FINAL REPORT

NON-ROUTINE MEDICAL SURVEY

OF

KAISER FOUNDATION HEALTH PLAN

A FULL-SERVICE HEALTH PLAN

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Final Report of a Non-Routine Medical Survey  
Kaiser Foundation Health Plan  
A Full Service Health Plan  
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EXECUTIVE SUMMARY

Pursuant to Section 1341(a) of the Knox-Keene Act ("Knox-Keene" or the "Act"), the Department of Managed Health Care (the "Department") is charged with enforcing the provisions of the Act and the Rules issued under the authority of the Act.\(^1\) The Act requires health care service plans to provide enrollees with access to quality health care services and to protect and promote the interests of enrollees. The Department’s Division of Plan Surveys conducts Medical Surveys to ensure health plans meet their Knox-Keene obligations.

In 2010, the Department noted an emerging trend in which the Plan routinely denied enrollees reimbursement for non-scheduled ambulance transport services, 911 calls. The Department concluded that the Plan failed to apply the reasonable person standard in adjudicating ambulance claims. In each of 11 cases, the Department issued a demand letter, directing the Plan to reimburse the enrollee for the cost of the ambulance services. After the Plan failed to reimburse the disputed ambulance transport claims, the Department notified the Plan on August 16, 2010 of the intent to conduct a Non-Routine Survey of the Plan’s ambulance claims processing.\(^2\)

Prior to commencing the survey, the Department provided written comments on the Plan’s ambulance claims review procedures and denial letters and offered to suspend the Non-Routine Survey if the Plan agreed to pay the ambulance transport claims previously denied and educate enrollees on the proper use of emergency ambulance services. The Department offered to work with the Plan in developing and implementing a series of corrective actions designed to resolve non-compliance with section 1371.5 (ambulance transport services) and in addition, address prior deficiencies to ensure compliance with 1371.4 (payment for out-of-network emergency

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\(^1\) References: “Section” is to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code Section 1340 et seq. [“the Act”]). References to “Rule” are to the regulations promulgated pursuant to the Act (Title 28 of the California Code of Regulations).

\(^2\) Pursuant to section 1382, and Rule 1300.82.1.
claims). After the Plan declined the Department’s offer, the Non-Routine Survey commenced on October 26, 2010.

**SURVEY SCOPE**

This Non-Routine Survey examined the Plan’s claims and grievance review processes for ambulance transport services. The survey was designed to determine whether the Plan correctly considered and applied; (1) the member’s EOC benefits and/or; 2) the statutory requirements for ambulance transport.

**BACKGROUND**

The Plan has had previous compliance issues in failing to properly apply the reasonable person standard in adjudicating claims for out-of-network emergency services claims. In December 2005, the Department conducted a Non-Routine Medical Survey to assess compliance with section 1371.4 and determined that the Plan did not apply the “prudent layperson” standard when evaluating payment for out-of-network emergency room services claims. That survey found the Plan routinely failed to consider whether a reasonably prudent person with the enrollee’s presenting symptoms and complaints would have believed he/she was experiencing an emergency medical condition. The Plan’s approach was to reimburse emergency services claims only when the medical records confirmed that the member had experienced an actual emergency medical condition.

These survey findings were referred to the Office of Enforcement. On April 7, 2007, the Department imposed a $500,000.00 administrative penalty. The Plan initially paid $250,000. The remaining $250,000.00 was suspended giving the Plan the opportunity to implement appropriate corrective action. However, the Help Center continued to receive consumer complaints challenging the Plan’s denial of reimbursement claims for emergency services. These consumer complaints were forwarded for an Independent Medical Review (IMR). When approximately 60% of the Plan’s reimbursement denials continued to be overturned by the IMR reviewers, the Plan was required to pay the suspended $250,000.00 fine. In addition, on a go forward basis, the Plan agreed to educate its enrollees on the proper use of emergency services and reimburse all emergency services claims until its claims and grievance and appeals processes complied with the reasonable person standard and was fully operational.

On August 26, 2009, the Plan submitted revised policies and procedures for processing out-of-network emergency services claims for the Department’s review and approval. On August 27, the Department notified the Plan that the revised policy did not comply with Knox-Keene Act’s requirements for the reimbursement of emergency services claims and that the policy was not to be implemented.

On May 16, 2011, the Plan notified the Department of its intent to reinstate a formal in-area out-of-network claims review process, beginning June 1, 2011. The Department is in process of evaluating the Plan’s revised claims review and grievance policy and procedure documents.

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3 A 2005 Non-Routine Survey evaluated Plan compliance with section 1371.4 (payment of out-of-network emergency claims) which resulted in Enforcement Action.

4 “An examination or survey is additional or non-routine for good cause . . . when the reason for such examination is, (1) The Plan’s noncompliance with written instructions from the Department.” Rule 1300.82.1
however, has not confirmed whether the Plan’s new processes correctly apply the reasonable person standard in compliance with section 1371.5.

**Requirements for Reimbursing Emergency Transports Claims**

The Plan did not apply the reasonable person standard in the adjudication of ambulance claims. Health and Safety Code Section 1371.5 states, “No health care service plan that provides basic health care services shall require prior authorization or refuse to pay for any ambulance or ambulance transport services . . . provided to an enrollee as a result of “911” emergency response system request for assistance if either of the following conditions apply:

1. The request was made for an emergency medical condition and ambulance transport services were required, or
2. An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.”

When the medical records do not support the existence of an actual emergency medical condition, section 1371.5 requires health plans to consider whether a reasonable person experiencing similar symptoms would have believed that those symptoms; (1) were an emergency medical condition and; (2) required ambulance transport. This analysis begins with an acknowledgement that the presenting symptoms, when evaluated retrospectively, were not, in fact, an emergency medical condition and that the ambulance transport was not, in fact, necessary.

**Kaiser’s Evidence of Coverage (EOC): Payment for Ambulance Services**

The plan also failed to apply its contractual provisions in adjudicating ambulance claims. The language set forth in the Plan benefits section of its Evidence of Coverage outlines the standards applied in determining payment for ambulance transport services and differs from the statutory mandate. Rather than utilizing the more objective standard of “an enrollee,” the Plan benefit language provides reimbursement for ambulance medical transport claims so long as: “you are not already being treated, and you reasonably believe that your condition requires ambulance transport.” This provision is a more subjective standard and requires the Plan to analyze the member’s specific rationale or thought process when making the 911 call for ambulance transport services.

**Survey Results**

**Significant Findings**

The Survey revealed that the health plan’s ambulance claim reimbursement denials relied solely on review of medical records focusing on the discharge diagnosis. If the medical records confirmed the existence of an emergency condition, this finding substantiated the need for ambulance transportation and the claim was paid. If an actual emergency condition was not

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5 As used in this Report, an "emergency medical condition" has the same meaning as in section 1317.1(b) of the Health and Safety Code. An "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Placing the patient's health in serious jeopardy; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part.
documented, reimbursement was denied. The Plan did not apply the benefit set forth in its EOC or the mandate outlined in section 1371.5.

In a number of cases, the medical records confirmed that the enrollee was experiencing an emergency medical condition; however, the Plan denied reimbursement of ambulance transport services.\(^6\) In these cases, the survey revealed the Plan used payment rules to guide the claims review such as whether other forms of transportation, in lieu of an ambulance, were available to transport the enrollee to the Emergency Department. In one case, failing to apply either the EOC or the statutory standard, the Plan reasoned that the member’s refusal to ask his wife to drive him to the hospital because of a concern that she could not safely help him into the family vehicle demonstrated that ambulance transport was not necessary.\(^7\)

The file review revealed that the Plan had no established processes for gathering information reflecting the member’s state of mind or for analyzing what an average person would have reasonably believed as part of the claims process. The Plan generally ignored the member’s explanation for seeking ambulance transport services when voluntarily provided by the enrollee during the grievance and appeal process.

These findings were consistent with the Plan’s statements during the Department’s initial investigation of the 11 consumer complaints. The Plan advised the Department that it was not required to apply the reasonable person standard in determining reimbursement for ambulance transport claims, and that such claims were appropriately denied if the medical records failed to establish an actual emergency medical condition.

The Plan ultimately reversed its position and conceded that a reasonable person standard was the appropriate standard for evaluating the reimbursement of ambulance transport claims. However, the Plan then asserted that its claims determinations had applied the correct standard and that poorly drafted denial letters failed to adequately articulate the Plan’s denial justification. The survey file review did not support this assertion.

