ESTORIA PATTON v. CONTINENTAL CASUALTY COMPANY and CNA GROUP LIFE ASSURANCE COMPANY

CIVIL ACTION No. 04-0220

UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

2005 U.S. Dist. LEXIS 5463

March 31, 2005, Decided

COUNSEL: [*1] For ESTORIA PATTON, Plaintiff: MARC H. SNYDER, FRANK & ROSEN, ELKINS PARK, PA.

For CONTINENTAL CASUALTY COMPANY, CNA GROUP LIFE ASSURANCE CO., Defendants: MICHAEL J. BURNS, CHRISTIE PABARUE MORTENSEN & YOUNG, PHILADELPHIA, PA.

JUDGES: TIMOTHY J. SAVAGE, J.

OPINION BY: TIMOTHY J. SAVAGE

OPINION

MEMORANDUM AND ORDER

Savage, J.

Estoria Patton brought this action against the defendants Continental Casualty Company and CNA Group Life Assurance Company (collectively referred to as "Continental"), [1] pursuant to the *Employee Retirement Income Security Act of 1974 ("ERISA")*, to recover short term disability benefits which Continental denied. Patton contends that Continental arbitrarily and capriciously denied her claim after her functionally disabling medical condition forced her to leave her employment. Both parties have moved for summary judgment.

1 At oral argument, defense counsel stated that although CNA and Continental are related but different corporate entities, benefits are payable by Continental Casualty Company, which is the proper defendant.

[*2] Admitting that Patton has had blepharospasm since November 2001, Continental maintains that she is not entitled to short term disability benefits because her condition did not prevent her from doing her job on a continuous basis.

After a thorough examination of the administrative record and after oral argument, we conclude that Continental's decision was not supported by substantial evidence. Applying a heightened standard of review, we find that Continental's denial of Patton's disability claim was arbitrary and capricious. Therefore, we shall grant summary judgment in favor of the plaintiff.

Background

Estoria Patton ("Patton"), a fifty-eight year old woman, had been employed at AmeriChoice Health Service, Inc. ("AmeriChoice") as a Registered Nurse Quality Management Coordinator since 1990. Her job

duties included reading, working on a computer, and reviewing files.

She was covered under a group short term disability insurance policy issued by Continental that was provided by her employer as part of its employee benefits plan. The policy and plan undisputably constitute an "employee welfare benefits plan" under *29 U.S.C. § 1102*. *Def. Mem. Supp.* **[*3]** *Cross-Mot. Summ. J.* at 2.

Patton began seeing various physicians for recurring eye problems in 2000. Initially, glaucoma was the primary diagnosis. As time passed, other eye symptoms developed. On November 23, 2001, Patton stopped working. *CCC* 00150. She filed a short term disability benefits claim on January 9, 2002.

Diane Pugh, a Continental nurse case manager, denied Patton's claim on February 4, 2002, after speaking with Patton, Patton's supervisor, and reviewing medical records. Patton requested reconsideration and submitted additional medical records. Pugh again denied the claim and sent it for formal appellate review.

Cheryl Sauerhoff of the appeals team affirmed the denial. She noted that the claimant had normal visual acuity and normal vision fields, moderate dry eyes, and significant meibomianitis. Sauerhoff determined that none of these conditions or the treatments prescribed for them prevented Patton from working.

Patton obtained counsel who requested reconsideration of the claim. Sauerhoff reopened it to consider new information regarding Patton's inability to work. Based on the "complexity" of the evidence, Sauerhoff sent Patton's file to an opthalmologist consultant, **[*4]** Dr. James L. Garvey, for review. Dr. Garvey opined that "it is reasonable to assume that if the claimant's episodes of blepharospasm are infrequent enough to allow her to drive, that she should be able to perform the visual demands of her chosen occupation." *CCC* 00006-07.

On November 26, 2003, after receiving Dr. Garvey's letter, Continental determined that Patton remained functional and her condition did not prevent her from working. Summarizing the bases for its determination at that time, Continental stated: Patton was able to drive; the episodic nature of her symptoms was not continuous, but intermittent; her condition had no organic basis; and, she had no loss of visual acuity. Therefore, it concluded that Patton was not disabled. *CCC* 00003.

Patton then instituted this action. The parties have agreed that disposition of the motions for summary judgment will decide the case in lieu of trial.

Blepharospasm

Blepharospasm is a condition where involuntary contractions of the facial muscles cause the eyelids to close, rendering the patient unable to see. *CCC* 00184 (Joseph Jankovic, M.D., *Blepharospasm: Neurological Considerations* (undated)). It may occur only **[*5]** in the eye area or may be associated with contractions of the facial muscles. STEDMAN'S MEDICAL DICTIONARY 213 (27th ed., 2000).

Blepharospasm is a specific subcategory of dystonia, the general term for involuntary muscle movements and spasms. Francisco Cardoso, M.D. and Joseph Jankovic, M.D., *Dystonia and Dyskinesia*, PSYCHIATRIC CLINIC N. AM., Dec. 1997, at 821-38, *available at* http://www.dystonia-support.org/LA-Dysto nia%20and%20Dyskinesia.htm ("*Cardoso & Jankovic, PSYCHIATRIC CLINIC article*").

The symptoms usually develop "in the fifth decade of life, affecting women more often than men." *Cardoso & Jankovic, PSYCHIATRIC CLINIC article*; *see also Albright v. Apfel, 1999 U.S. Dist. LEXIS 19039, No. 99-319, 1999 WL 1129102, at *2 n.4 (N.D. Ill. 1999)* (summarizing blepharospasm). Initially, patients experience excessive blinking, "often wrongly attributed to 'dry eyes.'" *Cardoso & Jankovic, PSYCHIATRIC CLINIC article*; *see also CCC* 00184 ("Other conditions often considered in differential diagnosis include . . . 'dry eyes' . . . ."). More sustained involuntary closure of the eyelids develops, causing "functional blindness in 15% of patients." *Cardoso & Jankovic, PSYCHIATRIC* **[*6]** *CLINIC article*. Many blepharospasm patients also experience lower facial spasms and painful light sensitivity. Stanley M. Saulny, M.D., *Blepharospasm, Benign Essential, at* http://www.emedicine.com/oph/topic202.ht m (last modified Aug. 18, 2004) ("*Saulny, emedicine article*"); *Cardoso & Jankovic, PSYCHIATRIC CLINIC article*.

Until the 1970s, dystonia was viewed as a psychological condition. More recently, some researchers believe that the condition may have an organic basis caused by brain lesions. *Cardoso & Jankovic,*

PSYCHIATRIC CLINIC article (citing A. Cammarota et al., *Cervical dystonia due to spinal cord ependymoma: Involvement of cervical cord segments in the pathogenesis of dystonia*, 10 MOVEMENT DISORDER 500-03 (1995)). Hence, it is properly characterized as a neuropathologic, rather than a psychopathologic, disorder.

