FILED
United States Court of Appeals
Tenth Circuit

May 15, 2023

Christopher M. Wolpert
Clerk of Court

PUBLISH

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

D. K.; K. K.

Plaintiffs - Appellees,

v.

UNITED BEHAVIORAL HEALTH; ALCATEL - LUCENT MEDICAL EXPENSE PLAN FOR ACTIVE MANAGEMENT EMPLOYEES,

Defendants - Appellants.

SECRETARY OF LABOR,

Amicus Curiae.

No. 21-4088

Appeal from the United States District Court
for the District of Utah
(D.C. No. 2:17-CV-01328-DAK)

Amy Shafer Berman (April N. Ross and Amy M. Pauli, with her on the briefs), Crowell & Moring, LLP, Washington, D.C., for Defendant – Appellant.

Brian S. King, Brian S. King, P.C., Salt Lake City, Utah, for Plaintiff – Appellee.

Susanna Benson (Rachel Uemoto with her on the brief), U.S. Department of Labor, Washington, D.C., for Amicus Curiae Acting Secretary of Labor Julie Su.[1]

[1] Pursuant to FRAP 43(c)(2), Acting Secretary Julie Su is automatically substituted for former Secretary of Labor Seema Nanda.

Before **CARSON**, Circuit Judge, **LUCERO**, Senior Circuit Judge, and **ROSSMAN**, Circuit Judge.

LUCERO, Senior Circuit Judge.

This case considers the procedural requirements for medical claims in insurance plans subject to the Employee Retirement Income Security Act ("ERISA"). Middle schooler A.K.[2] struggled with suicidal ideation for many years and attempted suicide numerous times, resulting in frequent emergency room visits and in-patient hospitalizations. A.K.'s physicians strongly recommended she enroll in a residential treatment facility to build the skills necessary to stabilize. Despite these recommendations and extensive evidence in the medical record, United Behavioral Health ("United") denied coverage for A.K.'s stay at a residential treatment facility beyond an initial three month period. Her parents appealed United's denial numerous times, requesting further clarification, and providing extensive medical evidence, yet United only replied with conclusory statements that did not address the evidence provided. As a result, A.K.'s parents brought this lawsuit contending United violated its fiduciary duties by failing to provide a "full and fair review" of their claim for

[2] Along with her parents, A.K. was an original plaintiff in the underlying decision. In the pendency of this appeal, A.K. passed away and accordingly has been removed from the caption. A.K.'s parents remain appellees against their insurer for claims denied and expenses incurred.

medical benefits. Both sides moved for summary judgment, and the district court ruled against United.

We consider whether United arbitrarily and capriciously denied A.K. medical benefits and whether the district court abused its discretion in awarding A.K. benefits rather than remanding to United for further review. We ultimately conclude that United did act arbitrarily and capriciously in not adequately engaging with the opinions of A.K.'s physicians and in not providing its reasoning for denials to A.K.'s parents. We also conclude the district court did not abuse its discretion by awarding A.K. benefits outright. Exercising jurisdiction under 28 U.S.C. § 1291, we **AFFIRM** the district court's grant of summary judgment and award of benefits.

I

A

A.K.'s struggles with anxiety began as a young child. By age seven, she began seeing a counselor for emotional outbursts, and by sixth grade her symptoms included signs of depression and anxiety. She began cutting herself with razor blades, requiring stitches. In the seventh grade she attempted suicide. After her suicide attempt, and over the next several years, A.K. was admitted to numerous inpatient hospitalization units, partial hospitalization programs, and short-term residential treatment centers.[3] Despite the best efforts of her parents and treatment

[3] Inpatient care refers to 24-hour care in a hospital setting. Day, or partial hospitalization, programs involve day-long treatments in which patients return to their home at night. Residential treatment programs allow the patient to live on-site and get day programming outside a hospital setting.

team, the admissions developed into a repeated cycle in which A.K. would be admitted to an intensive hospitalization unit after self-harming, transferred to a less intensive day program because United denied coverage, and attempt suicide soon after.

In March 2012, A.K. was sent to the emergency room following another suicide attempt and was admitted to the Seay Behavioral Center ("Seay") inpatient unit for treatment for mental health disorders. After one week, she transitioned to Seay's day program and was discharged ten days later. One week after discharge, A.K. ran away from home, and told police she intended to kill herself. She was then readmitted to Seay's inpatient unit, where she was diagnosed with "major depressive disorder."

In April, after two weeks at Seay, A.K was transferred to Cedar Crest Residential Treatment Center ("Cedar Crest"). After five weeks at Cedar Crest, she was discharged to a day program at Children's Medical Center. At that point, A.K. seemed to be stabilizing and her parents reenrolled her in school to begin the eighth grade. However, A.K. soon began cutting herself again—on several occasions so badly that she needed to go to the emergency room. As a result, she was reenrolled in the day program at Children's Medical Center, but ran away from home and attempted to strangle herself one week later. She was thereafter admitted to the inpatient program at the Center.

One week later, in October, United reconsidered if A.K.'s stay at Children's Medical was medically necessary. Due to A.K.'s multiple treatment episodes and

remissions, her treatment team at Children's Medical felt she was "at risk of self harm if not in an [inpatient] or [residential treatment center] setting." United denied coverage. United's denial letter stated that A.K. "could be treated by providers in a partial hospitalization program setting" because she denied having suicidal thoughts or intentions. A.K. was thus switched from the Children's Medical inpatient program to its day program. Three days later, she attempted to strangle herself and was readmitted to the inpatient unit.

