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7 UNITED STATES DISTRICT COURT
8 WESTERN DISTRICT OF WASHINGTON
9 AT SEATTLE

10 TODD R., et al.,

11 Plaintiffs,

12 v.

13 PREMERA BLUE CROSS BLUE
SHIELD OF ALASKA,

14 Defendant.

CASE NO. C17-1041JLR

FINDINGS OF FACT AND
CONCLUSIONS OF LAW AND
ORDER REGARDING THE
PARTIES' CROSS MOTIONS
FOR SUMMARY JUDGMENT

15
16 **I. INTRODUCTION**

17 Before the court are: (1) Defendant Premera Blue Cross Blue Shield of Alaska's
18 ("Premera") motion for summary judgment (Def. MSJ (Dkt. # 33)); and (2) Plaintiffs
19 Todd R., Suzanne R., and Lillian R.'s¹ (collectively, "Plaintiffs") motion for summary
20 judgment (Plf. MSJ (Dkt. # 37)). Plaintiffs seek review of Premera's denial of benefits

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22 ¹ Lillian R. was formerly known as Jonathon R. and is referred to as "Jon" or "Jonathon"
throughout the administrative record. (See Compl. (Dkt. # 2) ¶ 1 n.1; see generally AR (Dkt.
36) (sealed).)

1 under a group health benefits plan (“the Plan”), which is governed by the Employment
2 Retirement Security Act of 1974 (“ERISA”), 29 U.S.C. §§ 1001-1461. (See Compl.
3 (Dkt. # 2) ¶¶ 2, 9, at 7-8.) Specifically, Premera declined to cover a portion of Lillian
4 R.’s stay at a residential treatment center as not medically necessary. (See Def. MSJ at 1;
5 Plf. MSJ at 1-2.) Plaintiffs repeatedly appealed Premera’s decision, but at each level of
6 Plaintiffs’ administrative appeals Premera prevailed. (See Def. MSJ at 5-10; Plf. MSJ at
7 9-13.) After exhausting their administrative remedies, Plaintiffs sued Premera in an
8 effort to recover the denied benefits. (See generally Compl.) As discussed below, the
9 court construes the parties’ motions for summary judgment as trial memoranda submitted
10 in connection with a bench trial on the administrative record. See Fed. R. Civ. P. 52(a);
11 see also *infra* § II. Based on the court’s review of the record and its consideration of the
12 parties’ arguments,² the court concludes that Lillian R.’s residential treatment at issue
13 here was medically necessary and therefore covered under the Plan and enters judgment
14 on that issue in favor of Plaintiffs.

15 II. PROCEDURAL ISSUES

16 Before turning to the merits of the parties’ arguments, the court must determine
17 the appropriate procedural vehicle for considering the parties’ cross motions. The answer
18 depends, in part, on the applicable standard of review. See *Bunger v. Unum Life Ins. Co.*
19 *of Am.*, 196 F. Supp. 3d 1175, 1177 (W.D. Wash. 2016). An ERISA plan that does not
20 contain language conferring discretion upon the plan administrator is subject to a *de novo*

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² The court heard the argument of counsel on January 23, 2019.

1 standard of review by the district court. *See Firestone Tire & Rubber Co. v. Bruch*, 489
2 U.S. 101, 115 (1989) (“[W]e hold that a denial of benefits challenged under
3 § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives
4 the administrator or fiduciary discretionary authority to determine eligibility for benefits
5 or to construe the terms of the plan.”). Here, the parties agree that the proper standard of
6 review is *de novo*. (Plf. MSJ at 14 (“Premera’s decision to deny benefits to [Lillian]
7 should be reviewed *de novo*.”); Def. MSJ at 10 (“[T]he *de novo* standard . . . applies
8 here.”); Plf. Resp. at 2 (Dkt. # 43) (“The parties agree that this [c]ourt should apply a *de*
9 *novo* standard of review to assess the validity of [Lillian R.’s] need for residential
10 treatment and Premera’s responsibility to pay for that treatment.”).) The court accepts
11 the parties’ position and reviews the record *de novo*. *See Rorabaugh v. Cont’l Cas. Co.*,
12 321 F. App’x 708, 709 (9th Cir. 2009) (stating that the court may accept the parties’
13 stipulation to *de novo* review).

14 As noted above, the parties have filed cross motions for summary judgment. (*See*
15 Plf. MSJ; Def. MSJ.) The Ninth Circuit has held that in an ERISA benefits case, where
16 the court’s review is for abuse of discretion, summary judgment is the proper “conduit to
17 bring the legal question before the district court.” *Bendixen v. Standard Ins. Co.*, 185
18 F.3d 939, 942 (9th Cir. 1999), *overruled on other grounds by Abatie v. Alta Health &*
19 *Life Ins. Co.*, 458 F.3d 955, 965 (9th Cir. 2006) (*en banc*). However, where, like here,
20 the standard of review is *de novo*, the Ninth Circuit has not definitively identified the
21 appropriate vehicle for resolution of an ERISA benefits claim. *See Bunger*, 196 F. Supp.
22 3d at 1177. The *de novo* standard requires the court to make findings of fact and weigh

1 the evidence. *See Walker v. Am. Home Shield Long Term Disability Plan*, 180 F.3d
2 1065, 1069 (9th Cir. 1999) (stating that *de novo* review applies to the plan administrator’s
3 factual findings as well as plan interpretation). On *de novo* review, “[t]he trial court
4 performs an ‘independent and thorough inspection’ of the plan administrator’s decision in
5 order to determine if the plan administrator correctly or incorrectly denied benefits.”
6 *Leight v. Union Sec. Ins. Co.*, 189 F. Supp. 3d 1039, 1047 (D. Or. 2016) (quoting *Silver v.*
7 *Exec. Car Leasing Long-Term Disability Plan*, 466 F.3d 727, 733 (9th Cir. 2006)). Here,
8 the parties apparently brought their cross-motions for summary judgment simply as a
9 vehicle for positioning the case before the court and obtaining a decision. *See Stephanie*
10 *C. v. Blue Cross Blue Shield of Mass. HMO*, 852 F.3d 105, 110 (1st Cir. 2017) (“Thus—
11 as in the administrative law context—a motion for summary judgment is simply a
12 mechanism for positioning an ERISA benefit-denial case for a district court’s decision on
13 the record of proceedings before the plan administrator.”) (citing *Bard v. Bos. Shipping*
14 *Ass’n*, 471 F.3d 229, 235 (1st Cir. 2006) (explaining that “[i]n the ERISA context,
15 summary judgment is merely a vehicle for deciding the case”)). Yet, making factual
16 findings or weighing evidence is forbidden when considering a motion for summary
17 judgment. *See T.W. Elec. Serv., Inc. v. Pac. Elec. Contractors Ass’n*, 809 F.2d 626, 630
18 (9th Cir. 1987). Thus, a motion for summary judgment is ill-suited to the kind of review
19 the court must undertake here.

20 When considering a party’s appeal of the denial of benefits under ERISA, other
21 courts have utilized the procedures set forth in Federal Rule of Civil Procedure 52 for
22 conducting a trial on the administrative record. *See, e.g., Kearney v. Standard Ins. Co.*,

1 175 F.3d 1084, 1095 (9th Cir. 1999) (“[T]he district court may try the case on the record
2 that the administrator had before it.”); *Bunger*, 186 F. Supp. 3d at 1177-78; *Rabbat v.*
3 *Standard Ins. Co.*, 894 F. Supp. 2d 1311, 1314 (D. Or. 2012); *Leight*, 189 F. Supp. 3d at
4 1047-48; *see also* Fed. R. Civ. P. 52. The court agrees that when applying a *de novo*
5 standard in an ERISA benefits case, a trial on the administrative record under Rule 52,
6 which permits the court to make factual findings, evaluate credibility, and weigh
7 evidence, is a more appropriate vehicle for resolving the parties’ dispute. *See Casey v.*
8 *Uddeholm Corp.*, 32 F.3d 1094, 1099 (7th Cir. 1994) (ruling that on *de novo* review of an
9 ERISA benefits claim, the “appropriate proceeding[] . . . is a bench trial and not the
10 disposition of a summary judgment motion”); *Rabbat*, 894 F. Supp. 2d at 1314
11 (concluding that the appropriate procedural vehicle for adjudicating an ERISA claim
12 under *de novo* review is through a bench trial based on the administrative record); *Lee v.*
13 *Kaiser Found. Health Plan Long Term Disability Plan*, 812 F. Supp. 2d 1027, 1032
14 (N.D. Cal. 2011) (“*De novo* review on ERISA benefits claims is typically conducted as a
15 bench trial under Rule 52.”); *Sammons v. Regence Bluecross Blueshield of Or.*, No. 3:15-
16 CV-01703-SI, 2016 WL 1171019, at *2 (D. Or. Mar. 23, 2016), *aff’d*, 739 F. App’x 385
17 (9th Cir. 2018) (“The appropriate procedure to resolve this dispute is through a bench
18 trial on an administrative record.”). Although the parties have filed cross motions for
19 summary judgment, based on the foregoing authorities, the court construes the parties’
20 motions as trial memoranda submitted in connection with a bench trial on the
21 administrative record. *See Leight*, 189 F. Supp. 3d at 1048 (construing cross motions for
22 summary judgment as trial memoranda in the context of an ERISA benefits claim).

