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Ninth Circuit Affirms ERISA Plan Administrator's Decision, Validates Use of Industry Guidelines and Medical Evidence

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On March 5, 2019, Magistrate Judge Joseph C. Spero of the U.S. District Court for the Northern District of California issued his opinion in *Wit v. United Behavioral Health*, in which he attempted to significantly change how Employee Retirement Income Security Act (ERISA)–governed health plans were administered, particularly third-party administrators' reliance on medical necessity guidelines and the application of the abuse of discretion standard. The Ninth Circuit ultimately reversed the portions of the decision that were the most troublesome for ERISA plans and third-party administrators.

In *K.K.; I.B. v. Premera Blue Cross*, issued on February 6, 2025, the Ninth Circuit provided another indication that the approach taken by the district court in the *Wit* matter is in the past. There, the Ninth Circuit affirmed the district court's grant of summary judgment in favor of the ERISA plan administrator and the self-funded plan.

Quick Hits

- On February 6, 2025, the Ninth Circuit affirmed a lower court's grant of summary judgment in favor of an ERISA health benefits plan administrator and the plan, concluding that the denial of benefits for a plaintiff's treatment was reasonable and based on credible, contemporaneous medical evidence.
- The Ninth Circuit's decision underscores the importance of using validated medical necessity guidelines and supports plan administrators' discretion in making benefits determinations under ERISA.
- The Ninth Circuit emphasized that ambiguity and procedural irregularity in denying a claim do not alone constitute an abuse of discretion unless it affects a claimant's ability to submit responsive evidence, reinforcing the principle that decisions must be based on reasonable application of plan criteria.

Background

K.K. and I.B., K.K.'s daughter, sued the plan and Premera under ERISA to recover benefits for treatment provided to I.B. at the Eva Carlston Academy (ECA) psychiatric residential treatment center. Premera concluded that the treatment was not medically necessary within the meaning of the

plan.

I.B. was admitted to ECA shortly after completing a two-month stay at Pacific Quest, another in-patient treatment facility that provides a combination of therapeutic wilderness programs and residential treatment. Jason Adams, a Pacific Quest therapist, performed a psychological evaluation of I.B. and diagnosed her with nonverbal learning disorder, generalized anxiety disorder with obsessive-compulsive features, major depressive disorder, mild alcohol use disorder, and parent-child relational problems. He concluded that despite I.B.'s progress at Pacific Quest, it would be in her best interest upon discharge to enroll in a therapeutic residential treatment program. Tom Jameson, I.B.'s therapist at Pacific Quest, agreed with this assessment. Based on these recommendations, I.B. enrolled at ECA, where she remained for approximately one year.

K.K. did not seek pre-authorization for I.B.'s treatment at ECA and, in fact, only submitted her first claim for benefits under the plan in October 2017, more than nine months after I.B.'s admission to ECA. Premera denied this claim based on the conclusion that another round of residential treatment was not medically necessary under the terms of the plan. Premera concluded that after discharge from Pacific Quest, I.B. could have been effectively treated at a lower level of care, such as intensive outpatient or partial hospitalization.

The plaintiffs appealed this determination, which resulted in an independent medical review and an external review, as required under Washington State law. Those appeals upheld Premera's denial determination. The district court concluded that Premera and the plan did not abuse their discretion in concluding that the treatment at ECA was not medically necessary under the terms of the plan. In other words, Premera's decisions were reasonable.

The Ninth Circuit's Analysis

In affirming this decision, the Ninth Circuit found that under the plan's definition, treatment was medically necessary only if it was, among other things, "[i]n accordance with generally accepted standards of medical practice." The plan provided a description of generally accepted standards, such as standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors. The plan also provided that Premera had "adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations."

Pursuant to this provision, Premera used the InterQual guidelines—widely accepted guidelines for clinical decision support—which, according to the court, was reasonable, not an abuse of discretion, based on the credibility and validity of the criteria.

