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

In The Matter Of:	)	
	)	
H. P.,	)	OHA Case No. 11-FH-2420
	)	
Claimant.	)	DHCS Case No.
	)	

FAIR HEARING DECISION

STATEMENT OF THE CASE

H. P. (Claimant) is a recipient of Medicaid benefits (Ex. E1; undisputed hearing testimony). On October 16, 2011 the Claimant (a minor) and her adult escort travelled from No Name, Alaska to No Name, Alaska for medical treatment (Ex. H2; undisputed hearing testimony). On October 18, 2011 the Claimant (not her provider) requested retroactive Medicaid authorization and payment (i.e. reimbursement) for that travel (Ex. E-1; undisputed hearing testimony).

The State of Alaska Division of Health Care Services (DHCS or Division) never issued a formal denial letter with regard to the Claimant's request for retroactive travel authorization (Ex. A p. 2). However, DHCS's Hearing Representative acknowledged that there had been a *de facto* [1] denial of the Claimant's request for retroactive travel authorization (Johnson hearing testimony).[2]

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[1] "De facto" is defined as "in fact, in deed, actually (*Black's Law Dictionary* at 375 (West Publishing, Fifth Edition, 1979); and "in reality or fact; actually" (*Webster's II New Riverside University Dictionary*, Houghton Mifflin Co. 1984).

[2] The Division's position at hearing was that, because the Claimant's provider did not seek prior authorization, the Division did not actually *deny* any request for prior authorization, and (in turn) because the Division did not deny prior authorization, there was no need to send out a notice of adverse action. The issue in a case cannot, however be defined by *what did not happen*; it must be defined by *what did happen*. In this case, the Claimant's parents requested reimbursement, or retroactive authorization, for medically-related travel. Accordingly, the Division clearly could have issued a denial notice asserting that reimbursement or retroactive travel authorization could not be granted, based on a specific regulation, on the facts of this case.

It is arguable, based solely on the text of the applicable federal Medicaid regulation (42 C.F.R. § 431.201), that the Division was not required to send the Claimant a denial letter under the factual circumstances of this case. However in *Boatman v. Hammons*, 164 F.3d 286 (6th Cir. 1998), a federal appellate court construed the Medicaid regulations as *requiring written notice in all cases involving the denial of medically related travel*:

The Claimant's father requested a fair hearing with regard to the Division's denial of Medicaid travel authorization for his daughter on November 3, 2011 (Ex. C1). This Office has jurisdiction to resolve this case pursuant to 7 A.A.C. § 49.010.

The Claimant's hearing was held as scheduled on January 12, 2012 before Hearing Examiner Jay Durych. The minor Claimant was represented by her father C. P., who participated in the hearing by telephone and represented and testified on behalf of the Claimant. J. P., the Claimant's grandfather, and B. P., the Claimant's grandmother, also participated in the hearing by telephone and testified on their granddaughter's behalf.

Shelly Boyer-Wood, a Program Coordinator I employed by DHCS, attended the hearing in person and represented and testified on behalf of the Division. Gerry Johnson, a Medical Assistance Administrator III employed by DHCS, participated in the hearing by telephone and also represented and testified on behalf of the Division. Kristina Walters, a Medical Assistance Administrator II employed by DHCS, attended the hearing in person and testified on behalf of the Division.[3]

> Some explanation for case worker denial of transportation assistance should be given in writing, and this written communication should include the fact that there are review procedures available.
> . . . .
>
> The content of the federal regulation at issue here is clear - states must ensure that Medicaid recipients have transportation to and from medical service providers. It is therefore necessary to provide applicants with written notice of a denial of assistance, including some explanation of the reasons therefore and the availability of review of the decision.

Also, Alaska's "Fair Hearings" regulation 7 A.A.C. § 49.060 applies here *in addition to* the federal Medicaid regulations and case law. That regulation provides in relevant part that "[t]he division shall give written notice to the client at least 10 days before the date the division intends to take action denying, suspending, reducing, or terminating assistance, unless . . . . [not applicable]." This case involves a Division action denying assistance. Accordingly, written notice of adverse action was required here pursuant to 7 A.A.C. § 49.060.

