By that Order I also granted plaintiff's motion for summary judgment in part and denied it in part. Specifically, I concluded that the plan administrator's denial of plaintiff's disability benefits was arbitrary and capricious because it failed to consider the effect of plaintiff's medication on his ability to work. Accordingly, I remanded the matter to the plan administrator, Kemper National Services, for further proceedings to examine the issue of whether plaintiff's pain management regimen rendered him disabled, and required plaintiff to supplement the record for the plan administrator's review.

By letter dated June 6, 2007, Kemper's successor as plan administrator, Aetna Life Insurance Company, issued its final determination. Aetna concluded that there was "a lack of medical and psychological evidence" to substantiate plaintiff's disability.[1] Therefore, it affirmed Kemper's decision denying

[1] The letter from Aetna Senior Appeal Specialist Lina M. Camacho states that in reaching this conclusion, Aetna reviewed the following documents: (1) a Job Analysis Worksheet for an Electronic and Photonic Processor; (2) operative reports from Orlando Regional Medical Center dated June 3, 1996 and April 7, 1997; (3) an office note from Dr. O'Connor dated September 17, 2002; (4) a progress note from Dr. Kenneth Choquette, D.O. dated September 23, 2002; (5) a Behavioral Health Clinician Statement dated October 21, 2002; (6) an Orthopaedic Associates of Allentown-Orthopedic Evaluation dated October 31, 2002; (7) a BHU review dated November 4, 2002; (8) a Disability Certificate from Macungie Medical Group dated November 25, 2002; (9) Initial Physician reports from Dr. Michael O'Connor dated September

plaintiff's claim for short-term disability benefits. (Defendant's motion, Exhibit F). The parties subsequently filed their cross-motions for summary judgment. On September 18, 2007, I heard oral argument on the within motions, and took the matter under advisement. Hence this Memorandum.

FACTS

The parties agree that no genuine issues of material fact exist. During a Rule 16 telephone status conference held on November 22, 2005, the parties agreed that this case would be disposed of by cross-motions for summary judgment based on the record before the plan administrator when it made its decision to deny plaintiff benefits. See Rule 16 Conference Order (Docket

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23, 2002, October 8, 2002 and October 25, 2002; (10) Physician Progress Reports dated November 20, 2002, December 21, 2002 and January 2, 2003; (11) a CT of the Cervical spine without contrast report dated March 28, 2001; (12) an

(Footnote 1 continued):

(Continuation of footnote 1):

MRI of the lumbar spine without contrast report dated August 31, 2002; (13) a lab report from Quest Diagnostics dated September 25, 2002; (14) a prior peer review completed by an independent peer physician specializing in Neurology dated January 7, 2003; (15) a copy of the STD termination dated January 14, 2003; (16) a progress note from Pennsylvania Pain Management, Inc. dated January 20, 2003; (17) plaintiff's appeal letter dated March 20, 2003; (18) a letter from Dr. O'Connor dated February 19, 2003; (19) a medical report from Dr. Douglas Nathanson dated February 4, 2003; (20) a physical therapy progress note, not dated; (21) a prior peer review completed by an independent peer physician specializing in orthopedic surgery dated April 10, 2003; (22) an appeal determination letter dated April 18, 2003; (23) an Order of this court dated March 29, 2003; (24) a letter from David L. Deratzian, attorney at law; and (25) a letter from Dr. O'Connor dated April 16, 2007. Defendant's motion, Exhibit F.

Although Aetna's letter does not specify, I infer that the March 29, 2007 Order to which the letter refers is my Order remanding this matter for further consideration of whether plaintiff's medication regimen renders him disabled.

Entry No. 17). Based upon the pleadings, record papers, depositions, exhibits, and the parties' statements of undisputed facts, the pertinent facts are as follows.[2]

Plaintiff Marion has been employed with Agere, Inc. or one of its predecessor companies since 1984. Most recently, he was employed as an electronic and photonic processor at defendant Agere. The physical workload of an electronic and photonic processor is described as "light to sedentary" physical work.

