BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

IN THE MATTER OF THE FIRST AMENDED ACCUSATION AGAINST:	Enforcement Matter Nos.: 14-321, 14-437, 14-466, 15-173
Blue Cross of California,	OAH No. 2016070020
Respondent.	

DECISION

On March 29, 2017, the Department of Managed Health Care (DMHC) issued a Notice of Nonadoption of the Proposed Decision notifying the parties that the DMHC considered, but did not adopt the attached Proposed Decision of the Administrative Law Judge Coren D. Wong dated February 14, 2017, for the above-titled matter. The DMHC authorized the parties to file written argument, and notified the parties that the DMHC would thereafter decide the case itself under the provisions of Government Code section 11517, subdivision (c)(2)(E). On April 28, 2017, the DMHC received the parties' written arguments.

After due consideration of the record, including the transcript, and the parties' written argument, the DMHC concludes that Administrative Law Judge Wong's proposed penalty is insufficient but that the balance of the Proposed Decision is appropriate and correct. You are advised that, in accordance with Government Code section 11517, subdivision (c)(2)(E), the DMHC hereby adopts as its Decision the Proposed Decision except those provisions that assign a penalty amount, which are not adopted and are substituted as set forth below. *Alford v. Department of Motor Vehicles* (2000) 79 Cal.App.4th 560, 567 [94 Cal.Rptr.2d 222] ("[T]he agency may reject the administrative law judge's proposed decision... and then decide the case by concluding that the administrative law judge's proposed penalty was insufficient but that the balance of the administrative law judge's proposed decision is appropriate and correct.")

The findings of fact and determination of issues set forth in the Proposed Decision are adopted and incorporated herein by reference as though set forth in full with the following substitutions.

1. Revise "$20,000" to "$50,000" in the Summary section of Page 2.

2. Revise paragraph 26 on page 9 to read as follows: "In assessing the administrative penalty against Blue Cross of California, the Department determined that $50,000 was the appropriate penalty amount after consideration of the factors set forth in California Code of Regulations, title 28, section 1300.86, subdivision (b). Three factors weighed heavily in the Department's assignment of the penalty amounts. First, the nature and extent to which the plan has taken corrective action to ensure the violation will not recur. Second, whether the violation is an isolated incident. And third, the amount of the penalty necessary to deter similar violations in the future. As set out in the Discussion, the gravamen of the dispute is the interpretation of California Code of Regulations, title 28, section 1300.74.30, subdivision (k)(2). Thus, Blue Cross of California's violations are the direct consequence of the plan's misinterpretation of the law. Notwithstanding the overwhelming support for the Department's position, Blue Cross of California remains steadfast that it has done nothing wrong, and therefore has not taken any corrective action. The plan's position and inaction force the Department to conclude that violations will recur and that a penalty amount large enough to be a catalyst for corrective action is necessary. Finally, based on the consideration of the nature, scope, and gravity of the violation in the expedited IMR matter, the Department finds that a higher penalty amount relative to the other matters is warranted."
3. Revise paragraph 27 on page 9 to read as follows: "When all the evidence is considered, an administrative penalty of $10,000 for each of Blue Cross of California's violations of the Act in Enforcement Matter Nos. 14-437, 14-466 and 15-173 (the standard IMR cases), and an administrative penalty of $20,000 for Blue Cross of California's violations in Enforcement Matter No. 14-321 (the expedited IMR case), for a total penalty of $50,000, is appropriate."
4. Remove the "ORDER" section on page 14, for substitution with the attached Order.

You are advised that, in accordance with Government Code section 11519, the Decision and Order becomes effective 30 days after it is delivered or mailed, on June 15, 2017. You are further advised that, in accordance with Government Code section 11521, the time limit for petitioning for reconsideration is prior to the effective date of the Decision and Order, or before the termination of a stay when so granted for the purpose of filing an application for reconsideration.

Date: May 16, 2017

Michelle Rouillard

Michelle Rouillard
For Department of Managed Health Care

BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: BLUE CROSS OF CALIFORNIA, Respondent.	Case Nos. 14-321, 14-437, 14-466, 15-173 OAH No. 2016070020

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on December 9 and 12, 2016, in Sacramento, California.