The Plan’s processes and procedures for adjudicating ambulance transport claims; 1) do not require the development of the minimum information needed to determine the reasonable belief that ambulance transport was necessary; 2) utilize clinical information to justify that an actual emergency was present; and 3) apply arbitrary rules to interpret the patient’s clinical presentation and motivations accessing ambulance transport services.

Finally, the Plan’s grievance resolution letters sent to enrollees, upon upholding the Plan’s original denial of reimbursement for ambulance transport services, do not consistently contain a clear and concise explanation for the basis of the denial, and do not cite the EOC benefit provision when denying reimbursement as required by the Act.

**DEFICIENCIES**

This Non-Routine Medical Survey identified four deficiencies:

1. The Plan is operating at variance with its EOC benefit language;

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\(^6\) Case # 518251, 516831, 513444

\(^7\) Case # 512799
2. The Plan’s claims adjudication processes for ambulance transport claims fail to consider or analyze whether an average person reasonably believed that their condition required ambulance transport services;
3. The Plan’s grievance and appeals processes fail to consider or analyze whether an average person reasonably believed that their condition required ambulance transport services. Specifically, the Plan’s grievance and appeals files do not reflect that consideration is given to the enrollee’s explanation for accessing ambulance transport services; and
4. Grievance denial letters do not include a clear and concise explanation for the denial, nor do they cite the EOC contract provisions that support the Plan’s determination.

RECOMMENDATIONS

In accordance with section 1380(g) of the Act, Department analysts offer advice and assistance to the Plan in the form of survey recommendations. Survey recommendations are intended to alert the Plan to weaknesses in its operations that have the potential to become deficiencies in the future.

This Non-Routine Medical Survey identified two recommendations:

1. Ensure that enrollees have the ability to submit a grievance involving an emergency ambulance claim denial, handled by the Plan’s Special Services Department, by phone, fax, email, online, or in writing.

2. Develop a method to identify who directed or requested the ambulance transport as part of its analysis of whether a claim for the ambulance transport should be properly reimbursed.

The Preliminary Report was issued to the Plan on May 24, 2011. The Plan had 45 days to file a written statement with the Director describing the action taken to correct the identified deficiencies and the results of such action. Within 45 days of the date the Department provided the Report to the Plan, the Plan has an opportunity to review the Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

A COPY OF THIS REPORT HAS BEEN REFERRED TO THE DEPARTMENT’S OFFICE OF ENFORCEMENT
DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

FINAL REPORT
NON- ROUTINE MEDICAL SURVEY

OF
KAISER FOUNDATION HEALTH PLAN, INC.
A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: JANUARY 20, 2012
DATE ISSUED TO PUBLIC FILE: JANUARY 30, 2012

SECTION I: SURVEY HISTORY

Section 1382 of the Knox-Keene Act grants the Director the legal authority to conduct examinations of the administrative affairs of any health care service plan as often as deemed necessary to protect the interests of subscribers and enrollees. The Department noted a pattern in which the Plan denied enrollees reimbursement for non-scheduled ambulance transport services, 911 calls. In each of 11 cases, the Department issued a demand letter directing the Plan to reimburse the enrollee for the cost of the ambulance services. After the Plan failed to reimburse the disputed ambulance transport claims, the Department notified the Plan on August 16, 2010 of the intent to conduct a Non-Routine Survey of the Plan’s ambulance claims processing. In accordance with Title 28 CCR Rule 1300.82.1, “An examination or survey is additional or non-routine for good cause . . . when the reason for such examination is, (1) The Plan’s noncompliance with written instructions from the Department.”

The Department commenced a Non-Routine Survey on October 26, 2010, to audit the Plan’s compliance with section 1371.5 and investigate the pattern of ambulance claim denials. The survey evaluated the Plan’s non-scheduled ambulance claims adjudication and enrollee grievance processes. The survey was officially closed on November 9, 2011. The Department held an Exit Conference with the Plan on December 17, 2010; giving notice to the Plan of the Department’s findings. The following Report contains the results of the survey and the Department’s compliance determinations.

PLAN BACKGROUND

Kaiser Permanente began in the 1930s and offers a comprehensive health care delivery system, including ambulatory care, preventive services, hospital care, behavioral health, home health care, rehabilitation services, and skilled nursing services. Its operations in California are divided into two distinct geographic service areas: the Southern California Region, headquartered in Pasadena, and the Northern California Region in Oakland.

Plan enrollees access primary-care services through one of two for-profit medical groups; The Permanente Medical Group, Northern California or the Southern California Medical Group.

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8 Section 1382(a)
9 Pursuant to section 1382 and Rule 1300.82.1
Specialty care, with few exceptions, is provided through The Permanente Medical Group or the Southern California Medical Group. Hospital services are typically provided by Kaiser Foundation Hospitals.

**NON-ROUTINE SURVEY SCOPE AND METHODOLOGY**

This Non-Routine Survey assessed the compliance of the Plan’s ambulance transport claims adjudication operations and grievance processes (January through July 2010) with; 1) the Knox-Keene Act (Act) provisions governing payment of non-scheduled ambulance transport services to determine whether the operations complied with the law and; 2) the Plan’s EOC provisions relating to reimbursement for ambulance transport services.

1) **THE PLAN’S STATUTORY OBLIGATIONS TO REIMBURSE AMBULANCE TRANSPORT CLAIMS IS SET FORTH IN SECTION 1371.5, WHICH PROVIDES:**

(a) No health care service plan that provides basic health care services shall require prior authorization or refuse to pay for any ambulance or ambulance transport services, referred to in paragraph (6) of subdivision (b) of Section 1345, provided to an enrollee as a result of a "911" emergency response system request for assistance if either of the following conditions apply:

(1) The request was made for an emergency medical condition and ambulance transport services were required.

(2) An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services. [Emphasis Added]

(b) As used in this section, "emergency medical condition" has the same meaning as in Health and Safety Code Section 1317.1.

(c) The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.

(d) A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance transport services were never performed, an emergency condition did not exist, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.

Health and Safety Code Section 1317.1 provides:

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10 The phrase "emergency condition did not exist" contained in subdivision (d) of new section 1371.5 is not intended to modify, but rather is reflective of, the reasonableness standard set forth in subdivisions (a), (b), and (c). [AB 984 Bill Analysis, pg. 3 of 3]
(b) An "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

2) KAISER’S EVIDENCE OF COVERAGE: PAYMENT FOR AMBULANCE TRANSPORT SERVICES PROVIDES:

That the Plan will reimburse an ambulance transport claim so long as “you are not already being treated, and you reasonably believe that your condition requires ambulance transport.” This provision establishes the Plan’s payment obligation which bears the responsibility to gather facts establishing, or not, the enrollee’s reasonable belief that his condition required ambulance transport services. [Emphasis Added]

The Department’s approach in evaluating the Plan’s operations consisted of:

(a) Interviews with Plan staff ranging from front-line member services representatives to director-level decision makers;
(b) A review of key documents such as policies, procedures, and business rules;
(c) An in-depth re-review of all ambulance claims complaints received at the Help Center; and
(d) A detailed review of a random sample of enrollee claim and grievance files.

OVERVIEW OF THE PLAN’S AMBULANCE CLAIMS ADJUDICATION PROCESS

In preparation for this survey, the Department reviewed the Plan’s operations and processes for adjudicating non-scheduled ambulance claims and processing of appeals arising from denied reimbursements. The following provides an overview of the Plan’s operations in the review of ambulance claims and appeals at the time of the Department’s Non-Routine Survey:

THE KAISER AMBULANCE CLAIMS ADJUDICATION PROCESS

The Plan contracts with a third-party vendor, EMI, to review and pay ambulance claims. The Plan establishes EMI operating policies and procedures and business rules used in the initial review of ambulance claims. EMI conducts a “first level” claims review and has the authority to approve payment of ambulance claims. EMI refers possible claim denials to the Plan for evaluation and review.

Once referred to the Plan, the claim is researched and reviewed by the Plan’s non-clinical staff. The Plan staff may either pay the claim or if questions remain, refer the claim for Physician review. Only a Physician Reviewer is authorized to deny an ambulance claim.
Kaiser Foundation Health Plan
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Kaiser Claims Adjudication Policies and Procedures
The Plan’s “Clinical Review of Claims” policy document, directs the adjudication process for payment for all out-of-network providers. The document describes the process for adjudicating an ambulance claim that is “pended” by the Plan’s non-clinical staff. The document also sets forth the Plan’s standard of review when determining whether to pay or deny an ambulance transport claim. The policy instructs staff that the medical records must establish the existence of an emergency medical condition and to apply the subjective reasonable person standard in evaluating the claim.

