IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

- -

PAMELA GIBSON,

Plaintiff,

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Defendant.

OPINION and ORDER

10-cv-246-bbc

- -

Plaintiff Pamela Gibson contends that defendant Unum Life Insurance Company violated her rights under the Employee Retirement Income Security Act by denying her claim for long-term disability benefits and failing to provide medical records that she requested. The parties' cross motions for summary judgment are now before the court.

With respect to the denial of benefits, I cannot reach the merits of the claim because plaintiff failed to properly exhaust her administrative remedies, as required by the law of this circuit. Plaintiff's other claim fails because liability for failing to provide plan documents is limited to the plan administrator, which in this case is plaintiff's employer, not defendant. Accordingly, I will grant defendant's motion for summary judgment and deny plaintiff's motion.

From the parties' proposed findings of fact and the record, I find that the following facts are undisputed.

UNDISPUTED FACTS

A. The Plan

Plaintiff Pamela Gibson was employed by Entegris, Inc. as a "quality control technician." Her "primary responsibilities" were "quality notifications, receiving and final inspection, customer complaint handling and returns, new and change product qualifications and control, statistical process control and general metrology, application and control." Entegris provided plaintiff a group long-term disability plan through defendant Unum Life Insurance Company. Entegris is the plan administrator.

The plan included the following provisions:

> HOW DOES UNUM DEFINE DISABILITY?
>
> You are disabled when Unum determines that:
>
> - you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
> - you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.
>
> * * *
>
> LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and

- cannot be reasonably omitted or modified.

* * *

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision for review will be made not later than 45 days following receipt of the written request for review.[1]

B. Plaintiff's Claim for Disability Benefits

Plaintiff stopped working for defendant on July 23, 2007 and requested short-term disability benefits for fibromyalgia and chronic fatigue syndrome. In a letter dated August 17, 2007, defendant approved short-term disability benefits beginning on July 30, 2007, and continued to approve them through January 2008, when the plan's short-term disability period ended.

Defendant began reviewing plaintiff's claim for long-term disability benefits on

[1] Plaintiff objects to some of defendant's proposed findings of fact regarding the language in the plan because defendant cited the wrong page or a page that was missing from the copy of the plan defendant provided to this court. E.g., Plt.'s Resp. to Dft.'s PFOF ¶¶ 3-4, dkt. #41. Defendant's lack of care in preparing and citing the record did not harm plaintiff because she provided the court a full copy of the plan that includes the cited language.

January 31, 2008. At this time, plaintiff returned to work on a part-time basis, but she continued to miss days. Her nurse practitioner blamed this on increased pain and fatigue and "disrupted sleep." On July 16, 2008, plaintiff underwent a sleep study after which the nurse practitioner conducting the study concluded that the results were "predominately consistent with REM behavior disorder."

In October 2008, defendant concluded that it was "unable to determine current or past functionality with the records in the file." As a result, defendant hired Mark C. Agre, M.D., M.S., to conduct an "independent medical examination" of plaintiff on December 1, 2008.

After the examination, Agre concluded in his report that plaintiff "meet[s] the American College of Rheumatology criteria for the classification of fibromyalgia," but that "[f]ibromyalgia, by its nature, is a subjective-based determination. By its nature there is no real clinical data to support it other than self-reported tenderness on palpatory examination, and history." With respect to chronic fatigue syndrome, he wrote that he is "unable to confirm or deny" a diagnosis. In addition, he wrote that "deconditioning and weakness are basically objectively noted on physical exam, but [this] is typical in my clinic as a musculoskeletal physical medical clinic in many clients, and the vast majority of these work full-time and unrestricted." He concluded that he could not "objectively present data or findings that would preclude this individual from being appropriately full-time employed."

However, he also concluded that he "would not expect" her to carry more than 15 pounds "occasionally" or 8 pounds "frequent[ly]" and that he "would not anticipate her standing, sitting consistently beyond ~ 30-60 minutes without the ability to change positions."

In a portion of Agre's report titled "Record Review," he included the following passage:

> Handwritten note from Chanhassen Chiropractic 10/10/07: Among the objective findings of the chiropractor include tenderness palpating cervical and thoracic area. Pain increases with weather changes. Decreased active range of motion of the cervical-lumbar spine, subluxation C1-2, C6-7, T1-2, L4-5, right and left sacroiliac. States she had never been to a chiropractor before. Notes include 10/10, 10/11, 10/17, 10/22 and 10/24/07: first being a new condition, slight improvement the next two and exacerbated the next two. I suspect she discontinued at that point. It appears manual therapy was directed at the cervical, lumbar and sacroiliac joints and thoracic initially.

Using Agre's report, defendant conducted an occupational analysis to determine whether the demands of plaintiff's occupation exceeded her restrictions. It concluded that "the demands of this occupation as performed in the general economy do not exceed the IME restrictions and limitations (i.e. the lifting of 15 pounds occasionally and 7 pounds frequently with intermittent sitting, standing and walking every 30 to 60 minutes)."

In a letter dated December 23, 2008, defendant informed plaintiff that it was discontinuing her benefits:

> Based on the information in our file, we have concluded that disability is not supported by medical documentation. Your primary diagnosis as indicated in your medical records is Fibromyalgia and Chronic Fatigue Syndrome. You

> underwent a sleep study which documented possible REM behavior otherwise unremarkable. There was no evidence of hypersomnolence or narcolepsy. However, you continued to complain of fatigue and diffuse pain. Additional lab reports found no evidence of rheumatological, infectious or autoimmune disorder.
>
> Our onsite physician contacted Dr. Baum [sic; Ms. Baum, nurse practitioner] on October 22, 2008, who agreed that an Independent Medical Examination (IME) would be beneficial. The IME was completed and concluded that you are able to return to work full-time with specific restrictions and limitations such as lifting 15 pounds occasionally and 7 pounds frequently with intermittent sitting, standing and walking every 30 to 60 minutes.
>
> We completed an Occupational Analysis (OA) to determine if these restrictions prevent you from performing the duties of your occupation as performed in the general economy. Based on the OA, the demands of your occupation do not exceed the IME restrictions and limitations.
>
> The IME provided also indicated that you would need a graduated return to work. Specifically, 4 hours per day, 5 days a week for two weeks, then increase by one hour per day every two weeks until full-time due to your deconditioning. We have agreed to provide you with full benefits during this time frame which will be extended to February 16, 2009.

On February 18, 2009, plaintiff underwent a "functional capacities assessment." The conclusion of that assessment was that plaintiff's "physical capabilities fall below the sedentary work level." On March 26, 2009, plaintiff provided a copy of the report to defendant, which forwarded it to Agre for review. In response, Agre wrote that he "continue[s] to feel there is work she could/will be able to do, but needs to work up to it."

In a letter dated April 29, 2009, defendant declined to change its decision:

> We reviewed the Functional Capacities Assessment (FCA) which you

> completed on February 18, 2009, and forwarded a copy of the assessment to Dr. Agre. Dr. Agre completed your Independent Medical Examination (IME) on December 1, 2008. Dr. Agre concluded that the FCA did not change his previous opinion and that you could return to work half time, and work your way to full time incrementally. We considered this graduated return to work upon our determination and benefits were provided to February 16, 2009. Therefore, your LTD claim remains closed.

C. Appeal and Records Request

In a letter dated May 26, 2009, plaintiff (through counsel) asked defendant for a copy of the administrative record. Plaintiff concluded the letter with the following sentence: "While this letter shall constitute notice of the appeal of denial, it is requested that Unum not take any action to consider the appeal until such time as we have had an opportunity to both review the current Administrative Record, and to supplement the record with additional documentary evidence to support Ms. Gibson's claim." Defendant responded on May 28, stating, "We hope to make a determination on your client's claim within 45 days of receiving your client's appeal, unless special circumstances extend the time needed to make a determination." In a letter to plaintiff dated May 29, 2009, defendant wrote the following:

> We have received your letter dated May 26, 2009 indicating your intent to appeal our decision on your client's Long Term Disability claim.
>
> Please note that Ms. Gibson's request for appeal must be received in writing by Unum Life Insurance Company of America no later than 180 days from the date your client received our decision letter of December 23, 2008. If you are in need of an extension of time to submit the appeal, please notify us in writing.

Defendant provided plaintiff a copy of the "long term disability administrative record" on June 2, 2009. However, plaintiff told defendant that records from the Chanhassen Chiropractic Clinic and the Allina Medical Clinic were missing. In response, defendant told plaintiff that the records from the Chanhassen clinic were included in plaintiff's "short term disability claim file" and that it would provide the file upon written request. However, defendant stated that it did "not see notes from Allina Medical Clinic" in either file.

On July 27, 2009, plaintiff provided defendant an affidavit in which she identified alleged "omissions and misstatements of fact" in Agre's report. In response, defendant called plaintiff to ask whether she wished defendant to begin reviewing the appeal. Plaintiff's counsel stated that "he will review the file and let [defendant] know."

