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

9 Attorneys for Complainant

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

12 IN THE MATTER OF:

13 **HEALTH NET OF CALIFORNIA, INC.,**
14 Respondent.

OAH No.:

Enforcement Matter No.: 12-165

ACCUSATION

15
16
17 **I.**

18 **INTRODUCTION**

19 The California Department of Managed Health Care (DMHC or the Department) brings the
20 present action to assess administrative penalties against HEALTH NET OF CALIFORNIA, INC.
21 (Respondent) pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as
22 amended (the Act) (Health & Saf. Code, § 1340, et seq.) Respondent is a health care service plan
23 licensed under and regulated by the Knox-Keene Act.

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
6 Regs., tit. 28, § 1300.67(c).)

7 9. Health care service plans must “*Establish and maintain a grievance system ... that shall*
8 *ensure adequate consideration of enrollee grievances ...*” (Health & Saf. Code, § 1368(a)(1).)

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

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

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

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

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

1 *grammatical patterns, reduced vocabulary and inability to follow directions. One or a*
2 *combination of these characteristics may occur in children who are affected by language*
3 *learning disabilities or developmental language delay.” [Underlining in original.]*

4 21. In five of the complaints received by the Department, Respondent and/or its contracted
5 provider groups have cited and/or quoted the Plan’s Health Net National Medical Policy #218 Physical
6 and Occupational Therapy as justification for their denial of coverage for occupational therapy
7 services.

8 22. The Health Net National Medical Policy #218 Physical and Occupational Therapy
9 states in relevant part at pages 3-4 as follows:

10 *“Medical necessity of occupational therapy has not been demonstrated for: ... [¶] Sensory*
11 *and auditory integration therapies for the management of individuals with various*
12 *communications, behavioral, emotional, and learning disorders.”*

13 23. In one case, Respondent cited both its then-current (February 2010) National Medical
14 Policy #274 Autism Spectrum Disorders and Pervasive Developmental Disorders: Diagnosis and
15 Treatment and its National Medical Policy #218 Physical and Occupational Therapy to justify its
16 denial of coverage for medically necessary speech and occupational therapy services for an enrollee
17 with an autism spectrum disorder.

18 24. In the remaining cases, Respondent cited the language from the exclusion for
19 Rehabilitative Therapy in its Evidence of Coverage (EOC) as justification for its denial. Prior to 2012,
20 the Rehabilitative Therapy exclusion in Respondent’s EOCs excluded coverage for speech and/or
21 occupational therapy services unless the enrollee’s condition had a physical cause.

22 25. In each of the above 41 instances, Respondent has unlawfully categorically denied
23 coverage for speech therapy and/or occupational therapy on the grounds that the enrollee did not have
24 a sufficient physical ailment to trigger coverage, and without regard to whether the requested therapy
25 was medically necessary to treat the enrollee’s condition.

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

1 Respondent failed to adequately consider its enrollees' grievances. Further, Respondent's conduct
2 unnecessarily delayed the authorization for these services by an average of 88.07 days. Thus,
3 Respondent wrongfully failed to give adequate consideration to its enrollee's grievances in violation of
4 Health and Safety Code 1368(a)(1) and is subject to discipline under Health and Safety Code section
5 1386(b)(6).
6

7 THIRD CAUSE FOR DISCIPLINE

8 38. Health care service plans are subject to discipline by the Director if they operate at
9 variance with the basic organizational documents filed with the Department pursuant to Health and
10 Safety Code section 1351, or the published plan. (Health & Saf. Code, § 1386(b)(1).) The EOC is one
11 of the basic organizational documents filed with the Department pursuant to Health and Safety Code
12 section 1351. (Health & Saf. Code, § 1351(f).)
13

14 39. At all times relevant, Respondent's EOC states that it covers medically necessary
15 Rehabilitation Therapy (defined as speech therapy, occupational therapy and Physical Therapy)
16 subject to the terms of its Rehabilitation Therapy Exclusion.
17

18 40. Prior to March 4, 2011, the Rehabilitation Therapy Exclusion in the EOC excluded
19 coverage for rehabilitative therapies except for enrollees whose deficits were caused by a "*Defined*
20 *Disease, injury or surgical procedure....*" Effective March 4, 2011, this condition was removed from
21 the Rehabilitation Therapy Exclusion and Respondent's various EOCs were subsequently updated to
22 reflect this change.

23 41. On nine occasions after January 1, 2012, Respondent's delegated medical groups
24 denied coverage for speech and/or occupational therapy for enrollees with developmental disabilities
25 on the basis that the enrollee's deficits lacked a physical cause.

26 42. On six occasions after January 1, 2012, Respondent denied coverage for speech
27 and/occupational therapy for enrollees with developmental disabilities on the basis that the enrollees'
28 deficits lacked a physical cause.

43. In each case the Plan and/or its delegate acted at variance with the terms of its EOC.

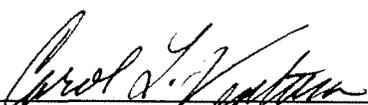
1 **PRAYER**

2 **WHEREFORE**, Complainant prays that a decision be rendered by the Director of the
3 Department of Managed Health Care assessing an administrative penalty against the Respondent, in
4 the amount of \$300,000.00 for the violations of the Knox-Keene Act and the accompanying rules and
5 regulations it has committed as alleged in this Accusation.

6 **WHEREFORE**, Complainant further prays as follows: 1) That the Director of the
7 Department of Managed Health Care shall order Respondent to identify those of its current and former
8 enrollees who were denied coverage for speech and/or occupational therapy on the basis that they did
9 not meet the criteria in Respondent's national medical policies from January 1, 2010 to the present; 2)
10 Under the Director's order, Respondent shall be ordered to reimburse and/or pay these enrollees for
11 the reasonable expenses they incurred to secure those services; 3) Under the Director's order,
12 Respondent shall complete the identification and reimbursement of such current and former enrollees
13 within 120 days of the date of the Director's order; 4) Under the Director's order, Respondent shall
14 report its progress to the Department's Office of Enforcement every thirty (30) calendar days until all
15 affected enrollees have been reimbursed; and 5) For such other and further relief, as the Director
16 deems proper.

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20 Dated:

November 18, 2013


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