CALIFORNIA OFFICE OF ADMINISTRATIVE LAW

SACRAMENTO, CALIFORNIA

In re: Request for Regulatory Determination filed by the Union of American Physicians and Dentists concerning certain Department of Health Services' Medi-Cal guidelines and procedures[1]	1987 OAL Determination No. 10 [Docket No. 86-016] August 6, 1987 Determination Pursuant to Government Code Section 11347.5; Title 1, California Administrative Code, Chapter 1, Article 2

Determination by:

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SYNOPSIS

The issue presented to the Office of Administrative Law was whether certain guidelines pertaining to physicians treating Medi-Cal patients were "regulations" required to be adopted in compliance with the Administrative Procedure Act.

The Office of Administrative Law has concluded that the Department of Health Services has unlawfully supplemented regulations concerning claims submission and audit procedures of the Medi-Cal program.

THE ISSUE PRESENTED [2]

The Office of Administrative Law ("OAL") has been requested to determine whether or not the following two Bulletins, four pages from the Medi-Cal Provider Manual, and one particular methodology utilized by the Department of Health Services ("DHS") in conducting audits of physicians who are Medi-Cal providers are "regulations" as defined in Government Code section 11342, subdivision (b), and are therefore invalid and unenforceable unless adopted as regulations and filed with the Secretary of State in accordance with the Administrative Procedure Act ("APA"):

1. "Medi-Cal Bulletin" dated July 1978; "Medi-Cal Update" (Medical Services Bulletin No. 66) dated May 1983;

2. Medi-Cal Provider Manual for medical services, pages 3-77 through 3-80; and

3. DHS' policy of using a statistical sampling and extrapolation method for determining overpayment when auditing physicians.

THE DECISION [3,4,5,6,7,8]

The Office of Administrative Law finds that the Department of Health Services' above noted Bulletins, pages of the Medi-Cal Provider Manual, and audit procedure (1) are subject to the requirements of the APA, (2) are "regulations" as defined in the APA and (3) are therefore invalid and unenforceable unless adopted as regulations and filed with the Secretary of State in accordance with the APA.[9]

I. AGENCY, AUTHORITY, APPLICABILITY OF APA; BACKGROUND

Agency

In 1965, the Medi-Cal program[10] was created by the Legislature as a response to Title XIX of the Social Security Act, which authorized federal financial support to states which adopted conforming medical assistance programs. It was the intent of the Legislature

> "to provide, to the extent possible, through the provisions of this [Medi-Cal Act], for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of such care would jeopardize the person or family's future minimum self-maintenance and security."[11] [Emphasis added.]

In 1978, as part of an executive branch reorganization, the Department of Health Services was made responsible for the administration of the Medi-Cal program. Welfare and Institutions Code section 10721 provides in part:

> "The director [of DHS] shall administer [the Medi-Cal Act] . . . and any other law pertaining to the administration of health care services and medical assistance."

Authority [12]

The Director of DHS has been granted general rulemaking authority through Welfare and Institutions Code section 10725. Section 10725 provides in part:

> "The director [of DHS] may adopt regulations, orders, or standards of general application to implement, interpret, or make specific the law enforced by [DHS], and such regulations, orders, and standards shall be adopted, amended, or repealed by the director only in accordance with the [APA] . . . ." [Emphasis added.]

Welfare and Institutions Code section 14124.5 provides DHS with specific rulemaking authority as it applies to the Medi-Cal program. Section 14124.5 states in part that the

> "director [of DHS] may . . . adopt, amend or repeal, in accordance with the [APA], such reasonable rules and regulations as may be necessary or proper to carry out the purposes and intent of [the Medi-Cal Act] and to enable

> it to exercise the powers and perform the duties conferred upon it by [the Medi-Cal Act] not inconsistent with any of the provisions of any statute of this state." [Emphasis added.]

Applicability of the APA to Agency's Quasi-Legislative Enactments

Welfare and Institutions Code sections 10725 and 14124.5, cited above, specifically state that Medi-Cal-related quasi-legislative enactments of DHS are subject to the procedural requirements of the APA.

