ATTACHMENT A

THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

In the Matter of the Appeal of the Allowable Amount for Reimbursement for Psychotherapy Services of: BRADLEY D. HEINZ, Respondent.	Case No. 2011-0114 OAH No. 2015030110

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on May 2 and November 28, 2016, in Sacramento, California.

Christopher C. Phillips, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Attorney John M. Jensen of the Law Offices of John Michael Jensen represented respondent Bradley D. Heinz, who was present throughout the hearing.

Evidence was received, and the record was left open for the parties to submit simultaneous closing and reply briefs. The parties' respective closing briefs are marked as Exhibits 27 (CalPERS's) and II (Mr. Heinz's),[1] and Mr. Heinz's reply brief is marked as Exhibit JJ. CalPERS did not file a reply brief. The record was closed, and the matter was submitted for decision on January 23, 2017.

[1] Prior to filing his closing brief, Mr. Heinz filed a Request for Official Notice, Declaration of John Michael Jensen, Exhibit I (Exhibit HH), requesting that judicial notice be taken of the Evidence of Coverage for the PERS Choice Basic Plan that was in effect from January 1 through December 31, 2010. But a prerequisite to taking either mandatory or permissive judicial notice is that the evidence to be noticed is relevant. (*People ex rel. Bill Lockyer v. Shamrock Foods Company* (2000) 24 Cal.4th 415, 423, fn. 2.) As discussed further below, the timeframe relevant to this appeal is 2008 through 2009. Additionally, the record was closed for the receipt of evidence at the conclusion of the hearing on November 28, 2016, and Mr. Heinz did not request or obtain leave of court to submit Exhibit HH. Therefore, his request is denied, and Exhibit HH was not considered for any purpose in deciding this matter.

PUBLIC EMPLOYEES RETIREMENT SYSTEM
FILED February 6 2017

SUMMARY

Mr. Heinz treated with Joe Walker, M.D., in 2008 and 2009. At the time, Mr. Heinz was a member of the PERS Care (2008) and PERS Choice (2009) health plans, and Dr. Walker was a non-preferred provider under both plans. Anthem Blue Cross, the third-party administrator of both plans, paid Mr. Heinz's claims for those services in accordance with the applicable Evidence of Coverage's (EOC) provisions regarding treatment provided by non-preferred providers. Mr. Heinz's requested additional reimbursement for Dr. Walker's services by participating in Anthem Blue Cross's internal grievance and appeals process. Dissatisfied with the results, he requested a "paper review" of the decision by CalPERS. After CalPERS upheld Anthem Blue Cross's payment of claims, he filed a formal appeal and requested a fair hearing before CalPERS's Board of Administration.[2]

FACTUAL FINDINGS

Pertinent Factual Background

1. Mr. Heinz is a member of CalPERS by virtue of his employment with the Judicial Council of California. As such, he was entitled to health benefits pursuant to the Public Employees' Medical and Hospital Care Act (Gov. Code, § 22750 et seq.) at all times relevant.

2. Mr. Heinz was enrolled in the PERS Care health plan from January 1, 2006, through December 31, 2008, and was provided a copy of the EOC each year. He was enrolled in the PERS Choice health plan from January 1, 2009, through December 31, 2009, and was provided a copy of the EOC. At all times relevant, Anthem Blue Cross was the third-party administrator of both plans.

3. At all times relevant, the PERS Care and PERS Choice health plans were preferred provider plans, and Anthem Blue Cross contracted with a Preferred Provider Organization (PPO) to provide health care services to its members. A PPO is a managed care organization of medical doctors, hospitals, and other health care providers. PPOs enter into contracts with insurance companies or their third-party administrators to provide health care services at reduced rates to members of the insurer's health plan. The member may obtain treatment from providers who do not have an agreement with his insurer or its administrator, but will often pay higher rates for doing so than if he obtained the same

[2] Mr. Heinz attempted in his trial brief, at hearing, and in his post-hearing briefs to expand the issues on appeal. As explained in the Legal Conclusions below, however, only those issues raised during Anthem Blue Cross's internal grievance and appeals process are the proper subject of a fair hearing before the Board of Administration. Therefore, the sole issue to be resolved on appeal is whether Anthem Blue Cross complied with the terms of the applicable EOCs in denying Mr. Heinz's request for additional reimbursement for services provided by Dr. Walker in 2008 and 2009.

treatment from one who does. Health care providers within the PPO with which the particular health plan or third-party administrator contracts are referred to as "preferred providers," while all others are referred to as "non-preferred providers."

