



section that contains a concise statement of material facts as to which the party contends a genuine issue exists. Each fact in dispute shall be numbered by paragraph, shall refer with particularity to those portions of the record upon which the opposing party relies, and, if applicable, shall state the number of movant’s fact that is disputed. (2) If the party opposing summary judgment relies on any facts not contained in movant’s memorandum, that party shall set forth each additional fact in a separately numbered paragraph, supported by references to the record . . . .<sup>1</sup>

The rule further states that: “all material facts set forth in the statement of the movant *shall be deemed admitted* for the purpose of summary judgment unless specifically controverted by the statement of the opposing party.”<sup>2</sup> “The enforcement of this rule does not depend on the movant filing an objection or showing prejudice from the opposing party’s non-compliance.”<sup>3</sup>

Plaintiff has not even attempted to controvert Continental’s eighty-four factual contentions as required by Rule 56.1. Nor has plaintiff presented any additional factual contentions in separately numbered paragraphs; instead, plaintiff has presented a narrative with references to the record interspersed throughout. The Court will not sift through plaintiff’s lengthy narrative in an attempt to identify controverted facts. “The very purpose of Rule 56.1 is to avoid such a misdirection of judicial resources. Moreover, such an approach would vitiate the explicit sanction contained within the rule – the requirement that the facts which are not admitted or denied will be deemed admitted.”<sup>4</sup> Thus, pursuant to Rule 56.1, the facts presented in Continental’s motion are deemed uncontroverted.

The Court notes that even if plaintiff had included his factual statements in separately numbered

---

<sup>1</sup>D. Kan. R. 56.1(b).

<sup>2</sup>D. Kan. R. 56.1(a).

<sup>3</sup>*Harnett v. Parris*, 925 F. Supp. 1496, 1500 n.1 (D. Kan. 1996).

<sup>4</sup>*Joshua W. v. Bd. of Ed. of Wichita Public Schools U.S.D. No. 259*, 13 F. Supp. 2d 1199, 1205 n.6 (D. Kan. 1998).

paragraphs, many of his allegations would be irrelevant to the Court's de novo review of the decision to deny him benefits. On a de novo review of a benefit decision, a court is restricted to the administrative record absent exceptional circumstances justifying the expansion of the record through additional discovery.<sup>5</sup> The exception to the rule only applies where "circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision."<sup>6</sup> Evidence outside of the record may be admissible in the following circumstances:

claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; the availability of very limited administrative review procedures with little or no evidentiary record; the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; instances where the payor and the administrator are the same entity and the court is concerned about impartiality; claims which would have been insurance contract claims prior to ERISA; and circumstances in which there is additional evidence that the claimant could not have presented in the administrative process.<sup>7</sup>

Even in these circumstances, a court is not required to admit evidence outside of the administrative record.<sup>8</sup> Moreover, a court should "only admit the additional evidence if the party seeking to introduce it can demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision was made."<sup>9</sup>

Although plaintiff suggests that additional evidence is necessary to conduct an adequate de

---

<sup>5</sup>*Hall v. UNUM Life Ins. Co. of Am.*, 300 F.3d 1197, 1202 (10th Cir. 2002).

<sup>6</sup>*Id.*

<sup>7</sup>*Id.* at 1203.

<sup>8</sup>*Id.*

<sup>9</sup>*Id.*

novo review of Continental's decision, plaintiff has not even attempted to demonstrate the requisite "exception circumstances" necessary to admit evidence not found in the administrative record. Plaintiff stresses that Continental was responsible for both making the decision to award benefits and for paying the benefits. But, the mere fact that the payor and administrator are the same entity does not mean that a court should automatically allow the admission of additional evidence.<sup>10</sup> The Tenth Circuit has stated that:

The administrator and payor are often the same party for many ERISA benefit plans. If we were to adopt a blanket rule that the admission of additional evidence should be allowed whenever the same party is the administrator and payor, then it will not be the unusual case in which additional evidence is admitted. It would be commonplace.<sup>11</sup>

In the context of admitting additional evidence based upon a possible conflict, evidence should only be admitted to the extent that the party seeking its admission can show that it is relevant to the conflict of interest and that the conflict of interest in fact requires the admission of the evidence.<sup>12</sup>

Here, there has been no showing by plaintiff of the manner or extent in which the conflict of interest affected Continental's decision. Instead, plaintiff baldly asserts that due to the conflict of interest, Continental failed to conduct its decision-making duties in a fair and reasonable manner. This assertion is apparently based on Continental's denial of his benefits, not on facts or evidence, and as such, is insufficient to expand the record. Further, the Court's independent review of the administrative record does not reveal any reason, an alleged conflict of interest or otherwise, to depart from the rule

---

<sup>10</sup>*Id.* at 1205.