1 Accordingly, pursuant to Rule 52(a), the court issues the following findings of fact and
2 conclusions of law based on a *de novo* review of the record.³

3 III. FINDINGS OF FACT

4 A. The Parties

5 1. Plaintiffs reside in Matanuska-Susitna Borough, Alaska. (Compl. ¶ 1.) Todd
6 R. and Suzanne R. are the parents of Lillian R. (*Id.*)

7 2. Todd R. is a participant in the Plan, which is a fully-insured employee welfare
8 benefits plan under ERISA, and Lillian R. is a beneficiary of the Plan. (*Id.* ¶¶ 2, 5.)
9 Lillian R.’s coverage under the Plan commenced on May 1, 2014.

10 3. Premera is an insurance company, and Premera admits that it is the claims
11 administrator for the Plan. (*See* Def. MSJ at 2.)

12 B. The Plan’s Terms and Premera’s Medical Policy

13 4. The Plan states: “This plan does not cover services that are not medically
14 necessary, even if they are court-ordered.” (AR (Dkt. # 36) (sealed) at 002379, 011702.)

15 5. The Plan defines what is “medically necessary” or a “medical necessity” as:

16 Services and supplies that a doctor, exercising prudent clinical judgment,
17 would use with a patient to prevent, evaluate, diagnose or treat an illness,
injury, disease or its symptoms. These services must:

- 18 • Agree with generally accepted standards of medical practice

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21 ³ To the extent any findings of fact may be deemed conclusions of law, they shall also be
22 considered conclusions. Similarly, to the extent any conclusions as stated may be deemed
findings of fact, they shall also be considered findings. *See In re Bubble Up Delaware, Inc.*, 684
F.2d 1259, 1262 (9th Cir. 1982).

- 1 • Be clinically appropriate in type, frequency, extent, site and duration. They must also be considered effective for the patient’s illness, injury or
2 disease
- 3 • Not be mostly for the convenience of the patient, doctor, or other health
4 care provider. They do not cost more than another service or series of
5 services that are at least as likely to produce equivalent therapeutic or
6 diagnostic results for the diagnosis or treatment of patient’s illness, injury
7 or disease.

6 For these purposes, “generally accepted standards of medical practice”
7 means standards that are based on credible scientific evidence published in
8 peer reviewed medical literature. This published evidence is recognized by
9 the relevant medical community, physician specialty society
10 recommendations and the views of doctors practicing in relevant clinical
11 areas and any other relevant factors.

12 (AR at 002382, 011722.)

13 6. The Plan states that “[b]enefits for covered services are subject to . . .
14 [m]edical . . . policies” that “are used to administer the terms of the plan.” (*Id.* at 11683.)
15 The Plan specifies that “[m]edical policies are generally used to determine if a member
16 has coverage for a specific procedure or service” and “are based on accepted clinical
17 practice guidelines and industry standards accepted by organizations like the American
18 Medical Association (AMA).” (*Id.*)

19 7. Premera’s criteria for evaluating the medical necessity of residential treatment
20 is set forth in its medical policy, which is entitled: “Residential Acute Behavioral Health
21 Level of Care, Child or Adolescent” (hereinafter, “Medical Policy”). (*See id.* at
22 007137-40.) Premera licensed its Medical Policy from MCG Health, which develops
evidence-based clinical review guidelines, generally known as the “Milliman Care

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1 Guidelines,” for use by healthcare and government organizations. (*Id.*; *see also id.* at
2 007151.)

3 8. Under the Medical Policy, admission to residential care is appropriate for a
4 child or adolescent exposed to one or more of the following risks: (1) “[i]mmminent
5 danger to self”; (2) “[i]mmminent danger to others”; (3) “[l]ife-threatening inability to
6 receive adequate care from caretakers”; (4) “[s]evere disability or disorder requiring
7 acute residential intervention”; (5) “[s]evere comorbid substance abuse disorder that must
8 be controlled . . . to achieve stabilization of primary psychiatric disorder”; or (6)
9 “[p]atient has currently stabilized during inpatient treatment stay for severe symptoms or
10 behavior and requires a structured setting with continued around-the-clock behavioral
11 care.” (*Id.* at 007137.) The Medical Policy sets forth more detailed criteria concerning
12 the first four of these factors. (*Id.*)

13 9. In its briefing, Premera paraphrased the sixth risk for determining the medical
14 necessity of residential treatment for adolescents as: “the patient requires a structured
15 setting with continued around-the-clock behavioral care.” (Def. Resp. at 5.) Premera’s
16 paraphrase omitted the first portion of the clause referencing the requirement that the
17 patient has “currently stabilized during inpatient treatment stay for severe symptoms or
18 behavior.” (*See id.*)

19 10. During oral argument, Premera’s counsel argued that the term “inpatient
20 treatment stay” in the sixth risk for determining the medical necessity of adolescent
21 residential treatment refers only to an inpatient hospital stay. Yet, nothing in the medical
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1 policy expressly so limits the term “inpatient treatment stay” to solely hospital stays.

2 (*See* AR at 007137.)

3 11. The Plan expressly defines the term “inpatient” as:

4 Someone who is admitted to a healthcare facility for an overnight stay. We
5 also use this word to describe services you get while you are an inpatient.

6 (*Id.* at 011722.)

7 12. The Plan expressly defines the term “Hospital” as:

8 A healthcare facility that meets all of these criteria:

- 9 • It operates legally as a hospital in the state where it is located
- 10 • It has facilities for the diagnosis, treatment and acute care of
11 injured and ill persons as inpatients
- 12 • It has a staff of doctors that provides or supervises care
- 13 • It has 24-hour nursing services provided by or supervised by
14 registered nurses

15 A facility is *not* considered a hospital if it operates mainly for any of the
16 purposes below:

- 17 • As a rest home, nursing home, or convalescent home
- 18 • As a residential treatment center or health resort
- 19 • To provide hospice care for terminally ill patients
- 20 • To care for the elderly
- 21 • To treat chemical dependency or tuberculosis

22 (*AR* at 011722 (*italics in original*).)

17 **C. Lillian R.’s Treatment**

18 13. Dr. Shubu Ghosh is a psychiatrist who treated Lillian R. from February 8,
19 2011, until July 16, 2013. (*Id.* at 000403.) During this period, Dr. Ghosh saw Lillian R.
20 on a weekly basis for therapy sessions. (*Id.*) Dr. Ghosh also prescribed medications for
21 Lillian R. (*Id.*) After Lillian R. stopped seeing Dr. Ghosh, in July 2013, Dr. Ghosh
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1 continued to consult with Todd R. and Suzanne R., Lillian R.'s parents, concerning
2 Lillian R. (*Id.* at 000404.)

3 14. Based on his treatment of Lillian R., Dr. Ghosh concluded that inpatient
4 residential care was the only treatment option for Lillian R. (*See id.* at 000404-05 (“It is
5 my opinion that inpatient residential care was the only option for [Lillian R.]. [Lillian R.]
6 needed inpatient residential level of care.”).) He further stated that Lillian R.'s parents
7 “had exhausted all outpatient avenues and [Lillian R.] required intensive treatment to
8 cope with h[er] debilitating depression, anxiety and behavior problems.” (*Id.* at 000405.)
9 Dr. Ghosh “recommended inpatient residential care because [he] was concerned for
10 [Lillian R.'s] safety.” (*Id.* at 000405.)