After a few days at Children's Medical, A.K. was transferred to Meridell Achievement Center ("Meridell"), a residential treatment center. United initially denied coverage of A.K.'s stay at Meridell but overturned the denial after A.K.'s parents appealed. After two months, A.K. was discharged from Meridell to the day program at Excel Center ("Excel"), and began to cut herself again. Nonetheless, A.K. was discharged from Excel after five weeks, and returned to middle school. Two months later, A.K. cut her wrists again. At that point, she was admitted to inpatient care at University Behavioral Center ("University") for major depressive disorder and suicidal ideation.

A.K. spent ten days in treatment at University before being discharged in April 2013. Two days after discharge, she began cutting herself again. Following emergency room care, she was admitted to Glen Oaks Hospital ("Glen Oaks") for inpatient treatment. She was discharged a week later. Two weeks later, she cut herself again, went to the ER, and was readmitted to University's inpatient unit.

After a week at University, A.K. was discharged to Meridell for residential treatment. According to A.K.'s parents, Meridell staff indicated A.K. needed eight to eighteen months of residential treatment to address the underlying mental health disorders leading to her suicidal behavior. In response, A.K.'s parents began researching long-term care facilities and United's coverage options. In the midst of their search and during A.K.'s tenth week at Meridell, United denied continued coverage on grounds that A.K. "has been successful in working toward her recovery" and "no longer appears to be a threat to herself or others." A.K.'s parents appealed, but United upheld the denial. A.K. was then discharged from Meridell to the day program at Excel. Three days later, returning to form, she cut herself in the arm and groin, nearly severing her femoral artery. A.K. was readmitted to the Children's Medical inpatient program, whose physicians noted she "need[ed] long term placement."

A.K. spent over a week in inpatient treatment at Children's Medical before being discharged to Meridell for residential treatment in August 2013. The treatment team at Children's Medical also recommended A.K. attend a residential treatment program for ten to eighteen months. They reported A.K. required concentrated time to develop the emotional regulation, positive coping, and relationship skills, among others, needed to return home safely. A.K. improved at Meridell while her parents researched and applied to waitlists for long-term care facilities. However, United cited A.K.'s improvement to again deny further coverage at Meridell, noting that she "move[d] in her recovery by improving her coping skills and working with her

treatment team. [So] [i]t appears [A.K.] is ready to transfer to a longer term residential [facility.]"

In summary, between her first emergency room visit in March 2012 and her discharge from Meridell in November 2013, A.K. had no less than ten psychiatric emergency room visits. She also spent over 55 total days in inpatient care, over 55 total days in partial hospitalization day programs, and over 235 total days in residential treatment centers. Because she was moved to lower-level care upon stabilization or slight improvement, she lacked the stability necessary to develop the skills to succeed outside of a 24-hour care setting. These hospitalizations and treatments disrupted her sixth- and seventh-grade years, further harming her ability to thrive as an ordinary middle school child.

It is uncontested that for 20 months A.K. moved between emergency rooms, inpatient facilities, and day programs. During the same period, United repeatedly scaled down A.K.'s treatment.

B

A.K. is a beneficiary of her father's medical plan, administered by United. The plan covers medically necessary treatment that conforms to plan requirements. A particular service is medically necessary if "medically appropriate for the diagnosis or treatment of an Illness, Pregnancy or accidental injury." The plan established guidelines to evaluate the medical appropriateness of particular areas of treatment based on the following general standards:

> (i) It is accepted by the health care profession in the U.S. as the most appropriate level of care. . .
> (ii) It is the safest and most effective level of care for the condition being treated.
> (iii) It is appropriate and required for the diagnosis or treatment of the accidental injury, Illness or Pregnancy.
> (iv) There is not a less intensive or more appropriate place of service, diagnostic or treatment alternative that could have been used in lieu of the place of service or supply given.

The plan specifically developed guidelines to evaluate coverage of treatment for Major Depressive Disorder and Dysthymic Disorder. To be covered, treatment must be "consistent with generally accepted standards of clinical practice," "backed by credible research," "consistent with [United]'s clinical best practice guidelines," and "clinically appropriate for the member's behavioral health condition based on generally accepted standards of clinical practice and benchmarks." That is, the service must meet certain quality standards and appropriately address the diagnosis. A reviewer considers if the intensity of care is appropriate and if the member's treatment could occur safely at a lower level of care. For mental health care, for example, the reviewer may consider if a patient can achieve their goals in day programming rather than inpatient care. To that end, "[t]here is a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time." For this consideration, reviewers look at the member's ongoing needs. They are guided to "weigh[] the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends" and consider improvement "within the broader framework

of the member's recovery and resiliency goals." Discharge from care may be appropriate if "[t]he goals for the current episode have been accomplished."

A.K.'s plan included coverage for Residential Treatment Centers, facilities with 24-hour care and behavioral health treatment for patients who do not need the intensity of inpatient care. These facilities act as "an extension of or an alternative to acute Hospital care," and "provide[] services which are less intensive than acute In-Patient care, but satisf[y] the requirement for a protected and structured environment in cases where Outpatient treatment is not appropriate." However, the plan discontinues coverage for Residential Treatment Centers and recommends discharge[4] if treatment becomes "custodial," defined as "services that don't seek to cure, are provided when the member's condition is unchanging, are not required to maintain stabilization, or don't have to be delivered by trained clinical personnel." Reviewers evaluating A.K. for discontinued coverage were required to specifically address her ongoing needs and levels of functioning.

A.K.'s plan sets out specific requirements for denial procedures. Denials must include "[t]he specific reason or reasons for the denial" and "[s]pecific reference[s] to pertinent Plan provisions on which the denial was based." Denials based on medical necessity must include "an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's

[4] For discharge, indications that care is custodial includes: 1) The member's signs and symptoms have been stabilized, resolved, or a baseline level of functioning has been achieved; 2) The member's condition is not improving; or 3) The intensity of active treatment in Inpatient is no longer required.

circumstances or a statement that such explanation will be provided upon request." Claimants may appeal denials. In responding to such appeals, the "decision on review" must also provide "[t]he specific [] reasons for the adverse benefit determination," and "specific reference to pertinent Plan provisions on which the adverse benefit determination is based." For medical necessity determinations, the "decision on review" must also provide "either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's circumstances or a statement that such explanation will be provided upon request." Finally, the plan allows claimants to request a third-party review of appeals.