<sup>11</sup>*Id.*

<sup>12</sup>*Id.*

that “it is the unusual case in which the district court should allow supplementation of the record.”<sup>13</sup> Consequently, many of the facts contained in plaintiff’s narrative response would not be considered even if he had complied with local rules.

The following facts contained in defendant’s summary judgment memorandum and which find support in the record, are uncontroverted:

Plaintiff was born on March 27, 1941, and began practicing medicine in July 1970 with Lincoln Center-OB-GYN, P.A. (“Lincoln”). He became a full partner in the practice on or about July 1, 1975. From July 1, 1970 through November 1997, Plaintiff’s practice included both obstetrics and gynecology. On November 28, 2001, plaintiff filed an amended complaint based upon a Long Term Disability Insurance Protection Plan, No. SR-83074913 (“the Plan”) issued to Lincoln for the benefit of its eligible employees. The Plan provides that all active, full-time physicians are eligible for coverage following thirty days of employment. The Plan became effective on May 1, 1997, and replaced prior disability income protection coverage obtained by Lincoln. Plaintiff has alleged that he was disabled as defined by the Plan.

Continental is the underwriter and Continental Casualty Co., CNA was designated to adjudicate claims under the Plan. Continental is the responsible party for payment of disability income protection benefits under the Plan. The monthly benefit, pursuant to the Plan, is sixty percent of the monthly salary subject to a maximum monthly benefit of \$7,500. The benefit may also be reduced according to certain benefit reduction language in the Plan. Under the terms of the Plan, the maximum

---

<sup>13</sup>*Id.* at 1203.

period disability benefits are payable, if the insured's disability began before the insured's 60th birthday, is the insured's 65th birthday. Based upon plaintiff's annual salary of \$148,405.68, plaintiff's maximum monthly benefit, absent appropriate offsets, would be \$7,420. Plaintiff has been awarded social security benefits commencing March 2003 in the amount of \$1,367 per month.

The Plan provides for an elimination period of 180 days, during which time a Plan participant must remain totally or partially disabled before benefits are payable. The definition of disability under the terms of the Plan includes:

You are considered disabled and eligible for benefits if, due to an accident or sickness which causes loss commencing while your coverage is in force, you are unable . . . to perform each of the material duties pertaining to your specialty in the practice of medicine (for doctors) . . . or to perform all the material duties of your regular specialty (for doctors) . . . on a full time basis, but are

- a. performing at least one of the material duties of your regular specialty/occupation or another occupation on a part-time or full-time basis, and
- b. are currently earning less than 80% per month of your pre-disability earnings due to that same injury or sickness. If you are disabled, you must be under the care of a doctor other than yourself.

In 1988, plaintiff experienced back problems culminating in an examination by Dr. David Fitzgerald on January 18, 1989. Plaintiff reported a one-month history of low back pain without history of any trauma. During the examination, plaintiff reported experiencing intermittent episodes of transient low back pain and radicular right lower extremity pain to the ankle laterally, worst in the early morning hours. Specifically, plaintiff complained of pain associated with dressing and getting in and out of automobiles. During the week before his examination, plaintiff was taking ibuprofen in 400 mg doses, four to five times a day. Dr. Fitzgerald's impressions were lumbosacral radiculopathy, sensory only.

Dr. Fitzgerald asked plaintiff, given the increase in radicular component of this pain, to secure a CT scan of the lumbosacral canal, as well as plain x-rays of the lumbosacral spine. The Radiology Consultation Report stated that there appeared “to be significant bulge at the L4-5 with disc density material producing posterior displacement of the dural sac particularly on slice 18 and 19. There is also obscuration of the epidural fat on the right side at this level indicating that the disc probably extends to involve the L4 nerve root on the right side at this level.”

