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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-2123
	)	
Claimant.	)	DHCS Case No. [redacted]
_____	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

[redacted] (Claimant) was a recipient of Medicaid benefits (undisputed hearing testimony). At some time between August 17, 2009 and October 19, 2009 the Claimant requested Medicaid authorization for non-emergency medically-related travel [1] to Seattle, for him and his escort / wife, during late October 2009 (undisputed hearing testimony).

The State of Alaska Division of Health Care Services (DHCS or Division) denied the Claimant's request on October 19, 2009 (Exs. D1 – D3). The Claimant's representative requested a fair hearing with regard to the Division's denial of Medicaid travel authorization on October 20, 2009 (Exs. F2 – F3).

A hearing was held as scheduled on December 3, 2009 before Hearing Officer Jay Durych. The Claimant was represented by attorney [redacted], Esq. of Alaska Legal Services Corporation. Mr. [redacted] participated in the hearing by telephone and argued the case on behalf of the Claimant. The Claimant participated in the hearing by telephone and testified on his own behalf. [redacted], Esq. of the State of Alaska Department of Law, Attorney General's Office attended the hearing in person and represented the Division. Medical Assistance Administrator [redacted] attended the hearing in person and testified on behalf of the Division. [2]

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[1] The expenses for which Medicaid coverage was granted, and for which Medicaid coverage is once again sought, include airline fares, taxi fares, lodging, and meals (see, for example, Exhibits D1 – D2). However, for purposes of brevity, these four types of expenses will be referred to collectively in this decision as "travel expenses."

[2] Ms. [redacted] is DHCS' Medicaid Travel Manager ([redacted] testimony). She oversees prior authorizations for Medicaid travel. *Id*.

All testimony and exhibits offered by the parties at the hearing were admitted into evidence. At the end of the hearing the record was closed and the case was submitted for decision.

This Office has jurisdiction to resolve this case pursuant to 7 AAC 49.010.

ISSUES

It was not disputed that Medicaid had previously paid for the Claimant and his escort (his wife) to travel from their home in Juneau, Alaska to Virginia Mason Medical Center in Seattle, Washington in August 2009 for a colonoscopy and back surgery. It was also not disputed that the Claimant did not undergo the procedures for which the August 2009 travel had been authorized.

The Claimant basically asserted that he had good reasons for not undergoing the procedures at issue in August 2009; that it was therefore reasonable for him to refuse the procedures in August 2009; and that the Division should therefore have approved his subsequent request to travel to Seattle in October 2009 for the same medical procedures.

The Division's position is that Medicaid will still pay for the procedures at issue (i.e. a colonoscopy and back surgery), but that it cannot pay for the travel costs of the Claimant and his escort a second time ([redacted] testimony). The Division basically asserted that it was not reasonable for the Claimant to refuse the procedures in August 2009, and that paying for a second trip to Seattle for the Claimant to undergo the same medical procedures for which the first trip had been authorized and paid would therefore be "excessive or inappropriate for the distance travelled or inconsistent with the [Claimant's] medical needs" under 7 AAC 43.502(e)(1).

Based on the contentions of the parties, the issues to be determined are:

1. Was it reasonable for the Claimant to refuse the procedures (i.e. a colonoscopy and back surgery) for which Medicaid had paid to send him to Seattle during August 2009?

2. Based on the answer to (1), above, would it be "excessive or inappropriate for the distance travelled or inconsistent with the [Claimant's] medical needs" to require Medicaid to pay for a second trip to Seattle to enable the Claimant to undergo the same medical procedures for which the first trip had been authorized?

FINDINGS OF FACT

The following facts were proven by a preponderance of the evidence:

1. The Claimant was a recipient of Medicaid benefits (undisputed hearing testimony).

2. The Claimant has a very complex medical history (Ex. E15). The Claimant's colon was damaged in 1999 when he underwent radiation treatment for prostate cancer (Claimant testimony). He requires periodic colonoscopies because of a history of multiple precancerous colonic polyps, including a large one with high-grade dysplasia (Ex. E-15). His colonoscopies cannot be performed in Alaska because his colon is unusually long and tortuous and his cardiopulmonary status is very fragile (Ex. E15). Prior to the events at issue here the Claimant had made four prior trips to Seattle

to undergo specialized colonoscopies administered by [redacted], M.D. of the Virginia Mason Clinic (Ex. E15; Claimant testimony). These colonoscopies are administered under general anesthetic and using specialized endoscopic equipment and techniques (Ex. E15; Claimant testimony).

