

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA**

ARLENE C. ALFORD,)	
)	
Plaintiff,)	
)	
v.)	1:05CV207
)	
)	
METROPOLITAN LIFE INSURANCE)	
COMPANY,)	
)	
Defendant .)	

RECOMMENDATION OF UNITED STATES MAGISTRATE JUDGE

This case arises from a dispute between Arlene C. Alford (“Plaintiff” or “Ms. Alford”) and Defendant Metropolitan Life Insurance Company (“MetLife”) concerning the denial of long-term disability benefits for Ms. Alford. This matter is presently before the court on the following motions: Plaintiff’s Motion for Summary Judgment [Docket No. 13]; Plaintiff’s Motion for Pre-Judgment Interest, Attorneys’ Fees and Costs [Docket No. 15]; and Defendant’s Motion for Summary Judgment [Docket No. 21]. Because the parties have not consented to the jurisdiction of a magistrate judge, the court must deal with the dispositive motions for summary judgment by way of recommended disposition.

For the reasons set forth below, it will be recommended that Plaintiff’s Motion for Summary Judgment be granted, that Defendant’s Motion for Summary Judgment be denied, and that Plaintiff’s Motion for Pre-Judgment Interest, Attorneys’ Fees and

Costs be granted as to Pre-Judgment Interest and Costs but denied as to Attorneys' Fees.

I. FACTS

Ms. Alford began her employment with Bank of America on August 31, 1998, and worked there in administrative positions until her last day of work on January 20, 2004. In her last position as a Research and Adjustments Representative II, her salary was \$2,143.33 per month. Ms. Alford's job responsibilities required her to work at a computer station most of the day, researching accounts for mortgage and vehicle release of lien requests. To perform her job, Ms. Alford sat for 7-8 hours a day, and she was required to have repetitive use and fine finger dexterity of her right hand for 7-8 hours daily. She also was required to stand, walk, bend over, twist, and reach above shoulder level 1-2 hours daily.

During her employment, Ms. Alford was covered under the Bank of America Long-Term Disability Plan ("the Plan"), an employee benefit plan that provides certain benefits in the event of long-term disability. MetLife insures the Plan and has discretionary authority to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. (Pl. Sum. J. Br., Ex. 2 at 13). Disability is defined under the Plan as follows:

"Disability" or **"Disabled"** means that, due to an Injury or Sickness, you require the Appropriate Care and Treatment of a Doctor unless, in the opinion of a Doctor, future or continued treatment would be of no benefit and:

1. you are unable to perform each of the material duties of your own occupation; and
2. after the first 24 months of benefit payments, you must also be unable to perform each of the material duties of any gainful work or service for which you are reasonably qualified taking into consideration your training, education, experience and past earnings; or
3. you, while unable to perform all of the material duties of your own occupation on a full-time basis, are:
 - a. performing at least one of the material duties of your own occupation or any other gainful work or service on a part-time or full-time basis; and
 - b. earning currently at least less than 40% less per month than your Indexed Basic Monthly Earnings due to that same Injury or Sickness.

(Ex. 2 at 6). The Plan also provides a 180-day elimination period, meaning long term disability benefits cannot be paid until a claimant has had 180 consecutive days of disability. Ms. Alford, as a new claimant, contends that she is disabled under the first definition set forth in the Plan, *i.e.*, that she is unable to perform the material duties of her regular job.

On January 9, 2004, Plaintiff was examined by Dr. Thomas Spangler, an orthopedic surgeon, for back pain. Dr. Spangler diagnosed lumbar degenerative disc disease and facet arthritis, and he administered lidocaine injections. He also prescribed narcotic pain medication. (R. at 91).¹ On January 20, 2004, Plaintiff was

¹ The administrative record is attached to Plaintiff's motion for summary judgment as Exhibit 1. The record is referred to in this Recommendation as "R. at _."

examined by Dr. James Spencer, her primary care physician, whose notes indicate that Plaintiff complained of 13 days of back pain that began when she turned during a bone density test, that the shots Dr. Spangler had administered had brought only temporary relief, and that the pain medication was not working. Dr. Spencer recommended that Ms. Alford remain out of work until January 26, 2004. (R. at 86). On March 3, 2004, Plaintiff was examined by a neurosurgeon, Dr. Thomas A. Sweasey, for multiple joint complaints, which she blamed on fibromyalgia, and increased back pain. Dr. Sweasey ruled out surgery as an option and recommended that Plaintiff see a rheumatologist. (R. at 67).

Plaintiff remained out of work and applied for short-term disability benefits on February 11, 2004. Her application included a "Certification of Health Care Provider" form signed by Dr. Spencer on February 13, 2004. Dr. Spencer stated that Plaintiff had "degenerative disc disease of the cervical and lumbrosacral spine, with exacerbation of low back pain on 1/7/04. Severely decreased ability to bend, move, sit as of 1/20/04." (R. at 21). An MRI exam performed on January 29, 2004, showed a degenerated disc at T11 - T12 with a slight disc bulge, mild degeneration and a slight disc bulge at L4 - L5 and a degenerated disc and signs of previous surgery at L5 - S1. Dr. Spencer opined that Plaintiff's prognosis was "fair, can last days to months, and nearly always recurs (unpredictably)," and he recommended that Plaintiff remain out of work for a total of two months. He also recommended that she be seen by a neurosurgeon for possible epidural steroid injections. (R. at 19-21).