In September 2002, Mr. Marion applied for short-term benefits under the Plan. Under the Plan, in order for Mr. Marion to be entitled to benefits, the plan administrator must determine

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[2] My original Rule 16 Status Conference Order dated November 22, 2005 required, in pertinent part, that "any party filing a motion for summary judgment or partial summary judgment shall file and serve, in addition to a brief, a separate short concise statement, in numbered paragraphs, of the material facts about which the moving party contends there is no genuine dispute. The moving party shall support each such material fact with specific citations to the record, and, where practicable, attach copies of the relevant portions of the record."

In their original summary judgment motions filed March 15, 2006, the parties included statements of fact with citations to the record within the body of their respective motions, but did not file separate, numbered statements of fact. Plaintiff's second motion for summary judgment, filed June 29, 2007, contains a section titled "Statement of Undisputed Facts."

Defendant's second motion for summary judgment, filed July 27, 2007, states that "[t]he facts relating to the identity of the parties, the relationship between Kemper and Agere, the terms of the Plan, plaintiff's employment with Agere, plaintiff's initial claim for short-term disability benefits, and plaintiff's appeal of Kemper's denial of benefits are undisputed and unchanged since defendant's and plaintiff's first cross-motions for summary judgment. The only new facts are those related to the actions taken by the parties pursuant to the [March 29, 2007 Order remanding the case for further review by the plan administrator]."

that he cannot perform any of the substantial and material duties of the job he had before his disability, and that he is unable to be accommodated at another job within the company.

In his claim for benefits, Mr. Marion alleged that he was unable to perform his job duties because of physical disabilities related to his back condition. Mr. Marion has a history of neck and back pain. On June 3, 1996, he underwent a cervical laminectomy at C6-7. On April 7, 1997, he underwent an anterior cervical discectomy and fusion at C4-5 and C5-6 with bank bone graft and segmental plating. On August 31, 2002 an MRI of the lumbar spine revealed a mild broad-based right paracentral disc protrusion at L4-5 and a broad-based central disc protrusion at L5-S1.

These medical complications, as well as the pain medication which plaintiff was taking to control his back pain, were the basis for the opinion of plaintiff's treating physician, Michael O'Connor, D.O., that plaintiff was permanently disabled. Mr. Marion also had another treating physician, Kenneth J. Choquette, D.O.

Mr. Marion was preliminarily granted short-term benefits under the Plan on October 8, 2002. His benefits continued until January 14, 2003. The benefits were discontinued because a physician peer review conducted by Vaughn D. Cohan,

M.D. found that there was no objective physical proof for finding that Mr. Marion was disabled from performing his job as an electronic and photonic processor. Kemper, acting as the plan administrator, relied on this opinion and decided that plaintiff should not continue to receive short-term benefits. Plaintiff was advised that he could appeal this decision.

Mr. Marion appealed the plan administrator's decision to deny him benefits. After plaintiff appealed, a neurologist, Lawrence Blumberg, M.D., reviewed Mr. Marion's appeal. Dr. Blumberg concurred with Dr. Cohan that there was no objective physical evidence that plaintiff was physically disabled. On April 18, 2003, Kemper advised Mr. Marion that his appeal was denied and that his administrative rights had been exhausted. Plaintiff subsequently filed this action.

CONTENTIONS

Plaintiff's Contentions

Plaintiff contends that Aetna's decision to affirm Kemper's denial of benefits was arbitrary and capricious because it ignored uncontradicted evidence that plaintiff's pain management regimen renders him unable to work. Specifically, plaintiff avers that he was consistently treated with multiple narcotics and that representatives of Kemper were aware, as early as September 2002, that plaintiff's physicians were concerned

that the effects of a narcotic pain management regimen would prevent plaintiff from safely working.