What causes the condition is unknown, and "most view blepharospasm as a defect in circuit activity, rather than a defect at a specific locus" of the brain. *Saulny, emedicine article*. The condition is aggravated by stress and relieved by relaxation, causing many treating physicians to incorrectly suspect that the source of the condition **[*7]** is mental or psychological. *CCC* 000184. Even with treatment, the condition often progressively deteriorates. *See Saulny, emedicine article.*

Blepharospasm medical literature is limited. Consequently, a doctor may not have had prior contact with a known case or an awareness of the condition. *CCC* 00179. Patients are frequently treated with antidepressants and tranquilizers because their physicians incorrectly diagnose the problem as emotionally rooted. *CCC* 00179.

Botulinum toxin ("botox") is a recent advancement in the treatment of blepharospasm. *CCC* 00184. For patients who do not respond to Botox and medical therapy, a surgical procedure, "limited myectomy," may relieve symptoms by removing the spasmodic muscles around the upper eyelid. *CCC* 00185 (James R. Patrinely, M.D., *Update on the Limited Myectomy* (undated)).

The Policy

Continental's policy provides short term disability benefits to a temporarily disabled employee at the rate of seventy percent of her weekly earnings or $ 1000 a week, whichever is less, for a maximum period of eleven weeks or until benefits become payable under the long term disability policy, whichever occurs first. *POLICY* **[*8]** 00003, 00009. An employee is considered "disabled" if she suffers from an injury or sickness that physically or mentally impairs the employee so severely that she is "continuously unable to perform the Material and Substantial Duties of [her] Regular Occupation." [2] *POLICY* 000015. The policy defines "Material and Substantial Duties" as "the necessary functions" of the employee's occupation. *POLICY* 00021.

2 The employee also must not be working for wages in any other occupation for which she is or becomes qualified by education, training or experience. *POLICY* 00015. This is not at issue in this case because it is undisputed that Patton has not worked since stopping on November 23, 2001.

To qualify for short term disability payments, an insured must be disabled for thirty consecutive days after she stops working. *POLICY* 00009, 00015. The policy requires an insured to provide specific information to Continental, including the date the disability began, its cause, the prognosis, proof of medical **[*9]** treatment, and objective medical findings. *POLICY* 00019.

ERISA Standard of Review

The denial of benefits under an ERISA qualified plan must be reviewed using a deferential standard. Where the plan administrator has discretion to interpret the plan and to decide whether benefits are payable, the fiduciary's exercise of discretion is judged by an arbitrary and capricious standard. *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989)*. A court is not free to substitute its judgment for that of the administrator. *Abnathya v. Hoffmann-La Roche, Inc., 2 F.3d 40, 41 (3d Cir. 1993)*. Accordingly, deferring to the plan administrator, a court will not reverse the administrator's decision unless it was "without reason, unsupported by substantial evidence or erroneous as a matter of law." *Id. at 45*.

Where the evidence raises a question of the plan administrator's impartiality or there is an inherent conflict of interest, a heightened standard of review is demanded. *Pinto v. Reliance Std. Life Ins. Co., 214 F.3d 377 (3d Cir. 2000)*; *see also Goldstein v. Johnson & Johnson, 251 F.3d 433, 442 (3d Cir. 2001)*. **[*10]** A reviewing court must focus its heightened review in light of "the nature and degree of apparent conflicts" between the insurer and the employer. The greater the conflict, the less deference that is given. *Pinto, 214 F.3d at 393*.

Such a conflict of interest arises when an insurance company funds, interprets, and administers a disability plan because "the nature of the relationship between the funds, the decision, and the beneficiary invites self-dealing and therefore requires closer scrutiny." *Pinto, 214 F.3d at 383-84*. The Third Circuit treats these arrangements as creating an inherent conflict of interest,

requiring greater scrutiny. *Id. at 387, 390*.

Where there is an inherent conflict requiring a heightened standard of review, a court must use a sliding-scale approach, giving less deference to the administrator's decision as the level of the conflict rises. *Id. at 391-92*. Courts consider several factors to determine on a case-by-case basis whether the application of a heightened standard is appropriate based on an inherent conflict of interest, including "the sophistication of the parties, the information accessible **[*11]** to the parties, the exact financial arrangement between the insurer and the company . . . and the current status of the fiduciary." *Id. at 392*.

Even absent an inherent conflict, procedural bias in the review process also mandates a closer look at the decisionmaking, utilizing a moderately heightened standard of review. *Kosiba v. Merck & Co., 384 F.3d 58, 67-68 (3d Cir. 2004)*. Procedural anomalies can appear in a variety of ways. Examples of procedural bias that invite a higher standard of review include: relying on the opinions of non-treating over treating physicians without reason, *Kosiba, 384 F.3d at 67-68*; failing to follow a plan's notification provisions and conducting self-serving paper reviews of medical files, *Lemaire v. Hartford Life & Accident Ins. Co., 69 Fed. Appx. 88, 2003 WL 21500334, at **4 (3d Cir. 2003)*; relying on favorable parts while discarding unfavorable parts in a medical report, *Pinto,214 F.3d at 393-94*; denying benefits based on inadequate information and lax investigatory procedures, *Friess v. Reliance Std. Life Ins. Co., 122 F. Supp. 2d 566, 574-75 (E.D. Pa. 2000)* **[*12]** (Brody, J.); and ignoring the recommendations of an insurance company's own employees that benefits be reinstated, *Pinto, 214 F.3d at 394*. In situations where a financial conflict of interest is compounded by evidence of procedural bias, a "significantly heightened" standard applies. *Kosiba, 384 F.3d at 68*.

Here, the plan gives Continental the discretionary authority to interpret its terms and determine eligibility for benefits: "The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to benefits in accordance with the Plan." *POLICY* 00023. It also funds the plan. Thus, a heightened standard of review will be applied.

Applying a heightened standard of review, we shall analyze the evidence Continental relied upon in determining that Patton was not entitled to benefits. We shall also examine Continental's treatment of the evidence to see if there were any procedural anomalies further heightening our scrutiny.

Evidence Available to Continental

In considering Patton's claim, Continental reviewed the medical records and diagnostic reports from **[*13]** eight physicians who treated her from 2000 to 2003, and interviews with both Patton and her work supervisor. It had medical literature on blepharospasm, the condition which the parties agree Patton has. Finally, in making its decision, Continental received a two-paragraph report and opinion of the doctor it had hired to review these records.

These materials revealed that Patton's eye problems evolved over time, and adversely affected her work, culminating in her leaving her employment. Initially, she developed narrow angle glaucoma. Eventually, other difficulties arose, including light sensitivity, dry eyes, and excessive blinking. After misdiagnosing "dry eye syndrome," her physicians unsuccessfully treated her with conventional dry eye syndrome treatments, such as punctal plugs and artificial tears. Her condition was finally correctly diagnosed as blepharospasm.