Plan Process for Evaluating Ambulance Claims Appeals
When an enrollee appeals the Plan’s decision to deny payment or reimbursement of an ambulance transport claim, the appeal is processed by the Plan’s Special Services Department, a division of the Claims Review Department. Special Services is separate from Member Services.

When Special Services receives the appeal, they conduct a de novo review of the claim, separate from the original claims review, to determine payment of the claim. An appeal is subject to three levels of review:

1. First, a non-clinical Appeals Specialist reviews the case.
2. Second, a Nurse Reviewer, if the Appeals Specialist cannot overturn the original determination and pay the claim.
3. Third, Grievance Rounds, a group of reviewers consisting of non-clinical staff, nurses and Physician Reviewers, if the Nurse Reviewer is unable to reach a decision to pay the claim. An appeal which is denied can only be issued by Grievance Rounds.

The appeals staff evaluate the same records used in the prior claims review (e.g. ambulance records, emergency room records, and advice nurse logs), as well as the appeal letter submitted by the enrollee. Policies in place prior to the commencement of the Non-Routine Survey in October 2010 referred to the Physician’s judgment in determining whether or not a safe transportation alternative was available. Subsequent policy revisions, in close proximity to the survey, referenced the reasonable person standard and states that the medical condition “requires the clinical support of ambulance transportation.” [Emphasis Added]

Significant Factual Findings
The Plan’s claim payment process does not include consideration of the Plan’s EOC provision for payment of non-scheduled ambulance transport claims. The EOC provisions have not been incorporated into the Plan’s claim review or appeals policies, procedures, or operations.

Neither the Plan’s claims payment operation nor the appeal review process demonstrated compliance with the statutory reasonable layperson standard when adjudicating ambulance transport claims or in reviewing the denial on appeal.

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11 In general, enrollee grievances and appeals are handled through the Plan’s Member Services Department.
12 The Plan’s policy defines the reasonable person as an individual with average knowledge of health and medicine.
This was further substantiated by findings that the Plan relies on the same clinical facts and medical records to support the review of ambulance claims or appeals. Both claims and appeals staff defer to the clinical facts to support the payment decision. Based on statute, the clinical facts, alone are not the basis for the reasonable person analysis; whether the enrollee reasonably believed their condition was an emergency and reasonably believed ambulance transport was required.

Despite its assertion that it seeks enrollee medical history and additional statements as necessary, the case files showed no instances in which the Plan requested or obtained additional enrollee information prior to the denial. In the absence of enrollee statements, the Plan has developed arbitrary rules used during claims review and during the appeals to guide decisions on whether or not the ambulance claim will be paid. Finally, the Plan’s grievance resolution letters do not contain a clear and concise explanation for the basis of the denial, nor cite the EOC benefit provision when denying reimbursement.
NON-ROUTINE SURVEY REPORT

SURVEY RESULTS

DEFICIENCIES

The Department identified four compliance deficiencies during this Non-Routine Medical Survey.

Deficiency #1: The Plan is operating at variance with its EOC in the adjudication and payment of ambulance transport claims and in the subsequent grievance and appeal process.

[Section 1386(b)(1)]

The Plan’s approved Evidence of Coverage states that the Plan will pay for ambulance services if “you reasonably believed your condition required ambulance transport.”[13] [Emphasis Added] This EOC provision sets forth a more subjective standard than the standard mandated by section 1371.5 of the Act relating to the reimbursement of emergency transport claims. The use of the word “you” references the enrollee’s individual thoughts and impression taking into consideration his personal knowledge and experience. In contrast, section 1371.5 considers whether an enrollee [Emphasis Added] reasonably believed: (1) that his condition was an emergency; and (2) that the condition required emergency transport.

Based on the plain and ordinary meaning applied to provisions of insurance contracts,[14] if “you,” as an enrollee making the 911 call, reasonably believed your condition warranted ambulance transport, the EOC provision assures that the claim will be paid.

However, the EOC standard is not incorporated in the Plan’s policies or procedures or operations and practice. During interviews, the Plan’s staff did not cite the EOC in considering claim payment or during the appeal process. The Plan does not reference the EOC standard when initially adjudicating ambulance transport claims or during any subsequent grievance and appeal processes. Rather, the Plan reports that it applies the requirements of section 1371.5 (and, therefore, not the EOC) when initially adjudicating claims and during any subsequent grievance or appeal review initiated by the enrollee appeal.

Deficiency #2: When adjudicating non-scheduled ambulance transport claims, the Plan does not apply the statutory framework to determine whether the enrollee reasonably believed that the condition required ambulance transport services.

[Section 1371.5(a)]

The Plan does not request or obtain the minimum enrollee information or consider the enrollee’s circumstances in determining whether an enrollee reasonably believed that the condition required

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14 “The words of a contract generally are to be understood in their ordinary and popular sense unless the parties use them in a technical sense or a special meaning is given to them by usage.” (Helfand v. National Union Fire Ins. Co. (1992) 10 Cal.App.4th 869, 879)
ambulance transport services. Instead, the Plan relies solely on clinical information to evaluate whether the enrollee decision to access ambulance transport services was reasonable;

The Plan requires, as a condition of payment, that the clinical information either substantiates an actual emergency medical condition existed or corroborates the enrollee’s complaint at the time of the 911 call. The Plan applies arbitrary rules to interpret the patient’s clinical presentation and to determine the enrollee’s motivations for calling 911.

**Deficiency #3:** When processing ambulance claims appeals, the Plan fails to apply the statutory framework and does not consider the enrollee’s explanation for utilizing ambulance transport services when determining whether the enrollee reasonably believed the condition required ambulance transport.  
[Section 1371.5(a)]

The Plan requires its grievance and appeal staff to document the existence of clinical findings to corroborate the need for ambulance transport. The Plan applies arbitrary rules to interpret the patient’s clinical presentation and to evaluate the enrollee’s actions in calling 911.

**Deficiency #4:** The Plan’s grievance denial letters do not include a clear and concise explanation for the Plan’s decision to deny the enrollee reimbursement for their use of ambulance transport services and do not reference relevant EOC provisions.  
[Section 1368(a)(5); rule 1300.68(d)(5)]

The Plan’s grievance resolution letters sent to enrollees, upon upholding the Plan’s original denial of reimbursement for ambulance transport services, do not consistently contain a clear and concise explanation for the basis of the denial, and do not cite the EOC benefit provision when denying reimbursement as required by the Act.

Section II of this Report contains a discussion of these deficiencies, and Appendix C contains the complete text of the relevant statutes and rules.

**RECOMMENDATIONS**

In accordance with section 1380(g), Department analysts offer advice and assistance to the Plan in the form of survey recommendations. Although a response to identified Recommendations is not statutorily required, it is highly recommended. These Recommendations are not a statement of current Plan deficiencies. Survey Recommendations are intended to alert the Plan to weaknesses in its operations or systems that have the potential to become deficiencies in the future.

**GRIEVANCES AND APPEALS**

1. Ensure that enrollees have the ability to submit a grievance involving an emergency ambulance claim denial, handled by the Plan’s Special Services Department, by phone, fax, email, online, or in writing.
EMERGENCY SERVICES – CLAIMS PAYMENT

2. Develop a method to identify who directed or requested the ambulance transport as part of its analysis of whether a claim for the ambulance transport should be properly reimbursed.
## SECTION II: 2010 SURVEY DEFICIENCIES - DISCUSSION OF FACTUAL FINDINGS, IMPLICATIONS FOR IDENTIFIED DEFICIENCIES, AND CURRENT STATUS

### OPERATING IN VARIANCE WITH HEALTH PLAN’S EOC

**Deficiency #1:** The Plan is operating at variance with its EOC in the adjudication and payment of ambulance transport claims and in the subsequent grievance and appeal process.

