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STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
OFFICE OF HEARINGS AND APPEALS

In the Matter of	)	
	)	
[redacted],	)	OHA Case No. 09-FH-93
	)	
Claimant.	)	Division Case No. [redacted]
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) is an Alaskan resident. On January 9, 2009, [redacted] Behavioral Health Systems ([redacted]), a residential psychiatric care facility, requested prior approval from the Alaska Medicaid program for the Claimant's inpatient psychiatric treatment.[1] (Ex. E, p. 14) On January 27, 2009, Qualis Health[2] (Qualis), acting on behalf of the State of Alaska Department of Health and Social Services, Division of Behavioral Health (Division), sent the Claimant written notice that his request for inpatient psychiatric treatment was denied. (Ex. F) The Claimant requested a fair hearing on February 9, 2009. (Ex. C) This office has jurisdiction pursuant to 7 AAC 49.010.

Pursuant to the Claimant's request, a hearing was held on March 23, 24, and 25, 2009. The Claimant attended in person. [redacted], Esq., with the Federal Defender's Office, attended in person and represented the Claimant. [redacted], Esq., an investigator with the Federal Defender's Office, attended in person and testified on the Claimant's behalf. Dr. [redacted], Ph.D, and Dr. [redacted], Ph.D, attended telephonically and testified on behalf of the Claimant. Dr. [redacted], M.D., the medical director at [redacted], attended telephonically and testified on behalf of the Claimant.

[1] The actual request for approval is not contained in the record, merely the computer record of its receipt. (Ex. E, p. 14)

[2] Qualis Health is a private business that is contracted to perform Medicaid eligibility reviews for the State of Alaska Department of Health and Social Services.

[redacted], Esq., Assistant Attorney General, appeared in person and represented the Division on March 23 and 24, 2008. [redacted] attended the March 25, 2009 portion of the hearing telephonically. [redacted], a medical reviewer with Qualis, appeared in person and testified on behalf of the Division. Dr. [redacted], M.D., a psychiatrist medical reviewer with Qualis, appeared both in person (March 24) and telephonically (March 25), and testified on behalf of the Division.

The record was held open after hearing for post-hearing briefing, which was completed on April 10, 2009.

ISSUE

Was the Division correct when it denied the Claimant's request that Medicaid coverage be approved for the Claimant's residential psychiatric treatment at [redacted]?

FINDINGS OF FACT

The following facts are found by a preponderance of the evidence.

1. The Claimant is currently [redacted] years old (birth date [redacted]). (Ex. 1)

2. The Claimant was arrested on April 24, 2008 on federal felony child pornography charges. (Ex. 2, pp. 1 - 2) He is not in custody, but has a third-party custodian. (Ex. 1, p. 2)

3. [redacted] is a psychiatric residential care facility located in [redacted] that has a treatment program for young men, ages [redacted]. ([redacted] testimony) The treatment program deals with sexual offense issues and substance abuse issues. *Id.* Paraphilia is a mental disorder treated at [redacted]. *Id.*

4. [redacted] made two requests in December 2008, on behalf of the Claimant, for Medicaid preapproval of the Claimant's proposed residential treatment at [redacted], each of which was denied. ([redacted] testimony) [redacted] resubmitted the request on January 9, 2009. (Ex. E, p. 14) Qualis Health reviewed the Claimant's request for treatment and denied it again on January 15, 2009, and informed [redacted] they could request an internal appeal from Qualis. (Ex. D) On January 16, 2009, [redacted] submitted its appeal to Qualis. (Ex. E, pp. 5 – 6) On January 27, 2009, Qualis again denied the Claimant's request. (Ex. F)

5. [redacted] is employed by Qualis where she performs clinical reviews of applications for residential treatment. ([redacted] testimony) She has a Master's degree in social work. *Id.* She reviewed the application for the Claimant to be treated at [redacted]. *Id.* She did not find a need for residential placement at [redacted] and referred the case to Dr. Winn, the medical director for Qualis's contract with the Division, for his review. *Id.*