4. Prior to January 1, 2008, Mr. Heinz received treatment from Joe Walker, M.D. At the time, Dr. Walker was a preferred provider of the PERS Care health plan. Mr. Heinz continued to treat with Dr. Walker from January 1, 2008, through December 31, 2009, during which Dr. Walker was a non-preferred provider of the PERS Care (2008) and PERS Choice (2009) health plans.

5. Anthem Blue Cross paid for the treatment Dr. Walker provided Mr. Heinz in 2008 and 2009 in accordance with the language in the appropriate EOC regarding services rendered by non-preferred providers. While Mr. Heinz did not dispute that Dr. Walker was a non-preferred provider, he disagreed with the manner in which Anthem Blue Cross calculated the amount paid for Dr. Walker's services. Specifically, he believed it was required to pay 60 percent of the usual, customary or reasonable rates for Dr. Walker's services, rather than 60 percent of the "Allowable Amount" for those services.

6. Mr. Heinz requested additional reimbursement for the treatment Dr. Walker provided in 2008 and 2009 by participating in Anthem Blue Cross's internal grievance and appeals process. His appeal was denied, and he requested a "paper review" of the decision by CalPERS's Health Benefits Division. CalPERS upheld Anthem Blue Cross's decision, and he filed a formal appeal and request for a fair hearing before CalPERS's Board of Administration. On March 2, 2015, Kathleen Donneson, Chief of CalPERS's Health Plan Administration Division, signed the Statement of Issues solely in her official capacity.

Pertinent Language of the Applicable EOC's

7. At all relevant times, the PERS Care health plan paid for "physician services" provided by a preferred provider to a member who resides "within the area" as follows:

> Physician office visits, physician outpatient hospital visits and physician outpatient urgent care visits by a Preferred Provider are paid at Blue Cross' Allowable Amount or the local Blue Cross and/or Blue Shield Plan's Allowable Amount less the Member's twenty dollar ($20) copayment. The twenty dollar ($20) copayment will also apply to the physician or health professional visits for diabetes self-management education. The twenty dollar ($20) copayment does not apply to physician visits related to mental health (for other than severe mental illness and serious emotional disturbances of a child) or substance abuse. Note: This copayment applies to the charge for the physician visit only.

> Other covered services provided by a Preferred Provider are paid at ninety percent (90%) of the Allowable Amount, except for services with a twenty dollar ($20) copayment. This includes any separate facility charge by an affiliated hospital for a covered office visit to a physician. Plan Members are responsible for the remaining ten percent (10%) and any charges for non-covered services if provided by a Preferred Provider. Preventative care services received from a Preferred Provider are paid at one hundred percent (100%) of the Allowable Amount when billed with a routine or preventative care diagnosis.
>
> **NOTE**: Members who reside within a Preferred Provider area and receive services from a Non-Preferred Provider will be reimbursed at the Non-Preferred Provider level as stated below in (b).

(Bold original.)

And if the same services are provided by a non-preferred provider to a patient who resided "within the area," the PERS Care plan paid as follows:

> Covered services provided by a Non-Preferred Provider are paid at sixty percent (60%) of the Allowable Amount. Plan Members are responsible for the remaining forty percent (40%) and all charges in excess of the Allowable Amount, plus all charges for non-covered services.
>
> **NOTE**: Regardless of the reason (medical or otherwise), referrals by Preferred Providers to Non-Preferred Providers will be reimbursed at the Non-Preferred Provider level.

(Bold original.)