**Statutory/Regulatory Reference:** Section 1386(b)(1)

**Discussion:** Section 1386(b) states, “The following acts or omissions constitute grounds for disciplinary action by the Director:

1. The Plan is 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 as contained in its application for licensure. . .”

The Plan’s EOC states that the Plan will pay an ambulance claim so long as: “you are not already being treated, and you reasonably believe that your condition requires ambulance transport.” [Emphasis Added]

Based on the plain and ordinary meaning applied to provisions of insurance contracts,\(^{15}\) if the enrollee making the 911 call reasonably believed their condition warranted ambulance transport, the EOC provision assures that the claim will be paid. The Plan’s EOC provisions regarding payment for ambulance transport, references three conditions; 1) “you,” a subjective standard considering the individual’s unique qualities and experience; 2) reasonably believed, a determination based on the individual’s unique traits and characteristics; and 3) your condition required ambulance transport.

The plain and ordinary meaning of the word “you,” focuses on the individual member rather than an “average member” and therefore requires a subjective evaluation of the individual member’s thought processes and conduct. This provision establishes the Plan’s payment obligation and requires the Plan to ascertain facts and circumstances leading up to the enrollee’s decision to use ambulance transport services in order to determine whether, the enrollee reasonably believed that his condition required ambulance transport. Relevant information would likely include the enrollee’s medical history, family health history, educational level, and may under the appropriate circumstances, include gender, language, and culture.

Because the EOC’s reimbursement standard focuses solely on whether “you reasonably believed” that his/her condition requires ambulance transport, the enrollee is not required to

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\(^{15}\) “The words of a contract generally are to be understood in their ordinary and popular sense unless the parties use them in a technical sense or a special meaning is given to them by usage.” (Helfand v. National Union Fire Ins. Co. (1992) 10 Cal.App.4th 869, 879)
independently establish that they reasonably believed their condition was an emergency medical condition. As a result, the EOC benefit for ambulance transport is not as restrictive as the statutory requirements under section 1371.5.

The Survey Team confirmed, based on a review of Plan documents, case files and interviews, that the Plan does not consider or apply this EOC language: (1) when initially adjudicating claims; or (2) when resolving enrollee appeals or grievances of the Plan’s initial claims payment denial.

Implications: Based on the EOC, the enrollee may reasonably assume the ambulance claim will be paid. However, the Plan neither considers nor applies the EOC provision in the adjudication of the claim and payment is denied. Subsequently, the enrollee is billed and expected to pay.

If the Plan correctly applied the EOC provisions for ambulance transport in the adjudication of the claim or during the appeals process, it is more likely the Plan, not the enrollee, would be financially responsible for payment of the ambulance transport claim under the standard set forth in the health care coverage agreement.

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department, signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan’s Compliance Effort: The Plan instituted the following actions to correct this deficiency:

1) The Plan submitted its corrective action response on July 15, 2011 and a revised response on October 7, 2011. The Plan stated it would apply its current EOC standard to the adjudication of ambulance claims and appeals, “You are not already being treated, and you reasonably believe that your condition requires ambulance transport.” This was supported by a revised policy, “Emergency Ambulance (911) Claims Review (Initial Review) Policy, updated September 26, 2011, that cites to the Plan’s EOC provision for coverage of 911 emergency transport.

2) On June 27, 2011, the Plan proposed an amendment to its EOC description for coverage of emergency ambulance transport. The amendment intended to align the Plan’s EOC language with section 1371.5 (eFiling #20111317). The Plan arranged a meeting with the Department to expedite approval.

In mid-September 2011, the Plan gained interim approval of proposed EOC language, “A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance services.” The Department agreed that the

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16 Pursuant to section 1380(h)(2)
17 Pursuant to rule 1300.80.10
18 The Plan submitted a response to the Preliminary Non-Routine Survey Report on July 15, 2011. The Department reviewed the response and on August 30, 2011, the Department provided written comment and feedback regarding the Plan’s efforts to correct the deficiencies and requested a revised response be submitted to the Department on or before September 30, 2011. The Plan requested and the Department granted a one week extension. The Plan’s revised response was received on October 7, 2011.
Plan could print 2012 EOCs using this standard with the caveat “pending regulatory approval.”

3) Due to the potential confusion in changing the EOC standard and language after January 1, 2012, the Plan assured the Department that the current EOC language would be used in practice until the Department’s final approval. Once approved, the claims review policy would be revised and the ambulance claims with dates of service prior to January 1, 2012 would be adjudicated using the applicable EOC language in effect on the date of service.

4) The Plan conducted training of Clinical Review staff in the proper application of the Plan’s EOC standard in reviewing emergency claims. This was demonstrated by the production of a September 13, 2011 meeting agenda, training sign-in sheets for both northern and southern California with staff signatures.

Department’s Finding Concerning Plan’s Compliance Effort:

STATUS: NOT CORRECTED

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

The Plan has revised its policies, conducted staff training, and attests to the implementation of its EOC standard to adjudication of emergency claims payment. These changes appear likely to support Plan compliance with the requirements of the Act. However, proposed EOC changes are pending final Department approval and will likely require additional modifications to emergency claims review practices after January 1, 2012.

In order to confirm the Plan’s compliance, the Department must conduct a review of the adjudication of emergency ambulance claims process with file review once the Plan’s operations have stabilized and sufficient numbers of claims have been processed. The Plan’s ongoing corrective actions and whether these actions have resulted in practices that comply with the standard of review (EOC and/or statute) must be confirmed through the Department’s direct review of emergency ambulance claims and grievance files.

The Department anticipates conducting a Follow Up Survey of the Plan’s emergency claims and grievance review operations in the second half of 2012.

**EMERGENCY SERVICES – NON-SCHEDULED AMBULANCE CLAIMS PAYMENT**

Deficiency #2: When adjudicating non-scheduled ambulance transport claims, the Plan does not apply the statutory framework to determine whether the enrollee reasonably believed that the condition required ambulance transport services.

Statutory/Regulatory Reference: Section 1371.5

Discussion: Section 1371.5 prohibits a health plan from refusing to pay for any ambulance or ambulance transport services if either condition applies:
The request was made for an emergency medical condition and ambulance transport services were required, or

An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

This Non-Routine Survey focused on the second threshold in section 1371.5(b); whether the enrollee reasonably believed that the condition required ambulance transport services. The Plan provides coverage and automatically pays for emergency services within the Plan’s network. The Plan does not condition payment for in-plan emergency services on the determination of whether the enrollee reasonably believed the condition was an emergency medical condition.

Pursuant to an August 2008 agreement with the Department, the Plan agreed to suspend the application of the reasonable person standard when adjudicating in-area/out-of-network emergency service claims until a compliant review process was operational. Hence, the Plan has not conditioned payment for in-area/out-of-network emergency services on whether the enrollee reasonably believed the condition was an emergency medical condition since August 2008. Instead, the Plan represented that it would reimburse all emergency service claims and, when appropriate, educate the member on the proper use of emergency room services.

Subdivision (c) of section 1371.5 emphasizes that when determining the reasonableness of the enrollee’s belief, the Plan’s reimbursement determination, “should not be solely based on a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.” Accordingly, the Survey Team focused on the Plan’s use and reliance on clinical facts and information in its claims and appeals review processes.

While Plan staff indicated in several interviews, that the claims review process attempts to determine what the enrollee was experiencing at the time the enrollee called 911, a review of the Plan’s emergency transport claim files revealed that the Plan does not request or obtain the minimum information needed to determine whether the enrollee reasonably believed that ambulance transport was required. Rather, the Plan relies on available clinical information to determine whether the member’s decision to access ambulance transport services was justified. The reliance on clinical information to justify claim payment was confirmed through the following:

1) The claim file information consists of a standard set of two or three clinically prepared documents. The Plan’s Physician Reviewer confirmed the Plan only looks at the documents available in the claim file, which typically includes: the ambulance report, emergency department record, and advice log notes. If a call were made to the Plan prior to the 911 call, the call record may also be included in the file. These records are the accounts of clinicians and are designed to document the clinical signs and symptoms of the enrollee. They typically provide little or no insight into the reasonableness of the enrollee’s belief that emergency transport was necessary. This

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19 On May 16, 2011, the Plan provided notice to the Department of its intent to reinstate the claims adjudication process for in-area out-of-network emergency services claims on June 1, 2011. The Department is in process of reviewing the Plan’s revised policies and procedures, however, has not confirmed Plan compliance with the application of the reasonable person standard in adjudicating out-of-network emergency service claims.
documentation rarely quotes the enrollee and almost never sets forth the enrollee’s thought processes at the time of the 911 call.