6. Ms. [redacted] found the Claimant did not meet criteria for out of state residential psychiatric treatment for the following reasons:

a. While the Claimant's diagnosis of Paraphilia (DSM IV TR 302.9)[3] was an acceptable diagnosis for Medicaid purposes, it "would [not] support that being a primary diagnosis in a residential psychiatric treatment center." ([redacted] testimony)

b. The Claimant does not have a history of psychiatric or psychotropic medication, other than being treated for ADHD in the fourth and ninth grades. *Id.*

c. The Claimant has not tried and failed at a lower level of care, such as outpatient therapy. *Id.*

d. The Claimant's symptoms, including his lack of any physical contact (with a victim), did not support a residential treatment program. *Id.*

7. The Claimant was referred to Dr. [redacted], Ph.D, by his federal public defender, for psychological testing. (Ex. 2, p. 1; [redacted] testimony)

8. Dr. [redacted] has a Ph.D. in clinical psychology. (Smith testimony) He has been working with adolescent and adult sexual offenders since 1982. *Id.* He is approved as a Sex Offender Treatment Supervisor by the State of Alaska. (Ex. 3; Smith testimony) He helped design the sexual offender treatment program at Hiland Mountain Correctional Center. ([redacted] testimony) He currently consults with two adolescent treatment programs, the Volunteers of America substance abuse treatment program and the Alaska Children's Services residential juvenile offender treatment program. *Id.* He also does evaluations for private attorneys, the Office of Children's Services, the Office of Public Advocacy, the Attorney General's office, the District Attorney's office, and the Public Defender's office. *Id.* He estimated that over the past 20 years, he has treated between 1,000 to 2,000 individuals with clinical paraphilia or pedophilia issues. *Id.*

9. Dr. [redacted] has met with the Claimant on 5 separate occasions: June 4, 2008, June 18, 2008, June 25, 2008, July 28, 2008, and January 6, 2009. (Ex. 1, p. 1; Ex. 2, p. 1) He has seen the Claimant for approximately 7 hours total. ([redacted] testimony) After meeting with the Claimant and administering psychological tests to the Claimant, Dr. [redacted] concluded as follows:

a. The Claimant's Axis 1 psychological diagnoses are: Adolescent Antisocial Behavior, Cannabis Dependence in partial remission, Paraphilia Not Otherwise Specified, ADHD,[4] predominantly hyperactive impulsive type. (Ex. 2, p. 10) Dr. Smith explained that Paraphilia is a broad term for sexually deviant behavior:

> Paraphilia is a broader term indicating that there is a deviant sexual interest pattern that may or may not fit the - - the criteria for pedophilia. For example in [the Claimant's]

[3] Ms. [redacted] initially referred to Claimant's diagnosis as being for Psychosexual Disorder and stated that she later found out that the diagnosis was for Paraphilia. *See Diagnostic and Statistical Manual of Mental Disorders IV TR* 576 (4th Edition, Text Revision 2003)

[4] Attention Deficit Hyperactivity Disorder.

> case, his viewing of internet images included adult images but also child images. It wasn't exclusively a focus on children, and therefore the sexual interest diagnosis better fit paraphilia as opposed to pedophilia.

([redacted] testimony)

b. The Claimant has a Global Assessment of Functioning of 50. (Ex. 2, p. 10)

c. Dr. [redacted] August 7, 2008 report recommended that the Claimant "would benefit from community-based treatment such as that provided by Department off (sic) Corrections approved providers for his sexually deviant interest and Internet pornography access" and that the Claimant "needs to be monitored in the community and not allowed unsupervised access to minor female children as a precaution." (Ex. 2, p. 12)

d. Dr. [redacted] wrote a "Summary of Mental Status Examination" report regarding his January 6, 2009 examination of the Claimant. (Ex. 1) That report concluded that the Claimant "is potentially treatable in the community but would benefit most from a long-term multidisciplinary residential facility with services for young adults with co-occurring disorders." (Ex. 1, p. 2)

