STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Ankit Grover, Appellant, v. South Carolina Public Employee Benefit Authority, Employee Insurance Program, Respondent.	)	Docket No. 18-ALJ-30-0435-AP **ORDER**

STATEMENT OF THE CASE

This matter is before the South Carolina Administrative Law Court (ALC or Court) in its appellate capacity pursuant to subsection 1-23-600(D) of the South Carolina Code (Supp. 2016). In the case *sub judice*, Ankit Grover (Grover or Dependent) seeks judicial review of a decision issued by the Health Appeals Committee (Committee), part of the South Carolina Public Employee Benefit Authority, Employee Insurance Program (PEBA).[1] Specifically, Grover challenges the Committee's decision to deny his insurance claim for residential rehabilitation substance abuse treatment from March 29, 2016, until his date of discharge under the Group Health Benefits Plan of the Employees of the State of South Carolina, the Public School Districts, and Participating Entities (Plan).[2] Upon careful consideration of the Record on Appeal (Record), arguments advanced in the parties' briefs, and the applicable provisions of the Plan, the Court affirms the Committee's decision.

BACKGROUND

General Background

The State of South Carolina through PEBA established the Plan to provide, among other items, health insurance coverage to participating public employees. By its stated purpose, the Plan seeks "to provide for the payment of illness, accident, or other benefits to the participants of this Plan and their eligible dependents." To manage behavioral health cases and process behavioral

[1] Effective July 1, 2012, the Employee Insurance Program was transferred to, and incorporated into, PEBA. S.C. Code Ann. § 9-4-10(I) (2019).

[2] References to the Plan in this Order refer to the version in effect throughout 2016.

health claims under the Plan, PEBA, as the Plan Administrator, retained a Behavioral Health Manager. Companion Benefit Alternatives (CBA)[3] served as the Behavioral Health Manager and, likewise, the Third Party Claims Processor. At all relevant times to this matter, Grover's father, Varun Grover (Claimant), participated as a Subscriber [4] to the Plan through his employment with Clemson University, a state-covered entity.[5] Because Claimant retained dependent child coverage for Grover from January 1, 1991, until August 1, 2016,[6] Grover also participated in the Plan throughout this period as a covered dependent.[7]

Grover has a long history of drug abuse and dependence. In an effort to have Grover receive additional treatment for his addiction and prevent continued relapse, on March 7, 2016, a member of Southwest Carolina Treatment Center, LLC (SCTC), Jennifer Jones, M Ed, CAC II, authored a letter to the Admissions Office of Pavillon Treatment Center (Pavillon), a center for the treatment of alcoholism and other drug addictions located in Mill Spring, North Carolina.[8] The letter described, *inter alia*, Grover's past drug abuse and dependence along with his unsuccessful rehabilitative outpatient efforts at SCTC, which began on June 5, 2014, and continued intermittently until February 26, 2016. In closing, Jones stated that, "[i]t is the opinion of this program that [] Grover has given evidence of Chronic Relapse and a need for a higher level of care." Additionally, in seeking Grover's admittance to Pavillon, the letter specified: "It is our hope that your program will be able to give the necessary evaluation and support that will help him gain a long and healthy recovery from substance use disorder."

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[3] CBA is a wholly-owned subsidiary of BlueCross BlueShield South Carolina (BCBSSC). The Plan is self-insured, meaning that the funds and the rules at issue belong to the State, and third-party claims administrators, such as CBA and BCBSSC, administer claims with those funds in accordance with the Plan's rules. To that end, CBA reviews behavioral health claims to ensure that the services an individual received are covered under the Plan and medically necessary.

[4] In relevant part, the Plan defines a Subscriber as an active or retired employee.

[5] Under the Plan, state-covered entity means "[a]ny State agency, public school district, or any other entity granted the right to participate in the Plan by law and participating in the Plan."

[6] August 1, 2016, represents the date correlating to the first month after Grover turned twenty-six years old.

[7] In relevant part, the Plan defines a Dependent under paragraph 2.26 as a "[c]hild younger than 26 years of age. The Plan Administrator [PEBA] may require the Subscriber to submit due proof of the Child's relationship with the Subscriber within 31 days of enrollment, and at such other reasonable times[.]" The Plan goes on to define Covered Dependent as "[a] Subscriber's Dependent, who has met the eligibility requirements and is enrolled under the Plan."

[8] The Committee attributed this letter to Dr. Richard Sherman, D.O., who is the physician listed on the SCTC letterhead.

Thereafter, on March 12, 2016, Pavillon admitted Grover for inpatient substance abuse treatment. Grover's diagnoses included: "cannabis use disorder, severe, sedative hypnotic use disorder, severe, opiate use disorder, severe[,] and alcohol use disorder, moderate."[9] His multiaxial diagnosis[10] was: Axis I: alcohol dependence; cannabis dependence; Axis II: deferred; Axis III: essential (hemorrhagic) thrombocythemia; Axis IV: primary support; Axis V: a Global Assessment of Functioning of 25.[11] In a March 12, 2016, nursing assessment, Grover reported his drug usage history, which included his last use of certain drugs: last used an opiate on March 12, 2016; last used cannabis on March l, 2016; last used Xanax on March 10, 2016; last used alcohol on March 9, 2016; and he reported no use of Oxycodone in the past thirty days.

Following his admission, Grover resided at Pavillon and received various forms of treatment through his discharge, which, according to a May 24, 2016, letter from Pavillon's chief operating officer, occurred on May 27, 2016.[12] After his discharge, Grover stayed at Pavillon Place recovery residence in Greenville, South Carolina, for approximately three months. According to his last medical record, a September 13, 2016, psychiatric note, Grover denied any relapse and reported that he had been attending meetings.

Independent Physician Reviews of Grover's Records

Prior to the Committee's review, CBA had several independent physicians examine Grover's file to assist in determining whether to grant or deny benefits for his residential

[9] His diagnoses also included hypertension and exercise-induced asthma.

[10] A multiaxial assessment includes five Axes, summarized in order as follows: I-clinical disorders and other related conditions; II-personality disorders or mental retardation; III-general medical conditions; IV-psychosocial and environmental problems; V-overall global assessment of functioning. *See Am. Psychiatric Ass'n, Diagnostic, & Statistical Manual of Mental Disorders* (4th ed. text rev. 2000).