2) **Information regarding the enrollee’s medical history was absent from claims review files.** The Plan’s Physician Reviewer represented that the enrollee’s medical history may be relevant and is considered when assessing the enrollee’s decision to use ambulance transport. However, the Plan’s claim files lacked documentation to support that such consideration is actually given. The claim files only discuss the ambulance and emergency department reports, and occasionally the advice log of enrollee contacts prior to the 911 call. None of the claim files surveyed contained or discussed the enrollee’s medical history or past medical records.

3) **The Plan neither obtains the 911 transcript of the enrollee’s call nor contacts the enrollee to gain the enrollee’s perspective as part of the Plan’s reasonable person analysis.** None of the claim files surveyed contained: 1) the 911 transcript, or 2) any contact notes where the Plan had attempted to ascertain the enrollee’s account of the events leading to the decision to use ambulance services. The review of claim files did not reveal Plan efforts to ascertain the enrollee’s reasoning or concerns when calling 911.

In order for the Plan to comply with the requirements of section 1371.5, the Plan must first accurately ascertain the enrollee’s symptoms, complaints, and reasoning before it can evaluate whether an average person would have reasonably believed that those symptoms, complaints, and reasoning required ambulance transport. At a minimum, contacting the enrollee for an explanation, obtaining the enrollee’s past medical history and/or obtaining the 911 transcript is vital information necessary to understand why the enrollee used the disputed ambulance services. Only after this minimal information is gathered can the Plan fairly assess whether an average person under similar circumstance would believe that ambulance transport was necessary.

During interviews with Plan staff, they explained that when the emergency medical records include the enrollee’s description of symptoms that would justify a reasonable belief that emergency transport was necessary, the Plan requires, as a condition of payment, that the emergency room medical records corroborate the enrollee’s description of his symptoms. As a result, if the enrollee’s emergency room medical diagnosis does not substantiate an actual emergency, or the clinical facts are not consistent with the enrollee’s statements, the Plan does not reimburse the ambulance transport claim. Hence, the claims review process evaluates the consistency of the enrollee’s statements to the eventual diagnosis rather than considering the reasonableness of the enrollee’s belief that the symptoms he/she was experiencing justified the decision to call for ambulance transport.

Almost without exception, claim files revealed that in practice the Plan justifies its decision to deny reimbursement for ambulance transport on the treating Physician’s ultimate medical diagnosis. The Plan’s template claim denial letters include the statement, “The ambulance transportation you ordered for [enrollee’s diagnosed condition] did not require emergency transportation,” illustrating the Plan’s practice to base the decision to pay or deny

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20 Case #’s, 512376, 512799, 503943, and 502515. Claims # 201017279713200
reimbursement for the ambulance transport claim on the enrollee’s diagnosis and not on the enrollee’s reasonable belief that the condition required ambulance transportation.

In general, the Plan’s claim denial determinations fail to ascertain, discuss, or consider the enrollee’s description of his symptoms or his explanation for utilizing ambulance transport. Considering that section 1371.5(c) prohibits the Plan from solely relying on a retrospective analysis of emergency provider’s clinical findings or discharge diagnosis, it is not possible for the Plan to properly analyze the reasonableness of the enrollee’s decision to secure ambulance transport services when it fails to consider the enrollee’s explanation and reasoning.

Consequently, the Department finds the Plan’s practice of sole reliance on the clinical facts to determine whether an ambulance transport claim should be reimbursed violates the requirements of 1371.5.

The Plan applies arbitrary payment rules to interpret the patient’s clinical presentation and motivations in calling 911. Plan interviews and file review revealed that the Plan’s claims adjudicators and Physician Reviewers apply 5 primary tests or rules to assess whether the claim should be paid.

1. “First, Worst, Different” test – If the patient suffers from a chronic condition, the ambulance claims will be paid only if there is information to confirm this is the first time the patient has experienced the symptoms, the worst the patient has experienced or different from what they have experienced in the past.

2. If an enrollee has been experiencing symptoms over multiple days but there has been no change in the symptoms at the time of the 911 call, the claim is denied.

3. If the enrollee is ambulatory upon ambulance arrival, there is a presumption that the enrollee was not experiencing an emergency.

4. In order to be considered an emergency, the symptoms must have occurred suddenly.

5. If other transportation was available, the claim is denied. During interviews, a Plan representative stated that the ambulance is not a “fancy taxi” and if the enrollee does not require medical attention in transit between home and hospital, the ambulance is not necessary.

These rules are based on the Plan’s emphasis on the clinical facts and findings, not on the enrollee’s thought processes or description of complaints or symptoms at the time the enrollee called for ambulance services. Section 1371.5 focuses on the enrollee’s reasonable belief; it does not authorize or contemplate that a Plan would impose arbitrary rules to determine whether to reimburse the enrollee’s use of ambulance services.

Rather than ascertaining the enrollee’s explanation for utilizing ambulance transport services, the Plan interprets the enrollee’s motivation by applying these arbitrary “payment rules” to the ambulance claim. The enrollee is automatically charged with prior knowledge of all aspects of their chronic condition and assumed to have the requisite knowledge to accurately judge the severity of their symptoms. Simply stated, if the symptoms are not the “first, worst or different,” the Plan summarily concludes that the enrollee knew or should have known that the symptoms
experienced at the time of the call did not constitute an emergency medical condition and an ambulance was not necessary.

In situations where the enrollee waits to seek care or call an ambulance, the Plan policy is to automatically deny the claim without analyzing whether the symptoms became more rather than less severe. The Plan rationale appears to be that the “belated” use of ambulance transport is always a matter of convenience. There is no analysis of whether an average person would have reasonably believed that the use of ambulance transport was necessary. The ability to ambulate, the timing of symptoms, and whether other forms of transportation were available or contemplated by the enrollee prior to calling 911 are used as claim denial triggers resulting in a rule-based decision to deny the claim. None of the payment rules require the Plan to obtain additional information from the enrollee or consider the enrollee’s subjective complaints and impressions at the time of the 911 call.

These arbitrary rules and tests developed by clinicians and applied to the review of non-scheduled (911) ambulance transport claims are not designed to capture, nor do they consider the reasonable belief and circumstances in making the 911 call. These claims review rules impose a retroactive clinical standard to judge the enrollee’s actions; disregarding the reasonable belief standard, required in the Act.

The Plan’s apparent concern that, without stringent limitations, enrollees will misuse or overuse the 911 safety net system does not justify ignoring a statutory mandate or instituting an arbitrary test; that if the enrollee could have taken a taxi, summoned a ride from a neighbor or spouse or driven themselves to the hospital, reimbursement for ambulance transport should be denied.

There is nothing in section 1371.5 that imposes a duty on the enrollee to call a taxi, summon a neighbor or spouse or chance driving themselves to the hospital when they reasonably believe that emergency transport is necessary. In fact, the use of these alternate means of transportation could be counter indicated and jeopardize the safety of both the enrollee and the general public.

Implications: The Plan relies on the clinical facts of the ambulance claims documentation and fails to apply the reasonable person standard set forth in section 1371.5. The plan does not obtain the enrollee’s medical history or statements which are critical to any evaluation under the statute. The Plan’s use of clinically based business rules is inconsistent with a consideration of the enrollee’s reasonable belief and motivations for utilizing ambulance services.

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department, signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.

Plan’s Compliance Effort: To correct this deficiency, the Plan provided written descriptions of operational changes and instituted the following actions:

The Plan revised its Emergency Ambulance (911) Claims Initial Review Policy to obtain a member statement prior to denying an ambulance claim. On October 7, 2011, the Plan provided

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21 Pursuant to section 1380(h)(2)
22 Pursuant to rule 1300.80.10
the Department a draft “Request for Information” letter to be sent to an enrollee requesting information as to the circumstances and reasons for calling 911/ emergency ambulance services.

The letter instructs the enrollee to provide the information using an enclosed form. The enrollee must return the form within 45 days using pre-paid envelope or fax. The letter includes a direct telephone contact number for the member to call with questions regarding the claims review process. Once the member’s statement is received, the claim is re-evaluated using the member’s impressions and experience as expressed in the statement.

The Plan revised its policy to require the review of available Plan medical records if the enrollee indicates that their past medical history influenced their decision to call the emergency ambulance.

If it is determined that the enrollee’s actions were not consistent with a reasonable person, all information is forwarded to a Physician for review. A Physician re-assesses the claim with the enrollee’s statement and a medical record determines; 1) was the ambulance medically necessary and if not, 2) whether the enrollee met the reasonable person standard.

The Department’s Report cited the Plan’s reliance on payment rules in adjudicating claims and processing the enrollee appeals. In response, the Plan stated that Health Plan Clinical Review uses ICD-9 codes and example scenarios to help examiners make quick decisions to pay an emergency ambulance claim. The use of ICD-9 codes is an industry standards and an integral part of auto-adjudication.

Although the examiner is not required to pay the claim based on the example provided, they may not deny the claim. The claim must be forwarded for further review. The Plan conceded that the description of a symptom that is not the “first or worst” would “require more in-depth examination to determine if the circumstances were such that a person with this known medical history had extenuating circumstances that made them reasonably believe they were in jeopardy and needed the services of an emergency ambulance.”

Scenarios such as infant with febrile seizure, motor vehicle accident with no injuries or persistent vomiting with diarrhea are given to examiners as examples where no actual medical emergency exists that requires the use of an ambulance, but that most of the time it will be determined to be consistent with the reasonable person standard and payable. “This type of example, and the discussion it can generate, helps to promote consistency in application of the standards.” The Plan’s revised claims review policy states, “no ICD-9 codes or scenarios are automatically denied without review.”

If the claim denial was based on the reasonable person analysis, the denial letter will reference the Plan’s analysis of; 1) “reasonable belief that an emergency exists, and 2) whether the services of emergency transportation was necessary.”

The Plan has instituted monthly oversight meetings between the Claims Compliance Team and the Clinical Review Team to monitor the Claims and Clinical Review processes. Audit results and open corrective action plans “will be reviewed each month by the Health Plan Clinical

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Review and reported to the Compliance Director for California Claims and Health Plan Regulatory Services.”

Department’s Finding Concerning Plan’s Compliance Effort:

STATUS: NOT CORRECTED

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

While the Plan has taken substantial steps to revise policies and implement changes consistent with the statute, the Department finds that in order to confirm the Plan’s compliance, the Department needs to review the Plan’s grievance and appeals files where emergency ambulance claims have been adjudicated once the sufficient numbers of claims have been processed following the full implementation of the Plan’s corrective actions to verify whether the Plan’s corrective actions have resulted in Knox-Keene Act compliance.

The Department anticipates conducting a Follow Up Survey of the Plan’s emergency claims and grievance review operations in the second half of 2012.

GRIEVANCE AND APPEAL PROCESSING AND ADJUDICATION

Deficiency #3: When processing ambulance claims appeals, the Plan fails to apply the statutory framework and does not consider the enrollee’s explanation for utilizing ambulance transport services when determining whether the enrollee reasonably believed the condition required ambulance transport.

Statutory/Regulatory Reference: Section 1371.5(a)

Discussion: When enrollees appeal the Plan’s denial of reimbursement for their use of ambulance services, the enrollees often include an explanation or justification for utilizing ambulance services. In reviewing an appeal, the Plan’s appeal staff re-assesses the documents previously reviewed during the claims adjudication process. During interviews, the Appeals Specialists stated that the most important question to ask is, “what was the member thinking at the time they called 911?” The staff described their process to place him/herself in the enrollee’s shoes, and to rely on the enrollee’s letter to understand the circumstances of the 911 call.

While the staff stated that the enrollee letter is used to evaluate the enrollee’s state of mind at the time of the 911 call, in practice they conceded that they were trained not to rely on the enrollee’s explanation if the clinical information did not corroborate the enrollee’s statements. This restrictive use of the enrollee’s explanation is memorialized in the Special Services Operations Policy, which states, “The member’s statement is of primary importance, but the medical record must support what the member is saying.”

1) The results of Department file review of grievance and appeal files showed the Plan requires that the clinical information demonstrate the need for ambulance services as a prerequisite for reimbursement.

Where the clinical records did not support the need for ambulance transport or the symptoms described by the enrollee in his/her appeal letter, the Plan’s reimbursement denial of the ambulance transport claim was upheld. See case examples:

**Case # 513444:** The Plan upheld the claim denial because “the enrollee’s recollection of her condition (e.g., “uncontrollably shaking,” “unable to steady myself and/or stand up”) was inconsistent with the information documented in the paramedic report and the Emergency Department records from that day.”

**Case # 3829963:** According to the ambulance report, patient was found lying in bed upon arrival; report described the severity level as "mild," but did not include a statement about whether she could walk to the ambulance. According to the Emergency Department report, the patient was experiencing a new incident of moderate pain, aching and shooting pain.

In her appeal letter to the Plan, the enrollee described a sharp indescribable pain when bending over after her shower. The pain took her to the floor, she was unable to walk, her son called paramedics, the paramedics had to lift her into the gurney, and she could not work for over a week. In its written decision, the grievance rounds denied payment because, “per paramedics, pain was mild.”

**Case # 3776235:** Seventy-three year old enrollee states in her grievance letter that she awoke in the middle of the night with pain through her entire upper body. She could not sit up and rolled to the floor to call 911. She described a history of thorax outlet syndrome and transient ischemic attacks (TIA). She thought she was having a stroke or heart attack.

The Plan upheld the claim denial on appeal. The Plan reasoned that the medical records did not reflect the patient’s statements. The ambulance report stated the enrollee was sitting upright in moderate distress, patient thought her left shoulder was broken, sat upright in ambulance because laying down would be too painful. The enrollee would not allow the EMT to examine her; the patient attributed the pain to a deep tissue massage.

Emergency Department notes stated that the patient refused pain medications, and able to walk to x-ray, however, would not sit or lay down due to pain. The notes stated the patient had experienced pain for a few days post-deep tissue massage but woke up with worse pain through back and left shoulder. The file revealed that the Plan did not look at the member’s prior medical history regarding TIAs and thorax outlet syndrome. The grievance analysis focused only on shoulder pain and stated that the medical records did not support the enrollee’s statement.

2) **During the review of an enrollee appeal, the Plan does not evaluate or consider the enrollee’s statements concerning past medical history and how this information influenced the enrollee’s decision to call 911.**
For example:

**Case #4017401:** The ambulance report dated 5/27/10, states a 39-year-old female, complaining of headache, was found lying in bed. Patient was transported to the ER due to headache for 5 days and weakness. Per ambulance report, patient required all treatment provided, patient transported in the semi-fowler position. Ambulance report included checked boxes for “Medically Necessary” and “Required Stretcher.”

The member stated in her appeal letter that she had a stroke in the past and was admitted to the Hospital for 7 days of care and recovery. On the date of the ambulance transport, she was unable to drive herself. That day she experienced passing out and severe headache with tingling in the left arm, causing patient concern for stroke.

The Plan’s appeal file failed to reveal any analysis or consideration of the member’s past history with stroke or consideration of the member’s statements that she believed she was having a stroke at the time of the ambulance request. The Physician Reviewer notes revealed, “No weakness or numbness in EMS or ED report. No distress per ed [Emergency Department] md.” The denial was upheld and the grievance resolution letter stated, “The ambulance transportation you ordered for headache of five days did not require emergency transportation.” The Plan’s review illustrates reliance on the medical record clinical facts to uphold the denial and gave no credence to the enrollee’s statements.

3) **During the review of an enrollee appeal, the Plan applies clinically based payment rules to the clinical facts and the enrollee’s statements to judge the enrollee’s actions in calling 911.**

The appeals staff and Physician Reviewers apply the same clinically based business rules to determine payment of the ambulance claim as used by claims review staff. The enrollee’s appeal is subject to the same “First, Worst, Different” test, the sudden onset of symptoms test, whether the enrollee had the ability to ambulate when the ambulance arrived rule, and the availability of alternative transportation rule, when deciding to overturn the denial.

Even in situations where the enrollee believed they were experiencing an emergency medical condition and stated that they called the ambulance because they had no other way to get to the hospital and could not find anyone who could transport them, the Plan’s Appeals Specialists stated that this is not sufficient justification to use ambulance transport. However, there is nothing in the statutory language that requires an enrollee to exhaust all possible alternative means of travel to an emergency facility, prior to calling 911. However, even where the enrollee unsuccessfully attempted to locate an alternative mode of transport to the hospital, the Plan continued to deny reimbursement for the ambulance transport on appeal. For example,

**In Case #512799:** The enrollee weighed 350 lbs. and had undergone back surgery. It had been several days post-surgery with no bowel movement. In the enrollee’s statement, his wife called his Physician and the office nurse instructed the enrollee to go to the emergency room. The enrollee was in pain secondary to his surgery, suffered from
gout, and had difficulty walking. However, the following enrollee statements were not considered in determining payment for the ambulance transport.