Kyle C. Monson, Assistant Chief Counsel, and Heidi L. Lehrman, Attorney III, represented complainant Drew Brereton, Interim Deputy Director and Chief Counsel of the Office of Enforcement, Department of Managed Health Care (Department), State of California.

Attorneys Michael J. Daponde and Eunice C. Majam-Simpson of the law firm Daponde Szabo Rowe PC represented respondent Blue Cross of California. Terry German, Managing Associate General Counsel, also appeared on behalf of Blue Cross of California.

Evidence was received, and the record was left open for the parties to submit simultaneous closing and reply briefs. The parties' respective closing briefs are marked as Exhibits 40 (complainant's) and 41 (Blue Cross of California's), and their respective reply briefs are marked as Exhibits 42 (complainant's) and 43 (Blue Cross of California's). The record was closed and the matter submitted for decision on February 3, 2017.

SUMMARY

Complainant seeks to assess an administrative penalty against Blue Cross of California for its violations of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Health & Saf. Code, § 1340 et seq., the Act). A preponderance of the evidence established Blue Cross of California violated the Act by failing to timely produce additional medical records requested for four patients during the Department's Independent Medical Review process. Therefore, legal cause exists to impose an administrative penalty against

Blue Cross of California. The evidence established that an administrative penalty in the total sum of $20,000 is reasonable and appropriate.

FACTUAL FINDINGS

Background

1. Health care service plans doing business in the State of California are licensed and regulated by the Department pursuant to the Act.[1] On January 7, 1993, Blue Cross of California was issued health care service plan license number 933 0303 by the Department of Corporations, the predecessor to the Department.

2. The Act provides for the Independent Medical Review (IMR) process, whereby an enrollee whose health care plan has denied, modified, or delayed health care services on the basis that the service is not medically necessary may obtain an independent determination of the medical necessity of that service by an IMR organization with whom the Department contracts. There are strict deadlines for the plan and its contracting providers to provide the necessary medical records and information to the review organization during the IMR process.

3. The Department conducted an investigation regarding allegations that Blue Cross of California did not comply with the applicable deadlines for providing medical records and other necessary information to the review organization during the IMR process for multiple enrollees. The Department concluded Blue Cross of California failed to comply with the applicable deadlines with regard to four patients. On October 28, 2016, complainant signed the First Amended Accusation seeking to impose an administrative penalty against Blue Cross of California in the amount of $50,000 for those failures.

Alleged Failures to Comply with IMR Deadlines

Patient JS

4. Patient JS requested Blue Cross of California's prior authorization for admission into the Eating Disorder Partial Hospitalization Program at Castlewood West Treatment Center, a health care service recommended by her treatment provider. Blue Cross of California performed a utilization review of the requested health care service, determined it was not medically necessary, and denied the request. Patient JS filed an internal grievance with Blue Cross of California challenging the denial, which was denied.

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[1] Former Health and Safety Code section 1341 vested the responsibility for overseeing health care service plans in the Commissioner of Corporations. That statute was repealed in 1999 and replaced by a new Health and Safety Code section 1341, which now vests such authority in the Director of the Department. (Stats. 1975, ch. 941, § 2, p. 2071 [repealed]; Stats. 1999, ch. 525, § 22 [reenacted].)

5. Patient JS timely filed an IMR Application/Complaint Form (application) with the Department seeking an independent determination of the medical necessity for admission into the Eating Disorder Partial Hospitalization Program at Castlewood West Treatment Center. The Department reviewed the application, and determined Patient JS qualified for an expedited IMR. On June 19, 2014, the Department gave Blue Cross of California notice that Patient JS qualified for an expedited IMR, and requested that all relevant medical records be sent to MAXIMUS Federal Services, Inc. (MAXIMUS), the IMR organization with whom the Department contracted to perform IMRs, within 24 hours of the date of the notice.

6. Blue Cross of California did not provide the requested records, and on June 20, 2014, MAXIMUS sent Blue Cross of California a facsimile cover sheet asking it to **"Please submit all medical records pertaining to this patient's IMR. No medical records have been submitted for review."** (Bold original.) Blue Cross of California responded the same day by facsimile, "We have requested records from the facility, but have not received them yet. We will forward to you once we receive them, thank you." Blue Cross of California produced the requested medical records to MAXIMUS on June 24, 2014, the day after they were received from the provider.

Patient AT

7. Patient AT's treatment provider recommended she undergo a clinical chemistry test to determine the amount of a particular drug in her blood and to test for the presence of antibodies to that drug in her blood. The test was performed on December 23, 2013, and a claim for payment was submitted to Blue Cross of California. Blue Cross of California performed a utilization review of the service performed, determined it was not medically necessary, and denied the claim. Patient AT filed an internal grievance with Blue Cross of California challenging the denial, which was denied.

8. Patient AT timely filed an application with the Department seeking an independent determination of the medical necessity of the chemistry test performed. The Department reviewed the application, and determined Patient AT qualified for a standard IMR. On July 11, 2014, the Department gave Blue Cross of California notice that Patient AT qualified for a standard IMR, and requested that all relevant medical records be sent to MAXIMUS within three business days of the date of the notice.

9. On July 16, 2014, MAXIMUS sent Blue Cross of California a facsimile cover sheet asking it to "Please submit all medical records from the ordering physician from December 2012 through December 2013." Blue Cross of California received the requested medical records on July 25, 2014, and produced them to MAXIMUS the same day.

Patient JAy

10. Patient JAy requested Blue Cross of California's prior authorization for an endoscopic injection/implant, a health care service recommended by her treatment provider. Blue Cross of California performed a utilization review of the requested health care service,

determined it was not medically necessary, and denied the request. Patient JAy filed an internal grievance with Blue Cross of California challenging the denial, which was denied.

11. Patient JAy timely filed an application with the Department seeking an independent determination of the medical necessity of an endoscopic injection/implant. The Department reviewed the application, and determined Patient JAy qualified for a standard IMR. On August 15, 2014, the Department gave Blue Cross of California notice that Patient JAy qualified for a standard IMR, and requested that all relevant medical records be sent to MAXIMUS within three business days of the date of the notice.

12. Maximus sent Blue Cross of California a facsimile cover sheet asking it to "Please submit the following: The enrollee's medical records from requesting provider Stephen Hightower, MD from August 2013 to present. *We received one page of medical records dated 6/12/14, difficult to read.*" (Italics in original.) There was a discrepancy in the evidence over the date on which Blue Cross of California received the request. The cover sheet is dated August 25, 2014, and that was the date Blue Cross of California argued it received the request. On the other hand, the proof of transmission sheet indicates the facsimile was sent on August 22, 2014. And while the transmission sheet also indicates the facsimile was not received because there was "no answer," the Department contends the cover sheet was sent successfully later that day. Blue Cross of California produced the requested records on September 3, 2014.

Patient PB

13. Patient PB requested Blue Cross of California's prior authorization for additional physical therapy visits, a health care service recommended by his treatment provider. Blue Cross of California performed a utilization review of the requested health care service, determined it was not medically necessary, and denied the request. Patient PB filed an internal grievance with Blue Cross of California challenging the denial, which was denied.

14. Patient PB timely filed an application with the Department seeking an independent determination of the medical necessity of additional physical therapy visits. The Department reviewed the application, and determined Patient PB qualified for a standard IMR. On October 27, 2014, the Department gave Blue Cross of California notice that Patient PB qualified for a standard IMR, and requested that all relevant medical records be sent to MAXIMUS within three business days of the date of the notice.

15. Maximus sent Blue Cross of California a facsimile cover sheet asking it to "Please submit the following: The enrollee's medical/treatment records from January 2014 to present. *(We received a progress note dated 4/21/14).*" (Italics original.) There was a discrepancy in the evidence over the date on which Blue Cross of California received the request. On the one hand, the cover sheet is dated November 11, 2014, and Blue Cross of California argued it was received on that date. On the other hand, the proof of transmission sheet indicates the facsimile was successfully sent on November 5, 2014. Additionally, the

employee who sent the facsimile testified at hearing that she dated the cover sheet incorrectly, explaining that November 11, 2014, was Veterans Day and she did not work that day. Blue Cross of California provided the requested records on November 18, 2014.