Plaintiff's application for short term disability benefits was approved and she received the benefits for a total of six months, the maximum period allowed.

On March 24, 2004, Plaintiff was examined by Dr. Spencer. Plaintiff reported to Dr. Spencer that she had continued back pain with occasional weakness in her right leg, that it hurt her to bend or move and that she was feeling tired. Dr. Spencer noted that Dr. Sweasey had ruled out surgery and recommended that she be seen by a rheumatologist. Dr. Spencer diagnosed chronic back pain, fatigue and hyperlipidemia.² (R. at 85).

On April 8, 2004, Plaintiff was examined by Dr. Elliot Semble, a rheumatologist. Dr. Semble noted that Plaintiff "has had diffuse musculoskeletal pain for several years," with a recent exacerbation of symptoms. Dr. Semble reviewed Dr. Spencer's office notes and performed his own physical examination of Plaintiff. In his examination of Plaintiff's bones and joints, Dr. Semble noted "Tender points ... in a typical fibrositis distribution. Inspection and palpation of joints reveals limited motion of her right shoulder and neck. Gait and station are within normal limits. Low back reveals decreased anterior flexion." Dr. Semble's diagnostic impression was fibromyalgia. (R. at 99).

² Hyperlipidemia (also spelled as Hyperlipidaemia) is a general term for elevated concentrations of any or all of the lipids in the plasma, such as cholesterol, triglycerides and lipoproteins. See On-line Medical Dictionary at <http://cancerweb.ncl.ac.uk/cgi-bin/omd?hyperlipidemia> (last visited March 1, 2007).

On April 23, 2004, Plaintiff was again examined by Dr. Sweasey, who noted that Plaintiff continued to complain of neck and back pain and reported difficulty using her right arm at times. Dr. Sweasey also noted that Plaintiff had normal strength and gait, and he stated that he had nothing to offer her from a surgical standpoint. He recommended a “fairly aggressive rehabilitation program.” (R. at 68).

On May 6, 2004, Plaintiff was again seen by Dr. Semble. Plaintiff reported a “flare in her illness with increased musculoskeletal pain along with muscle tenderness and morning stiffness, which lasts about 30 minutes in duration.” Dr. Semble noted “tender points in a typical fibrositis distribution” but no signs of inflammation, and functional range of motion. He noted his diagnostic impression of fibromyalgia, increased her pain medication and added Ambien to her drug regimen. (R. at 106). Dr. Semble also completed an Attending Physician Form, indicating a diagnosis of “729.1 Fibromyalgia.” He reported subjective symptoms of pain, fatigue and non-restful sleep and listed “tender points” as objective findings. (R. at 107).

Ms. Alford submitted her claim for long term disability benefits on May 11, 2004. With her claim form, Ms. Alford included an Activities of Daily Living report in which she wrote that she had “severe back pain due to bulging disc, fibromyalgia - all over muscle pain - unable to sit, walk, bend or stand for more than 10-15 minutes at a time. [U]nable to concentrate - depression.” (R. at 34). Ms. Alford also

submitted Dr. Semble's Attending Physician's Statement dated May 6, 2004, listing a primary diagnosis of fibromyalgia, with subjective symptoms of "pain, fatigue" with objective findings of "tender points." Dr. Semble indicated that Plaintiff was taking pain medication for her condition. He also noted that Plaintiff's psychological functioning was severely limited: "Class 5 - significant loss of psychological, physiological, personal and social adjustment." Dr. Semble's evaluation indicated that Plaintiff could sit/stand/walk 0-1 hours intermittently; could not climb/twist/bend/stoop or reach above shoulder level; could occasionally lift up to 10 pounds; and had no ability to perform fine finger movement, eye/hand movements and pushing/pulling. Dr. Semble stated that Plaintiff was unable to work "due to pain, fatigue." (R. at 24-25).

On May 19, 2004, Plaintiff was examined by Dr. Spangler for "Recheck of back following 1/9/04 treatment." Dr. Spangler's notes indicate that Plaintiff reported that her back continued to hurt but "patient really hurts all over with her fibromyalgia." His physical examination showed:

Patient is tender diffusely, but especially over the right shoulder and subacromial area above and below the clavicle, over the plexus and down the arm. There is very poor right shoulder posture. The lower back is very tender; extension and flexion both are painful. Patient is tender over both buttocks. Wright's hyper abduction test is positive on the right.

Dr. Spangler's diagnostic impression was:

Right shoulder bursitis and impingement. Patient has increased neurologic symptoms in the right arm related to TOS compression with

poor shoulder posture. Patient has chronic back pain with DDD and fibromyalgia. I would be hesitant to recommend any type of fusion given her severe limitation related to fibromyalgia.