In a letter dated August 21, 2009, plaintiff renewed her request for the records from the Chanhassen and Allina clinics. The same day, defendant sent plaintiff the short-term disability file (which included the Chanhassen records) and informed plaintiff that it did not have records from the Allina clinic. In addition, defendant stated that "we are now beyond [the] time frame" for filing an appeal.

In a letter to defendant dated December 23, 2009, plaintiff wrote the following:

> On May 26, 2009, we appealed Unum's termination of Ms. Gibson's benefits. Since that time we have provided you with Ms. Gibson's Affidavit and her signed medical authorization. We are requesting that Unum immediately

> reverse the termination of Ms. Gibson's benefits based on the medical evidence in the file that her fibromyalgia, fatigue and sleep disorder prevent her from performing the substantial duties of her work.
>
> The objective evidence of Ms. Gibson's disability includes positive CMV lab test result ordered by [the nurse practitioner]. In addition, the 07.16.08 Sleep Study reveals Ms. Gibson's REM behavior disorder and possibility of parasomnia. The 11.16.07 physical examination performed by Rheumatology Nurse Associates established clinical evidence of 18/18 tender points. Moreover, the 2.18.09 Functional Capacities Assessment proves that Ms. Gibson is able to lift and carry only 5 lbs., has generalized deconditioning, functional limitations in stair climbing, standing and bilateral hand strength. Her grip was also functionally limited.
>
> Based on the objective medical evidence in Unum's possession, it is clear that Ms. Gibson qualifies for LTD benefits under the policy. Thank you for your timely attention to this matter.

In response, defendant wrote, "Because we received your request for review on December 23, 2009, which is well beyond the 180-day deadline, we regret that we cannot review your client's claim and the original decision must stand."

OPINION

A. Exhaustion of Administrative Remedies

It is undisputed that defendant made its decision to deny plaintiff's claim for long-term disability benefits on December 28, 2008, and that plaintiff did not ask defendant to take action on her appeal until December 23, 2009. Under the plan, plaintiff had "180 days from the receipt of notice of an adverse benefit determination to file an appeal." Plaintiff

does not suggest that there was a substantial delay between the time defendant issued its decision and when she received it. Cf. Baldwin County Welcome Center v. Brown, 466 U.S. 147, 148 n.1 (1984) (applying presumption that plaintiff received letter from Equal Employment Opportunities Commission three days after commission issued letter).

ERISA does not include a provision mandating exhaustion of administrative remedies before filing a lawsuit, but the Court of Appeals for the Seventh Circuit has imposed one on its own. Powell v. AT&T Communications, Inc., 938 F.2d 823 (7th Cir. 1991) ("[T]he strong federal policy encouraging private resolution of ERISA-related disputes mandates the application of the exhaustion doctrine to statutory claims for breach of a fiduciary duty under ERISA."). Although early cases such as Powell suggested that courts have great discretion in determining whether exhaustion is required in a particular case, more recent cases have framed it as a requirement. E.g., Contilli v. Local 705 International Brotherhood of Teamsters Pension Fund, 559 F.3d 720, 724 (7th Cir. 2009) ("Exhaustion of administrative remedies is one of ERISA's requirements."); Zhou v. Guardian Life Ins. Co. of America, 295 F.3d 677, 679 (7th Cir. 2002) ("As a pre-requisite to filing suit, an ERISA plaintiff must exhaust his internal administrative remedies."). Further, the court of appeals has held that the consequence of a failure to exhaust in an ERISA case is dismissal rather than a remand to the administrator to complete the exhaustion process. Stark v. PPM America, Inc., 354 F.3d 666, 672 (7th Cir. 2004) ("[T]he proper remedy is dismissal of the

case. [Plaintiff] cannot be allowed to skip the administrative procedure, cause the defendants to incur litigation costs, and then, after losing, be allowed to exhaust his remedies.").

Most of the cases in this circuit regarding exhaustion under ERISA seem to involve a party who tried to skip one or more steps in the administrative review process. This case is a bit different, because the question is not whether plaintiff was required to file an appeal, but whether she needed to request review within the deadlines set by defendant.