Patton began treating with her family physician, Dr. Veronica Gabriel, for dry eye problems in May 2001. Dr. Gabriel suspected narrow angle glaucoma. *CCC* 00163. She learned that Patton had laser eye surgery at Wills Eye Hospital and had been prescribed "various opthalmologic preparations," including steroid eyedrops, **[*14]** during the previous year. Over-the-counter medications failed to alleviate Patton's dry eye symptoms. Dr. Gabriel noted that Patton had sustained a jaw fracture and memory deficits from a 1985 motor vehicle accident. In May 2001, Dr. Gabriel referred Patton back to Dr. Jonathan Myers, who had performed the laser surgery, to consider the possibility that Patton had Sjogren's syndrome. [3] *CCC* 00163. At that time, Dr. Gabriel concluded that Patton's symptoms were "almost causing a work disability." *CCC* 00163.

> 3 Sjogren's syndrome is a systemic autoimmune disorder initially characterized by dry mouth and eyes. STEDMAN'S MEDICAL DICTIONARY 1537 (under definition of "syndrome") (25th ed., 1990); Sjogren's Syndrome Foundation, Inc., About Sjogren's Syndrome, *What is Sjogren's*

Syndrome?, *at* http://www.sjogrens.org/syndrome (last visited March 2, 2005).

Although Dr. Myers had seen Patton for glaucoma in 2000, his treatment records covering these early visits are not in the administrative record. The earliest **[*15]** report from Dr. Myers is dated May 2001. He found Patton's chronic angle closure glaucoma stable with reasonable pressure control. Attempting to relieve Patton's significant dry eye symptoms, he modified her prescription eye medications. As of May 18, 2001, Dr. Myers felt that her condition had not yet become disabling, though it made her significantly uncomfortable. *CCC* 00220. Characterizing her symptoms as "significant but not severe," he could not conclusively diagnose Sjogren's syndrome. *CCC* 00220. In the summer of 2001, Patton reported to Dr. Myers that she was having "trouble with reading." *CCC* 00241.

When Dr. Gabriel saw her again on August 10, 2001, Patton's dry eye syndrome had become "severe." Dr. Gabriel again mentioned Sjogren's syndrome as a possible diagnosis. *CCC* 161. After Patton reported to Dr. Myers on November 2, 2001, that she was "having [a] very difficult time reading," Dr. Myers referred her to Dr. Christopher J. Rapuano, an opthalmologist, for a corneal evaluation. *CCC* 00237.

Dr. Rapuano documented that Patton was "currently having a difficult time with dryness and severe problems reading." *CCC* 00160. Her vision was 20/20 in both **[*16]** eyes. He diagnosed Patton with severe and significant meibomianitis and mild to moderate dry eyes. He treated her with warm compresses, preservative-free tear drops, and erythromycin ointment. *CCC* 00160.

Patton stopped working on November 23, 2001. Reporting that "she can't keep her eyes open long enough to read and function at work," she returned to Dr. Rapuano on November 28, 2001. *CCC* 00230. Opining that "it was reasonable to try punctal occulsion" to relieve the symptoms in her left eye, Dr. Rapuano placed a silicone plug in Patton's left lower tear duct.

The plug did not help. So, Patton returned to Dr. Rapuano on December 14, 2001. He observed that the plug was in "perfect" position and that his patient had some intraocular pressure. His examination showed stable blepharitis [4] and meibomianitis. [5] He suggested that she consider seeing a neuro-opthalmologist if her symptoms did not improve.

4 Blepharitis is a common and chronic eyelid inflammation condition that is not related to blepharospasm. *See* Benign Essential Blepharospasm Research Foundation, BEBRF Blepharospasm Pages, *What Is Blepharospasm?*, *at* http://www.blepharospasm.org (last modified March 1, 2005) ("Blepharospasm should not be confused with . . . Blepharitis - an inflammatory condition of the lids due to infection or allergies.").

[*17]

5 Meibomianitis is the chronic inflammation of the Meiobian glands, the oil-secreting glands on the interior of the eyelid. National Library of Medicine and National Institute of Health, MedlinePlus Medical Encyclopedia, *Meibomianitis*, *at* http://www.nlm.nih.gov/medlineplus/ency/article/001621.htm (last updated December 23, 2002).

Patton applied for short term disability benefits on January 9, 2001. In support of her claim, Patton submitted a form completed by Dr. Gabriel which indicated that Patton was disabled. Dr. Gabriel stated that Patton's opthalmologic treatment was ongoing, that her return-to-work date was uncertain, and that she likely could not resume full duties upon returning to work. *CCC* 00153. The diagnoses were chronic meibomianitis, dry eye syndrome, and suspected narrow angle glaucoma. [6]

6 Another opthalmologist, Dr. T. Ramsey Thorp, saw Patton on January 10, 2002. In his letter to Dr. Gabriel of January 25, 2002, he noted that Patton was using Trusopt 2% and Timoptic 1/2 % on both eyes twice per day. This is the only record from Dr. Thorp; however, many other physicians directed their letters summarizing Patton's treatment to him. Yet, it is unclear what his role was in Patton's treatment.

[*18] In a Medical Assessment Tool form which she submitted to Continental on January 24, 2002, Dr. Gabriel indicated that Patton's primary diagnosis was unexplained vision loss, with secondary diagnoses of dry eye syndrome, and narrow angle glaucoma. She also recorded that treatment was being carried out by specialists in neurology and opthalmology. *CCC* 00150. She observed that Patton's eyes closed involuntarily when she was reading and that she was having trouble focusing

on print when reading. *CCC* 00154.

As Dr. Rapuano had suggested, Patton saw a neuro-opthalmologist, Dr. Lawrence A. Kerson, on February 5, 2002. He learned that her eye problems impeded her ability to read, drive, and focus on her computer screen; that she walked into things; and, she had trouble using her eyes functionally. *CCC* 00113. Dr. Kerson could not discern a clear explanation for Patton's vision symptoms. *CCC* 00114. His differential diagnosis was a structural brain lesion, or "perhaps some neuropsychological issue," or a psychiatric explanation. Because he believed her 1985 head injury could be relevant to a diagnosis, he recommended a brain MRI and a neuropsychological evaluation. *CCC* 00114.

[*19] While observing Patton reading, Dr. Kerson saw that she was unable to concentrate after the first few lines and that her eyes closed. He opined that her eyes closed because she was uncomfortable with the reading. He noticed "adventitious movements" with Patton's lower face and mouth, and that after the book was removed, her eyes "were able to open." *CCC* 00115.

Patton returned to Dr. Myers on February 22, 2002, reporting that she had driving and reading problems and "still [had] to watch where [she] walks." *CCC* 00236. When Patton saw Dr. Kerson on February 26, 2002, he wrote that it was "quite clear that she has eyelid and mouth and other facial muscular movements that are adventitious and not at all typical of the kind of organic dyskinetic movements we sometimes see." He suspected that the muscular problems were "almost certainly psychiatrically/anxiety generated." *CCC* 00109. He recommended psychotropic medication and thought an anti-depressant or anti-anxiety medication might be useful. *CCC* 00109.

When Dr. Myers saw Pattonon March 28, 2002, she was still having trouble reading and driving. *CCC* 00233. Testing revealed that she had almost full field vision **[*20]** in her right eye and an enlarged blind spot in the left eye. She had trouble keeping her eyelid open while he was testing her left eye. *CCC* 00233-234. Dr. Myers recommended that she continue her current medication.

On April 10, 2002, due to a change in insurance, Patton began seeing Dr. Joan Beckwith at the Philadelphia Department of Public Health. Dr. Beckwith's report references a history of "eye lid spasms." *CCC* 00036. She documented "blepharospasm and facial dystonia," as well as closed angle glaucoma and dry eyes. *CCC* 00021. On July 2, 2002, after conducting a physical examination, reviewing Patton's medical records and clinical history, and performing tests and diagnostic procedures, Dr. Beckwith concluded that Pattonwas" permanently disabled" due primarily to her blepharospasm and facial dystonia, and secondarily to glaucoma. *CCC* 00174 (Philadelphia Department of Public Welfare form).

In a letter to Temple University's Opthalmology Clinic dated August 8, 2002, Dr. Myers summarized Patton's history. [7] He reported that since he began treating Patton in September 2000, she had developed chronic angle closure glaucoma, peripheral iridotomies, ocular pressure, **[*21]** persistent inflammation, blepharitis, meibomianitis and "significant difficulties with dry eye syndrome." *CCC* 00253. By June of 2001, her left eye had developed an enlarged blind spot and possibly early Bjerrum scotoma. [8] *CCC* 00254. During vision field testing in early 2002, Patton had difficulty keeping her left eye open. *CCC* 00254.

7 A change in Patton's health insurance required her to switch physicians.

8 Also known as an arcuate scotoma, Bjerrum scotoma is a comet-shaped arching blind spot occurring in some glaucoma patients. STEDMAN'S MEDICAL DICTIONARY 1395 (under definition of "scotoma") (25th ed., 1990); *see also* The Joint Commission on Allied Health Personnel in Ophthalmology, Catalog of Continuing Education Courses, Module 11: The Visual Pathways and Visual Field Defects, Section 3: Types of Visual Field Defects,"*Location and Shape*," *at* http://www.eyetec.net/group3/M11S3.htm (last visited March 2, 2005) (containing visual images).

Patton saw Dr. Beckwith approximately **[*22]** ten times between April 10, 2002, and July 16, 2003. *CCC* 00023-00037. On each visit, the doctor noted Patton's continuing eye trouble. During this same time period, Patton made four visits to the Temple University Hospital Opthalmology Clinic, between June 14 and December 16, 2002, for light sensitivity and eye spasms. *CCC* 00063-64, *CCC* 00072-75, *CCC* 00077-78.

On February 4, 2003, when Dr. Steven L. Galetta, a neuro-opthalmologist, saw Patton, he found that she had dry eyes, difficulty focusing her eyes, excessive blinking

and spontaneous facial movements. *CCC* 00060. He wrote that "her eyelid closure seems to be precipitated by anxiety and she has trouble with controlling it voluntarily." *CCC* 00060. Dr. Galetta suspected Meige's Syndrome and advised that Patton see an oculoplastic specialist for possible Botox injections to help her. *CCC* 00060-61.

At Dr. Galetta's suggestion, Dr. Beckwith referred Patton to Dr. Allen Wulcon March 10, 2003, for treatment of blepharospasm and Meige's Syndrome. [9] *CCC* 00026. Dr. Wulc saw Patton on March 27, 2003. He learned that her blepharospasm had been present for approximately two years. He opined that her involuntary **[*23]** eye closure resulted in "essential blindness," and that, without treatment, she is unable to perform work involving vision. *CCC* 00177. He wrote, "she should not be driving and not be in a position where visual function is necessary for work." *CCC* 00177.

9 Meige's Syndrome is a term sometimes used interchangeably with blepharospasm. The term Meige's Syndrome is appropriately used when a patient has jaw and tongue movement in addition to blepharospasm. Dystonia On-Line Support Group, *Dystonia Defined*, *at* http://www.dystonia-support.org/dystonia %20defined.htm (last visited Mar. 29, 2005).

Continental's Consideration of the Evidence

Continental assigned Patton's claim to Diane J. Pugh, a Continental nurse case manager. [10] Describing Patton's symptoms as vague, Continental requested medical records from Patton's treating physicians and conducted telephone interviews with the plaintiff and her employer. CCC 00104. When Pugh called Dr. Rapuano to verify Patton's near vision, she was told that **[*24]** Patton had perfect reading vision. CCC 00105. Pugh called Patton again, who stated that the problem "began a while ago" and that she cannot read because her eyes blink and close, and she cannot keep them open. Pugh contacted Dr. Gabriel who told her that Patton had trouble keeping her eyes open when reading and that "her restriction is no reading." *CCC* 00105.

10 Continental had initially assigned Patton's claim to "A. Richards." A. Richards made notes on the claim analysis record on January 11 and January 23, 2002. *CCC* 00106. All notes in the claim analysis record after January 23, 2002, were made by Diane J. Pugh.

Pugh decided that Patton's description of her symptoms was not corroborated by the evidence. She stated that despite plaintiff's contention that she could not see to read, one of her doctors stated that she had "perfect reading vision"; her employer did not corroborate incidents of Patton walking into walls; and, her family practitioner had not personally observed a spasmodic episode. *CCC* **[*25]** 00104-00105.

Characterizing Patton's complaints to Dr. Gabriel as "subjective," *CCC* 00104-105, Pugh denied Patton's claim on February 4, 2002. *CCC* 00137-138. The initial denial letter notes that Patton's reported difficulty in keeping her eyes open and focused when reading was not supported by the medical evidence. Pugh stated that although Patton may have a condition, the "medical evidence in your file does not support impairment in your function that would preclude you from the Material and Substantial Duties of your Regular Occupation." *CCC* 00137-138.

After receiving the denial, Patton requested reconsideration and submitted additional medical records and information to Continental, including records from a 1985 motor vehicle accident in which she suffered head injuries and Dr. Kerson's report from her February 5, 2002, visit. *CCC* 00269. Citing Dr. Kerson's evaluation, Pugh found that Patton had 20/20 visual acuity in each eye, reactive and normal pupils, healthy fundi, normal corneas, full ocular mobility, and normal eyelids. *CCC* 00104. She noted that Dr. Kerson, after observing Patton's eye and facial movement problems while Patton attempted to read a book, **[*26]** opined that her eyes closed because she was "very uncomfortable" with the reading, and observed what he characterized as "adventitious movements" with Patton's lower face and mouth. *CCC* 00115.

Pugh also reviewed a recent brain MRI that Dr. Kerson had ordered, and one taken on February 8, 1985, after a motor vehicle accident. *CCC* 00104; *CCC* 00122. In a second report dated February2 6, 2002, Dr. Kerson, referencing Patton's eyelid, mouth and facial movements, noted that he suspected a psychological source. *CCC* 00109.