This raises the issue of the proper remedy in a case in which an *applicant* for a Medicaid benefit is not given proper notice. It is clear, pursuant to four fairly recent Alaska Supreme Court decisions, that a new, legally sufficient notice must be issued before an agency may *reduce, terminate, or recoup benefits*. *See Baker v. State of Alaska Department of Health & Social Services*, 191 P.3d 1005, 1009 (Alaska 2008), *Allen v. State of Alaska Department of Health & Social Services, Division of Public Assistance*, 203 P.3d 1155, 1168 – 1170 (Alaska 2009), *Heitz v. State, Dept. of Health & Social Services*, 215 P.3d 302, 308 (Alaska 2009), and *Smart v. State of Alaska Department of Health & Social Services*, 237 P.3d 1010, 1016 (Alaska 2010).

The Division's denial notice in this case was not just inadequate, it was nonexistent. This case, however, involves the denial of a *new Medicaid benefit* rather than the reduction, termination, or recoupment of *existing Medicaid benefits*. The United States Supreme Court does not appear to have addressed whether an *applicant* has a protected property interest in benefits he or she hopes to receive. *Walters v. National Association of Radiation Survivors*, 473 U.S. 305, 320 n. 8, 105 S.Ct. 3180, 87 L.Ed.2d 220 (1985). Likewise, the cases cited in the preceding paragraph indicate that the Alaska Supreme Court has not, at least as yet, extended to applicants for new benefits the "re-noticing remedy" recognized as to those who have previously qualified for benefits. Finally, the Claimant received actual notice of the reasons for the denial, by way of the Division's Fair Hearing Position Statement, two months in advance of the hearing. Accordingly, the undersigned finds that due process does not require belated issuance of a notice of adverse action under the particular circumstances of this case.

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

Jennifer Bigelow, Medicaid travel manager for the No Name branch of U.S. Travel, participated in the hearing by telephone and testified on behalf of the Division.

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 became ripe for decision.

ISSUE

The Claimant did not assert, and the record does not indicate, that the travel at issue was emergency travel as defined by 7 A.A.C. § 120.415. Accordingly, the issue to be determined is:

> Was the Division correct to deny the Claimant's request for reimbursement for airfare for the minor Claimant and one adult escort, for non-emergency travel from No Name to No Name which occurred on Sunday, October 16, 2011, based on the assertion that the Claimant had not obtained prior authorization for that travel?

FINDINGS OF FACT

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

1. Affiliated Computer Services (ACS) is a company with which the Division has contracted to handle prior authorization requests in the first instance (Boyer-Wood and Walters testimony). During normal business hours (8:00 a.m. – 5:00 p.m. Monday through Friday), Medicaid recipients are required to contact ACS to request prior authorization for medically-related travel. *Id.*

2. U.S. Travel is a company with which the Division has contracted to make travel arrangements for recipients of Medicaid in Alaska (Boyer-Wood testimony). U.S. Travel's phone lines are open from 7:00 a.m. until 7:00 p.m. seven days per week (Walters testimony).

3. During evening and weekend hours when ACS is closed, Medicaid-approved providers (such as No Name Regional Hospital) may call U.S. Travel and book one-way airfare for Medicaid recipients with urgent medically-related travel needs (Bigelow testimony). If the provider has all the necessary information when they call, U.S. Travel can have an airline seat booked within five (5) minutes after receiving the call. U.S. Travel then follows-up with ACS the next business day to confirm authorization (Bigelow testimony).

4. If a provider calls U.S. Travel while U.S. Travel is closed (i.e. between the hours of 7:00 p.m. and 7:00 a.m.), a recording tells the provider to call a toll-free number (Bigelow testimony). If the provider calls that number, the call is forwarded to the appropriate U.S. Travel employee, who answers the call on his or her cell phone regardless of the time of day (Bigelow testimony).

5. Thus, a *provider* request for Medicaid travel authorization for a recipient can be addressed by ACS and/or U.S. Travel 24 hours per day (Bigelow testimony). When U.S. Travel books provider-requested airline travel for a Medicaid recipient as described above, the transaction is essentially paperless (Bigelow testimony). All the Medicaid recipient needs to do is present his or her identification to the airline ticketing agent; the ticketing agent then issues the traveler his or her boarding pass (Bigelow testimony).

6. U.S. Travel will not book medically-related travel based on the request of the Medicaid *recipient*; the request must come from the *provider* (Bigelow testimony).

7. Hospitals such as No Name Regional Hospital and No Name Hospital are familiar with Medicaid prior authorization requirements (Walters testimony). They are aware that they should call ACS or U.S. Travel, to obtain prior authorization, whenever a Medicaid recipient needs to travel to obtain medical treatment (Boyer-Wood and Walters testimony).

8. The Claimant and her family live in No Name, Alaska (undisputed hearing testimony). The Claimant was eligible for Medicaid benefits during the period June 2011 - November 2011 (Ex. E1); she has previously received Medicaid benefits (undisputed hearing testimony).

9. The Claimant took a horseback riding lesson in the early afternoon of Sunday, XXXX 16, 2011 (Exs. G4, G7). While riding at about 12:45 p.m., the Claimant was thrown from the horse, fell 3-4 feet, and injured her left arm (Exs. G4, G7).

10. The Claimant's grandmother immediately drove her to the hospital (Exs. G-4, G7). The Claimant and her grandmother arrived at No Name Regional Hospital in No Name on Sunday, XXXX 16, 2011 at approximately 2:08 p.m. (Exs. G4, G7). The Claimant's grandmother presented the Claimant's Denali KidCare card to the hospital upon admission (B. P. testimony).

11. The Claimant was crying and complaining of severe pain (Exs. G4, G7). The hospital's emergency department took x-rays of the Claimant's left elbow (Exs. G5, G10). These x-rays revealed the following (Ex. G5):

> Displaced, oblique supraconylar and intracondylar fracture of the distal left humerus consistent with Salter-Harris II. Soft tissue swelling. Joint effusion.

12. The emergency department gave the Claimant morphine and splinted her broken left arm (Exs. G5, G7). The Claimant's care was then transferred to Dr. H (Ex. G5).

13. Dr. H diagnosed the Claimant's injury as a supracondylar fracture of the left humerus (Ex. G5). Dr. H consulted with No Name surgeon Dr. G regarding the Claimant's case (Exs. G5, G6). Dr. G advised that he did not perform the surgery needed by the Claimant, and recommended that the Claimant be referred to an orthopedic specialist in No Name or Seattle (Exs. G5, G6). Dr. H advised B. P. of this at approximately 5:00 p.m. (B. P. testimony).

14. Dr. H then made a few telephone calls, and Dr. R in No Name agreed to accept the Claimant as a patient (Ex. G6). At about 5:30 p.m. Dr. H met with B. P. in the waiting room and asked if she and the Claimant could make a flight to No Name later that evening (B. P. testimony). Dr. H's nurse brought out a phone book, and B. P. called Alaska Airlines and made reservations for a 7:30 p.m. flight to No Name (B. P. testimony). She had never made arrangements for Medicaid travel before, and nobody at the hospital said anything about calling ACS or U.S. Travel (B. P. testimony).

15. A copy of an e-mail confirmation letter from Alaska Airlines, sent at 6:18 p.m. on Sunday, XXXX 16, 2011, indicates that a flight was booked for J. P., B. P., and the Claimant just prior to that time (Exs. F1, H1). The flight was scheduled to depart No Name at 7:45 p.m. and arrive in No Name at 9:29 p.m. later that evening (Exs. F1, H1).

16. The cost of the airline tickets was $300.70 per person, for a total of $902.10 (Exs. F1, H1). The airline tickets were charged to / paid for by J. P.'s Visa card (Ex. H2).

17. Neither the referring hospital (No Name) nor the receiving hospital (No Name) contacted U.S. Travel to request prior authorization for the Claimant's (or her escort's) travel from No Name to No Name on October 16, 2011 (Bigelow, Boyer-Wood, and Walters testimony).

18. After the airline reservations were made and the plane tickets were charged, Dr. H and/or a nurse counseled the Claimant regarding proper care of her arm, and discharged the Claimant at about 6:30 p.m. in "stable" and "good" condition (Exs. G5, G9).

19. The Claimant and her grandparents flew to No Name later that evening (J. P. testimony). Surgery was performed in No Name on Monday, October 17, 2011 to mend the Claimant's broken left arm (Boyer-Wood testimony).

20. On October 18, 2011 the Claimant's parents or grandparents (i.e. not her provider) requested retroactive Medicaid authorization and payment (i.e. reimbursement) of the airfare for the flight from No Name to No Name on Sunday, October 16, 2011 (Ex. E-1; undisputed hearing testimony). On October 19, 2011 Alaska Medicaid received a prior authorization request for return travel from No Name to No Name for the Claimant and one escort (Boyer-Wood testimony). The prior authorization request for the return travel was approved by Alaska Medicaid and is not at issue in this case (Boyer-Wood testimony).

21. At the hearing of January 12, 2012 C. P. testified in relevant part as follows:

a. He has had a child participating in the Denali KidCare Program for over ten (10) years. Never during that time did ACS or the Division advise him or give him literature regarding the procedures to be followed in arranging Medicaid-funded travel.

b. It was not his family's responsibility to obtain prior travel authorization, it was No Name Regional Hospital's responsibility.

