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Court Orders Reevaluation of Child's Residential Treatment Claim Denial

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D.B. v. United Healthcare Ins. Co., 2023 WL 3766102 (D. Utah 2023)

A participant with coverage under two health plans sued both plans after they denied claims related to her child's residential treatment for depression, anxiety, lack of focus, and extreme hyperactivity. The court reviewed both denials under the arbitrary and capricious standard (which generally upholds an ERISA plan administrator's claim determination unless it was an abuse of discretion).

The court upheld one plan's denial, concluding that the plan terms clearly covered residential treatment centers only if they provided 24-hour onsite nursing services, which this facility did not. The participant also argued that this requirement violated the mental health parity rules because the plan did not expressly include a 24-hour-onsite-nursing requirement for analogous medical/surgical facilities such as skilled nursing facilities. The court dismissed this claim, finding that the plan covered skilled nursing facilities only if they were "duly licensed" and that 24-hour onsite nursing was a component of all applicable licensing requirements—thus, there was no disparity.

With respect to the other plan, the court analyzed a different issue: the participant's claim that the plan's denial for lack of medical necessity failed to specifically address the medical opinions of the child's treating physicians. Relying on a recent Tenth Circuit decision, the court explained that the plan administrator was required to "engage with and address" treating providers' recommendations in its denial letters, and its failure to do so in concluding that the child was medically and mentally stable was an abuse of discretion. The court sent the claim back for reevaluation, directing the plan administrator to specifically address the participant's arguments in support of coverage of the child's residential treatment. In light of the remand to the plan administrator, the court dismissed—at least for now—a separate mental health parity claim against this plan.

EBIA Comment: ERISA plans must provide claimants with full and fair review of claims and adverse benefit determinations. This decision reaffirms the importance of demonstrating that the plan has engaged with treating providers' opinions when denying claims based on medical necessity. And while the participant's mental health parity claims were thus far unsuccessful, compliance with the mental health parity requirements is a focus of agency enforcement and should be a priority for plans. For more information, see EBIA's ERISA Compliance manual at Sections XXXIV.H ("'Full and Fair Review' Procedures for Group Health Claims and Appeals") and XXXIV.N ("How to Protect Claim Denials From Being Reversed in Court"). See also EBIA's Health Care Reform manual at Section XV ("Appeals Process and External Review Requirements"), EBIA's Self-Insured Health Plans manual at Section XXVI ("Claims and Appeals"), and EBIA's Group Health Plan Mandates manual at Sections IX.E ("Mental Health Parity: Nonquantitative Treatment Limitations") and IX.G ("Disclosure of Criteria for Medical Necessity Determinations, Claims Denials, and Other Document Requests").

Contributing Editors: EBIA Staff.