No. 13-2379

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

NANCY A. HARRISON,
Plaintiff-Appellant,

v.

WELLS FARGO BANK, N.A. et al.,
Defendants-Appellees.

On Appeal from the United States District Court
for the Eastern District of Virginia at Richmond

SECRETARY OF LABOR AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLANT

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QUESTION PRESENTED

This case involves a claim for short-term disability benefits by Nancy Harrison during a period when she was undergoing three surgical procedures for an extremely enlarged thyroid that pressed on her trachea and extended into her chest cavity and was suffering psychological difficulties because of the sudden death of her husband, which exacerbated previous psychological difficulties that followed the deaths of her children and mother in a house fire seven years earlier. Wells Fargo – the plan sponsor, plan administrator and final decisionmaker under an ERISA-covered disability plan – originally granted her claim for short-term disability benefits starting in June 2011. It cut off her disability benefits as of September 10, 2011, without obtaining necessary and readily-available medical evidence and without informing her that this evidence was necessary to perfect her claim.

The question presented is whether the district court erred in upholding the administrator's determination, particularly given the administrator's failure to obtain necessary and readily-available medical records and assessment from the claimant's treating psychiatrist or to inform the claimant that this evidence was necessary to perfect her claim as required by the ERISA's claims procedure regulation.

STATEMENT OF IDENTITY, INTEREST, AND AUTHORITY TO FILE

The Secretary has primary enforcement and interpretive authority for Title I of ERISA. See 29 U.S.C. §§1134, 1135. The Secretary's interests include promoting uniformity of law, protecting plan participants and beneficiaries, enforcing fiduciary standards, and ensuring the financial stability of employee benefit plans. See Secretary of Labor v. Fitzsimmons, 805 F.2d 682, 692-93 (7th Cir. 1986) (en banc). In this case, the district court interpreted case law in the Fourth Circuit to deprive a plan participant of a meaningful review of a denial of benefits by deferring to the decision of a claims administrator that acted without obtaining readily-available medical information necessary to decide this claim. Because the Secretary has an interest in ensuring that plan fiduciaries strictly comply with their fiduciary obligations as set forth in ERISA section 404, 29 U.S.C. § 1104, and that they give proper consideration to the claims of plan participants and beneficiaries as required under ERISA section 503, 29 U.S.C. § 1133, and the accompanying claims regulation, the Secretary files this amicus brief, under Federal Rule of Appellate Procedure 29(a), in support of plaintiff's argument that Wells Fargo violated its fiduciary duties and abused its discretion when it failed to adequately investigate Harrison's claim.

STATEMENT OF THE CASE

1. Factual Background

At the time she initially made her claim for benefits in June 2011, Harrison was a 32-year-old employee of Wells Fargo, who participated in the company's self-funded disability plan, the Wells Fargo and Company Short-Term Disability Plan (Plan). Wells Fargo was both the sponsor and administrator of the plan, as well as the named trustee. Joint Appendix ("JA") 425-503. Although it delegated responsibility for initial claims administration and decisionmaking to Liberty Life Assurance Company of Boston, Wells Fargo itself retained discretionary authority to make final benefits determinations through its Wells Fargo Short-Term Disability Appeals Committee (Committee). JA 484.

Harrison worked as an On-line Customer Service Representative for Wells Fargo. JA 39. Her job was described by the company as sedentary and entailed answering customer service calls on the phone and computer, responding to customer service emails, and selling Wells Fargo products. JA 200-201. She was required to work 10-hour shifts four days a week and, among other things, to stay attentive and focused in a "fast-paced" environment and manage stress when dealing with sometimes irate customers in a calm and professional manner. JA 200-201.

Under the Plan terms, Harrison was entitled to short-term disability benefits if she had a medically certified health condition (including a psychological condition) that rendered her unable to perform the "essential functions" of her own job (elsewhere described by the Plan as an inability to perform "some or all of her job duties"). JA 475. Although the Plan states that it is the participant's responsibility to ensure that Liberty receives necessary medical records, JA 479, it also states that if the claim is denied because Liberty did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. JA 484. Moreover, the Plan explicitly provides that Liberty may contact the claimant's physicians to obtain medical information, provided that a release from the claimant is obtained (JA 477, 480), which Liberty obtained from Harrison in this case in June of 2011. JA 225. The Plan also states that a claimant may file a claim based on a new disability so long as he or she is on an approved leave of absence at the time of the request. JA 480. Finally, under the terms of Wells Fargo's related long-term disability plan, unless Harrison received short-term disability benefits for 26 weeks, she could not apply for and obtain long-term disability benefits. JA 481-482.