22. At the hearing of January 12, 2012 J. P. testified in relevant part as follows:

a. Both he and his wife accompanied the Claimant to No Name, but they are only seeking reimbursement for the airfare of the Claimant and for one escort.

b. It was not his family's responsibility to obtain prior travel authorization, it was No Name Regional Hospital's responsibility.

23. At the hearing of January 12, 2012 Kristina Walters testified in relevant part as follows:

a. The medical provider is the entity which determines whether Medicaid travel is emergency travel or non-emergency travel. In this case, because the hospital did not seek prior authorization, the travel was not classified by the hospital as either emergency travel or non-emergency travel. However, there is no indication from the hospital records that the doctor felt that emergency travel was necessary in this case.

b. It is the medical provider's responsibility to request prior authorization of Medicaid-funded travel. It is not the responsibility of the Medicaid recipient to do so.

c. The Claimant had never previously utilized Medicaid-funded travel services. Accordingly, the P.s had no previous experience with Medicaid travel's prior authorization procedures.

d. She is not aware of any statute, regulation, or policy in the Medicaid travel program which would authorize a Medicaid recipient to book travel without prior authorization, pay for that travel, and then seek reimbursement of the travel expenses from Medicaid.

e. Had the Claimant's medical provider submitted a prior authorization request for the Claimant's travel on October 16, 2011, the request would have been approved.

24. At the hearing of January 12, 2012 Shelly Boyer-Wood testified in relevant part:

a. The Division does not assert that the travel at issue was not medically necessary. The Division asserts only that the Claimant did not obtain prior authorization for the travel.

b. It is the responsibility of the Medicaid recipient (or, if a minor, the parent or guardian) to be aware of the rules and regulations pertaining to the Medicaid and Denali KidCare programs.

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

This case involves the Division's de-facto denial of a claimant's request for retro-active authorization of Medicaid travel benefits. The party seeking a change in the status quo or existing state of affairs normally bears the burden of proof. [4] 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.

A party in an administrative proceeding can assume that preponderance of the evidence is the applicable standard of proof unless otherwise stated. [5] 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. 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.[6]

II. The Medicaid Program – In General.

Medicaid was established by Title XIX of the Social Security Act in 1965 to provide medical assistance to certain low-income needy individuals and families. 42 U.S.C. § 1396 *et. seq*.

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

5 *Amerada Hess Pipeline Corp. v. Alaska Public Utilities Commission*, 711 P.2d 1170 (Alaska 1986).

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

Medicaid is a cooperative federal-state program that is jointly financed with federal and state funds. *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 501, 110 S.Ct. 2510, 110 L.Ed.2d 455 (1990). Medicaid is, in the words of the late Judge Friendly, "a statute of unparalleled complexity." *DeJesus v. Perales*, 770 F.2d 316, 321 (2nd Cir. 1985).

On the federal level, the Secretary of the U.S. Department of Health and Human Services ("HHS") administers the Medicaid Program through the Centers for Medicare & Medicaid Services ("CMS"), formerly known as the Health Care Financing Administration ("HCFA"). Because Medicaid is a federal program, many of its requirements are contained in the Code of Federal Regulations (CFRs) at Title 42, Part 435 and Title 45, Part 233. The Medicaid Program's general eligibility requirements are set forth at 42 C.F.R. Sections 435.2 – 435.1102.

The Alaska Department of Health and Social Services administers the Medicaid program on the state level. Alaska's statutes implementing the federal Medicaid program are set forth at A.S. § 47.07.010 – A.S. § 47.07.900. Alaska's regulations implementing the Medicaid program are set forth in the Alaska Administrative Code at Title 7, Chapters 43 and Chapters 100 – 160.

III. Medicaid Transportation and Accommodation Services.

Pursuant to 42 C.F.R. § 431.53, a state Medicaid plan must (a) specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and (b) describe the methods that the agency will use to meet this requirement.

Under federal law, a Medicaid agency may "place appropriate limits on a service based on criteria such as medical necessity or utilization control." 42 C.F.R. § 440.230(D). "A prior authorization system is one of the accepted utilization control procedures that can be employed as a limitation on the service provided to medical recipients." *Jeneski v. Myers*, 209 Cal.Rptr. 178, 187 (Cal. App. 2nd Div. 1984).

The Alaska state Medicaid regulations governing medical transportation and accommodation services are located primarily at 7 A.A.C. § 120.400 - 7 A.A.C. § 120.490.

