EXHIBIT A

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(916) 255-0904 Voice
(916) 255-2490 Fax
mclark@dmhc.ca.gov e-mail
www.hmohelp.ca.gov

May 14, 2008

Patient:
DMHC#: 400272 - IMR01
Health Plan: Anthem Blue Cross of California

WRITTEN DECISION ADOPTING DETERMINATION OF INDEPENDENT MEDICAL REVIEW ORGANIZATION

Type:	Medical Necessity
Medical Condition:	Autism
Disputed Treatment:	Applied Behavioral Analysis
IMRO Determination:	Overturned Decision of Health Plan

Thank you for submitting your Application for Independent Medical Review to the HMO Help Center at the Department of Managed Health Care. The Department regulates HMOs and other health plans in California.

Your request for authorization and coverage for continued ABA therapy for your son was referred to the Department's Independent Medical Review organization, where independent medical providers resolve disputes about health care services.

In your son's case, the independent provider determined that the service you requested is medically necessary. This decision overturns the original denial by Anthem Blue Cross of California\Individual Plan. The service must be authorized within five working days.

If you encounter problems or delays in obtaining this service, please contact me immediately at (916) 255-0904. You may also visit our website at www.hmohelp.ca.gov. Our website has additional information regarding the Department and patients' rights in California.

Marlette Clark
IMR Compliance Manager
HMO Help Center

cc: Anthem Blue Cross of California

MAXIMUS Center For Health Dispute Resolution 3130 Kilgore Road, Suite 100
Rancho Cordova, CA 95670
Tel: [916] 364-8146 • Fax: [916] 364-8134

May 14, 2008

Summary: The Center for Health Dispute Resolution (CHDR) has determined that the requested therapy is medically necessary for treatment of the enrollee's medical condition. Therefore, CHDR has decided that Anthem Blue Cross of California's denial of the requested therapy should be Overturned.

Enrollee Name:
Patient Name
Health Plan: Anthem Blue Cross of California
DMHC Case File #: 400272
Dates of Service: Pre-Service

Deai

You filed an Independent Medical Review request with the California Department of Managed Health Care. The Department assigned your Independent Medical Review to us, the Center for Health Dispute Resolution (also called CHDR).

We, CHDR, are under contract with the Department to make "independent medical review" decisions in appeals such as yours. This means we employ qualified doctors and other health care professionals who study the enrollee's case file and medical records to decide if the care you requested is or is not medically necessary. CHDR is part of a company called MAXIMUS, Inc. MAXIMUS, CHDR, and all of our reviewers are impartial and independent. We are paid for this work by the California Department of Managed Health Care, not by health plans.

Summary of Our Decision:

The parent of a four-year-old male enrollee has requested authorization and coverage for continued ABA therapy. The Health Plan has denied this request indicating that the requested therapy is not medically necessary for treatment of the enrollee's autism.

One physician reviewer performed a medical necessity Independent Medical Review. The physician reviewer overturned the Health Plan's denial on the basis that the requested therapy is medically necessary.

CHDR's physician reviewer examined all of the medical records and documentation submitted, and has carefully considered all of the arguments submitted by you, the enrollee's providers, and the Health Plan.

Physician Reviewer Qualifications:

CHDR's decision was made by an independent physician who has no affiliation with Anthem Blue Cross of California. CHDR's physician reviewer is actively practicing and is board certified in neurology, child neurology and pediatrics.

Attached to this letter you will find CHDR's physician reviewer's report.

Appeal of CHDR's Decision:

You cannot appeal this decision. The Department of Managed Health Care does not accept appeals of a CHDR decision. The decision of CHDR is final.

Explanation of CHDR's Services:

Please be aware that CHDR is providing an independent review service. CHDR is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care are the sole responsibility of the patient and that patient's physician. CHDR is not liable for any consequences arising from these decisions.

Sincerely,
The Center for Health Dispute Resolution

Thomas Naughton
California Independent Medical Review Project

CC: State of California Department of Managed Health Care

Anthem Blue Cross of California

TN/hf

THE CENTER FOR HEALTH DISPUTE RESOLUTION
CALIFORNIA MEDICAL PROFESSIONAL REVIEWER REPORT

Biography:

I am board certified in pediatrics, psychiatry and neurology, and I am actively practicing. I am knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of the treatment under review. In addition, I hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the treatment under review. I have no history of disciplinary action or sanctions against my license.

Adequacy of Medical Records and Clinical Information:

Medical Records and Other Clinical Records for Review

1. Enrollee medical records dated 1/27/05 through 2/04/08.
2. Letter from . MD dated 10/03/06.
3. Letter from , MD dated 2/07/07.
4. Letter from , MD, MSc, FRCPC dated 12/07/06.

Reviewer Assessment of Records

I find the medical records and other clinical information legible and absent any relevant deficiency.

Summary Review Determination:

The parent of a four-year-old male enrollee has requested authorization and coverage for continued ABA therapy. The Health Plan has denied this request indicating that the requested therapy is not medically necessary for treatment of the enrollee's autism.

A review of the record indicates that the enrollee has been diagnosed with autism, moderate receptive and severe expressive language disorder and oral and verbal apraxia. The provider reports that it is medically necessary for the enrollee to have in-home ABA therapy. The provider reports that after the diagnosis of autism was made, the enrollee made improvements with his communication skills, development and functioning. On 2/04/08, the progress notes indicate that the enrollee made year-to-year gains in his receptive language skills and maintained a moderately-delayed severity level. The provider noted that the enrollee has made tremendous progress with his articulation skills, but the verbal apraxia continues to present challenges.

The Health Plan indicates that the requested therapy is not a covered benefit because there is no coverage for mental health services that are provided by an unlicensed individual.

At issue in this case is whether the requested therapy is medically necessary for treatment of the enrollee's medical condition.

Alternative Service Offered by Plan

Not known at this time.

My Determination

I have determined that the requested therapy is medically necessary for treatment of the patient's medical condition. Therefore, the Health Plan's denial should be overturned.

Evidence for My Determination:

Evidence Submitted for Review

1. Department of Defense Report and Plan on Services to Military Dependent Children with Autism. 2007.

2. Health Plan Coverage Information.

Additional Evidence Cited by CHDR Reviewer

I have reviewed the submitted evidence and performed a search of the relevant medical literature. I have found the clinical evidence demonstrates the requested therapy is medically necessary.

1. Lovaas, O. I. Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 1987;55:3-9.

2. McEachin, J. J., Smith, T., & Lovaas, O. I. Long-term outcome for children with autism who received early intensive behavioral treatment. *Am J on Mental Retardation*, 1993;97(4):359-372.

3. Cohen, H., Amerine-Dickens, M., and Smith, T. Early Intensive Behavioral Treatment: Replication of the UCLA Model in a Community Setting. *J of Dev Pediatrics*, 2006;27 (2):145-155.

Summary of Relevant Patient Medical History and Current Condition:

The patient is a four-year-old male who has been diagnosed with autism. Significant improvement has occurred with various modalities of therapy, including applied behavioral analysis therapy (ABA). The patient's parent has requested authorization and coverage for continued ABA therapy. The Health Plan has denied this request, and this is the subject of the appeal.

Analysis and Findings:

ABA therapy has been shown to be efficacious in the treatment of autism and autism spectrum disorders. Improvements as a result of intensive early intervention with ABA therapy have been demonstrated in terms of measured IQ as well as in adaptive, social and communicative skills in comparison to control patients who did not have ABA treatment. These gains have been shown to be sustained over time, with documented follow-up of as long as 6 years in one follow-up study. Further, these findings have been replicated by other studies. In the case of the enrollee, progress with the ABA therapy has been documented with regard to his communication skills (particularly receptive language) and adaptive functional skills. There is no alternative treatment modality that would be as effective for the treatment of this patient. Based upon the information set forth above, I have determined the requested therapy is medically necessary for treatment of the patient's medical condition. The Health Plan's denial should be overturned.

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(916) 255-0904 Voice
(916) 255-2490 Fax
mclark@dmhc.ca.gov e-mail
www.hmohelp.ca.gov

June 11, 2008

Patient:
DMHC#: 399810 - IMR01
Health Plan: Anthem Blue Cross of California\Individual Plan

WRITTEN DECISION ADOPTING DETERMINATION OF INDEPENDENT MEDICAL REVIEW ORGANIZATION

Type: Medical Necessity
Medical Condition: Autism
Disputed Treatment: Applied Behavioral Analysis
IMRO Determination: Overturned Decision of Health Plan

Thank you for submitting your Application for Independent Medical Review to the HMO Help Center at the Department of Managed Health Care. The Department regulates HMOs and other health plans in California.

Your request for reimbursement for the Applied Behavioral Analysis your daughter received from September 1, 2007, through December 21, 2007, was referred to the Department's Independent Medical Review organization, where independent medical providers resolve disputes about health care services.

In your case, the independent provider determined that the service you requested was medically necessary. This decision overturns the original denial by Anthem Blue Cross of California\Individual Plan. Reimbursement must be authorized within five working days.

If you encounter problems or delays in obtaining this service, please contact me immediately at (916) 255-0904. You may also visit our website at www.hmohelp.ca.gov. Our website has additional information regarding the Department and patients' rights in California.

Marlette Clark
IMR Compliance Manager
HMO Help Center

cc: Anthem Blue Cross of California\Individual Plan

MAXIMUS Center For Health Dispute Resolution
3130 Kilgore Road, Suite 100
Rancho Cordova, CA 95670
Tel: [916] 364-8146 • Fax: [916] 364-8134

June 11, 2008

Summary: The Center for Health Dispute Resolution (CHDR) has determined that the services at issue were medically necessary for treatment of the enrollee's medical condition. Therefore, CHDR has decided that Anthem Blue Cross of California's denial of the services at issue should be Overturned.

Enrollee Name:
Patient Name:
Health Plan: Anthem Blue Cross of California
DMHC Case File #: 399810
Dates of Service: 9/01/07 through 12/21/07

Dear

You filed an Independent Medical Review request with the California Department of Managed Health Care. The Department assigned your Independent Medical Review to us, the Center for Health Dispute Resolution (also called CHDR).

We, CHDR, are under contract with the Department to make "independent medical review" decisions in appeals such as yours. This means we employ qualified doctors and other health care professionals who study the enrollee's case file and medical records to decide if the care you requested is or is not medically necessary. CHDR is part of a company called MAXIMUS, Inc. MAXIMUS, CHDR, and all of our reviewers are impartial and independent. We are paid for this work by the California Department of Managed Health Care, not by health plans.

Summary of Our Decision:

The parent of an eleven-year-old enrollee has requested reimbursement for Applied Behavioral Analysis (ABA). The Health Plan has denied this request indicating that the services at issue were not medically necessary for treatment of the enrollee's autism.

One physician reviewer performed a medical necessity Independent Medical Review. The physician reviewer overturned the Health Plan's denial on the basis that the services at issue were medically necessary.

CHDR's physician reviewer examined all of the medical records and documentation submitted, and has carefully considered all of the arguments submitted by you, the enrollee's providers, and the Health Plan.

Physician Reviewer Qualifications:

CHDR's decision was made by an independent physician who has no affiliation with Anthem Blue Cross of California. CHDR's physician reviewer is actively practicing and is board certified in pediatrics and neurology.

Attached to this letter you will find CHDR's physician reviewer's report.

Appeal of CHDR's Decision:

You cannot appeal this decision. The Department of Managed Health Care does not accept appeals of a CHDR decision. The decision of CHDR is final.

Explanation of CHDR's Services:

Please be aware that CHDR is providing an independent review service. CHDR is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care are the sole responsibility of the patient and that patient's physician. CHDR is not liable for any consequences arising from these decisions.

Sincerely,
The Center for Health Dispute Resolution

Thomas Naughton
California Independent Medical Review Project

CC: State of California Department of Managed Health Care

Anthem Blue Cross of California

THE CENTER FOR HEALTH DISPUTE RESOLUTION CALIFORNIA MEDICAL PROFESSIONAL REVIEWER REPORT

Biography:

I am board certified in pediatrics and neurology, and I am actively practicing. I have been in practice for over 20 years, and I am a Professor of Pediatrics and Neurology at an academic medical institution. I am knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review. In addition, I hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the treatment under review. I have no history of disciplinary action or sanctions against my license.

Adequacy of Medical Records and Clinical Information:

Medical Records and Other Clinical Records for Review

1. Enrollee medical records dated 2/20/07 through 5/20/08.
2. Letter from ɜr, MD dated 4/28/08.

Reviewer Assessment of Records

I find the medical records and other clinical information legible and absent any relevant deficiency.

Summary Review Determination:

The parent of an eleven-year-old female enrollee has requested reimbursement for Applied Behavioral Analysis (ABA). The Health Plan has denied this request indicating that the services at issue were not medically necessary for treatment of the enrollee's autism.

A review of the record indicates that the enrollee has been diagnosed with autism. The provider reports that the enrollee has been receiving in-home behavioral services, 6 hours per week. The provider reports that the program focuses on organizational skills, compliance, joint attention, increased expressive and receptive language, identifying emotion and feeling states and social and language reciprocity. The parent of the enrollee is seeking reimbursement for ABA services provided from 9/01/07 through 12/21/07.

The Health Plan indicates that the services at issue were not covered as the providers were not licensed. The Health Plan reports that the services at issue were not medically necessary.

At issue in this case is whether the services at issue were medically necessary for treatment of the enrollee's medical condition.

Alternative Service Offered by Plan

Not applicable.

My Determination

I have determined that the services at issue were medically necessary for treatment of the patient's medical condition. Therefore, the Health Plan's denial should be overturned.

Evidence For My Determination:

Evidence Submitted for Review

Health Plan Combined Evidence of Coverage and Disclosure Form.

Additional Evidence Cited by CHDR Reviewer

I have reviewed the submitted evidence and performed a search of the relevant medical literature. The following evidence supports my decision:

1. American Academy of Pediatrics Management of Children with autism spectrum disorders. Pediatrics, 2007;120;162-1182, [1164].

2. Campbell JM. Efficacy of behavioral intervention for reducing problem behavior in persons with autism: a quantitative synthesis of single subject research. Res Dev Disabil: 2003:24:120-138.

3. Cohen, H. Amentine-Dickens, Smith T. Early intensive behavioral treatment: replication of the UCLA model in a community setting. J Dev Behav Pediatr. 2006:27[2 suppl]:s143-s155.

4. Eldevik S. Elkeseth S. Jahr E. Smith T. Effects of low-intensity behavioral treatment for children with autism and mental retardation. J Autism Dev Disord. 2006;36:211-224.

Summary of Relevant Patient Medical History and Current Condition:

The patient is an 11-year-old female with a diagnosis of autism. She was referred for in home Applied Behavioral Analysis (ABA) therapy by her primary care physician. The patient has received intensive six-hour in home therapy that has been rendered by a therapist who is supervised by a licensed psychologist. Notes indicate that the psychologist met biweekly with the therapist to supervise the therapist and countersigned all the therapist's quarterly reports. These reports indicate significant improvement in communication and social skills in the patient.

Analysis and Findings:

The provision of ABA by a therapist who is closely supervised by a licensed psychologist is common practice and established as an effective and appropriate method of providing

ABA. In addition, ABA is an established accepted therapy for the treatment of autism. There is sufficient evidence to support its utility and effectiveness. Moreover, the patient's records clearly demonstrate marked improvement in the patient's communication and social skills. ABA is not considered experimental or an unproven therapeutic approach to the autistic child. It is strongly recommended as a standard care program by the Committee on Developmental Disabilities of the American Academy of Pediatrics. No standard therapy supplied in a school or office setting would be as beneficial as the therapy at issue in this case.

Therefore, I have determined that the services at issue were medically necessary for treatment of the patient's medical condition. The Health Plan's denial should be overturned.

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
916-255-0988 Phone
916-255-2285 Fax
lgage@dmhc.ca.gov
www.hmohelp.ca.gov

September 4, 2008

Patient:
DMHC#: 414200 - IMR01
Health Plan: Anthem Blue Cross of California\Individual Plan

WRITTEN DECISION ADOPTING DETERMINATION OF INDEPENDENT MEDICAL REVIEW ORGANIZATION

Type: Medical Necessity
Medical Condition: Autism
Disputed Treatment: Behavior Modification Therapy
IMRO Determination: Overturned Decision of Health Plan

Thank you for submitting your Application for Independent Medical Review to the HMO Help Center at the Department of Managed Health Care. The Department regulates HMOs and other health plans in California.

Your request for reimbursement and prospective coverage for behavior modification therapy to treat your son's autism was referred to the Department's Independent Medical Review organization, where independent medical providers resolve disputes about health care services.

In your son's case, the independent provider determined that the service you requested is medically necessary. This decision overturns the original denial by Anthem Blue Cross of California\Individual Plan. The service must be authorized within five working days.

If you encounter problems or delays in obtaining this service, please contact me immediately at 916-255-0988. You may also visit our website at www.hmohelp.ca.gov. Our website has additional information regarding the Department and patients' rights in California.

Lyn Gage, Manager
IMR and Clinical Review
HMO Help Center

cc: Anthem Blue Cross of California\Individual Plan

MAXIMUS Center For Health Dispute Resolution
11000 Olson Drive, Suite 200
Rancho Cordova, CA 95670
Tel: [916] 364-8146 • Fax: [916] 364-8134

September 3, 2008

Summary: The Center for Health Dispute Resolution (CHDR) has determined that the therapy at issue was and is medically necessary for treatment of the enrollee's medical condition. Therefore, CHDR has decided that Anthem Blue Cross of California's denial of the therapy at issue should be Overturned.

Enrollee Name:
Patient Name:
Health Plan: Anthem Blue Cross of California
DMHC Case File #: 414200
Dates of Service: Retrospective and Pre-Service

Dear

You filed an Independent Medical Review request with the California Department of Managed Health Care. The Department assigned your Independent Medical Review to us, the Center for Health Dispute Resolution (also called CHDR).

We, CHDR, are under contract with the Department to make "independent medical review" decisions in appeals such as yours. This means we employ qualified doctors and other health care professionals who study the enrollee's case file and medical records to decide if the care you requested is or is not medically necessary. CHDR is part of a company called MAXIMUS, Inc. MAXIMUS, CHDR, and all of our reviewers are impartial and independent. We are paid for this work by the California Department of Managed Health Care, not by health plans.

Summary of Our Decision:

The parent of an eight-year-old male enrollee has requested reimbursement and authorization and coverage for behavior modification therapy. The Health Plan has denied this request indicating that the therapy at issue was not and is not medically necessary for treatment of the enrollee's condition.

One physician reviewer performed a medical necessity Independent Medical Review. The physician reviewer overturned the Health Plan's denial on the basis that the therapy at issue was and is medically necessary.

CHDR's physician reviewer examined all of the medical records and documentation submitted, and has carefully considered all of the arguments submitted by you, the enrollee's providers, and the Health Plan.

Physician Reviewer Qualifications:

CHDR's decision was made by an independent physician who has no affiliation with Anthem Blue Cross of California. CHDR's physician reviewer is actively practicing and is board certified in pediatrics and neurology.

Attached to this letter you will find CHDR's physician reviewer's report.

Appeal of CHDR's Decision:

You cannot appeal this decision. The Department of Managed Health Care does not accept appeals of a CHDR decision. The decision of CHDR is final.

Explanation of CHDR's Services:

Please be aware that CHDR is providing an independent review service. CHDR is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care are the sole responsibility of the patient and that patient's physician. CHDR is not liable for any consequences arising from these decisions.

Sincerely,
The Center for Health Dispute Resolution

Thomas Naughton
California Independent Medical Review Project

CC: State of California Department of Managed Health Care

Anthem Blue Cross of California

TN/SB

THE CENTER FOR HEALTH DISPUTE RESOLUTION
CALIFORNIA MEDICAL PROFESSIONAL REVIEWER REPORT

Biography:

I am board certified in pediatrics and neurology, and I am actively practicing. I am licensed to practice in California. I have been in practice for over 20 years and am a Professor of Pediatrics and Neurology at an academic medical institution. I am knowledgeable in the treatment of the enrollee's medical condition, knowledgeable about the proposed treatment, and familiar with guidelines and protocols in the area of treatment under review. In addition, I hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the treatment under review. I have no history of disciplinary action or sanctions against my license.

Adequacy of Medical Records and Clinical Information:

Medical Records and Other Clinical Records for Review

1. Enrollee medical records dated 8/25/03 through 7/15/08.
2. Letters from the enrollee's father dated 7/14/08 and 8/17/08.
3. Letter from , PhD, BCBA and , MSW dated 11/15/06.

Reviewer Assessment of Records

I find the medical records and other clinical information legible and absent any relevant deficiency.

Summary Review Determination:

The parent of an eight-year-old male enrollee has requested reimbursement and authorization and coverage for behavior modification therapy. The Health Plan has denied this request indicating that the therapy at issue was not and is not medically necessary for treatment of the enrollee's condition.

A review of the record indicates that the enrollee has been receiving behavior modification therapy since July 2006. On 7/15/08, medical records indicate that the enrollee demonstrates maladaptive and stereotypic behaviors. These behaviors include noncompliance, aggression and tantrums. Stereotypic behaviors include verbal, vestibular, visual and oral motor stereotypy. On this same date, the provider's recommendations included mainstreaming to social activities a minimum of two times throughout his day at school and maintaining current behavioral interventions for maladaptive and stereotypic behaviors.

The Health Plan indicates that unlicensed individuals are providing the actual services and supervision. Therefore, the Health Plan states that since there are no benefits for services provided by unlicensed individuals, coverage is denied.

At issue in this case is whether the therapy at issue was and/or is medically necessary for treatment of the enrollee's medical condition. If yes, at issue is whether such medically necessary treatment is appropriately provided by licensed providers, providers that have a certificate from a professional organization and/or individuals who are supervised by a licensed or certified provider.

Alternative Service Offered by Plan

Not applicable.

My Determination

I have determined that the therapy at issue was and is medically necessary for treatment of the patient's medical condition. Therefore, the Health Plan's denial should be overturned.

Evidence for My Determination:

Evidence Submitted for Review

1. Health Plan Combined Evidence of Coverage and Disclosure Form.

2. Health Plan Behavioral Health Medical Necessity Criteria.

Additional Evidence Cited by CHDR Reviewer

I have reviewed the submitted evidence and performed a search of the relevant medical literature. The following evidence supports my decision:

1. Lovass, O. Behavioral treatment and normal educational and intellectual functioning in young autistic children. *J Consult and Clin Psych*, 1987;55:3-9.

2. McEachin, J., et al. Long-term outcome for children with autism who received early intensive behavioral treatment. *Am J on Ment Retard*, 1993;97:359-372.

Summary of Relevant Patient Medical History and Current Condition:

The patient is an eight-year-old male who was diagnosed with autism on 8/26/03. The patient's child neurologist recommended behavioral modification, speech and occupational therapies. Ten hours per week of applied behavioral analysis and eight hours per month of parental instruction have also been recommended by the Center for Autism and Related Disorders, Inc. On 7/15/08, the medical notes indicate improvement

in verbal skills, ability to follow directions and social skills over two years of ongoing therapy. Measurable goals are targeted within specific time frames in 2008 and 2009. The clinical director for Center for Autism and Related Disorders, Inc. is board certified as a clinical psychologist and is licensed as a psychologist in California. The administrator is licensed by the state of California as a social worker. Presumably, the actual ABA in home therapists are in training to be psychologists or family therapists or interns gathering the 1000 hours of supervised therapy to be able to be licensed in California. The Health Plan has denied coverage for behavior modification therapy, and the patient is appealing this denial.

Analysis and Findings:

The medical literature confirms the success of ABA, both after several years of therapy and after long-term follow-up. In this instance, therapy is being supervised by qualified and licensed psychologists and social workers. The utilization of trainees in the medical arts has a long tradition of encouraging and depending on unlicensed personnel. Medical students and interns are supervised, but practice unlicensed medicine. Post-graduate psychologists and family therapists all need to spend three years of supervised clinical practice to be able to sit for the licensing examination. Thus, supervised therapy by a licensed therapist is licensed therapy by proxy. Based upon the information set forth above, I have determined the therapy at issue was and is medically necessary for treatment of the patient's medical condition. The Health Plan's denial should be overturned.

EXHIBIT B

1415 L STREET
SUITE 850
SACRAMENTO, CA 95814

916.552.2910 P
916.443.1037 F
CALHEALTHPLANS.ORG

June 18, 2008

Lucinda Ehnes, Director
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, California 95814

Via Email: cehnes@dmhc.ca.gov

Dear Ms. Ehnes:

The California Association of Health Plans recognizes and supports the importance of early childhood screening, diagnosis and treatment for Autism Spectrum Disorder (ASD). California's health plans take seriously our commitment to cover medical interventions for ASD, and our role among all of the jurisdictions that have a shared responsibility for offering services and treatments to children with autism and their families.