On May 20, 2011, Harrison was admitted to a hospital emergency room based on complaints of chest pain. JA 62 -63. The doctors there discovered a large mass in her chest cavity, which her primary care physician, Dr. Mark

Petrizzi, hypothesized, was an enlarged thyroid extending from Harrison's neck into her chest. JA 139-161. At the same time, Harrison was being treated for depression and receiving Lexapro, as well as Valium. JA 146. In his August 2011 medical report, Dr. Petrizzi increased Harrison's dosage of Lexapro from 10 mg to 20 mg. JA 99, 111, 114-116.

Harrison stopped working on June 8, 2011, and the next day underwent a surgical biopsy called a bronchoscopy, JA 193, which revealed that the mass was thyroid tissue, as Dr. Petrizzi suspected, and that it was causing significant compression of Harrison's trachea. She was referred to an ear, nose and throat specialist, Dr. Daniel Van Himbergen, who recommended surgery to remove her thyroid. JA 146-153. Before she could have this surgery, however, her husband died unexpectedly on July 1, 2011, and she went back to Dr. Petrizzi complaining of depression and chest pain. JA 286. Dr. Petrizzi performed an electrocardiogram, which was normal, and referred her to a psychiatrist, Dr. Glenn, whom she began to see for treatment of her depression. JA 286.

On August 17, 2011, Harrison underwent the recommended surgery, a thyroidectomy, performed by Dr. Van Himbergen and described by him as significantly more difficult than normal thyroid surgery due to the size and location of the thyroid tissue involved. Indeed, although this surgery was successful in removing Harrison's thyroid, the mass in her chest could not be removed during

this procedure. JA 328-333. Afterwards, her symptoms were noted by Van Himbergen to be "slightly improved," but she continued to complain of chest pain, leg pain and swelling, shortness of breath and difficulty swallowing. JA 350-357. Moreover, she had developed a new problem: right shoulder pain due to a rotator cuff injury, which occurred during surgery. JA 320. Furthermore, she continued to suffer from depression and anxiety, and she began treatment with the psychiatrist, Dr. Glenn, to whom she was referred for treatment of her psychological symptoms. And because she still had a mass of thyroid tissue in her chest, she was scheduled to undergo another surgery to remove this mass. On October 31, 2011, she underwent this surgical procedure, called a sternotomy, which entailed splitting her sternum to reach and attempt to remove the remaining thyroid tissue in her chest. This surgery, performed by Dr. Darius Hollings, a thoracic surgeon, was only partially successful, in that not all of the tissue could be removed. JA 372-373

2. Harrison's Claim for Benefits

Shortly after stopping work in June, Harrison applied for short-term disability benefits beginning on June 8, 2011, which were initially approved by Liberty at the first level of review under the Plan. JA 240-241; 388. On June 23, 2011, Harrison provided Liberty with an "Authorization to Obtain and Release Information." JA 225. On August 25, 2011, Liberty contacted Harrison about her

expected return to work, at which time she explained that she was having additional surgery in October and that she was scheduled to again see Dr. Van Himbergen, who had performed the thyroidectomy, on September 7, 2011. As a result of this call, Liberty extended her short-term disability benefits through September 10, 2011. JA 380.

On September 9, 2011, the day before benefits were scheduled to end, Liberty called Harrison for an update on her condition. She reiterated that she was going to have additional surgery to remove the remaining masses and that, in the meantime, she was taking medicine in an attempt to shrink the thyroid tissue in her chest in advance of the surgery. In addition, she informed Liberty about the rotator cuff injury resulting from her prior surgery. Liberty also obtained medical records from Dr. Petrizzi and Dr. Van Himbergen, which continued to report complaints of chest pain from the remaining masses in her chest and confirmed that she had a rotator cuff injury, was suffering from depression and was going to have additional surgery. Despite all of this, and without seeking to contact any of her doctors for additional information, Liberty concluded that Harrison was not entitled to additional benefits beyond September 10, 2011, and it informed Harrison of this decision through a phone call on September 16, 2011, and a letter of the same date. During this call, Harrison informed Liberty that, above and beyond her physical

conditions, she was also suffering from disabling depression and post-traumatic stress disorder. JA 389-390.[1]

