BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of:	)	
	)	
G J. T	)	OAH No. 10-0415-PER
	)	Agency No. PRH2010-0805

DECISION

I. Introduction

G J. T submitted a claim under his health care plan for the cost of a multi-focal intraocular lens. The claim was denied on the ground that the lens was not medically necessary. Mr. T exhausted his appeals under the health care plan, and the denial was upheld by the administrator. Mr. T filed an appeal to the Office of Administrative Hearings.

The parties filed cross-motions for summary adjudication. The undisputed evidence establishes that Mr. T has received payment under the health plan's medical benefit for the cost of cataract surgery and implantation of an intraocular lens and for the cost of a mono-focal intraocular lens. The undisputed evidence also establishes that the cost of a mono-focal intraocular lens plus corrective eyeglasses is less than the cost of a multi-focal intraocular lens. Accordingly, the additional cost of a multi-focal intraocular lens is not a covered expense.

The administrator has also shown, by undisputed evidence, that Mr. T did not reasonably rely on the information provided by the benefits administrator in electing to have a multi-focal lens implant rather than a mono-focal lens plus eyeglasses. Accordingly, the administrator is not equitably estopped to deny coverage.

For these reasons, the administrator's motion for summary adjudication is granted, and Mr. T's motion is denied.

II. Facts

G J. T is a retired employee in the Public Employees' Retirement System. As such, he is entitled to benefits under the retiree health care plan.

On January 5, 2009, Mr. T was examined by Dr. Kenneth A. Jones, M.D., who is associated with the Ozark Eye Center (Ozark).[1] Dr. Jones determined that Mr. T had cataracts in both eyes and that it was medically necessary to have cataract surgery and to implant intraocular lenses to correct his condition.[2] Dr. Jones informed Mr. T that there are two choices for the type

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1 Ex. B.

2 Ex. B; R. 39.

of intraocular lens to be implanted: a mono-focal lens or a multi-focal lens.[3] A mono-focal lens provides distance vision, and with such a lens a person must wear eyeglasses for near vision.[4] A multi-focal intraocular lens provides both near and distance vision, and with such a lens a person generally does not require eyeglasses for near vision.[5] Dr. Jones told Mr. T that multi-focal lenses were not covered by Medicare and that coverage by private insurance depended on the plan.[6]

On January 9, 2009, at Mr. T's request, Ozark called Premera, the benefits administrator, to inquire about coverage for a multi-focal lens.[7] Ozark informed Premera that the lens would be billed under code V2788 and would not be covered by Medicare.[8] Premera stated that precertification was not required, and that the lens would be covered if medically necessary, and that the denial of coverage by Medicare would be taken into consideration.[9] Ozark immediately called Mr. T and reported the conversation; Mr. T was told that there was "no guarantee [of coverage] either way," and that the multi-focal lenses cost $2,000 each.[10] About a half an hour after Ozark's call to Premera, Mr. T's wife called Premera.[11] She informed Premera that her husband had been given a choice between a mono-focal ("single") lens, or a multi-focal ("multiple") lens with a service code of V2788.[12] Premera informed her that the V2788 code was not on a list of excluded items, and that coverage for the lens implanted would be determined based upon medical necessity and the amount charged.[13] Premera informed Ms. T

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3 Ex. B; R. 39. Mr. T was not informed of the availability of a third type of intraocular lens, known as an accommodative lens, which provides near, intermediate and distance vision by mimicking the plasticity of the natural lens. Payment for an accommodative lens (Crystalens) was the subject of In Re V.C., OAH No. 09-0553-PER (Office of Administrative Hearings 2010). The patient in that case was ruled out for use of a multi-focal intraocular lens due to a previous condition. *Id.*, at 2, note 6. Both multi-focal and accommodative lenses are identified as presbyopia-correcting lens for purposes of Medicare terminology. *See* R. 56; CMS Manual, Publication 100-04, Transmittal 636 August 5, 2005); www.cms.gov/HospitalOutpatientPPS/Downloads/PCIol+ACIol.pdf (accessed May 13, 2011).

