

**BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA**

In the Matter of the Cease and Desist Order Against:	Enforcement Matter No. 11-366
 BLUE CROSS OF CALIFORNIA,	 OAH No. 2012080513
 Respondent.	

DECISION

This matter was heard from May 20 to May 23, 2013, by Julie Cabos-Owen, Administrative Law Judge (ALJ), Office of Administrative Hearings, in Los Angeles, California.

Christopher B. Lee and Heidi L. Lehrman, of the California Department of Managed Health Care (DMHC), represented the DMHC's Office of Enforcement and Anthony Manzanetti, who signed the cease and desist order, dated July 16, 2012, in this matter (Cease and Desist Order), in his official capacity as Deputy Director, Office of Enforcement, DMHC.

Michael McClelland, of McClelland Advocacy, Ltd., represented Blue Cross of California dba Anthem Blue Cross (Blue Cross) at the hearing. Michael J. Daponde, of Wilke, Fleury, Hoffelt, Gould & Birney, LLP, began representing Blue Cross as of October 22, 2013, and has replaced Mr. McClelland as attorney of record in this matter.

ALJ Cabos-Owen received oral and documentary evidence from May 20 to May 23, 2013. Two witnesses testified before ALJ Cabos-Owen: Gary Auer, a director in Blue Cross's Special Investigations Unit (SIU), and Dr. Lori Pelliccioni, a health care consultant at the Center for Health Care Compliance and Assistant Adjunct Professor at the University of California, Los Angeles, School of Public Health.

Nineteen exhibits were entered into evidence. Exhibit 3 (Bates nos. 0531-0533, 0715-0716, 3277-3281, 3747-3754, 3759-3769, and 3920-3922), Exhibit 5, Exhibit 6, Exhibit J (last 34 pages), and Exhibit L (54 pages, excluding the first 10 and last 4 pages of the exhibit), or portions thereof, were sealed to protect personal health information (PHI).

The record was held open for the submission of post-hearing briefs, and the matter was submitted for decision on August 2, 2013. ALJ Cabos-Owen issued a proposed decision on August 27, 2013. On October 14, 2013, the Director of the DMHC notified the parties that he would decide this matter on the record, pursuant to Government Code section 11517, subdivision (c)(2)(E). Both parties submitted additional written argument, pursuant to Government Code section 11517, subdivision (c)(2)(E)(ii), on October 28, 2013.

FINDINGS OF FACT

At all relevant times, Blue Cross has been licensed in the State of California as a health care service plan, subject to the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). (Health & Saf. Code, § 1340 et seq.)

In February 2011, as required under the Knox-Keene Act, Blue Cross filed its Antifraud Annual Report with the DMHC. The Antifraud Annual Report set forth Blue Cross's objectives and procedures for preventing fraud, waste, and abuse, and noted that, as part of its fraud-combatting strategies, Blue Cross maintains an internal Special Investigations Unit (SIU). Twenty-two special investigators review issues regarding specific providers, and six clinical investigators examine recurrent provider problems.

Matters come under SIU investigation in various ways: fraud unit internal investigations, referrals from other Blue Cross units, enrollee complaints, and industry alerts. When internally investigating a potential billing issue, the SIU looks at the claims data for outliers – providers who have received more payments than average, for example – and then reviews the outliers' claims to see if the claims comply with billing guidelines and if services were rendered. In terms of billing guidelines, Mr. Auer testified that Blue Cross relies on the American Medical Association (AMA) billing guidelines and the Centers for Medicare and Medicaid Services (CMS) billing guidelines. Blue Cross's provider contracts require providers to use AMA Current Procedural Technology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding systems in their bills when seeking reimbursement for services they have provided. Blue Cross pays providers for their services based on the codes billed.

When SIU identifies billing problems it believes are due to provider coding issues, it refers the cases to the Clinical Investigations Unit (CIU), which sends letters to the targeted providers. According to Mr. Auer, the letters initiate a dialogue with the provider regarding reimbursement and do not include service dates or other information regarding the claims at issue.

