AMERICAN ARBITRATION ASSOCIATION

Commercial Arbitration Tribunal

In the Matter of the Arbitration between

Re: 72 193 00477 07 JENF

Sarah [redacted] INTERIM AWARD OF ARBITRATOR

vs.

Aetna Health of California, Inc.

I, the undersigned Arbitrator, having been designated by the parties and having heard and considered the oral argument of counsel, and having read and considered the documentary evidence (including the 1449-page Administrative Record) furnished to me by counsel, and the Declarations and memoranda of points and authorities, and written briefs of counsel, do hereby issue this Interim Award.

INTRODUCTION.

The Claimant in this case seeks a determination of coverage (under her father's employment-furnished [redacted] HMO Health Benefits Plan, the "Plan", with the Respondent) for certain residential health care treatment provided to her by Pine Ridge Academy Youth Care Inc. (a residential treatment facility located in the state of Utah) over the period of time from March 14, 2007 to on or about August 31, 2007.

The residential health care treatment presumably required either a referral from Claimant's primary health care physician ("PCP") or some other type of pre-authorization – as medically necessary – from the Respondent. However, it appeared that the Claimant was never assigned to a PCP by the Respondent and the Claimant's mother apparently, albeit mistakenly, assumed that the treatment had been 'authorized' by the Respondent when the Respondent telephonically informed her that Youth Care was an Aetna-contracted/approved facility. Notwithstanding the foregoing, the Respondent did nevertheless in good faith undertake to determine whether the treatment was medically necessary and, as such, 'covered' under the HMO Plan in question.

Claimant, initially acting without legal counsel, sought a determination of Plan coverage for a specific period of time only from March 14 to March 25 of 2007 plus prospective assurance that coverage would also apply for periods of time after March 25, of 2007. This initial action was undertaken on behalf of Claimant (who was then a minor) by her mother who was not a lawyer. The requests for coverage and prospective assurance were denied by the Respondent on the 'record' that was presented to it. And its denial was subsequently affirmed after the conclusion of an expedited Independent Medical Review ("IMR") that was undertaken (at Claimant's request) by the Center for Health Dispute Resolution

("CHDR", an independent privately-owned entity with which the California Department of Managed Health Care, "CDMHC", had contracted for such reviews).

When the CDMCH affirmed the Respondent's denial of coverage, based on the IMR review, the Claimant had exhausted her administrative remedies and could have sought further relief either (a) from a federal tribunal (as permitted under applicable ERISA regulations) or (b) from an arbitration with the American Arbitration Association ("AAA"). Faced with these choices, the Claimant engaged legal counsel, [redacted] (who was subsequently suspended from practice on September 1, 2010 and later disbarred on November 18, 2011), and -- after [redacted] had filed for arbitration with the AAA on or about May 9, 2007 -- counsel for the parties jointly agreed to place the matter in abeyance and postpone the taking of any further formal action until such time as the residential care treatment had been concluded and a complete Administrative Record was available.

The Claimant's stay at the Youth Care residential treatment facility ended on or about August 31, 2007, and many months later (after no meaningful action had been taken by [redacted] in spite of Aetna's counsel's commendable efforts to remind [redacted] of the passage of time) on or about May 14, 2010, Russell G. Petti informed the AAA that he had been retained to represent the Claimant in this proceeding – after which it took counsel for both parties, i.e. Russell Petti and Courtney Hill (each of whom at all times acted in good faith in their dealings with one another) many months to assemble an agreed-upon Administrative Record. Once that Record had been assembled, counsel further agreed to submit this matter to a Hearing based on that record – together with their respective Briefs, Declarations and oral argument. That Hearing took place on March 9, 2012 beginning at 9 a.m. and concluding on or about 1:30 p.m.

Counsel further agreed that there were two 'separate' denials of coverage that were at issue: i.e., **first,** the denial of the Claimant's initial filing in 2007 (by her mother) for the period from March 14 to March 27, 2007, and **second,** the denial of a 2010 filing by counsel for the period from March 14, 2007 to August 31, 2007. Counsel further agreed that

a) as to the 2007 denial, the it could be considered and reviewed by the arbitrator both on a *de novo* basis and on the basis of an 'arbitrary and capricious abuse of discretion'; and
b) as to the 2010 denial, it could be considered and reviewed by the arbitrator only on the basis of an 'arbitrary and capricious abuse of discretion'.

DISCUSSION

At the time of the initial 2007 filing and denial of coverage, the Claimant was not represented by counsel, but rather by her mother who – as nearly as could be determined from the record – was not broadly experienced in any of the matters that were relevant and at issue in such a filing. Further, there was no independent personal examination of the patient that was undertaken by any physician on behalf of the Respondent. Instead the Respondent and the IMR relied solely on the documentary evidence that was available to them, which was significantly less complete than the evidence that was eventually furnished to the Respondent in connection with its subsequent "documents only" 2010 denial. Accordingly, I have determined that the first denial should be reviewed and considered by me on

a *de novo* basis (and, to the extent appropriate, on the basis of an 'arbitrary and capricious abuse of discretion' as well). .

As to the second denial, which occurred in 2010, I am allowed to consider it only on the basis of an arbitrary and capricious abuse of discretion – as to which counsel for both parties presented considerable oral argument. Most tellingly, however, were (1) certain 'conclusions' on the part of the physicians who participated in the denial to the effect that the Claimant could receive satisfactory out-patient daycare at considerably less costly facilities that were not 'residential' and that were close to her home, and (2) the inexplicable entries on the Level of Care Assessment Tool ("LOCAT") form by Dr. Friedlander – who himself not only never examined the patient (*n.b.*, there is precedent upholding decisions re: "medical necessity" that are made solely on the basis of examinations of the record) but whose arithmetic was faulty and whose entries were incomplete. The much earlier 'conclusions' by Peter W. Williams, MD (at AET 28 and 29) were also based on his review of the Claimant's file and not on any *personal* examination of her. The conclusions of both Drs. Williams and Friedlander disregard the statements of other professionals (both psychiatrists and therapists) who, unlike the reviewing physicians in this case, had *personally* seen and treated the Claimant – to the effect that she was a danger both to herself and to others and that she could not be relied upon either (1) to take her medications without supervision or (2) to remain voluntarily, i.e., without restraint, at an out-patient daycare hospital or other facility.

CONCLUSION

I conclude that the services provided by Youth Care to the Claimant were medically necessary and as such were a covered benefit under the Plan in question. In reaching my conclusion, I reviewed the first denial *de novo* and did not believe that that denial constituted an abuse of discretion to the same degree as the second denial since at the time of that initial/first denial there was not as much material to be considered by Respondent or by the CHDR as later became available [once the Claimant was represented by competent counsel] for Dr. Friedlander and others to consider in reaching their conclusions for the second denial. As to the second denial, I conclude that it did involve an arbitrary and capricious abuse of discretion.

INTERIM AWARD

Therefore the Respondent is obligated to honor and process the Claims for the Youth Care services in amounts that the Plan provides for residential care treatment of the sort received by the Claimant from Youth Care, subject to such limitations as the Plan may provide for the duration of coverage of such services.

Since Claimant is the prevailing party in this proceeding, she may also be entitled to an Award of attorneys' fees and costs [e.g., see 29 USCA Sections 1132(g)(1)]. Therefore, Claimant's counsel shall file and serve his written request for such fees and costs on or before April 27, 2012, and Aetna's counsel shall file her response/objections thereto, if any, on or before May 29, 2012. Unless either counsel requests oral argument on the subject of attorneys' fees, my decision will be based on the

filings. And once I have reached a decision on the question of attorneys' fees and costs, it will be incorporated in a "Final Award" which will be issued in due course.

Alan Stamm

Alan Stamm, Arbitrator March 27, 2012