Shortly thereafter, Harrison, who was not represented by counsel, appealed the decision and submitted additional materials, including a letter from Dr. Petrizzi. In this letter, Dr. Petrizzi expressed his view that Harrison's continued chest pain, as well as the significant anxiety for which he had referred her to a psychiatrist, made her unable to return to her job, which he recognized entailed "desk work." She also submitted her own letter, explaining that she was suffering from "severe depression" due to the loss of her husband and felt unable to return to work until she could "process [her] grief." She included the telephone numbers for each of her treating physicians, including Dr. Glenn, her psychiatrist. Immediately thereafter, she called Liberty to inquire about filing a new claim for short-term

[1] The district court stated that Harrison was told to provide medical documentation of Harrison's psychological condition in support of an appeal. JA 548. Although there was no testimony in district court on the issue, the district court probably based its statement on notations concerning telephone calls with Harrison in the claims materials. The denial letter did not, however, tell Harrison she needed to provide documentation from her treating psychiatrist about her psychological condition, but instead just generally informed Harrison that she must provide "all documentation, such as hospital records, discharge summaries, exam findings, operative reports, office visit notes, diagnostic test results, chiropractic notes, physical therapy notes, orthopedic notes, endocrinology notes, referrals, consultations, restrictions, limitations, treatment plans, and any other medical information from all treating providers, which you feel will support your claim for continued benefits." As discussed infra, the Department's regulations, like the plan documents in this case, require written notification of documentation needed to support an appeal, which was not provided in this denial letter.

disability benefits and was informed, contrary to the Plan terms, that she could not do so unless she returned to work. JA 342-357.

In response to this appeal, Liberty had her claim reviewed by a nurse consultant, who made no attempt to contact Dr. Glenn (or her other doctors), but instead concluded that Harrison did not have an impairment that prevented her from performing her duties as a "mortgage consultant," which was not, of course, her job. JA 338-340. By letter of November 28, 2011, Liberty advised Harrison that it was upholding its benefit denial on the basis of the nurse's review, concluding that "the medical evidence did not contain physical or mental exam status findings, diagnostic test results, evidence of a marked prolonged deterioration, or other medical documentation substantiating that your symptoms were of such severity that they resulted in restrictions and limitations rendering you unable to perform the essential duties of your job," which Liberty, like the reviewing nurse, incorrectly described as a "mortgage consultant." JA 338-340. The denial did not notify claimant that medical records had not been obtained from Dr. Glenn or that those records might be necessary to perfect her claim. JA 338-340.

Again acting pro se, Harrison appealed the denial for second-level review under the Plan. JA 342-344. In support of this appeal, she submitted a letter detailing her psychological difficulties and explaining that she was "currently on

approved medical leave of absence with Wells Fargo because of what I have been through physically and emotionally." JA 342-344. In addition, she submitted a letter from her sister, who was her primary caregiver during this time, detailing Harrison's significant physical and psychological difficulties and how these affected her ability to perform even simple activities of daily living. JA 345-346. Harrison also submitted additional medical records from Dr. Petrizzi and Dr. Hollings in support of her claim. JA 372-381.

In response to the newly submitted materials, Wells Fargo, which had responsibility at this level of appeal for deciding the claim, sought medical opinions from both an internal medicine specialist, Dr. Dan Gerstenblitt, and a psychiatrist, Dr. A.E. Daniel. Dr. Gerstenblitt opined that "there was nothing really to indicate that she could not return to work in a sedentary type occupation" and that "the fact that the patient had chest pain is not necessarily a reason to be unable to work." JA 394-395; 397-401. Without any more analysis of the medical evidence or the specific requirements of Harrison's job, and without accounting for the letter from Harrison's sister documenting her lack of functionality at home, Dr. Gerstenblitt concluded that "as of September 7, 2011, she was fully recovered from her thyroidectomy, and evidence-based guidelines would support a return to clerical work by September 11, 2011." JA 394-395; 397-401.

On the other hand, the report from Dr. Daniel, the reviewing psychiatrist, was simply inconclusive. He spoke to Dr. Petrizzi, whom he noted "deferred her psychiatric status to Dr. Glen[n]." But Dr. Daniel did not request her medical records from Dr. Glenn or make any effort to contact him. Instead, Dr. Daniel concluded that while "the loss of her children and mother in a family fire could have cause PTSD, which could have been aggravated by the loss of her husband and current health issues . . . [i]n the absence of psychiatric/psychological records or telephone conference with her psychologist, an opinion as to whether her psychiatric status limited her functional capacity cannot be provided." JA 391-393.