4 R. 39.

5 R. 39; Ex. B.

6 Ex. B.

7 Ex. B; R. 39, 46, 49, 76.

8 Ex. A; R. 139.

9 Ex. A; R. 139.

10 Ex. A.

11 Ex. A; R. 140.

12 R. 140. Medical service and procedure codes generated by the American Medical Association's Current Procedural Terminology (CPT) are used as basis for the federally-mandated Healthcare Common Procedure Coding System (HCPCS) for purposes of Medicare and Medicaid. *See* Reply, Ex. A; Rebuttal, Ex. C, Ex. D.

13 R. 140.

that the provider could request a benefits advisory to determine if the lens would be covered, and provided a telephone number to call.[14]

The Ts reported what they had been told to Ozark.[15] The next day, January 9, Ozark's insurance coordinator, consistent with Premera's suggestion that it call for a benefits advisory, called Premera again, at the number Premera had provided, to inquire about coverage for a multi-focal lens.[16] The Premera representative at that number stated that because the procedure was not on the "m[edical] n[ecssity] list to review" a benefits advisory was not available; the call was transferred to a customer service representative.[17] Ozark's insurance coordinator was again told that the V2788 procedure code would not be reviewed for medical necessity in advance because it was not on the list to be reviewed; she was told that the code was "accepted" and was not "an exclusion" but that coverage would not be decided until after the procedure was performed.[18] Later that day, Ozark's insurance coordinator reported to Ms. T what Premera had told her, and informed Ms. T that Ozark could not "guarantee any payment from the insurance on the premium iol [intraocular lens] cost."[19] Ms. T was told that "if they [the insurance] don't pay, they [the Ts] will owe the remaining balance."[20] Ms. T said they would think about it and then decide.[21] On January 12, Ms. T called Premera again and discussed the matter further.[22]

This was the first time, in some 35 years of dealing with health care coverage under the Alaska health care plans, that Mr. T had experienced a refusal to provide a predetermination based on the coding provided.[23] Ultimately, Mr. T elected to have the multi-focal lens implanted. When he made that decision, he was aware that the cost of a multi-focal lens would

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14 R. 140

15 Ex. A.

16 Ex. A.

17 Ex. A; R. 141.

18 Ex. A, Ex. B; R. 141, 142 ("advise provider that the code v2788 is not something that we will review for medical necessity ahead of time as medicare is primary and it is not on the list to be reviewed"). According to Premera's notes, Ozark was told that if Medicare denied the claim as a non-covered service, Premera would "apply to the members benefits"; if the claim was denied as not medically necessary, then Premera would deny it as well. R. 142. Ozark's notes are to the same effect. Ex. A.

19 Ex. A.

20 Ex. A.

21 Ex. A.

22 Premera's note of this conversation states that the caller was told "would not be covered under plan, is not med nec – would be cosmetic." R. 143. Mr. T specifically and quite directly denies this. Response at 7 ("On page 14, line 5 referring to this phone call, the note referred to is completely untrue. B T was not told this would not be covered under the plan, she was not told it was not medically necessary, and the word cosmetic was never used in response to any of these inquires."). Because the evidence on this issue is disputed, no finding has been made regarding whether coverage was directly denied in the January 12 conversation.

23 Opp. at 6.

not be covered by Medicare.[24] In part, Mr. T's choice of a multi-focal lens was based on consideration of the relative cost of a multi-focal lens (with no eyeglasses) compared with the cost of a mono-focal lens (with eyeglasses).[25] Mr. T also relied on Premera's statements that V2788 is an "accepted" code, that a multi-focal lens was not on the "non-covered" list, and that pre-certification was not necessary and would not be provided prior to surgery.[26] Dr. Jones performed the cataract surgery on March 17 and 31, 2009,[27] as an outpatient procedure at Ozark, which is an ambulatory surgical center.[28] An Alcon Restor posterior chamber multi-focal intraocular lens was inserted in both eyes.[29] Each lens cost $2,000.[30]

Ozark and Dr. Jones submitted claims for payment directly to Premera. Their claims totaled $11,391.43,[31] including (for each date): (1) Ozark's facility charges, submitted under service code 66984 ("cataract removal with insertion of intraocular lens")[32] (2 x $1,755.00) with the diagnosis of 366.16 (nuclear sclerosis);[33] (2) Ozark's charges for the multi-focal lens, submitted under service code V2788 ("Presbyopia correcting function of intraocular lens"),[34] with the notation GY (not covered by Medicare)[35] and the diagnosis code of 367.4 (presbyopia)[36] (2 x $2,000.00);[37] (3) Dr. Jones's fee (2 x $1,550),[38] and (4) other charges.[39] Medicare, the primary insurer, paid $3,133.10 towards the cataract removal and lens implant;[40]

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[24] Opp. at 2 ("Claimant and provider…were are that Medicare would not cover MULTI's") (emphasis in original).

[25] R. 40, 45, 49, 75-76.

[26] R. 40, 45, 49, 75-76.

[27] R. 134-135.

[28] R. 123.

[29] R. 134-135. This lens is recognized as a presbyopia-correcting lens for purposes of Medicare. *See* www.cms.gov/HospitalOutpatientPPS/Downloads/PCIol+ACIol.pdf (accessed May 13, 2011).

[30] Ex. A.

[31] This is consistent with the $5,072.36 charged for implantation of a single accommodative intraocular lens in In Re V.C., OAH No. 09-0553-PER at 3.

[32] Rebuttal, Ex. C, p. 2; R. 128.

[33] R. 118, 128, 129 (March 17).

[34] Reply, Ex. A, p. 2; Rebuttal, Ex. C, p. 1; R. 103.

[35] Reply, Ex. A, p. 3.

[36] Presbyopia has been described as:

> [A]n age-associated progressive loss of the focusing power of the lens of the eye resulting in difficulty seeing objects at hear distance, or close-up. Presbyopia occurs as the natural lens of the eye becomes thicker and less flexible with age.

Centers for Medicare & Medicaid Services, Ruling No. 05-01 (May 3, 2005).

[37] R. 67, 69, 71, 82, 97, 113. It appears that Ozark initially submitted the facility charge and the charge for the lens as a single claim for $3,755 on each date, and that it was separated out by Premera. *See* R. 130.

[38] R. 113, 123.

[39] R. 123, 128. The other charges for March 17 were $360.00, and for March 17 were $421.43.

[40] R. 107, 123. It appears that Ozark initially submitted the facility charge and the additional cost of the lens as a single claim for $3,755 on each date, and that it was separated out by Premera. *See* R. 130.

Premera paid the remaining $376.90. Similarly, it appears that Dr. Jones's fee and the other charges were paid in full by Medicare and Premera, for total payments of $7,391.43,[41] leaving a balance unpaid of $4,000, which represents the cost of the multi-focal lenses.

Premera initially denied the claims of $2,000 for service code V2788 in their entirety.[42] The appeal procedure resulted in a determination that the cost of a mono-focal lens plus future eyeglasses or contacts was less than the cost of a multi-focal lens, and that the additional cost of a multi-focal lens was therefore not medically necessary as that term is defined in the health care plan,[43] but that the claim should be paid at the amount commensurate with the recognized cost of a mono-focal intraocular lens.[44] Thereafter, Premera paid $150 for each lens.[45]

III. Discussion

A motion for summary adjudication in an administrative hearing is equivalent to a motion for summary judgment in a court case.[46] It is a means of resolving disputes without an evidentiary hearing and testimony by witnesses, when the central underlying facts are not in contention. In order to be entitled to summary adjudication, a party must present evidence that, if unrebutted, establishes that party's right to a decision in its favor; if the party meets that threshold, then the other party must present evidence that creates a genuine dispute as to a material fact.[47] In evaluating a motion for summary adjudication, if there is any room for differing interpretations, all facts are to be viewed, and inferences drawn, in the light most favorable to the party against whom judgment may be granted.[48]

In this case, the parties' motions raise two distinct issues: first, is the cost of a multi-focal lens a covered expense under the plan; and second, if the cost is not a covered expense, is the administrator estopped to deny coverage. The first issue depends on the relative cost of a multi-focal lens as compared with a mono-focal lens plus eyeglasses: coverage extends to all services and supplies that are medically necessary, and the health care plan provides that a service or supply is medically necessary if it is expected to alleviate a condition and is less expensive than

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41 R. 82.

42 R. 99-102.

43 R. 93.

44 R. 72 ("Pls allow payment for this service as if the 'monofocal' lens had been used, as a [mono-focal lens] is medically necessary."). *See* R. 68, 70.

45 R. 97-98.

46 *See, e.g.*, Schikora v. State, Dept. of Revenue, 7 P.3d 938, 940-41, 946 (Alaska 2000).

47 2 AAC 64.250(b). An issue of fact is "material" if it would make a difference in the outcome. *See* Whaley v. State, 438 P.2d 718, 720 (Alaska 1968).

48 Samaniego v. City of Kodiak, 2 P.3d 78, 82-83 (Alaska 2000).

alternative services or supplies. The second issue depends on whether Mr. T reasonably relied on the information Premera provided to him as a basis for choosing a multi-focal lens rather than a mono-focal lens plus eyeglasses.

A. Undisputed Evidence Shows That The Claim Was Properly Denied

1. The Claim Is For The Cost Of Multi-Focal Lenses

It is undisputed that Mr. T required cataract surgery, and that cataract surgery requires implantation of an intraocular lens. It is Medicare policy to pay for that portion of the cost of implanting a multi-focal lens during the course of cataract surgery that is equal to the cost of implanting a mono-focal lens.[49] Similarly, medical benefits under the plan include the cost of cataract surgery and implanting a mono-focal intraocular lens, as well as the cost of a mono-focal lens itself, even if a multi-focal lens was implanted.[50]

In this case, Ozark's facility charge was $1,755 per eye, which under Medicare rules should have included the cost of a mono-focal intraocular lens,[51] and Dr. Jones's fee was $1,500 per eye. All of those charges, along with other miscellaneous charges, were submitted under procedure code 66984. Mr. T received the full benefit of $7,391.43 payable under Medicare and the health care plan for the services billed under procedure code 66984, which covered the Ozark's charges and Dr. Jones's fee for cataract surgery and implantation of mono-focal intraocular lenses, including the cost of a mono-focal lens. At issue in this case is the remaining $4,000 that was unpaid, which consists entirely of the additional cost of multi-focal lens over the cost of mono-focal lenses. That cost was submitted to Premera by Ozark under the code V2788,

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49 *See* R. 54 (Centers for Medicare & Medicaid Services, Ruling No. 05-01) (May 3, 2005).

50 *See* In Re V.C. at 7.

51 Medicare billing procedures are detailed in the CMS Online Medicare Claims Manual (hereinafter, "Claims Manual"), available at www.cms.gov/Manuals/IOM (accessed May 13, 2011).The provisions applicable to cataract surgery and implantation of a presbyopia-correcting lens are detailed in the Claims Manual, Ch. 32, §120. Billing procedures vary, depending on whether the procedure is performed in an office or in a doctor's office, a hospital or an ambulatory surgical center, but in all cases the procedure is billed as if a conventional lens had been implanted. *Id.* When the procedure is performed in an ambulatory surgical center, the cost of the lens is considered rolled into the facility charge and Medicare does not make a separate payment for the lens. *Id.* In those cases, the charges associated with the services, including the cost of a mono-focal lens, are submitted under the code 66984, whether the lens actually implanted is a mono-focal lens or a multi-focal lens; the facility is directed to "report HCPCS code V2788 to indicate any additional charges that accrue for insertion of a [presbyopia-correcting intraocular lens]." *See id.*, §120.2; Rebuttal, Ex. E, p. 2 ("[T]he new HCPCS code V2788…should be used to track and account for non-covered services associated with the insertion of a [multi-focal] lens. Code V2788 may be used by…ASC's to reflect charges for the [multi-focal] lens."); CMCS Manual, Publication 100-04, Transmittal 636 (August 5, 2005) ("The facility shall bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or presbyopia-correcting IOL is inserted.").

which is the code for the "presbyopia correcting function of intraocular lens," with the modifier GY, signifying that item was not Medicare-eligible.

2. A More Costly Item Is Not Medically Necessary

Mr. T's claim is based on the medical benefit provisions of the health care plan. The health care plan provides medical benefits coverage for services and supplies that are medically necessary to treat a physical or medical condition.[52] In general, a service or supply is medically necessary to treat a condition if it is "expected to improve or maintain…health or to ease pain and suffering without aggravating the condition or causing additional health problems."[53] But the plan includes an additional criterion, namely that to be medically necessary a service or supply must be "no more costly than another service or supply (taking into account all health expenses incurred in connection with the service or supply)."[54] Accordingly, a multi-focal lens implanted as a treatment for cataracts is not a covered expense if it is more costly than a mono-focal lens plus eyeglasses as a treatment for cataracts.

Mr. T argues that because a mono-focal lens would have left him with impaired vision, the implantation of a multi-focal lens was medically necessary. But implantation of a multi-focal lens is not the only possible form of treatment for cataracts. The undisputed evidence is that implantation of a mono-focal intraocular lens, coupled with eyeglasses, is an effective treatment for cataracts.[55] It may be, as Mr. T points out, that an alternative treatment that is more expensive may be deemed medically necessary because it is more effective, has a higher success rate, has fewer side effects, or otherwise provides a medical benefit beyond a less expensive treatment.[56] However, Mr. T has not asserted that implantation of a multi-focal lens provides a medical benefit as compared with implantation of a mono-focal lens plus eyeglasses. Rather, he asserts that implantation of a multi-focal lens provides a medical benefit as compared with implantation of a mono-focal lens, a fact that is undisputed. More to the point is the relevant Medicare ruling, which expressly observes that "[a]…single presbyopia-correcting lens essentially provides what is otherwise achieved by two separate items: an implantable

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52 R. 63 (Health Care Plan, p. 17).

53 *Id.* Presumably, this is what Dr. Jones meant when he said that a multi-focal lens was medically necessary.

54 R. 64 (Health Care Plan, p. 18).

55 R. 55-56, 93. By statute, Medicare provides payment for one pair of eyeglasses following implantation of an intraocular lens. R. 56.

56 Response at 2 (comparing pegleg to prosthetic leg, and inpatient drug and alcohol treatment to outpatient treatment).

conventional IOL (one that is not presbyopia-correcting), and eyeglasses or contact lenses."[57] This is evidence that a multi-focal lens provides no medical benefit as compared with a mono-focal lens plus eyeglasses. Mr. T has neither argued nor presented evidence to the contrary, and it is therefore established, for purposes of this motion, that multi-focal lenses provide no medical benefit as compared with mono-focal lenses plus eyeglasses.

3. A Multi-Focal Lens Is More Costly

In order to determine which of two alternative treatment options is less costly for purposes of medical necessity, the total "health expenses incurred in connection" with those two options must be compared. Thus, in order for a multi-focal intraocular lens to be considered medically necessary for the treatment of cataracts, it must be shown that the cost of such a lens is equal to or less than the cost of a mono-focal lens plus eyeglasses.

The evidence regarding the cost of a multi-focal lens is undisputed: Ozark asserted, and there is no evidence to the contrary, that such a lens costs $2,000.[58] In addition, the administrator has submitted evidence, in the form of a statement by the claims reviewer, that the cost of a mono-focal lens plus eyeglasses is less than the cost of a multi-focal lens.[59] Mr. T has not submitted any evidence to refute the claims reviewer's assertion, or to establish the actual cost of a mono-focal lens plus eyeglasses.[60]

Because there is undisputed evidence that the cost of a multi-focal lens exceeds the cost of a mono-focal lens plus eyeglasses, and that a multi-focal lens provides no medical benefit as compared with a mono-focal lens plus eyeglasses, the administrator is entitled to summary adjudication on the issue of medical necessity.

B. Estoppel

For purposes of this case, it will be presumed that the administrator is estopped to deny coverage if (1) the benefits administrator asserts that a particular service or supply is covered; (2)

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[57] R. 56.

[58] If the $2,000 cost quoted by Ozark and charged under code V2788 GY is the total cost of a multi-focal lens, rather than just the additional cost of a multi-focal lens as compared with a mono-focal lens, then it would appear that Mr. T should be credited by Ozark with payment of that portion of the total cost of a multi-focal lens that is equal to the cost of a mono-focal intraocular lens, since Medicaid and Premera have paid the full amount charged under procedure code 66984, and that charge should have included the total cost of a mono-focal lens. *See* note 51, *supra*.

[59] R. 93.

