

**ATTACHMENT A**

**THE PROPOSED DECISION**

**BEFORE THE  
BOARD OF ADMINISTRATION  
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM  
STATE OF CALIFORNIA**

**In the Matter of the Appeal Regarding Denial of Payment of  
Services by a Non-Preferred Provider of:**

**ANDREW C. SISK, Respondent.**

**Case No. 2019-0704**

**OAH No. 2019080689**

**PROPOSED DECISION**

Heather M. Rowan, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on November 18, 2019, in Sacramento, California.

Kevin Kreutz, Attorney, represented the California Public Employees' Retirement System (CalPERS).

Andrew C. Sisk (respondent) appeared and represented himself.

Evidence was received, the record was closed, and the matter was submitted on November 18, 2019.

PUBLIC EMPLOYEES RETIREMENT SYSTEM  
FILED December 5 20 19  
Cheryl

## **ISSUE**

Whether Anthem Blue Cross (Anthem) appropriately denied additional payment toward the claims for services respondent received from Non-Preferred Providers on March 12 and 13, 2018.<sup>1</sup>

## **FACTUAL FINDINGS**

1. CalPERS is the agency charged with administering the Public Employees' Medical and Hospital Care Act (PEMHCA). PEMHCA authorizes and requires the Board of Administration to provide health benefits for State of California employees, dependents, annuitants, as well as for employees and annuitants of contracting public agencies which elect to contract with CalPERS for health benefit coverage.

2. At all relevant times, respondent worked for the County of Placer, which contracts with CalPERS for health benefit coverage. By virtue of respondent's employment, he is eligible for CalPERS Health Benefits. Respondent was enrolled in the PERS Choice health benefits plan, which Anthem administered by contract with CalPERS. PERS Choice is a self-funded, preferred provider plan (PPO) CalPERS offers to those eligible for health care benefits under PEMHCA.

### **Respondent's Health Benefit Plan: PERS Choice**

3. Sheri Alvarado is a Research Data Specialist for CalPERS's Health Plan Administration Division. She testified at hearing. Ms. Alvarado reviewed respondent's

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<sup>1</sup> On page 14, line 13, the Statement of Issues mistakenly refers to March 2013.

appeal. She is familiar with the PERS Choice, self-funded PPO Plan. She explained Anthem's health benefit coverage for Preferred Providers and Non-Preferred Providers.

4. Ms. Alvarado explained that all members are provided with an Explanation of Coverage Booklet (EOC) that explains the terms of the health benefits. The EOC contains the terms and conditions of the plan, including, but not limited to, provisions concerning benefits, claims and payment of claims. The EOC explains that Anthem "works with an extensive network of 'Preferred Providers' throughout California." These providers participate in the Prudent Buyer Plan, and have agreed to accept payment amounts that Anthem sets. The "Allowable Amounts" are usually lower than what other doctors or hospitals charge for the same services. When contracting with Anthem, providers agree to an Allowable Amount in exchange for referrals from Anthem's in-network list of providers or hospitals. Ms. Alvarado explained that the Allowable Amount is based on the geographical location, other providers' charges, and other considerations.

5. Not all doctors and hospitals contract with Anthem, however. These "Non-Preferred Providers" are not listed on Anthem's network of providers, and are not limited to accepting payment up to Anthem's Allowable Amount. The EOC cautions that Preferred Hospitals, or in-network hospitals, may contract with doctors who do not participate in the Prudent Buyer Plan, or are not Preferred Providers.

6. The following provisions were in effect at all times relevant to Respondent's appeal:

**ALLOWABLE AMOUNT**

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) relative to the value of other services, market considerations, and provider charge patterns; 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 Shield Plan determines is appropriate considering the particular circumstances and the services rendered.

## **PHYSICIAN SERVICES**

[11] . . . [11]

Covered Services provided by a Non-Preferred Provider are paid at 60% of the Allowable Amount. Plan Members are responsible for the remaining 40% and all charges in excess of the Allowable Amount, plus all charges for non-covered services.

[11] . . . [11]

## **Emergency Care**

Physician services for emergency care provided by Preferred and Non-Preferred Providers are paid at 80% of the Allowable Amount. Members are responsible for the remaining 20%. In addition, when services are provided by a Non-Preferred Provider, Members are also responsible for all charges in excess of the Allowable Amount plus all charges for non-covered services. Some emergency room Physicians are Non-Preferred Providers at Preferred Hospitals.

### **EMERGENCY CARE SERVICES**

80% PPO, Out-of-Area, or Non-PPO

Emergency Care Services are subject to the Maximum Calendar Year Medical Financial Responsibility limits.