[11] The Global Assessment of Functioning (GAF) is a numeric scale (0 through 100) used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological functioning of adults. A GAF score in the 21-30 range indicates "Behavior is considered influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas." *Am. Psychiatric Ass'n, Diagnostic, & Statistical Manual of Mental Disorders* (4th ed. text rev. 2000). The Committee noted that Grover's GAF rose to 30 by March 14, 2016.

[12] The Committee did not make a factual finding regarding Grover's date of discharge and this Court is unable to do so on appeal. Grover references May 27, 2016, as the date of discharge in the "Statement of the Case" section of his brief. *See* SCALC Rule 37(B) ("Any matters stated or alleged in a party's statement [of the Case] shall be binding on that party."). In its brief, PEBA, while not supplying a date of discharge, does not take issue with Appellant's asserted date of discharge. Nevertheless, for clarity in the discussion to follow, Grover's discharge date will be referred to as "May 2016". The Court further notes that the May 27, 2016, letter also detailed that Grover had completed the "Professionals program" while at Pavillon.

rehabilitation substance abuse treatment at Pavillon.[13] First, on March 14, 2016, a board-certified psychiatrist with a specialty in addiction medicine, Zachary Stroud, M.D., reviewed Grover's file. Upon completion, Dr. Stroud recommended that Grover's request for residential rehabilitation substance abuse treatment benefits from his admission through his date of discharge be denied. Dr. Stroud specified:

> A [residential level of care] is being requested for this patient [Grover] who has primarily an opioid and THC [cannabis] use disorder. Irregular Xanax and [alcohol] use are reported. His [urinalysis] is positive for THC only. The [patient does not] currently appear to be in any imminent danger at this time and there is no indication that he could not be managed outside of a 24 [hour] monitored environment. He has been on medication assisted treatment such as Suboxone and Methadone in the past and has continued to use other opioids. Vivitrol may be another treatment option. His parents are listed as being a sober support. All of the items listed in the treatment plan (CD education, therapy, relapse prevention) could be addressed in a less intensive setting. The outpatient setting also requires the patient to cope with everyday situations that will be encountered on discharge and may promote better coping skills. Criteria 2 and 4 are not met.[14] I would not approve. The [patient] could be managed at a [lower level of care] like [intensive outpatient program treatment] while also in sober living and/or while receiving medication assisted treatment such as Naltrexone/Vivitrol.

Next, on March 17, 2016, board-certified adult psychiatrist, Richard Cottrell, D.O, reviewed the clinical information and concluded that Grover did not meet CBA's medical necessity criteria for admission for residential rehabilitation substance abuse treatment. Dr. Cottrell found that no severe functional impairments were reported. He noted that Grover was not reported to have any medical or mental health issues that would require twenty-four-hour supervision. He also

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[13] CBA also had several independent physicians review Grover's separate claim for inpatient substance abuse treatment while at Pavillon. All of these physicians, with the exception of Dr. April Richardson, recommended denying coverage for inpatient substance abuse treatment. The Committee awarded Grover benefits for this level of care from March 12-March 14, 2016, and this conclusion is unchallenged on appeal. Accordingly, the Court has omitted any discussion of reviews dealing solely with inpatient substance abuse treatment.

[14] CBA's 2016 Substance Use Disorder Residential Treatment - Rehabilitation Admission Criteria provides certain requirements, including criteria two and four, that must be met. Criterion two provides that an individual must exhibit that "[a]ctive Substance Use Disorder related behaviors have occurred within one week of the current treatment episode and the member is manifesting acute behavioral health/Substance Use Disorder related symptoms that would result in serious harm and cannot be managed outside of a 24-hour structured setting." Criterion four provides that there must be a "clear clinical indication that if treatment services as currently provided in the plan of care were withdrawn, the patient's condition would deteriorate and likely require the patient to be moved to a more supervised level of care."

observed that there were no abnormal vitals, severe medication side effects, threatening or physically aggressive behavior, acute comorbid medical complications or acute withdrawal symptoms reported. Based on the foregoing, Dr. Cottrell opined that Grover could be treated safely and effectively at a lower level of care. Thereafter, on March 22, 2016, Dr. Stroud conducted a second review of Grover's clinical records. In recommending that Grover's request for residential rehabilitation substance abuse treatment be denied, Dr. Stroud provided the same explanation as he previously did on March 14, 2016.

CBA then sent Grover's file to Phillip Helding, D.O., a board-certified adult, child, and adolescent psychiatrist. On August 29, 2016, Dr. Helding recommended denying all of Grover's residential rehabilitation substance abuse treatment as not medically necessary. He offered the following justification:

> [Grover] has no dangerous withdrawal. [Grover] is not at risk for a higher level of care. [Grover] has not had multiple unsuccessful attempts at recovery at a less restrictive level of care. [Grover] is not an imminent risk to self or others. [Grover] has no medical or mental health issues that require this level of care. [Grover] has no aggressive or threatening behaviors. [Grover] can be treated at a less restrictive level of care.

After the receipt of additional medical records on January 12 and January 19, 2017, PEBA requested that CBA perform an additional medical review of Grover's file.[15] On May 10, 2017, a board-certified psychiatrist, April Richardson, M.D., conducted a final independent review. Regarding Grover's residential rehabilitation substance abuse treatment, Dr. Richardson recommended that his claim be approved from March 15, 2016, through March 28, 2016. However, after March 28, 2016, Dr. Richardson recommended denying the remaining dates of service. In reaching her conclusion, Dr. Richardson stated, in relevant part:

> The facility initially requested [an] inpatient detoxification level of care for a patient with opioid, sedative/hypnotic, alcohol, and cannabis use disorder. He was using sedative/hypnotics daily for the past 2-3 months and was using a quantity sufficient to cause withdrawal symptoms. He was on Suboxone at the time as well for opioid use disorder. This combination can be dangerous if unsupervised. He was also drinking 2-5 drinks on a regular basis, drinking 20 out of the prior 30 days. Due to both sedative/hypnotic use and alcohol use, he would be at risk for withdrawal complications. . . . [R]egarding the request for Residential

[15] Significantly, these records included the March 7, 2016, letter from Dr. Sherman (Jennifer Jones, M Ed, CAC II) referenced earlier, which the Committee observed had not been received by PEBA previously, and an undated statement from John M. Roberts, M.D., one of Grover's attending physicians at Pavillon. Dr. Roberts' letter will be discussed in detail, *infra*.