8. "Allowable Amount" is defined as:

> The Anthem Blue Cross (applying to Members residing in California or Out-of-Area) or the local Blue Cross and/or Blue Shield Plan (applying to Members outside California) allowance for Negotiated Amount as defined below for the service(s) rendered, or the provider's Billed Charge, whichever is less.

The Allowance is:

1. the amount that Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based on such factors as the Plan's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge pattern; or

2. such other amount as the Preferred Provider and Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan have agreed will be accepted as payment for the service(s) rendered; or

3. if an amount is not determined as described in either (1) or (2) above, the amount that Anthem Blue Cross or the local Blue Cross and/or Blue Show Plan determines is appropriate considering the particular circumstances and the services rendered.

9. The PERS Choice health plan had a payment structure identical to the PERS Care health plan during the relevant timeframe. It also defined "Allowable Amount" in a similar manner.

Summary

10. It was undisputed Dr. Walker was a non-preferred provider under the PERS Care and the PERS Choice health plans in 2008 and 2009, respectively. Anthem Blue Cross paid for his treatment of Mr. Heinz during those years at the non-preferred provider level specified in the applicable EOC. In particular, it paid 60 percent of the Allowable Amount. Therefore, Anthem Blue Cross did not err in the amount it paid for Mr. Heinz's claims for those services, he is not entitled to additional reimbursement for those services, and his appeal of CalPERS's determination that Anthem Blue Cross complied with the terms of the applicable EOC in denying his request for additional reimbursement should be denied.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Mr. Heinz bears the burden of proving Anthem Blue Cross did not comply with the terms of the applicable EOC in denying his request for additional reimbursement for services provided by Dr. Walker in 2008 and 2009, and he must do so by a preponderance of the evidence. (*Coffin v. Alcoholic Beverage Control Appeals Board* (2006) 139 Cal.App.4th

471, 476 [the party appealing an agency's decision bears the burden of proof in matters initiated by filing a statement of issues]; see, Evid. Code, § 115 ["Except as otherwise provided by law, the burden of proof requires proof by a preponderance of the evidence"].)

Applicable Law

2. The purpose of the Public Employees' Medical and Hospital Care Act (Gov. Code, § 22750 et seq.) is to promote increased economy and efficiency in state employment, provide an incentive to prospective and current state employees by offering health insurance plans similar to those provided in the private sector, and protect the state's interests in its employees by ensuring their good health. (Gov. Code, § 22751.) Therefore, "an employee or annuitant is eligible to enroll in an approved health benefit plan, in accordance with this part and the regulations of the board." (Gov. Code, § 22800, subd. (a).)

3. CalPERS's Board of Administration is charged with the task of entering "into contracts with carriers offering health benefit plans or with entities offering services relating to the administration of health benefit plans." (Gov. Code, § 22850, subd. (a).) Such contracts "shall contain a detailed statement of benefits offered and shall include maximums, limitations, exclusions, and other definitions of benefits as the board deems necessary or desirable." (Gov. Code, § 22853, subd. (a).) The detailed statements are commonly referred to as an "evidence of coverage." (Health & Saf. Code, § 1345, subd. (d) [defining "evidence of coverage" as a document issued to the subscriber or enrollee which specifies the coverage to which he is entitled under the health benefit plan].)

4. Government Code section 22848 provides the employee or annuitant the right to appeal coverage decisions made by his health benefit plan as follows:

> An employee or annuitant who is dissatisfied with any action or failure to act in connection with his or her coverage or the coverage of his or her family members under this part shall have the right to appeal to the board and shall be accorded an opportunity for a fair hearing. The hearing shall be conducted, in so far as practicable, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3.

5. Prior to filing an appeal seeking a fair hearing, however, the employee or annuitant must exhaust the health plan's grievance and appeals process. (Cal. Code Regs., tit. 2, § 599.518.) And if his concerns are not resolved through that process, he must seek an administrative review by CalPERS's Health Benefits Division before requesting a fair hearing. (Cal. Code Regs., tit. 2, § 599.518, subd. (d).) The administrative review is commonly referred to as a "paper review."

