ATTACHMENT A

THE PROPOSED DECISION
BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES’ RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Appeal of Denial of Additional Benefit Coverage for Services by,

HENRY MORENO, Respondent

Agency Case No. 2019-0940

OAH No. 2019120454

PROPOSED DECISION

Adam L. Berg, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter telephonically on September 21, 2020, pursuant to Executive Orders N-25-20, N-33-20, and N-63-20 pertaining to the COVID-19 pandemic.

Kevin Kreutz, Senior Attorney, represented complainant, Marta Green, Chief, Health Plan Administration Division, California Public Employees’ Retirement System, State of California (CalPERS).

Henry Moreno, respondent, represented himself.

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on September 21, 2020.
ISSUE

Is Mr. Moreno eligible for additional benefit coverage for medical services provided to Renee Moreno on February 7, 2019?

FACTUAL FINDINGS

Background

1. Under the Public Employees' Medical and Hospital Care Act (PEMHCA), CalPERS offers multiple health plan options for CalPERS members and their dependents. PERS Select is a preferred provider organization (PPO) offered by CalPERS and administered by a third-party, Anthem Blue Cross (Anthem).

2. Mr. Moreno is a local safety member of CalPERS. By virtue of his employment, Mr. Moreno and his wife, Renee Moreno, are eligible for health coverage under PEMHCA. Mr. Moreno elected to enroll in PERS Select PPO (the Plan) for himself and his wife.

3. On March 18, 2019, Anthem processed a claim for payment for services provided by Summerlin Surgical Associates (Summerlin)/Dr. Kevin Petersen, for abdominal hernia surgery performed on Mrs. Moreno on February 7, 2019. Mr. and Mrs. Moreno requested reimbursement based on $7,100 billed by Summerlin/Dr. Petersen. Because neither Summerlin nor Dr. Petersen were part of Anthem's preferred provider network for the Plan, Anthem processed the claim as a non-preferred provider. By statement dated March 28, 2019, Anthem notified Mr. and Mrs. Moreno that the requested amount exceeded the maximum allowed amount for the procedure by $6,618.80. Accordingly, Anthem authorized payment to Mr. Moreno in the amount
of $288.72, which reflected the maximum authorized less respondent’s 40 percent coinsurance amount of $192.48.

4. On April 8, 2019, Mrs. Moreno submitted an appeal to Anthem requesting that the claim should be approved as an Out of Network Referral and the Plan’s allowable amount should be increased. By letter dated June 6, 2019, Anthem denied respondent’s request because services were provided by a non-preferred provider and there were 1,535 general surgeons in respondent’s service area that were preferred providers. As such, Anthem determined that the claim was not eligible for payment exceeding 60 percent of the allowable amount.

5. On June 24, 2019, respondent requested CalPERS conduct an administrative review of Anthem’s decision. On July 25, 2019, CalPERS notified respondent that following review, Anthem appropriately denied additional benefit coverage for services provided by Summerlin/Dr. Petersen.


7. On November 21, 2019, complainant filed a statement of issues. The issue to be decided is whether Anthem appropriately denied additional benefit coverage for services provided by Summerlin/Dr. Petersen. This hearing followed.

Testimony by Mr. and Mrs. Moreno

8. The testimony of Mr. and Mrs. Moreno is summarized as follows: Mrs. Moreno previously had three invasive surgeries involving synthetic mesh for her bladder. Two of the surgeries involved removing the synthetic mesh, which had caused significant medical problems. As a result of the surgeries, Mrs. Moreno developed weakening of the abdominal wall, which caused bilateral incision hernias. Mrs. Moreno
sought treatment for the hernias but was informed by multiple surgeons within the Anthem network that they only used synthetic mesh for repair. Mrs. Moreno also consulted with an immunologist and allergy specialist, who determined that she had allergic reactions to synthetic mesh material. Thus, Mrs. Moreno determined she would only treat with a surgeon who would not use synthetic mesh for the hernia repair. Mr. and Mrs. Moreno only located three physicians who would perform the surgery without synthetic mesh. None of the surgeons were Anthem preferred providers. After consulting with one of these surgeons, Dr. Petersen, they were confident that he was the right physician to perform the surgery. Mr. and Mrs. Moreno were aware that Dr. Petersen did not accept insurance and was not within Anthem's network of preferred providers. They submitted the claim for reimbursement with the understanding that they would be reimbursed at 60 percent of the charges. They were surprised when they found that Anthem would only reimburse at 60 percent of the maximum allowed rate, which at approximately $500, was considerably less than their out-of-pocket expenses of $7,100.

9. Mr. and Mrs. Moreno submitted their claim to Anthem, which included an invoice from Summerlin/Dr. Petersen for $7,100. The cost of the surgery was a "bundled" amount that included all expenses of the surgery. Although the invoice was not submitted as evidence, it presumably did not include a breakdown of individual charges, such as anesthesiology and post-operative care.

2019 PERS Select Evidence of Coverage

10. The 2019 PERS Select Evidence of Coverage (EOC) governs the provisions of health coverage under the Plan. The following is summary of the relevant provisions:
The Plan maintains a network of “preferred providers” who accept payment amounts set by Anthem for their services. These “Allowable Amounts” are determined by Anthem as the 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, and market considerations. The Allowable Amounts are usually lower than what other physicians and hospitals charge for their services, so the member’s portion of the charges will also be lower. Preferred Providers have agreed to accept the Plan’s payment, plus applicable member deductibles and copayments/coinsurance, as payment in full for covered services. The Preferred Provider also agrees to submit a claim for payment directly, and the benefits of the Plan are paid directly to the provider. Covered services provided by a Preferred Provider are paid at 80 percent of the Allowable Amount. The member is responsible for the remaining 20 percent of coinsurance. When covered medical services are received from a Preferred Provider, the maximum calendar year coinsurance responsibility is $3,000.