In or around November 1997, plaintiff ceased nightly and weekend on-call obligations and terminated his obstetrics practice and began to limit his practice to gynecology. Plaintiff’s practice had included both obstetrics and gynecology from July 1, 1970 through November 1997. When plaintiff terminated his obstetrics practice, he had not seen a physician for his back since 1989.

Three months after terminating his obstetrics practice and limiting his practice to gynecology, plaintiff was examined and treated by Dr. Baker, commencing February 26, 1998. Dr. Baker’s notes from plaintiff’s initial visit to him indicate that plaintiff entered “on self-referral for evaluation of the left hip area and left leg pain which has been present about a year. He has been taking Ibuprofen almost daily for this. He has been recently doing some exercises which he thinks help.” The notes from Dr. Baker further indicated that plaintiff was doing 100 sit-ups each morning in a “real crunch position.” However, he was not doing that at the present time. Plaintiff did not reduce his hours on the advice of his physicians. Plaintiff, from November 1997 through October 28, 1998, continued to practice gynecology for Lincoln, including surgery at times as often as four to five times per week.

The claims process began when plaintiff submitted forms to Continental via Stedman Insurance Group by letter dated April 24, 1998. During the claim review process, the entire claim, including

medical records, was reviewed by the Nurse Case Manager, Rita Stevens; the disability specialist, Sharon Green; and, later, Continental's Appeals Committee, Cheryl Sauerhoff and Donna Gatling.

Included with the claim materials was the Employee's Statement prepared by plaintiff and dated March 30, 1998, which indicated that plaintiff suffered from "a progressive injury over the past 10+ years" that "causes severe pain." Plaintiff further indicated that at that time he had not stopped working. In the LTD Employer's Statement, Lincoln indicated that plaintiff was continuing to work despite pain and that his daily activities include "1 -3 hrs per day doing surgery; 1-2 hrs doing rounds in 2 hospitals and 6-8 hrs per day in clinic." Based upon additional information provided to Continental, from the time plaintiff's claim was submitted until October 28, 1998, the date he had previously told Lincoln he intended to retire, plaintiff continued to perform his gynecological duties, including surgery four to five times per week.

The Employee's Job Activities Statement, also prepared by plaintiff, indicated that plaintiff frequently stood and occasionally sat, walked and crawled. Plaintiff also reported moderate lifting, carrying, pushing and pulling. The Employer's Job Activities Statement dated April 13, 1998 and signed by Fred Vance, Lincoln's Plan administrator, was incomplete and provided limited information regarding plaintiff's occupational requirements.

The Physician's Statement prepared by Dr. Baker dated May 4, 1998, contained a diagnosis of spondylolisthesis and refers to symptoms of back and leg pain. Dr. Baker also indicated that plaintiff had limited forward flexion to 70 degrees and degenerative spondylosthesis at L4-5. The specific limitations imposed on plaintiff by Dr. Baker included "standing and perineal flexion accentuate the pain (lumbar) with radiculopathy." He also noted that plaintiff was "[l]imited to minimal sustained lifting."

Dr. Baker further indicated that plaintiff's prognosis would be helped with fusion/decompression in the future, although he did not believe that plaintiff would recover.

According to the medical records provided by Dr. Baker, plaintiff was seen by him from February 26, 1998 through April 9, 1998, and thereafter was scheduled to follow up on an as-needed basis. Plaintiff only saw Dr. Baker three times between February 1998 and April 1998. In April 9, 1998 examination notes from Dr. Baker, plaintiff reported that with activity and if he was on his feet a good deal, he had discomfort in the back and left leg. Dr. Baker's impression in April 1998 was "[s]pondylolisthesis with radiculopathy mostly left leg, somewhat improved following steroid injection and reduction of activity."

An additional undated Physician's Statement prepared by the MRI Center of Kansas indicated a diagnosis of radiculopathy of left leg due to Grade I spondylolisthesis at L4-5. The specific limitation imposed was "avoid standing for long periods of time" and the prognosis for recovery and return to work was "fair-good." Dr. Peterson, who performed and reviewed plaintiff's MRI was of the opinion that plaintiff had "degenerative disc disease, bulging of the disc and osteophyte formation which in conjunction with a Grade I spondylolisthesis causes mild central stenosis and moderate narrowing of the lateral recess on the left side at L4-5."

