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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. 10-FH-2215
)
Claimant.) DHCS Case No. [REDACTED]
___________________________________)

FAIR HEARING DECISION

STATEMENT OF THE CASE

[REDACTED] (Claimant) was a recipient of Medicaid benefits (undisputed hearing testimony). On May 26, 2010 the State of Alaska Division of Health Care Services (DHCS or Division) mailed a notice to the Claimant advising that she had been placed in the Care Management Program for twelve months of eligibility starting July 1, 2010 (Exs. D-1, D-2). [1] The Claimant requested a fair hearing with regard to the Division's action on June 16, 2010 (Ex. C-1).

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

A hearing was held as scheduled on July 27, 2010 before Hearing Examiner Jay Durych. The Claimant participated in the hearing by telephone, represented herself, and testified on her own behalf. [REDACTED], Medical Assistance Administrator III for the State of Alaska Division of Health Care Services, attended the hearing in person to represent DHCS. Also present for DHCS, as either witnesses or observers, were Medical Assistance Administrator III [REDACTED] of DHCS, [REDACTED] of Affiliated Computer Services, Inc. (ACS), [REDACTED], R.N. of ACS, and [REDACTED] of ACS. [REDACTED], [REDACTED], and [REDACTED] were sworn and testified in that order. All testimony offered by the witnesses at hearing was admitted into evidence.

DHCS then requested that its hearing exhibits be admitted into evidence. The Claimant objected to DHCS' Ex. E-4, asserting that if that summary were admitted, then the rest of the Claimant's medical records for the period in question should also be admitted for context.

[1] To be precise, the notice which was sent to the Claimant was actually prepared and mailed by Affiliated Computer Services, Inc. (ACS). However, it was not disputed that ACS performed the actions in question on behalf of DHCS. Accordingly, the actions of ACS are legally attributable to DHCS.

The Claimant's objection was sustained.[2] The Division's exhibits were admitted into evidence. However, the Division was ordered to provide the Claimant with a copy of all medical records that it considered in making its decision to refer the Claimant to the Care Management Program. The Division was ordered to provide the records at issue to the Claimant by Friday, August 13, 2010. The Claimant was given until Friday, August 27, 2010 to review those records and to file with this Office the specific pages of those records which she wished this Office to consider.

The Claimant did not provide this Office with any additional medical records. Neither did she advise this Office that the Division had failed in any way to comply with this Office's order regarding the production of medical records. Accordingly, on August 27, 2010 the record in this case was closed and the case was deemed submitted for decision.

ISSUE

Was the Division correct when, on May 26, 2010, it mailed a notice to the Claimant advising that she had been placed in the Care Management Program for twelve months of eligibility starting July 1, 2010?

SUMMARY OF DECISION

The Claimant's over-use use of medical services justified her placement in the Care Management Program pursuant to 7 AAC 105.600(b-c). The Division was therefore correct when on May 26, 2010 it mailed a notice to the Claimant advising that she had been placed in the Care Management Program for twelve months of eligibility starting July 1, 2010.

FINDINGS OF FACT

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

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

2. Prior to April 19, 2010 Affiliated Computer Services, Inc. (ACS) performed a Phase 1 and Phase 2 review of the Claimant's utilization of Medicaid services to determine whether the Claimant was an appropriate candidate for the Care Management Program (████ testimony; █████ testimony).

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[2] See Rule 106 of the Alaska Rules of Evidence: "When a writing or recorded statement or part thereof is introduced by a party, an adverse party may require the introduction at that time of any other part or any other writing or recorded statement which ought in fairness to be considered contemporaneously with it." While the formal rules of evidence generally do not apply in administrative hearings (*see Racine v. State, Dept. of Transp. and Public Facilities,* 663 P.2d 555 (Alaska 1983), the Alaska Supreme Court has indicated that formal rules may be applied where necessary to satisfy due process requirements (*see Stigall v. Anchorage Municipality Police and Fire Retirement Board*, 718 P.2d 943 (Alaska 1986). In this case, statistical analysis played a significant role in the Division's decision to refer the Claimant to the Care Management Program (see Findings of Fact, below). Accordingly, in the particular factual context of this case, due process required that the Claimant be given *an opportunity* to prove that the records chosen as exhibits by the Division were not representative and/or that the Division's statistical analysis was flawed. The fact that the Claimant ultimately chose not to provide this Office with any additional medical records is not relevant.