6. The PERS Care health plan provides the following grievance and appeals procedure:

The procedures outlined below are designed to ensure the Plan Member full and fair consideration of complaints submitted to the Plan. The procedure should be followed carefully and in the order listed.

Claims for payment must be submitted to Blue Cross within ninety (90) days after the date of the medical service, if reasonably possible, but in no event, except for the absence of legal capacity, may claims be submitted later than fifteen (15) months from the date of service or payment will be denied.

The following procedure shall be used to resolve any dispute which results from any act, error, or omission with respect to any medical claim filed by or on behalf of a Plan Member. (See Utilization Review Appeal Procedure on pages 81 through 83 for procedures used to resolve any dispute which results from a medical necessity determination by Blue Cross' Review Center.)

The cost of copying and mailing medical records required for Blue Cross to review its determination is the responsibility of the person or entity requesting the review.

1. Notice of Claim Denial

In the event any claim for benefits is denied, in whole or in part, Blue Cross shall notify the Plan Member of such denial in writing. The notice shall contain specific reasons for such denial and an explanation of the Plan's review and appeal procedure.

2. Objection to Claim Processing or Denial

An aggrieved Plan Member may object by writing to Blue Cross' Customer Service Department within sixty (60) days of the discovery of any act, error, or omission with regard to a properly submitted claim; or within sixty (60) days of receipt of a notice of claim denial. The objection must set forth all reasons in support of the proposition that an act, error, or omission occurred.

3. Time Limits for Response to Objection

Blue Cross will acknowledge receipt of the complaint by written notice to the Member within twenty (20) days.

Blue Cross will then either affirm or resolve the denial within thirty (30) days. If the case involves an imminent threat to the Member's health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of the grievance will be expedited. If Blue Cross affirms the denial or fails to respond within thirty (30) days after receiving the request for review and the Member still objects to an act, error, or omission as stated above, the Member made proceed to item 4 below.

4. Request for Reconsideration

If the Plan Member is not satisfied with the response to the initial inquiry, he or she may request reconsideration within sixty (60) days of receiving notice of Blue Cross' response. The request should be submitted in writing to the Customer Service Department. Any additional information that would affect the decision should be included. Blue Cross of California will acknowledge receipt of the reconsideration request by written notice to the Member within twenty (20) days. Blue Cross will then either affirm or resolve the denial within thirty (30) days.

5. Request for Administrative Review

If the Plan Member is not satisfied with the response to the Request for Reconsideration, he or she may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on pages 86 and 87.

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The PERS Choice health plan provides a similar process.

Conclusion

7. Mr. Heinz did not meet his burden of demonstrating Anthem Blue Cross failed to comply with the terms of the applicable EOC in denying his request for additional reimbursement for services provided by Dr. Walker in 2008 and 2009. The relevant EOC specifies that "physician services" provided by a non-preferred provider will be paid at the rate of 60 percent of the Allowable Amount. Mr. Heinz's argument that he was entitled to be paid 60 percent of the usual, customary or reasonable rates for Dr. Walker's services is without merit. (See, e.g., *YDM Management Co., Inc. v. Aetna Life Insurance Company*

(U.S. Dist. Ct., C.D.Cal., March 28, 2016, CV 15-00897 DDP) 2016 WL 1254162, 5 [concluding out-of-network providers are not entitled to payment based on the reasonable and customary value of their services provided]; citing, *Orthopedic Specialists of Southern California v. California Public Employees' Retirement System* (2014) 228 Cal.App.4th 644, 648 [concluding the EOC for the PERS Choice health plan "allows Anthem itself to determine what is an appropriate amount to pay an out-of-network provider for nonemergency services"].) Therefore, his appeal of CalPERS's determination that Anthem Blue Cross complied with the terms of the applicable EOCs in denying his requests for additional reimbursement for services rendered by a non-preferred provider should be denied.

ORDER

Respondent Bradley D. Heinz's appeal is DENIED.

DATED: February 3, 2017

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COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings