BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS

In the Matter of	)	
	)	
T O. T	)	OAH No. 15-1204-PER
	)	Agency No. 2015-0706

DECISION

I. INTRODUCTION

T T had cardiac bypass surgery. He submitted a claim to the Alaska Care Retiree Health Plan in the amount of $34,700. The Plan, through its claims administrator, Aetna, covered $22,752, of the total billed.[1] Aetna denied full payment because it determined that the bill exceeded its recognized charge for the procedures.

Mr. T appealed the partial payment denial.[2] He raised serious questions as to Aetna's data reliability and recognized charge calculation. The Division did not rebut these challenges. Additionally, Aetna did not use the correct geographic area when computing the recognized charge percentage. Because Aetna incorrectly calculated the recognized charge, Mr. T is entitled to full payment for the billed services.

II. FACTS

A. Billing and coverage.

On May 1, 2014, Mr. T underwent double coronary artery bypass surgery, performed by Dr. Pedro Valdes.[3] Before the procedure, Dr. Valdes' office requested precertification from Aetna.[4] Aetna asked the procedure code, date of service, and if Mr. T had other medical coverage.[5] Aetna did not mention, and Dr. Valdes' office did not ask, if the claims would be paid in full. Nor did either caller discuss whether Dr. Valdes was in or out-of-network, and what affect that may have on payment. Aetna approved the request.

After the surgery, Dr. Valdes' office submitted a claim for $34,700, under two separate billing codes. Under code 33533, coronary artery bypass, he billed $31,600.[6] Under code 33517, coronary artery bypass graft, he billed $3,100.[7] Aetna covered $22,172 for the bypass

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1 R77.
2 R1-9; R38-42; R69-73.
3 T testimony; R79-80.
4 R86.
5 R86-87.
6 R77.
7 R77. The EOB lists the procedures as coronary artery bypass and coronary artery bypass graft. The diagnostic code description lists 33533 as coronary artery bypass, using arterial graft(s); single arterial graft, and lists 33517 as coronary artery bypass, using venous graft(s); single vein graft. *See* R82.

and $580 for the graft.[8] Aetna's Explanation of Benefits (EOB) stated that the Plan pays based on recognized charges and that the submitted charge exceeded the recognized charge. The EOB also stated that Mr. T may owe the remaining $11,948.[9]

Mr. T appealed. Aetna upheld the partial payment in its "level one" appeal. The decision letter cited an excerpt from the Plan's 2003 Retiree Insurance Information Booklet for calculating the recognized charge.[10] Aetna upheld the partial payment in its "level two" appeal as well. The level two appeal decision letter cited the 2014 Booklet language for recognized charge calculation.[11] Among other changes, the 2014 Plan amendments altered the recognized charge explanation.

The level two appeal letter included the data tables that Aetna used to determine the recognized charge for each procedure.[12] Aetna uses data from a national non-profit, FAIR Health, to calculate recognized charges.[13] The table for both procedure codes included the following language: "FAIR Health, Inc. 2011, All Rights Reserved. CPT 2010 American Medical Association (AMA), All Rights Reserved." The area profile was "Area 995," which is the beginning of zip codes in the greater Anchorage area. For billing code 33533, the table included the following percentiles:

PERCENTILES						
50TH	60TH	70TH	75TH	80TH	85TH	90TH
21796	21796	21796	21796	21796	21796	22172

The following table was for billing code 33517:

PERCENTILES						
50TH	60TH	70TH	75TH	80TH	85TH	90TH
486	500	513	514	527	540	580

The tables did not include the number of total area charges, or data points, for either billing code.[14]

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8 R77.
9 R77.
10 R70.
11 R41. The 2014 Retiree Plan amendments were made as attachments to the 2003 Booklet. For ease of reference, the terms 2003 Booklet and 2014 Booklet (actually the 2003 Booklet with 2014 amendments) will be used throughout this decision to identify the two Plan versions at issue. Both are available at: http://doa.alaska.gov/drb/alaskaCare/retiree/publications/booklets.html
12 R40.
13 R59.
14 R40. "Num of charge" appeared as a table heading, but the cell below was blank.

Mr. T appealed to the Office of Administrative Hearings in July 2014.[15] After a number of delays, the hearing occurred on May 23, 2016.[16] Mr. T represented himself. Assistant Attorney General, Thomas Dosik, represented the Division.

B. Document production and coverage questions.

In early 2016, Mr. T let the Division know that he believed the 2003 Booklet controlled coverage, as opposed to the 2014 Booklet.[17] He explained that this belief arose from an October 27, 2014, letter to retirees from Commissioner Thayer, former Commissioner of Administration. The parties agreed that which Booklet controlled would have a significant impact on the case's outcome.[18] The Division requested, and was granted, a continuance to research this issue.

In his prehearing brief and at hearing, Mr. T again asserted that the 2003 Booklet controls. The Division responded that it was unable to locate the October 2014 letter and maintained that the 2014 Booklet controls. The record remained open after the hearing in order for Mr. T to provide a copy of the letter. He did so on the day of hearing. The letter states, among other things, that the 2003 Retiree Plan Booklet is the "current plan document."[19] Commissioner Thayer goes on to say, "Next year, we will try again to engage with the members to update the 2003 Retiree Plan Booklet."[20]

The record was also left open for the Division to provide three pieces of information: 1) briefing regarding the effect of Commissioner Thayer's letter; 2) information from Division personnel confirming the 2014 retiree health plan changes' compliance with *Duncan v. Retired Public Employees Association;* and 3) additional information on recognized charge calculation.[21] The Division's deadline was June 6, 2016. Mr. T's deadline for any response to the Division was June 13, 2016. On June 14, 2016, the day after record closure, the Division requested an extension of its deadline to respond. The Division stated that it was yet to receive recognized charge information from Aetna. Mr. T objected to the extension.

The extension was denied for two reasons. First, the Division did not request the extension before its deadline ran. In fact, it waited until after Mr. T's deadline had passed and it did not contact Mr. T in advance to explain why it was late and negotiate an extension. The

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15 R2.

16 Both parties were amendable to continuances. Mr. T travels frequently and the Division wanted time to explore issues raised in Mr. T's appeal.

17 Status conference, January 13, 2016.

18 Status conference, January 13, 2016.

19 Ex. A, Letter to Retired Public Employee from Commissioner Curtis Thayer, p.2, October 27, 2014.

20 Ex. A.

21 *See* 71 P.3d 882 (Alaska 2003).

Division could have easily submitted the other information on time and requested an extension on the remaining information, or requested an extension before record closure. Second, the Division failed to timely respond or follow up on other commitments for months leading up to hearing.[22] Further, the Division knew that the recognized charge was at issue. It should have produced this information to Mr. T in advance of the hearing or at least brought witnesses who could testify about the calculation of the recognized charge to the hearing. Therefore, the Division did not have good cause to justify this deadline extension request.

III. DISCUSSION

Mr. T has the burden of proof to establish that the Division's payment authorization was, more likely than not, incorrect.[23] He raised several issues in his appeal. Mr. T's argument that the Plan should cover the entire billed amount can be broken down into a few main categories:

- Aetna's recognized charge calculation is incorrect and the data is not available for fact checking.
- Aetna's process lacks transparency and has poor customer interface.
- Plan changes, including lower reimbursement rates, amount to an unconstitutional diminishment of retirees' accrued rights under the Alaska Constitution.[24]

Because this case can be determined on the recognized charge issue alone, the other issues are not examined.

A. The 2003 Booklet controls.

The Booklet is the insurance contract for Plan members.[25] Insurance contracts are treated as contracts of adhesion.[26] They are construed "so as to provide that coverage a layperson would have reasonably expected from a lay interpretation of the policy terms."[27] "Additionally, insurance coverage provisions should be broadly construed while exclusions are interpreted

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[22] The Division stated on record multiple times that it would contact Mr. T and attempt to resolve the matter. Mr. T repeatedly informed the OAH that no such follow up was forthcoming. Additionally, the Division did not timely respond to OAH requests for follow up with Mr. T before hearing. OAH staff had to follow up with Division staff on at least two occasions in order to get status updates that were already overdue.

[23] *See* 2 AAC 64.290(e).

[24] The Division asserted, through its attorney, that the 2014 Health Plan amendments complied with the requirements described in *Duncan* for making changes to the retiree health plan. The OAH ordered the Division to confirm that an actuarial analysis of the Health Plan changes was completed before adoption of the 2014 amendments. Confirmation from Division staff was ordered over the Division's objection. The Division did not supply the requested confirmation. Without this confirmation, it is impossible to determine whether the *Duncan* requirements were met.

[25] *In re DM*, OAH No. 08-0153-PER (2008), page 2.

[26] *Whispering Creek Condominium Owner Association v. Alaska National Insurance Company*¸ 774 P.2d 176, 177 (Alaska 1989).

[27] *Whispering Creek,* 774 P.2d at 177 – 178.

narrowly."[28] If insurance policy language is ambiguous, a tribunal will accept the interpretation that most favors the insured.[29]

In order to determine the appropriate recognized charge, we must first determine what Plan language controls. The Division, both in hearing and on its website, lists January 1, 2014, as the effective date of the plan amendments. However, Commissioner Thayer's letter contradicts this information. In his October 27, 2014, letter, the Commissioner states that the 2003 Booklet is the current plan and that the Department would again attempt changes the following year.[30] The Division did not address the effect of Commissioner Thayer's letter.

The Division is subordinate to the Commissioner. According to the Commissioner's letter, the 2003 Booklet controlled until at least the end of 2014. The Division cannot ignore the letter or claim in good faith that it did not mean what it said. It is not clear when, if ever, the 2014 Booklet became effective, but it was not effective on May 1, 2014, the day of Mr. T's surgery. Consequently, Mr. T's claim must be analyzed under the 2003 Booklet's language.

B. Recognized charge calculation.

According to the 2003 Booklet, the Plan pays for medical services based on the recognized charge.[31] There are four different ways of calculating the recognized charge. First, if Aetna has an agreement with the health care provider, then the agreed-upon amount is the recognized charge. Dr. Valdes is an out-of-network provider and does not have an agreed-upon charge for services with Aetna.[32]

When there is no agreed-upon charge, the recognized charge is the lowest of:

- The provider's usual charge for furnishing the service.
- The charge the claims administrator determines to be appropriate based on factors such as the cost for providing the same or similar service or supply and the manner in which charges for the service or supply are made.
- The charge the claims administrator determines to be the recognized charge percentage made for that service or supply.[33]

In this case, Aetna used the recognized charge percentage.

The 2003 Booklet describes how the recognized charge percentage is determined:

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28 *Whispering Creek*, 774 P.2d at 178.
29 *Bering Strait School District v. RLI Insurance Company*, 873 P.2d 1292, 1295 (Alaska 1994).
30 Ex. A.
31 R89 – R91.
32 R38.
33 R89 – R91.

> The recognized charge percentage is the charge determined by the claims administrator on a semi-annual basis to be in the 90th percentage of the charges made for a service or supply by providers in the geographic area where it is furnished. The recognized charge is determined by collecting the claims submitted for each procedure, defined by the procedure code, in a specific geographic area. The highest and lowest charges are ignored and the charge that allows 90% of all the claims to be paid in full is set as the recognized charge for that procedure. The geographic area is determined by where the procedure is performed. For example, most procedures in Juneau are based on charges submitted from all Southeast Alaska. Some types of procedures, such as surgery, are based on statewide claims data to ensure sufficient information to establish a recognized charge.[34]

Under the 2014 amendments, the recognized charge is calculated as

> the lesser of:
> - What the provider bills or submits for that service or supply; or
> - the 90th Percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies….[35]

C. Data quality concerns.

Mr. T raised salient concerns about the recognized charge calculation that were left unaddressed by the Division. First, he raised issues of the recognized charge's recentness. Aetna became the Plan's third party claims administrator on January 1, 2014. Aetna updates its systems with FAIR health data within 180 days of receiving them.[36] Mr. T's surgery was on May 1, 2014, just 120 days after Aetna became the claims administrator. Mr. T questioned whether Aetna had updated its systems with FAIR Health data before his surgery. Although the level two appeal denial letter says that the recognized charges are current as of June 2014, no one from Aetna or the Division testified to the accuracy of the letter's claim.[37]

Second, the only dates on the document containing FAIR Health's cost information are 2010 and 2011.[38] Mr. T suggested that Aetna may have calculated its recognized charge with data several years old. The Division asserted that these dates indicate copyright, not the data's collection year. Another OAH decision, *In re W S-B*, overturned Aetna's recognized charge where data year was called into question and the appellant provided an alternate recognized

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34 R90.
35 R41.
36 R59.
37 R41.
38 R40.

charge calculation from a different FAIR Health source.[39] In *W S-B*, like here, no one from the Division or Aetna with actual knowledge of FAIR Health's calculation process testified. While Mr. T did not provide an alternate recognized charge calculation, like the claimant in *W S-B*, he did testify that his provider and two other cardiac specialists in the Anchorage area do not provide charge data to FAIR Health. This, too, casts doubt on the reliability of Aetna's recognized charge determination.

In addition to concerns raised by Mr. T, the table percentiles, at least for billing code 33533, also call into question FAIR Health's data adequacy. Aetna's level two appeal decision letter explained that "CRED CODE L" in billing code 33533's table meant it was "local creditable data."[40] The table contains seven percentile options, ranging from 50th to 90th percentile. Six of the seven, with the exception of the 90th percentile read "21796." It is difficult to conceive of a sufficient "creditable" data set that would have six of seven identical percentiles.

W S-B raised a similar concern. There, the data set contained nine procedures, with several of the same percentiles.[41] The record here does not contain the number of procedures in each data set and, as in *W S-B*, no explanation for the repeating percentile was given. *W S-B* inferred that the data set with repeated identical percentile numbers was less reliable than the proffered alternative.[42] Given that Aetna apparently used even fewer data points than in *W S-B* when it determined the recognized charge in Mr. T's case, the same questions of data dependability arise.

Mr. T challenged the recognized charge and requested additional information on its calculation at each stage, beginning at the second level appeal and continuing through the hearing. He was not attempting to uncover proprietary information, but get answers to reasonable questions. How often does the recognized charge get updated? What is the look back period, six months, several years? How reliable is the data set? How large is the data pool? Are specialists' charges included in the data pool?

Mr. T's appeal questions put the Division on notice that recognized charge calculation was an issue. It had the opportunity to establish its data accuracy at hearing. After hearing, the Division was ordered to supply additional information supporting its recognized charge calculation and failed to do so. The Division argued that Mr. T's assertions were mere

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39 *See In re W S-B*, OAH No. 15-1143-PER (OAH 2016), available at: http://aws.state.ak.us/officeofadminhearings/Documents/PER/PER151143.pdf.

40 R40. Billing code 33517's data was "CRED CODE J," meaning it was locally derived.

41 *W S-B* at p. 10.

42 *W S-B* at p. 12.

speculation, with no facts to back him up. This overlooks the fact that Mr. T did not have access to Aetna or the Division's recognized charge calculation process, even though he had been asking these questions for over a year.[43] When a party fails to produce evidence in its control, an inference may be made that the unproduced evidence would have been unfavorable.[44]

A slight negative inference is made here. Mr. T raised several doubts concerning data source and calculation. This alone, without an alternate recognized charge analysis, as supplied by *W S-B*, might not justify a decision in Mr. T's favor. Data reliability concerns, however, combined with Aetna's use of a smaller geographic pool than promised warrant finding against the Division.

D. The provider's charge is the appropriate recognized charge.

According to the 2003 Booklet, "Some types of procedures, such as surgery, are based on statewide claims data to ensure sufficient information to establish a recognized charge."[45] A double bypass, like Mr. T had, is a surgery. Therefore, the recognized charge should have been based on a statewide geographic area.[46] Here, the claims administrator did not use a statewide geographic area when calculating the recognized charge percentage. Instead, it used the greater Anchorage area.[47] Using the greater Anchorage area appears permissible under the 2014 Booklet, but is not under the plain language of the 2003 Booklet.

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[43] *See* R5-9; R45-48; T prehearing brief.

[44] "The general rule is well settled that where a party fails to produce, or to explain the omission of, relevant evidence within his control, the jury may infer that such evidence would be unfavorable to him. Accordingly, it is held that the failure of a party to produce the testimony of an available witness on a material issue warrants the inference that the testimony, if presented, would be adverse to such party." *Presumption or inference from party's failure to produce witnesses in hi control, as affected by his introduction of some evidence on the matter in question,* 135 A.L.R. 1375, current on Westlaw Next as of July 2016.

"Failure to call a witness or produce evidence does not automatically warrant an adverse inference. Before the inference can be applied the potential witness must be available, must appear to have special information that is relevant to the case and not merely cumulative, and the witness must be one that would ordinarily be expected to favor the party against whom the inference is directed." *Grimes v. Haslett*, 641 P.2d 813, 821 (Alaska 1982), citing *C. McCormick, Law of Evidence* s 272, at 656-57 (2d ed. 1972).

The Division had information relevant to the recognized charge calculation and a Division or Aetna employee would ordinarily be expected to favor the Division. The "merely cumulative" is not at issue in this case because the Division did not provide any witnesses.

[45] R90.

[46] An argument could be made that the "statewide claims data" sentence is ambiguous. The sentence could modify the sentence above, meaning only Southeast or smaller communities would rely on a statewide pool. It could also mean that a statewide pool is used only if insufficient data exists within the specific geographic area. Because this issue was not addressed at hearing and ambiguities are resolved in favor of the insured, the sentence is interpreted as described above.

[47] R40; Ex. 3.

A previous retiree health care case, *In re D. T.*, held that a recognized charge calculation that does not comply with the Booklet language, even if reasonable, is inappropriate.[48] That decision held that because the claims administrator's recognized charge calculation did not align with the Booklet's geographic delineation language, the provider's charge should be used instead.[49]

The same logic applies here. The 2003 Booklet states that the geographic pool for surgeries would be the entire state of Alaska, not the greater Anchorage area only. Of the four recognized charge options, the provider's charge is now the only viable option. As stated, Aetna does not have an agreement with Dr. Valdes; that method is unavailable. Next, Aetna did not use the "same or similar service or supply and the manner in which charges for the service or supply are made" option. At this late date, and without any supporting information in the record, that potential option is no longer available. Therefore, relying on *D. T.*, the appropriate recognized charge calculation must be based on Dr. Valdes' submitted charges.

IV. CONCLUSION

Mr. T, like W S-B, pointed out significant issues with the recognized charge calculation and its data quality. The Division did not respond or explain these apparent defects. In addition, the Division used the incorrect geographic area to calculate recognized charge, as it did in *D. T.* Both *D. T.* and *W S-B*, therefore, support a finding that, in this specific case, the Division's recognized charge calculation cannot be relied upon.

Mr. T is entitled to full payment on the contested claims. The Plan must provide an additional $11,948, in coverage.[50]

DATED this 28th day of July, 2016.

Signed
Bride Seifert
Administrative Law Judge

[48] *See In re D. T.*, OAH 10-0577-PER, at pp. 6-7 (OAH 2011), available at: http://aws.state.ak.us/officeofadminhearings/Documents/PER/PER100577.pdf?_ga=1.43592421.114931172.1436232472.

[49] *See In re D. T.*, at p.7.

[50] $34,700 - $22,752 = $11,948.

ADOPTION

This Order is issued under the authority of AS 39.35.006. The undersigned, in accordance with AS 44.64.060, adopts this Final 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 Rule of Appellate Procedure 602(a)(2) within 30 days of the date of this decision.

DATED this 23rd day of August, 2016.

Signed
Bride Seifert
Administrative Law Judge

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