On the basis of these peer reviews, and without attempting to contact Dr. Glenn or obtain relevant medical records or his opinion, the committee at Wells Fargo charged with conducting the final review upheld the denial of benefits after September 10, 2011. In the denial letter Wells Fargo sent to Harrison on May 24, 2012, it concluded that "there is no documented evidence that would indicate ongoing impairment that would preclude [her] ability to do [her] job," and that "there is no documented evidence that [her] anxiety symptoms limited [her] functional capacity." JA 389-390.

3. Procedural History and Rulings

On May 2, 2013, Harrison filed a two-count complaint in the Eastern District of Virginia against the Plan and Wells Fargo, alleging that the denial of

benefits after September 10, 2011, was improper under ERISA section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and that she had been denied the "full and fair" review of her benefit claim required by ERISA section 503, 29 U.S.C. § 1133. She alternatively asked the court either to reinstate her short-term disability benefits or to send the case back to Liberty for it to conduct a "full and fair" review. JA 5-11.

Harrison argued that Wells Fargo's denial was unreasonable because: (1) it unreasonably concluded that Harrison had "fully recovered" from her August 17, 2011 thyroidectomy; (2) it unreasonably viewed the medical records selectively in its favor; (3) it unreasonably relied on flawed peer review, especially from Dr. Gerstenblitt; (4) it unreasonably discounted evidence submitted by Harrison and her sister describing her limited functional capacity; (5) it unreasonably failed to obtain medical records or other information from Dr. Glenn, her treating psychiatrist; and (6) it inadequately and incorrectly analyzed Harrison's occupational duties. See Plaintiff's Opposition to Defendants' Motion for Summary Judgment at pp. 15-18. As support for her argument that Wells Fargo had an obligation to obtain needed information from Dr. Glenn, Harrison cited the Tenth Circuit's decision in Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 807 (10th Cir. 2004), which held that a fiduciary has an obligation to obtain available information when the record evidence indicates that the information might confirm

the claimant's theory of entitlement, and there is little or no record evidence to refute the theory. Id. at 17-18.

In a decision issued on November 8, 2013, the district court granted summary judgment to the defendants, concluding that the denial of benefits was not an abuse of discretion under the plan. In rendering its decision in favor of defendants, the district court reviewed the decision under an abuse of discretion standard because the Plan language gave Wells Fargo full discretionary authority to administer and interpret the Plan, and applied the eight non-exclusive factors to consider for an abuse of discretion set forth in Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 342 (4th Cir. 2000). JA 553. The court began by noting that "[w]hile the administrative record provides some subjective support in favor of Harrison's incapacity, objective indications of her physical and psychological limitations are severely lacking in the administrative record." JA 553. The court then noted that the record provided support for three different medical conditions – Harrison's rotator cuff injury, her psychological difficulties, and her thyroid condition – which either separately or in combination could have provided a basis for her disability claim, and considered each in turn. JA 554 -555.

The court quickly disposed of the rotator cuff injury, noting that Harrison did not show that this injury precluded her from performing the essential functions of her job. JA 555. Turning next to Harrison's psychological difficulties, the court

likewise found the objective medical evidence supporting this claim to be lacking. In this regard, the court reasoned that Dr. Petrizzi "deferred Harrison's treatment entirely to Dr. Glenn and neither Harrison nor Dr. Glenn ever provided objective medical documentation to support the conclusion that Harrison's anxiety made her unable to perform her job duties." JA 555. Thus, noting that Harrison had repeatedly been informed that it was her duty "to provide all documentation supporting her claim," and that the Plan language supported this, the court essentially faulted Harrison for failing to submit documentation from Dr. Glenn supporting her claim of psychological impairment. JA 556. In this regard, the court rejected Harrison's argument that the failure by Liberty to contact Dr. Glenn when it had contacted Dr. Petrizzi was unreasonable, reasoning that this was in essence an estoppel argument of the kind that the Fourth Circuit had previously rejected where there is Plan language to the contrary. JA 557, citing HealthSouth Rehab. Hosp. v. Am. Nat'l Red Cross, 101 F.3d 1005, 1010 (4th Cir. 1996). Similarly, the court rejected Harrison's reliance on the Tenth Circuit's Gaither decision, which held that ERISA's administrators have the duty to seek out "readily available information" in some benefits cases. JA 557. Although the court found that the Tenth Circuit's reasoning in Gaither to be "sound," the court concluded that the Fourth Circuit had already held that ERISA administrators "have no duty to seek out additional information supporting a claim where the record contains