11 15. Tad Summer is a licensed clinical social worker who worked with Lillian R.
12 from March 20, 2013, to December 27, 2013. (*Id.* at 000407.) Mr. Summer worked with
13 Lillian R. on her primary diagnoses of oppositional defiant disorder, depressive disorder,
14 and anxiety disorder. (*Id.* at 000408.) During September 2013, Mr. Summer increased
15 his sessions with Lillian R. to twice per week due to Lillian R.'s “continued oppositional
16 behaviors, depression and trust issues.” (*Id.* at 000407.) During the months that Mr.
17 Summer was treating Lillian R., Lillian R. ran away from home twice, “became
18 assaultive with [her] mother,” and “began self injurious behaviors.” (*Id.* at 000407-08.)
19 At the beginning of December 2013, Mr. Summer did not believe that “there was any
20 more that could be done [for Lillian R.] in an out patient basis,” and he recommended
21 that Lillian R.'s parents place Lillian R. in residential treatment. (*Id.* at 000408.)

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1 16. On December 31, 2013, or January 1, 2014, when Lillian R. was 15 years old,
2 her parents admitted her to residential treatment at Elevations Residential Treatment
3 Center (“Elevations”)⁴ with initial diagnoses of post-traumatic stress disorder, major
4 depressive disorder, and recurrent, moderate parent/child relational problem. (AR
5 011558; *see also* Compl. ¶¶ 28-29.) In addition, Lillian R. was diagnosed with persistent
6 headaches “with unreliable pain control.” (AR at 011558.) The psychiatric evaluation
7 also noted the presence of “[s]ignificant family stressors, including [the] interplay of [a]
8 sibling illness (cancer) with [Lillian R.’s] recurrent headaches, which [we]re improved
9 but not resolved, [a] decline in academic standing, enmeshment with [a] girlfriend and
10 associated gender identity diffusion.” (*Id.*)

11 17. According to evidence submitted by Premera in support of its motion for
12 summary judgment, Elevations is a “medically comprehensive residential treatment
13 center[,]” which provides “a combination of intensive psychiatric treatment and
14 personalized care.” (Payton Decl. (Dkt. # 34) ¶ 2, Ex. 1 at 2.)

15 18. Lillian R.’s January 10, 2014, master treatment plan at Elevations identified
16 additional diagnoses of anxiety disorder, eating disorder, identity problem, problems with
17 the primary support group, problems related to the social environment, and educational
18 problems. (AR at 011481.)⁵

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20 ⁴ Previously, Elevations was known as Island View Residential Treatment Center (AR at
000023), but the court refers to this facility as Elevations throughout this order.

21 ⁵ In their response to Premera’s motion, Plaintiffs assert that Lillian R. “was receiving
22 subacute care for chronic problems that could not be treated in an outpatient setting.” (Plf. Resp.
(Dkt. # 43) at 4 (citing AR at 000192-202, 000404-05).)

1 19. Dr. Laura B. Brockbank, an examining psychologist, conducted a
2 “comprehensive psychological evaluation” of Lillian R. in February 2014, while Lillian
3 R. was undergoing treatment at Elevations. (*Id.* at 000031-32, 000425.) She “strongly
4 recommended that [Lillian R.] complete the program at [Elevations].” (*Id.* at 000031,
5 000427.) She also concluded that “[u]nless some change can occur on the family-system
6 level, it is unlikely that [Lillian R.] will be successful at home.” (*Id.* at 000429.)

7 20. Lillian R. was treated at Elevations until June 21, 2015, when she was
8 discharged. (*Id.* at 009258.)

9 **D. Plaintiff’s Claim for Lillian R.’s Treatment and Premera’s Denial**

10 21. Plaintiffs seek reimbursement from the Plan for the residential treatment that
11 Lillian R. received at Elevations after April 30, 2014. (Compl. ¶ 34; *see* AR at 00049.)

12 22. Plaintiffs submitted claims to Premera for Lillian R.’s residential treatment at
13 Elevations for the period beginning on May 1, 2014, until the end of her stay. (Compl.
14 ¶¶ 28, 30-31.) Although Lillian R. was admitted to Elevations on December 31, 2013, or
15 January 1, 2014, Plaintiffs’ claim applies only to Lillian R.’s treatment at Elevations after
16 April 30, 2014, because May 1, 2014, is the effective date of the Plan. (AR at 000005.)
17 Lillian R. was covered by a different health plan prior to May 1, 2014, and that plan is
18 not a subject of this dispute. (*See id.*)

19 23. On November 18, 2014, Premera denied Plaintiffs’ claims from May 1, 2014,
20 through August 31, 2014, as untimely submitted and denied the claims from September 1,
21 2014, forward, as not medically necessary. (Compl. ¶ 31; AR at 000049-54.)

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1 24. In its denial letter, Premera advised Plaintiffs that its evaluation of the medical
2 necessity of Lillian R.’s residency at Elevations was based on the Plan, the application of
3 Premera’s criteria as set forth in the Medical Policy, and a “review of the information
4 given to us by [Elevations].” (AR at 000050.)

5 25. Premera’s November 18, 2014, denial letter stated:

6 Continued residential care to treat a mental health condition is not medically
7 necessary after 4/30/14. Information from your provider does not show
8 evidence of continued high-risk behavior, immediate threat of high-risk
9 behavior, life-threatening inability to provide self-care or to receive adequate
10 care from caretakers, severe mental health symptoms, or need for a structured
11 setting and continued around-the-clock care to treat a severe mental health
12 condition that partly stabilized during inpatient care. The information from
13 your provider also does not indicate that the most intensive non-residential
level of care will still be unable to control your mental health difficulties, or
that you need continued treatment for a severe Substance Use Disorder in
order to [sic] your mental health disorder. The information from your
provider indicates that you can be treated at a lower level of care. The
difficulties that you are still experiencing are usually safely treated at a lower
level of care, such as partial hospitalization or outpatient treatment. Your
health plan covers only medically necessary services.

14 (*Id.*)

15 **E. Plaintiffs’ Level I Appeal of Premera’s Denial**

16 26. On May 13, 2015, Plaintiffs appealed Premera’s denial of coverage through
17 Premera’s internal appeal process (“Level I Appeal”). (Compl. ¶ 32; AR at 000016-47.)

18 27. Plaintiffs made three arguments in their Level I Appeal letter. (AR at
19 000016-47.) First, Plaintiffs argued that Premera’s Medical Policy did not comport with
20 generally accepted standards of care and was too restrictive. (*Id.* at 000020-22.)

21 Plaintiffs cited to the American Academy of Child and Adolescent Psychiatry
22 (“AACAP”) Practice Parameters and other medical literature on the standard of care.

1 (*Id.*) Second, Plaintiffs argued that Lillian R.’s treatment was medically necessary, and
2 they included a detailed chronology of Lillian R.’s behavior, past treatments and
3 medications, as well as Lillian R.’s medical records and Elevations treatment records.
4 (*Id.* at 000022-46.) Third, Plaintiffs asserted that by denying coverage for Lillian R.’s
5 residential treatment, Premera violated the Parity Act⁶ by providing a lower level of care
6 for mental health services than for medical services. (*Id.* at 000045-46.)

7 28. Plaintiffs’ Level I Appeal included a letter from a psychiatrist and a letter
8 from a licensed clinical social worker—both of whom treated Lillian R. prior to her
9 admission at Elevations. (*Id.* at 000403-05; 000407-08; *see also id.* at 000027-31.)

10 29. The first letter was from Dr. Ghosh. (*Id.* at 000403-05.) As noted above, Dr.
11 Ghosh treated Lillian R. weekly from February 8, 2011, to July 16, 2013. (*Id.* at
12 000403.) Dr. Ghosh stated that it was his “opinion that inpatient residential care was the
13 only option for [Lillian R.]” (*Id.* at 000404-05.)

