2023 WL 6852026
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United States District Court, C.D. California.

PAM STRINGER, Plaintiff,

v.

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, et al., Defendant.

Case No. 2:23-cv-00237-SPG-AFM
|
Filed 09/18/2023

ORDER DENYING PLAINTIFF'S MOTION TO AUGMENT THE ADMINISTRATIVE RECORD [ECF No. 33]

HON. SHERILYN PEACE GARNETT UNITED STATES DISTRICT JUDGE

***1** Before the Court is Plaintiff Pam Stringer's ("Plaintiff") Motion to Augment the Administrative Record. ("Motion") (ECF No. 33). Plaintiff moves to supplement the administrative record ("AR") in this ERISA governed action with the June 1 and June 5, 2023, Cognitive Functional Assessment by Psychologist Bahareh Talei, Psy.D. ("Talei Assessment") (ECF No. 33-5, Exh. 4). Defendant Guardian Life Insurance Company of America filed a timely opposition to the Motion. ("Opposition") (ECF No. 38). Having reviewed the moving papers and considered the parties' arguments, the Court DENIES Plaintiff's Motion.

I. BACKGROUND

At the time of Plaintiff's initial claim for long term disability, Plaintiff was insured by Guardian's Group Policy Number G-00543193 issued to her employer NSMG Shared Services, LLC. ("Complaint") (ECF No. 1, ¶ 8). This policy included disability insurance coverage. (*Id.* at ¶ 9). Prior to her at-issue disability, Plaintiff was the Sales Manager for NSMG Shared Services, a position that required her to meet sales quotas, and recruit, train, and hire retail sales advisors. (*Id.* at ¶ 12).

On September 23, 2020, Plaintiff suffered an accident in her home involving a large wayward cabinet door. (Mot. at 5). Plaintiff went to Thousand Oaks Urgent Care for treatment. Her initial symptoms included headaches, confusion, and tinnitus. (Compl., ¶ 14). When her symptoms did not subside, Plaintiff sought and obtained treatment at West Hills Hospital on October 24, 2020. (*Id.*).

Plaintiff's last full day of work was on November 10, 2020. (*Id.* ¶ 15). In submitting her claim for LTD coverage to Defendant, Plaintiff explained that she was unable to perform the duties of her job because of confusion caused by the injury of September 23rd. *Id.* In support of her claim to Defendant, Plaintiff submitted an Attending Physician Statement form completed by Dr. Paul Dudley, a neurologist, who diagnosed Plaintiff with disorientation. (*Id.* ¶ 19).

At or around October 5, 2021, Defendant informed Plaintiff that her claim for long-term disability was conditionally approved, though additional medical information would be needed for full approval. (ECF No. 33-3 at 2) ("When you [sic] Long Term Disability was approved, additional medical was needed to support the disability."). [1] Additionally, in communications dated February 25, 2021, and April 2, 2021, Defendant stated that "additional information is needed to evaluate your eligibility for benefits." (ECF No. 38-2 at 117); *see also* (ECF No. 38-2 at 123) ("We previously outlined for you the information necessary to complete the review of your claim; however, we have not received all requested information required due to matters beyond control of the plan resulting from COVID-19."). Plaintiff's treating physicians sent in some additional medical records, including a cognitive assessment form completed by Dr. Vesco in June 2021. (ECF No. 33-3 at 2). Defendant's in-house nurse case manager assessed this information and concluded that it was "reasonable that Plaintiff had limitations to [Plaintiff's] ability to work due

to post-concussive syndrome," which was manifesting in various symptoms and that such "limitations were supported through June 2021 when [Plaintiff was] scheduled to see a new neurologist." (ECF No. 33-4 at 4). However, the nurse advised that, "to assess [Plaintiff's] disability beyond June 2021, ... updated treatment records and testing information would be needed." (*Id.*). When no such testing information was received, Defendant, in a letter dated December 21, 2021, denied Plaintiff's claim for Long Term Disability. (ECF No. 33-3 at 2). Defendant noted Plaintiff's right to appeal, and Plaintiff exercised that right on or about February 1, 2022. (ECF No. 38-2 at 323). Finding that Plaintiff still failed to submit documentation adequate to substantiate her disability claim, Defendant affirmed the denial of LTD on March 17, 2022. (ETC No. 38-2 at 320).