Plaintiff also submitted the medical records from Dr. Baker from February 26, 1998 to May 4, 1998; Menninger Clinic dated January 18, 1989; MRI Center of Kansas from March 4, 1998 and September 10, 1998; and Dr. Sergio Delgado dated September 10, 1998. The medical records reflect that plaintiff began experiencing back pain in 1988 and 1989 but continued to work as an obstetrician-gynecologist. Plaintiff's medical records next reflect treatment by Dr. Baker in February 1998,

approximately nine years after the initial onset of his condition.

On June 9, 1998, Continental's Nurse Case Manager, Rita Stevens, and Disability Specialist, Sharon Green, conducted a telephone interview with plaintiff. According to the notes from the telephone interview, plaintiff reported at this time that he was not being treated by other doctors and that he had not had an EMG or MRI performed. Plaintiff further reported that his problems began in 1988, with a bulging disc. Plaintiff reported that he had given up obstetrics at the end of 1997, without seeing a physician for his back condition since 1988, but was still practicing gynecology, including four to five surgeries per week. Plaintiff stated that he intended to give up everything in October 1998 and retire. Plaintiff's self-reported restrictions included no prolonged walking, standing, and he was to refrain from lifting. Plaintiff was taking ibuprofen, was not in physical therapy, and had not recently consulted a neurologist.

Continental requested and obtained a peer review/physician consult of plaintiff's medical records by an outside physician, Dr. Donald E. Pearson, M.D., of Regional Orthopaedic Associates. Dr. Pearson was forwarded all of plaintiff's medical records on June 12, 1998 and, after his review of all of the medical records submitted by plaintiff as well as the job analysis and plaintiff's work demands, concluded that plaintiff was "capable of performing all of the activities of an obstetrician without any type of restrictions." Dr. Pearson further concluded that even if plaintiff's symptoms increased, he did not see a need for surgical intervention and recommended that plaintiff simply limit the amount of standing to no more than two hours at a time without a 15-20 minute break and, if problems increase, limit any type of lifting to 25-30 lbs. He stated, "[o]therwise I would not have any further recommendations or any further treatment."

In addition to plaintiff's medical records, Continental's representatives interviewed plaintiff and reviewed EZDOT reports classifying the occupational demands of an obstetrician and a gynecologist as "light duty." Continental also retained MJM Investigations, Inc. to conduct video surveillance of plaintiff, which was done on June 26 and 27, 1998.<sup>14</sup> The minimal amount of video footage obtained, nine minutes and thirty-one seconds, did not demonstrate any noticeable limping by plaintiff or any other visible sign of injury.

On July 15, 1998, Sharon Green, Continental's disability specialist, sent plaintiff a letter denying his claim for benefits. According to the letter, the denial was based largely upon a lack of medical evidence demonstrating that plaintiff was unable to perform each of the material duties of an obstetrician-gynecologist. Ms. Green referred to the interview with plaintiff and specifically identified the medical records discussed *infra* that were reviewed as well as plaintiff's occupational requirements. Ms. Green noted that even after plaintiff submitted his claim for disability, and even though the MRI results documented a condition of spondylolisthesis, plaintiff continued to perform gynecological duties, which were similar to obstetrical duties, and averaged between four to five surgeries per week, and did not intend to retire until October 1998. Ms. Green stated that "the medical records do not support a condition severe enough to cause a disability or prevent you from performing each of the material duties as an Obstetrician or Gynecologist. In fact, the MRI done 3/4/98 shows mild stenosis and moderate narrowing which has not inhibited your ability to function and, therefore, is not considered severe and disabling."

---

<sup>14</sup>Continental has filed a Motion for Leave to file the video tape conventionally. For good cause shown, the Court grants the Motion for Leave.