evidence supporting denial." JA 557-558 (citing Elliott v. Sara Lee Corp., 190 F.3d 601 (4th Cir. 1999); Berry v. Ciba-Geigy Corp., 761 F.2d 1003, 1008 (4th Cir. 1985)). The court recognized that Harrison's claim did not fall neatly within the Fourth Circuit's Elliott rule because, with the exception of Dr. Petrizzi's "conclusory diagnosis and Harrison's self-reported troubles," the record was "completely devoid of evidence supporting either approval or denial of the benefits." JA 558. The court reasoned that "[a]rguably in this case, the material considered by Wells Fargo was lacking, as was the material provided by Harrison." JA 558. The court nevertheless concluded that, given the Plan language, which placed on Harrison the burden to provide the evidence supporting her claim, the defendants did not act unreasonably in denying benefits. Id., citing Booth, 201 F.3d at 342 (requiring consideration, among other factors, of the relevant plan language).

In its analysis of Harrison's thyroid condition, the court pointed out, as an initial matter, that "Wells Fargo based its denial . . . only on Harrison's ability to work between September 11, 2011, and the date of Harrison's sternotomy," and noted that "there is a distinct lack of objective medical evidence in the record to guide a determination of whether Harrison suffered from physical limitations precluding her from working" during this period. JA 560. The only "objective" evidence, in the court's view, was the letter from the thoracic surgeon, Dr.

Hollings, which was not available until the second-level appeal and which indicated decreased air and blood flow resulting from the remaining mass in her chest, thus supporting her complaints of pain and shortness of breath even before her sternotomy. JA 560. The court considered the remaining evidence from Harrison and her doctors, including the report from the peer review doctor, to be both subjective and conflicting as to the severity of her conditions and concluded that Wells Fargo did not abuse its discretion in concluding that this evidence was insufficient to show that Harrison was unable to perform her essential job duties. In so holding, the court rejected Harrison's arguments that Wells Fargo cherry-picked or disregarded any evidence, erred in relying on the peer review doctor over Harrison's treating physician, and failed to properly analyze the requirements of Harrison's job.

SUMMARY OF THE ARGUMENT

1. Wells Fargo, as the plan fiduciary charged with making benefits determinations under the disability plan it offered to its employees, had an obligation to seek out the readily-available medical evidence from Harrison's psychiatrist about the extent of Harrison's psychological problems. This obligation has been recognized by the Tenth Circuit and is supported by decisions from the Seventh and Ninth Circuits. In Gaither v. Aetna Life Assur. Co., 394 F.3d 792 (10th Cir. 2004), the court held that an administrator abuses its discretion if it fails

to investigate a claim where record evidence suggests that the information might confirm claimant's theory of entitlement and there is little or no evidence to refute the claim. Here, although Wells Fargo arranged for peer review of the medical evidence by both an internal medicine specialist and a psychiatrist, the reviewing psychiatrist made no effort to contact Harrison's treating psychiatrist or obtain the necessary medical records from him, even though he had been given the name of her treating psychiatrist and Harrison had signed a medical release. Wells Fargo then denied benefits based on the reviewing psychiatrist's conclusion that there simply was not enough medical evidence for him to provide an opinion about whether Harrison was disabled by her psychiatric status. As the fiduciary decisionmaker, Wells Fargo had an obligation to seek to obtain this needed medical evidence and its failure to do so under the circumstances of this case was an abuse of discretion.

2. Wells Fargo also violated the Secretary's claims regulation and its own Plan terms by failing to specifically inform Harrison in its written denials that she should submit evidence from her treating psychiatrist. This deficiency separately supports a conclusion that Wells Fargo abused its discretion in denying Harrison's claim for benefits.

ARGUMENT

A CLAIMS ADMINISTRATOR ABUSES ITS DISCRETION IF ITS BENEFITS DENIAL IS NOT BASED ON A FULL AND FAIR REVIEW OF ALL RELEVANT FACTS AND CIRCUMSTANCES

A. Wells Fargo, as the fiduciary decisionmaker in this case, abused its discretion by failing to obtain and consider readily-available information necessary to decide Harrison's benefit claim