“I was in pain from my surgery, could not walk without a walker. My gout had flared up was in my ankle, severe pain...” “We have 2 vehicles; a truck and an suv. I could not climb into either, I weigh 350 lbs. I couldn’t expect my wife to lift me into either vehicle. I reasonably believed my condition required ambulance transportation.”

Despite this explanation, Plan refused to reimburse the enrollee’s ambulance transport claim because the enrollee had other modes of transportation available to go to the Emergency Department.

In case #513444: The enrollee called an ambulance to transport her to the emergency room due to full body pain, and left leg pain. The enrollee had a diagnosis of Lupus and had also sustained a left leg fracture a week before the 911 call. In the emergency room, the Physician noted she may be having medication withdrawal from oxycontin and suffered from non-healing of her fracture. The Plan denied payment of the ambulance claim because the “ambulance transport you ordered for full body pain did not require emergency transportation.”

The Plan’s response to the Department defended the claim denial based on the enrollee’s acknowledgement that her family contact was out of town and therefore, “she needed a ride to the Emergency Department. “The Plan dismissed the enrollee’s account that she was “uncontrollably shaking” and “unable to steady myself and/or stand up,” because this information was “inconsistent with the information documented in the paramedic report and the Emergency Department records from that day.” In the Plan’s response to the Department the Plan stated, “There must be a medical need for the services of an ambulance.”

The Plan’s grievance and appeal processes do not correctly implement the requirements of section 1371.5 because they do not consider the relevant facts and circumstances when evaluating whether the enrollee reasonably believed his/her condition required ambulance transport.

Implications:
These unwarranted denials have a potential chilling effect on whether enrollees will timely access medically necessary emergency care. If enrollees delay seeking ambulance transport when they reasonably believe they are experiencing an emergency medical condition because they fear the Plan will not reimburse the ambulance provider, that delay could result in substantial harm or death.

Corrective Action: Within 45 days following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department, signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.
**Plan’s Compliance Effort:** To correct this deficiency, the Plan provided written descriptions of operational changes and instituted the following actions:

The Plan’s documented requirements for processing an emergency ambulance appeal involving the reasonable person analysis include, but are not limited to the following: 1) first responder report, if any, 2) paramedic report, with particulate note of member’s complaint as listed by the dispatcher and to the paramedic when they arrived on scene, 3) the emergency room intake record, and 4) medical record review if the enrollee references medical history in their statement.

The Plan’s grievance resolution letters have been modified to reference the reasonable person standard. If denied, the Plan’s letter must reference why the reasonable person standard was not met, relying on member statements/impressions of the events and analysis of all available information.

The Department cited the “payment rule” in its deficiency of the Plan’s application of the reasonable person analysis in processing an appeal. The Plan asserted that clinically based business rules, are “guidelines” used by reviewers. The Plan utilizes guidelines for training and education purposes and that the only “payment rules” are those promulgated by the Plan to its third-party claims processor.

The Department cited the Plan’s practice to require corroboration between the enrollee’s subjective statements and the clinical facts to support claim payment. The Plan’s response noted that “if the member’s contemporaneous statement(s) as noted in the subjective section of the ambulance run report and/or in the medical records are clearly at variance with the member’s retrospective statement in the claim or appeal process…” there is a legitimate concern that the member has exaggerated his/her condition or beliefs/feelings at the time of the incident.

**Department’s Finding Concerning Plan’s Compliance Effort:**

**STATUS: NOT CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

The Department notes that the Plan’s explanations for using payment guidelines or in deferring to the clinical facts when enrollee statements appear to vary with the objective clinical information are consistent with statements made during the survey, however, in application, these policies provided factual support for these deficiencies. The Department must re-evaluate in the context of file review to ensure the Plan’s policies are not a substitute for the application of the reasonable person standard.

The Department continues to find that the Plan’s reliance on documented clinical facts to judge the reasonableness of the enrollee’s subjective statements, and the Plan’s use of payment guidelines in its claims and appeals review process, raise concerns as to the Plan’s correct application of the reasonable person standard.

The Department anticipates conducting a Follow Up Survey of the Plan’s emergency claims and grievance review operations during the second half of 2012.
Deficiency #4: The Plan’s grievance denial letters do not include a clear and concise explanation for the denial, nor do they cite the EOC contract provision that support the Plan’s determination.

Statutory/Regulatory Reference: Section 1368(a)(5); rule 1300.68(d)(5)

Discussion: Section 1368(a)(5) requires health plans to provide their enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the Plan's decision. When the enrollee’s grievance involves the delay, denial, or modification of a request for health care services, the Plan’s determination letters must describe the criteria used and the clinical reasons for the decision.

The Department reviewed 33 enrollee appeal files. In every file reviewed, the grievance appeal determination letter used the same language that the Plan used in its original claim denial letter. The determination letters are at least, in part, form letters that use the template:

“The ambulance transport you ordered for [condition] did not require ambulance transportation.”

No further explanation for the denial, description of the criteria or guidelines or the benefit language noted in the Plan’s EOC was disclosed to the enrollee in the appeal resolution letters. Section 1368(a)(5) requires the Plan to clearly and concisely explain why the enrollee’s decision to use ambulance transport services did not meet the statutory criteria of 1371.5 and/or the EOC’s more subjective standard.

Implications: The Plan’s failure to provide a clear and concise explanation for its decision to deny the enrollee reimbursement for the use of ambulance services and the grounds for that decision creates barriers to the enrollee’s understanding of his health benefits and could hinder one’s ability to secure assistance through either Department’s IMR or complaint processes.

Grievance File Review – Denial Letters

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<td>33</td>
<td>Letter references the EOC Provision that supports denial of payment</td>
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Corrective Action: Within 45 days\(^{27}\) following notice to a Plan of a deficiency, the Plan is required to file a written statement with the Department, signed by an officer of the Plan, describing any actions that have been taken to correct the deficiency.\(^{28}\)

\(^{27}\) Pursuant to section 1380(h)(2)

\(^{28}\) Pursuant to rule 1300.80.10
Plan’s Compliance Effort: To correct this deficiency, the Plan provided written descriptions of operational changes and instituted the following actions:

The Plan revised the claim denial and grievance letters to include more details of the Plan’s consideration of enrollee impressions and information in its reasonable person analysis and to include the Plan’s EOC standard.

Both letter templates include new instructions for the authoring nurse to include subjective statements from the member, the member’s written impressions and interpretation of events, the clinical facts, and an analysis of how the member’s statement and supporting clinical facts led to the Plan’s determination. The letter templates also instruct the nurse to “reference the two requirements: belief that an emergency exists and that the services of emergency ambulance transportation were necessary.”

Department’s Finding Concerning Plan’s Compliance Effort:

STATUS: NOT CORRECTED

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

While the Plan has taken substantial steps to revise template letters and implement changes consistent with the statute, the Department finds that in order to confirm the Plan’s compliance, the Department must review actual claims denial and grievance letters to verify the letters reflect the application of the reasonable person analysis. The Plan’s ongoing corrective actions and whether these actions have resulted in practices that comply with the standard of review must be confirmed through a follow-up file review survey.

The Department anticipates conducting a Follow Up Survey of the Plan’s emergency claims and grievance letters in the second half of 2012.
SECTION III: DISCUSSION OF RECOMMENDATIONS

In accordance with section 1380(g) of the Act, Department analysts offer advice and assistance to the Plan in the form of survey recommendations. The Plan is not required to respond to the Department’s recommendations. Survey recommendations are intended to alert the Plan to weaknesses in its operations that have the potential to become deficiencies in the future. The Plan responded to these recommendations on October 7, 2011.

GRIEVANCES AND APPEALS

1. Enrollees must have the ability to submit a grievance involving an emergency ambulance claim denial, handled by the Plan’s Special Services Department, by phone, fax, email, online, or in writing.

In at least two files reviewed by the Survey Team, the file indicated that an enrollee called Member Services to file a grievance regarding the emergency claim denial. However, the Member Services staff declined to accept the grievance. Rather the enrollee was instructed to submit the grievance in writing and to mail it to Special Services.

According to sections 1368(a)(4)(B), 1368.015, and rule 1300.68(b)(4), an enrollee has the right to submit a grievance by phone, fax, email, online, or in writing. Although grievances involving a claim denial are handled in Special Services, a separate unit at the Plan, the enrollee is entitled to a grievance process which allows filing one time, using any method referenced in the statute. Even if the Plan separates grievances into two different branches, the filing of a grievance should appear seamless to the enrollee.

