

AUG 6 1987
At 4:45 o'clock P.M.
MARCH FONG EU, Secretary of State
By *John Bates*
Deputy Secretary of State

CALIFORNIA OFFICE OF ADMINISTRATIVE LAW

SACRAMENTO, CALIFORNIA

In re:) 1987 OAL Determination No. 10
Request for Regulatory)
Determination filed by) [Docket No. 86-016]
the Union of American)
Physicians and Dentists) August 6, 1987
concerning certain)
Department of Health) Determination Pursuant to
Services' Medi-Cal) Government Code Section
guidelines and) 11347.5; Title 1,
procedures¹) California Administrative
Code, Chapter 1, Article 2

Determination by:


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SYNOPSIS

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

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

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THE ISSUE PRESENTED 2

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

1. "Medi-Cal Bulletin" dated July 1978; "Medi-Cal Update" (Medical Services Bulletin No. 66) dated May 1983;
2. Medi-Cal Provider Manual for medical services, pages 3-77 through 3-80; and
3. DHS' policy of using a statistical sampling and extrapolation method for determining overpayment when auditing physicians.

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

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

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I. AGENCY, AUTHORITY, APPLICABILITY OF APA; BACKGROUND

Agency

In 1965, the Medi-Cal program¹⁰ was created by the Legislature as a response to Title XIX of the Social Security Act, which authorized federal financial support to states which adopted conforming medical assistance programs. It was the intent of the Legislature

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

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

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

Authority 12

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

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

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

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

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

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

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

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

Background

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

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

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

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

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

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

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

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

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

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

"the following Medi-Cal program guidelines:

1. Section 51476 of the California Administrative Code, Title 22, addresses the requirement to keep and maintain records which fully disclose the type and extent of service.
2. Medi-Cal Bulletin, dated July 1978, defines the criteria for office visit levels of service.
3. Medical [sic] Provider Manual, pages 3-77 through 3-80 provides specific guidelines for the documentation of physician office visits.
4. Medical Bulletin [Medi-Cal Update], dated May 1983 provides updated guidelines for documentation of physician office visits." [Emphasis added.]

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

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

II. CHALLENGED RULES

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

Challenged Rule 1

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

Challenged Rule 2

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

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Challenged Rule 3

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

Challenged Rule 4

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

III. DISCUSSION OF DISPOSITIVE ISSUES

There are two main issues before us:¹⁸

- (1) WHETHER THE CHALLENGED RULES ARE REGULATIONS WITHIN THE MEANING OF THE KEY PROVISION OF GOVERNMENT CODE SECTION 11342.
- (2) WHETHER THE CHALLENGED RULES FALL WITHIN ANY ESTABLISHED EXCEPTION TO APA REQUIREMENTS.

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

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

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

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

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

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chapter" [Emphasis added.]

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

First, is the informal rule either

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

Second, does the informal rule either

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

Analysis of the Challenged Rules

CHALLENGED RULE 1: THE 1978 MEDI-CAL BULLETIN

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

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

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

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

The RVS provides (among others) two definitions:

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

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

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

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

Basically, the 1978 Bulletin supplements the formally adopted RVS code descriptions by defining six recognized levels of service¹⁹ that the physician must use in categorizing and coding the services he or she renders to Medi-Cal patients. After each definition, the Bulletin lists examples of conditions, diagnoses, treatments, etc. that are to be coded as that defined level of service.

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

"LIMITED LEVEL OF SERVICE: A level of service pertaining to the evaluation of a circumscribed acute illness or to the periodic re-evaluation of a problem including an interval history and examination, the review of effectiveness of past medical management, the ordering and evaluation of appropriate diagnostic tests, the adjustment of therapeutic management as indicated, and the discussion of findings and/or medical management.

For example:

- a. Treatment of an acute respiratory infection.
- b. Review of interval history, physical status and control of a diabetic patient.
- c. Review of hospital course, studies, orders and chest examination of patient with rheumatic heart disease recovering from acute congestive failure; revision of orders and limited exchange with nursing staff.
- d. Review of interval history, physical status and adjustment of medication in patient with compensated arteriosclerotic heart disease on chronic diuretic therapy.

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- e. Review of mental status findings, limited team conference (exchange with nursing and ancillary personnel), and revision of medical management orders on a patient with a toxic psychosis.
- f. Review of recent history, determination of blood pressure, auscultation of heart and lungs and adjustment of medication in essential hypertension." [Emphasis added.]

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

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

* * * * *

CHALLENGED RULE 2: THE 1983 MEDI-CAL BULLETIN

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

"Use of Physician Office Visit Codes and Documentation Requirements

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

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

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

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

The 1983 Update continues:

"where it has been determined by [DHS] that claims for services are not substantiated or are unnecessary, DHS may initiate one or more of the following administrative actions:

Recovery of Overpayments [cite omitted]

Special Claims Review [cite omitted]

Prior Authorization [cite omitted]

Suspension from the Program [cite omitted]."

[Emphasis added.]

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

Analysis of Agency Position

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

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

* * * * *

Argument Number 1--Concerning Challenged Rules 1 and 2

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

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

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

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Argument Number 2--Concerning Challenged Rules 1 and 2

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

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

* * * * *

Argument Number 3--Concerning Challenged Rules 1 and 2

DHS argues that the Bulletins are not standards of general application because they are applied by the audit team on a case-by-case basis. In support of this position, DHS (1) states that courts have long recognized that an agency may administer a program solely through case-by-case evaluation or review²⁸ and (2) further asserts that three California cases have endorsed the principle that an agency is free to administer by individual order rather than by general rule. Of the three cases DHS cites as purportedly endorsing this "tenet of administrative law," only one makes any true mention of this principle. In California Optometric Association v. Lackner²⁹ the court cites California Association of Nursing Homes v. Williams³⁰ for the principle that "Administrative agencies have wide latitude in fashioning procedures for the pursuit of their inquiries." However, California Association of Nursing Homes continues: "Procedural elasticity cannot be stretched into disregard of the law's [APA's] public hearing demand."³¹

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As previously noted, DHS admits that "The information contained in these documents is applied by the audit team physician in a case-by-case review of each provider." In other words, each time a Medi-Cal patient's medical record is reviewed for audit purposes, the definitions contained in the Bulletins are applied. DHS does not say that sometimes some definitions are applied to a certain case and then not applied to another case, but rather that the applicable definitions are uniformly used as guidelines in all the cases, even though the cases are necessarily reviewed one at a time.

The California Supreme Court stated in Pacific Legal Foundation v. California Coastal Commission³²:

The action under consideration--adoption of guidelines interpreting the Coastal Act's access provisions--unquestionably falls within the category of quasi-legislative agency action, as opposed to quasi-judicial or adjudicatory proceedings. The guidelines are the formulation of a general policy intended to govern future permit decisions, rather than the application of rules to the peculiar facts of an individual case.³³ [Emphasis added.]