The Fourth Circuit has not squarely addressed the question of whether a claims administrator, as a fiduciary to the plan and its participants, has a duty to seek necessary and readily-available additional information in deciding a claim for plan benefit. In the Secretary's view, ERISA's "full and fair" review provision, 29 U.S.C § 1133, which rejects an adversarial approach in claims processing and instead requires both adequate notice of the basis for a denial and a meaningful dialogue between claimant and claims administrator, in tandem with ERISA's fiduciary prudence and loyalty provisions, see 29 U.S.C. § 1104, require a claims administrator to investigate and seek to obtain readily-available information necessary to decide a benefit claim. A fiduciary decisionmaker who fails to do so abuses its discretion in denying benefits. For this reason, we urge the Fourth Circuit to follow the lead of the Tenth Circuit, which has correctly held that a claims administrator cannot ignore readily-available information that could confirm a participant's entitlement to benefits under an ERISA plan.

In the Tenth Circuit case, an employee of Monsanto, Donald B. Gaither, needed to take a significant amount of narcotics in order to control the bone pain caused by his multiple myeloma. Gaither, 394 F.3d at 794-95. Gaither filed a claim for disability benefits after he "was suspended from employment because his employer determined that his medical condition – his use of narcotic painkillers – made him unable to perform his job." Id. at 794. "At the same time, his employer's ERISA plan administrator [Aetna] denied him disability benefits because his medical condition did not render him unable to perform his job." Id. When the administrator defended "on the essential ground that it did not know, and was under no obligation to find out, why Gaither lost his job," the Tenth Circuit balked and reversed the district court's decision affirming the denial. The court acknowledged language in the relevant plan stating "that the claimant has a duty to provide relevant evidence." Id. at 804. But, relying on other plan language that both granted Aetna discretion to determine the type of evidence needed to evaluate a claim's validity and required the participant to cooperate with any request for information, the court pointed out that "[b]oth in theory and practice, the Plan gave Aetna considerable discretion to gather evidence as needed, and allowed Aetna to request both medical and nonmedical information about the case from Monsanto." Id. at 806. Because of this, and because "the signs in the record were sufficient to alert Aetna to the possibility of a narcotics relapse," the court rejected Aetna's

contention "that the obligation to gather evidence in support of his claim is Mr. Gaither's alone," and instead agreed with Gaither that "Aetna acted arbitrarily and capriciously by denying his claim without obtaining more information first." Id. at 804.

In reaching this conclusion, the Tenth Circuit correctly relied on indications in ERISA's claims procedure provision and its accompanying regulation (which, as in this case, was adopted in the language of the plan itself) that claims processing is meant to be collaborative, not adversarial. See Gaither, 394 F.3d at 807. Thus, the court cited earlier Tenth Circuit precedent, which correctly recognized that because the claims regulation "'calls for [] a meaningful dialogue between ERISA plan administrators and their beneficiaries . . . if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it.'" Id. (citing Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 635 (10th Cir. 2003), quoting Booton v. Lockheed Med. Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997)). Moreover, the court reasoned that although "a fiduciary has a duty to protect a plan's assets against spurious claims; it also has a duty to see that those entitled to benefits receive them." 394 F.3d at 807-08. Indeed, to comply with its statutory duties, a fiduciary deciding a claim "must consider the interests of deserving beneficiaries as it would its own," when "presented with a claim that a

little more evidence may prove valid [the fiduciary] should seek to get to the truth of the matter." Id. at 808.

Moreover, Gaither correctly distinguished earlier decisions from the Tenth Circuit that had held that "'[i]f a plan participant fails to bring evidence to the attention of the administrator, the participant cannot complain of the administrator's failure to consider this evidence.'" 394 F.3d at 804 (quoting Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 381 (10th Cir. 1992) and citing Nance v. Sun Life Assur. Co., 294 F.3d 1263, 1269 (10th Cir. 1996)). The court reasoned that those cases merely stood for the general principle that "nothing in ERISA requires plan administrators to go fishing for evidence favorable to a claim when it has not been brought to their attention that such evidence exists." Gaither, 394 F.3d at 804. Nor did the court see any conflict with the Fifth Circuit's en banc decision in Vega v. Nat'l Life Ins. Servs., Inc., 188 F.3d 287, 298 (5th Cir. 1999), which refused to place "the burden solely on the administrator to generate evidence relevant to deciding the claim," or with the Fourth Circuit's decision in LeFebre v. Westinghouse Elec. Corp., 747 F.2d 197, 208 (4th Cir. 1984), which held that plan fiduciaries had "no duty" to seek out "a doctor whose testimony might contradict the medical reports from reliable physicians that had been submitted." None of those decisions stood as an impediment to the "narrow principle" that that court announced: "that fiduciaries cannot shut their eyes to