During 2010 and 2011, Blue Cross, through its CIU, sent over 500 letters to various contracting and non-contracting providers¹ seeking reimbursement for overpaid claims (the Blue Cross Letters).² The majority of the Blue Cross Letters followed the same format and sought reimbursement based on generalized assertions that the providers were engaged in upcoding, unbundling, or miscoding.³ The Blue Cross letters contained the following statements:

¹ "Contracting providers" are health care service providers that entered into contractual agreements that set forth the relationship between Blue Cross and the providers, including payment rates, etc. "Non-contracting providers" are health care service providers that do not have contractual agreements with Blue Cross.

² The Blue Cross Letters were entered into evidence as Exhibit 3. The Cease and Desist Order indicates that 548 letters are at issue. It is not clear that there are exactly 548 potentially problematic letters. For example, several letters in Exhibit 3 were sent to providers outside of California (see Exhibit 3, Bates nos. 458-466); there is no explanation in the record regarding their relevance in this matter. The precise number of letters, however, is not determinative of the issues in this matter.

³ According to the federal Department of Health and Human Services, "upcoding" is the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient. (63 Fed. Reg. 8990 (Feb. 23, 1998).) "Unbundling" is the practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed

- Blue Cross had audited the provider, (sometimes going back as far as 2007);
- Due to the provider's coding error (*i.e.*, upcoding, unbundling, or miscoding), Blue Cross had overpaid the provider, such that the provider must reimburse Blue Cross for the stated amount;
- Blue Cross expected the provider to code for services using the AMA CPT and HCPCS codebooks, as required by the general provider contract, when applicable;⁴ and
- The service(s) at issue should be properly coded.

In each letter, Blue Cross also indicated that the provider could, upon request, receive an itemization of the at-issue claims and that the provider could contact Blue Cross to discuss the issue further.

A small number of the Blue Cross Letters alleged that the provider had billed for services not rendered.⁵ In contrast to the letters regarding upcoding, unbundling, and miscoding, the letters regarding services not rendered typically included patient names and some discussion of the underlying facts.

On July 16, 2012, the DMHC issued the Cease and Desist Order against Blue Cross. The operative paragraphs of the Cease and Desist Order read as follows:

Paragraph 1:

[Blue Cross] is hereby ordered to cease and desist from violating California Code of Regulations, title 28, section 1300.71, subdivision (d)(3), by ceasing any and all attempts to obtain reimbursement from any provider without, for each claim of overpayment, notifying the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of the service, and a clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Paragraph 2:

together and therefore at a reduced cost. (*Id.*) "Miscoding" is the practice of billing using an incorrect code for the service performed. (See <http://thefreedictionary.com/>.)

⁴ Blue Cross failed to attach or refer to provider contract provisions requiring certain billing standards. Blue Cross also failed to offer the contracts into evidence, so the relevant provisions of the provider contracts are not in the record.

⁵ Billing for services not rendered is the practice of submitting a claim that represents that the provider performed a service all or part of which was simply not performed. (63 Fed. Reg. 8990 (Feb. 23, 1998).) The Cease and Desist Order indicates that 13 of the Blue Cross Letters requested reimbursement due to billing for services not rendered, but as with the overall number of the Blue Cross Letters, the precise number of letters regarding services not rendered is not determinative of the issues in this matter.

[Blue Cross] is hereby ordered to cease and desist from violating California Code of Regulations, title 28, section 1300.71, subdivision (b)(5), by ceasing any and all attempts to obtain reimbursement for the overpayment of a claim after 365 days of the date of payment for which [Blue Cross] has not demonstrated that the overpayment was caused in whole or in part by a representation made by the provider that was false, the representation was made by the provider without any reasonable ground for believing the representation to be true, and that [Blue Cross] was unaware of the falsity of the representation and was justified in relying on the representation.