C

In November 2013, A.K.'s parents recognized that her cyclical treatment course had not provided her with stability necessary for sustained improvement, particularly because United repeatedly recommended discharge immediately upon stabilization in 24-hour care. Having been advised of A.K.'s need for a long-term residential facility, A.K.'s parents applied for a "case exception" with United and requested coverage for twelve months of treatment. They provided extensive evidence in support of their assertion that A.K. required a long-term residential facility, including letters from A.K.'s treating physicians. In one letter, Ms. Weaster, a program therapist at Meridell, recommended "ongoing specialized residential treatment . . . upon discharge from Meridell in order to keep [A.K.] safe and give her the best possible chance for full recovery from her complex clinical issues." Ms.

Weaster stated that despite A.K.'s improvement during residential treatment, "she continues to exhibit emotional reactivity that places her at ongoing risk of relapse when discharged to home. She is precariously balanced and quickly regresses to self-injury and suicidal thoughts and/or behaviors when not in a monitored 24-hour a day therapeutic setting."

In another letter, Dr. Diederich, an attending physician at Children's Medical wrote that "[o]ver the course of working with [A.K.] through multiple inpatient admissions with her as well as seeing the results of the more typical intermediate-duration residential placements, she has struggled to make the needed progress to be successful in the home." He considered A.K. part of "a small subset of children that cannot make the needed changes unless they are in a single, consistent program that will keep them until they can develop the needed skills to be safe." He noted that while A.K. may be processing and progressing, "her speed of [] processing is much slower than her peer group," which "will make many of the processes seem slower and ineffective, when really she needs a greater length of time to allow these skills to be developed." He recommended A.K. be placed in long-term residential treatment.

Finally, Dr. Riedel, the medical director of Meridell, provided his medical opinion of A.K. based on her numerous admissions. He wrote that A.K. seemed to respond "well to the external structure provided by the residential treatment center setting," but tended to "decompensate[] upon discharge[] due to her not having been able to internalize and consolidate gains." He advised that A.K. "needs a long-term

residential treatment center placement to accomplish the goals necessary for her to succeed and have a chan[c]e at sustaining a healthy life."

In sum, multiple treatment professionals reported that A.K. would need long-term residential treatment to address her underlying mental health disorders. These professionals uniformly noted that A.K. needed to develop various skills to address her disorders and only long-term residential treatment would position her to do so. Short-term and day treatment were simply inadequate for A.K.

United's third-party reviewer, IPRO, handled A.K.'s case exception request. IPRO considered if two months of residential treatment would be appropriate given that A.K. recently spent over two months in residential treatment at Meridell. They determined A.K.'s suicide attempts days after her discharge from Meridell indicated that "another two month stay . . . is not enough treatment as it is too risky to discharge her out of a 24-hour residential treatment." IPRO noted A.K. needed specialized treatment to improve coping skills and emotional regulation needed to exist outside a 24-hour setting and avoid self-harm. Nonetheless, IPRO approved residential treatment for three months rather than the requested twelve, but indicated an additional assessment would occur after three months to determine continued coverage. In coming to their conclusion, IPRO specifically noted the concerns of the treating professionals outlined in their letters and discussed A.K.'s extensive medical history. In November 2013, based on the IPRO approval, A.K.'s parents enrolled her in Discovery Girls Ranch ("Discovery"), a residential facility.

In February 2014, as A.K.'s initial three-month stay at Discovery was coming to an end, A.K.'s parents requested coverage for additional time at Discovery. This began a series of denials, appeals for reconsideration, and requests for more information. United's first reviewer stated A.K. "appears to require Mental Health Residential Treatment Center long term Level of Care." However, the reviewer mistakenly believed A.K.'s plan categorically excluded out-of-network residential treatment. Though this was a misreading of A.K.'s plan, the reviewer denied coverage on those grounds.

A.K.'s parents appealed, pointing out the exclusion did not apply to their plan and thus the reviewer's denial was erroneous. Nevertheless, the second reviewer repeated the error. That reviewer noted that "[b]ased upon current medical records, [A.K.] appears to require Mental Health Residential long term level of care." The reviewer again mistakenly denied care, believing that A.K.'s plan excluded coverage for out-of-network residential treatment.

The parents appealed again, repeating that their plan did not categorically exclude coverage, as the reviewers had believed. This request provided United with a description of A.K.'s medical records, including an additional letter from Discovery's Dr. Lowe, who stated that early discharge was highly risky because A.K. "has not learned to regulate her mood outside a structured therapeutic facility and would return to old patterns of self-harm as evidenced by her recent poor relationship[] choices, increased anxiety, emotional reactivity, refusal to use healthy

coping skills, resulting in increased depression, suicidal thoughts and cutting herself."

United recognized its error in categorically denying coverage and re-started the appeals process. In December 2014, ten months after initially requesting to extend residential treatment at Discovery, A.K.'s parents received United's first denial review that directly considered medical necessity, not the mistaken exclusion. This third denial letter stated that "medical necessity was not met," citing A.K.'s lack of injurious behavior while at Discovery and her stable diagnosis.