e. In response to a question about whether residential treatment for the Claimant, specifically the Benchmark program, was medically necessary, Dr. [redacted] answered "Yeah. My opinion would be that the residential program at [redacted] would best fit [the Claimant's] particular set of circumstances." ([redacted] testimony) Dr. [redacted] reasoning was:

   i. Most treatment programs are geared either to adolescents who are between 13 to 18 years old or adults between 30 to 40 years old, that the Claimant falls between adolescent and adult programs, and that [redacted] offers one of the few young adult programs available in the U.S. *Id.*

   ii. The Claimant is too old for any Alaskan adolescent treatment programs and that "there are no intensive adult programs available in Alaska." *Id.*

   iii. He explained the change in his August 2008 report's recommendation of community based treatment to his January 2009 report's recommendation of residential treatment was due to him becoming aware of the [redacted] program, the Claimant's "potential dangerousness, I guess is the term, or risk of recidivism," and his co-occurring factors. *Id.*

   iv. He further explained residential treatment was more appropriate for individuals with co-occurring disorders to reduce the "likelihood of relapse or reoffending." *Id.* The Claimant's co-occurring disorders are "issues of impulsivity that are related to his historical Attention Deficit Disorder diagnosis," "a predisposition to a chemical dependency, which is

a co-occurring issue that's often seen" in sexually addictive or deviant behaviors, and "documented sexually deviant behavior." *Id.*

10. Dr. [redacted] has a Ph.D in psychology, and is a certified Chemical Dependency counselor. ([redacted] testimony) He has been in practice since 1996. *Id.* He is approved as a Sex Offender Treatment provider by the State of Alaska. (Ex. 3) He was a treatment provider at the Hiland Mountain Correctional Center Sex Offender Program for 9 years. ([redacted] testimony) He has treated individuals with diagnoses of both Paraphilia and Pedophilia. *Id.*

11. Dr. [redacted] has met with the Claimant for 4 hours as a treating psychologist. ([redacted] testimony) He has reviewed the Claimant's medical, educational, and court records. *Id.* He concluded that it was clinically necessary for the Claimant to receive treatment in an inpatient or residential program, specifically the [redacted] program. *Id.* His conclusion was based upon the following:

a. He was not aware of community outpatient treatment options for the Claimant. *Id.*

b. Given the Claimant's involvement with child pornography, he requires more than outpatient treatment. *Id.* An intensive treatment program with group treatment is the best forum for treating the Claimant and his denial issues. *Id.*

c. Inpatient psychiatric treatment is reasonably expected to improve the Claimant's condition or prevent his regression. *Id.*

d. If he did not know about the [redacted] program, he would be searching for a similar residential program for the Claimant's treatment. *Id.*

12. [redacted] is an investigator with the Federal Defender's office. ([redacted] testimony) She researched whether there were local residential treatment options for the Claimant in Alaska and was unable to find any. *Id.* In her research, she spoke to Dr. [redacted] Dr. [redacted], Dr. [redacted], and criminal defense lawyers. *Id.*

13. [redacted], M.D., is the medical director at [redacted]. ([redacted] testimony) He is certified with his local juvenile sex offender treatment group. *Id.* He has not met the Claimant. *Id.* He reviewed Dr. [redacted] evaluation of the Claimant. *Id.* He concluded that the Claimant was appropriate for residential treatment at [redacted] for the following reasons:

a. The Claimant has an inadequate social network, high level of impulsivity, mood disorders, and a substance abuse history that increase his risk of committing a future sexual offense. *Id.*

b. The Claimant is sexualized to child pornography. *Id.*

c. Dr. [redacted] recommended that the Claimant not have unsupervised contact with minor females, which is difficult to implement on an outpatient basis. *Id.*

d. Outpatient therapy would only handle sexual issues, and not the variety of issues facing the Claimant. *Id.*

14. Dr. [redacted], M.D., is a psychiatrist in Anchorage. ([redacted] testimony) His professional experience includes being the chief of psychiatry for the Alaska Native Medical Center, working at the Alaska Psychiatric Institute, and having served as a president of the Alaska Psychiatric Association. *Id.* He has been in private practice since 1979, and currently has a general psychiatric practice. *Id.* He currently provides clinical review services for Qualis, and provided clinical review services for Qualis' predecessor for 8 years. *Id.* He lectures on pornography and internet pornography addiction. *Id.*