3. As explained in more detail below, ACS' "Phase 1" review demonstrated a statistically exceptional frequency of use of several categories of medical items and services by the Claimant. ACS' "Phase 2" review of the Claimant's utilization of Medicaid services documented that the Claimant should be placed into the Care Management Program (Exs. D-1 through D-27; Exs. E-1 through E-9).

4. On April 19, 2010 a physician from the Patients First Medical Clinic completed ACS' Provider Care Statement for Care Management Program (Ex. E-1). The physician stated that he agreed that the Claimant "would benefit from the Care Management Program," and that he was "willing to provide [the Claimant] with basic medical care while [she was] in the Care Management Program." *Id.*

5. On May 26, 2010 ACS' clinical reviewer [redacted], R.N. completed a Care Management Program Phase 2 Medical Review Summary on the Claimant (Exs. E-2 through E-5). That summary provides in relevant part as follows:

> . . . . This recipient was chosen for a full review as there were multiple "exceptions" that were represented from the statistical analysis of Medicaid services provided in ACS' Phase 1 Initial Review. Exceptions occur when the recipient exceeds their peer group norm. Exceptions are computed at two times the standard deviation plus the peer group average for each report. Exceptions are defined in [7 AAC 105.600].
>
> Exceptions. [The Claimant] "excepted-out" in 10 areas during the 15 month review. [These were]: [1] number of rendering physicians, [2] number of rendering pharmacies, [3] number of drug prescriptions, [4] number of different drugs, [5] number of different RX controlled drugs, [6] number of physician office visits, [7] number of emergency room visits, [8] number of prescribers [for] all RX drugs, [9] number of prescribers [for] controlled drugs, [and] [10] number of different diagnosis codes.
>
> [Exceptions 1, 2, and 6, above] are the focus of this review and will be evaluated using the following criteria: concurrent care with other provider, closely adjoining dates of service with other providers, same date-of-service with other providers for same/similar presenting complaint, diagnosis and consistency of medical history provided, [and] prescription medication activity/compliance with recommended treatment.
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> * * * * * * * * * * * *
>
> Medical History and Conditions. [The Claimant] has a documented medical history that includes but is not limited to: asthma, reflux esophagitis, and morbid obesity. Her surgical history that is documented includes, but is not limited to: C-sections, tonsillectomy, right knee surgery and gallbladder surgery.
>
> During the fifteen month review, [the Claimant] was diagnosed with 70 different ICD-9 codes . . . . This statistical analysis does not dispute the formal diagnoses that have been recognized by qualified medical providers. This analysis does expose difficulties with continuity of care and many inconsistencies that are documented in the medical records submitted . . . .

Medical Facilities: Usage and Treatment. [The Claimant] has sought the services of 35 providers and 9 pharmacies over the review period. Records were received and reviewed from each of the medical facilities to complete this statistical analysis . . . .

. . . . [The Claimant] has received many medical evaluations, diagnostic tests, and referrals to specialists. One of the complications from her medical care that is evidenced in the records is a concern of "non-compliance' for medical therapies recommended for her chronic pain condition.

Therapies and treatments have been mainly pharmacological in nature. Ongoing care along with numerous clinic and emergency department visits have resulted in narcotic injections and prescription medications from multiple classifications . . . .

* * * * * * * * * * * *

Summary of Findings. After careful consideration of [the Claimant's] age diagnosis, complications of medical conditions, chronic illnesses, number of different physicians and hospitals, and type of medical care received, [the Claimant's] activity illustrates and corroborates multiple exceptions [11]. This review finds numerous concerns as follows:

1. Concurrent care and/or closely adjoining dates of service and/or same date of service for same/similar presenting complaint.

2. Confirmation of all exceptions has been validated with this review of [the Claimant's medical records].

3. No documentation is present to indicate if providers were aware of their colleagues' prescription activity with [the Claimant].

4. Confirmation of exceptions related to pharmacy providers used by [the Claimant]. No documentation is present or could be located to justify multiple pharmacy use over and above standard.

5. The need to create an ongoing relationship with one provider to establish formal "continuity of care" to better meet required medical needs has been identified.