> Rehabilitation level of care, the patient [Grover] had been in several lower levels of care. Immediately prior to admission to this level of care, he was attending an intensive outpatient treatment program and was on medication assisted treatment (Subutex). Despite this intensive treatment, he continued to use substances. He would benefit from a more structured level of care, and decompensation in a less restrictive setting would have been likely. I would approve 2 weeks of Residential Rehabilitation level of care. With covered dates: 3/15/16-3/28/16. After 3/28/16, he could be treated in a less restrictive setting.

Procedural History

On March 14, 2016, CBA sent identical letters to Grover, his provider, and Pavillon denying benefits for residential rehabilitation substance abuse treatment from his admission through his discharge. Benefits were denied because Pavillon's "clinical information did not document risk of medical complications if [Grover was] not receiving, 24-hour a day, medically monitored treatment." Afterward, on March 22, 2016, CBA again sent matching letters to Grover, his provider, and Pavillon regarding its decision to deny benefits for Grover's residential rehabilitation substance abuse treatment from admission through his discharge. CBA based its denial on the same rationale stated in its March 14, 2016, decision. Following Grover's July 1, 2016, appeal, on August 30, 2016, CBA sent identical letters to Grover's counsel, Pavillon, and Grover's provider noting Grover's claim for residential rehabilitation substance abuse treatment was denied as not medically necessary. CBA reasoned that Pavillon's "clinical information did not document withdrawal symptoms and/or unstable medical issues due to substance abuse, nor unstable mental health symptoms requiring medical monitoring and management in a 24[-]hour structured setting."

After Grover availed himself of CBA's appeal process, on September 15, 2016, PEBA received a letter from Grover's counsel, who, on his behalf, sought review of CBA's most recent decision. Pursuant to that request and after gathering Grover's claim file from CBA, PEBA referred Grover's appeal to the Committee for a *de novo* review. In the interim, on January 19, 2017, PEBA received a letter from Grover's counsel asking the Committee to consider an enclosed, undated statement from one of Grover's treating physicians at Pavillon, a board-certified psychiatrist with a specialty in addiction medicine, John M. Roberts, M.D. In his statement, Dr. Roberts recounted Grover's substance abuse history, the ramifications stemming from his abuse, and his treatment history. In particular, Dr. Roberts characterized Grover's substance abuse history as "substantial and prolonged." Additionally, regarding the treatment Grover received before

admittance to Pavillon,[16] Dr. Roberts observed that Grover "attempted several rounds of outpatient treatment to no avail" and emphasized that those "outpatient treatments would be successful for a period of time, however, [] Grover continuously and consistently relapsed after [those] outpatient treatments." In conclusion, Dr. Roberts opined that it was medically necessary, as that phrase is defined in the Plan, for Grover to be engaged in a residential rehabilitation substance abuse treatment program from his admission at Pavillon through his discharge. To that end, Dr. Roberts explained:

> I think [] Grover's history clearly demonstrates that intensive outpatient programs are not conducive to his needs and did not adequately treat him. It is my medical opinion that only an inpatient hospital stay with around the clock supervision and little to no access to the outside world and/or triggers is what [] Grover needed in order to adequately cope with his addiction.
>
> I believe it can be seen from his previous attempts at intensive outpatient programs that these programs do not fit his needs. Therefore, I believe that it was medically necessary for him to receive residential treatment beginning March 12, 2016[,] at [Pavillon]. During his hospitalization[,] he was able to detox and learn to handle his addiction. I do not believe that he would have been able to effectively withdraw from using cannabis, benzodiazepines, opiates, and alcohol while engaged in an intensive outpatient program as his history seems to indicate that such treatment was not effective.

On January 3, 2018, the Committee issued an initial decision.[17] The Committee approved Grover's claim for inpatient substance abuse treatment from March 12, 2016, through March 14, 2016, and two weeks of his residential rehabilitation substance abuse treatment claim from March 15, 2016, through March 28, 2016. The Committee denied all later dates of treatment for residential rehabilitation substance abuse on the grounds that it was not medically necessary.

On January 17, 2018, Grover filed an appeal with the ALC seeking judicial review of the Committee's decision. The matter was assigned to the undersigned on January 25, 2018. Following PEBA's Motion for Remand and Dismissal Without Prejudice by and with the consent of Grover, on May 8, 2018, the Court dismissed the matter without prejudice and remanded it to the

[16] Dr. Roberts also noted Grover received psychiatric treatment in 2010, 2012, and 2013, and attended outpatient and intensive outpatient programs in 2015 and 2016.

[17] As will be explained *infra*, that decision is not the subject of the present appeal. Rather, following the Court's remand, the Committee issued the presently challenged decision on November 9, 2018. The November 9, 2018, decision, however, incorporates the majority of the initial decision.

Committee for consideration of additional records that had been inadvertently omitted during the Committee's review process.

Given the Court's remand, the Committee, on June 13, 2018, again met and considered Grover's appeal and conducted a *de novo* review.[18] Following examination of Grover's medical records, the pertinent provisions of the Plan, and all other documents contained in the administrative record, on November 9, 2018, the Committee issued its decision. The sole issue before the Committee was whether CBA correctly denied Grover's request for benefits for his residential rehabilitation substance treatment from March 29, 2016, through his date of discharge.[19] Ultimately, the Committee determined: "Attorney's request for benefits for Dependent's residential rehabilitation substance abuse treatment at Pavillon, from March 29, 2016[,] through his date of discharge, was properly denied as not medically necessary; no benefits are payable for the treatment pursuant to paragraphs 2.49, 7.7, and 9.A of the Plan."

Subsequently, on November 21, 2018, Grover properly filed his Notice of Appeal with this Court seeking review of the Committee's decision. This matter was assigned to the undersigned on November 29, 2018. On January 14, 2019, PEBA timely filed the Record. On March 15, 2019, and April 3, 2019, Grover and PEBA respectively timely filed their appellate briefs.

STANDARD OF REVIEW

Significant to this appeal, PEBA's board of directors has the authority to establish the procedure by which Employee Insurance Program decisions are made. *See* S.C. Code Ann. § 1-11-710(C) (2005). This subsection establishes PEBA as the final agency arbiter of disputes under the Plan and further provides:

> Notwithstanding Sections 1-23-310 and 1-23-320 or any other provision of law, claims for benefits under any self-insured plan of insurance offered by the State to state and public school district employees and other eligible individuals must be resolved by procedures established by the board [Board of Directors of the South Carolina Public Employee Benefit Authority], which shall constitute the exclusive remedy for these claims, subject only to judicial review consistent with the standards provided in Section 1-23-380.

Id.

[18] This review included the evidence previously considered by the Committee during its initial review and the additional documents that were inadvertently omitted from Grover's claim file.

[19] Grover's request for benefits for inpatient substance abuse treatment was approved from March 12, 2016, through March 14, 2016, and his residential rehabilitation substance abuse treatment was approved from March 15, 2016, through March 28, 2016. The dates approved by the Committee are no longer in dispute.

Because this case is before the Court on appeal from a final decision of the Committee, the Court's review is governed by section 1-23-380 of the South Carolina Code of Laws (Supp. 2016). *See* S.C. Code Ann. § 1-23-600(E) (Supp. 2016) (directing administrative law judges to conduct appellate review in the same manner prescribed in section 1-23-380). Pursuant to this standard, the Court "may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact." *Id.* § 1-23-380(5) (Supp. 2016). Although the Court may affirm the agency's decision or remand for additional proceedings, the Court's review in determining whether to reverse or modify an agency decision is circumscribed to the following:

> The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
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> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) made upon unlawful procedure;
> (d) affected by other error of law;
> (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Id. § 1-23-380(5)(a)-(f) (Supp. 2016). Therefore, the Court can reverse the Committee "if the findings are affected by error of law, are not supported by substantial evidence, or are characterized by abuse of discretion or clearly unwarranted exercise of discretion." *Olson v. S.C. Dep't of Health & Envtl. Control*, 379 S.C. 57, 63, 663 S.E.2d 497, 501 (Ct. App. 2008). Furthermore, when reviewing, the Court is generally confined to the record presented and, as such, will not consider any fact that does not appear in the record. S.C. Code Ann. § 1-23-380(4) (Supp. 2016); *see also* SCALC Rule 36(G).

ISSUE ON APPEAL

> Whether substantial evidence supports the Committee's decision to deny Grover's claim for residential rehabilitation substance abuse treatment from March 29, 2016, through discharge.[20]

DISCUSSION

[20] While Grover lists the issue as whether he is entitled to "dependent rehabilitation substance abuse treatment from March 28, 2016[,] through date of discharge[,]" the Court believes that he committed a scrivener's error as the Committee awarded him benefits for March 28, 2016, but denied benefits for residential rehabilitation substance abuse treatment from March 29, 2016, through discharge.

Grover contends that reversal is warranted on the basis that the Committee's decision to deny his claim is clearly erroneous in view of the reliable, probative, and substantial evidence on the entire Record. For the reasons that follow, the Court disagrees.

I. Applicable Statutory Authority, Provisions of the Plan, and CBA's Utilization Guidelines.

Eligibility requirements for participation in PEBA plans for both active and retired employees are set forth by statute:

> (A) The Board shall:
>
> > (1) make available to active and retired employees of this State and its public school districts and *their eligible dependents* group health, dental, life, accidental death and dismemberment, and disability insurance plans and benefits in an equitable manner and of maximum benefit to those covered within the available resources[.]

S.C. Code Ann. § 1-11-710(A)(1) (Supp. 2016) (emphasis added). The Plan, which is established for active employees of this State and their eligible dependents, contains several definitions and provisions that are germane to this appeal. Initially, under paragraph 1.1, the Plan's stated purpose "is to provide for the payment of illness, accident, or other benefits to the participants of this Plan and their eligible dependents." In that regard, paragraph 2.22 of the Plan defines Covered Medical Benefit as:

> Medical services . . . Medically Necessary in the diagnosis or treatment of an illness or injury, performed and reimbursed in the least costly setting required by the Covered Person's condition, and which are within the benefits provided in the Plan and not otherwise excluded by any term, condition, limitation or exclusion of this Plan.

More precisely, Covered Medical Benefits, as described in paragraph 7.2(M) of the Plan, includes: "Inpatient treatment of Behavioral Health Disorders,[21] Alcoholism,[22] and Drug

[21] Under paragraph 2.11 of the Plan, Behavioral Health Disorders means:

> Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind or other condition that is defined, described or classified as a psychiatric disorder or condition in the latest publication of the American Psychiatric Association entitled *Diagnostic and Statistical Manual of Mental Disorders*, or other similar authority generally recognized by Behavioral Health Providers, and which is not otherwise excluded by the terms and conditions of this Plan.

[22] Under paragraph 2.5 of the Plan, Alcoholism means "[a] morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health and social or economic functioning."

Abuse,[23] up to the benefits specified in paragraph 7.7 in a Hospital, and, where applicable, subject to Pre-Certification by the Behavioral Health Manager[.]" Under article 9 of the Plan, whether any services, supplies, or charges, will be excluded turns on whether they are Medically Necessary:

> No benefits will be provided under Any Article of this Plan for any service, supply or charges for the following:
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> A. Any service or charge for service which is not Medically Necessary as defined in paragraph 2.49; any service or charge for service which is performed in a more costly setting than that required by a Covered Person's condition, in which case benefits will be limited to the benefits due had the services been performed in the least costly setting required by the Covered Person's condition.

The Plan goes on to define "Medical Necessity," "Medically Necessary," or "Necessary Service and Supply" under paragraph 2.49 as:

> A procedure, service or supply that meets all of the following criteria:
>
> A. Is required to identify or treat an existing condition, illness or injury; and
> B. Is prescribed or ordered by a Physician; and
> C. Is consistent for treatment of the Covered Person's illness, injury, or condition, and is rendered in accordance with recognized, appropriate medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered; and
> D. Is required for reasons other than the convenience of the patient; and
> E. Results in measurable, identifiable progress in treating the Covered Person's condition, illness, or injury.
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> The fact that a procedure, service or supply is prescribed by a Physician, or that a Physician asserts that a procedure, service or supply is necessary to avoid the potential onset of a condition or abnormality in the future, does not automatically mean that such procedure, service or supply is Medically Necessary or meets the definition of Medical Necessity in this Plan.

Relevant to this instance, paragraph 7.7 of the Plan addresses coverage of Behavioral Health Disorders and provides that "the Plan will pay covered expenses for inpatient, outpatient, or Partial Hospitalization Programs rendered by a Behavioral Health Provider [24] for Behavioral

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[23] Under paragraph 2.28 of the Plan, Drug Abuse means "[t]he excessive consumption, ingestion, injection, or other utilization of any drug or other substance not medically prescribed or administered or the over-utilization or excessive consumption of any drug which is medically prescribed or administered."

[24] Paragraph 2.13 defines Behavioral Health Provider as:

> A psychiatrist, psychologist, psychological/neuropsychological tester, Master's Level Therapist, Registered Nurse (including Advanced Practice Registered Nurse), full Board Certified Behavior Analyst (for Applied Behavioral Analysis only), or any other entity or individual or institutional health care provider eligible

Health Disorders, Alcoholism, and Drug Abuse." However, "[a]ll care must be in accord with the utilization guidelines established by the Behavioral Health Manager for specified levels of care, and, where applicable, pre-certified by the Behavioral Health Manager." In accordance with paragraph 7.7 of the Plan, CBA's 2016 Substance Use Disorder Residential Treatment - Rehabilitation Admission Criteria provides:

> *Must have **all:***
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> *1) *A DSM diagnosis of Substance Use Disorder, which is the primary focus of treatment each program day.*
> *2) *Active Substance Use Disorder related behaviors have occurred within one week of the current treatment episode and the member is manifesting acute behavioral health/Substance Use Disorder related symptoms that would result in serious harm and cannot be managed outside of a 24-hour*
> *structured setting.*
> *3) *The treatment is individualized and not determined by a programmatic timeframe. It is expected that the patient will be prepared to receive a significant amount of care in the community.*
> *4) *There is clear clinical indication that if treatment services as currently provided in the plan of care were withdrawn, the patient's condition would deteriorate and likely require the patient to be moved to a more supervised level of care.*
> *5) *There is a reasonable expectation that sobriety is an attainable goal, despite repeated relapses, and this treatment is not expected to be successful in a lower level of care.*
>
> ***SERVICE INTENSITY***
> *Must have **all:***
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> *6) * The facility is licensed by the appropriate agency.*
> *7) * The facility maintains permanent and full-time facilities for bed care of resident patients.*
> *8) * The patient is seen daily by a licensed or certified for chemical dependency, behavioral health practitioner with appropriate documentation for each contact.*
> *9) *A psychiatrist, addictionologist or physician extender is responsible for diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week and as indicated and is available 24 hours per day, seven days per week.*
> *10) * Licensed clinical or certified for chemical dependency staff is available on site 24 hours per day, seven days per week, to adequately supervise the patient's medical and psychological needs.*

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to participate in the Behavioral Health Provider Network and acting within the scope of his or its own current, active license.

*11) * The facility has a registered nurse (RN) present on site that is in charge of patient care along with one or more RNs or licensed practical nurses (LPNs) on site at all times (24 hours per day, seven days per week).*

*12) * The facility is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, halfway house, sober living residence, wilderness camp or any other facility that provides custodial care.*

CBA's 2016 Substance Use Disorder Residential Treatment- Rehabilitation Continued Stay Review Criteria (Continued Stay Review Criteria) states:

***NOTE:** Completing the program structure (fixed number of visits, waiting for family interventions, completion of step work, written autobiography. etc.) is not the sole reason for continued stay in the program.*

*Must have **all:***

*1) * The patient's condition continues to meet admission criteria and this level of care remains necessary to treat the intensity, frequency and duration of current behaviors and symptoms.*

*2) * There is compliance with all aspects of the treatment plan, unless clinically precluded as documented by the facility. Treatment plan must demonstrate how the patient is expected to promote personal responsibility and reintegration into the network systems of work, education and family life.*

*3) * Treatment plan and documentation reflect opportunities for the patient to practice skills gained in residential treatment setting. There is evidence of documented weekly outings and family/therapeutic passes of increasing frequency and intensity, unless clinical precluded as documented by the facility.*

*4) * There is reasonable expectation for further improvement in the targeted acute behavioral health symptom(s) with continued rehabilitation treatment at this level of care that only this level of care can provide.*

*5) * If treatment progress is not evident, then there is documentation of treatment plan revisions to address lack of progress and there is fair likelihood that the member will demonstrate progress with these changes.*

*6) *Active discharge planning is documented and updated weekly with attention given to family issues. living situation. follow-up care and other issues, as dictated by the clinical condition.*

*7) * Weekly family sessions by a licensed behavioral health practitioner occur face-to-face, via telephone or via secure electronic means, unless clinically precluded as documented by the facility.*

*8) * There is significant documentation of inadequate progress on problems that could lead to early relapse, despite intensive daily facility interventions/treatment planning **and** this requires the ongoing structure of this level of care to assess and treat in a timely fashion.*

SERVICE INTENSITY

*Must have **all:***

*9) * The facility is licensed by the appropriate agency.*

*10) * The facility maintains permanent and full-time facilities for bed care of resident patients.*

*11) * The patient is seen daily by a licensed or certified for chemical dependency, behavioral health practitioner with appropriate documentation or each contact.*

*12) *A psychiatrist, addictionologist or physician extender is responsible for diagnostic evaluation, provides face-to-face evaluation services with documentation a minimum of once per week and as indicated and is available 24 hours per day, seven days per week.*

*13) * Licensed clinical or certified for chemical dependency staff is available on site 24 hours per day, seven days per week, to adequately supervise the patient's medical and psychological needs.*

*14) *The facility has a registered nurse (RN) present on site that is in charge of patient care along with one or more RNs or licensed practical nurses (LPNs) on site at all times (24 hours per day, seven days per week).*

*15) * The facility is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, halfway house, sober living residence, wilderness camp or any other facility that provides custodial care.*

Lastly, CBA's 2016 Substance Use Disorder Residential Treatment- Rehabilitation Discharge Criteria (Discharge Criteria) reads:

If one of these is met, requirements for benefit approval are no longer satisfied:

1) Despite intensive efforts, the patient remains non-compliant with the treatment plan and thus is unlikely to benefit from further treatment.