3. The State of Alaska Division of Health Care Services (DHCS or Division) authorized the Claimant to travel to Virginia Mason Medical Center in August 2009 for two procedures: a colonoscopy and back (lumbar spine) surgery ([redacted] testimony).

4. Medicaid found that travel to Seattle for the two procedures (a colonoscopy and back surgery) were medically necessary based on telephone calls and written reports from the Claimant's physicians, including a report by [redacted], M.D. dated June 5, 2009 (Exs. E12 – E13) ([redacted] testimony).

5. The Claimant and his wife flew from Juneau, Alaska to Seattle, Washington on Sunday, August 9, 2009 (Claimant testimony). The flight was paid for by Medicaid (undisputed hearing testimony).

6. The normal pre-colonoscopy cleansing procedure takes about 8 hours (Claimant testimony). However, the pre-colonoscopy cleansing procedure used before the colonoscopy scheduled in August 2009 took three (3) days (Claimant testimony). The Claimant was not allowed to eat from Saturday, August 8, 2009 until Tuesday, August 11, 2009 in preparation for his colonoscopy (Claimant testimony).

7. The Claimant underwent several medical tests on Monday, August 10, 2009 (Claimant testimony).

8. The Claimant was scheduled for his colonoscopy on Tuesday, August 11, 2009 (Claimant testimony). However, when he arrived for the appointment he told the nurse that he could not proceed because his bowels were still moving (i.e. there was still material in his colon) (Claimant testimony). He also advised the nurse that there was blood in his stool. *Id.*

9. The nurse went back and got a doctor (Claimant testimony). The doctor told the Claimant that he would hook him up to some machine and "suck that stuff out of you right now" (Claimant testimony). This frightened the Claimant because no reference was made to the administration of any anesthesia prior to this procedure (Claimant testimony). The Claimant was also concerned because this doctor did not appear to realize that the Claimant's colon was unusually long and tortuous and that special care was therefore necessary (Claimant testimony). The Claimant declined to have the colonoscopy performed at that time. *Id.*

10. A clinic note by [redacted], M.D. dated August 11, 2009 indicates a different perspective on why the Claimant refused the colonoscopy, and states in relevant part as follows (Ex. E-4):

> He [the Claimant] does not want his colonoscopy done today because he is focusing on back pain and back issues. This is despite the fact that he has already completed his prep . . . .

* * * * * * * * * * *

. . . . the patient adamantly refuses to undergo colonoscopy today. He says he will reschedule his colonoscopy sometime in September.

11. Later on Tuesday, August 11, 2009 the Claimant had a cat-scan performed (Claimant testimony).

12. On Wednesday, August 12, 2009 the Claimant had a pulmonary test performed (Claimant testimony). The Claimant also saw Dr. [redacted] (his back doctor) on Wednesday, August 12, 2009 and again on Thursday, August 13, 2009 (Claimant testimony).

13. During the first (Wednesday, August 12th) visit Dr. [redacted] asked the Claimant questions and gave him a booklet on back surgery (Claimant testimony). During the second visit (Thursday, August 13th) Dr. [redacted] referred the Claimant to the anesthesiologist. *Id.*

14. The Claimant's appointment with the anesthesiologist was at about 10:30 a.m. on Thursday, August 13th (Claimant testimony). When the Claimant arrived at the anesthesiologist's office a nurse got the Claimant's chart and told him that they needed to take another blood draw for more tests (Claimant testimony). The nurse took that blood draw, and two subsequent blood draws, for a total of three blood draws that day (Claimant testimony).

15. At approximately 11:30 a.m. on Thursday, August 13th the Claimant was sent to the office of internist [redacted], M.D. (Claimant testimony). The Claimant was then sent to lunch. *Id.* After a brief lunch the Claimant went back to Dr. [redacted]'s office. *Id.* He underwent more tests. *Id.* He then waited for the results in Dr. [redacted]'s office from approximately 1:00 p.m. to 5:20 p.m. *Id.* When the results came back Dr. [redacted] initially advised the Claimant that he was cleared for back surgery at 6:00 a.m. the next morning. *Id.* However, by 6:00 p.m. that evening the reporting time for the surgery had been moved back to 9:00 a.m. *Id.*

16. The Claimant reported to the surgical waiting room by 9:00 a.m. on Friday, August 14, 2009 (Claimant testimony). There were a lot of sick people in the waiting room coughing and sneezing. *Id.* After a while the Claimant began to get anxious and nervous because he had been sitting and waiting. *Id.* Finally a nurse came into the waiting room and told him that she needed to take another blood draw. *Id.* The Claimant questioned the nurse about who ordered the blood test and why. *Id.* The nurse was not able to answer the Claimant's questions. *Id.* At that point the Claimant became frightened because he "knew something was going wrong." *Id.*

17. A nurse then approached the Claimant and said she wanted to take the Claimant to the Patient Relations office (Claimant testimony). Another nurse was there ready to take the Claimant to surgery. *Id.*

18. The Claimant went to the Patient Relations office (Claimant testimony). A man there named [redacted] tried to call the Claimant's various doctors to determine why the additional blood work had been ordered. *Id.* [redacted] was unable to reach anyone who could explain what was going on. *Id.*

19. The Claimant waited at the Patient Relations office for a call back from a doctor until after 12:00 p.m. (noon) on Friday, August 14 (Claimant testimony). The Claimant did not hear back from a doctor or receive any explanation regarding the additional blood work. *Id.* At that time the Claimant decided not to submit to the additional blood draw and not to proceed with the back surgery. *Id.* An important factor in the Claimant's making of this decision was that the Claimant had

previously died during an operation and been resuscitated, and he did not want to risk this happening again when he could not get answers to his medical questions. *Id.*

20. On August 14, 2009 the Claimant's back surgeon, [redacted], M.D., prepared a report which stated in relevant part as follows (Exs. E5 – E7):

> . . . . [The Claimant] is an extremely high-risk patient for having any surgical procedures. . . .
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> * * * * * * * * * * *
>
> . . . . When he arrived, the way I understand it . . . he had been having some diarrhea and he was not clear and they really could not do an effective colonoscopy and he was unhappy with the practitioner. Therefore even though the bleeding had seemed to stop he had not really been cleared as they had planned. The other thing that was noted is that his creatinine had gone way up from the time he was last in Alaska until the time his blood was drawn here on [August 11] . . . . [H]owever it was felt that . . . he was safe enough to have the lumbar spine surgery but obviously he is at high risk . . . .
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> * * * * * * * * * * *
>
> The anesthesia clinic called me yesterday morning the day before the scheduled surgery and told me that they did not feel the patient was ready to go because he had not had the colonoscopy and his hematocrit had dropped to 31% and his creatinine was way up. I have to defer to them to make a safe decision, so what was done was that the patient was then referred to the general internal medicine clinic where he was worked up throughout the day, he had a couple of blood draws, and his creatinine improved dramatically. His hematocrit had [also] come back up to 35%. Throughout the day then the decision was made to not bother with the colonoscopy until after the back surgery because his hematocrit had stabilized and they felt he was medically cleared for surgery.
>
> The patient was taken off the schedule in the morning . . . [but] . . . they were able to get the patient back on the schedule into his original spot for today's surgery.
>
> Early this morning [August 14, 2009] . . . I explained all of this to the anesthesiologist who was actually going to be taking care of the patient today and she indicated that she thought it was reasonable to just repeat his electrolytes and his hematocrit and make sure everything was still stable today . . . . I thought that was completely reasonable so she put the orders in for the lab work . . . . [W]e were [subsequently] called by the check-in area and they said the patient was there but he refused to have his blood drawn. Both of us indicated to the staff in the pre-op area that we felt it was for the patient's safety that we wanted to repeat the electrolytes and the hematocrit and not for any personal gain of our own, just to make it safer for him. He refused and then he asked if he could come upstairs and have [the blood] drawn when he had his I.V. placed . . . . I stated that the patient needed to have the blood drawn before he came upstairs so we could look at the numbers and just make a decision as to whether or not he should even come upstairs and have the surgery.

> Apparently he did not like that or want to do that, so he and his wife just left the pre-op area and by the time I had completely finished [with his prior patient] he had still never come back to the pre-op area. Therefore we had to cancel the surgery as we [did] not even have a patient . . . .