By letter dated September 10, 1998, plaintiff appealed Continental's determination. Plaintiff did not submit any additional medical evidence in support of his claim for disability benefits with his letter appealing Continental's determination, but prior to review by the Appeals Committee, plaintiff did submit additional medical information from Dr. Delgado, who interviewed plaintiff on September 10, 1998. Cheryl Sauerhoff, Appeals Committee Member, confirmed the denial on behalf of the Appeals Committee on November 9, 1998. The denial was upheld after a review of the information contained in the Claim File, including the additional information submitted by Dr. Delgado. Ms. Sauerhoff noted that the examinations performed by plaintiff's treating physician, Dr. Baker, did not reveal any significant sensory loss, no muscle loss or atrophy and no significant neurological deficits.

The Committee determined that although Dr. Delgado disagreed with some of the findings of Dr. Baker and Dr. Fitzgerald, himself determining based upon his own review of the March 4, 1998 MRI that plaintiff had grade I spondylolisthesis of L4 -L5 in 1988 and 1989 and that in 1998 the stenosis was moderate to severe with impingement on the L4 root, the medical findings taken as a whole would not preclude plaintiff from performing the material duties of his light duty occupation as an obstetrician-gynecologist. The Committee stated that plaintiff had "basically continued to work with essentially the same findings for the past 10 years. The medical records provided do not show any significant deterioration or worsening of your condition prior to your decision to reduce your workload."

Following the Appeals Committee's denial of his benefits, plaintiff filed a consumer complaint/inquiry with the Kansas Insurance Department. In response to the Insurance Department's inquiry, Louise H. Seraaj, Assistant Vice President for Continental, outlined the claims process and

explained Continental's position, "we have concluded that the medical findings are not substantially different than those provided for the period during which he actively worked and performed the duties of his specialty and practice in the practice of medicine." In response to a second letter from the Insurance Department, Louise Seraaj further explained Continental's decision by reciting the definition of disability in the Plan and reviewing plaintiff's functional limitations. Ms. Seraaj noted that plaintiff's functional limitations were within the physical requirements of his occupation, and that the medications being taken by plaintiff did not reflect severe chronic pain on the part of plaintiff.

On August 3, 2000, plaintiff's initial attorney, George Farrell, sent a letter to Continental enclosing a new evaluation from Dr. Delgado performed on July 11, 2000. The new evaluation, addressed to Mr. Farrell, was a follow-up on the evaluation performed by Dr. Delgado on September 10, 1998, nearly two years earlier. The report from Dr. Delgado provided that plaintiff was still under medical care for the same condition by Dr. Baker. At the time of this follow-up report, plaintiff reported to Dr. Delgado that during his usual schedule, plaintiff "averages 12 hours of work a day when fully active. Most of it requires prolonged standing, particularly during surgery. He occasionally sits for patient conferences which also aggravate his symptoms so he cannot do these activities for any prolonged period of time."

Dr. Delgado's evaluation provided that:

My impression continues to be that [plaintiff] has a moderately severe progressive spinal stenosis with lateral recess stenosis and disc degeneration with foraminal encroachment which, at this point, appears to be well controlled by limiting his activities, use of TENS unit for pain control, anti-inflammatories and epidural steroid injections every three to four months.

Dr. Delgado stated that his "general impression is that [plaintiff] should continue with his present

limitation of work activities and that he is completely disabled from performing all work activities which are all in relation to the disease process which has been thoroughly evaluated and for which treatment is being rendered.” No new medical records were submitted with this follow-up report. No additional treatment records were submitted.

Continental again referred plaintiff’s claim to the Appeals Committee, along with the report prepared by Dr. Delgado. After reviewing the additional information provided, the Appeals Committee stated that Continental’s decision to deny benefits remained unchanged because:

The report from Dr. Delgado does not substantiate that your client was continuously unable to perform his occupation/specialty from the date he last worked in October 1998. Although the report does indicate that your client could continue with his present limitation of work activities we still are unable to reverse the previous decision without any findings. Since your client was not found to be disabled during the elimination period, no benefits are payable. Please be advised that verification a medical condition exists does not confirm your client’s inability to perform the duties of his own specialty nor does it prove any disabling impairment. Your client was capable of working for 10 years with the same findings and the medical evidence fails to substantiate a condition that would have prevented him from continuing.