On March 8, 2002, Pugh advised Patton that the additional information did not change Continental's decision to deny benefits, and that her claim would be

sent for "formal appeals review." *CCC* 00102, 00104. The review was conducted by Cheryl Sauerhoff of the Appeals Team, who wrote Patton on April 16, 2002, affirming the denial of her claim. *CCC* 00267-268.

Sauerhoff had reviewed Doylestown Hospital records from Patton's 1985 motor vehicle accident, including a head CT scan; Dr. Kerson's February 5 and 26, 2002, summaries; Dr. Gabriel's records; a February 13, 2002, brain MRI; and, records from Wills Eye Hospital, including those of Dr. Rapuano. **[*27]** Sauerhoff noted that Dr. Rapuano's evaluation showed normal visual acuity and visual field examinations, mild to moderate dry eyes and significant meibomianitis. The recommended treatment for these conditions included warm compresses, artificial tears, and ointment. *CCC* 00267-68.

Sauerhoff concluded that none of these conditions or treatments prevented Patton from working. *CCC* 00268. She referenced that Dr. Kerson had observed that Patton's eyelid, mouth, and facial movements were "not typical of organic dyskinetic movements"; suspected that her condition had a psychiatric or anxiety generated basis; and, recommended anti-anxiety medication and neurological studies. On the basis of Dr. Kerson's report, Sauerhoff decided that there was no mental or physical condition or impairment that would prevent Patton from working. *CCC* 00268.

Patton obtained counsel, who requested that Continental reopen the claim. Sauerhoff, while noting that nearly a year had passed since the denial, agreed to reconsider Patton's file to evaluate new medical information that addressed the existence of a continuous disability from November 23, 2001, to the present. *CCC* 00098.

Patton's counsel **[*28]** submitted additional medical records and reports, including neurology reports, neuro-opthalmology exams, and an oculoplastic surgeon's assessment. *CCC* 00020-94. Considering the newly submitted information and the "complexity" of the condition, Sauerhoff decided to get an opinion from a consultant hired by Continental, Dr. Garvey.

Dr. Garvey wrote a letter on November 12, 2003, opining that "it is reasonable to assume that if the claimant's episodes of blepharospasm are infrequent enough to allow her to drive, that she should be able to perform the visual demands of her chosen occupation." *CCC* 00006-07. After receiving Dr. Garvey's letter, Continental contacted Patton's counsel on November 19, 2003, to inquire about her driving. *CCC* 00013. On November 20, 2003, Patton's counsel faxed a letter response, advising that Patton occasionally drove with significant limitations. *CCC* 000010-12. There is no evidence that Sauerhoff transmitted this additional information to Dr. Garvey for his consideration.

On November 26, 2003, Continental determined that because Patton remained functional and was capable of driving, she was not prevented from working, and, therefore, did not **[*29]** qualify as disabled under the policy. *CCC* 00003.

Analysis

Continental determined that Patton was not disabled because she had no "functional loss or impairment that would have prevented her from working." It cited the following bases for its determination: the episodes of involuntary muscle spasms were intermittent and not continuous as required by the policy; there was no organic basis for the symptoms; Patton failed to submit objective medical findings; she had no visual loss or impairment; and, she "remained functional, to include driving, albeit on a limited basis." *CCC* 00003.

We must determine whether Continental acted arbitrarily and capriciously when it decided that Patton was not eligible for short term disability benefits. Applying a heightened standard of review, we shall examine the reasons given by Continental for denying benefits to see if they are supported by substantial evidence, and ask whether Continental's application of the policy to the facts was reasonable. In doing so, we shall carefully scrutinize the record for potential procedural anomalies that Patton has raised.

Procedural anomalies in this case invite an even more heightened standard of **[*30]** review than the one provoked by the inherent financial conflict created by Continental's status as both funder and administrator of the plan. Summarizing, the record reveals that Continental relied on Dr. Garvey's two-paragraph report which failed to take into account Patton's actual limitations and discounted, without explanation, contrary opinions of treating physicians; and failed to provide Dr. Garvey with the information about Patton's driving limitations which Continental knew that Dr. Garvey did not have and which were essential to his ultimate opinion.

Taken together or considered alone, these instances of procedural irregularities evidence a bias mandating that less deference be given to Continental's decision.

Dr. Garvey's Opinion

Continental proclaims Dr. Garvey's opinion as "ultimately, the linchpin of Continental's claim determination (and this case)." *Defs.' Mem. in Supp. Cross-Mot. Summ. J.* at 7. Therefore, we shall examine it carefully to determine if Continental's reliance on it was justifiable.

Dr. Garvey was hired by Continental to review the claim and to give his opinion whether the information he was supplied supported a functional loss or impairment **[*31]** that would have prevented Patton from visually performing her occupation that required her to review files and work on a computer, as of November 23, 2001. *CCC* 00006. His entire report consists of the following two paragraphs:

> This claimant has been diagnosed by more than one physician with involuntary muscle spasms of the muscles around the eye, and face. While the spasms are occurring the claimant would be unable to function at her chosen occupation. It is reported throughout the medical record that these episodes likely do not have an organic basis and are episodic. This condition has not precluded the claimant from driving, although she admits with difficulty. It is reasonable to assume that if the claimant's episodes of blepharospasm are infrequent enough to allow her to drive, that she should be able to perform the visual demands of her chosen occupation.
>
> It is documented in the medical notes that this condition existed as of 11/23/2001 in some physician's notes, while in others that examined her at that time (Christopher Rapuano, M.D.) no mention of spasm is noted.

CCC 00006-00007.

When the Supreme Court held, in *Black & Decker Disability Plan v. Nord, 538 U.S. 822, 829-30, 155 L. Ed. 2d 1034, 123 S. Ct. 1965 (2003),* **[*32]** that the rule giving special deference to a treating physician's opinion in Social Security cases did not apply to ERISA disability cases, it did not grant insurers a license to disregard or cursorily consider the opinions of the physicians who were familiar with and treated the insured. The Court concluded that deference may not be warranted when a treating physician had only a short relationship with the patient, or when the insurer's retained consultant is a specialist and the treating physician is a general practitioner. *Id. at 832*. At the same time, it acknowledged that a treating physician in many cases has a greater opportunity to know and observe the patient than do consultants retained by a plan. *Id.*

Nord did *not* state that treating physicians' opinions are never entitled to deference over retained consultants' opinions. Rather, *Nord* instructs that "courts have no warrant to require administrators *automatically* to accord special weight to the opinions of a claimant's physician," and that courts may not "impose on plan administrators a discrete burden of explanation when they credit *reliable* evidence that conflicts with a treating **[*33]** physician's evaluation." *Id. at 834* (emphasis added).

The Supreme Court's instruction does not authorize an insurer to give conclusive weight to an unreliable report of a non-treating physician. Nor does it insulate plan decisionmakers every time they decide to overrule a treating physician's report in favor of a consultant's opinion. *Nord, 538 U.S. at 834* ("Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician.").

Dr. Garvey acknowledges that several physicians diagnosed Patton with blepharospasm which existed as of November 23, 2001. He agrees that she is "unable to function at her chosen occupation" when the involuntary spasms occur. Yet, he posits that, nevertheless, "she should be able to perform the visual demands of her chosen occupation" because the episodes do not prevent her from driving.