If a member elects to treat with a Non-Preferred Provider, payment for services may be substantially less than the amount billed. In addition to the deductible and coinsurance, the member is responsible for any difference between the Allowable Amount and the amount billed by the Non-Preferred Provider. Services through a non-preferred provider require the member to submit a claim for reimbursement. Claims must be submitted within 15 months from the date of service. Claim submissions are required to contain specified information including diagnoses, the types of service, and amount charged for each service. In addition, the member must submit a copy of the provider’s billing showing the services rendered and the dates of treatment. Covered services provided by a Non-Preferred Provider are paid at 60 percent of the Allowable Amount. When covered medical services are received from a Non-Preferred
Provider, there is no maximum coinsurance financial responsibility and the member will be responsible for any charges that exceed the Allowable Amount.

Members are permitted to contact Anthem and ask to be provided with information on how much the Plan will pay for certain planned procedures to be performed by a Non-Preferred Provider. The member must request that Anthem send a form to the Non-Preferred Provider, who is then required to complete the required information such as the specific procedure code numbers and projected dollar amounts for the proposed procedure. After receiving the completed form from the Non-Preferred Provider, Anthem will determine the Allowable Amounts and send a copy of this information will to the member and Non-Preferred Provider.

The plan allows for certain members who live outside a 50-mile radius of a Preferred Provider to obtain reimbursement for services from a Non-Preferred Provider following an authorized referral. The plan will then cover the services at 80 percent of the Allowable Amount.

The EOC provides a list of covered physician services and hospital benefits, including ambulatory surgical centers, where inguinal hernia repair is a covered service. Again, the EOC specifies that covered services by a Non-Preferred Provider are paid at 60 percent of the Allowable Amount. Members are responsible for the remaining 40 percent and all charges in excess of the Allowable Amount.

Evaluation

11. Mr. and Mrs. Moreno contend that it was medically necessary for them to treat with a physician who would not use synthetic mesh during the hernia repair. Although they contacted several Anthem Preferred Providers, all of them indicated they used synthetic mesh. Thus, Mr. and Mrs. Moreno decided to seek treatment from
a Non-Preferred Provider. As clearly indicated in multiple parts of the EOC, the Plan only reimburses covered services by Non-Preferred Providers at 60 percent of the Allowable Amount. While Mr. and Mrs. Moreno understood that their coinsurance would be 40 percent, rather than 20 percent, for treating with a Non-Preferred Provider, they apparently did not appreciate that reimbursement was based on the Allowable Amount – not the amount billed. Clearly, they were disappointed to see that the Allowable Amount for the hernia repair was $481.20, which after their 40 percent coinsurance, resulted in reimbursement of only $288.72. However, this amount accurately reflects what respondent is entitled under the Plan.

While the Plan pays significantly less for services obtained by Non-Preferred Providers, the Allowable Amount of $481.20 for a hernia repair under general anesthesia is intuitively low. Reason dictates that there were other covered services provided by Summerlin/Dr. Petersen that were not specified in respondent’s request for reimbursement, such as general anesthesia and post-operative services. Had respondent submitted an itemized bill with specific procedure codes, Anthem might have reimbursed other covered services. However, because it appears Mr. and Mrs. Moreno submitted only a “bundled” invoice, with presumably a single procedure code, reimbursement was determined solely based on that information. Ultimately, when seeking reimbursement from a Non-Preferred Provider, it is the member’s responsibility to submit the documentation required under the EOC, and to provide the correct information on those documents. Based on the documentation submitted to Anthem, Anthem appropriately processed the claim.
LEGAL CONCLUSIONS

Applicable Statutes and Regulations

1. The CalPERS Health Program is governed by the PEMHCA and its implementing regulations. (Gov. Code, § 22750 et seq.; Cal. Code Regs., tit. 2, § 599.500 et seq.)

2. The CalPERS board 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].)

3. 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.

4. Mr. Moreno 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 above, the cost of services respondent received from Summerlin/Dr. Petersen exceeded Anthem’s Allowable Amount for the service. The EOC specifically states that the Allowable Amount is frequently lower than what is customarily charged. (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”].) Mr. and Mrs. Moreno elected to treat with a Non-Preferred Provider with the understanding that they would incur greater costs. Although their reason for doing so was based on medical considerations, i.e. a surgeon who would not use synthetic mesh, the EOC provides no exception for a member to use a Non-Preferred Provider for this reason. The only provision allowing for higher coverage for a Non-Preferred Provider is where there are no Preferred Providers in the member’s geographic vicinity, which is not applicable here. While it is understandable why Mr. and Mrs. Moreno elected to proceed with a Non-Preferred Provider under these circumstances, the EOC clearly indicated that they would incur greater financial responsibility for the procedure. Accordingly, Anthem appropriately provided benefit coverage based on the information submitted in respondent’s request for reimbursement.

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ORDER

The appeal by respondent Henry Moreno is denied.

DATE: October 19, 2020

ADAM L. BERG
Administrative Law Judge
Office of Administrative Hearings