Dr. Spangler administered injections of pain medication and changed Plaintiff's medication regimen. (R. at 91).

On May 25, 2004, MetLife notified Plaintiff that her claim had been denied for failure to provide "office visit notes and objective test results from your date last worked through the present from your attending physician(s)." (R. at 89-90). The denial letter said that the claim would be evaluated once those records were received. *Id.*

On June 10, 2004 Plaintiff was again examined by Dr. Semble, the rheumatologist. He noted "tender points ... in a typical fibrositis distribution," and again indicated a diagnosis of fibromyalgia. Dr. Semble also stated that he discussed Plaintiff's medications with her at length, noting that she was currently taking four different medications. (R. at 107).

On June 21, 2004, Plaintiff was informed by telephone that her claim had been denied for failure to submit any medical evidence to support her claim of disability. (R. at 135). On June 25, 2004, Plaintiff submitted medical records to MetLife, and included in these records were office notes from Dr. Spangler from May 8, 1996, through January 9, 2004. On June 30, 2004, MetLife requested Dr. Semble's records of treatment from January 20, 2004, to the present and any objective test results to support Plaintiff's claim. (R. at 103-04).

On July 6, 2004, MetLife sent Plaintiff a letter stating that her claim had been reviewed by a nurse who determined that Plaintiff had failed to submit convincing proof of disability. The denial letter summarized the medical evidence submitted by Plaintiff but concluded that, although her treating physician had diagnosed fibromyalgia, there was no documentation to support Plaintiff's restrictions and limitations. MetLife advised Plaintiff that the claim would "remain in declined status" but would be re-evaluated upon receipt of Dr. Semble's records. (R. at 95-98). Dr. Semble faxed treatment records to MetLife on August 3, 2004. (R. at 99-105).

On August 6, 2004, MetLife sent Plaintiff a letter stating that it had reviewed Dr. Semble's notes but that those notes did not impact the decision to deny the claim. The letter concluded that:

The records we have on file indicate that you have had multiple complaints of pain since you[r] last date at work, and that you were seeing several specialists. Lab work was drawn on May 26, 2004. The lab results were within normal limits, aside from elevated cholesterol. A repeat lumbar MRI does not indicate any change from your previous MRI. The most recent medical records indicate that you are independent in all of your activities of daily living. You were encouraged to engage in physical activities. Your physical and mental examinations were within normal limits. The records indicate that you have tender point[s] consistent with fibromyalgia, and that you are relatively stable.

The medical information does not support a musculoskeletal impairment of such a severity as to preclude you from performing your own occupation as a Research and Adjustments Representative II for Bank of America. For this reason, you remain in declined status. A Disability Appeal Request Form has been provided should you choose to appeal this decision.

(R. at 111-12).

On August 20, 2004, Plaintiff appealed the denial decision. (R. at 113-18). The internal records of MetLife show that on September 9, 2004, a second nurse consultant reviewed Plaintiff's medical file and concluded that "the medical documentation does not provide functional impairments of the severity that would preclude [Plaintiff] from performing a sedentary job on a sustained basis from 1/20/04 through 7/19/04." The nurse consultant noted that none of Plaintiff's four physicians ever noted she appeared fatigued, tired or sluggish; or that she had difficulty sitting, bending, moving or lifting. The nurse consultant observed that Plaintiff's orthopedic doctor and neurologist did not comment on any conditions disabling her from work; that her primary care physician gave her an estimated return to work date of March 20, 2004; and that her rheumatologist, though opining that Plaintiff was unable to work, did not "provide the picture of a person disabled from a sedentary job." (R. 144-45).

On September 30, 2004, MetLife sent Plaintiff a final denial letter, upholding the original decision to deny her claim for long-term disability benefits. The letter concluded: "Although you have subjective complaints of pain and fatigue, after a careful review we have determined that the medical information on file does not support a level of severity in your conditions that would prevent you from doing your job for any employer longer than the 180 day elimination period in your plan." Further, Ms. Alford was informed that she had exhausted her administrative remedies under the Plan and that no further appeals would be considered. (R. at

126-30). On October 5, 2004, pursuant to a request by Plaintiff, MetLife sent Plaintiff a copy of its claim file. In the transmittal letter, MetLife stated that Plaintiff's claim was reviewed by two nurse consultants. (R. at 131).

Ms. Alford initiated this judicial action on March 8, 2005, asserting a right to long-term disability benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"). See 28 U.S.C. §1132(a)(1)(B). She filed a Motion for Summary Judgment and a Motion for Pre-Judgment Interest, Attorney's Fees and Costs on January 9, 2006. Defendant filed a Motion for Summary Judgment on January 30, 2006. Briefing has been completed and these motions are ready for a ruling.³

II. DISCUSSION

A. Motions for Summary Judgment

Summary judgment is proper only when "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." FED. R. CIV. P. 56(c). A party seeking summary judgment "bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of the [record] which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). Once the moving party has met its burden, the non-moving party must then "set forth

³ With apologies to all, I acknowledge that this case has lain dormant in the clerk's office for much too long. Unfortunately, while they are infrequent, administrative oversights do occur, and in this instance, although these motions were filed in early 2006, they were not referred to me until February 16, 2007.

specific facts showing that there is a genuine issue for trial.” *Matsushita Elec. Indus. Co. Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87 (1986) (quoting FED. R. CIV. P. 56(e)).