In the matter before us, the DHS audit team routinely applies the same definitions of levels of service, as they relate to documentation requirements, during the audit review of each patient's records. Accordingly, we reach the same conclusion here as the Supreme Court did in the above-cited case, that the definitions (guidelines) are the formulation of a general policy intended to apply to future claims and future audits.

Other California case law undercuts DHS' basic premise that it is free to do as it likes so long as it labels its enactments "quasi-judicial" or "ad hoc."

First, in Hillery v. Rushen,³⁴ the state agency argued that where an administrative problem must be handled "flexibly or in minute detail," it was appropriate for the agency to utilize informal guidelines.³⁵ The Hillery court rejected this argument, noting that no such exemption was provided by the California APA, and concluded that:

"'guidelines' after all, clearly constitute 'standard[s] of general application' within the meaning of California's definition of 'regulation.'" [Citation omitted.]

Hence, DHS may have the choice to proceed with its audits (and to process its Medi-Cal claims) on a case-by-case basis varying the criteria as required, but when the Department elects to conduct these audits (and to process these claims)

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by routinely applying certain standards of general application, such "guidelines" must first be adopted in compliance with the procedural requirements of the APA.

Second, even assuming that the challenged enactments involved the exercise of quasi-judicial authority, that fact would not immunize them from compliance with the APA. In City of Santa Barbara v. California Coastal Zone Commission,³⁶ the court rejected agency efforts to enforce an informally issued rule specifying where quasi-judicial permit appeals were to be filed. Further, Government Code section 11347.5 prohibits all enactments which informally supplement regulations or statutes; it contains no "quasi-judicial" exception.

We therefore reject this third argument.

* * * * *

Argument Number 4--Concerning Challenged Rules 1 and 2

DHS argues that the Bulletins do not implement the statutory and regulatory standards of reimbursement because they were published by a private sector fiscal intermediary which lacks any delegated rulemaking authority.

Though DHS cites no authority for the above statement, it is true that the Bulletins were published by the fiscal intermediary. Further, we assume ~~arguendo~~ that such a contractor lacks delegated rulemaking authority. However, this company was merely the mechanical means used by DHS to issue the informal rules (e.g., definitions) that are contained in bulletins.

The evidence strongly indicates that DHS is fully responsible for the Bulletins.

First, the 1978 Medi-Cal Bulletin (challenged rule 1) specifically states:

The Department of Health [Services] has requested publication of the following definitions to supplement information in the [RVS Codes contained in the regulations] and to help clarify billing guidelines [Emphasis added.]

Second, the Medi-Cal Update is part of the updating system for the Medi-Cal Provider Manual published by CSC, which is under contract to DHS as the fiscal intermediary to process claims submitted by providers for services rendered to Medi-Cal recipients. The Medi-Cal Provider Manual for medical services contains an inside cover letter on DHS letterhead which specifically states that the Manual "has been prepared

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by [CSC] in cooperation with [DHS]. The purpose of this manual is to give health professionals a concise explanation of Medi-Cal billing instructions and procedures." (Emphasis added.)

Third, pages 3-77 through 3-80 of this Manual, which are at issue in this request for determination, are located in section 3, titled "Program Policy Statements." The first paragraph of section 3 states:

"Program Policy Statements are the responsibility of the State Department of Health Services."
[Emphasis added.]

For all these reasons, therefore, we must reject the argument that DHS is not responsible for the contents of the Manual or its updating bulletins. Agencies cannot evade their statutory rulemaking obligations by the simple expedient of contracting out the job of distributing their underground regulations.

Even assuming that the original issuance of these challenged rules was somehow exempt from APA requirements, the fact that DHS itself twice mailed copies of these rules to the requester fully establishes departmental responsibility.

* * * * *

Argument Number 5--Concerning Challenged Rules 1 and 2

DHS alleges that the decision of Goleta Valley Community Hospital v. State Department of Health Services³⁷ is not applicable in the matter before us. In Goleta Valley, DHS sent a letter adopting one interpretation of an ambiguous regulation. Later, the agency sent a second letter interpreting the regulation in a different way. The court found that:

"a written interpretation of a rule or regulation which concerns a matter of import generally to those dealing with the interpreting agency cannot escape scrutiny on the ground it does no more than govern the agency's internal affairs. [cite omitted]" [Emphasis added.]

The letter was found to be procedurally invalid in light of APA requirements and therefore to merit no weight as an agency interpretation of a regulation.

DHS makes the following arguments and distinctions between Goleta Valley and the issues before us. First, DHS states

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that the invalid interpretive letter in Goleta Valley was applied to the provider at a point in the process where the provider's appeal rights had automatically vested; whereas here, the Medi-Cal Bulletins set forth only examples and the amount of overpayment is still dependent upon individual review (before appeal rights vest). This distinction is not persuasive because in the absence of an express statutory exemption,³⁸ the APA is applicable to the exercise of any quasi-legislative power regardless of the point in the process at which it is exercised.

Second, DHS makes the distinction that the letter was issued by DHS, which has general and specific rulemaking authority; whereas here, the Bulletins were published by a private fiscal intermediary which has no rulemaking authority. We reject the argument that this distinction is significant for the same reasons as stated in argument number 4 above.

Third, DHS alleges that the interpretive letter was prepared by DHS counsel for review and implementation by appointed officials; whereas here, the Bulletins were reprinted almost verbatim from a guide printed by a provider special-interest group. We are not persuaded by this distinction and argument either. The source of the informal rule is not the determining factor in deciding whether the rule is a "regulation." If a rule, regulation, order, or standard of general application is adopted by the state agency to implement, interpret, or make specific the law enforced or administered by it, then it is a "regulation" as defined by the APA.³⁹ We have already found, above, that the Bulletins are standards of general application, and that they implement or make specific the law enforced or administered by DHS.

Lastly, DHS claims the interpretive letter was intended to be binding; whereas, the Bulletins at issue were intended to be guiding. This argument is not viable for the following reasons.

A. Whether or not an agency action is regulatory in nature hinges on the effect and impact on the public-- not on the agency's characterization of the action.⁴⁰ Similar arguments of this nature were rejected in prior OAL determinations.⁴¹

B. Government Code section 11347.5 specifically prohibits a state agency from issuing, utilizing, or enforcing any guideline which is a "regulation" as defined by the APA unless the guideline is adopted pursuant to the APA. We have determined that the Bulletins meet the APA definition of "regulation."

C. The California Supreme Court has found that agency rules labeled "guides," which are contained in agency

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bulletins or directed to the public in the form of circulars or bulletins, have no legal effect unless promulgated in substantial compliance with the APA.⁴²

Based on the above discussion, we reject the DHS contentions and find that Goleta Valley is applicable to the matter before us.