***2** In an October 7, 2022, letter in which Plaintiff cited 29 CFR 2560.503-1(g)(i), Plaintiff requested a "complete copy of the administrative record" as soon as possible within 15 days of the date of the letter. (ECF No. 38-2 at 325). Plaintiff received the records on October 25, 2022. (ECF No. 38-2 at 328). This litigation was filed on January 12, 2023. (ECF No. 1).

Plaintiff now seeks to augment the administrative record with the Talei Assessment. Defendant opposes the Motion.

II. Legal Standard

The parties agree that this Court should conduct a *de novo* review of Guardian Life's claim determination. (ECF No. 29). Generally, what the "district court is doing in an ERISA benefits denial case is making something akin to a credibility determination about the insurance company's or plan administrator's reason for denying coverage under a particular plan and a particular set of medical records and other records." *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 969 (9th Cir. 2006). Generally, these cases are reviewed and decided on the record that was before the claims or plan administrator. *See Kearney v. Standard Ins. Co.*, 175 F.3d 1084, 1090-91 (9th Cir. 1999) ("[T]he record that was before the administrator furnishes the primary basis for review.... [T]he district court ha[s] discretion to allow evidence that was not before the plan administrator 'only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review.... [I]n most cases only the evidence that was before the plan administrator should be considered." (quoting *Mongeluzo v. Baxter Travenol Long Term Disability Ben. Plan*, 46 F.3d 938, 944 (9th Cir. 1995))).

However, this rule is not absolute. Under some circumstances, record augmentation is warranted. For example, "if the administrator did not provide a full and fair hearing, as required by [section 1133(2) of] ERISA, the court must be in a position to assess the effect of that failure and, before it can do so, must permit the participant to present additional evidence." *Abatie*, 458 F.3d at 972–73 (citation omitted). Additionally, the Ninth Circuit has adopted a "non-exhaustive list of exceptional circumstances where introduction of evidence beyond the administrative record could be considered necessary." *Opeta v. Nw. Airlines Pension Plan for Contract Emp's*, 484 F.3d 1211, 1217 (9th Cir. 2007). That list includes the following circumstances: (1) "claims that require consideration of complex medical questions or issues regarding the credibility of medical experts," (2) "the availability of very limited administrative review procedures with little or no evidentiary record," (3) "the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts," (4) "instances where the payor and the administrator are the same entity and the court is concerned about impartiality," (5) "claims which would have been insurance contract claims prior to ERISA," and (6) "circumstances in which there is additional evidence that the claimant could not have presented in the administrative process." *Id.* (quoting *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 101, 1027 (4th Cir. 1993)).

Overall, however, "the purposes of ERISA ... warrant significant restraints on the district court's ability to allow evidence beyond what was presented to the administrator," and "a district court should not take additional evidence merely because someone at a later time comes up with new evidence that was not presented to the plan administrator." *Mongeluzo*, 46 F.3d at 943, 944 (alteration in original) (quoting *Quesinberry*, 987 F.2d at 1025). "Where there was a sufficiently developed record before the plan administrator[,] the court should not review documents not submitted to the plan administrator prior to its decision." *Mongeluzo*, 46 F.3d at 943.

III. DISCUSSION

***3** Plaintiff seeks to admit into the Administrative Record the June 1, 2023, and June 5, 2023, Cognitive Functional Assessment by Psychologist Bahareh Talei, Psy.D. because, in her view, Defendant did not inform Plaintiff that neuropsych testing was required. Thus, Plaintiff asserts it was Defendant's failure to communicate that prevented Plaintiff from both obtaining and providing the assessment during the administrative process. (Mot. at 7). This is, Plaintiff argues, a violation of 29 C.F.R. § 2560.503 –1(g)(iii), which states that a plan administrator must provide "[a] description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary." *See also Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011) (holding that to conform "to the claim procedure required by statute and regulation," the insurer is required to "explain, upon denial, any additional information needed" to support a claim for benefits); 29 U.S.C. § 1133(2) (ERISA requires that "every employee benefit plan shall[ ] afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."). Plaintiff argues that this Court should make the Talei Assessment part of the administrative record because Defendant failed to communicate that neuropsych testing was required to perfect her claim.