Hospital benefits are subject to the Maximum Calendar Year Medical Financial Responsibility Limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

7. Ms. Alvarado explained that once a plan member's deductible is satisfied, Anthem pays 80 percent of the Allowable Amount for Preferred Providers and the member is responsible for the remaining 20 percent. Preferred Providers agree to write off any charge in excess of the Allowable Amount.

8. As stated in the EOC, Anthem pays 60 percent of its Allowable Amount for Non-Preferred Providers, and the member is responsible for the remaining 40 percent plus all charges in excess of the Allowable Amount. Anthem acknowledges, however, that an emergency situation does not always allow a member to choose the provider. In these instances, Anthem pays Non-Preferred Providers 80 percent of the Allowable Amount. The member is responsible for the remaining 20 percent plus all charges in excess of the Allowable Amount.

9. Ms. Alvarado is not aware of any circumstances in which Anthem considers a Non-Preferred Provider to be a Preferred Provider, even in an emergency. Ms. Alvarado suggested that Non-Preferred Providers have the option to write off the remaining amount for which the member is responsible.

10. The PERS Choice plan has a cap on the amount a member pays out-of-pocket per calendar year. When the member meets that amount, Anthem pays 100 percent of the Allowable Amount.

### **March 2018 Incident**

11. On March 11, 2018, respondent experienced a "new-onset generalized tonic clonic seizure with loss of consciousness" while in his home. He was transported by ambulance to Sutter Roseville Hospital (Sutter). Sutter performed an MRI on respondent, which revealed a large tumor in the front left side of his brain. The doctors determined that emergency surgery was required, which was scheduled for the following day. Dr. Hamid Aliabadi of Spine and Neurosurgery Associates was the doctor Sutter consulted for "emergency neurosurgical intervention," or brain surgery. Dr. Aliabadi ordered a full-body MRI prior to the brain surgery, which revealed a large, cancerous tumor in respondent's kidney.

Due to the urgency of the brain tumor, Dr. Aliabadi performed the brain surgery on March 12, 2018, at Sutter. Surgery to remove respondent's kidney tumor was scheduled for a later date. Dr. Aliabadi submitted a letter in support of respondent's appeal regarding respondent's diagnoses in March 2018. He opined that without the emergency brain surgery, respondent would have had continuing seizure activity, neurological decline, and "possible coma and death." Respondent was also at risk of paralysis.

12. Sutter is within Anthem's "Preferred Provider Network." Spine and Neurosurgery Associates, including Dr. Aliabadi, is not. Sutter and Spine and Neurosurgery Associates submitted claims to Anthem for services respondent received on March 12 and 13, 2018. The Sutter claims were paid per the contract between Anthem and Sutter as a Preferred Provider. Spine and Neurosurgery Associates billed Anthem in two separate bills. Claim number 18103BL9355 (first claim) totaled \$31,153, and claim number 18103BL9356 (second claim) was \$5,311.

Anthem processed the first claim on May 15, 2018. Anthem determined that \$1,353 for "microscope," was not allowed, and \$26,210.31 exceeded its Allowable Amount. Anthem paid 60 percent of the Allowable Amount, or \$2,143.01, and respondent was responsible for \$28,991.99. Anthem processed the second claim on April 17, 2018. Anthem determined \$4,775.83 of the claim exceeded the Allowable Amount. The Explanation of Benefits stated respondent was responsible to pay

\$4,775.83, but did not assign a co-insurance amount.<sup>2</sup> Anthem paid \$535.17 for this claim.

## **Respondent's Appeals**

13. On July 22, 2018, respondent filed a grievance regarding the payments, which Anthem reviewed. On September 25, 2018, Anthem informed respondent that his appeal was granted in part, and denied in part. Anthem stated that it would not pay the full amount requested, but would increase payment from 60 percent of the Allowable Amount to 80 percent of the Allowable Amount after finding the services were rendered on an emergency basis.

14. Following Anthem's September 25, 2018 letter, Anthem determined respondent had reached his maximum out-of-pocket expenditure for the calendar year. Consequently, on September 27, 2018, Anthem reprocessed both claims, and issued a payment at 100 percent of the Allowable Amount.<sup>3</sup> Anthem paid \$8,396.95 of the total \$31,135 on the first claim, and \$1,231.25 of the total \$5,311 on the second claim. Respondent appealed the reprocessed claims because he disagreed with Anthem's payments to Spine and Neurosurgery Associates as nonparticipating providers. He requested that Anthem consider Spine and Neurosurgery Associates Preferred Providers for the submitted claims for services he received at an in-network

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<sup>2</sup> Anthem appears to have paid 100 percent of the Allowable Amount on this claim, contrary to the assertion in the Statement of Issues. No explanation is provided.