Additionally, the APA applies to all state agencies, except those "in the judicial or legislative department."[13] Since DHS is in neither the judicial nor the legislative branch of state government, we conclude that APA rulemaking requirements generally apply to DHS.[14]

Background

The following undisputed facts and circumstances, as provided by the requester,[15] have given rise to the present Determination.

The requester in this determination proceeding is the Union of American Physicians and Dentists ("UAPD"), many members of which are providers of services under the Medi-Cal program. The Medi-Cal program allows low income people to become certified Medi-Cal beneficiaries, which entitles them to receive certain health care services, including physician services, at minimal cost. Doctors and other professionals who participate in the Medi-Cal program are known as "providers." For the guidance of providers, DHS supplies the 5,766-page Medi-Cal Provider Manual, which is periodically updated by Medi-Cal Bulletins.

A Medi-Cal beneficiary presents his or her Medi-Cal card to the provider to prove eligibility. The provider then treats the beneficiary, and submits a claim directly to DHS. DHS then makes a payment to that provider based on the service he or she lists on the Medi-Cal claim form. The provider accepts that payment subject to later audit by DHS.

The following undisputed summary of the audit process was also provided by the requester.[16]

To make a claim for services rendered to a Medi-Cal beneficiary, the physician selects a code number (from the California Relative Value Studies ("RVS Codes")) which properly describes the medical service rendered to the patient. The physician then submits the claim form with the code number and is paid by DHS according to that code number.

The modern title for the RVS Codes is the California Standard Nomenclature ("CSN"). Section 51503, subdivision (b), of Title 22 of the California Administrative Code ("CAC") incorporates by reference "the '1969 California Relative Value Studies,' fifth edition, published by the California Medical Association." (Emphasis added.)

Audits are conducted as follows. After selecting a physician for audit, DHS sends an audit team, generally composed of a physician, a nurse, and an analyst, into the physician's office to review the charts of Medi-Cal patients who were treated over a specified period of time. The audit team reviews the patients' charts and makes a determination concerning whether the information contained in each chart is sufficient to explain the provider's claims for that patient. The reviewer can either decide that a physician claimed too much, or that the service was billed properly. The audit team conducts an exit interview with the physician and issues an audit report with its findings. If the audit team concludes that the physician owes money to the state, the physician has the option of contesting this finding in an adjudicative hearing held before an administrative law judge employed by DHS.

In May 1985, UAPD asked DHS for its "written guidelines for the proper written documentation required in providers[']progress notes or records for the following procedure numbers:

Procedure number[s] 90050, 90060, 90070 and 90080."

DHS responded, presuming that the request "pertain[ed] to Medi-Cal documentation requirements," by sending

"the following Medi-Cal program guidelines:

1. Section 51476 of the California Administrative Code, Title 22, addresses the requirement to keep and maintain records which fully disclose the type and extent of service.

2. Medi-Cal Bulletin, dated July 1978, defines the criteria for office visit levels of service.

3. Medical [sic] Provider Manual, pages 3-77 through 3-80 provides specific guidelines for the documentation of physician office visits.

4. Medical Bulletin [Medi-Cal Update], dated May 1983 provides updated guidelines for documentation of physician office visits." [Emphasis added.]

In June 1985, in a second, separate letter, UAPD requested from DHS the "written criteria used by the Department for evaluating if a provider's progress notes satisfy the appropriateness and quality of medical services requirements." UAPD specifically requested the information in regard to RVS Codes 90050, 90060, 90070 and 90080. DHS responded once again by sending UAPD the "Medi-Cal Bulletin . . . dated July, 1978" (the same Bulletin listed above in number 2); and "Medi-Cal Update, Medical Services Bulletin No. 66, dated May 1983" (the same Bulletin listed above in number 4). DHS concluded the letter by stating "These are the only two written criteria available and are the ones used by the Department." (Emphasis added.)

In December 1986, UAPD filed a Request for Regulatory Determination with OAL concerning the two above noted bulletins, certain pages from the Medi-Cal Provider Manual, and the statistical sampling technique used by DHS when conducting audits of Medi-Cal physician providers.