LEGAL CONCLUSIONS

I. DMHC Enforcement Authority

Health and Safety Code section 1341, subdivision (c), provides that the Director of the DMHC may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the Knox-Keene Act. Health and Safety Code section 1344, subdivision (a), allows the DMHC to issue any “orders necessary to carry out the provisions” of the Knox-Keene Act. Consistent with that provision, Health and Safety Code section 1391, subdivision (a)(1), authorizes the Director of the DMHC to issue cease and desist orders for violations of the Knox-Keene Act or rules issued pursuant to the Knox-Keene Act. The DMHC therefore properly issued the Cease and Desist Order pursuant to those provisions.

II. Evidentiary Standard and Burden of Proof

Administrative proceedings require that evidence presented be reviewed under a preponderance of the evidence standard, pursuant to Evidence Code section 115, unless the statute governing the matter provides a different evidentiary standard. (See *San Benito Foods v. Veneman* (1996) 50 Cal.App.4th 1889, 1892-1893 [58 Cal.Rptr.2d 571].) Neither the provision of the Knox-Keene Act nor the related regulations at issue here – Health and Safety Code section 1371.1, California Code of Regulations, title 28, section 1300.71, subdivisions (b)(5) and (d)(3) – provide an evidentiary standard. Therefore, the preponderance of the evidence standard from Evidence Code section 115 applies.

Health and Safety Code section 1343.5 provides, “[i]n any proceeding under [the Knox-Keene Act], the burden of proving an exemption or exception from a definition is upon the person claiming it.” Evidence Code section 500 provides, “a party has the burden of proof as to each fact[,] the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting.”

III. Statutory Construction

The first step in interpreting a statute is to look to the language of the statute. (*People v. Lopez* (2003) 31 Cal.4th 1051, 1057 (citing *People v. Lawrence* (2000) 24 Cal.4th 219, 230 [99 Cal.Rptr. 570]).) If statutory language is “clear and unambiguous, the plain meaning of the statute governs.” (*Id.*) In construing a statute, the word “shall” is read as mandatory where construing it otherwise would render the statute ineffective and meaningless. (See *Carter v. Seaboard Fin.*

Co. (1949) 33 Cal.3d 564, 573 [203 P.2d 758].) Establishing that a statute is mandatory can be done by examining the legislative intent, by “gather[ing] from the nature and character of the act to be done, and from the consequences which would follow the doing or failure to do the particular act at the required time,” and keeping in mind any public purpose the statute is supposed to serve. (See *Morris v. County of Marin* (1977) 18 Cal.3d 901, 910 [136 Cal.Rptr. 251].)

Additionally, “[i]f . . . the language supports more than one reasonable construction, [a court] may consider a variety of extrinsic aids, including the ostensible objects to be achieved, the evils to be remedied, the legislative history, public policy, contemporaneous administrative construction, and the statutory scheme of which the statute is a part. Using these extrinsic aids, [a court] select[s] the construction that comports most closely with the apparent intent of the Legislature, with a view to promoting rather than defeating the general purpose of the statute, and avoid an interpretation that would lead to absurd consequences.” (*Lopez*, 31 Cal.4th at 1057 (citing *People v. Sinohui* (2002) 28 Cal.4th 205, 211-212 [120 Cal.Rptr.2d 783]).)

IV. California Code of Regulations, Title 28, Section 1300.71, Subdivision (d)(3),⁶ Requires a Plan Seeking Reimbursement to Notify a Provider of the Claims, the Names of the Patients, and the Dates of Service, and to Provide a Clear Explanation of the Basis Upon Which the Plan Is Seeking Reimbursement

A. The Parties’ Arguments

At the hearing and in its hearing briefs, Blue Cross advanced four main arguments. First, Blue Cross argued that the Blue Cross Letters were not requests for reimbursement, but instead were attempts by Blue Cross to open dialogues with providers. Second, Blue Cross argued that its Antifraud Annual Report alerted the DMHC to Blue Cross’s strategies for combatting fraud, including policing upcoding and unbundling, and notifying providers regarding billing issues. Third, Blue Cross argued that even though it did not provide all of the information required by Subdivision (d)(3) in the Blue Cross Letters, it offered to send the providers secure emails containing all of the claims information upon provider request. Finally, Blue Cross argued it could not send providers claims information in the mailed letters because the Health Insurance Portability and Accountability Act (HIPAA) requires Blue Cross to protect PHI, which could be compromised if the letters did not reach their intended destinations.⁷ In its October 28, 2013, written argument, Blue Cross conceded that the Blue Cross Letters did not comply with Subdivision (d)(3), but instead argued that a plan’s “technical failure to strictly follow” Subdivision (d)(3) should not negate the plan’s ability to seek reimbursement for overpayments due to fraud or misrepresentation.

The DMHC maintained at the hearing and in its hearing briefs that the Blue Cross Letters were not merely attempts to open dialogues with providers because, before sending the Blue Cross Letters, Blue Cross had already determined that it had overpaid the affected providers. The

⁶ References to “Subdivision (d)(3)” and “Subdivision (b)(5)” refer to those subdivisions of California Code of Regulations, title 28, section 1300.71.

⁷ These arguments were the heart of Blue Cross’s defense at the hearing and in its hearing briefs, though Blue Cross made a number of secondary and tertiary arguments as well.

DMHC also demonstrated that none of the letters provided all of the information required by Subdivision (d)(3) and therefore violated Subdivision (d)(3). In its October 28, 2013, submission, the DMHC continued to argue that Blue Cross violated Subdivision (d)(3).

B. Analysis

Subdivision (d)(3) enumerates the information a health plan must include in its notices seeking reimbursement:

If a plan or a plan's capitated provider determines that it has overpaid a claim, it shall notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service and including a clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Subdivision (d)(3) plainly states that a plan requesting reimbursement "shall" provide a provider with a separate written notice regarding the reimbursement and include in its initial notice to the provider the claims at issue, patient names, dates of service, and a clear explanation of the grounds for seeking reimbursement. The "shall" in Subdivision (d)(3) is mandatory. To construe the term otherwise would render the provision a mere guide as to how plans might try seeking reimbursement. (See *Morris*, 18 Cal.3d at 910.) Such an interpretation would be pointless in the overall context of the regulation, which is designed to ensure that plan's provide a fast, fair and cost-effective dispute resolution mechanism. Fairness dictates that health plans, at a minimum, provide sufficient information about the disputed claim so the provider can intelligently respond to the health plan's assertion that it over paid the provider's claims.

None of the Blue Cross Letters provided all of the Subdivision (d)(3) notice items, a fact Blue Cross does not dispute. A few of the letters included patient names and some limited factual assertions regarding Blue Cross's belief that the claims were for services not rendered, but those letters also failed to identify the specific claims and dates of service.

Blue Cross's arguments that the Blue Cross Letters did not need to comply with Subdivision (d)(3) are without merit. First, the argument that the Blue Cross Letters did not seek reimbursement is contradicted by the fact that the Blue Cross Letters clearly state that Blue Cross was seeking reimbursement of specific dollar amounts. It is equally clear that providers understood that Blue Cross was seeking reimbursement because, according to Mr. Auer, some providers reimbursed Blue Cross after receiving the letters. Second, while Blue Cross filed its Antifraud Annual Report with the DMHC, the report did not disclose that Blue Cross intended to seek reimbursement from providers without giving providers the information required in Subdivision (d)(3). Acceptance of an antifraud filing in no way endorsed or approved Blue Cross's strategy of sending providers reimbursement letters without the required Subdivision (d)(3) information. Third, Subdivision (d)(3) requires Blue Cross to seek reimbursement from providers by sending a "separate notice clearly identifying the claim, the name of the patient, the date of service, and . . . a clear explanation" of the basis on which Blue Cross was seeking reimbursement. Offering to send claims information upon request wholly fails to meet the notice requirements of Subdivision (d)(3). Finally, Blue Cross can easily comply with Subdivision

(d)(3) without compromising patient privacy. Blue Cross routinely sends PHI via encrypted email in compliance with HIPAA and can make special delivery arrangements, such as sending materials via restricted mail, if necessary.

Because none of the Blue Cross Letters contained the basic information required by Subdivision (d)(3), none of the Blue Cross letters complied with Health and Safety Code section 1371.1 or Subdivision (d)(3), and were therefore improperly sent. While the inquiry could end here, it is still appropriate to give guidance on the notice requirements under Subdivision (b)(5) for plans seeking reimbursement based on alleged fraud or misrepresentation.

V. California Code of Regulations, Title 28, Section 1300.71, Subdivision (b)(5), Requires a Plan Seeking Reimbursement Beyond the 365-Day Limit to Meet the Requirements of Subdivision (d)(3) and to Provide a Clear Explanation for Its Belief That an Overpayment Was Due to Provider Fraud or Misrepresentation

A. The Parties' Arguments

At the hearing and in its hearing briefs, Blue Cross argued that its letters described upcoding, unbundling, and miscoding in sufficient detail to meet the requirements of Subdivision (b)(5). The plan maintained that generalized discussions of upcoding, unbundling, or miscoding were sufficient to allow it to collect overpayments after the 365-day time limit because those practices involve fraud or misrepresentation. In its October 28, 2013, written argument Blue Cross reiterated that argument, but went on to additionally argue, without legal support, that the notice elements required by Subdivision (d)(3) are not a prerequisite to meeting the fraud exemption in Subdivision (b)(5). Blue Cross maintained that Subdivision (b)(5) is unenforceable because, as a regulation, it impermissibly shortens the time a plan may recover overpayments when compared to other existing law.

The DMHC argued that the Blue Cross Letters were clearly requests for reimbursement, yet the plan failed to provide the providers with all of the information required by Subdivision (d)(3) or with a clear explanation of why the plan believed the alleged payments were due to fraud or misrepresentation. The DMHC maintained that simply making the unsupported statement that a provider has engaged in upcoding or unbundling does not provide a "clear explanation" of the plan's belief that the provider engaged in fraud or misrepresentation, as required under Subdivision (d)(3). The DMHC also argued that Blue Cross did not meet its burden of proof under Health and Safety Code section 1343.5, by demonstrating that it meets the fraud exemption, or Evidence Code section 500, by proving the facts essential to its defense.

B. Analysis

1. Subdivision (b)(5) Requires Health Plans to Comply with Both Subdivision (d)(3) and Sufficiently Explain the Basis for Its Belief That Its Alleged Overpayment Was Due to the Provider's Fraud or Misrepresentation

Subdivision (b)(5) provides:

A plan or a plan's capitated provider shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code Section 1371.1, unless the plan or the plan's capitated provider sends a written request for reimbursement to the provider within 365 days of the Date of Payment on the overpaid claim. The written notice shall include the information specified in section (d)(3). The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the provider.

Subdivision (b)(5) thus expressly requires plans to comply with the notice requirements of Subdivision (d)(3). In addition, in order to qualify for the exception to the 365 day limitation on recouping overpayments, a plan must set forth facts, that if true, would be sufficient to establish that the provider has engaged in fraud or misrepresentation. (See *Committee on Children's Television, Inc. v. General Foods Corp* (1983) 35 Cal.3d 197, 217 [197 Cal.Rptr. 783].)

A fraud or misrepresentation accusation, at a minimum, must identify the provider conduct suggestive of fraud or misrepresentation.⁸ Typically, this should include demonstrating that the overpayment was caused in whole or in part by a representation made by the provider that was false, that the representation was made by the provider without any reasonable ground for believing the representation to be true, and that the health plan was unaware of the falsity of the representation and was justified in relying on the representation. CA Civil Code section 1572; *Agric. Ins. Co. v. Superior Court* (1999) 70 Cal. App. 4th 385 [82 Cal. Rptr. 2d 594]. Generic statements identifying various types of conduct that can potentially involve fraud or misrepresentation is not sufficient because those generalized statements do not offer the provider "certain definite charges which can be intelligently met." (See, *Committee on Children's Television, Inc. v. General Foods Corp* (1983) 35 Cal.3d 197, 217 [197 Cal.Rptr. 783].)

Indeed, the articulated purpose of Subdivision (b)(5) is to require plans to provide a clear explanation to providers, so that providers can meaningfully respond to plans' requests for reimbursement. According to the Final Statement of Reasons issued during the rulemaking process for California Code of Regulations, title 28, section 1300.71, the purpose of Subdivision (b)(5) is to "set forth the maximum time frame to assert requests for reimbursement of overpayment of claims" and that the provision was "necessary to ensure that plans and plans' capitated providers do not engage in unfair payment patterns in violation of Health & Safety Section 1371.1." The purpose of giving the provider notice of the plan's position that it overpaid the claim due to provider fraud or misrepresentation is to offer the provider a fair opportunity to respond to the plan's allegations.

⁸ An allegation that the provider has billed for services not rendered may be enough to identify allegedly fraudulent conduct; however, if a plan does not identify the disputed claim and date of services it fails to comply with Subdivision (d)(3), and therefore fails to qualify for the exception to the 365-day time limit on requesting reimbursement for overpaid claims.

Subdivision (b)(5) explicitly requires plans to comply with Subdivision (d)(3)'s notice requirements. As with Subdivision (d)(3), the "shall" in Subdivision (b)(5) is mandatory, as it would otherwise rendered the provision pointless. (See *Morris*, 18 Cal.3d at 910.) Therefore, a plan cannot meet the basic requirements of Subdivision (b)(5) without complying with Subdivision (d)(3) and providing the appropriate notice – including the claims, dates, patients, and a clear explanation of the basis for reimbursement – to the provider when the plan commences its reimbursement efforts.⁹

Additionally, if the plan is seeking reimbursement due to provider fraud or misrepresentation, beyond the 365-day time limit for seeking reimbursement ordinarily imposed by Subdivision (b)(5), it must provide all of the information required by Subdivision (b)(5) – the standard claim information required by Subdivision (d)(3), plus an explanation of why the plan believes the provider engaged in fraud or misrepresentation. Both disclosure components are absolutely necessary if the provider is to have an opportunity to respond to the plan's allegation that the provider has engaged in fraud or misrepresentation, and to ensure that the plan's provider dispute resolution mechanism is fair. Requiring plans to comply with Subdivision (d)(3)'s notice requirements including giving a clear explanation of why a plan believes fraud or misrepresentation has occurred fulfills the provision's purpose of ensuring that provider dispute resolution mechanisms offer providers a fair opportunity to respond to plans.

Contrary to Blue Cross's assertion, making general statements that a provider engaged in upcoding or unbundling does not meet the plain requirements of Subdivision (b)(5). Seeking reimbursement based on generalized, unsupported, allegations of provider fraud or misrepresentation that are not tied to specific claims frustrates the clear purpose of Subdivision (b)(5), which is to foster full disclosure and avoid unfair payment practices by health plans.¹⁰ Requiring compliance with Subdivisions (b)(5) and (d)(3) does not limit a plan's right to seek reimbursement from providers who engage in fraud or misrepresentation. Subdivisions (b)(5) and (d)(3) simply requires health plans to provide the provider with a fair opportunity to respond to the plan's assertions that it overpaid a claim.