A.K.'s parents appealed for a third time, pointing out the inconsistent denial rationales and requesting justification for the medical necessity denial. They included an additional letter from Dr. Riedel of Meridell in their appeal, which stated that as of July 2013, "[A.K.] is on a slow but steady course" and "[i]t will be critical and crucial that medical stability be reached and she be allowed to continue the work that she is doing and to continue to consolidate gains." He went on to say that "discharge at this time would certainly jeopardize [A.K.'s] prognosis," "[g]iven [her] extensive history since childhood, [including] the multiple acute psychiatric hospitalizations that have been very disruptive to [her] and her family and have [fostered] more negative cognitive sets of being a failure and damaged."

The third appeal specifically requested: 1) further clarification as to the weight given to the medical opinions of A.K.'s various treatment professionals, 2) clarification on how medical necessity could not be found, given the clinical record provided, and 3) evidence of the clinical references relied on for the opinion. The

fourth reviewer found that continued treatment was not medically necessary because A.K.'s goals of admission had been met, "which were to consolidate [A.K.]'s gains so that she could control her[] self injurious behavior." That reviewer did not include information about the weight given to medical opinions, did not discuss the clinical record, and provided no direct clinical references.

A.K.'s parents requested an external review—their fourth appeal. They stated United had not shown "positive proof that a fair review was ever conducted" and requested a "full, fair, and thorough independent third party review." The third-party reviewer noted the various medical evidence provided and the prior denial letters. That reviewer found A.K. had made some improvement and was able to focus on schoolwork. The reviewer remarked that "there is not evidence during [A.K.'s time at Discovery] that remainder in a residential setting was the safest and most effective level of care" and posited that A.K.'s behavior could be managed in day programs. The reviewer concluded it was not medically necessary for A.K. to remain in residential treatment.

D

After the fifth denial, A.K.'s parents filed this lawsuit which asserted United breached its fiduciary duty to provide a full and fair review of claim denials. Specifically, they claimed United improperly categorized their claim as not medically necessary, that United's denial letters disregarded and did not engage with the opinions of A.K.'s treating physicians, and that United failed to apply the terms of

the plan to specific portions of A.K.'s medical records. In the district court, both parties moved for summary judgement.

The district court found United acted arbitrarily and capriciously for four independent reasons: 1) United abused its discretion in classifying A.K.'s care as custodial; 2) United did not fairly engage with the medical opinions of A.K.'s treating professionals; 3) United's denials did not contain reasoned analysis or specific citations to the medical record; and 4) United demonstrated a shifting and inconsistent rationale for denying benefits.[5] The district court ordered United to pay for A.K.'s treatment at Discovery, rather than remanding for internal review. United now appeals that ruling to us.

II

We review the district court's grant of summary judgement de novo, applying the same standard as the district court. Eugene S. v. Horizon Blue Cross Blue Shield of N.J., 663 F.3d 1124, 1130 (10th Cir. 2011).

Because United had "discretionary authority to determine eligibility for benefits or to construe the terms of the plan," we review the denial of benefits under an arbitrary and capricious standard. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). This deference arises out of ERISA's roots in trust law and imposition of fiduciary responsibility on administrators. Id. at 110. Under arbitrary and capricious review, the actions of ERISA administrators are upheld if reasonable

[5] We uphold the second and third of these independent grounds and decline to consider the other independent reasons for the district court's decision.

and supported by substantial evidence. Adamson v. Unum Life Ins. Co. of Am., 455 F.3d 1209, 1212 (10th Cir. 2006).

We review a district court's choice of remedy for abuse of discretion. Dowie v. Indep. Drivers Ass'n Pension Plan, 934 F.2d 1168, 1170 (10th Cir. 1991). Under the abuse of discretion standard, we defer to the district court's judgment if it is rationally "sustainable on the law and facts." Shook v. Bd. of Cnty. Comm'rs, 543 F.3d 597, 603 (10th Cir. 2008).

III

United challenges the district court's conclusion that it violated multiple ERISA requirements.[6] ERISA sets minimum standards for employer-sponsored health plans, which may be administered by a separate entity. 29 U.S.C. § 1001. Administrators, like United, are analogous to trustees of common-law trusts and their benefit determinations constitute fiduciary acts. Metro. Life Ins. v. Glenn, 554 U.S.

[6] We address United's motion to file a corrected appendix, partially under seal. Under the Tenth Circuit Rules of Appellate Procedure, appellants must provide an appendix "sufficient for considering and deciding the issues on appeal." 10th Cir. R. 30.1(B)(1). United's initial appendix did not include certain documents required under our Local Rules, as United concedes. However, once notified, United immediately moved to file and produced a substantive supplemental appendix which meets our requirements. We may certify a supplemental record when material is lacking due to "error or accident." Fed. R. App. P. 10(e)(2)(c). We do not decline an appeal if an insufficient appendix is mere "noncompliance with some useful but nonessential procedural admonition," but rather concern ourselves when such insufficiencies raise "an effective barrier to informed, substantive appellate review." McGinnis v. Gustafson, 978 F.2d 1199, 1201 (10th Cir. 1992). A.K.'s parents have not demonstrated how United's quickly remedied error could foreclose our effective review. Thus, United's motion is GRANTED and we decline the assertion that we should dismiss this appeal based on an insufficient appendix.

105, 111 (2008). That is, in determining benefit eligibility, "the administrator owes a special duty of loyalty to the plan beneficiaries." Id.

ERISA requires administrators to follow specific procedures for benefit denials. Administrators must "provide adequate notice in writing . . . setting forth the specific reasons for such denial" and "afford a reasonable opportunity . . . for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U.S.C. § 1133 (emphasis added). Claimants' full and fair review of a denial must include: "knowing what evidence the decision-maker relied upon, having an opportunity to address the accuracy and reliability of the evidence, and having the decision-maker consider the evidence presented by both parties prior to reaching and rendering his decision." Sage v. Automation, Inc. Pensions Plan & Trust, 845 F.2d 885, 893-94 (10th Cir. 1988).

Arbitrary and capricious review of the reasonableness of a benefits decision considers if it (1) "was the result of a reasoned and principled process, (2) is consistent with any prior interpretations by the plan administrator, (3) is reasonable in light of any external standards, and (4) is consistent with the purposes of the plan." Flinders v. Workforce Stabilization Plan of Phillips Petrol. Co., 491 F.3d 1180, 1193 (10th Cir. 2007) (internal citations omitted). The "consistent with the purposes of the plan" requirement means a plan administrator acts arbitrarily and capriciously if the administrator "fail[s] to consistently apply the terms of an ERISA plan" or provides "an interpretation inconsistent with the plan's unambiguous language." Tracy O. v. Anthem Blue Cross Life & Health Ins., 807 F. App'x 845, 854 (10th Cir. 2020).

A

United alleges it did not arbitrarily and capriciously fail to engage with the opinions of A.K.'s treating physicians. First, United claims it was not required to engage with treating physician opinions. Second, United claims the district court erred in only looking for proof of engagement with treating physician opinions in the denial letters provided to the claimant. United argues the district court should have considered the internal notes of reviewers, which would show it engaged with the treating physician opinions. The district court reviewed the denial letters alone and found United failed to engage as required with the medical opinions of A.K.'s treating physicians. We agree.

To their first argument, United says it was not required to engage with treating physician opinions. United claims that ERISA requirements differ for medical benefit claims and long-term disability claims, and lesser requirements for medical claims relieve them of any duty to review A.K.'s treating physician opinions. To determine United's duty, we consider ERISA caselaw and regulations.[7]

[7] To assist our evaluation of ERISA regulations, the Department of Labor (DOL) submitted an amicus brief. The nonprofit ERISA Industry Committee moved to submit an amicus brief responding to the DOL's amicus brief. The ERISA industry brief raises issues of judicial overreach into notice-and-comment rulemaking. We may consider arguments raised only in amicus briefs, but only in exceptional circumstances, such as "jurisdictional questions or . . . issue[s] of federalism or comity that could be considered sua sponte." Tyler v. City of Manhattan, 118 F.3d 1400, 1404 (10th Cir. 1997). The amicus brief discusses the appropriate role for courts in reviewing regulations, a topic we may consider sua sponte, and the motion is thus GRANTED.

When reviewing a claim for benefits, an administrator is not required to defer to the opinions of a treating physician. Black & Decker Disability Plan v. Nord, 538 U.S. 822, 831 (2003). However, a reviewer may not arbitrarily refuse to credit such opinions if they constitute reliable evidence from the claimant. Id. at 834. Medical opinions are regularly proffered as proof of a claim, and we have held reviewers "cannot shut their eyes to readily available information . . . [that may] confirm the beneficiary's theory of entitlement." Gaither v. Aetna Life Ins. Co., 394 F.3d 792, 807 (10th Cir. 2004). Therefore, if United arbitrarily refused to credit and effectively "shut their eyes" to the medical opinions of A.K.'s treating physicians, it acted arbitrarily and capriciously.

In reviewing A.K.'s claim, United specifically declined A.K.'s parents' request to consider extensive treatment opinions. A.K.'s parents provided treatment opinions from Ms. Weaster of Meridell, Dr. Diederich of Children's Medical, Dr. Reidell of Meridell, and Dr. Lowe of Discovery. Each of these treating physicians recommended that A.K. stay long-term at a residential treatment facility. Ms. Weaster noted that "ongoing specialized residential treatment . . . [would] give [A.K.] the best possible chance for a full recovery from her complex clinical issues." Dr. Diederich recommended A.K. be placed in a "single consistent program that will keep [her] until [she] can develop the needed skills to be safe." Dr. Riedel advised that A.K. "needs a long-term residential treatment center placement to accomplish the goals necessary for her to succeed and have a chance at sustaining a healthy life." Dr. Lowe asserted that A.K. "has not learned to regulate her mood outside a

structured therapeutic facility and would return to old patterns of self-harm" if discharged. United was not required to defer to Ms. Weaster, Dr. Diederich, Dr. Riedel, or Dr. Lowe's opinions but it could not simply and arbitrarily refuse to credit them. These readily available opinions would have confirmed A.K.'s theory of entitlement to coverage for her care, and United was required to engage with and address them. By not providing an explanation for rejecting or not following these opinions, that is, not "engaging" with these opinions, United effectively "shut its eyes" to readily available medical information. We hold United acted arbitrarily and capriciously.

United argues its actions were not arbitrary and capricious because it met certain ERISA regulatory requirements. It points to regulations which discuss requirements for engagement with medical opinions in ERISA disability plans. We recognize the textual difference in the ERISA disability and ERISA medical regulations pointed out by United, but disagree that the dialogue absolves United from its duty to engage in meaningful dialogue that includes a full and fair review of the insured's claim.

The regulations at issue updated the requirements administrators must follow when reviewing ERISA disability claims. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92,316, 92,316 (Dec 19, 2016). For ERISA health benefit claims, the Affordable Care Act ("ACA") strengthened procedural requirements for claim review. Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent

Coverage, Appeals, and Patient Protections Under the Affordable Care Act, 80 Fed. Reg. 72,192, 72,217 (Nov. 18, 2015). The Department of Labor chose to update ERISA disability claims largely to match. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,318.

The regulations require that administrators of ERISA disability claims issue benefit determinations containing "[a] discussion of the decision, including an explanation of the basis for disagreeing with or not following: the views presented by the claimant to the plan of health care professionals treating the claimant." Id. at 92,341; 29 CFR § 2560.503-1 (g)(1)(vii)(A)(i) (emphasis added). The information required upon review of the determination is identical. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,341; 29 CFR § 2560.503-1 (j)(6)(i)(A). The preamble noted that, in the Department's view, many of the requirements of the final rule were already required by existing ERISA regulations. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,317. However, they had found plans regularly did not apply "the letter or spirit" of existing regulatory requirements, thus an additional, more precise regulation was necessary. Id. at 92320. The preamble noted the Department was particularly concerned about the disproportionate litigation by ERISA disability plans, the "aggressive posture insurers and plans can take to disability claims," and the "judicially recognized conflicts of interest insurers and plans often have in deciding benefit claims." Id. at 92317.

United argues that the regulations established stricter requirements for ERISA disability claims while declining to establish the same requirement for ERISA medical claims. Id. at 92,318. This is simply not the case. These were guidelines clarifying the requirements for ERISA disability claims and were not requesting nor clarifying requirements for ERISA health plans. Id. at 92,316.[8] Further, the rule specifically noted the Department was merely making explicit requirements for claims review that were already required under ERISA, as prompted by confusion and litigation among claimants and insurers. Id. at 92,317. The Department's action detailing more precise requirements in ERISA disability claims does not absolve United of providing a full and fair review for health benefit claims.

These regulations, like ERISA itself, serve as minimum guidelines. 29 U.S.C. § 1001. Even if the regulations could be read as setting different baseline requirements for medical and disability claims,[9] ERISA nevertheless holds

[8] Such clarification is permissible. See Ramsey v. Commissioner of Internal Revenue, 66 F.2d 316, 318 (10th Cir. 1933) ("A regulation may make explicit what is general and clear up uncertainty.").

[9] It may be that a different baseline level of review is required for ERISA health benefit and disability claims. In that case, we consider that insurers commenting on the proposed rule suggested that most health benefits claims differ from disability claims in that they occur for a short period of time, rarely involve outside consultation, are isolated, and have limited medical information. Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. at 92,318. This logic implies that plans reviewing health benefit claims involving 1) human review of claims, 2) extensive medical information, 3) outside consultation, 4) complex determinations, and 5) a long period of time should specifically engage with medical opinions.

Applying those factors to A.K.'s situation, the result is clear: United should have engaged with the treating physician opinions. A.K. provided extensive medical

administrators to their greater fiduciary duty. An administrator must provide full and fair review of the evidence presented, through a reasonable process, as consistent with the plan. Flinders v. Workforce Stabilization Plan of Phillips Petro. Co., 491 F.3d 1180, 1193 (10th Cir. 2007). Administrators may not shirk their broad fiduciary responsibilities by pointing to a lack of specified minimum standards in a narrow area. "There is more to plan (or trust) administration than simply complying with the specific duties imposed by the plan documents or statutory regime; it also includes the activities that are 'ordinary and natural means' of achieving the 'objective' of the plan." Varity Corp. v. Howe, 516 U.S. 489, 504 (1996). The regulations do not relieve United of its responsibility to engage with medical opinions in health benefit claims.

United's second argument is that if required to engage with the opinions of A.K.'s physicians, its internal notes prove it did so. It argues the district court should have looked beyond the denial letter provided to A.K. and considered the internal notes of United's reviewers. The district court limited its review to the denial letters and found little evidence therein that reviewers engaged with treating professionals' opinions. The sole reference to treating professional's opinions the district court

---

information for United's review. Her treating teams consistently referred her to outside treating professionals who uniformly stated her need for residential care. A.K.'s case was decidedly complex, involving multiple diagnoses. Twenty months passed from A.K.'s first visit to the E.R. for cutting her wrists to her intake at Discovery. Even if the regulations establish a different baseline for some claims, a reasonable interpretation is that United is required to specifically engage with A.K.'s treating physician opinions.

found in the denial letters was a passing comment that the purpose of the treatment was to consolidate A.K.'s gains. The district court concluded United did not engage with A.K.'s extensive professional opinions.

The district court was correct to focus its review on the denial letters. ERISA denial letters play a particular role in ensuring full and fair review. ERISA regulations require that denial letters be comprehensive and include requests for additional information, steps claimants may take for further review, and specific reasons for the denial. 29 C.F.R. § 2560.503-1(f)(3); 29 C.F.R. § 2560.503-1(h)(3), (4). We have followed the Ninth Circuit in interpreting these regulations to call for a "meaningful dialogue." Gilbertson v. Allied Signal, 328 F.3d 625, 635 (10th Cir. 2003) (citing Booton v. Lockheed Medical Benefit Plan, 110 F.3d 1461, 1463 (9th Cir. 1997)). As that circuit noted:

> In simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries. If benefits are denied ... the reason for the denial must be stated in reasonably clear language, ... if the plan administrators believe that more information is needed to make a reasoned decision, they must ask for it. There is nothing extraordinary about this: it's how civilized people communicate with each other regarding important matters.

Booton, 110 F.3d at 1463. Accordingly, United must engage in reasonable, "meaningful dialogue" in their denials.

A.K.'s parents attempted to engage in meaningful dialogue with United regarding the denial of coverage by referencing the treating physician opinions. When United denied coverage due to medical necessity, notably in its third denial overall, the reviewer stated that "[t]he purpose of the admission was to consolidate

[A.K.'s] gains, as she had a history of regressing when not in a structured environment." In a three-page letter, the reviewer reasoned that further time at Discovery was not medically necessary because 1) A.K.'s diagnoses upon admission to Discovery of two different depressive disorders, anxiety disorder, and personality issues had not changed during her time there, and 2) A.K. had not attempted self-injury "in the three months prior to the adverse determination." Notably, A.K. was in active treatment at Discovery during those three months.

When A.K.'s parents appealed the denial of coverage for medical necessity, they even specifically requested justification with reference to treating physician opinions. A.K. provided the opinion of Dr. Riedel from Meridell, to address the third reviewer's reasoning that lack of change to A.K.'s diagnosis demonstrated residential treatment was no longer necessary. That opinion stated A.K. was on a "slow but steady course" and needed "to continue the work she is doing and to continue to consolidate gains," noting that A.K.'s extensive hospitalization history had been disruptive, and discharge could jeopardize progress. A.K.'s parents requested they be informed "what weight is given [to] the above professional opinions when making your next determination."

When the fourth reviewer responded to this appeal, however, they did not discuss or engage with Dr. Riedel's opinion or previously provided treating physician opinions. The fourth reviewer repeated the statements of the third reviewer in a two-page letter, stating that A.K.'s diagnoses did not change in her time at Discovery and there was no evidence of self-injurious behavior. That letter concluded that A.K.'s

treatment was not medically necessary without mentioning or addressing the treating physician opinions provided on appeal.

When A.K.'s parents appealed for a fourth time, they requested an external review. They again specifically requested that "an explanation of what weight was given to the opinions of [A.K.]'s treatment team who provided first-hand knowledge of her treatment." They noted the fourth reviewer did not address the issues they raised in their previous appeal.

The external reviewer, the fifth reviewer of A.K.'s claim, repeated the prior reviewers' reasoning. That reviewer found A.K.'s continued residential treatment not necessary because A.K. "had improved" and necessary structure could be gained in an outpatient setting. Noting that A.K. "continued to have treatment resistant behaviors" and "act[ed] out behaviorally," the reviewer nonetheless stated that "[t]hese [issues] could have been managed at a therapeutic school with intensive outpatient behavioral supports." The reviewer further noted that A.K.'s prior physicians had recommended a lengthy residential program, but dismissed those recommendations without addressing the specific reasons the physicians gave.

If the fifth reviewer had addressed those reasons, they necessarily would have wrestled with medical advice stating that A.K. needed ongoing 24-hour residential programming to build the skills necessary to survive at home, despite her temporary stabilization when in 24-hour care. For example, the reviewer would have had to address the opinion of Dr. Diederich, who stated that A.K. was part of "a small subset of children that cannot make the needed changes unless they are in a single,

consistent program that will keep them until they can develop the needed skills to be safe." Moreover, that A.K.'s acting out and treatment-resistance were because "her speed of [] processing is much slower than her peer group," which "will make many of the processes seem slower and ineffective, when really she needs a greater length of time to allow these skills to be developed." Similarly, the reviewer would have had to address the assertion by Dr. Lowe of Discovery, who stated that early discharge carried high risks because A.K. "has not learned to regulate her mood outside a structured therapeutic facility and would return to old patterns of self-harm as evidenced by her recent poor relationship[] choices, increased anxiety, emotional reactivity, refusal to use healthy coping skills, resulting in increased depression, suicidal thoughts and cutting herself." Thus, the reviewer would have had to justify their conclusion that A.K. "acting out" could be managed in an outpatient setting.

United's reviewers were not required to defer to the treating physician opinions provided. However, their duties under ERISA require them to address medical opinions, particularly those which may contradict their findings. This is the core of meaningful dialogue: if benefits are denied and the claimant provides potential counterevidence from medical opinions, the reviewer must respond to the opinions. This back-and-forth is "how civilized people communicate with each other regarding important matters." Booton, 110 F.3d at 1463. Interpreting United's legal requirements to be anything less is unreasonable. In refusing to address the treating physician opinions presented to it which could have confirmed A.K.'s need for benefits, United acted arbitrarily and capriciously.

Plan administrators must provide claimants with the rationales for denial prior to litigation because plan administrators who "have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary," preclude the claimant from "full and meaningful dialogue regarding the denial of benefits." Spradley v. Owens-Illinois Hourly Emps. Welfare Benefit Plan, 686 F.3d 1135, 1140 (10th Cir. 2012) (citation and quotation omitted). The Tenth Circuit has expressed concern that ERISA claimants would be denied timely and specific explanations and be "sandbagged by after-the-fact plan interpretations devised for purposes of litigation." Flinders v. Workforce Stabilization Plan of Phillips Petro. Co., 491 F.3d 1180, 1191 (10th Cir. 2007) (citation and quotation omitted). Lack of engagement with medical opinions is a basis for appeal of a claim, so a claimant must be informed if they received a full and fair review. It cannot be that the depth of an administrator's engagement with medical opinion would be revealed only when the record is presented for litigation. For these reasons, the district court appropriately did not credit information that was not shared with the beneficiary.

In sum, we hold United acted arbitrarily and capriciously in not engaging with the medical opinions of A.K.'s treating professionals and the district court did not err in limiting its review to denial letter provided to claimants.

B

We turn next to United's sufficiency of explanation claim. United challenges the district court's conclusion that it failed to explain its denial by applying the terms

of the plan to A.K.'s medical records. The district court found United's failure to cite any facts in the medical record constituted conclusory reasoning and thus United acted arbitrarily and capriciously. We take the district court's view of the matter.

When addressing claimant's evidence, ERISA's full and fair review requires the administrator "take[] into account all comments, documents, records, and other information submitted by the claimant relating to the claim." 29 C.F.R. § 2560.503-1(h)(2)(iv). An administrator's explanation for a denial provided during a full and fair review cannot merely reference the claimant's evidence. See Rasenack ex. Rel. Tribolet v. AIG Life Ins. Co., 585 F.3d 1311, 1326 (10th Cir. 2009). Rather, ERISA procedural regulations require the administrator "provide the claimant with a comprehensible statement of reasons for the [initial] denial." Gilbertson v. Allied Signal, Inc., 328 F.3d 625, 635 (10th Cir. 2003). In referring to a claimant's medical records, administrator statements may not be conclusory and any health conclusions must be backed up with reasoning and citations to the record. McMillan v. AT&T Umbrella Benefit Plan No. 1, 746 F. App'x 697, 705-06 (10th Cir. 2018). In other words, given that United was provided with extensive information, its conclusory responses without citing the medical record, did not constitute a full and fair review.