We recognize the critical need to effectively coordinate our responsibilities with the regional centers, schools and in-home treatment programs which provide children and their families with valuable services, including educational, custodial and social services. However, private health insurance has not and should not bear the sole responsibility of financing and providing all of these services.

As the California Legislative Blue Ribbon Commission on Autism notes, there are no guidelines about who has responsibility for providing the various services and support that children with autism appropriately require. This lack of clarity is a serious public policy issue which requires a thoughtful discussion among all of the parties involved.

However, this lack of clarity surfaces at the DMHC when questions of health insurance responsibility are sent to the Department's Independent Medical Review (IMR) process. In particular, this confusion over coverage responsibilities is most apparent in the IMR decisions about a plan's obligation to cover Applied Behavior Analysis (ABA) therapy. These IMR decisions are evenly divided.

Even though ABA may well offer significant benefits to many autistic children, ABA therapy generally is an educational program that focuses on behavioral changes. For this reason, plans appropriately exclude this therapy from coverage for medically necessary care under the standard definitions of health plan services.

Furthermore, we are concerned that the Department's use of the IMR process for questions of "coverage," rather than "medical necessity," jeopardizes the integrity of the IMR process. This is an important distinction, which the courts have ratified in prior instances where potentially beneficial services are sought, but which are excluded from the scope of services for which private health insurance is responsible.

Shifting significantly more responsibility for non-medical ASD services to private health insurance will have a substantial impact on the cost and availability of coverage. Health plans provide a range of treatment services, as appropriate, in the treatment of members with ASD. Examples include skilled rehab treatment, physical therapy, occupational therapy, and combinations of these treatments. However, the educational and social services not covered by medical benefit plans are very costly. On a preliminary basis, we estimate that expanded coverage would cost the industry between $250 million and $1 billion annually, a range which on its own should be reason to proceed thoughtfully in this discussion. Previous studies by the University of California Office of the President have estimated that cost increases of this magnitude leads to California employers and residents dropping coverage.

We are concerned that the DMHC is heading down a path that will lead to coverage mandates for non-medical services, educational support, social services or services that are not medical in nature. In turn, you could establish a precedent for mandates of such services for other developmental or medical conditions, only worsening many of the same issues we are raising with regard to autism.

We urge caution. A deliberative public policy process, inclusive of all stakeholders, is vital to sorting out the proper roles for the different jurisdictions providing services and coverage for persons with autism and analyzing the costs of care to support children with autism.

We note that SB 1563, which is currently pending in the Assembly, directs the Department, in coordination with the Department of Insurance, to consider the pending best practice recommendations from the Department of Developmental Services (DDS) and then develop coverage guidelines for health plans and insurers. We further note that the health plan industry has been actively engaged in offering amendments to SB 1563 in hopes that the process envisioned by the legislation will be thorough and inclusive.

Sincerely yours,

Christopher C. Ohman
President and CEO

cc: Kim Belshe, Secretary, Health and Human Services Agency
Dale Bonner, Secretary, Business, Transportation and Housing Agency
CAHP Board of Directors
The Honorable Darrell Steinberg
The Honorable Don Perata

EXHIBIT C

Kaiser Foundation Health Plan, Inc.
Health Plan Regulatory Services California Regions

Transmitted via E-mail

November 15, 2008

Mr. Kevin Donohue
Assistant Chief Counsel, HMO Help Center
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

Dear Kevin,

This letter is in response to your November 5, 2008 email to Victor Sipos and me, referencing the October 27th presentation we made to the Department of Managed Health Care (the Department) about the Plan's delivery of health care for members with Autism Spectrum Disorder (ASD). In that email you stated that "it was apparent from the Plan's autism presentation that it currently relies on the Regional Centers for the delivery of care to its members with autism and that it currently does not have an adequate network to timely provide the medically necessary services for its members with autism." Kaiser Permanente is committed to providing high quality care to our members, including our members with ASD. We do not agree with your assertion and we would like to clarify the Department's interpretation.

1. Regional Centers. The Plan's licensed health care providers, including physicians, provide, and the Plan covers, medically necessary health care services to our members with ASD. This is the Plan's obligation, regardless of whether the Regional Centers or anyone else pays for or provides or could provide the same services. Because members with ASD may also need services besides health care services, we provide parents with information about those services and we collaborate with the providers of those services. We described to you the health care services we cover in the fields of speech therapy, occupational therapy and behavioral health. Neither the Plan nor its providers rely upon Regional Centers for the delivery of medically necessary health care to our members with ASD.

As a health care service plan licensed under the Knox Keene Act, the Plan is required to "...arrange for the provision of health care services to subscribers and enrollees, or to pay for or reimburse any part of the cost for those services..."(California Health and Safety Code Section 1345 f(2)). Therefore, we do not arrange for or pay for or reimburse for services which are not health care services.

Mailing Address
P.O. Box 12983
Oakland, California 94604-2983

As we discussed during our presentation, members with ASD may need varying types of special or unique education to acquire the skills and knowledge that members without ASD acquire from social interactions and in school. All children, including children with ASD, benefit from the acquisition of skills and knowledge -- members with ASD may need to be taught those skills and acquire that knowledge differently. We do not arrange for, pay for, or reimburse for the many teaching methods currently available to teach these members, including applied behavioral analysis and discrete trial training, or for other teaching methods offered by various providers.

The Department has expressed a view that the mental health parity statute in California requires health care service plans to cover all medically necessary service for ASD children, and that because there may be potential benefit from ABA, it is therefore medically necessary. As a result, the Department has forwarded to IMR requests for services that have not traditionally been viewed as health care services. In so doing, the Department has implicitly determined that these are covered services, but has not articulated clear standards for this determination. The Department's legal position is at odds with the legal analysis of the California Association of Health Plans and as we understand it, that of the Department of Insurance (CDI). In addition, the Department's view of the parity statute and its application of medical necessity to services which are not health care services has significant implications for the allocation of responsibility between health insurance and other sectors and ultimately for the affordability of health insurance in California since this interpretation could apply to a number of educational services for a range of developmental disabilities.

We believe that the law in this area needs clarification so that the implications are understood and the standards are clear. In furtherance of that goal, we believe that it would be valuable if the Department, CDI, representatives from health plans and insurers, the purchaser community, the school system, and the Regional Centers, including clinical autism providers, convened to discuss the allocation of responsibility for the services which may be necessary for children with developmental disabilities, including ASD. It is also important to have a definitive legal determination on the interpretation of the parity statute and on the definition of health care services as used throughout the Knox-Keene Act.

2. Adequate Network. As we described during our presentation, Kaiser Permanente is doing end-to-end assessments of our health care for ASD children, including determining whether we have the most effective allocation of provider resources. If we identify specific shortages of providers as part of our ongoing assessments, we will ensure that our contracted medical groups recruit in those areas, just as we would for providers treating medical conditions other than ASD. We would also like to reduce wait times for multidisciplinary assessments. As the number of children diagnosed with ASD grows, we will continue to assess the need for increased capacity as part of our continuous quality improvement efforts. In the same light, we will continue with

C01384

current efforts to enhance coordination within the Kaiser Permanente delivery system to better serve the growing population of members diagnosed with ASD.

At this time, we are not planning any substantial change in the type of care we provide to the ASD population. We will continue to provide medically necessary health care services, and as the science and medicine of health care for members with ASD evolves in the future, we will certainly make any necessary changes. However, because we are not expanding coverage into non-health care services or beyond current contractual obligations, we are not developing a business plan for such services. If there is a definitive legal determination that requires coverage of additional services, we will need to make certain adjustments in our network and set educational goals and measurement paradigms, as will other health care service plans and health insurers. This will have significant implications for the organization and delivery of health care services and the affordability of health coverage, adding a not-insignificant amount to the cost of health insurance premiums for all public and private purchasers.

3. IMR. We appreciate the opportunity offered in your letter to meet and discuss potential improvements to the IMR process. We are currently in the process of gathering information that will inform that discussion with specific examples of the Plan's concerns. We will provide you with some dates that will work for us to meet with you in Sacramento, hopefully before the end of the year.

Please contact us if you would like any further information.

Sincerely,

Lisa Koltun
Vice President
Health Plan Regulatory Services
Kaiser Permanente

cc: Cindy Ehnes, Department of Managed Health Care
Marcy Gallagher, Department of Managed Health Care
Bobbie Reagan, Department of Managed Health Care
Jerry Fleming, Kaiser Permanente
Bill Wehrle, Kaiser Permanente
Victor Sipos, Kaiser Permanente

EXHIBIT D

NOW STREAMING: "The View from the Bay"

ASSIGNMENT 7

Woman fights Kaiser on autism policy

Thursday, November 06, 2008

By Carolyn Johnson

FREMONT, CA (KGO) -- Many families with children who have autism face an ongoing struggle of how to get treatment for their kids once they are diagnosed. Behavioral therapy at the earliest possible age is widely accepted as the best course of treatment, but many insurance plans argue it is not medically necessary. Here is the story of a Fremont mother who took on the policy at Kaiser.

When Muhammed Almaliti was about 15 months old, his mom, Feda, noticed significant changes in his behavior.

"He lost eye contact, he wouldn't play anymore, he lost speech, and I just kept saying, something's wrong with my son," said Feda.

Story continues below

Advertisement

In fact, there was. Doctors diagnosed him with autism, but Feda says she soon learned Kaiser would not provide comprehensive treatment for her severely affected son.

"They just kept saying that, 'We don't give services to kids with autism.' And that's what really upset me is why kids with autism? Why don't they get services? Why do other kids get services and my kid doesn't?" said Feda.

"I think one of the biggest tragedies is the health plans are for-profit businesses (*see footnote). They make a lot of money, they collect premiums, these families pay premiums and they expect to get health insurance coverage," said Kristin Jacobson who represents the Alliance of California Autism Organizations and is the Autism Speaks Advocacy Chair for California. She says Kaiser is not alone in passing off responsibilities for treatment to school districts and regional centers.

"This is a medical condition. There's definitely an educational component that needs to be addressed by the school districts, but it's a medical condition," said Jacobson.

For two years Feda pushed Kaiser to provide treatment. Kaiser points it out it did give Muhammed more than 60 sessions of occupational therapy along with intensive feeding training and consultation with a pediatric psychiatrist. However, Feda says Kaiser twice discontinued the OT, once calling it educational.

"One thing that does come up is that every time you say, 'My child needs speech or my child needs occupational therapy,' they'll say, 'Well this is a behavioral problem, this is not a medical problem.' They say it's not medically necessary,'" said Feda.

"We have no argument that these have become standard treatments or standard services, the question remains are they medical services and should they be delivered under the rubric of a health insurance plan," said Dr. Sharon Levine, associate executive director of Kaiser Permanente. "Skill acquisition, whether it's play skills or academic skills, is not a health care service."

Regardless, Feda persisted and succeeded in getting speech therapy for Muhammed. It was eliminated though after four sessions, for what Kaiser called a "lack of progress."

"Which is absurd for a child this young and as effected as my child," said Feda. "If my child had cancer, they wouldn't say go get service somewhere else, they would treat the cancer. So why can't you treat my child's autism?"

"Attempting to return someone to the state that they were in before is a very different set of clinical situations than attempting to develop and acquire skills," said Dr. Levine.

Feda was frustrated she could not get recommendations or denials from Kaiser in writing.

"There's nothing you can do with that. You can't go to the Department of Managed

Health Care, you can't go to any other state agency that regulates insurance companies. There's nothing you can do. It stops right there," said Feda.

However, Feda figured out a way around it. She spent a week drafting a letter detailing two years of verbal denials from five different healthcare providers. Kaiser would have to respond to it in writing.

They did, but disagreed. Her grievance ultimately reached the Department of Managed Health Care and her son's case received an independent medical review or IMR. It is a legally binding decision, in this case, by a doctor board certified in pediatrics and neurology who wrote, "I have determined that the requested services are medically necessary for treatment of the patient's medical condition. Therefore, the health plan's denial should be overturned."

"I was so, so happy. It was just an amazing victory. It was a lot of hard work," said Feda.

The IMR noted: "All of the services being requested by the patient are now the standard recommendations for autistic children -- two hours occupational therapy, two hours speech therapy and 26 hours of ABA per week."

This is an example of ABA or applied behavior analysis. It is intensive one-on-one therapy to help children with autism learn basic skills, from communicating to playing with others; skills that typical children learn naturally. It is a treatment deemed medically necessary by the IMR.

Does this change things? Could this open the floodgates? Will this one decision make a difference or do you take these case by case by case? We posed those questions to Dr. Levine.

"IMR was intentionally set up to address individual, specific issues. We don't think that the issue of contract can be or should be or was intended to be resolved through the independent medical review process," said Dr. Levine.

Advocates like Jacobson are energized by the decision.

"With proper treatment, there is an enormous amount of evidence that

children make significant progress and can become much more fully functioning members of society," said Jacobson.

That is what Feda wants for her son and for all families struggling with autism.

"I hope that ultimately not everyone has to fight their own fight. I hope that it's just going to be a covered treatment for children with autism," said Feda.

Feda now runs an online help group for other families struggling to get the coverage they feel they deserve.

**Note: Kaiser is a not-for-profit entity.*

Part two of this story: No one wants to pay for autism treatments

Resources:

- Kaiser Permanente Comments on Autism
- California insurance help support group - to assist in getting coverage for treatment: click here
  To subscribe send an e-mail to ASDInsuranceHelp-subscribe@yahoogroups.com
- How to get involved to support insurance reform: www.autismvotes.org
- DMHC: www.hmohelp.ca.gov, or 1-888-HMO-2219; Bobbie Reagan (deputy director) 1-916-255-2405. (DMHC regulates about 80 percent of health plans covered by CA law, most HMOs and some PPOs (Blue Cross, Blue Shield)
- DOI: 1-800-927- Help (4357) (DOI regulates about 20% of health plans covered by CA law)
- Kaiser Support Group click here To subscribe send an e-mail to kaiserspectrumkids-subscribe@yahoogroups.com
- Autism Insurance Website www.insurancehelpforautism.com
- Chris Angelo's analysis and letter: click here
- Medicare usual and customary rates: click here
- Literature: click here
- e-mail a parent advocate, we are happy to try to answer your questions if we can:
  karenfes@sbcglobal.net
  kjacobson5@yahoo.com
  feda77@gmail.com

(Copyright ©2009 KGO-TV/DT. All Rights Reserved.)

EXHIBIT E

California
LOS ANGELES DAILY JOURNAL • THURSDAY, FEBRUARY 12, 2009 • PAGE 3

As War Escalates Over Autism Treatment, Parents Fire Volley

By Evan George
Daily Journal Staff Writer

LOS ANGELES — Disability rights advocates filed a statewide discrimination lawsuit against Kaiser Permanente and its medical group Wednesday, claiming the Oakland-based health plan must pay for medical services it routinely denies to autistic children.

The Berkeley-based legal aid group Disability Rights Advocates filed the case in Alameda County Superior Court on behalf of families with autistic children enrolled with Kaiser. The suit does not seek financial damages, but rather a judicial declaration that Kaiser must bear the cost of the treatments.

The civil rights class action is the latest push by parent advocates to make Kaiser, the country's largest nonprofit health plan, pay for costly autism therapies. Health plans have long held that intensive treatments for the disorder are educational in nature rather than medical, and thus better handled by schools rather than medical professionals.

The lawsuit comes at a crucial time in the war over who must pay for autism treatments. Parents in California have recently won a string of victories against Kaiser by requesting a second opinion, called an Independent Medical Review, from the state. Until now, that appeals process has been the only way to win contested treatments.

But as of last month state officials said they are considering changing the rules for who can appeal. They said the change is in response to a move by Kaiser to use new language that avoids the issue of "medical necessity" in its denial decisions.

Several plaintiffs in the new lawsuit said state regulators were caving to industry pressure, because overturned decisions cost the plans hundreds of thousands of dollars.

Sid Wolinsky, director of litigation for Disability Rights Advocates, said his group's lawsuit was needed in order to demand "systemic reform" from Kaiser.

"It is blatantly illegal to not cover autism, so [Kaiser] resorts to subterfuge and it has a variety of excuses and those excuses constantly shift," Wolinsky said.

A Kaiser spokesman drew a distinction between medical treatments and other services for autistic patients.

"It is important to understand that not every service an autistic child needs or receives is a health care service," spokesman Jim Anderson said. "Many are educational or social services that have not been, and should not be, part of a health care benefits plan. Many of these services have been, and are today, appropriately provided by schools and social service agencies."

Plaintiffs in the suit include parents like Lissa Anderson, who has sought intensive behavior therapies for her 5-year-old son, Alex. "No parent should have to go through this," Anderson said about the fight for therapy. "It's grueling, and it's horrifying to know your son is not getting the treatment that he needs."

Parents and the group Equal Care for Autism accuse Kaiser of a "multi-faceted, unlawful corporate policy calculated to avoid the cost of providing effective treatment to autistic children." Kaiser's policy of refusing to cover certain treatments harms thousands of families that pay premiums for coverage, the complaint contends, and violates the Unruh Civil Rights Act as well as the state's Unfair Competition Law.

Autism is a neurobiological disorder that is typically diagnosed in children as young as 1. Studies show that autism rates are rising, with one of every 150 children born in the United States now diagnosed with the disorder.

The most hotly contested cases center on one autism therapy in particular — a treatment called Applied Behavior Analysis, known as ABA, in which a trained specialist supervises a child more than 20 hours week in order to teach new behaviors.

Behavior therapy can cost families that pay out-of-pocket more than $5,000 per month. Health plans argue those costs would inflate premiums at a time when health costs are skyrocketing.

The plans frequently refused ABA because for years doctors considered it experimental.

But that position is beginning to differ from what is emerging as prevailing medical opinion. A growing number of research studies have found that behavioral therapies for autism disorders are standard and effective pediatric treatments. An October 2007 article in the Official Journal of the American Academy of Pediatrics said the effectiveness of ABA as a medical treatment was "well documented."

That shift in medical opinion has swung in favor of patients in the appeal process.

Since 2008, California has ordered more than a dozen reversals overturning Kaiser's policy that intensive autism treatments are not medically necessary. Those second opinion decisions are conducted by independent medical reviewers retained by the state's Department of Managed Health Care.

In 11 out of 12 cases in which ABA

therapy was sought last year, medical reviewers sided with patients that the treatment was "medically necessary."

Still, health care plans may soon have other means to deny the treatments and avoid appeals, by changing the legal language they use to justify coverage denials. Typically denials have said ABA therapy is "not medically necessary." Late last year that began to change. Kaiser has begun issuing denial letters contending behavior therapies are "not a health care service."

The difference matters because the denial is what triggers a state appeal. The shift means the cases could be decided as contractual disputes rather than medical decisions.

The Department of Managed Health Care last month quietly suspended 15 appeals over autism coverage. Officials said they were re-reviewing eligibility rules.

Several parents interviewed said their requests for independent medical reviews had been approved as far back as October but then were delayed without explanation. They complained that the rules for the crucial appeal process were being re-written under industry pressure.

After the Daily Journal asked questions about the suspended cases — more than half of which involved Kaiser enrollees — the department said it would allow those cases to go forward after all. But a spokeswoman said they could be the last of the cases to go to Independent Medical Reviews.

"We will be announcing some new guidelines or criteria in the coming weeks," Lynne Randolph, deputy director of communications for the Department of Managed Health care, said last month. "The department is going to be looking at the legal question of how coverage issues square with current state law, and provide additional clarification to patients and health plans because we do have a gray area now," she added.

Health law experts questioned why officials would reconsider the eligibility rules now, after issuing dozens of rulings in favor of patients.

"It is very peculiar to me why [the department] has changed direction in mid-stream ... after they've made a series of decisions," said Bryan Liang, executive director of the Institute of Health Law Studies at the California Western School of Law. Liang called the independent reviews a "pretty typical approach to determine whether something is covered or not."

Randolph said that all "issues of medical necessity" would continue being resolved through the appeal process.

Anderson, the mother who is a plaintiff in the new lawsuit, said she herself was awaiting an appeal that was suspended for months. "I'm on pins just waiting," she said.

---

evan_george@dailyjournal.com

EXHIBIT F

February 24, 2009

Ms. Cindy Ehnes
Director
California Department of Managed Health Care
980 9th Street, Suite 2450
Sacramento, CA 95814

Via U.S. Mail (Return Receipt Requested) and Facsimile

Re: DMHC Actions to Deny Medically Necessary Autism Treatment

Dear Ms. Ehnes:

Consumer Watchdog has become aware that the Department of Managed Health Care (DMHC) has recently undertaken certain actions, apparently in response to pressure from health plans on both the agency and the Governor's office, regarding autism benefits. A recent report in the *Los Angeles Daily Journal* suggests that, at the request of unspecified health plans, the DMHC temporarily suspended the processing of requests for Independent Medical Reviews from parents whose autistic children have been denied medically necessary treatment. The newspaper quotes a member of your staff to the effect that the DMHC is preparing to take additional actions, the apparent intent of which is to permit DMHC licensees – i.e., health plans, including HMOs and Preferred Provider Organizations (PPOs) – to deny coverage for medically necessary treatment to autistic children. We write on behalf of Consumer Watchdog to remind the DMHC of its responsibilities under California law and to inform the Department that should it attempt to abdicate those responsibilities, we will seek immediate judicial intervention.

Health Plans Must Provide Coverage for the Treatment of Autism on the Same Terms as Other Medical Conditions

In 1999, responding to widespread outrage over the refusal of health insurers to cover treatment for severe mental illnesses, including autism and other mental disorders, the California Legislature enacted the California Mental Health Parity Act (see Health & Safety Code § 1374.72(d)(7)), and the DMHC promulgated regulations thereunder (see Cal. Code Regs., tit. 28, § 1300.74.72). In that Act, the Legislature *mandated* that health plans and health insurers provide coverage for the diagnosis and medically necessary treatment of mental illnesses, including autism, to the same extent that they provide coverage for treatment of physical illnesses. (See Health & Safety Code § 1374.72(a) and (d).) Pursuant to Health and Safety Code section 1390, a violation of section 1374.72 (or any provision of the relevant chapter) and

any rule promulgated thereunder is punishable by a $10,000 fine and/or imprisonment for up to one year.

In enacting that statute, the Legislature specifically acknowledged that because "[t]he failure to provide adequate coverage for mental illnesses in private health insurance policies has resulted in significant increased expenditures for state and local governments," it was important to require health care plans to cover care and treatment for mental illnesses, including autism. (Section 1, Stats. 1999, c. 534 (A.B. 88).)

Section 1374.72, subdivision (a), requires health care service plans to provide coverage for the "medically necessary" treatment of autism. "Medical necessity" is determined by the "specific needs" of the member and "any of the following" factors: "peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service"; "nationally recognized professional standards"; "expert opinion"; "generally accepted standards of medical practice"; and "treatments [that] are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious." (See Health & Safety Code § 1374.33(b).) The law also requires health care service plans to "ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes." (Health & Safety Code § 1367.01(b); see also see also *id.*, subd. (f).)

Applied Behavioral Analysis is a form of behavioral therapy that has been scientifically determined to alter and improve brain functioning in children with autism.[1] It is considered a "standard treatment" for autism, based upon nationally recognized professional standards, and is proven in the medical literature to be effective. For example, the Journal of the American Academy of Pediatrics, in an article on Autism Spectrum Disorders,[2] states that behavioral interventions are the cornerstone of management of "Autism Spectrum Disorders" (ASD). The Journal concludes that the effectiveness of Applied Behavioral Analysis "has been well documented through five decades of research" and that children "who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups." The Centers for Disease Control and Prevention and the National Institute of Mental Health concur that psychosocial and behavioral interventions are key parts of comprehensive treatment programs for children with autism.[3] The most common interventions include Applied Behavioral Analysis; according to *Mental Health: A Report of the Surgeon General*, "thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior."[4]

---

[1] Behavioral therapy constitutes a "benefit" for purposes of Health & Safety Code § 1374.72(b).

[2] Myers, Johnson, "Clinical Report: Management of Children with Autism Spectrum Disorders," *Pediatrics* Vol. 120, No 5 (2007) pp.1162-1182 (http://www.pediatrics.org/cgi/content/full/120/5/1162, last visited February 23, 2009).

[3] Autism Information Center, Centers for Disease Control and Prevention (http://www.cdc.gov/ncbddd/autism/treatment.htm, last visited February 23, 2009); National Institute of Mental Health (http://www.nimh.nih.gov/health/publications/autism/complete-index.shtml, last visited February 23, 2009).

[4] Mental Health: A Report of the Surgeon General, Chapter 3 (http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec6.html#autism, last visited February 23, 2009).

Because Applied Behavioral Analysis is a "medically necessary" treatment for autism spectrum disorders – virtually all IMR rulings over the past year confirm that conclusion – all health care service plans in California must provide coverage for it to their enrollees.