14 30. The second letter was from Mr. Summer, the licensed clinical social worker
15 who treated Lillian R. from March 20, 2013, through December 27, 2013. (*Id.* at
16 000407-08.) At the beginning of December 2013, Mr. Sumner recommended residential
17 treatment for Lillian R, and Todd R. and Suzanne R. placed Lillian R. in residential
18 treatment shortly thereafter. (*Id.* at 000408.)

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22 ⁶ *See* 29 U.S.C. § 1185a(a)(3)(A)(ii).

1 31. Neither Dr. Ghosh nor Mr. Sumner treated Lillian R. during the period of her
2 inpatient residential treatment at Elevations. (*See id.* at 000403-08.) Neither Dr. Ghosh
3 nor Mr. Sumner made any assessment of Lillian R. while she was at Elevations. (*See id.*)

4 32. In their Level I Appeal letter, Plaintiffs also highlighted the evaluation of Dr.
5 Brockbank, an examining psychologist, who evaluated Lillian R. in February 2014,
6 during the course of Lillian R.'s treatment at Elevations. (AR at 000031-32.) Lillian R.'s
7 therapist and parents requested the "comprehensive psychological evaluation" to obtain
8 information concerning Lillian R.'s "cognitive, academic, personality and mental health
9 functioning." (*Id.* at 000411, 000425.) They also requested "[r]ecommendations for
10 educational and treatment planning." (*Id.* at 000411)

11 33. In her evaluation, Dr. Brockbank noted that Lillian R. "is beginning to make
12 progress while at [Elevations]." (*Id.* at 000427.) She also opined that "[g]iven continued
13 intervention and therapeutic support, [Lillian R.'s] prognosis for continued improvement
14 is good." (*Id.*) As a result of her evaluation, Dr. Brockbank "strongly recommended that
15 [Lillian R.] complete the program at [Elevations]." (*Id.* at 000031, 000427.) She stated
16 that "[g]iven [Lillian R.'s] history of running away and suicidal ideation, it is
17 recommended that [s]he is closely monitored." (*Id.* at 000032.) She also stated that if
18 Lillian R. "becomes upset or angry, [s]he may attempt to run from the program"
19 (*Id.*) In addition, Dr. Brockbank noted that "[u]nless some change can occur on the
20 family-system level, it is unlikely that [Lillian R.] will be successful at home." (*Id.* at
21 000429.)

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1 34. In their Level I Appeal letter, Plaintiffs also provided several progress and
2 therapy notes from Lillian R.’s time at Elevations. (*Id.* at 000033-34.) These notes
3 describe Lillian R.’s temperament on various occasions as “upset,” “discouraged at how
4 far away [she] is from [her] ideal self,” “anxious,” “irritable,” “isolating,” and
5 “depressed.” (*Id.* at 000033-35.)

6 35. The notes also document a period of time in which Lillian R. experienced
7 thoughts or urges of suicide or self-harm. On June 12, 2014, the notes indicate that staff
8 checked on Lillian R. to see if she still had thoughts of self-harm. (*See id.* at 011750.)
9 Lillian R. stated that she was unsure and promised to tell staff if she does have these
10 thoughts. (*Id.*) On June 13, 2014, Lillian R. stated that she could manage herself. (*Id.*)
11 On June 15, 2014, Lillian R. stated that she had an urge to self-harm. (*Id.*) On June 16,
12 2014, “[Lillian R.] was placed on self harm [sic] precautions for self harm [sic] ideation,”
13 she “felt a strong desire to cut” like she used to, she “could not make a commitment for
14 safety and did not feel confident that [she] could go to staff before harming [her]self.”
15 (*Id.* at 000036.) In addition, her “suicidal thoughts continued.” (*Id.*) On June 17, 2014,
16 Elevations took Lillian R. off of self-harm precautions. (*Id.* at 011750.) On June 19 and
17 20, 2014, Lillian R. stated that she still had thoughts of self-harm. (*Id.*) On June 23,
18 2014, Lillian R. said that she had thoughts of self-harm but would not act on them. (*Id.*)

19 36. Based on the letters and various progress and therapy notes, Plaintiffs argued
20 that Lillian R. “continue[d] to need [a residential] level of care in order to complete [her]
21 master treatment plan goals so that [she could] be successfully treated at a lower level of

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1 care.” (*Id.* at 000045.) Plaintiffs maintained that if Lillian R. had been “discharged on
2 May 1, 2014, [she] would have quickly regressed into [her] prior behaviors.” (*Id.*)

3 37. As a part of Plaintiffs’ Level I Appeal, Premera asked an “Independent
4 Physician Reviewer” to review its decision to deny coverage. (*See* AR 011655-60.) Dr.
5 William Holmes, MD, who is board certified by the American Board of Psychiatry and
6 Neurology in Child and Adolescent Psychiatry (*id.* at 011658), reviewed Plaintiffs’ Level
7 I Appeal submissions and other relevant claim information, including the Master
8 Treatment Plan, treatment notes and shift logs from Elevations, the Plan language, and
9 Premera’s Medical Policy (*id.* at 011655).

10 38. Dr. Holmes concluded that “the service provided, mental health residential
11 treatment center stay from 5/1/14 to 4/30/15, was not medically necessary based on the
12 provided medical policy and plan language.” (*Id.* at 011656.) Specifically, he stated:

13 The service provided was not medically necessary based on the provided
14 medical [sic]. There was no medical necessity for residential treatment
15 center level of care for dated [sic] of service 5/1/14 forward. By 5/1/14, there
16 was no evidence of symptom severity that would require the ongoing
17 intensity of the residential treatment center level of care. It was noted that
18 the patient continued to display chronic difficulties with mood, anxiety,
19 oppositional behavior, and interpersonal conflict after 5/1/14. However,
20 these difficulties are of a chronic nature for the patient and were not of a
21 severity to warrant 24 hour [sic] treatment. It was noted that on occasion the
22 patient voiced thoughts of self-harm. However, at no time was there
evidence of imminent risk of harm to self or others, as well as no episodes of
self-harming behavior. There was also no evidence of deterioration of
functioning that would require the level of intensive treatment found in the
residential center setting.

(*Id.*)

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1 39. Premera denied Plaintiffs’ Level I Appeal on June 16, 2015. (*Id.* at
2 002410-13 (Level I Appeal decision).) Premera affirmed its prior decision that
3 residential treatment was not medically necessary after April 30, 2014. (*Id.* at 002410.)
4 Specifically, Premera stated:

5 By May 1, 2014, [Lillian R.’s] symptoms were not of a severity that would
6 warrant the continued use of a residential treatment center level of care,
7 though [s]he continued to display chronic problems related to h[er] mood and
8 feelings of being “overwhelmed.” However, these symptoms could have
9 been treated in a less restrictive level of care. Therefore, your appeal is being
10 upheld in accordance to the terms of the health plan, as the mental health
11 residential treatment center stay from May 1, 2014, through April 30, 2015,
12 was not medically necessary.

13 (*Id.*)

14 40. In its June 16, 2015, denial letter, Premera also responded to Plaintiffs’
15 assertion that Premera’s use of the Milliman Care Guidelines was improper. (*See id.*)
16 Premera stated it was not aware of credible scientific evidence that the AACAP Practice
17 Parameters—preferred by Plaintiffs—would be more appropriate than the Milliman Care
18 Guidelines, and Premera asserted that it had “acted in accordance with [P]lan
19 requirements and used evidence-based standards for evaluating the medical necessity of
20 [Plaintiffs’] claims.” (*Id.* at 002410-11.)

21 41. Finally, Premera denied that it had violated the Parity Act.⁷ (*Id.* at 002411.)
22 Premera stated that “[t]he evidentiary standards, processes, and strategies used to develop
Premera’s mental health medical policies are no more restrictive than the standards,
processes, and strategies used to develop Premera’s medical and surgical medical

⁷ *See* 29 U.S.C. § 1185a(a)(3)(A)(ii).