Based upon a date of loss of March 30, 1998, the 180 day elimination period lasted until approximately September 25, 1998. Plaintiff did not cease work until October 28, 1998.

## **II. Motion for Summary Judgment**

### **A. Legal Standard**

Summary judgment is appropriate “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law.”<sup>15</sup> The requirement of a “genuine”

---

<sup>15</sup>Fed. R. Civ. P. 56(c).

issue of fact means that the evidence is such that a reasonable jury could return a verdict for the nonmoving party.<sup>16</sup> Essentially, the inquiry is “whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law.”<sup>17</sup>

The moving party bears the initial burden of demonstrating the absence of a genuine issue of material fact. This burden may be met by showing that there is a lack of evidence to support the nonmoving party’s case.<sup>18</sup> Once the moving party has properly supported its motion for summary judgment, the burden shifts to the nonmoving party to show that there is a genuine issue of material fact left for trial.<sup>19</sup> “A party opposing a properly supported motion for summary judgment may not rest on mere allegations or denials of [its] pleading, but must set forth specific facts showing that there is a genuine issue for trial.”<sup>20</sup> Therefore, the mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment.<sup>21</sup> The Court must consider the record in the light most favorable to the nonmoving party.<sup>22</sup>

Although plaintiff has not responded to Continental’s factual contentions, this alone does not make summary judgment proper, for plaintiff’s burden to respond arises only if the motion is properly

---

<sup>16</sup>See *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

<sup>17</sup>*Id.* at 251-52.

<sup>18</sup>See *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986).

<sup>19</sup>See *Anderson*, 477 U.S. at 256.

<sup>20</sup>*Id.*

<sup>21</sup>See *id.*

<sup>22</sup>See *Bee v. Greaves*, 744 F.2d 1387, 1396 (10th Cir. 1984), *cert. denied* 469 U.S. 1214 (1985).

supported in the first instance.<sup>23</sup> “Accordingly, summary judgment is appropriate under Rule 56(e) only when the moving party has met its initial burden of production under Rule 56(c).”<sup>24</sup> If the evidence presented by the moving party does not satisfy this burden, “summary judgment must be denied *even if no opposing evidentiary matter is presented.*”<sup>25</sup> Thus, if a nonmoving party fails to properly respond to a motion for summary judgment, the court must first examine the moving party’s submission to determine if it has met its initial burden of demonstrating that no material issues of fact remain for trial and that the moving party is entitled to judgment as a matter of law.

The Court notes that summary judgment is not a “disfavored procedural shortcut”; rather, it is an important procedure “designed to secure the just, speedy and inexpensive determination of every action.”<sup>26</sup>

## **B. Discussion**

ERISA provides a detailed and comprehensive set of federal regulations governing the provision of benefits to employees by employers, including disability benefits.<sup>27</sup> ERISA gives a plan beneficiary the right to federal court review of benefit denials, but does not establish the standard of review for such decisions.<sup>28</sup> The Court has already determined that the applicable standard of review

---

<sup>23</sup>See *Reed v. Bennett*, 312 F.3d 1190, 1195 (10th Cir. 2002).

<sup>24</sup>*Id.* at 1194.

<sup>25</sup>*Id.*

<sup>26</sup>*Celotex*, 477 U.S. at 327 (quoting Fed. R. Civ. P. 1).

<sup>27</sup>*Hall*, 300 F.3d at 1200.

<sup>28</sup>*Id.*

applicable in this case is de novo. Thus, the court reviews Continental's decision without deference to that decision and without any presumption of correctness.<sup>29</sup> When a court reviews a decision de novo, it simply decides whether or not it agrees with the decision under review.<sup>30</sup>

Notably, plaintiff spends little time discussing the definition of disability in the Plan, which is at the heart of Continental's decision to deny him benefits. Pursuant to the Plan, plaintiff had to be "unable to perform each of the material duties pertaining to [his] specialty in the practice of medicine" to be totally disabled. And, plaintiff must have been disabled throughout the entire Elimination Period, which lasted from March 30, 1998 until September 25, 1998. It is undisputed, however, that plaintiff continued to work from March 30, 1998 until October 29, 1998 as a gynecologist and continued to perform surgeries four to five times per week. It is also undisputed that the jobs of obstetrician and gynecologist are classified as light duty, and the duties of each specialty are similar.<sup>31</sup> Thus, even a cursory review of the administrative record illustrates that plaintiff was not disabled, nor unable to perform each of the material duties of an obstetrician under the Plan.

