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FILED
NOV 18 2013
DEPARTMENT OF MANAGED HEALTH CARE
BY Filing Clerk

Attorneys for Complainant

BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE

OF THE STATE OF CALIFORNIA

IN THE MATTER OF:	OAH No.:
CALIFORNIA PHYSICIANS' SERVICE, DBA BLUE SHIELD OF CALIFORNIA,	Enforcement Matter No.: 13-321
Respondent.	**ACCUSATION**

I.

INTRODUCTION

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

II.

PARTIES

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

2. At all times pertinent to the allegations herein, Respondent has been a full-service health care service plan as defined by Health and Safety Code section 1345, subdivision (f), and is subject to the regulatory provisions of the Act. Respondent is the holder of health care service plan license number 933-0043 which was issued on July 27, 1978, by the Commissioner of the Department of Corporations, predecessor to the Director of the DMHC. Respondent's principal corporate office is located at 50 Beale Street, 22d Floor, San Francisco CA 94105.

III.

JURISDICTION

3. This Accusation is brought before the Director of the Department (Director) under the authority conferred in the Act and title 28 of the California Code of Regulations, as specified below.

4. The Department is charged with the task of regulating managed care in the State of California and ensuring that the entities which sell managed care products in California, known as health care service plans, are in compliance with their obligations under the Act. (Health & Saf. Code, §§ 1341(a) and 1345(f).)

5. The Director is responsible for the performance of all duties and responsibilities vested by law in the Department, including the administration and enforcement of the Act and the rules and regulations adopted thereunder. (Health & Saf. Code, §§ 1341(c) and 1346(a)(5).)

6. Health and Safety Code section 1386(a) authorizes the Director to take disciplinary action against a health care service plan under the appropriate circumstances. The Director is authorized to assess administrative penalties against the plan if the Director determines, after appropriate notice and opportunity for a hearing, that the plan has committed any of the acts or omissions enumerated in Health and Safety Code section 1386(b) which constitute grounds for disciplinary action.

7. Health and Safety Code section 1386(b)(6) states that the grounds for disciplinary action include instances where "*The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.*"

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

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

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

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

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

13. Health and Safety Code section 1386(b)(1) states, in pertinent part, that the Department's licensees are subject to discipline for "*operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352 , or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan ..., unless amendments allowing the variation have been submitted to, and approved by, the director.*" Among the basic organizational documents that are filed pursuant to Health and Safety Code section 1351 are, "*A copy of the forms of evidence of coverage ....*" (Health & Saf. Code, § 1351(f).)

14. All hearings before the Director are to be held in accordance with the Administrative Procedure Act (Govt. Code, §§ 11500 through 11529.), and the Director has all of the powers granted

under that Act. (Health & Saf. Code, § 1397(a).) The factors for determining an appropriate penalty for violations of the Knox-Keene Act are set forth in California Code of Regulations, title 28, section 1300.86.

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 therapy services.

16. Since July 2011, Respondent has received at least 14 requests from enrollees seeking speech therapy services which have been denied. The Department has received complaints from each of these enrollees.

17. In all 14 of the complaints received by the Department, Blue Shield and/or its contracted provider groups have cited and/or quoted the Plan's medical policy on speech therapy as justification for their denial of coverage for speech therapy services.

18. The Blue Shield medical policy on speech therapy states in relevant part as follows:

"*Speech therapy is the treatment of communication impairment and swallowing disorder related to a specifically diagnosable disease, injury or congenital defect…*;" and "*Speech therapy is considered* ***medically necessary*** *when* ***all*** *of the following criteria are met:* [¶] *Speech therapy services are used in the treatment of communication impairment or swallowing disorders resulting from illness, injury, surgery or a congenital anomaly of* ***any*** *of the following: Nervous System* [¶] *Vocal Organs* [¶] *Swallowing Organs* [¶] *Auditory Organs….*" [Capitalization and bolding in original.]

19. The Plan's medical policy on speech therapy is not incorporated by reference into the Evidence of Coverage (EOC).

20. In each of the above-referenced 14 cases, Respondent and/or its contracted medical groups have unlawfully categorically denied coverage for speech therapy on the ground that the enrollee did not have a sufficient physical condition to trigger coverage, and did not consider whether the requested therapy was medically necessary to treat the enrollee's condition.

21. For children with developmental disabilities, expressive language disorders and speech delays, Respondent categorically denies coverage for speech therapy on the basis that the enrollee's impairment is not caused by a physical condition such as a defined illness, disease, injury, congenital anatomic anomaly, or surgery.

22. Under the Act, speech therapy is a required basic health care service; therefore Respondent's denial of coverage for speech therapy based on a lack of physical impairment is illegal and contrary to the Act.

