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 Benefit Coverage for Skilled Care of:

VICTOR WANEK,

Respondent.

Agency Case No. 2023-0652

OAH No. 2024010423

PROPOSED DECISION

Administrative Law Judge Cindy F. Forman (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on September 16, 2024.

Preet Kaur, Senior Attorney, appeared on behalf of complainant Dennis Devore, Chief, Strategic Health Operations Division, Board of Administration, California Public Employees' Retirement System (CalPERS).

John Wanek (J.W.), son of respondent Victor Wanek (respondent), appeared on behalf of respondent, now deceased, under California Probate Code section 13051, which authorized J.W. to act on respondent's behalf in this matter. Sandra Wanek,

respondent's surviving spouse, who was present at the hearing, agreed that J.W. was authorized to act on respondent's behalf.

The ALJ heard testimony and received documentary evidence. The record was closed and the matter was submitted for decision on September 16, 2024.

SUMMARY

At issue in this proceeding is whether CalPERS correctly affirmed respondent's health insurer's denial of respondent's request for coverage of skilled nursing care provided to respondent after August 16, 2022. Respondent failed to prove by a preponderance of the evidence that extended skilled nursing care was medically necessary to treat his medical condition after August 16, 2022, under the terms and conditions of his medical insurance policy, and therefore the requested coverage was warranted. Accordingly, the denial of respondent's coverage request is affirmed.

FACTUAL FINDINGS

Jurisdictional Matters

1. The CalPERS Health Program is governed by the Public Employees' Medical and Hospital Care Act (PEMHCA) commencing with Government Code sections 22750 et seq. and implemented through California Code of Regulations Title 2 (CCR). PEMHCA authorizes and requires the CalPERS Board of Administration to provide health benefits for state employees, dependents, and annuitants, as well as for employees and annuitants of contracting public agencies electing to contract with CalPERS for health benefits coverage. PEMHCA is subject to the terms and conditions

of the PEMHCA regulations. (State Employees' Medical and Hospital Care Act Regs., CCR, § 599.500 et seq.)

2. Respondent worked for the Los Angeles Police Department for 25 years and as a State police officer for eight years. At all relevant times, respondent was enrolled in a health benefit plan provided by CalPERS. On August 19, 2022, respondent, through J.W., requested benefit coverage for skilled nursing care from August 16 through August 22, 2022.

3. By letter dated March 30, 2023, CalPERS notified respondent of its determination upholding the denial of respondent's request for coverage for an extended stay at a skilled nursing facility (SNF) from August 16, 2022, through September 19, 2022. CalPERS based its decision on findings by four separate medical reviewers that extended care at an SNF was not medically necessary for respondent's medical condition under the terms and conditions of respondent's health benefit plan.

4. By letter dated April 24, 2023, respondent filed a timely appeal and requested an administrative hearing. Although respondent's initial request for coverage was for the period between August 16 and August 22, 2022, the appeal was for coverage between August 16 to September 19, 2022. (Exhibit 4.) In response, on December 20, 2023, complainant in his official capacity filed the Statement of Issues seeking confirmation that respondent's insurer had appropriately denied coverage for respondent's skilled nursing care from August 16, 2022, through September 19, 2022, as not medically necessary as defined in respondent's insurance plan. This hearing followed.

5. All jurisdictional requirements are met.

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Respondent's Health Insurance

6. At all relevant times, respondent was enrolled in the PERS Platinum Basic Plan (PERS Platinum) Preferred Provider Organization (PPO) health care plan offered by CalPERS under PEMCHA. As a PPO, PERS Platinum allows members to manage their health care through the selection of physicians, hospitals, and other specialists who they determine will best meet their needs.

7. At the time of respondent's coverage request, Anthem Blue Cross (Anthem) administered PERS Platinum medical claims under a contract with CalPERS.

8. The PERS Platinum Evidence of Coverage (EOC) serves as the contract between the subscriber and CalPERS and governs which health care benefits are payable to the subscriber. When respondent elected to receive health benefits under PERS Platinum, the EOC became the contract for services between himself and CalPERS.

9. The 2022 PERS Platinum EOC effective January 1, 2022, to December 31, 2022, sets forth the conditions of PERS Platinum, including those pertaining to benefits, claims, and payment of claims. (See Exhibit 16.)

10. The 2022 PERS Platinum EOC booklet, which explains the policy terms in effect when respondent made his benefit request and subsequent appeal, provides the following explanation of "Medical Necessity":

> MEDICAL NECESSITY
>
> The benefits of this Plan are provided only for those services that are determined to be Medically Necessary; however, even Medically Necessary services are subject to

the Benefit Limitations, Exceptions And Exclusions section starting on page 72. "Medically Necessary" services are procedures, treatments, supplies, devices, equipment, facilities or Drugs (all services) that a qualified Health Professional . . . exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice (i.e., standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors); and

- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and

- not primarily for the convenience of the covered individual, Physician or other health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the

diagnosis or treatment of that covered individual's illness, injury or disease.

The fact that a provider may prescribe, order, recommend or approve a service, supply, or hospitalization does not in itself make it Medically Necessary. The Plan reviews services to assure that they meet the Medical Necessity criteria above. The Plan's review processes are consistent with processes found in other managed care environments and are consistent with the Plan's medical and pharmacy policies. A service may be determined not to be Medically Necessary even though it may be considered beneficial to the patient. (Bold added for emphasis.)

Inpatient Hospital services or supplies which are generally not considered Medically Necessary include, but are not limited to, hospitalization:

1. for diagnostic studies or rehabilitative care that could have been provided on an Outpatient basis or in a nursing facility;

2. for medical observation or evaluation;

3. to remove the patient from his or her customary work and/or home for rest, relaxation, personal comfort, or environmental change (e.g., see definition of Custodial Care on page 111); or

4. for preoperative work-up the night before surgery.

Similarly, nursing facility services or Outpatient services may not always be considered Medically Necessary.

(Exhibit 16, p. A114 (bold in original.))

11. The 2022 PERS Platinum EOC booklet provides the following explanation of the medical and hospital benefits provided under the health plan:

MEDICAL AND HOSPITAL BENEFITS

Skilled Nursing and Rehabilitation Care

First 10 days: 90% PPO and Out-of-Area
Next 170 days: 80% PPO and Out-of-Area
For all Non-PPO services: 60%

Admission and services in connection with confinement in a Skilled Nursing Facility must be precertified by the Review Center as soon as possible, but no later than 3 business days before admission. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 30) and/or denial of benefits.

Benefits are provided for Medically Necessary confinement in a Skilled Nursing Facility, if necessary, instead of Hospital

confinement, up to 180 days combined for both Preferred Providers and Non-Preferred Providers, during each Calendar Year. Room and board charges in excess of the facility's established semi-private room rate are not covered. These benefits will only be provided if services are:

1. prescribed by the patient's Physician;
2. for skilled and not Custodial Care; and
3. for the continued treatment of an injury or illness.

(Exhibit 16, p. A117.)

12. The 2022 PERS Platinum EOC booklet provides the following explanation of utilization review under the health plan:

UTILIZATION REVIEW

Utilization review is designed to involve you in an educational process that evaluates whether health care services are Medically Necessary, provided in the most appropriate setting, and consistent with acceptable treatment patterns found in established managed care environments. Anthem Blue Cross' Review Center reviews Inpatient hospitalizations, including emergencies but excluding maternity admissions under a 48-hour Stay for a normal delivery or a 96-hour Stay for a Cesarean delivery and admissions for mastectomy or lymph node dissection. The Review Center also reviews other medical services, including treatment of mental disorders, substance use

disorders and Outpatient surgical procedures. Precertification by the Review Center is required before these benefits will be payable.

Reviewing where services are provided

A service must be Medically Necessary to be a covered service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting/ place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/ place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens, the service can be requested again in another place and will be reviewed again for medical necessity. At times a different provider or facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing

imaging center, infusion center, ambulatory surgery center, or in a Physician's office.

- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Contacting the Review Center when necessary, before receiving services, and complying with the Review Center's recommendations can help you receive maximum benefit coverage and thus minimize your financial responsibility. The Review Center may monitor your care during treatment and throughout a hospitalization to help ensure that quality medical care is efficiently delivered.

Services which are determined by the Review Center not to be Medically Necessary or efficiently delivered may not be covered under the Plan. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 30) and/or denial of benefits. [¶] . . . [¶]

(Exhibit 16, p. A118.)

13. The 2022 PERS Platinum EOC booklet provides the following explanation of benefit limitations, exceptions, and exclusions under the health plan:

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

[¶] . . . [¶]

9. Custodial Care

a. Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change (for example assisting the patient in meeting his or her activities of daily living) or Physical Therapy.

b. Custodial Care or rest cures provided either in the home or in a facility, unless provided under the Hospice Care Benefit.

c. Services provided by a rest home, a home for the aged, a custodial nursing home, or any similar facility.

d. Services provided by a Skilled Nursing Facility, unless specifically stated under the Skilled Nursing and Rehabilitation Care benefit. [¶] . . . [¶]

33. Rehabilitation or Rehabilitative Care

a. Inpatient charges in connection with a Hospital Stay primarily for environmental change, or treatment of chronic pain unless provided under the Hospice Benefit.

b. Outpatient charges in connection with conditioning exercise programs (formal or informal).

c. Any testing, training or Rehabilitation for educational, developmental or vocational purposes, except as specifically provided under the Autism Spectrum Disorder benefit description on pages 34-35. [¶]

35. Residential accommodations.

Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Facility. This exclusion includes procedures, equipment, services, supplies or charges for the following but not limited to:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. [¶] . . . [¶]

(Exhibit 16, pp. A119, A122.)

14. The 2022 PERS Platinum EOC booklet defines "Rehabilitation or Rehabilitative Care" as: "care furnished primarily to restore an individual's ability to function as normally as possible after a disabling disease, illness, injury or substance use disorder. Rehabilitation or rehabilitative care services consist of the combined use of medical, social, educational, occupational/vocational treatment modalities and are provided with the expectation that the patient has restorative potential and will realize significant improvement in a reasonable length of time." (Exhibit 16, p. A123.)

Respondent's Health Condition and Basis for Coverage Request

15. On June 28, 2022, respondent fell in his home and suffered a subacute right subdural hematoma. Respondent, who was in his nineties, was hospitalized for several weeks, during which period he contracted COVID-19. After his recovery from COVID-19, respondent was admitted to an SNF on July 19, 2022. Anthem approved his stay and agreed to provide insurance coverage for his SNF costs through August 15, 2022.

16. At the SNF, respondent received physical therapy, occupational therapy, and speech therapy. He also used a Foley catheter, which according to respondent's wife, needed to be replaced every four weeks by a registered nurse.

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17. The available medical records regarding respondent's stay at the SNF through August 15, 2022, are incomplete. The records do not include notes from respondent's treating physician, Mohammed Farooqui, M.D. The records consist mostly of nursing notes or notes from the speech, physical, or occupational therapists who treated respondent.

18. Most of respondent's medical records from his stay at the SNF were not made part of the evidentiary record of this case. The relevant medical records of respondent's stay at the SNF through August 15, 2022, as described by the medical reviewers, note the following:

- On August 2, 2022, respondent required maximum assistance with hygiene, partial/ moderate assistance with lower body dressing, partial/ moderate assistance with toilet transfer, and maximum assistance with toileting hygiene.

- On August 3, 2022, respondent was unmotivated to participate in therapy and refused further therapeutic exercise.

- On August 4, 2022, respondent participated in upper extremity exercises but refused to participate in standing exercises.

- On August 5, 2022, respondent required minimal/ supervision assistance for functional mobility and activities of daily living. However, respondent refused to get dressed and insisted on staying in bed.

- On August 8, 2022, respondent was able to ambulate 200 feet back and forth with a front-wheeled walker. Respondent demonstrated good balance overall and appeared short of breath after each lap.

- On August 15, 2022, respondent required maximum assistance with lower body dressing and toileting. It was also noted respondent's assistance levels for lower body dressing, perineal hygiene, and lower body dressing were unchanged from the reported August 2 and August 8, 2022 dates of service. There was also no change in supervision for the level of care for bed mobility.

(Exhibit 10, p. A52.)

19. Additional reports from respondent's speech therapist, occupational therapist, and physical therapist indicate respondent continued to receive therapy between August 9 and August 12, 2024. (Exhibit A.) Respondent's speech therapist and occupational therapist each noted respondent demonstrated potential for rehabilitation, but maximum improvement had yet to be attained. (*Id.,* pp. B3, B5.) Respondent's physical therapist noted respondent's consistent progress toward reaching his goals, but the physical therapy report shows no change in respondent's progress between August 2 and August 15, 2022. (*Id.*, pp. B6–B7.) The reports contain each therapist's explanation as to why respondent requires continued therapy services as part of his skilled care.

20. At a date not made clear in the record, but sometime earlier than August 17, 2024, respondent requested coverage for an additional seven days at the SNF, i.e., for coverage from August 16, 2022, through August 22, 2022. (Exhibit 15, p. A101.) J.W. testified the request was based on the recommendation of respondent's doctor. According to J.W., respondent's goal was to return home to live with his wife, and respondent's doctor verbally assured J.W. that continued physical therapy, speech therapy, and occupational therapy treatment at an SNF would be the best way to achieve that goal. J.W. asserted the notes provided to Anthem and the other medical

reviewers were incomplete because they did not contain respondent's doctor's thoughts regarding respondent's need for continued SNF care.

21. Respondent stayed at the SNF from August 16, 2022, until September 19, 2022, at respondent's personal expense. J.W. testified the cost of respondent's stay totaled $24,000, which respondent paid.

22. Pertinent medical records of respondent's post-August 16, 2022 stay at the SNF indicate respondent was alert and oriented and continued to receive physical therapy, occupational therapy, and speech therapy at the SNF. (Exhibit 14.) The medical reviewers noted the following:

- On August 16, 2022, respondent was resting in bed without complaints of pain or shortness of breath. Respondent continued to receive physical therapy, occupational therapy, and speech therapy.

- On September 12, 2022, respondent was sleeping without medical issues. Respondent continued to receive physical therapy and occupational therapy for functional mobility and speech therapy for symbolic dysfunction. Respondent required the assistance of one person for his activities of daily living.

(Exhibit 13, p.A66.)

23. On September 19, 2022, respondent moved to an assisted living facility where he continued to receive therapy on an outpatient basis. Respondent passed away on April 8, 2024.

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Denial of Respondent's Request for Extended SNF Services and Subsequent Review

24. CalPERS following its established procedures in handling respondent's appeal of Anthem's denial of respondent's request for SNF benefits. Sheri Alvarado, a CalPERS health benefit analyst with 15 years of experience, explained CalPERS' process of handling member appeals involving health care benefits. When a member requests coverage for a particular benefit, the health plan, Anthem, in this case, adjudicates the request first. A CalPERS member has the right to appeal Anthem's decision. Anthem then hears the first appeal. If the member still disagrees with Anthem's decision, the member has the right to have his appeal heard by an independent reviewer outside of Anthem's purview. Anthem plays no role in the substantive independent review of a member's appeal. If the member is still dissatisfied, CalPERS commissions an independent medical review based on the medical records and member appeal documents. CalPERS makes its determination after reviewing each reviewer's findings.

25. In a letter dated August 17, 2022, Anthem denied respondent's request to stay at the SNF past August 15, 2022, based on the absence of medical necessity as defined in the EOC. After reviewing respondent's medical records, Anthem found respondent's skilled services could be managed at a lower level of care. Respondent could move about with light help, and Anthem determined there was no reason respondent could not receive his physical, speech, and occupational therapies on an outpatient basis or at a custodial facility. Anthem further found respondent had not shown progress in therapy and did not have a therapeutic response to treatment. (Exhibit 6, p. A34.)

26. On August 19, 2022, J.W. requested an urgent appeal review of Anthem's August 17, 2022 denial. (Exhibit 7.) In a letter dated September 22, 2022, Anthem

informed respondent a board-certified physician clinical reviewer who specialized in physical medicine and rehabilitation recommended upholding Anthem's denial, and Joseph Karam, M.D., Anthem's Medical Director Reviewer, who is board certified and specializes in general surgery and critical care medicine, denied respondent's coverage request based upon the reviewer's recommendation. Anthem again found an extension of respondent's stay at the SNF was not medically necessary because respondent's care needs could "be met in another place," such as in his home with support or a custodial facility. (Exhibit 8, p. A41.)

27. On November 21, 2022, J.W. requested CalPERS to arrange an independent external review of respondent's request and Anthem's denial. (Exhibit 9.) CalPERS referred the matter to Advanced Medical Reviews (AMR), which assigned a peer reviewer to review respondent's case. Based on the AMR review of respondent's available medical records, the reviewer found respondent's continued stay at an SNF to be medically unnecessary under the PERS Platinum policy. The AMR reviewer noted as follows:

> While skilled nursing level of care is within the standard of care in the treatment with patients with ongoing mobility and functional deficits following subdural hematoma and debility following hospitalizations (Carnahan et al., Burke et al., MCG), this patient was not making sufficient progress to support medical necessity at this level of care. As per guidelines and literature, this level of treatment is necessary when meaningful functional progress is being made. The patient is documented as being max assist with hygiene and mod assist with lower body dressing from 8/2/2022 and on

8/15/2022, the patient was max assist with lower body dressing and max assist with toileting. Per PT, the patient was still supervised with bed mobility and the patient was ambulating on 8/8/2022 up to 200ft x2 with contact guard assist with a front wheeled walker. Additionally, 8/16/2022 documentation indicates ambulation of 170ft at min to contact guard assist with a front wheeled walker.

Given the lack of meaningful functional progress in both ADL's and mobility, ongoing stay from the 8/16/2022 to 8/22/2022 dates of service would not be considered medically necessary. Functional progress up to this date does not support ongoing treatment at the SNF level of care. Additionally there is no documentation of any ongoing medical Issues that require this level of care for management.

[¶] . . . [¶]

The requested ongoing stay at the SNF level of care is not medically necessary based on the insurance certificate. Given the lack of progress up to the dates in question, ongoing treatment would not be clinically appropriate and would not be considered effective for the patient's functional deficits.

[¶] . . . [¶]

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> The health plan should not cover the proposed treatment. Ongoing management at this level of care for ongoing rehabilitation can be managed at a lower level of care. There was a plateau with regards to progress leading up to the dates in question. Additional formal rehabilitation at the SNF level of care is not medically necessary.

(Exhibit 10, p. A53.) CalPERS informed respondent of the AMR reviewer's findings on January 10, 2023.

28. On January 16, 2023, J.W. requested a CalPERS administrative review of respondent's request for extended SNF services and Anthem's coverage denial. (Exhibit 11.) CalPERS submitted the matter to National Medical Reviews Inc. (NMR) for an independent review. Although respondent's initial appeal sought coverage from August 16, 2022, to August 22, 2022, Andrew Nava, M.D., the NMR reviewer, reviewed respondent's medical records through September 19, 2022 (when respondent left the SNF), in making his determination. In addition to the available medical records, Dr. Nava reviewed correspondence from J.W. explaining why respondent had refused to participate in physical therapy and asserting that overall respondent had showed continued improvement in his strength abilities over time while at the SNF. Dr. Nava upheld the denial of respondent's claim as follows:

> In this case, the member was initially admitted for weakness status post fall. He has been undergoing physical therapy, occupational therapy and speech therapy in a skilled nursing facility environment. The request is for ongoing stay at the skilled nursing facility between 08/16/2022 and 09/19/2022; however, there are no recent physician

progress notes, no abnormal objective examination findings, no acute medical issues, and no evidence why the member cannot participate in the lower level of care, such as outpatient physical therapy or occupational therapy.

Given the nature of this member's clinical issues, the ongoing stay at the skilled nursing facility between 08/16/2022 and 09/19/2022 is considered not medically necessary.

(Exhibit 13, p. A66.)

29. CalPERS accepted the findings of the report of the AMR reviewer and the report of the NMR reviewer. In its March 30, 2023 letter to J.W. denying respondent's coverage request, CalPERS cited those findings as well as the pertinent sections of the EOC to uphold Anthem's denial of coverage. Specifically, CalPERS noted (1) the skilled nursing services requested were not medically necessary because they were not for the continued treatment of any injury or illness and the services could be provided at a lower level facility; and (2) the PERS Platinum plan did not provide coverage for services not considered medically necessary. (Exhibit 3.)

30. At hearing, Lisa LeTellier, M.D., another NMRI reviewer, testified regarding her review of respondent's available medical records. Dr. LeTellier is board-certified to practice physical medicine and rehabilitation and has held a South Carolina medical license for 12 years. In addition to working as an NMRI reviewer, Dr. LeTellier practices medicine for the Veterans Health Administration. Dr. LeTellier explained that skilled nursing care was medically necessary under the following circumstances: if a patient required daily skilled nursing services such as complex wound care,

intravenous fluid infusions, or diabetic care; if a patient required daily skilled rehabilitation treatment; or if a patient needed skilled inpatient services only provided by SNFs. Based on her review of the available medical records, Dr. LeTellier found respondent did not meet any of these criteria, and therefore she agreed with Dr. Nava that an extended SNF stay was not medically necessary for respondent. Dr. LeTellier noted respondent's records contained no clinician notes justifying an extended stay, and the nursing notes did not indicate an extended stay was required, in part because the notes did not show respondent had any significant active medical issues. Dr. LeTellier therefore believed respondent could have progressed at a lower level of care by receiving outpatient therapy while in his home, in a custodial facility, or in an assisted living facility.

31. According to Dr. LeTellier, respondent's use of a Foley catheter would not itself warrant treatment at an SNF. Dr. LeTellier also acknowledged the clinical notes by respondent's physician may have provided reasons to extend respondent's SNF stay, but the SNF had not provided these notes to Anthem or the reviewers.

Basis of Respondent's Administrative Appeal

32. J.W. acknowledged the medical records of respondent's stay at the SNF provided to Anthem and the reviewers were incomplete as they did not contain any clinician notes. J.W. also acknowledged respondent continued to receive physical, occupational, and speech therapies after respondent's discharge from the SNF.

33. At hearing and in his appeals filed on respondent's behalf, J.W., however, contended the medical reviewers failed to take into account several factors when upholding Anthem's denial of respondent's coverage claim. First, the reviewers failed to acknowledge respondent could not go home from the SNF because his 86-year-old

wife's own health concerns made it impossible for her to care for respondent. Second, J.W. contended that during respondent's stay at the SNF, respondent continued to be treated for chronic prostatic hypertrophy, which J.W. believed was likely the predominant cause of respondent's fall. According to J.W., the resolution of the appropriate treatment for respondent's condition still had not been determined as of August 15, 2022, although he acknowledged the condition was not in the notes provided to Anthem or the other reviewers. Third, J.W. attributed respondent's need for more extensive and sustained therapy to respondent's COVID-19 infection during his hospitalization. J.W. asserted respondent decompensated because hospital quarantine requirements meant that respondent did not receive any physical, occupational, or speech therapy services during the two weeks he was hospitalized. COVID-19 staff infections at the SNF further delayed respondent's receipt of therapies, and J.W. contended the delays extended the time needed for respondent's rehabilitative care past August 15, 2022.

LEGAL CONCLUSIONS

1. Jurisdiction for this proceeding exists under Government Code section 22848, which provides:

> 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 of appeal to the board and shall be accorded an opportunity for a fair hearing. The hearings shall be conducted, insofar as practicable,

pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3.

2. Respondent has the burden of establishing by a preponderance of the evidence that his benefits claim is within the scope of the coverage provided by the 2022 PERS Platinum health plan. (*Dyer v. Northbrook Property and Casualty Insurance Co.* (1989) 210 Cal.App.3d 1540, 1547 ("the burden is on the insured to prove that an event is a claim within the scope of the basic coverage [Citation]."); *McCoy v. Bd. of Retirement* (1986) 183 Cal.App.3d 1044, 1051, fn. 5.) Respondent has not met his burden.

3. The EOC governs the benefits payable to respondent. To receive reimbursement, the service in question must be a covered benefit and medically necessary. Whether a service is medically necessary is defined under the terms of the EOC.

4. The EOC defines "medically necessary" services as those provided to an insured for preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms and are (i) provided in accordance with medical standards, (ii) clinically appropriate and effective, (iii) not primarily for the convenience of the insured or the physician or other health care provider, and (iv) not more costly than an alternative service at least as likely to produce equivalent therapeutic or diagnostic results. Services can be deemed not to be medically necessary even though they are beneficial to the patient and recommended by the patient's caregiver. Additionally, services that can be safely provided in a lower level of care or lower cost setting/ place of care are not medically necessary if they are given in a higher level of care, or higher cost setting/ place of care. Moreover, to be eligible for covered rehabilitative care,

there must be an expectation that the patient has restorative potential and will realize significant improvement in a reasonable length of time. (Factual Findings 10–13.)

5. Respondent failed to prove extended care at the SNF was medically necessary. (Factual Findings 6–31.) Respondent's coverage request was formally reviewed by four different medical doctors, and each of those reviewers, in addition to Dr. LeTellier, found the available medical records failed to show continued SNF care was medically necessary as defined in the PERS Platinum policy EOC. (Factual Findings 25–31.) The available medical records did not indicate respondent suffered from a condition requiring skilled nursing services or that the services provided at the SNF could not be replicated at a lower-level facility. As J.W. acknowledged, respondent's chronic prostatic hypertrophy was not noted in the available SNF records, and there was no determination such a condition would require continued skilled care. While J.W. asserted the physical, occupational, and speech therapies offered at the SNF benefitted respondent and were recommended by his treatment providers, there was no evidence respondent's abilities were markedly improved during his approved stay at the SNF and no evidence the therapies could not have been provided in a less costly manner to the same effect at home, on an out-patient basis, at a custodial facility, or at an assisted living facility, as the PERS Platinum policy required for coverage. On the contrary, the evidence showed respondent received physical, occupational, and speech therapies while he was at the assisted living facility, and he continued to benefit from those therapies. Finally, whether the requested benefit was medically necessary did not rest on whether respondent could return home. (Factual Findings 6–14, 32, 33.)

6. Accordingly, based on the available medical records and the opinions of the four medical reviewers in addition to Dr. LeTellier, extending respondent's stay at the SNF from August 16, 2022, to September 19, 2022, was not medically necessary.

Respondent is therefore responsible for the costs incurred at the SNF starting from August 16, 2022.

ORDER

Anthem Blue Cross's denial of respondent Victor Wanek's request for reimbursement of the costs of his extended stay from August 16, 2022, to September 19, 2022, at a skilled nursing facility is affirmed. The appeal filed by respondent is denied.

DATE: 10/16/2024

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings