

**STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF MANAGED HEALTH CARE**

Matter No.: 11-366

Licensee: BLUE CROSS OF CALIFORNIA
License No.: 933 0303



ORDER

**The Director of the
Department of Managed Health Care**

The Director of the Department of Managed Health Care (the "Director") after investigation, effective this date does hereby ORDER:

PART A.

CEASE AND DESIST

1. Blue Cross of California, Inc. ("Plan") 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 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.

2. The Plan 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 the Plan 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 the Plan was unaware of the falsity of the representation and was justified in relying upon the representation.

PART B.

FINDINGS

I.

1. The Director is vested with the responsibility to administer and enforce the Knox-Keene Health Care Service Plan Act of 1975, as amended (“Knox-Keene Act”), codified at Health and Safety Code section 1340, et seq.

2. Blue Cross of California, Inc. (“Plan”), is now, and has been since July 1, 1991, a full service health care service plan (File No. 933 0303) licensed pursuant to Health and Safety Code section 1353. Its principal place of business is located at 1 Wellpoint Way, Thousand Oaks, CA 91362. The Plan is subject to the Knox-Keene Act and Title 28 of the California Code of Regulations, promulgated pursuant to the Knox-Keene Act.

II.

3. The Director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the Knox-Keene Act. (Health & Saf. Code, § 1341.)

4. The Director may adopt, amend, and rescind any rules, forms, and orders that are necessary to carry out the provisions of the Knox-Keene Act. (Health & Saf. Code, § 1344.)

5. The Director may issue an order directing a health care service plan or any representative thereof or any other person to cease and desist from engaging in any act or practice in violation of the provisions of the Knox-Keene Act, any rule adopted pursuant to the Knox-Keene Act, or any order issued by the Director pursuant to the Knox-Keene Act. (Health & Saf. Code, § 1391.)

6. California Code of Regulations, title 28, section 1300.71, subdivision (d)(3), provides that, if a health care service plan 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

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patient, the date of service and including a clear explanation of the basis upon which the health care service plan believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

7. California Code of Regulations, title 28, section 1300.71, subdivision (b)(5), provides that a health care service plan shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code section 1371.1, unless the health care service plan sends a written request for reimbursement to the provider within 365 days of the date of payment on the overpaid claim. The 365 day time limit does not apply if the overpayment was caused in whole or in part by fraud or misrepresentation

III.

FACTS

8. The Plan is a health care service plan which contracts with a network of providers for the provision of medical services for the benefit of the Plan's members.

9. Pursuant to Health and Safety Code section 1371 and California Code of Regulations, title 28, section 1300.71, providers seek payment from the Plan for the provision of medical services provided to the Plan's members. The Plan is required to provide compensation to its providers for the provision of medical services.

10. Between 2008 and 2011, the Plan began seeking reimbursement from providers in 548 requests for which the plan asserted claims were overpaid and for which the date of payment was more than 365 days before the date of the request for reimbursement of the asserted overpayment. The Plan formalized the request by mailing 548 letters.

11. None of the Plan's 548 letters notifying providers of the asserted overpayments clearly identified the claim, the name of the patient, or the date of service for which reimbursement for overpayment was sought. Instead, the Plan's letters listed only a specific total dollar amount for which the Plan sought reimbursement and invited the provider to contact the Plan for additional information or negotiation.

12. Of these 548 requests, the Plan asserted as to 13 providers that the provider had billed for services that they had not rendered. For the remaining 535 requests (the “535 Cases”), the Plan asserted that the providers had improperly coded the claims by upcoding, unbundling, or miscoding based on the CPT-4 Codebook; the *Principles of CPT Coding*; the AMA periodical *CPT Assistant*; the *National Correct Coding Manual*; *CPT 2001 Changes, An Insider’s View*; *CPT Changes 2008, An Insider’s View*; *CPT Changes 2009, An Insider’s View*; and other scholarly literature and professional articles regarding CPT coding practices.

13. In these 535 Cases, the Plan initiated a request for reimbursement of the asserted overpayment by sending a letter to the provider which explained the Plan’s method of review, the coding pattern being investigated, and a description of the relevant AMA CPT Codebook, publication, literature, publication, or article which supported the Plan’s position. The plan did not assert or demonstrate that the overpayment by the Plan 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 the Plan was unaware of the falsity of, and was justified in relying upon, the representation.

IV.

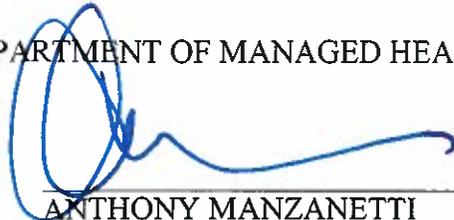
VIOLATIONS

14. The Department finds that, in each and every one of the letters requesting reimbursement for overpayment in the 548 requests, the Plan sought reimbursement without providing the notice required by California Code of Regulations, title 28, section 1300.71, subdivision (d)(3). In seeking reimbursement from the providers, the Plan failed to notify the provider in writing through a separate notice clearly identifying the claim, the name of the patient, the date of 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, all of which are required by California Code of Regulations, title 28, section 1300.71, subdivision (d)(3).

15. The Department finds that in the 535 Cases the Plan has failed to assert or demonstrate a factual basis sufficient to show fraud or misrepresentation on the part of the provider in that the Plan failed to assert or demonstrate 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 the Plan was unaware of the falsity of, was justified in relying upon, the representation. As such, the Department finds that the Plan has not established a misrepresentation within the meaning of California Code of Regulations, title 28, section 1300.71, subdivision (b)(5), on the part of the providers sufficient to enable the Plan to seek reimbursement for alleged overpayments beyond 365 days of the date of payment.

This Order shall be effective immediately and shall continue in full force and effect until further Order of the Director.

DEPARTMENT OF MANAGED HEALTH CARE



ANTHONY MANZANETTI
Deputy Director | Chief Counsel
Office of Enforcement

Dated: July 16, 2012

