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DEPARTMENT OF MANAGED HEALTH CARE  
BY *[Signature]*  
Filing Clerk

8 Attorneys for Complainant

9 BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE  
10 OF THE STATE OF CALIFORNIA  
11

12 IN THE MATTER OF:

13 **BLUE CROSS OF CALIFORNIA, DBA**  
14 **ANTHEM BLUE CROSS,**

15 Respondent.

OAH No.:

Enforcement Matter No.: 13-319

**ACCUSATION**

18 **I.**

19 **INTRODUCTION**

20 The California Department of Managed Health Care (DMHC or the Department) brings the  
21 present action to assess administrative penalties against BLUE CROSS OF CALIFORNIA, DBA  
22 ANTHEM BLUE CROSS (Respondent) pursuant to the provisions of the Knox-Keene Health Care  
23 Service Plan Act of 1975, as amended (the Act). (Health & Saf. Code, § 1340, et seq.)

24 **II.**

25 **PARTIES**

26 1. Carol L. Ventura (Complainant) is the Deputy Director and Chief Counsel of the  
27 Department's Office of Enforcement. Complainant brings this Accusation solely in her official  
28 capacity as Deputy Director and Chief Counsel of the Office of Enforcement for the Department.



1           8.       Health and Safety Code section 1367(i) states in pertinent part, that “A *health care*  
2 *service plan contract shall provide to subscribers and enrollees all of the basic health care services*  
3 *included in subdivision (b) of Section 1345.*” Basic health care services include “*ambulatory care*  
4 *services.*” (Health & Saf. Code, § 1345(b)(2).) Ambulatory care services include “*diagnostic and*  
5 *treatment services, physical therapy, speech therapy, occupational therapy services.*” (Cal. Code Regs.,  
6 tit. 28, § 1300.67(c).)

7           9.       Health and Safety Code section 1386(b)(7) states that the Department’s licensees are  
8 subject to discipline for “*any conduct that constitutes fraud or dishonest dealing or unfair competition*  
9 *as defined by Section 17200 of the Business and Professions Code.*” Unfair competition “*shall mean*  
10 *any unlawful, unfair or fraudulent business act or practice.*” (Bus. & Prof. Code, § 17200.)

11           10.      Health care service plans are authorized to conduct utilization review to determine  
12 whether services requested by providers are medically necessary. (Health & Saf. Code, § 1367.01(a).)  
13 A health care service plan may delegate this authority to its contracted medical groups or independent  
14 practice associations. (*Ibid.*)

15           11.      Health care service plans must “*Establish and maintain a grievance system ... under*  
16 *which enrollees may submit their grievances to the plan.*” (Health & Saf. Code, § 1368(a)(1); Cal. Code  
17 Regs., tit. 28, § 1300.68(a).)

18           12.      Health care service plans are obligated to process and reimburse claims for covered  
19 services received by their enrollees. (Health & Saf. Code, § 1371; Cal. Code Regs., tit. 28, § 1300.71.)

20           13.      Health care service plans which provide coverage for hospital, medical and surgical  
21 services shall provide coverage for the medically necessary treatment for autism. (Health & Saf. Code,  
22 § 1374.72(a); Cal. Code Regs., tit. 28, § 1300.74.72(a).)

23           14.      All hearings before the Director are to be held in accordance with the Administrative  
24 Procedure Act (Govt. Code, §§ 11500 through 11529.), and the Director has all of the powers granted  
25 under that Act. (Health & Saf. Code, § 1397(a).) The factors for determining an appropriate penalty  
26 for violations of the Knox-Keene Act are set forth in California Code of Regulations, title 28, section  
27 1300.86.

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IV.

FACTUAL ALLEGATIONS

15. Respondent provides coverage for its enrollees for hospital, medical and surgical services. Respondent routinely, and in the regular course of business, receives requests from its enrollees seeking speech and/or occupational therapy services.

16. Since January 2010, Respondent has received at least 24 requests from enrollees seeking speech and/or occupational therapy services which have been denied. The Department has received complaints from each of these enrollees.