Discussion

16. There was no dispute over the facts material to the determination of this matter, except as to the dates on which Blue Cross of California received MAXIMUS's request for additional records for Patient JAy (August 22 versus August 25) and Patient PB (November 5 versus November 11). With regard to Patient JAy, the conflict in the evidence need not be resolved because Blue Cross of California produced the additional records late, regardless of the date on which it received MAXIMUS's request. And with regard to Patient PB, the persuasive evidence established that Blue Cross of California received MAXIMUS's request on November 5, 2014.

17. The gravamen of the parties' dispute is when Blue Cross of California's obligation to produce the additional records requested by MAXIMUS commenced for each patient. The Department, on the one hand, argued it commenced upon Blue Cross of California's receipt of the particular request. Blue Cross of California, however, argued the obligation did not commence until it received the requested records from the treatment provider. But it admitted in its prehearing brief it "was one (1) day late in producing the requested documents to Maximus" (footnote omitted) for JAy, based on its production of the records "within six (6) business days from the time it received the request from Maximus." (Underline original.) Implied in the argument is the concession that the obligation commenced upon Blue Cross of California's receipt of the request, rather than its receipt of the records.

18. For the reasons explained in the Legal Conclusions, Blue Cross of California's obligation to produce the additional records requested by MAXIMUS arose on the date it received each request. The records were supposed to be produced within five business days (24 hours for Patient JS) of that date. Therefore, the evidence established the following:

a. Blue Cross of California received MAXIMUS's request for additional records for Patient JS on June 20, 2014. It was required to produce the records no later than June 21, 2014. But the records were not produced until June 25, 2014, four days late.

b. Blue Cross of California received MAXIMUS's request for additional records for Patient AT on July 16, 2014, and was required to produce the records no later than July 23, 2014. The records were produced on June 25, 2014, two days late.

c. Blue Cross of California was required to produce the additional records requested for Patient JAy on August 29 or September 2, 2014,[2] depending on whether MAXIMUS's request was received on August 22 or 25, 2014. But it is unnecessary to

[2] September 1, 2014, was Labor Day.

determine when the request was received because the records were not produced until September 3, 2014.

d. Blue Cross of California received MAXIMUS's request for additional records for Patient PB on November 5, 2014, and the records were due November 13, 2014. The records were not produced until November 18, 2014, five days late.

Summary

19. Blue Cross of California violated the Act by producing additional records requested by MAXIMUS more than five business days after receiving the requests for Patients AT, JAy, and PB, and more than 24 hours after receipt of the request for Patient JS. Therefore, the evidence established that cause exists to impose an administrative penalty against Blue Cross of California for the reasons explained in the Legal Conclusions below.

20. Blue Cross of California's defense of unclean hands was not persuasive, because it failed to establish that the Department's alleged failure to provide timely notice that each patient's application was approved somehow impaired Blue Cross of California's ability to produce in a timely manner the additional documents subsequently requested. As explained in Legal Conclusion 7, Blue Cross of California's obligation to produce those documents for each patient did not commence until *after* it received MAXIMUS's request for them, which occurred after the Department provided notice it had approved the particular application. (See, *Fibreboard Paper Products Corp. v. East Bay Union of Machinists, Local 1304, United Steelworkers of America, AFL-CIO* (1964) 227 Cal.App.2d 675, 728-729 ["The misconduct which brings the clean hands doctrine into operation must relate directly to the transaction concerning which the complaint is made, i.e., it must pertain to the very subject matter involved and affect the equitable relations between the parties. Accordingly, relief is not denied because the plaintiff may have acted improperly in the past or because such prior misconduct may indirectly affect the problem before the court"].)

Besides, Blue Cross of California conceded in its opening brief there was no evidence of when the Department deemed any of the four applications complete, the event which triggered the Department's obligation to give the plan notice within seven days as explained in Legal Conclusion 3.

