UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION
No. 5:03-CV-86-BR(3)

FILED 4-1-04 US DISTRICT COURT, EDNC CLERK

TONY W. DRIVER, Plaintiff,

v.

NORTEL NETWORKS, INC., Defendant.

ORDER

This matter is before the court on the parties' cross-motions for summary judgment and defendant's contemporaneous motions to strike plaintiff's jury demand[1] and to strike the 22 September 2003 affidavit of plaintiff's counsel. Additionally, on 2 March 2004, defendant filed a suggestion of subsequently decided authority. With regard to plaintiff's motion, defendant has responded, plaintiff has not replied, and the time within which to do so has expired. With regard to defendant's motion for summary judgment, plaintiff has responded and defendant has replied. This matter is now ripe for disposition.

I. BACKGROUND

Plaintiff filed this action against defendant seeking an award of long-term disability benefits under a disability insurance policy ("the plan") administered and funded by defendant. Compl. ¶ 1; Answ. ¶ 3. Plaintiff filed his complaint in state court against defendant and the Prudential Insurance Company of America ("Prudential"), and defendant and Prudential removed the action to this court on 31 January 2003. Prudential was subsequently dismissed by stipulation of the parties

[1] "Plaintiff agrees that a jury trial is not warranted under prevailing Fourth Circuit case law. [Defendant]'s motion to strike should be considered as moot as the case should be resolved by the granting of summary judgment to one side or the other." Pl.'s Br. Opp. Def.'s Mot. Summ. J. at 16.

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on 4 April 2003.[2]

Prior to the claimed disability, plaintiff was a full-time employee of defendant as a Senior Specialist Technician and Technical Writer. Compl. ¶ 6. Plaintiff applied for and received short-term disability ("STD") benefits from defendant in February 2001 "due to his back condition." Id. ¶ 11. Plaintiff underwent surgery in June 2001, and on 30 July 2001, plaintiff applied for long-term disability ("LTD") benefits. Id. ¶¶ 11-12. Plaintiff's claim was initially denied on 28 August 2001, and he appealed the determination according to the plan's procedures, receiving a final denial by letter dated 18 November 2002. Id. ¶¶ 13-15. Plaintiff subsequently filed this action.

Evidence in the record indicates as follows. With regard to plaintiff's physical condition, plaintiff first complained of lower back pain to his general practitioner on 25 January 2001. R. at 576.[3] That doctor referred him to a chiropractor, who diagnosed plaintiff with lumbar segmental syndrome, lumbalgia, myalgia/myositis, lumbar neuritis/radiculitis, and lumbar disc degeneration. Id. at 537. In response to a questionnaire from defendant, the chiropractor stated that plaintiff "would benefit from [a functional abilities evaluation] . . . arranged by [defendant.]" Id. at 571. After approximately one month of treatment, the chiropractor recommended that plaintiff see an orthopedist. Id. at 564.

Plaintiff began treatment with the orthopedist, Dr. Nelson, on 20 March 2001, who ordered an MRI. R. at 341. The MRI, performed on 26 March 2001, showed degenerative changes (which

[2] It appears that Prudential "administers the process to obtain long-term disability . . . benefits, including the initial review of claims and the first level of administrative appeal of a benefit denial." Def.'s Br. Supp. Mot. Summ. J. at 2 (citing R. at 6, 11). The parties do not contend that Prudential is a necessary party to resolution of the instant motions.

[3] The administrative record is attached to both parties' motions for summary judgment. The record includes the summary plan description of the plan at issue, and the pages are bates stamped sequentially from 1 to 622. The bates stamp mark includes the letters NOR, which the court found unnecessary to use in referring to pages of the record.