Dr. Garvey premised his opinion on his perception of Patton's driving ability. He assumed that if her "episodes of blepharospasm are infrequent enough to allow her to drive, that she should be able to perform the visual demands of her chosen occupation." *CCC* **[*34]** 00006-7. However, his file review on November 11, 2003, was without the benefit of a full understanding of

Patton's limited driving ability which Patton's attorney later provided Sauerhoff in a letter dated November 20, 2003. Dr. Garvey, therefore, *could not have been aware* of the significant limitations on Patton's driving when he authored his letter.

At oral argument, defense counsel stated that Sauerhoff asked about Patton's driving ability because Dr. Garvey wanted the information, citing a November 19, 2003 telephone conversation between Sauerhoff and Dr. Garvey. *CCC* 00013. Even if Sauerhoff did ask Patton's counsel about her driving ability based on an inquiry from Dr. Garvey, it is apparent that Dr. Garvey had already finished his November 11, 2003 report prior to asking Sauerhoff the question on November 19, 2003. Dr. Garvey's asking about Patton's driving ability after he issued his report raises a concern that he may have been questioning his own opinion.

Patton's attorney responded to Sauerhoff's inquiry on November 20, 2003, providing Sauerhoff with detailed limitations on Patton's driving. Either Sauerhoff did not advise Dr. Garvey of Patton's actual driving **[*35]** limitations after he issued his report, or she did and Dr. Garvey chose to ignore it. In either event, Dr. Garvey's report was unreliable because its basic premise was incorrect.

Dr. Garvey was presented with multiple medical records that demonstrated that Patton had significant limitations affecting her ability to perform the functions of her job. This documentation demanded a discerning review in light of Dr. Garvey's contrary opinion. He does not discuss the treating doctors' findings nor does he explain why he discarded or discounted them. Dr. Garvey notes the absence of any spasms recorded in Dr. Rapuano's notes, while glossing over other doctors' documentation of the condition. He either ignores or did not read Dr. Kerson's note of February 2002, stating "watching her in front of me today, it is quite clear that she has eyelid and mouth and other facial muscular movements that are adventitious and not at all typical of the kind of organic dyskinetic movements we sometimes see." *CCC* 00109. Dr. Galetta noted that her "blinking is out of proportion to her dry eyes and appears to be somewhat out of her voluntary control," and that he saw "movement of the lower face suggesting **[*36]** the diagnosis of Meige's syndrome." CCC 00160.

Dr. Garvey likewise ignores the findings of other physicians who examined Patton around November and December 2001. He does not reference or appear to have considered the following pertinent findings: "unexplained vision loss" (Dr. Gabriel, January 24, 2002); Patton's inability to keep her eyes open at work and unable to read (Dr. Rapuano, November 2, 2001, and November 28, 2001); the failure of the silicone punctal plug (Dr. Rapuano, November 28, 2001, and December 14, 2001); possible Sjogren's syndrome (Dr. Myers and Dr. Gabriel, May, 18, 2001 and August 10, 2001); "severe" dry eye syndrome (Dr. Gabriel, August 10, 2001); severe and significant meibomianitis (Dr. Rapuano, November 2, 2001); possible early stages of Bjerrum scotoma (Dr. Myers, June 2001, as reported in August 8, 2002 overview); and movements of the face and mouth (Dr. Kerson, February 5, 2002); and difficulty keeping her eye open during a vision field test (Dr. Myers, March 28, 2002).

Continental had the right to have Patton examined. *POLICY* 00019. It chose not to do so. That Dr. Garvey never examined Patton alone is not conclusive. Nevertheless, it is relevant **[*37]** in light of his shallow analysis and the lack of meaningful discussion of the medical evidence in his two-paragraph letter.

In light of the fact that blepharospasm manifests through clinical symptoms, that is, observable symptoms, Continental's decision to rely on Dr. Garvey's paper review rather than the reports of multiple physicians who physically examined Patton in a clinical setting calls into question Continental's reliance on Dr. Garvey as the pillar of its decision. *Cf. Sanderson v. Continental Cas. Corp., 279 F. Supp. 2d 466, 474 (D. Del. 2003)* (Sleet, J.) (noting that an insurer's reliance on a consultant's paper review is "troubling" when a condition manifests clinically); *Friess v. Reliance Std. Life Ins. Co., 122 F. Supp. 2d 566, 574-75 (E.D. Pa. 2000)* (Brody, J.) ("While [the insurer] is not required to order an independent examination, the failure to examine may indicate an inattentive process.").

Indeed, Continental's reliance on Dr. Garvey's opinion and its rejection of the opinions of those who treated and examined Patton raises a suggestion that Continental's review was inattentive or was inclined to grasp upon any opinion to **[*38]** support its decision to deny benefits. His report consists of a mere two paragraphs and is based on an assumption. No curriculum vitae was submitted with his report. We have no idea what his qualifications are or even if he is licensed. [11]

11 Dr. Garvey's unreliable

At oral argument, defense counsel conceded that there is nothing in the record, other than Dr. Garvey's own letterhead, to verify that Dr. Garvey is qualified, practicing or licensed.

Substantial evidence exists when the record contains sufficient evidence that would lead a reasonable person to agree with the administrator's decision. *Courson v. Bert Bell NFL Player Retirement Plan, 214 F.3d 136, 142 (3d 2000)*. Dr. Garvey's assumption was not supported by substantial evidence. He cites a single incomplete and inaccurate fact, to the exclusion of other detailed evidence, to support his opinion. He does not factor into his analysis that Patton was driving only short distances, that driving caused her significant stress, and that she **[*39]** only drove in unpopulated areas and during daylight hours. Significantly, he ignores Dr. Wulc's admonition that Patton should not be driving. He does not explain why he assumed she was driving when Dr. Wulc said she should not be. Even without a heightened standard of review, that one piece of inconclusive evidence cannot suffice to support Continental's adverse benefits decision.

In the context of the record, Continental's decision to credit report over multiple treating physicians' evaluations was not reasonable and not supported by substantial evidence. We recognize that we cannot automatically defer to treating physicians in this ERISA case. However, where a Plan defers to a two-paragraph non-treating physician's opinion over credible multiple treating physician reports, without analysis and explanation, there is a procedural bias.

Patton's Driving Ability

Continental adopted Dr. Garvey's impression that Patton has remained functional because she can drive. However, as we have seen, Dr. Garvey's opinion is based on the assumption that Patton drives without limitations. In its brief, Continental stated that "IF PLAINTIFF'S SYMPTOMS WERE SO SEVERE AND CONTINUOUS SHE WOULD **[*40]** NOT BE DRIVING AT ALL," contending that Dr. Garvey's scant analysis of the record trumps Dr. Wulc's examination of Patton. *Def. Mem. Supp. Cross-Mot. Summ J.* at16. As we have noted, Dr. Garvey does not discuss the multitude of references to Patton's disability in the record, nor does he explain why the physicians who had treated Patton got it wrong. Therefore, we shall independently consider the evidence of Patton's driving to see if it can sustain Dr. Garvey's opinion.

Without referencing anything else Patton can or cannot do, Continental points to her "driving, albeit on a limited basis," as evidence that she is functional in the physical requirements of her job. *CCC* 00003. The information supplied to Continental established that she drove with significant limitations. She only drives short distances and cannot drive at night. When she must drive, she finds it stressful. For longer trips, she takes public transportation or rides with others. Even walking is hard on her eyes and she must look down. She bumps into people and things. *CCC* 00009.

None of these limitations were considered by Dr. Garvey because he was never given the information or he ignored it. Sauerhoff **[*41]** knew that Dr. Garvey's conclusion rested solely upon his understanding that Patton drove a car. Yet, she did not ask him to review the newly-acquired evidence directly bearing on the premise of his conclusion, evidence that called into question the validity of his opinion and evidence he had requested.

Continental's denial offers no specific information regarding the limitations on distance, duration, or time of day, and ignores her driving limitations in favor of a general note that her driving is on a "limited basis."

Patton's limited driving is not fatal to her claim. The policy directs us to look at the material and substantial duties of her job and determine whether her condition precluded her from performing those duties. Her job duties do not require her to drive. "Reading" was a material job function. Significantly, Continental does not address Patton's functionality in the areas essential to her occupation - reading, working on a computer and reviewing files. In fact, there is no evidence that she can do these tasks. On the contrary, there is evidence that she cannot. Instead of evaluating the effects of her condition on her ability to read and perform her job duties, Continental **[*42]** made the assumption that because she drove on a limited basis, she could work. This leap is not supported by the evidence.

Lack of an Organic Basis

Continental also contended that Patton's symptoms lack an "organic basis." [12] Whether Patton's symptoms have an "organic basis" as opposed to a psychotropic or

functional one is irrelevant. Continental's short term disability policy covers both physical and mental impairments. *POLICY* 00015. As Continental's counsel conceded at oral argument, even if Patton's symptoms and condition arise from a psychogenic or functional source rather than an organic one, they are covered under the policy terms. Thus, Continental has now abandoned this argument.

12 In the medical context, organic means "of, relating to, or arising in a bodily organ." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 817 (10th ed., 2001). An "organic disorder" is one "caused by a detectable physiological or structural change in an organ." Princeton University Cognitive Science Laboratory, *WordNet: a lexigal database for the English language*, *at* http://wordnet.princeton.edu/cgi-bin/web wn2.0?stage=1&word=organic+disorder (last visited March 24, 2005). A "functional" or psychogenic disorder is one with no known or detectable organic basis to explain the symptoms. STEDMAN'S MEDICAL DICTIONARY 456, 1285 (25th ed., 1990).

[*43] Episodic Nature of Blepharospasm

Although the physicians could not conclusively determine the etiology of Patton's symptoms, they agree on the physical findings and the presence of the symptoms. Continental suggests that because the involuntary facial spasms are intermittent, and not *constant*, Patton is not disabled as defined in the policy. It cites the policy provision that requires that she be "continuously unable to perform the Material and Substantial Duties of [her] Regular Occupation." *POLICY* 00015.

Medical literature that Continental had establishes that blepharospasm is frequently misdiagnosed and not well-understood. Dr. Kerson characterized the facial movements as "adventitious" and suspected a psychological source. Dr. Myers noted that she had difficulty keeping her eyes open. The literature warns that blepharospasm is often misdiagnosed as "dry eyes" - the exact condition for which Patton's physicians had been unsuccessfully treating her.

A spasm is an "involuntary and abnormal muscular contraction." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 1124 (10th ed., 2001). Because one may be a symptomatic at times does not mean that the condition causing the episodic **[*44]** manifestation of symptoms is not constant. Under Continental's interpretation, one who had any disease would never be disabled if the manifestation of its symptoms was episodic. This interpretation is unreasonable and we will not uphold Continental's decision on this basis.

Visual Acuity

To support its decision, Continental also cited the absence of "evidence of any visual loss or impairment," apparently using the term "visual loss" to mean visual acuity. *CCC* 00003. [13] However, no physician has suggested that her visual acuity - her ability to see details at near and far distances - is affected and causing her inability to perform her job duties. The fact that she has perfect or near perfect vision when she is not experiencing spasms is irrelevant to the inquiry. What is pertinent is whether she can do her job when the muscles around her eyes involuntarily close her eyelids. As Dr. Wulc concluded, her condition causes "essential blindness," unrelated to visual acuity, rendering her unable to continuously perform her necessary job duties. Continental has now abandoned the argument that Patton's perfect visual acuity as a basis for its decision.

13 Visual acuity is "the relative ability of the visual organ to resolve details that is usu. expressed as the reciprocal of the minimum angular separation in minutes of two lines just resolvable as separate and that forms in the average human eye at an angle of one minute." MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY 1317 (10th ed., 2001).

Demonstrating a failure to comprehend the nature of blepharospasm, Sauerhoff noted "there appears to be some conflicting info, i.e., visual acuity 20/20, but how were eyes able to stay open for testing? Also references that don't suggest that Ms. Patton has this condition continuously." *CCC* 00016 (10/15/03). She was apparently unaware that Patton physically held her eyes open to drive and to allow physicians to conduct vision field testing.

[*45] Absence of "Objective" Medical Findings

Continental now argues that Patton failed to submit

objective medical findings supporting her disability claim. *Def. Mem. Supp. Cross-Mot. Summ J.* at 8. Sauerhoff did not include this reason in her denial of the claim. CCC 00003. Now, Continental's counsel suggests that Patton was malingering, arguing that she was manufacturing reasons to get out of work. To support this suggestion, Continental points to the lack of objective medical tests. *Def. Mem. Supp. Cross-Mot. Summ J.* at 10.

In Sauerhoff's denial, there is no mention of the absence of objective medical findings. Now Continental relies on policy language requiring "objective medical findings," such as "tests, procedures, or clinical examinations standardly accepted in the practice of medicine" for the disabling condition at issue. *POLICY* 00019. Patton did present reports based upon clinical examinations. Demanding tests and procedures is unjustified when Continental knew from the medical literature that there was no laboratory test available to confirm plaintiff's condition, which only manifests itself through clinical findings. *CCC* 00183 (George W. Paulson, M.D. **[*46]** , *Meige's Syndrome* (undated) ("Observation is how the diagnosis is made, not by the laboratory.")). *Cf. Sanderson v. Continental Cas. Corp., 279 F. Supp. 2d 466, 474 (D. Del. 2003)* (Sleet, J.) (noting that the condition of fibromyalgia manifests through clinical symptoms, not lab tests); *Colby v. UnumProvident, 328 F. Supp. 2d 186, 192 (D. Mass. 2004)* (noting that while plaintiff's cause of disability, a stroke, could be confirmed by diagnostic testing, no "diagnostic test" existed to document his subsequent physical limitations). If it had doubted the clinical findings, Continental could have exercised its right to have Patton examined.

"In some contexts, it may not be arbitrary and capricious to require a claimant to submit clinical evidence of the etiology of allegedly disabling symptoms in order to verify that there is no malingering." *Mitchell v. Eastman Kodak Co., 113 F.3d 433, 442 (3d Cir. 1997)*. Nevertheless, if the condition is not one for which a definitive test exists, and no known etiology exists, a plan administrator cannot insert an implied "clinical evidence of etiology" requirement into a plan. *Mitchell, 113 F.3d at 443* **[*47]** (in the context of chronic fatigue syndrome, which is universally recognized as a severe disability but has no known etiology, arbitrary and capricious to require submission of clinical etiology evidence by implying such a burden of proof).

In arguing the absence of objective medical evidence, Continental points to the absence of a contemporaneous, "clear, definitive" notation by any doctor that plaintiff was totally disabled. Such a written finding is unnecessary if the medical records themselves demonstrate that the patient had the condition prior to her stopping work. *Mitchell v. Eastman Kodak Co., 113 F.3d 433, 441 (3d Cir. 1997)*. A verification of disability written after the insured became disabled can serve as credible evidence explaining how the symptoms had been disabling, despite the lack of a diagnosis and a clear understanding of the condition at the time it had become disabling. *Mitchell, 113 F.3d at 441* (plaintiff's physicians documented that he had disabling symptoms prior to the date he stopped working in January 1989; disability finding was supported by a 1994 letter which clearly explained how his symptoms were disabling, despite **[*48]** earlier physicians' unfamiliarity with the condition of chronic fatigue syndrome).

Dr. Wulc's June 2003 letter indicates his examination revealed that Patton had involuntary closure of the upper eyelids bilaterally, and twitching around the mouth and eyelids. CCC 00177. He stated that the condition had been present for two years. He warned that even with Botox treatment, which she had not yet had, Patton still might not be able to perform her job functions. *CCC* 00177-178.

Further, it is not reasonable to rely upon the absence of any note by a doctor placing a "restriction" on Patton's reading as evidence of a lack of objective medical findings because such a note could be superfluous where Patton was in fact *incapable* of reading. In fact, Dr. Gabriel had noted in a conversation with Pugh in January 2002 that Patton's "restriction is no reading." *CCC* 00105.

Patton Was Disabled During the Elimination Period

Pugh initially discounted the presence of any disabling condition at all, calling Patton's complaints "subjective" and her symptoms vague. Now, changing position, Continental argues that because Patton's blepharospasm had not yet reached its nadir on November 23, 2001, it **[*49]** did not preclude her from working at that time.

To be eligible for short term disability benefits, an insured must be disabled under the policy definitions for thirty consecutive days after the day she stops working. *POLICY* 00009, 00015. An insured is disabled if she

suffers from an injury or sickness that physically or mentally impairs the employee so severely that she is "continuously unable to perform the Material and Substantial Duties of [her] Regular Occupation." [14] *POLICY* 000015.

> 14 The employee must also not be working for wages in any other occupation for which she is or becomes qualified by education, training or experience. *POLICY* 00015. Alternatively, the employee can satisfy an "earnings qualifier," which is not at issue in this case. *POLICY* 00015.

Continental's final denial of benefits states that Continental "is not disputing Ms. Patton's symptoms and condition." *CCC* 00003. It concedes that she "does have involuntary muscle spasms involving the muscles around the eye and **[*50]** face," and that the symptoms and blepharospasm condition were present in November 2001. *CCC* 00003. Yet, referring to the elimination period provision, Continental contends that while plaintiff had vision loss and other symptoms around November 2001, there was insufficient evidence demonstrating a severe functional loss that would have precluded her from performing her occupation. *Def. Mem. Supp. Cross-Mot. Summ. J.* at 5.

Uncertainty on the part of Patton's doctors about the cause of her disabling symptoms does not reduce the force of the medical evidence that her condition was preventing her from doing her job. Continental states that "it is not disputed that plaintiff did report through this time frame to the eye specialists and 'subspecialists' that she experienced trouble reading and had eye twitching, but it is also clear that these reports did not result in any doctor, even Dr. Gabriel, opining in any clear, definitive manner in the reports that plaintiff was disabled due to her eye problems or even unable to read." *Defs.' Mem. Supp. Cross-Mot. Summ. J.* at 12. However, merely because Patton's condition was not accurately diagnosed until after the elimination period **[*51]** does not mean that had not been able to perform her job duties during that time.

Dr. Wulc opined that Patton is incapable of performing work that would involve vision, a requirement of her job. *CCC* 00105, 00177. Earlier in the elimination period, Patton was reporting to physicians that she was unable to keep her eyes open at work and that she could not read. Dr. Gabriel described "unexplained vision loss" and "severe" dry eye syndrome. In November 2001, Dr. Rapuano noted that Patton was unable to keep her eyes open at work and unable to read, characterizing her meibomianitis as "severe" and "significant." In short, although the condition had not been correctly diagnosed, it existed. *Cf. Mitchell v. Eastman Kodak Co., 113 F.3d 433 (3d Cir. 1997)* (the early difficulty of treating physicians to accurately diagnose a condition and to understand how the condition disabled the plaintiff did not support the plan administrator's "not disabled" conclusion).

Reviewing her medical records overall, it is apparent that her condition was deteriorating and impeded her job performance months before she left her employment. In May 2001, six months before Patton stopped working, **[*52]** Dr. Myers stated that he did not yet believe that she should be considered disabled at that time, but that her discomfort was significant. Patton saw Dr. Rapuano three times within six weeks in November and December 2001. As of November 23, 2001, Patton was unable to read at work and unable to perform her job duties. Thus, applying a significantly heightened standard of review based on the presence of procedural anomalies and the inherent conflict of interest, we find that Continental's decision was arbitrary and capricious. *Kosiba, 384 F.3d at 68*.

Conclusion

After carefully reviewing the administrative record and applying a significantly heightened standard of review, we find that Continental acted arbitrarily and capriciously in denying Patton's disability claim. Its decision was unreasonable and not supported by substantial evidence. Therefore, summary judgment will be granted in favor of the plaintiff.

ORDER

AND NOW, this 31st day of March, 2005, upon consideration of the cross-motions for summary judgment (Document Nos. 5, 6), and after oral argument, it is **ORDERED** as follows:

1. The defendants' motion for summary judgment is **[*53] DENIED**.

2. The plaintiff's motion for summary judgment is **GRANTED**.

3. No later than **April 29, 2005**, the parties shall

submit a proposed order awarding the plaintiff relief consistent with this Court's memorandum opinion accompanying this Order. If the parties cannot agree on a proposed order, they shall file separate proposed orders accompanied by explanations not to exceed three pages. Judgment will be entered in favor of plaintiff Estoria Patton and against defendants Continental Casualty Company and CNA Group Life Assurance Company after the parties have complied with the preceding paragraph.

TIMOTHY J. SAVAGE, J.