In making a determination on a summary judgment motion, the court must view the evidence in the light most favorable to the non-moving party, according that party the benefit of all reasonable inferences. *Bailey v. Blue Cross & Blue Shield of Va.*, 67 F.3d 53, 56 (4th Cir. 1995). Mere allegations and denials, however, are insufficient to establish a genuine issue of material fact. See *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Judges are not “required to submit a question to a jury merely because some evidence has been introduced by the party having the burden of proof, unless the evidence be of such a character that it would warrant the jury in finding a verdict in favor of that party.” *Id.* at 251 (internal quotations and citations omitted). Thus, the moving party can bear its burden either by presenting affirmative evidence or by demonstrating that the non-moving party’s evidence is insufficient to establish its claim. *Celotex*, 477 U.S. at 331 (Brennan, J., dissenting). “[A] complete failure of proof concerning an essential element of [a plaintiff’s] case necessarily renders all other facts immaterial.” *Celotex*, 477 U.S. at 323.

The applicable standard of review of the denial of benefits under an ERISA plan is well-settled. Where a plan administrator is granted discretionary authority to determine benefit eligibility or construe the terms of the plan, the denial of benefits

must be reviewed for abuse of discretion. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114-15 (1989); *Ellis v. Metropolitan Life Ins. Co.*, 126 F.3d 228, 232 (4th Cir. 1997). Under this deferential standard, an administrator's decision will not be disturbed as long as it is reasonable, even if this court would have come to a different independent conclusion. *Ellis*, 126 F.3d at 232. "Such a decision is reasonable if it is 'the result of a deliberate, principled reasoning process and if it is supported by substantial evidence.'" *Id.* (quoting *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 788 (4th Cir. 1995)). The Plan at issue here states that benefits will be paid if the proof of disability is "satisfactory" to MetLife. (Pl. Sum. J. Br., Ex. 2 at 171). The "Bank of America Associate Handbook 2002", moreover, provides that "[t]he existence of a disability is determined by the insurance company, based on medical evidence acceptable to it." (*Id.*, Ex. 3 at 200). While the Fourth Circuit has not definitively interpreted whether "satisfactory proof" language grants discretion to the plan administrator, several unpublished, per curiam opinions indicate that such language does confer discretion. See, e.g., *O'Bryhim v. Reliance Standard Life Ins. Co.*, No. 98-1472, 1999 WL 617891 at *5, n.7 (4th Cir. August 16, 1999) (unpublished). Because the Plan at issue clearly vests MetLife with discretionary authority to both interpret the terms of the Plan and determine benefit eligibility, the abuse of discretion standard is appropriate in this case.

The Court of Appeals for the Fourth Circuit has set out a number of factors that courts may consider when determining the reasonableness of a benefits

decision: (1) the language of the plan; (2) the purposes and goals of the plan; (3) the adequacy of the materials considered to make the decision and the degree to which they support it; (4) whether the fiduciary's interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan; (5) whether the decisionmaking process was reasoned and principled; (6) whether the decision was consistent with the procedural and substantive requirements of ERISA; (7) any external standard relevant to the exercise of discretion; and (8) the fiduciary's motives and any conflict of interest it may have. *Booth v. Wal-Mart Stores, Inc. Assocs. Health and Welfare Plan*, 201 F.3d 335, 342-43 (4th Cir. 2000).⁴

“A fiduciary’s conflict of interest, in addition to serving as a factor in the reasonableness inquiry, may operate to reduce the deference given to a discretionary decision of that fiduciary.” *Id.* at 343 n.2. Where a conflict of interest is established, the deference afforded the fiduciary’s decision “will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict.” *Ellis*, 126 F.3d at 233. “The more incentive for the administrator or fiduciary to benefit itself by a certain interpretation of benefit eligibility or other plan terms, the

⁴ I confess that this listing of factors is not much help. Rather, I find more beneficial a recent statement by a panel of the court to the effect that reasonableness is an open-ended inquiry that may consider the eight *Booth* factors, “*in addition to other relevant issues.*” *Donnell v. Met. Life Ins. Co.*, 165 Fed. Appx. 288, 295 n.6 (emphasis added) (citing *Stup v. Unum Life Ins. Co. of America*, 390 F.3d 301, 307 (4th Cir. 2004)). The panel reconciled the two standards simply viewing the *Booth* factors “as more particularized statements of the elements that constitute a ‘deliberate, principled reasoning process’ and ‘substantial evidence’ and of the reasons for applying a modified abuse of discretion standard of review.

more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it." *Id*; see *Stup v. Unum Life Ins. Co. of America*, 390 F.3d 301, 307 (4th Cir. 2004) (applying a sliding -scale abuse of discretion review in conflict of interest cases; a court must apply less deference "to the degree necessary to neutralize any untoward influence resulting from the conflict").