Plaintiff argues that neither Kemper nor Aetna have directly contradicted the findings of Dr. O'Connor, one of plaintiff's treating physicians, who determined that plaintiff is impaired by the necessary medical regimen. Plaintiff avers that because Aetna had no information directly refuting the treating physician's opinion that the medication made it unsafe for plaintiff to work, the plan administrator arbitrarily and capriciously denied his benefits. Therefore, plaintiff contends that the determination should be reversed and benefits awarded.

Defendant's Contentions

Defendant contends that, based on the evidence in plaintiff's file, including the reports of three independent peer physicians who conducted a thorough review of plaintiff's medical records, Aetna reasonably determined that the information plaintiff and his doctors submitted did not support a finding of disability entitling plaintiff to disability benefits under the Plan.

Defendant avers that, to supplement the record for the plan administrator's review, plaintiff submitted only a single letter from one of his treating physicians, Dr. O'Connor, which contained no medical diagnosis, test results, reports or notes of observations. Rather, defendant contends that the letter

contained only Dr. O'Connor's opinions that (1) plaintiff's medications can cause side effects including somnolence and decreased ability to concentrate; (2) such side effects may be magnified by interaction with other medications plaintiff was taking; and (3) plaintiff was unable to work at Agere because of side effects from his narcotic medication. Thus, defendant argues that because plaintiff failed to provide objective evidence of actual effects of symptoms of his pain regimen, his claim cannot succeed.

Moreover, defendant avers that the plan administrator was not required to accept the unsupported conclusions of plaintiff's treating physician, even if the reviewing physicians did not present directly conflicting evidence. Therefore, defendant argues that Aetna appropriately relied on the independent peer physicians' review in making its determination that plaintiff was not entitled to benefits. Defendant contends that because Aetna's decision is supported by substantial evidence, the court should not disturb the plan administrator's denial of benefits.

STANDARD OF REVIEW

In considering a motion for summary judgment, the court must determine whether "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of

material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c). See also Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247, 106 S.Ct. 2505, 2509-2510, 91 L.Ed.2d 202, 211 (1986); Federal Home Loan Mortgage Corporation v. Scottsdale Insurance Company, 316 F.3d 431, 443 (3d Cir. 2003). Only facts that may affect the outcome of a case are "material". Moreover, all reasonable inferences from the record are drawn in favor of the non-movant. Anderson, 477 U.S. at 255, 106 S.Ct. at 2513, 91 L.Ed.2d at 216.

Although the movant has the initial burden of demonstrating the absence of genuine issues of material fact, the non-movant must then establish the existence of each element on which it bears the burden of proof. See Watson v. Eastman Kodak Company, 235 F.3d 851, 857-858 (3d Cir. 2000). A plaintiff cannot avert summary judgment with speculation or by resting on the allegations in his pleadings, but rather he must present competent evidence from which a jury could reasonably find in his favor. Ridgewood Board of Education v. N.E. for M.E., 172 F.3d 238, 252 (3d Cir. 1999); Woods v. Bentsen, 889 F.Supp. 179, 184 (E.D.Pa. 1995).

DISCUSSION

The issue before the court is whether the plan administrator's decision to deny plaintiff disability benefits should be affirmed, or reversed as arbitrary and capricious.

Under ERISA, a beneficiary of a benefits plan may bring an action to recover benefits due him under the plan. 29 U.S.C. § 1132(a)(1)(B); Poehlmann v. Deutsche Bank Americas Severance Pay Plan, 2005 U.S. Dist. LEXIS 16118, at *13 (E.D.Pa. Aug. 8, 2005)(Schiller, J.). However, ERISA is silent on the proper standards by which the district court should review fact findings made by plan administrators. Luby v. Teamsters Health, Welfare & Pension Trust Funds, 944 F.2d 1176, 1179 (3d Cir. 1991).

In Firestone Tire and Rubber Company v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 956-957, 103 L.Ed.2d 80, 95 (1989), the United States Supreme Court held that courts must review a denial of ERISA benefits under a de novo standard unless the "benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." When the plan confers such discretion, courts apply an arbitrary and capricious standard of review. Smathers v. Multi-Tool Inc./Multi-Plastics, Inc. Employee Health and Welfare Plan, 298 F.3d 191, 194 (3d Cir. 2002); Doyle v. Nationwide Insurance Companies & Affiliates Employee Health Care Plan, 240 F.Supp.2d 328, 335 (E.D.Pa. 2003).