To counter Continental's denial of benefits due to plaintiff's failure to qualify as totally disabled, plaintiff states that he never claimed he was disabled or entitled to benefits prior to November 1, 1998. But, plaintiff applied for disability benefits on March 30, 1998; his claim was denied in a letter dated July 15, 1998; the denial was appealed on September 10, 1998. Thus, plaintiff now states that he

---

<sup>29</sup>*See Hammers v. Aetna Life Ins. Co.*, 962 F. Supp. 1404, 1406 (D. Kan. 1997).

<sup>30</sup>*Id.*

<sup>31</sup>Plaintiff suggests that his job really was not "light duty"; however, he has failed to controvert this fact and it is deemed admitted. Moreover, Continental relied on EZDOT standards in classifying plaintiff's position as light duty and plaintiff has not suggested that such reliance was improper.

never claimed he was disabled before November 1, 1998, even though by that time, his claim had been processed, denied and appealed. Surely plaintiff could not have known on March 30, 1998, that he would be “unable to perform each of the material duties pertaining to [his] specialty,” nearly six months later. In short, plaintiff’s contentions are disingenuous.

Additionally, plaintiff takes issue with the definition of totally disabled on fairness grounds. He states that “to adopt the defendant’s argument would be to rule that the only individuals who could ever be entitled to receive disability benefits are those who can work one day and then suddenly become unable to work the next day.” The Plan, however, does not require that a plaintiff become suddenly unable to work. Instead, it requires that a plaintiff be unable to perform each of the material duties of his specialty during the 180 day elimination period. It is uncontroverted that based upon a date of loss of March 30, 1998, the 180 day elimination period lasted until approximately September 25, 1998. It is also uncontroverted that plaintiff did not cease work until October 28, 1998. That plaintiff finds the 180 day elimination period unfair, and only became aware of “how difficult and unfair the claim process” was upon attempting to collect under the terms of the policy, does not change the Plan requirements or terms.

An analysis of the Plan terms clearly shows that plaintiff was not totally disabled, and thus, not entitled to benefits. Nevertheless, the Court will address plaintiff’s claims that Continental failed to perform its duties in a fair and reasonable manner by: (1) relying completely on the opinions of Dr. Pearson, who never examined plaintiff; (2) not posing the question, “Can claimant perform each and every essential duty of his profession full time?” to Dr. Baker, plaintiff’s treating physician; and

(3) ignoring the painful conditions that plaintiff had experienced as early as 1989.

Plaintiff's suggestion that Continental relied exclusively on Dr. Pearson in reaching its decision to deny benefits is false. Rather, Continental reviewed all available medical evidence including: Dr. Fitzgerald's records from January 1989; Dr. Baker's records from plaintiff's three visits between February 26, 1998 and May 4, 1998; Menninger Clinic's records dated January 18, 1989; MRI Center of Kansas' records from March 4, 1998 and September 10, 1998; and Dr. Sergio Delgado's records dated September 10, 1998. Continental also reviewed the Employee Statement and the Employee's Job Activities Statement prepared by plaintiff, the Employer's Job Activities Statement prepared by Lincoln, Dr. Baker's Physician's Statement and a Physician Statement prepared by MRI Center of Kansas. Continental conducted an interview of plaintiff, reviewed EZDOT reports classifying the occupational demands of an obstetrician and a gynecologist as "light duty," and retained MJM Investigations, Inc. to conduct video surveillance of plaintiff. And, Continental reviewed Dr. Delgado's evaluation performed on July 11, 2000, more than two years after plaintiff initially sought benefits, before the claim was denied again by the Appeals Committee. All of this evidence is *in addition* to the peer review performed by Dr. Pearson. Moreover, the fact that Dr. Pearson did not personally examine plaintiff does not vitiate his conclusion, based on his review of all available evidence, that plaintiff was not totally disabled as defined by the Plan.