2) There is significant documented reduction in the intensity, duration and frequency of the symptoms/behaviors that resulted in the admission so that the patient's current behaviors and symptoms meet criteria for another level of care.

3) The patient has reached treatment goals as outlined in the master treatment plan or has reached maximum benefit from the treatment.

4) The individual no longer meets criteria for this level of care, but discharge disposition and/or planning has not yet been completed and/or placement is pending.

II. Substantial Evidence Supports the Committee's Decision.

As noted *supra*, Grover generally contends that the Committee's decision to deny his claim is unsupported by substantial evidence. The thrust of Grover's sole assignment of error, however, concentrates on the Committee's reliance on the reviewing physicians' medical opinions,[25] which he maintains were problematic for the following reasons: (1) they "cherry picked" evidence from his medical records; and (2) they ignored pertinent evidence [26] that supported the medical necessity of his residential rehabilitation substance abuse treatment from March 29, 2016, through discharge.[27]

Before analyzing whether substantial evidence supports the Committee's conclusion, the Court will briefly address Grover's specific claims regarding the reviewing physicians' opinions and the Committee's reliance thereon. To further his assertion that the reviewing physicians ignored evidence that demonstrated the medical necessity of his care, Grover maintains that "[n]owhere in [the] reviewing physicians' opinions do any of them discuss [his] various attempts at outpatient treatments and how those have been unsuccessful. The only references to previous outpatient treatment is [sic] only in passing, if it is mentioned at all." Grover further insists that

[25] By failing to name the "reviewing physicians," the Court is left to speculate as to their identity. This is especially problematic given that numerous independent physicians reviewed Grover's claim for either residential rehabilitation substance abuse treatment or inpatient substance abuse treatment. Notwithstanding, out of the abundance of caution and given that only a portion of Grover's residential rehabilitation substance abuse treatment is at issue, the Court assumes that Grover is referring to each of the four physicians who reviewed his file exclusively for residential rehabilitation substance abuse treatment. Those physicians include: Dr. Stroud, Dr. Helding, Dr. Cottrell, and Dr. Richardson.

[26] As will be explored further below, the Court believes the "pertinent evidence" to which he refers is evidence relating to his various attempts at outpatient treatment and Dr. Roberts' undated statement.

[27] Grover cites *Winkler v. Metropolitan Life Ins. Co.*, 170 Fed. Appx. 167 (2d Cir. 2006) in support of his assertion regarding "cherry picking" and *Waldoch v. Medtronic, Inc.*, 757 F.3d 822 (8th Cir. 2014) in support of his contention regarding pertinent evidence. Regardless of whether or not these cases constitute binding authority, this Court does not take issue with the propositions for which Grover relies upon them. As will become clear, however, the Court believes that the Committee performed a comprehensive evaluation of all the evidence before it and further, did not engage in "cherry picking." Moreover, the Court has considered both previous ALC decisions Grover appended to his brief and notes that *White v. South Carolina Budget & Control Board* No. 07-ALJ-30-0567-AP, 2008 WL 4659524 (S.C. Admin. Law Judge Div. Sept. 22, 2008) is particularly applicable here because of the ALC's recognition that under the substantial evidence standard, the Court's role is not to weigh conflicting evidence but to determine whether sufficient evidence exists to support the agency decision.

"none of [PEBA's] reviewing physicians seem to give any of [his] failed outpatient attempts at treatment consideration in their opinions." A review of Dr. Richardson's statement causes the Court to reject Grover's position. To wit, before providing her recommendation, Dr. Richardson unequivocally discussed Grover's past attempts at intensive outpatient treatment and observed that, despite said treatment, he continued to use substances:

> Regarding the request for Residential Rehabilitation level of care, the patient [Grover] had been in several lower levels of care. Immediately prior to admission to this level of care, he was attending an intensive outpatient treatment program and was on medication assisted treatment (Subutex). Despite this intensive treatment, he continued to use substances. He would benefit from a more structured level of care, and decompensation in a less restrictive setting would have been likely.

Likewise, and more importantly, the Committee explicitly made detailed factual findings regarding Grover's past outpatient treatment history and incorporated Dr. Richardson's entire review.

Moreover, to the extent Grover discounts the reviewing physicians' opinions on the basis that "none of [them] ever discuss or address Dr. Roberts' opinion[,]" the Record contains no evidence that Dr. Roberts' opinion was provided to any of the reviewing physicians as part of their respective assessments, and Grover has pointed to no evidence establishing such. Indeed, the Record reveals that Dr. Roberts' statement was supplied to PEBA as part of a letter received on January 19, 2017, a date well after three of the four reviewing physicians—Drs. Stroud, Helding, and Cottrell—had evaluated Grover's claim for residential rehabilitation substance abuse treatment.[28] While Dr. Richardson does not specifically reference Dr. Roberts' opinion, given PEBA's receipt of the same in January 2017, that opinion would have, conceivably, been made a part of Grover's file at the time of her review.[29] Even so, assuming *arguendo* that Dr. Roberts' statement was not supplied to any of the reviewing physicians, Grover can hardly establish prejudice therefrom as PEBA, in its *de novo* review, directly considered the statement and made

[28] Because Dr. Roberts' statement is undated, the Court can only speculate as to when he authored it. Given that Dr. Roberts opined that Grover's residential rehabilitation substance treatment was medically necessary effective March 12, 2016, and extending through his discharge, it seems logical that the letter was completed after Grover's May 2016 discharge.