21. Also unpersuasive was Blue Cross of California's claim that it substantially complied with the timeframes for producing additional documents for each patient. (*Malek v. Blue Cross of California* (2004) 121 Cal.App.4th 44, 72 ["[T]he doctrine [of substantial compliance] excuses literal noncompliance with a statute only when there has been 'actual compliance in respect to the substance essential to every reasonable objective of the statute.' [Citation]"].) The purpose of the Act is to ensure enrollees have their grievances against their health care service plans resolved expeditiously as explained in Factual Finding 23. The deadline for providing additional records provided in California Code of Regulations, title 22, section 1300.74.30, subdivision (k)(2), furthers that purpose by requiring plans to

produce additional records requested by the review organization within five business days (24 hours for expedited cases) of receiving the request.

Blue Cross of California failed to demonstrate how its production of Patient JS's, AT's, JAy's, and PB's records four, two, at least one, and five days late, respectively, helped ensure those enrollees had their grievances resolved expeditiously. (See, *Coast Pump Associates v. Stephen Tyler Corporation* (1976) 62 Cal.App.3d 421, 427 [party alleging substantial compliance bears burden of proof]; see also, *Freeman v. Vista de Santa Barbara Associates LLP* (2012) 207 Cal.App.4th 791,796-797 [owner of mobile home park did not substantially comply with notice requirements of Civ. Code, § 798.25, subd. (b), by giving mobile home owner notice pursuant to Civ. Code, § 798.25, subd. (a), because the notice requirements of each subdivision serves different purposes]; cf, [*Cal-Air Conditioning, Inc. v. Auburn Unified School District* (1993) 21 Cal.App.4th 655, 668-670 [excusing prime contractor's literal noncompliance with Pub. Contract Code, § 4107.5's requirement that it provide written notice of inadvertent clerical error to awarding authority and subcontractor allegedly listed in error within two days of opening prime bids, because prime contractor actually complied with statute's purpose of providing notice of error when it gave awarding authority written notice and subcontractor oral notice within one day].)

Amount of the Administrative Penalty

22. The Department has adopted criteria for consideration in determining the appropriate amount of the administrative penalty to impose against a health care service plan that violates the Act. (Cal. Code Regs., tit. 28, § 1300.86, subd. (a).) Criteria relevant to Blue Cross of California's violations include the following:

> (1) The nature, scope, and gravity of the violation;
>
> [¶] . . . [¶]
>
> (3) The plan's history of violations;
>
> [¶] . . . [¶]
>
> (7) The nature and extent to which the plan has taken corrective action to ensure the violation will not recur;
>
> (8) The financial status of the plan;
>
> [¶] . . . [¶]
>
> (10) Whether the violation is an isolated incident; and/or
>
> (11) The amount of the penalty necessary to deter similar violations in the future.

(Cal. Code Regs., tit. 28, § 1300.86, subd. (b).)

23. As previously discussed, the IMR process allows an enrollee to obtain an independent determination of whether a health care service recommended by her treatment provider is medically necessary after her health care service plan has denied, modified, or delayed the service on the basis it is not. In enacting the Act, the Legislature expressly declared its "intent and purpose . . . to promote the delivery and the quality of health and medical care to the people of the State of California who enroll in, or subscribe for the services rendered by, a health care service plan or specialized health care service plan by accomplishing all of the following: . . . (h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department." (Health & Saf. Code, § 1342.) This legislative intent is expressed through the short deadlines within which health service plans are required to produce medical records and other relevant documents during the IMR process imposed by the Act and the Department's regulations. And neither the Act nor any regulation provides for different deadlines based on the nature of the service which was denied, modified, or delayed.

24. Blue Cross of California's delay in producing the additional records requested by MAXIMUS for the four patients discussed above was contrary to Legislature's intent when enacting the Act, regardless of the length of the delay. The delay in producing Patient JS's additional records was particularly egregious because she qualified for an expedited IMR, and no records were initially produced in response to the Department's notice. As explained further in Legal Conclusion 4, MAXIMUS's request for "all medical records from the ordering physician from December 2012 through December 2013" for Patient AT encompassed records which should have been produced in response to the Department's notice, but it took nine days to produce them.[3] MAXIMUS's request for additional records for Patient JAy was for the records originally produced in response to the Department's notice to be resent because one page was "difficult to read." Yet it took Blue Cross of California 14 days to resend those records.

