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Tenth Circuit Finds District Court Applied Wrong Standard of Review in Evaluating Plan Administrator's Medical Necessity Determination

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In *Lyn M. v. Premera Blue Cross*, 2020 U.S. App. LEXIS 23395 (10th Cir. July 24, 2020), the Tenth Circuit held that a district court had applied the wrong standard of review and incorrectly evaluated an ERISA plan administrator's medical necessity determination when granting summary judgment to an insurer that had denied coverage for a plan participant's residential mental health treatment.

The case involved a claim for health benefits by the parents of a teenage girl who had a longstanding history of mental illness. Premera Blue Cross ("Premera"), the claims administrator of the ERISA plan ("Plan"), agreed to cover the first 11 days of treatment under the Plan's coverage for psychiatric residential treatment, but declined coverage for the subsequent 14 months. After exhausting their administrative remedies, the parents sued in Utah district court, seeking reimbursement for $80,000 in out-of-pocket expenses.

Applying a discretionary standard of review, the district court granted summary judgment in favor of Premera, finding that the evidence failed to establish that the claimant met the medical necessity criteria under the Plan. The Tenth Circuit reversed on two primary grounds.

First, the Tenth Circuit held that the district court improperly applied a discretionary standard of review. Although the Plan published its reservation of discretionary authority in a document called the "Plan Instrument," according to the court, it failed to give participants sufficient notice that the document existed. Plan participants received a Summary Plan Description which did not mention discretionary authority or disclose the existence of the Plan Instrument. The Summary Plan Description did state that participants may ask to examine Plan documents that were relevant to their claim. However, the Tenth Circuit found that this statement "did not suggest the existence of another document affecting judicial review." Accordingly, the court held that the district court incorrectly applied an arbitrary-and-capricious standard instead of conducting a *de novo* review.

Second, the Tenth Circuit held that Premera had improperly applied its criteria for medical necessity. Under the Plan, the necessity of medical care for residential mental health treatment is determined by(1) general criteria set forth in the Summary Plan Description, and (2) a separate medical policy titled

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"Behavioral Health: Psychiatric Residential Treatment." In its administrative appeal, the court held that the Plan relied solely on the Summary Plan Description but failed to apply the separate criteria set forth in the medical policy document

The court further held that Premera took a similar approach with respect to administering its medical review in connection with the appeal. Premera sent the claimant's medical records to a physician certified in child and adolescent psychiatry. While the company sent the doctor a copy of the medical policy, it told him that the document "should not be used as the basis for the determination of this review." The court thus concluded that "[b]y failing to use the medical policy's criteria, Premera acted arbitrarily and capriciously."

Accordingly, the court reversed the district court's grant of summary judgment and remanded the case to the district court to conduct a *de novo* review of Premera's claim decision. *Lyn M.* provides a cautionary tale for Plans to implement all aspects of their published medical necessity criteria when evaluating claims for mental health and substance abuse treatment.

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