The parties agree that the arbitrary and capricious standard of review applies.[3] Therefore, I do not consider whether a conflict of interest exists that warrants a less

[3] See plaintiff's motion, pages 14-16, and defendant's motion, pages 5-6.

deferential, heightened form of arbitrary and capricious review. See Pinto v. Reliance Standard Life Insurance Co., 214 F.3d 377 (3d Cir. 2000). Thus, I apply the arbitrary and capricious standard.

Under arbitrary and capricious review, a court may overturn the plan administrator's decision "only if [the decision] is without reason, unsupported by substantial evidence or erroneous as a matter of law." Abnathya v. Hoffman-La Roche, Inc., 2 F.3d 40, 45 (3d Cir. 1993)(internal quotations omitted). A court cannot second guess or overturn the plan administrator's decision for the purpose of substituting the court's own judgment. Id.

As discussed above, by Order dated March 29, 2007, I concluded that the plan administrator's initial determination denying plaintiff's benefits was arbitrary and capricious because it only considered plaintiff's impairments in the absence of his medication, even though the plan administrator was aware that at least one of the treating physicians was concerned about the effects of the medication. Moreover, I determined that there was insufficient evidence in the record for the plan administrator to determine that plaintiff's medication did not render him disabled under the terms of the plan. Therefore, I remanded the matter for plaintiff to supplement the record and for further evaluation

by the plan administrator.

On remand, the plan administrator, now Aetna, upheld the decision of its predecessor, Kemper. In its letter to plaintiff dated June 6, 2007, Aetna stated that plaintiff's file had been reviewed by an independent peer physician specializing in physiatry, orthopedic surgery and psychiatry. Moreover, the peer review physician conducted a conference call with plaintiff's treating physician, Dr. O'Connor.[4]

The Aetna Appeal Committee concluded that there was a "lack of medical and psychological evidence (i.e., behavioral observations, mental status examinations, functional examination findings, range of motion measurements, diagnostic testing, etc.) to substantiate [plaintiff's] disability".[5] Therefore, Aetna upheld Kemper's decision to deny plaintiff's benefits. Plaintiff argues that Aetna's decision was arbitrary and capricious because it did not directly refute Dr. O'Connor's opinion that plaintiff's pain medication rendered him unable to work.

A plan administrator may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician. However, the plan administrator is not required to accord special weight to the opinions of a claimant's physician. Moreover, a court may not "impose on plan

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[4] Defendant's motion, Exhibit F.

[5] Id.

administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834, 123 S.Ct. 1965, 1972, 155 L.Ed.2d 1034, 1044 (2003). This standard applies even when a peer-review physician does not conduct a physical examination of a patient, and his opinion is based solely on a review of the patient's record. See Dinote v. United of Omaha Life Ins. Co., 331 F.Supp.2d 341, 347-349 (E.D.Pa. 2004).

Nevertheless, a plan administrator must give notice to a claimant of the specific reason or reasons why his claim was denied. Trump v. General Electric Pension Plan, 1992 U.S.Dist. LEXIS 7372, at *16 (E.D.Pa. May 5, 1992)(Waldman, J.); 29 C.F.R. § 2560.503-1(g).

A professional disagreement between the plan's physicians and the claimant's treating physician does not automatically amount to an arbitrary refusal to credit the treating physician's opinion. See Stratton v. E.I. DuPont de Nemours & Co., 363 F.3d 250, 258 (3d Cir. 2004); see also Schlegel v. Life Insurance Company of North America, 269 F.Supp.2d 612, 627-628 (E.D.Pa. 2003).