B. Analysis

In the present case, Plaintiff argues that the termination of her long-term disability benefits was unreasonable and constituted an abuse of discretion because MetLife: (1) arbitrarily rejected Plaintiff's evidence, including the statements of two treating physicians, without consulting a physician; (2) discounted considerable subjective evidence of disability⁵ and based its decision on nurse reviews that relied on incomplete and misrepresented medical records; (3) violated ERISA regulations in its review of her claim;⁶ and (4) had a conflict of interest.

⁵ The plain language of the Plan requires that claimants provide "proof of disability, satisfactory to Metropolitan." (Ex. 2 at 171) It does not specifically require "objective" evidence of disability.

⁶ The ERISA regulation that Plaintiff asserts was violated by MetLife in the handling of her claim is that "the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment," 29 C.F.R. § 2560.503-1(h)(3)(iii) (2002). This regulation deals with the notice requirements of the decision on internal review. Plaintiff would have the court decide that MetLife violated this regulation by not consulting a doctor with expertise with fibromyalgia in its review of Plaintiff's claim. In view of this court's disposition of this matter on other grounds, it is unnecessary to the outcome of this case for the court to find a regulatory violation and the court declines to do so.

MetLife clearly has a conflict of interest in this case because it both insures the Plan and has authority to determine eligibility for benefits. While such a conflict of interest necessitates a reduction of deference afforded a benefits decision and requires the decision to be more objectively reasonable and to have stronger evidentiary support, the conflict may be “greatly mitigated” by reliance on independent physicians to conduct claims reviews. See *Ellis*, 126 F.3d at 234. In this case, however, as noted in the recitation of the facts, MetLife relied on two nurse consultants to review Plaintiff’s claim and no independent physician conducted a review. While there is no requirement under the Plan that a physician conduct the claim review, the failure of MetLife to use an independent physician necessarily reduces the degree of deference given to the decision of the plan administrator to deny benefits.

MetLife contends that it acted reasonably in requiring some objective evidence as to the effect of Plaintiff’s condition on her ability to perform sedentary work. This court notes, again, that the terms of the Plan do not specifically require “objective” medical evidence as proof of disability. Moreover, the nature of fibromyalgia is such that neither its presence nor its severity can be verified by purely objective laboratory tests. “Fibromyalgia is a rheumatic disease with . . . symptoms including ‘significant pain and fatigue,’ tenderness, stiffness of joints, and disturbed sleep.” *Stup v. Unum Life Ins. Co. Of America*, 390 F.3d 301, 303 (4th Cir. 2004) (citing Nat’l Institutes of Health, *Questions & Answers About Fibromyalgia* 1 (rev. June 2004),

<http://www.niams.nih.gov/hi/topics/fibromyalgia/Fibromyalgia.pdf>). Fibromyalgia is diagnosed by doctors based on tenderness of at least eleven of eighteen standard trigger points on the body and it can clearly interfere with an individual's ability to carry on daily activities. *Stup*, 390 F.3d at 303. Thus, despite the subjectivity inherent in diagnosing fibromyalgia, which requires patients to self-report their sensations of pain and tenderness, courts have held that claimants were entitled to disability benefits due to impaired functioning resulting from fibromyalgia. See, e.g., *Stup*; *Godfrey v. BellSouth Telecommunications, Inc.*, 89 F.3d 755, 759-60 (11th Cir. 1996); *Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 799-800 (9th Cir. 1997); *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914, 919 (7th Cir. 2003).

Moreover, Plaintiff's medical records contain significant corroborative evidence in the form of tests and clinical observations. As early as 1997, Dr. Spangler noted "multiple tender spots suggestive of fibromyalgia." (R. at 74). Over the course of the next few years, Plaintiff was treated by several different doctors who consistently noted tender spots, pain, and fatigue. While it is true that on occasion one of Plaintiff's doctors noted normal range of motion, or normal gait, the overall picture from the medical records is one of a patient in increasing pain and limited in her activities. Her doctors regularly changed her medications, adding or deleting medicines, to try to alleviate her pain, but the record indicates that these attempts were largely unsuccessful. Nothing in the medical records indicates that Plaintiff is malingering or exaggerating her symptoms and resulting limitations.

Ms. Alford's treating rheumatologist noted the presence of typical fibrositic tender points, as well as her complaints of other fibromyalgia-related symptoms which were noted by her other treating physicians, and thus appears to have had a medically sound basis for his diagnosis and conclusions. Rather than challenge Dr. Semble's findings with its own medical examination, MetLife elected to have two registered nurses simply review Ms. Alford's file. MetLife's nurse consultants countered these assessments primarily by asserting that the severity of Ms. Alford's condition was substantiated only by self-reported symptoms rather than by objective evidence. Nevertheless, the fact that Ms. Alford's physicians could not use a completely objective test to evaluate the severity of her fibromyalgia does not undermine Dr. Semble's considered medical opinion, based on his in-person examinations, that her condition rendered her incapable of performing her occupation. While plan administrators are not required to accord special deference to the opinions of treating physicians, *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 825 (2003), the failure of MetLife to have a physician review the records, or indeed, to have an independent examination of Ms. Alford by nurses or doctors, affords less weight to the opinions of the nurses, since fibromyalgia produces symptoms that must be reported by the patient to the physician and that can be evaluated more fully through an actual examination, rather than by a mere review of a patient's medical record.