1 policies.” (*Id.*) Premera confirmed that “[a]t the time of service, Premera used the
2 Milliman Care Guidelines for all inpatient services, including mental health, medical, and
3 surgical services,” and thus was “in compliance with federal mental health parity law.”
4 (*Id.*)

5 **F. Plaintiffs’ Level II Appeal**

6 42. On August 10, 2015, Plaintiffs requested a Level II Appeal of Premera’s
7 denial of coverage. (*See id.* at 002428-33.) In addition to the medical records provided
8 in their Level I Appeal, Plaintiffs also provided the remainder of Lillian R.’s medical
9 records from Elevations. (*See id.* at 002431.)

10 43. In their Level II Appeal, Plaintiffs argued that Premera failed to advise them
11 of the weight given to Lillian R.’s medical records. (*Id.* at 002430.) They questioned
12 whether Premera’s Level I Appeal decision was based on a “continued stay criteria” or a
13 “discharge criteria.” (*Id.* at 002431.) They criticized the alleged burden imposed by the
14 Medical Policy, which they again asserted violated the federal Parity Act,⁸ and provided
15 additional medical records to support their contention that residential treatment for Lillian
16 R. was medically necessary. (*Id.* at 002431-33.) They asked Premera to cite specific
17 examples in the medical records that supported Premera’s denial of Lillian R.’s claim,
18 which they asserted was required under ERISA. (*Id.* at 002433.) Finally, they
19 challenged Premera’s determination that certain portions of Lillian R.’s claims were not
20 timely submitted. (*Id.* at 2429-30.)

21
22

⁸ *See* 29 U.S.C. § 1185a(a)(3)(A)(ii).

1 44. To review Plaintiffs’ Level II Appeal and Lillian R.’s file, Premera assigned a
2 panel consisting of (1) a physician, who is a medical director and board certified in
3 internal medicine, (2) a Member Contracts Operations Manager, and (3) a New Group
4 and Product Implementation Manager. (*See id.* at 007151.) The panel reviewed all of the
5 materials that Plaintiffs submitted with both their Level I and Level II Appeals, Dr.
6 Holmes’s findings as the Independent Physician Reviewer, Premera’s Medical Policy,
7 Lillian R.’s medical records, and the Plan language. (*Id.*)

8 45. On September 10, 2015, the Level II Appeal panel upheld Premera’s Level I
9 Appeal determination denying coverage. (*Id.*) However, the Level II Appeal panel
10 acknowledged that all of Plaintiffs’ claims were timely submitted and agreed to review
11 the claims Premera had previously determined to be untimely. (*Id.* at 007152.)

12 46. Addressing the medical records, the Level II Appeal panel stated that the
13 records “did not include a comprehensive evaluation, but only a narrative of daily group
14 assessments, or intermittent doctor interviews.” (*Id.*) Further, the records “indicated the
15 absence of a plan for self harm [sic], or to harm others, and no evidence of the severe
16 symptoms which could not have been treated in an intensive outpatient management
17 program.” (*Id.*) The panel explained that the “purpose of residential treatment admission
18 is stabilization in the context of a short term stay” and that “the severity of illness for
19 [residential treatment] level of care [is] not documented in the clinical notes from the
20 facility.” (*Id.*)

21 47. The panel noted Plaintiffs’ request for specific references in the medical
22 records that support Premera’s belief that Lillian R.’s treatment was not medically

1 necessary, but explained that Premera’s determination was “based on an absence of
2 record of severe symptoms which could not have been treated in an intensive outpatient
3 program.” (*Id.*)

4 48. The panel noted Plaintiffs’ request that Premera apply or consider the AACAP
5 Practice Parameters, but explained that Milliman Care Guidelines “are generally accepted
6 standards of medical practice” and “Premera’s medical policies are applied consistently
7 for all plan members.” (*Id.*) Accordingly, Premera explained that it could not
8 “accommodate a member request to apply a different medical policy for a specific
9 claim.” (*Id.*)

10 49. With respect to Plaintiffs’ claim that Premera’s denial violated the Parity Act,⁹
11 the panel stated that the Milliman Care Guidelines do not require “proof of acute
12 deterioration in capacity” in order to be covered for continuing residential treatment.
13 (*Id.*) Further, the panel stated that, like residential care for mental health issues, “Premera
14 does not cover continued inpatient or residential care for medical or surgical services
15 after such care is no longer medically necessary.” (*Id.*)

16 **G. Plaintiffs’ Request for an Independent Review**

17 50. After a member exhausts Premera’s internal appeals, the Plan offers members
18 an external review option. (*Id.* at 002385-86.)

19 51. On December 18, 2015, Plaintiffs requested an independent review of
20 Premera’s decision. (*Id.* at 007170-72.) MCMC, LLC (“MCMC”) conducted the
21

22 ⁹ See 29 U.S.C. § 1185a(a)(3)(A)(ii).

1 independent review. (*See id.* at 011740-52.) The physician reviewer from MCMC, who
2 is anonymous, is board-certified in psychiatry with a sub-certification in child and
3 adolescent psychiatry. (*Id.* at 011747.) The physician reviewer is also an attending staff
4 physician at several northwest hospitals, as well as a clinical instructor. (*Id.*) The
5 physician reviewer is also an author of peer-reviewed medical literature, a member of the
6 American Academy of Child and Adolescent Psychiatry, the American Psychoanalytic
7 Association, and the Academy of Occupational and Organizational Psychiatrists. (*Id.*)

8 52. On January 14, 2016, MCMC upheld Premera’s denial of coverage for Lillian
9 R.’s residential treatment. (*Id.* at 011745-52.) MCMC’s independent physician reviewer
10 concluded that a residential treatment center was not medically necessary from May 1,
11 2014, through June 21, 2015. (*Id.* at 011746, 011751.) The physician reviewer noted
12 that during the time period in question, Lillian R. “had periods of time at home during
13 which [she] was not receiving residential treatment and [her] clinical course continued.”
14 (*Id.*) The physician reviewer concluded that this demonstrated that “alternative therapies
15 and approaches . . . would have been as likely to be effective during the period of time.”
16 (*Id.*) Further, the physician reviewer stated, “since there are less intensive alternative
17 approaches that would have as much of a chance of improving h[er] condition as the
18 treatment that [s]he was receiving at Elevations, withholding treatment would not have
19 reasonably been expected to affect the patient’s health adversely.” (*Id.* at 011751.)

20 53. In the clinical summary portion of MCMC’s report, the independent physician
21 reviewer stated that, in the months following May 2014, with certain stated exceptions,
22 “in general, [Lillian R.] ha[d] no significant behavioral difficulty and denie[d] self harm

1 [sic] urges.” (*Id.* at 011750.) The independent physician reviewer then specifically noted
2 the particular instances in June 2014, during which Lillian R. expressed thoughts of or
3 urges to self-harm. (*Id.*)

4 **IV. CONCLUSIONS OF LAW**

5 **A. Jurisdiction**

6 1. The court has jurisdiction over this case under 29 U.S.C. § 1132(e)(1) and 28
7 U.S.C. § 1331.

8 **B. Standards under ERISA**

9 2. ERISA provides that a qualifying ERISA plan “participant” may bring a civil
10 action in federal court “to recover benefits due to him under the terms of his plan, to
11 enforce his rights under the terms of the plan, or to clarify his rights to future benefits
12 under the terms of the plan[.]” 29 U.S.C. § 1132(a)(1)(B); *Metro. Life Ins. Co. v. Glenn*,
13 554 U.S. 105, 108 (2008) (ERISA “permits a person denied benefits under an employee
14 benefit plan to challenge that denial in federal court.”). The court finds that Todd R. is a
15 qualified participant and Lillian R. is a beneficiary of the Plan.

16 3. As discussed above, ERISA does not set forth the appropriate standard of
17 review for actions challenging benefit eligibility determinations. *Firestone*, 489 U.S. at
18 109. The parties, however, have agreed that *de novo* review is appropriate here. (*See* Plf.
19 MSJ at 14; Def. MSJ at 10; Plf. Resp. at 2.) The court accepts the parties’ stipulation and
20 reviews the record *de novo*. *See Rorabaugh*, 321 F. App’x. at 709.