25. While there was no evidence of prior violations of the Act by Blue Cross of California, there also was no evidence of any subsequent corrective action it has taken to eliminate or minimize the chances of future delays. In fact, it remained steadfast throughout

[3] Complainant did not allege Blue Cross of California's failure to produce initial records for Patient JS or AT as a basis for imposing an administrative penalty, and neither failure may serve such purpose now. (See, e.g., *Wheeler v. State Board of Forestry* (1983) 144 Cal.App.3d 522, 527-528 [an order imposing discipline must be based on the allegations in the accusation].)

the hearing and post-hearing briefing that it did nothing wrong.[4] Blue Cross of California is a corporation with $6.8 billion in assets.[5]

26. The Department did not cite to any standards for determining the appropriate amount of the administrative penalty to impose for Blue Cross of California's violations of the Act, and did not articulate how it calculated the $50,000 penalty proposed in the First Amended Accusation. Health and Safety Code section 1374.34, subdivision (b), provides for a mandatory administrative penalty "of not less than five thousand dollars ($5,000) for each day" a plan delays implementing the Department's decision resolving an application through the IMR process. The statute also provides that "a plan shall not engage in any conduct that has the effect of prolonging the independent review process." (Health & Saf. Code, § 1374.34, subd. (b).) Therefore, while not directly applicable, the language imposing a minimum $5,000 administrative penalty for each day a plan delays implementing a decision provides some guidance for determining the appropriate administrative penalty for Blue Cross of California's violations of the Act.

27. When all the evidence is considered, an administrative penalty of $5,000 for each of Blue Cross of California's violations of the Act, for a total penalty of $20,000, is reasonable and appropriate.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Complainant has the burden of proving the grounds for imposing an administrative penalty alleged in the First Amended Accusation, and he must do so by a preponderance of the evidence. (See, *Owen v. Sands* (2009) 176 Cal.App.4th 985, 989-994.) Evidence that is deemed to preponderate must amount to "substantial evidence." (*Weiser v. Board of Retirement* (1984) 152 Cal.App.3d 775, 783.) And to be "substantial," evidence must be reasonable in nature, credible, and of solid value. (*In re Teed's Estate* (1952) 112 Cal.App.2d 638, 644.)

Applicable Law

2. Every health care service plan licensed in California must "establish and maintain a grievance system approved by the department under which enrollees may submit their grievances to the plan." (Health & Saf. Code, § 1368, subd. (a)(1).) If the enrollee is

[4] A position contrary to that taken in its prehearing brief, as discussed in Factual Finding 17.

[5] According to its Quarterly Financial Reporting Form for the quarter ending September 30, 2016.

not satisfied with the outcome of her grievance, or the grievance remains unresolved for 30 days, and the grievance concerns the plan's denial, modification, or delay of a "disputed health care service"[6] on the basis that the service is not medically necessary, she may apply to the Department for an IMR. (Health & Saf. Code, §§ 1368, subd. (b)(1)(A), 1374.30, subd. (e).) The following are the three criteria for qualifying for an IMR:

> (1)(A) The enrollee's provider has recommended a health care service as medically necessary, or
>
> (B) The enrollee has received urgent care or emergency services that a provider determined was medically necessary, or
>
> (C) The enrollee, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the enrollee seeks independent review. The plan shall expedite access to an in-plan provider upon request of an enrollee. The in-plan provider need not recommend the disputed health care service as a condition for the enrollee to be eligible for an independent review.
>
> For purposes of this article, the enrollee's provider may be an out-of-plan provider. However, the plan shall have no liability for payment of services provided by an out-of-plan provider, except as provided pursuant to subdivision (c) of Section 1374.34.
>
> (2) The disputed health care service has been denied, modified, or delayed by the plan, or by one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary.
>
> (3) The enrollee has filed a grievance with the plan or its contracting provider pursuant to Section 1368, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The enrollee shall not be required to participate in the plan's grievance process for more than 30 days. In the case of a

[6] A "'disputed health care service' means any healthcare service eligible for coverage and payment under a health care service plan contract that has been denied, modified, or delayed by a decision of the plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary." (Health & Saf. Code, § 1374.30, subd. (b).)