7 A.A.C. § 105.130, titled "Services Requiring Prior Authorization," provides in relevant part as follows:

> (a) Except as otherwise provided in 7 AAC 105 - 7 AAC 160, the department will not pay for the following services unless the department has given prior authorization for the service:
>
> > (1) nonemergency, medically necessary transportation and accommodation services . . . .
>
> . . . .
>
> (b) Except as provided in 7 AAC 140.320, failure to obtain the required prior authorization may result in nonpayment, regardless of the eligibility of the recipient or the appropriateness of the services.
>
> (c) For prior authorization, factors that the department will consider include the service's medical necessity, clinical effectiveness, cost-effectiveness, and likelihood

> of adverse effects, as well as service-specific requirements in 7 AAC 105 - 7 AAC 160 . . . .
>
> (d) The department may pay for a service under (a) of this section without prior authorization if prior authorization was not possible before the service was provided....

7 A.A.C. § 120.405, titled "Transportation and Accommodation Covered Services," provides in relevant part as follows:

> (a) The department will pay a provider for only those transportation and accommodation services that are (1) provided to assist the recipient in receiving medically necessary services; and (2) authorized by the department under 7 AAC 120.410 and 7 AAC 120.415.
>
> (b) The department may approve transportation and accommodations outside the recipient's community of residence to obtain medically necessary services for the recipient if (1) those services are not available in the recipient's community....
>
> (c) The department will not pay for (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 . . . . (5) transportation and accommodations on weekends if . . . (B) the department did not give prior authorization for the weekend travel; or (C) the weekend travel is not medically necessary . . . .

7 A.A.C. § 120.410, titled "Prior Authorization for Nonemergency Transportation Services," provides in relevant part as follows:

> (a) Except as provided in (d) of this section, and except for transportation services subject to prior authorization under 7 AAC 110.205(c) and (d), transportation and accommodation services that are not required by a medical emergency must receive prior authorization from the department before the time that the service is provided.
>
> (b) The recipient's health care provider shall request prior authorization for medically necessary transportation and accommodations on behalf the recipient by submitting the request to the department . . . .
>
> . . . .
>
> (d) The department will pay for nonemergency transportation and accommodation services provided without prior authorization if (1) a recipient is forced to change authorized travel plans for reasons beyond the recipient's control, including the cancellation of an airline flight due to weather conditions or the closing of an airport for security reasons; or (2) the medical service for which the recipient traveled reveals the need for additional services, screening, or treatment that requires the recipient to stay longer than previously approved.

7 A.A.C. § 120.430, titled "Authorized Escort," provides in relevant part as follows:

> (a) The department will approve transportation and accommodation services for an authorized escort to accompany a recipient during travel authorized by the department for medical treatment if (1) the recipient is 17 years of age or younger; or
>
> . . . .
>
> (b) All transportation and accommodation services for an authorized escort must be approved by the department before the time that the transportation and accommodation services are provided. The recipient's health care provider must request authorization for an escort at the same time transportation and accommodation services are requested for the recipient . . . .

ANALYSIS

Introduction: Undisputed Facts and Definition of Issue.

The facts of this case are essentially undisputed. The Claimant and her grandparents flew from No Name to No Name on Sunday, October 16, 2011 to obtain non-emergency medical treatment for the Claimant (*see* Findings of Fact at Paragraphs 15-19). The Claimant's medical provider did not obtain prior authorization for Medicaid funding for this travel prior to the flight. *Id.* The Claimant's parents and grandparents had no knowledge of any prior authorization requirement for Medicaid-funded travel (*see* Findings of Fact at Paragraphs 14, 21). Even had they known about the prior authorization requirement, they would not have been permitted to obtain prior authorization because prior authorization must be obtained by the health care provider (*see* Findings of Fact at Paragraphs 6, 23(b)). The Claimant's grandparents paid the airfare for the flight from No Name to No Name in the amount of $300.70 per person. *Id.*

The Claimant is requesting reimbursement for the cost of the airfare for herself and one adult escort ($601.40) (*see* Findings of Fact at Paragraph 22(a)). Accordingly, the issue to be determined is whether the Division was correct to deny the Claimant's request for reimbursement for non-emergency travel, which was not previously authorized by Medicaid, when the failure to obtain prior authorization was due to no fault of the Claimant.