The Court finds that Plaintiff's argument suffers from two flaws. First, the communications during the administration of the LTD Claim, the December 2021 denial letter, the March 2022 appeal denial letter, and the proof of loss requirements in the LTD Coverage all state that objective evidence is required as part of the proof of loss.[2] The LTD Coverage states that Objective Evidence "may include, but is not limited to: (a) diagnostic testing; (b) laboratory reports; and (c) medical records of a doctor's exam documenting: (i) clinical signs; (ii) presence of symptoms; and (iii) test results consistent with generally accepted medical standards supported by nationally recognized authorities in the healthcare field." (ECF No. 33-3 at 3). Given that Defendant made known to Plaintiff on four separate occasions that objective evidence was necessary to perfect her claim, Defendant did not violate the required procedures. Indeed, the March 17, 2022, appeal denial letter spends several paragraphs explaining –in non-technical language – the various insufficiencies of Plaintiff's claim. (ECF No. 33-4 at 3). This repeated communication by Defendant to Plaintiff does not, then, constitute a deprivation of a "full and fair review" by the insurer. *Abatie*, 458 F.3d at 955. The Court therefore finds that the Defendant engaged in no procedural violations.

Second, although Plaintiff argues repeatedly Defendant failed to communicate that neuropsych testing specifically is required, the Court agrees with Defendant that this is not borne out by the record. The record repeatedly states that objective evidence is required, and Defendant made clear that objective evidence of *cognitive* deficiencies would likely satisfy the request. (ECF No. 33-4 at 4). Given that procedural protections were adequate in this case, the reference to "neuropsych" in the Claim Notes is not alone sufficient to suggest that Defendant failed to communicate necessary claim information to Plaintiff.

Nevertheless, a district court has discretion to allow an augmentation of the administrative record. The Ninth Circuit has emphasized however that such discretion should be exercised "*only* when circumstances *clearly establish* that additional evidence is *necessary* to conduct an adequate de novo review of the benefit decision." *Opeta v. Nw. Airlines Pension Plan for Contract Emp's*, 484 F.3d 1211, 1217 (9th Cir. 2007) (quoting *Mongeluzo v. Baxter Travenol Long Term Disability Plan*, 46 F.3d 938, 943-44 (9th Cir. 1995)) (emphasis in *Opeta*). The Court will thus consider the non-exhaustive list of "exceptional circumstance" set forth in *Quesinberry* to determine if Plaintiff has clearly established that introduction of "evidence beyond the administrative record could be considered necessary." *Opeta*, at 1217 (quoting *Quesinberry*, 987 F.2d at 1025).

***4** The first factor concerns whether Plaintiff's claim requires consideration of complex medical questions or issues regarding the credibility of medical experts. (*Id.*) Plaintiff asserts that it is "beyond dispute" that this case involves complex medical issues. (Mot. at 10). While ordinarily a cognitive impairment has the potential of being a complex medical issue, the Court finds based on the parties' submissions to date that Plaintiff's case does not meet this description. Instead, the issues in Plaintiff's case center around whether sufficient evidentiary support for Plaintiff's medical impairments was presented for the relevant time period after June 2021. Further, the parties' submissions do not demonstrate that the core dispute involves the credibility of Plaintiff's medical experts or a fundamental "disagreement among medical experts," as Plaintiff so characterizes the issues. *See* (Mot. at 15). Indeed, although Plaintiff takes exception to her medical records being reviewed by Defendant's in-house nurse case manager, *see* (Mot. at 19 (stating Defendant accepted "the opinions of an underqualified nurse reviewer" over Plaintiff's treating physicians), as Plaintiff points out, the nurse actually concluded, consistent with Plaintiff's experts, "that it was reasonable that

[Plaintiff] had [cognitive] limitations to her ability to work due to post-concussive syndrome" which the nurse observed was manifested in a variety of symptoms reported by Dr. Vesco. (Mot. at 15; ECF No. 33-4 at 4). Further, although the nurse noted from Plaintiff's medical records that Plaintiff's computed tomography (CT) scan completed in October 2020 and a magnetic resonance imaging (MRI) completed in November 2020 showed no abnormalities, the nurse nevertheless concluded based on the information Plaintiff's physicians provided that Plaintiff's "limitations were supported through June 2021." (ECF No. 33-4 at 4). However, the nurse also noted that, "to assess [Plaintiff's] disability beyond June 2021, ... updated treatment records and testing information would be needed." (*Id.*).