21 4. “When conducting a *de novo* review of the record, the court does not give
22 deference to the claim administrator’s decision, but rather determines in the first instance

1 | if the claimant has adequately established” his or her claim “under the terms of the plan.”
2 | *Muniz v. Amec Constr. Mgmt., Inc.*, 623 F.3d 1290, 1295-96 (9th Cir. 2010); *see also*
3 | *Perryman v. Provident Life & Acc. Ins. Co.*, 690 F. Supp. 2d 917, 942 (D. Ariz. 2010)
4 | (stating that the administrator’s “evaluation of the evidence is not accorded any deference
5 | or presumption of correctness”). In reviewing the administrative record and other
6 | admissible evidence, the court “evaluates the persuasiveness of each party’s case, which
7 | necessarily entails making reasonable inferences where appropriate.” *Oldoerp v. Wells*
8 | *Fargo & Co. Long Term Disability Plan*, 12 F. Supp. 3d 1237, 1251 (N.D. Cal. 2014)
9 | (quoting *Schramm v. CNA Fin. Corp. Insured Grp. Benefits Program*, 718 F. Supp. 2d
10 | 1151, 1162 (N.D. Cal. 2010)).

11 | 5. When a district court “reviews a plan administrator’s decision under the *de*
12 | *novo* standard of review, the burden of proof is placed on the claimant.” *Muniz*, 623 F.3d
13 | at 1294; *see also Schramm*, 718 F. Supp. 2d at 1162 (“In an ERISA case involving *de*
14 | *novo* review, the plaintiff has the burden of showing entitlement to benefits.”); *Horton v.*
15 | *Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir. 1998) (the claimant
16 | “bears the burden of proving his entitlement to contractual benefits”).

17 | 6. “Under *de novo* review, the rules ordinarily associated with the interpretation
18 | of insurance policies apply.” *Leight*, 189 F. Supp. 3d at 1047 (citing *Lang v. Long-Term*
19 | *Disability Plan of Sponsor Applied Remote Tech., Inc.*, 125 F.3d 794, 799 (9th Cir.
20 | 1997)). Accordingly, the court construes any ambiguities in the Plan against Premera and
21 | is required “to adopt [a] reasonable interpretation advanced by [the insured].” *See Lang*,
22 | 125 F.3d at 799.

1 **C. Plaintiffs' Entitlement to Benefits**

2 7. In deciding whether the Plan provides coverage for Lillian R.'s inpatient
3 residential treatment at Elevations, the court begins with the Plan's language. The Plan
4 states that it covers "inpatient [and] residential treatment . . . to manage or reduce the
5 effects of a mental condition." (AR at 002374.) However, the parties agree that the Plan
6 excludes services that are not "medically necessary." (*Id.* at 002379; *see* Def. Mot. at 4;
7 Plf. Mot. at 2-3.) Thus, the crux of the issue that the court must decide is whether
8 Plaintiffs have met their burden of proving that Lillian R.'s treatment at Elevations from
9 May 1, 2014, through June 21, 2015, was "medically necessary" and therefore not
10 excluded from coverage under the Plan.

11 8. Premera's criteria for evaluating the "medical necessity" of residential
12 treatment is set forth in its Medical Policy, which in turn is based on the Milliman Care
13 Guidelines. (Def. Mot. at 5 (acknowledging this fact); *see also supra* § III.B ¶ 7.)
14 Premera's evaluation of the medical necessity of Lillian R.'s treatment at Elevations and
15 Premera's ultimate denial of coverage for that treatment "was based on Premera's criteria
16 set forth in the Medical Policy and a 'review of the information given to [Premera] by
17 [Elevations].'" (AR at 000050.)

18 9. Plaintiffs argue that Premera's reliance on the Medical Policy was in error and
19 that Premera should have instead applied the principles they argued could be found in the
20 AACAP. (Plf. Mot. at 10 (citing AR at 000019-22).) However, the court need not decide
21 which standard to apply in evaluating "medical necessity," because it concludes that
22

1 Lillian R.’s treatment qualifies as medically necessary even when applying Premera’s
2 Medical Policy.

3 10. Premera argues that the weight of the evidence falls in its favor because in
4 denying coverage it relied on an independent physician reviewer, allowed Plaintiffs two
5 levels of internal appeals, and then submitted to an external independent review of its
6 decision by MCMC—all of which affirmed its original decision to deny coverage. (*See*
7 *Def. Mot.* at 12-17.) For the reasons stated below, the court disagrees and concludes on
8 *de novo* review that Plaintiffs have met their burden of demonstrating that Lillian R.’s
9 treatment at Elevations was medically necessary and therefore covered under the Plan.

10 11. As described herein, the court concludes that Lillian R.’s treatment qualifies
11 as “medically necessary” because it falls within the sixth risk listed in Premera’s Medical
12 Policy. (*See AR* at 007137; *see supra* § III.B. ¶ 8.)

13 12. The sixth risk listed in Premera’s Medical Policy provides that residential
14 care is appropriate for an adolescent where the “[p]atient has currently stabilized during
15 [an] inpatient treatment stay for severe symptoms or behavior and requires a structured
16 setting with continued around-the-clock behavioral care.” (*See AR* at 007137; *see supra*
17 § III.B. ¶ 8.) As discussed below, the court concludes, based on its *de novo* review of the
18 record, that Lillian R. was initially admitted for “inpatient treatment” at Elevations “for
19 severe symptoms or behavior,” subsequently stabilized as a result of her treatment at
20 Elevations, but, based on Dr. Brockbank’s evaluation, continued to require the
21 “structured setting” and “continued around-the-clock behavioral care” available at
22 Elevations. (*See AR* at 007137; *see supra* § III.B. ¶ 8.)

1 13. Premera responds in two ways. First, in its November 18, 2014, denial letter,
2 Premera stated that Lillian R.’s care did not fall with the sixth risk listed in Premera’s
3 Medical Policy and therefore was not medically necessary because “[i]nformation from
4 [Elevations] d[id] not show evidence of . . . [the] need for a structured setting and
5 continued around-the-clock care to treat [a] severe mental health condition that partly
6 stabilized during inpatient care.” (AR at 000050.) However, as discussed below,
7 Premera did not adequately take into account certain medical evidence submitted by
8 Plaintiffs that supports coverage.

9 14. Second, at oral argument, Premera’s counsel argued that the sixth risk listed in
10 the Medical Policy does not apply because it requires the adolescent patient to have
11 “stabilized during [an] inpatient treatment stay for severe symptoms,” and Lillian R.’s
12 residential treatment stay at Elevations did not qualify as an “inpatient treatment stay.”
13 (*See id.* at 007137.) Premera’s counsel argued that the term “inpatient” refers solely to
14 inpatient hospital stays and not to residential treatment center stays, and thus, the sixth
15 risk does not apply because Lillian R. “was never in inpatient hospitalization.” In other
16 words, Premera argues that the Medical Policy’s sixth risk only applies where an
17 adolescent is first admitted to inpatient hospitalization for severe symptoms, stabilizes at
18 that level of care, and then is downgraded to a residential level of care. Premera’s
19 counsel also argued that Lillian R.’s initial admission at Elevations was not for “severe
20 symptoms” as is also required under the Medical Policy’s sixth risk.

21 15. The court will address both of Premera’s arguments, but in reverse order.

22 //

1 1. The Plan’s Language and the Medical Policy’s Sixth Risk

2 16. As noted above, “the rules ordinarily associated with the interpretation of
3 insurance policies apply” in this case. *See Leight*, 189 F. Supp. 3d at 1047 (citing *Lang*,
4 125 F.3d at 799). Thus, the court construes any ambiguities in the Plan against Premera.
5 *See Lang*, 125 F.3d at 799. In addition, Premera’s Medical Policy is specifically
6 referenced and therefore incorporated into the Plan. (*See* AR at 011683; *see supra* § III.B
7 ¶ 6.) Further, Premera’s counsel admitted during oral argument that Premera’s Medical
8 Policy “is part of the contract” or Plan. Thus, the court extends the application of the
9 foregoing rules to its interpretation of Premera’s Medical Policy and construes any
10 ambiguities in the Medical Policy against Premera.

11 *a. Inpatient*

12 17. Applying the foregoing rules and for the reasons stated below, the court
13 concludes that the term “inpatient,” as it is used in the sixth risk listed in Premera’s
14 Medical Policy, is not limited solely to hospital admissions but applies to admissions at
15 other healthcare facilities, including residential treatment centers such as Elevations.