The parties do not cite any cases in which the Court of Appeals for the Seventh Circuit considered whether an untimely appeal should be treated in the same way as no appeal at all for the purpose of the ERISA exhaustion requirement, but I do not believe that there is a relevant difference for three reasons. First, other courts have concluded that dismissal is required for an untimely administrative appeal. Chorosevic v. MetLife Choices, 600 F.3d 934, 944-45 (8th Cir. 2010) ("[D]eeming [plaintiff's untimely] appeals exhausted . . . would enable claimants to easily circumvent a plan's appeals procedure, thereby rendering toothless a plan's time limits for claims and appeals."); Swanson v. Hearst Corp. Long Term Disability Plan, 586 F.3d 1016, 1019 (5th Cir. 2009) (affirming dismissal of ERISA claim for failure to exhaust when plaintiff failed to comply with defendant's 180-day appeal deadline); Gayle v. United Parcel Service, Inc., 401 F.3d 222, 228 (4th Cir. 2005) (affirming dismissal of ERISA claim for untimely administrative appeal because "[s]uch

procrastination would not only prejudice more punctilious participants, but might well eviscerate the 180-day deadline entirely"). Plaintiff does not cite any cases in which a court has come to a contrary conclusion.

Second, the Court of Appeals for the Seventh Circuit has held that dismissal is appropriate if the claimant failed to comply with a deadline in the plan for filing a lawsuit after completing the exhaustion process. Abena v. Metropolitan Life Insurance Co., 544 F.3d 880, 884 (7th Cir. 2008). If a plan may shorten the statute of limitations for filing a lawsuit, it is difficult to see why it could not impose its own internal deadlines. (In Aebna, the court stated that the deadline must be a reasonable one, but plaintiff does not argue that 180 days is an inadequate amount of time as a general matter.)

Finally, the Supreme Court has held that, when exhaustion is required, the general rule is that the plaintiff must "compl[y] with an agency's deadlines and other critical procedural rules because no adjudicative system can function effectively without imposing some orderly structure on the course of its proceedings." Woodford v. Ngo, 548 U.S. 81, 90-91 (2006) (concluding that prisoner's failure to comply with 15-day grievance deadline required dismissal of case). The parties identify no reason why exhaustion in the ERISA context would depart from the general rule.

Although defendant raises the issue of exhaustion in its opening brief, surprisingly, plaintiff does not directly respond to the argument in her response brief. However, in the

context of discussing other issues and in her proposed findings of fact, plaintiff hints at two reasons she believes that dismissal is not appropriate. First, plaintiff suggests that she *did* appeal the decision when she sent defendant a letter on May 26, 2009 in which she wrote the following: "While this letter shall constitute notice of the appeal of denial, it is requested that Unum not take any action to consider the appeal until such time as we have had an opportunity to both review the current Administrative Record, and to supplement the record with additional documentary evidence to support Ms. Gibson's claim."

Plaintiff cites no authority for the proposition that a claimant may toll the deadline for appeal simply by telling the administrator to do so. The plan states that a claimant has "180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review." Olson Aff., dkt. #24-6, at 128. This language suggests that defendant equates an "appeal" with a "request for review." Thus, a claimant has not filed an appeal for the purpose of the 180-day deadline until she asks the administrator to take action on it.

No other conclusion makes any sense. A notice of appeal serves no purpose if the appeal cannot move forward until the appellant gives further approval. Accepting plaintiff's position would render meaningless any deadline for appeal in the plan and give the claimant the ability to delay an appeal for years simply by filing a "placeholder" with the

administrator.

To the extent the plan leaves any ambiguity, defendant clarified the deadline in its May 29 letter to defendant in which it told plaintiff that it still needed an appeal from her within 180 days of the December 23 decision and that she should ask for an extension if she needed one. Defendant reminded plaintiff of the deadline again in July when plaintiff filed an affidavit with defendant. At that time, defendant expressly asked plaintiff whether she wished defendant to begin review of the appeal, but she told defendant to wait. Even when defendant told plaintiff in August 2009 that her appeal deadline had expired, plaintiff waited another four months before asking defendant to begin review. Under these circumstances, plaintiff cannot argue plausibly that she did not have adequate notice of her obligations under the plan or that she acted diligently in pursuing her administrative remedies. Swanson, 586 F.3d at 1017 (ERISA plaintiff did not toll deadline for filing administrative appeal by sending defendant letter stating, "[p]lease accept this letter as notice of Debra Swanson's intention to appeal your decision terminating her benefits under the above referenced policy. Once we have had adequate time to review and supplement the record, we will notify you in writing to proceed with Debra Swanson's administrative appeal under the terms of the Plan.").