An analysis of the record that was before the plan administrator here discloses no objective evidence to dispute the conclusion that Plaintiff suffers from

fibromyalgia. In fact, the second nurse who reviewed the records appears to concede the diagnosis of fibromyalgia.⁷ The question then becomes whether or not the plan administrator abused its discretion in determining that, despite suffering from fibromyalgia, Plaintiff was, nonetheless, capable of maintaining employment. Only if this court can conclude that the decision to deny benefits was reasonable and supported by substantial evidence can summary judgment be granted to the Defendant.

Fibromyalgia cases clearly present difficult factual scenarios for courts reviewing disability claims. In this case, however, it is impossible to ignore the considered opinion of two of Plaintiff's own physicians that she was unable to perform the requirements of sedentary work. In February 2004, Dr. Spencer stated that Plaintiff 's ability to sit, bend and move was severely decreased. Dr. Spencer, while stating that Plaintiff would be able to return to work in March 2004, also noted her prognosis to be "fair, can last days to months, and nearly always recurs (unpredictably)." (R. at 19-21). By March, Plaintiff, her symptoms continuing, had seen a neurosurgeon who ruled out surgery as an option and recommended that she see a rheumatologist. In April 2004, the rheumatologist, Dr. Semble, noted Plaintiff's

⁷ The July 6, 2004, denial letter states that "the most recent examination findings do not indicate multiple tender areas" and that Ms. Alford's claim would be reevaluated once Dr. Semble submitted his records. (R. at 98). These records, as discussed above, noted Dr. Semble's findings of "tender points in a typical fibrositis distribution" and a diagnosis of fibromyalgia. MetLife's final denial letter summarized Dr. Semble's findings and did not include the earlier language questioning the diagnosis of fibromyalgia. In fact, the diary notes of the second consulting nurse state, after a review of Dr. Semble's reports, "EE does have tender points consistent with fibromyalgia and is relatively stable" and "DX code remains fibromyalgia." (R. at 143).

diffuse musculoskeletal pain, morning stiffness, fatigue, non-restful sleep and posterior headaches. In May 2004, Dr. Semble again noted Plaintiff's increased pain and muscle tenderness and found "tender points" in a "typical fibrositis distribution." Dr. Semble stated that Plaintiff was "essentially independent for activities of daily living but severely restricted in physical and social activities due to pain and fatigue." (R. at 106). In his Attending Physician Statement, Dr. Semble noted that Plaintiff could sit, stand and walk less than one hour per day and could work less than one hour per day as a result of pain and fatigue. (R. at 23-25). These limitations clearly are not consistent with the ability to perform even sedentary work.

In addition, the characterization by the consulting nurse that Plaintiff was independent in all her activities of daily living understates the degree of limitation noted both by Plaintiff's doctors and by Plaintiff herself. While Plaintiff states in her Activities of Daily Living Questionnaire that she is capable of taking care of her daily needs, the extent of her limitation is fairly apparent from her answers. She states that she can do housework, but she can only perform one or two household chores a day. Plaintiff states that she cannot stand in lines, cannot walk, cannot travel long distances in the car and that she often requires assistance with grocery shopping or driving. She cannot sit for long periods of time and she is unable to get more than a few hours of sleep a night because she cannot get comfortable. (R. at 43-50). In a telephone interview with one of the nurse consultants, Plaintiff stated that she "does what she can, but [tries] not to overdo it." She also stated that she tries to

swim when she can but has to be careful because of her back problems. Plaintiff also stated that she wants to work and has “tried everything” but “just cannot do this anymore.” (R. at 139). A claimant does not have to be completely immobile or bedridden in order to qualify for disability benefits. See *Hawkins v. First Union Corporation Long-Term Disability Plan*, 326 F.3d 914, 918 (7th Cir. 2003) (stating that the choice of a claimant suffering from fibromyalgia to “push[] himself to engage in a certain amount of painful and fatiguing activity ... does not prove that he is not disabled”).

The record before the court shows a claimant who suffers from fibromyalgia and resulting limitations. When the totality of the record is considered, Ms. Alford’s examining physicians’ opinions are substantially more persuasive than the opinions of MetLife’s in-house nurse consultants, especially in view of the fact that there was no independent examination by a physician. Further, the objective evidence, combined with the subjective evidence which cannot be ignored, supports the treating physicians’ opinions. Based on the foregoing, the court finds that MetLife abused its discretion in denying long-term disability benefits to Ms. Alford.

C. Pre-Judgment Interest, Attorneys’ Fees And Costs

Plaintiff has filed a motion for pre-judgment interest, attorneys’ fees and costs. As set forth below, this court recommends that the motion for pre-judgment interest and costs be granted but that the motion for attorneys’ fees be denied.