Dr. Nelson diagnosed as severe degenerative disc disease) in the lumbar region of the spine. Id. at 343-45. Dr. Nelson placed plaintiff on a regimen of physical therapy, which was subsequently discontinued, as it resulted in "limited to no gains[.]" Id. at 548, 552. On 27 April 2001, the physical therapist noted plaintiff was "very uncomfortable/pain" in her objective examination of plaintiff. Id. at 553. On 15 May 2001, Dr. Nelson completed a questionnaire from defendant diagnosing plaintiff with "mechanical back pain" and stated that plaintiff's "low back [and] . . . right leg pain" were observed in his physical examination of plaintiff. Id. at 590-91. Dr. Nelson ultimately referred plaintiff to Dr. Bullard, a neurosurgeon. Id. at 342.

Plaintiff began treatment with Dr. Bullard on 24 May 2001. R. at 287. On 6 June 2001, Dr. Bullard noted that plaintiff's "symptoms are very unusual, but could easily fit with th[e] degree of cord compression" observed in a 26 May 2001 MRI of the cervical portion of the spine. Id. at 286. Dr. Bullard recommended surgical treatment, which he performed on 13 June 2001. Id. at 283-85. On 27 September 2001 (after defendant's initial denial of plaintiff's claim), Dr. Bullard stated that plaintiff "describes numbness of the hands and feet, ... only transient episodes of neck discomfort[,]" although he "continues to have significant restrictions from his neck," that plaintiff's "numbness of the hands and feet . . . . are improved with [medication,]" and that plaintiff's "low back and right flank pain . . . are still not clearly delineated in terms of cause[.]"[4] Id. at 259.

Pursuant to a recommendation by Dr. Bullard, plaintiff was also seen by a spine specialist

[4] In this note, Dr. Bullard also describes an episode from the prior week in which plaintiff "was working on his car and bent over to pick up a compressor and had acute onset of right thigh discomfort with radiation into proximal portion of the calf." R. at 259. Dr. Bullard's subsequent note of 18 October 2001 relates an incident in which plaintiff "had trouble grasping the steering wheel while driving his children to school last week." Id. at 265. The importance of these activities is a subject of much dispute between the parties, in terms of whether they indicate a higher level of functional capacity than plaintiff claims he has. Pl.'s Br. Supp. Mot. Summ. J. at 18; Def.'s Br. Supp. Mot. Summ. J. at 17-18. The compressor is also the subject of defendant's motion to strike the affidavit of plaintiff's counsel. These issues will be discussed infra.

on 7 May 2002, who stated that additional surgery was not appropriate and recommended consultation with a pain specialist. R. at 517-19. Plaintiff then went to a pain specialist on 5 July 2002 who noted that plaintiff's degenerative disk disease "is sever[e] for his age" and recommended a regimen of long-acting narcotics for pain. Id. at 440-42.

Specifically with regard to plaintiff's capacity to work, Dr. Nelson's note of 20 March 2001 describes plaintiff's pain as "incapacitating" and states that plaintiff "is unable to work or drive in his car." R. at 341. Although Dr. Nelson's note of 29 March 2001 stated that plaintiff "may return to light duty work[,]"[5] id. at 346, he completed a certification two weeks later on 12 April 2001 indicating that plaintiff could "not return to work as yet[,]" id. at 580. Dr. Nelson's final observation of plaintiff on 15 May 2001 was that plaintiff's "back + leg pain" was "objective data that 'disables' [plaintiff] from his sedentary position and prevents return to work[.]" Id. at 590-91. Dr. Bullard submitted forms to defendant on 13 June and 12 July 2001 stating that plaintiff could not return to work at that time. Dr. Bullard has stated that plaintiff "continues to have significant restrictions from his neck, which I suspect are going to be permanent. I also believe that these will almost certainly limit him from being able to return to full employment at the level for which he has educational credentials." Id. at 259. Dr. Bullard's 31 July 2001 attending physician's statement for plaintiff's LTD application stated that plaintiff's physical symptoms of neck pain, low back pain and numbness meant that he "can not work[,]" that he could perform no work duties "@ present[,]" and