[60] The cost of a mono-focal lens could be determined by the benefits administrator reviewing charges submitted by providers when a mono-focal lens is implanted in an office setting. In those cases, the cost of a mono-focal lens is submitted for insurance payment under the code V2632.

the retiree reasonably relies on that assertion in obtaining the service or supply; (3) a claim for coverage is denied; and (4) estoppel serves the interest of justice so as to limit public injury.[61]

1. Assertion of Coverage

Mr. T does not dispute the fact that, as the administrator points out, Premera never made an affirmative representation that a multi-focal lens is covered. The administrator suggests that this is sufficient to show that the first element of a claim of estoppel (assertion of coverage) has not been established. However, it is not necessary, for purposes of estoppel, that a party must make an affirmative representation. Rather, a party who fails to disclose information that it is under a duty to disclose may be held responsible for silence.[62]

In this case, Mr. T made a request for information concerning coverage for a specific item in the course of a specific medical procedure; he argues that Premera should have provided a direct answer regarding coverage for a multi-focal lens, and that in the absence of a direct answer from Premera, the administrator is estopped to deny coverage.[63] The administrator has not directly denied that Premera had a duty to provide a direct response to Mr. T's inquiry, given the information that Mr. T provided.[64] Rather, the administrator asserts that it did give a direct response, when Ozark was told on January 9 that if Medicare denied the claim, "we will also deny," and when Ms. T was told on January 12 "the lenses would not be covered…because they were not medically necessary."[65]

The referenced statements are insufficient to establish, for purposes of the administrator's motion, that Premera informed Mr. T that a multi-focal lens was not covered. The first statement is not a denial of coverage for a multi-focal lens, but rather a statement that coverage would depend on what Medicare did. According to Premera's notes, it told Ozark on January 9 that if

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[61] The general principles applicable to estoppel against the administrator were stated in Crum v. Stalnaker, 936 P.2d 1254, 1256 (Alaska 1997) and have been restated as they would apply in the context of a coverage issue. No prior Alaska Supreme Court decision addresses estoppel in that context, and this decision should not be taken as a ruling that estoppel applies in that context.

[62] *See* Crum v. Stalnaker, 936 P.2d at 1258.

[63] Response at 6-7. Mr. T states that Wells Fargo, the current benefits administrator, has informed him that a request such as his would be give a direct answer prior to surgery.

[64] This is not a case in which the assertion is that the division failed to contact a member and provide information relevant to a claim that had not been filed. *See* In Re A.H., OAH No. 07-0392-PER at 7 (Office of Administrative Hearings 2008) ("The division does not have an obligation or duty to seek out every member who files for a workers' compensation claim and provide them with an occupational disability application."). Nor is this a case in which the division failed to contact a member with respect to an ambiguity in an application that had been filed. *See* In Re D.E.W., OAH No. 07-0142-TRS at 18 (Office of Administrative Hearings 2008) (estoppel applied where division failed to contact member to determine intent when reviewing application with "obvious discrepancy").

[65] Motion at 15.

Medicare denied the claim as non-covered, Premera would "apply to the members benefits" [*sic*]: this is far from a denial of coverage under the health care plan. As for the second statement, Mr. T has quite directly and specifically denied it was made,[66] and thus it is not undisputed and must be disregarded for purposes of the administrator's motion. For these reasons, the administrator has not established by undisputed evidence that Mr. T was told that the multi-focal lens was not covered. Accordingly, because the administrator has not denied that the benefits administrator had a duty to disclose that fact in response to a specific inquiry, the administrator has not established a right to summary adjudication on the first element of estoppel.

2. Reasonable Reliance

The crux of the dispute between the parties concerns the second element of a claim of estoppel (reasonable reliance). The administrator argues that "Mr. T's provider and his spouse both were given sufficient information by Premera to know that [multi-focal lenses] were not a covered benefit."[67] This, in substance, is an assertion that Mr. T could not reasonably rely on the information he was provided, in its totality, as a basis for concluding that a multi-focal lens was a covered expense. Mr. T's position is that Premera's statements that V2788 was an "accepted" code and that coverage for the lens did not need to be predetermined because it was not on the review list, coupled with Premera's failure to provide a direct response to the question whether the lens would be covered, is sufficient to establish grounds for estoppel.[68] He argues that it is logical (*i.e.*, reasonable) for a patient to conclude, when the benefits administrator says that a code is "accepted" and does not need to be reviewed in advance and that a pre-determination of coverage is not required, that the item that is the subject of the code is covered.[69]

Mr. T focuses only on the information provided to him that is favorable to his view: that the code was valid, predetermination was not required, and a multi-focal lens was not on the review list. Looking only to that information, even the administrator would apparently concede that Mr. T would reasonably have believed that the implantation of a multi-focal lens was a covered service.[70] But in deciding whether reliance is reasonable, <u>all</u> of the information provided to Mr. T by Premera must be taken into account. In addition to the information that

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66 *See* note 14, *supra*.
67 Motion at 15.
68 Response at 4.
69 Response at 7.
70 R. 9 (P. Shier to G. T, 7/8/2010 at 2, sec. 4).

