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Arkansas
State Claims Commission

SEP 23 2019

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Please print in ink or type

BEFORE THE STATE CLAIMS COMMISSION

Of the State of Arkansas

☐ Mr.
☐ Mrs.
☒ Ms.
☐ Miss

Jessica Middleton, **Claimant**

vs.

State of Arkansas, Respondent

Do Not Write in These Spaces
Claim No.
Date Filed (Month) (Day) (Year)
Amount of Claim $
Fund

COMPLAINT

Jessica Middleton (Name), **the above named Claimant, of** [redacted] (Street or R.F.D. & No.) (City) [redacted] (State) (Zip Code) (Daytime Phone No.) **County of** [redacted] **represented by** Brandon W. Lacy (Legal Counsel, if any, for Claim)

of 630 S. Main Street (Street and No.) Jonesboro (City) AR (State) 72401 (Zip Code) 870-277-1144 (Phone No.) 870-277-1143 (Fax No.), **says:**

State agency involved: AR DFA, Employee Benefits Division **Amount sought:**

Month, day, year and place of incident or service:

Explanation: See attached Explanation and Exhibits

As parts of this complaint, the claimant makes the statements, and answers the following questions, as indicated: (1) Has claim been presented to any state department or officer thereof? Yes (Yes or No); when? January (Month) 11 (Day) 2019 (Year); to whom? AR Benefits Appeals Department (Department) P. O. Box 15610, Little Rock, AR: and that the following action was taken thereon: denied

and that $ 0.00 was paid thereon: (2) Has any third person or corporation an interest in this claim? No; if so, state name and address (Name) (Street or R.F.D. & No.) (City) (State) (Zip Code)

and that the nature thereof is as follows: : and was acquired on , in the following manner:

THE UNDERSIGNED states on oath that he or she is familiar with the matters and things set forth in the above complaint, and that he or she verily believes that they are true.

Brandon Lacy
(Print Claimant/Representative Name)

(Signature of Claimant/Representative)

STEPHANIE CRAWFORD
NOTARY PUBLIC STATE OF ARKANSAS
MY COMMISSION # 12364146
EXPIRES: January 14, 2028
Greene County

(SEAL)

SWORN TO and subscribed before me at Jonesboro (City) AR (State)

on this 18 (Date) day of September (Month), 2019 (Year)

Stephanie Crawford
(Notary Public)

My Commission Expires: January (Month) 14 (Day) 2028 (Year)

SF1- R7/99

Explanation

Claimant, Jessica Middleton, is a resident of Pulaski County. This is a breach of contract claim against the State of Arkansas Department of Finance & Administration, Employee Benefits Division, for benefits under Ms. Middleton's health insurance program with the State of Arkansas. At all relevant times, Ms. Middleton was an employee of the State of Arkansas, as general counsel with the Arkansas Public Employees Retirement System. As such, she was eligible to participate in the State and Public School Life and Health Insurance Program established pursuant to Ark. Code Ann. § 21-5-401.

In 2016, Ms. Middleton underwent a medical procedure in which [redacted] injections were administered as a treatment regimen due to a medically-necessary reason. Unfortunately, the administration of these injections resulted in severe necrosis of the skin and underlying soft tissue, causing Ms. Middleton's left buttock to become severely necrotic, creating an open wound and producing a severe deficit requiring multiple tissue grafting surgeries and a flap surgery for wound closure. Photographs of this condition were submitted to the Health Program as part of the claim process, and are included with the exhibits attached hereto. The necrosis led to a complete decline in muscle function in the lower extremities. Surgeries were performed on March 24, 2017, July 14, 2017, and October 27, 2017, and each of these surgeries was covered by Ms. Middleton's previous health insurance carrier. The last surgery performed on March 16, 2018 was filed with her new insurance program, Health Advantage, but payment was denied.

Ms. Middleton's plastic surgeon, Dr. Melanie Prince, indicated that the diagnosis for the treatment to correct the necrosis encompassed the scar that was secondary to a medically-necessary injection that caused the breakdown of the skin and soft tissue, subsequently resulting in the wound that required flap surgery. The surgery was performed by Dr. Prince at Baptist Health Medical

Center, and Dr. Bryan Mullooly was the anesthesiologist for the procedure. The procedure was performed on March 16, 2018. Dr. Prince has attested that the surgery to treat the necrosis and the scar was medically-necessary.

The Program, through its claims administrator, Health Advantage, denied payment for the services performed Drs. Mullooly, Prince, and Baptist Health Medical Center on the basis that the treatment was cosmetic in nature as defined by the Programs' Summary Plan Description exclusions. *See* Exhibit 1.

On January 11, 2019, Ms. Middleton, through counsel, submitted a formal appeal of this denial to the ARBenefits Appeals Department. *See* Exhibit 2. The appeal pointed out that, applying the Plan language of the definition of "cosmetic service" found in the Summary Plan Description, treatment is considered cosmetic only if it is a "non-medically-necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease, state, physical appearance, or disfigurement caused by an accident, birth defect, to correct or naturally improve a physiological function." (emphasis added). Because the diagnoses for the treatment encompassed the scar that was secondary to a medically-necessary injection that caused the breakdown of the skin and soft tissue subsequently resulting in the wound that required flap surgery, the procedure was done to restore bodily function and correct physical appearance caused by an accident, and to correct physiological function. Thus, the treatment does not meet the definition of cosmetic services as defined in the Plan.

On January 18, 2019, Ms. Middleton's counsel received correspondence from Health Advantage, the Plan Administrator, indicating that Ms. Middleton's only available appeal option at that point was through ARBenefits. *See* Exhibit 3. On January 23, 2019, Ms. Middleton's counsel

received correspondence from the Employee Benefits Division confirming its original decision that the services rendered on March 16, 2018 are considered cosmetic. *See* Exhibit 4.