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[5] This note is another subject of much dispute between the parties. The record indicates that plaintiff called a case manager monitoring his medical progress on 13 April 2001 and told her that Dr. Nelson's statement that plaintiff could return to light duty work "was entered in his chart in error[.]" R. at 563. Defendant notes that "Dr. Nelson has never retracted or repudiated the statements in this note[]" and argues that "this stopped the running of the 26-week STD period that is a pre-condition for payment of LTD benefits." Def.'s Br. Supp. Mot. Summ. J. at 4, 10. Plaintiff points out that defendant never stopped paying plaintiff STD benefits, that "[a]n ability to perform 'light duty' does not mean that [plaintiff] was able to perform his job[,]" and that Dr. Nelson's notes dated less than 2 weeks before and exactly 2 weeks after the 29 March 2001 note both indicated that plaintiff could not work. Pl.'s Br. Supp. Mot. Summ. J. at 21-22.

that no changes to plaintiff's job would allow him to return to work. Id. at 313-14.

Defendant reviewed plaintiff's application, and interviewed plaintiff by telephone on 23 August 2001. R. at 394-95. Defendant issued its initial denial of plaintiff's claim by letter dated 28 August 2001. Id. at 239-42. The letter summarized the medical file reviewed by defendant, briefly reviewed plaintiff's job duties ("sit[ting] at computer and condens[ing] 200 to 400 pages of reading material to a 20 to 30 page instructional manual for customers"), and noted that plaintiff had reported that he could not sit for longer than thirty minutes, do "any . . . activity that require[s] repetitive arm motion" and that "walking seems to help elevate [sic] [his] low back pain."[6] Id. The letter concluded that plaintiff's claim was denied because plaintiff did not return to light duty work after Dr. Nelson's 29 March 2001 note, because he recovered from his 13 June 2001 surgery by 7 August 2001,[7] and because the "objective medical evidence" did not support plaintiff's inability to work. Id.

Plaintiff appealed, and defendant denied his appeal on 3 January 2002, again concluding that Dr. Nelson had released plaintiff to return to light duty work on 29 March 2001 and that plaintiff had recovered from his surgery "as of September 2001" and that "the medical documentation in file [sic] does not provide evidence of an impairment which would have prevented [plaintiff] from returning to work in March 2001." Id. at 403-05. Plaintiff appealed a second time, and defendant issued its final denial on 18 November 2002. Id. at 411-15. The denial focused on the fact that plaintiff was not receiving physical therapy, and once again concluded that plaintiff had recovered

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[6] The court is fairly certain that the intended word is "alleviate," as the entire text mentions that plaintiff takes short walks in the evening in order to "elevate" his low back pain.

[7] This conclusion appears to be based on Dr. Bullard's note on the date of surgery estimating that it would take eight weeks for plaintiff to recover from the surgery. R. at 248. The court notes that Dr. Bullard stated that it would take "*approx[imately]* 6-8 weeks" for plaintiff to recover from the surgery. R. at 248 (emphasis added).

from his 13 June 2001 surgery and that it was "reasonable . . . to conclude that [plaintiff] ignored a valid return to work release issued by [Dr. Nelson] on March 29, 2001 since there is no indication of a retroactive 'correction' of that statement by his physician." Id.

II. DISCUSSION

A. Summary Judgment Standard

Summary judgment is appropriate in those cases in which there is no genuine dispute as to a material fact, and in which it appears that the moving party is entitled to judgment as a matter of law. See Fed. R. Civ. P. 56(c); Haavistola v. Community Fire Co. of Rising Sun, Inc., 6 F.3d 211, 214 (4th Cir. 1993). Summary judgment should be granted in those cases "in which it is perfectly clear that no genuine issue of material fact remains unresolved and inquiry into the facts is unnecessary to clarify the application of the law." Haavistola, 6 F.3d at 214. In making this determination, the court draws all permissible inferences from the underlying facts in the light most favorable to the party opposing the motion. See id. "[W]here the record taken as a whole could not lead to a rational trier of fact to find for the non-moving party, disposition by summary judgment is appropriate." Teamsters Joint Council No. 83 v. Centra, Inc., 947 F.2d 115, 119 (4th Cir. 1991).

B. Standard of Review under ERISA

It is undisputed that the plan is governed by ERISA. Pl.'s Br. Supp. Mot. Summ. J. at 1; Def.'s Br. Supp. Mot. Summ. J. at 1. Plaintiff brings a claim for benefits under 29 U.S.C. § 1132(a)(1)(B), which requires the court to review the plan administrator's decision to deny benefits. See Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 341 (4th Cir. 2000). The parties agree that defendant is the plan administrator, and that the terms of the plan give defendant the discretion to determine plaintiff's eligibility for benefits. Pl.'s Br. Supp. Mot. Summ. J. at 15; Def.'s Br. Supp. Mot. Summ. J. at 12.

The parties also agree that defendant both insures and administers the plan; however, defendant does not agree with plaintiff that application of a "modified abuse of discretion" standard of review is appropriate. Pl.'s Br. Supp. Mot. Summ. J. at 15; Def.'s Br. Opp. Pl.'s Mot. Summ. J. at 2-3. Under this standard, the court does "not act as deferentially as would otherwise be appropriate. Rather, [the court] . . . review[s] the merits of the [administrator's decision] . . . to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries." Doe v. Group Hospitalization & Medical Services, 3 F.3d 80, 87 (4th Cir. 1993). "[I]f the court believes the decision both reasonable and correct, it may simply affirm the decision notwithstanding the conflict. Under the sliding scale analysis, the ultimate question . . . is whether the plaintiff received a full and fair review." Conrad v. Continental Cas. Co., 232 F. Supp. 2d 600, 602-03 (E.D.N.C. 2002) (citations omitted).

Defendant cites to two cases from the Second and Seventh Circuit Courts of Appeals for the proposition that "plaintiff has the burden to show (1) that a conflict of interest actually exists, and (2) that the decision maker *was in fact influenced* by the defendant's dual role." Def.'s Br. Opp. Pl.'s Mot. Summ. J. at 3 (emphasis in original). The court finds no such requirement in this circuit, and will follow the Fourth Circuit's enunciation of the modified abuse of discretion approach as set forth in Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 233 (4th Cir. 1997), in which defendant's financial conflict of interest "is just one of several [factors] that a court should consider in determining whether [defendant] has abused the discretion vested in it." See also Booth, 201 F.3d at 342-43 (setting forth eight non-exclusive factors for the district court to evaluate, including any potential conflict of interest).

C. Plaintiff's Claim for Benefits

Under the plan, plaintiff is "Totally Disabled for LTD if a Physician certifies that [he] cannot

work because of an Illness or accidental Injury, and the clinical evidence supports this opinion." R. at 36. The dispute between the parties centers on what the plan means by "clinical evidence" and whether "the clinical evidence" supports plaintiff's claim. See Pl.'s Br. Opp. Def.'s Mot. Summ. J. at 2-5; Def.'s Br. Supp. Mot. Summ. J. at 15. The Fourth Circuit "ha[s] held repeatedly that ambiguous language [in an insurance policy] must be construed against the drafter." Bailey v. Blue Cross & Blue Shield of Va., 67 F.3d 53, 58 (4th Cir. 1995) (applied in the ERISA context in Tester v. Reliance Standard Life Ins. Co., 228 F.3d 372, 375 (4th Cir. 2000)). See also Wheeler v. Dynamic Eng'g Inc., 62 F.3d 634, 638 (4th Cir.1995) (stating that an ERISA plan should be interpreted "under ordinary principles of contract law, enforcing the plan's plain language in its ordinary sense").