1. Pre-Judgment Interest

Ms. Alford also asks this court to award her pre-judgment interest. “The award of pre-judgment interest is discretionary with the trial court.” *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017, 1028 (4th Cir. 1993) (en banc). Defendant argues that an ERISA claimant may recover pre-judgment interest only when the Plan specifically allows such a remedy. This argument is without merit.

Plaintiff brought this action under ERISA Section 502(a)(1)(B),⁸ which provides that “[a] civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan... .” While interest is not explicitly provided for under the Plan here, an award of pre-judgment interest is proper where it is necessary to make a Plaintiff whole. See, e.g., *Moore v. CapitalCare, Inc.*, 461 F.3d 1, 12-13 (D.C.Cir. 2006) (“We believe that a beneficiary’s ‘recover[y] [of] benefits due to him under the terms of his plan’ . . . includes not only the benefits withheld but also their time value. . . . Prejudgment interest, therefore, should be denied only if exceptional circumstances – claimant’s bad faith, dilatoriness or frivolous claim – make the award unfair.”); *Skretvedt v. E.I. DuPont De Nemours*, 372 F.3d 193, 207-08 (3rd Cir. 2004) (“We now make explicit that . . . an ERISA plaintiff who prevails under § 502(a)(1)(B) in seeking an award of benefits may request prejudgment interest under that section as part of his or her benefits award.”); *Ford v. Uniroyal Pension Plan*, 154 F.3d 613, 618 (6th Cir. 1998) (“Awards

⁸ 29 U.S.C. § 1132(a)(1)(B).

of prejudgment interest pursuant to [§502(a)(1)(B)], however, are not punitive, but simply compensate a beneficiary for the lost interest value of money wrongly withheld from him or her.”). This court notes as well, that although *Quesinberry* involved a different ERISA section and thus is not squarely on point, the Fourth Circuit stated in very broad terms that pre-judgment interest is recoverable in ERISA cases: “ERISA does not specifically provide for pre-judgment interest, and absent a statutory mandate the award of pre-judgment interest is discretionary with the trial court.” 987 F. 3d at 1030.

One court has held that prejudgment interest is not available in an ERISA case where the employee plan does not specifically provide for such an award. *Flint v. ABB, Inc.*, 337 F.3d 1326 (11th Cir. 2003). *Flint*, however, is distinguishable from this case (and the other cases cited where prejudgment interest was awarded) because the defendant in *Flint* had voluntarily paid retroactive disability benefits to the plaintiff and the plaintiff brought a separate claim solely to recover interest on the payment. The court in *Flint* held that § 502 (a)(1)(B) would not support an *independent* claim for benefits. Unlike the plaintiff in *Flint*, who had already received his benefits, Plaintiff here is seeking a judgment awarding her benefits. The benefits to which Plaintiff is entitled under this Recommendation are reasonably capable of being ascertained and she has been denied the use of the money to which she was legally entitled in 2004. An award of pre-judgment interest is essential to allow Plaintiff to recover the full value of the benefits awarded her in this litigation, and such an award fully comports with the remedial purposes of ERISA.

The parties also disagree as to what pre-judgment interest rate would apply in this case. Although the federal rate for post-judgment interest is set by statute, there is no federal statute establishing pre-judgment interest rates. Plaintiff notes that on the effective date of termination of her disability benefits,⁹ the federal judgment rate was 2.02% but had risen to 4.35% on the date her brief was filed.¹⁰ Some courts have applied the applicable state interest rate in awarding pre-judgment interest. See *Quesinberry*, 987 F.2d at 1031 (applying Virginia rate of interest); *Smith v. American International Life Assurance Co.*, 50 F.3d 956, 958 (11th Cir. 1995) (court looked to Georgia's post-judgment interest rate for guidance in determining pre-judgment interest rate); *Florence Nightingale Nursing Service, Inc. v. Blue Cross/Blue Shield of Alabama*, 41 F.3d 1476, 1484 (11th Cir.1995) (applying higher Alabama statutory rate of interest to be paid by an insurer if a claim has been denied for invalid reasons); *Hansen v. Continental Ins. Co.*, 940 F.2d 971, 984 (5th Cir. 1991) (applying Texas judgment interest rate). As noted by Plaintiff, the legal rate of interest in North Carolina is 8%. N.C. GEN. STAT. §24-1 (2005).

Defendant contends that the court should apply the federal judgment rate of interest, which is "a rate equal to the weekly average 1-year maturity Treasury yield, as published by the Board of Governors of the Federal Reserve System for the calendar week preceding the date of the judgment." 28 U.S.C. § 1961. Adapting this standard to Plaintiff's situation, according to Defendant, one would calculate the

⁹ July 19, 2004

¹⁰ January 9, 2006.

same rate with reference to the date that MetLife wrongfully denied her long term disability benefits, September 30, 2004, or 2.10%.