15. Dr. [redacted] reviewed the Claimant's request for Medicaid coverage for his placement in the [redacted] program for Qualis. (Winn testimony) He spoke to Dr. [redacted], a physician at [redacted]. ([redacted] testimony; [redacted] testimony) He did not meet or personally evaluate the Claimant. *Id.* He did not speak to either Dr. [redacted] or Dr. [redacted] about the Claimant's case. ([redacted] testimony)

16. Dr. [redacted] concluded that while the Claimant had a supportable diagnosis (Paraphilia) in the appropriate diagnostic code range, the Claimant's treatment needs could be served at an outpatient level for the following reasons:

a. He does not have clinically acute symptoms such as suicidal or homicidal thoughts. ([redacted] testimony; Ex. E, p. 23)

b. His deviant behavior occurred some time ago, and there is no ongoing activity. ([redacted] testimony)

c. He is existing in the community without problems. ([redacted] testimony; Ex. E, p. 23)

d. He has not had "physical involvement with youth or children." ([redacted] testimony)

e. Pornography viewing "can be treated by a mental health professional that's familiar with addictive type behaviors and - - thinking." *Id.*

f. Residential treatment potentially could reinforce the Claimant's sexually deviant behavior. (Ex. E, p. 23; [redacted] testimony)

17. Dr. [redacted] was not aware of any in-state Alaska residential treatment programs for young adult sexual deviants. (Winn testimony)

PRINCIPLES OF LAW

This case involves the question of whether or not the Division was correct when it denied the Claimant's request that Medicaid authorize and pay for his residential treatment at Benchmark.

Because this case involves an application for benefits, the Claimant has the burden of proof[5] by a preponderance of the evidence.[6]

Federal Medicaid regulation 42 CFR 441.152 lists three minimum requirements that must each be met before the Medicaid program will provide coverage for an individual under the age of 21 placed in a residential psychiatric treatment center:

> (1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
> (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
> (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

42 CFR 441.152(a). These requirements are mirrored in Alaska regulation 7 AAC 43.552(b)(2). In addition, the Alaska regulations require that when an individual under the age of 21 is involved, he must have a Global Assessment of Function of 50 or less. 7 AAC 43.486(b)(9). The Division's interpretation of the state and federal regulations is contained in its *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria* (Revision Date: April 2008).[7] (Ex. G, pp. 99 – 105) There is no evidence that this document has been promulgated as a regulation pursuant to the Administrative Procedure Act. *See* fn. 7 above.

The Division's interpretation of its own regulation is reviewed under the *reasonable basis standard*; the Division is deferred to unless the interpretation is "plainly erroneous and inconsistent with the regulation." *Lauth v. State,* 12 P.3d 181, 184 (Alaska 2000) A deferential standard of review for an agency's interpretation of its own regulation is only required when the

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[5] "Ordinarily the party seeking a change in the status quo has the burden of proof." *State, Alcohol Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985)

[6] Preponderance of the evidence is the normal standard of proof in an administrative proceeding. *Amerada Hess Pipeline v. Alaska Public Utilities Comm'n,* 711 P.2d 1170, n. 14 at 1179 (Alaska 1986). Preponderance of the evidence is defined as "[e]vidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not." Black's Law Dictionary 1064 (5th Ed. 1979)

[7] The *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria* (Revision Date: April 2008), is Appendix C to the Division's *Inpatient Psychiatric Review Provider Manual. See* the Division's April 6, 2009 Closing Brief, n. 4 at page 7. The *Inpatient Psychiatric Review Provider Manual* was not introduced into evidence, merely it's Appendix C, the *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria* (Revision Date: April 2008). (Ex. G, pp. 99 – 105) The Division did not argue or demonstrate that the *Inpatient Psychiatric Review Provider Manual l* has been adopted as a regulation. Further, while 7 AAC 43.552(g) specifically adopts the "*Alaska Medicaid Protocols and Medical Necessity Criteria for Inpatient and Residential Psychiatric Treatment: Medicaid Payment Prior Authorization Manual,* as revised as of August 18, 2000" as a regulation by reference, neither the Division's *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria* (Revision Date: April 2008) nor the Division's *Inpatient Psychiatric Review Provider Manual* are listed in the regulation (7 AAC 43.552(g)) as having been adopted by reference.