21. The Claimant and his wife returned to Juneau, Alaska on or about Sunday, August 16, 2009 (Claimant testimony).

22. The Claimant did not receive an explanation for the additional blood work until approximately 8:00 a.m. on Monday, August 17, 2009 when he received a phone call from Dr. [redacted] (the back surgeon) (Claimant testimony). The doctor advised that he had ordered the additional blood work because the anesthesiologist had told him that the results of the prior blood tests were not satisfactory. *Id.*

23. Dr. [redacted]'s memorandum regarding his August 17, 2009 telephone conversation with the Claimant states in relevant part as follows (Ex. E8):

> . . . . [The Claimant] explained to me that the thing that really bothered him was that the lab people came right to the pre-op waiting room and wanted to draw his blood right there. He felt that was [an] unsterile and unprofessional place to try and draw blood because people were coughing and sneezing. He explained that had he been asked to go to the lab and have [the blood work] done he would have done it even though he wanted a better explanation of why we were checking more blood. I told him it was only for his own safety that we were getting additional labs, but he said that no one really explained it well to him and he was really put off by [the place that] the blood was going to be drawn.
>
> The second thing that is still upsetting him is that when he went in for the colonoscopy and was still having diarrhea, he said that he would not be able to do it at that time but the practitioner told him that they would be able to suck out the colon and still get good pictures. The patient did not believe that and refused to do the procedure. I cannot comment on that because I have never done a colonoscopy or seen one done and so I just do not know whether that could have been done adequately for that circumstance or not.

* * * * * * * * * * *

24. At some time between August 17, 2009 and October 19, 2009 the Claimant again requested Medicaid authorization for non-emergency medically-related travel to Seattle, for he and his escort / wife, for a colonoscopy and back surgery (undisputed hearing testimony).

25. The Division denied the Claimant's request on October 19, 2009 (Exs. D1 – D3). The Division's denial letter stated in relevant part as follows:

> Request for travel October 21-22 to Seattle is denied based on regulation 7 AAC 43.502(e)(1). Medicaid met your travel need [from] August 9, 2009 [through] August 16, 2009. Upon review, it was determined there was a voluntary refusal of medical procedures [in] August 2009.

26. Medicaid denied the October 2009 travel request because the Claimant had "gone against medical advice" in not having the colonoscopy and back surgery procedures performed in Seattle during August 2009 ([redacted] testimony).

27. Medicaid denied the Claimant's October travel request based on a clinic note by [redacted], M.D. dated August 11, 2009 (Ex. E4; see also paragraph 10, above), and based on a report by [redacted], M.D. dated August 14, 2009 (Exs. E5 – E-7; see also paragraph 20, above) ([redacted] testimony).

28. The Claimant's representative requested a fair hearing with regard to the Division's denial of Medicaid travel authorization on October 20, 2009 (Exs. F2 – F3).

29. It was not disputed that the Claimant's trip to Seattle in August 2009 was a taxing and difficult week for both he and his wife.

30. The Claimant stated that he is not seeking to go back to Virginia Mason for back surgery; he is now seeking the Medicaid travel authorization solely for the colonoscopy (Claimant testimony).

31. If Medicaid authorized the Claimant to travel back to Virginia Mason for another different but still medically necessary procedure, the Claimant could have the procedures at issue (i.e. the colonoscopy and back surgery) performed during the same trip, and Medicaid would pay the travel costs for the trip based on the new (not previously refused) procedure(s) ([redacted] testimony).

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

This case involves the Division's denial of a claimant's initial application or claim for Medicaid benefits. The party seeking a change in the status quo or existing state of affairs normally bears the burden of proof. [3] In this case, the Claimant is attempting to change the existing state of affairs by obtaining Medicaid travel benefits. Accordingly, the Claimant bears the burden of proof in this case.

The regulations applicable to this case do not specify any particular standard of proof. Therefore, the "preponderance of the evidence" standard is the standard of proof applicable to this case. [4] This standard is met when the evidence, taken as a whole, shows that the facts sought to be proved are more probable than not or more likely than not. [5]

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[3] *State of Alaska Alcoholic Beverage Control Board v. Decker*, 700 P.2d 483, 485 (Alaska 1985).

[4] A party in an administrative proceeding can assume that preponderance of the evidence is the applicable standard of proof unless otherwise stated. *Amerada Hess Pipeline Corp. v. Alaska Public Utilities Commission*, 711 P.2d 1170 (Alaska 1986).

[5] *Black's Law Dictionary* at 1064 (West Publishing, 5th Edition, 1979).