[29] This is significant for another reason. Drs. Stroud and Cottrell reviewed Grover's records in March 2016, a period in which Grover was still undergoing treatment at Pavillon and prior to his May 2016 discharge. Thus, only Drs. Helding and Richardson ostensibly had the complete medical file from Pavillon at the time of their respective reviews. Although Dr. Helding would have had complete medical records from Pavillon, he would not have had Dr. Roberts' letter at the time of his review.

factual findings therefrom. *See Sanders v. Wal-Mart Stores, Inc*., 379 S.C. 554, 562, 666 S.E.2d 297, 301 (Ct. App. 2008) ("An error not shown to be prejudicial does not constitute grounds for reversal.") (quoting *JKT Co. v. Hardwick*, 274, S.C. 413, 419, 265 S.E.2d 510, 513 (1980)); *see also Visual Graphics Leasing Corp. v. Lucia*, 311 S.C. 484, 489, 429 S.E.2d 839, 841 (Ct. App. 1993) ("An error is not reversible unless it is material and prejudicial to the substantial rights of the appellant.") (citation omitted).

In view of the foregoing, the Record amply makes plain that the Committee, the entity ultimately tasked with determining whether an individual's claim for a procedure, service or supply meets the Plan's definition of medical necessity, did not "cherry pick" from Grover's medical records and ignore relevant evidence in making its determination. To the contrary, PEBA's final decision evinces an exhaustive review of Grover's complete records. It made numerous findings of fact including those related to Grover's medical and treatment history prior to admission to Pavillon, and his treatment while at Pavillon. Moreover, as outlined earlier, PEBA specifically considered Dr. Roberts' statement.

At any rate, the decisive question is not whether the Committee did or did not wrongfully rely on the reviewing physicians' opinions, but whether the Committee's conclusion—denying his claim for residential rehabilitation substance abuse treatment from March 29, 2016, through discharge—is supported by substantial evidence. In that regard, Grover fails to recognize that the Committee, in rejecting his claim for residential rehabilitation substance abuse treatment for the period at issue, did not exclusively rely on the reviewing physicians' opinions. Rather, along with the reviewing physicians' opinions, the Committee grounded its determination on a full review of Grover's records, the pertinent provisions of the Plan, and CBA's utilization guidelines. Specifically, the Committee found that, from March 29, 2016, until his discharge, Grover failed to satisfy either criterion one or eight of CBA's Continued Stay Review Criteria. The Committee also found that Grover satisfied criterion two of CBA's Discharge Criteria.[30] As a result, the Committee determined that Grover's residential rehabilitation substance abuse treatment at Pavillon from March 29, 2016, through his discharge was not medically necessary pursuant to paragraph 2.49 of the Plan.

[30] The requirements of criteria one and eight of CBA's Continued Stay Review Criteria and criterion two of the Discharge Criteria are detailed above.

Accordingly, the issue now before the Court is whether there is substantial evidence in the Record to support the Committee's denial of his claim for residential rehabilitation substance abuse treatment for the specified period. Because Grover is challenging the Committee's decision, he has the burden of proving that said decision is unsupported by substantial evidence. *See Waters v. S.C. Land Res. Conservation Comm'n,* 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996) (citation omitted); *see generally Kearse v. State Health & Human Servs. Fin. Comm'n*, 318 S.C. 198, 200, 456 S.E.2d 892, 893 (1995) ("The findings of the agency are presumed correct and will be set aside only if unsupported by substantial evidence.") (citation omitted). "Substantial evidence" has been identified as something less than the weight of evidence. *Bilton v. Best W. Royal Motor Lodge*, 282 S.C. 634, 641, 321 S.E.2d 63, 68 (Ct. App. 1984). However, "[s]ubstantial evidence is not a mere scintilla; rather, it is evidence which, considering the record as a whole, would allow reasonable minds to reach the same conclusion as the agency." *Friends of the Earth v. Pub. Serv. Comm'n of S.C.*, 387 S.C. 360, 366, 692 S.E.2d 910, 913 (2010) (citation omitted). Stated differently, "[t]he possibility of drawing two inconsistent conclusions from the evidence will not mean the agency's conclusion was unsupported by substantial evidence. *Waters*, 321 S.C. at 226, 467 S.E.2d at 917 (1996) (citation omitted).

In the case at bar, viewing the Record as a whole, Grover's medical records in conjunction with the opinion of Dr. Richardson provide sufficient evidence to support the Committee's decision, clearly meeting the substantial evidence threshold.[31] Initially, as found by the Committee, Grover's medical records indicate that his condition improved between March 24, 2016, and March 30, 2016. A progress note dated March 24, 2016, suggests that Grover was still experiencing problems with migraine headaches and that he "[c]ontinues express anxiety regarding tapering off of Suboxone with. He denies suicidal or homicidal ideations. No evidence of agitation but affect is anxious mood is described is anxious. Insight judgment is poor." Following March 24, 2016, the Record does not contain any medical record for Grover until March 30, 2016. On that date, a psychiatric note indicated that Grover was less anxious and less "med seeking." The only

[31] The Court does not, by implication, discount the opinions of the other independent physicians—Drs. Stroud, Cottrell, and Helding—and further finds that the Committee did not err to the extent it relied upon those opinions. Those opinions provide additional evidence to support the Committee's decision since each of those physicians recommended denying Grover's claim for residential rehabilitation substance abuse treatment in its entirety—from admission through his date of discharge. Notwithstanding, the Court has chosen to highlight Dr. Richardson's opinion for the purposes of its substantial evidence inquiry as it was rendered upon the most complete set of records available.

difficultly Grover experienced involved sleeping, where he had problems with falling asleep and multiple night awakenings.