Unfortunately, as DMHC is well aware, a number of plans are refusing to comply with the plain dictates of the law. Numerous suits are pending against health care service plans in California for failure to provide Applied Behavioral Analysis. (See, e.g., *Andrew Arce v. Kaiser Foundation Health Plan, Inc. et al.*, Los Angeles Superior Court Case No. BC 388689 and *Frank Nagle v. Kaiser Foundation Health Plan, Inc., et al.*, Los Angeles Superior Court Case No. BC 406272). A lawsuit filed on February 11, 2009 on behalf of parents and guardians of autistic children alleges that Kaiser and its physicians now systematically refuse to provide the treatment. In a practice that appears to have been adopted by many health care service plans, Kaiser has re-classified ABA treatment as "educational" in nature, and has referred patients to local schools and other taxpayer-supported programs. (See *Lissa Anderson. v. Kaiser Foundation Health Plan, Inc., et al.*, Alameda County Superior Court No. RG 09435560.)

Until recently, the DMHC has properly responded to patient complaints by ordering health care service plans to comply with IMR decisions and provide coverage for Applied Behavioral Analysis treatment for autistic children. However, it now appears that in response to intense pressure from the industry, the DMHC is preparing to reverse course.

The Department May Not Delay Processing Requests for An Independent Medical Review

Under California law, when a health care service plan or one of its contracting providers denies, delays, or modifies a covered medical treatment to one of its members on the basis that it is "not medically necessary," the member has the right to seek an Independent Medical Review (IMR). Pursuant to the process established by Heath & Safety Code section 1370.4 and Article 5.5 of Chapter 2.2 of Division 2 (§§ 1374.30 through 1374.36), members may file a request for an Independent Medical Review (IMR) with the DMHC, and the DMHC must act expeditiously. Regulations promulgated by the DMHC require the agency to determine whether to accept the request and advise the member as well as the health plan of its decision within seven days. The plan must then submit all of the relevant information to the Independent Medical Review organization within three days. (Cal. Code Regs., tit. 28, § 1300.74.30(i) and (j).)

According to a February 12, 2009 report in the *Los Angeles Daily Journal,* the DMHC suspended fifteen IMR requests last month – apparently including requests that the agency had approved as far back as October of last year – while Department officials "re-review eligibility rules."

Such delays jeopardize the health and safety of health care service plan members, which is why the regulations require the DMHC to act on requests within seven days. There is no lawful basis for the DMHC to delay processing IMR requests.

The Department May Not Excuse A Licensee from Providing "Medically Necessary" Care

DMHC spokesperson Lynn Randolph told the Daily Journal that DMHC "will be announcing some new guidelines or criteria in the coming weeks...The department is going to be looking at the legal question of how coverage issues square with current state law, and provide additional clarification to patients and health plans because we do have a gray area now."

To the contrary, there is no "gray area," the health care service plans' machinations notwithstanding. There are no exceptions to the legal requirement that the plans provide coverage for "medically necessary" treatment to autistic patients. Re-labeling the required medical treatments as "educational services" will not excuse the plans from their statutory responsibility. "Medically necessary" treatment must be provided, no matter what form it takes and no matter what the plans cynically attempt to call it.

Moreover, the DMHC has no authority to authorize a licensee to engage in such a subterfuge. In fact, the DMHC is obligated to *prevent* health care service plans from violating their members' legal rights. The DMHC's responsibilities begin with California Health & Safety Code section 1341. Pursuant to section 1341(a), the DMHC has a mandatory duty to execute "the laws of this state relating to health care service plans and the health care service plan business including, but not limited to, those laws directing the "department to ensure that health care service plans provide enrollees with access to quality health care services and protect and promote the interest of enrollees." The director of DMHC "shall be responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department." (*Id.*, subd. (c).)

It is your responsibility to enforce the laws of the state of California as written, and, to that end, to resist and reject pressure from the health care industry seeking to evade those laws. Millions of Californians, including those stricken by autism, and their parents and caregivers, expect no less of you and your staff. Should you fail to perform your duties in this regard, we intend to hold you accountable in the courts.

Sincerely,

Harvey Rosenfield

Pamela Pressley

cc: Governor Arnold Schwarzenegger
Dale Bonner, Secretary, Business, Transportation and Housing Agency

EXHIBIT G

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

March 9, 2009

TO: **Licensed Full Service Health Plans and Specialized Mental Health Care Service Plans**

FROM: **Richard D. Martin, Deputy Director**
Department of Managed Health Care

RE: **Improving Plan Performance to Address Autism Spectrum Disorders**

The Department of Managed Health Care (DMHC) is committed to ensuring that individuals with Autism Spectrum Disorders (ASD) receive the care they are entitled to under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and accompanying regulations. Last year, the DMHC conducted a series of workgroup meetings to gain information from participating stakeholders and individuals about the problems encountered in securing treatment for ASD. Since the ASD workgroup meetings concluded, the DMHC has been actively monitoring the performance and progress of health care service plans (health plans) in addressing areas of concern identified in those meetings.

Part A. Evaluation, Referral and Adequacy of Network for Persons with ASD.

Based on information received during the ASD workgroup meetings, the DMHC is directing health plans to significantly improve their performance in all of the following areas to ensure compliance with the Knox-Keene Act:

1) Plans must have adequate processes for the evaluation, screening, and diagnosis of patients for ASD in order to ensure these patients receive the right care at the right time. Specifically, the DMHC will be asking plans to:

    - Demonstrate, during the DMHC's routine medical survey, that their systems and processes support timely screening and diagnosis, paying particular attention to the DMHC's Mental Health Parity regulation, which requires:

        - Continuity and coordination of care consistent with professionally recognized, evidence-based standards of practice.

        - Collaboration between medical and mental health providers to ensure appropriate diagnosis, treatment and referral.

- Providing timely information to the Help Center's Complaint Division to assist in the resolution of complaints relating to timely screening and diagnostic services.

- Providing medical records in a timely manner for independent medical reviews (IMR) resulting from the plan's denial of service requests based on lack of medical necessity or experimental/investigational services.

- Timely responding to the DMHC's request to review systemic problems identified through the complaint and IMR systems.

2) Plans must assure that treatment plans are developed by qualified and licensed providers, and include information about available health care treatment options, which have been discussed with the health plan enrollee or parent.

   - During the routine medical survey, health plans will provide documentation showing that the plan promotes a standard of provider communication that adequately communicates its health care treatment recommendations to the health plan enrollee or member. The DMHC's survey team will conduct file reviews to timely confirm coordination between medical and mental health providers and adequate oversight of procedures to confirm that health care treatment goals have been established and communicated to the enrollee or parent.

   - On an ongoing basis, the Help Center will monitor the adequacy of treatment plans to address ASD based upon enrollee complaints.

3) Plans are required to coordinate covered services for the treatment of ASD among their various providers to help implement treatment plans.

   - The DMHC will confirm that the plan has established processes to facilitate timely communication, sharing of necessary information, and coordination of care between and among an enrollee's medical and mental health providers. The DMHC will query health plans about the mechanisms used to support coordination, such as case management, patient advocate liaisons, and contacts made with public agencies.

4) Plans must maintain an adequate network of doctors and other health care providers for carrying out these services.

   - The DMHC, through routine medical surveys and call center trends, will evaluate the number and geographic distribution of providers in the health plan's network.

Part B. Treatment for Persons with ASD.

Health plans must do the following:

1. Cover all basic health care services required under the Knox-Keene Act, including speech, physical, and occupational therapies for persons with ASD, when those health care services are medically necessary.

   - The DMHC will conduct a review of health plan disclosures to consumers, and will require revisions to the Evidence of Coverage and other applicable documents as necessary to comply with mental health parity laws.

2. Provide mental health services only through providers who are licensed or certified in accordance with applicable California law.

3. May not categorically exclude any particular health care treatment or therapy for Autism Spectrum Disorder.

The DMHC will do the following:

1. Continue to enforce existing law regarding the grievance and the IMR process.

   - Any disputes about services for the treatment of ASD patients will be processed the same as for other conditions.

   - The DMHC will initially make a determination whether the service being sought is a covered health care service. If that determination is made in the affirmative, then any claim that a service is either: (1) experimental or investigational; or, (2) is not medically necessary to treat the patient's condition, will be referred for IMR as required under California law.

2. Initiate the rulemaking process to formalize plan requirements and provide additional clarity through an open and public process.

Please feel free to contact DMHC Deputy Director for Communications Lynne Randolph at (916) 445-7442 should you need additional information.

EXHIBIT H

March 11, 2009

Ms. Cindy Ehnes
Director
California Department of Managed Health Care
980 9th Street, Suite 2450
Sacramento, CA 95814

Via U.S. Mail (Return Receipt Requested) and Facsimile

Re: March 9, 2009 Memo from DMHC to Health Plans re "Improving Plan Performance to Address Autism Spectrum Disorders" Is Illegal And Must Be Withdrawn

Dear Ms. Ehnes:

The March 9, 2009 memorandum from DMHC to health care service plans re "Improving Plan Performance to Address Autism Spectrum Disorders" is an unlawful "underground regulation" and must be withdrawn.

On February 24, 2009, we wrote you in response to reports in the news media that, after extensive lobbying behind closed doors, the DMHC was preparing to authorize health care service plans under its jurisdiction to refuse to pay for medically necessary treatment, in the form of applied behavioral therapies, required by those afflicted with Autistic Spectrum Disorders. According to the news reports, the plans sought DMHC approval to re-classify such medically required treatments as "educational" benefits that, the plans would then argue, are not "covered benefits" under the policies they issue. Such a policy change would allow the plans to evade the statutory requirement that doctors, not HMO bureaucrats, decide what treatment is medically necessary. We warned you that any action by the DMHC to authorize such a misapplication of California law would be a violation of the DMHC's statutory responsibilities.

We are in receipt of a memorandum, issued by the DMHC two days ago under the name of the Deputy Director, which adopts precisely the unlawful reinterpretation of state law advocated by the industry that we warned you against.

Moreover, the March 9 memorandum is itself unlawful. Government Code section 11340.5 prohibits state agencies from issuing any "guideline, criterion, bulletin, manual, instruction, order, [or] standard of general application..." to "implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure" (Gov. Code § 11342.600) unless it has been adopted through the formal rulemaking process. That process requires public notice, public hearings and a record that supports the agency's action. (Government Code § 11340 et seq.) As you should know, these statutory requirements are intended to prevent precisely the kind of arbitrary agency action at the behest of private industry that is reflected in the March 9 memorandum.

Indeed, the March 9 memorandum itself acknowledges that the policies it purports to adopt require a rulemaking. It states that "[t]he DMHC will do the following: ... Initiate the rulemaking process to formalize plan requirements and provide additional clarity through an open and public process." Yet the DMHC seeks to evade the statutory rulemaking process by attempting to authorize a change in the legal duties of its licensees through a three page memorandum that is devoid of any reasoning and that reflects only behind closed doors lobbying by the industry,[1] to the exclusion of the public.

The DMHC must immediately withdraw the March 9 memorandum. If it fails to do so, we will take legal action.

Sincerely,

Harvey Rosenfield

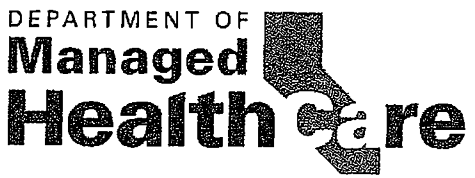
Pamela Pressley

cc: Governor Arnold Schwarzenegger
Dale Bonner, Secretary, Business, Transportation and Housing Agency

---

[1] We note that the DMHC has also failed to comply with our February 17, 2009 Public Records Act (PRA) request, in which we demanded that the agency provide us with copies of all communications between the industry and agency staff as well as calendars that would reveal private meetings between the industry and the agency. On February 27, the DMHC responded to our letter by requesting a fourteen-day extension to Friday, March 13, 2009. We expect your immediate compliance with Government Code section 6253.

EXHIBIT I



STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

March 23, 2009

Harvey Rosenfield
Pamela Pressley
Consumer Watchdog
1750 Ocean Park Boulevard, #200
Santa Monica, CA 90405-4938

Re: Your Letter Dated March 12, 2009

Dear Mr. Rosenfield and Ms. Pressley:

Thank you for your letter dated March 12, 2009, regarding the letter from the Department of Managed Health Care (DMHC) to health plans on the subject of "Improving Plan Performance to Address Autism Spectrum Disorder." I understand that you have significant concerns about our letter to health plans; however, as explained below I believe that your concerns may be misplaced.