II. The Medicaid Program – In General.

Medicaid is an entitlement program created by the federal government. See DPA website at http://health.hss.state.ak.us/dpa/programs/medicaid/ (date accessed July 31, 2009). It is the primary public program for financing basic health and long-term care services for low-income Alaskans. *Id.* The Medicaid program is administered in Alaska by the Division of Health Care Services (DHCS). *Id.*

III. Medicaid Transportation and Accommodation Services.

The Alaska state Medicaid regulations governing medical transportation and accommodation services are located at 7 AAC 43.501 - 7 AAC 43.530.

7 AAC 43.502, titled "Transportation and Accommodation Services; General Requirements", provides in relevant part as follows:

> (a) The department will pay for only those transportation and accommodation services that are (1) medically necessary; (2) authorized by the department; and (3) performed by an Alaska provider or an out-of-state provider that is enrolled as a Medicaid provider in Alaska at the time the services are performed.
>
> (b) A Medicaid recipient's health care provider shall request authorization for medically necessary transportation and accommodations for the recipient. The health care provider shall request authorization for accommodation services at the same time it requests authorization for transportation services.
>
> * * * * * * * * * * * *
>
> (e) *The department will not pay for the following:*
>
> > *(1) transportation or accommodations that the department determines to be excessive or inappropriate for the distance traveled or inconsistent with the medical needs of the recipient*; [Emphasis added].
>
> * * * * * * * * * * * *

IV. Authority Of Administrative Agencies To Decide Issues Of Constitutional Law.

"Administrative agencies do not have jurisdiction to decide issues of constitutional law." *Alaska Public Interest Research Group v. State*, 167 P.3d 27, 36 (Alaska 2007).

Whether a statute or regulation is vague or overbroad presents a constitutional issue. *See generally Florida Association of Professional Lobbyists, Inc. v. Division of Legislative Information Services of the Florida Office of Legislative Services*, 525 F.3d 1073 (11th Cir. 2008); see also Laurence Tribe, *American Constitutional Law* § 12-32 (Second Edition 1988).

ANALYSIS

I. Introduction: Contentions of the Parties; Definition of Issues.

As noted at page 2, above, the Division's position is that Medicaid will still pay for the procedures at issue (i.e. a colonoscopy and back surgery), but that it cannot pay for the travel costs of the Claimant and his escort a second time ([redacted] testimony). The Division basically asserted that it was not reasonable for the Claimant to refuse the procedures in August 2009, and that paying for a second trip to Seattle for the Claimant to undergo the same medical procedures for which the first trip had been authorized and paid would therefore be "excessive or inappropriate for the distance travelled or inconsistent with the [Claimant's] medical needs" under 7 AAC 43.502(e)(1).

The Claimant's counsel essentially made the following two arguments. First, the Claimant asserted that the only regulation on point, 7 AAC 43.502(e)(1), is vague and/or overbroad. Second, the Claimant asserted that it was reasonable for the Claimant to refuse the procedures at issue in August 2009 considering the Claimant's prior medical history, the arduousness of the many tests to which the Claimant was subjected during his stay in Seattle, and the other particular circumstances of his trip.

Resolving the parties' contentions requires a factual determination as to the reasonableness of the Claimant's refusal of the colonoscopy and back surgery procedures during his August 2009 trip to Seattle. However, before this factual issue can be resolved, there are two legal issues which must be addressed (see Sections II and III, below).

The Claimant bears the burden of proof by a preponderance of the evidence (see Principles of Law, above). The Claimant's assertions will be examined in the order stated above.

II. This Office Does Not Have the Authority to Invalidate 7 AAC 43.502(e)(1) on Grounds of Vagueness or Over-Broadness.

The Claimant asserts that 7 AAC 43.502(e)(1) is vague and/or overbroad. However, the question of whether a statute or regulation is vague or overbroad presents a constitutional issue. [6]

A fundamental principle of administrative law is that administrative agencies in the executive branch of government do not have jurisdiction to decide issues of constitutional law. [7] This is because the power to decide that a statute or regulation is unconstitutional is a judicial power to be exercised by the courts, the judicial branch of government. [8]

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[6] *See generally Florida Association of Professional Lobbyists, Inc. v. Division of Legislative Information Services of the Florida Office of Legislative Services*, 525 F.3d 1073 (11th Cir. 2008); see also Laurence Tribe, *American Constitutional Law* § 12-32 (Second Edition 1988).