Among the documents considered by the plan administrator on remand is the April 16, 2007 letter from Dr. O'Connor, plaintiff's treating physician, which plaintiff

submitted to Aetna pursuant to my March 29, 2007 Order. In pertinent part, Dr. O'Connor's letter states:

> Jeffrey Marion has been continuously under my care since 2001. Among the medical issues I treat him for are chronic neck pain and chronic back pain. His treatment is rendered by me, in conjunction with Dr. Kenneth Choquette, of Pennsylvania Pain Management. My primary role has been the management of pain medication. Over the past five years, Mr. Marion has been prescribed various different analgesic (pain) medications of the narcotic and non-narcotic variety.
>
> Despite the injections performed by Dr. Choquette, Mr. Marion requires high doses to manage his pain and retain any level of normal function in his daily life. Unfortunately, these medications can cause somnolence and decreased ability to concentrate. The effect of his medication can also be magnified by interactions with other medications he takes for an unrelated problem.
>
> Mr. Marion was unable to perform his job at Agere because of the somnolence and other side effects of his narcotic medication. Additionally, he was unable to perform any job whatsoever due to these same side effects.
>
> These medications are all necessary and no substitutes have been found, so Mr. Marion was and is a risk in many work environments.

Defendant's motion, Exhibit B.

Defendant contends that Dr. O'Connor's letter fails to present objective medical evidence supporting plaintiff's claim that his medication has actual side effects or symptoms that render him disabled. Rather, defendant argues that Dr. O'Connor's letter merely reasserts plaintiff's previous claims without providing clinical reports or diagnostic tests to support them. Therefore, defendant asserts that Aetna was justified in

relying on the findings of peer physicians Eddie Sassoon, M.D.; Robert Ennis, M.D.; and Barry M. Glassman, M.D., each of whom reviewed plaintiff's record and concluded that it did not support plaintiff's claim for disability benefits.

In his report dated May 15, 2007, Dr. Sassoon concluded that "While Dr. O'Connor raises the concern that the claimant has been treated with narcotic medications that may result in somnolence there are no documented episodes of somnolence...or neuropsychological screens indicating any cognitive or high-level thought process deficits. The examination from Dr. O'Connor on 2/4/03 revealed clinical and oriented memory concentration appropriate." Defendant's motion, Exhibit C.

Dr. Sassoon specifically addressed whether plaintiff's medication renders him unable to work. In response to the question "Do the medications that Mr. Marion is taking impact his ability to perform the duties of his job?", Dr. Sassoon answered

> No. There is no evidence of impaired neuropsychological screen or functional deficits from a cognitive or fine motor coordination perspective that would preclude the claimant from performing duties of his job. Additional information will be gladly reviewed. This therefore does not support disability from claimant's occupation for the entire period in time.

Defendant's motion, Exhibit C. Additionally, Dr. Sassoon indicated he had attempted to consult with Dr. Choquette, one of

plaintiff's treating physicians, but was unsuccessful. Id.

Dr. Ennis, an orthopedic surgeon, conducted a conference call with Dr. O'Connor in addition to reviewing plaintiff's record. His report dated May 18, 2007 acknowledges Dr. O'Connor's position that plaintiff "is experiencing somnolence and side effects of these medications which impaired his ability to concentrate and caused cognitive effects making return to work activities difficult according to him." However, Dr. Ennis also notes that "[t]here is no independent documentation of these medications [sic] side effect other than that noted in Dr. O'Connor's note of 4/16/07." Defendant's motion, Exhibit D.

Ultimately, Dr. Ennis's report does not answer the question of whether plaintiff's pain management regimen renders him unable to work. Dr. Ennis found this question to be "beyond the scope of [his] orthopedic evaluation" and concluded that the medical record and documentation did not, from an orthopedic perspective, support a functional impairment that would preclude plaintiff from returning to his job duties. Defendant's motion, Exhibit D.

Psychiatrist Barry Glassman's report dated May 29, 2007 found that Dr. O'Connor had "provide[d] no behavioral observations or mental status examination" and that there was "no documentation that the claimant's medications are impacting his

ability to perform the duties of his job." Defendant's motion, Exhibit E.

All three peer review physicians concluded that the record does not support plaintiff's claim that he is disabled and unable to work. As discussed above, Dr. Ennis did not directly address whether plaintiff's medication, as opposed to his physical condition, prevents him from working. Nevertheless, Dr. Ennis did note that plaintiff had not submitted independent evidence of the side effects, aside from Dr. O'Connor's letter.

Plaintiff contends that because none of the three peer physicians directly contradict Dr. O'Connor's finding that plaintiff is impaired by his medication, Aetna acted arbitrarily and capriciously in refusing to credit Dr. O'Connor's opinion. Specifically, plaintiff argues that Black & Decker's holding that courts may not "impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation" does not apply here, because the plan administrator did not actually credit contradictory evidence, but rather found that plaintiff had not supported his claim with satisfactory evidence. See Black & Decker, 538 U.S. at 834, 123 S.Ct. at 1972, 155 L.Ed.2d at 1044.

Plaintiff cites no authority for his assertion that where a plan administrator's consultants do not directly find evidence to contradict the treating physician's opinion, Black &

Decker does not apply and the Plan must credit the treating physician's evaluation or explain its reasons for failing to do so. Indeed, as plaintiff concedes, Black & Decker specifically rejects the so-called "treating physician rule" under which many Circuit Courts of Appeals previously required that a treating physician's opinion be accorded more weight than that of a consultant. Black & Decker, 538 U.S. at 834, 123 S.Ct. at 1972, 155 L.Ed.2d at 1044.

Moreover, under Black & Decker, I cannot require Aetna to explain its decision to credit reliable evidence (specifically, the peer reviews) which conflicts with Dr. O'Connor's evaluation. 538 U.S. at 834, 123 S.Ct. at 1972, 155 L.Ed.2d at 1044. Plaintiff presents no evidence indicating that the peer physicians' conclusions are unreliable.

While the plan administrator may not arbitrarily refuse to credit a claimant's reliable evidence, I conclude that, in this case, it has not done so. Aetna specified in its letter denying benefits that it had considered Dr. O'Connor's April 16, 2007 letter, together with numerous other documents. Defendant's motion, Exhibit F.

Moreover, each of the peer physicians' reports makes clear that the physicians considered Dr. O'Connor's concern that the side effects of plaintiff's medication affected his ability to work. Two of the three, specifically Dr. Sassoon and Dr.

Glassman, concluded that the record did not support Dr. O'Connor's assertions regarding the side effects of plaintiff's medication. Defendant's motion, Exhibits C, E. (Dr. Ennis, although concluding that the medication's side effects were beyond the scope of his evaluation, also concluded that the record did not support plaintiff's claim of disability precluding him from working. Defendant's motion, Exhibit D.) Moreover, Dr. Ennis spoke directly to Dr. O'Connor by conference call. Id.[6]

[6] Plaintiff avers that the plan administrator improperly reads into the Plan a requirement of "objective medical evidence." Plaintiff is correct that the Plan does include the phrase "objective medical evidence" in order to successfully obtain benefits. See Appendix, pages 491-517 (summary plan description of the Plan). However, the Plan does require, among other things, that a claimant "[p]rovide information from [his] physician, satisfactory to the Plan Administrator, certifying [claimant's] disability, including the nature and frequency of [claimant's] treatment." Appendix, page 502.

Plaintiff relies on Cohen v. Standard Insurance Company, 155 F.Supp.2d 346, 354 (E.D.Pa. 2001) and Mitchell v. Eastman Kodak Company, 113 F.3d 433, 442 (3d Cir. 1997) for the proposition that Aetna is not allowed to require "objective medical evidence" of plaintiff's disability because the Plan does not expressly require it.

Mitchell limits its holding to the particular context of that case, in which a claimant submitted "undisputed facts" to support his claim that he suffered from chronic fatigue syndrome ("CFS") and was unable to work. Mitchell, 113 F.3d at 442-443. The court determined that it was arbitrary and capricious for the plan administrator to require clinical evidence of the etiology of CFS because it was widely accepted in the medical and legal communities that, in fact, no "'dipstick' laboratory test" for CFS exists. Therefore, it would be impossible for the claimant to make a clinical showing of his disease, even though it is "universally recognized as a severe disability". Id. at 443.