I. The Regulations Require Prior Authorization Unless Obtaining it Would not be Possible.

The regulations applicable to this case are clear. The department will not pay nonemergency, medically necessary transportation and accommodation services unless the department has given prior authorization for the service. *See* 7 A.A.C. § 105.130(a)(1), 7 A.A.C. § 120.405(c), and 7 A.A.C. § 120.410(a). This is the case even where the recipient is otherwise eligible and the travel is otherwise appropriate. *See* 7 A.A.C. § 105.130(b).

The only exception to the prior authorization requirement is in situations in which "prior authorization was not possible before the service was provided . . . ." *See* 7 A.A.C. § 105.130(b). Examples of two specific situations in which prior authorization is not deemed possible, (which are not applicable here), are set forth in 7 A.A.C. § 120.410(d).

In this case there was certainly not an over-abundance of time between the time the doctor determined that the Claimant should be flown to No Name, and the time that the flight from No Name to No Name was scheduled to depart. *See* Findings of Fact at Paragraphs 13-15. However, based on the testimony of Ms. Bigelow and Ms. Walters, it is clear that prior authorization *could* have been obtained in this case had it been sought. *See* Findings of Fact at Paragraphs 3-5. Because it was possible to obtain prior authorization for the travel at issue in this case, the prior authorization requirement applies pursuant to 7 A.A.C. § 105.130(a)(1), 7 A.A.C. § 120.405(c), and 7 A.A.C. § 120.410(a).

II. The Prior Authorization Requirement Applies Even Though the Claimant was not at Fault.

It is the medical provider's responsibility to request prior authorization of Medicaid-funded travel. *See* Findings of Fact at Paragraph 23(b) It is not the responsibility of the Medicaid recipient to do so. *Id.* Hospitals such as No Name Regional Hospital and No Name Hospital are familiar with Medicaid prior authorization requirements (Walters testimony). They are aware that they should call ACS or U.S. Travel, to obtain prior authorization, whenever a Medicaid recipient needs to travel to obtain medical treatment (Boyer-Wood and Walters testimony). Accordingly, it is clear that it was not the Claimant's fault that prior authorization was not obtained for the flight from No Name to No Name.

Unfortunately, the regulations provide no exception to the prior authorization requirement for those situations (like this one) in which the health care provider fails to act (see Principles of Law at pp. 7-9, above). Further, in *Burke v. Houston NANA, L.L.C.*, 222 P.3d 851, 868 – 869 (Alaska 2010), the Alaska Supreme Court stated that an administrative agency is "bound by [its] regulations just as the public is bound by them." Accordingly, pursuant to the *Burke* decision, the Division does not have the discretion to relax or make exceptions to the Medicaid travel program's prior authorization requirement on a case-by-case basis. Finally, the *Burke* decision also prevents this Office from making a special exception to the prior authorization requirement on behalf of the Claimant.

CONCLUSIONS OF LAW

1. Because the Claimant's medical provider failed to obtain prior authorization for the Claimant's nonemergency, medically necessary air travel, and because it was not impossible for the Claimant's medical provider to obtain prior authorization under the circumstances of this case, the Claimant and her escort are not eligible for reimbursement of their airfare pursuant to Alaska Medicaid regulations 7 A.A.C. § 105.130(a)(1), 7 A.A.C. § 120.405(c), and 7 A.A.C. § 120.410(a).

2. Even though the failure to obtain prior travel authorization was the fault of the Claimant's medical provider(s), and was not due to any fault of the Claimant or her parents or grandparents, neither the Division nor this Office have the authority to create an exception to the prior authorization requirement so as to reimburse the Claimant for the airfare at issue in this case.

DECISION

The Division was correct to deny the Claimant's request for reimbursement for airfare, in the amount of $300.70 per person, for the minor Claimant and one adult escort, for non-emergency travel from No Name to No Name which occurred on Sunday, October 16, 2011.

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. 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. To appeal, send a written request directly to:

Director, Division of Health Care Services
Department of Health and Social Services
4501 Business Park Boulevard, Suite 24
No Name, Alaska 99503-7167

DATED this 23rd day of May, 2012.

/Signed/
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on May 23, 2012 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 secure / encrypted e-mail, as follows:

Claimant (via Certified Mail, Return Receipt Requested)

Gerry Johnson, DHCS Hearing Representative
Shelly Boyer-Wood, DHCS Hearing Representative

Kimberli Poppe-Smart, Director, DHCS
Erin E. Walker-Tolles, Public Assistance Program Officer
Joy Dunkin, Training Specialist III
Kari L. Lindsey, Administrative Assistant II

By: */Signed/*
J. Albert Levitre, Jr.
Law Office Assistant I