II. CHALLENGED RULES

Before beginning the discussion of dispositive issues, it is important that the challenged rules are clearly identified. There are four rules that are the subject of this determination:

Challenged Rule 1

"Medi-Cal Bulletin" dated July 1978, (No. 86B (Professional), No. 103B (Institutional)), published by Medi-Cal Intermediary Operations ("MIO"). In 1978, providers submitted their payment claims for services rendered to Medi-Cal beneficiaries to MIO, the "fiscal intermediary." MIO was subsequently replaced as fiscal intermediary by Computer Sciences Corporation.

Challenged Rule 2

"Medi-Cal Update" dated May 1983, Medical Services Bulletin No. 66, published and issued by Computer Sciences Corporation ("CSC") in cooperation with DHS. These Bulletins are provided as part of the updating service for the Medi-Cal Provider Manual also published by CSC, pursuant to a contract with DHS.

Challenged Rule 3

Pages 3-77 through 3-80 of the Medi-Cal Provider Manual for medical services,[17] published by CSC in cooperation with DHS.

Challenged Rule 4

A probability sampling and statistical extrapolation method used by DHS for determining overpayment when auditing physicians.

III. DISCUSSION OF DISPOSITIVE ISSUES

There are two main issues before us:[18]

(1) WHETHER THE CHALLENGED RULES ARE REGULATIONS WITHIN THE MEANING OF THE KEY PROVISION OF GOVERNMENT CODE SECTION 11342.

(2) WHETHER THE CHALLENGED RULES FALL WITHIN ANY ESTABLISHED EXCEPTION TO APA REQUIREMENTS.

FIRST, WE INQUIRE WHETHER THE CHALLENGED RULES ARE "REGULATIONS" WITHIN THE MEANING OF THE KEY PROVISION OF GOVERNMENT CODE SECTION 11342.

In pertinent part, Government Code section 11342, subdivision (b) defines "regulation" as:

> ". . . every rule, regulation, order or standard of general application or the amendment, supplement or revision of any such rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure . . . ." [Emphasis added.]

Government Code section 11347.5, authorizing OAL to determine whether or not agency rules are "regulations," provides in part:

> "No state agency shall issue, utilize, enforce or attempt to enforce any guideline, criterion, bulletin, manual, instruction [or] . . . standard of general application . . . which is a regulation as defined in subdivision (b) of section 11342, unless the guideline, criterion, bulletin, manual, instruction [or] . . . standard of application . . . has been adopted as a regulation and filed with the Secretary of State pursuant to this

chapter . . . ." [Emphasis added.]

Applying the definition of "regulation" found in Government Code section 11342, subdivision (b) involves a two-part inquiry:

First, is the informal rule either

- a rule or standard of general application or
- a modification or supplement to such a rule?

Second, does the informal rule either

- implement, interpret, or make specific the law enforced or administered by the agency or
- govern the agency's procedure?

Analysis of the Challenged Rules

CHALLENGED RULE 1: THE 1978 MEDI-CAL BULLETIN

Medi-Cal covers several alternative services physicians may provide to returning patients. These services, with assigned billing codes, include:

"90050 Limited examination, evaluation and/or treatment, same or new illness

90060 Intermediate examination, evaluation and/or treatment, same or new illness"

What do the terms "limited" and "intermediate" mean? How does a physician know which code to enter on the claim form?

The RVS provides (among others) two definitions:

"LIMITED EXAMINATION, EVALUATION OR TREATMENT: One which may include a brief or interval history, examination, discussion of findings and/or rendering of service."

"INTERMEDIATE HISTORY AND PHYSICAL EXAMINATION: A complete history and physical examination of one or more organ systems, but not requiring a comprehensive evaluation of the patient as a whole."

The "1978 MEDI-CAL BULLETIN" forthrightly announces its purpose:

> "The Department of Health [now known as DHS] has requested publication of the following definitions to supplement information in the CMA Relative Value Studies and to help clarify billing guidelines for physician and podiatrist services provided to Medi-Cal beneficiaries. These definitions . . . apply to billings submitted directly to the Medi-Cal Program both by these providers and by hospitals, hospital outpatient departments and organized outpatient clinics." [Emphasis added.]

Basically, the 1978 Bulletin supplements the formally adopted RVS code descriptions by defining six recognized levels of service[19] that the physician must use in categorizing and coding the services he or she renders to Medi-Cal patients. After each definition, the Bulletin lists examples of conditions, diagnoses, treatments, etc. that are to be coded as that defined level of service.

The Bulletin supplements the duly-adopted RVS codes with provisions such as:

> "LIMITED LEVEL OF SERVICE: A level of service pertaining to the evaluation of a circumscribed acute illness or to the periodic re-evaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings and/or medical management.
>
> For example:
>
> a. Treatment of an acute respiratory infection.
>
> b. Review of interval history, physical status and control of a diabetic patient.
>
> c. Review of hospital course, studies, orders and chest examination of patient with rheumatic heart disease recovering from acute congestive failure; revision of orders and limited exchange with nursing staff.
>
> d. Review of interval history, physical status and adjustment of medication in patient with compensated arteriosclerotic heart disease on chronic diuretic therapy.

e. Review of mental status findings, limited team conference (exchange with nursing and ancillary personnel), and revision of medical management orders on a patient with a toxic psychosis.

f. Review of recent history, determination of blood pressure, auscultation of heart and lungs and adjustment of medication in essential hypertension." [Emphasis added.]

None of the emphasized language appears in the duly-adopted RVS. The Bulletin's general statements further define the types of treatment billable under code 90050. Example "a" clearly indicates that all physicians treating returning patients for acute respiratory infections are to bill for service 90050.

We conclude, therefore, that this 1978 MEDI-CAL BULLETIN IS A STANDARD OF GENERAL APPLICATION. It applies statewide to all physician and podiatrist providers as well as hospitals, etc., which provide services to Medi-Cal beneficiaries. This BULLETIN ALSO INTERPRETS OR MAKES SPECIFIC THE LAW ENFORCED BY DHS. As stated earlier, DHS is responsible for the administration of the Medi-Cal program. Part of that program is paying providers for services rendered. In its response letter,[20] DHS states that the 1978 Medi-Cal Bulletin is a "Medi-Cal program guideline" and that it "defines the criteria for office visit levels of service" as it "pertains to Medi-Cal documentation requirements." (Emphasis added.) The Medi-Cal Bulletin states "the following definitions . . . supplement information in the [RVS Codes] and . . . help clarify billing guidelines." (Emphasis added.)

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CHALLENGED RULE 2: THE 1983 MEDI-CAL BULLETIN

The 1983 Medi-Cal Update Bulletin was published by CSC as part of its update service for the Medi-Cal Provider Manual. This Bulletin further supplements the duly-adopted RVS Codes:

"Use of Physician Office Visit Codes and Documentation Requirements

[DHS] review of Medi-Cal provider records has shown that incorrect or inappropriate billing of physician office visits and consultations is due to billing higher RVS/CSN codes than the patient's medical needs indicate or that documentation supports. For example, the program's coverage for return office visits is

> ordinarily limited to RVS/CSN 90050 or less, depending on the length of the visit and the need for a physician to be present. Higher RVS/CSN coded visits are covered only when there has been a substantial change in the patient's condition, or a substantial new illness, or when other circumstances clearly require extensive re-evaluation of the patient's condition. . . . [Par.][I]t is essential that providers are aware of the correct billing codes and documentation requirements." [Emphasis in original.]

Included with challenged rule 2 (the 1983 Medi-Cal Update Bulletin) were pages 3-77 through 3-80 of the Medi-Cal Provider Manual for medical services (challenged rule 3). The Medi-Cal Update explains that these pages are

> "[t]o assist providers in designating the correct billing codes for physician services . . . and are intended to supplement the definitions in the [RVS/CSN Codes]. These definitions are being republished and were previously sent to providers in a Medi-Cal bulletin dated July 1978 [the other Bulletin which is at issue in this Determination]." [Emphasis added.]

The 1983 Update continues:

> "where it has been determined by [DHS] that claims for services are not substantiated or are unnecessary, DHS may initiate one or more of the following administrative actions:
>
> Recovery of Overpayments [cite omitted]
>
> Special Claims Review [cite omitted]
>
> Prior Authorization [cite omitted]
>
> Suspension from the Program [cite omitted]."
>
> [Emphasis added.]

Clearly, as was the case with the 1978 Medi-Cal Bulletin discussed above, the 1983 Medi-Cal Update Bulletin is a standard of general application used by DHS to interpret regulations concerning the Medi-Cal program.[21]

Analysis of Agency Position

DHS advances several lengthy arguments to support the proposition that challenged rules 1 and 2 (the 1978 and 1983

Bulletins) are not "regulations" as defined in Government Code 11342, subdivision (b).

* * * * *

Argument Number 1--Concerning Challenged Rules 1 and 2

DHS argues that the Bulletins are "merely advisory" and therefore "do not have the force and effect of law."[22] A similar argument was made by the Board of Equalization concerning its Letter No. 85/128 issued to County Assessors. The Board argued that Letter No. 85/128 "was exempt from APA requirements because it is simply a non-binding piece of good advice to assessors."[23] OAL found that the Board of Equalization Letter was designed to neutralize a regulatory provision and appeared to be legally binding.[24]

We similarly reject DHS' argument that challenged rules 1 and 2 are "merely advisory." Both the 1978 and 1983 Medi-Cal Bulletins state that the definitions are intended to supplement information in the RVS Codes (which are officially incorporated by reference in title 22, CAC, section 51503), to help clarify billing guidelines, and they apply to billings submitted directly to the Medi-Cal program. The 1983 Medi-Cal Update ominously states that if DHS determines "that claims for services are not substantiated or are unnecessary," then DHS may initiate one or more of specified "adverse consequences." In its response, DHS admits that the "information [definitions] contained in these documents [Bulletins] is ultimately applied by the audit team physician in a case-by-case review of each provider."[25] (Emphasis added.) DHS also agrees that not following the proper billing codes, i.e., submitting claims for services not substantiated or unnecessary, could result in certain "adverse consequences."[26]

We conclude, therefore, that the Bulletins implement or interpret statutory or regulatory law, that they are standards of general application, and that they have the appearance of being binding. Even if we were to assume that the DHS Bulletins were "merely advisory," Government Code section 11347.5 makes clear that an underground regulation need not be "enforced" in order to violate the statute; an underground regulation which is merely "issued" or "utilized" also violates the statute. Had the Legislature intended to grant DHS special authorization to issue "advisory" standards, it could have provided DHS with that specific statutory authority.[27]

* * * * *

Argument Number 2--Concerning Challenged Rules 1 and 2

Citing no authority, DHS claims that the "examples" listed in the Bulletins are, "by common definition," merely illustrations of a rule which do not create a new rule.

Apparently it is the Department's position that the examples offered in the Bulletins do not have the effect of interpreting or making specific the laws enforced by the Department. This conclusion is incorrect. The examples provide illustrations of what we will presume is the correct classification of specific medical procedures within a hierarchy of several levels of physician-provided services. Standing alone, without examples, the definitions of these levels of service are insufficient for affected persons to conclusively determine the correct classification of all medical services provided by physicians. Challenged rules 1 and 2 both unequivocally state that the additional definitions they provide not only illustrate, but supplement other definitions, which were adopted in compliance with APA procedures. By supplementing an existing regulation with definitions which provide greater specificity and which interpret the existing rule, DHS has unlawfully issued "underground regulations."

* * * * *

Argument Number 3--Concerning Challenged Rules 1 and 2

DHS argues that the Bulletins are not standards of general application because they are applied by the audit team on a case-by-case basis. In support of this position, DHS (1) states that courts have long recognized that an agency may administer a program solely through case-by-case evaluation or review[28] and (2) further asserts that three California cases have endorsed the principle that an agency is free to administer by individual order rather than by general rule. Of the three cases DHS cites as purportedly endorsing this "tenet of administrative law," only one makes any true mention of this principle. In California Optometric Association v. Lackner[29] the court cites California Association of Nursing Homes v. Williams[30] for the principle that "Administrative agencies have wide latitude in fashioning procedures for the pursuit of their inquiries." However, California Association of Nursing Homes continues: "Procedural elasticity cannot be stretched into disregard of the law's [APA's] public hearing demand."[31]