> grievance that requires expedited review pursuant to Section 1368.01, the enrollee shall not be required to participate in the plan's grievance process for more than three days.

(Health & Saf. Code, § 1374.30, subd. (j); see, Cal. Code Regs., tit. 28, § 1300.74.30, subd. (b).)

3. If the enrollee's application meets the eligibility criteria specified in Health and Safety Code section 1374.30, subdivision (j),

> [T]he director shall notify the enrollee and the enrollee's health care plan . . . within seven (7) calendar days of receipt of a completed application for a routine request and within 48 hours of receipt of a completed application for an expedited review. The notification shall identify the independent medical review organization, whether the review shall be conducted on an expedited or routine basis and other information deemed necessary by the Department.

(Cal. Code Regs., tit. 28, § 1300.74.30, subd. (i).)

4. The plan or its contracting providers must produce the "initial documents" to the review organization within 24 hours of receipt of the Department's notice "if there is an imminent and serious threat to the health of the enrollee." (Health & Saf. Code, § 1374.31, subd. (a).) Otherwise, the documents must be provided within three business days. (Health & Saf. Code, § 1374.30, subd. (n).)

The "initial documents" include:

> (1)(A) A copy of all of the enrollee's medical records in the possession of the plan or its contracting providers relevant to each of the following:
>
> (i) The enrollee's medical condition.
>
> (ii) The health care services being provided by the plan and its contracting providers for the condition.
>
> (iii) The disputed health care services requested by the enrollee for the condition.
>
> [¶] . . . [¶]
>
> (2) A copy of all information provided to the enrollee by the plan and any of its contracting providers concerning plan and

> provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the plan and to the plan's contracting providers in support of the enrollee's request for disputed health care services. This documentation shall include the written response to the enrollee's grievance, required by paragraph (4) of subdivision (a) of Section 1368. The confidentiality of any enrollee medical information shall be maintained pursuant to applicable state and federal laws.
>
> (3) A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity. The plan shall concurrently provide a copy of documents required by this paragraph, except for any information found by the director to be legally privileged information, to the enrollee and the enrollee's provider. The department and the independent medical review organization shall maintain the confidentiality of any information found by the director to be the proprietary information of the plan.

(*Ibid.*; Cal. Code Regs., tit. 28, § 1300.74.30, subd. (j).)

5. The plan has a continuing duty to produce "additional records" in its possession or the possession of its contracting providers after producing the initial documents. Health and Safety Code section 1374.30, subdivision (n)(1)(B), provides:

> Any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The plan shall concurrently provide a copy of medical records required by this subparagraph to the enrollee or the enrollee's provider, if authorized by the enrollee, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

6. California Code of Regulations, title 28, section 1300.74.30, subdivision (k), divides the "additional records" the plan must produce into one of two categories: 1) those records that should have been disclosed as part of the plan's initial disclosure, but were not

because they either were not in the plan's or its contracting providers' possession or did not exist; and 2) those records that were not subject to initial disclosure, but the review organization subsequently determined were necessary for it to consider in making a decision. There are two different timeframes for producing additional records, depending on which category of records is being produced: 1) within five business days (24 hours in expedited cases) of the plan's receipt of the former records; and 2) within five business days (24 hours in expedited cases) of the plan's receipt of the request for the latter records. (Cal. Code of Regs., tit. 28, § 1300.74.30, subd. (k)(1), (2).)

7. The above interpretation of California Code of Regulations, title 28, section 1300.74.30, subdivision (k), is consistent with the language of Health and Safety Code section 1374.30, subdivision (n)(1)(B), and well-settled rules for interpreting statutes and regulations. (See, *Metropolitan Water District of Southern California v. Superior Court* (2004) 32 Cal.4th 491, 502 [express statutory distinctions are presumed to have been deliberately made, unless the entire statutory scheme suggests otherwise]; *Diablo Valley College Faculty Senate v. Contra Costa Community College District* (2007) 148 Cal.App.4th 1023, 1037 ["Rules governing the interpretation of statutes also apply to interpretation of regulations"]; *Pacific Gas and Electric Co. v. Superior Court* (2006) 144 Cal.App.4th 19, 24 ["we also interpret the words of a regulation in context, harmonizing to the extent possible all provisions relating to the same subject matter"].)

In light of the above, Blue Cross of California was required to produce the additional records requested by MAXIMUS for Patients AT, JAy, and PB no later than five business after its receipt of the request, and the records requested for Patient JS no later than 24 hours after its receipt of the request.

Cause for Imposing an Administrative Penalty

8. The Department may impose an administrative penalty against a health care service plan on any basis for which it may discipline the plan's license. (Health & Saf. Code, § 1386, subd. (a).) Discipline may be imposed if "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." (Health & Saf. Code, § 1386, subd. (b)(6).) Blue Cross of California violated California Code of Regulations, title 28, section 1300.74.30, subdivision (k)(2), on four separate occasions as discussed above. Therefore, cause exists to impose an administrative penalty pursuant to Health and Safety Code section 1386, subdivision (a), as that statute relates to Health and Safety Code section 1386, subdivision (b)(6), and California Code of Regulations, title 28, section 1300.74.30, subdivision (k)(2).

9. "A plan shall not engage in any conduct that has the effect of prolonging the independent review process." (Health & Saf. Code, § 1374.34, subd. (b).) Blue Cross of California's failure to produce the records requested by MAXIMUS for Patients JS, AT, Jay, and PB by the applicable deadlines as discussed above prolonged the IMR process for each

patient. Therefore, cause exists to impose an administrative penalty pursuant to Health and Safety Code section 1386, subdivision (a), as that statute relates to Health and Safety Code sections 1374.34, subdivision (b), and 1386, subdivision (b)(6).

Conclusion

10. When all the evidence is considered, cause exists to impose an administrative penalty against Blue Cross of California for the reasons explained in Legal Conclusions 8 and 9, individually and collectively. An administrative penalty in the total amount of $20,000 is reasonable and appropriate for the reasons explained in Factual Findings 22 through 27.

ORDER

Blue Cross of California's appeal is DENIED, and an administrative penalty in the total sum of $20,000 is imposed.

DATED: February 14, 2017

DocuSigned by:
Coren D. Wong
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COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

IN THE MATTER OF THE FIRST AMENDED ACCUSATION AGAINST:	Enforcement Matter Nos.: 14-321, 14-437, 14-466, 15-173
Blue Cross of California,	OAH No. 2016070020
Respondent.	

ORDER

Respondent Blue Cross of California dba Anthem Blue Cross, due to its violation of California Code of Regulations, title 28, section 1300.74.30, subdivision (k)(2), Health and Safety Code section 1374.34, subdivision (b), and Health and Safety Code section 1386, subdivision (b)(6), shall pay to the Department of Managed Health Care an administrative penalty in the total amount of $50,000. Payment in full shall be made within 30 days of the effective date of the Decision and Order, as directed by the Department of Managed Health Care.

Date: May 16, 2017

Michelle Rouillard
For Department of Managed Health Care

PROOF OF SERVICE

In the Matter of the First Amended Accusation Against Blue Cross of California
OAH No. 2016070020

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. My business address is:

980 9th Street, Suite 500
Sacramento, CA 95814

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 this practice, correspondence placed in the internal mail collection for sending via registered mail at the Department of Managed Health Care is deposited with the United State Postal Service that same day in the ordinary course of business.

On May 16, 2017, I served the attached **Decision and Order,** on the interested parties in this action 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, addressed as follows:

Michael J Daponde
Eunice C. Majam-Simpson
Daponde Szabo Rowe PC
500 Capitol Mall, Suite 2260
Sacramento, CA 95814

Terry German
Blue Cross of California
DBA: Anthem Blue Cross
1121 L Street, Suite 500
Sacramento, CA 95814

Heidi L. Lehrman
Kyle C. Monson
Drew Brereton
Office of Enforcement
Department of Managed Health Care
980 9th 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 that this declaration was executed on May 16, 2017, at Sacramento, California.

Phuc Nguyen
Printed Name


Signature