Mr. T highlights, there is undisputed evidence that Ozark was told that coverage was contingent on what Medicare did,[71] and that both Mr. T and his wife were told by Ozark, in two separate conversations, that there was no guarantee that Premera would pay for a multi-focal lens.[72] In addition, Mr. T himself has asserted his choice of a multi-focal lens was based in part on his own consideration of the relative cost of a mono-focal lens plus glasses as compared with the cost of a multi-focal lens.[73] That relative cost is precisely what the health care plan provides is the basis for a determination of medical necessity. Thus, by Mr. T's own admission, his choice of a multi-focal lens was, in part, the result of his own independent judgment as to relative cost, a judgment that he made without any reference at all to information provided by Premera.

Because undisputed evidence shows that Ozark was informed that coverage was contingent on what Medicare did, both Mr. T and his wife were informed that there was no guarantee of payment by insurance, and Mr. T made an independent judgment as to the relative cost of the services requested, the administrator has shown that, in light of all the information provided to him,[74] Mr. T did not reasonably rely on Premera's failure to directly deny coverage as a basis for his decision to obtain a multi-focal lens. Therefore, the administrator is entitled to summary adjudication on the issue of estoppel.

IV. Conclusion

Coverage for the additional cost of a multi-focal intraocular lens is excluded under the medical benefit because, according to the undisputed evidence submitted by the administrator, such a lens is more expensive than a mono-focal intraocular lens plus eyeglasses and that is an alternative treatment that is at least equally medically beneficial. Mr. T was informed, before his surgery, that there was no guarantee of coverage for a multi-focal intraocular lens, and he relied in part on his own independent determination of relative costs in electing that lens; the administrator is therefore not estopped to deny coverage for such a lens.

The administrator's denial of the claim for payment for the additional cost of a multi-focal intraocular lens is **AFFIRMED**.

DATED May 20, 2011. By *Signed*
Andrew M. Hemenway
Administrative Law Judge

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71 *Supra*, notes 9, 10.
72 *Supra*, notes 10, 19.
73 *Supra*, note 25.
74 Ozark contacted Premera at Mr. T's request and reported back to him.

Adoption

Mr. T filed a proposal for action objecting to the proposed decision on several grounds, three of which will be briefly addressed:

(1) Adequacy of Treatment

Mr. T objects that the logic of the proposed decision is such that if payment is restricted to the least expensive option for treatment, then patients will be forced to accept less than adequate care, such as a pegleg in lieu of a prosthetic leg. However, as pointed out in the proposed decision, Mr. T did not present any evidence that the combination of a monofocal intraocular lens plus eyeglasses provides any less of a medical benefit than a multifocal intraocular lens, or that he will have any less visual capacity using a monofocal lens plus eyeglasses than he would have using a multifocal lens. For this reason, paying only for a monofocal lens plus eyeglasses as a treatment for cataracts is not comparable to paying only for a pegleg as a treatment for loss of a leg. That is a false analogy.

(2) Overall Cost

Mr. T objects that the cost of replacing frames and lens regularly will over time make the cost of a monofocal lens plus eyeglasses greater than the cost of a multifocal intraocular lens. However, there is no evidence in the record to support that argument, and the administrative law judge must make a decision based on the evidence in the record.

(3) Estoppel

Mr. T objects that he, unlike the patient in the prior case mentioned in the proposed decision, did his best to find out if a multifocal lens would be covered, and that it is not fair that he should have to pay for such a lens when the benefits administrator repeatedly failed to give him the correct answer before he incurred the expense. As explained in the proposed decision, Mr. T expected to be paid based on the information provided by the benefits administrator that suggested coverage, but he disregarded the benefits administrator's specific statement that there was no guarantee of coverage, and because he disregarded that warning, the doctrine of estoppel does not apply.

This Decision is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Decision as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 14th day of July, 2011.

By: *Signed*
Andrew M. Hemenway
Administrative Law Judge

[This document has been modified to conform to the technical standards for publication.]