Recommendation. Following an extensive review of records submitted to [ACS], and concurring with providers who returned ACS' *Provider Statement* for Care Management Program, our Registered Nurse Clinical Reviewer has determined that [the Claimant] has met criteria for placement in the Care Management Program . . . . [The Claimant] has used an item or service paid for under Medicaid or General Relief Medical Assistance at a frequency or in an amount that is not medically necessary . . . . It is further noted that [the Claimant's] continuity of care and medical service needs can safely and efficiently be met by formal assignment to the State of Alaska's Medical Assistance Care Management Program.

6. On May 26, 2010 ACS mailed to the Claimant a Notice of Placement in the Care Management Program, with supporting documentation (Exs. D-1 through D-16). The notice stated in relevant part as follows:

* * * * * * * * * * * *

> Due to your usage of Medicaid services, a report was generated and has been assessed by [ACS] on behalf of [DHCS]. This report showed that from January 2009 to March 2010 your use of the following exceptions exceeded the usage of services by those in your peer group of adults age 19-34:
>
> Number of rendering physicians, number of rendering pharmacies, number of drug prescriptions, number of different drugs, number of different RX controlled drugs, number of physician office visits, number of emergency room visits, number of prescribers [for] all RX drugs, number of prescribers [for] controlled drugs, [and] number of different diagnosis codes. [3]
>
> A clinical review performed by a qualified health care professional found that your usage of the above listed areas during January 2009 to March 2010 was at a level that is not medically necessary. These services have been found to be not medically necessary because:
>
> > 1. Concurrent care and/or closely adjoining dates of service and/or same date of service for same/similar presenting complaint.
> >
> > 2. Confirmation of all exceptions has been validated with this review of [the Claimant's medical records].
> >
> > 3. No documentation is present to indicate if providers were aware of their colleagues' prescription activity with [the Claimant].
> >
> > 4. Confirmation of exceptions related to pharmacy providers used by [the Claimant]. No documentation is present or could be located to justify multiple pharmacy use over and above standard.
> >
> > 5. The need to create an ongoing relationship with one provider to establish formal "continuity of care" to better meet required medical needs has been identified. [4]

* * * * * * * * * * * *

> These findings have determined that your choice of providers will be restricted under the Care Management Program (CMP) guidelines of service for twelve months of eligibility starting **July 1, 2010**.

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[3] The text quoted in this paragraph was presented in a dual-column format in the original document. The *format* of this text was changed for inclusion in this decision. However, the *content* of the text in the above paragraph is the same as in the original document.

[4] Numbered items 1 through 5 were printed in bold in the original document.

In accordance with 42 CFR 431.54(e) and 7 AAC 105.600, the following providers have been selected and have agreed to act as your primary providers for the Care Management Program . . . . Physician: [redacted] . . . . Pharmacy: Carrs Pharmacy No. 0520 . . . .

7. On July 27, 2010 [redacted] of Affiliated Computer Services, Inc. credibly testified in relevant part as follows:

a. ACS' role in the Phase 1 Review Process is to perform the analysis of the Claimant's medical treatment "exceptions." The exact mathematical formula which defines an exception is stated in the applicable regulations. In simple terms, "exceptions" are defined as twice the standard deviation plus the Claimant's peer group average.

b. "Exceptional" activity generally identifies only the top 2% to 3% of utilization in any particular medical services category.

c. If a Phase 1 review appears to indicate over-utilization, a 15 month window of utilization activity is next reviewed. This larger sample period is then analyzed to either confirm or refute the initial (Phase 1) finding of over-utilization. This is the process that ACS followed in the Claimant's case and in all other cases.

d. In this case, ACS initially identified the Claimant as a candidate for the Care Management Program through a statistical analysis of the Claimant's utilization of medical items and services (i.e. by the identification of "exceptions"). The period examined in this case was January 1, 2009 through March 31, 2010.

e. Exhibits D-5 through D-16 show the evidence considered by ACS in the Phase 1 review. ACS' "Phase 1" review demonstrated a statistically exceptional frequency of use of several categories of medical items and services by the Claimant.

f. As indicated by Exhibit D-6, the Claimant ranked 32nd out of over 11,000 individuals in her peer group (persons aged 19-34) in terms of utilization of medical items and services.

g. As indicated by Exhibit D-6, the Claimant had a total of 35 exceptions during a 15 month period. *Any one (1) of those exceptions would make her eligible for placement in the Care Management Program.*

h. As indicated by Exhibits D-10 through D-12, the Claimant used 35 different medical providers during a 15 month period. Exhibit D-10 documents both emergency room visits and in-patient care stays. Even so, the use of this many medical providers indicates an over-utilization of medical services.

i. As indicated by Exhibit D-10, the Claimant used nine (9) different pharmacies during the 15 month sample period. In addition, the Claimant received narcotics from a number of different issuers instead of from a single primary source of care. This indicates an over-utilization of prescription medications.

j. The Claimant had a fairly low percentage of visits to primary care providers, and a fairly high percentage of emergency room visits. This is another indication of over-utilization of medical services.