Plaintiff also notes that Dr. Pearson is from Orlando, Florida, which is also the location of defendant's claims office. To the extent plaintiff intends to suggest that Dr. Pearson is not credible simply because his office is also located in Orlando, the Court rejects plaintiff's suggestion in toto.

Plaintiff has proffered no evidence that Dr. Pearson's peer review of Continental's decision was suspect. Instead, both the medical evidence and the actions of plaintiff himself confirm Dr. Pearson's conclusion: that plaintiff was not totally disabled.

Plaintiff also argues that Continental erred in denying him benefits by not posing the question, "Can claimant perform each and every essential duty of his profession full time?" to Dr. Baker, plaintiff's treating physician. Plaintiff also claims that "had that question been asked of Dr. Baker, he would have answered it no - that the plaintiff was physically unable to perform each and every essential duty of his profession." Yet, Dr. Baker's own records rebut this assumption. The only restrictions placed upon plaintiff by Dr. Baker were no prolonged walking, standing, and no lifting. These restrictions do not suggest that plaintiff was unable to perform each of his duties as set forth by plaintiff in his Job Activities Statement, particularly when plaintiff continued to treat patients and conduct surgery during the elimination period.

Moreover, plaintiff does not cite to the administrative record in support of his assumption that Dr. Baker would have found plaintiff unable to perform each of the material duties of an obstetrician. He attempts to argue that Dr. Baker's determination that plaintiff was disabled pursuant to the definition of "disabled" of another insurance policy necessarily indicates that Dr. Baker would have found plaintiff disabled under Continental's policy. But, this evidence is not in the administrative record and plaintiff has not shown exceptional circumstances to supplement the record with new evidence; thus, the Court need not even consider plaintiff's argument. Even assuming the evidence could be considered, it is irrelevant. Dr. Baker's conclusions regarding plaintiff in another dispute have no bearing on this

proceeding. It is not clear that the definition of disability in the two policies is the same; nor that the elimination period is the same. Most importantly, plaintiff's own actions belie his suggestion that Dr. Baker would have stated he was unable to perform each of his material duties; plaintiff was working during the elimination period and thus, clearly able to perform one, if not more, of the material duties of an obstetrician. For all of these reasons, the Court rejects plaintiff's suggestion that Continental erred.

Finally, plaintiff claims that Continental's decision to deny him benefits was incorrect in that it ignored the painful conditions that plaintiff had experienced as early as 1989. But, plaintiff reported his pain to Continental in an interview; and, in his Employee Statement, which was considered by Continental, plaintiff stated that he suffered from "a progressive injury over the past 10+ years" that "causes severe pain." Despite this pain, plaintiff reported that he continued to work and that his daily activities included "1-3 hrs per day doing surgery; 1-2 hours doing rounds in 2 hospitals and 6-8 hrs per day in clinic." Thus, not only did Continental consider plaintiff's pain, but plaintiff's pain, alone, did not render him totally disabled under the Plan for he continued to work during the elimination period. Even if Continental had ignored his pain, plaintiff's self report of severe pain is not equivalent to him being unable to perform each of his material duties.

In conclusion, the Court determines based upon its de novo review of the administrative record that plaintiff was not totally disabled as defined by the Plan, and that the denial of benefits was proper. Further, the Court determines that there are no disputed issues of fact suggesting that the determination was incorrect and that summary judgment is proper. The Court therefore grants defendant's motion for summary judgment.

### **III. Motion for Bifurcation of Trial**

In light of the Court's grant of summary judgment to defendant, the motion for bifurcation of trial is denied as moot.

**IT IS THEREFORE ORDERED BY THE COURT** that defendant's Motion for Summary Judgment (Doc. 93) is GRANTED.

**IT IS FURTHER ORDERED BY THE COURT** that defendant's Motion for Leave to File Exhibit C to its Motion for Summary Judgment Conventionally (Doc. 90) is GRANTED.

**IT IS FURTHER ORDERED BY THE COURT** that defendant's Motion for Bifurcation of Trial (Doc. 91) is DENIED as moot.

IT IS SO ORDERED.

Dated this 9<sup>th</sup> day of August, 2004.

S/ Julie A. Robinson

Julie A. Robinson

United States District Judge