Quoting *Winter ex rel. United States v. Gardens Regional Hospital & Medical Center, Inc.*, the court found that the InterQual criteria were "'reviewed and validated by a national panel of clinicians and medical experts, and represent[ed] a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and/or primary care physicians.'"

The court also relied on *Norfolk County Retirement System v. Community Health Systems, Inc.*, where the court found that these criteria "'were developed by independent companies with no financial interest in admitting more inpatients than outpatients'"; "'were written by a panel of 1,100 doctors and reference 16,000 medical sources'"; and were used by "'[a]bout 3,700 hospitals.'"

Having validated these criteria, the court then found that Premera's decision that I.B.'s residential treatment was not medically necessary under these criteria also was reasonable. Premera concluded that I.B.'s condition had improved enough during her time at Pacific Quest that she no longer met the InterQual criteria for residential treatment when she entered ECA. Significantly, the court recognized that Premera's decision was based on the "most contemporaneous assessments" of I.B.'s condition, assessments that took place a few weeks before I.B. was discharged from Pacific Quest and a psychiatric evaluation that took place within two weeks of I.B.'s admission to ECA.

Premera's reliance on contemporaneous medical evidence was critical to rebut the plaintiffs' argument that Premera had failed to specifically address letters of medical necessity from I.B.'s treating providers. Quoting the Supreme Court of the United States' opinion in *Black & Decker Disability Plan v. Nord*, the court concluded that "'courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation.'"

The court went on to state that "[b]ecause I.B.'s treating providers wrote their letters of medical necessity one year after I.B.'s admission to Eva Carlston Academy and did not base them on firsthand evaluations of I.B. around the time of her admission, Premera did not abuse its discretion by rejecting their conclusions and instead reaching a contrary conclusion supported by the more contemporaneous, firsthand assessments of Dr. Adams and Dr. Simon." In other words, even though Adams had recommended further treatment at ECA, Premera was not unreasonable in its conclusion that his clinical notes did not support medical necessity as that term was defined in the plan.

The plaintiffs also argued that Premera abused its discretion because it "failed to engage in a meaningful dialogue and instead only provided vague reasons for denying their claim." In rejecting this argument, the court concluded that ambiguity alone was not enough to establish an abuse of discretion in this instance. The plaintiffs must also show that the ambiguities affected their ability to submit responsive evidence to perfect their claim, and, if the record were reopened, they could introduce favorable evidence that would call for a different result.

Conclusion

It is not possible to read an opinion addressing the mental health struggles of a child without empathy for the child and the parents who are seeking what they believe is appropriate care. Certainly, it is understandable that parents will want to provide residential treatment in which the child is supervised constantly.

At the same time, I.B. was in residential care for fourteen months. The court noted that the issue was whether I.B. could be treated at a lower level of care after leaving Pacific Quest. Typically, plan administrators offer intensive outpatient or partial hospitalization level of care for a child leaving residential treatment. The issue is not residential treatment or nothing; the issue typically is residential treatment, partial hospitalization, or intensive outpatient.

ERISA does not mandate the extent of the plans that employers can offer. Employers design plans that fit their needs, which often include discretionary language. Employers have to be able to enforce the terms of plans and make medical necessity decisions concerning the level of care to ensure the viability of the plans. The court's recognition of the reasonableness of the application of the InterQual criteria is an important tool to help plans make this type of decision. After *Wit*, the finding that the application of such guidelines was reasonable is a welcome result.

In addition, the court's willingness to uphold the decision based on contemporaneous clinical evidence affirms the importance of clinical facts and the reasonableness of relying on those facts rather than having to follow the opinion of the treating physician when the contemporaneous evidence does not support medical necessity, as defined in the plan.

Finally, the conclusion that an ambiguity alone is not enough—and that the ambiguity must be tied to the outcome of the claim—is significant because it ties the analysis back to where it should be: determining whether the decision was reasonable.

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