[7] See *Alaska Public Interest Research Group v. State*, 167 P.3d 27, 36 (Alaska 2007) ("administrative agencies do not have jurisdiction to decide issues of constitutional law"); *Howard v. Federal Aviation Administration*, 17 F.3d 1213, 1218 (9th Cir. 1994) and *Gilbert v. National Transportation Safety Board*, 80 F.3d 364, 366-367 (9th Cir. 1996) (an agency does not have the authority to adjudicate the constitutionality of its own regulations, and a hearing officer who derives his authority from an agency does not have the authority to determine that an agency regulation is unconstitutional or invalid).

The Office of Hearings and Appeals, while separate from the Division of Health Care Services, is still an executive branch administrative agency within the Department of Health and Social Services. Accordingly, the principle that administrative agencies do not have jurisdiction to decide issues of constitutional law applies to this Office.

In summary, the Office of Hearings and Appeals does not have jurisdiction to decide constitutional issues. Accordingly, the Claimant's constitutional arguments are noted for the record, but they cannot be resolved by this Office in this decision.

III. Should 7 AAC 43.502(e)(1) Be Interpreted Based On A Reasonableness Standard?

The parties appear to agree that 7 AAC 43.502(e)(1) should be interpreted using an implied standard of reasonableness. Moreover, there is no indication in the plain text or legislative history of 7 AAC 43.502(e)(1) that a strict construction should be applied to its interpretation. Similarly, no judicial precedent exists which would require a strict construction. Finally, standards of reasonableness have been adopted in many other areas of the law. [9] Accordingly, it is appropriate to apply a standard of reasonableness in the interpretation and application of 7 AAC 43.502(e)(1) just as courts have done in other areas of the law.

There are, however, two different standards of reasonableness, (i.e. *objective* reasonableness [10] or *subjective* [11] reasonableness), that could potentially be applied in the interpretation of 7 AAC 43.502(e)(1). In other areas of the law where a standard of reasonableness has been applied, the standard adopted has been an *objective* standard rather than a *subjective* standard. [12] Accordingly, it is appropriate to apply a standard of *objective* reasonableness here. Applying this standard, the issue is not whether it was reasonable for the Claimant (with his subjective inclinations, thoughts and fears) to have refused the medical procedures at issue. Rather, the issue is whether a reasonable man would have so acted under similar circumstances.

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8 *State Department of Administration, etc. vs. State Department of Administration, etc*., 326 So. 2d 187 (Fla. 1st D.C.A. 1976).

9 See, for example, *Ozenna v. State*, 619 P.2d 477 (Alaska 1980) (criminal law issues); *Kennedy Associates, Inc. v. Fischer*, 667 P.2d 174 (Alaska 1983) (contract issues); *Wallace v. Rosen*, 765 N.E.2d 192 (Ind. App. 2002) (negligence claims).

10 "Objective" is defined in relevant part as "uninfluenced by emotion, surmise, or personal opinion." *Webster's II New Riverside University Dictionary* at 810 (Houghton Mifflin Company 1994).

11 "Subjective is defined in relevant part as "of, produced by, or resulting from an individual's mind or state of mind . . . particular to a given individual . . . existing only within the experiencer's mind and incapable of external verification . . . " *Webster's II New Riverside University Dictionary* at 1153 (Houghton Mifflin Company 1994).

12 See, for example, *Ozenna v. State*, 619 P.2d 477 (Alaska 1980) (criminal law issues); *Kennedy Associates, Inc. v. Fischer*, 667 P.2d 174 (Alaska 1983) (contract issues); *Wallace v. Rosen*, 765 N.E.2d 192 (Ind. App. 2002) (negligence claims).

IV. Was It Reasonable For The Claimant to Refuse the Procedures?

A. The Colonoscopy.

The evidence is conflicting as to why the Claimant refused the colonoscopy. The Claimant's explanation was basically that he was afraid that the person performing the colonoscopy was not aware of the particular problems with the Claimant's colon and that the Claimant might be seriously injured or might even die during the procedure (see Findings of Fact at paragraph 9, above). The clinic note by [redacted], M.D. dated August 11, 2009 (Ex. E-4) states, however, that the Claimant told Dr. [redacted] that he refused the colonoscopy because he wanted to focus on back pain and back issues.