17. In 23 of the complaints received by the Department, Respondent and/or its contracted provider groups have cited and/or quoted the Plan's National Clinical UM Guidelines (national medical policy) #CG-REHAB-06 as justification for their denial of coverage for speech therapy services.

18. The Anthem national medical policy #CG-REHAB-06 states in relevant part as follows:

*“Speech-language pathology services (SLP) are considered **medically necessary** when ALL of the following criteria are met: [¶] 1. The services are used in the treatment of communication impairment or swallowing disorders resulting from **illness, injury, surgery, congenital abnormality....**”* [Capitalization and bolding in original.]

19. In three of the complaints received by the Department, Respondent and/or its contracted provider groups have cited and/or quoted the Plan's National Clinical UM Guidelines (national medical policy) #CG-REHAB-05 for occupational therapy as justification for their denial of coverage for occupational therapy services.

20. The Anthem national medical policy #CG-REHAB-05 states in relevant part as follows:

*“Occupational therapy (OT) services are considered **medically necessary** when ALL of the following criteria are met: [¶] 1. The therapy is aimed at preventing disability or improving, adapting or restoring functions which have been impaired or permanently lost as a result of **illness, injury, loss of a body part, or congenital abnormality....**”* [Capitalization and bolding in original.]

21. In each of the above 24 instances, Respondent has categorically denied coverage for speech therapy and/or occupational therapy on the ground that the enrollee did not have a sufficient

1 physical condition to trigger coverage, and did not consider whether the requested therapy was  
2 medically necessary to treat the enrollee's condition.

3 22. In one of the above-referenced cases, Respondent denied coverage for requested  
4 occupational therapy services for the treatment of an enrollee's autism spectrum disorder on the basis  
5 that the requested services were not a covered benefit under the Plan contract.

6 23. For children with developmental disabilities, expressive language disorders, speech  
7 delays and cerebral palsy, Respondent categorically denies coverage for speech and/or occupational  
8 therapy on the basis that the enrollee does not have a physical condition such as a defined illness,  
9 disease, injury, congenital anatomic anomaly, or surgery.

10 24. Under the Act, speech and occupational therapy are required basic health care services,  
11 and therefore Respondent's denial of coverage for speech and/or occupational therapy based on a lack  
12 of physical impairment is illegal and contrary to the Act.

13 25. The Department has determined that Respondent's denials of speech and/or occupational  
14 therapy should not have been denied based on coverage, but rather should have been reviewed to  
15 determine whether the services were medically necessary.

16 26. The Department sent each of the above-referenced cases that were denied by  
17 Respondent to the Independent Medical Review ("IMR") for an evaluation of the medical necessity of  
18 the enrollee's requested service.

19 27. The IMR determined that the requested speech therapy and/or occupational therapy were  
20 medically necessary in each of the 24 cases.

21 28. Respondent continues to illegally deny enrollee requests seeking services for speech  
22 and/or occupational therapy.

23 **FIRST CAUSE FOR DISCIPLINE**

24 29. Health care service plans which violate any portion of the Act or the Department's  
25 regulations are subject to discipline by the Department. (Health & Saf. Code, § 1386(b)(6). Medically  
26 necessary speech therapy and occupational therapy are basic health care services which Respondent is  
27 mandated to cover. (Health & Saf. Code, §§ 1345(b), 1367(i); Cal. Code Regs., tit. 28, § 1300.67(c).)  
28 Thus, Respondent is required to cover medically necessary speech and occupational therapy.





1 complete the identification and reimbursement of such current and former enrollees within 120 days of  
2 the date of the Director's order; 4) Under the Director's order, Respondent shall report its progress to  
3 the Department's Office of Enforcement every thirty (30) calendar days until all affected enrollees have  
4 been reimbursed; and 5) For such other and further relief, as the Director deems proper.

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7 Dated: November 18, 2013

  
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8 CAROL L. VENTURA  
9 Deputy Director | Chief Counsel  
10 Office of Enforcement  
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