The plan does not define the term "clinical evidence." Additionally, the parties have not cited, and the court has not found, any cases defining the term "clinical evidence" in the context of disability. The dictionary defines "clinical" as "involving direct observation of the patient" or "diagnosable by or based on clinical observation[.]" Merriam-Webster Online Dictionary, *available at* http://www.m-w.com/ (last visited 26 March 2004). The dictionary defines "evidence" as (among other things) "an outward sign[,]" "something that furnishes proof[,]" and "one who bears witness." Id. Therefore, the court concludes that the plain, ordinary sense of "clinical evidence" could certainly include plaintiff's description of his symptoms to his doctors (and his outward signs of discomfort), who were able to diagnose his pain through their direct observations of plaintiff in the course of treatment. See, e.g., R. at 440-42 (pain specialist noted that during the examination, plaintiff had "some eye spasms after sitting for greater than 30 minutes and some twitching in his right hand").

Defendant contends the only evidence of plaintiff's pain is his own description of that pain

and that such "evidence" is insufficient in the absence of objective medical data supporting plaintiff's description. Def.'s Br. Supp. Mot. Summ. J. at 15. However, "[n]o test can measure how much pain a person feels. Indeed, each person's experience of pain is unique . . . . Pain, moreover, often persists despite ignorance of its precise etiology." Smith v. Continental Cas. Co., 276 F. Supp. 2d 447, 454 (D. Md. 2003). Therefore,

> [o]nce an underlying physical or mental impairment that could reasonably be expected to cause pain is shown by medically acceptable objective evidence, such as clinical or laboratory diagnostic techniques, the [plan administrator] must evaluate the disabling effects of a disability claimant's pain, even though its intensity or severity is shown only by subjective evidence. *If an underlying impairment capable of causing pain is shown, its intensity can, by itself, support a finding of disability.* Objective medical evidence of pain, its intensity or degree (i.e., manifestations of the functional effects of pain such as deteriorating nerve or muscle tissue, muscle spasm, or sensory or motory disruption), if available, should be obtained and considered. *Because pain is not readily susceptible of objective proof, however, the absence of objective medical evidence of the intensity, severity, degree or functional effect of pain is not determinative.*
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> Because a claimant need not present clinical or diagnostic evidence to support the severity of pain, a plan administrator cannot discount self-reports of disabling pain solely because the objective medical evidence does not fully support them. Excess pain is, by definition, pain that is unsupported by objective medical findings.

Id. at 454-55 (emphasis added) (quotations omitted) (citing Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 919 (7th Cir. 2003); O'Donnell v. Barnhart, 318 F.3d 811, 816 (8th Cir. 2003); Light v. Social Sec. Admin., 119 F.3d 789, 792 (9th Cir.1997); Hyatt v. Sullivan, 899 F.2d 329, 337 (4th Cir. 1990); Cotton v. Bowen, 799 F.2d 1403, 1407 (9th Cir. 1986)).[8]

Dr. Bullard specifically found that plaintiff's symptoms, although "unusual, . . . *could easily*

[8] Some of these cases are Social Security disability appeals. The standard for evaluating disability claims based on subjective complaints of pain has primarily been articulated in the Social Security disability context, but these cases are "relevant and applicable in the context of an ERISA determination[]" on this issue. Conrad, 232 F. Supp. 2d at 604 (citing Willis v. Baxter Int'l Inc., 175 F. Supp. 2d 819, 833 (W.D.N.C. 2001)).

fit with th[e] degree of cord compression" observed in a MRI. R. at 286 (emphasis added). Furthermore, it appears to the court that none of the medical professionals who have treated plaintiff has questioned plaintiff's description of the severity of his symptoms or suspected any malingering. The fact that plaintiff's physicians have all confirmed his diagnosis may, in itself, constitute "objective evidence of [plaintiff's] disability." Conrad, 232 F. Supp. 2d at 604 (finding that diagnosis of three physicians that the plaintiff had fibromyalgia was sufficient objective medical evidence even "[t]hough [the plaintiff] was not able to give [the defendant] test results which conclusively established fibromyalgia"). There is no conflicting medical evidence requiring defendant to choose one diagnosis over another. See Elliott v. Sara Lee Corp., 190 F.3d 601, 606 (4th Cir. 1999) (not an abuse of discretion for a plan administrator to deny benefits where conflicting medical reports are presented).