8. On July 27, 2010 [redacted], R.N. of Affiliated Computer Services, Inc. credibly testified in relevant part as follows:

a. She is a registered nurse with 36 years' experience. She is employed by ACS. She is a clinical reviewer.

b. Once the Phase 1 review has been completed, it is her job to review the medical records to confirm the exceptions identified in the Phase 1 analysis.

c. The Phase 2 review process is where the exceptions previously found in Phase 1 are reviewed for concurrent care with other providers, closely adjoining dates of service with other providers, diagnosis and consistency of medical history provided, prescription medicine activity, and compliance with recommended medical treatment.

d. Her Phase 2 review in this case covered the period January 1, 2009 through March 31, 2010. As part of her Phase 2 review she reviewed every medical record for every one of the Claimant's dates of service during the period January 1, 2009 through March 31, 2010. She analyzed how the Claimant used her medical items or services, and whether that usage was medically necessary.

e. She prepared a Care Management Program Phase 2 Medical Review Summary on the Claimant (Exs. E-2 through E-5). In reaching her conclusions regarding the lack of medical necessity for many of the medical services received by the Claimant during the period in question, she considered the Claimant's age, the Claimant's diagnosis, complications of the Claimant's medical conditions, the Claimant's chronic illnesses, the number of different physicians and hospitals used by the Claimant, and the type of medical care received by the Claimant.

f. In reviewing the Claimant's medical records she found multiple instances of concurrent care and non-compliance with recommended medical treatment.

9. At the hearing of July 27, 2010 the Claimant testified in relevant part as follows:

a. She is not the average 19-34 year old. She is only 30 years old, but she has had over 200 surgeries. She has so many health problems that the portion of her medical bills which were not covered by insurance, alone, total more than one million dollars.

b. She had two surgeries in 2008. In 2009 she had three surgeries within approximately six months. A week following her March 23, 2009 Emergency Room visit, the Claimant had to have her gallbladder removed.

c. The reason she has seen so many different doctors is that her primary care physician will refer her to different specialists for her various medical problems, and then those specialist physicians will sometimes in turn refer her to another doctor.

d. The reason she has used a number of different pharmacies has to do with her having a baby and with transportation issues. She goes to the pharmacy nearest where she is at the time, rather than going to a single pharmacy which may be all the way across town.

e. She has so many different doctors' orders / recommended treatments that she cannot possibly comply with them all. If she did, she would never be able to leave the hospital.

f. She has no problem with Dr. [redacted] as her primary care physician, except in that he will not allow her to see another primary care physician who has been caring for her mental health needs. She is very concerned that changing her mental health provider will adversely affect her treatment and her mental health status; she is worried that it will make her suicidal.

PRINCIPLES OF LAW

I. Burden of Proof and Standard of Proof.

This case involves the Division's placement of the Claimant into its Medicaid Care Management Program. The party seeking a change in the status quo or existing state of affairs normally bears the burden of proof. [5] Here, the Division is attempting to change the existing state of affairs by referring the Claimant into the Care Management Program. Accordingly, the Division 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. [6] 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. [7]

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 USC § 1396 et. seq. 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). It is the primary public program for financing basic health and long-term care services for low-income Alaskans. *See* DPA website at http://health.hss.state.ak.us/dpa/programs/medicaid/ (date accessed July 31, 2009). The Medicaid program is administered in Alaska by the Department of Health and Social Services' Division of Health Care Services (DHCS). *Id.*

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

6 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).

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

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 CFR Sections 435.2 – 435.1102.

The State of Alaska's statutes implementing the federal Medicaid program are set forth at A.S. 47.07.010 – A.S.47.07.900. The State of Alaska's regulations implementing the Medicaid program are set forth in the Alaska Administrative Code at Title 7, Chapters 43 and Chapters 100 – 160.

<u>III. The Medicaid Care Management Program – Relevant Federal Regulations.</u>

42 C.F.R. § 456.3, titled "Statewide Surveillance and Utilization Control Program," provides in relevant part as follows:

> The Medicaid agency must implement a statewide surveillance and utilization control program that (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; (b) Assesses the quality of those services; (c) Provides for the control of the utilization of all services provided under the plan in accordance with Subpart B of this part; and (d) Provides for the control of the utilization of inpatient services . . . .

42 C.F.R. § 431.54, titled "Exceptions to Certain State Plan Requirements," provides in relevant part as follows:

> (e) Lock-in of recipients who over-utilize Medicaid services. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only. The agency may impose these restrictions only if the following conditions are met: (1) The agency gives the recipient notice and opportunity for a hearing . . . before imposing the restrictions. (2) The agency ensures that the recipient has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services of adequate quality. (3) The restrictions do not apply to emergency services . . . .

<u>IV. The Medicaid Care Management Program – Relevant State Statutes and Regulations.</u>

Alaska Statute (AS) § 47.07.030, titled "Medical Services to be Provided," states in relevant part as follows:

> (d) The department may establish as optional services a primary care case management system or a managed care organization contract in which certain eligible individuals are required to enroll and seek approval from a case manager or the managed care organization before receiving certain services. The department shall establish enrollment criteria and determine eligibility for services consistent with federal and state law.

Alaska Administrative Code § 7 AAC 105.600, titled "Restriction of Recipient's Choice of Providers," states in relevant part as follows:

> (a) The department may restrict a recipient's choice of medical providers if the department finds that a recipient has used Medicaid services at a frequency or amount that is not medically necessary as provided in (b) and (c) of this section.
>
> (b) In order for a recipient to be identified as a potential candidate for restriction under this section, *one of the following* must occur: [8]
>
>> (1) a referral is made . . . indicating that the recipient has used a medical item or service at a frequency or amount that is not medically necessary;
>>
>> (2) the recipient receives prescriptions from one or more providers for medication in total average daily doses that exceed those recommended in *Drug Facts and Comparisons*, adopted by reference in 7 AAC 160.900;
>>
>> (3) the recipient, during a period of not less than three consecutive months, uses a medical item or service with a frequency that exceeds two standard deviations from the arithmetic mean of the frequency of use of the medical item or service by recipients of medical assistance programs administered by the department who have used the medical item or service as shown in the department's most recent statistical analysis of usage of that medical item or service.
>
> (c) Once a recipient is identified under (b) of this section, the department will conduct an individualized clinical review of the recipient's medical and billing history to determine how the recipient has used the disputed medical item or service and whether that usage was medically necessary. The review must be conducted by a qualified health care professional. The reviewer shall consider (1) the recipient's age; (2) the recipient's diagnosis; (3) complications of the recipient's medical conditions; (4) the recipient's chronic illnesses; (5) the number of different physicians and hospitals used by the recipient; and (6) the type of medical care received by the recipient.
>
> (d) If after the review under (c) of this section is complete the reviewer determines that the recipient's use of a medical item or service is not medically necessary, the department will (1) monitor the recipient's usage for 90 days; or (2) notify the recipient in writing that the department will restrict a recipient's choice of provider as provided in (e) of this section.
>
> (e) If the department determines that it is necessary to restrict a recipient's choice of provider under (d)(2) of this section, the department will first offer the recipient the opportunity for a fair hearing in accordance with 7 AAC 49. The department may immediately restrict the recipient's choice of providers if the recipient does not request a

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[8] 7 AAC 105.600(b) contains what ACS' analysis refers to as the "Phase 1" criteria (█ testimony). As indicated in the regulation, *the Division need prove only one (1) of the three (3) alternate criteria in order to advance to the "Phase 2" analysis.* The factors considered in the "Phase 2" analysis are set forth in subsection (c) of 7 AAC 105.600 (█ testimony).

hearing 30 days or less after receiving notice of the department's intent to impose a restriction.

(f) If the department prevails after a fair hearing or the recipient does not request a fair hearing 30 days or less after receiving notice of the department's intent to impose a restriction, the department will select one primary care provider and one pharmacy within reasonable proximity to the recipient's home. The department will mark the recipient's identification card or medical coupons with the word "RESTRICTED" and the name of the designated provider and pharmacy. The recipient may obtain services and items from only the designated provider and pharmacy, except as follows: (1) the recipient may receive medical services from another enrolled provider if the designated provider refers the recipient to the other enrolled provider; (2) the recipient may receive emergency services from any enrolled provider . . . .