<sup>3</sup> The Allowable Amount increased following Anthem's determination that respondent received emergency medical care.

hospital, and pay the full amount on each claim. On December 18, 2018, Anthem informed respondent that it had denied the appeal.

15. On January 23, 2019, respondent appealed Anthem's determination. Anthem informed respondent that his next step was to request Administrative Review from CalPERS. On January 30, 2019, CalPERS informed respondent it had received his request for Administrative review. On the same day, CalPERS sent a Request for Health Plan Information to Anthem to obtain all relevant information regarding respondent's appeal. After a review of all pertinent information, CalPERS upheld Anthem's denial. CalPERS determined that doctors at Spine and Neurosurgery Associates were Non-Preferred Providers, and Anthem's determination to pay 100 percent of the Allowable Amount was correct.

16. By letter dated February 11, 2019, respondent appealed that determination. He requested that Anthem be required to consider Spine and Neurosurgery Associates as Preferred Providers, and to pay the remaining \$22,738.05 on the first claim and \$4,079.75 on the second. On August 31, 2019 CalPERS made and filed the Statement of Issues. Respondent timely appealed. The matter was set for an evidentiary hearing before an Administrative Law Judge of the OAH, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

### **Respondent's Argument**

17. Respondent understands the provisions in the EOC. He argued, however, that in an emergency such as his, Anthem should consider Spine and Neurosurgery Associates to be Preferred Providers. He was taken to a hospital in an ambulance and was given no choice regarding the doctors who treated him. Dr. Aliabadi provided

respondent life-saving treatment. That Dr. Aliabadi was assigned to respondent's case was beyond his control. Further, all of the other doctors who treated respondent on March 12 and 13, 2018, were Preferred Providers, and paid as such. Respondent also expressed frustration that no one confirmed that the doctor Sutter assigned to him would be covered under respondent's plan. He believes he should not be responsible for the amount claimed that was above the Allowable Amount.

## **Discussion**

18. There is no disagreement that respondent received life-saving treatment on an emergency basis at a Preferred Hospital. Neither does respondent dispute that Dr. Aliabadi is not a Preferred Provider. Given the circumstances that respondent was not in a position to choose a provider, or even know who was treating him, respondent's argument that Anthem should be required to consider Dr. Aliabadi a Preferred Provider is reasonable. But there is no support in law or the EOC that supports this position.

19. Additionally, even if Anthem considered Dr. Aliabadi and Spine and Neurosurgery Associates Preferred Providers, the result would be the same. Anthem paid 80 percent of the Allowable Amount to Sutter, and 100 percent of the Allowable Amount to Spine and Neurosurgery Associates, because respondent had met his out-of-pocket maximum. The amount Spine and Neurosurgery Associates billed for its services was in excess of the Allowable Amount. Anthem does not pay in excess of the Allowable Amount, whether the provider is in-network or not. If Spine and Neurosurgery Associates contracted with Anthem, it, not Anthem, would have been forced to write off the amount in excess of the Allowable Amount. As it stands, per the EOC, respondent is responsible to pay the additional amount, unless Spine and Neurosurgery Associates agrees to reduce the bill.

## LEGAL CONCLUSIONS

1. The party asserting the affirmative in an administrative action has the burden of going forward and the burden of persuasion by the preponderance of the evidence. (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051; Evid. Code, § 500.) Because there is no applicable standard of proof provided in the PEMHCA, the standard to be applied is the preponderance of the evidence. (Evid. Code, § 115.)

2. The PERS Choice EOC functions as the contract between respondent and CalPERS. Respondent is bound by its terms. Anthem Blue Cross's EOC's provisions govern the level of reimbursement for covered benefits. (Cal. Code Regs., tit. 2, § 599.508.)

3. Respondent did not meet his burden of demonstrating that Anthem failed to comply with the terms of the EOC in denying his request for additional benefit coverage. As set forth in the Factual Findings, the cost of services respondent received from Dr. Aliabadi of Spine and Neurosurgery Associates exceeded Anthem's Allowable Amount for the service. The denial of coverage for respondent's emergency services from a Non-Preferred Provider was justified and consistent with the terms of the EOC. Respondent's appeal from CalPERS's determination that Anthem complied with the terms of the EOC in denying his request for additional benefit coverage must be denied.

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**ORDER**

Respondent Andrew C. Sisk's appeal is DENIED.

DATE: December 5, 2019

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*Heather M. Rowan*  
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HEATHER M. ROWAN

Administrative Law Judge

Office of Administrative Hearings