The denial letters only contained four statements that referenced A.K.'s condition specifically: 1) that her diagnosis and medications did not change extensively from admission to Discovery to the date of the review, 2) that the record lacked evidence of self-injurious behavior during her time at Discovery, 3) that she had "treatment resistant behaviors," and 4) that she "continued to act out

behaviorally." None of these statements were supported by citation to the record or discussed A.K.'s extensive medical history. Moreover, they could have also supported a finding that A.K. needed ongoing treatment, but the reviewers simply concluded that they indicated A.K. could be treated at a lower level of care. These statements thus lacked "any analysis, let alone a reasoned analysis." McMillan, 746 F. App'x at 706. Accordingly, the statements were conclusory and A.K.'s denial was arbitrary.

United again argues that the district court erred in not considering plan administrators' notes, which it claims adequately cite to the medical record. We reiterate our conclusion that ERISA regulations require denial letters themselves to be comprehensive, 29 C.F.R. § 2560.503-1(f)(3); 29 C.F.R. § 2560.503-1(h)(3), (4), in order to form a "meaningful dialogue" for a full and fair review, Gilbertson, 328 F.3d at 635. Review of the explanation provided to claimants must focus on the content of the denial letters.

Moreover, A.K.'s plan required that the denial letters contain sufficient explanations. An ERISA administrator is held to the specific promises in the plan because ERISA's "linchpin" is its "focus on the written terms of the plan." M & G Polymers USA, LLC v. Tackett, 574 U.S. 427, 435 (2015). We have held that a plan administrator must interpret ERISA plans consistently with the plan's unambiguous language. Tracy O. v. Anthem Blue Cross Life & Health Ins., 807 F. App'x 845, 854 (10th Cir. 2020). Therefore, United must provide the type of explanations unambiguously promised in A.K.'s plan documents.

A.K.'s plan required claims administrators to provide a written denial notification which must include "[t]he specific reason or reasons for the denial" and "[s]pecific reference to pertinent Plan provisions on which the denial was based." For denials based on medical necessity, A.K.'s plan required "an explanation of the scientific or clinical judgment for the determination, or a statement applying the terms of the Plan to the Participant's circumstances, or a statement that such explanation will be provided upon request." This requirement is similar to United's statutory obligations under ERISA. See 29 C.F.R. § 2560.503-1(g)(v)(B). We hold these plan document requirements unambiguously charge the plan administrator with supplying the specific reason for its denial and specific reference to the pertinent plan provision on which it was based. Review of the information provided to claimant may be appropriately limited to the denial letters.

We therefore conclude the district court correctly found that United acted arbitrarily and capriciously in not providing analysis or citations to the medical record in its denial letters.

IV

United also argues the district court abused its discretion when it awarded A.K. benefits outright. A court may remand for further administrative review if it determines the administrator's flawed handling could be cured by a renewed evaluation to address, for example, a "fail[ure] to make adequate findings or to explain adequately the grounds for a decision." Caldwell v. Life Ins. Co. of N. Am., 287 F.3d 1276, 1288 (10th Cir. 2002). See also Rekstad v. U.S. Bancorp, 451 F.3d

1114, 1121-22 (10th Cir. 20026) (remanding for plan administrator to examine relevant evidence). By contrast, a court may award benefits when the record shows that benefits should clearly have been awarded by the administrator. See Weber v. GE Grp. Life. Assurance Co., 541 F.3d 1002, 1015 (10th Cir. 2008). That is not the only instance in which a court may award benefits. If a plan administrator's actions were clearly arbitrary and capricious, then remand is unnecessary, and a reviewing court may award benefits. DeGrado v. Jefferson Pilot Fin. Ins. Co., 451 F.3d 1161, 1175-76 (10th Cir. 2006). Other circuits have similarly found remand unnecessary for procedural flaws. As the Second Circuit explained, remand to an insurer is not appropriate if it "serve[s] primarily to give the defendants an opportunity to retool a defective [appeals] system." Zervos v. Verizon New York, Inc., 277 F.3d 635, 648 (2d Cir. 2002). The Ninth Circuit has expressed concern with giving an additional "bite at the apple" to ERISA administrators acting unjustly. See Grosz-Salomon v. Paul Revere Life Ins. Co., 237 F.3d 1154, 1163 (9th Cir. 2001).

In considering if such a rule is appropriate here, we consider the function of judicial review for ERISA administrators. The Supreme Court has reiterated that judicial deference to ERISA plan administrators is premised on their fiduciary roles. See, e.g., Varity Corp. v. Howe, 516 U.S. 489, 506 (1996). ERISA requires fiduciaries to "discharge [their] duties with respect to a plan solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104. When the administrator's actions or structure threaten their ability to act as a proper fiduciary, the Court has given administrators' decisions less deference. See Firestone Tire and Rubber Co. v.

Bruch, 489 U.S. 101, 107-09 (1989) (disallowing the arbitrary and capricious standard of review when there is a possible conflict of interest for the administrator); Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 118 (2008) (disallowing deferential review when considering the specific facts of the case). When Congress "careful[ly] balance[ed] the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans," Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987), it did not give administrators unlimited freedom to act improperly towards claimants.

We conclude that the district court did not abuse its discretion in declining to remand. Considering the administrator's clear and repeated procedural errors in denying this claim, it would be contrary to ERISA fiduciary principles to mandate a remand and provide an additional "bite at the apple."

V

We **AFFIRM** the decision of the district court, including its grant of summary judgment favoring Plaintiff-Appellees and its order of benefits.