In *Quesinberry*, the district court applied the Virginia judgment rate in awarding pre-judgment interest. The Fourth Circuit affirmed, leaving the calculation of pre-judgment interest within the discretion of the district court. Plaintiff here has been without the use or benefit of her money for over two and a half years now. During that period, interest rates have fluctuated, but what is inescapable is that an award of pre-judgment interest at 2004 rates would not adequately compensate Plaintiff for the loss of use of the funds to which she was entitled. There is no magic figure which the court must use, but in balancing the equities in the present case, the court finds that the appropriate rate would be the present federal rate of 5.07%. See *Edmonds v. Hughes Aircraft Co.*, No. Civ.A. 1:96-1368-A, 1998 WL 782016, at *2, *3 (E. D. Va. Nov. 6, 1998) (noting that courts may look for guidance to state law and other sources in setting ERISA pre-judgment interests rates; and court may take into account equitable factors to compensate a plaintiff for loss of the use of money over time). Calculation of this amount should run from the date Plaintiff was entitled to begin receiving disability benefits, July 20, 2004, *i.e.*, 180 days after she last worked.

2. Attorneys' Fees

ERISA provides that "the court in its discretion may allow a reasonable attorney's fee" 29 U.S.C. §1132(g). "Thus, ERISA places the determination of

whether attorneys' fees should be awarded in an ERISA action completely within the discretion of the district court." *Quesinberry*, 987 F.2d at 1028. In *Quesinberry*, the court stated that district courts are required to justify an award or denial of attorneys' fees on the basis of five factors:

(1) degree of opposing parties' culpability or bad faith; (2) ability of opposing parties to satisfy an award of attorneys' fees; (3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions.

Id. at 1029 (quoting *Reinking v. Philadelphia Am. Life Ins. Co.*, 910 F.2d 1210, 1217-18 (4th Cir.1990)). This five factor analysis is not a rigid test but rather is intended to provide general guidelines to courts in determining whether to award attorneys' fees. *Id.* No single factor is decisive but together they illustrate the concerns a court should look at it determining whether to award attorneys' fees. *Id.*

Plaintiff contends that all of the factors except the fourth justify an award of attorney's fees and costs. Plaintiff specifically argues that bad faith on the part of MetLife supports an award of attorney's fees. This court disagrees. There is scant evidence in the record that MetLife acted in bad faith by denying Plaintiff's claim. While it is true that this court has found that MetLife's decision was not supported by substantial evidence, that finding does not automatically mean that MetLife's actions amounted to bad faith. Culpability and bad faith require more than mere negligence

or mistake. *Carolina Care Plan Inc. v. McKenzie*, 467 F.3d 383, 390 (4th Cir. 2006). The record clearly shows that MetLife kept Plaintiff apprised of the decision process and afforded her the opportunity to submit medical records during the process. MetLife did not engage in any underhanded activities with regard to Plaintiff's claim, nor did it unreasonably delay the claim process. That being the case, this court cannot find that MetLife acted in bad faith when it denied Plaintiff's claim.

The second *Quesinberry* factor weighs in Plaintiff's favor. Clearly, MetLife, as a large insurance company, has the greater ability to satisfy an award of attorneys' fees. The third and fifth factors, however, do not favor Plaintiff so readily. Plaintiff has not shown that requiring MetLife to pay attorneys fees would have any kind of deterrent effect on its actions in the future. Moreover, just because this court is recommending that Plaintiff be awarded benefits does not automatically result in an award of attorneys' fees. See *Carolina Care Plan*, 467 F.3d at 391 ("[A] court cannot rely solely on an administrator's improper denial of coverage on a single claim to support an award of fees to a claimant."). Under these circumstances, and in view of the absence of bad faith on the part of MetLife, the balance weighs against an award of attorneys' fees in this case.

3. Costs

The award of costs to an ERISA claimant, like an award of attorneys' fees, is within the discretion of the court. 29 U.S.C. § 1132(g) (2006). Plaintiff is entitled to recovery of her costs in this action. The terms "costs" in § 1132 refers to the same

items of “costs” listed in 28 U.S.C. § 1920. See *Emmenegger v. Bull Moose Tube Co.*, 33 F. Supp.2d 1127 (E.D. Mo. 1998). If the district court accepts this Recommendation, therefore, Plaintiff may submit an application to the Clerk of Court for an award reimbursing her for allowable costs under the statute.

III. CONCLUSION

IT IS THEREFORE RECOMMENDED that Plaintiff’s Motion for Summary Judgment [Docket No. 13] be **GRANTED**. Plaintiff should be awarded benefits as provided under the Plan from July 20, 2004. **IT IS FURTHER RECOMMENDED** that Defendant’s Motion for Summary Judgment [Docket No. 21] be **DENIED**, and that Plaintiff’s Motion for Prejudgment Interest, Attorneys’ Fees and Costs [Docket No. 15] be **GRANTED** as to Pre-Judgment Interest and Costs and **DENIED** as to Attorneys’ Fees.



Wallace W. Dixon
UNITED STATES MAGISTRATE JUDGE

Durham, North Carolina

March 5, 2007