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Denial of Mental Health Treatment Benefits Ruled Improper under Milliman Care Guidelines

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In *Jessica U. v. Health Care Service Corp.*, a Montana district court held that an ERISA plan administrator improperly denied benefits for mental health residential treatment based solely on so-called "Milliman Care Guidelines" that were not included in the plan documents.

The Milliman Care Guidelines ("MCG") are a set of health industry best practices, guidelines and diagnostic criteria published by MCG Health for providers and health plans. Although the MCG are widely used by health care professionals, the *Jessica U.* case illustrates that plan administrators must use caution when relying on the guidelines, or other materials outside of the plan, as grounds to deny health benefits.

In *Jessica U.*, the plaintiff was a teenage dependent beneficiary under a group health plan provided by her father's employer with a history of gastric issues and panic attacks that prevented her from attending school. She spent three months at a Montana residential treatment center ("RTC") for an eating disorder in mid-2015. Upon admission, center medical staff found that the plaintiff met the diagnostic criteria for anorexia nervosa and generalized anxiety disorder, and that a major depressive disorder could not be ruled out.

Plaintiff sought coverage for the RTC treatment under an ERISA plan (the "Plan") issued by defendant Health Care Service Corporation, operating in Montana as Blue Cross Blue Shield of Montana ("BCBS"). The Plan covered treatment at RTCs, so long as the treatment was deemed "medically necessary, " as defined by the Plan. Additionally, in making a determination of "medical necessity," the Plan allowed for BCBS to consider "standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the view of physicians practicing in relevant clinical areas and any other relevant factors." Significantly, however, the Plan did not specifically refer to the MCG.

BCBS approved coverage for the first three months of the plaintiff's residential treatment, after which she returned home. Soon afterwards, the plaintiff's symptoms resurfaced and she sought coverage for additional treatment at the RTC. BCBS denied coverage for the additional treatment, relying solely on the

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MCG to conclude that the plaintiff's RTC treatment was not "medically necessary." Specifically, BCBS found that the plaintiff was not in imminent danger to herself or others, had no issues with self-care, had no severe disability requiring acute residential intervention, had no co-morbid substance abuse disorder, and did not require a structured setting with continued around-the-clock care – standards which are included in the MCG but not explicitly set forth in the Plan documents.

Plaintiff exhausted her administrative remedies and then filed a federal lawsuit challenging the denial.

Granting the plaintiff's motion for summary judgment, the district court stated that a plan administrator might properly use the MCG as a supplemental tool for analyzing a mental health benefits claim. BCBS, however, erred by relying solely on the guidelines in denying the plaintiff's claim because they involved acute care factors that had limited application to a case involving a non-acute admission.

As a result, the court stated, BCBS's review missed the mark because "many relevant factors detailed in [plaintiff's] treatment, progress, and struggles were not considered by BCBS. Conversely, there were factors applied in [plaintiff's] request for benefits that had absolutely no relation to her unique mental health issues."

Rejecting BCBS's approach, the court applied a *de novo* review of the administrative record and held that the plaintiff had satisfied the Plan's definition of medical necessity. The *Jessica U.* case is a reminder for plan administrators to act judiciously when relying on third-party documents and to make sure that those documents directly address the conditions claimed.

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