readily available information when the evidence in the record suggests that the information might confirm the beneficiary's theory of entitlement and when they have little or no evidence in the record to refute that theory." Gaither, 394 F.3d at 807.[2] Furthermore, as the Tenth Circuit correctly recognized, id., this kind of limited duty is supported by decisions of other courts of appeals. See, e.g., Booton, 110 F.3d at 1463-64 (finding denial of benefits arbitrary and capricious where "lacking necessary – and easily obtainable – evidence, Aetna made its decision blindfolded") (citing Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 538 (9th Cir. 1990) (burden is on plan to obtain adequate information to make decision) ; Quinn v. Blue Cross & Blue Shield Ass'n, 161 F.3d 472, 476 (7th Cir. 1998) (decision arbitrary and capricious where administrator in denying disability claim failed to make "reasonable inquiry" about the claimant's skills and ability to work), abrogated in part on other grounds by Hardt v. Reliance Standard Life Ins. Co., 560 U.S. 242, 251-52 (2010).[3]

Gaither supports the same conclusion in this case. As in Gaither, the plan terms charging claimants with the burden to provide evidence supporting their

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[2] The other two Fourth Circuit decisions cited by the district court – Elliott and Berry – are distinguishable on the same basis.

[3] The court also cited the Eighth Circuit's decision in Woo v. Deluxe Corp., 144 F.3d 1157, 1161 (8th Cir. 1998). We believe, however, that this case stands for the somewhat different proposition that, in doing a medical review of a claim involving an "uncommon disease," an administrator should employ a doctor with the relevant medical expertise rather than a general practitioner.

claims is countered by plan language that "in both theory and practice" allowed Liberty to contact the claimant's physicians to obtain medical information, provided that a release from the claimant was obtained, as happened in this case.[4] While the claims regulation does not expressly require a claims administrator to seek to obtain necessary medical evidence, such a requirement is certainly consistent with the general principles animating the regulation, which contemplates a collaborative process, and with section 503, which broadly requires "full and fair review" of any benefit denial. 29 U.S.C. § 1103. Even more importantly, placing an obligation on the fiduciaries deciding the claims to obtain such known and easily-available evidence where, as here, the record is lacking, is most consistent with ERISA's fiduciary duty provisions, which provide that fiduciaries must act with the utmost care and in the undivided interests of the plan participants and beneficiaries, 29 U.S.C. § 1104(a)(1)(A), (B). See also 29 C.F.R. § 2560.503-1(h)(1) (decision on appeal of adverse benefit determination must be decided by a

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[4] The Plan stresses that the claimant must complete and sign a medical release form and further states that "to expedite processing of your claim, Liberty may need to contact your physician to obtain medical information concerning your disability." Thus, far from suggesting that only claimants have an obligation to supply supporting medical information, the Plan seems to place the initial onus on Liberty to request needed medical information either from the doctors directly or from the claimant who then has the "responsibility to see that Liberty receives requested medical proof." JA 480.

named fiduciary); Metropolitan Life Ins. Co. v. Glenn, 554 U.S. 105, 111 (2008) (benefit determination is a fiduciary act).

The conduct of both Liberty and Wells Fargo during the claim process, however, was anything but collaborative. As early as October 2011, Liberty and by extension Wells Fargo were aware that Dr. Glenn was treating Harrison for her psychological disorders. Despite this knowledge, when Wells Fargo requested a general psychiatry peer review from Dr. Daniel in March of 2012, it provided the contact information for Dr. Petrizzi, but omitted contact information for Dr. Glenn. JA 42. Nor did Dr. Daniel himself seek to contact Dr. Glenn after he learned from Dr. Petrizzi that Dr. Glenn was the doctor who could provide the relevant information about Harrison's psychiatric status. Moreover, both Liberty and Wells Fargo knew that the materials they had, absent input from Dr. Glenn, were inadequate for them to make a proper determination whether Harrison's medical impairments precluded her from performing the essential parts of her job. In fact, Dr. Daniel's report expressly pointed out the deficiency in the record, stating that he could not make a proper assessment of Harrison's mental functionality without the benefit of input from Dr. Glenn. JA 391-393 (noting that that he "could not provide an opinion as to whether Harrison's psychiatric status limited her functional capacity without records or consultation with" her treating psychiatrist). Given these circumstances, the district court erred in concluding that Wells Fargo

had no duty to seek this information.[5] This case presents the Fourth Circuit with the opportunity to join the Tenth Circuit in recognizing the duty of Wells Fargo as the fiduciary decisionmaker to seek to obtain and consider this readily-available evidence necessary to deciding a claim for benefits, and to hold that its failure to do so constituted an abuse of discretion.