Alternatively, plaintiff suggests that her failure to seek review earlier is defendant's fault because it had not produced all of the documents she requested. Although she does not

say so expressly, this suggests that plaintiff is attempting to invoke the exception that exists to the exhaustion requirement "if there is a lack of meaningful access to review procedures." Stark, 354 F.3d at 671. For example, in Wilczynski, 93 F.3d at 402-04, the court held that a claimant's failure to file an administrative appeal may be excused when the administrator fails to provide "pertinent documents" on which it relied to deny benefits.

This line of argument cannot carry the day for multiple reasons. First, plaintiff has not established that she needed any of the requested documents to file a proper appeal. Counts v. American Gen. Life & Accident Insurance Co., 111 F.3d 105, 109 (11th Cir.1997)(ERISA administrator's failure to answer requests for information about benefits decision did not justify failure to exhaust where plaintiff was not denied meaningful access to administrative review process). With respect to the documents from the Allina clinic, plaintiff has failed to show even that defendant ever *had* those documents and she does not cite any instance in which defendant relied on them. With respect to the documents from the Chanhassen Chiropractic Clinic, plaintiff cites one passage from the report of Mark Agre, who conducted the "Independent Medical Evaluation" on behalf of defendant. In the portion of the report titled "Record Review," Agre identifies a "[h]andwritten note" from the clinic stating that plaintiff had "tenderness palpating" and a decreased range of motion in multiple areas. Olson Aff., dkt. #24-2, at 50. However, Agre did not rely on that note in his conclusions or question the note's accuracy, which makes sense because the note is

consistent with Agre's view that plaintiff "meet[s] the American College of Rheumatology criteria for the classification of fibromyalgia." Defendant did not cite the note in its decision to deny benefits.

For her part, plaintiff has not identified a single reason why the records from the Chanhassen clinic would be important to her administrative appeal. Tellingly, plaintiff did not cite any records from the clinic in her December 23 letter requesting review and she has not relied on them in her briefs or proposed findings of fact filed in this court. Even if plaintiff believed that she needed those records to file an appeal, she could have asked for an extension of time as suggested by defendant, explaining her reasons for doing so. Instead, plaintiff simply ignored defendant's repeated reminders that her time was running out.

Even if I assumed that plaintiff's request for the Chanhassen records stayed her deadline, that would not be enough to save her claim. Plaintiff did not ask defendant for those documents until May 26, 2009, five months after defendant issued its decision; defendant provided the records in late August 2009; and plaintiff requested review on December 23, 2009, another four months later. Plaintiff does not suggest that defendant was required to provide records to her before she requested them or otherwise argue that the five months that lapsed before her request should be excluded from the calculation of her deadline. Thus, even if I exclude the time that plaintiff was waiting for the clinic records, this would buy plaintiff three extra months, but it would still leave a nine-month period

between the decision and request for review, which is still well over the 180-day deadline. Accordingly, plaintiff's claim that defendant acted unreasonably in denying her claim for long-term disability benefits must be dismissed for plaintiff's failure to exhaust her administrative remedies.

B. Records Request

Under 29 U.S.C. § 1132(c)(1), "[a]ny administrator . . .who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary . . . within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal." In a one-page argument, plaintiff says that defendant may be held liable under this provision for failing to provide within 30 days the records from the Chanhassen and Allina clinics. She cites 29 C.F.R. § 2560.503-1(h)(2)(iii), which states that "a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits." A document is "relevant" if it "[w]as relied upon in making the benefit determination" or "[w]as submitted, considered, or generated in the course of making the benefit determination." 29 C.F.R. § 2560.503-1(m)(8).

Plaintiff did not include this claim in her complaint, but defendant does not object

to the claim on that ground. However, defendant is correct that liability under § 1132(c)(1) is limited to the *plan* administrator, Mondry v. American Family Mutual Insurance Co., 557 F.3d 781, 794 (7th Cir. 2009), which in this case is plaintiff's employer. The court of appeals has "rejected the contention that other parties, including claims administrators, can be held liable for the failure to supply participants with the plan documents they seek." Id. Accordingly, even if I assume that the requested documents were "relevant" under the regulations and that defendant had the ability to provide those documents, plaintiff cannot prevail on a claim under § 1132(c)(1) against defendant.

ORDER

IT IS ORDERED that defendant Unum Life Insurance Company's motion for summary judgment, dkt. #30, is GRANTED and plaintiff Pamela Gibson's motion for summary judgment, dkt. #21, is DENIED. The clerk of court is directed to enter judgment

in favor of defendant and close this case.

Entered this 3d day of January, 2011.

BY THE COURT:
/s/
BARBARA B. CRABB
District Judge