* * * * *

Argument Number 6--Concerning Challenged Rules 1 and 2

UAPD contends that the 1983 Medi-Cal Update supplements RVS Code 90050 and creates a presumption that any service billed at the 90060 level is suspect and subject to an audit adjustment. The Medi-Cal Update provides in part:

"For example, the program's coverage for return office visits is ordinarily limited to RVS/CSN 90050 or less, depending on the length of the visit and the need for a physician to be present. Higher RVS/CSN coded visits are covered only when there has been a substantial change in the patient's condition, or a substantial new illness, or when other circumstances clearly require extensive re-evaluation of the patient's condition." [First emphasis was added.]

~~RVS Code 90050 (a provision duly incorporated by reference into the CAC) is listed under the heading of "ESTABLISHED PATIENT" and is defined simply as:~~

	Unit Value
90050 <u>Limited</u> examination, evaluation and/or treatment, same or new illness	16.0

DHS denies that this Medi-Cal Update statement creates a presumption. The Update allegedly does no more than advise providers of a problem and give an example of that problem. This explanation by DHS has been previously rejected in our discussion of argument numbers 1 and 2.

The language clearly reveals a presumption: the program's coverage for return office visits is ordinarily limited to RVS/CSN 90050 or less. A similar presumption was found to be regulatory in nature in the Coastal Commission determination.⁴³ In another recent determination, we stated:

"[A]llocating burdens of proof and creating presumptions are critically important methods

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of structuring legal proceedings.'[44] It is difficult to imagine a situation in which an informal rule that explicitly creates a presumption and then indicates how to rebut it could be characterized as non-regulatory."⁴⁵

Conclusion Re: Rules 1 and 2

We are not persuaded by any of DHS' arguments. We therefore conclude that both of the Medi-Cal Bulletins are "regulations" as defined in Government Code section 11342, subdivision (b).

* * * * *

CHALLENGED RULE 3: MEDI-CAL PROVIDER MANUAL, pp. 3-77--3-80

As previously noted, this rule is part of Section 3, "Program Policy Statements," pages 3-77 through 3-80, of the Medi-Cal Provider Manual for medical services. In determining whether challenged rule 3 is a "regulation," OAL makes the same two-part inquiry utilized in the analysis of challenged rules 1 and 2. OAL's analysis focuses first upon the question of whether the rule in question is a rule or standard of general application. If the rule is applied generally, then OAL's inquiry continues, to determine whether the rule implements, interprets, or makes specific the law enforced or administered by the agency.

The first paragraph of Section 3 announces:

"Program Policy Statements are the responsibility of the State Department of Health Services."
[Emphasis added.]

Challenged rule 3 was included with the 1983 Medi-Cal Update Bulletin (challenged rule 2) as part of the update service provided by CSC, to be inserted as replacement pages in the Manual. The Medi-Cal Update Bulletin also made the following reference to these new pages being added to the Manual:

"To assist providers in designating the correct billing codes for physician services, manual replacement pages are included with this bulletin containing definitions taken from the . . . 'Current Procedural Terminology' [also known as CPT-4] . . . and are intended to supplement the definitions in the [RVS/CSN Codes]. These definitions are

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being republished and were previously sent to providers in a Medi-Cal bulletin dated July 1978."⁴⁶ [Emphasis added.]

It is noteworthy that these Manual pages were supplied by DHS as part of its official response to UAPD's first letter as "Medi-Cal program guidelines" to provide "specific guidelines for the documentation of physician office visits." (Emphasis added.) These same pages were also included in the second letter of response (from the DHS legal office) to UAPD and, together with the Bulletins, were identified by DHS as the only two "written criteria available." The Department freely admitted its use of the Bulletins and the Manual for evaluating whether "a provider's progress notes satisfy the appropriateness and quality of medical services requirements." (Emphasis added.)

Considering the foregoing information, it is obvious that challenged rule 3 is a "regulation." First, the definitions and examples are standards of general application. They apply statewide (1) to all participating physicians, and (2) in each case the DHS audit team reviews. Second, they supplement the RVS Codes in Title 22, CAC, section 51503, just as they were "intended" to do.

Conclusion Re: Challenged Rule 3

Hence, we conclude that the definitions and examples contained on pages 3-77 through 3-80 of the Medi-Cal Provider Manual for medical services are "regulations" as defined in Government Code section 11342, subdivision (b).

* * * * *

CHALLENGED RULE 4: PARTICULAR AUDITING TECHNIQUES

The last challenged rule is DHS' policy of using a particular probability sampling and statistical extrapolation process when auditing physicians and determining the amount of overpayment. Once again, the inquiry begins with consideration of whether challenged rule 4 is a "regulation."

Title 22, CAC, section 51488.2 describes the technique used when auditing pharmacists. Section 51488.2 provides:

"(a) A probability sample may be used in auditing to determine the recoverable amount

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due from a pharmacy provider. When a probability sample is used to determine the recoverable amount for the universe from which the sample was drawn, an appropriate and commonly accepted statistical procedure, such as the ratio of means estimator, shall be used to calculate the audit findings. If a probability sample is used to determine the amount recoverable, failure to execute the probability sampling according to accepted statistical procedures will invalidate expansion to the universe sampled.

"(b) Whenever a probability sampling method is used to determine the amount of recovery, the demand for recovery shall be accompanied by a clear statement of:

- (1) The specification of the universe that was sampled.
- (2) The sample size and method of selecting the sample.
- (3) The formulas and calculation procedures used to determine the recoverable amount.
- (4) Confidence level used to evaluate the precision of the audit findings."

UAPD alleges that this same probability sampling and extrapolation process is being used when auditing physicians, without first being formally adopted pursuant to APA procedural requirements. UAPD presented copies of five letters sent to physicians who had been audited. Each letter contained the following paragraph:

"It has been determined that you have been overpaid \$[amount omitted]. This was calculated by applying the ratio of overpayment found in a random sample to the total Medi-Cal payments you received during the review period. . . ." [Emphasis added.]

UAPD alleges that these "letters were sent to Medi-Cal physicians throughout the state, and are typical and standardized in format and appearance with letters received by UAPD members and other physician providers after an audit."⁴⁷ DHS does not deny this allegation.

We conclude that this audit procedure is a standard of general application. It is applied in every Medi-Cal case reviewed by DHS audit teams and is used to determine the

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amount of overpayment. This audit procedure implements Welfare and Institutions Code section 14170, which states:

"Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by it."
[Emphasis added.]

Section 14133 of the Welfare and Institutions Code provides in part:

"Utilization controls that may be applied to the services set forth in section 14132 which are subject to utilization controls shall be limited to:

(c) Postservice postpayment audit, which is review for medical necessity and program coverage after service was rendered and the claim paid. The department may take appropriate steps to recover payments made if subsequent investigation uncovers evidence that the claim should not have been paid."
[Emphasis added.]

Title 22, CAC, section 52458.1 describes the causes for recovery of provider overpayments, i.e., payments were in excess of program payment ceilings or allowable costs; ~~payments were for services not documented in the provider's records, or for services where the provider's documentation justifies only a lower level of payment, etc.~~ Section 51476 of this same title provides in part:

"(a) Each provider shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of services provided to a Medi-Cal beneficiary." [Emphasis added.]

DHS arguably has the rulemaking authority (based upon the above noted sections) to adopt regulations concerning the use of probability sampling and statistical extrapolation when auditing Medi-Cal providers. This is evidenced by DHS' formal adoption of Title 22, CAC, section 51488.2, which allows such audit procedures when reviewing pharmacists.

Before DHS can legally prescribe general application of a particular method of probability sampling and statistical extrapolation for audits of physician providers, however, it must comply with the requirements of the APA.⁴⁸ To implement this procedure before formally adopting such a regulation violates Government Code section 11347.5, which provides:

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"No state agency shall issue, utilize, [or] enforce . . . any guideline, criterion, bulletin, manual, [or] standard of general application . . . which is a regulation as defined [by the APA] unless the guideline, [etc.] has been adopted pursuant to the [APA]."

Conclusion Re: Challenged Rule 4

Hence, the use of a selected method of probability sampling and statistical extrapolation for the performance of audits of physicians and for determination of the amounts of overpayments is a "regulation."⁴⁹

DHS further alleges that recent developments indicate that statistical extrapolation is an accepted practice in the industry, if not actually upheld by some courts nationwide. Even assuming arguendo that statistical extrapolation were an accepted method in California, the acceptability of this method is not the real issue in this determination. The issue is whether the statistical extrapolation method under review is a "regulation" as defined by the APA. Citing Securities and Exchange Commission v. Chenery Corporation,⁵⁰ DHS strives to justify its failure to formally adopt a regulation permitting statistical sampling and extrapolation for the auditing of physician providers by stating that this audit technique was still in the "development" stage until recently. DHS cites Chenery as holding that "some principles must await their own development." Medi-Cal program audits have been conducted for approximately 20 years. Physician providers have been receiving form letters from at least as early as July 1984 stating that their overpayment "was calculated by applying the ratio of overpayment found in a random sample to the total Medi-Cal payments you received during the review period."

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IV. HAVING CONCLUDED THAT THE FOUR CHALLENGED RULES ARE "REGULATIONS" AS DEFINED BY GOVERNMENT CODE SECTION 11342, SUBDIVISION (b),⁵¹ WE NOW INQUIRE WHETHER THE CHALLENGED RULES FALL WITHIN ANY LEGALLY ESTABLISHED EXCEPTION TO APA REQUIREMENTS.

Rules concerning certain activities of state agencies--for instance, "internal management"--are not subject to the procedural requirements of the APA.⁵²

WE CONCLUDE THAT NONE OF THE RECOGNIZED EXCEPTIONS (SET OUT IN NOTE 52) APPLY TO THE CHALLENGED RULES.

However, DHS argues that APA requirements do not apply to its use of probability sampling and statistical extrapolation for the following reasons.

Argument A

Citing no authority, DHS asserts that the "generalized" due process protections afforded by the rulemaking provisions of the APA are "overshadowed" by the personalized due process protections in the legal provisions applying to administrative hearings. DHS specifically argues that the provider's due process rights are adequately protected by the appeal provisions in Title 22, CAC, Article 1.5.

We reject this argument. DHS overlooks the primary goals of the APA--fostering meaningful public participation and developing a record permitting effective judicial review.⁵³ The policies reflected in the APA are (1) that the public should be accorded an opportunity to comment on proposed rules before they take effect and (2) that a court reviewing a challenged agency rule should have the benefit of a complete record explaining the necessity and purpose of the rule. Due process may well require that certain notice and hearing rights be subsequently accorded before properly-adopted rules may be legally applied to a particular private person. However, the fact that the procedures involved in such an after-the-fact administrative proceeding may pass muster under the due process clause, does not excuse a state agency from meeting its statutory responsibility to formally adopt as regulations those "guidelines" that were applied to the public. If the provider's legal rights were not recognized until he or she reached the appeal stage, neither of the APA objectives would be met. The Legislature clearly did not intend that the public forfeit its statutory right to have a voice in the formulation of crucial rules merely because an agency avoided violating the due process clause in structuring related quasi-adjudicatory hearings.

All quasi-legislative activity by state agencies is subject to APA public notice and comment requirements unless expressly exempted by statute.⁵⁴ Lacking an express

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statutory exemption, DHS must adopt its Medi-Cal claim and audit rules pursuant to the APA.

* * * * *

Argument B

DHS argues that its use of statistical sampling and extrapolation does not affect a legal right "significant" to the physician providers and that APA due process protections apply only to significant personal or property interests. DHS argues that the use of sampling and extrapolation "only curtails the provider's ability to overcharge the Medi-Cal program" by requiring the provider "to document all his claims for service pursuant to existing record-keeping requirements. (Citation omitted.)"

The APA is a statutory enactment. Its requirements apply to all state agency rulemaking activities not expressly exempt from its provisions. There is no exemption from APA requirements for regulations which do not affect significant personal or property interests. DHS has not cited any basis for its conclusion that such an exemption exists.

Assuming arguendo that argument B were legally viable, the provider clearly does have a property interest in the money he or she receives as reimbursement for Medi-Cal services rendered.

Is the provider's interest significant? We note that the adjustment letters appended to the UAPD request appear to reflect five and six figure deductions for insufficiently documented claims. Apparently, DHS does not consider five and six figure sums of money (\$10,000 to \$999,999) as "significant." Consider, however, if the provider's interest were not significant, why would DHS accord the provider a full due process appeals proceeding?⁵⁵

* * * * *

Argument C

DHS cites City of San Joaquin v. State Board of Equalization⁵⁶ as support for its argument that statistical auditing is valid and exempt from formal APA adoption requirements. In San Joaquin, the Court of Appeal held that a tax revenue pooling procedure, which was adopted "merely as a statistical accounting technique" by the State Board of Equalization ("Board") to "enable the Board to allocate, as expediently and economically as possible, to each city which

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joined the tax program, its fair share of sales taxes collected by the Board on that city's behalf,"⁵⁷ was not a "regulation" within the meaning of the APA. (Emphasis added.)

The "statistical accounting technique" in San Joaquin provided as follows:

"Briefly, all revenues received by the Board from the collection of local sales taxes imposed throughout a county are placed in a county-wide pool and are allocated by the Board to the taxing jurisdictions of that county on a quarterly basis. As to sales taxes imposed on over-the-counter sales, the revenues are allocated to each taxing jurisdiction in direct proportion to the reported sales attributable to such jurisdiction. But, as to sales taxes derived from construction contracts, the taxes are returned to the cities and the county on the same ratio as such cities and county receive revenue from over-the-counter sales for the same quarterly periods. Thus, each city is not allocated sales taxes imposed in connection with construction contracts, on a transaction for transaction basis; it receives its prorated share of all such taxes collected by the Board under a formula which is geared to the revenues the city receives from the over-the-counter sales." [Emphasis added.]

Subsequent cases have characterized the above San Joaquin holding as finding that the challenged pooling rule fell within the internal management exception.⁵⁸ However this San Joaquin holding is characterized, it is clear that it is no longer "good law," it is no longer authoritative. We base this conclusion on a review of the opinion in San Joaquin, of the briefs filed in that case, and on the subsequent history of San Joaquin. We reject the pooling procedure holding for these reasons:

(1) This San Joaquin holding is inconsistent with the holding of the Court of Appeal in City of San Marcos v. California Highway Commission,⁵⁹ which involved state rules governing allocation of funds among local government entities. Finding that the Department of Transportation rules were invalid absent formal adoption, the San Marcos court found that it did not

"appear that those rules and practices which have evolved in connection with reviewing and making allocations among applicants for grade separation funds have been assembled in a repository accessible to the public. More importantly, it does not appear that the affected local agencies have had an

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opportunity to participate in the formulation of the rules."⁶⁰ [Emphasis added.]

Citing San Joaquin, the San Marcos court stated that the "better reasoned view is to regard the 'internal management' exception narrowly so as to encompass accounting techniques and the like." (Emphasis added.) The reality is, however, that San Joaquin read the internal management exception very broadly. Or, put another way, San Joaquin read the definition of "regulation" very narrowly.

(2) We need not linger over the question of which court (San Joaquin or San Marcos) had the correct view in, respectively, 1970 and 1976, because a higher court resolved the conflict in 1978. The California Supreme Court, in Armistead v. State Personnel Board,⁶¹ clearly and authoritatively adopted the "narrow" view of the scope of the internal management exception and the "broad" view of the definition of "regulation." The San Joaquin holding so heavily relied upon by DHS cannot be reconciled with the subsequent ruling by the Supreme Court in Armistead, which proclaimed:

"A major aim of the APA was to provide a procedure whereby people to be affected may be heard on the merits of the proposed rules. [Par.] [R]ules that ~~interpret and implement other rules have~~ no legal effect unless they have been promulgated in substantial compliance with the APA."⁶² [Emphasis added.]

(3) Subsequent to San Joaquin, the California Legislature ratified Armistead's broad reading of "regulation" by enacting Government Code section 11347.5.

(4) The San Joaquin court inappropriately focused on the substantive merit of the pooling procedure: the court states that the procedure was "expedient and economical." This is beside the point. We can assume arguendo that any given agency policy is absolutely unassailable from a policy perspective. Having presumably arrived at a sound policy, the agency is nonetheless required by law to initiate APA procedures-- if the policy falls within the broad definition of "regulation" prescribed by the Legislature.

Further, DHS seems to argue that any statistical accounting or auditing technique is exempt from APA requirements. This argument goes too far. What if a statewide bond issue were passed and the administering

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state agency informally issued guidelines allocating 99% of the funds to the smallest county in the state, 1% to Los Angeles County, and nothing to the remaining counties?

We conclude that accounting or statistical techniques must be reviewed on a case by case basis to determine whether or not the technique at issue falls within the broadly defined term "regulation."

We assume arguendo that selection of statistical sampling techniques is within the scope of DHS' delegated powers; however, the exercise of such powers must be in full compliance with the APA. We reject the argument that San Joaquin controls the outcome of the current dispute concerning the validity of the sampling technique.

* * * * *

Argument D

DHS states "that the courts have imposed APA rulemaking requirements upon agencies only in situations where the affected public had no alternative means of administrative due process prior to the agency action." DHS cites California Optometric Association v. Lackner⁶³ as authority for this statement.

We reject this argument for the following reasons.

a. The APA, not the courts, imposes rulemaking requirements upon the agencies, and not "only in situations where the affected public [has] no alternative means" Government Code section 11346 specifically states that the rulemaking requirements of the APA are applicable to the exercise of any quasi-legislative power unless expressly exempted by the Legislature.

b. DHS' reliance on California Optometric Association as support for this statement is misplaced. California Optometric Association clearly follows the ruling in California Association of Nursing Homes:

"One objective of the APA is assurance of meaningful public participation in the adoption of administrative regulations by state agencies; another is creation of an administrative record assuring effective judicial review. [Cite omitted.]"⁶⁴
[Emphasis added.]

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c. DHS continues with this argument by stating:

"The generalized due process protections afforded by the notice and comment provisions of APA rulemaking are more than compensated for by the personal notice and specific opportunity to comment afforded through [the provider's] appeal process."

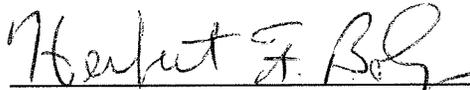
We reject this argument for the same reasons cited in argument A, supra.

WE CONCLUDE that DHS' probability sampling and statistical extrapolation method of auditing providers is not statutorily exempted from APA requirements.

V. CONCLUSION

For the reasons set forth above, OAL finds that the Medi-Cal Bulletin, dated July 1978; the Medi-Cal Update Bulletin, dated May 1983; pages 3-77 through 3-80 of the Medi-Cal Provider Manual for Medical Services; and DHS' use of a probability sampling and statistical extrapolation method for determining overpayments when auditing physician providers (1) are subject to the requirements of the APA, (2) are "regulations" as defined in the APA, and (3) are therefore invalid and unenforceable unless adopted as regulations and filed with the Secretary of State in accordance with the APA.

DATE: August 6, 1987


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- 1 In this proceeding, the Union of American Physicians and Dentists was represented by Melissa M. Meith, Esq., of Livingston and Mattesich Law Corporation, 1130 K Street, Suite 250, Sacramento, CA 95814 (916) 442-1111. The Department of Health Services was represented by Diane E. Shell, Deputy Director and Chief Counsel; Ivy M. Holden, Assistant Chief Counsel; and Linda Jane Slaughter, Staff Attorney (916) 322-4929.

- 2 The legal background of the regulatory determination process --including a survey of governing case law--is discussed at length in note 2 to 1986 OAL Determination No. 1 (Board of Chiropractic Examiners, April 9, 1986, Docket No. 85-011), California Administrative Notice Register 86, No. 16-Z, April 18, 1986, pp. B-14--B-16; typewritten version, notes pp. 1-4. See also Wheeler v. State Board of Forestry (1983) 144 Cal.App.3d 522, 192 Cal.Rptr. 693 (overturning Board's decision to revoke license for "gross incompetence in . . . practice" due to lack of regulation articulating standard by which to measure licensee's competence); City of Santa Barbara v. California Coastal Zone Conservation Commission (1977) 75 Cal.App.3d 572, 580, 142 Cal.Rptr. 356, 361 (rejecting Commission's attempt to enforce as law a rule specifying where permit appeals must be filed--a rule appearing solely on a form not made part of the CAC). For an additional example of a case holding a "rule" invalid because (in part) it was not adopted pursuant to the APA, see National Elevator Services, Inc. v. Department of Industrial Relations (1982) 136 Cal.App.3d 131, 186 Cal.Rptr. 165 (internal legal memorandum informally adopting narrow interpretation of statute enforced by DIR). Also, in Association for Retarded Citizens--California v. Department of Developmental Services (1985) 38 Cal.3d 384, 396 n.5, 211 Cal.Rptr. 758, 764 n.5, the court avoided the issue of whether a DDS directive was an underground regulation, deciding instead that the directive presented "authority" and "consistency" problems. In Johnston v. Department of Personnel Administration (1987) 236 Cal.Rptr. 853, 857, the Third District Court of Appeal found that the Department of Personnel Administration's "administrative interpretation" regarding the protest procedure for transfer of civil service employees was not promulgated in substantial compliance with the APA and therefore was not entitled to the usual deference accorded to formal agency interpretation of a statute.

- 3 As we have indicated elsewhere, an OAL determination concerning a challenged "informal rule" is entitled to great weight in both judicial and adjudicatory administrative proceedings. See 1986 OAL Determination No. 3 (Board of Equalization, May 28, 1986, Docket No. 85-004), California Administrative Notice Register 86, No. 24-Z, June 13, 1986,

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p. B-22; typewritten version, pp. 7-8; Culligan Water Conditioning of Bellflower, Inc. v. State Board of Equalization (1976) 17 Cal.3d 86, 94, 130 Cal.Rptr. 321, 324-325. The Legislature's special concern that OAL determinations be given appropriate weight in other proceedings is evidenced by the directive contained in Government Code section 11347.5: "The office's determination shall be published in the California Administrative Notice Register and be made available to . . . the courts." (Emphasis added.)

- 4 UAPD submitted an additional comment to OAL. This comment pointed out the fact that DHS had submitted a "Notice of Proposed Action" to OAL for publication and included UAPD's comment to DHS concerning this notice. This comment was considered in making this Determination.

A timely "Memorandum in Response to Request for a Regulations Determination" was received from DHS and was considered in making this Determination.

In general, in order to obtain full presentation of contrasting viewpoints, we encourage affected agencies to submit responses. If the affected agency concludes that part or all of the challenged rule is in fact an underground regulation, it would be helpful, if circumstances permit, for the agency to concede that point and to permit OAL to devote ~~its resources to analysis of truly contested issues.~~

- 5 An OAL finding that a challenged rule is illegal unless adopted "as a regulation" does not of course exclude the possibility that the rule could be validated by subsequent incorporation in a statute.
- 6 Pursuant to Title 1, CAC, section 127, this Determination shall become effective on the 30th day after filing with the Secretary of State.
- 7 DHS is not unfamiliar with decisions holding that certain "rules" are invalid unless adopted pursuant to the APA. See California Association of Nursing Homes, etc. v. Williams (1970) 4 Cal.App.3d 800, 84 Cal.Rptr. 590 (changes to Medi-Cal "Schedule of Maximum Allowances" mandated by the Department of Finance); California Medical Association v. Brian (1973) 30 Cal.App.3d 637, 106 Cal.Rptr. 555 ("Medi-Cal consultant guidelines" interpreting and supplementing regulations); Goleta Valley Community Hospital v. State Department of Health Services (1983) 149 Cal.App.3d 1124, 197 Cal.Rptr. 294 (agency letter erroneously re-interpreting

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Medi-Cal hospital reimbursement regulation); and Planned Parenthood v. Swoap (1985) 173 Cal.App.3d 1187, 219 Cal.Rptr. 664 (agency statement narrowly interpreting Budget Act provision).

- 8 The requester has asked (at page 14 of the Request) for OAL to rule upon the following contention: that "in addition to utilizing Bulletins and manuals unlawfully, DHS is using case by case, or ad hoc, standards which may be written, or may exist only in the minds of the reviewers, in determining whether a patient chart is adequate." (Emphasis added.) The requester asserts (1) that application of such "ad hoc" standards violates the due process clause and (2) that the "standards" are "regulations" within the meaning of the California APA.

If standards have been articulated neither in writing nor orally, then there is no "standard of general application" and no violation of section 11347.5. If, at some later date, the requester can produce evidence consistent with Title 1, California Administrative Code, section 122, that one or more articulable standards are being used by DHS in the documentation review process in violation of section 11347.5, the requester may submit another request pursuant to Title 1.

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- 9 We refer to the portion of the APA which concerns rulemaking by state agencies: Chapter 3.5 of Part 1 ("Office of Administrative Law") of Division 3 of Title 2 of the Government Code, Sections 11340 through 11356. Chapters 4 and 5, also part of the APA, concern administrative adjudication rather than rulemaking.

- 10 Medi-Cal Act (chapter 7, part 3, division 9, of the Welfare and Institutions Code, sections 14000 - 14196.1).

- 11 Welfare and Institutions Code section 14000.

- 12 We discuss the affected agency's rulemaking authority (see Gov. Code, sec. 11349(b)) in the context of reviewing a Request for Determination for the purposes of exploring the nature of the dispute and of attempting to ascertain whether or not the agency's rulemaking statute expressly requires APA compliance. If the affected agency should later elect to submit for OAL review a regulation proposed for inclusion in the California Administrative Code, OAL will, pursuant to Government Code section 11349.1(a), review the proposed regulation in light of the APA's procedural and substantive

requirements.

The APA requires all proposed regulations to meet the six substantive standards of necessity, authority, clarity, consistency, reference, and nonduplication. OAL does not review alleged "underground regulations" to determine whether or not they meet the six substantive standards applicable to regulations proposed for formal adoption.

The question of whether the challenged rule would pass muster under the six substantive standards need not be decided until such a regulatory filing is submitted to us under Government Code section 11349.1(a). At that point, the filing will be carefully reviewed to ensure that it fully complies with all applicable legal requirements.

Comments from the public are very helpful to us in our review of proposed regulations. We encourage any person who detects any sort of legal deficiency in a proposed regulation to file comments with the rulemaking agency during the 45-day public comment period. Such comments may lead the rulemaking agency to modify the proposed regulation.

If review of a duly-filed public comment leads us to conclude that a regulation submitted to OAL does not in fact satisfy an APA requirement, OAL will disapprove the regulation. Government Code section 11349.1.

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- 13 Government Code section 11342(a). See Government Code sections 11343 and 11346. See also 27 Ops.Cal.Atty.Gen. 56, 59 (1956).
 - 14 See Poschman v. Dumke (1973) 31 Cal.App.3d 932, 943, 107 Cal.Rptr. 596, 609.
 - 15 See Request for Regulatory Determination, pp. 1 - 2.
 - 16 See Request for Regulatory Determination, pp. 5 - 6.
 - 17 The Medi-Cal Provider Manual has a total of 5,766 pages. It is broken down into the following six components:

Medical Services	1260 pages
Inpatient/Outpatient	1200 pages
Drug Claims Manual	1016 pages
Allied Health Services	800 pages
Long Term Care	800 pages
Vision Care	690 pages

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Hence, pages 3-77 through 3-80 are four out of 1260 pages of the Medi-Cal Provider Manual for medical services.

- 18 See Faulkner v. California Toll Bridge Authority (1953) 40 Cal.2d 317, 324 (point 1); Winzler & Kelly v. Department of Industrial Relations (1981) 121 Cal.App.3d 120, 174 Cal.Rptr. 744 (points 1 and 2); cases cited in note 2 of 1986 OAL Determination No. 1. A complete reference to this earlier Determination may be found in note 2 to today's Determination.
- 19 The six recognized levels of service are:
Minimal Level of Service; Brief Level of Service;
Limited Level of Service; Intermediate Level of Service;
Extended Level of Service; and Comprehensive Level of Service.
- 20 Letter dated May 28, 1985, from DHS to UAPD.
- 21 Along with the Medi-Cal Bulletin, DHS characterized the Medi-Cal Update in its May 28, 1986 letter to UAPD as a "Medi-Cal program guideline" that "updated guidelines for documentation of physician office visits." (Emphasis added.)
- 22 DHS "Memorandum in Response to Request for a Regulations Determination," p. 3.
- 23 1986 OAL Determination No. 3 (Board of Equalization, May 28, 1986, Docket No. 85-004), California Administrative Notice Register 86, No. 24-Z, June 13, 1986, p. B-28, typewritten version, pp. 17-18.

Similar arguments, and the reasons for rejecting those arguments, may also be found in the Coastal Commission Determination: 1986 OAL Determination No. 2 (Coastal Commission, April 30, 1986, Docket No. 85-003), California Administrative Notice Register 86, No. 20-Z, May 16, 1986, pp. B-31--B-34.
- 24 Id., California Administrative Notice Register, No. 24-Z, p. B-23, typewritten version, p. 10.

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25 See note 22, supra, p. 5.

26 Id., p. 11.

27 See 1986 OAL Determination No. 6 (Bay Conservation and Development Commission, September 3, 1986, Docket No. 86-002), California Administrative Notice Register 86, No. 38-Z, September 19, 1986, pp. B-25--B-26, and n. 28, typewritten version, pp. 12-13, and n. 28.

28 In support of this contention, DHS cites Securities and Exchange Commission v. Chenery Corporation (1947) 332 U.S. 194, 67 S.Ct. 1575. In Chenery, the U.S. Supreme Court determined that in special situations it was necessary for the agency to retain power to deal with problems on a case-by-case basis if the administrative process was to be effective. The Court referred to the following special situations which would justify resolution of a problem on a case-by-case basis:

"[P]roblems may arise in a case which the administrative agency could not reasonably foresee, problems which must be solved despite the absence of a relevant general rule. Or the agency may not have had sufficient experience with a particular problem to warrant rigidifying its tentative judgment into a hard and fast rule. Or the problem may be so specialized and varying in nature as to be impossible of capture within the boundaries of a general rule. . . . [T]he choice made between proceeding by general rule or by individual, ad hoc litigation is one that lies primarily in the informed discretion of the administrative agency." Id., 332 U.S. at pp. 202-203.

Chenery is readily distinguishable from the matter at hand on the following grounds:

(1) Chenery involved interpretation of the federal APA--a statute that differs substantially from the California APA. Perhaps the most notable difference is that the federal APA lacks California's comprehensive ban on underground regulations--Government Code section 11347.5. In its response, DHS relies heavily on the much criticized Chenery case. (1 Koch, Administrative Law and Practice, (1985) pp. 73-75.) As we have noted in earlier determinations, cases interpreting the federal APA are at best of limited value in construing the unique California APA. (See 1986 OAL Determination No. 2 (Coastal Commission, April 30, 1986, Docket No. 85-003), California Administrative

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Notice Register 86, No. 20-Z, May 16, 1986, p. B-34, typewritten version, p. 8; 1986 OAL Determination No. 4 (State Board of Equalization, June 25, 1986, Docket No. 85-005), California Administrative Notice Register 86, No. 28-Z, July 11, 1986, p. B-25, n. 35, typewritten version, p. 6, n. 35.)

(2) Unlike the situation at hand, in which DHS has published and distributed authoritative "guidelines" clearly intended to apply to future claim submissions and audit proceedings, the agency in Chenery (the SEC) had chosen to proceed without any previously announced rules or guidelines. The fact that the U.S. Supreme Court, construing federal law, upheld the SEC's determination to create rules in the future through adjudication would seem to be of very limited assistance in aiding us in deciding whether or not certain informally issued rules are valid.

(3) In any event, the record does not reveal that DHS has experienced any of the special problems noted by the Supreme Court. The Medi-Cal program has been operative since March 1966. Providers have been audited for many years. The problem of provider overpayment is reasonably foreseeable; can be solved by regulations (in fact, regulations have been formally adopted to solve statistical sampling problems relating to pharmacists); has been the experience of DHS for approximately 20 years; and is not so specialized and varying in nature "as to be impossible of capture within the boundaries of a general rule" (again, regulations have already been adopted in this area). DHS argues that rules concerning physicians were not ripe for adoption until several years after a statistical regulation applying to pharmacists was adopted because physician claims are much more complex than pharmacist claims. If this is the case, it is curious that the long-awaited statistical regulation applying to physicians (proposed section 51458.2 of Title 22 of the CAC) is virtually identical to the longstanding pharmacist regulation (section 51488.2).

(4) It is also worth noting that the Securities and Exchange Commission was acting in a quasi-judicial capacity in Chenery and not in a quasi-legislative role. Federal law may allow for the resolution of program problems on a case-by-case basis in special situations; however, California law explicitly states that the rulemaking requirements of the APA are "applicable to the exercise of any quasi-legislative power conferred by any statute heretofore or hereafter enacted." (Emphasis added.) Government Code section 11346.

29 (1976) 60 Cal.App.3d 500, 131 Cal.Rptr. 744.

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30 (1970) 4 Cal.App. 3d 800, 813, 84 Cal.Rptr. 590, 599.

31 Id.

32 (1982) 33 Cal.3d 158, 188 Cal.Rptr. 104.

33 Id., 33 Cal.3d at p. 168.

34 (9th Cir. 1983) 720 F.2d 1132.

35 Id., at pp. 1135-1136.

36 (1977) 75 Cal.App.3d 522, 192 Cal.Rptr. 693.

37 (1983) 149 Cal.App.3d 1124, 197 Cal.Rptr. 294.

38 See Government Code section 11346.

39 See Government Code section 11342, subdivision (b).

40 See Winzler & Kelly v. Department of Industrial Relations (1981) 121 Cal.App.3d 120, 128, 174 Cal.Rptr. 744.

41 See 1986 OAL Determination No. 2 (Coastal Commission, April 30, 1986, Docket No. 85-003), California Administrative Notice Register 86, No. 20-Z, May 16, 1986, pp. B-31--B-43; 1986 OAL Determination No. 3 (Board of Equalization, May 28, 1986, Docket No. 85-004), California Administrative Notice Register 86, No. 24-Z, June 13, 1986, pp. B-18--B-34; 1986 OAL Determination No. 6 (Bay Conservation and Development Commission, September 3, 1986, Docket No. 86-002), California Administrative Notice Register 86, No. 38-Z, September 19, 1986, pp. B-18--B-35.

42 See Armistead v. State Personnel Board, (1978) 22 Cal.3d 198, 206, 149 Cal.Rptr. 1.

43 See note 41, supra, for the full citation of 1987 OAL Determination No. 2.

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- 44 Id., California Administrative Notice Register 86, No. 20-Z, May 16, 1986, pp. B-37; B-42, n. 29; typewritten version, pp. 13 & 24, n. 29.
- 45 1987 OAL Determination No. 5 (State Personnel Board, April 30, 1987, Docket No. 86-011), California Administrative Notice Register 87, No. 20-Z, May 15, 1987, p. B-54; typewritten version, p. 17.
- 46 DHS has implicitly recognized that the supplemental CPT definitions cannot be utilized in the administration of the Medi-Cal program unless formally adopted as regulations. DHS' notice of proposed regulation (concerning the CPT definitions) to be adopted was printed in the California Administrative Notice Register 87, No. 28-Z, July 10, 1987, pp. A-5--A-7.
- 47 See Request for Regulatory Determination, p. 18.
- 48 DHS disagrees with this conclusion, and, in its Response to this Request, maintains that its case-by-case use of statistical sampling/extrapolation in its audits has been repeatedly tested and upheld in administrative hearings. Cited in support of this assertion are the written decisions issued by DHS in two audit appeals. We note that in DHS' Proposed Interlocutory Decision issued in the matter of Angie Mouttapa, M.D., DHS correctly pointed out "The Department's mere administrative decision that it is legal to find overpayments in these cases based upon probability sampling cannot be given a quasi-legislative effect to control the decision in this forum [i.e., the administrative hearing]." The Proposed Interlocutory Decision points out that the challenge to DHS (that is DHS' general procedures and collection methods presented by the appealing physician's objection to the use of probability sampling to determine the existence of overpayments, would more appropriately be made before a court or OAL. Whereas the Proposed Interlocutory Decision in the Mouttapa case acknowledges that the decision maker in that proceeding had no power to review or confer validity upon DHS' general application of probability sampling for physician audits, the decision's conclusion that the use of a statistical probability sample to prove an overpayment is not a quasi-legislative act is of no persuasive value.

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- 49 OAL notes that DHS has submitted a notice of proposed regulation for publication. See California Administrative Notice Register 87, No. 13-Z, March 27, 1987, pp. A-30--A-31. Basically, this regulation specifies that DHS may use probability sampling and statistical extrapolation to determine the amount of overpayment to be recovered from all categories of Medi-Cal providers as the result of an audit. DHS is to be commended for promptly addressing the underlying AB 1013 (Government Code section 11347.5) problem by initiating a rulemaking.

As this Determination was being prepared for filing, DHS submitted a rulemaking proposal for review and filing with the Secretary of State.

- 50 See note 28, supra, for full citation of this case.

- 51 Any doubts as to whether or not DHS must formally adopt the above noted informal rules as regulations are removed by careful review of Welfare and Institutions Code section 10725, which states that not only "regulations," but also "orders and standards of general application" must be adopted "only in accordance with the [APA]." (Emphasis added.) By employing the latter two additional terms, it is clear that the Legislature intended that APA notice and hearing requirements apply to a broader category of DHS enactments than is the case with most agencies' general rulemaking statutes. Assuming arguendo that the challenged rules are not "regulations," we conclude that they are either "orders" or "standards of general application" within the meaning of section 10725.

- 52 The following provisions of law may also permit agencies to avoid the APA's requirements under some circumstances, but do not apply to the case at hand:

- a. Rules relating only to the internal management of the state agency. Government Code section 11342(b).
- b. Forms prescribed by a state agency or any instructions relating to the use of the form, except where a regulation is required to implement the law under which the form is issued. Government Code section 11342(b).
- c. Rules that "establish[] or fix[] rates, prices or tariffs." Government Code section 11343(a)(1).
- d. Rules directed to a specifically named person or

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group of persons and which do not apply generally or throughout the state. Government Code section 11343(a)(3).

- e. Legal rulings of counsel issued by the Franchise Tax Board or the State Board of Equalization. Government Code section 11342(b).
- f. Contractual provisions previously agreed to by the complaining party. City of San Joaquin v. State Board of Equalization (1970) 9 Cal.App.3d 365, 376, 88 Cal.Rptr. 12, 20 (sales tax allocation method was part of a contract which plaintiff had signed without protest); see Roth v. Department of Veterans Affairs (1980) 110 Cal.App.3d 622, 167 Cal.Rptr. 552 (dictum); Nadler v. California Veterans Board (1984) 152 Cal.App.3d 707, 719, 199 Cal.Rptr. 546, 553 (same); but see Government Code section 11346 (no provision for non-statutory exceptions to APA requirements); see International Association of Fire Fighters v. City of San Leandro (1986) 181 Cal.App.3d 179, 182 226 Cal.Rptr. 238, 240 (contracting party not estopped from challenging legality of "void and unenforceable" contract provision to which party had previously agreed); see Perdue v. Crocker National Bank (1985) 38 Cal.3d 913, 926, 216 Cal.Rptr. 345, 353 ("contract of adhesion" will be denied enforcement if deemed unduly oppressive or unconscionable).

The above is not intended as an exhaustive list of possible APA exceptions.

- 53 California Optometric Association v. Lackner (1976) 60 Cal.App.3d 500, 506, 131 Cal.Rptr. 744, 748; citing California Association of Nursing Homes v. Williams (1970) 4 Cal.App.3d 800, 810-812, 84 Cal.Rptr. 590.
- 54 See Government Code section 11346.
- 55 See Welfare and Institutions Code section 14171 (discusses appeals).
- 56 (1970) 9 Cal.App.3d 365, 88 Cal.Rptr. 12.
- 57 Id., 9 Cal.App.3d at page 375.

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- 58 Poschman v. Dumke (1973) 31 Cal.App.3d 932, 107 Cal.Rptr. 596; City of San Marcos v. California Highway Commission, Department of Transportation (1976) 60 Cal.App.3d 383, 131 Cal.Rptr. 804.
- 59 (1976) 60 Cal.App.3d 383, 131 Cal.Rptr. 804.
- 60 Id., 60 Cal.App.3d at page 409.
- 61 (1978) 22 Cal.3d 198, 149 Cal.Rptr. 1.
- 62 Id., 22 Cal.3d at page 204.
- 63 (1976) 60 Cal.App.3d 500, 131 Cal.Rptr. 744.
- 64 Id., 60 Cal.App.3d at page 506.
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