"administrative regulation has been adopted in accordance with the procedures set forth in the Administrative Procedure Act." *Kelly v. Zamarello,* 486 P.2d 906, 911 (Alaska 1971) An agency interpretation of a regulation that supplements, revises, or makes a regulation more specific, is itself a regulation, and in order to be followed must be adopted pursuant to the Administrative Procedure Act. *Jerrel v. State, Dept of Natural Resources,* 999 P.2d 138, 144 (Alaska 2000) (reh. den.).

The federal courts have held that an individual's physician's[8] opinion regarding whether a treatment is necessary is presumed to be correct:

> The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.

Weaver v. Reagen, 886 F.2d 194, 200 (8th Cir. 1989). In general, more weight is given to a treating physician's opinion than the opinions of those who do not treat a claimant. *Lester v. Chater,* 81 F.3d 821, 830 (9th Cir. 1996) An examining physician's opinion is "entitled to greater weight than the opinion of a nonexamining physician." *Id.* at 830 – 831. An administrative law judge must provide "clear and convincing" reasons for rejecting the uncontradicted opinion of either a treating or examining physician. *Id.* Even when a treating or examining physician's opinion is contradicted, that opinion "can only be rejected for specific and legitimate reasons that are supported by substantial evidence in the record." *Id.* at 830 – 831. "The opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician *or* a treating physician." *Id. at 831.*

ANALYSIS

The federal Medicaid regulations set forth three criteria that the Claimant must satisfy in order for the Medicaid program to pay for the Claimant's residential psychiatric placement:

> (1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
> (2) Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
> (3) The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

42 CFR 441.152(a).

The Alaska Medicaid regulations adopt these three criteria, 7 AAC 43.552(b)(2). The Alaska regulations add an additional factor, that when the individual is under the age of 21, he must

[8] The term "physician" includes psychologist. *Lester v. Chater,* 81 F.3d 821, fn. 7 at 830 (9th Cir. 1996)

have a Global Assessment of Functioning of 50 or less.[9] 7 AAC 43.486(b)(9). Each of these criteria will be addressed in turn.

1. Ambulatory Care Resources Available In The Community

The first element the Claimant must prove is that community ambulatory resources do not meet his treatment needs. 42 CFR 441.152(a); 7 AAC 43.552(b)(2). The Division interprets this requirement as meaning that a "less restrictive level of care" is either not available or will not meet the Claimant's needs. *See* Alaska State Medicaid Program *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria*, Criterion A1 and A2. (Revision Date: April 2008) (Ex. G, pp. 99 – 105) Because the regulatory term "ambulatory" plainly means "mobile," i.e. non-residential or "less restrictive," this is a reasonable interpretation of the regulation. *Lauth v. State*, 12 P.3d 181, 184 (Alaska 2000)

The Division's *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria*, Criterion A4 and A5, with regard to the "ambulatory needs" criteria contains an additional requirement that less restrictive treatment alternatives have been tried and failed. (Ex. G, pp 101 – 102). This requirement is not contained in either the federal or the Alaska Medicaid regulations. *See* 42 CFR 441.152(a); 7 AAC 43.552(b)(2). Because the Division's *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria* adds a substantial requirement to the federal and state regulation, it must be adopted pursuant to the Administrative Procedure Act as explained below.

An agency's reasonable interpretation of its own regulation is entitled to deference. *Lauth v. State*, 12 P.3d 181, 184 (Alaska 2000) However, when an "interpretation" of a regulation adds a substantial requirement to the regulation, it is itself a regulation that must be adopted pursuant to the Administrative Procedure Act in order to be followed.