The Claimant's testimony appeared to be quite sincere and therefore generally credible. However, the Claimant does have a financial interest in having Medicaid cover the cost of a second trip to Seattle for the colonoscopy. Dr. [redacted], on the other hand, has no reason or incentive to misrepresent the Claimant's statements as to why he refused the colonoscopy.

For this reason, although it is a close issue, Dr. [redacted]'s explanation for the Claimant's refusal of the colonoscopy is more credible than is the Claimant's own explanation for his refusal. Accordingly, the Claimant's refusal of the colonoscopy in August 2009 because he wanted to focus on back pain and back issues at that time was not reasonable. Therefore, requiring Medicaid to pay the travel costs for a second trip to Seattle, for the same medical procedure refused during the first trip, would be "*excessive or inappropriate for the distance traveled"* pursuant to 7 AAC 43.502(e)(1).

B. The Back Surgery.

The reasons for refusing the back surgery stated by the Claimant at the hearing were essentially consistent with Dr. [redacted]'s records regarding his conversations and other contact with the Claimant (see Findings of Fact at Paragraphs 16-20 and 22-23). There were clearly legitimate reasons for the Claimant to be anxious and even fearful of the surgery. A reasonable man might well have deferred the surgery until the questions raised by the need for additional blood work had been addressed by the Claimant's doctor.

However, before leaving town, a reasonable man would have contacted DHCS, explained the situation, and requested a few additional days in Seattle so that the surgery could be performed if his concerns were resolved to his satisfaction. A reasonable man would not have simply got on a plane to go back to Juneau, after having incurred the expense of travel to and lodging in Seattle, without such further attempts to have the surgery performed. The fact that the Claimant's concerns appeared to have been resolved by his telephone conversation with Dr. [redacted], immediately after the Claimant's return to Juneau, underscores this (see Ex. E8).

In summary, the Claimant's refusal of the additional blood work (and thus his back surgery) was not reasonable under the circumstances because it is likely that his concerns would have been resolved had he extended his stay in Seattle and allowed more time to hear back from Dr. [redacted]. Accordingly, the Claimant's refusal of the back surgery in August 2009 was not reasonable. Therefore, requiring Medicaid to pay the travel costs for a second trip to Seattle, for the same

medical procedure refused during the first trip, would be "*excessive or inappropriate for the distance traveled"* pursuant to 7 AAC 43.502(e)(1).

CONCLUSIONS OF LAW

1. The Office of Hearings and Appeals does not have jurisdiction to decide constitutional issues such as whether a statute or regulation is impermissibly vague or overbroad. Accordingly, the Claimant's assertion that 7 AAC 43.502(e)(1) is vague and/or overbroad cannot be resolved by this Office in this decision.

2. It is appropriate to imply a standard of reasonableness in the interpretation and application of 7 AAC 43.502(e)(1). This reasonableness standard is an objective standard, not a subjective standard.

3. Under the circumstances of this case, it was not objectively reasonable for the Claimant to refuse the procedures (a colonoscopy and a back surgery) for which Medicaid had paid for his travel to Seattle in August 2009.

4. Requiring the Division to pay for a second trip to Seattle for the Claimant to undergo the same medical procedures for which the August 2009 trip had been authorized and paid would thus be "excessive or inappropriate for the distance travelled" under 7 AAC 43.502(e)(1).

5. The Division was therefore correct when on October 19, 2009 it denied the Claimant's request for prior authorization for Medicaid's payment of travel expenses so that the Claimant and his escort / wife could go to Seattle, Washington during October 2009 for a colonoscopy and back surgery.

DECISION

The Division was correct when on October 19, 2009 it denied the Claimant's request for prior authorization for Medicaid's payment of travel expenses so that the Claimant and his escort / wife could go to Seattle, Washington during October 2009 for a colonoscopy and back surgery.

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, send a written request directly to:

Director of the Division of Public Assistance
Department of Health and Social Services
PO Box 110640
Juneau, AK 99811-0640

If the Claimant appeals, the request must be sent within 15 days from the date of receipt of this Decision. Filing an appeal with the Director could result in the reversal of this Decision.

DATED this [27th] day of January, 2010.

_____
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this [27th] day of January 2010 true and correct copies of the foregoing document were sent to the Claimant via U.S.P.S. mail, and to the remainder of the service list by e-mail, as follows:

Claimant's Counsel:
[redacted], Esq.,
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