16 18. First, despite Premera’s argument that its Medical Policy limits the term
17 “inpatient” to circumstances involving a hospital admission, the court finds no such
18 limitation in the language of the Medical Policy. The admission guidelines for
19 adolescents to residential care contained in Premera’s Medical Policy do not (1)
20 specifically define the term “inpatient” as that term is used in the sixth risk, or (2)
21 expressly limit the term “inpatient” to mean only hospital admissions. (*See* AR at
22 007137-38.)

1 19. Further, the terms “inpatient” and “residential care” are used interchangeably
2 throughout the medical records. For example, Dr. Ghosh specifically describes
3 “residential care” as “inpatient.” (*See id.* at 000404-05 (“It is my opinion that inpatient
4 residential care was the only option for [Lillian R.] [Lillian R.] needed inpatient
5 residential level of care.”).) Moreover, Premera repeatedly describes Lillian R.’s
6 “residential care” at Elevations as “inpatient” throughout its own briefing. (*See* Def. MSJ
7 at 10 (“On January 14, 2016, MCMC upheld Premera’s denial of coverage for inpatient
8 residential treatment.”), *id.* at 13 (“The medical evidence offered by Plaintiffs fails to
9 raise an issue of fact as to whether [Lillian R.’s] condition was at such an acute level as to
10 require inpatient care.”), *id.* at 15; Def. Resp. (Dkt. # 44) at 10, 22.) Indeed, at oral
11 argument, Premera’s counsel agreed that the terms “residential” and “inpatient” are used
12 interchangeably throughout the medical records.

13 20. The language of the Plan itself supports the conclusion that the term
14 “inpatient” refers to a broader category of overnight stays than just hospitalizations. The
15 Plan expressly defines the term “inpatient” as “[s]omeone who is admitted to a healthcare
16 facility for an overnight stay.” (AR at 011722; *see supra* § III.B ¶ 11.) Thus, the
17 definition of “inpatient” is not expressly limited solely to an individual who is admitted to
18 a hospital.

19 21. Further, the Plan specifically defines the term “hospital” as only one type of
20 healthcare facility that meets a series of specific criteria. (AR at 011722; *see supra*
21 § III.B ¶ 12.) The Plan goes on to provide that a facility “is *not* considered a hospital if it
22 operates mainly . . . [a]s a residential treatment center.” (AR at 011722 (*italics in*

1 original).) Thus, contrary to Premera’s counsel’s assertion, the term “inpatient”
2 necessarily includes more than just a person who is admitted to a hospital; the term also
3 applies to a person who is admitted overnight to other types of healthcare facilities.

4 22. The Plan does not expressly define “healthcare facility” (*see generally* AR at
5 011719-24), but the court concludes that Elevations falls within the meaning of this term.
6 As noted above, evidence submitted by Premera describes Elevations as a “medically
7 comprehensive residential treatment center[,]” which provides “a combination of
8 intensive psychiatric treatment and personalized care.” (Payton Decl. ¶ 2, Ex. 1 at 2.)
9 Thus, the court concludes that Lillian R.’s treatment at Elevations falls within the Plan’s
10 definition of “inpatient” as “[s]omeone who is admitted to a healthcare facility for an
11 overnight stay.” (*See* AR at 011722.)

12 23. Based on the foregoing analysis, the court concludes that Lillian R.’s initial
13 admission to Elevations qualifies as an “inpatient treatment stay” under the sixth risk
14 listed in Premera’s Medical Policy.

15 *b. Severe Symptoms*

16 24. The court also concludes—contrary to Premera’s counsel’s assertion at oral
17 argument—that Lillian R.’s initial admission to Elevations was “for severe symptoms” as
18 is also required under the sixth provision of Premera’s Medical Policy. (*See id.* at
19 011722.) As noted above, during the months immediately preceding Lillian R.’s
20 admission to Elevations, Lillian R. ran away from home twice, “became assaultive with
21 [her] mother,” and “began self injurious behaviors.” (*Id.* at 000407-08.) Mr. Summer,
22 the licensed clinical social worker who was treating Lillian R. at the time, concluded in

1 December 2013 that there was nothing more that could be done for her in an outpatient
2 setting and residential treatment was recommended. (*Id.* at 000408.) Further, Dr. Ghosh,
3 the psychiatrist who treated Lillian R. immediately prior to Mr. Summer, also concluded
4 that inpatient residential care was the only treatment option for Lillian R. because her
5 parents had exhausted all outpatient treatment options and Dr. Ghosh was concerned for
6 Lillian R.’s safety. (*Id.* at 000404-05.)

7 25. Thus, the court rejects Premera’s position at oral argument that the sixth risk
8 contained in its Medical Policy is inapplicable because Lillian R.’s initial admission at
9 Elevations was not “for an inpatient treatment stay for severe symptoms.” To the
10 contrary, the court concludes that Lillian R.’s initial admission at Elevations was “an
11 inpatient treatment stay for severe symptoms.”

12 2. Evidence of Medical Necessity

13 26. As noted above, in its denial letter to Plaintiffs, Premera stated that Lillian
14 R.’s stay at Elevations after April 30, 2014, did not fall with the sixth risk delineated in
15 Premera’s Medical Policy and therefore was not medically necessary because
16 “[i]nformation from [Elevations] d[id] not show evidence of . . . [the] need for a
17 structured setting and continued around-the-clock care to treat [a] severe mental health
18 condition that partly stabilized during inpatient care.” (AR at 000050.) In so concluding,
19 Premera failed to adequately consider and/or evaluate certain portions of the medical
20 record.

21 27. Specifically, Premera does not adequately account for Dr. Brockbank’s
22 February 2014 psychological evaluation of Lillian R. In her evaluation, Dr. Brockbank

1 | noted that Lillian R. was “beginning to make progress while at [Elevations],” and
2 | “[g]iven continued intervention and therapeutic support, [Lillian R.’s] prognosis for
3 | continued improvement is good.” (*Id.* at 000427.) However, she “strongly
4 | recommended that [Lillian R.] complete the program at Elevations.” (*Id.* at 000031,
5 | 000427.) She supported her recommendation by noting Lillian R.’s history of running
6 | away and suicidal ideation. (*Id.* at 000032.) She also assessed that Lillian R. might
7 | attempt to run from the program (*id.*) and, without some changes, was unlikely to be
8 | successful at home (*id.* at 000429). Dr. Brockbank’s assessment, performed
9 | approximately two months prior to the period for which Plaintiffs are seeking coverage,
10 | supports the court’s conclusion that Lillian R.’s continued treatment was medically
11 | necessary under the terms of the Plan because her treatment fell within the confines of the
12 | sixth risk listed in Premera’s Medical Policy. In other words, Lillian R. had “currently
13 | stabilized during [an] inpatient treatment stay” at Elevations “for severe symptoms or
14 | behavior” but still “require[d] a structured setting with continued around-the-clock
15 | behavioral care” at Elevations. (*See id.* at 007137.)

16 | 28. Further, Dr. Brockbank’s assessment and her recommendation that Lillian R.
17 | remain in the treatment program at Elevations is supported by additional evidence in
18 | Elevation’s clinical notes. In June 2014, just four months after Dr. Brockbank’s
19 | assessment, Lillian R. began once again to experience suicidal ideation and self-harm
20 | urges. *See supra* § III.E ¶ 35. Further, Lillian R. could not always make a commitment
21 | to her own safety or that feel confident that she would notify staff before harming herself.

22 | *Id.*

1 29. Despite this critical evidence in support of the medical necessity of Lillian R’s
2 continued participation in the Elevations residential treatment program, Premera never
3 even discusses Dr. Brockbank’s evaluation in any of its briefing. (*See generally* Def.
4 Mot., Def. Resp., Def. Reply (Dkt. # 46).)

5 30. Further, the medical evaluations upon which Premera relies do not sufficiently
6 account for Dr. Brockbank’s opinion or the medical records concerning Lillian R.’s
7 propensity to self-harm. For example, during Plaintiffs’ Level I Appeal, to support his
8 conclusion that Lillian’s treatment after May 1, 2014, was not medically necessary, Dr.
9 Holmes states “there was no evidence of symptom severity that would require the
10 ongoing intensity of the residential treatment center level of care,” although he
11 acknowledges “that on occasion the patient voiced thoughts of self-harm.” (AR at
12 011656.) Nevertheless, he discounts this fact by stating that “at no time was there
13 evidence of imminent risk of harm to self or others, as well as no episodes of
14 self-harming behavior,” and “no evidence of deterioration of functioning that would
15 require the level of intensive treatment found in the residential center setting.” (*Id.*) He
16 concludes that Lillian R.’s “symptoms could have been treated in a less restrictive level
17 of care.” (*Id.* at 011657.) Yet, Dr. Holmes never references Dr. Brockbank’s evaluation
18 or provides any explanation as to why he is discounting Dr. Brockbank’s strong
19 recommendation that Lillian R. complete the program at Elevations. Further, Dr. Holmes
20 fails to note that Lillian R. was placed on self-harm precautions at least once in June 2014
21 because she could not make a commitment for her own safety or assure the staff at
22 Elevations that she would alert them before harming herself. (*Id.* at 000036); *see supra*

1 § III.E ¶ 35. Finally, contrary to Dr. Holmes’ assertion, the sixth risk listed in the Medical
2 Policy does not require a “deterioration of functioning,” but actually applies to a patient
3 who “has currently stabilized,” but continues to “require[] a structured setting with
4 continued around-the-clock behavioral care.” (See AR at 007137.) As the court
5 indicated above, this fits the description provided by Dr. Brockbank in her assessment of
6 Lillian R.

7 31. When assessing Dr. Holmes’s and Dr. Brockbank’s opinions, the court places
8 greater weight on Dr. Brockbank’s assessment that Lillian R. needed to remain at
9 Elevations than on Dr. Holmes’s assessment that she did not. Significantly, Dr.
10 Brockbank’s “comprehensive psychological evaluation” included a direct examination of
11 Lillian R. (*see generally id.* at 000410-30), while Dr. Holmes’ assessment did not (*see*
12 *generally id.* at 011655-60). Instead, Dr. Holmes’s assessment was based solely on his
13 review of Lillian R.’s medical and other records. (*See id.*)

14 32. Unlike in a social security administration case, there is no rule requiring
15 ERISA plan administrators to afford greater weight to examining and treating doctors.
16 *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003). However, this
17 does not mean that a district court, engaging in *de novo* review, cannot evaluate and give
18 appropriate weight to an examining doctor’s conclusions, if it finds those opinions
19 reliable and probative. *See Paese v. Hartford Life & Accident Ins. Co.*, 449 F.3d 435,
20 442 (2d Cir. 2006) (affirming the greater weight the district court placed on a treating
21 physician’s conclusions); *Gallegos v. Prudential Ins. Co. of Am.*, No. 16-CV-01268-BLF,
22 2017 WL 2418008, at *9 (N.D. Cal. June 5, 2017) (placing greater weight on treating

1 physician’s opinion). Here, the court so finds, and accordingly places greater weight on
2 Dr. Brockbank’s assessment than that of Dr. Holmes.

3 33. In Plaintiffs’ Level II Appeal, the reviewing panel stated that the records “did
4 not include a comprehensive evaluation, but only a narrative of daily group assessments,
5 or intermittent doctor interviews.” (AR at 007152.) This statement ignores Dr.
6 Brockbank’s comprehensive assessment entirely. Further, the panel states that the
7 records indicate “the absence of a plan for self harm [sic] . . . and no evidence of the
8 severe symptoms which could not have been treated in an intensive outpatient
9 management program.” (*Id.*) This statement ignores the clinical notes indicating that
10 Elevation’s staff had placed Lillian R. on self-harm precautions because she could not
11 commit to informing staff prior to acting on her suicidal or other self-harming thoughts or
12 urges. *See supra* § III.E ¶ 35. It also ignores Dr. Brockbank’s assessment that Lillian R.
13 may attempt to run from the program and that, without changes on the family-system
14 level, Lillian R. would likely be unsuccessful at home. *See supra* § III.E ¶ 33. Because
15 the panel either ignored or failed to account for significant evidence in the record before
16 it, the court places little or no weight on the Level II Appeal panel’s conclusions
17 concerning the medical necessity of Lillian’s residential treatment.

18 34. Further, for the same reasons that the court placed greater weight on Dr.
19 Brockbank’s evaluation of Lillian R. than Dr. Holmes’s evaluation, the court also places
20 greater weight on Dr. Brockbank’s evaluation, which included an examination of Lillian
21 R., than the opinion or evaluation of the Level II Appeal reviewing panel, which did not.
22 *See supra* § IV.C ¶¶ 31-32.

1 35. As noted above, MCMC’s independent physician reviewer also affirmed
2 Premera’s denial of coverage. *See supra* § III.G. ¶ 52. Nevertheless, the court places
3 little weight on this evidence. First, the physician reviewer concluded that because
4 Lillian R. “had periods of time at home during which [she] was not receiving residential
5 treatment and [her] clinical course continued,” “alternative therapies and approaches . . .
6 would have been effective during the time period.” (AR at 011746, 011751.) Yet, this
7 conclusion contradicts Dr. Brockbank’s strong recommendation that Lillian R. complete
8 the Elevations program and her conclusion that, absent changes on the family-system
9 level, “it is unlikely that [Lillian R.] will be successful at home.” (*Id.* at 000427,
10 000429.) Although the independent physician reviewer notes Dr. Brockbank’s
11 evaluation, he does not explain the inconsistencies between his recommendations and
12 hers. (*See id.* at 011749.)

13 36. Further, providing Lillian R. with periods of time at home as she progressed
14 through the program at Elevations is consistent with Dr. Brockbank’s treatment
15 recommendations. (*See id.* at 000430.) Dr. Brockbank recommended that, once Lillian
16 R. “had achieved [her] current treatment goals,” she should be allowed to apply her “new
17 coping and self-management skills to a less structured environment,” “while gradually
18 exposing [her] to real life situations and stressors.” (*Id.* at 000430.) In other words,
19 although Lillian R. ultimately reached points in her treatment when she was ready to try
20 out her new skills in a “less structured” and “real life” environment, which included short
21 stints at home, these experiences were not inconsistent with her need to return to
22

1 Elevations’ “structured setting” and “continued around-the-clock behavioral care” until
2 she was medically ready for a complete discharge from the program. (*See id.* at 007137.)

3 37. In addition, for the same reasons that the court places greater weight on Dr.
4 Brockbank’s evaluation of Lillian R. than Dr. Holmes’s evaluation or the Level II Appeal
5 panel’s evaluation, the court also places greater weight on Dr. Brockbank’s evaluation,
6 which included an examination of Lillian R., than the independent physician reviewer,
7 which did not. *See supra* § IV.C ¶¶ 31-32, 34.

8 38. The court concludes that, based on the records submitted, including Dr.
9 Brockbank’s evaluation and recommendation that Lillian R. complete the Elevations
10 program, along with other records that support Dr. Brockbank’s conclusion, including
11 clinical notes showing that Lillian R. continued to experience suicidal and self-harm
12 ideation and urges while at Elevations, Plaintiffs have met their burden of proving that
13 Lillian R.’s treatment at Elevations from May 1, 2014, to June 21, 2015, was medically
14 necessary and therefore covered under the Plan.

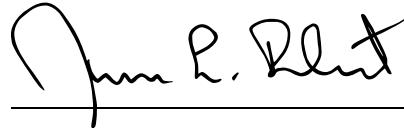
15 39. The court will determine the amount of damages for which Premera is liable
16 to Plaintiffs, as well as Plaintiffs’ entitlement to prejudgment interest, attorney’s fees, and
17 costs following additional briefing by the parties.

18 V. CONCLUSION

19 Based on the foregoing findings of fact and conclusions of law, the court
20 GRANTS Plaintiffs’ motion (Dkt. # 37) and DENIES Premera’s motion (Dkt. # 33). The
21 court further concludes that Lillian R.’s residential treatment at Elevations from May 1,
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1 2014, to June 21, 2015, was medically necessary and therefore covered under the Plan
2 and enters judgment on that issue in favor of Plaintiffs.

3 Dated this 30th day of January, 2019.

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6 JAMES L. ROBART
7 United States District Judge
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