The Alaska Supreme Court discussed the effect of an agency "interpretation" of a regulation that was itself a regulation in *Jerrel v. State, Dept of Natural Resources*, 999 P.2d 138 (Alaska 2000). In *Jerrel*, agency (Department of Natural Resources) terminated Jerrel's state grazing lease, because Jerrel had not complied with its regulation that livestock on the grazing leasehold had to be marked, and that the marking had to be visible from a 20 foot distance. The applicable regulation only provided that the livestock had to be marked, without any specifics.

In *Jerrel*, the Court held the agency's interpretation of its regulation that livestock on a state grazing lease be marked to require the marking be visible from 20 feet, was itself a regulation because it "'supplemented,' 'revised,' and 'made [the marking regulation] specific.'" *Jerrel* at 144. The Court held because the "interpretation" of the marking regulation was itself a regulation, in order for it to apply, it had to be adopted pursuant to the Alaska Administrative Procedure Act. *Id.* The Court then declined to follow the agency's "interpretation" of the regulation and reversed the termination of Jerrel's grazing lease, because the agency's

[9] The Global Assessment of Functioning score is considered under criteria 2, the requirement for inpatient services. *See Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria.* (Ex. G, p. 103)

"interpretation" of the original livestock marking regulation had not been properly adopted as a regulation itself. *Id.* at 144 – 145.

Jerrel is relevant authority for this case. The Division did not argue or show that the *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria* (Revision Date: April 2008) had been adopted into regulation, arguing instead that its interpretation required deference on the part of the hearing officer.[10] The Division's interpretation limiting residential treatment to individuals who have tried and failed at less restrictive treatment alternatives, added a substantial new requirement to the federal and state Medicaid regulations. It therefore "'supplemented,' 'revised,' and 'made [the residential psychiatric treatment regulation] specific.'"

The requirement that residential treatment is limited to persons who have tried at failed at less restrictive treatment alternatives is therefore itself a regulation, not merely an interpretation of the regulation. Because this requirement was not adopted into regulation under Administrative Procedure Act, it has no effect and the Division cannot rely upon it to support its decision. Accordingly, this discussion will address only the **regulation's** requirement that "ambulatory care resources available in the community" do not meet the Claimant's treatment needs. 42 CFR 441.152(a); 7 AAC 43.552(b)(2).

Three extremely well qualified mental health professionals, Drs. [redacted], [redacted], and [redacted] testified in this case. Dr. [redacted] has evaluated him. Dr. [redacted] has treated him. Dr. [redacted] reviewed his application for placement at Benchmark.

Drs. [redacted] and [redacted] are mental health professionals who are well versed in the treatment of persons with sexual deviant psychological disorders. Their qualifications and background demonstrate that they are well aware of treatment programs for sexual deviancy in the State of Alaska. In fact, Dr. [redacted] consults with two adolescent treatment programs, the Volunteers of America substance abuse treatment program and the Alaska Children's Services residential juvenile offender treatment program. *See* Finding of Fact 8 above. Both Dr. [redacted] and Dr. [redacted] concluded that the Claimant, because of his age, is not appropriate for either adolescent or adult treatment programs. They also testified that there were no residential treatment options for the Claimant in the State of Alaska. Dr. [redacted] was also not aware of community outpatient treatment options for the Claimant. *See* Finding of Fact 11(a) above.

This would leave the Claimant with individual treatment options. Dr. [redacted] stated the Claimant could be treated on an outpatient basis. He has not had contact with the Claimant, nor has he discussed the Claimant's treatment with either Dr. [redacted] or Dr. [redacted] He felt that the Claimant's lack of acute symptoms, the fact he has not been a physical perpetrator, and the fact his pertinent behavior, viewing of child pornography, occurred in the past, meant that he could be treated on an outpatient basis for addictive behavior.