2. The DMHC Must Ensure That Plan Dispute Resolution Mechanisms Are Fast and Fair

Blue Cross's argument that Subdivision (b)(5) is unenforceable because the DMHC exceeded its authority in adopting the 365-day limit in that regulation, when other limitations periods – for breach of contract, quantum meruit, etc. – already existed, is misguided. First, Government Code section 11374 provides that when an agency has express authority to adopt regulations to implement, interpret, or otherwise make specific a statute, those regulations are valid and

⁹ Whether fraud or misrepresentation actually occurred is not at issue or whether upcoding and unbundling are, de facto, fraud or misrepresentation is not at issue. The issue is whether Blue Cross sufficiently identified, in its letters to providers, which claims it believed were products of fraud or misrepresentation, and the basis for that belief.

¹⁰ Additionally, "every contract calls for the highest degree of good faith and honest dealing between the parties." (*Nelson v. Abraham* (1947) 29 Cal.2d 745, 750 [177 P.2d 931].) Blue Cross's letters to its contracting providers failed to include the minimum information providers need to respond to Blue Cross's belief that the providers had acted fraudulently or made misrepresentations. Health and Safety Code section 1367, subdivision (h)(1), also requires provider contracts be fair and reasonable.

effective as long as they are consistent and not in conflict with the statute and are reasonably necessary to effectuate the purpose of the statute. Indeed, “[c]ourts have long recognized that the Legislature may elect to defer to and rely upon the expertise of administrative agencies” to implement regulations to effectuate particular regulatory designs. (See *Credit Ins. Gen. Agents Assoc. of Cal., Inc. v. Payne* (1976) 16 Cal.3d 651, 656 [128 Cal.Rptr. 881].)

Health and Safety Code section 1371.38 directed the DMHC to adopt regulations to ensure “any dispute resolution mechanism of a plan is fair, fast, and cost effective” Seeking reimbursement for overpaid claims is one dispute resolution mechanism plans employ. Subdivision (b)(5)’s 365-day limit therefore fulfills the statutory directive that the DMHC ensure that plans offer providers “fast” dispute resolution.

Second, “it is well established that a specific provision prevails over a general one relating to the same subject.” (*Dept. of Alcoholic Beverage Control v. Alcoholic Beverage Control Appeals Bd.* (1999) 71 Cal.App.4th 1518, 1524 [84 Cal. Rptr. 2d 621].) The Knox-Keene Act is a specific piece of legislation that provides for the regulation of particular entities, health care service plans. The legislature, in regulating particular entities, can limit the rights of those entities by creating legislation directing administrative bodies to regulate entities in a particular manner. In this case, the Knox-Keene Act directs the DMHC to ensure that plan dispute resolution mechanisms – such as letters requesting reimbursement for overpayment – are fast and fair. Blue Cross relies on general legal principles to support its position that Subdivision (b)(5) is unenforceable. However, because Blue Cross is a health care service plan subject to the Knox-Keene Act, Title 28, Section 1300.71, Subdivision (d)(3) properly establishes time limits for health plans to seek recoupment for claims that it believes were over paid.

C. Conclusion

All of the Blue Cross Letters seeking reimbursement for overpaid claims failed to comply with the notice requirements of Subdivision (d)(3). In addition, the Blue Cross letters seeking reimbursement beyond the 365-day time limit (the majority of the requests) also failed to comply with Subdivision (b)(5)’s requirement to include a clear explanation of the plan’s belief that the overpayment was caused in whole or in part by a representation made by the provider that was false, the representation was made by the provider without any reasonable ground for believing the representation to be true, and that Blue Cross was unaware of the falsity of the representation and was justified in relying on the representation.¹¹

¹¹ The majority of the Blue Cross Letters referred to date ranges that included dates outside the 365-day time limit. The few letters that referenced date ranges within the 365-day limit – that therefore did not require the fraud exemption – still did not meet Subdivision (d)(3)’s requirements and, as such, were still improperly sent.

Also, Paragraph 15 of the Cease and Desist Order stated that in the 535 letters seeking reimbursement based on upcoding, unbundling, and miscoding, Blue Cross failed to assert or demonstrate a factual basis sufficient to show fraud or misrepresentation on the part of the provider. Paragraph 15 potentially excluded the letters regarding services not rendered from its assessment of Blue Cross’s failure to assert a sufficient factual basis to show fraud or misrepresentation. However, none of the Blue Cross Letters contained all of the information required by Subdivision (d)(3), so any letters requiring the fraud exemption did not meet the requirements for that exemption.

**BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA**

In the Matter of the Cease and Desist Order Against:

Enforcement Matter No. 11-366

BLUE CROSS OF CALIFORNIA,

OAH No. 2012080513

Respondent.

ORDER

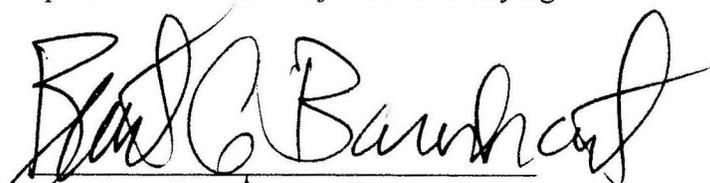
The Cease and Desist Order, signed on July 16, 2012, issued against Blue Cross of California is affirmed, with the clarification that all of the letters that are the subject of this matter failed to meet the notice requirements of California Code of Regulations, title 28, section 1300.71, subdivision (d)(3). For all letters sent more than 365 days after the alleged overpayments, Blue Cross of California failed to meet the fraud exemption in California Code of Regulations, title 28, section 1300.71, subdivision (b)(5).

Blue Cross of California shall cease and desist from violating California Code of Regulations, title 28, section 1300.71, subdivision (d)(3), by ceasing any and all attempts to obtain reimbursement from any provider without, for each claim of overpayment, notifying the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of the service, and a clear explanation of the basis upon which the plan or the plan's capitated provider believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

Blue Cross of California shall also cease and desist from violating California Code of Regulations, title 28, section 1300.71, subdivision (b)(5), by ceasing any and all attempts to obtain reimbursement for the overpayment of a claim after 365 days of the date of payment for which Blue Cross of California has not provided the providers the information required by California Code of Regulations, title 28, section 1300.71, subdivision (d)(3), and with the facts upon which Blue Cross of California concluded that the overpayment was caused in whole or in part by a representation made by the provider that was false, the representation was made by the provider without any reasonable ground for believing the representation to be true, and that Blue Cross of California was unaware of the falsity of the representation and was justified in relying on the representation.

Date: November 22 2012





Brent A. Barnhart

Director, Department of Managed Health Care

PROOF OF SERVICE

In the Matter of the Cease and Desist Order Against Blue Cross of California
OAH No. 2012080513

I declare:

I am an attorney at the Department of Managed Health Care, in Sacramento County, California, and am an active member of the California State Bar. I am 18 years of age or older and am not a party to this matter. I am familiar with the business practice at the Department of Managed Health Care for the collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system for sending via registered mail at the Department of Managed Health Care is deposited with the United States Postal Service that same day in the ordinary course of business.

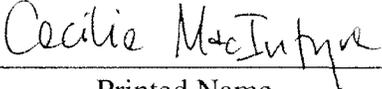
On November 22, 2013, I served the attached **Decision and Order** by placing true copies thereof enclosed in sealed envelopes with registered mail receipts and with postage thereon fully prepaid, in the internal mail collection system at the Department of Managed Health Care at 980 9th Street, Suite 500, Sacramento, California 95814-2738, addressed as follows:

Michael J. Daponde, Esq.
Wilke, Fleury, Hoffelt, Gould & Birney, LLP
400 Capitol Mall, 22nd Floor
Sacramento, CA 95814

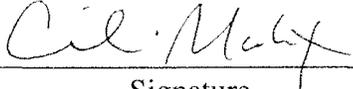
Christopher Lee
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Blue Cross of California
1121 L Street, Suite 500
Sacramento, CA 95814

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on November 22, 2013, at Sacramento, California.



Printed Name



Signature