Essentially, defendant has disregarded the diagnoses of plaintiff's physicians and their opinions regarding plaintiff's inability to work and concluded that because (as plaintiff's physicians acknowledge) the precise etiology of plaintiff's symptoms cannot be determined by a test, those symptoms do not exist. Yet, each of plaintiff's physicians has agreed that he has these symptoms despite the fact that they do not show up on tests. See R. at 265 (Dr. Bullard's 18 October 2001 statement that test results have been "relatively non-diagnostic" in terms of plaintiff's symptoms), 282 (Dr. Bullard's 12 July 2001 statement that plaintiff's pain "continues to be a major problem" although EMG and nerve conduction studies and MRI were "unremarkable" and "x-rays show a stable construct"), 442 (pain specialist's 5 July 2002 "assessment" of plaintiff as having "[l]ow back pain with radicular symptoms related to severe degenerative disk disease causing chronic nerve root irritation symptoms" despite normal results during a neurological examination), 486 (Dr. Nelson's 15 May 2001 statement that plaintiff's back and leg pain is "objective data that 'disables' [plaintiff]

from his sedentary position and prevents return to work"), 516 (neurologist's 30 November 2001 assessment that tests performed came out normal, so although the neurologist "can't find a cause for [plaintiff's] parasthesias, . . . it looks as if he is simply just a gentleman who has parasthesias of unknown etiology"), 517-19 (neurosurgeon's 8 July 2002 "assessment/diagnos[i]s" that plaintiff "has low back and right leg symptoms" although "four separate EMGs of the lower extremities . . . are negative" and the most recent x-ray "did not demonstrate any abnormal motion" and surgery was not indicated). The court concludes that defendant has abused its discretion by looking to the test results as the only acceptable "clinical evidence" instead of the diagnoses of numerous physicians based on their professional observations of plaintiff. See Lain v. UNUM Life Ins. Co. of America, 279 F.3d 337, 347 (5th Cir. 2002) (abuse of discretion for insurer to focus on "normal" test results to deny benefits because test results could not clinically measure insured's pain).

Instead of obtaining any independent examination or functional capacity evaluation of plaintiff, defendant has focused on isolated events in the record, such as the fact that plaintiff attempted to pick up a compressor[9] and drove his children to school one day, and a statement (Dr. Nelson's 29 March 2001 statement that plaintiff could return to light duty work) which may be a typographical error. In the court's opinion, it is not the fact that plaintiff attempted to pick up a compressor that is relevant to the outcome of the instant motions, but the fact that plaintiff experienced a "rather acute onset of radicular pain" when he attempted to pick it up, see R. at 259. Likewise, it is not the fact that plaintiff drove his children to school one day which seems important

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[9] Turning briefly to defendant's motion to strike the affidavit of plaintiff's counsel, it is true that in ruling on a motion for summary judgment, the court is limited to the consideration of admissible evidence under Fed. R. Civ. P. 56(e). See Lifschultz Fast Freight, Inc. v. Consolidated Freightways Corp., et al., 805 F. Supp. 1277, 1284 (D.S.C. 1992) (citing Wright & Miller, Federal Practice and Procedure § 2722). The court will deny the motion as moot, as it finds it unnecessary to rely on the affidavit of plaintiff's counsel in reaching its decision on the motions for summary judgment.

to the court, but rather the fact that he "has difficulty making a fist and, in fact, had trouble grasping the steering wheel while driving his children to school . . . ." Id. at 265; see also Lain, 279 F.3d at 346-47 (insured's spending time at home doing research on her medical condition did not equate to ability to practice law in office); Hines v. Unum Life Ins. Co. of Am., 110 F. Supp. 2d 458, 463-64 (W.D. Va. 2000) (concluding that insurer's rejection of plaintiff's disability claim based on "twenty hours of surveillance . . . . in the face of eight years of documented medical evidence . . . by no less than eight physicians ranging in speciality . . . , all of whom believed in [plaintiff]'s claimed condition; in the face of documented treatment ranging from medication . . . to physical therapy" was an abuse of discretion).