Drs. [redacted] and [redacted], however, disagree with Dr. [redacted] on this point. Dr. [redacted] opinion was that the combination of the Claimant's disorders, his Paraphilia, impulsivity (ADHD), and chemical dependency, made residential treatment the appropriate treatment for him. Dr. [redacted] also discussed the Claimant's denial, and the fact that an inpatient treatment program with group

[10] *See* the Division's April 6, 2009 Closing Brief at p. 3. *Also see* fn. 7 above.

therapy would be best. Again, Dr. [redacted] was not aware of community outpatient programs available to the Claimant.

In addition to Drs. [redacted], [redacted], and [redacted], two other mental health care professionals testified in this case, Ms. [redacted] and Dr. [redacted]. Ms. [redacted] is employed by Qualis, the contractor hired by the Division. She has a Master's degree in social work. She reviewed the Claimant's application for treatment at [redacted] and opined the Claimant did not meet the Division's criteria for placement at [redacted]. Dr. [redacted] M.D. is the medical director at [redacted]. He opined the Claimant was appropriate for treatment at [redacted]. Neither Ms. [redacted] nor Dr. [redacted] examined or treated the Claimant.

Under the Medicaid scheme, greater weight is placed on the opinions of treating and examining physicians than those of nonexaming physicians. *Lester v. Chater*, 81 F.3d 821, 830 - 831 (9th Cir. 1996). In this case, the opinions of the Claimant's examining and treating physicians are in accord. Both Drs. [redacted] and [redacted] agreed that the Claimant should be treated at [redacted]. Dr. [redacted], who was not an examining or treating physician and whose opinion is therefore given less weight than that of Drs. [redacted] and [redacted], concurred.

In contrast, Dr. [redacted] and Ms. [redacted], who did not examine nor treat the Claimant, disagreed with Drs. [redacted], [redacted], and [redacted]. Dr. [redacted] opined the Claimant could be treated in the community. Ms. [redacted] opined the Claimant did not meet the Division's requirements for residential psychiatric treatment. Substantial evidence is required to ignore the opinions of examining and treating professionals. *Lester* at 830 - 831. With due respect to Dr. [redacted] experience and opinion, and Ms. [redacted] experience and opinion, their testimony and opinions did not rise to the level of substantial evidence, which is required to overcome the Medicaid program's presumption in favor of treating and examining professionals opinions: "[t]he opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician *or* a treating physician." *Id. at 831.*

A review of the evidence, and the deference accorded treating and examining physician's opinions, shows the Claimant has met his burden of proof on this issue. The preponderance of the evidence demonstrates that Claimant satisfies the first criterion, that "[a]mbulatory care resources available in the community do not meet the treatment needs of the recipient." 42 CFR 441.152(a)(1); 7 AAC 43.552(b)(2)(a).

2. Requirement for Inpatient Services.

The second element the Claimant must prove is that his psychiatric condition requires inpatient treatment under the direction of a physician. 42 CFR 441.152(a); 7 AAC 43.552(b)(2). In order to satisfy this element, the Division's *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria*, Criterion B2 and B 3, requires that a Claimant (a) have an Axis I primary diagnosis between 290. – 316,[11] and (b) have a Global Assessment of Functioning of 50 or less. (Ex. G, p. 103) The Claimant satisfies both these factors. He undisputedly has an Axis I

[11] It should be noted that this requirement for a specific diagnostic code is not contained in either the state or federal applicable regulation. *See* 42 CFR 441.152(a); 7 AAC 43.552(b)(2).

diagnosis of Paraphilia, which has the code of 302.9 (DSM IV TR 302.9), which falls in the acceptable diagnosis range of 290. – 316. It is also undisputed that he has a Global Assessment of Functioning of 50. The Claimant has met his burden of proof on this issue.

In addition, Drs. [redacted] and [redacted] the Claimant's examining and treating physicians, as discussed above, provided a clear explanation of why the Claimant should be treated on an inpatient basis.

3. Reasonable Expectation of Improvement

The third element the Claimant must prove is that the treatment is reasonably expected to improve his condition or prevent further regression so that the services will no longer be needed. 42 CFR 441.152(a); 7 AAC 43.552(b)(2). The Division's *Residential Psychiatric Treatment Center (RPTC) Medical Necessity Criteria* offers no guidance on this issue. It discusses the elements required in a patient's plan of care. (Ex. G, pp. 104 – 105) However, the Claimant's proposed plan of care has not been raised as an issue in this case. The following discussion will therefore just discuss the evidence regarding whether the Claimant's treatment at Benchmark can reasonably be expected to improve or prevent regression of his condition.

Dr. [redacted], the Claimant's treating psychologist, opined that the Claimant's treatment at [redacted] was reasonably expected to improve his condition. Dr. [redacted], who examined and tested the Claimant, opined residential treatment was more appropriate for individuals with co-occurring disorders to reduce the "likelihood of relapse or reoffending." ([redacted] testimony) Both of these opinions demonstrate that the Claimant's proposed treatment at [redacted] "can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed." 42 CFR 441.152(a)(3); 7 AAC 43.552(b)(2)(c).

In contrast, Dr. [redacted] statement that residential treatment could potentially reinforce the Claimant's behavior was based solely upon his review of documents and is given less weight than the opinion of the Claimant's examining and treating physicians. Accordingly, the Claimant has met his burden of proof on this issue.

In summary, the Claimant has met his burden of proof. After weighing the evidence, the preponderance of the evidence demonstrates that ambulatory resources are not available to the Claimant in the community, that residential (i.e. inpatient) psychiatric treatment is necessary, and that the residential psychiatric treatment at [redacted] can reasonably be expected to improve his condition or prevent regression. It is troubling that both Dr. [redacted] and Ms. [redacted] have minimized the Claimant's sexually deviant behavior because it has been non-contact. Child pornography is not victimless. In addition, the Claimant's impulsivity and substance abuse issues, coupled with his Paraphilia, as testified to by Dr. [redacted], demonstrate that the Claimant is at risk for recidivism or worse.

The Division is undoubtedly aware this Decision appears contrary to a prior decision issued by this Office, *In Re D. S.* OHA Case No. 07-FH-1308. D. S. was found not eligible for residential psychiatric placement. That case is factually distinguishable in that [redacted] had been in multiple residential psychiatric placements where his sexual deviancy issues had been treated, with little

or no success. Additionally, there was scant psychological or psychiatric evidence presented regarding either the necessity for his treatment or his amenability to future treatment. In short, unlike the instant case, there was no reasonable expectation of [redacted] treatment being successful or preventing regression.

CONCLUSIONS OF LAW

The Claimant has met his burden of proof by a preponderance of the evidence and established the following:

1. There are no ambulatory treatment options available to the Claimant in the community that will meet his treatment needs.

2. The Claimant's psychiatric condition requires services on an inpatient basis under the direction of a physician.

3. Inpatient psychiatric treatment at [redacted] is reasonably expected to improve the Claimant's condition or prevent his regression.

4. The Division was therefore not correct to deny the Claimant's application for inpatient services at [redacted].

DECISION

The Division was not correct to deny the Claimant's application for inpatient psychiatric treatment at [redacted].

APPEAL RIGHTS

If for any reason the Claimant is not satisfied with this decision, the Claimant has the right to appeal by requesting a review by the Director. To do this, the Claimant must send a written request directly to:

Director of the Division of Behavioral Health
Department of Health and Social Services
3601 C St., Suite 934
Anchorage, Alaska 99503

If you appeal, you must send your request within 15 days from the date you receive this letter. Filing an appeal with the Director could result in the reversal of the Hearing Authority's decision.

DATED this 12th day of May 2009.

Larry Pederson
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this 12th day of May 2009, true and correct copies of the foregoing were sent:

By First Class Mail, Certified, Return Receipt Request to Claimant's advocate, Mary Geddes, Esq.,

and to the following by electronic mail:

[redacted], Esq., Assistant Attorney General
[redacted], Esq.
[redacted], Director
[redacted], Policy & Program Development
[redacted], Policy & Program Development
[redacted], Staff Development & Training

_____
Al Levitre, Law Office Assistant I