Plan’s response to the Department: The Plan denies this violation and claims that they do accept verbal grievances and that “[t]his is current practice and will continue to be so.”

EMERGENCY SERVICES – CLAIMS PAYMENT

2. Develop a method to determine who called 911 before adjudicating the claim.

The Plan’s policies outline that an ambulance claim will be paid if a bystander or someone other than the enrollee called 911 on behalf of the enrollee. In two of the grievance files reviewed by the Department, the Plan ultimately reversed its denial of the claim because it learned from the enrollee’s grievance letter that the enrollee had not called 911. The Plan should develop a method for determining who called 911 during the initial claims review process so an enrollee is not forced to appeal and bring this information to the Plan’s attention during the appeals process. The Plan’s current process creates unnecessary delays in paying the claim when the claim clearly falls within the Plan’s benefit coverage.

Plan’s response to the Department: In the event a claim cannot be automatically paid and is pended for additional review, the Plan’s member request for information letter and completion of the member statement of emergency form ask the enrollee to identify who directed or requested the ambulance transport. The letter requests the following information from the enrollee: “A description in your own words of the reason for calling 911 on (date). If you did not personally place the call to 911, please also tell us who called on your behalf.”
SECTION IV: SURVEY CONCLUSION

The Department has completed its Routine Medical Survey. The Department will conduct a Follow up Review of the Plan in the second half of 2012.
DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS

PRELIMINARY REPORT
NON-ROUTINE MEDICAL SURVEY

OF
KAISER FOUNDATION HEALTH PLAN, INC.
A FULL SERVICE HEALTH PLAN

DATE ISSUED TO PLAN: January 20, 2012
DATE ISSUED TO PUBLIC FILE: January 30, 2012

APPENDICES
## A. SURVEY TIMELINE

### TABLE 1

Timeline of Current Survey Activities

<table>
<thead>
<tr>
<th>CURRENT SURVEY ACTIVITY</th>
<th>DATE</th>
</tr>
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<tbody>
<tr>
<td>Notification Letter and Request for Documents</td>
<td>August 16, 2010</td>
</tr>
<tr>
<td>Pre-Survey Documents Due</td>
<td>September 2, 2010</td>
</tr>
<tr>
<td>Non-Routine Survey Onsite Start Date</td>
<td>October 25, 2010</td>
</tr>
<tr>
<td>Non-Routine Survey Onsite Completed</td>
<td>October 28, 2010</td>
</tr>
<tr>
<td>Non-Routine Survey Close Date</td>
<td>November 9, 2010</td>
</tr>
<tr>
<td>Preliminary Report Issued</td>
<td>May 24, 2011</td>
</tr>
<tr>
<td>Final Report for Routine Survey Issued</td>
<td>January 20, 2012</td>
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</table>
## B. LIST OF FILES REVIEWED

<table>
<thead>
<tr>
<th>Type of Case Files Reviewed</th>
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<tr>
<td><strong>Utilization Management</strong></td>
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<td>200936279782900</td>
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<tr>
<td><strong>Grievances</strong></td>
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<td></td>
<td>3829963</td>
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</table>
C. APPLICABLE STATUTES AND REGULATIONS

Section 1317.1(b)
(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

Section 1368(a)(4)(B)
(a) Every plan shall do all of the following:
(4)(B) Grievances received by telephone, by facsimile, by e-mail, or online through the plan’s Internet Web site pursuant to Section 1368.015, that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the next business day following receipt are exempt from the requirements of subparagraph (A) and paragraph (5). The plan shall maintain a log of all these grievances. The log shall be periodically reviewed by the plan and shall include the following information for each complaint:
(i) The date of the call.
(ii) The name of the complainant.
(iii) The complainant’s member identification number.
(iv) The nature of the grievance.
(v) The nature of the resolution.
(vi) The name of the plan representative who took the call and resolved the grievance.

Section 1368(a)(5)
(a) Every plan shall do all of the following:
(5) Provide subscribers and enrollees with written responses to grievances, with a clear and concise explanation of the reasons for the plan’s response. For grievances involving the delay, denial, or modification of health care services, the plan response shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

Section 1368.015
(a) Effective July 1, 2003, every plan with an Internet Web site shall provide an online form through its Internet Web site that subscribers or enrollees can use to file with the plan a grievance, as described in Section 1368, online.
(b) The Internet Web site shall have an easily accessible online grievance submission procedure that shall be accessible through a hyperlink on the Internet Web site's home page or member

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services portal clearly identified as "GRIEVANCE FORM." All information submitted through this process shall be processed through a secure server.

(c) The online grievance submission process shall be approved by the Department of Managed Health Care and shall meet the following requirements:

(1) It shall utilize an online grievance form in HTML format that allows the user to enter required information directly into the form.

(2) It shall allow the subscriber or enrollee to preview the grievance that will be submitted, including the opportunity to edit the form prior to submittal.

(3) It shall include a current hyperlink to the California Department of Managed Health Care Internet Web site, and shall include a statement in a legible font that is clearly distinguishable from other content on the page and is in a legible size and type, containing the following language:

"The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (insert health plan's telephone number) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online."

The plan shall update the URL, hyperlink, and telephone numbers in this statement as necessary.

(d) A plan that utilizes a hardware system that does not have the minimum system requirements to support the software necessary to meet the requirements of this section is exempt from these requirements until January 1, 2006.

(e) For purposes of this section, the following terms shall have the following meanings:

(1) "Homepage" means the first page or welcome page of an Internet Web site that serves as a starting point for navigation of the Internet Web site.

(2) "HTML" means Hypertext Markup Language, the authoring language used to create documents on the World Wide Web, which defines the structure and layout of a Web document.

(3) "Hyperlink" means a special HTML code that allows text or graphics to serve as a link that, when clicked on, takes a user to another place in the same document, to another document, or to another Internet Web site or Web page.

(4) "Member services portal" means the first page or welcome page of an Internet Web site that can be reached directly by the Internet Web site's homepage and that serves as a starting point for a navigation of member services available on the Internet Web site.

(5) "Secure server" means an Internet connection to an Internet Web site that encrypts and decrypts transmissions, protecting them against third-party tampering and allowing for the secure transfer of data.

(6) "URL" or "Uniform Resource Locator" means the address of an Internet Web site or the location of a resource on the World Wide Web that allows a browser to locate and retrieve the Internet Web site or the resource.
(7) "Internet Web site" means a site or location on the World Wide Web.

(f) (1) Every health care service plan, except a plan that primarily serves Medi-Cal or Healthy Families Program enrollees, shall maintain an Internet Web site. For a health care service plan that provides coverage for professional mental health services, the Internet Web site shall include, but not be limited to, providing information to subscribers, enrollees, and providers that will assist subscribers and enrollees in accessing mental health services as well as the information described in Section 1368.016.

(2) The provision in paragraph (1) that requires compliance with Section 1368.016 shall not apply to a health care service plan that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its enrollees, provided that the health care service plan provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with Section 1368.016.

Section 1371.5
(a) No health care service plan that provides basic health care services shall require prior authorization or refuse to pay for any ambulance or ambulance transport services, referred to in paragraph (6) of subdivision (b) of Section 1345, provided to an enrollee as a result of a "911" emergency response system request for assistance if either of the following conditions apply:

(1) The request was made for an emergency medical condition and ambulance transport services were required.

(2) An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

(b) As used in this section, "emergency medical condition" has the same meaning as in Section 1317.1.

(c) The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.

(d) A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance transport services were never performed, an emergency condition did not exist, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.

Section 1386(b)(1)
(b) The following acts or omissions constitute grounds for disciplinary action by the director:

(1) The plan is 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 as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

Rule 1300.68(b)(4)
(b) The plan's grievance system shall include the following:

(4) The plan shall maintain a toll-free number, or a local telephone number in each service area, for the filing of grievances.
Rule 1300.68(d)(5)
(d) The plan shall respond to grievances as follows:
(5) Plan responses to grievances involving a determination that the requested service is not a covered benefit shall specify the provision in the contract, evidence of coverage or member handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the grievant to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applied to the specific health care service or benefit requested by the enrollee.
In addition to the notice set forth at Section 1368.02(b) of the Act, the response shall also include a notice that if the enrollee believes the decision was denied on the grounds that it was not medically necessary, the Department should be contacted to determine whether the decision is eligible for an independent medical review.