Additionally, according to Defendant's March 17, 2022, denial letter, Defendant's Long Term Disability Claims Department also determined "there was objective medical evidence to support limitations which would prevent [Plaintiff] from performing the duties of [her] own occupation on a full-time basis through June 2021," but the letter also represents that Plaintiff was advised that, "to continue to assess [Plaintiff's] claim, ... [Defendant] required updated treatment records for the period of June 1, 2021 onward." (*Id.*). Thereafter, at Defendant's request, Dr. Vesco provided records that Plaintiff visited Dr. Vesco on July 9, 2021, where Plaintiff complained of cognitive impairment, and had two subsequent visits with Dr. Vesco during which Plaintiff complained of other possibly unrelated issues. (*Id.*). Although Defendant continued to request "objective tests or findings to confirm [Plaintiff's] subjective reports of cognitive deficits" for the period after June 2021 and continued to pay benefits until December 2021, Plaintiff has not shown that any additional objective evidence was provided to Defendant. (*Id.* at 4-5). Indeed, it does not appear from Plaintiff's submissions that Plaintiff obtained additional objective testing until the Talei Assessment in June 2023 – over a year after the March 2022 denial of Plaintiff's appeal. Thus, Plaintiff has not clearly established under factor one that the issues concerning the medical complexity of Plaintiff's condition or the qualifications or credibility of her medical experts warrant augmenting the administrative record.

Factor two allows the Court to augment the administrative record when the availability of administrative review procedures is very limited, with little or no evidentiary record available. *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1027 (4th Cir. 1993). Plaintiff argues that, if the Talei Assessment is excluded, this Court will have to rule on an incomplete record. But this is not the standard. Instead, the second *Quesinberry* factor inquires whether the Court will have to work with "little or no evidentiary record." *Id.* This is not the case here. Plaintiff represents that the entire administrative record, only a portion of which she has provided, is approximately 1776 pages and contains Plaintiff's medical records, as well as the various communications between the parties and Plaintiff's treating physicians. *See* (ECF Nos. 33-1 ¶ 2; 38-1). According to the parties, the documents outline the various aspects of Plaintiff's claim over the relevant time period. Thus, the fact that Plaintiff has recently obtained a new cognitive assessment is not, alone, a basis to augment the record. *See* Mongeluzo, 46 F.3d at 943, 944 ("a district court should not take additional evidence merely because someone at a later time comes up with new evidence that was not presented to the plan administrator.") (quoting *Quesinberry*, 987 F.2d at 1025). Hence, factor two does not necessitate augmenting the administrative record.

***5** Factor three allows a court to augment the record if the evidence concerns the interpretation of the terms of the plan rather than specific facts. *Id.* Plaintiff's Motion does not challenge the meaning of any terms in the plan. Instead, Plaintiff argues Defendant failed to disclose the need for "neuropsych" testing and that, "by referencing the need for "neuropsych" testing, [Defendant] has effectively already conceded the relevance of [the Talei Assessment]." (Mot. at 16). As stated previously, however, Plaintiff has not shown references to "neuropsych" testing in her claims file established a requirement that such particular type of objective evidence be presented. This factor, then, does not weigh in favor of augmenting the record.

Factor four allows a court to augment the record in instances where the payor and the administrator are the same entity *and* the court is concerned about impartiality. *Opeta*, 848 F.3d at 1217. Factor five considers whether the claim would have been an insurance contract claim prior to ERISA. (*Id.*). Here, under factor four Plaintiff alleges correctly that Defendant was acting as both the funding source of plan disability benefits and also claim administrator when it denied Plaintiff's claim. (Mot. at 12). Defendant does not dispute the presence of these factors. Similarly, under factor five, it is undisputed that this case would have been an insurance contract claim prior to ERISA. The Court notes, however, that Plaintiff has not pointed to evidence in support of the Motion clearly establishing the denial of her claim was likely due to impartiality. Nor has the Court's review of Plaintiff's

submissions in support of the Motion raised a particular cause for concern based on impartiality. Thus, Plaintiff has not clearly established under either factors four or five that augmenting the record is necessary.