B. Wells Fargo violated the claims regulation, and thereby failed to provide Harrison with a full and fair review

Wells Fargo's abuse of discretion in failing to obtain medical information from Dr. Glenn was compounded by its failure to inform Harrison in its written denials that she needed to submit critical evidence from Dr. Glenn. For this reason, the denials in this case did not comply with the Secretary's claims regulation, which requires that adverse benefit determinations inform the claimant of the specific reasons for the denial, in a manner calculated to be understood by the claimant, including by specifying what additional evidence is necessary to perfect the claim. 29 C.F.R. § 2560.503-1(b)(1), (g)(1)(iii).[6] The denials in this

[5] The district court was also incorrect in viewing this as an impermissible estoppel argument. While Wells Fargo's failure to contact Dr. Glenn after being given his contact information is particularly troubling, this is evidence that Wells Fargo abused its discretion in failing to obtain critical information, not an argument that the reviewing doctor or Wells Fargo was estopped in some way.

[6] The regulation provides, in pertinent part:

> (b) *Obligation to establish and maintain reasonable claims procedures.* Every employee benefit plan shall establish and maintain reasonable

case did not satisfy this requirement because they never specifically informed Harrison that she needed to provide medical records from Dr. Glenn, her treating psychiatrist. JA 284-286; 340-342; and 391-392. For the same reason, the denials also violated the Plan itself, which similarly requires that if the claim is denied because Liberty did not receive sufficient information, the claims decision must describe the additional information needed and explain why such information is needed. See Booth, 201 F.3d at 342 (requiring consideration of whether the decision was consistent with the procedural and substantive requirements of ERISA).

This failure to inform Harrison that she needed to submit supporting medical evidence from Dr. Glenn was particularly glaring given Wells Fargo's reliance on the lack of objective medical evidence documenting the extent of Harrison's

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> procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations . . . . The claims procedures for a plan will be deemed reasonable only if –
> (1) The claims procedures comply with the requirements of [the following] paragraphs . . . of this section . . . .
>
> (g) *Manner and content of notification of benefit determination.* (1) . . . the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. . . . The notification shall set forth, in a manner calculated to be understood by the claimant -- . . .
> (iii) **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**

29 C.F.R. § 2560.503-1 (b)(1), (g)(1)(iii) (emphasis added).

psychological difficulties and its failure to obtain the information itself, despite its ability to do so. Moreover, given this lack of detail in Wells Fargo's written communication with her, as well as the fact that she signed a medical release form early on, which Liberty and Wells Fargo used to obtain records and opinions from some of her other doctors, Harrison could have justifiably believed that Liberty and Wells Fargo had obtained and considered Dr. Glenn's medical information in making their determinations. See Harden v. Am. Ex., 384 F.3d 498 (8th Cir. 2004) (where plan claimant signed required authorization and release of medical records, it is more than reasonable for claimant to believe that plan administrator had obtained the available records and that they were part of the documentation that had been specifically reviewed, although not specifically listed). It bears noting that Harrison – who was pro se and undergoing and recovering from multiple surgeries while trying to come to grips with the unexpected death of her husband – did not request a copy of the administrative record until after she retained counsel in December, 2012.

The Fourth Circuit requires claims "administrators' decisions to adhere both to the text of ERISA and the plan to which they have contracted; to rest on sound evidence and sound reasoning; and to result from a fair and searching process." Evans v. Eaton Corp., 514 F.3d 315, 322-23 (4th Cir. 2008). The decision in this

case does not. The deficiencies described above render the denials in this case unreasonable under an abuse of discretion standard.

CONCLUSION

For the above reasons, the Secretary requests that this Court reverse the district court's decision and remand for that court either to reinstate Harrison's short-term disability benefits based on her ability to perform her job during the relevant period, or, at a minimum, send the case back to Wells Fargo for "full and fair review."

Dated: March 31, 2014

Respectfully submitted,

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

No. 13-2379 **Caption:** Nancy A. Harrison v. Wells Fargo, N.A., et al.,

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(s) Gail A. Perry

Attorney for U.S. Department of Labor

Dated: March 31, 2014

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I certify that on March 31, 2014 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

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