Cohen held that a plan administrator arbitrarily and capriciously denied a claimant benefits on the basis that he had not supplied objective medical evidence that work stress increased his risk of accelerating heart disease. Specifically, the court found that the Plan required only that plaintiff prove his disability "as a result of sickness, injury, or pregnancy" and defined sickness as "sickness, illness, or disease", rather than requiring "objective medical evidence." The court held that because plaintiff had submitted "substantial objective evidence," including the opinions of his treating physicians and objective medical literature, the Plan was arbitrary and capricious in denying benefits. Cohen, 155 F.Supp.2d at 354.

I conclude that neither Mitchell nor Cohen is applicable here.

All three concluded that the record did not support plaintiff's claim.

The plan administrator has a duty to resolve factual disputes, including those in the medical record. Sollon v. Ohio Casualty Insurance Company, 396 F.Supp.2d 560, 586 (W.D.Pa. 2005) (Standish, J.). That a plan administrator resolves competing opinions in a manner unfavorable to a claimant does not constitute an abuse of discretion. See Johnston v. Hartford Life and Accident Insurance Company, 2004 WL 1858070, at *10 (E.D.Pa. Aug. 19, 2004)(Kelly, Robert F., S.J.).

The plan administrator is not required to accord special weight to Dr. O'Connor's opinion, nor is it required to

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First, Mitchell clearly limits its holding to the context of that particular case. Here, plaintiff does not suggest that he cannot prove the etiology of his condition, but rather that he does not have to. On the contrary, the Plan requires plaintiff to supply "information...satisfactory to the Plan Administrator, certifying your disability." The Plan's determination that plaintiff has not met this burden does not render its decision arbitrary and capricious. See Johnston v. Hartford Life and Accident Insurance Company, 2004 WL 1858070, at *10 (E.D.Pa. Aug. 19, 2004)(Kelly, Robert F., S.J.).

(Footnote 6 continued):

(Continuation of footnote 6):

See also Dinote, 331 F.Supp.2d at 349, which notes that "For conditions with known etiologies, insurance companies commonly require that the insured party provides objective medical evidence before he receives disability benefits" and concluded that the plan's request for additional objective evidence of plaintiff's "widely recognized ailments with established etiologies" was not unreasonable.

Second, Cohen is inapplicable because the court found "substantial evidence" that defendant's conflict of interest played a role in the plan's decision to deny the claimant's benefits, and therefore applied a heightened arbitrary and capricious standard. Cohen, 155 F.Supp.2d at 252. As discussed supra, here plaintiff has not alleged that a conflict of interest exists which justifies the application of a heightened standard of review, and agrees that the arbitrary and capricious standard should be applied.

explain its decision to credit the peer physicians' conclusion that the record does not support plaintiff's claim. Black & Decker, 538 U.S. at 834, 123 S.Ct. at 1972, 155 L.Ed.2d at 1044; see also Stratton, 363 F.3d at 258. Because the peer physicians considered Dr. O'Connor's opinion and addressed it in each of their respective reports, I conclude that Aetna's decision is supported by substantial evidence. Abnathya, 2 F.3d at 45. Moreover, it is clear that the peer reviewers actively attempted to collaborate with plaintiff's treating physicians. See Dinote, 331 F.Supp.2d at 349.

Therefore, I conclude that Aetna, in its discretion, permissibly resolved the issue of plaintiff's alleged disability by crediting the reports of the peer physicians which concluded that the record did not support Dr. O'Connor's opinion. Because Aetna's decision was not arbitrary or capricious, I grant defendant's motion for summary judgment.

CONCLUSION

For all the foregoing reasons, I grant defendant's motion for summary judgment and deny plaintiff's motion for summary judgment, and I enter judgment in favor of defendant and against plaintiff.