Likewise, following March 30, 2016, Grover's remaining medical records disclosed continued progress on his condition. In fact, while two treatment progress review notes—dated April 2, 2016, and April 8, 2016—specified that Grover remained a good candidate for his current level of care, even those notes documented that his condition had improved.[32] For example, the April 2, 2016, treatment progress review detailed that Grover appeared to become more emotionally stable, his anxiety levels had decreased, and his mood was euthymic with a bright effect.[33] The only unusual incident reported was that Grover had difficulty sleeping. Similarly, Grover's treatment progress review note dated April 8, 2016, stated: "He continues to make progress on obtaining emotional stability and becoming less emotionally reactive. He reported that his overall levels of anxiety have decreased." Notably, by April 7, 2016, Grover denied withdrawal symptoms. Also, Grover was open to simplifying medications and "continuing titrating off of medications as he undergoes treatment." Dr. Roberts remarked that Grover was much more appropriate, had no evidence of drug seeking, and appeared less anxious. On April 26, 2016, by his own subjective account, Grover continued to feel better. Finally, on May 18, 2016, as part of a medical follow up, Grover reported if he had any cravings, it was solely for alcohol.[34]

Taking into account the foregoing, the Committee reached the following conclusions:

> Under CBA's Substance Use Disorder Residential Treatment - Rehabilitation Continued Stay Criteria, criterion 1 requires that the patient's condition continues to meet admission criteria and the level of care remains necessary to treat the intensity, frequency, and duration of the patient's current behaviors and symptoms. Criterion 8 requires significant documentation of inadequate progress on problems that could lead to early relapse, despite intensive daily facility interventions and treatment

[32] The April 2, 2016, note observed that Grover's chemical dependency and relapse proneness objectives were not met and the April 8, 2016, note stated that his relapse proneness objecting were not met. The April 8, 2016, note also observed that, with regard to his chemical dependence, Grover reported an "ongoing commitment to sobriety."

[33] *Merriam-Webster* defines euthymia as "normal, tranquil mental state or mood." Merriam-Webster Online, https://www.merriam-webster.com/medical/euthymia (last visited April 13, 2020).

[34] Curiously, despite asserting that if PEBA had "adequately reviewed the medical records and provider statement it would have seen that [he] was still experiencing severe mental health and substance abuse issues that necessitated his continued stay" and that "the medical records contained in the record clearly point to those issues[,]" Grover has failed to call the Court's attention to any specific instances within his medical records that substantiate such.

> planning, requiring the ongoing structure of this level of care to assess and treat in a timely fashion. On March 23, 2016, Pavilion noted [Grover] was still prone to relapse and his objectives were not met. On the following day, [Grover] had a migraine and difficulty sleeping, but he was doing well on his medications and was undergoing medication adjustments. The next record provided by Pavilion, was dated March 30, 2016, and only sleep issues were reported. By April 2, 2016, [Grover] appeared even more emotionally stable, his anxiety had decreased, and his mood had improved. The subsequent records submitted noted further improvements. Based on the submitted records, [Grover's] condition improved between March 24, 2016 and March 30, 2016. A psychiatrist reviewed the records, and found [Grover] would benefit from a continued stay through March 28, 2016, but he could be treated in a less restrictive setting as of March 29, 2016 and beyond. This meant [Grover] no longer continued to meet the admission criteria and his residential rehabilitation level of care no longer remained necessary to treat the intensity, frequency, and duration of his current behaviors and symptoms, as required by criterion 1. Further, based on the same records and psychiatrist review as recounted above, there was no significant documentation of inadequate progress on problems that could lead to early relapse requiring the ongoing structure of the residential rehabilitation level of care, as required by criterion 8. As such, the Committee found [Grover] did not meet criteria 1 and 8.[35]

In addition to the objective information in Grover's medical records, the opinion of Dr. Richardson must be emphasized. Crucially, following her review of Grover's file, Dr. Richardson recommended approving two weeks of residential rehabilitation substance abuse treatment, from March 15, 2016, to March 28, 2016; however, she did not share the same sentiment following March 28, 2016. Specifically, having evaluated his complete file, Dr. Richardson opined that "after 3/28/16, [Grover] could be treated in a less restrictive setting." [36] Furthermore, while the Court recognizes that Dr. Roberts' opinion in his undated statement—that it was medically necessary, as that phrase is defined in the Plan, for Grover to be engaged in the residential hospital program at Pavillon effective March 12, 2016, and extending through his discharge—diametrically opposes

[35] Because of Grover's improvement, the Committee further determined that Grover met criterion 2 of CBA's Substance Use Disorder Residential Treatment – Rehabilitation Discharge Criteria which required "significant documented reduction in the intensity, duration, and frequency of the symptoms/behaviors that resulted in the admission, so that the patient's current behaviors and symptoms meet criteria for another level of care" Satisfaction of any of the four Rehabilitation Discharge Criteria triggers a denial of continued care.

[36] The Court further notes that this opinion is not inconsistent with that of Dr. Helding, who also had an opportunity to review Grover's file after his May 2016 discharge, as well as the other independent consulting physicians—Drs. Stroud and Cottrell—who also believed Grover could be treated in a less restrictive setting.

the opinion of Dr. Richardson and provides some evidence in support of the claim, Grover, nevertheless, has failed to meet his burden of proving that the Committee's decision is unsupported by substantial evidence, the standard this Court must use on appeal. *See Waters*, 321 S.C. at 226, 467 S.E.2d at 917 ("The possibility of drawing two inconsistent conclusions from the evidence will not mean the agency's conclusion was unsupported by substantial evidence."); *see also Wilson v. State Budget & Control Bd. Emp. Ins. Program*, 374 S.C. 300, 305, 648 S.E.2d 310, 313 (Ct. App. 2007) (holding that although a doctor and Social Security Administration found otherwise, substantial evidence refuted the appellant's disability claim)

In summary, Grover's medical records and the opinions offered by Dr. Richardson and the other independent consulting physicians provide evidence upon which a reasonable mind could reach the same conclusion as the Committee. As such, while the Court is sympathetic to Grover's struggles with drug addiction and applauds his quest for rehabilitation, the decision of the Committee is affirmed.

ORDER

IT IS HEREBY ORDERED that, based on the foregoing, the Committee's decision is **AFFIRMED.**

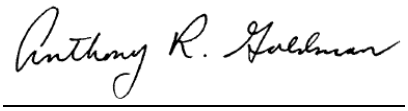
AND IT IS SO ORDERED.

April 16, 2020
Columbia, S.C.

Milton G. Kimpson, Judge
South Carolina Administrative Law Court

CERTIFICATE OF SERVICE

I, Anthony R. Goldman, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail to the address provided by the party(ies) and/or their attorney(s).



April 16, 2020
Columbia, S.C.

Anthony R. Goldman
Judicial Law Clerk