On April 22, 2019, Ms. Middleton's counsel submitted a second appeal of the Employee Benefit Division's determination pursuant to the terms of the Summary Plan Description. The second appeal repeated the arguments concerning the medical necessity of the procedure. The second appeal further pointed out that, based upon the explanation provided by Dr. Prince, the procedure meets the definition of a "reconstructive" procedure under the terms of the Plan. According to the Summary Plan Description, "reconstructive procedures are covered as correction of defects due to accidents or defects caused by treatment of covered services." The SPD includes as an example of a reconstructive surgery the reconstruction of a breast in which a cancer-related surgery has been performed and reconstruction of the other breast is required to produce a symmetrical appearance. Here, given the breakdown of skin and muscle tissue in the buttock following the administration of the [redacted] injections, the procedure was required not only to restore muscle function, but also to create a symmetric appearance between the left and right buttock. Given that the procedure was medically-necessary, it was not cosmetic. Because it was reconstructive, it is clearly covered by the terms of the Plan. *See* Exhibit 5.

On April 30, 2019, the Employee Benefits Division Appeals Department wrote Ms. Middleton's counsel denying the second appeal and reaffirming its prior decision that the procedure at issue was a cosmetic procedure. *See* Exhibit 6.

On May 3, 2019, Ms. Middleton's counsel wrote the Employee Benefits Division Appeals Department to request an external appeal from the Independent Review Organization ("IRO") concerning the Health Advantage and ARBenefits Appeals Department's denials of the claim. *See*

Exhibit 7. On June 20, 2019, the Employee Benefits Division Appeals Department wrote Ms. Middleton's counsel declining the request for an IRO given that the decision involved a Plan exclusion not subject to an external appeal. *See* Exhibit 8. All administrative appeal options have been exhausted. This action follows.

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

JESSICA MIDDLETON **CLAIMANT**

V. **CLAIM NO. 200293**

DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES **RESPONDENT**

ORDER

Now before the Arkansas State Claims Commission (the "Claims Commission") is the motion filed by Jessica Middleton (the "Claimant") for summary judgment as to her claim against the Department of Transformation and Shared Services (the "Respondent"). At the hearing held April 15, 2021, Claimant was represented by Brandon Lacy. Mitch Rouse appeared on behalf of Respondent.

Background

1. Claimant filed her claim in September 2019 against the Employee Benefits Division (EBD) of the Arkansas Department of Finance and Administration. Claimant's breach of contract claim is based upon EBD's denial of coverage for a medical procedure on Claimant's left buttock (the "Procedure").

2. Respondent denied liability.[1]

3. In December 2020, Claimant filed a motion for summary judgment, arguing that the Procedure was medically necessary—not cosmetic—such that Respondent breached its contract with Claimant by denying coverage. In support of the motion, Claimant attached a copy of the AR Benefits Summary Plan Description (the "Plan"); excerpts of the deposition of Shalada Toles (the deputy director of EBD); the sworn affidavit of Dr. Melanie Prince (the surgeon who

[1] Respondent advised in the cover letter to its answer that, through the passage of the Transformation and Efficiencies Act of 2019, EBD was transferred from the Department of Finance and Administration to Respondent.

performed the procedure at issue); a July 31, 2019, letter from Dr. Prince; and seven letters between Claimant's counsel, EBD, and Health Advantage. Relying upon Ms. Toles' deposition, Claimant explained the relationship between Claimant, EBD, and Health Advantage:[2]

> The Plan is administered by a third-party administrator, Health Advantage. The Plan is funded by premium payments made by employees, which are then placed into a "pot," and Health Advantage makes the decisions regarding whether or not to pay the claims. [EBD] . . . makes the determinations of whether or not a person is eligible to participate in the program. EBD also oversees the collection of premiums and reimburses Health Advantage for claims paid to providers. In other words, the Plan is a contract between the employees and the State. The State determines eligibility for participation, collects the funds from the eligible employees, and pays the claims subject to their approval by Health Advantage.

Looking to the specific language of the Plan, Claimant noted the cosmetic service exclusion and explanation of what reconstructive surgeries are permitted:[3]

> Exclusions and Limitations
> . . .
> **Cosmetic Services**: All services, procedures, or complications related to or complications resulting from cosmetic surgery are not covered.
> . . .
> **Reconstructive Surgery**: Reconstructive procedures are covered as correction of defects due to accidents or defects caused by treatment of covered services. Any example of a covered reconstructive surgery includes the reconstruction of the breast on which a cancer-related surgery has been performed and reconstruction of the other breast to produce a symmetrical appearance. . . .

(emphasis in original). Claimant also noted the definitions of "cosmetic services" and "medically necessary" in the Plan:[4]

> ***Cosmetic Services*** – Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, to correct or naturally improve a physiological function.

[2] *See* Cl's Brief in Support of Motion for Summary Judgment at p. 2 (internal citations omitted).
[3] *See* Ex. 1 to Cl's Motion for Summary Judgment at pp. 73, 77.
[4] *See id*. at pp. 99, 101.

> ***Medically Necessary*** – Health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

(emphasis in original). Claimant submitted a sworn affidavit from Dr. Prince, in which Dr. Prince provided the following testimony regarding the Procedure:[5]

> I, Melanie Prince, M.D., being of sound mind and authorized to make the following statements based upon my own personal knowledge, state as follows:
>
> 1. I am a plastic surgeon in Little Rock, Arkansas.
>
> 2. Jessica Middleton was a patient of mine beginning on February 22, 2017, when she consulted with me for scars on her left and right buttock . . . [after she received] injections administered by another physician. . . .
>
> 3. Unfortunately, the injections created a severe contour deformity of the buttocks secondary to necrosis of the skin and underlying soft tissue.
>
> 4. According to Ms. Middleton, Dr. James Yuen, a plastic and reconstructive surgeon at the University of Arkansas for Medical Sciences hospital, treated Ms. Middleton in 2016 after her left buttock became necrotic following injections. This created an open wound producing a severe deficit requiring flap surgery for wound closure.
>
> 5. Beginning March 2017, I performed multiple tissue grafting surgeries to repair the remaining soft tissue deficit of the buttock. Those surgeries were performed on March 24, 2017, July 14, 2017, and October 27, 2017.
>
> . . .
>
> 7. I performed a fourth surgery on March 16, 2017, and the bills for this procedure were filed with Ms. Middleton's new insurance carrier, Health Advantage. The claim for payment of these charges was denied.
>
> 8. The appropriate ICD-10 code for the procedure performed is as follows: L90.5-scar conditions and fibrosis of the skin. This diagnosis encompasses the scar that was secondary to injections that caused the breakdown of the skin and soft tissue subsequently resulting in the wound that required flap surgery.
>
> . . .
>
> 10. No one from Health Advantage or the Arkansas Benefits Appeals Department has ever contacted me or my office for a peer-to-peer consult concerning the nature of the procedure, the medical necessity of the procedure, or whether or not the procedure was cosmetic.

[5] *See* Ex. 3 to Cl's Motion for Summary Judgment.

> 11. It is also my opinion that the procedure I performed on March 16, 2018 was not cosmetic in nature. . . . Because the procedure I performed on Ms. Middleton was to correct a disfigurement caused by a medical complication, it was not a cosmetic service.
>
> 12. In my opinion it also qualifies as a reconstructive procedure because it was performed to correct a defect due to a medical complication of a covered service.
>
> . . .

Claimant argued that she has unsuccessfully exhausted all administrative remedies through the Plan, including first level reviews, second level reviews, and even requesting an "external appeal by an Independent Review Organization (IRO) . . . to consider issues such as medical necessity of a procedure or medication."[6] Claimant also argued that the Plan is ambiguous as to the available administrative remedies, in light of these two statements in the Plan:[7]

> Members who have been denied a service or requested change have the option to file a complaint or an appeal with EBD.
>
> . . .
>
> Excluded services are not subject to appeal but a letter or complaint requesting a review of the allowable benefit can be sent to the Board via the Quality Assurance department at EBD.

Claimant stated that she is entitled to summary judgment on her breach of contract claim because (1) she entered into a contract (the Plan) with the State of Arkansas for health insurance benefits, (2) the State was required to pay for covered medical services, (3) Claimant did what the Plan required of her, and (4) the State did not make the required payments under the Plan. As to whether the Procedure was cosmetic or medically necessary, Claimant argued that:[8]

> Either the service should never have been considered cosmetic to begin with because it was medically necessary and was performed to restore bodily function and [to] correct a disfigurement caused by an accident, or it could have been considered cosmetic but was covered regardless because it was reconstructive in nature. Either way, the services were covered.

[6] *See* Cl's Brief in Support of Motion for Summary Judgment at p. 6.
[7] *See* Ex. 1 to Cl's Motion for Summary Judgment at p. 82.
[8] *See* Cl's Brief in Support of Motion for Summary Judgment at p. 12.

Claimant noted that the Plan did not require tissue-grafting services to be pre-certified.[9]

4. In response, Respondent argued that the Plan is "clear and unambiguous that . . . the benefits claimed as cosmetic services are excluded services." Respondent also argued that the question of whether the Procedure was cosmetic or medically necessary is a fact question precluding summary judgment. With regard to Dr. Prince, Respondent stated that:[10]

> Respondent does not dispute Dr. Prince's qualifications, but rather relied on the Health Advantage Medical Director Review Decision performed by Kristin Lower, M.D., a trainer and qualified medical professional, who reviewed the medical records submitted and ultimately determined the procedure was cosmetic in nature. The assertion by Dr. Prince and the determination by Dr. Lower is an issue of material fact, not law, and as such, summary judgment should not be granted.

Respondent did not attach any affidavits or other documents to its response.

5. In her reply brief, Claimant noted that "there is no evidence whatsoever in the record in support of the determination" reached by EBD, in contrast to Dr. Prince's sworn testimony as to the medical necessity of the Procedure and the reconstructive, not cosmetic, nature of the Procedure.[11] As to the reference to Dr. Lower in Respondent's response, Claimant argued the following:[12]

> Remarkably, now that discovery is complete and in responding to a dispositive motion, EBD for the first time references a Dr. Kristin Lower, who allegedly provided an opinion that the service was cosmetic. Nowhere in EBD's discovery responses was this name ever mentioned, despite the fact that her identity was requested a number of different ways. At no time during the EBD Deputy Director's deposition did she mention that she relied upon an opinion of a physician, or did she even reference this person. The only Health Advantage employee she identified in her deposition was Takisha Sanders. Nowhere in EBD's document production in this case is there a document or report referencing or mentioning this Dr. Lower. EBD does not even attach such a document, or an affidavit, as an exhibit to its response. In short, there is no evidence in the record concerning this person or such an opinion.

[9] *See id*. at p. 12, fn 1 (citing to Ex. 1 to Cl's Motion for Summary Judgment at p. 19).
[10] *See* Resp's Brief in Support of Response to Motion for Summary Judgment at p. 4.
[11] *See* Cl's Reply to Response to Motion for Summary Judgment at pp. 1–2.
[12] *See id*. at p. 5.

(internal citations omitted). Claimant also stated that had Dr. Lower been identified or if any documentation from Dr. Lower had been produced by Respondent during discovery, Claimant's counsel would have deposed Dr. Lower.[13]

6. At the hearing, Claimant argued that the Procedure was not cosmetic because it corrected a physical disfigurement and that it was reconstructive. Claimant noted that any ambiguity in the Plan must be construed against the drafter of the Plan under Arkansas law. Claimant detailed the efforts taken to seek review of the coverage denial.

7. In response to a question from a commissioner, Claimant argued that the appropriate standard of review of the Plan is *de novo*. Claimant stated that there was no affidavit from Dr. Lower anywhere in the record and no evidence of a medical decision made by EBD.

8. Respondent argued that cosmetic procedures are excluded with no right of appeal under the Plan. Respondent clarified that EBD has final authority over the third party administrator (Health Advantage), and that the chief medical officer made the determination for Health Advantage. Respondent conceded that EBD erred in giving Claimant more appeals than allowed. Respondent disagreed with Claimant's reconstructive surgery analogy because breast reconstruction coverage is mandated by statute.

9. In response to a question from a commissioner as to the appropriate standard of review, Respondent declined to argue that the agency's decision was entitled to any deference and instead stated that the only standard of review that the Claims Commission should consider for purposes of deciding Claimant's motion is the summary judgment standard found in Ark. R. Civ. Proc. 56.

[13] *See id*. at p. 5, fn 1.

10. In response to a question from a commissioner as to whether Respondent has met proof with proof as required by Ark. R. Civ. Proc. 56, Respondent stated that Dr. Lower's determination is in the record.

11. Following the hearing, Respondent transmitted Dr. Lower's medical determination to the Claims Commission, stating that it was inadvertently left out of Respondent's response.

Summary Judgment Standard

12. Pursuant to Rule 56(c)(2), summary judgment is appropriate when there are no genuine issues as to any material fact, and the moving party is entitled to judgment as a matter of law. *See Hisaw v. State Farm Mutual Auto Insurance Co.*, 353 Ark. 668, 122 S.W.3d 1 (2003). Summary judgment motions are subject to a shifting burden, in that once the moving party has made a *prima facie* showing of entitlement to summary judgment, "the opposing party must demonstrate a genuine issue of material fact by meeting proof with proof." *Milam v. Bank of Cabot*, 327 Ark. 256, 262, 937 S.W.3d 653, 656 (1997). Summary judgment shall be entered in favor of the movant where the party opposing the motion "rest[s] upon the mere allegations or denials of his pleadings" and does not "by affidavits or as otherwise provided in this rule . . . set forth specific facts showing that there is a genuine issue for trial." Ark. R. Civ. Proc. 56(e).

Findings of Fact and Conclusions of Law

Based on a review of the pleadings and argument of the parties, the Claims Commission hereby finds as follows:

13. The Claims Commission finds that the parties are in agreement that the Plan constituted a contract between the parties.

14. The Claims Commission finds that the parties are in agreement as to the relationship between EBD and Health Advantage.

15. The Claims Commission finds that the parties are in agreement as to the definitions of "cosmetic services" and "medically necessary" in the Plan; the exclusion in the Plan for "cosmetic services;" and the "reconstructive surgery" provision in the Plan. The Claims Commission finds these provisions to be unambiguous, such that the construction of these provisions is an issue of law. *Barrows/Thompson, LLC v. HB Ven II, LP*, 2020 Ark. App. 208, 599 S.W.3d 637 ("In summary-judgment cases involving the interpretation of a contract, if provisions of the contract are unambiguous, their construction is an issue of law for the circuit court.").

16. The Claims Commission finds that Dr. Prince's affidavit is persuasive and well-taken.

17. In light of Dr. Prince's sworn affidavit, the Claims Commission finds that Claimant has stated a *prima facie* showing of entitlement to summary judgment. *See Milam*, 327 Ark. at 262, 937 S.W.2d at 656.

18. The Claims Commission finds that Respondent has not met proof with proof, such that Claimant is entitled to summary judgment. Instead, contrary to the requirement of Ark. R. Civ. Proc. 56(e), Respondent "rest[ed] upon the mere allegations or denials of his pleadings . . . [and did not] by affidavits or as otherwise provided in this rule . . . set forth specific facts showing that there is a genuine issue for trial." While Respondent did submit a form after the hearing which purports to be Dr. Lower's medical determination regarding the Procedure (the "Lower Form"), the Lower Form is not sworn testimony.

19. The Claims Commission further notes that, upon review of the documents produced by Respondent in response to discovery, it does not appear that the Lower Form was produced to Claimant in discovery despite numerous requests in which it would appear to be relevant:

> Request for Production No. 1: Please produce your claim file for the claim that is the subject of this lawsuit.

> Request for Production No. 3: Please produce all correspondence, letters, memoranda, communications, or documents in your possession that reference or relate to the claim for benefits made on behalf of Jessica Middleton. If you maintain that any such documents are privileged, please produce a privilege log.
>
> Interrogatory No. 1: Please identify by name, address, occupation, title, and phone numbers, all persons with knowledge of the claim for the benefits made on behalf of Jessica Middleton.
>
> Interrogatory No. 3: State the names and addresses of all persons having knowledge of any relevant facts concerning the incidents set forth in Claimant's Complaint and describe specifically the information relative to the incidents possessed by each person.
>
> Interrogatory No. 4: Please give the names, addresses, and telephone [numbers] of all persons who you [or] your attorney may call as (a) lay or (b) expert witnesses at trial of this case and state the subject matter on which they are expected to testify, the substance of facts and opinions to which they are expected to testify, and a summary of the grounds for each opinion.
>
> Request for Production No. 7: Please produce all documents which reference the Claimant identified herein and relate to her allegations in this lawsuit.
>
> Request for Production No. 8: Please produce each document, exhibit, diagram, photograph, videotape, or other demonstrative evidence that you may introduce into evidence or refer to at the trial of this matter, or that you may show to the Court during Opening Statement, Closing Argument, or at any other time, or that may be relied upon by any witness identified in your response to the above interrogatories.
>
> Interrogatory No. 7: Please identify any and all individuals who participated in the decision to deny the Claimant's benefits.
>
> Request for Production No. 14: Please produce all correspondence between Health Advantage and the State of Arkansas regarding Jessica Middleton.
>
> Request for Production No. 15: Please produce all documents in your possession that reference Jessica Middleton. To the extent that you maintain that all responsive documents are privileged, please [provide] a privilege log.

To the extent that Respondent did not have the Lower Form in its possession at the time that it responded to discovery in February 2020, Respondent must have become aware of the Lower Form before February 2021, when it responded to the instant motion and referenced Dr. Lower's opinion. However, it does not appear that discovery responses were supplemented in order to provide

Claimant with the Lower Form. Moreover, Respondent was on notice as to the potential discovery issue with Dr. Lower when Claimant filed her reply brief castigating Respondent for mentioning Dr. Lower for the first time in response to Claimant's motion for summary judgment.

20. Additionally, the Claims Commission finds that common sense dictates coverage for the Procedure under the unambiguous provisions. The Procedure does not appear to be a "cosmetic service" because it was intended "to correct a . . . disfigurement" caused by a medical complication" and to "restore bodily function."[14] However, even if it was a cosmetic service, the Claims Commission finds Claimant's breast reconstruction analogy to be apt, such that the Procedure could also be covered as reconstructive surgery. The Claims Commission further finds Respondent's argument that Arkansas law requires coverage for breast reconstruction surgery to be unpersuasive.

21. While the Claims Commission finds that the Lower Form is unpersuasive for the purpose of defeating summary judgment, the Claims Commission also finds that the Lower Form appears to show the cursory nature of the review given to Claimant's file and requests for appeal. To the extent that Dr. Prince's description of an "aesthetic gluteal deformity"[15] formed the basis of the denial of coverage, the Claims Commission finds that a reliance upon this description instead of Claimant's medical history is monumentally unfair to Claimant, as it trivializes both the Procedure and the function issues experienced by Claimant.

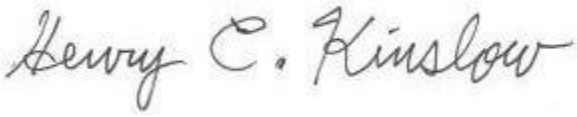
22. The Claims Commission hereby unanimously GRANTS Claimant's motion for summary judgment with respect to liability. The Claims Commission will give the parties 30 days to try to agree upon damages. An agreement by the parties on the appropriate amount of damages will not waive Respondent's right to appeal this Claims Commission decision on liability once a

[14] *See* Ex. 1 to Cl's Motion for Summary Judgment at p. 99.
[15] *See* Claimant's Complaint at p. 24.

final order is entered. Should the parties be unable to agree upon damages in the next 30 days, the Claims Commission will schedule a hearing on damages.

IT IS SO ORDERED.

ARKANSAS STATE CLAIMS COMMISSION
Dexter Booth



ARKANSAS STATE CLAIMS COMMISSION
Henry Kinslow, Chair

ARKANSAS STATE CLAIMS COMMISSION
Paul Morris

DATE: April 21, 2021

Notice(s) which may apply to your claim

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1)(B)(ii). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a)(3).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(a). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

JESSICA MIDDLETON **CLAIMANT**

V. **CLAIM NO. 200293**

DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES **RESPONDENT**

ORDER

Now before the Arkansas State Claims Commission (the "Claims Commission") is the motion filed by Jessica Middleton (the "Claimant") for entry of judgment and attorney's fees as to her claim against the Department of Transformation and Shared Services (the "Respondent"). Also pending is Claimant's motion to exclude Respondent's proposed testimony and exhibits. At the hearing held January 13, 2022, Claimant was represented by Brandon Lacy, and Lauren Ballard and Jennifer Davis appeared on behalf of Respondent.

The Claims Commission noted that it previously granted Claimant's motion for summary judgment on April 21, 2021. The Claims Commission also noted that this hearing is on Claimant's pending motions and is not a hearing on damages.

Upon a question from a commissioner as to whether Claimant accounted for the deductible or copays owed by Claimant in arriving at its target number, Claimant stated that there was a dispute over the amount of the deductible and that co-insurance is not applicable.

Upon a question from a commissioner as to whether the providers are actively trying to collect these bills, Claimant stated that Dr. Prince's bill and the anesthesiology bill had been paid by Claimant in full. Claimant also paid $770 to Baptist Health.

Upon a question from a commissioner as to whether Claimant would object to an award directing payment to her for the bills she paid and to Baptist Health for the outstanding bill,

Claimant stated that the accounts need to be satisfied and that Claimant would not object to an award paying the providers directly.

Upon a question from a commissioner regarding the amount owed by Respondent, Respondent stated that it would like to re-run these claims to take advantage of Health Advantage's agreements with these providers, which would substantially lower the amounts owed by Claimant (in the form of coinsurance) and Respondent. Respondent affirmatively stated that there is no intention to leave Claimant on the hook for any amount.

Upon a question from a commissioner regarding the twelve percent statutory penalty, Respondent stated that the Employee Benefits Division of Respondent is not one of the types of insurers listed in the statute and that if the penalty applies, it should be applied to the re-run claim amounts. Claimant disagreed with Respondent's interpretation of Ark. Code Ann. § 23-79-208 and noted that Ark. Code Ann. § 23-79-210 references self-funded insurance. However, Claimant did not object to the penalty being calculated on the re-run claim amounts.

Upon a question from a commissioner regarding attorney's fees, Respondent stated that attorney's fees are discretionary and asked the Claims Commission not to award attorney's fees. Respondent noted that the contingency fee agreement is more appropriate. In response, Claimant conceded that the Claims Commission has broad discretion regarding attorney's fees but stated that there have been over $2,000 in expenses, as well as a number of motions and a significant number of documents to review. If the Claims Commission were to only award $900 in attorney's fees, that would hinder a claimant from being able to hire an attorney in a similar future claim. Respondent agreed with Claimant that the expenses should be reimbursed but stated that $900 attorney's fees would avoid a windfall to Claimant's counsel.

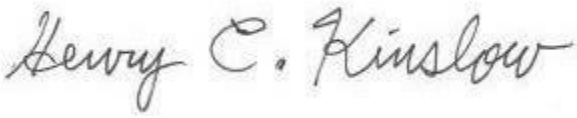
Upon a question from a commissioner regarding prejudgment interest, Claimant stated that the amount is based on the compensatory damage award, which is currently a moving target.

The Claims Commission notes that there a number of issues that need to be discussed by the parties, including the applicable deductible ($350 as mentioned by Claimant or $500 as mentioned by Respondent?) and whether co-insurance applies to these medical bills. The Claims Commission encourages the parties to discuss and try to resolve the issue of damages, including interest, statutory penalty, and attorney's fees.

The Claims Commission will hold Claimant's motions and will schedule a hearing on damages to be held in approximately six months. Any additional discovery should be completed in sufficient time to allow the parties to meet all deadlines for prehearing materials, which will be listed in the hearing letter to be sent contemporaneously with this order.

IT IS SO ORDERED.

ARKANSAS STATE CLAIMS COMMISSION
Courtney Baird



ARKANSAS STATE CLAIMS COMMISSION
Henry Kinslow

ARKANSAS STATE CLAIMS COMMISSION
Paul Morris, Chair

DATE: January 21, 2022

Notice(s) which may apply to your claim

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1)(B)(ii). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a)(3).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(a). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

JESSICA MIDDLETON **CLAIMANT**

V. **CLAIM NO. 200293**

DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES **RESPONDENT**

ORDER

Now before the Arkansas State Claims Commission (the "Claims Commission") is the damages portion of the claim filed by Jessica Middleton (the "Claimant") against the Department of Transformation and Shared Services (the "Respondent"). At the hearing held August 18, 2022, Claimant was represented by Brandon Lacy. Lauren Ballard and Jennifer Davis appeared on behalf of Respondent.

Procedural History

1. Claimant filed her claim in September 2019 against the Employee Benefits Division (EBD) of the Arkansas Department of Finance and Administration. Claimant's breach of contract claim is based upon EBD's denial of coverage for a medical procedure on Claimant's left buttock (the "Procedure").

2. Respondent denied liability.

3. Following a hearing on Claimant's subsequent motion for summary judgment, the Claims Commission entered an order on April 21, 2021, granting Claimant's motion with respect to the issue of liability. In that order, the Claims Commission instructed the parties to attempt to resolve the amount of Claimant's damages.

4. The parties were unable to agree on the amount of Claimant's damages, and following a January 13, 2022, hearing on pending motions, the Claims Commission scheduled this damages hearing.

5. At the beginning of the hearing, upon a question from a commissioner, the parties confirmed that Respondent resubmitted Claimant's bills to the insurer, that Claimant's outstanding bills were resolved, and that she subsequently received reimbursement from the medical providers in the total amount of $2,342.54. The parties also confirmed the remaining issues: (1) whether Claimant is entitled to pre-judgment interest and, if so, the amount; (2) whether Claimant is entitled to the twelve-percent statutory penalty; and (3) whether Claimant is entitled to attorney's fees and costs and, if so, the amount.

Pre-Judgment Interest

6. The chair commissioner noted that, under *Woodline Motor Freight, Inc. v. Troutman Oil Co.*, 327 Ark. 448 (1997), the test for whether pre-judgment interest should be applied is whether the amount of damages was ascertainable at the time of injury.

7. Claimant argued that the amount of pre-judgment was ascertainable by mathematical calculation once the claims were re-run and that six percent pre-judgment interest should be awarded on Claimant's actual damages.

8. Respondent conceded that the damages were ascertainable. Respondent agreed that six percent is the correct amount if the Claims Commission awards pre-judgment interest.

9. In view of the parties' agreement, the Claims Commission awards pre-judgment interest in the amount of $521.82, representing six percent per annum from January 23, 2019,[1] until the entry of this order.[2]

[1] On January 23, 2019, Claimant received notice from Respondent's Employee Benefits Division confirming its denial of insurance benefits for Claimant's medical procedure.

[2] Pre-judgment interest is awarded per annum (per year). Six percent of $2,342.54 is $140.55 per year, which can be further broken down to $0.39 per day. There are 1338 days from January 23, 2019, until September 22, 2022. Multiplying 1338 days by $0.39 equals $520.65.

Statutory Penalty

10. Ark. Code Ann. § 23-79-208(a)(1) provides:

> In all cases in which loss occurs and the cargo, property, marine, casualty, fidelity, surety, cyclone, tornado, life, accident and health, medical, hospital, or surgical benefit insurance company and fraternal benefit society or farmers' mutual aid association or company liable therefor shall fail to pay the losses within the time specified in the policy after demand is made, the person, firm, corporation, or association shall be liable to pay the holder of the policy or his or her assigns, in addition to the amount of the loss, twelve percent (12%) damages upon the amount of the loss, together with all reasonable attorney's fees for the prosecution and collection of the loss.

11. The chair commissioner noted that claims against the State typically do not end up in the courts, so there is no caselaw whether Ark. Code Ann. § 23-79-208(a)(1) applies to the State. The chair commissioner also noted a concern about awarding this penalty against the State, which is different than awarding damages.

12. Claimant argued that the language of the statute is clear and that the penalty should be applied.

13. Respondent agreed that the language of the statute is clear but concluded that the penalty should not apply because the statute does not specify self-insurers or pooled funds. Respondent asserted that its Employee Benefits Division does not fall within the statute.

14. Claimant argued that the statute includes health insurers and that insurance is defined as including pooled funds.

15. Upon a question from a commissioner, Respondent stated that the third party administrator would not be responsible for the penalty.

16. In light of the uncertainty as to whether Ark. Code Ann. § 23-79-208(a)(1) applies to Respondent, the Claims Commission declines to award the penalty to Claimant in this matter.

Attorney's Fees and Costs

17. Had the Claims Commission found that the statutory penalty in Ark. Code Ann. § 23-79-208(a)(1) applied in the instant claim, Claimant would be entitled to an award for "all reasonable attorney's fees" under the same statute. However, the Claims Commission's decision regarding the statutory penalty does not entirely resolve the issue of attorney's fees, as "a reasonable attorney's fee" may be awarded under Ark. Code Ann. § 16-22-308 "to the prevailing party in a "civil action to recover on an open account, statement of account, account stated . . . or contract . . . [for] services, or breach of contract."

18. Upon a question from a commissioner, the parties agreed that the attorney's fees would be mandatory if Ark. Code Ann. § 23-79-208 applied and that attorney's fees are discretionary under Ark. Code Ann. § 16-22-308.

19. The chair commissioner noted Respondent's objection to any attorney fees award, as well as Respondent's alternative argument that Claimant's attorney's fee should be $937.02 plus costs. The chair commissioner noted Claimant's position that $20,445.45 should be awarded in attorney's fees and costs.

20. The chair commissioner noted that Claimant's attorney submitted documentation of 73.5 hours of time spent on this matter through May 21, 2021, and that, if the Claims Commission were to award the amount of attorney's fees alternatively recommended by Respondent ($937.02), that award would equate to approximately $13 per hour for Claimant's attorney. The chair commissioner also noted that the minimum wage in Arkansas is currently $11 per hour.

21. Respondent argued that Claimant's attorney made the decision to use a contingency fee agreement in this matter and that Claimant's attorney is experienced in this work. If the Claims Commission does not award any attorney's fees to Claimant, Claimant would be obligated to pay

$937.02 plus costs to Claimant's attorney in satisfaction of her agreement with him. Respondent argued that the State should not have to pay more than what Claimant would have to pay.

22. Claimant argued that a $20,445.45 attorney fee award would not represent a windfall. Claimant stated that Respondent's argument is almost disingenuous given that Claimant originally filed her claim seeking the amount of her medical bills. Claimant noted that there are several factors to consider in calculating attorney's fee awards, as explained by the Arkansas Supreme Court in *Chrisco v. Sun Indus. Inc.*, 304 Ark. 227, 800 S.W.2d 717 (1990).

23. Upon a question from a commissioner, Claimant stated that the contingency fee rate was 40 percent in recognition that this was a tough case. Respondent responded that the attorney's fees under Ark. Code Ann. § 16-22-308 are discretionary and that Claimant's attorney could have set up the agreement to bill Claimant hourly.

24. Upon a question from a commissioner as to the total amount of medical bills that Claimant was faced with prior to filing this claim, Claimant stated that the amount was $17,546.70.

25. Upon a question from a commissioner as to whether the appropriate number would be 40 percent of the $17,546.70 amount, Respondent stated that amount did not include the deductible or coinsurance amount but is better than the amount billed by Claimant's attorney. Claimant replied, stating that the contingency fee should not be calculated from the amount of the original bills because Claimant's actual damages are the amount of Claimant's refund.

26. In *Chrisco*, the Arkansas Supreme Court set out factors to consider in computing attorney's fees:

> …although there is no fixed formula in determining the computation of attorney's fees, the courts should be guided by recognized factors in making their decision, including the experience and ability of the attorney, the time and labor required to perform the legal service properly, the amount involved in the case and the results obtained, the novelty and difficulty of the issues involved, the fee customarily charged in the locality for similar legal services, whether the fee is fixed or contingent, the time limitation imposed upon the client or by the circumstances,

> and the likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.

304 Ark. 227, 229–30, 800 S.W.2d 717, 718–19 (1990).

27. In *Southern Farm Bureau Cas. Ins. Co. v. Krouse*, 2010 Ark. App. 493, 375 S.W.3d 763, the Arkansas Court of Appeals specifically disagreed that a contingency fee contract should control the fee award:

> Farm Bureau specifically contends that the contingency-fee contract should have controlled the fee award. We disagree. Although there existed some kind of contingency fee contract, that was but one factor to consider overall.

28. The Claims Commission finds that an award of attorney's fees and costs under Ark. Code Ann. § 16-22-308 is appropriate in this matter. In analyzing the factors outlined in *Chrisco*, including the considerable experience and ability of Claimant's attorney; the remarkable amount of time, expense, and effort necessary for Claimant to have her medical procedure covered by her insurance; the results obtained by Claimant's attorney; the novelty and difficulty of such a claim against Respondent; and the fee agreement between Claimant and Claimant's attorney, the Claims Commission finds that Respondent's alternative proposal to be woefully insufficient. As such, and taking all of these factors into account, Claims Commission awards Claimant $15,000.00 in attorney's fees plus $2,044.98 in costs.

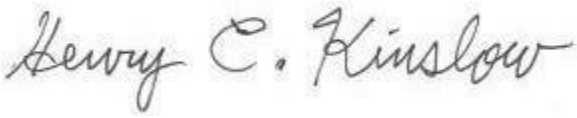
29. In arriving at this decision, the Claims Commission also finds Claimant's attorney persuasive when he spoke about the likelihood that, in the absence of a fair and reasonable attorney's fee award, potential future claimants with similar meritorious claims may not be able to hire competent representation for complex issues such as the ones involved in this claim.

Conclusion

30. The Claims Commission unanimously AWARDS Claimant $521.82 in pre-judgment interest, $15,000.00 in attorney's fees, and $2,044.98 in costs, for a total of $17,566.80.

IT IS SO ORDERED.

ARKANSAS STATE CLAIMS COMMISSION
Courtney Baird



ARKANSAS STATE CLAIMS COMMISSION
Henry Kinslow

ARKANSAS STATE CLAIMS COMMISSION
Paul Morris, Chair

DATE: September 22, 2022

Notice(s) which may apply to your claim

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1)(B)(ii). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a)(3).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(a). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).

IN THE ARKANSAS STATE CLAIMS COMMISSION

JESSICA MIDDLETON **CLAIMANT**

v. **CASE NO. 200293**

STATE OF ARKANSAS
DEPARTMENT OF TRANSFORMATION
AND SHARED SERVICES **RESPONDENT**

NOTICE OF APPEAL

COMES NOW the Respondent, the Department of Transformation and Shared Services ("TSS" or "Respondent"), by and through its attorney, Lauren Ballard, and for its Notice of Appeal, states as follows:

1. Arkansas Code Annotated § 19-10-211(a)(1) allows appeal of a final order on a claim before the commission to the General Assembly.

2. On September 23, 2022, the Arkansas Claims Commission (Commission) entered an Order awarding damages to the Claimant. The Commission awarded $521.82 in pre-judgment interest, $15,000.00 in attorneys fees, and $2,044.98 in costs for a total damages award of $17,566.80.

3. The Department of Transformation and Shared Services (TSS) files this Notice of Appeal pursuant to Ark. Code Ann. § 19-10-211(a)(1). TSS's appeal is limited to the award of $15,000.00 in attorney's fees for the reasons set out in its prior briefings to the Commission and as memorialized in the Commission's Order.

Respectfully Submitted,

Lauren Ballard, AR2012126
Attorney for the Respondent
Department of Transformation and
Shared Services
501 Woodlane Street, Ste. 201
Little Rock, AR 72201

CERTIFICATE OF SERVICE

I, Lauren Ballard, do hereby certify that I transmitted a true and correct copy of the foregoing pleading on this 2nd day of November 2022 to:

Brandon Lacy
Lacy Law Firm
Email: brandon@lacylawfirm.com

Arkansas State Claims Commission
Email: ASCCpleadings@arkansas.gov
Kathryn.Irby@arkansas.gov

_____
Lauren Ballard

IN THE ARKANSAS STATE CLAIMS COMMISSION

JESSICA MIDDLETON **CLAIMANT**

V. **CLAIM NO. 200293**

STATE OF ARKANSAS
DEPARTMENT OF FINANCE AND ADMINISTRATION **RESPONDENT**

CLAIMANT'S NOTICE OF CROSS-APPEAL

Comes the Claimant, Jessica Middleton, by and through her attorney, Brandon Lacy of Lacy Law Firm, and for her Notice of Cross-Appeal, states:

1. Arkansas Code Annotated § 19-10-211(a)(1) allows appeal of a final order on a claim before the Commission to the General Assembly.

2. On September 23, 2022, the Arkansas Claims Commission ("Commission") entered an Order awarding damages to the Claimant. The Commission awarded $521.82 in pre-judgment interest, $15,000.00 in attorney's fees, and $2,044.98 in costs for a total damages award of $17,566.80.

3. The Department of Transformation and Shared Services ("TSS") filed its Notice of Appeal pursuant to Ark. Code Ann. § 19-10-211(a)(1) on November 2, 2022. TSS's notice states that it is only appealing the attorney's fee calculation.

3. Claimant, Jessica Middleton, files this Cross-Notice of Appeal pursuant to Ark. Code Ann. § 19-10-201(a)(1) and Ark. R. App P. 3(d). Claimant likewise seeks to appeal only the attorney's fee calculation.

Respectfully Submitted,

By: Brandon W. Lacy #2003098

Brandon Lacy
LACY LAW FIRM
202 West Meadow
Fayetteville, AR 72701
Ph: (479) 957-9645
Brandon@lacylawfirm.com

CERTIFICATE OF SERVICE

I, Brandon W. Lacy, certify that a copy of the foregoing pleading was served, via email and U.S. Mail, upon the following counsel of record in the above captioned case on November 21, 2022:

Ms. Lauren Ballard
Department of Transformation and Shared Services
501 Woodlane Street, Suite 201
Little Rock, AR 72201
Lauren.Ballard@arkansas.gov

Brandon W. Lacy #2003098