Your letter indicates that the DMHC has made decisions based upon "closed door" meetings between the department and health plans. However, as mentioned in our March 9th letter, over a period of several months the DMHC held multiple meetings with all stakeholders including mental health advocates, interested legislative staff, and health plans in an attempt to understand the nature of the complex issues involved. These meetings led the DMHC to conclude that plans needed to be reminded of the requirements for the treatment of Autism Spectrum Disorder (ASD) that *currently* exist under California statutes and the DMHC's existing regulations.

Rather than being an "underground regulation" this letter was a reiteration of existing law. Our March 9th letter reminded plans of their duty to perform evaluation and screening of patients as is currently required under Health and Safety Code Section 1374.72 and the existing mental health parity regulation in title 28 of the California Code of Regulations Section 1300.74.72. Similarly, the letter mentioned the duty owed by plans to ensure that patients with ASD are treated through licensed providers as is required under the existing regulation and as is required for all other medical conditions. (See, title 28 of the California Code of Regulations Section 1300.74.72 (b).) As to other reminders included in our letter, surely there can be no doubt that various provisions of

the Knox-Keene Act and existing regulations require that health plans provide all basic health care services? (See, for example Health and Safety Code Section 1367 (i) as made more specific by title 28 of the California Code of Regulations Section 1300.67.) Similarly, other requirements specified in the letter are imposed by existing regulations that mandate continuity of care and accessibility of services. (See, title 28 of the California Code of Regulations Sections 1300.67.1 and 1300.67.2, respectively.) Finally, references to the grievance and independent medical review process are well supported in existing California statutes and regulations. (See, Health and Safety Code Sections 1368-1368.04, 1374.30-1374.35 and title 28 of the California Code of Regulations Sections 1300.68-1300.68.1 and 1300.74.30.)

Your letter cites various press reports, which predate the DMHC's March 9th letter, for the proposition that the DMHC would permit plans to refuse to pay for applied behavioral therapies. However, in our letter we stated that plans "[m]ay *not* categorically exclude any particular health care treatment or therapy for Autism Spectrum Disorder." Thus, covered health care benefits will be considered on a case-by-case basis and will not be categorically denied.

You have cited our letter's mention of a planned new rulemaking action as evidence that we believe that our letter must be promulgated as a regulation. However, that brief reference states only that the DMHC intends to draft a new regulation to make additional requirements that will clarify and make specific various legal mandates for the care of patients under the mental health parity statute.

Mr. Rosenfield and Ms. Pressley, I hope that this letter clarifies some of the misunderstandings about the DMHC's March 9, 2009 letter. Should you have any additional questions or concerns, please feel free to contact me.

Sincerely,

Braulio Montesino
General Counsel
Department of Managed Health Care

EXHIBIT J

Los Angeles
Daily Journal

MONDAY,
MAY 11, 2009
VOL. 122 NO. 88
$ 3.00

In Reversal, State Refuses to Review Autism Coverage Complaints

By Evan George
Daily Journal Staff Writer

LOS ANGELES — When Kevin Epstein appealed his insurer's denial of coverage for his son's autism to state regulators, he thought he had an airtight case.

Other parents had made health plans pay by requesting a legally binding second opinion that the treatment is needed. Epstein said he also had proof that his insurer, Blue Shield of California, had approved the costly care before changing its tune.

But when he took his complaint to the state agency that investigates health coverage disputes, he was shocked at the response: They wouldn't even hear his case.

Elliot Epstein, 3, is one of five children in the last month who have been denied the chance for an independent medical review. The denials signal a sharp turn by the Department of Managed Health Care, which regulates HMOs.

The change comes on the heels of a controversial memo, in which department officials signaled they may no longer review complaints regarding the most expensive autism therapy, called applied behavior analysis or ABA, on the basis of medical need.

Until recently, parents had made gains by asking the state to intervene. Last year, 18 out of 19 autism treatment denials were overturned in favor of patients.

Now, it appears that recourse is closing. The change benefits health insurance companies, and makes California vulnerable to a legal challenge that it has made policy without proper input.

"What the department has done marks a substantive shift and they're not going through the proper public vetting process," said Brietta Clark, a professor at Loyola Law School who studies health access issues. "The department is letting plans re-frame their denial so they can avoid independent medical review."

Regulators counter they have simply changed the way they interpret existing law.

"We don't believe we have engaged in an underground regulation process," spokeswoman Lynne Randolph said in a recent interview.

Autism cases that were sent to the appeals process in the past "weren't wrong, but we did not apply that legal analysis to those cases," Randolph explained.

Essentially that new analysis holds that if a service is not guaranteed in a health insurance policy, the policyholder is not eligible for an appeal even if that service is "medically necessary." That could make winning ABA therapy much harder.

The change caught some in the legislature by surprise. "We have a lot of concerns and questions about how these new decisions comport with the department's earlier guidelines," said David Panush, a health policy consultant to state Senate President Pro Tem Darrell

See Page 8 — IN

In Reversal, State Now Refuses to Review Disputes Over Insurance Coverage for Autism

Continued from page 1

Steinberg, D-Sacramento.

Fighting to receive autism care, especially ABA therapy, from insurers has become a hot-button issue for patients in California. Three class actions, including a discrimination claim against Kaiser Permanente, were filed in the last year over autism coverage.

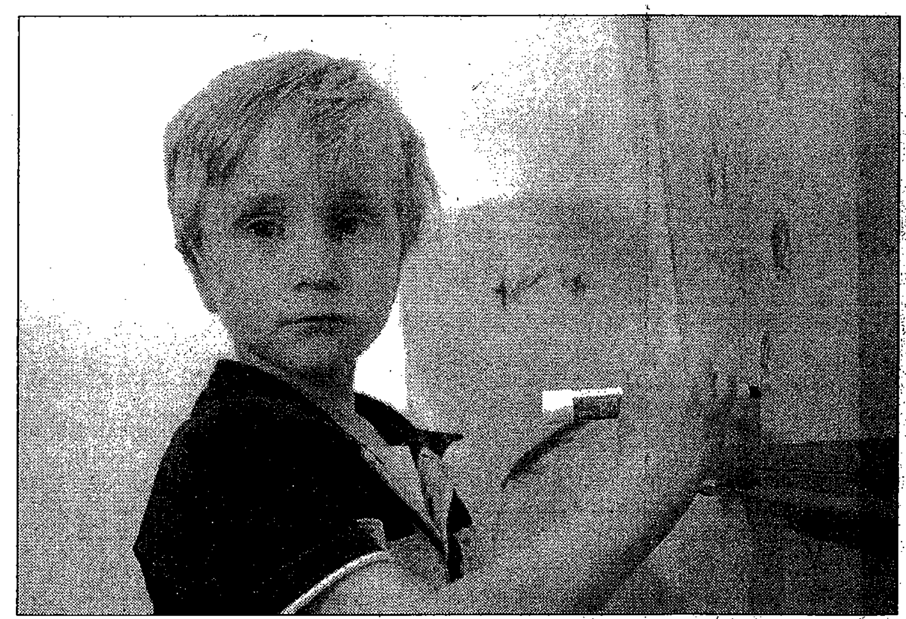
State mental health parity law requires insurers to treat mental illness like other health ailments. But insurers balk at paying treatments they claim are educational, not medical.

Autism is considered a spectrum of neuro-biological disorders that can be diagnosed in children as young as 1 year old. Studies show that autism rates are rising, with one of every 150 children born in the United States now diagnosed with the disorder.

Autism treatments, which aim to correct behavior and teach children how to function despite the disorder, have become a sticking point because of their high cost. ABA therapy can span several hours a day and cost as much as $70,000 a year.

When insurers deny coverage, state regional centers and public schools shoulder many of the services for Californians with autism — raising the question of whether taxpayers should shoulder the burden of paying for such recommended treatments.

A study released this week by the California Department of Developmental Services showed the number of autistic Californians turning to state regional centers for services jumped by almost 1,200% in the last 20 years.



S. TODD ROGERS / Daily Journal

Elliott Epstein, 3, loves to draw. He is a higher functioning autistic who is able to interact with people. The state has declined to review a dispute over his insurance.

Rachel Choi is a Kaiser member in Fremont who fought for several months to receive ABA therapy for her 5-year-old son.

Kaiser maintains many autism treatments are educational and not medicine.

Choi said her son receives half-hour sessions in speech and occupational therapy from the school district. But she believes Kaiser must cover more intensive care.

"We pay $900 in premiums and then when we need services they say 'No,'" Choi said. "Why bother having insurance?"

So Choi filed a grievance with Kaiser and then appealed to the state. She had her coverage complaint denied by the Department of Managed Health Care this week.

The department has acknowledged that five families were sent the denial letters. Critics said they expect a wave of similar rejections.

The letters themselves paint the most detailed picture yet of the legal reasoning behind denying new autism appeals.

In a May 4 letter to Choi, regulators wrote that the dispute "does not qualify" for an independent medical review because the ABA treatment she requested is not a health care service.

The denial quoted Kaiser policy saying the therapy was "custodial care" because it "can be provided safely and effectively by non-licensed individuals." It compared the autism treatment to nursing assistance with daily tasks like walking, getting in and out of bed, bathing, and dressing.

The definition is crucial because state law requires "health plans to provide health care services through appropriately licensed or certified providers," the letter read.

Rather than argue that the treatment is not medically necessary, which can trigger a state review, the plans now contend the therapy is not a health care service.

The change in language, regulators said, has led them to reconsider whether the issue belongs in independent medical review after all.

Kristin Jacobson, a patient advocate, said requiring a licensed professional was just the latest in a string of excuses because it sets criteria that cannot be met.

The problem is California does not require a license to perform ABA therapy, so few specialists have one. Jacobson said the department should have rejected that reasoning.

"The regulatory agency has let them down," Jacobson said.

Spokeswoman Randolph said that the department was looking at each case separately and would send those that qualify to an independent medical review. But the provider involved would have to license among other criteria. "We are trying to find a way to get the treatment provided," she said.

Randolph added that the department has forced Kaiser to offer other autism services to its members.

Finding a licensed provider that fits the bill is difficult, many said. California lawmakers could mandate licensing for autism therapy through new legislation.

But Clark, at Loyola Law School, said the license issue was "disturbing" because it is not applied in other health care disputes and could be discrimination. "The plans are not being consistent, they are only using that reason to keep from paying for autism," Clark said.

That was the Catch-22 that has kept Epstein, of Los Altos, from being reimbursed by Blue Shield for his son's medical bills.

Epstein searched for a specialist last fall after Elliot was diagnosed, but he could not find one in-network. After conferring with Blue Shield and ensuring the treatment would be covered, he went elsewhere, paid out of pocket and submitted his authorized bills. Five months later and after bills had accumulated, Blue Shield denied payment altogether, saying treatments had to come from a licensed provider.

Frustrated, Epstein asked again to see a list of licensed specialists that would be covered. He said he was unable to locate a provider that meets the criteria.

"Show me the list of licensed providers," Epstein said. "It doesn't exist."

---

evan_george@dailyjournal.com

EXHIBIT K

March 20, 2009

To the Parent(s) of

Subscriber Name:
Patient Name:
DMHC Case # 443466

Dear

This letter is in reference to the complaint you filed with the Department of Managed Health Care (DMHC) regarding the claims for services provided by Creative Learning Center, Amy McDonnell Travers, M.S., CCC-SLP, Lori Bond, Ph.D., Hamaguchi and Associates and Judy Crosariol, OTR. We will address the claims from each provider separately below.

With respect to the claims for services provided to by Hamaguchi and Associates, our records have confirmed that Blue Shield has reprocessed all claims for services provided by Hamaguchi and Associates to allow at the billed amount and pay at the preferred level of benefits. A letter dated March 2, 2009 was sent to you to advise that these claims had been sent for adjustment. Please see below table which reflects the claims Blue Shield has received and reprocessed for the above referenced provider:

Claim Number	Date of Service	Billed Amount	Allowed Amount	Member Copay	Blue Shield Payment
11083010661506	10/15/08	$234.00	$234.00	$10.00	$224.00
11083050950704	10/21/08-10/23/08	$234.00	$234.00	$20.00	$214.00
11083051133606	10/14/08 – 10/16/08	$234.00	$234.00	$20.00	$214.00
11083160731606	10/28/08 – 10/30/08	$234.00	$234.00	$20.00	$214.00
11083240601604	11/4/08 – 11/6/08	$234.00	$234.00	$20.00	$214.00
11083290603906	11/11/08 – 11/13/08	$234.00	$234.00	$20.00	$214.00
05083458250004	11/20/08	$117.00	$117.00	$10.00	$107.00
05083458250204	11/18/08	$117.00	$117.00	$10.00	$107.00
05083458290004	11/25/08	$117.00	$117.00	$10.00	$107.00
05090208190102	12/9/08	$117.00	$117.00	$10.00	$107.00
05090208190202	12/11/08	$117.00	$117.00	$10.00	$107.00
05090618870102	12/02/08 – 12/07/08	$234.00	$234.00	$20.00	$214.00

Our records indicate that you also filed a grievance with Blue Shield on March 5, 2009 regarding the claim for services rendered by Hamaguchi and Associates on November 25, 2008. As noted above, Blue Shield has processed this claim to allow as billed and pay at the preferred benefit level. This letter shall serve our response to your grievance filed on March 5, 2009 concerning this claim. Please be advised that future services provided to by Hamaguchi and Associates will also be processed allow at the billed charges and according to the preferred provider benefits of your health plan.

During our review, it was noted that a corrected procedure code of 99366 (Team conference) was submitted on the claim for services provided by Amy McDonnell Travers from October 2, 2008 through October 6, 2008 and was received by Blue Shield on February 3, 2009. Our records indicate that this procedure code was paid by Blue Shield under claim number 11083290603802 on February 6, 2009 and you were responsible for a copayment of $10.00 as well as all charges above Blue Shield's Allowed Amount of $41.72.

The information provided to the Department of Managed Health Care (DMHC) included a corrected procedure code for the services provided by Lori Bond, Ph.D., on October 7, 2008 for a Team Conference (procedure code 99367) with corrected units of service. Please be advised that Blue Shield has submitted the claim for these services for adjustment to reflect that a corrected procedure code was submitted with the appropriate units of service. This claim will be adjusted to allow benefits. You will receive a revised Explanation of Benefits (EOB) for this claim shortly. Since Dr. Bond is not a preferred provider with Blue Shield's Mental Health Services Administrator (MHSA), you are responsible for the applicable copayment of 30% of Blue Shield's allowed amount as well as all charges above Blue Shield's Allowed Amount.

Blue Shield has reviewed the claims for services provided by Judy Crosariol, OTR, and determined that these claims are payable up to the billed charges and according to the preferred provider benefit level of your health plan. Therefore, the claims for services provided by Judy Crosariol, OTR, were sent for adjustment. Future services rendered to by Judy Crosariol, OTR, will also be processed to allow as billed and pay at the preferred benefit level. Please see the below table which reflects the claims Blue Shield has received and reprocessed for the above referenced provider:

Claim Number	Date of Service	Billed Amount	Allowed Amount	Subscriber Copay	Subscriber Deductible	Blue Shield Payment
11083171061102	10/22/08-11-3-08	$285.00	$285.00	$30.00	$0.00	$255.00
05083468290004	11/3/08-11/25/08	$485.00	$485.00	$20.00	$0.00	$465.00
05090208040502	12/2/08-12/30/08	$380.00	$380.00	$40.00	$0.00	$340.00
05090208040602	10/22/08-11/03/08	$285.00	$285.00	$0.00	$0.00	$285.00
05090618870000	01/06/09-01/27/09	$380.00	$380.00	$40.00	$49.68	$290.32

The additional information provided to Ms. Melodie Whitney, Counsel at DMHC, for the services rendered by Creative Learning Center, was forwarded Blue Shield for review. We have contacted the Creative Learning Center and confirmed that the services provided to for Applied Behavioral Analysis (ABA) are not being provided by licensed providers, but rather individuals who have University degrees in psychology and behavior management. We have further confirmed that the individuals providing this service do not hold valid California health care licenses. Please be advised that your Blue Shield benefit plan provides benefits for health care services provided by licensed health care professionals. Unfortunately, since these services are not being provided by licensed health care professionals, no benefits are being provided.

Please be advised that, based upon the above information, Blue Shield has reprocessed all claims received from Creative Learning Center to deny as the providers of the classification listed are not covered under your health plan benefits. A revised Explanation of Benefits (EOB) for each claim will be sent to you shortly.

If you have additional questions regarding this matter, please contact me directly at the telephone number listed below. If you have questions regarding your health plan, please contact your Customer Service Department at (800) 200-3242.

Sincerely,

Natalia Lander, Coordinator
Grievance Department
(916) 350-6178

Enclosures

- Information regarding DMHC
- Information regarding ERISA
- Information regarding Language Assistance Service

cc: DMHC

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-466-2219 Toll Free
1-916-255-2284 Fax
helpline@dmhc.ca.gov

April 2, 2009

Re:

Blue Shield of California
DMHC Complaint No. 443466

Dear

Thank you for submitting your complaint to the Help Center at the Department of Managed Health Care. The Department regulates HMOs and other health plans in California.

Your complaint concerns your request that Blue Shield of California (Blue Shield) provide coverage for services your son, received from Creative Learning Centers, Judy Crosariol, OTR/L, Hamaguchi and Associates and Mosaic Child and Family Therapy Services (Lori Bond, Ph.D. and Amy Travers, M.S., CCC-SLP).

With respect to the disputed services received from Creative Learning Center, Blue Shield denied reimbursement because "services rendered by providers of this classification are not a benefit."

The *Knox-Keene Act* and implementing regulations require health plans to provide health care services through appropriately licensed or certified providers. The Department has confirmed that the service was not performed by health care providers licensed or certified under authority of applicable California laws relating to medical licensure and certification. The Department has also confirmed that the authorization that you stated was provided by Optum was only applicable to providers in the Blue Shield Mental Health Services Administrator (MHSA) provider network and not an authorization for Creative Learning Center.

Based on the information submitted, the Department is unable to conclude that Blue Shield's denial of reimbursement for the service provided by Creative Learning Center violates the requirements of the *Knox-Keene Act.*

With respect to the disputed occupational therapy services received from Judy Crosario, OTR/L, Blue Shield has reprocessed these claims and will pay them at the participating provider rate. Blue Shield has expressed that it will continue to process claims pending periodic reviews to determine medical necessity and appropriateness of continued services.

With respect to the disputed speech therapy services received from Hamaguchi and Associates, Blue Shield has agreed to reprocess these claims at the participating provider rate pending periodic reviews to determine medical necessity and appropriates of continued services.

With respect to the disputed diagnostic evaluations received from Mosaic Child and Family Therapy Services for providers, Lori Bond, Ph.D. and Amy Travers, M.S., CCC-SLP, the claims have been processed at the non-participating level. All claims resubmitted to correct billing code errors and other issues with therapy units have been reprocessed as well.

With respect to your request for future services with Creative Learning Center, Blue Shield has offered to provide in-plan cognitive behavioral therapy if . "requires a level of service that can only be provided by a licensed mental health professional through the MHSA subject to evaluation and review of appropriateness and coverage." Optum is the MHSA for Blue Shield and has provided you with referrals to in-plan providers in the past. Please contact Optum for referrals to providers who can assist with providing the mental health services that may require.

This letter is our final decision concerning your complaint. Your formal request today for an IMR on the issue of ABA can not be granted as your complaint is based on covered benefits which have been addressed according to your Evidence of Coverage. This means we completed our review and closed your file. We may use the information in your complaint in our ongoing regulation of health plans. If you need further assistance, you may wish to contact your own private attorney.

If you have any questions, please call us toll-free at 1-888-466-2219. You may also visit our website (www.healthhelp.ca.gov) for additional information regarding patients' rights in California.

Sincerely,

Melodie Whitney

Melodie Whitney
Staff Counsel
DMHC Help Center

cc: Blue Shield of California

January 6, 2009

Kaiser Foundation Health Plan, Inc.
Member Case Resolution Center

RE:
MR#: 12073452

Dear

Your request for to receive speech therapy, occupational therapy, and Applied Behavioral Analysis (ABA) Therapy for treatment of his recently diagnoses of an autism spectrum disorder has now been reviewed. After carefully reviewing s records and other available information, your request has been denied.

A representative from the following area participated in the review of your request:

- Medical Director, Internal Medicine, Member Case Resolution Center

With regard to your request for speech therapy the Medical Center Review Committee in consultation with Director of the Autism Spectrum Disorder (ASD) Center has determined that since does not have any specific medical deficits, such as an oral motor deficit, speech therapy is not medically necessary for 's condition at this time.

With regard to your request for occupational therapy (OT) the Medical Center Review Committee has reviewed the Autism Spectrum Disorder (ASD) Center's evaluation for and has determined that there is insufficient clinical information to determine if occupational therapy is medically necessary for at this time. The Committee recommends an occupational therapy evaluation to determine 's current medical needs. A referral will be submitted for this evaluation, and you will be contacted directly by the Occupational Therapy department to schedule a convenient appointment for you and If you do not receive a call within 10 business days please contact me at the number listed at the end of the letter for assistance in obtaining an appointment.

Your request for ABA therapy for is denied because, as set forth in 's Evidence of Coverage (EOC), the Plan's coverage is limited to health care services. The Plan does not cover non-health care services, such as teaching social and communication skills, special education, and academic and communication coaching, tutoring and instruction. Since ABA is a learning theory designed to teach skills that others may learn from observation your request for ABA is denied.

Mailing Address:
4460 Hacienda Drive, 4th Floor, Building B
Pleasanton, California 94588

Please note this denial was based the terms and conditions of 's agreement with Kaiser as set forth in the Kaiser Permanente 2008 Evidence of Coverage ("EOC"), Purchaser Group Kaiser Permanente for Individuals and Families, and Purchaser ID Number 800100, which states, in pertinent part, as follows:

> "**Benefits and Cost Sharing**: We cover the Services described in this "Benefits and Cost Sharing" section, subject to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, only if all of the following conditions are satisfied:
>
> - The Services are Medically Necessary
> - The Services are provided, prescribed, authorized, or directed by a Plan Physician....." (EOC, page 16-17)
>
> The term "Services" is defined as "Health care services or items" (EOC, page 6)
>
> The term "Medically Necessary" is defined as "A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community." (EOC, page 4)

Your request is being automatically referred to our Regional Appeals Committee for additional review. We will resolve your grievance within thirty (30) days from the initial date of our receipt of your grievance.

If you have any additional information which was not already provided to the Member Services department, but that you would like the Health Plan to consider, we must receive it no later than January 12, 2008. You may send this information to my attention via fax (925) 924-5165 or at the Member Services Department at the following address:

Kaiser Permanente Foundation Health Plan
Member Case Resolution Center
4480 Hacienda Drive, 4th Floor Bldg B
Pleasanton, CA 94588
Attn: Member Appeals
A. Silas

Please be assured that we take your concerns seriously, and the issue you have raised will be addressed by the appropriate department(s) within the Kaiser Permanente Medical Care Program. We at Kaiser Permanente continually strive to meet the expectation of our members for high standards in all aspects of their health care. All member concerns are carefully reviewed and handled, with the goal of preventing similar concerns and ensuring that we continue to provide quality health care and

service to all our members, consistent with both the laws governing health care service plans and our own internal policies and procedures. Please understand, however, that all such reviews are subject to statutory confidentiality and privacy considerations, and results cannot be disclosed.

You may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion, as applicable, on which the denial decision was based, upon request, by calling **1-866-369-0606**.

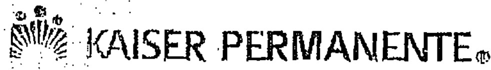
Department of Managed Health Care Complaint Process

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 Kaiser Foundation Health Plan at **1-800-464-4000** 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.

If you have any further questions, please feel free to call me at (925) 924-6932, Monday through Friday from 9:30 AM to 5:00 PM.

Sincerely,

A. Silas
Senior Case Manager
Member Services Department
PH: (925) 924-6932
FX: (925) 924-5165



Kaiser Foundation Health Plan, Inc.
Member Case Resolution Center

January 20, 2009

RE:
MR#: 12073452

Dear

Kaiser Foundation Health Plan's Regional Appeals Committee has met to review your request for to receive speech therapy, occupational therapy, and Applied Behavioral Analysis (ABA) Therapy for treatment of his recently diagnoses of an autism spectrum disorder. After a careful review of your records and other relevant information, the Committee has denied your request.

The following individuals participated in the review of your request:

- Physician Consultant, Developmental Pediatrics
- Physician Consultant, Internal Medicine/Infectious Disease
- Physician Consultant, Pediatrics
- Vice Chair of the Chiefs for Psychiatry
- Physician Consultant, Child/Adolescent Psychiatry
- Physician Advisor, Member Services, Member Case Resolution Center
- Director of Psychiatry
- Ph.D. Psychologist
- Therapist, Speech Pathology
- Therapist, Occupational Therapy

This denial was based on the following reason(s):

With regard to your request for speech therapy, it was determined that does not have an anatomical abnormality such as an oral motor deficit, or a speech or voice disorder due to an anatomical defect or function therefore the request for speech and language therapy are not considered to be medically necessary. Training to address a developmental language delay is not a health care service, but rather an educational service.

Mailing Address:
4480 Hacienda Drive, 4th Floor, Building B
Pleasanton, California 94588

With regard to your request for occupational therapy (OT) the Committee has reviewed the Autism Spectrum Disorder (ASD) Center's evaluation for and has determined that there is insufficient clinical information to determine if occupational therapy is medically necessary for at this time. The Committee recommends moves forward with the occupational therapy evaluation to determine his current medical needs. A referral has been submitted for this evaluation, and you will be contacted directly by the Occupational Therapy department to schedule a convenient appointment for you and If you do not receive a call within 10 business days please contact me at the number listed at the end of the letter for assistance in obtaining an appointment.

Your request for ABA therapy for is denied because, as set forth in 's Evidence of Coverage (EOC), the Plan's coverage is limited to health care services. The Plan does not cover non-health care services, such as teaching social and communication skills, special education, and academic and communication coaching, tutoring and instruction. Since ABA is a learning theory designed to teach skills that others may learn from observation your request for ABA is denied.

Please note this denial was based the terms and conditions of 's agreement with Kaiser as set forth in the Kaiser Permanente 2008 Evidence of Coverage ("EOC"), Purchaser Group Kaiser Permanente for Individuals and Families, and Purchaser ID Number 800100, which states, in pertinent part, as follows:

> "**Benefits and Cost Sharing**: We cover the Services described in this "Benefits and Cost Sharing" section, subject to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, only if all of the following conditions are satisfied:
>
> - The Services are Medically Necessary
> - The Services are provided, prescribed, authorized, or directed by a Plan Physician....." (EOC, page 16-17)
>
> The term "Services" is defined as "Health care services or items" (EOC, page 6)
>
> The term "Medically Necessary" is defined as "A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community." (EOC, page 4)

Please be assured that we take your concerns seriously, and the issue you have raised will be addressed by the appropriate department(s) within the Kaiser Permanente Medical Care Program. We at Kaiser Permanente continually strive to meet the

expectation of our members for high standards in all aspects of their health care. All member concerns are carefully reviewed and handled, with the goal of preventing similar concerns and ensuring that we continue to provide quality health care and service to all our members, consistent with both the laws governing health care service plans and our own internal policies and procedures. Please understand, however, that all such reviews are subject to statutory confidentiality and privacy considerations, and results cannot be disclosed.

Access to Relevant Materials Used by the Plan

You have a right to access and receive a free copy of any materials (documents, records or other information) relevant to your case. Relevant materials are those that:

- We relied on to inform us when making our decision;
- Materials that we received, or that we considered or generated, when making our decision, whether or not we actually relied on them in making our final decision; and
- Materials concerning your request that may show that we used appropriate administrative processes and safeguards in making our benefit decisions.

You may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion, as applicable, on which the denial decision was based, upon request, by calling **1-866-369-0606**.

This completes Kaiser Foundation Health Plan's internal grievance process. If you find this decision unsatisfactory, the following options are available to you or your authorized representative:

HOW TO DISPUTE THIS DETERMINATION

Department of Managed Health Care Complaint Process

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 Kaiser Foundation Health Plan at **1-800-464-4000** and use your health plan' 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.

Independent Medical Review

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us. Additional information about IMR can be obtained from your *Evidence of Coverage* or California's Department of Managed Health Care at **www.hmohelp.ca.gov.**

Following completion of your IMR review, the DMHC will notify you and us of its final determination. If the DMHC decision is in your favor, we will reimburse you or notify you promptly regarding how to obtain services.

Binding Arbitration

Except for Small Claims Court cases and, if your group must comply with ERISA, certain benefit-related disputes, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to your Health Plan membership, must be decided by binding arbitration, under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. This includes claims for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This is a summary, please refer to your *Evidence of Coverage* for the complete arbitration provision.

Please be advised that whether your arbitration provisions are enforceable or are unenforceable will be determined by the application and interpretation of various laws. These include Health & Safety Code section 1363.1, which pertains to required disclosures of arbitration provisions. Additional information regarding the California laws pertaining to arbitration of healthcare claims(s) can be accessed on the internet at the California Department of Managed Health Care's web site **(http://www.hmohelp.ca.gov/).**

ERISA APPEAL RIGHTS ALSO INCLUDE THE FOLLOWING:

Civil Actions Under ERISA

If your health benefits are provided through an Employee Retirement and Income Security Act (ERISA)-qualified employee welfare benefit plan, you have the right to bring a civil action under Section 502(a) of ERISA if your claim has not been approved and all required internal reviews have been completed. If you are not sure whether your group is an ERISA- qualified employee welfare plan, you should contact your employer.

If you have any questions or would like to obtain copies of relevant materials of your case file, please feel free to call me at (925) 924-6932, Monday through Friday from 9:30 AM to 5:00 PM.

Sincerely,

A. Silas
Senior Case Manager
Member Services Department
PH: (925) 924-6932
FX: (925) 924-5165

Attachments:

IMR Application
IMR Application Instructions
DMHC addressed envelope

442350

Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725
1-888-466-2219 Toll Free
916-255-2285 Fax
helpline@dmhc.ca.gov
www.healthhelp.ca.gov

March 25, 2009

Ms. Paula Farrell
Kaiser Foundation Health Plan Inc.
2101 Webster Street
8th Floor
Oakland, CA 94612

Patient:
DMHC#: 442350 - IMR01
Health Plan: Kaiser Foundation Health Plan Inc.

Dear

Thank you for submitting an Application for Independent Medical Review (IMR) to the Help Center at the Department of Managed Health Care on behalf of your son, The Department regulates HMOs and other health plans in California.

The IMR process is designed to review health plan service denials based on medical necessity and /or experimental and investigational criteria. The IMR process is not designed to review and resolve coverage disputes. Your IMR application requests an independent medical review for four separate service denials: (1) speech and language therapy, (2) occupational therapy, (3) social skills group therapy, and (4) Home Based Applied Behavioral Analysis (ABA).

First Treatment Request for speech and language therapy. The Plan denied these services on the basis that speech and language therapy are not considered to be medically necessary. The Department has determined that this denial qualifies for IMR review.

Second Treatment Request for occupational therapy. The Plan denied this service on the basis that "there is insufficient clinical information to determine if occupational therapy is medically necessary for at this time." The Department has determined that this denial qualifies for IMR review.

Third Treatment Request for social skills group therapy. The Plan denied this service on the basis that "it was determined that the requested therapy is not medically necessary for the treatment of 's medical condition at this time." The Department has determined that this denial qualifies for IMR review.

MAR-31-2009 10:16 5108968636 96% P.02

The speech and language therapy, occupational therapy, and social skills group therapy service denials will be referred to the Department's Independent Medical Review organization to resolve. Attached are the questions that will be submitted to CHDR for assignment today. We have requested CHDR to complete its determination as quickly as possible.

Within three business days of the date of this letter, Kaiser is required to provide the review organization a copy of all of the enrollee's medical records in the possession of the plan or its contracting providers relevant to the following:

- The enrollee's medical condition;
- The health care services being provided by the plan and its contracting providers for the condition; and
- The disputed health care services requested by the enrollee for the condition.

Also, any newly developed or discovered relevant medical records in the possession of the plan or its contracting providers after the initial documents must be forwarded immediately to the review organization.

Your health plan may not have records for treatment received from non-plan physicians or other providers. If you have additional relevant medical information, please send it immediately with reference to the IMR case number, via FAX to (916) 255-2286 or mail to:

Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2738

Any medical records submitted for IMR review from non-contracted physician/providers and not considered in the health plan appeal will be forwarded to your plan for review.

If either you or the Plan desire to comment on this IMR matter, please submit any comments in writing directly to CHDR at the address above. Your submission should be provided within the next 7 days. You should also provide a copy of the material submitted to CHDR to each other at the above addresses.

You are not required to submit an additional statement. There is no need to copy the Department on any materials sent to CHDR.

Upon completion, a copy of the IMR decision will be provided to you and your health plan. Please be aware that the determination made by the review organization is binding. If the decision is in your favor, the health plan will be required to provide the services you have requested. If the decision is in favor of the health plan, the plan will not be required to provide the services you requested

If your physician believes that your son is in urgent need of the disputed medical services or if you have any other questions, please contact me immediately at 916-255-2400 to determine if the case qualifies for an expedited review. Should you obtain the disputed medical services outside of the health plan prior to receiving the IMR decision, the health plan may not be required to reimburse you for the out-of-plan services.

Fourth Treatment Request for Home Based ABA therapy. The Plan denied this service on the basis that "the Plan's coverage is limited to health care services." Because the denial raises a coverage issue rather than one of medical necessity or a denial based on a claim that the treatment is experimental or investigational, this issue will be processed as a standard complaint. Following the resolution of this coverage issue, this service denial will be evaluated for IMR eligibility.

If you have any questions, please call us toll-free at 1-888-466-2219. You may also visit our website at www.healthhelp.ca.gov. Our website has additional information regarding the Department and patients' rights in California.

Sincerely,

Kristene Mapile
Staff Counsel
Help Center

Enclosure

EXHIBIT L

Friday, April 10, 2009

Cindy Ehnes
Director
California Department of Managed Health Care
980 9th Street, Suite 2450
Sacramento, CA 95814

Via Facsimile, Return Receipt Requested

Re: **Public Records Act Request**

Dear Ms. Ehnes,

Pursuant to California Government Code § 6253(b) of the Public Records Act, and Article 1, section 3 of the California Constitution, Consumer Watchdog hereby requests that the Department of Managed Health Care ("Department") provide it with:

1. Records of all "summary of [Department] findings" and information about any corrective actions taken, redacted to protect the identity of the consumer where necessary, regarding the final disposition of ABA grievances, including documents showing the reasons why the Department found the plan to be, or not to be, in compliance with any applicable laws, regulations, or orders of the director regarding Applied Behavioral Analysis ("ABA") treatments pursuant to Health & Safety Code § 1368(b)(5)(A)-(C) from 1/01/00 to the present.

2. Copies of all IMR applications, redacted to protect the identity of the consumer where necessary, regarding ABA treatments pursuant to Health & Safety Code § 1374.30(m), and copies of the corresponding IMR decisions, from 1/01/00 to the present.

3. Any consumer call logs, databases, or complaint analyses or summaries of consumer complaints to the California HMO Help Center (1-888-466-2219) regarding health plan denials of ABA on the grounds that ABA is not a covered benefit or is not medically necessary, including documents showing how the complaint was resolved, from 1/01/00 to the present.

4. Any records of consumer grievances regarding denials of ABA treatment in which the Department concluded that the grievance was eligible for review under the IMR system pursuant to Health & Safety Code § 1368(b)(3), and documents showing the outcome of those IMR decisions, from 1/01/00 to the present.

5. Department comment letters issued between 1/01/00-12/31/02 regarding coverage exclusions in, and revisions to, Evidence of Coverage (EOC) and/or subscriber contracts.

6. Department comment letters issued between 1/01/00-12/31/02 regarding coverage exclusions in, and revisions to, Evidence of Coverage (EOC) and/or subscriber contracts in connection with health plan compliance with AB 88 (Stats. 1999, c. 534).

Any public records withheld from production for inspection should be separately identified and should be accompanied by the claimed justification for withholding as provided by Gov. Code § 6255, stating the nature of the document withheld, the specific exemption under which the document is being withheld, and the public interest served by withholding said document. We reserve the right to appeal your decision to withhold any materials.

Should you contend that a portion of a particular document is exempt from disclosure due to confidentiality, we also request pursuant to Gov. Code § 6253(a) that the exempt portion be redacted and the remaining portion be produced for our inspection.

Consumer Watchdog is prepared to pay reasonable search and duplication fees in connection with this request. However, agencies have discretion to waive fees in order to provide greater access to public records pursuant to Gov. Code § 6253(e). (*See North Co. Parents Organization v. Cal. Dept. of Educ.*, 28 Cal. Rptr. 2d 359, 361 (Ct. App. 1994)). As the information which is the subject of this request is of primary benefit to the public to inform how taxpayer dollars are being spent, we ask that you waive all search and duplication fees.

Consistent with § 6253(c), we expect to hear from you within ten days. If you have any questions concerning the scope of our Public Records Act request, please contact the undersigned at (310) 392-0522 ext. 319.

Sincerely,

Jerry Flanagan