(g) The department may only restrict provider choice for a reasonable period of time, not to exceed 12 months of eligibility. The department will review the restriction annually. If the department determines that the restriction should extend beyond 12 months of eligibility, the department will provide the recipient notice and an opportunity for a new fair hearing under (d)(2) and (e) of this section.

(h) The designation of the primary care provider or pharmacy under (f) of this section may be changed only if (1) the primary care provider or pharmacy requests the change; (2) the primary care provider or pharmacy dis-enrolls from the Medicaid program; (3) the recipient moves to a new geographic area; or (4) the department finds that the recipient does not have reasonable access to Medicaid services of adequate quality.

(i) Except as provided in (f) of this section, the department will pay only a provider designated under this section for the provision of medical services to a recipient whose identification card or medical coupons are marked "RESTRICTED."

(j) In this section, "qualified health care professional" means a health care provider who is licensed under AS 08 and whose area of licensure relates to the service or item identified under (b) of this section.

ANALYSIS

The ultimate issue in this case is whether the Division was correct to place the Claimant in the Care Management Program for twelve months of Medicaid eligibility starting July 1, 2010. The criteria for placement into the Care Management Program are set forth in 7 AAC 105.600(b-c).

In order to require placement of the Claimant in the Care Management Program, the Division must first demonstrate that the Claimant meets *at least one (1)* of the three (3) *alternate* "Phase 1" criteria described in 7 AAC 105.600(b). The Division must *then* demonstrate that the Claimant satisfies the "Phase 2" criteria set forth in 7 AAC 105.600(c).

I. The Division Demonstrated That the Claimant Satisfies at Least One of the "Phase 1" Criteria.

The first criterion for placement in the Care Management Program is stated in 7 AAC 105.600(b). That provision requires *either* (1) that one of the Claimant's health care providers advise the Division

that the Claimant has used a medical item or service at a frequency or amount that is not medically necessary, *or* (2) that the Claimant receive prescriptions in total average daily doses that exceed those recommended in *Drug Facts and Comparisons*, *or* (3) that the Claimant, during a period of at least three (3) consecutive months, uses a medical item or service with a frequency that is statistically exceptional. As indicated above, it is not necessary for the Division to show that the Claimant satisfies all three of these criteria. Rather, pursuant to 7 AAC 105.600(b), *Division need only show that the Claimant satisfies one (1) of the three (3) criteria.* [9]

The last of the alternate "Phase 1" criteria is whether the Claimant, during a period of at least three (3) consecutive months, used a medical item or service with a frequency that is statistically exceptional. This is the criterion on which the evidence presented by ACS was primarily focused. This criterion was met, in this case, for the reasons discussed below.

Careful review of the data provided by ACS in this case indicates that the exceptions asserted in a few categories may be inflated due to ACS' practice of counting the several providers working within the same clinic as separate providers. [10] However, *the remainder of the exceptions* identified by ACS *are not* affected by the possible statistical inflation identified above. *The exceptions which are not subject to this possible inflation, and which are thus clearly valid*, are the exceptions concerning the number of rendering pharmacies, the number of drug prescriptions, the number of different drugs, the number of different RX controlled drugs, the number of emergency room visits, and the number of different diagnosis codes. As indicated by Exhibit D-6, the Claimant had a total of 35 exceptions during a 15 month period, with at least one exception in each of the 6 "untainted" categories referenced above. *Any one (1) of those exceptions would make her eligible for placement in the Care Management Program* (███ hearing testimony).

In summary, the Claimant met *at least* one of 7 AAC 105.600(b)'s three *alternative* "Phase 1" criteria (i.e. the third criterion based on the Claimant's statistically exceptional frequency of use of medical items or services). *See* ███ testimony; *see also* Exs. D-1 through D-27 and E-1. Accordingly, it was appropriate for ACS to proceed with a "Phase 2" analysis pursuant to 7 AAC 105.600(c).