Finally, the Court must inquire whether the claimant could not have presented the relevant evidence in the administrative process. *Opeta*, 848 F.3d at 1217. Here, Plaintiff alleges that she could not have presented the objective evidence because she was not made aware of its necessity. (Mot. at 5). Defendant counters that it gave Plaintiff numerous opportunities to cure the deficiencies in her claim. (Opp. at 18). The Court has already found that Defendant's notice that Plaintiff needed to provide objective evidence of her claimed cognitive impairment was sufficient under the governing standards. That said, the sixth *Quesinberry* factor raises a slightly different question, namely, whether there were "circumstances in which there is additional evidence that the claimant could not have presented in the administrative process." *Opeta*, 848 F.3d at 1217. The focus is, then, on whether the claimant had the possibility to present the additional evidence in dispute.

Here, Plaintiff was initially notified by the December 2021 letter that her claim for disability had been denied, that she had 180 days to appeal, and that she should submit any requested additional medical and/or other information during that time frame. *See* (ECF No. 33-3 at 6) ("Submit your formal request for reconsideration in writing within 180 days of the date you receive the attached letter with the additional medical and/or other information mentioned within the letter."). While an argument could be made that Plaintiff's request for reconsideration less than 60 days after the December 2021 denial letter and Defendant's completion of the appeal a little over a month after Plaintiff's request significantly shortened the minimum 180 day time period Plaintiff would otherwise have had to obtain and submit the requested objective evidence, that argument is defeated by the fact that Plaintiff did not obtain such evidence until June of 2023 – well over a year after her appeal was denied. The Court finds, therefore, that this final factor does not warrant augmenting the record.

***6** In sum, Plaintiff has not clearly established under any of the exceptional circumstances identified in *Quesinberry* that granting Plaintiff's motion to augment the administrative record is appropriate. [3] While the Court recognizes that both Plaintiff and Defendant's reconsideration process could have benefited from the additional objective evidence Defendant was requesting, the Court does not find that these circumstances render consideration of the Talei Assessment *necessary* to conduct *de novo* review of the benefits decision. As such, the Court DENIES Plaintiff's Motion to Augment the Administrative Record.

IV. CONCLUSION

For the foregoing reasons, the Court DENIES Plaintiff s Motion to Augment the Administrative Record.

IT IS SO ORDERED.

All Citations

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Footnotes

1 Plaintiff represents to this Court that Plaintiff's conditional approval from Defendant was sent on October 5, 2021. (Mot. at 8). This fact is referenced by the Appeal Denial Letter at ECF No. 33-4, though the Court appears not have been provided with the original conditional approval letter.

2 There is a seeming typographical error in the March 2022 appeal denial letter that goes unnoticed by both parties. (ECF No. 33-4 at 5). At a critical part of the denial explanation, Guardian writes, "Although you have consistently reported subjective complaints of severe dizziness, balance difficulties, and problems with cognition, there are no subjective

[sic] findings that would support your inability to work." From context, it appears to the Court that this should read "no *objective* findings." For instance, one paragraph above Guardian writes "there were no objective testing records to support your complaints of cognitive impairment that would provide restrictions and limitations which would have prevented you from performing the duties of your own occupation on a full-time basis."

3 Based on the parties' communications during the meet and confer process in which they discussed possible alternatives to the Motion, the Court and parties discussed during the hearing on the Motion the mechanics of a stay or remand of the proceedings if the Court were to determine the Motion should be granted. However, from its review of the facts in the case and applicable law, the Court also expressed doubt during the hearing that Plaintiff had met her burden of establishing augmentation of the record is appropriate. Upon careful consideration of the arguments during the hearing, the parties' submissions, the record, and the law governing the issues in this case, the Court concludes denial of the Motion is appropriate.

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