A "review of the record . . . reveals that the process by which [defendant] reached its decision to [deny plaintiff]'s LTD benefits was not reasoned and that its decision was not supported by the evidence. [Defendant] reached its decision only by misreading some evidence and by taking other bits of evidence out of context. Reasonably read, the evidence does not support [defendant]'s conclusion . . . ." that plaintiff is ineligible for disability benefits. Myers v. Hercules, Inc., 253 F.3d 761, 768 (4th Cir. 2001) (citing Booth, 201 F.3d at 344). Plaintiff has repeatedly indicated that sitting aggravates his symptoms and that he has constant numbness in his fingers and hands. These limitations clearly preclude a person from plaintiff's former position, which required him to sit at a computer all day and type, and defendant has made no effort to determine whether plaintiff could perform some other job with his education, skills, and training. See Watson v. Unumprovident Corp., 185 F. Supp. 2d 579, 582 (D. Md. 2002) (noting that insurer never "sought an independent medical examination of [plaintiff] (as the policy permits), or the performance of any relevant tests or evaluations").

D. Attorney's Fees and Prejudgment Interest

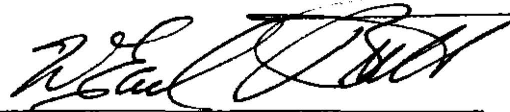
Plaintiff seeks attorney's fees, costs, and prejudgment interest on unpaid benefits. ERISA provides that a "court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C.A. § 1132(g)(1). The court is required to apply a five-factor test to determine whether attorney's fees should be awarded, see Quesinberry v. Life Ins. Co. of North Am., 987 F.2d 1017, 1028-29 (4th Cir.1993), and once the court determines a fee award is appropriate under Quesinberry, the court then proceeds to assess the reasonableness of the fees requested, see Denzler v. Questech, Inc., 80 F.3d 97, 104 (4th Cir. 1996). With regard to prejudgment interest, "ERISA does not specifically provide for pre-judgment interest, and . . . [therefore] the award of pre-judgment interest is discretionary with the trial court." Quesinberry, 987 F.2d at 1030. An award of prejudgment interest is appropriate to compensate a plaintiff for the loss of the use of money and to make the plaintiff whole. See id. at 1031. The court will defer ruling on plaintiff's request for attorney's fees, costs, and prejudgment interest until the issue has been more fully briefed by the parties, including the appropriate rate of prejudgment interest. See Edmonds v. Hughes Aircraft Co., No. Civ. A. 1:96-1368-A, 1998 WL 782016, *2 (E.D. Va. Nov. 6, 1998) (noting that some courts have applied the state rate for interest on judgments as the prejudgment interest rate on awards of benefits under ERISA, while other courts have used the post-judgment interest rate set forth in 28 U.S.C. § 1961(a)).

III. CONCLUSION

For the foregoing reasons, defendant's motion for summary judgment is DENIED. Plaintiff's motion for summary judgment is ALLOWED. It is ORDERED, ADJUDGED, and DECREED that plaintiff have and recover of defendant all benefits due under the plan from 6 August 2001 until plaintiff is no longer eligible for benefits, and to reinstate plaintiff and his family

in any additional benefits, such as health plan coverage, life insurance and retirement benefits, to which he is entitled. Plaintiff is DIRECTED to file a brief on the issues of attorney's fees, costs and prejudgment interest within twenty (20) days of the date this order is filed. The defendant shall have twenty (20) days from the date of service of plaintiff's brief to respond. No reply will be permitted. The motions to strike plaintiff's jury demand and the affidavit of plaintiff's counsel are DENIED AS MOOT.

This 31 March 2004.



W. EARL BRITT
Senior United States District Judge

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