II. The Division Also Demonstrated That the Claimant Satisfies the "Phase 2" Criteria.

Pursuant to 7 AAC 105.600(c), ACS was next required to conduct an individualized clinical review of the Claimant's medical history and to determine how the Claimant used the medical items or services, and whether that usage was medically necessary. That "Phase 2" review was required to be conducted by a qualified health care professional and to consider (1) the Claimant's age; (2) the Claimant's

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[9] With regard to the first of the alternate criteria, Dr. ███'s Provider Statement for Care Management Program (Ex. E-1) states only that he "agrees that [the Claimant] would benefit from the Care Management Program." The Provider Statement *does not state,* as required by 7 AAC 105.600(b), that the Claimant has used a medical item or service at a frequency or amount that is not medically necessary. Accordingly, the first Phase 1 criterion is not satisfied here.

The second of the alternate criteria is whether the Claimant received prescriptions in total average daily doses that exceeded those recommended in *Drug Facts and Comparisons*. The Division did not assert, in its Notice of Placement in the Care Management Program (Exs. D-1 through D-16), that the Claimant met this criterion. Accordingly, the second Phase 1 criterion is not satisfied here.

[10] This inflation appears to affect ACS' calculation of exceptions with regard to four of the categories of exceptions that ACS has asserted in this case: the number of rendering physicians, the number of physician office visits, the number of prescribers of all prescription drugs, and the number of prescribers of controlled drugs. *See* Exs. D-1, D-10, D-11, and D-12.

diagnosis; (3) complications of the Claimant's medical conditions; (4) the Claimant's chronic illnesses; (5) the number of different physicians and hospitals used by the Claimant; and (6) the type of medical care received by the Claimant.

In this case, the individualized clinical review of the Claimant's medical history was conducted by [redacted], R.N. of ACS ([redacted] testimony). Ms. [redacted] was qualified to perform this clinical review because (1) she is a "qualified health care professional" under 7 AAC 105.600(j) since she is a registered nurse licensed under AS 08.68.160 - AS 08.68.410; and (2) since she is a registered nurse, her "area of licensure" relates to the medical services at issue under 7 AAC 105.600(b).

Ms. [redacted] reviewed the Claimant's entire medical history for the 15 month period in question, determined how the Claimant used her medical items or services, and determined whether that usage was medically necessary ([redacted] testimony; *see also* Exs. E-1 through E-5). In conducting her analysis, she considered the Claimant's age, the Claimant's diagnosis, complications of the Claimant's medical conditions, the Claimant's chronic illnesses, the number of different physicians and hospitals used by the Claimant, and the type of medical care received by the Claimant. *See* [redacted] testimony; *see also* Ex. E-5). After consideration of all these factors, Ms. [redacted] concluded that the Claimant had over-used Medicaid services (used medical items or services at a frequency or amount not medically necessary), and that the Claimant was therefore eligible for placement in the Care Management Program pursuant to 7 AAC 105.600(b-c). Ms. [redacted]' conclusions appear to be correct based on the statistics and medical records in the hearing record in this case (*see* Exs. D-1 through D-27 and Exs. E-1 through E-9).

III. Summary.

In summary, the Division carried its burden and proved, by a preponderance of the evidence, that the Claimant's over-use of medical services justified her placement in the Care Management Program pursuant to 7 AAC 105.600(b-c). The Division was therefore correct when on May 26, 2010 it mailed a notice to the Claimant advising that she had been placed in the Care Management Program for twelve months of Medicaid eligibility starting July 1, 2010.

CONCLUSIONS OF LAW

1. The Division carried its burden and proved, by a preponderance of the evidence, that the Claimant's over-use of medical services justified her placement in the Care Management Program pursuant to 7 AAC 105.600(b-c).

2. The Division was therefore correct when, on May 26, 2010, it mailed a notice to the Claimant advising that she had been placed in the Care Management Program for twelve months of Medicaid eligibility starting July 1, 2010.

DECISION

The Division was correct when on May 26, 2010 it mailed a notice to the Claimant advising that she had been placed in the Care Management Program for twelve months of Medicaid eligibility starting July 1, 2010.

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, Division of Health Care Services
Department of Health and Social Services
4501 Business Park Boulevard, Suite 24
Anchorage, Alaska 99503-7167

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 15th day of October, 2010.

(signed)
____
Jay Durych
Hearing Authority

CERTIFICATE OF SERVICE

I certify that on this 15th day of October 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 (via Certified Mail, Return Receipt Requested)
[redacted], Fair Hearing Representative

[redacted], Director, DHCS
[redacted], Policy & Program Development
[redacted], Staff Development & Training
[redacted], Eligibility Technician I

(signed)
____
J. Albert Levitre, Jr.
Law Office Assistant I