23. The Department has determined that Respondent's denials of speech therapy should not have been denied based on coverage, but rather should have been reviewed to determine whether the services were medically necessary.

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

25. The IMR determined that the requested speech therapy were medically necessary in each of the 14 cases.

26. Respondent continues to illegally deny enrollee requests seeking services for speech therapy.

FIRST CAUSE FOR DISCIPLINE

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

28. Since June 2011, Respondent and/or its delegated medical groups denied coverage for medically necessary speech therapy services for at least 14 enrollees on the basis that the enrollee's deficits were not caused by a defined disease, illness, injury or surgery. In each of these cases, the Department's IMR determined that these services were medically necessary. Thus, Respondent

wrongfully denied coverage for medically necessary basic health services in violation of Health and Safety Code section 1367(i) and is subject to discipline under Health and Safety Code section 1386(b)(6).

SECOND CAUSE FOR DISCIPLINE

29. The Department may discipline its licensees for "*any conduct that constitutes fraud or dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Professions Code.*" (UCL) (Health & Saf. Code, § 1386(b)(7).)

30. "[U]nfair competition shall mean and include any unlawful, unfair or fraudulent business act or practice..." (Bus. & Prof. Code, § 17200.)

31. An unlawful business practice or act under the UCL means an act or practice, committed pursuant to business activity, which is at the same time forbidden by law. Conduct by a health care service plan in violation of the Knox-Keene Act is therefore considered unfair competition under the UCL.

32. As a health care service plan, Respondent's business activities include claims processing, utilization management review and the resolution of enrollee grievances. (Health & Saf. Code, §§ 1367.01(a), 1368(a)(1), 1371; Cal. Code Regs., tit. 28, § 1300.68(a).) Respondent delegates some of these functions to its delegated medical groups. (Health & Saf. Code, §§ 1367.01(a), 1371.)

33. Because medically necessary speech therapy is a basic health care service which Respondent is obligated to cover, Respondent and/or its delegates may not lawfully deny coverage for speech therapy on the basis that the enrollees lacked a physical cause for their impairment. (Health & Saf. Code, §§ 1345(b), 1367(i); Cal. Code Regs., tit. 28, § 1300.67(c).)

34. In 14 cases since June 2011, Respondent and its delegated medical groups, acting pursuant to the Respondent's business activities, denied coverage for speech therapy on the basis that the enrollees lacked a physical cause for their impairment.

35. Thus, Respondent and/or its delegates engaged in conduct that meets the definition of an unlawful business practice within the meaning of the UCL. Because the actions of Respondent and/or its delegates constitute unfair competition, as defined by the UCL, Respondent is subject to disciplinary action by the Department. (Health & Saf. Code, § 1386(b)(7).)

THIRD CAUSE FOR DISCIPLINE

36. Health care service plans are subject to discipline by the Director if they operate at variance with the basic organizational documents filed with the Department pursuant to Health and Safety Code section 1351, or the published plan. (Health & Saf. Code, § 1386(b)(1).) The EOC is one of the basic organizational documents filed with the Department pursuant to Health and Safety Code section 1351. (Health & Saf. Code, § 1351(f).)

37. Medically necessary speech therapy is a basic health care service which Respondent is mandated to cover. (Health & Saf. Code, §§ 1345(b), 1367(i); Cal. Code Regs., tit. 28, § 1300.67(c).) Statutory coverage mandates are incorporated into the terms of the EOC and provisions to the contrary are nullified and superseded. (*Samson v. Transamerica* (1981) 30 Cal.3d. 220, 231.) Thus, medically necessary speech therapy are covered benefits under the terms of the EOC.

38. Respondent's medical policy on speech therapy is not incorporated by reference into the EOC.

39. In 13 of the 14 cases referenced above, Respondent and/or its contracted provider groups have cited and/or quoted Respondent's medical policy on speech therapy as justification for their denial of coverage for speech therapy services

40. Since this medical policy is not incorporated by reference into the EOC, Respondent's use of this policy to deny enrollee coverage authorization requests are acts at variance with the terms of the EOC. Thus, Respondent is subject to disciplinary action by the Department. (Health & Saf. Code, § 1386(b)(1).)

PRAYER

WHEREFORE, Complainant prays as follows: 1) That the Director of the Department of Managed Health Care shall order Respondent to identify those of its current and former enrollees who were denied coverage for speech therapy on the basis that they did not meet the criteria in Respondent's medical policy on ST from January 1, 2010 to the present; 2) Under the Director's order, Respondent shall be ordered to reimburse and/or pay these enrollees for the reasonable expenses they incurred to secure those services; 3) Under the Director's order, Respondent shall complete the identification and reimbursement of such current and former enrollees within 120 days of the date of the Director's order;

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

Dated: November 18, 2013

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